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Comprehensive Review of the National HIV/AIDS and Opioid Agonist Maintenance Treatment Programmes of Ukraine

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Remote mission report

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Abbreviations

APH	Alliance for Public Health
ART	Antiretroviral therapy
ARV	Antiretroviral
CBO	Community-based organisation
CCM	Country Coordinating Mechanism
CLM	Community-led monitoring
CD4	Cluster of differentiation 4
CDC	Centers for Disease Control and Prevention
CSO	Civil society organisation
DTG	Dolutegravir
DR	Drug resistance
EID	Early Infant Diagnosis
EECA	Eastern Europe and Central Asia
EFV	Efavirenz
EQA	External Quality Assessment
EU	European Union
FSW	Female sex-workers
GARPR	Global AIDS response progress report
GDP	Gross domestic product
The Global Fund	The Global Fund to fight AIDS, TB and Malaria
GHSS	Global Health sector strategies for HIV, viral hepatitis and STIs
HBsAg	hepatitis B surface antigen
HBV	hepatitis B virus
HCV	hepatitis C virus
HIVDR	HIV drug resistance
HPV	human papillomavirus
HTC	HIV testing and counselling
IBBS	Integrated Bio-Behavioural Surveillance
KP	Key population
LAIB	Long-Acting Injectable Buprenorphine
LIMS	Laboratory Information Management System
LQMS	Laboratory Quality Management System
MoF	Ministry of Finance
MoH	Ministry of Health
MoJ	Ministry of Justice
MoVA	Ministry for Veterans Affairs

MSM	men who have sex with men
MTCT	mother-to-child transmission
NEP	Needle and Syringe Exchange Programme
NGO	nongovernmental organisation
NB	non-binary
NHSU	National Health Service of Ukraine
NSP	National Strategic Plan
NSUM	Network scale-up method
OAMT	Opioid Agonist Maintenance Treatment
OI	opportunistic infection
PCR	polymerase chain reaction
PEP	post-exposure prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PFM	Public Financial Management
PHC	primary health care
PIT	provider-initiated testing
PLHIV	people living with HIV
PMG	Programme of Medical Guarantees
PMTCT	prevention of mother-to-child transmission
PrEP	pre-exposure prophylaxis
PSE	population size estimate
PTSD	post-traumatic stress disorder
PWID	people who inject drugs
PWUD	people who use drugs
RDT	rapid diagnostic test
SE MPU	State Enterprise "Medical Procurement of Ukraine"
SW	sex workers
SUD	Substance Use Disorders
TAF	tenofovir alafenamide
TB	tuberculosis
TDF	tenofovir disoproxil fumarate
TG	Transgender
TGW	Transgender women
TPT	tuberculosis preventive therapy
UAH	Ukrainian Hryvnia
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme

UNFPA	United Nations Population Fund
UNODC	The United Nations Office on Drugs and Crime
UPHC	State Institution “Public Health Centre” of the Ministry of Health of Ukraine
USAID	United States Agency for International Development
VL	viral load
WHO	World Health Organization

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1. Executive summary

This report presents a comprehensive review of Ukraine's national HIV and Opioid Agonist Maintenance Treatment (OAMT) programmes, conducted by WHO/Europe at the request of the Ministry of Health (MoH) of Ukraine in September–November 2025. Building on the 2023 assessment, it examines progress and remaining gaps in implementing the National Strategy on HIV/AIDS, Tuberculosis and Viral Hepatitis through 2030 (NS2030) over 2023-2025. The review combines a desk analysis of policies, guidelines, programme data, and partner reports with virtual consultations involving government institutions, regional public health bodies, non-governmental organisations (NGOs), community networks and development partners.

Ukraine's HIV response is guided by NS2030 and aligned with SDG 3.3, WHO/Europe action plans and the 2021 UN Political Declaration on HIV/AIDS. It is embedded in a health system that has undergone major financing and service-delivery reforms, including the establishment of the National Health Service of Ukraine (NHSU) as a single purchaser, the Programme of Medical Guarantees (PMG), and a strong national e-health infrastructure. These reforms have underpinned health-system resilience during full-scale war, large-scale displacement and damage to infrastructure, providing a platform to maintain service coverage and introduce adaptive delivery models.

In Ukraine, the HIV epidemic remains concentrated among key populations (KPs), including people who inject drugs (PWID), men who have sex with men (MSM), and sex workers (SW), with sexual transmission now accounting for most new infections. While HIV prevalence is high in prison settings and among transgender women (TGW), available data suggest these groups play a more limited role in driving overall epidemic dynamics.

The review found that Ukraine's HIV and OAMT programmes remain among well-performing programmes in the WHO European Region. Governance is supported by a coherent legal and policy framework that integrates HIV, OAMT, Tuberculosis and viral hepatitis, with clearly defined institutional roles for MoH, the Public Health Centre of the MOH of Ukraine (UPHC), NHSU, regional CDCs and Centres for Socially Significant Diseases. The Country Coordinating Mechanism (CCM) provides a mature platform for inclusive coordination. Core HIV, harm-reduction and OAMT services have been maintained and adapted through central procurement, flexible supply chains and innovations such as multi-month ART dispensing, mobile and take-home OAMT, telehealth and community-based models. Community networks of PLHIV and PWUD are central to outreach, adherence and continuity of care. PMG and NHSU's purchasing role, backed by strong public

financial management and digital systems, offers a solid basis for commissioning HIV and OAMT within broader UHC reforms.

At the same time, several areas need further strengthening:

- **Governance and coordination**: The policy framework for HIV response requires further advancement to fully eliminate barriers to equitable access, especially for key and vulnerable populations. Strengthening subnational coordination mechanisms is essential to ensure consistent implementation and effective roll-out of HIV response initiatives aligned with national priorities.
- **Financing and sustainability**: HIV and OAMT services are financed through a combination of sources: the PMG, which includes dedicated HIV and OAMT programmes; the state budget programme 'Public Health and Epidemic Control', which funds public health interventions including social contracting with NGOs; and external donors, notably temporary support from the Global Fund. Nevertheless, HIV-related spending is under strain, and prevention, harm-reduction, and community outreach activities remain heavily reliant on external financing. There is scope to increase the share of PMG resources allocated to HIV and OAMT and to adjust capitation rates so that they more closely reflect service-delivery costs, as well as to explore the introduction of pay-for-performance indicators for OHC providers, thereby improving their incentives to contract for HIV and OAMT at the PHC level and supporting more consistent access across regions.
- **Human resources:** Workforce shortages, displacement and ageing, especially in eastern and rural areas, put pressure on service delivery.
- **Information systems and M&E**: Multiple parallel data systems (NGOs, UPHC, NHSU, e-health) have limited interoperability, constraining real-time surveillance, case management across providers and consolidated monitoring of the cascade and KPs. Closer alignment of the M&E framework with WHO regional action plans and more consistent reporting of transmission modes would strengthen accountability and planning.
- **Prevention coverage and equity**: While treatment outcomes among those on ART are strong, prevention coverage remains uneven. Coverage gaps, regional inequities, and operational barriers intensified by the war require focused efforts to reinforce and adapt prevention services. Strengthening service continuity, scaling pre-exposure prophylaxis (PrEP), supporting community-led delivery, and integrating prevention in emerging priority groups, including veterans, displaced populations, and people in closed settings, are essential to sustaining national progress and preventing new HIV infections

- **Access to treatment and care services through greater integration into primary health care**: OAMT, harm reduction and PrEP are not yet fully embedded in PHC packages nationwide, and access for KPs, people in prisons, and emerging groups (e.g. users of new psychoactive substances) varies by geography and availability of external funding.
  Within this context, the report highlights the following strategic directions for the next phase of NS2030 implementation and the Global Fund 2026 funding request:
- **Protect and optimise public funding for HIV and OAMT**. Preserve budget space for core HIV, OAMT and public-health functions; progressively adjust NHSU's HIV and OAMT tariffs to reflect realistic service costs; and further strengthen the role of PHC providers in delivering HIV and OAMT services to encourage uptake by PHC providers and reduce regional inequities.
- **Strengthen governance and human resources to support decentralisation policies**. Address capacity gaps in regional CDCs; institutionalise oblast-level multi-stakeholder coordination platforms; and operationalise the National Public Health HR Development Programme with an early focus on decentralised HIV/OAMT delivery, community-level competencies and PHC leadership.
- **Maintain uninterrupted access to quality-assured commodities and HIV/OAMT services:** Diversify and extend financing arrangements for prevention commodities and OAMT medicines, reinforce quality assurance and pharmacovigilance, and develop practical transition plans for donor-funded services, particularly in prisons and for community-led outreach and prevention. Introduce respectful, rights-based service delivery standards (including KPs) into national quality-of-care frameworks.
- **Integrate data systems and improve M&E**. Move towards an integrated data architecture linking NGO, UPHC, NHSU and e-health platforms; ensure regional CDCs have timely access to consolidated data for planning and contracting; and align surveillance and M&E with NS2030 and WHO regional frameworks.

Overall, the review concludes that Ukraine has demonstrated substantial resilience and innovation in sustaining its HIV and OAMT response under full-scale war, and that institutional foundations are strong enough to absorb and manage a greater share of services within national systems. At the same time, fiscal constraints, workforce pressures, dependence on external funding for prevention and fragmented data systems make continued investment and system strengthening essential. The findings of this review are intended to guide the revision of NS2030 implementation plans and the preparation of Ukraine's Global Fund 2026 funding request, with a focus on resilience, equity and the long-term sustainability of the HIV and OAMT response.

2. Background and Context

2.1 National Strategic and Policy Framework

Ukraine's HIV response is anchored in the National Strategy on HIV/AIDS, Tuberculosis and Viral Hepatitis through 2030 (NS2030) and aligned with SDG 3.3, the WHO/Europe action plans for 2022–2030, and the 2021 UN Political Declaration on HIV/AIDS. This policy alignment provides a coherent framework for ending HIV as a public-health threat by 2030, while responding to the realities of war, displacement, supply-chain volatility, and fiscal pressure.

NS2030 commits to measurable reductions in HIV incidence and mortality, and to equitable access to prevention, testing, treatment, and care. Translating global targets into practice requires embedding prevention (including PrEP), timely testing and linkage, same-day ART initiation, continuity of care, viral load (VL) monitoring, and linkages to OAMT within primary health care (PHC) and the national purchasing architecture. The Program of Medical Guarantees should consistently commission these services through the national purchaser, ensuring scale and sustainability.

To address emerging service-delivery challenges and sustain program gains, and at the request of the MoH of Ukraine, the World Health Organization (WHO) conducted a comprehensive review of the national HIV programme in September 2025. The review was explicitly framed by the NS2030, which positions disease prevention and control as a national priority in pursuit of the United Nations Sustainable Development Goals and the UN Political Declaration on HIV/AIDS.

Consistent with NS2030, the review approach and judgments were guided by: (i) respect for human rights and non-discrimination across all characteristics; (ii) the primacy of the right to health, emphasizing fair access and enabling conditions for people to care for their own health and that of others; (iii) transparency and openness, ensuring meaningful public engagement and clear accountability of managing entities; and (iv) validity, through evidence-based methods, expert input, unbiased data, and prudent use of available and potential resources; (v) pro-activeness by anticipating risks and adjusting implementation approaches; (vi) setting measurable goals with clear intermediate and final targets with verifiable indicators; (vii) intersectoral cooperation by acknowledging coordinated roles and accountability across health, social, penitentiary and education sectors, local authorities and civil society; and (viii) continuity and succession by maintaining strategic focus irrespective of external factors and institutionalizing learning, experience, and capacity transfer.

2.2 Health System and Reform Environment

Overview of the national health reform

Since the adoption of the 2017 Law on Government Financial Guarantees, Ukraine has moved from fragmented, input-based budgeting to an explicit entitlement model, the PMG, with the NHSU as the single national purchaser. Entitlements are funded from general government revenues, pooling is increasingly centralised, and provider payment has shifted to capitation in primary health care (PHC) and to activity-based approaches for specialist and inpatient care. These purchasing functions are underpinned by a unified national e-health system. This configuration links resources to population needs and strengthens incentives for efficiency and quality.[1]

PHC has become the system's principal entry point and coordination hub. By 2022, PHC enrolment covered more than 70 percent of the population. The PMG expanded to include specialised and emergency care, tuberculosis (TB) services, mental health services, and COVID-19 vaccination. Hospitals began reporting cases using Australian Refined DRGs in preparation for DRG-based payment. The Affordable Medicines Programme (AMP) has been integrated with PHC to improve access to essential outpatient medicines.

The reform architecture relies on public health intelligence and national institutions. The UPHC, together with the NHSU and Medical Procurement of Ukraine(SE MPU), remains central to surveillance, purchasing, and medicines policy. This institutional alignment supports routine decision-making and accountability. The legal framework for health financing reform remains in place during martial law, with implementation adjusted as needed to fit the current context.

Digital infrastructure is a notable strength of the reform. Before the full-scale invasion, 97 percent of facilities were connected to the national e-health central database, NHSU-endorsed medical information systems were mandatory for providers, and public dashboards supported transparency. These foundations enable purchasing, e-referrals, and e-prescribing at scale.[1]

National pooling has also supported financial stabilisation. As shocks accumulated, the NHSU's central budget and explicit PMG entitlements helped maintain coverage and allowed the timely introduction of new packages, including those needed for preparedness and care in areas experiencing hostilities[2].

War impact on service continuity, health infrastructure, and human resources

According to the joint WHO and World Bank review published in 2024, access to services has improved compared with the first year of the full-scale invasion, including access to primary health care, with

1.Health financing in Ukraine: reform, resilience and recovery. Copenhagen: WHO Regional Office for Europe; 2024. Licence: CC BY-NC-SA 3.0 IGO

2 Habicht J, Hellowell M, Kutzin J. Sustaining progress towards universal health coverage amidst a full-scale war: learning from Ukraine. *Bull World Health Organ.* 2024;102(7):436–438. PMID: 38850221; PMCID: PMC11308602.

fewer patients postponing essential care. Utilisation patterns indicate a gradual normalisation of care-seeking outside the most affected areas, supported by the national entitlement under the Programme of Medical Guarantees and continued purchasing through the NHSU.[1]

The WB/WHO review[1] notes that despite some progress, households continue to face salient obstacles. The costs of medicines and treatment remain a frequent constraint, as do time and transport burdens; in some settings, patients reported refusals of care or temporary unavailability of services.[3] These challenges are particularly evident among internally displaced persons and communities close to areas of active or recent hostilities, where access to family doctors and medicines is comparatively lower. Structural factors amplify these barriers, including limited pharmacy networks in rural areas and the need to travel to fill e-prescriptions, as well as incomplete or outdated PHC declarations among displaced populations.

Infrastructure losses have been substantial and geographically concentrated. Structural damage has occurred primarily in northern, eastern, and southern oblasts. Access to water in health facilities has been most constrained in southern oblasts following the Kakhovka dam destruction in June 2023.[4] As of December 2023, direct damage to health-sector infrastructure is estimated at 1.4 billion United States dollars. Recovery and reconstruction needs for 2024 to 2033 are estimated at 14.2 billion United States dollars, including 873 million United States dollars prioritised in 2024.[5] The recovery agenda provides an opportunity to build back better by expanding PHC capacity, optimising hospital infrastructure, and strengthening multidisciplinary care.

Population movement has been large and disruptive for population-based and activity-based financing. By November 2023, an estimated 6.2 million Ukrainians remained registered abroad, mostly in Europe, and 3.7 million were internally displaced. These dynamics imply a smaller near-term population and complicate equitable resource allocation.

Registration and continuity at PHC are affected. Approximately 14 percent of Ukrainians had yet to sign a declaration with a PHC provider by early 2024, and only about 2.8 percent changed registration during 2022 to 2023 despite large internal movements. Among internally displaced persons, an estimated 19 percent updated their declarations. Keeping declarations current is essential for continuity of care and for ensuring that funds flow to the correct PHC providers.

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3 Health needs assessment of the adult population in Ukraine: survey report: October 2023. Copenhagen: WHO Regional Office for Europe; 2024 (WHO/EURO:2024-6904-46670-73154; https://iris.who.int/handle/10665/375967).

4 World Bank, Government of Ukraine, European Union, United Nations. Ukraine: third rapid damage and needs assessment (RDNA 3): February 2022–December 2023. Washington (DC): World Bank; 2024 (https://documents.worldbank.org/en/ publication/documents-reports/documentdetail/099021324115085807/ p1801741bea12c012189ca16d95d8c2556a).

5 Principles to guide health system recovery and transformation in Ukraine. Copenhagen: WHO Regional Office for Europe; 2022 (WHO/EURO:2022-5750-45515- 65155; https://iris.who.int/handle/10665/358446).

The full-scale invasion has also resulted in significant shortages of health-care workers, particularly in eastern Ukraine. [6] WHO (2024) health labour market analyses reveal a notable workforce shortage in Ukraine, with only 1.1 nurses per doctor (compared with the EU average of 2.3), high vacancy rates, an ageing workforce, and severe rural maldistribution, leaving many primary care and nursing posts unfilled, especially in underserved areas.

War-affected oblasts experienced additional declines in staffing, with substantial drops in the number of family doctors and nurses in partially occupied and de-occupied regions (for example, in Luhansk from 2021 to 2023, the number of family doctors declined by 18% and the number of specialists declined by 8%).[7] It should also be noted that widespread damage to facilities and service disruptions in war-affected areas have made maintaining services harder and working conditions more challenging. Collectively, these factors have intensified workforce shortages in the areas with the greatest needs, undermining continuity of care and slowing the recovery of essential services in high-priority regions.

Implications for service integration, digital transformation, and emergency resilience

Integration around PHC is ongoing. Access to complementary PHC packages varies by locality because providers opt into these packages. Examples include TB directly observed therapy, HIV care, opioid agonist therapy, mobile palliative care, COVID-19 vaccination, and PHC-specific mental health services. Because uptake is provider-driven, availability is uneven and equity can be affected.

Medicine access remains a central determinant of financial protection and effective coverage. In 2024, the AMP listed 515 medicines, of which 192 were fully free and the remainder were subsidised. Access is uneven, particularly in rural areas. Approximately 89 percent of villages do not have a pharmacy, and only 22 percent of e-prescriptions issued in villages were filled within the same village. To bridge physical gaps, measures now include multi-year contracts with pharmacies, mobile pharmacy modalities in oblasts affected by hostilities and in de-occupied areas, and mail delivery through the national postal operator Ukrposhta.[8]

The digital system both enabled continuity and required adaptive measures. Wartime disruption led the NHSU to temporarily relax e-health reporting so that providers could sustain essential services. The data-driven payment system was suspended from March to July 2022 in favour of fixed monthly transfers. Nationally, the share of facilities submitting e-health data fell in the initial months of the war, and connectivity and data completeness remain constrained in occupied and frontline areas. Even so,

6 Results of initial health labour market analysis in Ukraine. Copenhagen: WHO Regional Office for Europe; 2024. Licence: CC BY-NC-SA 3.0 IGO.

7 Results of initial health labour market analysis in Ukraine. Copenhagen: WHO Regional Office for Europe; 2024. Licence: CC BY-NC-SA 3.0 IGO.

8 Health financing in Ukraine: reform, resilience and recovery. Copenhagen: WHO Regional Office for Europe; 2024. Licence: CC BY-NC-SA 3.0 IGO.

the pre-war digital architecture, including near-universal connectivity to the central database, continues to support transparency and the gradual recovery of routine analytics and performance monitoring. Emergency resilience has been operationalised through targeted purchasing instruments during martial law. Special transfers helped facilities meet new minimum salaries in 2022. In 2023 and 2024, designated readiness payments were introduced to support preparedness nationwide. Additional support was provided for potential nuclear-related incidents in oblasts with nuclear power plants. These mechanisms complement NHSU contracting in areas of active hostilities and in temporarily occupied territories.[8]

Sustaining reform progress during times of crisis highlights the importance of strong institutions and effective governance. The NHSU, SE MPU, and the UPHC continue to play a key role in ensuring efficient use of resources, reliable medical supplies, and strong public health intelligence. The broader reform framework is built on centralised funding, clear service entitlements, integration around primary health care, and digitalised purchasing. These elements have created a solid foundation for maintaining health coverage during the crisis and for gradually resuming performance-based operations as conditions improve.

2.3 Purpose and Scope of the Review

The purpose of the review is to assess progress, gaps, and system-wide performance in the implementation of the **National Strategy on HIV/AIDS, Tuberculosis and Viral Hepatitis 2020–2030 (NS2030)** during 2023-2024, with particular attention to attainment of national objectives and alignment with global and regional commitments, including the **UN Political Declaration on HIV and AIDS**, **SDG 3.3**, and the **WHO European Region Action Plans for ending AIDS, viral hepatitis, and sexually transmitted infections (2022–2030)**.

The review examines the impact of the war on HIV services and identifies immediate recovery priorities for inclusion in the forthcoming national action plan. The findings will support evidence-based planning, strengthen program resilience and sustainability, and inform Ukraine's next **Global Fund funding application for 2026**.

The assessment focuses on five key domains:

1. **Resilient and Sustainable Systems for Health**, including governance, financing, service organisation, community systems, workforce, access to essential health services for KPs, and the implications of donor transition.
2. **Epidemic Patterns, Surveillance, and Monitoring and Evaluation**, including case-based and bio-behavioural surveillance, population size estimates (PSE), trends across key and affected populations, and use of strategic information for program adaptation.
3. **Prevention Services for KPs**, including access, coverage, quality, community-based models, prison settings, PrEP implementation (including CAB-LA), and readiness for EMTCT validation.

4. **HIV Testing, Diagnosis, and Clinical Monitoring**, including testing policies and algorithms, provider-initiated testing and counselling (PITC), community-based and self-testing models, digital testing services, laboratory quality systems, integration with TB and hepatitis testing, and HIV DR monitoring.
5. **HIV Treatment and Linkage to Care**, including alignment of treatment policies with WHO guidance, cascade performance and progress towards the 95-95-95 targets, treatment effectiveness and viral suppression, ARV supply and forecasting, management of OIs, and integration with TB, hepatitis, and OAMT services.

This comprehensive review aims to guide national and partner efforts to accelerate progress towards ending AIDS as a public health threat by 2030 in Ukraine.

The review Terms of Reference (Tor) is provided in Annex 1.

Annex 2 presents the mission agenda, including the schedule of online meetings and interviews conducted on the HIV response and access to OAMT services.

3. Methodology

3.1 Review Phases

The review team assessed progress and gaps in implementing the National Strategy on HIV/AIDS, Tuberculosis and Viral Hepatitis 2020-2030. Building on the review undertaken in 2023, the assessment examined trends since that review and incorporated updated information through 2025. The review was conducted in three phases: a desk review, a virtual mission, and consolidation of findings with stakeholder debriefing and report submission.

Phase 1: Desk review. The team conducted a structured review of national strategies and policies, HIV testing guidelines and diagnostic algorithms, HIV treatment standards and guidelines, PrEP standards and guidelines, OAMT guidelines, prevention guidance, monitoring and evaluation data, and major partner and donor reports.

Phase 2: Virtual mission. In September 2025, the team held virtual interviews and consultations with the MoH, the UPHC, the NHSU, NGOs, community-led and civil society organisations (CSOs), and bilateral and multilateral development partners. Discussions focused on service delivery, purchasing and integration, supply security, surveillance and data, human rights, and programme resilience.

Phase 3: Consolidation and reporting. In October and November 2025, the team triangulated evidence from documents and interviews, validated preliminary findings with stakeholders during a virtual debrief, and finalised the written report for submission.

The focal points from the UPHC of the MoH of Ukraine were Dr. Larysa Hetman for HIV and Iryna Ivanchuk for OAMT. They supported stakeholder mapping, document flow, and scheduling throughout the review.

A series of virtual meetings and focused group discussions were organised with governmental institutions, community representatives, and development partners. Despite the operating context, participation was broad, and scheduling proceeded with minimal disruption. The detailed agenda is provided in Annex 2.

Based on the desk review and key informant interviews, the review team developed a set of recommended actions specifically for each programme area. Each recommendation is assigned a priority level, a lead and co-lead implementer, and an indicative implementation timeline. The timeline is phased to reflect realistic sequencing. The year 2026 refers to needs assessment, policy design, regulatory decisions, approval of frameworks, and pilot or initial rollout. The period 2027-2028 reflects the scale-up of effective approaches, incorporation into contracting and purchasing mechanisms, and routine application by oblast structures. The year 2030 reflects full institutionalisation, where measures become standard national practice and are sustained within national systems. This phased approach is intended to distinguish actions requiring early policy and regulatory attention from those that require medium- and longer-term operational integration, stable financing arrangements, and robust delivery capacity at the subnational level.

3.2. Analytical Framework

The HIV and OAMT programme review applied a structured analytical framework based on five key evaluation dimensions: relevance, effectiveness, efficiency, sustainability, and equity. These criteria guided the assessment of policies, governance, financing, workforce capacity, service delivery models, and community systems. Each dimension helped determine how well current interventions meet population needs, achieve intended results, use available resources efficiently, remain resilient during the war, and ensure equitable access for key and affected populations.

The review compared and integrated information from multiple sources. Quantitative data (e.g. surveillance indicators, programme monitoring results, and financial data) were examined together with qualitative insights from online interviews, stakeholder consultations, and document reviews. Drawing on multiple information sources helped confirm key findings and identify gaps. It also provided a clearer view of programme functioning, acknowledging the limited data available from occupied and war-affected regions.

The expert team reviewed all indicators and analytical elements against the National Strategy on HIV/AIDS, Tuberculosis and Viral Hepatitis 2020-2030 (NS2030) and considered them in relation to the WHO regional action plans for ending AIDS, viral hepatitis, and sexually transmitted infections (2022-2030). This approach allowed the team to conduct an assessment that reflects national priorities, aligns with regional and global commitments, and supports recommendations grounded in established strategic directions.

3.3. Limitations

The review was conducted under conditions shaped by the ongoing war in Ukraine, which influenced the modalities of information gathering. Due to security considerations, the expert team was unable to conduct in-country visits and instead relied on online interviews, virtual meetings, and desk review. While these approaches enabled broad engagement with national counterparts, implementing partners, and service providers, they did not allow for direct observation of facilities and field settings.

Data availability also varied across the country. Information from fully occupied regions was not accessible, and reporting from areas affected by active war was incomplete. These gaps are understandable given the context and should be interpreted as contextual limitations rather than weaknesses of the national monitoring system. They nevertheless reduce the level of detail available for assessing epidemic dynamics and service delivery in the most affected areas.

Fluctuations observed in funding and service trends should also be viewed within the realities of an evolving wartime environment, including population displacement, changes in denominators, and operational constraints on service delivery in occupied or hard-to-reach regions. These factors are external to programme management and should be appropriately considered when interpreting national progress.

Despite these constraints, the review benefitted from extensive engagement with national institutions, partners, and technical experts, and the findings provide a reliable and comprehensive assessment of the HIV and OAMT response within the current context.

4. HIV Programme Review

4.1. Governance, Coordination and Human Resources

Context

Ukraine's governance of the HIV and OAMT national response is grounded in a comprehensive policy and institutional framework that has remained functional under extremely challenging conditions during the war. The national response is guided by established laws on HIV, as well as an integrated national strategy that sets a common objective of ending AIDS, TB, and hepatitis by 2030. This strategy is supported by detailed technical policies and protocols, including the national HIV testing strategy and clinical protocols and standards.[9,10,11] and the National Strategy for addressing human rights-related barriers to HIV and TB services by 2023.

The governance model for HIV and OAMT programmes is characterised by clearly defined roles and lines of accountability, as well as a strong capacity for national-level coordination. Governance responsibilities are explicitly assigned across levels and state institutions.[12] The Cabinet of Ministers sets national policy and endorses strategic priorities. The MoH issues regulations, defines clinical and public health standards, and provides overall stewardship of HIV, OAMT, TB, and hepatitis services. The UPHC is responsible for technical leadership and day-to-day coordination of programme implementation, including surveillance, prevention, and continuity of treatment. Regional Centres for Disease Control contribute to the implementation of national public health priorities at the subnational level and may provide technical input and coordination support, while primary responsibility for operational implementation, performance monitoring, and service continuity (including under emergency conditions) rests with authorised health facilities. National stakeholders note that Regional CDCs (Centres for Disease Control and Prevention) capacity in these areas varies significantly and remains limited in many regions. Specialised Centres for Socially Significant Diseases provide direct clinical and support services for HIV, TB, hepatitis, and OAMT clients, including high-risk and hard-to-reach groups. The CCM and its technical working groups act as formal coordination and accountability platforms, bringing together government, providers, and civil society to align national financing, Global Fund and other partner support, and implementation decisions, and to resolve bottlenecks in service continuity.

9 Standard of Medical Care for HIV Infection, Order of the Ministry of Health of Ukraine dated June 3, 2025 No. 916
10 Approved by Order of the Ministry of Health of Ukraine dated September 17, 2022 No. 1695
procedure for providing medical care using telemedicine, rehabilitation care using telerehabilitation during the period of martial law in Ukraine or its individual localities
11 Ministry of Health of Ukraine State Expert Center of the Ministry of Health of Ukraine State Institution "Public Health Center of the Ministry of Health of Ukraine" Evidence-based clinical guideline "Prevention of Mother-to-Child Transmission of HIV" 2022
12 Law of Ukraine about Public Health System, Vedomosti Verkhovna Rada of Ukraine (VVR), 2023

Public health reform in Ukraine[13] has significantly reshaped coordination of the HIV response at the local level. The decentralisation of public health functions and the establishment of regional public health centres have shifted responsibilities for planning, surveillance, and service coordination closer to communities. While this has created opportunities for more tailored, locally driven HIV responses, it has also revealed capacity gaps and variable levels of technical expertise across regions. Ensuring effective HIV coordination now depends on strengthening local public health leadership, improving data and surveillance functions, and fostering collaboration between health authorities, HIV service providers, and civil society.

Importantly, Ukraine has demonstrated the capacity to sustain continuity of essential HIV, harm reduction, and OAMT services despite the impact of the war. Access to antiretroviral therapy (ART), harm reduction services, and treatment for people who use drugs (PWUD) has been maintained and, where necessary, adapted rather than interrupted. Under the leadership of the MoH, the UPHC in close collaboration with the NHSU and with the support of international partners (including the United States Government, the Global Fund, PEPFAR, WHO, UNAIDS, and others), prioritised core services, mobilised resources, and coordinated delivery models to protect continuity of care.[14]

Community networks, in particular networks of people living with HIV (PLHIV) and PWUD, have played an essential role within this response. These networks have supported outreach, treatment adherence, and service continuity through flexible and context-appropriate delivery approaches such as multi-month dispensing of ART, mobile provision of opioid agonist therapy, and wider use of take-home dosing. These adaptations have allowed services to remain available in areas where facility-based access is limited.

Despite the ongoing war, Ukraine continues to work toward achieving the 95-95-95 HIV targets and to expand OAMT coverage. This indicates not only emergency response capacity, but also an ability to adjust delivery models and sustain long-term programme objectives under adverse conditions. There is also a clear commitment at the national level within the MoH, UPHC, NHSU, and partner institutions to maintain coordinated leadership and continued support for HIV and OAMT services as public health priorities.

13 Aligning health and decentralization reform in Ukraine. Copenhagen: WHO Regional Office for Europe; 2021. Licence: CC BY-NC-SA 3.0 IGO.

14 Center for Public Health of the Ministry of Health of Ukraine. Accessed on October 20th 2025. https://phc.org.ua/kontrol-zakhvoryuvan/vilsnid

Achievements

The following achievements illustrate a governance system that is able to set policy, coordinate nationally, secure and distribute essential commodities, and keep services operational for populations most at risk, even in the context of ongoing war.

Continuity of essential HIV and OAMT services during full-scale war: Ukraine has sustained access to ART, harm reduction, and OAMT despite the pressures of full-scale war. This ability to maintain treatment and support services under extreme conditions reflects strong national stewardship and operational discipline.

A coherent policy and legal framework for an integrated infectious disease response: The national response is guided by a clear set of policies and a public health legal framework that addresses HIV, OAMT, TB, and viral hepatitis in an integrated manner. By positioning these areas as part of one coordinated public health agenda, rather than as separate vertical programmes, Ukraine has created an enabling environment for joint planning, shared accountability, and consistent standards of care.

Progressive alignment with European Union (EU) standards on blood safety: Ongoing work to align national blood safety policies with EU directives demonstrates a sustained commitment to quality, safety, and international best practice. This process signals readiness to harmonise critical elements of communicable disease control, patient protection, and transfusion safety with broader European regulatory and public health expectations.

Inclusive national coordination through the CCM: The CCM continues to function as a strong multisectoral platform that brings together government institutions, technical agencies, CSOs, and community networks. Its mandate has expanded beyond HIV and OST to include coordination of the national hepatitis C response. This broad mandate reinforces the principle that prevention, treatment, and harm reduction for people living with HIV, PWUD, and other KPs are national priorities requiring joint oversight and shared responsibility.

Centralised procurement and resilient supply chain management for ART and OAMT: Procurement of antiretroviral (ARV) medicines and OAMT medications is organised centrally through the AMP with substantial support from international partners. This approach is complemented by a national supply chain system capable of distributing commodities reliably across regions, including to areas affected by instability or displacement. The result is continuity of treatment availability at scale, with reduced risk of stockouts and improved predictability for service providers.

Public Health Workforce Development Programme[15] has been endorsed by the MoH early in 2025. By building leadership pipelines, aligning training with WHO/ASPHER standards, and introducing incentives to attract and retain talent outside major cities, the policy gives the system a realistic path to stabilise, professionalise, and protect the public health workforce through 2030, which is a prerequisite for surveillance, outbreak response, and national health security.

High level of institutional, professional, and community commitment: The response has been underpinned by the competence and dedication of national institutions, health professionals, and non-governmental organisations. Health staff have continued service delivery under highly adverse circumstances; NGOs and community groups have ensured outreach, adherence support, and linkage to care for key and vulnerable populations; and national bodies have provided policy direction and coordination. This collective effort has been central to sustaining HIV and OAMT services and is a notable achievement of Ukraine's governance model.

Challenges

Capacity building needs of regional CDCs: Under the Public Health Law, regional CDCs are responsible for public health and epidemiological surveillance in general, including HIV, among other conditions of public health importance. Regional CDCs do not directly coordinate clinical HIV services, but they may guide public health action based on epidemiological insights.

Ongoing structural reforms and fiscal adjustments have created a context in which these centres are still in the process of fully building the staffing, budget flexibility, and technical resources needed to consistently perform these functions across all oblasts. As this capacity continues to develop, certain public health functions are being supported by national institutions and external partners, which helps ensure continuity while regional capabilities are further strengthened.

Variable subnational coordination: At the national level, multisectoral coordination is well established and benefits from structured platforms and clear leadership. At the oblast level, however, coordination can be more ad hoc and is not always systematically linked to ongoing health reforms or financing priorities. This can lead to uneven implementation of policies related to HIV and OAMT, and it can slow decision-making for issues that require rapid, context-specific responses (for example, ensuring continuity of services for displaced populations). Strengthening subnational governance and better aligning oblast-level coordination with national strategic directions, particularly in regions with more limited capacity, remains an area for further work.

15 Ukraine's national "Human Resources Development Programme for the Public Health System to 2030." MoH Order No. 65 as of January 9th 2025

Maintaining Community Capacity: In the context of decentralisation, the effectiveness of the HIV response increasingly depends on strong community systems that can complement public health services. Community-based organisations play a central role in this effort, delivering trusted, client-centred prevention, adherence support, and outreach services that reach KPs more effectively than many traditional providers. As responsibilities shift to the local level, continuous funding and coordinated engagement with local authorities become even more important to sustain access to essential HIV prevention and support services. Strengthening community systems through more predictable financing, clearer contracting arrangements, and structured collaboration with public providers is therefore critical to ensuring a resilient, equitable, and effective HIV response at the local level.

Financial sustainability of prevention and outreach: Before the escalation of the war, Ukraine had transitioned the majority of basic HIV prevention and outreach services (including services for KPs) toward increased domestic funding through social contracting, while extended service packages and certain services remained heavily donor-reliant.[16] Many prevention, harm reduction, and community outreach interventions continue to rely on donor financing. While external support has been essential to maintaining continuity during the crisis, the reliance on external funding creates long-term vulnerability, particularly for services that are highly important to epidemic control but are not yet fully embedded in routine state-funded health packages.

Health workforce-related challenges: Workforce shortages, internal displacement, out-migration of trained staff, and uneven progress with decentralisation have placed direct pressure on service delivery. As found by the Labour Market analysis (2024), around 15% to 25% of positions are vacant for doctors, nurses, midwives, physiotherapists, laboratory technicians, and X-ray technicians. These gaps translate into shortages of experienced providers able to deliver HIV and OAMT services at the required scale for key and high-risk populations, while those who remain face high workload and security-related stress. Maintaining competency, coverage, and continuity of care in this context requires targeted retention incentives, task-sharing and redistribution of clinical functions, and systematic supportive supervision to keep services stable under pressure. The labour market analysis report mentioned above also points to the need for capacity building for community-level HIV and OAMT service delivery (including primary health care providers and community-based organisations). While the National Public Health HR Development Programme focuses on strengthening the public health workforce overall, integrating HIV-related competencies into the national public health

16 Independent review of the Ukraine's Transition Plan 2018-2021 *By Centre for Health Policies and Studies (PAS Centre)* , January 2023.

competency framework would provide a sustainable, long-term approach to addressing existing gaps across the diverse professions involved in the HIV response. This direction is further supported by ongoing initiatives to assess HIV service–related competencies and to develop capacity development strategies and technical assistance plans for HIV and TB.

HIV-related stigma remains an important challenge, particularly as decentralisation places greater responsibility for planning and delivering services at the local level. While local authorities are increasingly positioned to shape more responsive HIV programmes, varying levels of governance capacity and limited experience with KP needs may slow progress. Strengthening local leadership, building practical skills, and integrating stigma-reduction approaches into community outreach and service delivery will be essential to ensure that decentralisation supports a more inclusive and effective HIV response.

There has already been measurable progress: according to a 2023 “progress assessment” under the Global Fund’s “Breaking Down Barriers” initiative, Ukraine had among the most advanced programming to remove human-rights related barriers to HIV services. This included efforts to reduce stigma and discrimination, promote non-discriminatory care, and empower key/vulnerable populations to claim their rights.

The 2025 National HIV Standards of Ukraine acknowledge principles of respectful, non-discriminatory, and rights-based service delivery, including for KPs. At the same time, gaps remain in fully integrating human-rights programming into everyday service delivery, ensuring consistent training, monitoring, and support across regions (especially war-affected or displaced populations).[17]

Challenges related to health information system integration: Multiple information systems are in use across NGOs, the UPHC, the NHSU, operating with national eHealth platforms- these function as integrated components of a single digital health ecosystem. Together, they support service delivery, strategic purchasing, financing flows, and health information reporting, with eHealth solutions underpinning NHSU contracting, claims processing, and monitoring functions rather than functioning as separate or standalone systems. Closer integration of data flows would facilitate more timely surveillance, allow smoother case management across providers, and support planning of service coverage for mobile and high-priority populations, including those receiving services from both public facilities and community-based organisations. Improving alignment in this way would also enhance oversight, reduce administrative duplication, and support continuity of care.

17. UKRAINE Progress Assessment Global Fund Breaking Down Barriers Initiative December 2023

Recommendations

The table below presents recommended actions to strengthen governance, coordination, and human resources in the HIV and OAMT response in Ukraine.

Recommendations for strengthening governance, coordination, and human resources in the HIV and OAMT response	Priority	Implementer(s)	2026	2027–2028	2030
Strengthen Governance Capacity to support decentralisation					
Conduct a systematic assessment of barriers and capacity gaps affecting regional CDCs to clarify the scope and feasibility of decentralisation, including the appropriate balance of surveillance functions, decision-making authority, and structural responsibilities at the oblast level.	High	MoH, UPHC, Regional CDCs	x	x	
Align stigma-reduction efforts with primary health care strengthening and universal health coverage reforms, and support implementation of respectful, rights-based service delivery standards (including KPs) in line with the national quality of care frameworks.	Medium	MoH, UPHC, NHSU, PHC providers	x	x	x
Maintain structured engagement of community-based organisations alongside public providers as trusted, cost-effective delivery partners for prevention, adherence support, and outreach, even under fiscal pressure.	High	MoH, UPHC, NHSU, NGOs/CSOs, International Partners	x	x	x
Address workforce shortages and build capacity					
Position HIV and OAMT decentralisation as the initial practical application of Goal 1(National HR Development Programme 2025) by expediting the legal and HR measures, e.g., defining the public health workforce, formalising role classifications and scopes of practice (including for non-physician staff), and establishing monitoring and workforce planning with priority at the community level.	High	MoH (HR/Policy), UPHC, NHSU, Regional CDCs	x	x	
Develop and endorse a focused, accredited competency and continuing professional development pathway for community-level HIV and OAMT services	High	MoH, UPHC (training/technical), NHSU		x	x

(aligned with Goal 2 of the National Public Health HR Programme 2025) by defining required skills, integrating these into national competency and education standards, and ensuring that completion counts toward formal professional advancement.		(contracting/payment levers), Professional Associations, Regional CDCs			
Support the establishment and targeted development of municipal/PHC-level leadership for decentralised HIV and OAMT services, positioning Goal 3's (National HR Development Programme 2025)[3] leadership, management, and incentive measures (including strengthened local management capacity and sustainable financing/retention mechanisms) as the initial area of practical implementation.	High	MoH (HR/Policy), UPHC, NHSU, Regional CDCs	x	x	
Ensure sustainable and quality-assured HIV and OAMT commodities					
Explore diversified and longer-term financing options beyond currently functional donor-supported mechanisms to ensure sustained access to HIV prevention commodities (including syringes, condoms, and lubricants), to gradually reduce reliance on short-term external funding.	Medium	MoH, Ministry of Finance (MoF), Central Procurement (PMG), UPHC, NHSU	x	x	x
Strengthen quality assurance and pharmacovigilance for locally manufactured opioid agonist medications through systematic batch testing and ongoing safety/quality monitoring.	High	MoH, UPHC, State Medicines Regulatory Authority / Pharmacovigilance Unit	x	x	x
Maintain and enhance coordination and data integration					
Institutionalise and formalise multi-stakeholder coordination platforms at the oblast level to align decentralised implementation (HIV, OAMT, TB, hepatitis, harm reduction) with national reform priorities and external partner support.	High	MoH, UPHC, Regional CDCs, Oblast Health Departments, CCM Secretariat	x	x	x

NGOs should prepare and implement a time-bound data migration plan, including full mapping of NGO-managed data to UPHC fields and coordinated transfer of historical datasets, with a designated focal point to ensure a smooth transition to national UPHC data systems.	High	NGOs/CSOs,UPHC, NHSU, Regional CDCs,	x	x	x

4.2. Financing and Sustainability

Health Financing Context

Ukraine's per capita spending on health in 2021 (the latest year for which internationally comparable data are available) exceeded the average for lower-middle-income countries (LMICs) in the WHO European Region but was lower than the regional average.[18] As a percentage of Ukraine's Gross Domestic Product (GDP), current expenditure on health increased from 7.1% in 2019 to 8.2% in 2021, with 47.9% of total health spending coming from private sources, predominantly consisting of out-of-pocket payments. The share of Ukraine's health budget in total government spending in 2021 was 10.6% (up from 7.7% in 2019), which accounted for 4.3% of GDP.[19]

Prior to the full-scale invasion of Ukraine by the Russian Federation, the government's total (consolidated) health budget had demonstrated significant positive dynamics, doubling during the period of 2017-2021 from 102.0 billion to 203.6 billion Ukrainian Hryvnia (UAH) . Despite the serious challenges that Ukraine's public finances are facing since 2022, the government's commitment to the health sector remains strong (see Table 1).

Table 1.Consolidated health budget of Ukraine, 2022-2026 (UAH)

	2022	2023	2024	2025	2026
State budget funding for the health sector*	184.3	179.3	201.4	217.0	258.0

* - 2022-2024 - executed budget, 2025 – approved budget, 2026 – plan.

Source: Ministry of Finance of Ukraine. Official website. https://mof.gov.ua/uk/state-budget

It is important to note that any comparisons of public budget allocations for the health sector in Ukraine before and after 2022 should be considered with caution, due to the significant change

18 Health Systems in Action: Ukraine, 2024. World Health Organization Regional Office for Europe and European Observatory of Health Systems and Policies.

19 WHO Global Health Expenditure Database, https://apps.who.int/nha/database/Select/Indicators/en Accessed on September 14, 2025.

in the population and the territorial coverage of services by the government caused by the ongoing war.

Achievements

Ukraine has implemented comprehensive health financing reforms over the last years, initiated by the passage of the Law "On State Financial Guarantees of Medical Service to the Population" in 2017. Establishment of the NHSU in 2018 as a single national purchasing agency enabled strategic contracting of providers and introduction of new payment mechanisms.[20] NHSU contracts public and private health care providers and is responsible for implementing the Affordable Medicines Programme (AMP) and the PMG. The PMG comprises service packages that cover either treatment of specific diseases (such as TB and HIV) or types of medical care (e.g. PHC, emergency services or palliative care). The number of service packages has increased from 33 in 2020 to 44 in 2025.[21]

Ukraine has established strong Public Financial Management (PFM) systems at national and sub-national levels, with high rates of health budget execution.[22] Central government spending on the PMG is pooled in a single central budget programme managed by NHSU, which accounts for around 75-80% of the government's health spending (2024-2025). MOH directly manages a certain portion of the health budget for implementing public health and other programmes at the national level, while regional and local authorities provide supplemental funding to the health system to cover utility costs, as well as current and capital renovation costs of the facilities under their ownership.

HIV and OAMT services are covered under the following two PMG service packages, which define the scope of the services, conditions for service delivery (outpatient), and the requirements for organisation of services, including for the medical personnel and necessary equipment:

1. Diagnosis, treatment and support of persons with HIV (and suspected to have HIV)
2. Treatment of individuals with mental and behavioural disorders due to opioid use using substitution maintenance therapy medications.[23, 24]

Health care providers contracted by the NHSU to deliver HIV and OAMT services are paid based on a fixed capitation rate per patient per year. For 2025, the rates were approved at 4091.04 UAH and 6874.2

20 The Law of Ukraine "On State Financial Guarantees of Medical Service to the Population". October 19, 2017. https://zakon.rada.gov.ua/laws/show/2168-19?lang=en#Text
21 National Health Service of Ukraine. Programme of Medical Guarantees 2025.
22 Budget Execution in Health. Case Study: Ukraine (unpublished) 2022
23 National Health Service of Ukraine. The Program of Medical Guarantees 2025. HIV service package.
24 National Health Service of Ukraine. The Program of Medical Guarantees 2025. OAMT service package.

UAH for HIV and OAMT, respectively.[25] Contracted providers are paid monthly, based on the average number of patients in treatment during the month, multiplied by 1/12 of the annual capitation rate.

Beyond PMG funding, the state budget also earmarks HIV prevention expenditures under the budget programme “Public Health and Epidemic Control” (budget code 2301040), which supports social contracting with non-governmental organisations. The programme allocations were approved at UAH 4.34 million in 2022 and have remained broadly consistent, recorded as UAH 4.37 million in 2025 and UAH 4.68 million in the 2026 state budget draft. Before the full-scale invasion, these funds were allocated and spent according to established mechanisms. Since the war began, the UPHC has continued to use those contracting procedures, although financing is currently provided through the Global Fund project. It is worth noting that the draft State Budget for 2026 already includes government allocations to restore domestic financing for social contracting.

Challenges

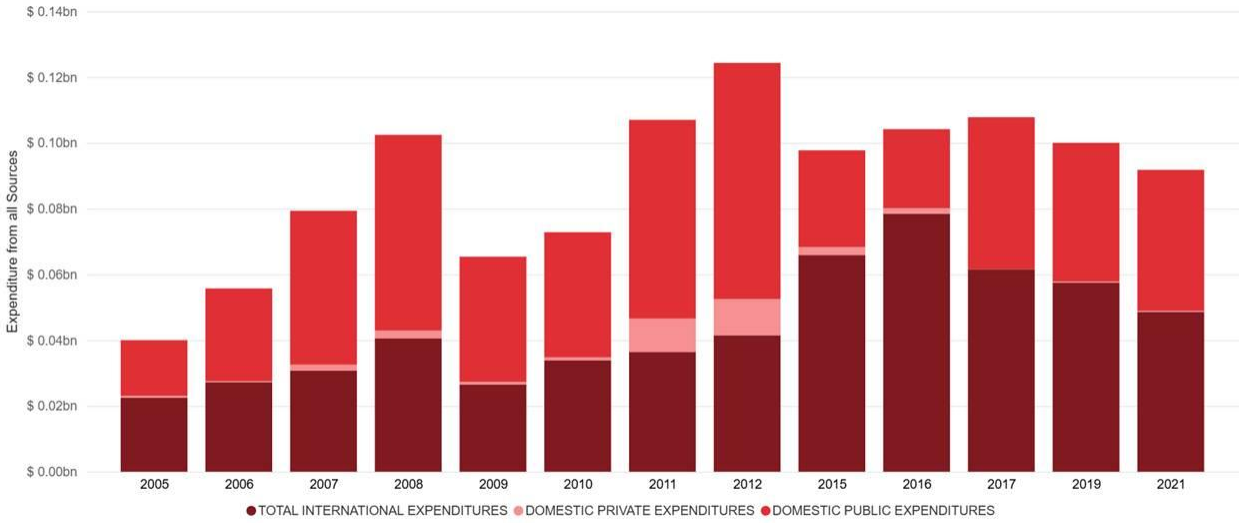
Total expenditure on HIV from all sources in 2021 (the latest year for which the UNAIDS country data is available) was around 91.8 million US dollars, from which 52.9% (or 48.6 million USD) was external funding, 46.7% (42.9 million USD) came from domestic public expenditure, the remaining 0.4% (269.7 thousand USD) reported as domestic private expenditure (see Figure 1). The share of external funding for HIV in Ukraine in 2021 was higher than the Eastern Europe and Central Asia (EECA) regional average (24%) and the global average for the low- and middle-income countries (46%).

Detailed breakdown of total expenditure by specific programmes and activities demonstrates that the largest share of the total costs (39.5% or 36.3 million USD) was spent on treatment, care and support, followed by governance and sustainability activities (31 million USD or 33.8%) and prevention measures (18.4 million USD or 20% of the total). Other activities accounted for 6.7% of the total costs.[26]

25 Cabinet of Ministers of Ukraine. Resolution No. 1503 of December 24, 2024 “On some issues of the implementation of the program of state guarantees of medical care for the population in 2025”.

26 UNAIDS, Global AIDS Monitoring GARPR report, July 2025

Figure 1.Reported expenditures on HIV from all funding sources in Ukraine, 2005-2021



Source: UNAIDS, Global AIDS Monitoring GARPR, reports, July 2025. HIV Financial Dashboard, Accessed on October 14, 2025.

While the total HIV expenditures demonstrate a general tendency of decline over the last years, certain positive trends can also be observed, such as an increase in the share of domestic public expenditures from 23% in 2016 to 46.7% in 2021 and a decrease in the share of private expenditures from 2.5% in 2015 to 0.4% in 2021. These tendencies attest to improved accessibility of HIV services for the population and a higher reliance on domestic resources.

Table 2 below provides information on the total funding of these services by NHSU during 2022-2024.

Table 2. Financing of HIV and OAMT Services by NHSU, 2022-2024

Indicator	**2022**	**2023**	**2024**
1. Health Care Services for People with HIV			
1.1 Number of contracted health facilities	418	328	325
1.2 Financing (UAH thousand)	460,416.7	361,631.0	420,559.0
2. OAMT services			
2.1 Financing (UAH thousand)	177,926.6	118,408.2	127,825.7
Total payments to health care providers (for all types of care) by NHSU (UAH thousand)	145,656,392.3	133,850,227.7	151,306,502.3
Share of payments for HIV Services in total	0.32%	0.27%	0.28%
Share of payments for OAMT services in total	0.12%	0.09%	0.08%

Source: NHSU annual reports 2022-2024. https://edata.e-health.gov.ua/e-data/zviti

The data demonstrates that while there were absolute reductions in 2023 compared to the previous year (22% in HIV and 33% in OAMT financing), a relative increase is noticed in 2024 compared to 2023. The decline in contracted health facilities is due to the ongoing war: about 20% of Ukraine remains occupied, and many facilities cannot be funded because they have been destroyed, are inaccessible, or cannot complete verification and reporting.

According to the information provided by the UPHC, these reductions had limited impact on the delivery of essential services to the patients, as the health facilities have received financial support from both external donors (including procurement of medicine and diagnostic tests, and supplies with the Global Fund financing), and from regional and local authorities. **These fluctuations in funding trends should be assessed in the context of the extremely challenging situation of an ongoing war in Ukraine, considering the population statistics and service delivery limitations in occupied regions.**

The overall availability of both domestic and external sources for sustaining the necessary levels of funding for the HIV programme in Ukraine remains challenging. According to UNAIDS, as of April 2025, due to the suspension of US-funded ARV deliveries, critical gaps in ARV availability were expected as early as the second quarter of 2025, and the PrEP programme was also at high risk due to halted procurement.[27] Even with external funding suspended, the mechanisms established by Ukraine's health-financing reforms allowed the system to absorb the shock and continue service delivery.

Although the funding decrease can partly be explained by a decline in programme beneficiaries due to war-related migration, providers raised concerns during the country mission about the capitation rate for both HIV and OAMT services, which may not fully reflect the service delivery costs, thus reducing the motivation of health care providers to deliver high-quality services. This also affects the willingness of PHC providers to apply to NHSU for additional packages for delivery of HIV and OAMT services. Although the NHSU provides additional funding for these packages, the decision to apply for them rests with individual providers. As a result, the adoption of supplementary services under the PHC package has been inconsistent and limited, which may undermine equitable access to these services across various regions. The share of the PHC providers that were contracted by NHSU to deliver HIV services was 3.7% in 2021, 4.6% in 2022 and 4.5% in 2023, while the same indicator for OAMT services was 2.4%, 2.7% and 2.5%, respectively.[28]

27 UNAIDS: Impact of US funding cuts on HIV programmes in Ukraine. 22 April 2025
28 Health financing in Ukraine: reform, resilience and recovery. Copenhagen: WHO Regional Office for Europe; 2024.

Recommendations

Recommendations on financing and sustainability of the HIV response	Priority	Implementer	Implementation timeline		
			2026	2027-2028	2030
Focus on protecting the public funding for essential HIV/AIDS and OAMT services and public health functions to ensure their continuity	High	Cabinet of Ministers	X	X	X
Revise and update the capitation rates (tariffs) for HIV and OAMT services used by NHSU for paying the contracted health care providers to reflect the full costs necessary for high-quality service delivery. Consider the introduction of additional pay-for-performance indicators to increase providers' motivation.	High	NHSU	X		
Strengthen the role of primary health care providers in delivering HIV and OAMT services by building PHC capacity to apply for and provide these services, including ensuring adequate, trained staff; enhancing facility readiness and clinical competencies; reinforcing organisational structures and referral pathways; and securing access to essential tools and resources.	High	NHSU, UPHC		X	

4.3. Epidemic patterns, HIV surveillance and M&E systems

4.3.1. Epidemic Context

The HIV epidemic in Ukraine is primarily affecting KPs, namely PWID, female sex workers (FSW), MSM, and TGW. The country's HIV epidemic began in the early 1990s, primarily among PWID and

peaked around the year 2000, involving other KPs and their partners. The epidemic varies across the regions, with a higher number of reported cases per 100,000 population in the south-east.
Estimates of the number of PLHIV made using the UNAIDS Spectrum tool since the war started are not used by the UPHC due to challenges in estimating the total number of people in Ukraine. Uncertainty about the number of people living in Ukraine creates a barrier to modelling the HIV epidemic and estimating the number of PLHIV in the country, as well as HIV incidence and mortality. The war and occupation of the country have led to large-scale population displacement and disruption of healthcare services, including HIV surveillance. Routinely collected health data, including data from HIV case reporting, should be interpreted with caution, particularly from territories where the impact of the war is more prominent. Uncertain population denominators, challenges in tracking displaced populations in and outside Ukraine and regionally variable surveillance capacities limit the ability to accurately model HIV incidence, prevalence and mortality.
According to UPHC data, 137,780 PLHIV were registered in healthcare facilities at the end of 2024 and 118,701 of these (86.1%) were on ART. As per data reported in the GAM, 98,051 patients on ART received a VL test in 2024, which is a VL testing coverage of 82.6%. Among those tested, 96.0% had a suppressed VL. However, no data were available. [29] The number of patients on ART in 2024 (n=118,701) was considerably lower compared to 2021 (n= 152,226), most likely due to migration from the country because of the war and the loss of patients residing in occupied territories. [30] Ukrainian refugees constituted 10.2% (n = 2,338) of all 2022 HIV diagnoses in the EU/EEA, which was a 10-fold increase from 2021.

4.3.2. HIV epidemic among key populations

Among KPs, PWID continue to represent the largest group with the highest HIV prevalence, estimated at 16.5% in 2023 (Table 3). While HIV prevalence is lower than in previous years, the sub-regional analysis hasn't shown a statistically meaningful decrease in HIV prevalence. The main challenge in the HIV treatment cascade for PWID lies at the first step: it is currently estimated that only about two-thirds of PWID living with HIV are aware of their status.
The second-highest HIV prevalence among KPs is in MSM (6.8% in 2024). In contrast to PWID, there are signs of increasing HIV prevalence in MSM in at least some regions. The HIV treatment cascade

29 HIV Bulletin 2024. Kyiv: Public Health Center, 2025.
30 Reyes-Urueña J , Marrone G, Noori T et al. HIV diagnoses among people born in Ukraine reported by EU/EEA countries in 2022: impact on regional HIV trends and implications for healthcare planning. Euro Surveill 2023; 28(48):2300642.

(95-95-95) among MSM is estimated at 89-99-92, respectively, and awareness of one's HIV-positive status has shown the most significant progress over the past three years.

Regarding SWs, PSEs are available only for the pre-war period. NGO representatives and public health workers point to a possible increase in women's engagement in sex work in war-affected regions. Therefore, despite the relatively low HIV prevalence detected in 2021 and the overall declining trend observed over the past 20 years (including among SW under the age of 25), the epidemiological significance of this group may increase due to changing circumstances and population dynamics.

Globally, HIV prevalence is typically higher among TGW, while among transgender men and non-binary individuals, it tends to be substantially lower. Ukraine's Integrated Bio-Behavioural Surveillance (IBBS) data indicate HIV prevalence of 2–4% across groups. The transgender and non-binary population is estimated at 12,800.

People in prisons and other closed settings represent another group with high HIV prevalence (8.0%). Awareness of HIV status in this group is far from target values (71.2%), which is partly explained by overall suboptimal testing coverage (77.9% were ever tested) and both sexual and parenteral transmission risks are present.

Table 3.HIV among key populations: key data

KP	IBBS						Size estimation		
	HIV prevalence, last estimate	HIV prevalence-previous estimate	Treatment cascade 95-95-95	HIV testing and HIV status awareness (GAM)[31]	Risk behaviour indicator	Sampling method, sample size, year	Size estimation, thousands	Year	Method
PWID	16.5%↓	20.3% (2020) 22.6% (2017)	68.9% - 86.7% - 78.1%	55.6%	93.9% (used clean syringe during last injection)	RDS, N=5,000 2023	Region-based estimates, no country estimate available 295,9 350,0	2023 2020 2018	Combination of several methods Network scale-up (NSUP) Combination of several methods
MSM	6.8%↑↔	3.9% (2021)	88.6%	65.0% - tested	67.5% (condom use	RDS,	-	2025	Sites-based estimates

31 Standard GAM indicator: % of KP who were tested for HIV in the past 12 months or know they are living with HIV

KP	IBBS						Size estimation		
	HIV prevalence, last estimate	HIV prevalence-previous estimate	Treatment cascade 95-95-95	HIV testing and HIV status awareness (GAM)[31]	Risk behaviour indicator	Sampling method, sample size, year	Size estimation, thousands	Year	Method
		8.0% (2015)	- 98.6% - 91.8%	during 12 months	during last anal sex with male partner)	N=3,490 2024	202.2 152.3	2021 2020	Extrapolation NSUP
TG	2.7% (2.4% - TGW, 3.7% - TGM, 2.1% - non-binary)	2% - TGW, 0% - TGM (2020)	75% - 100% - 100%	49.2%	63.5% (condom use during last sex)	non-probability sample, N=600 2024	12.8 10.0 8.2	2022 2020 2020	Coefficients, NSUP NSUP Combination of methods
SW	3.1% ↓	7.0% (2016) 7.3% (2013)	83.1% - 93.8% - 79.7%	64.2%	92.4% (condom use during last sex with clients)	TLS N=5,450 2021	78.4 86.6 (both female and male)	2020 2018	NSUP Combination of methods
People in prisons and other closed settings	8.0%↔	8.9% (2019) 7.6% (2017)	71.2%- No data - No data	77,9% - ever tested	Not defined	IBBS, stratified quota sample, N=1,500 2023	39.7	2024	Official register

The disruptive effects of the war can significantly influence epidemiological dynamics among KPs through multiple pathways. Existing evidence remains limited, yet several studies and expert assessments point to a number of potential mechanisms.

These include: (1) changes in risk behaviours, such as a possible increase in substance use or other high-risk practices among certain groups (including both civilians and military personnel in frontline areas) driven by traumatic stress; (2) reductions or shifts in patterns of drug use driven by disruptions in drug markets (availability, quality, and price); and (3) engagement in sex work or other high-risk behaviours by individuals not previously involved, including sex-work as a survival strategy.

Taken together, these observations suggest potential substantial changes in risk behaviours, yet current evidence is insufficient to determine whether these constitute new, distinct population groups worth intervention.

Other war-related effects include (4) disruptions to HIV prevention, testing, and treatment services, which vary across regions; and (5) increased mortality. Additionally, large-scale internal and external migration, including among KPs, and loss of control over certain territories with lack of valid estimates on those changes complicate the interpretation of epidemiological data. Implementation of IBBS has faced recruitment and logistical challenges, particularly among men, which may introduce further biases.

Given these diverse and sometimes opposing influences, as well as data limitations, a straightforward interpretation of trends is not feasible without careful, contextualised analysis supported by expert consensus.

4.3.3. HIV case reporting data

As per data available in the Bulletin "HIV Infection in Ukraine" No. 56, in 2024, 10,038 HIV cases were newly diagnosed, and of these 65.5% were men and 74.7% were in the age group 25-49 years.32 The majority of newly reported HIV cases in 2024 were residents of urban areas (72.6%). It should be noted that the share of newly reported cases among rural residents increased from 18.9% in 2021 to 27.4% in 2024.

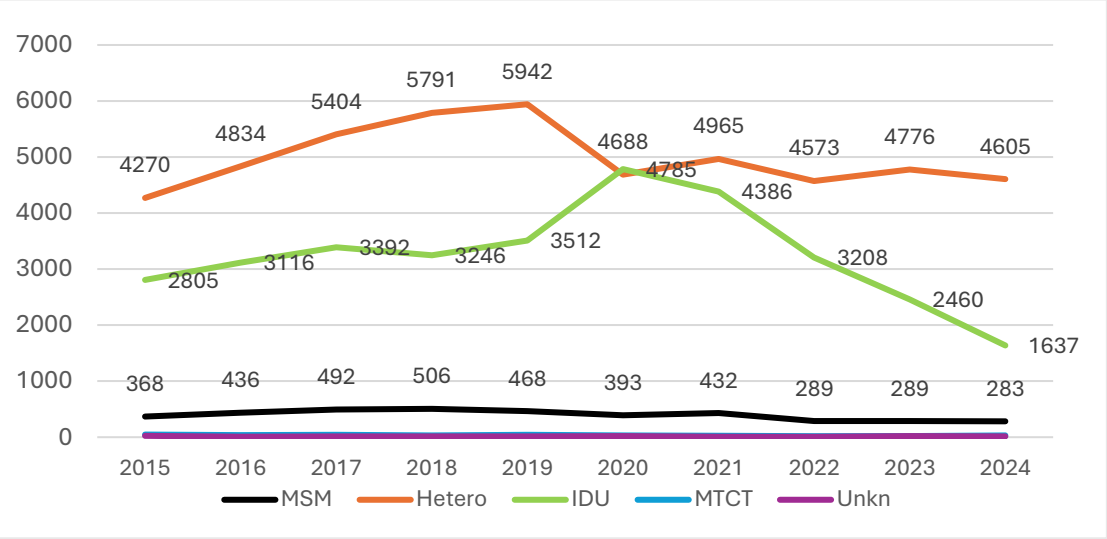
In the 2015-2024 period, the number of newly reported HIV cases peaked in 2019 when 16,357 cases were reported and since then steadily declined. In 2024, approximately 50% of newly diagnosed cases were from four regions: Dnipropetrovsk (n=2,064), Odesa (n=1,381), Kharkiv (n=654) regions and the city of Kyiv (n=909). According to data presented in the Bulletin "HIV Infection in Ukraine" No. 56, the number of newly reported HIV cases could be 32.2 per 100,000 population in the whole country and the highest in Dnipropetrovsk (65.3), Odesa (65.8), Kherson (67.6) and Donetsk (104.3).**Error! Bookmark not defined.** Reported sexual mode of transmission increased in the past 10 years, reaching 80.1% in 2024. Overall, in 2024, 19.1% of HIV cases were attributed to parenteral transmission, though some regions reported considerably higher proportions - Kharkiv (44.5%), Lviv (35.8%) and Kherson (33.0%).

During the 2014-2025 period, the dominant reported mode of transmission in men was heterosexual (*Figure 2*). In 2024, of 6,572 newly reported male cases, 70.1% were reported as being due to

32 Also available at NATIONAL PORTAL strategic information in the field of public health

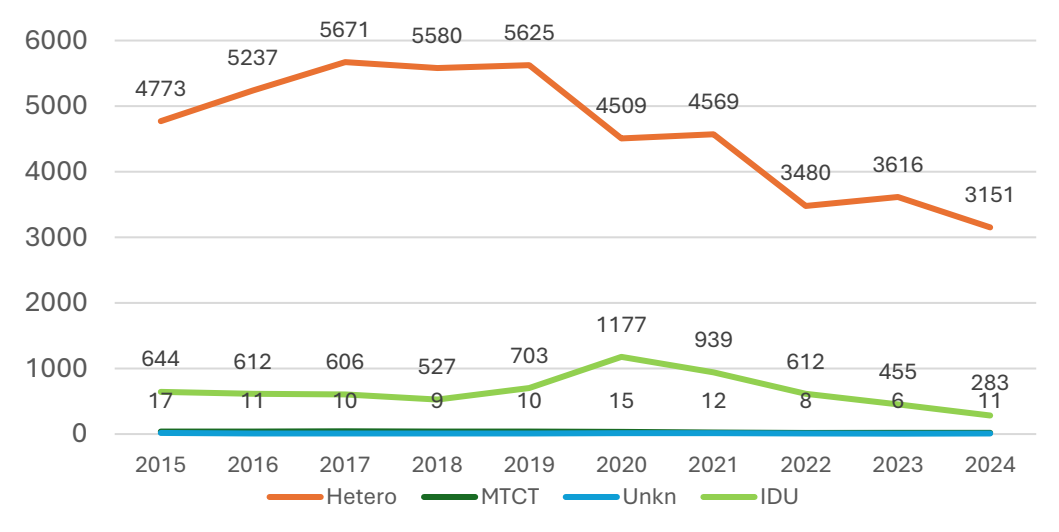
heterosexual transmission, 24.9% as IDU, and only 4.3% as MSM. Notably, reported cases attributed to injecting drug use (IDU) have declined steeply since 2020.

Figure 2. Newly reported HIV cases in men by modes of transmission, 2015-2024



As in men, the number of reported HIV cases in women peaked in 2019 (n=6,375) and afterwards declined steadily to 3,466 cases in 2024. Out of all cases in 2024, 90.9% were reported as due to heterosexual transmission and 8.2% as IDU. The proportion of cases attributed to injecting drug use declined between 2020-2024 (**Error! Reference source not found.**).

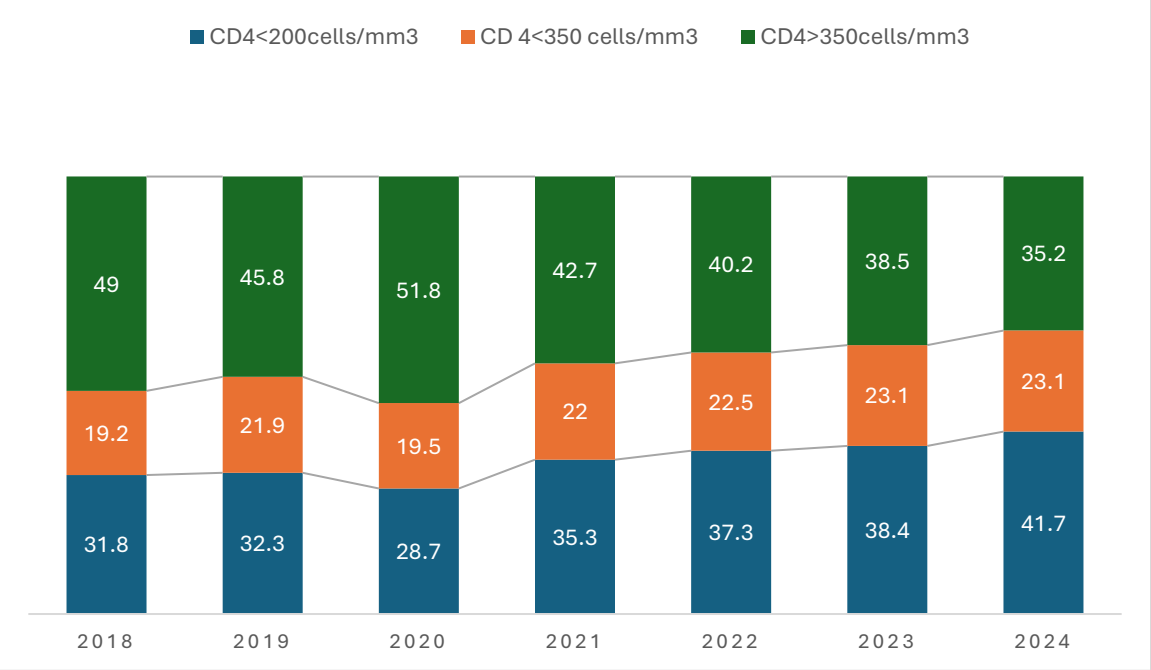
Figure 3. Newly reported HIV cases in women by modes of transmission, 2015-2024



The ratio of female to male cases attributed to heterosexual transmission was around 1:1.05 in 2019-2021, since 2022 it has exceeded 1:1.3, indicating likely over-reporting of heterosexual transmission in

men. In generalised HIV epidemics with dominant heterosexual transmission, the male-to-female ratio is approximately 1:1.2.[33] Since 2022 in particular, there has been an excess of male heterosexual cases, which implies that a certain number of these cases were due to male-to-male or IDU transmission or that females infected with HIV are undiagnosed and/or under-reported. Studies carried out in Ukraine in the past decade identified under-reporting of male-to-male and IDU transmission in case reporting data, which limits the utilisation of these data for programming purposes.[34, 35] Under-reporting of these behaviours is likely due to fears of stigma and discrimination in the health sector. Coverage with Cluster of Differentiation 4 (CD4) count testing was 91.2% in 2024. **Error! Reference source not found.** shows that since 2020, there has been a continuous increase in the percentage of newly diagnosed HIV cases whose CD4 count was below 200 cells/mm^3. This increase might be due to improved identification of individuals with long-standing HIV infection following the scale-up of HIV testing. In 2024, the share of people diagnosed with HIV infection with CD4 <200 /mm^3 approached 50% in the Dnipropetrovsk, Rivne, Zakarpattia and Odesa regions.

Figure 4. Percentage of HIV cases diagnosed by CD4 count categories



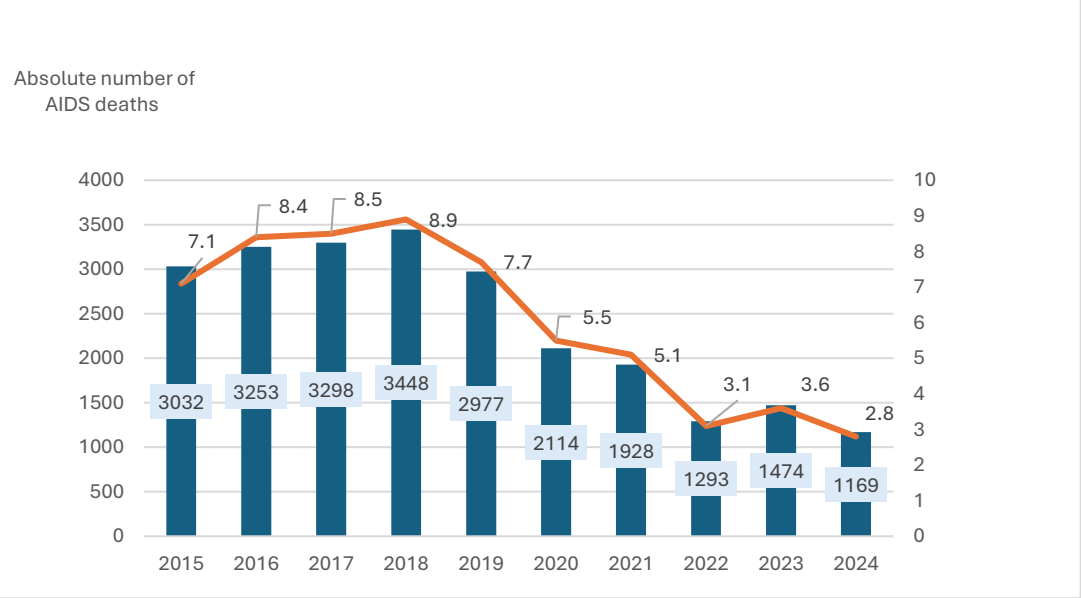
33 Hegdahl HK, Fylkesnes KM, Sandoy IF. Sex Differences in HIV Prevalence Persist over Time: Evidence from 18 Countries in Sub-Saharan Africa. PLoS One 2016; 11(2):e0148502.
34 Čakalo JI, Božičević I, Vitek CR, Mandel JS, Salyuk TO, Rutherford GW. Misclassification of men with reported HIV infection in Ukraine. AIDS Behav. 2015; 19:1938–40
35 Dumchev K, Kornilova M, Kulchynska R, Azarskova M, Vitek C. Improved ascertainment of modes of HIV transmission in Ukraine indicates importance of drug injecting and homosexual risk. BMC Public Health 2020;20(1):1288.

Of those newly diagnosed in 2024, 90.1% were linked to care, which is a substantial increase compared to 82.7% in 2020.

4.3.4. HIV mortality reporting

The total number of PLHIV who died of AIDS peaked in 2018 when 3,448 cases of deaths were reported and declined afterwards, likely due to improved access to ART. In 2023 and 2024, 1,474 and 1,169 AIDS deaths were reported, respectively. Similarly, the AIDS mortality rate declined from 8.9/ 100,000 in 2018 to 2.8/ 100,000 in 2024 (
Figure 5). This shows success in reducing HIV-related mortality. The reported AIDS mortality rate was highest in Donetsk (13.1), Odesa (11.3), Dnipropetrovsk (9.2) and Mykolaiv (6.3).
Of note is that reported mortality data are to some extent under-estimated, primarily due to disruptions in reporting brought by the war.

Figure 5.Absolute number of AIDS deaths and number of AIDS deaths per 100,000 population



4.3.5. HIV Testing Data

In 2024, approximately 2.59 million HIV tests were done, compared to 1.96 million in 2020. HIV positivity in the testing data declined, from 1.1% in 2020 to 0.5% in 2024.
In 2024, 51% of the total volume of tests was provided in seven regions. The highest HIV test positivity was in Odesa (0.93%), Donetsk (0.9%) and Kharkiv (0.82%) regions.

4.3.6. Early warning indicators and surveys of HIV drug resistance

In recent years, increasing attention has been paid to monitoring HIV DR in Ukraine as part of efforts to sustain the effectiveness of ART and strengthen national treatment programmes. A series of national surveys have been undertaken to assess both acquired and pre-treatment HIV DR, as well as key early warning indicators (EWIs) that reflect programme performance, patient retention, and viral suppression outcomes. Data collected between 2020 and 2025 provide important evidence on resistance patterns and programmatic gaps, supporting continued optimisation of ART regimens and HIV care quality across the country.

The survey of acquired HIV DR conducted in 2020-2023 included 594 patients from 11 oblasts. Inclusion criteria were having VL over 1000 copies/ml and being on ART at least 9 months. HIV resistance mutations were detected in 301 samples (50.7%). Resistance to any NNRTI was detected in 264 (44.4%) of the samples and to any PI in nine (1.5%). Among individuals receiving dolutegravir (DTG)-containing regimens (n = 366), the weighted prevalence of DTG resistance was 6.6% (95% CI: 2.3–10.9).

Another survey of acquired HIV DR is being conducted in 2024-2025 and as per protocol 933 patients who have been on DTG-based ART regimens should have been recruited. Only 693 patients were recruited because the number of patients with virological failure on DTG-based regimens was lower than anticipated. Analysis of data from this study is underway.

The first nationally representative survey of pre-treatment HIV DR was done in 2023 and included 208 patients. Prior ARV exposure was recorded in 35.5% of patients. HIV DR to NNRTIs (EFV/NVP) was found in an overall 8.1% samples and in 13.7% of those with prior ARV exposure. HIV DR to tenofovir disoproxil fumarate (TDF) / tenofovir alafenamide (TAF) was 0.1–0.2%. No HIV DR was found to INSTI and PIs.

The first nationally representative survey of HIV drug resistance among newly diagnosed HIV-infected children under 18 months began in 2024. The field stage continues in 2025.

Data on early warning indicators (EWIs) are available for cohorts that started treatment in 2020, 2021, 2022 and 2023 and included 5,509, 5,076, 4,405 and 4,508 patients, respectively. Retention on ART at 12 months after initiation was sub-optimal - 81.2% for the 2020 cohort, 81.0% for the 2021 cohort, 78.1% for the 2022 cohort and 84.8% for the 2023 cohort. VL testing at 12 months – in 2020, 2021 and 2022 was 52.5%, 52.7% and 58.6%, respectively, which is sub-optimal and different from the cascade

indicators provided in GAM. This requires further understanding in terms of sampling and representativeness of EWIs. VL suppression among those tested was relatively high – 94.3%, 94.7% and 93.9%. It is encouraging that retention improved when 2023 cohort data are compared with 2022.

These findings underscore Ukraine's ongoing progress in monitoring and managing HIV treatment effectiveness, while also highlighting areas requiring continued programmatic strengthening. The consistently high levels of viral suppression among those tested demonstrate the effectiveness of current ART regimens; however, sub-optimal retention and limited VL testing coverage point to the need for targeted interventions to enhance continuity of care. The ongoing and planned HIV DR surveys (supported through national and international collaboration) will provide essential evidence to guide policy decisions, inform updates to national treatment guidelines, and sustain progress toward achieving optimal ART outcomes and epidemic control.

4.3.7. Strategic Information and Data Collection Tools

Context

A. *Indicators of the State Strategy for Combating HIV/AIDS, Tuberculosis, and Viral Hepatitis and the progress towards their achievement*

The Strategic Goal 1 of the State Strategy for Combating HIV/AIDS, Tuberculosis, and Viral Hepatitis for the Period Until 2030 is to reduce HIV incidence and mortality. The strategy includes seven key indicators to evaluate progress. Among these, two are impact indicators: the rate of mother-to-child transmission of HIV and AIDS-related mortality per 100,000 population. The target for mother-to-child transmission (≤2%) is projected to be maintained in 2025. Reliable estimates for achieving a 50% reduction in AIDS-related mortality by 2025 are not available. Although registered AIDS-related deaths have declined, limitations in statistical and demographic data, as well as weaknesses in the death registration system, prevent robust conclusions.

The proportion of PLHIV on ART who are virally suppressed exceeded both the UNAIDS target and State Strategy targets (96% in 2024), while treatment coverage among those aware of their status although significantly improved compared with baseline fell short of both UNAIDS and State Strategy targets (86.1%). Data on the proportion of PLHIV aware of their status are not available due to uncertainties in the total population number.

Other indicators include reaching 80% prevention coverage for each KP and 15% OST coverage among PWID with opioid dependence. Achievement of these targets was planned to be measured using the estimated population size as the denominator; however, for 2024, this is not feasible due to

the lack of reliable data. Based on the available estimates derived from the latest IBBS surveys, it seems that, while OST targets were achieved (15.4%), the prevention coverage targets were most likely not met for any of the groups[36]. Comparing coverage across groups is challenging due to differences in indicators and timeframes used.

Comparison with the Regional Action Plan highlights areas for further alignment (Annex 3). Notable gaps include the absence of HIV morbidity impact indicators in the Ukrainian State Strategy, more modest prevention and treatment targets, and a lack of indicators addressing stigma, discrimination, and gender-based violence. In addition, some indicators lack disaggregation, such as HIV-related deaths by specific conditions (e.g., cryptococcal meningitis, TB, severe bacterial infections) and cascades by age group, sex, and KPs, including migrants.

The seven key strategy indicators are complemented by 20 tasks in the Operational Plan, encompassing a total of 50 indicators across three technical areas: prevention of new HIV infections, effective case detection, and universal access to HIV treatment. In the first half of 2025, a substantial proportion of coverage activities fell short of planned targets.

The dedicated web-portal **"HIV Monitoring in Ukraine"** https://npsi.phc.org.ua/en/ accumulates key up-to-date indicator regarding HIV- monitoring in the country and regional levels. This is a comprehensive online tool maintained by the UPHC, providing over 200 HIV-related indicators with detailed definitions, visualisations, and multiple levels of disaggregation (regional, gender etc.). One of the key advantages of this platform is that it integrates data from various stakeholders, including health facilities, NGOs implementing prevention programmes, as well as PSE and IBBS surveys, although the latter could be included with substantial delay presumably due to the time needed for discussion and verification. While recent modelling-based indicators are not currently presented and recent data on mother-to-child transmission (e.g., labor among mothers with HIV, available up to 2022) are not yet reflected, it remains a major open and transparent decision-support resource for monitoring the HIV epidemic at national and regional levels.

Overall, the Strategy and Operational Plan provide a framework for monitoring and evaluating the HIV response. **Nevertheless, a comprehensive national framework for HIV surveillance and**

36. MSM, GAM indicator, 3 months period: 28.2% (2021). 2024 data are in progress: coverage among prevention program clients – 70.3%, non-clients – 13.4%
Transgender people, GAM indicator, 3 months period: 15.5%-16.2% depend on the service type, 10.8% - at least 2 services (2024)
PWID, 12-months period: 36.6% - 42.7% depending on the service (2023)
SW, GAM indicator, 3 months period: 38.5% - at least one service, 30.2% - at least 2 services; 12-months period: 49.8% - at least one service, 47.0% - at least 2 services; (2021)

monitoring, clearly specifying the surveillance activities, timelines, and responsible entities for data collection was not available.

B. Strategic information system and data collection tools

Ukraine has a comprehensive HIV strategic information system that includes HIV case reporting, reporting on HIV mortality, HIV prevention and treatment monitoring data, a survey of acquired HIV DR done in 2020-2023, EWIs of HIV DR, IBBS, and PSE, and a number of programme implementation and evaluation studies. HIV strategic information is coordinated by the UPHC

The main information management systems of the UPHC are:

- Information system "Monitoring of socially significant diseases", which collects data on patients in HIV and TB care and on OAMT, their laboratory test results, and generates information for accounting and procurement planning. The system also has a module on HIV prevention.
- Information system on epidemiological surveillance, which collects case reporting data on infectious and occupational diseases, including HIV.

The information system "**Monitoring of socially significant diseases**" entered pilot operation on 27 November 2015, and industrial use on 25 June 2022. As of 2025, the system includes approximately 227,000 medical records of HIV patients in care from 492 ART clinics. It also includes a prevention of mother-to-child transmission (PMTCT) module.

The Information and Analytical System “Management of Services for Socially Dangerous Diseases” (IAS MSSDD) enables centralised monitoring of the quality, coverage, and continuity of prevention services for KPs—including outreach, testing, and linkage to care—alongside care and support services for PLHIV. However, as noted during the review, the system has limited built-in analytical functionality and capability to produce real-time data dashboards, particularly at facility-level. The system enables longitudinal analysis; however, longitudinal data on ART retention and VL suppression are available to a limited extent. There are plans underway to transfer HIV case reporting from regional AIDS centres to regional Centres for Disease Control (CDCs). HIV case-based surveillance is currently being piloted in three regions, and once established, it will be transferred to CDCs.

Since 2023, IAS MSSDD has been improved, in particular the Prevention Module. Subsequent redevelopment by the UPHC ensured alignment with national information system requirements, expanded system functionality, and enabled monitoring of prevention and support services for KPs.

The Syrex database of the Alliance for Public Health (APH) Ukraine is used as open-access software for monitoring and recording of information on clients from the KPs reached and services provided in community-based HIV prevention programmes. Clients are registered by using a unique alphanumeric

identification code (UIC), to record commodities and services provided across various projects. The system provides the opportunity to conduct sophisticated longitudinal analyses of patient cohorts and can be integrated with data from innovative projects. An example of the latter is the optimised case-finding approach using a social network strategy, which is implemented by the APH Ukraine.

In parallel, another software monitoring system DataCheck, originally developed and maintained by the organisation 100% Life, is being used by various NGOs to track their clients from different groups, including PLHIV. It has now fully replaced the previously used Go++ system. The UPHC utilises a similar programme based on DataCheck's functionality to track prevention efforts carried out by NGOs contracted by the state.

Overall, data collection systems are managed entirely electronically; however, in regions with limited connectivity or electricity supply, especially in frontline areas, paper forms could occasionally be used and later entered into the electronic system.

Ukraine has long-standing experience in conducting IBBS and PSE as key components of its strategic information tools and continues to utilise them. The UPHC coordinates all IBBS and PSE activities nationwide, including planning, methodology development, and data collection, while interested stakeholders, including NGOs, participate in the various stages, particularly study design and validation of results. Additionally, various stakeholders, such as NGOs, and research organisations also produce various studies to inform HIV-related policies and practices.

The recommendation from the review conducted in 2023 to prioritise collection of information on migration in KPs, PLHIV and clients of prevention programmes has been partially implemented. Exchange of information with European countries on the number of Ukrainian refugees living with HIV and their access to ART has been limited. Additionally, some of the recommendations that have not been met are to develop a multi-year HIV surveillance plan and optimize interoperability of different electronic databases.

Achievements

Despite considerable logistical and infrastructural challenges caused by the ongoing war, Ukraine has maintained a stable and functional HIV surveillance, strategic information, and monitoring and evaluation system. Many surveillance components are already in place, including case-based reporting, IBBS, routinely collected prevention, testing, and treatment monitoring data, EWIs of HIV DR, and special studies addressing programmatic needs. Facility-level data on EWIs are available, which enables evidence-based service quality improvement, where needed.

The country continues to implement large-scale IBBS across all major KPs including MSM, PWID, transgender and gender-diverse people, and people in prisons and other closed settings, with strong

participation and coordination among national and regional stakeholders. The next rounds of IBBS (among people in prisons, people who use non-injection drugs and sex-workers) are already included in the plan to be implemented in 2026. The country also plans to address with IBBS potential emerging priority populations, including military personnel.

There is ongoing progress in integrating various datasets and analytical tools, alongside data verification and deduplication efforts to better estimate the number of PLHIV on ART and to assess coverage with different interventions.

Overall, the system continues to provide key data for evidence-based decision-making, ensuring that surveillance and monitoring activities remain operational and informative even under crisis conditions. The transparency and openness of the key data for various stakeholders, ensured through dedicated online portal and websites of partner organisations, is indeed an important country's achievement.

Challenges

The HIV strategic information system faces interrelated governance, surveillance, and funding challenges, some of which have arisen or been exacerbated by the ongoing war, that limit its ability to provide a complete and timely picture of the epidemic.

From a governance perspective, some gaps need to be addressed to improve the effectiveness of HIV surveillance and M&E. A detailed national plan to guide surveillance and monitoring activities is currently lacking, and coordination within the Technical Working Group remains insufficient, particularly in setting research priorities, aligning future studies across stakeholders, and ensuring consistent, timely dissemination of results.

From a surveillance perspective, several interlinked gaps constrain understanding of the epidemic. There is an absence of reliable or acceptable estimates of the general population, PLHIV and KPs; pre-war estimates are unreliable due to migration, mobilisation, and possibly changes in the number of people involved in drug use and sex work. Misclassification of MSM and IDU mode of transmission in HIV case reporting data further undermines data quality. EWI indicators are not available in the HIV Bulletin, including data on longer-term retention on ART, while detailed IBBS reports are published with delay and most KP size estimates have not been updated. Longitudinal patient outcomes (loss to follow-up, retention) remain largely unpublished. There is limited real-time availability of key treatment outcomes at a facility level, which is important for service quality improvement.

These weaknesses are compounded by the absence of modelled impact indicators (HIV incidence, prevalence, mortality, MTCT) and coverage indicators (KP prevention coverage, OST coverage) due to

uncertainties in total population estimates. The absence of prevention coverage indicators significantly limits decision-makers' ability to understand progress and identify bottlenecks in the implemented activities. Current guidelines37 emphasize that monitoring prevention targets should rely on both programme-based data (which require a PSE) and survey-based data. In the absence of programme-based estimates, the use of survey-based indicators can still provide important insights into progress in prevention among KPs. Careful analysis of survey-based data with some limitations could also be useful to understand OST coverage while the prorgamme-based estimates are unfeasible[38].

Finally, the lack of data from fully occupied regions and incomplete reporting from areas affected by armed conflict during the war further limits the ability to assess the real epidemic situation.

From a systemic perspective, several issues affect the coherence and usability of HIV strategic information. There is a misalignment between national HIV indicators and those in the Regional Action Plan, including the lack of morbidity-related indicators and of indicators that monitor the broader environment such as stigma, discrimination and violence, as well as disaggregation of some indicators (like 95-95-95 cascade) by KP, age and gender. The absence of a unified national Unique Identifier Code (UIC) further limits the ability to reliably track individuals across services, although harmonisation efforts are currently underway. In addition, the HIV Bulletin has occasional weaknesses, including structural inconsistencies, data flow issues and challenges in interpretation, which reduce its effectiveness as a core reference document for policymakers and programme managers.

It should also be noted that certain new data management approaches (including verification by mobile phone number of KP clients) may compromise clients′ confidentiality, recruitment and retention if not carefully managed.

In terms of resource availability, due to declining support overall and to research in particular from major donors such as PEPFAR and the Global Fund to fight AIDS, TB and Malaria (the Global Fund) , as well as uncertainties regarding the next rounds of support from the Global Fund, the implementation of research initiatives, particularly those not directly related to programmatic activities, has become increasingly uncertain and risks remaining underfunded. The local sources of funding for M&E activities today are also unclear.

37 **World Health Organization.** *Consolidated HIV strategic information guidelines: driving impact through programme monitoring and management.* Geneva: WHO; 22 April 2020. ISBN 978-92-4-000073-5. Available at: https://www.who.int/publications/i/item/9789240000735

38 **UNAIDS. (2021).** ***Global AIDS Monitoring 2022: Indicators and questions for monitoring progress on the 2021 Political Declaration on HIV and AIDS*****. Geneva: UNAIDS.** URL: https://indicatorregistry.unaids.org/sites/default/files/2022-global-aids-monitoring_en.pdf

In terms of data collection, due to the war, the priority is to continue with strengthening routine, programmatic data collection systems.

Recommendations

Recommendations for strengthening the Strategic Information system	Priority	Implementer	Implementation timeline		
			2026	2027-2028	2030
Reinvigorate TWG on HIV surveillance and M&E	High	MoH, UHPC	X		
Develop a national strategy/plan for HIV surveillance and M&E, including the sources of funding	High	MoH, UHPC	X		
Align national indicators with the Regional Action Plan, including morbidity targets and enabling environment (stigma, discrimination, and violence)	High	MoH, UHPC	X	X	X
Continue HIV case-based surveillance	High	UHPC	X	X	
Conduct PSE (including virtual platforms)	High	UHPC, NGOs	X		
Implement BBS and BBS-Lite in KPs and bridging populations	High	UHPC, NGOs	X	X	X
Ensure interoperability across platforms that collect HIV treatment, case-based surveillance and vital statistics data	High	UHPC	X	X	
Use IBBS data to measure indicators related to KP coverage by prevention services in addition to programme-based data	Medium	UHPC	X	X	X
Improve data exchange on PLHIV abroad (for ART and VL outcomes)	Medium	MoH, UHPC	X	X	
Make available and publish data on VL testing in people on ART and retention on ART to better	Medium	UHPC	X	X	X

understand the HIV cascade indicators					
Enable real-time facility-level treatment data use	Medium	UHPC	X	X	X
Conduct formative assessment for new populations of interest (PWUD, military personnel, SWs in the war-affected areas etc.)	Medium	UHPC, NGOs	X	X	
Adjust for MoT misclassification in HIV case reporting	Medium	UHPC	X	X	
Improve vital statistics and reporting of deaths in PLHIV	Medium	UHPC, MoH	X	X	
Enhance the HIV Bulletin (in terms of the structure, clarityand interpretation)	Low	UHPC	X		

4.4. Prevention services for key populations and other groups

Context and achievements

Ukraine continues to prioritise HIV prevention and service delivery for key and vulnerable populations despite the ongoing war and challenging humanitarian context. National policies and regulatory frameworks have been regularly updated to align with evolving epidemiological patterns and service needs, ensuring that essential HIV prevention, care, and support interventions remain accessible across all regions.

In 2023, MoH updated Order No 1632 which defines seven KPs for HIV prevention and care: partners of HIV-positive individuals; PWID and their sexual partners;MSM; SWs; persons in or released from penitentiary/pre-trial detention institutions; and transgender people. In recognition of the current security context, a number of interviewed entities highlighted military personnel as a vulnerable group, however due to restricted access to data and operational constraints during wartime, it was not possible to justify it.

Service standards, implementation requirements and legal aspects are outlined in various MoH orders, including drafts for amendments such as: (i) Order No 140 (26.01.2024) on care and support services for people living with HIV; (ii) Order No 288 (20.02.2024) on HIV prevention services among high-risk groups;

(iii) Order No 1556 (08.07.2019) on the method for calculating marginal tariffs for HIV services; and (iv) Order No 1681 (23.07.2019) on marginal tariffs for HIV services.

Despite the war, HIV prevention services continued across Ukraine. In 2024, 29 NGOs funded by the Global Fund operated HIV-prevention interventions for KPs (SW, MSM, PWID) in 24 oblasts.[39] As there are other funding sources supporting NGOs, these figures may not fully represent the national picture.

Demand has increased for integrated mobile services, which combine HIV, TB, and primary health care with humanitarian support such as transport, winter supplies, and power sources. Approximately 50 mobile clinics are currently operational, ensuring continued access to essential HIV prevention and care services in hard-to-reach and war-affected areas.

Complementing these community-based efforts, the Help24 TeleHealth digital platform has expanded rapidly, becoming a key innovation in HIV prevention and care delivery within a broader national digital ecosystem. By 2025, it had distributed thousands of prevention kits and provided nearly 10,000 consultations. The platform offers online outreach, diagnostics, telemedicine, ART delivery and supports displaced and vulnerable groups.

Help24 operates alongside other digital platforms and community-based initiatives in Ukraine that also support HIV testing and prevention. These include services offering postal delivery of self-tests, condoms, lubricants, and informational materials, as well as online consultations and referral to health facilities. Several national hotlines further contribute to reaching KPs and linking them to prevention and care. Aligned with Ukraine's National Telemedicine Development Strategy (2023), this growing digital ecosystem has helped to reduce access barriers during wartime by reaching previously underserved clients through chatbots, mobile applications, social networks, and peer-driven online interventions, providing a more comprehensive picture of ongoing digital innovations in Ukraine.

Challenges

Implementation of prevention programmes in Ukraine faced a range of evolving challenges. The ongoing war has shifted client priorities from health to immediate safety and social needs. A deteriorating security situation marked by frequent air-raid alerts and shelling, together with damaged health infrastructure and severe strain on the health workforce, has significantly reduced access to health services and increased the burden of trauma, rehabilitation, and mental health needs.

39 Progress update Disbursement Report, 31 Dec 2024

NGOs report a decrease in funding and in the workforce and capacity, limited access to services, especially in reaching MSM and SWs; uneven regional coverage and weak rural infrastructure; and high mobility of clients and staff were causing service disruptions. The growing need for mental health-related services is noted both for staff and for clients.

Uncertain and restricted State and donor financing, together with the continued exclusion of HIV prevention commodities from the State budget, and the misalignment of service tariffs with inflationary trends, pose ongoing challenges to ensuring the long-term sustainability of HIV programmes.
Additionally, the absence of up-to-date epidemiological and PSE data on selected KPs highlights the need for updated and more robust programmatic data.[40]
The coverage of prevention interventions in 2022 has decreased compared to 2021, which has been related to many factors, including the temporary occupation of part of Ukrainian territories. Despite the active war phase, the coverage has increased in 2023 (Table 4)

Table 4. HIV Prevention intervention and coverage of KPs 2022-2024, targets for 2025-2026

Year	**(client coverage)**					
		PWID	SW	MSM	TG*	Total**
	Target	289,896	55,337	59,740	12,800	
2021[41]	Achieved	286,896	59,740	55,337	3,647	401,973
	%	99%	108%	93%	27%	
2022	Target	203,283	53,410	47,582	12,800	304,275
	Achieved	176,917	43,888	42,079	3,689	262,884
	%	87%	82%	88%	29%	86%
Change 2021-2022		38%	27%	24%	1%	35%
2023	Target	194,558	44,906	44,829	12,800	284,293
	Achieved	220,235	50,023	50,509	4,496	320,767
	%	113%	111%	113%	35.1%	113%
2024	Target	207,351	54,488	48,533	12,800	310,372
	Achieved	209,279	48,232	46,902	5,720	304,413
	%	101%	89%	97%	45%	98%
Plan 2025		211,498	55,577	49,503	5,800	316,578
Plan 2026		215,727	56,688	50,493	6,450	322,908

*Data source for 2021-2023 from Information Bulletin, HIV in Ukraine, Nr.55, 2024; data for 2024 from APH (aph.org.ua/en/resources/statistics) ; ** Total does not include TG population;

40 Kovtun, O., Paniotto, V., Sakhno, Y. *et al.* Size estimation of key populations and 'bridge populations' based on the network scale-up method in Ukraine. *BMC Public Health* **24**, 979 (2024). https://doi.org/10.1186/s12889-024-18501-1
41 Information bulletin nr.53, HIV in Ukraine. Public Health Center of the MoH of Ukraine, 2022

4.4.1. Prevention Services for PWID

Context and achievements

Prevention interventions for PWID include basic and extended service packages. The basic prevention package of services covers sterile injecting equipment and alcohol wipes, condoms and lubricants, counselling and testing for HIV, screening for TB and other services, including legal aid. The extended package of services includes hepatitis C Virus (HCV) testing, PrEP counselling, and case management. In 2024, a total of 2,024 NGO-operated sites provided services for PWID. The services were delivered at stationary sites, by outreach, mobile clinics and pharmacies. Although the coverage of PWID with the prevention programme has been increasing over the last three years from 176 917 (87% of the target, Table 4) in 2022 to 209 279 (101% of the target) in 2024 the number of sterile needles and syringes distributed among PWID has been 81.6 per programme client/year, which has increased from 51 per person/year[42], however still falls low to the WHO/UNAIDS[43] defined population-level NSP targets. HCV treatment for KPs was progressively decentralised to NGO- based community settings. Since 2015, and up to mid-2025 there were 14,901 individuals treated on community platforms 43 field HCF sites, including 6,518 during the period of 2022-2025[44].

The latest estimate of the number of PWID in Ukraine was **296,000 (2020,** Table 3**)**. However, the active phase of the war marked by large-scale population displacement within the country and across borders, as well as the temporary occupation of several oblasts, has rendered these estimates outdated and created significant challenges for the planning and continuous implementation of HIV prevention programmes.

The 2023 IBBS showed HIV prevalence of 16.5%, lower than IBBS in 2020 of 20.3%, however there were large regional variations, with Odesa showing the highest HIV prevalence of 22.1%. The data from the monitoring of recent HIV infection indicates that the highest proportion of recent HIV infection has been observed among females, who acquired HIV through injecting drug use.[45]

Available data from the IBBS provides a valuable evidence base for understanding the evolving needs of PWID and identifying which types of preventive services would be most beneficial. The findings highlight shifting demographic and behavioural patterns within the PWID population and underscore the

42 UNAIDS Epidemic response, People who inject drugs at aidsinfo.unaids.org.
43 Global Health Sector Strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections for the period 2022-2030 (GHSS), July, 2022.
44 Alliance for Public Health. Presentation, 2025 September 29.
45 Implementation of monitoring system and response to recent HIV infection in Ukraine. PHC, PEPFAR. Digest, Jan 2025, 1(3)

importance of tailoring harm reduction interventions to ensure their continued relevance and effectiveness in the current context.

In 2023, the IBBS survey showed a significant ageing of the PWID population, women comprised 20.5% of participants, with unusually high shares in Dnipro (41.5%) and Cherkasy (32.5%). Opioids remained dominant: 60% injected street methadone in the past year. Illegally obtained pharmaceutical methadone (in tablet form, obtained from the black market) was used by 27%, while 15% used methadone from OAMT programmes. The proportion of stimulant injections (mainly amphetamines and synthetic cathinones) declined sharply from 40% in 2017 to 22% in 2023.

The proportion of those who know their HIV status has been higher in 2023 - 69% compared to 64.4% in 2020. Among those who know their status, 94.2% were linked to HCFs for diagnosis confirmation in 2020, compared to 92.1% in the 2023 survey. The involvement in prevention programmes was mentioned by 29.6% in 2023, which is lower than in 2020, when 32.3% indicated being clients of harm reduction programmes.

Between 2020 and 2023, a notable increase occurred in the coverage of HIV prevention services. Access to sterile syringes increased from 26.3% to 43.6%, condom provision rose from 22.1% to 37.7%, and HIV testing coverage improved from 20.2% to 35.1%. These gains likely reflect successful adaptation and resilience of harm reduction programmes to crises, such as COVID 19 and active war phase.

Challenges

IBBS results indicate that HIV prevalence is stabilizing. However, persistent injection and sexual risk behaviors, regional disparities, and limited access to harm reduction and OAMT continue to threaten progress. An important systemic challenge is the very limited engagement of PWID with OAMT services, IBBS in 2023 revealed that more than 60% of PWID were either unaware of OAMT or expressed no interest in starting it, and only one-third reported receiving any prevention services from NGOs. Gaps were particularly notable in Vinnytsia, Dnipro, and Lviv.

Harmful alcohol use affected 17.2% of PWID. Unsafe injection practices remain widespread; 6.1% reported to using sterile syringes during their last injection, and 35.5% reported at least one high-risk injection practice in the past month. The most frequent behaviours included reusing one’s own syringe (34%), sharing containers (20%), and using front-/back-loaded syringes (20%). Risk behaviours were more common among women, stimulant users, and those mixing opioids and stimulants. Pharmacies (68%) and NGOs (24%) were the main sources of sterile syringes.

Condom use during the last sexual intercourse was reported by 45% (lower among women). Sex work was more common among female PWID, particularly in Dnipro and Cherkasy, reflecting economic hardship and proximity to military zones.

The IBBS 2023 findings highlight wide variation and inconsistency in the quality of services for PWID. Many clients valued NGO-based services for their confidentiality and trust, but reported concerns about the quality of medical care, including limited availability of medications (e.g., OAMT), stockouts of prevention supplies, long waiting times, and poor provider attitudes. While commodities were generally adequate where services functioned, supply reliability and consistency remain key concerns, particularly in war-affected and rural areas. Limited access to naloxone was also reported.

Some PWID reported experiencing disrespectful or stigmatising attitudes from healthcare staff, which discouraged them from seeking further care. Continuity of services and coordination between NGOs and healthcare facilities were also inconsistent, particularly in war-affected regions. These findings highlight persistent gaps in the quality and accessibility of care, especially outside major cities and among marginalised groups such as women and displaced persons. At the same time, the emerging use of new psychoactive substances (NPS) is reshaping the drug-use landscape, while existing HIV prevention efforts do not fully meet the needs of those who use these substances. Pilot initiatives such as the distribution of “PartyBox” harm-reduction kits (which include oral HIV self-tests, condoms, lubricants and HIV-prevention outreach) and the provision of drug checking and other tailored services for young people experimenting with NPS and other substances represent evolving approaches to reach these populations; however, their impact and scalability still require further evaluation. These secondary-prevention measures should be embedded within broader primary-prevention efforts aimed at preventing or delaying initiation of drug use among young people (for example, through school-based education, youth-friendly counselling and psychosocial support), and clearly communicated so that they are not perceived as encouraging drug use but as mitigating health risks among those who already use drugs.

Criminalisation of drug use and possession for personal consumption, with 36.9% having been incarcerated, along with mandatory recording into addiction registries, perpetuates stigma, poverty, and poor access to services. Access to HIV prevention and treatment services among PWID in Ukraine is hindered by low awareness and interest in OAMT, limited coverage of services provided by NGOs, and persistent stigma and discrimination. Motivation of potential clients is an issue for harm reduction service implementers. Programme clients experienced a change in their priorities. They lost interest in HIV and harm reduction interventions as they cannot meet their basic needs. It became difficult to motivate people to get tested. Many PWID have experienced loss of temporary income as a result of labour market disruptions linked to large-scale internal migration and increased competition for limited job opportunities, including from internally displaced persons. These challenges have been further exacerbated by the

impacts of the war. Damage to infrastructure, economic hardship, and displacement have increased the risks of disruptions to harm reduction and treatment continuity. Mental health problems, poverty, privacy concerns and criminalisation further discourage service uptake, while knowledge gaps about prevention tools and uneven regional access continue to limit effective engagement in prevention activities and further linkage to care. The programme also faces constraints in funding emergency and continuous care services for vulnerable clients.

Recent global and Ukraine-specific analyses show that supply-chain disruptions remain a significant risk, underscoring the need to strengthen stock management and contingency planning.[46,47] Involving service users and community-led monitoring (CLM) in assessing commodity quality and availability is also promoted as good practice to ensure that supplies are acceptable, appropriate, and responsive to PWUD needs.

Recommendations

Recommendations on improving access to quality preventive services for PWID	Priority	Implementer	Timeline		
			2026	2027-2028	2030
Prioritise geographically districts (oblasts, or lower level where the surveillance data is available) with the highest HIV prevalence for scale up of harm reduction services, ensure uninterrupted supplies of commodities, including syringes, naloxone and condoms.	High	APH, NGOs	**x**		
Support flexible service delivery models (including mobile and community-based services) and continue developing online services with strong community input. Online programmes should	High	NGOs, mobile service providers, health service providers through digital platforms	**x**		

46 Public Health Centre of Ukraine. National response to HIV, TB, Viral Hepatitis and Substitution Maintenance Therapy in the Conditions of War, 2023 Annual Report.

47 USAID OIG. PEPFAR in Ukraine: USAID Ukraine Achieved Mixed Results When Implementing Programs Due to Wartime Challenges and did not conduct independent performance monitoring. (Audit Report, 2025).

be made more flexible and less restrictive—for example, by reviewing and, where appropriate, removing phone verification—while further assessing verification mechanisms to ensure a balanced approach between clients' interests, provider accountability, and State requirements for proper use of funds.					
Should additional funding be available, scale up tailored prevention services for PWUD – including those using new psychoactive substances (NPS) and more established drugs – through community-based interventions, anonymous drug checking, access to safer snorting/smoking equipment and safe drinking water, and by regularly adapting materials to evolving drug scenes and local needs of PWUD communities.	Medium	Harm-reduction NGOs, PHC		**x**	
Should funding be available, improve service provider competences: training for non-stigmatising (Health care facilities), trauma-informed, gender-sensitive approaches; regular supervision and mental health support.	Medium	Training institutions, HCF MoH, NGOs		**x**	
In the context of the full-scale war in Ukraine, build on and further	High	MoH, emergency	**x**		

strengthen existing contingency mechanisms to ensure continuity of HIV prevention services in war-affected and other crisis settings. This includes planning for uninterrupted services during displacement or infrastructure damage (e.g. mobile dispensing, outreach and telehealth) and institutionalising these approaches within national preparedness and emergency-response frameworks.		response units, coordinators of mobile clinics			
Address stigma and criminalisation: advocate for the decriminalisation of drug use and the discontinuation of mandatory recording into addiction registries. Strengthen collaboration with law enforcement to reduce harassment and barriers to care.	Medium	Policy makers (MoJ, Parliament), civil society, law enforcement institutions;		**x**	
Strengthen coordination and referral pathways between harm-reduction services and existing treatment programmes under the PMG – including hepatitis C and TB care, ART/PrEP, opioid agonist/addiction treatment, and detox/rehab and mental health services – to ensure that PWUD can receive continuous, integrated care. Where significant gaps or fragmentation persist, consider piloting more integrated PMG	High	MoH, Treatment and care service providers, NGOs	**x**		

arrangements for people with substance-use disorders in collaboration with NHSU and civil-society providers.					
Strengthen and formalise collaboration with state, municipal and NGO providers of psychological and mental-health services to ensure systematic linkages with harm-reduction and treatment programmes. This may include mapping available services, establishing standard operating procedures for two-way referrals, integrating brief counselling at harm-reduction sites, and using shared (consent-based) case management to support clients with trauma, depression, or substance-use-related mental-health needs.	Medium	NGOs, mental health services, peer-networks		**x**	
Strengthen coordination between NGOs and the health system: improve referral pathways, data exchange and joint planning to create a seamless continuum of care.	High	MoH, NGO consortia, monitoring & evaluation units	**x**		
Should funding be available, increase awareness and demand creation: run communication campaigns and peer education to improve knowledge about HIV prevention, PrEP, OAMT, and U=U.	Medium/ low	Communications teams, peer-educator networks, NGOs		**x**	**x**

Ensure commodity quality and supply security by using flexible procurement mechanisms, systematic quality-assurance processes, and structured user-feedback mechanisms, and by maintaining appropriate emergency buffer stocks at national and regional levels to prevent stockouts of key HIV and harm-reduction commodities.	High	Procurement units, MoH, donor agencies	**x**		
Target underserved groups: tailor interventions for women, young PWUD and displaced persons to ensure equitable access and inclusion.	High	Programme implementers, outreach NGOs, community networks	**x**		

4.4.2. Prevention Services for MSM

Context and achievements

The minimum package of preventive services for MSM includes condom and lubricant distribution, screening for TB, HIV testing, counselling and awareness raising. The extended package includes testing for hepatitis C and B, PrEP counselling, and referrals to legal aid.

In 2022, 68,292 unique MSM clients were registered in NGO-run prevention programmes (17 NGOs) and 45,780 of those (≈22.6% of the estimated MSM population, or ≈67% of the registered clients) received the “minimum package” of services (condom + consultation). According to the APH data, NGOs targeting MSM in Ukraine were found to be “highly cost-effective” in preventing HIV infections.[48]

MSM have been involved in early uptake of PrEP and have reached the highest numbers among all KPs (see PrEP subchapter). To address the needs of MSM who use stimulant drugs in sexualised drug use (chemsex) a pilot project for the distribution of PartyBox has been implemented. The harm reduction kit

48 Trickey A, Walker JG, Bivegete S, Semchuk N, Saliuk T, Varetska O, Stone J, Vickerman P. Impact and cost-effectiveness of non-governmental organizations on the HIV epidemic in Ukraine among MSM. AIDS. 2022 Nov 15;36(14):2025-2034.

included condoms, lubricants, HIV self-tests, a safe snorting kit for psychoactive substances (PAS), reagents testing for PAS, and informational and promotional materials.

In addition, online services provided harm reduction and HIV prevention counselling and facilitated referral to care and support programmes for ART initiation and linkage to PrEP. Postal delivery combined with online services proved to be an efficient alternative modality for providing prevention interventions.

Operational research has been integrated with service delivery, with several risk-based clusters identified. Higher risk profiles included polydrug use and higher-risk sexual behavior. The data is used to identify these risks and better address them with prevention interventions. Telegram chatbots were developed and implemented to expand the distribution of self-tests to clients' partners and to enable recording of self-test results and referrals.

Challenges

The most recent estimated number of MSM in Ukraine is 202,200 people (2022), however it may not reflect the current reality. According to the latest round of the IBBS (2024), the prevalence of HIV among MSM was 6.8% with some regional variation, concentrated in key urban areas

The 2024 IBBS among MSM[49] reported internal displacement due to the war, reflecting significant migration within Ukraine. As to their HIV status,79% were aware of it. Condom use during the last male sexual contact varied by city, typically between 50-70%. Awareness of pre-exposure prophylaxis (PrEP) increased significantly compared to earlier rounds, yet actual use remained low. Among the reasons for non-use included perceived low risk (48%), fear of side effects (27%), and lack of knowledge about where to obtain PrEP (6%).

In addition to the effects of the war and large-scale mobilisation, the 2024 IBBS among MSM highlighted ongoing HIV transmission risks and service coverage gaps. The coverage of MSM with prevention interventions remains the lowest among KPs, at 23%, although the programme coverage has fluctuated over time (Table 4). Coverage also varies considerably across regions.

The MSM population is recognised internationally as a group at increased risk of infection for hepatitis B. European survey data (e.g. EMIS) show that self-reported hepatitis B virus (HBV) vaccination coverage in this group remains incomplete even where such recommendations exist. In Ukraine, MoH Order No. 595 (as revised in 2024) already includes MSM among the groups for whom hepatitis B vaccination is recommended; at the same time, recent national seroprevalence data indicate substantial lifetime exposure to HBV in the general adult population, underscoring the importance of

49 Integrated Bio-behavioural Surveillance survey among MSM, draft report, 2024, Ukraine.

maximising protection in higher-risk groups. The preliminary results of IBBS 2024 do not provide the data on vaccination levels. During the interviews with representatives of MSM community, it was noted that some individuals are unaware that hepatitis B vaccination exists. Previous IBBS 2021 indicates that Hepatitis B testing is formally available to MSM through national HIV and viral hepatitis services, including community-based programmes and facilities that offer combined testing for HIV and other infections. Uptake and awareness of HBV testing among MSM remain insufficient, with many not routinely screened or unsure of their testing history. Vaccination coverage is clearly suboptimal: just 17% of MSM reported being vaccinated against hepatitis B, 76% said they were not vaccinated, and 7% did not know, pointing to large gaps in protection in this KP despite long-standing availability of the vaccine.

Since the start of the full-scale war in Ukraine, millions of people have been displaced inside the country or forced to flee abroad, with KPs MSM facing heightened vulnerability due to disrupted services, stigma and insecurity in shelters and transit settings. UNAIDS and Inter-Agency Standing Committee guidance on HIV in humanitarian settings emphasise that HIV prevention, testing and linkage to care, including targeted programmes for KPs, should be systematically integrated into emergency responses, camp/shelter management and mobile health outreach. In Ukraine, mobile clinics, community-run LGBTI shelters and humanitarian projects supported by APH and partners already provide HIV services and humanitarian aid to internally displaced persons, frontline communities and LGBTI people. Building on these models, embedding MSM-sensitive HIV prevention – including confidential HIV and STI testing, condoms and lubricants, PEP/PrEP information, and referral to MSM-led services – into IDP shelters, mobile health teams and emergency outreach is essential to maintain prevention coverage for MSM affected by displacement and war.

In Ukraine, MSM-led and other community-led organisations already play a central role in CLM, including under the Global Fund, the US-funded programmes, where KPs such as MSM systematically assess the availability, accessibility and quality of HIV services. Recent UNDP assessment[50] confirms that Ukrainian communities have substantial CLM experience and that CLM is especially important during the full-scale war for identifying service disruptions, human-rights violations and access barriers in conflict-affected areas; however, they also highlight gaps such as fragmented tools, irregular data collection and limited use of community-generated data in national monitoring and decision-making. Against this backdrop, the recommendation seeks not to introduce CLM anew, but to consolidate and systematise MSM-led CLM in Ukraine by sharpening MSM-specific indicators, strengthening MSM

50 The Assessment of the Ability of Community-Led Organizations in Ukraine to Monitor the Quality and Completeness of HIV-Associated Service Packages. SYNTHESIS REPORT. (2023, May). KYIV, UKRAIN

NGOs' role in analysing CLM data, and ensuring regular joint review and follow-up with service providers and public purchasers so that CLM findings lead to concrete improvements in the accessibility and quality of MSM-oriented HIV services during the war and beyond.

Over the past decade, Ukraine has implemented a wide range of communication and human-rights programmes to address HIV- and LGBT-related stigma, supported by national authorities, Global Fund investments and international partners. These include media campaigns, legal-literacy and "know your rights" initiatives, and, more recently, large-scale digital interventions such as the national TEST-poruch platform, which has shown high reach and cost-effective engagement of KPs, including MSM, during wartime.[51] At the same time, PLHIV stigma surveys and national opinion polls indicate that, although support for equal rights has grown, a substantial share of the population still expresses negative attitudes toward LGBT people.[52] Against this backdrop, the potential approach would be on consolidating and enhancing existing efforts by ensuring that MSM-specific messages are systematically integrated into national and local communication strategies, prioritising outreach to war-affected regions and displaced communities, and using community-led approaches and monitoring to track whether communication and advocacy activities translate into improved access, reduced stigma in services and better health outcomes for MSM.

Due to increased mental health needs in Ukraine especially among KPs national reforms – including the National Mental Health and Psychosocial Support Programme and updated HIV/KP prevention standards (e.g. MoH Order No. 288) – have already formally incorporated basic mental health support into primary care and HIV prevention packages, yet recent assessments among KPs highlight low awareness of available services, significant barriers to access, and uneven integration of mental health support within HIV-service NGOs and family doctor practices. Therefore, efforts should focus on these existing mental-health components by expanding provider capacity for screening and brief counselling for anxiety, depression, insomnia and post-traumatic stress disorder (PTSD), improving referral pathways to specialised care, ensuring supervision and quality assurance, and enhancing accessibility through community-based and digital/telehealth services tailored to MSM (and other KPs).

51 Aleksandrenko H, Chervak O, Krasnikova K, Shevchenko M, Yurochko T.
Digital Health Initiative for HIV Testing Promotion in War-Affected Ukraine: Effectiveness Evaluation. Preprint, May 2025. DOI: 10.21203/rs.3.rs-6640828/v1

52 Kyiv International Institute of Sociology (KIIS). Attitude of Ukrainian society towards LGBTQ people and their rights. Public opinion survey results, 17 June 2024. (https://www.kiis.com.ua/?lang=eng&cat=reports&id=1417&page=1)

Recommendations

Recommendation on improving access to quality preventive services for MSM	Priority	Implementer	Timeline		
			2026	2027-2028	2030
Sustain and expand online interventions targeted to MSM (ads on dating apps, online outreach).	High	NGOs, prevention service providers	x		
Create linkage to hepatitis B vaccination and integrate it into MSM-oriented HIV prevention services.	High	MGOs providing services to MSM, health care facilities	x		
Embed MSM-sensitive HIV prevention into humanitarian and displacement responses in war-affected areas by integrating confidential HIV/STI testing, condom and lubricant provision, PEP/PrEP information, and referral to MSM-friendly services into IDP shelters, community-run safe spaces, mobile health teams, and other emergency outreach mechanisms.	High	Humanitarian agencies, mobile health teams, NGOs	x		
Consolidate and strengthen MSM-led CLM by ensuring that MSM-focused NGOs and networks are centrally involved not only in data collection but also in planning CLM priorities, refining indicators on accessibility and quality of MSM services, and participating in regular joint review meetings with	Medium	NGOs providing services for MSM; APH, PHC;			

service providers, purchasers, and authorities. CLM findings should feed into concrete improvement plans (e.g. changes in clinic procedures, outreach models, and contracting requirements) and be systematically used to monitor follow-up actions.					
Strengthen and sustain context-sensitive communication and advocacy initiatives to reduce stigma and discrimination toward MSM, building on existing national and community efforts. Prioritise co-designed messaging with MSM-led organisations, strategic use of digital and targeted media channels, and tailored campaigns for key audiences (health-care providers, humanitarian actors, local authorities and the general public), with mechanisms to monitor changes in attitudes and service uptake.	Medium	CSOs, advocacy networks, and government		x	
Should additional funding be available, evaluate the intervention of “chemsex” safety boxes and based on the results consider including in the routine provision of services.	Medium	UPHC, consultant			
Should additional funding be available, develop a coordinated scale-up plan for MSM prevention that builds on the effective service models already recommended in this report – including telehealth platforms (such as Help24), one-stop and mobile clinics, peer-led	Medium	NGOs providing services for KPs, Humanitarian agencies,			

outreach, HIV self-testing, and collaboration with humanitarian actors and LGBT-friendly shelters for internally displaced people – to close the largest coverage gaps while avoiding duplication and ensuring clear prioritisation of investments.		mobile health teams, NGOs			
Should additional funding be available: • Train health providers in non-judgmental, inclusive care to increase trust and reduce stigma. • Provide structured social-adherence and case-management support for MSM and other KPs – for example, peer-navigator or social-worker follow-up after testing, active linkage and accompanied referrals to HIV, viral hepatitis and STI services, appointment reminders, and problem-solving support for social barriers to treatment – delivered through NGOs, community outreach teams and primary healthcare facilities under MoH/UPHC-approved protocols.	Medium/ low	MoH, UPHC, HIV prevention programme implementers, mental health service providers, primary healthcare networks, NGOs		X	X
Should additional funding be available, strengthen implementation of the mental-health components within MSM prevention packages by expanding provider capacity for basic screening and brief counselling, improving referral pathways to specialised care, and enhancing accessibility and quality,					

including through community-based and digital/telehealth services.					
Should additional funding be available, strengthen structural and rights-based components of MSM programmes by institutionalising MSM-sensitive anti-stigma/anti-bias training for health, social and humanitarian providers; supporting community-based legal aid and systematic documentation of rights violations; and using CLM and stigma data to inform targeted advocacy for policy and procedural changes that remove practical barriers to services for MSM.	Medium/ low	CSOs, advocacy networks, and government		x	x

4.4.3. Prevention Services for Sex Workers (SWs)

Context and achievements

There were no recent PSEs for SWs, the latest number was as of 2020, 76,000. [53] It is assumed that war-induced socioeconomic changes (including large-scale internal and external displacement, loss of housing, and reduced employment opportunities) have contributed to an increase in the number of SWs. Access to health care facilities, particularly in areas close to the frontline, has been severely constrained.

The basic package of services included consultations, provision of condoms and lubricants, HIV and syphilis testing, TB screening, and counselling. It also included targeted education and referral to legal aid. In 2024, coverage of SWs with preventive interventions reached 89% of the planned target.

53 Kovtun, O., Paniotto, V., Sakhno, Y. *et al.* Size estimation of key populations and 'bridge populations' based on the network scale-up method in Ukraine. *BMC Public Health* **24**, 979 (2024). https://doi.org/10.1186/s12889-024-18501

The 2021 IBBS among SWs[54] conducted during the onset of the full-scale war showed that over 40% reported moving between cities to find clients or safer working conditions. Most SWs reported both regular and casual clients; condom use remained high but inconsistent. A vast majority (92% of SWs) reported that they used a condom the last time they had a client, but only around 70% used condoms consistently with clients in the past month, and even fewer with non-clients.

Virtual platforms (social media and websites) have become the primary method for finding clients, replacing traditional outdoor venues. Alcohol use was widespread, and around 15% reported using illicit drugs, including 4% who injected. Nearly one-third experienced physical or sexual violence, often from clients or police. Violence and substance use were correlated with lower condom use and higher HIV risk. Around 60% of SWs were NGO clients, benefiting from free condoms, testing, and counselling. Nonetheless, 30% still purchased condoms on their own, possibly indicating unmet prevention needs. Access to healthcare remained limited, with stigma, discrimination, and police harassment cited as major barriers. Depression symptoms were reported by over 40% of participants. The IBBS highlights a decline in HIV prevalence and improved prevention coverage among SWs, but persistent vulnerabilities driven by economic instability, migration, violence, and stigma. Sustained support for community-based services, harm reduction, PrEP access, and protection from violence remains essential to consolidate gains in HIV control and to safeguard the health and rights of SWs.

As a part of specialised services, a mobile sexual health clinic model has been established for vulnerable women, including those with multiple sexual partners and those engaged in sex work. Among other specialists, there is a gynaecologist providing sexual and reproductive health services, screening for gender-based violence, and organising referrals to psychological support. A pilot launched in February 2025 has expanded to 3 mobile clinics operating in Donetsk, Kharkiv and Zaporizhzhia oblasts. During 108 outreach visits, services were provided to 1,632 women.

Challenges

A growing challenge reported by interviewees was an increase in informal sex work in war-affected areas and limited access to prevention and health services, as security and safety impact the service provision models. These signals need to be explored more in depth to be supported by qualitative or quantitative evidence.

Sex work is criminalised, which has long placed SWs in a vulnerable position. Since the start of the full-scale Russian invasion, this legal status has further exacerbated their marginalisation. Many in the SW

54 Kovtun, O., Kulchynska, R., & Sazonova, Y. (2023). Integrated Biological and Behavioral Surveillance among Sex Workers in Ukraine, 2021: Report on the Findings of the Study. Kyiv: Alliance for Public Health

community have lost their income or seen it drastically reduced, and many are struggling to afford rent and meet basic living needs. SWs (including those with children or other dependents) face difficulties in accessing shelters. This is particularly challenging for those who use illegal drugs, whereas those receiving OAMT are generally more likely to be admitted.

National HIV-prevention standards in Ukraine explicitly allow flexible, needs-based condom distribution, without predetermined numeric limits per client, and outreach workers are not required to restrict the number of condoms they provide. Since 2024, national procurement has also expanded to include female condoms and a broader range of condom types, reflecting preferences identified through community consultations and better aligning supplies with the needs of different groups of SWs.

At the same time, some SWs and outreach providers interviewed during the assessment described practical access issues in specific localities and periods, linked mainly to wartime conditions – for example, temporary stock disruptions, logistical and transport challenges, or difficulties reaching certain hotspots, particularly in or near conflict-affected areas. These challenges should therefore be understood as context-specific implementation and supply-chain issues, rather than structural policy limits on the volume of condoms per client. Only 35 SWs were using PrEP in the first quarter of 2025, indicating that PrEP demand-generation activities are not tailored to SWs needs.

Programme data and the 2021 IBBS indicate that, despite high overall coverage of SWs with preventive interventions, important gaps persist for specific sub-groups. In particular, key informant interviews highlighted that SWs who use psychoactive substances – including those who inject (SW–PWID) – may receive fewer condoms and harm-reduction commodities because they are coded primarily as PWID, that informal sex work in war-affected areas is increasing, and that those working outdoors or in saunas/massage salons face heightened safety risks, police harassment and limited access to fixed-site services. Low-income and low-education SWs also struggle to navigate services and to cover basic needs, which constrains their ability to prioritise health. Against this backdrop, prioritising underserved sub-groups means not only directing more outreach to them, but tailoring service models: integrating full harm-reduction packages (NSP, OAT referral, overdose prevention) for SW–PWID; providing simplified information, active accompaniment and linkage to social support for low-income/low-education SWs; and expanding evening/night and venue-based outreach, discreet condom and self-test distribution, and strong referral links to mobile sexual-health clinics, GBV and legal-aid services for those working outdoors and in saunas/massage salons.

Recommendations

Recommendations on improving access to quality preventive services for SWs	Priority	Implementer	Timeline		
			2026	2027-2028	2030
Prioritise underserved sub-groups of SWs (SW–PWID, low-income/low-education SWs and those working outdoors or in saunas/massage salons) by – enhancing integrated HIV/STI (and, where feasible, HBV/HCV) screening and fast-track linkage to treatment in outreach, mobile and fixed-site services; – integrating harm-reduction services for SW–PWID (needle/syringe distribution, OAT referral, overdose prevention) within SW programmes; – strengthening peer-led outreach and navigation in indoor and hard-to-reach venues (saunas, massage salons, apartments, online-to-offline settings); and – developing clear pathways for GBV/violence prevention, legal aid, and mental-health/psychosocial support, with particular attention to war-affected areas.	High	NGOs, community networks, mobile clinic services	X		
Address violence and legal vulnerability by supporting evidence-informed dialogue on decriminalisation and other legal reforms affecting SWs; scaling up legal-aid and rights-literacy services for SWs; and establishing or strengthening collaboration mechanisms with	High	Parliament and MoJ, NGOs providing services for KPs	X		

law enforcement and local authorities to reduce harassment, extortion and violence.					
Integrate routine HIV prevention into primary care by training family doctors and primary-health staff to provide stigma-free, confidential and comprehensive care for SWs, including integrated HIV/STI screening, vaccination offers where relevant, and tailored counselling.	High	MoH, primary health care level; professional medical associations, SW NGOs	X		
Should additional funding be available, adapt and broaden the prevention package based on SW-identified needs by including GBV/violence-related services, and expanding responses to other health conditions (harmful alcohol/drug use, mental health, STIs) within SW programmes.	Medium	APH, UPHC, NGOs, organisation procuring commodities;		x	
Expand digital/web outreach by using secure online platforms, social media and targeted ads to inform SWs about available HIV prevention, testing and SRH services offered by community organisations, and by linking digital outreach to peer navigation and service uptake monitoring.	Medium	Prevention service providers, community organisations, social-media agencies		X	
Should additional funding be available, empower community involvement by strengthening peer-to-peer service delivery, involving SW communities in the co-design and monitoring of services, and supporting SW-led advocacy and rights-awareness activities to reduce stigma, discrimination and violence.	Medium	SW community networks, advocacy NGOs		X	
Build condom negotiation & risk-reduction skills: integrate practical training for SWs on	Medium	Training institutions,		X	

consistent condom use (including oral sex) and on mitigating risks with alcohol or drug use during sex work.		SW programmes, peer educators			
Should additional funding be available, promote biomedical prevention: increase awareness and access to PrEP and PEP among SWs, integrating counselling on benefits and side-effects into routine visits, and ensuring clear information about where and how to obtain these services.	Medium	HIV prevention programme, clinics, SW-friendly service sites	X		
Support HIV self-testing by expanding availability of self-testing kits through community and outreach channels, providing clear instructions and remote/online counselling options, ensuring linkage to confirmatory testing and treatment, and considering the introduction of dual HIV/syphilis self-testing where feasible.	High	NGOs, test-kit distributors, online outreach platforms	X		
Should additional funding become available, strengthen sexual and reproductive health (SRH) services within sex-worker prevention programmes by providing education on modern contraception methods, pregnancy care and safe conception, and enhanced PMTCT of HIV.	Medium	SRH service providers, maternal health clinics, SW outreach NGOs		X	

4.4.4. Prevention services for trans and gender diverse people

Context and achievements

The estimated number of trans and gender diverse people (trans* people) in Ukraine, according to the study published in 2024, was 9,963 [7,7352-12,571].[55] The minimal package of services included distribution of condoms and lubricants, counselling of social workers and healthcare specialists, assisted self-testing for HIV, syphilis and hepatitis C testing, screening for TB. In addition, clients were offered referral to endocrinologists, provision of hormone replacement therapy medications, PrEP, and further medical, psychological, legal and social support. The coverage of the provision of services is included in Table 6. Integrated IBBS among transgender (TG) and non-binary (NB) individuals was implemented in 2024 in five cities. A total of 600 participants (trans women, trans men, and NB individuals) were recruited. The study faced logistical constraints due to the ongoing war and limited population size, so the results are not nationally representative. Condom use during the last sex was 74%, but consistent use was only 45%. One third reported any drug use (mostly non-injecting). Nearly 25% avoided medical care due to fear or prior discrimination. Many respondents reported stigma in public spaces and fear of visibility as TG or NB persons. NGO clients were more likely to receive condoms, PrEP/PEP information, and HIV testing referrals. About half (49%) demonstrated comprehensive knowledge of HIV prevention.

The trans* community has historically received services mainly from organisations implementing prevention programmes for MSM, and the service package provided to trans* people has been similar to that offered to the MSM population. A specific HIV prevention package for the TG population was developed in 2022. Currently, several NGOs provide services for TG. The NGO, “Cohort,” participates in Global Fund programmes focused on legal support and advocacy/mobilisation for trans people. “Convictus” previously offered free hormone therapy and now conducts small group meetings for trans individuals. The “Cohort” paralegal team (senior paralegal, peer paralegal, and lawyer) receives legal referrals from community members and works with partner organisations (e.g. “Prozhektor” in Odesa) to handle strategic court cases via memoranda of cooperation.

“Cohort” conducts around 100 community meetings annually across 12 regions (some online, due to safety) to share information, provide referrals, and maintain a “friendly doctors” database. Since 2021, “Cohort” has offered peer consultations—frequently on gender transition, medical referrals, and wartime considerations such as military registration status.

The NGO MOD Partner (Odesa) and Convictus-Ukraine (Kyiv) provide HIV prevention and testing services for trans* people. These services operate in major cities (e.g. Kharkiv, Lviv, Mykolaiv), and

55 Kovtun, O., Paniotto, V., Sakhno, Y. et al. Size estimation of key populations and ‘bridge populations’ based on the network scale-up method in Ukraine. BMC Public Health 24, 979 (2024). https://doi.org/10.1186/s12889-024-18501-1

largely depend on local coordination capacity. A multidisciplinary medical team in Odesa provides diagnostic services, gender-affirming care (on a fee basis), and issues legal gender change certificates.

Challenges

Trans* people in Ukraine have access to basic HIV prevention services through NGO-led, community-based programmes. However, a truly trans-oriented prevention package that would integrate gender-affirming care, mental health, legal support, tailored outreach, and flexible service delivery is not yet fully in place. Access to services tends to be concentrated in large cities; many trans individuals who live elsewhere may not be reached. Financial barriers are also common - many trans people cannot afford hormonal therapy or medical fees and lack stable income or housing.

Security risks raise barriers to travel or participation in public events, especially for trans women without legal recognition (documents changed to affirm their gender identity) or trans men who have not formally changed registration. The war has aggravated all challenges: displaced individuals, restricted movement, shifting service continuity, and heightened reliance on humanitarian aid over prevention services.

A programmatic data reporting issue has been noted during the interview on potential misclassifications by some NGOs of cisgender clients as trans to meet programme targets, which undermines accurate coverage.

National PrEP targets for trans* people are very low (e.g. 20 clients in 2024), raising questions about unmet demand. In IBBS (2024)[56] 60.5% had heard of PrEP; only 3.8% had used it in the last year (more information on PrEP in subchapter “PrEP”). Full awareness of HIV/PrEP/PEP demonstrated 21.3% (highest among trans men at 27.4%), 18.8% had never been tested for HIV; 29.7% had not been tested in over 12 months. Prevention programme coverage was low: ~15–16% for condoms, safer-sex counselling, and STI testing (some variation by gender identity).

Many HIV service providers prioritise clients from other risk groups (e.g., PWID, MSM, SWs). Trans* people without those risk profiles can be excluded or forced to falsely claim belonging to those groups to access services. Service providers often lack training on transgender health issues, increasing the risk of unintentional psychological harm. Frequent instances of prejudice or discrimination against transgender clients were reported.

The main sources of information about HIV prevention for trans* people are the Internet and social media, but some trans* individuals are less active online and miss out on prevention activities. Some

56. 2024 Biobehavioral study among transgender and non-binary people. PHC. Presentation, July 2025. Kyiv https://phc.org.ua/sites/default/files/users/user161/PDF_IBBS_TG_NB_eng_v2.pdf

organisations require identity verification via social media, which can conflict with a person's need for anonymity regarding their gender identity.

There were legal barriers to work with trans* people reported by the governmental institutions, as the recognition of this population as a legal gender had no appropriate legislation. International Classification of Diseases (ICD-10) included a psychiatric diagnosis called "Transsexualism" (F64.0). In Ukraine the clinical protocol "Gender dysphoria" (2016), which regulates the process of transgender transition, is outdated and still based on the old ICD 10 classification. The updated ICD 11 excludes psychiatric diagnosis F64, transgender as a phenomenon is not considered a pathology, but it is not yet adopted in Ukraine. This issue also influences access to vitally needed medical services.

Recommendations

Recommendations on improving access to quality preventive services for trans* people	Priority	Implementer	Timeline		
			2026	2027-2028	2030
Strengthen inclusive healthcare, mental-health support, and targeted prevention (PrEP, condoms, harm reduction) for trans* people; ensure needle/syringe programmes and OAMT are accessible and acceptable for trans* persons. Provide training for specialists working in those programmes on non-judgmental and competent assistance for trans* clients.	High	UPHC, harm-reduction services, mental-health providers, NGOs	X		
Strengthen information outreach beyond social media – expand to include channels accessible to less-connected trans* persons (e.g., community networks, peers, offline materials).	High	Trans*-community organisations/NGOs	X		
Strengthen access and uptake via peer-based outreach, internet-recruitment, referral/navigation,	High	NGOs, health service providers, and	X		

telehealth, confidentiality protections, and flexible service delivery models.		community health services			
Should additional funding be available provide integrated services: offer HIV prevention in parallel or together with gender-affirming care, in sensitive, stigma-free environments, mental health, prevention and treatment of cervical cancer, contraception and safe abortion, conception care, screening and treatment for hazardous alcohol and other substance use, hepatitis B&C diagnosis and referral to treatment;	Medium	Trans*-friendly clinics, gender-affirming service providers, HIV programmes		x	
Adapt identification/access procedures so trans* people can receive services anonymously and without needing to fit into other risk-group classifications.	Medium	MoH, service delivery sites, NGOs		X	
Should additional funding be available, develop and implement training programmes for NGO and public-health staff to increase competence and sensitivity toward transgender clients.	Medium	Medical training institutions, NGOs, professional associations		X	
Expand and tailor services for trans* people with an individualised approach, ensuring inclusivity regardless of background or identity expression and adjust outreach, counselling and support accordingly.	Medium	Community-based organisations, health services providers		X	

Should additional funding be available, create or strengthen safe-shelter programmes and crisis-support networks for trans* individuals (including displaced people and those outside major cities), linked to HIV, mental-health and legal services to reduce vulnerability, violence and treatment interruption.	Medium	Humanitarian agencies, trans* rights NGOs, local government/municipal services		X	
Simplify and de-medicalise legal gender recognition in line with ICD-11, updating national clinical protocols so that trans* identity is no longer treated as a psychiatric disorder and ensuring that documentation procedures support safe access to health services and accurate health records for epidemiological purposes.	Medium	MoH,		X	
Monitor implementation of Ukraine's transition to ICD-11 (MoH Order No. 703, April 2025) by engaging relevant health institutions and professional associations, and by training clinicians and registrars on new coding and recording practices that reduce barriers to care and improve the quality of HIV and health data for trans* people.	Medium	MoH, professional medical associations, trans-NGOs		X	
Include gender-affirming care in the Programme of Medical Guarantees to reduce out-of-pocket costs and	Medium-low	MoH		X	X

reliance on informal hormone use, improve continuity of care, and create better opportunities to integrate HIV prevention, testing and treatment within routine contacts with the health system.					

4.4.5. Prevention Services for people in prisons and other closed settings

Context and achievements

The State Penitentiary Service of Ukraine under the Ministry of Justice (MoJ) is the main authority responsible for managing prisons, pre-trial detention centres, and correctional colonies in Ukraine. The war has caused losses of about 20% of the prison population, due to displacement, facility loss, damage, or captivity of some institutions.[57] There were about 91 prisons (correctional institutions) in total, though 7 were reported to be under occupation since February 2022, 2 completely destroyed, and about 12 have suffered extensive damage. There were 37.782 prison inmates (September 2025). HIV prevalence was 7.9%.[58]

The findings of 2023 IBBS show that HIV prevalence among prisoners remains high at around 8%, though stable compared to previous years (8.9 % in 2019). Hepatitis C prevalence reached 29 percent, confirming widespread co-infection and ongoing transmission risks, while hepatitis B prevalence was about 4 percent. Women's facilities demonstrated somewhat higher HIV and hepatitis rates than men's, reflecting both biological vulnerability and structural factors such as lower service access and stigma. Regional differences were also evident: the South-Eastern and Southern departments recorded the highest levels of infection, while Central-Western establishments showed the lowest.

Knowledge about HIV prevention remains insufficient. Only about three-quarters of prisoners answered all HIV prevention questions correctly, and awareness regarding hepatitis B and C prevention was notably lower (around 25–30 percent). Misconceptions persist concerning everyday transmission, condom use, and tattooing risks. Limited access to accurate health information and the absence of systematic education programmes contribute to these knowledge gaps.

57. Ukraine – Prison conditions, 2024 update. The Danish Immigration Service, 2024 (https://us.dk/media/tx1o42fe/ukraine-prison-conditions-2024.pdf
58. PHC, HIV infection in Ukraine. Informational bulletin nr.56

Testing coverage has improved, but has not yet achieved high coverage. Approximately 72 percent of respondents reported having ever been tested for HIV, and less than half had ever been tested for viral hepatitis. Awareness of testing opportunities and post-test counselling remains inconsistent between facilities. Nevertheless, most identified people living with HIV were aware of their status, and 93 percent of them received ART, indicating good treatment continuity within the system once diagnosis is established.

Risk behaviours continue to play a significant role in transmission. The study documented ongoing use of psychoactive substances, including injection drugs, and the practice of tattooing with non-sterile instruments, both associated with elevated infection risks. Unprotected sexual activity, though less frequent, still occurs, particularly during conjugal or informal visits. These behaviours reflect gaps in harm-reduction access, as needle-exchange programmes and opioid substitution therapy remain limited in geographic coverage.

Testing for HIV and other infectious diseases is available in the prisons. Needle and syringe exchange activities have been recently initiated and implemented in two prisons. There are plans to expand the Needle and Syringe Exchange Programme (NEP) to another two prisons. In 2024 there were 57,760 needles and syringes distributed with no incidents reported. In addition, 672,000 condoms and lubricants were distributed. PrEP is also available for prisoners since 2022 and has seen significant uptake (more information in the subchapter on PrEP). Access to naloxone is mandatory in every medical unit for all penitentiary facilities. The procurement of naloxone is done by the penitentiary service and is available in every medical facility of the penitentiary sector.

Collaboration with NGOs is taking place to provide trainings and services at penitentiary institutions. Peer counsellors selected from those detained are trained to support the programmes. Post-release support services are provided. Although due to affiliation to different ministries (penitentiary system to the MoJ and civil sector health care and prevention to the MoH), establishing continuity of services has been challenging. Nonetheless, inter-ministerial collaboration has strengthened in recent years, improving coordination between these parallel systems and contributing to better continuity of care.

Challenges

Implementation of prevention activities in penitentiary facilities faces several systemic constraints. Almost full reliance on donor funding is an important risk for sustainability. Limited resources, particularly for infrastructure renovation, hinder the creation of conditions that fully meet regulatory requirements. Coordination with the civilian health sector remains challenging due to different ministerial affiliations and governance arrangements. Securing staff buy-in for new approaches requires additional efforts in change

management, training, and communication. Obtaining licenses to provide medical services can be difficult when high standards must be met in ageing facilities. In addition, the centralised procurement system offers limited flexibility for adapting the range of commodities to facility-specific needs.

Overall, the 2023 IBBS confirms that Ukrainian prisons remain a critical priority for the national HIV and hepatitis response. Despite measurable progress in testing and treatment continuity, the persistence of high infection levels, ongoing risky practices, and uneven prevention coverage underscores the need to further strengthen health education, harm-reduction programmes, and integrated service delivery.

Available data confirm a high HIV burden among people in detention in Ukraine, but current surveillance systems provide limited information on where and how infections are acquired, as Recent Infection Surveillance (RIS) is not yet implemented in prisons. Existing monitoring and qualitative reports suggest multiple potential transmission routes in penitentiary settings – including sexual contact (consensual and coercive), injecting drug use with shared equipment, and occasional non-sterile tattooing or medical procedures – yet their relative contribution to ongoing transmission is poorly quantified. Strengthening surveillance by introducing RIS in prisons, alongside a brief behavioural module on risk practices and ART continuity, would generate much-needed evidence on in-prison transmission dynamics and allow HIV prevention, harm reduction and continuity-of-care interventions to be more precisely targeted both during incarceration and in the transition to community care after release.

Access to preventive and treatment services varies considerably. While ART availability is nearly universal, prevention services - condom distribution, access to bleach, lubricants, health education - are not systematically provided in all facilities. Opportunities for psychological counselling and social support are also uneven. There are also structural barriers such as overcrowding, limited staffing, and occasional interruptions in medical supply chains, exacerbated by wartime disruptions and constrained funding.

Sustained collaboration between the penitentiary system, the MoH, NGOs, and international partners will be essential to close remaining gaps and achieve national targets for ending AIDS by 2030.

Recommendations

Recommendations on improving access to quality HIV preventive services in prisons	**Priority**	**Implementer**	**Timeline**		
			2026	**2027-2028**	**2030**
Enhance HIV and viral hepatitis awareness:	High	Prison health services, UPHC, NGOs working in penitentiary settings	X		
• Strengthen education programmes on HIV, HBV, HCV transmission and prevention in prison settings.					
• Develop targeted materials explaining risks of oral/anal sex without condoms, needle & syringe sharing, mother-to-child transmission.					

• Disseminate materials through posters, TV/radio in institutions, peer educators, and counselling sessions for wide coverage and retention.					
Strengthen HIV surveillance and prevention in prisons by extending Recent Infection Surveillance (RIS) to penitentiary settings and using the data to refine targeted prevention and harm-reduction measures for people in detention and after release.	High	Prison health services, UPHC	X		
Expand access to testing & counselling:	High	Prison medical units, UPHC, NGO partners, state penitentiary service	X		
• Ensure routine voluntary testing for HIV, syphilis, HBV and HCV upon entry, periodically during imprisonment, and prior to release.					
• Include pre- and post-test counselling for all inmates, emphasising confidentiality and linkage to care.					
• Improve prisoners' awareness of where and how to access testing services inside and after release.					
Should additional funding be available, strengthen prevention by scaling up harm-reduction programmes in all penitentiary facilities — including needle/syringe programmes	High/medium	State Penitentiary Service, MoH, NGOs providing harm reduction services;	X	X	
Should additional funding be available promote safer sexual behaviour, including:	Medium	Prison health & education services, NGOs, peer networks within prisons		X	
• Increase access to condoms and lubricants in all institutions (not only in medical units and visiting rooms).					
• Conduct counselling and information sessions on HIV & STI prevention, especially for prisoners with sexual relations (with visitors or other inmates).					
• Engage prisoners as peer educators/volunteers to normalise prevention practices and reduce stigma.					
Strengthen participation & motivation:	Medium	Prison social/psychological services, NGOs, faith-based		X	
• Introduce incentive mechanisms (certificates, privileges, recognition) to encourage prisoner participation in prevention & education programmes.					
• Support group and individual activities (discussion sessions, support groups,					

sport/cultural events) where prevention themes are integrated.		organisations, peer groups			
• Engage public organisations and prison social-psychological services to co-organise preventive interventions.					
Improve health-service integration:	High	MoH, UPHC, State Penitentiary Service, NGOs supporting released prisoners	X		
• Strengthen referral mechanisms for testing, treatment and psychosocial support after release.					
• Ensure continuity of care when inmates transition out of prison.					
Should additional funding be available, provide capacity building & institutional support:	Medium	MoH, State Penitentiary Service, UPHC, training institutes, NGOs		X	
• Train prison medical and psychological staff in modern HIV prevention, harm-reduction and counselling approaches.					
• Foster inter-sectoral collaboration between the State Penitentiary Service, MoH, UPHC, and NGOs.					

4.4.6. Prevention Services for other groups

4.4.6.1. Prevention Services for military personnel in active duty

The ongoing war in Ukraine has profoundly affected the country's public-health infrastructure, including the continuity and accessibility of HIV prevention and treatment services. Ukraine has maintained an effective national HIV programme even under emergency conditions. However, based on reports from NGOs, some of the populations at risk or affected by HIV may be deployed on the frontline and be away from existing civilian services, have limited access to prevention services and possibly be exposed at high risk of HIV transmission. Given the restricted nature of information due to security considerations, there was no available official data to confirm or refute these risks detailed below. There may be limited access to HIV testing, pre- and post-exposure prophylaxis (PrEP/PEP), ART, and harm-reduction services, increasing vulnerability to infection and transmission.[59]

It is important to differentiate between service members deployed in active combat zones and those serving at permanent duty stations or in rear-area roles, as their risk profiles and access to services differ.

59. PHC (2023). National Strategic Plan for the Response to HIV/AIDS 2023–2030. Kyiv.

Personnel deployed near the front line face severe logistical constraints and a focus on life-saving trauma care, which can deprioritise HIV prevention, including HIV/STI testing, and timely PEP. At more stable bases and training centres, opportunities for prevention, counselling and follow-up care are greater, but may still be affected by frequent rotation, staff shortages and competing operational priorities.

Destruction of medical infrastructure in front-line regions and instability of supply chains may have disrupted the delivery of essential prevention tools such as condoms, lubricants, self-testing kits, and ART refills. In active combat environments, logistics tend to focus primarily on emergency medical needs, with HIV prevention taking lower priority. As a result, continuity of preventive services remains weak, particularly in eastern and southern oblasts where combat intensity is high.[60]

Within the partnership with APH, four mobile clinics staffed by military personnel provide HIV and viral-hepatitis testing in selected locations, offering an important complement to hospital-based services and a more acceptable entry point for some soldiers. However, coverage remains partial and fragmented, and there is no consolidated data disaggregated by deployment status, branch of service or role (e.g. combat, support, medical).

Institutional and policy barriers also contribute to the problem. Although Ukraine's national HIV strategy recognises the armed forces as part of the general population, the Ministry of Defence (MoD) lacks a specific, formalised HIV-prevention policy. This absence of a dedicated protocol leads to uneven implementation across units and medical departments. In particular, OAMT - a critical harm-reduction measure for people with opioid dependence - remains inaccessible within military premises due to existing legal and security regulations. Soldiers on OAMT must rely on civilian clinics, which is problematic and pose challenges of continuity of care during deployment. Coordination between the MoD and the MoH's UPHC is limited, meaning that data on testing, prevention, ART continuity, and PrEP uptake among active-duty personnel are fragmented or missing.[61,62]

Current legislation requires HIV testing at entry into military service, but results are confidential and not publicly disclosed. Social and cultural factors compound these institutional barriers. Stigma and fear of disclosure remain widespread within the military hierarchy. Many soldiers may avoid HIV testing or treatment because they may fear losing their status, being stigmatised by peers, or facing disciplinary measures. The rigid command structure and lack of confidentiality in small units discourage open discussion about sexual health or drug use. Even when prevention materials are available, low awareness about confidentiality and accessibility limits their use.[63,64]

60 Global Fund (2024). Ukraine Country Profile and Emergency HIV/TB Continuity Update. Geneva
61 Ministry of Health of Ukraine (2022). Guidelines on HIV Prevention, Testing and Care. Kyiv
62 UNDP Ukraine (2024). Sustaining Health Services During War: Humanitarian Health and HIV Response Report. Kyiv.
63 KFF (2020). HIV Prevention among Military and Uniformed Services: Global Review. Washington, DC. 7
64 UNAIDS (2023). Country Factsheet: Ukraine 2023. Geneva.

Gaps in service availability and knowledge further restrict access. Military medical personnel, often overburdened with trauma and emergency care, have limited training in HIV prevention, counselling, and use of PEP or PrEP. HIV education for recruits and officers is inconsistent - sometimes replaced by brief safety briefings without deeper discussion of sexual or behavioural risks. As a result, knowledge about HIV transmission, condom use, and preventive medication remains inadequate.[65]

The analysis of HIV risk in military settings also needs to reflect different types of exposure. Service members may face blood-borne risks related to injuries, emergency care, field surgery and blood transfusions. These risks are particularly relevant for combat medics, frontline medical staff and first responders, who may be exposed to blood and body fluids under extremely challenging conditions. Clear protocols for standard precautions, immediate access to PEP, and documentation of occupational exposures are therefore critical components of HIV prevention in the armed forces.

The psychosocial burden of war also influences risk behaviour. Combat exposure, prolonged stress, separation from families, and alcohol or substance use increase vulnerability to unsafe sexual practices. Cases of transactional sex and unprotected relations have been reported among soldiers stationed in new areas, especially where access to condoms or testing is limited. Mental-health issues—such as anxiety, depression, and PTSD—can reduce motivation to engage in health-seeking or preventive behaviour. [66,67]

Systemic and funding constraints undermine sustainability. Donor-funded programmes such as those supported by the Global Fund, USAID, and PEPFAR focus mainly on civilian populations and key groups but rarely extend directly to the defence sector. As a result, the military depends heavily on NGO partnerships for access to HIV testing, prevention kits, and educational activities.[68,69]

Recommendations

Recommendations for improving access to quality HIV preventive services for military personnel in active duty	Priority	Implementer	Timeline		
			2026	2027-2028	2030
Advocate for intersectoral policy collaboration to adopt a Ministry of Defense (MoD) order on HIV	High	MoD, UPHC, NGOs working at the frontline	X		

65 UNAIDS (2022). Regional Analysis: HIV Prevention in Conflict Settings in Eastern Europe and Central Asia. Geneva.
66 Global Fund (2023). Emergency Support for HIV Services in Frontline Regions of Ukraine. Geneva.
67 Pankov, O. et al. (2024). Maintaining HIV Services During War: Journal of the International AIDS Society, 27(3), e26142.
68 Alliance for Public Health (2023). Annual Report on HIV Prevention and Harm Reduction in Wartime Ukraine. Kyiv.
69 UNDP (2024). Sustaining Health Services During War. Kyiv

prevention and care that integrates HIV testing, PEP/PrEP provision, condom distribution, and clear referral mechanisms.					
Ensure reliable access to HIV-prevention commodities for military personnel (condoms, lubricant, rapid tests, PrEP/PEP) through MoD logistics channels, differentiating supply strategies for frontline deployments and permanent bases; and, in line with security regulations, support continuity of OAMT and other addiction-treatment services during pre-enlistment assessment, non-combat postings and demobilisation, to prevent treatment interruption.	High	MoD logistics unit, procurement agencies, HIV programme partners	X		
Integrate role-specific HIV-prevention training for military medical personnel and commanders, including modules on occupational blood exposure (e.g. treating injuries, blood transfusions, emergency aid), correct use of PEP/PrEP, confidentiality and non-discrimination, and communication of accurate information about mandatory and voluntary HIV testing.	High	MoD medical corps, UPHC, accredited training institutes/NGOs	X		
Establish and scale up confidential, stigma-free HIV testing options for military personnel—such as self-testing, discreet counselling and outreach/testing at permanent duty stations—complementing existing	High	MoD health services, UPHC, NGO partners with experience in KPs	X		

entry-testing requirements and ensuring voluntary repeat testing and linkage to care without disclosure to peers or the chain of command.					
Strengthen coordination between MoD, UPHC and NGOs for monitoring HIV, ensuring ART support continuity and referral pathways for service members.	Medium	MoD health services, UPHC, HIV-service NGOs		X	
Expand mental-health and psychosocial support services linked to HIV prevention for military personnel, with particular attention to those exposed to combat, repeated casualties or medical evacuations (including combat medics and frontline medical staff), addressing trauma, war-related stress, harmful alcohol use and other factors that increase vulnerability to HIV risk.	Medium	MoD medical/psych services, mental-health NGOs, HIV-prevention programmes		X	
Include structured HIV-prevention modules in military health-education curricula and in-service training (for medics, commanders and deployed units), covering sexual-health risks, blood-borne and occupational exposures, standard precautions, PEP/PrEP, stigma reduction and pathways to confidential support.	Medium	MoD training academies, UPHC, medical education institutions		X	

4.4.6.2. Prevention Services for Veterans

There are around 1.2 million veterans in Ukraine[70] and the Ministry for Veterans Affairs (MoVA) of Ukraine is strategically positioned to bridge health, social, and reintegration services for a rapidly growing veteran population. Comparable prevalence data for military personnel or veterans in Ukraine for HIV or hepatitis vs general male population is not available. Given the risk environment (mobilisation, combat stress, displacement, disrupted healthcare etc.), it is plausible that war veterans or active military personnel in Ukraine may have a higher risk of acquiring HIV and viral hepatitis compared to the general male population. By embedding HIV prevention into its service framework and forming structured partnerships with MoH, UPHC, NGOs, and international donors, the Ministry can protect veterans' health, prevent new HIV infections, and strengthen Ukraine's resilience in post-war recovery.

Thus, the Ministry currently acknowledges HIV, viral hepatitis, and related infections as relevant health risks for veterans and includes them in its communicative services, notably on the ministry's own website, there is a page dedicated to "Diagnostics and treatment of HIV, hepatitis and other infectious diseases"[71]. However, publicly available information is limited regarding the ministry's active implementation of HIV prevention programmes (e.g. provision of condoms, PrEP, PEP, testing outreach, linkage to care) specifically under veterans' services. There is no detailed description on the site of proactive prevention campaigns or dedicated HIV services tailored to veterans beyond diagnostic/treatment referral encouragement.

As many veterans have had prolonged exposure to war-affected settings, displacement, injuries, antipain medications, substance use, and social reintegration challenges, they are a group that may have specific risk profiles and may benefit from tailored prevention efforts.

There is limited publicly accessible data on HIV and viral hepatitis prevalence, incidence, or service uptake among veterans specifically, which makes it difficult for stakeholders to plan and tailor interventions or measure impact. Veterans are more eager to take services in veterans-related organisations as an entry point than in NGOs providing specialised services for HIV prevention.

Several pilot projects have been implemented in collaboration with NGOs. *Community-Based HIV Testing Pilot for Veterans* to reach ex-combatants with high-risk behaviours. The pilot was implemented in five regions, using peer veterans. At the time of assessment, there were 1400 veterans reached with HIV testing services, and the final report was under preparation during the mission. Another initiative is related to digital strategies for HIV service uptake (GoPoruch platform) for individuals with high-risk behaviour.

70 https://ukraine.iom.int/ua10-2025-ip87-promoting-social-cohesion-and-veteran-reintegration-ukraine-through-evidence-based-and-locally-owned-responses-and-capacities

71 https://mva.gov.ua/veteranam/diagnostics-and-treatment-of-hiv-hepatitis-and-other-infectious-diseases

The project showed strong potential to expand demand generation, link new and high-risk populations to community-based HIV services, and integrate multi-disease testing. Lessons emphasize the complementary value of digital campaigns and referral link strategies.

The limited scope of active prevention programming is a gap that warrants particular attention. There is scant evidence of primary prevention services (e.g. condom distribution, outreach, PrEP/PEP) within its veteran-oriented operations. What is documented is largely advocacy for veterans to undergo screening and seek care, rather than direct delivery of prevention interventions. There is an overlap with other health actors: Prevention and care of HIV in Ukraine have been mostly under the domain of the MoH, the UPHC, NGOs, and donor programmes.

Recommendations

Recommendations for improving access to quality HIV preventive services for veterans	**Priority**	**Implementer**	**Timeline**		
			2026	**2027-2028**	**2030**
Consider a rapid assessment/survey among active military personnel/recently demobilised veterans in Ukraine to estimate the prevalence of HIV, hepatitis B (HBV) and hepatitis C (HCV) infection, and assess key behavioural risks	**High**	**MoVA, MoH, UPHC;**	**X**		
Based on the results of the assessment, tailor and integrate HIV prevention interventions into the veterans' health, rehabilitation & reintegration framework:	High	MoVA, MoH, UPHC, veteran-services agencies, NGOs	X		
• Develop a "Veterans' Health & Infectious Disease Prevention Protocol" aligned with the Public Health Center of the Ministry of Health of Ukraine (UPHC) andthe MoH guidelines.					
Institutionalize inter-ministerial coordination:	High		X		

• Formalise collaboration between MoVA, MoH, and the Ministry of Defense (MoD) through a memorandum of cooperation to ensure continuity of HIV prevention and care from active service through transition to civilian life		MoVA, MoH, MoD, UPHC, veteran NGOs			
• MoVA strengthens its capacity to coordinate post-service health interventions for veterans, including HIV prevention, harm reduction, and continuity of care. A coordination function within MoVA should include training staff and regional focal points on HIV and related comorbidities, development of standard operating procedures and referral pathways in collaboration with MoH, PHC facilities, and NGOs.					
Establish routine HIV and hepatitis screening for veterans:	medium	MoVA, UPHC, regional health departments, veteran clinics		X	
• Make HIV, HBV and HCV testing part of post-service medical assessment and annual check-ups for veterans.					
• MoVA to establish formal coordination mechanisms with UPHC and regional health departments to ensure that veterans who screen positive are promptly referred for confirmatory testing and enrolled in appropriate treatment.					
• Use mobile labs or integrate testing into veterans' clinics.					

Ensure access to condoms, self-testing, PEP and PrEP through veteran health facilities:	High	MoVA, UPHC, ART centers, donor agencies, veteran hubs	X		
• Make veteran health centers and community hubs distribution points for prevention commodities (condoms, lubricants, self-tests).					
• In higher-risk veteran sub-groups offer PrEP/PEP in partnership with ART centers.					
Based on the results of the rapid assessment, consider Integration of harm-reduction and substance-use services for veterans:	High	MoVA, MoH, UPHC, harm-reduction NGOs, veteran health services	X		
• Work with MoH and UPHC to provide access to OAMT, harm-reduction services, and psychosocial counselling for veterans with substance-use disorders.					
• Ensure continuity of any OAMT begun during service or before.					
Consider expanding mental health & psychosocial support (MHPSS) programmes to include HIV prevention components:	Medium	MoVA, mental-health services, veteran NGOs, HIV-prevention programmes		X	
• Rehabilitation and reintegration programmes include MHPSS components that address risk behaviours, trauma, safe practices, HIV/STI prevention.					
• Train psychologists to provide counselling on HIV prevention, risk					

behaviour, and HIV adherence support for veterans living with HIV.					
Develop an information campaign on HIV prevention and veteran health rights:	Medium	MoVA, veteran NGOs, communication agencies, UPHC		X	
• MoVA leads a communication campaign targeting veterans and their families to raise awareness of HIV prevention, testing options, and health services.					
• Use social media, veteran hubs, military radio/TV, and emphasise confidentiality and early testing.					
Build a joint monitoring & referral system for veterans' health, including HIV prevention:	Medium	MoVA, UPHC, MoH, veteran health services, Monitoring units of relevant organisations.		X	
• MoVA collaborates with UPHC to establish a shared data/referral system tracking veterans' access to HIV testing, prevention, and treatment while safeguarding confidentiality.					
• Integrate with UPHC's electronic health monitoring systems to improve reporting and early identification of gaps.					

4.4.7. HIV Pre-Exposure Prophylaxis (PrEP)

Context and achievements

Oral PrEP was first introduced in Ukraine through a pilot project in 2017. In 2019, national rollout started, as PrEP was included in the National Strategy on HIV/AIDS, with annual targets for PrEP coverage set starting from 2021. In 2021, PrEP was included in the PMG, and access for everyone is now guaranteed by multiple legal provisions. A specific section on oral PrEP has been introduced in the national Medical Standards for HIV in the 2022 revision, which has been expanded in the 2025 revision to include CAB-LA.

The 2025 revision is broadly aligned with WHO technical guidance on PrEP, with only minor discrepancies. According to the Medical Standards, PrEP is available upon request to all people at substantial risk of HIV, including all KPs and adolescents ≥15 years. Rapid HIV Ab/Ag testing (recommended for oral PrEP initiation and required for CAB-LA) was introduced in the 2025 revision, along with the possibility of prescribing doxyPEP to PrEP clients. PrEP counselling and linkage are well integrated within other HIV services regulated by the Medical Standards.

Counselling for PrEP has been added to the extended package of HIV prevention services for KPs in 2024, contributing to improving awareness and linkage to care. Strong referral pathways from NGOs serving KPs and healthcare facilities, including PHC, are in place in most regions and supported by both national HIV prevention programmes and donor-funded projects.

Oral PrEP is available across all regions in 305 healthcare facilities, including 30 PHC centres across 9 regions and over 200 secondary hospitals across all regions (as of March 2025). The process of decentralisation of PrEP services is ongoing, guided by the national strategy for decentralisation and also within donor-funded projects. The majority of PrEP clients are still followed in regional reference centres for HIV and centres in the most populous cities, with a positive trend for people followed in local centres. PrEP has been available in prisons since 2022, but it is not yet available in military healthcare facilities. Simplified pathways are in place for military personnel to access it in civilian facilities.

The delivery of PrEP services is still medicalised and largely facility-based, with differentiated models introduced since 2022, including telehealth visits for initiation and continuation, the use of HIV self-tests, home delivery of medications via post, visits, and dispensation through mobile vans. Telehealth services for PrEP initiation and continuation are provided mainly through the Help 24 platform, which is implemented by the APH with financial support from the Global Fund. Providers and centres that have the technical capacity can provide telehealth services, following the indications of the MoH Order No. 1695 of 2022. PrEP can be shipped by post by healthcare centres with an appropriate Standard

Operating Procedure in place. Telehealth PrEP services are supported by HIV testing performed in private labs or through self-testing.

Both in the context of shrinking funding and continuing hostilities, but also in the perspective of improving access to services now and after the war ends, continued delivery of telehealth services should be prioritised.

PrEP services are funded through a mix of national and donor sources, while drugs are currently procured only through donor funds, as are all ARVs. Initially, PrEP was procured through PEPFAR, but the US government's stop orders caused disruptions in the supply chain, therefore it is now procured through the Global Fund. Support to PrEP clients is provided across the continuum of care by social workers from CSOs, also through incentives (e.g. phone credit and food vouchers) and reimbursement of travel costs, which are covered by multiple funding streams.

Individual-level data of PrEP clients is collected and reported in IS SSD through dedicated forms, recently updated. Additionally, facilities maintain records of PrEP stocks, prescriptions, and dispensation, allowing for constant monitoring of available supplies.

PrEP uptake increased steadily between 2019 and 2023, slowing down during 2024 (Figure 6).

Between 2022 and 2024, no significant changes were seen in the distribution among KPs, apart from a reduction in MSM clients, possibly a result of conscription and/or migration.

Persistence in the national PrEP programme within 6 months of initiation was recently estimated at approximately 40%, notably lower than real-world data from other settings[72]. While wartime conditions affected persistence in frontline locations, overall persistence was similar to pre-invasion estimates.

CAB-LA roll-out began in August 2024 and is now available in Kyiv, Lviv and Chernihiv. In October 2025, 4050 additional doses were received to expand availability to 22 regions. Trainings for participating healthcare facilities have been conducted, and the national rollout has started. During the first year of implementation, 194 people received CAB-LA, mostly MSM.

[72] Moon EG, Ihnatiuk AP, Kazanzhy AP, Danylenko OV, Hetman LI, Manhart LE, et al. HIV Pre-exposure Prophylaxis (PrEP) Uptake and Persistence in Wartime Ukraine: Analysis of Data from a Scaled PrEP Program. AIDS Behav. 2025 Oct;29(10):3253–63. https://doi.org/10.1007/s10461-025-04773-0.

Figure 6. Number of clients who received PrEP services in Ukraine at least once during the year (2017-2024

Source: programmatic and IS SSD data, UPHC

The number of oral PrEP clients who seroconverted was very low (8 in 2022, 7 in 2023, 1 in 2024). One CAB-LA client seroconverted in 2025 despite optimal adherence to the injection schedule; their first VL result was too low for resistance testing and a VL test after ART initiation is pending.
Continued progress, notwithstanding the full-scale invasion, loss of control of some territories, migration, reduced capacity for service delivery and supply-chain disruptions, proves the resilience of healthcare and community systems, and the effectiveness of differentiated delivery models.

Feasibility of lenacapavir introduction

A donation of lenacapavir (LEN) for PrEP through PEPFAR was announced in September 2025, with implementation starting possibly in 2026. The feasibility of LEN introduction was assessed by analysing the process followed for CAB-LA introduction, programmatic data on CAB-LA implementation, interviews with healthcare providers and community health workers, and a draft report on CAB-LA implementation by UPHC.
A roadmap for CAB-LA introduction was drafted in 2023 by all stakeholders involved, and a Working Group was established. The steps and timeline of this roadmap were broadly followed, and CAB-LA for PrEP was registered in a relatively short time. The rollout of CAB-LA proceeded smoothly, also thanks to a strong collaboration with CSOs. During the review, no significant barrier to LEN introduction emerged, with healthcare providers and community health workers showing their willingness and readiness to provide an additional PrEP regimen. According to the draft report by UPHC, CAB-LA clients were generally satisfied with both long-acting injectable PrEP and its delivery model. Few

participants reported difficulties in navigating the clinic in Kyiv, while the clinic in Lviv was praised for its efficiency. Some participants already reported interest in LEN for PrEP.

The successful introduction and upcoming scale-up of CAB-LA demonstrate that introduction of LEN is feasible, with accurate planning and solid collaboration between all stakeholders. Therefore, the roadmap for CAB-LA introduction can be used as a blueprint for LEN introduction. Due to the 6-monthly injection schedule, LEN will be easier to roll out compared to CAB-LA, and is likely to reduce strain for healthcare facilities and providers. LEN could facilitate PrEP uptake and optimal use, especially in the regions where access to health facilities is most impacted by active hostilities. The preparation of a framework for LEN introduction, including a roadmap, should start promptly.

Key challenges

According to the latest IBBS surveys, PrEP awareness is still inadequate across all KPs (between 60.5% and 23.8%). PrEP use in the previous 12 months was 28% in MSM, 6.8% in people in prisons, 5% in PWID, 2.7% in SWs, 2.3% in trans* people, while up to 55% of PWID and 45% of SWs were interested in starting PrEP, under different conditions. Whenever data was available, people receiving services from CSOs always had significantly higher rates of PrEP awareness (PWID and SWs) and PrEP uptake (PWID). Lack of awareness and adequate knowledge on PrEP is still a significant barrier to access across all KPs, preventing people who may benefit from PrEP from making informed choices. Facility-based delivery of PrEP still represents a significant barrier to PrEP access, which is partly mitigated by the availability of donor-funded telehealth services and the involvement of CSOs and community health workers in PrEP delivery. Delivery in PHC is also likely to lower thresholds to access, however the relative scarcity of specialists and the existing burden of PHC providers may limit the scope and sustainability of decentralisation. Task-sharing and task-shifting with trained community health workers can help relieve the burden of specialists and facilities, at the same time supporting decentralisation, integrated service delivery, and improving cost-efficiency. According to WHO guidance, all steps of PrEP delivery (counselling, rapid HIV testing, prescription and dispensation) can be provided independently by lay and peer providers who have received adequate training and where appropriate pathways are in place for cases where a specialist consultation is needed. Task-sharing with nurses and other health professionals for certain components of PrEP delivery is already implemented in many facilities. Although there are examples where specialists provide certain components of PrEP services in community-based settings and referral to clinics is facilitated, PrEP is dispensed only in healthcare facilities. Because HIV testing and PrEP are classified as medical services, they need to be provided in locations and by providers who have a license for medical

practice. While assisted self-testing is already implemented in community-based settings, a regulatory reform is needed for lay providers to be able to independently perform rapid HIV testing. While technically possible for CSOs to obtain a license, few licensed community-based clinics exist. As licenses can cover multiple locations and providers at a time, this opportunity can be explored strategically and at a large scale (e.g. by extending a regional facility license to cover suitable CSOs' premises in the region). Alternatively, technical support could be provided to individual CSOs willing to obtain a license. Pharmacy-based delivery of ARVs is under consideration by a Working Group of the MoH but would also require extensive regulatory reform. Dispensation in pharmacies could complement telehealth models, reducing the costs for shipping medications.

Barriers specific to a KP were also observed. First, trans* people prioritise access to gender-affirming care services over other health services, such as HIV prevention, as confirmed in the latest IBBS survey. Therefore, simplification and de-medicalisation of legal gender recognition, following the 11th revision of the WHO International Classification of Diseases and Related Health Problems (ICD-11), along with the inclusion of gender-affirming care in the PMG, will enable increased uptake of HIV prevention services among trans* people (see also Prevention services for trans* and gender diverse people above). Similarly, full decriminalisation of sex work will enable improved access. Lastly, a recent study among PWID in Kyiv suggests that participants used oral PrEP periodically when the perceived risk of HIV exposure was higher [73,74]. The IBBS among PWID also highlighted inconvenient dosing schedules as one of the main reasons for stopping PrEP, which may also contribute to less frequent use. CAB-LA and LEN can be considered for people who experience challenges with oral PrEP dosing schedules.

National targets for PrEP uptake in the last three years were convenience-based and have not been reached. For the 2021-2023 and 2024-2026 funding cycles, PrEP coverage targets by KP were largely based on the distribution of PrEP clients in 2019 and 2022, respectively. Success in reaching these targets has been mixed and was achieved consistently only among people in prisons.

Use of the UNAIDS tools to set PrEP uptake targets in KPs for the next cycle, as suggested by the Global Fund, presents certain challenges relating to the representativeness of the results of the latest IBBS surveys and the lack of reliable PSEs. Setting targets based only on current levels risks perpetuating existing structural barriers to PrEP access, and current targets for trans* people specifically seem to be disproportionately low. Estimates based on PEPFAR programmatic data for

73 Dumchev K, Kornilova M, Makarenko O, Antoniak S, Liulchuk M, Cottrell ML, et al. Low daily oral PrEP adherence and low validity of self-report in a randomized trial among PWID in Ukraine. International Journal of Drug Policy. 2024 Jan;123:104284. https://doi.org/10.1016/j.drugpo.2023.104284.

74 Morozova O, Kornilova M, Makarenko O, Antoniak S, Liulchuk M, Varetska O, et al. Patterns of daily oral HIV PrEP adherence among people who inject drugs in Ukraine: an analysis of biomarkers. J Int AIDS Soc. 2024 July;27(S3):e26319. https://doi.org/10.1002/jia2.26319.

2023 showed stark inequalities in unmet needs between MSM, SWs and PWID[75], although with significant progress in covering unmet PrEP need at the national level compared to 2020[76]. Therefore, the next targets should also consider unmet PrEP need and equitable access. WHO Regional Office for Europe is adapting the QuantPrEP tool developed by the Regional Office for the Americas to estimate PrEP needs[77], will make it available to Ukraine and will provide support for using it to set targets for 2027-2028.

Estimation of PrEP-to-need ratios (number of PrEP users divided by new HIV diagnoses) can be used to compare equity in PrEP access, across different populations, regions or other relevant parameters, and to assess progress over time[78]. However, calculating these estimates requires accurate data on KP status for new HIV infections, which are not consistently available for trans* people and are possibly under-estimated for MSM.

As part of target-setting, populations and subgroups where increased PrEP uptake would have the highest impact can be identified by estimating the number needed to treat (NNT), that is the number of people who need to be on PrEP to prevent 1 new HIV infection[7980]. Calculating NNT estimates still requires accurate surveillance data, but programmatic data (e.g.from IS SSD or Syrex) can be used to estimate annual incidence among KPs for this scope.

As reliable PSEs and longitudinal estimates of HIV incidence and prevalence are not available after the full-scale invasion, effectiveness and coverage of the national programme are difficult to assess more precisely. Estimation of PrEP coverage, with similar disaggregation of other PrEP indicators, based on individual-level data on the number of visits attended and volume of PrEP dispensed as recorded in IS SSD (e.g. months covered by PrEP during the reporting period), could provide additional insights to this end, and highlight whether and where significant gaps exist.

In some instances, over-reliance on incentives seems to favour volume of services delivered over quality and relevance. On one hand, in the context of a deteriorated humanitarian and security situation

75 Mukherjee TI, Yep M, Koluch M, Abayneh SA, Eyassu G, Manfredini E, et al. Disparities in PrEP use and unmet need across PEPFAR-supported programs: doubling down on prevention to put people first and end AIDS as a public health threat by 2030. Front Reprod Health. 2024 Dec 13;6:1488970. https://doi.org/10.3389/frph.2024.1488970.

76 Kerzner M, De AK, Yee R, Keating R, Djomand G, Stash S, et al. Pre-exposure prophylaxis (PrEP) uptake and service delivery adaptations during the first wave of the COVID-19 pandemic in 21 PEPFAR-funded countries. PLoS ONE. 2022 Apr 5;17(4):e0266280. https://doi.org/10.1371/journal.pone.0266280.

77 QUANTPrEP: a tool to estimate Oral HIV pre-exposure prophylaxis (PrEP) needs and implementation costs. Available at: https://www.paho.org/en/topics/hivsti-surveillance-and-monitoring/quantprep-tool-estimate-oral-hiv-pre-exposure-prophylaxis.

78 See Coukan F, Sullivan A, Mitchell H, Jaffer S, Williams A, Saunders J, et al. Impact of national commissioning of pre-exposure prophylaxis (PrEP) on equity of access in England: a PrEP-to-need ratio investigation. Sex Trans Infect. 2024 May 1;100(3):166–72. https://doi.org/10.1136/sextrans-2023-055989.

79 See Beyrer C, Tomaras GD, Gelderblom HC, Gray GE, Janes HE, Bekker L-G, et al. Is HIV epidemic control by 2030 realistic? Lancet HIV. 2024;11(7):e489–94. http://doi.org/10.1016/S2352-3018(24)00098-5.

80 See also Sharma I, Hill A. Global HIV Incidence Analysis and Implications for Affordability using CAB-LA versus Continuous and Event-Driven Oral PrEP. Clin Infect Dis. 2023 Sep 4;78(2):386–394. https://doi.org/10.1093/cid/ciad537.

due to the full-scale invasion, the provision of substantial incentives may attract people to services they are not motivated to use. On the other hand, if salaries or other incentives for service providers or social workers depend heavily on the number of clients enrolled or followed, rather than on work hours, they may experience undue pressure. This may contribute to suboptimal PrEP use and financial inefficiencies. Once CLM is fully integrated into IS SSD, service quality metrics can guide incentives for organisations and providers, based on targets jointly agreed upon by the stakeholders involved.
Referral networks between NGOs, PHC and facilities providing PrEP services are heavily dependent on donor funding and time-limited projects. Disruptions in delivery of HIV prevention services have been reported due to the temporary suspension of US funding and the reprioritisation of Global Fund grants. PrEP coverage is likely to suffer if less resources are allocated in the next funding cycles, as healthcare facilities do not have adequate capacity for outreach and demand creation, independently.
Also in the framework of shrinking funding for HIV programmes, integrated and combined testing for HIV, syphilis and viral hepatitis should be further explored to improve cost-efficiencies. Dual HIV/syphilis RDTs are currently used only in ANC, while multiplex RDTs for HIV, syphilis and viral hepatitis could not be procured before receiving WHO prequalification. Broad use of HIV Ab/Ag RDTs for PrEP initiation and continuation should be reconsidered in light of recent findings, due to higher costs and lack of strong evidence supporting their prioritisation over Ab-only RDTs[81][82][83]. Use of HIV Ab/Ag RDTs can be focused for cases where acute HIV infection is suspected or CAB-LA initiations.

Recommendations

Recommendations for improving access to and coverage with Prep	Priority	Implementer	Implementation timeline		
			2026	2027-2028	2030
Ensure consistent delivery of PrEP counselling as part of the extended package of services provided to KPs.	High	CSOs, PRs	x	x	
Maintain and further invest in PrEP demand creation activities aimed at all KPs,	Medium	UPHC, PRs, CSOs	x	x	

81 WHO. Guidelines on lenacapavir for HIV prevention and testing strategies for long-acting injectable pre-exposure prophylaxis (PrEP). 2025. pp. 31-32. Available at: https://iris.who.int/handle/10665/381892.
82 Irwanto I, Kawi NH, Luis H, Rahmawati DP, Sihotang EP, Januraga PP, et al. Incorporating acute HIV infection screening, same-day diagnosis and antiretroviral treatment into routine services for key populations at sexual health clinics in Indonesia: a baseline analysis of the INTERACT prospective study. J Int AIDS Soc. 2025 Apr 28;28(5). https://doi.org/10.1002/jia2.26463.
83 Ciglenecki I, Ntshalintshali N, Mukooza E, Lekelem S, Mavimbela M, Dlamini S, et al. Low sensitivity of the fourth-generation antigen/antibody HIV rapid diagnostic test Determine™ HIV Early Detect for detection of acute HIV infection at the point of care in rural Eswatini: a diagnostic accuracy study. J Int AIDS Soc. 2025 Jul;28(7):e26517. https://doi.org/10.1002/jia2.26517.

and ensure they are tailored for each KP.					
Prioritise continued delivery of telehealth PrEP services in the next funding cycle.	High	Donors, MoH, UPHC	x	x	
Support decentralisation of PrEP services (counselling for initiation and continuation, rapid HIV testing, prescription and dispensation). with task sharing and task-shifting with lay providers, and pharmacy-based delivery	Medium	MoH, UPHC, donors		x	
Identify the most efficient procedure for CSOs to obtain a license allowing community-based delivery of PrEP services and dispensation. Provide guidance and technical assistance to CSOs willing to obtain such a license.	Medium	MoH, UPHC		x	
Establish PrEP coverage targets for 2027-2029 considering also unmet needs of KPs and equitable access.	Medium	PRs, donors	x		
Provide food and other humanitarian aid (as needed) to KPs regardless of fruition of other services	High	CSOs, PRs	x		
Review the current incentives system for PrEP clients and plan for a transition towards reimbursement mechanisms covering actual costs incurred (e.g. transportation).	Medium	PRs, donors		x	
Define and implement a mixed form of performance-based funding for each service model and type of service provider involved in PrEP delivery, that balances outputs, outcomes and	Medium	PRs, CSOs, UPHC, representatives of service providers		x	

quality measures from CLM, jointly with all stakeholders involved.					
Review use of HIV Ab/Ag, dual and multiplex tests for HIV, syphilis and viral hepatitis to improve integration and gain cost efficiencies.	Medium	UPHC, PRs, donors, CSOs	x	x	
Prepare a roadmap for LEN implementation.	High	MoH, UPHC, CSOs, PRs, donors	x		
Adopt the WHO recommendations on LEN and doxyPEP (upcoming) into national standards.	High	MoH, UPHC,	x		

4.4.8. HIV PMTCT- Triple elimination initiative

Context

Ukraine has consistently demonstrated strong political will and public health commitment to the elimination of mother-to-child transmission (EMTCT) of HIV, hepatitis B and syphilis at both national and regional levels.

Maternal and child health services have remained a priority even under conditions of full-scale war, displacement and resource constraints, with efforts made to preserve antenatal care, skilled birth attendance and postnatal follow-up.

A national validation committee for the EMTCT as well as relevant validation committees in the regions have been functioning for many years. With the support of international partners, several assessments of the readiness to apply for EMTCT of HIV and syphilis were organised in 2019-2022.

In 2023, with the support of UNICEF and within the framework of the project *Technical assistance for monitoring, coordination and access to PMTCT for HIV among pregnant women, mothers and children*, UPHC conducted the rapid assessment of the needs for further development of the PMTCT programme. The assessment included interviews with 32 health care staff from 23 regions. Among the challenges identified was a lack of qualified specialists in PMTCT, which was attributed to displacement of staff from war-affected areas. A minority of respondents did not support the use of dual tests for HIV and syphilis. Approximately 80% of respondents did not report on reductions in HIV testing in pregnant women and HIV exposed children. However, a limited supply of HIV tests was reported in the occupied regions and adjacent territories (Kherson, Chernihiv and **Zaporizhzhia**). In the Donetsk, Chernihiv,

Ternopil, Vinnytsia and Kharkiv regions, access to testing for pregnant women was primarily limited by the lack of transport, women's lack of funds for travel, logistics problems and the arrival of pregnant women from border areas. The assessment did not find any disruptions in the provision of ART to pregnant women and post-exposure prophylaxis (PEP) to HIV exposed children. Respondents indicated suboptimal provision of the following services: testing of partners of pregnant women, contraceptives to women who inject drugs and medicines to stop lactation in HIV positive women. The majority indicated that PMTCT data do not include the private sector.

UPHC developed a Roadmap of EMTCT of HIV, HBV and syphilis for the 2025-2027 period that lists programme activities that will enable progress towards EMTCT, with associated targets and timelines for implementation. A number of activities are listed, including inclusion of partners of pregnant women with positive HIV, HBV, HCV, and syphilis test results in medical care (target: ≥95%) and completion of treatment for syphilis and HCV in partners (target: ≥95%).

The UPHC conducted pilot testing of the PMTCT module in IS SSD and, as of 2025, deployed the full version across all health facilities providing HIV care, including those responsible for PMTCT services. This development ensured standardised data collection, improved continuity of care, and strengthened national oversight of PMTCT indicators.

National clinical guidelines for PMTCT are largely aligned with WHO recommendations, including routine HIV, HBV and syphilis testing in pregnancy, timely initiation of ART for pregnant women living with HIV, provision of appropriate ARV prophylaxis for HIV-exposed infants, and vaccination and prophylaxis protocols for HBV. According to the national guidelines "Prevention of mother-to-child transmission of HIV" approved by the order of the MoH of Ukraine no. 692 dated 26.04.2022, TDF + 3TC (or FTC) +DTG is indicated as a preferred regimen. However, in the first trimester, DTG is allowed with informed consent due to "neural tube defect risk". The main provisions for the obstetric management of women living with HIV are as follows: mode of delivery is chosen based on obstetric indications and VL before delivery (vaginal delivery if VL <50 copies/mL at 36 weeks, Cesarean section at 38–39 weeks if VL ≥50 copies/mL). Intravenous infusion of zidovudine during labour (intrapartum) is still recommended in case of VL>1000 copies and untreated women with unknown VL level (WHO currently does not recommend the use of intrapartum intravenous zidovudine, regardless of maternal VL). Postnatal prophylaxis is risk-based: very low risk - ZDV monotherapy for 2 weeks; low risk - ZDV monotherapy for 4 weeks; high risk - triple regimen (ZDV + 3TC + NVP). Formula feeding is a preferred option, but breastfeeding should be supported if this option is chosen by a woman with maternal VL <50 copies/mL and strict adherence ensured with monthly VL monitoring during breastfeeding and 2 months after its cessation. NAT testing for Early Infant Diagnosis (EID) is recommended for non-

breastfed children: at birth (≤48h), 6 weeks, 12 weeks; for breastfed children: at birth (≤48h), 2 weeks, monthly during breastfeeding, plus 4 & 8 weeks post-breastfeeding (missing NAT testing at 9 months of age as per WHO recommendations)

As a result of these policies and programmes, the overall number of children living with HIV has been decreasing over time, reflecting both improved prevention of vertical transmission and better early diagnosis and linkage to care. Continued attention to service continuity for displaced pregnant women, integration of PMTCT into primary health care and reproductive health services, and targeted support for high-burden regions will be essential to sustain progress towards EMTCT certification.

Data on EMTCT of HIV

The number of HIV-positive pregnant women was decreasing in the 2022-2024 period, from 1416 in 2022 to 1232 in 2023 and 1083 in 2024. Among these, the proportion newly diagnosed with HIV during pregnancy also declined, from 29.9% in 2022 to 25.7% in 2024.

The number of children born to HIV positive pregnant women was 1423 in 2022, 1226 in 2023 and 1125 in 2024, while the number of abortions was 69, 61 and 50, respectively.

Table 7 shows the key HIV EMTCT indicators for the 2022-2024 period provided by UPHC. Coverage with ANC services, HIV testing in pregnant women and ART was higher than 95% in 2023 and 2024, which indicates that these elimination targets were achieved. HIV testing at the 34-36 weeks of pregnancy was conducted in 88.3% of women in 2022, 95.0% in 2023 and 92.8% in 2024.

VL testing coverage in HIV exposed infants at 2 months after birth was over 95% in 2022-2024 and the HIV MTCT rate in those tested at 2 months after birth was below 2.0%. In 2024, only one region had the rate of MTCT of HIV at two months after birth higher than 2.0% - Kharkiv (5.3%). Coverage with PEP was over 95% in HIV exposed children in 2022-2024.

It is worth noting the low percentage of newly diagnosed HIV positive women who were diagnosed in the first 12 weeks of pregnancy - 25% in 2022 and 30% in 2023 and 2024.

Table 7. Key EMTCT of HIV indicators, programme data

	2022	2023	2024
	%	%	%
Coverage with ANC services	99.8	99.7	99.8
HIV testing in pregnant women	98.5	98.3	98.5
ART coverage in HIV positive pregnant women	94.4	97.3	97.3
VL testing coverage in HIV exposed infants at 2 months after birth	91.6	98.2	99.0
HIV MTCT rate (at 2 months after birth)	1,6	1,5	0,5
Number of children diagnosed as HIV positive with EID (2 months after birth)	21	18	6

However, longitudinal monitoring indicates that the HIV MTCT rate at 18 months of age was 2.25% in the cohort of children born in 2020 (n=1950), 2.27% in those born in 2021 (n=1929) and 2.36% in the 2022 cohort (n=1318). A substantial number of children had undetermined status at 18 months after birth – 31.9% in the 2020 cohort, and 29.3% and 16.2% in the 2021 and 2022 cohorts, respectively. The annual number of new HIV diagnoses among children aged 0–17: 59 cases in 2022, 74 cases in 2023, and 75 cases in 2024, with many cases attributable to mother-to-child transmission (35 cases in 2022, 37 cases in 2023, and 50 cases in 2024) but not included in the MTCT rate calculation.
Over 98% of HIV exposed children received post-exposure ARV prophylaxis in 2022-2024 and reportedly over 99% of infants born in 2022-2024 were not breastfed.

Achievements

Ukraine has achieved and sustained very high coverage across the core components of EMTCT. Antenatal care is almost universal, with more than 99% of pregnant women attending at least one visit, and over 98% of them are tested for HIV during pregnancy, including with the use of WHO - recommended dual HIV/syphilis rapid diagnostic tests (RDTs). Among those diagnosed with HIV, more than 97% receive ART, and the proportion of women with newly diagnosed HIV in pregnancy has been decreasing, indicating earlier diagnosis and linkage to care among women of reproductive age. Congenital syphilis prevention is closely integrated with HIV efforts under the triple elimination framework, including the use of dual HIV/syphilis tests in ANC.

EID has steadily improved, allowing earlier confirmation of HIV status in infants and timely initiation of treatment when needed. Coverage of ARV prophylaxis for HIV-exposed infants is consistently very high, with 98–99% receiving a full course according to national protocols. In addition, more than 99% of HIV-exposed infants are not breastfed, in line with national guidance to minimise postnatal transmission risk. Together, these results point to a robust PMTCT platform, strong alignment with WHO recommendations, and real progress toward EMTCT targets, reflected in the declining number of children living with HIV in Ukraine.

Challenges

Despite strong overall performance, several challenges continue to affect progress towards EMTCT. Large-scale internal and external migration of pregnant women, and later their newborns, makes it difficult to ensure continuity of care and complete follow-up of the full PMTCT cascade. Access to services in war-affected and rural areas is constrained by damaged infrastructure, shortages of health personnel and population displacement. Coordination between the public and private health sectors is not always consistent, which can lead to gaps in recording, reporting and follow-up of women and infants who receive care outside the public system.

The proportion of HIV-exposed children with undetermined HIV status, although decreasing over time, remains relatively high (from 31.9% in 2020 to 16.2% in 2022), indicating that a substantial number of infants are still lost along the diagnostic and follow-up pathway. The HIV MTCT rate in cohorts born in 2020-2022 is higher than 2.0%. The annual number of new paediatric HIV diagnoses also remains of concern (60, 66 and 65 in 2022–2024), with many cases attributable to mother-to-child transmission (35, 38 and 50 respectively), underscoring the need to further strengthen case finding and follow-up among exposed infants and children.

For hepatitis B, gaps in prevention remain more pronounced. Hepatitis B surface antigen (HBsAg) testing coverage during pregnancy, while gradually improving, was still only 69.5% in 2024, and both the three-dose hepatitis B vaccination series (HepB3) and timely birth dose (HepB-BD) remain below WHO targets. These shortfalls highlight the importance of integrating HBV testing and immunisation more effectively into ANC, delivery and child-health services, with particular attention to war-affected and hard-to-reach areas.

Although the assessment of services related to MTCT of syphilis was not included in this review, there were some reports that, in the absence of long-acting BPG (benzathine penicillin G), patients diagnosed with syphilis are hospitalised for 21 days to get treatment with alternative antibiotics. One of the indicated problems is that BPG is not registered in the country.

Considering the national commitment and goal to apply for the validation of EMTCT, currently existing disease-specific articles of the criminal code (criminalising HIV and STIs exposure and transmission) would be a substantial barrier to achieving this milestone.

Recommendations

Recommendations on achieving EMTCT targets	Priority	Implementer	2026	2027–2028	2030
Improve data collection on EMTCT indicators; integrate ANC and obstetric care into the national health information system; strengthen EMTCT reporting from private providers	High	MoH, UPHC, NHSU, eHealth, Regional health departments, professional associations, private providers	X		
Continue conducting cohort follow-up of HIV-exposed infants and mothers to confirm EMTCT targets	High	MoH, UPHC, Regional CDCs, maternity and paediatric facilities	X	X	
Address the high rate of undetermined final HIV status in HIV exposed children by implementing more effective interventions to trace children lost to follow-up from care	High	MoH, UHPC	X		
Undertake a dedicated assessment of EMTCT data quality and systems, with potential involvement of external experts	Medium	MoH, UPHC, WHO and other partners	X	X	X
Implement comprehensive case reviews for every HIV MTCT case to identify gaps and inform corrective actions	High	MoH, UPHC, regional/municipal health authorities, maternity and paediatric facilities	X		
Update national PMTCT guidelines in line with the most recent WHO recommendations: • Use **DTG in the treatment regimen** for pregnant women **at any stage of pregnancy;** • **consider discontinuing** intrapartum **intravenous zidovudine in case** of using a **three-drug regimen** for infant prophylaxis;	Medium	MoH, UPHC, WHO, and other partners	X		

• **Update regimen for postnatal prophylaxis in line with 2025 WHO recommendations: low risk - six weeks with a single drug (NVP as the preferred option, DTG or 3TC as alternatives), high risk - a three-drug regimen appropriate for age for six weeks with transition to ABC/3TC+DTG as the preferred option, additional provisions for breastfed infants;** Consider additional **NAT testing** for exposed children at 9 months of age.					
Scale-up testing among partners of pregnant women and monitor its coverage	Medium	MoH, UPHC, ANC providers	X	X	
Continue with rapid assessments of gaps in the PMTCT programme to enable the identification of emerging issues that require remedial actions	Medium	MoH, UHPC		X	
C**ontinue us**ing **dual HIV/syphilis RDTs for** screening among **pregnant women**	High	MoH, UPHC, NHSU, procurement agency, ANC providers	X	X	X
Ensure universal HBsAg testing of pregnant women, including consideration of multiplex (e.g. HIV/syphilis/HBsAg) testing	High	MoH, UPHC, NHSU, procurement agency, ANC providers	X		
Ensure timely hepatitis B birth dose and completion of HepB3 vaccination for all infants	High	MoH, National immunisation programme, maternity and child-health services, regional health authorities	X	X	X
Continue national advocacy and dialogue with partners to decriminalize HIV exposure and	Medium	Parliament, MoJ, MoH, Ombudsperson,	X	X	X

transmission (removal of disease-specific article in Criminal Code)		human-rights institutions, PLHIV and KP networks, CSOs, international partners			
Ensure procurement and access to BPG for all pregnant women diagnosed with syphilis	High	MoH, UPHC, STIs healthcare centres, procurement agency, ANC providers	X	X	X

4.5. HIV Testing and Diagnosis

Context

HIV testing services continued to expand across multiple platforms, including primary health care (PHC) facilities, community-based services, and NGO-led initiatives. The standard of medical care for HIV infection was approved by Ministerial Order in June 2025. At present, modalities of HIV testing in Ukraine in accordance with current legislation include provider-initiated HIV testing and counselling(HTC), index testing, self-testing, self-testing with support, and HIV testing by NGOs. Total number of tests performed increased from around 1,6 million in 2022 to over 2,5 million in 2024, predominantly reflecting increased use of RDTs. A 15% increase in the total number of HIV tests performed was recorded in 2024 compared with 2023, reflecting significant progress in outreach and service coverage.

In the period 2021 – 2023, a verification study of testing algorithms has been conducted, in line with WHO recommendations. Nevertheless, the obtained results are not being taken into account for the procurement of test supplies, which is decentralised and performed at the regional level. Of note, in spite of the observed increase in testing, the number of new diagnoses has decreased. Furthermore, late diagnosis is still an issue, with over 60% of patients diagnosed as late presenters (with a number of CD4+ T cells <350/mL), and this proportion is increasing. Still, EID was successfully integrated into maternity and paediatric services using dried blood spot (DBS) sampling, as of 2025 - 28 laboratories perform tests for EID compared to 5 laboratories in 2021, improving turnaround time (from 2.5 months to up to 7 days) and reducing loss to follow-up among HIV-exposed infants.

The introduction of multiplex RDTs, particularly HIV/syphilis and HIV/HBV combinations, enhanced efficiency and resource utilisation, with rapid tests now representing approximately 61% of all tests performed nationally. Public awareness campaigns, regulatory improvements, and strong NGO participation further expanded testing access, particularly for key and hard-to-reach populations.

Achievements

Significant progress was achieved in expanding and diversifying HIV testing services nationwide, reflecting stronger programmatic coordination, innovation, and community engagement. Key achievements include:

- Changes in legislation promoting expanded access to HIV testing
- Increase in HIV testing by 15% between 2023 and 2024, due to increased use of rapid tests, representing 61% of national HIV testing in 2024.
- EID integrated into routine maternity care using DBS.
- Multiplex RDTs (HIV/syphilis, HIV/HBV) introduced and scaled.
- 61% of national HIV testing is now conducted through rapid tests.
- Capacity building and legislative improvements enhanced national testing quality and oversight.
- NGO-led community testing (“A0 testing”) expanded, demonstrating high performance and linkage to care.
- Wide range of testing modalities adopted, including mobile clinics, index testing, and social network approaches.

Challenges

While notable gains have been achieved, persistent challenges hinder the full optimisation and sustainability of HIV testing services. The main constraints identified are as follows:

- Service delivery disruptions in war-affected areas.
- Regional fragmentation of RDT procurement and variable RDT leading to variable RDT quality and limiting access to tests in line with the results of the national verification study, leading to inconsistent use of the verified algorithm.
- Declining positivity rates without sufficient targeted testing strategies.
- Absence of a unified national digital HIV testing reporting system.
- Progress towards HIV/TB diagnostic integration and coverage of HIV testing for “opt-out” groups, reaching or exceeding target values for 2024

Recommendations

Based on current programmatic gaps and implementation challenges, the following recommendations propose actions to improve diagnostic performance and strengthen system resilience.

Recommendations for improving the testing and diagnostic performance of the HIV programme	Priority	Implementer	Implementation timeline		
			2026	2027-2028	2030
Develop and deploy a unified national digital HIV testing reporting tool integrating facility and NGO data.	High	MoH, Partners	x		
Consider centralised procurement of WHO-prequalified multiplex RDTs to enhance quality and cost efficiency.	High	MoH, National Procurement Agency, Donors	x	x	
Strengthen HIV/TB diagnostic integration (LAM, Xpert, CrAg) in high-burden regions.	High	MoH, National TB Programme	x	x	
Sustain and expand NGO-led and self-testing programmes targeting KPs.	Medium	MoH, NGOs, Community Networks		x	
Ensure procurement of RDTs according to national validation and provide regulatory oversight.	High	MoH, National Regulatory Authority	x		
Develop targeted testing strategies to address declining positivity rates.	Medium	MoH, National AIDS Programme		x	x

4.6. HIV Laboratory Services

Context

HIV-related laboratory services in Ukraine are delivered through 30 regional laboratories, which provide confirmatory and specialised diagnostics. Among them, 27 laboratories perform HIV VL testing, and 28 laboratories provide CD4 testing as of 2024. HIV reference laboratory functions are performed by the UPHC.

Implementation of structural health care reforms at different levels, centralised specialised HIV diagnostics and confirmatory testing in Ukraine, with testing services centralised in six reference laboratories providing confirmation, VL, CD4 testing and specialised diagnostics. Sanger sequencing capacity was established at the National Reference Laboratory to support HIV DR surveillance. National Reference Laboratory participated by performing sequencing in monitoring of acquired HIV DR started

in the period 2020-2023 and 2024-2025, with two rounds of the donor-supported project Continuous Acquired HIV Drug Resistance (CADRE).

External Quality Assessment (EQA) programmes for HIV RNA, serology, and RDTs have been implemented through international, national, and regional EQA programmes for laboratory tests related to HIV, contributing to significant improvement in overall laboratory performance. Reference Laboratory for HIV/AIDS Diagnostics has been conducting EQA of HIV serological markers detection by instrumental methods since 2018.

In the period 2022-2024, the Reference Laboratory for HIV/AIDS Diagnostics and a number of testing laboratories participated in an international EQA scheme for HIV RNA and DNA, with a solid score for HIV RNA testing continuously over 95% and an increase in the score for HIV DNA of over 20% in 2024 compared to 2023. During the last two years, the National Reference Laboratory at the UPHC has coordinated trainings and methodological support for testing laboratories and HIV testing service providers. In the period 2021-2024, the distance learning platform of UPHC has been developed, with 19 distance learning courses on HIV issues, 9 of which are related to the provision of HIV testing services.

Rollout of laboratory information management systems (LIMS) is underway to improve data management and reporting. Implementation of Laboratory Quality Management System (LQMS) and quality assurance are considered and reinforced at the national level, with an increasing number of laboratories interested in being accredited nationally according to ISO 15189. High staff turnover is among the major obstacles to achieving this.

However, persistent gaps remain in equipment maintenance, reagent supply, and sample referral systems. CD4 testing is constrained by outdated platforms and reagent shortages, and VL testing capacity remains uneven across regions. Financial fragmentation, with laboratories operating under separate facility budgets, has limited the development of a unified national laboratory optimisation strategy.

Achievements

Significant progress has been made in strengthening HIV laboratory systems, with notable achievements in quality assurance, network optimisation, and advanced diagnostic capacity. Key accomplishments include:

- HIV confirmation and specialised diagnostics are centralised in six reference laboratories.
- EQA programmes implemented and laboratory quality improved by ~20% since 2021.
- Sequencing capacity established for DR surveillance.

- LIMS tools developed and progressively rolled out.
- Post-2022 disruptions largely addressed, restoring core laboratory services.

Challenges

Despite notable progress, several structural and operational challenges continue to limit the efficiency, equity, and sustainability of HIV laboratory services. Key challenges include:

- Limited CD4 testing capacity due to outdated equipment and reagent shortages.
- Uneven VL coverage across regions.
- Fragmented laboratory financing and procurement structures.
- Lack of a validated national laboratory optimisation strategy.
- Weak sample transport and referral systems.
- High staff turnover and heavy reliance on donor funding.

Recommendations

Based on identified gaps and operational challenges within the national laboratory network, the following recommendations outline priority actions to strengthen diagnostic capacity, optimise resource management, and ensure the long-term sustainability of the system.

Recommendations for strengthening HIV diagnostic capacity	**Priority**	**Implementer**	**Implementation timeline**		
			2026	2027-2028	2030
Expand VL and CD4 testing capacity, integrating point-of-care platforms.	**High**	MoH, National HIV Lab Network, Partners	x	X	
Develop and adopt a national laboratory optimisation strategy to guide network design, resource allocation, and technology use.	**High**	MoH, National Reference Labs, WHO	x	X	
Centralise procurement mechanisms and align donor support with national priorities.	**High**	MoH, Procurement Agency, Donors	x	X	

Strengthen sample referral logistics and cold chain management.	**Medium**	MoH, Regional Labs		x	
Implement an integrated national LIMS across all laboratory tiers.	**Medium**	MoH, Partners		x	x
Strengthen the laboratory workforce through structured training, mentorship, and onboarding programmes.	**High**	MoH, Training Institutes	x	x	
Consolidate and nationally coordinate EQA programmes for all HIV-related tests.	**High**	MoH, National QA Programme	x		
Mobilise domestic financing to progressively reduce reliance on donor funding.	**Medium**	MoH, MoF		x	x

4.7. HIV treatment and linkage to effective care for HIV and common comorbidities

4.7.1. HIV Treatment and Clinical Management

Context

Despite the ongoing war, large-scale migration, and extensive damage to health infrastructure, maintaining ART provision, delivery, and access to care remains a top national health priority. Continuous efforts have focused on ensuring uninterrupted treatment for displaced populations, sustaining decentralised service delivery, and protecting supply chains to maintain national standards for HIV care. Coordination between the MoH, regional health facilities providing ART services and humanitarian partners has been key to preserving ART continuity under extreme circumstances. The focus has also expanded toward integrating HIV services into general health systems, including family medicine and primary care networks where feasible.

Achievements

The HIV treatment cascade (Figure 7)[84] shows notable progress, demonstrating the resilience and adaptability of the health system under crisis conditions. While the **first 95** remains difficult to assess due to population displacement, occupation, and migration, the **second 95** has reached approximately 86% (range 73–100% by region), and the **third 95 is 96%**, though some areas still lack comprehensive VL monitoring.

The Ukraine protocols on HIV treatment and care align with WHO recommendations to initiate ART in all people living with HIV, regardless of CD4 count or clinical stage, with encouragement of same-day or rapid ART initiation. ART initiation is recommended independent of CD4 count and WHO clinical stage, with a rapid start including the day of diagnosis. Limited, clinically justified delay only for CNS opportunistic infections (OIs). TLD (tenofovir/lamivudine/dolutegravir) has become the national first-line standard, supported by national resistance data. Efavirenz (EFV)-based regimens are rarely used. Only a small proportion of patients are on second/ third-line regimens (only darunavir/r as a 3d agent available), and regimen switches are made only after adherence evaluation, recognising TLD's high barrier to resistance (See Table 5). Use of DRV/r (darunavir/ritonavir) as a PI option is consistent with the WHO recognising DRV/r's role in optimised subsequent regimens

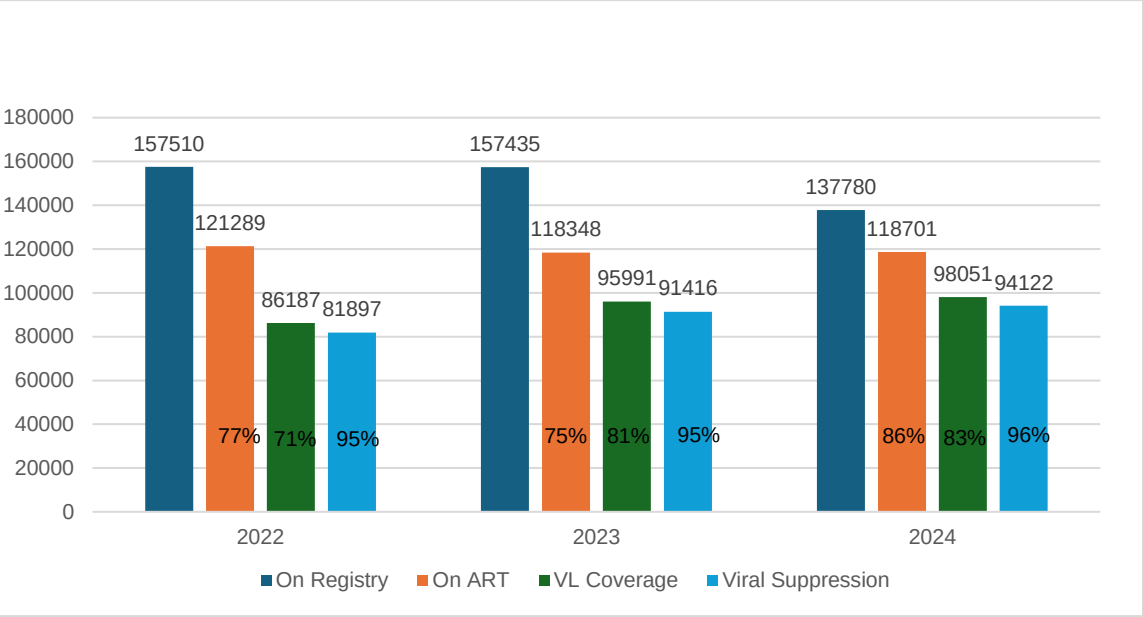
Table 5. Patients' (Adults and adolescents) distribution per treatment regimen

TDF/3TC/DTG	92010	89710	2300
TAF/FTC/DTG	6637	6477	160
TDF/FTC + DTG	200	151	49
TDF/FTC + DRV/rtv	319	293	26
TDF/FTC+DRV + rtv	290	290	
TDF/FTC+RAL	128	128	
ABC/3TC/DTG	3612	3491	121
ABC/3TC + DTG	455	455	
ABC/3TC + DRV/rtv	18	18	
ABC/3TC + DRV + rtv	46	46	
ABC/3TC + RAL	17	17	
AZT/3TC + DTG	180	149	31
AZT/3TC + DRV/rtv	8	1	7
AZT/3TC + DRV + rtv	16	16	
AZT/3TC + RAL	4	4	
3TC + DTG	391	391	

84. Department of HIV Management and Response, State Institution Centre for Public Health of the Ministry of Health of Ukraine, **HIV Program in Ukraine, Presentation as of October 2025**

TDF/3TC/EFV	5050	4901	149
TDF/FTC	41	41	
3TC	18	18	
DTG	11	11	
3TC	10	10	
DTG	2	2	
3TC	3	3	
RTV	1	1	
3TC	1	1	
AZT/3TC	1	1	
RAL	1	1	
LPV/r	1	1	

Figure 7. HIV Care Cascade in Ukraine in 2022-2024



Adherence rates are high overall, and most cases of loss-to-follow-up are related to displacement or destroyed infrastructure rather than poor compliance. (See

Table 6)

Table 6. Cascade of HIV medical services by region

Region	2022 year							2023 year							2024 year						
	on TO	on ART	II_95 (%)	Examined at VN	Coverage of VN	<1000	III_95 (%)	on TO	on ART	II_95 (%)	Examined at VN	Coverage of VN	<1000	III_95 (%)	on TO	on ART	II_95 (%)	Examined at VN	Coverage of VN	<1000	III_95 (%)
Ukraine	**157,510**	**121,289**	**77**	**86,187**	**71%**	**81,897**	**95**	**157,435**	**118,348**	**75**	**95,991**	**81%**	**91,416**	**95**	**137,780**	**118,701**	**86**	**98,051**	**83%**	**94 122**	**96**
Vinnytsia region	3,260	2,445	**75**	2,099	86%	1,945	**93**	3,431	2,437	**71**	2,052	84%	1,914	**93**	3,028	2,530	**84**	2,294	91%	2,190	**95**
Volyn region	2 108	1,749	**83**	1,140	65%	1,048	**92**	2,062	1,794	**87**	1,518	85%	1,436	**95**	1,981	1,959	**99**	1,602	82%	1,523	**95**
Dnipropetrovsk region	29,293	25,985	**89**	18,332	71%	17,530	**96**	29,628	27,027	**91**	20,545	76%	19,717	**96**	28,436	26,471	**93**	21,725	82%	20,732	**95**
Donetsk region	11,148	4,427	**40**	2 116	48%	1,994	**94**	10,520	4,231	**40**	3,014	71%	2,898	**96**	7,886	4,003	**51**	2,872	72%	2,755	**96**
Zhytomyr region	3,274	2,810	**86**	2,467	88%	2,281	**92**	3,477	2,880	**83**	2,587	90%	2,441	**94**	3,289	3,051	**93**	2,641	87%	2,537	**96**
Transcarpathian region	1,093	808	**74**	482	60%	468	**97**	1,070	808	**76**	570	71%	552	**97**	807	802	**99**	678	85%	642	**95**
Zaporizhia region	4,497	3,801	**85**	1,949	51%	1,824	**94**	4,537	2,044	**45**	1,766	86%	1,629	**92**	2,166	2,087	**96**	1,665	80%	1,609	**97**
Ivano-Frankivsk region	1,219	1,201	**99**	863	72%	792	**92**	1,333	1,222	**92**	896	73%	831	**93**	1,214	1,233	**102**	1,074	87%	1,031	**96**
Kyiv region	8,074	6,603	**82**	4,598	70%	4,322	**94**	8,210	6,339	**77**	5,504	87%	5,233	**95**	7,008	6 126	**87**	4,891	80%	4,706	**96**
Kirovohrad region	3,394	3,096	**91**	2,477	80%	2,374	**96**	3,501	3,339	**95**	2,794	84%	2,648	**95**	3,512	3,458	**98**	2,626	76%	2,482	**95**
Luhansk region	1,986	215	**11**	348	162%	317	**91**	1,847	71	**4**	19	27%	19	**100**	270	64	**24**	32	50%	32	**100**
Lviv region	4,277	3,325	**78**	2,636	79%	2,480	**94**	4,690	3,548	**76**	3,143	89%	2,979	**95**	4,937	3,640	**74**	3,175	87%	3,038	**96**
Mykolaiv region	8 104	6,470	**80**	5,085	79%	4,808	**95**	8,137	6,606	**81**	6,295	95%	5,983	**95**	7,642	6,797	**89**	6,300	93%	6 116	**97**
Odesa region	27,248	20,039	**74**	13,937	70%	13,210	**95**	25,745	17,631	**68**	14,507	82%	13,669	**94**	20 202	16,858	**83**	13,890	82%	13,237	**95**
Poltava region	3,710	3,407	**92**	2,742	80%	2,662	**97**	3,785	3,430	**91**	2,699	79%	2,615	**97**	3,667	3,593	**98**	3,044	85%	2,984	**98**
Rivne region	2,335	2,203	**94**	1,752	80%	1,675	**96**	2,445	2,371	**97**	1,774	75%	1,699	**96**	2,500	2,476	**99**	1,771	72%	1,659	**94**
Sumy region	1,776	1,357	**76**	993	73%	934	**94**	1,617	1,416	**88**	1,217	86%	1,165	**96**	1,617	1,520	**94**	1,283	84%	1,217	**95**
Ternopil region	858	770	**90**	537	70%	506	**94**	922	804	**87**	648	81%	595	**92**	911	832	**91**	644	77%	612	**95**
Kharkiv region	5,523	3,633	**66**	2,036	56%	1,834	**90**	5,779	3,850	**67**	3,187	83%	2,913	**91**	6,239	4,194	**67**	3,335	80%	3 114	**93**
Kherson region	4,547	1,515	**33**	1,266	84%	1,193	**94**	4 115	1,127	**27**	398	35%	372	**93**	3,329	1,155	**35**	786	68%	725	**92**
Khmelnytskyi region	2,366	1,994	**84**	1,253	63%	1,173	**94**	2,414	2,056	**85**	1,538	75%	1,442	**94**	2,242	2,193	**98**	1,691	77%	1,598	**95**
Cherkasy region	3,993	3,868	**97**	3,511	91%	3,407	**97**	4,041	3,832	**95**	3,787	99%	3,682	**97**	4 141	3,940	**95**	3,810	97%	3,756	**99**
Chernivtsi region	1,087	903	**83**	639	71%	575	**90**	1,155	909	**79**	790	87%	717	**91**	911	944	**104**	719	76%	681	**95**
Chernihiv region	4,065	3,828	**94**	3,087	81%	3,022	**98**	4 174	3,890	**93**	3,405	88%	3,319	**97**	4 165	3,988	**96**	3,488	87%	3,433	**98**
Kyiv (DZ)	18,275	11,530	**63**	9,842	85%	9,523	**97**	18,800	11,374	**61**	11,338	100%	10,948	**97**	15,680	11,484	**73**	12,015	105%	11,713	**97**
Kyiv (DoH+MoH,NAMS)	21,582	14,837	69					22,112	14,686	66					18,983	14,787	78				

As shown in Table 7, across the four war-affected regions, the overall number of ART sites remained stable between 2023 and 2024 (74 sites) but declined slightly to 71 sites by 2025.[84] At the same time, the number of occupied or non-functional sites increased from 37 in 2023 to 39 in 2024 and remained unchanged in 2025, indicating persistent disruptions in service availability.

Donetsk experienced the most notable deterioration, with occupied sites rising steadily from 4 to 7 and a slight reduction in total facilities by 2025. Luhansk and Kherson demonstrated no improvement over the three years, with occupancy levels remaining unchanged (6 in Luhansk and 12 in Kherson). Overall, the data reflect continued challenges in maintaining full ART service functionality in regions affected by ongoing hostilities.

Table 7. Operational ART sites in war-affected regions

Region	As of 01.01.23	As of 01.01.24	As of 01.01.25

	Total ART	Of these, occupied	Total ART	Of these, occupied	Total ART	Of these, occupied
Donetsk	25	4	25	6	23	7
Zaporizhzhia	18	15	18	15	18	14
Luhansk	11	6	11	6	10	6
Kherson	20	12	20	12	20	12
In general	**74**	**37**	**74**	**39**	**71**	**39**

Resistance testing is available for patients with >1000 copies/mL VL, though testing remains centralised in Kyiv and underutilised at regional levels.

Decentralisation of HIV care, initiated before the full-scale Russian invasion, remains a major achievement. Regional centres continue to coordinate ART and PrEP services. Outpatient treatment packages now cover ART and routine laboratory monitoring for most patients, and medication delivery systems are in place to reach even displaced or hard-to-reach populations. National HIV clinical standards were updated in 2025, aligned with WHO and other international recommendations and integrated into ongoing professional education. The national standards of HIV care service delivery follow the WHO recommendations on differentiated services delivery (DSD) for stable patients: e.g. include multi-month dispensing (up to 12 months in stable patients); reduced visit frequency; use of telemedicine and community linkage; adaptations for emergency and wartime contexts.

Challenges

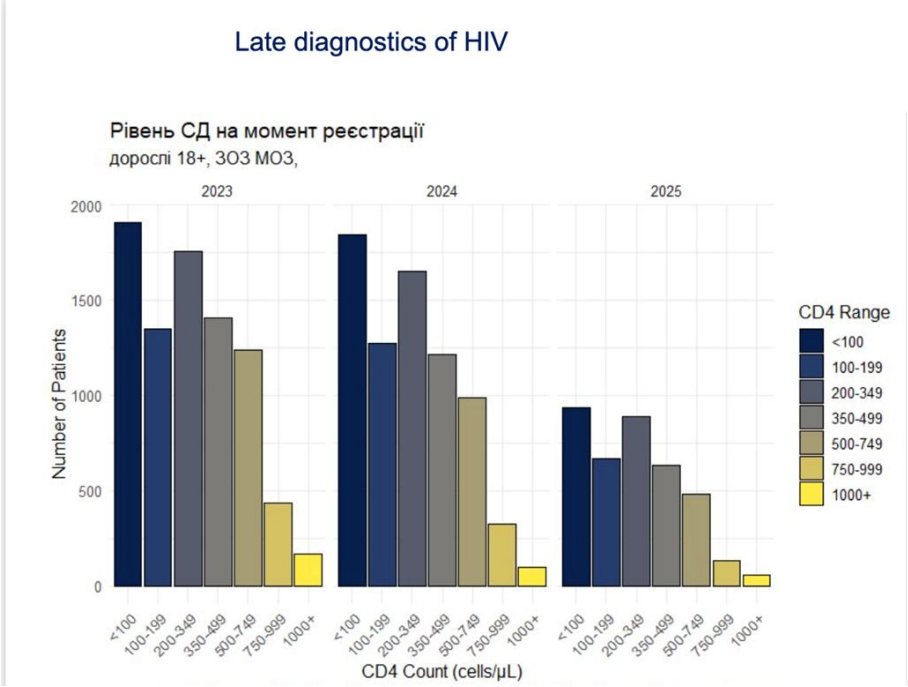
Despite notable progress in decentralising HIV services, significant systemic and contextual challenges persist. The ongoing war and large-scale population movements have disrupted the geographic distribution of medical personnel, resulting in exceptionally high patient loads in some ART-providing facilities (e.g., Zhytomyr and Chernihiv), where individual physicians may be responsible for up to 3,000 patients. While primary care physicians are legally authorised to prescribe ART, provide follow-up, and deliver HIV care following patient enrolment by ART specialists, their effective involvement varies in practice. In some settings, capacity constraints—such as limited access to on-site laboratory services, uneven availability of trained staff, and high workloads—continue to affect the extent to which HIV treatment and monitoring can be fully integrated into primary care, particularly in conflict-affected and high-burden areas.

Regional disparities persist in ART initiation and VL testing in certain regions, such as Odessa, where up to 15% of patients attending care at least once a year do not receive ART. Some individuals collect medication without follow-up monitoring, increasing the risk of undetected virological failure. Understanding of second- and third-line ART options remains limited, as darunavir/ritonavir is often seen as the only available regimen for treatment failure. Although HIV DR testing possibilities exist for

individualised optimisation of treatment regimens, it is used outside Kyiv on rare needs, aligning with the WHO recommendation of a strengthened early warning indicators system to prevent HIV DR and have an organised country-wide system of HIV DR surveillance by conducting national representative surveys once every two to three years. WHO HIV DR surveillance report 2024[85] states that early data are becoming available from standardised cross-sectional HIV DR surveys in countries, including Ukraine. The multi-country analysis (that included Ukraine data) from this WHO source suggests that the prevalence of DTG resistance among individuals receiving DTG-based ART with viral non-suppression (≥1000 copies/mL) was higher than anticipated based on clinical trials. This indicated the need to continue to strengthen the HIV DR surveillance, especially also focusing on integrase inhibitors. While treatment failure in individual HIV clinical management cases is typically managed by assuming poor adherence rather than conducting virological analysis, it shows a good public health approach at the national level. For 3rd line ART for treatment optimisation purposes, it is recommended to consider genotyping and proper HIV DR results to be carefully examined to guide ART adjustments accordingly. A high proportion of patients continue to initiate ART at advanced disease stages (stage III/IV) (Figure 8), particularly among those outside traditional risk groups. In some regions, up to 70% of new initiations fall into these categories. Plans for routine HIV testing in inpatient facilities have not yet been implemented, leaving opportunities for earlier diagnosis unmet.

85 . HIV drug resistance: brief report 2024. Geneva: World Health Organization; 2024. Licence: CC BY-NC-SA 3.0 IGO https://www.who.int/publications/i/item/9789240086319

Figure 8.Trends in Late HIV Diagnosis Based on CD4 Count at Registration, 2023–2025



Treatment optimisation has always been one of the main priorities in revisions of national protocols. However, given the latest evidence, several suggestions should be considered for future protocols revisions:

- Even though the number of Raltegravir (RAL) containing regimens is low overall in the ART provisions breakdown, for continued ART optimisation approaches, potential replacement of RAL to DTG in RAL-containing regimens should be considered.
- While injectable long-acting agents (e.g., CAB-LA for PrEP) are acknowledged as well included in the current version of the national protocols, long-acting ART for treatment is not yet considered as a fully integrated option. WHO supports the gradual adoption of long-acting ART for treatment where feasible. Ukraine's guideline remains primarily oral-ART focused. The updated WHO recommendations 2025[86] state: long-acting injectable cabotegravir + rilpivirine can be used as an alternative switching option for adults and adolescents with undetectable HIV VL on oral ART and without active hepatitis B infection. Given the current context in the country, it may not be a high priority for a change, yet it would need to be considered in the longer term.

86 Overview of WHO recommendations on HIV and sexually transmitted infection testing, prevention, treatment, care and service delivery. Geneva: World Health Organization; 2025. https://doi.org/10.2471/B09471. Licence: CC BY-NC-SA 3.0 IGO; https://creativecommons.org/licenses/by-nc-sa/3.0/igo

Recommendations

Recommendations for improving HIV treatment and Clinical management	Priority	Implementer	Implementation timeline		
			2026	2027-2028	2030
Ensure ART initiation for all patients in care and close regional gaps (e.g., Odessa).	High	MoH, NHSU, regional authorities	X		
Consider continued support to ART optimisation: (1) Replacement of RAL by DTG for RAL-containing regimens. (2) gradual adoption of long-acting ART for treatment, where feasible	Medium	UPHC	X	X	
Expand VL testing coverage and monitoring, including for displaced and remote populations.	High	MoH, UPHC	X	X	
Increase access to resistance testing; train clinicians in interpretation and integrate findings into care decisions.	Medium	UPHC	X	X	
Strengthen early diagnosis and linkage to care, focusing on late presenters and non-classical risk groups.	High	UPHC	X	X	
Build HIV management capacity in primary care to allow family doctors to manage stable ART patients.	Medium	UPHC	X	X	X
Maintain uninterrupted ART and PrEP supply chains, ensuring	High	MoH, NHSU, UPHC,	X	X	X

access for displaced and hard-to-reach populations.		implementing partners			

4.7.2. Management of comorbidities and opportunistic infections (OIs)

Context

National standards for managing OIs were updated in 2025, fully incorporating WHO guidelines and recommendations for emerging infections such as Mpox. Increasingly, patients with OIs are treated in general hospital departments (neurology, internal medicine, etc.), improving access and reducing stigma. However, non-specialist hospital staff often lack experience in advanced HIV/AIDS management, and inpatient AIDS care remains unfunded under existing reimbursement systems, which only cover outpatient care.

Dynamics of cases of OIs by nosology for 2022-2024 (Table *8*) show that the overall burden of OIs remains high, with only modest fluctuations between 2022 and 2024 and substantial numbers already recorded in the first half of 2025. Oropharyngeal candidiasis and bacterial infections continue to account for the largest share of initiated treatment courses, indicating persistent immune suppression among a considerable portion of patients. Several infections (including herpes zoster, pneumocystis pneumonia, and local HSV forms) show an upward or sustained high trend, suggesting ongoing late presentation or interruptions in ART. Meanwhile, severe or less common infections such as cryptococcal meningitis, toxoplasmosis, and systemic candidiasis fluctuate from year to year but remain significant contributors to morbidity. Rare conditions, including cryptosporidiosis and disseminated mycoses, occur sporadically. Overall, the pattern reflects continued challenges in early diagnosis, consistent ART retention, and management of advanced HIV disease, underscoring the need for strengthened prevention, adherence support, and clinical follow-up.

Table 8. Dynamics of cases of OIs by nosology for 2022-2024

Name of OI	Number of OI treatment courses initiated			
	2022	2023	2024	6 months 2025
Local forms of infections caused by HSV-1 and HSV-2	1183	1254	1950	684
Generalised forms of infections caused by HSV-1 and HSV-2	152	262	88	76
Herpes zoster	824	1074	1166	525
CMV retinitis, colitis	425	236	223	223
Oropharyngeal candidiasis	8745	7253	7161	3682
Systemic candidiasis	668	833	676	287

Disseminated mycoses (coccidiomycosis, histoplasmosis)	26	191	9	1
Bacterial pneumonia	2580	2111	2171	1054
Other bacterial infections	4850	3777	4011	1611
Nontuberculous mycobacterial infection	73	97	39	21
Pneumocystis pneumonia	633	955	962	383
Toxoplasmosis (cerebral, chorioretinitis)	436	642	452	208
Cryptococcal meningitis	127	215	176	102
Cryptosporidiosis, isosporosis	9	1	2	1
Visceral leishmaniasis	0	0	0	0
Kaposi's sarcoma	28	21	26	7
Lymphomas (non-Hodgkin's, Hodgkin's T-cell lymphoma)	25	27	52	20
Total	**20784**	**18949**	**19164**	**8885**

Achievements

The 2025 standards for prophylaxis and treatment of OIs mark a major alignment with global treatment protocols.

The current National Strategy till 2030 explicitly addresses the prevention, diagnosis, and management of OIs and AIDS-related conditions among people living with HIV. It emphasises timely clinical monitoring, effective ART, management of treatment-related adverse events, and comprehensive care for co-morbidities. In addition, the Strategy ensures access to preventive and curative services for TB, including TB preventive treatment for people living with HIV.

These strategic directions are fully **aligned with the WHO consolidated guidelines, which recommend integrated, patient-centred HIV care, systematic screening and management of OIs, routine monitoring of treatment safety and efficacy, and the provision of TB preventive treatment as an essential component of HIV services**.

Integration of HIV and OI care within general hospitals has expanded access to inpatient services. On the one hand, inpatient treatment of people with HIV and AIDS in specialist hospital departments such as neurology, internal medicine, etc. reduces stigmatisation of patients, but at the same time makes treatment more difficult due to a lack of expertise in HIV and AIDS issues.

Diagnostic capacity has improved, particularly with the introduction of CrAg testing for cryptococcal meningitis. Liposomal Amphotericin B is now available nationally, though not consistently at regional

levels. Ongoing training and supervision programmes led by the National HIV Programme and partners have begun strengthening clinical capacity among hospital physicians.

Ukraine's MOH "Procedure for screening and early diagnosis of cervical cancer and monitoring of women in risk groups" (MOH Order №1368, registered as z1274-24) includes HIV related areas: HIV is listed as a risk factor for cervical cancer; legislation states risk-group screening approach for women living with HIV/AIDS specifically from age 25, every 5 years, with referral for Pap test and/or human papillomavirus (HPV) PCR test. **HPV vaccination is *not yet part of the routine National Immunisation Schedule*** in Ukraine; it has been available only on a private/self-paid basis. A policy change already occurred in the country and is expected to enter into force from 2026. Starting 1 January 2026, free HPV vaccination will be introduced into Ukraine's National Calendar of Preventive Vaccinations for girls aged 12–13 years. A 9-valent HPV vaccine is expected to be provided through this national immunisation programme.

Challenges

Despite these achievements, significant challenges remain in ensuring equitable and comprehensive management of OIs across the country. A major structural gap persists in the financing of inpatient AIDS care. There is still no dedicated reimbursement mechanism, which limits hospitals' willingness and capacity to admit and properly manage patients with severe HIV-related or advanced immunodeficiency conditions. This results in delayed referrals, fragmented care, and suboptimal management of life-threatening complications.

The national guideline includes elements of the WHO's AHD package, which is acknowledged through this review and discussions with various levels of experts in the country. However, the national protocols do not present the AHD package as a fully bundled, standardised intervention. It would be suitable to consider, along with systematic CrAg screening, expanding access and availability at points of care of TB-LAM testing and its easy adapted use, as well as rapid OIs prophylaxis and treatment bundle.

The distribution of newly registered HIV-infected persons (15+ years) by CD4 lymphocyte levels, in Odessa areas (Figure 9 and Figure 10) indicates a reduction in timely HIV diagnosis in Odesa between 2022 and 2024. The proportion of people diagnosed late, particularly with CD4 <200 cells/mm^3, is high and rising. This suggests that many individuals are not being reached by prevention, testing, and early-detection services.

Figure 9. Distribution of newly registered HIV-infected persons (15+ years) by CD4 lymphocyte levels, in Odessa areas in 2022

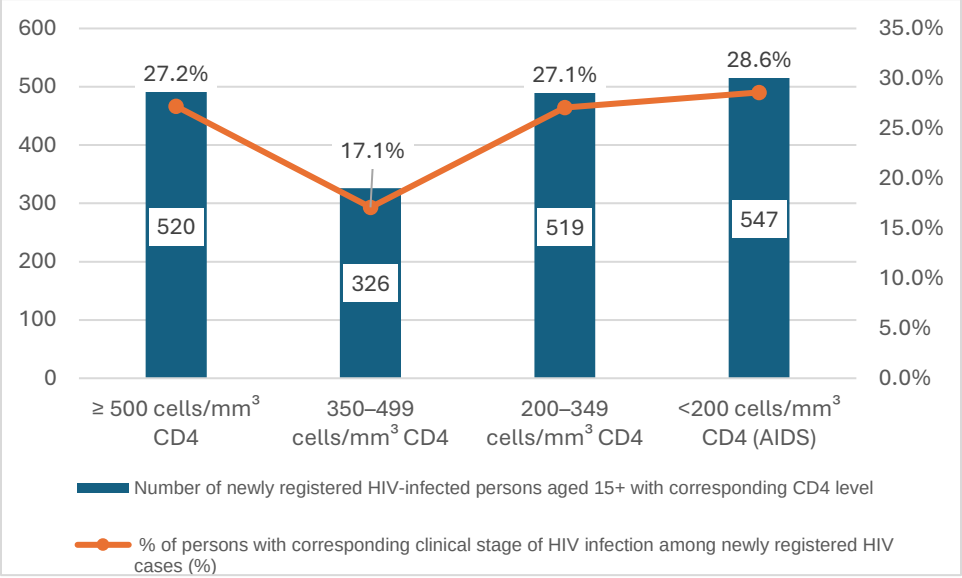
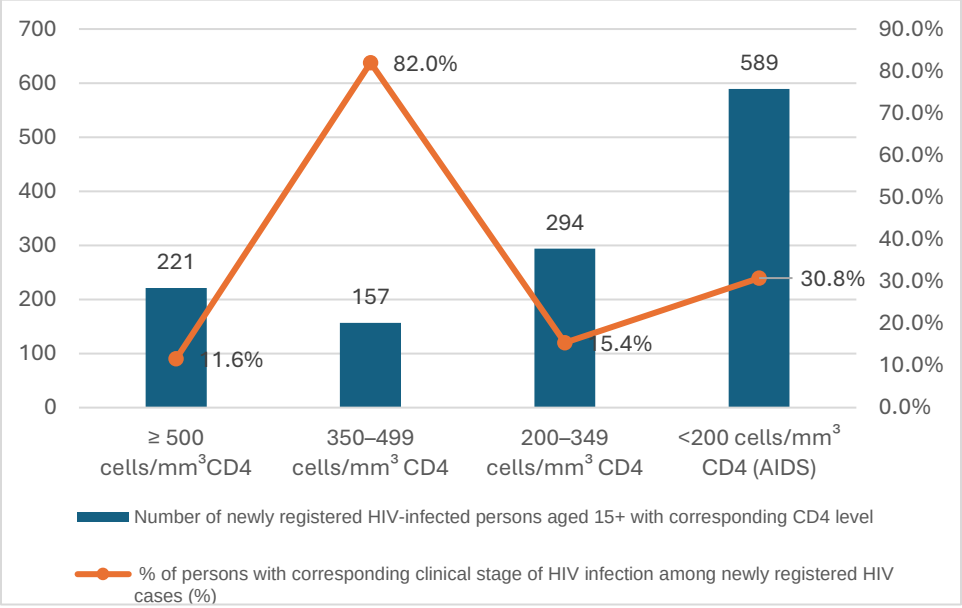


Figure 10.Distribution of newly registered HIV-infected persons (15+ years) by CD4 lymphocyte levels, in Odessa areas in 2024



Clinical capacity also remains limited. Most general hospital physicians and internists have insufficient training in advanced HIV management, particularly in inpatient and critical care settings. This lack of specialised competence often leads to delayed diagnosis, inappropriate empirical therapy, and difficulties in managing treatment complications or drug–drug interactions in complex patients.

Essential medicines for OI treatment remain scarce or inconsistently distributed between regions. **Benzathine/procaine penicillin**, the standard treatments for syphilis, are frequently unavailable. Moreover, **national syphilis treatment protocols currently contain incorrect dosage and regimen recommendations for penicillin**, requiring urgent revision to align with WHO guidance and international best practices.

Flucytosine, a component of therapy for cryptococcal meningitis, remains entirely unavailable in the country, leaving treatment incomplete and increasing mortality risk. Although **liposomal Amphotericin B** is available nationally, its access is uneven, outside major cities.

Diagnostic capability for **Mycobacterium avium complex (MAC)** and several other opportunistic pathogens remains very limited. Most regional laboratories lack bacteriological or molecular testing capacity, which delays diagnosis and prevents evidence-based management of disseminated infections.

Strengthening laboratory infrastructure and integrating advanced diagnostic algorithms are therefore critical priorities for reducing mortality associated with late-stage HIV disease.

WHO increasingly emphasises integrated HIV and non-communicable diseases (NCD) care, particularly for ageing populations. The Ukraine national guideline addresses comorbidities; it would benefit from a more in-depth section on how to operationalise integrated HIV–NCD service models, considering the country context. This is a challenge to address, given the overall epidemiological transition and the need to advance the care of chronic conditions and overall services integration.

Within the national HIV protocol itself, TB prevention regimen selection appears to be **externalised** to other TB guidance rather than specified and clarified if there is a specific consideration for people living with HIV in terms of preferred approach in TB preventive treatment options. Considering recent evidence and updates of WHO recommendations that occurred in 2025, it would be beneficial for the country to consider prioritising rifapentine-based shorter regimens, specifically 3HP for tuberculosis preventive therapy (TPT) in PLHIV, as recommended by WHO.

From 2026 onward, all girls aged 12–13 in Ukraine should be eligible for free HPV vaccination. Girls and women living with HIV do not currently have a special funded provision beyond this age-based policy — unless they fall into the 12–13 age band or obtain vaccination privately or locally funded by a regional/municipal programme. Clinical national guidance on immunisation recommends that people living with HIV receive a three-dose schedule of HPV vaccine regardless of age (as a risk group). However, that is not yet reflected in the national immunisation programme's free HPV vaccination policy and needs to be further monitored for addressing the needs of people living with HIV, along with overall national immunisation plan implementation.

Recommendations

Recommendations for improving management of comorbidities and OIs among patients with HIV/AIDS	Priority	Implementer	Implementation timeline		
			2026	2027-2028	2030
Introduce reimbursement packages for inpatient AIDS care and strengthen collaboration between HIV specialists and general hospital departments.	High	MoH and NHS of Ukraine	X		
Ensure consistent regional availability of liposomal Amphotericin B and provide national-level clinical training on therapeutic regimens.	High	MoH, UPHC	X	X	
Secure sustainable supply of benzathine/procaine penicillin in the national essential medicines list.	High	MoH, UPHC	X	X	
Develop bacteriological and molecular diagnostic capacity for Mycobacterium avium and other OIs at regional laboratories.	Medium	UPHC	X	X	
Continue implementation of the 2025 OI treatment standards and roll out structured training for general hospital staff.	High	UPHC	X	X	X
Assure that people living with HIV receive a scheduled HPV vaccine regardless of age, following the new immunisation policy starting to be implemented in 2026	High	MoH, UPHC	X	X	X

5. OAMT Programme Review

5.1 Programme Overview and Context

Ukraine continues to face a significant public health challenge related to opioid use disorders. While 2019 estimates indicate that approximately 278,000PWID were potentially in need of OAMT[87]. These

87 Government of Ukraine. (2025). *Strategy of Drug Policy for the period up to 2030*. Kiev: Order of the Cabinet of Ministers of Ukraine of August 20, 2025, No. 920-p

figures are now outdated and require careful contextualisation. Since 2019, Ukraine has undergone profound demographic, social, and behavioural shifts - particularly following the full-scale Russian invasion - which significantly affect the validity of pre-war PSEs. Relying on this older data without qualification may lead to inaccurate assessments of programme coverage, especially given that national objectives for OAMT scale-up are often calculated as a percentage of the estimated PWID population. Consequently, while the 2019 data serves as a historical reference, there is a critical need for updated population size assessments to ensure that strategic planning and progress monitoring are based on robust, current evidence.

In response, the country has progressively scaled up its OAMT programme, which is recognised as a cost-effective and crucial intervention for reducing the transmission of HIV and Hepatitis C Virus (HCV) and stabilising the health and social status of thousands of individuals.

Since its inception in 2004 with donor support, the OAMT programme has transitioned to significant state funding, with services now included in the Medical Guarantee Programme since 2020. As of June 30, 2025, a total of 33,029 patients were receiving OAMT across Ukraine[88]. This represents a 6.9% increase in patient numbers from the second half of 2024. (Figure *11*) [89]The services are delivered through a mix of communal (21,974 patients), private (10,485 patients), and penitentiary (570 patients) healthcare facilities (Figure *12*). Methadone remains the predominant medication, used by over 88% of patients in both public and private sectors.

88 UPHC. (2025). Report on Opioid Substitution Therapy (OST), mental health, and substance use disorders for the first half of 2025.

89 Iryna Ivanchuk, STATUS OF IMPLEMENTATION OF SUBSTITUTION MAINTENANCE THERAPY IN UKRAINE AS OF APRIL 1, 2025. Presentation for the WHO mission on September 24, 2025

Figure 11. Number of Patients enrolled in OAMT programme in 2020-2025

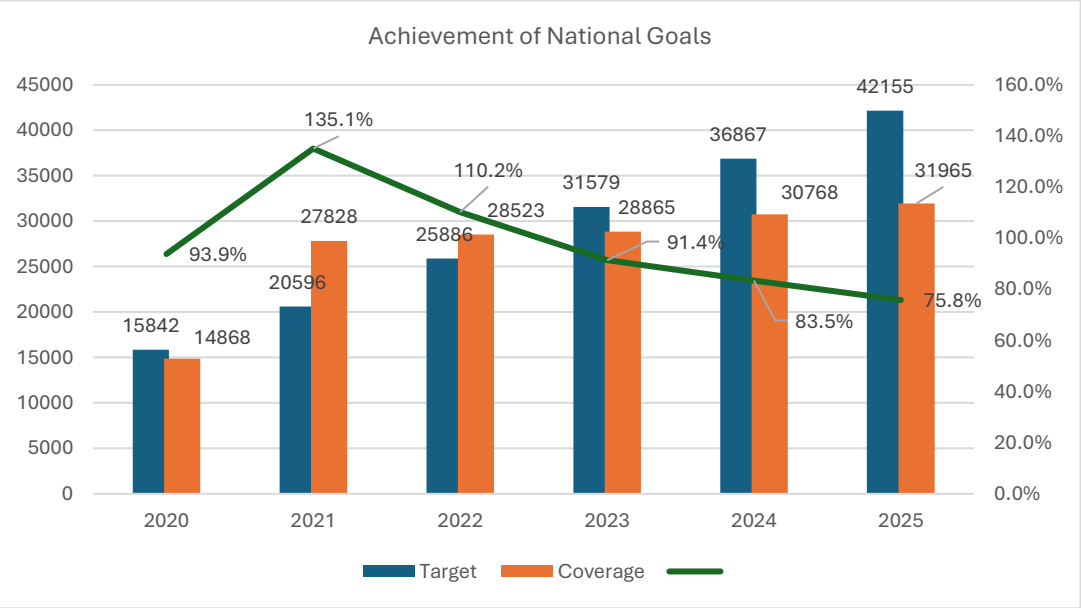
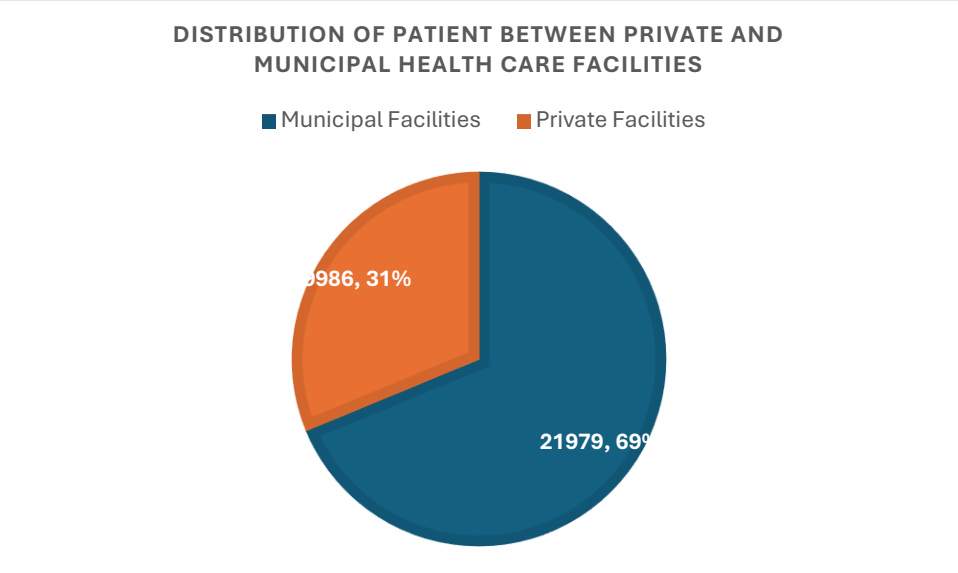


Figure 12. Patients' distribution between private and municipal health facilities



The services are delivered through a mix of communal (21,974 patients), private (10,485 patients), and penitentiary (570 patients) healthcare facilities. Methadone remains the predominant medication, used by over 88% of patients in both public and private sectors.

The ongoing full-scale Russian invasion has profoundly impacted service delivery. While presenting immense challenges, it has also spurred rapid adaptations, such as extending take-home dosing

periods up to 30 days to ensure treatment continuity for displaced patients. Despite the war, the programme has demonstrated remarkable resilience, continuing to enrol new patients and expand its reach. National policy reflects a commitment to this expansion, with the national strategy setting a target to increase OAMT coverage to 40% by 2030, while the operational plan for the Drug Policy Strategy aims to have 68,595 patients in treatment by that year[Error! Bookmark not defined.], a number which is likely derived from the older PWID population estimates.

5.2 Achievements

The OAMT programme in Ukraine has demonstrated substantial progress and innovation, marked by a supportive regulatory environment, expansion of services, and a strong focus on patient-centred care.

Supportive Regulatory Framework and State Commitment

The state has shown clear political support for OAMT, translating into enabling regulations and full state funding for medications and services through the Programme of Medical Guarantees. Key regulatory reforms have removed significant barriers to access. Notably, amendments to the MoH Order №200 have allowed doctors of any speciality to provide OAMT, permitted prescription-based dispensing, and enabled private facilities to deliver services. Furthermore, the abolition of the Soviet-era "narcological registry" has been a critical step in reducing stigma and encouraging individuals to seek help.

In 2025, new and updated medical care standards for substance use disorders (SUD) were approved, further aligning national practice with international guidelines. Updated standard "Mental and behavioural disorders due to opioid use" (Approved July 11, 2025**)** outlines the comprehensive scope of medical services that OAMT providers are required to offer. It focuses on a patient-centred approach that combines medication with integrated health services and support.

Program Expansion and Increased Access

The number of OAMT patients has steadily increased, reaching 33,029 by mid-2025. This growth is supported by the expansion of service delivery sites. In the first half of 2025 alone, eight new communal healthcare facilities began providing OAMT, with further expansion planned for the year.

A major achievement has been the expansion of OAMT within the penitentiary system. After being introduced in 2021, the programme has grown to 21 sites in prisons, serving 570 patients as of 2025 with plans for further expansion[90]. This is particularly vital given that 8% of the prison population is HIV-positive. Good continuity of care is crucial for individuals both entering and leaving the penitentiary system. For those entering, there appears to be a functioning mechanism ensuring that individuals who were on OAMT in the civil sector continue their treatment after being detained. Likewise, ensuring

90 UPHC. (2025). Report on Opioid Substitution Therapy (OST), mental health, and substance use disorders for the first half of 2025.

continuity upon release is a key national objective. The Drug Policy Strategy calls for the development of comprehensive pre-release and post-release support programmes to create an effective referral system for uninterrupted treatment and rehabilitation services after individuals leave prison[91].

Innovative Service Delivery and Patient-Centred Care

Ukraine has embraced innovative, patient-friendly service delivery models. The widespread use of take-home dosing has been a cornerstone of the programme's flexibility and resilience, particularly during the COVID-19 pandemic and the ongoing war. Currently, 93.2% of patients receive their medication for self-administration[3], which reduces the burden on clinics and allows patients more time for social and economic activities. This broad application of take-home dosing is an important step forward, but it requires careful consideration and mitigation of potential risks related to overdose, medication diversion, and misuse to ensure patient safety and programme integrity.

The piloting of Video Observed Treatment (VOT) has proven to be a highly successful innovation. A 2023 study found the method to be feasible and effective, with a 97.1% success rate for planned video sessions[92]. The vast majority of patients (82.9%) rated their experience with VOT positively, and 87% were successfully transitioned to self-administered treatment afterwards. Patients highlighted that VOT helped them adhere to their medication regimen and saved significant travel time, as many spend over an hour travelling to their clinic.

Linkage to Care and High Patient Satisfaction

State OAMT sites demonstrate a high rate of testing for infectious diseases and a strong linkage to care. Among OAMT patients living with HIV in public facilities, ART coverage is 98.1%, a testament to effective integration. Patient satisfaction with OAMT services is consistently high. A survey conducted in August 2025 found an overall satisfaction rate of 84%, exceeding the 70% target[93]. Patients expressed high satisfaction with the competence and professionalism of doctors and nurses, the quality of care, and the attitude of staff. The trust between patients and staff has reportedly improved since the start of the war, as patients witness the extraordinary efforts made to ensure continuous care.

5.3 Challenges

Despite its successes, the OAMT programme faces a number of significant challenges related to staffing, funding, service quality in the private sector, and persistent stigma.

91 Government of Ukraine. (2025). *Strategy of Drug Policy for the period up to 2030*. Kiev: Order of the Cabinet of Ministers of Ukraine of August 20, 2025, No. 920-p

92 Karagodina E.G. (2023). EVALUATION OF TELEHEALTH AND VIDEO SURVEILLANCE OF TREATMENT OF PATIENTS RECEIVING OST. Qualitative study report commissioned by UPHC, Kiev.

93 UPHC. (2025). Satisfaction with Opioid Substitution Therapy (OST) Services. Kiev.

Staffing Gaps and Provider Reluctance

A shortage of qualified specialists, particularly psychiatrists and narcologists, is a principal obstacle to expanding OAMT services, a problem significantly exacerbated by the full-scale Russian invasion and its competing health priorities. While integrating OAMT into Primary Health Care (PHC) facilities presents an effective pathway to overcome this specialist shortage - a model successfully demonstrated in previous pilot studies[94] – engagement remains limited. This reluctance is partly driven by economic and motivational factors. While the NHSU provides financing for HIV and OAMT services through specific packages, the capitation rates were approved years ago and may not fully reflect current service delivery costs. This can make the service appear economically unattractive to some healthcare workers. Compounding this is persistent stigma; stakeholders note an unwillingness among some providers to work with what they perceive as a "difficult and marginalised" patient population. These financial and social factors create a barrier to recruiting and retaining staff, preventing the health system from leveraging the full potential of PHC facilities.

Quality of Care and Oversight in Private Clinics

While the involvement of private clinics helps improve coverage, it also presents significant challenges regarding quality of care and oversight. Many private sites do not collaborate with the state system, provide data on patient numbers, or report through the national information system, which violates regulations. This creates a risk of patients receiving medication from both state and private sites simultaneously, increasing the risk of diversion to the illegal market.

Furthermore, many private facilities do not provide essential integrated services like psychosocial support or screening for infectious diseases. Reports suggest non-adherence to stabilisation protocols, including immediate take-home dosing and, critically, the co-prescription of psychoactive drugs. This latter practice is reportedly used to ease staff duties by placating patients who find the combined effects desirable, a strategy that may prioritise staff convenience over clinical need.

Strengthening Linkages for Mental Health Integration

There has been an expected increase in mental health problems among OAMT patients, including depression and PTSD, since the start of the war. Addressing these co-occurring needs is a priority. National standards explicitly require OAMT providers to routinely screen patients for depression,

94 Machavariani E, Bromberg DJ, Dumchev K, Esserman D, Earnshaw VA, Pykalo I, Filippovich M, Ivasiy R, Ahmad B, Long J, Haddad MS, Madden LM, Oliveros D, Dvoriak S, Altice FL. Decrease in provider stigma is associated with improved quality health indicators among individuals receiving methadone in primary care centers in Ukraine. Int J Drug Policy. 2025 Feb;136:104682. doi: 10.1016/j.drugpo.

anxiety disorders, and other mental health conditions. However, challenges remain in ensuring that patients identified during screening receive the comprehensive care they need.

The challenge is not necessarily one of funding structure; in fact, the current financing model, where SUD treatment and mental health care are covered by different packages, allows facilities to receive multiple streams of funding, which supports their financial sustainability. Merging these into a single mandatory package could risk reducing the number of eligible providers and limiting overall funding. Instead, the difficulty lies in operational coordination.

While narcologists are responsible for initial screening, the primary hurdle is establishing effective referral pathways and coordination between narcologists and mental health specialists. Currently, linkages between these services can be fragmented. Improving the capacity of OAMT providers to not only screen but also effectively link patients to specialised mental health care - and strengthening the collaboration between these departments - is essential to ensure patients receive holistic support.

Balancing Medication Choice and Patient Awareness

There is a significant prevalence of methadone prescription in Ukraine compared to buprenorphine. This distribution is influenced by complex factors, including patient preference, where methadone is often favoured due to its specific pharmacological characteristics and perceived suitability for long-term stabilisation.

However, to ensure a fully patient-centred approach, it is crucial that this distribution reflects informed choice rather than habit or lack of awareness. Buprenorphine offers a distinct safety profile and may be more suitable for patients with less severe dependence or those seeking different treatment outcomes. The current imbalance suggests a need for better communication and education. There may be a gap in information that prevents some patients from considering buprenorphine. Expanding educational efforts for both clinicians and patients regarding the benefits and advantages of buprenorphine could help ensure that treatment decisions are truly individualised and responsive to diverse patient needs.

Persistent Stigma and Misinformation

Myths and stigma surrounding OAMT remain a significant barrier to programme expansion and patient engagement. Many potential patients still incorrectly believe they will be added to a "narcological registry," despite its abolishment, highlighting a need for better awareness activities. This low demand, driven by misinformation and a disbelief in the treatment's efficacy, hinders efforts to meet national coverage targets.

5.4 Recommendations

To build on the programme's successes and address the identified challenges, the following recommendations are proposed, focusing on improving the quality of care and expanding coverage.

Recommendations for improving the quality of OAMT services and expanding coverage	Priority	Implementer	Implementation timeline		
I. Expanding Access and Provider Engagement			2026	2027-2028	2030
1. Strengthen PHC Engagement Through Capacity Building and Support: Strengthen PHC engagement by focusing on non-financial enablers. This can be done through implementing targeted information activities to reduce stigma, and providing technical assistance to new sites. Expand targeted capacity-building activities for medical staff, especially in primary care settings. These initiatives can build upon existing certified online training modules and focus on the evidence-based effectiveness of OAMT, the clinical nature of addiction, and the benefits of a harm-reduction approach. The goal is to address the unwillingness to work with this marginalised population and foster an enabling, non-judgmental environment for patients.	High	MoH, NHSU	x	x	
2. Strengthen Civil Society Organisations (CSO) Role in Combating Stigma and Driving Enrolment: Strengthen the role of CSOs to combat stigma and increase patient demand by focusing on targeted information campaigns. Implement specific, peer-led educational interventions to directly dismantle prevalent myths, particularly regarding the fear of the "narcological registry" and misconceptions about treatment efficacy. Acknowledging that	High	Civil Society CSOs, MoH, UPHC	x	x	

CSO-based models currently contribute a relatively small share of new enrolments, efforts must focus on scaling their outreach effectiveness. This should include training peer workers to deliver accurate clinical information and providing active peer navigation (accompaniment) to treatment sites to bridge the gap between initial contact and enrolment.					
3. Re-assess the Potential of Mobile Clinics with Evidence-Based Analysis: The potential of mobile clinics should be re-assessed. While concerns over medication diversion and cost-effectiveness have hindered their use, a targeted cost-effectiveness analysis and comparative study must first be conducted. This analysis must compare mobile ambulatory units with alternative service delivery models (e.g., stationary sites). The decision to adopt a mobile model must be grounded in this operational assessment	Medium	MoH, NHSU, CSOs		x	
II. Improving Quality and Integration of Care					
4. Strengthen Quality Control and Oversight by enforcing mandatory, real-time reporting into the national information system for all providers (including private providers) and conducting regular audits to ensure adherence to clinical protocols.	High	MoH, State Service of Ukraine on Medicines and Drug Control	x	x	x
5. Improve Operational Linkages for Integrated Mental Health Care: Strengthen the operational linkages and clinical coordination between narcology and specialised mental health services. While screening for co-occurring disorders is mandatory, establish clear, streamlined referral pathways to ensure patients receive	Medium	MoH, NHSU	x	x	

continuous and coordinated care for mental health conditions (e.g., depression, PTSD) when identified.					
6. Enhance awareness for patient-centred medication choice: Promote patient-centred medication choice by implementing targeted educational initiatives for physicians and patients on the distinct benefits of both methadone and buprenorphine. This will foster a shared decision-making model guided by individual patient needs rather than historical prescribing habits.	Medium	MoH, UPHC, Relevant Medical Bodies	x	x	
III. Modernising Treatment Modalities and Safety			x	x	
7. Scale Up Long-Acting Injectable Buprenorphine (LAIB): Building on the successful piloting of LAIB in Ukraine, expand access to this treatment modality across the country. This expansion will reduce the burden of daily clinic visits for patients, improve adherence, and significantly mitigate the risk of medication diversion associated with oral formulations.	Medium	MoH, NHSU, International Donors			
8. Strengthen Safety Protocols for Take-home Dosing: To ensure the safety of the widespread take-home dosing policy, develop and implement standardised risk assessment tools for clinicians. These tools should help providers identify patients at high risk of overdose or diversion before prescribing extended take-home doses. Furthermore, develop specific mitigation strategies, such as more frequent monitoring or shorter dosing intervals for patients identified as unstable, ensuring a balance between flexibility and safety.	High	MoH, Expert Groups	x		
9. Expand Overdose Prevention (Naloxone) Distribution: Implement a comprehensive Take-Home Naloxone	Medium	MoH, CSOs, PHC Providers	x		

(THN) programme. This should go beyond simple availability to include proactive distribution of naloxone kits to all OAMT patients, particularly upon induction and release from penitentiary institutions. Crucially, expand training on overdose recognition and naloxone administration to family members and social networks of patients to create a wider safety net.					

6. Enabling environment: rights, gender, communities

Community systems are a core pillar of Ukraine's HIV, hepatitis and STI response. Community members and CSOs actively contribute to nearly all health and structural interventions recommended by WHO for KPs. In addition to delivering medical and psychosocial services and screening for infectious diseases, community actors lead structural interventions such as advocacy for supportive laws, policies and financing; efforts to decriminalize behaviours associated with KPs (drug use and possession, sex work, etc.); reducing stigma and discrimination; promoting accessible and acceptable services for KPs; and addressing gender-based violence.

Service delivery by CSOs is built around community-based and community-led models that complement and reinforce the public health system. Existing community-centred approaches include: fixed and mobile service delivery (including mobile vans), community-based testing, case finding for HIV, TB and viral hepatitis, initiation of treatment and adherence support (including psychosocial support), CLM and research, and advocacy for comprehensive service packages and service sustainability.

Successive emergencies – first COVID-19, then full-scale war – created major pressures on the health system and on the national HIV response, but also highlighted the resilience and adaptability of community systems. CSOs rapidly expanded their roles beyond HIV to address urgent humanitarian needs of KPs and the general population. Using existing infrastructure (drop-in centres, mobile vans, outreach teams) and human resources, they organised humanitarian convoys, supported telemedicine and other IT solutions, and contributed to rebuilding efforts. Their activities included transporting several thousand tons of humanitarian supplies, procuring and delivering food and hygiene kits, organising shelters for internally displaced persons, and ensuring continued delivery of ARV and TB medicines and other essential medical commodities to highly affected and hard-to-reach communities.

Organisations of people living with HIV (PLHIV) have also played a critical role during the war. They continue to operate wherever possible, supporting people living with and vulnerable to HIV, protecting their rights (including through legal aid for survivors of sexual violence), and providing psychological support. They assist with emergency evacuation and temporary accommodation, organise ART delivery to “hot spots”, arrange transport for patients, and provide HIV testing (including index testing and HIV/HCV testing) and distribution of self-testing kits. PLHIV networks have mobilised donations from within Ukraine and internationally to support people affected by occupation and hostilities, as well as healthcare workers and facilities.

Achievements

In Ukraine, extensive networks of NGOs and Community-Based Organisations (CBOs) represent almost all KP constituencies (PWID, FSW, MSM, TG, prisoners, veterans and others). Over the last decade, substantial investments have been made in leadership development, advocacy skills and organisational strengthening. These efforts have built community capacity to engage in policy dialogue, participate in technical working groups, shape national strategies, and communicate evidence-based messages to both decision-makers and affected communities. Community structures now routinely contribute to agenda-setting, monitoring of national programmes, and mobilisation around funding and legal reforms.

CLM is in place and increasingly systematic, covering access to services, quality of care, user experience, and instances of rights violations. CLM tools and reporting mechanisms are used to document barriers in real time and feed structured evidence into national and regional decision-making forums. Since the start of full-scale war, CLM has been expanded to capture displacement-related issues, including continuity of treatment and prevention services for internally displaced persons and refugees, disruptions along referral pathways, and protection risks. This has enabled rapid identification of service gaps and informed programmatic adjustments by both state and non-state providers.

Challenges

While CLM mechanisms have been strengthened and are increasingly generating structured data and reports, their integration into formal national M&E and coordination systems remains partial. CLM findings are not yet consistently embedded in routine dashboards, performance reviews or decision-making cycles at national and oblast levels. This limits the ability to systematically translate community evidence on access, quality and rights violations into programmatic or regulatory adjustments, and raises questions about the long-term institutional and financial sustainability of CLM platforms.

Several interviews pointed to insufficient and fragmented resourcing for community empowerment, advocacy and human-rights work. Core functions such as leadership development, legal literacy,

strategic communication and movement-building are often funded on a short-term, project-by-project basis. This can weaken continuity of engagement, reduce the ability of networks to retain skilled staff, and constrain their capacity to respond rapidly to emerging threats (e.g. new restrictive regulations, policing practices, or service disruptions).

Although community representatives are formally included in multisectoral decision-making bodies and programme planning processes (e.g. CCM, technical working groups, national and regional task forces), they report that in some cases their input is not sufficiently reflected in final decisions or implementation modalities. This perceived gap between participation and influence can lead to consultation fatigue and risks undermining trust. Strengthening feedback loops, documenting how community recommendations are considered, and jointly tracking follow-up actions would help enhance the effectiveness and credibility of participatory mechanisms.

The legal and policy environment continues to pose structural barriers. KPs still face risks associated with the criminalisation of drug use and possession, sex work, and HIV transmission/exposure, as well as related administrative offences. These frameworks contribute to police harassment, fear of disclosure, and reluctance to seek prevention, testing or treatment, particularly among the most marginalised groups. They also limit the ability of community organisations to operate openly, expand services and scale up peer-led interventions.

Stigma and discrimination in healthcare and social-service settings towards KPs, people living with HIV and OAMT patients remain a significant concern. Reported issues include judgmental attitudes, breaches of confidentiality, reluctance to provide services, and inappropriate or outdated clinical practices. These experiences directly deter service use, delay diagnosis and treatment initiation, and undermine adherence. Expanded stigma-reduction programmes, continuous professional education, and stronger accountability mechanisms for rights violations are needed to ensure that the health system fully supports equitable access for all communities.

Recommendations

Recommendations for improving the policy environment and strengthening community systems for HIV response	Priority	Implementer	2026	2027–2028	2030
Systematically link CLM data to national and regional M&E and coordination mechanisms; routinise feedback	High	MoH, UPHC, NHSU, Regional CDCs, CCM, national KP/PLHIV	Map existing CLM initiatives; agree on core CLM indicators; pilot regular presentation of	Integrate CLM indicators into routine dashboards and reviews; expand CLM coverage to	CLM is fully embedded in national M&E and coordination cycles; periodic review and

and accountability; ensure broad regional representation		networks, CSOs	CLM data in national/oblast coordination meetings	under-represented oblasts and KP groups; formalise feedback loops and response plans	update of CLM tools and indicators
Adequately resource and support community-led responses to implement transition plans and navigate policy/legal changes, especially at the regional level	High	MoH, MoF, CCM, Global Fund, PEPFAR, other donors, national CSO/KP networks, NHSU	Define community-system priorities in NS2030 and Global Fund 2026 request; design core-funding lines for community coordination, CLM, advocacy and legal support	Gradually increase predictable funding for community-led responses (including regional level); pilot domestic co-financing and/or NHSU contracting where feasible	Community-led functions (CLM, advocacy, legal support, coordination) are substantially financed from domestic sources and integrated into routine planning/budgeting
Reduce legal and policy barriers that limit access and drive inequities (criminalisation of drug use/possession, sex work, HIV transmission)	High	Parliament, MoJ, MoH, MoI, Prosecutor's Office, Ombudsperson, KP and PLHIV networks, human-rights CSOs	Conduct legal and policy review with community participation; develop a time-bound law and policy reform roadmap	Implement agreed legal/policy changes in phases; align law enforcement and prosecutorial practice with public health goals; monitor impact with community input	Review progress and remaining gaps; consolidate protective legal norms and safeguards against regression
Address HIV-related stigma and discrimination in healthcare, law enforcement, penitentiary and social service settings (training and integration into Quality-of-Care systems)	High	MoH, professional associations, MoI, Penitentiary Service/MoJ, MoVA, social-service authorities, KP and PLHIV networks	Develop standardised stigma-reduction and rights-based training packages; agree on indicators and QoC/accreditation requirements	Roll out training nationwide (beyond HIV specialists); integrate stigma-reduction and rights indicators into QoC, supervision and accreditation; operationalise complaint/redress mechanisms	Institutionalise stigma-reduction as a routine component of pre-/in-service training and QoC; periodic measurement and public reporting of stigma indicators

7. Conclusions

Ukraine's HIV and OAMT response remains ahead of the curve in the WHO European Region, despite the profound disruptions of full-scale war. A strong policy and institutional framework articulated in

NS2030, a well-functioning national purchaser (NHSU), robust public health institutions (UPHC and regional CDCs), and an established collaboration with international partners and community-based organisations, have allowed the country to maintain core HIV, OAMT, and harm-reduction services under extreme pressure and to align technical approaches closely with WHO recommendations.

The review confirms substantial achievements: high ART coverage and viral suppression among those on treatment; continuity and gradual expansion of OAMT; scale-up of differentiated and community-based delivery models; and effective use of innovation, including telehealth platforms, mobile clinics, multi-month dispensing, and new prevention technologies such as CAB-LA. Harm-reduction services in prisons have progressed markedly, and national institutions have demonstrated the capacity to absorb and manage donor-supported programmes and procurement functions. Civil-society and community organisations remain indispensable partners for outreach, adherence support, and service delivery to key and vulnerable populations.

At the same time, these gains remain vulnerable and require continued attention. War-related damage to infrastructure, displacement, and economic hardship have contributed to regional inequities and placed additional pressure on an already limited health workforce. Prevention and outreach efforts (particularly for KPs, people in prisons, and emerging groups such as users of new psychoactive substances) still rely substantially on external funding. Further strengthening of information systems, closer alignment of M&E with regional action plans, and more complete reporting of transmission modes would enhance the ability to monitor programme performance and adjust interventions. Continued progress on PHC-based integration, decentralisation of HIV and OAMT, and data interoperability across oblasts will be essential to ensure a more consistent and resilient response nationwide.

Going forward, consolidating and protecting the gains of the HIV National Programme in the context of tightening fiscal space and ongoing security risks should be a strategic priority. This will require: safeguarding public funding for core HIV, OAMT, and public-health functions; updating tariffs and embedding HIV and OAMT more firmly within PHC packages; accelerating HR reforms and capacity-building for regional CDCs and UPHC teams; completing integration of strategic information systems and aligning the M&E framework with WHO regional action plans; and developing concrete transition plans for donor-funded prevention, including in prisons. Maintaining the structured engagement of NGOs and community networks, and addressing legal and stigma-related barriers (including criminalisation of drug use), will be critical to sustaining coverage among KPs.

The findings of this review are intended to guide the revision of NS2030 implementation plans and the preparation of Ukraine’s Global Fund 2026 funding request, with a clear focus on resilience, equity, and the long-term sustainability of the HIV and OAMT response.

Annex 1.Terms of Reference for comprehensive review of the National HIV/AIDS, Opioid Agonist Maintenance Treatment, Tuberculosis, and Viral Hepatitis Programmes in 2023–2024 in Ukraine

Context

Ukraine adopted a public health approach to countering epidemics and in 2019 the Cabinet of Ministers approved a new unified National Strategy on HIV/AIDS, Tuberculosis and Viral Hepatitis 2020-2030 (NS2030) with objectives and targets aligned to Sustainable Development Goal (SDG) 3.3. The National Strategy recognises that: "*A key priority of public health and social development policies is the prevention of diseases that have the greatest negative socio-demographic and economic impact on the way towards integration with the global and European communities in pursuit of the implementation of United Nations Sustainable Development Goals, and the Association Agreement between Ukraine, on the one part, and the European Union, the European Atomic Energy Community, and their Member States, on the other part*".

The goals of the National Strategy are based on the following key principles which will guide the comprehensive review:

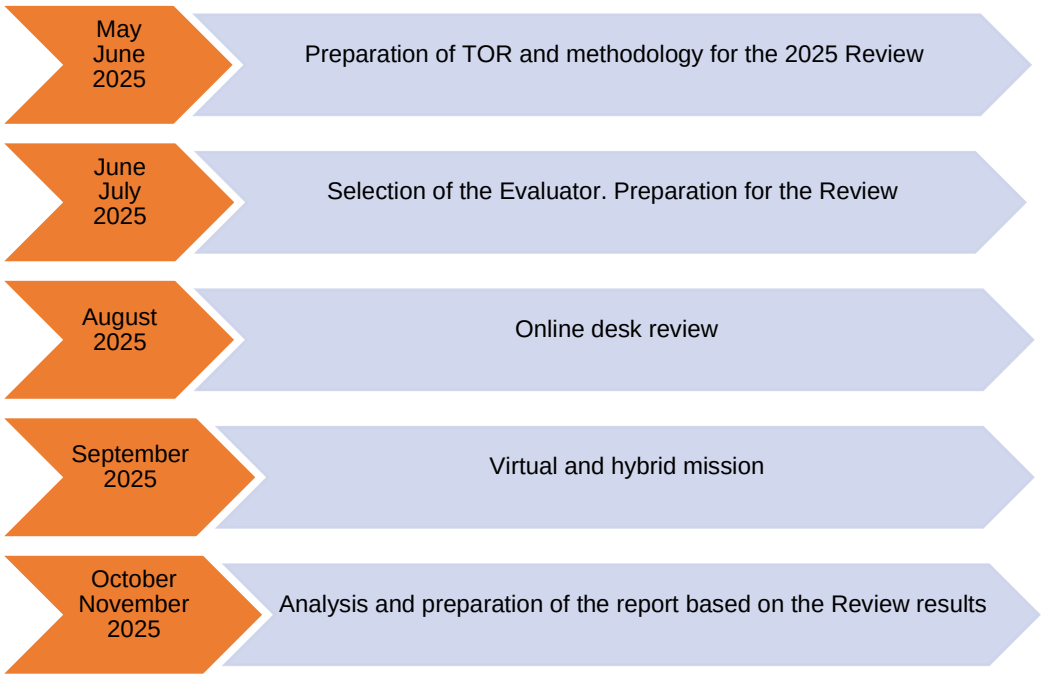
- respect for human rights and non-discrimination by health, age, social status, sexual orientation, gender identity, occupation, and other attributes, as well as ensuring equality, including gender, and the enjoyment of human rights and freedoms, regardless of those characteristics;

- the priority of the right for health, which not only provides full, fair access to health services, but also creates favourable conditions for exercising this right and proactive care for own health and health of the surroundings;
- transparency and openness — providing the public with tools for meaningful involvement and influence, and ensuring proper accountability and responsibility of management entities;
- validity — taking evidence-based approaches resting on expertise and unbiased data, with an awareness of the process sequence and consideration of the optimal use of available and potential resources;
- pro-activeness — policymaking and action to anticipate projected challenges and ensure that reasonable adjustments are made to improve approaches to the Strategy implementation;
- measurable goals and critical review — defining clear intermediate and final goals and objectives, the effectiveness of which can be measured and evaluated;
- intersectoral cooperation — effective interaction, coordination of efforts and efficient governance through the distribution of powers among the performers in line with their specific functions;
- continuity and succession — maintaining the focus on the Strategy goals and objectives irrespective of political or other factors; accumulation, and transfer of positive experience, managerial, scientific and technical capacity.

The country has set ambitious goals for the development of programmes, and a full-scale review of the current state of HIV/AIDS, TB, Opioid Agonist Maintenance Treatment and Viral Hepatitis services is needed in order to make management decisions on their further development based on the data obtained, including an analysis of programme synergies, particularly in the provision of integrated services for KPs. The results of the review may serve as a basis for informed decision-making on programme improvement, priority setting, more efficient resource utilisation, development of integrated service delivery approaches, and formulation of recommendations for strategic planning at the national level. The end users of the review results may include the Ministry of Health of Ukraine, national focal points of the programme implementation, other governmental institutions, international partners and donor organisations, research institutions, local self-government bodies, representatives of civil society, as well as providers of medical and social services at the national, regional, and local levels.

Review implementation timeline

The review of the implementation of interventions within the national responses to the HIV, TB, VH, and OAMT programmes for 2023-2024 will be conducted in phases, scheduled for completion by the end of 2025. Preliminary timelines have been estimated for the implementation of each review stage.



Review steps

The Review will include the following phases and components:

I. Preparatory phase

1. Preparation for the mission;
2. Defining the main programme areas and topics that should be included within the scope of the Review;
3. Defining the Review team (including external review team);
4. Briefing of the review team on purpose, objectives, methodology and outcomes of the Review; roles and responsibilities of the Review team; and in-country orientation, prior to field visits;
5. Development by the Review team and approval of checklists and indicators for assessing programme implementation;

	6. Development by the Review team and approval of the sample size and geographical coverage according to the Review components;
II. Desk review	7. Data collection and Desk review to systematically review relevant strategic and programme documents; 8. Discussion of the Desk Review results with the Review Team; 9. Development of the agenda for virtual meetings/interviews;
III. Virtual mission	10. Initial briefing with MoH, UPHC and other key stakeholders on the review purpose, objectives, methodology and outcomes, and introduction of the Review team; 11. Virtual Review (HIV Hep OAMT) and hybrid review (TB); 12. Synthesising of findings and recommendations for development of main findings and recommendations; 13. Inclusive stakeholders' consultations to discuss the main findings and initial recommendations of the review; 14. Debriefing of the Minister of health and/or senior MoH authority on the main findings and initial recommendations;
IV. Report development	15. Synthesising of findings and recommendations and development of the review report; 16. Consolidation and finalisation of the review report; 17. Dissemination.

Planning for virtual visits

National-level visit

Key stakeholder to be considered for the interviews include the following:

- Relevant Programme managers and other programme personnel
- Senior MoH officials
- National coordination and review mechanism/body on programmes
- Related health institutions (regulatory, research, procurement)
- Other ministries and public sectors, policy makers, including parliamentarians
- CSOs, civil society platform, and affected communities
- Interest groups (professional associations, advocacy groups, consumer groups)

- Academic institutions, including medical educational and research institutions, and individual experts
- Development partners (technical agencies, donors, etc.)

District-level visit

Key stakeholder to be considered for the interviews include the following:

- Programme managers and other programme personnel
- District leadership and other sectors
- Public health providers
- Other health care providers
- organisationCSOs and TB-affected communities
- Interest groups (women, men and young people)
- Community leaders

Health facility-level visit

Key stakeholder to be considered for the interviews include the following:

- Head of facility or representative
- Responsible staff for programme and for sub-areas
- Health care providers (facility staff and others)
- Patients and clients (informed consent is required)
- People affected by the diseases
- KPs
- Other beneficiaries
- Members of facility advisory/support bodies

Community-level visit

Key stakeholder to be considered for the interviews include the following:

- Local communities
- Community leaders
- Community members
- Interest groups (women, youth, men, clubs, religious groups)
- People affected by the diseases
- KPs

- Community level service providers

Review of the HIV Programme Component

1. Background

As of April 1, 2025, there were 135,922 people living with HIV under medical supervision in healthcare facilities, which corresponds to 331.5 per 100,000 population (intensity indicators calculated according to population data from the State Statistics Service of Ukraine which include only territories under government control). According to official registration, the highest prevalence rates of HIV infection per 100,000 population were recorded, as in the previous period, in Dnipropetrovsk (915.0), Odesa (833.5), Mykolaiv (699.8) regions, and Kyiv city (528.5). Compared to the first quarter of 2024, the dispensary group across Ukraine decreased by 13.5%, with a negative growth observed in 20 regions: Zaporizhzhia (-50.8%), Kherson (-29.9%), Donetsk (-28.2%), Odesa (-24.5%), and Luhansk - by 7 times.

In 2024, 29 NGOs were involved in providing HIV prevention services, implementing 87 agreements targeting SW, MSM, and PWID. In total, 304,413 individuals from KPs received HIV prevention services in 2024. Any health provider who has relevant training can diagnose HIV and initiate ART. This will contribute to expansion of the number of service providers in the country, by expanding the range of providers able to test, diagnose, initiate ART and provide clinical follow-up. In 2023, the PrEP programme covered 13,147 individuals, which is 4,072 more than in 2022. Among them, 41% were MSM; 19% were PWID; and 1% wereSWs. This demonstrates an effective expansion of access to preventive services for KPs.

The number of HIV tests conducted in Ukraine rose to 2.5 million in 2024, in 2023, 2,250,940 HIV tests were performed in Ukrainian healthcare facilities, which is nearly 40% more than in 2022 (1,612,841 tests). According to the National Statistics 10,038 people were diagnosed with HIV for the first time in 2024, while 11,658 people received a first-time HIV diagnosis in 2023. A significant contribution to the increased testing coverage was made by NGOs, which provided HIV testing among KPs through outreach activities, mobile services, and at specialised service centres. As of January 1, 2024, 118,348 people living with HIV (PLHIV) were receiving ART, which underscores increased access to treatment. In 2023, HIV prevention, diagnosis, and treatment were available to patients in 322 healthcare facilities across the country. For 2024, 367 healthcare facilities signed contracts with the NHSU to provide medical services for patients with HIV. The volume of HIV testing services increased by 39.6% in 2023.

The ongoing health reform has been changing how HIV services are organised and financed. Since 2019, Ukraine has been procuring and providing state-funded HIV prevention services for KPs at risk of HIV

infection and care and support (C&S) for people living with HIV, following Paragraph seven, Provision 20, Part one, Article 8 of the Law of Ukraine "On the Public Health System", and Provision 7 of the Procedure for the Use of Budgetary Funds Allocated for the Programme "Public Health and Epidemic Control Measures". Within the C&S programme, in 2024, services were provided by 21 NGOs in 24 regions, excluding the Luhansk region due to the temporary occupation and Russia's full-scale invasion of Ukraine. In total, 22,678 PLHIV received C&S services in 2024.

Since February 24, 2022, the health emergency stemming from the Russian Federation’s aggression has had devastating impact on people’s health and impact on the progress towards national HIV targets. The health impact of the war in Ukraine requires both immediate and long-term response. Despite the challenges posed by the war, national HIV programmes continue to evolve, adapting to new realities and the population's needs.

International cooperation plays a vital role in this process, through which Ukraine gains access to the most current prevention and treatment methods. The continued development of these programmes is key to achieving control over the HIV epidemic and improving the nation's public health. Financial support from the Global Fund has also played a significant role in implementing HIV response programmes. In December 2023, it was agreed to allocate over $165 million in grant funding for the 2024–2026 HIV and TB programmes. These funds are designated for medical support for Ukrainians living with HIV and TB, as well as for combating socially significant diseases. However, as of early 2025, the situation has changed due to a review of funding for US programmes, particularly those supported by CDC and USAID. In the context of global financial challenges and revision of international aid priorities, a significant portion of grant funding has been reduced or frozen. This creates additional difficulties in accessing HIV services and necessitates the restructuring of activities and the search for alternative resources. Funding cuts negatively impact the operations of many NGOs that provide patient social support. The lack of stable funding could lead to decreased HIV case detection, an increase in treatment interruptions, and higher mortality rates.

2. Programme review

The primary objective of the review is to assess the progress and gaps in implementation of the National Strategy on HIV/AIDS, Tuberculosis and Viral Hepatitis 2020-2030 (NS2030), progress towards the attainment of objectives and achievement of targets therein and provide recommendations for the development of an action plan, in light of the principles of the Political Declaration on HIV and AIDS “On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030“ adopted

by the UN General Assembly on 7 June, Development Goal (SDG) 3.3, 2022-2030 regional Action Plans for ending AIDS and eliminating hepatitis and STIs in the WHO European region. The review will include a review of the disruption of HIV services due to the war and will provide short-term recommendations on recovery plan to be included in the action plan. The review results will assess progress towards achievement of global and national targets also be used for the preparation of the next Global Fund funding application in 2026.

The HIV review will focus on following key areas:

A. Resilient and sustainable systems for health

- Assessment of governance of HIV OAMT and Hepatitis national response, including leadership, coordination/engagement of partners and community in the HIV programme. Interinstitutional action (e.g., interministerial and/or intersectoral collaboration) and engagement with stakeholders
- Review financing of HIV, VH and OAMT programmes and service packages and payment mechanisms to ensure universal health coverage of KPs.
- Assess the impact of funding cuts, adaptations that have been made, remaining challenges and recommendations (including prioritisation of interventions) for the future and implications for transition to domestic funding and sustainability of services currently supported by donors (and from state funding, as well as adequacy of the available funds compared to the estimated needs for each programme area and funding needs to ensure continuity of services.
- Review health and community workforce, including distribution, professional development and requirements in place to ensure delivery of quality care across the continuum of care
- Review service organisation service delivery with PHC, civil society, communities and public health agencies or institutions, including people-centred and differentiated service delivery
- Review community systems and engagement of communities in service delivery, accountability, and enabling environment
- Assess the resilience of communicable disease response in the context of permacrisis and futureproofing for health emergencies and other epidemics.

B. Epidemic patterns, HIV surveillance and M&E systems

- Review M&E system and performance against indicators in the national strategic plan
- Review the performance against National Strategy targets and their alignment with the Regional Action Plans for Ending AIDS and the Epidemics of Viral Hepatitis and Sexually Transmitted Infections 2022–2030.

- Assess the dynamics of HIV transmission and help understand trends in various population groups (KPs, MTCT, paediatric infections).
- Review case-based surveillance, IBBS and PSEs for KPs.
- Assess the use of data for developing and adjusting prevention, testing, treatment, and support programmes for people living with HIV;
- Assess the relevance, completeness, and regularity of available surveys, and whether it meets the needs of the health care system.

C. Review of prevention services for key populations and other groups

[NS2030 Operational Goal 1. Prevent new cases of HIV]

- Assess access to comprehensive prevention services for KPs, including the services provided by CBOs, funded by the national budgets and donor funds;
- Review availability and quality of combination prevention services provision for each KP group (including services provided in prisons);
- Review availability, coverage, and effectiveness of the provision of PrEP, including introduction and related implementation CAB-LA and a rapid feasibility assessment of LEN PrEP introduction to inform potential future planning and funding opportunities.
- Review service delivery models for prevention, including community-based models;
- Assess readiness for validation of elimination of mother-to-child transmission (EMTCT) of HIV;

D. Review of HIV testing and diagnosis and clinical monitoring

[NS2030 Operational Goal 2. Improve the system for effective detection of HIV cases]

- Review HIV testing strategy, HIV testing algorithm and alignment with latest WHO guidelines;
- Assess testing service delivery models availability of HIV testing, the network of facilities that provide relevant services
- Assess provider-initiated HIV testing, and counselling (PITC), community-based testing (CBT) and self-testing models, coverage, and yield.
- Assess the availability and utilisation of digital HIV services, including online platforms, mobile applications, telehealth counselling, and remote self-testing support, as well as their integration into the overall HIV testing strategy;
- Assess progress towards full coverage of HIV testing services for all TB patients and recipients of comprehensive preventive services for KPs;

- Assess progress towards full coverage of HIV testing services for all pregnant women and their partners with HIV testing and EID;
- Provide recommendations on how to ensure earlier diagnosis, improve testing yield among KPs and how to reach 95% of PLHIV knowing their status;
- Assess the quality of integrated HIV, hepatitis, OAMT and TB testing services for key overlapping populations.
- Review the role of the reference lab and other labs doing HIV testing;
- Assess the quality of laboratory services, in particular quality monitoring for medical devices used to diagnose HIV, developing effective diagnostic algorithms and external quality assurance programmes.
- Review HIV DR testing

E. Review of HIV treatment and linkage to effective care for HIV and common comorbidities

[NS2030 Operational Goal 3. Ensure holistic access to HIV treatment]

- Review HIV treatment and care policy and national guidelines and alignment with WHO guidelines;
- Assess progress towards 95:95:95 targets inART and review cascade of care.
- Assess treatment effectiveness and review progress towards achievement of an undetectable VL of HIV;
- Review ARV forecasting, procurement and supply;
- Review progress towards timely and effective treatment monitoring and follow-up, adverse reactions monitoring and treatment of OIs;
- Assess the state of implementation of TB-HIV-hepatitis and other service integration;
- Assess progress towards the full provision of preventive treatment of TB to PLHIV;
- Review prevention of HIV resistance;
- Assess progress in primary prevention of OIs, including service delivery model and procurement and supply of medications.

3. Review team

Name	Technical Area / Topic
WHO Europe	
Stela BIVOL	HIV Hep OAMT Team Lead
Vyacheslav GRANKOV	HIV and OAMT coordination
Marcelo NAVEIRA	Hepatitis coordination
Giorgi KUCHUKHIDZE	Strategic information coordination
Soudeh EHSANI	Lab coordination
WHO Headquarters	
Nathan Ford, scientist,	HIV services delivery and co-morbidities
Elena Vovc, medical officer,	HIV/TB, comorbidities, quality of care
Ajay Rangaraj, technical officer	Advanced HIV disease and co-morbidities
Antons Mozalevsksis, medical officer,	KPs, OAMT, hepatitis
Pascal Jolivet, diagnostics and lab	HIV testing and laboratory
WHO Country Office Ukraine	
Ogtay GOZALOV	
HIV	
Tamar Gabunia	Report consolidation and writing and resilient and sustainable systems for health
Ivana Bozicevic Ksenya Eritsyan	HIV epi review: case-based surveillance, sentinel surveillance, estimates, M&E
Giedrius Likatavicius	KP programmes and OAMT
Robert Koch Institute representative	PrEP
Maja Stanojevic Dorien Van den Bossche (ITM WHO CC)	HIV testing, laboratory, DR
Pavel Khaykin	HIV treatment and co-morbidities

4. Methodology

The Review will assess the progress and gaps in implementation of the National Strategy on HIV/AIDS, Tuberculosis and Viral Hepatitis 2023-2024.

The HIV review consists of two phases:

1. The online desk review of the National Strategy, national HIV testing guidelines and diagnostic algorithms, national HIV treatment standards and guidelines, PrEP standards and guidelines, prevention guidelines, Global Fund proposal and reports, PEPFAR CDC/USAID documents and other reports including from MoH/UPHC.
2. The second phase is a country [95]virtual mission. During the mission the experts will interact with relevant institutions and facilities at national and regional/local level and discuss with key informants: policymakers, health care providers, community and beneficiaries, MoH/UPHC, NHSU, NGOs (including the Global Fund PRs), CDC/USAID PEFFAR, UNAIDS, UNICEF, UNDP, UNODC, Global Fund, other national partners where appropriate.

The exact list of stakeholders to be interviewed and level of sites will be developed together with UPHC focal points for the review (Larysa Hetman).

The Review team will use the tools developed in the WHO Guide to Conducting Programme Reviews for HIV, Viral Hepatitis and Sexually Transmitted Infections 2023[96].

5. Deliverables

- Key findings and recommendations on main areas of HIV Review will be developed by the mission members and presented to the national stakeholders at the end of the virtual review mission (October 2025).
- All team members will provide their written contribution (key findings and recommendations) using the template by mid-November 2025.
- Final report with findings and recommendations will be submitted to the MOH by December 15, 2025.

The report will be posted on the official website of the WHO Regional Office for Europe.

6. References

95 Subject to emergency restrictions and conflict conditions, remote mode and with sensitivity to site conditions and staff capacity

96 https://www.who.int/publications/i/item/9789240079472

National Strategy on HIV/AIDS, Tuberculosis and Viral Hepatitis Response (2020-2030) RATIFIED by the Directive of the Cabinet of Ministers of Ukraine November 27, 2019, No. 1415-p
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WHO Guide to Conducting Programme Reviews for HIV, Viral Hepatitis and Sexually Transmitted Infections: https://www.who.int/publications/i/item/9789240079472

Review of the OAMT Programme Component

1. Background

The Opioid Agonist Methadone Therapy (OAMT) programme in Ukraine is one of the most important elements of the national strategy to combat HIV/AIDS and drug addiction. The goal of this therapy is to replace the use of illicit drugs with controlled medicines, which helps reduce the physical and psychological craving for drugs, improve patients' health status, and, crucially, lower the risks of HIV, Hepatitis C, and other infections transmission. OAMT is a key tool in combating the HIV epidemic in Ukraine, as it significantly reduces HIV transmission among PWID. For example, opioid substitution programmes (methadone/buprenorphine) show that the risk of HIV infection among injecting drug users is reduced by approximately 50–60%, along with a significant reduction in the sharing of injection equipment.[97]

As of January 1, 2025, the OAMT programme covers 30,768 patients across Ukraine (including patients in municipal (21,845), and private (8,923) health care facilities (HCF)). Of these patients, 19,246 receive methadone hydrochloride (sublingual tablets), additionally 8188 in private HCF; 2,322 receive buprenorphine hydrochloride (sublingual tablets), 735 patients in private HCF; 158 receive buprenorphine hydrochloride (long-acting formulation), and 119 receive buprenorphine hydrochloride/naloxone (sublingual tablets). It not only reduces the physical risks associated with drug addiction but also helps decrease the overdose mortality rate, as replacing illicit drugs with controlled medications reduces the likelihood of fatal outcomes. Furthermore, patients undergoing OAMT experience significantly better

97 Andrea J. Low, Gitau Mburu, Nicky J. Welton, Margaret T. May, Charlotte F. Davies, Clare French, Katy M. Turner, Katharine J. Looker, Hannah Christensen, Susie McLean, Tim Rhodes, Lucy Platt, Matthew Hickman, Andy Guise, Peter Vickerman, Impact of Opioid Substitution Therapy on Antiretroviral Therapy Outcomes: A Systematic Review and Meta-Analysis, Clinical Infectious Diseases, Volume 63, Issue 8, 15 October 2016, Pages 1094–1104, https://doi.org/10.1093/cid/ciw416

health compared to those not receiving such treatment, enabling them to lead more active social lives and reducing levels of social isolation and depression, which are common among individuals with drug addiction.

The OAMT programme helps to significantly improve patients' health, reduce the HIV infection rate among PWID, and decrease the number of overdose cases. Additionally, it offers economic benefits to the state. According to estimates, every dollar spent on OAMT brings economic benefits by reducing expenditures on treating comorbidities such as Hepatitis C and TB, as well as on managing overdoses and other consequences of drug addiction. Moreover, the programme helps lessen the burden on the healthcare system as a whole by decreasing the number of hospitalisations and infections related to drug use. For example, citing preliminary results from the 2024 study "Study of the Impact of the Coronavirus Pandemic on OAMT Treatment Retention," it can be noted that higher dosage levels positively influence retention, irrespective of all other variables such as treatment regimen, time period, and patient sociodemographic and clinical characteristics.

At the same time, the OAMT programme faces several serious challenges that can hinder its effectiveness. According to the findings of the study "Opioid Substitution Therapy (OAMT): Assessment of Barriers to OAMT Access and Review of Service Delivery Models in the Context of Their Effectiveness," one of the main challenges and barriers to OAMT access is a lack of belief that OAMT will help patients overcome addiction and positively impact their overall health. Other significant reasons included reluctance to visit the clinic daily, unwillingness to be registered with addiction services, and fears about the loss of personal data confidentiality. Responses from OAMT participants about what prevented them from starting OAMT sooner were very similar: they most frequently cited the conviction that OAMT merely substitutes one drug for another and is not a treatment, as well as an unwillingness to be "tied" to a clinic and to be registered with addiction services. Difficulties related to organisational conditions are also significant, although some of these are exacerbated by a lack of correct information among potential patients, for example, regarding the availability of OAMT sites or vacant slots at them.
In early 2023, the UPHC participated in a national dialogue between Ukrainian representatives and the Global Fund, held in Poland. One of the main areas of discussion was plans for the OAMT programme development. Six priorities for OAMT programme development for 2024–2026 were identified:

- Strengthening the system for monitoring and evaluating OAMT service quality through the implementation of a medical information system (MIS) – a unified patient registry;
- Improving the regulatory framework to remove barriers to OAMT services;

- Expanding the programme and access to OAMT services through the introduction of telemedicine approaches;
- Supporting service providers and improving knowledge about OAMT and comorbidities;
- Improving OAMT service quality in the areas of: diagnosis and treatment of comorbid mental health conditions; implementation of effective and evidence-based psychosocial interventions and interventions aimed at reducing alcohol consumption; diagnosis and treatment of other comorbidities; symptomatic treatment of adverse reactions to OAMT medications;
- Developing and implementing a comprehensive intersectoral plan for information and communication activities to counter misconceptions about OAMT.

This event enabled Ukrainian state bodies, non-governmental organisations, and international partners to formulate a grant application based on the needs for HIV and TB treatment in Ukraine.

2. Programme review

The primary objective of the review is to assess the progress and gaps in implementation of the National Strategy on HIV/AIDS, Tuberculosis and Viral Hepatitis 2020-2030 (NS2030), progress towards the attainment of objectives and achievement of targets therein and provide recommendations for the development of an action plan. The review will help determine whether the programme meets existing needs, whether there are gaps in ensuring access to treatment, and whether resources are being used effectively enough. These results can form the basis for optimising funding and expanding the programme, which will contribute to reducing social and medical costs for treating individuals with addiction, as well as for the prevention of HIV and hepatitis transmission. Consideration of the review results will also allow for the development of a more precise national strategy to combat drug addiction and HIV/AIDS, ensuring more effective use of state resources.

The review will include key services within the OAMT programme:

- Assess of access and coverage of treatment in the public and private sectors;
- Assess of the quality-of-service provision in the public and private sectors;
- Ensuring diagnosis of comorbid diseases, treatment and referral as needed;
- Review of integrated services, such as TB, HIV, HBV, mental health screening, and psychosocial support;
- Assess the implementation, regulatory framework, and effectiveness of mobile OAMT units as a service delivery model for improving access in hard-to-reach and war -affected areas;
- Assess of the effectiveness of referrals to OAMT by NGOs and the patient community;

- Assess of Human Resources potential and civil society engagement in the programme.

3. **Participants**
   - David Otiashvili
   - Giedrius Likatavicius
   - Pavel Khaykin
   - Antons Mozalevskis

4. Methodology

The review will assess the progress and gaps in implementation of the National Strategy on HIV/AIDS, Tuberculosis and Viral Hepatitis 2023-2024.

The OAMT review consists of two phases:

1. The online desk review of the National Strategy, OAMT guidelines, prevention guidelines, Global Fund proposal and reports, and other reports including from MoH/UPHC.
2. The second phase is a country [98]virtual mission. During the mission the experts will interact with relevant institutions and facilities at national and regional/local level and discuss with key informants: policymakers, health care providers, community and beneficiaries, MoH/UPHC, NHSU, NGOs (including the Global Fund PRs), CDC/USAID PEFFAR, UNAIDS, UNICEF, UNDP, UNODC, Global Fund, other national partners where appropriate. The exact list of stakeholders to be interviewed and level of sites will be developed together with UPHC focal points for the review (Irina Ivanchuk).

5. Deliverables

- Key findings and recommendations on main areas of OAMT Review will be developed by the mission members and presented to the national stakeholders at the end of the virtual review mission on 24 October 2025.
- All team members will provide their written contribution (key findings and recommendations) using the template by mid-November 2025.
- Final report with findings and recommendations will be submitted to the MOH by December 15, 2025.

98 Subject to emergency restrictions and conflict conditions, remote mode and with sensitivity to site conditions and staff capacity

6. References

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Annex 2. HIV and OAMT programmes review mission agenda

Date	Time	Organisation (topic)	Participants
Friday, 12th September	13.00-14.00	Initial briefing with UPHC, partners, CSOs	UPHC deputy directors and technical areas focal points
Monday, 15th September	09.00-10.30	Opioid substitution treatment(OAMT) services at the regional level (Dnipro)	"DNIPROPETROVSK MULTIDISCIPLINARY CLINICAL HOSPITAL FOR PSYCHIATRIC CARE" OF THE DNIPROPETROVSK REGIONAL COUNCIL: Наталія Романівна Галицька-Пасічник, Дорохіна Лариса Василівна,
Monday, 15th September	13.00-14.30	Opioid substitution treatment (OAMT) services at the regional level (Lviv)	Lviv Regional Medical Centre for the Prevention and Treatment of Addiction
Monday, 15th September	09.00-10.30	UPHC - Human rights	UPHC focal point - Serhii Myroniuk
Monday, 15th September	11.00-12.30	UPHC e-Health, Data systems for HIV, VH, OAMT	IT-department UPHC (Kurdus)
Monday, 15th September	13.00-14.30	UPHC - Surveillance; M&E	Surveillance Department UPHC M&E Department UPHC (Antonenko, Bugaenko)
Monday, 15th September	13.00-14.30	FGD with SW/Meeting with SW community leader	Community leaders: SW
Monday, 15th September	15.00-16.30	AHF (prevention, testing, treatment)	AHF focal points (YaroViatcheslav Grankov Lopatina)
Wednesday, 17th September	09.00-10.30	Opioid substitution treatment (OAMT) services at the regional level (Poltava)	Poltava Regional Centre for Addiction Treatment" of the Poltava Regional Council
Wednesday, 17th September	11:00-12:30	NGO Positive Women	Olena Stryzhak
Wednesday, 17th September	11.00-12.30	HIV/VH at Gromashevsky Institute	SI "L.V. Gromashevsky Institute of Epidemiology and Infectious Diseases of the NAMS of Ukraine" (Svitlana Antoniak)
Wednesday, 17th September	13.00-14.30	CO "100 Percent Life" (introductory)	100 % Life focal points
Wednesday, 17th September	15.00-16.30	CO "100 Percent Life" (services provision) + project Health Link	100 % Life focal points (Olena Hasisova) 100 % Life /USAID project Health Link (USAID)-ended in 2024

Date	Time	Organisation (topic)	Participants
Wednesday, 17th September	16.30-18.00	CO "100 Percent Life" (procurement, monitoring)	100 % Life focal points
Thursday, 18th September	09.00-11.00	UPHC - HIV prevention	UPHC focal points - Legkostup, Shevchenko, Ryzhenko, Ohorodnyk, Martsynovska
Thursday, 18th September	11.30-13.30	UPHC - HIV testing (programme component)	UPHC focal points -Legkostup, Trotsenko, Bondareva
Thursday, 18th September	14.00-15.30	Project INNOVATIONS IN COMBATING HIV ("Community action in HIV Control")	Volodymyr Kurpita, Olha Petrash, Inna Schwab
Thursday, 18th September		UNICEF (eMTCT)	UNICEF focal points
Thursday, 18th September	16.00-17.00	UPHC - services for KP	UPHC focal points - Legkostup
Friday, 19th September	09.00-10.30	UPHC - Management of pharmaceuticals and other medical products	UPHC focal points -Kovaleva
Friday, 19th September		HIV management at the regional level (Kyiv region)+ HIV Lab	KNP KOR “Kyiv Regional Specialised Centre”, Tetiana Zemliak + Convictus
Friday, 19th September		REACH-95 project (USAID)	REACH-95 project (PATH)
Friday, 19th September	14.30-16.00	HIV management at the regional level (Zhytomir) + HIV Lab	KNP “Regional Medical Specialised Centre” ZHOR, Kutyshenko Maksym + Perspective
Friday, 19th September	16.00-17.30	Department of Treatment, Infectious Diseases and Dermatovenerology, Bogomolets National Medical University,	Igor Zaitsev, Doctor of Medical Sciences, Professor of the Department of Treatment, Infectious Diseases, and Dermatology and Venereology, Bogomolets National Medical University тел. 380505349238.
Monday, 22nd September	09.00-10.30	UPHC: governance, financing, HR, funds cut	UPHC focal points - Gvozdetska, Hetman, Ivanchuk, Vovchenko, Yurchenko
Monday, 22nd September	10.00-11.30	HIV management at the regional level (Chernihiv)+HIV Lab	KNP “Chernihiv Regional Hospital” CHOR, Ityna Teslenok + Convictus
Monday, 22nd September	11.30-13.00	The Health Center of the State Penitentiary Service of Ukraine	The Health Center of the State Penitentiary Service of Ukraine Ігор Миколайович Петров
Monday, 22nd September	13.30-15.30	UPHC: treatment monitoring, HIVDR	UPHC focal points - Liulchuk, Riabokon, Babiy, Hetman
Monday, 22nd September	13.30-15.30	FGD with PWUD/ Meeting with PWUD community leaders VOLNA,	Zelenina Natalia, regional representative. 095 898 85 42

Date	Time	Organisation (topic)	Participants
Monday, 22nd September	13.30-15.30	UPHC Research&Innovations	research department UPHC
Tuesday, 23rd September	09.00-10.30	Academy of Family Medicine of Ukraine (viral hepatitis issues)	Representative of ASMU, Iryna Voloshyna
Tuesday, 23rd September	09.00-10.30	UPHC - HIV testing & diagnostics (Lab component)	Reference laboratory for HIV/AIDS diagnostics UPHC focal points - Andriyanova, Sheyko Chaikovska
Tuesday, 23rd September	11.00-12.30	opioid substitution treatment (OAMT) services at the regional level (Donetsk)	Medical Centre for the Prevention and Treatment of Addiction in Kramatorsk
Tuesday, 23rd September	11.00-12.30	CCM oversight committee; CCM secretariat	CCM oversight committee; CCM secretariat
Tuesday, 23rd September	16.00-17.30	Meeting with community leader: FREE ZONE	FREE ZONE Director
Wednesday, 24th September	09.00-10.30	HIV management at the regional level (Odessa)+ HIV LaB	“Odessa Regional Centre for Socially Significant Diseases”, Oleksandr Tolstopiatov ALT VIVA
Wednesday, 24th September	09.00-10.30	The Health Centre of the State Penitentiary Service of Ukraine	The Health Centre of the State Penitentiary Service of Ukraine Ігор Миколайович Петров
Wednesday, 24th September	10.30-12.30	UPHC -HIV treatment & co-infection	UPHC focal points - Hetman?, Klimova, Riabokon, Samsonova, Kovaleva
Wednesday, 24th September	11.00-12.00	Personal experience	
Wednesday, 24th September	13.00-14.30	UPHC: OAMT	UPHC OAMT focal points, Іванчук І., Гриценко В.
Wednesday, 24th September	14.30-16.00	UPHC: OAMT	UPHC OAMT focal points, Іванчук І., Гриценко В.
Wednesday, 24th September	14.30-16.00	US state Dep	ACOORD Health team
Wednesday, 24th September	16.00-17.30	FGD with MSM/ Meeting with MSM community leader	Community leaders: MSM
Wednesday, 24th September	16.00-17.30	UNAIDS (overview, strategic information, testing, humanitarian response, recovery)	UNAIDS focal points

Date	Time	Organisation (topic)	Participants
Thursday, 25th September	09.00-10.30	PEPFAR (strategic information, treatment and diagnostics)	PEPFAR focal points
Thursday, 25th September	11.00-12.00	CDC (overview)	CDC focal points
Thursday, 25th September	12.00-13.00	CDC (strategic information+LAB)	CDC focal points
Thursday, 25th September	13.00-14.00	CDC (laboratory)	CDC focal points
Thursday, 25th September	15.00-16.00	CDC (prophylactics and treatment, OAMT)	CDC focal points
Thursday, 25th September	16.00-17.30	NGO Research&Innovations	Ukrainian Institute on Public Health Policy (UIPHP)
Thursday, 25th September	16.00-17.30	UNODC (drug policy)	UNODC focal point
Friday, 26th September	09.00-10.00	APH - introductory	APH focal points
Friday, 26th September	10.00-11.30	APH (testing, linkage and other services)	APH focal points Pavlo Skala Parkhomenko Maryna Zakrevska Yevheniia
Friday, 26th September	10.00-11.30	MPU - Management of pharmaceuticals and other medical products	State Enterprise “Medical Procurement of Ukraine” (SE “MPU”)
Friday, 26th September	12.00-13.30	APH (M&E, digital platforms, CLM)	APH focal points
Friday, 26th September	12.00-13.30	FGD with MSM/ Meeting with MSM community leader	Community leaders: MSM
Friday, 26th September	14.00-15.30	APH (OAMT, prevention KP)_ hep C microelimination	APH focal points
Friday, 26th September	14.00-15.30	Blood centre	СДУ «Український центр трансплант-координації», deputy director
Wednesday, 1st October	12:00-13:30	Debrief	Deputy Minister Igor Kuzin, Volodymyr Kurpita, UPHC Director General, Olga Gvozdetska, Deputy Director General of UPHC and the focal points per technical areas

Annex 3. Comparison of indicators of Ukraine State Strategy for Combating HIV/AIDS, Tuberculosis and Viral Hepatitis for the Period Until 2030 and operational plan for its implementation and the WHO regional action plan to end AIDS and the epidemics of viral hepatitis and STIs 2022–2030

Indicator type	National strategy and operational plan	2025 target	Regional action plan	2025 target	Comment
Impact	Not available	NA	Number of new HIV infections (adult and child) per year	-75% as of 2010	No measures for HIV morbidity in National strategy and action plan
	Frequency of mother-to-child transmission of HIV -	ÿ 2	NA	NA	
	Reducing AIDS-related mortality per 100,000	-50% as of 2015	Number of HIV-related deaths	-50% as of 2010	No mention of disaggregation by HIV-associated cryptococcal meningitis, TB and severe bacterial infections In National strategy
Coverage	Percentage of PLHIV, who know their status	90%	Percentage of PLHIV, who know their status	95%	Targets of National strategy are lower than ones of Regional strategy for 2025, but same for 2030
Coverage	Percentage of people living with HIV and know their HIV status, who are receiving ART	90%	Percentage of people diagnosed with HIV receiving ART	95%	No mention of the target to be achieved in all ages, sexes and KPs, including migrants, as well as all ages and sexes in National strategy. Targets of National strategy are lower than ones of Regional strategy for 2025, but same for 2030
Coverage	Percentage of people living with HIV, and who are on treatment, achieving VL suppression	94%	Percentage of people living with HIV, and who are on treatment, achieving VL suppression	95%	
Coverage	Coverage of representatives	80%	Percentage of people at risk of	95%	Targets of National strategy are lower than

Indicator type	National strategy and operational plan	2025 target	Regional action plan	2025 target	Comment
	of each KP group with comprehensive prevention services		HIV who use combination prevention with a defined service package		ones of Regional strategy for both 2025 and 2030
Coverage	Coverage by OST from the estimated number of people who inject opioids and have dependence	15%	Percentage of opioid-dependent PWID who receive OST	40%	In Regional Action plan this indicator is a part of viral hepatis strategic direction. of National strategy are lower than ones of Regional strategy for 2025, but same for 2030
Coverage	Not available	NA	Condom/lubricant use at last sex with a client or non-regular partner, %	90%	
Coverage	Not available	NA	Number of needles/syringes distributed per year per person who injects drugs (as part of comprehensive harm-reduction programme)	200	
Coverage	Number of people covered by PrEP of HIV infection	16500	Number of people who received PrEP at least once during the year	500 000 (5x times as of 2020)	
Coverage	Not available	NA	Percentage of eligible people living with HIV receiving preventive treatment for TB	99%	
Coverage	Not available	NA	Percentage of new HIV diagnoses which are diagnosed at a late stage of disease (CD4 < 350)	20%	
Coverage	Not available	NA	Percentage of people living with HIV and people at	95%	

Indicator type	National strategy and operational plan	2025 target	Regional action plan	2025 target	Comment
			risk who are linked to other integrated health services, including for STIs and VH		
Supporting environment	Not available	NA	Percentage of people living with HIV and KPs experiencing stigma and discrimination	< 10%	
Supporting environment	Not available	NA	Gender equality – prevalence of recent (last 12 months) intimate partner violence among women and girls 15–49 years old	11%	