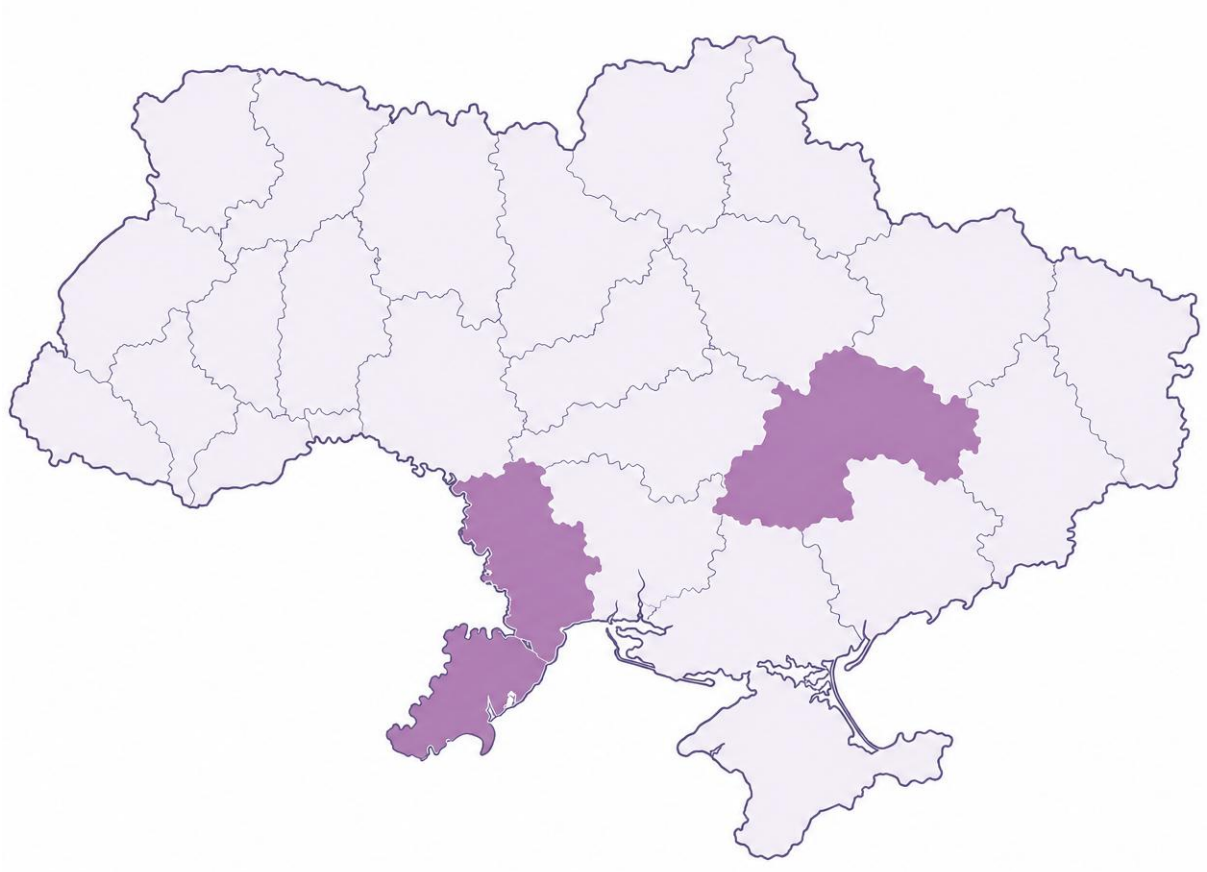
ASSESSMENT OF BARRIERS TO SERVICES FOR THE PREVENTION OF VERTICAL TRANSMISSION OF HIV IN DNIPROPETROVSK AND ODESA OBLASTS

Analytical report

based on community-led research
of women living with HIV



Kyiv, 2026

CONTENT

GLOSSARY AND CONVENTIONS

AIDS	Acquired immunodeficiency syndrome
Antenatal care facility	Institutions providing antenatal care (antenatal clinics)
ART	Antiretroviral therapy
ARV	Antiretroviral (therapy)
CO	Charitable organisation
DoH	Department of Health
EMTCT	Elimination of mother-to-child transmission
FGD	Focus group discussions
HIV	Human immunodeficiency virus
IDP	Internally displaced person
MoH	Ministry of Health
NGO	Non-governmental organisation
OST	Opioid substitution therapy
PCR	Polymerase chain reaction
Perinatal care facility	Institutions providing perinatal care (maternity hospital)
PHC facility	Primary health care facility
PNP	Infant post-natal prophylaxis
PLHIV health facility	Institutions providing medical supervision of people living with HIV
PHC of MoH	State institution “Public Health Centre of the Ministry of Health of Ukraine”
PMTCT	Prevention of mother-to-child transmission of HIV
RC EMTCT	EMTCT Regional Committee
SRH	Sexual and reproductive health
STIs	Sexually transmitted infections
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children’s Fund
UTC	United territorial community
WHO	World Health Organisation

RESEARCH TEAM

Organisers of the research

The charitable organisation "Positive women"[1] represents the national community of women living with HIV, bringing together participants from all regions of Ukraine (except areas outside the control of the government of Ukraine), who advocate for the rights of women in Ukraine, especially those living with HIV and vulnerable to HIV. "Positive women" promotes ideas of empowerment, comprehensive support and development of HIV-positive women. The Organisation was created by women living with HIV in 2011, officially registered in February 2013. The Organisation's mission is to unite women activists so that women living with HIV in Ukraine can exercise their rights and opportunities freely, without barriers and restrictions, and feel protected from stigma, discrimination and violence.

Research Team

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Disclaimer

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[1] Website of the CO "Positive Women" www.pw.org

ABOUT RESEARCH

Purpose and objectives of the research

The purpose of the research is to examine barriers to services on the path to achieving the elimination of vertical transmission of HIV in Dnipropetrovsk and Odesa oblasts.

Objectives of the research:

- To examine the key gaps, barriers and unmet needs of recipients and providers of services aimed at eliminating vertical transmission of HIV in Dnipropetrovsk and Odesa oblasts, and possible ways to overcome them.
- To identify the main factors contributing to developing and the main obstacles to organising intersectoral cooperation and coordination at the regional level.
- To develop recommendations for increasing the effectiveness of measures to prevent vertical transmission of HIV and reducing barriers to access to services for women, adolescents and children living with HIV.

Geography of the research

The research was conducted in two oblasts of Ukraine – Dnipropetrovsk and Odesa. Along with residents of large cities in the selected oblasts, the research examined the experiences of HIV-positive women, adolescent girls, and parents of HIV-exposed children from small towns and rural areas.

Research components

The research used a mixed-method approach and consisted of three main components: desk review, quantitative survey, and qualitative research. Triangulation of results from each component contributed to a comprehensive analysis and understanding of existing problems, as well as identifying potential ways to improve interventions to eliminate vertical transmission of HIV.

The desk review included processing of data available in open sources, as well as information received in response to official requests to the MoH of Ukraine/PHC of the MoH and the Departments of Health of the Dnipropetrovsk and Odesa State Oblast Administrations. The results of the desk review were taken into account during the preparation of the main report on the results of the research for the interpretation and contextualisation of the quantitative and qualitative components of the data.

As part of the quantitative component[2] an online survey of women living with HIV and with experience of pregnancy and childbirth was conducted to assess the level of accessibility and responsiveness of HIV services to needs, as well as to identify existing barriers to accessing and using services.

The qualitative component[3] involved conducting in-depth interviews and focus group discussions (FGDs) among target groups relevant to the EMTCT activities to understand the gaps, barriers, and unmet needs of service recipients and providers related to HIV, the functioning of the surveillance system, intersectoral collaboration, and coordination of activities to prevent vertical transmission of HIV at the regional level.

Data collection period: October 2025.

The research protocol underwent ethical review by the Ethics Commission of the State Institution "Public Health Centre of the Ministry of Health of Ukraine" and received approval (IRB2025-174 dated October 13, 2025)[4].

[2] Annex 2
[3] Annex 3
[4] Annex 1

KEY FINDINGS

Epidemic burden and effectiveness of PMTCT interventions

Dnipropetrovsk and Odesa oblasts contribute disproportionately to the burden of HIV among children in Ukraine. These two oblasts are home to about a third of HIV-positive pregnant women, 43% of registered HIV-positive and 32% of HIV-exposed children, and 39% of all registered cases of vertical transmission. Every third child and adolescent aged 0–18 years living with HIV also falls in these oblasts. This reflects not only the high prevalence of HIV among the adult population, but also the increased burden on the PMTCT service system in conditions of internal migration, war and social vulnerability. The missed cases of vertical transmission of HIV and the identification of 240 HIV-positive children outside the PMTCT programme in Ukraine in 2022–2025, almost half of which fall in Dnipropetrovsk oblast, Odesa oblast and Kyiv city, indicate the existence of vulnerable spots in the continuum of services.

Dnipropetrovsk oblast remains the region with the highest HIV epidemic burden in Ukraine, particularly in terms of prevalence among the adult population and pregnant women. Despite difficult security and social conditions, the implementation of the PMTCT programme has reduced the incidence of vertical HIV transmission from 2.3% in 2022 to 1.4% in 2025. At the same time, a number of certain factors and gaps affect the effectiveness of measures to prevent vertical transmission of HIV in the region: a high proportion of HIV-positive pregnant women from key groups (21% in 2025); up to 10% of pregnant women living with HIV are not under supervision in antenatal clinics, have low adherence to ART or refuse treatment, including after childbirth; a significant proportion (about 30%) of women with late detection of HIV-positive status (after 24 weeks of pregnancy, during or after childbirth); insufficient coverage of the third stage of Early Infant Diagnosis (PCR for NA detection) among children aged 3–4 months (54% in 2025); low coverage of serological testing of children aged 18 months and older to establish the final HIV status (as of 01.01.2026, 58 children remain untested).

Odesa oblast is one of the regions with a high level of HIV prevalence, as evidenced by the HIV prevalence rate among pregnant women exceeding 1%. The frequency of vertical HIV transmission increased from 0.5% in 2024 to 2.0% in 2025 (2.0% in 2022; 1.1% in 2023). It is important to consider a number of factors and gaps that affect the effectiveness of PMTCT measures in the region: almost half of HIV-positive pregnant women live in small towns and villages (48% in 2025); a significant proportion of women (28%) with late detection of HIV-positive status (after 24 weeks of pregnancy, during or after childbirth); insufficient coverage of HIV-exposed children with the second (51% in 2025) and third (58% in 2025) stages of Early Infant Diagnosis.

Regulatory and legal framework for PMTCT and current challenges

Military actions and related humanitarian challenges have necessitated the adaptation of the current regulatory framework to crisis conditions, the introduction of flexible organisational models, simplified clinical routes, and enhanced intersectoral cooperation to ensure continuous access of women and children to vital medical and social services. During 2019–2025, the regulatory framework in the field of PMTCT in Ukraine was significantly updated: state guarantees of free access to services were established, PMTCT was integrated into the packages of the Programme of Medical Guarantees, modern standards and clinical guidelines were approved, and the basis for the implementation of PMTCT measures at the regional level was created. At the same time, important issues remain that need to be addressed: some regulatory acts are outdated or have lost their validity and do not take into account the need to integrate measures against HIV, syphilis and viral hepatitis B; the packages of the Programme of Medical Guarantees do not fully cover key PMTCT measures; there is a lack of

regulatory documents on the organisation of obstetric and gynaecological care, especially in emergency and post-war situations. Further improvement of regulatory and legal acts in the field of PMTCT should be based on the principles of clear interdepartmental coordination and orientation to the needs of women living with HIV and in vulnerable situations, taking into account post-war recovery strategies of the health care system, as well as strengthening the health of mothers and children.

Integration of services to eliminate vertical transmission of three infections

Of particular relevance is the regulation of measures that require greater integration of health services to eliminate vertical transmission not only of HIV, but also of syphilis and hepatitis B. This is in line with the Global Health Sector Strategy on HIV, Viral Hepatitis and STIs for 2022–2030, the UN Sustainable Development Goals, and the WHO approach of "integrated, people-centred services".

In order to implement the above tasks, in 2025, a multidisciplinary working group began preparing a national document – the Standard of Medical Care "Prevention of Mother-to-Child Transmission of HIV, Syphilis, and Viral Hepatitis B", which will provide a comprehensive approach to the prevention of vertical transmission of the three infections. In the context of implementing the "triple elimination" approach (HIV, syphilis, viral hepatitis), the issue of integrating HIV data with registries of patients with sexually transmitted infections and viral hepatitis remains unsettled, which does not allow for comprehensive inter-programme monitoring.

PMTCT reporting system

Despite progress in digitalization, the PMTCT reporting system in Ukraine remains largely paper-based, which complicates timely data analysis and use for management decisions. One of the key problems is the lack of a full-fledged unified electronic PMTCT registry and established electronic information exchange between institutions providing assistance to pregnant women and children (antenatal clinics, maternity hospitals, primary health care institutions), as well as limited or no data exchange with private health care institutions.

Human resources and financial challenges in the context of health care system reform

The reform of the health care system has created the prerequisites for the integration of PMTCT services at the primary level, but the issues of financing, staffing and clear coordination remain unresolved. As a result of the reform of the secondary level of medical care, specialised institutions that traditionally provided PMTCT services were reorganised, in particular, regional AIDS prevention and control centres were liquidated. Optimisation of personnel has led to the loss and dispersion of trained PMTCT specialists, which has negatively affected the quality of coordination, support and monitoring of PMTCT measures at the regional level. The packages of the Programme of Medical Guarantees of the National Health Insurance Fund of Ukraine do not include a separate component for monitoring and evaluating measures to eliminate mother-to-child transmission of HIV. As a result, specialists responsible for maintaining electronic records of HIV-positive women and children born to HIV-positive mothers are not provided with appropriate financial incentives.

The shortage of personnel in the field of providing medical care to HIV-positive women and their children remains a pressing problem that requires an immediate solution to ensure high-quality and continuous medical care. As a result of demographic changes, migration and war, the number of women giving birth has significantly decreased, which reduces the burden on medical institutions, but does not solve the problem of the shortage of specialists. For the effective integration of PMTCT at the

primary level, it is necessary to ensure stable funding, strengthen the human resources of family doctors and create clear mechanisms for interdepartmental coordination. Only under such conditions will the system be able to guarantee the continuity, accessibility and quality of PMTCT services and support for HIV-positive women and children.

Financing and external support for the health care system

Global instability and the reallocation of funding to address simultaneous global crises have led to a reduction in external support for the health system in Ukraine, limiting the ability to provide critical health interventions and services. To strengthen PMTCT efforts, it is important to align budgets across all funding sources during the development and approval of the next round of the operational plan of the State Strategy to Combat HIV/AIDS, Tuberculosis and Viral Hepatitis by 2030. This should take into account the review of financing of medical service packages provided to health care institutions under the programme of state guarantees of medical care for the population, the possibilities of state financing of HIV prevention, as well as support for international projects and organisations that may be involved in the process of validation of the EMTCT in Ukraine. The implementation and strengthening of the PMTCT programme should be carried out in accordance with the Health Care System Restoration Plan, which provides for the phased implementation of measures to develop the health care system in a new format of ensuring the quality and accessibility of medical services.

Gaps in the completeness of PMTCT services

Gaps in the completeness of PMTCT services during pregnancy and in the postpartum period (in accordance with medical care standards) were most often observed in relation to women's socio-behavioural vulnerabilities, especially in the Odesa oblast. Screening for drug use using the ASSIST questionnaire, assessment of the psycho-social state of the pregnant woman and possible antenatal depression, and risk assessment for domestic and gender-based violence are often not conducted by medical workers during the first visit of an HIV-positive pregnant woman to an antenatal care facility or a primary health centre. Half of HIV-positive women in labour undergo a cytological examination of the cervix at an antenatal clinic 3 months after delivery.

Gaps in the completeness of PMTCT services for children were most often identified in counselling parents/guardians of HIV-exposed children on adherence to long-term prophylactic ARV therapy and safe breastfeeding. In particular, two-thirds of mothers in Odesa oblast did not receive written instructions on post-natal prophylaxis (PNP) and on breastfeeding. Pneumocystis pneumonia prophylaxis from 4-6 weeks of age was provided to only one in six children in Odesa oblast.

At the same time, a paediatric infectious disease specialist from the Dnipropetrovsk oblast believes it is advisable to change the approach to the pneumocystis pneumonia prophylaxis in HIV-exposed children, in particular for mothers with a low risk of vertical HIV transmission. The doctor suggests not prescribing cotrimoxazole prophylaxis to children whose mothers have a low risk of HIV transmission (high adherence to ART, achieved viral suppression at the time of delivery), and the child's first two HIV status tests based on Early Infant Diagnosis results are negative (DBS PCR in the first 48 hours and PCR at the age of 1-2 months). From practical experience, she notes that Biseptol often causes anaemia in children. The doctor also questions the appropriateness of prescribing three drugs for 28 days for post-natal prophylaxis (PNP) and believes that for mothers with a high risk of vertical transmission, one drug is enough. For mothers with a low risk of transmission (long time on ART and viral load less than 40 copies), she suggests not prescribing PNP, relying on global and European experience.

Timeliness and availability of PMTCT services

Analysis of the timeliness and accessibility of PMTCT services for women living with HIV indicates positive trends in the field of medical support for pregnancy and Early Infant Diagnosis. The majority of pregnant women are registered in the first trimester, regularly visit obstetricians-gynaecologists and infectious disease specialists, and demonstrate high adherence to virological monitoring. At the same time, there is a significant proportion of pregnant women who are registered after 24 weeks of pregnancy, there are problems with untimely laboratory tests in children, in particular the second and third PCR, missed visits due to financial, transport, psychological barriers, as well as fear of stigma and discrimination, especially in remote hromadas and among displaced women.

Financial accessibility

Financial accessibility of health services for women living with HIV remains a serious problem, exacerbated by stigma, discrimination, socio-economic factors, dependence on male partners and the impact of war. The majority of women are in a difficult financial situation: 44% reported that their household income is not enough to meet daily needs, and 34% — it is not enough at all. A significant number of respondents (42%) reported that they had to pay for health services in municipal institutions, including during pregnancy (39%), in the postpartum period (21%), and for care of an HIV-exposed child (8%). The situation differs depending on the region: women from Dnipropetrovsk oblast paid for services 2.5 times less often than women from Odesa oblast. Maternity hospitals in Odesa are especially often mentioned, in particular the Odesa Oblast Perinatal Centre. Financial insolvency is the main reason for missing visits to doctors. Despite existing programmes to support formula feeding, 90% of mothers bought milk formulas for their children on their own. A third of women depend on financial support from their partner or husband to pay for transportation to a medical facility or an HIV and PMTCT specialist. Community activists also reported cases where women were forced to pay for services such as caesarean sections, postpartum medications, pain relief in the maternity hospital, as well as for “HIV-positive status” and disinfectants. Financial considerations prevented clients from seeking medical care, especially when free examinations were ordered together with paid tests. It was separately noted that fear of stigmatisation and the requirement to pay for services prevented women from seeking antenatal clinics.

Protecting the rights of HIV-positive women and overcoming discrimination in the health care sector

The findings of the research emphasize the need to strengthen the protection of the rights of HIV-positive women in the health care sector, implement systematic measures to combat discrimination and obstetric violence, and raise awareness among both patients and health care workers. A third of women living with HIV have experienced obstetric violence or discrimination in health care facilities. The most common forms of violations are disclosure of the diagnosis, psychological violence, and denial of medical services. It is significant that 22% of women do not identify the cases of violence or discrimination they have experienced, which indicates a low level of awareness of their rights.

In Dnipropetrovsk oblast, intolerant attitude of medical staff, especially in maternity hospitals, is confirmed by reports from both patients themselves and infectious disease doctors, who are forced to personally intervene and conduct explanatory work among colleagues. There are alarming reports when some doctors advise women living with HIV to terminate their pregnancies, which indicates a significant level of prejudice and lack of awareness about modern options for safe motherhood for HIV-positive women. However, most HIV-positive women do not dare to file complaints officially, limiting themselves to verbal appeals, which complicates the fight against stigma and discrimination. In Odesa oblast, stigma and discrimination remain a problem in remote hromadas and maternity

wards. Some health workers avoid physical examinations or are unwilling to care for HIV-positive children. However, official complaints about such actions are extremely rare, mainly due to distrust of the system and fear of disclosure of status. Despite this, the majority of health workers interviewed note an increase in the level of tolerance both in health facilities and in society as a whole. A positive example is the increase in the number of discordant couples, which indicates the gradual destruction of stereotypes about HIV.

Community activists and HIV service providers from NGOs documented cases of stigma and discrimination from health workers in the areas of reproductive health, maternity, and access to medical care. Discrimination occurred on the basis of HIV-positive status, drug addiction, history of tuberculosis, and status of an internally displaced person (IDP), and took the following forms: pressure on reproductive choices; public humiliation, verbal aggression; violation of confidentiality; refusal to provide services due to registration; obstetric violence and extortion of money; stigmatisation of discordant couples; attempts to get rid of a pregnant woman with a history of HIV-TB coinfection, using increased bureaucracy; admission of HIV-positive women last in line; isolation of drug-addicted women and coercion to abandon the child; and refusal to register resettlements by family doctors. At the same time, the support and tolerant attitude of medical staff demonstrate positive changes in attitudes towards HIV-positive patients.

According to the interviewed professionals holding managerial positions in Dnipropetrovsk oblast, in recent years, there has been a significant improvement in the attitude of medical personnel towards HIV-positive women, children and adolescents. The level of tolerance has increased, and cases of discrimination have become isolated and rare. Complaints about inappropriate behaviour of medical workers towards HIV-positive patients are infrequent and are mainly related to the personal characteristics of individual workers, rather than to a systemic problem of discrimination. If high-profile cases of discrimination or stigmatisation arise, they are promptly reviewed by the institution's management and medical councils, and discussed at meetings of regional advisory bodies on TB/HIV and EMTCT. The last widely known complaint concerned the inappropriate behaviour of a perinatal centre doctor towards an HIV-positive woman in labour. Patients' complaints are mostly oral, and even in cases of informal appeals, the institution's administration reacts, provides answers, and conducts explanatory conversations. In health care facilities subordinate to the Dnipropetrovsk Oblast Medical Centre for Socially Significant Diseases, policies on preventing discrimination have been implemented, which are regularly updated and their implementation is monitored. Thematic trainings, separate sessions on preventing stigma and discrimination, as well as information work through social networks are held for staff. The last update of documents on preventing discrimination took place in February 2025 in all medical facilities of the oblast. At the same time, not all managers, in particular the head of the postpartum department, are informed about the existence of such a policy in their facility, which indicates the need to spread the experience of the AIDS service to maternity care facilities and other medical facilities related to the provision of PMTCT services.

In the Odesa oblast, the level of stigma and discrimination on the part of medical staff was assessed by specialists ambiguously. On the one hand, it is recognised that the issue of stigmatisation has not yet been fully resolved, on the other hand, there is an increase in tolerance and a rarity of cases of discrimination. Staff are increasingly showing a positive attitude and do not single out HIV-positive patients among others. There are isolated cases of stigmatisation and discrimination, especially in remote hromadas of the oblast. For example, a patient complained about isolation in a medical facility, however, the complaints are mostly oral. One of the reasons for the lack of written complaints is the reluctance of patients to disclose their HIV status due to fear of disclosure. Systematic work to raise staff awareness is carried out through regular explanations, education and training, especially for new employees and interns. Special attention is paid to correct information about the ways of HIV transmission and stigma prevention. At the level of institutions, there is currently no formalised policy on preventing discrimination, but there is an understanding of the need for its implementation. Practical examples demonstrate the importance of conducting training for interns and young

employees to create a tolerant environment. At the level of the city health department, there is a complaints department that analyses patient complaints. Educational activities, including in cooperation with international partners, are aimed at overcoming stigma among medical students. An important component of the training is communication with activists from the community of women living with HIV, which helps to form a tolerant attitude in future medical workers. Experience shows that first-year students often show stigma towards HIV-positive people, so work in this direction should be active and systematic.

Service providers and community activists cited a number of examples of stigma, including multiple stigma, judgment, lack of kindness and sensitivity towards girls and women due to their HIV-positive status, low adherence to ARV treatment, lifestyle or behaviour (e.g. sex work, drug use). FGD participants highlighted that stigma significantly affects women's willingness to seek health services and creates serious barriers to accessing services. Neglect reinforces internalised stigma, which leads to shame, guilt, fear of judgment, self-isolation, and low self-esteem, which in turn prevents women from seeking help, treatment, or support. In contrast, tolerance and sensitivity on the part of health workers increase trust in the health care system and motivate women experiencing multiple stigmatisation to seek medical care.

The data presented indicate an urgent need for further training of medical workers, the formation of a tolerant attitude towards HIV-positive patients and the introduction of mechanisms for protecting their rights to ensure quality medical care. To ensure equal, dignified and safe treatment of HIV-positive women, it is important to develop systemic approaches to raising awareness among medical staff, implement non-discrimination policies, conduct regular training on the prevention of HIV-related stigma, support advocacy and protection of the rights of HIV-positive women, and encourage patients to file formal complaints in case of violation of their rights.

Satisfaction with services at different levels of health care andNGO-based services

HIV-service NGOs and health care facilities providing services to people living with HIV (PLHIV health facilities) demonstrate the highest level of satisfaction among women living with HIV. This confirms the importance of their role in supporting HIV-positive women, especially in terms of accessibility, counselling, and non-discrimination. The greatest dissatisfaction with services is observed with maternity hospitals, particularly among women from Odesa oblast. This indicates the need to improve the quality and sensitivity of such facilities to the needs of women living with HIV, as well as the importance of reducing stigma, discrimination, and financial pressure.

The level of satisfaction with medical services has significant regional differences. In Dnipropetrovsk oblast, most women report satisfaction with services at all levels of medical care. In Odesa oblast, only PLHIV health facilities receive positive ratings. At the same time, it is in Odesa oblast that the highest level of satisfaction with non-medical services based on HIV-service NGOs is observed.

The qualitative component of the study among mothers of HIV-exposed children confirms that satisfaction is determined not only by the professional competence of medical personnel, but also by their attitude towards the woman and child, the absence of discrimination, the availability of consultations and the possibility of receiving humanitarian assistance. Non-medical social services, including social support, home delivery of medicines, peer support and humanitarian assistance, are rated very highly and are an important factor in improving the quality of life of women and their children.

Impact of war and IDP women

The full-scale russian invasion of Ukraine has significantly affected the availability, completeness and quality of PMTCT services, in health care facilities, as well as HIV-service NGOs. Due to the changing priorities of the population, health issues are being relegated to the background, as the main focus is on survival, safety and ensuring basic needs. Despite the existing difficulties and challenges, medical workers are making maximum efforts to ensure proper medical support for HIV-positive women, in particular IDPs.

Dnipropetrovsk oblast is characterised by a significant influx of displaced persons, partial occupation since 2025, and constant shelling of frontline cities, especially in the east, near the border with Zaporizhzhia and Donetsk oblasts. Due to complications caused by the war, ART is increasingly being sent to patients by mail, and visits to medical facilities are becoming less frequent. This makes it difficult for doctors to ensure adherence to treatment in pregnant women, conduct monitoring, timely identify problems, and provide necessary assistance. At the same time, medical workers are understanding when women are unable to come to the facility due to objective reasons related to the war. Doctors recorded cases of ART interruption in women arriving from the occupied territories and restored their access to treatment. A significant influx of new patients in 2022, as well as the evacuation of women from the Dnipropetrovsk oblast to other oblasts of Ukraine, leads to difficulties in maintaining records. Many displaced women do not want to register in new medical institutions, which is why doctors have to search for patients on their own. Children who have left abroad often remain under-examined up to 18 months, which creates difficulties with their registration. The lack of medical documentation for IDP children, in particular form 63 with a list of vaccinations, complicates full medical support. The Secretary of the RC EMTCT noted the experience of effective cooperation with the migration service in the issues of restoring documents for IDP women. As a result of the escalation of hostilities, medical personnel are being evacuated from areas close to the front line. The antenatal clinic in one of the Dnipro districts was forced to move to another building of the medical facility, being located on the first floor to ensure quick access to shelter and increase the level of safety for staff and patients. An obstetrician-gynaecologist reported an increase in the number of appeals from IDP women who have been subjected to sexualised violence (regardless of HIV status).

In the Odesa oblast, due to delays in the supply of drugs, medical institutions are forced to reduce the period of ART provision from six months or a year to three months. This creates additional stress for patients, especially those who move frequently or travel abroad. In the first months of the war, there was a mass exodus of medical workers (especially women). The workload on staff increased significantly — at the same time, a large number of patients arrived who needed emergency ART provision due to the uncertainty of the situation. Medical workers worked in difficult conditions, often in reduced numbers, demonstrating resilience and dedication. Some patients left abroad or to rural areas, which complicated registration, monitoring and further diagnostics, especially for HIV-exposed children. Some children were left without re-examination or were “lost” to the health care system. At the same time, new support centres for IDPs and people who have experienced violence were opened, which had a positive impact on supporting women. Some men stopped visiting health care facilities due to fear of being stopped at checkpoints, which in some cases led to the discontinuation of ART. Close relatives (wives, mothers) are often forced to receive therapy instead of male patients, so women take care of their relatives’ access to treatment. In addition, an infectious disease doctor from a remote hromada independently organised the delivery of ART to patients. He also noted an increase in the number of cases of HIV, hepatitis, and sexually transmitted infections, including syphilis, over the past year. In addition, the doctor emphasized that the general population has become less inclined to examinations and testing, which negatively affects Early Infant Diagnosis and prevention of HIV.

The war in Ukraine has significantly changed the working conditions for NGOs and the lives of HIV-positive women themselves, especially among IDPs. NGO-based service providers and community activists outlined a number of challenges that have arisen in terms of access to and quality of health

and social services for women living with HIV under martial law. IDP women, after being displaced to remote hromadas, especially rural areas, often do not know where to turn for help and where to register. This leads to cases where they arrive to give birth unscreened, without undergoing the necessary diagnostics and testing for HIV during pregnancy. IDP women interrupt ART after displacement to remote hromadas. Migrant women who have gone abroad are often reluctant to disclose their HIV status in their new countries of residence, and are therefore forced to return to Ukraine regularly for routine testing and ARV treatment. In occupied territories, patients are often left without access to ART. Military operations, destruction of infrastructure, and disruption of transport connections make it difficult to reach medical facilities, especially in evacuation areas. Alternative transport options (e.g., private carriers) are expensive or dangerous, and male carriers often refuse to travel due to the risk of encountering representatives of the Territorial Centre of Recruitment and Social Support. For IDP women, health issues are secondary, as the primary priority is to address basic needs: finding housing, ensuring security, and resolving issues related to document renewal. The outflow and turnover of qualified medical personnel and HIV service NGO workers has increased the workload for those who remain. Due to the mobilisation of men, women are left alone with their children. Some men are either at the front or have gone missing, while others are hiding and not working. Men who are not serving often avoid meetings with representatives of the Territorial Centre of Recruitment and Social Support, which is why they refuse to visit doctors or accompany women and children to medical or other institutions. As a result, women are forced to independently resolve all issues related to childcare, everyday life, and receiving services. Additional stress is caused by the need for women to independently search for a son, husband or other family member who disappeared after meeting with the Territorial Centre of Recruitment and Social Support, which worsens their psychological state. In conditions of war, the general mental health of clients and service providers at the community level deteriorates. Social support is provided during air raids and power outages. Activists noted the difficulty of registering newborn children, in particular, digital services, such as the “Diia” portal, do not always work, which forces women to personally visit state institutions and stand in queues for several hours, because the institution is closed during air raids.

Residents of remote hromadas

Women from remote hromadas face a number of significant barriers to accessing HIV and PMTCT medical and social services. The main obstacles are the geographical remoteness of institutions, the lack of services at the place of residence, the lack of specialists (in particular, infectious disease doctors), as well as the fear of stigma and disclosure of the diagnosis, which is especially acute in small settlements. For the Odesa oblast, this group is extremely important in the context of the PMTCT programme, as almost half of HIV-positive pregnant women live in small towns and villages (56% in 2022, 68% in 2023, 53% in 2024, 48% in 2025). Remoteness from health care institutions limits the possibility of timely assistance for both the pregnant woman and her unborn child.

From their own experience, health workers identified a number of problematic issues for HIV-positive women in remote hromadas. In particular, among the main obstacles is the prevalence of stigma and discrimination, which in some cases takes on threatening forms, such as attempts at eviction by local authorities (village head, Dnipropetrovsk oblast). Such a negative social climate deepens women’s isolation and creates additional difficulties in accessing medical and social services. In addition, the lack of access to ART, HIV and CD4 tests, and the shortage of specialists (infectious disease specialist, narcologist, phthisiologist) at the place of residence force women to travel considerable distances to receive services in the regional centre, which complicates timely treatment and support. An infectious disease specialist at the primary health care centre, who observes HIV-positive people, reported that the key medical facility of the Velykodolynske territorial community of the Odesa district of the Odesa oblast does not have a “Dovira” office, ART is not issued, and it is also impossible to undergo a viral load and CD4 test. Because of this, HIV-positive patients have to travel up to 50 km to the oblast centre

(Odesa) or Ovidiopol to receive treatment and undergo appropriate examinations. In addition, patients also have to go to Odesa or another settlement in the Odesa oblast to receive consultations from a narcologist and phthisiologist, and to treat hepatitis B and C. For a long time, there was no infectious disease specialist at the specified primary health care facility, which further complicated access to quality medical services for women living with HIV.

A community activist from Dnipropetrovsk oblast noted that the established ART dispensing schedules in PLHIV health facilities do not meet the real needs of rural women. This leads to cases of ART interruption during pregnancy, negates the efforts of NGO workers to provide social support and support adherence to ARV treatment, and further exacerbates the problem of the geographical remoteness of PLHIV health facilities for HIV-positive women. In a specific case, social workers spent a long time persuading a pregnant woman to come for ART, helped her financially with transportation, but when she arrived "not on the day they dispense," she was denied ARV medication. As a result, the woman discontinued treatment till giving birth. By addressing the geographical accessibility of HIV and PMTCT services, activists see improved access through the expansion of primary care ART delivery sites, particularly in PMTCT centres, which will reduce the burden on PLHIV health facilities. The need to support mail-order ART delivery services was also noted. Activists also identified fear of disclosure as a barrier to accessing PMTCT services in rural areas and small towns. This leads to HIV-positive women preferring to be monitored in the oblast centre rather than at their place of residence, and avoiding contact with health workers in their communities, such as family doctors, paediatricians, and gynaecologists. Socioeconomic factors such as poverty and high child care burdens further complicate access to health and non-health services for women living with HIV in remote hromadas. Existing projects of HIV service NGOs in both regions cannot fully meet the needs of women in remote hromadas, especially in terms of psychosocial and humanitarian support.

Unlike large cities, access to free infant formula is often extremely limited for residents of small hromadas. The lack of funding for the purchase of formula is confirmed by responses to hromada activists' inquiries in the Dnipropetrovsk oblast: out of 10 hromadas that responded, only 6 purchase infant formula. There is also no unified approach to calculating funds per child, for example, one hromada allocates 32 thousand hryvnias per child, while another allocates only 5 thousand. The lack or absence of budget funds is partially compensated by humanitarian assistance through PLHIV health facilities or projects of non-governmental organisations, but not all residents of rural areas have access to such support.

Packaging of paediatric Zidovudine

The practice of dispensing the ARV drug Zidovudine (AZT) into syringes for post-natal prophylaxis for HIV-exposed children was introduced due to the lack of the necessary amount of the paediatric form of the drug for each dose according to the prescribed treatment regimen. In the maternity hospital, the dose measurement process is monitored by trained medical personnel, and dispensing AZT syrup at the level of the obstetric health care institution (maternity hospital) is clinically justified due to the shortage of the paediatric form of the drug. However, after discharge home, the responsibility for administering PNP passes to the mother. There are known cases when mothers accidentally or through carelessness spilled all the syrup for PNP at home. In particular, the mother of an HIV-exposed child from a rural area of the Odesa oblast sought help, and an HIV-service NGO organised the delivery of a new supply of drugs, having agreed with the AIDS centre. Such situations illustrate the risk of incorrect dosing in mothers, which can lead to a violation of the PNP regimen.

According to the results of in-depth interviews, some mothers reported that in the perinatal care facility (maternity hospital) they were always given a ready-made dose of the drug for PNP in syringes, so they did not acquire practical skills in measuring the dose themselves. Most mothers could not remember either the name or the dosage of the drug that their child received during the 28 days. In

addition, according to the results of the online survey (n=89), 15% of HIV-positive mothers did not receive training on measuring the dose of the ARV drug, and 38% did not receive written instructions on taking PNP; the vast majority of them were women from the Odesa oblast.

The full course of preventive ARV treatment for newborns (28 days) under the supervision of medical professionals in the Dnipropetrovsk oblast is regulated by the Order of the Department of Health of the Dnipropetrovsk Oblast State Administration of 18.11.2024 No. 1194/0/197-24. In practice, this is accompanied by the mandatory stay of mothers with an HIV-exposed child for 28 days in maternity wards, perinatal centres, mother and child centres, children's hospitals, etc. This rule applies even to women with high adherence to ART and low risk of HIV transmission. The problem lies in the packaging of the paediatric form of the drug Zidovudine (AZT), which is 200 ml, when a three-week course requires less than 100 ml (excluding the week in the hospital under the supervision of medical workers). Legally, doctors are acting correctly, adhering to current legislation: according to the Order of the Ministry of Health of Ukraine No. 360 of 19.07.2005, the primary packaging must not be broken during retail sale, and the Law of Ukraine "On Medicinal Products" guarantees safety and accuracy of the dose. For a more thorough analysis of the situation, the results of in-depth interviews with four mothers of HIV-exposed and HIV-positive children in the Dnipropetrovsk oblast were taken into account. Only one child underwent PNP for 28 days in the hospital (the mother had previously recorded low adherence to ART, the child's first and second PCR were negative). The mothers of the other three children were discharged from the maternity hospital on the 5th, 11th, and 8th day after birth, respectively. In the latter case, low adherence to ART was also recorded, and the first DBS PCR was positive. Thus, women had the opportunity to conduct PNP at home, regardless of the level of risk of HIV transmission.

This situation demonstrates the clinical need for dosing to ensure accurate PNP, but it also poses risks to the efficacy and safety of treatment. To minimise these risks, it is necessary to ensure the availability of paediatric ARV formulations, provide parental education, and develop formal protocols for safe dosing outside the hospital.

Breastfeeding

In general, the practice of breastfeeding counselling and support for HIV-positive women in Ukraine largely does not meet modern PMTCT standards and clinical recommendations. The vast majority of health workers ignore or openly deny the possibility of such a choice for women who have achieved viral suppression on ART and have high adherence to treatment. Breastfeeding counselling is often transferred to community activists, and health workers focus exclusively on formula feeding, without informing women about their right to choose.

Examples of adequate breastfeeding support remain rare and depend on the personal awareness and position of individual doctors, while most specialists either do not have practical experience or are not ready to advise in accordance with the new standards. This situation creates barriers to the realisation of the rights of women with HIV and increases social stigmatisation. At the same time, the lack of adequate financial and organisational support for regular monitoring of the health of the mother and child during breastfeeding forces even informed women to choose formula feeding.

To ensure the rights of HIV-positive women and effectively implement modern PMTCT approaches, it is necessary to change counselling practices, strengthen the training of health workers, ensure a unified approach to informing about breastfeeding options, and create conditions for regular clinical support for mothers and children who choose to breastfeed. Without this, recommendations will remain only "on paper", and women will be left without a real choice.

The role of social support and guidance

The social component (support, care and guidance) is a critical factor in the success of PMTCT programmes, especially in areas with high epidemic burden. Evidence suggests that treatment refusal, low adherence to ART, lack of information about the child's place of residence and loss of mother-child pairs to follow-up often have social roots: internal and external migration, fear or experience of stigma and discrimination, socio-economic and psychological problems that limit access to PMTCT services during wartime. Further reduction of HIV cases among children is impossible without systematic strengthening of intersectoral interaction, in particular: integration of medical and social services for pregnant women and families with children; development of social support programmes for HIV-positive women during and after pregnancy; active involvement of non-governmental organisations in working with IDPs, socially vulnerable families, especially in rural areas and remote hromadas; prioritisation of Dnipropetrovsk and Odesa oblasts as key regions for intensive interventions within the framework of PMTCT. Ensuring effective coordination between medical, social and administrative structures is an important prerequisite for overcoming existing programme gaps and vulnerabilities in the continuum of PMTCT services.

HIV-service NGOs and the community of women living with HIV

A number of HIV-service NGOs, including organisations led by the community of people/women living with HIV, are active in Dnipropetrovsk and Odesa oblasts. They play a key role in implementing measures to prevent vertical transmission of HIV, acting both as providers of relevant services and as the voice of the community of women living with HIV in advisory and coordinating bodies on TB/HIV and EMTCT at the city and oblast levels. NGOs cooperate with municipal and private medical institutions, social service centres, crisis and rehabilitation centres, specialists, other NGOs, religious communities and charitable foundations.

Social support throughout the PMTCT continuum of services

Participants in focus group discussions noted the implementation of a multidisciplinary approach that ensures effective interaction and coordination in the process of pregnancy support for women living with HIV, as well as medical monitoring of HIV-exposed children in accordance with industry health standards. The activities of multidisciplinary teams at opioid substitution therapy (OST) sites, which provide comprehensive assistance to HIV-positive women with drug addiction, as well as intersectoral cooperation in the field of combating tuberculosis, in particular among HIV-positive patients, were particularly noted.

Activists and NGO employees regularly consult HIV-positive pregnant women on a peer basis. Social and psychological assistance to an HIV-positive pregnant woman includes a set of measures that meet industry standards: referral to specialised doctors (obstetrician-gynaecologist, infectious disease specialist, phthisiologist, narcologist), tuberculosis screening, assessment of psychosocial status and risk of violence, timely registration, monitoring adherence to ARV therapy, as well as protection of women's rights and interests. When conducting consultations, NGO employees often rely on their own experience of pregnancy and childbirth, cooperate with partner NGOs and specialists to provide a full range of services according to the needs of the pregnant woman. Consultations are held in the form of individual or group consultations, offline or online, on the territory of the NGO or on the basis of health care facilities.

Social and psychological assistance to an HIV-positive woman in labour or delivery includes: consultations on partnered births, formula feeding and taking ARV drugs, the use of cabergoline to suppress lactation, assessment of the mother's psychosocial status and the risk of postnatal depression, monitoring the risk of domestic/gender-based violence, monitoring adherence to

treatment, screening for tuberculosis, consultations on contraception in the postpartum period, protection of the rights and interests of the mother and child, as well as prevention of newborn abandonment.

The participation of representatives of the community of women living with HIV (CO "Positive Women Odesa") in the city coordination council contributed to the advocacy of the issue of ensuring financing for drugs to suppress lactation in HIV-positive women in childbirth in Odesa. In particular, on 26.06.2024, at the XXXI session of the Odesa City Council, the allocation of 131 thousand UAH was supported for the purchase of relevant drugs within the framework of the city programme "Health" for 2024–2026.

HIV-service NGOs, including community-led organisations, provide a wide range of psychosocial assistance and support to parents (guardians) of HIV-exposed children, including: counselling on the child's medical management and PNP, post-test counselling based on the child's HIV test results, recommendations on safe feeding, information on obtaining and dispensing breast milk substitutes, provision of humanitarian assistance, clarification of legislative issues and benefits, and protection of the rights of the mother and child. HIV-service NGOs play an important role in ensuring access to and timeliness of Early Infant Diagnosis in HIV-exposed children. In particular, transportation of the mother with the child (or children) to the place of blood sampling is organised, communication with doctors is maintained to inform and monitor the timeliness of the diagnosis, and medical workers are also provided to remote hromadas to collect blood for PCR.

This comprehensive approach helps reduce barriers, increase adherence to treatment, and empower HIV-positive women and children, ultimately leading to more sustainable outcomes in preventing mother-to-child transmission of HIV.

Coordination system for the elimination of vertical transmission of HIV

The coordination system in the field of elimination of vertical transmission of HIV in the Dnipropetrovsk oblast is a stable and structured mechanism that allows for the effective implementation of PMTCT measures, responding to wartime challenges, and ensuring respect for the rights of women and children, despite limited resources and difficult conditions. During 2023–2025, the composition and work plan of the Working Group on Validation of Elimination of Mother-to-Child Transmission of HIV under the Department of Health of the Dnipropetrovsk Oblast Administration (RC EMTCT) were regularly updated, the Roadmap was approved, and a clear coordination structure between health care institutions, the Regional Coordination Council for Combating Tuberculosis and HIV/AIDS under the Oblast State Administration, civil society, and national HIV and PMTCT bodies were established. Quarterly reports and analytical reports are sent to the PHC of MoH, which demonstrates proper monitoring and accountability. An important component was the implementation of patient itineraries, the identification of responsible persons, as well as the strengthening of the role of NGOs in social support. The orders on health service centres approved ethical codes of conduct, policies to reduce stigma and discrimination against people living with HIV, which contributes to the protection of human rights and gender equality. In accordance with the updated routes, access to ARV drugs and specialised care for children is ensured. The activity of the RC EMTCT is positively assessed: holding four meetings annually, analysing cases of vertical HIV transmission, organising monitoring visits, training medical workers, as well as holding online seminars on the prevention of violence, stigma and discrimination. The implementation of internal regulations on the ethical code of conduct in 100% of institutions providing PMTCT services is noted. The community of women living with HIV is actively involved in the work of the RC EMTCT. Access to public information on the work of the Regional Coordination Council for Combating Tuberculosis and HIV/AIDS is ensured (composition of the council, annual work plans, agendas and minutes of meetings). At the same time, information about the RC EMTCT is absent or limited in the public space.

During 2023–2025, the system for coordinating activities on the EMTCT in the Odesa oblast is characterised by instability and insufficient integration into the activities of regional coordination bodies, weak intersectoral interaction and insufficient institutional stability in emergency situations are noted. The composition of the Regional Interdepartmental Working Group on Validation of Elimination of Cases of Mother-to-Child Transmission of HIV at the Department of Health of the Odesa Oblast Administration (RC EMTCT) was updated in accordance with personnel changes; however, the group meetings were never held in 2024–2025. The meeting of the Coordination Council for Combating Tuberculosis and HIV/AIDS at the oblast state administration was held for the first time in October 2025 after a long break, and PMTCT issues were included in the Council's agenda. Organisational and programme activities were partially implemented, and some were postponed to the next year due to personnel changes and lack of funding. Health care institutions have not developed and implemented routes for providing PMTCT services in emergency situations, taking into account the needs of key groups. A positive aspect is the provision of social support for HIV-positive women by non-governmental organisations, as well as training events for medical workers. According to the results of the monitoring visit of the National Council in 2024, an adequate level of implementation of PMTCT measures was noted, and some indicators exceeded the national average. At the same time, measures to comply with human rights, gender equality, and community participation were not actually implemented. Access to public information regarding the activities of the Regional Coordination Council and the RC EMTCT is not provided.

Adolescent girls living with HIV

Socio-demographic and life circumstances. HIV status disclosure

An analysis of the socio-demographic and life circumstances of eight girls living with HIV indicates their vulnerability to various social and psychological challenges. A significant part of the respondents live in single-parent families, often under the care of only one parent, a grandmother or an uncle. The war caused the displacement of some girls, which complicates adaptation and psycho-emotional state. Also, some girls are raised in large families.

Girls living with HIV from birth in most cases learned about their diagnosis before adolescence, which is in line with current professional recommendations. Usually, the status is disclosed by parents or guardians, such as a mother, father, grandmother or uncle. In two cases, the girls were informed about their HIV status by doctors. However, based on the results of in-depth interviews with medical workers, a situation is known where a 23-year-old woman does not know about her status because her mother is afraid to disclose it. The doctor notes that she has no way to influence the situation. At the same time, current legislation allows adolescents to receive medical care from the age of 14 without parental consent.

According to the observations of doctors who have experience working with adolescents, grandmothers-caregivers need the most support in disclosing their child's HIV status, because they often try to hide the diagnosis from the child, jeopardising adherence to ARV treatment.

Medical surveillance related to HIV

Most girls regularly visit a doctor or maintain remote contact with him, demonstrating a responsible attitude to their health. However, in rural and remote hromadas, the frequency of in-person visits is reduced due to external factors, in particular the impact of war. Some girls note a high level of trust in their doctors, which contributes to adaptation to the diagnosis and treatment. At the same time, some avoid communicating with medical workers due to fear or psychological discomfort, which can negatively affect the quality of medical support. Remote interaction (via messengers, receiving

medicines by mail) has become a convenient alternative in conditions of martial law, limited mobility and geographical remoteness.

Antiretroviral therapy and awareness level

All adolescent girls interviewed are receiving ART and perceive treatment as an integral part of their lives. However, awareness of specific concepts related to HIV and ART (e.g., CD4, viral load, ART adherence) remains low – only a few participants can explain them or name their own medications and virological monitoring indicators. Despite this, most girls demonstrate adherence to treatment even without knowing the term “ART adherence”.

Treatment monitoring and support

Adolescents are gradually moving towards self-management of their treatment, but a significant proportion still rely on adult support (mother, grandmother or other family members) to take their medication and receive information about treatment. This highlights the need to develop self-management skills among adolescent girls. Adolescents are generally responsible for adhering to their ART regimen, although they often needed support or reminders in the initial stages. Personal stories of loss, support from family and health care providers are motivating factors, although there are cases of skipping or interrupting treatment for personal reasons.

Communication with doctors

Not all girls have direct access to doctors in terms of HIV and treatment issues. Most girls confirmed that they had this opportunity, while in two cases the main source of information about ART and related issues remained the mother or grandmother. Based on the results of in-depth interviews with medical workers, it can be concluded that most doctors rely on parents to form adherence to ART, avoid direct communication with the child, conduct such counselling in the presence of parents, or expect appropriate permission from parents (or guardians). In a separate case, the use of a strategy of intimidation of a girl with low adherence regarding possible criminal prosecution in case of transmission of HIV to a sexual partner was recorded.

Sexual and reproductive health. Understanding the prospect of giving birth to an HIV-negative child

Participants generally demonstrate a sufficient level of awareness of sexual and reproductive health, but there are significant gaps in knowledge about STI prevention, pre- and post-exposure prophylaxis of HIV, HPV, and the availability of certain services. Most girls know about the possibility of giving birth to an HIV-negative child thanks to ART, have access to information about safe sex and contraception, and can contact health workers with sexual health issues. At the same time, only a few know about free means for safe sex or the possibility of free abortion. There is an insufficiently developed understanding of the concept of active consent in sexual relations, as well as limited access to regular preventive examinations by a gynaecologist. The most common sources of information are health workers, family, the Internet, and HIV service organisations. Girls are generally open to discussing sexual health issues, although some of them feel ashamed or afraid of the reaction of doctors or society.

Stigma and discrimination

Stigma and discrimination remain acute problems for girls living with HIV. Two girls from Dnipropetrovsk oblast reported experiencing stigma and discrimination in the school environment, which led to social isolation and reduced self-esteem. Some girls faced prejudice in the community and within their partners' families. The support of their partners and friends helped the girls maintain a sense of dignity and confidence. At the same time, the level of awareness of the concepts of "stigma" and "discrimination" remains low, which increases the risk of repeated negative situations. Only a part of the girls know about the possibilities of protecting their rights and ways to get help; the majority remain without sufficient information about support and tools for human rights protection.

Mental health

Mental health problems are common among girls living with HIV: they often experience shame, anxiety, loneliness, fear, panic attacks, low self-esteem, self-blame, and sleep problems. These conditions are caused both by the diagnosis and by other life circumstances, including the impact of war. At the same time, professional psychological or psychiatric help remains inaccessible and girls rarely seek it.

The role of HIV-service NGOs

HIV-service NGOs play a significant role in supporting girls living with HIV. Most are well informed about support groups, psychological, nutritional and humanitarian assistance and actively use these services. However, the insufficient level of awareness of counselling on forming adherence to ART and counseling on HIV status disclosure indicates the need to strengthen the information work of NGOs among adolescent girls. A friendly approach to providing services, the ability to choose a support format (individual or group meetings, meetings of adolescents or adult women), which takes into account the psychological characteristics of girls, is especially appreciated. Social workers play a key role in supporting and helping to solve life issues — from delivering medicines to legal consultations. However, social anxiety, fear and technical barriers (for example, poor internet) can limit access to online services, which should be taken into account when organising assistance.

KEY RECOMMENDATIONS

1. Improving the accessibility and quality of PMTCT services

1.1 Gaps and bottlenecks in the PMTCT service continuum: To ensure effective coordination between medical, social and administrative structures to overcome existing gaps and bottlenecks in the PMTCT continuum of services: refusal of HIV-positive pregnant women from medical observation in antenatal clinics or late registration (after 24 weeks); low adherence to ART, refusal of treatment, including after childbirth; lack of information about the child's place of residence and loss of the mother-child pair for observation; late detection of HIV-positive status (after 24 weeks of pregnancy, during or after childbirth); insufficient coverage of the second and third stages of Early Infant Diagnosis (PCR for NA detection); low or insufficient coverage of serological testing of children aged 18 months and older; low coverage of screening for drug use, mental health, and risks of domestic/gender-based violence during first visits to antenatal clinics or primary health care centres; insufficient coverage of HIV-positive women in childbirth with cervical cytology in antenatal clinics.

1.2 Social support throughout the PMTCT continuum of services: To develop interventions that integrate medical and social components across the PMTCT continuum of services, involving HIV-serving NGOs and the community of women living with HIV. Identify regions with the highest HIV epidemic burden, in particular Dnipropetrovsk and Odesa oblasts, as priorities for intensive PMTCT interventions when preparing Ukraine's new request to the Global Fund for funding for the TB and HIV/AIDS programme in 2027–2029, taking into account the results of this research. The impact and consequences of war should be a cross-cutting issue in the provision of PMTCT services, in particular, it is important to collaborate with NGOs to dispense and deliver ART in areas with damaged or destroyed health infrastructure, shortages of human resources, and disrupted transport connections.

1.3 Mental health of women living with HIV: To ensure perinatal and maternal mental health management of women living with HIV (which improves maternal well-being and positively impacts child care and development outcomes, whereas maternal depression is associated with adverse outcomes for children). Integrate prevention, screening, assessment and treatment of perinatal depression into HIV prevention and early childhood health and development services.

1.4 Clinical protocols: To submit the proposals of the research participant (paediatric infectious disease specialist) regarding changes in the approach to PNP and pneumocystis pneumonia prophylaxis in HIV-exposed children for mothers with low risk of vertical HIV transmission for consideration by the multidisciplinary working group on the development of a new standard of medical care "Prevention of mother-to-child transmission of HIV, syphilis and viral hepatitis B"[5] (For more details, see the sections "Key findings" or "PMTCT services for the newborns").

1.5 Packaging of paediatric Zidovudine: To ensure the effectiveness and safety of PNP, it is necessary to update the issue of access to the paediatric form of Zidovudine (AZT) at the national level and consolidate efforts to find a solution together with international partners and pharmaceutical companies. To minimise risks, train mothers (parents) on measuring the dose of the ARV drug, always provide written instructions for taking PNP, and develop official protocols for safe dosing of the drug outside the hospital.

1.6 Breastfeeding: To conduct activities to achieve consensus between the community of women living with HIV and the community of health workers involved in the provision of PMTCT services

[5] https://moz.gov.ua/uk/decrees/nakaz-moz-ukrayini-vid-17-10-2025-1589-pro-vnesennya-zmini-do-nakazu-ministerstva-ohoroni-zdorov-ya-ukrayini-vid-18-serpnya-2020-roku-1908

on breastfeeding for women who have achieved viral suppression on ART with appropriate adherence. To ensure the rights of HIV-positive women and effectively implement modern standards of medical care and clinical recommendations on PMTCT, it is necessary to change counselling practices, strengthen the training of health workers, ensure a unified approach to informing about breastfeeding options, and create conditions for regular clinical support for mothers and children who choose to breastfeed.

1.7 Community capacity: To support the capacity and meaningful participation of representatives of the community of women living with HIV in shaping policies and measures to eliminate vertical transmission of HIV, including budgeting, monitoring and evaluation of processes and indicators, at the local and national levels. Dissemination of successful community advocacy experiences (CO "Positive Women Odesa"), in particular, ensuring financing of drugs for lactation suppression in HIV-positive women in labour in Odesa from the local budget (procurement within the framework of the city programme "Health" for 2024–2026).

2. Protecting rights and overcoming discrimination in health care

2.1 Community capacity development: To support and develop a network of paralegals from the women living with HIV community with expertise in PMTCT issues. To conduct ongoing community-led monitoring of the rights of women living with HIV, accessibility and quality of PMTCT services; disseminate and discuss its results with all key stakeholders. To conduct information campaigns and educational activities that improve legal awareness of women living with HIV, including on a peer basis. To ensure meaningful participation of women living with HIV community representatives in assessments of the legal environment, regulatory and legal acts, and advocacy for legislative changes that affect their lives and health. To develop and improve the capacity of women community representatives to hold the government accountable for implementing international obligations and Ukrainian laws; submit alternative (shadow) reports on the implementation of the provisions of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and other UN treaty bodies.

2.2 Policies and training: To implement and monitor anti-discrimination policies in all health facilities involved in PMTCT services. To regularly review cases of violations of the rights of HIV-positive women at meetings of regional TB/HIV and EPMT advisory bodies and ensure appropriate responses. To develop clear, evidence-based and human rights-based guidelines for providing reproductive health and maternity care to women living with HIV, including informed consent, breastfeeding, privacy, pain management, etc. To integrate a respectful approach and training on HIV-related stigmatisation into medical and obstetric care curricula. To conduct regular sessions on patient rights, diversity sensitivity, autonomy, social justice, confidentiality, and access to quality care in in-service training courses. PMTCT programmes and services should clearly recognise the voluntary, fully informed and autonomous decision-making of women living with HIV regarding the care they need during pregnancy and childbirth. The experience of doctors who demonstrate respectful, empathetic and compassionate attitudes should be shared by involving such professionals in training other health workers, young doctors, interns and students. The development and implementation of training modules should be carried out in collaboration with the community of women living with HIV.

2.3 Access to justice: To increase the visibility of the legal needs of women living with HIV to the human rights community; support and develop cooperation between HIV-service NGOs and human rights organisations. To provide financial support for professional legal assistance for women who have experienced obstetric violence and/or discrimination. To educate,

encourage and assist women to file formal written complaints about discriminatory actions by health personnel. To provide women with the opportunity to report violations of their rights without fear of consequences for themselves, their health or the health of their children. To develop community-led interventions for marginalised and vulnerable groups of women to improve their access to PMTCT services, including women living with HIV, women who use drugs, sex workers, women who have experienced violence, displaced women and women living in rural areas. To stop stigmatising women with low ART adherence by instead offering increased social and peer support.

3. Ensuring the financial accessibility of services

3.1 Informing about the Programme of Medical Guarantees: To conduct annual monitoring of the NHSU packages in health care facilities that provide PMTCT services. To constantly inform HIV-positive pregnant women about the opportunities provided by the Programme of Medical Guarantees: regardless of their place of registration or residence, patients have the right to independently choose any medical institution in the country contracted with the NHSU under package No. 7 "Medical assistance during childbirth"[6]; medical care during childbirth is free of charge both when delivered by an emergency medical team (ambulance) and when self-referred. Similarly, all necessary consultations, laboratory and instrumental examinations and medical observation of a pregnant woman from registration to childbirth are free of charge in institutions that have an agreement with the National Health Insurance Fund under package No. 35 "Management of pregnancy in outpatient conditions"[7].

3.2 Responding and supporting the most vulnerable: The problem of financial accessibility of medical services for women living with HIV should be visible to all stakeholders. It is necessary to include in the work plan of regional councils on combating TB/HIV and the RC EMTCT the consideration of cases and complaints about the unlawful demand for payment for medical services, especially in maternity care facilities, where such cases occur most often. To conduct an assessment of the financial accessibility of services during monitoring visits as a component of regional EMTCT Roadmaps. In order to reduce the financial burden on women, the level of financial capacity should be taken into account when planning social support programmes, since lack of funds is the main reason for missing visits to doctors. To strengthen humanitarian support for large and low-income families, as well as teach women to plan for potential costs of pregnancy and childbirth, in particular when drawing up an individual plan for pregnancy and childbirth. To advocate for the expansion of purchases of breast milk substitutes from local budgets, as well as compensate for their shortage through humanitarian programmes. To educate, encourage and assist women to file formal complaints about demands for improper payment for medical services, in particular through the NHSU website, where they can leave questions, comments, suggestions, statements and complaints[8]. To inform women about the features of medical support in private clinics and family doctors-PEs, in particular, about the lack of the possibility of receiving free milk formulas. Advocate for increasing the amount of monthly state assistance to HIV-exposed children before their HIV status is determined and to children living with HIV (CMU resolution as amended from 26.04.2024 No. 463)[9].

3.3 Humanitarian initiatives: To support and develop humanitarian initiatives that facilitate access of women living with HIV to humanitarian assistance to overcome the consequences of war,

[6] https://nszu.gov.ua/gromadianam/bezoplatni-poslugi-v-programi-medicnix-garantii-20-1/prioritetni-stacionarni-poslugi-1/medicna-dopomoga-pri-pologax
[7] https://nszu.gov.ua/gromadianam/bezoplatni-poslugi-v-programi-medicnix-garantii-20-1/ambulatorni-poslugi-1/vedennia-vagitnosti-v-ambulatornix-umovax
[8] https://nszu.gov.ua/gromadianam/onlain-formi/zvorotnii-zviazok-tut-vi-mozete-zalisiti-svoyi-zapi
[9] https://zakon.rada.gov.ua/laws/show/463-2024-%D0%BF#Text

primarily to meet basic and security needs. To include women living with HIV in the list of vulnerable groups in need of humanitarian assistance, ensuring mechanisms for maintaining anonymity and confidentiality. To support effective and inclusive communication with the community of women living with HIV when collecting humanitarian needs and distributing resources.

4. Improving access to services for residents of remote hromadas

4.1 Geographic and administrative accessibility: To expand the network of ART dispensing sites at the primary health care level, in particular in PHC facilities in rural areas. To review and adapt the established ART dispensing schedules in PLHIV health facilities, taking into account the real needs of women from rural hromadas, eliminating situations when a patient arrives during working hours but cannot receive treatment (for example, dispensing is not available on Fridays or in the last week of the month; or dispensing is carried out only before lunch). To ensure sustainable access of pregnant women to medical services in remote hromadas by involving mobile clinics, field medical teams, and organising remote consultations. This approach will minimise security and socio-economic barriers to timely examination and treatment.

4.2 Multidisciplinary approach and psychosocial support: To provide resource support to HIV-service NGOs working in rural areas. For women under medical supervision in the PLHIV health facility in oblast or district centres, the design of psychosocial services should include delivery of ARV drugs by post, as well as coverage of transportation costs for timely virological monitoring during pregnancy, early diagnosis of HIV-exposed children, and visits to specialists (phthisiologist, narcologist, etc.). To support the work of multidisciplinary teams, which may include a social worker, psychologist, and doctor, who travel to remote hromadas to provide medical and social services, including collecting blood samples for early diagnosis in children and providing humanitarian assistance. To encourage the participation of women from remote hromadas in online events organised by the community: training, support groups, individual and group counselling, “Living with HIV” schools, etc. Special attention should be paid to targeted assistance to families with children, particularly those with many children and those in need.

4.3 Cooperation with hromadas: To prioritise women from remote hromadas as a separate target group in PMTCT programme interventions in Dnipropetrovsk and Odesa oblasts, including in Roadmap activities. To develop partnerships with local governments and health care institutions of territorial communities for a comprehensive response to the needs of women living with HIV in remote areas. To regularly invite leaders of local governments and/or leaders of key health care facilities of united territorial communities (UTCs) to meetings of the oblast council to coordinate actions and discuss current issues related to supporting women with HIV in remote hromadas. To pay special attention to ensuring access to infant formula at the expense of local budgets, as well as implementing measures to overcome stigma and discrimination related to HIV.

5. Providing comprehensive support to IDP women

5.1 Continuity of ART: To provide ART for a longer period of time, taking into account the individual needs and life circumstances of women living with HIV during martial law. To provide HIV care and treatment programmes with the necessary resources to organise mail-order delivery of medicines, primarily for IDP women moving to remote hromadas, to ensure continuity of ART.

5.2 Access to medical care: To respond to cases of family doctors refusing to sign a declaration with displaced women; create and regularly update lists of friendly doctors and recommend that IDP

women contact them to sign a declaration. To provide access to information about places to receive medical and social services. To provide for the inclusion of representatives of the migration service in regional advisory bodies on HIV and HIV/AIDS for effective interagency cooperation on document renewal.

5.3 Psychosocial support: To provide comprehensive psychosocial support for HIV-positive IDP women, including: psychological support, adaptation assistance, assistance in restoring documents, registration in a new place, assistance in receiving social benefits, registration as an IDP, finding housing or temporary shelter, humanitarian assistance, as well as support in resolving child care issues (placement in kindergarten or school), support for HIV-exposed and HIV-positive children. To provide additional resource and informational support to NGOs working with HIV-positive IDP women, and promote the activities of support centres in regions with a high flow of resettlement.

5.4 Interregional coordination: To improve interregional coordination and registration of IDPs living with HIV to ensure continuity of care, treatment, and monitoring of PMTCT indicators in the context of ongoing population migration. To ensure targeted transfer of social support for HIV-positive pregnant women and HIV-exposed children between regions (from one NGO to another).

6. Strengthening the coordination system in the field of elimination of vertical transmission of HIV

6.1 Organisational sustainability of regional committees (working groups) during the war period: To form permanent and reserve staff of committees (RC EMTCT), involving representatives of civil society and the community of women living with HIV. To approve official regulations on the format of meetings, provide for a quarterly work schedule and a mechanism for online meetings in case of emergencies. To develop a clear mechanism for information exchange between health care institutions, RC EMTCT and the PHC of MoH for timely reporting. To study funding opportunities and conduct advocacy to ensure the work of the RC EMTCT secretariat, organise meetings and conduct monitoring visits, including institutions in remote communities. Funding can be provided both at the expense of local budgets and resources of international donor organisations, in particular within the framework of Ukraine's new request to the Global Fund for financing the programme to combat tuberculosis and HIV/AIDS in 2027–2029, UN agencies and other partners.

6.2 Inter-sectoral coordination: To integrate the activities of the RC EMTCT into the work plans of the regional TB/HIV coordination councils, as well as relevant working groups or subcommittees. At least twice a year, to hear reports on the achievements and challenges of the PMTCT programme at the regional council, prepared by both government and non-governmental organisations, with an analysis of access to services for women from key and vulnerable groups, in particular IDP women and residents of remote hromadas. To introduce standardised forms of protocols, including algorithms for responding to cases of treatment interruption, untimely Early Infant Diagnosis, violations of patients' rights or social risks caused by the war. To conduct mapping of available resources and medical and non-medical (social) PMTCT services in the region, as well as an assessment of unmet needs. To provide appropriate informational, methodological, technical and financial assistance at the national level to the RC EMTCT through the PHC of MoH; committees on programme issues[10] and regional policy[11] of the National Council on Combating TB and HIV/AIDS, the national working group on the elimination of vertical

[10] https://moz.gov.ua/uk/komitet-z-programnih-pitan
[11] https://moz.gov.ua/uk/komitet-z-regionalnoi-politiki

transmission of HIV, syphilis, and viral hepatitis B and C. To take into account in the work plans of the RC EMTCT the expansion of the activities of the committees to the areas of elimination of mother-to-child transmission of syphilis and viral hepatitis ("triple elimination").

6.3 Monitoring and controlling activities: To conduct a quarterly audit of the implementation of regional Roadmaps, verifying the actual functioning of patient routes, ensuring social support and implementing policies to prevent discrimination. Introduce a system of "key readiness indicators" with a list of clear indicators to assess the organisational, personnel and resource capacity and actual readiness of the RC EMTCT to perform its functions. To use electronic platforms for collecting and automatically aggregating data to ensure prompt access to summarised information and reduce delays in data submission and analysis (module "Prevention of HIV transmission from mother to child" as a component of the information system "Monitoring of socially significant diseases"). To organise regular training on organisational management of the PMTCT programme and response to critical cases for all those directly involved in planning, coordinating and implementing PMTCT activities at the regional level: medical and social workers involved in the provision of PMTCT services, staff responsible for monitoring and data collection, members of the RC of the EMTCT. To conduct monitoring visits at the national level. To provide access to public information on the work of the Regional Coordinating Council for Combating Tuberculosis and HIV/AIDS and the RC of the EMTCT (composition of the council and committee, annual work plans, agendas and minutes of meetings).

7. Adolescent girls living with HIV

7.1 Disclosure of HIV status: To ensure that children receive information about their HIV-positive status before they reach adolescence. To educate and support parents in disclosing their HIV status to their child; special attention is needed for grandmothers-caregivers, who often experience difficulties in this regard. To teach adolescents safe methods of disclosing their HIV status to others. To involve HIV-service NGOs with experience in supporting children, adolescents and their families in this work.

7.2 Psychological support: To strengthen individual psychological work with adolescents who feel fear or discomfort in communicating with doctors, as well as with those who have experienced the loss of relatives or face stigma. To organise individual and group consultations for adolescents aimed at adapting to long-term treatment and overcoming fears. To introduce programmes for exchanging experiences between generations - teenage girls and women living with HIV, as well as actively involve adolescents in the "Living with HIV" school. To support the development of a network of adolescents living with HIV in Ukraine. To ensure access of adolescent girls to professional psychological, psychotherapeutic and psychiatric care.

7.3 Increasing awareness and accountability for ART: To implement educational programmes for adolescents on adherence to ARV treatment, actively involve adolescent girls in the patients' schools. To conduct training activities for relatives and caregivers on communication, motivating adolescents to adhere to the treatment regimen, and encourage the gradual transition of adolescents to self-control over medication, reducing excessive guardianship and control by adults. To develop in adolescents the skills of self-control over medication, understanding the importance of treatment, and responsibility for their own health.

7.4 Improving communication between adolescents and health care professionals: To improve the skills of health workers in empathetic communication with adolescents, focusing on explaining complex concepts in simple language and creating an atmosphere of trust. To provide direct contact between adolescents and doctors to obtain information about treatment and care. To

ensure regular and open communication between adolescents and health workers, including remote consultations for those living in rural areas or with limited mobility due to martial law.

7.5 Raising awareness about SRH and access to services: To fill gaps in adolescents' knowledge about active consent in sexual relations, STI prevention, pre- and post-exposure prophylaxis of HIV, HPV, and accessibility of SRH services, including free contraceptives. To ensure access of adolescent girls living with HIV to the free vaccination programme against HPV infection, which began in Ukraine in early 2026 (Gardasil 9 vaccine). To encourage regular preventive examinations by a gynaecologist, especially for those who have had sexual relations. To maintain an open dialogue about sexual health with family, partners, and health workers.

7.6 Overcoming stigma and discrimination: To ensure the confidentiality of information about a child's HIV status, preventing its disclosure in educational institutions or the community. To conduct information campaigns and educational activities that increase the legal literacy of adolescents living with HIV, including on a peer-to-peer basis. To implement information sessions for adolescents and their families on legal protection, possibilities for judicial and extrajudicial conflict resolution. To inform adolescents about available paralegal and legal services based on HIV service organisations.

RESEARCH FINDINGS

Introduction

Epidemiological situation with HIV infection and PMTCT in Ukraine, Dnipropetrovsk and Odesa oblasts

According to the State Institution "Public Health Centre of the Ministry of Health of Ukraine" (PHC of MoH), as of 01.01.2026, 130,676 people living with HIV were under medical supervision in health care facilities, which is 318.7 per 100,000 population. The **highest HIV prevalence rates**, as in previous periods, remain in **Dnipropetrovsk** (901.2) and **Odesa** (773.4) oblasts[12].

In 2025, 8,024 new cases of HIV infection were officially registered (19.6 per 100,000 population). The highest incidence rates were recorded in Dnipropetrovsk (46.4) and Odesa (45.6) oblasts. At the same time, the incidence rate of HIV infection decreased by 20% in the country compared to 2024, in particular in **Dnipropetrovsk oblast** – by 30%, in **Odesa oblast** – by 23%.

The South-Eastern regions, Kyiv oblast and Kyiv city remain areas of epidemiological tension, where about 70% of people living with HIV (PLHIV) live. Monitoring of internally displaced persons (IDPs) shows that every third HIV-positive person (36%) arrived from other regions to **Dnipropetrovsk oblast**, 14% - to **Odesa oblast**.

In Ukraine, HIV testing coverage among pregnant women has remained consistently high (>95%) since 2001, when the state-run Prevention of Mother-to-Child Transmission of HIV (PMTCT) programme was launched. The total **number of pregnant women** living with HIV **has been decreasing** annually, from 2,203 in 2019 to 914 in 2025, with a third of them (32%) living in **Dnipropetrovsk** and **Odesa** oblasts. Epidemiological monitoring data confirm high (≥1%) HIV prevalence among pregnant women in seven regions of Ukraine: Kherson (2%), Odesa (1.5%), Donetsk, Mykolaiv (1.3%), Dnipropetrovsk (1.2%), Kirovohrad and Chernihiv (1.1%) oblasts[13].

As of 01.01.2026, **5019 children** born to HIV-positive women **were under medical supervision** in Ukraine, of which 2574 children have a confirmed HIV-positive status, and 2445 children remain with an unspecified HIV status (HIV-exposed children). **The largest share** of HIV-positive (43%) and HIV-exposed (32%) children registered **is concentrated in Dnipropetrovsk and Odesa oblasts**. Such data are critically important for predicting the burden on the PMTCT programme in these regions, in particular regarding the needs for testing, treatment and further medical and social support of children and their immediate environment.

Ukraine continues to demonstrate sustained progress in eliminating mother-to-child transmission of HIV and maintains key PMTCT monitoring and evaluation indicators at a high level[14], despite significant challenges posed by the full-scale war (see Table 1).

[12] https://phc.org.ua/sites/default/files/users/user161/hiv_aids_statistics_operinfo_2025.12_0.pdf
[13] https://phc.org.ua/sites/default/files/users/user161/Site_Buleten_56_fin.pdf
[14] Operational data of the PHC of MoH based on regional reports on the implementation of measures of the regional Roadmap for the elimination of mother-to-child transmission of HIV infection

Table 1. Indicators of monitoring measures to prevent vertical transmission of HIV in Ukraine

Indicators	2022	2023	2024	2025
Number of HIV-positive pregnant women	1416	1232	1083	914
Number of births in HIV-positive pregnant women	1410	1216	1122	914
Number of HIV-exposed children (live births)	1423	1226	1125	922
ART coverage of pregnant women	94,4%	97,3%	97,3%	97,4%
Coverage of pregnant women with prenatal screening (34-36 weeks of pregnancy)	88,3%	95,0%	92,8%	92,5%
Coverage of HIV-exposed children with PNP	98,5%	99,4%	98,7%	98,9%
Coverage of HIV-exposed children with HIV Early Infant Diagnosis (EID) (PCR for NA detection)	91,6%	98,2%	99,0%	99,2%
Coverage of HIV-exposed children with cotrimoxazole prophylaxis	86,3%	94,3%	91,9%	93,8%
Coverage of HIV-exposed children with formula feeding	99,1%	99,5%	99,6%	99,2%
Number of HIV-positive children according to HIV Early Infant Diagnosis (EID) (PCR for NA detection)	21	18	6	14
Frequency of mother-to-child HIV transmission according to HIV Early Infant Diagnosis (EID)	1,6%	1,5%	0,5%	1,5%

During 2022–2025, among HIV-positive pregnant women, almost 75% of women were under medical supervision for HIV before pregnancy; about 13% of women **belong to key groups**, mainly sexual partners of people living with HIV; more than 40% of HIV-positive pregnant women are **residents of rural areas and small towns**. At the same time, there is a decrease in the share of women whose HIV-positive status was first-time established during pregnancy — from 34.5% in 2022 to 24.1% in 2025, including during childbirth or after childbirth — from 11.3% to 4.7%, respectively.

A positive trend is the increase in the proportion of women who continued antiretroviral therapy (ART) after childbirth, from 93.0% in 2022 to 97.4% in 2025. At the same time, despite the generally high level of ART coverage among pregnant women living with HIV, **166 pregnant women did not receive ART during the war**, of whom **42% lived in Dnipropetrovsk and Odesa oblasts and the city of Kyiv**. The main **reasons for not receiving ART during pregnancy** were the lack of women being registered at antenatal clinics, refusal of treatment, low adherence to ART and self-discontinuation of medication, as well as factors related to security and access to medical services, in particular the remoteness of the place of residence and the risks of shelling.

The vast majority of children born to women living with HIV in Ukraine during 2022–2025 were covered by key measures for the prevention and diagnosis of HIV infection in accordance with national standards of medical care. In 2025, 915 newborns (99.2%) underwent HIV Early Infant Diagnosis and were on formula feeding, 912 children (98.9%) received post-natal prophylaxis. As of 01.01.2026, 784 (85.5%) HIV-exposed children **were provided with milk formulas** at the expense of the local budget and humanitarian/charitable assistance.

The frequency of mother-to-child transmission of HIV (MTCT) **in Ukraine** in 2018 reached the WHO global target (≤2%) and during the war period ranged from 0.5% to 1.6%, with an average value of 1.3%. During 2022–2025, according to the HIV Early Infant Diagnosis data, no cases of HIV infection were registered among HIV-exposed children in five regions of Ukraine: Volyn, Kyiv, Rivne, Ternopil and Chernivtsi oblasts. At the same time, in other regions during the full-scale war, a total of 59 HIV-positive children were registered, of which 13 (22%) were born in **Dnipropetrovsk oblast**, 10 (17%) — in **Odesa oblast** and 7 (12%) — in the city of Kyiv.

As of 01.01.2026, according to the results of cohort monitoring, 213 children over 18 months of age born in 2022 and 183 children born in 2023 remained untested for HIV. The main reasons for this were the refusal of parents to have their child tested, as well as the lack of up-to-date information about their place of residence. The largest number of such cases was recorded in Dnipropetrovsk and Odesa oblasts and the city of Kyiv, which indicates insufficient coverage of serological testing of children aged 18 months and older to establish the final HIV status in these regions.

According to the PHC of MoH, during 2022–2025, 240 HIV-positive children under the age of 18 were identified in Ukraine due to epidemiological or clinical indications after birth, mainly among children born to women living with HIV. Almost half of such cases (47.8%) were registered in Dnipropetrovsk, Kyiv, Odesa oblasts and the city of Kyiv, which indicates the presence of missed cases of vertical transmission in previous years.

As of 01.01.2026, 1,145 children aged 0–14 years living with HIV were under medical supervision, of whom 1,058 (92.4%) were receiving ART, as well as 597 adolescents aged 15–17 years, of whom 538 (90.1%) were covered by ART. At the same time, every third child aged 0–18 years living with HIV lives in Dnipropetrovsk and Odesa oblasts.

Dnipropetrovsk oblast

As of 01.01.2026, 237 children aged 0–14 years living with HIV were under medical supervision in Dnipropetrovsk oblast, of whom 206 (86.9%) were receiving antiretroviral treatment, as well as 109 adolescents aged 15–17 years, of whom 92 (84.4%) were covered by ART. Losses in the treatment continuum of children and adolescents living with HIV are primarily associated with changes in place of residence and loss of contact with the medical system, as well as insufficient level of social support and psychosocial support, especially for adolescents. The ratio of HIV-positive boys and girls aged 0–17 years inclusive is 1:1 (50% and 50%).

Children and adolescents living with HIV are mainly under medical supervision in the Dnipropetrovsk Oblast Centre for Socially Significant Diseases (45.5%), as well as in health care facilities in the cities of Dnipro and Kryvyi Rih (50.0%). The remaining children receive medical care in health care facilities in district-level cities - the cities of Kamianske, Nikopol, Pavlohrad, Ternivka, Zhovti Vody, Marhanets, as well as in facilities in the Kryvyi Rih and Nikopol districts.

As of the end of 2025, 137 (97.9%) HIV-exposed children under 12 months of age in Dnipropetrovsk oblast were provided with adapted milk formulas. Of these, 130 children received formulas at the expense of the local budget, 7 — at the expense of humanitarian aid, another 3 — at the expense of their parents; 3 children left the oblast for this period.

The number of mothers who received monthly state assistance for HIV-exposed children and children living with HIV (in accordance with the Resolution of the Cabinet of Ministers of Ukraine No. 463 as amended dated 26.04.2024) at the end of 2024 was 445 people, and as of October 1, 2025 — 373 people.

Odesa oblast

As of 01.01.2026, 160 children aged 0–14 years living with HIV were under medical supervision in the Odesa oblast, of whom 154 (96.2%) were receiving antiretroviral treatment, as well as 78 adolescents aged 15–17 years, of whom 76 (97.4%) were covered by ART. Some children experienced short-term interruptions in treatment due to temporary evacuation with their parents or children from orphanages and boarding schools staying outside the country.

The majority of children and adolescents living with HIV (about 60%) live in district-level settlements, 30% in Odesa, the rest in cities of district significance: Bilhorod-Dnistrovskyi, Izmail, Chornomorsk, Pivdenne, Teplodar, Podilsk. The ratio of HIV-positive boys to girls is 1:1.2 (45% and 55%).

As of the end of 2025, 151 HIV-exposed children under 12 months of age (100%) in the Odesa oblast were provided with adopted milk formulas; 50 children received adopted milk formulas from the local budget, 2 — from humanitarian aid, 99 — from their own funds and other sources of financing. The number of mothers receiving monthly state assistance for HIV-exposed children and children living with HIV at the end of 2024 was 414 people, and as of 01.10.2025 — 371 people.

Availability and accessibility of services

Resource availability

Regulatory and legal framework for PMTCT issues

State guarantees of ensuring free access to services for the prevention of mother-to-child transmission of HIV, with the aim of reducing to zero (elimination) vertical transmission of HIV in Ukraine, are enshrined in the Law of Ukraine "On Combating the Spread of Diseases Caused by the Human Immunodeficiency Virus (HIV) and Legal and Social Protection of People Living with HIV".

In order to implement the above-mentioned state guarantees, PMTCT services are integrated into a number of packages of the **Programme of Medical Guarantees**, which ensures continuity of medical care for women and children at all stages – from planning and managing pregnancy to childbirth and the postpartum period:

- **Diagnosis, treatment and support of people living with HIV (and people suspected of having HIV)** – testing, antiretroviral therapy, medical and social support.
- **Outpatient prevention, diagnosis, monitoring, and treatment** – HIV testing, medical care, and pregnancy management.
- **Inpatient care for adults and children without surgical operations** – providing medical care to pregnant women with complicated pregnancies and extragenital pathologies, including HIV testing.
- **Primary medical care** – observation of a woman with an uncomplicated pregnancy, pregnancy diagnostics and HIV testing (including rapid tests), if necessary – referral to an obstetrician-gynaecologist.
- **Outpatient pregnancy management** – HIV testing, referral of the pregnant woman to a multidisciplinary consultation to agree on a plan for pregnancy and childbirth management in high-risk women, preparation for childbirth with the provision of informational and psychological support.
- **Medical care during childbirth** – testing for HIV and syphilis, collecting and examining dried blood spot (DBS) samples from children born to HIV-positive women, provision of post-natal prophylaxis for newborns, counselling on breastfeeding and postpartum contraception, provision of planned caesarean section in health care facilities of levels II–III of perinatal care.
- **Medical care for newborns in complex neonatal cases** – collection of DBS, provision of post-natal prophylaxis, support and promotion of breastfeeding, including the use of specialised foods for children with special needs.
- **Medical rehabilitation of premature and/or sick infants during the first three years of life** – conducting additional laboratory tests in accordance with industry standards in the field of health care.

Regulatory changes in the field of PMTCT in Ukraine (2019–2025)

In recent years, Ukraine has undergone significant regulatory changes in the field of combating HIV infection, in particular regarding the prevention of mother-to-child transmission of HIV, which have formed modern approaches and comprehensive measures aimed at preventing cases of vertical transmission of HIV, in particular:

- **Updated approaches to HIV prevention, testing and treatment with enhanced guarantees of access of pregnant women, women in childbirth and children to free medical services, which creates a legal basis for PMTCT at all levels of care provision:** Law of Ukraine "On Combating the Spread of Diseases Caused by the Human Immunodeficiency Virus (HIV) and Legal and

Social Protection of People Living with HIV" dated 12.12.1991 No. 1972-XII as amended on January 12, 2023 No. 2869-IX[15] .

- **For the first time, the course for the elimination of PMTCT has been established at the strategic level as one of the key goals of the state policy in the field of HIV:** Order of the Cabinet of Ministers of Ukraine dated 27.11.2019 No. 1415-r. "On approval of the State Strategy for combating HIV/AIDS, tuberculosis and viral hepatitis for the period until 2030"[16] .
- **PMTCT measures have been specified, in particular, the integration of HIV testing into PMTCT, intersectoral interaction and monitoring of elimination results:** Order of the Cabinet of Ministers of Ukraine dated 18.06.2024 No. 564-r "On approval of the operational plan of measures for the implementation in 2024-2026 of the State Strategy for combating HIV/AIDS, tuberculosis and viral hepatitis for the period until 2030"[17].
- **A mechanism for monthly state assistance to HIV-exposed children has been introduced, which strengthens the social component of PMTCT and the continuity of medical supervision from birth:** Resolution of the Cabinet of Ministers of Ukraine dated 26.04.2024 No. 463 "Some issues of payment of monthly state assistance to HIV-exposed children before their HIV status is established and to children living with HIV"[18].
- **The quality system for laboratory diagnostics of HIV has been improved, which is critical for early detection of HIV in pregnant women and infants and timely initiation of PMTCT measures:** Order of the Ministry of Health of 05.04.2019 No. 794 "On improving the quality management system for laboratory tests in the field of combating HIV infection/AIDS", registered with the Ministry of Justice of Ukraine on 01.07.2019 under No. 698/33669 (as amended on 31.12.2021)[19].
- **Changes have been made for women living with HIV regarding the possibility of receiving assisted reproductive technology services for budget funds in the event of an undetectable viral load:** Order of the Ministry of Health of 22.04.2019 No. 933 "On Amendments to Appendix 1 to the Procedure for Referring Women for the First Course of Infertility Treatment with Assisted Reproductive Technologies for Absolute Indications for Budget Funds"[20] .
- **Organisational measures to eliminate PMTCT have been identified, with an emphasis on coordinating PMTCT measures at the regional level:** Order of the Ministry of Health of 6.09.2021 No. 1887 "On organising the implementation of measures to eliminate mother-to-child transmission of HIV infection"[21].
- **Clinical guidelines and standards of medical care for PMTCT have been approved, which establish modern evidence-based approaches to the management of HIV-positive pregnant women and newborns:** Order of the Ministry of Health of Ukraine dated 26.04.2022 No. 692 "On approval of the evidence-based clinical guideline "Prevention of HIV transmission from mother to child" and standards of medical care "Prevention of HIV transmission from mother to child"[22].
- **Approaches to HIV treatment have been unified and PMTCT has been integrated into the continuous medical care pathway:** Order of the Ministry of Health of Ukraine dated 16.11.2022 No. 2092 "On approval of the Standards of Medical Care "HIV Infection"" (as amended on 15.08.2023), which became invalid due to the approval by Order of the Ministry

[15] https://zakon.rada.gov.ua/laws/show/1972-12#Text
[16] https://zakon.rada.gov.ua/laws/show/1415-2019-p#Text
[17] https://zakon.rada.gov.ua/laws/show/564-2024-%D1%80#Text
[18] https://zakon.rada.gov.ua/laws/show/463-2024-n#Text
[19] https://zakon.rada.gov.ua/laws/show/z0698-19#Text
[20] https://zakon.rada.gov.ua/laws/show/z0506-19#Text
[21] https://moz.gov.ua/uk/decrees/nakaz-moz-ukraini-vid-06092021--1887-pro-organizaciju-vikonannja-zahodiv-z-eliminacii-peredachi-vil-infekcii-vid-materi-do-ditini
[22] https://www.dec.gov.ua/mtd/profilaktyka-peredachi-vil-vid-materi-do-dytyny/

of Health of Ukraine dated 03.06.2025 No. 916 of the updated adoption of the Standard of Medical Care "HIV Infection"[23].

- **The list of key groups for HIV infection has been updated, which affects approaches to testing women of reproductive age within the framework of PMTCT:** Order of the Ministry of Health of 15.09.2023 No. 1632 "On Approval of the List of Key Groups for HIV Infection and Criteria for Their Determination", registered with the Ministry of Justice of Ukraine on 16.10.2023 under No. 1804/40860[24].
- **The procedure for assigning and paying assistance to HIV-exposed children has been regulated, which complements medical PMTCT measures with social support:** Order of the Ministry of Health of Ukraine dated 07.06.2024 No. 994 "On approval of the form of the Application for the assignment and payment of monthly state assistance to HIV-exposed children before their HIV status is established and to children living with HIV"[25].

At the same time, there is an urgent **need to improve and harmonise** other regulatory and legal frameworks that affect the effectiveness of PMTCT measures, as they are outdated, do not take into account modern organisational, medical, social and financial aspects of the health care system, or are absent altogether:

- Order of the Ministry of Health of Ukraine, the Ministry of Education and Science of Ukraine, the Ministry of Family, Youth and Sports of Ukraine, the State Department of Ukraine for the Execution of Sentences, the Ministry of Labour and Social Policy of Ukraine dated 23.11.2007 No. 740/1030/4154/321/614a "On measures to organise the prevention of HIV transmission from mother to child, medical care and social support for HIV-infected children and their families";
- Order of the Ministry of Health of Ukraine dated 21.01.2014 No. 59 "On approval of the Unified Clinical Protocol for primary, secondary (specialised), tertiary (highly specialised) medical care "Family Planning"";
- Order of the Ministry of Health of Ukraine dated 09.08.2022 No. 1437 "On Approval of the Standards of Medical Care "Normal Pregnancy"";
- There is no order of the Ministry of Health of Ukraine on the organisation of obstetric and gynaecological care due to the loss of validity in 2023 of the order of the Ministry of Health of Ukraine dated 15.07.2001 No. 417 "On the organisation of outpatient obstetric and gynaecological care in Ukraine";
- It is necessary to finalise and formally consolidate all key prevention and treatment measures in the packages of the Programme of Medical Guarantees (NHSU), namely antiretroviral therapy for women in whom HIV was detected during childbirth, drugs to stop lactation in women with HIV, index testing of pregnant women, ensuring pre-exposure prophylaxis for pregnant women and their sexual partners from serodiscordant couples, etc.

The multidisciplinary working group for the development of Medical Care Standards "Prevention of Mother-to-Child Transmission of HIV", approved by Order of the Ministry of Health of Ukraine No. 1589 of 17.10.2025, has begun work on the preparation of a national document that will ensure the **prevention of vertical transmission of three infections**, namely the Medical Care Standard "Prevention of Mother-to-Child Transmission of HIV, Syphilis, and Hepatitis B".

From 01.01.2026, **an updated Preventive Vaccination Calendar came into effect** in Ukraine, which includes mandatory vaccination against 11 infectious diseases: tuberculosis, viral hepatitis B, measles, mumps, rubella, polio, diphtheria, tetanus, whooping cough, Hib infection, and **human papillomavirus (HPV)**. Medical Procurement of Ukraine (MPU), at the request of the MoH, concluded a contract for the purchase of a 9-valent vaccine against human papillomavirus, taking into account changes in the

[23] https://moz.gov.ua/uk/decrees/nakaz-moz-ukraini-vid-16112022--2092-pro-zatverdzhennja-standartiv-medichnoi-dopomogi-vil-infekcija
[24] https://zakon.rada.gov.ua/laws/show/z1804-23#Text
[25] https://zakon.rada.gov.ua/laws/show/z0939-24#Text

national Preventive Vaccination Calendar (Order of the Ministry of Health No. 396 dated 05.03.2025 "On Approval of Amendments to Chapters 1, 2 of Section II of the Preventive Vaccination Calendar in Ukraine"[26]). Free vaccination against HPV infection according to a single-dose regimen is provided for girls aged 12-13 years. The purchased vaccine "Gardasil 9" is manufactured by the American company Merck Sharp & Dohme (MSD). The MPU concluded a managed access agreement (MAA) with the manufacturer for two years.

The 9-valent vaccine against HPV infection provides protection against nine types of the virus: 6, 11, 16, 18, 31, 33, 45, 52, 58. Including two types of HPV with high oncogenic risk - 16 and 18, which, according to WHO[27], account for about 70% of cervical cancer. In Dnipropetrovsk and Odesa oblasts [28], as well as throughout Ukraine, free vaccination of girls 12–13 years old against HPV for the prevention of cervical cancer has been launched. Vaccination is carried out in children's clinics and primary health care centres at the place of residence.

Human resources

Qualitative component

In-depth interviews with 7 people in management positions

In general, the shortage of personnel in the field of providing medical care to HIV-positive women and children remains an urgent problem that requires an immediate solution to ensure high-quality and continuous medical care. As a result of demographic changes, migration and war, the number of women giving birth has significantly decreased, which reduces the burden on medical institutions, but does not solve the problem of the shortage of specialists. Based on the information provided on the availability of specialists in the field of providing medical services to HIV-positive women during pregnancy, childbirth, the postpartum period and HIV-exposed children in Dnipropetrovsk and Odesa oblasts, the following generalisations can be made:

Dnipropetrovsk oblast

In Dnipropetrovsk oblast, there is an acute **shortage of specialists** in AIDS service institutions, especially **paediatricians, infectious disease** specialists, and gynaecologists. Only a few doctors work in city and district centres, and some institutions are completely left without specialists due to staff rotation, layoffs, and the consequences of the war (*"There is an issue with specialised doctors, paediatricians, infectious disease specialists, specifically in the service institutions. Yes, there are very few of them, we have three per oblast. We (Dnipropetrovsk Oblast Medical Centre for Socially Significant Diseases), in the city (Dnipro), in Kryvyi Rih, I don't know now whether there are still working in Nikopol or not, because everything is changing every day now. There are few of them, there are very few of these doctors. There are also very few gynaecologists, if we talk directly about the AIDS service institutions. We don't have any, we had a gynaecologist, she left when the war started. There was a gynaecologist in the city (Dnipro) and there is a gynaecologist in our branch in Kryvyi Rih"*). In the city of Kryvyi Rih, there is **a shortage of neonatologists, family doctors, and obstetricians-gynaecologists**, which leads to vacant positions in medical institutions and an additional burden on existing specialists (*"We don't have enough staff at all. We have a shortage of staff in the city. Neonatologists, family doctors at the level of PHC facilities. And we also have vacancies for obstetricians and gynaecologists"*).

[26] https://zakon.rada.gov.ua/laws/show/z0443-25#Text
[27] https://www.who.int/teams/health-product-policy-and-standards/standards-and-specifications/norms-and-standards/vaccine-standardization/human-papillomavirus
[28] https://od.cdc.gov.ua/news/3774/

Odesa oblast

In recent years, the Odesa oblast has maintained a sufficient level of provision of infectious disease doctors and obstetricians-gynaecologists who have undergone appropriate training (*"I can say that, probably, there are enough of them. We have enough institutions, in principle, for all. We have practically no change in doctors"*). However, due to the health care reform and migration of personnel, the number of infectious disease doctors has decreased somewhat, but there are still enough of them for the needs of the region (*"There are enough specialists, there are enough infectious disease doctors. Their number has decreased a little in the oblast after the health care reform was carried out. Some hospitals have increased in size, others have closed, so the number has decreased. But, as far as I communicate with all the infectious disease doctors in the oblast, I know that there are enough of them in general"*). The greatest **staff shortage** is observed among **paediatricians and neonatologists**, which is partly due to the closure of the relevant faculty at the medical university and the lack of young specialists (*"We don't have many specialists like paediatricians. Perhaps the reason is that our medical university closed the faculty, now the university is working to restore it. We will have a paediatric faculty again. And the problem, as far as I know, is with neonatologists. This is a problem, it is common, perhaps in the whole country. It is a very difficult specialty").* Separately, the personnel shortage at the level of the city of Odesa was noted, caused by migration, the age of employees, and the war situation *("We now have a personnel shortage, because some people have left, some people have already finished their work due to age, some have joined the Armed Forces of Ukraine. But the number of women has also decreased"*).

Financial resources

Global instability and the reallocation of funding to address simultaneous global crises have led to a reduction in external support for the health system in Ukraine, limiting the ability to provide critical health interventions and services. PEPFAR's new 2025 strategy, "America First Global Health Strategy"[29] prioritises cooperation with the most affected countries, focuses on global HIV goals, partnerships, and building resilient health systems, with an emphasis on national ownership to achieve and support the global goal of ending AIDS as a public health threat.

Financing of health care institutions providing PMTCT services is carried out mainly through the National Health Service of Ukraine within the framework of the Programme of Medical Guarantees. Additional sources of financing are funds from the state budget, in particular for centralised purchases of antiretroviral drugs and medical products, as well as for the payment of monthly state assistance to HIV-exposed children until their HIV status is established and to children living with HIV. In addition, financing can be attracted from local budgets and international technical assistance. The institutions' own revenues are formed, in particular, at the expense of paid services (for example, improved conditions of stay in maternity wards, etc.).

Since the beginning of the full-scale war, public funding has not been sufficient to fully cover the needs for ART and HIV diagnostics, and therefore some ARV drugs and test kits have been additionally provided with the support of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF) and PEPFAR.

According to the PHC of MoH, as of 01.01.2026, 115,650 people living with HIV in Ukraine are receiving antiretroviral therapy, of whom 95,016 people (82.2%) are provided with treatment at the expense of the state budget, and 20,634 people (17.8%) are provided with treatment within the framework of international technical assistance programmes (GF, PEPFAR). HIV Early Infant Diagnosis is also fully carried out at the expense of the state budget, which indicates a gradual restoration and strengthening of the state's financial capacity in this area.

[29] https://www.state.gov/america-first-global-health-strategy?utm_sourc

To strengthen PMTCT measures, it is important to coordinate budgets between all sources of funding during the development and approval of the next round of the operational plan of the State Strategy to Combat HIV/AIDS, Tuberculosis and Viral Hepatitis until 2030. This should take into account the review of financing of medical service packages provided to health care institutions under the programme of state guarantees of medical care for the population, the possibilities of state financing of HIV prevention, as well as support for international projects and organisations that may be involved in the process of validating the PMTCT in Ukraine. The implementation and strengthening of the PMTCT programme should be carried out in accordance with the Health System Restoration Plan[30], which provides for the phased implementation of measures to develop the health care system in a new format ensuring the quality and accessibility of medical services.

Information systems

In order to automate the collection of statistical data, in 2018, with the support of UNICEF, the first medical information system "Prevention of HIV Transmission from Mother to Child" (BabyMIS) was developed and implemented in 25 regions in Ukraine, which ensured the **entry, storage and exchange, including retrospective, of data on HIV-positive pregnant women and children** born to HIV-positive mothers, with the possibility of their correction and addition at a convenient time.

A training course on using the BabyMIS system was also developed and posted on the online platform of the PHC of MoH. At the same time, the implementation of BabyMIS was limited to the oblast level of health care institutions and did not provide for the expansion of the network of users at the local level, which made it difficult to enter and receive data in a timely manner. In addition, the system operated autonomously and was not integrated with the information system "Monitoring of Socially Significant Diseases" (IS SSD), which led to duplication of data on HIV-positive pregnant women and children in two information systems.

In order to ensure a centralised approach to collecting, processing, and analysing PMTCT data, with the support of the US President's Emergency Initiative for HIV/AIDS Relief (PEPFAR), the "Prevention of Mother-to-Child Transmission of HIV" module was developed in 2023–2024 as a component of the IS SSD (IS PMTCT).

In the first half of 2025, in accordance with the Order of the MoH dated 19.02.2025 No. 286, a pilot operation of the IS PMTCT was carried out, as a result of which, from 15.07.2025, its industrial version was implemented for all health care institutions that provide medical supervision for HIV-positive people and have access to the IS SSD. The IS PMTCT operates according to a three-level access hierarchy (national, regional and local levels) and ensures automation of the processes of collecting, storing and processing PMTCT data, increasing the completeness, reliability and efficiency of information, reducing the number of errors and preventing data duplication. Access to individual IS PMTCT data is provided at the local and regional levels, while at the national level, only aggregated information is used.

[30] https://www.kmu.gov.ua/news/uriad-predstavyv-proekt-planu-vidnovlennia-systemy-okhorony-zdorovia

Geographic and administrative accessibility

Quantitative component

Survey of 100 women living with HIV with experience of pregnancy and childbirth

The most **geographically accessible** HIV and PMTCT specialists for the survey participants are **a family doctor (or paediatrician)** in primary health care (36% - very close, 48% - not far away) and **an obstetrician-gynaecologist** in the antenatal care department (**antenatal clinic**) (33% - very close, 45% - not far away).

The most **geographically remote** are **an obstetrician-gynaecologist and neonatologist** of the maternity ward (maternity hospital) (30% - far to travel) and an infectious disease specialist **(or paediatric infectious disease specialist)** providing medical care to people/children living with HIV (40% - far to travel).

The vast majority have **no complaints on the time and schedule** of specialists/staff appointments, testing, or dispensing PEP or ART in medical facilities that provide HIV and PMTCT services ("The time or schedule is convenient"): Family doctor (or paediatrician) of primary health care (91%), Obstetrician-gynaecologist of the antenatal care department (antenatal clinic) (92%), Infectious disease specialist (or paediatric infectious disease specialist) providing medical care to people/children living with HIV (91%). At the same time, every tenth person in Dnipropetrovsk oblast considers the working hours of specialists of **PHC facilities** (5 out of 50) and **PLHIV health facilities** (5 out of 50) **to be inconvenient**.

Qualitative component

In-depth interviews with 8 mothers of HIV-exposed and HIV-positive children

Dnipropetrovsk oblast

Two mothers noted that **it is not far and convenient for them to get to the facility where the child is constantly monitored** (*"Four tram stops", "15-20 minutes by public transport. Yes, convenient"*). At the same time, two other respondents noted that **it is far, inconvenient or expensive for them to get** to the medical facility *("An hour to go (by public transport), or even more if you go by trolleybuses and then by tram, because there is not always money. And if by minibuses, then 40-50 minutes… It is not convenient, I called a taxi when necessary", "Kanatna Str. is far from me. I take a taxi; I pay 500 hryvnias"*). All mothers have **no complaints on the time and schedule** of receiving specialists, conducting tests, and issuing ART (*"Everything suits me. They are generally good", "Everything is good here for us"*).

Odesa oblast

Three mothers noted that **it is not far and convenient for them to get to the facility where the child is constantly monitored** (*"Nearby, within two districts. 10 minutes on foot", "family doctor is 500 meters away. "Dovira" office is 7 km away, if not by car, then we drive 20 minutes", "200 meters to walk. 5-7 minutes on foot. Both "Dovira" office and family doctor, it's all here near us"*). One mother noted that **it is far and inconvenient for her to get to** the medical facility where the child is monitored by a paediatric infectious disease specialist (Odesa) (*"An hour, for sure. It's not convenient. I don't like it. It's so problematic for me to use public transport with him in a stroller").* All mothers have **no complaints on the time and schedule** of specialist appointments, tests, or the issuance of PNP or ART (*"Everything is convenient", "The schedule works fine for me", "No complaints"*).

Focus group discussions with 16 community service providers and activists

Dnipropetrovsk oblast

Community activists gave examples of **inconvenient days of the week and times of ART dispensing for patients**: only until the 25th of each month, only from 08:00 to 13:00, ARV drugs are not dispensed on Fridays (*"The ARV drug dispensing schedules are not for the whole month. In AIDS centres - during the first 3 weeks until the 25th. From the 26th to the 31st, it is impossible to get the treatment. And this is not very convenient. There are also complaints that the treatment can be obtained from 8 am to 1 pm, I think, until 1 pm. After this time, the woman will not be able to get the treatment or if she does get it, she will be questioned for not showing up on time", "They also do not dispense treatment on Fridays. That is, they do not dispense it from the 25th to the 31st and for a limited time. Fridays of each week are also excluded"*).

Financial accessibility

Qualitative component

Survey of 100 women living with HIV with experience of pregnancy and childbirth

The majority of respondents **live in poverty**. 44% of respondents indicated that their household income is not quite enough to meet daily needs, and in case of 34% - not enough at all. Usually enough - 10%, mostly enough - 6%, completely enough - only 4%.

42% **had to pay for medical services** in a municipal institution, in particular:

- During pregnancy (39%: 10 – Dnipropetrovsk oblast, 29 – Odesa oblast)
- During childbirth (34%: 7 – Dnipropetrovsk oblast, 23 – Odesa oblast)
- In the postpartum period (21%: 6 – Dnipropetrovsk oblast, 13 – Odesa oblast)
- While caring for an HIV-exposed child (8%: 3 – Dnipropetrovsk oblast, 4 – Odesa oblast).

The situation varies significantly at the oblast level. Respondents from Dnipropetrovsk oblast reported paying 2.5 times less for medical services than in Odesa oblast (12 – Dnipropetrovsk oblast, 30 – Odesa oblast). Maternity hospitals in Odesa were mentioned most often, in particular the Odesa Oblast Perinatal Centre.

The vast majority have **financial access** to key HIV and PMTCT specialists **or sometimes have access** to them: Family doctor (or paediatrician) in primary health care (89%), Obstetrician-gynaecologist in the antenatal care department (antenatal clinic) (85%), Obstetrician-gynaecologist and neonatologist in the maternity care department (maternity hospital) (83%), Infectious disease specialist (or paediatric infectious disease specialist) providing medical care to people/children living with HIV (86%). Most often, this access concerns **PHC facilities** and **antenatal clinics** (57%). At the same time, every fifth respondent in the Odesa oblast **have no financial access** to **antenatal clinic** specialists (10 out of 50).

Financial insolvency ranks first among **the reasons for missing doctor visits** (17 out of 39 respondents who missed visits prescribed by a doctor: 9 – Dnipropetrovsk oblast, 8 – Odesa oblast). The vast majority of mothers surveyed **had to purchase milk formulas** for their child on their own (90%), and only one in ten did not have to (7 – Dnipropetrovsk oblast, 2 – Odesa oblast). Almost every third respondent confirmed her **financial dependence on a partner or husband** to pay for transportation to an institution or specialist for HIV and PMTCT (30%) or more than a third among women who have a partner or husband (30 out of 84).

Qualitative component

In-depth interviews with 8 mothers of HIV-exposed and HIV-positive children

Dnipropetrovsk oblast

When asked **"Did you have to pay for medical services?"** all mothers answered "No". However, one woman answered with a remark about her own choice of choosing a paid ward and paying for an anaesthesiologist (Maternity Department of City Clinical Hospital No. 9, Dnipro) (*"My husband and I decided that we wanted to be in a paid ward. This is purely our personal choice. And we paid the anaesthesiologist, because I had very low haemoglobin, I had health problems. And we paid the anaesthesiologist, let me say, 1200. They asked us if we could afford it? We said we could. By force, no way. When I went to the hospital, they told me everything was free for you"*). **No mother received infant formula** from a health care facility **at the expense of the local budget**. Two respondents received infant formula from paediatric infectious disease doctors as **humanitarian aid** (City AIDS Centre, Dnipropetrovsk Oblast Medical Centre for Socially Significant Diseases). **All mothers had to purchase infant formula on their own**. One mother constantly turns to charitable organisations for help. Two mothers noted that it was **far, inconvenient, or expensive** for them to get to the medical facility where the child was constantly monitored (*"It takes an hour to get there (by public transport), or even more if you go by trolleybuses and then by tram, because there is not always enough money. And if you take minibuses, then 40-50 minutes… It is not convenient, I called a taxi when necessary", "Kanatna Str. is far from me. I take a taxi; I pay 500 hryvnias"*).

Odesa oblast

When asked **"Did you have to pay for medical services?"** three mothers answered "No". At the same time, one woman answered that in the Odesa Oblast Perinatal Centre she **had to pay** for syringes, formula for the baby, syrups that the doctor prescribed due to the fact that the baby was premature, and summed up at the end that "there was nothing free" (except for the free ward) (*"I was in a separate ward for free. Yes, I paid for syringes, for formula. Yes, in the oblast maternity hospital for premature babies, a jar cost 800 hryvnias. Then they even prescribed two syrups because he was premature. I didn't want to buy this syrup. He kept coming to me and arguing about what I needed. I went and bought these two syrups. There was nothing free there. A lot was needed every day"*). Two mothers **received formula** from health institutions, **at the expense of the local budget** (from family doctors, in a polyclinic in Odesa and in the village of Bilyne), of whom the Odesa resident added that she constantly turns to charitable foundations for help. One mother was offered milk formulas by a paediatric infectious disease specialist from the "Dovira" office as **humanitarian aid**, but she refused because the proposed formulas were not suitable (Chornomorsk). One mother received milk formulas from a social worker from the "Dovira" office as **humanitarian aid** (Liubashivka). All mothers **had to purchase milk formulas on their own**.

Focus group discussions with 16 community service providers and activists

Dnipropetrovsk oblast

The FGD participants mentioned cases when women **had to pay for medical services** (caesarean section, medications for postpartum care) in the Mechnikov maternity hospital. These violations were considered, at the initiative of community activists, during meetings of the consultative and advisory bodies on combating HIV/TB and EPMD. In addition, a FGD participant noted the need to pay for lung X-rays (*"Fluorography is done for free, but if you need an X-ray, you have to pay for it. And this is an obstacle. Doctors usually ask to bring the X-ray report itself. They say that the fluorography image does not show the changes that occur in the lungs"*). A community-based service provider gave an example of when **financial considerations prevented clients from seeking or using services** at a medical facility. In particular, this applies to free viral load and CD4 cell tests when they are prescribed together with **paid tests** at the city AIDS centre (clinical and biochemical blood tests) (*"I was contacted that there was a charge for a clinical and biochemical blood test, 150 hryvnias. And I still had to buy a syringe. Of*

course, this is a barrier. When I say that I need to take tests for viral load and CD4, the woman immediately says, "I don't have the money for this". Because when the doctor sends a referral, she writes all the tests in a package, gives an appointment and takes money from the woman, she already thinks that she pays for CD4 and viral load").

Odesa oblast

FGD participants mentioned cases when women **had to pay for medical services**, in particular, pain relief for postpartum care in the maternity hospital, and noted **the need to pay for "having an HIV-positive status"**, for disinfectants, and for PCR testing for hepatitis B virus and TORCH infections (*"Maternity hospital No. 2. The woman had a difficult birth. She had many lacerations. Well, the doctor told her directly that removing the stitches would be painful, but if she gave money, it wouldn't be so painful", "Things that require a certain amount, mandatory money, based on status. Yes, there is such a thing. In maternity wards. In antenatal clinics", "In scheduled tests during pregnancy. In antenatal clinics on Kotovsky for hepatitis B, for PCR HBs-antigen. Screening is not an issue, but HBs-antigen is for money, plus TORCH infections", "Because she has HIV status, she also gave money for disinfectants and everything else"*). A community-based service provider gave an example of when **financial considerations, combined with fear of stigma, stopped a client from seeking or using PMTCT services** at a community health centre (*"They are afraid of stigma and extortion, and that's why they don't go. "I won't go to an antenatal clinic, why? I don't have money"*).

Quality of medical care

Completeness of PMTCT services in accordance with health care standards

HIV testing

Quantitative component

Survey of 100 women living with HIV with experience of pregnancy and childbirth

The vast majority **voluntarily underwent HIV testing** (93%), received **pre-test** (91%) and **post-test** (93%) counselling.

Qualitative component

In-depth interviews with 8 mothers of HIV-exposed and HIV-positive children

Dnipropetrovsk oblast

All four women confirmed that **HIV testing was voluntary**. **None of them received pre-test information** and, conversely, **all received post-test counselling** after their HIV test.

Odesa oblast

All four women confirmed that **HIV testing was voluntary**. **None received pre-test information**. Three women received **post-test counselling** after their HIV test. Despite a positive second test during pregnancy, one woman **learned about HIV three weeks after giving birth** and, consequently, went into labour without ART.

PMTCT services during pregnancy

Quantitative component

Survey of 100 women living with HIV with experience of pregnancy and childbirth

The vast majority or most of the respondents **confirmed receiving information services (counselling) on PMTCT issues during the current (or last) pregnancy** in a medical facility that meet the standards of medical care: safe delivery (natural (vaginal) birth or caesarean section) (97%), discussion of the risks of postpartum HIV transmission during breastfeeding and recommendations for feeding the child with infant formula (96%), benefits and safety of ART with achieving a viral load level of <50 copies of HIV RNA/ml in blood plasma (91%), use of effective contraceptive methods to prevent unwanted pregnancy in the future (90%), list of necessary vaccinations, according to the individual vaccination calendar (83%), prevention of perinatal transmission of syphilis, hepatitis B and hepatitis C viruses (83%), the need to use condoms to prevent STIs during the current pregnancy (76%), the appropriateness of counselling sexual partners (73%), the benefits of taking vitamin D and folic acid to prevent miscarriage (69%).

Most of the women surveyed **were screened** for viral hepatitis B and C during their last pregnancy (84%) and screened for tuberculosis using a screening questionnaire during their first pregnancy visit to their family doctor or antenatal clinic (70%). Obstetricians and gynaecologists at antenatal clinics informed the majority of women about the possibility of elective delivery (with a viral load of less than 50 HIV RNA copies/ml) or caesarean section (with a viral load of ≥ 50 HIV RNA copies/ml) (93%).

Measures **not carried out for the majority** of respondents: Assessment of the psycho-social state of the pregnant woman and possible antenatal depression (44%), Assessment of the risk of domestic and gender-based violence (37%). However, this is done at the expense of the Odesa oblast. In the Dnipropetrovsk oblast, the majority of respondents underwent an assessment of the risks of domestic or gender-based violence and mental health screening. Screening for drug use using the "ASSIST" questionnaire was **not carried out for the majority** of respondents in both oblasts (29%).

PMTCT services during labour and postpartum

Quantitative component

Survey of 100 women living with HIV with experience of pregnancy and childbirth

The vast majority or most of the respondents reported that as HIV-positive mothers and women giving birth in a medical facility, they **received** the following services: consultation with an obstetrician-gynaecologist in the maternity hospital (department) on issues of formula feeding of the child and taking ARV drugs by the child (88%), consultation on the need to use a drug (cabergoline) to suppress lactation after childbirth (in case of a decision on formula feeding) (82%), as well as a medical examination by an infectious disease specialist at the medical facility in connection with HIV and monitoring of adherence to ARV treatment after childbirth for 4–6 weeks after childbirth (79%), medical examination within 4–6 weeks after childbirth by an obstetrician-gynaecologist at an antenatal clinic (77%), counselling on the use of contraceptive methods in the postpartum period at each visit to an obstetrician-gynaecologist at an antenatal clinic (73%), screening questionnaire for tuberculosis at each visit to an infectious disease specialist at a medical facility in connection with HIV (62%).

Measures **not carried out for the majority** of respondents: cytological examination of the cervix in the antenatal clinic 3 months after delivery by an obstetrician-gynaecologist of the antenatal clinic (48%), assessment of the mother's psychosocial status and possible postnatal depression in the first 6 weeks after delivery by an obstetrician-gynaecologist of the antenatal clinic (32%), assessment of the risk of domestic/gender violence at each visit to the obstetrician-gynaecologist of the antenatal clinic (29%). However, this is done at the expense of the Odesa oblast. In the Dnipropetrovsk oblast, the majority of respondents received the above services.

PMTCT services for newborns

Quantitative component

Survey of 100 women living with HIV with experience of pregnancy and childbirth

Counselling parents/guardians of an HIV-exposed child regarding adherence to long-term prophylactic ARV therapy by the child

All respondents who gave birth (89 women) **confirmed receiving** the following **information services** in medical institutions in accordance with the standards of medical care: information about the ways of HIV transmission from mother to child and reducing this risk under the influence of ARV drugs (100%), explanation of the mode of action of ARV drugs and the key role of ARV prophylaxis in suppressing the HIV virus (100%), instructions for taking each drug (100%). (*One woman (Odesa) learned about HIV after giving birth, and, accordingly, she did not receive services as an HIV-positive pregnant woman and mother, and her child - timely PMTCT measures).

The vast majority of mothers also **confirmed receiving** the following information services: discussion of possible obstacles to adherence to appointments and advice on how to prevent or eliminate them (92%), training in measuring the dose of ARVs (81%), recommendations on technical tools that help adhere to medication regimens (80%), information about peer-to-peer support groups for HIV-positive women (75%).

Most mothers **were provided with written instructions on how to give their child medication** (57%), however, 38% **did not confirm** receipt of such instructions. There is a significant difference between regions: in Dnipropetrovsk oblast, the vast majority of women received instructions (36 out of 46), while in Odesa oblast — only a little over a third (15 out of 43)

Counselling parents/guardians of an HIV-exposed child regarding the child's further medical management

All respondents who gave birth to a child **were informed** about the need for supervision of the child by a general practitioner-family doctor/district paediatrician at the place of residence and by a specialist of the territorial health care institution that provides medical supervision for HIV-positive people (100%). The vast majority of mothers were also **informed** about the importance of careful medical supervision to preserve the child's health (98%) and the peculiarities of vaccinating the child before clarifying his/her HIV status, adhering to the child's vaccination schedule taking into account his/her HIV status (96%).

Post-natal prophylaxis and Early Infant Diagnosis

The majority of mothers **confirmed that the parents (guardians) of an HIV-exposed child provided written consent for PMTCT measures** (62%). In Dnipropetrovsk oblast, they constitute the vast majority (40 out of 46), and in Odesa oblast – only a little more than a third (15 out of 43).

93% of mothers surveyed confirmed that the neonatologist at the maternity hospital **prescribed post-natal prophylaxis (PNP) to their child within the first 4 hours of life**. Two HIV-exposed children from Odesa oblast were not prescribed PNP within the first 4 hours of life (among them, a child whose mother learned about her HIV-positive status after childbirth). 98% of mothers confirmed that their child **received or is currently receiving PNP within 28 days** of birth. Two HIV-exposed children from Odesa oblast did not receive PNP within 28 days of birth (among them, a child whose mother learned about her HIV-positive status after childbirth).

Almost all women confirmed that they had their **first HIV status test (by PCR) in the first 2 days** (48 hours) after birth in the maternity hospital (99%). The exception is a child whose mother learned about

her HIV-positive status after giving birth (Odesa oblast). One woman reported a positive result of the first test (Dnipro city).

77 women confirmed that the **second HIV status test (PCR)** was performed **at the age of 1-2 months** from birth, this test was not done in case of the children of 6 women, 4 children were not yet of the appropriate age. One woman reported a positive result of the first test (Nikopol, Dnipropetrovsk oblast). 47 women confirmed that **the third HIV status test (PCR)** was performed **at the age of 3-4 months** from birth, this test was not done in case of the children of 11 women, 27 children were not yet of the appropriate age. 19 women confirmed that their child was tested for antibodies after reaching **18 months** for **the final assessment of HIV status**, 1 child was not tested, 66 children were not yet of the appropriate age.

All mothers whose children tested positive for HIV status (2 children – Dnipropetrovsk oblast, 1 child – Odesa oblast) confirmed that the child had undergone PCR (qualitative) and viral load testing, **was immediately prescribed and started on ART**, and was retested to confirm infection.

The vast majority of 89 mothers confirmed that they always received **post-test counselling after each child's HIV test** (78%), and in case of 12 women – it was sometimes provided (13%).

Pneumocystis pneumonia prophylaxis

Only 31 out of 89 mothers confirmed that their children had received **pneumocystis pneumonia prophylaxis from 4-6 weeks of age** (35%), and the children of more than half **did not** (52%). In Dnipropetrovsk oblast, most children received such prophylaxis (24 out of 46), and in Odesa oblast — only one in six (7 out of 43). There is a significant discrepancy with the official statistics.

Feeding a child

The majority of mothers confirmed receiving **written instructions on feeding their child** (60%), while a third received no instructions (34%). In Dnipropetrovsk oblast, the vast majority received instructions (39 out of 46), in Odesa region — only a third (14 out of 43).

The vast majority of mothers were informed about **factors that increase the risk of HIV transmission through breast milk** (97%). Almost all children are formula-fed (88 out of 89, 99%). The exception is a woman who learned about her HIV-positive status after giving birth (Odesa oblast).

Most mothers whose children are formula-fed **confirmed** receiving consultations on **the procedure for receiving free breast milk substitutes** (72%), every fourth one was not consulted (25%). In Odesa oblast, the share of unconsulted women is 2.7 times higher than in Dnipropetrovsk oblast, where the vast majority (38 out of 46) confirmed receiving such consultations from medical workers.

The majority of mothers confirmed receiving **infant formula** from a medical facility **at the expense of the local budget** (free of charge) (56%), a significant proportion did not receive it (44%). In Dnipropetrovsk oblast, two-thirds of respondents received infant formula (31 out of 45), in Odesa oblast — less than half (18 out of 42).

Qualitative component

In-depth interviews with 8 mothers of HIV-exposed and HIV-positive children

Dnipropetrovsk oblast

Counselling parents/guardians of an HIV-exposed child

All four women were **provided with access to ART** before their last pregnancy and laboratory diagnostics.

Medical workers provided mothers of HIV-exposed children with appropriate counselling on **adherence to long-term prophylactic ARV treatment by the child and subsequent medical support** in accordance with the standards of medical care, in particular in PLHIV health facilities, antenatal care facilities, perinatal care facilities and PHC facilities.

Some aspects of information services need to be improved, as not all respondents confirmed receiving them. These include: counselling on taking each medication for the child, providing written instructions, training in measuring the dosage of the medication, discussing possible obstacles to taking the medication, recommendations for preventing or eliminating them, advice on using technology to support medication adherence, and information about peer support groups for HIV-positive women.

Post-natal prophylaxis and Early Infant Diagnosis

Medical workers **fully ensured the appointment (first 4 hours of life) and receipt of PNP (28 days)** by HIV-exposed children, as well as the necessary laboratory diagnostics to clarify the HIV status according to the child's age. **An HIV-positive child was promptly prescribed ART** after receiving a positive result from the first test. All four respondents confirmed that they underwent post-test counselling based on the results of each HIV test of their child; one of them noted that she was only informed of the results without additional counselling.

Medical monitoring of the child

All four children are or **were under medical supervision in the PLHIV health facility**. Three respondents noted that the supervision is carried out at the City AIDS Centre (Branch under "Infectious Diseases" of the Municipal Non-Profit Enterprise "City Clinical Hospital №4" of Dnipro City Council), and one — at the Dnipropetrovsk Oblast Medical Centre for Socially Significant Diseases of the Dnipropetrovsk Oblast Council.

In addition, **the monitoring** is carried out by **family doctors** at the place of residence. One respondent reported monitoring in an outpatient clinic, another — in two institutions (an outpatient clinic and a private clinic). Another mother noted that the monitoring took place in another settlement in the oblast, where the older child was monitored before moving to Dnipro. One respondent was unable to organise the monitoring due to problems with documents, in particular, the lack of a birth certificate (*"We did not go to the family doctor with him. Problems with documents, I cannot make him a birth certificate"*).

One mother compared the quality of communication between a family paediatrician at a private clinic and a doctor at a municipal institution. She noted that a doctor at a private clinic is always in touch and responds promptly to requests, which increases trust in him. In contrast, a family doctor at a municipal institution, having a significant workload, often does not answer calls even in critical situations (*"We have a family doctor, when she is needed, she cannot be reached, she does not pick up the phone. She previously monitored other children. She is a good doctor, she has a lot of experience, that's obvious. Maybe because a person simply has a big workload. Even when my child was in intensive care, I started calling her, it was in vain", "He (the family paediatrician at a private clinic) is always in touch. And you can write to him at any time, he always answers"*).

Pneumocystis pneumonia prophylaxis

All four mothers confirmed that their children were prescribed **pneumocystis pneumonia prophylaxis from 4-6 weeks of age**. Three children received prophylaxis with Biseptol. The exception was one child (aged 1 month 14 days), the mother had not yet purchased the necessary drug.

Routine immunisation

Only one mother (child age 9 months) confirmed that her **child had been routinely immunised according to the Preventive Vaccination Schedule**, including **BCG vaccination** in the maternity hospital

(Maternity Hospital of the I.I. Mechnikov Hospital). One mother (child age 1 month 14 days) plans to have BCG administered in the near future (*"No, not yet. I have an appointment at Kanatna Str. tomorrow, he needs to be vaccinated"*).

One mother (child deregistered after 18 months) has not vaccinated her child at all and is currently hesitant about the need for vaccination (*"I haven't done anything, I'm still thinking about it", "BCG wasn't done because the hospital said it couldn't be done because it's a live vaccine, and I didn't do it anyway. They've already deregistered [and] I'm now thinking about it. Since they got the child deregistered, I'm thinking about it, I don't know yet"*). One mother (2-year-old child with confirmed HIV-positive status) reported that her child had received one vaccination in the maternity hospital, probably the hepatitis B vaccine (*"We haven't done anything yet. Only what was allowed in the maternity ward. They administered the one vaccine that was allowed for us. They didn't do anything else. They didn't do BCG because he's positive"*). At the same time, she noted that the family paediatrician advises and insists on immunisation (*"He said, well, it needs to be done. We can start step by step with, he says, what we have. We haven't done anything yet, we're not ready yet. I'll start, yes, we'll do something"*).

Feeding a child

Two respondents confirmed **receiving written recommendations on feeding their child**. One respondent reported that the recommendations were given only verbally, and another was guided by her own experience caring for older children.

All four respondents indicated that **they had been informed about the risk factors for HIV transmission through breast milk**, including low adherence to ART. Counselling was usually limited to recommendations to refrain from breastfeeding. None of the respondents confirmed breastfeeding; **all children** received or **are receiving breast milk substitutes** (milk formula). During the mother and child's stay in the maternity hospital, doctors provided milk formula free of charge.

One respondent was counselled on **the procedure for obtaining free breast milk substitutes** (by a family doctor). Two others noted that medical workers did not provide them with such counselling; at the same time, one of them received relevant information from a psychologist from an HIV-service NGO ("Positive Women"), and another used her own previous experience.

Odesa oblast

Counselling parents/guardians of an HIV-exposed child

Three women were **provided with access to ART** before their last pregnancy and laboratory diagnostics. One woman went into labour without ART (found out about HIV after giving birth, had an HIV-positive child). After giving birth, she refused to register for HIV and receive ARV treatment for a year, denying her HIV-positive status.

Medical workers provided mothers of HIV-exposed children with appropriate counselling on **adherence to long-term prophylactic ARV treatment by the child and subsequent medical support** in accordance with the standards of medical care, in particular in PLHIV health facilities, antenatal care facilities, perinatal care facilities and PHC facilities.

Some aspects of information services need to be improved, as not all respondents confirmed receiving them. These include: counselling on the routes of HIV transmission from mother to child and risk reduction under the influence of ARV drugs, counselling on the mode of action of ARV drugs and the key role of ARV prophylaxis in suppressing the HIV virus; and information about peer support groups for HIV-positive women.

Post-natal prophylaxis and Early Infant Diagnosis

Medical workers **fully ensured the appointment (first 4 hours of life) and receipt of PNP (28 days)** by three HIV-exposed newborns, except for one child whose mother was diagnosed with HIV three weeks

after childbirth. These children also had their **first DBS PCR test within the first 48 hours of birth** in the maternity ward. Two children tested negative; one child tested positive.

Children with **a negative result of the first PCR test**:

- The second PCR test was performed on the child of the first respondent **with a delay**, at the age of three months, the third was **not performed** at all (the child is seven months old). The second result was negative. The child is under supervision until the age of 18 months by a paediatric infectious disease specialist of the Odesa Oblast Centre for Socially Significant Diseases (Odesa Oblast Council).
- The second respondent's child **underwent** a second and third PCR tests, both results were negative. After reaching the age of 18 months, antibody testing was performed (negative result); the child was removed from the register.

Children with **a positive result of the first PCR test**:

- One case concerns a woman who tested HIV-positive three weeks after giving birth. Accordingly, the child was **not tested for HIV using DBS PCR** within the first 48 hours and **PNP was not prescribed** in a timely manner. The child was premature, born at 32 weeks, and spent a long time in intensive care. The mother could not remember the exact date of the PCR; after confirming the HIV status, she experienced severe emotional stress and stigmatisation from the medical staff. The woman recalled that blood was taken from the child's heel for analysis at the perinatal centre. **ART** (Zidovir, Lamivudine, Dolutegravir, syrups) **was prescribed** to the child after three weeks of age by a neonatologist at the Odesa Oblast Perinatal Centre. At nine months, **the viral load was high**; after two years, the viral load decreased from 4970 to 60 copies.
- Another woman took ART for a long time before and during pregnancy. Two weeks after PCR and viral load determination, the child was **prescribed ART** (the woman does not remember the names of the drugs) by an infectious disease specialist at the Dovira office (Liubashivska Multi-Profile Hospital). **The viral load level was undetectable**.

Three respondents confirmed that they were **provided with post-test counselling based on the results of each child's HIV test**. At the same time, one mother noted that she had to call doctors on her own initiative to find out the results of her HIV-exposed child's test and **wait for a month for an answer** (Bilyne) (*"I called the "Dovira" office myself to find it out. Maybe a month passed. They're still sending people here until they get an answer from Odesa. Either no one was in the system, or the system just fails. It takes so long"*).

Medical monitoring of the child

All four children **are under medical supervision** (or were until their HIV status was clarified) **in the PLHIV health facilities**: Odesa Oblast Centre for Socially Significant Diseases of Odesa Oblast Council (two children), "Dovira" office of the Balty Central District Hospital of the Balty City Council (one child), "Dovira" office of the Liubashivka Multi-Profile Hospital of Liubashivka Village Council (one child).

A mother from the village of Bilyne noted an almost complete lack of contact with the doctor, communicating mainly with the nurse at the "Dovira" office. In contrast, a respondent from Liubashivka emphasized a high level of accessibility and constant communication with the family doctor and the social worker at the "Dovira" office (*"I still call my daughter's family doctor at 10-11 pm, and I call Olena, she actually told me to call 24/7, at any time"*). A mother from Odesa also reported regular contact with a paediatric infectious disease specialist at the Odesa Oblast Centre for Socially Significant Diseases (*"She is always in touch with me. I even wrote to her yesterday, saying that I need more syrups, that I have for one or two times only. She is on vacation, but responded. Tomorrow, I have to go to her, get them already"*).

All four children **are being monitored by family doctors** at their place of residence. A woman from the village of Bilyne noted that her child had not been monitored by a family paediatrician for two months due to the lack of a birth certificate and the inability to sign a declaration. The outpatient clinic nurse conducted basic measurements (weighing, etc.) during this period. Regular paediatric observation was started after the settlement of documentary issues and the registration of the declaration (*"(Was a regular examination by a paediatrician carried out - once a month?) The first months, until we could not get the declaration, it was rare. And after six months, we went there regularly. I had problems with my biometric passport and, as a result, we could not issue a birth certificate. And without a certificate, the doctor did not include me into the declaration. The data was entered incorrectly, at the passport desk. A mistake, and they were correcting it for a very long time. The nurse, yes, she could still weigh and measure there. In the outpatient clinic"*)

Pneumocystis pneumonia prophylaxis

All four respondents confirmed that their children were **prescribed and administered pneumocystis pneumonia prophylaxis**. However, none of them answered confidently and could not recall the name of the drug (Biseptol).

Routine immunisation

One mother (age of the child 7 months) confirmed that **the child had been routinely immunised according to the Preventive Vaccination Schedule**, including **BCG** vaccination in the maternity hospital on the second day after the child was born (Chornomorsk). At the same time, she noted that all **vaccinations were paid** (*"At our Chornomorsk hospital, all vaccinations are paid. We ordered them at the Podorozhnyk pharmacy. We bought everything. They gave us a choice of either their vaccinations or we bought them ourselves. They had Macedonia there, we bought France. The names were the same, but the manufacturers were different. We consulted and decided that it was better, of course, to buy the vaccine"*). One mother (child deregistered after 18 months, village of Bilyne) confirmed that the child had been routinely vaccinated. The BCG vaccination was carried out at the age of one and a half years in the children's hospital in Balty. One mother (child with confirmed HIV-positive status) reported that the child had been vaccinated with BCG in the perinatal centre (doctors did not know about the mother's HIV-positive status). Routine immunisation is carried out under the supervision of doctors, in particular, vaccination against measles, rubella and mumps (MMR) was not carried out (*"By the way, he was vaccinated against BCG, but, in fact, we were not allowed to. In addition, they said that we cannot be vaccinated against measles, rubella, mumps"*). One mother (child with confirmed HIV-positive status) reported that the BCG vaccination was carried out for the child after the age of one year in the "Dovira" office in the urban-type settlement of Liubashivka.

Feeding a child

One mother confirmed **receiving written recommendations on feeding her child**. At the same time, another noted that doctors did not advise her on this issue, as they considered her sufficiently knowledgeable due to her experience with older children (*"They told me all this only with my first child. They kind of knew that I was already knowledgeable. Maybe that's why they simply didn't advise me"*).

All four respondents confirmed that they had been informed about **factors that increase the risk of HIV transmission through breast milk**, such as low adherence to ART. However, counselling was usually limited to recommendations to avoid breastfeeding. No respondent confirmed breastfeeding; **all children** received or are receiving breast **milk substitutes** (formulas).

Three respondents were consulted about **the procedure for receiving free breast milk substitutes** (family paediatrician – 2 respondents, social worker of the "Dovira" office – 1 respondent). One respondent knew from experience in caring for older children.

Two respondents **received formula from health facilities, at the expense of the local budget** (from family doctors, at a polyclinic in Odesa and in the village of Bilyne), of which the Odesa resident added that she constantly turns to charitable foundations for help (*"They were already given out through a family doctor. Four packs a month. From the "Dovira" office, I understand, through our family doctor. He belongs to the district hospital. (Was there enough of them?) No, I had to buy more", "Yes, yes. I got it from a doctor at a state polyclinic. I went to volunteers from all kinds of foundations. There were times when there wasn't enough formula and I bought it with my own money"*). One respondent was offered milk formulas by a paediatric infectious disease specialist at the Dovira clinic as **humanitarian** aid, but she **refused** because the proposed formulas were not suitable (Chornomorsk city) (*"We didn't get any. They offered Nan or Humana. But our child wouldn't eat enough of Nan, plus he had terrible colic. We switched to Maliutka Premium, we really liked it, and I just refused others"*). One respondent received milk formulas from a social worker at the Dovira office as **humanitarian aid** (Liubashivka urban-type settlement) (*"I received formulas, Olena (a social worker) would bring them home to me, and call me when she had them, she gave me both diapers and formulas. (Did you have to buy milk formulas yourself?) Of course. Yes"*). **All** mothers **had to buy milk formulas themselves**.

State benefits and payments for HIV-exposed and HIV-positive children

HIV-exposed children

In Dnipropetrovsk oblast, one respondent reported **receiving monthly state assistance** for HIV-exposed children and children living with HIV (in accordance with the Resolution of the Cabinet of Ministers of Ukraine as amended dated 26.04.2024 No. 463[31]) (*"Yes, I received it. The paediatric infectious disease specialist told me. When we came for the first PCR test, we were a month old, and she said, you are entitled to this small amount. I received it on my bank card"*). Another respondent submitted documents for this benefit, but at the time of the interview, she had not received the payment. One respondent deliberately **refused to apply for** monthly state assistance because of its small size (*"Let's put it this way, I just didn't want to. I'll be honest, bluntly, this handout, well, means nothing, because you can't even pay for the formula with it"*). Two respondents learned about the possibility of state support from doctors, another from an employee of an NGO.

In Odesa oblast, **no mother received monthly state assistance** for HIV-exposed children and children living with HIV. One respondent refused to apply for this assistance because of the need to travel from Chornomorsk to Odesa with her child to submit documents ("*I refused because it is inconvenient for me to travel from Chornomorsk to Odesa with a small child. I immediately told them that no, I will not go. I refused to apply"*). Another mother (village of Bilyne) had a negative experience — she applied for her older child, but did not receive any payments (*"None (I do not receive). I applied for the older one, but I did not receive anything. All the documents were accepted, but no money was credited to the account. Nothing happened. (And where exactly did you apply for this assistance?) At the oblast AIDS centre"*).

HIV-positive children

In Dnipropetrovsk oblast, one respondent whose child has an established HIV-positive status confirmed that the child has **the status of a child with a disability and receives social assistance from the state** in the amount of 2,934 hryvnias (Dnipro city). In addition, she receives state social assistance for low-income families in the amount of about 13,000 hryvnias for all children (*"I receive disability payments for a child, I have low-income status. I refused to become a single mother because the girls told me that it would not help at current prices, it is better for you to have low-income status by 400 hryvnias more than as a single mother"*).

In the Odesa oblast, one respondent (Liubashivka urban-type settlement), whose child has an established HIV-positive status, confirmed that the child has **the status of a child with a disability** and

[31] https://zakon.rada.gov.ua/laws/show/463-2024-%D0%BF#Text

receives social assistance from the state in the amount of 2,595 hryvnias. Another respondent (Odesa city) receives social benefits as a single mother and state social assistance to low-income families, but **has not registered her child as a child with a disability** due to difficulties with visiting the Pension Fund, especially during air raids (*"I still don't receive anything. I haven't done anything yet. My problem is that they have now transferred everything to the Pension Fund. I remember that I went to register social benefits as a single mother, as a low-income person. To be honest, I don't want to go to that building anymore. The air raid starts – they don't accept me. And that's why it's always such a hard time for me*").

In-depth interviews with 10 providers of medical PMTCT services

A paediatric infectious disease specialist from the Dnipropetrovsk oblast believes it is appropriate to rethink the approach to post-natal prophylaxis and pneumocystis pneumonia prophylaxis in HIV-exposed children, in particular for mothers with a low risk of vertical HIV transmission.

The current standard of care states that pneumocystis pneumonia prophylaxis with cotrimoxazole (TMP/SMX) is prescribed to all children from 4 weeks of age until 2 negative HIV nucleic acid detection results are obtained (one at 6-8 weeks of age, the second at 3 months of age), provided that the child has not been breastfed for at least 6 weeks before the first negative result and in the absence of clinical manifestations of HIV infection. Instead, the doctor believes that prophylaxis with Biseptol is not necessary for children whose mothers have a low risk of HIV transmission (high adherence to ART, achieved viral suppression at the time of delivery), and the child's first two HIV status tests based on Early Infant Diagnosis are negative (DBS PCR in the first 48 hours and PCR at the age of 1-2 months). From practical experience, she notes that Biseptol often causes anaemia in children:

"I have a suggestion – to review Biseptol for children born to mothers with low risk, with negative DBS PCR. They will be healthy. Mothers who have been on therapy for many years, they do not need Biseptol for the pneumocystis pneumonia prophylaxis, there will be no positive child. Previously, this was very relevant, but now it is not so much, because the DBS is already negative, the first PCR is negative, although it is still in the protocol, I believe that it should be reviewed. They are already receiving Zidovudine, which also needs to be cancelled, because, for example, in Europe they do not give Zidovudine if the mother gave birth before the age of 40. It causes anaemia, of course. All children I examine have anaemia after AZT. Biseptol causes even greater anaemia. Therefore, if the DBS is negative, the mother has been on therapy for 10 years, I do not prescribe Biseptol. And if the PCR is negative in a month, then we definitely do not continue it anymore, if it was prescribed by the family doctor. Now I think that we need to revise this protocol a little".

The doctor also questions the appropriateness of prescribing three drugs for 28 days for post-natal prophylaxis (PNP) and believes that for mothers at high risk of vertical transmission, one drug is sufficient. For mothers at low risk of transmission (long time on ART and viral load less than 40 copies), she suggests not prescribing PNP, relying on global and European experience:

"I don't believe in the prevention that a child receives. If he/she has already received this virus internally, then 28 days with three drugs will not save her. Therefore, in case of high risk, it is worth considering prescribing one drug for 28 days, and a mother who gave birth with a viral load of less than 40 copies, who has been taking therapy for 10, 8, 5 years, can probably do without it. There is world and European experience".

Structural violence and discrimination

Quantitative component

Survey of 100 women living with HIV with experience of pregnancy and childbirth

Key concepts of obstetric violence

Respondents were provided with definitions and examples of key concepts of obstetric violence, namely:

Verbal and other psychological violence: shouting, insults, humiliation, accusations, threats, intimidation, the requirement to clean the ward or place of stay in a medical institution on one's own, pressure to perform any procedure without a valid reason, ignoring requests for help, isolation.

Physical violence: slapping, hitting certain parts of the body, rough handling, squeezing the foetus during contractions (fundal pressure technique), roughly spreading the legs, forcing a certain position for childbirth

Unconsented medical procedures, i.e. procedures for which you have NOT given your oral or written consent (except in emergency situations where the life of the woman and/or foetus is at risk and the woman is unconscious): perineotomy/episiotomy (cutting the area between the vaginal opening and the anus), application of obstetric forceps to remove the foetus, caesarean section, amniotomy (forcible rupture of the amniotic sac), insertion of an intrauterine contraceptive device, application of prostaglandin gel to the cervix to stimulate labour, use of injections or vaginal tablets to stimulate labour, surgical sterilisation (a medical procedure that makes it impossible to have children in the future).

Prevalence of obstetric violence and discrimination

The majority of respondents **did not experience any form of obstetric violence and discrimination** (54%). However, **more than a third** (36%) **reported** the following forms of **obstetric violence and discrimination**:

- Breach of confidentiality/disclosure of HIV status/unconsented disclosure of information about a woman's health or the health of her child to third parties (18%)
- Verbal and other psychological violence (15%)
- Denial to provide certain medical procedures and/or services (8%)
- Physical violence (7%).
- Unconsented medical procedures (4%).

Breach of confidentiality

Breach of confidentiality/disclosure of HIV status/unconsented disclosure of information about a woman's health or the health of her child to third parties was carried out to: family members (4 respondents), another medical worker (14), social worker (3), other patients (2), others ("*At my children's school and at my workplace*" - comment of a respondent from the village of Liashkivka, Dnipropetrovsk oblast) (1).

Denial to provide certain medical procedures and services

Medical procedures and/or services to which access was **denied** (8 respondents):

- Pain relief (4 respondents; *"They gave me pain relief, but only after my husband paid 100 US dollars to the anaesthesiologist"* - comment of a respondent from Vilkove village, Odesa oblast)
- Counselling on breastfeeding (e.g., prohibiting breastfeeding instead of providing informed choice) (3)

- Dealing with postpartum complications (3)
- Counselling on contraception (preventing unwanted pregnancy) (2)
- Pelvic floor counselling (helps strengthen muscles weakened by pregnancy and childbirth, reducing the risk of urinary incontinence) (1).

Recognising violence and discrimination

Summarising their experiences, 86% of respondents answered that they had not experienced obstetric violence or discrimination, and 14% chose the answer "I have experienced obstetric violence and/or discrimination". This contradicts previous responses, where 36% indicated at least one form of violence and/or discrimination, and indicates **a misconception about obstetric violence and discrimination and an inability to identify these phenomena** among 22% of women (10 – Dnipropetrovsk oblast, 12 – Odesa oblast). Accordingly, only 14 out of 36 respondents answered the question about health care workers who committed obstetric violence or discrimination and the impact of these actions on the mental and emotional well-being of the woman. Among **the perpetrators of obstetric violence and/or discrimination**, the most frequently mentioned were nurses/midwives (8 respondents) and head doctors/head of departments (4 respondents), as well as doctors (3), nurses (3), and administrative staff (1).

Reasons for discrimination

The vast majority of women who answered the question about **the characteristic on which they were discriminated against in a medical institution** considered their **HIV status** to be such a ground (12 out of 14 respondents), as well as socio-economic status (5), age (2), experience with drug use (1), and it is difficult to answer (2).

Impact of violence/discrimination

Three out of 14 women believe that violence/discrimination **has harmed their health**. Ten women have experienced varying degrees of **impact of violence/discrimination on their mental and emotional well-being**, and four have not experienced any effects:

- Mild impact (e.g., stress, anxiety) (5)
- Moderate impact (e.g., depression, loss of confidence) (2)
- Strong impact (e.g., trauma, severe depression) (3)
- No impact (4).

For 10 out of 14 respondents, experiences of violence/discrimination **have influenced their desire or decision to seek** reproductive health, maternity, HIV or PMTCT **services** in the future: they avoid certain health workers or facilities.

Qualitative component

In-depth interviews with 8 mothers of HIV-exposed and HIV-positive children

Dnipropetrovsk oblast

Manifestations of discrimination by the management of medical institutions against HIV-positive women occur mainly in the form of emotional pressure, incorrect communication and demands to provide additional documents or explanations. This is especially noticeable in cases where patients do not report their status immediately, in particular due to fear of stigmatisation or other circumstances. Such situations lead to psychological stress, feelings of shame and resentment, which can negatively affect trust in the medical system as a whole. At the same time, the majority of medical staff demonstrate tolerance and support, which helps patients feel accepted and protected. This indicates a gradual change in attitudes towards HIV-positive patients, although individual cases of discrimination remain relevant.

Two women had conflicts with the management of the medical institution (head, chief physician) **due to failure to disclose their HIV status** during pregnancy or childbirth. In the first case, this happened during pregnancy management **in the antenatal clinic**, when the first HIV test was negative and the pregnant woman kept quiet about her HIV-positive status (*"…I had to confess to her, I was afraid, because I had done many gynaecological surgeries with her before, but I didn't tell her that I had a status"*). The second test was already positive. At the same time, the woman noted the tolerance and support of other medical staff at the institution (*"in general, the medical staff said, "Don't worry, you know how many of us have people like you, you're just like everyone else..."*). In the second case, it happened during childbirth in **a maternity hospital**, when **an IDP woman did not have an exchange card with her. The head doctor intimidated the woman by calling the police** (*"The head doctor, when he found out that I had a status, started shouting that I had no right to remain silent, that he would call the police right away. And that, God forbid, I infected the girls, well, the nurses who delivered me. This was in the presence of medical staff. In Nikopol. He said it with such a rude attitude"*).

Odesa oblast

The experiences of the respondents indicate the presence of cases of discrimination and stigmatisation by medical staff in maternity wards, which is a form of obstetric violence. Such attitudes were expressed in detachment, prejudice, unwillingness to fully perform professional duties and the use of offensive expressions towards HIV-positive women in labour. At the same time, individual representatives of the medical staff demonstrated tolerance and understanding, which indicates the heterogeneity of attitudes in different institutions and among different medical workers.

Two respondents reported cases where they experienced **discrimination and/or stigmatising treatment from medical staff** due to their HIV-positive status. In both cases, this occurred **in maternity wards**, indicating obstetric violence. In both cases, the women in labour described themselves as being treated as "outcasts". In the first case, the woman experienced biased and detached treatment from an obstetrician-gynaecologist during labour and postpartum, which affected the quality of medical care. At the same time, the woman noted the tolerance of other medical staff at the facility (*"Not all medical staff (have a negative attitude). Some are understanding"*). In the second case, after revealing the HIV status of the woman in labour, the medical staff radically changed their attitude towards her and the child, demonstrated excessive caution, avoided physical contact, used excessive means of protection and disinfection, and used stigmatising expressions. The paediatrician asked if the woman had washed the door handles, the nurses entered the woman's room in protective gowns and constantly disinfected, did not approach or touch the patient, and called her among themselves "AIDS-sick". This led to even greater isolation of the woman, refusal to accept her HIV status and start ART, and negatively affected her emotional state at a time when the woman needed support and help the most ("*The paediatrician who works in the maternity ward says to me, "Did you wash the door handle?" And they even disinfected the door handle after me. They washed everything in the room, they didn't touch anything. It was very unpleasant. I felt like an outcast there*").

In-depth interviews with 10 providers of medical PMTCT services

Dnipropetrovsk oblast

Doctors' experience shows that cases of discrimination and stigmatisation of HIV-positive women in medical institutions in Dnipropetrovsk oblast still occur. There are disturbing reports of individual doctors advising women living with HIV to terminate their pregnancies, which indicates a significant level of prejudice and lack of awareness about modern options for safe motherhood for HIV-positive women. Intolerant attitude from medical staff, especially in maternity hospitals, is confirmed by reports from both patients themselves and infectious disease doctors, who are forced to personally intervene and conduct explanatory work among colleagues. However, most HIV-positive women do not dare to file complaints officially, limiting themselves to verbal appeals or enduring humiliating

treatment, which complicates the fight against stigma and discrimination. The reason for this is the fear of disclosing the status and distrust in the possibility of a fair resolution of the conflict. In the issue of obtaining an advisory opinion from the PLHIV health facility regarding the results of the examination of an HIV-exposed child and recommendations for the family doctor or paediatrician at the place of residence, the practice of maintaining the confidentiality of the mother's diagnosis is important (sensitivity to mothers' requests not to disclose information about HIV status to family doctors or paediatricians, preventing information about the child's HIV registration in the medical record).

One obstetrician-gynaecologist at **an antenatal clinic** (antenatal health facility) **confirmed the case of an oral complaint** from an HIV-positive woman in his institution. The response was a reprimand and a warning about administrative and criminal liability. He also noted that in the case of a written complaint, he was ready to dismiss the offender (*"Unfortunately, such cases were present. My response, as the head, was, firstly, a reprimand. Secondly, I said that if there were any more, then it could be criminal or administrative liability, there are also such legislative points. (Were the complaints submitted in writing or orally?) Orally. If it were in writing, then it would be dismissal, with all the ensuing consequences"*). The obstetrician-gynaecologist also reported cases where women living with HIV were told by other doctors **to terminate their pregnancies and not have children** (*"I had examples when women came to me for pregnancy registration, and the doctors had a very strong stigma towards them, even to the point of telling them that this pregnancy needed to be terminated, they were intimidated that they should not just give birth"*).

One paediatric infectious disease specialist (PLHIV health facility) confirmed that her HIV-positive patients reported **intolerant attitudes** from medical workers in other medical facilities, in particular in **a maternity hospital**, and she personally responded by communicating with such doctors (*"There have been complaints about the not-so-nice attitude towards positive girls in a maternity hospital. You ask how the birth went. There are still women who say that they would like the attitude to be different, so that they wouldn't shout in the corridors "AIDS-sick". I can call sometimes, if something is so blatant, and tell the doctor that there is this and that complaint"*). The doctor also reported that **HIV-positive patients do not want to file complaints** against doctors and gave examples of when she encouraged a woman to file a complaint (*"I tell girls, speak up, there is advocacy, there is protection of rights, protection of information. Recently, we even set up one mother, saying that if you have such a negative experience, others will follow you, and that is also not good. Women do not file complaints, let's put it this way. They can scold themselves while being there, or they can tolerate it"*). Regarding receiving **an advisory opinion** with the results of the child's examination and **recommendations for the family doctor** who is observing the child, it is important to note **the practice of maintaining the confidentiality of the mother's diagnosis**. In particular, the doctor is sensitive to mothers' requests not to disclose information about their diagnosis to family doctors and paediatricians: "*I don't give an advisory opinion. I don't want them to paste into the child's card that they were registered. We once developed such an insert; family doctors kept it until the child was deregistered. Why should it remain in the child's medical card that they were born to an HIV-positive mother? In some of them it remains, in others – no. Many mothers ask that this not happen".*

Odesa oblast

The situation in the Odesa oblast demonstrates the presence of contradictory trends: on the one hand, the level of tolerance is gradually increasing, on the other hand, isolated manifestations of stigmatisation and discrimination remain problematic, especially in remote hromadas and maternity wards. Patients often face humiliating and offensive treatment, and some health workers avoid physical examinations or do not want to take care of HIV-positive children. However, official complaints about such actions are extremely rare, mainly due to distrust of the system and fear of disclosing the status. Despite this, the majority of health workers interviewed note an increase in the level of tolerance both in medical institutions and in society as a whole. A positive example is the increase in the number of discordant couples, which indicates the gradual destruction of stereotypes about HIV.

At the same time, some experts note that stigma and discrimination do not disappear completely, but only take on new, less noticeable forms.

One paediatric infectious disease physician (PLHIV health facility) confirmed that her HIV-positive patients reported **intolerant attitudes** from medical workers in other health care facilities, including **the maternity hospital** (*"Mothers come in offended after giving birth. There are many complaints. There are complaints about maternity hospitals, many complain because they are treated like second-class citizens there. It is unpleasant, insulting, even humiliating. It happens. As soon as medical workers learn about the status, their attitude immediately changes"*). One infectious disease physician (PHC facility) from **a remote hromada** confirmed that he knew of cases when infectious disease physicians, gynaecologists, and therapists **did not want to conduct a physical examination** of HIV-positive patients, paediatricians **did not want to treat HIV-positive children**, and reacted violently when they learned about the child's HIV-positive status. The doctor added that for him this is an everyday occurrence ("*There have been cases of patients being treated – when infectious disease specialists, gynaecologists, and therapists did not want to even conduct a physical examination of the patient. There are paediatricians who do not want to treat HIV-positive children. This is something I encounter every day. It was just recently that a child started having a nosebleed and the doctor decided to perform a tamponade without gloves. And when the mother told her, a very, let's say, violent reaction followed. With hysteria, with everything going on. That is, I do not like such behaviour*"). The doctor also noted that **HIV-positive women** usually **do not file complaints** about doctors' misconduct, or complain only verbally, informally, and agreed that the reason is women's lack of faith in justice ("*These are unofficial complaints. Verbal. Yes. Because of HIV. You see, this is a very, very small percentage when officially HIV-infected people file any complaints. (And why, in your opinion? They don't believe in justice?) Of course. Of course, they don't believe*").

All respondents from among health care workers note **greater tolerance towards women living with HIV** compared to previous years, both in health care facilities and in society as a whole. As an example, they cite a large number of discordant couples (*"Anyway, society has become more tolerant. If before men did not know for years that a woman was positive, or vice versa, now this is not the case. We have a lot of discordant couples"*). However, a doctor working in a remote hromada in the Odesa oblast is less optimistic, believing **that stigma and discrimination** are simply **changing form** (*"Stigmatisation and discrimination, yes, they have become less. But they still happen, unfortunately, let's put it this way, if before it was completely "don't come near me", now it is "here she comes"*).

Focus group discussions with 16 community service providers and activists

Dnipropetrovsk oblast

Community activists and HIV service providers from NGOs provided case examples of support for HIV-positive women, including pregnant and postpartum women, over the past three years. In these cases, HIV-positive patients suffered stigma and discrimination from reproductive health professionals, including obstetric violence. Discrimination occurred on the basis of HIV-positive status (and drug addiction in one case) and took the following forms:

Pressure on reproductive choices: psychological pressure to force an abortion; accusations that a woman did not have an abortion; accusations that a woman gave birth to an HIV-positive child; reproaches that a woman became pregnant and gave birth to "those like her"; intimidation that the child will be born with HIV.

Violation of ethical norms (public humiliation, verbal aggression): verbal insults, shouting; doctors forced the woman in labour to clean up after herself in the corridor after her waters broke.

Denial of access to medical services: a private clinic denied a woman IVF treatment due to her HIV status, without even allowing her to have a consultation (the woman was literally not allowed to enter, and after the refusal, the staff began to disinfect the premises).

Breach of confidentiality: disclosing the diagnosis to relatives.

Refusal to consider complaints: in a situation where a woman was unable (uncapable) to file a complaint on her own due to her health condition, the medical facility management refused to respond to an appeal from the NGO case manager regarding the actions of the medical staff, leaving the patient without legal protection.

Financial abuse and extortion: demand to pay for childbirth (caesarean section), demand to purchase medication that was later not needed.

Among the institutions where discrimination against HIV-positive women occurred were: Kryvyi Rih Perinatal Centre with a hospital, Private Gynaecological Clinic ISIDA, Kyiv, Mechnikov Maternity Hospital, Dnipro, Kryvyi Rih City Clinical Maternity Hospital No. 1, Dnipropetrovsk Oblast Perinatal Centre with a hospital, Dnipro, City AIDS Centre, Dnipro.

A community activist shared her own experience of how doctors' attitudes **influenced her desire to seek medical services** from PLHIV health facilities. She has **minimised her visits to doctors** and only comes for mandatory tests, and receives ART by mail.

Despite the difficulties and cases of stigma and discrimination, another activist also noted **changes for the better in the attitude of doctors** towards women living with HIV: "*Still, the attitude has changed and there are a lot of doctors now who are tolerant, who perceive a woman regardless of her categories of vulnerability, precisely as a woman, precisely as a patient. I cannot help but note this. There are neonatologists, there are gynaecologists, those who perceive any woman precisely as a person, precisely as a woman who needs help".*

Odesa oblast

Community activists and HIV service providers from NGOs provided case examples of support for HIV-positive women, including pregnant women and women giving birth, over the past three years. In these cases, HIV-positive patients suffered stigma and discrimination from health workers in the field of reproductive health, including manifestations of obstetric violence, motherhood and access to primary health care. Discrimination occurred on the basis of HIV-positive status, drug addiction, history of tuberculosis and IDP status, and took the following forms:

Refusal to provide services due to registration: women without oblast registration (residents of Odesa) were not admitted to the oblast maternity hospital, but sent to other institutions (*"there is a fourth maternity hospital for city residents nearby"*).

Obstetric violence and extortion: in a maternity hospital, a doctor demanded a bribe from a woman in labour for pain relief during postpartum care (for less painful removal of stitches after a difficult delivery).

Stigmatisation of a discordant couple: medical staff allowed themselves to make comments about the HIV-negative husband of an HIV-positive woman in labour, advising him to "divorce" his wife.

Attempts to get rid of a pregnant woman with a history of HIV-TB coinfection by applying increased bureaucracy: even with all the necessary documents that the woman had carefully prepared regarding her recovery from tuberculosis, after hospitalisation, additional certificates were required from her in an attempt to discharge her from the maternity ward.

Last in line: discrimination occurred during appointments, when HIV-positive women were admitted last in line at the antenatal clinic, arguing that "another, healthy, clean woman will have to sit after you".

Isolation and coercion to abandon the child: in the maternity hospital, HIV-positive women from the group of drug users were isolated in separate rooms with bars (isolation room); in one case, a lawyer was called and the woman was forced to sign an abdication of the child when she asked for permission to leave the ward for a while.

Refusal to register displaced women: at the beginning of the war, there were refusals to register IDP women in antenatal clinics, and family doctors often refused to sign a declaration.

Among the institutions where discrimination against HIV-positive women occurred were: Odesa Oblast Perinatal Centre, Odesa, 2nd Maternity Hospital, Odesa, Antenatal Clinic "in the Filatov District".

Two participants of the FGD noted that **the fear of stigma and discrimination** is a significant barrier to seeking medical services, based on their own experience (*"I can't tell every doctor about this. This is especially true of gynaecology. We have a few gynaecologists who don't pay attention to it at all. The majority, especially narrow specialists, when you come, God forbid they say that you have such and such a story", "Even now, having worked for 18 years, I don't disclose my status to every doctor. Because of stigma and prejudice"*).

In-depth interviews with 7 people in management positions

Dnipropetrovsk oblast

The interviewed specialists note that in recent years they have observed a significant **improvement in the attitude of medical personnel towards HIV-positive women**, children and adolescents. The level of tolerance has increased, and cases of discrimination have become rare ("*This is already a very rare phenomenon*"). Complaints about inappropriate behaviour of medical workers towards HIV-positive patients are rare and, as a rule, are associated with the personal traits of individual workers, rather than with a systemic problem of discrimination.

High-profile cases, if they arise, are promptly considered by the institution's management and medical councils, discussions are held at meetings of regional advisory bodies on TB/HIV and EMTCT. The last widely known complaint was about the incorrect behaviour of an anaesthesiologist of the Kryvyi Rih Perinatal Centre in relation to an HIV-positive woman in labour. **Patients' complaints are mainly oral**, and even in cases of informal appeals, the institution's administration reacts, gives answers and holds explanatory conversations.

In the health facilities subordinate to the Dnipropetrovsk Oblast Medical Centre for Socially Significant Diseases, there are **policies on preventing discrimination**, which are regularly updated and their implementation is monitored. Thematic trainings for staff, separate sessions on preventing stigma and discrimination, as well as information work through social networks are carried out (*"The last time we updated these documents in all medical facilities of the Dnipropetrovsk oblast was in February of this year. They reported to us, sent us their orders, and so on. Each training that we conduct, we have a separate session on preventing stigma and discrimination*"). At the same time, the head of the postpartum department is not informed about the existence of such a policy in her facility (*"I have not seen such a document, maybe it exists, I do not know"*). This indicates the need to spread the experience of the AIDS service to obstetric health facilities and other health facilities related to the provision of PMTCT services.

Odesa oblast

The respondents assessed the level of stigma and discrimination from the medical staff in different ways. On the one hand, they **admit that the issue of stigmatisation has not yet been fully resolved**, on the other hand, they note that **the level of tolerance is increasing**, and cases of discrimination are becoming rarer. (*"I think that the attitude has become more positive. The staff understands this and*

does not single out these people at all", "As far as I know, talking to our doctors, unfortunately, we still have stigma. It remains, and we need to work actively with this issue").

Respondents are aware of individual cases of stigmatisation and discrimination, particularly in remote hromadas of the oblast — a patient complained about isolation in a medical facility. However, these complaints are usually verbal (*"There are verbal complaints from HIV-positive people, for example, that they were isolated. I go to the districts. I ask the patient; do you like everything here? No, you see, they locked me up, told me not to go out", "The complaints were only verbal"*). **Problems with written complaints** are partly related to the reluctance of patients to disclose their HIV status due to fear of disclosure (*"They just don't want to write. Maybe they don't want to disclose their status"*).

Systematic work to raise staff awareness is carried out through regular explanations, education and training, especially for new employees and interns. Particular attention is paid to correct information about the ways of HIV transmission and the prevention of stigma.

There is currently no formalised **policy on preventing discrimination** at the institution level, but there is an understanding of the need for its implementation (*"There is no such policy at the institution level. I think there should be one. For example, I make rounds in the department. There are four people lying in the ward. I go in and they tell me B-20. I say, why say that? Someone will hear, they will clarify that it is B-20. There is no need to say that. There is a medical history, we will look into everything. These are interns who came. In general, I think that training should be conducted. And with interns, it is a must. They come to work; it is a big problem"*). There is a department of appeals at the level of the city health department that analyses complaints.

Training activities, including in cooperation with international partners, are aimed at **overcoming stigma among medical students**, which is an important step towards creating a tolerant environment in the future. It is important to note that a component of the students' training was communication with activists from the community of women living with HIV (*"It turned out that our students were very stigmatised towards HIV-infected people. These are first-year students. We conducted a survey and found that they even said that if an HIV-infected person came to see them, they would not work with them"*).

Timeliness of PMTCT services

Quantitative component

Survey of 100 women living with HIV with experience of pregnancy and childbirth

Timeliness of registration due to pregnancy

Timeliness of registration among women living with HIV is **quite high**: the absolute majority of respondents (73%) registered in the first trimester of pregnancy, which meets modern standards for providing PMTCT. However, every fourth was observed after 12 weeks (26%). One woman from the Dnipropetrovsk oblast was not observed by doctors at all in connection with pregnancy.

Frequency of visits to an obstetrician-gynaecologist

Among 87 women whose pregnancies ended in childbirth and who were under medical supervision in a medical institution, there was **a high frequency of visits to an obstetrician-gynaecologist** at an antenatal clinic to monitor the course of pregnancy: more than half had 8 or more visits (55%), another 21% had 4–7 visits. A lower number of visits was more often noted among women from rural areas or small towns. Thus, most women have a high level of adherence to regular medical examinations during pregnancy.

HIV diagnosis during pregnancy, registration and ART prescription

Among the 16 women who learned about HIV during their last pregnancy, **most were diagnosed in the first trimester** (13), with a few cases in the second (2), third (1) trimesters, or postpartum (1). Most **were registered with the infection specialist at the PLHIV health facility** within a week of diagnosis (11 out of 16), and ART was prescribed mostly within two weeks (13), which is in line with current standards.

Regularity of virological monitoring

Good adherence to virological monitoring can be observed: the vast majority of women **measured their viral load** within the last year (11% - within the last month, 33% - in the last 3 months, 30% - in the last six months, 16% - from 6 months to 1 year ago). At the same time, every tenth woman (all from Odesa oblast) measured their viral load more than a year ago (10%).

Early Infant Diagnosis

Six HIV-exposed children **did not undergo a second PCR test** at the age of 1-2 months on time (4 – Dnipropetrovsk oblast, 2 – Odesa oblast). 11 children **did not undergo a third PCR test** at the age of 3-4 months **on time** (4 – Dnipropetrovsk oblast, 7 – Odesa oblast). One child **did not undergo a timely antibody test for the final assessment of HIV status** after the child reached 18 months (Odesa oblast).

Missed doctor visits

The respondents demonstrate the highest commitment to visits to infectious disease specialists/paediatric infectious disease specialists at the PLHIV health facility (80% did not miss visits). The majority of the surveyed women also never missed visits to obstetricians-gynaecologists (70%) and family doctors or paediatricians (68%). In general, the majority (61%) **never missed scheduled visits**. However, in the Dnipropetrovsk oblast, the number of women who missed visits to the relevant specialists is significantly higher than in the Odesa oblast (25 versus 14). Most often, women from the Dnipropetrovsk oblast missed visits to a family doctor (or paediatrician) at the PHC facility (4 – quite often, 6 – sometimes). The main **reasons for missing visits**: **financial insolvency** (17: 9 – Dnipropetrovsk oblast, 8 – Odesa oblast), **employment at work or housework** (14: 8 – Dnipropetrovsk oblast, 6 – Odesa oblast), **poor health, including mental health** (11: 7 – Dnipropetrovsk oblast, 4 – Odesa oblast), **the burden of caring for other family members** (10: 7 – Dnipropetrovsk oblast, 3 – Odesa oblast), **the consequences of armed aggression** (shelling, disruption of transport infrastructure, air raids, etc.) (7: 6 – Dnipropetrovsk oblast, 1 – Odesa oblast), as well as **fear of stigma and discrimination** (4: 4 – Dnipropetrovsk oblast).

Qualitative component

In-depth interviews with 8 mothers of HIV-exposed and HIV-positive children

Timeliness of HIV Early Infant Diagnosis

Dnipropetrovsk oblast

The mother of an HIV-positive child (Dnipro) has difficulties **ensuring the timeliness of laboratory tests**, which is manifested in **missed visits** to the city AIDS centre. The main reasons are conflicts with medical staff and financial burden, in particular the need to pay for transportation (taxi) to travel to a medical facility (*"I cannot always find five hundred hryvnias to come"*). One mother of an HIV-exposed child **missed the third PCR test** and gave **an example of support** from **a paediatric infectious disease specialist (Dnipropetrovsk Oblast Medical Centre for Socially Significant Diseases of the Dnipropetrovsk Oblast Council)** when the doctor organised **a blood test at home**: *"My health condition did not really allow me to travel. And the weather was already, as they say, not ideal, because it was very cold. And dragging the child through the cold was also not an option. Therefore, the doctor*

called me herself and said, we will come to you by a certain time and do another test for the child. She came with a lab technician, they took some tests, and a week later the girl called me and said it was negative".

Одеська область

One mother (Odesa) **learned about her HIV-positive status** only three weeks **after the birth of her child**, so the pregnancy and childbirth took place without ART. Another mother (Chornomorsk) notes that **the second PCR test** for her child was **performed late**, and **the third was not performed** at all (the child is 7 months old). The reason for the violation of the visit schedule is the lack of possibility of transporting the child from Chornomorsk to Odesa to the PLHIV health facility due to the husband's illness (he used to provide such trips with his own transport) (*"We went to Leontovych for blood test in the third month, but we could not travel with the child anymore. Because my husband had a serious operation, and we were simply immobile. And I was afraid to transport the child in a minibus. We explained to them and they said that when my husband gets back on his feet, we should come and do tests"*).

In-depth interviews with 10 providers of medical PMTCT services

Timeliness of registration due to pregnancy

Dnipropetrovsk oblast

According to the observations of health care workers (PLHIV health facilities, antenatal health facilities, PHC facilities), including those involved in reporting, the majority of HIV-positive women **are registered in connection with pregnancy in the first trimester** (*"I do all the reports. Many, more than 60 percent, are registered before 12 weeks. There are those who register before 12, 8, 9 weeks and even earlier. Gynaecologists do not admit them very early. The largest percentage were registered before 12", "12 weeks. On average, yes. Three months", "Every quarter I monitor the registration of HIV-infected people, at what period they register. In most cases, this is before 12 weeks of pregnancy. In second place is the second trimester, after 13 to 24 weeks. And extremely rarely, but unfortunately, there are those who register at later periods. Unfortunately, there are also those who are admitted to the maternity ward when already in labour, often not observed at all"*).

Odesa oblast

According to the observations of health care workers (PLHIV health facilities), including those involved in reporting, the majority of HIV-positive women **are registered due to pregnancy in the second trimester** (*"They are registered at different terms of pregnancy. Most are up to 24 weeks. From 12 to 24 weeks, it's about 60 percent. All the latter, both after 24 and at 38 weeks", "Most often, let's say, it's the 20th week, the second trimester. It's very rare when it's in the first weeks, the first months"*).

Factors influencing the timely registration of HIV-positive pregnant women

According to doctors, **timely registration** of HIV-positive pregnant women depends on the following factors:

Territorial affiliation, remoteness of medical services: Residents of remote hromadas or rural areas register for pregnancy later (*"It depends on, let's say, territorial affiliation. The further from the oblast centre, the more difficult it is to do all these things. That is, to go somewhere, to plan, something else. In the oblast centre, in the city of Dnipro, in particular, it is not a problem", "There are various obstacles, perhaps remoteness"*).

Pregnancy experience during a lifetime with HIV: Pregnant women who are newly diagnosed tend to register later than those who have already had a pregnancy experience while living with HIV. Women who have already undergone medical observation during previous pregnancies and are taking ART usually register by 12 weeks. For them, the process is less stressful and perceived as usual (*"Those who are already HIV-positive and who have already been observed for the first time, then the second, third, they come like everyone else, by 12 weeks exactly", "It's not, as they say, dangerous for women who have been HIV-infected for a long time and are taking ART. I'm somehow calmer, well, I didn't have time to register"*).

Fear of stigma and discrimination, or previous **experience of stigma and discrimination**, can lead women to postpone registration. Fears of negative attitudes from health workers affect women's decisions to seek help, sometimes they are even advised to terminate their pregnancy due to their HIV status (*"I think it depends on the fact that there are simply some fears that they will not be perceived in the medical institution. I have had examples when women came to me for pregnancy registration, and the doctors had a very strong stigma towards them, even to the point of telling them that this pregnancy should be terminated, they were intimidated that they should not just give birth"*).

Military operations: War shifts women's priorities towards ensuring basic security needs, and health care often takes a back seat. In such conditions, timely registration can be complicated, as security issues become paramount (*"The situation itself, now in the country, the war, it has become an obstacle. People, of course, are moving, perhaps, to safer places. Believe me, they just don't consider it like this, today it is 11 weeks, and tomorrow is already 13")*.

Organisation and attitude to one's own health: If a woman takes her condition seriously and is interested in pregnancy, she seeks to see doctors and register as soon as possible (*"It depends on the woman's organisation, how seriously she takes her condition, how worried she is about the pregnancy", "If a woman is interested in this pregnancy, she runs to the doctors early. Today I had a woman, she is 7 weeks pregnant, but she was already going to register for pregnancy. Although the shortest period is 12 weeks. That is, then you can have an ultrasound. It all depends on the woman herself"*).

Timeliness of HIV Early Infant Diagnosis

A paediatric infectious disease specialist at the oblast PLHIV health facility (Dnipropetrovsk oblast) noted that **the second PCR test for HIV status** at the age of 1–2 months **is not always performed on time** for HIV-exposed children from **remote hromadas**. Samples are collected at the age of 2.5, 3, or 4 months due to difficulties in getting women to medical facilities. To solve this problem, children are tested during field visits of a multidisciplinary team to remote communities (*"After the first test, they come for the second. Or we go to the districts. As we go to this district, we examine them. The second PCR may not be in a month, or in two, but in two and a half, or three, or sometimes even four. Now it is very difficult to get to us, or even to the Dovira's office"*).

Focus group discussions with 16 community service providers and activists

Timeliness of receiving adapted milk formulas at the expense of local budgets

A community activist from Kryvyi Rih (Dnipropetrovsk oblast) noted that HIV-positive mothers often **receive adapted infant formula from family doctors with a significant delay**, which can last up to six months: *"Usually, women who sign a declaration with a family doctor here wait a month, a month and a half. And sometimes they wait for this infant formula for half a year"*.

Residents of remote hromadas

Qualitative component

In-depth interviews with 10 providers of medical PMTCT services

From their own experience, doctors have identified a number of problematic issues for HIV-positive women in remote hromadas. In particular, the main obstacles include the prevalence of stigma and discrimination, which in some cases takes on threatening forms, such as attempts at eviction by local authorities (village head). In addition, the lack of access to ART, HIV and CD4 testing, and the shortage of specialised doctors (infectious disease specialist, narcologist, phthisiologist) at the place of residence force women to travel considerable distances to receive services in the oblast centre, which complicates timely treatment and support.

Dnipropetrovsk oblast

A paediatric infectious disease specialist at the oblast PLHIV health facility reported a case of **stigma and discrimination** in a small community: the village head tried to evict a woman after learning about her HIV-positive status (*"There are village heads who evict after learning that positive people are walking around the village. The village head"*).

Odesa oblast

(Example of the Velykodolynske territorial community of the Odesa district of the Odesa region)

Lack of ART provision and testing for viral load and CD4 at the place of residence: An infectious disease specialist at the PHC facility, who treats HIV-positive people, reported that the key hromada's health facility does not have a "Dovira" office, and there is no provision of ART and testing for vial load and SD4. HIV-positive patients have to travel up to 50 km to Odesa (25 km one way) or Ovidiopol to receive treatment and undergo appropriate tests.

The proposed solution to the problem is to open a Dovira's office on the basis of the PHC facility, to receive the NHSU package "Diagnosis, treatment and support of people with HIV infection" in 2026 (*"Counselling and diagnosis are already provided. But receiving therapy in the PHC facility is not. Providing ART is already the prerogative of the Centre for Socially Significant Diseases, because we don't have therapy. It is issued either by Ovidiopol, a nearby district, or Odesa. The head doctor really wants to open a Dovira's office so that ARV therapy can be provided. Due to receiving packages, only now it will all come back again, I mean, the therapy itself. Starting in the new year, a new package will be provided at the expense of the NHSU. Because I have a lot of HIV-infected people who have far to travel. It means getting to the Centre for Socially Significant Diseases or to Ovidiopol, making an appointment, and there it takes hours of reception and they may not be admitted on this day, but, for example, in 2-3 days. Therefore, there are a number of components here. That is, transport, in addition to various bureaucratic moments that delay, postpone the receipt of therapy directly. CD4 is taken either in Ovidiopol or Odesa. Where ART is given, it is about 50 km. Far away"*).

Lack of specialised doctors: Patients have to go to the oblast centre (Odesa) or another settlement in the Odesa oblast to receive consultations from a narcologist and phthisiologist, and treatment for hepatitis B and C; there was no infectious disease specialist for a long time (*"When I arrived, there was no infectious disease specialist at all for a very long time. Most of the patients went to Odesa or Ovidiopol to receive therapy. There was no one to issue them, register them, and so on", "We don't have a narcologist, he is in Odesa. We haven't had a phthisiologist in Velykodolynske for a long time. That is, there is a shortage, usually, of specialists", "(What further actions should be taken in the event of drug addiction in a pregnant woman?) Referral to Odesa, to the oblast perinatal centre, there are specialists there. The distance from Odesa to Velykodolynske is 30 kilometres, and about 30 more, if not more, from Odesa to the end of the village of Kotovsky", "If hepatitis B and C are positive, then they are also referred for free therapy for the treatment of hepatitis C or hepatitis B. But this is only in Odesa. There is no such thing in Ovidiopol either"*).

Focus group discussions with 16 community service providers and activists

Women from remote hromadas face a number of significant barriers to accessing HIV and PMTCT health and social services. The main obstacles are the geographical distance of facilities, limited ART dispensing schedules, a shortage of specialised doctors (including infectious disease doctors), and the fear of disclosing the diagnosis, which is especially acute in small settlements. Restrictions on ART dispensing schedules can lead to interruption of treatment during pregnancy. Community activists see the solution to this problem as expanding ART dispensing sites at the primary level and introducing mail-order drug delivery services, which is especially relevant for residents of remote areas. However, the fear of disclosing the status often forces women to avoid contact with local health workers and turn to doctors in oblast centres, even if this creates additional difficulties and exacerbates the problem of accessibility.

Dnipropetrovsk oblast

Restricting ART dispensing schedules in PLHIV health facilities does not meet the needs of women from rural areas and remote hromadas, leads to cases of ART interruption during pregnancy, nullifies the efforts of NGO workers to provide social support and ensure adherence to ARV treatment, further exacerbating the problem of geographical remoteness of PLHIV health facilities for HIV-positive women (*"It is very inconvenient, because sometimes it happens that you consult a woman, motivate her to come, we had such a case with a pregnant woman from a village, ask her to come, and send her money so that she would come. She comes, calls, says "they didn't give me the medicine because I came at the wrong time, not on the day they give it". Listen, you are just nullifying all the work. As a result, the woman disappeared, and we only found her in the maternity hospital during childbirth, without ART. Thank God, the child is negative*" (Kryvyi Rih)). By addressing the problems associated with the geographical accessibility of medical services related to HIV and PMTCT, activists see improved access through **the expansion of ART dispensing sites at the primary level**, in particular at the PHC facilities, which will reduce the burden on the PLHIV health facilities. The need to support ART delivery services by mail was also noted (*"There are other offices where it may be more convenient, for example, taking tests, sending ART by Nova Poshta", "Soon the 9th PHC facility on the left bank will open, the ARV therapy will be provided there. The more such ART sites there are in the city, at the primary level, closer to home, the more convenient it is. The more such ART sites are opened at the PHC facilities, the more accessible and of higher quality it will be for women, including pregnant women, in the first place"*). A community representative noted **the lack of specialists (infectious disease doctors) in remote hromadas and rural areas** (*"If these are small hromadas, then there are not enough doctors. It is precisely infectious disease doctors who are not available in the localities. A nurse works there, or a family doctor. In other words, it is precisely the specialised doctors who are already lacking in small hromadas"*). The activists also singled out **the fear of disclosing the diagnosis** as a barrier to seeking PMTCT services in rural areas and small towns. This leads to the fact that HIV-positive women prefer to be monitored in the oblast centre, rather than at their place of residence, and **avoid contact with medical workers in their hromadas**, for example, family doctors, paediatricians, gynaecologists (*"Women from small settlements do not want to register, they are afraid of revealing their status. And they usually turn to the oblast AIDS centre and register there. They do not turn to a gynaecologist, or they are afraid to go to a family doctor in their settlement, so that their status is not disclosed, because the settlement is small. Even there were cases, when the orderly, the nurse, and so on, they disclose the women's status, and the whole village knows"*).

Socioeconomic factors, such as poverty and high child care burdens, further complicate access to health and non-health services for women living with HIV in remote hromadas. Existing HIV-service NGO projects cannot fully meet the needs of women in remote hromadas, especially in terms of psychosocial and humanitarian support.

Odesa oblast

A community activist noted that **existing projects of HIV-service NGOs** that provide non-medical social and psychological PMTCT services to women **in remote hromadas** and rural areas **are unable to cover existing needs**. Problems with access to services are exacerbated by socio-economic factors, including **poverty and the burden of childcare** (*"The oblast is poorly covered. Services, consultations for HIV-positive pregnant women", "Population impoverishment. We go to the districts, it's a total disaster. You can't see this in Odesa. But what we saw in the districts is five, six, seven children. We came to Liubashivka, there are at least two children per mother", "She can't physically carry 5 children. Now with an HIV-positive child, she asked for baby food, because they didn't purchase it in this particular locality. We will now send baby food"*).

Adolescent girls living with HIV

Qualitative component

In-depth interviews with 8 adolescent girls living with HIV

Socio-demographic characteristics

Place of residence.

Dnipropetrovsk oblast: Dnipro city (2), Samar city, Krasivske village, Kryvyi Rih district. **Odesa oblast:** Odesa city (2), Biliaivka city, Liubashivka urban-type settlement, Podilsk district. Age: 14 years (4 girls), 15 years (1), 16 years (2), 17 years (1).

Of the eight girls, only one is raised in a complete family. The remaining seven girls live in single-parent families: three are raised only by their mother, one by their father, two girls are raised by their grandmother, and one by their uncle. Two participants come from large families (more than three children in a family). One girl from Odesa is an internally displaced person from the Dnipropetrovsk oblast. Another girl was forced to go abroad for three months due to the russian war against Ukraine. At the time of the survey, all girls were studying at school, lyceum, or college (according to age group).

Disclosure and acceptance of HIV status

The girls learned about their HIV status either in preschool (3 girls), or in junior high school (2 girls), or in high school (3 girls), that is, all learned before adolescence (8, 11, 4-5, 3, 5, 13, 8-9, 11-12). Experts believe that a child with HIV should be informed about their diagnosis before adolescence. Seven girls have been living with HIV since birth, one girl was diagnosed with HIV at the age of 13.

Four girls learned about their HIV-positive status from their parents (mother or father), two from guardians (grandmother or uncle), and two more directly from medical professionals (*"At about 8 years old. My father told me. After my mother died, I found out that I had the same disease as her. After my mother died, they told me. Before that, they didn't want to tell me", "We were in the hospital when my uncle asked the doctors to explain, I was about 11 years old. My uncle also knew, but he asked that the doctors explain it, because, in his opinion, they could explain everything to me in detail", "My mother, when I already understood her well, she told me that I had HIV from birth. I found out when I was 3 years old. I don't remember much, but I remember that my mother and I were talking in the kitchen, and she told me, daughter, look, when I was pregnant, I had HIV, when I gave birth to you, I passed it to you", "My sister got sick and the doctors advised me to do this test. My mother decided to make sure that other family members didn't have it. They decided to do all the tests and everyone had it. I was 13, I took the tests and the result was positive, and my mother told me about it. First to my mother. And then in Kyiv I talked to the doctors at the hospital about it", "I found out when I was 8-9 years old. Before that, I didn't know, I didn't take any medications at all. (My grandmother told me)", "I found out when I was 11-12, probably when I started taking pills. (The doctors told you?) Yes, because I was*

always curious why I had to go somewhere, donate blood, take some pills. That's why they told me. At the place where I get my medications").

The girls' reactions to the news about HIV varied: from indifference (*"in no way", "it wasn't really important", "I didn't understand what it was, so I didn't really focus on it", "normally")* to fear *("it was scary", "people die from it"*). Currently, most of the interviewed HIV-positive girls have adapted to life with HIV and note that HIV does not bother them, or they have already come to terms with the diagnosis (*"For me, HIV is something that I do not note", "In ordinary life, I don't put myself lower or higher than anyone. I'm an ordinary person", "It's never been a problem for me", "I've come to terms with it a long time ago", "It's already starting to be a kind of norm", "I've come to terms with it and will continue to live on"*). At the same time, one girl from the Dnipropetrovsk oblast needs additional psychological and social support to overcome difficulties in the field of mental health associated with living with HIV, the loss of her mother, social stigma at school and in the community.

Medical surveillance related to HIV

Dnipropetrovsk oblast

Three girls visit a doctor (HIV medical supervision) quarterly (Dnipro city – 2, Samar city – 1). One of the girls notes a special attachment to her doctor (*"I really like my doctor; she is very kind. I see her every three months"*). One girl (a resident of a rural area, Krasivske village) has not seen a doctor for HIV medical supervision in the past year (*"We saw each other about a year ago. Yes, it was a long time ago, I don't know why we stopped coming. I used to see her once a year, we came for a full check-up. Every time I came once a year, they checked me out completely, they did an examination there, took blood, asked if I was taking my medication"*). At the same time, she noted that over the past month, the doctor has been communicating with her via Viber, checking on how the girl is feeling (*"She asked how I feel, if everything is okay, and if no one is insulting me now. That was about a month ago"*). Basically, her uncle (guardian) maintains contact with the doctor, since the girl is afraid of communication (*"Mostly my uncle, because I'm a little afraid to communicate with them. I don't know, I'm afraid of communication"*). The girl is sent ARV drugs via Nova Poshta (*"She sends them via Nova Poshta"*). The reason for the decrease in the frequency of visits to the doctor may be **the impact of the war** (*"I stopped seeing the doctors who consulted me right when the war started. They moved somewhere and we stopped communicating with these doctors, only via Viber. The doctors used to give me pills themselves when I came. Now they give them to me via mail"*).

Odesa oblast

One girl (Biliaivka city) visits a doctor in Odesa every six months. During periods of missing ART, the frequency of visits increased to once every three months, after the condition stabilised, she returned to once every six months: *"Once every six months or so. During the period when I skipped therapy, it was once every three months or so. And then, when everything got better, it was once every six months".* In addition, the girl is also observed at the National Children's Specialised Hospital of the MoH "OKHMATDYT" in Kyiv. One girl (Liubashivka urban-type settlement) could not name the exact frequency of visits to the doctor, but reported that the last visit was two months ago. One girl (Odesa city) visits an infectious disease specialist with varying frequency, depending on the need to donate blood or receive medications. The last visit took place three days ago to receive ART: *"When I donate blood, well, every five, four months. Sometimes, when I come to get pills. (Your last visit?) Recently. Three days ago. I had to get the drugs".* One girl (Odesa city) noted that she had only been to the medical facility once, where her grandmother, the caregiver, receives ART once every three months: *"I almost never go there. I was there once, when the medicines were picked up. So, basically, my grandmother goes there herself. Once every three months".* At the same time, the girl undergoes regular medical supervision by a paediatrician at the children's hospital at her place of residence: *"We are registered in another hospital. The children's hospital is not far from my house, paediatrician B.".*

ARV treatment and awareness of ART-related concepts

All adolescent girls who participated in the research **were receiving antiretroviral therapy (ART)** at the time of the research.

Only one girl (Biliaivka city, Odesa oblast) was able to give a relevant explanation of the concept of **CD4 cells** (in her own words) (*"Well, healthy cells, in general. Responsible for immunity"*). She received this information from psychologists and social workers of the "OKHMATDYT" National Centre for the Prevention of Diseases and Immunisation in Kyiv. The rest of the girls were either unable to explain the meaning of CD4 at all or did not know what it was at all.

Also, only one girl (Biliaivka city, Odesa oblast) was able **to name the ARV drugs she takes** (*"Tenofovir, I think, Lamivudine and Dolutegravir, I guess"*). Other participants do not remember the names of their medications, do not read them or rely on adults, in particular, their mother or grandmother, in this matter (*"They give them to me, I know that these are my drugs and that's it", "I don't read them. They just give me boxes. And I have to take pills from this box, that's all", "No. I can't name them, I don't remember", "I can't say exactly what these drugs are called. My mother knows more about them than I do", "Unfortunately, I don't know. It's a blue jar, big, I don't remember the name", "Something starts with "A". I don't really read them"*).

Five girls **take ART on their own and monitor adherence to the treatment regimen** (3 from Dnipropetrovsk oblast, 2 from Odesa oblast). They describe how over time they learned to take their own medication, although at first, they felt afraid or needed adult supervision (*"Before, my uncle was there to monitor. That is, I had to take the pills and drink them with him. Somewhere until I was 14 years old. Then my uncle said that he was going to the field, and I was at home. He said, now you can drink them yourself. I was afraid to drink them myself several times, my body could not drink them itself, because it remembers that someone was always watching me so that I drank them. How can I do it alone? What if I forget that I drank them and drink them twice? At first it was scary, but then at about 15 years everything was fine with me. I calmly drank them and that was it. I know that I drank them and everything is fine. I lie down and sleep"*, "*My grandmother used to control me, but now I'm on my own. I just have one pill. I used to take three pills a day. I took one in the morning and two in the evening. And then I switched to one drug. I take it at 10 o'clock in the evening, just wash it down with water and that's it. My grandmother used to have an alarm clock because I could forget. Now I have an alarm clock myself, but I usually prepare water for myself beforehand and just drink it").*

In three cases, the mother or grandmother is fully or partially responsible for taking ART (1 – Dnipropetrovsk oblast, 2 – Odesa oblast). (*"Mom is responsible. (Do you rely entirely on mom?) No, I can do it myself. Sometimes I ask my mom to remind me to take the medicine. If I have already taken it, I don't ask her", "Mom, she gives it", "Grandma, but usually I do"*).

Three girls have an idea about **viral load**, understand its importance and can answer when it was last checked (1 – Dnipropetrovsk oblast, 2 – Odesa oblast). They know that an increase in viral load is associated with a violation of the ART regimen, which can lead to a deterioration in health (*"This is when you don't take this treatment, and this viral load, it grows. Somewhere in late spring (I checked it). Everything was fine. Up to forty", "Yes. I also checked in Kyiv. This is when you break the therapy and the viral load grows, that is, the virus progresses. And your health deteriorates a lot. This is a decrease in immunity, the progression of various diseases. It was 13 thousand. That was a lot, it was a lot", "I just know already. This is when I missed the pill period, and then there was a strong viral load. It seems that something was increasing there. Probably a month ago (I checked it). It seems that everything is fine. Well, the indicators are fine"*). Other participants do not have a clear idea of this concept and rely on their mother's knowledge or cannot explain what viral load is (3 – Dnipropetrovsk oblast, 2 – Odesa oblast).

None of the interviewed girls are familiar with the concept of **"adherence to ART"** (*"No. I have never heard such a definition", "Oh no, I have never heard", "Adherence is a new word for me, but I do follow*

the regimen"). None confirmed awareness and receipt of the social service "adherence counselling". At the same time, the girls demonstrate good adherence and responsible attitude to ARV treatment. For most of them, living with HIV is associated with regular ART intake. One of the girls was particularly affected by the experience of losing her mother, who did not take her medication, which motivated her to adhere to the therapy. The girls perceive the treatment as an integral part of their lives. They note that taking the medication regularly allows them to live a full life, do their usual activities and be confident in their health. Some of the participants note that at first it was difficult for them to get used to the idea of constantly taking pills, but the support of their mother or other relatives helped to change their attitude towards the therapy to a positive one (*"I still had in my head the fact that my mother didn't want to take the pills. I understood that if I didn't take the pills, the same fate awaited me. I remembered how much my mother was in pain. I somehow became very scared. I remembered how much my mother described her pain, and I understood how scary it would be", "Before, I didn't take this one very well. They even tried to force me to take the pill, they offered me yogurt when my mother was still alive. And now I'm on my own, without my uncle's control, I quickly drink it in the evening and that's it", "I'm fine with it. I take therapy every day, I get regular tests to check my health", "At first, I didn't understand what it was like to take pills all my life. Support from my mother, we talked. She told me that there was nothing wrong with it, nothing critical if you take pills all the time. And I realised that you can live with it if you take the therapy correctly, that there will be no serious consequences", "It's just an illness and that's it. If I take my medication, then everything is ok", "I realised that I can live peacefully, if I take my medications, everything will be fine. At first, I didn't understand what it was, and then I read it, I was really scared, then I typed some questions into Google and asked my doctor, who I'm registered with. She said that I can calmly live my life, do whatever I want, if I take the medications. An infectious disease doctor. I go to her to get my medications and blood test").* Now all the girls are accustomed and calm about ARV treatment, understanding its necessity for their own health *("Okay", "It's completely normal. I understand that I need it", "It's normal, I'm used to it", "I'm ok about treatment. If it helps me, then of course, it's good", "It's good, I'm used to it", "I didn't really like it as a child. And then I got used to it").*

Among the difficulties they encountered earlier, three girls mentioned side effects of ART (nausea) and difficulty swallowing large pills or the unpleasant taste of the medication. They used sweets or other products to make it easier to take.

Two girls (Odesa oblast) reported cases of **interruption of ARV treatment** (*"It happened like this. I interrupted it before", "At that time I somehow broke down and got fed up. I had missed pills"*).

Six girls confirmed that they have direct communication with the doctor on HIV issues, when they can directly ask questions about their treatment (*"Yes, I can, if I want to ask a question about something that I feel wrong. For example, I took the pills and I felt something wrong, some nausea or some pain. If there is a side effect, I can write and tell her that something is wrong, that something is wrong with me*"). However, two girls (Odesa oblast) do not have such direct communication with the doctor on HIV, and the main source of information about ART and related issues is their mother or grandmother (*"(Did your doctor told you how, when to take the pills, what therapy you take and why it is important?) No, only my mother. She only talks to my mother"*).

Sexual and reproductive health. Understanding the prospect of having an HIV-negative child

Six girls demonstrate heterosexual preferences in relationships, one does not distinguish people by gender or sex for falling in love, and another girl noted that she is unable to fall in love. Three girls had experience of sexual relations with HIV-negative partners, forming **discordant couples**. When asked who they could talk to about sex, two girls chose their mother, two — a sexual partner, one — a friend, one — a sister, one — a grandmother or aunt. Two girls noted that they have no one to talk about this topic or did not like to talk about it.

Seven girls know about **the possibility of giving birth to an HIV-negative child**, one was not interested in this issue. Six girls understand that for this it is necessary to take ART, one does not know the details.

One girl relies on personal experience — her younger sister is HIV-negative, because her mother took drugs during pregnancy (*"I don't know, to be honest. I just haven't delved into how women with HIV status give birth. It's somehow difficult to think about giving birth to a child yet, at 14 years old"*).

Among those who know, six know what is needed for this, in particular taking ART, and one does not know (*"One should always take medications during pregnancy", "Take your medications in full. And during pregnancy, it is mandatory. Because I have personal experience in this. Because my mother did not take medications at first. Well, I am the first child, and by the way, she was not told whether she could take medications or not. She was afraid that if she took medications, it might affect me in some way. That is why she did not take them, that is why I am HIV-positive. And my younger sister is HIV-negative", "I know. They told me that there is already a pill so that the child will be born healthy", "Yes, I know. Take therapy. And monitor the status", "I know. My mother already told me about it, that I can give birth to a child without HIV"*).

Seven girls know where to get information about STIs, safe sex, condom and contraceptive use, mentioning among the sources medical workers, mothers, fathers, sister, Internet, HIV service NGOs (*"The gynaecologist told me this, or my parents told me this. Or I read it on the Internet", "On the Internet, on websites. Or I asked my sister, because she had experience. You can ask the doctor himself. He will clearly explain thoroughly", "In a special centre, in a special hospital too. Or you can ask your doctor", "I can ask in the group "Positive Women". They always answer this question for me. But it is easier for me to ask my mother, because I am a little embarrassed to ask other women. I am somehow ashamed of it", "My mom tells me, or I search on the Internet", "I ask my mother, I also talked to doctors", "Google and there is a doctor. And a social worker"*). One girl doesn't know what sexually transmitted infections are.

In the case of an STI, six girls believe that they can receive diagnosis and treatment without fear of condemnation from medical workers. At the same time, one girl (Dnipropetrovsk oblast) expressed concerns about possible condemnation (*"I think there will be some condemnation. Because some people don't really treat it well. I heard about it. We have a friend, she told us about it, that she came to the hospital and they didn't even want to treat her so that she could be cured"*).

All girls can contact their doctors with questions about sexual health and needs (*"Yes. Our infectious disease specialist. I can ask her anything", "Yes. (the doctor responsible for the treatment?) I trust her the most", "Yes, I can ask. To ask about something", "I think so. One doctor (AIDS centre)", "Let's say, either in our village, I can talk to the doctor, or in Kyiv"*).

Only one girl (Dnipropetrovsk oblast) knows where to get free products necessary for a pleasant and safe sex life (lubricants, female and male condoms, contraceptives, etc.) (*"It's free at the doctor's, or at the AIDS centre, they have it there").* Other girls do not have such information *("Online store, pharmacy. I don't know about free ones"*).

Only one girl (Odesa oblast) knows what **active consent in sexual relations** means (*"So that you are not forced against your will. And when you have the opportunity to say "no"*). None of the three girls with experience of sexual relations reported cases of sexualised violence (when they did not understand what happened, being in a state of alcoholic or drug intoxication, against their will, not being able to stop their partner or say "no", regretting that it happened to them).

None of the girls had unplanned pregnancies. Seven girls believe that they do not have **access to safe and free or affordable abortion** if they need it or do not know whether they have such access (*"This is the first time I hear about free abortion", "Honestly, I do not know. I have not even asked this question or thought about it"*). Among them, one noted that although she believes that there is no access, she can ask the women from the HIV service NGO (*"I don't think. But I can ask the women from "Positive Women". Maybe they can help me with something. They help me a lot. Lately, over the past three years, I have really enjoyed spending time with them"*). One girl suggests that such access should be available in Ukraine (*"I think it is possible in Ukraine*").

Two girls (Dnipropetrovsk oblast) can talk to other girls or women living with HIV who will give advice on healthy motherhood (*"I have friends from centres, or a doctor, or girls like you, for example. (Do you mean in non-governmental organisations?) Yes", "Yes, there are, but I don't want a child yet"*). One girl prefers to talk about motherhood with doctors, and another is afraid to talk to others (*"No, I can't. Only with doctors", "No. Because I'm afraid to talk to others. If someone turns to me, then I'll talk. But I'm afraid to approach and start a conversation myself"*).

Two girls (Dnipropetrovsk oblast) reported access (or partial access) to free family planning/contraception services through the AIDS centre or gynaecologist consultations (*"Yes. At the AIDS centre", "The gynaecologist told us everything. She told us about contraceptives, but they didn't provide them"*). All three girls with experience of sexual relations confirmed that they can use family planning/contraception services without resistance from my sexual partner.

All eight girls **do not know** what **pre- and post-exposure prophylaxis** is, and do not know where to get it. Despite the extreme importance of cervical cancer prevention for girls and women living with HIV, a significant proportion of girls (6 out of 8) do not know what **human papillomavirus** (HPV) is. Only two (Dnipropetrovsk oblast) indicated that they have information about HPV, one of them had been vaccinated against HPV at an AIDS centre.

Only three girls (Dnipropetrovsk oblast – 2, Odesa oblast – 1) regularly undergo **preventive examinations at a gynaecologist** (*"I take smears once a year") ("Yes. I have a family doctor in Dnipro", "This month I will be there for the second time, because I have very painful period. I will go to her on Wednesday, to the gynaecologist, oblast hospital. I was there in the spring. I will go for the third time soon", "Yes. I take smears once a year. There is a polyclinic in Biliaivka, at the gynaecologist"*).

Understanding the concepts of "stigma" and "discrimination"

None of the girls interviewed could define the concept of "stigma", and six girls do not understand the meaning of the word "discrimination." Only two girls (Odesa oblast) had an idea about discrimination and could explain this phenomenon in their own words (*"Probably, as an unfair treatment of a person, or a group of people with some certain characteristics, such as disability, for example," "Discrimination is when a person is discriminated against because of what makes them different from others"*).

Experiences of stigma and discrimination

One girl (Odesa oblast) was asked by a gynaecologist how she had contracted HIV ("*Sometimes they asked in the hospital, I don't remember exactly. Well, they just asked, like, how did it happen, like, from birth, if it came from the mother with milk. It was probably a year and a half ago. When I went to the gynaecologist*").

One girl (Dnipropetrovsk oblast) faced the disclosure of the secret of her diagnosis by a medical worker to educators, which led to stigmatisation and discrimination at the school where the girl studied. The school principal began to call for the purchase of gloves and masks for protection, but the girl's mother defended her rights, emphasizing the absence of a threat to her surroundings and the possibility of legal proceedings *("Yes, I faced it. The school principal found out and started to panic. Somehow, she understood it from the note. She said that everyone needed gloves, masks, something like that. Yes, at school, to the kids I studied with. It was fourth or third grade. Mom immediately took my side. Mom said that this was a court case, and I wouldn't cause any danger. And that's it, she (the principal) just didn't say anything else about it").*

Another girl from Dnipropetrovsk oblast experienced stigma in **the hromada** (from neighbours) and at **school** due to her HIV-positive status. The neighbours learned about the diagnosis during a phone conversation between her mother and a doctor, after which they began to mock and tell others. At school, the girl was bullied, called "contagious" and others refused to be friends with her. However, when she shared her experience at the hospital, she was offered the help of a social worker (*"At school, when they found out that I had an illness. They started saying that I was probably contagious, that I*

couldn't communicate with anyone. The classes were smaller for the most part. I mean, I was constantly being bullied like that. They called me names, that I was contagious and that I couldn't be friends with anyone. Now that's not the case anymore. Now, after the war and the coronavirus, everyone forgot about it. (How old were you then?) Ten or eleven, something like that", "I had neighbours who, when they found out that my mom and I had this illness, probably started laughing at us a little. It was a little embarrassing. They told other neighbours, they said, can you imagine, they're like sick. They're sick, they're contagious. They just laughed, made fun of me, and told others about it. (How did they find out about your HIV status?) They heard. From my mom's phone conversation. Because the doctor called her and asked how my well-being. The neighbours heard it, they were nearby and heard it. Mom simply had poor hearing because of work. She constantly had headaches, she had poor hearing. So, she often asked questions, turned on the speakerphone to hear better", "I have a social worker. One day I was in the hospital, when I started telling her that I was being bullied, they said that they could give me a social worker").

Also, one girl (Dnipropetrovsk oblast) faced stigma from her **boyfriend's** (partner's) **parents** because of her HIV-positive status. Despite this, she receives support from her partner and friend, who emphasize acceptance and treatment of her as an ordinary person (*"When my boyfriend's parents found out, they reacted very badly to it. We had a big conflict. But the guy told his parents that I don't care, whether she's sick or not, it doesn't matter to me. I love her and that's it. My friend also said, you're my friend, I don't care whether you're sick or not. There's no other attitude towards me. That's the attitude, like towards an ordinary person. And that's all. And I understand that it's very good"*).

Awareness of rights protection mechanisms

Three girls know where to complain or seek help in case of violation of their rights as a girl living with HIV. They mentioned courts, police, doctors, HIV service organisations as possible sources of help (*"Yes. I know that this is a court case, as I can understand. I can ask for help. And my doctor is also involved in this. Or the police, I can write a statement", "I know where to ask or ask for help. I can ask for help at "Positive Women", they will help me with this", "The police, probably"*). However, the other five girls are not aware of the existing mechanisms for protecting their rights.

Mental health

Mental health problems are common among girls living with HIV. The main conditions most frequently mentioned by them were shame, loneliness, self-blame, low self-esteem, anxiety, fear, panic attacks and sleep problems, including insomnia. Seven girls reported having these conditions, linking them directly to their HIV diagnosis or to other causes.

Five girls who experienced insomnia or sleep problems did not associate these difficulties with their HIV diagnosis. At the same time, three girls associated a sense of shame with HIV (two still felt shame, but did not associate it with HIV), two — low self-esteem (two more — did not associate), one girl experienced self-blame due to HIV (three — did not associate), one noted that anxiety, fear and panic attacks arise in connection with HIV (three — did not associate), one girl associated loneliness with HIV (four — did not associate). Internal denial and unwillingness to accept her diagnosis was noted by one girl (seven — did not have such a problem). One girl also noted the impact of the war on mental health, in particular the fear of shelling and explosions (*"I remember thinking that it was my fault. When my mother died, I thought that it was my fault. I thought that I should have just not been born and all that. Because they also told me that, in principle, I wasn't even planned. I thought that if I hadn't been born, she would have been healthy", "There was a situation when I forgot to take the pills. My hands were shaking. I didn't know what to do. I was scared", "Sometimes I don't really want to, I just don't feel like going outside. That is, they tell me to go for a walk, get some fresh air. I say no, I feel calmer at home, I draw, I paint. And sometimes I don't even feel like going outside, going somewhere", "Because I have almost no friends, I often feel lonely. I constantly think that it's because of my illness. Many people already know about it. That's why no one even makes friends with me", "It was connected with explosions. I was very afraid of it. When it was especially loud in Dnipro, I was very afraid, I cried.*

I was stressed about it. I was very scared. My mother calms me down, and my older brother, but I still have a little bit of panic. I am very afraid of it").

Two girls sought help from doctors, their mother, and an HIV-service NGO to address their mental health issues (*"I just started feeling nauseous and went to the toilet. Then I came out and started suffocating. They told me to go to the hospital. I went to the hospital," "Yes, I did. Either to Positive Women, or my mother listened and talked to me. Then I calm down"*).

Social services based on HIV-service NGOs

Girls are most informed about the possibility of receiving the following social services through HIV-service NGOs: support groups for adolescents, people and women living with HIV (six know, four have attended); food support (six know and have received); humanitarian aid, except for food (hygiene kits, clothes, power banks, etc.) (six know and have received); psychological assistance (psychological consultations, psychotherapy) (five know, four have received).

Girls are least informed about the following services: psychiatric treatment (one girl), assistance in receiving social benefits and funds from charitable funds in connection with HIV (one), staying in a shelter, refuge, crisis centre or apartment (two), evacuation or transportation to a safer place (two). None are informed about the possibility of counselling on issues of forming adherence to ART.

Only girls from Dnipropetrovsk oblast confirmed attending support groups and were also able to name the HIV service organisations where they received assistance: "Positive Women", "Caritas", "100% Life Dnipro", "Oberih".

Among other services received, the girls noted: delivery of ART (four), financial support (four), training in HIV transmission prevention and the formation of healthy lifestyle skills (four), dispensing of medications (except ART) and payment for diagnostics (four), accompaniment to relevant specialists (two), legal or paralegal counselling and support (documentation) (two), counselling on disclosing HIV status to others (one) (*"We were given certificates. We could go to a store, give a certificate", "We have a woman at Caritas who has been guiding me since birth, she told us that there was this group ("Positive Women"). I really like it here. Always. (What kind of support group is it?) I like a group with women more than with teenagers. I understand everything well there. I am shy with teenagers", "We went to the gynaecologist. They made an appointment for me. Now I have my doctor, whom I can call every day and ask questions", "My social worker wrote to me about it. We went to some kind of conference on the phone. We sat there and talked. There were several teenagers there. And we talked to each other. I had very bad internet and I was getting knocked out. So, I couldn't fully listen to everything. I couldn't stay there for long. I was there for literally 10 minutes. I was scared to say anything. Because I'm the biggest sociophobe, so I was, I don't know, kind of scared. But, in principle, it was a little interesting", "Yes, I visited (support groups). We went for therapy, and there were girls there, they invited us (to the AIDS centre?) Yes. The girls sat there; they invited me every time. I came. There were interesting facts. I was at a camp with children. It was also interesting, a year ago, I was in Lviv with them. It's ok. It's interesting, now not very often, but when they invite me, then I come. I try to come").*

In-depth interviews with 10 providers of medical PMTCT services

Dnipropetrovsk oblast

Experience working with adolescents living with HIV

Two health care workers from the PLHIV health facility in Dnipropetrovsk oblast (Dnipro and Kryvyi Rih) noted their significant experience working with adolescents living with HIV. They demonstrate a friendly and caring attitude, as well as an understanding of the problem and needs of this group.

According to one of the doctors, disclosure of HIV status to a child usually occurs after reaching the age of nine.

The role of parents and doctors in disclosing a child's HIV status

Parents often want doctors to tell their children about their HIV status, but the doctor insists that it is the parents who should have this conversation. She provides advice on how to prepare for the conversation. It is noted that parents' fears about the child's negative reaction are mostly exaggerated (*"Parents want the doctor to tell them, not them. But I tell them that they should do it themselves. Find a time and place. There should be a good relationship. Not to fight in the morning, and then tell them everything in the evening. I haven't seen a single HIV-positive child who wanted to jump off the roof or blame the parents. These are more of the parents' fears"*).

In some cases, doctors disclosed the status in the presence of the parents, but they want the first conversation to take place in the family circle (*"Several times I explained the situation in the presence of the parents. But I try to have the parents do it"*).

A case is also described where the mother ignored the child's diagnosis (the boy was diagnosed at the age of 16), and the doctors took responsibility for disclosing the status and supporting the teenager. The child also received counselling on disclosing his status to others and asked questions about the future and the possibility of starting a family. The doctor emphasizes the importance of discussing such issues, especially for teenagers who are learning about their diagnosis for the first time and have no experience communicating with other children living with HIV (*"We have a 16-year-old boy diagnosed this year. The mother doesn't go into contact at all, the mother is positive, she wasn't interested in the child, what was going on with him, how he was doing. The child was in the hospital for two months, she never came. His paediatrician works in an infectious disease hospital. We had to talk to him about his status. I want to tell you that he asked such competent questions at the age of 16. And will I be able to start a family? I say, why not? I say, what are the obstacles if you take everything correctly and the virus is blocked", "I say, the only thing is that if it's a serious relationship, you will feel that it's a serious relationship. Because I wouldn't advise disclosing your status right and left. Not to everyone. Of course, we talk about it, it worries them, they listen. Especially those who don't communicate with children*").

At the same time, it was reported that the infectious disease doctor (Kryvyi Rih) is limited in her ability to fully consult on the issue of disclosure of status due to part-time employment. This need is compensated by cooperation with NGOs that conduct support and training groups for children and adolescents (*"A paediatrician who works part-time, I don't think she has so much time to sit here and consult, thank God, she still has time for visits. If there is such a request, then most people refer to cooperation with social workers, girls who work with children, they have groups, schools, classes. (On the basis of non-governmental organisations?) Yes, mostly them. If something like that is needed, we have had such situations, with this grandmother, I see that neither the girls can reach her there, nor she, I had to do everything herself"*).

Features of working with grandmothers-caregivers

Often, grandmothers-caregivers turn for help in disclosing the child's HIV status. Due to the fears and excessive caution of grandmothers, problems arise with adherence to treatment in adolescents who are not aware of their status. The doctor made significant efforts to ensure that the 14-year-old child learned about his HIV status and received support in treatment issues. Effective cooperation with doctors of the National Centre for the Prevention of HIV Infections "OKHMATDYT" was especially noted (*"(Are parents supported in disclosing their child's HIV status?) Of course, if parents say they can't, it's not so much the parents as the grandmothers. Parents, somehow, we can do it together with them", "The boy is 14 years old, the grandmother doesn't want to tell him, she hides those pills somewhere, crushes them somewhere, throws them into something. I see that the child is simply wasting away, the virus is growing, and she.... I fought with that grandmother for a long time. I sent him to Kyiv, of course. Thanks to Oksana Viktorovna Soldatenkova. She's basically my lifesaver. I used to get a little angry at*

the grandmother. Sometimes I even blackmailed me, saying I'll just write to social services, take the child away from her, I won't give you any right to lose the child. A normal, good child who was healthy. I say, do you really think he can't read and doesn't know where he is going. The institution says "AIDS Centre". I say, does he have a mobile phone? Yes. Does he have the Internet? Yes. Well, he knows what is all about. Talk to him about it, it's his inner protest against you that you don't talk to him about it. The boy is normal, we talked to him, we both cried, sat, hugged each other").

Developing treatment adherence in adolescents

Different approaches to forming adherence to treatment are indicated. One doctor conducts direct communication with adolescents regarding adherence to ART, talking to them "face to face", without involving parents, if adolescents already know about their status. Adolescents seek advice on the risk of transmitting HIV to partners, openly ask questions, call to clarify details (*"I do not do this via parents. Face to face", "When children know about something and ask you. And children, they even call, but I can infect my partner, the boy recently called too"*).

Otherwise, preference is given to counselling in the presence of parents. When good adherence to treatment is noted, doctors switch to direct communication with the child (*"We try to have them come with their parents. If there is good adherence and it is clear that everyone is interested, and there is somehow a more open and friendly relationship with the teenagers, then they come on their own. It is easy; it is clearly simple this way"*).

Sexual and reproductive health counselling

Sexual and reproductive health (SRH) consultations are conducted. The doctor notes that adolescents are not shy about discussing these issues, and boys are less shy than girls (*"Yes (I do the counselling). Maybe not as thoroughly as it should be. Questions are discussed, they ask. They are not shy. You know, even boys are less shy than girls," "It is definitely being done"*).

Odesa oblast

Experience working with adolescents living with HIV

Two health care workers from the PLHIV health facility in Odesa oblast (Odesa) shared their experience working with adolescents living with HIV. A gynaecologist from the PLHIV health facility reported on medical monitoring of two underage pregnant girls: *"I have two pregnant girls under the age of 18"*. The paediatric infectious disease doctor has less than two years of experience.

The role of parents and doctors in disclosing a child's HIV status

Disclosure of HIV status to a child occurs at different ages, but there is a case where a young woman aged 23 does not know about her HIV-positive status because her mother is afraid to tell her. The doctor believes that there is nothing she can do. It is worth noting that current legislation allows adolescents from the age of 14 to receive medical care without parental consent (including HIV testing[32] and receiving ART) (*"It happens at different ages. Someone knows it since childhood, and someone at 23 still doesn't know what she or he has. I have a mother like that, she's still afraid. The girl is 23, but she feeds her pills. And there's nothing I can do about it"*). The grandmother-caretaker's fears about disclosing the HIV status to a 17-year-old girl were also noted (*"It varies a lot. Sometimes, from the age of 12, from the age of 10, and sometimes they drag her up to the age of 17 and think that the child comes here and doesn't know how to read, grandmothers are naive, they think that children don't understand this"*). The doctor believes that it is necessary to allow child protection services to be notified about the non-disclosure of the child's HIV status so that parents (guardians) are afraid of "losing" custody ("*This is non-disclosure of the status, at least they allowed social services to disclose*

[32] https://phc.org.ua/news/pidlitok-mozhe-bez-batkiv-otrimati-konsultaciyu-schodo-zasobiv-profilaktiki-vil

it, you understand? The social services, child protection services, we have no right. So that child protection services somehow have an influence, the threat of losing the child, of being taken away").

Doctors understand the importance of disclosing the child's HIV status before they start having sex, but parents are rarely provided with assistance in disclosing the child's status; grandmothers and guardians need it first and foremost: *"(It happens rarely, but it happens. Some, especially grandmothers and guardians, have a child who is already 17 years old and doesn't know. Do you think she doesn't know? Oh, don't tell me. I say, we have to tell her. Well, how can we not tell her? A girl's sexual life is already beginning. Do you think she's still a little child? Of course, we have to tell her all this, and when they ask, I talk to them myself about what it is, that it's the immune system, that it's protection against all diseases. That is, I explain everything in a way that's accessible", "It's provided, but only psychologically")*.

One doctor reported that counselling adolescents on disclosing their status to others is most often carried out by the institution's psychologists, although she had undergone field training (*"They consult, not us. It's more the psychologists who do it. We were also taught on courses, but I haven't had such experience yet"*). Another doctor spoke about very contradictory approaches to counselling adolescents on disclosing their status to others and forming a commitment to ART, in particular, intimidation with criminal liability for transmitting HIV[33] (*"A 14-15-year-old girl who is already sexually active and her mother cannot cope with her. Then I tell her that she is already criminally liable, that you should also think about someone you live with, if you are already doing it all in such an adult way. That is why we also hold such conversations to tell that it can even be criminally punished. Someone can complain about who she slept with, and if she doesn't take the pills… I have one girl like this"*). Doctors explain mothers' fears about disclosing their child's HIV status by fear of reporting their own HIV status (*"Some people say it's like vitamins, they make it up. (They don't want to hurt their children?) Yes. They're afraid to explain themselves, why they have it"*).

Developing treatment adherence in adolescents

The formation of adherence to ART is mostly up to the parents: first they are counselled so that they can explain to the child about the status and the need to take medication, and only then, when the parents confirm that the child is informed, direct work with the teenager begins. In communicating with teenagers, doctors try to involve parents (*"This is on parents. That is, we counsel parents. In order for the teenager to understand and accept this status and the pills that they must take, we first consult the parents. And only then, if the parents tell us that we told them about the status, then we start working with the teenagers"*).

Doctors can communicate directly with the adolescent in the presence of the parents or without them, if there is trust and a good relationship, or if the parents cannot reach the child. Usually, doctors emphasize parental consent (*"Yes, but in the presence of parents. (And you don't consult without parents?) Without parents, well, it's allowed by law from the age of 14, yes, but I also need the help of parents too, because they communicate with the child every day. We don't want to risk the child perceiving us incorrectly. If we already have an established relationship with this child, then yes. And if we see that the child is wavering back and forth, then we involve the parents", "(Are you talking directly about adherence to ART from the age of 14?) Yes, I can. If the parents allow it, yes. (According to the law, you can do it even without the parents' consent) With teenagers, yes, of course. She was one of those. I reached out to her, called and talked a lot. Mom can't reach out; we did reach out. She came back, started taking it. So far, the tests are good. God grant that it will be so, so that she doesn't get into bad company again"*).

[33] https://pw.org.ua/wp-content/uploads/2022/12/pw-statement-on-hiv-criminalization-2021.pdf

Sexual and reproductive health counselling

Counselling on sexual and reproductive health of adolescents is conducted without the presence of parents, if the teenager wants privacy, which allows them to learn about possible situations of violence or other sensitive moments (*"We ask the child if they don't want to. Not all children can tell their parents what's happening. Then you can ask the child more about whether there was violence, whether there was something they didn't like. This is more often done without parents", "For example, we talked with mom, and then she came herself without mom"*).

Satisfaction with services at different levels of health care and NGO-based services

HIV-service NGOs and health care facilities providing services to people living with HIV (PLHIV health facilities) demonstrate the highest level of satisfaction among respondents. This confirms the importance of their role in supporting HIV-positive women, especially in terms of accessibility, counselling, and non-discrimination. The greatest dissatisfaction with services is observed in maternity hospitals, in particular among women from Odesa oblast. This indicates the need to improve the quality and sensitivity of such facilities to the needs of women living with HIV.

The level of satisfaction with medical services differs between regions: in Dnipropetrovsk oblast, most respondents are satisfied with services at all levels, while in Odesa oblast, only PLHIV health facilities receive positive assessments. At the same time, it is in Odesa oblast that the highest level of satisfaction with non-medical services based on HIV-service NGOs is observed. The qualitative component confirms that satisfaction is determined not only by the professional competence of medical personnel, but also by their attitude towards women and children, the absence of discrimination, the availability of consultations and the possibility of receiving humanitarian assistance. Non-medical social services, in particular social support, home delivery of medicines, peer support and humanitarian assistance, are rated very highly and are an important factor in improving the quality of life of women and their children.

Quantitative component

Survey of 100 women living with HIV with experience of pregnancy and childbirth

Respondents showed **the highest level of satisfaction** with PMTCT services towards **HIV-service NGOs** (51% - satisfied, 38% - very satisfied) and health care facilities providing services to people living with HIV (**PLHIV health facilities**) (59% - satisfied, 22% - very satisfied). Respondents showed **the highest level of dissatisfaction** with services towards maternity hospitals (maternity departments) (15% - not at all satisfied, 9% - dissatisfied), primarily women from Odesa oblast.

If we compare satisfaction with services by oblast, then, unlike Odesa oblast, respondents from Dnipropetrovsk oblast are mostly or in most cases satisfied with PMTCT medical services, including primary health care facilities, antenatal clinics (prenatal care departments), maternity hospitals (maternity care departments), institutions that provide medical care to people living with HIV. In Odesa oblast, the majority of respondents expressed satisfaction with medical services only with institutions that provide medical care to people living with HIV. At the same time, in Odesa oblast, a significantly larger proportion of respondents are very satisfied with non-medical services (based on HIV-service NGOs) compared to Dnipropetrovsk oblast.

Qualitative component

In-depth interviews with 8 mothers of HIV-exposed and HIV-positive children

When asked about **satisfaction with the services received in medical institutions regarding the care of the child**, on a scale from 1 to 7 (1 means complete dissatisfaction, and 7 means absolute satisfaction):

Dnipropetrovsk oblast

Three respondents gave 7 points (Dnipro city). One respondent (mother of an HIV-positive child) ranked satisfaction differently, depending on the doctors – from full satisfaction (paediatrician of a private clinic, staff and children's doctor of the maternity ward) to "not very satisfied" (paediatric infectious disease doctor and nurse of the PLHIV health facility) (Dnipro city).

Odesa oblast

Two respondents gave 7 points (Chornomorsk city, Liubashivka urban-type settlement). One respondent ranked satisfaction differently, depending on the doctors – from absolute satisfaction (infectious disease doctors of the PLHIV health facility) to complete dissatisfaction (medical staff of the perinatal centre) (Odesa city). One respondent gave 5 points (family doctor of the PHC facility) (Bilyne village).

Mothers' assessments are usually determined by the attitude of medical staff towards the woman and child, the absence of discrimination or vice versa, high-quality counselling, the ability to get answers to questions, accessibility in communications, and the ability to receive additional (humanitarian) assistance.

When asked about **satisfaction with non-medical services received (based on HIV service organisations) regarding child support** on a scale from 1 to 7 (1 means complete dissatisfaction, and 7 means absolute satisfaction):

Dnipropetrovsk oblast

Respondents answered either "Seven" (3 respondents) or "Satisfied" (1 respondent).

Odesa oblast

All four respondents answered "Seven".

The ratings are usually based on the caring attitude of the staff towards the woman and the child, support during difficult times for the woman, including peer support, high-quality counselling, home delivery of medicines, accessibility of services, the possibility of receiving humanitarian assistance, and the absence of discrimination.

The impact of war on the availability and quality of medical and social services

russia's full-scale invasion of Ukraine has significantly impacted the availability, completeness, and quality of PMTCT services in health facilities, as well as HIV-service NGOs.

Qualitative component

in-depth interviews with 10 providers of medical PMTCT services

Dnipropetrovsk oblast

Is characterised by a significant influx of displaced women, partial occupation since 2025, and constant shelling of frontline cities, especially in the east, near the border with Zaporizhzhia and Donetsk

oblasts. In this context, a number of specific challenges arise that affect the organisation of medical and social services for women.

Reduction of direct contact between doctors and patients. Due to complications caused by the war, ART is increasingly being sent to patients by mail, and visits to medical facilities are becoming less frequent. This makes it difficult for doctors to ensure adherence to treatment in pregnant women, conduct monitoring, timely identify problems and provide necessary assistance. At the same time, medical workers are understanding when women are unable to come to the facility due to objective reasons related to the war (disruption of transport, air raids, shelling, etc.) *("We started sending more medications via Nova Poshta. On the one hand, for those who take medications, it's very good. On the other hand, this process is uncontrolled. The doctor-patient contact has disappeared. I'm all for the doctor being a doctor and seeing the patient. And it seems to me that this was reflected in this pregnant woman who was receiving and not taking medications. They don't ask questions. Maybe something was bothering her, if she had come with medications, we could have talked and consulted once more, she could ask some questions to the social worker. But without this, it's also impossible now - the trains stopped running, e.g., to the same Marhanets", "People started moving away. We started losing our patients, looking for them. You know, at that time they didn't bother to let me know where they were going. It was very much like that at first. And now, like everywhere else. There are alarms, there is bombing, it's clear that no one will come. I call her myself, tell her to stay home, don't go anywhere"*).

ART interruption in HIV-positive IDP women from occupied territories. Doctors recorded cases of ART interruption in women arriving from occupied territories and restored their access to treatment *("They came from the territories of Donetsk and Zaporizhzhia oblasts, some were not provided with PMTCT prevention assistance. They came, and you understood that they had status, you asked if they had given you drugs there, they said that they had not been able to receive prophylaxis there for a long time. And we did everything from the start here"*).

Monitoring and registration of IDPs, migrant women and their children. A significant influx of new patients in 2022, as well as the evacuation of women from the Dnipropetrovsk oblast to other oblasts of Ukraine, leads to difficulties in maintaining records. Many displaced women do not want to register in new medical institutions, which is why doctors have to look for patients on their own. Children who have left abroad often remain unexamined up to 18 months, which creates difficulties with their registration. The lack of medical documentation for IDP children, in particular form 63 with a list of vaccinations, complicates full medical support (*"The mothers (under my supervision) left the districts. They are in touch; they did not register at the new place. Although I give them the coordinates in Poltava, Cherkasy", "Children are not deregistered, there are many of them at the age 18 months who have not returned. They just send ELISA, some from other countries. They sent it and it is good. I note that the ELISA is negative. There is no contact with someone. Some promise to come, bring it someday. Some have nowhere to go", "The problem with IDPs is that it is not always possible to have appropriate medical documentation. It is not always possible to see the vaccinations, an adequate form 63, of HIV-positive children who came from other regions. Not everything is entered into the electronic system, especially from Luhansk, Donetsk oblasts. This is a problem*").

Shortage, outflow and/or migration of human resources and resolution of security issues. As a result of the escalation of hostilities, medical personnel are being evacuated from areas close to the front line (for example, nurses from the Pokrovskyi district moved to the Poltava oblast). The antenatal clinic is forced to move to another building of the medical facility, being located on the first floor to ensure quick access to shelter and increase the level of safety for staff and patients (*"Nurses left for the Poltava oblast; in general, the entire Pokrovskyi district", "In 2022, there was a very large flow of patients. For security reasons, we moved out of this building, we received patients in the maternity ward on the first floor so that we could hide in shelter"*).

Vulnerability to sexualised violence among IDP women. An obstetrician-gynaecologist reported an increase in the number of appeals from IDP women who had experienced sexualised violence

(regardless of HIV status): "*The war is having an impact, there are more people seeking help. Most of them come from the conflict zone or from occupied territories. Both pregnant and non-pregnant. And women who were raped, and they had unwanted pregnancies, and they did not know their status. And that was it, unfortunately".*

Despite the existing difficulties and challenges, medical workers are making every effort **to provide due medical support to HIV-positive women, in particular IDPs** (*"In principle, we provide assistance as it was before. There was a situation when a woman from Mariupol, who is HIV-positive, came to us with a child in her arms. They were in our maternity ward for several days. We provided assistance to her and the child, gave them therapy for a course", "In terms of resource provision, express tests, additional examinations, hospitalisations, and the provision of medical care, everything is fine. We have not encountered such problems", "We have never refused anyone"*).

The war has significantly complicated the work of the health care system in **Odesa oblast**. Despite these challenges, medical workers in Odesa oblast are demonstrating resilience, dedication and are looking for new approaches to supporting patients, including HIV-positive women and children, so as not to leave them without help in the most difficult times. Below are the main aspects of the impact of the war, based on the collected reports from doctors.

Reduction in the number of ART dispensing: Due to delays in the supply of drugs, medical institutions are forced to reduce the period of dispensing ART from six months or a year to three months. The drugs arrive with a delay, which forces medical workers to act carefully so as not to run out of supplies. This creates additional stress for patients, especially those who often move or travel abroad (*"The possibility of dispensing ART has decreased. Previously, we used to give it for six months and a year. Someone leaves, someone returns, someone goes abroad after six months. Now we give it for a shorter period, only for three months. Because the drugs arrive with a delay of a year. They have only just arrived for 2025. I should not be left with an empty warehouse, to put it bluntly"*).

Outflow of medical personnel, sharp increase in workload. In the first months of the war, there was a massive outflow of medical workers (especially women). The workload on the staff increased significantly — at the same time a large number of patients arrived who needed emergency ART due to the uncertainty of the situation. Medical workers worked in difficult conditions, often in reduced numbers, demonstrating resilience and dedication. In the most difficult months of the war, volunteer support partially compensated for logistical and personnel problems (*"In February 2022, the three of us stayed here, me and two nurses. And people were coming and coming. We had 85 people come in one day. People said that they were leaving. Something was flying over their heads, anxiety. We have a mountain of these cards", "In the first months of the war, when everyone was scared, left, hid, many female doctors from maternity wards fled. There were mainly pensioners there, and we stayed, who decided not to go. But everything was provided. Volunteers brought without problems everything that was missing"*).

Monitoring and registration of IDPs, migrants and their children. Some patients went abroad or to rural areas, which complicated registration, monitoring and further diagnostics, especially of HIV-exposed children. Some children were left without a second examination or were "lost" to the health care system (*"Parents moved to some villages and did not examine their children. Some went abroad, we cannot find them, what is the fate of this child. Some did one PCR and that was it, they are already abroad"*).

Development of new social services (support for IDPs, protection from violence). At the same time, new support centres for IDPs and assistance to people who have experienced violence have opened, which has had a positive impact on supporting women (*"I know that an IDP assistance centre has been launched. Both pregnant and non-pregnant women go there. Some centres have opened to combat violence. In my opinion, the situation has improved for women"*).

Worsening access to medical services for HIV-positive men. Some men stopped visiting health care facilities due to fear of being stopped at checkpoints, which in some cases even led to the discontinuation of ART. Due to difficult access to medical facilities, close relatives (wives, mothers) are often forced to receive therapy instead of male patients, thus women take care of access to treatment for their relatives. In addition, an infectious disease specialist from a rural area personally organised the delivery of ART to patients (*"It affected the availability of men, twenty percent are received by relatives, a woman, or someone close. Anxiety, transport does not run. There is less transport". "I have a large number of men who have abandoned therapy. It is precisely because of this manhunt (Territorial Centre of Recruitment and Social Support) that men could not move freely. Both by Nova Poshta and I personally travelled, took therapy and brought it to them"*).

Deterioration of the epidemiological situation regarding HIV, hepatitis and STIs. An infectious disease doctor working in a rural area noted an increase in the number of cases of HIV, hepatitis and sexually transmitted infections, including syphilis, over the past year. The doctor also added that people have become less inclined to detection and testing, which negatively affects early diagnosis and prevention of HIV (*"Over the past year, because of these checkpoints, not only HIV infection has spread. Hepatitis and STIs are growing. Over the past year, I have had 13 cases of syphilis, primary and secondary. More in women than in men. This is a really big problem"*).

Focus group discussions with 16 community service providers and activists

The war in Ukraine has significantly changed the working conditions for NGOs and the lives of HIV-positive women themselves, especially among IDPs. NGO-based service providers and community activists outlined a number of challenges that have arisen in the area of access to and quality of health and social services for women living with HIV under martial law. The main problems and barriers are listed below.

Monitoring IDPs during pregnancy. IDP women, after moving to remote hromadas, especially rural areas, often do not know where to turn for help and where to register. This leads to cases when they come to give birth unexamined, without undergoing the necessary diagnostics and testing for HIV during pregnancy (*"There are a lot of women who come to give birth unexamined, who do not go to antenatal clinics. Based on my clients, they move with their children, with their families somewhere to the villages, so that it is quiet there, so as not to be afraid of bombings. Already in the maternity ward we start supporting them, put them on ART and accompany the children", "Women left and they did not take ART, because they did not know where they could turn. Especially when it is a small hromada"*).

Ensuring continuity of ART. IDP women interrupt ART after moving to remote hromadas. Migrant women who have gone abroad are often reluctant to disclose their HIV status in their new countries of residence, and are therefore forced to return to Ukraine regularly for routine testing and ARV treatment. In occupied territories, patients are often left without access to ART. Military action, destruction of infrastructure, and disruption of transport connections make it difficult to reach health facilities, especially in evacuation areas. Alternative transport options (e.g., private carriers) are expensive or unsafe, and male carriers often refuse to travel due to the risk of encountering representatives of the Territorial Centre of Recruitment and Social Support (*"A lot of women have left Ukraine. Some of them do not want to register and receive ART abroad. Women do not want to disclose their positive status. They want to receive ART in Ukraine. They are forced to come to Ukraine once every three months, once every six months. Find time, find funds to come, take routine tests, examinations and still receive ART", "If we take the beginning of the war, those cities that were occupied. I had a woman, 15 cells, she was in a panic, left without therapy. We sent medication via volunteers who could still transport them somehow. Then the connection was lost at some stage and it was impossible to transfer", "The front is approaching, from Sloviansk, she says that the highway is already being heavily shelled, it is very difficult to get to the oblast centre, they are constantly under shelling", "We have hromadas, e.g., Synelnykove district, there is no longer any (transport) connection,*

there is practically evacuation going on there. Previously, they could arrive, asked their friends. And now it is almost impossible to find a car because of the Territorial Centre of Recruitment and Social Support. If the minibuses were not running, they would negotiate with drivers they knew, in a neighbouring house. If the driver was a man, they told me that it was impossible to find a car to take you to the city").

Health is not a priority during war. For IDP women, the issue of health is secondary, because the first priority is to solve basic needs: find housing, ensure security, and also resolve issues related to restoring documents (*"It is more difficult to work with displaced women, they really have needs that need to be solved here and now, e.g., housing. As for pregnant women, they are sometimes delayed in terms of when they come to the doctor. I understand why this is the case with people – it is not their priority right now", "Sometimes there are problems with documents. If it is Donetsk oblast, Luhansk oblast, Crimea. Doctors provide services to positive women, but sometimes they don't see them at passport desks", "People who run away are left without documents, it takes a certain amount of time for these documents to be restored. While she was leaving, she forgot to take that jar (ART) with her"*).

Lack and turnover of human resources in medical institutions and HIV-service NGOs. The outflow and turnover of qualified medical personnel and HIV-service NGO workers have led to an increase in the workload for those who remain. This, in turn, leads to a general deterioration in mental health among workers (*"Staff turnover, medical personnel. We have had a paediatrician change in the city centre several times", "Social workers have left, there is no one to work with. There are too many professionals left to count on the fingers", "Many specialists, doctors, social workers are leaving", "The work has doubled due to the war"*).

The burden of care for women. Due to the mobilisation of men, women are left alone with their children. Some men are either at the front or missing, and some are hiding and not working. Men who are not serving often avoid meetings with representatives of the Territorial Centre of Recruitment and Social Support, which is why they refuse to visit doctors or accompany a woman with a child to medical or other institutions. As a result, women are forced to independently solve all issues related to caring for children, everyday life, and receiving services. Additional stress is caused by the need for women to independently search for their son, husband, or other family member who disappeared after meeting with the Territorial Centre of Recruitment and Social Support, which worsens their psychological state (*"There are no men, women are forced to do everything themselves, they do everything themselves and work", "Many women whose husbands are at the front were left alone with their children. Some of us are missing. And a woman who is a prisoner of war, HIV-positive woman. The men were taken to the front. Some are hiding, some are not working. The roads are blocked in Odesa, everyone is being taken away", "Our HIV-positive child, he confirmed his disability after 18 years. He is 25 years old. They are enlisting him to the army and his mother, our HIV-positive social worker, who is currently in serious physical condition, has been looking for the child for three days"*).

Challenges of social support under martial law. In wartime, the general mental health of clients and service providers at the community level deteriorates. Social support is provided even during air raids and power outages. Activists noted the difficulty of registering newborns, in particular, digital services, such as the "Diia" portal, do not always work, which forces women to personally visit government institutions and stand in queues for several hours, as the institution is closed during air raids (*"It's difficult, because you see that a colleague is burning out at work, you try to help her and also to keep your psychological state. We cried together, but we were at work, clients came who also cried", "First of all, it's a psycho-emotional state, everyone - social workers, doctors, and coordinators. It's very difficult. That night we simply didn't sleep in the city of Chornomorsk. There was no light for a day. Anyway, we got dressed and moved on", "Clients, they simply don't see the point of even getting treatment. It's already become difficult to work. Especially for men. They are afraid of the Territorial Centre of Recruitment and Social Support, they don't go for treatment", "Now a newborn child can be registered through the "Diia" portal, but, unfortunately, it doesn't always work. You have to take the newborn child and go to the Pension Fund. You have to stand with this little one for three hours, it is a*

luck if there is no air raid. The child is crying, wants to eat already. Mom feeds the child during the visit to register baby", "Air alarms. Every moment is golden. Standing for two hours, keeping a client in the Tax Office or in some institution, is really very difficult. Then we lose them, they leave").

PMTCT programme effectiveness

Indicators of implementation of PMTCT programmes in Dnipropetrovsk and Odesa oblasts

Dnipropetrovsk oblast

Dnipropetrovsk oblast remains one of the regions with **the highest HIV epidemic burden in Ukraine**, particularly in terms of prevalence among **the adult population and pregnant women**. At the same time, the oblast serves as a regional centre for receiving IDPs, which complicates the organisation of medical surveillance and monitoring of compliance with clinical routes in relation to HIV.

Despite the difficult security and social conditions, the implementation of the PMTCT programme in the oblast ensured the maintenance of high levels of programme indicators. Coverage of pregnant women with ART, post-natal prophylaxis of newborns, Early Infant Diagnostics and formula feeding generally meet national goals, which allowed to reduce the frequency of vertical transmission of HIV from 2.3% in 2022 to 1.4% in 2025 (see Table 2).

Table 2. Indicators of monitoring measures to prevent vertical transmission of HIV in the Dnipropetrovsk oblast

Indicators	2022	2023	2024	2025
Number of HIV-positive pregnant women	202	221	169	131
of whom - IDP	5	7	6	3
of whom - residents of villages / small town	26 (13%)	18 (8%)	29 (17%)	23 (18%)
Number of births in HIV-positive pregnant women	216	189	186	144
Number of HIV-exposed children (live births)	228	190	188	143
ART coverage of pregnant women	97,7%	96,8%	97,8%	95,1%
Coverage of pregnant women with prenatal screening (34-36 weeks of pregnancy)	85,5%	83,6%	90,7%	90,3%
Coverage of HIV-exposed children with PNP	97,8%	97,9%	97,9%	98,6%
Coverage of HIV-exposed children with Early Infant Diagnosis (DBS PCR)	96,9%	96,3%	98,4%	98,6%
Coverage of HIV-exposed children with cotrimoxazole prophylaxis	87,7%	86,8%	83,0%	88,8%
Coverage of HIV-exposed children with artificial feeding	99,1%	99,5%	100%	99,2%
Number of HIV-positive children, according to Early Infant Diagnosis (DBS PCR)	5	4	2	2
Frequency of mother-to-child HIV transmission, based on Early Infant Diagnosis data	2,3%	2,2%	1,1%	1,4%

At the same time, the results of the desk analysis indicate the presence of a number of **factors and gaps** that could potentially prevent further reductions in the level of vertical HIV transmission in the region, namely:

- **a high proportion of HIV-positive pregnant women from key groups**, mainly sexual partners of PLHIV, PWID, and partners of PWID (26% in 2022, 19% in 2023–2024, 21% in 2025);
- up to 10% of pregnant women living with HIV **are not monitored in antenatal clinics, have low adherence to ART or refuse treatment**, including after childbirth;
- **a high proportion of women with late detection of HIV-positive status** (after 24 weeks of pregnancy, during or after childbirth), which averages about 30%;
- **insufficient coverage of the third stage of Early Infant Diagnostics** (DBS PCR) among children aged 3–4 months (68% in 2022, 67% in 2023, 42% in 2024, 54% in 2025);
- **low coverage of serological testing of children aged 18 months and older** to establish final HIV status: as of 01.01.2026, 151 children (72.2%) were tested, while 58 children remain untested due to being outside the country, loss of contact with families, or parents refusing to have their child tested.

Odesa oblast

Odesa oblast is one of the regions **with a high level of HIV prevalence**, as evidenced by the level of HIV prevalence **among pregnant women** exceeding 1%. In the period 2022–2025, the oblast maintained high rates of morbidity among the adult population. At the same time, the successful implementation of the PMTCT programme contributed to the growth and achievement of high levels of key programme monitoring indicators, which, despite the challenges of a full-scale war, remained at a high level (see Table 3).

Table 3. Indicators of monitoring measures to prevent vertical transmission of HIV in the Odesa oblast

Indicators	2022	2023	2024	2025
Number of HIV-positive pregnant women	212	154	185	159
of whom - residents of villages / small town	120 (56%)	105 (68%)	99 (53%)	76 (48%)
Number of births in HIV-positive pregnant women	235	185	190	149
Number of HIV-exposed children (live births)	239	187	189	151
ART coverage of pregnant women	97,4%	98,4%	96,4%	98,7%
Coverage of pregnant women with prenatal screening (34-36 weeks of pregnancy)	90,6%	95,1%	94,7%	98,0%
Coverage of HIV-exposed children with PNP	99,6%	100%	98,9%	100%
Coverage of HIV-exposed children with Early Infant Diagnosis (DBS PCR)	84,5%	95,7%	100%	100%
Coverage of HIV-exposed children with cotrimoxazole prophylaxis	87,4%	100%	100%	97,4%
Coverage of HIV-exposed children with artificial feeding	99,6%	100%	100%	100%
Number of HIV-positive children, according to Early Infant Diagnosis (DBS PCR)	4	2	1	3
Frequency of mother-to-child HIV transmission, based on Early Infant Diagnosis data	2,0%	1,1%	0,5%	2,0%

Based on a desk analysis, **factors and gaps** that could potentially complicate the control of vertical transmission of HIV in the region were identified:

- almost half of HIV-positive pregnant women **live in small towns and villages** (56% in 2022, 68% in 2023, 53% in 2024, 48% in 2025); remote living from health care facilities and socio-economic barriers limit timely access of pregnant women and their unborn children to medical services;
- there remains **a significant proportion of women with late detection of HIV-positive status** — after 24 weeks of pregnancy, during or after childbirth; during the war period this figure decreased from 44% to 28%;
- **insufficient coverage of HIV-exposed children with the second** (55% in 2022 and 51% in 2025) and **third** (30% in 2022 and 58% in 2025) stages of **Early Infant Diagnostics** due to objective obstacles for parents to visit health care facilities (risk of shelling, fear of using transport due to SARS) and refusal to undergo examination.

Monitoring and evaluation of PMTCT activities

Monitoring of measures to prevent mother-to-child transmission of HIV in Ukraine is carried out in accordance with the Order of the MoH dated August 3, 2012 No. 612 "On approval of forms of primary accounting documentation and reporting on issues of monitoring measures to prevent mother-to-child transmission of HIV, instructions for filling them out"[34], which regulates:

- **Collection of accounting data** from health care facilities that provide antenatal and perinatal care and medical surveillance of HIV-exposed children;
- **Generalisation and aggregation of PMTCT data** according to annual reporting forms: form No. 63 "Prevention of HIV transmission from mother to child" and form No. 63-1 "Frequency of HIV transmission from mother to child".

In accordance with the order of the MoH dated 06.09.2021 No. 1887, quarterly information was introduced to the PHC of MoH on the implementation of regional work plans for the elimination of mother-to-child transmission of HIV. The process is carried out in coordination with oblast administrations. The first reporting year — 2022 — coincided with the beginning of a full-scale war in Ukraine, which led to personnel and technical limitations, as a result of which reporting was received from only 15 regions.

In order to ensure continuous monitoring of PMTCT measures **under martial law**, with the support of UNICEF, in 2022–2023 the PHC of MoH organised **a monthly collection of regional operational data and PMTCT indicators**, and responsible persons for this area were identified at the oblast level.

Starting from 2023, the PHC of MoH contributed to the resumption of the work of regional committees (working groups) on the validation of the elimination of mother-to-child transmission of HIV (RC EMTCT) under the structural units on health issues and **the systematic collection of quarterly reporting** was resumed. Within the framework of the operational plan of measures for the implementation in 2024–2026 of the State Strategy for Combating HIV/AIDS, Tuberculosis and Viral Hepatitis for the period until 2030, approved in 2024, quarterly collection of information on the implementation of EMTCT measures at the national and regional levels was ensured. The summarised data is submitted to the MoH for making management decisions.

Using PMTCT data

Information on the prevention of mother-to-child transmission of HIV is public and available on the official resources of the Public Health Centre of the Ministry of Health of Ukraine and partner organisations.

[34] https://zakon.rada.gov.ua/laws/show/z1483-12#Text

The main national analytical source is the annual "Information Bulletin "HIV Infection in Ukraine"", published by the PHC of MoH and containing aggregated data. In addition, the data are regularly analysed within the framework of coordination meetings at the regional and national levels and presented in the section "Elimination of HIV Transmission from Mother to Child" on the National Portal of Strategic Information in the Field of Public Health of the PHC of MoH[35].

At the same time, the use of PMTCT data at the regional level remains uneven and requires improved analytical support and effective use of data for PMTCT programme management.

Gaps in the PMTCT monitoring and reporting system

Despite progress in digitalisation, the PMTCT reporting system in Ukraine **remains** largely **paper-based**, which complicates timely data analysis and use for management decisions. One of the key problems is **the lack of a full-fledged unified electronic PMTCT registry and established electronic information exchange** between institutions providing assistance to pregnant women and children (antenatal clinics, maternity hospitals, primary health care institutions), as well as **limited data exchange with private health care institutions**.

In the context of implementing the "triple elimination" approach (HIV, syphilis, viral hepatitis B), the issue of integrating HIV data with registries of patients with sexually transmitted infections and viral hepatitis remains unresolved, which does not allow for comprehensive inter-programme monitoring.

As a result of the reform of the secondary level of medical care, specialised institutions that traditionally provided PMTCT services were reorganised, in particular, oblast AIDS prevention and control centres were liquidated. Optimisation of staffing led to **the loss and dispersion of trained PMTCT specialists**, which negatively affected the quality of coordination, support and monitoring of PMTCT activities at the regional level.

The NHSU packages of the Programme of Medical Guarantees **lack a separate component for monitoring and evaluating** measures to eliminate mother-to-child transmission of HIV. As a result, specialists responsible for maintaining electronic records of HIV-positive women and children born to HIV-positive mothers **are not provided with appropriate financial incentives**.

PMTCT programme coordination and intersectoral cooperation

Advisory and consultative bodies on EMTCT issues

By Order of the MoH dated 19.08.2019 No. 1829, **an interdepartmental working group on the validation of the elimination of mother-to-child transmission of HIV and syphilis** (IWG EMTCT) was established, which included representatives of state bodies, public and international organisations. The main goal of the IWG EMTCT as **an advisory body of the MoH** was to organise and implement the validation process of the elimination of mother-to-child transmission of HIV and syphilis in Ukraine in accordance with the requirements of the Global Validation Advisory Committee of Mother-to-Child Transmission of HIV and syphilis at the WHO. The functions of the technical executor of the tasks of the IWG EMTCT were assigned to the working group on preparation for validation of Mother-to-Child Transmission of HIV and syphilis, approved by Order of the PHC of MoH dated 19.04.2018 No. 24.

According to the results of the monitoring of the IWG EMTCT, it was found that the main gaps in the effectiveness of preventing mother-to-child transmission of HIV are insufficient administration of PMTCT services in the regions, the absence of regional strategies towards elimination, and the lack of complete information on the effectiveness of PMTCT measures at the health facility level.

[35] https://npsi.phc.org.ua/HIV_Monitoring?indicator=301&tab=description

As part of the work of the IWG EMTCT, **Roadmaps for the Elimination of Mother-to-Child Transmission of HIV and Syphilis** (EMTCT Roadmaps) were developed, taking into account the recommendations of WHO pre-validation missions and national needs to achieve target indicators and meet validation requirements.

By the Decision of the National Council for Combating Tuberculosis and HIV/AIDS (National Council) dated 22.08.2019 and in accordance with the Order of the Vice Prime Minister of Ukraine dated 29.08.2019 No. 27962/3/1-19, the EMTCT Roadmap was approved in September 2019 and **regional committees for validation of the EMTCT (RC EMTCT) were instructed to be created** at oblast state administrations. The covering letter of the MoH dated 25.10.2019 No. 26-04/43472/2-19 to oblast state administrations **identified 20 EMTCT Roadmap indicators**, on which regional committees for validation of the EMTCT were **to carry out quarterly reporting**.

By the Order of the MoH dated 6.09.2021 No. 1887 "On the organisation of the implementation of measures to eliminate mother-to-child transmission of HIV infection", **the function of coordination and organisational and methodological management of EMTCT measures was assigned to the PHC of MoH**. In accordance with the aforementioned Order, during 2021–2022, **25 regional EMTCT committees** in the field of HIV infection **were updated or created**; representatives of the community of women living with HIV from the CO "Positive Women", including from Dnipropetrovsk and Odesa oblasts, were included in the created committees in 21 oblasts.

The results of the work of the IWG EMTCT, which performed the functions of the National Validation Committee, in accordance with the protocol decision of 23.12.2022, **confirmed Ukraine's commitment to the elimination of mother-to-child transmission of HIV, syphilis, and viral hepatitis**. It was noted that, thanks to the integration of the efforts of the state, international, and public sectors within the framework of the IWG EMTCT activities, the appropriate level of PMTCT measures and the achievement of established indicators for passing the validation process were supported. However, taking into account the objective organisational and political challenges associated with the COVID-19 pandemic (since March 2020) and the large-scale war (since 24.02.2022), the state's **insufficient readiness for the WHO international validation procedure was determined**. At the same time, it was considered appropriate to continue the activities of the working group with an emphasis on coordinating the organisational activities of the EPMD, as well as to consider an updated format for its work under the leadership of the State Institution "Public Health Centre of the Ministry of Health of Ukraine" with an updated composition and expanded powers with the support of the MoH.

In 2023, by Order of the PHC of MoH (16.05.2023), **a Working Group on the Elimination of Mother-to-Child Transmission of HIV in Ukraine** (WG EMTCT) was established. The group developed **a National Roadmap for the Elimination of Mother-to-Child Transmission of HIV for 2023–2024**, which was approved at a joint meeting of the National Council committees on 13.07.2023. In accordance with the updated national roadmap, **25 regional roadmaps were developed** and changes were made to the work plans of the regional committees (RC EMTCT) for 2023–2024. The issues of implementing PMTCT measures and assessing data quality were discussed at two interregional meetings, meetings of the National Council committees and the WG EMTCT, as well as during separate meetings with regional PMTCT M&E coordinators.

The main coordination challenge in 2022–2023 was the restoration of the proper work of the RC EMTCT. To overcome the problems of the WG EMTCT at the PHC of MoH, coordination of the implementation of roadmaps was strengthened, methodological support for the regions was organised, control over the regularity of meetings and timeliness of reporting was introduced, and the update of medical service routes in the field of PMTCT was initiated. Meanwhile, the CO "Positive Women" took care of the observance of human rights, gender equality and community involvement (the 4th component of the validation process), monitored cases of stigma and discrimination, advocated for the interests of women with HIV, and participated in the work of advisory and consultative bodies.

In 2024, by Order of the PHC of MoH (26.04.2024), **the composition of the Working Group** on the Elimination of Mother-to-Child Transmission of HIV **was updated**. To unify the assessment of the implementation of regional roadmaps, **a new form of quarterly reporting** was developed and implemented. A study of the algorithm of interaction between health care institutions and NGOs in the field of PMTCT was also conducted. During the year, the composition of the RC EMTCT was updated in 20 regions, including Dnipropetrovsk and Odesa oblasts. In most regions, the work was assessed as satisfactory, except for **Odesa oblast**, where no meeting on the implementation of the regional EMTCT roadmap was held.

In order to unite national efforts for **the triple elimination** of mother-to-child transmission of HIV, syphilis, and viral hepatitis B and C, as well as to integrate relevant measures into the medical care system, **the Working Group** on the Elimination of Vertical Transmission of HIV, Syphilis, and Viral Hepatitis B and C was established by the Order of the PHC of MoH dated 20.05.2024 No. 08-агд. The personal composition and regulations of the Working Group were approved. The main tasks of the Working Group were to develop a national roadmap for triple elimination in accordance with the goals of the State Strategy for Combating HIV/AIDS, Tuberculosis, and Viral Hepatitis by 2030, coordinate intersectoral measures to prevent vertical transmission of infections, and strengthen the system for monitoring and evaluating the effectiveness of the implemented measures at the national and regional levels, taking into account all components of the elimination process.

As part of the activities of the updated National Working Group on HIV, syphilis and hepatitis B, **a new edition of the Roadmap** for the elimination of mother-to-child transmission of HIV, syphilis and hepatitis B virus has been prepared, which includes integrated measures for hepatitis C for the period 2025–2027. The Roadmap was presented and agreed upon at the meeting of the Committee on Programme Issues of the National Council on 30.10.2025. Monitoring of the implementation of the "Roadmap on HIV for 2025–2027" will be carried out at the national level annually, at the regional level – quarterly. Financing of the measures will be provided at the expense of state and local budgets, international technical assistance, charitable contributions and other sources not prohibited by the current legislation of Ukraine.

In 2025, the regional EMTCT committees continued to coordinate activities to implement regional roadmaps. The EMTCT system in the fourth year of the war demonstrated stable performance and maintained validation indicators, but requires additional strengthening in regions with personnel changes and limited access to resources. From 2026, the committees plan **to expand their activities** to the elimination of mother-to-child transmission of **syphilis and viral hepatitis**.

The reallocation of funds from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF), in particular, savings between programme areas, led to **the termination of financial support for the secretaries of the RC EMTCT**, which was carried out during 2024 and the first half of 2025 within the framework of the GF programme "Sustainable response to the HIV and TB epidemics in the context of war and reconstruction of Ukraine"[36].

General conclusions on the coordination and work of the RC EMTCT

Dnipropetrovsk oblast

The coordination system for eliminating vertical transmission of HIV in Dnipropetrovsk oblast is a stable and structured mechanism that allows for the effective implementation of PMTCT measures, responding to wartime challenges, and ensuring respect for the rights of women and children, despite limited resources and difficult conditions. During 2023–2025, regular updates of the composition and work plan of the regional committee (RC EMTCT), approval of the Roadmap, as well as a clear coordination structure between health care institutions, the regional coordination council, civil society,

[36] https://phc.org.ua/pro-centr/proekti/proekt-gf-2024-2026

and national HIV and PMTCT bodies were ensured. Quarterly reports and analytical reports are sent to the PHC of MoH, which demonstrates proper monitoring and accountability.

An important component was the implementation of patient routes, the identification of responsible persons, and the strengthening of the role of NGOs in social support. The orders on health care facilities approved ethical codes of conduct, policies to reduce stigma and discrimination against people living with HIV, which contributes to the protection of human rights and gender equality. In accordance with the updated routes, access to ARV drugs and specialised assistance to children was ensured. During an in-depth interview, the secretary of the RC EMTCT noted the experience of effective cooperation with the migration service on the restoration of documents for IDP women, which improves access to medical services. Coordination is carried out through the oblast coordination council. This emphasizes the importance of consultative and advisory bodies in ensuring interdepartmental interaction, as well as the need to integrate the activities of the RC EMTCT and the oblast council:

"We have very active cooperation with the migration service, through the coordination council. On the issue of assistance in restoring documents. We have resolved this issue. There are a lot of resettlements now. On the one hand, this is necessary for the patients themselves, if they do not have a passport or an ITN, it is somehow so difficult. On the other hand, this is very important for medical institutions, because if the patient does not have these documents, he/she is not registered in the e-health system and medical institutions do not receive funding for the treatment of these patients. The law of Ukraine stipulates that, regardless of citizenship, there is a person, he/she is HIV-infected, we must provide them with medical care. And there are a lot of such people, unfortunately, especially since the beginning of the war. Therefore, it is impossible to separate the prevention of vertical transmission from the general work on the prevention of HIV infection. Let's say, it is one and the same. Therefore, we are very connected".

The activity of the RC EMTCT is positively assessed: holding four meetings annually, analysing cases of vertical HIV transmission, organising monitoring visits, training medical workers, as well as online seminars on the prevention of violence, stigma and discrimination. The implementation of internal regulations on the ethical code of conduct in 100% of institutions providing PMTCT services is noted. The community of women living with HIV is actively involved in the work of the RC EMTCT. Social support on PMTCT issues is provided mainly within the framework of NGO project activities, and the procurement of social services from local budgets during the period of martial law is not carried out. Access to public information on the work of the regional coordination council on combating tuberculosis and HIV/AIDS is provided (composition of the council, annual work plans, agenda and minutes of meetings). At the same time, information about the RC EMTCT is absent or limited in the public space.

2023. The order of the Department of Health of the Dnipropetrovsk Oblast Military Administration dated 06.10.2023 No. 1442/0/197-23 "On improving the organisation of implementation of measures to eliminate mother-to-child transmission of HIV in the Dnipropetrovsk oblast" **approved the personnel composition and work plan of the Working Group on Validation of Elimination of Mother-to-Child Transmission of HIV** (RC EMTCT), as well as **the Roadmap** (EMTCT Roadmap). Analytical reports and quarterly reports on the implementation of EMTCT measures are submitted to the PHC of MoH. At the meeting of **the Coordination Council for Combating Tuberculosis and HIV/AIDS** at the Dnipropetrovsk Oblast Military Administration[37], **the results of the implementation of the regional Roadmap** are presented. Orders on the health care facilities approved **patient routes and responsible persons** who ensure **compliance with medical care standards** and provide information for generalisation and **reporting** on the validation of the EMTCT. The main problems identified were: insufficient testing of sexual partners, incomplete screening of pregnant women for CD4 and viral load

[37] https://www.dnipro-rcssd.info/workokr

due to temporary displacement of women due to hostilities, inability to visit medical facilities, and women's refusal to receive treatment or examination of their child.

2024. By Order of the Department of Health of the Dnipropetrovsk Oblast Military Administration dated 17.06.2024 No. 685/0/197-24, **the composition of the RC EMTCT was updated**. During the year, four meetings of the RC EMTCT were held, during which cases of vertical HIV transmission for 2023 were analysed. PMTCT issues were considered at two meetings of the regional coordination council for combating TB/HIV, as well as **during a monitoring visit of the National Council** for Combating Tuberculosis and HIV/AIDS to the Dnipropetrovsk oblast (29–30.05.2024). In all **health care facilities involved in the provision of PMTCT services**, **orders** were approved **on the implementation of the regional Roadmap**, **responsible persons and patient routes** were identified. Internal regulations (**ethical codes of conduct**) **to protect women from violence, stigma and discrimination** were approved in 70% of institutions related to PMTCT. 97% of PMTCT facilities have **implemented policies to reduce stigma and discrimination** against people living with HIV. **Social support** is provided within the framework of **NGO** project activities. The Order of the Department of Health of the Dnipropetrovsk Oblast Military Administration "On the organisation of post-natal prophylaxis of HIV infection for children born to women with HIV-positive status" (No. 1194/0/197-24 dated 18.12.2024) approved updated routes: **obtaining ARV drugs to provide PMTCT and providing specialised assistance to children** to prevent vertical transmission of HIV in health care facilities of the Dnipropetrovsk oblast.

2025. By Order of Department of Health of the Dnipropetrovsk Oblast Military Administration dated 06.05.2025 No. 412/0/197-25, **the composition of the RC EMTCT was updated**. Four working group meetings were held during the year. PMTCT issues were considered at two meetings of the regional coordination council for combating TB/HIV and included in the council's work plan for 2026. During the year, a number of **monitoring visits** were carried out to health facilities and **training of medical workers on PMTCT issues** was conducted. In cases of refusal of treatment, conversations are held with parents or guardians, after which notifications are sent to district social services regarding the violation of the child's rights. In the direction of compliance with human rights, gender equality and community participation, four online seminars were held **on the prevention of violence, stigma and discrimination**. Internal regulations on the ethical code of conduct were approved in 100% of institutions related to PMTCT. 100% of institutions have implemented policies to reduce stigma and discrimination against people living with HIV. **Social support** is provided within the framework of **NGO** project activities; tenders for the purchase of social services from local budgets were not held during the martial law period.

Odesa oblast

During 2023–2025, the system for coordinating EMTCT activities in the Odesa oblast is characterised by instability and insufficient integration into the activities of regional coordination bodies, weak intersectoral interaction and insufficient institutional stability in emergency situations. The composition of the Regional Interdepartmental Working Group on Validation of Elimination of Mother-to-Child Transmission of HIV (RC EMTCT) was updated in accordance with personnel changes, but the group's meetings were never held in 2024–2025. The meeting of the Coordinating Council on Combating Tuberculosis and HIV/AIDS was held for the first time in October 2025 after a long break, and PMTCT issues were included in the council's agenda.

Organisational and programme activities were partially implemented, and some were postponed to the next year due to personnel changes and lack of funding. Health care facilities have not developed and implemented routes for providing PMTCT services in emergency situations, taking into account the needs of key groups. A positive aspect is the provision of social support for HIV-positive women by non-governmental organizations, as well as training activities for medical workers. According to the results of the National Council's monitoring visit, an adequate level of implementation of PMTCT activities in the region was noted, and some PMTCT indicators exceed the national average. At the

same time, measures to respect human rights, gender equality, and community participation were not actually implemented.

2023. By Order of the Department of Health of the Odesa Oblast Military Administration dated 28.03.2023 No. 396-OD, **the personnel composition of the Regional Interdepartmental Working Group on Validation of Elimination of Cases of HIV Transmission from Mother to Child (RC EMTCT) was updated**, taking into account changes in personnel composition. Analytical reports and quarterly reports on the implementation of EMTCT measures are submitted to the PHC of MoH. The work of the committee was not heard at the meetings of the oblast **Coordination Council on Combating Tuberculosis and HIV/AIDS** at the Odesa Oblast Military Administration due to a change in leadership in the Department of Health and the Odesa Oblast Centre for Socially Significant Diseases. Organisational and programme **activities were partially implemented or postponed** to 2024. The main problems are underfunding from the city budget, which has led to parents purchasing formula milk at their own expense for 40% of children, a lack of funds for monitoring visits to district antenatal clinics, and an insufficient number of rapid tests for screening pregnant women and their sexual partners by family doctors.

2024. By Order of the Department of Health of the Odesa Oblast State Administration dated 30.04.2024 No. 372-OD, **the composition of the RC EMTCT was updated**. By order dated 06.05.2024 No. 388-OD, **the regional action plan** for 2024 **was approved**. At the same time, during the year, **no meetings of the working group were held**, and the issues of its activities **were not considered at the meetings of the regional coordination council** for combating TB/HIV due to personnel changes and the need to make changes to the composition of the committee. **Monitoring visits** were carried out to health facilities and **training events** were held for medical workers on PMTCT issues. However, **routes for providing PMTCT services in emergency situations, taking into account the needs of key groups, have not been developed** and **implemented**. **Social support** for HIV-positive women is provided within the framework of project activities by 10 NGOs, in particular by three organisations for HIV-positive pregnant women. In case of violations of the rights of the child, the information is transmitted to social services and NGOs for appropriate response. In the area of observance of human rights, gender equality and community participation, **measures have not been implemented**. According to **the results of the monitoring visit of the National Council** (23–24.09.2024), it was noted that the Odesa oblast **ensures an adequate level of implementation of EMTCT measures**, and certain EMTCT indicators exceed the national average.

2025. The update of the composition of the RC EMTCT is planned for 2026. During 2025**, no working group meetings were held**; PMTCT issues were considered at one meeting of the regional coordination council for combating TB/HIV (02.10.2025). During the year, 10 **monitoring visits** were carried out to health facilities and **training of medical workers** on PMTCT was conducted. The update of the registers of health facilities providing obstetric care in the areas of HIV testing was initiated. **Social support** for HIV-positive women is carried out within the framework of the project activities of 10 NGOs. **Routes for providing PMTCT services in emergency situations have not been developed**. **Measures have not been implemented** in the areas of respect for human rights, gender equality, and community participation.

Community Perspectives

The potential of non-governmental organisations

Qualitative component

Focus group discussions with 16 community-based service providers and activists

A number of HIV-service NGOs, including organisations led by the community of people/women living with HIV, are active in Dnipropetrovsk and Odesa oblasts. They play an important role in implementing measures to prevent vertical transmission of HIV, acting both as providers of relevant services and as the voice of the community of women living with HIV in advisory and coordinating bodies on TB/HIV and EMTCT at the city and oblast levels. NGOs cooperate with municipal and private medical institutions, social service centres, crisis and rehabilitation centres, specialised doctors, other NGOs, religious communities and charitable foundations.

In response to the question about the importance of PMTCT services at the community level, FGD participants noted that the community and HIV-service NGOs provide or facilitate better access to services for women living with HIV. This is explained by a greater level of trust in people with similar experiences, peer counselling, psychological support, accessibility of services at the community level, empathy of service providers, establishment of effective communication with health workers about women's needs and challenges, as well as the opportunity to be a voice for those who cannot protect themselves on their own.

Experience and achievements in providing PMTCT services

The FGD participants confirmed the use of **a multidisciplinary approach** that promotes effective interaction and coordination in the process of monitoring the pregnancy of women living with HIV and medical support of HIV-exposed children in accordance with industry health standards. Examples of organising the work of **multidisciplinary teams (MDTs)** were given, and mechanisms for communication and referral of patients in need of psychosocial support to NGOs were described.

The activities of the MDT at the sites of opioid substitution therapy (OST) were separately noted, which provide comprehensive assistance to HIV-positive women with drug addiction, as well as intersectoral cooperation in the field of combating tuberculosis, in particular among HIV-positive patients (*"We referred the woman to an obstetrician-gynaecologist so that she could register. Of course, we have more than one such woman who is pregnant and starts OST. Screening for tuberculosis is mandatory, we undergo it, we directly screen. Assessment of psychosocial status, possible depression - we have a screening questionnaire, she answers questions, we have psychologists, psychiatrists, and a psychotherapist, so they immediately pick up if something happens. Domestic or gender violence - in addition to helping the woman, we try to pull the partner up. We have a consultation with an infectious disease doctor at the site, it is an integrated service, so it mandatory. Also, protection, respect for rights and interests, adherence to continuity of treatment, delivery of drugs, etc."*).

Social support throughout the PMTCT continuum of services

Peer counselling of HIV-positive pregnant women. Activists and NGO employees regularly provide peer counselling to HIV-positive pregnant women. The main topics of counselling include: the benefits and safety of ART, prevention of miscarriage, the need to use condoms, counselling partners, prevention of perinatal transmission of syphilis, hepatitis B and hepatitis C viruses, vaccination, healthy nutrition, safe childbirth, discussion of the risks of postpartum HIV transmission during breastfeeding, formula feeding, and effective contraception (*"I advised a woman who used street drugs on the*

importance of following all the doctors' recommendations. Then we brought her to the OST website. We redirected her to "Positive Women", where she was consulted on a peer basis, and she easily gave birth, everything is fine with her", "I conducted peer consultations on the benefits and safety of ART, as well as the use of effective methods of contraception to prevent unwanted pregnancy, and on supporting a healthy diet", "I have been living with my status since 2003, I found it out during pregnancy. I have repeatedly had cases when women found out that they were pregnant with a positive status. I shared my experience, talked about what medicine has evolved to now, that today it is not a problem at all. There were many questions, first at the first offline meeting, then it was over the phone. There was support and I not only provided psychological assistance, but also referred to psychologists", "Once I was pregnant, now I conduct full consultations, share personal experience and what is according to the protocols").

Providing social and psychological assistance to an HIV-positive pregnant woman includes a set of measures that meet industry standards in the field of health care: referral to specialised doctors (obstetrician-gynaecologist, infectious disease specialist, tuberculosis specialist, narcologist), tuberculosis screening, assessment of psychosocial status and risk of violence, timely registration, monitoring adherence to ARV therapy, as well as protection of the woman's rights and interests (*"There were both pregnant women and women in labour, whom we referred to crisis centres and provided them with support. Timely registration of a pregnant woman in a health centre is a constant practice for us, we cooperate with a gynaecologist who guides our pregnant women living with HIV, and she refers them to us for support", "Protecting the rights and interests of an HIV-positive woman during pregnancy is, in general, a red line in our activities", "At the beginning of the full-scale campaign, with joint efforts with 100% Life, one pregnant girl was taken abroad", "I have a screening for tuberculosis in my primary documentation, we conduct it necessarily at the first offline meeting", "The Positive Women Odesa Charity Foundation is involved in all these services. If a woman with drug addiction comes, I send her to the "Era myloserdia". If a woman is pregnant with suspected tuberculosis or if the doctor called, I know I'll redirect to "Life Plus". If this woman is with poor adherence, it's a Care and Support project, I'll send her to "Alternative", if it's Chornomorsk or closer"*).

When providing consultations, NGO workers often draw on their own experience of pregnancy and childbirth, and collaborate with partner NGOs and specialists to provide a full range of services, in accordance with the needs of the pregnant woman. Consultations are held in the form of individual or group consultations, offline or online, on the territory of the NGO or on the basis of health care institutions (*"We provide individual consultations both offline and online. Online in the event that the woman cannot come, or she is in a remote hromada", "We provide services not only in the organisation, but also on the territory of maternity hospitals, in the antenatal clinic when we are informed about a difficult case", "I can go with her, starting from a gynaecologist and ending with a psychiatrist, psychologist, narcologist and all the specialists who are needed at this moment"*).

Providing social and psychological support to an HIV-positive woman in labour. FGD participants confirmed that their organisations have experience in providing comprehensive social and psychological support to HIV-positive women during labour and the postpartum period. Such support includes: counselling on partnered birth, formula feeding and taking ARV drugs, the use of cabergoline to suppress lactation, assessment of the mother's psychosocial status and the risk of postnatal depression, monitoring the risk of domestic/gender-based violence, monitoring adherence to treatment, screening for tuberculosis, counselling on contraception in the postpartum period, protection of the rights and interests of the mother and child, and prevention of newborn abandonment ("*A woman with many children, I helped her find housing. I redirected her to a shelter in Poltava, where she stayed. I helped her move to another country in the midst of the war", "We have a psychologist to whom social workers refer clients with signs of depression"*).

Ensuring access to a drug (cabergoline) for postpartum lactation suppression: NGO contribution

Procurement with local budget funds (Odesa city): *"Odesa is the first region in Ukraine that managed to purchase drugs to stop lactation with local budget money last year within the health programme. This was our proposal, our advocacy. I made a request. As of today, the funds have been budgeted in the 2026-2028 health programme. The medication is available".* (community leader, FGD participant)

On 26.06.2024, at the XXXI session of the Odesa City Council of the VIII convocation, the issue of making amendments to the city target programme "Health" for 2024-2026, approved by the Decision of the Odesa City Council of 29.11.2023, namely the purchase of drugs to stop lactation in women living with HIV, was raised. The purchase of drugs was supported in the amount of UAH 131 thousand.

Procurement within the framework of existing projects providing services to women living with HIV (Dnipro city): "*I came here (Positive Women) to get pills so that there would be no milk. They gave it to me, I drank it. Then I got sick again, I called Violetta, asked, can I get it again? She says, yes, you can, come. When I came to receive them, she said, you can also get this help, they gave me formula, diapers. (How did you find out about the NGO's services?) When I came the second time to register again, for therapy. At Kanatna, I was introduced to Violetta. My gynaecologist, with whom I am registered".* (mother of an HIV-exposed child, participant in in-depth interviews)

Providing social and psychological assistance to parents (guardians) of an HIV-exposed child. HIV-service NGOs, including community-led organisations, provide a wide range of psychosocial assistance and support, including: counselling on the child's medical management and PNP, post-test counselling based on the child's HIV test results, recommendations on safe feeding, information on obtaining and dispensing breast milk substitutes, provision of humanitarian assistance, clarification of legislative issues and benefits, and protection of the rights of the mother and child (*"The medical staff of the perinatal centre, already knowing our contacts, referred women who were lying with their babies for 28 days after giving birth to us to solve their urgent problems. There was a case when a woman from the Kherson oblast, from the deoccupied territory, gave birth in the perinatal centre and the social services wanted to take her child from her. We started accompanying her, did not let them take the child. Then we found a shelter for her, put her on ARV therapy. The child had prophylaxis, and she is now in a shelter", "We helped to arrange social benefits that are paid up to a year and a half", "A woman with drug addiction, whose rights were violated by the maternity hospital, we quickly registered her, made a declaration and the family doctor called us and said that she had already received formula milk. After discharge from the perinatal centre, literally two weeks had passed, she had already been prescribed formula milk for the baby"*).

HIV-service NGOs play an important role in **ensuring access and timeliness of early diagnosis in HIV-exposed children**. In particular, they directly organise the transportation of the mother with the child (or children) to the place of blood sampling, support communication with doctors who seek help in informing and monitoring timely diagnosis for the child, and also ensure the travel of medical workers to remote hromadas, where, among other services, blood sampling for PCR is carried out (*"We are currently implementing a project with the support of UNICEF and we have the opportunity to travel to remote hromadas with a multidisciplinary team, where a nurse and a doctor are also present, and collect PCR from children in a timely manner", "We advise girls, tell them step by step what they should do. We also help take them to the AIDS centre, we are constantly on the phone, or call a taxi if we have such an opportunity, or we just come, pick them up and go by public transport. We had such a case, twins. The case manager arrived, waited for about an hour until they woke up, while their mother dressed them. And she took them, the twins, to the AIDS centre. The city is big and sometimes this is an obstacle for girls with small children to travel and donate blood"*).

Laws or institutional practices that limit access to services

Community activists are convinced that Ukraine has provided the necessary legal framework for the elimination of vertical transmission of HIV. However, inadequate implementation or enforcement of existing laws can become obstacles to the quality and effective provision of services and the implementation of the PMTCT programme. This also applies to by-laws and institutional practices that either do not take into account the specific needs and vulnerabilities of women living with HIV during pregnancy, childbirth, and care for an HIV-exposed child, or contradict modern standards of PMTCT care and clinical recommendations. According to activists, such practices include:

- **Mothers and doctors become "hostages" of the packaging of paediatric Zidovudine**

The practice of dispensing the ARV drug Zidovudine (AZT) into syringes for PNP in HIV-exposed children occurs due to the unavailability of the paediatric form of the drug in the required quantity for each individual dose according to the prescribed preventive treatment regimen. In the maternity hospital (delivery), the process of measuring the dose of the drug is monitored by trained medical personnel, and the practice of dispensing AZT syrup at the level of the perinatal care facility is clinically justified due to the lack of a paediatric form of the drug. However, after discharge home, PNP becomes the responsibility of the mother. As a community activist noted during the FGD, she knows of cases when mothers accidentally or carelessly spilled all the liquid (PNP-syrup) at home. In particular, the mother of an HIV-exposed child from a rural area of the Odesa oblast asked for help, and an HIV-service NGO organised the delivery of a new supply of drugs, having agreed this with the AIDS centre. Such situations demonstrate not only the risk of incorrect dosage in mothers – they can lead to a violation of the PNP regimen. The community leader added that the practice of pouring Zidovudine (AZT) syrup into a syringe contradicts the current legislation. The Order of the MoH of 19.07.2005 No. 360[38] states that **breaking the primary packaging of the drug is prohibited** (i.e.: pouring into another container without the manufacturer's packaging is not allowed) (*"The problem is the pouring of ARV drugs into syringes. PNP drugs are given home in syringes for a woman who does not always understand how to pour this dosage, how to store it correctly. Women are different here. I have encountered a situation where the drug is spilled, she is afraid to go to the doctors, to confess to them, and the child does not receive prophylaxis. There was an appeal for help from a woman from a remote hromada, we ran to the AIDS centre in Odesa and transferred it to the oblast, but, still, the reception regime was violated. Why can't the necessary forms of hermetic packaging be provided? By law, doctors do not have the right to open a jar of drugs and pour it into something"*).

The relevance of this issue is confirmed by other research groups. During in-depth interviews, some mothers reported that in the perinatal health facilities they were always given a ready-made dosage of the PNP drug in syringes, that is, they did not acquire practical skills in measuring the dose of the drug themselves. Most mothers could not recall either the name or the dosage of the drug (or drugs) that the child received during 28 days. In addition, according to the results of an online survey of HIV-positive mothers (n=89), 15% (13) of respondents **did not receive training on measuring the dose of the ARV drug**, and 38% (34*) **did not receive written instructions on taking PNP**, where the lion's share was women from the Odesa region. (*34: 7 – Dnipropetrovsk oblast, 27 – Odesa oblast)

The full course of preventive ARV treatment for newborns (28 days) under the supervision of medical workers in the Dnipropetrovsk oblast is regulated by the Order of the Department of Health of the Dnipropetrovsk Oblast Military Administration of 18.11.2024 No. 1194/0/197-24 "On the organisation of HIV prevention for children born to women with HIV-positive status". In practice, this is accompanied by **the mandatory detention of mothers with an HIV-exposed child for 28 days in medical institutions**: maternity wards, perinatal centres with a hospital, mother and child centres, children's hospitals, etc. This rule applies even to women with high adherence to ART and low risk of HIV transmission. Doctors explain to community activists that the problem lies in the packaging of the

[38] https://zakon.rada.gov.ua/laws/show/z0782-05

paediatric form of the drug Zidovudine (AZT), which is 200 ml, when a three-week course requires less than 100 ml (if you count minus the week in the hospital under the supervision of medical workers). From a legal point of view, doctors are acting correctly — they comply with current legislation: according to the Order of the MoH No. 360 of 19.07.2005, the primary packaging must not be broken during retail sale, and the Law of Ukraine "On Medicinal Products" guarantees safety and accuracy of the dose ("*What motivates doctors, why do they not let a woman go home, even with high adherence, within 28 days? Because there is no Zidovudine, a liquid form, that is, a whole blister, they cannot give it to the mother, the woman in labour. I personally contacted doctors to get these drugs. Doctors do not always go to the appointment; they say that it cannot be transported when it is unopened"*).

For a more thorough analysis of the situation, it is advisable to take into account the results of in-depth interviews with four mothers of HIV-exposed and HIV-positive children in the Dnipropetrovsk oblast. Only one child underwent PNP for 28 days in a hospital setting (the mother had previously recorded low adherence to ART, the child's first and second PCRs were negative). The mothers of the other three children were discharged from the maternity hospital on the 5th, 11th, and 8th day after the child's birth, respectively. In the latter case, low adherence to ART was also recorded, and the first DBS PCR was positive. Thus, women had the opportunity to conduct PNP at home, regardless of the level of risk of HIV transmission.

This situation demonstrates the clinical need for dosing for accurate PNP, but poses risks to treatment efficacy and safety. To minimise these risks, it is necessary to ensure the availability of paediatric formulations of ARV drugs, conduct parental education, and develop formal protocols for safe dosing of the drug outside the hospital.

- **Terms of PNP in mothers with very low risk of HIV transmission**

The community activist noted that doctors are ignoring recommendation 9.1.1 of the clinical guideline, when **Zidovudine monotherapy is recommended for 2 weeks for HIV-exposed children from mothers with a very low risk of HIV transmission** (Evidence-based clinical guideline "Prevention of HIV transmission from mother to child", Order of the MoH No. 692 of 26.04.2022). ("*The Order No. 692 states that a woman who has high adherence to treatment can give prophylaxis to her child for 14 days, not 28. Why do they keep it for 28 days all the time – that's the question*").

- **Implementation of PMTCT standards and clinical recommendations for breastfeeding**

Community representatives have repeatedly reported that health workers ignore current PMTCT standards and recommendation 9.4.4 of the clinical guideline "Choosing to breastfeed" for women who have achieved viral suppression on ART with proper adherence. In addition, doctors categorically deny the possibility of such an option for an HIV-positive woman and advise exclusively on formula feeding. HIV-positive pregnant women and mothers-to-be mostly receive information about the right to choose, risks and features of breastfeeding, including the need for additional clinical monitoring of the mother and child, from activists in the community of women living with HIV. Community leaders are also aware of the consequences and risks of promoting breastfeeding: additional financial burden on PLHIV health facilities and restrictions on the possibility of monthly visits to medical institutions for clinical monitoring by women with children, especially under martial law (*"Regarding breastfeeding, you probably noticed that none of my colleagues said that positive women can breastfeed. That is, this information is not available at all and this particular problem needs to be updated. There are protocols for breastfeeding, where the mother and child must be checked every month. In the Odesa oblast, everyone is prescribed formula feeding of children. I once said, "Maybe she is going to breastfeed?", I was thrown out the door. AIDS centres do not have money for routine diagnostics of citizens, and doing viral load every month to a woman who wants to breastfeed is unlikely", "She gave birth to a healthy boy. She also asked about breastfeeding. When we advised her that there was still a risk and she needed to be checked constantly, every month, she decided to be on formula feeding, she did not take the risk"*).

The activists' observations and experiences are also supported by the reports of health workers and people in management positions obtained during in-depth interviews. Doctors usually advise abstinence or convince HIV-positive women not to breastfeed their children. In some cases, it was obvious that doctors were not familiar with the latest standards for breastfeeding; some expressed frank surprise at the presence of such an option in the standard of medical care. When asked about observations and comments on the latest standards of medical care for PMTCT and the clinical institution of 2022, a specialist in a leadership position suggested defining formula feeding as the only acceptable option for feeding HIV-exposed children, without exceptions.

The only example of support and knowledge of standards for breastfeeding during in-depth interviews was demonstrated by a paediatric infectious disease specialist in Dnipro (Dnipropetrovsk Oblast Medical Centre for Socially Significant Diseases): *"(What happens when a woman decides to breastfeed?) Nothing happens, she breastfeeds. According to the protocol, every month we have to examine the mother and child. She has to take therapy, and the child has to take it. We have single women, one or two, who always breastfeed. No positive children were born. The protocol is not maintained, if you want to ask. (The frequency of monitoring is not maintained?) And it is impossible to maintain it. Conducting examinations every month. It is probably expensive if they are going to breastfeed so en masse. And then, probably, it should not be done. There are pregnant women to whom I would recommend breastfeeding myself. They have been on therapy for 5-7-8 years. They are absolutely adequate women. It is safe if they take medication. But they themselves are not ready yet. The doctor is more ready than the woman. They say, no, no. We gave birth, the DBS is negative".*

Neonatologist, Dnipro: *"It hasn't happened in my practice. (And if it does, do you have instructions on how to consult in this case?) In principle, I know, but I can't say for sure that I will do it 100% correctly. Although, in principle, I understand that she needs to be recommended".*

Family doctor, Dnipro: *"There were no such cases at all, thank God. We are trying our best to explain the situation, to explain these risks".*

Obstetrician-gynaecologist, Odesa: *"We convince her that she cannot breastfeed with this disease. And many agree. I have never had the other way".*

Infectious disease doctor, Odesa: *"We don't have a question about whether a woman can. That is, the woman is explained that we can measure the amount of viral load in a woman's body, but we cannot measure the amount of viral load in milk. Therefore, if she wants to take a risk, I understand that it is her right. But first, a lot of work is done to ensure that the woman does not risk the child".*

Paediatrician-infectious disease specialist, Odesa: *"I didn't have any of these. She needs to be told how much it can harm her health and that of her child. (If she decides to breastfeed, what counselling will she be offered and what support will be provided?) Support by providing free milk formulas. If the mother is buying her formula because it is expensive there, maybe some have them, the reason she wants it".*

A specialist who holds a managerial position, Dnipro: *"My personal opinion on the issue of formula feeding is the following. The updated orders spell out everything very well, that we must give women the opportunity to choose. Somewhere there was a missed dose of antiretroviral drugs, somewhere something happened. And a woman, today her viral load is good, everything is fine, she is breastfeeding her child. And then something happened, and she did not pass the HIV test, and she persists - I was given information that I can breastfeed, and she has a risk of infecting the child. (What is your proposal?) Formula feeding. Exclusively. Milk formulas are adapted, good. Why do we ourselves offer breastfeeding, having a risk of infecting the child? I don't know".*

In general, the practice of breastfeeding counselling and support for HIV-positive women in Ukraine largely does not meet modern PMTCT standards and clinical recommendations. The vast majority of health workers ignore or openly deny the possibility of such a choice for women who have achieved viral suppression on ART and have high adherence to treatment. Breastfeeding counselling is often

transferred to community activists, and health workers focus exclusively on formula feeding, without informing women about their right to choose.

Individual examples of adequate breastfeeding support remain rare and depend on the personal awareness and position of individual doctors, while most specialists either do not have practical experience or are not ready to advise in accordance with the new standards. This situation creates barriers to the realisation of the rights of women with HIV and increases social stigmatisation. At the same time, the lack of adequate financial and organisational support for regular monitoring of the health of the mother and child during breastfeeding forces even informed women to choose formula feeding.

To ensure the rights of HIV-positive women and effectively implement modern PMTCT approaches, it is necessary to change counselling practices, strengthen the training of health workers, ensure a unified approach to informing about breastfeeding options, and create conditions for regular clinical support for mothers and children who choose to breastfeed. Without this, recommendations will remain only "on paper," and women will be left without a real choice.

- **Access to adapted milk formulas for HIV-exposed children**

Health care workers and specialists in managerial positions, as well as activists and community-based service providers who provide social support and monitor the availability of services, confirm the purchase from local budgets and the issuance of breast milk substitutes by family doctors of primary health care centres at the place of residence. Data on the number of children born, registered and those requiring formula are regularly collected and reported (*"I always try to explain that you must contact your family doctor. Money is now being allocated and formulas are being purchased at the expense of local communities", "In the city (Kryvyi Rih) there is a city programme that regulates free distribution of milk formulas for these categories of people. By place of residence. This is "Malysh", "Maliutka". We give all the figures, the number of births, the number of children, the number registered, the number of those in need. Everything is given, every quarter", "Yes. We had formulas. No problems. (Do they meet the needs of women?) Yes. High-quality", "Children's clinics are provided under the city programme"*).

However, these programmes cover mainly oblast centres and large cities (Dnipro, Odesa, Kryvyi Rih, Kamianske, Pavlohrad), where **the procurement of adapted milk formulas** for children born to HIV-positive mothers is **part of local health programmes**.

Unlike large cities, **access to free infant formula is often extremely limited for residents of small hromadas**. The reasons for this are diverse: lack of needs assessment and appropriate planning, limited community resources ("rich and poor hromadas"), and dishonesty of officials. The lack of funding for the purchase of formula is confirmed by responses to community activists' inquiries in the Dnipropetrovsk oblast: out of 10 hromadas that responded, only 6 purchase infant formula. There is also no unified approach to calculating funds per child, for example, one hromada allocates 32 thousand hryvnias per child for 12 months, while another allocates only 5 thousand. The lack or absence of budget funds is partially compensated by humanitarian assistance through PLHIV health facilities or projects of non-governmental organisations, but not all residents of rural areas have access to such support (*"Family doctors know what needs to be distributed. They mostly give formula. (Is there enough supply?) Not always. There are such small outpatient clinics. It depends on the person on site who has to provide the budget for it", "This is the lack of funding for the purchase of formulas. I sent requests to hromadas and they answered me. Out of 10 hromadas, only 6 purchase infant formula for babies. Moreover, there is no unified approach to the purchase of infant formula. For example, one hromada allocates 32 thousand for one child, the second community – 5 thousand. That is, children's access to formula is completely unequal here", "Now with an HIV-positive child, she asked for baby food, because in this particular united territorial community they did not buy it for them", "Hromadas are very different. There are rich hromadas. And there are poor ones. That is why the funding is different. Plus, a tender is being held, the price offered will be allocated. We are not there we give out*

money", "In very small village councils this is done with funds from the PHC facilities. It makes no sense to create a separate programme for the purchase of milk formulas for one child per year. Perhaps that is why the answers were that separate funding is not provided").

It is also important to note that **private family doctors-entrepreneurs** (family doctors as individual entrepreneurs) **do not have access to infant formulas purchased at the expense of local budgets**. Mothers of HIV-exposed children should be informed about this, since misunderstanding the procedure for providing free formulas leads to complaints against health care workers of PLHIV. Individual entrepreneurs do not provide infant formulas, this is done by municipal institutions (PHC facilities). Women who have concluded contracts with private family doctors do not receive formulas under local programmes, which causes misunderstanding and requires additional clarification (*"The only thing is that individual entrepreneurs do not issue them. But family doctors – PHC facilities, state institutions, municipal enterprises – those, yes", "Now we have a lot of individual entrepreneurs who have signed contracts. They have no relation to local budgets in any way. It was Kryvyi Rih, a woman complains that she is not provided with milk formulas. She comes to the AIDS centre, they tell her: we really do not issue milk formulas, go to your family doctor. But the woman did not specify with which family doctor she signed a contract for a primary medical care package. If it is a municipal enterprise, then yes, it is there. And if it is an individual entrepreneur, then, of course, it is not. She came to this family doctor, and the family doctor, being a private entrepreneur, says: I do not do this"*).

➡ **Accountability of private medical institutions**

Every year, the number of pregnant women receiving medical services in private clinics is increasing. At the same time, information about such patients and their children is practically not reflected in state statistical reporting. This negatively affects the completeness of statistical indicators and the quality of management decisions in the field of PMTCT, and also creates the risk of losing the pair "HIV-positive mother – HIV-exposed child" from the perspective of the health care system and disrupting the continuity of medical support ("*Private clinics have started to open, and these children, for some reason, are not taken into account in the state structure. In our region, this is exactly the case. We are losing them altogether from sight. Apparently, there must be some mechanism for private clinics to somehow reflect pregnant women, reflect, report children exposed to HIV or already HIV-positive children"*).

In order to ensure full accounting of pregnant women and children involved in PMTCT programmes, it is advisable to introduce an effective mechanism for data exchange and consolidation between the private and public sectors, as well as ensure mandatory reporting by private health care institutions in accordance with the current regulatory framework.

The role of non-governmental organisations in monitoring services and advocating for improvements

Community-led research and monitoring of women living with HIV

During 2022-2025, the CO "Positive Women" organised and conducted the following community-led research, which included coverage of the Dnipropetrovsk and Odesa oblasts:

- Research on the provision of services to women with HIV who are planning a pregnancy, pregnant women and postpartum women in the field of sexual and reproductive health at the oblast level of Ukraine (2022)[39]

[39] https://pw.org.ua/wp-content/uploads/2022/12/doslidzhennya-yekom_srz-pozytyvni-zhinky_2021-1.pdf

- Obstetric violence against HIV-positive women in Ukraine (2023)[40]
- Analysis of barriers to access to social and health services for women living with HIV and vulnerable to HIV in Ukraine (2023)[41]
- Assessment of the implementation of WHO recommendations in the field of sexual and reproductive health and rights of women living with HIV in Ukraine (2024)[42]
- Impact of war on women living with HIV in Ukraine (2024)[43]
- Assessment of the availability and quality of HIV, tuberculosis, sexual and reproductive health services for women living with HIV (2024[44], 2025[45])
- Identifying barriers to access to services for the prevention of mother-to-child transmission of HIV (2024[46], 2025[47]).

Representatives of the community of women living with HIV in Dnipropetrovsk and Odesa oblasts actively monitor the provision of access to breast milk substitutes for HIV-exposed children, financed from local budgets. To do this, they submit official requests to local government bodies, which helps ensure accountability and transparency in the implementation of current legislation. This approach allows for the systematic identification of financing problems in individual hromadas, analysis of purchases, and inclusion of issues on the agenda of regional advisory and consultative bodies on HIV and HIV/AIDS. Thanks to this, the hromada is able to respond to existing challenges in a consolidated manner and discuss problematic issues in the relevant regional platforms: *"The representative of "Positive Women" made requests and presented the results to our coordination council, and there they showed not very good results. Some did not answer, some wrote "no". It was well done, this study, these requests. "The territorial hromadas heard this, we really hope, and paid attention to the Coordination Council" (secretary of the RC EMTCT, specialist of the Dnipropetrovsk Oblast Medical Centre for Socially Significant Diseases)*.

Community participation in regional HIV and EMTCT advisory bodies

Dnipropetrovsk oblast

Coordination Council for Combating Tuberculosis and HIV/AIDS at the Oblast State Administration

The community of women living with HIV has the opportunity to present the results of NGO work, community-led research and **promote access to services** that are important for women living with HIV. The reports cover: analysis of accessibility to HIV, TB and SRH services for HIV-positive women, including issues of EMTCT and cases of **violations of the rights of HIV-positive patients** in maternity hospitals in the Dnipropetrovsk oblast; analysis of procurement of breast milk substitutes for HIV-exposed children at the expense of local budgets and problems with access to milk formulas for women from remote hromadas.

Working group on validation of elimination of mother-to-child transmission of HIV infection at the Department of Health of the Dnipropetrovsk Oblast Military Administration

[40] https://pw.org.ua/wp-content/uploads/2023/11/akusherske-nasylstvo-shhodo-vil-pozytyvnyh-zhinok-v-ukrayini.pdf
[41] https://pw.org.ua/wp-content/uploads/2023/03/ukr-1.pdf
[42] https://pw.org.ua/wp-content/uploads/2024/04/zvit-za-rezultatamy-opytuvannya-oczinka-vprovadzhennya-rekomendaczij-vooz-u-sferi-ohorony-seksualnogo-ta-reproduktyvnogo-zdorovya-ta-prav-zhinok-yaki-zhyvut-z-vil-v-ukrayini.pdf
[43] https://euneighbourseast.eu/news/publications/the-impact-of-war-on-women-living-with-hiv-in-ukraine/
[44] https://pw.org.ua/wp-content/uploads/2024/11/oczinka-dostupnosti-ta-yakosti-poslug-z-vil-tuberkulozu-ta-seksualnogo-i-reproduktyvnogo-zdorovya-dlya-zhinok-yaki-zhyvut-z-vil.pdf
[45] https://pw.org.ua/wp-content/uploads/2025/09/oczinka-dostupnosti-ta-yakosti-poslug-z-vil-tuberkulozu-seksualnogo-i-reproduktyvnogo-zdorovya-dlya-zhinok-yaki-zhyvut-z-vil.pdf
[46] https://pw.org.ua/wp-content/uploads/2024/12/vyznachennya-baryeriv-u-dostupi-do-poslug-z-profilaktyky-peredachi-vil-vid-materi-do-dytyny-sered-zhinok-yaki-zhyvut-z-vil.pdf
[47] https://pw.org.ua/wp-content/uploads/2025/12/vyznachennya-baryeriv-u-dostupi-do-poslug-z-profilaktyky-peredachi-vil-vid-materi-do-dytyny-sered-zhinok-yaki-zhyvut-z-vil.pdf

RC EMTCT serves as a platform for addressing cases of rights violations and discriminatory treatment of women living with HIV in medical institutions. Community activists were able to receive professional recommendations on the preparation of information materials for HIV-positive women, present the results of a community-led study, and discuss the development of an appendix to the **Roadmap for the Elimination of Mother-to-Child Transmission of HIV** with **a patient route** for HIV-positive women during pregnancy, childbirth, the postpartum period, and medical follow-up of an HIV-exposed child. The appendix also contains contact information for institutions and organisations in the Dnipro region that provide medical, psychological, and social support to women living with HIV.

Odesa oblast

City of Odesa: City Coordination Council for Combating HIV/AIDS, Tuberculosis and Viral Hepatitis

The participation of a representative of the community of women living with HIV in the city council served as the basis for advocacy on the issue of **ensuring funding for a drug to suppress lactation in HIV-positive postpartum women** in the city of Odesa by including appropriate funding in the local health care programme.

Coordinating Council for Combating Tuberculosis and HIV/AIDS at the Odesa Oblast State Administration

The Council had not been working for several years before the meeting, which took place in early October 2025. After a significant break, the meeting of the Regional Council on Combating TB/HIV was held on October 2, 2025, where a representative of the community of women living with HIV was an invited participant (without having an official membership). The community activist drew attention to the need **to consolidate efforts to start the work of the RC EMTCT** in the Odesa oblast and the challenges associated with the procurement of breast milk substitutes for HIV-exposed children at the expense of local budgets and access to milk formulas for women from remote hromadas.

Regional Interdepartmental Working Group on Validation of Elimination of Mother-to-Child Transmission of HIV at the Department of Health of the Odesa Oblast Military Administration

A community representative who is a member of the RC EMTCT noted that **the Working Group is actually not functioning, and meetings have never been held**. She also reported that there is an order in Odesa oblast that regulates the implementation of **the Roadmap measures for the elimination of mother-to-child transmission of HIV**. However, the community activist is not familiar with the text of the relevant order and has not participated in the processes of preparation, planning, monitoring and evaluation of the implementation of the Roadmap measures.

ANNEXES

Annex 1. Conclusion of the Ethics Commission of the Public Health Centre of the MoH of Ukraine

Institutional Review Board of
SI "Public Health Centre MoH of Ukraine"
Registration number:
Institutional Review Board (#0013025)
Federal Wide Assurance (#0030968)

41 Yaroslavska Street, Kyiv, 04071, E-mail: irb@phc.org.ua

13.10.2025 №552

To: Olena Stryzhak, Chair of the Board, CO "Positive Women"
From: Institutional Review Board of SI "Public Health Centre MoH of Ukraine
Subject: *"Assessment of barriers to services for the prevention of vertical transmission of HIV in Dnipropetrovsk and Odesa oblasts"*
Date of expertise: 13.10.2025
ID No. of expertise: IRB2025-174

Dear Olena,
Institutional Review Board of SI "Public Health Centre MoH of Ukraine" has considered the Protocol of the research "Assessment of barriers to services for the prevention of vertical transmission of HIV in Dnipropetrovsk and Odesa oblasts" 2.0: 02.10.2025, applicant: Olena Stryzhak, Chair of the Board, CO "Positive Women", using a full ethical review procedure and noted the following:

1. TEAM QUALIFICATION
Recommended: Approved, no recommendations.

2. DESCRIPTION OF THE RESEARCH
Recommended: Approved, no recommendations.

3. DESIGN OF THE RESEARCH
Recommended: Approved, no recommendations.

4. RISKS AND BENEFITS
Recommended: Approved, no recommendations.

5. CONFIDENTIALITY
Recommended: Approved, no recommendations.

6. INFORMED CONSENT PROCESS
Recommended: Approved, no recommendations.

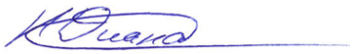
7. INFORMED CONSENT CONTENT
Recommended: Approved, no recommendations.

8. RESEARCH QUALITY CONTROL

Recommended: Approved, no recommendations.

9. GENERAL CONCLUSION
Subject to re-submission
Approved without change *- The Protocol and accompanying documents do not require changes*
Approved after clarification *- The Protocol and accompanying documents require insignificant changes*
Subject to re-submission *- The Protocol and accompanying documents require significant changes*
Not approved *- The Protocol and accompanying documents are not approved*
Comment:

General conclusion: Approved without change.

Secretary of the Board  **Kocheharova D.V.**

Annex 2. Report on the findings of an online survey of women living with HIV with experience of pregnancy and childbirth

The survey was conducted as part of a community-led study of women living with HIV **"Assessment of Barriers to Services for the Prevention of Vertical Transmission of HIV in Dnipropetrovsk and Odesa Oblasts"** from October 14 to 29, 2025.

The criteria for including respondents in the survey are:

- diagnosed with HIV infection at the time of the last pregnancy or childbirth
- aged 18 years and older
- are pregnant at the time of the study or have had experience of pregnancy and/or childbirth within the last 3 years prior to the study
- received medical services related to pregnancy, childbirth and/or care for an HIV-exposed child in municipal institutions in Dnipropetrovsk or Odesa oblasts
- were or are recipients of services of the CO "Positive Women" in the cities of Dnipro or Odesa
- provided voluntary informed consent to participate in the study.

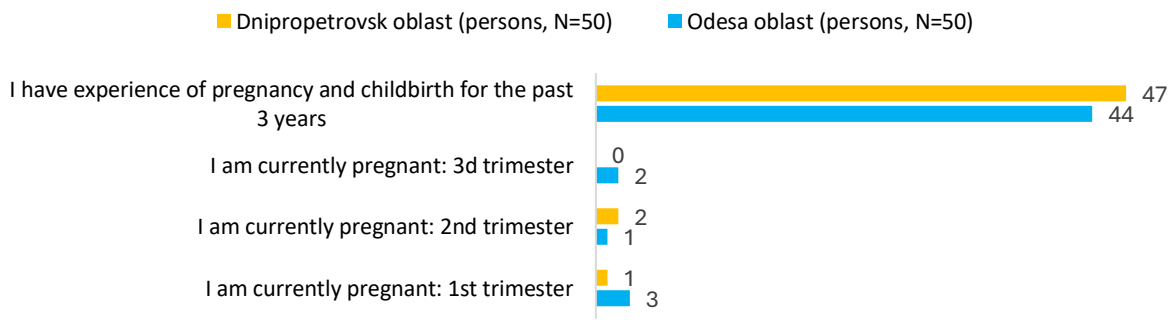
Survey findings

Experience of pregnancy and childbirth

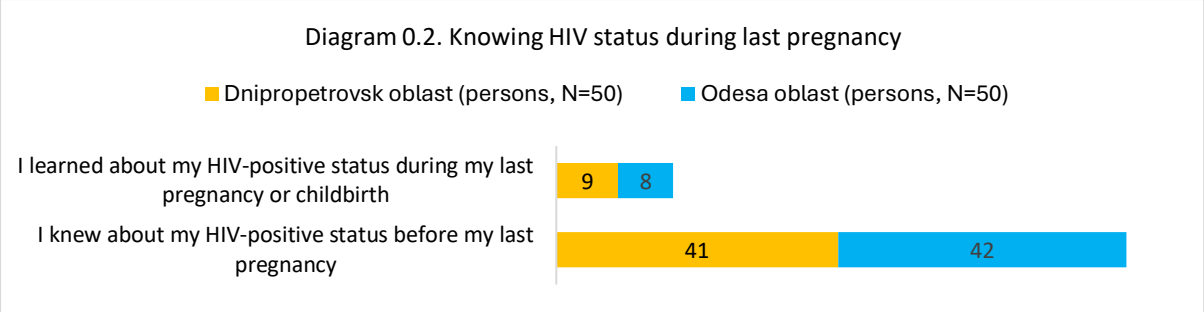
The survey included 100 women living with HIV with experience of pregnancy or pregnancy and childbirth within the last 3 (three) years, including:

- 50 women living in Dnipropetrovsk oblast
- 50 women living in Odesa oblast
- Nine respondents (9%) were pregnant at the time of the survey (4 women in the 1st trimester, 3 women in the 2nd trimester, 2 women in the 3d trimester). Of them, 3 women were from Dnipropetrovsk oblast, and 6 women – from Odesa oblast. See Diagram 0.1.

Diagram 0.1. Experience of pregnancy and childbirth

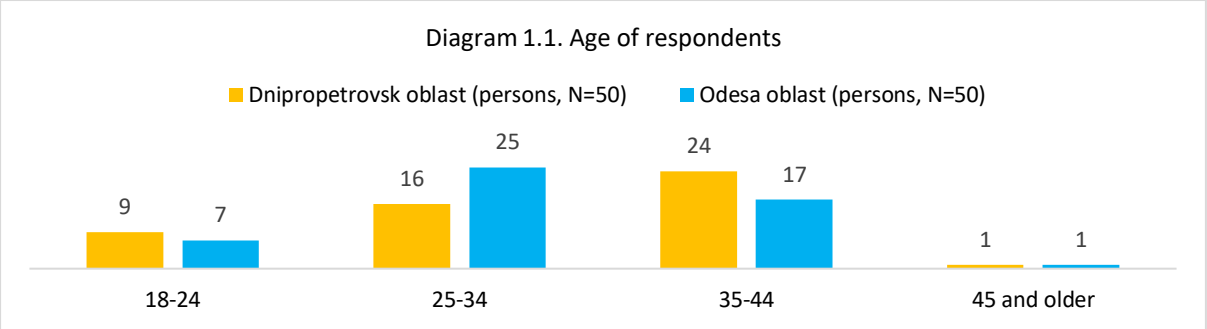


The vast majority of women knew about their HIV-positive status before their last pregnancy (83%). 17% of respondents learned about their HIV-positive status during their last pregnancy or childbirth (or after childbirth) (9 women in Dnipropetrovsk oblast, 8 women in Odesa oblast). See Diagram 0.2.

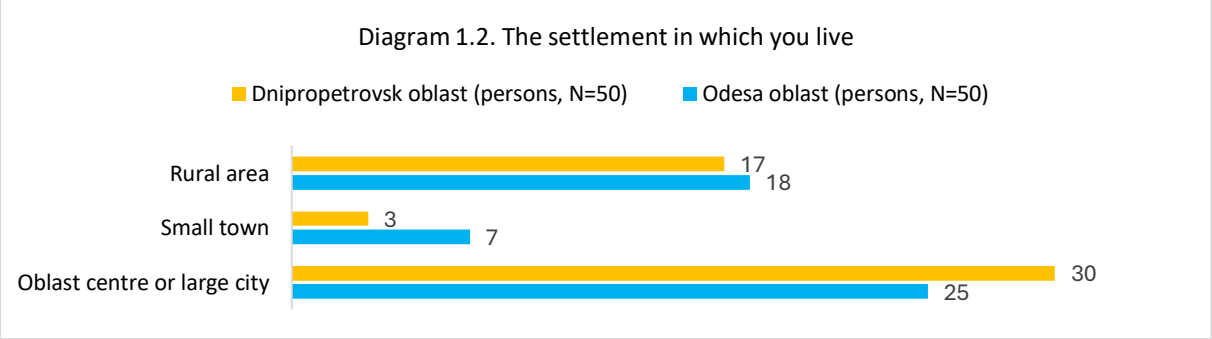


Socio-demographic characteristics

The vast majority of respondents at the time of the survey were aged 25-34 (41%) or 35-44 (41%), one in six (16%) was aged 18-24. Women aged 45 and older are significantly less represented (2%). See Diagram 1.1. The vast majority of respondents have secondary or secondary technical education (89%). 19% of women have higher or incomplete higher education.



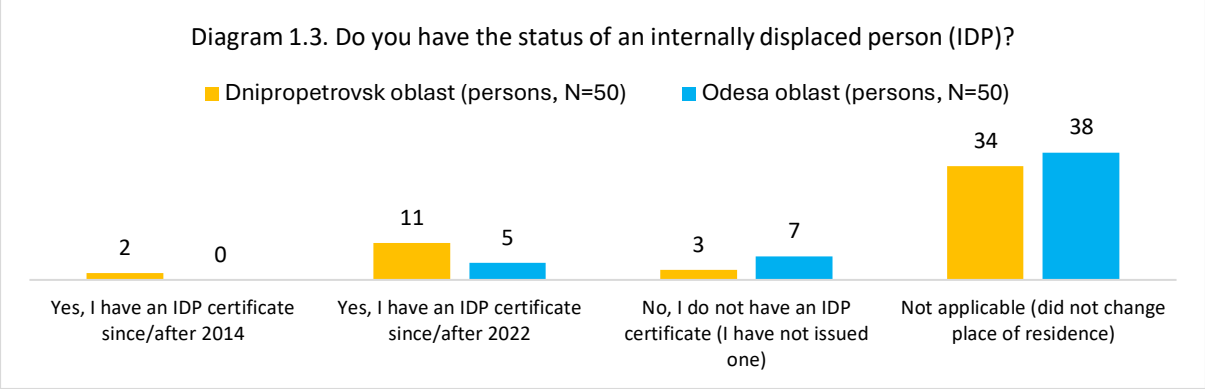
Slightly more than half of the survey participants live in an oblast centre or a large city (55%). Every tenth respondent lives in small towns (10%), and every third lives in rural areas (35%). See Diagram 1.2.



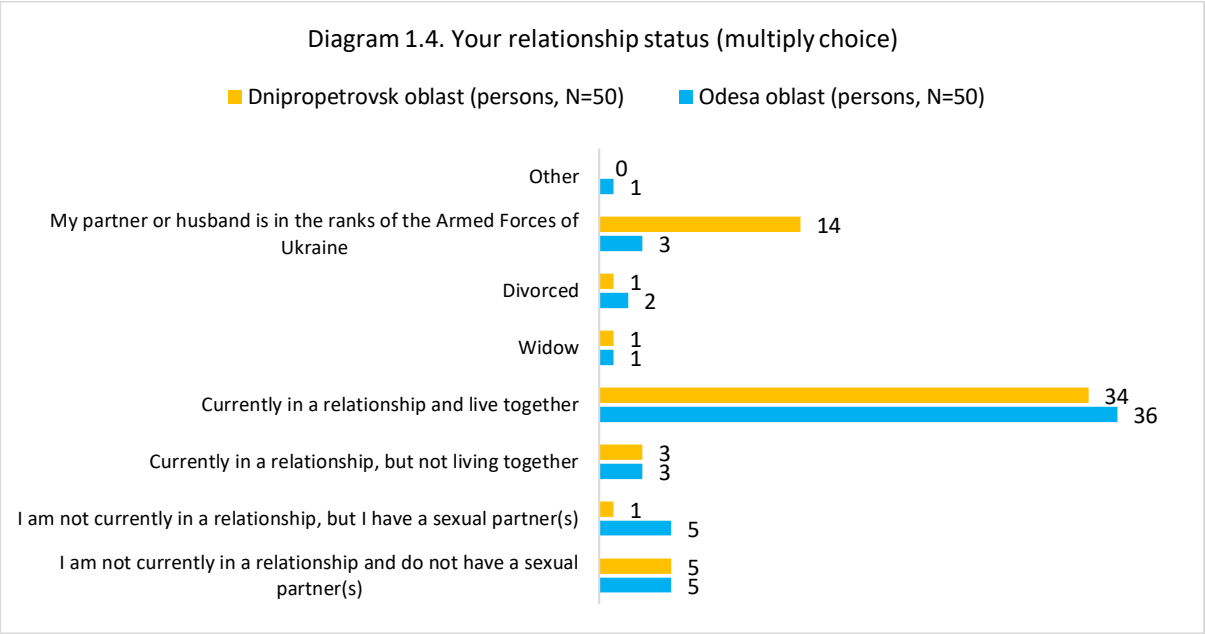
List of settlements covered by the study:

- *in Dnipropetrovsk oblast*: cities – Dnipro, Kryvyi Rih, Nikopol, Pavlohrad, Verkhivtseve, Zhovti Vody, Pidhorodne; villages or urban-type settlements – Babaikivka, Vyshchetarasivka, Holubivka, Dniprovske, Karnaukhivka, Kilchen, Liubymivka, Liashkivka, Manvelivka, Mykhailivka, Savro, Solone, Taromske, Shyroke, Tsarychanka.
- *in Odesa oblast*: cities – Odesa, Biliaivka, Izmail, Podilsk, Reni; villages or urban-type settlements – Avanhard, Bilka, Bilolissia, Velykodolynske, Vilkove, Dibrivka, Dobrooleksandrivka, Kamianka, Kryzhanivka, Mykolaivka, Oleksandrivka, Prylymanske, Starokozache, Usatove, Fontanka, Shyriaievo.

16% of respondents have the official status of an internally displaced person (IDP) since/after 2022, and 2% of participants have it since 2014. 10% of respondents have not issued an IDP certificate. See Diagram 1.3.

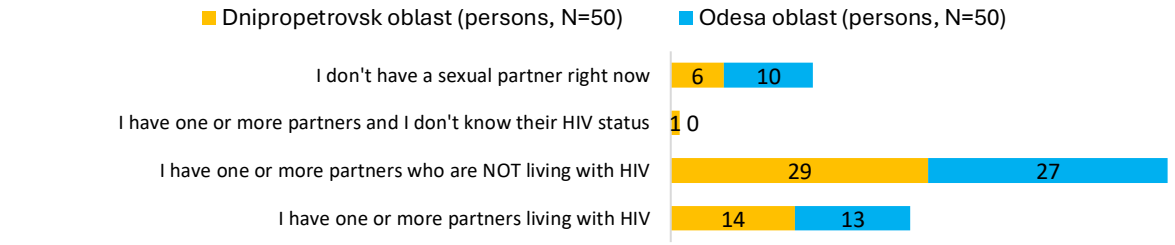


70% of respondents indicated that they are in a relationship and live together with their partner, 6% - in a relationship but do not live together, 5% - not in a relationship but have a sexual partner(s), 9% - not in a relationship and do not have a sexual partner(s). 17% of respondents have a partner serving in the Armed Forces of Ukraine (mostly women from Dnipropetrovsk oblast). 2 women are widows; 3 women are divorced. Among other things, one respondent noted: *"My husband is in the ranks of the State Border Guard Service of Ukraine".* See Diagram 1.4. More than half of the respondents (57%) are officially married, and every fourth (24%) lives in a voluntary union without official registration.



Slightly more than half of the respondents are in **discordant couples** (56%), meaning they have one or more partners who are not living with HIV. Every fourth woman surveyed has one or more partners living with HIV (27%). One respondent does not know the HIV status of her partner. 16% of respondents said they do not have a sexual partner at the moment. See Diagram 1.5.

Diagram 1.5. HIV status of partner(s)



The vast majority are on maternity leave (76%). 9% of women are employed and receive a salary, 4% of respondents are self-employed or run their own business, 15% are unemployed, one respondent works in the informal sector (without a formal employment contract), and two women are retired due to health reasons.

Two women (currently pregnant) have no children (2%). 25% of respondents have one child (all mothers of minor children), 32% have two children (97% of them are mothers of minors), 23% have 3 children (57% of them are mothers of minors), 18% have 4 or more children (61% of them are mothers of minors). See Diagram 1.6.

The majority of respondents **live in poverty**. 44% of respondents said that their household income is not quite enough to meet daily needs, and 34% said it is not enough at all. 10% said it is usually enough, 6% said it is mostly enough, and only 4% said it is completely enough to meet daily needs. See Diagram 1.7.

Every tenth of the surveyed women indicated experience with drug use (10%), and exactly 10% have partners with experience with drug use. 6% of the respondents are participants in an opioid substitution therapy (OST) programme. Two women had previously been in a correctional colony (2%), three women – in a pre-trial detention centre/isolator (3%). One woman was or is a sex worker (1%). 8% of respondents have a history of active tuberculosis and another 8% of women surveyed were or are living with hepatitis C. 7% have experienced domestic violence. 5% of respondents live with a disability, and 4% have children with special needs. The majority responded that the socio-behavioural characteristics and vulnerabilities listed do not apply to them (65%). See Diagram 1.8.

Diagram 1.6. Having children (persons, N=100)

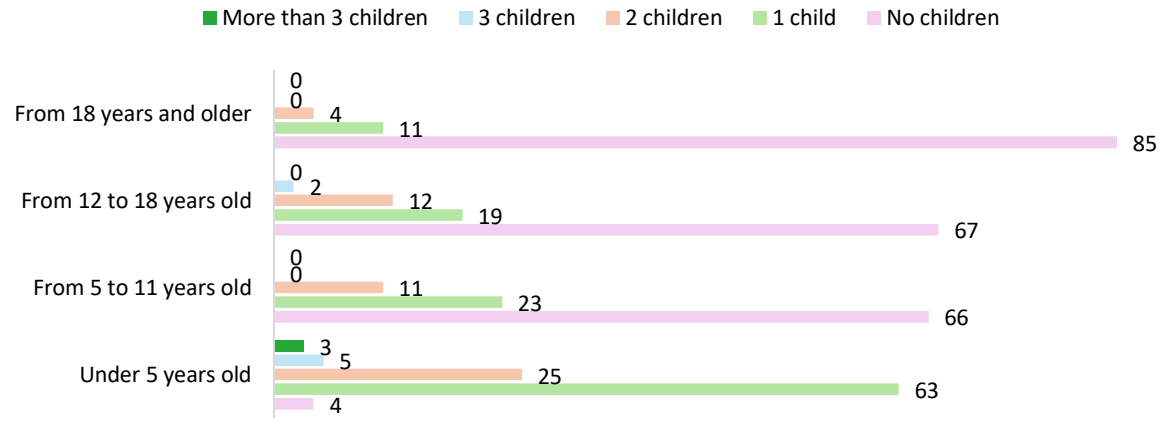
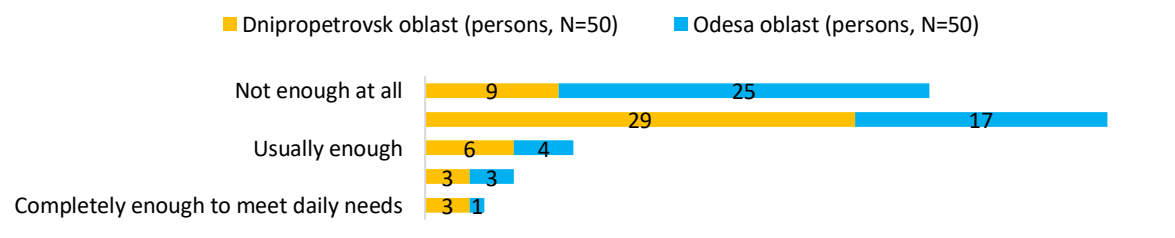
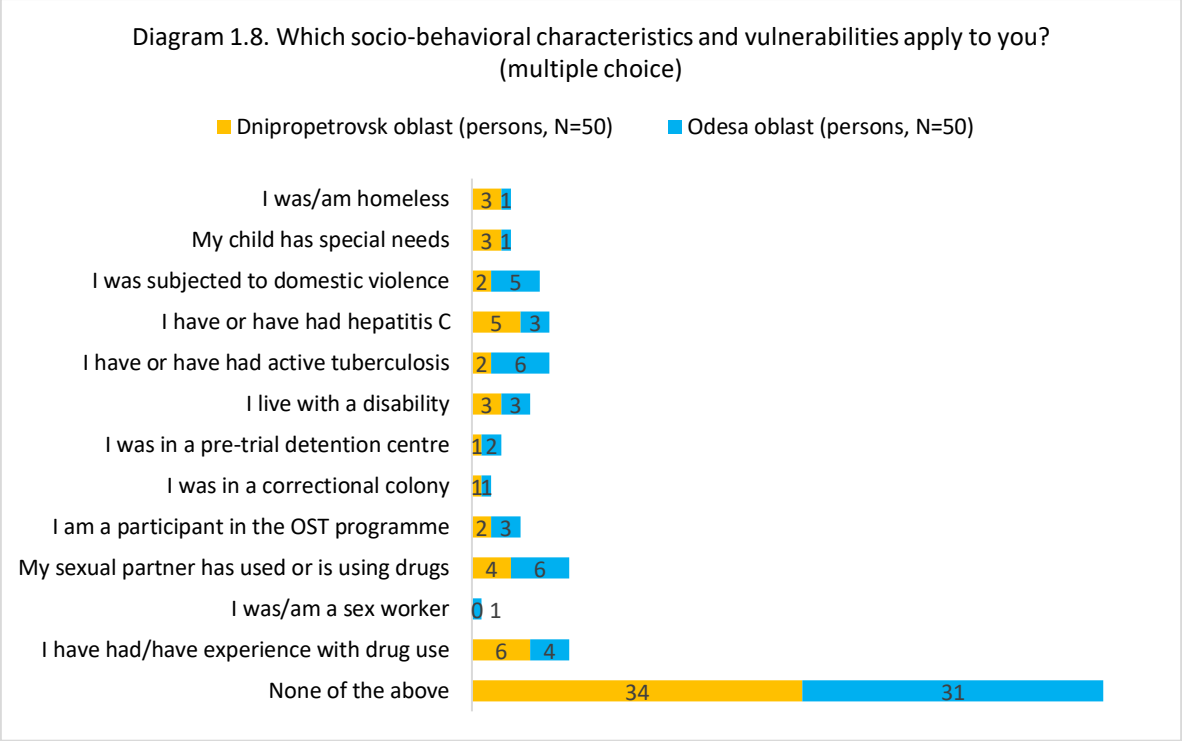


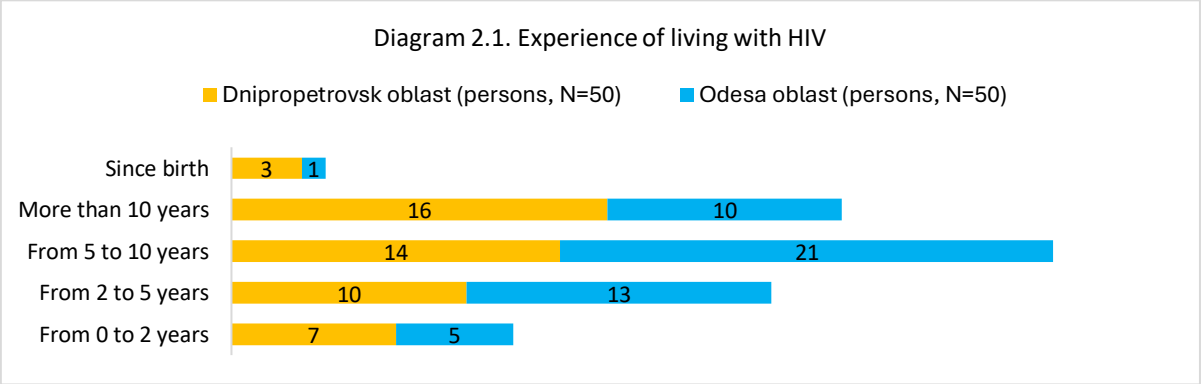
Diagram 1.7. Does your household have enough money to pay for daily needs?



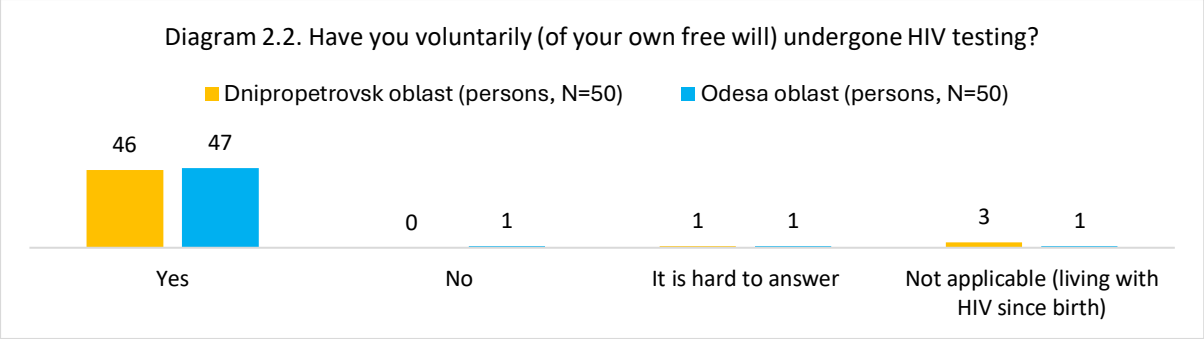


Living with HIV and ARV treatment

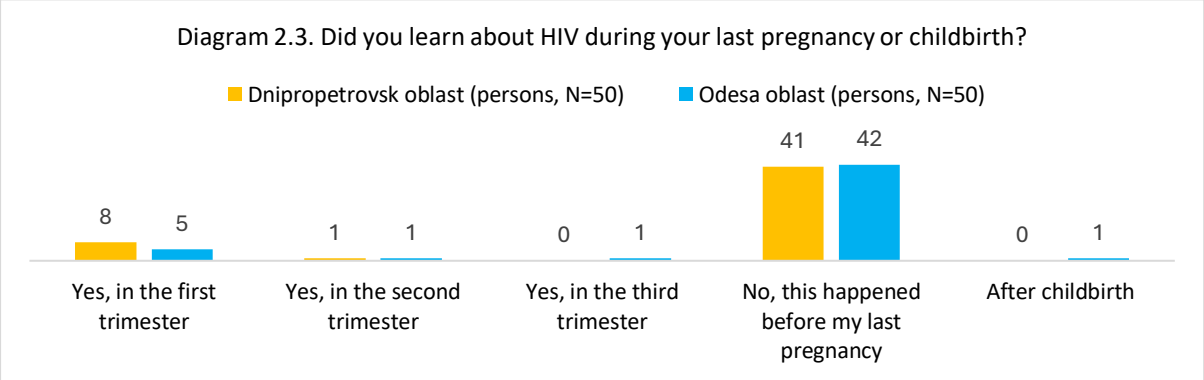
Four study participants have been living with HIV since birth (4%). A quarter of respondents have been living with HIV for more than 10 years (26%), another quarter – for 2 to 5 years (23%). More than a third of respondents have been living with HIV for 5 to 10 years (35%). 12% of women have been living with HIV for less than 2 years. See Diagram 2.1.



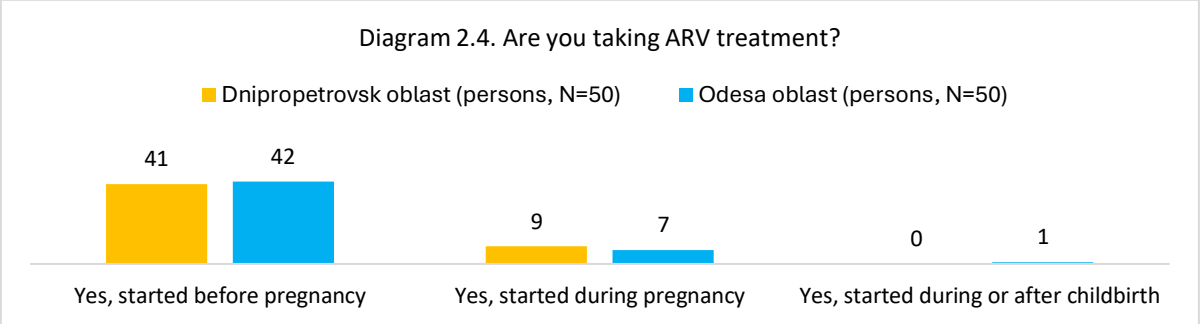
The vast majority of respondents voluntarily underwent HIV testing (93%), received pre-test (91%) and post-test (93%) counselling. 4% of respondents did not undergo pre-test counselling, one woman was “hard to answer” whether it was done or not. One respondent did not undergo post-test counselling, and two women were “hard to answer” whether it was done or not. See Diagram 2.2.



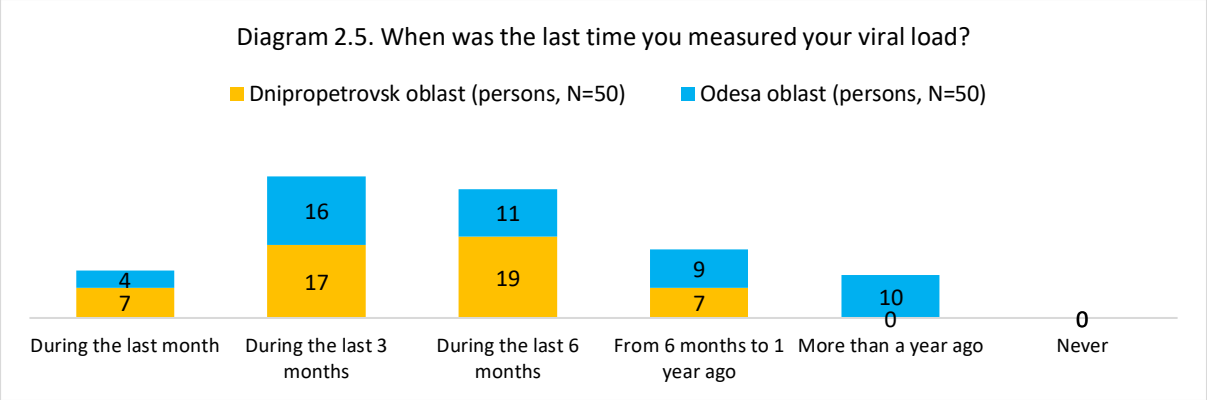
The vast majority of women learned about their HIV-positive status before their last pregnancy (83%). Every sixth respondent **learned about HIV during their last pregnancy** (16%), of whom 13 women learned in the 1st trimester, 2 women – in the 2nd trimester, and 1 woman – in the 3rd trimester. One woman (from Odesa oblast) **learned about HIV after giving birth**. See Diagram 2.3.



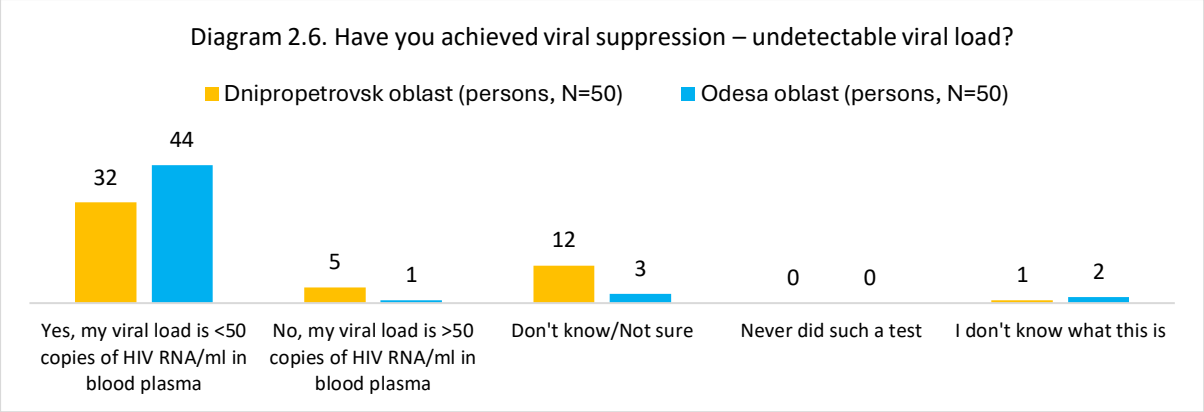
All women, without exception, **were taking ART** at the time of the survey. The vast majority started ART before their last pregnancy (83%). 16% of respondents started ARV treatment during pregnancy and one woman started it after giving birth. See Diagram 2.4.



Good adherence to virological monitoring can be observed among the surveyed women. The vast majority of women **measured their viral load** within the last year, namely: 11% - within the last month, 33% - within the last 3 months, 30% - within the last six months, 16% - from 6 months to 1 year ago. At the same time, one in ten (all from Odesa oblast) measured their viral load more than a year ago (10%). See Diagram 2.5.



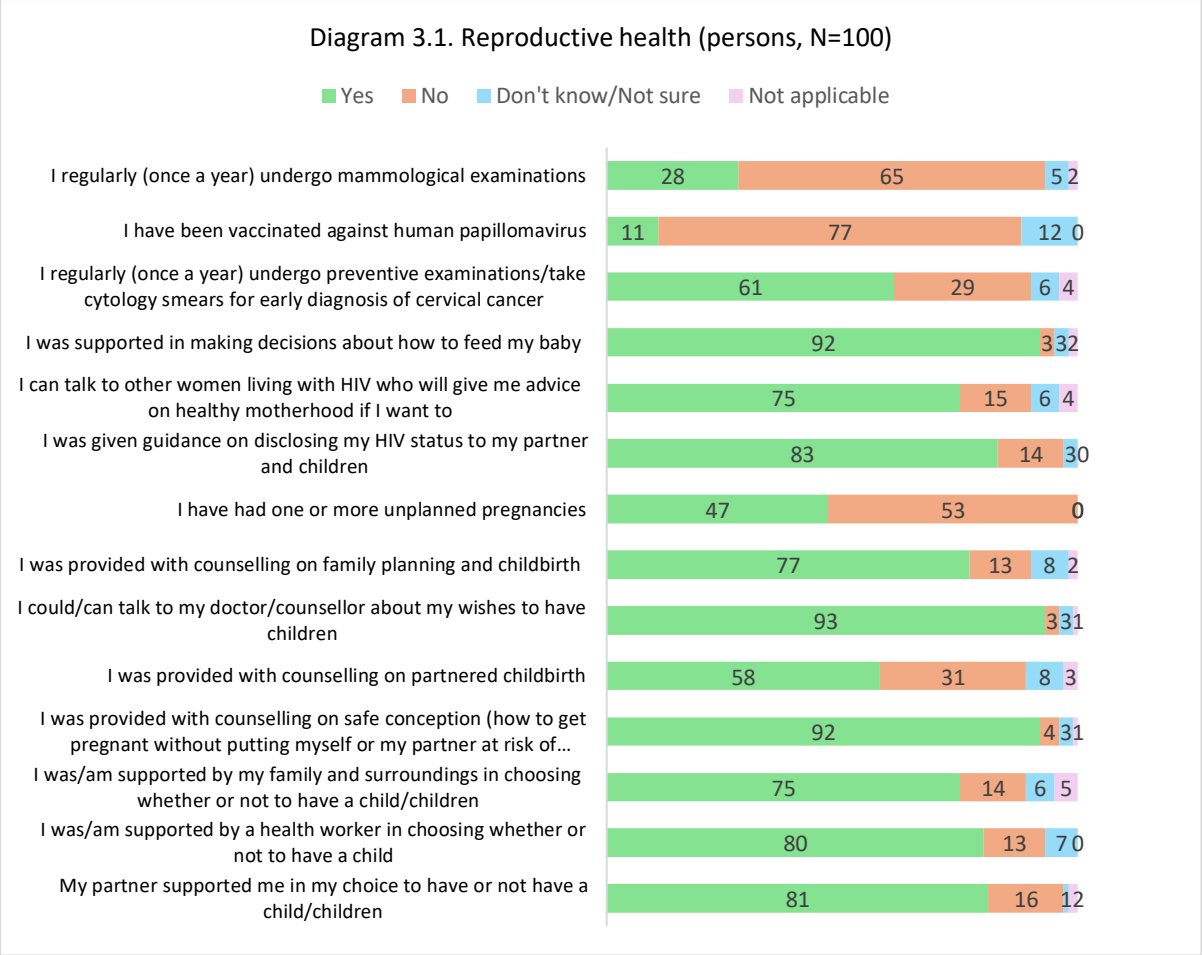
The vast majority of women **achieved viral suppression** (76%), and 6% of respondents indicated that they had detectable viral load (>50 copies of HIV RNA/ml in blood plasma), of whom 5 women were from Dnipropetrovsk oblast, 1 woman from Odesa oblast. At the same time, 15% of respondents do not know or are unsure about their viral load indicators, and 3 women do not know at all what undetectable viral load means. See Diagram 2.6.



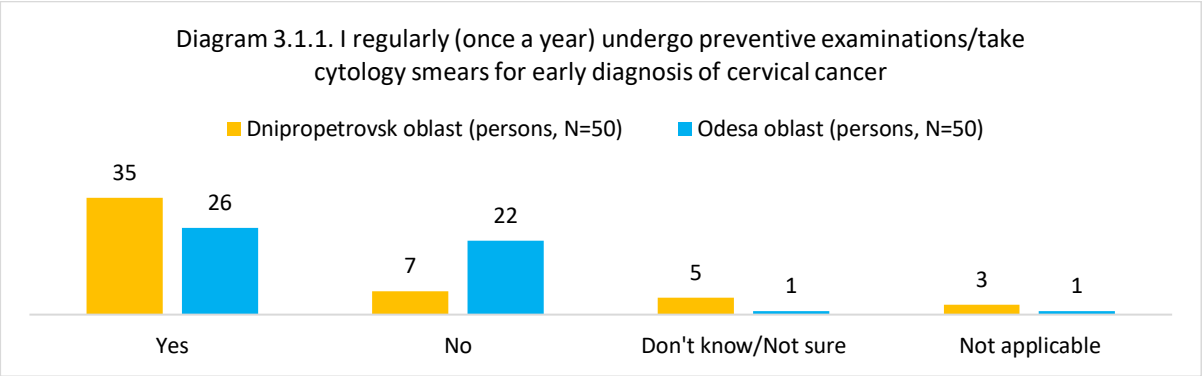
Reproductive health and rights of women living with HIV

On questions related to **reproductive health** care and related support (including information services), the overwhelming majority of respondents answered "Yes" to the following statements in the questionnaire:

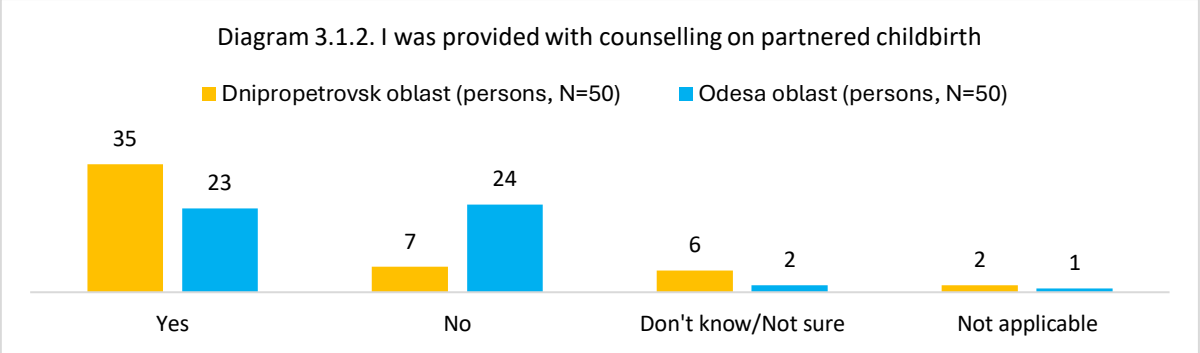
- I could/can talk to my doctor/counsellor about my wishes to have children (93%)
- I was provided with counselling on safe conception (how to get pregnant without putting myself or my partner at risk of transmitting HIV or other STIs) (92%)
- I was supported in making decisions about how to feed my baby (92%)
- I was given guidance on disclosing my HIV status to my partner and children (83%)
- My partner supported me in my choice to have or not have a child/children (81%)
- I was/am supported by a health worker in choosing whether or not to have a child (80%)
- I was provided with counselling on family planning and childbirth (77%)
- I was/am supported by my family and surroundings in choosing whether or not to have a child/children (75%)
- I can talk to other women living with HIV who will give me advice on healthy motherhood if I want to (75%). See Diagram 3.1.



At the same time, it is important to note the already lower proportion of women who regularly undergo preventive examinations/take cytology smears for early diagnosis of cervical cancer (61%), which is extremely important for women living with HIV. This issue is primarily relevant for the Odesa oblast, where 22 women out of 50 do not undergo regular cervical cancer diagnosis. See Diagram 3.1.1.



Only 58% of respondents received counselling on partnered childbirth, and almost a third did not receive such counselling (31%), mostly respondents from Odesa oblast. See Diagram 3.1.2. Gaps in family planning measures are indicated by the fact that almost half of women had one or more unplanned pregnancies (47%). Only 28% of respondents confirmed regular (once a year) mammograms, and only every tenth respondent was vaccinated against human papillomavirus (HPV) (11%).

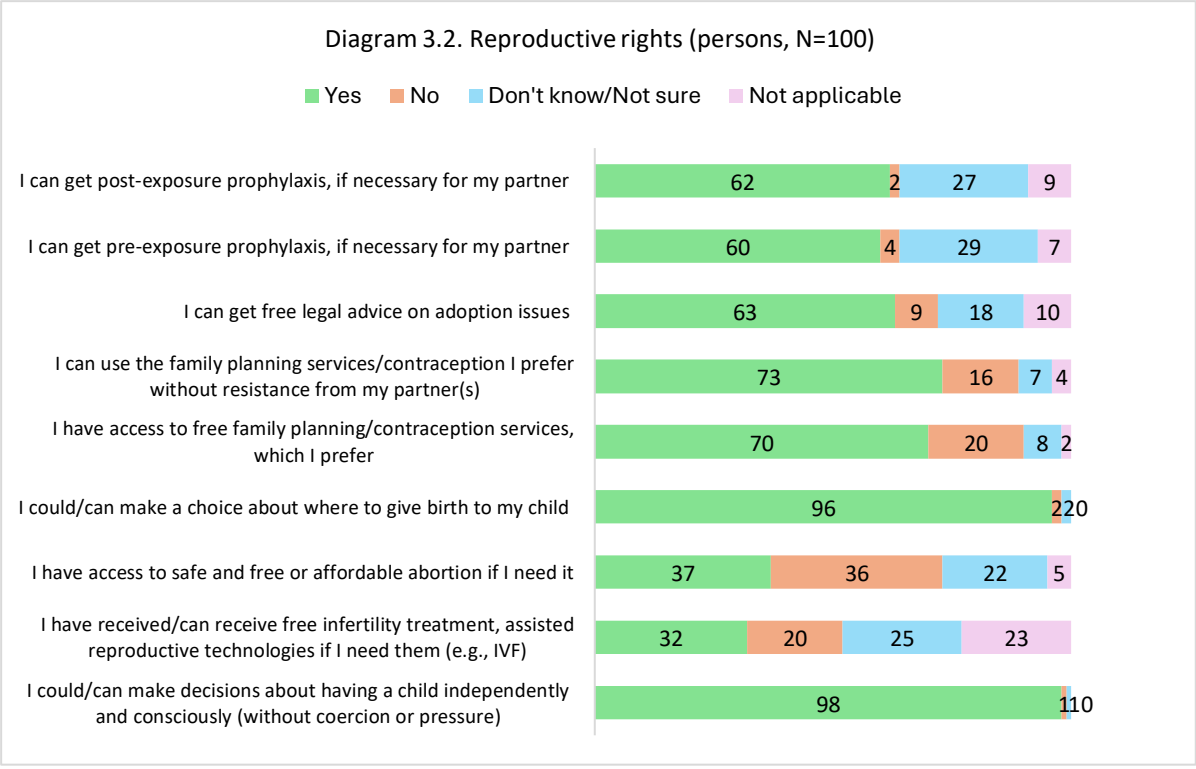


On questions related to the protection of **reproductive rights** and appropriate support (including information services), the overwhelming majority of respondents answered "Yes" to the following statements in the questionnaire:

- I could/can make decisions about having a child independently and consciously (without coercion or pressure) (98%)
- I could/can make a choice about where to give birth to my child (96%)
- I can use the family planning services/contraception I prefer without resistance from my partner(s) (73%).

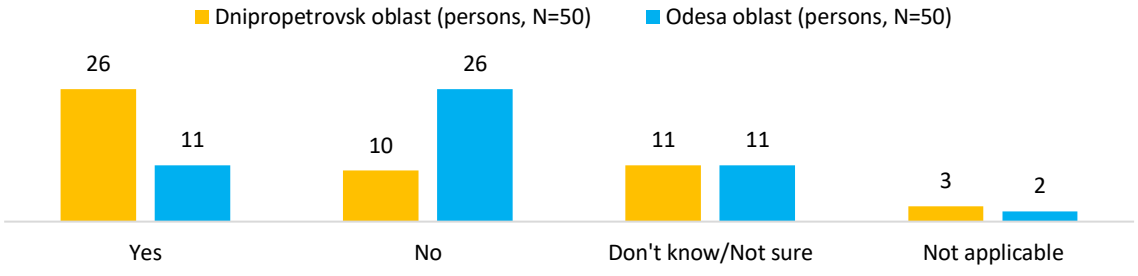
The majority, but to a lesser extent, confirmed access to:

- free family planning/contraception services preferred by women (70%)
- free legal advice on adoption issues (63%)
- post-exposure prophylaxis, if necessary for the woman's partner (62%), but there is also a significant share of respondents' ignorance on this issue (29%).
- pre-exposure prophylaxis, if necessary for the woman's partner (60%), but there is also a significant share of respondents' ignorance on this issue (27%). See Diagram 3.2.



It is worrying that only 37% of respondents believe that they have access to safe and free or affordable abortion if they need it (36% believe that they do not have such access, and 22% do not know or are not sure whether such access exists). See Diagram 3.2.1.

Diagram 3.2.1. I have access to safe and free or affordable abortion if I need it

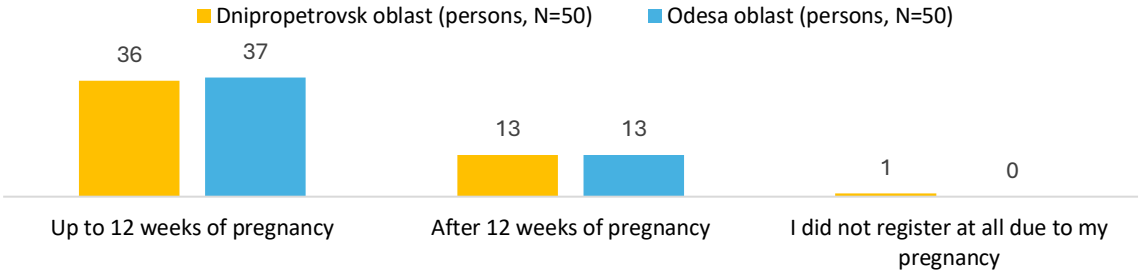


The possibility of receiving free infertility treatment and assisted reproductive technologies (e.g., IVF) was confirmed by less than a third of women (32%) (20% believe that they do not have such an opportunity, and every fourth (25%) is unaware of such an opportunity).

PMTCT services during pregnancy

The majority of women surveyed (73%) registered for pregnancy in the first trimester (up to 12 weeks of pregnancy), and every fourth respondent registered after 12 weeks of pregnancy (26%). One woman (Dnipropetrovsk oblast) was not observed by doctors at all in connection with pregnancy. Another woman (Odesa oblast) was observed as a pregnant woman without HIV (diagnosed after childbirth). See Diagram 4.1.

Diagram 4.1. When did you register with an obstetrician-gynecologist at an antenatal clinic due to your pregnancy?

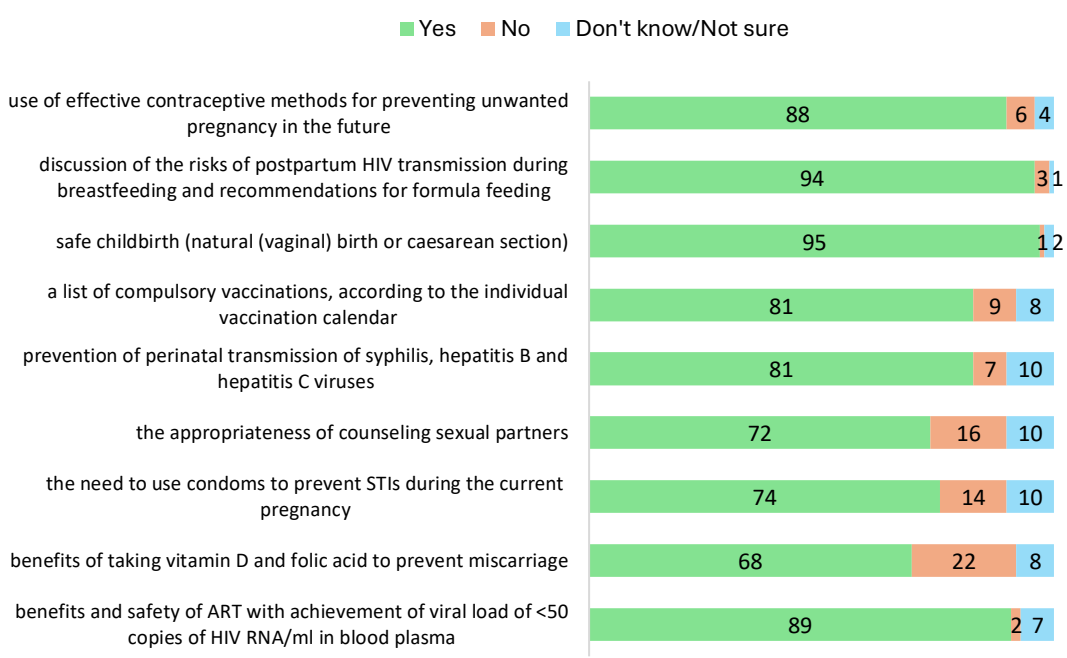


The vast majority of respondents confirmed receiving information services (counselling) on PMTCT issues during the current (or last) pregnancy, as specified in the standards of medical care, in a medical facility on the following topics:

- safe childbirth (natural (vaginal) birth or caesarean section) (97%)
- discussion of the risks of postpartum HIV transmission during breastfeeding and recommendations for formula feeding (96%)
- benefits and safety of ART with achievement of viral load of <50 copies of HIV RNA/ml in blood plasma (91%)
- use of effective contraceptive methods for preventing unwanted pregnancy in the future (90%)
- a list of compulsory vaccinations, according to the individual vaccination calendar (83%)
- prevention of perinatal transmission of syphilis, hepatitis B and hepatitis C viruses (83%)
- the need to use condoms to prevent STIs during the current pregnancy (76%).

Slightly less frequently, but for the majority of respondents, counselling was provided on the appropriateness of counselling sexual partners (73%) and the benefits of taking vitamin D and folic acid to prevent miscarriage (69%). See Diagram 4.2.

Diagram 4.2. Did you receive counselling during your current (or last) pregnancy at a medical facility on the issues listed below?



The lowest coverage rates of information services by oblast:

- *in Odesa oblast*: counselling on the benefits of taking vitamin D and folic acid for the prevention of miscarriage (28 out of 49 women received the service, 17 did not receive it, 4 did not know or were not sure whether they received it or not). See Diagram 4.2.1.
- *in Dnipropetrovsk oblast:* counselling on the need to use condoms to prevent STIs during the current pregnancy (33 out of 49 women received the service, 8 did not, 8 do not know or are not sure whether they received it or not). See Diagram 4.2.2.

Diagram 4.2.1. Have you been counseled about the benefits of taking vitamin D and folic acid to prevent miscarriage?

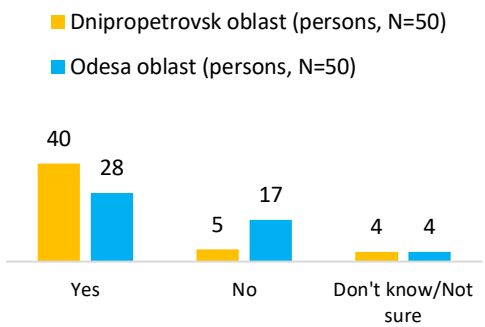
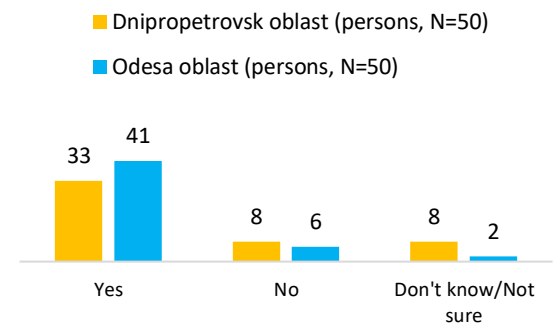


Diagram 4.2.2. Have you been counseled about the need to use condoms to prevent STIs during your current pregnancy?

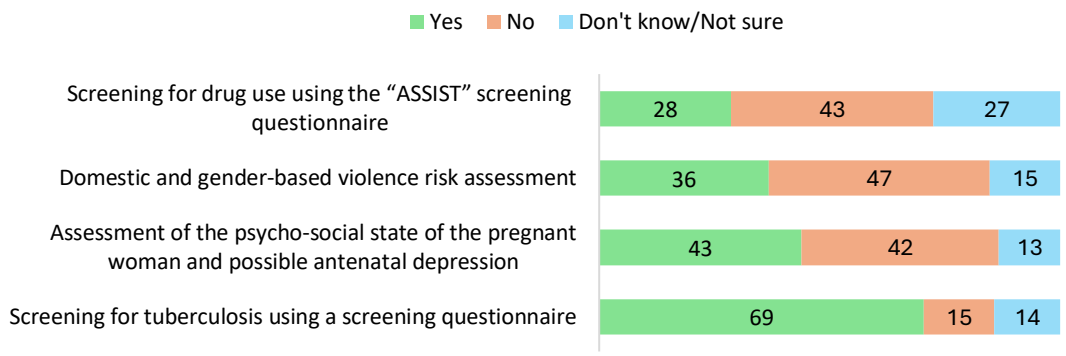


The vast majority of respondents were screened for viral hepatitis B and C during their last pregnancy (84%), 7% were not, and 9% do not know or are not sure whether they were screened or not.

During their first visit to a general practitioner or antenatal clinic due to pregnancy, most respondents were screened for tuberculosis using a screening questionnaire (70%). See Diagram 4.3. Other measures specified in the standards of medical care for pregnant HIV-positive women were not carried out for the majority of respondents, namely:

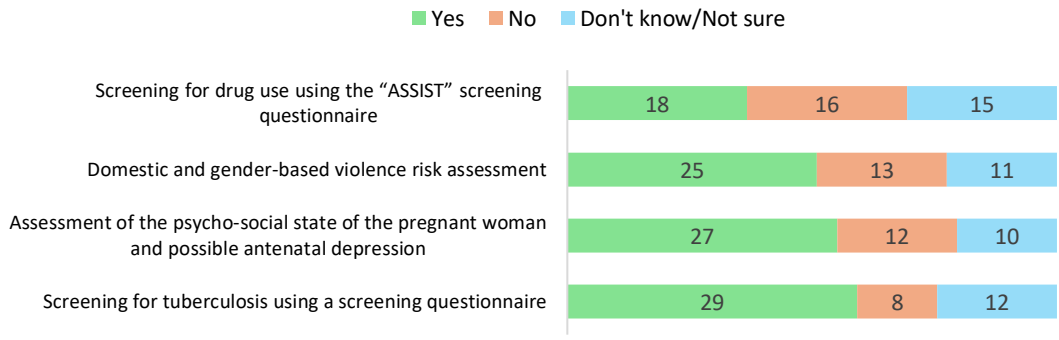
- Assessment of the psycho-social state of the pregnant woman and possible antenatal depression (44%)
- Domestic and gender-based violence risk assessment (37%)
- Screening for drug use using the "ASSIST" screening questionnaire (29%).

Diagram 4.3. During your first visit to your family doctor or antenatal clinic regarding your pregnancy, did you receive the following services? (persons, N=98)



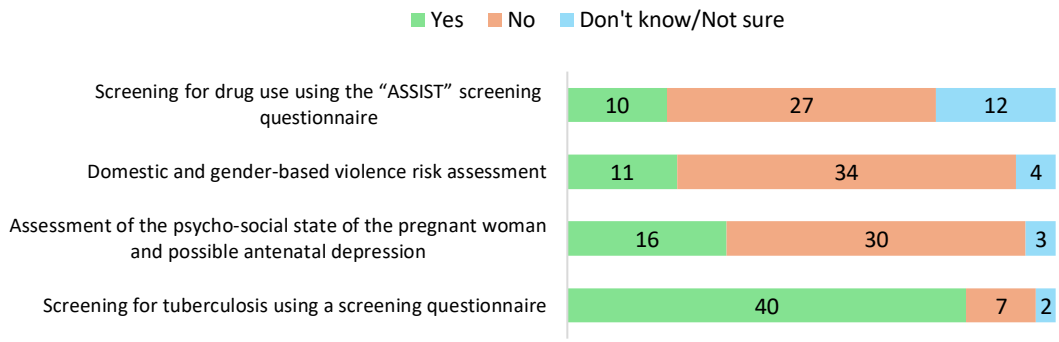
If we look at the breakdown of individual oblasts, the Dnipropetrovsk oblast has a lower tuberculosis screening coverage rate compared to the Odesa oblast (29 versus 40 women who confirmed having undergone screening), although there remains a significant proportion of women (a quarter of respondents from the Dnipropetrovsk oblast) who do not know or are not sure about undergoing such screening. See Diagram 4.3.1, Diagram 4.3.2.

Diagram 4.3.1. Dnipropetrovsk oblast: Measures during the first visit to a family doctor or antenatal clinic due to pregnancy (persons, N=49)



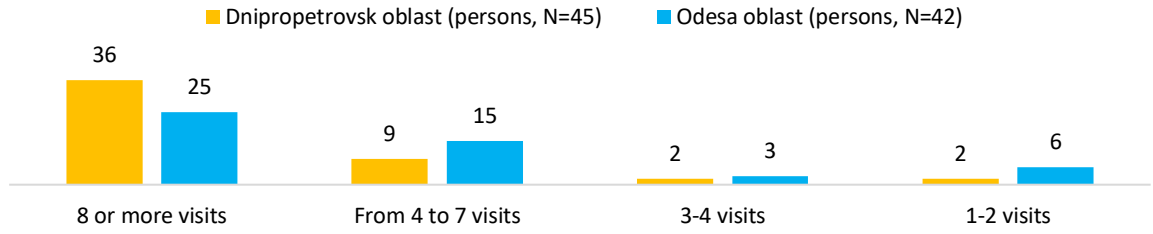
In Odesa oblast, unlike Dnipropetrovsk oblast, the majority of respondents did not undergo a risk assessment for domestic or gender-based violence and mental health screening (in particular, possible antenatal depression), as well as screening for drug use. See Diagram 4.3.2.

Diagram 4.3.2. Odesa oblast: Measures during the first visit to a family doctor or antenatal clinic due to pregnancy (persons, N=49)



Among women whose pregnancies ended in childbirth and who were observed in a medical facility during pregnancy (87 respondents), a fairly high frequency of visits to an obstetrician-gynaecologist at an antenatal clinic to monitor the course of pregnancy can be noted: 8 or more visits – 55%, from 4 to 7 visits – 21%. Among the 7 women who reported 1-2 visits to a doctor during pregnancy: 3 women live in rural areas (Odesa oblast), 2 women live in small towns (one in each oblast), 2 women live in oblast centres (Dnipro and Odesa). See Diagram 4.4.

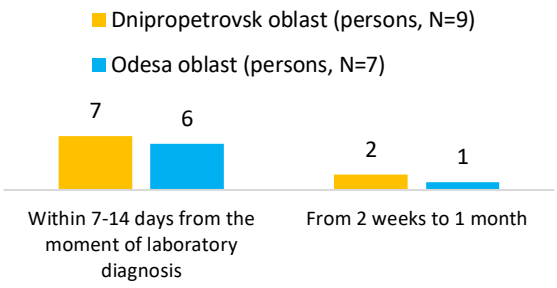
Diagram 4.4. How often have you visited or are you visiting an obstetrician-gynaecologist at an antenatal clinic to monitor the course of your pregnancy?



Most women *who learned about HIV during their last pregnancy* (16 respondents: 9 – from Dnipropetrovsk oblast, 7 – from Odesa oblast) were registered at a medical institution for HIV infection by an infectious disease physician within 7 days from the moment of laboratory diagnosis (11 respondents), 3 women – from 8 days to 2 weeks, 2 women – from 2 weeks to 1 month. See Diagram 4.5. After being registered at a medical facility for HIV infection, the infectious disease physician prescribed antiretroviral treatment for the vast majority of newly diagnosed women for 2 weeks (13 respondents), and for 3 women for a period of 2 weeks to 1 month. See Diagram 4.6.

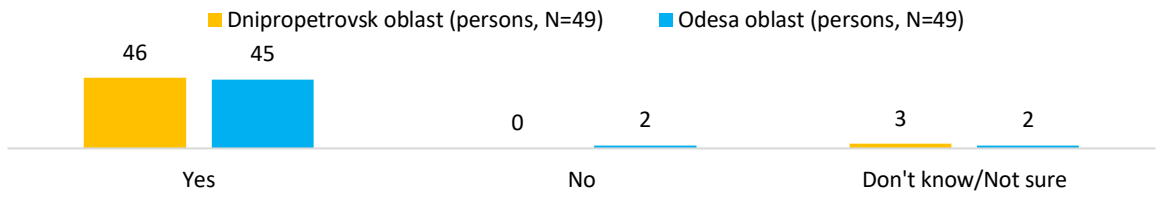
Diagram 4.5. When were you registered at a medical facility with an infectious disease specialist due to HIV?

Diagram 4.6. After being registered at a medical facility due to HIV, when did the infectious disease doctor prescribe ART for you?



The vast majority of women were informed by an obstetrician-gynaecologist at the antenatal clinic about the possibility of considering planned delivery (with a viral load of less than 50 HIV RNA copies/ml) or caesarean section (with a viral load of ≥ 50 HIV RNA copies/ml) (93%). See Diagram 4.7.

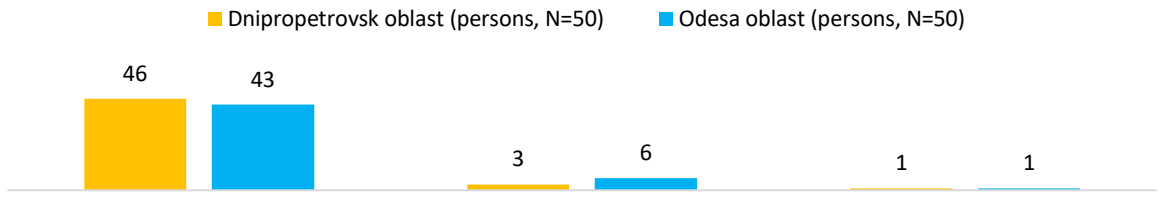
Diagram 4.7. Has the obstetrician-gynaecologist at the antenatal clinic informed you about the possibility of considering a planned delivery (viral load <50) or a caesarean section (viral load ≥ 50)?



PMTCT services during childbirth and postpartum

The vast majority of women gave birth to a child following their last pregnancy (89%). 9 respondents are still pregnant. 2 women have not given birth to a child. See Diagram 5.1.

Diagram 5.1. Did you give birth to a child following your last pregnancy?



The vast majority or majority of respondents confirmed receiving the following services at a medical facility as an HIV-positive pregnant woman and woman in labour:

- Consultation by an obstetrician-gynaecologist in the maternity hospital (department) on issues of formula feeding and taking ARV drugs by the child (88%)
- Counselling on the need to use a drug (cabergoline) to suppress lactation after childbirth (in case of a decision to formula feed) (82%)
- Medical examination in relation to HIV by an infectious disease specialist at the medical facility and monitoring of adherence to ARV treatment after childbirth within 4–6 weeks after childbirth (79%)
- Medical examination within 4-6 weeks after childbirth by an obstetrician-gynaecologist at an antenatal clinic (77%)
- Counselling on the use of contraceptive methods in the postpartum period at each visit to the obstetrician-gynaecologist of the antenatal clinic (73%)
- Screening questionnaire for tuberculosis at every visit to an infectious disease specialist at a medical facility in connection with HIV (62%).

Other measures specified in the standards of medical care for HIV-positive pregnant women and women in labour were not carried out for the majority of respondents, namely:

- A cytological examination of the cervix at the antenatal clinic 3 months after childbirth by an obstetrician-gynaecologist of the antenatal clinic (48%)
- Assessment of the mother's psychosocial status and possible postnatal depression in the first 6 weeks after childbirth by an obstetrician-gynaecologist at the antenatal clinic (32%)
- Risk assessment for domestic/gender-based violence at each visit by an obstetrician-gynaecologist at an antenatal clinic (29%). See Diagram 5.2.

In Odesa oblast, unlike Dnipropetrovsk oblast, the majority of respondents did not undergo a risk assessment for domestic or gender-based violence and mental health screening (in particular, possible postnatal depression), and almost half of women did not undergo a cytological examination of the cervix 3 months after childbirth. See Diagram 5.2.1.

Diagram 5.2.1. Odesa oblast: Have you received the following services as an HIV-positive pregnant woman and woman in labour? (persons, N=43)

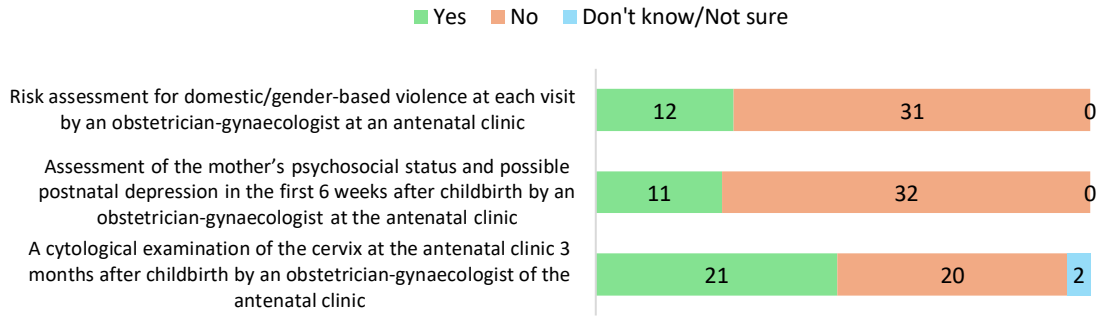
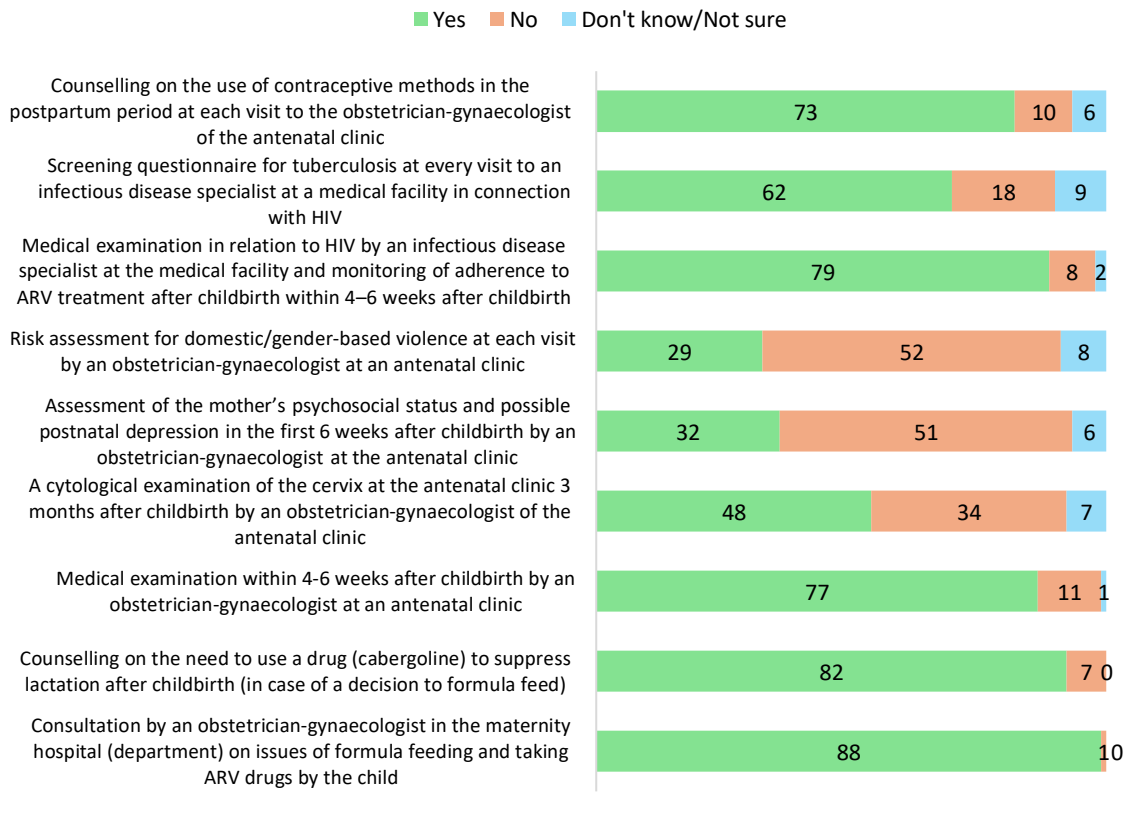


Diagram 5.2. Have you received the following services as an HIV-positive pregnant woman and woman in labour? (persons, N=89)



PMTCT services for newborns

All respondents who gave birth to a child (89 women: 46 – Dnipropetrovsk oblast, 43 women – Odesa oblast*) confirmed receiving at the medical facility the following information services specified in the standards of medical care as part of **counselling parents/guardians of an HIV-exposed child regarding adherence to long-term prophylactic ARV therapy by the child** (*One woman (Odesa) learned about HIV after giving birth, and,

accordingly, she did not receive services as an HIV-positive pregnant woman and woman in labour, and her child did not receive timely PMTCT measures):

- information about the ways of HIV transmission from mother to child and the reduction of this risk under the influence of ARV therapy was provided (100%)
- the mode of action of ARV therapy and the key role of ARV prophylaxis in suppressing the HIV virus were shared (100%)
- information on how to take each medication was provided (100%).

The vast majority of mothers also confirmed receiving the following information services at the medical facility:

- possible barriers to adherence were discussed and advice on how to prevent or eliminate them was provided (92%)
- training on how to measure the dose of ARV medication was provided (81%)
- technical tools that help adhere to medication regimens to prevent skipping were recommended (80%)
- information about peer support groups for HIV-positive women was provided (75%).

Most mothers were given written instructions on how to give their child medication (57%), but 34 women did not confirm that they were given written instructions (38%). See Diagram 6.1. At the same time, 27 out of 34 respondents resided in the Odesa oblast. That is, the vast majority of women from Dnipropetrovsk oblast (36 out of 46 respondents) received this service, in contrast to Odesa oblast, where only slightly more than a third of women answered this question in the affirmative (15 out of 43 respondents). See Diagram 6.1.1.

Diagram 6.1. Counselling on adherence to long-term prophylactic ARV therapy by the child (persons, N=89)

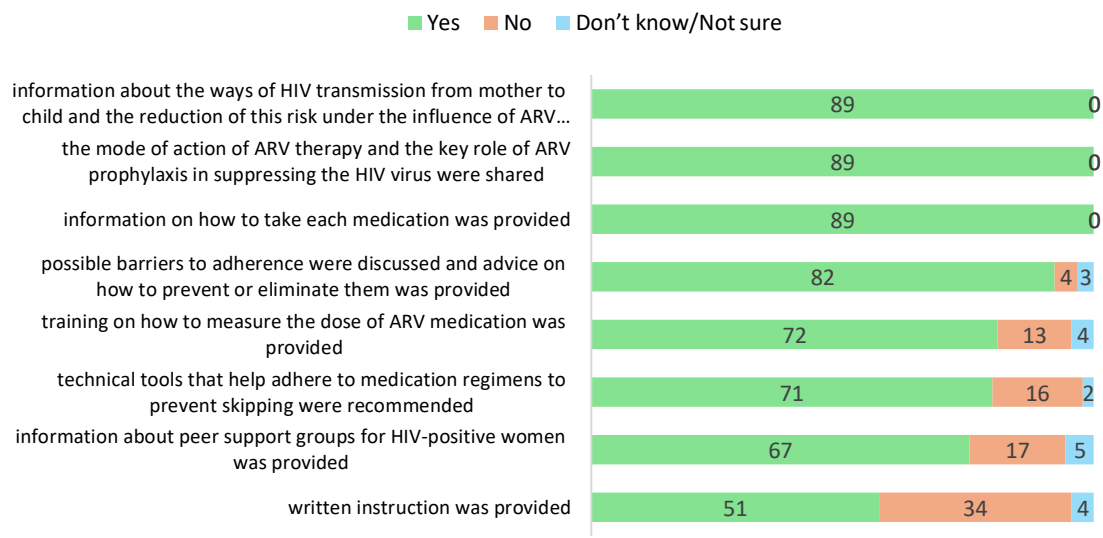
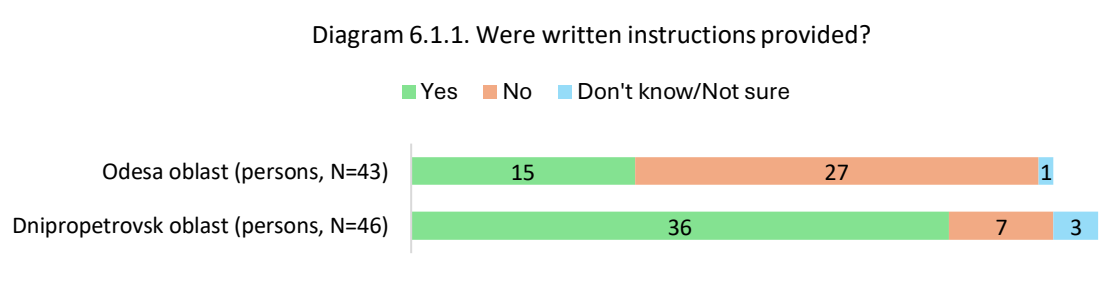


Diagram 6.1.1. Were written instructions provided?



All respondents who gave birth to a child confirmed receiving from a medical facility the following information service, which is specified in the standards of medical care as part of **counselling parents/guardians of an HIV-exposed child regarding the child's further medical management**:

- information about the need for supervision of the child by a general practitioner/family doctor/district paediatrician at the place of residence and by a specialist at the territorial health centre that provides medical supervision for HIV-positive people was given (100%).

The vast majority of mothers also confirmed receiving the following information services from medical professionals:

- the importance of careful medical supervision to maintain the child's health was explained (98%)
- the specifics of the child's vaccination before clarifying their HIV status and adherence to the child's vaccination schedule taking into account their HIV status (96%) were informed about. See Diagram 6.2.

The majority of mothers (55 respondents out of 89) confirmed that the parents (guardians) of an HIV-exposed child provided written consent for measures to prevent mother-to-child transmission of HIV (62%). At the same time, the proportion of such respondents varies significantly at the oblast level. In Dnipropetrovsk oblast, they make up the vast majority (40 respondents out of 46), and in Odesa oblast, they make up only a little more than a third (15 respondents out of 43). Also in Odesa oblast, 6 women reported that they were not asked for consent, and a significant proportion of women (19 respondents out of 43) do not know at all or are not sure whether they gave consent or not. See Diagram 6.3.

Diagram 6.2. Counselling by medical professionals on the child's further medical management (persons, N=89)

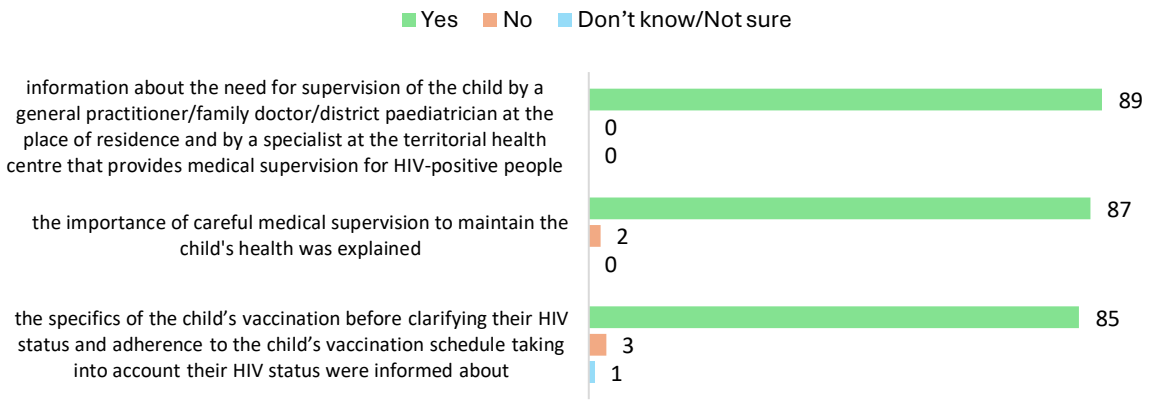
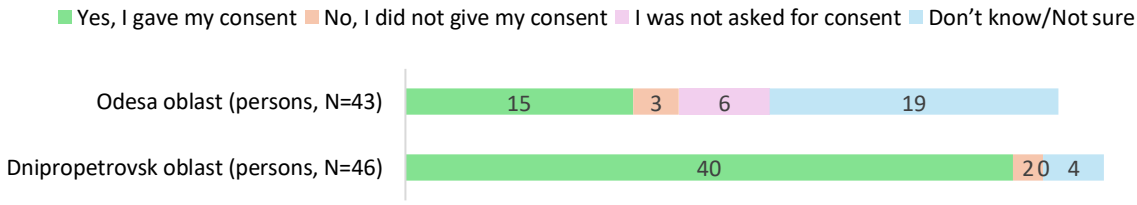


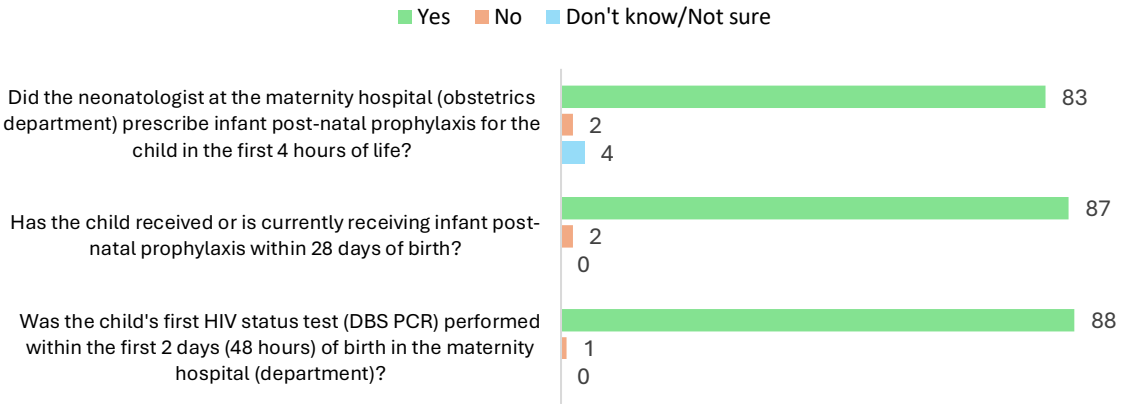
Diagram 6.3. As parents (guardians) of an HIV-exposed child, have you provided a written consent to implement measures to prevent mother-to-child transmission of HIV?



83 mothers (44 – Dnipropetrovsk oblast, 39 – Odesa oblast) out of 89 confirmed that the neonatologist of the maternity hospital (obstetrics department) prescribed infant post-natal prophylaxis (PNP) to the child in the first 4 hours of life (93%), 4 women (2 – from Dnipropetrovsk oblast, 2 – from Odesa oblast) do not know or are hesitant. Two HIV-exposed children from Odesa oblast were not prescribed PNP in the first 4 hours of life (among them, a child whose mother learned about her HIV-positive status after giving birth). 87 mothers (46 – Dnipropetrovsk oblast, 41 – Odesa oblast) confirmed that their child received or is currently receiving PNP within 28 days of birth (98%). Two HIV-exposed children from Odesa oblast did not receive PNP within 28 days of birth (among them, a child whose mother learned about her HIV-positive status after giving birth). Almost all women

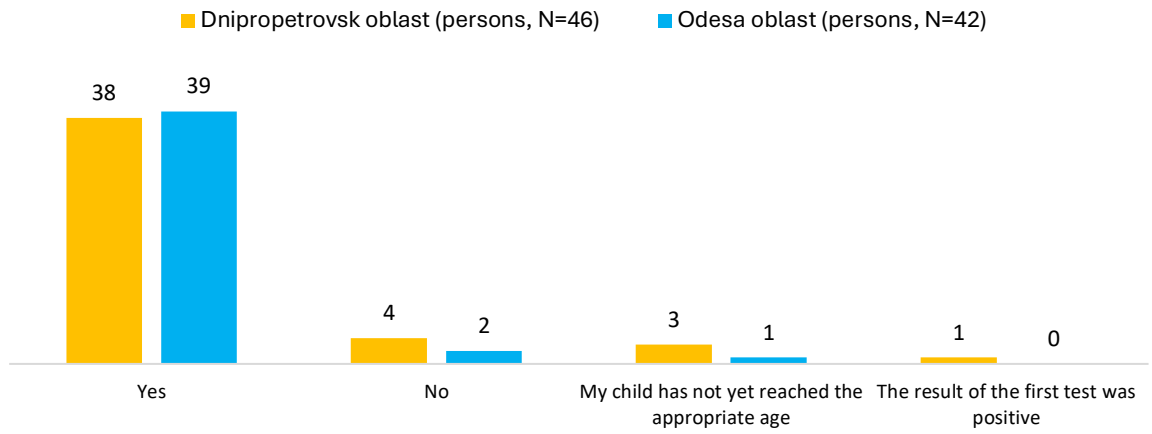
(88 mothers: 46 - Dnipropetrovsk oblast, 42 - Odesa oblast) confirmed that their child had their **first HIV test** (using the dried blood spot PCR method) in the first 2 days (48 hours) after birth in the maternity hospital (department) (99%). The exception is a child whose mother learned about her HIV-positive status after giving birth (Odesa oblast). See Diagram 6.4.

Diagram 6.4. Infant post-natal prophylaxis and the first HIV status test for the child (DBS PCR) (persons, N=89)

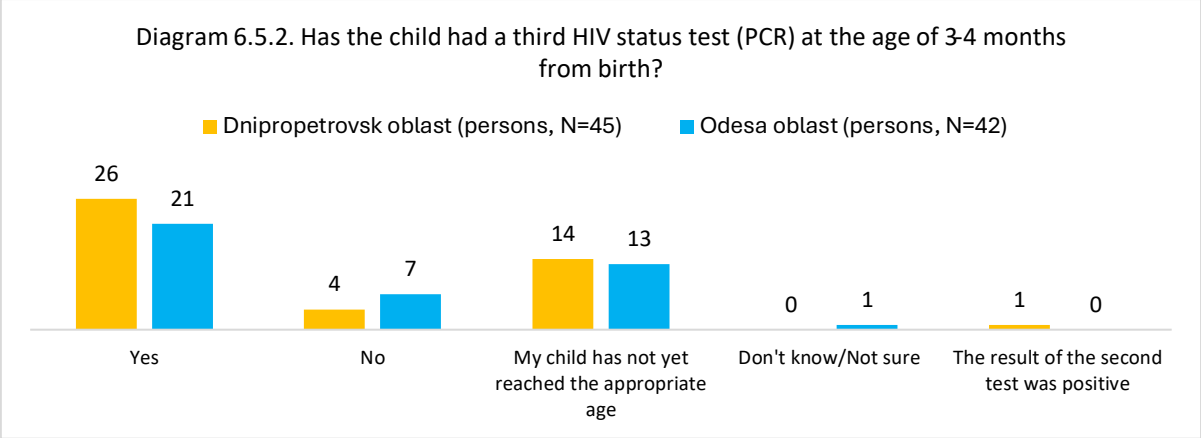


One woman among 88 mothers whose children underwent the first DBS PCR test reported that the result of the first test was positive (Dnipro, Dnipropetrovsk oblast). 77 women (38 – Dnipropetrovsk oblast, 39 – Odesa oblast) confirmed that their child had a **second HIV test** (PCR) at the age of 1-2 months from birth, and the children of 6 women were not tested (4 – Dnipropetrovsk oblast, 2 – Odesa oblast). 4 respondents noted that their child had not yet reached the appropriate age. See Diagram 6.5.1.

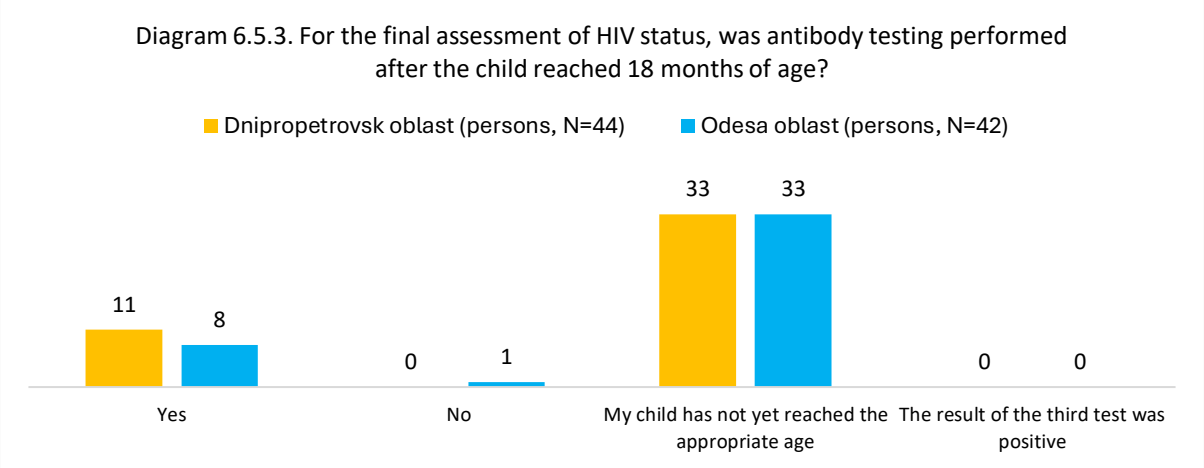
Diagram 6.5.1. Has the child had a second HIV status test (PCR) at the age of 1-2 months from birth?



One woman among 77 mothers whose children underwent a second HIV test reported that the result of the second test was positive (Nikopol, Dnipropetrovsk oblast). 47 women (26 – Dnipropetrovsk oblast, 21 – Odesa oblast) confirmed that their child had **a third HIV test** (PCR) at the age of 3-4 months from birth, and children of 11 women were not tested (4 – Dnipropetrovsk oblast, 7 – Odesa oblast). 27 respondents noted that their child had not yet reached the appropriate age. See Diagram 6.5.2.

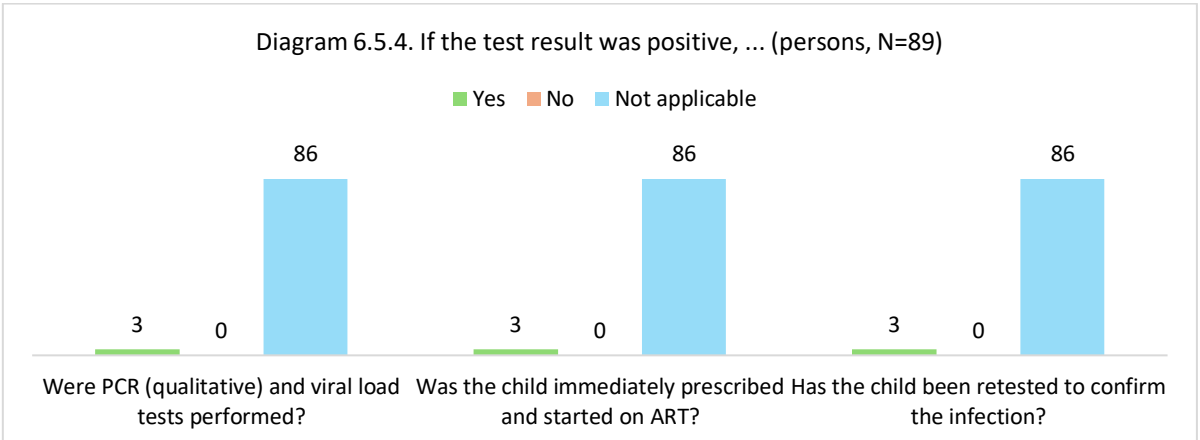


19 women (11 respondents – Dnipropetrovsk oblast, 8 respondents – Odesa oblast) confirmed that their child was tested for antibodies for a final assessment of HIV status after the child reached 18 months of age, while the child of 1 woman was not tested (Odesa oblast). 66 respondents noted that their child had not yet reached the appropriate age. See Diagram 6.5.3.

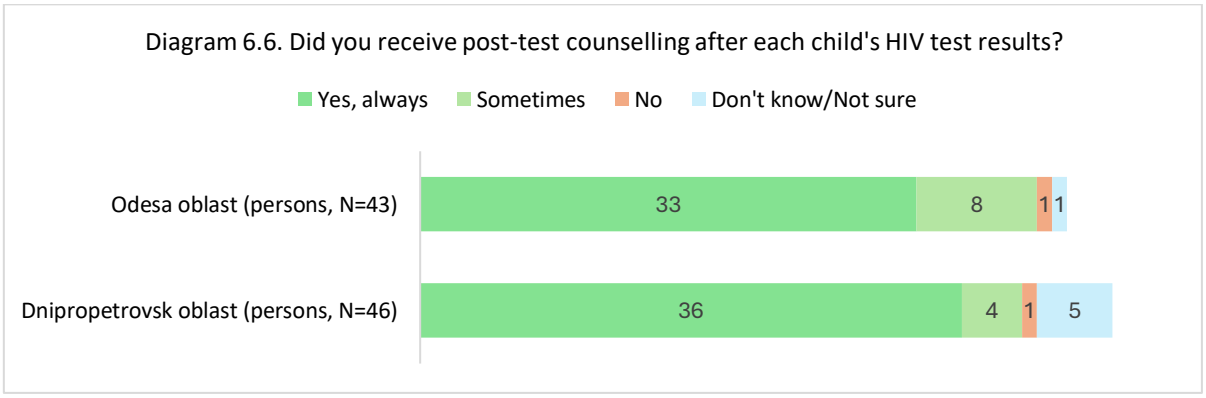


HIV-exposed children who tested positive for HIV status

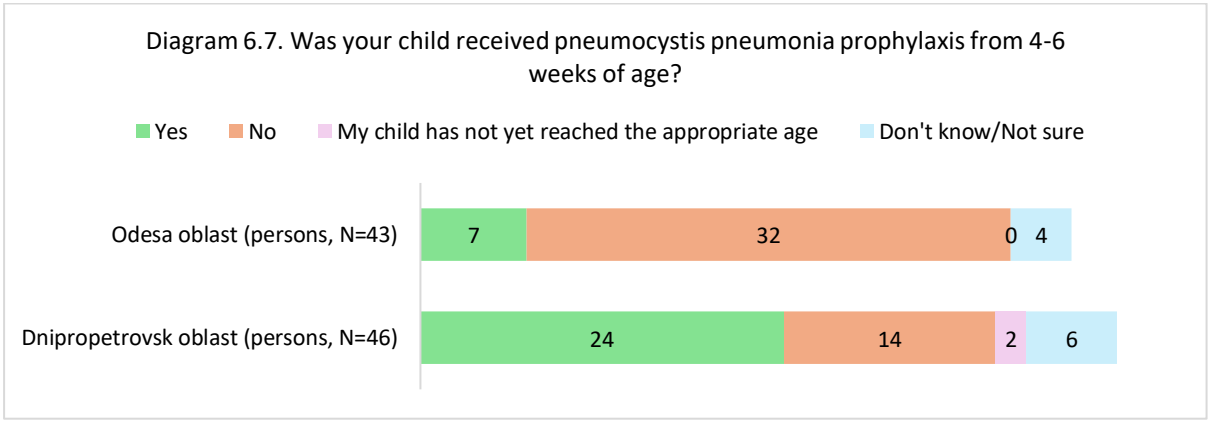
All three mothers whose children tested positive for HIV status (2 – Dnipropetrovsk oblast, 1 – Odesa oblast) confirmed that their child had a PCR (qualitative) and viral load test, that the child was immediately prescribed and started on ART, and that the child was retested to confirm the infection. See Diagram 6.5.4.



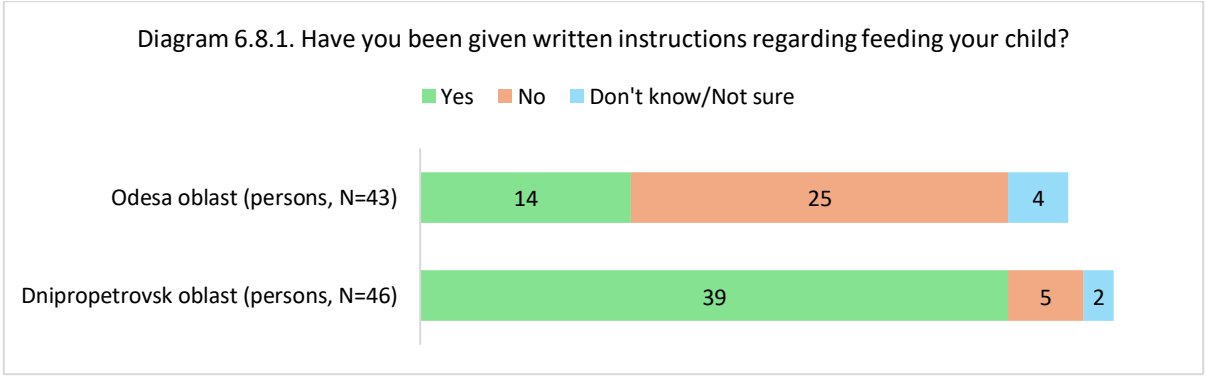
The vast majority of 89 mothers confirmed that they always received post-test counselling based on the results of each child's HIV test (69 women: 36 – Dnipropetrovsk oblast, 33 - Odesa oblast) (78%), and 12 women sometimes received (4 – Dnipropetrovsk oblast, 8 – Odesa oblast) (13%). Post-test counselling was not provided for 2 women, and 6 women do not know or are not sure whether it was provided. See Diagram 6.6.



Only 31 women out of 89 mothers confirmed that their child received pneumocystis pneumonia (PCP) prophylaxis starting at 4 to 6 weeks of age (35%), and more than half – 46 respondents – answered that their child was not received (52%). 10 women do not know or are not sure whether their children have been vaccinated or not. At the same time, the situation varies significantly at the oblast level. In Dnipropetrovsk oblast, the proportion of children who received PCP prophylaxis is the majority (24 respondents out of 46), while in Odesa oblast, only one in six (7 respondents out of 43). See Diagram 6.7.

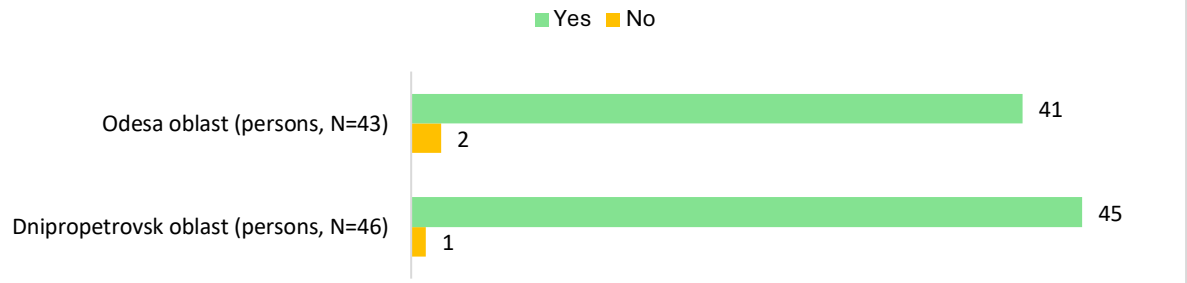


The majority of mothers – 53 women out of 89 – confirmed that they had been given written instructions on feeding their child (60%), while a third – 30 women out of 89 – said that they had not (34%). 6 women did not know or were not sure whether they had been given instructions or not. Again, the situation varies by oblast. While in Dnipropetrovsk oblast the vast majority of mothers were given written instructions on feeding their child (39 out of 46), in Odesa oblast they were only a third (14 out of 43). See Diagram 6.8.1.



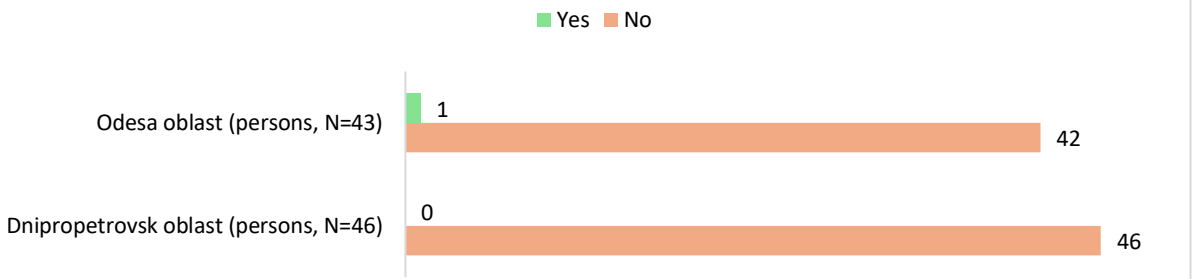
The vast majority of mothers reported factors that increase the risk of HIV transmission through breast milk, such as low ART adherence, mixed feeding, including solid foods (97%). See Diagram 6.8.2.

Diagram 6.8.2. Have you been informed about factors that increase the risk of HIV transmission through breast milk, such as low ART adherence, mixed feeding, including solid foods?



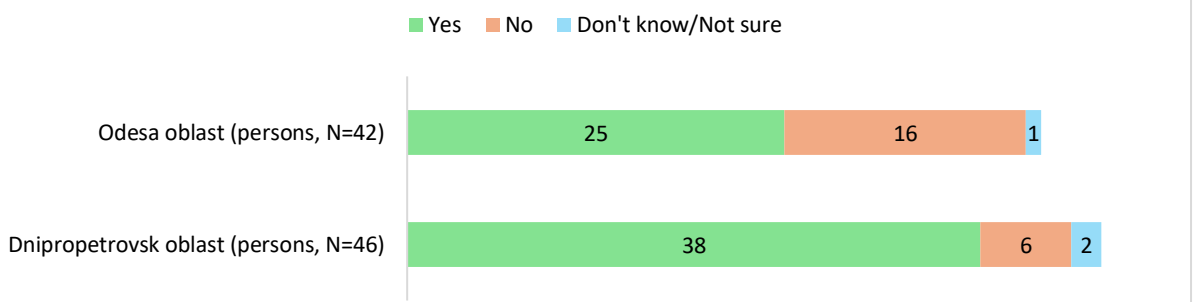
Almost all mothers have a child on formula feeding (88 respondents out of 89) (99%). The exception is a woman who found out about her HIV-positive status after giving birth (Odesa oblast). See Diagram 6.8.3.

Diagram 6.8.3. Have you breastfed (are you breastfeeding) your child?



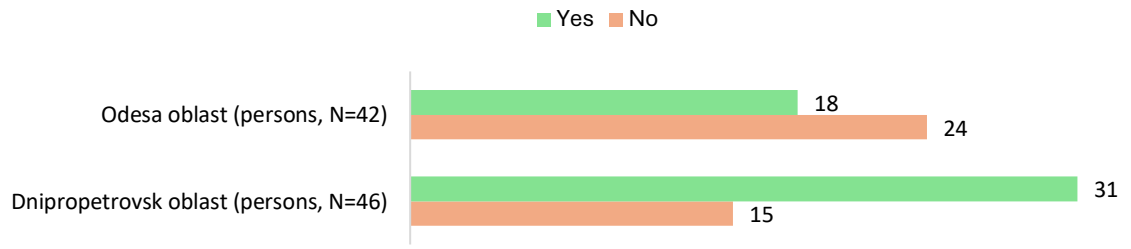
Among 88 mothers whose children are formula-fed, the majority – 63 women – confirmed that they were informed by medical professionals about the procedure for obtaining free breast milk substitutes (72%), while every fourth – 22 women – were not informed (25%). However, in Odesa oblast, the share of women who were not informed about receiving breast milk substitutes free of charge is 2,7 times higher compared to Dnipropetrovsk oblast, where the vast majority (38 out of 46) confirmed such counselling by medical professionals. See Diagram 6.8.4.

Diagram 6.8.4. Have you been informed by medical professionals about the procedure for obtaining free breast milk substitutes?



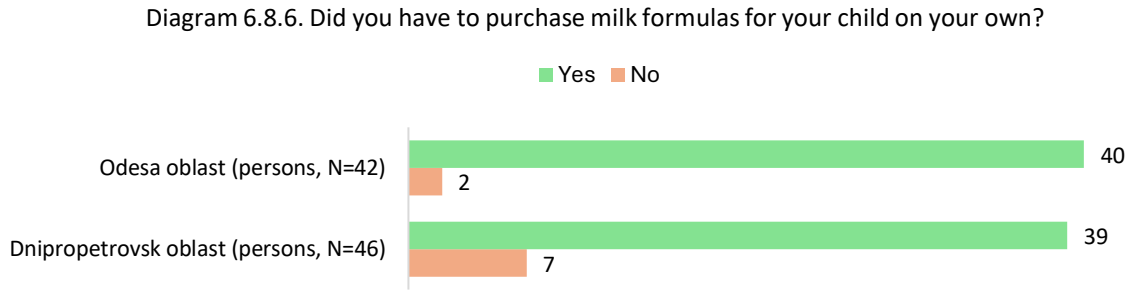
The majority of mothers – 49 women out of 88 – confirmed that they received infant formula from a health facility at the expense of the local budget (free of charge) (56%). However, a significant proportion – 39 women – did not receive it (44%). At the same time, in Dnipropetrovsk oblast, two-thirds of respondents (31 out of 45) received infant formula, and in Odesa oblast – less than half (18 out of 42). See Diagram 6.8.5.

Diagram 6.8.5. Have you received infant formula from a health facility at the expense of the local budget (free of charge)?



The vast majority of mothers surveyed (79 women: 39 – Dnipropetrovsk oblast, 40 – Odesa oblast) had to purchase milk formulas for their child on their own (90%), and only one in ten (9 women, including 7 from Dnipropetrovsk oblast) did not have to. See Diagram 6.8.6.

Diagram 6.8.6. Did you have to purchase milk formulas for your child on your own?



Experiences of obstetric violence and discrimination

In this section of the online questionnaire, respondents were provided with definitions and examples of key concepts of obstetric violence, namely:

- **Verbal and other psychological violence**: shouting, insults, humiliation, accusations, threats, intimidation, the requirement to clean the ward or place of stay in a medical institution on one's own, pressure to perform any procedure without a valid reason, ignoring requests for help, isolation.
- **Physical violence**: slapping, hitting certain parts of the body, rough handling, pushing the foetus out, roughly spreading the legs, forcing into a particular delivery position.
- **Unconsented medical procedures**, i.e. procedures for which you did NOT give verbal or written consent (The exception is emergency situations when the life of the woman and/or foetus is at risk and the woman is unconscious): perineotomy/episiotomy (cutting the area between the vaginal opening and the anus), application of obstetric forceps to remove the foetus, caesarean section, amniotomy (forcibly rupturing the amniotic sac), application of prostaglandin gel to the cervix to stimulate labour, using injections or vaginal tablets to stimulate labour, surgical sterilisation (a medical procedure that makes it impossible to have children in the future), insertion of an intrauterine contraceptive device.

The majority of respondents did not experience any form of obstetric violence or discrimination (54%). However, at the oblast level, this share increases in Dnipropetrovsk oblast (32 out of 50) and decreases in Odesa oblast (22 out of 50). 10% of respondents answered "Don't know/Not sure" or "Not applicable" to at least one form of obstetric violence. See Diagram 7.1.

At the same time, more than a third of respondents (36%) reported the following forms of obstetric violence and discrimination they experienced:

- Breach of confidentiality/disclosure of HIV status/unconsented disclosure of information about a woman's health or the health of her child to third parties (18%: 8 women – Dnipropetrovsk oblast, 10 women – Odesa oblast)
- Verbal and other psychological violence (15%: 6 women – Dnipropetrovsk oblast, 9 women – Odesa oblast)
- Physical violence (7%: 4 women – Dnipropetrovsk oblast, 3 women – Odesa oblast)
- Unconsented medical procedures (4%: 2 women – Dnipropetrovsk oblast, 2 women – Odesa oblast). See Diagram 7.1.1.

Diagram 7.1. Experiences of obstetric violence and discrimination (persons, N=100)

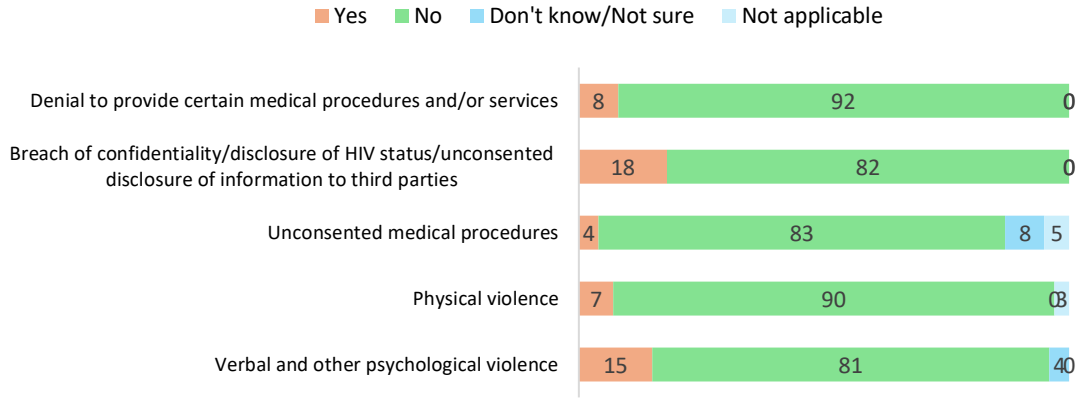
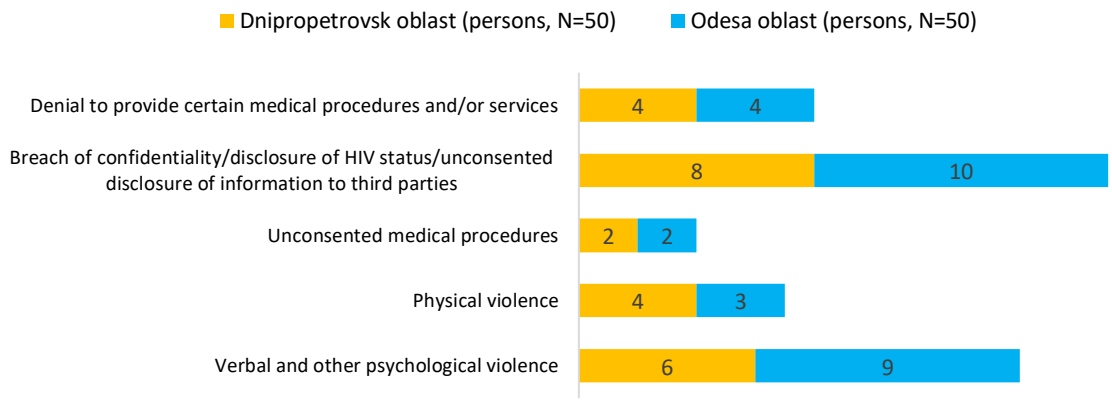


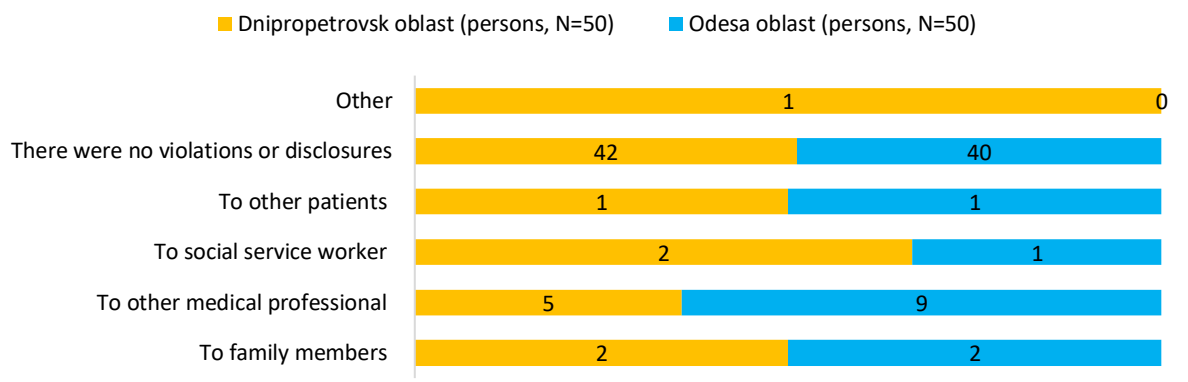
Diagram 7.1.1. Experiences of obstetric violence and discrimination



The violation of confidentiality/disclosure of HIV status/transfer of information about a woman's health or the health of her child without the woman's consent to third parties occurred as follows:

- to family members (4 respondents)
- to other medical professional (14 respondents)
- to social service worker (3 respondents)
- to other patients (2 respondents)
- other ("*At the school where my children studied and at my workplace*" – comment by a respondent from the village of Lyashkivka, Dnipropetrovsk oblast) (1 respondent). See Diagram 7.1.2.

Diagram 7.1.2. Breach of confidentiality/disclosure of HIV status/unconsented disclosure of information to third parties (multiple choice)

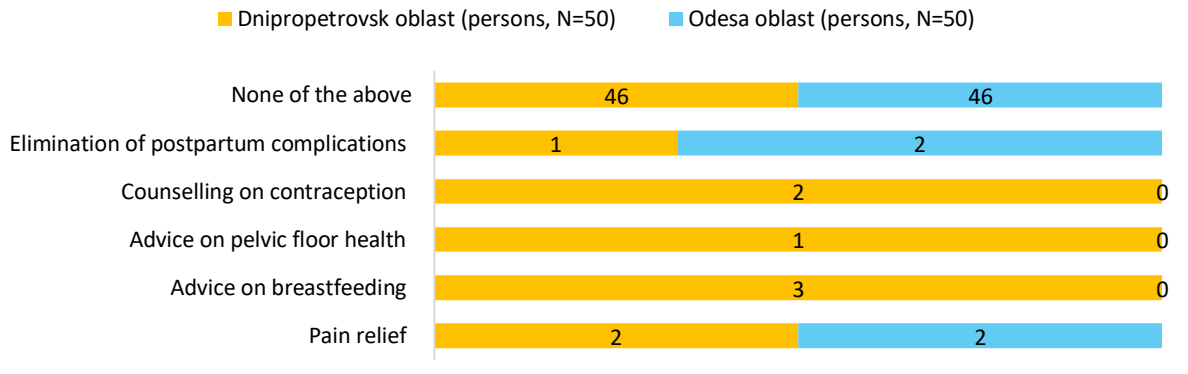


None of the women surveyed was denied the following medical procedures and/or services: medical (pills) or surgical abortion (0%); cervical coagulation (cauterisation) (0%); diagnosis and support for postpartum depression (0%).

If we consider medical procedures and/or services that 8 respondents reported being denied access to, the list would be as follows:

- Pain relief (4 respondents; *"They gave me pain relief, but only after my husband paid 100 USD to the anaesthetist"* – comment from a respondent from the village of Vilkove, Odesa oblast)
- Advice on breastfeeding (e.g., discouraging breastfeeding instead of providing informed choice) (3 respondents)
- Elimination of postpartum complications (3 respondents)
- Counselling on contraception (prevention of unwanted pregnancy) (2 respondents)
- Advice on pelvic floor health (helps strengthen muscles weakened by pregnancy and childbirth, reducing the risk of urinary incontinence) (1 respondent). See Diagram 7.1.3.

Diagram 7.1.3. Have you been denied certain medical procedures and/or services? (multiple choice)



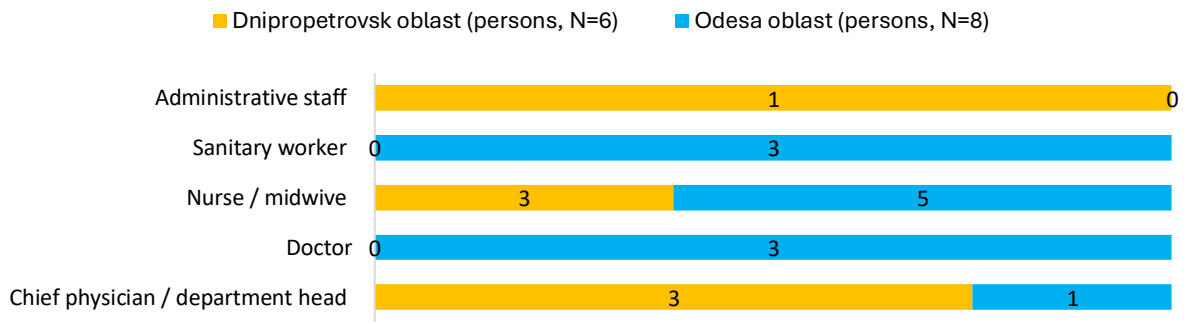
Summarising their experiences, 86% of respondents answered that "I have not experienced obstetric violence or discrimination", while 14% chose the answer "I have experienced obstetric violence and/or discrimination". This contradicts previous responses, where 36% indicated at least one form of violence and/or discrimination, and indicates a misconception about obstetric violence and discrimination and an inability to identify these phenomena in 22% of women (10 women from Dnipropetrovsk oblast, 12 women from Odesa oblast). Among them, the following were previously reported:

- breach of confidentiality/disclosure of HIV status/unconsented disclosure of information about a woman's health or the health of her child to third parties (14 respondents)
- refusal to provide certain medical procedures and/or services (5 respondents)
- cases of psychological violence (4 respondents)
- case of physical violence (1 respondent)
- unconsented medical procedures (1 respondent).

Accordingly, only 14 out of 36 respondents answered questions about healthcare workers who committed obstetric violence or discrimination and the impact of these actions on women's mental and emotional well-being. Among offenders who committed obstetric violence and/or discrimination are:

- nurse / midwife (8 respondents)
- chief physician / department head (4 respondents)
- doctor (3 respondents)
- sanitary worker (3 respondents)
- administrative staff (1 respondent). See Diagram 7.2.

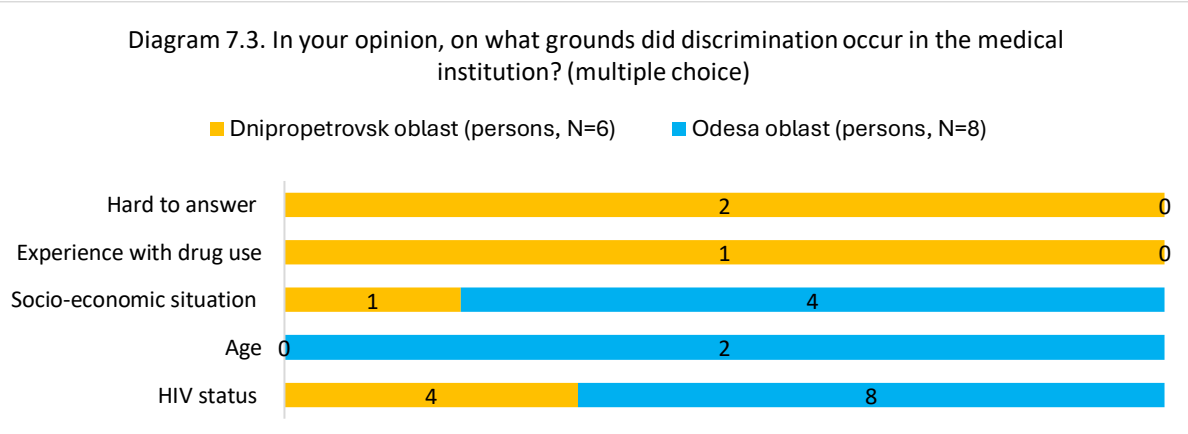
Diagram 7.2. If you have experienced any form of obstetric violence or discrimination (listed above), who committed it (perpetrator)? (multiple choice)



The vast majority of women who responded to questions about the grounds for discrimination in medical facilities consider their HIV status to be such grounds:

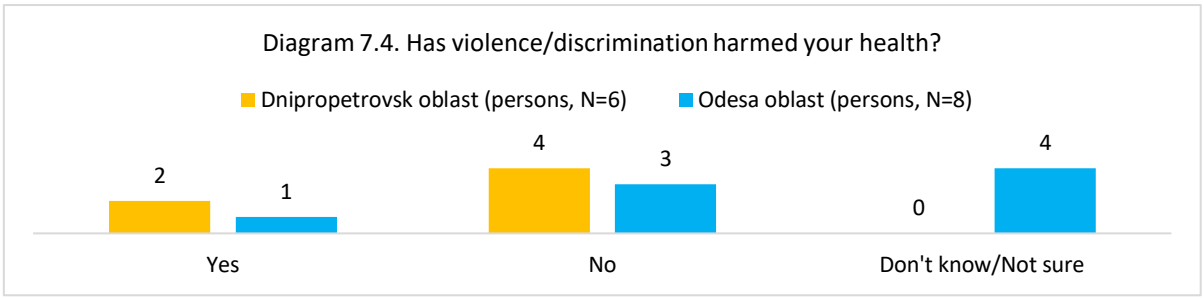
- HIV status (12 respondents)
- Socio-economic situation (5 respondents)
- Age (2 respondents)
- Experience with drug use (1 respondent)
- Hard to answer (2 respondents). See Diagram 7.3.

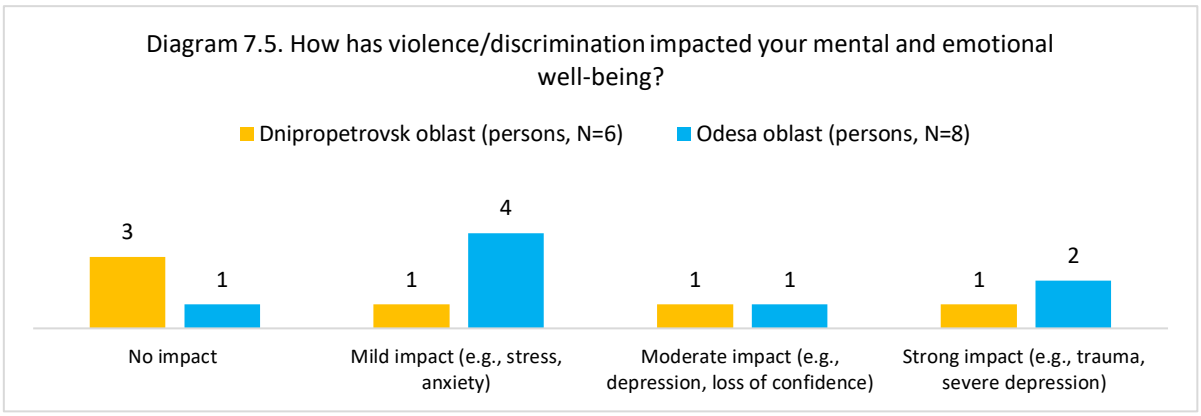
Diagram 7.3. In your opinion, on what grounds did discrimination occur in the medical institution? (multiple choice)



Three women out of 14 believe that violence/discrimination has harmed their health. See Diagram 7.4. Ten respondents noted the impact of violence/discrimination on their mental and emotional well-being, while four respondents did not feel any consequences:

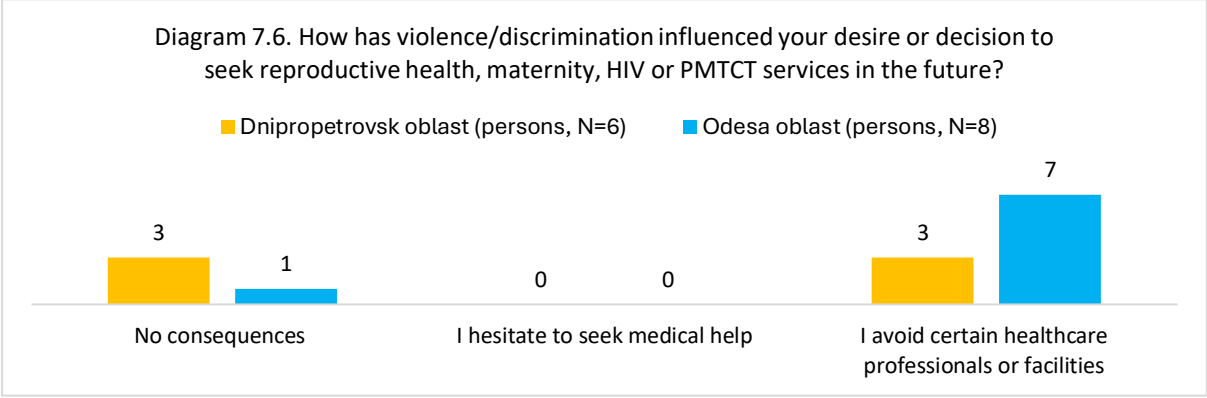
- Mild impact (e.g., stress, anxiety) (5 respondents)
- Moderate impact (e.g., depression, loss of confidence) (2 respondents)
- Strong impact (e.g., trauma, severe depression) (3 respondents)
- No impact (4 respondents). See Diagram 7.5.





For 10 respondents, violence/discrimination influenced their desire or decision to seek reproductive health, maternity, HIV-related or PMTCT services in the future:

- I avoid certain healthcare professionals or facilities (10 respondents)
- No consequences (4 respondents). See Diagram 7.6.



Accessibility of HIV and PMTCT services and barriers to their receipt

Geographical, administrative and financial accessibility

The most geographically accessible to the survey participants are the following HIV and PMTCT specialists (the vast majority noted “It’s very close to where I live” or “It’s not far to get there”):

- Primary care family doctor (or paediatrician) (36% - very close, 48% - not far to get there)
- Obstetrician-gynaecologist in a prenatal care department (antenatal clinic) (33% - very close, 45% - not far to get there).

The most geographically remote are the following institutions or specialists (more than a quarter chose "It's far to get there"):

- Obstetrician-gynaecologist and neonatologist of the maternity ward (maternity hospital) (30%: 27 out of 89 respondents who are concerned)
- Infectious disease specialist (or paediatric infectious disease specialist) providing medical care to people/children living with HIV (40%: 17 respondents – Dnipropetrovsk oblast, 23 respondents – Odesa oblast). See Diagram 8.1.

The vast majority of respondents have finances that allow or sometimes allow them to access key HIV and PMTCT specialists:

- Primary care family doctor (or paediatrician) (89%)
- Obstetrician-gynaecologist in a prenatal care department (antenatal clinic) (85%)
- Obstetrician-gynaecologist and neonatologist of the maternity ward (maternity hospital (83%)
- Infectious disease specialist (or paediatric infectious disease specialist) providing medical care to people/children living with HIV (86%). See Diagram 8.2.

Most often, this access concerns primary health care facilities and antenatal clinic (57% answered "Yes"). At the same time, every fifth respondent in the Odesa oblast does not have the financial means to reach antenatal clinic (10 respondents out of 50).

Diagram 8.1. How far is it (or was it) for you to travel to your HIV and PMTCT facility/specialist? (persons, N=100)

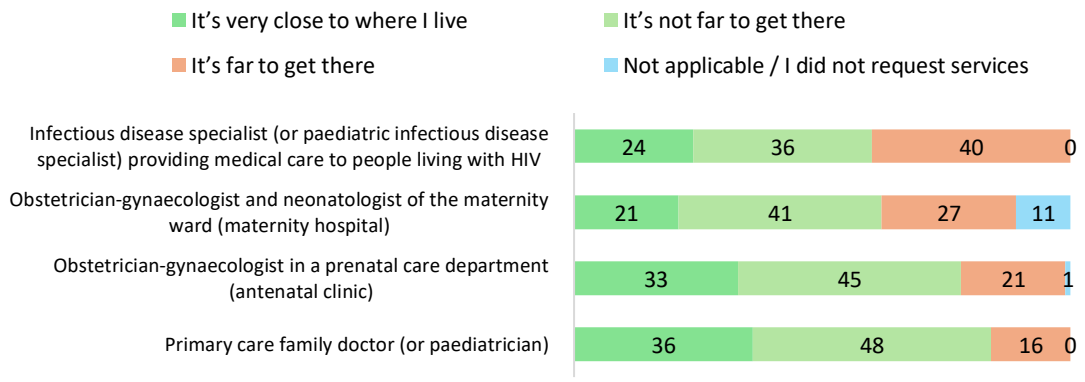
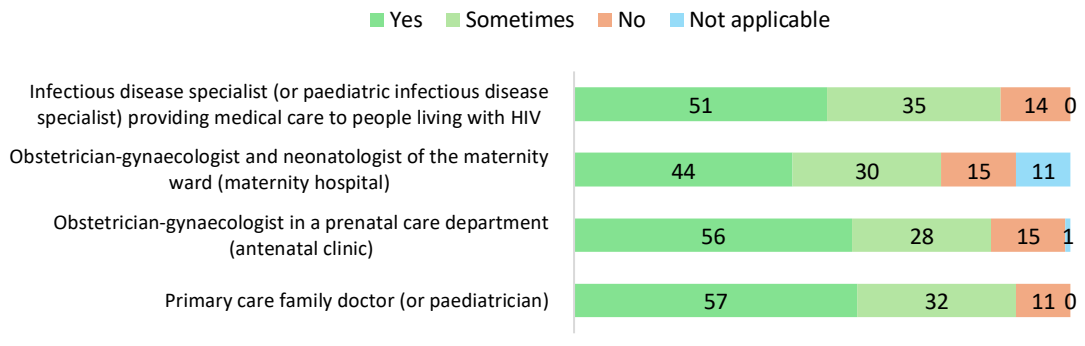
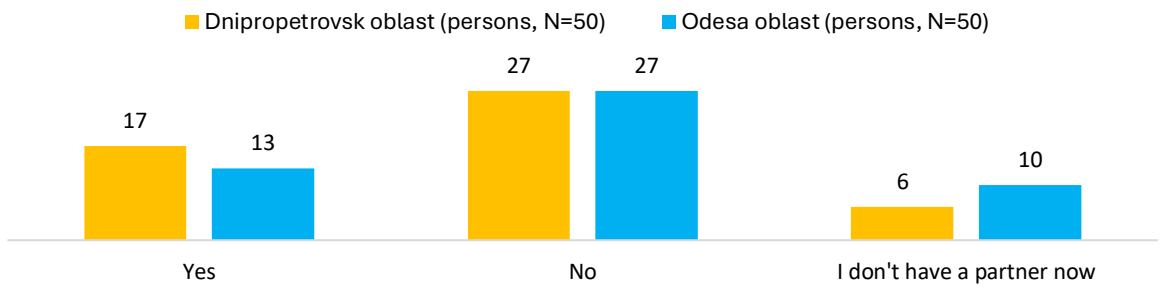


Diagram 8.2. Do your finances allow you to travel to an HIV and PMTCT facility/specialist? (persons, N=100)



Almost every third respondent confirmed their **financial dependence on a partner or husband** (30%), or more than a third among women who have a partner or husband (30 respondents out of 84). See Diagram 8.3.

Diagram 8.3. Does your access to money depend on your partner or husband to pay for transportation to an HIV and PMTCT facility/specialist?

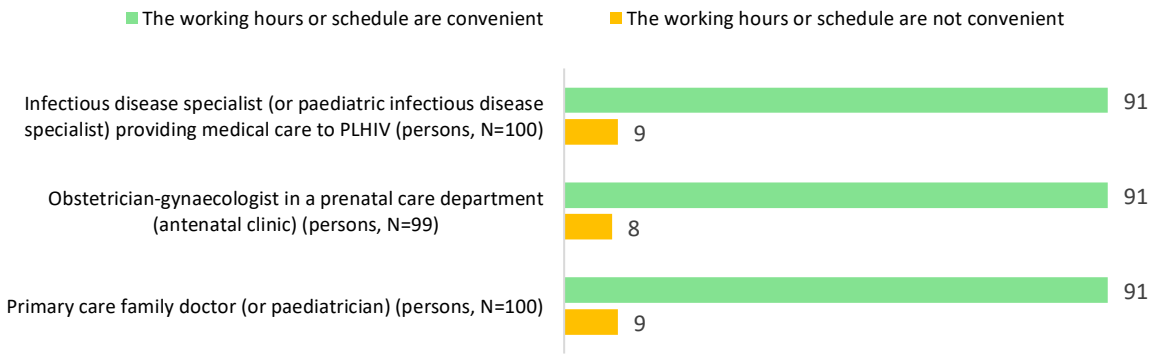


The vast majority of women have no complaints about the time and schedule of doctors' appointment, conducting tests, issuing ART in medical facilities that provide HIV and PMTCT services (*this question does not apply to maternity wards/maternity hospitals):

- Primary care family doctor (or paediatrician) (91%)
- Obstetrician-gynaecologist in a prenatal care department (antenatal clinic) (92%)
- Infectious disease specialist (or paediatric infectious disease specialist) providing medical care to people/children living with HIV (91%). See Diagram 8.4.

At the same time, every tenth respondent in the Dnipropetrovsk oblast considers the working hours of primary health care (5 out of 50) and institutions providing medical care to PLHIV (5 out of 50) to be inconvenient.

Diagram 8.4. Do you have any complaints regarding the time and schedule of specialist appointments, testing, and dispensing of ART?



The respondents demonstrate the best frequency of visits prescribed by a doctor in relation to visits to infectious disease specialists who provide medical care to people/children living with HIV (the vast majority indicated that they never missed a visit to a medical facility):

- Infectious disease specialist (or paediatric infectious disease specialist) providing medical care to people/children living with HIV (80%)
- Obstetrician-gynaecologist in a prenatal care department (antenatal clinic) (70%)
- Primary care family doctor (or paediatrician) (68%).

In total, 61 survey participants answered that they had never missed a visit. At the same time, the number of women who missed a visit to the specified specialists was significantly higher in Dnipropetrovsk oblast compared to Odesa oblast (25 and 14, respectively). Women from Dnipropetrovsk oblast most often missed visits to their

family doctor (or paediatrician) for primary health care (4 – quite often, 6 – sometimes). See Diagrams 8.5.1 and 8.5.2.

Diagram 8.5.1. Dnipropetrovsk oblast: Have you missed the appointment to visit a medical facility that was prescribed by a doctor?

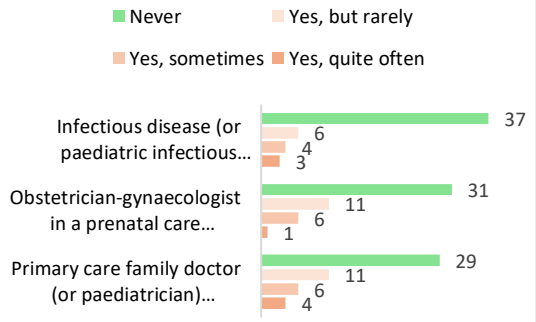
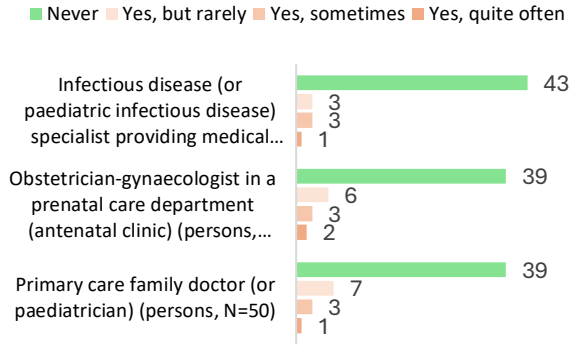


Diagram 8.5.2. Odesa oblast: Have you missed the appointment to visit a medical facility that was prescribed by a doctor?

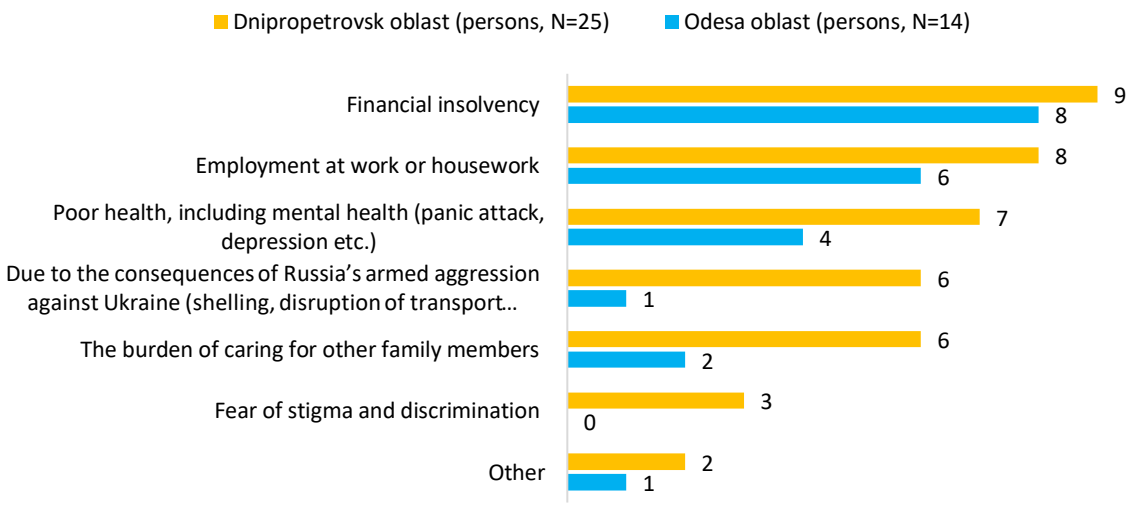


As for **the reasons for missing visit(s)**, it should be noted that the impact of the war is felt to a much greater extent by residents of the Dnipropetrovsk oblast, and fear of stigma and discrimination was noted as a reason for missing visits only by respondents from the Dnipropetrovsk oblast:

- Financial insolvency (17 respondents: 9 – Dnipropetrovsk oblast, 8 – Odesa oblast)
- Employment at work or housework (14 respondents: 8 – Dnipropetrovsk oblast, 6 – Odesa oblast)
- Poor health, including mental health (panic attack, depression etc.) (11 respondents: 7 – Dnipropetrovsk oblast, 4 – Odesa oblast)
- The burden of caring for other family members (8 respondents: 6 – Dnipropetrovsk oblast, 2 – Odesa oblast)
- Due to the consequences of Russia's armed aggression against Ukraine (shelling, disruption of transport infrastructure, air raids, etc.) (7 respondents: 6 – Dnipropetrovsk oblast, 1 – Odesa oblast)
- Fear of stigma and discrimination (3 respondents: 3 – Dnipropetrovsk oblast). See Diagram 8.6.

Among other things (3 respondents), women also added the following reasons: "*There was no one to leave the children with*", "*Bad relationship with the family doctor*" – Dnipropetrovsk oblast, "A sick child" – Odesa oblast.

Diagram 8.6. Please tell us about the reasons for missing visit(s) (multiple choice)



42 survey participants (12 respondents – Dnipropetrovsk oblast, 30 respondents – Odesa oblast) **had to pay** for medical services in a municipal facility, in particular:

- During pregnancy (39%: 10 respondents – Dnipropetrovsk oblast, 29 respondents – Odesa oblast)
- During childbirth (34%: 7 respondents – Dnipropetrovsk oblast, 23 respondents – Odesa oblast)
- In the postpartum period (21%: 6 respondents – Dnipropetrovsk oblast, 13 respondents – Odesa oblast)
- In connection with caring for an HIV-exposed child (8%: 3 respondents – Dnipropetrovsk oblast, 4 respondents – Odesa oblast).

Again, it is worth emphasizing that the situation varies significantly at the oblast level. While in Dnipropetrovsk oblast, almost every fourth respondent reported paying for medical services, in Odesa oblast – more than every second one. See Diagram 8.7.1 and Diagram 8.7.2.

The vast majority of women who had to pay for medical services live in poverty. 14 respondents (5 – from Dnipropetrovsk oblast, 9 – from Odesa oblast) previously reported that their household does not have enough money to cover daily needs, and 20 respondents (5 – from Dnipropetrovsk oblast, 15 – from Odesa oblast) reported that there is not enough money at all.

Almost half of these women live in the oblast centre - 20 respondents (5 – Dnipropetrovsk oblast, 15 – Odesa oblast). Slightly fewer - 18 women - live in rural areas (6 – Dnipropetrovsk oblast, 12 – Odesa oblast). Four respondents are residents of small towns (1 – Dnipropetrovsk oblast, 3 – Odesa oblast).

It was the respondents from the Odesa oblast who provided the most detailed and extensive answers to the open-ended question in the questionnaire about the institutions and medical services for which they had to pay, named the positions and full names of some medical workers, and the amounts paid. Maternity hospitals were most frequently mentioned, including the Odesa Oblast Perinatal Centre. In addition, women from the Odesa oblast provided examples of how fees for services were collected, including improper demands for payment, pressure on the woman and/or her husband, and examples of disrespectful treatment by medical staff and obstetric violence.

Diagram 8.7.1. Dnipropetrovsk oblast: Have you ever had to pay for PMTCT medical services in a municipal facility?

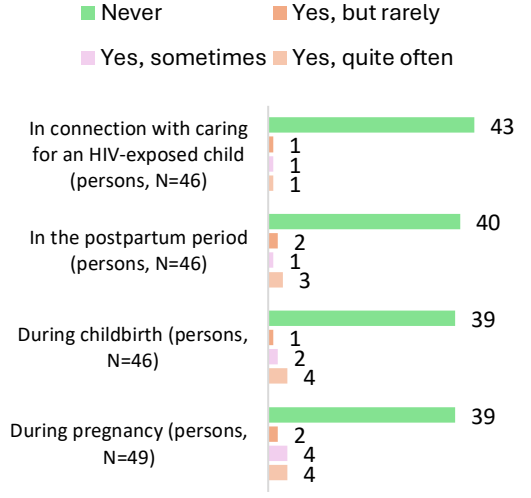
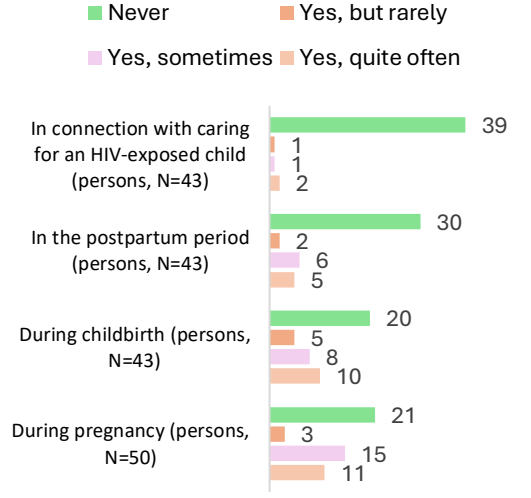


Diagram 8.7.2. Odesa oblast: Have you ever had to pay for PMTCT medical services in a municipal facility?



Below are quotes from respondents in response to an open-ended question - *If you answered "Yes" at least once to the previous question*, please tell me who, in which institution, for which service and how much you paid in a municipal medical institution. The answer was provided by 35 respondents (6 – Dnipropetrovsk oblast, 29 – Odesa oblast) out of 42 women to whom this question applies (quite often or sometimes or rarely had to pay for medical services). 6 respondents did not answer anything, and one answered "I don't remember".

Dnipropetrovsk oblast

Respondent's answer	Locality
When I was planning my pregnancy, I went to a doctor at a state institution, but privately. I paid for each visit during pregnancy, but it was on my own initiative, 300-500 UAH. The birth was by caesarean section and during the operation I also had additional nodes removed (fibroids). We agreed on everything in advance, it cost 12,000 UAH. + a list of medications of approximately 5,000 UAH. We chose a paid shared ward at the maternity hospital rates - 2500 UAH for the entire stay (we were there for 10 days). I did not pay separately for injections, IVs or other procedures	Dnipro
During pregnancy, I only paid for ultrasound/screening up to 500 UAH	Dnipro
For tests	village of Manvelivka, Vasylkivskyi district
Maternity hospital on Lenin street - ECG before registering for childbirth	Dnipro
Paid 15,000 UAH for childbirth, caesarean section	Dnipro
4500 UAH in Mechnikov maternity hospital for epidural anaesthesia	village of Holubivka, Novomoskovskyi district

Odesa oblast

Respondent's answer	Locality
7th maternity hospital, Odesa	Odesa
Some tests at the clinic at the place of residence	village of Oleksandrivka
Odesa Oblast Perinatal Centre	village of Shyriaievo
After the caesarean section, they gave me a letter with medicine to buy or pay for and they would buy it themselves	Reni, Izmailskyi district
I had a paid caesarean section	Biliaivka
Odesa, 4th maternity hospital, antenatal clinic at 11 Serhii Yadov St.	Odesa
2nd maternity hospital, Odesa. The fee for the ward (I was put in a separate room), anaesthesia, caesarean section and tubal ligation. I don't remember how much, to whom, but all this cost about 40,000 UAH	village of Prylymanske, rural cooperative of Avanhard-2
For anaesthesia 1000 UAH	Odesa
Odesa Oblast Maternity Hospital, paid in full for all tests and for the ward. Tests for 450 and 250 UAH are collected by midwives. I also paid 200 UAH for an ultrasound, for a Doppler, which is done very often, I paid 200 UAH for the first time, then 100 UAH each time. I paid 200 USD to Dr. B., who performed the delivery, and 2,000 to the anaesthesiologists. An ultrasound for the child is also paid - 200 UAH. In the postpartum ward, they also charge for tests and have a very bad attitude towards women in labour. Gynaecologists will not do anything without money, and they also charge 450 UAH for a discharge	village of Kamianka, Biliaivskyi district
Odesa Oblast Maternity Hospital. Blood tests, ultrasound, gave money for medicine. To the sanitary worker for cleaning. To the nurses to be attentive and polite	Odesa
7th maternity hospital, Odesa	Odesa
Odesa Oblast Maternity Hospital. We paid for tests, additional disinfection products, and remuneration for medical workers	village of Kryzhanivka
Oblast maternity hospital in Odesa. I paid for tests, diagnostics, and paid for the birth to the midwife and doctor	Odesa
7th maternity hospital. I paid for tests, ultrasound, medicine	Odesa
1st maternity hospital, Odesa. Ultrasound, blood tests, urine tests, gave money for the department, and for the children's department	village of Dobrooleksandrivka
5th maternity hospital. They demanded money for sterilising the bottle every day. Payment after a caesarean section	Odesa

In the maternity hospital 4 Odesa (to everyone who delivered birth), and then the head doctor hinted that the paediatrician should also be given money ... and unfortunately, I paid, I was after anaesthesia and not very well remembered	village of Fontanka
4th maternity hospital, Odesa	Odesa
Payment for ultrasound and tests at the antenatal clinic	Urban-type settlements of Avanhard
For tests in Smartlab and ultrasound	Odesa
Oblast maternity hospital. Paid for tests, disinfection, ultrasound	Odesa
Maternity hospital #5. I gave birth there in 2023. Anaesthesiologist B.D. was very insistent on paying for the epidural anaesthesia, assuring my husband that they, the doctors, pay for it out of their own pockets, purchasing it personally. At that moment, there was no strength to argue and prove anything. The decision was made to pay. He also humiliated me in labour in front of the staff, saying that he had never seen anyone as loud (I screamed during labour), unorganised, and lazy as me. That I was the first in his practice who couldn't give birth in an hour and twenty minutes during labour and also acted pathetic. All the other staff was gradually shutting him up and making remarks. I thanked the other staff with money voluntarily. The only thing I would like to note, although it may not be relevant to the topic. None of the medical staff asked me a single question or provided any advice about the umbilical cord blood, which they took and quickly took to the refrigerator. The bet was made that I wouldn't notice. But I noticed. And the next day, I even asked a question. But they made a fool of me by slightly going off topic	village of Vilkove
2nd maternity hospital in Odesa, paid for ultrasound, tests	village of Starokozache
For tests	Odesa
In the Odesa oblast maternity hospital, immediately after giving birth, but I replied that I didn't have money, only 500 UAH, so they took 300 for the injection and 200 as gratitude	Odesa
Oblast maternity hospital. Paid for tests, ultrasound, and childbirth fees	Odesa
For anaesthesia 2000	village of Mykolaivka, Bilhorod-Dnistrovskyi district
For tests	Biliaivka
Oblast maternity hospital in Odesa. Ultrasound, blood tests, cardiogram, ultrasound of the heart, bronchoscopy, for a paediatrician's appointment, for a spermogram	village of Usatove

HIV and PMTCT services based on HIV-service NGOs

The most commonly used PMTCT services based on HIV-service non-governmental organisations (NGOs) for respondents are (received by 90% or more of respondents):

- Counselling on available medical services for the prevention of mother-to-child transmission of HIV (in-person, online, bots, etc.) (80% - constantly, 7% - occasionally, 5% - once)
- Counselling on safe feeding of the child (79% - constantly, 10% - occasionally, 2% - once)
- Counselling parents/guardians of an HIV-exposed child regarding the child's medical management (25% - constantly, 41% - occasionally, 24% - once). See Diagram 9.1.

The vast majority of respondents constantly or occasionally received the following services related to HIV and PMTCT from an HIV-service NGO:

- Establishing and monitoring of adherence and intake of ARV drugs, monitoring of the study on the viral load of HIV-positive pregnant women (81%)
- Informing on the procedure for receiving free breast milk substitutes at the expense of the local budget (81%)
- Peer counselling for HIV-positive pregnant women (80%)

- Ensuring timely early diagnosis of HIV infection in a child using PCR (to assess the child's HIV status) (78%)
- Counselling on current legislation and benefits for mother and child, including legal and/or paralegal consulting and/or support (documentation, benefits, payments) (76%).

Most respondents constantly or occasionally received the following HIV and PMTCT services from an HIV-service NGO (a significant proportion of one-time services is added):

- Support groups for women living with HIV (69%)
- ART delivery (69%)
- Protection of the rights and interests of the mother and/or child in case of discrimination or violence in medical institutions (60%)
- Dispensing of medicines (except ART) (60%)
- Humanitarian aid, other than food and medicine (hygiene kits, diapers, clothes, power banks, etc.) (52%; and an additional 13% - once)
- Provision of baby formula for HIV-exposed children (50%; and an additional 11% - once).

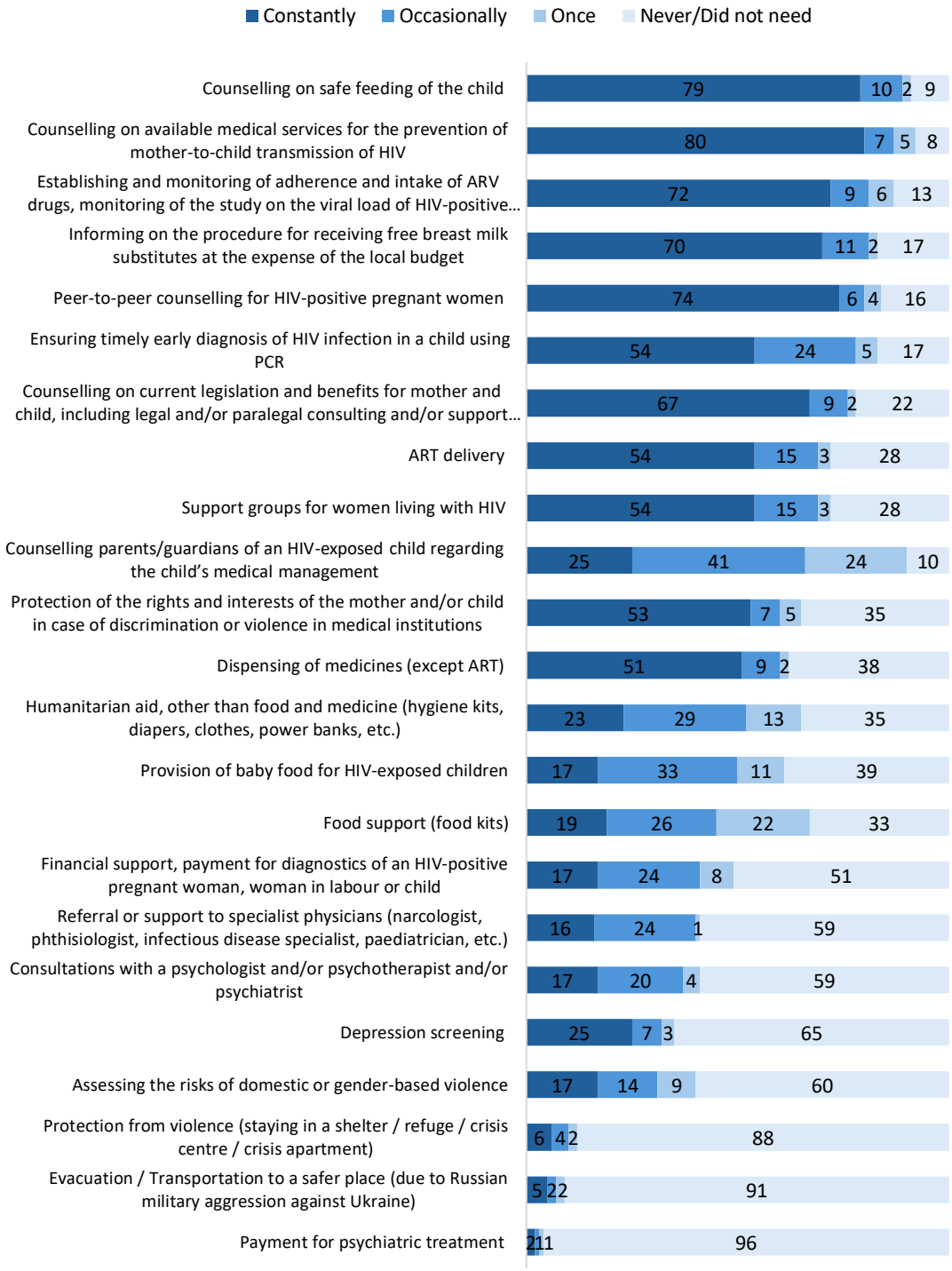
Also, the majority of respondents received food support (food packages), but with a lower frequency compared to the above-mentioned services (19% - constantly; 26% - occasionally; 22% - once). To a lesser extent, respondents (less than half of respondents) used the following services on the basis of NGOs:

- Financial support, payment for diagnostics of an HIV-positive pregnant woman, woman in labour or child (17% - constantly; 24% - occasionally; 8% - once)
- Referral or support to specialist physicians (narcologist, phthisiologist, infectious disease specialist, paediatrician, etc.) (16% - constantly; 24% - occasionally; 1% - once)
- Consultations with a psychologist and/or psychotherapist and/or psychiatrist (17% - constantly; 20% - occasionally; 4% - once)
- Depression screening (32%) (25% - constantly; 27% - occasionally; 3% - once)
- Assessing the risks of domestic or gender-based violence (17% - constantly; 14% - occasionally; 9% - once).

The least consumed NGO services among the survey participants are:

- Protection from violence (staying in a shelter / refuge / crisis centre / crisis apartment) (6% - constantly; 4% - occasionally; 2% - once)
- Evacuation / Transportation to a safer place (due to Russian military aggression against Ukraine) (5% - constantly; 2% - occasionally; 2% - once)
- Payment for psychiatric treatment (2% - constantly; 1% - occasionally; 1% - once).

Diagram 9.1. HIV and PMTCT services based on HIV-service NGOs (N=100)



Satisfaction with the quality of HIV and PMTCT services

Respondents showed the highest level of satisfaction with PMTCT services towards HIV-service NGOs (51% - satisfied, 38% - very satisfied) and health care facilities that provide services to people living with HIV (59% - satisfied, 22% - very satisfied). Respondents showed the highest level of dissatisfaction with services towards maternity hospitals (maternity departments) (15% - not at all satisfied, 9% - dissatisfied), primarily women from Odesa oblast. See Diagram 10.1 and Diagram 10.1.3.

Diagram 10.1. How satisfied are you with the overall quality of services you received during pregnancy and/or childbirth and/or in the postpartum period and/or in connection with the care of an HIV-exposed child?

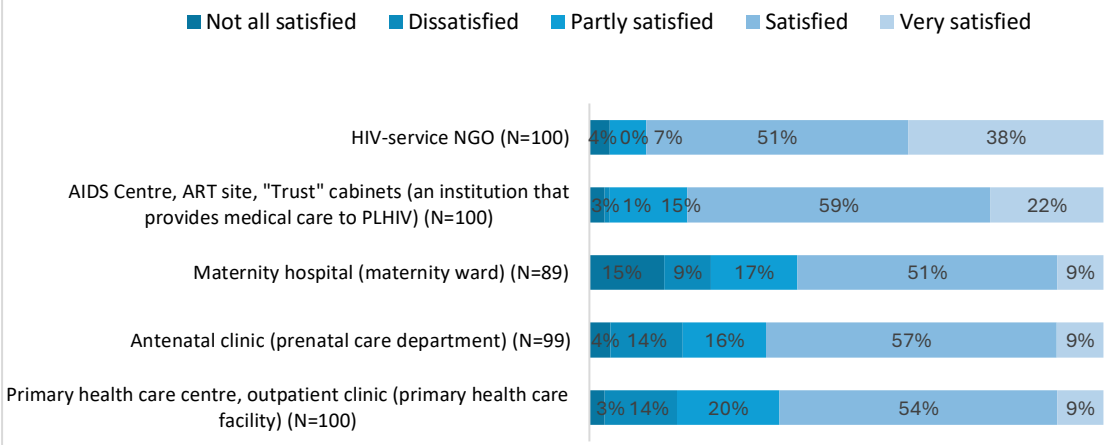
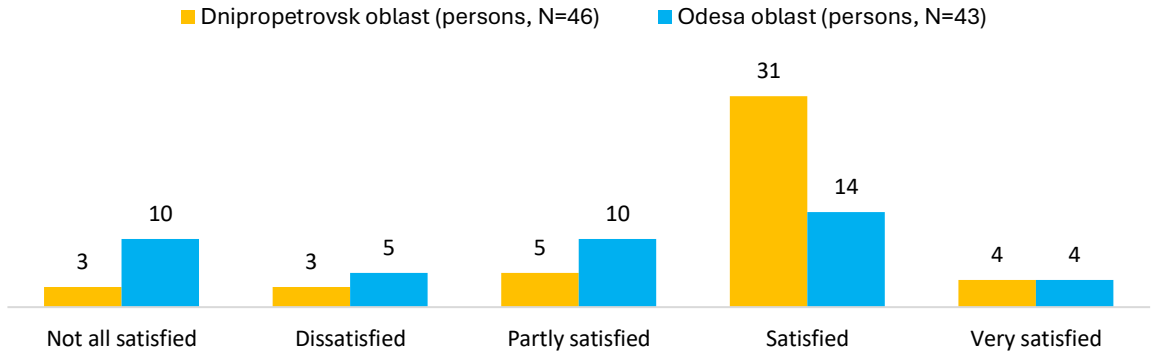


Diagram 10.1.3. Satisfaction with services - Maternity hospital (maternity care department)



If we compare satisfaction with services by oblast, then, unlike Odesa oblast, respondents from Dnipropetrovsk oblast are mostly or in most cases satisfied with PMTCT medical services, including primary health care facilities, antenatal clinics (prenatal care departments), maternity hospitals (maternity care departments), and facilities that provide medical care to people living with HIV. In Odesa oblast, the majority of respondents expressed satisfaction with medical services only with facilities that provide medical care to people living with HIV. At the same time, in Odesa oblast, a significantly larger proportion of respondents are very satisfied with non-medical services (based on HIV-service NGOs) compared to Dnipropetrovsk oblast. See Diagram 10.1.1 and Diagram 10.1.2.

Diagram 10.1.1. Dnipropetrovsk oblast: How satisfied are you with the overall quality of services you received during pregnancy and/or childbirth and/or in the postpartum period and/or in connection with caring for an HIV-exposed child? (persons, N=50)

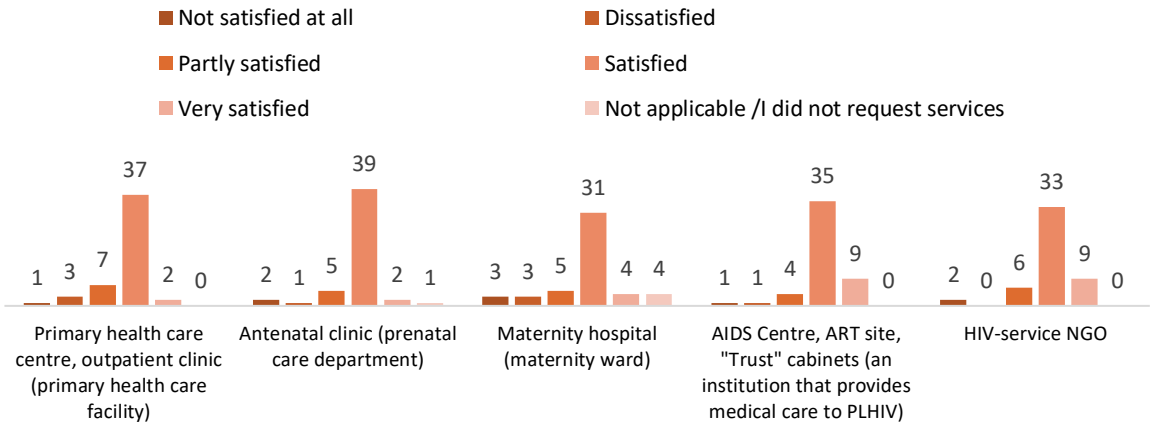
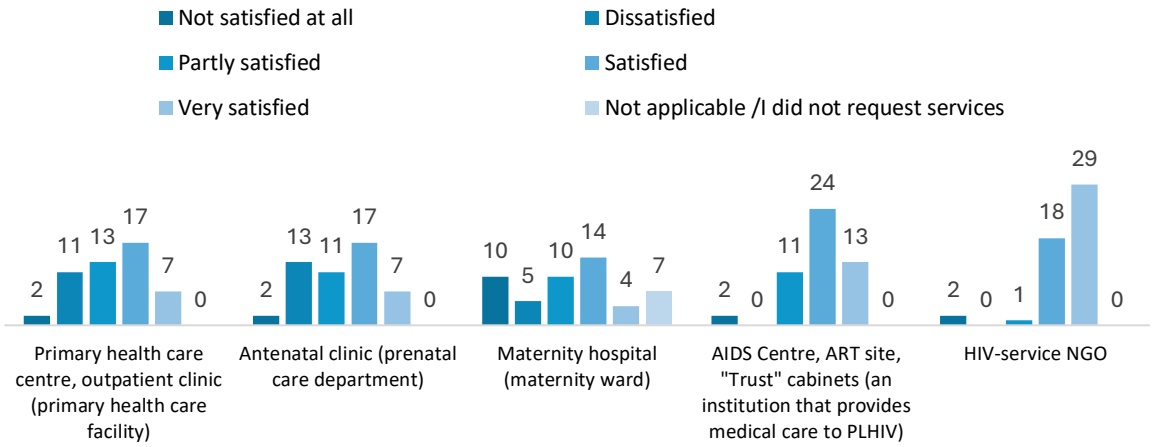


Diagram 10.1.2. Odesa oblast: How satisfied are you with the overall quality of services you received during pregnancy and/or childbirth and/or in the postpartum period and/or in connection with caring for an HIV-exposed child? (persons, N=50)



Annex 3. Qualitative component sample

Qualitative component sample:

№	Target group	Inclusion criteria	Sample size			Method
			Dnipropetrovsk oblast	Odesa oblast	Totally	
1	Adolescent girls living with HIV	- age from 14 to 17 years inclusive - received medical services related to HIV in the target oblast within the last 3 years - received or are receiving services from HIV-service NGOs or representatives of the CO "Positive Women" have access to such girls - provided voluntary informed consent	4	4	8	In-depth interview
2	Mothers/legal guardians of HIV-exposed and HIV-positive children	- is the legal representative of an HIV-exposed or HIV-positive child under 3 years of age at the time of the research (biological mother, guardian, adoptive mother or other legal representative) - received HIV-related medical services in the target oblast within the last 3 years - received or are receiving services from HIV-service NGOs or representatives of the CO "Positive Women" have access to such parents - provided voluntary informed consent	4	4	8	In-depth interview
3	Health workers providing PMTCT services	- work as a medical worker in a health care facility that provides PMTCT services in the target oblast (PHC facility, antenatal care facility, perinatal care facility, PLHIV health facility) - provided voluntary informed consent	5	5	10	In-depth interview
4	Specialists in management positions	- work in positions of heads of departments/departments of health care/health facilities providing PMTCT services or members of the regional TB/AIDS Council or/and RC EMTCT in the target oblast - provided voluntary informed consent	4	3	7	In-depth interview
5.1	Community-based PMTCT service providers	- at least 2 years of experience in the non-governmental sector, in particular in a community-led HIV service NGO in the target oblast - experience in providing services to HIV-positive pregnant and/or postpartum women and/or HIV-exposed and HIV-positive children and adolescents: social/outreach workers OR peer counsellors OR paralegals OR is a community representative in the regional TB/AIDS Council or/and RC EMTCT - provided voluntary informed consent	6	6	12	FGD
5.2	Community representatives in the regional TB/AIDS Council or/and RC EMTCT		2	2	4	FGD

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