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A photograph showing two women sitting at a table in what appears to be a temporary workspace or office. The woman on the right is wearing a light blue shirt and an orange vest, and is looking down at a document on the table. The woman on the left is partially visible, wearing glasses. In the background, there are several cardboard boxes stacked on a table covered with a white cloth with yellow stripes. The wall behind them is peeling and damaged.

Health needs assessment of the adult population in Ukraine

Survey report

April 2024



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Abstract

The ongoing full-scale invasion by the Russian Federation continues to exert unprecedented pressure on all aspects of public life in Ukraine. Despite the significant negative impact of the war, the findings indicate that the country's health system remains resilient, and that access to health services is good.

This study examines the access to primary health care facilities and family doctors in Ukraine as of April 2024, with a focus on internally displaced persons (IDPs) and frontline regions. Eight per cent of households reported no access to primary health care. Seven per cent lack a signed declaration with a family doctor, and 23% have changed their family doctor since the war began, primarily due to dissatisfaction or relocation. Access to health services remains high, although 54% of respondents needed medical assistance recently, with 65% facing problems and 10% unable to obtain needed services. Almost all households faced issues obtaining medicines, primarily due to price increases. Awareness of Ukraine's Affordable Medicines Programme is low. IDPs and residents of frontline regions face greater challenges in accessing health care, with IDPs particularly affected by the lack of knowledge about health-care facilities and higher rates of unmet medical needs.

Keywords

UKRAINE

EUROPE

HEALTH CARE QUALITY, ACCESS, AND EVALUATION

HEALTH SERVICES

WAR EXPOSURE

SURVEYS AND QUESTIONNAIRES

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Executive summary

The WHO Country Office in Ukraine conducted a quantitative, serial, cross-sectional study to assess the self-reported health needs and access to health services among the adult population in Ukraine. So far, five rounds of data collection have been conducted: Round 1 in September 2022, Round 2 in December 2022, Round 3 in April 2023, Round 4 in October 2023 and Round 5 in April 2024, each comprising a sample size of 4000 respondents. Data collection was facilitated by the Sociological group “Rating” through computer-assisted telephone interviews.

As of April 2024, 8% of households lacked access to their primary health-care facility, with 7% unaware of its location. Since the war began, 23% of respondents have changed their family doctor, with 10% changing because they were dissatisfied with the service quality. Currently, 5% lack access to a family doctor, and 7% cannot visit their doctor in person but have remote access.

In the 3 months prior to the survey, 54% of respondents needed medical assistance, with 65% encountering problems while receiving services. About 10% could not access needed services, and 7% could not access any services at all. Most sought care for chronic conditions (45%) and primary health care (33%).

One third of households delayed medical care despite needing it, primarily due to self-treatment (58%) and expecting issues to resolve on their own (37%).

Nearly all households (81%) faced problems obtaining necessary medicines, mainly due to increased prices (71%). Additionally, 32% lacked funds for medications. Issues related to pharmacy operations have decreased, but 6% of households could still not get needed medicines. Awareness of the Affordable Medicines Programme in Ukraine is low (59%), with less than a third (30%) successfully using it.

The primary concern related to health is the cost of medicines and treatment (46%). The severity of issues related to medicine availability decreased from 21% in December 2022 to 15% in April 2024. More than a quarter (27%) feel that specific health-care services or treatments are lacking in their community.

In the past 3 months, 87% of households reported health-related expenses, with 30% for medical services. Among these, 13% experienced informal payments in health facilities, and 10% made charitable donations.

Internally displaced persons (IDPs) face significant challenges, with 13% unaware of their primary health facility’s location compared with 6% among local communities. One third of IDPs who had moved in the past 3 months were unaware of their primary health facility’s location; however, the figure improved to only 9% for those who had relocated over a year ago. IDPs also face greater difficulty accessing family doctors (11% compared with 4% among local communities), with 25% lacking access among recent movers. Frontline regions show higher rates of individuals without access to family doctors (6%), particularly in the most affected regions (9%).

Methodology

Background

The timing of the war, which coincided with the SARS-CoV-2 (COVID-19) pandemic, posed an enormous challenge for Ukraine's already overburdened health-care system, including its health-care workforce. Large-scale attacks led to significant population displacement within and outside the country. Coupled with unprecedented attacks on health-care facilities, this triggered a humanitarian crisis with both short- and long-term public health consequences in Ukraine.

In February 2022, the conflict in Ukraine escalated into a war, resulting in a brain drain and a shortage of health-care professionals, particularly in the eastern regions of the country. The current invasion has likely exacerbated pre-existing public health issues (1). As of July 2024, there have been 1865 attacks on health care in Ukraine (2). Approximately 14.5 million people in Ukraine will require multisectoral humanitarian assistance due to the ongoing war (3). According to the International Organization for Migration, as of April 2024, 3.5 million people are internally displaced within Ukraine (4).

Despite multiple rapid needs assessments conducted since 24 February 2022, obtaining accurate information on health needs and access to health care in Ukraine remains challenging. The situation is highly volatile, with frequent population movements, the retaking of control over areas previously under temporary military control of the Russian Federation, and the restoration of public and private health-care facilities, including pharmacies. Therefore, monitoring the dynamics of health needs in Ukraine is crucial for both the government and the international humanitarian community.

WHO Country Office in Ukraine is conducting a serial cross-sectional survey to assess and monitor priority health needs and the level of access to different categories of health services (packages) among internally displaced persons (IDPs) and people in their home communities. The results of this survey will inform the development of policies and programmes to address the evolving health needs of the people of Ukraine.

The results of the health needs assessment in October 2023 showed that the demand for and access to health-care services remained consistent with the results of the April 2023 survey, with only minor variations observed (5). Health-care services for chronic diseases, primary health care, and children's health care continued to be the most sought after. Access to primary health-care facilities and family doctors was notably high through enhanced contact methods, including in-person visits and online messaging platforms. However, at the same time, one in four people still delayed medical care for reasons such as self-treatment or minor symptoms; cost as a reason for delay had decreased but remained a significant factor.

In the October 2023 survey, while the demand for routine vaccinations for children, and tetanus and diphtheria vaccines for adults, had remained stable, the demand for COVID-19 vaccinations had significantly declined. Seven per cent of respondents still lacked access to needed medications, even though issues such as high cost and long pharmacy queues had decreased. However, challenges remained in ensuring the availability of prescription medications.

Finding essential medical information had become slightly easier, with family doctors being a primary source of health information and a decreased overall interest in various types of medical information. IDPs continued to experience more difficulties in accessing health care and medications compared with those who had remained in their communities. Households in areas with ongoing hostilities had limited access to family doctors and faced more challenges in affording medicines and medical services than residents in other regions.

Study aims and objectives

This study aims to gain insight into the main self-reported health needs of IDPs and people in their home communities at national and macroregional level, particularly in terms of access to primary and specialized health services, medicines, and other essential health services. The findings of this study will inform the planning and implementation of the emergency response and recovery from the disruption caused by the ongoing war in Ukraine by both the Government of Ukraine and international development agencies.

The specific objectives are to:

- monitor the self-reported health needs of the general population of Ukraine, including IDPs and people in their home communities;
- monitor self-reported access to primary health-care services, family doctors, basic medicines, and barriers in accessing these services at macroregional and/or priority oblast level;
- monitor self-reported access to specialized services and medicines at macroregional level;
- document changes in these factors over time to understand the effect of continuing population movement, active combat, new developments, events, and measures taken to address the gaps;
- identify subgroups within IDPs and people in their home communities with the greatest unmet needs to inform priority interventions;
- explore geographical variability in health needs and access to primary and specialized services; and

- assess the source of health information and level of trust in various sources of health information.

Study design

This is a quantitative, serial cross-sectional study that will use a survey questionnaire to collect data in five waves between September 2022 and April 2024. By assessing the same core variables over time, the study team will be able to monitor the situation and identify the critical health needs of the population in a volatile situation and guide appropriate responses by the government and partners. However, depending on programmatic needs, the questionnaire may be updated as needed, but the core variables will always be included.

Sampling strategy

The total sample of 4000 adult Ukrainians was chosen to achieve an acceptable level of congruence between the distribution of the current demographics in the sample and the adult population currently in Ukraine (age, gender, rural/urban living area, and macroregional). This was done by matching the estimated current population composition in Ukraine derived from various available sources of data. Based on the study team's preliminary work, varying estimates indicated that approximately 30% of respondents had at least one family member who had attempted to access general health services since 24 February 2022 (6). While these estimates are not representative of the entire population, they suggest that a sample size of 4000 is necessary to explore access to health services in Ukraine. Extrapolating from this sample could yield approximately 1200 observations that will enable exploration of the main challenges at population level.

The inclusion criteria include anyone 18 years or older residing in Ukraine at the time of data collection. The exclusion criteria are people under 18 years of age or those not residing in Ukraine at the time of data collection.

The computer-assisted telephone interviews (CATI) method used in the survey is based on a 100% random sample of mobile phone numbers, generated by a special software that uses 12 codes of the three largest mobile operators in Ukraine: Kyivstar, Vodafone Ukraine and lifecell. Each randomly generated number package includes an equal number of each code (050, 063, 066, 067, 068, 073, 093, 095, 096, 097, 098, 099).

Data collection instrument

The data collection instrument (questionnaire) was developed based on a tool designed for emergency settings. It was then contextualized to the current circumstances of people in Ukraine. The questionnaire was designed and approved by the WHO Country Office in Ukraine and programmed into the CATI software by the Sociological group "Rating". The questionnaire was translated into Ukrainian and Russian, which are understood by over 99% of Ukraine's adult population. No back translation was performed for this project. However, during the pre-test review, several modifications were made to bring the translation closer to the original English meaning.

Round 1 aimed to obtain a complete picture of the level of access to health care throughout the active phase of the war with the Russian Federation. Therefore, the assessed period in Round 1 was set as 24 February to 9 September 2022, which was approximately 6 months. In Round 2 the assessed period was 3 months. This difference in time-frames probably influenced the distribution of answers to certain questions. The next rounds, including Round 5, also used a 3-month assessed period, and the data between rounds 2, 3, 4 and 5 are fully comparable.

Fieldwork

The Sociological group “Rating” is a nongovernmental and independent research organization that specializes in various types of sociological research in compliance with international standards, as approved by ESOMAR and World Association for Public Opinion research (WAPOR) codes.

Data for the assessment were collected in five rounds:

- Round 1 was conducted on 9–14 September 2022
- Round 2 was conducted on 5–17 December 2022
- Round 3 was conducted on 23–29 April 2023
- Round 4 was conducted on 28 September–5 October 2023
- Round 5 was conducted on 26 April–1 May 2024.

For Round 5, a total of 94 interviewers were initially recruited. All the interviewers had completed at least secondary-level education, and 92% were female. All the interviewers had more than six months of experience conducting telephone interviews, and all were trained before conducting the interviews. The average interview duration was 16.5 minutes. The field force size was 94 interviewers, three supervisors (audio control checkers), one coach and one field manager. Each supervisor performed daily monitoring of the appearance on phone lines, start and end times of interviews, and conducted daily selective listening to recordings of the interviews. According to the results of the checks, no deviations from the methodology were revealed.

Data management and analysis

The survey data obtained are weighted by regional (oblast of residence and type of settlement), gender, and age indicators using data from the State Statistics Service of Ukraine as of 1 January 2021. For regional distribution, weighting was based on the parameter “Where did you live before 24 February 2022?” This approach helps to assess the internal movement of Ukrainian people and to obtain an estimated picture of the current population structure based on the parameter “Where do you live now?”

During the analysis of Round 2 data, various weighting scenarios were examined:

- according to statistics as of the end of 2021
- according to Oxford University population estimates as of 15 September 2022
- without weighting.

The results for different weighting scenarios were not significantly different. Therefore, the decision was made to keep the weighting based on statistical data, as this ensures that the estimates are representative of the current population structure in each round.

After the data collection and quality control, the data were transferred to the WHO Country Office in Ukraine for processing via secure electronic channels in .csv and .sav format. The data are non-identifiable and are stored on password-protected computers. Only WHO Country Office in Ukraine research team members have access to the raw data. The study findings and data collected as part of this project belong to the WHO Country Office in Ukraine. WHO shall use the data in anonymized form to prepare considerations for national health authorities in Ukraine and other countries, for future research projects, and to share with WHO technical staff and partner organizations involved in the emergency response.

The data were analysed using the SPSS statistical package. During the first round of data collection, an automated script (code) was created to prepare the data analysis. Descriptive statistics were used to describe the results of the study. The 95% confidence interval was used to measure the accuracy of the estimated parameters and differences between target groups (macroregional and displacement status).

For Round 5, regional analysis involved updating the four macroregions studied in previous rounds, following government regulations set forth in Order No. 309 of the Ministry for Reintegration of the Temporarily Occupied Territories issued on 22 December 2022. Nine frontline regions were divided to form two macroregions: the most affected regions (Donetsk, Zaporizhzhia, Kharkiv, Kherson) and regions of increased vulnerability (Dnipropetrovsk, Mykolayiv, Odesa, Sumy, Chernihiv). Kyiv city was analysed separately as it usually differs from other regions, and the fourth macroregion included all other regions of Ukraine, which are less affected by war. To ensure accurate comparisons, this was also applied retrospectively to the data from the previous four rounds.

In this report, the target audience analysis focuses on two groups: IDPs and those who have remained in their home communities. Other target groups (based on type of settlement, age, sex and income level) are also important when assessing health needs. However, to maximize the focus on the impact of the war on the health-care system in Ukraine, this report is limited to analysis of these two groups. The Round 1 report provides a detailed analysis broken down by type of settlement, age, sex and income level.

Ethical considerations

This type of survey is generally regarded as low-risk research. However, people who are currently experiencing and fleeing war may be emotionally vulnerable and sensitive to certain topics. Therefore, many steps were taken to create a safe space for participants and to mitigate the impact of potential adverse reactions. Moreover, the study uses non-identifiable data about humans. The variables and information requested do not allow the identification of specific ethnic or disadvantaged population groups.

The interview questions were developed based on standardized questions for needs assessments in an emergency context, with sensitivity to the participants' emotional state.

Any potentially controversial or emotionally charged questions were avoided, as were questions about the participants' experiences during the war or displacement, except for those directly related to health service needs, access to health care or health-related experiences. Interviewers were also briefed on individual protection referrals to apply to cases where participants disclosed sensitive information and would require special support and services.

The study does not involve deception because participants were fully informed about the study before they agreed to participate. They are also debriefed at the end of the interviews, which means that they were given more information about the study and any potential risks involved. No physical or socioeconomic risks are associated with participation in this study and no adverse events are foreseen.

Participation in this study is strictly voluntary. Only participants who provided informed consent were included. Participants were informed that leaving the interview at any time posed no danger or risk to themselves or their loved ones. Informed consent is obtained before the questionnaire begins and includes consent to participate in the research.

The data collection instrument is not designed to collect personally identifiable information, and none is collected as part of the research. If participants disclose such information during, before or after the interview, it will be redacted from all study-related documents.

Participant surveys are assigned a unique code that cannot be traced back to specific respondents. This safeguards the confidentiality of participants. The code is generated at random and is not associated with any participant-specific information.

Participants are provided with the contact information of a researcher at the WHO Country Office in Ukraine to contact if they require clarification about the study, have any questions or concerns, or would like to be kept informed of research outcomes.

Participation in this study raises no or minimal ethical concerns. The data collected are anonymized and participation is voluntary. The study protocol has been submitted and approved by the institutional review board of the charitable organization the Ukrainian Institute on Public Health Policy (Federalwide Assurance number 00029648). Additionally, ethical clearance has been obtained from the WHO Research Ethics Review Committee (WHO ERC) because the research is based on the collection of nonsensitive anonymous data, which are exempt from ERC review.

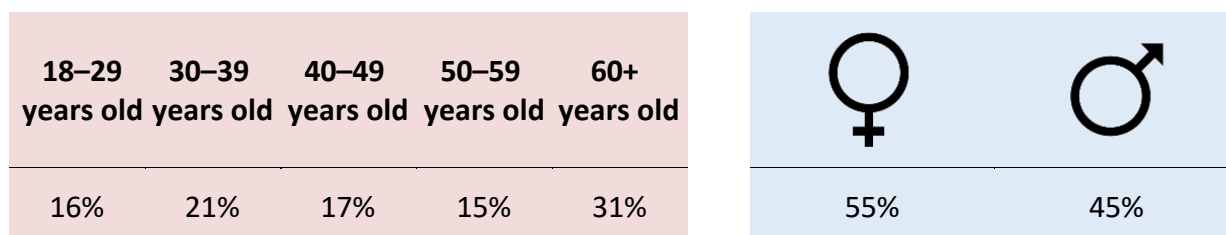
Prior to data collection, informed consent is obtained from all participants. Respondents are provided with information about how their data will be processed during the study, in accordance with the General Data Protection Regulation and national laws on personal data protection. The information notice is available upon request, and respondents can review it before providing their consent to participate. Participant consent is also obtained for the discussion to be recorded (for quality control purposes).

As part of the informed consent process, respondents are informed that they may withdraw at any time and that doing so will not result in any penalty or affect the health care or other services they receive. They are informed that they may withdraw their consent to the use of their data before the end of the call.

Section 1. Portrait of the respondents

In April 2024, during Round 5 of data collection, a total of 4000 respondents were interviewed. The geographical and gender distribution were consistent with national demographic statistics, with 68% living in urban areas and 32% in rural areas, and with 45% male and 55% female.

In the household composition data, 36% of households included members aged 65 years or older, and 35% had chronic conditions. Children under 18 years of age were present in 37% of households, and 3% of households included pregnant or lactating women.

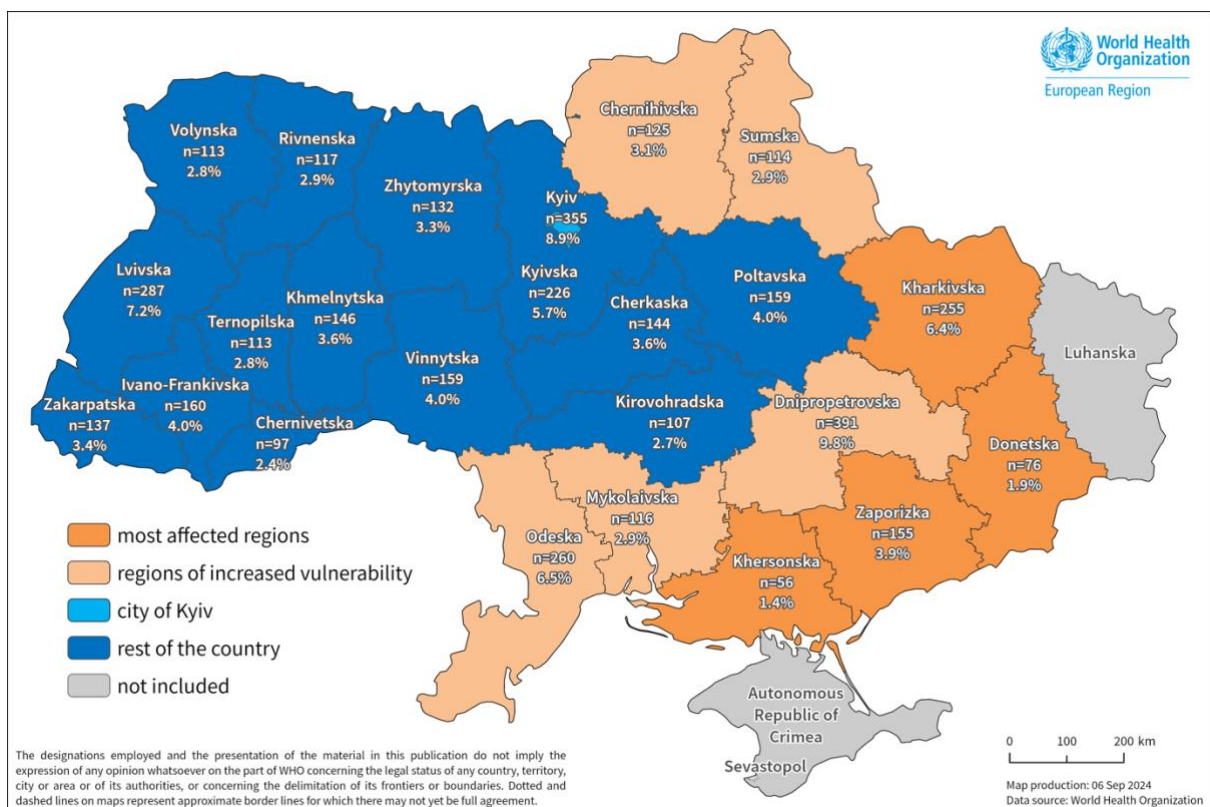


The survey reached households from all oblasts, except the Luhansk oblast and the Autonomous Republic of Crimea. The number and proportion of respondents from each oblast is shown in Fig. 1.1, and Fig. 1.2 shows the number and proportion of respondents in each of the four macroregions (the most affected regions, the regions of increased vulnerability, the city of Kyiv, and the rest of the country).

Fig. 1.1. Respondents by oblast



Fig. 1.2. Respondents by oblast status



The migration of Ukrainians within and outside Ukraine has been constant since the start of the war on 24 February 2022. In April 2024, 19% of respondents indicated that they had moved since the start of the war (Table 1.1). Furthermore, 70% of these respondents indicated that the move was caused directly by the war. Of those who have changed their place of residence since the start of the war, 68% moved more than 12 months ago, 15% moved 6–12 months ago, and 8% moved 3–6 months ago. Of note, 7% indicated that they had moved in the past 3 months. More than a half (54%) have official IDP status, which was received after February 2022.

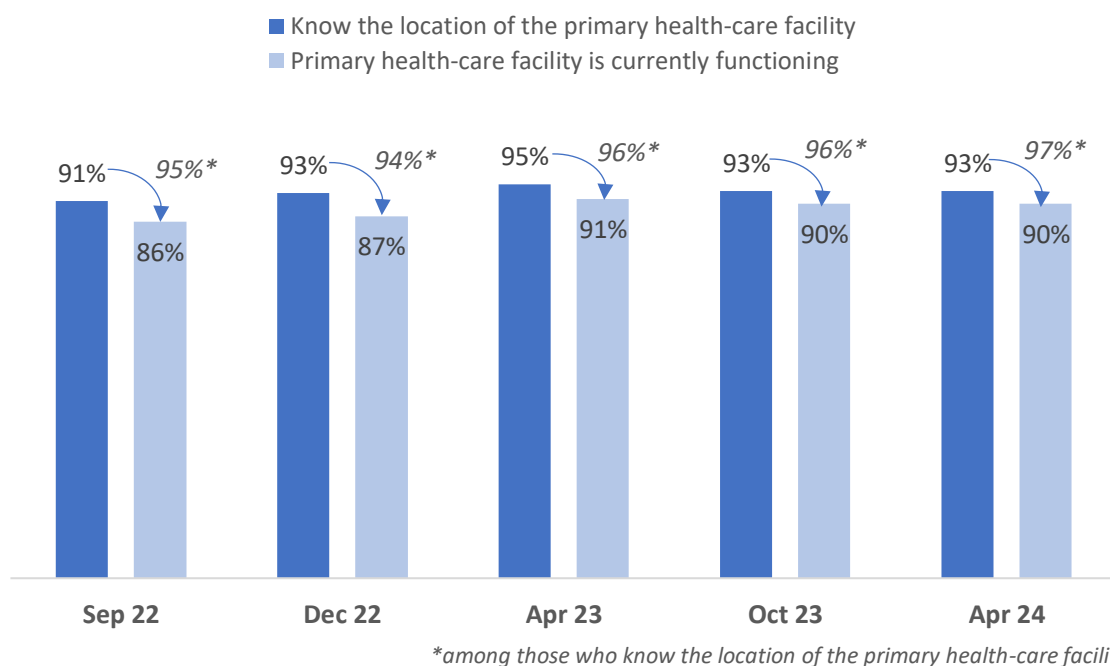
Table 1.1. Proportion of respondents who have been internally displaced

Place of residence	Sep 22	Dec 22	Apr 23	Oct 23	Apr 24
Live in the same place	82.1%	83.7%	81.8%	79.9%	80.8%
Moved after 24 February 2022	17.9%	16.3%	18.2%	20.1%	19.2%

Section 2. Access to primary health care and a family doctor

In April 2024, the questions related to awareness of primary health-care facilities and their current status of functionality had not changed since the previous round of data collection in December 2023. Awareness remained high, with nearly all households (93%) knowing the location of their primary health-care facility, and 97% of those who knew the location reporting that it was functioning (Fig. 2.1).

Fig. 2.1. Proportion of households that know the location and functioning of their primary health-care facility



IDPs remain more vulnerable: 13% reported that they did not know the location of their primary health-care facility compared with 6% of local communities. Moreover, among IDPs who have moved in the past 3 months, 32% indicated no awareness of the location of their primary health-care facility. However, IDPs adapt over time, and among IDPs who relocated 6–12 months ago and more than 12 months ago the proportion who did not know the location of their primary health-care facility had decreasing to 16% and 9%, respectively (Table 2.1).

Table 2.1. Access to a primary health-care facility

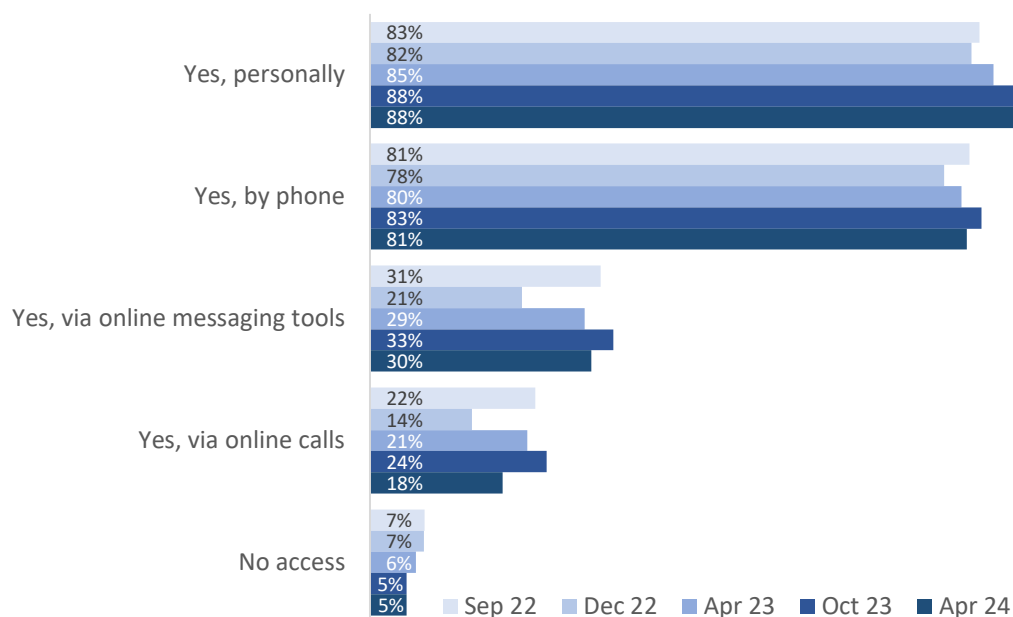
Respondent residence status	Did not know location of primary health-care facility
Host communities	6%
IDPs	13%
Relocated 3 months ago or less	32%
Relocated 3–6 months ago	22%
Relocated 6–12 months ago	16%
Relocated more than 12 months ago	9%

Over 50% of respondents indicated that the travel time to their primary health-care facility was within 15 minutes. However, 13% of respondents reported that their journey took more than 30 minutes. The median time to get to the primary health-care facility was 15 minutes. Regarding the mode of transportation, nearly half (44%) of the respondents could reach the facility on foot, while the remaining respondents relied on either public (22%) or private transportation (26%).

Predictably, in rural areas, the travel time to primary health-care facilities was significantly longer than that in urban areas. In rural areas, 20% of respondents required more than 30 minutes to reach a primary health-care facility, comparing with 10% in oblast centres and 8% in other cities. Additionally, 34% of respondents from rural areas could travel to the facility on foot, compared with 50% in oblast centres and 47% in other cities.

Access to a family doctor remained unchanged in April 2024, with only 5% of households reporting that they did not have access to a family doctor. An additional 7% of respondents do not have the opportunity to visit their family doctor in person although they have a remote connection. However, there was a significant decrease in the households' ability to contact their family doctor through remote channels such as phone or online tools (Fig. 2.2).

Fig. 2.2. Access to a family doctor



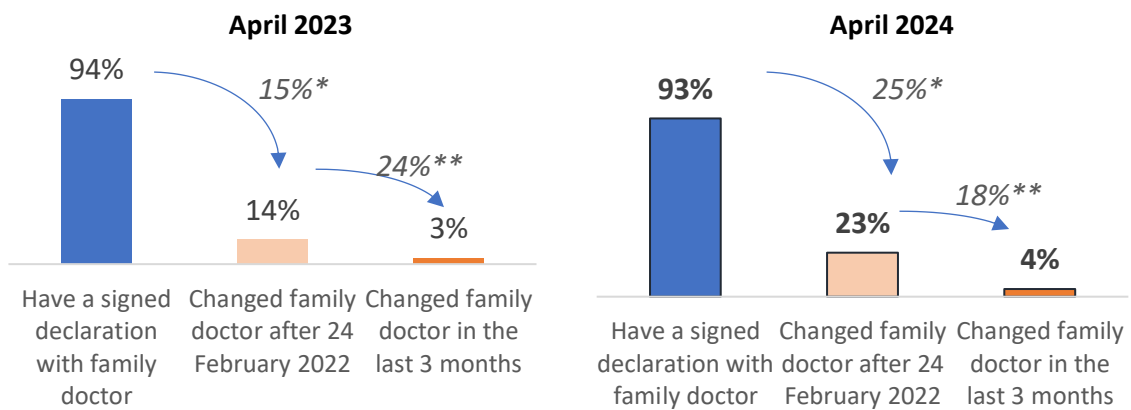
In terms of geographical breakdown, a significantly higher share of respondents from Kyiv city (10%) and most affected regions (9%) had no access to a family doctor compared with 5% in the regions with increased vulnerability and 3% in the rest of the country. Eleven percent of IDPs reported no access to a family doctor compared with 4% for local populations (Table 2.2).

Table 2.2. No access to a family doctor

Respondent residence status	No access to a family doctor
Host communities	4%
IDPs	11%
Relocated 3 months ago or less	25%
Relocated 3–6 months ago	9%
Relocated 6–12 months ago	5%
Relocated more than 12 months ago	9%

In April 2024, the survey team reused the set of questions about declarations signed with family doctors that was used in April 2023. Ninety-three per cent of households have signed a declaration with a family doctor. Of those who have signed a declaration, 25% have changed family doctors since 24 February 2022, which is a significant increase compared with 15% in April 2023. Furthermore, 18% of households who have changed family doctors since 24 February 2022 have done so in the past 3 months (Fig. 2.3).

Fig. 2.3. Experience of changing a declaration with a family doctor



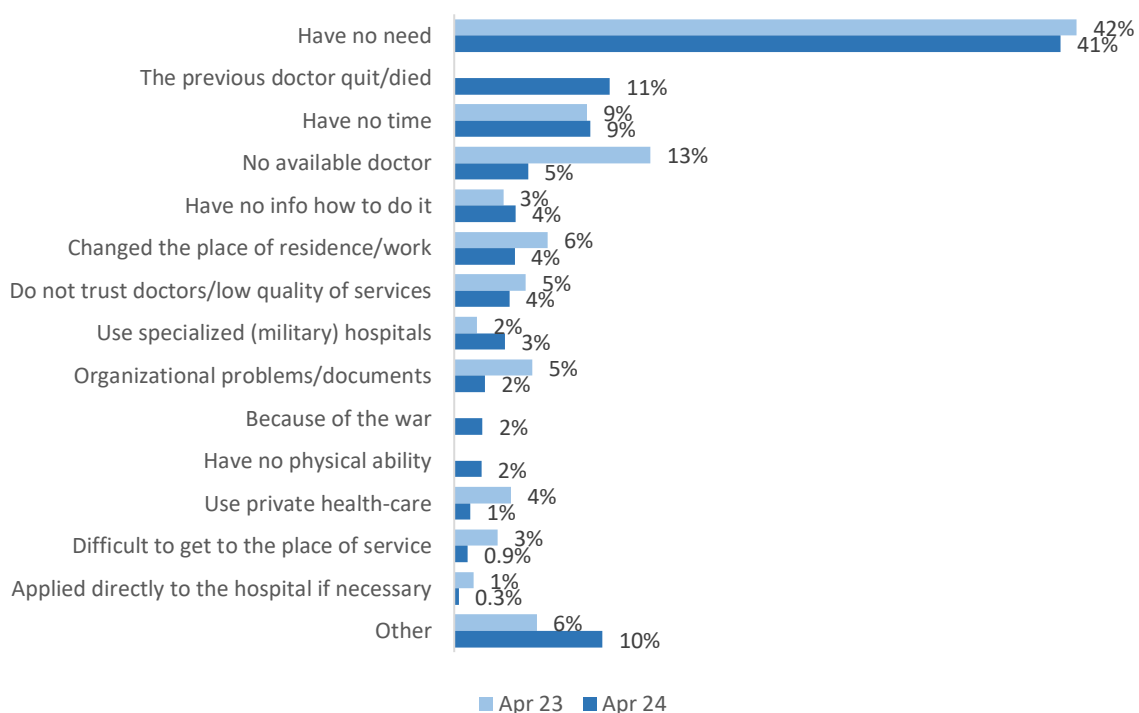
**among those who have a signed declaration with a family doctor*

***among those who changed family doctor after 24 February 2022*

Among IDPs, the proportion of individuals who have a signed health-care declaration is significantly lower (89%) than for local communities (94%), particularly among those who have recently relocated. Specifically, 25% of recent movers reported the absence of a signed declaration.

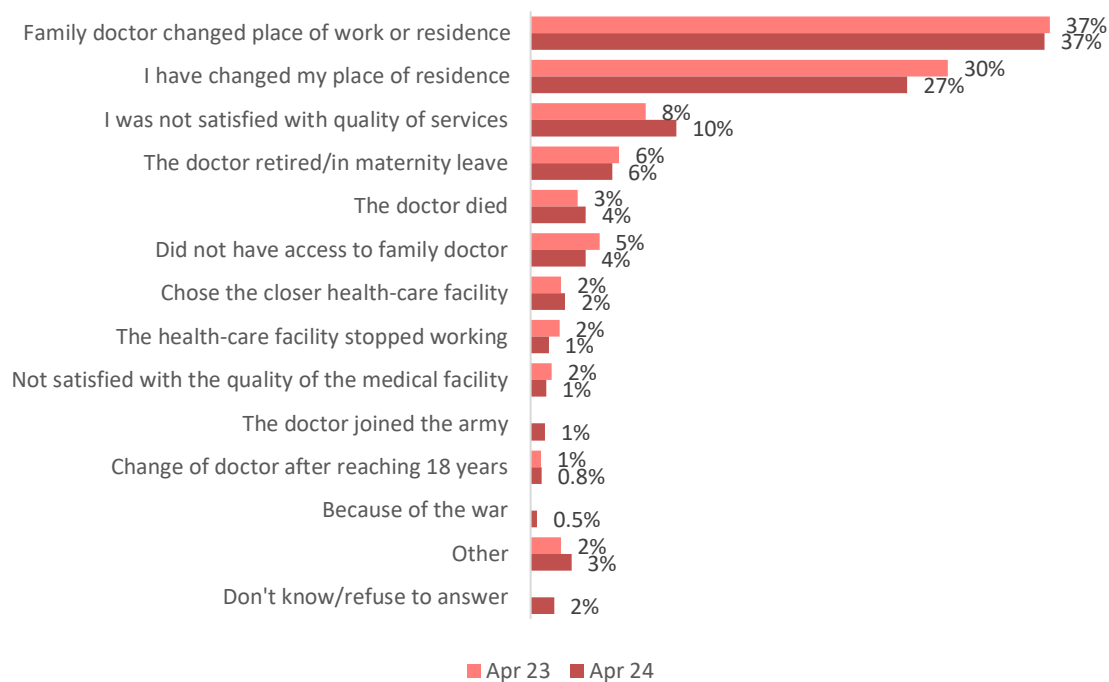
The primary reasons for not having a signed declaration with a family doctor are cited as a lack of necessity or time. Additionally, 5% of respondents indicated the unavailability of a doctor in their area, and 4% reported being unaware of the process to obtain one (Fig. 2.4).

Fig. 2.4. Reason for not having signed a declaration with a family doctor (among those who do not have a signed declaration)



The primary reasons for changing family doctors were changes in the workplace or residence by either the family doctor or the respondent (Fig. 2.5). Furthermore, 10% of respondents who changed doctors did so because of dissatisfaction with the quality of services. Additionally, 7% of respondents encountered problems when changing their family doctor. Most of these issues were related to the unavailability of a doctor for a new declaration.

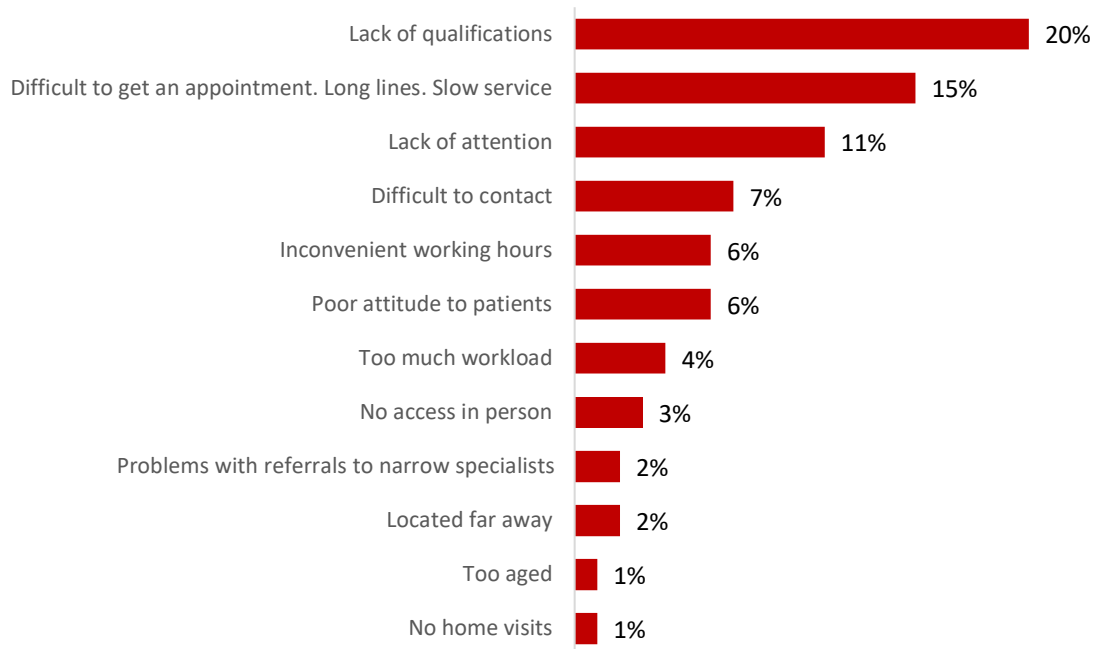
Fig. 2.5. Main reasons for changing family doctors (among those who changed family doctors since 24 February 2022)



In April 2024, a set of questions related to being satisfied or unsatisfied with the family doctor with whom the respondent had a signed declaration was added. According to the results, almost two thirds of the respondents (63%) were completely satisfied with their family doctor, 22% were generally satisfied, only 5% rated their satisfaction below average, and 7% did not know or refused to answer.

The main reasons among those who were not completely satisfied with their family doctor included a lack of qualifications (20%), difficulty in getting an appointment (15%) and a lack of attention (11%) (Fig. 2.6).

Fig. 2.6. Reasons to be unsatisfied with the family doctor*



**Among those who were not fully satisfied with their family doctor*

In this round, we asked why IDPs who did not change their family doctor after relocation chose to retain their existing doctor. The majority indicated that they had no need to change and were satisfied with their current doctor and maintained a remote connection (Fig. 2.7). Only 1% cited external barriers, such as the absence of an available doctor.

Additionally, we asked local citizens without access to a family doctor about their reasons for not signing a new declaration. Most respondents stated that they lacked the physical ability to visit a doctor, despite the availability of some home visits (Fig. 2.8). A significant portion also reported no perceived need for a new declaration. Furthermore, 4% of respondents indicated nonavailability of family doctors.

Fig. 2.7. The reasons why IDPs did not change their family doctor after relocation

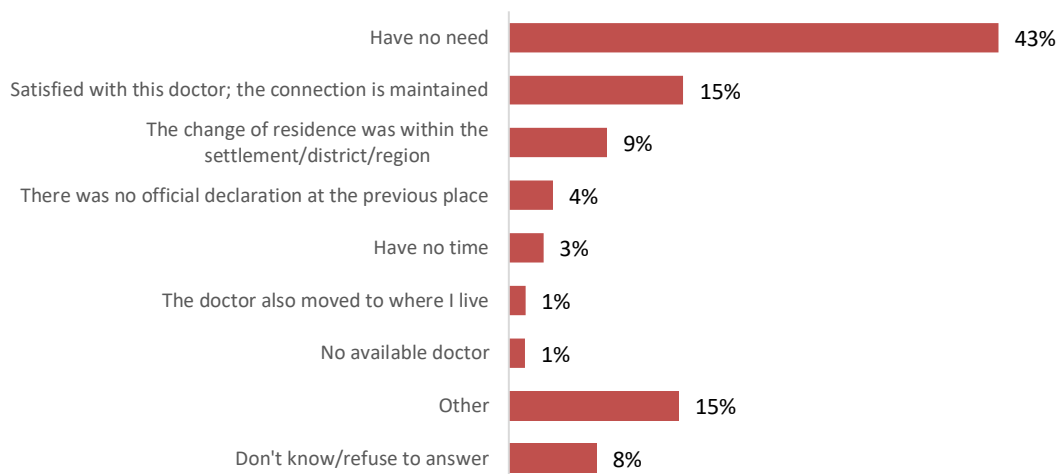
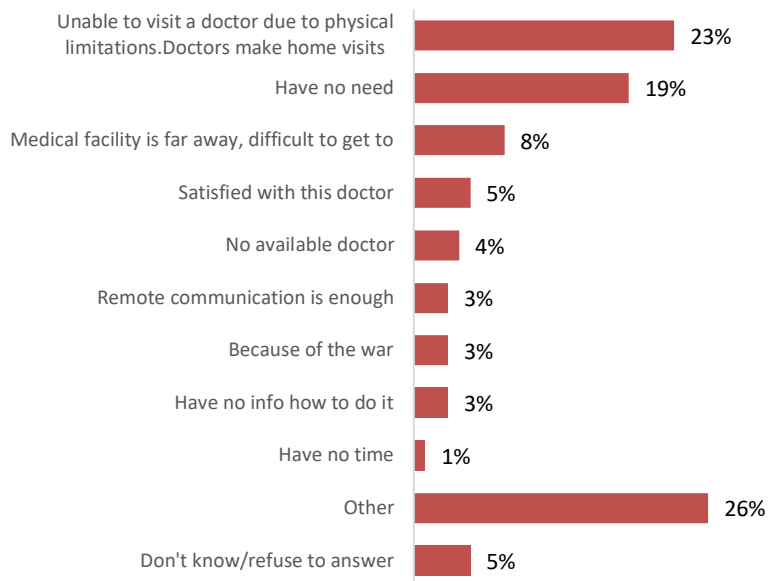


Fig. 2.8. The reasons why local communities without access to a family doctor did not sign a new doctor declaration



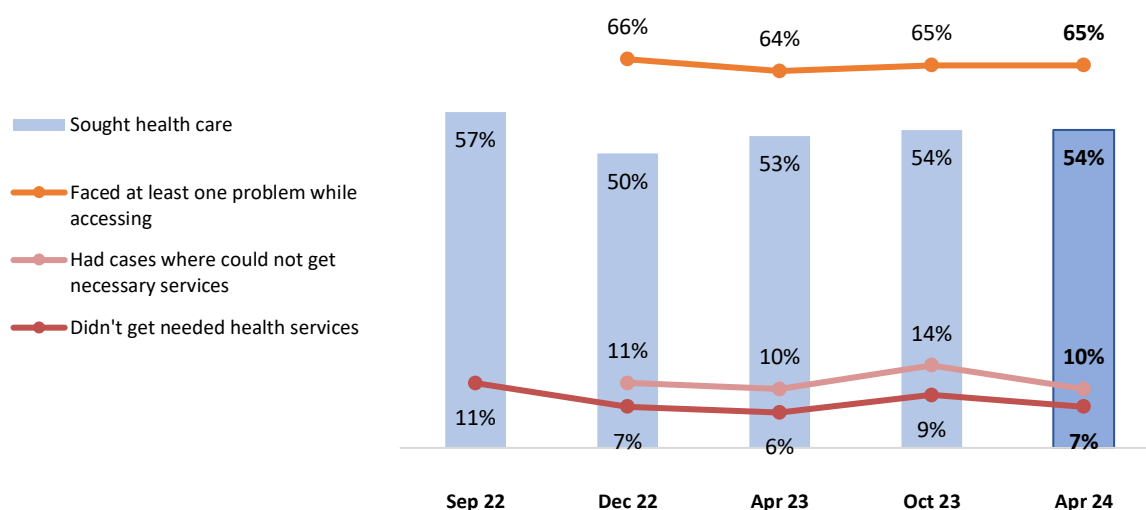
Section 3. Access to health-care

Changes in health-care access

In April 2024, the overall accessibility of health care services remained relatively stable. Approximately 54% of respondents reported needing some form of medical assistance. Among those seeking health care, 65% encountered at least one issue while attempting to receive services. Notably, 10% of individuals who sought health care experienced situations where they were unable to access necessary services, and 7% were completely unable to obtain any services. These represent a significant improvement compared to October 2023, when 14% and 9% of households, respectively, faced such challenges (Fig. 3.1).

Furthermore, it is important to highlight the regional disparities in access to health care. In frontline regions, particularly in the most affected areas, a significantly lower percentage of respondents attempted to access medical care compared to other regions, with 46% and 57% of respondents, respectively, seeking medical services.

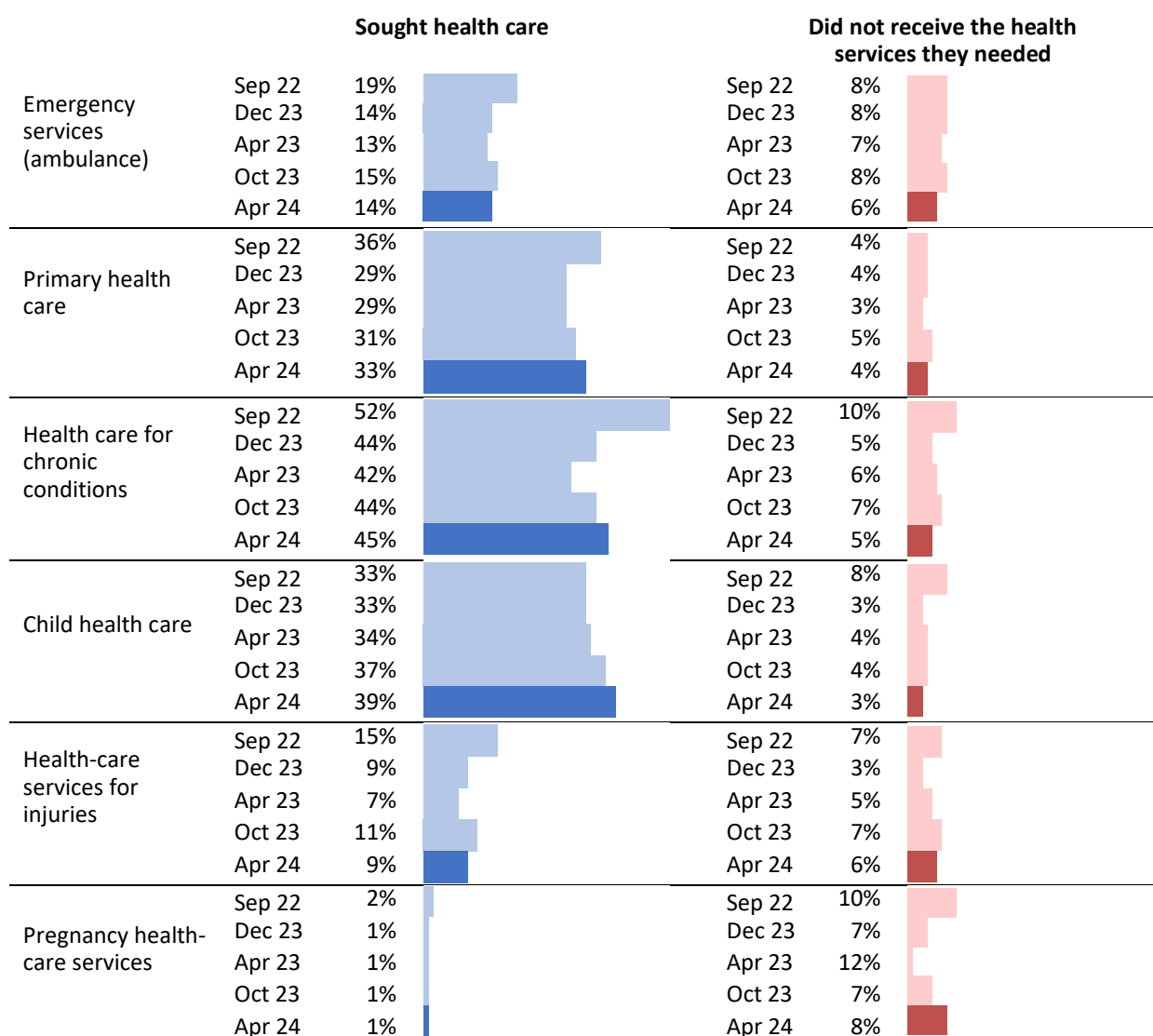
Fig. 3.1. Dynamics of access to general health care services



As in the previous round, most households sought care for chronic diseases (45%) and primary health care (33%) (Fig. 3.2). Among respondents with children, more than one third (39%)

needed paediatric care. Access to all health services remained unchanged, ranging from 92% to 97%, depending on the type of service.

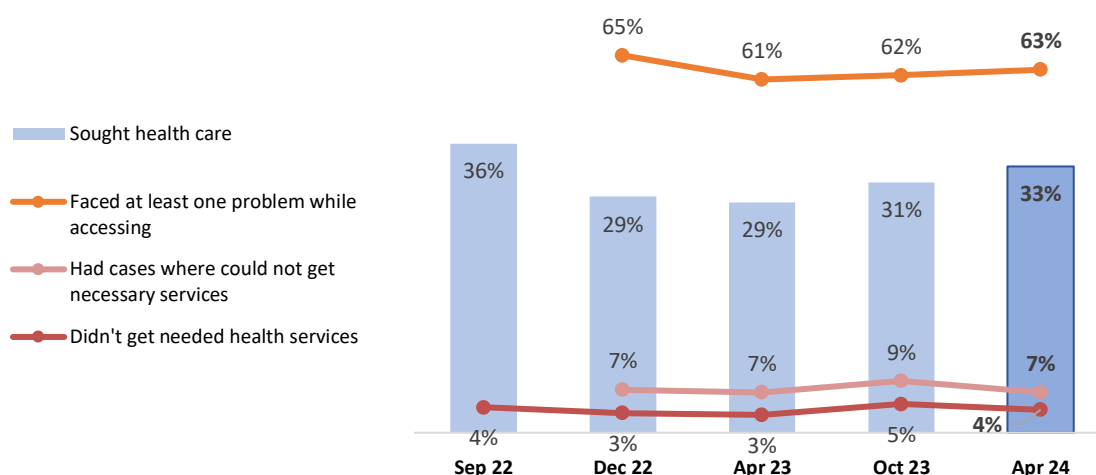
Fig. 3.2. Dynamics of access to health care



Primary health care

The level of access to primary care in April 2024 did not differ significantly from that in the previous rounds. Thirty-three per cent of households sought primary health-care services in the 3 months prior to the survey (Fig. 3.2). Of these, 63% reported encountering at least one barrier to access. Seven per cent of households reported encountering situations in which they were unable to receive needed primary health-care services, and 4% were unable to access any primary care services.

Fig. 3.2. Dynamics of access to primary health care



In October 2023, the most commonly reported problems while accessing health care were the cost of medicines, followed by the cost of treatment and the time needed to access services, and the findings had been similar in April 2023. In April 2024, compared with October 2023, the percentage of households indicating that the cost of treatment was a problem significantly decreased from 28% to 22% (Fig. 3.3). The proportion of respondents who faced problems due to unofficial payments also decreased from 11% in October 2023 to 6% in April 2024.

The main barriers that led to not receiving services in April 2024 were different from those in October 2023. In April 2024, the most common barrier hindering households from accessing primary health care were the refusal to provide services (17%) and the unavailability of services (13%) (Fig. 3.4). Another important barrier was the time to receive the services.

Fig. 3.3. Problems when seeking primary care services

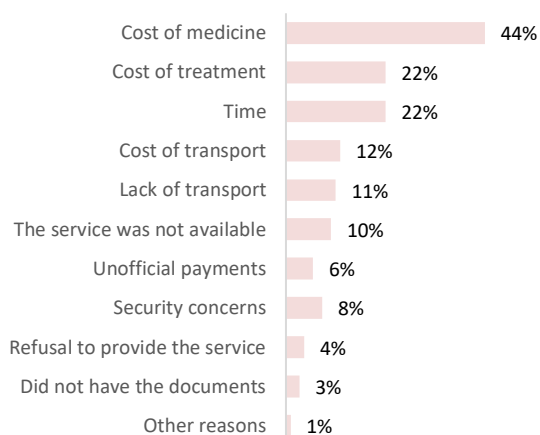
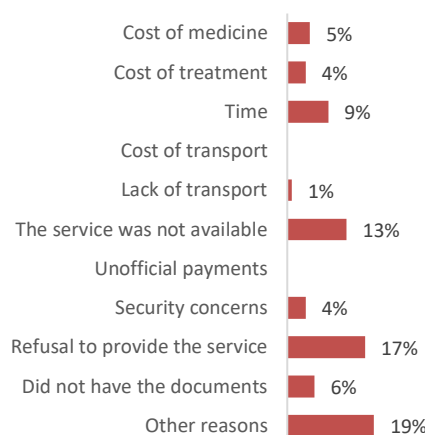


Fig. 3.4. Main barriers to access to primary care



In the current round, no significant differences were found between IDPs and local communities in terms of access to primary health care, as 6% of IDPs and 7% of local communities indicated cases of primary health-care services not being received. However,

IDPs were more likely to report challenges involving time (26%) and unavailability of services (12%) than local communities (21% and 9%, respectively). Moreover, time as the main barrier to accessing primary health care was significantly higher among IDPs (33%) than among local communities (4%).

Households from the most affected regions (26%) and regions with increased vulnerability (31%) sought primary health care significantly less than those in the rest of the country (36%). In April 2024, the share of households who had cases when household members could not get necessary primary health-care services was significantly higher in the most affected regions (12%) than in the rest of the country (6%). Seven per cent of households in the most affected regions did not receive the primary health-care services they needed, compared with 4% in the rest of the country (Table 3.1).

Table 3.1. Access to primary health care by region type

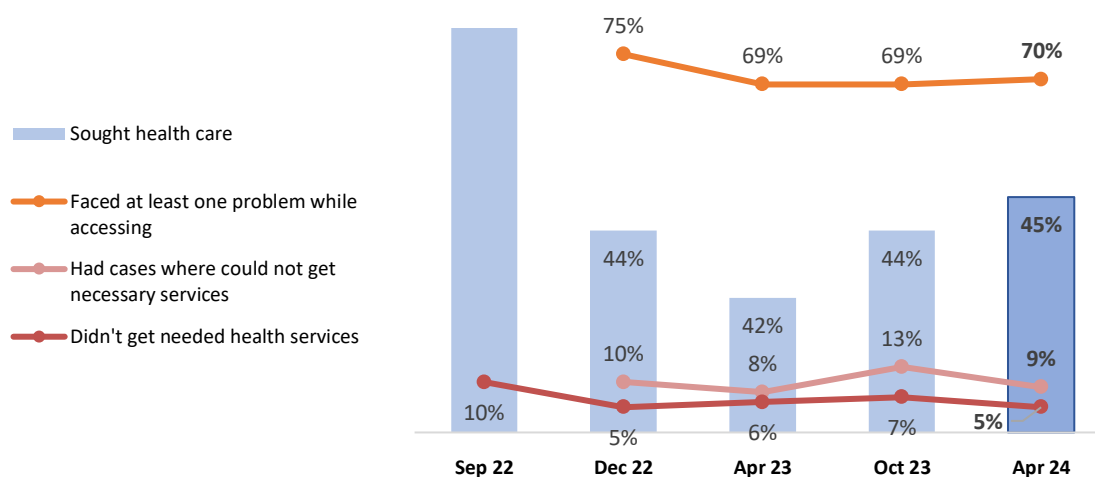
		Sought health care	Faced at least one problem when accessing	Instances where they could not receive the necessary services	Did not receive the health services they needed
The most affected regions	Sep 22	27%	--	–	7%
	Dec 22	23%	72%	6%	1%
	Apr 23	20%	61%	9%	4%
	Oct 23	26%	65%	12%	9%
	Apr 24	26%	71%	12%	7%
Regions with increased vulnerability	Sep 22	34%	56%	–	4%
	Dec 22	27%	72%	8%	4%
	Apr 23	26%	67%	8%	2%
	Oct 23	31%	61%	8%	5%
	Apr 24	31%	65%	6%	3%
City of Kyiv	Sep 22	41%	–	–	5%
	Dec 22	28%	62%	10%	4%
	Apr 23	35%	58%	8%	3%
	Oct 23	31%	66%	9%	6%
	Apr 24	34%	68%	10%	6%
Rest of the country	Sep 22	38%	–	–	4%
	Dec 22	32%	62%	7%	3%
	Apr 23	31%	60%	6%	4%
	Oct 23	31%	62%	8%	5%
	Apr 24	36%	60%	6%	4%

In this round, problems related to security were significantly higher among households residing in the most affected regions (15%) and regions of increased vulnerability (10%) compared with the rest of Ukraine (5%). Unavailability of services was also more prevalent in the most affected regions (16%) than the rest of the country (8%).

Health care for chronic conditions

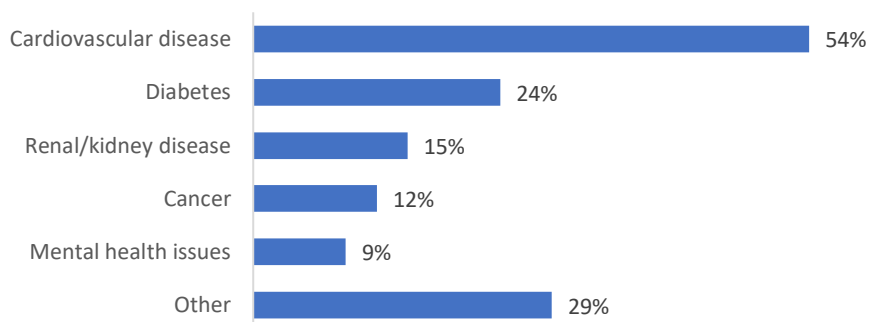
In April 2024, 35% of all households reported having a family member with a chronic condition. Forty-five per cent of those who reported having family members with chronic diseases sought health care for their condition in the 3 months prior to the survey (Fig. 3.5).

Fig. 3.5. Dynamics of access to care for a chronic condition



Respondents sought assistance for 54% of family members with cardiovascular diseases and 24% of members with diabetes (Fig. 3.6). Of the individuals with chronic conditions, 78% received care at home while 33% received inpatient care.

Fig. 3.6. Chronic conditions for which respondents sought care



Seventy per cent of those seeking treatment for a chronic condition faced at least one problem. Most households (55%) who sought care indicated that the cost of medicines was their greatest challenge (Fig. 3.7). The cost of treatment (29%), time (21%) and transport challenges (17% for cost of transport and 15% for lack of transport) were also significant problems. Compared with the October 2023 round, a significant decrease in the need for unofficial payments was reported (13% to 7%).

Nine cent of households reported instances when they were unable to receive health services for their chronic condition. Five per cent of households were entirely unable to receive necessary services. The primary barriers to health-care access for chronic conditions were the

unavailability of the services needed (21%), the cost of medicines (18%) and the cost of treatment (13%) (Fig. 3.8).

Fig. 3.7. Problems when seeking health care related to a chronic condition

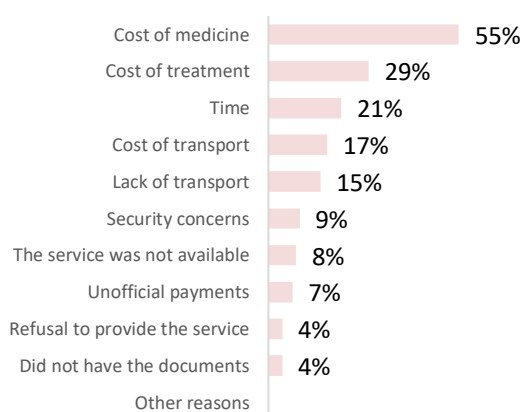
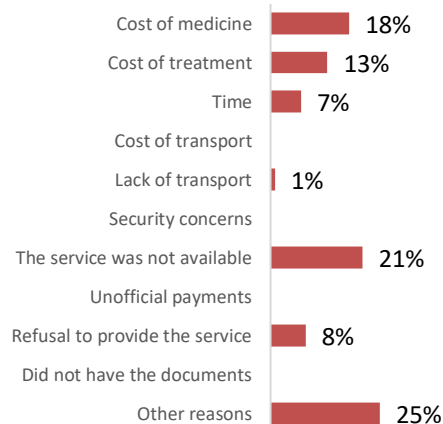


Fig. 3.8. Main barriers to access to health care related to a chronic condition



Among IDPs, the proportion who were unable to access the services they needed decreased compared with the previous round, from 27% to 7% (Table 3.2).

Table 3.2. Access to health care related to a chronic condition by displacement status

		Sought health care	Faced at least one problem when accessing	Instances where they could not receive the necessary services	Did not receive the health services they needed
IDPs	Sep 22	49%	–	–	11%
	Dec 22	42%	80%	14%	7%
	Apr 23	41%	79%	11%	7%
	Oct 23	38%	78%	27%	12%
	Apr 24	45%	73%	7%	5%
People in their home communities	Sep 22	53%	–	–	10%
	Dec 22	44%	74%	10%	5%
	Apr 23	43%	67%	8%	6%
	Oct 23	45%	68%	10%	6%
	Apr 24	45%	70%	10%	5%

There were no significant differences in terms of the share of households who sought health care for chronic conditions at the macroregional level. In April 2024, 43% of households in the most affected regions sought care for chronic conditions and 77% of them faced at least one problem accessing health care (Table 3.3). However, security concerns were significantly higher in the most affected regions (18%) than the rest of the country (7%).

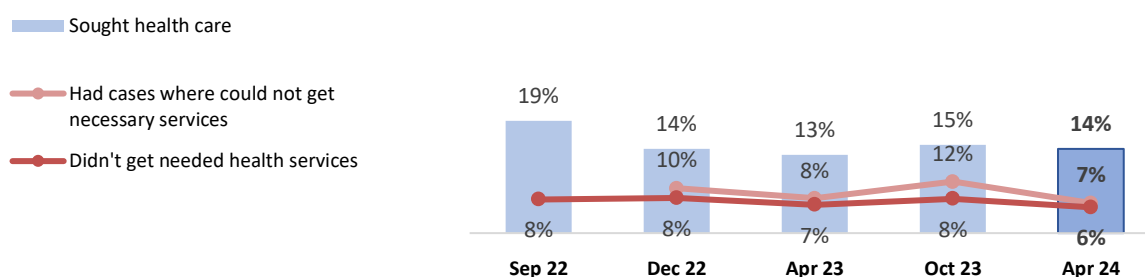
Table 3.3. Access to health care related to a chronic condition by region

		Sought health care	Faced at least one problem when accessing	Instances where they could not receive the necessary services	Did not receive the health services they needed
The most affected regions	Sep 22	38%	–	–	14%
	Dec 22	40%	82%	8%	3%
	Apr 23	34%	69%	9%	6%
	Oct 23	41%	68%	13%	6%
	Apr 24	43%	77%	7%	4%
Regions of increased vulnerability	Sep 22	47%	–	–	7%
	Dec 22	43%	70%	15%	5%
	Apr 23	41%	71%	12%	8%
	Oct 23	34%	70%	11%	6%
	Apr 24	43%	66%	8%	4%
City of Kyiv	Sep 22	56%	–	–	6%
	Dec 22	44%	73%	10%	5%
	Apr 23	41%	79%	10%	10%
	Oct 23	49%	69%	16%	8%
	Apr 24	42%	66%	14%	6%
Rest of the country	Sep 22	57%	–	–	11%
	Dec 22	45%	76%	9%	6%
	Apr 23	46%	67%	6%	5%
	Oct 23	48%	70%	13%	7%
	Apr 24	47%	72%	10%	6%

Emergency (ambulance) service

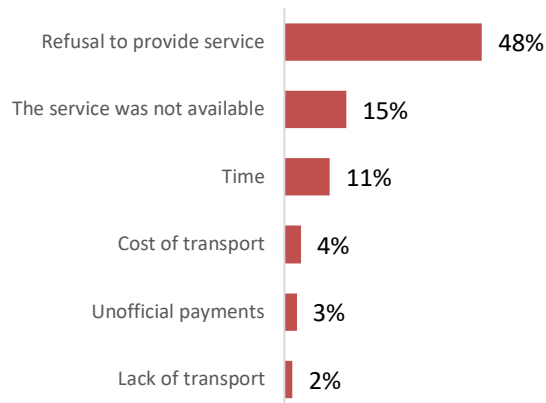
In April 2024, access to emergency medical assistance (ambulance services) remained stable and unchanged from the previous round, with 15% and 14% seeking emergency services in October 2023 and April 2024, respectively (Fig. 3.9). Of these, 7% were unable to obtain the services they needed, which is a significant decrease from 12% in October 2023. Furthermore, 6% did not receive any of the services they needed.

Fig. 3.9. Dynamics of access to emergency medical services



The leading cause of lack of access to services was refusal to provide services, as reported by 48% of those who could not receive the services, followed by nonavailability of emergency services (15%) (Fig. 3.10).

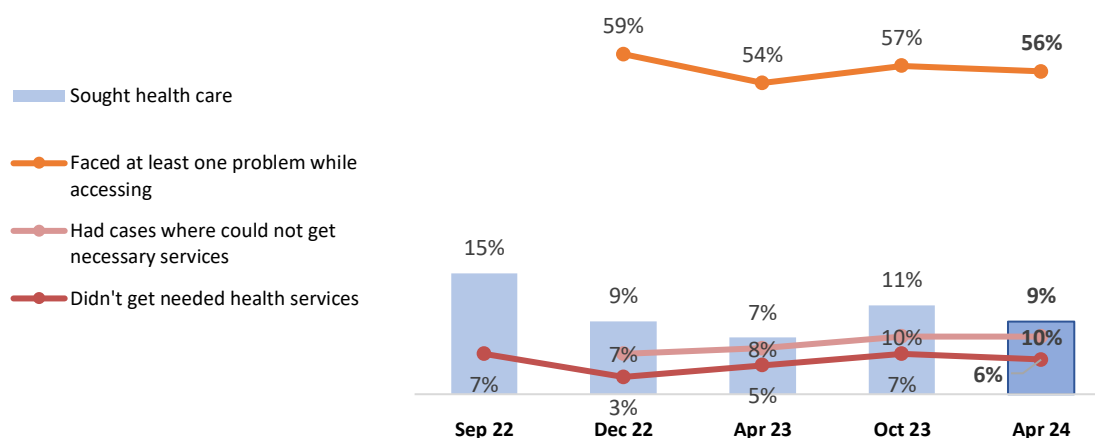
Fig. 3.10. Main barriers to access to emergency medical services



Health-care services for injuries

In April 2024, 9% of households reported seeking medical care for injuries in the 3 months prior to the survey (Fig. 3.11), which is significantly lower than the 11% reported in the previous round in October 2023. More than half (56%) of those who sought medical care in the current round reported encountering at least one problem.

Fig. 3.11. Dynamics of access to health-care services for injuries



The main problems with accessing services for injuries were the cost of medicines (35%) and the cost of treatment (23%) (Fig. 3.12). In April 2024, 10% of households cited issues associated with unofficial payments, which represents a decrease from 16% in October 2023. Additionally, 10% of households faced instances in which they were unable to access the services they sought, and 6% received no services at all. Problems related to unavailability of services and refusals were significantly lower than in the previous round, with 6% and 4%, respectively, in April 2024 versus 13% and 9%, respectively, in October 2023.

The cost of medicines (10%), lack of needed documents (10%) and refusals to provide services (16%), were the leading barriers to accessing health services related to injuries (Fig. 3.13).

Fig. 3.12. Problems when seeking health-care services for injuries

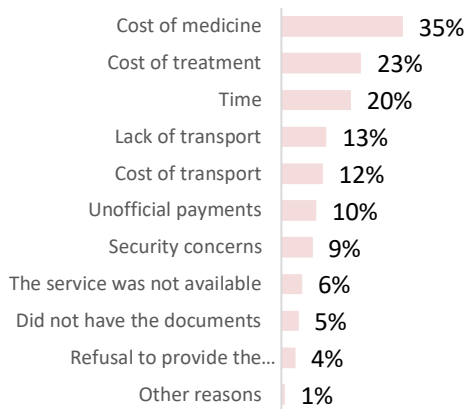
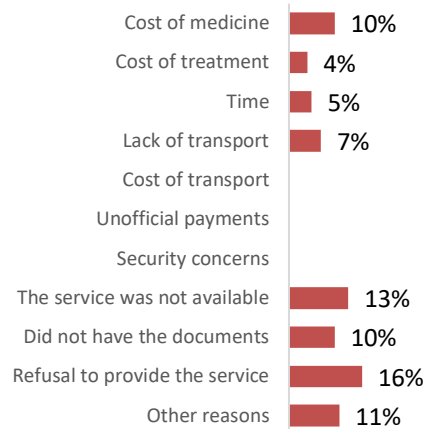


Fig. 3.13. Main barriers to access to health-care services for injuries

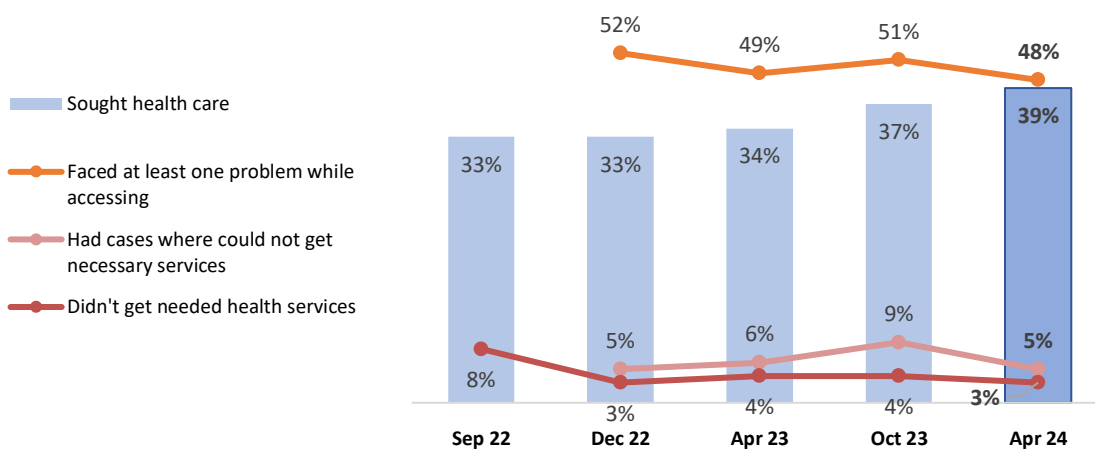


No differences were observed between IDPs and people in their local communities.

Health care for a child

More than one third (39%) of households that included a child sought medical care for the child in the 3 months prior to the survey (Fig. 3.14).

Fig. 3.14. Dynamics of access to health care for a child



Of the households that sought health care for a child, 48% encountered at least one problem. The most significant of which were the cost of medicines (31%), the time required to reach the services (17%) and the cost of treatment (11%) (Fig. 3.15). Five per cent of those who sought medical care for a child were unable to obtain the necessary services. Refusals (17%) and lack of availability (10%) of services were the primary barriers (Fig. 3.16). Three per cent of households that sought medical care for their children did not receive any services.

Fig. 3.15. Problems when seeking health care for a child

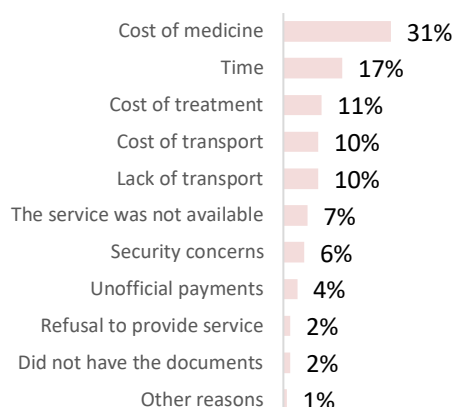
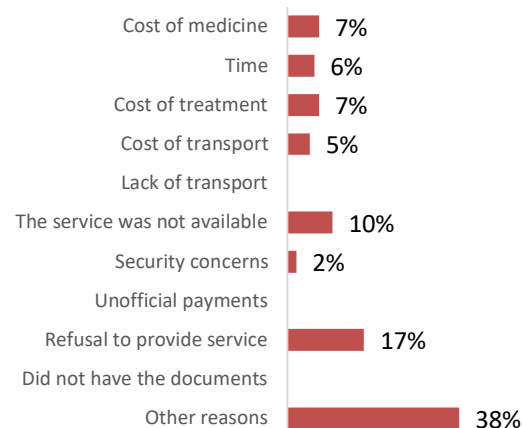


Fig. 3.16. Main barriers to access to health care for a child



Among IDPs and those who remained in their local communities, no differences were observed in terms of access to health care for children. Households from the most affected regions (27%) and regions of increased vulnerability (34%) sought significantly less health care for children compared with the rest of the country (44%) (Table 3.4).

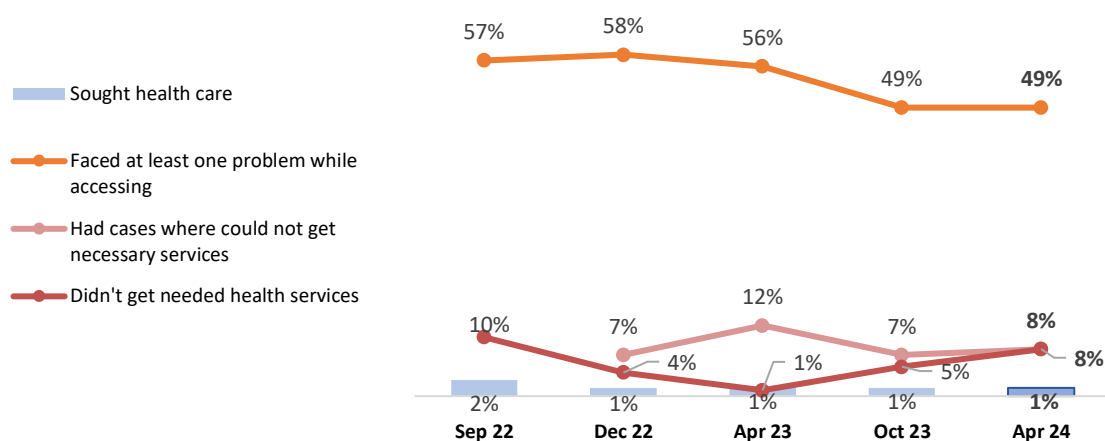
Table 3.4. Access to health care for a child by region

		Sought health care	Faced at least one problem when accessing	Instances where they could not receive the necessary services	Did not receive the health services they needed
The most affected regions	Sep 22	31%	–	–	8%
	Dec 22	20%	59%	2%	2%
	Apr 23	20%	60%	9%	6%
	Oct 23	25%	53%	2%	0%
	Apr 24	27%	51%	6%	1%
Regions of increased vulnerability	Sep 22	31%	–	–	5%
	Dec 22	27%	66%	9%	2%
	Apr 23	31%	52%	6%	5%
	Oct 23	30%	48%	10%	4%
	Apr 24	34%	41%	3%	2%
City of Kyiv	Sep 22	32%	–	–	2%
	Dec 22	32%	53%	0%	0%
	Apr 23	27%	61%	7%	0%
	Oct 23	42%	58%	11%	6%
	Apr 24	36%	67%	9%	7%
Rest of the country	Sep 22	35%	–	–	10%
	Dec 22	38%	47%	5%	4%
	Apr 23	37%	46%	5%	4%
	Oct 23	41%	50%	9%	4%
	Apr 24	44%	48%	6%	3%

Pregnancy health-care services

In April 2024, as in previous rounds, in the 3 months prior to the survey, only 1% of households sought pregnancy-related health services (Fig. 3.17). Of these, 49% encountered at least one problem when receiving care. The main problems were the cost of medicines (30%), the cost of treatment (14%) and time (17%). Eight per cent of those who sought pregnancy health-care services experienced situations where they were unable to receive services, and 8% did not receive any services.

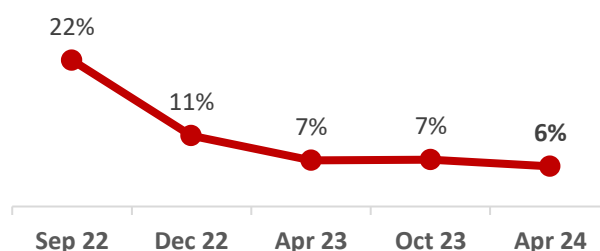
Fig. 3.17. Dynamics of access to prenatal health-care services



Section 4. Access to medicines

In this round in April 2024, the level of access to medicines remained unchanged, with 6% of households reporting that they had been unable to obtain the medications they needed in the past 3 months and almost all households (81%) face problems in obtaining necessary medicines (Fig. 4.1). Conversely, issues related to the operation of pharmacies have decreased in relevance, including closures, long lines and shortages of medicines. Similarly, the proportion of respondents encountering problems with prescriptions has also declined.

Fig. 4.1. Share of households that could not obtain necessary medicines



The breakdown by IDP status or at the macroregional level did not show any significant differences since the last round of data collection in October 2023 (Table 4.1). The latest data indicate that IDP status and the time since the last move does not affect access to medicines.

Table 4.1. Households that could not obtain necessary medicines by IDP status and region

	IDPs	People in their home communities	Most affected	Increased vulnerability	Kyiv city	Rest of the country
Sep 22	29%	20%	32%	28%	25%	16%
Dec 22	12%	10%	17%	11%	9%	9%
Apr 23	8%	7%	10%	8%	7%	6%
Oct 23	9%	6%	9%	7%	7%	6%
Apr 24	7%	6%	7%	7%	10%	5%

In April 2024, the primary difficulties were associated with medications for heart (27%), high blood pressure (27%), pain (26%) and antibiotics (20%) (Table 4.2). Slight increases in difficulties accessing heart medicines and high blood pressure medicines were reported in April 2024 comparing with October 2023 (Table 4.2).

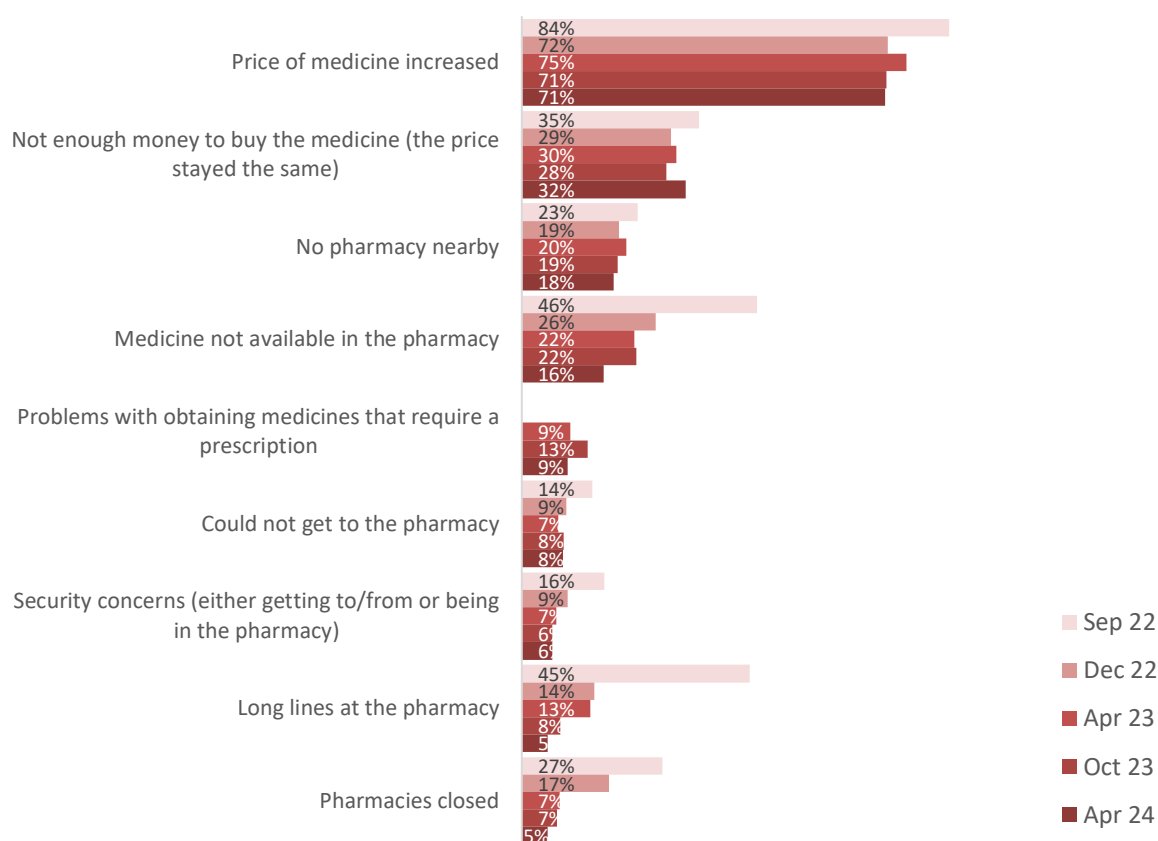
Table 4.2. Main types of difficult-to-find medicines

Type of medication	Sep 22	Dec 22	Apr 23	Oct 23	Apr 24
Cardiovascular	49%	36%	34%	19%	27%
High blood pressure	50%	37%	33%	22%	27%
Pain	41%	34%	38%	25%	26%
Antibiotics	32%	28%	30%	21%	20%
Sedative drugs	33%	19%	21%	14%	14%
Diabetes	17%	8%	10%	10%	13%
Mental health	10%	10%	13%	9%	9%
Pulmonary	10%	10%	7%	5%	5%
Antiseptics	17%	7%	11%	3%	4%
Fever	15%	6%	10%	6%	4%
Birth control	3%	2%	1%	1%	2%
Other	15%	22%	22%	27%	32%

The predominant issue in April 2024, as in October 2023, was the rising cost of medications, which affected 71% of respondents (Fig. 4.2). Additionally, one third of respondents (32%) reported a lack of funds for medications, despite stable medication prices. This figure has increased significantly from 28% in October 2023.

System-based problems have significantly decreased since October 2023. The availability of medicines was a concern for 16% of respondents in April 2024, down from 22% in October 2023. Furthermore, a smaller share of respondents (5%) encountered problems with long lines, and 5% reported pharmacy closures, compared with 7% in October 2023.

Fig. 4.2. Main problems with obtaining medicines



Affordable Medicines Programme

Among respondents who could not get necessary medicines, 52% indicated that they were unable to access medicines because they could not pay for them. At the same time, more than half (55%) reported that they did not know about the Affordable Medicines Programme.

Only 59% of households overall knew about the Affordable Medicines Programme. Of these, less than a third (30%) have successfully used the programme and received medicines in the past 3 months, and 4% have tried but were unsuccessful in receiving medicines (Fig. 4.3 and Fig. 4.4).

Moreover, among all households, 12% received medicines free of charge in health-care facilities and 6% received medicines as humanitarian aid from nongovernmental organizations (NGOs). Only 12% of IDPs have received medicines under the Affordable Medicines Programme compared with 19% in local communities. However, 10% of IDPs have received medicines as humanitarian aid from NGOs compared with 6% of local communities.

The breakdown at the macroregional level indicated that 15% of respondents living in the most affected regions have received medicines as humanitarian aid from NGOs comparing with 7% in regions of increased vulnerability, and 5% and 4% in Kyiv city and the rest of the country, respectively.

Fig. 4.3. Know about Affordable Medicines Programme:

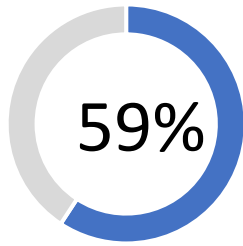
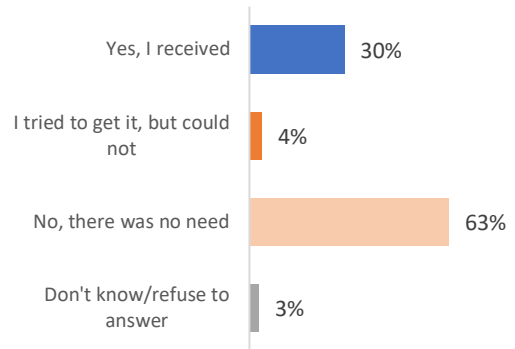


Fig. 4.4. Received medicines under the Affordable Medicines Programme*:



*Among those who know about Affordable Medicines Programme

Section 5. Health behaviour

Postponed medical care

The proportion of households that reported delayed medical care increased from 23% in October 2023 to 32% in April 2024. This significant increase is concerning, as almost one in three households have reported delayed care. In terms of households that reported delayed medical care in April 2023, there was no significant difference between IDPs and people in their home communities. The increase in delayed health care was reported in all regions. By macroregion, a higher proportion of households reported delaying medical care in Kyiv city (37%) than in the most affected regions (31%) or the rest of the country (31%) (Table 5.1).

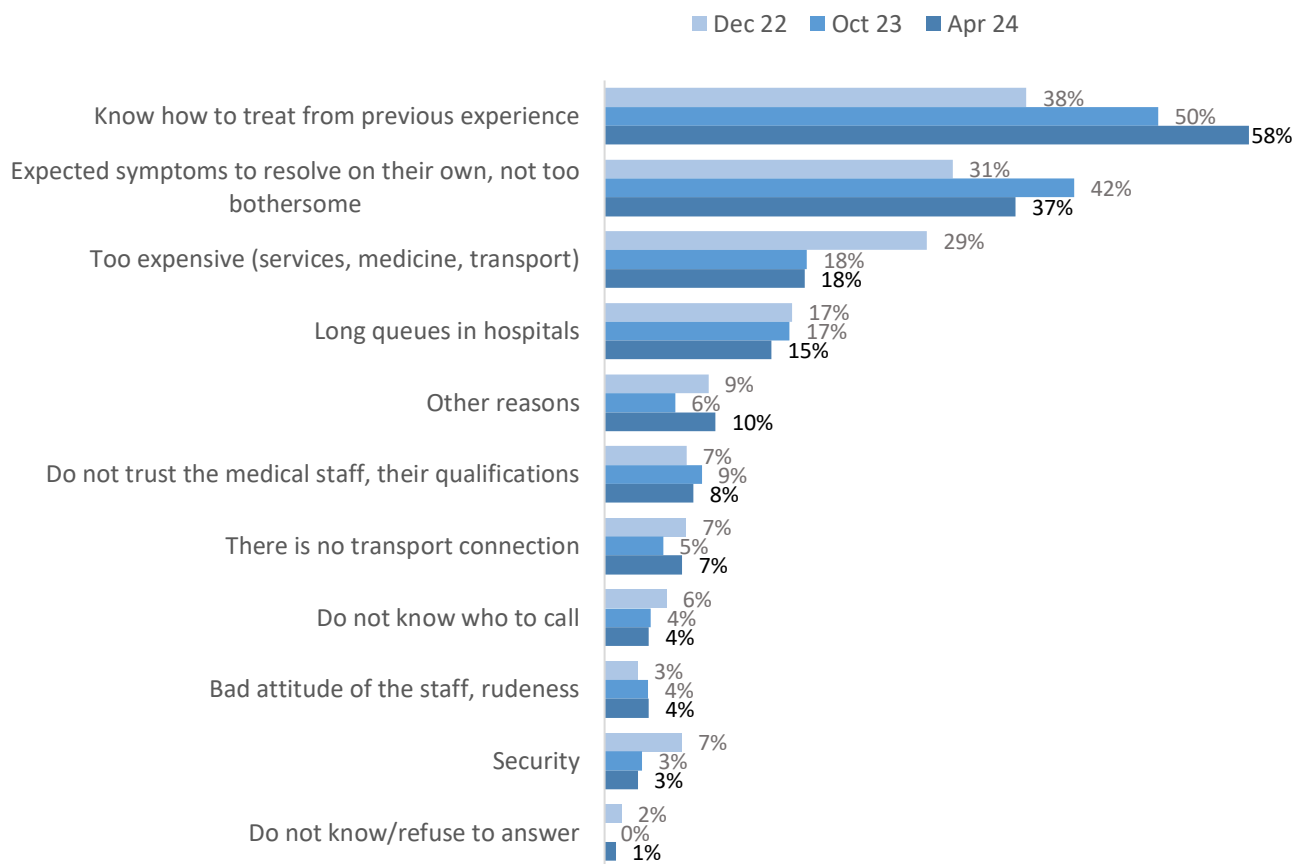
Table 5.1. Instances in the last 3 months when someone in the household did not see a doctor when it was necessary by status and area

	IDPs	People in their home communities	Most affected	Increased vulnerability	Kyiv city	Rest of the country
Dec 22	26%	28%	28%	29%	32%	27%
Apr 23	26%	24%	25%	25%	28%	23%
Oct 23	22%	23%	21%	21%	25%	24%
Apr 24	31%	32%	31%	33%	37%	31%

The question about the reasons for postponing medical care was included again in April 2024. However, self-treatment (58%) remained the main reason for postponing medical care, which was a significant increase from the 51% in October 2023 (Fig. 5.1).

In October 2023, 42% had postponed medical care because they had minor symptoms that they felt would resolve and were not too bothersome, but this decreased to 37% in April 2024. By contrast, cost as a reason (18%) remained unchanged from October 2023 to April 2024.

Fig. 5.1. Reasons for postponing medical care



Section 6. Medical expenses

Income

The April 2024 survey results did not show any changes in household income. The proportion of households with a monthly income of less than 10 000 hryvnias remained the biggest group followed by the group with an income of 10 000–20 000 hryvnias. Moreover, the proportion of households with an income over 30 000 hryvnias remained around 10% in April 2024 (Fig. 6.1).

Household expenditure on health-care services and medicines

The structure of medical expenses remained unchanged, without a significant difference between the rounds of data collection, with the majority (35%) of households incurring minor expenses (less than 10% of their income) and 25% of households having average expenses on health care (Fig. 6.2).

Fig. 6.1. Monthly household income

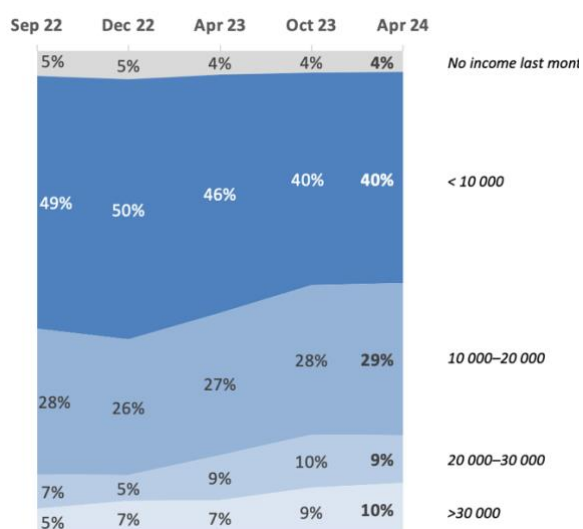
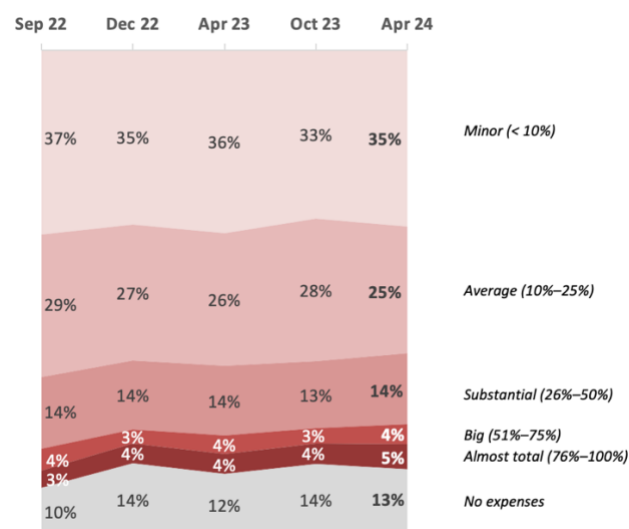


Fig. 6.2. Share of household expenditure on health-care services and medicines

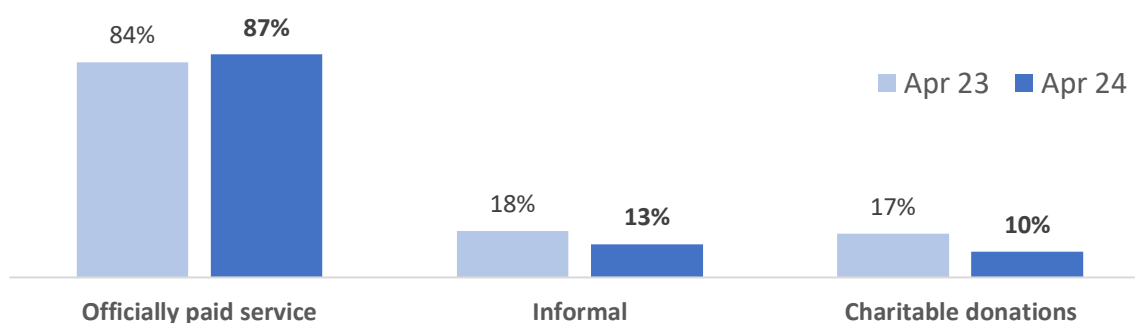


Experience in receiving paid health services

In April 2024, questions to assess medical service-specific costs were added. In the previous month, 30% of households had expenses on health-care services and medicines, compared with 28% in April 2023. By macroregion, the proportion of people who incurred medical expenses was significantly higher in the city of Kyiv (39%) than in the rest of the country (29%). Furthermore, the proportion of households with medical expenses was 28% and 29% in the most affected regions and those with increased vulnerability, respectively. Residents in oblast centres indicated increased paid health services (36%) compared with other cities (29%) and rural areas (23%).

Eighty-seven per cent of households who incurred expenses on medical services used officially paid services. However, 13% of households paid informally and 10% made charitable contributions, which were significant decreases from the results for informal and charitable contributions in April 2023 (Fig. 6.3). Informal payments were more prevalent in rural areas (17%) and other cities (18%), compared with 8% in oblast centres. Charitable donations also significantly decreased, especially in oblast centres (16% in April 2023 to 8% in April 2024) (Table 6.1).

Fig. 6.3. Form of payment for paid medical services*



* Among those who have expenses specifically for medical services

Table 6.1. Form of payment for paid medical services by type of settlement

	April 2023			April 2024		
	Oblast centre	Another city of the oblast	Rural	Oblast centre	Another city of the oblast	Rural
Officially paid service	86%	81%	84%	89%	84%	88%
Informal	14%	24%	17%	8%	18%	17%
Charitable donations	16%	18%	16%	8%	12%	11%
Difficult to answer/refuse to answer	2%	3%	3%	4%	5%	3%

Regarding the breakdown by macroregions from April 2023 to April 2024, decreases of informal and charitable donations were the general trend. However, informal payments (20%) and charitable donations (13%) were higher in the regions with increased vulnerability comparing with other macroregions in April 2024 (Table 6.2).

Table 6.2. Form of payment for paid medical services by region

	April 2023				April 2024			
	Most affected	Increased vulnerability	Kyiv city	Rest of the country	Most affected	Increased vulnerability	Kyiv city	Rest of the country
Officially paid service	78%	80%	90%	85%	83%	83%	93%	89%
Informal	20%	20%	16%	17%	13%	20%	7%	12%
Charitable donations	20%	19%	14%	16%	7%	13%	8%	9%
Difficult to answer/refuse to answer	3%	4%	2%	2%	6%	5%	2%	4%

A new section of questions related to the in-depth understanding of paid medical services was added in April 2024. Among those respondents who indicated having expenses specifically for medical services, most of the paid medical services were initiated by the respondents themselves (40%) or by doctors at public health-care facilities (37%). However, they received paid services mainly in private medical institutions (64%) (Fig. 6.4 and Fig. 6.5).

Fig. 6.4. Initiator of paid medical services*

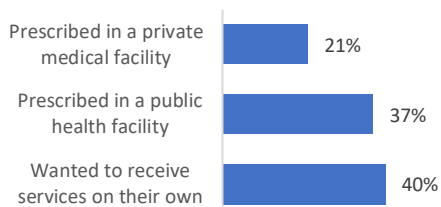
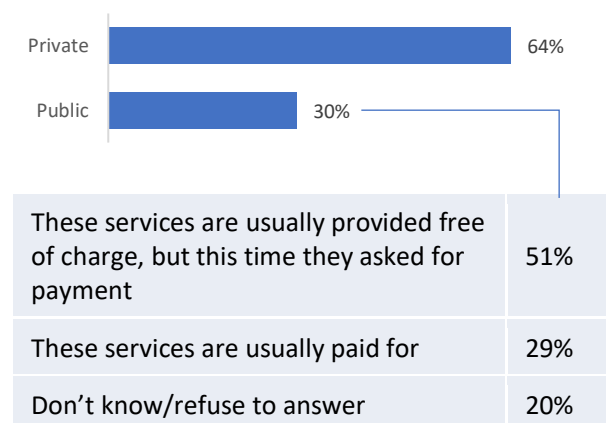


Fig. 6.5. Facility where paid services were received*

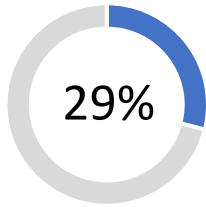


** Among those who have expenses specifically for medical services*

More than a quarter of those who paid for medical services (29%) reported that they could theoretically receive these services for free at another medical facility. However, they mostly had less confidence in the quality of services in the free facility (36%) (Fig. 6.6).

Fig. 6.6. Reason not to get these medical services for free at another medical facility

Could get these services for free in another health-care facility*



Main reasons of not getting these medical services for free at another medical facility **

I had less trust to the facility or doctor where the requested service was provided free of charge	36%
The health care facility where the service was provided free of charge was too far away	18%
The health care facility where the service was provided free of charge was closed	6%

*Among those who have expenses specifically for medical services

**Among those who could get these services for free in another health-care facility

Section 7. General health problems

The set of questions related to general problems related to health was used during Round 2 in December 2022. The main problem has remained unchanged: the cost of medicines and treatment (46%). At the same time, the severity of problems related to the availability of medicines decreased from 21% in December 2022 to 15% in April 2024 (Fig. 7.1).

The urgency of certain health problems has increased compared with December 2022. The increase may relate to changes in behaviour since the first year of the war in 2022. At this time, people had other priority issues and did not take care of their own health. Secondly, it was a period of frequent blackouts, when not all facilities were working stably (Fig. 7.2).

Fig. 7.1. Main structural problems with the health-care system related to health

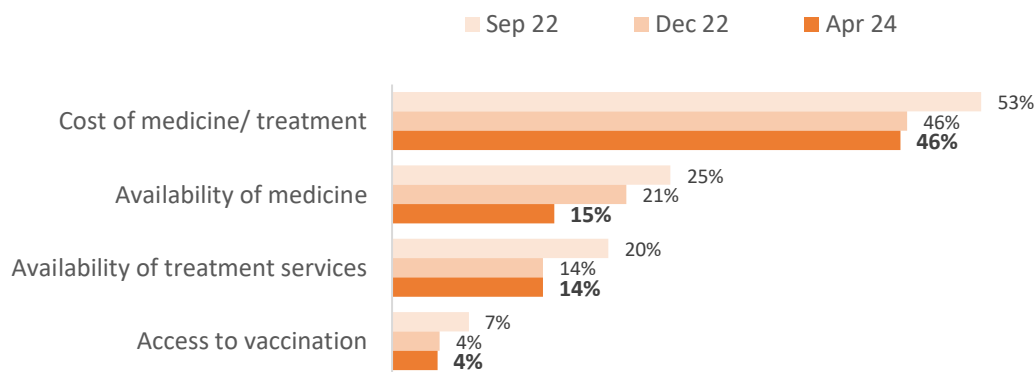
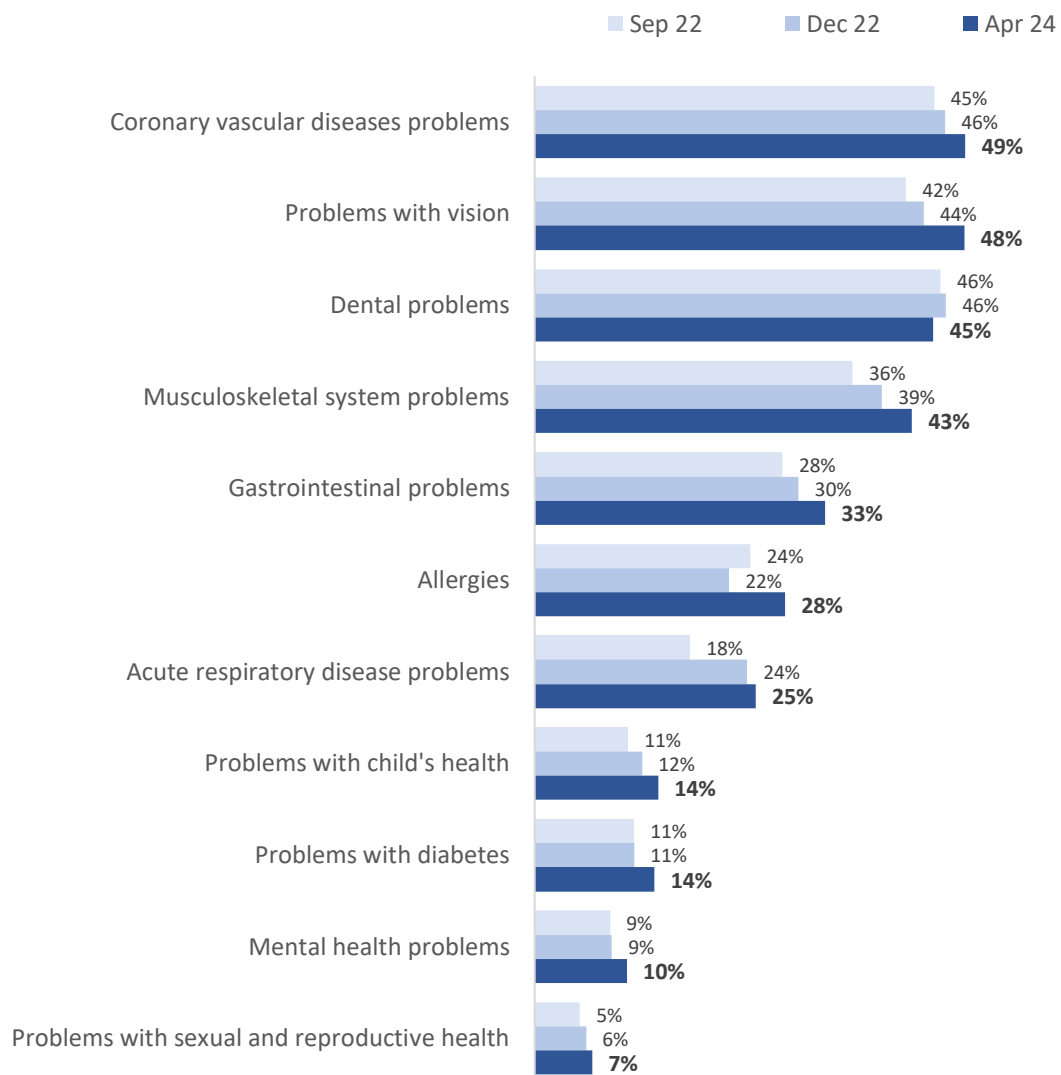


Fig. 7.2. Main personal health problems



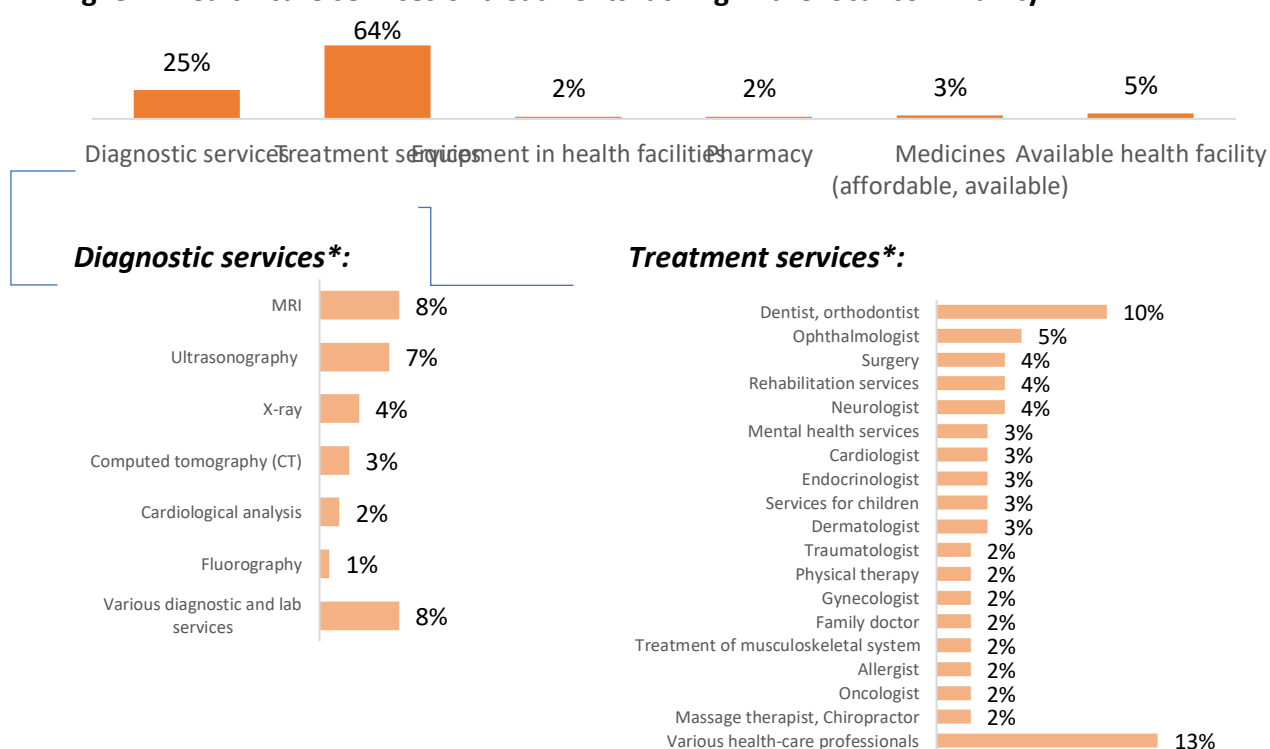
Section 8. General health needs

More than a quarter of households (27%) felt that specific health-care services or treatments were lacking in their community. This lack of services or treatments was most noticeable in small cities and rural areas (30% and 33%, respectively).

Among respondents who felt that specific health-care services or treatments were lacking, two thirds (64%) noted a lack of treatment services, in particular in dental care (10%). A lack of diagnostic services was noted by 25% of respondents, mainly in terms of magnetic resonance imaging (MRI) and ultrasound examinations (Fig. 8.1).

Only 19% of IDPs reported a lack of health-care services in the community, compared with 28% of the local community. By macroregional breakdown, 29% and 20% of respondents from the rest of the country and from Kyiv city, respectively, reported a lack of health-care services in the community. A similar proportion of respondents from the most affected regions and from regions with increased vulnerability reported a lack of health-care services in the community (24% and 26%, respectively).

Fig. 8.1. Health-care services or treatments lacking in the local community



* among those who feel that specific health-care services or treatments are lacking in their community

Summary

Access to primary health care facilities and family doctors

As of April 2024, 8% of households did not have access to their primary health-care facility. Of these, 7% were unaware of the facility's location. Additionally, 7% of respondents did not have a signed declaration with a family doctor. Since the beginning of the war, 23% of respondents have changed their family doctor, with 4% making this change in the past 3 months. The primary reasons for changing doctors included changes in workplace or residence by either the doctor or the respondent. However, 10% of those who changed family doctors did so because they were dissatisfied with the quality of services. Currently, 5% of respondents do not have access to a family doctor, and 7% cannot visit their doctor in person but have remote access.

Access to health services

In April 2024, 54% of respondents had needed some form of medical assistance in the prior 3 months. Of those who sought medical care, 65% faced at least one problem while receiving services. Approximately 10% of respondents could not get the needed services, and 7% could not get any services at all. These figures represent an improvement from October 2023, when the figures were 14% and 9%, respectively. Most households sought health care for chronic conditions (45%) and primary health care (33%). Among households with children, over one third needed paediatric care. Access to health services remained stable, with 93–96% of respondents able to obtain the services they needed. However, significant difficulties were reported in obtaining ambulance services and treating injuries, with 6% of respondents finding that health care for injuries and emergency health care were unavailable.

Postponement of care

In April 2024, the proportion of households that did not seek medical care despite needing it increased to one third of all respondents. The main reason for postponing care was that 58% of participants believed that they knew how to treat the health problem themselves. Additionally, approximately one third of respondents did not visit a doctor because they expected their health issue to resolve on its own and did not find it bothersome enough to seek professional help.

Access to medicines

Nearly all households (81%) faced problems in obtaining necessary medicines. The main issue was the increase in the price of medicines, with 71% of respondents affected. Additionally, 32% of respondents reported a lack of money for medications, up from 28% in October 2023,

despite no change in the price of medications. Problems related to pharmacy operations, such as closures, long lines and medicine shortages, have decreased. The level of access to medicines remained unchanged, with 6% of households unable to get the medicines they needed in the prior 3 months. The main difficulties arose with medications for heart disease, high blood pressure and pain. Among those who did not obtain needed medicines, 52% cited an inability to pay for them. Despite the financial challenges, only 59% of households were aware of the Affordable Medicines Programme, and less than a third (30%) had successfully used it in the prior 3 months, while 4% had tried but were unsuccessful.

General health problems

The primary concern among respondents remained the cost of medicines and treatment, with 46% identifying it as a major issue. The severity of problems related to the availability of medicines had decreased from 21% in December 2022 to 15% in April 2024. More than a quarter (27%) of households felt that specific health-care services or treatments were lacking in their community.

Health expenses

Eighty-seven per cent of households reported having some health-related expenses in the previous 3 months, with 30% specifically spending on medical services. Among these respondents, 13% experienced informal payments in health facilities, and 10% made payments in the form of charitable donations.

IDPs and frontline regions

IDPs are particularly affected, with 13% unaware of their primary health facility's location, compared with 6% among local communities. Among IDPs who had moved in the previous 3 months, this figure was one third. However, IDPs who had relocated over a year ago had adapted, with only 9% not knowing their facility's location.

IDPs faced greater challenges, with 11% lacking access to a family doctor, compared with 4% among host communities. This figure reached 25% for those who had relocated in the previous 3 months. In frontline regions, higher proportions of individuals lacked access to family doctors (6%), especially in the most affected regions (9%). Additionally, 7% of all respondents did not have a signed declaration with a family doctor, a figure significantly higher among IDPs, particularly those who had recently moved (25%).

Overall satisfaction with family doctors was high, with 63% of respondents expressing the highest level of satisfaction. However, 23% of respondents have changed their family doctor since the war began, with IDPs more likely to do so (48%) compared with local residents (19%). Frontline region residents, especially in the most affected regions, also reported higher rates of changing their family doctors. Rural residents change family doctors less frequently than urban citizens, probably because of fewer available options.

In frontline regions, a lower proportion of individuals sought medical care than in non-frontline regions (46% versus 57%).

Limitations of the study

The study team recognizes that the emergency context imposes certain limitations on the study.

Even if the proposed sampling strategy is used to ensure as representative a sample as possible, some population groups are expected not to be reached. These include the elderly, people in rural areas with limited access to phones or facing connectivity issues, and disadvantaged population groups such as migrants, people who are homeless or people with mental health conditions. These population groups may bear a greater burden from the current emergency than the average Ukrainian citizen. As a result, the survey cannot claim to represent their views, and the social benefit of the study may consequently diminish. The findings of the survey need to be interpreted in this context. Conducting supplementary, more tailored, focused data collection with specific population groups may be considered.

Since the findings related to the population at large may not apply to specific disadvantaged population groups, this affects the generalizability of the study's findings. To overcome these limitations, the impact of recommendations informed by this study on specific populations will be cautiously considered before a wide-scale rollout. This can be done by conducting targeted outreach and communication initiatives or tailoring service provision plans to the needs of specific groups. The data may be limited to territories with active cell phone services during the data collection period. Due to the current circumstances, it is difficult to predict which of the regions will not be sufficiently represented in the survey. However, the study team hopes to overcome some of these limitations by increasing the sample size to 4000 participants. This is significantly larger than the sample size of previous representative national surveys in Ukraine, which have typically ranged from 1000 to 2000 participants.

In addition, the complexity of the current crisis and the public response is immense, and CATI can only serve to monitor a few key topics rather than explore them in depth. Crucially, this survey can identify issues of concern that may need to be explored through other means, such as supplementary qualitative data collection.

Another limitation of the study is that the items included in the instrument have been widely used in emergency settings. However, only a few of them have been validated through a rigorous process in the context of war. This is due to the ethical principles of data collection during an emergency and the need to prioritize efforts, and it needs to be considered a limitation in the interpretation of the findings.

Self-reported behaviours can be unreliable, as they can be biased by social desirability and other factors. This means that the findings related to behaviour should be interpreted with caution, as they may not accurately reflect actual behaviour. Although recruiting people via phone and conducting interviews using CATI has some limitations compared with face-to-face interviews, it was widely used during the COVID-19 pandemic. The Sociological group "Rating" is currently conducting multiple public opinion surveys in Ukraine using the same recruitment and data collection strategy. They have found that people in Ukraine are willing to share data, especially when they see the benefits of their contributions to the public good. In light of the current emergency, the advantages of this approach outweigh the limitations. Additionally, this rapid health needs assessment can contribute important insights that will inform response and recovery planning, despite its limitations.

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¹ All references were accessed on 04 July 2024.

The WHO Regional Office for Europe

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