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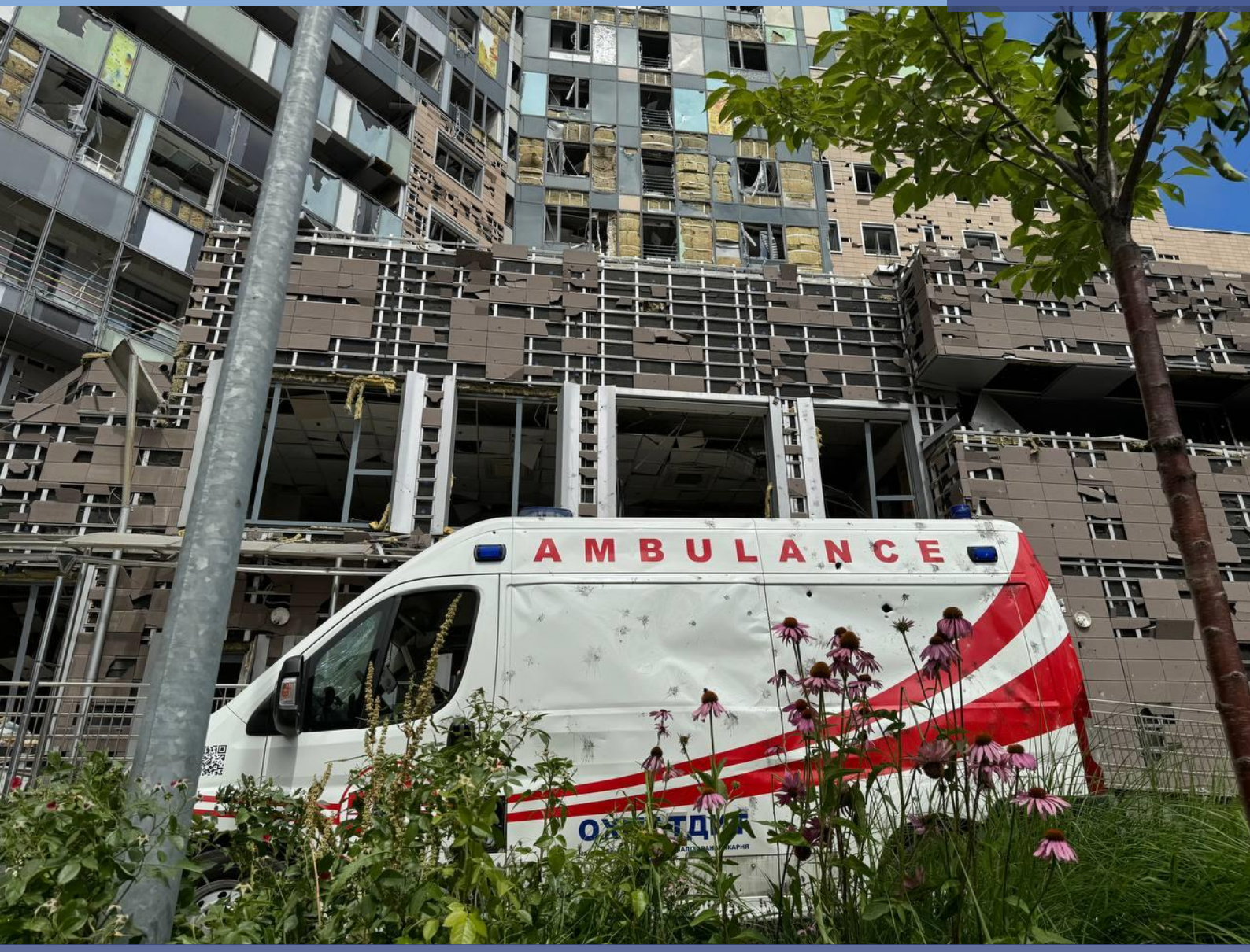

Health needs assessment of the adult population in Ukraine

Survey report

October 2024

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Abstract

The war 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 adequate.

The survey assessed health-care access and challenges across various groups, revealing high awareness of primary health care facilities, with 94% of respondents aware of their local facilities. Internally displaced persons faced greater challenges, particularly in accessing primary care and family doctors. Preventive care uptake was low, with 37% of those who had signed declarations and visited a family doctor in person in the last year not undergoing exams in the past year. Eight per cent of households still face problems with obtaining medicines, mostly related to increased prices and affordability. Vaccination rates were stable, although demand for coronavirus disease 2019 (COVID-19) vaccines remains low after a significant decline in 2023. Health expenses improved in the affordability of medicines (66%) and paid medical services (44%), but affordability remained a concern in frontline areas. Since the start of the war, 68% of respondents reported a decline in health, with sleep and mental health disorders and musculoskeletal issues most prevalent.

Keywords:

UKRAINE

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HEALTH SERVICES

WAR EXPOSURE

SURVEYS AND QUESTIONNAIRES

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Executive summary

The October 2024 health-care survey included 4000 respondents representing diverse demographics across Ukraine with 10.4% response rate.

Awareness of local primary health care facilities was high, with 94% of respondents aware of their nearest facility, and 91% reporting that the facility was functional. However, internally displaced persons (IDPs) faced greater challenges, with 12% unaware of their primary care facility, compared to 5% for people who have remained in their home communities. Access to family doctors remained high and stable, even though remote consultations increased notably.

Preventive care uptake levels were concerning, as 71% of people who had signed health-care declarations visited a family doctor for an in-person consultation in the last year, and 37% of them did not undergo preventive exams. IDPs faced a higher degree of barriers at 44%.

While hypertension and diabetes screenings were common, regional disparities in access to care remained, particularly for chronic conditions. Cost of treatment and unavailability of services were significant barriers. Health-care delays increased, with 35% of households reporting postponed medical care, often due to self-treatment.

Access to medications remained stable, with 8% of households unable to obtain necessary medicines in the last three months. Barriers included high medication costs (73% of respondents), not having enough money for medicines and unavailability of medicines in pharmacies. The unavailability of medicines increased, and heart, blood pressure and pain medications remained the most difficult to obtain. The Affordable Medicines Programme raised awareness (62%), but issues with unavailability and preferred brands persisted.

Routine vaccinations for children and adults remained stable, but demand for the COVID-19 vaccine remains low after a significant decline in 2023. Access to human papillomavirus (HPV) and influenza vaccines was limited, with 63% unable to access HPV vaccines and 23% unable to access influenza vaccines.

Household income showed a positive shift, with a decrease in those earning less than 10 000 hryvnias and an increase in those earning over 30 000 hryvnias. Despite improvements in affordability for medical services and medicines, frontline areas still faced greater challenges in affordability of paid medical services (35%) than in rest of the country (55%).

Additionally, 45% of respondents required health information, particularly about chronic disease treatments and accessing health services.

Since the onset of the war, 68% of respondents reported a decline in health, with sleep and mental health disorders and musculoskeletal issues being the most prevalent. Women experienced higher rates of sleep disorders (75%) and mental health issues (66%) than men (59% and 56% respectively).

Methodology

Background

The timing of the war, which coincided with the coronavirus disease (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 December 2024, there have been 2184 attacks on health care in Ukraine *(2)*. Nearly 15 million people in Ukraine will require multisectoral humanitarian assistance due to the ongoing war *(3)*. According to the International Organization for Migration, as of November 2024, nearly 3.6 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, 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.

The 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 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 April 2024 showed that the demand for and access to health-care services remained consistent with the results of the October 2023 survey, with only minor variations observed *(5)*.

Eight per cent of households reported no access to primary health care. Seven per cent do not have 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, though 54% of respondents needed medical assistance recently, with 65% facing problems and 10% unable to obtain the services they needed. Almost all households faced issues with 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.

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 humanitarian and development organization including UN 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;
- analyse changes in above mentioned outcomes 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; and
- analyse geographic variability in health needs and access to primary and specialized services.

Study design

This is a quantitative, serial cross-sectional study that used a survey questionnaire to collect data in several rounds between September 2022 and April 2025. 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. 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. Therefore, the assessed period in Round 1 was set as 24 February to 9 September 2022, which was approximately six months. In Round 2 the assessed period was three months. This difference in time frames probably influenced the distribution of answers to certain questions. The next rounds, including Round 5, also used a three-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
- Round 6 was conducted on 18–25 October 2024.

For Round 6, a total of 98 interviewers were initially recruited. All the interviewers had completed at least secondary-level education, and 94% 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 22 minutes. The field force size was 98 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 the 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 of 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, Zaporizhzhya, 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 the 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 considered 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 from the war may be emotionally vulnerable and sensitive to certain topics. Therefore, various 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 complete 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 minimal or no 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 October 2024, during Round 6 of data collection, a total of 4000 respondents were interviewed with 10.4% response rate. The total number of those who picked up the phone was 42 506 The geographic and gender distribution was 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, one third (33%) of households included members aged 65 years or older, and 30% had chronic conditions. Children under 18 years of age were present in 38% of households, and 3% of households included pregnant or lactating women.

18–29 years old	30–39 years old	40–49 years old	50–59 years old	60+ years old
16%	20%	18%	17%	29%

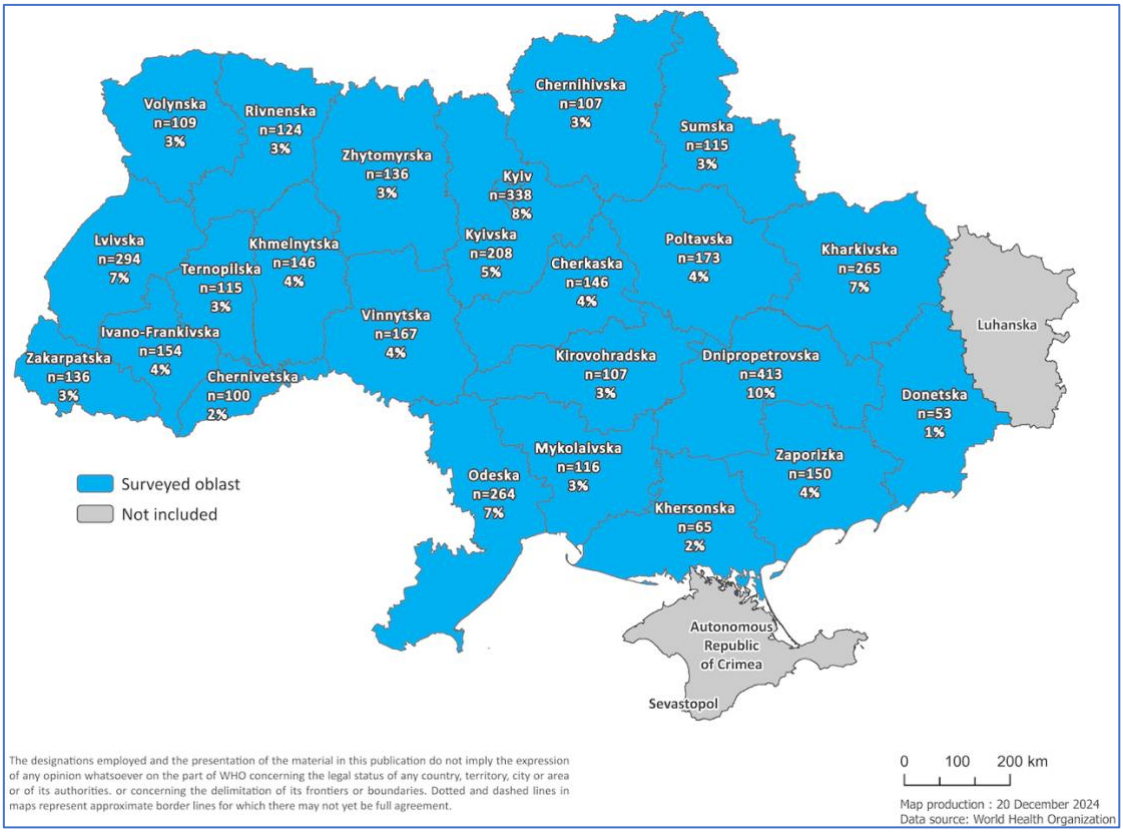
♀	♂
55%	45%

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

Table 1.1. Respondents by oblast status, N

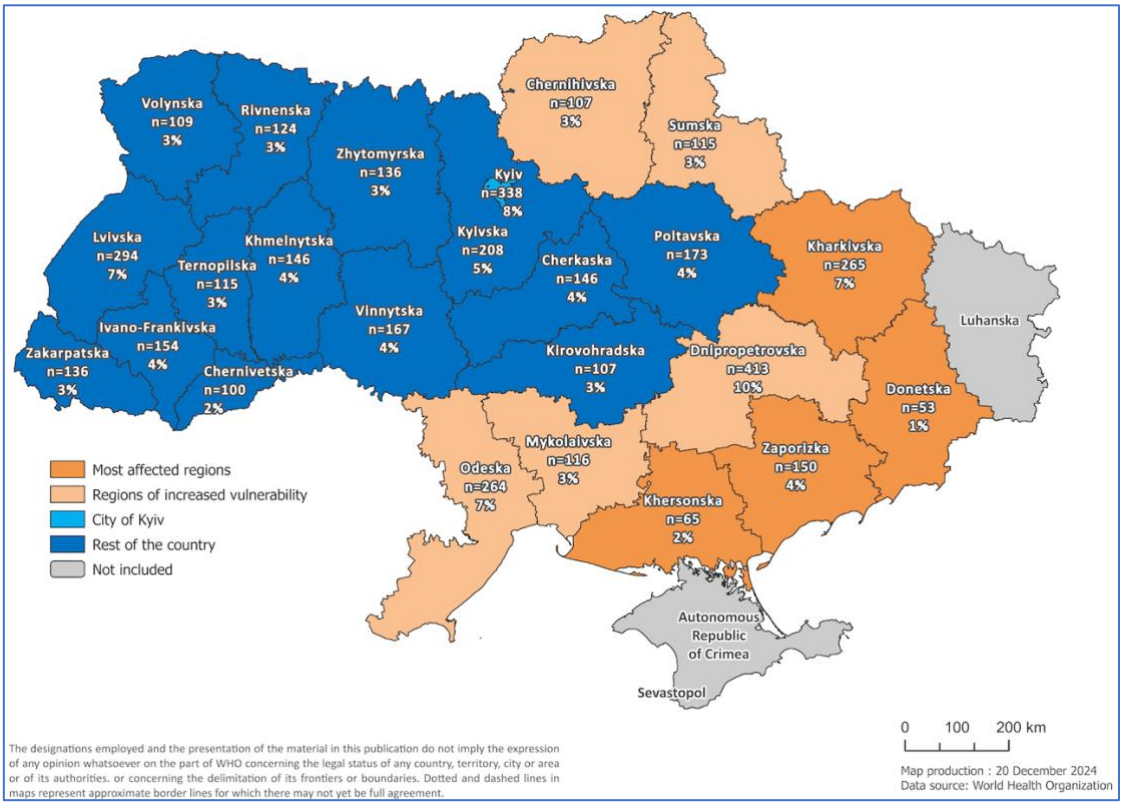
Macro region	Sep 22	Dec 22	Apr 23	Oct 23	Apr 24	Oct 24
Most affected regions	478	529	535	553	542	533
Regions of increased vulnerability	1009	1005	1015	974	1007	1016
City of Kyiv	342	323	342	359	355	338
Rest of the country	2171	2144	2109	2114	2098	2115

Fig. 1.1. Respondents by oblast



The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city or area or of its authorities. or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines in maps represent approximate border lines for which there may not yet be full agreement.

Fig. 1.2. Respondents by oblast status



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The migration of Ukrainians within and outside Ukraine has been constant since the start of the war on 24 February 2022. In October 2024, 21% of respondents indicated that they had moved from the same place since the start of the war (Table 1.2, Table 1.3).

Furthermore, 73% 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, 62% moved more than 12 months ago, 11% moved 6–12 months ago and 10% moved 3–6 months ago. Of note, 15% indicated that they had moved less than three months ago (Table 1.4). More than half (52%) have official IDP status, which was received after February 2022.

Table 1.2. Proportion of respondents who have been internally displaced

Place of residence	Sep 22	Dec 22	Apr 23	Oct 23	Apr 24	Oct 24
Live in the same place	82.1%	83.7%	81.8%	79.9%	80.8%	78.7%
Moved after 24 February 2022	17.9%	16.3%	18.2%	20.1%	19.2%	21.3%

Table 1.3. Respondents who have changed place of residence, N

Place of residence	Sep 22	Dec 22	Apr 23	Oct 23	Apr 24	Oct 24
Live in the same place	3284	3351	3273	3195	3234	3151
Moved after 24 February 2022	716	650	728	805	768	851

Table 1.4. Proportion of respondents by timing of relocation

Changed place of residence	Apr 24	Oct 24
Less than 3 months ago	7%	15%
3–6 months ago	8%	10%
6–12 months ago	15%	11%
More than 12 months ago	68%	62%

In October 2024, a new question related to relocating was added to the survey tool. According to the results, 16% of the respondents relocated after February 2022 (Table 1.5).

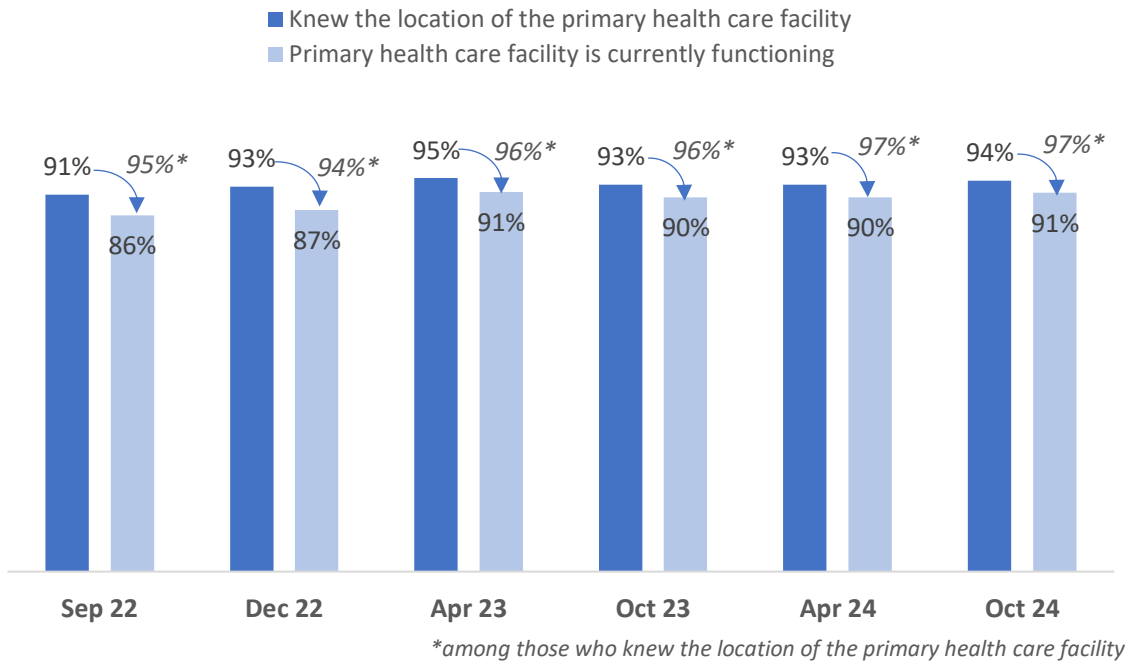
Table 1.5. Respondents who have changed the settlement of residence, N

Settlement	Sep 22	Dec 22	Apr 23	Oct 23	Apr 24	Oct 24
Live in the same settlement	-	-	-	-	-	3359
Changed settlement after 24 February 2022	-	-	-	-	-	643

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

In October 2024, the indicators related to awareness of primary health care facilities and their functional status had not changed since the previous round of data collection in April 2024. Awareness remained high, with nearly all households (94%) 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 knew the location and functioning of their primary health care facility



*among those who knew the location of the primary health care facility

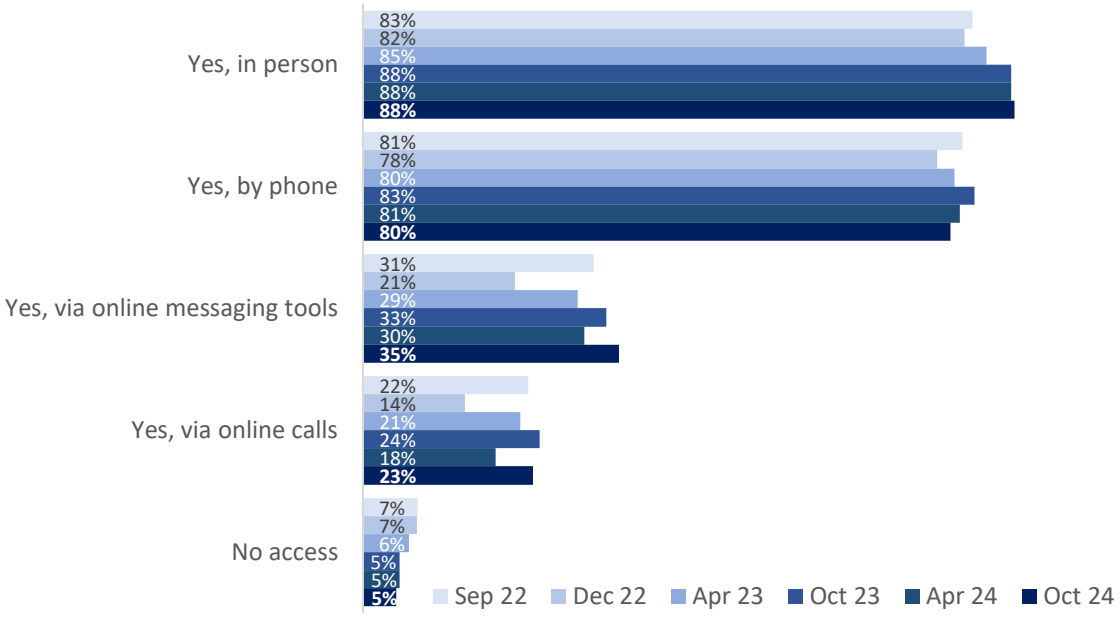
IDPs remain more vulnerable: 12% reported that they did not know the location of their primary health care facility compared to 5% of local communities, which represents a significant difference. Moreover, among IDPs who moved 3–6 months ago, 21% did not know the location of the primary health care facility. However, for those who relocated a longer time ago – 6–12 months ago and more than 12 months ago – the share of those who did not know the location of the primary health care facility was still higher (8% and 10%, respectively) than for people who have remained in their home communities (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
Local communities	5%
IDPs	12%
Relocated less than 3 months ago	12%
Relocated 3–6 months ago	21%
Relocated 6–12 months ago	8%
Relocated more than 12 months ago	10%

Access to a family doctor remained unchanged in October 2024 from the previous two rounds of data collection, with only 5% of households reporting that they did not have access to a family doctor. An additional 7% of respondents are unable to visit their family doctor in person, but they do have a remote connection. However, there was a significant increase in the households' ability to contact their family doctor through remote channels such as online messaging tools or online tools compared to April 2024 (Fig. 2.2).

Fig. 2.2. Access to a family doctor



In terms of geographic breakdown, a higher share of respondents from Kyiv city (8%) had no access to a family doctor, compared to 6% in regions of increased vulnerability and 5% in the most affected regions. In the rest of the country, 3% did not have access to a family doctor in the last three months. Nine per cent of IDPs reported having no access to a family doctor, compared to 4% for local populations, which represented a significant difference (Table 2.2).

Table 2.2. No access to a family doctor

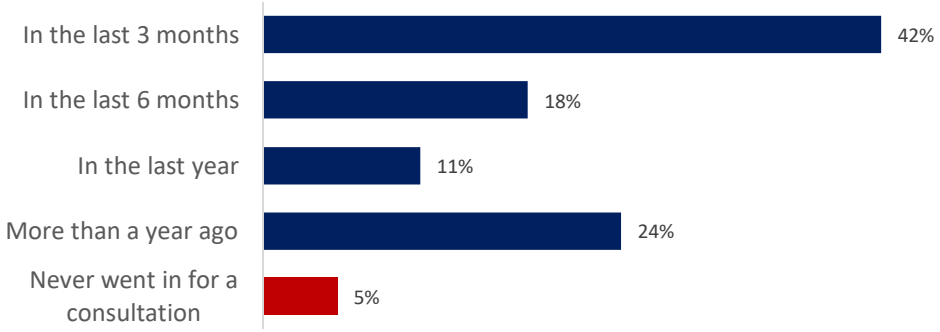
Respondent residence status	No access to a family doctor
Local communities	4%
IDPs	9%
Relocated less than 3 months ago	15%
Relocated 3–6 months ago	16%
Relocated 6–12 months ago	10%
Relocated more than 12 months ago	6%

The gender analysis revealed that a significantly higher share of males (6%) than females (3%) had no access to a family doctor. Additionally, a lower share of males had in-person (87%) or phone access to a family doctor (77%) than females (90% and 82%, respectively).

As of October 2024, 92% of respondents had a signed declaration with a family doctor, which did not differ from previous rounds' results. Among IDPs, the proportion of people who did not have a signed health-care declaration is significantly higher (12%) than for people in their local communities (5%). A breakdown by microregion reveals that residents of the city of Kyiv (11%) and both the most affected frontline areas and areas of increased vulnerability (7%) did not have a signed declaration with a family doctor, compared to 5% in the rest of the country.

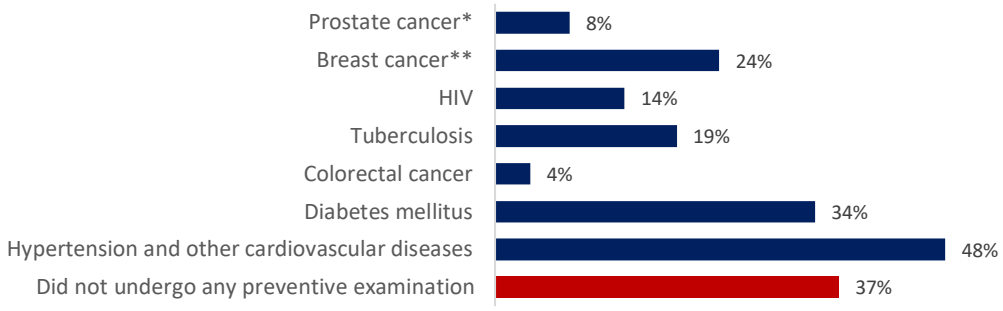
In October 2024, the survey team added a set of questions related to in-person visits to a family doctor and preventive medical examinations that should be provided by family doctors. For the majority of those who had a signed declaration, the last in-person visit was in the past three months (42%). However, one in four (24%) had their last visit to a family doctor more than one year ago, and 5% never had a consultation (Fig. 2.3).

Fig. 2.3. Last in-person consultation with a family doctor



For those who had their visit in the last year, an additional question on preventive medical examinations was included. The results indicate that more than one third (37%) did not undergo any preventive examination. The most common preventive examinations were for hypertension and other cardiovascular diseases and diabetes (Fig. 2.4).

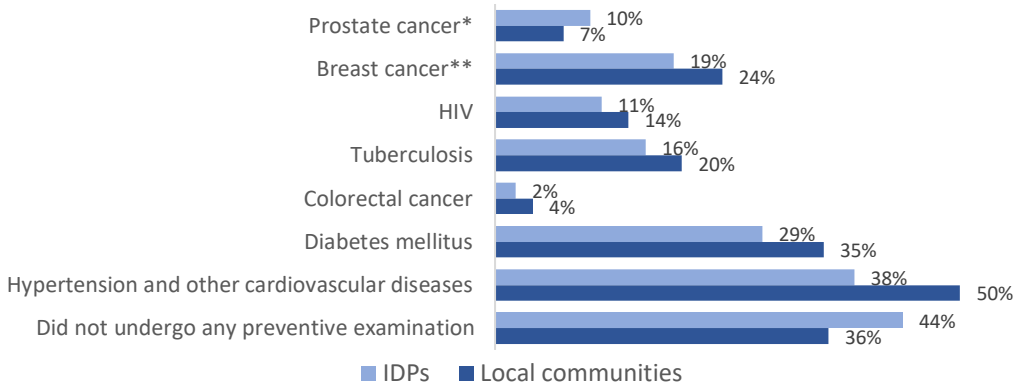
Fig. 2.4. Respondents who underwent preventive examinations with a family doctor in the last year



** Males who had an in-person consultation with a family doctor in the last year*
*** Females who had an in-person consultation with a family doctor in the last year*

A significantly higher share of IDPs did not undergo any preventive medical examination in the last year (44%) compared to 36% of people in their home communities. Moreover, people remaining in their home communities were more likely to have undergone screening for hypertension and cardiovascular diseases (50%) than IDPs (38%). The same applies to screening for diabetes (35% for people remaining in their home communities and 29% for IDPs) (Fig. 2.5).

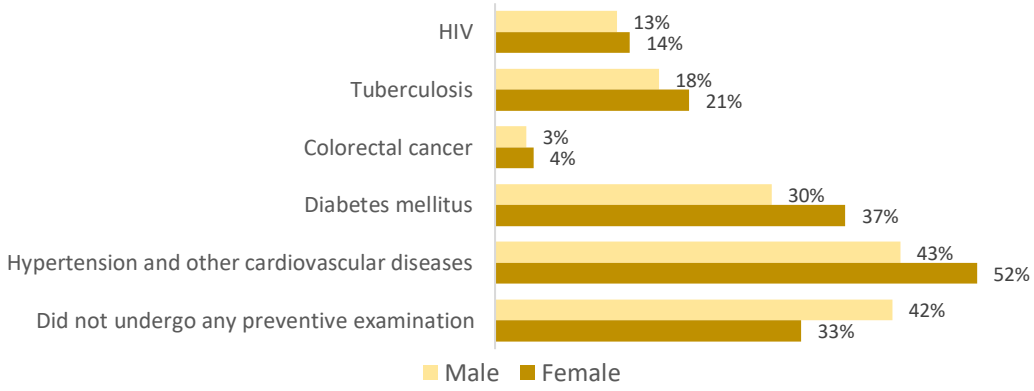
Fig. 2.5. Preventive examinations received from a family doctor in the last year by IDP status



** Males who had an in-person consultation with a family doctor in the last year*
*** Females who had an in-person consultation with a family doctor in the last year*

The gender analysis reveals that a much higher share of males (42%) than females (33%) did not undergo any preventive medical examinations. Males also were significantly less frequently screened for hypertension and cardiovascular diseases (43%) and diabetes (30%) (Fig. 2.6).

Fig. 2.6. Preventive examinations received from a family doctor in the last year by sex



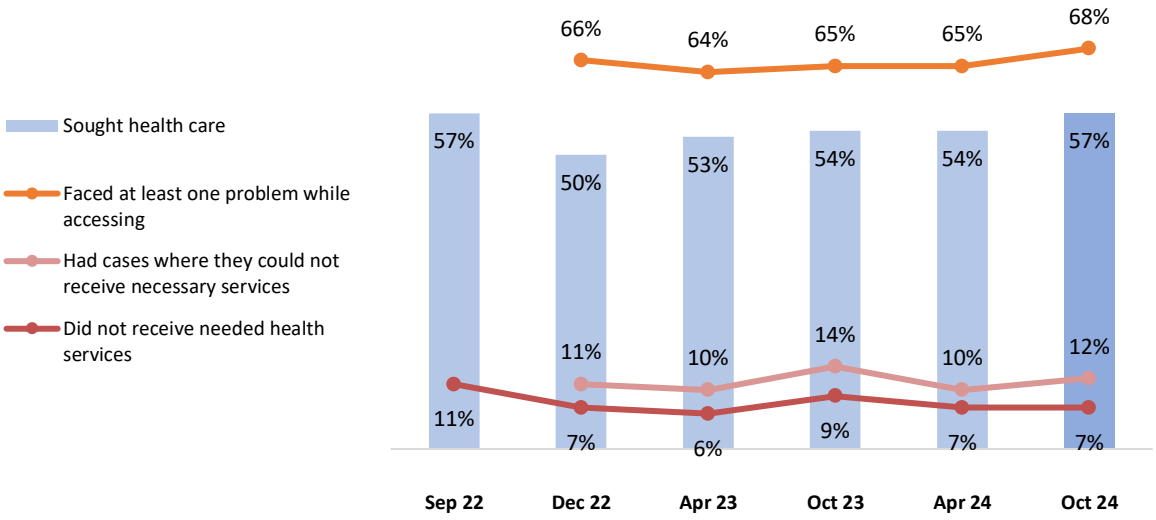
Section 3. Access to health care

Changes in health-care access

As indicated in the survey results over the last several rounds, in general, the accessibility of health-care services remained relatively stable. More than half of respondents (57%) reported needing some form of medical services. Among those seeking health care, two thirds (68%) faced at least one issue while attempting to receive medical care. One in 10 (12%) people who sought health care experienced situations in which they were unable to access the services they needed, and 7% were completely unable to obtain any services (Fig. 3.1).

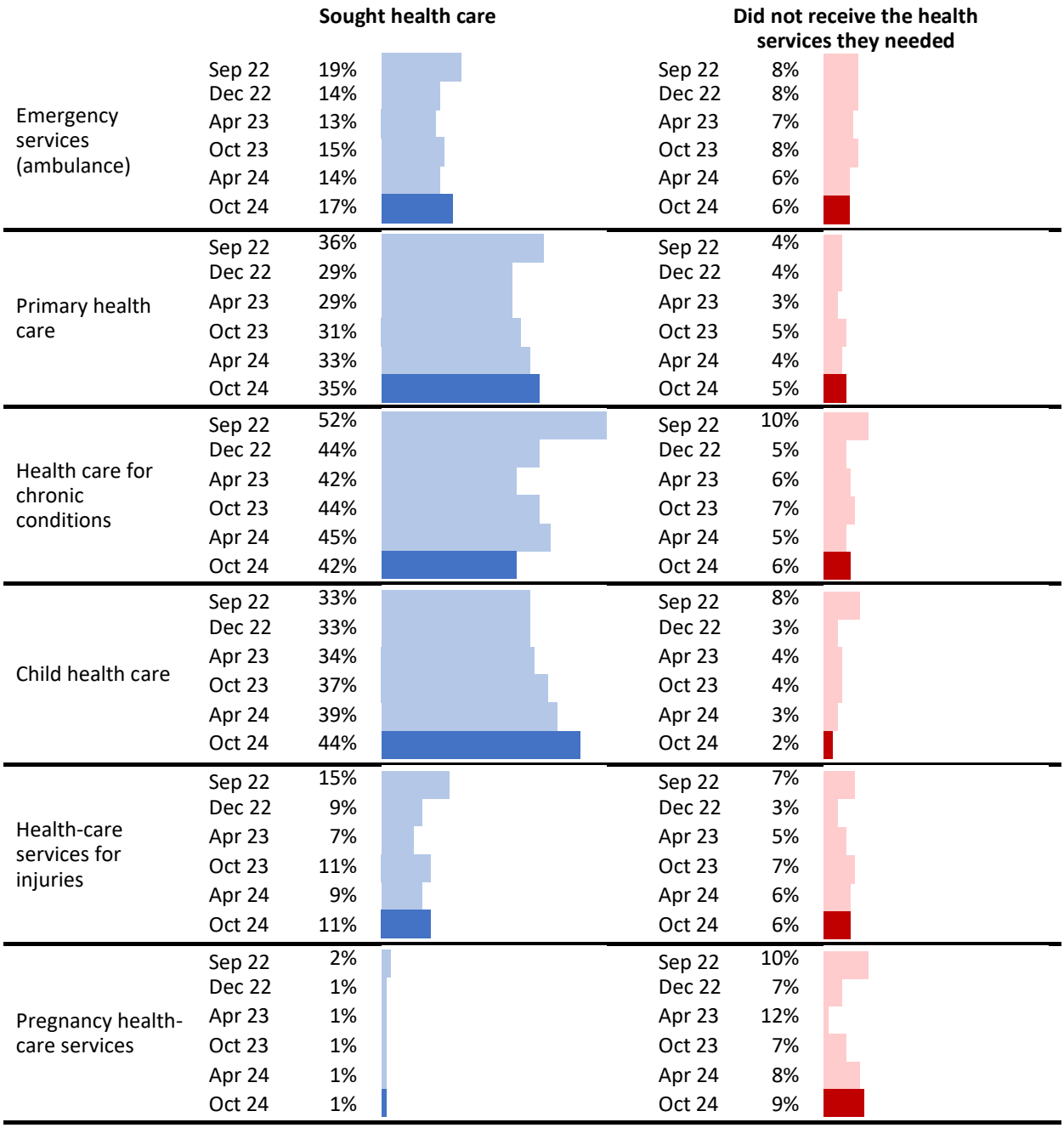
In addition, a trend that indicates regional disparities in access to health care was reported in October 2024. In frontline regions, both in the most affected areas and in areas of increased vulnerability, a significantly lower percentage of respondents attempted to access medical care compared to other regions, with 50% and 54% of respondents, respectively, seeking medical services, compared to 57% in the city of Kyiv and 60% in the rest of the country.

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



Compared to previous rounds, in October 2024, the majority of households sought care for children (44%) and chronic conditions (42%) (Fig. 3.2). More than one third of households (35%) needed primary health care services. Access to all health services remained unchanged, reaching more than 90% for each type of health-care service.

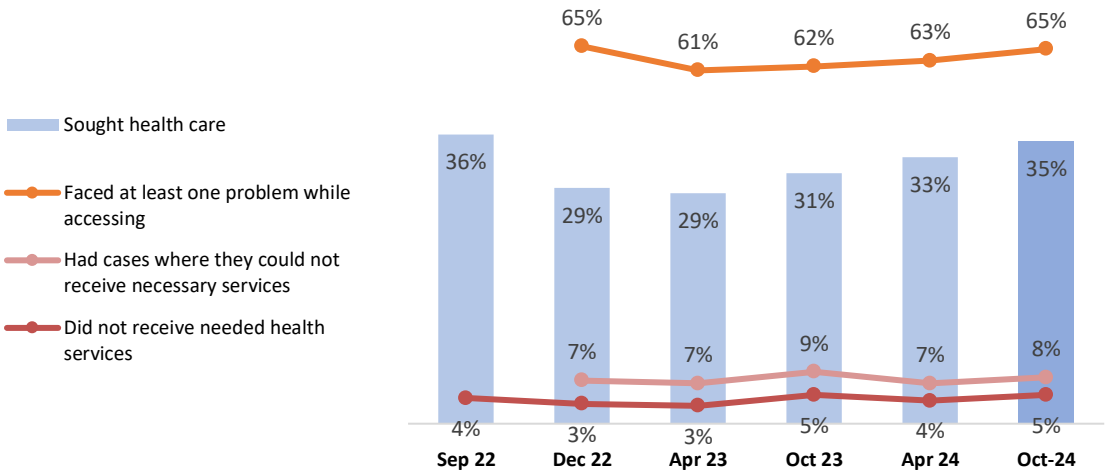
Fig. 3.2. Dynamics of access to health care



Primary health care

The level of access to primary care in October 2024 did not differ significantly from that in the previous rounds. Thirty-five per cent of households sought primary health care services in the three months prior to the survey (Fig. 3.3). Of these, 65% reported encountering at least one barrier to access. Eight per cent of households reported encountering situations in which they were unable to receive the primary health care services they needed, and 5% were unable to access any primary care services.

Fig. 3.3. Dynamics of access to primary health care



In October 2024, the most commonly reported barrier in accessing health care was cost of medicines (46%). Compared to the results of the previous round in April 2024, the percentage of households citing cost of treatment as a problem significantly increased from 22% to 29% (Fig. 3.4). The proportion of respondents who faced problems due to unofficial payments also increased significantly from 6% in April 2024 to 10% in October 2024.

There were no significant changes between April 2024 and October 2024 in terms of barriers that led to not receiving services. According to the results of this round of data collection, the most common barriers hindering households from accessing primary health care were unavailability of services (21%) and refusal to provide services (14%) (Fig. 3.5). Another important barrier was time to receive the services (12%).

Fig. 3.4. Problems when seeking primary care services

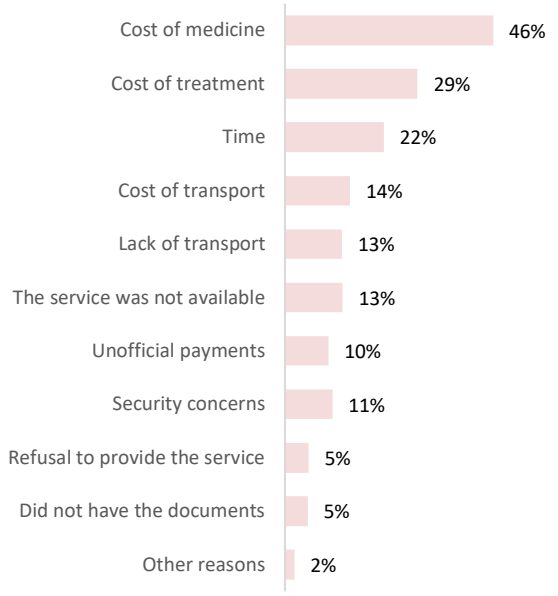
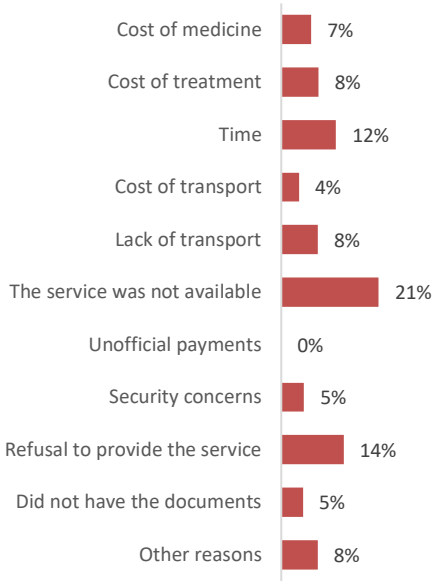


Fig. 3.5. Main barriers to access to primary care



In the current round, no significant differences were found between IDPs and people in their home communities in terms of access to primary health care, as 8% of both IDPs and people in their home communities reported cases of not receiving primary health care services. However, IDPs were more likely to report challenges involving cost of treatment (36%) than people remaining in their home communities (28%). Moreover, refusal to provide health-care services/consultations as the main barrier to accessing primary health care was significantly higher among IDPs (43%) than among people in their home communities (9%).

Households from regions of increased vulnerability (30%) were much less likely to seek primary health care than those in the rest of the country (38%). In October 2024, the share of households who faced at least one problem accessing primary health care was much higher in the most affected areas (77%) and in areas of increased vulnerability (70%) than in the rest of the country (61%) (Table 3.1).

Security concerns as a barrier in accessing primary health care were much higher in the most affected regions (22%) compared to the rest of the country (7%), or even regions of increased vulnerability (11%). The cost of medicines was the primary barrier to access to primary health care in all the macroregions, but it was much higher in the most affected regions (56%) than in the rest of the country (42%). A significantly lower share of respondents from the most affected regions and areas of increased vulnerability (23% and 30%, respectively) did not face any problems compared to the rest of the country (39%).

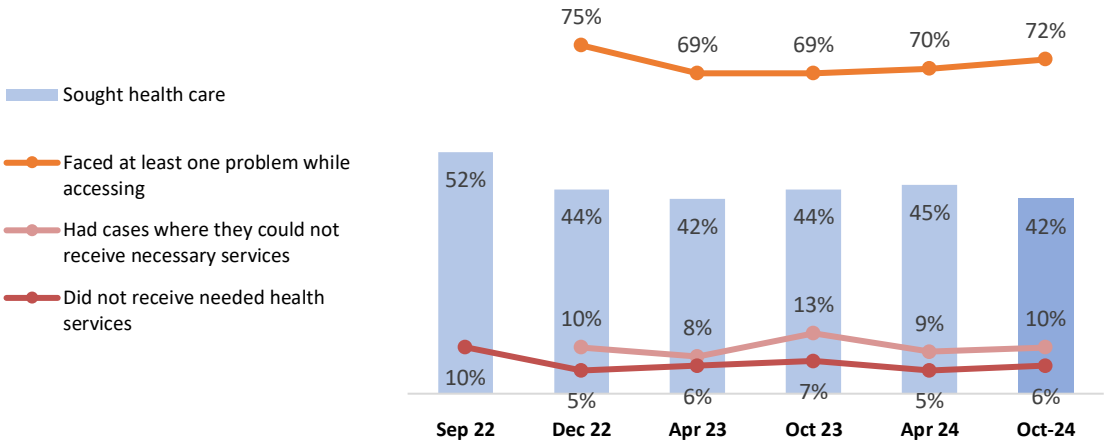
Table 3.1. Access to primary health care by region type

		Sought health care	Faced at least one problem when accessing	Had instances where they could not receive the necessary services	Did not receive the health services they needed
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%
	Oct 24	**32%**	**77%**	**10%**	**8%**
Regions of 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%
	Oct 24	**30%**	**70%**	**7%**	**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%
	Oct 24	**36%**	**68%**	**11%**	**9%**
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%
	Oct 24	**38%**	**61%**	**8%**	**4%**

Health care for chronic conditions

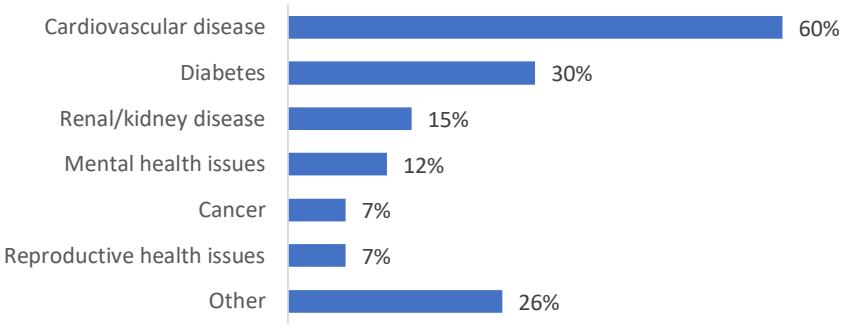
In October 2024, 30% of all households reported having a family member with a chronic condition. Forty-two per cent of those who reported having family members with chronic diseases sought health care for their condition in the three months prior to the survey (Fig. 3.6).

Fig. 3.6. Dynamics of access to care for a chronic condition



Respondents sought assistance for 60% of family members with cardiovascular diseases and 30% of members with diabetes (Fig. 3.7). Among people with chronic conditions, 85% received care at home, which was significantly higher than 78% in April 2024, while 31% received inpatient care.

Fig. 3.7. Chronic conditions for which respondents sought care



Seventy-two per cent of those seeking treatment for a chronic condition faced at least one barrier. Most households (61%) who sought care indicated that the cost of medicines was their greatest challenge (Fig. 3.8). Cost of treatment (38%) as a barrier increased considerably from 29% in April 2024. Cost of transport (26%) and time (24%) were also cited as significant barriers.

Ten per cent of households reported instances when they were unable to receive health services for their chronic condition, and 6% of households were entirely unable to receive the services they needed. The primary barriers to health-care access for chronic conditions were unavailability of the services needed (29%), cost of treatment (16%) and cost of medicines (11%) (Fig. 3.9).

Fig. 3.8. Problems when seeking health care related to a chronic condition

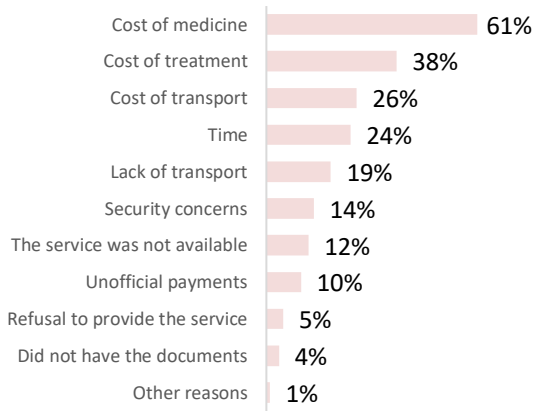
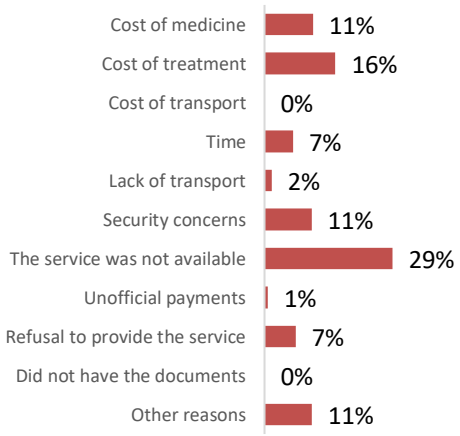


Fig. 3.9. Main barriers to access to health care related to a chronic condition



IDPs were more likely to seek health-care services for reproductive health issues (15%) than people in their home communities (5%). On the other hand, people in their home communities were more likely to seek health care for cardiovascular diseases (64%) than IDPs (41%). A statistical significance regarding problems and barriers in access to health care for chronic conditions between those who relocated to another settlement (IDPs) and people in their home communities was not found (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	Had instances where they could not receive the necessary services	Did not receive the health services they needed
IDPs	Oct 24	43%	63%	12%	11%
People in their home communities	Oct 24	42%	73%	10%	5%

In October 2024, a lower share of respondents residing in the most affected areas sought health care for chronic conditions, but three of four (74%) faced problems accessing it (Table 3.3). No significant differences were reported regarding problems and barriers, with cost of treatment and medicines remaining the main barrier.

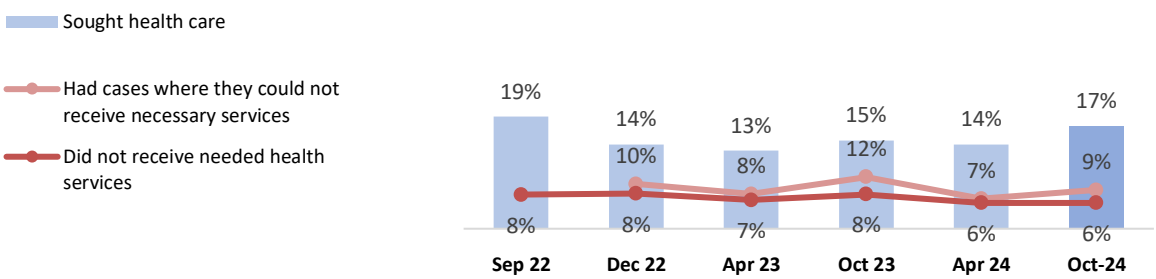
Table 3.3. Access to health care related to a chronic condition by region

		Sought health care	Faced at least one problem when accessing	Had instances where they could not receive the necessary services	Did not receive the health services they needed
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%
	Oct 24	36%	72%	9%	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%
	Oct 24	43%	74%	9%	8%
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%
	Oct 24	42%	73%	17%	8%
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%
	Oct 24	43%	70%	10%	5%

Emergency (ambulance) services

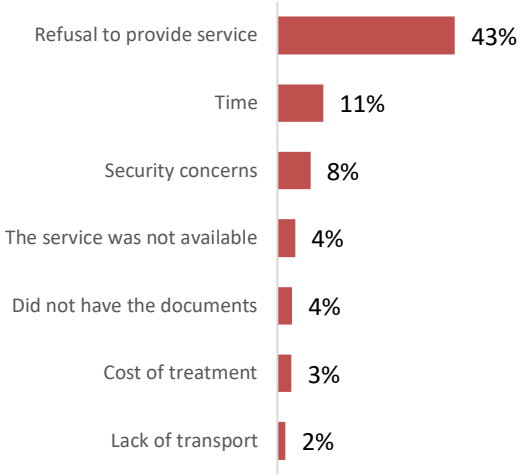
In October 2024, access to emergency medical assistance (ambulance services) remained stable and unchanged from the previous round, with a higher share of 17% and 14% seeking emergency services in October 2024 and April 2024, respectively (Fig. 3.10). Of these, 9% were unable to obtain the services they needed. Furthermore, 6% did not receive any of the services they needed.

Fig. 3.10. Dynamics of access to emergency medical services



The leading cause of lack of access to services was refusal to provide the services, as reported by 43% of those who could not receive the services, followed by time needed to receive the services (11%) (Fig. 3.11).

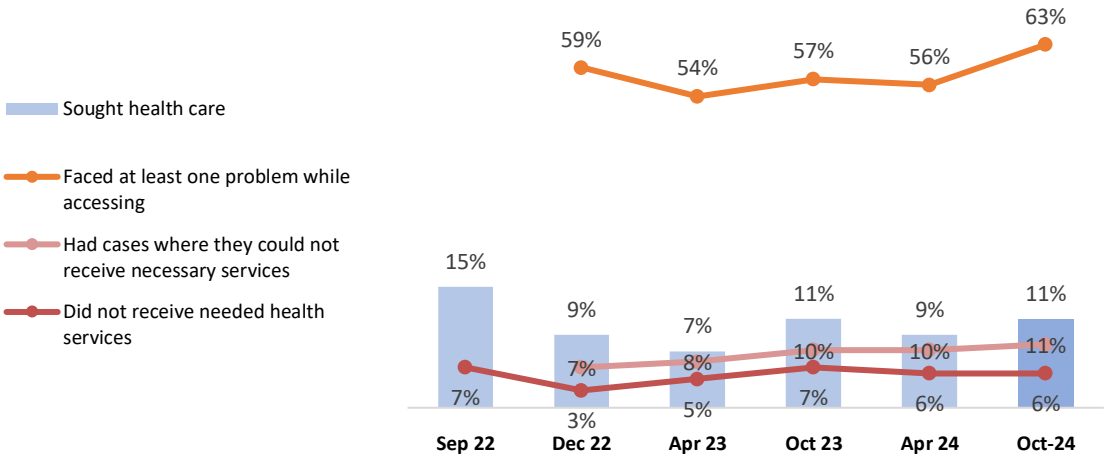
Fig. 3.11. Main barriers to access to emergency medical services



Health-care services for injuries

In October 2024, 11% of households reported seeking medical care for injuries in the three months prior to the survey (Fig. 3.12), which is significantly higher than the 9% reported in the previous round in April 2024. Almost two thirds (63%) of those who sought medical care in the current round reported encountering at least one problem.

Fig. 3.12. Dynamics of access to health-care services for injuries



The main problems with accessing services for injuries were cost of medicines (40%) and cost of treatment (26%) (Fig. 3.13). In October 2024, nearly a quarter of the respondents reported time as a problem and 11% of households cited issues associated with unofficial payments. Additionally, 11% 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 (20%) and refusal to provide the services (12%) were the main barriers in October 2024 (Fig. 3.14).

Fig. 3.13. Problems when seeking health-care services for injuries

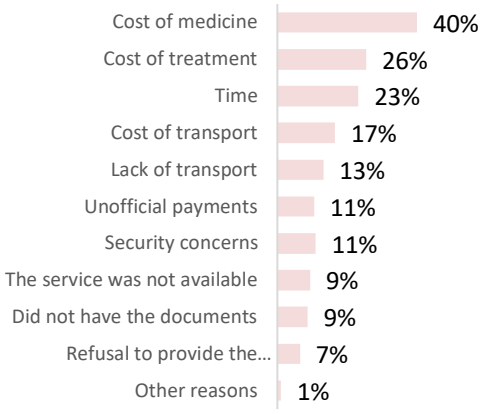
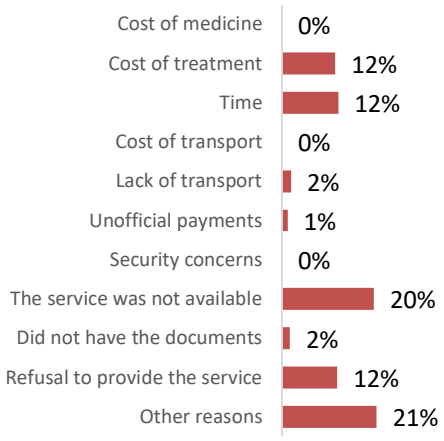


Fig. 3.14. Main barriers to access to health-care services for injuries

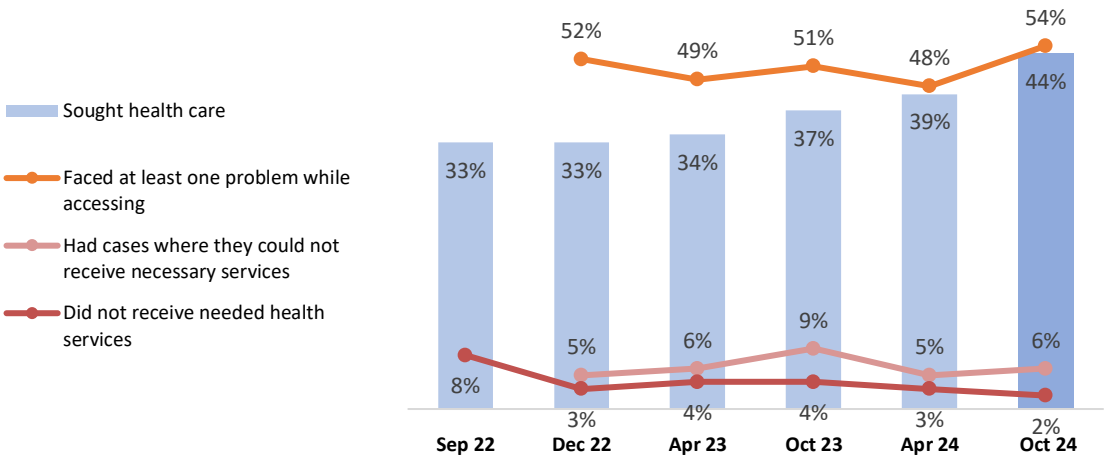


No differences were observed between IDPs and people in their home communities in this regard.

Health care for a child

Thirty-eight per cent of the households that participated in the survey had children among their members. Almost half of them (44%) sought medical care for the children in the three months prior to the survey (Fig. 3.15).

Fig. 3.15. Dynamics of access to health care for a child



Of the households that sought health care for a child, more than half (54%) encountered at least one problem, the most significant of which were cost of medicines (37%) and cost of treatment (21%), which was much higher in October 2024 than in April 2024 (11%) (Fig. 3.16). Six per cent of those who sought medical care for a child were unable to obtain the necessary services, and unavailability of services was the primary barrier (35%) (Fig. 3.17). Two per cent of households that sought medical care for their children did not receive any services.

Fig. 3.16. Problems when seeking health care for a child

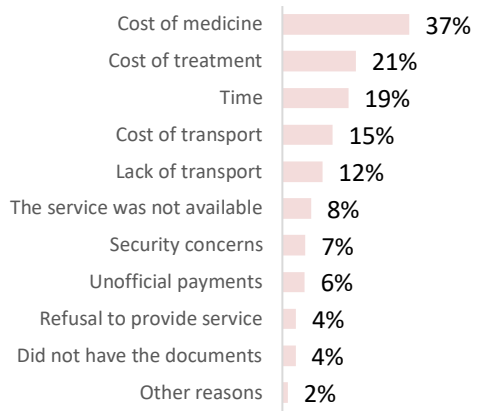
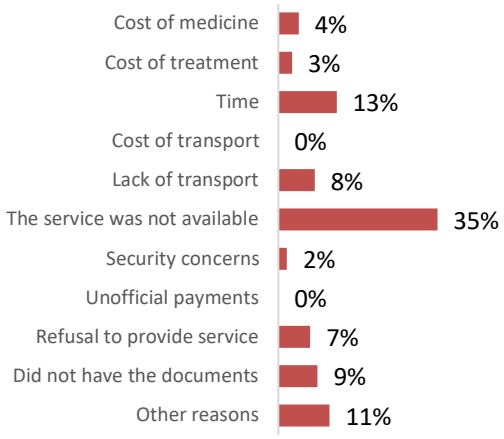


Fig. 3.17. Main barriers to access to health care for a child



Among IDPs and those who remained in their home communities, no differences were observed in terms of access to health care for children. A higher share of households from the most affected regions (44%) sought health care for children in October 2024 than in April 2024 (27%) (Table 3.4).

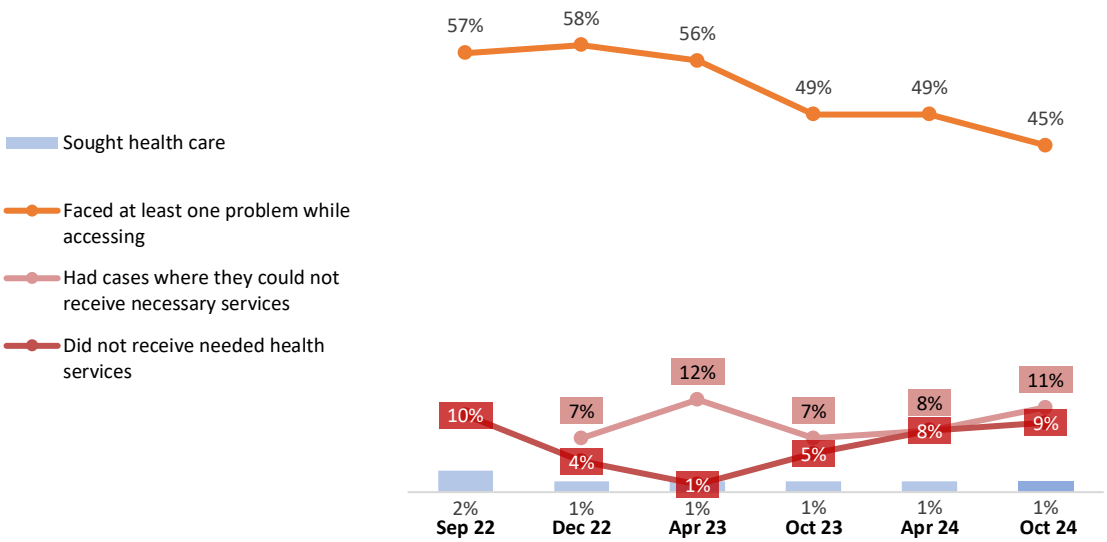
Table 3.4. Access to health care for a child by region

		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
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%
	Oct 24	44%	51%	4%	2%
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%
	Oct 24	35%	57%	8%	3%
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%
	Oct 24	47%	51%	6%	2%
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%
	Oct 24	45%	54%	5%	1%

Pregnancy health-care services

In October 2024, as in the previous rounds, in the three months prior to the survey, only 1% of households sought pregnancy-related health services (Fig. 3.18). Of these, 45% encountered at least one problem when s care. The main problems were cost of medicines (28%), cost of treatment (25%) and time (9%). Eleven per cent of those who sought pregnancy health-care services experienced situations where they were unable to receive services, and 9% did not receive any services.

Fig. 3.18. Dynamics of access to prenatal health-care services



Section 4. Access to laboratory and instrumental diagnostics

Access to laboratory diagnostics

In October 2024, two new sets of questions related to laboratory and instrumental diagnostics were added.

In the last three months, 51% of respondents reported that they or their household members needed to undergo laboratory tests such as blood or urine tests. Of those, 83% managed to complete all necessary tests, while 11% partially completed them, and 6% were unable to complete the required tests (Fig. 4.1 and Fig. 4.2).

Fig. 4.1. Respondents who needed to undergo laboratory tests (e.g. blood, urine) in the last three months

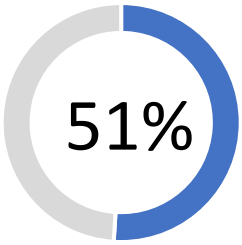
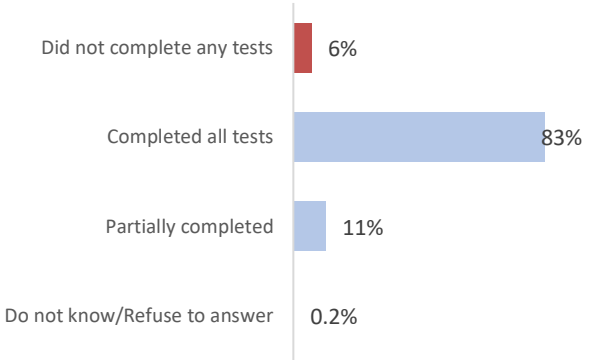


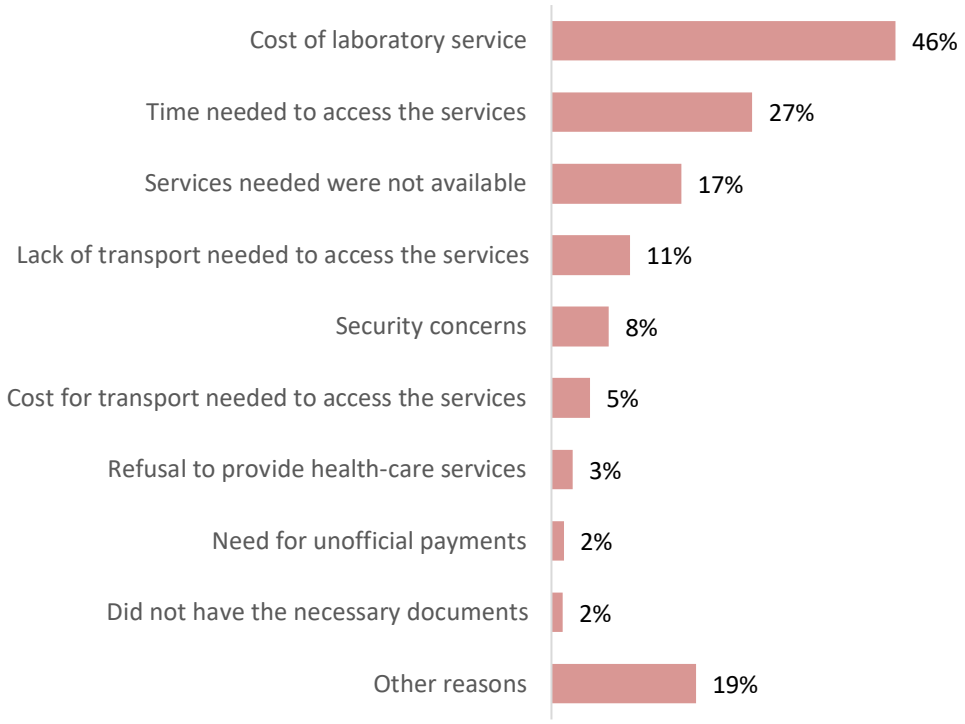
Fig. 4.2 Respondents who completed the necessary laboratory tests*



**Among those who needed to complete laboratory tests*

Several barriers were identified among those who could not complete the necessary laboratory tests. The most frequently reported issue was cost of laboratory services (46%), followed by time required to access these services (27%). Other notable challenges included unavailability of health-care professionals or required services (17%), lack of transportation (11%) and security concerns during travel or while at the facility (8%). Additional reasons, such as logistical or administrative issues, were cited by 19% of respondents (Fig. 4.3).

Fig. 4.3. Reasons why respondents did not undergo all the necessary laboratory tests



Public laboratories were the most commonly used facilities, with 67% of respondents accessing services there, followed by private laboratories (54%). In terms of cost, only 37% of respondents completed all tests free of charge. Meanwhile, 32% reported that some tests were free while others required payment, and 30% indicated that all tests were paid (Fig. 4.4 and Fig. 4.5).

Fig. 4.4. Facility at which laboratory tests were completed*

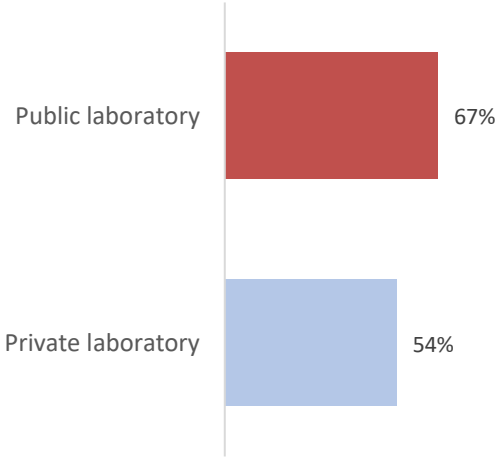
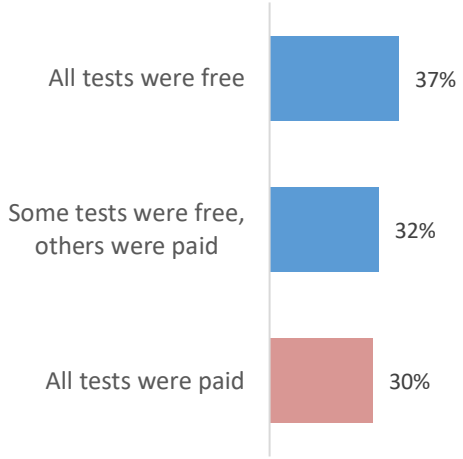


Fig. 4.5. Payment for laboratory tests*



**Among those who got all needed laboratory diagnostics*

Access to instrumental diagnostic tests

In the last three months, 39% of respondents reported that they or their household members required instrumental diagnostic tests, such as magnetic resonance imaging (MRI), electrocardiograms (ECG), computed tomography (CT) scans, or ultrasounds. Among these, 72% managed to complete all necessary tests, 12% reported partial completion, and 16% were unable to complete the required diagnostics (Fig. 4.6 and Fig. 4.7).

Fig. 4.6. Respondents who underwent instrumental diagnostic tests (e.g. MRI, ECG, CT scan, ultrasound) in the last three months

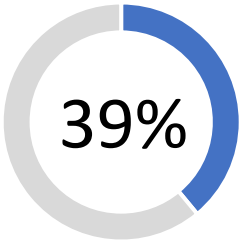
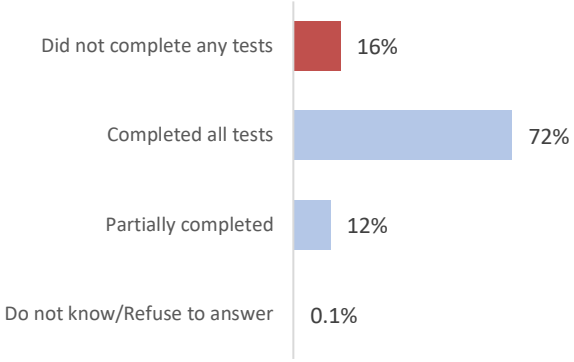


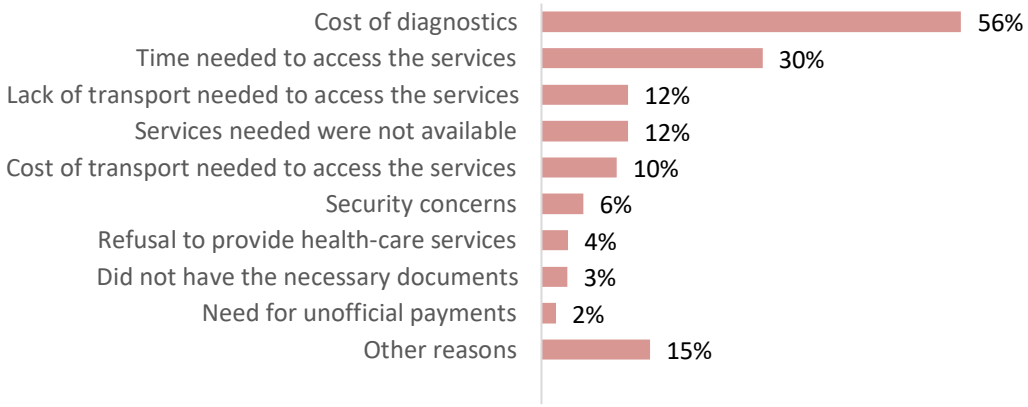
Fig. 4.7 Respondents who completed the necessary instrumental diagnostic tests*



**Among those who needed to complete instrumental diagnostic tests*

The most commonly reported barrier to completing these tests was cost of diagnostics, cited by 56% of respondents. Other notable obstacles included time required to access the services (30%), lack of transportation (12%) and unavailability of health-care professionals or services (12%). Additional challenges included cost of transportation (10%) and, to a lesser extent, security concerns during travel or while at the facility (6%). A small percentage of respondents (2%) cited the need for unofficial payments, while 15% cited other unspecified reasons (Fig. 4.8).

Fig. 4.8. Reasons why respondents did not undergo all the necessary instrumental diagnostic tests



Respondents used both public and private laboratories for their diagnostic needs, with 54% reporting visits to public laboratories and 58% – to private laboratories, indicating that some

may have accessed services at both types of facilities. Regarding cost of services, only 29% of respondents completed all necessary diagnostic tests free of charge. In comparison, 23% reported a mix of free and paid services, while 47% indicated that they had paid for all services (Fig. 4.9 and Fig. 4.10).

Fig. 4.9. Facility at which instrumental diagnostic tests were completed*

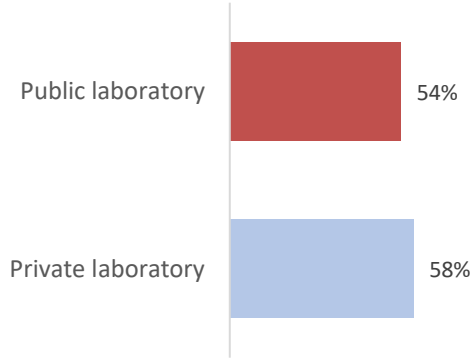
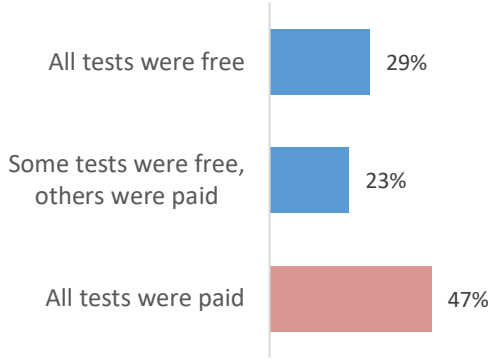


Fig. 4.10. Payment for instrumental diagnostics tests*

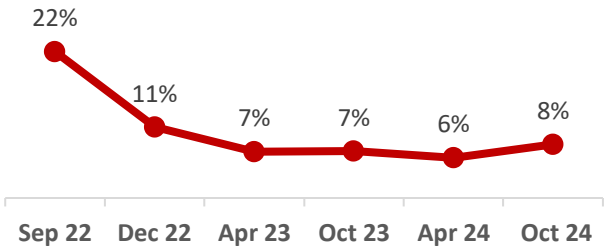


**Among those who got all needed instrumental diagnostics*

Section 5. Access to medicines

In October 2024, the level of access to medicines remained stable, with 8% of households reporting that they had been unable to obtain the medications they needed in the past three months, and almost all households (82%) facing problems in obtaining the necessary medicines (Fig. 5.1). Conversely, issues related to the operation of pharmacies decreased in relevance, including closures and long lines. However, unavailability of medicines was significantly higher in October 2024 (21%) than in April 2024 (16%). Similarly, the proportion of respondents encountering problems with prescriptions increased from 9% in April 2024 to 12% in October 2024.

Fig. 5.1. Share of households that could not obtain the necessary medicines



A breakdown by IDP status revealed that 9% of IDPs could not obtain needed medicines in the last three months. Problems such as pharmacy closures (9%) were significantly higher among IDPs, but increased prices were much higher among people in their home communities than among IDPs (74% and 68%, respectively). At macroregional level, no significant differences have been identified since the last round of data collection in April 2024 (Table 5.1).

Table 5.1. Households that could not obtain the necessary medicines by region

	Most affected	Increased vulnerability	Kyiv city	Rest of the country
Sep 22	32%	28%	25%	16%
Dec 22	17%	11%	9%	9%
Apr 23	10%	8%	7%	6%
Oct 23	9%	7%	7%	6%
Apr 24	7%	7%	10%	5%
Oct 24	**8%**	**8%**	**8%**	**8%**

The top three most difficult-to-obtain medicines in October 2024 did not change, with the primary difficulties associated with heart (25%), high blood pressure (22%) and pain (21%) medications (Table 5.2). Significant changes were not reported, aside from a decrease in other types of medication from 32% in April 2024 to 14% in October 2024.

Table 5.2. Main types of difficult-to-find medicines

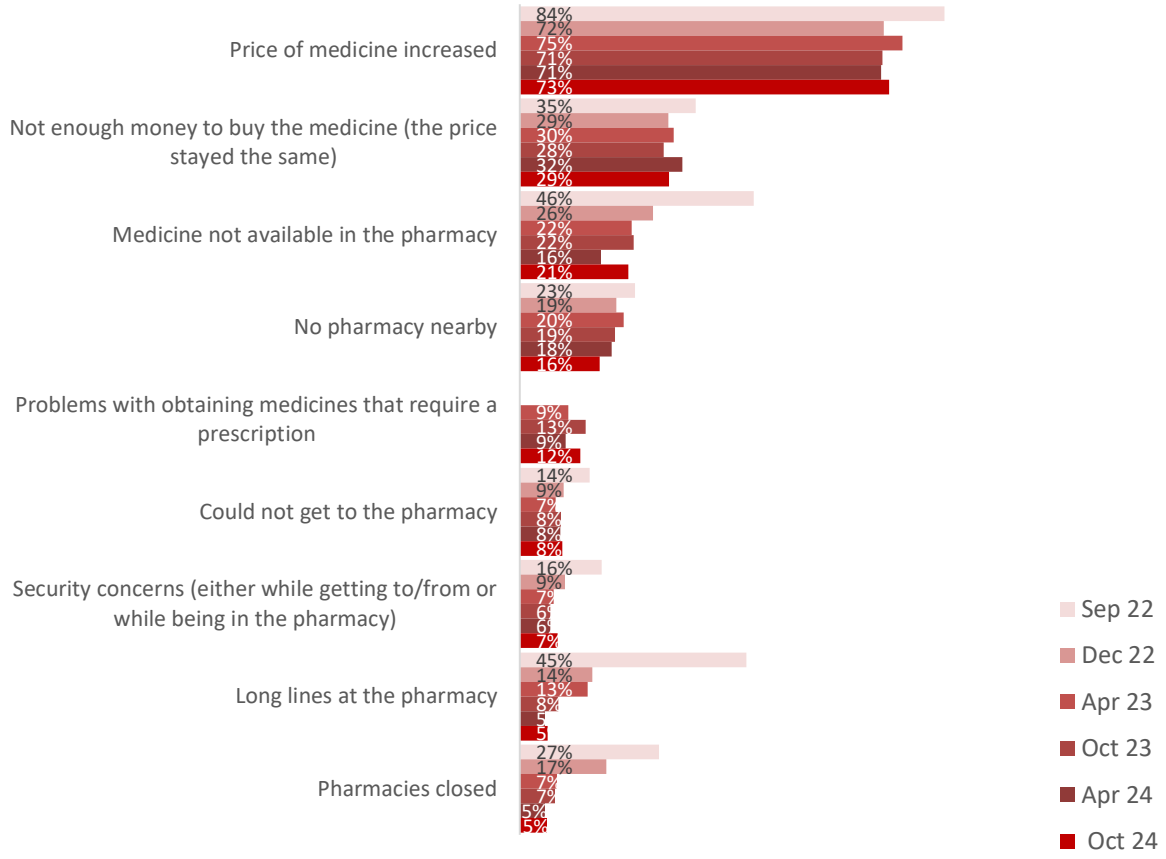
Type of medication	Sep 22	Dec 22	Apr 23	Oct 23	Apr 24	Oct 24
Cardiovascular	49%	36%	34%	19%	27%	**25%**
High blood pressure	50%	37%	33%	22%	27%	**22%**
Pain	41%	34%	38%	25%	26%	**21%**
Antibiotics	32%	28%	30%	21%	20%	**16%**
Sedative drugs	33%	19%	21%	14%	14%	**14%**
Diabetes	17%	8%	10%	10%	13%	**12%**
Mental health	10%	10%	13%	9%	9%	**10%**
Pulmonary	10%	10%	7%	5%	5%	**5%**
Fever	15%	6%	10%	6%	4%	**4%**
Antiseptics	17%	7%	11%	3%	4%	**2%**
Birth control	3%	2%	1%	1%	2%	**-**
Other	15%	22%	22%	27%	32%	**14%**

The main problem in October 2024, as in the previous rounds of data collection, was rising cost of medications, which affected 73% of respondents (Fig. 5.2). Additionally, one third of respondents (29%) reported a lack of funds for medications, despite stable medication prices.

Systemic problems have significantly increased since April 2024. Availability of medicines was a concern for 21% of respondents in October 2024, up from 16% in April 2024. Furthermore, a higher share of households faced problems with obtaining prescribed medicines – 12% in October 2024 compared to 9% in April 2024 (Fig. 5.2).

IDPs were more likely to face the barrier of pharmacy closures (9%) than people in their home communities (5%), but increased prices were reported by a much higher share of respondents remaining in their home communities than by IDPs (7% and 68%, respectively).
Seven per cent of respondents from the most affected areas reported pharmacy closures compared to 4% in other regions. Security concerns were more predominant in the most affected areas (17%) and in areas of increased vulnerability (8%) than in the rest of the country (5%).

Fig. 5.2. Main problems with obtaining medicines



Affordable Medicines Programme

Almost two thirds (62%) of the respondents reported that they knew about the Affordable Medicines Programme, which represents a significant increase since April 2024 (55%). Of these, nearly a quarter (24%) successfully used the programme and received medicines in the past three months, and 5% tried but were unsuccessful in receiving medicines. There was a significant increase in those who knew about the programme but did not need medicines – from 64% in April 2024 to 68% in October 2024 (Fig. 5.3 and Fig. 5.4).

Moreover, of those who obtained medicines under the Affordable Medicines Programme, the vast majority obtained them at pharmacies (89%), 29% – directly from a doctor at a medical facility, and 2% – through the national postal service Ukrposhta.

The survey team included additional questions to explore the option of receiving the medicines under the Affordable Medicines Programme by post. The results indicate that 40% knew about this option. A breakdown by status reveals that a significantly higher share of IDPs received medicines by post compared to people in their home communities (8% and 1%, respectively).

Fig. 5.3. Respondents who knew about the Affordable Medicines Programme

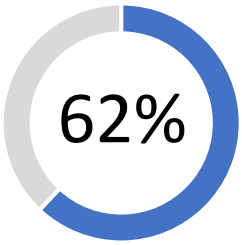
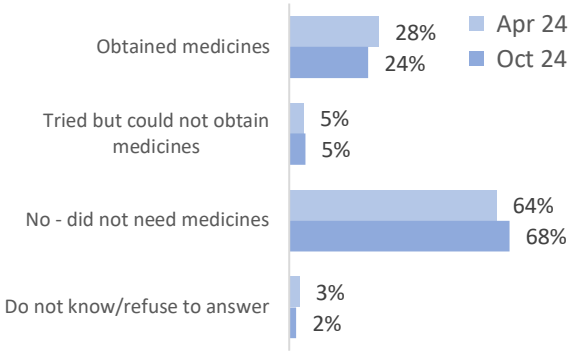


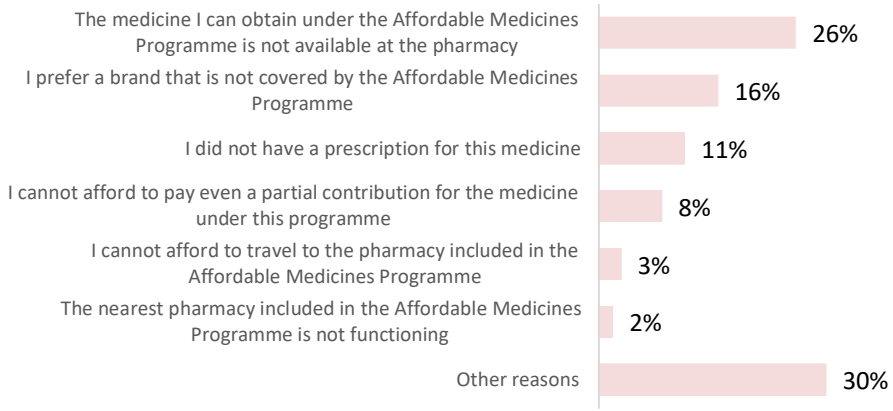
Fig. 5.4. Respondents who received medicines under the Affordable Medicines Programme*



**Among those who knew about the Affordable Medicines Programme*

A new question about reasons for not receiving medicines under the Affordable Medicines Programme was also added in October 2024. The results indicate that the main reasons were unavailability of medicines in pharmacies (26%) or unavailability of the preferred brand of medicine under the Programme (16%) (Fig. 5.5).

Fig. 5.5. Reasons why respondents could not receive medicines under the Affordable Medicines Programme



Section 6. Access to vaccination

In terms of access to vaccination, no significant differences were observed between October 2023 and October 2024. The proportion of households that attempted to receive routine vaccinations for children and the tetanus/diphtheria vaccine for adults remained unchanged. The demand for the COVID-19 vaccine dropped significantly in October 2023. The trend continued in October 2024, with only 3% of households seeking this type of vaccine (Fig. 6.1).

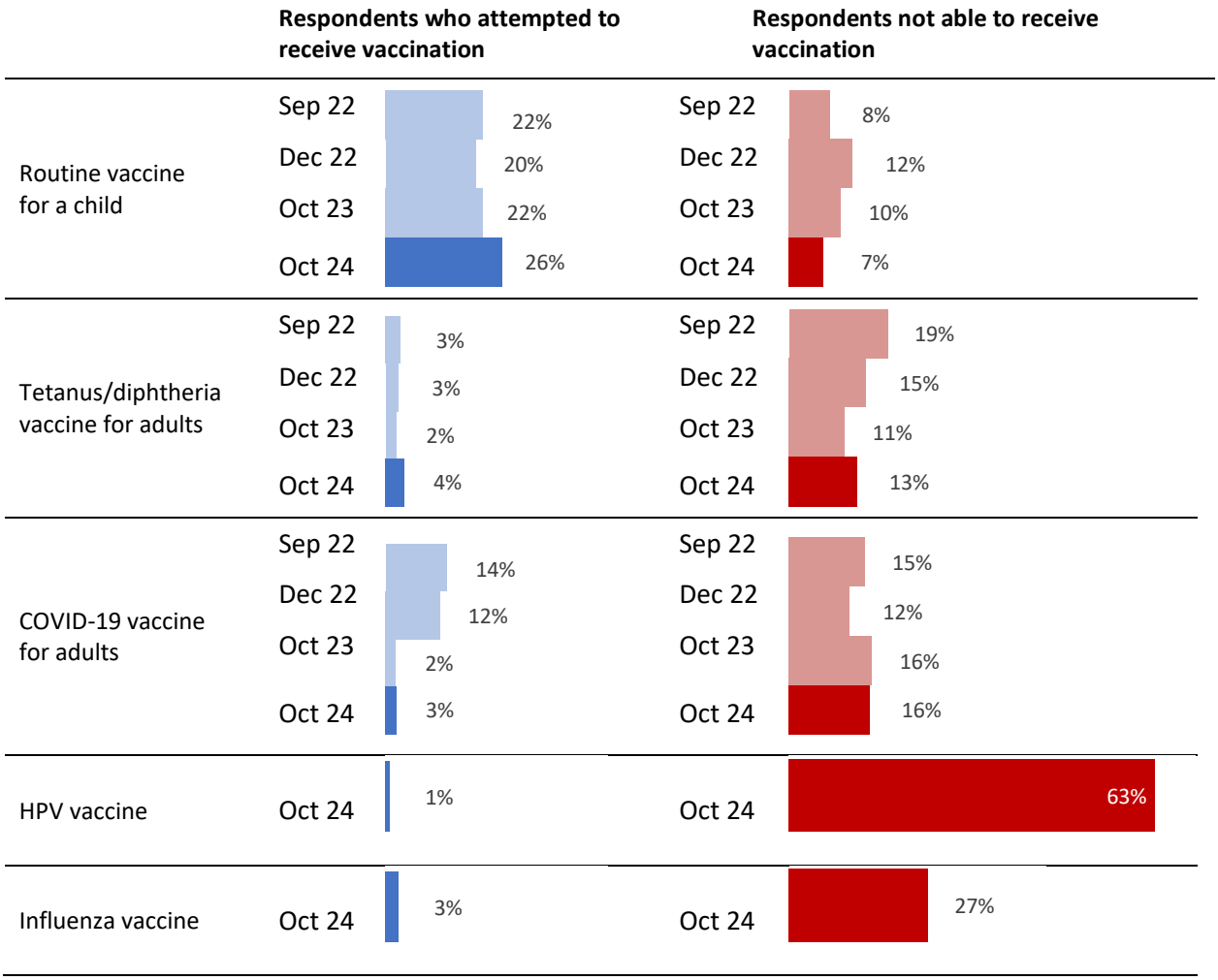
The share of those who were not able to receive needed vaccinations also remained largely unchanged, as vaccinations were available for the majority of those who sought them.
A breakdown by status revealed that a significantly higher share of IDPs (33%) sought routine vaccinations for children than of people residing in their home communities (25%).

In October 2024, the survey team added new questions on access to the HPV and influenza vaccinations. The results showed that 1% and 3% of households, respectively, sought these types of vaccinations. However, nearly two thirds (63%) of those who attempted to receive the HPV vaccination were not able to access it. In addition, one in four (23%) could not access the influenza vaccination.

The section on the influenza vaccination also included additional questions. The most common source of vaccination was the family doctor (56%). One in four (26%) received the influenza vaccination at a private medical facility. Respectively, 16% and 15% were able to receive the vaccine at work and during a doctor's appointment at a health-care facility. Notably, 8% were vaccinated at home.

Aside from the respondents who attempted to receive the influenza vaccination, an additional 11% indicated planning to receive it soon. Of those, 82% were planning to obtain it from a family doctor and 21% – at a private medical facility.

Fig. 6.1. Changes in access to vaccination



Section 7. Health behaviour

Mental health

In October 2023, 14% of respondents reported that members of their households were too upset or anxious to carry out their usual daily activities. One year later, in October 2024, this share was higher – 18%. No significant difference was reported between IDPs and those who remained in their home communities (Table 7.1).

Table 7.1. Respondents who were too upset or worried to carry out their usual daily activities by area

	Areas with active hostilities	Areas that experienced hostilities in the past	City of Kyiv	Rest of the country
Sep 22	14%	13%	9%	15%
Dec 22	13%	13%	13%	14%
Apr 23	16%	12%	11%	12%
Oct 23	14%	15%	12%	14%
Oct 24	20%	18%	19%	18%

Postponed medical care

The proportion of households that reported delayed medical care rose from 32% in April 2024 to 35% in October 2024. This represented a significant increase, with more than one in three households reporting delayed care. In terms of households that reported delayed medical care in October 2024, there was no significant difference between IDPs and people who remained in their home communities. The increase in delayed health care was reported in all regions. By macroregion, a higher proportion of households in Kyiv city reported delaying medical care (41%) than in the most affected regions (32%) or in the rest of the country (36%) (Table 7.2).

Table 7.2. Instances in the last three months of a household member not seeking needed medical care by area

	Most affected	Increased vulnerability	Kyiv city	Rest of the country
Dec 22	28%	29%	32%	27%
Apr 23	25%	25%	28%	23%
Oct 23	21%	21%	25%	24%
Apr 24	31%	33%	37%	31%
Oct 24	32%	34%	41%	36%

A question about the reasons for postponing medical care was included in the October 2024 survey. Self-treatment (58%) was the main reason for postponing medical care, which represented a significant increase from the 51% reported in October 2023, but has remained at a stable level since April 2024 (Fig. 7.1).

In October 2024, 40% of respondents had postponed medical care because they had minor symptoms that they felt would resolve on their own and considered them not too bothersome. Notably, 16% or one in six was postponing medical care because it was too expensive.

Fig. 7.1. Reasons for postponing medical care

Section 8. Medical expenses

Income

The October 2024 survey results show significant changes in household income. The proportion of households with a monthly income of less than 10 000 hryvnias remained the biggest group (36%) and decreased significantly from 40% in October 2024. The second largest group with an income of 10 000–20 000 hryvnias (29%) remained unchanged. Moreover, the proportion of households with an income over 30 000 hryvnias increased to 13% from 10% in April 2024 (Fig. 8.1).

Household expenditure on health-care services and medicines

The structure of medical expenses has also changed since April 2024, with a significant increase from 25% to 28% in households having average expenses on health care, and a decrease from 5% to 3% in households spending almost all their income on medical expenses (Fig. 8.2).

Fig. 8.1. Monthly household income

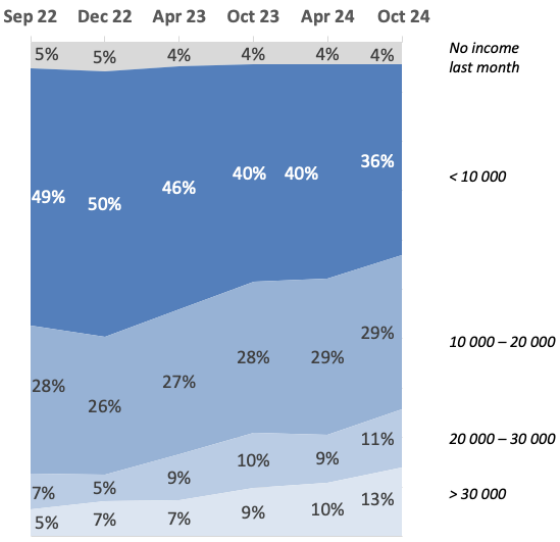
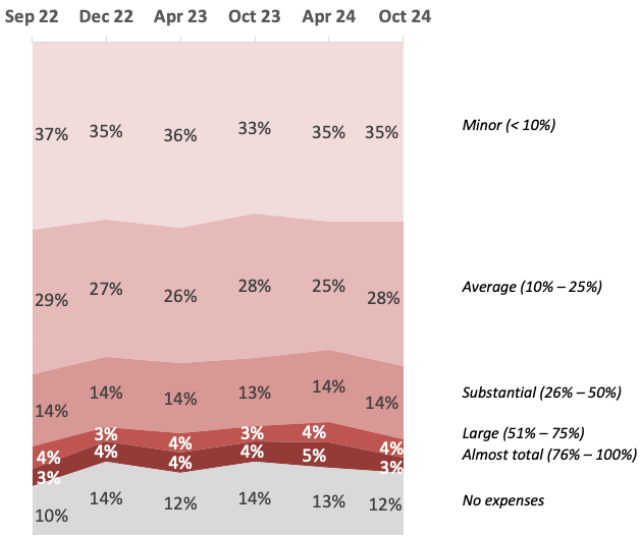


Fig. 8.2. Share of household expenditure on health-care services and medicines



The analyses by areas reveals that significantly lower share of households in most affected areas had minor expenses (30%) compared to rest of the country (36%), but at the same time a higher share in most affected areas (16%) had stated no expenses compared to other regions (Table 8.1).

Table 8.1. Share of household expenditure on health-care services and medicines by area

	Areas with active hostilities	Areas that experienced hostilities in the past	City of Kyiv	Rest of the country
Minor (< 10%)	30%	33%	43%	36%
Average (10% – 25%)	31%	31%	28%	27%
Substantial (26% – 50%)	14%	14%	12%	15%
Large (51% – 75%)	4%	4%	2%	4%
Almost total (76% – 100%)	3%	3%	2%	4%
No expenses	16%	11%	10%	11%

Ability to afford medicines and paid medical services

The data collected in October 2024 showed continued improvement in the affordability of medicines and paid medical services. The share of people who could not afford these services was much lower in October 2021 than in October 2023. However, more than one third (37%) still could not afford paid medical services.

The share of those who found medicines to be affordable increased significantly from 63% in October 2023 to 66% in October 2024.

The proportion of households able to afford paid medical services increased from 28% in September 2022 to 38% in October 2023 and significantly to 44% in October 2024 (Fig. 8.3, Fig. 8.4).

Fig. 8.3. Ability to afford medicines

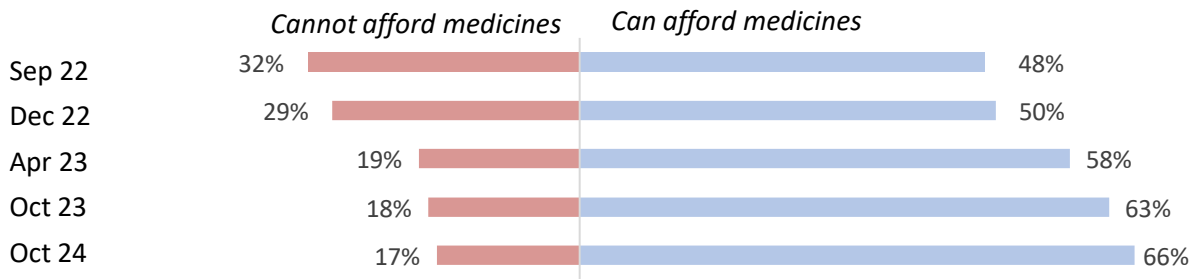
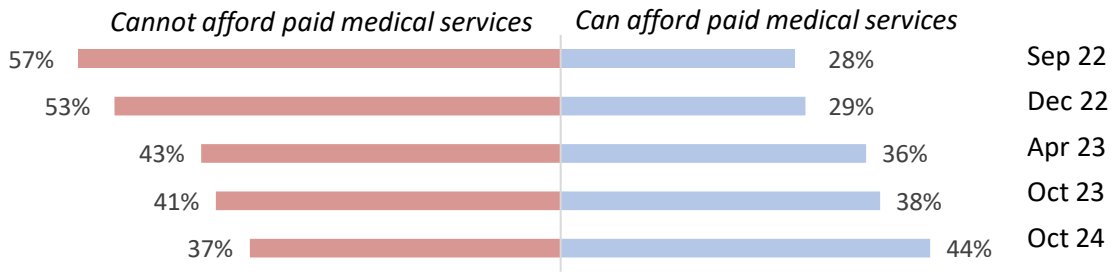


Fig. 8.4. Ability to afford paid medical services



No significant differences between IDPs and people remaining in their home communities were reported in October 2024. However, households in frontline areas, both those most affected and areas of increased vulnerability, were still less likely to be able to afford paid medical services (45% and 41%, respectively) than those in the city of Kyiv (26%) or the rest of Ukraine (34%). Paid medical services were also less affordable for the majority of respondents residing in areas with active hostilities (51%) and areas that experienced hostilities in the past (43%) than for those in the city of Kyiv (36%) and the rest of the country (37%).

Section 9. Medical insurance

In October 2024, a new section with two questions on the availability of medical insurance was added. Overall, 18% of respondents reported having medical insurance (Fig. 9.1). Variations were observed across demographic and socioeconomic groups. Respondents residing in urban areas, particularly in oblast centers (20%) or other cities (20%), were more likely to have medical insurance than those in rural areas (15%). Additionally, a higher proportion of male respondents reported having medical insurance compared to females (23% vs 14%). Medical insurance coverage was also more common among respondents aged 30–39 and 40–49 (23%) years compared to those aged 60 years and older (9%). A positive correlation with income level was identified, indicating that the availability of medical insurance increases with higher household income levels.

The most common type of insurance was private insurance from a current or former employer (51%). In addition, 14% of respondents reported having medical insurance through their spouse's employer, and 49% had a direct contract with an insurance company (Fig. 9.2).

Fig. 9.1. Respondents who have medical insurance

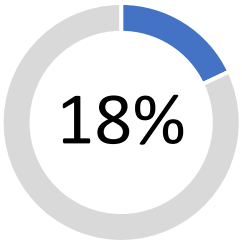
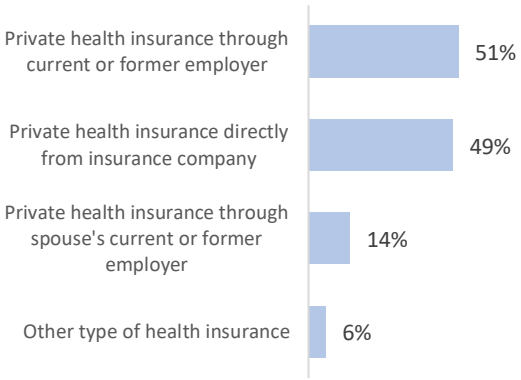


Fig. 9.2. Type of medical insurance reported*



**Among those who have medical insurance*

Section 10. Health information

A question on health information was added since the October 2023 survey. It revealed that 45% of respondents sought information related to health, which was higher than the 43% reported one year ago. The type of information needed did not change significantly, with treatment for chronic diseases (19%), access to health services (18%), mental health services (14%) and treatment for injuries (13%) among the most common types of health information sought by the respondents in October 2024 (Fig. 10.2).

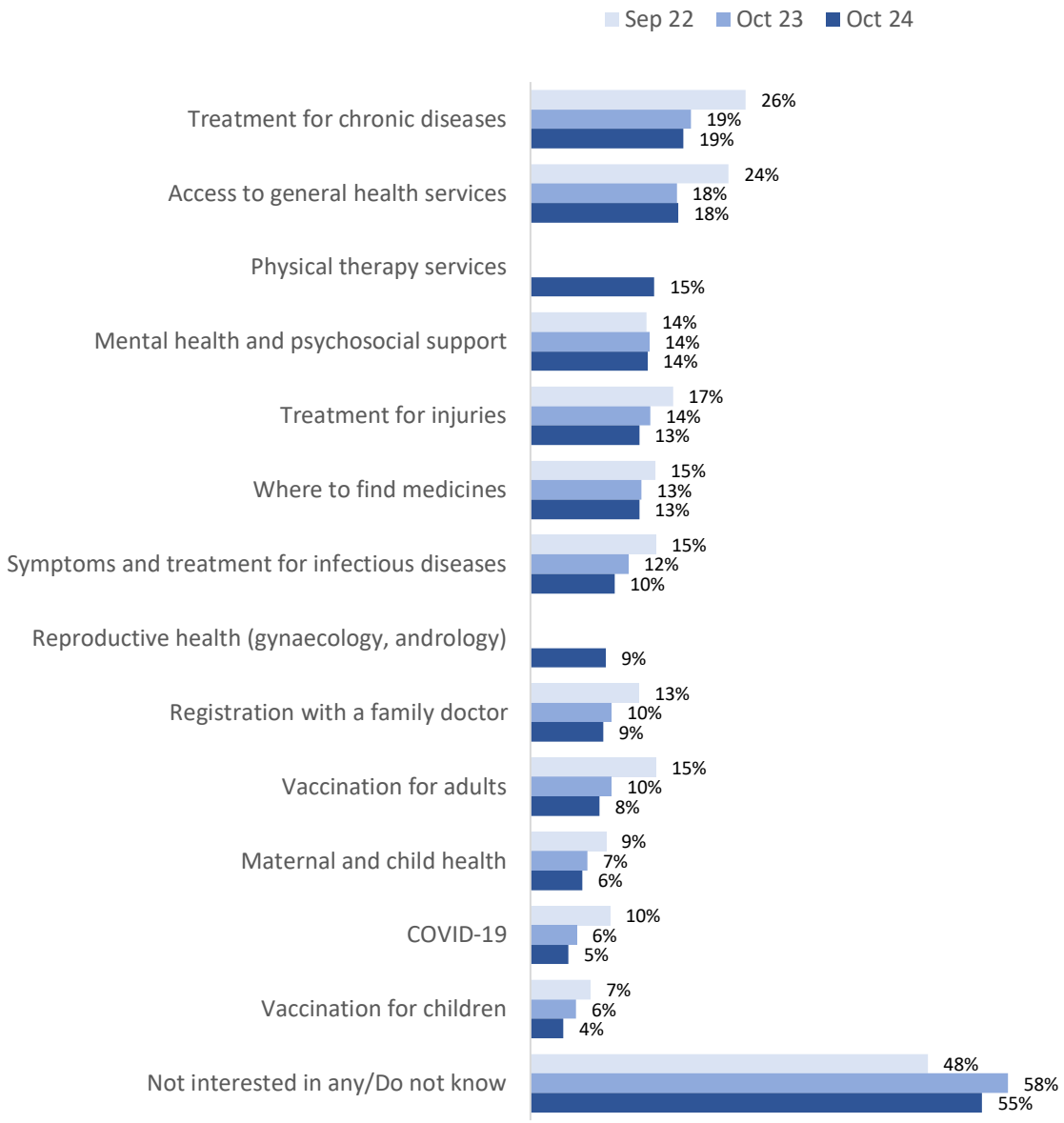
Compared to the results from October 2023, a significant decrease in health information on vaccination for children was reported in October 2024 (6% vs 4%).

No significant difference was identified between people who were internally displaced and those who remained in their home communities. A geographic breakdown resulted in similar findings, showing no significant differences in the information needed across the macroregions.

Compared to the first round in September 2022 and in October 2024, no significant changes regarding ease of obtaining health information were reported. The figures are stable, with three fourths of households indicating that the health information they needed was easy to find (Fig. 10.1).

Fig. 10.1. Ease of obtaining health information

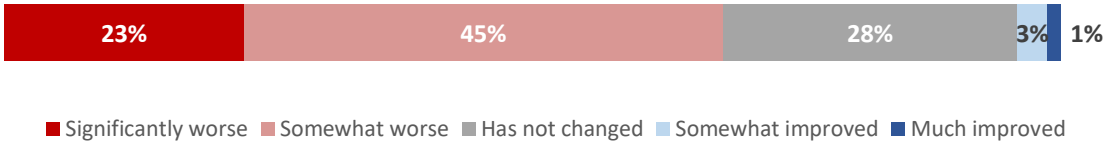
Fig. 10.2. Health information sought by respondents



Section 11. Health changes after 24 February 2022

A new set of questions was added to gauge the respondents' subjective perception of health status and access to health-care services after 24 February 2022.
Since the beginning of the war, a significant portion of the population has reported a decline in their health status. A combined 68% of respondents expressed that their health had worsened, with 23% stating it had become significantly worse and 45% indicating it was somewhat worse. Only a small minority noted any improvement, with 3% reporting slight improvement and 1% reporting significant improvement. For a considerable proportion (28%), there had been no noticeable change in health status (Fig. 11.1).

Fig. 11.1. Health status change since 24 February 2022



During an examination of specific health issues, sleep disorders emerged as the most frequently reported problem, affecting 68% of those who reported worsening health. Musculoskeletal issues, including joint and back pain, were another major concern, reported by 66% of respondents. Mental health conditions such as anxiety, depression and post-traumatic stress disorder were also prevalent, with 62% indicating that these issues had worsened. Neurological disorders, such as migraines and persistent headaches, were reported by 58%, while 56% noted impairments in vision or hearing. A similarly high proportion (55%) expressed that their immune system had weakened. Other common health challenges included cardiovascular diseases (53%), respiratory disorders (31%) and gastrointestinal disorders (36%) (Fig. 11.2).

The data highlight notable gender differences in health conditions. Women report higher rates of sleep disorders (75% vs 59%), mental health issues (66% vs 56%), respiratory problems (33% vs 28%), weakened immune systems (61% vs 46%) and neurological disorders (63% vs 50%) than men. Conversely, injuries are more common among men (22% vs 8%) (Fig. 11.4).

The analysis shows several significant differences in health conditions between IDPs and people remaining in their home communities. IDPs have a lower prevalence of cardiovascular diseases (46% vs 54%), respiratory problems (25% vs 33%) and musculoskeletal issues (58% vs 67%) than people in their home communities (Fig. 11.3).

Fig. 11.2. Health problems that have worsened the most since 24 February 2022

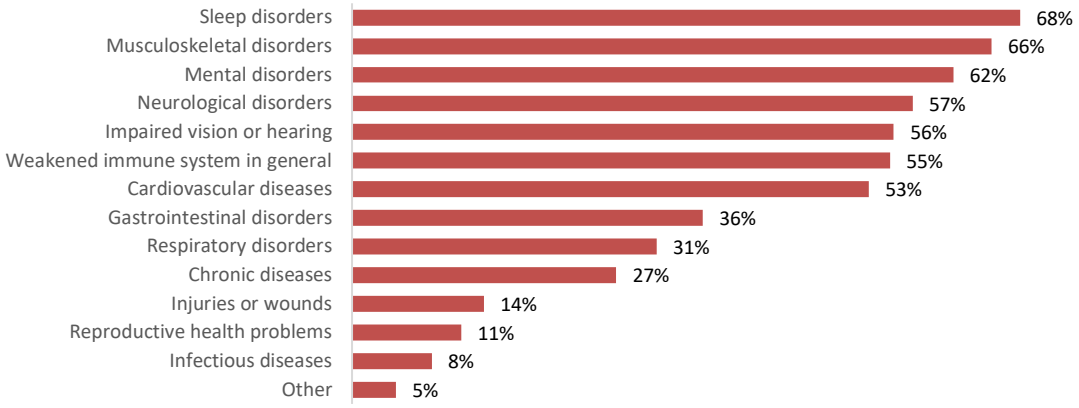


Fig. 11.3. Health problems that have worsened the most since 24 February 2022 by IDP status

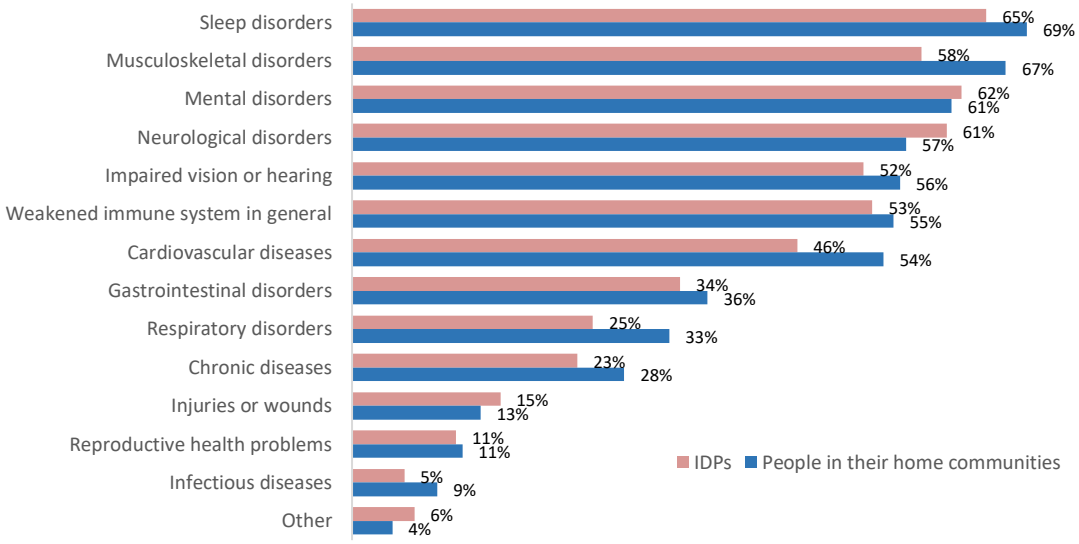
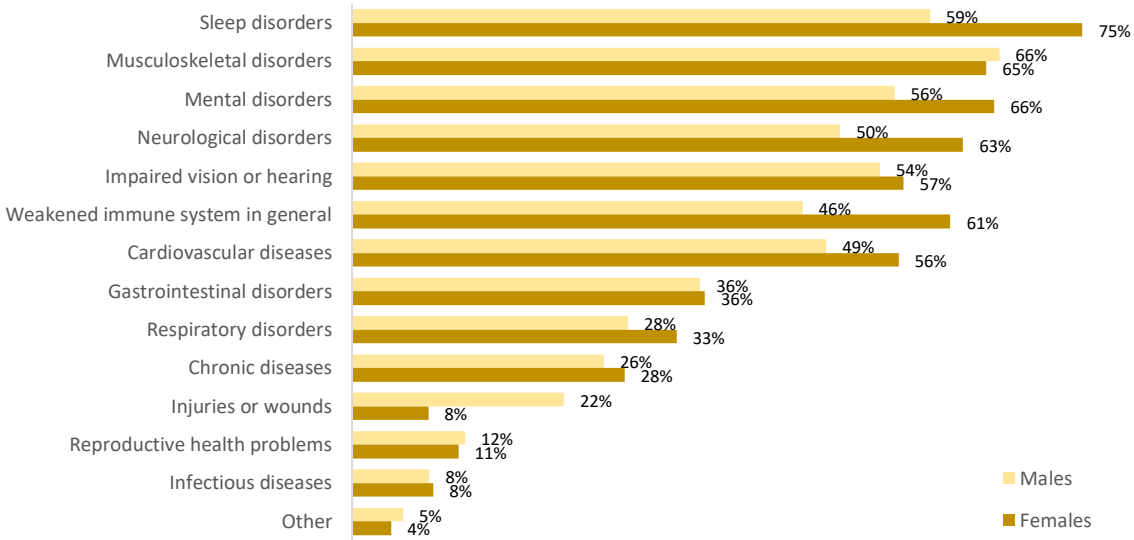


Fig. 11.4. Health problems that have worsened the most since 24 February 2022 by sex



Access to health-care services since 24 February 2022 has also been a critical issue. For the majority, access to health care remained unchanged, with 59% reporting no difference. However, 26% experienced a decline in access, with 10% noting that access had deteriorated significantly, and 16% stating it had slightly worsened. On the other hand, 12% of respondents reported improvements, suggesting some localized progress or efforts to enhance health-care delivery.

The perceived quality of health-care services in the area further paints a mixed picture. While over half of the respondents (55%) observed no changes in quality, 20% experienced a decline. Of these, 7% described significant deterioration, and 13% noted slight declines. Meanwhile, 16% saw improvements, with 13% reporting slight improvements and 4% reporting significant advancements.

Summary

Access to primary health care facilities and family doctors

The survey revealed high awareness of primary health care facilities, with 94% of respondents aware of their local facilities and 91% reporting that they were functional. However, a larger proportion of respondents in Kyiv city (8%) reported no access to a family doctor, compared to 6% in regions of increased vulnerability, 5% in the most affected regions and 3% in the rest of the country over the past three months. IDPs faced greater challenges, with 12% unaware of the location of their primary care facility, compared to 5% of people in their home communities. Access to family doctors showed minimal change, with 5% lacking access and a rise in remote consultations compared to earlier rounds. Males were more likely than females to lack access or rely on remote consultations. Preventive consultation uptake was concerning, as 71% of people who had signed health-care declarations visited a family doctor in person for a consultation in the last year, and 37% of them did not undergo preventive screening, especially among IDPs (44%).

Access to health services

Access to health-care services remained stable, but 68% of health-care seekers faced at least one barrier, such as cost of medicines (46%) and unofficial payments (10%).
Regional disparities continued, with the most affected regions and vulnerable populations facing increased barriers to care, including security concerns and higher costs.

Access to diagnostics

Fifty-one per cent of households required laboratory tests, and 39% needed instrumental diagnostics. The most common barriers were cost and time involved in completing these tests. Public laboratories were most frequently used, with only 37% of respondents completing tests free of charge. Respondents from the most affected areas reported a lower rate of undergoing laboratory diagnostics (47%) compared to those in the rest of the country (54%). Similarly, the rate of instrumental diagnostics was lower in areas of increased vulnerability (35%) than in the rest of the country (40%).

Access to medicines

Access to medicines remained stable, with 8% of households unable to obtain the necessary medications in the past three months, and 82% reporting difficulties in acquiring them. Pharmacy-related issues, such as closures and long queues, decreased in significance, while unavailability of medicines rose from 16% in April to 21% in October 2024. The issue of closed pharmacies was more common in the most affected oblasts (7%) compared to the rest of the

country (4%). Security concerns were also reported more frequently in frontline areas than in other regions. IDPs were more likely than people in their home communities to face issues with closed pharmacies (9% vs 5%), while those remaining in their home communities experienced higher prices. Heart, blood pressure and pain medications were the most difficult to obtain. The rising cost of medications remained the primary concern, affecting 73% of respondents. Awareness of the Affordable Medicines Programme rose significantly, with 62% of respondents stating that they were familiar with it. Among those aware, 24% had successfully used the Programme.

Vaccination access

Vaccination access remained largely unchanged, with routine vaccinations for children and the tetanus/diphtheria vaccine for adults consistently sought. However, demand for the COVID-19 vaccine remained low after a significant decline in 2023, with only 3% of households seeking it. Inability to access required vaccinations remained stable, with higher demand for routine child vaccinations among IDPs (33%, compared to 25% for people in their home communities). New questions revealed that 1% sought HPV vaccination, and 3% sought influenza vaccination, with two thirds unable to access HPV vaccines, and a quarter unable to access influenza vaccines.

Postponement of care

Health-care delays increased, with 35% of households reporting postponed medical care in October 2024, up from 32% in April 2024. The main reason for the delay was self-treatment (58%).

Health expenses

Household income trends revealed a decrease in the proportion of those earning less than 10 000 hryvnias, with an increase in those earning over 30 000 hryvnias. The structure of medical expenses shifted, with more people spending an average amount on health care. Affordability of medicines and medical services improved, with fewer households unable to afford medical services (37%) and more able to afford medicines (66%). However, frontline areas continued to face greater challenges in affording paid medical services.

Health changes since the war

Since the start of the war, 68% of respondents reported a decline in health, with sleep and mental disorders (68% and 62%, respectively) and musculoskeletal issues (66%) being the most prevalent. Women indicated higher rates of sleep disorders (75% vs 59%) and mental health issues (66% vs 56%) than men. IDPs had lower rates of cardiovascular diseases (46% vs 54%) and musculoskeletal disorders (58% vs 67%) compared to people remaining in their home communities. Access to health care remained largely unchanged for 59%, though 26% noted a decline in access. The quality of health-care services remained stable for 55%, but 20% experienced a decline in service quality, while 16% noted improvements.

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 not expected 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 and 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 to 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. The group has 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 study can contribute important insights that will inform response and recovery planning, despite its limitations.

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[1] All references were accessed on 24 December 2024.

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