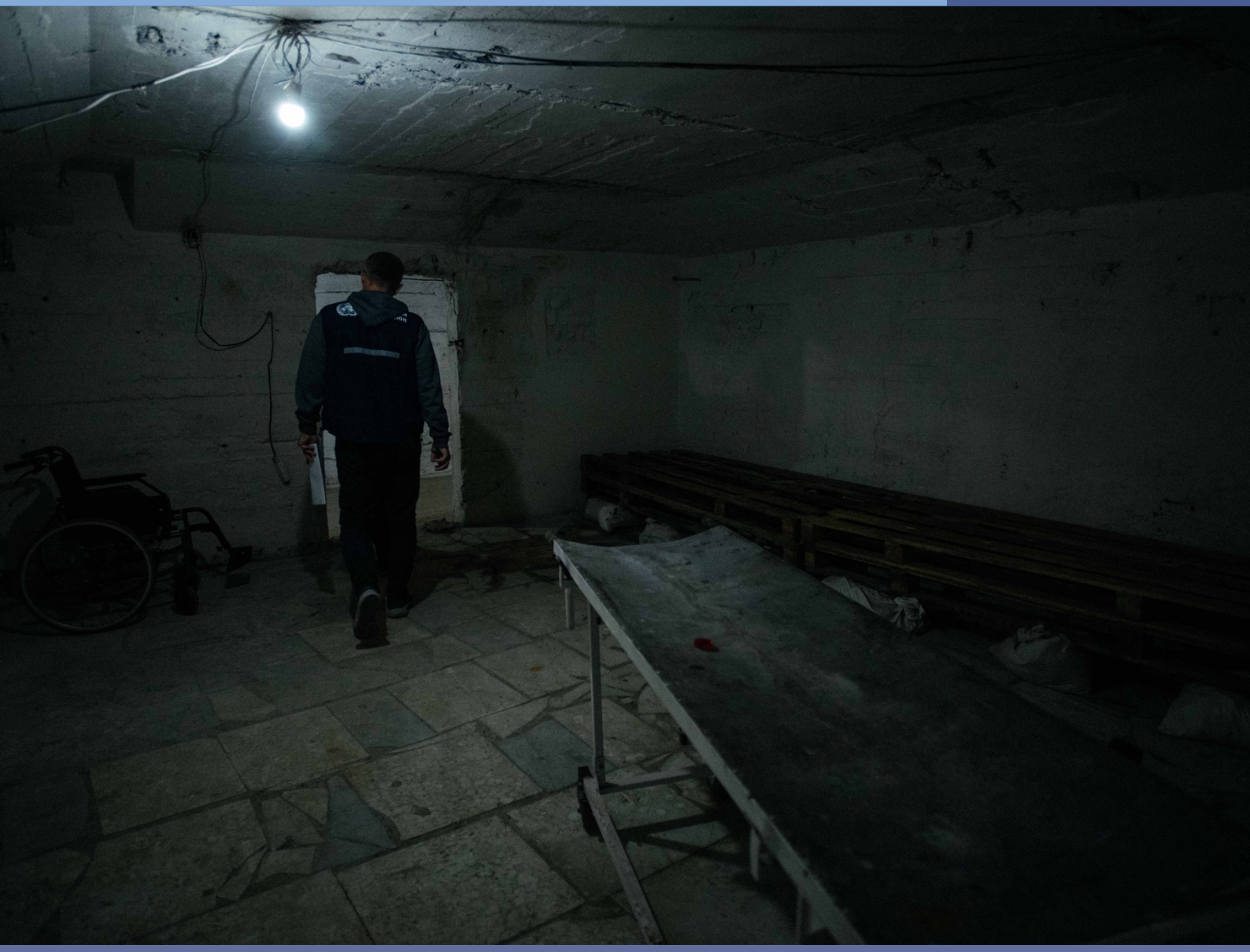
World Health Organization

European Region



Health needs assessment of the adult population in Ukraine

Survey report

April 2025

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Abstract

The ongoing war in Ukraine continues to place immense strain on the country's health system and population. Despite these challenges, findings from the April 2025 national household survey indicate that the health system remains resilient, with generally high awareness and accessibility of primary health care services. Overall, 93% of households knew the location of their primary health care facility, though access gaps persist among internally displaced persons and in front-line regions.

Most respondents maintained signed declarations with family doctors and satisfaction with care remained high, despite issues such as overloaded providers and long waiting times. However, preventive care uptake declined sharply, and barriers to accessing general and chronic care – particularly high medicine costs – remain significant.

Mental health needs continue to be a priority, with over 70% of respondents reporting symptoms of anxiety, depression or severe stress in the past year, yet only one in five sought professional help. Challenges in accessing medicines and rehabilitation services persist, driven largely by affordability and availability issues.

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The document was further refined through revisions by Denise Assaf (Health Information Management Unit Lead) and Dr Jarno Habicht (WHO Country Office in Ukraine Representative).

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Executive summary

In April 2025, a national household survey was conducted across Ukraine (excluding temporarily occupied Luhansk oblast and Crimea) with 4000 respondents per wave, focusing on macroregional analysis and vulnerable groups, including internally displaced persons (IDPs) and front-line populations. The survey highlights evolving access to health services, barriers to care and health needs under ongoing conflict conditions.

Primary health care access and awareness remain high overall, with 93% of households knowing the location of their facility and 97% reporting it as functional. However, gaps persist among IDPs, particularly recent arrivals, with 20% unaware of facility locations. While most respondents had in-person access to family doctors, 4% had no access at all. IDPs and rural residents reported more limited access. About 29% overall changed their doctor since February 2022, with a significantly higher rate (57%) among IDPs.

Preventive examinations saw declining participation, with 44% not undergoing screenings in April 2025, up from 27% six months before. Screenings for HIV, tuberculosis, diabetes, hypertension and breast cancer were notably low.

Access to general health care remains challenging: 56% needed care and, among them, 64% encountered at least one barrier. Cost of medicines and treatment remains the top obstacle. In front-line regions, fewer people sought care, primarily for chronic conditions and primary care needs.

Chronic condition care is increasingly critical; 34% reported household members with chronic diseases, yet 12% could not receive needed care. Medicine costs (59%) and treatment expenses (36%) were the most cited barriers, with security concerns disproportionately affecting IDPs.

Rehabilitation services were used by 9% of respondents, but 60% faced obstacles and 25% could not access the services they needed. Public facilities remain the main provider.

Diagnostics access varied: 52% needed laboratory tests (80% completed) and 40% needed instrumental diagnostics (69% completed).

Mental health needs remain high, with 72% experiencing issues in the past year, including anxiety and depression. Only 20% sought professional help, though most were satisfied with the support received.

Medicines and affordability are ongoing concerns; 82% faced problems obtaining medicines, primarily due to high prices and financial constraints. Awareness of the Affordable Medicines Programme rose to 65%, though uptake remains limited.

Financial barriers continue, with 86% reporting medical expenses and 11% still making informal payments. Delayed care was reported by 35% and perceived lack of local services increased to 32%, particularly in rural and small towns.

Methodology

Background

The onset of the war, coinciding with the coronavirus disease (COVID-19) pandemic, placed an immense strain on Ukraine's already overburdened health system and workforce. Widespread attacks resulted in large-scale internal and external displacement, while targeted strikes on health facilities further exacerbated the humanitarian crisis, creating both immediate and long-term public health challenges.

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 30 June 2025, there have been 2481 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 April 2025, nearly 3.8 million people are internally displaced within Ukraine *(4)*.

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

Awareness of primary health care facilities remained high (94%), though IDPs reported more challenges in accessing care and family doctors. Barriers to services persisted, with 68% of seekers facing issues like medicine costs and unofficial payments. Access to diagnostics was limited mainly by cost and time, especially in war-affected regions. While 8% of households could not obtain the medicines they needed, 82% reported difficulties, with high prices being the main concern. Pharmacy closures and medicine shortages were more common in front-line areas. Awareness of the Affordable Medicines Programme (AMP) increased to 62%, though only 24% of those aware used it. Vaccination access remained stable, with low COVID-19 vaccine demand and higher child vaccination needs among IDPs. Delays in care rose

slightly, mainly due to self-treatment. Although affordability improved overall, front-line areas faced greater challenges. Since the war's start, 68% reported worse health, especially sleep, mental and musculoskeletal problems. Women and IDPs showed distinct patterns in health impacts.

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 organizations, including United Nations 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 the 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 interview (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, 5 and 6 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 European Society for Opinion and Marketing Research and World Association for Public Opinion Research codes.

Data for the assessment were collected in seven 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
- Round 7 was conducted on 28 April–4 May 2025.

For Round 7, a total of 101 interviewers were initially recruited. All the interviewers had completed at least secondary-level education and 96% 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 20 minutes. The field force size was 101 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 and 6 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 front-line regions were divided into two macroregions: the most affected regions (Donetsk,

Kharkiv, Kherson, Zaporizhzhya) and regions of increased vulnerability (Chernihiv, Dnipropetrovsk, Mykolayiv, Odesa, Sumy). 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.

For Round 7, macroregions were revised to reflect the current situation on the ground. Sumy oblast was reclassified from an area of increased vulnerability to one of the most affected regions due to renewed hostilities along the northern border. This change was also applied retrospectively to previous rounds to ensure continuity in trend analysis.

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 (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 2025, during Round 7 of data collection, a total of 4006 respondents were interviewed with a 9.2% response rate. The total number of those who picked up the phone was 47 956. The geographic, age and gender distribution was consistent with national demographic statistics, with 68% living in urban areas and 32% in rural areas, 29% representing 60 and above age group, and with 45% male and 55% female (Table 1.1. and 1.2).

In the household composition data, 33% of households included members aged 65 years or older, and 34% had chronic conditions. Children under 18 years of age were present in 36% of households, and 3% of households included pregnant or lactating women. Twenty-seven per cent of households also included people who have disabilities (actual condition, regardless of whether they have an officially recognized group of disability).

Table 1.1. Respondents by age group

18–29 years old	30–39 years old	40–49 years old	50–59 years old	60+ years old
15%	21%	17%	17%	29%

Table 1.2. Respondents by sex

♀	♂
55%	45%

For Round 7 of data collection, the survey team modified the macroregions to represent the actual situation on the ground. The Sumy oblast was moved from the increased vulnerability category to the most affected regions since the active combat activities had restarted on the northern border. This change in macroregions was also implemented retrospectively to the data from previous rounds to have a continued analysis of the trends.

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 Table 1.3. Table 1.4 shows the number and proportion of respondents in each of the four macroregions (most affected regions, regions of increased vulnerability, Kyiv city and rest of the country).

Table 1.3 Respondents by oblast, percentage and N

Oblast	Proportion, %	N=	Oblast	Proportion, %	N=
1. Vinnytsya	4%	174	13. Odesa	7%	271
2. Volyn	3%	106	14. Poltava	4%	167
3. Dnipropetrovsk	10%	388	15. Rivne	3%	125
4. Donetsk	2%	62	16. Sumy	3%	113
5. Zhytomyr	3%	124	17. Ternopil	3%	119
6. Zakarpattya	3%	135	18. Kharkiv	6%	260
7. Zaporizhzhya	4%	150	19. Kherson	2%	62
8. Ivano-Frankivsk	4%	154	20. Khmelnytsky	4%	148
9. Kyiv	6%	221	21. Cherkasy	4%	144
10. Kirovohrad	3%	113	22. Chernivtsi	3%	105
11. Lviv	7%	279	23. Chernihiv	3%	111
12. Mykolayiv	3%	122	24. Kyiv city	9%	354

Table 1.4. Respondents by oblast status

Macroregion	Sep 22	Dec 22	Apr 23	Oct 23	Apr 24	Oct 24	Apr 25
Most affected regions	15%	16%	16%	17%	16%	16%	16%
Regions of increased vulnerability	22%	22%	22%	22%	22%	23%	22%
Kyiv city	9%	8%	9%	9%	9%	8%	9%
Rest of the country	54%	54%	53%	53%	52%	53%	53%

The migration of Ukrainians within and outside Ukraine has been constant since the start of the war on 24 February 2022. In April 2025, 22% of respondents indicated that they had moved since the start of the war (Tables 1.5 and 1.6).

Furthermore, 69% 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, 14% moved 6–12 months ago and 9% moved 3–6 months ago. Of note, 8% indicated that they had moved less than three months ago (Table 1.7). Almost half (49%) have official IDP status, which was received after February 2022.

Table 1.5. Proportion of respondents who have been internally displaced

Place of residence	Sep 22	Dec 22	Apr 23	Oct 23	Apr 24	Oct 24	Apr 25
Live in the same place	82.1%	83.7%	81.8%	79.9%	80.8%	78.7%	78.5%
Moved after 24 February 2022	17.9%	16.3%	18.2%	20.1%	19.2%	21.3%	22.5%

Table 1.6. Respondents who have changed place of residence, N

Place of residence	Sep 22	Dec 22	Apr 23	Oct 23	Apr 24	Oct 24	Apr 25
Live in the same place	3284	3351	3273	3195	3234	3151	3143
Moved after 24 February 2022	716	650	728	805	768	851	863

Table 1.7. Proportion of respondents by timing of relocation

Changed place of residence	Apr 24	Oct 24	Apr 25
Less than 3 months ago	7%	15%	8%
3–6 months ago	8%	10%	9%
6–12 months ago	15%	11%	14%
More than 12 months ago	68%	62%	68%

In October 2024, a new question related to relocating was added to the survey tool. The question was repeated in April 2025 and according to the results, 16% of the respondents relocated after February 2022 (Table 1.8).

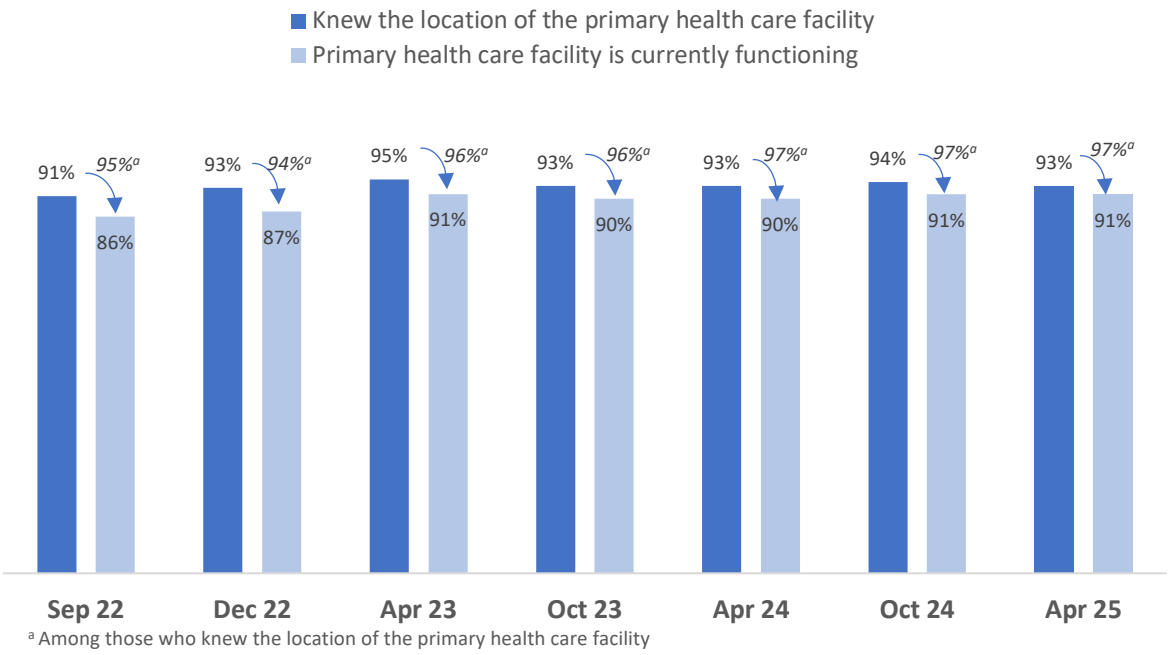
Table 1.8. Respondents who have changed the settlement of residence, percentage and N

Settlement	Oct 24, %	Oct 24, N=	Apr 25, %	Apr 25, N=
Live in the same settlement	84%	3359	84%	3349
Changed settlement after 24 February 2022	16%	643	16%	657

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

In April 2025, the indicators related to awareness of primary health care facilities and their functional status remain stable with a high awareness among the general population about primary health care facilities. Nearly all households (93%) know the location of their primary health care facility, with 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 functional status of their primary health care facility



[a] Among those who knew the location of the primary health care facility

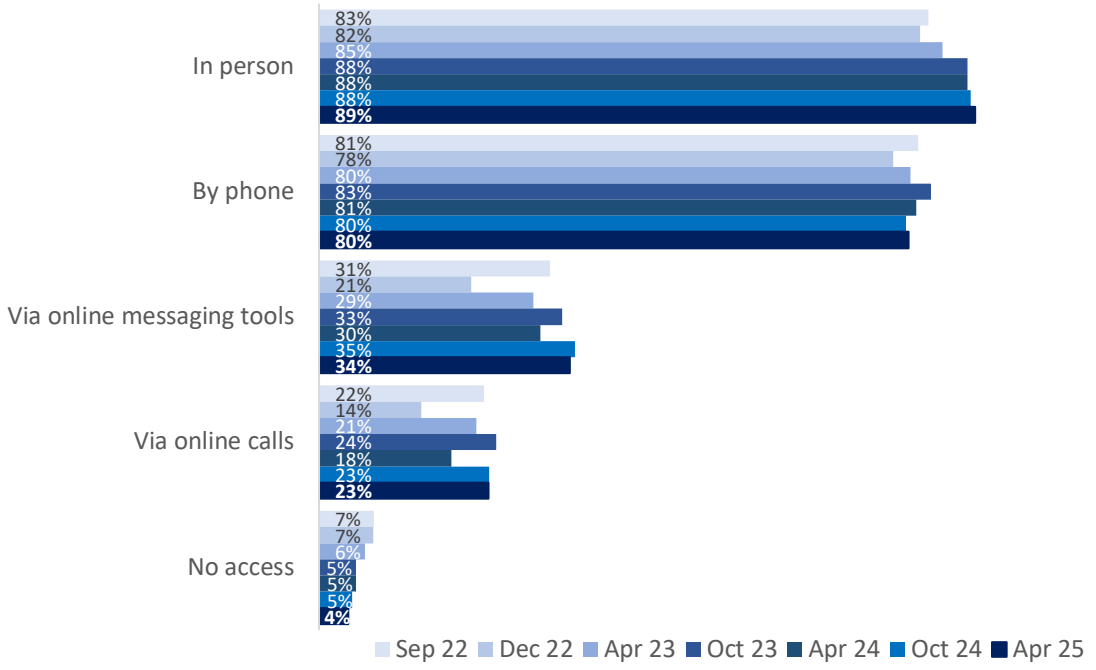
IDPs remain more vulnerable: 11% reported that they did not know the location of their primary health care facility compared to 8% of people in their home communities, which represents a significant difference. In addition, among IDPs who moved less than 12 months ago, 20% did not know the location of the primary health care facility compared to those who moved more than 12 months ago (7%) (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
People in their home communities	8%
IDPs	11%
Relocated less than 3 months ago	22%
Relocated 3–6 months ago	28%
Relocated 6–12 months ago	12%
Relocated more than 12 months ago	6%

Access to a family doctor remained unchanged in April 2025 from the previous rounds of data collection, with only 4% of households reporting that they did not have access to a family doctor. For the majority of respondents, in-person access to a family doctor was available (89%), followed by remote channels like phone (80%), online messaging tools (34%) and online calls (23%) (Fig. 2.2).

Fig. 2.2. Access to a family doctor



In terms of geographic breakdown, a higher share of respondents from regions of increased vulnerability (5%) had no access to a family doctor, compared to 3% in the rest of the country. Residents of the most affected regions and regions of increased vulnerability also had lower in-person access to family doctors (84% and 87%, respectively) than the rest of the country (91%). Eight per cent of IDPs reported having no access to a family doctor, compared to 3%

of people in their home communities, which represented a significant difference (Table 2.2). Moreover, IDPs reported less access to a family doctor via in-person visits than people in their home communities (77% and 91%, respectively).

Table 2.2. No access to a family doctor

Respondent residence status	No access to a family doctor
People in their home communities	3%
IDPs	8%
Relocated less than 3 months ago	14%
Relocated 3–6 months ago	6%
Relocated 6–12 months ago	11%
Relocated more than 12 months ago	6%

Gender analysis revealed that a significantly higher share of males (5%) than females (3%) had no access to a family doctor. Additionally, a lower share of males had in-person (86%) or phone access to a family doctor (77%) than females (91% and 83%, respectively).

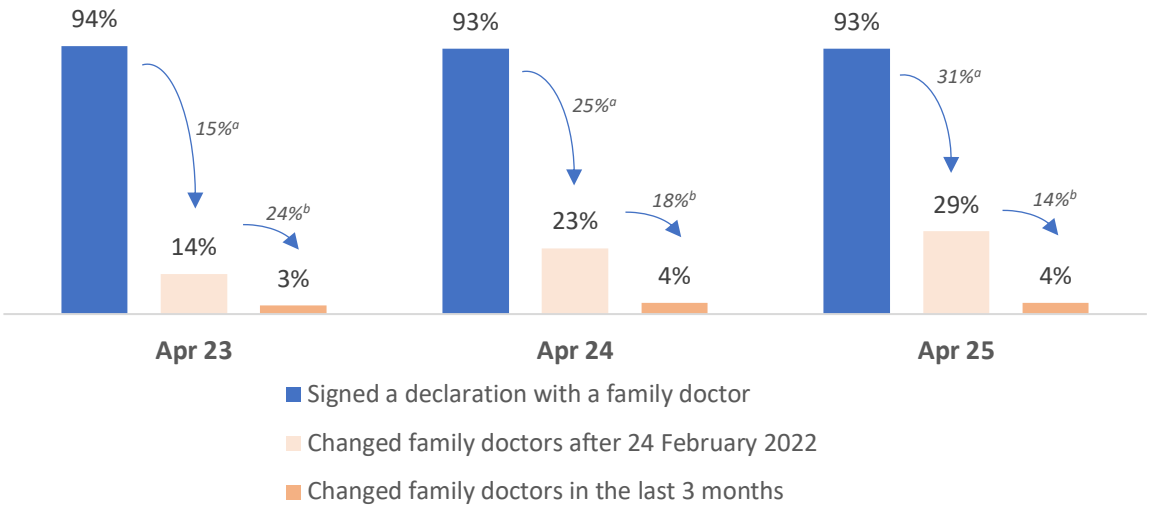
According to the results, the majority of respondents were able to get to a primary health care facility on foot (41%) in April 2025, followed by personal (30%) and public transportation (23%).

As of April 2025, 93% 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 (9%) than among people in their home communities (5%). A breakdown by microregion reveals that residents of Kyiv city (9%) did not have a signed declaration with a family doctor, compared to 5% in the rest of the country and in front-line regions.

Thirty-one per cent have changed family doctors since 24 February 2022, which is a significant increase compared to 25% in October 2024. Furthermore, 14% of households who have changed family doctors since 24 February 2022 have done so in the past three months (Fig. 2.3).

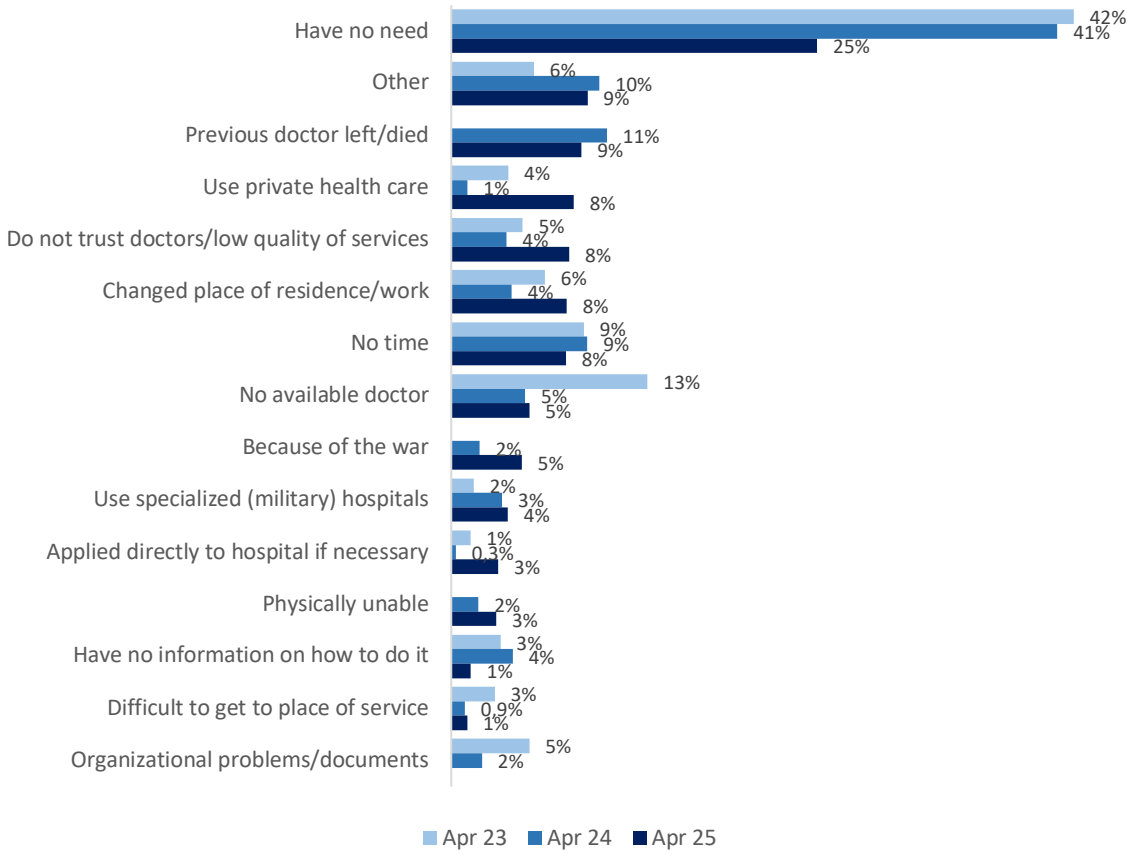
The main reason for not having a signed declaration was not having a need for it (25%). Other reasons, such as lack of time, distrust, low service quality or a doctor's departure, accounted for approximately 8–9% (Fig. 2.4.). It is also worth noting that 5% did not sign a declaration with a family doctor because of the war.

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



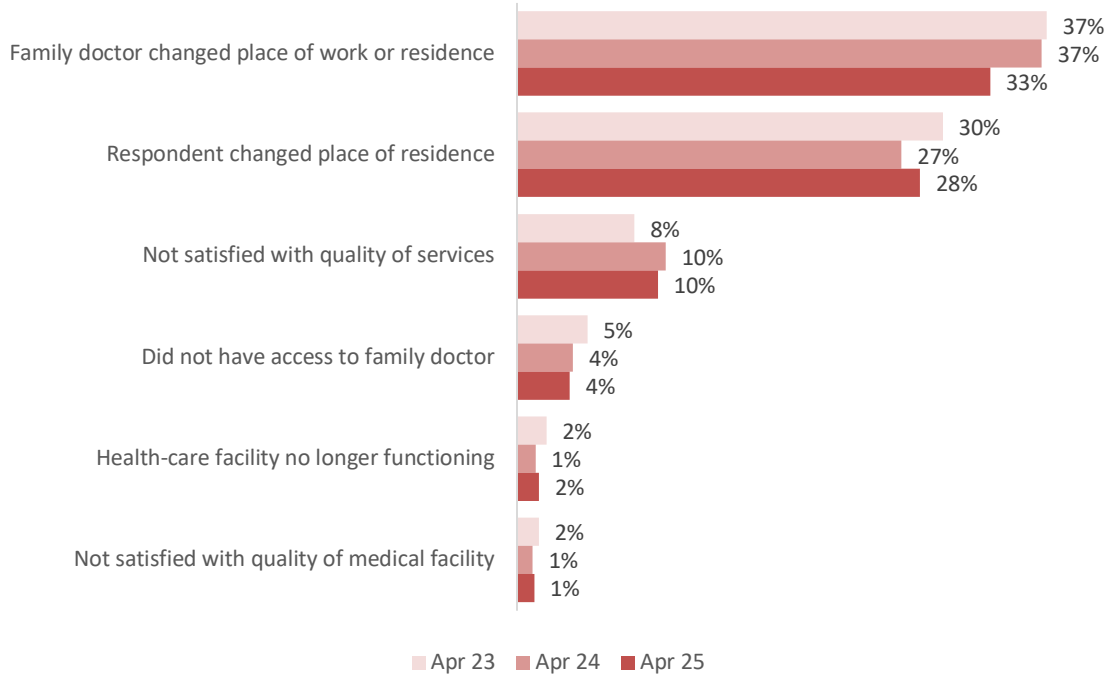
[a] Among those who signed a declaration with a family doctor
[b] Among those who changed their family doctor after 24 February 2022

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



No significant changes in the reasons for changing the family doctor have been reported compared to the previous available results. The primary reasons for changing family doctors were changes in the workplace or residence for either the family doctor or the respondent (33%) (Fig. 2.5). Furthermore, 10% of the respondents who changed doctors did so because of dissatisfaction with the quality of services. Additionally, 13% reported problems when changing the family doctor (mainly lack of available doctors or technical problems when completing the declaration).

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

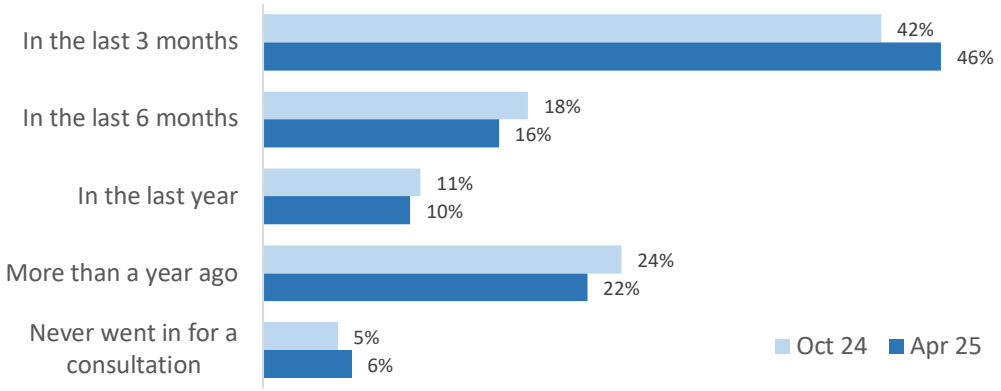


In April 2025, according to the results, almost two thirds of the respondents (64%) were completely satisfied with their family doctor, only 5% rated their satisfaction below average and 4% did not know or refused to answer.

The main reasons among those who were not completely satisfied with their family doctor included the family doctor being overbooked (41%), long queues (38%) and the fact that the family doctor does not offer home visits (36%). Almost one third (30%) reported difficulties with securing an appointment and problems contacting the doctor (27%).

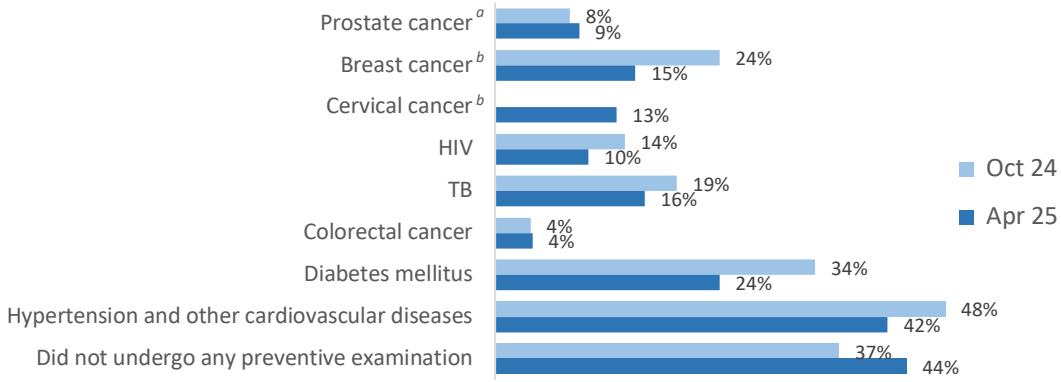
In April 2025, the survey team continued to monitor the set of questions related to in-person visits to a family doctor and preventive medical examinations that should be provided by family doctors. For the majority of those who had a signed declaration, the last in-person visit took place in the past three months (46%). However, one in five (22%) had their last visit to a family doctor more than one year ago and 6% never had a consultation (Fig. 2.6).

Fig. 2.6. 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 a significant increase in the proportion of those who did not undergo any preventive examinations from 27% in October 2024 to 44% in April 2025. This trend was also spotted in the breakdown by type of examination. HIV, tuberculosis (TB), diabetes and hypertension screenings were reported by a significantly lower share of respondents, as was breast cancer screening among female respondents (Fig. 2.7).

Fig. 2.7. Respondents who underwent preventive examinations with a family doctor in the last year



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

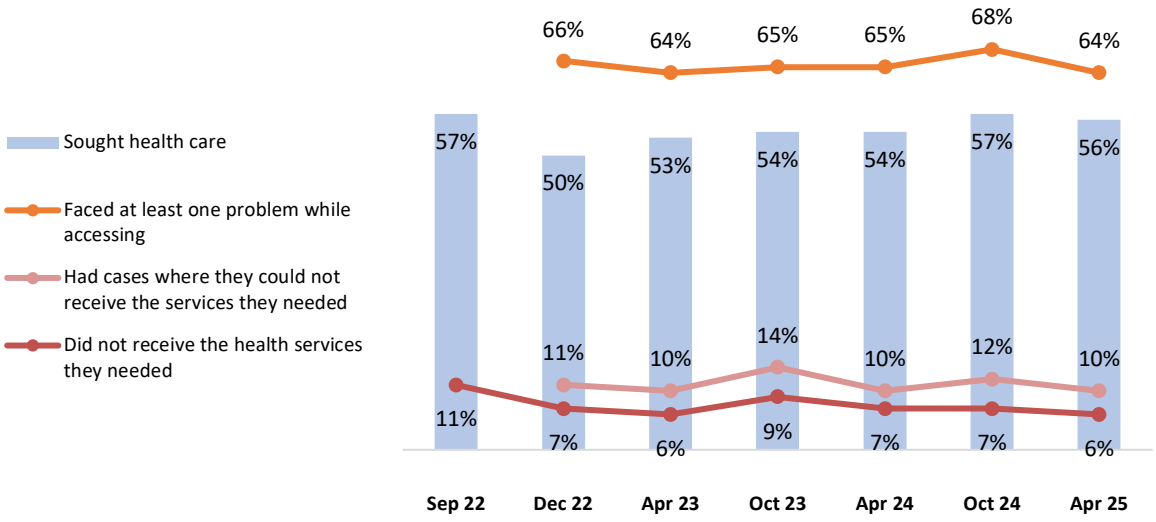
Section 3. Access to health care

Changes in health-care access

According to findings from recent survey rounds, overall access to health-care services has remained relatively steady. Just over half of respondents (56%) indicated that they required some form of medical assistance. Among those who sought care, nearly two thirds (64%) encountered at least one barrier when trying to obtain medical services. Additionally, one in 10 (10%) people were unable to access the specific care they needed, while 6% could not receive any medical services at all (see Fig. 3.1).

Moreover, regional disparities in access to care were highlighted in April 2025. In front-line regions – encompassing both the most severely affected areas and those with heightened vulnerability – a smaller share of respondents reported seeking medical services, with only 48% and 54%, respectively, compared to 58% in Kyiv and other parts of the country.

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



In April 2025, most households primarily sought care for chronic conditions, accounting for 40% of the cases (Fig. 3.2). Additionally, over one third (34%) required primary health care services. Notably, the proportion of households seeking health services for children declined significantly compared to October 2024. Overall, access to all categories of health services remained consistent, with availability exceeding 90% for each service type.

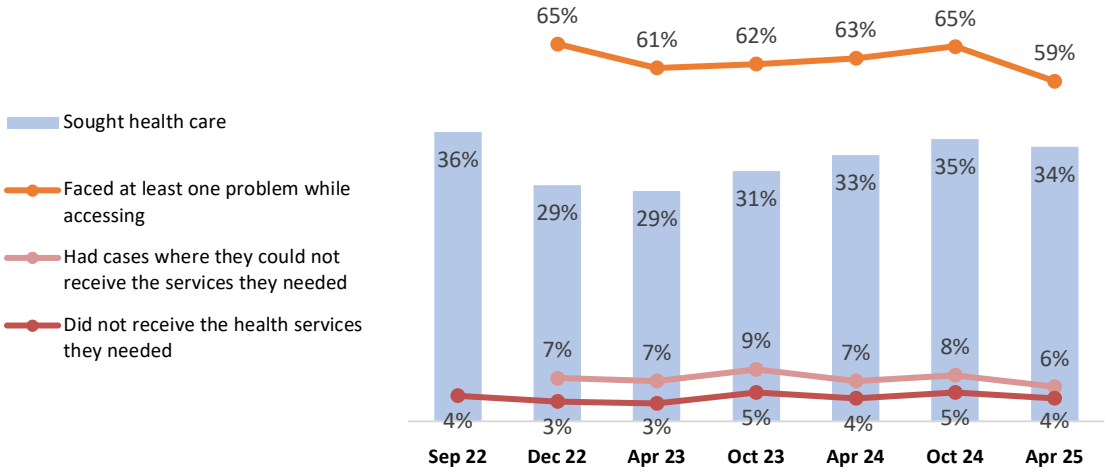
Fig. 3.2. Dynamics of access to health care

	Sought health care		Did not receive the health services they needed	
Emergency services (ambulance)	Sep 22	19%	Sep 22	8%
	Dec 22	14%	Dec 22	8%
	Apr 23	13%	Apr 23	7%
	Oct 23	15%	Oct 23	8%
	Apr 24	14%	Apr 24	6%
	Oct 24	17%	Oct 24	6%
	Apr 25	15%	Apr 25	7%
Primary health care	Sep 22	36%	Sep 22	4%
	Dec 22	29%	Dec 22	4%
	Apr 23	29%	Apr 23	3%
	Oct 23	31%	Oct 23	5%
	Apr 24	33%	Apr 24	4%
	Oct 24	35%	Oct 24	5%
	Apr 25	34%	Apr 25	4%
Health care for chronic conditions	Sep 22	52%	Sep 22	10%
	Dec 22	44%	Dec 22	5%
	Apr 23	42%	Apr 23	6%
	Oct 23	44%	Oct 23	7%
	Apr 24	45%	Apr 24	5%
	Oct 24	42%	Oct 24	6%
	Apr 25	40%	Apr 25	5%
Health care for a child	Sep 22	33%	Sep 22	8%
	Dec 22	33%	Dec 22	3%
	Apr 23	34%	Apr 23	4%
	Oct 23	37%	Oct 23	4%
	Apr 24	39%	Apr 24	3%
	Oct 24	44%	Oct 24	2%
	Apr 25	38%	Apr 25	2%
Health-care services for injuries	Sep 22	15%	Sep 22	7%
	Dec 22	9%	Dec 22	3%
	Apr 23	7%	Apr 23	5%
	Oct 23	11%	Oct 23	7%
	Apr 24	9%	Apr 24	6%
	Oct 24	11%	Oct 24	6%
	Apr 25	9%	Apr 25	7%
Pregnancy health-care services	Sep 22	2%	Sep 22	10%
	Dec 22	1%	Dec 22	7%
	Apr 23	1%	Apr 23	12%
	Oct 23	1%	Oct 23	7%
	Apr 24	1%	Apr 24	8%
	Oct 24	1%	Oct 24	9%
	Apr 25	2%	Apr 25	5%

Primary health care

The level of access to primary care in April 2025 did not differ significantly from that in the previous rounds. Thirty-four per cent of households sought primary health care services in the three months prior to the survey (Fig. 3.3). Of these, 59% reported encountering at least one barrier to access, which was significantly lower than in October 2024 (65%). Six per cent of households reported encountering situations in which they were unable to receive the primary health care services they needed and 4% were unable to access any primary care services.

Fig. 3.3. Dynamics of access to primary health care



In April 2025, the most commonly reported barrier in accessing health care was cost of medicines (41%). Compared to the results of the previous round in October 2024, the percentage of households citing cost of medicines and treatment as a problem significantly decreased from 46% to 41% and from 29% to 23%, respectively (Fig. 3.4). The proportion of respondents who faced refusals in primary health care decreased significantly from 5% in October 2024 to 3% in April 2025.

There were no significant changes between October 2024 and April 2025 in terms of what prevented respondents from 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 (16%) and refusal to provide services (15%) (Fig. 3.5). Another important barrier was cost of treatment (13%).

Fig. 3.4. Problems when seeking primary care services

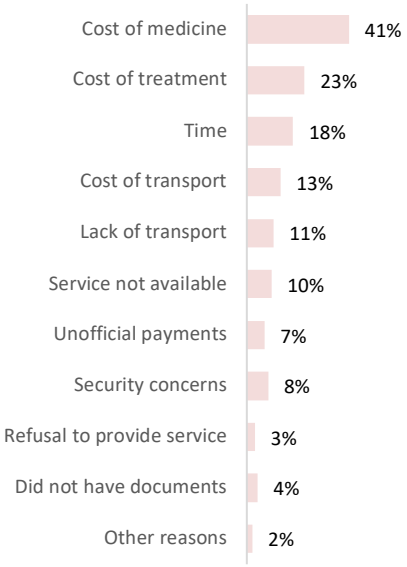
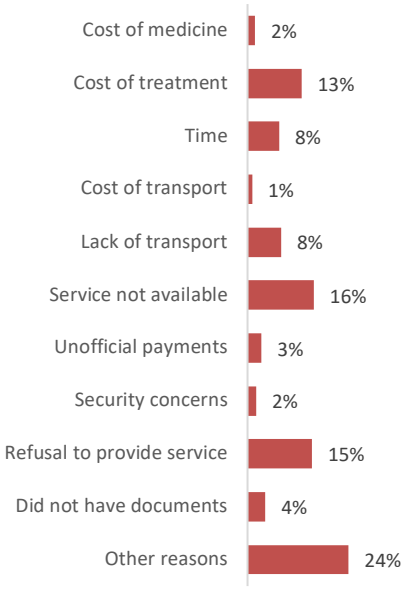


Fig. 3.5. Main barriers to access to primary care



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 5% of IDPs and 4% of people in their home communities reported cases of not receiving primary health care services. Moreover, refusal to provide health-care services or consultations as the main barrier to accessing primary health care was significantly higher among IDPs (29%) than among people in their home communities (12%).

Households from the most affected areas (29%) were much less likely to seek primary health care than those in the rest of the country (36%). In April 2025, the share of households who faced at least one problem accessing primary health care was much higher in regions of increased vulnerability (68%) than in the rest of the country (57%) (Table 3.1).

Respondents from the most affected regions were less likely to seek primary health care (32%) than the rest of the country (38%). At the same time, respondents in regions of increased vulnerability (68%) faced problems accessing more often than the rest of the country (57%). Cost of medicines was the main problem with accessing primary health care in all the macroregions, but it was much more pronounced in the most affected regions (48% in regions of increased vulnerability and 42% in the most affected regions) than in the rest of the country (38%).

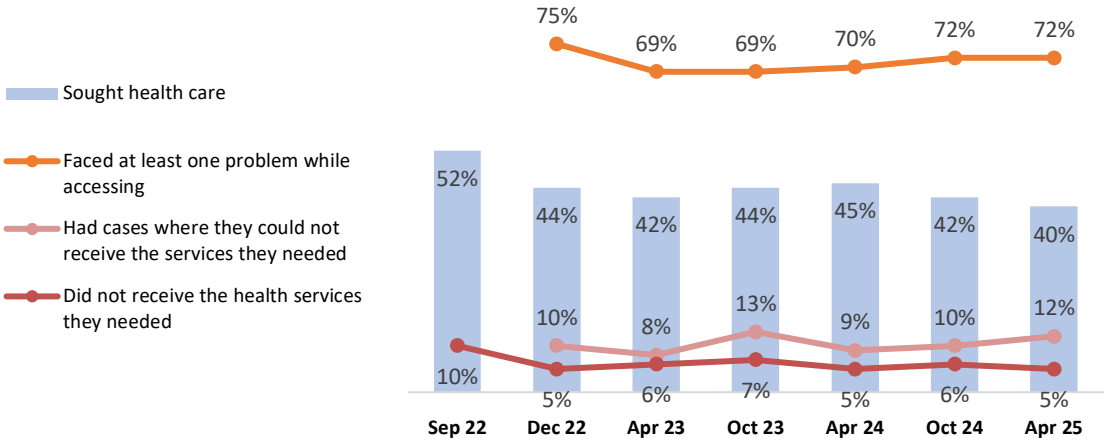
Table 3.1. Access to primary health care by region type

		Sought health care	Faced at least one problem when accessing	Had instances where they could not receive the services they needed	Did not receive the services they needed
Most affected regions	Sep 22	31%	-	-	6%
	Dec 22	24%	69%	6%	2%
	Apr 23	22%	59%	7%	3%
	Oct 23	26%	63%	11%	8%
	Apr 24	28%	69%	10%	6%
	Oct 24	32%	77%	10%	7%
	Apr 25	29%	56%	3%	1%
Regions of increased vulnerability	Sep 22	32%	57%	-	4%
	Dec 22	26%	74%	9%	5%
	Apr 23	25%	69%	8%	2%
	Oct 23	32%	61%	8%	5%
	Apr 24	30%	65%	6%	3%
	Oct 24	30%	69%	7%	4%
	Apr 25	32%	68%	7%	4%
Kyiv city	Sep 22	41%	-	-	5%
	Dec 22	28%	62%	10%	4%
	Apr 23	35%	58%	8%	3%
	Oct 23	33%	66%	9%	6%
	Apr 24	34%	68%	10%	6%
	Oct 24	36%	68%	11%	9%
	Apr 25	36%	60%	10%	7%
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%
	Apr 25	36%	57%	6%	4%

Health care for chronic conditions

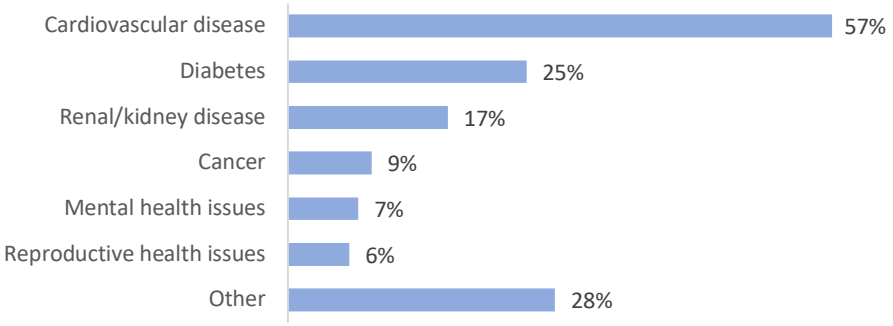
In April 2025, 34% of all households reported having a family member with a chronic condition, which was significantly higher than in the last round (28%). Forty per cent of those who reported having family members with chronic diseases sought health care for their condition in the three months prior to the survey (Fig. 3.6).

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



Respondents sought assistance for family members with cardiovascular diseases (57%) and diabetes (25%) (Fig. 3.7). Among people with chronic conditions, 81% received care at home, while 30% 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 problem. Most households (59%) who sought care indicated that the cost of medicines was their greatest challenge (Fig. 3.8). Cost of treatment as a problem remained stable (36%). Lack of transportation as a problem to access decreased significantly from 19% in October 2024 to 11% in April 2025.

Twelve per cent of households reported instances when they were unable to receive health services for their chronic condition, and 5% 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 (16%), time needed to receive services (14%) and cost of medicines (12%) (Fig. 3.9).

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

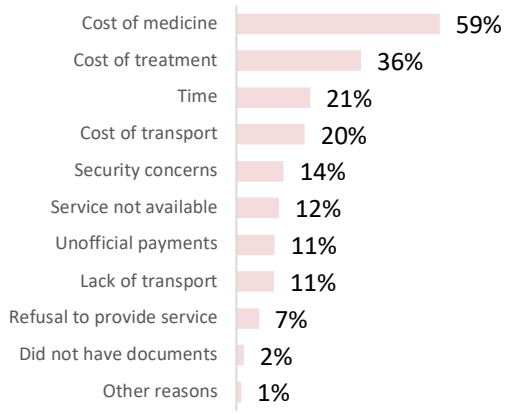
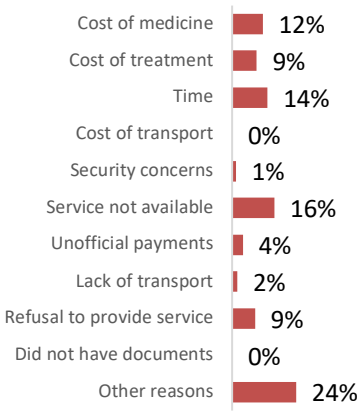


Fig. 3.9. Main barriers to access to health care related to a chronic condition



No significant differences in the types of health conditions were reported in April 2025. 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 found in the higher security concerns among IDPs (33%) compared to 10% among people in their home communities (Table 3.2). Respondents from the most affected regions also experienced more problems with security (21%) compared to 12% in the rest of the country.

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 services they needed	Did not receive the services they needed
IDPs	Oct 24	43%	63%	12%	11%
	Apr 25	40%	80%	13%	8%
People in their home communities	Oct 24	42%	73%	10%	5%
	Apr 25	39%	71%	11%	5%

In April 2025, a lower share of respondents residing in the most affected areas sought health care for a chronic condition (Table 3.3). No significant differences were reported regarding problems and barriers, with cost of treatment and medicines remaining the main barrier.

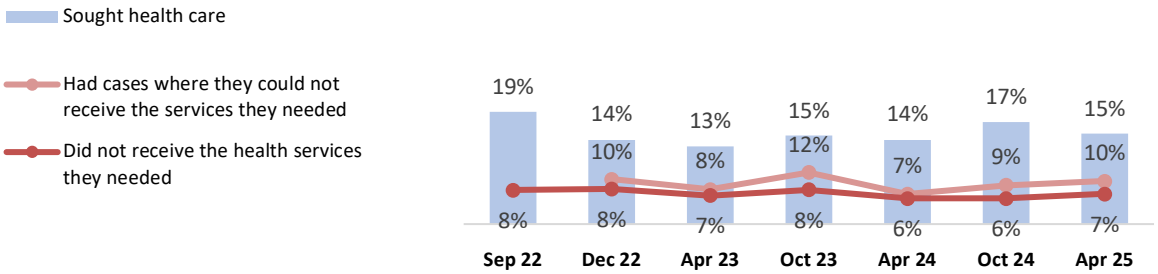
Table 3.3. Access to health care related to a chronic condition by region

		Sought health care	Faced at least one problem when accessing	Had instances where they could not receive the services they needed	Did not receive the services they needed
Most affected regions	Sep 22	39%	-	-	13%
	Dec 22	41%	78%	10%	3%
	Apr 23	35%	66%	8%	5%
	Oct 23	39%	66%	11%	6%
	Apr 24	44%	70%	6%	3%
	Oct 24	41%	72%	8%	5%
	Apr 25	37%	72%	10%	7%
Regions of increased vulnerability	Sep 22	48%	-	-	7%
	Dec 22	43%	72%	15%	6%
	Apr 23	41%	74%	13%	9%
	Oct 23	35%	72%	12%	6%
	Apr 24	42%	70%	10%	5%
	Oct 24	40%	74%	10%	8%
	Apr 25	38%	75%	13%	6%
Kyiv city	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%
	Apr 25	42%	76%	14%	10%
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%
	Apr 25	41%	70%	11%	4%

Emergency (ambulance) services

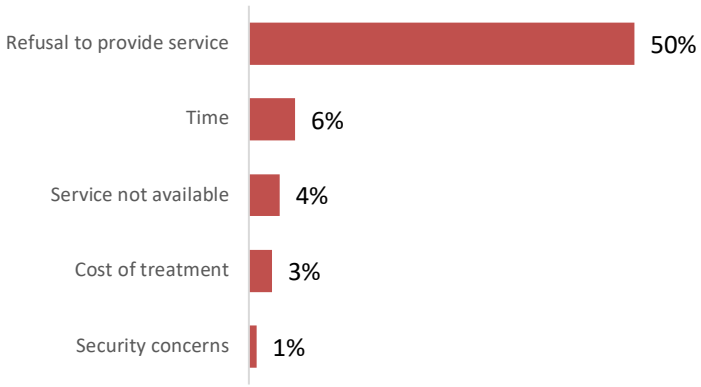
In April 2025, access to emergency medical assistance (ambulance services) remained stable and unchanged from the previous rounds, with 15% seeking emergency services (Fig. 3.10). Of these, 10% were unable to obtain the services they needed. Furthermore, 7% did not receive any of the services they needed.

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 50% of those who could not receive the services (Fig. 3.11). The significantly higher share of respondents in regions of increased vulnerability reported instances of inability to obtain the emergency services they needed (21%) compared to 7% in the rest of the country and 4% in Kyiv city.

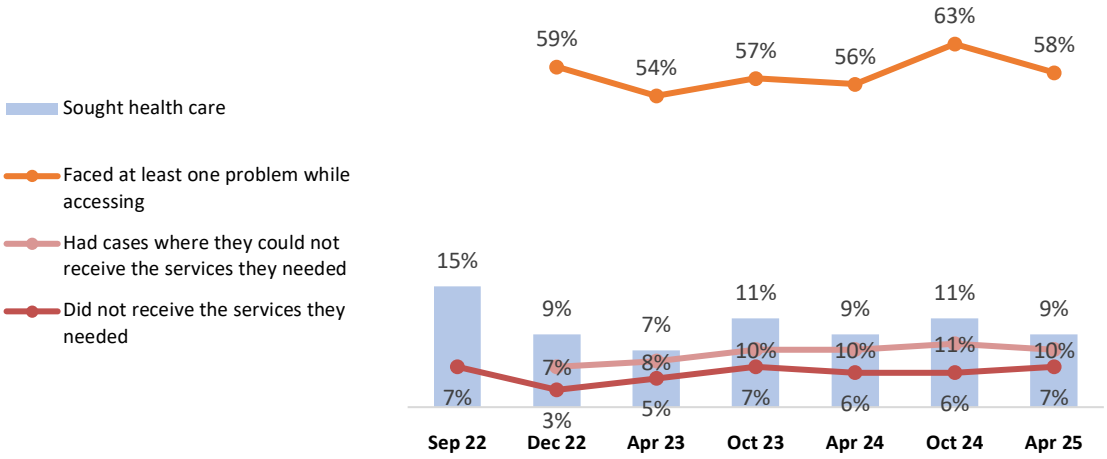
Fig. 3.11. Main barriers to access to emergency medical services



Health-care services for injuries

In April 2025, 9% of households reported seeking medical care for injuries in the three months prior to the survey (Fig. 3.12). More than half (58%) 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 health-care services for injuries were cost of medicines (34%) and cost of treatment (22%) (Fig. 3.13). In addition, one in five (21%) of the respondents reported time as a problem and 15% of households cited cost of transportation. Additionally, 10% of households faced instances in which they were unable to access the services they sought and 7% received no services at all. Refusal to provide services (26%) and unavailability of services (16%) were the main barriers in April 2025 (Fig. 3.14).

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

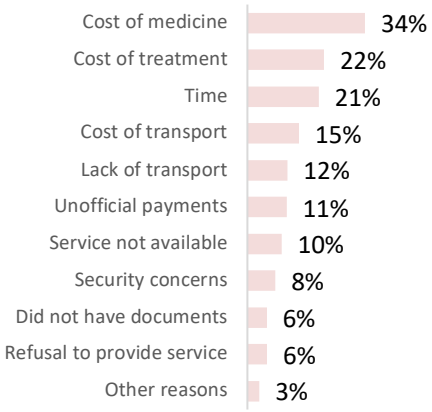
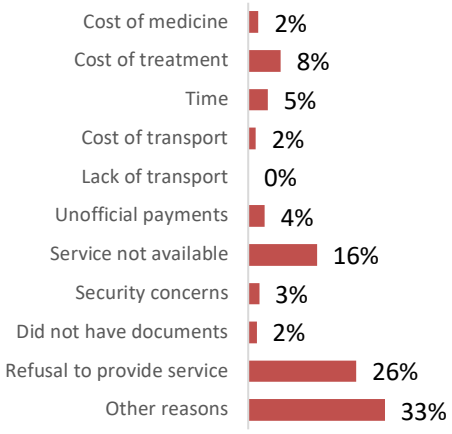


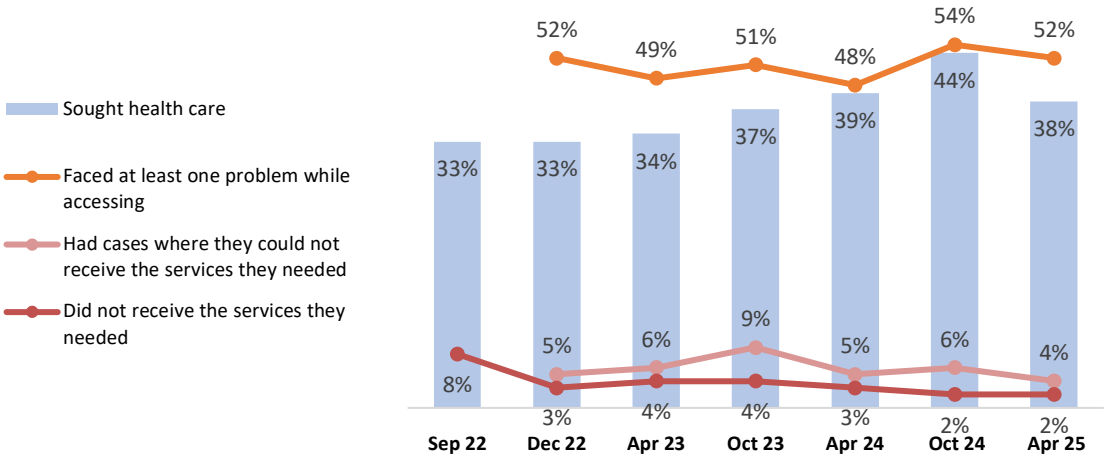
Fig. 3.14. Main barriers to access to health-care services for injuries



Health care for a child

Thirty-six per cent of the households that participated in the survey had children among their members. However, in April 2025, a significantly lower share of those households (38%) sought health care for children compared to 44% in October 2024 (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 (52%) encountered at least one problem, the most significant of which were cost of medicines (33%), cost of treatment (15%) and time (18%) (Fig. 3.16). Four per cent of those who sought medical care for a child were unable to obtain the services they needed, and unavailability of services was the primary barrier (30%) (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

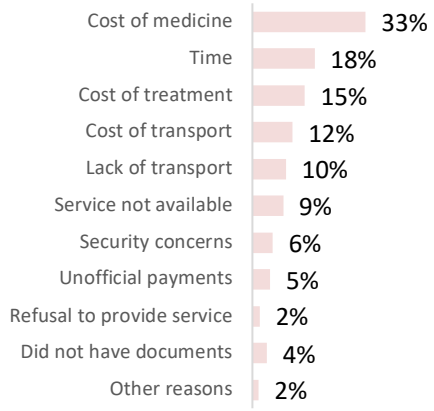
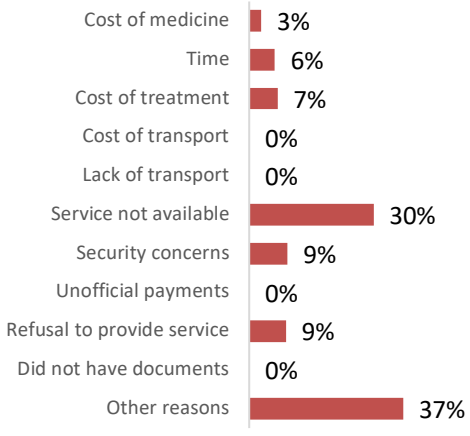


Fig. 3.17. Main barriers to access to health care for a child



Among IDPs and those who remained in their home communities, no differences were observed in terms of access to health care for children (Table 3.4). A higher share of households from regions of increased vulnerability were faced with unavailability of services for children (15%) compared to the rest of the country (6%).

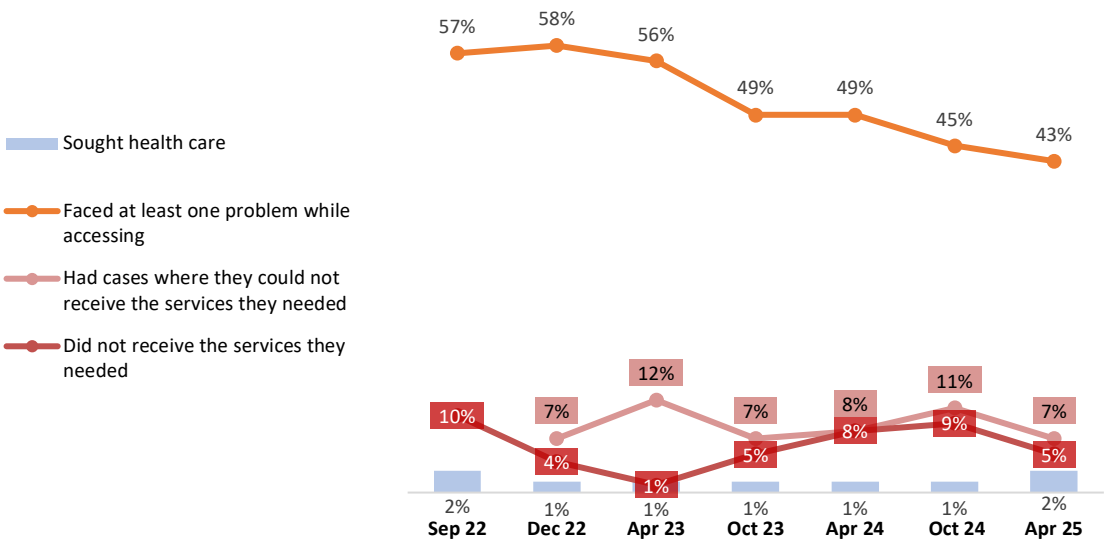
Table 3.4. Access to health care for a child by region

		Sought health care	Faced at least one problem when accessing	Instances where they could not receive the services they needed	Did not receive the services they needed
Most affected regions	Sep 22	33%	-	-	7%
	Dec 22	22%	66%	2%	2%
	Apr 23	25%	55%	8%	4%
	Oct 23	25%	56%	4%	0%
	Apr 24	30%	48%	4%	1%
	Oct 24	37%	55%	3%	1%
	Apr 25	35%	59%	6%	2%
Regions of increased vulnerability	Sep 22	30%	-	-	6%
	Dec 22	26%	64%	10%	3%
	Apr 23	30%	52%	6%	6%
	Oct 23	31%	46%	10%	4%
	Apr 24	33%	41%	3%	2%
	Oct 24	43%	56%	8%	4%
	Apr 25	37%	59%	5%	3%
Kyiv city	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%
	Apr 25	39%	42%	9%	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%
	Apr 25	39%	49%	3%	2%

Pregnancy health-care services

In April 2025, just 2% of households reported seeking pregnancy-related health services (see Fig. 3.18). Among these, 43% faced at least one challenge when trying to access care. The most commonly reported issues were cost of medicines (32%), treatment expenses (19%) and transportation costs (15%). Additionally, 7% of those seeking pregnancy-related services were unable to access the care they needed, 5% did not receive any services at all.

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 and the survey team decided to monitor key indicators in April 2025.

In the last three months, half of respondents (52%) reported that they or their household members needed to undergo laboratory tests such as blood or urine tests. Of those, 80% managed to complete all the necessary tests, while 11% partially completed them and 8% were unable to complete the required tests (Figs. 4.1 and 4.2). The differences between the IDPs and people in their home communities, and across different macroregions, were not reported. A higher share of respondents residing in oblast centres cited the need to use laboratory services (56%) compared to residents of rural areas (48%).

Fig. 4.1. Respondents who needed to undergo laboratory tests (such as blood or urine tests) in the last three months

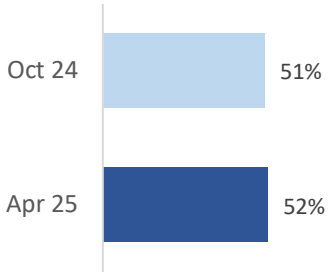
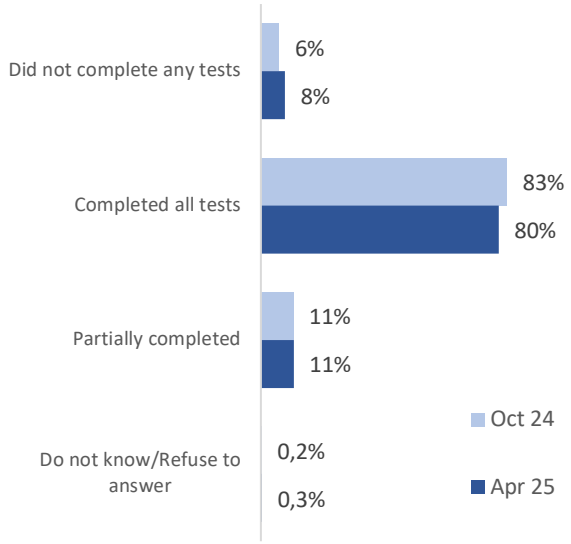


Fig. 4.2. Respondents who completed the necessary laboratory tests[a]



[a] Among those who needed to complete laboratory tests

Access to instrumental diagnostic tests

In April 2025, 40% 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, 69% managed to complete all the necessary tests, 12% reported partial completion and almost one in five (19%) were unable to complete the required diagnostics (Figs. 4.3 and 4.4).

Fig. 4.3. Respondents who underwent instrumental diagnostic tests (such as MRI, ECG, CT scans or ultrasounds) in the last three months

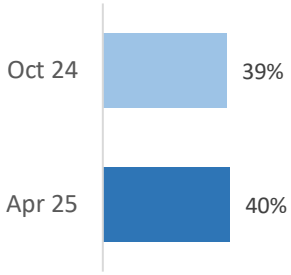
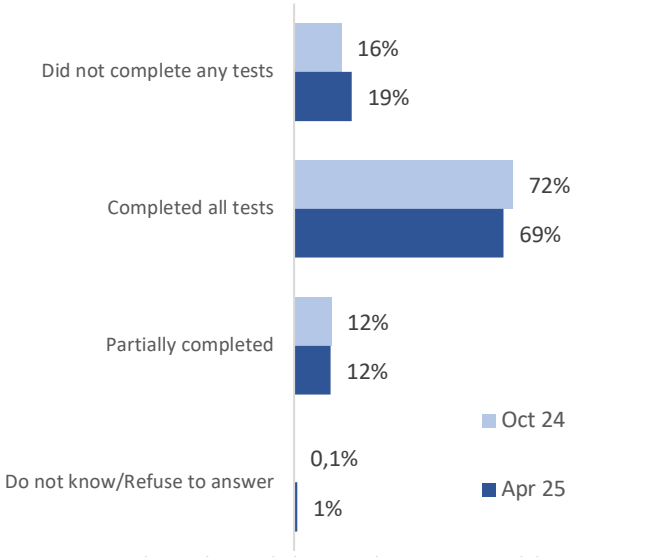


Fig. 4.4. Respondents who completed the necessary instrumental diagnostic tests[a]



[a] Among those who needed to complete instrumental diagnostic tests

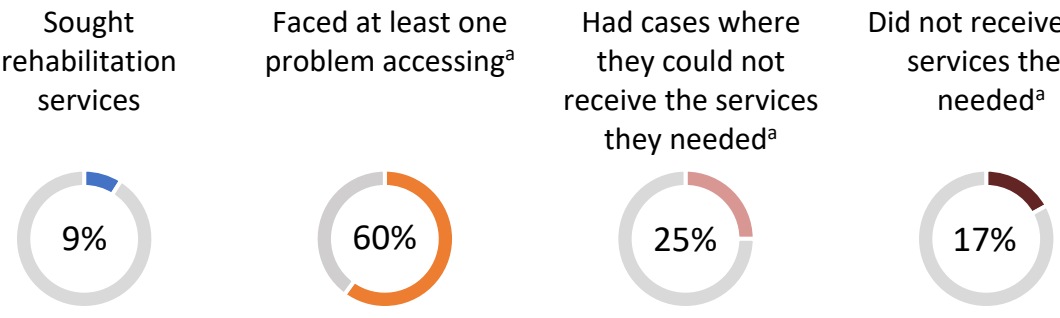
Section 5. Access to rehabilitation services

In the past three months, 9% of all surveyed households reported seeking rehabilitation services due to trauma or health conditions. Among these, 60% encountered at least one problem when attempting to access care. The most common problems were similar to those reported for other types of health care, namely cost of medicines and cost of treatment (such as rehabilitation sessions or services). Notably, the third most frequently cited barrier was lack of information on where to obtain rehabilitation services (Fig. 5.1).

A quarter (25%) of those who sought rehabilitation services found themselves unable to access the care they needed – a share considerably higher than for other types of health-care services tracked, which typically ranged from 4% to 12%. The main barriers to accessing rehabilitation services included the cost of medicines, refusal to provide services, lack of information, time required to reach services and unavailability of services or health professionals (Figs. 5.2 and 5.3).

Furthermore, 17% of respondents were not able to receive any rehabilitation services at all, higher than the proportion reported for other services (2–7%).

Fig. 5.1. Dynamics of access to rehabilitation health-care services



[a] Among those who sought rehabilitation services

Fig. 5.2. Problems when seeking rehabilitation health-care services

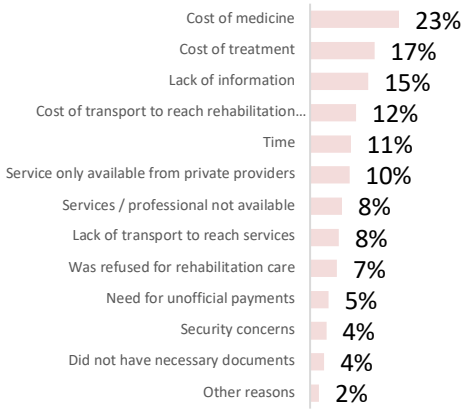
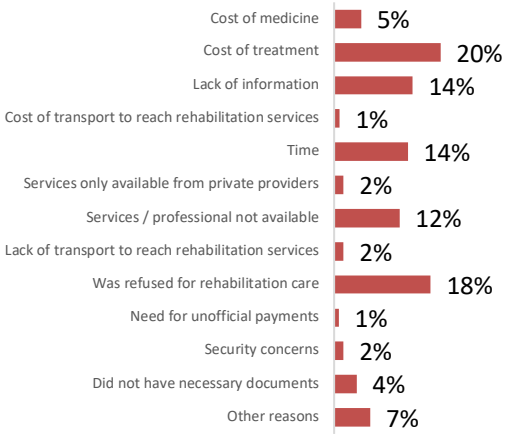


Fig. 5.3. Main barriers to access to rehabilitation health-care services



Most respondents accessed rehabilitation services at public health-care facilities (82%), while nearly one third (32%) received them at private facilities (Figs. 5.4 and 5.5). In terms of cost, over half of those who sought rehabilitation (55%) received all services completely free of charge. Meanwhile, 26% reported paying for some of the services and 17% paid for all their rehabilitation care out of pocket (Fig. 5.6).

Some differences in rehabilitation service indicators were observed among specific groups. However, a more detailed, customized analysis focused on these differences will soon be conducted separately for the rehabilitation team.

Fifty-six per cent reported being informed by a family doctor or another primary health care provider that they may need rehabilitation services for health conditions such as injury, stroke or other acute health conditions.

Fig. 5.4. Form of rehabilitation services received*

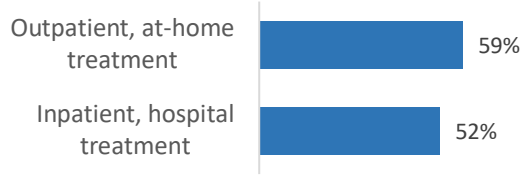
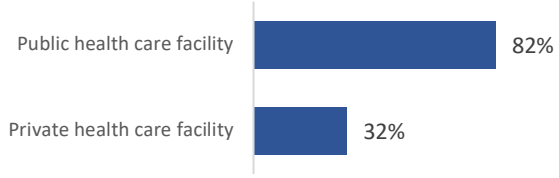
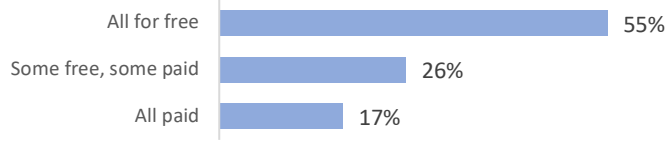


Fig. 5.5. Place of receiving rehabilitation services[a]



[a] Among those who received rehabilitation services

Fig. 5.6. Form of payment for rehabilitation services[a]



[a] Among those who received rehabilitation services

Section 6. Mental health status

Mental health status

After the October 2024 increase in the proportion of households reporting having members who were too upset or anxious to carry out their normal daily activities, the April 2025 observation revealed a significant decrease to 16%. No significant difference was reported between IDPs and people who remained in their home communities (Table 6.1).

Table 6.1. Respondents who were too upset or worried to carry out their normal daily activities by area

	Areas with active hostilities	Areas that experienced hostilities in the past	Kyiv city	Rest of the country
Sep 22	14%	13%	9%	15%
Dec 22	12%	14%	13%	13%
Apr 23	15%	13%	11%	12%
Oct 23	14%	14%	12%	14%
Oct 24	19%	18%	19%	18%
Apr 25	14%	16%	14%	16%

Access to health care for mental health

Mental health is one of the top priority areas in Ukraine, with numerous partners and organizations working in this area. A new set of questions envisioned as a deep-dive into mental health and access to health-care services was added in the April 2025 survey round. According to the results, 72% of the adult population of Ukraine had experienced mental health challenges in the last 12 months.

Among the issues reported, the most prevalent were those related to feeling irritable, constantly worried, overly anxious or having trouble relaxing (62%), followed by low mood, trouble sleeping, poor appetite or difficulty concentrating (60%) and feeling very stressed (54%) (Figs. 6.1 and 6.2).

A large share of respondents (64%) reported knowing how to cope with stress, and among them, nearly four out of five (79%) actively used self-help strategies to manage long-term stress or other mental health challenges (Figs. 6.3 and 6.4).

Half of the respondents (50%) reported experiencing severe stress or other mental health problems during the most recent two-month period. Despite the high prevalence of mental health issues, only 20% of those affected sought help from at least one type of specialist. Specifically, 13% consulted a family doctor, 15% visited a specialized mental health professional and 8% turned to a non-medical specialist. Encouragingly, between 84% and 92% of those who did seek support were able to successfully receive the assistance they needed and were generally satisfied with the care provided (Fig. 6.5).

Among those who sought mental health support, satisfaction levels were consistently high. Over 90% expressed satisfaction with the services received from family doctors, mental health specialists and non-medical specialists. Notably, family doctors were the most highly rated source of support, with two thirds (64%) of respondents reporting being particularly satisfied with the help they received (Fig. 6.6).

Meanwhile, 33% of people experiencing mental health issues reported taking medications – 8% did so regularly, while 25% used them occasionally. In this group, only 28% obtained all their medications with a prescription and 11% reported obtaining some medicines without prescriptions. A substantial proportion (60%) acquired medications without a prescription (Figs. 6.7, 6.8 and 6.9).

Fig. 6.1. Experienced severe stress or other mental health problems, such as low mood, trouble sleeping or anxiety, in the past two months*

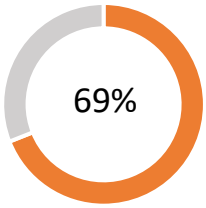
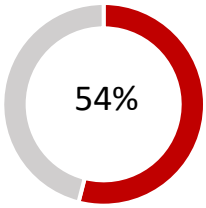


Fig. 6.2. Felt that mental health problems made it difficult for them to maintain their normal activities at work or at home or to interact with other people[a]



[a] Among those who experienced mental health issues in the last 12 months

Fig. 6.3. Know of any self-help techniques to overcome stress (such as breathing, relaxation or circles of control)

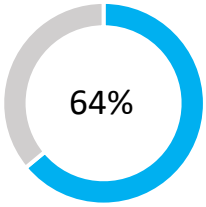
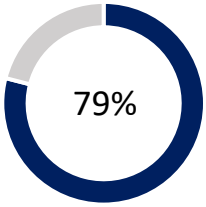


Fig. 6.4. Used any of the self-help techniques to deal with long-term stress or other mental health issuesa



[a] Among those who experienced mental health issues in the last 12 months

Fig. 6.5. Experience with accessing mental health help

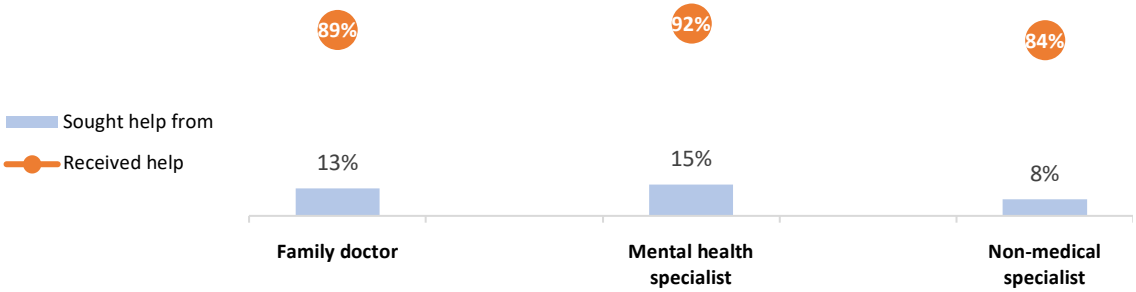


Fig. 6.6. Level of satisfaction with the help received for mental health issues

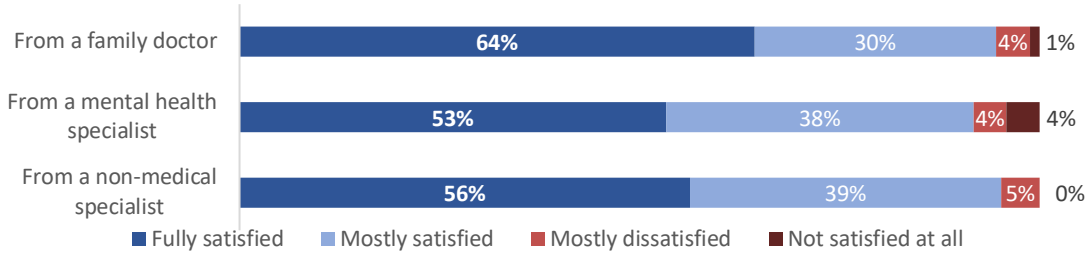


Fig. 6.7. Took medications to deal with mental health problems[a]

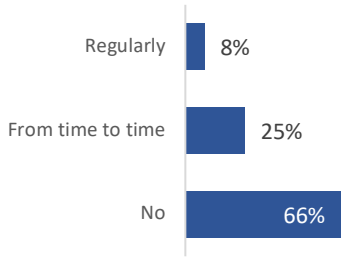


Fig. 6.8. Received medicines to deal with mental health problems through a prescription from a doctor[b]

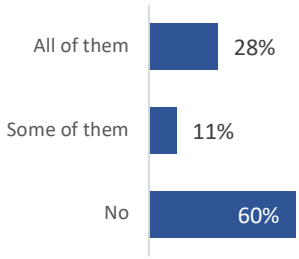
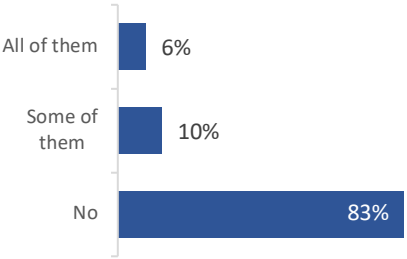


Fig. 6.9. Received medicines to deal with mental health problems under the AMP[c]



[a] Among those who had mental health problems in the last 12 months
[b] Among those who took any medications to deal with mental health problems
[c] Among those who received medicines to deal with mental health problems through a prescription from a doctor

All the differences observed between the groups were significant, highlighting distinct patterns in mental health experiences among IDPs compared to people living in their home communities. A significantly higher proportion of IDPs reported experiencing stress in the past 12 months, with 80% of IDPs affected, compared to 74% of people in their home communities. Moreover, a greater share of IDPs indicated knowing self-help techniques for managing stress – such as breathing exercises, relaxation practices and circles of control techniques – with 69% of IDPs familiar with these strategies, compared to 63% of those living in their home communities.

In terms of seeking professional support, IDPs were more likely to consult a mental health specialist, with 21% doing so, while this was reported by only 14% of people living in their home communities. When considering the broader category of mental health support, 26%

of IDPs sought mental health help from a specialist (family doctor, mental health specialist or non-mental health specialist), compared to 19% of people in their home communities.

A regional breakdown further highlights these differences. People living in regions of increased vulnerability reported higher levels of stress in the past 12 months, with 57% affected, compared to 52% among those living in the rest of the country. In the most recent two-month period, stress was also more common among respondents in the most affected areas, where 76% reported feeling stressed, and in regions of increased vulnerability, where 72% reported stress, compared to 66% in the rest of the country.

Analysis by sex reveals additional disparities. Males were less likely than females to report experiencing stress in the past 12 months, with 66% of men affected, compared to 77% of women. Similarly, during the past two months, men reported lower levels of stress, low mood, irritability, constant worry, excessive anxiety and trouble relaxing compared to women.

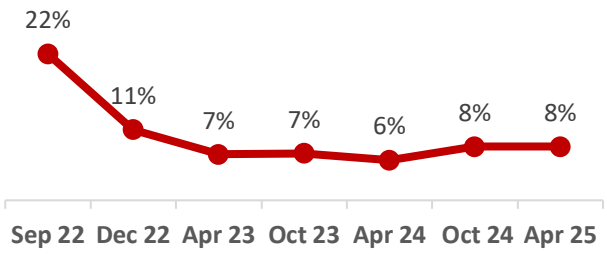
Regarding knowledge and use of self-help strategies, men were slightly less aware of these techniques, with 58% reporting knowledge of them compared to 59% of women. Among those who were familiar with self-help strategies, a lower proportion of men actually used them, with 75% of men applying these techniques, compared to 82% of women.

In terms of seeking formal support, men were less likely to consult a family doctor for mental health issues, with only 10% doing so compared to 15% of women. Additionally, a significantly higher share of men reported not taking any medications for mental health concerns, with 74% of men not using medications, compared to 61% of women.

Section 7. Access to medicines

In April 2025, 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 81% of households facing problems in obtaining the necessary medicines (Fig. 7.1).

Fig. 7.1. Share of households that could not obtain the medicines they needed



A breakdown by IDP status revealed that 9% of IDPs could not obtain the medicines they needed in the last three months. However, increased prices were much more likely to be cited by people in their home communities than by IDPs (73% and 65%, respectively). At macroregional level, no significant differences in terms of access have been identified since the last round of data collection in October 2024, but security issues remained significantly higher in the most affected areas (17%) compared to Kyiv city (3%) and the rest of the country (5%) (Table 7.1).

Table 7.1. Households that could not obtain the medicines they needed by region

	Most affected	Increased vulnerability	Kyiv city	Rest of the country
Sep 22	35%	26%	25%	16%
Dec 22	16%	11%	9%	9%
Apr 23	9%	9%	7%	6%
Oct 23	9%	7%	7%	6%
Apr 24	7%	7%	10%	5%
Oct 24	7%	8%	8%	8%
Apr 25	8%	8%	8%	8%

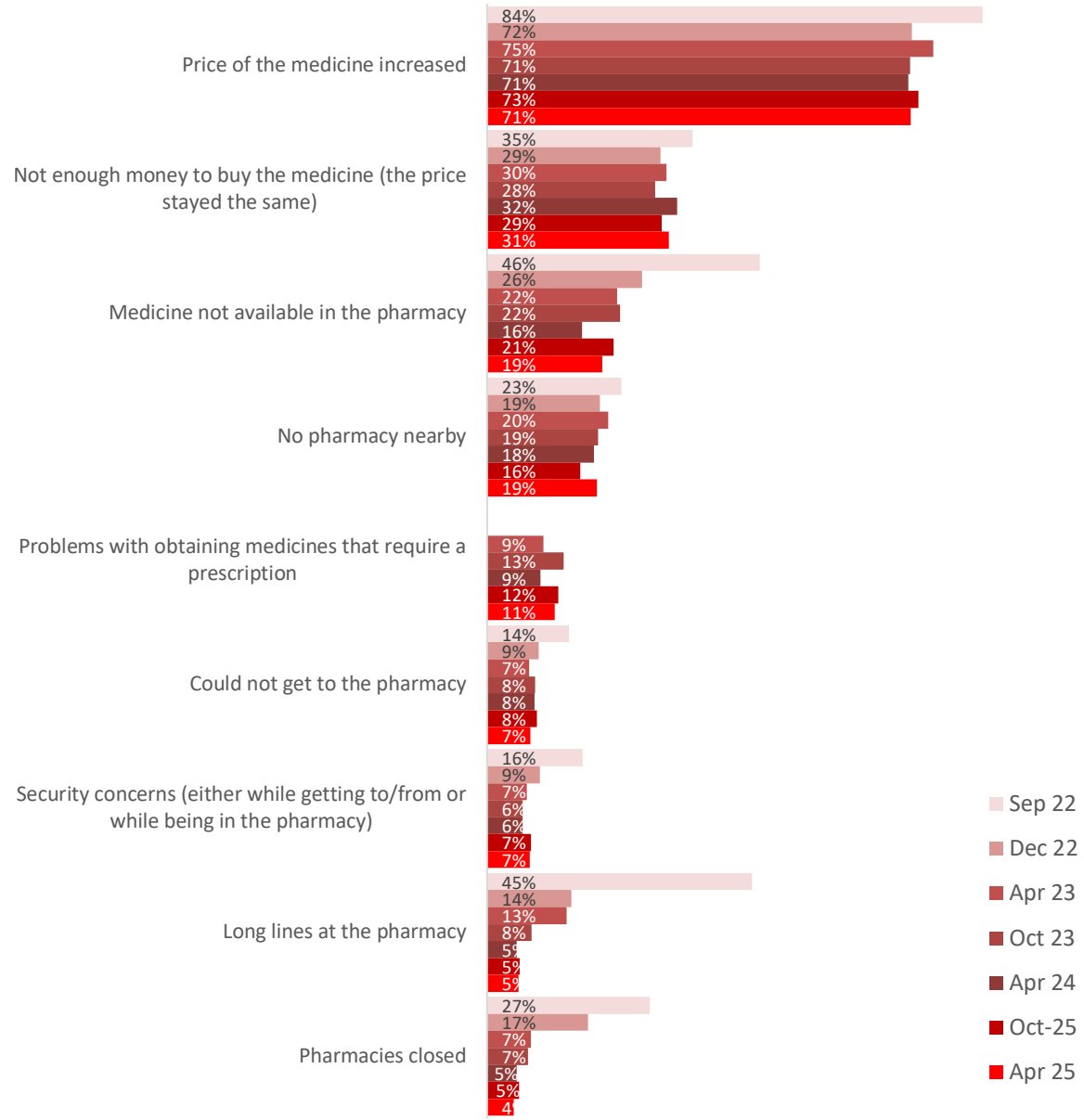
The top three most difficult-to-obtain medicines in April 2025 did not change, with the primary difficulties being associated with high blood pressure (23%), heart (22%) and pain (18%) medications (Table 7.2). Significant changes were not reported, but IDPs reported significantly fewer issues with obtaining heart medicines (11%) than people in their home communities (25%).

Table 7.2. Main types of difficult-to-find medicines

Type of medication	Sep 22	Dec 22	Apr 23	Oct 23	Apr 24	Oct 24	Apr 25
High blood pressure	50%	37%	33%	22%	27%	22%	23%
Cardiovascular	49%	36%	34%	19%	27%	25%	22%
Pain	41%	34%	38%	25%	26%	21%	18%
Antibiotics	32%	28%	30%	21%	20%	16%	16%
Sedative drugs	33%	19%	21%	14%	14%	14%	12%
Mental health	10%	10%	13%	9%	9%	10%	10%
Diabetes	17%	8%	10%	10%	13%	12%	9%
Pulmonary	10%	10%	7%	5%	5%	5%	4%
Fever	15%	6%	10%	6%	4%	4%	2%
Antiseptics	17%	7%	11%	3%	4%	2%	2%
Birth control	3%	2%	1%	1%	2%	-	1%
Other	15%	22%	22%	27%	32%	14%	16%

The main problem in April 2025, as in the previous rounds of data collection, was the rising cost of medications, which affected 71% of respondents. Additionally, one third of respondents (31%) reported lacking the funds for the medications. However, unavailability of pharmacies was significantly higher in April 2025 (19%) than in October 2024 (16%) (Fig. 7.2).

Fig. 7.2. Main problems with obtaining medicines



Affordable Medicines Programme

Almost two thirds (65%) of the respondents reported that they knew about the AMP, which represents a significant increase since April 2024 (55%) and October 2024 (62%). Of these, almost one third (29%) successfully used the programme and received medicines in the past three months, which increased significantly since October 2024 (25%), and 5% tried but were unsuccessful in receiving medicines. There was a significant decrease in those who knew about the programme, but did not need medicines – from 68% in October 2024 to 63% in April 2025 (Figs. 7.3 and 7.4).

Moreover, of those who obtained medicines under the AMP, the vast majority obtained them at pharmacies (86%), 28% – directly from a doctor at a medical facility, and 3% – through the national postal service Ukrposhta (Fig. 7.5).

Fig. 7.3. Respondents who knew about the AMP

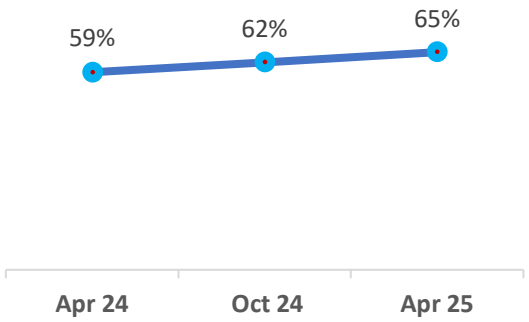
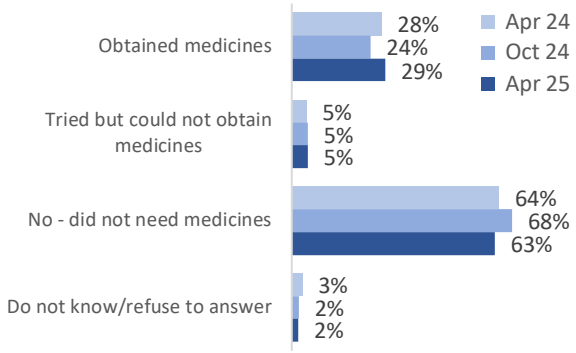
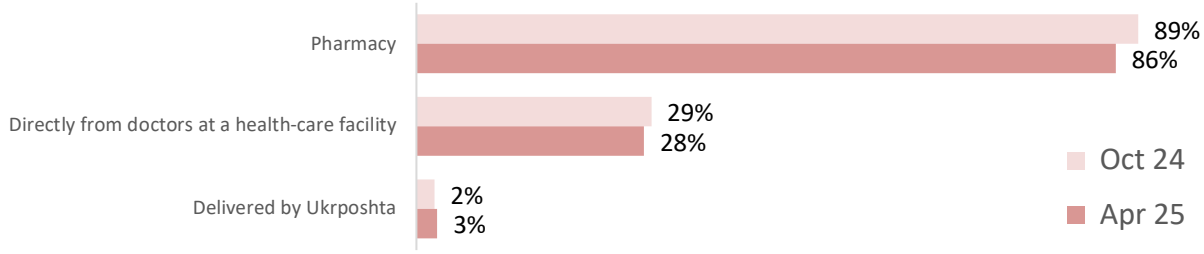


Fig. 7.4. Respondents who received medicines under the AMP[a]



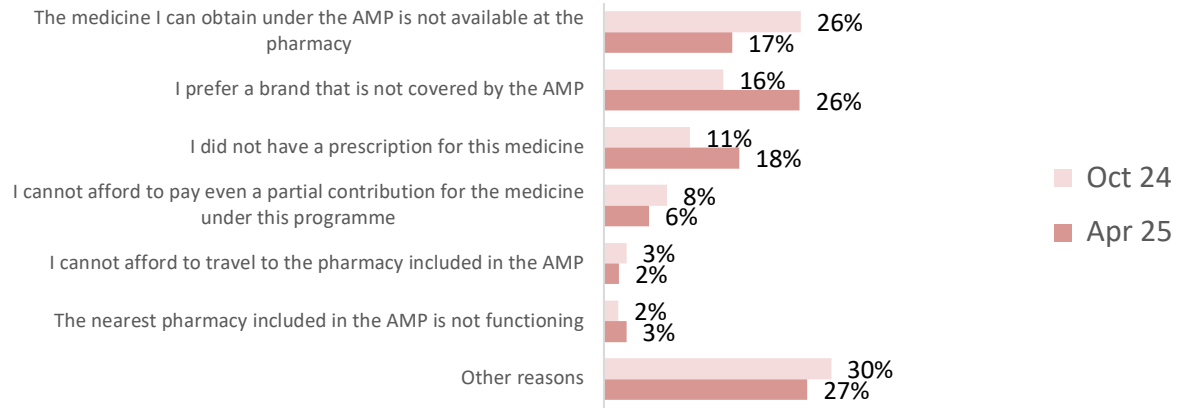
[a] Among those who knew about the AMP

Fig. 7.5. Place of receiving medicines under the AMP



The main reasons for not receiving medicines under the AMP were unavailability of the preferred brand of medicine under the Programme (26%) and not having a prescription (18%) (Fig. 7.6).

Fig. 7.6. Reasons why respondents could not receive medicines under the AMP[a]



[a] Among those unable to obtain medicines under the AMP

Moreover, among all households, 12% received medicines free of charge at health-care facilities and 5% received medicines as humanitarian aid from nongovernmental organizations (NGOs). However, 9% of IDPs received medicines as humanitarian aid from

NGOs, compared to 4% of people in their home communities. Otherwise, people in their home communities were more likely to receive medicines under the AMP (20%), compared to 15% for IDPs.

A breakdown at the macroregional level indicated that 10% of respondents living in the most affected regions received medicines as humanitarian aid from NGOs, compared to 4% reported for the rest of the country. Additionally, a significantly higher share of residents in the most affected regions received medicines free of charge at health-care facilities (16%), compared to 11% in regions of increased vulnerability.

Section 8. Health behaviour

Delayed medical care

In April 2025, the share of households reporting delayed care remained at 35%, the same as in October 2024. Among those who experienced delays in accessing medical services, there was no significant difference between IDPs and people in their home communities. However, an increase in delayed care was noted in front-line regions. At the macroregional level, a greater proportion of households in regions of increased vulnerability (38%) and in Kyiv city (37%) reported postponing medical care (see Table 8.1).

Table 8.1. 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	29%	28%	32%	27%
Apr 23	25%	25%	28%	23%
Oct 23	20%	22%	25%	24%
Apr 24	31%	33%	37%	31%
Oct 24	31%	35%	41%	36%
Apr 25	33%	38%	37%	35%

General health needs in the community

Since this question was last asked, the proportion of respondents who perceived a lack of health-care services in their communities has risen notably, from 27% in April 2024 to 32% in April 2025. A quarter of households living in oblast centres (25%) reported gaps in specific health services or treatments. However, this perception was significantly higher in small cities (37%) and rural areas (36%). Among IDPs, only 25% reported a lack of available health services in their communities, compared to 34% of people in their home communities. At the macroregional level, 34% of respondents in the rest of the country reported insufficient health services in their area – a figure significantly higher than in the most affected regions, where it stood at 28%.

Section 9. Medical expenses

Income

The April 2025 survey results indicate no major changes in household income compared to October 2024. Households with a monthly income below 10 000 hryvnias continued to constitute the largest group (36%), but this share dropped notably from 40% in April 2024. The second-largest group, those earning between 10 000 and 20 000 hryvnias (27%), remained stable. Additionally, the proportion of households with an income exceeding 30 000 hryvnias rose to 14%, up from 10% in April 2024 (see Fig. 9.1).

Household expenditure on health-care services and medicines

In April 2025, 86% of respondents reported having some expenses related to medical issues. One third of them (32%) had expenses specifically for health-care services. The structure of medical expenses has not changed significantly, except for those who had no expenses – the share increased significantly from 12% in October 2024 to 14% in April 2025 (Fig. 9.2).

Fig. 9.1. Monthly household income

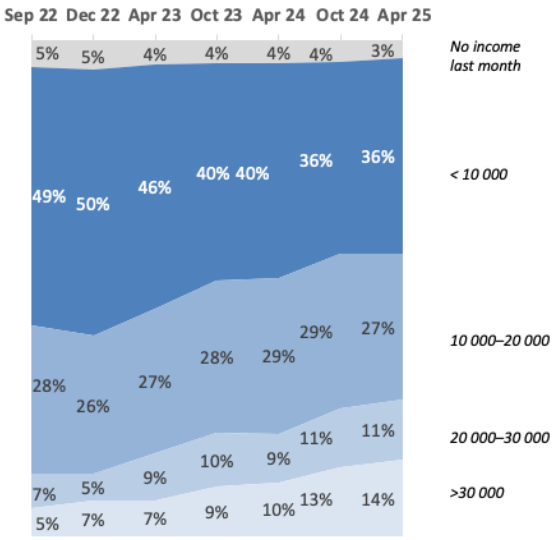
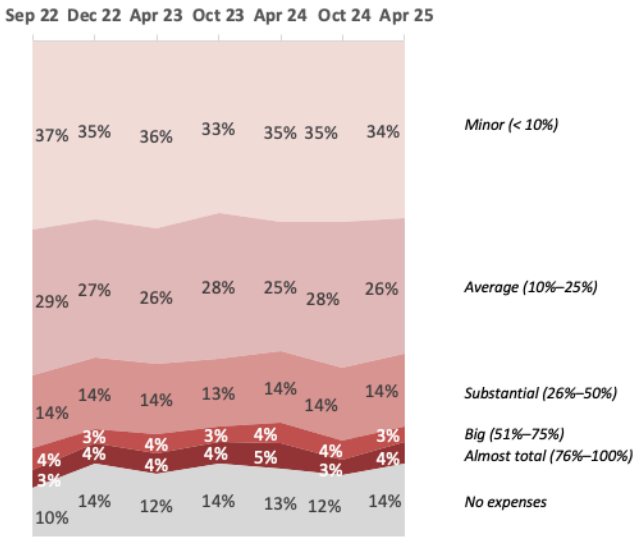


Fig. 9.2. Share of household expenditure on health-care services and medicines



An analysis by area shows that a significantly smaller proportion of households in the most affected regions reported having minor medical expenses (29%) compared to households in the rest of the country (36%). At the same time, a lower share of households in the most affected areas (3%) indicated spending nearly all their income on medical expenses, compared to 6% in regions of increased vulnerability (Table 9.1).

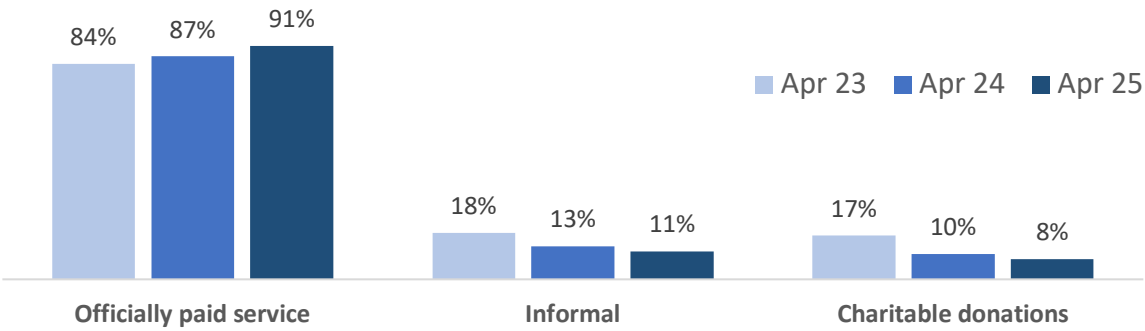
Table 9.1. Share of household expenditure on health-care services and medicines by area

	Most affected	Increased vulnerability	Kyiv city	Rest of the country
Minor (< 10%)	29%	30%	38%	36%
Average (10–25%)	28%	27%	25%	25%
Substantial (26–50%)	16%	16%	13%	14%
Large (51–75%)	3%	4%	3%	3%
Almost total (76–100%)	3%	6%	4%	4%
No expenses	16%	13%	14%	13%

Experience with receiving paid health services

Ninety-one per cent of households who incurred expenses on medical services used officially paid services. This share increased significantly from 87% in April 2024 (Fig. 9.3). However, 11% of households paid informally and 8% made charitable contributions (Fig. 9.3). Informal payments continued to be more prevalent in rural areas (16%) and other cities (12%), compared to 6% in oblast centres (Table 9.2).

Fig. 9.3. Form of payment for paid medical services[a]



[a]Among those who have expenses specifically for medical services

Table 9.2. Form of payment for paid medical services by type of settlement

	April 2023			April 2024			April 2025		
	Oblast centre	Another city of the oblast	Rural	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%	93%	87%	83%
Informal	14%	24%	17%	8%	18%	17%	6%	12%	16%
Charitable donations	16%	18%	16%	8%	12%	11%	7%	3%	9%
Difficult to answer/refuse to answer	2%	3%	3%	4%	5%	3%	3%	5%	8%

Among respondents who reported spending specifically on medical services, the majority paid for services that had been prescribed by doctors at public health-care facilities (46%), marking a significant increase compared to April 2024. In contrast, there was a notable decline in the share of those who chose to seek services independently, dropping from 40% in April 2024 to 33% in April 2025. No significant changes were observed regarding the type of health-care facility where paid services were obtained, with nearly two thirds (63%) continuing to receive these services at public health-care facilities (Fig. 9.4 and Fig. 9.5).

Fig. 9.4. Initiator of paid medical services[a]

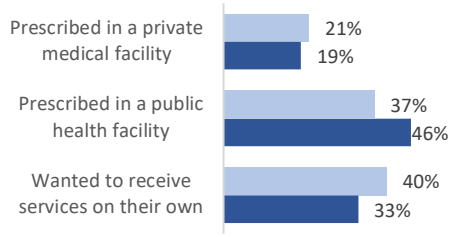
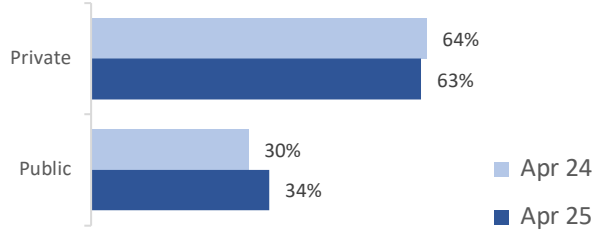


Fig. 9.5. Facility where paid services were received[a]



[a] Among those who have expenses specifically for medical services

Summary

Access to primary health care facilities and family doctors

In April 2025, a national household survey was conducted in Ukraine, collecting data at the household level, with some individual-level insights. Data collection was performed through CATI with a sample of 4000 respondents per wave, using random sampling. The survey included respondents from all regions of Ukraine except the temporarily occupied Luhansk oblast and the Autonomous Republic of Crimea. The sample does not allow for oblast-level comparison but enables analysis at macroregional levels. Vulnerable groups such as IDPs and people in front-line areas receive special focus. The nine front-line regions are divided into "most affected regions" (Donetsk, Kharkiv, Kherson, Zaporizhzhya, and Sumy, newly moved to this group) and "regions of increased vulnerability" (Chernihiv, Dnipropetrovsk, Mykolayiv and Odesa).

Awareness and access to primary health care

Awareness of primary health care facility locations remained high: 93% of households knew the location of their primary health care facility and 97% reported that it was functioning.

IDPs remained more vulnerable: 11% did not know the location of a primary health care facility, compared to 8% among people in their home communities. Among recent IDPs (moved less than 12 months ago), 20% did not know the location, compared to 7% among longer-settled (moved more than 12 months ago) IDPs.

Access to family doctors remained high overall, but 4% noted they had no access at all and 7% lacked in-person access but maintained remote contact. IDPs reported lower access (8% without access compared to 3% among people in their home communities). Rural residents also reported poorer access.

In the most affected regions and regions of increased vulnerability, residents had lower in-person access to family doctors (84% and 87%, respectively) compared to 91% in other regions. Among IDPs, 8% had no access and 77% had in-person access, compared to 3% and 91% among people in their home communities, respectively. Gender differences were observed: males reported lower in-person (86%) and phone (77%) access than females (91% and 83%).

Family doctor declarations and changes

Ninety-three per cent of respondents had a signed declaration with a family doctor. Among IDPs, 9% did not have a declaration (compared to 5% among people in their home communities). In Kyiv, 9% lacked a declaration, compared to 5% elsewhere. The main reason for not having a declaration was no need (25%); other reasons included lack of time, distrust,

low quality of care or a doctor's departure (approximately 8–9%). Additionally, 5% cited war-related reasons.

About 29% of respondents with a signed declaration changed their family doctor since 24 February 2022; 4% did so in the last three months. Among IDPs, this figure was significantly higher at 57% compared to 24% among people in their home communities. The main reasons included the doctor's or respondent's relocation (33% and 28%, respectively), dissatisfaction with quality (10%) and technical problems or lack of available doctors (13%).

Use and satisfaction with family doctors

Most respondents (64%) were completely satisfied with their family doctor, and only 5% rated their satisfaction below average. Key dissatisfaction factors included doctor overload (41%), long queues (38%) and no home visits (36%). Additionally, 30% cited difficulty securing appointments and 27% mentioned difficulties getting in touch.

The majority of respondents (46%) had visited their family doctor in person within the last three months. However, 22% had not visited in over a year and 6% had never visited.

Preventive examinations

A significant increase was observed in those not undergoing preventive screenings, from 27% in October 2024 to 44% in April 2025. Lower rates of screenings for HIV, TB, diabetes, hypertension and breast cancer among women were reported in the period surveyed.

Access to general health care

Overall, 56% of respondents needed medical services. Nearly two thirds (64%) experienced at least one problem; 10% could not receive the care they needed and 6% received no services at all.

In front-line regions, fewer respondents sought care (48% in the most affected regions and 54% in regions of increased vulnerability) than in other parts of Ukraine. The main reasons for care-seeking were chronic conditions (40%) and primary care needs (34%).

Health care for chronic conditions

Thirty-four per cent of households had a member with a chronic condition (up from 28%). Among them, 40% sought care recently. Cost of medicines was the most significant barrier (59%), followed by cost of treatment (36%). Lack of transportation as a barrier decreased significantly (from 19% to 11%).

Twelve per cent could not receive care for a chronic condition and 5% received no care at all. IDPs reported more security-related barriers (33%) than people in their home communities (10%).

Emergency services, injuries and health care for children

Fifteen per cent sought emergency services; 10% could not obtain the services they needed and 7% received no care at all. In the most affected regions, inability to access emergency services was much higher (21% compared to 7% elsewhere).

For injuries, 9% sought care, with 58% encountering problems. Barriers included cost of medicines (34%), cost of treatment (22%) and time (21%).

Thirty-six per cent of the households surveyed had children; of those, 38% have sought care for a child (down from 44%). Over half faced problems, mostly related to cost. Four per cent did not receive the care needed for the child.

Rehabilitation services

Nine per cent sought rehabilitation services in the past three months; of those, 60% faced at least one problem. The main barriers included cost of medicines and treatment and lack of information on where to obtain services. Twenty-five per cent could not obtain the services they needed (which is higher than the 4–12% reported for other types of services). Seventeen per cent received no services at all. Most accessed rehabilitation at public facilities (82%); 32% received rehabilitation care at private health care facilities. Over half received free services, with 26% paying partially and 17% paying the full amount.

Fifty-six per cent of respondents reported being informed by a family doctor or primary care provider about needing rehabilitation for certain conditions.

Diagnostics

Slightly more than half (52%) of respondents needed laboratory tests. Of those, 80% completed all the testing required, with 11% completing it partially and 8% not completing it at all.

Forty per cent reported requiring instrumental diagnostics. Of those, 69% completed the diagnostics, with 12% reporting partial completion and 19% not completing it at all.

Mental health

Mental health remains a priority. Seventy-two per cent of respondents experienced mental health issues in the past year, including anxiety (62%), depression (60%) and severe stress (54%). Half reported stress in the last two months. Only 20% sought help and among them, 84–92% received and were satisfied with care.

Thirty-three per cent took medications for mental health, with 8% taking them regularly and 25% – occasionally. Sixty per cent acquired them without a prescription. Among IDPs, 80% experienced stress compared to 74% among people in their home communities; 26% sought mental health support (compared to 19% of people in their home communities).

Medicines and AMP

Eighty-two per cent faced problems obtaining medicines, mostly due to rising prices (71%) and lack of money (31%). Eight per cent were unable to obtain the medicines they needed in the past three months.

Sixty-five per cent were aware of the AMP, up from 59% a year ago. Twenty-nine per cent received medicines through the AMP, with 5% being unsuccessful. Twelve per cent received medicines free of charge at health-care facilities and 5% – from NGOs. IDPs were more likely to receive medicines from NGOs (9% compared to 4% for people in their home communities).

Income and medical expenses

The share of households with an income of less than 10 000 hryvnias decreased to 36% (from 40%). Households with an income of more than 30 000 hryvnias increased to 14%. Eighty-six per cent had medical expenses, of which one third was allocated specifically to health-care services. The share of respondents paying officially for health-care services increased, but 11% still paid informally and 8% paid via charitable donations.

Delayed care and lack of services

Overall, 35% reported delaying the care they needed, with higher shares in front-line regions and Kyiv city.

Thirty-two per cent perceived a lack of certain services in their communities, up from 27% a year ago. This number was higher for respondents in rural and small towns.

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 20 July 2025.

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