Regional Refugee Response
for the Ukraine Situation

NAVIGATING HEALTH AND WELL-BEING CHALLENGES FOR REFUGEES FROM UKRAINE

An Inter-Agency Exploration of Data

2nd edition

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Cover photograph:
Inna Kovalenko, cultural mediator, shares information about health services with Ukrainian refugees in Romania. © Mihai von Eremia

Executive summary

The war in Ukraine, now in its third year, continues to have devastating effects on the Ukrainian population, triggering one of the largest displacement crises in Europe since World War II. As of December 2024, over 6.2 million Ukrainian refugees have been recorded across Europe, the majority of whom are women, children, and older persons. The European Union extended the Temporary Protection Directive until March 2026, granting Ukrainian refugees access to essential health services, education, and other critical support. The Republic of Moldova followed this model and also introduced Temporary Protection for Ukrainian refugees.

In 2024, to assess the health and mental health situation of Ukrainian refugees, their access to services, and the barriers they face across countries, Regional Refugee Response Plan (RRP) health and mental health and psychosocial support (MHPSS) partners conducted a regional analysis of the Socio-Economic Insights Survey (SEIS) data from 10 refugee-hosting countries: Bulgaria, Czechia, Estonia, Hungary, Latvia, Lithuania, Poland, Republic of Moldova, Romania, and Slovakia. The analysis includes a comparison with key indicators collected in 2023.

Key finding from the regional analysis include:

Health as a priority need: Access to healthcare remains a top-three priority for 33% of households, consistent with 2023 findings (34%), and was nearly equally prioritized by women and men. Healthcare was a greater priority for households with members who have disabilities (56%) or chronic illnesses (45%), compared to 21% for households without these vulnerabilities.

Access to care: In the 30 days prior to the survey, 83% of the individuals requiring healthcare were able to access services, indicating a slight decrease from 88% in 2023. Unmet healthcare needs were notably higher among persons with chronic illnesses (21%) and disabilities (18%) compared to those without these vulnerabilities (12%). Refugees' ability to navigate host-country health systems improved, reflected in a decrease of challenges in securing appointments which fell from 38% in 2023—when it was the top barrier—to 21% in 2024, aided by information and awareness efforts from health authorities and RRP partners.

Health expenditures continued to account for a significant portion of household budgets, averaging 8% of total expenditures—roughly the same (9%) as in 2023. The health expenditure share was higher for households with chronically ill members, who spent 12% on average, compared to 5% for those without. Similarly, households with a member with a disability allocated 15% of their expenditures to health, nearly double the 8% spent by other households.

Barriers to accessing **sexual and reproductive health (SRH) services** affected 5% of women and girls, with long wait times (33%) and financial barriers such as transport costs (23%) and clinic fees (19%) being named as the most common obstacles.

Vaccination coverage among Ukrainian refugees remains low. Using measles as a proxy for childhood vaccinations,

measles vaccination coverage for children stood at 83%, similar to 84% in 2023, falling short of the 95% target.

Mental health and psychosocial needs are a significant and growing concern for Ukrainian refugees, with 23% of individuals reporting mental health and psychosocial problems that affect their daily functioning and 36% of households reporting at least one member affected. This represents a rise from 19% of individuals and 30% of households in 2023. Women, especially those aged 35 and older, consistently reported higher levels of mental health problems than men. Individuals with chronic illnesses or disabilities reported higher MHPSS needs, with 41% of those with chronic conditions and 51% of those with disabilities experiencing mental health challenges.

Access to mental health and psychosocial support: Among individuals reporting mental health or psychosocial problems affecting daily functioning, less than half (46%) sought support, highlighting the need to address barriers such as poor awareness about and confidence in services, stigma, and language and availability constraints. Experiences accessing support differed among women and men, with the latter seeking support less often.

Types and outcomes of MHPSS: Among individuals accessing support, a majority utilized formal services such as psychotherapy or counseling (44%), creative psychosocial activities (19%), structured group or individual interventions (17%), and school-based services (13% of children).

Informal support also played a vital role, with 33% receiving help from family or friends and 12% accessing spiritual support. Overall, 88% of those who received support reported improved wellbeing, though there are notable differences depending on gender and age.

The recommendations drawn from this analysis focus on addressing the health and mental health and psychosocial needs and barriers identified in the SEIS, tailoring them to the specific data and context of each country. To enhance policy development, it will be crucial to improve monitoring of refugees' health, including sexual and reproductive health and mental health, through inclusion of disaggregated refugee data into national data systems. This will require effective collaboration among health organizations, statistical offices, and partners. Addressing capacity issues in national health systems, such as workforce shortages and long wait times, can be supported through telemedicine and temporarily integrating Ukrainian healthcare workers. Refugees with chronic illnesses and disabilities require targeted interventions to meet their health and MHPSS needs, including through health financing mechanisms. Continued efforts are also required to address persistent access barriers through context-specific strategies, including providing refugees with information on navigating health systems and preventive health services such as vaccination.

Expanding community-based MHPSS services that integrate formal services and promote the use of informal supports will enhance service delivery. Public awareness campaigns, tailored to both refugees and host communities, should aim to reduce stigma and improve knowledge of available support. Gender-responsive and age-sensitive approaches are necessary, particularly for adult men and adolescent boys, to encourage help-seeking behaviours and ensure that services are tailored to the specific needs of children and adolescents. Lastly, further research is required to gain a deeper understanding of unmet health needs—including SRH and MHPSS needs—and the barriers to access, to inform more effective, inclusive, and context-sensitive interventions.

Context

In its third year, the war in Ukraine continues to have a devastating impact on the people in Ukraine and causes massive displacement of populations into the European region and beyond. As of 12 December 2024, 6.2 million refugees from Ukraine were recorded in Europe[1]. Approximately 81% of the refugees are women and children and 13% of the population is older than 60 years[2]. The refugee population includes other vulnerable groups such as persons with disabilities, stateless persons, sexual and gender diverse minorities, and ethnic minorities. In June 2024, the European Council adopted a decision to extend the European Union (EU) Temporary Protection Directive until 4 March 2026[3], granting Ukrainian refugees in the EU access to benefits, including health.

Refugees are vulnerable and at risk of poor health outcomes due to disruptions in access to health care in their country of origin, experiences during their journey, and challenges in settling in a new country. For the Ukrainian refugee population, predominantly comprised of women, children and older persons, access to primary health care services, including mental health and psychosocial support, child health and nutrition, sexual and reproductive health, non-communicable diseases (NCDs), rehabilitation and health education to increase health literacy and empower health decision-making, is critical. Among older persons, NCDs are most prevalent, necessitating uninterrupted access to care for managing illnesses. Communicable diseases are a concern as the movement of refugees in and out of host countries disrupts access to disease prevention, detection and treatment programmes, increasing the health risks.

Mental health is a significant concern, with particularly high needs in populations fleeing conflict. WHO estimates that one in five people affected by conflict (22.1%) have a mental health condition, including 13.0% with mild, 4.0% with moderate, and 5.1% with severe conditions[4]. Refugees may have experienced conflict-related violence and other adversities prior to displacement and likely face current stressors associated with adapting to new environments, languages, and cultures, economic and housing instability, limited social support networks and uncertainties about their future and those left behind in Ukraine. These factors may contribute to mental health and psychosocial problems that can persist for many years if left unaddressed.

Refugee receiving and hosting countries have shown generosity and kept borders open while adapting to a protracted stay of the refugees as the situation in Ukraine remains volatile and prospects for refugees returning home remain grim. Under the Temporary Protection Directive or other protection mechanisms implemented in most countries, refugees have access to health care benefits, but certain groups may be left out according to country-specific practices – for example, those who do not apply for temporary protection and those who temporarily return to Ukraine or move from one location to another and are deregistered[5].

Health systems in refugee-receiving countries have made substantial efforts to meet the needs of Ukrainian refugees. However, challenges in host country health systems, such as health workforce shortages, long waiting lists, and language barriers affect access to care and may discourage health-seeking among refugees. Refugees' movement within and out of countries present challenges for local health providers to register and provide required services. At the same time, there are

1. Ukraine Refugee Situation (accessed 12 Dec 2024)
2. Ukraine Situation: Regional Refugee Response Plan 2025
3. https://www.consilium.europa.eu/en/press/press-releases/2024/06/25/ukrainian-refugees-council-extends-temporary-protection-until-march-2026/
4. Charlson, F., van Ommeren, M., Flaxman, A., Cornett, J., Whiteford, H. and Saxena, S., 2019. New WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis. The Lancet, 394: 240-248.
5. Eurofound (2024), Social impact of migration: Addressing the challenges of receiving and integrating Ukrainian refugees, Publications Office of the European Union, Luxembourg

negative perceptions of Ukrainian refugees in some host communities including perceived overuse of health services and preferential treatment[6]. As the refugees stay longer, sustainable solutions to meeting health needs of refugees and host communities, including sustainable financing, refugee data integration, integration of the refugee health workforce, and enhanced service delivery including mental health services, are critical.

Through regional multi-agency collaboration, multisector needs assessments have been conducted in refugee-receiving countries since 2022 to collect information on the needs of refugees, including those related to health, nutrition and mental health and psychosocial support. These assessments support partners' understanding of the level of access to essential services among refugees and outcomes enable governments and partners to identify priorities for the response. In 2024, a social-economic lens was added in assessing the needs of refugees in the Socio-Economic Insights Study (SEIS) conducted in ten countries (Bulgaria, Czechia, Estonia, Hungary, Latvia, Lithuania, Poland, Republic of Moldova, Romania, and Slovakia).

Methodology

The regional analysis is grounded in consolidated data from the Socio-Economic Insights Survey (SEIS), conducted across ten countries: Bulgaria, Czechia, Estonia, Hungary, Latvia, Lithuania, Poland, Republic of Moldova, Romania, and Slovakia. Data for the country-specific SEISs were collected through in-person interviews from May to July 2024.

The total sample size comprises **8,720 households** and **19,803 household members**, with respondents providing information on behalf of all individuals within their households.

COUNTRY	SAMPLE SIZE 2023	SAMPLE SIZE 2024
Bulgaria	1,054	1,072
Czechia	1,218	1,215
Estonia	-	600
Hungary	682	801
Latvia	-	600
Lithuania	-	638
Moldova	890	622
Poland	5,645	1,290
Romania	1,222	1,008
Slovakia	819	874
Total	**11,530**	**8,720**

Each country adopted a unique sampling approach, dependent on factors such as the availability of sampling frames and information regarding population distribution by geographic area and accommodation type. A combination of different sampling methods was used, typically incorporating multiple stages and blending convenience sampling, cluster random sampling, and simple random sampling (the latter being exclusive to Romania). It is important to highlight that Hungary and Moldova modified its sampling approach, which limits the comparability of its results across years.

6. Kerusauskaite, I., Nimkar, R., Mulloy, L., Slota, A. (2023). Risks to Community Cohesion between Ukrainian Refugees and Host Communities in Central Europe. Community Cohesion in Central Europe project.

For the regional analysis, population weights were applied based on the most up-to-date refugee population figures for each country, ensuring the findings accurately represented the broader regional refugee population. To maintain comparability, the figures for 2023 presented in this report were also re-estimated using survey weights.

This report utilises the criteria of the Washington Group on Disability Statistics Short Set on Functioning (WG-SS)[7]. The assessment included a comprehensive set of questions covering mobility, vision, hearing, cognition, self-care, and communication. For the purpose of this report, disability is defined as level 3 and above, indicating significant limitations in functioning ('a lot of difficulty' or 'cannot do at all'). For indicators related to chronic illness and vaccination, respondents self-reported whether they or any household members had a chronic illness and whether children in the household had received measles vaccine.

To facilitate trend monitoring, the questionnaires were standardized across all countries, ensuring consistency in the majority of indicators between 2023 and 2024. Since the 2023 regional survey did not include data from Latvia, Lithuania, and Estonia, values for these countries were excluded from the 2023–2024 comparison. To maintain accuracy, only valid responses were included in the calculations, with responses such as 'prefer not to answer' or 'do not know' excluded. To facilitate interpretation, certain response options were consolidated into broader categorical variables.

To protect data privacy and maintain confidentiality, informed consent was obtained and documented from all participants, with clear explanations provided regarding the purpose and use of the data. The complete questionnaires, along with the consolidated anonymized dataset, are available in the UNHCR Microdata Library.

Limitations

This analysis has several limitations that should be considered when interpreting the findings. First, due to sampling constraints (lack of complete sampling frame) and the non-probabilistic selection of respondents, the results may not fully represent the entire Ukrainian refugee population. Additionally, the choice of sampling locations may have introduced a bias toward more vulnerable segments of the population. Variations in sampling approaches and data collection periods across countries can also affect comparability.

The findings on disability, chronic illness, and vaccination are based on self-reports and were not verified against medical records, which may impact their accuracy.

A high non-response rate was observed for sensitive questions related to mental health, psychosocial well-being, protection, income and expenditure which could affect the completeness of the data. Additionally, the survey results for certain indicators, such as infant and young child feeding and SRH barriers, should be interpreted with caution due to the small sample size or low response rates. As a result, some indicators could not be further analyzed to assess how factors such as gender, age, disability, or place of residence impact access to health and MHPSS services.

It is also important to note that there were slight differences in the questionnaire across countries and years, such as adjustments to answer options. Therefore, the regional trend analysis was limited to questions that were consistently used across all participating countries and years to ensure comparability. Furthermore, certain indicators were excluded from the regional analysis due to insufficient sample size or the unavailability of data across all countries.

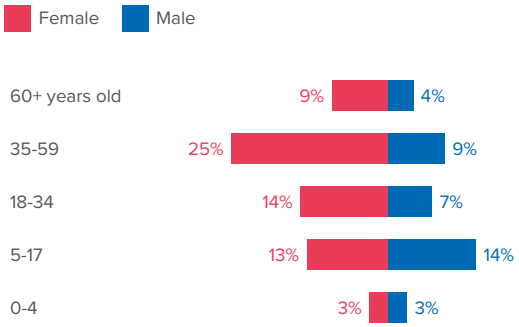
7. https://www.washingtongroup-disability.com/question-sets/wg-short-set-on-functioning-wg-ss/

The survey methodology relied on a single household member (the respondent) answering health and MHPSS questions on behalf of all household members, which may have limited the ability to fully capture the unique needs and experiences of each individual. Furthermore, the questionnaire itself was constrained to a limited range of questions, which may have restricted the depth of data collected on complex and multifaceted topics, such as mental health and psychosocial well-being. Additionally, sensitive topics such as mental health and sexual and reproductive health may have been underreported, depending on the respondent's comfort level and the presence of others during the interview.

Sample demographics

The sample comprises 8,720 households, encompassing 19,803 individual household members. The population pyramid for this sample indicates that the majority of individuals are women aged 35–59 (25%), followed by women aged 18–34 (14%). To minimize potential biases due to gender imbalances, indicators were disaggregated by gender and age, allowing comparisons within consistent age groups. No significant gender disparity is observed in the sample in children; consequently, indicators related to child health were not impacted. The sample included 194 pregnant women and 247 breastfeeding women.

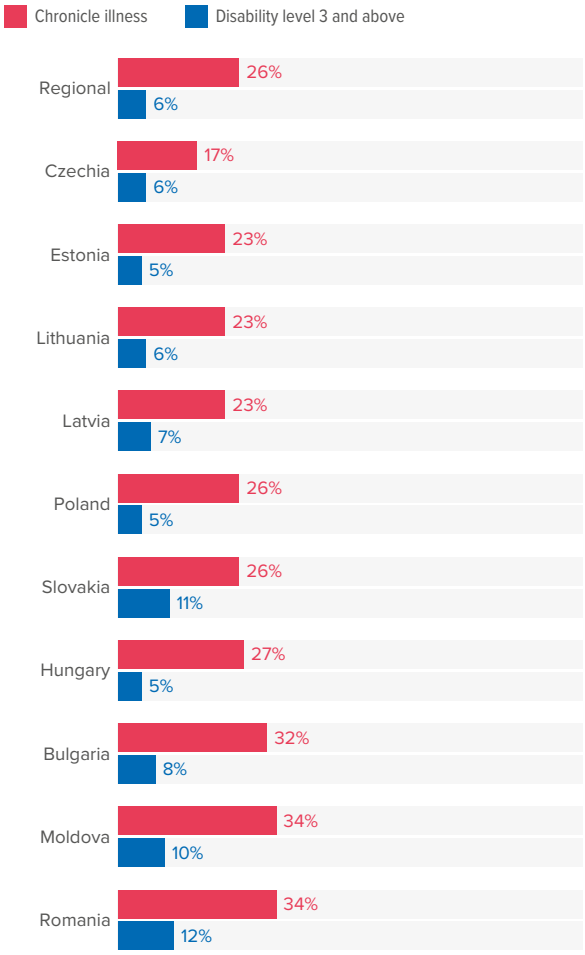
POPULATION PYRAMID



(N=19,803)

In terms of other demographic characteristics, 6% of individuals self-reported a disability (1,435 individuals out of a sample of 18,679). Among the countries surveyed, Estonia, Hungary, and Poland reported the lowest percentage of refugees with disabilities at 5%, while Romania reported the highest at 12%.

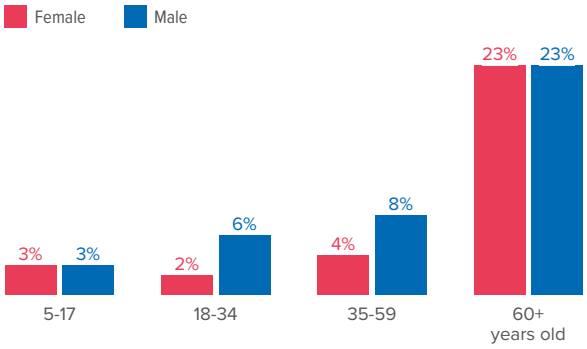
% OF INDIVIDUALS REPORTED WITH A CHRONIC ILLNESS AND THOSE WITH DISABILITY LEVEL 3 AND ABOVE



(Chronic Illness N=19,622, Disability N=18,679)

Regionally, 6% of men aged 18–34 report a disability, compared to 2% of women in this age group. A similar trend is observed for the 35–59 age group, with 8% of men and 4% of women reporting a disability respectively. The higher prevalence among men is likely related to the fact that men without a disability are less likely to leave Ukraine.

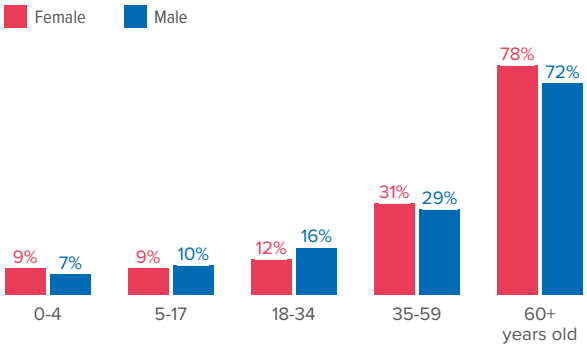
% OF INDIVIDUALS WITH DISABILITY BY AGE AND GENDER



(N=18,679)

Regionally, 26% of individuals self-reported a chronic illness (5,384 individuals out of a sample of 19,622), with rates ranging from 17% in Czechia to 34% in Moldova and Romania, closely followed by Bulgaria at 32%. Chronic illnesses increase with age, with 77% of individuals over 60 reporting a chronic condition (78% of women, 72% of men). Regionally, women above the age of 35 self-reported a higher rate of chronic illness compared to men.

% OF INDIVIDUALS WITH CHRONIC ILLNESS BY AGE AND GENDER



(N=19,622)

These findings suggest that health services should be tailored to address these gender and age-related dynamics, as should the dissemination of information about available services.

Health analysis

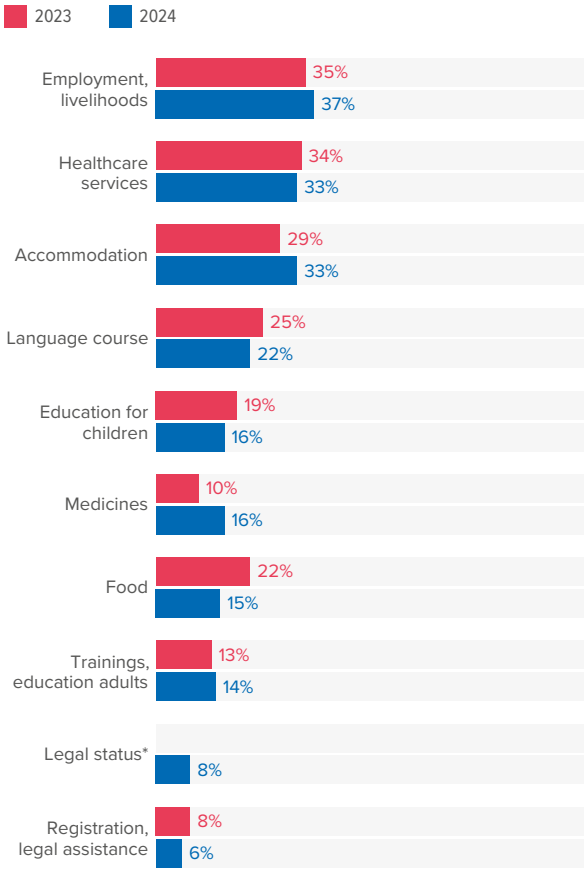
Health remains a priority need

Access to health services has remained a priority need and is ranked among the top three priorities by 33% of households, second only to employment and livelihoods support. The identification of health as a priority is consistent with 2023, where 34% of households ranked health among their top three needs.

Variations exist across countries, health care was the top priority need for respondents in half the countries (Bulgaria, Hungary, Moldova, Romania, and Latvia). In 2024, health care became a top priority for 49% of households in Romania, a shift from 38% in 2023, potentially indicating barriers and changes in the level of access.

Regionally, women and men prioritized health care nearly equally with respectively 34% and 32% identifying it as a priority need. For women, health was the second highest priority after employment compared to men who prioritized it third after employment and accommodation.

TOP 10 PRIORITY NEEDS (OUT OF THOSE WHO REPORTED)



(2023 N=9,466, 2024 N=7,140)
* Not included in 2023 survey

TOP 10 PRIORITY NEEDS (OUT OF THOSE WHO REPORTED), BY COUNTRY

Top 1 | Top 2 | Top 3 priority

	Regional	Bulgaria	Czechia	Estonia	Hungary	Latvia	Lithuania	Moldova	Poland	Romania	Slovakia
Healthcare services	33%	42%		29%	37%	52%	29%	43%	33%	49%	24%
Employment livelihoods	37%		30%	43%		38%	38%	40%	43%	36%	
Accommodation	33%	31%	37%		36%				32%	38%	49%
Language courses			33%	43%		35%	28%				
Food		37%			35%						31%
Medicine								34%			

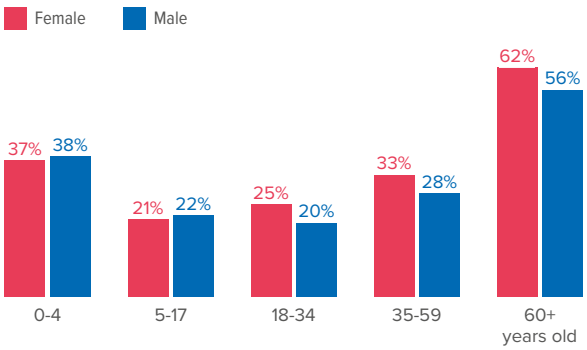
(N=7,140)

For households with a member with disability, health was the top priority with 56% of households reporting this as priority need compared to 30% of those without disability. Likewise, 45% of households with chronic illnesses identified healthcare access as their top priority, whereas households without chronically ill members ranked it fourth, with only 22% considering it a priority need. This indicates a modest decrease compared to 2023 when 58% of households with a member with disability and 48% of those with individuals with a chronic illness cited health as their top priority.

Need to access health care

Regionally, 31% of individuals experienced health problems 30 days prior to the survey and needed to access health care. The reported experience of health problems was higher among under-fives (37%) and those over the age of 60 (60%), and it was higher among women above 18 years (36%) compared to men (31%). The discrepancies between women and men in terms of experiencing a health problem is particularly pronounced in Estonia, Latvia, and Lithuania, where the rates of experiencing a health problem are 10% higher among women compared to men.

% OF INDIVIDUALS EXPERIENCED HEALTH PROBLEM IN LAST 30 DAYS BY GENDER AND AGE

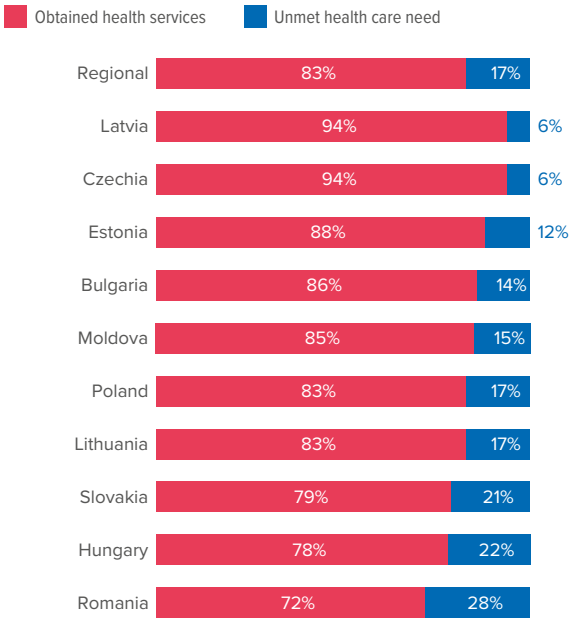


(N=19,637)

Access to care

Regionally, of the individuals who experienced health problems 30 days prior to the survey, 83% were able to obtain care, compared to 88% in 2023. With host countries continuing to implement necessary legislation that allows refugees access to health care, reported access to health services has remained above 70% in all countries. However, after three years of the crisis, a steady improvement in access has been seen in only a few countries notably Bulgaria and Czechia. Notably, access to needed care was highest in Latvia and Czechia at 94%.

% OF INDIVIDUALS WITH ACCESS TO HEALTH SERVICES (OUT OF THOSE WHO REPORTED A HEALTH PROBLEM IN THE LAST 30 DAYS)



(N=6,108)

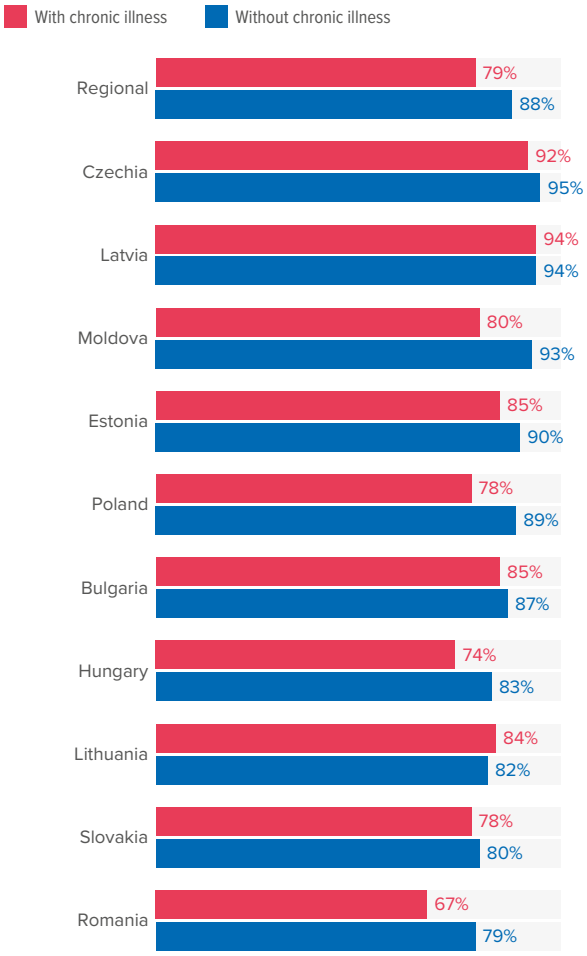
While the majority of people were able to access health care services, 17% were able to access needed care across the region. The unmet need was reported highest in Romania (28%), Hungary (22%), and Slovakia (21%).

Regionally, unmet health needs were higher for individuals with chronic illnesses compared to those without chronic illnesses (21% vs 12%) and higher compared to 2023 (15% vs 10%). Similarly, unmet

health needs were regionally reported higher among those with disabilities (23%) and higher compared to 2023 (14%). Notably, respondents with a disability in Latvia, Czechia, Bulgaria, Lithuania and Slovakia reported a similar level of access to health care as those without a disability.

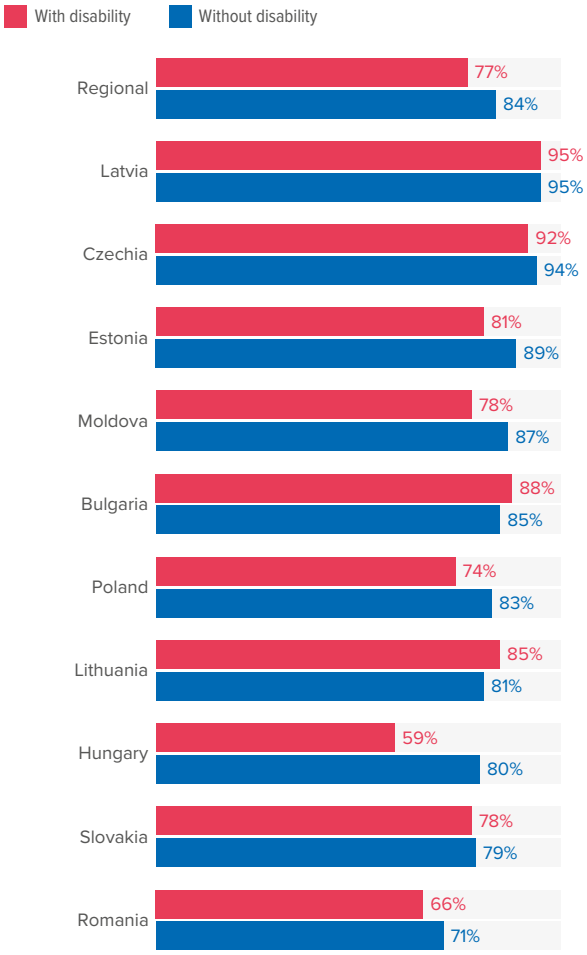
Unmet health needs are higher among recent arrivals. Of those who arrived in 2024, 28% reported difficulties in accessing care, compared to 19% of those who arrived in 2023 and 16% of those who arrived in 2022.

% OF INDIVIDUALS WITH CHRONIC ILLNESS THAT ARE ABLE TO ACCESS TO HEALTH CARE



(N=6,052)

% OF INDIVIDUALS WITH A DISABILITY THAT ARE ABLE TO ACCESS TO HEALTH CARE



(N=5,695)

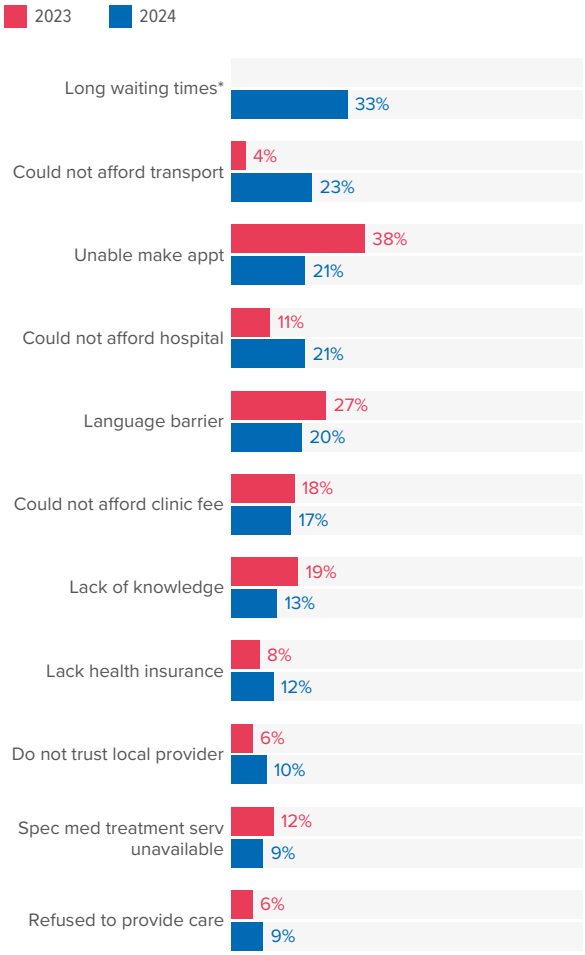
Barriers in accessing care

For individuals who experienced challenges in accessing care, the main barriers were long wait times (33%), unaffordable transport costs (23%), and inability to make an appointment (21%), indicating a shift in barriers compared to 2023. With the health worker shortage in Europe long waiting times are renowned and potentially exasperated by the increase in the refugee population. Although challenges in making an appointment remain among the top three barriers, the percentage of those experiencing this difficulty has decreased to 21% from 38% in 2023, when it was the topmost challenge. For those who arrived in 2024, challenges in making an appointment remained however the top barrier (34%). This points to improvements in navigating the host country's health systems for those who arrived before 2024, supported by the extensive information and awareness efforts of health authorities and RRP health partners. At the same time, it highlights the continuous need for information sharing to ensure effective access to care.

The cost of care and language are still barriers among those seeking care, and regionally, when compared to 2023, the proportion of those who reported experiencing cost barriers has increased, while it has not changed for language barriers. In Romania where unmet needs are the highest, cost and language barriers were the most reported barriers after long waiting times. In Hungary, language is the most reported barrier (53%).

While the primary barrier to accessing healthcare reported by both women and men was long wait times, women reported unaffordable transport costs (25%) and hospital fees (21%) as their next most significant barriers. In contrast, men reported language difficulties (22%) and the inability to make an appointment (22%) as their top barriers after long wait times.

BARRIERS TO ACCESSING HEALTH CARE

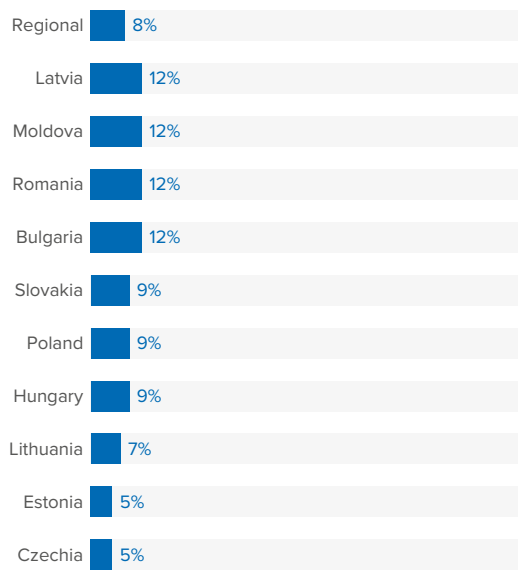


(2023 N=1071, 2024 N=1,040)
* Included under Others in 2023 (Total Others 2023: 5%)

Health expenditures and health insurance

Regionally health expenditures, on average, were 8% of all household expenditures in the 30 days preceding the survey, a slight reduction from 9% in 2023. In Latvia, Moldova, Romania and Bulgaria, the share of health expenditures was more than 10% of the household expenditures.

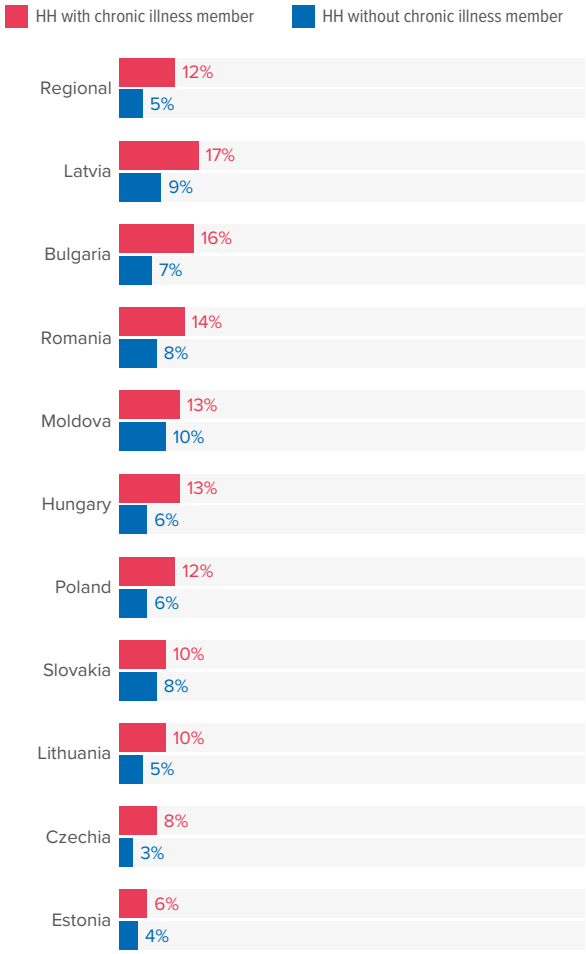
AVERAGE SHARE OF HOUSEHOLDS' EXPENDITURE ALLOCATED TO HEALTH



(N=5,671)

In households with a chronically ill member, the share of health expenditure was nearly double compared to those without (12% vs 5%), highlighting vulnerability and financial pressure in these households. The average share of health expenditure in households with children was 7%, while it was 9.5% in households without children.

AVERAGE SHARE OF HEALTH EXPENDITURE OF HOUSEHOLDS WITH/ WITHOUT MEMBERS WITH CHRONIC ILLNESS

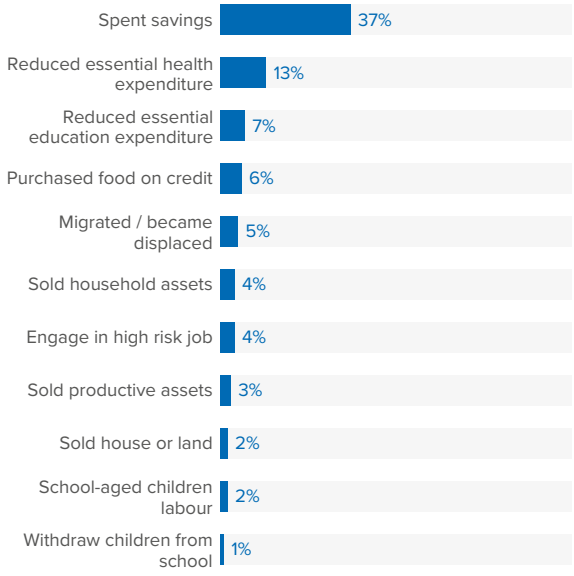


(N=5,671)

The survey also reviewed household coping mechanisms where households had insufficient funds to meet all basic needs. While more than a third of respondents reported spending their savings to meet basic needs, reducing essential health expenditures (including medicines) was the second most common coping mechanisms and used by 13% of the respondents.

This coping strategy is reported highest in Romania (36%), Hungary (23%), and Bulgaria (18%). Notably, in these countries, cost of care was the second most reported barrier to accessing care after long waiting times. Delaying care has negative implications on the health of individuals, including poorer health outcomes and an increased burden on health systems dealing with more complex and chronic conditions.

% OF HOUSEHOLDS WHO USED COPING MECHANISMS DUE TO LACK OF FUNDS IN THE LAST 30 DAYS

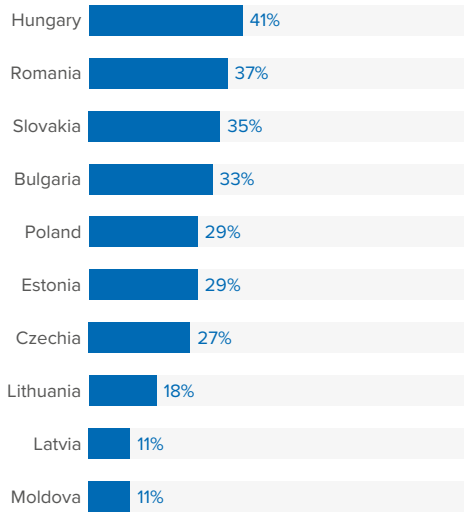


(N=8,720)

Reasons for visiting Ukraine

Altogether 42% of respondents have visited Ukraine at least once since February 2022. Regionally, the second most common reason for visiting was to access healthcare services (28%), following visits to relatives (57%). The proportion of those visiting for healthcare varied significantly by country, with respondents in Hungary (40%), Slovakia (37%), and Romania (36%) showing the highest rates, while it was lower in Lithuania (19%), Latvia (13%), and Moldova (10%). These findings align with previously reported higher unmet healthcare needs in Hungary (22%), Slovakia (21%), and Romania (28%), suggesting that seeking healthcare in Ukraine serves as a coping strategy to address these unmet needs.

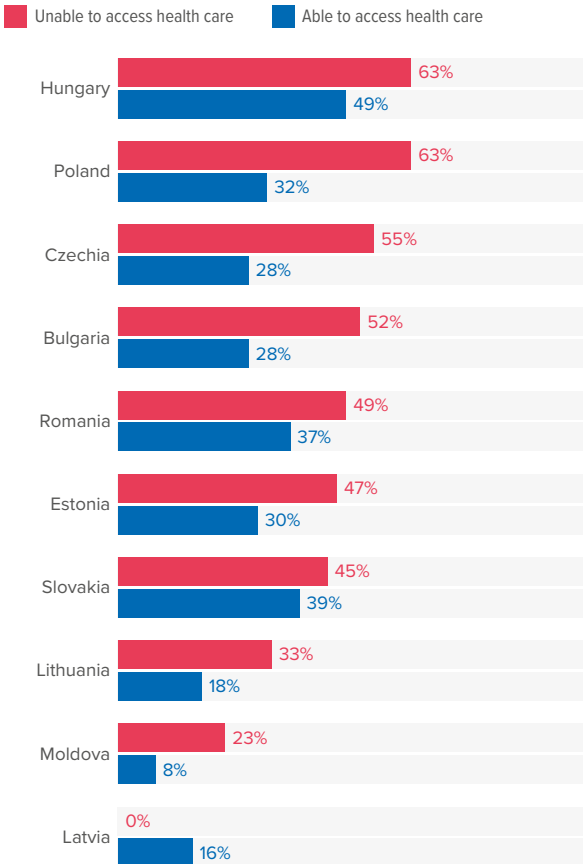
% OF HOUSEHOLDS WHO CITED SEEKING HEALTH CARE AS REASON TO VISIT UKRAINE



(N=3,596)

Respondents who faced constrains in accessing care were more likely to identify seeking health care as reason for visiting Ukraine in all countries, with the exception of Latvia.

REASONS SEEKING HEALTHCARE FOR VISIT TO UKRAINE BY OBTAINED CARE STATUS



(N=3,596)

Respondents with a chronic illness were more likely to cite accessing health care as reason for visiting compared to those without (33% vs 23%). Among households with a member who has a disability, healthcare access was the primary reason for visiting (38%), compared to 26% for households without a member with disability. There were no immediate gender differences concerning the prevalence of healthcare as a reason for women and men to visit Ukraine.

Access to sexual and reproductive health services

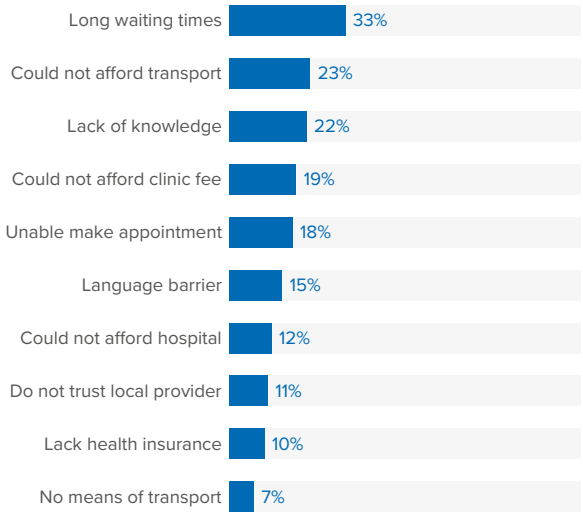
General SRH Services Access

Acknowledging that 63% of the Ukrainian refugees are women and girls, with 34% of the total refugee population being women in reproductive age between 15- 49 of age, the survey added a focus to explore access and barriers to sexual and reproductive health (SRH) services for women. SRH services include family planning; prenatal and postnatal care, safe delivery including Emergency Obstetric and Newborn Care (EmONC); clinical management of rape; prevention, detection and treatment of reproductive tract infections, sexually transmitted infections and HIV; and referrals to higher level obstetric care or specialized SRH services.

Across the region, 5% of women reported to have faced barriers in accessing SRH services, though access level varies by country. In Latvia and Bulgaria, only 1 % and 2% of women respectively reported barriers, indicating good access to SRH services. However, in Lithuania and Romania 9% and 6% of women respectively reported barriers in accessing SRH services.

Among the 5% who reported access constraints, the primary barrier to accessing SRH services was long waiting times, affecting 33%. Financial barriers also posed challenges, with 23% of women reporting difficulties covering transportation costs, 19% struggling with clinic fees, and 12% with hospital fees. Additionally, 21% lacked knowledge of where to access SRH care and 19% were unable to make appointments, reflecting both informational and administrative barriers to SRH services.

BARRIERS TO ACCESSING SRH SERVICES



(N=363)

In urban areas, financial barriers, such as transportation costs and clinic fees, were the most reported obstacles to accessing SRH services. In contrast, women in rural settings faced challenges primarily related to knowledge of services, appointment-making and language barriers.

Barriers in accessing SRH care for different groups

The number of respondents who faced barriers in accessing SRH services in the adolescent, youth, pregnant and breastfeeding women, and persons with disabilities categories was low, and data needs to be interpreted with caution. However, the findings offer valuable insights into the experiences of individuals in these categories.

Among adolescent girls aged 15- 17 who faced access barriers (N=13), the lack of knowledge took the lead ahead of the waiting times and financial barriers. Moreover, compared to women, adolescent girls reported lower levels of trust in local healthcare providers. For all young women aged 18-24 who reported barriers (N=30), the most significant were long waiting times and inability to make an appointment.

Among pregnant and breastfeeding women (N=441), 5% reported facing barriers in accessing SRH services. For those experiencing barriers, half lacked knowledge about where to access SRH services and one in five did not trust local healthcare providers, in addition to facing language barriers.

Women with a disability reported more barriers with 11% across the region (N=29) compared to those without disability (5%).

An in-depth assessment is needed to better understand sexual and reproductive health (SRH) needs, the role of SRH access barriers in decisions to visit Ukraine, and how these barriers vary among women of different age groups, pregnant and breastfeeding women, and women with disabilities.

Support services for survivors of gender-based violence

Services for survivors of gender-based violence encompass a range of functions, including safety and security, legal assistance, healthcare, mental health and psychosocial support. A critical component is access to clinical management of rape to ensure timely medical treatment and care. As this service is provided by the health care sector, as part of SRH, it is included in this analysis.

The SEIS identified gaps in awareness about on available GBV services. In 2024, 38% of respondents were unaware of health services providing support to GBV survivors in their area, while 58% were unaware of available psychosocial support services. Respondents were less aware of health services in rural areas (45%) compared to urban areas (37%). Key barriers to accessing GBV-related services in general included lack of awareness (58%), language and cultural barriers (53%) and stigma/ shame (46%). This indicates that additional coordinated efforts between the health, protection and GBV working groups and partners are required to enable access to all lifesaving GBV-related services including clinical management of rape.

Child health, vaccination and nutrition

INDICATOR*	AGE RANGE	NUMBER/ TOTAL	PREVALENCE (%)
Timely initiation of breastfeeding (within one hour of delivery)	0-23 months	153/274	57%
Exclusive breastfeeding under 6 months	0-5 months	15/38	37%

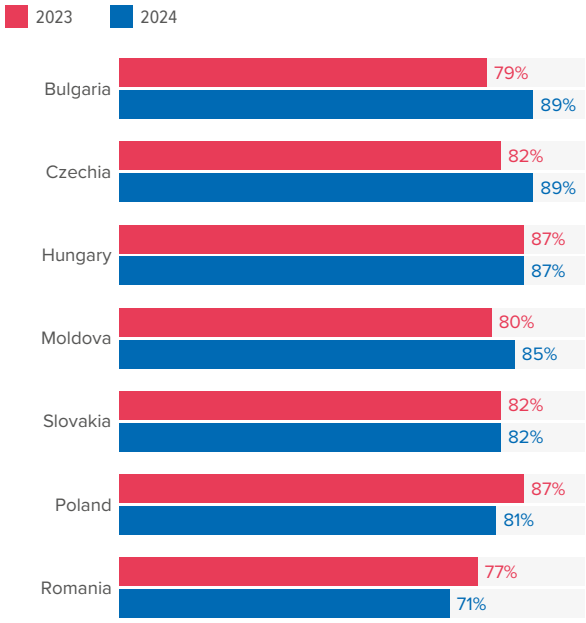
* Excluding Estonia, Hungary

Breastfeeding practices for infants and young children directly influence their nutritional health during the first two years of life and play a crucial role in child survival. From the survey results, the proportion of children 0-23 months who had timely initiation of breastfeeding was 57% and the rate of exclusive breastfeeding for the first six months of life was 37% in the region. Data need to be interpreted with caution given the very low number of respondents.

Two doses of measles vaccine are recommended for optimal protection against measles; the survey assessed therefore first and second dose measles vaccination coverage in children aged 9 months to 5 years. In average, 83% of children received at least one measles vaccine, similar to results from 2023 when 84% of children had received at least one dose. Coverage was lowest in Romania with 71% where respondents reported also greater constraints in accessing health services. Vaccine coverage increased notably in Moldova, Czechia and Bulgaria compared to 2023. In comparison, measles vaccination coverage within Ukraine reached 92% for the 1st dose of measles vaccine and 87% for second dose [8] (WHO, 2023).

Regionally, only 54% of all children received the recommended second measles vaccine. Vaccination coverage is below the 95% target required to interrupt community transmission of measles.

% OF CHILDREN RECEIVED AT LEAST ONE MEASLES VACCINE



(2023 N=1,539, 2024 N=1,320)

Data need to be interpreted with caution as they rely on recall and were not verified against individual vaccination records.

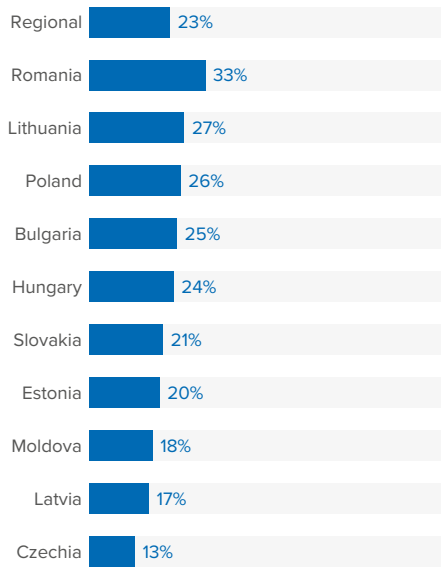
8. https://immunizationdata.who.int/dashboard/regions/european-region/UKR accessed on 06.11.2024

Mental Health and Psychosocial Support (MHPSS)

Reported mental health and psychosocial problems

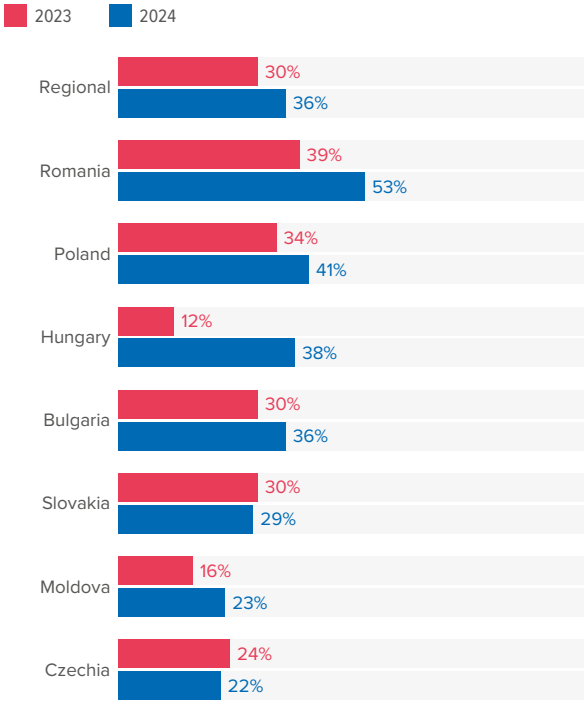
Regionally, 23% of individuals reported experiencing mental health and psychosocial problems that affect their daily functioning, with 36% of households reporting at least one member affected. This is an increase compared to 2023, when 19% of individuals and 30% of households reported mental health and psychosocial problems. There are notable regional variations in reported MHPSS needs, with the percentage of individuals with such needs ranging between 13% (Czechia) and 33% (Romania). In 2023, Czechia also had the lowest and Romania the highest percentage of mental health or psychosocial problems on individual and household level. Stigma surrounding the disclosure of mental health challenges within the Ukrainian community likely means that the actual prevalence of mental health and psychosocial problems may be underreported.

% OF INDIVIDUALS EXPERIENCING MENTAL HEALTH OR PSYCHOSOCIAL PROBLEMS BY COUNTRY



(N=8,540)

% OF HOUSEHOLDS WITH AT LEAST ONE MEMBER WITH MENTAL HEALTH OR PSYCHOSOCIAL PROBLEMS BY YEAR AND COUNTRY



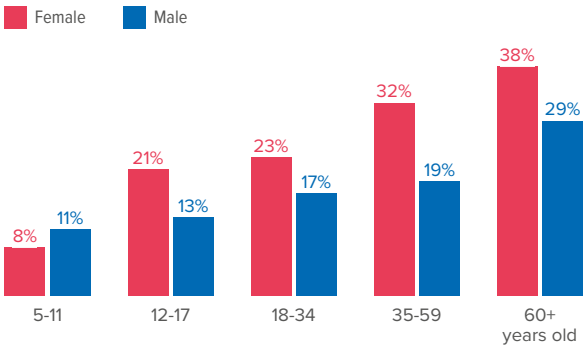
(2023 N=11,277, 2024 N=6,730)

There were considerable age and gender differences regionally, with older age groups reporting more mental health and psychosocial

problems, and in each age group females reporting more problems than males, except among children under the age of 11, where boys reported slightly more problems than girls.

These overall upward trends underscore that, even in the third year of the Ukraine response, mental health and psychosocial needs remain a significant and growing challenge requiring sustained support, attention, and increased financing to ensure adequate care and resources are available.

% OF INDIVIDUALS WITH MENTAL HEALTH OR PSYCHOSOCIAL PROBLEMS BY AGE GROUP AND GENDER

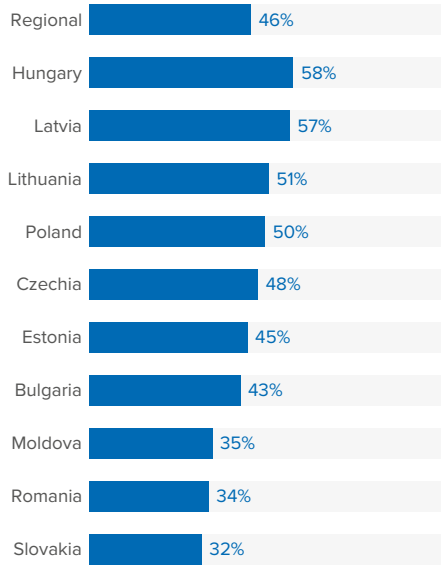


(N=17,972)

Access to Mental Health and Psychosocial Support

Among the 23% of individuals reported to have mental health or psychosocial problems affecting daily functioning (such as the ability to get out of bed, care for oneself or others, or carry out daily activities such as cooking, going to school), 46% (47% of women and girls; 42% of men and boys) reported trying to access support. This means that more than half (54%) of individuals experiencing such problems did not try to access support, which may be due to multiple factors, including stigma, mental health awareness, or other access barriers.

% OF INDIVIDUALS WHO REPORT EXPERIENCING MENTAL HEALTH AND PSYCHOSOCIAL PROBLEMS AND TRIED TO ACCESS SUPPORT BY COUNTRY



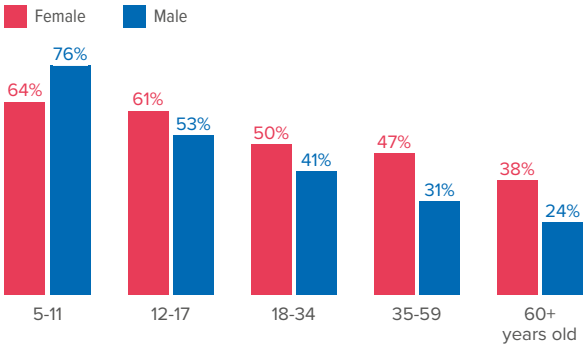
(N=4,053)

Of those individuals who reported trying to access support, almost all (96% overall; 97% of women, 94% of men) reported successfully accessing and receiving some sort of support. This high rate of access is partly explained by the inclusion of both formal services, such as psychotherapy, psychiatric care, or structured group interventions, and informal support, such as help from family, friends, employers, or spiritual leaders. By encompassing a broad spectrum of support mechanisms, the findings capture the diverse ways individuals seek and receive assistance, highlighting the importance of informal networks in complementing formal MHPSS services.

Attempts to access support differed by age, with caregivers of the youngest age group (5–11 years) being the most likely to seek support on their behalf, while older persons less often attempted to access support. In addition, in both 2023 and 2024, there were consistent gender differences in attempts to access support. In all age groups except children under 11, females attempted to access support more often than males. The gender gap in seeking support was most pronounced in the older age groups: among individuals aged 35-59, 47% of women tried to access services compared to only 31% of men, suggesting potential social and cultural

stigma limiting help-seeking behaviors among adult men. Conversely, for children aged 5–11, caregivers sought support for 76% of boys and 64% of girls. These findings highlight the complex interplay of gender and societal norms in influencing help-seeking behaviours, warranting further investigation.

% OF INDIVIDUALS WHO TRIED TO ACCESS MENTAL HEALTH SUPPORT BY AGE AND GENDER



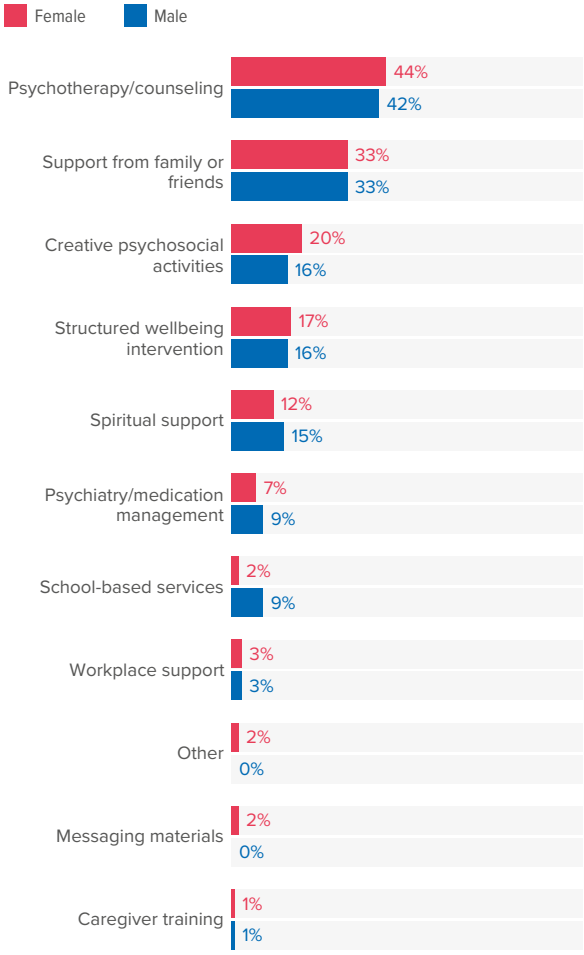
(N=4,052)

Types of Support

Regarding types of support received, most participants reported utilizing formal services with psychotherapy/counselling services being the most common (44%). Smaller numbers participated in creative psychosocial activities (19%), group or individual structured interventions designed to improve well-being (17%), psychiatry/medication management (8%), school-based services (4% overall; for children under 18, 13%), support gained from messaging materials (2%), and training for caregivers in how to support children in distress (1%). These formal services, provided by professionals or by trained specialists and non-specialists, aim to address both clinical and subclinical mental health needs through structured, evidence-informed approaches.

Informal support also played a significant role, with 33% of participants receiving support from family and friends, 12% accessing spiritual support, and 3% receiving support from their employer (e.g., flexible work arrangements). These informal mechanisms, while less structured, complement formal services by fostering emotional connection and practical assistance through personal relationships and community networks.

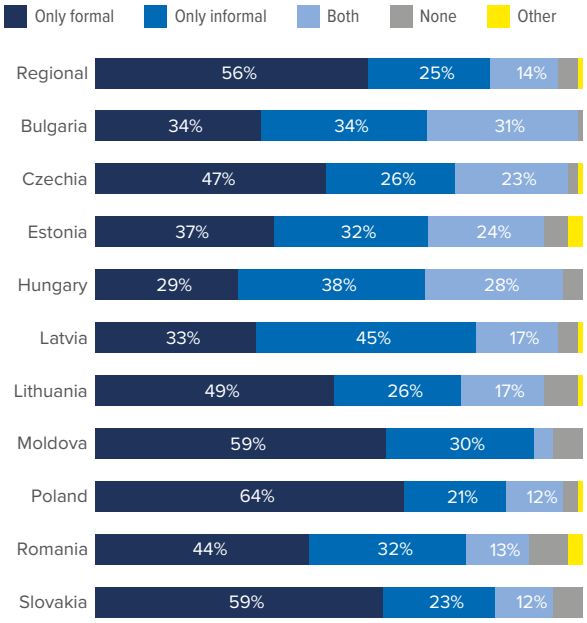
TYPE OF MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT RECEIVED BY GENDER



(N=1,715)

Regionally, 56% of participants reported receiving only formal services, 25% reported receiving only informal support, and 14% of participants reported receiving both formal and informal forms of support. Forms of support varied across countries, with uptake of formal services ranging from 29% of participants in Hungary to 64% of participants in Poland. In some settings with lower use of formal services, participants appeared somewhat more likely to seek out or use informal supports.

% OF INDIVIDUALS WHO ACCESSED FORMAL AND INFORMAL SUPPORT BY COUNTRY

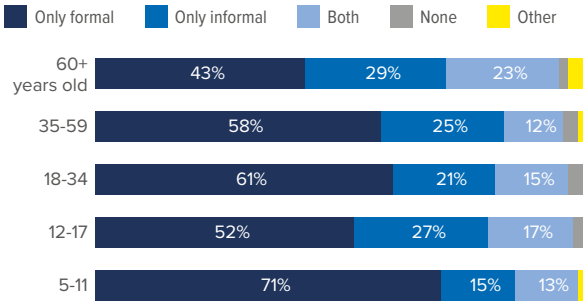


(N=1,716)

Interestingly, while women and girls and younger men and boys were more likely to access formal services than informal supports, older men (age 35 and older) were more likely to access informal supports than formal services. These results may suggest that while older men are less likely to access formal MHPSS services, perhaps due to stigma or other factors, some may turn to informal means, such as support from friends, family and spirituality.

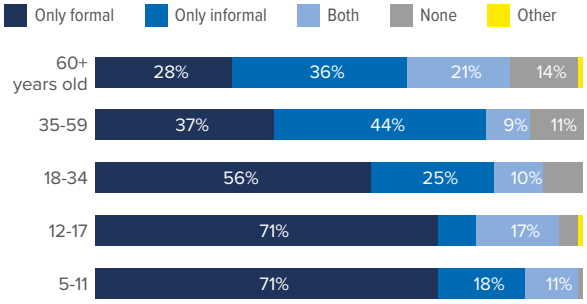
% OF INDIVIDUALS WHO ACCESSED FORMAL AND INFORMAL SUPPORT BY AGE AND GENDER

GENDER = FEMALE



(N=1,355)

GENDER = MALE



(N=360)

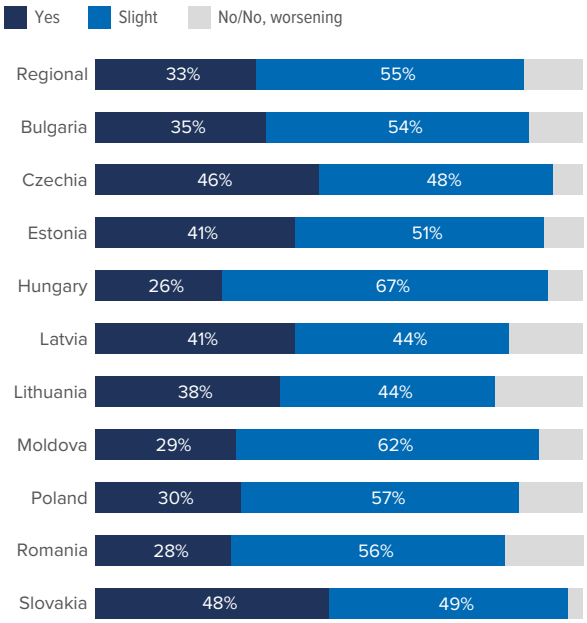
Location of Received MHPSS

MHPSS services were most commonly accessed in community centres (38%), followed by online platforms (18%), reception hubs such as Blue Dots (14%), healthcare settings (13%), religious settings (11%), schools (8%), workplaces (4%), and through phone or hotlines (4%). Additionally, 11% indicated “other” locations. This distribution underscores the importance of diverse and accessible service locations to meet varied needs and preferences, leveraging both formal and informal support systems.

Outcomes of Mental Health and Psychosocial Support

Among those who accessed MHPSS, 33% answered "yes" when asked whether they experienced improvement, while 55% reported a "slight" improvement, resulting in a combined positive response rate of 88%.

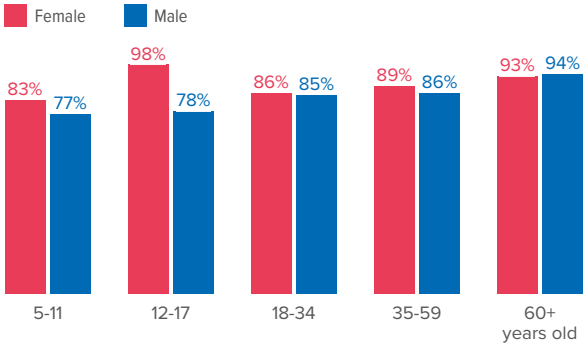
% OF INDIVIDUALS WHO RECEIVED MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT SERVICES AND REPORT IMPROVEMENT IN WELL-BEING BY COUNTRY



(N=1,662)

Gender analyses revealed that 90% of women and 84% of men reported improvement. Respondents reported that, among children under 18, 85% demonstrated some form of improvement, 13% no improvement, and 2% worsening. Outcomes for children varied by age and gender, with 98% of adolescent girls (12-17 years) showing improvement compared to 78% of boys in the same age group, while among younger children (5-11 years), 83% of girls and 77% of boys showed improvement. Among adults, positive outcomes were relatively consistent across gender, with older adults aged 60+ reporting the highest improvement rates (93% for women and 94% for men).

% OF INDIVIDUALS WHO RECEIVED MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT SERVICES AND REPORT IMPROVEMENT IN WELL-BEING BY AGE AND GENDER



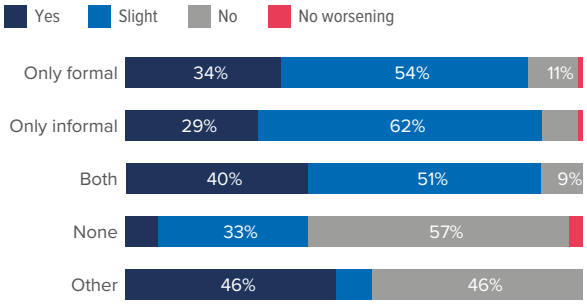
(N=1,661)

Outcomes were relatively consistent across types of support. Those who accessed only formal support (e.g., psychotherapy or structured group interventions) reported improvement in 88% of cases (with 34% stating "yes" and 54% reporting "slight" improvement). Individuals relying on only informal support (e.g., help from friends, family, or employers) reported improvement in 91% of cases, with slightly fewer reporting "yes" (29%) and a higher percentage indicating "slight" improvement (62%). Meanwhile, those who accessed both formal and informal support were slightly more likely to state "yes" regarding improvement (40%), with 51% indicating "slight" improvement (for a total of 91% of cases reporting some improvement). Although differences are small, results imply that a combination of support types may be associated with enhanced perceived effectiveness. Further research is needed to explore this potential relationship.

These findings demonstrate that, overall, those who accessed support perceived this support to be beneficial. Results reinforce the importance of integrating both formal and informal support mechanisms to maximize positive outcomes, as well as tailoring interventions to demographic and country-specific needs to enhance the well-being of individuals receiving MHPSS services. The data also

underscores the need to further explore how combinations of support types contribute to better outcomes and how service accessibility and quality can be optimized across different settings.

% OF INDIVIDUALS WHO RECEIVED INFORMAL VS FORMAL MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT SERVICES AND REPORT IMPROVEMENT

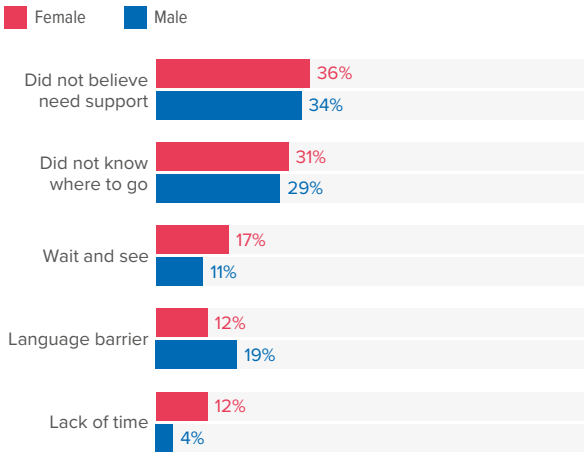


(N=1,662)

Barriers to accessing Mental Health and Psychosocial Support services

The most common reported barrier to accessing MHPSS services was not believing that one needed support (36% in women, 34% in men), followed by not knowing where to go (31% in women; 29% in men). One in six (16%) of respondents reported adopting a "wait-and-see" approach. Other barriers included language barriers (14%), lack of time (10%), inability to afford services (7%), lack of service availability (5%), stigma (4%), long waiting time (4%), lack of trust (3%), work commitments (3%), transportation (2%), and insecurity/safety concerns (2%) and other factors (5%). Results show that, despite reporting mental health problems that impede functioning, more than a third of respondents did not perceive a need for MHPSS, which may stem from a lack of mental health literacy, stigma or lack of confidence in services. Insufficient awareness about available resources is also a primary barrier across the region, with language barriers posing additional challenges in certain countries. Women were more likely to report lacking time to seek services (12%) than were men (4%), which may be linked to their multiple other responsibilities related to livelihoods, household responsibilities, and care work. Addressing these barriers requires tailored interventions to improve awareness, reduce stigma and increase confidence in services, enhance linguistic accessibility, and address logistical and availability constraints (especially among women), ultimately improving access to MHPSS services.

SELF-REPORTED BARRIERS TO ACCESSING MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT SERVICES BY GENDER AT REGIONAL LEVEL (TOP 5)



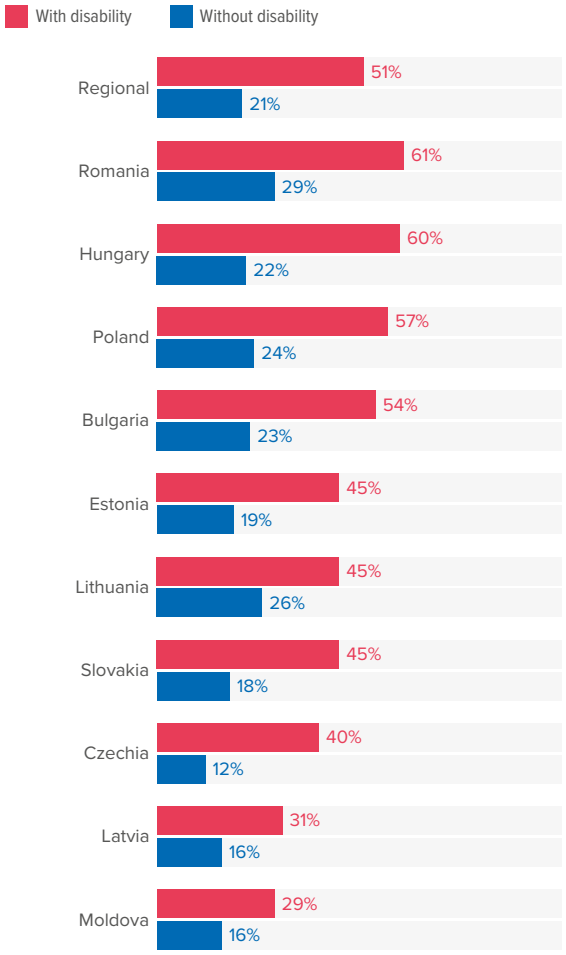
(N=1,682)

Disability and MHPSS

Mental health and psychosocial problems were significantly more often reported by individuals with disabilities (51%, up from 42% in 2023) compared to those without disabilities (21%, up from 17% in 2023). This highlights the heightened vulnerability of individuals with disabilities to mental health and psychosocial challenges, which are often exacerbated by social barriers such as limited accessibility, social exclusion, stigma, and a lack of support systems. There are clear variations across countries, with Romania (61%) and Hungary (60%) reporting the highest percentage of problems among individuals with disabilities, while Moldova (29%) and Latvia (31%) reported the lowest percentage.

The overlap between certain mental health problems, such as difficulties with memory, concentration, or self-care, and the criteria used to assess disability further demonstrates the complex interplay between these factors. The data also suggests that structural and systemic differences between countries may influence outcomes, as reflected in the varying rates reported. These findings highlight the critical need for inclusive MHPSS strategies that address the unique needs of individuals with disabilities and provide targeted interventions to reduce barriers and ensure equitable access to support. Additionally, further analysis of country-specific contexts could help uncover underlying factors driving these disparities.

% OF INDIVIDUALS WHO REPORTED EXPERIENCING A MENTAL HEALTH OR PSYCHOSOCIAL PROBLEM BY DISABILITY STATUS AND COUNTRY

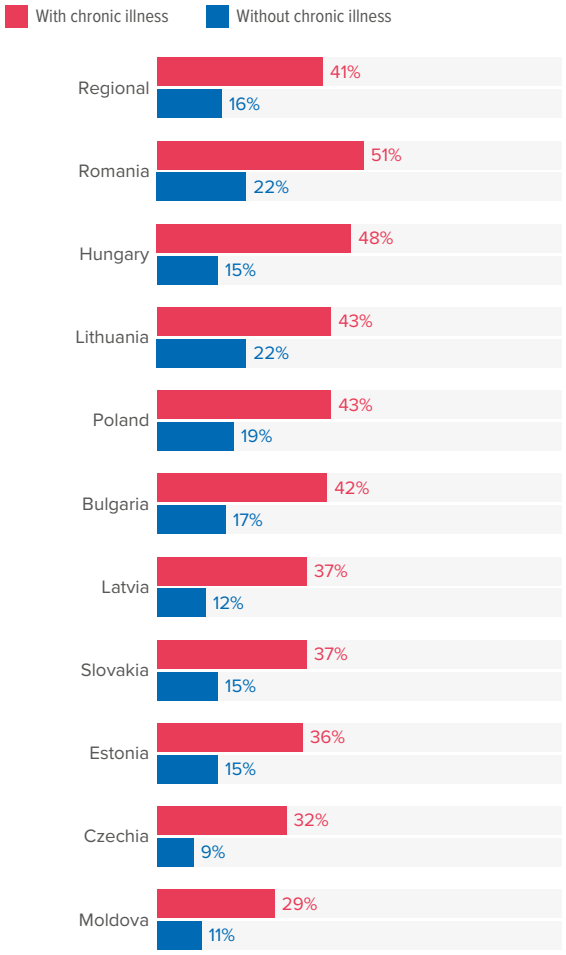


(N=17,934)

Chronic illness and MHPSS

Among individuals with chronic illnesses, 41% reported experiencing mental health and psychosocial problems in 2024 (44% of women, 36% of men), up from 33% in 2023 (36% of women, 28% of men). In contrast, only 16% of individuals without chronic illnesses reported such problems in 2024 (20% of women and 11% of men), compared to 13% in 2023 (15% of women and 9% of men). These findings reinforce the strong interplay between chronic health conditions and mental health challenges, emphasizing the need for integrated care models that holistically address both physical and mental health to provide effective and comprehensive support for those managing chronic illnesses.

% OF INDIVIDUALS WHO REPORTED EXPERIENCING A MENTAL HEALTH OR PSYCHOSOCIAL PROBLEM BY CHRONIC ILLNESS STATUS AND COUNTRY

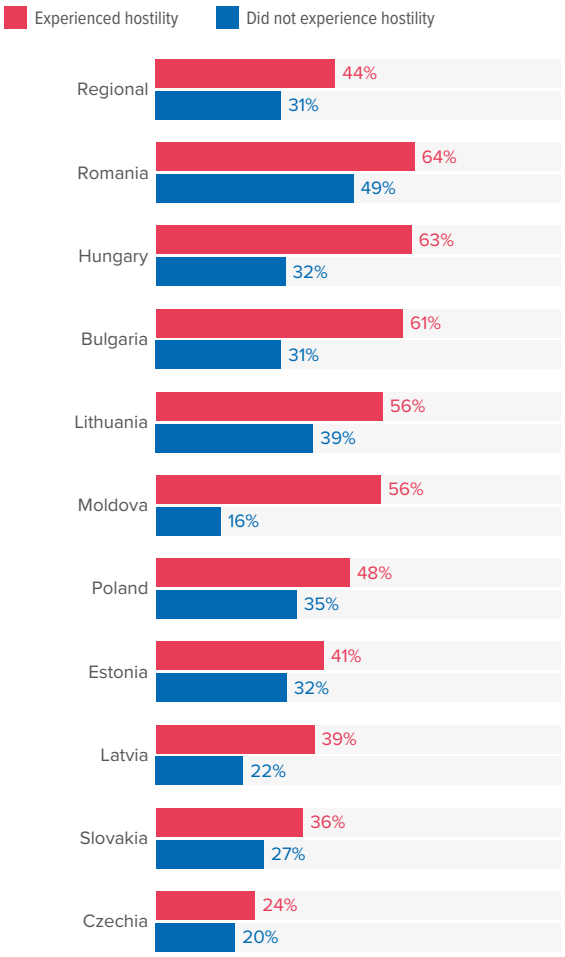


(N=17,867)

Social cohesion and MHPSS

An association between perceived hostility and mental health challenges remains evident across the region, with households experiencing hostility in their social environment more likely to report mental health and psychosocial problems (44%) compared to those not experiencing hostility (31%). Perceived hostility may increase vulnerability to distress, while distress may in turn influence individuals to perceive their environments as more hostile, creating a reinforcing cycle. This trend is consistent across countries, with notable between-country differences: Romania continues to report the highest percentage of problems both for households experiencing hostility (64%) and those not experiencing hostility (49%), while Czechia consistently reports the lowest percentages in both categories (24% and 20%, respectively). Significant differences also emerged between countries such as Hungary and Moldova, where the prevalence of mental health and psychosocial problems in households experiencing hostility is relatively high (63% and 56%, respectively), but the prevalence among those not experiencing hostility diverges dramatically (32% in Hungary versus 16% in Moldova). These findings highlight the importance of addressing perceived hostility and its impact on mental health, through targeted, country-specific MHPSS and social cohesion interventions.

% OF HOUSEHOLDS WITH AT LEAST ONE MEMBER REPORTED EXPERIENCING A MENTAL HEALTH OR PSYCHOSOCIAL PROBLEM BY SOCIAL COHESION AND COUNTRY



(N=8,540)

Recommendations

Host countries and communities have made commendable and continuous efforts to support refugees in accessing essential health and MHPSS services. While most respondents reported adequate access, barriers to services changed and increased for some refugees. These changes do not take the same form for all refugees, and intersectional factors related to gender, age, disability, and chronic illness continue to impact the experiences and needs of refugees from Ukraine in this regard. The recommendations below highlight key priorities and actions for governments and RRP partners to address these challenges and enhance refugees' access to care in host countries.

These actions aim to support governments and local communities in strengthening health and MHPSS systems in areas impacted by refugee arrivals and advancing the integration of refugees into national systems. Achieving these goals will require long-term planning and sustained funding commitments.

Integrate monitoring of health needs and barriers to accessing and utilizing healthcare, including for SRH and mental health services, into national data collection mechanisms by collecting disaggregated data for refugees through routine health information systems and surveys to inform policy decisions. Collaboration between statistics offices, Ministries of Health, institutes of public health, social institutions and other partners could ensure sustainability of monitoring efforts and generate robust information for local service providers and national level policy makers. This is in line with recommendations elsewhere for diversity sensitive national health monitoring surveys and systems that collect data to monitor population groups[9].

Continue to **address capacity problems in national health systems** to enable effective access to health and MHPSS services, such as the health workforce shortages that underlie problems such as long waiting times for both refugees and host populations, including through use of telemedicine and intensified efforts to integrate Ukrainian healthcare workers. Sustainable financing for health care services with targeted increase for facilities that have increased demand due to refugee population could address this challenge.

9. Integration of migrant and refugee data in health information systems in Europe: advancing evidence, policy and practice

Address persistent health and MHPSS service access barriers with context-appropriate approaches, drawing on lessons from successful strategies in different countries. Efforts to educate and support refugees in navigating the health system, including making appointments and registering with general practitioners, are essential as these remain among the top barriers to accessing care. Innovative approaches may be required to address transport barriers, including through cash-based interventions. Furthermore, actions to improve language and cultural sensitivity in service provision, such as offering language interpretation services and integrating Ukrainian health workers into the healthcare system temporarily, would help address language barriers.

Address the health care and MHPSS needs of at-risk groups such as persons with chronic illnesses and disabilities by implementing targeted interventions, enhancing risk communication and community engagement, and strengthening health financing mechanisms. This includes advancing integrated care models that embed mental health services within general health care settings, ensuring a holistic approach to refugee well-being by providing accessible, comprehensive, and coordinated support tailored to the complex needs of individuals.

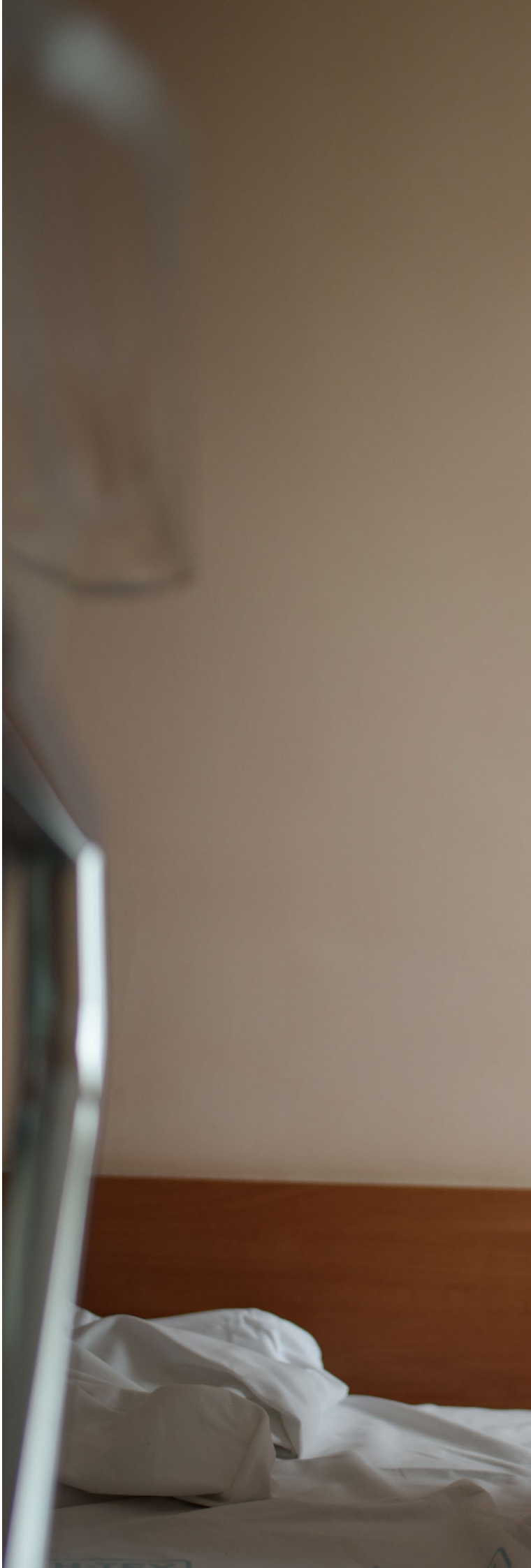
Strengthen and expand the availability, quality, and accessibility of community-based MHPSS that both integrates formal services and promotes the use of informal supports. These supports should be embedded in initiatives for health, protection, education, and livelihoods to ensure a comprehensive and coordinated cross-sectoral approach to mental health and psychosocial well-being. This includes services such as psychotherapy, structured group and individual interventions for children and adults, creative and recreational psychosocial activities, and national and regional public campaigns to reduce stigma and foster help-seeking behaviours.

Promote gender-responsive and age-sensitive approaches, developing targeted interventions to address gender disparities in accessing MHPSS, particularly for adult men who are less likely to seek support and adolescent boys who report lower perceived improvement from services.

Address social cohesion to improve mental health, implementing interventions that strengthen social cohesion, especially in countries where perceived hostility is strongly linked to higher prevalence of mental health and psychosocial problems. This includes fostering inclusive community programmes, promoting dialogue between host and displaced populations, and addressing perceptions of hostility to mitigate its reinforcing impact on mental health.

Actively involve refugees in the planning, delivery, and evaluation of health and MHPSS responses through mechanisms such as advisory groups and participatory assessments. Employing refugees as community health and MHPSS workers, interpreters, or cultural mediators can improve service accessibility, build trust, and promote sustainable, inclusive healthcare systems.

Conduct further research to better understand the unmet needs and barriers to accessing health services, including SRH and MHPSS, and how these challenges affect refugees and host communities differently. This should also include qualitative research to explore the root causes of higher prevalence rates among certain demographics or regions, incorporating personalized feedback from affected individuals to inform more targeted interventions. While the SEIS provides valuable insights into refugee perceptions of services, complementary research from the provider perspective is crucial to identify systemic barriers and understand the long-term impacts of displacement on health and mental health. Such comprehensive research will inform the development of more effective and sustainable strategies to address these challenges.



Yulia and her newborn son, Misha, at a clinical hospital in Chisinau, Moldova. © UNFPA Moldova/Mihail Calarașan

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