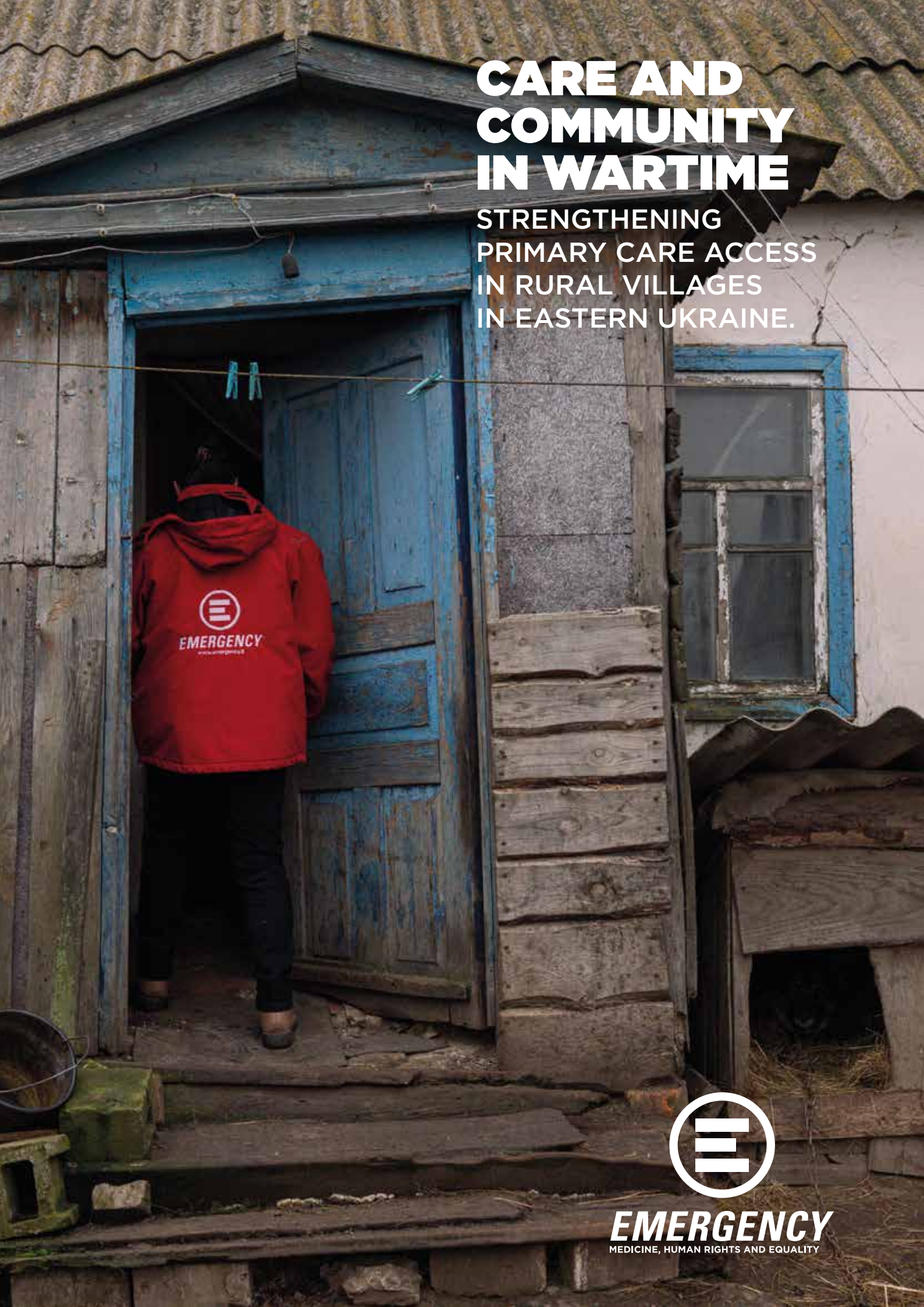


# CARE AND COMMUNITY IN WARTIME

## STRENGTHENING PRIMARY CARE ACCESS IN RURAL VILLAGES IN EASTERN UKRAINE.

EMERGENCY
MEDICINE, HUMAN RIGHTS AND EQUALITY

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## EMERGENCY ONG ETS

is an independent non-governmental organisation founded in Italy in 1994 with two objectives: to provide free, high-quality medical and surgical treatment to victims of war, landmines and poverty, and to promote a culture of peace, solidarity and respect for human rights.

EMERGENCY believes that treatment is a fundamental human right and should be recognised as such for every individual. For treatment to be truly accessible, it must be completely free of charge; for it to be effective, it must be of high quality.

Since 1994, EMERGENCY has worked in 21 countries around the world, providing free care to more than 14 million people.

EMERGENCY
MEDICINE, HUMAN RIGHTS AND EQUALITY

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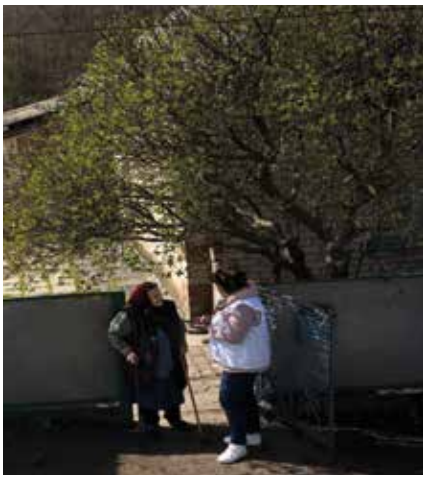






# EXECUTIVE SUMMARY

Building on over a decade of territorial disputes and diplomatic turmoil, four years of war have put Ukraine's healthcare system under extreme strain, driving a humanitarian crisis of staggering proportions. Since 24 February 2022, more than 2,800 attacks on healthcare facilities have severely damaged critical infrastructure, while the health workforce has contracted by 14%, leaving 9.2 million people without adequate health support. The human toll is catastrophic: nearly 49,000 civilian casualties, including almost 13,900 deaths, with violence continuing to intensify – 2025 alone saw a 31% increase over the previous year.

Economic losses exceeding USD 499 billion have pushed an additional 1.8 million Ukrainians into **poverty**, severely restricting access to essential services for over 9 million people now living below the poverty line. Access to medicines is especially critical, as **out-of-pocket payments** account for nearly half of total health expenditure, with medicines representing the largest share, placing essential treatments beyond reach for many.

As **humanitarian needs** surge to 13 million people, the crisis has reached a critical juncture. Yet with the authorities continuing to prioritise defence and security, funding remains critically inadequate. Only 53.5% of the 2025 Humanitarian Response Plan was financially secured, leaving millions without the support they need.

Along the **frontline and in Ukraine's widespread rural areas**, basic services have become unavailable and emergency response has slowed dramatically. The internal displacement of 3.7 million people has fundamentally altered population dynamics, patient profiles and healthcare needs. Those left behind in areas close to the frontlines are predominantly elderly residents and persons with disabilities or chronic conditions. These communities **face the greatest vulnerabilities and risk being overlooked** in the humanitarian strategic response. Pre-existing barriers including workforce shortages, limited transportation, deteriorating road infrastructure and scarce medical facilities have been severely compounded by ongoing conflict and economic collapse. Here, access to care has significantly worsened as a **direct consequence of the deteriorating operational environment**.

Against this backdrop of growing humanitarian needs, EMERGENCY has been operating in conflict-affected areas of Donetsk region (oblast) since January 2024, working to restore access to primary care through a three-pillar, comprehensive and community-based model.

- **Infrastructure Rehabilitation.** EMERGENCY has rehabilitated 7 permanent clinics, installed 6 semi-mobile units and provided support to 1 additional facility across 14 villages in the Oleksandrivka area, ensuring a nurse-led network that brings healthcare closer to those who need it most.

- **Community Health Workers.** Central to the approach are Community Health Workers (CHWs) who bridge the gap between isolated households and healthcare facilities. Between June 2024 and October 2025, 11 CHWs conducted 10,842 home visits, including 3,644 first visits and 7,180 follow-up consultations. Nearly half of the community members (49.8%) were still receiving sustained support six months after first contact.

- **Referral Pathways.** CHWs have facilitated patient's navigation of healthcare services and coordination of care, by booking 547 general practitioner appointments, arranging 27 specialist visits, requesting 196 home visits for mobility-constrained patients and referring beneficiaries to First Aid Points in 655 instances.

EMERGENCY has progressively expanded its community-oriented primary care model to **Kharkiv oblast**. Beginning with rural municipalities (hromadas), such as Blyzniuky and Barvinkove, 13 clinics are expected to be supported and 11 CHWs to be recruited during the project's implementation. The model is strengthened through a structured partnership with V. N. Karazin Kharkiv National University and the Regional Phthisiopulmonology Centre.

Data gathered by CHWs reveal the **critical scale of unmet** needs: 2 in 3 community members report at least one health concern, with **access to medicines** emerging as the most critical barrier for 75% of those reached. Prior to the CHWs visits, only half (50%) had seen a health worker in the previous 6 months. CHWs are also centrally positioned to **identify vulnerabilities** and respond before needs become a crisis. Women, elderly and patients with chronic conditions were found to experience greater obstacles.

To complement the data collected by CHWs, EMERGENCY administered a **questionnaire to 388 community members** across 11 rural villages in Donetsk between October 2025 and January 2026, examining key war-related barriers to healthcare access. The findings reveal that, in rural areas, the **impact of war extends far beyond active fighting and manifests in multifaceted obstacles** – such as transportation barriers, workforce shortages, and rising costs – leaving the health system overburdened and local communities with decreased access to essential care.

The majority of respondents (84%) report an **increased difficulty in arranging safe transport to reach care** since February 2022. Indeed, **transportation** emerges as the primary barrier, affecting 73.7% of respondents across all demographic groups due to destroyed roads, fuel shortages and limited public services. Emergency medical services have deteriorated significantly, with nearly one-third of respondents reporting slower or less reliable ambulance response, while specialist care has become increasingly inaccessible.

**Economic pressures** compound these access challenges: 94.3% of households report higher medicine prices, 77.1% face increased transportation costs and 59.5% have experienced decreased household income, a triple burden driving families toward catastrophic health expenditure. These barriers appear to disproportionately affect people already at risk.

**Security** continues to constrain access to healthcare, with nearly a quarter (24.7%) of respondents reporting associated barriers. However, direct conflict-related obstacles were only marginally cited as causes of delay, reflecting the project's implementation in areas removed from the frontline, where constraints are predominantly logistical and financial.

Despite sustained pressures, satisfaction with available health services remains relatively high, likely reflecting trust in health workers, reduced expectations under prolonged disruption and elements of system resilience. Nonetheless, **information and service navigation** gaps remain a significant barrier, with one-third of respondents reporting increased difficulty in finding or understanding health information since February 2022. These challenges are further intensified by conflict-related volatility and layered vulnerabilities, including limited connectivity, low motivation and sensory impairments.

**The barriers encountered are interconnected** and lead to a system where access to healthcare increasingly depends on geography and income rather than need. EMERGENCY's experience demonstrates that even in conflict-affected contexts, structural barriers to healthcare access can be addressed through **an innovative, scalable and context-sensitive model of comprehensive primary healthcare**. By prioritising trust-building and strengthening the continuity and coordination of services, this approach helps close persistent access gaps. The sustainability of the model is underpinned by **strong community ownership** and the meaningful engagement of local actors and community members throughout its design and implementation.

The **recommendations** in this report, drawn from the affected communities, call for (1) Securing necessary funds for health; (2) Flexible, multi-year financing between humanitarian and longer term aid; (3) Improving access to care through structural interventions, health workforce capacity building and transport; (4) Containing out-of-pocket expenses and fulfilling the right to health cost-free; (5) Investing in community engagement and trained CHWs as a vital link for continuity of care; (6) Ensuring functional referral pathways and coordination of care.

## OUTREACH

- 14 rural villages, where EMERGENCY operates, home to around 10,000 people
- 3,644 people reached through EMERGENCY's activities
- 388 anonymous questionnaires to community members

# INTRODUCTION

Since the launch of the full-scale Russian military invasion on 24 February 2022, Ukraine's capacity to provide healthcare and the population's fundamental right to health have been severely undermined. Direct attacks on health facilities, large-scale displacement of civilians, the internal and external migration of health professionals, medicine shortages, and damaged infrastructure have sharply reduced access to care, especially in frontline, hard-to-reach, and rural areas.

Areas directly affected by fighting and along the frontlines are now among the most underserved in the country, with limited availability of basic services and increased financial pressure on households. The war has also brought to the surface **pre-existing weaknesses** in the health system.

Since January 2024, EMERGENCY has been operating in Ukraine, progressively expanding activities in **Donetsk and Kharkiv regions (oblasts)**. The organisation has developed an integrated intervention that ensures a **people-centred and comprehensive approach, aiming to** guarantee **continuity and coordination of care** while simultaneously lowering access barriers and strengthening community engagement. The multifaceted approach combines: (1) **Support to nurse-led clinics**, by providing means to deliver care and guaranteeing adequate health infrastructure and staffing; (2) A **Community Health Worker (CHW)-led outreach component** acting as an intermediary between communities and public health services to facilitate access and improve the quality and cultural competence of care; and (3) **Referral pathways to higher levels of care** developed in collaboration with hospital directors and local primary healthcare authorities for patients requiring further investigation or specialist treatment.

Thanks to their rooted presence in local communities, CHWs' door-to-door outreach offers a unique opportunity to collect **first-hand information on access to care** and on the health status of people living in remote war-affected villages. The digital tool used during household assessments (CommCare) provides a secure, ready-to-use platform to generate an updated picture of health needs after four years of conflict, captured through the perspectives of patients and families who have remained.

The first part of this report presents EMERGENCY's project in Ukraine and the quantitative data collected at community level. Testimonies from local stakeholders and patients' stories, gathered throughout the project's implementation, complement the descriptive analysis, and convey lived experiences on the ground. The second part focuses on qualitative data from an anonymous questionnaire on access to care, administered during outreach activities, to explore main barriers and perceived needs for individuals and their communities.

By combining quantitative and qualitative methods, the report investigates the **principal barriers to accessing care** and **examines how the war has affected continuity and coordination of care**. In doing so, it amplifies the voice of local communities in discussions on health and the response to their needs and strengthens accountability towards affected populations.


Building on the study's findings, the report concludes with **recommendations** for increasing access to care in remote areas and proposes an **innovative, scalable, context-sensitive model for comprehensive primary healthcare** that could be replicated across the country or in similar humanitarian crises.

# STUDY FRAMEWORK

**Access to care** refers to the extent to which health systems enable individuals to recognise their health needs, seek care, reach services in a timely manner, afford them without financial hardship, and receive appropriate and responsive treatment.[1] Measuring access is crucial for **health-system planning and effective resource allocation** and serves as a practical proxy for service availability and coverage. The concept of access is closely linked to **continuity and coordination of care**, defined respectively as the patient's experience of coherent and consistent care over time, and the organisational processes that connect services and providers to deliver integrated, timely, and effective care.[2] **Effective continuity** and **coordination** are indispensable for the long-term management of chronic non-communicable diseases, as well as for communicable diseases, from prevention and screening through to treatment and follow-up.

Inherently complex even in peacetime, ensuring access, continuity and coordination of care become even more challenging during war, when health services are disrupted and populations are left underserved, slowing progress toward universal health coverage.

To develop a comprehensive understanding of the challenges faced by Ukrainians in accessing medical care and the impact of the war on continuity and coordination of care, the research team integrated **two existing conceptual frameworks** into a single analytical model.

The **first model**, developed by **S. Thaddeus & D. Maine**[3], conceptualises the **three delays** that can occur along a patient's pathway to care:

- In the patient's decision to seek care;
- In reaching an appropriate facility; and
- In receiving adequate care once at the facility.

This framework allows the study to capture barriers experienced directly by individuals and households.

The **second model**[4] adapted from the WHO Framework of Continuity and Coordination of care, provides a structured lens to assess **how armed conflict disrupts care pathways**. It examines five interlinked domains: 1) the people involved in the care continuum (i.e., healthcare professionals, patients, and informal or formal caregivers); 2) the hardware required to deliver care (i.e., infrastructure, utilities, equipment, and supplies); 3) the services that constitute the care pathway, from health promotion to curative interventions, and long-term follow-up; 4) the linkages that connect people, assets, and services, including referrals, information systems, and workforce pipelines; and, 5) the governance arrangements regulating these interactions.

By merging these two frameworks, the study highlights the beneficiaries reached, activities performed, and vulnerabilities identified by EMERGENCY, while situating the results within wider health determinants at individual, community and system levels. This combined approach enables a **holistic assessment** of how war affects care-seeking and how health-system functions are either preserved or disrupted. It also offers a clear interpretative framework to assess how EMERGENCY's community-based model contributes to maintaining continuity and coordination of care along the patient pathway.

# METHODOLOGY

EMERGENCY carried out a mixed-methods study from October 2025 to January 2026 in 11 rural villages of Donetsk oblast. The research consisted of two phases, combining quantitative and qualitative methodologies.

1. **Phase 1:** Analysis of health-related data collected by CHWs during their daily activities, to assess beneficiaries' characteristics, their health needs, and CHWs' actions to strengthen continuity of care.

2. **Phase 2:** Questionnaires for beneficiaries visited by CHWs, to identify barriers to access to care and notable changes since February 2022.

In the first phase, data from household registration and follow-up visits performed by CHWs, as recorded in a digital smartphone platform (CommCare[5]) was analysed. Data included demographics (age, gender, marital status, employment, household size, relocation status, transport access), previous contact with health services, health status (functional status, chronic conditions, treatment adherence), expressed needs for services or support, and CHW actions (referrals, counselling, provision of materials).

In the second phase, the research team developed a 12-question survey based on the study framework. The questionnaire included multiple-choice and ranking items to explore how four years of war have affected access to continuity, and coordination of care for the Ukrainian population. It was translated from English into Ukrainian and uploaded onto CommCare in clear, jargon-free language so that the tool could be easily explained to both the CHWs administering it and the beneficiaries completing it. The survey was administered to a sample of EMERGENCY beneficiaries selected to ensure coverage across districts and to reflect different genders and age groups. Given the extreme volatility of the context, with the frontline located approximately 40-50 km from the data-collection sites, no formal sample-size estimate was performed. Respondents were informed about the purpose of the study and provided verbal consent to participate anonymously. The research team closely monitored data-collection progress and provided support as needed. Survey data were collected between November and December 2025.

A descriptive analysis of quantitative household data was performed using Excel and RStudio software in December 2025. Questionnaire data were entered into an Excel database and analysed in January 2026 using RStudio. After independent analysis of the findings of the two phases, the results were combined to validate the results. All relevant ethical principles were considered when collecting, storing and managing data in all phases of the research. Oral informed consent was obtained from all participants, no personal identifiers were collected, and all data were anonymised, stored securely, and accessed only by the research team.

# STRENGTHS AND LIMITATIONS

This study has several methodological strengths. First, it adopts a rigorous mixed-methods design that integrates two complementary sources of evidence: 1) routine programmatic data collected by CHWs through their daily door-to-door activity; and 2) a structured questionnaire administered to beneficiaries. This approach allowed the research team to combine descriptive patterns with explanatory insights, strengthening the internal validity of the findings and ensuring that interpretations are grounded in the realities of service delivery.

A second strength lies in the direct, real-world nature of the data. CHWs operate daily in frontline-affected rural areas and interact with individuals who face significant barriers to care. Their digital records, therefore, capture dimensions of vulnerability, need and continuity of care that are not visible in facility-based or administrative datasets. Coupling these with the survey on access barriers further ensures that the study reflects both community-level experiences and system-level constraints, providing a holistic picture of health system functioning under conflict.

The study is also anchored in a robust theoretical foundation, combining the Three Delays model and a structured framework on continuity and coordination of care. This blended framework guides data collection, enhances conceptual clarity, and allows findings to be interpreted within established global health paradigms. Ethical and context-sensitive approaches were adopted throughout, including anonymised data handling, oral informed consent and adaptation of tools to local language and security constraints.

The study also has limitations. The volatile security environment and proximity to the frontline prevented the use of probabilistic sampling. Therefore, survey results are not statistically representative of all rural communities in eastern Ukraine. Routine CHW data, while valuable, may vary in completeness due to workload, mobility issues, and the early stage of digital system deployment. Beneficiary surveys rely on self-reported experiences, introducing potential recall or perception bias. Finally, the geographic focus on 11 villages in Donetsk oblast restricts generalisability, and evolving conflict dynamics over the data-collection period may have influenced responses. Despite these limitations, the integration of multiple data streams and perspectives provides a robust and operationally relevant understanding of continuity and coordination of care in a conflict-affected setting.

# CONTEXT ANALYSIS

After years of territorial disputes and instability, on 24 February 2022, the Russian Federation launched a full-scale invasion of Ukraine. Four years on, the conflict continues to have devastating consequences: Russia occupies around 20% of Ukraine's territory[6], and **hostilities intensified in 2025**.

According to the Office of the United Nations High Commissioner for Human Rights (OHCHR), civilian casualties recorded between January and September 2025 were 31% higher than during the same period in 2024. June and July 2025 were the deadliest months since May 2022, with July setting a new monthly record of civilian casualties. Since the onset of the war, **fighting and airstrikes have caused over 49,000 civilian casualties**, including nearly 13,900 deaths.[7]

An estimated **3.7 million people are internally displaced (IDPs)**, while 6.9 million Ukrainians have sought refuge abroad, primarily across Europe. Many now face protracted displacement, grappling with challenges related to integration, employment, housing, and psychosocial well-being. Intensified attacks have triggered **new waves of displacement**, particularly in Sumy, Donetsk, Kharkiv and Dnipropetrov oblasts. Between March and May 2025, the International Organisation for Migration (IOM) estimates that more than 42,000 people fled frontline areas.[8] While interest in return remains strong – 61% of refugees and 73% of IDPs express a desire to eventually return home – the realisation of these intentions remains heavily constrained by **insecurity, damaged infrastructure, and the absence of basic services in affected areas**.

The impact of the war extends far beyond immediate injuries, with **landmines and explosive remnants of war (ERW)**, creating one of the most severe and long-term threats to civilian safety. Ukraine is now considered the **most heavily mine-contaminated country in the world**.[9] As of 2025, an estimated 139,000 km – more than a quarter of the country's territory – is suspected to be contaminated, particularly along the 1,000-kilometre frontline. Around 6 million people currently live in areas exposed to mine hazards. The socioeconomic implications reinforce the scale of the challenge. Landmine contamination suppresses Ukraine's gross-domestic product (GDP) by an estimated USD 11.2 billion annually. In heavily affected oblasts such as Kharkiv, Mykolaiv, Sumy, and Chernihiv, the impact on regional GDP exceeds 20%, limiting livelihoods and agricultural production, thus **compromising the food security of local communities**.[10]

The conflict has caused **widespread destruction to civilian infrastructure**, severely affecting the daily lives of millions and disrupting essential services across the country, including schools, hospitals, housing, and utilities. The United Nations Development Programme (UNDP) estimates that **approximately 13% of Ukraine's total housing stock has been either damaged or destroyed**. The energy sector has also suffered extensive damage, resulting in significant **destruction to power generation facilities, transmission and distribution networks**, as well as district heating systems in most of the country. When considering all sectors, the oblasts of Donetsk, Kharkiv, Luhansk, Zaporizhzhia, Kherson, and Kyiv have been disproportionately affected, together accounting for roughly 72% of the total recorded damages across the country.[11]

Ukraine has suffered **economic losses exceeding $499 billion** due to disrupted economic activities and widespread unemployment. The war has pushed an additional 1.8 million people into poverty, bringing the **total number of Ukrainians living in poverty to over 9 million**. Agricultural and industrial regions in the east have been largely destroyed, crippling essential infrastructure, while urban economies have collapsed, with many businesses shuttered or operating at minimal capacity.[12]

**The humanitarian situation in Ukraine remains critical**. Civilians continue to bear the brunt of relentless military operations, while humanitarian actors face mounting obstacles to ensuring safe, sustained, and principled access to populations in need. **Nearly 13 million people needed humanitarian assistance** in 2025. Humanitarian actors launched a coordinated appeal of US$ 2.63 billion for 2025, aiming to provide lifesaving and life-sustaining multisectoral assistance to an estimated 6 million people. However, funding coverage remained critically insufficient, and only half (53.5%) of the humanitarian response plan was financially secured by the end of 2025. Consequently, interventions had to be reprioritised during the year, aiming to support approximately 4.8 million individuals in 2025 given the limited resources.[13] Anticipating a surge in needs during the autumn-winter season, a separate Response Plan for 2025–2026, covering the period from October 2025 to March 2026, was developed. This plan requests an additional US$ 277.7 million to deliver multisectoral support to around 1.7 million of the most vulnerable people during the cold season.[14] Combined with the data on infrastructure damage and rising humanitarian needs, these figures underscore the scale of both the human and financial challenge facing Ukraine, where millions are in urgent need of basic services, shelter, protection and recovery support.

# THE UKRAINIAN HEALTH SYSTEM

**The war has severely disrupted the functioning of Ukraine's health system.**

Continuous attacks on health facilities, widespread damage to critical infrastructure, and interruptions to essential services have steadily eroded system capacity. **Since February 2022**, the World Health Organization (WHO) Surveillance System for Attacks on Health Care (SSA)[15] has verified **more than 2,800 attacks on health services** in Ukraine, accounting for more than 45% of all incidents recorded globally during this period and resulting in 224 deaths and 9,902 injuries among health personnel and patients.
These shocks hit **a system already constrained by long-standing structural weaknesses**, including an overreliance on specialised and inpatient care, underfunded primary healthcare (PHC), insufficient gatekeeping and limited patient-centeredness.[16]

Since Ukraine became independent in 1991, successive governments have pledged to modernise its health system and close long-standing funding gaps. Despite reforms, incentives still do not sufficiently promote quality or health outcomes, and financial protection remains weak.[17]
The **2017 health reform** introduced significant changes, including decentralisation, a stronger role for the Ministry of Health in national policy, and the creation of the **National Health Service of Ukraine** (NHSU) as a strategic purchaser of services. Contracting with public and private providers and defining benefits packages for medicines and essential services contributed to improving availability and access to healthcare services.[18]

While reforms have contributed to reducing **informal payments** in primary care, such payments remain a major obstacle to equitable access across much of the health system. **Access to medicines** is especially critical. The Affordable Medicines Programme covers only a limited set of conditions and medicines, and persistent gaps in prescribing, dispensing and regulatory oversight continue to restrict access. As a result, **out-of-pocket payments account for nearly half of total health expenditure**, with medicines representing the largest share. In 2021, 54% of all household health payments spending in Ukraine went toward medicines, followed by inpatient care at 25%, a pattern that has changed little over time.[19]

These financial pressures disproportionately affect poorer households, which consistently allocate a higher proportion of their out-of-pocket spending to medicines, while wealthier households spend proportionally more on inpatient services. **Medicines remain the leading driver of catastrophic health spending**, which affects 17.1% of households.[20] Such catastrophic health spending is heavily concentrated **among rural and low-income households**, pushing many deeper into poverty and forcing harmful trade-offs.
The war has further exacerbated these vulnerabilities by eroding households' ability to pay for care, while simultaneously increasing health needs and barriers to access.

The health system capacity has been further strained by **severe workforce shortages**. Even prior to the invasion, staffing levels were below the European Union (EU) and WHO European Region averages. Since the war began, the health workforce is estimated to have decreased by 14% – with the **loss of 89,000 medical professionals in a single year** (in 2022).[21] Rural areas are disproportionately affected, with only 17% of doctors and 7% of nurses serving nearly one-third of the population, which further exacerbates **access disparities** at a time of heightened medical and psychosocial need.[22] Reduced staffing now affects more than half of all health facilities, limiting service availability and continuity of care.

Despite these pressures, the system has demonstrated notable resilience. According to the latest WHO HeRAMS report (August 2025), **over 97% of health facilities remain at least partially operational**.[23] Yet, many continue to face overlapping constraints, including service limitations, structural damage, equipment shortages, security threats and reduced accessibility – conditions that collectively impede the delivery of safe and timely care.

Data reveal **critical gaps in the delivery and availability of health services**. Non-communicable disease and mental health services are among the most disrupted, unavailable in 68% of facilities. Sexual and reproductive health services are unavailable in 61% of facilities. Even core services face substantial deficits: general clinical and trauma care are unavailable in 51% of facilities, child health and nutrition services in 50%, and communicable disease management in 46%.[24]

These gaps are compounded by extensive infrastructure damage, nearly 90% of which stems from conflict-related incidents and looting. Additional factors, including maintenance shortfalls (around 10%), insecurity (75%), and physical access barriers (30%) further restrict the population's ability to seek timely care, preventing communities from safely reaching health facilities.[25]

Despite ongoing health demands, **Ukraine's wartime priorities have shifted away from healthcare and toward defence and security**. The share of the **national budget allocated to health decreased sharply from 11% in 2021 to just 4.9% in 2023**.[26] Public spending on PHC is particularly low compared to regional standards. In 2020, PHC accounted for only 0.75% of GDP, and per-person PHC spending was the lowest in the WHO European Region at US$ 104, of which just US$ 26 came from public sources. Overall, **only 26% of total PHC expenditure is publicly financed**, reflecting the limited public contribution to medicine costs and the resulting financial burden on households.[27]


## PRIMARY CARE LEVEL IN UKRAINE

Primary care in Ukraine is delivered by both **public and private actors**, operating under three legal statuses: public communal providers, private institutions, or FOPs (i.e. private practices owned by a doctor). All providers can sign contracts with the NHSU.[28] Most contracted primary care facilities are still publicly owned, but the number of private providers joining the system has been steadily growing since the 2017 health reform.

Local authorities in Ukraine are responsible for establishing primary care networks, yet development remains uneven. Following decentralisation, which shifted ownership of many primary care facilities to smaller local administrative units, gaps in coverage and service fragmentation have become more pronounced. Furthermore, because primary care networks are designed separately from other levels of care and are not fully aligned with national contracting arrangements, the Ministry of Health has limited leverage to enforce uniform standards, resulting in variable coordination and performance across the country. A growing number of **hospitals** are being contracted to provide primary care services, with the number of people registered to hospital-based family doctors rising sharply and the number of hospitals offering PHC increasing from 78 in 2020 to over 200 in 2022.[29] This trend is largely driven by financial incentives, but it risks weakening primary care as hospitals may use their funding to support specialist services, creating fragmentation and potentially reducing the focus on strong, community-based primary care.

Primary care services are mainly delivered by family doctors, general practitioners (therapists), and paediatricians. A key challenge for the primary care system is the **ageing workforce**. About half of all family doctors are over 50 years old, and current medical training does not fully match the expanding and changing role of PHC.

Primary care doctors continue to spend a significant share of their time on **non-clinical tasks** such as documentation and administrative work, limiting the time available for direct patient care. At the same time, the primary care **nursing workforce is critically underutilised**: nurses are too few, lack a clearly defined clinical role, and are largely confined to administrative work, despite regulations allowing them to independently provide a substantial share of primary care services. This imbalance in responsibilities reduces efficiency, undermine service quality, and puts unnecessary strain on health workers.[30]

The full-scale war has placed additional pressure on primary care providers. Their non-clinical workload has grown significantly, with responsibilities such as repairing damaged facilities, managing logistics, organising humanitarian assistance, ensuring access to water, electricity and heating, and responding to increased data and reporting requirements.[31]

To address these structural and workforce challenges, Ukraine adopted the **Healthcare System Development Strategy 2030** in January 2025, together with an operational plan for 2025–2027. The strategy aims to expand the range of services offered at primary care level, strengthen prevention and health promotion, improve continuity of care, and deepen links between health and social services. It also seeks to respond to increasing needs for rehabilitation and mental health support.

# HEALTH NEEDS

Prior to conflict escalation, Ukraine already faced significant health challenges, with a life expectancy of 70.9 years (2021) more than five years below the WHO European Region average, and **one of the highest mortality rates in Europe**, with a substantial proportion of deaths from preventable causes.[33]

Since the full-scale invasion, population health has deteriorated sharply: WHO's Ukraine Health Needs Assessment published in April 2025 shows that 68% of Ukrainians report their health has worsened in the last four years.[34] This decline is closely linked to growing barriers to care. Among those who needed medical care in the past year, 64% encountered at least one obstacle when trying to access services.[35]

Access barriers vary and can be especially severe in hard-to-reach and frontline areas, where community-based healthcare is often absent. Here, patients are forced to travel long distances, sometimes up to 20 kilometres on unpaved or unsafe roads, to reach the nearest facility,[36] resulting in 35% of household, delaying essential medical visits.[37] These geographic and security constraints not only leave many cut off from routine and urgent care, but also suppress care-seeking behaviour, contributing to persistently low perceived health needs, especially regarding screening and immunisation services.[38]

The **departure of skilled birth attendants** has also created serious gaps in maternal health services, leaving pregnant women without timely, safe, or skilled support during pregnancy and delivery. Meanwhile, price increases and supply shortages in pharmacies have restricted access to life-saving treatment, with 81% of households reporting difficulty obtaining necessary medicines.[39] **Low health literacy compounds the situation**, especially among older adults and people with lower levels of education, by undermining effective care-seeking and adherence to treatment.[40]

Together, these access barriers have deepened **health inequities**, placing already vulnerable communities at heightened risk of preventable morbidity and mortality, and leaving 9.2 million individuals in need of health-related support.[41]

The conflict has also reshaped the **patient profile** at the primary care level. Needs related to **cardiovascular diseases, physical rehabilitation and mental health** have increased significantly, while demand for preventive services, including routine immunisations, has declined.[42]

Non-communicable diseases (NCDs) dominate the disease burden, accounting for over 80% of deaths. Premature NCD, in particular, is more than double the EU average, driven by widespread risk factors such as hypertension, poor diet, and tobacco use.[43] Treatment adherence remains low, particularly for high blood pressure and diabetes[44], while hospital directors report that the **disruptions to the primary care's gatekeeping function** and interruptions in chronic disease treatment have led to more frequent and more severe hospitalisations.[45]

**Communicable diseases are another major concern and further strain the health system**. In 2022, the estimated incidence of **tuberculosis** (TB) in Ukraine rose to about 90 cases per 100,000 population, among the highest in the WHO European Region.[46] Ukraine is also a high-burden country for multidrug (MDR) and extensively drug-resistant (XDR) TB, with high levels of drug resistance reported among both new and previously treated TB cases.[47] **Human immunodeficiency virus (HIV)** status awareness reached 79% in 2022, yet early detection targets remain unmet, and TB/HIV co-infections rates continue to rise. Interruptions in case-finding, diagnosis and treatment continuity leave many potential TB and HIV cases undetected and untreated.[48] Meanwhile, immunisation rates, although improving, remain below the 95% coverage required for herd immunity, particularly for measles, polio, and DTP (diphtheria, tetanus, and pertussis).[49]

**Mental health needs** have surged as a direct consequence of the war. 9.6 million people are estimated to be at risk of, or already living with, anxiety, depression, or post-traumatic stress, a staggering reflection of prolonged exposure to violence, displacement and insecurity.[50] This has been perceived by all impacted by the war, those who remained in place, those who were displaced within Ukraine, and those who sought safety abroad.[51] Yet, only 20% of people affected have sought help from at least one type of specialist.[52]

**Landmines and ERW** continue to cause regular civilian casualties, resulting in traumatic injuries, amputations, long-term disability, and severe psychological impact for survivors and their families. Since February 2022, more than 1,500 civilian casualties have been attributed to mines and ERW. The threats due to contamination are expected to persist for decades[53], obstructing access to essential services – health facilities, ambulance routes, farmland, and infrastructure – further undermining population health and recovery.

**Rehabilitation needs** have also increased dramatically since 2022. As of April 2025, 60% of people in need still faced barriers to accessing rehabilitation, and 1 in 4 could not access rehab services at all.[54] Assistive technologies remain particularly inaccessible due to lengthy and bureaucratic approval processes.[55] These gaps carry profound long-term consequences for social inclusion, employment, and recovery, especially for already vulnerable populations.

# EMERGENCY'S INTERVENTION

EMERGENCY is a humanitarian organisation founded in 1994 to provide medical and surgical care to civilians impacted by conflict and poverty. Since its establishment, EMERGENCY has acquired extensive experience in war surgery, first aid, stabilisation and rehabilitation services in several contexts, including Afghanistan, Iraq and Libya.

Through its presence in countries afflicted by violence and explosive hazards, EMERGENCY has witnessed the systemic impact of war on civilian populations. Beyond direct injuries, entire communities suffer from the disruption of health systems, with vulnerable groups – especially women, children, the elderly and the disabled – being disproportionately affected. Consequently, EMERGENCY has expanded its core mandate to include specialties such as paediatrics and maternal and neonatal care, ensuring essential hospital services reach those most in need.

To guarantee continuity of care from prevention to follow-up, EMERGENCY has developed integrated models of care centred around its hospitals in complex crisis zones. These facilities provide free, high-quality specialised services and training programmes for local professionals. They function as central hubs for primary care clinics and first aid trauma posts, facilitating safe referral pathways for cases requiring further investigation or higher levels of care.

Over time, the organisation's competencies have grown to include migrant health projects in both formal camps and informal settlements for refugees and internally displaced people (IDPs) in Iraq and Sudan. Additionally, EMERGENCY implements social and medical activities in Italy to support individuals excluded from the national healthcare system.

Leveraging these diverse and well-established experiences, EMERGENCY has implemented an innovative, context-sensitive model in Ukraine. This approach bridges the organisation's knowledge of war-affected territories with community-based primary care, maintaining a specific focus on the social determinants of health and indicators of medical exclusion.

## START OF OPERATIONS IN UKRAINE

Between April and December 2022, EMERGENCY provided **primary medical care, cultural mediation and psychological support in Bălți, Moldova**, to people fleeing the war in Ukraine. As the influx of asylum seekers stabilised and the Moldovan health system strengthened, the project was concluded. However, the presence in Bălți served as a strategic entry point, enabling EMERGENCY to gain critical insights into the Ukrainian context and facilitating two exploratory field missions in late 2022 and early 2023.

In September 2023, a **comprehensive needs assessment** was conducted in the Donetsk region to map available resources and identify critical gaps, establishing an evidence-based foundation for targeted intervention. The findings revealed that while larger central health facilities in urban settings demonstrated resilience – remaining fully or partially operational – smaller villages and rural frontline communities faced severe barriers to access. Pre-existing challenges, such as limited transportation, poor road infrastructure and a scarcity of medical facilities, have been exacerbated by the conflict and the ensuing economic crisis.

Military occupation and the repurposing of administrative buildings have further degraded primary healthcare infrastructure. Consequently, a drastically reduced population – composed mainly of elderly residents and persons with disabilities – must rely on rudimentary, understaffed and poorly equipped facilities. The breakdown of primary care has undermined its role as a gatekeeping mechanism, resulting in hospitals becoming overwhelmed by patients with untreated or neglected chronic conditions. Furthermore, programmes for immunisations and for screening HIV and TB were also reported to be insufficient.

Based on these findings, EMERGENCY prioritised intervention in the **remote, hard-to-reach villages of Donetsk**. In coordination with local health authorities and in alignment with the Ukrainian health system, a model was developed to complement the existing health response. This model focuses on facilitating **comprehensive access to primary care** while ensuring **formal referral pathways** to higher levels of specialised treatment.

"*Every time I hear a plane, I feel afraid. So many pass by every day - fighter jets, helicopters... it's a sound I've come to know all too well. I have lived alone for more than two years now. My children left, and they were right to do so: it is too dangerous here. The village was attacked shortly after the war began. Missiles exploded near my house, and the blast wave shattered every window. Afterward, my eldest son travelled from Kramatorsk because he couldn't get in touch with me. He covered my windows with plastic sheeting. I've lived without glass ever since - two whole winters like this, and it's freezing inside. I simply don't have the money to fix them. My youngest son was evacuated with his family. I haven't seen him since the start of the war, though we speak on the phone occasionally. As for my middle child, he lives in the occupied territories. I haven't heard from him in almost three years.*"

**Lydia,** 75 years old,
Community member of Mykhailivka

Given that the target areas consist of small villages of approximately 350–400 inhabitants each in Oleksandrivka hromada (municipality), near Kramatorsk, EMERGENCY has implemented a person-centred approach through integrated community case management.

## DESCRIPTION OF THE INTERVENTION MODEL

EMERGENCY's intervention in Ukraine is built around a comprehensive healthcare model designed to **restore access to essential medical services** in areas where conflict has severely disrupted public health systems. The programme has been operating predominantly in rural districts of **Donetsk oblast**, where ongoing insecurity, damaged infrastructure and the displacement of health professionals have left entire communities without reliable access to care. In these contexts, the organisation has developed an intervention that responds simultaneously to **immediate humanitarian needs and the structural weaknesses of local healthcare delivery, ensuring continuity of services in a volatile and protracted crisis environment.**
The intervention model is built upon three interconnected pillars:

1. Critical Infrastructure Rehabilitation and Deployment
2. Healthcare Delivery through Trained Community Health Workers
3. Integrated Care through Effective Referral Pathways

### CRITICAL INFRASTRUCTURE REHABILITATION AND DEPLOYMENT

At the core of EMERGENCY's intervention model is the restoration of primary healthcare infrastructure. In the Donetsk region, EMERGENCY supports **a network of nurse-led clinics serving 14 villages** in the Oleksandrivka area. The project aims at re-establishing access through the rehabilitation of damaged public facilities and the deployment of prefabricated modular structures converted into fully functional outpatient clinics. Each facility is comprehensively equipped with essential medical devices, supplies and pharmaceuticals.

In parallel, EMERGENCY is delivering a structured capacity-building package for local health staff working in clinics throughout the region. **Additional focused trainings addressed frontline safety and emergency readiness, including** hypertension detection and community education, **Psychological First Aid and certified Basic Life Support with Defibrillation**.

A defining feature of this approach is its adaptability to volatile security contexts. Modular clinic structures can be rapidly relocated if frontlines shift or access routes become compromised, ensuring continuity of care even as conditions evolve. All services are provided entirely free of charge, removing financial barriers and reinforcing the principle that healthcare should be based on need alone.

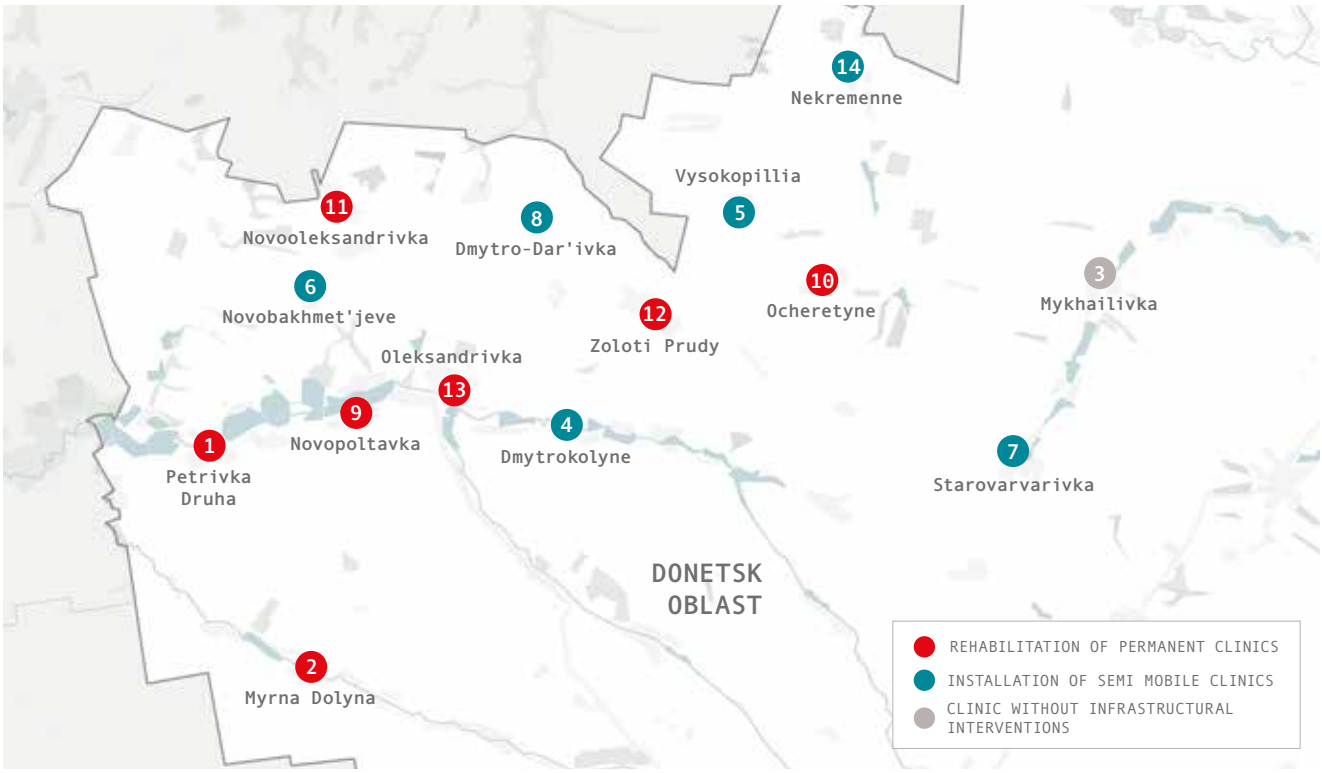
**This project component restores both physical infrastructure and functional capacity of the primary healthcare system.** It establishes the foundation upon which community outreach, chronic disease management and referral pathways are built, ensuring essential healthcare remains accessible, responsive and resilient.

"*Before this clinic opened, people in the area didn't have proper medical assistance. Since the Oleksandrivka clinic is 10 kilometres away, many residents, particularly the elderly, were unable to make the trip. This facility is vital for the community.*"

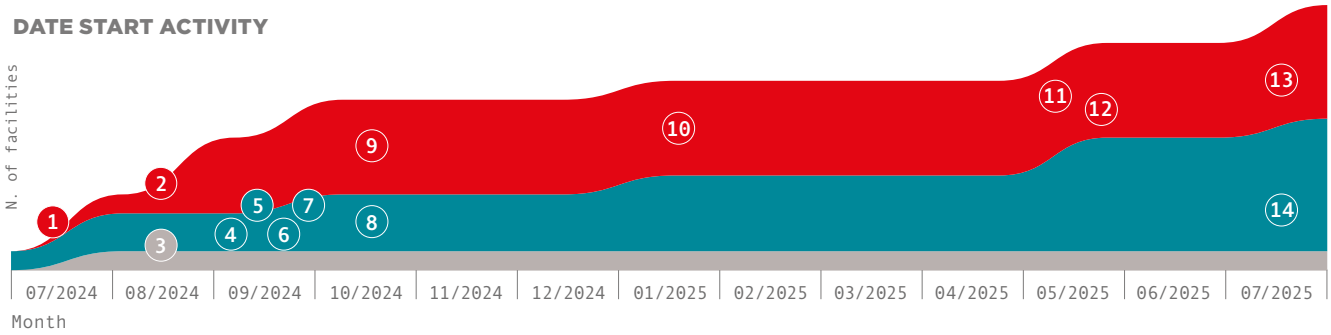
**Natalia,** Primary Care Nurse, Novopoltavka

"*People speak about this project very warmly. First, it increased the "feldshers'" working hours, which benefits everyone. Then there are the semi-mobile containers and the renovation of existing facilities: in some villages there was no health point at all, and now people have a comfortable place where they can receive care. The clinics are also equipped with new furniture, medical equipment, supplies, consumables, diapers, and more. For remote villages, this is a real step forward—these small places are often overlooked.*"

**Head of Primary Medical and Sanitary Care Centre,**
Oleksandrivka Hromada, Donetsk Oblast

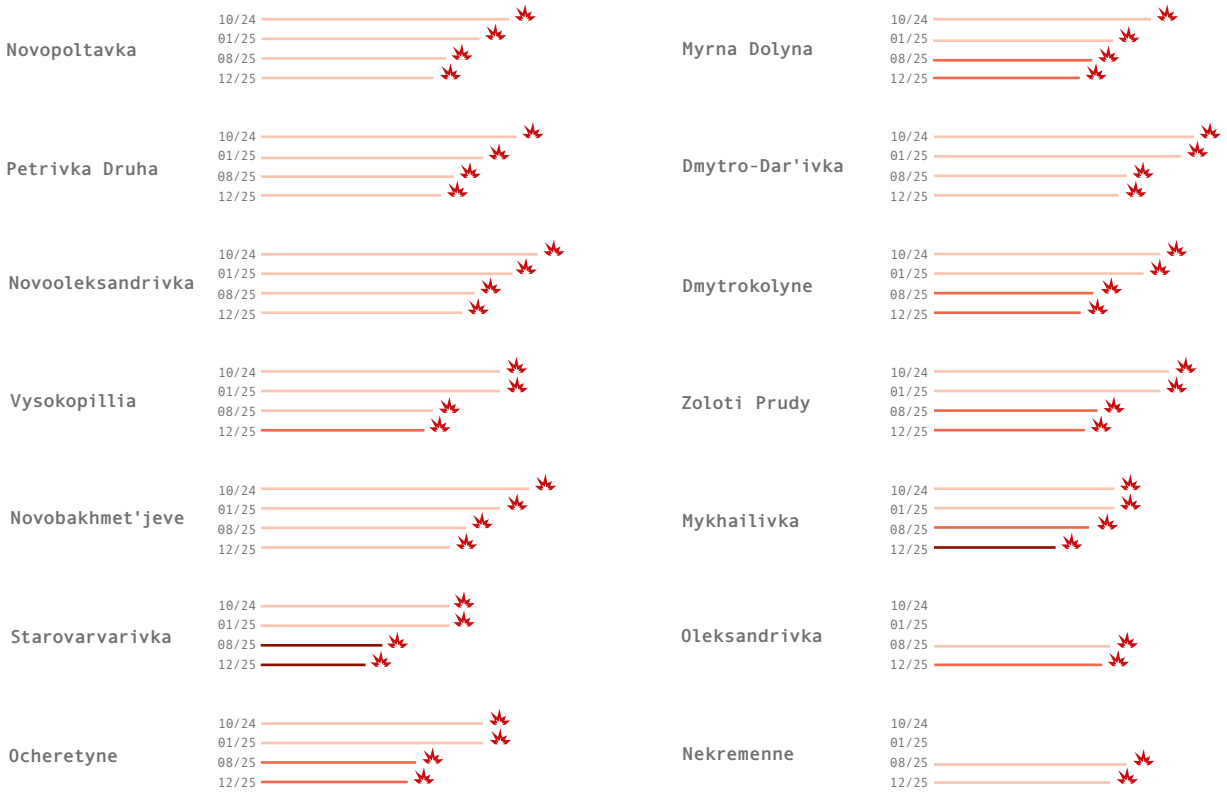



## DATE START ACTIVITY




## DISTANCE FROM FRONTLINE

More than 40 Km
40 Km to 30 Km
Less than 30 Km



## HEALTHCARE DELIVERY THROUGH TRAINED COMMUNITY HEALTH WORKERS

EMERGENCY's intervention model centres on community-based healthcare delivery through a **structured Community Health Worker (CHW) programme** designed to reach populations isolated from services due to insecurity, limited mobility or infrastructure collapse.

Recruited from the communities they serve, CHWs act as trained intermediaries between healthcare facilities and households, facilitating access while enhancing the quality, cultural competence and acceptability of care. CHWs conduct door-to-door visits to assess individual and household health needs, identify vulnerable patients (including the elderly, people with disabilities, and those with chronic conditions) and facilitate referrals to EMERGENCY-supported clinics or other relevant health services.

Beyond addressing medical needs, the CHW model responds to the **emotional and psychological toll of prolonged exposure to violence and displacement**. By integrating psychosocial support at the community level within a framework of trust and familiarity, CHWs help mitigate the mental health burden while reducing stigma around seeking care.

In areas where recruiting CHWs proved difficult, **feldshers** - mid-level primary care nurses providing basic medical care and triage - **serve as the main care providers**. Supported by CHW activities and in agreement with the Oleksandrivka Department of Health, they fill a critical gap in regions that remained unattractive to medical personnel coming from other parts of the country.

To ensure quality and consistency, CHWs and feldshers receive **ongoing training and supervision** in health promotion and prevention, chronic disease follow-up care, Basic Life Support and Defibrillation (BLSD), basic care and service orientation, professional ethics and confidentiality, and mental health first aid.

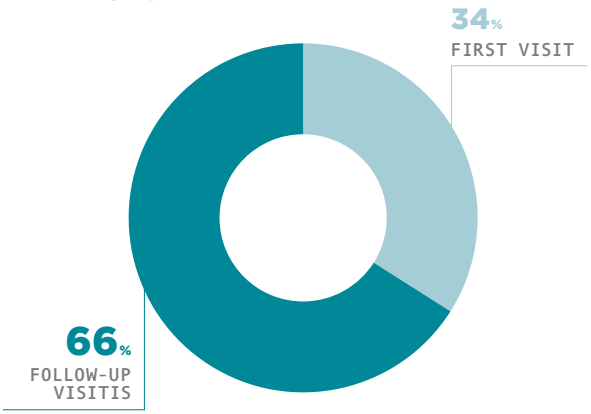
All activities are monitored through a **digital case management platform** (CommCare) that tracks encounters, referrals and emerging health trends, enabling evidence-informed planning, rapid gap identification and effective coordination with local health authorities.

Between June 2024 and October 2025, 11 CHWs performed a total of **10,842 home visits** in the Oleksandrivka hromada, including 3,644 first visits and 7,180 follow-up visits. The programme's strength lies in its consistency: **half (49.8%) of all community members reached remained supported six months after their first visit**. These ongoing follow-ups are crucial for building trust, guaranteeing continuity of care and improving treatment adherence over the long term.

**11** CHWs recruited and trained

**8** training sessions implemented

**OVERALL ACTIVITY**




*"During my interview, they asked if I could ride a bike. I said no, and my friends worried I wouldn't get the job. Instead, I was hired and I learned to pedal. It wasn't easy at my age, but now I cycle between four villages: Busynivka, Marivka, Myrna Dolyna, and Novostepanivka. My workday starts at 8:00a.m. With my bike, phone and notebook, I visit residents to check on them and fill out my reports. Everyone knows me now; they often invite me in for coffee. Most of the people I care for are elderly and live alone. Beyond their many health problems, what they often need most is simply someone to listen to them."*

**Natalia**, CHW, Marivka

*"We are left on our own: our only daughter fled with her family to the Kharkiv region and has not returned. We haven't seen her for almost two years. We need someone like Natalia, our CHW, someone to help us, because otherwise it is just the two of us facing all these difficulties. An old proverb says: 'If we are alive, we will not die.' This is how we live, with only the hope that peace will come soon."*

**Raisa and Victor**, 54 and 57 years old, Community members of Marivka

The activities performed by CHWs during their visits include **psychosocial support** (42.6%), **health education** (26.3%), **and health system orientation** (17%). They also helped communities connect to care when needed, providing **referral-related support** such as seeking advice from nurses or doctors (4.2%). **Direct medicine delivery accounted for only 1.5%** of recorded activities, suggesting that medication-related support was provided predominantly through facilitation mechanisms rather than physical delivery, such as helping community members to navigate prescriptions, to identify where medicines could be obtained and to use existing public channels for ordering and home delivery, as well as coordinating with local health staff when barriers arose.

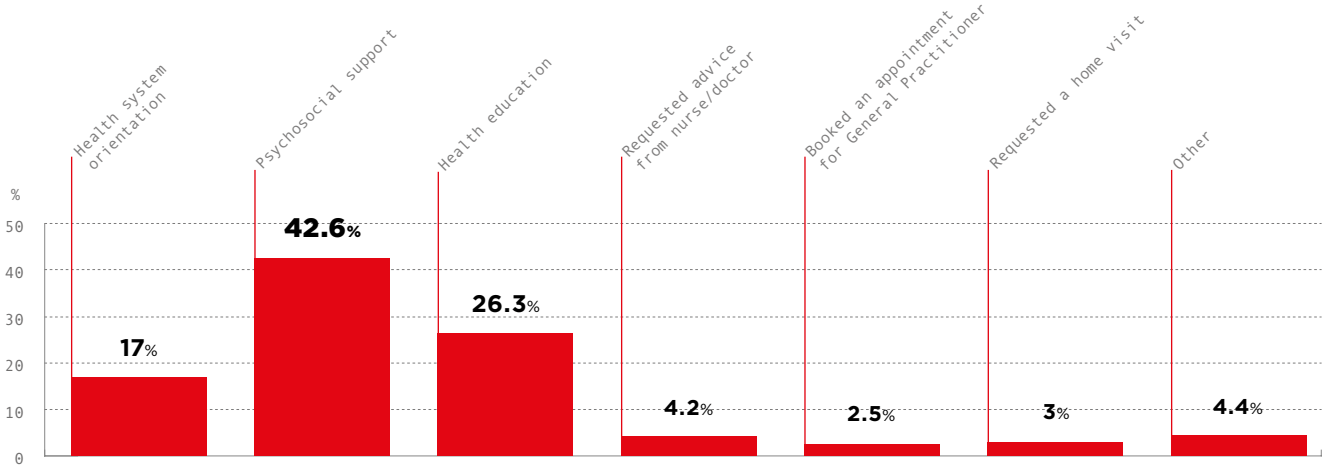
**CHWs have been effective in improving treatment adherence** for people living with chronic conditions. Notably, of the 78 community members who initially struggled to adhere to their therapy, 48 (61.5%) achieved adherence following CHW support. However, a significant challenge remains: when distance is the primary obstacle, non-adherence is much more likely to persist compared to when the barrier is economic. This demonstrates that while CHWs are highly effective at guiding patients through national health systems, geographic barriers require broader, more systemic solutions to ensure no one is left behind by the distance to care.

"

*"CHWs are recruited directly from the hromada. The project hired 11 people from remote villages, so support comes from within the communities themselves. They moved from unemployment into paid work, received training and gained stable income. The same applies to feldshers: before the project many could only work part-time because the health system did not fully cover their salaries. With EMERGENCY's co-funding they can work full-time, cover a larger share of the population and provide more consistent services. Their salaries also generate local tax revenue, which strengthens the hromada budget."*

**Major Deputy,** Oleksandrivka Hromada, Donetsk Oblast

**ACTIVITY PERFORMED BY CHWS**



## INTEGRATED CARE THROUGH EFFECTIVE REFERRAL PATHWAYS

EMERGENCY's intervention ensures patients can **access the full continuum of care through structured referral pathways** that link frontline clinics to secondary and tertiary facilities. In collaboration with hospital directors and local primary healthcare authorities, these pathways enable timely access to specialist consultations, diagnostic investigations and advanced treatment, while reinforcing coordination between community-based services and the broader health system.

Within this framework, **CHWs play a central facilitation role in making referrals operational and effective**. During routine household visits, CHWs identify clinical and social needs, assess barriers to access, and activate the most appropriate pathway in close coordination with publicly employed nurses and doctors. This includes triaging situations that require urgent attention, initiating rapid contact with health staff, supporting appointment scheduling with higher levels of care, organising home-based follow-up when mobility is limited and guiding beneficiaries to the nearest First Aid Point when in-person assessment is needed. In practice, CHWs function as **a link between households, the primary care team, and higher levels of care**, helping ensure that referrals translate into effective service use rather than remaining unmet recommendations.

Programme records from June 2024 to October 2025 show that referral-related support was a consistent component of CHW activity. **CHWs requested clinical advice from a nurse or doctor 907 times** (4.2%) and initiated emergency contacts with health staff in 112 instances (0.5%), proving the activation of an operational warning mechanism for rapid escalation when acute concerns emerged. CHWs also facilitated planned access to care by **booking 547 appointments with general practitioners** (2.5%) and **27 appointments for specialist visits** (0.1%), reflecting structured navigation of facility-based services. **For beneficiaries facing mobility constraints, CHWs requested 196 home visits** (0.9%), supporting clinical assessment without requiring travel. In addition, CHWs strengthened the interface between community outreach and facility-based primary care by **sending beneficiaries to a First Aid Point in 655 instances** (3%).

Taken together, these actions illustrate a **referral function that is both proactive and responsive**. By combining household-level assessment, real-time coordination with health staff, and practical facilitation of appointments and home visits, **the model supports care coordination and helps reduce avoidable delays**, particularly for older adults, persons with disabilities, and other beneficiaries with limited ability to travel.

> "*With Anna, the CHW, we form a real team. We constantly exchange information, divide up the visits, and when the clinic is empty, we go out to find those in need. If someone hasn't shown up in a while, we drop by to check their blood pressure and blood sugar, or simply to see how they are doing. Many are reluctant to have regular check-ups, but I always try to convince them to see their doctor at least every six months.*"
>
> **Inna**, Feldsher, Dmytrokolyna

## SUPPORT FOR THE INTERIM EVACUATION POINT

As the frontline in Donetsk oblast moved closer to Oleksandrivka and neighbouring villages in late summer 2025, a sharp rise in evacuations quickly exceeded the capacity of local services. An Interim Evacuation Point was therefore established in a local school to receive people arriving from settlements within 15–20 km of the frontline and transiting on towards Lozova and Pavlohrad. Working alongside local health and civil authorities, EMERGENCY supported the Interim Evacuation Point with one nurse, one CHW per shift and one psychologist.

Between 22 August 2025 and 8 January 2026, the Interim Evacuation Point registered 8,397 people in total, including 1,638 children, 1,380 persons with disabilities, 249 people with reduced mobility, and 17 bedridden evacuees. Over the same period, 444 people received medical services on site. The largest caseload was recorded in the initial phase of operations, with 3,263 registrations between 22 August and 30 September, followed by 2,945 registrations from 1 October to 1 November. The flow then declined to 1,987 registrations from 1 November to 19 December and 202 registrations from 19 December to 8 January.

CHWs and clinical staff rapidly assessed health and social needs, prioritised the most vulnerable, facilitated access to essential medicines and organised safe referrals for those requiring further care. Beyond immediate treatment, CHWs provided practical orientation on how to continue chronic therapies after relocation, basic psychological first aid and support to older people, persons with disabilities and individuals travelling alone. This experience shows how an evacuation hub that integrates elements of community-based care can help maintain continuity of care at a time when people are at high risk of being lost to the health system.

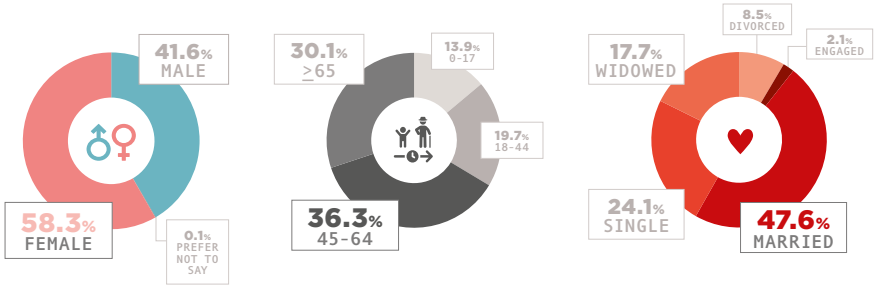
> *"Local authorities set up an Interim Evacuation Centre to welcome those displaced from their homes. It is primarily a place to rest, receive medical care and recover some strength before being moved further west. EMERGENCY has supported the Centre by providing medical and psychosocial assistance, stabilising people as they arrive and caring for those fleeing the conflict. I still remember that first night: hundreds of people wrapped in blankets, sleeping on camping beds, with the echo of the shelling still ringing in their ears. One elderly man whispered: 'At least here, we can breathe'."*
>
> **Ali Msahir Ali,**
> EMERGENCY Field Coordinator in Ukraine

# DATA COLLECTED DURING HOME VISITS ON COMMUNITIES

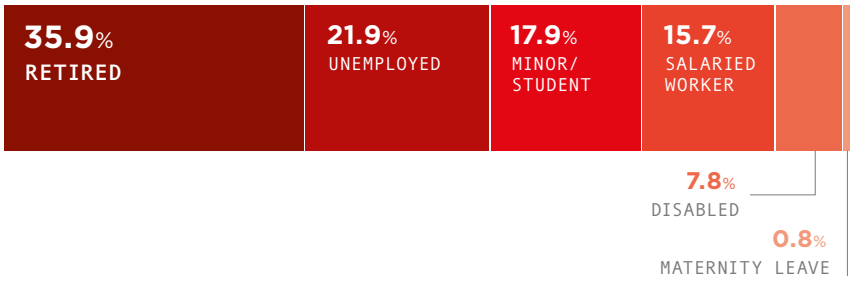
The following sections present the demographic characteristics of community members reached by CHWs, vulnerability profiles and key barriers to care.

## PROFILE OF COMMUNITY MEMBERS

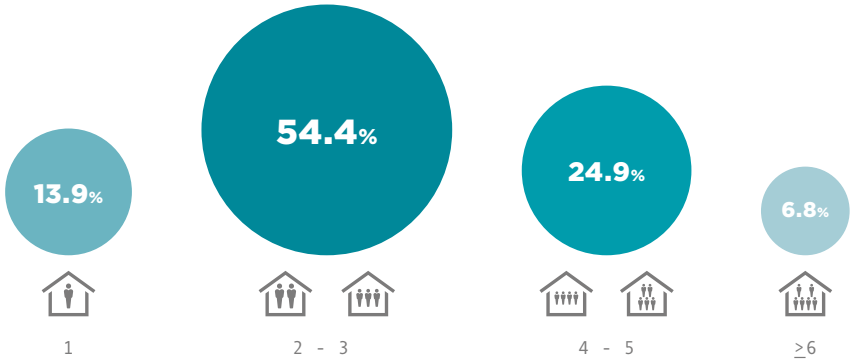
Out of 3,644 people reached by CHWs, most were women (58%), with the largest groups being adults aged 45–64 years (36%) and older people ≥65 years (30%). Social vulnerability was common: retired (36%) and unemployed (22%) people represent the biggest shares, and most lived in small households of 2–3 people (54%).




### GENDER, AGE, AND MARITAL STATUS

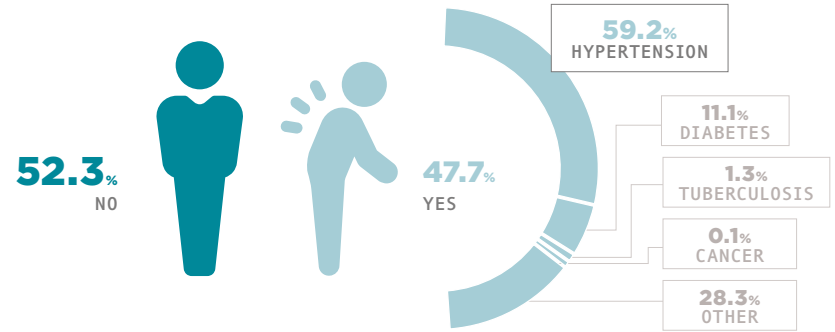



### EMPLOYMENT STATUS

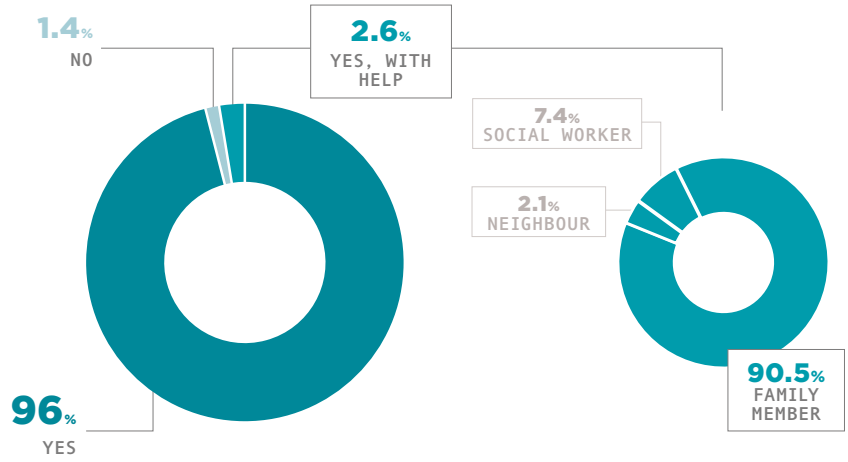



### HOUSEHOLD MEMBERS

**Nearly half of the community members (48%) were living with at least one chronic condition**, with hypertension (59%) and diabetes (11%) accounting for most cases. **Around 4% were bedridden or needed assistance to get out of bed**, with support coming almost entirely from family members (91%), highlighting the care burden placed on families in a setting where formal support is limited.

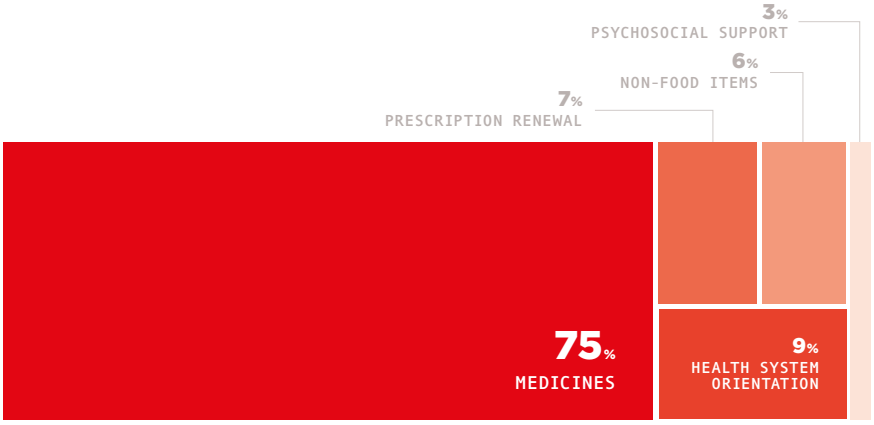



### IN CHRONIC TREATMENT




ABILITY TO GET OUT OF BED

Health needs remain widespread: two in three community members (67%) reported at least one need. **Access to medicines represents the most significant gap** (75%), followed by health system orientation (9%), **prescription renewal** (7%), requests for **essential non-food items** like diapers (6%), and **psychosocial support** (3%).



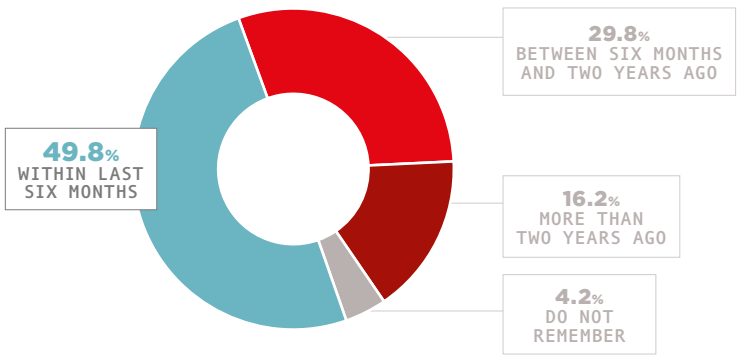

HEALTH NEEDS REPORTED BY COMMUNITY MEMBERS

# VULNERABILITY MAPPING

This section maps vulnerabilities across three critical dimensions to identify those most at risk: 1) **physical access** (the ability to reach a First Aid Point, or FAP); 2) **continuity of care** (the need for follow-up); and 3) **displacement** (relocation since the full-scale invasion in February 2022). This section considers **1,617 community members with available data**.

### PHYSICAL ACCESS

Access to care was reportedly uneven. Only half (50%) had seen a health worker in the previous six months, while a worrying 16% had gone more than two years without any contact.

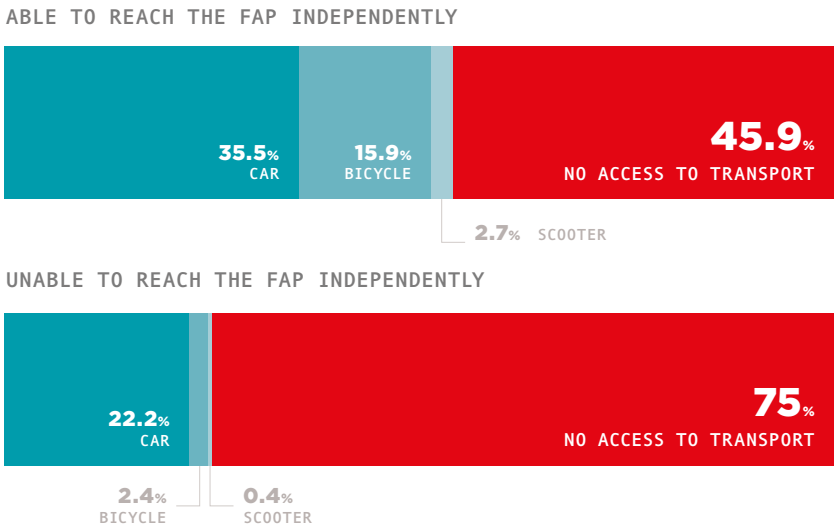



LAST TIME SEEN BY A HEALTHCARE WORKER

"*Having a healthcare facility in this village is vital because reaching the nearest medical centre is complicated. You need a means of transport, and since the war broke out, there is nothing left here. I do not have a driver's license, and even if I did, I wouldn't have a car to get to Oleksandrivka, the nearest town. Most of the residents in this village are elderly and, like me, do not own cars. I used to ride a bicycle, but at my age, I can no longer manage it.*"

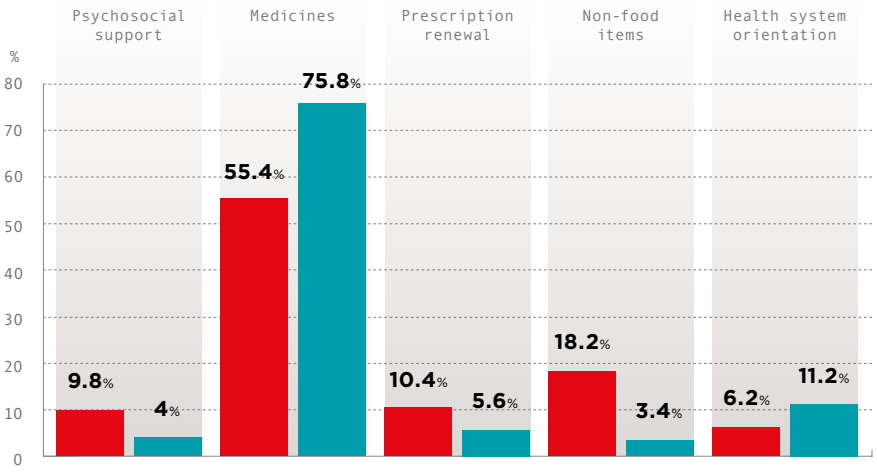
**Katerina**, 54 years old, Community member of Novopoltavka

16% said they could not reach a FAP independently. Those unable to reach a FAP were more often **women** (68.7% vs. 55.8%) and **substantially older**: 61.1% of those aged ≥65 years struggled to gain access, compared to just 25.1% of younger groups. These individuals also faced higher **socio-economic vulnerabilities**, being more likely to be retired, widowed or living alone. **Transport emerged as a key barrier**: while 50% of the total population lacked household access to transport, this figures spikes to 3 in 4 for those unable to reach a FAP.




**HOUSEHOLD ACCESS TO TRANSPORT**

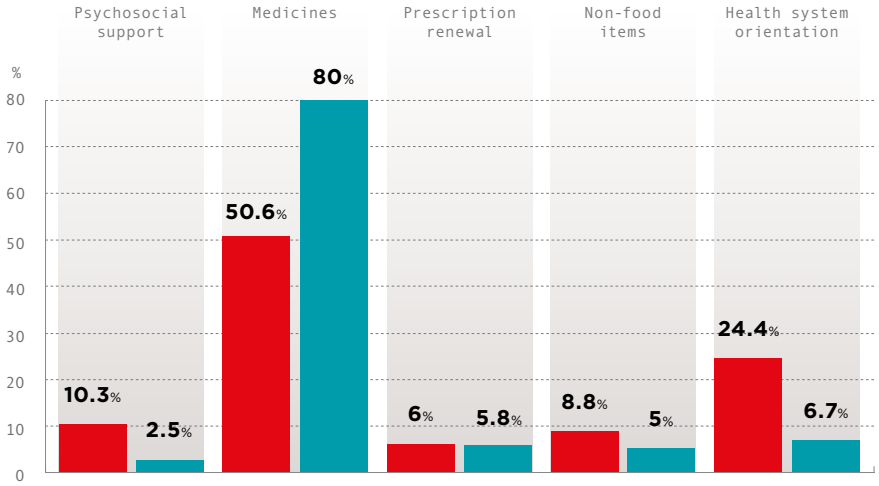
Community members unable to reach a FAP are significantly more fragile compared to those who can travel independently. **Only 71% could get out of bed on their own**, compared with 99% among those who can reach a FAP. Members of the first group were also more likely to be **in chronic treatment** (68% vs 52%). Their needs also differed: those unable to reach the FAP more often asked for psychosocial support (9.8% vs 4.0%), prescription renewals (10.4% vs 5.6%), and diapers (18.2% vs 3.4%). This highlights a critical level of dependency and a pressing need for dedicated home-based care. CHWs took into consideration the differences between the two groups, adapting their activities and focusing more on health system orientation for those people who were unable to reach a FAP.




**HEALTH NEEDS REPORTED BY COMMUNITY MEMBERS BY ABILITY TO REACH THE FAP INDEPENDENTLY**

## CONTINUITY OF CARE

**Community members who received follow-up were more often women** (63.8% vs. 50.5%), **middle-aged or older adults** (75.3% of those aged ≥45, vs. 53.9%) and retired (41.4% vs. 28.2%). They tended to live in **smaller households** (1-3 people: 73.9% vs. 61.4%), and more often reported **no contact with a healthcare provider in the past two years** (18.3% vs. 13.2%). They were also **more likely to be in chronic treatment** (52% vs. 41%) and reported higher needs for psychosocial support, non-food items and health system orientation. Considering this, CHWs efforts for this group concentrated on health education and referral support.



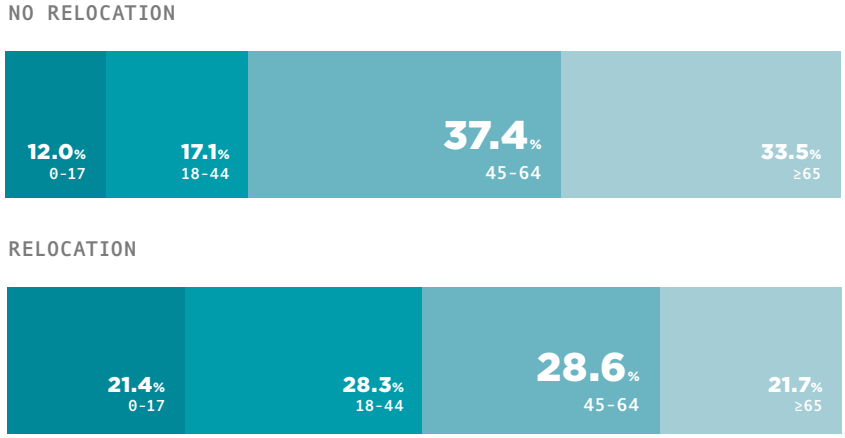

Follow-up

No Follow-up

**HEALTH NEEDS REPORTED BY BENEFICIARIES BY FOLLOW-UP STATUS**

## DISPLACEMENT

374 (23.1%) community members reported having relocated after the full-scale invasion in February 2022, while 1,243 (76.9%) had not. **Those relocated were more often women** (63.9% vs. 55.9%) **and noticeably younger** (21.4% aged <17, vs. 12.0%). They also tended to live in **larger households** (4–5 members: 32.4% vs. 18.5%).




Children and adolescents (0-17)

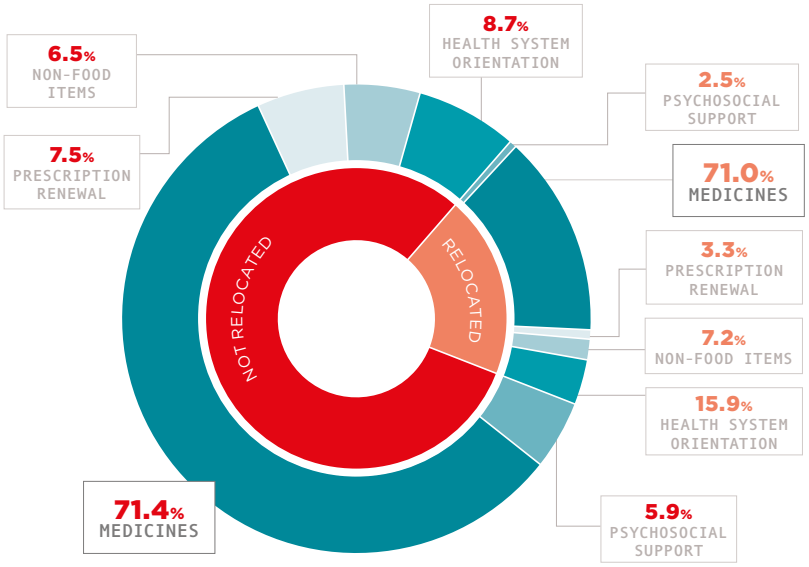
Young adults (18-44)

Middle-aged adults (45-64)r

Older adults (≥65)

**AGE GROUPS BY RELOCATION STATUS**

Relocated individuals were slightly less likely to be in chronic treatment than those not relocated (49.7% vs 55.6%). While both groups are equally in need of medicines, other health needs differ, with non-relocated people requiring more psychosocial support and prescription renewals.




**HEALTH NEEDS REPORTED BY BENEFICIARIES BY RELOCATION STATUS**

# SCALING UP AND DEEPENING THE MODEL IN KHARKIV OBLAST

Building on the experience in Donetsk, EMERGENCY has progressively extended its community-oriented primary care model to **Kharkiv oblast**, beginning with rural hromadas such as **Blyzniuky and Barvinkove**. The core configuration remains the same, with CHWs working in close connection with nurse-led facilities, local health professionals and referral hospitals. Here, the project aims to support 13 nurse-led clinics with renovation works, whenever needed, and/or the supply of technical and medical equipment. At the time of writing this report, renovations are ongoing in 3 facilities. Two additional clinics will be renovated, while 1 prefabricated container will be installed. All the facilities identified will receive tailored support by October 2026.

The model in Kharkiv has been further developed through the **integration of new components that strengthen prevention, early detection and system resilience**.

The model has been strengthened through **a structured partnership with V. N. Karazin Kharkiv National University and the Regional Phthisiopulmonology Centre**. Together, these institutions and EMERGENCY have introduced an **integrated screening component for tuberculosis, HIV and viral hepatitis delivered through mobile medical units** working in close linkage with CHWs and primary care facilities. This focus reflects the high national burden of drug-resistant TB, TB and HIV co-infection, and chronic viral hepatitis in Ukraine, and the well-documented risk that conflict-related disruption will interrupt diagnosis, treatment and follow-up. By **combining household-level profiling by CHWs with targeted outreach by mobile teams**, the intervention aims to **detect infections earlier among high risk and underserved groups, and to preserve continuity of care** along the full pathway from screening to treatment and follow-up, even under conditions of insecurity.

> *"Right now, the hromada has nine active outpatient clinics and 16 active FAPs, but another 10 FAPs are no longer functioning – three were destroyed and seven are closed simply because there are no health staff to run them. Several remote settlements are no longer served, and buses run only twice a week, so many people end up paying out of pocket for private taxis just to reach a health facility."*
>
> **Major Deputy**, Barvinkove Hromada, Kharkiv Oblast

> *"We're seeing too many hospital admissions that can be prevented, especially for hypertension and diabetes. Many patients come in late, with poorly controlled conditions, often because they don't fully understand their illness or how to manage it. They need clearer information and closer follow-up."*
>
> **Head of the General Medicine Department**, Blyzniuky Hospital, Blyzniuky Hromada, Kharkiv Oblast

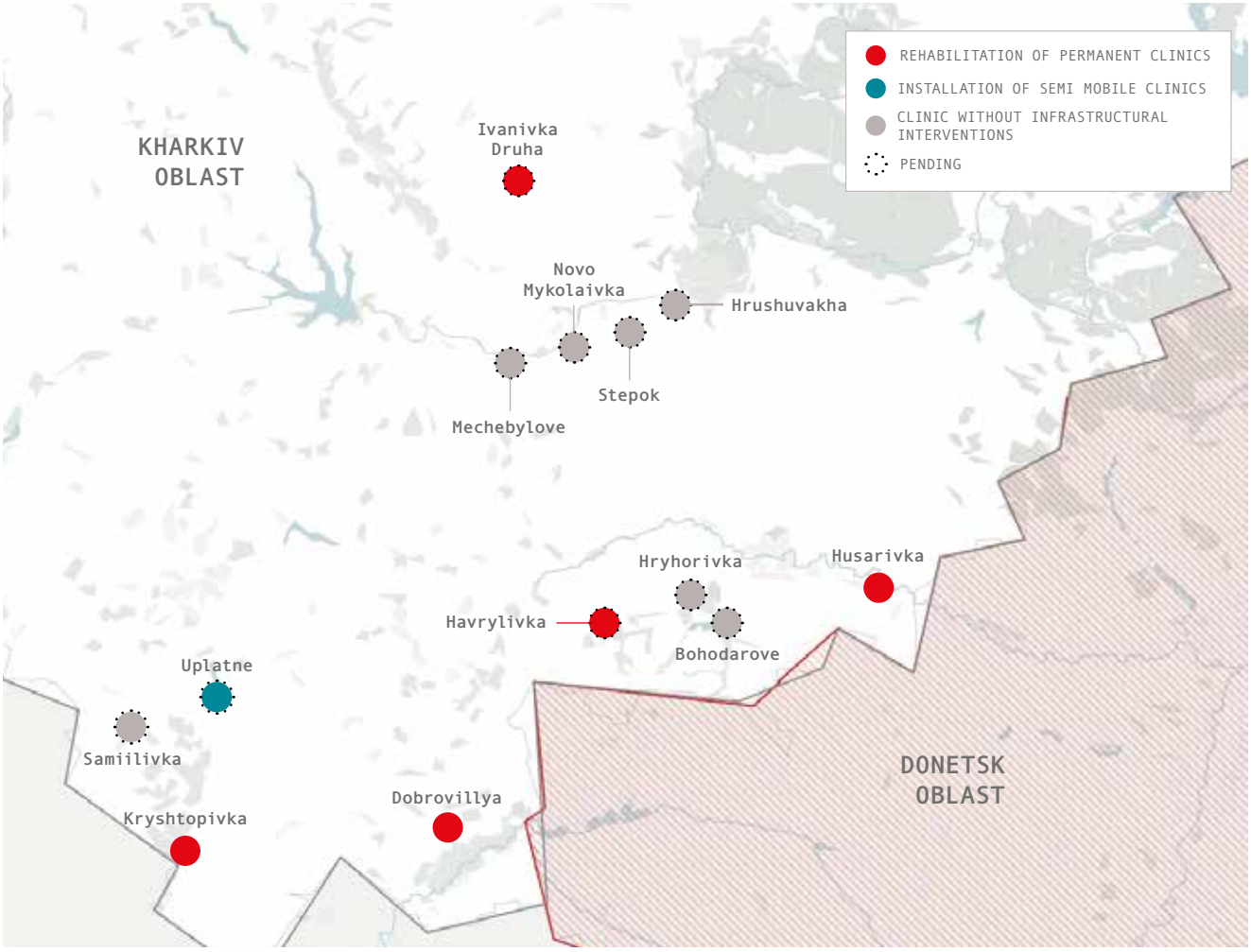
The same partnership underpins a broader capacity building effort. Academic and hospital specialists, together with EMERGENCY health staff, collaboratively provide **joint training and continuous medical education for family doctors, nurses and CHWs** on updated national and international guidelines, diagnostic algorithms, infection prevention and control, and stigma reduction. This reinforces clinical quality, supports more confident management of TB, HIV and hepatitis at the primary care level, and embeds the model within local professional networks rather than as an external humanitarian add-on.

Local ownership has also deepened. **Hromada administrations in Kharkiv participate in the identification of priority villages, in the planning of mobile clinic routes and in the monitoring of results**.

In addition to 11 CHWs employed by EMERGENCY, the activities can count on the presence of 2 CHWs directly hired by the local admnistration of Blyzniuky, further boosting the project sustainability.

Taken together, the extension of the model to Kharkiv, the integration of TB and HIV screening and training with university and regional hospital partners, and the **gradual sharing of financial responsibility with local authorities** all point to a progressively more embedded, preventive and resilient primary care system that can sustain continuity of care for chronic and infectious diseases during the war and beyond.

> *"We're short on specialists. Many have moved to safer areas in the west, and it's hard to replace them. And we really need to restart training: a lot of our family doctors are over 50 and haven't had refresher courses in years, so they're doing their best without up-to-date support."*
>
> **Major Deputy,** Barvinkove Hromada, Kharkiv Oblast

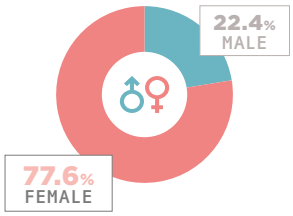



# SURVEY ON ACCESS TO CARE IN UKRAINE

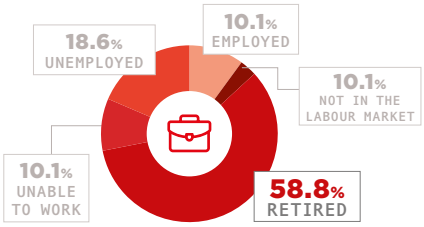
The final dataset for analysis consisted of 388 respondents who provided consent, drawn from an initial pool of 462 submitted questionnaires. The sample was predominantly female, with 301 women (77.6%) and 87 men (22. 4%). The mean age was 61.8 years old, ranging from 18 to 97.
Most respondents were retired (58.8%), while 18.6% were unemployed and only 10% were employed. A further 9.5% reported disability or inability to work, and 3.1% were not working for other reasons such as study or maternity leave.
Nearly half of respondents lived alone (46.1%), while 29.4% reported two-person households and 24.8% reported households of three or more people.

## DEMOGRAPHIC VARIABLES

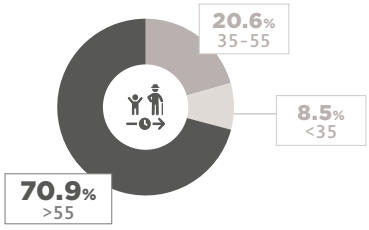
GENDER



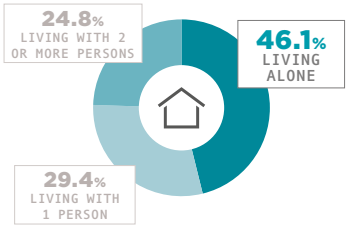

EMPLOYMENT STATUS




AGE




HOUSEHOLD SIZE

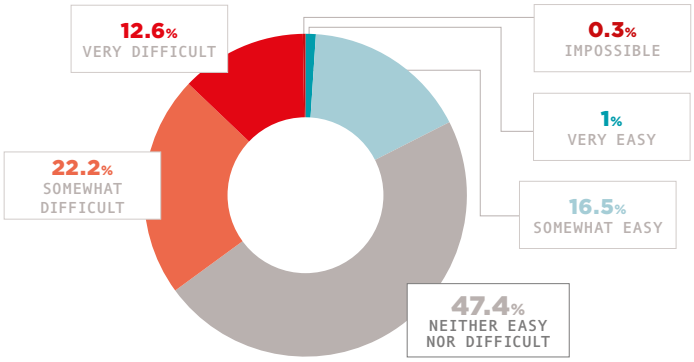



Out of 3,644 people reached by CHWs, 388 community members responded to the survey.

# ACCESS TO CARE SINCE FEBRUARY 2022

### EASE OF SEEKING CARE

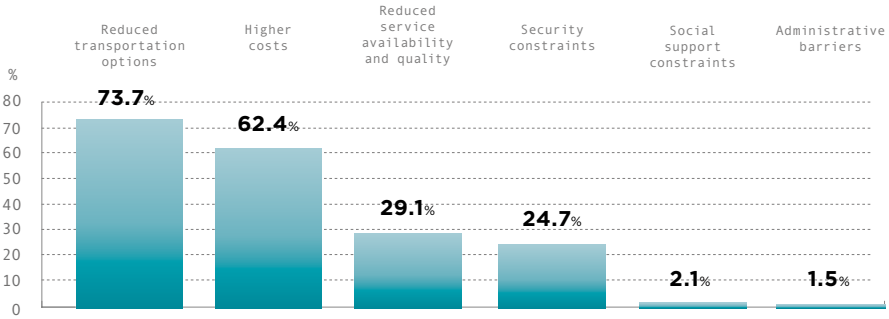
Nearly half of respondents reported that **seeking care since February 2022 was neither easy nor difficult (47.4%), while 34.8% described it as somewhat difficult or very difficult**. Difficulty seeking care tended to be more commonly reported among retired respondents and among those living in larger households, while **men tended to report less difficulty than women**.





**EASE OF SEEKING CARE**

Worsened access to care was driven primarily by **reduced transportation options (73.7%)** and **higher costs (62.4%)**. These were followed by **reduced service availability and quality (29.1%)** and **security constraints (24.7%)**, while social support constraints, such as lack of caregivers or family support, and administrative barriers, such as lack of family doctor registration, were less frequently reported.

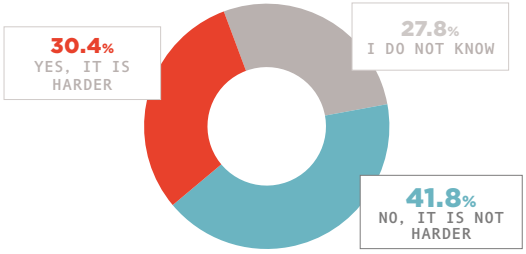



**BARRIERS TO CARE**

### ACCESS TO HEALTH INFORMATION

The most common sources of information about health and health services were **healthcare providers (69.6%) and family or friends (49.5%)**. Internet and social media was reported by 31.4%, and local authorities or community leaders by 29.4%, while mass media and support organisations (i.e., NGOs) were less frequently reported (19.8% and 16.5%, respectively).

Compared with the situation prior to February 2022, 30.4% of respondents reported that it is harder to find or understand information about health and health services, while 41.8% reported no increase in difficulty, and 27.8% reported that they did not know. **Difficulties finding and understanding health information were reported more frequently by older people**.

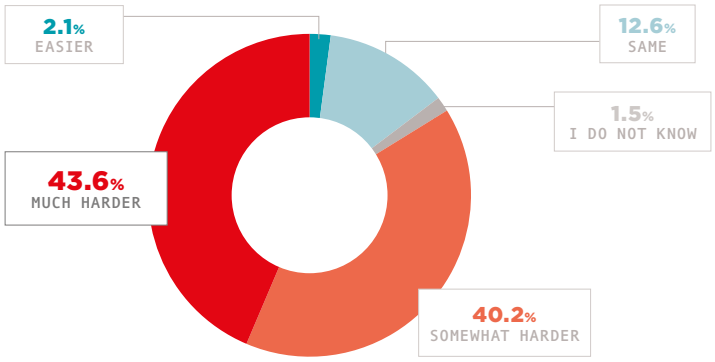



**EASE TO FIND OR UNDERSTAND HEALTH INFORMATION**

When asked about reasons why finding or understanding information about health and health services had become harder after February 2022, the most frequently cited reason was that available information was difficult to interpret (39.2%), followed by lack of internet access (21.4%), not knowing where to find information and not having time to read it properly (11.3% each), and low interest (9%). **Free text responses further suggested that difficulties in interpreting information were also linked to rapidly changing information and individual barriers such as impaired vision or hearing**.

### EASE OF REACHING CARE

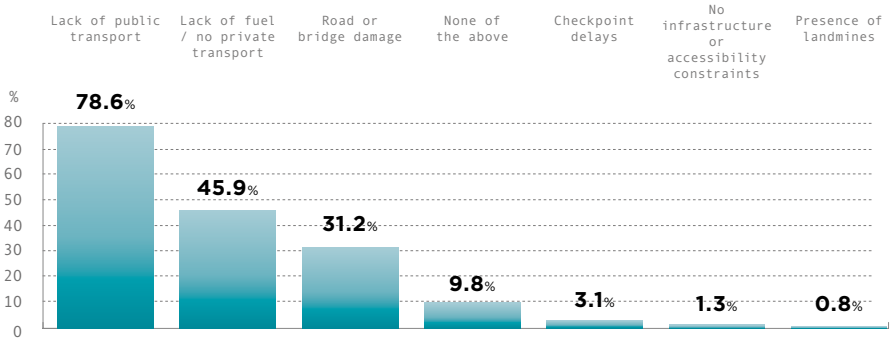
Since February 2022, the majority of respondents reported **increased difficulty in arranging safe transport to reach care: 43.6% found it much harder** and **40.2% found it somewhat harder**. These barriers were broadly cross-cutting, with similar patterns observed regardless of gender, age, employment or household situation.




Easier
Same
I do not know
Somewhat harder
Much harder

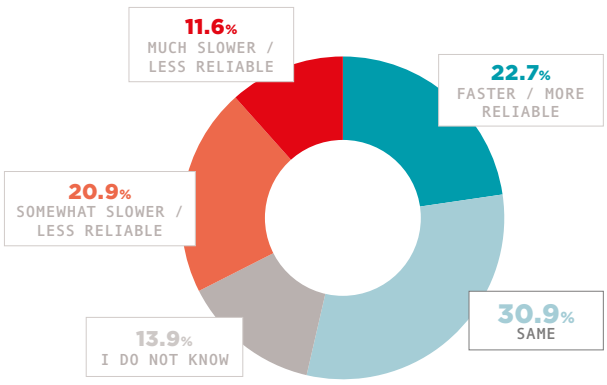
**DIFFICULTY ARRANGING TRANSPORT**

The most commonly reported factor increasing travel time to reach care was **lack of public transport** (78.6%), followed by **lack of fuel or no private transport** (45.9%) and **road or bridge damage** (31.2%). Checkpoint delays and the presence of landmines were less frequently reported (3.1% and 0.8%, respectively).




**FACTORS INCREASING TRAVEL TIME TO REACH CARE**

When asked about the **reliability of ambulance or medical transport dispatch** since February 2022, responses were divided. While **32.5% of respondents cited slower or less reliable service**, this was nearly matched by **30.9% who reported no change**. In contrast, a smaller group of 22.7% perceived dispatch as faster or more reliable.

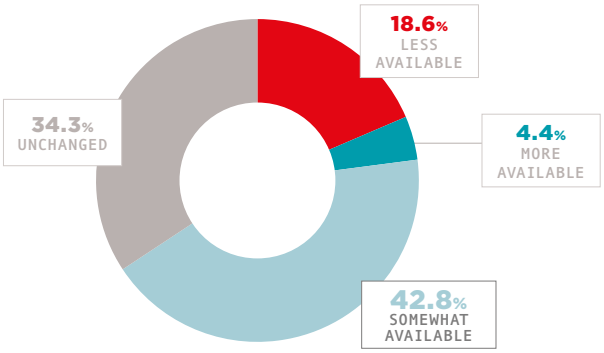



Faster / More reliable
Same
I do not know
Somewhat slower / Less reliable
Much slower / Less reliable

**RELIABILITY OF AMBULANCE DISPATCH**

## AVAILABILITY OF OUTREACH ACTIVITIES

Compared with the situation prior to February 2022, most respondents reported that **outreach activities such as vaccinations and mobile clinics were either somewhat available or unchanged** (42.8% and 34.3%, respectively). A smaller share reported reduced availability (18.6%), while 4.4% reported that outreach activities were more available.

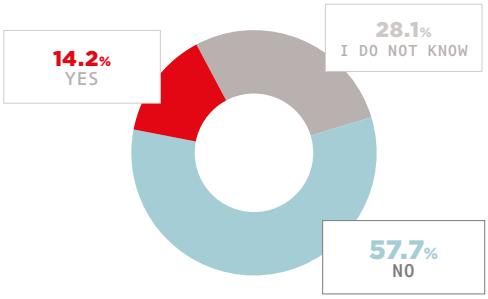




**OUTREACH ACTIVITIES AVAILABILITY**

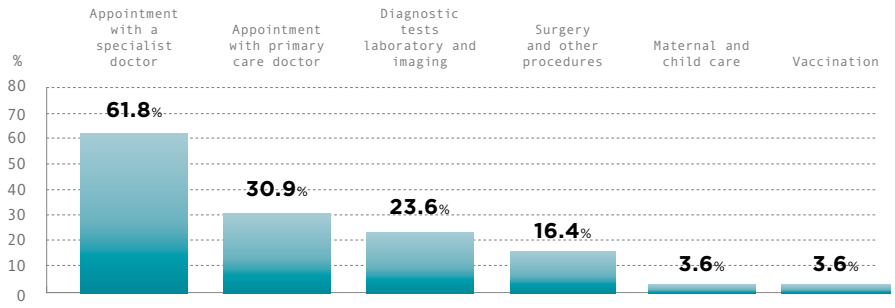
## DELAYS IN RECEIVING CARE IN THE PAST 12 MONTHS

14.2% of respondents reported significant delays in receiving care over the past 12 months, while 57.7% reported no delays and 28.1% were unsure. Reported delays were broadly similar across gender, age, employment and household groups, suggesting that delays are a cross-cutting issue rather than concentrated in a specific subgroup. Overall, these findings indicate relatively consistent access across population groups and point to a degree of system resilience during the period assessed.




**SIGNIFICANT DELAYS**

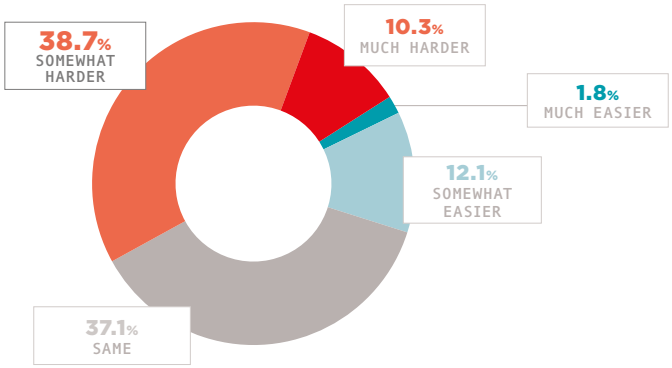
Among respondents who reported significant delays, the most frequently affected services were **appointments with specialist doctors** (61.8%), followed by **appointments with primary care doctors** (30.9%), **delays in diagnostic tests** (23.6%) **and delays in surgery or other procedures** (16.4%), while maternal and childcare and vaccination delays were each reported by 3.6%




**SERVICES MOST FREQUENTLY AFFECTED BY DELAYS**

### AFFORDABILITY OF CARE

Compared with the situation prior to February 2022, **49% of respondents reported that healthcare costs had made it harder to receive care when needed**, including 38.7% who reported it was somewhat harder and 10.3% much harder. A further 37.1% reported no change, while 13.9% reported it was easier. **This difficulty tended to be reported more often by older respondents, by those living alone and by retired people**.

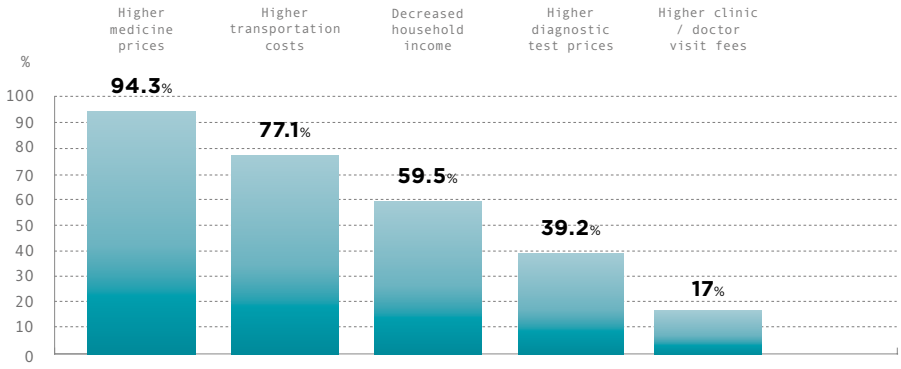






CHANGES IN AFFORDABILITY

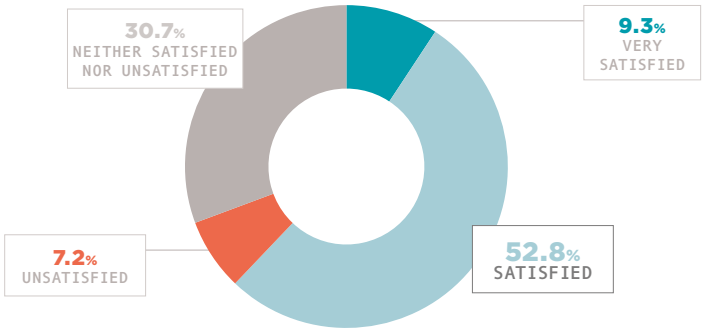
Since February 2022, the most frequently reported cost-related barrier to receiving care was **higher medicine prices (94.3%), higher transportation costs (77.1%)** and **decreased household income (59.5%)**. Higher diagnostic test costs were reported by 39.2%, while higher clinic or doctor visit fees were reported by 17%.




COST-RELATED BARRIERS TO RECEIVING CARE

## SATISFACTION WITH AVAILABLE HEALTH SERVICES

In the past 12 months, most respondents reported being satisfied with the health services available when they fell ill or were injured, with **52.8% satisfied and a further 9.3% very satisfied**. A further 30.7% reported being neither satisfied nor unsatisfied, while 7.2% reported being unsatisfied.



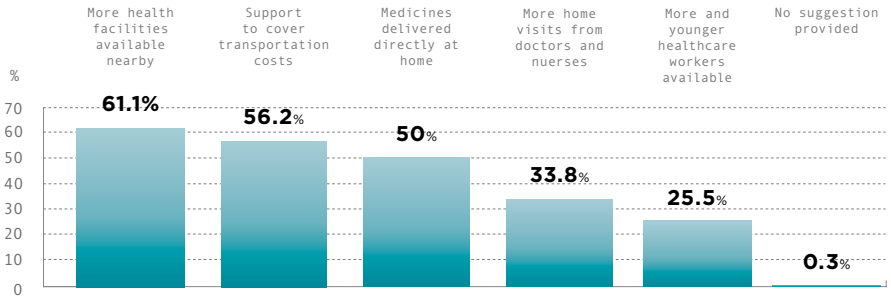




SATISFACTION WITH AVAILABLE HEALTH SERVICES

# SUGGESTED CHANGES TO IMPROVE ACCESS AND CONTINUITY OF CARE

Respondents most frequently recommended **increasing the availability of nearby health facilities (61.1%)** and **providing support to cover transportation costs (56.2%)**. Home delivery of medicines was also commonly suggested (50%), followed by more home visits from doctors and nurses (33.8%). A quarter of respondents, 25.5%, suggested increasing the availability of healthcare workers.




SUGGESTED CHANGES

# CONCLUSIONS

This report brings together routine data collected by CHWs during their outreach activities and findings from a survey on access to care since the start of the war. It offers a detailed **view of the main health needs and barriers** in Ukraine's remote war-affected villages. The study reflects the **lived experience of Ukrainian people, giving voice to the affected communities and increasing the accountability of humanitarian interventions** designed to support them. Ultimately, findings identify key war-related obstacles to equal and effective access to care and underscore the concrete role of CHWs in reducing their impact.

## IMPACT OF PROTRACTED CONFLICT ON ACCESS TO CARE

In a country like Ukraine, characterised by such **widespread rural communities**, insufficient attention has been directed toward addressing the needs of those who remained. For these populations, access to care has significantly worsened as a direct consequence of the deteriorating operational environment. Indeed, in Donetsk and Kharkiv oblasts, constraints are primarily structural rather than preference-driven, with transport and cost emerging as dominant cross-cutting bottlenecks since February 2022.

**Transport is the main system failure** across the continuum of care for most people reached, representing a shared challenge among communities rather than a niche vulnerability. A lack of public transport and private vehicles, coupled with scarce fuel and damaged roads, serves as a key determinant in delayed care. Notably, 16% of community members report they cannot reach a clinic independently. Health services are also affected, showing the double-edged impact of transport disruption. **One in 3 respondents report ambulances and medical transport are slower or less reliable, while vaccinations and outreach services become less available.** When transport fails, people cannot reach care in time, services cannot reach communities, and avoidable complications and preventable deaths increase.

Even when people seek care and reach a facility, many cannot obtain timely, appropriate treatment. Delays are reported across the pathway, from primary care services to specialist consultations and diagnostics, indicating system strain at multiple levels. For instance, among those who experienced significant delays, **most (61.8%) struggled to have an appointment with specialist doctors**.

Limited-service availability is compounded by financial constraints. **Half of respondents report increased health-related costs**, making it harder to secure needed care. **Higher medicine prices, rising transport costs and decreased household incomes** turn access into a question of affordability. These barriers appear to disproportionately affect people already at risk, including those living alone, older adults and retired individuals, increasing the likelihood of deterioration of health conditions, complications and avoidable hospitalisation.

Security remains a relevant constraint, with **one quarter of respondents (24.7%) reporting reduced access to healthcare due to security concerns**. However, direct war-related barriers – such as checkpoint delays and landmines – were only marginally cited as causes of delay. As obstacles strictly linked to active fighting, sudden escalations or time spent sheltering were not explicitly investigated, the impact of insecurity on timely care may be underestimated. Nonetheless, findings should be interpreted in light of the operational context, where frontlines are clearly marked and defined. The activities are implemented with an **approximate 25 km buffer from the frontline**; in these areas, the impact of war is manifested through **transportation gaps, limited infrastructure, health workforce shortages and increased costs rather than acute security incidents**. Furthermore, frequent evacuations have impacted the project's human resources management; as staff relocated due to insecurity, rapid operational adjustments were required to maintain continuity. Finally, given that almost a quarter of respondents reported relocation since February 2022, it is plausible that those who remain closer to the frontline face even more severe access constraints than those captured in this survey.

Despite these pressures, **satisfaction with available services remains high**, with fewer than 1 in 10 reporting dissatisfaction and 57.7% reporting no significant delays. This likely reflects **trust in health staff, low expectations under prolonged disruption and elements of health system resilience**, rather than an absence of unmet needs.

Information and navigation gaps are a meaningful access barrier. **One in 3 respondents reports that since February 2022, it has become harder to find or understand information about health and health services**, most often because information is difficult to interpret, particularly among older adults and retired individuals. This aligns with previously documented poor health literacy in Ukraine,[56] with **conflict volatility making these gaps more acute**. Shelling, displacement and sudden access restrictions can

change, often overnight, which facilities are functioning and which providers are available. Health workers remain the main trusted source, indicating that outreach should include structured navigation support, not only clinical advice.

Finally, **lack of internet access, low motivation and sensory impairments** – such as reduced vision or hearing – can limit people's ability to seek care even when services exist. Vulnerability is therefore layered. **Individual constraints collide with system breakdowns and compound each other, leaving the most vulnerable behind**.

## A COMMUNITY-BASED LINKAGE BETWEEN HOUSEHOLDS AND SERVICES

In this setting, EMERGENCY's community-oriented primary care project places **CHWs in a pivotal position to identify vulnerabilities and respond before needs become a crisis**. Displacement linked to ongoing hostilities, social vulnerability associated with unemployment, retirement or living alone, and clinical vulnerability related to older age and chronic conditions frequently overlap. By documenting these intersecting risks at household level, CHWs generate a **practical, real-time map of who is being left behind and should be prioritised**. This supports targeted outreach, strengthens trust, and improves the acceptability and reach of health services for people who might otherwise remain invisible to the system.

Through **10,842 home visits**, CHWs identified people who struggle to reach facilities, supported registration with a family doctor, explained treatment plans in plain language and alerted nurses or doctors when a situation deteriorated. For people who are anxious, isolated or unsure about their entitlements, this relational work can be as important as the clinical visit.

**Equity of reach** is a central contribution of the model. CHWs systematically reach people who are least able to seek care independently. These include older adults living alone, people with disabilities, individuals with mobility limitations and households who have been displaced from frontline areas. Mapping these contacts creates a granular **picture of vulnerability that can inform local priorities** and make resource allocation more accountable.

In terms of tasks performed by the CHWs, **psychosocial support is the most prominent activity** (44.5%), followed by health education (25.6%). This reflects an operational reality in protracted conflict. **Mental health needs** are pervasive and often untreated. In a context where anxiety, depression and post-traumatic stress disorder are highly prevalent,[57] CHWs provide accessible first-line support, continuity and a trusted point of contact. In parallel, **health promotion** remains essential. CHWs translate complex information into actionable guidance, from vaccination to non-communicable disease management, supporting informed decisions despite disruption, fear and limited access to reliable information.

## CONTINUITY AND COORDINATION UNDER PRESSURE

CHWs maintain **continuity and coordination of care** processes in a system where people are constantly at risk of falling out of care. They identify reasons for treatment interruption and help re-establish **adherence**, whether by physically delivering prescriptions and medicines or by facilitating access to existing public channels for ordering and home delivery. This role is reflected in the improvement observed among community members who initially struggled with adherence, with more than half later reporting compliance. Programme data also suggest **improved continuity among people who had not seen a health worker in a long time**, particularly older adults and people with chronic diseases now receiving repeated home visits. The survey similarly indicates that CHW visits and nurse follow-up help people remain connected to the health system over time.

CHWs also act as a bridge between remote communities and the local health system to improve coordination of care, supporting clearer and more **functional referral pathways**. Through household visits, they identify needs, assess barriers and coordinate directly with local nurses and doctors. This enables escalation when warning signs emerge, planned booking when specialist input is needed, and home-based follow-up when mobility is limited. **In 655 instances, a referral to a First Aid Point was activated, while clinical advice was requested 907 times**. The consistent volume of referral-related actions over time suggests that this is not an occasional activity but a core function that **reduces avoidable delays** and **protects the most vulnerable**.

CHWs proved particularly critical when a **major influx of evacuees** from frontline areas led local authorities to establish an **Interim Evacuation Point**. They were tasked with rapidly assessing health and social needs, prioritising the most vulnerable and organising safe referrals for those requiring further care. Just as importantly, CHWs helped displaced people maintain chronic therapies and offered psychological first aid and practical navigation of the health system, reducing the risk of being lost to follow up at the moment of greatest fragility. This experience illustrates how locally embedded CHWs can become an essential **pillar of community response, even during acute displacement**.

## IMPLICATIONS FOR ADAPTATION AND SCALE-UP

Several factors make this project **feasible and sustainable in a humanitarian crisis**.

First, it is **co-designed with local actors and communities**. The needs assessment and the prioritisation of both facilities to rehabilitate and villages to be covered by CHWs were carried out together with frontline health workers, local service providers and relevant authorities. This approach helps ensure the intervention reflects local priorities and can be implemented through existing structures that people already rely on.

Second, because CHWs are recruited, trained, and remunerated within their own communities, local employment and retention are significantly bolstered. **Leveraging local human capital for civilian services** is vital during wartime, as it builds transferable skills that remain within the community and foster long-term resilience.

Third, **referrals and prescriptions are embedded within national mechanisms**, avoiding parallel systems and supporting progressive cost-sharing and realistic handover planning.

Together, these elements strengthen project sustainability, ownership and coordination, improve acceptance, and reduce duplication when resources are scarce. Visit-level data show that almost **half of enrolled community members are still followed six months after first contact**. As local administrations increasingly help plan, track and co-fund CHW roles, the programme is built to last, shifting from a temporary humanitarian response to a locally owned and stronger primary care system.

## THE PATH FORWARD

**Local communities ask for more functioning facilities, support with transport costs and more home visits**. Scaling up and replicating EMERGENCY's community-oriented primary care model in **Kharkiv Oblast** responds directly to these priorities. The project will extend CHW-linked and nurse-led primary care to rural hromadas, where access has been intermittent and facility closures and staff shortages have left entire settlements effectively unserved. The next phase should pair the CHW backbone with mobile outreach and targeted home-based care, so prevention, follow-up and continuity are independent from a patient's ability to travel.

Within this approach, the **integration of TB, HIV and hepatitis screening** through partnerships with the university and the regional hospital is a concrete step toward more uninterrupted care pathways in a context with both high prevalence and high disruption. As the programme matures, embedding these screenings - where appropriate and in line with national strategies - can help maintain continuity during and after the war, and reduce the burden of late diagnoses.

Conflict in eastern Ukraine is actively preventing people from seeking, reaching and receiving timely, appropriate care, with the steepest impact on those already facing vulnerabilities. EMERGENCY's model shows that **an innovative, scalable, context-sensitive model for comprehensive primary healthcare can reduce these gaps by restoring trust and supporting continuity and coordination of care**, even during ongoing hostilities.

# RECOMMENDATIONS

**1 Securing necessary funds for health**

The international community and the Ukrainian authorities should dedicate adequate funding to support the humanitarian response and the delivery of basic health services in both urban and rural areas. With only half of the Humanitarian Response Plan secured in 2025 and a drastic reduction in national budget allocated to health in favour of defence and security, it is urgent to respond to the funding appeal of USD 90 million for health in 2026, giving priority to regions most affected by the war and close to the frontlines.

**2 Flexible, multi-year financing between humanitarian and longer term aid**

The international community should pave the way for long-term resilience in Ukraine, without compromising the ability to provide aid according to humanitarian principles during wartime. Without coordinated funding, health services risk being fragmented and inequitably distributed, leading to underserved, neglected regions that already host the most vulnerable and isolated communities. In a protracted conflict environment, this must include a shift towards multi-annual and flexible funding cycles, strengthening healthcare delivery from the community to specialist services. This approach must meet the needs of direct victims – such as the wounded and the displaced – as well as of hosting communities and other vulnerable groups. Furthermore, funding flexibility must allow for rapid adjustments to respond to frontline shifts.

**3 Improving access to care through structural interventions, health workforce capacity building and transport**

Healthcare services must be more accessible, appropriate and equitable. With support from international donors, local and national authorities should work towards increasing the availability of health facilities, renovating and improving health infrastructure, and ensuring context-appropriate technology and pharmaceutical supplies. In remote rural areas, these investments should focus on strengthening functional primary care points with reliable essential services, clear referral routes and predictable outreach. At the same time, it is crucial to invest in capacity building programmes for healthcare workers to guarantee the quality and safety of health services. Targeted transport solutions for non-emergency referrals and ambulance dispatch should also be prioritised to ensure the physical reachability of care.

**4 Containing out-of-pockets expenses and fulfilling the right to health, cost-free**

International donors and the Ukrainian authorities should explore ways to reduce out-of-pocket payments and secure a sustainable national budget to support the health system. Access to medicine represents a primary barrier to the right to health for Ukraine's people, and an expansion of the Affordable Medicines Programme should be evaluated and prioritised to ensure that treatment is accessible to all, regardless of socio-economic status.

**5 Investing in community engagement and trained Community Health Workers as a vital link for continuity of care**

An informed and resourced workforce at community level should be integrated into the Ukrainian authorities' health strategies to build a more equitable and resilient system. In conflict-affected regions, where frontlines and service availability may change rapidly, households need a trusted first point of contact and guidance to navigate the system effectively and access life-saving services. When adequately trained, supervised and resourced, CHWs significantly mitigate barriers and improve continuity of care, especially in remote settings. CHWs also enable a proactive and anticipatory model that prioritises outreach and follow-up for the most vulnerable, who are at higher risk of being left behind.

**6 Ensuring functional referral pathways and coordination of care**

In conflict-affected regions, primary healthcare and community outreach must be seamlessly linked to higher levels of care. International donors and the Ukrainian authorities should prioritise the strengthening of clinical referral pathways, ensuring that patients identified at the community level who require specialised care can be safely and rapidly transferred to equipped hospitals, so that improved care-seeking translates into better health outcomes.

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