Regional Refugee Response
for the Ukraine Situation

NAVIGATING HEALTH AND WELL-BEING CHALLENGES FOR REFUGEES FROM UKRAINE

An Inter-Agency Exploration of Data

May 2024

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Cover photograph:

Olga, 38, fled from Donetsk in eastern Ukraine in the summer of 2022 with her children (9 and 11) and partner Volodymyr. Their house had been destroyed by a bomb exposion. Olga is now undergoing cancer treatment at a hospital in Krasnobrod, eastern Poland.
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Executive summary

Since the full-scale invasion of Ukraine on 24 February 2022, devastating impacts have affected the country and wider region, triggering what was one of the world's fastest-growing displacement and humanitarian crises in the European Region since World War II. In support of Ukrainian refugees, the European Union activated the Temporary Protection Directive that enabled access to essential services, including essential health services, education, and others. The Republic of Moldova followed this model and also introduced temporary protection for Ukrainian refugees.

Regional Refugee Response Plan (RRP) partners leading the work in health have conducted a regional analysis of Multi-Sector Needs Assessment (MSNA) data from the refugee-receiving countries: Bulgaria, Czech Republic, Hungary, Poland, Republic of Moldova, Romania, and Slovakia.

Key finding from the regional analysis for health, including mental health and psychosocial support (MHPSS) and other health related topics, include:

Health care is a top priority need reported by refugees surveyed across most countries. 34% of respondents stated health care as one of the top three needs, only slightly behind employment and livelihoods. Importantly, 51% of households with a person with a disability reported access to health care among their top priority needs.

Regarding access to health care, 28% of all household members reported needing to access health care in the 30 days prior to the survey. Of those who required health care, 89% were able to access health services without problems while 11% reported an unmet health care need. Self-reported barriers to accessing health services included the inability to make an appointment (38% of those who reported barriers), language barriers (27%), and lack of knowledge on how to access health services (19%). Persons with a chronic disease had higher unmet health needs than those without (14% vs. 9%). Analyzing access by gender, more women respondents reported a need to access health services relative to male respondents.

On average 9% of all household expenditures were for health care. Households with a person with a disability reported significantly higher share of health care expenditures (15% vs. 8%), households with a chronically ill member similarly reported significantly higher share of health care expenditures compared to those without chronic diseases (13% vs. 5%).

Vaccination coverage among refugees from Ukraine is low and remains a concern. Using measles as a proxy for childhood vaccinations, 84% of children received at least one measles vaccine against a target of 95% coverage.

Regionally, the importance of mental health and psychosocial support services was highlighted with 19% of individuals reporting mental health related problems. These issues vary by age and gender, with females consistently reporting higher levels, especially among those aged 35 and older. Notably, among children under 11, more boys than girls were reported as exhibiting problems related to mental health.

Among the individuals who were reported to have mental health or psychosocial problems and expressed needing support, only 45% reported successfully accessing and receiving MHPSS services. Common barriers include not knowing where to seek help, which was more prevalent among females, and a lack of will or reluctance to pursue support, which was more common among males.

Individuals with disabilities experience a higher prevalence of MHPSS problems, with 42% reporting such issues compared to 17% among those without disabilities. Additionally, among individuals with chronic illnesses, 33% reported experiencing mental health and psychosocial problems, compared to 13% of those without chronic illnesses.

From these findings, recommendations include addressing the health needs and identified barriers outlined in the MSNA, tailored to country-level data and context. Results highlighted the need to address the immunization gaps among refugee children in host countries in addition to ensuring equitable access to care for people with chronic diseases or disabilities including through health financing mechanisms. For mental health and psychosocial support, targeted and tailored MHPSS interventions should be upscaled to address gaps in mental health support to effectively meet the needs within communities while recognizing the varying impact of mental health challenges at the individual level and among specific populations. To help address some of the barriers to accessing MHPSS, initiatives to raise awareness and reduce stigma surrounding mental health and well-being are recommended. Lastly, opportunities to share lessons and experiences in providing health and MHPSS services can support learning across refugee-hosting countries. Additionally, further research is needed to understand the unmet needs and barriers to access to health, including sexual and reproductive health, and MHPSS services and how and whether they affect refugees and host communities differently in addition to differences across country context, gender, and age groups.

Context

An estimated 6 million Ukrainian refugees are still recorded across Europe, with more than 30 million recorded border crossings from Ukraine and over 20 million crossings back into Ukraine since 24 February 2022.[1] The majority of these refugees from Ukraine are registered for asylum, Temporary Protection, or similar national protection schemes in a hosting country in Europe.1 Approximately 80% of refugees are women and children and 15% of displaced refugee households have an elderly person over the age of 60.[2] There are other vulnerable and marginalized populations among refugee populations in hosting countries, including persons with disabilities, stateless persons, sexual and gender diverse minorities, and ethnic minorities.

Health care service disruptions within Ukraine, coupled with the consequences of conflict and displacement, have also increased the affected population's vulnerability to certain conditions. Sexual and reproductive health (SRH) needs are high, including increased risk of unfavorable pregnancy outcomes, unintended pregnancies, and the consequences of gender-based violence (GBV). Low vaccination coverage among the Ukrainian population remains a concern with the possible increased risk of outbreaks of preventable communicable diseases. Additionally, refugees with non-communicable diseases (NCDs) including cancer, mental health needs, or any other chronic condition are at risk of treatment interruptions or delays. This can lead to acute health needs and may cause considerable, long-term burden on the health care systems of refugee-receiving countries. Mental health and psychosocial support needs of refugees have also become more evident as the crisis has become protracted.

Governments in all countries receiving and hosting refugees from Ukraine have generously kept their borders open, swiftly modifying their legislation on health provisions at the start of the conflict to grant access to national health services through the European Union (EU) Temporary Protection Directive (TPD) and complementary national decrees. While response from receiving countries is characterized by dynamic adaptability to evolving health and social needs of displaced persons, barriers to accessing care persist, including lack of medical history documentation, lack of clarity of health insurance coverage, financial and administrative barriers, and language and cultural differences.[3]

At the same time, the impact of the refugee influx on the host communities and local health systems are important to consider. In some cases, the capacity of countries' health systems has been able to accommodate and meet the needs of both refugees and host communities. In others, the refugee situation has revealed and exacerbated underlying gaps in health systems and unmet needs remain. Additionally, host communities' perceptions of Ukrainian refugees have shifted now that it has been more than two years since the start of the crisis, with some refugee-hosting country nationals expressing discriminatory rhetoric towards refugees or perceived differences in provision and quality of health services.3 Refugee Response Plan[4] partners have increased efforts in the area of integration and social inclusion of refugees from Ukraine, including in the health workforce and the integration of Ukrainian health professionals in countries like Poland.

In a regional multi-agency collaboration, the second Ukraine Refugee Situation Multi-Sector Needs Assessment was conducted to collect information on the needs of refugees in refugee-receiving countries (Bulgaria, Czech Republic, Hungary,

1 See https://data.unhcr.org/en/situations/ukraine (as of 15 February 2024).
2 See https://data.unhcr.org/en/dataviz/330?sv=54&geo=0 (as of 15 December 2023).
3 Behavioural and Cultural Insights studies in Czechia, Poland, Romania, Slovakia, and Slovenia on access to and uptake of health services by Ukranian refugees. WHO; December 2023.
4 The Ukraine Refugee Response Plan (RRP) is a comprehensive Inter-Agency plan to address the humanitarian needs of refugees from Ukraine in the following host countries: Belarus, Bulgaria, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Republic of Moldova, Poland, Romania, and Slovakia. https://data.unhcr.org/en/documents/details/105903

Poland, Republic of Moldova, Romania, and Slovakia), including those related to health and mental health and psychosocial support outlined in this chapter. The assessment supports partners' understanding of the level of access to basic services among refugees and if and how refugees' needs are being met in their respective host countries. The analysis of country-specific MSNA data along with this regional level analysis aimed to monitor access to health and MHPSS services and identify priorities for health as well as other sectors included in the MSNA such as protection, education, shelter, and socio-economic inclusion and livelihoods. Results can help inform government and partner priorities and activities for the continued refugee response and protracted situation for countries hosting refugees from Ukraine within the European region.

Methodology

Data for the country-specific MSNAs were collected through in person interviews from June to September 2023. The data used for this health analysis comes from the anonymized version of the MSNA 2023 regional dataset available at UNHCR Microdata Library. The total sample size comprises 11,496 households and 26,857 household members. The indicators and correlations were calculated using valid responses only; therefore, respondents who selected "prefer not to answer" or "don't know" were excluded from the calculation. To facilitate the interpretation of results, some response options were grouped into categorical variables.

This report employs the Washington Group on Disability Statistics framework, defining disability as level 3 disability for the purpose of this survey. Level 3 disability refers to individuals experiencing significant limitations in functioning, as assessed through a comprehensive set of questions covering mobility, vision, hearing, cognition, self-care, and communication.

For the indicators related to chronic illness and vaccination, respondents were directly asked if they or their household member have a chronic illness and if the children have received polio and measles vaccination. The vaccination card was not consulted during the interviews. The complete questionnaires are available at UNHCR Microdata Library.

Limitations

This analysis presents limitations concerning the generalization of results. First, there is a potential sampling bias due to non-probabilistic household selection and data collection period, which can differ across country-level datasets. Male respondents are underrepresented in the sample and the gender difference in results might not be representative of the general population.

Additionally, the questionnaire had slight differences across countries, not all questions were included in all countries. Certain indicators have been omitted from the regional analysis due to either insufficient sample size or unavailability of the variable across countries. That is the case of the indicators for households' awareness of available health care-related support and children accessing meals at school. In addition, polio vaccination data were removed as 32% of respondents did not recall the number of polio vaccine doses received or preferred not to answer and vaccination data could not be verified against vaccination records.

Data on several other indicators need to be interpreted with caution due to the sample size (e.g. breastfeeding) or unavailability of the indicators across countries (e.g. barriers to SRH services).

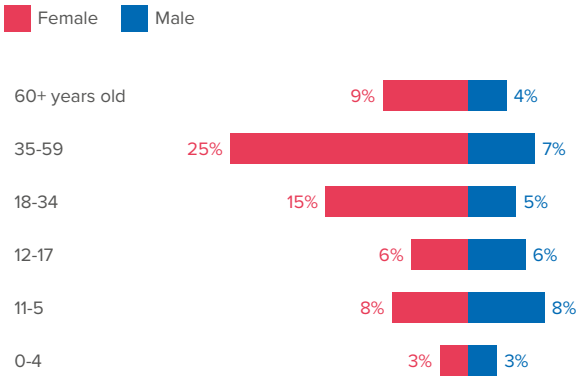
One limitation of this assessment is the lack of information about SRH service availability, accessibility, and quality. There was only one question regarding SRH in the current MSNA questionnaire, that solely looked at general SRH access, without specification of different essential SRH areas and by different age groups. Additionally, this indicator was not captured by two countries, which makes it difficult to analyze SRH access across the region.

The MHPSS questions used in the survey were answered by one family member (the survey respondent) regarding each household member. Therefore, the results may not capture the full extent to which individuals are affected by mental health problems or in need of MHPSS. Also, with sensitive issues such as mental health and SRH, respondents may prefer not to answer in a household survey or depending on who is present during the interview.

Sample demographics

The population pyramid of the sample used in this analysis show that most household members are female aged 35 to 59 (25%), followed by female aged 18-34 (15%). To minimize bias results due to gender imbalances, indicators were disaggregated by gender and age and the comparison done by the same age groups. The gender disparity is not observed for respondents younger than 18 years old; therefore, indicators related to vaccination and school enrollment were not affected.

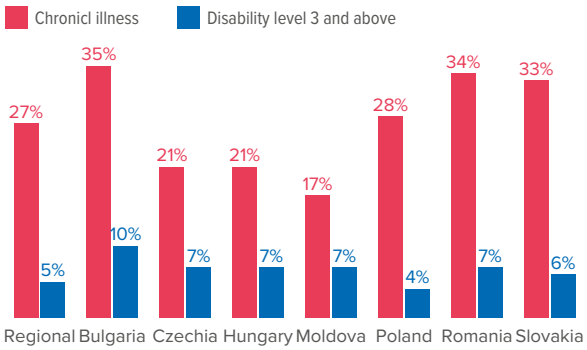
POPULATION PYRAMID



Regarding other demographic characteristics of the sample, 6% self-reported a level 3 WGD disability (1,691 individuals out of the 26,857 individuals sampled; non-weighted). Among the countries surveyed, Poland reported the lowest percentage of refugee individuals with a disability at 4% with Bulgaria reporting the highest at 10%.

Regionally, 27% of participants self-reported a chronic illness (7,569 individuals; non-weighted) ranging from 17% in the Republic of Moldova to 35% in Bulgaria, with Romania and Slovakia closely following with 34% and 33%, respectively. Self-reported prevalence increases with age, with 70% of those above 60 years reporting a chronic disease.

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

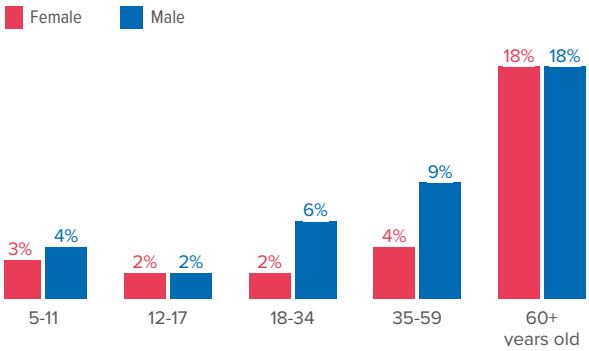


(Chronic Illness N=26,583 ; Disability N=26,857)

There is a higher incidence of respondents with a disability and chronic illness among men compared to women. The percentage of male respondents aged 18 to 34 reporting a level 3 WGD disability is 6% compared to 2% among female respondents. A similar trend is seen for respondents aged 35 to 59, with 9% of male respondents and 4% of female respondents reporting a disability.

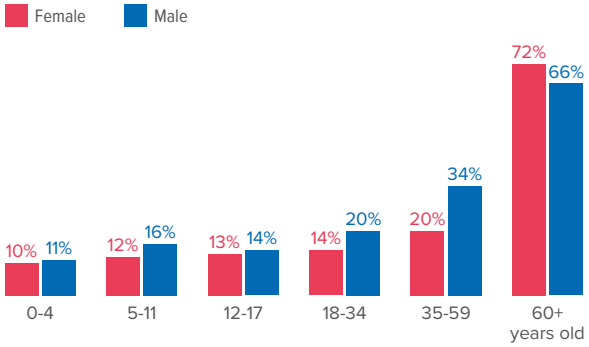
A similar trend was observed for self-reported chronic illnesses with men in the age group 18 to 59 reporting higher prevalence of chronic diseases. Conversely, more women above the age 60 presented with chronic diseases than men (72% vs. 60%). This suggests that the provision of health services should be tailored to these gender and age dynamics, as should the provision of information on these services.

INDIVIDUALS WITH DISABILITY BY AGE AND GENDER



(N=26,583)

INDIVIDUALS WITH CHRONIC ILLNESS BY AGE AND GENDER



(N=11,438)

Analysis by topics and indicators under Health

Health as a priority need

Access to health services was identified as a priority need of the household in the survey with 34% of respondents highlighting it as one of the top three needs, only slightly behind employment and livelihoods. Significant variations exist across countries: health care was the priority need for respondents in Bulgaria (53%) and the Republic of Moldova (52%) while it was not a top three priority in Czech Republic and Hungary, indicating potentially different levels of access to health services across the region. No difference was found in the prioritization of needs for health care between female and male headed households. Importantly, 51% of households with persons with a disability indicated access to health services as one of their top three priority needs compared to 24% of households without a member with a disability.

Access to health services

Access to health services has improved over time as refugees became more familiar with host countries' health systems and health regulations were adjusted to expand entitlements in some

TOP 3 PRIORITY NEEDS

Top 1 | Top 2 | Top 3 priority

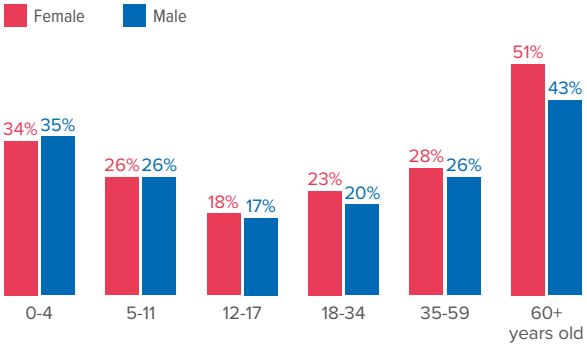
	Regional	Bulgaria	Czechia	Hungary	Moldova	Poland	Romania	Slovakia
Employment & livelihoods	35%		36%			38%		30%
Healthcare services	34%	53%			52%	32%	38%	44%
Accommodation	29%	31%	34%	49%		28%	46%	
Food		45%		41%	34%		34%	
Language courses			32%	34%				25%
Winter clothes					30%			

(N=9,418)

cases. For example, as of 1 September 2023 the Slovak government decided Ukrainian refugees benefiting from Temporary Protection in Slovakia would be eligible for essential health care coverage nearly identical to that available to Slovak citizens.

From the regional MSNA data, 28% of all household members required access to health care in the 30 days prior to the survey, with minor variations across countries. More female respondents reported a higher need to access health services relative to male respondents. This is particularly the case for women between the ages of 18 and 34 and women over the age of 60, of whom 23% and 51% reported such a need compared to 20% of men between the ages of 18 and 34 and 43% of men over the age of 60.

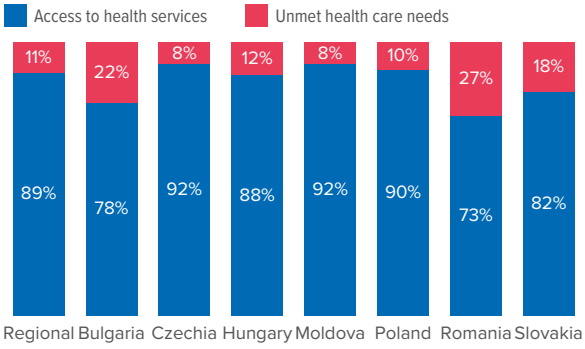
NEED TO ACCESS TO HEALTH SERVICES BY AGE AND GENDER



(N=26,749)

Of those who required health care, 89% were able to access health services without problems while 11% reported an unmet health care need. Significant differences remain between countries with the least access constraints being reported in Czech Republic and the Republic of Moldova (8%) compared to 22% in Bulgaria and 27% in Romania. With the exception of the Republic of Moldova, these findings broadly align with the findings for health care as a priority need identified by the respondents in the previous section.

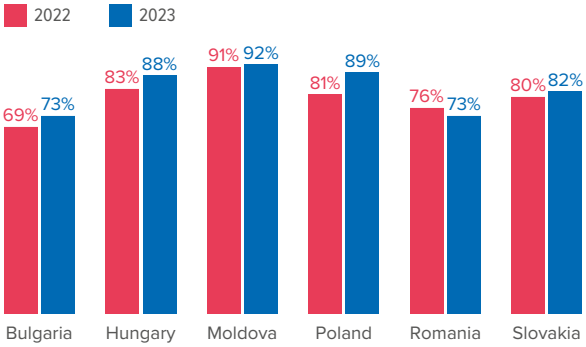
% OF INDIVIDUALS WITH ACCESS TO HEALTH SERVICES



(N=7,395)

Comparing data from 2022 and 2023, access to health care services has remained constant or improved in all countries, with the exception of Romania where access reduced slightly.

% OF INDIVIDUALS WITH ACCESS TO HEALTH SERVICES 2022-2023



(2023 N=7,395)

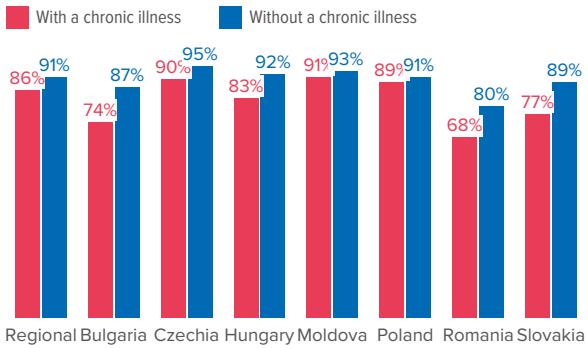
For the 11% of individuals who experienced difficulties in accessing health services, the type of barriers varied significantly between countries. Key barriers within the region included the inability to make an appointment (38%), language barriers (27%), and lack of knowledge on how to access health services (19%). Barriers differed for men and women, 41% of female respondents reported that they faced barriers to accessing health services as they were unable to make their appointment, while this was identified as a barrier by 32% of male respondents.

Additional barriers were reported at the country level including financial barriers, lack of insurance coverage, and transportation challenges. This is

reflective of specific country regulations with regards to access to health services, while TP holders are entitled to access essential services as a minimum, co-payments may be applicable for e.g. specialized services or medication. A unique barrier mentioned in the Republic of Moldova was the unavailability of specific medication or treatment, indicating difficulties refugees face in accessing the same kind of care they received in Ukraine. No differences in access to health services were found between men and women or between those living in urban and rural areas.

Persons with a chronic disease had significantly higher unmet health needs than those without a chronic disease (14% vs. 9%, p<0.01). Differences in unmet health needs for those with chronic diseases were statistically significant for all countries except the Republic of Moldova.

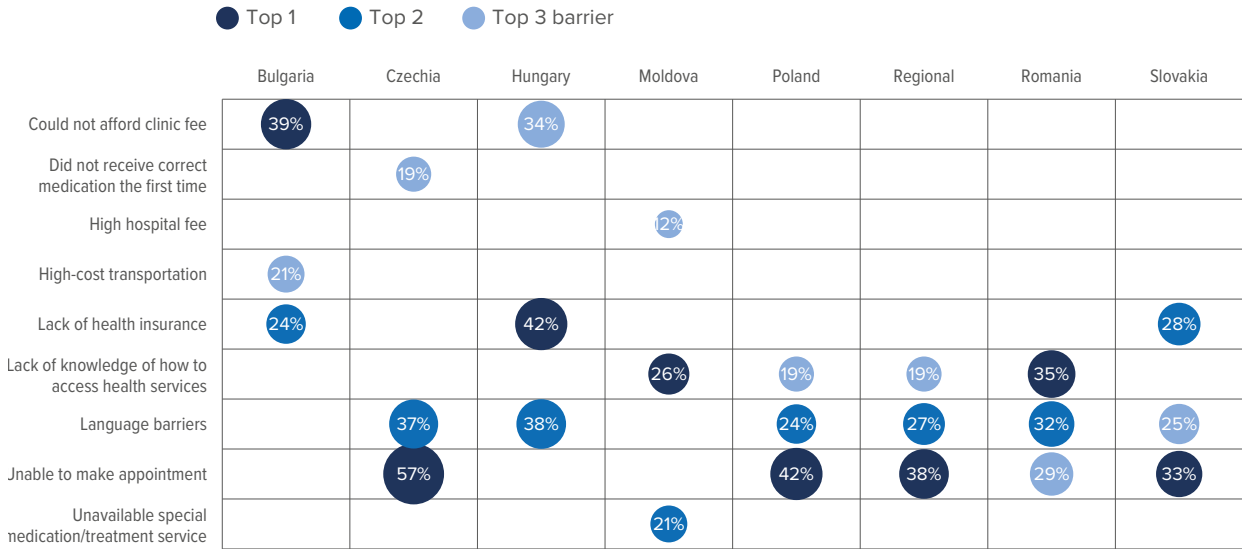
% OF INDIVIDUALS WITH A CHRONIC ILLNESS THAT ARE ABLE TO ACCESS TO HEALTH CARE



(N=7,319)

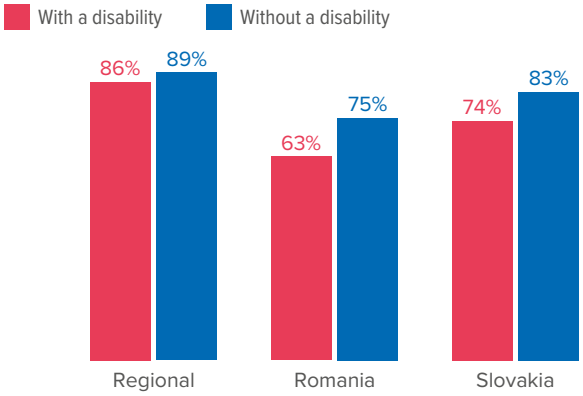
Persons with disabilities faced significantly more barriers in accessing health services in Romania (37% vs. 25% of persons without a disability, p<0.01) and Slovakia (26% vs. 17%, p<0.06); no difference was found in the remaining countries.

SELF-REPORTED BARRIERS TO ACCESSING HEALTH CARE AMONG THOSE WITH UNMET HEALTH NEEDS



(N=427)

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



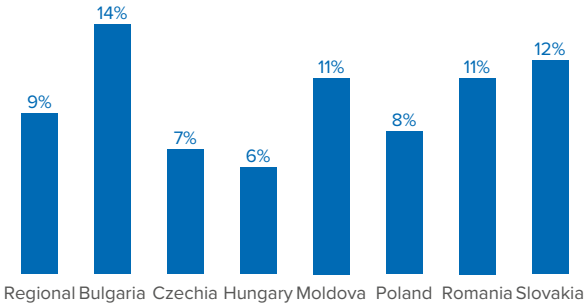
(N=7,395)

While access to health care is overall ensured for the majority of respondents according to the survey, it does remain a reason for refugees to return for short-term visits to Ukraine. The Regional Intentions Report #5[5] found that 50% of refugees returned to Ukraine for short-term visits and access to health care was reported as the second-most frequent motivation (33%).

Health expenditures

Health expenditures amounted on average to 9% of all household expenditures in the 30 days preceding the survey, with no difference found between female and male headed households. Expenditures were highest in Bulgaria, Slovakia and the Republic of Moldova, aligned to the countries where health was identified as a priority need by respondents.

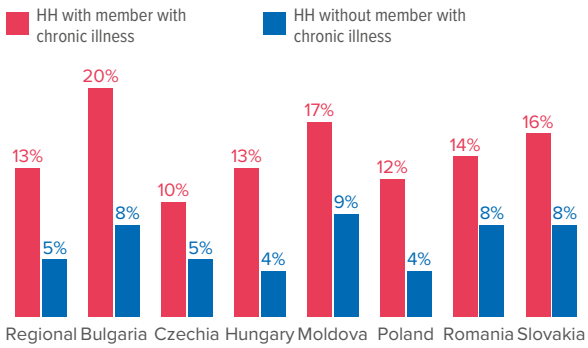
AVERAGE SHARE OF HOUSEHOLDS' EXPENDITURE ALLOCATED TO HEALTH



(N=7,574)

Households where a member reported a disability had significantly higher health care expenditures than other households (15% vs. 8%). Similarly, households where at least one member had a chronic illness had significantly higher health care expenditures. The average share of health expenditure for households without chronically ill members was 5%, whereas the average share of health expenditure for households with chronically ill members was 13%.

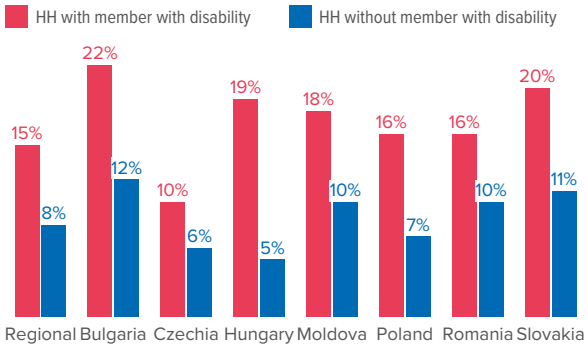
AVERAGE PERCENTAGE OF HEALTH EXPENDITURE OF HOUSEHOLDS WITH MEMBERS WITH CHRONIC ILLNESS



(N=7,539)

5 Regional Intentions Report #5; Lives on Hold: Intentions and perceptions of refugees, refugee returnees and IDPs from Ukraine. UNHCR; February 2024. https://data.unhcr.org/en/documents/details/106738

AVERAGE PERCENTAGE OF HEALTH EXPENDITURE OF HOUSEHOLDS WITH MEMBERS WITH DISABILITY



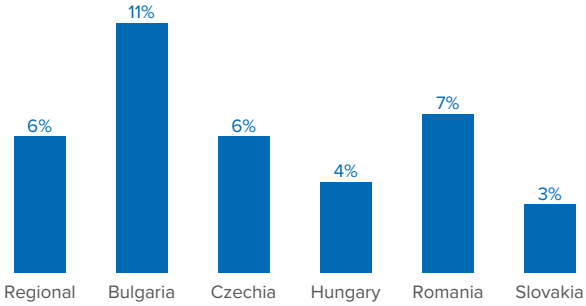
(N=7,574)

Households used a variety of coping strategies when resources were insufficient to meet their daily needs. 13% of households reduced expenditures in health in the past 7 days where resources were insufficient to meet all needs, ranging from 6% in Czech Republic and Hungary to 22% in Bulgaria and 32% in Romania.

Access to sexual and reproductive health and gender-based violence health services

The survey explored barriers in accessing sexual and reproductive health services, that varied significantly between countries. Regionally 6% of households reported that at least one woman in the household faced access constraints, ranging from 3% of households reporting barriers in Slovakia to 11% in Bulgaria. The regional data, however, need to be interpreted with caution as the indicator was not collected in Poland and the Republic of Moldova. The exact barriers that women experienced need to be further explored, as well as the general challenges (e.g. language, insurance, etc.) and sensitivities around reproductive health in particular (e.g. family planning, access to post-abortion care) that could play a significant role as suggested in other reports.[6]

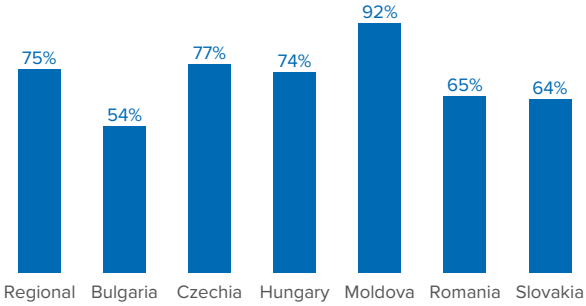
% OF HOUSEHOLDS WITH AT LEAST ONE WOMAN THAT SELF-REPORTED BARRIERS TO ACCESSING SEXUAL AND REPRODUCTIVE HEALTH



(N=3,877)

Regionally, 75% of the respondents knew how to access gender-based violence related health services. Findings differed significantly between countries, indicating different levels of awareness and potential different levels of access to these critical services.

% OF RESPONDENTS WHO KNOW HOW TO ACCESS GBV-RELATED HEALTH SERVICES



(N=5,779)

Child health, vaccination, and nutrition

Prevalence of Infant and Young Child Breastfeeding Practices Indicators (excluding Poland and the Republic of Moldova)

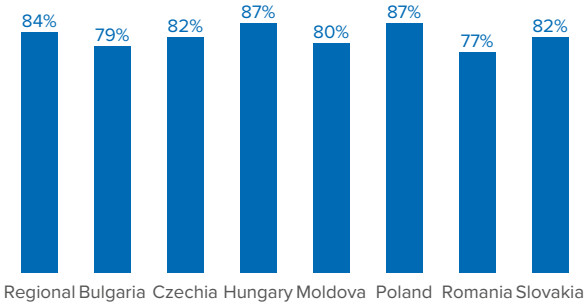
6 Care in Crisis: Failures to guarantee the sexual and reproductive health and rights of refugees from Ukraine in Hungary, Poland, Romania and Slovakia. Center for Reproductive Rights; May 2023. https://reproductiverights.org/ukraine-report-care-in-crisis/

INDICATOR	AGE RANGE	NUMBER/ TOTAL	PREVA-LENCE (%)	95% CI
Timely initiation of breastfeeding	0-23 months	120/189	64.3%	(56.2-71.5)
Exclusive breastfeeding under 6 months	0-5 months	16/46	27.7%	(15.9-43.7)

Infant and young child feeding and breastfeeding practices directly affect the nutritional status of children under two years of age and, ultimately, influence child survival. Protecting, and improving on, appropriate infant and young child feeding practices in children aged 0-23 months is therefore critical to improved nutrition, health, and development of children.[7] From the MSNA results, the proportion of children 0-23 months who had timely initiation of breastfeeding was 64% and the rate of exclusive breastfeeding for the first six months of life was 28% in the region (excluding Poland and the Republic of Moldova). This is below the UNHCR targets of ≥85% and ≥75% respectively and WHO and UNICEF's global target of 70% for exclusive breastfeeding under 6 months.[8] These findings provide a general idea of the status of infant and young feeding practices among the surveyed population, but due to the small sample size especially for breastfeeding and wide confidence intervals data should be interpreted with caution.

The survey assessed the measles vaccination coverage in children aged 9 months to 5 years. In average, 84% of children received at least one measles vaccine, with children in Romania having the lowest measles coverage (77%) compared to the highest coverage in Hungary and Poland (87%). In comparison, measles vaccination coverage within Ukraine was reported as 74% for the first dose of measles vaccine and 69% for second dose.[9] Data need to be interpreted with caution as they rely on recall and were not verified against individual vaccination records.

% OF CHILDREN (9MO-5YEARS) WHO HAVE RECEIVED MEASLES VACCINATION



(N=1,539)

Mental Health and Psychosocial Support

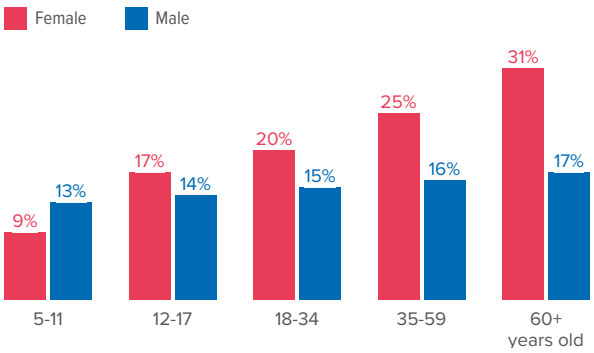
Prevalence of mental health and psychosocial problems

Regionally, 19% of individuals reported experiencing mental health and psychosocial problems that affect their daily functioning, with 30% of households reporting at least one member affected. This prevalence rate is consistent with the findings of a global systematic review and meta-analysis conducted by WHO, which estimates that one in five conflict-affected individuals (22.1%) have a mental health condition[10]. Country-level analyses revealed that the prevalence of mental health and psychosocial problems ranged between 12% (Hungary) and 39% (Romania) of households having at least one member experiencing mental health or psychosocial problems. Due to the stigma associated with disclosing mental health problems

7 WHO Indicators for Assessing Infant and Young Child Feeding Practices. WHO; 2010.
8 Global breastfeeding scorecard 2023. UNICEF and WHO; 2023. Global breastfeeding scorecard 2023.pdf (unicef.org)
9 See https://immunizationdata.who.int/pages/profiles/ukr.html (accessed 29 February 2024).
10 New WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis (thelancet.com)

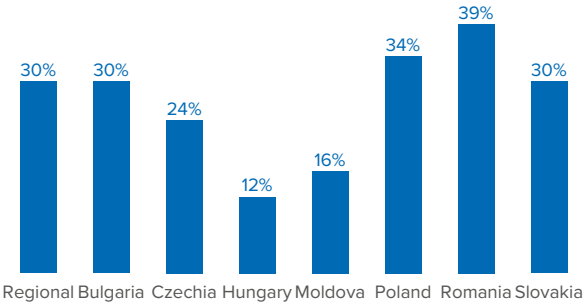
within the Ukrainian community the actual percentage of individuals and households with mental health and psychosocial problems could be higher than reported. Regionally, mental health and psychosocial problems increased with age and differed by gender. Across all age groups over 12, females consistently reported higher levels of such problems, with the largest disparity among those aged 35 and older. However, among children under age 11, there were more boys with mental health problems than girls.

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



(N=25,157)

% OF HOUSEHOLDS WITH AT LEAST ONE MEMBER EXPERIENCING MENTAL HEALTH OR PSYCHOSOCIAL PROBLEMS

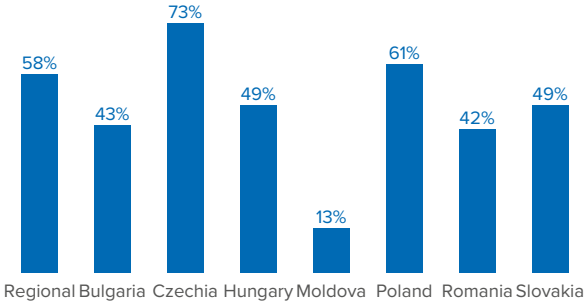


(N=11,277)

Need for Mental Health and Psychosocial Support services

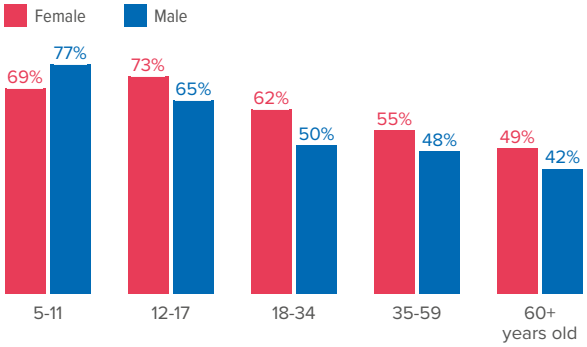
Among the 19% of individual household members reported to have mental health or psychosocial problems affecting daily functioning (such as ability to get out of bed, caring for self or others, or doing daily activities such as cooking), 58% were identified by the main respondent as needing support services. This means that 42% of individuals experiencing such problems did not subsequently report needing support, which may be due to multiple factors, including stigma or other access barriers.

% OF INDIVIDUALS WHO REPORT EXPERIENCING MENTAL HEALTH PROBLEMS AND EXPRESSED A NEED FOR SUPPORT



(N=4,461)

NEED MENTAL HEALTH SUPPORT BY AGE AND GENDER



(N=4,461)

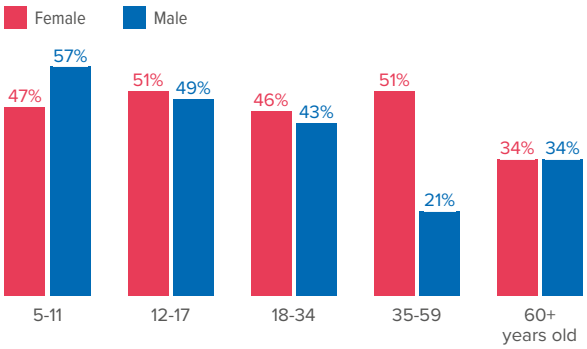
Access to Mental Health and Psychosocial Support services

Of the 58% of individuals who were identified as needing support, 45% reported successfully accessing and receiving MHPSS services. While a considerable portion of individuals who expressed a need for support were able to receive such services, more than half of individuals did not. This

indicates a need to improve access to services. Gender disparity in receiving support is evident, particularly among individuals aged 35-59, where 51% of women but only 21% of men reported receiving assistance. In contrast, among children aged 5-11, 57% of boys and 47% of girls received support. This discrepancy may suggest the presence of social and cultural stigma hindering access to MHPSS among adult men, necessitating further investigation.

Regarding types of services received, most participants reported receiving psychotherapy/ counseling services (71%), with smaller numbers participating in group or individual supports using a structured intervention designed to improve well-being (26%), creative activities with MHPSS components (18%), psychiatry/medication management (17%), and training for caregivers in how to support children in distress (2%).

WANTED AND RECEIVED MENTAL HEALTH SUPPORT BY AGE AND GENDER

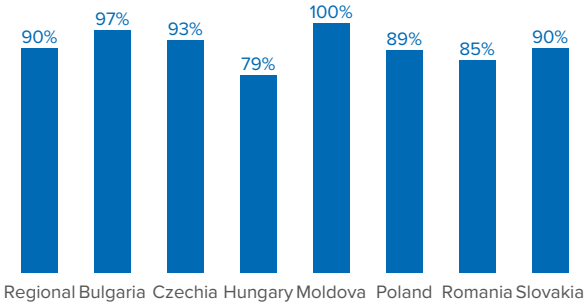


(N=2,339)

Outcomes of Mental Health and Psychosocial Support services

Among those who accessed MHPSS services, 90% self-reported an improvement in well-being. This encouraging result indicates that in most cases, MHPSS services are perceived as effective in addressing mental health and psychosocial needs, ultimately leading to positive outcomes and improved overall well-being.

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



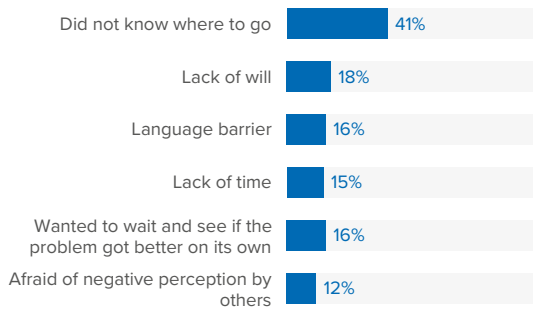
(N=992)

Barriers to accessing Mental Health and Psychosocial Support services

The most common reported barrier to accessing MHPSS services was not knowing where to go (41%), which was slightly more common among females (42%) than males (39%). Results suggest that lack of awareness about available resources is a primary barrier across the region, with language barriers posing additional challenges in certain countries. Financial constraints were also reported in some settings, while others cited time constraints as the primary barrier. Some respondents reported lacking the will to pursue support, which was more prevalent among males (22%) than females (16%), possibly indicating stigma among male refugees. Similarly, a notable percentage of respondents adopted a “wait-and-see” approach.

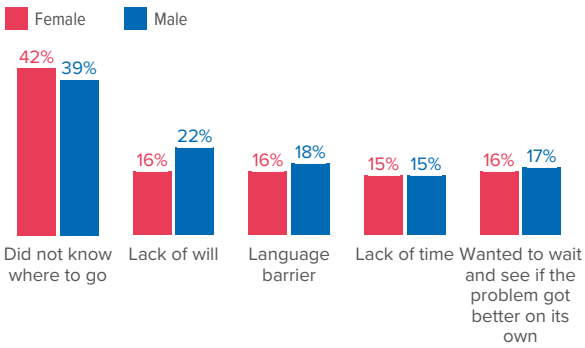
Notably, 12% of individuals also reported that they are afraid of the negative perception of others as a barrier to help seeking. Prioritizing community-based approaches can provide a less stigmatizing alternative to traditional psychological support, thus fostering a more supportive mental health and well-being environment. Addressing this and other barriers requires tailored interventions to improve awareness, reduce stigma and increase confidence in services, enhance linguistic accessibility, and address logistical constraints, ultimately improving access to MHPSS services.

SELF-REPORTED BARRIERS TO ACCESSING MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT SERVICES AT REGIONAL LEVEL



(N=1,286)

SELF-REPORTED BARRIERS TO ACCESSING MENTAL HEALTH SERVICES BY GENDER AT REGIONAL LEVEL

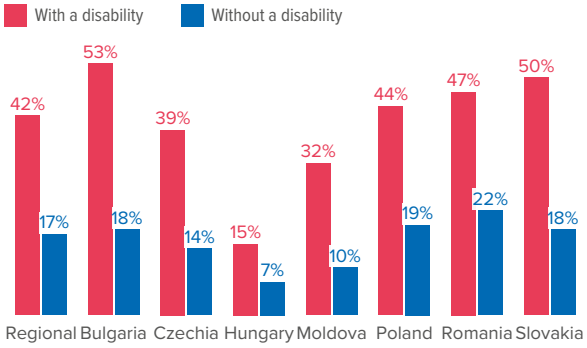


(N=1,286)

Disability and MHPSS

MHPSS problems were more prevalent among individuals with disabilities (42% experienced MHPSS problems) compared to those without disabilities (17% experienced MHPSS problems). This suggests that disability, which includes difficulties seeing, hearing, with mobility, remembering or concentrating, and in self-care, is a key factor for consideration in the context of mental health and psychosocial support needs. When interpreting these results, one should note overlap among constructs, such that in some cases MHPSS problems may entail difficulties with remembering or concentrating and/or with self-care and may themselves constitute disability. Still, diverse forms of disability may increase vulnerability to mental health and psychosocial problems, highlighting the need for ensuring inclusion of individuals with disabilities in MHPSS activities and for targeted interventions for individuals with disabilities to address needs effectively.

% OF INDIVIDUALS WHO REPORTED EXPERIENCING A MHPSS PROBLEM

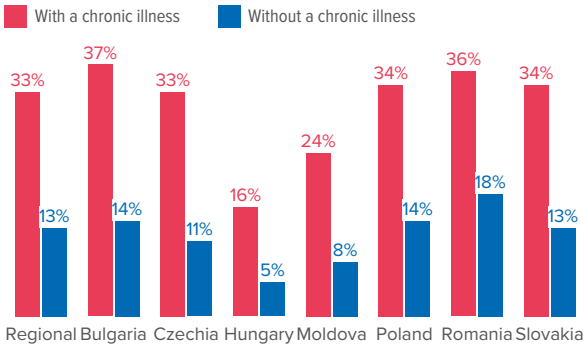


(N=25,157)

Chronic illness and MHPSS

Among individuals with chronic illnesses, 33% reported experiencing mental health and psychosocial problems, whereas only 13% of those without chronic illnesses did so. Results highlight that chronic health conditions and mental health needs are likely to co-exist and underscore the importance of integrated health care approaches that address both physical and psychological needs to ensure comprehensive and effective support for individuals managing chronic illnesses.

% OF INDIVIDUALS WHO REPORTED EXPERIENCING A MHPSS PROBLEM

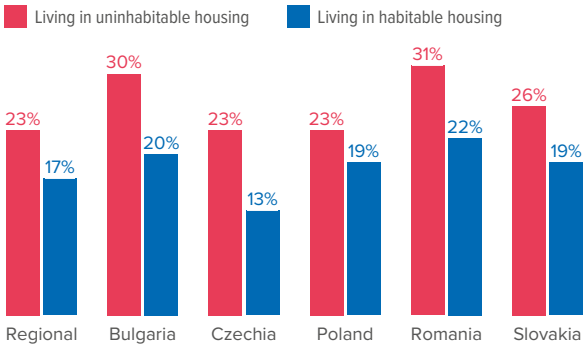


(N=24,954)

Housing and MHPSS

Analyses revealed an association between MHPSS needs and housing conditions, such that 22% of individuals living in housing deemed uninhabitable reported experiencing mental health problems, while only 17% of those residing in habitable housing did so. While this does not conclusively indicate a causal relationship, the association between the two does serve to underscore that access to habitable and safe housing may be an important factor in promoting well-being. Initiatives to improve housing standards and provide adequate living conditions and other basic needs may help mitigate the risk of mental health issues. It is important to note that pre-existing mental health difficulties may also impede the ability of individuals and families to advocate for and seek access to habitable housing. Tailored support for these individuals may help to ensure that access to housing is as equitable as possible.

REPORTED MHPSS PROBLEMS VS. HOUSING CONDITIONS

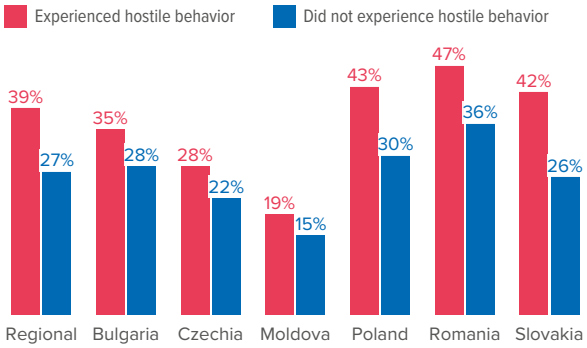


(N=24,905)

Social cohesion and MHPSS

A notable association was found between perceived hostility and mental health challenges. Those who reported experiencing hostile behaviour or attitudes from members of the host population were more likely to report mental health and psychosocial problems (39%) than those who did not report experiencing hostile behaviour (27%). Perceived hostility may increase vulnerability to distress, and at the same time, those with mental health problems may be targeted with greater hostility and/or perceive their environments as more hostile. Prevalence of mental health problems when environments are perceived as hostile varies by countries, with countries like Bulgaria reporting lower rates of mental health problems compared to Poland and Czech Republic. Regardless, the overall relationship between perceived hostility and mental health problems was consistent across the region, highlighting the importance of addressing social cohesion and mental health concerns in tandem through integrated intervention strategies.

REPORTED MHPSS PROBLEMS VS. PERCEIVED HOSTILITY



(N=10,932)

Recommendations

Refugees have been supported by host countries and communities to access the health services they need. While the majority of those interviewed reported adequate access to health services, barriers to accessing health care persist for some. The following recommendations outline priorities and actions that governments and health partners can take to address refugees' health needs and improve their access to care in refugee-hosting countries.

All actions are intended to support governments and local communities to strengthen health systems in areas impacted by refugee influx and foster inclusion of refugees in national systems where not yet fully achieved. This will require an increased need for long-term planning as well as sustained funding.

Address the barriers outlined in the MSNA, tailored to country-level data and context, including through enhanced risk communication and community engagement to overcome persisting barriers related to language and understanding of the health system and entitlements, including through cultural mediators. This should be combined with training of health workers on governmental health provisions and regulations for refugees along with other approaches to address financial and administrative barriers.

Advocate with national health service providers to tailor health service provision to address specific needs and barriers related to **age, gender, and disability status**.

Address the unmet health needs of children including closing the immunization gaps of refugees and local populations including increasing awareness for routine immunization, addressing barriers and increasing access to vaccination services. Furthermore, upscale support to enable exclusive breastfeeding and address the needs of infants and young children who are not breastfed.

Upscale actions to ensure equitable access to health care for **persons with chronic diseases and disabilities** including through targeted interventions, risk communication and community engagement, and health financing mechanisms.

Upscale targeted MHPSS interventions across all layers of the IASC pyramid, tailoring support to address individual and population specific needs, including individuals with disabilities, chronic illnesses, and children and youth. Ensure these supports are adequately available across urban and rural settings.

Identify and address barriers to accessing MHPSS services, such as stigma, cultural norms, gender, limited availability of services, language, financial constraints, and lack of awareness about available support. Develop campaigns and educational initiatives to raise awareness and reduce stigma around mental health to encourage open dialogue and help-seeking behaviors within communities.

Recognize and consider the impact of surrounding conditions, including housing and social cohesion, on mental health and psychosocial well-being. Advocate to improve living and social conditions for the prevention and mitigation of mental health problems and enhancing overall well-being. Facilitate and encourage positive encounters between refugee and host communities to support social connection and improve relationships.

Enable regular sharing of knowledge, experiences, and best practices in providing health care and mental health and psychosocial support in refugee-receiving countries for cross-country learning and possible adaptation as well as cross-sectoral exchanges. Likewise, regular data exchange between service providers, government counterparts, and humanitarian coordinators needs to be strengthened to ensure better planning and early identification of gaps.

Conduct further research to understand the unmet needs and barriers to access to health, including sexual and reproductive health, and MHPSS services and how and whether they affect refugees and host communities differently. Additional research is also required to more fully understand how health needs, access, and barriers differ by country context, gender, and age groups.

NAVIGATING HEALTH AND WELL-BEING CHALLENGES FOR REFUGEES FROM UKRAINE

An inter-agency exploration of health and MHPSS data

May 2024

Regional Refugee Response for the Ukraine Situation