World Health Organization

European Region

Continuity of essential health services during the war in Ukraine

Assessment results

2022–2023

Contents

Acknowledgements

This factsheet was prepared in the context of the Biennial Collaborative Agreement between the Ministry of Health of Ukraine and the WHO Regional Office for Europe. Technical support was received from the Integrated Health Services Unit, Universal Health Coverage/Life Course Division, WHO headquarters. The Ministry of Health of Ukraine carried out the overall coordination of the assessment and the National Health Service of Ukraine supported sample development and the data collection process.

Jarno Habicht, WHO Representative in Ukraine and Head of the WHO Country Office in Ukraine, was the conceptual and technical lead. The factsheet was produced by Julia Novak, Denys Dmytriiev and Tomas Roubal from the WHO Country Office in Ukraine. The team owes a debt of gratitude to those who provided technical contributions: Antoni Dedeu, WHO European Centre for Primary Health Care; Óscar Brito Fernandes, Niek Klazinga and Dionne Kringos, experts from the WHO Collaborating Centre for Quality and Equity in Primary Health Care Systems, Amsterdam University Medical Centres, Netherlands (Kingdom of the); Maria Yashchenko and Roman Bystrov, WHO Country Office in Ukraine, who supported the data analysis; and Olga Melnychuk, Mariia Shylo and Inna Volosevych, experts from Info Sapiens, Ukraine who collected the data.

This work was made possible thanks to a financial contribution from the Government of Canada. It contents are the sole responsibility of WHO and do not necessarily reflect the views of the Government of Canada.

Abbreviations

CBRN	chemical, biological, radiological and nuclear
COVID-19	coronavirus disease 2019
IDPs	internally displaced persons
PPE	personal protective equipment
NCD	noncommunicable diseases
NHSU	National Health Service of Ukraine
PHC	primary health care
STI	sexually transmitted infection

Definitions of Terms

By type of facility	Primary health care (PHC) centre	PHC facilities (primary care centre/clinic, family doctor)
	Specialized facility	Secondary health care facilities (curative-diagnostics centres, city policlinics, district policlinics, outpatient clinics, paramedic and midwifery centres, medical centres and hospitals – city and district) that apart from specialized care provide PHC services
By managing authority	Non-public	Non-public facilities (private for profit, independent private practices)
	Public	Public facilities (communal non-commercial enterprises)
By type of location	Urban	Health-care facilities from urban locations
	Rural	Health-care facilities from rural locations
By type of territory	Government-controlled	Health-care facilities located in the territories that were constantly under the control of the Government of Ukraine during the full-scale war.
	Regained	Health-care facilities located in currently Government-controlled territories that had been temporarily occupied by the Russian Federation since 24 February 2022

Introduction

Ukraine's primary health care (PHC) system has been under strain since the onset of the COVID-19 pandemic and has been yet further stressed, and recovery undermined, by the full-scale invasion of the Russian Federation since 24 February 2022. The war has brought further challenges for access to health care and significantly changed the health needs of the population and continuum of care.

To assess the impact of both these emergencies on the PHC system and on the continuity of essential health services, three rounds of surveys using the WHO Continuity of Essential Health Services Facility assessment tool[1] have been conducted: two of them in 2021 (assessing the impact of COVID-19) and the third one in early 2023 – capturing the impact, and marking one year, of the war in Ukraine (24 February 2022 – February 2023).

This factsheet outlines the key results from the latest survey, touching on the published results of the earlier surveys[2] as points of comparison. The findings can be used to inform the government of Ukraine and other relevant stakeholders on the impact of the war on essential health services to enable adaptations towards a more resilient PHC system and to contribute to the progress towards universal health coverage goals.

[1] Continuity of essential health services: facility assessment tool: a module from the suite of health service capacity assessments in the context of the COVID-19 pandemic: interim guidance 20 October 2020. Geneva: World Health Organization; 2020 (https://iris.who.int/handle/10665/336254, access date 29 September 2023).

[2] Continuity of essential health services in Ukraine during the COVID-19 pandemic: key findings from two surveys conducted in April and November 2021. Copenhagen: WHO Regional Office for Europe; 2023 (https://www.who.int/europe/publications/i/item/WHO-EURO-2023-7242-47008-68690, access date 29 September 2023).

Methodological considerations

The WHO Continuity of Essential Health Services Facility assessment tool – part of a comprehensive set of health service capacity assessment tools – was designed to assess essential health service continuity while managing patients with coronavirus disease 2019 (COVID-19) but was adapted for the context of war.

This latest survey was sent to a representative sample of facility managers who oversee 1866 facilities providing PHC services (maximum theoretical sample error of 3.8%) and replicated the sample design used in the two earlier COVID-19 surveys: the sample was built based on the number of primary care physicians in each facility stratified by urban and rural areas, across macro-regions (centre, east, Kyiv, north, south and west), and proportional to the number of doctors in each stratum. The database of PHC facilities was provided by the National Health Service of Ukraine (NHSU).

The fieldwork was conducted by the Limited Liability Company “Info Sapiens” via computer-assisted telephone interviews.

A boost sample in facilities in rural settings was pursued to gather sufficient cases for analysis.

The response rate for this third survey was 27% and completion rate was 83%.

Results

Key data characteristics:

Overall 500 facilities were surveyed, with:

- 466 located in urban settings and 34 in rural settings
- 482 in government-controlled territories and 18 in regained territories
- 278 PHC centres and 140 specialized facilities
- 255 public and 245 non-public.

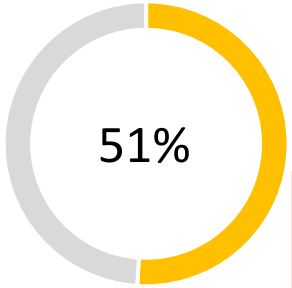
The results are composed of four sections:

1) Staffing
2) Financial Management
3) Service Delivery and Utilizations
4) Resilience in Emergency Situations

Staffing

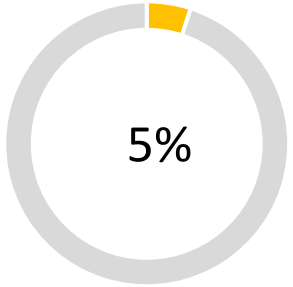
The impact of the war on staffing in health-care facilities

Staff either having **left or not shown up** since 24 February 2022



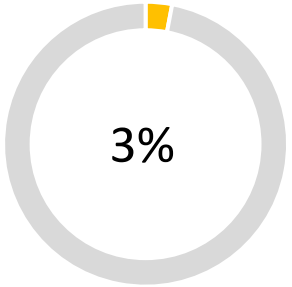
of all facilities

More often reported by public facilities (66%) than by non-public (34%)



of all staff in all facilities
(**2348** out of **43 106** staff)

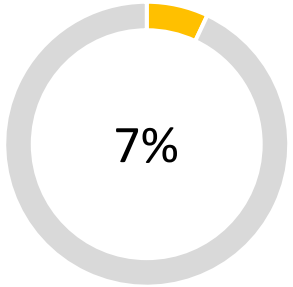
Staff **injured** because of the war



of all facilities

22 staff members have been injured.
In 12 facilities, one person in each, in 5 facilities, two people in each.

Mental health support requested for staff

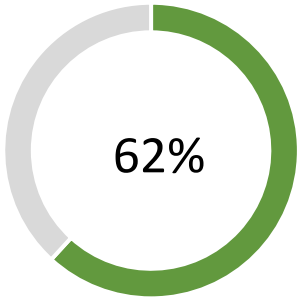


of all facilities

36% in regained territories
6% in government-controlled territories

1 facility (Zhytomyr Region, urban area, public sector) reported staff **dying** because of the war.

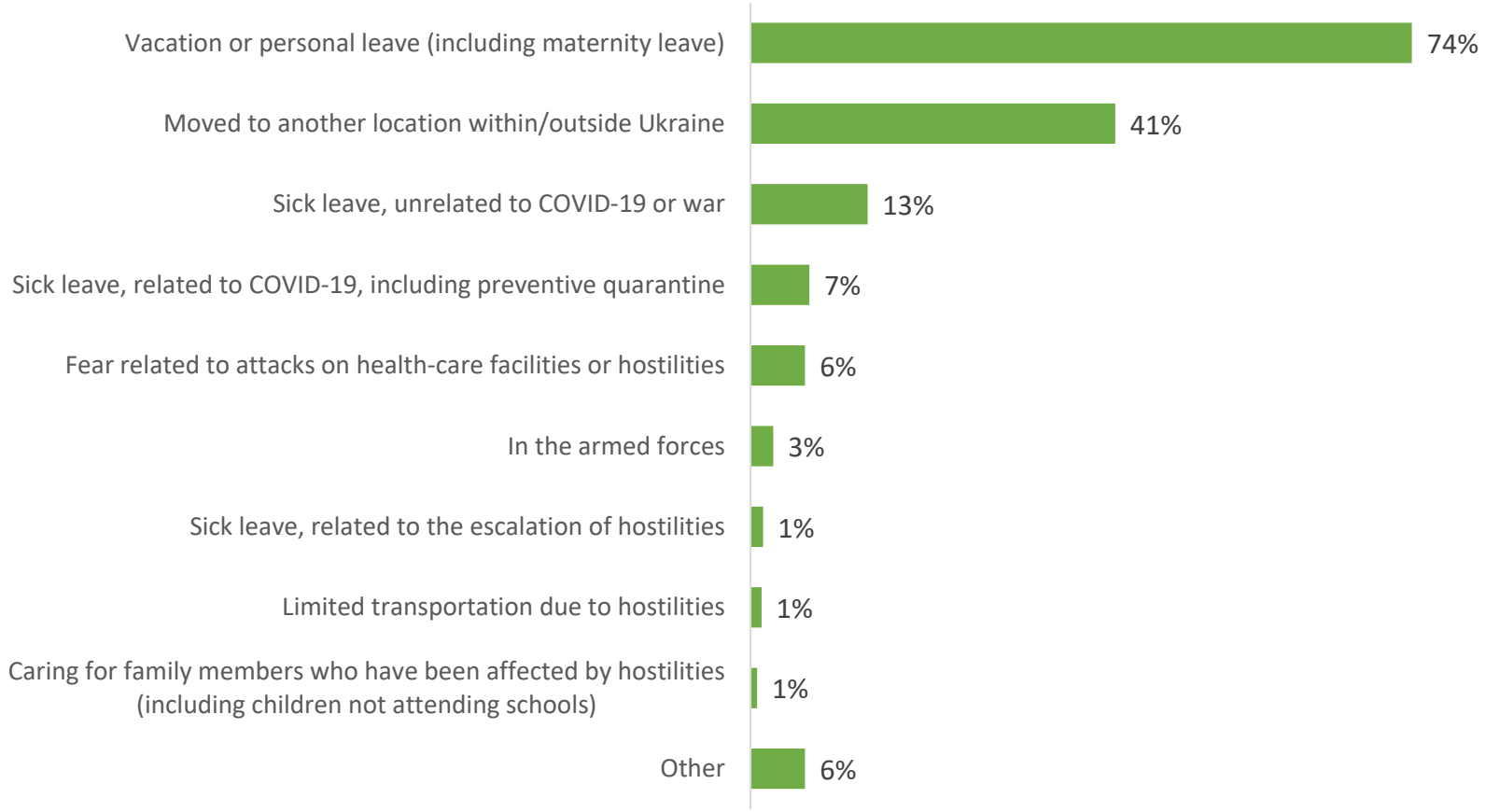
Leave or absence since/due to the escalation of hostilities



of all facilities reported **staff being on leave or absent** since/due to the escalation of hostilities, mostly in public facilities

In large facilities, health-care workers were able to take leave, whereas in small facilities workers were often unable to rest (76% versus 47% within non-public facilities)

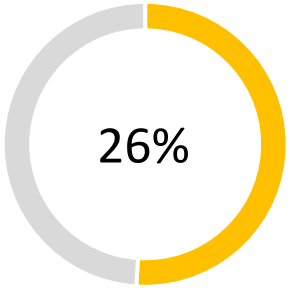
The main **reasons for staff leave or absence** were vacation or personal leave (relevant for three quarters of facilities), although 41% of facilities experienced personnel relocation related to the war*



*Among those who have had any staff on leave or absent at any time since/due to the escalation of hostilities

Changes in how health workers are being managed

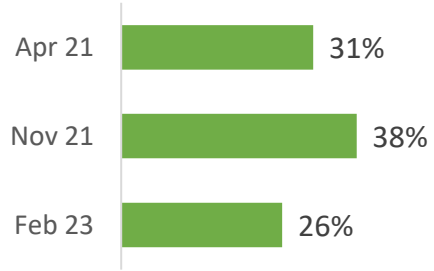
PHC facilities were able to quickly adapt in managing their workforce to population needs



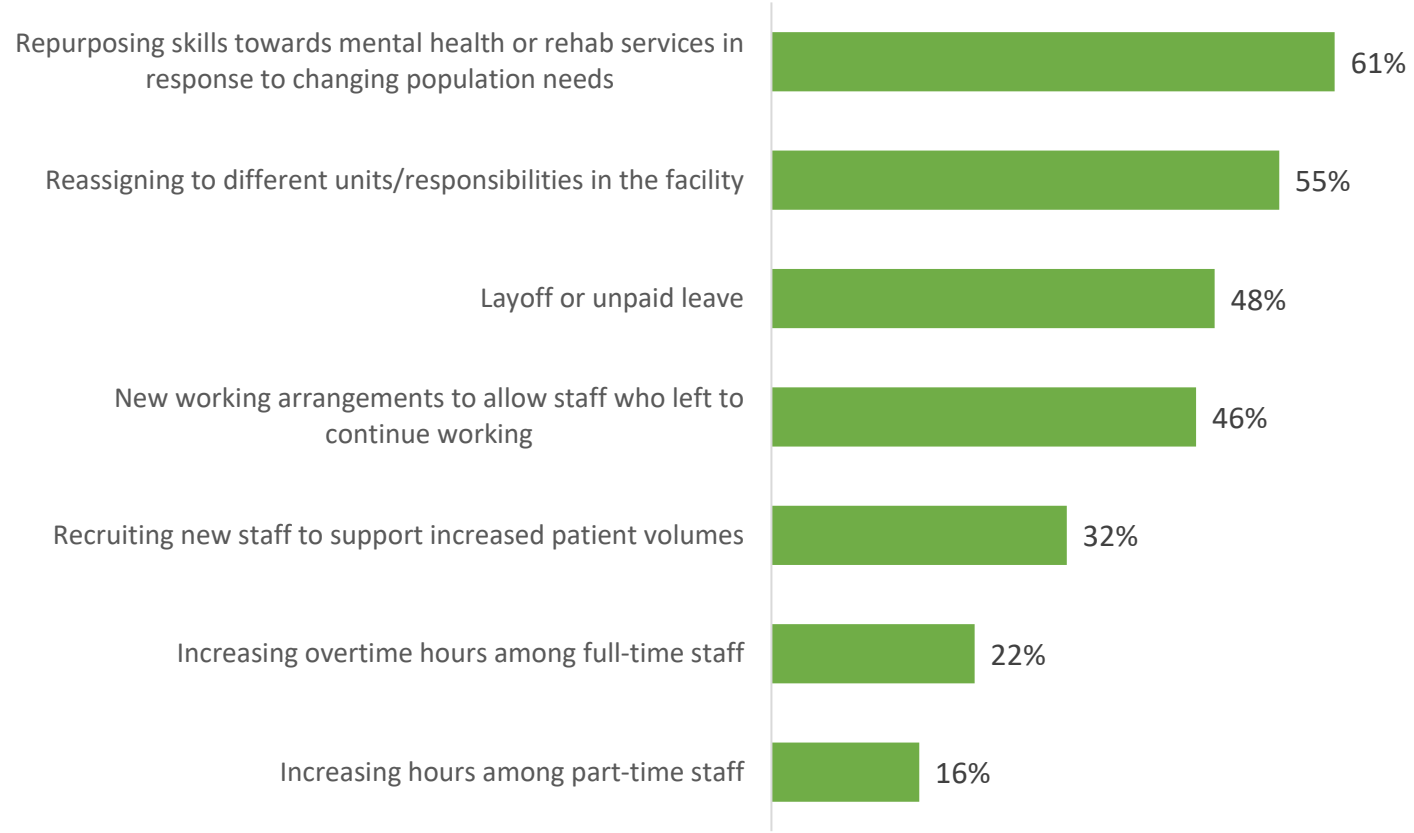
of all facilities had adapted human resources management since the escalation of hostilities because of changes in patient volume or patient needs related to the hostilities

Changes were more frequently reported by specialized than PHC facilities (37% versus 22%) and by public than non-public facilities (32% versus 19%)

In 2021, more facilities reported that human resources management had changed in the past 3 months (due to COVID-19) than those reporting changes due to the war



The main **changes** in managing health workers were related to 1) repurposing skills towards mental health or rehab services, and 2) reassigning to different units\responsibilities in the facility*



*Among those who made any changes to the way in which health workers are managed since the escalation of hostilities

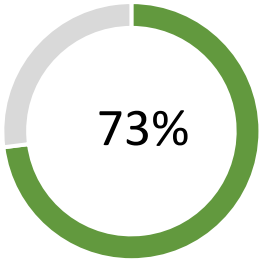
Changes in how health workers are being managed (contd.)

Layoff or unpaid leave was twice as likely to be the reason for staff leave/absence with public providers (compared to private). Specialized care providers reported increasing overtime hours among full-time staff three times as often as PHC workers .

	PHC centres	Specialized facilities	Non-public	Public
Repurposing skills towards mental health or rehab services in response to changing population needs	64%	63%	60%	62%
Reassigning to different units/responsibilities in the facility	44%	61%	66%	49%
Layoff or unpaid leave	42%	61%	27%	60%
New working arrangements to allow staff who left to continue working	44%	46%	56%	40%
Recruiting new staff to support increased patient volumes	17%	41%	47%	23%
Increasing overtime hours among full-time staff	11%	35%	23%	22%
Increasing hours among part-time staff	15%	15%	16%	16%

*Among those facilities who made any changes to the way in which health workers are managed since the escalation of hostilities

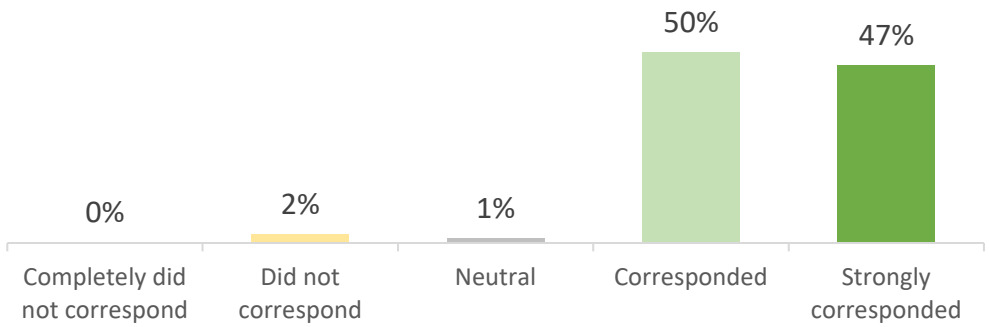
Training or support related to changed population needs



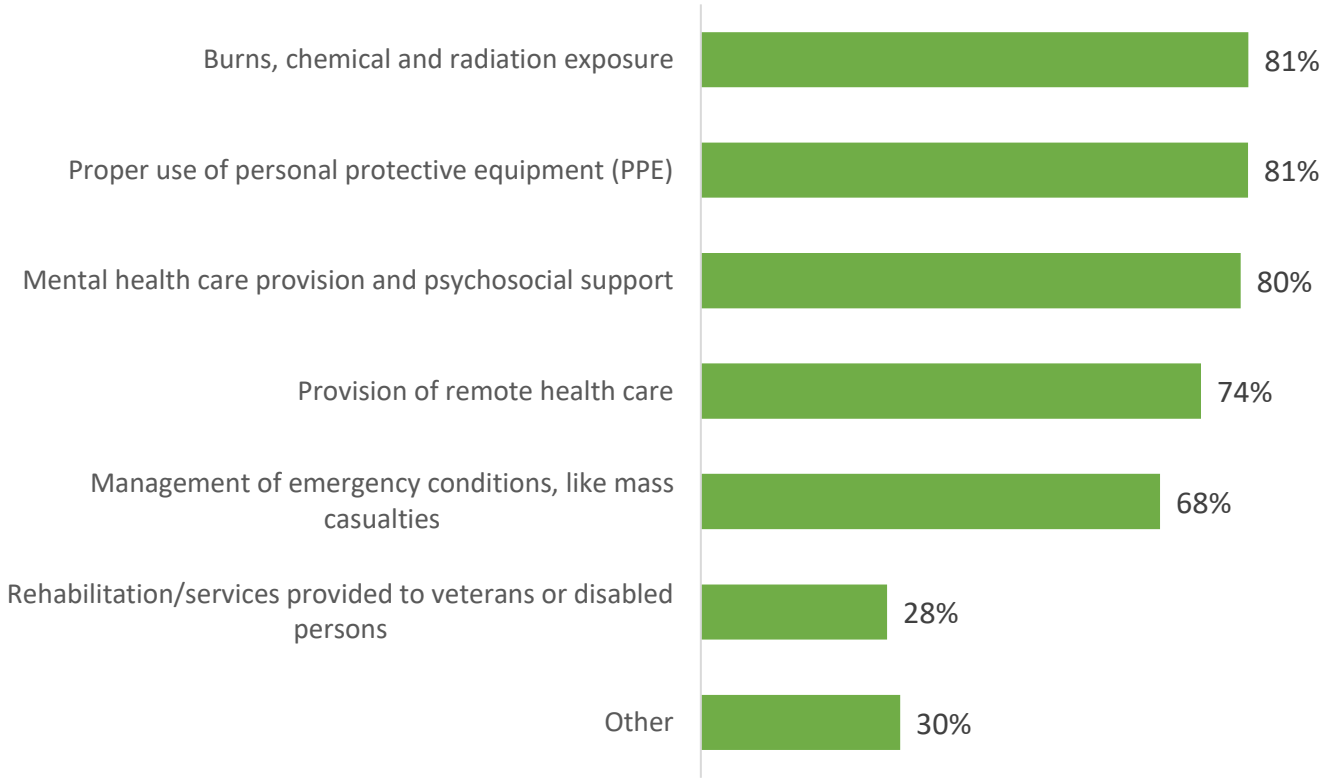
of all facilities engaged in further training of their staff to address changed population needs, especially in chemical, biological, radiological and nuclear (CBRN) exposure and mental health, with 47% of trainings strongly matching staff needs.

This further training was carried out in 79% of public versus 67% of non-public facilities

Trainings are highly **corresponded to staff needs***



The **topics of trainings** received*



There is still space for improvement, especially in private and smaller PHC facilities, and in the areas of mass casualty and rehabilitation

*Among those who received training or support related to changed population needs due to the war

Training or support related to changed population needs (contd.)

The **topics of trainings** received*

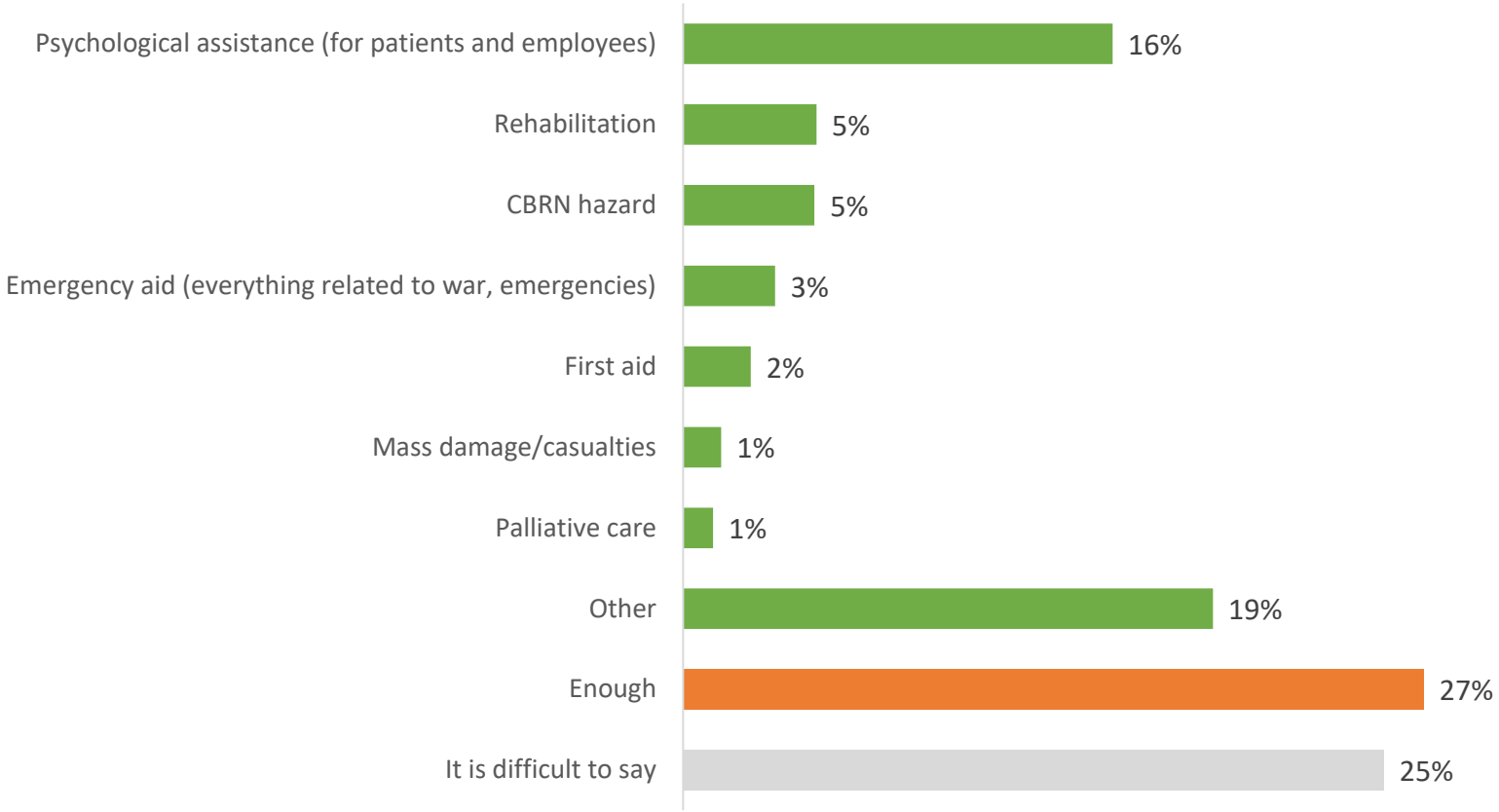
	PHC centres	Specialized facilities	Non-public	Public
Burns, chemical and radiation exposure	77%	86%	70%	91%
Proper use of PPE	81%	89%	69%	92%
Mental health care provision and psychosocial support	83%	81%	82%	79%
Provision of remote health care	79%	69%	75%	74%
Management of emergency conditions, like mass casualties	65%	72%	55%	79%
Rehabilitation/services provided to veterans or disabled	23%	41%	20%	34%

Public providers better cover trainings related to changed population needs, particularly on topics such as CBRN exposure, PPE, management emergency and rehabilitation.

* Among those who received training or support related to changed population needs due to the war

Training Needs

Staff required more training in mental health care in PHC centres and specialized facilities



PHC centres reported less need for training compared to specialized facilities (31% versus 14% answered “enough”)

* Among those who received training or support related to changed population needs due to the war

Financial management

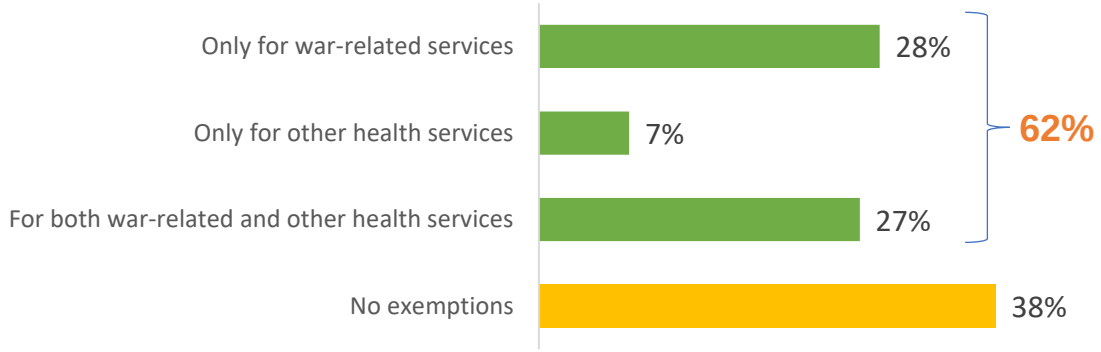
Changes in user fees

25% of all facilities **charge user fees**

Fees are charged more often in urban (26%) than in rural (12%) settings

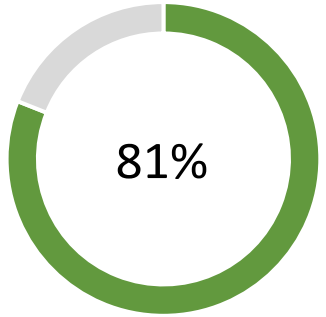
The share of facilities that charge fees has been growing since 2021 (up from 8% in April 2021 and 14% in November 2021*)*

62% **exempted user fees** for certain services since hostilities escalated*



Fees are more often exempted in non-public (73%) than in public facilities (47%)

During the COVID-19 pandemic, the share of facilities exempting fees was higher, with 86% in April 2021 and 82% in November 2021



of all facilities have exempted user fees **for certain vulnerable populations** (e.g. war veterans or active combatants) since the hostilities escalated*

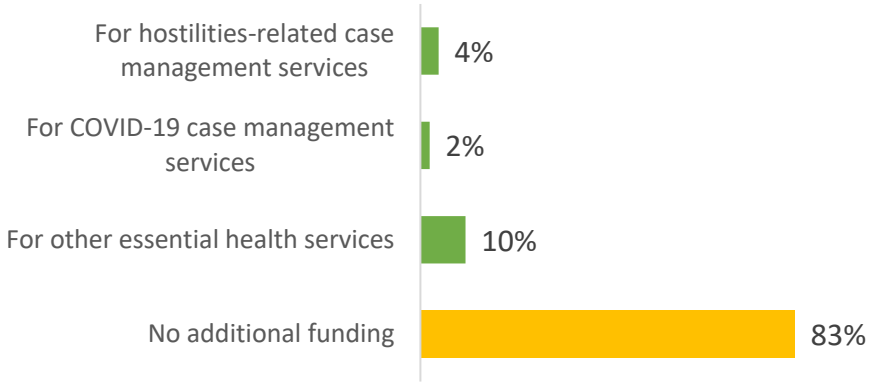
In November 2021, only 33% of facilities had exempted user fees for certain vulnerable populations over the previous 3 months

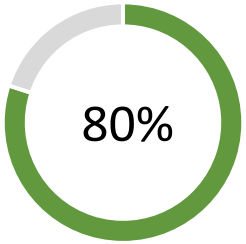
User fees are charged by 25% of PHC facilities of which half have increased prices since the war started. In most public PHC facilities charging user fees, some services are exempted; 81% of these facilities exempt some population groups from paying user fees. These are mainly facilities in urban areas.

*Among those who charge user fees

Additional funding

16% of all facilities (31% public versus 3% non-public) **received additional funding** to ensure the maintenance of essential health services during hostilities

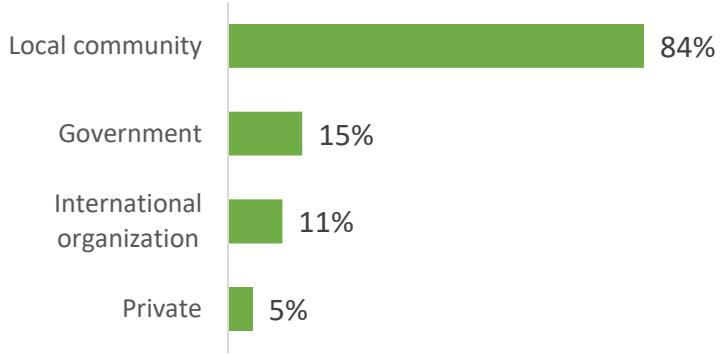




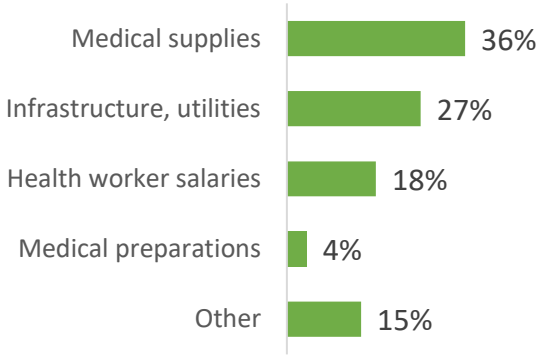
Considered additional funding **sufficient to address needs***

The share of those who received additional financing (for COVID-19 efforts) were higher before the war – 34% in April 2021 and 38% in November 2021

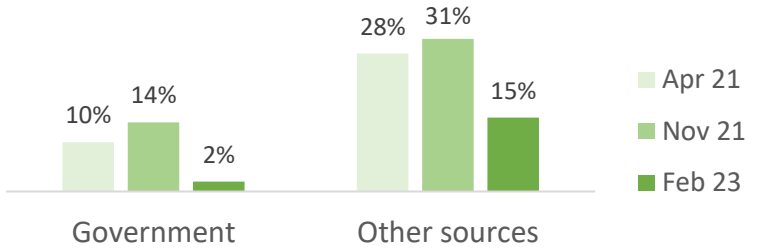
The main **source** of additional funding is from local communities*



Additional funding was mostly **requested for** medical supplies and infrastructure needs*



Among all facilities, the share of those who had received additional funding in the past year as of February 2022 from either the Government or other sources is lower than for COVID-19



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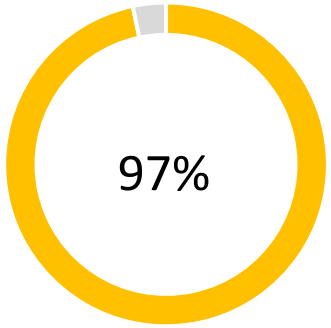
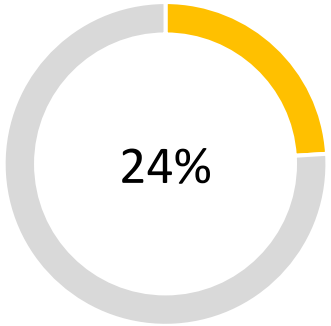
* Among those who received additional funding to ensure the maintenance of essential health services during the hostilities

Payment and overtime work

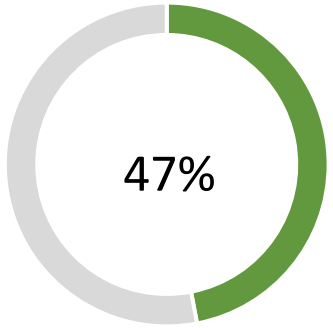


of personnel received their **salary on time**, in accordance with regular payment schedules, since hostilities escalated

For six facilities (35% of total with payment delays), a delay in salary payment was associated with issues with the NHSU



of all facilities had personnel who have worked **overtime** since hostilities escalated



of facilities paid all personnel who have worked overtime since hostilities escalated (**overtime payment**)*

Even during the war, PHC facilities have managed to continue paying salaries to health workers, with half of facilities paying for overtime whenever relevant.

*Among those who have personnel who have worked overtime since hostilities escalated

Service delivery and utilization

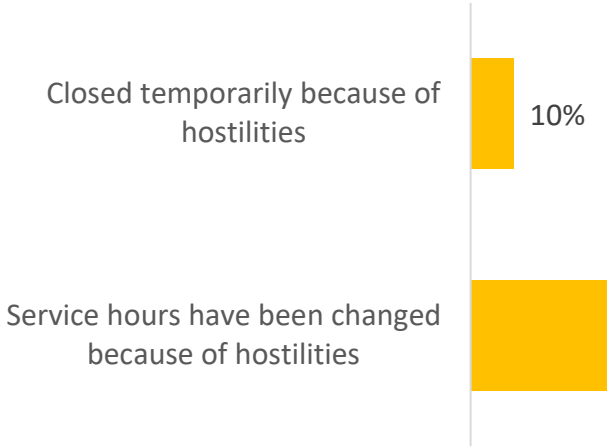
Changes in service delivery made by facilities since the start of the active hostilities

	PHC centres	Specialized facilities	Non-public	Public	Urban	Rural	Government-controlled	Regained
Provide electronic or tele-prescriptions	34%	36%	45%	42%	43%	51%	43%	61%
Shifted clinical encounters to digital platforms, e.g. teleconsultations	32%	36%	47%	36%	41%	43%	41%	61%
Doctor's consultations via phone	31%	36%	47%	35%	41%	43%	40%	55%
Extended prescriptions of medicines for long-term use	30%	27%	39%	36%	37%	44%	37%	49%
Treat patients not registered with the PHC facility/doctor	27%	25%	40%	31%	35%	38%	36%	8%
Use novel dispensing approaches for medicines	26%	24%	36%	32%	34%	37%	34%	39%
Provide all care in a single visit for multiple morbidities	25%	23%	38%	30%	34%	32%	35%	8%
Doctor's consultations via video link	25%	27%	40%	26%	33%	27%	33%	33%
Monitor patients through remote monitoring	26%	23%	38%	28%	33%	25%	33%	31%
Support self-care interventions wherever appropriate	24%	21%	34%	27%	30%	32%	31%	22%
Give priority to seeing high-risk patients	23%	21%	31%	27%	29%	31%	29%	25%
Nursing care by phone	24%	27%	28%	30%	28%	40%	28%	55%
Provide home-based care for certain patients	20%	21%	26%	25%	25%	31%	26%	25%
Nursing care via video link	15%	15%	14%	22%	18%	14%	18%	13%
Redirect patients to alternative health-care facilities	6%	15%	9%	9%	9%	7%	9%	0%
Suspended the provision of specific services	4%	14%	9%	7%	8%	0%	8%	0%
Reduced the volume of specific services	4%	15%	6%	9%	8%	1%	7%	20%
Reduced the scope of specific services	4%	14%	4%	9%	7%	2%	6%	20%

In regained territories, 20% of all facilities reduced the volume and scope of services provided and over 60% relied on digital solutions and digital consultations.

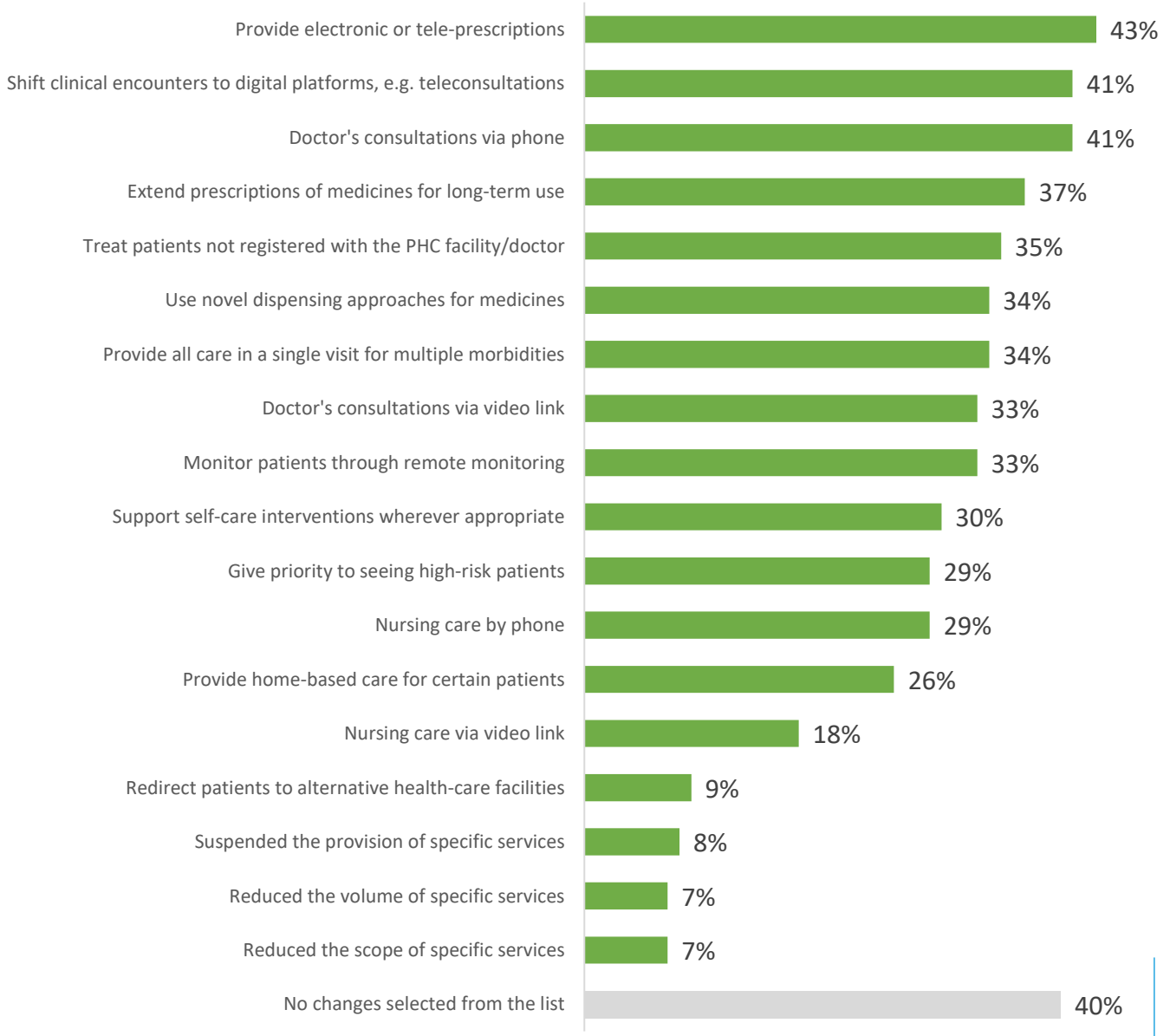
Changes in service delivery made by facilities since the start of the active hostilities (contd.)

The majority of facilities have stayed open, providing essential services during the hostilities. Just under half of facilities have adapted working hours and used digital solutions (phone or teleconsultation, electronic-prescriptions). More that a third of PHC facilities also have provided free services for non-registered patients

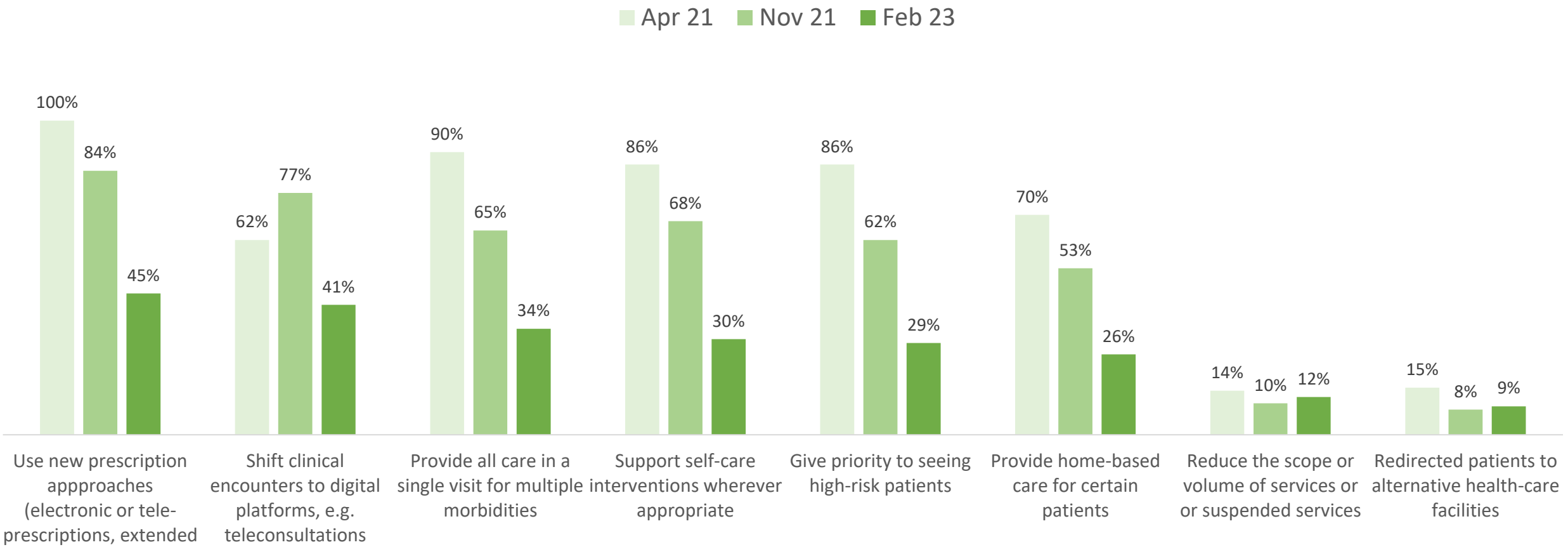


Only 10% of all facilities had been temporarily closed due to the war and almost half of them changed service hours. Non-public facilities have been closed more often than public facilities (17% versus 4%)

In April and November 2021, 1% of facilities had closed temporarily, and 91% and 36% respectively had changed service hours because of a COVID-19 outbreak in the previous 3 months.



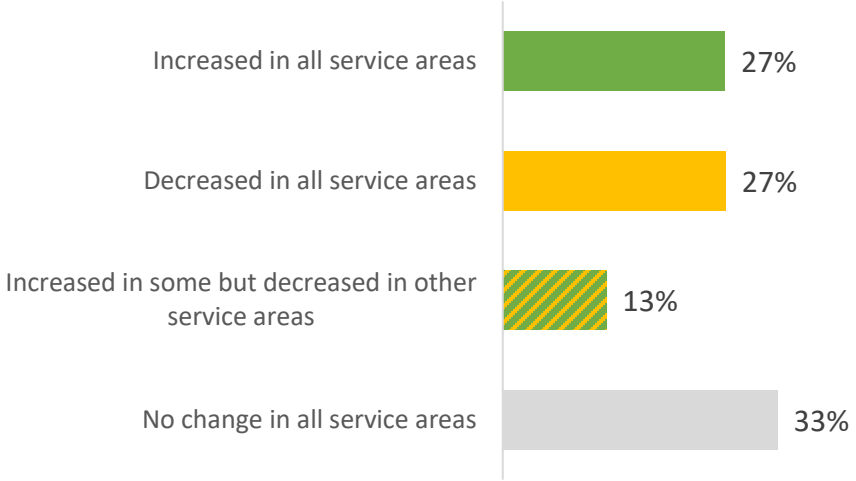
Changes in service delivery made by facilities since the start of the active hostilities (contd.)



Significantly fewer facilities had provided different types/modalities of services (e.g. outreach services, digital platforms for teleconsultations, electronic prescriptions, support for self-care interventions) during the war than compared to in the COVID-19 pandemic. However, overall, the scope or volume of services did not significantly change.

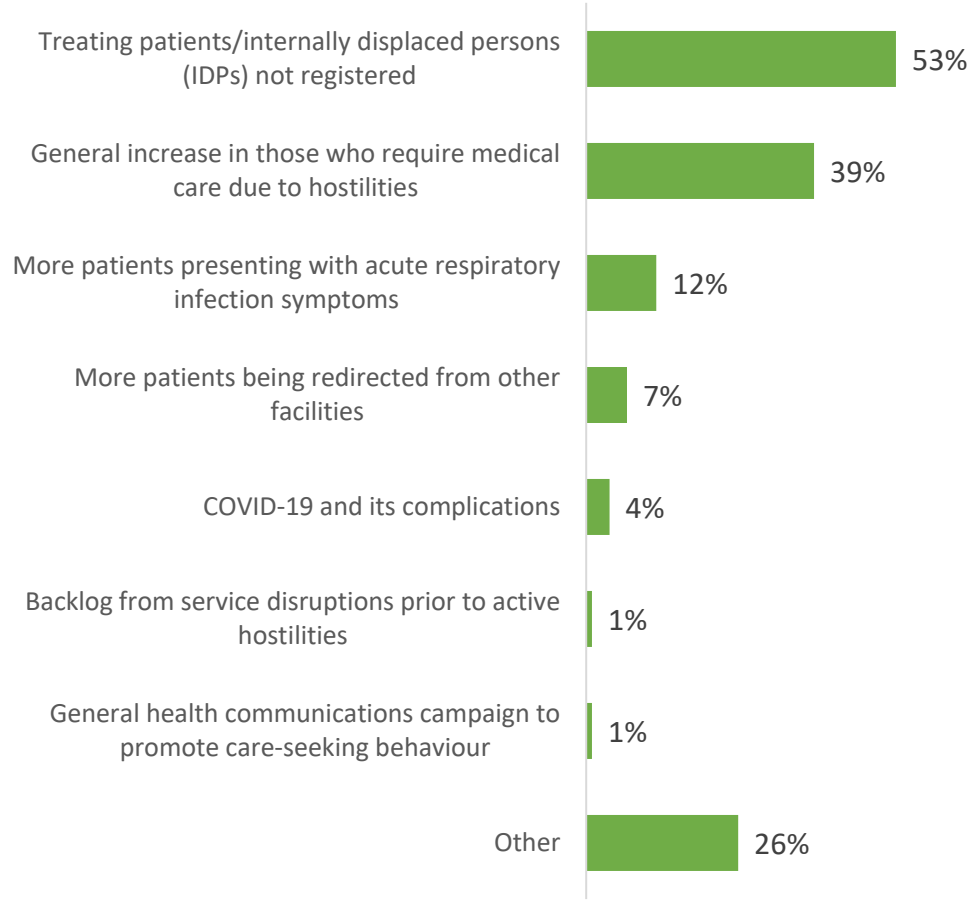
Changes in outpatient attendance

Two thirds of facilities observed **changes in outpatient attendance** during the active hostilities



An increased volume of services was mainly linked to caring for non-registered patients, and nearly 40% of facilities reported increased patient needs due to hostilities. COVID-19 has become a negligible issue as only 4% of facilities reported any increase in need due to the COVID-19 pandemic.

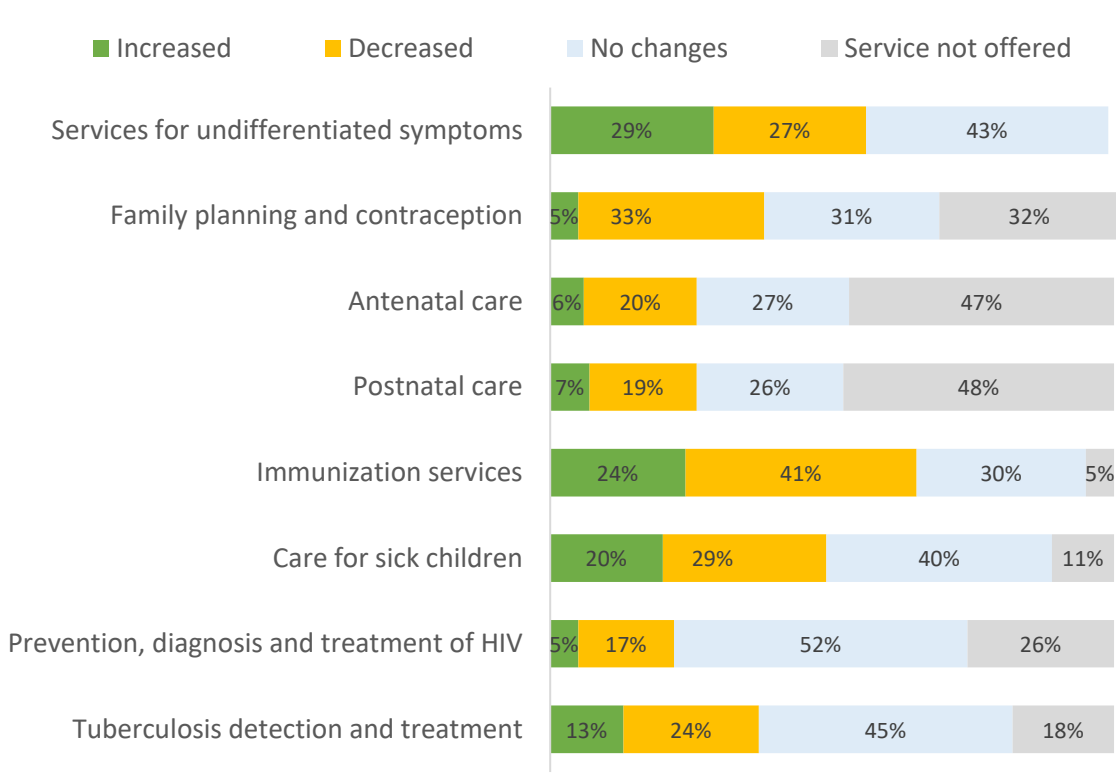
The main **reasons** for the increase in outpatient attendance are the rise of unregistered patients and an increase in the flow of patients as a result of military actions *

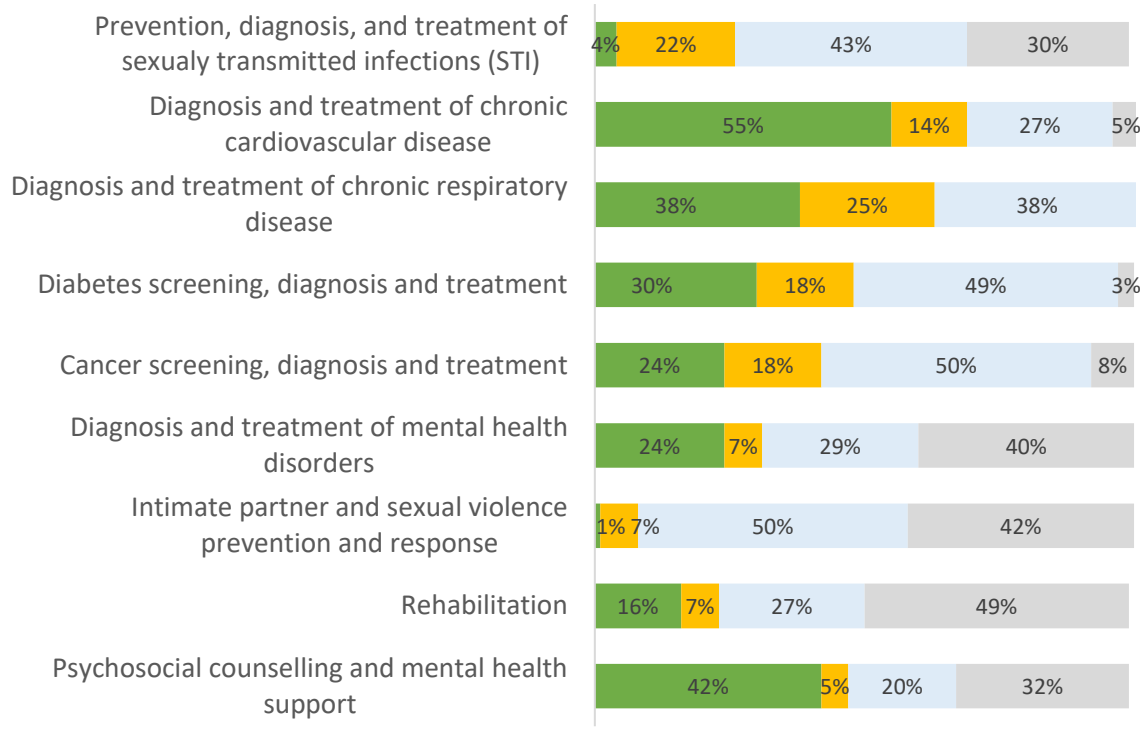


*Among those who observed increasing in outpatient attendance

Changes in service delivery since the active hostilities

Changes in **services***





The most significant increases in service delivery were reportedly related to chronic cardiovascular disease diagnosis and treatment, mental health and chronic respiratory disease. Decreases were reported in immunization services, sick child care and services for undifferentiated symptoms.

*Among those who observed changes in outpatient attendance

Changes in service delivery since the active hostilities (contd.)*

	PHC centres				Specialized facilities			
	Increased	Decreased	No changes	Service not offered	Increased	Decreased	No changes	Service not offered
Services for undifferentiated symptoms	37%	23%	40%	0%	17%	31%	51%	1%
Family planning and contraception	6%	24%	33%	38%	4%	42%	30%	25%
Antenatal care	5%	13%	29%	53%	8%	30%	24%	38%
Postnatal care	6%	14%	27%	54%	9%	27%	24%	40%
Immunization services	32%	38%	28%	2%	16%	44%	29%	10%
Care for sick children	26%	23%	46%	5%	14%	37%	34%	15%
Prevention, diagnosis and treatment of HIV	4%	12%	55%	30%	8%	17%	48%	27%
Tuberculosis detection and treatment	15%	16%	49%	19%	12%	29%	40%	19%
Prevention, diagnosis and treatment of sexually transmitted infections (STIs)	3%	15%	42%	40%	5%	34%	45%	16%
Diagnosis and treatment of chronic cardiovascular disease	64%	12%	21%	3%	45%	14%	31%	10%
Diagnosis and treatment of chronic respiratory disease	44%	22%	34%	0%	31%	25%	44%	0%
Diabetes screening, diagnosis and treatment	34%	13%	50%	2%	23%	24%	50%	3%
Cancer screening, diagnosis and treatment	26%	16%	52%	6%	18%	19%	50%	14%
Diagnosis and treatment of mental health disorders	22%	3%	29%	46%	19%	10%	31%	40%
Intimate partner and sexual violence prevention and response	1%	3%	46%	49%	1%	12%	52%	35%
Rehabilitation	10%	0%	25%	65%	27%	10%	30%	33%
Psychosocial counselling and mental health support	36%	3%	21%	41%	49%	6%	20%	26%

PHC centres reported an increase in immunization services and in chronic cardiovascular disease diagnosis and treatment more frequently than specialized facilities whereas specialized facilities more often reported a decrease in family planning, contraception services, antenatal care, postnatal care, STI prevention and treatment, and gender-based violence response – while one third of them reported an increase in rehabilitation services.

*Among those who observed changes in outpatient attendance

Changes in service delivery since the active hostilities (contd.)*

	Urban				Rural			
	Increased	Decreased	No changes	Service not offered	Increased	Decreased	No changes	Service not offered
Services for undifferentiated symptoms	29%	29%	42%	0%	31%	7%	62%	0%
Family planning and contraception	5%	34%	30%	32%	4%	17%	40%	38%
Antenatal care	6%	20%	26%	48%	6%	20%	46%	28%
Postnatal care	6%	19%	25%	50%	10%	28%	40%	22%
Immunization services	25%	41%	29%	5%	21%	43%	36%	0%
Care for sick children	20%	30%	38%	11%	15%	6%	74%	5%
Prevention, diagnosis and treatment of HIV	5%	17%	51%	27%	6%	10%	67%	18%
Tuberculosis detection and treatment	14%	25%	43%	18%	8%	13%	71%	7%
Prevention, diagnosis and treatment of STI	4%	23%	42%	30%	4%	11%	58%	26%
Diagnosis and treatment of chronic cardiovascular disease	54%	14%	27%	5%	70%	3%	24%	3%
Diagnosis and treatment of chronic respiratory disease	37%	26%	37%	0%	42%	6%	51%	0%
Diabetes screening, diagnosis and treatment	30%	20%	48%	3%	36%	1%	59%	3%
Cancer screening, diagnosis and treatment	24%	19%	50%	7%	28%	4%	56%	13%
Diagnosis and treatment of mental health disorders	23%	8%	29%	40%	31%	5%	35%	29%
Intimate partner and sexual violence prevention and response	1%	7%	48%	44%	0%	3%	74%	23%
Rehabilitation	16%	8%	27%	49%	23%	3%	28%	47%
Psychosocial counselling and mental health support	42%	6%	20%	33%	42%	3%	23%	32%

Changes in service delivery were more notable in urban settings, where facilities more often decreased services (e.g., care for sick children, cancer screening, diabetes screening and treatment, chronic respiratory disorders).

* Among those who observed changes in outpatient attendance

Changes in service delivery since the active hostilities contd.*

	Government-controlled				Regained			
	Increased	Decreased	No changes	The service is not offered	Increased	Decreased	No changes	The service is not offered
Services for undifferentiated symptoms	30%	26%	43%	0%	7%	47%	45%	0%
Family planning and contraception	5%	32%	30%	33%	0%	40%	39%	21%
Antenatal care	6%	19%	26%	48%	0%	35%	50%	15%
Postnatal care	7%	18%	26%	49%	0%	39%	39%	22%
Immunization services	25%	40%	30%	5%	7%	75%	17%	0%
Care for sick children	21%	29%	39%	11%	0%	33%	65%	3%
Prevention, diagnosis and treatment of HIV	5%	16%	51%	27%	0%	33%	60%	7%
Tuberculosis detection and treatment	13%	25%	45%	17%	15%	10%	50%	25%
Prevention, diagnosis and treatment of STI	4%	23%	43%	30%	0%	7%	53%	40%
Diagnosis and treatment of chronic cardiovascular disease	56%	13%	27%	5%	35%	33%	32%	0%
Diagnosis and treatment of chronic respiratory disease	39%	23%	37%	0%	0%	55%	45%	0%
Diabetes screening, diagnosis and treatment	31%	18%	49%	3%	21%	33%	46%	0%
Cancer screening, diagnosis and treatment	25%	17%	51%	7%	7%	33%	46%	14%
Diagnosis and treatment of mental health disorders	24%	7%	30%	39%	24%	7%	15%	54%
Intimate partner and sexual violence prevention and response	1%	7%	50%	42%	0%	7%	53%	40%
Rehabilitation	17%	7%	28%	48%	7%	7%	7%	78%
Psychosocial counselling and mental health support	42%	5%	21%	32%	36%	7%	7%	49%

In regained territories a significant increase in mental health services was reported, while the majority of other services decreased or stayed at pre-war levels

*Among those who observed changes in outpatient attendance

Outreach services

91% of facilities usually provide **community outreach or home-visit services**.

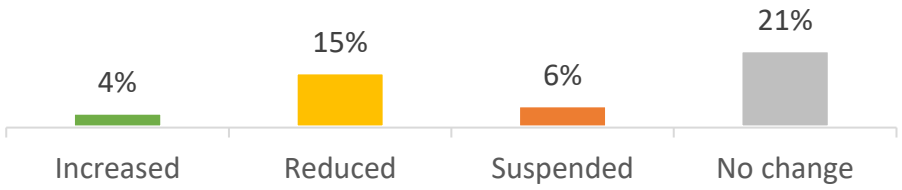
9% have mobile clinics

46% offer immunization outreach

58% visit IDPs in their places of residence

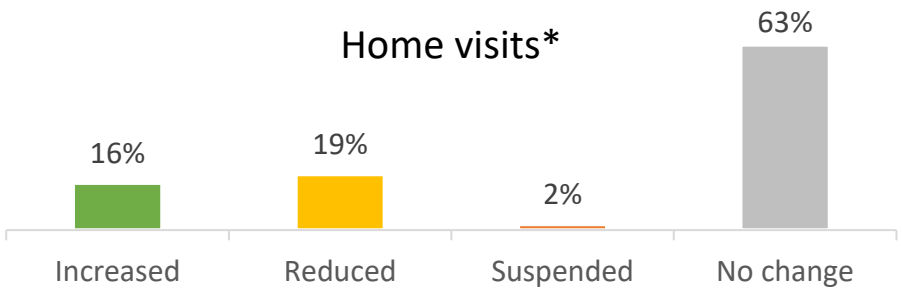
Changes in the frequency of different types of outreach services since the war started:

Immunization outreach*

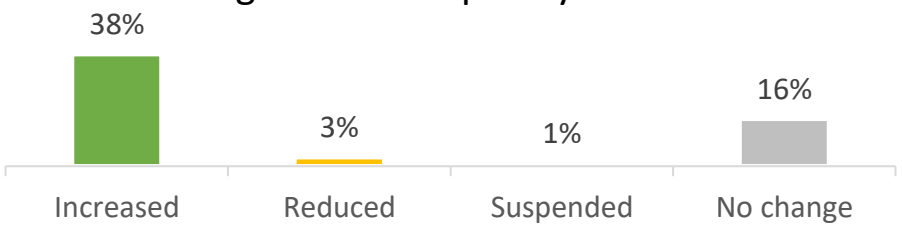


Mobile clinics*

Home visits*



Visiting IDPs in temporary residence*



The number of PHC facilities where community outreach and home visits decreased is higher than the number of facilities that expanded such services since the war began. Although more that 90% of PHC facilities offer home services, only 9% have mobile clinics. Around half offer outreach vaccination or visits to IDPs in their places of residence.

*Among those who usually provide community outreach or home-visit services

Changes in the frequency of outreach services*

	Non-public					Public				
	Increased	Reduced	Suspended	No change	Not offered	Increased	Reduced	Suspended	No change	Not offered
Immunization outreach	2%	4%	5%	8%	81%	5%	25%	8%	32%	30%
Mobile clinics	1%	1%	0%	0%	98%	8%	3%	1%	2%	85%
Home visits	9%	19%	4%	69%	0%	23%	19%	0%	57%	0%
Visiting IDPs in their places of temporary residence	22%	4%	0%	16%	57%	53%	3%	1%	17%	26%

	Urban					Rural				
	Increased	Reduced	Suspended	No change	Not offered	Increased	Reduced	Suspended	No change	Not offered
Immunization outreach	4%	15%	7%	19%	56%	3%	23%	4%	36%	35%
Mobile clinics	5%	2%	1%	1%	92%	5%	0%	0%	7%	88%
Home visits	16%	20%	2%	62%	0%	23%	9%	0%	68%	0%
Visiting IDPs in their places of temporary residence	37%	4%	1%	16%	42%	52%	2%	0%	23%	23%

	Government-controlled					Regained				
	Increased	Reduced	Suspended	No change	Not offered	Increased	Reduced	Suspended	No change	Not offered
Immunization outreach	4%	14%	6%	21%	55%	0%	35%	27%	12%	26%
Mobile clinics	5%	2%	0%	1%	91%	0%	0%	6%	0%	94%
Home visits	17%	19%	1%	63%	0%	12%	18%	21%	50%	0%
Visiting IDPs in their places of temporary residence	40%	4%	1%	16%	40%	12%	0%	0%	26%	62%

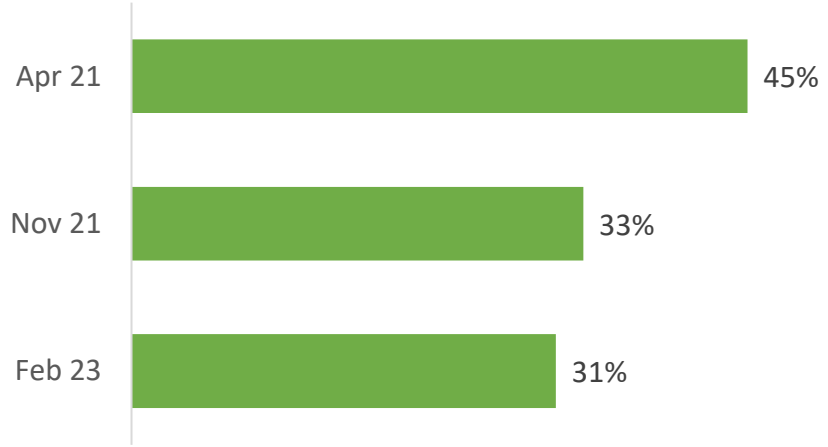
Home visits and vaccination outreach are usually conducted by public PHC providers and more often in rural areas, while one fifth of PHC facilities in regained territories reported suspending such services. A 40% increase in visiting IDPs was reported in government-controlled a territories.

* Among those who usually provide community outreach or home-visit services

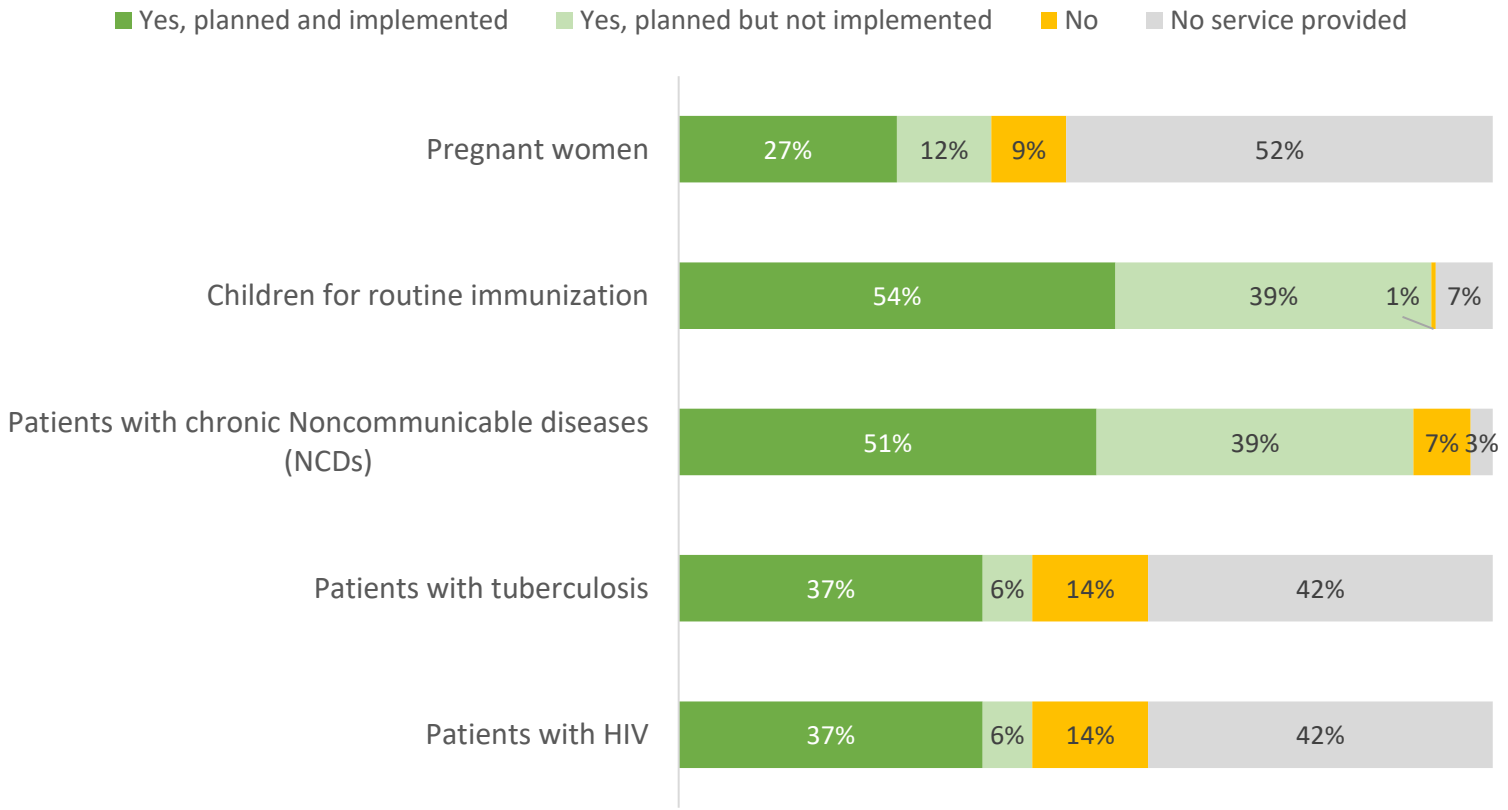
Care for patients who miss routine appointments

39% of facilities have developed plans to deliver services to patients who miss routine appointments since the war started

Facilities that have developed plans to deliver services for patients who missed their routine appointments and shortlisted the patients who have missed appointments*



Planning for routine appointments and missed care has continued during the active hostilities at the similar levels to November 2021



During the war, over half of all facilities scheduled routine appointments for child immunization and NCD care.

* Among those who developed plans to deliver services for patients who missed routine appointments

Plans made for targeted catch-up for the following patient groups who have missed scheduled appointments*

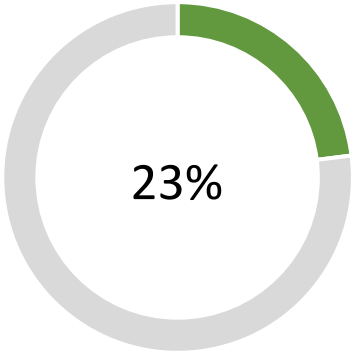
Routine scheduled appointments are mostly performed in rural areas, where both children's routine immunization and NCD services were provided by 72% of facilities.

Missed tuberculosis and HIV services were significantly better planned and implemented in rural areas.

		Urban	Rural
Pregnant women	Yes, planned and implemented	27%	26%
	Yes, planned but not implemented	11%	26%
	No	9%	19%
	No service provided	54%	29%
Children for routine immunization	Yes, planned and implemented	52%	72%
	Yes, planned but not implemented	40%	28%
	No	1%	0%
	No service provided	7%	0%
Patients with chronic NCDs	Yes, planned and implemented	50%	72%
	Yes, planned but not implemented	41%	12%
	No	7%	12%
	No service provided	3%	4%
Patients with tuberculosis	Yes, planned and implemented	35%	77%
	Yes, planned but not implemented	6%	10%
	No	15%	9%
	No service provided	45%	4%
Patients with HIV	Yes, planned and implemented	26%	57%
	Yes, planned but not implemented	6%	0%
	No	15%	18%
	No service provided	54%	24%

*Among those who developed plans to deliver services for patients who missed routine appointments since the war started

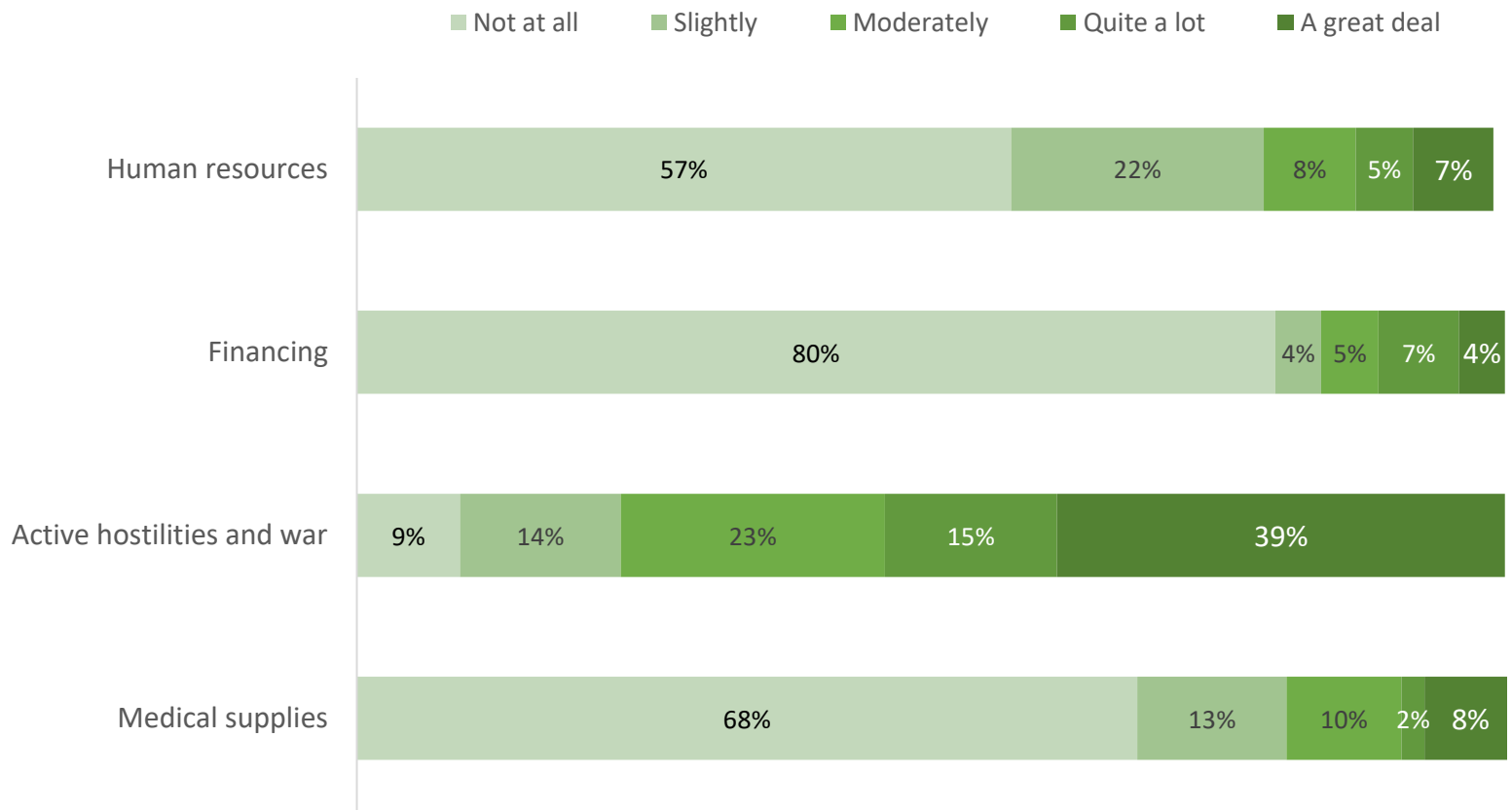
Disruption of services



of all facilities reported **disruptions in services** since the war started

More facilities from urban areas (25%) reported disruptions in services since the war started compared to rural locations (9%)

The main **issues contributing to the disruption**, related to the war



*Among those who have had a disruption in services provided by the facility since the war started

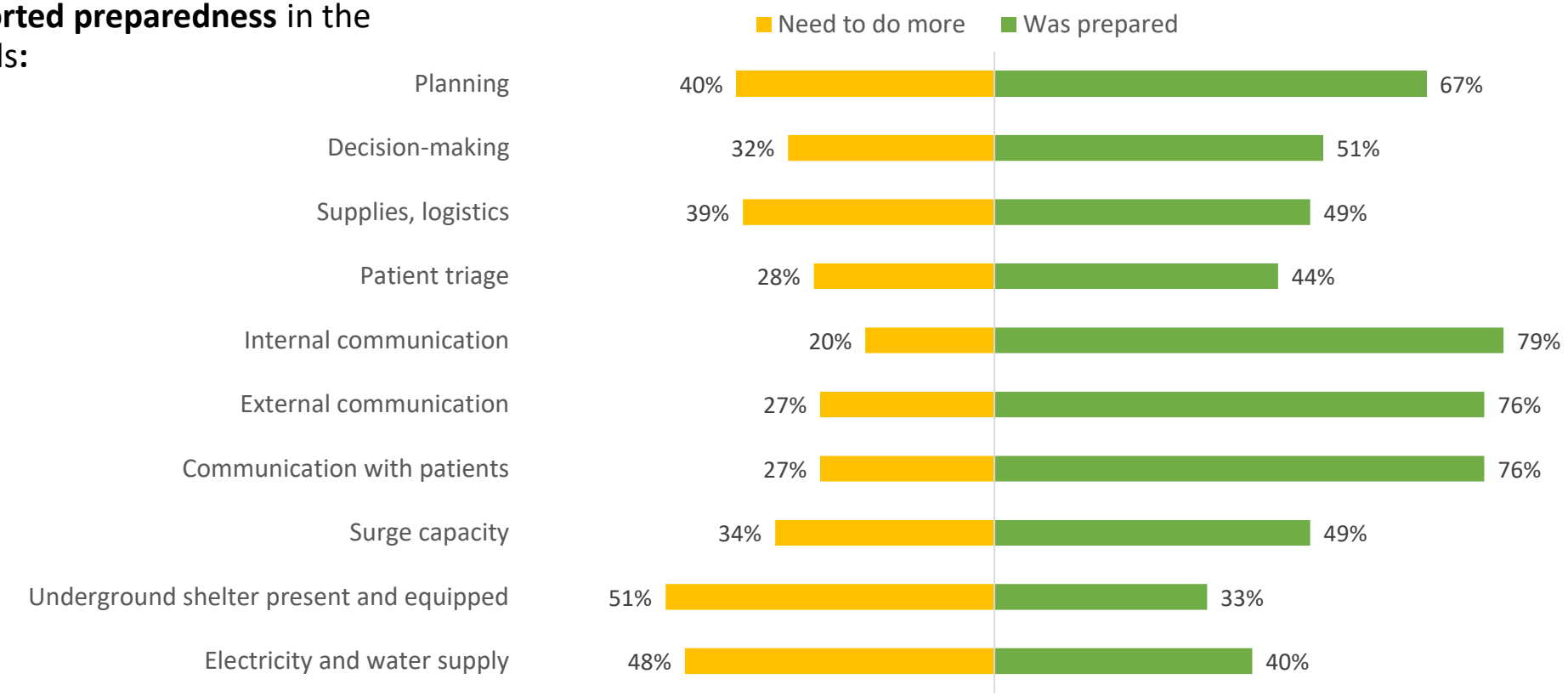
Resilience in emergency situations

Preparedness for emergency situations

65% of facilities were well prepared for emergency situations (53% quite a lot, 12% a great deal) before hostilities escalated
7% were not immediately prepared for emergency situations (4% slightly prepared, 6% not at all)

Facilities in regained territories were less prepared for emergency situations before the hostilities (31% not prepared) compared to those in government-controlled territories (3% not prepared)

Facilities reported preparedness in the following fields:



Preparedness for emergency situations

Overall, public providers reported better preparedness for emergency situations.

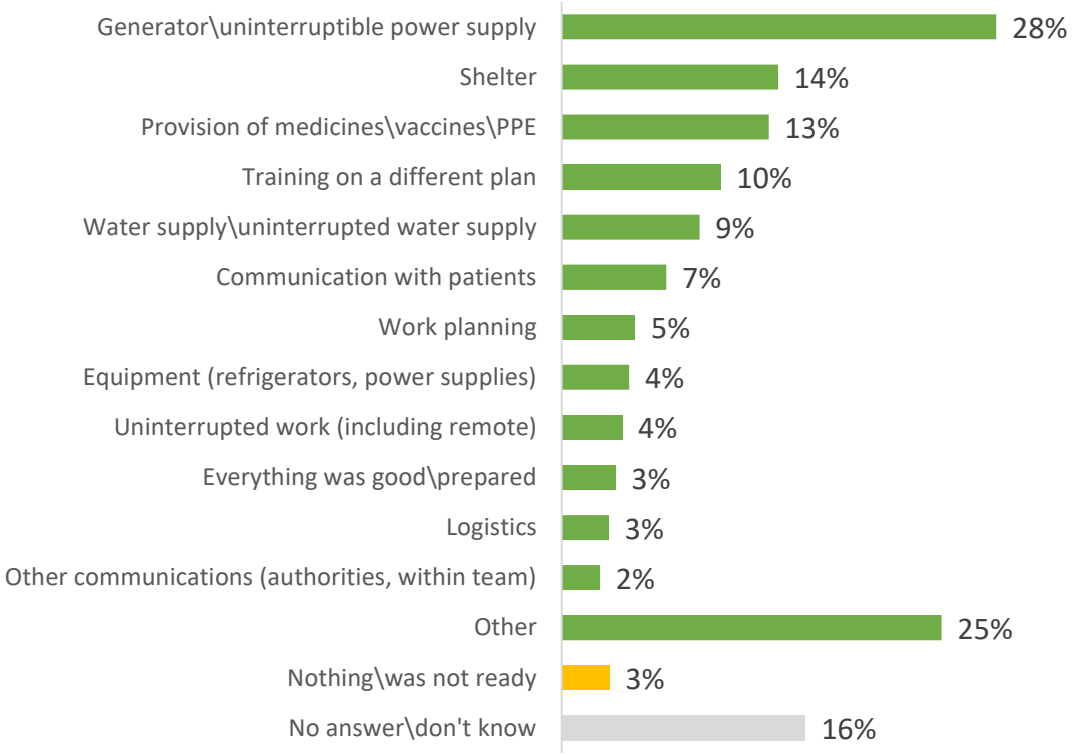
Facilities reported preparedness in the following fields:	PHC centres	Specialized facilities	Non-public	Public	Urban	Rural
Planning (any emergency plan)	68%	78%	53%	81%	67%	76%
Decision-making (presence of a focal point for emergencies/team)	51%	60%	40%	61%	50%	59%
Supplies, logistics	51%	57%	42%	56%	48%	59%
Patient triage	43%	52%	40%	47%	42%	59%
Internal communication	83%	83%	75%	83%	79%	78%
External communication (with authorities)	80%	81%	70%	81%	76%	74%
Communication with patients	78%	78%	74%	77%	76%	76%
Surge capacity	53%	50%	46%	51%	49%	46%
Underground shelter present and equipped	26%	49%	24%	41%	33%	21%
Electricity and water supply	35%	58%	29%	50%	40%	38%

Resilience to emergency situations

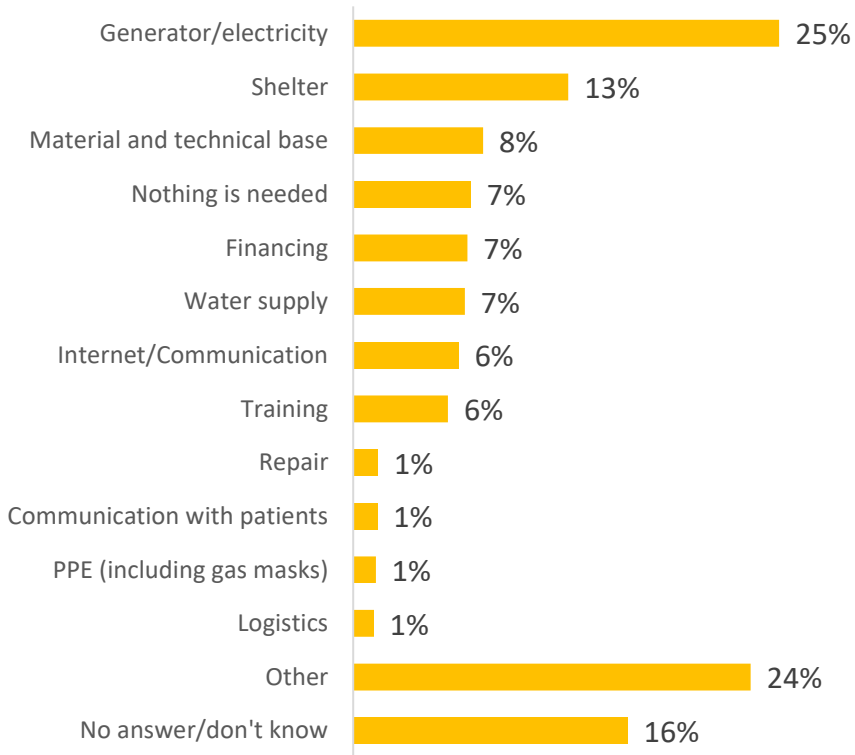
74% of facilities highly rate their resilience to emergencies (57% quite a lot, 17% a great deal)
5% rate their resilience to emergencies at a low level (4% slightly, 1% not at all)

Facilities in regained territories are less resilient to emergencies than those in government-controlled territories (25% versus 4%)

Done well by health facilities before hostilities escalated to improve resilience



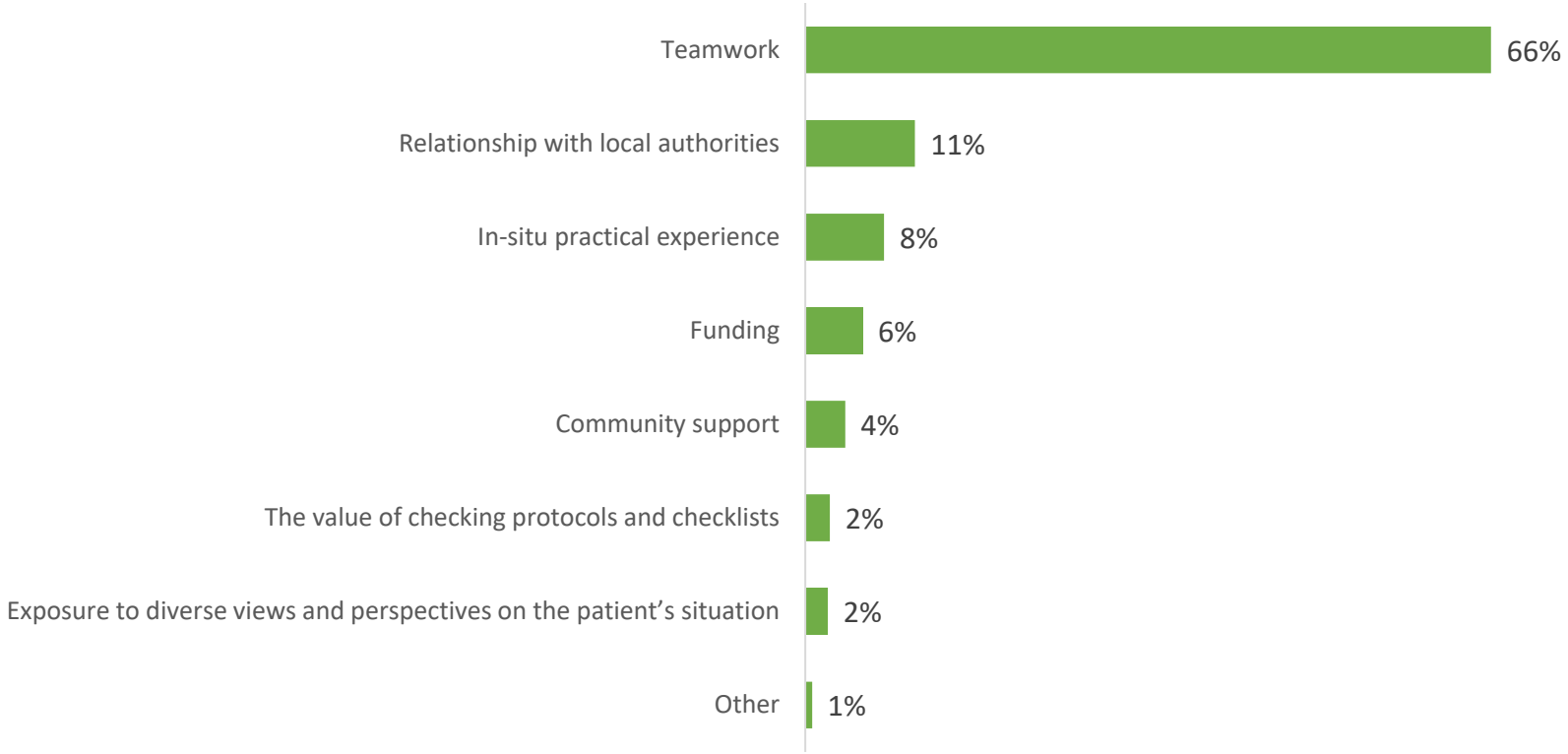
Should be done to improve resilience as the war continues



Approximately the same number of facilities reported power generator supply (28%) and shelter availability (14%) as an achievement of the facility contributing to resilience as those reporting the same areas as needing improvement (25% and 13% respectively)

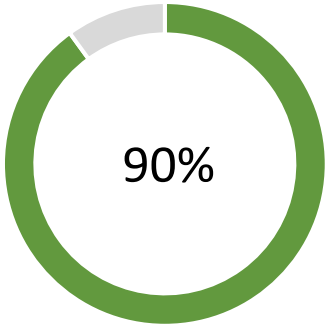
Factors contributing most to health-care facility resilience

The informants believe that the **key factors** that contribute significantly to their medical facility's resilience are **teamwork and relationships with local authorities**

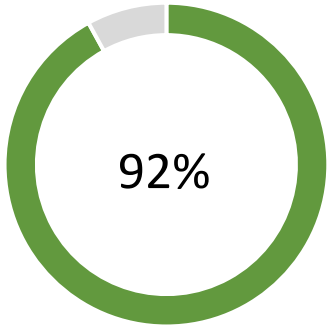


Funding is more relevant as a factor contributing to a facility's resilience for PHC centres than for specialized facilities (8% versus 2%), and for facilities in regained territories than in government-controlled territories (25% versus 5%)

Impact of resilience measures on service delivery



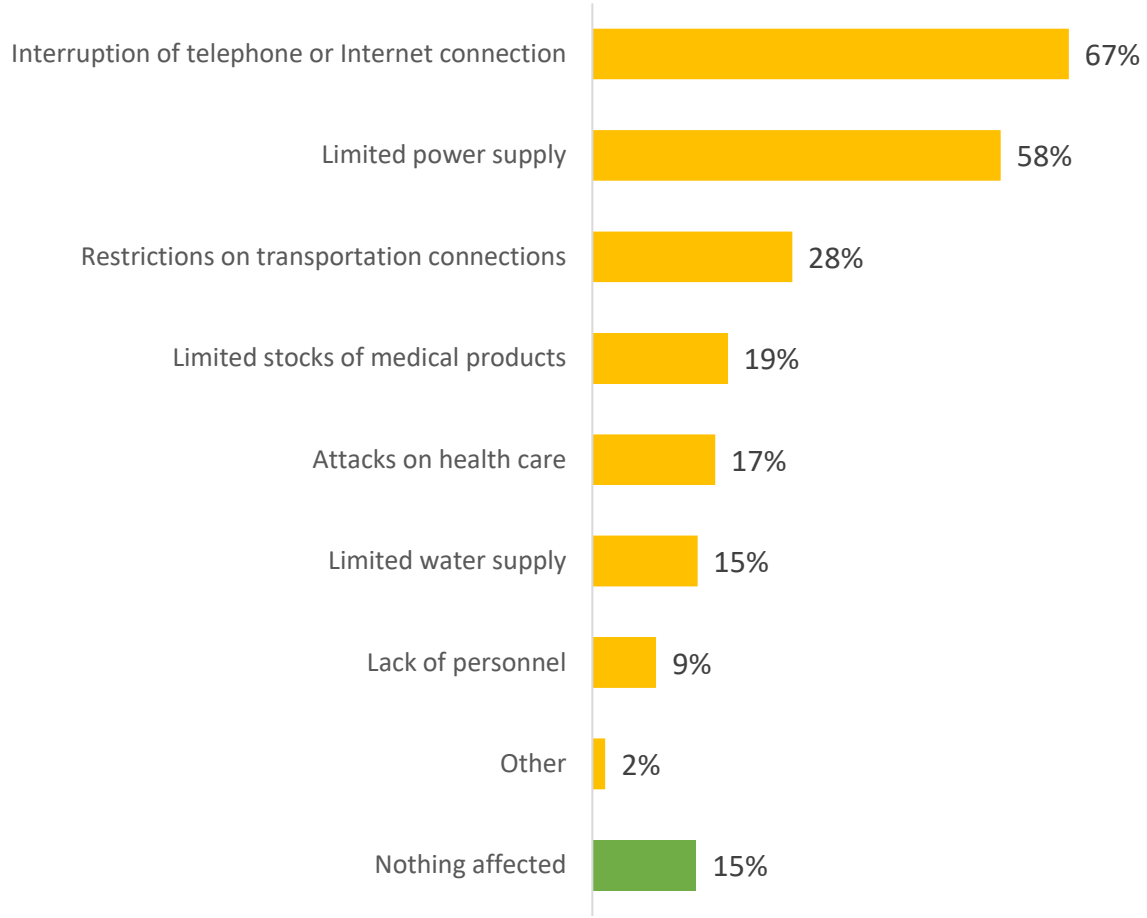
of all facilities said that **adaptations and adjustments used are appropriate to maintain work**

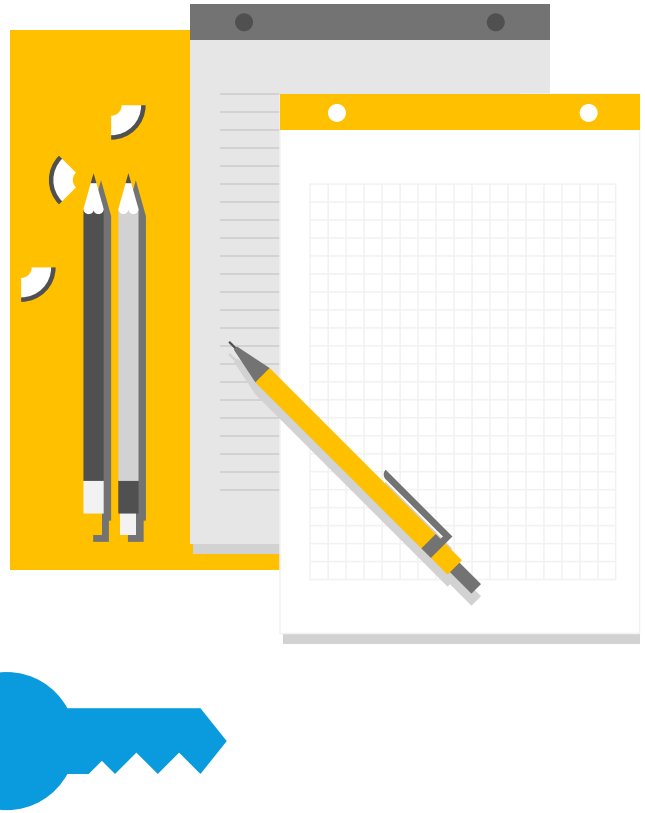


of all facilities reported that **measures** taken to increase resilience improved **patient safety**

In regained territories, fewer facilities reported that these measures improved patient safety (75% versus 93% in government-controlled territories)

Key barriers that hinder successful interventions/service delivery are related to problems with phone or Internet connection and with electricity.





Key findings and conclusions

Key findings – Staffing

The war has had an impact on PHC staffing

- Half of PHC facilities have been affected by staff absence since the outbreak of hostilities although the overall number of staff that have remained and continued to provide services was high.
- Mental health services for staff need to be made available in regained areas with over a third of facilities indicating that they need support in this regard.
- The main changes in health worker management during the hostilities have been the repurposing of skills towards mental health or rehabilitation services and the reassignment of staff to different units/ responsibilities, although overall the impact of the hostilities on health worker management appears to have been less than for that of the COVID-19 pandemic.
- Public facilities were more likely to have reported staff layoffs or unpaid leave than private facilities.
- Specialized facilities were three times more likely to report increased staff overtime than PHC centres.
- Three quarters of facilities engaged in further staff training, to address changed population needs, especially in CBRN exposure and mental health. The relevance of training could be improved especially among private and smaller PHC facilities, and in the areas of mass casualty management and rehabilitation.

Key findings – Financial management

Financing contributed to sustainability strengthened with additional funds from owners and donors

- The reliance on financing from patients has not significantly changed since the start of the war. A quarter of all health-care facilities charge user fees – half of which have increased prices since the war started. Some services and population groups (e.g. veterans) are exempt from fees.
- One third of public providers had received additional funds from facility owners and donors since the war began – significantly lower than for the COVID-19 pandemic – with 20% of facilities reporting that additional funding was not sufficient. Almost no additional public funds were directed towards private facilities.
- The vast majority of PHC facilities have managed to continue paying salaries to health workers, with half of facilities paying for overtime where relevant – bringing stability to health-care workers in the time of war.

Key findings – Service Delivery

Changes in service delivery vary

- The war has caused large and changing population movement together with the changing needs to which the PHC facilities had to adapt quickly, while increasing or decreasing volume of services.
- Public PHC facilities have stayed open, providing essential services during the war period. Half of facilities have adapted working hours and use digital solutions – especially in regained territories – where required. More than a third of PHC facilities provided free services for non-registered patients.
- In regained areas however, one fifth of PHC facilities have reduced the volume and scope of provided services since the onset of hostilities.
- The number of PHC facilities where community outreach and home visits decreased is higher than the number of facilities that expanded such services since the war started – with one fifth of PHC facilities in regained territories suspending such services.
- While the number of service modalities decreased slightly, the overall scope or volume of services remained relatively stable. Facilities in urban areas reported more reductions in services compared to rural facilities.
- Rural facilities have more actively developed and implemented plans to deliver services to patients with tuberculosis and HIV, as well as to pregnant women.

Key findings – Resilience in Emergency Situations

PHC facilities have shown resilience by adapting to the challenges of the war

- Two thirds of PHC facilities managers believed they were **well** prepared for an emergency although one third in regained territories reported that they were **poorly** prepared (over four times the rate in government-controlled territories). Public facilities were better prepared.
- Most PHC facilities are resilient to the war situation and have quickly adapted with alternate power supplies, shelters and supplies of medicines and vaccines.
- Teamwork and relationships with local authorities were stated as being the key resilience factors.

Conclusions

The PHC system in Ukraine has displayed notable resilience and adaptability during the dual challenges of the COVID-19 pandemic and the war.

While there are areas that require attention, such as mental health support for staff and financial stability, the health-care workforce's dedication and readiness for emergencies are commendable. While nearly half of PHC facilities have experienced staff absences, the majority have managed to continue providing services with the available workforce. Strong teamwork and relationships with local authorities were identified as key factors contributing to the resilience of PHC facilities during these challenging times.

The assessment showed that the war impact varies depending on the territories (government-controlled, regained) and type of facility (private, public, PHC centre specialized facility), and the reconstruction and recovery mechanisms required in regained territories will need further investigation to maintain access to and restore health systems.

Tailoring support to different types of facilities and maintaining a focus on training and preparedness are key strategies to strengthen the health-care system in the face of ongoing challenges. Continuous monitoring and flexibility in response will be essential to ensure the system's stability and effectiveness in providing care to the population on the way to achieving universal health coverage and the sustainable development goals.