ACCESS TO HEALTH-CARE SERVICES FOR OLDER PERSONS AND PERSONS WITH DISABILITIES LIVING IN EASTERN UKRAINE ALONG THE “LINE OF CONTACT”
ACCESS TO HEALTH-CARE SERVICES FOR OLDER PERSONS AND PERSONS WITH DISABILITIES LIVING IN EASTERN UKRAINE ALONG THE “LINE OF CONTACT”
ABSTRACT
The conflict in eastern Ukraine has caused a deterioration in the level of access to good-quality health-care services, and people living in the area – particularly those living closer to the “line of contact” – face difficulties seeking such services. In the two oblasts of Luhansk and Donetsk, where health indicators were among the lowest even before the conflict, the situation has grown worse, leaving those living in the area to face increased health expenditure, including transport costs and out-of-pocket payments for services that are supposed to be free.

The humanitarian crisis in Ukraine is particularly hard on older persons, with 30% of all people in need of humanitarian assistance aged 60 years or over. Younger people have fled the area in search of better livelihood opportunities elsewhere, leaving behind the majority of older persons and persons with disabilities to live on their own. Limited mobility and lack of alternative transport arrangements mean that these population groups require regular care that is close to their places of residence.

This paper gives an analysis of secondary data collected by HelpAge International as part of a project targeting beneficiaries of humanitarian aid in the two oblasts in 2018 and 2019. Levels of access to health-care services in the two years under review are compared; then recommendations are made for short- and long-term measures that would help to address the particular health-care needs of the population groups concerned.

Address requests about publications of the WHO Regional Office for Europe to:
Publications
WHO Regional Office for Europe
UN City, Marmorvej 51
DK-2100 Copenhagen Ø, Denmark
Alternatively, complete an online request form for documentation, health information, or for permission to quote or translate, on the Regional Office website (http://www.euro.who.int/pubrequest).

Document number: WHO/EURO:2021-2038-41793-57267

© World Health Organization 2021

Some rights reserved. This work is available under the Creative Commons Attribution-NonCommercial-ShareAlike 3.0 IGO licence (CC BY-NC-SA 3.0 IGO; https://creativecommons.org/licenses/by-nc-sa/3.0/igo).

Under the terms of this licence, you may copy, redistribute and adapt the work for non-commercial purposes, provided the work is appropriately cited, as indicated below. In any use of this work, there should be no suggestion that WHO endorses any specific organization, products or services. The use of the WHO logo is not permitted. If you adapt the work, then you must license your work under the same or equivalent Creative Commons licence. If you create a translation of this work, you should add the following disclaimer along with the suggested citation: “This translation was not created by the World Health Organization (WHO). WHO is not responsible for the content or accuracy of this translation. The original English edition shall be the binding and authentic edition: Access to health-care services for older persons and persons with disabilities living in Eastern Ukraine along the “line of contact”. Copenhagen: WHO Regional Office for Europe; 2021”.

Any mediation relating to disputes arising under the licence shall be conducted in accordance with the mediation rules of the World Intellectual Property Organization (http://www.wipo.int/amc/en/mediation/rules/).

Suggested citation. Access to health-care services for older persons and persons with disabilities living in Eastern Ukraine along the “line of contact”. Copenhagen: WHO Regional Office for Europe; 2021. Licence: CC BY-NC-SA 3.0 IGO.

Cataloguing-in-Publication (CIP) data. CIP data are available at http://apps.who.int/iris.

Sales, rights and licensing. To purchase WHO publications, see http://apps.who.int/bookorders. To submit requests for commercial use and queries on rights and licensing, see http://www.who.int/about/licensing.

Third-party materials. If you wish to reuse material from this work that is attributed to a third party, such as tables, figures or images, it is your responsibility to determine whether permission is needed for that reuse and to obtain permission from the copyright holder. The risk of claims resulting from infringement of any third-party-owned component in the work rests solely with the user.

General disclaimers. The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers’ products does not imply that they are endorsed or recommended by WHO in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by WHO to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall WHO be liable for damages arising from its use.

All photos: ©WHO
CONTENTS

Page

Acknowledgements ..................................................................................................... iv
Abbreviations ............................................................................................................... iv

1. Introduction .......................................................................................................... 2

2. Study aims ............................................................................................................ 6

3. Methodology overview ........................................................................................ 8

4. Major factors affecting access to health-care services for older PWDs ........ 12
   4.1 Proximity to “line of contact” .......................................................................... 13
   4.2 Top spending and access to health care .......................................................... 16
   4.3 Correlation with other variables .................................................................... 16
   4.4 Comparison between the two oblasts .......................................................... 18

5. Conclusions and key recommendations .......................................................... 20

References .............................................................................................................. 24

Annex 1. Vulnerability assessment form ............................................................. 26
ACKNOWLEDGEMENTS

The authors of this report are: Aron Aregay, WHE Information Management and Risk Assessment Officer; Dr Caroline Clarinval, Coordinator, WHE Team Lead (until March 2020); Anna Rich, Protection Cluster Coordinator, United Nations High Commissioner for Refugees, Ukraine; Eva Schmidt, Office of the United Nations High Commissioner for Human Rights; Dr Jarno Habicht, WHO Country Representative, Ukraine.

The authors would like to acknowledge the role of HelpAge International in making anonymized data for beneficiaries of humanitarian aid in the years 2018 and 2019 available for analysis. Special thanks go to the technical team at Fjelltopp Ltd., who assisted with statistical analysis of the secondary data as the write-up process was delayed for an extended period of time due to unavoidable circumstances.

ABBREVIATIONS

CRPD ......................... Convention on the Rights of Persons with Disabilities
GCA ......................... government-controlled area
IDP ......................... internally displaced person
NGCA ....................... non-government-controlled area
PWD ......................... person with disabilities
INTRODUCTION
In 2020, eastern Ukraine entered the sixth year of an armed conflict that has affected 5.2 million people and left 3.5 million in need of humanitarian assistance (1). The Office of the United Nations High Commissioner for Human Rights recorded 107 conflict-related civilian casualties (18 killed and 89 injured) in 2020. By 31 July 2020, the total death toll of civilians since 2014 had reached at least 3367, and more than 7000 had been injured (of whom an estimated 1000 became persons with disabilities (PWDs)). Despite the fall in civilian casualties, ceasefire violations and exchanges of fire across the “line of contact” continue to occur, albeit at a very low level since measures to strengthen the ceasefire came into force on 27 July 2020. The long-term consequences of the conflict significantly affect PWDs and impede their access to good-quality health-care services. It also increases stress and mental health problems. Following the onset of conflict, many have left the area, leaving older persons behind in isolated areas or forcing them to resettle in nearby areas as internally displaced persons (IDPs) (2). While the impact is felt by all members of the communities concerned, it disproportionately affects older persons because of their increased health-care needs.

The right to access health-care services is enshrined in several major international documents that have been ratified by Ukraine. Of particular relevance are Article 12 of the International Covenant on Economic, Social and Cultural Rights, Article 25 of the Convention on the Rights of Persons with Disabilities (CRPD), and Articles 11, 12 and 14 of the Convention on the Elimination of All Forms of Discrimination against Women. The Universal Declaration of Human Rights (Article 25) also mentions health as part of the right to an adequate standard of living. The CRPD includes state obligations to provide PWDs with the same range, quality and standard of free or affordable health-care programmes as provided to other persons; these should encompass sexual and reproductive health and population-based public health programmes and services designed to minimize and prevent further disabilities (including to older persons); and such services should be provided in as close proximity as possible to people’s own communities (including in rural areas).

In 2018 the Committee on the Rights of Persons with Disabilities recommended that states should adopt specific measures to achieve inclusive equality, particularly with respect to PWDs who experience intersectional discrimination, such as women, girls, children, older persons and indigenous people (3).

Among more specific documents on the rights of older persons, in 1991 the United Nations General Assembly adopted, in its Resolution 46/91, the Principles for Older Persons, paragraphs 1 and 11 of which provide for the right of older persons to access adequate health care (4). In addition, United Nations Sustainable Development Goal No. 3 states that healthy lives should be ensured and well-being promoted for all at all ages. In her 2019 report on the situation of older persons in emergency settings, the Independent Expert on the Enjoyment of All Human Rights by Older Persons notes that physical challenges that come with age but do not normally decrease the quality of life or significantly decrease the capacity for daily functioning of an older person may become serious impediments in an emergency (5). She added that social connectedness in an emergency situation helps to protect the health and well-being of an older person by providing emotional and practical, informational and appraisal support.
The Guidance note on disability and emergency risk management for health, prepared by WHO, indicates that emergencies, in particular, can increase the vulnerability of people experiencing disability (6). Emergencies also create a new generation of people who experience disability due to injuries, poor basic surgical and medical care, emergency-induced mental health and psychological problems, abandonment, and breakdown in support structures and preventive health care.

The applicable national legislation does not contain specific legal requirements concerning the rights of older PWDs to access health-care services. Such rights are mentioned in general terms in the Law on the Basics of Health Protection, which envisages the right of everyone to health protection (Article 6); the Law on the Basics of Social Protection of Persons with Disabilities (Article 4 imposes an obligation on state bodies to ensure the rights of PWDs to participate in public life by, inter alia, protecting their health); and the Law on Psychiatric Assistance, which guarantees free-of-charge psychiatric assistance to all citizens (Article 5). The Law on Ensuring the Rights and Freedoms of Internally Displaced Persons establishes additional rights specifically for displaced PWDs and older persons, making provision of rehabilitation means, medical services and medications in cases provided by the law.

Ukraine has one of the “oldest” humanitarian crises: 30% of all people in need of humanitarian assistance are 60 years or over (1). They constitute over 50% of registered IDPs and 41% of the population living in isolated settlements in government-controlled areas (GCAs) along the “contact line” separating GCAs and non-government-controlled areas (NGCAs) (2). Over 60% of those crossing the “contact line” daily between NGCAs and GCAs are older persons (3). Older persons often face overlapping vulnerabilities such as chronic disease, disability and dire financial constraints, with a high proportion of older women among the conflict-affected population.

In eastern Ukraine, older persons may belong to several groups with specific needs: isolated single older women and men who are frail or have disabilities; isolated older couples or couples where one or both partners have disabilities; isolated older women and men living with young dependents or living in families unable to support their older relatives; and older persons living in institutional settings such as long-term care homes. Many older PWDs do not have an official disability certificate, depriving them of government disability support. A needs assessment showed that, of the 4595 older persons surveyed in 2018, almost 800 were bedridden or immobile, of whom only 136 held a disability certificate (5). Older persons, particularly when they have a disability, are often overlooked during consultations on the planning and delivery of humanitarian assistance (6). Their needs therefore tend to remain unidentified and neglected, and their capacity to be active participants in recovery and response is often ignored by humanitarian actors.

Almost all older persons (97%) have at least one chronic disease, which is a major protection issue. In NGCAs, as well as in isolated settlements in Donetsk and Luhansko oblasts, many younger people have left in search of jobs, which exacerbates isolation by disrupting or breaking down the support networks and structures that older persons may have previously relied on. The vast majority of older persons in eastern Ukraine report feelings of depression,
anxiety and helplessness, and loneliness is one of the main causes of these feelings. Older persons, especially those with disabilities, suffer further harms as a consequence of limited freedom of movement, lack of transport and insecurity due to contamination by landmines/explosive remnants of war and to continued hostilities that impact conflict-affected people as a whole as well as those with limited or no physical mobility. Over half of older persons require assistive products, including walking frames, canes and toilet chairs (7). This also contributes to difficulty at checkpoints – these are often not adapted to their needs, and crossing them may involve queuing for extended periods of time in harsh weather conditions.
2 STUDY AIMS
The aims of this study were twofold:

1. To analyse secondary datasets, quantify access to health-care services for older persons and PWDs, according to their proximity to the “line of contact”, and assess other major factors affecting access to health-care services; and

2. To develop a set of evidence-based recommendations to adjust the operational response, giving particular consideration to human rights and protection issues related to PWDs.
3 METHODOLOGY OVERVIEW
This quantitative research study was based on datasets received from HelpAge International Ukraine. The available datasets covered the period 2016–2019. Prior to starting the analysis, the data were reviewed and missing data excluded. The questionnaire changed significantly over these years, which only allowed a comparison of selected variables of the most recent datasets for the period 2018–2019.

The survey was conducted among persons aged 60 years and over. The mean age of participants was 73.0±8.3 years and the median age 72 years. For each year, the sample size exceeded 6500 interviews (6693 in 2018 and 6533 in 2019). Most interviewees were female (74% in 2018 and 76% in 2019). The majority of interviews took place in locations close to the “contact line” (particularly in 2019). Twenty-three raions were represented in 2018, including GCAs and NGCAs, while 13 raions in GCAs of eastern Ukraine were represented in 2019, 11 of which were the same as in 2018. Of the raions that were present in both years, the analysis focused on nine with a sample size of over 300 beneficiaries of humanitarian aid.

The initial data collection was conducted by HelpAge and carried out with the help of volunteers. The questionnaire was presented to persons aged 60 years and over, who were targeted on the basis of specific vulnerabilities. The majority of the questions were structured as satisfaction scores, which simplified data analysis by producing categorical answers (see Annex 1).

The data consist of categorical variables, most of which are ordered on a scale of 1 to 5. To quantify level of correlation between ordinal variables (on the 1–5 scale), the Kendall rank correlation coefficient was used – a test that preserves the order of results and does not assume any prior knowledge of distribution; it assumes values between −1 (perfect negative correlation) and 1 (perfect correlation), with 0 meaning that variables are independent. When comparing access to health services with proximity to the “contact line”, the study used the Mann–Whitney test, as the distribution does not pass the Shapiro–Wilk test for normality. Cross-tabulation between the number of categorical variables and Pearson’s chi-squared test was used to report statistical significance of association. To quantify level of correlation, the analysis calculated bias-corrected Cramér’s V statistic. This study bias – towards more sensitive locations and including the most vulnerable citizens – makes some data more difficult to interpret but strengthens the conclusions in otherwise underrepresented groups.

Table 1 presents selected variables and their descriptions and responses. In the analysis, 11 ordinal variables were analysed using an inverted Likert scale, with 1 being the most positive answer and 5 the most negative. Some variables when combined into groups showed significant correlation.

In addition, the data were disaggregated by oblast and raion to explore geographical variation of trends. Categories of expenditure, humanitarian aid received, and sources of income were used in the categorical analysis.

The ability to move independently was correlated with access to health-care services for the sample. The study did not focus on isolated settlements because they were not included in the data sample. However, the available datasets included PWDs along the “line of contact".
Table 1. Description of major variables analysed in the study

<table>
<thead>
<tr>
<th>ID</th>
<th>Variable</th>
<th>Description</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>age</td>
<td>Age group</td>
<td>60s, 70s, 80s, 90+</td>
</tr>
<tr>
<td>2</td>
<td>family</td>
<td>Close family members nearby</td>
<td>More than 3, 2, 1, only visits, alone</td>
</tr>
<tr>
<td>3</td>
<td>income</td>
<td>Sources of income</td>
<td>From “none” to state pension and other state help</td>
</tr>
<tr>
<td>4</td>
<td>sociality (soc&amp;ind)</td>
<td>Amount of social interaction/communication</td>
<td>From “most of the time spent with relatives” to “isolated”</td>
</tr>
<tr>
<td>5</td>
<td>isolation (soc&amp;ind)</td>
<td>How often person is isolated</td>
<td>From “never” to “always”</td>
</tr>
<tr>
<td>6</td>
<td>independence (soc&amp;ind)</td>
<td>Independence in daily activities</td>
<td>From “independent” to “dependent”</td>
</tr>
<tr>
<td>7</td>
<td>mobility (soc&amp;ind)</td>
<td>Mobility</td>
<td>From “mobile” to “immobile”</td>
</tr>
<tr>
<td>8</td>
<td>stairs (soc&amp;ind)</td>
<td>Difficulty climbing stairs</td>
<td>From “no difficulty” to “not being able to”</td>
</tr>
<tr>
<td>9</td>
<td>water</td>
<td>Access to safe water</td>
<td>From having drinkable water at home to not having any access to safe water</td>
</tr>
<tr>
<td>10</td>
<td>sanitation</td>
<td>Access to sanitation</td>
<td>From having access at home adapted to limited mobility to none</td>
</tr>
<tr>
<td>11</td>
<td>access to health care (hs_access)</td>
<td>Access to health services</td>
<td>The main variable: satisfaction in ease of access to health services; from “free of charge and often” to “no access”</td>
</tr>
</tbody>
</table>
MAJOR FACTORS AFFECTING ACCESS TO HEALTH-CARE SERVICES FOR OLDER PWDs
Despite primary health care being provided free of charge in Ukraine, the country's investment in health amounted to 2.9% of gross domestic product (GDP) in 2015, which was lower than the average of countries in the WHO European Region (5%) and the European Union (6%). Out-of-pocket payments grew as a share of total spending on health, reaching 48% in 2015, which was among the highest in the European Region (8). Ukrainian citizens were effectively paying twice for their health care: when they paid their taxes and when they accessed services through out-of-pocket contributions. This situation was further aggravated in conflict-affected areas in eastern Ukraine where income-generating opportunities were very limited, especially for older PWDs. The HelpAge data show that in 2018 the sole income source for 74% of older persons was their pension, which was scarcely sufficient to cover their basic needs; and in 2019, the figure was even higher, with 81% of older persons depending on their pension alone.

Hundreds of thousands of pensioners have lost access to their main source of income, their pension, because of the armed conflict, and some of these pensioners are PWDs, who are in even more difficult circumstances. Over the six years of the conflict, the government has not created a mechanism to make pension payments to its citizens, thereby exacerbating their daily lives still further. Older persons living along the “contact line” and in isolated communities are among the most vulnerable, as there are no adequate social services available and no access to goods and services to meet their basic needs. The lack of public transport in both regions affected by the conflict means that people struggle to access amenities such as markets, pharmacies and other health-care facilities. Basically, there is no possibility of community engagement and socializing, and people’s mental health and psychosocial well-being are affected. In spite of the grave situation, there has been no government response or attempt to meet people’s needs. Unlike young and able-bodied people, older persons, people with limited mobility and PWDs have very limited opportunity to access their entitlements and to enjoy their rights.

A pension is the sole or main source of income for older persons and PWDs. Because of the conflict, people living in territory controlled by armed groups face difficulties receiving their pensions, as they have to cross the “contact line” on a regular basis to receive their entitlements. As a result of the partial closure of the entry–exit crossing points, older persons living in NGCAs are unable to access their pensions and other financial benefits in GCAs. In addition, IDPs living in government-controlled territory who have relinquished their IDP certificate face impediments in getting their pensions. There is no adequate and accessible system for payment of pensions, nor is there a satisfactory policy for integration of IDPs, including PWDs and older persons, into the new communities they are displaced to.

Older PWDs living along the “contact line” are the worst affected. Multiple factors, such as absence of public transport, markets and pharmacies, lack of job and entertainment opportunities, and lost livelihoods, have contributed to a worsening of the situation for civilians – a situation that is aggravated further by insecurity due to ceasefire violations and mine contamination (9).

4.1 Proximity to “line of contact”

The impact of the conflict is most acutely felt close to the “contact line”, where most of the ceasefire violations and shelling occur. The results of the data analysis for
2018 and 2019 show that those living closer to the “contact line” had significantly lower access to health-care services than those residing further from the “contact line” (Fig. 1 and 2).

Fig. 1. Access to health-care facilities in 2018

- The orange lines indicate the middle value of the distribution (median); the boxes extend from the 25th to the 75th percentile; the whiskers extend from the minimum to the maximum observed value. Access to health care is a significant predictor of distance to “contact line”: the p value is smaller than 0.01 for a Mann–Whitney test.

Comparing the trends in the group that reported seldom or never having access to health care and the group that always or very often did so, the beneficiaries from 2018 were more diverse in geographical distribution than those from 2019. Moreover, both groups lived further from the “line of contact” in 2018 than their counterparts in 2019. Despite this improvement, the data show that the level of access to health care declined the closer we get to the “line of contact” (Fig. 3).

Fig. 3. Comparison of poor access (“seldom” and “never”) and reasonable access (“always” and “very often”) with distance to “contact line”, 2018 and 2019

- The orange lines indicate the middle value of the distribution (median); the boxes extend from the 25th to the 75th percentile; the whiskers extend from the minimum to the maximum observed value. We can see that, because of the wider geographical scope of the study, the results for 2018 have a much higher standard deviation than those for 2019.
Table 2 shows a comparison of the total sample points collected in 2018 and 2019, and the general improvement in the proportion of the disabled population who reported that they always or very often had access to health care.

Table 2. Frequency table of access to health care, by category and year

<table>
<thead>
<tr>
<th>Access to health care</th>
<th>2018 (n)</th>
<th>2018 (%)</th>
<th>2019 (n)</th>
<th>2019 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always</td>
<td>229</td>
<td>3</td>
<td>955</td>
<td>15</td>
</tr>
<tr>
<td>Very often</td>
<td>648</td>
<td>10</td>
<td>285</td>
<td>4</td>
</tr>
<tr>
<td>Often</td>
<td>1111</td>
<td>17</td>
<td>1991</td>
<td>31</td>
</tr>
<tr>
<td>Seldom</td>
<td>4407</td>
<td>66</td>
<td>2964</td>
<td>47</td>
</tr>
<tr>
<td>Never</td>
<td>266</td>
<td>4</td>
<td>151</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>6661</td>
<td>100</td>
<td>6346</td>
<td>100</td>
</tr>
</tbody>
</table>

Though the sample population and size are not the same for the two years under comparison, there was improvement in the proportion of people who reported that they always had access to health care. However, there was not much progress in the number of people who never or seldom had access to health care. Compared to 2018, there was a reduction in 2019, but about half of beneficiaries still reported that they had seldom or never had access to health care, which highlights the fact that needs remained unmet.

When looking at settlement distribution of sample points – in this case, beneficiaries along the “contact line” in 2018 and 2019. Access had improved, in particular, along the north-eastern part of the line close to Stanitsia Luhanska. Spatial analysis has shown there was an overall improvement in access to health care over this period. However, a significant proportion of the older population with disabilities remained with limited or no access to healthcare services.
4.2 Top spending and access to health care

The humanitarian crisis in eastern Ukraine has isolated primary health-care units in GCAs from specialized services in secondary or tertiary hospitals located in urban centres in NGCAs (7). The broken referral system is one of the reasons why residents are obliged to visit hospitals where out-of-pocket payment is quite common (on top of high transport costs) – in some places, higher than the costs of treatment. Using data on major spending among beneficiaries collected by HelpAge International, a cross-tabulation with level of access to health care shows that, in both 2018 and 2019, medication accounted for the largest proportion of spending across the board, but especially for those who had less access to health care (Fig. 4). There was not much difference between the results for the two years, with medication accounting for 71% of spending by those who never had access to health care in 2018 and 72% in 2019.

Fig. 4. Cross-tabulation between top spending and access to health care in 2018 and 2019

Between 2018 and 2019 expenditure on medication fell from 60% to 45% for those who reported that they always or often had access to health care. However, those who reported that they never had access to health care were the ones who spent most of their income on medication. In other words, those who needed the health services most were the ones with no access at all.

4.3 Correlation with other variables

An estimate of the correlation coefficient among a set of selected ordinary variables shows that access to health had the strongest correlation, in both 2018 and 2019, with “independence”, which assesses a person’s ability to move and perform their tasks independently and without assistance (Fig. 5). The finding shows that PWDs with mobility challenges – especially those who did not have family members to support them – were among the most affected group that required appropriate interventions.
**Fig. 5. Correlation between access to health care and selected ordinal variables, 2018 and 2019**

Furthermore, the analysis pulled together six variables – age, access to shelter, mobility, income, moving independently and disability status – and created a composite “vulnerability index” (Fig. 6). These variables were selected after reviewing the correlation with access to health care. The composite index was created as an aggregate score by giving equal weight to all six variables.

**Fig. 6. Cross-tabulation between vulnerability index and access to health care in 2018 and 2019**

*The reported value is a Kendall rank correlation coefficient, which ranges from −1 to 1; a value of 0 indicates no correlation.*

*The graphs are normalized for each vulnerability index. Answers on access to health care range from 1 (“always have access”) to 5 (“never have access”). The same pattern applies to the vulnerability index: 1 (“low vulnerability”) to 5 (“high vulnerability”).*
When comparing the vulnerability index vis-à-vis access to health-care services, 80% of those with the highest vulnerability index rarely had access to health care in 2018, but this figure declined to 60% in 2019. When we look at the group who were least vulnerable, only 37% reported that they always had access to health-care services in 2018, but this proportion increased significantly to 81% in 2019.

4.4 Comparison between the two oblasts

A comparison between the two oblasts, Donetsk and Luhansk, was conducted in order to understand if there was a difference in the level of access to health care not explained by the unequal distribution of beneficiaries in the two regions. In both oblasts, there was an increase between 2018 and 2019 in the proportion of beneficiaries who reported that they always had access to health-care services. Similarly, in both oblasts there was a reduction between 2018 and 2019 in the proportion of beneficiaries who seldom had access to health-care services, with a higher reduction in Luhansk; the same was true of those who never had access to health-care services. Overall, there was an improvement in access to health care over the period 2018–2019, with Luhansk showing a higher level of improvement than Donetsk (Fig. 7). Nevertheless, there was still a significant number of people with no or limited access to primary health care in both oblasts.

Fig. 7. Access to health care, by oblast and year

There is a clear difference in the level of access between the poor-performing raion Bakhmutskyi (worst access to health services and minimal change between 2018 and 2019) and Marinskyi (best-performing raion in 2019 and biggest improvement since 2018) (Fig. 8). Despite such exceptions, the majority of raions have comparable levels of access to health care, with only modest improvements in 2019.
Fig. 8. Access to primary health care, by best- and worst-performing raion and year

Access to health care

- never
- seldom
- often
- very often
- always

Percentage of beneficiaries (%)
CONCLUSIONS AND KEY RECOMMENDATIONS
Globally, an estimated 15% of people have some type of disability, a proportion which is likely to be higher in humanitarian crises, yet the ways in which assistance and protection are provided for PWDs in humanitarian settings need to be modified (10). There is good evidence that PWDs are more likely to have poorer health than the general population and their health status may differ depending on the nature of their impairment (11). The humanitarian context in eastern Ukraine is no different to this: a joint Health and Protection Cluster paper highlighted that meaningful access to good-quality health care and medicine is one of the key health and protection concerns for many people living in the conflict-affected areas and particularly for those living closer to the “line of contact” or crossing it (7).

The humanitarian response in the eastern conflict areas has placed older persons and PWDs at the centre of the humanitarian programme cycle, both at planning and implementation phases, and response projects are assessed accordingly. The findings in this paper are encouraging, bearing witness to the efforts that have been made, but it is also evident that there are still big gaps that need to be filled. PWDs still face a range of barriers, such as limited mobility and inability to access and pay for health-care services, medication, and specialized services or assistive devices. Their living conditions are generally poor, and for the most part they rely on their caregivers, families and neighbours for support (1).

The secondary data analysis on the level of access to health care shows that older persons and PWDs living closer to the “line of contact” had a significantly lower level of access to health-care services; this is in line with the multisectoral needs assessment carried out in 2019 and prior years, which found that a higher proportion of households reporting difficulties accessing health-care services were those residing within 0–5 km of the “line of contact” (12). This was true of beneficiaries targeted in 2018 and 2019, as the area close to the “line of contact” was the most affected by the conflict, causing a breakdown in the referral pathway, a deterioration of the health-care infrastructure and an exodus of trained medical workers leaving the area to work elsewhere.

Generally, access to health-care services showed an improvement in 2019, when 15% of beneficiaries reported that they always had access to health-care services, compared to only 3% in 2018. There was also a reduction in the proportion of beneficiaries who seldom or never had access, from 70% in 2018 to 49% in 2019. While these improvements were encouraging, the situation remained far from ideal, as the figures imply that 85% of beneficiaries still faced varying degrees of difficulty accessing health-care services. The figures are in fact far worse than those obtained in the multisectoral needs assessment conducted by REACH in 2019, in which 54% of households reported some difficulties accessing health care in 2018, and 53% in 2019 (12).

Older persons and PWDs rely heavily on their pensions, which are rarely enough to cover their day-to-day needs, and the situation is even worse for those living in conflict-affected areas. The analysis highlighted that medication accounted for the biggest share of spending across the board, but the proportion was even higher for those who had least access to health services. There was a marked variation in expenditure between those who had good access to health care and those who did not: in 2019, 43% of those with good access to health care reported that medication was their major area of expenditure, while the corresponding figure for those who did not have good access was 72%. This suggests that those who needed health services most were unable to get them, and so had to spend much of their income on medication.
According to the correlation coefficient, independence – the ability to move and perform routine tasks independently – had the strongest correlation with the level of access to health care, followed by sociability and mobility, which are both related to disability. The composite vulnerability index, created by aggregating the scores of six different variables, also indicated that age, access to shelter, income and documentation of disability status were factors that can affect the level of access to care.

Further disaggregation of data at oblast and raion level allows us to see if there was any significant difference in access to health care. In both Luhansk and Donetsk, there was an improvement in level of access in 2019 compared to the previous year, but there was not enough evidence to conclude that one oblast had better access to care than the other. The analysis at raion level was not significantly different from that at oblast level (although there were a few raions with exceptionally good or bad levels of access). Overall, there was a significant shortfall in both oblasts in the provision of accessible health-care services to PWDs residing in settlements along the “line of contact”.

Based on the major findings of the secondary data analysis, the key recommendations are as follows.

**Access to health services and health infrastructure**

- Regional health authorities, together with humanitarian actors, should address the immediate health needs of older persons and PWDs, particularly those living in proximity to the “line of contact”. Utmost attention should be given to older persons and PWDs at planning, implementation, monitoring and evaluation of the humanitarian response programme.

- Humanitarian organizations, particularly Health and Protection Cluster partners, should design targeted interventions that can reduce the high expenditure on medication made by older persons and PWDs. Humanitarian response plans should bring basic and emergency health-care services closer to the older population, especially PWDs, and incorporate home-based care and delivery of prescription medicine. Support for public transport projects in the conflict-affected areas should also be disability-inclusive, so that PWDs can access public transport to reach health services in urban centres.

- Health authorities and partner organizations should invest in repairing the health infrastructure and ensure that public transport is available in eastern conflict areas so that communities do not have to travel long distances to urban centres in search of specialized health-care services. This repair work should make health infrastructure accessible to older persons with limited mobility and PWDs. People living along the “contact line” spend a significant part of their income on transport, a cost that could easily be saved if local hospital services were maintained. It is equally important to ensure that adequately trained health-care workers are in place to provide specialized services to communities that are most in need of them.

**Health financing and reform**

- The current health system reform should make adjustments to ensure that it meets the needs of older persons and PWDs living in conflict-affected areas whose income sources are highly dependent on a pension or disability allowance.
• Decentralization reform should be conducted in coordination with the health reform in such a way that amalgamated communities (*hromadas*) adopt an administrative structure that is aligned with that of the existing health-care referral system.

• Adequate public funding should be allocated to make all health-care facilities accessible to PWDs and older persons with limited mobility in terms of both architecture and information access. Staff at such facilities should also be trained in how to provide medical assistance to PWDs. Particular attention should be paid to sexual and reproductive health services, including appropriate equipment (gynaecological chairs, mammograms, X-rays, etc.) that is accessible to women with disabilities.

• Adequate public funding should be allocated to habilitation and rehabilitation programmes and technical and other means of rehabilitation. Timely and accessible information on existing rehabilitation programmes and assistive devices for which they are eligible should be provided to PWDs.

• Adequate public funding should be provided for further extension of the network of palliative care facilities in the conflict-affected regions.

• Adequate public funding should be provided for mental health programmes for the conflict-affected population, taking full account of the needs of older persons and PWDs and ensuring that such programmes are accessible to them.

• Consideration should be given to changes in the affordable drug programme so that it meets the needs of older persons and PWDs residing in proximity to the “line of contact”. The programme is designed to work via SMS in which a prescription code is sent to a patient's phone and the patient is then required to travel to a nearby pharmacy to collect their drugs (the previous system allowed one person in a village or community to collect several prescriptions).

**Protection and human rights**

• In planning, response and recovery phases of emergency management, it is essential to take into account the fact that older persons are often the last to leave their places of origin, and when they are displaced, they risk remaining in a situation of protracted displacement. Appropriate resources should be allocated, and the rights of older persons in such situations should be recognized and upheld.

• Adoption of the amendments to pension legislation that human rights and humanitarian organizations have drafted would facilitate access to basic services and give older persons and PWDs the opportunity to enjoy their rights with dignity and respect.
REFERENCES


## 1. General information

| 1.1 Interviewer (last name and first name): |  
| 1.2 Volunteer’s code: |  
| 1.3 Date of interview: |  
| 1.4 Oblast: | □ Donetsk □ Luhansk  
| 1.5 Name of location: |  
| 1.6 Last name, first name and patronymic of beneficiary: |  
| 1.7 Beneficiary’s code: |  
| 1.8 Sex: | □ M □ F  
| 1.9 Date of birth: |  
| 1.10 Age: | □ 60-69 □ 70-79 □ 80-89 □ 90+  
| 1.11 Address of residence (at time of interview): |  
| 1.12 Family status: | □ Single □ Married □ Widowed □ Divorced  
| 1.13 Loss/absence of documents: | □ Yes □ No  
| 1.14 Mobility of beneficiary: | □ Mobile □ Limited mobility □ Immobile  
| 1.15 Contact telephone number: |  
| 1.16 Do you have a carer? | □ Yes (24-hour) □ Yes (part-time) □ No (in need) □ No (no need)  
| 1.17 Do you have a disability (official document): | □ Yes (Group _______ ) □ No  

## 2. Vulnerability assessment

| 2. Vulnerability assessment |  
| 1. Legal status: | □ Legal status  
| 2. Family support: | □ Family support  

### Low

- Do not belong to the category of IDPs
- Newly registered as IDP but unable to receive state support
- On the waiting list for registration
- Alone

### Medium

- Newly registered as IDP and eligible to receive state support
- > 1 or with members contacting the person by phone

### High

- Registered and with access to state support
- > 3 How many family members are there?
### 3. Access to an income
<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always (access to pension, salary, state benefits, aids)</td>
<td>Very often (access to pension, salary, some state benefits)</td>
<td>Often (access to pension)</td>
<td>Seldom</td>
<td>Never (lack of access to possible entitlements)</td>
</tr>
</tbody>
</table>

### 4. Social interaction
<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does beneficiary communicate with others?</td>
<td>Feels himself/herself as a fully fledged member of society, surrounded by relatives and family</td>
<td>Most of his/her time spent with his/her relatives and family</td>
<td>Sometimes feels isolated</td>
<td>Communication with others is limited</td>
</tr>
</tbody>
</table>

### 5. Activity of daily living
<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fully independent</td>
<td>Mostly independent</td>
<td>Independent but with some adaptive measures</td>
<td>Limited independence (needs help for home cleaning, walking, etc.)</td>
<td>Fully dependent</td>
</tr>
</tbody>
</table>

### 6. Access to safe water
<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the individual have access to safe drinkable water?</td>
<td>Always (drinkable tap water in the flat/house)</td>
<td>Very often (six times a week)</td>
<td>Often (four times a week)</td>
<td>Seldom</td>
</tr>
</tbody>
</table>

### 7. Access to sanitation
<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the individual have access to sanitation?</td>
<td>Always (inside of the house; adapted for people with limited mobility)</td>
<td>Very often (facility outside the main house, in the garden)</td>
<td>Limited access</td>
<td>Seldom (inappropriate facility, very old, in need of repair)</td>
</tr>
</tbody>
</table>
### 8. Access to health facilities

<table>
<thead>
<tr>
<th>Does the individual have access to adequate health services?</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always (has free access to health services and medication)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very often (has free access to health services but not medication)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Often (has access to basic health services)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seldom (health services not fully available)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never (has no access to health services and medication)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 9. Access to durable shelter

<table>
<thead>
<tr>
<th>Does the individual live in a shelter that is suitable for both summer and winter?</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suitable for both winter and summer: ventilation, furnishing, heating</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suitable for winter: heating, furnishing and other suitable conditions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suitable for summer: ventilated</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not suitable for summer or winter: unable to control ventilation, no furnishing, no heating and partially damaged housing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shelter partially/completely destroyed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Overall score

### 3. Protection/psychosocial vulnerability

- **3.1 Feeling of loneliness:**
  - □ Yes □ No
- **3.2 Participates in social activities:**
  - □ Yes □ No
- **3.3 Sleep disorders:**
  - □ Yes □ No
- **3.4 Persistent memories of conflict:**
  - □ Yes □ No
- **3.5 Crying/weeping attacks:**
  - □ Yes □ No
- **3.6 Conflict behaviour with those around you:**
  - □ Yes □ No
- **3.7 Violence:** □ No □ Physical □ Sexual □ Gender-based □ Psychological □ Verbal abuse □ Financial abuse

### 4. Health/physical vulnerability

- **4.1 Chronic illness:**
  - □ Diabetes □ Cardiovascular disease □ Respiratory disease □ Locomotor system □ Oncology □ Other (please specify)
- **4.2 Screening: Arm circumference (mm)**
  - _____________
- **4.3 Do you have difficulty seeing even if wearing glasses?**
  - □ No – no difficulty □ Yes – some difficulty □ Yes – a lot of difficulty □ Cannot do at all
- **4.4 Do you have difficulty hearing even if using a hearing aid?**
  - □ No – no difficulty □ Yes – some difficulty □ Yes – a lot of difficulty □ Cannot do at all
- **4.5 Do you have difficulty walking or climbing stairs?**
  - □ No – no difficulty □ Yes – some difficulty □ Yes – a lot of difficulty □ Cannot do at all
4.6 Using your usual language, do you have difficulty communicating (for example, understanding or being understood by others)?
- No – no difficulty
- Yes – some difficulty
- Yes – a lot of difficulty
- Cannot do at all

4.7 Do you have difficulty remembering or concentrating?
(0 = none, 3 = a lot)
- 0
- 1
- 2
- 3

4.8 Do you have difficulty with (self-care such as) washing all over, dressing, or going to the toilet?
- No – no difficulty
- Yes – some difficulty
- Yes – a lot of difficulty
- Cannot do at all

4.9 Do you have difficulty moving independently?
- In bed: Yes No
- Around the room: Yes No
- In the street: Yes No

5. Economic vulnerability

5.1 Source of income of the beneficiary:
- Salary
- Pension
- Disability allowance
- Assistance from relatives
- Household
- IDP allowance

5.2 Source of income of the family at the moment:
- Unemployment allowance
- Salary
- Pension
- Disability allowance
- Assistance from relatives
- Household
- IDP allowance

5.3 Accommodation:
- Own house
- Apartment
- Rental housing
- No housing

5.4 Do you have dependents?
- Family members: Yes No
- Including children under 18: Yes No

5.5 Do you receive humanitarian assistance?
- No
- Food
- Non-food items
- Cash vouchers
- Repairs to damaged housing
- Other (please specify) ____________________

5.6 Have you had to reduce the number of food intakes during the last year?
- Yes
- No

5.7 Have food markets/stores been available over the last year?
- Yes
- No

5.8 Have you had debts over the last year?
- Yes
- No

5.9 What do you spend most money on each month?
- Food
- Medicines
- Transport
- Repairing damage to housing
- Winter clothes
- Hygiene items
- Clothes
- Supporting rehabilitation equipment (hearing aids, wheelchairs, crutches, etc.)
- Rent for housing
- Utility bills

6. Non-food item (NFI) needs

6.1 Cane:
- Yes
- No

6.2 Walking frame:
- Yes
- No

6.3 Crutches
- Yes
- No

6.4 Toilet chair:
- Yes
- No

6.5 Hygiene kit:
- Yes
- No

6.6 Miscellaneous assistive aid (for immobile):
- Yes
- No

6.7 Diapers:
- Yes
- No
- Size ____________________

6.8 Blanket:
- Yes
- No

According to the Law of Ukraine “On Protection of Personal Data”, I, _______________________________ , give my consent that HelpAge International collect, store, process and transfer my personal data to government and local self-government agencies, government organizations, institutions, humanitarian organizations, etc., with a view to the possible provision of aid to me and/or members of my family and/or my relatives and/or those who are under my guardianship. I have been informed of the purpose of collecting, storing, processing and transferring my personal data, and I understand this purpose.

Signature _______________________________ Date _____________________________
The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

Member States

Albania
Andorra
Armenia
Austria
Azerbaijan
Belarus
Belgium
Bosnia and Herzegovina
Bulgaria
Croatia
Cyprus
Czechia
Denmark
Estonia
Finland
France
Georgia
Germany
Greece
Hungary
Iceland
Ireland
Israel
Italy
Kazakhstan
Kyrgyzstan
Latvia
Lithuania
Luxembourg
Malta
Monaco
Montenegro
Netherlands
North Macedonia
Norway
Poland
Portugal
Republic of Moldova
Romania
Russian Federation
San Marino
Serbia
Slovakia
Slovenia
Spain
Sweden
Switzerland
Tajikistan
Turkey
Turkmenistan
Ukraine
United Kingdom
Uzbekistan