Health Tracker survey: factsheet

Round 1, November–December 2025

World Health Organization

European Region

Executive summary

The Health Tracker survey (Round 1, November–December 2025; n = 4000) provides a national snapshot of population health and access to health-care services in Ukraine. Internal displacement remains widespread: among respondents who relocated after February 2022, 80% reported war-related displacement and approximately 60% hold official internally displaced status. A significant share of respondents reported worsening health compared to a year earlier, particularly in frontline regions, where poor or very poor health and worsened mental health were reported more frequently than in other regions.

Primary health care (PHC) remains the most accessible level of care. Overall, 68% of respondents visited a family doctor in the last 12 months, and satisfaction among those with a signed declaration was high (85%). Appointment systems generally functioned well, with most patients seen within one or two days, but wait times at facilities persisted for a substantial share of patients.

Access challenges were more pronounced for specialized services and cardiovascular and surgical care. Thirty-four per cent of respondents reported needing specialized care and 22% needed cardiovascular care. While most respondents who sought care were able to receive it, many reported delays, partial access and financial barriers.

Access to medicines remains constrained, particularly in frontline areas, where financial barriers, security concerns and pharmacy closures were more frequently reported. Antibiotic use in the past three months was widespread, with higher reliance on non-prescription sources in the most affected regions. Overall, 30% of respondents reported health-care expenditures in the past month, many reported postponing care and noted that psychosocial distress affected their daily activities, which underscores persistent pressures on both health services and household well-being.

Background

In an effort to maintain, scale up and further develop the Health needs assessment (HNA) survey for 2025–2026, the WHO Country Office in Ukraine initiated a revision and optimization of the methodology to strengthen in-depth analytical capacity and enhance relevance for a broad range of users, including internal WHO programmes, Health Cluster partners, external stakeholders and the Government of Ukraine.

As part of the methodological review, taking into account both existing features and opportunities for expansion, the transition from the HNA to a Health Tracker survey was proposed. Based on the completed review of the HNA methodology and identified needs of the WHO Country Office in Ukraine and national stakeholders, the preferred scenario focused on targeted methodological updates to ensure alignment with the evolving context, characterized by a shift from acute to protracted emergency. This included transforming the study into a health-focused omnibus survey – a serial, cross-sectional, multipurpose quantitative survey designed to generate data across multiple health domains relevant to response, recovery and reform efforts.

The modular structure of the questionnaire, combined with increased data collection frequency, enables the inclusion of additional thematic blocks and supports the information needs of multiple stakeholders within a single survey framework. The flexible design, regular implementation and short intervals between rounds allow for timely monitoring of changes and rapid adaptation to emerging challenges. Quarterly data collection further enables the aggregation of consecutive rounds into larger analytical datasets, increasing sample size and allowing more granular analysis, including at oblast level.

The study was developed with substantial technical input from the WHO Country Office in Ukraine and is led by experts with extensive experience in designing and implementing surveys in humanitarian settings, including health systems and health emergency response. The methodology and data collection tools were reviewed by representatives of the Public Health Center of the Ministry of Health of Ukraine to support coordination and strengthen data use at the national level.

Methodology

The Health Tracker is implemented as a serial, cross-sectional quantitative survey with a modular questionnaire design. Data collection is conducted on a quarterly basis, with flexibility to increase frequency in response to emerging issues and evolving information needs. Each survey round requires approximately 10–30 minutes to complete. Data for Round 1 were collected through computer-assisted telephone interviews (CATI) by a contracted local data collection partner and analysed using standardized SPSS syntax and R scripts developed for this purpose.

The modular structure of the questionnaire and the regularity of data collection allow for the inclusion of multiple thematic blocks while maintaining responsiveness to changing contextual dynamics. The quarterly implementation schedule enables the aggregation of data from adjacent rounds, increasing effective sample size and supporting more granular analyses, including at oblast level. While the cross-sectional design does not allow for causal inference, it provides timely snapshots of self-reported needs, access to services and health-related outcomes.

The study population includes adults aged 18 years and older residing in Ukraine at the time of data collection. People under 18 years of age and those not residing in Ukraine during the fielding period were excluded. As noted in the study limitations, the use of CATI in the context of population movement and an evolving sampling frame may result in underrepresentation of certain population groups, including older persons and people in the most vulnerable situations with limited access to mobile connectivity.

Participation in the survey is voluntary and no financial incentives are provided. To ensure adequate alignment between the demographic distribution of the sample and that of the adult population currently residing in Ukraine – by age, sex, area of residence (urban/rural) and macroregion – a sample size of n = 4000 respondents per round was used. This sample size is designed to reflect the current estimated population structure in Ukraine, based on the best available data from multiple sources.

Sociodemographic information

Table 1. Sociodemographic information of the respondents

a) Type of settlement	
Oblast centre	38%
Other city in the oblast	29%
Rural	33%

b) Gender	
Male	38%
Female	62%

c) Age	
18–29 years	11%
30–39 years	16%
40–49 years	20%
50–59 years	18%
60+ years	35%

d) Live with	
Children under 18 years	33%
People over 65 years	33%
People with a chronic disease	35%
People who are pregnant or lactating	2%
People who have disabilities *(actual condition, regardless of whether they have an officially recognized category of disability or not)*	10%
People who have disabilities *(officially, officially recognized category of disability)*	25%
None of the above	43%

e) Oblast of residence	N	%
1. Vinnytsya	163	4%
2. Volyn	125	3%
3. Dnipropetrovsk	424	11%
4. Donetsk	47	1%
5. Zhytomyr	113	3%
6. Zakarpattya	110	3%
7. Zaporizhzhya	105	3%
8. Ivano-Frankivsk	143	4%
9. Kyiv	269	7%
10. Kirovohrad	116	3%
11. Luhansk	0	0%
12. Lviv	237	6%
13. Mykolayiv	151	4%
14. Odesa	228	6%
15. Poltava	154	4%
16. Rivne	117	3%
17. Sumy	133	3%
18. Ternopil	106	3%
19. Kharkiv	323	8%
20. Kherson	53	1%
21. Khmelnytsky	140	3%
22. Cherkasy	141	4%
23. Chernivtsi	94	2%
24. Chernihiv	124	3%
25. Kyiv city	385	10%

f) Macroregions	
Most affected oblasts *(Donetsk, Zaporizhzhya, Kharkiv, Kherson, Sumy)*	13%
Oblasts of increased vulnerability *(Dnipropetrovsk, Mykolayiv, Odesa, Chernihiv)*	26%
Kyiv city	10%
Rest of the country	51%

People who have been internally displaced

15% changed place of residence since 24 February 2022

80% of relocations caused by the war*

60% have official internally displaced person (IDP) status*

Figure 1. Timing of the relocation*

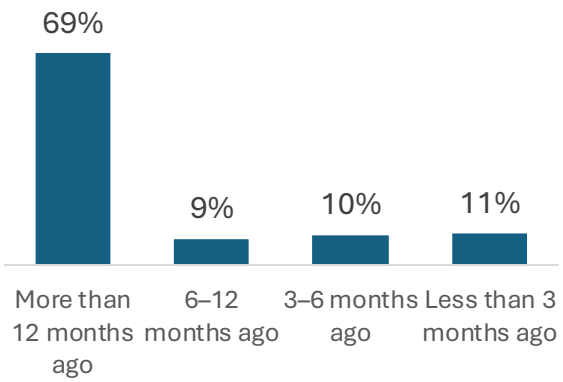


Figure 2. Current living situation*

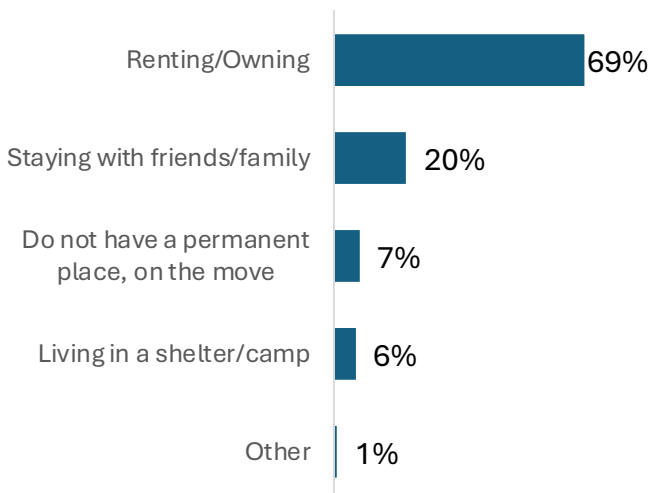


Table 2. Oblast of origin and current residence among internally displaced respondents

Oblast of residence*	Relocated from	Currently live in
1. Vinnytsya	2%	3%
2. Volyn	1%	1%
3. Dnipropetrovsk	7%	15%
4. Donetsk	19%	2%
5. Zhytomyr	1%	2%
6. Zakarpattya	1%	3%
7. Zaporizhzhya	7%	4%
8. Ivano-Frankivsk	1%	4%
9. Kyiv	3%	7%
10. Kirovohrad	1%	2%
11. Luhansk	5%	0%
12. Lviv	2%	6%
13. Mykolayiv	4%	4%
14. Odesa	3%	4%
15. Poltava	2%	5%
16. Rivne	1%	2%
17. Sumy	5%	4%
18. Ternopil	2%	2%
19. Kharkiv	13%	10%
20. Kherson	9%	2%
21. Khmelnytsky	2%	2%
22. Cherkasy	1%	2%
23. Chernivtsi	1%	3%
24. Chernihiv	3%	3%
25. Kyiv city	4%	9%

* Among those whose place of residence changed after 24 February 2022

Health status in the past 12 months

Figure 3. Current health status

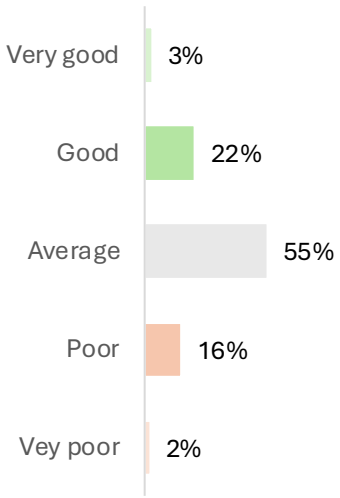


Figure 4. Health status compared to a year ago

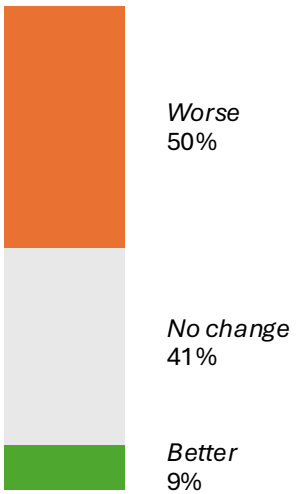


Figure 5. Health services compared to a year ago

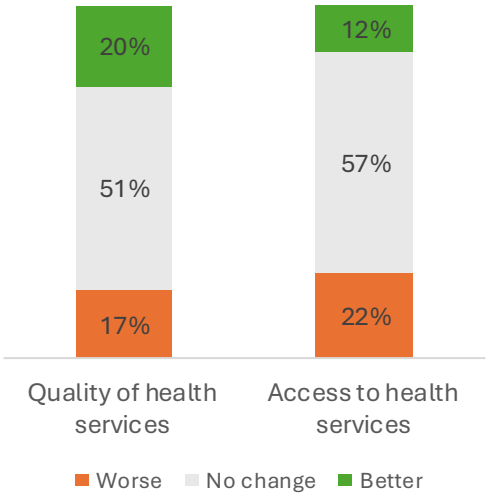
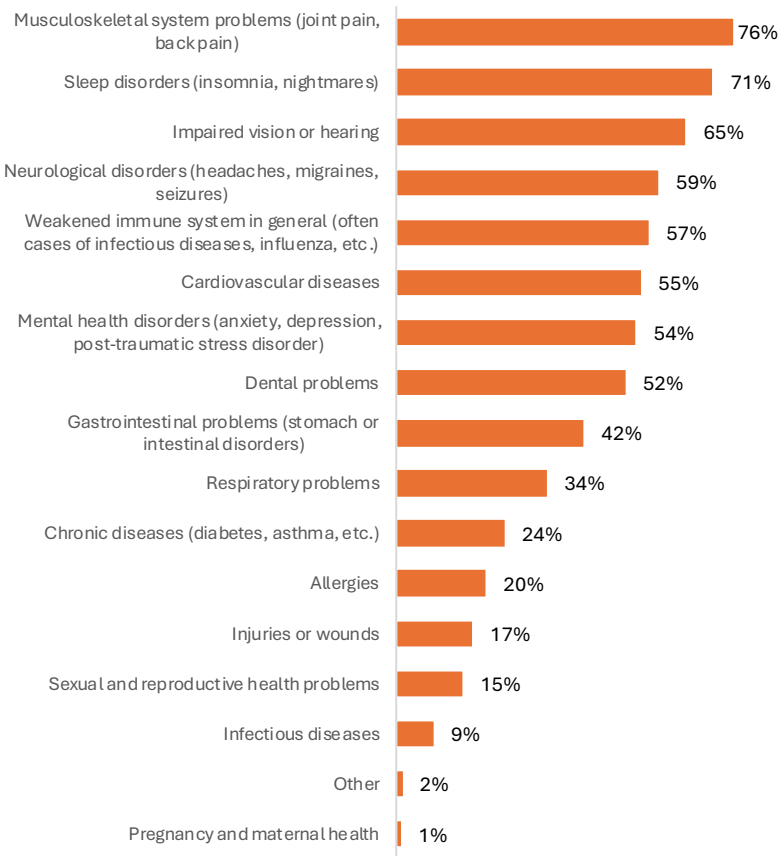


Figure 6. Health problems that have worsened since start of the war*



**Among those who assessed their current health status as worse than a year ago*

Focus on IDPs and frontline areas

IDPs were more likely than people residing in their home communities to report an improvement in their health over the past 12 months (12% vs 8%). However, IDPs reported mental health problems (63% vs 53%) and dental issues (59% vs 50%) much more frequently than people residing in their home communities.

In the most affected regions, 59% of respondents assessed their health as poor or very poor, compared to 47% in other parts of the country. Mental health problems that had worsened over the past 12 months were reported more often in the most affected regions (62%) than in other parts of Ukraine (52%).

Deterioration in access to health-care services was reported more frequently in the most affected regions than in other parts of the country (29% vs 20%). Respondents in frontline areas – both most affected and regions of increased vulnerability – were less likely than those in other parts of the country to report improvements in health-care quality (16% vs 23%).

Access to a family doctor

Figure 7. Access to a family doctor

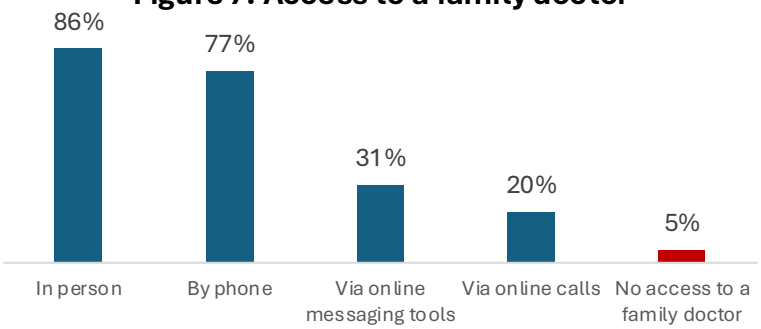
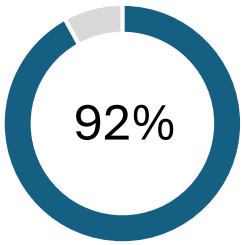


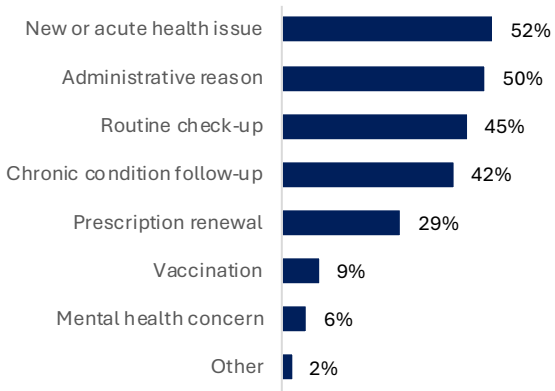
Figure 8. Have a signed declaration with a family doctor



68%

Visited a family doctor in the last 12 months

Figure 9. Reasons for the most recent visit to a family doctor*



Focus on IDPs and frontline areas

Lack of access to a family doctor was reported more frequently by IDPs than people residing in their home communities (10% vs 4%), as was the absence of a signed declaration (11% vs 5%). Respondents residing in their home communities were more likely than IDPs to have visited a family doctor in the past 12 months (69% vs 60%).

Respondents residing in the most affected regions were more likely than those in other parts of the country to have had no access to a family doctor (7% vs 4%). In-person access to a family doctor was the lowest in the most affected regions (80%), compared to regions of increased vulnerability (86%) and other parts of the country (88%).

Figure 10. Satisfaction with a family doctor**

Despite lower access, IDPs were more likely to report being satisfied with their family doctor. At the same time, a substantially higher share of IDPs than people living in their home communities indicated that their family doctor was located too far away (55% vs 27%).

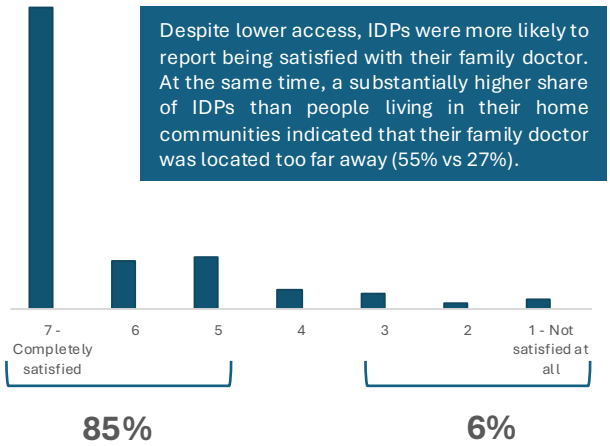
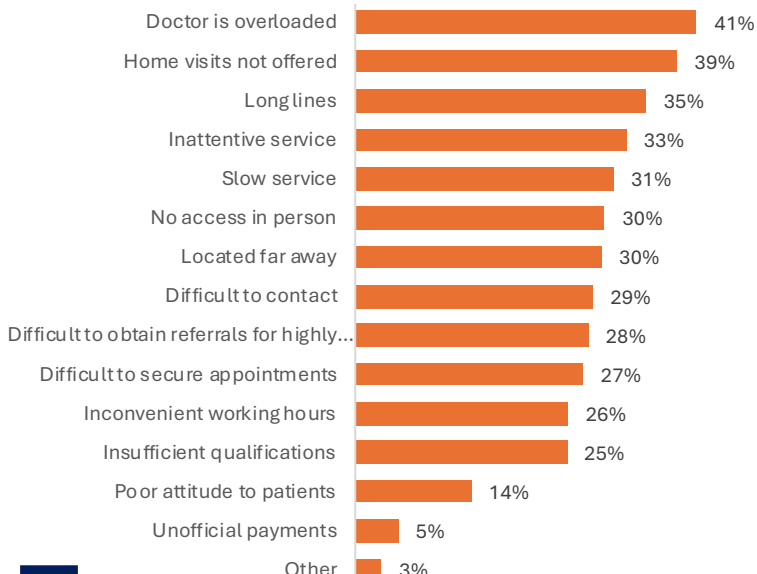


Figure 11. Reasons for not being fully satisfied with a family doctor***



*Among those who visited a family doctor in the last 12 months
** Among those who have a signed declaration
*** Among those who are not fully satisfied with a family doctor

Appointment to see a family doctor

Figure 12. How the appointment was made

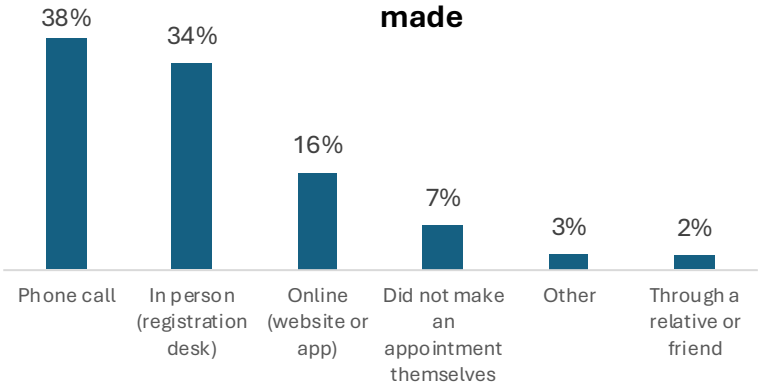


Figure 13. Made the appointment in advance**

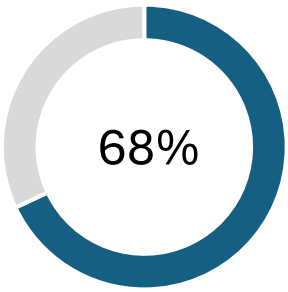


Figure 14. Time between making the appointment and being seen by the family doctor**

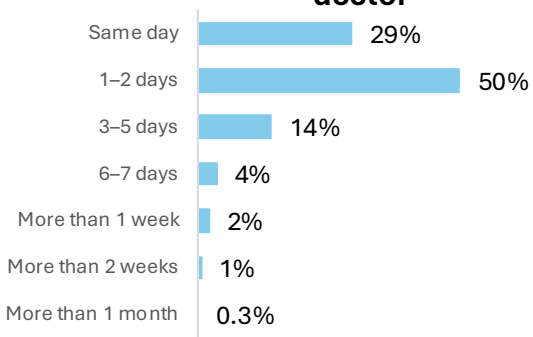
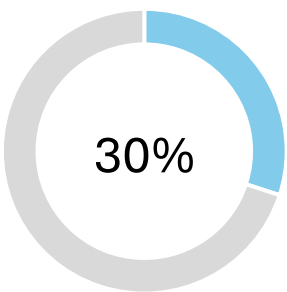


Figure 15. Experienced waiting in line despite having an appointment**

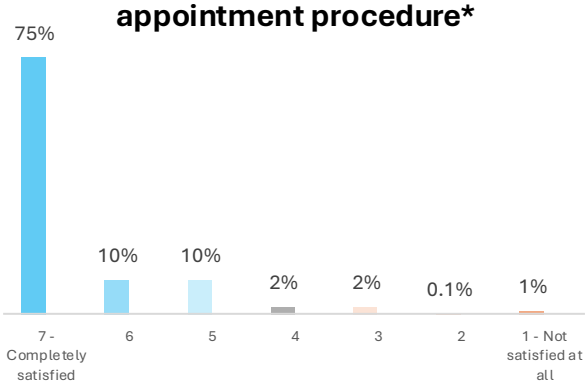


Most respondents contacted their family doctor directly to arrange their most recent appointment, most commonly by phone (38%) or in person at the registration desk (34%), while digital tools were used by 16%. Overall, 62% scheduled their appointment for a specific date and time.

Among those with scheduled appointments, access was generally timely: 29% were seen on the same day and 50% were seen within 1–2 days. However, 30% of respondents reported having to wait in line at the facility despite having an appointment, which indicates operational delays in service delivery.

Satisfaction with the appointment process was very high, with 95% of respondents reporting high satisfaction. Only 5% assessed their experience as average or poor, suggesting that short wait times largely translated into positive overall perceptions of access to family doctors.

Figure 16. Satisfaction with the appointment procedure*



*Among those who visited a family doctor in the last 12 months
** Among those who made an appointment in advance for a specific date and time

Access to PHC services

Figure 17. Needed PHC services

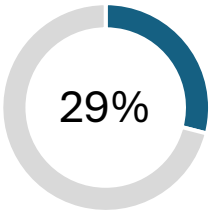


Figure 18. Sought PHC services*

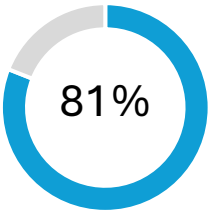


Figure 19. Faced problems accessing**

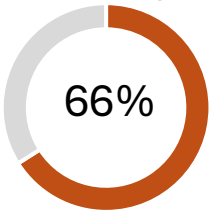


Figure 20. Were able to receive PHC services**

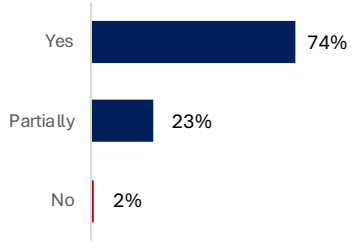


Figure 21. Problems encountered while accessing**

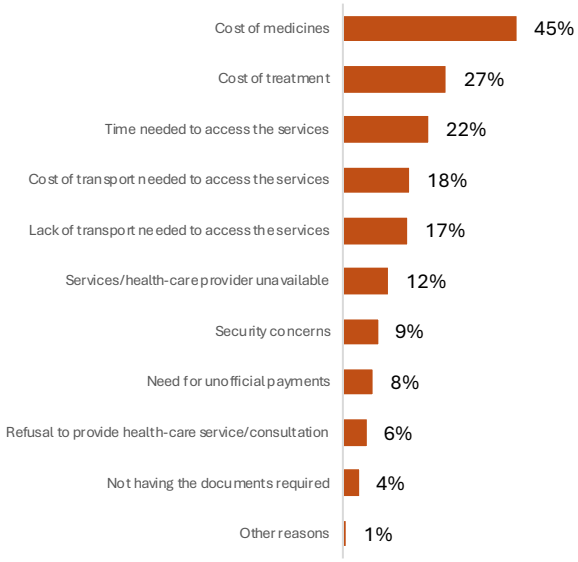


Figure 22. Main reason for not receiving PHC services***

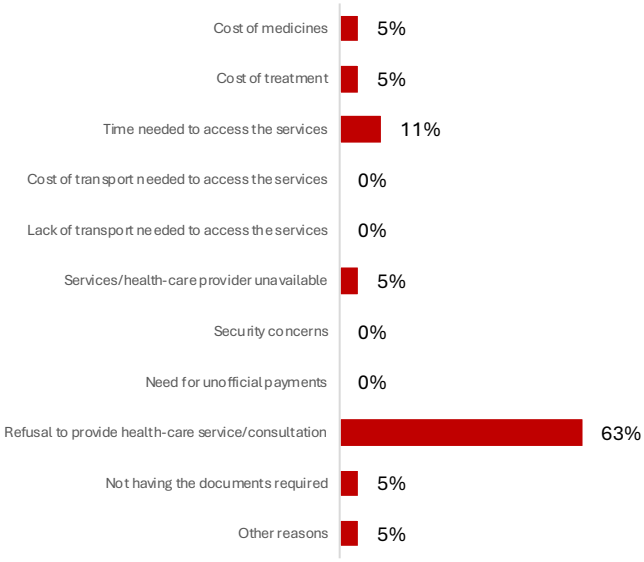


Figure 23. Place of receiving services****

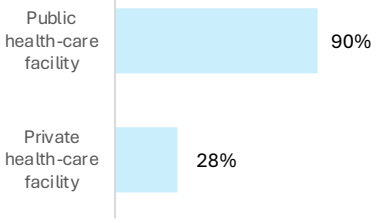
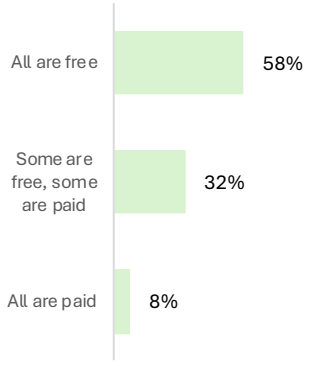


Figure 24. Out-of-pocket payments*****



Focus on IDPs and frontline areas

Respondents in regions of increased vulnerability were more likely than those in other parts of the country to report problems with accessing PHC services (74% vs 62%).

*Among those who needed PHC services
** Among those who sought PHC services
*** Among those who were unable to receive PHC services
**** Among those who were able to receive PHC services

Access to specialized health-care services

Figure 25. Needed specialized services

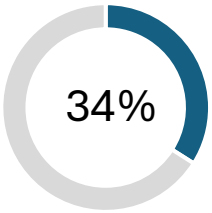


Figure 26. Sought specialized services*

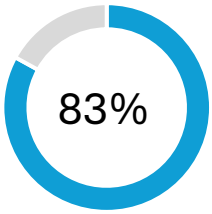


Figure 27. Were able to receive services**

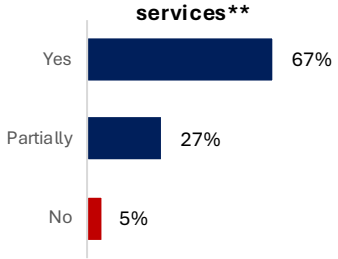
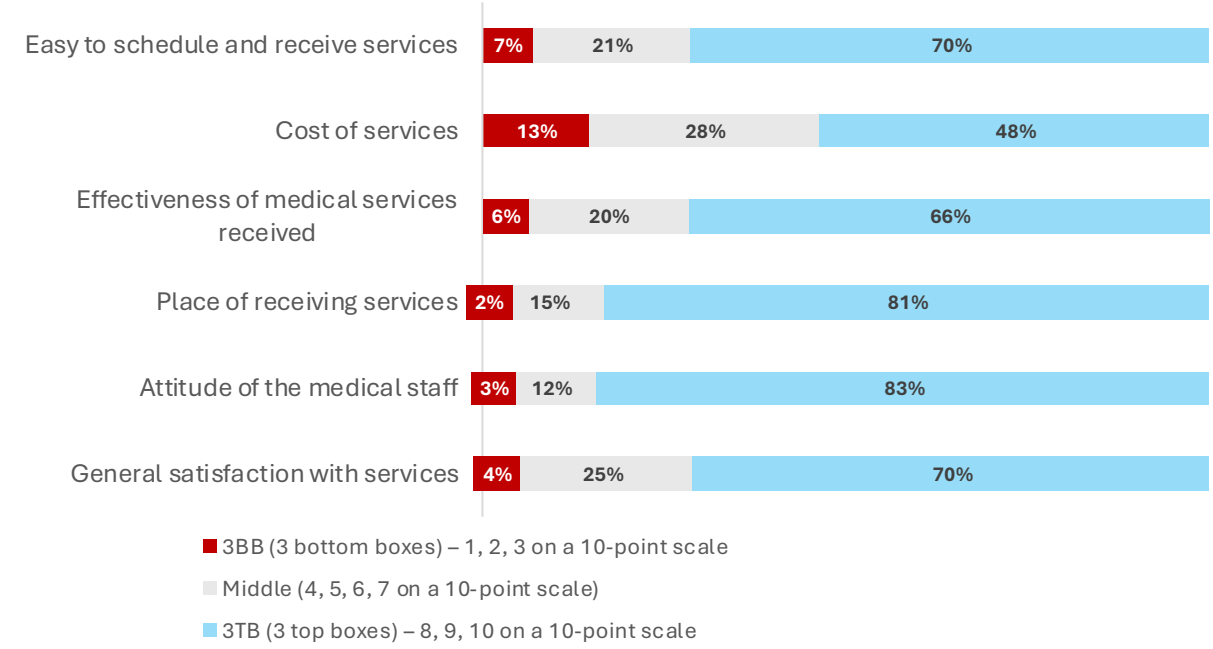


Figure 28. Satisfaction with specialized services***



In the past three months, 34% of respondents reported that they or someone in their household needed specialized medical care beyond primary care, family doctor or emergency services. Among those with identified needs, the vast majority actively sought specialized care (83%), which indicates high perceived necessity and demand for these services (Fig. 24 and Fig. 26).

Among respondents who needed specialized medical care, 67% reported receiving all the services they needed, while 27% were only able to receive care partially. A smaller share (5%) reported being unable to access the specialized services they needed, highlighting persistent gaps in continuity and completeness of care (Fig. 27).

Overall satisfaction with the most recent instance of specialized care was high, with 70% reporting positive experiences. Satisfaction was particularly strong with health-care staff attitudes (83%) and service location and conditions (81%). Lower satisfaction was reported for cost-related aspects, with fewer respondents rating the experience positively (48%), which indicates that financial barriers remain a key concern despite generally favourable service quality (Fig.28).

*Among those who needed specialized services
** Among those who sought specialized services
*** Among those who were able to receive specialized services

Access to cardiovascular care

Figure 29. Needed cardiovascular care

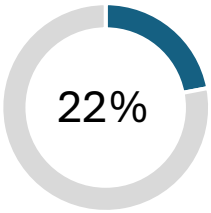


Figure 30. Sought cardiovascular care*

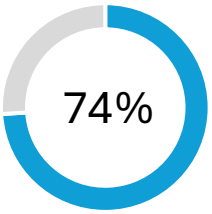


Figure 31. Faced problems accessing**

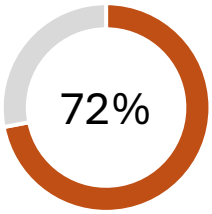
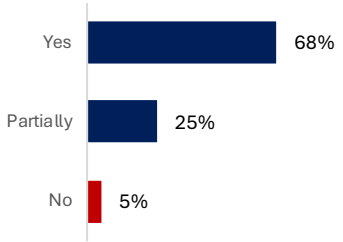


Figure 32. Were able to receive services**



In the past three months, 22% of respondents reported that they or someone in their household needed health-care services for cardiovascular diseases. Among those with identified needs, most sought care (74%), indicating substantial demand for cardiovascular care despite ongoing access challenges (Fig 30). Among respondents who sought cardiovascular care, nearly three quarters (72%) reported facing at least one problem (Fig. 31). The most frequently reported barriers were cost of medicines (54%), cost of treatment and consultations (29%) and time required to access services (21%) (Fig. 33).

Despite reliance on public facilities, out-of-pocket payments remained common. Almost half of respondents reported paying at least part of the cost of cardiovascular care, with 32% reporting a combination of free and paid services, and 16% reporting that all services were paid (Fig. 37).

Figure 33. Problems encountered while accessing**

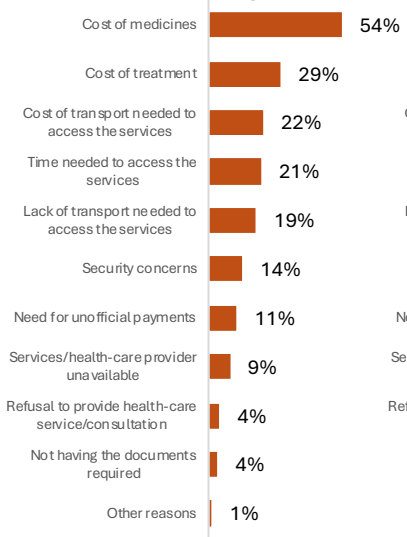


Figure 34. Main reason for not receiving cardiovascular care***

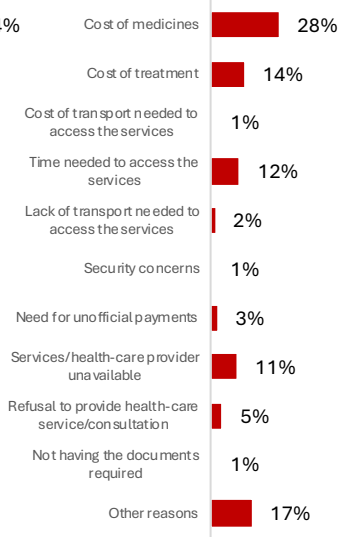


Figure 35. Form of receiving services****

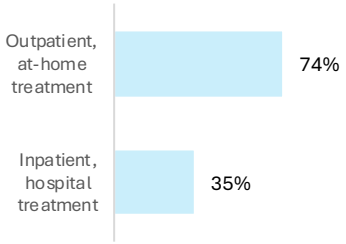


Figure 36. Place of receiving services****

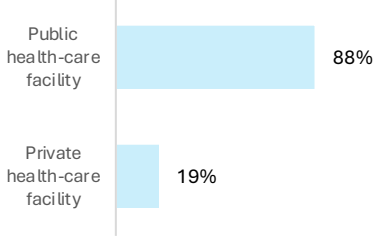
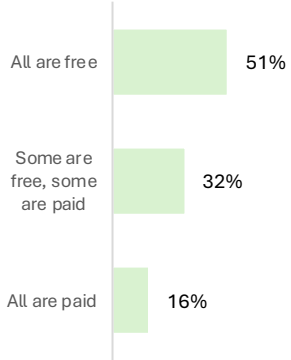


Figure 37. Out-of-pocket payments****



*Among those who needed cardiovascular care
** Among those who sought cardiovascular care
*** Among those who were unable to receive cardiovascular care
**** Among those who were able to receive cardiovascular care

Access to surgical care

Figure 38. Needed surgical care

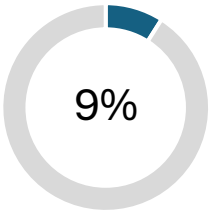


Figure 39. Sought surgical care*

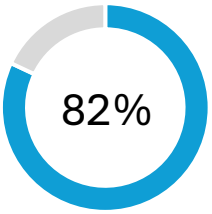


Figure 40. Faced problems accessing**

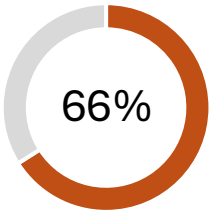
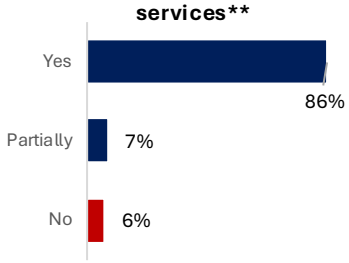


Figure 41. Were able to receive services**



Focus on IDPs and frontline areas

IDPs were more likely than people living in their home communities to report receiving surgical care at private health-care facilities (36% vs 17%).

People living in frontline regions reported problems accessing surgical care much more often than respondents in other parts of the country (83% vs 62%).

Figure 42. Problems encountered while accessing**

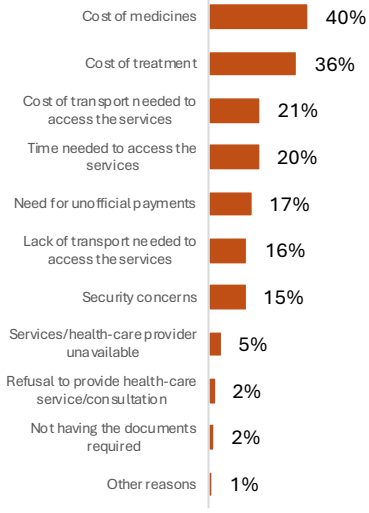


Figure 43. Main reason for not receiving surgical care***

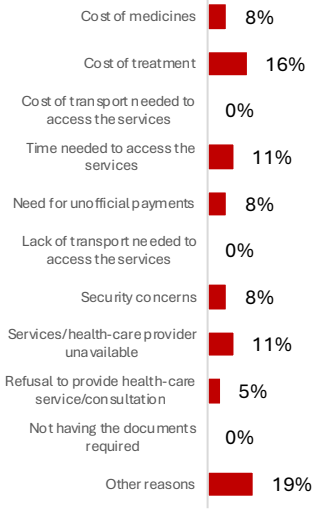


Figure 44. Form of receiving services****

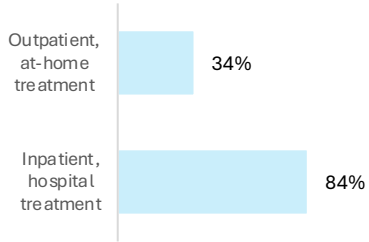


Figure 45. Place of receiving services****

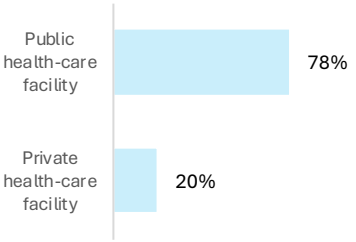
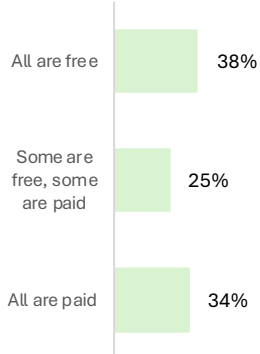


Figure 46. Out-of-pocket payments****



*Among those who needed surgical care
** Among those who sought surgical care
*** Among those who were unable to receive surgical care
**** Among those who were able to receive surgical care

Access to medicines

Figure 47. Needed medicines

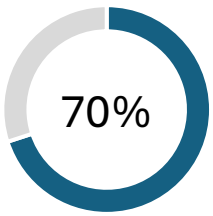


Figure 48. Faced problems with obtaining medicines*

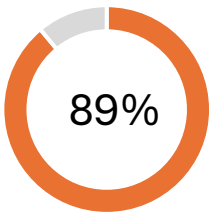


Figure 49. Were unable to obtain the medicines needed*

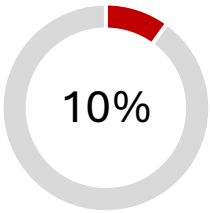
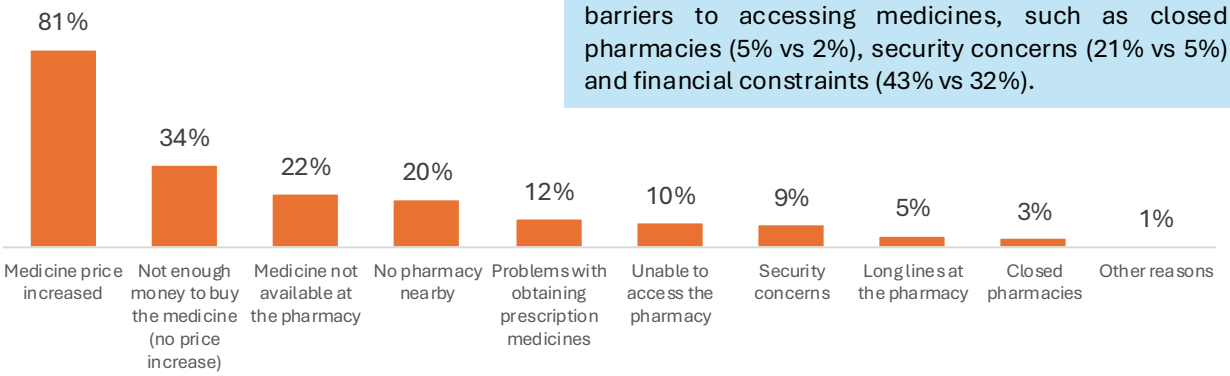


Figure 50. Problems with obtaining medicines*



Focus on frontline areas

Respondents in frontline regions were more likely than respondents in other parts of the country to face barriers to accessing medicines, such as closed pharmacies (5% vs 2%), security concerns (21% vs 5%) and financial constraints (43% vs 32%).

Antibiotic use

Figure 51. Used antibiotics in the last 3 months

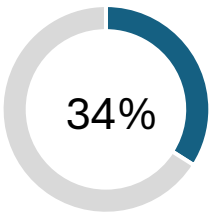


Figure 52. Method of procuring the antibiotics**

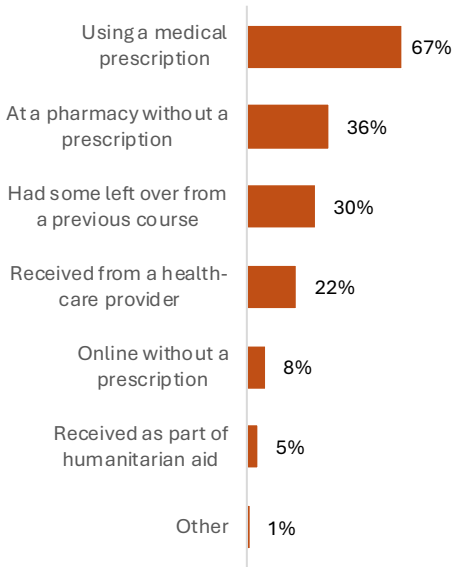
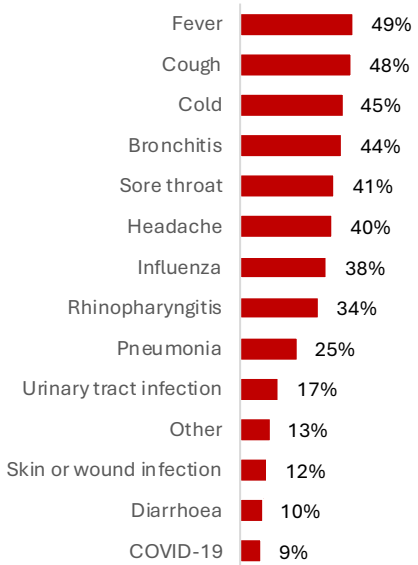


Figure 53. Conditions for which antibiotics were used**



Focus on frontline areas

Among respondents who used antibiotics in the past three months, those in the most affected regions were more likely than respondents in other parts of the country to obtain antibiotics online without a prescription (14% vs 7%).

*Among those who needed medicines
** Among those who used medicines in the last three months

Health behaviour and expenditures

Figure 54. Too upset or worried to do their usual daily activities

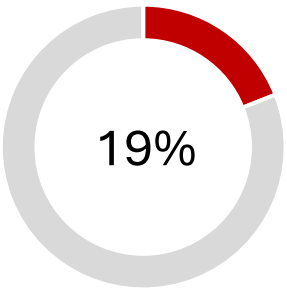


Figure 55. Postponed health care

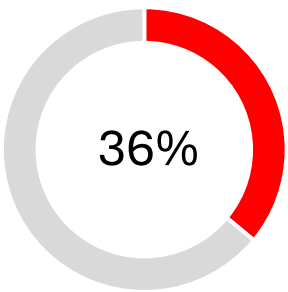


Figure 56. Monthly household income

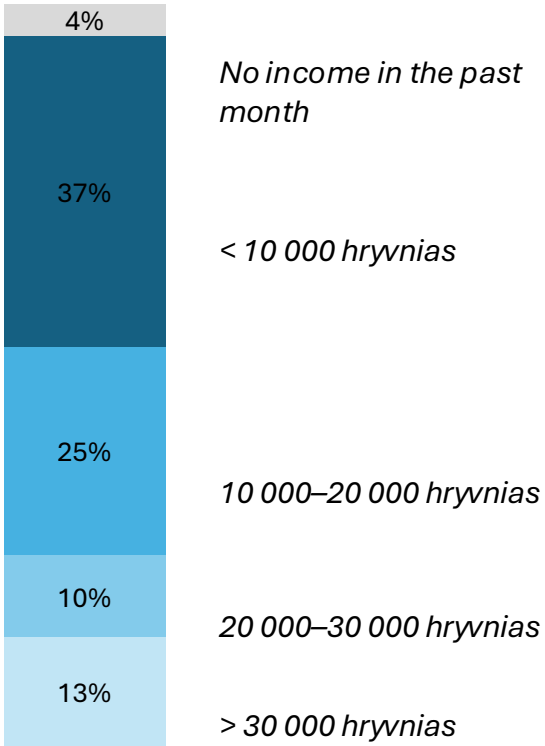
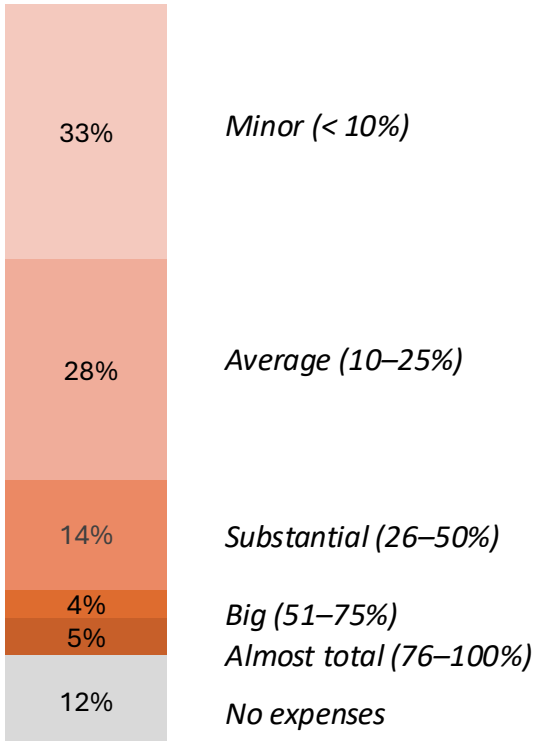


Figure 57. Household expenditures on health care and medicines*



30% Had expenses related to health-care services in the past month

*Among those who have an income

Summary

Round 1 of the Health Tracker survey was conducted in November–December 2025 among a nationally representative sample of 4000 adults residing in Ukraine. The survey provides quantitative evidence on population health status, access to health-care services and medicines and related financial pressures in the context of the ongoing war.

Internal displacement remains widespread. Among respondents whose place of residence changed after 24 February 2022, 80% reported that the relocation was directly caused by the war and approximately 60% currently hold official IDP status.

A notable proportion of respondents assessed their health as worse than it was a year earlier, most frequently attributing the deterioration to war-related stress and disruptions. Mental health problems and dental issues were among the most commonly reported conditions. IDPs were more likely than people living in their home communities to report that their mental health problems (63% vs 53%) and dental issues (59% vs 50%) had worsened. In the most affected regions, 59% of respondents assessed their health as poor or very poor, compared to 47% in other parts of the country, and 62% reported worsening mental health over the past 12 months.

PHC remains comparatively accessible. Overall, 68% of respondents reported visiting a family doctor and the majority had a signed declaration. Among those with a signed declaration, 85% reported being satisfied with their family doctor. Access gaps persist among specific groups: IDPs were more likely than people living in their home communities to report not having access to a family doctor (10% vs 4%) and not having a signed declaration (11% vs 5%).

Among respondents who visited a family doctor in the past 12 months, 62% reported scheduling an appointment for a specific date and time. Of these, 29% were seen on the same day and 50% were seen within one or two days. Nonetheless, 30% reported waiting in line at the facility despite having an appointment. Overall satisfaction with the appointment process was very high (95%).

Access challenges go beyond primary care. Among respondents who needed PHC services, a substantial proportion reported difficulties related to wait times, availability of services and financial barriers. Respondents in regions of increased vulnerability reported problems with accessing PHC more frequently than those in other parts of the country (74% vs 62%).

Demand for specialized health care remains high, with 34% of respondents reporting a need for specialized medical services. Among those, 83% actively sought care. While 67% reported receiving all the specialized services they needed, 27% received care only partially and 5% were unable to access services at all. Satisfaction with specialized care was generally high, particularly with staff attitudes (83%) and facility conditions (81%), but it was substantially lower for affordability, with only 48% reporting satisfaction with costs.

Twenty-two per cent of respondents reported needing cardiovascular care in the previous three months. Among those who sought care, 72% reported facing at least one problem with access. The most frequently cited barriers were the cost of medicines (54%), cost of consultations or treatment (29%) and time required to access services (21%).

Access to surgical care is uneven. Among respondents requiring surgical care, a high proportion reported difficulties in accessing care, particularly in frontline regions, where 83% reported problems with access compared to 62% in other parts of the country. IDPs were more likely to receive surgical care at private facilities than people living in their home communities (36% vs 17%), which indicates differential reliance on private-sector services.

A substantial share of respondents who needed medicines reported difficulties with obtaining them, most commonly due to high costs and availability issues. Respondents in frontline regions were more likely to report closed pharmacies, security constraints and financial barriers than respondents in other parts of the country. Antibiotic use in the previous three months was common, and among users in the most affected regions, antibiotics were more frequently obtained online without a prescription (14% vs 7%).

Household financial pressure remains pronounced. Thirty per cent of respondents reported health-care-related expenditures in the month preceding the survey. More than one third reported postponing health care and 19% reported being too upset or worried to carry out usual daily activities, which reflects ongoing psychosocial and economic strain.

Corrigendum
Health Tracker survey: factsheet. Round 1, November–December 2025
On p.10 the percentage values displayed in the data labels of Figures 17, 18 and 19 under “Access to PHC services” were incorrect in the published version. All three figures displayed the value 68%.

These values have been corrected as follows:
- Figure 17. Needed PHC services: 29%
- Figure 18. Sought PHC services: 81%
- Figure 19. Faced problems accessing: 66%

These corrections were incorporated into the electronic file on 18 February 2026.