



Health Tracker survey: factsheet

Round 2, March–April 2026



Executive summary

The second round of the Health Tracker survey, conducted in March–April 2026 among 4000 adults across Ukraine, indicates that access to essential health services remains largely functional despite the ongoing war. Most respondents had access to a family doctor (96%), a signed declaration (92%) and reported being able to receive the health-care services they needed. However, important disparities persist for internally displaced persons (IDPs) and residents of frontline and highly affected oblasts.

IDPs continued to face greater challenges in accessing primary health care. They were more likely to report lacking access to a family doctor (8% vs 3%), not having a signed declaration (9% vs 4%) and changing their family doctor during the previous year (24% vs 13%). While access to health-care services was generally similar between displaced and non-displaced populations, IDPs were substantially less likely to receive all required diabetes-related services (48% vs 73%).

Mental health remains one of the most significant concerns identified by the survey. Overall, 76% of respondents reported experiencing mental health difficulties during the previous 12 months and 70% reported significant psychological distress during the previous two months. The burden was even greater among IDPs and residents of the most affected oblasts, where 80% reported mental health problems. Higher levels of stress, anxiety and low mood were consistently observed among these populations.

Financial barriers continue to affect health-care access nationwide. The cost of medicines, treatment and transportation remained among the most frequently reported barriers to accessing care. In the most affected oblasts, respondents were considerably more likely to report security concerns when accessing medicines (23% vs 5%) and difficulties affording them (42% vs 34%). Winter conditions also continued to affect households, with 82% reporting disruptions to daily life and 35% reporting associated health problems.

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.

The results in this fact sheet present the second round of data collection conducted in March–April 2026.

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		e) Oblast of residence	N	%
Oblast centre	38%	1. Vinnytsia	187	5%
Other city in the oblast	29%	2. Volyn	116	3%
Rural	33%	3. Dnipropetrovsk	377	9%
b) Gender		4. Donetsk	36	1%
Male	37%	5. Zhytomyr	115	3%
Female	63%	6. Zakarpattia	74	2%
c) Age		7. Zaporizhzhia	110	3%
18–29 years	11%	8. Ivano-Frankivsk	148	4%
30–39 years	15%	9. Kyiv	265	7%
40–49 years	18%	10. Kirovohrad	125	3%
50–59 years	18%	11. Luhansk	0	0%
60+ years	37%	12. Lviv	262	7%
d) Live with		13. Mykolaiv	148	4%
Children under 18 years	31%	14. Odesa	220	5%
People over 65 years	32%	15. Poltava	187	5%
People with a chronic disease	34%	16. Rivne	133	3%
People who are pregnant or lactating	2%	17. Sumy	115	3%
People who have disabilities (actual condition, regardless of whether they have an officially recognized category of disability)	10%	18. Ternopil	110	3%
People who have disabilities (officially recognized category of disability)	24%	19. Kharkiv	326	8%
None of the above	44%	20. Kherson	36	1%
		21. Khmelnytskyi	153	4%
		22. Cherkasy	140	3%
		23. Chernivtsi	108	3%
		24. Chernihiv	139	3%
		25. Kyiv city	373	9%
f) Macroregions				
Most affected oblasts (Donetsk, Kharkiv, Kherson, Sumy, Zaporizhzhya)			13%	
Oblasts of increased vulnerability (Chernihiv, Dnipropetrovsk, Mykolayiv, Odesa)			25%	
Kyiv city			9%	
Rest of the country			53%	

People who have been internally displaced

16% changed place of residence since 24 February 2022

82% of relocations caused by the war^a

61% have official IDP status^a

Fig. 1. Timing of the relocation^a

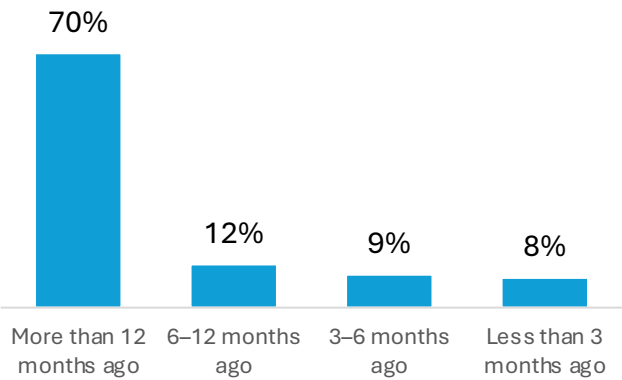


Fig. 2. Current living situation^a

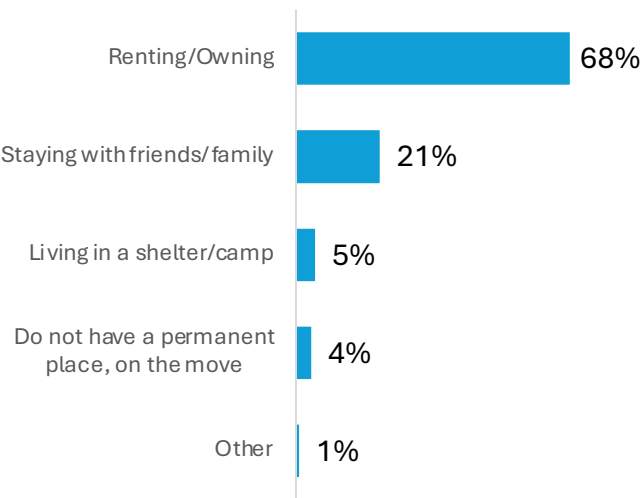


Table 2. Oblast of origin and current residence among internally displaced respondents

Oblast of residence*	Relocated from	Currently live in
1. Vinnytsya	1%	3%
2. Volyn	1%	1%
3. Dnipropetrovsk	6%	11%
4. Donetsk	26%	1%
5. Zhytomyr	1%	1%
6. Zakarpattya	1%	1%
7. Zaporizhzhya	7%	4%
8. Ivano-Frankivsk	1%	3%
9. Kyiv	6%	10%
10. Kirovohrad	2%	4%
11. Luhansk	4%	0%
12. Lviv	2%	5%
13. Mykolayiv	3%	2%
14. Odesa	3%	6%
15. Poltava	2%	6%
16. Rivne	1%	2%
17. Sumy	4%	3%
18. Ternopil	0%	2%
19. Kharkiv	15%	13%
20. Kherson	8%	1%
21. Khmelnytsky	1%	3%
22. Cherkasy	1%	3%
23. Chernivtsi	1%	3%
24. Chernihiv	2%	2%
25. Kyiv city	3%	10%

^a Among people whose place of residence changed after 24 February 2022

Access to a family doctor

Fig. 3. Access to a family doctor

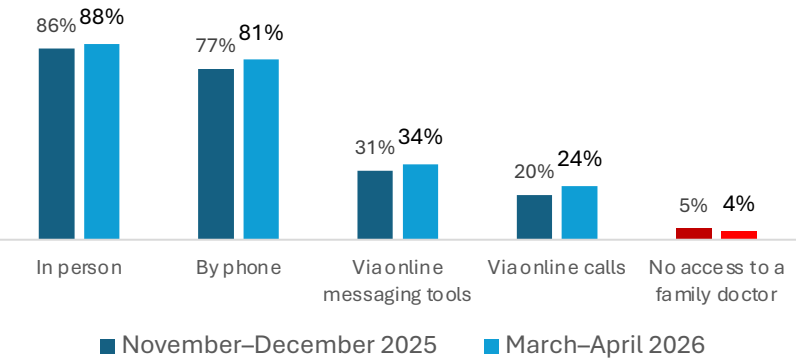
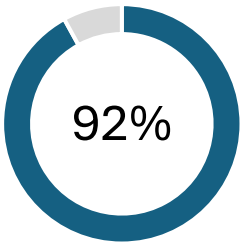


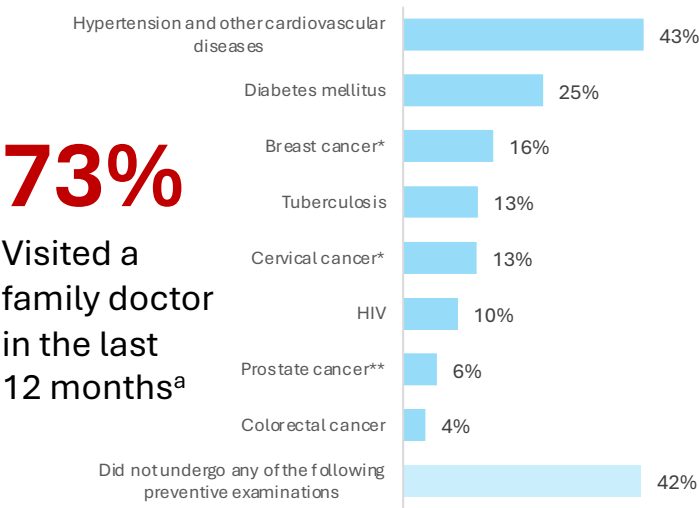
Fig. 4. Have a signed declaration with a family doctor



Focus on IDPs and frontline areas

During March–April 2026, IDPs more frequently reported lacking access to a family doctor than respondents living in their home communities (8% vs 3%). They were also more likely not to have a signed declaration with a family doctor (9% vs 4%). In the preceding 12 months, nearly one quarter of IDPs changed their declaration with a family doctor, compared to 13% of respondents residing in their home communities. Respondents living in their home communities were more likely than IDPs to have visited a family doctor during the same period (74% vs 66%). Respondents from the most affected regions reported a lack of access to a family doctor more often than those living elsewhere in the country (6% vs 3%). In-person access to family doctors was also lowest in the most affected regions (84%), compared to regions of increased vulnerability (86%) and other parts of the country (89%).

Fig. 5. Underwent preventive examinations with a family doctor^b



73%
Visited a family doctor in the last 12 months^a

^aamong women who personally visited a family doctor for a consultation in the last 12 months
^bamong men who personally visited a family doctor for a consultation in the last 12 months

Fig. 7. Reasons for changing family doctors^c

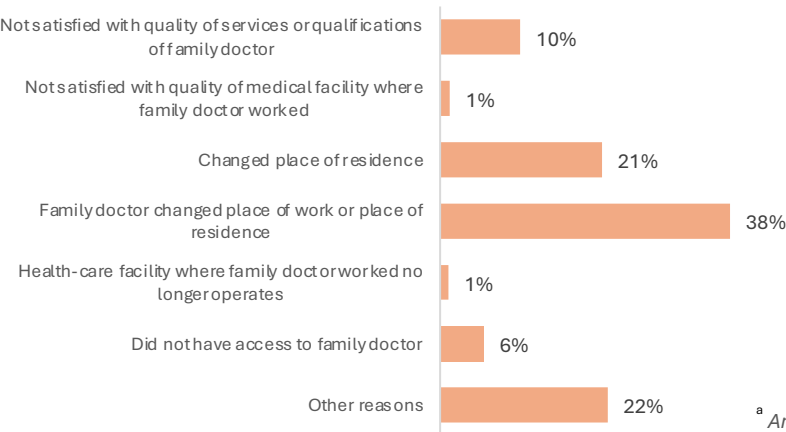
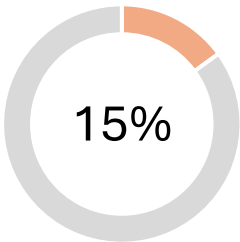


Fig. 6. Changed family doctors in the past year^a



^a Among people who have a signed declaration
^b Among people who visited a family doctor in the past 12 months
^c Among those who changed declaration with family doctor

Access to PHC services

Fig. 8. Needed PHC services

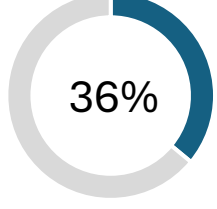


Fig. 9. Sought PHC services^a

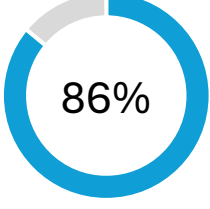


Fig. 10. Faced problems accessing^b

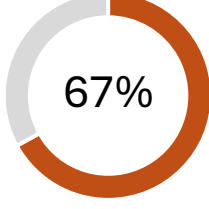


Fig. 11. Were able to receive PHC services^b

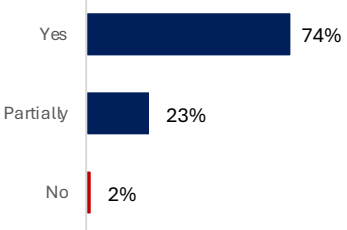


Fig. 12. Problems encountered while accessing^b

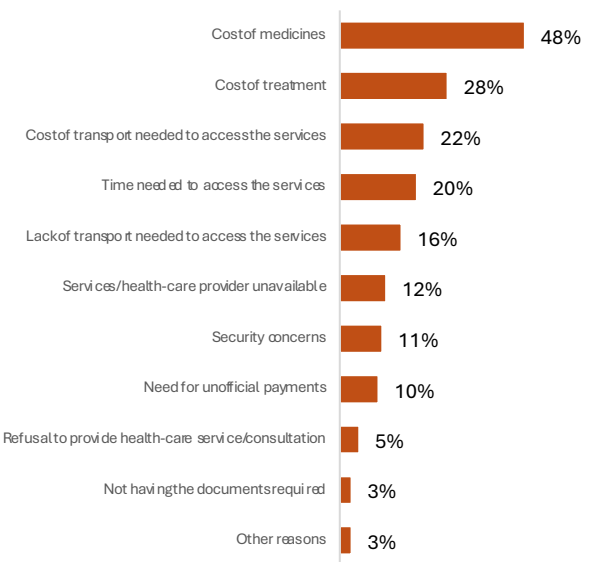
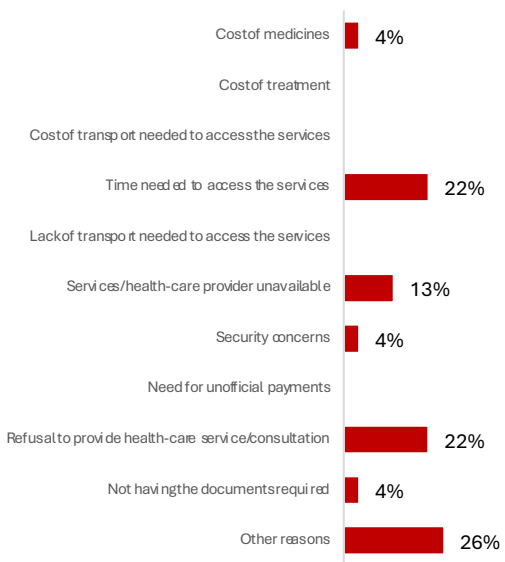


Fig. 13. Main reason for not receiving PHC services^c



Focus on IDPs and frontline areas

No significant differences in access to PHC services were identified between IDPs and respondents residing in their home communities. However, respondents living in regions of increased vulnerability were more likely to report a need for PHC services than those residing in other parts of the country (67% vs 62%). Security-related concerns also remained a problem to accessing care for residents of the most affected oblasts, reported by 17% of respondents compared with 9% in the rest of the country. Residents of the most affected oblasts were more likely to receive PHC services at public health-care facilities (97%). They were also more likely to report receiving all PHC services free of charge, with this proportion reaching 65% in the most affected oblasts, compared to 54% in other parts of the country.

Fig. 14. Place of receiving services^d

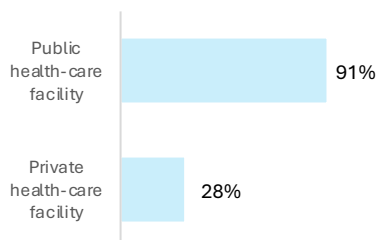
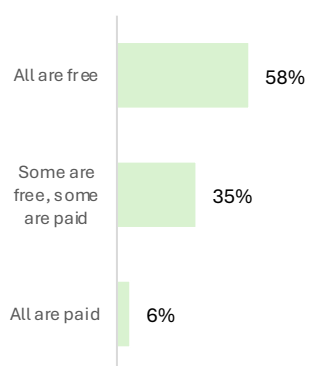


Fig. 15. Out-of-pocket payments^d



^a Among people who needed PHC services
^b Among people who sought PHC services
^c Among people who were unable to receive PHC services
^d Among people who were able to receive PHC services

Access to specialized health-care services

Fig. 16. Needed specialized services

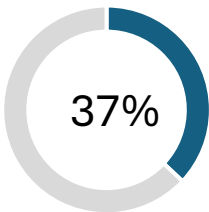


Fig. 17. Sought specialized services^a

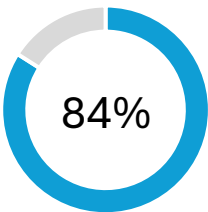
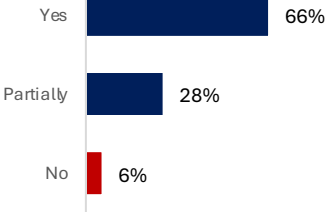


Fig. 18. Were able to receive services^b



Mental health status

Fig. 19. Experienced mental health issues in the last 12 months

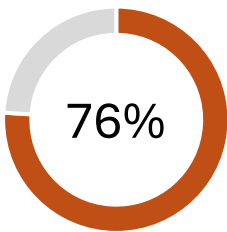
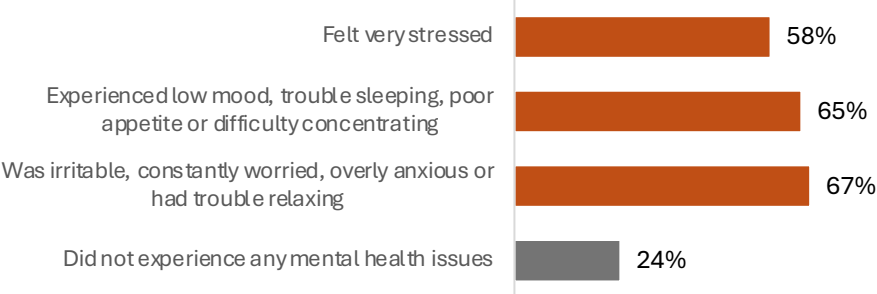


Fig. 20. Types of mental health issues in the last 12 months



70% Experienced significant stress or other mental health problems in the past two months^c

52% Found it difficult to maintain normal activities at work or at home or to interact with other people^c

Focus on IDPs

A higher proportion of IDPs reported experiencing mental health problems over the past 12 months compared to respondents residing in their home communities (80% vs 75%). Across all assessed domains, IDPs consistently reported higher levels of distress, including stress (64% vs 57%), low mood (70% vs 65%) and anxiety (73% vs 66%).

Focus on frontline areas

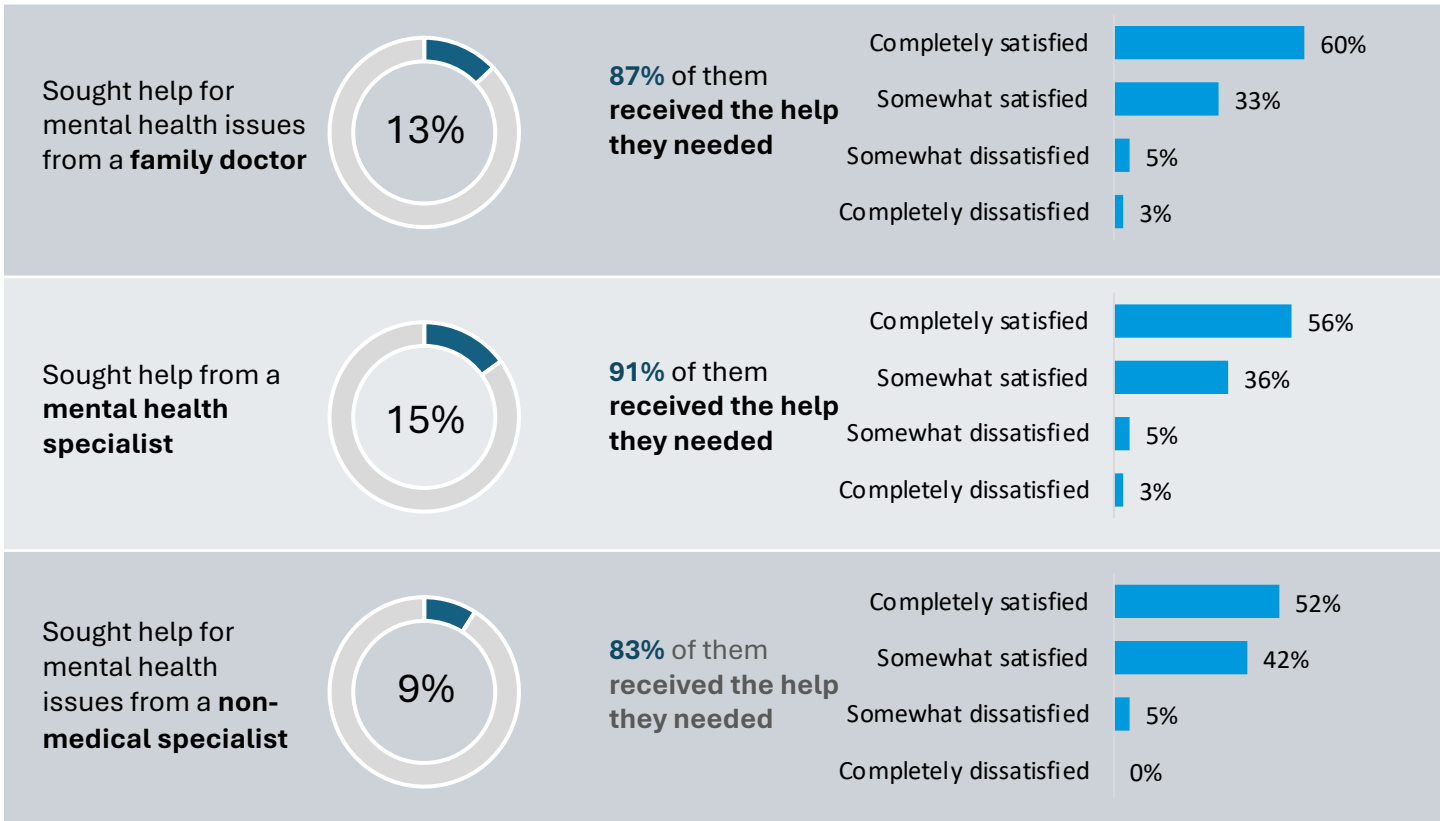
Respondents residing in the most affected oblasts also reported a higher prevalence of mental health problems compared to those living in other regions (80% vs 75%). A similar pattern was observed across all mental health domains, with higher levels of stress, low mood and anxiety reported in the most affected oblasts.

In addition, respondents in the most affected oblasts were more likely to report experiencing significant stress or other mental health difficulties, including low mood, sleep disturbances and anxiety within the past two months (76% vs 67%).

^a Among those who needed services
^b Among those who sought services
^c Among people who experienced mental health issues in the past 12 months

Mental health status

Fig. 21. Access to mental health support^a



A total of 35%* took medication to deal with mental health issues (8% regularly and 26% from time to time). Of those, 25% bought all these medicines (and 14% bought some of these medicines) with a prescription from a doctor. Only 17% of these medicines were received under Affordable Medicines Program (6% – all needed and 11% – some of the medicines).

^a Among people who experienced mental health issues in the past 12 months

Access to health-care services for diabetes

Fig. 22. Needed health-care services for diabetes

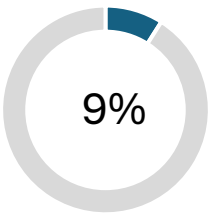


Fig. 23. Sought cardiovascular care^a

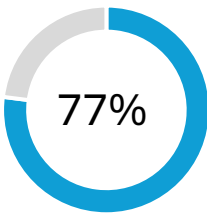


Fig. 24. Faced problems accessing^b

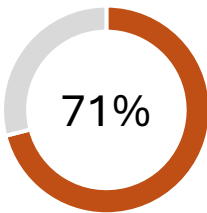
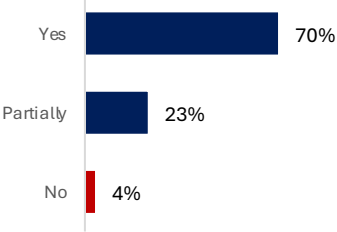


Fig. 25. Were able to receive services^b



Focus on IDPs and frontline areas

No significant differences were observed between IDPs and respondents residing in their home communities in terms of access to diabetes-related health care. Approximately 7% of IDPs and a comparable share of respondents in their home communities reported needing diabetes care and the majority of those in need sought services. Only a small proportion were unable to access the diabetes care they needed (6% of IDPs and 4% of respondents in their home communities). However, notable differences were observed in the completeness of care received: 48% of IDPs reported receiving all needed diabetes services, compared to 73% among respondents residing in their home communities, while 42% of IDPs received services only partially, compared to 21% among those in their home communities.

From a geographical perspective, respondents in regions of increased vulnerability were less likely to seek health care for diabetes despite needing it, with only 68% attempting to access services compared to those in other parts of the country (84%).

Fig. 26. Problems encountered while accessing^b

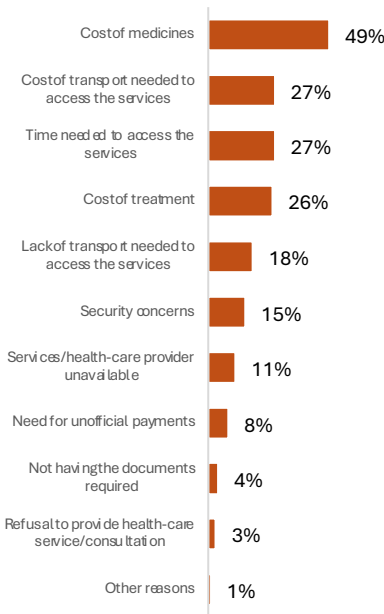


Fig. 27. Main reason for not receiving cardiovascular care^c

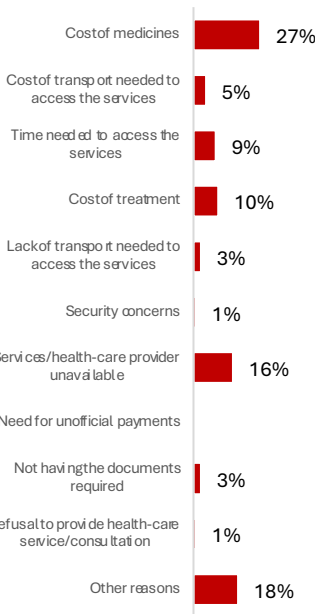


Fig. 28. Form of receiving services^d

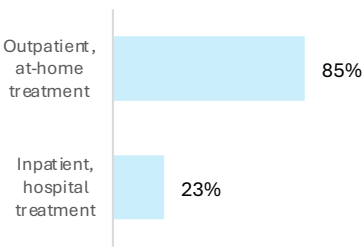


Fig. 29. Place of receiving services^d

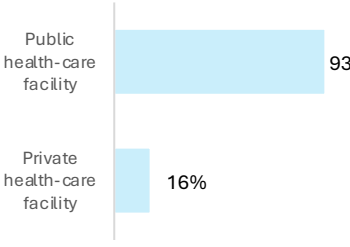
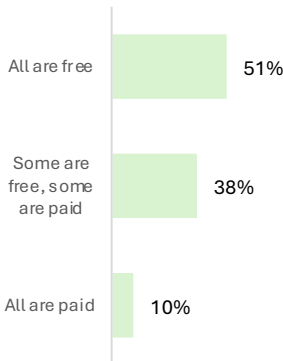


Fig. 30. Need for out-of-pocket payments for services^d



^a Among people who needed health-care services for diabetes
^b Among people who sought health-care services for diabetes
^c Among people who were unable to receive health-care services for diabetes
^d Among people who were able to receive health-care services for diabetes

Access to rehabilitation services

Fig. 31. Needed rehabilitation services

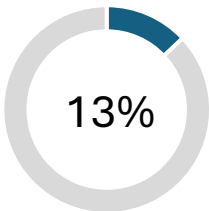


Fig. 32. Sought rehabilitation services^a

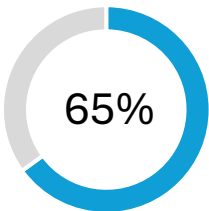


Fig. 33. Faced problems accessing^b

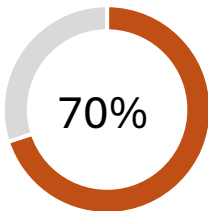


Fig. 34. Were able to receive services^b

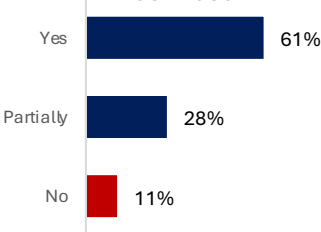


Fig. 35. Problems encountered while accessing^b

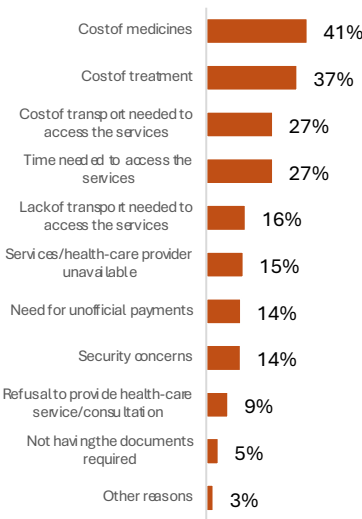
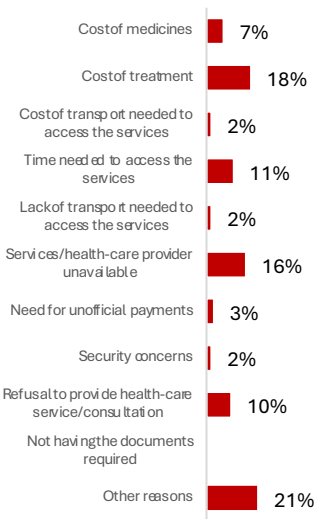


Fig. 36. Main reason for not receiving rehabilitation services^c



Focus on IDPs and frontline areas

No significant differences were identified between IDPs and respondents residing in their home communities in terms of access to rehabilitation health-care services. At the same time, respondents living in the most affected oblasts more frequently reported receiving the rehabilitation services they needed free of charge compared to those in other parts of the country (72% vs 48%).

Fig. 37. Form of receiving services^d

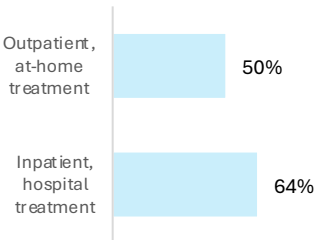


Fig. 38. Place of receiving services^d

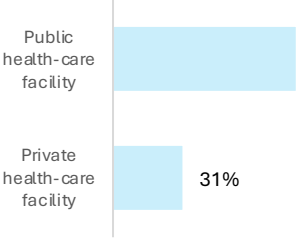
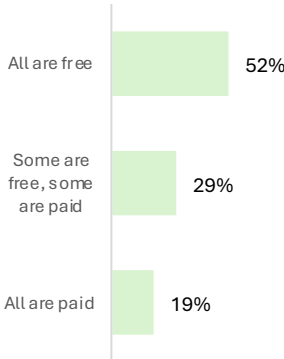


Fig. 39. Need for out-of-pocket payments^d



^a Among those who needed rehabilitation services
^b Among those who sought rehabilitation services
^c Among those who were unable to receive rehabilitation services
^d Among those who were able to receive rehabilitation services

Access to medicines

Fig. 40. Needed medicines

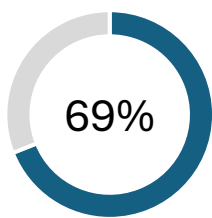


Fig. 41. Encountered problems with obtaining medicines^a

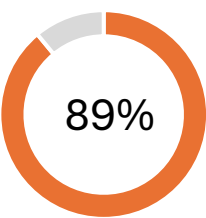


Fig. 42. Unable to obtain the medicines they needed^a

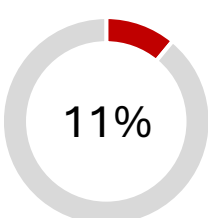
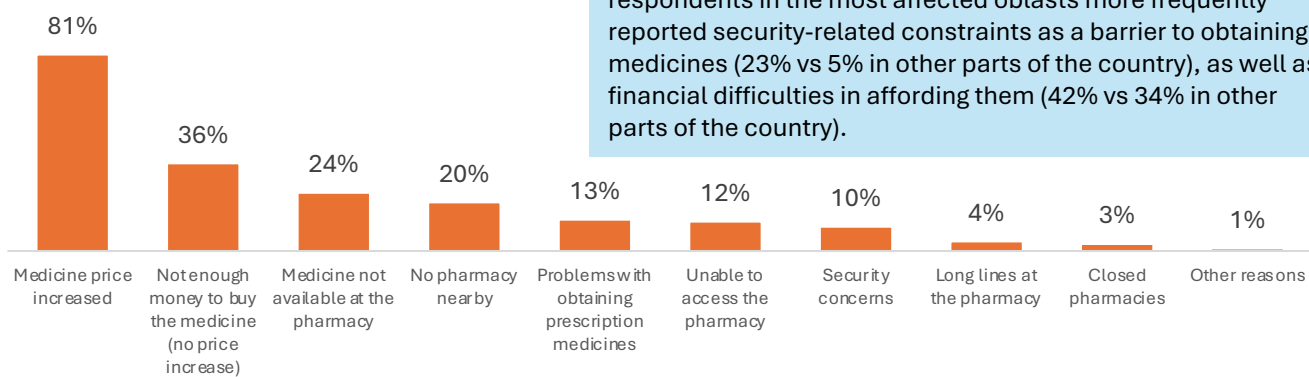


Fig. 43. Problems with obtaining medicines^a



Focus on frontline areas

No significant differences were identified in terms of access to or need for medicines between population groups. However, respondents in the most affected oblasts more frequently reported security-related constraints as a barrier to obtaining medicines (23% vs 5% in other parts of the country), as well as financial difficulties in affording them (42% vs 34% in other parts of the country).

Affordable Medicines Program (AMP)

68% Among people who needed medicines know about AMP^a

Fig. 45. Received medicines under AMP^b

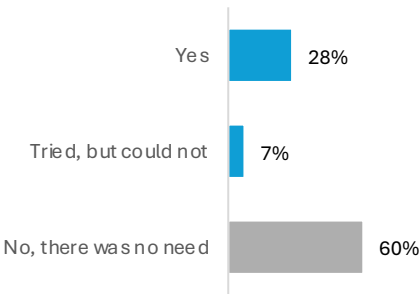


Fig. 47. Source for receiving medicines under AMP^c

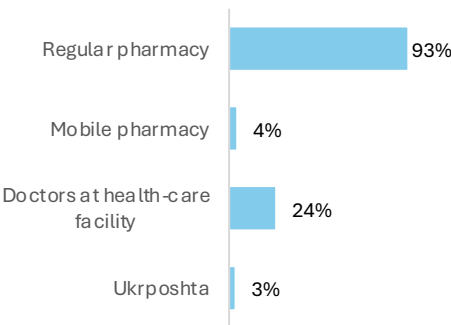
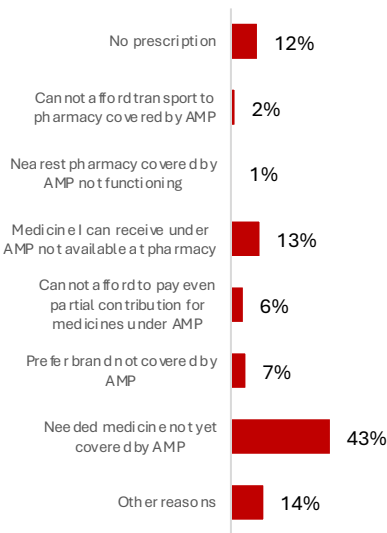


Fig. 46. Reasons for not receiving medicines under AMP^d



^a Among people who needed medicines
^b Among people who know about AMP
^c Among people who received medicines under AMP
^d Among people who could not receive medicines under AMP

Health behaviour and expenditures

Fig. 48. Postponed health care

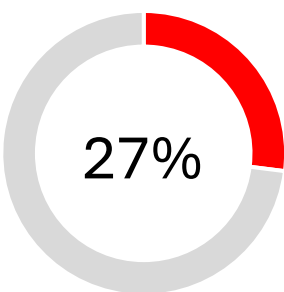


Fig. 49. Reason for postponing health care



Fig. 50. Monthly household income

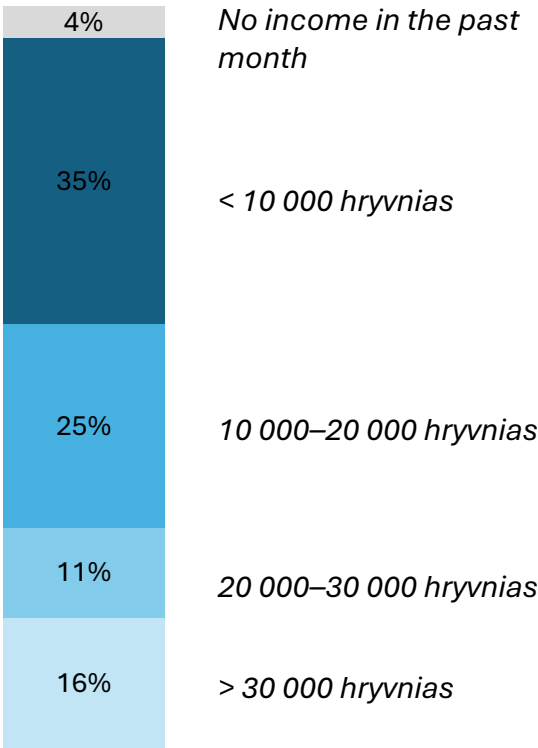
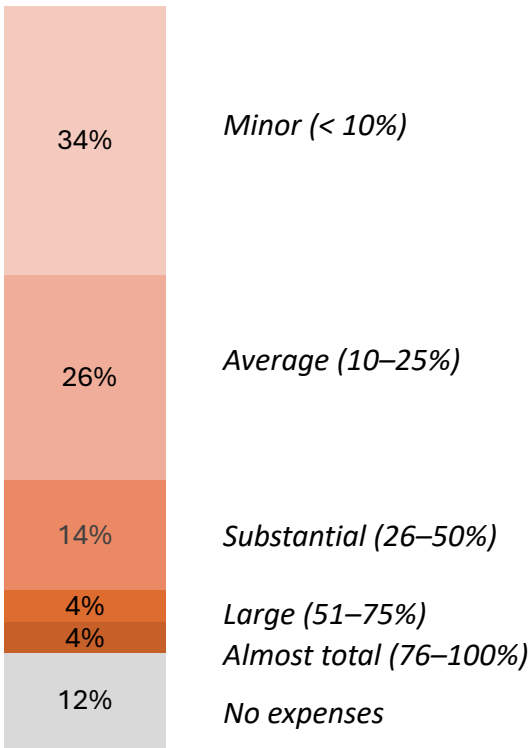


Fig. 51. Household expenditures on health care and medicines^a



33% Of households had expenses related to health-care services in the past month

^a Among people who have an income

Health problems during winter conditions

Fig. 52. Household routines that have been affected by winter conditions

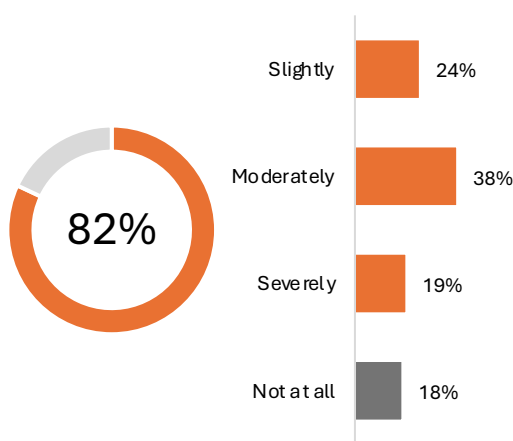


Fig. 53. Main difficulties experienced by households due to winter conditions^a

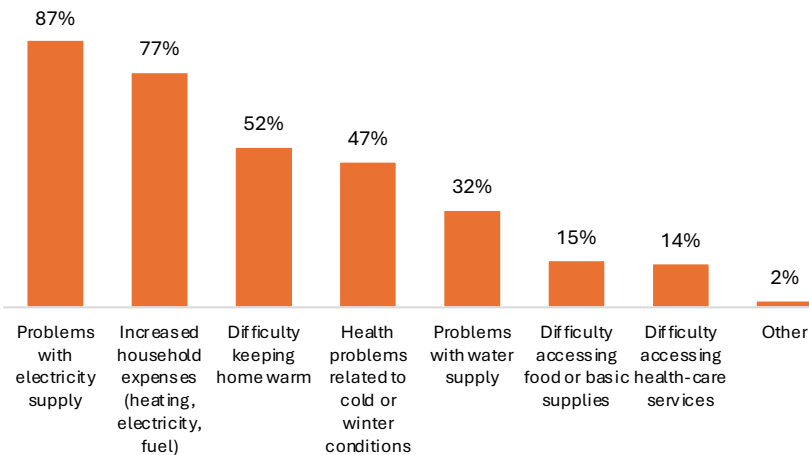


Fig. 54. Winter conditions led to health problems

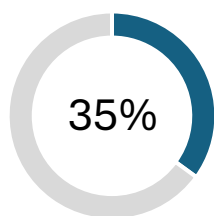


Fig. 55. Health problems faced because of winter conditions^b

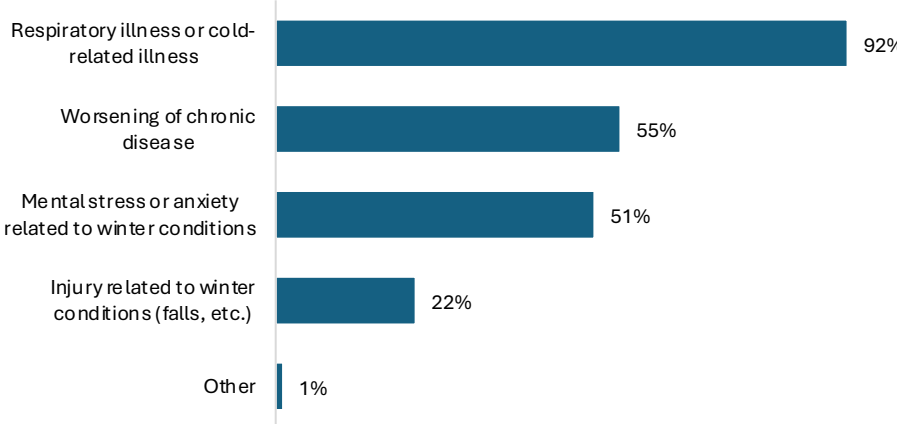


Fig. 56. Could not access health care due to winter conditions

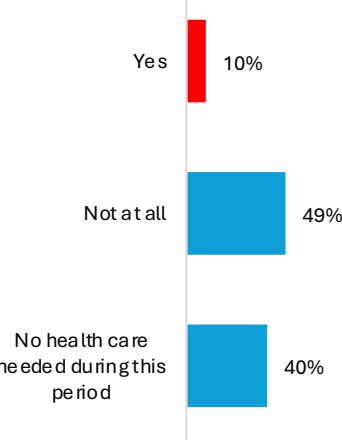
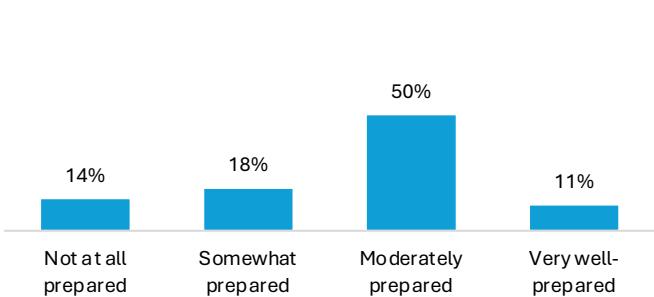


Fig. 57. Household preparedness to handle winter conditions



^a Among people who reported that winter conditions affected their household's daily life

^b Among people who reported that winter conditions led to health problems for anyone in their household

Summary

The second round of the Health Tracker survey was conducted in March–April 2026 among a nationally representative sample of 4000 adults residing in Ukraine. The findings indicate that access to essential health services remains broadly functional despite the ongoing war and protracted humanitarian context. However, important disparities continue to affect IDPs and populations residing in frontline and highly affected oblasts, particularly in relation to continuity of care, mental health, affordability and security-related barriers.

PHC remains the cornerstone of health-care access in Ukraine. Overall, only 4% of respondents reported having no access to a family doctor, while 92% reported having a signed declaration and 73% had visited a family doctor in the previous 12 months. Nevertheless, IDPs experienced greater challenges than non-displaced populations. IDPs were more than twice as likely to report lacking access to a family doctor (8% vs 3%) and not having a signed declaration (9% vs 4%). Nearly one quarter of IDPs (24%) changed their family doctor in the previous year compared to 13% of respondents residing in their home communities, reflecting the continued impact of displacement on continuity of care. Similar challenges were observed in the most affected oblasts, where respondents more frequently reported lack of access to a family doctor (6% vs 3%) and the lowest levels of in-person access (84% compared to 89% in other parts of the country).

Demand for health services remained high across the country. Approximately 64% of respondents reported needing PHC services and 86% of those in need sought care. Among those who sought services, 74% received all the care they needed and 23% only received some services. While no significant differences in PHC access were observed between IDPs and people in their home communities, residents of regions of increased vulnerability reported greater health-care needs (67% vs 62%). Security-related concerns continued to impede access for residents of the most affected oblasts (17% vs 9% elsewhere). At the same time, respondents in frontline areas relied more heavily on public health-care facilities (97%) and were more likely to receive all PHC services free of charge (65% vs 54%).

Mental health remains one of the most significant public health concerns identified by the survey. Three quarters of respondents (76%) reported experiencing stress, anxiety, low mood or other mental health difficulties in the previous 12 months, while 70% reported experiencing significant stress or mental health problems in the two months preceding the survey. Among those affected, more than half (52%) reported that these difficulties interfered with their normal daily activities. IDPs reported a higher prevalence of mental health problems than people in their home communities (80% vs 75%), including higher levels of stress (64% vs 57%), low mood (70% vs 65%) and anxiety (73% vs 66%).

Similar patterns were observed in the most affected oblasts, where 80% reported mental health difficulties in the previous year and 76% reported significant recent psychological distress, compared to 67% in other parts of the country. Despite these challenges, access to mental health support was relatively high among those who sought assistance, with 87% receiving the support they needed from family doctors, 91% from mental health specialists and 83% from non-medical providers. In addition, 35% of those experiencing mental health difficulties reported taking medication to manage their condition.

Management of chronic conditions remains an important concern. While access to diabetes-related care was generally maintained, disparities in continuity of care were evident. Among respondents requiring diabetes care, 77% sought care and 71% received all the services they needed. Although only a small proportion of respondents were unable to obtain diabetes care (6% of IDPs and 4% of people in their home communities), IDPs were considerably less likely to receive all the services they needed (48% vs 73%) and more likely to receive care only partially (42% vs 21%). Respondents in regions of increased vulnerability were also less likely to seek diabetes care despite needing it (68% vs 84%).

Access to rehabilitation services remained comparatively stable. Among respondents requiring rehabilitation care, 65% sought services and 70% received all the care they needed. No significant differences were observed between IDPs and non-displaced populations. However, residents of the most affected oblasts more frequently reported receiving rehabilitation services free of charge (72% vs 48%), reflecting targeted support in areas experiencing the greatest humanitarian pressures.

Access to medicines remains a critical challenge for many households. Overall, 69% of respondents reported needing medicines during the reference period. Among them, 89% encountered difficulties obtaining medicines and 11% were unable to obtain all the medicines they needed. Medicine affordability remained the most frequently reported barrier nationally. In the most affected oblasts, respondents were substantially more likely to report security-related barriers to obtaining medicines (23% vs 5%) and financial constraints affecting affordability (42% vs 34%). Awareness of the Affordable Medicines Program was relatively high (68%), even though reported limitations related to medicine availability and programme coverage indicate opportunities for further strengthening.

Winter conditions continued to affect household well-being and health outcomes. More than four in five households (82%) reported that winter conditions affected their daily routines, while 35% reported health problems related to winter conditions. The most commonly reported consequences included respiratory illnesses, worsening chronic diseases and increased mental stress or anxiety. One in 10 respondents reported being unable to access health care due to winter conditions. Rising household expenditures, difficulties maintaining adequate heating and disruptions to electricity and water supply remained major challenges during the winter period.