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Navigating new healthcare systems: a qualitative exploration of barriers, facilitators, and service utilization among Ukrainian refugees in five host countries

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Abstract

The invasion of Ukraine by the Russian Federation on 24 February 2022 displaced millions. While the European Union's Temporary Protection Directive aims to facilitate the right to healthcare for Ukrainian citizens staying in European Union Member States, health systems were already heavily burdened. Ensuring efficient and accessible care for refugees requires insights into individual and context-specific barriers to and facilitators of uptake of health services. In depth interviews were conducted between May 2022 and September 2023 in five countries receiving refugees from Ukraine. Interview guides and rapid analysis procedures followed a modified capability, opportunity, motivation-behaviour (COM-B) framework. Language was a cross-cutting issue touching all COM-B factors. Mental health services use was characterized by specific barriers and drivers across COM-B factors. Additional barriers include health literacy, long wait times for appointments, and lack of sufficient focus on the most vulnerable groups. Drivers include peer and community support, perceived high quality of care and trust in health workers. Successful navigation of new health systems depends on strong health literacy, availability of actionable information, additional support for the most vulnerable and support for health workers. Study insights can inform revisions to health services being offered to refugees from Ukraine and provide considerations for future refugee health crises in any location.

Introduction

The invasion of Ukraine by the Russian Federation on 24 February 2022 led to millions of people fleeing across borders. The United Nations High Commissioner for Refugees (UNHCR) estimates that ~6 million people from Ukraine are now living throughout Europe [1]. Displacement has multiple impacts on health [2]. The European Union's (EU) Temporary Protection Directive activated in response to the Ukraine crisis aims in part to facilitate the right to healthcare for Ukrainian citizens staying in EU Member States [3, 4]. However, health systems in refugee receiving countries were already burdened by the COVID-19 pandemic, healthcare worker burnout, system shortages and other constraints [5]. Ensuring care is accessible for refugees and efficient for already burdened health systems requires insights into individual and context-specific barriers and drivers of uptake of health services.

Studies from previous refugee crises have identified major challenges in the provision of health services for refugee populations, including communication (language skills, availability of interpreters, provider communication skills, information about host country health systems), continuity of care (ease of access to services, collaboration and coordination of services) and confidence (trust in a person or service), as well as legal, financial, geographical and cultural challenges [6–12]. Health literacy (the ability to access, understand, appraise, and use information and services in ways that promote and maintain good health and well-being [13]) is essential for accessing care and navigating the host country healthcare system [14]. Refugees who do not have appropriate information may be more likely to use emergency care services for routine or primary care issues [14]. Few studies have applied a comprehensive behavioural framework to analyse how individual, social, and systems factors interact across multiple host countries during an ongoing refugee crisis [11, 14].

The WHO Regional Office for Europe designed a qualitative study to explore refugee barriers and drivers of accessing healthcare services as part of the WHO-developed Tailoring Health programmes approach [15]. The theoretical framework underpinning the study is the modified capability–opportunity–motivation–behaviour (COM-B) framework [16, 17]. This framework considers both individual factors influencing behaviour (capability and motivation) and structural factors (physical and social opportunity) to provide a comprehensive yet actionable analysis of barriers and drivers that can be mapped to specific intervention types for rapid response. The studies were conducted between May 2022 and September 2023 in Czechia, Poland, Romania, Slovakia and Slovenia. The aim of this paper is to present a synthesis of key findings across these five countries to inform this and future refugee crisis response.

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Methods

Due to similar characteristics of early population movements, such as varied accommodation types and locations within host countries, and the urgent need for actionable data, a standard methodology was used. K.H. and M.S. developed a protocol and shared it with countries in the WHO European Region receiving refugees after 24 February 2022 via internal meetings. WHO country offices and health authorities in Czechia, Poland, Romania, Slovakia, and Slovenia chose to implement the study, each at different times. Each study was approved by a national institutional review board and the WHO ethical review committee (#0003760, #0003844, #0003932).

Inclusion criteria were age 18 years and above, leaving Ukraine because of the war and being in the host country for at least 2 weeks. Purposive maximum variation sampling was used to ensure that the study included as diverse a sample as possible by sex, age, education level, caretaker status, accommodation type, and geographical location within the host country. Interviews were conducted online to ensure reaching people in diverse settings.

Participant recruitment was conducted through social media, community support networks, non-governmental organizations working with refugees, and posters. A QR code linked potential participants to a four-question eligibility survey where they could leave contact information. Researchers P.A. and T.Z. scheduled interviews. Interviews lasted ∼1 hour and were conducted in Russian or Ukrainian languages, as preferred by the participant. Participation was voluntary. Participants provided verbal, recorded consent. Conversations followed a topic guide developed and structured according to the COM-B framework (see Supplemental Material), with questions covering all factors, including knowledge of services available, views on services, access to services, and the role of other people. Participants were paid the equivalent of €20 as compensation for their time and internet usage.

Between 21 and 35 in-depth interviews were conducted in each country. The majority of participants were female (Table 1), reflecting the overall profile of those who have left Ukraine since February 2022.

P.A. and T.Z. analysed results with oversight from M.S. and A.M. using country-specific rapid analysis procedure (RAP) sheets [18–20]. RAP sheets were used to systematically organize the data into a matrix of summarized responses according to the COM-B framework. This analysis approach was selected because it provides a standardized, efficient approach that enables real-time analysis during ongoing data collection while maintaining analytical rigour across countries. This was particularly valuable for our multidisciplinary team and the urgency of the situation requiring data for action. RAP sheets were completed by listening to recordings from each interview and summarizing data for each question in the predeveloped RAP sheet template. Each additional interview contributed to the summary, and illustrative quotes were highlighted. To ensure consistency and address discrepancies, the research team held regular meetings working towards a consensus in understanding the data. For quality control and training purposes, two transcripts from each country were translated into English.

For cross-country analysis, M.S. and A.M. systematically reviewed all country-specific RAP sheets and conducted thematic synthesis by developing analytical cross-country summaries structured according to the COM-B factors. Iterative analysis sessions between M.S. and A.M. allowed for extracting key findings from each country's RAP sheet, comparing themes across countries, identifying commonalities and variations, and outlining findings across countries and COM-B domains. This systematic comparative approach allowed for identifying overarching, data-driven issues, challenges and factors that were relevant for Ukrainian refugees regardless of context.

Results

Language created barriers across all COM factors, from making appointments to describing symptoms and understanding instructions from health providers. Use of mental health services was characterized by distinct barriers in addition to those related to other health services (Table 2). Additional thematic results are presented below according to COM factors.

Capability factors

In addition to language, health literacy was a key barrier influencing participants' access and utilization of healthcare services across the five host countries, illustrated by limited knowledge of how to navigate an unfamiliar health system, uncertainty about cost of services, insurance coverage, and specialized care. '… *[M]ost do not know at all where to go, what, why, my God. This is a very urgent problem, very urgent with regard to health, because we do not understand how this system works, we do not understand where to go, and we do not know where this information can be found*'.—Woman, Slovenia, 43 years old. While most were aware of free emergency care, participants often struggled to comprehend the primary care system, obtaining medication, children's health services, and support for those with chronic conditions or disabilities.

Positive personal experience with healthcare systems increased participants' self-efficacy—the belief that they could address their healthcare needs despite challenges. Learning about positive experiences of others within their strong social networks further bolstered this. Self-efficacy, however, also contributes to participants not seeking mental health support, relying on personal ability to cope with stressful experiences (Table 2).

Table 1. Population, sample size, and dates of data collection by country.

Country	Czechia	Poland	Romania	Slovakia	Slovenia
Total population[a]	10 873 689	36 685 849	19 056 116	5 926 740	2 120 937
Number of refugees from UKR[b]	370 980	970 120	162 180	125 940	12 325
Dates of data collection	May–Jun, 2023	Aug–Sep, 2022	May–Jun, 2022	Sep–Oct, 2022	Jul–Oct, 2022
Sample size	25	35	25	21	21
Female	24	34	20	18	18
50+	3	12	4	5	5

a: As of 2023, https://data.worldbank.org/indicator/SP.POP.TOTL.
b: As of September 2024, https://data.unhcr.org/en/situations/ukraine.
Alt Text: Table showing total population in the five study countries and number of refugees present in each country as of September 2024 and data collection dates, sample size, sex and age breakdowns.

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Table 2. COM factors impacting use of mental health services with illustrative quotes.

COM factor	Barrier
Capability	Individual lack of differentiation between mental health and psychosocial services versus psychiatry, nuances said to be rarely considered in Ukraine. Thinking that mental health services are only for severe cases or combat zone survivors. *'More information about psychological support, specifically, maybe some measures, explain what it is. Because people who really need support, they don't go because of some prejudices or even among Ukrainians, and among my friends, there is a scheme that I won't take it, even though it's all free, but maybe someone needs it more. And in fact, people*who *think that maybe someone needs it more, they need it the most. But they don't want to use this empathy and self-sacrifice because why would I take someone else's place*'. Woman, Slovenia, 21 years old
Social opportunity	Cultural stigma, including a legacy of punitive Soviet-era psychiatry. Stated preferences for relying on friends and family. *'In Ukraine, people used to think of psychologists as if you were some kind of weirdo if you went to see them. But I'm not sure if that opinion still holds today*'. Woman, Czechia, 31 years old
Physical opportunity	The format of services, including group settings where participants need to share personal information. Lack of more targeted services, such as for teenagers, children on the autistic spectrum, and people with chronic conditions (e.g. dialysis). Perceived variation in availability of services and information about services across countries. Those caring for young children or others cited a lack of alternative care options. *'First, it is difficult to acknowledge the need and choose to seek the help of a psychologist, and second—it is a group activity with strangers in an unfamiliar environment*'. Woman, Slovenia, 32 years old
Motivation	Concerns (real or perceived) that language barriers would prevent effective communication with mental health professionals. Self-efficacy and self-reliance for managing emotional and psychological problems meant many people reported not needing mental health support. Thinking someone else must need such services more. Skepticism about the effectiveness of short-term interventions and that mental health professionals without shared experience could help. *'(Regarding communication) Slovak with Ukrainian words: with Google Translate and a little English … It was difficult, that's why I don't go to a psychiatrist, I don't think that he will fully understand me*'. Woman, Slovakia, 33 years old.

Alt Text: Table showing barriers to uptake of mental health services according to COM-B factors, followed by illustrative quotes from study participants.

Social opportunity factors

Family members, friends, and other refugees were crucial sources of information, logistical and emotional support. '*The opinion of other refugees is very important, because this is an experience, because you are a blind kitten here … This is the main source of information, and from volunteers, of course*'.—Woman, Slovakia, 62 years old. While these relationships were predominantly with other Ukrainians, landlords and neighbours were also identified as important sources of information and served as bridges with the local community and services. Family, friends, and fellow refugees proved indispensable for more vulnerable participants (e.g. those living with disabilities or taking care of children with special needs).

Participants across different countries highlighted the paramount role of civil society in supporting Ukrainian refugees' access to healthcare services through leveraging local knowledge and making direct connections to the refugee community. In Poland, Slovenia, and Czechia specific organizations were mentioned as being highly trusted for providing concrete, hands-on support like providing actionable information, translation, finding Ukrainian-speaking doctors and arranging rehabilitation programs. ' … [O]*rganizations like Patchwork are given more state support because the government sees that they do their job, that they really help*'.—Woman, Poland, 37 years old.

Participants shared a mixed picture regarding the responsiveness of healthcare workers in the host countries. Several participants highlighted the benevolence and proficiency of doctors. '*Positive experience so far… I walked in with tears and left with a smile. We started asking how much do we owe you? And they tell us—only your smile on your face*'.—Woman, Romania, 40 years old.

However, there were also reports of challenges during interactions with healthcare staff. These instances were partly attributed to healthcare workers' frustrations with the administrative complexities of serving refugee patients, differences in treatment protocols and the language barrier. Participants able to access Russian/Ukrainian-speaking providers or had strong social connections tended to have more positive experiences. Those without such support often struggled to find care they considered empathetic and responsive.

Many participants expressed a strong desire to be active in finding solutions to their healthcare challenges rather than passive assistance recipients. In Slovakia, participants noted that young and middle-aged Ukrainians who had been in the country for some time sought to resolve issues independently rather than relying on local people. In Romania, younger, more educated participants often did not require extensive support and became key sources of information and assistance for their fellow refugees.

Physical opportunity factors

Participants noted challenges to accessing specialized care, including lack of available information and long wait times for appointments in large urban zones. In more remote areas, participants described fewer service delivery options but shorter waiting times. '*From what I've learned in online groups, it seems that in smaller towns like mine, the queues for medical services are usually shorter. However, when it comes to larger cities, the queues can be never-ending*'.—Woman, Czechia, 39 years old. Importantly, nearly all participants recognized that long wait times were faced by all regardless of nationality.

Those with the means often opted for private care to avoid long waiting times and receive specialized services '*I feel secure because I have money for private [medical] assistance. If I can't get it free, I'll seek private help*'.—Woman, Slovenia, 32 years old. Access to dental services was a widely voiced need. Citing high cost and lack of available dentists, participants reported visiting private facilities or delaying care until returning to Ukraine.

Availability and convenience of transportation to health facilities impacted physical access to services in all countries. Caretakers, the elderly, pregnant women, people with chronic conditions, disabilities or mental health concerns and those who recently arrived described more challenges with accessing services, including the inability to attend health facilities due to caring responsibilities and lack of accessible transportation. While mental health services were often available free of charge, the format of these services and other barriers hindered uptake (Table 2).

Participants talked at length about the lack of convenient booking systems for making appointments and language barriers further complicated the process. Even with appointments, participants

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described in-person queues at the healthcare facilities and opening hours of some healthcare facilities conflicting with work schedules.

While participants mentioned receiving official, printed information at border crossings, refugee camps and during the registration process, many reported the information provided was too general to act upon. Specific topics of interest included dentistry and vaccination, as many did not know where and how to access services or how to align childhood vaccinations schedules.

Motivation factors

In case of urgent medical need, whether perceived or real, participants sought out emergency care first. If they did not receive emergency care, they continued to navigate other options. Notably, medical services for children were almost always perceived as urgent. In cases where needs were not perceived as urgent, participants heavily weighted factors of accessibility, quality, and trust. '*In Ukraine, I had doctors* who *consulted me for years and built my trust, and then, here I am, in a foreign country, going to a perfect stranger, conscious of communication problems that lie ahead—of course, it's challenging psychologically, but there was no other way. When the need arose, we sought [medical assistance]*'.—Woman, Slovakia, 26 years old.

In some cases, participants opted for emergency care services even if they were aware the need was not urgent. In Poland, participants expressed confusion and fear of being fined if they called for an ambulance in a situation not officially classified as an emergency.

For many participants, quality of care was perceived as high based on their own experience, that of friends and family, and the belief that European healthcare would intrinsically be of high quality. '*There is trust because this is Europe; Poland is closer even to Ukraine, I would say, in terms of mode of being*'.—Woman, Poland, 25 years old. However, this perception was influenced strongly by specific negative experiences that were shared with and by others. Differences in treatment approaches caused concern, such as for high fever in children, which many thought was not taken seriously enough. Perceived and real lengthy wait times for appointments, testing and results often de-motivated people from using health services.

Many participants were impressed with the kind and caring attitude of health workers and felt that this increased their sense of safety and level of trust in the system as a whole. In Poland, participants noted that a lack of corruption in the healthcare system added to their sense of safety and trust. However, others shared negative personal experiences related to barriers that make it hard to build rapport with the physicians in host countries including language. '*Now I know for sure that the doctors at the University Hospital are the best for us, and they know Sofia, and I trust the doctors. At the same time, we always consult with our Ukrainian doctor, who is in charge of my child. I can't say I trust a certain doctor*'.—Woman, Poland, 37 years old. In Slovenia in particular, those who could afford to visit private doctors expressed a greater sense of security and confidence in the health system. Concerns were also raised about not being able to verify doctors' qualifications in the host country.

Discussion

This paper explores barriers and drivers related to refugee healthcare seeking behaviours and access in five refugee receiving countries at different times during the war in Ukraine and identifies common themes and potential actions that could be taken in response.

Language barriers and health literacy impacted participant's ability to understand their entitlements and navigate systems and influenced motivation and opportunity to access services. Having accessible, relevant, and actionable information available in a language they could understand was essential. Responsibility for these factors resides at both individual and structural levels. Refugees must make efforts to learn local languages and seek information. However, it is institutions that must ensure information can be easily found in translated, non-technical language [21].

Civil society was repeatedly praised for the support provided in understanding how health systems worked and in physically accessing care. It is essential that leaders recognize this—mostly volunteer—public contribution [22]. Few examples of perceived discrimination were shared. Relationships between refugees and local individuals such as landlords and neighbours were important and grew over time. Further research is needed to develop interventions and highlight success stories that can foster greater harmony between both groups.

Refugees who have resources are keen to help their peers and do not want to be passive recipients. In light of the importance we found of peer networks as information and support sources, identifying the front-runners among refugees and actively involving them to disseminate information is critical in any refugee crisis. By doing so and recognizing the role of shared social identity, communities can enhance their collective resilience and effectiveness in crisis situations [23, 24]. Developing programs to strengthen refugees' capacities for mutual support is essential for enhancing information sharing, resilience, and overall well-being.

Studies show that forced migration is a highly traumatic experience associated with short and long-term mental health issues [25–27]. Given the importance of mental health support, it is striking that many Ukrainian refugees did not access free services available. The studies revealed multiple barriers to accessing such services, ranging from beliefs and cultural context of the individual refugee to the nature of the services offered. Importantly, refugees from Ukraine brought with them stigma and historical perspectives of psychiatric care during the Soviet era [28], confirming a study showing country of origin perspectives regarding mental health may impact refugee uptake of services in any setting [29]. It is also important to note that interviewers did not distinguish between types of mental health issues or intervention range (psychosocial support to psychiatric treatment), preventing greater nuance in this analytical exploration and, therefore, a possible future research direction.

Refugees suffering from mental health issues may be an important component of vulnerable groups, along with elderly, pregnant women, mothers with young children, and people with a disability, who struggle more to find and benefit from services [30] and require additional support. With limited resources, governments and organizations may consider targeting services to those who most need them through qualitive research and community engagement.

Some participants described increased self-efficacy over time, possibly due to the lived experience of using health services. The importance of self-efficacy in good mental health is well known, and multiple studies among refugees have shown that those with higher self-efficacy tend to have higher well-being [31–33]. Findings from Sulaiman-Hill and Thompson [34] suggest that self-efficacy among refugees is worth further examination, as well as engaging successful refugee role models to promote self-efficacy.

Vaccination coverage in Ukraine has been found to be low and remains a concern. Using measles as a proxy, children in Ukraine have been well below the target of 95% coverage for the first and second dose of measles vaccination for several years, for example at 74% in 2022 and 85% in 2021 [35]. However, our data show that refugees often needed information on where and how to access vaccination, rather than needing to be convinced of its value. While we did not ask specific vaccine demand-related questions, it may be advisable for providers to take every opportunity to offer

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vaccination services to refugees, especially in countries with perceived high-quality care.

Supporting healthcare workers and acknowledging the additional burden that increasing numbers of patients bring is essential. A recent scoping review [7] emphasizes several quality of care issues to improve healthcare outcomes for refugees, including establishing trust between patients and healthcare providers, improving communication, promoting cultural and social sensitivity among practitioners, and ensuring sufficient time to address refugee needs. Worabo *et al.* [8] found that improved interpretation services and cultural competency training for healthcare providers could improve communication and trust between refugee patients and providers in the United States of America. However, additional resources for healthcare workers are needed as they take on such efforts.

We acknowledge several limitations in this study. First, self-selection of both participating countries and individuals may reflect greater capacity or interest in the topic. To enhance credibility and transferability, we employed diverse recruitment strategies across different channels, demographics, and locations.

Second, data collection at different times post-invasion may reflect different experience snapshots. We addressed this by systematically exploring participants' duration of stay and how their experiences, needs, and perspectives evolved.

Third, online interviews may have affected interviewer-participant rapport, though strong connections appeared to be established based on narrative richness, suggesting adequate trustworthiness while enabling broader geographical representation.

Last, concentration within EU countries limits the transferability of specific findings to Ukrainian refugees elsewhere globally.

Despite limitations, the methodological rigour of our cross-country synthesis and the "inferential *generalizability*" [36] of our findings to similar settings suggest that study insights can inform revisions to health services being offered to refugees from Ukraine and provide considerations for future refugee health crises in any location.

Conflict of interest: Authors report no conflicts of interest.

Key points

- The use of qualitative methods alongside other data collection can help target and tailor limited resources to improve refugee access to health services.
- Of critical concern to refugees are availability of actionable information, support for navigating new health systems, additional support for the most vulnerable, multicomponent approaches to increase use of mental health services, and tailored initiatives to overcome language barriers.
- It is essential to acknowledge the additional burden on healthcare workers that may result from increased demand for services and to support civil society organizations that often provide significant services.

Supplementary data

Supplementary data are available at *EURPUB* online.

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Data availability

Original recordings are not available to protect confidentiality. Summary RAP sheets will be shared on reasonable request to the corresponding author.

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