Multisectoral Needs Assessment (MSNA) 2022

Health and Nutrition Findings

March 2023

REACH Informing more effective humanitarian action

Health and Nutrition Key Takeaways

- About **a quarter of HHs were found to have Health Living Standard Gaps**, particularly in the East macro-region.
- Healthcare needs analysis demonstrated that **more than a quarter of individuals living in assessed HHs had a medical problem that made them consider getting healthcare**, and yet, **about a quarter of these individuals did not seek the healthcare services that they desired**, particularly in the East, South and North macro-regions.
- For these individuals with medical problems not seeking healthcare and those with an unmet healthcare need, the **most reported reasons were financially-related**, with respondents reporting their **HHs could not afford the costs of consultations or medications**.
- A limited number of HHs reported individuals with mental health conditions accessing mental health care (a limitation of such a HH-level survey), however, of those which did **more than a quarter could not access mental health care and medicines consistently**.
- HHs with certain demographic characteristics were found to more frequently have Health needs, particularly **60+ headed HHs, displaced HHs, and HHs with a member with a disability**.
- A small number of HHs with children below 24 months faced challenges when breastfeeding and feeding using breastmilk substitutes, however, for those which did the challenges were **mental stress for the caregiver when breastfeeding** and **lack of financial resources when using breastmilk substitutes**.

Contents

Donor and Partners

Donor: USAID FROM THE AMERICAN PEOPLE

Partners: OCHA, WFP World Food Programme, KIIS, DATA FRIENDLY SPACE

Complementary assessments: CCCM CLUSTER SUPPORTING DISPLACED COMMUNITIES, UNHCR The UN Refugee Agency

01

Methodology and Sampling

Coverage

Overall, the MSNA collected **13,449 HH-level** interviews across **23 oblasts** and **55 raions**.

- **12,804 face-to-face interviews** in accessible areas (REACH), and **645 computer assisted telephone interviews (CATI)** in inaccessible areas (WFP).
- The sample was structured to **prioritize data collection in conflict-affected areas**, with increased coverage of raions and resulted in a higher level of precision.
- Findings are representative at the raion level. Therefore, findings related to subsets of the total sample are indicative. When aggregated to the oblast and macro-region levels, findings also do not account for areas not covered by data collection, thus should be considered as indicative.

Overall, the MSNA collected 13,449 HH-level interviews in 23 oblasts and 55 raions across the whole of Ukraine.

These interviews were collected using a mixed method face-to-face (f2f) and telephone (CATI) interview data collection. REACH collected 12,804 HH (HH)-level interviews with the support of its own enumerators (data collection period 10 October - 4 November 2022). In inaccessible conflict-affected areas, the World Food Programme (WFP) conducted 645 HH-level CATI interviews (data collection period 14 November - 21 December 2022).

For reference, the CATI 'grouped' raions were in Donetska oblast (Bakhmutskyi, Kramatorskyi, Pokrovskyi, Volnovaskyi), Kharkivska oblast (Bohodukhivskyi, Chuhuivksyi, Iziumskyi, Kharkivskyi, Kupianksyi), and Mykolaviska oblast Bahstanksyi and Mykolaivkyi

Findings aggregated to the oblast, macro-region and national level do not take into consideration areas not covered by data collection and should therefore be considered as indicative rather than representative. It is also important to flag that data collection for Khersonska oblast was only conducted using the area of knowledge (AoK) approach,

the findings of which are shared below, and this oblast is therefore not captured in the f2f or CATI findings.

Demographically, the sample consisted of 8,712 (65%) female and 4,737 (35%) male respondents. These respondents were varied in age; 675 (5%) aged 18 to 25 years old, 4,725 (35%) aged 26 to 50 years old, 3,510 (26%) aged 51 to 65 years old and 4,590 (34%) aged 65+ years old. In terms of displacement, 1,080 were displaced, 1,350 were returnees and 11,069 were non-displaced, non-returnees (host community) respondents.

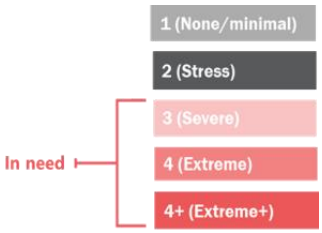
For more information on the MSNA methodology, sampling approach, research aims and questions, and limitations please go to: https://www.impact-repository.org/document/reach/a55a0d01/REACH_UKR_Methodology-Overview_MSNA-Bulletin_February-2023.pdf

Analysis Framework

Multi-Sectoral Needs Index (MSNI) and Living Standard Gaps (LSG) Analysis

The MSNI is a measure of both the magnitude and severity of unmet humanitarian needs across sectors, measured through Living Standard Gaps (LSGs)

- The *magnitude* is the total proportion of HHs affected (with at least one LSG)
- The *severity* is measured on a 5-point scale with the highest LSG forming the MSNI



	Sectoral LSG Severity Score						Final MSNI
	Food Sec	Health	WASH	Protection	Education	Etc.	
HH 1	**4**	**4**	**4**	**4**	3	3	**4**
HH 2	2	2	**4**	2	1	1	**4**
HH 3	3	3	3	**4+**	2	1	**4+**
Etc.	2	**3**	1	1	2	1	**3**

The MSNI is a measure of the HH's overall severity of humanitarian needs scale of 1 (None/Minimal) to 4 or 4+ (Extreme/Extreme+), as seen in the figure to the left, based on the highest severity of sectoral LSG severity scores identified in each HH. This methodology is roughly in line with the JIAF, however, we cannot go to a scale of 5 ('Catastrophic' in the JIAF) since this classification cannot be based on HH reporting alone, requiring an area-level approach and data triangulation.

The MSNI is determined through the following steps: First, the severity of each sectoral LSGs is calculated per HH, with HHs considered to meet a severity level criteria if one HH member meets the criteria. Next, a final severity score (MSNI) is determined for each HH based on the highest severity of sectoral LSGs identified in each HH.

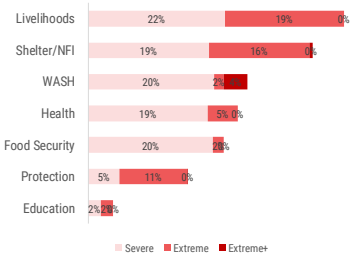
As shown in the example in the figure to the right, the highest severity score across the three HHs (HH) is taken to determine the MSNI.

Living standard gaps (LSGs) by sector

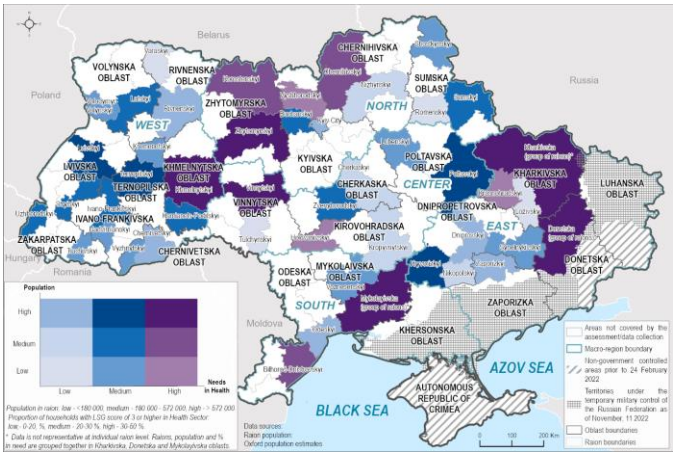
Sectors with the highest proportion of HHs found to have Severe or Extreme LSG severity scores were:

- Livelihoods
- Shelter & Non-Food Items (NFIs)
- Health

% of HHs found to have an LSG score of Severe, Extreme or Extreme+, per sector



% of assessed HHs with a Health Living Standard Gap Severity Score of 3 or 4, per raion



02

Health Living Standard Gap Analysis and Drivers

Analysis Framework

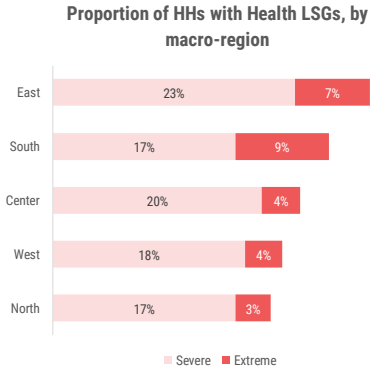
Health Living Standard Gap Framework

Critical indicators (measured at the individual level and aggregated to the HH level for LSG measurement):

1. % of individuals with unmet healthcare need and Washington Group category 3 or 4
2. % of individuals with access to mental health services

24% of assessed HHs nationally were found to have Severe or Extreme Health needs (i.e., had at least one member classified according to the critical indicators)

Findings suggest that HHs in regions affected directly by the conflict are more often to report LSGs with 30% of interviewed HHs in the East and 26% of interviewed HHs in the South found to have Severe or Extreme Health needs (LSG score of 3 or 4).

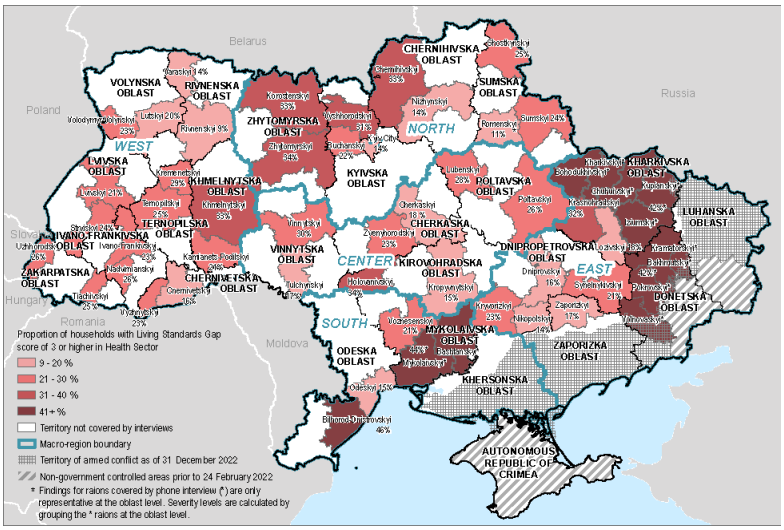


The Health Living Standard Gap (LSG) framework consists of 2 composite critical indicators. The first examines the existence of met and unmet healthcare needs alongside HH member Washington Group Severity Score (WG-SS); and the second examines access to mental health services. These indicators, measured at the individual level are then aggregated to the HH level and used to calculate the LSG at this level.

The following are the % of HHs with Severe and Extreme severity levels in the critical indicators;

1. Individuals unmet healthcare needs and WG-SS 3 or 4 – 24%
2. Individuals with access to mental health services – 11%

% of HHs with Severe (3) or Extreme (4) Health LSG severity scores

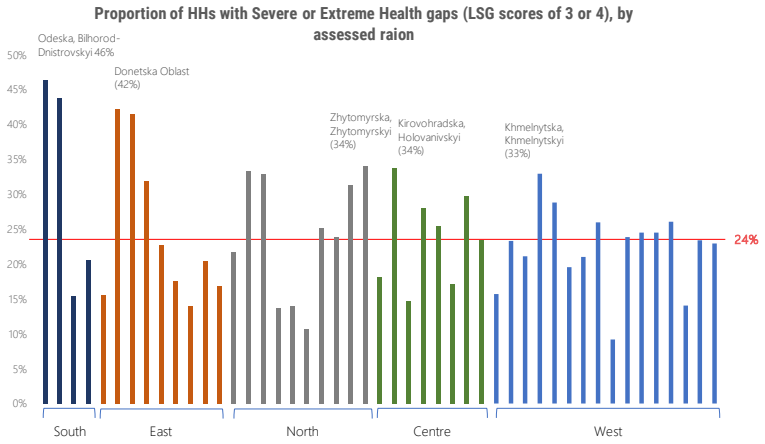


Here you have a map of the proportion of HHs falling into Severe or Extreme severity levels of Health LSGs when implementing the Health LSG framework.

Overall, the Health LSG was not one of the main drivers of the MSNI, however, there were three areas (one f2f sampled and three CATI sampled) with significantly higher Health LSGs severity scores than all other areas; Bilhorod Dnistrovskyi (46%), Mykolaivska (44%), Donetska (42%), and Kharkivska (42%).

Localised Health Living Standards Gaps

In some locations, higher than average % of HHs with severe and extreme gaps were found, suggesting a localised approach to prioritisation may be needed.

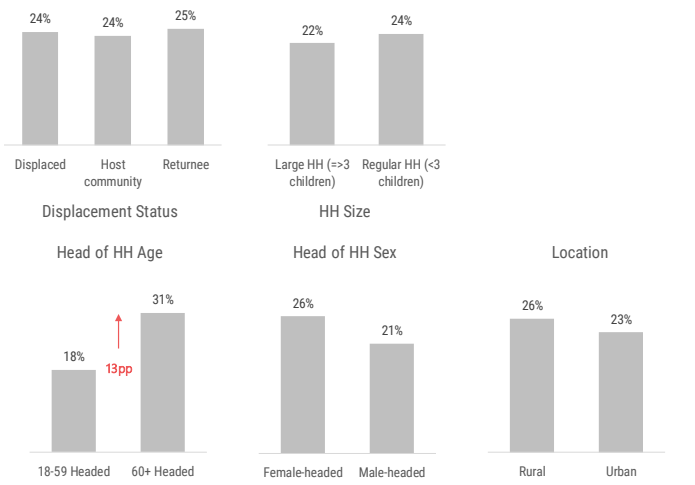


Here you have a graph of the localised Health living standard gaps, in which the proportion of HHs with Severe and Extreme needs can be observed.

Overall, the average proportion of HHs across the raions sampled was 24%, with the South region (to the left of the graph) having the highest regional average and the West region (to the right of the graph) having the lowest regional average.

Severe or Extreme unmet needs by demographic

Response to Health needs should consider the following:



Proportion of assessed HHs with severe or extreme unmet needs (LSG 3 or 4) by selected demographic group

Overall, findings suggest that almost a quarter (24%) of HHs across Ukraine have Health LSGs, with the highest macro-regional levels observed among assessed HHs in the East (30%) and the lowest levels observed in the North (21%).

Rural/Urban - There appears little difference between rural and urban HHs overall, although interviewed rural HHs were slightly more commonly found to have Health LSGs (26%) than urban HHs (23%). This pattern is seen across all regions with the exception of the East where urban HHs were more common to report Health LSGs (31%) than rural HHs (25%).

HH Size – Large size HHs (>3 children) interviewed were slightly more commonly found to have Health LSGs (24%) than regular HHs (<3 children) (22%). In the Center the highest proportion of Health LSGs were recorded where large HHs had considerably higher LSGs (49%) than any other group across all regions, although the sample was limited (n=38). Meanwhile, among interviewed HHs in the East, regular HHs had Health LSGs almost three times as often (31%) as large HHs (11%).

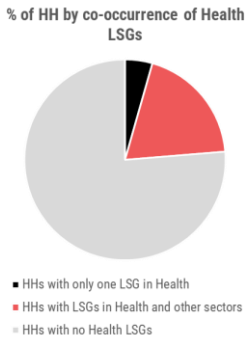
Displacement Status – The numbers of interviewed HHs with Health LSGs appear largely the same across displacement statuses (24%-25%), however, the greatest

variance was in the East where a higher proportion of HHs was found to have LSGs (38%) than any other HHs across all regions.

HoHH Age – 60+ headed HHs were more commonly found to have Health LSGs (31%) than 18-59 headed HHs (19%). This indicative pattern can be seen across all regions, particularly in the Center and the West where the proportion of 60+ headed HHs is both more than double (33% and 32%, respectively) the proportion of 18-59 headed HHs (16% and 14%, respectively). In the South the share of interviewed older-headed HHs with Extreme Health LSGs was also considerably higher (13%) than in any other region (max 8%).

HoHH Sex – Interviewed female-headed HHs slightly more commonly had Health LSGs (26%) than male-headed HHs (21%). This pattern can be seen across all regions, especially in the South (9% percentage points (pp) difference) and the Center (8% pp). Again, in the South region the share of female-headed HHs with Extreme Health LSGs is again notably higher (12%) than any other region.

Health LSG Needs Profile

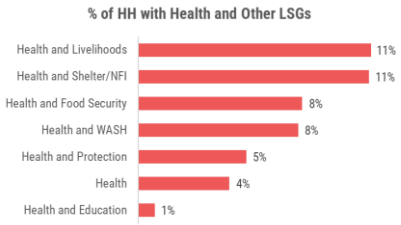


The majority of HHs that were found to have Severe or Extreme Health gaps (LSG 3 or 4) were also found to have a complex profile of needs that includes other sectors as well.

19% of assessed HHs were found to have Severe or Extreme LSGs in Health and at least one other sector.

4% of assessed HHs were classified with Severe or Extreme gaps only in Health.

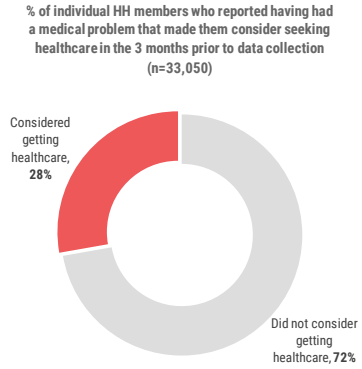
The most common combination of LSGs found among HHs with a Health LSG was the combination with a Livelihoods LSG (11% of HHs had concurring LSGs in these two sectors). Livelihoods was also the sector with the highest proportion of HHs found to have unmet needs (LSG), compared to the other assessed sectors.

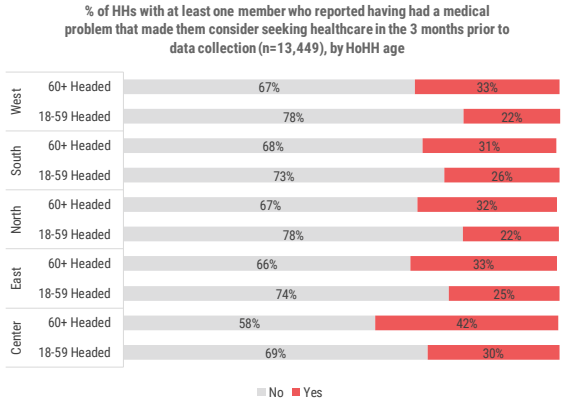


03
Health Indicator Analysis

Health Analysis

Individuals with an unmet health care need





[Asked to each HH member] In the past 3 months, did you (HH member) have any medical problem that made you consider getting health care?

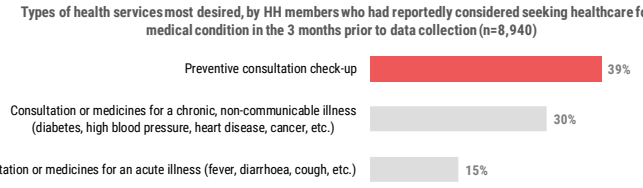
Overall, more than a quarter (28%) of HH members considered getting healthcare over the past 3 months, as visualised in the pie chart to the left. This pattern was largely followed across all regions apart from the Center in which more than a third (34%) of HH members did.

In comparison, more than a third (34%) of 60+ headed HHs had at least one member considered getting healthcare compared to less than a quarter (24%) of 18-59 headed HHs. This pattern was observed across all regions, as demonstrated in the graph to the right, with greatest disparity between the 18-59 headed HHs (22%) and 60+ headed HHs (33%) in the West.

The **CCCM Vulnerability Index** shows that around 40% of HH members from groups living in collective site reported at least one healthcare need.

Health Analysis

Individuals with an unmet healthcare need



Types of health services most desired, by HH members who had reportedly considered seeking healthcare for a medical condition in the 3 months prior to data collection (n=8,940), by HoHH sex and age

	Preventive consultation check-up	Consultation or medicines for a chronic, non-communicable illness	Consultation or medicines for an acute illness	Dental services	Laboratory services	Imaging
18-59 Headed	41%	20%	17%	15%	9%	8%
60+ Headed	37%	43%	12%	9%	8%	9%
Female-headed	38%	31%	15%	12%	7%	9%
Male-headed	40%	28%	15%	13%	9%	8%

[Asked to each HH member who reported YES to having a medical problem that made them consider getting healthcare] If you wanted to access health care services, what services were desired?

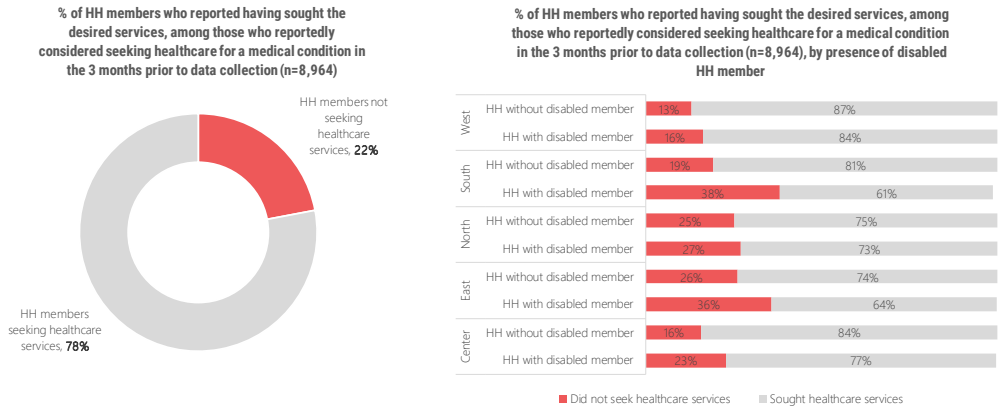
The most desired healthcare service by HH members was 'Preventative consultation check-up' (39%), followed by 'Consultation or medicines for chronic' (30%), and 'Non-communicable illness and consultation or medicine for an acute illness' (15%) as visualised in the graph above. These were the most desired healthcare services across all regions with 0% of HHs desiring abortion, GBV or substance abuse services and only 0.2% desiring delivery services.

When disaggregated by HoHH age and sex there were six healthcare services which were the same across all groups, illustrated in the table below. The only noteworthy outlier within this pattern was HH members from 60+ headed HHs being more likely to desire consultation or medicines for a chronic, non-communicable illness than preventative consultation check-ups.

The same trend found in MSNA was also observed in the **CCCM Vulnerability Index**, for IDPs HHs living in collective sites. Site residents also reported preventive consultation check-up (40%), followed by consultation or medicines for chronic, non communicable illness (30%), and consultation or medicines for an acute illness (23%).

Health Analysis

Individuals reporting not seeking healthcare



[Asked to each HH member who reported YES to having a medical problem that made them consider getting healthcare] Did you seek the desired health care service(s)?

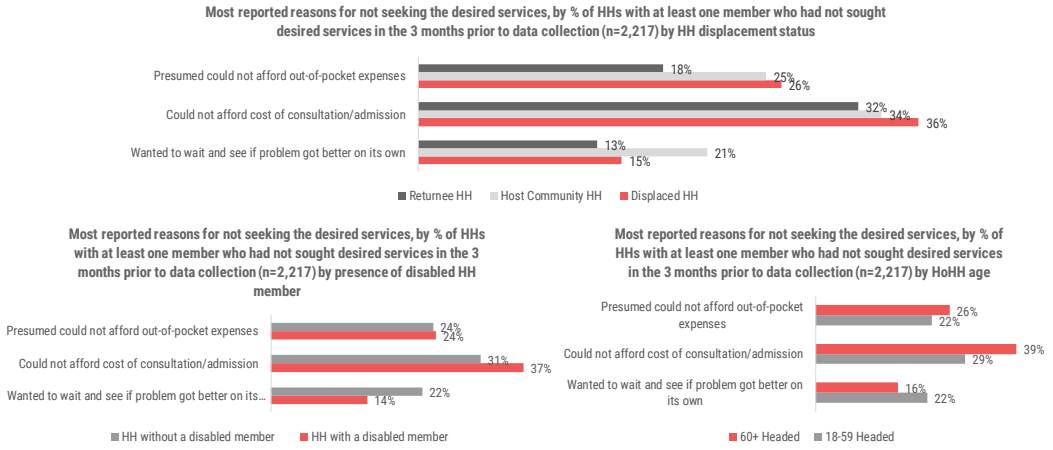
Overall, 78% of HH members who had a medical problem sought healthcare services, illustrated in the graph to the left, with the highest numbers in the West (86%) and the lowest in the East (70%) regions.

HH members from a HH with a disabled member were less likely to seek healthcare (73%) than those without (81%), a pattern which was observed across all regions in the graph to the right. In particular, 38% of HH members from a HH with a disabled member in the South and 36% in the East did not seek healthcare.

Similar to the MSNA trends, HHs living in collective sites assessed by the **CCCM Vulnerability Index**, reported higher level of HH members who considered getting healthcare and sought the services (85% of the members who considered getting healthcare). Only 6% of all members considered they needed healthcare and did not seek the services.

Health Analysis

Individuals reporting reasons for not seeking healthcare



[Asked to each HH member that reported NOT seeking healthcare services] If you did not seek the desired health care service(s), why not?

Overall, 'Could not afford' (34%), 'Presumed could not afford out-of-pocket expenses' (24%) and 'Wanted to wait and see if problem got better' (19%) were the reasons HHs most reported for not seeking desired healthcare services. This demonstrates the issue of affordability with healthcare.

When disaggregated by displacement status (the graph above) we see that this pattern of reasons is followed with the highest levels of reasons reported by displaced HHs, followed by host community HHs and returnee HHs. There is, however, an exception with 'Wanted to wait and see if problem got better' which HC HHs more commonly reported than displaced or returnee HHs.

Similarly, when disaggregated by disability (the graph to the lower left) we see that the pattern of reasons is followed with HH with a member with a disability reporting the first two reasons more than those HH without a member with a disability. However, again there is an exception in the third most reported reason with HHs without a disabled member reporting this reason for not seeking healthcare more

than HHs with one.

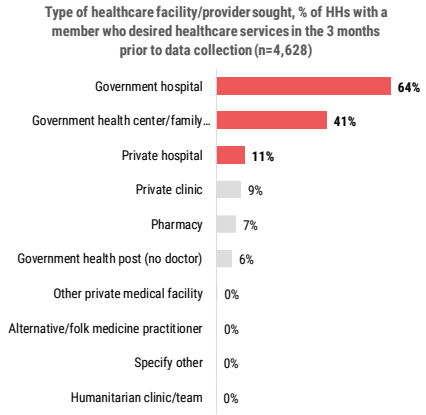
Finally, when disaggregated by HoHH age (the graph to the lower right) we see that the pattern is followed once again with 60+ headed HHs reported the first two reasons for not seeking desired healthcare services more than 18-59 headed HHs with a reverse in the pattern for the third reason.

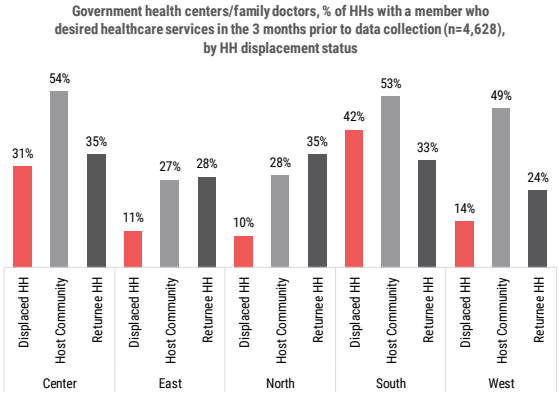
In conclusion, there are three common reasons for not seeking healthcare services desired with distinct patterns of disaggregation, with the exception of the third reason ('Wanted to wait and see if problem got better') which less traditionally vulnerable groups (host community HHs, HH with a member with a disability and 18–59 headed HHs) are more likely to use.

Data from the **CCCM Vulnerability Index** suggests that those HHs living in collective sites who did seek healthcare reportedly face issues related to the unaffordability to consultation or admission (30%).

Health Analysis

HHs reporting healthcare service providers visited





If you or anyone in your HH sought the health care services, they desired in the last three months, where did you/they go to seek those services?

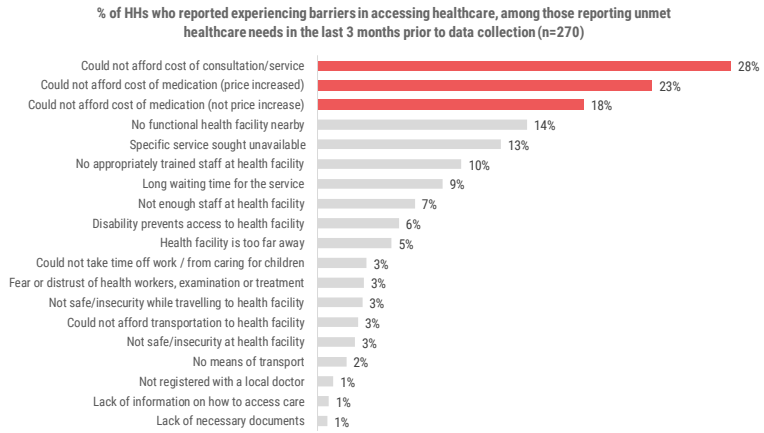
Overall, the three most reported healthcare facilities/providers to be sought by HHs who desired healthcare were government hospitals (64%), government health center/family doctor (41%) and private hospital (11%), as illustrated in the chart to the left. It is also noteworthy that alternative/folk medicine practitioner were reported by only 0.3% of HHs and humanitarian clinics and teams by only 0.1%.

When disaggregated by displacement status, usage of government health centers/family doctors demonstrates regional patterns with 49% of host community HHs in the West reportedly seeking them compared with only 14% of displaced HHs, as demonstrated in the chart to the right. Meanwhile in the North, 35% of returnee HHs reportedly sought health centers/family doctors compared with 10% of displaced HHs.

Data from the **CCCM Vulnerability Index** indicates the same trend regarding the places that IDPs living in collective sites visited in order to seek healthcare.

Health Analysis

HHs by self-reported barriers to accessing healthcare



Findings suggest particular differences in terms of barriers experienced by rural and urban HHs. For instance, while rural HHs more commonly reported **price increases** as a barrier than urban HHs, urban HHs particularly often reported a **lack of trained staff at the facility** compared to rural HHs.

[If there was any UNMET health care need] In the last 3 months, what barriers if any has your HH experienced to prevent you from accessing the health care you needed? [choose up to 3 most important]

Firstly, it is important to flag here that the sample used to create these findings was small as the indicator looked only at those with a healthcare need seeking it and is therefore small.

Overall, the three most reported barriers HHs experienced preventing them from accessing healthcare were that they could not afford the cost of the consultation/service (28%), could not afford the cost of medication, either because of price increase (23%) or not (18%), as illustrated in the graph.

Interestingly, when disaggregated by rural/urban the greatest disparity was with 'Could not afford cost of medication (price increased)' in which rural HHs were more than twice (38%) as likely as urban HHs (17%) to face barriers, and 'No appropriately trained staff at health facility' in which urban HHs were more than three times (13%) as likely as rural HHs (4%) to face barriers.

Trends identified in MSNA were similar to those found in the **CCCM Vulnerability Index** data, in which most of the IDPs HHs in collective sites reported being successful in accessing healthcare services, while only 9% informed that at least one member faced some barriers or did not receive the service. Among the main barriers, respondents highlighted the unaffordability to consultation (34%) and to medication (unaffordability not due to price increase: 21%; due to price increase: 20%).

Health Analysis

HHs by self-reported barriers to accessing health care

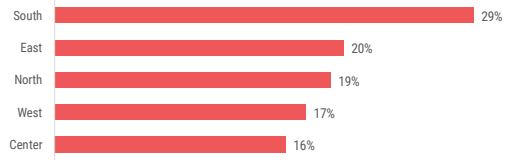
% of HHs who reported experiencing (Top Three) barriers in accessing healthcare, among those reporting unmet healthcare needs in the last 3 months prior to data collection (n=270), by macro-region

	Could not afford cost of medication (price increased)	No functional health facility nearby	Could not afford cost of consultation/service
East	11%	13%	4%
South	7%	5%	14%
North	9%	7%	7%
West	11%	7%	3%
Center	9%	5%	3%
Overall	10%	7%	5%

The two most commonly reported barriers were **could not afford medication** and **no functional healthcare facilities nearby**, a pattern was observed across all regions with the exception of the South, in which **could not afford cost of consultation/service** was most commonly reported.

Reducing HH healthcare expenses was the **third most frequently reported livelihood coping strategy** used overall, behind only 'spending savings' and 'taking on an additional job'.

% of HHs reporting having reduced healthcare expenses as a livelihood coping strategy in the 30 days prior to data collection



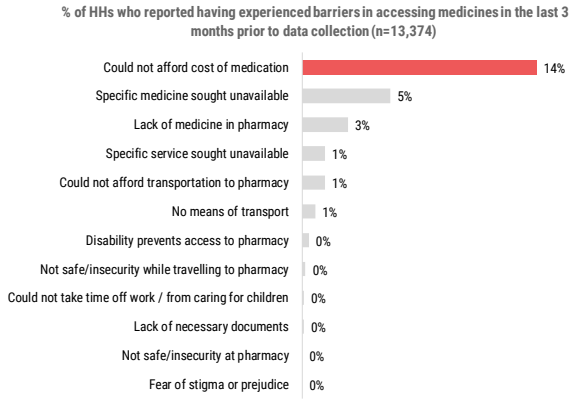
[If UNMET health care needs reported], In the last 3 months, what barriers if any has your HH experienced when accessing health care? [choose up to 3 most important]

For HHs with unmet healthcare needs over the past 3 months the two most reported barriers were 'Could not afford medication' (10%) and 'No functional healthcare facilities nearby' (7%), demonstrated in the table to the upper left, with overall reporting of all barriers much lower as HHs were able to meet their healthcare needs. These were the two most reported barriers except for HHs in the South, in which could not afford cost of consultation/service was most reported (14%).

When examining livelihood coping strategies, 19% of HHs overall used reducing health expenses as a coping strategy. This strategy was most frequently used in the South (29%) and least frequently used in the Center (16%), as illustrated in the graph to the lower right. Furthermore, female-headed HHs also used this coping strategy more often than male-headed HHs across all regions.

Health Analysis

HHs by self-reported barriers to accessing medicine



These patterns of barriers to accessing medicines were observed across all regions with HHs in the South reporting **'Could not afford cost of medication'** more frequently than HHs in other regions and with the exception of HHs in the East reporting **'Specific medicine sought unavailable'** more than twice as frequently as the overall average.

Findings suggest that **high costs of medication** might particularly pose barriers for HHs with members with disabilities or HHs with an older head of HH (60+); these HHs more commonly reported costs to be a barrier than HHs without members with disabilities or younger (18-59) HH heads, respectively.

If anyone in your HH sought medicines in the last 3 months, what barriers did they experience?

Overall, the most reported barrier to accessing medicine was that HHs 'Could not afford the cost' (14%), as seen in the graph. This was the same across all regions, although HHs in the South reported this barrier more frequently (18%) than in other regions and HHs in the East reported that 'The specific medicine their HH sought was unavailable' significantly more (11%) than the overall average. It is noteworthy that there were no significant differences between rural and urban HHs in barriers to accessing medicine.

When reviewing HHs that 'Could not afford the cost of medication' across various vulnerable group disaggregation it is noteworthy that 60+ headed HHs were twice as likely (20%) to report this barrier than 18-59 headed HHs (10%), while HH with a member with a disability more than twice as likely (24%) to report this barrier than those HH without a member with a disability (11%).

Equally, the affordability was the main barrier mentioned by IDPs in collective sites regarding the access to medicines. The **CCCM Vulnerability Index** data shows that 16% of HHs in collective sites highlighted that they could not afford the cost of medication.

Health Analysis

Individuals with access to mental health services

Among all HH members who reportedly wanted to access mental health services in the 3 months prior to data collection (n=353), % who were able to access it consistently

	No access to mental health care	Access to mental health care
Centre (n=54)	30%	55%
East (n=45)	4%	95%
North (n=114)	34%	66%
South (n=51)	22%	73%
West (n=81)	29%	67%
Overall (n=353)	**28%**	**69%**

Overall, the number of **HHs reporting that any member with a mental health condition had been cared for by a mental health professional was very low at just 3%.** When disaggregated by disability, HHs with a disabled member were more than three times as likely (7%) than HH without a disabled member (2%) to have someone cared for by a mental health professional.

Of those HHs with members which did access mental health care, however, those in the East were most likely to have access (95%) while those in the Center were least likely to have access (55%), as demonstrated in the table.

[For each person who wanted to access mental health care services] If yes, were they consistently able to access mental health services and/or medicine they needed in the last 3 months?

Firstly, it is important to flag here that the sample used to create these findings was small as the indicator looked only at those with a mental health care need seeking it. The sample is therefore particularly indicator.

Overall, the number of HHs reporting that any member with a mental health condition had been cared for by a mental health professional was very low at just 3%. This did not vary when disaggregated by HoHH sex, HoHH age or displacement status, however, HH with a member with a disability were more than three times as likely (7%) than HH without a member with a disability (2%) to have someone cared for by a mental health professional.

Of those HHs with members which did access mental health care, however, those in the East were most likely to have access (95%) while those in the Center were least likely to have access (55%), as demonstrated in the table.

The CCCM Vulnerability data shows that a similar percentage of IDPs HHs in collective site reported a member with a mental health condition, and 24% of HHs with a member with a mental health condition reported not being able to get mental healthcare consistently in the 3 months prior to the data collection.

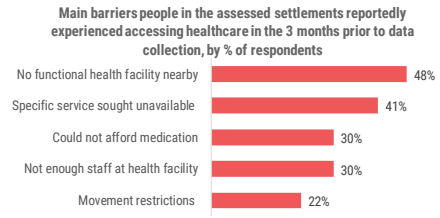
Area of Knowledge Analysis

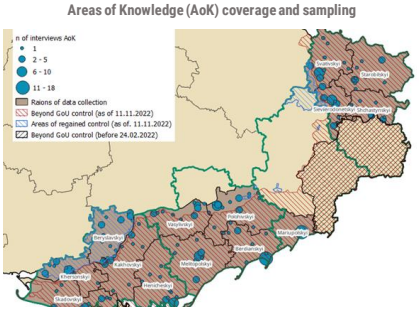
Methodology

- Area of Knowledge interviews were conducted by WFP with respondents who had either moved out of or had been in regular contact with families/friends in Luhanska, Zaporizka, Khersonska or Donetska oblasts, within the 14 days prior to data collection;
- Relatively small sample size of 268 interviews. Respondents reported not about their own HHs, but about their knowledge of the general situation in the areas of interest. Thus, findings are indicative (non-representative);
- Due to the complexity and sensitivity of data collection in these areas, an adjusted and shortened questionnaire was used, focusing only on the most critical indicators.

Health Findings

- 65% of respondents indicated that they didn't think people in the assessed areas were able to access healthcare services/facilities if needed.
- Three in ten respondents indicated medicines unaffordable for people in the assessed areas





Because of inaccessibility of some areas after February 2022 (temporarily beyond control of Ukrainian Government or closeness to the contact line), WFP conducted an assessment there using "Area of Knowledge" approach (interview with key informants, having the recent knowledge about the area). Respondents were asked to describe the conditions and needs of people the know in the area/settlement, or to assess the situation in the whole settlement. The sample was drawn from people internally displaced from the areas of interest. Data was collected via telephone interviews between early November 2022 and mid January 2023. Because of the sensitivity and the methodology, used for this survey, the questionnaire was adjusted. The cutoff dates used in the map were set to correspond with the commencement of data collection. Source for territory control: Institute of War Studies.

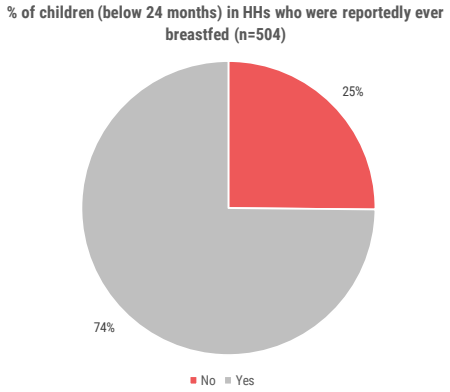
Considering the small sample size, sampling methodology (convenience sampling) and key informant-type approach, these findings should be considered as indicative only. Findings cannot be interpreted directly as prevalence for the people living in the settlements, but rather shares of respondents asked about living conditions in the settlements/areas of interest.

04

Nutrition Indicator Analysis

Nutrition Analysis

Breastfeeding Challenges



Among HHs which were breastfeeding (n=327), **16% reported facing challenges breastfeeding (n=60)**, the most frequent of which was not having enough breastmilk.

In comparison, of HHs reportedly using breastmilk substitutes (n=473), **14% reported challenges when feeding children**. The most frequently reported challenges no access to enough infant formular or powdered milk.

For every child that is below 24 months old. Was child ever breastfed? / If breastfeeding, what challenges, if any, were faced, for breastfeeding the child?

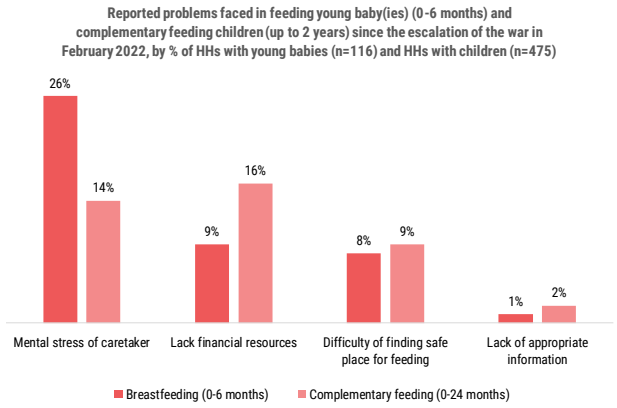
Overall, 74% of children below 24 months old (n=372) were breastfed, meaning that 25% of children below 24 months (n=125) were not. Of those which were breastfed, 16% faced challenges.

If using breastmilk substitutes, what challenges, if any, were faced in feeding these to the child?

When using breastmilk substitutes the most frequently reported challenge overall was 'no access to enough infant formula or powdered milk' (9%). There was no distinct rural/urban disparity, however, regionally HHs in the South reported 'no access to enough infant formula or powdered milk' (20%) more frequently than other regions

Nutrition Analysis

Feeding and Complementary Feeding Challenges



Overall, **45% of HHs with young babies 0-6 months reported problems in feeding** (n=52). The problem most reported by HHs was mental stress on the caregiver (n=26).

In comparison, **only 36% of HHs with children up to 2 years reported problems in complementary feeding** (n=171). The problem most reported by HHs was lack of financial resources (n=77) followed by mental stress on the caretaker (n=66).

[For every family that has at least one child from 0-6 months] Have you experienced any problems in feeding your young baby/ies (0-6 months) since the escalation of the war in February 2022?

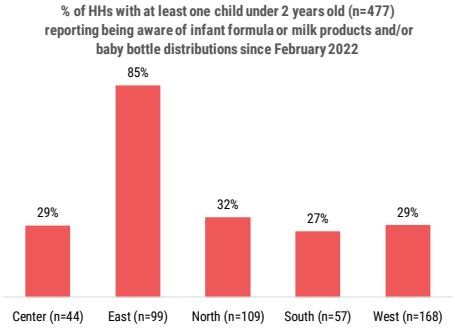
Overall, 45% of HHs with young babies 0-6 months reported problems in feeding (n=52). The problem most reported by HHs was mental stress on the caregiver (n=26).

H[For every family that has at least one child up to 2 years] Are there any problems with complementary feeding children up to 2 years since the escalation of the war in February 2022?

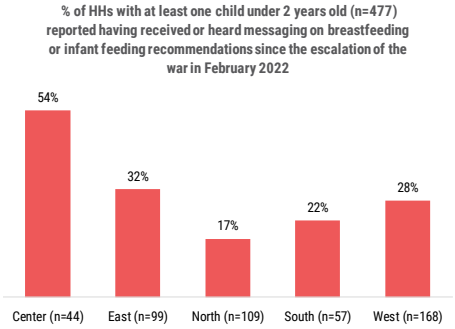
In comparison, only 36% of HHs with children up to 2 years reported problems in complementary feeding (n=171). The problem most reported by HHs was lack of financial resources (n=77) followed by mental stress on the caretaker (n=66).

Nutrition Analysis

Feeding Distribution and Awareness Raising



Overall, **around half (49%) of HHs that had at least one child up to 2 years old reported being unaware of any infant formula, milk products or baby bottle/teats had been distributed** since the start of the war in February 2022.



Furthermore, **almost two-thirds (63%) of HHs with at least one child up to 2 years old reported not having received or heard messaging** on breastfeeding or infant feeding from government or non-government actors.

[For every family that has at least one child up to 2 years] Since the escalation of the war in February 2022, are you aware of any infant formula or milk products (e.g. dried whole, semi-skimmed or skimmed milk powder, ready to use milk) and/or baby bottles/teats having been distributed? (n=477)

Overall, around half (49%) of HHs that had at least one child up to 2 years old reported being unaware of any infant formula, milk products or baby bottle/teats had been distributed since the start of the war in February 2022. Regionally, this pattern was followed across all regions, however, there was a notable exception to this pattern in the East, where HHs were more than twice as likely to be aware of infant formula, milk products or baby bottle/teat distribution.

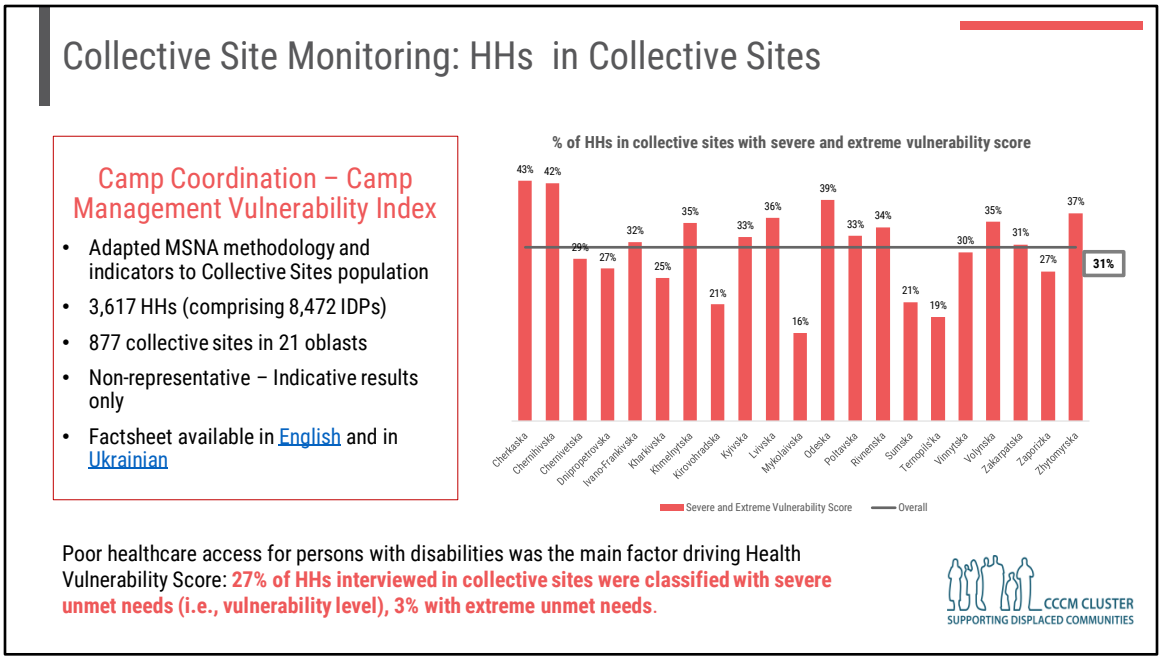
[For every family that has at least one child up to 2 years] Since the escalation of the war in February 2022, have you received or heard any messaging from government or non-government actors on breastfeeding or infant feeding recommendations? (n=477)

Furthermore, almost two-thirds (63%) of HHs with at least one child up to 2 years old reported not having received or heard messaging on breastfeeding or infant feeding from government or non-government actors.

This pattern was the same across all regions, especially the North, however, there was an exception to this pattern in the Center, where HHs were marginally more likely to have received this messaging than not, although the sample was very small (n=44).

05

Collective Site Population Indicator Analysis



Collective Site Monitoring: HHs in Collective Sites (CSs)

The Camp Coordination Camp Management (CCCM) Vulnerability Index is a round of data collection undertaken by the Collective Site Monitoring unit in coordination with the CCCM Cluster and with funding from the UNHCR.

The CCCM Vulnerability Index adapted the MSNA methodology and indicators to the population of IDPs living in collective sites. Note that some **indicators are specific to the CCCM Vulnerability Index**. A dedicated Factsheet with sectoral Vulnerability Scores and the overall CCCM Vulnerability Index, alongside a dataset with the results for every indicator (at the overall, rural-urban disaggregation, and oblast levels), is available following this **link**.

The results from the CCCM Vulnerability Index are only indicative.

In terms of coverage, 3,617 HHs were interviewed in face-to-face interviews, for a total of 8,472 IDPs. 877 collective sites were assessed in 21 government-controlled oblasts (all oblasts except Khersonska, Luhanska, Donetska, parts of Zaporizka). Sixty per cent (60%) of interviewed IDPs were women, and 40% men, with the age

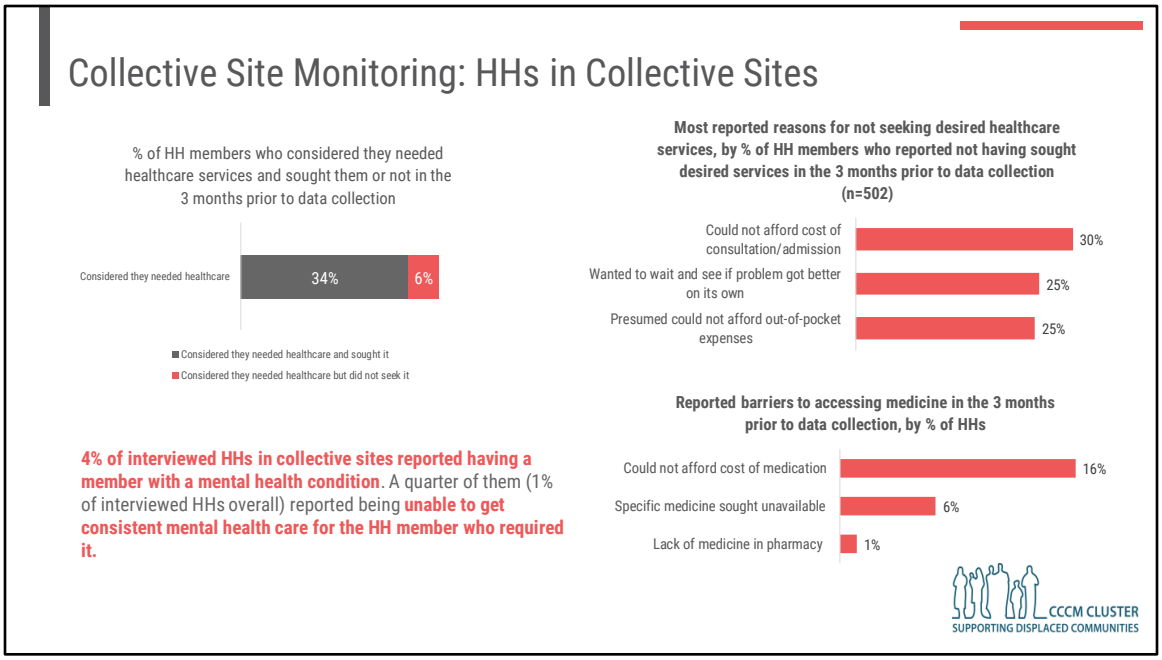
disaggregation as follows: 6% 0-5; 21% 6-17 years old; 48% 18-59; 25% above 60 years old

===
Health

The Health Vulnerability Score has the same underlying indicators as the MSNA Health LSG. With the caveat that the CCCM Vulnerability Index results are only **indicative**, the score can give an indication of the differences between the general population and the population living in collective sites. For instance, the proportion of HHs living in collective sites with a severe or extreme Health Vulnerability Score was 31%, higher than the general population.

With poor healthcare access for persons with disabilities as one of the main factors driving the Health Vulnerability Score for HHs in collective sites, it is important to note that the proportion of HHs comprising people with a reported disability (34%) is higher amidst HHs living in collective sites compared to the general population.

Regarding the geographic distribution, the proportion of HHs with a severe or extreme Health Vulnerability Score is not substantially different between HHs living in rural and urban collective sites.



Collective Site Monitoring: HHs in Collective Sites (CSs)

The proportion of members of HHs in collective sites who considered they needed healthcare was 40%, higher than in the general population. 34% of all members of HHs in collective sites sought the needed healthcare service, while 6% considered they needed healthcare but did not seek it.

The main barriers to access healthcare were predominantly related to affordability concerns, as were the barriers to access medicine. Reducing essential health expenditures was a livelihood coping strategy to maintain basic needs used by 23% of HHs in collective sites. At the same time, one of the main reasons to employ livelihood coping strategies was to pay for healthcare: 55% of HHs who employ livelihood coping strategies reported it as one of their main reason to do so.

Healthcare service providers sought by HHs in collective sites were predominantly government hospitals (75%), government health centre/family doctor (33%), private hospital (8%); similar proportions to the general population.

For any questions on these findings please contact

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