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Themed Paper - Case Report

## Ukraine refugee crisis: evolving needs and challenges

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## ABSTRACT

This case report examines the initial experience of Poland in responding to the refugee crisis triggered by the war in Ukraine. In the first 2 months of the crisis, more than 3 million Ukrainian refugees fled to Poland. The large influx of refugees rapidly overwhelmed local services and led to a complex humanitarian emergency. The initial priorities were to address basic human needs, such as shelter, infectious disease concerns and healthcare access, but evolved to include mental health, non-communicable diseases and protection needs. This necessitated a 'whole of society' response involving multiple agencies and civil society. Emerging lessons learned include the need for ongoing needs assessments, robust disease monitoring and surveillance, as well as flexible multisectoral responses that are culturally sensitive. Finally, Poland's efforts to integrate refugees may help mitigate some of the adverse consequences of the conflict-related migration.

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## Introduction

The war in Ukraine in 2022 has led to a serious humanitarian crisis both in Ukraine and its neighbouring countries. Between February and April 2022, more than 3 million Ukrainian refugees fled to Poland.<sup>1</sup> The direct effects of war, disruption to health care and the wider socio-economic impacts have created a complex health emergency. This posed multiple health challenges that included war-related trauma, infectious disease threats, non-communicable diseases (NCDs), as well as mental health and psychological impacts.<sup>2</sup> We present here a case report of the Polish experience and response to the refugee crisis.

## Methods

A rapid fact-finding mission was commissioned by the International Association of National Public Health Institutes (IANPHI) Europe to see first-hand the refugee situation and response in Poland. The aims were to understand the challenges faced by Poland, understand the needs of refugees, identify emerging lessons learned that may have wider generalizability and

explore the role of the national public health institute (NPHI) in the crisis.

The mission team was made up of four public health experts from Public Health Wales, UK Health Security Agency, Norwegian Institute of Public Health and Narodowy Instytut Zdrowia Publicznego – Państwowy Zakład Higieny (NIZP-PZH), Poland (Poland's NPHI). The team had a range of expertise in health protection, public health policy and strategy, epidemiology and surveillance and humanitarian emergency response. The mission visited Poland in May 2022. The mission was hosted and facilitated by NIZP-PZH.

The mission review incorporated a documentary review, key informant interviews, field visits and direct observations. First, a rapid documentary review of recent reports from the international agencies operating in Ukraine and Poland was conducted. The review looked for common themes, specifically of relevance to refugee health.

Unstructured interviews and discussions with key informants were conducted. Key informants were purposefully selected for the insight that they could provide on the refugee needs and response. Interviews were done face-to-face or remotely. Key informants included officials from the Ministry of Health, regional ministry, local municipality, local hospital, as well as Border Guards, Sanitary Inspectors, refugee reception centre managers and volunteers coordinator. Interviews were carried out in English or Polish with the assistance of an interpreter.

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Field visits and direct observation were also carried out at the border crossing at Korczowa, border reception point, refugee reception centre at Hala Kijowska, refugee reception point and accommodation centres in Krakow. Information collected from the desk review, interviews and field visits were collated and summarised in the following report. This case report is a condensed version of a substantially longer mission report to IANPHI.

## Findings

### *Scale and complexity of the refugee crisis*

The scale of the refugee influx was considerable, rising rapidly to more than 100,000 entering the country daily in the first few weeks of the crisis. This immense number of refugees very quickly overwhelmed the capacity of local services. Poland's refugee response therefore had to be rapidly scaled up to meet the surge of refugees. The refugees were a disparate population with multiple needs that were not static but evolved over time. This led to considerable complexity, and Poland had to adapt its responses accordingly. Multiple measures were implemented to protect and include refugees in host communities, as well as facilitate access to basic services, including shelter, health care and education.

The scale and complexity of the refugee crisis necessitated a 'whole of society' response from national government to local municipalities, including international organisations and civil society. The prominent role played by civil society was remarkable—local and international charities and volunteers operated refugee kitchens and childcare facilities, provided education for refugee children, offered homes and transport, donated large volumes of clothing and other non-food items and provided information on accessing services, medication or accommodation. The coordination of the multitude of actors was especially challenging, and these networks were strained in the early days. It also required regulation and oversight to minimise protection risks. Local municipalities and police, for example, registered volunteers, including drivers transporting refugees elsewhere.

### *Key needs*

#### *Shelter*

The refugees had multiple needs, of which shelter was a key priority for many new arrivals. Some initially came to live with family and friends already in Poland. However, many did not have a destination in mind, and those without family support networks locally were likely to be more vulnerable. The homeless refugees were temporarily housed in repurposed shopping centres, office buildings, or large-tented facilities. The facilities at these sites however varied considerably in quality and range. Refugees were also housed in rooms of multiple occupancy and had little privacy in such settings. Those who could afford it rented their own accommodation, but housing stock was often limited. One local solution implemented was efforts to encourage refugees to disperse to smaller cities and towns to lessen overcrowding and overburden on services in major cities. Although the temporary accommodation provided at the time might have been an acceptable short-term solution, over time, the need for long-term shelter support was increasing.<sup>3</sup>

#### *Infectious disease risks*

Another concern was the risk of infectious diseases. Preconflict, childhood vaccination uptake was suboptimal. In 2020, 85% of children in Ukraine received their first dose of measles vaccine, less than the recommended 95% coverage needed for population herd immunity.<sup>4</sup> The conflict has further hindered vaccination

programmes in Ukraine. In the worst conflict-affected areas, the risk of disease outbreaks was heightened by the lack of access to water, sanitation and hygiene, crowded conditions in bomb shelters and refugee centres, and disrupted vaccination programmes. Mobile refugee populations may also enable the spread of infectious diseases.

Key infectious disease threats identified included COVID-19,<sup>5</sup> poliomyelitis and measles that is endemic in both Ukraine and Poland.<sup>6</sup> Tuberculosis (TB) is also a concern, as Ukraine has high incidence of TB, including cases of extensively drug-resistant TB.<sup>7</sup> The conflict has hampered access to diagnostic services and treatment for both TB and HIV.<sup>2</sup>

Antimicrobial-resistant infections were also a concern because of challenges in adherence to treatment exacerbated by the scarcity of antibiotics. Prewar, Ukraine already had elevated the prevalence of hospital-associated antimicrobial-resistant infections.<sup>8</sup> The migration of infected persons may facilitate wider transmission of these resistant pathogens to health facilities elsewhere as well as abroad. It was also observed that some health posts in transit centres had received donated antibiotics, including broad-spectrum antibiotics (e.g. third-generation cephalosporins and piperacillin/tazobactam) not normally used in community settings. The unregulated and inappropriate use of these antibiotics may contribute to the emergence of resistant pathogens.

#### *Healthcare access for migrants*

Whilst Poland has offered similar levels of healthcare provision to the Ukrainian refugees as provided for Polish citizens, there were still issues. Refugees with little or no funds could not afford co-payment charges for prescriptions. Some used medications (e.g. antiretrovirals and anti-TB medications) that were not licensed or available in Poland. There was a risk of disruption for chronic disease treatment, worsened by the lack of patient health records. The wider impact of the refugee crisis on Poland's health system should also be considered. Before the crisis, Poland's health system was already straining with significant demands on its emergency care system and hospitals. The influx of refugees requiring health care added to their burdens. The Polish Ministry of Health also highlighted the need for assistance for the medical evacuation of some Ukrainian patients, such as transplant patients, to other countries for specialist treatment. However, this requires careful planning, coordination and pathways.

#### *NCDs and mental health*

A substantial proportion of refugee health needs were related to NCDs, such as diabetes, cardiovascular disease, chronic respiratory diseases (e.g. asthma) and cancer. Thirty percent of households in Ukraine had at least one person with a chronic disease who reported difficulties accessing care for their condition.<sup>2</sup> Interruption in the supply of medicines and access to health care will have impacted on disease management and outcomes.

A lot of psychological distress was also reported by the refugees<sup>3</sup> who were affected by family separation, loss, fear and worry about the future. Their experience of conflict-related trauma and psychological stress differed considerably, and at least one in five women were reported to have had suffered gender-based violence.<sup>2</sup> Psychological distress surfaced as behavioural issues in children, anxiety and sleep disturbances in adults. Various stress factors reported included the lack of ability to meet basic needs, lack of information and accommodation concerns.

Access to treatment for adults and children with pre-existing severe mental health conditions and psychosocial disabilities was a concern due to the lack of established referral pathways, language barriers and access requirements for clinical reassessment. More mental health and psychological support services were likely to be

needed, particularly for refugees with long-term mental health conditions. Furthermore, as the conflict dragged on, future waves of refugees may have experienced greater brutalisation effects of war, including former combatants. Some affected individuals may require specialist care, but such care is limited in Poland.

**Protection and safeguarding**

Most of the refugees (96%) were women and children, including unaccompanied and separated children, persons with specific needs, as well as older persons. There were also concerning media reports of conflict-related sexual violence in Ukraine,<sup>9</sup> but it was not possible to determine the scale of this issue due to stigma. As such, there were considerable protection risks<sup>10</sup> arising from family separation and loss of social support networks, mental health and psychological trauma, potential discrimination, limited access to services and financial resources, as well as risks of gender-based violence and human trafficking (see Fig. 1).

Transit sites were generally secure with controlled access and secure perimeters, and there was separate bespoke provision for unaccompanied or separated children appropriately arranged by the local municipalities. Volunteers and staff at transit centres had some awareness of safeguarding needs. However, there was reportedly limited identification and documentation of unaccompanied or separated children, limited refugee awareness of available services and high levels of distress amongst children and caregivers.<sup>10</sup> These challenges were greater for children with disability.

**Informational needs**

Refugees had substantial and diverse informational needs ranging from legal advice, transport and accommodation issues to advice on accessing services and health care. At transit centres, informational posters and advice desks were provided for refugees. SIM cards were also distributed free at reception centres, which helped refugees access sources of information, as well as stay in touch with family and friends. There were some innovations too, such as the use of QR codes and smartphone applications to enable translations and interpretations. There were also Web sites providing information in Ukrainian, but refugees tended to seek information from Ukrainian Web sites. Word-of-mouth was another key source of information, but this carried risks of misinformation.

**Evolving needs**

From the reports, it was apparent that the demographic profile of the refugees (and hence their needs) was evolving over time. For example, there were differences between the early wave of refugees and later waves. The more recent groups of refugees arrived after enduring weeks of conflict and difficult conditions in Ukraine and may therefore be more vulnerable.<sup>11</sup> There was also the issue of how vulnerable groups with specific needs were catered for, such as those with complex needs or disabilities. As refugee health needs continue to change, further follow-up multisectoral needs assessments will be required. Data collection also needed enhancement, as information flows from frontline providers were incomplete. The monitoring and surveillance of refugee health required standardisation too. It was also not straightforward ‘finding’ refugees, as not all refugees passed through reception centres or registered with the Polish.<sup>12</sup> This made it difficult to capture accurately refugee needs.

**Discussion**

Whilst refugee crises are not new, Poland’s experience is unique because of the scale and complexity of the displacement affecting a high-income country setting. Poland has had to contend with a wide array of issues, such as legislative changes to enable integration of the refugee population, crisis management and rapid scale-up, mobilisation and coordination of a ‘whole of society’ response, as well as adapting responses to the changing needs of the refugees. Their insights gained can help inform future refugee responses, particularly by high-income countries not experienced with refugee crises.

Based on the Polish experience, national public health institutes (NPHIs) can play several different roles in such refugee crises. NPHIs, in collaboration with other agencies, could conduct refugee needs assessments as well as forecast emerging needs. They are well placed to lead and coordinate disease surveillance and disease monitoring activities. They may also have a role in identifying key public health hazards (such as disease outbreaks) and assessing these risks. Other possible functions include monitoring and evaluating public health measures, assembling evidence reviews to guide refugee responses, as well as facilitating information sharing both between local partners as well as international partners.

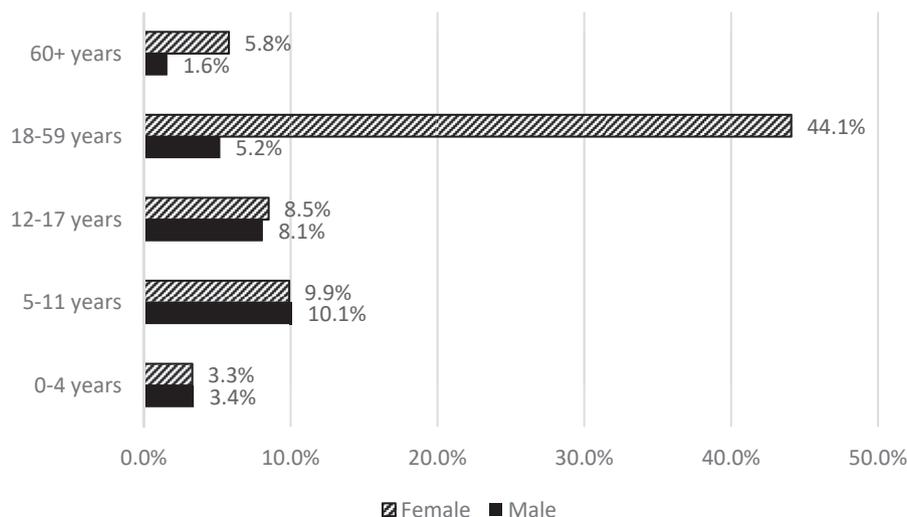


Fig. 1. Age and sex breakdown (PESEL registration). Source: UNHCR.<sup>3</sup>

Ongoing multisectoral needs assessments are essential, especially in view of the evolving picture on the ground. It is a demanding undertaking to precisely assess the needs of a mobile and changing refugee population. Needs assessments should look beyond infectious disease surveillance to wider health parameters, including NCDs, mental health, health risk factors, such as alcohol use, child education and development needs, housing and employment. They should also anticipate longer term issues, such as additional needs associated with the colder winter months, fuel poverty and unemployment or food insecurity and also consider plausible worst-case scenarios where contingencies may be required such as to cope with further surges in refugees.

Key to any response is robust data collection for health and disease monitoring and surveillance. National Public Health Institutions have a role here in providing the technical expertise needed to deliver and help improve real-time situational awareness and surveillance of both the refugee and host populations. This population health intelligence can help steer and inform refugee response policies, plans and actions. Further consideration include how to expand monitoring and surveillance beyond infectious diseases to include mental health and NCDs and capture the needs of vulnerable population groups (e.g. female-headed households, minority groups, and people with disabilities). Information sharing between key stakeholders is also essential and will be contingent on there being good data sharing agreements and mechanisms in place at the local, national as well as international levels. In turn, response measures also need to be culturally sensitive to ensure they address the needs and expectations of the refugees. This requires responders to develop an awareness of the culture, health profile and behaviours of the refugee population they serve. It is also important to be conscious of the potential impacts on host communities and risks of community tensions in the longer term especially if socio-economic conditions deteriorate.

As there were many agencies present and many programmatic interventions taking place, it is also vital that any external intervention are conducted in coordination with the national government and current coordination mechanisms so as to avoid duplication of effort. There is generally in emergency situations a tendency to focus on communicable disease threats. However, the burden of disease from NCDs, mental health and psychosocial conditions and other health needs are often greater and equally challenging to address. Furthermore, the management of NCDs is often poor in humanitarian crisis settings, and poor management of these conditions in turn can have serious long-term consequences.<sup>13</sup> Common issues include the need to ensure good access to care, continuation of care and treatment, delivery of multidisciplinary care where required and efficient pathways to care (including specialist provision).

Minimum standards of provision should be in line with international humanitarian standards.<sup>14</sup> In addition, because of the vulnerabilities of refugees, protection and safeguarding concerns remain of high importance. Responding organisations and staff at border points and transit sites must maintain protection and safeguarding standards,<sup>12</sup> and services at these sites should be protection sensitive. As refugees may move on to other countries, information sharing and coordination of protection mechanisms between receiving countries may help reinforce safeguards.

### Limitations

The mission was a rapid visit, and therefore, it was not possible to be comprehensive. There were other public health issues that were not examined thoroughly at the time, including reproductive health, maternal and child health, disabilities and dental health. These topic areas will benefit from further in-depth assessments.

The limited range of individuals interviewed may also not be representative of responders or the refugees. Most of the key informants interviewed were officials, and refugee perspectives were limited. That said, the findings were triangulated with secondary data from reports from other agencies that were complementary and corroborated the team's observations and findings. Finally, the refugee situation has changed swiftly in recent months. As these findings provide a snapshot in time, realities on the ground may have evolved since.

### Conclusion

Poland has displayed much generosity in welcoming Ukrainian refugees. This inclusive approach to integrate the refugee population will help mitigate some of the trauma and adverse mental health consequences.<sup>15</sup> There are undoubtedly going to be further challenges ahead, and refugee responses should continue to place the refugee at the centre, prioritising 'accountability to affected populations'. This will require close community engagement, so that emerging needs are optimally met.

### Author statements

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#### Ethical approval

This was a rapid assessment mission at the behest of IANPHI and NIZP-PZH. It is not a research study, and consequently institutional research ethics approval was not required.

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#### Competing interests

Author ACK Lee is the co-editor-in-chief of the journal Public Health but had no input or influence on the peer review and editorial decision for the article. No other competing interests declared.

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