Disability, displacement and COVID-19 in Ukraine: A scoping literature review of emerging challenges and vulnerabilities

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Glossary

COVID-19 – Coronavirus disease-19, caused by the novel coronavirus (SARS-CoV-2)

CRPD – Committee on the Rights of People with Disabilities (United Nations)

DESA – Department of Economic and Social Affairs (United Nations)

EASO – European Asylum Support Office

EIGE – European Institute for Gender Equality

EOHSP – European Observatory on Health Systems and Policies

GBP – Great British Pound (currency)

GCA – Government Controlled Area

GDP – Gross Domestic Product

HDI – Human Development Index

HRMMU - The UN Human Rights Monitoring Mission in Ukraine

HRW – Human Rights Watch

IDMC – Internal Displacement Monitoring Centre

IDPs – Internally displaced persons

IOM – International Organisation for Migration (United Nations)

NAPDU – National Assembly of People with Disabilities of Ukraine

NGCA – Non-government Controlled Area

NGO – Non-governmental Organisation

NHSU – National Health Service of Ukraine

NRC – Norwegian Refugee Council

OCHA – Office for the Coordination of Humanitarian Affairs (United Nations)

OECD – Organisation for Economic Co-operation and Development

OHCHR – Office of the High Commissioner for Human Rights (United Nations)

ONS – Office for National Statistics (UK)

OSCE – Organization for Security and Co-operation in Europe

PPE – Personal Protective Equipment

PTSD – Post-traumatic Stress Disorder

SSSU – State Statistical Service of Ukraine

UAH – Ukrainian Hryvnia (currency)

UNDP – United Nations Development Programme

UNHCR – United Nations High Commissioner for Refugees

UN HRC – United Nations Human Rights Council

USD – United States Dollar (currency)

WHO – World Health Organization

Foreword

This paper examines how people with disabilities in Ukraine have been affected by the COVID-19 pandemic, conflict and displacement. With Russia's invasion of Ukraine on 24th February 2022 the situation on the ground has rapidly worsened, and much of the information contained here refers to a context that has now fundamentally altered. The number of people in need of humanitarian aid at the time of writing (7th March) has reached 12 million and will inevitably rise further as the conflict continues (Office for the Coordination of Humanitarian Affairs [OCHA], 2022b). This includes 1.5 million refugees, but numbers are increasing day-by-day in an incredibly fluid situation, with current projections that the number of internally displaced will rise to almost 7 million (OCHA, 2022b).

In the face of overwhelming and urgent need as a result of the invasion, it can make the concerns highlighted in this paper recede in significance. However, attention to what the existing situation was in Ukraine for people with disabilities before the invasion highlights that they were already experiencing significant barriers to and inequalities within health and social care. These barriers and inequalities were further exacerbated by the COVID-19 pandemic and will subsequently experience another sharp deterioration due to military actions by Russia, with reports already emerging of deliberate attacks by the Russian armed forces on civilian infrastructure, including hospitals (Insecurity Insight, 2022). Prior to the invasion, the health system in Ukraine was already experiencing multiple weaknesses and vulnerabilities, as this review details. In addition to the disruption of conflict, there is now an influx of trauma patients and a lack of medical supplies – particularly oxygen for COVID-19 patients – which will only worsen as fighting continues (Health Cluster Ukraine, 2022b). Meanwhile, a shortage of adequate shelter for those who have been displaced – including cramped and overcrowded conditions – only increases the risk of outbreaks of infectious diseases, including COVID-19 (Health Cluster Ukraine, 2022b). For people with disabilities, there are further risks – crucial healthcare and safety information is often in inaccessible formats, and shelters are physically inaccessible, leaving them exposed to greater danger. For those living within institutions, there is a real risk of abandonment (European Disability Forum, 2022).

The risks that people with disabilities face in conflict or displacement situations are compounded by a lack of available data, making it difficult to estimate accurate numbers in many instances, with varying definitions of disability, accessibility issues and discrimination preventing reliable data gathering (Yasukawa, 2021, pp. 2, 5). However, it was estimated that in 2019 there were approximately 6.8 million people with disabilities living in displacement globally (United Nations Human Rights Council [UN HRC], 2020, p. 5). Despite this, people with disabilities are not typically consulted during coordination of humanitarian responses to displacement, meaning that their needs are unaccounted for both in the immediate aftermath of a displacement event and the longer-term management of protracted displacement (UN HRC, 2020, p. 8). These needs include access to health services, accessible housing, inclusive education and employment, information in accessible formats and mobility aids such as wheelchairs and crutches (UN HRC, 2020).

What can be stated with some certainty is that people with disabilities are disproportionately at risk during conflict and displacement. During the immediate crisis phase of a conflict and the initial stages of displacement after fleeing or losing homes, they face multiple difficulties, including: barriers to communication that affect their ability to communicate needs or receive important information during messages or announcements; limited mobility preventing them from evacuating dangerous areas; healthcare needs for the management of everyday or chronic conditions which are not met during a crisis, where additional barriers to accessing healthcare exist (Battle, 2015). During prolonged displacement, these barriers to accessing healthcare are further exacerbated, along with existing discrimination and ableism, making it more difficult for internally displaced persons with disabilities to find lasting solutions to their displacement (UN HRC, 2020, p. 6).

Given this, and the inevitable outcome of massive displacement as a result of the war in Ukraine, it will be of urgent and paramount need to include measures to gather accurate data on the number of people with disabilities who have been displaced and assess their needs in the immediate emergency response. Furthermore, as displacement becomes protracted for some people with disabilities they – and organisations supporting, and run by, people with disabilities – must be consulted to ensure their future needs are met and rights respected.

The following section provides a brief overview of how the pandemic has impacted upon people with disabilities, based on emerging evidence from studies in other locations across the globe. This provides a background for the challenges faced by people with disabilities more generally throughout the pandemic, before the paper moves on to give a brief overview of how literature was gathered, followed by the main body of the paper discussing the specific context of disability, displacement and COVID-19 in Ukraine.

1 – Introduction: The impact of COVID-19 on people with disabilities

At the time of writing on 7th March 2022, there have been almost 450 million cases of COVID-19 across the world and more than 6 million deaths (Dong, Du, & Gardner, 2020). As a fuller picture of the socio-economic impact of the COVID-19 pandemic across the world began to emerge (United Nations [UN], 2020b), its disproportionate impact on the most vulnerable individuals and communities became clear. Due to their high degree of socio-economic marginalisation, women, older persons, children, persons with disabilities and internally displaced persons have been identified as some of the 'at-risk populations' by the UN, requiring specific attention in the immediate development of responses to the pandemic (UN, 2020c, p. 7). This is supported through evidence documented by Kubenz and Kiwan (2021, p. 9) from across the globe, which suggests that people with disabilities can have a range of health conditions which make them more susceptible to serious infection and death. For example, according to the UK's Office for National Statistics (ONS, 2021), people with disabilities made up six in ten of all COVID-19 related deaths in England between March and November 2020; in comparison, only 17.2% of the study population were people with disabilities, suggesting the disproportionate impact of the pandemic on this group. However, not all people with disabilities have health conditions that make them especially susceptible to COVID-19, and caution is needed when interpreting figures to avoid misrepresenting all people with disabilities as vulnerable or weak and furthering damaging stereotypes (Kubenz & Kiwan, 2021, p. 9). People with disabilities may not be more at risk of contracting COVID-19 because of poor health, but because they face barriers to implementing additional hygiene precautions due to a general inaccessibility in the environment, difficulty in enacting social distancing, the need to use touch to obtain information or physical support, and difficulties accessing public health information (World Health Organization [WHO], 2020a, p. 2). These difficulties reflect the ways in which pandemic response planning by health authorities and national governments was frequently based on a normative conception of health, which served to exacerbate the exclusion and inequalities experienced by people with disabilities and others who do not fit models of 'normal' health (Goggin & Ellis, 2020). The following sections outline some of the most prominent challenges faced by people with disabilities that have been identified.

1.1 - Access to healthcare

During the COVID-19 pandemic, people with disabilities have faced barriers to accessing health services and public health information, and inequalities in healthcare provision (Armitage & Nellums, 2020; Kubenz & Kiwan, 2021). Responses to the pandemic, largely based on normative concepts of health and communication, failed to account for the unique needs of people with disabilities leading to their exclusion and marginalisation from even basic services and support, such as testing, rehabilitation for existing conditions, sanitation and hygiene, and public health information (Goggins & Ellis, 2020; Qi & Hu, 2020; Shakespeare, Ndagire, & Seketi, 2021). There are some indications that in the correct settings, telehealth or telemedicine – where support is provided over the phone or internet – was able to offset some of the negative impact experienced through a loss of face-to-face healthcare (Jeste et al., 2020; see also Zaagsma et al., 2020, on the Netherlands). However, people with disabilities can face additional barriers to the use of telemedicine due to

difficulties accessing certain forms of technology or communication (Annaswamy, Verduzco-Gutierrez, & Frieden, 2020; Verduzco-Gutierrez, Lara, & Annaswamy, 2021).

Access to public health messaging has been an issue for people with disabilities across the world during the pandemic, with much information on the virus, health measures and access to care and vaccinations not made available in formats suitable for those with sight or hearing issues (Office of the High Commissioner for Human Rights [OHCHR], 2020a, p. 8). A study of national health service websites from across the world during the pandemic found that only 4.7% had fully followed Web Content Accessibility guidelines to make information accessible for people with disabilities; in Europe, Ukraine's health service had the 3rd highest number of accessibility errors, behind only Bulgaria and Lithuania (Dror et al., 2020).

1.2 - Intersectional impacts

The pandemic has highlighted the deeply embedded and intersectional nature of inequalities faced by people with disabilities. Gender, sexuality, ethnicity, socio-economic situation and stage of life create diversity but, at the same time, multiple layers of discrimination and social exclusion for people with disabilities (Traustadóttir, 2006, p. 2), layers which have been amplified through the impact of COVID-19. This has resulted in the intensification of long-standing social and structural challenges and affected people's health, psychological wellbeing, and socioeconomic situation.

We know that people with disabilities are disproportionately represented among older people. According to the UN, more than 46% of people aged 60 and over have disabilities, and more than 250 million older people across the world have moderate to severe disabling conditions (Department of Economic and Social Affairs [DESA], n.d.). The disproportionate impact of the pandemic on older people has become clear though the COVID-19 related fatality rates for people over 80 years of age, which are recorded as five times the global average (UN, 2020a). We also know that people with disabilities are disproportionately represented among those living in poverty. The 2018 flagship report by the United Nations on disability and development is unequivocal in stating that "persons with disabilities, and their households, are more likely to live in poverty" (DESA, 2019, p. 34). A systematic review of poverty and disability in low- and middle-income countries (Banks, Kuper, & Polack, 2017) found strong evidence for a link between disability and poverty, suggesting that they operate in a cycle with each reinforcing the other. In Europe, more than 28% of all persons with disability lived in poverty and experienced social exclusion in 2018 – even before COVID-19 hit the continent (Uldry & Leenknecht, 2021). Emerging research from across the world demonstrates that the effects of COVID-19 are likely to have worse consequences for people from lower socio-economic backgrounds (Whitehead, Taylor-Robinson & Barr, 2021; World Bank, 2020), suggesting that the disproportionate representation of people with disabilities amongst the poor will translate into worse economic outcomes. This is corroborated by initial findings indicating that the pandemic is likely to increase the risk of poverty and job insecurity for people with disabilities (Banks, Davey, Shakespeare, & Kuper, 2021; Emerson et al., 2021; Maroto, Pettinicchio, & Lukk, 2021). In addition, disability remains a deeply gendered phenomenon and disability and gender have been argued to

"operate together to create the experiences of disabled people" (Traustadóttir, 2006, p. 2). In its review of the gendered nature of the pandemic's impact, the European Institute for Gender Equality (EIGE, 2021) suggests that COVID-19 derailed gender equality gains across Europe. Further gendered consequences are present across worse outcomes for education, employment and mobility, and an increased risk of abuse and violence (Kubenz & Kiwan, 2021, pp. 25-26, 34, 39, 47).

1.3 - Transport

The pandemic severely affected the availability of public transport in both urban and rural areas, with public transport restrictions introduced due to lockdowns affecting the daily lives of individuals and communities across the world. It is estimated that lockdowns and accompanying public behaviour changes resulted in a drop in the use of public transport ranging from 70-90% across major cities in China, Europe, Iran, the U.K., and the U.S. (Aloi et al., 2020; Bucsky, 2020; Jenelius & Cebecauer, 2020; Van Audenhove et al., 2020). Whilst levels of transport use fluctuated according to the restrictions in place and current levels of infection in local populations (Gkiotsalitis & Cats, 2021) the pandemic has the potential to reshape levels public transport use even once all restrictions are lifted (Beck & Hensher, 2020; Vickerman, 2021). However, public transport remains an important form of mobility for the poor (Guzman & Oviedo, 2018) and the impact of reduced levels of service during and, potentially, post-pandemic may serve to worsen existing inequalities (Gutiérrez, Miravet, & Domènech, 2020). For most people with disabilities, mobility remains one of the key factors determining their quality of life (Warren, Darshini, & Manderson, 2014), and the reduction in public transport services or loss of transport options altogether emerging as a key issue (Kubenz & Kiwan, 2021, p. 44). This has been compounded in some instance by poor communication of changes to transport scheduling, resulting in loss of access to essential health services and basic needs such as food (Cochran, 2020).

1.4 - Social isolation, loneliness and mental health

The growing volume of research on the psychological impact of COVID-19 highlights the overall detrimental impact of the pandemic on mental health, psychological wellbeing, and social interactions. In the US, based on the analysis of the nationally representative population surveys, Swaziek and Wozniak (2020) conclude that "mental health has worsened for individuals across the board. All identifiable demographic groups report worse mental health in the pandemic era than in a comparable pre-pandemic source" (p. 731). Even prior to the pandemic, isolation and loneliness have long been a feature of everyday life for people with disabilities. In her analysis of loneliness in life stories by people with disabilities in Finland, Tarvainen (2021) links normative models of society and social life as producing alienation and social isolation for people with disabilities through provoking feelings of bodily difference. So, while social distancing and health guidelines reduced social contact for all people and led to increased loneliness, emerging research and stories indicate that this has been heightened for people with disabilities due to the exacerbation of existing isolation and their exclusion from response planning (den Houting, 2020; Rose et al., 2020; Schormans, Hutton, Blake, Earle, & Head, 2021; Shakespeare et al., 2021; Steptoe & Di Gessa, 2021).

As Schormans et al. (2021) note, “pandemic responses – marked by ableism – reveal that governments have failed to consider disabled persons’ living situations, support requirements, and daily realities in pandemic planning” (p. 84). Speaking from the perspective of Canadian disability activists, they highlight the impact that social distancing routines had upon important everyday life routines, mundane activities, personal support and networks of support to people ‘labelled’ as ‘disabled,’ and how this demonstrated a lack of understanding toward, or dismissal of, people with disabilities by the authorities (Schormans et al., 2021). As discussed above, there are also intersectional impacts due to different aspects of an individual’s identity. For those with autism, maintaining social relationships may have already been difficult pre-pandemic and the impact of lockdowns and heightened anxiety due to the health crisis threatened already fragile networks of support and social contact (den Houting, 2020). People with disabilities in England were found to have poorer mental health outcomes if they were older (Steptoe and Di Gessa, 2021) or lived in low-income areas, where mental health declines were found to be sustained and long-lasting (Pierce et al., 2021). Finally, people with disabilities have faced further challenges in accessing education during the pandemic, which has affected educational outcomes and emotional well-being through heightened loneliness and isolation, particularly for children with disabilities (Dickinson & Yates, 2020; Jeste et al., 2020; Sakız, 2021). Overall, these studies suggest that there are further complexities to the intersectional nature of the impact of the pandemic through how different factors are connected to health and wellbeing outcomes such as loneliness and poor mental health.

2 - Structure of the paper and methods

This paper presents a synthesis of the available literature on the topics of disability, displacement and COVID-19 in Ukraine. The following sections will outline the situation of people with disabilities in Ukraine prior to the outbreak of the pandemic, with an overview of how the health system and the treatment of people with disabilities within it has been influenced by the legacy of Soviet health systems. The paper then moves on to outline current health reforms, their impact and challenges to implementing these, before detailing how COVID-19 affected health care and services within Ukraine. The final sections of the paper cover the origins of the conflict and its impact, particularly within the conflict-affected east of Ukraine. Here, displacement and disability are brought into conversation, particularly in considering the effects of the conflict on access to services, especially health services. The paper concludes with a brief consideration of how COVID-19 further impacted across these areas.

Although this discussion represents a scoping review, rather than a systematic narrative literature review, a brief overview is given here of the sources used to search for literature. As this paper has a social science/sociological focus, literature was selected primarily from the social sciences, with some limited inclusion of medical literature where relevant for discussion of COVID-19 and disability-related medical issues. Relevant subthemes were identified across the primary areas of disability, displacement and COVID-19 in Ukraine and searches were carried out using the online electronic databases of SCOPUS, ProQuest, Edinburgh Napier University LibrarySearch, Web of Science and individual journal databases. Forward and backward searching was used to identify further relevant literature, including grey literature. Further grey literature was identified through searching agency websites and databases, together with Google Scholar, ReliefWeb and web searches for specific terms. Additional searches were carried out periodically over the writing period of December 2021 to early March 2022 to identify any new relevant literature.

There were notable constraints in that there is a relative lack of English-language academic research on both COVID-19 and displacement in Ukraine, leading to a limited pool of academic articles and books. This is noted simply to highlight and acknowledge the limitations of this particular review in the literature pool that was accessible to the reviewer - there will be a greater range available if Ukrainian and Russian-language publications are included. Grey literature was relatively better served, with the majority concentrating on healthcare, disability and COVID-19. There were issues with the politicisation of some literature – both academic and grey – relating to the conflict and pro/anti Ukraine/Russia standpoints. It was not possible to verify the accuracy of these studies, so in the rare instance where a clear political agenda could be discerned in the research which may affect the reliability of results, it was removed from the literature pool. There were also no existing literature reviews available on the topic, and especially on the confluence of disability, displacement and COVID-19 in Ukraine, meaning that this paper represents a scoping exercise in the first place, and should not be interpreted as a systematic narrative literature review.

3 - People with disabilities in Ukraine

As of January 2021, 2,724,100 persons in Ukraine (or 6.5% of the population) were registered as having a disability (State Statistical Service of Ukraine [SSSU], 2021a, p. 1; SSSU, 2021b, p. 59). However, the actual number of people with disabilities is estimated to be much higher and has continued to increase (OHCHR, 2020a). The inadequate government systems for collating statistics related to disability have been criticised by the Council of Europe (Smusz-Kulesza, 2020) for providing only an aggregate number of people with disabilities and overlooking well-known barriers to official registration as a person with disability, including: the unavailability and inaccessibility of state-sponsored 'socio-medical commissions,' which remain the only mechanism through which an individual can be recognised as a person with disability in Ukraine; lack of identity documents; homelessness; and the link between official registration as a disabled person and the loss of other social security benefits, which discourages significant numbers of people with disabilities from registering as such. As a result, there is an absence of reliable data on the number of people with disabilities in Ukraine, which should be disaggregated, at a minimum, by types of disability, sex, age and dis/location. This, in turn, creates uncertainty over the needs of people with disabilities regarding health, employment, education and social outcomes. The following section covers how the health system in Ukraine is descended from Soviet-era models and the implications of this for the care and treatment of people with disabilities. The paper then moves on to look at the current health system, challenges and issues within this and the current state of ongoing reforms.

3.1 - Soviet legacies for people with disabilities

For many years, the health system of Ukraine remained largely unchanged from the Semashko model inherited from the Soviet Union following independence in 1991 (Romaniuk & Semigina, 2018). Under this centralised system, funding was provided based on capacity, creating an incentive for hospitals to have large numbers of beds and staff even if these were unused or poorly trained. As a result, for many years the health system did not accurately reflect the needs of local populations and made inefficient use of available resources (Lekhan, Rudiy, Shevchenko, Nitzan Kaluski, & Richardson, 2015, pp. xvi-xvii). Most government expenditure was focused on in-patient care requiring stays in hospital, meaning that out-patient services – such as those based in the community or not requiring a hospital stay – were subsequently under-funded and inadequate (Lekhan et al., 2015, p. xviii).

People with disabilities were largely hidden from public view within institutions during Soviet rule, and while some independent organisations were established by the disabled these were relatively short-lived, being appropriated and absorbed by the state (Phillips, 2009, pp. 12-13, 18-19). As Phillips (2009, p. 23) notes:

> [I]n the Soviet system, the needs, rights, and potential avenues of empowerment for people with disabilities were defined exclusively in the state's terms. The state defined what "social contributions" citizens with disabilities would be allowed to make, set the parameters of education and work possibilities for this population, and closely regulated the development of disability consciousness . . . In the Soviet

> Union, people with disabilities were considered subjects to be cared for and controlled, not active agents or stakeholders.

The legacy of these Soviet policies toward the treatment of the disabled in Ukraine has been long-lasting. Attitudes toward disability remain heavily influenced by Soviet-era approaches to healthcare for the disabled (Archer, Harper & Cameron, 2020, pp. 270-271), favouring institutional care over independent, community support for people with disabilities and their families. For people with intellectual and psychosocial disabilities there is a particular lack of support for community living, such as accessible and affordable housing, meaning that many continue to live within institutional settings (OHCHR, 2021a, p. 24). In former Soviet Union countries – including Ukraine – disability is associated with higher odds for reporting loneliness; this association is particularly strong for the more severely disabled, who are approximately two times more likely to feel lonely than those with less severe disabilities (Stickley et al., 2021).

As Petryna (2013) has argued, the complex politics of health in post-Soviet states such as Ukraine are being reconfigured through the dynamics created by the transition from socialism to capitalism (and latterly neoliberalism), and the ways in which "inequalities are being inscribed in the lives of populations through policies, scientific standards and regulations, and selective social protection and access to health care" (p. 219). Building on this argument, Sara Phillips (2011) has proposed that people with disabilities in Ukraine are increasingly being pushed to present their claims within the "proactive, self-reliant terms of neoliberal democracy" reflecting the "savvy ways that people learn to redefine and reposition themselves vis-à-vis the state in response to policy shifts" (p. 7). This includes individuals privileging some aspects of identity over others, such as de-emphasising their 'invalid' status in favour of "gender, occupation, or sphere of interest, or fulfillment of a particular social role (e.g., mother, activist, political actor, athlete)" (Phillips, 2011, p. 7; for more on neoliberalism and healthcare transformation, see Yankovvsky, 2011). However, Phillips (2011, p. 239) concludes:

> It is impossible to have social protection without rights, and vice versa, and in reality many of the disabled in Ukraine today are left with neither. There is also a basic tension between the growing prevalence of empowerment narratives that promote individual independence and self-sufficiency, and a lack of adequate state and community support to facilitate such self-possession. In the absence of such state- and community-based supports, many disabled persons and their friends and family members find it difficult or impossible to fully cope with the burden of care.

Despite the existence of some informal self-help groups, there is little support available in the community for the parents of children with disabilities, leading to many children being institutionalised by parents believing this will offer better care (Bridge 2005; see also Disability Rights International, 2015; Phillips, 2011). In a 2015 report, Disability Rights International (2015, p. iv) estimated that there was anywhere between 82,000 and 200,000 children – with and without disabilities – currently living in institutions across Ukraine, and that up to 90% of these children are likely to have been placed there by their parents, family or guardians (Postoliuk, Tatarchuk, Chupryna, Savchynskyi & Aliyeva, 2017, p. 12). It has

been estimated that there are around 7000 children with disabilities within such institutions across the country (Allday, Newell & Sukovskyy, 2020); however, more than half of the children's institutions in Ukraine – 351 out of 663 – are for the care of children with disabilities (Postoliuk et al., 2017, pp. 56-57), suggesting that this number may be far higher. Standards within these institutions are acknowledged to be generally poor, and many children come to suffer from additional physical, psychological and emotional developmental issues as a result (Disability Rights International, 2015; Postoliuk et al., 2017). Physical and sexual abuse, human trafficking and forced labour are also reported to be widespread (Disability Rights International, 2015, p. v). Although there have been recent reforms aimed at reducing the level of child institutionalisation within Ukraine, it continues to have one of the highest rates in the world (Hope and Homes for Children/Lumos, 2020, p. 2). Proposed amendments to the reforms also aim to exclude institutions which commonly care for children with disabilities and could mean that over 50,000 children remain institutionalised across the country; some disability rights organisations argue that this will "officially legitimise discrimination based on disability, allowing for the ongoing institutionalisation of such children and violation of their right to family life" (Disability Rights International/ENIL/Validity, 2021, p.3).

3.2 - Challenges in the current health system

Some aspects of Soviet-era healthcare have persisted since Ukrainian independence was declared in 1991, including, as one of the key tenets, universal access to free healthcare. This remains a guaranteed constitutional right as set out by Article 49 of the Ukrainian Constitution and further clarified by the Constitutional Court of Ukraine in its judgement in relation to Case No. 1-13/2002[1]. However, as admitted by the Ukrainian Ministry of Health, "budget deficits, economic crises, and a lack of reform resulted in a 'parallel world' where one had to solve healthcare problems through out-of-pocket informal payments and bribes" (Ministry of Health of Ukraine, n.d., para. 1).

In 2018, Ukraine's health expenditure per capita stood at 228 in current USD, placing it at 116th position (among 189) below Iraq and Tonga, and above Samoa and Bolivia (WHO, 2021b). At 8% of GDP this compares favourably with neighbouring countries such as Romania and Poland, where healthcare expenditure is around 6% of GDP[2] (WHO, 2021b). Yet, as late as 2018, more than half of all health spending in Ukraine was in the form of private payments by individuals (WHO/European Observatory on Health Systems and Policies [EOHSP], 2021, p. 9) meaning that individuals paid for treatment and medicines themselves, often through out-of-pocket payments (Lekhan et al., 2015, p. xviii) creating inequity in access to healthcare.

An earlier study in 2012 found that around 70% of respondents had made cash or in-kind payments for healthcare at some point, although only 30% reported being asked for such

[1] For Constitution of Ukraine and Case No. 1-13/2002 in English see: https://www.globalhealthrights.org/wp-content/uploads/2013/11/1-132002.pdf and https://rm.coe.int/constitution-of-ukraine/168071f58b. For Ukrainian versions see: https://konstitutsiya.com.ua/ru/st-49 and https://zakon.rada.gov.ua/laws/show/v010p710-02#Text.

[2] With higher GDP this smaller percentage nevertheless translates into greater individual spend, with Poland at 979 USD and Romania 687 USD per capita (WHO, 2021b).

payments. Instead, informal gratitude by the patient has been – historically, at least – a cultural aspect of the health care system in Ukraine, given to ensure "quality and access to care they desire" (Danyliv et al., 2012, p.277), rather than in response to a direct request from healthcare staff. Similarly, Rivkin-Fish (2011; see also Riska & Novelskaite, 2011) has argued that understanding these payments within Soviet and post-Soviet contexts as simply 'corruption' fails to recognise how they are used by patients and professionals to create relationships of trust within rigid bureaucracies that otherwise "routinize abuse for patients and professionals alike" (p. 11). However, the prevalence of payments for healthcare in Ukraine was found by Danyliv et al. (2012, p.281) to be especially burdensome, with approximately half of respondents (49.6%) stating that they did not seek medical care because they could not afford to pay. Others reported borrowing money from friends, family or banks in order to fund healthcare (Danyliv et al., 2012, p. 282). This led to catastrophic levels of health spending for approximately 16.7% of households in Ukraine, driving many into poverty (WHO/EOHSP, 2021, pp. 9 – 11). Poor health outcomes are further reflected in Ukraine's mortality rate of 14.7 per 1,000 people in 2019[3], higher than all neighbouring countries: Belarus (13), Moldova (12), Poland (11), Romania (13), Russia (13), and Slovakia (10) (World Bank, 2021a).

An additional challenge has been identified as the embedment within the Ukrainian health system of a medical model of health care, which pays little attention to the social elements and outcomes of health and illness. This is evident through the "systemic mistranslation and misuse of the term "healthcare" as "medical care", starting from the level of legislation, and resulting in misunderstanding of healthcare by many generations of healthcare workers and the general public" (Golyk et al., 2021, p. 1). Gutenbrunner, Tederko, Grabljevec and Nugraha (2018; see also Golyk et al., 2021, p. 7) highlight the relevance of this for people with disabilities, where the Soviet-era term "invalidity" – used to refer to disabilities – implies that conditions are an inherent attribute of the individual, as opposed to social understandings of disability as a circumstance that "occurs due to the interaction of a person with a health condition and the environment" (p. 340). Gutenbrunner et al. (2018) go on to state that as "all political documents in Ukraine are based on this outdated terminology" (p. 340), fundamental changes in terminology and understanding are needed within health reforms, in addition to structural changes of the health system.

The process of certification in Ukraine by which a person is assessed to be disabled or not is described as a 'medical-social commission,' which assesses the extent of the 'loss of health' and involves, primarily, medical experts. This process is largely descended from Soviet-era practices of 'ranking' disability by categories and using this to determine the level of social support and compensation individuals receive (Phillips, 2009, pp. 11-12). This system has been criticised for not being adjusted to different types of disability, and for its inflexibility and bureaucratic nature:

[3] The mortality rate is even higher for conflict-affected government controlled areas (GCAs) in the east; Donetska oblast reports 19.8 per 1000 people, while Luhanska oblast is 22.5 per 1000 people (Health Cluster Ukraine, 2022a, p. 13).

> Even people with severe permanent disabilities e.g. without a leg or legs must go through the tests several times. Apart from this, there is no possibility to acquire a duplicate of certificate in case of … losing it, to get a certificate in such a case the person must undergo the tests one more time. (Smusz-Kulesza, 2020, p. 29)

In March 2020, the Parliament of Ukraine suspended the requirement to undergo a re-validation of disability status (as a pre-condition for the payment of disability pensions) over the period in which national quarantine measures regarding COVID-19 were in force (see Verkhovna Rada of Ukraine, 2020).

Although public and state attitudes toward disability and people with disabilities have been slow to change from the Soviet era, there are indications that this is beginning to happen. Discussing rehabilitation healthcare for people with disabilities in Ukraine, Archer, Harper and Cameron (2020) found some evidence that increasing awareness of health issues and campaigning for better support by health professionals, combined with legal changes by the state, were changing mindsets toward disability. However, rehabilitation legislation in Ukraine still has significant gaps and only covers people with disabilities who have been officially certified as having a disability (Golyk et al., 2021). In its *Combined Second and Third Report on the Implementation of the Convention on the Rights of Persons with Disabilities (for 2015-2019 period)*, the Government of Ukraine (2020) details key responses to guidelines set out in the CRPD for legislation, social inclusion, accessibility of services and the environment, health, education, and employment, amongst others. Despite these promised changes, a recent report by the Council of Europe (Sumsz-Kulesza, 2020) concluded that, overall, Ukraine continues to fail to meet international obligations towards the rights of people with disabilities as set out in the European Social charter, both in theory and practice; regulations and policies to support people with disabilities are insufficient, and those that are in existence are not properly implemented. The report highlights: a lack of accurate data about people with disabilities in Ukraine; poor inclusion of people with disabilities within mainstream education, training and employment; and the general inaccessibility of the built environment (particularly crucial rehabilitation centres) and public transport.

3.3 - Health reforms

Outlining proposed reforms, Ukraine's Ministry of Health (2015) identified the health system as lagging behind European counterparts, with spending on health producing lower health outcomes than that seen in equivalent nations with similar spending. The health system itself was also described as inflexible, resistant to change and reliant on rigid and outdated financial structures. These were attributed to long-standing deficits caused by a lack of modernisation and inattention to the specific health needs of the population of Ukraine. Finally, corruption and inefficiency were highlighted as additional factors affecting the health service (Ministry of Health of Ukraine, 2015, p.5). Overall, the health system was described as bloated through inefficient funding models that promoted quantity of beds, facilities and staff over the quality of care these can offer and their ability to provide complex treatments (Ministry of Health of Ukraine, 2015).

At least five years before the current reforms were proposed, Bazylevych (2009) argued that public sentiment was very much in favour of over-hauling the health service, stating that it was "hard to over-emphasize the discontent of the local population" (p. 66) with paying for 'free' healthcare through out-of-pocket or informal payments. Bazylevych (2009) goes on to argue that access to free healthcare has come to be seen as a fundamental right for Ukrainians and a key role for the state, making the implications of inefficient reforms important not just for the health service itself but the wider "legitimacy and authority of the state" (p. 73).

In response to identified failings within the health system, the *National Health Reform Strategy for Ukraine 2015-2020* was developed[4] to foster "regulatory transformation and implementation of new financial mechanisms promoting human rights in health care" (Ministry of Health of Ukraine, 2015, p. 5); it was followed by new health financing legislation through the *Law on 'Government Financial Guarantees of Health Care Services' (Law 2168)* and a raft of related by-laws (see WHO & World Bank, 2019). Three core principles underlie the health reforms (Ministry of Health of Ukraine, 2015, pp. 5 – 6):

1 – To make the health service more people centred through a focus on people's needs and voices, closer and more meaningful engagement with communities, and an emphasis on trust, dialogue and relationships between health actors.

2 – To focus on outcomes where results guide decisions. This includes greater staff supervision and development and a commitment to use private providers for services only when this is cost effective and more efficient – combined with a greater transparency around the information base which is used to make decisions in this regard.

3 – An implementation focus, where ideas or proposals for changes should be accompanied by concrete plans for how to implement and monitor the success of these. Changes to health financing should be realistic and help to reduce financial barriers to accessing health services.

A key element of the reforms is that the health service will operate on a 'money follows the patient' basis, where funding is provided based on the needs of patients rather than to pay for beds, staff and hospitals regardless of actual need (Ministry of Health of Ukraine, n.d.). Central to this is the reformation of health service financing in Ukraine, facilitated through the creation of the National Health Service of Ukraine (NHSU) in 2018 (WHO/European Observatory on Health Systems and Policies [EOHSP], 2021, p. 8). Although reforms overall are aimed at decentralisation of services, the NHSU centralises all purchasing, such as contracting and payments with health care providers (WHO/EOHSP, 2021, p. 8). Health care facilities have simultaneously transitioned into not-for-profit, municipal organisations which can then be contracted through the NHSU, theoretically reducing instances where individuals are required or asked to make out-of-pocket payments for health care –

[4] There have been previous attempts to reform the health service in Ukraine, however, prior to 2015, these largely focused on governance and decision-making responsibilities, leaving the core structures for financing and delivery of care untouched. For a history of health reforms in Ukraine, including the most recent, see (WHO, 2021a, pp. 8-10).

however, there are very few actual mechanisms in place to protect patients from this (WHO/EOHSP, 2021, pp. 9, 13). Responsibility for decision making and management, meanwhile, has been delegated to regional and local authorities (WHO/EOHSP, 2021, p. 8). Patients also now have the ability to choose their own doctor, rather than this being assigned according to place of residence, incentivising doctors to improve quality of care in order to retain clients (Ministry of Health of Ukraine, n.d.). The de-linking of medical care from location is also of benefit to internally displaced persons (IDPs) and others who are not able to travel to a pre-determined location for medical care (European Asylum Support Office [EASO], 2021).

Current assessments of the reforms indicate that there are challenges remaining around the transfer of services and decision-making from a centralised to local level, with a general lack of preparedness for these transitions (EASO, 2021; Médicos del Mundo, 2021; WHO, 2021a) issues that have also been encountered in the reform of health services in other post-Soviet contexts (Schecter, 2011). As far back as 2011, some research predicted that reforms to deinstitutionalise the health service in Ukraine would encounter significant difficulties due to funding gaps and the absence of community services that are needed to replace centralised ones (Yankovskyy, 2011, pp. 40–43; see also Bazylevych, 2009). While the collapse of the Soviet Union – and the profound upsets this brought to the everyday lives of people – resulted in a proliferation of civil society organisations, Phillips (2005) argues these were about recognising "social and personal suffering" (p. 507) as much as compensating for inadequate state protections and services. So, although NGOs based in the community have also played an important role in advocating for particular causes, including for people with disabilities, and in helping people to navigate the complex bureaucracy around accessing services (Owczarzak et al., 2021), the continuation of a centralised health system meant that there was little development of community-based services for the provision of health care (Gutenbrunner et al., 2018).

A recent WHO (2021a) assessment of the reform, which acknowledges the impact of the pandemic, suggests that the pandemic and the attendant economic crisis presented national and local authorities with "unparalleled public health challenges, with reforms ongoing and incomplete" (p. 1), placing "great strain on health facilities and local budgets" (p. 34). This has been particularly felt in the impact upon the mental health services in Ukraine.

3.4 - Reforms to the mental health service in Ukraine

In 2018, prior to the COVID-19 pandemic, up to 4% of Ukraine's population – or 1,847,113 persons – accessed mental health services in the country (Skokauskas et al., 2020, p. 738). Recent reforms aimed to improve access to these services and address challenges such as low social awareness of mental health illnesses and stigmatisation of those affected (WHO, 2020b). However, the implementation of these reforms (impacted by the COVID-19 pandemic) has not been entirely successful, with state psychiatric hospitals reporting significant budget cuts of up to 50% and a reduction in available resources, especially staff (Skokauskas et al., 2020, pp. 738-739). Reforms have encountered similar obstacles and challenges to the wider ones attempted across the Ukrainian health service, in that there is

a lack of a clear path to achieve the reforms, and a lack of suitable community resources (Quirke, Suvalo, Sukhovii, & Zöllner, 2020; WHO, 2020b). In a 2020 report the World Psychiatric Association described these reforms – in combination with the COVID-19 pandemic – as pushing the Ukrainian mental health service into crisis (Chkonia et al., 2020). The report details how a reduction in funds for centralised services was not aligned with the provision of community resources, leading to reduction in staff levels and premature patient discharge into environments where no support was available. Potentially, more than 3000 full time staff will lose their positions following the reforms due to funding gaps which have seen psychiatric hospitals lose up to half of their income, whilst patient fatalities were reported within six weeks of early discharge (Chkonia et al., 2020, pp. 2, 5). The report concludes by arguing that effective reform needs to target individual and societal inequalities – such as those caused by poverty, conflict, and trauma – in addition to financial and clinical aspects, not only as good practice but as part of government obligations toward people with disabilities (including mental impairments) under the CRPD (Chkonia et al., 2020, p. 9).

Mental health also carries a considerable stigma within Ukraine, and whilst there is evidence that public attitudes are becoming more accepting of people with mental health needs, a recent survey still found that the majority of respondents viewed this negatively, believing that community-based support "would downgrade a neighbourhood and present a security risk" (Quirke, Klymchuk, Suvalo, Bakolis, & Thornicroft, 2021, p. 5). This echoes concerns voiced by Shelly Yankovskky (2011; 2016) that for reforms of the Ukrainian mental health service to be successful will require not just structural and policy changes, but cultural ones. The negative perception of mental health issues can also drive the use of alternative treatments, particularly self-medication through alcohol. The World Mental Health survey of Ukraine, conducted by the World Bank in 2002, found that almost one third of respondents reported experiencing one or more alcohol or psychiatric disorders over the course of their lifetime, with people living in eastern regions at higher risk (Bromet et al., 2005). A follow up study by Bromet et al. (2005, p. 687) found that in comparison to a similar survey conducted in Western Europe[5], Ukraine has far higher rates for alcoholism in men (26.5% compared to 9.3%) and depression in women (11.3% compared to 5.0%). Yet, despite these high levels of alcoholism and depression most respondents in Ukraine had not sought professional psychiatric help, which was attributed to a lack of awareness around mental health, the legacy of Soviet-era stigma attached to sufferers, and the generally poor state of mental health care in Ukraine at the time (Bromet et al., 2005, pp. 687-688).

In conclusion, the health system in Ukraine and attempts to reform it have been beset by problems rooted in the Soviet-era model of healthcare that was inherited following independence in 1991. Although free healthcare is a guaranteed right for Ukrainian citizens, this is in practice rarely achievable through the widespread and systematic use of out-of-

[5] Bromet et al. (2005) outline the compared survey as follows: "European Study of the Epidemiology of Mental Disorders (ESEMeD) study, in which the WMH-CIDI was administered to more than 20,000 adults ages 18 and older in Belgium, France, Germany, Italy, the Netherlands, and Spain. Seven disorders were analyzed in both [the Ukraine WMH survey and the ESEMeD study]: major depression, dysthymia, generalized anxiety disorder (GAD), social phobia, agoraphobia, panic, and alcohol abuse/dependence" (p. 687).

pocket payments, driving unsustainable levels of cost for healthcare for many poorer Ukrainians. At the same, the centralisation of healthcare within large hospitals and institutions created not only inefficiency, but conditions for health inequalities through stigmatisation of certain conditions, especially mental health and disability. As a result, there is a lack of community-based care available, which has caused further issues for the reform of health services where the removal of centralised services has not been supported with parallel implementation of community support. This has created issues accessing services, notably within mental health where severe funding shortfalls have been reported. Against this backdrop, social activism has provided some relief for groups who have found themselves excluded from the historical, Soviet-era healthcare model. However, social activism is not an adequate replacement for proper protections and rights guaranteed by the state. For people with disabilities – amongst others – this was demonstrated through the impact of the COVID-19 pandemic within Ukraine, which highlighted and intensified numerous failings in the health system and social support.

4 - The COVID-19 pandemic in Ukraine

Due to multiple, intersecting factors, the COVID-19 pandemic was a cause for heightened concern in Ukraine. The ageing and inadequate health system, combined with a high proportion of the population aged over 60 (23% in 2020) and the effects of the ongoing conflict in the east, created conditions which threatened to overburden the health system and degrade the social and economic stability of the country (OCHA, 2020a, pp. 6 – 10). This was of particular concern for vulnerable groups including some people with disabilities, and is reflected in the United Nation's (OHCHR, 2020a, p. 1) initial assessment of the impact of the pandemic on persons with disabilities in Ukraine, released in October 2020:

> The COVID-19 crisis has exacerbated existing institutional, attitudinal and environmental barriers that persons with disabilities face in exercising their rights and accessing basic services. HRMMU's monitoring of the human rights situation of persons with disabilities indicates that during the pandemic their access to healthcare, habilitation and rehabilitation services, education, social protection, work and employment has been further impeded. The COVID-19 crisis has also exposed a large gap between social services that are available in the community and the real needs of persons with disabilities. The lockdown also further aggravated the isolation and exclusion of persons with disabilities in Ukraine.

As of 1st September 2021, the total number of people diagnosed with COVID-19 in Ukraine stood at 2,288,371, including 2,208,865 people who recovered from the disease and 53,833 deaths (Government of Ukraine, 2021)[6]. However, it was estimated as far back as July 2021 that the COVID-19 pandemic had resulted in close to 80,000 excess deaths, in comparison to the average mortality data available (Organisation for Economic Co-operation and Development [OECD], 2021, p. 1), suggesting that the actual death toll may be higher. The Government of Ukraine does not collect data on COVID-19 infections disaggregated by disability (OHCHR, 2020a, p. 6). The distribution of confirmed cases by gender and age is provided by the Centre for Public Health (part of the Ministry of Health of Ukraine). As of 1st September 2021, among the 2,228,371 confirmed cases 60% were women and 40% were men. About 37% of all confirmed cases were among the 30-49 age group, 39% among the 50-69 age group, and 9% among the 70+ age group (Centre for Public Health, 2021).

A recent report by the World Health Organization and European Observatory on Health Systems and Policies (2021, pp. 18 – 20) highlighted that Ukraine lacked a pandemic response plan at the outset of the COVID-19 pandemic. During the early stages concerns were raised about the underreporting of its scale due to the unpreparedness of the Government to respond to a complex public health emergency, including insufficient testing capacity (Kossov, 2020a; 2020b). As of October 2021, Ukraine has carried out just over 13 million tests, resulting in a testing rate of 31,399 per 100,000 people, which is low when compared to other countries in Europe (Health Cluster Ukraine, 2022a, p. 19). According to a 2021 assessment by Nesteruk (preprint, 2021), the actual number of COVID-19 cases in

[6] The Ukrainian government portal for COVID-19 numbers was temporarily unavailable at the time of finalising writing on this review, meaning numbers could not be updated from this source. However, the John Hopkins University COVID-19 tracker shows 5,040,518 cases as of 23/03/2022, with 112,459 deaths (Dong et al., 2020).

Ukraine at the end of 2020 could have been underreported by a factor of up to 4.1. Unequal access to free testing has also been cited as a concern, as no priority was given to the elderly or those with chronic health conditions while people living in separatist-controlled areas faced additional barriers to accessing information on testing and tests themselves; it has been argued that these factors represent a fundamental violation of the equal right to healthcare that is guaranteed by the Ukrainian constitution (Dzhumageldiyeva, Serebriakova, Derevyanko, Zubatenko & Selikhov, 2021).

In addition to problems with testing and access to healthcare, Ukraine has one of the lowest vaccination rates in Europe, with only 34% of the population fully vaccinated as of January 2022, compared to a European average of 63% (Ritchie et al., 2022). As the pandemic advanced and case rates rose throughout the latter half of 2021 (Zinets & Karazy, 2021), this led to increasing levels of hospitalisation for the unvaccinated; in October 2021, it was estimated that 94.2% of the 27,488 people hospitalised due to COVID-19 in Ukraine were unvaccinated (UNICEF Ukraine, 2021). Low levels of vaccination are partially attributable to vaccine hesitancy (Holt, 2021), together with a government vaccination programme which prioritised healthcare workers[7] and security personnel over the elderly and those with chronic health conditions, meaning that free vaccination was delayed for vulnerable groups (Matiashova et al., 2021). However, a survey of people in Ukraine found that even were the vaccine free of charge, 60% of respondents would not take it (OECD, 2021, p. 2). In comparison, another study found that if the vaccine were free and *guaranteed safe* 61% of respondents would take it, while also finding indications that there was considerable suspicion and distrust of the vaccine and its safety amongst Ukrainians (Giles-Vernick et al., 2021, see also; Health Cluster Ukraine, 2022a, pp. 20 – 21). Misinformation has emerged as a significant source of anxiety for the public during the pandemic, and particularly for people with disabilities, where a lack of information on the impact of the virus on people with different health conditions has led to a spread of "fake news" (OHCHR, 2020a, p. 6). Russia has also been accused of using disinformation around COVID-19 as a form of hybrid warfare against Ukraine, undermining public trust in the government response to the pandemic and spreading confusion as to accessing services, resources or support related to COVID-19 (Patel, Moncayo, Conroy, Jordan & Erickson, 2020).

Multiple studies have shown that people with pre-existing or underlying conditions have markedly increased risks of hospital admission and death from COVID-19 (Centers for Disease Control and Prevention, 2021; Laosa et al., 2020; Poblador-Plou et al., 2020; Williamson et al., 2021). Within this context, unimpeded access to healthcare services (including access to medications) for the routine management of chronic conditions, and careful management of the COVID-19 transmission risk at healthcare facilities (when accessed for routine treatments) can be described as key dimensions in reducing the risk of mortality from COVID-19 for people with disabilities. According to an assessment of the impact of COVID-19 on human rights in Ukraine conducted by the United Nations Human

[7] Due to rising cases in November 2021, the Ukrainian government made vaccination mandatory for medical and municipal workers, in addition to earlier mandates for teachers and staff within state institutions (Polityuk, 2021).

Rights Monitoring Mission in Ukraine (HRMMU) between March and December 2020, "during the pandemic, persons with disabilities found their access to healthcare, habilitation and rehabilitation services…further impeded" (OHCHR, 2020b, p. 21); this was coupled with severe shortages or lack of access to personal protective equipment (PPE) (OHCHR, 2020a).

The introduction of quarantine restrictions in March 2020 exacerbated pre-existing barriers for people with disabilities to access health care services and created new ones including indefinite suspensions of planned treatments and face-to-face consultations, re-purposing of specialized hospitals into COVID-19 health facilities, and the suspension of public transport (OHCHR, 2020a). For people with disabilities who have mental health needs in Ukraine, the COVID-19 pandemic severely affected both their ability to access services and the quality of care available in institutionalised settings (OCHA, 2021a, p. 72). However, in a context where most mental health support is sought and received in institutionalised settings (Weissbecker et al., 2017) the pandemic made accessing all health care difficult for many Ukrainians, and exacerbated issues relating to the centralisation of mental health services (OCHA, 2021a, p. 73) with more than 75% of patients reported to have lost access to care during quarantine restrictions (Martsenkovskyi & Martsenkovsky, 2020). This was especially problematic for IDPs, soldiers and conflict-affected populations in the east of the country, who have a higher prevalence of mental illnesses such as post-traumatic stress disorder (PTSD), depression and anxiety (Colborne, 2015; Kuznestsova, Mikheiva, Catling, Round, & Babenko, 2019; Roberts et al., 2019).

4.1 - Economic factors

Ukraine has a Human Development Index (HDI) of 0.779 for 2019 – the most recent year available – slightly below the European average of 0.791; adjusted for inequality, Ukraine's level falls 6.5% to 0.728 which is a lower-than-average drop for the region (United Nations Development Programme [UNDP], 2020). However, GDP per capita in current USD for Ukraine is 3,727, significantly lower than neighbouring Poland (15,656), Romania (12,896) and Russia (10,127) (World Bank, 2021b). In terms of wealth distribution, Ukraine lags behind Europe and its neighbouring countries with the median wealth per adult estimated at USD 2,529 per adult in 2020, in comparison to USD 26,423 in Europe, USD 5,431 in Russia or USD 23,550 in Poland (Credit Suisse, 2021, p. 108). Estimates suggest that the COVID-19 pandemic will raise poverty levels in Ukraine from 27.2% absolute poverty[8] to between 43.6% – 50.8%, with a disproportionate impact on child poverty (from 32.9% – 51.3-58.5%), equating to somewhere between an additional 6 – 9 million people living in poverty (Borodchuk & Cherenko, 2020, pp. 1-2). The economic impact has been especially severe in conflict affected Donetska and Luhanska regions, where GDP had already declined by 61 and 72 percent respectively between 2013 and 2018 (OCHA, 2022a, p. 16). Unemployment rates in these areas were the highest in Ukraine in 2021, with households and communities along the contact line being the worst affected (OCHA, 2022a, p. 16).

In 2014, the United Nations Committee on the Rights of Persons with Disabilities (CRPD, 2014) noted the difficulties facing Ukraine because of the ongoing conflict in the east and

[8] Absolute poverty is defined by the Ukrainian government as households with expenditure lower than the actual subsistence level, which was defined as UAH 3,660.9 per month in 2019 (UNICEF Ukraine, 2020).

expressed concern about the level of the state disability pensions, which were deemed insufficient to meet basic human needs including nutrition, medical and social needs (Ministry of Social Policy of Ukraine, n.d.). About 80% of Ukrainian pensioners receive income that is less than the minimum subsistence level with women's pensions being, on average, 30% below those of men (Bachelet, 2021). The average monthly disability pension in Ukraine in 2020 was 2,641 UAH or 71 GBP[9] (SSSU, 2021b, p. 21). This compares to the minimum 2020 'subsistence level' as set out by the Government of Ukraine at 2,189 UAH (or 59 GBP) (SSSU, 2021b, p. 13). However, the 'factual subsistence level' which is calculated by the Ministry of Social Policy of Ukraine to take into account current prices (calculated in addition to the 'subsistence level' as set out by the yearly Law on the State Budget of Ukraine) was set at 3,845.21 UAH (or 103 GBP)[10]. This means that almost 1.5 million people with disabilities who receive state pension due to disability (SSSU, 2021b, p. 21), and who use this as their main source of income, lived in poverty (a shortfall of 33% below the 'factual subsistence level'). In response to the COVID-19 pandemic, in April 2020 the Ministry of Social Policy allocated a one-off 'social support' payment of 1,000 UAH (or 27 GBP) to people with disabilities whose monthly pension (including all statutory allowances) did not exceed 5,000 UAH (or 135 GBP) (Cabinet of Ministers of Ukraine, 2020).

No information on the labour market participation of people with disabilities (or government efforts to promote an inclusive labour market) is currently available on the websites or in any of the publications by the SSSU or the Ministry of Social Policy of Ukraine. The only reference to the overall number of people with disabilities in employment in Ukraine is provided in the *Combined Second and Third Reports of Ukraine on the Implementation of the Convention of the Rights of Persons with Disabilities* (Government of Ukraine, 2020, p. 44), which provides an aggregate figure of 776,000 employed persons with disabilities (as of July 2020), including 3% of people with the most complex disabilities, classified as 'Group 1', followed by 28% of people classified as belonging to 'Group 2', and 69% to 'Group 3'[11]. According to the National Assembly of People with Disabilities of Ukraine (NAPDU, 2020, p. 92), among 224,500 people with disabilities who were registered at the State Employment Service of Ukraine between 2015 and 2019 only 65,900 thousand (or 29%) were able to find employment.

In the absence of detailed statistics on the employment of people with disabilities it can be assumed that, as with virtually all areas of socio-economic life in Ukraine, the pandemic would have had an adverse impact on the already problematic situation with labour market

[9] Rate of exchange 1 GBP = 37.1714 UAH as of 6 August 2021

[10] According to the Statistical Service of Ukraine, overall, in the first six months of 2020, the income of 28.3% of all households in Ukraine was below the 'factual subsistence level' of 3,845.21 UAH (an increase of 2.8% in comparison to 2019). The Ukrainian law defines the substance level as the cost of essential food as well as a minimum set of non-food products needed to meet the basic social and cultural needs of the individual. See https://ukrstat.org/uk/operativ/operativ2018/gdvdg/vrduIpiv2020.zip

[11] Disabilities in Ukraine are classified into groups. Smusz-Kulesza (2020, p. 22) explains that: "Pursuant to art. 7 of the Law of Ukraine 'On Rehabilitation of Persons with Disabilities in Ukraine', depending on the degree of persistent impairment of bodily functions caused by illness, trauma (its consequences) or congenital impairments and possible limitation of everyday activities while communicating with outside environment caused by the loss of health, persons recognised as having a disability, are assigned to one of the three disability groups: group I, group II, or group III".

participation of people with disabilities. Studies that have emerged from other national contexts (see, for example, Emerson et al., 2021; Banks, Davey, Shakespeare, & Kuper, 2021; Maroto, Pettinicchio, & Lukk, 2021) demonstrate how the pandemic and disability-blind government responses had a negative impact on employment situations for workers everywhere, including people with disabilities.

5 - Displacement and the conflict in Ukraine

Now heading towards its eighth year, the conflict in Ukraine began in 2014, prompted by the revolution which ousted pro-Russian Ukrainian president Viktor Yanukovych. The revolution was used as justification by Russia for their invasion and annexation of Crimea, and the conflict subsequently spread to the Donetska and Luhanska regions of the country where separatists backed by Russia declared independence from the Ukrainian state, provoking an armed conflict which continues to this date (Cardona-Fox, 2020, p. 6). Ceasefire agreements were signed in 2014, and again in 2015 following a resumption of hostilities (Organization for Security and Co-operation in Europe [OSCE], 2015). After a period of decreasing hostilities in the conflict zone (OHCHR, 2021a, p. 6), there has been a marked increase in the number of ceasefire violations in the latter half of 2021 (OHCHR, 2021b, p. 7), accompanied by increasing fears of an expanded war between Ukraine and Russia amid troop build-ups, despite assurances from all parties that they remain committed to peace (United Nations Security Council, 2022).

One consequence of the conflict has been the establishment of a 427-km line of contact across the Donetska and Luhanska regions, dividing the government-controlled area (GCA) from the separatist controlled, or non-government-controlled area (NGCA). The contact line marks the front line of the conflict, and this zone – together with bordering areas on both sides – has seen the majority of violence and displacement (OCHA, 2022a). While there are now seven crossings for civilians to travel across the contact line, these are subject to frequent closure as they are affected by fluctuating levels of conflict and, more recently, quarantine measures due to the COVID-19 pandemic (United Nations High Commissioner for Refugees [UNHCR]/Right to Protection, 2022). The existence of the contact line has created numerous difficulties for populations living in the area, as it bisects essential infrastructure such as energy and water supplies while making access to health care, education, benefits, pensions and employment extremely difficult for those living in nearby communities or in NGCAs (OCHA, 2022a, pp. 17 – 18, 36). It has also become one of the most mined areas in the world and is contaminated with unexploded ordnance, posing a significant risk to civilians (OCHA, 2022a, p. 23).

Initial waves of displacement took place following the annexation of Crimea, as ethnic Crimean Tatars and pro-Ukrainian citizens fled the peninsula; this was followed by large-scale displacement events in the east of the country due to widespread fighting between Ukrainian government forces and Russian-backed separatists (Ferris, Mamutov, Moroz & Vynogradova, 2015, p. 7). Displacement had not been experienced on this scale in Ukraine in recent history and consequently there was a general lack of preparedness, with some actions by the Ukrainian government actually contributing further to displacement, for example, closing government offices and withdrawing social services such as pensions and benefits in NGCAs; this pushed many people who relied on these services to relocate into GCAs, where accommodation and support for IDPs was overwhelmed (Ferris et al., 2015, pp. 12 – 13). This also caused issues with the initial humanitarian response, as IDPs had to move between locations to access benefits, causing confusion with the registration and counting of people who had been displaced (OCHA, 2015, p. 2; see also, Ferris et al., 2015, pp. 16 –

18). With the state under considerable pressure, NGOs, oligarchs and civic activists stepped in to provide services that the state either could or did not (Phillips & Owczarzak, 2015) – including volunteer paramilitary forces with sometimes dubious and troubling political views (Umland, 2019).

5.1 - Challenges facing internally displaced persons in Ukraine

As of July 2021, 1,473,650 persons were registered as internally displaced by the Ministry of Social Policy of Ukraine[12], of which 51,586 are persons with disabilities (Ministry of Social Policy of Ukraine, 2021). Approximately 800,000 refugees also fled Ukraine to external destinations in the early stages of the conflict, primarily Russia (Ferris et al., 2015, p. 10). This proved to be temporary for the majority and as of January 2021 this number had dropped significantly to just over 70,000 (UNHCR Ukraine, 2021). As the conflict has continued the displacement situation for many IDPs within Ukraine has become a protracted one, and local integration has come to be seen as their preferred solution with 39% of IDPs stating that they now have no intention of returning to their place of origin (OCHA, 2022a, pp. 32 – 33). The main challenges facing IDPs relate to problems registering as an IDP and the issues this causes with accessing services and benefits, insufficient or inadequate housing, and exclusion from the labour market (OCHA, 2022a, p. 32).

As noted in a Norwegian Refugee Council (NRC, 2020) report, while there have been many legislative changes over the years in response to displacement in Ukraine, in the absence of reliable data on the number of displaced, their needs and sufficient resources, strategies and action plans "are likely to retain a rather declarative and theoretical character" (p. 5). Early restrictions on who could register as an IDP required valid identification and registration of a permanent residence to prove that an individual had been displaced from their normal place of residence (Internal Displacement Monitoring Centre [IDMC], 2016). This was particularly problematic for those who had no documents or had lost these during displacement, were not Ukrainian or were stateless (Ferris et al., 2015, p. 21). This also resulted in Ukrainian IDPs being excluded from voting during parliamentary and local elections in 2014 and 2015 as registration processes were difficult to follow and poorly publicised (Woroniecka-Krzyzanowska & Palaguta, 2016), although later legislative amendments simplified the process for IDPs to register to vote ahead of the 2020 local elections (UNHCR Ukraine, 2020). More recently, the Ukrainian government adopted the *IDP Integration and Medium-Term Solutions Strategy 2024 and the Operational Plan (2021-2023)* in order to formulate a national response strategy and policy framework to displacement. This strategy will focus on more long-term solutions to displacement and is "aimed at solving challenges in IDP housing, employment, social protection, access to education, health care, documentation, and IDP participation in local decision-making" (OCHA, 2022a, p. 19). There has also been increased attention on improving the accessibility of services for IDPs, particularly through using an app to access government services, including pensions. However, older people and people with disabilities can face additional

[12] UNHCR reports a lower figure of 854,000 IDPs in Ukraine, due to different methods of estimating numbers. The Ukrainian government also counts people still living in their usual residence within NGCA but who are registered as displaced (Health Cluster Ukraine, 2022a, p. 47).

barriers to the use of digital technologies, such as not having the required devices, tools or local infrastructure to access these (OCHA, 2022a, pp. 31, 35; on digital poverty, see Barrantes, 2007).

There have not been any camps set up for the displaced in Ukraine, but there have been collective centres established on disused state property, private premises or church premises which are used for housing large groups (Dean, 2017). However, most IDPs (62%) are now renting accommodation which brings additional pressures in the form of rent and utility bills, meaning that owning their own housing is the top priority for IDPs (International Organisation for Migration [IOM], 2021, p. 8). A shortage of suitable housing therefore remains one of the most pressing concerns, particularly for more vulnerable groups including people with disabilities (OCHA, 2022a, p. 33). Yet, as in other areas relating to displacement in Ukraine, there is a general lack of accurate or reliable information on the housing needs and available housing stock for IDPs (NRC, 2021).

IDPs also face a disadvantaged economic situation, with the average monthly salary for a displaced household approximately 40% lower than the average Ukrainian income and 14% lower than the subsistence level (OCHA, 2022a, p. 33). Vakhitova and Iavorskyi (2020) studied the labour market participation of IDPs living in Luhanska and Donetska GCAs and found that they were significantly more likely to be unemployed than non-IDPs up to two years following their initial displacement. The authors also suggest that economic crises and the structure of the Ukrainian labour market – with particular protections shielding incumbent workers against layoffs – make it difficult for local areas to flexibly adapt to and integrate new IDPs into employment (Vakhitova & Iavorskyi, 2020, p. 402). Problems within the labour market have contributed to an increasing outflow of young people from eastern areas, with many IDPs reportedly having no intention of returning; this has contributed to the Luhanska and Donetska oblasts having the highest median ages in Ukraine and a greater proportion of older people – including people with disabilities – dependent on others for care (OCHA, 2022a, p. 17). Gazizullin and Solodova (2019) estimate that 1 in 10 citizens in eastern Ukraine have disability status, with disabilities more common among men, the elderly and in rural settings.

5.2 - Impact of the conflict on access to health care and services

At a meeting of the UN Security Council in February 2020 (before the COVID-19 pandemic hit Europe and Ukraine), the crisis in and around Ukraine was described as “the most pressing security challenge in Europe”, with the OSCE Chair comparing Eastern Ukraine “to a post-apocalyptic landscape with thousands of people — many elderly and sick — in search of medical help” (UN, 2020b, para. 9). Approximately 300,000 internally displaced persons are part of the overall estimate of 2.9 million people in need of humanitarian assistance due to the conflict, including people living in NGCAs and along the ‘contact line’ in government-controlled areas (OCHA, 2022a, pp. 8 – 9). Of these people in need, approximately 400,000 are people with disabilities (OCHA, 2021d, p. 5) who form a greater proportion of the population in the eastern regions than in the rest of Ukraine (Health Cluster Ukraine, 2022a, p. 61).

As is commonly found in immediate post-crisis service landscapes, there was an early proliferation of NGOs and services providing aid for the internally displaced in Ukraine. However, there was very little provision for the needs of people with disabilities and particularly internally displaced people with disabilities who struggled with housing, employment and food security (Phillips & Owczarzak, 2015). Difficulties were compounded when the Ukrainian government cut funding for services in NGCAs, including pensions, following the outbreak of conflict in 2014. People living in these areas were required to register as IDPs and travel over the contact line to collect their pensions, creating conditions which discriminated against those with limited mobility or who were unable to travel (Human Rights Watch [HRW], 2020). When the contact line was closed in response to the COVID-19 pandemic, hardships were further exacerbated for those needing to cross over to GCAs in order to visit family or friends, access health care, check on properties or collect pensions (OCHA, 2021). As of December 2021, most crossings remained closed with only two in operation on both sides of the contact line, with the number of crossings (3,163) falling to only 1.3% of the level seen in December 2019 (UNHCR/Right to Protection, 2022, p. 1). Due to the effective closure of the crossings, an increasing number of civilians took to travelling to Ukraine via Russia, extending their journey by hundreds of kilometres in order to enter at the national border (UNHCR/Right to Protection, 2022, p. 2). The recent health reforms have improved the situation for IDPs somewhat as people are now able to register with a doctor of their choosing anywhere in Ukraine, easing the previous logistical and bureaucratic challenges which could require travel across the country to access services (EASO, 2021, p. 40).

The conflict has caused significant disruption to health services, with a near total breakdown in supply chains for medicines, medical supplies and equipment across the contact line, and staff shortages in NGCAs (OCHA, 2020a, p. 7), where healthcare facilities have reportedly been overwhelmed by the joint impact of the conflict and COVID-19 (UNICEF Ukraine, 2022). Vulnerable groups including the elderly and people with disabilities are at increased risk from the deteriorating health care situation (Health Cluster Ukraine, 2022a). The situation has been particularly severe for drug users and people with HIV; the annexation of Crimea by Russia resulted in the closure of HIV treatment centres, and Russian policy has been to discontinue any opioid substitution treatment for people who use drugs (Filippovych, 2015). Treatment and rehabilitation services have also been disrupted across the wider region of eastern Ukraine, particularly for IDPs who may be unable to register for services due to loss of documentation (Owczarzak, Karelin & Phillips, 2015). This is of note as the south and east areas of Ukraine – where the conflict is located – have the highest concentrations of people who inject drugs and/or have opioid dependency in Ukraine (Zaller et al., 2015).

The war in the Donbas also increased pressure on rehabilitation services due to injuries caused to military personnel and civilians (Golyk et al., 2021), and has significantly affected the mental health of the local population, veterans and the internally displaced, all of whom have a higher prevalence of mental illnesses such as PTSD, depression and anxiety (Colborne, 2015; Kuznestsova, Mikheiva, Catling, Round, & Babenko, 2019; Roberts et al., 2019). For example, a recent survey found that older people with disabilities living in conflict-affected areas of eastern Ukraine have very high levels of psychological distress

(32.2% of independent persons and 74% of moderately/severely dependent persons). Contributing factors may include the impact of the conflict itself (i.e., violent events) and increasing socioeconomic hardship (particularly for older persons relying on pensions), while respondents living in NGCA were more likely to be dependent on others and experience serious psychological distress (Summers, Leidman, Pereira & Bilukha, 2019). Overall, 40% of residents in GCAs of Donetska and Luhanska oblasts have reported trauma leading to PTSD, stress, anxiety and depression (Health Cluster Ukraine, 2022a, p.40). Amongst IDPs mental health needs were also acute, with one study reporting significant prevalence of PTSD (32%), depression (22%) and anxiety (17%) – despite this, almost three quarters of those surveyed who had mental health needs had not received any care (Roberts et al., 2019). In addition, of those who had accessed healthcare 44% reported having to pay for this (Roberts et al., 2019, p. 107). A separate study has indicated that approximately half of IDPs (48.75% - 57.6%) who have PTSD also experience clinically significant levels of disability (Shevlin et al., 2018).

6 - COVID-19 and the conflict – emerging and intersecting challenges

As the COVID-19 crisis continues to exacerbate existing inequalities and vulnerabilities in Ukraine, the hardships and deprivations faced by the conflict-affected population in eastern Ukraine and by people internally displaced by the conflict have also intensified (OHCHR, 2020a). A recent situation report released by the United Nations Office for the Coordination of Humanitarian Affairs (OCHA, 2021c, p. 5) stated that:

> Millions of people on both sides of the "contact line" face fatal risks, have limited access to essential services and experience shrinking livelihood opportunities daily. Moreover, the COVID-19 pandemic and its socioeconomic ramifications have strained the resilience of conflict-affected communities, increasing their reliance on humanitarian aid to survive.

Internally displaced people with disabilities have been identified as particularly at risk from COVID-19 (OHCHR, 2020a, p. 2), yet little qualitative or quantitative research exists to provide a comprehensive account of challenges faced by people with disabilities in Ukraine who live in a situation of protracted displacement, nor the impact of COVID-19 on their health and socio-economic wellbeing. A recent report from the United Nations International Organisation for Migration (IOM, 2021, p. 5) highlights the heightened vulnerability of IDPs to the impacts of COVID-19, and especially IDP households which contain a person with disabilities, 68% of which relied on government aid as their main source of income. The pandemic strained existing humanitarian aid programs across the country, with funds diverted from these to help manage immediate response efforts and the increased operational and logistic costs of delivering aid during the pandemic; in addition, the economic impact in terms of loss of livelihoods and reduction in earnings increased the needs of vulnerable populations, including IDPs (OCHA, 2020b, pp. 13 – 15). During the pandemic, 42% of IDP households with people with disabilities reported having enough money only for food, while 27% had to limit even food expenses (IOM, 2021, p. 6). For people with disabilities who live in the vicinity of the contact line (up to 5km), more than one third (37%) reported financial difficulties, whilst 22% were unable to register for social benefits due to a lack of transport in their area (OCHA, 2022a, p. 97).

Restrictions on mobility due to quarantine measures had a profound impact on people with disabilities residing in rural areas and compounded the existing difficulties of crossing the 'contact line' for civilian victims of the conflict in the east of the country. As reported by OHCHR (2020b, p. 5), all entry-exit points from GCAs into those controlled by separatists were closed between March and June 2020. Access to healthcare was one of the main reasons cited by civilians for crossing the line in both directions (OHCHR, 2020b, p. 10). As of February 2022, the contact line remains largely closed. This has had an especially harmful effect on older persons – who constitute 30% of the people in need of humanitarian assistance in Ukraine – who rely on crossing the contact line to access their pensions in GCAs (OCHA, 2022a, p. 48).For some IDPs – and others within Ukraine, such as stateless persons – a lack of identity documents has further complicated access to healthcare during the pandemic (Right to Protection, 2020; see also Burki, 2021).

7 - Theorising displacement and citizenship in Ukraine

As Cardona-Fox (2020, p. 17, 21) notes, although there is a large base of grey literature concentrating on humanitarian needs, data collection, IDP registration and legislative problems there is a lack of academic research into displacement in Ukraine. This is reflected in the limited pool of English-language academic research which is available as of January 2022, and which largely engages with questions of state-citizen interactions and integration of displaced persons into host communities.

Tania Bulakh (2020) concentrates on the ways in which the conflict has pushed IDPs into interactions with the bureaucratic state, and how this contact leads to reflections on citizenship and belonging. Referring to the concept of "controlled citizenship," she outlines the ways in which "administrative rationalities and hurdles" (Bulakh, 2020, p. 456) in Ukraine make IDPs subject to the control of the state, to the extent that they must "fashion themselves as deserving citizens" (p. 458). Bulakh brings this into conversation with the work of Phillips (2011) and Petryna (2013) discussed earlier in this review, which raises interesting parallels between the experiences of IDPs and people with disabilities in Ukraine, their navigations of bureaucracies that serve to classify and distinguish different groups, and the linkage of this classification to Soviet-era policies of social and health related welfare. As Bulakh (2020) notes, this "open[s] up a space for critical investigations of citizenship not as a fixed status but rather as a dynamic involvement in citizenship practices and ordeals" (p. 462). Although observing that there is a distinction between disability and displaced status, Bulakh does not fully consider that there may be a significant overlap between the two, or intersecting aspects of a person's identity; for example, many pensioners may be disabled, or a disabled person may be displaced. Her concluding observation that "institutions that are supposed to provide care instead serve to isolate and marginalise their clientele" (Bulakh, 2020, p. 476) could as easily be applied to the experiences of people with disabilities in Ukraine, particularly those within institutions.

Bulakh (2017) has proposed elsewhere that citizenship was also an underlying principle governing the response of local volunteer efforts to aid IDPs in Ukraine, where the idea of a shared citizenship prompted positive and sympathetic reactions in the first year of the conflict. However, Bulakh (2017, pp. 53 – 59) argues that this common identity crumbled as displacement became more protracted, with IDPs increasingly subject to negative stereotypes that associated their origin in the east with cowardice, criminality and the threat of a spreading conflict. This is supported by Kateryna Ivashchenko-Stadnik (2017), who has argued that even broadly positive attitudes towards IDPs in Ukraine must be contextualised to account for varying degrees of acceptance. Survey results revealed that in economic and political participation – for example, voting – IDPs are only partially accepted by host communities, which Ivashchenko-Stadnik (2017) suggests indicates that they are viewed as limited "semi-fellows and semi-citizens" (p. 42). Problematic reception of IDPs was exacerbated by the position of the Ukrainian government; in the early stages of the conflict the government denied that there was a displacement crisis and did little to counteract the spread of stereotypes against IDPs, which portrayed them as supporters of the separatist regions and Russia, and opposed to the 2014 revolution (Ferris et al., 2015,

pp. 13 – 14). Rimpiläinen (2020; for more on Ukrainian citizenship and identity, see Barrington, 2021) argues that this may play a part toward the formation of "a more unitary conception of the nation in Ukraine at the expense of the IDPs as an 'other'" (pp. 482 – 483), by positioning stereotypes of fraudulent IDPs claiming benefits and committing crime with NGCAs and Russian occupation against the unified Ukrainian state.

Viktoriya Sereda (2020; see also Sasse & Lackner, 2018) has argued that citizenship serves as an important marker for IDPs in signifying their belonging to Ukraine and host communities, and that through complex and difficult bureaucratic interactions "state and local administration officials are the main group that repeatedly treat IDPs as alien and 'other', thus implicitly questioning their belonging in the community" (p. 424). Discussing difficulties in voting access for IDPs in Ukraine during 2014 – 2015, Woroniecka-Krzyzanowska and Palaguta (2016) note that "ensuring IDPs' equal access to the electoral process could have been an important way to affirm their citizenship rights and agency" (p. 42). Similarly, Krakhmalova (2019) has argued that access to justice is so important for Ukrainian IDPs as – among other things – it is one of the ways in which the Ukrainian state is legitimated to its citizens.

8 - Conclusion

This review provides an initial overview on the available English-language literature on disability, displacement and COVID-19 in Ukraine. It has documented that while there has been progress from the Soviet-era health care model that Ukraine inherited on gaining independence, there are ongoing concerns that must be addressed through reforms to the health and political systems. The prevalence of out-of-pocket payments has created an unmanageable economic burden to healthcare that excludes many of the poorest from accessing what should be a guaranteed constitutional right. Reforms should, and in theory are, attempting to remove this, but there are currently challenges to implementing the decentralisation of healthcare within Ukraine that may block their effectiveness.

People with disabilities continue to be underserved through the complex bureaucracies that govern access to services, and what remains an overly centralised health system with insufficient community support to fully support their integration, involvement and contribution to Ukrainian society. The impact of the COVID-19 pandemic has been serious and wide-ranging for people with disabilities across the globe, and Ukraine is no exception. Access to healthcare and other support services has been limited, while restrictions on mobility and social mixing have increased loneliness and mental health concerns. As the repercussions continue to be felt, indicators are that poverty and employment outcomes for people with disabilities will significantly worsen. In order for this to be accurately assessed, it is vital that the quality and quantity of data available on people with disabilities in Ukraine is improved upon.

The conflict in the eastern regions of Ukraine has severely impacted the health of the affected population and degraded the provision of healthcare, while the effects of conflict have negatively impacted on the mental health of local people, the displaced and veterans. For people who have been displaced, there have been issues in registering as an IDP and accessing services, suitable housing, employment and health care. While a significant number of the people who have been displaced are people with disabilities, there is again an urgent need for more accurate data in order to properly assess their immediate needs and the impact that displacement has had upon them.

The concentration of available literature on questions of belonging and citizenship perhaps indicates the unique context of civil conflict and rupture within the Ukrainian state which underlies the conflict itself. In particular, questions of how the treatment of displaced persons and other vulnerable groups – including people with disabilities – indicates levels of legitimacy for the Ukrainian state is of interest and could usefully be linked with changes in governance following the revolution of 2014; general ideological shifts towards neoliberalism and western values, such as those embodied in the decentralisation reforms to political and health infrastructure in the country; and the emergence of Ukrainian national identity and nationalism.

One limitation of this review is that Ukrainian and Russian-language literature has not been included. The need for greater engagement with eastern European scholars and their work has been noted some time ago (Rivkin-Fish, 2011), and any future reviews may helpfully

expand the literature pool through engaging with these sources. Placing these in conversation with the English language literature that is available may provide an interesting commentary on parallels between research communities and subjects of concern and provide new insights.

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