ACCESS TO HEALTHCARE FOR UKRAINIAN REFUGEES UNDER TEMPORARY PROTECTION

An Advocacy FAQ

May 2026

Preamble

On 24 February 2022, russia launched a full-scale military invasion of Ukraine, triggering the largest forced displacement crisis in Europe since the Second World War. Within weeks, millions of Ukrainians fled across borders into EU member states. In response, the European Union activated the Temporary Protection Directive (TPD, 2001/55/EC) for the first time in its twenty-year history, granting Ukrainian nationals rapid, collective protection without requiring individual asylum procedures.

The TPD provides displaced Ukrainians with the right to reside, work, access education, and, critically, access healthcare across EU member states. The operationalization of healthcare entitlements has been left to national governments, resulting in dramatically unequal protection across the EU. As of 28 February 2026, 4.40 million non-EU citizens who fled Ukraine held temporary protection status across EU member states, a figure that has grown continuously since 2022. The Directive was extended until 4 March 2027, but this final extension demands urgent transition planning, particularly for people dependent on uninterrupted, life-sustaining treatments.

This FAQ is addressed to EU institutions, national governments, and civil society advocates. It consolidates peer-reviewed evidence and official data to make the case that healthcare continuity for people living with HIV (PLHIV), people affected by tuberculosis (TB), people who use drugs (PWUD), and other key and vulnerable populations must be a legally enforceable, non-negotiable component of any TPD transition mechanism.

Q1. What healthcare rights do Ukrainian refugees under the Temporary Protection Directive currently have?

The TPD sets a minimum floor of entitlements across all EU member states, including access to emergency and acute care, treatment for chronic conditions, paediatric and obstetric care, and nationally scheduled vaccinations. It was activated by unanimous Council Decision on 4 March 2022 and has been extended each year since, most recently until 4 March 2027.

In practice, the Directive leaves operationalization to individual member states, producing unequal outcomes. A comparative analysis across all 27 EU member states confirmed that while all have made the necessary legal provisions, large variations in healthcare benefits and financial coverage exist, with significant barriers related to language, system capacity, administrative complexity, and lack of awareness persisting on both provider and beneficiary sides (Kashnitsky et al., 2026).

Some countries integrated Ukrainian refugees into national health insurance on terms broadly equivalent to those of citizens, notably Germany, Czechia, Austria, and the Netherlands. Others maintained more limited, tiered, or discretionary systems: for example, in Romania and Bulgaria, access beyond emergency care required active registration steps that many refugees could not navigate (Kardas et al., 2025).

Healthcare access in the EU remains deeply nationally determined, governed by 27 distinct legal frameworks, insurance architectures, and administrative cultures, with no binding minimum standard enforceable at EU level. Access is further stratified by geography within each country: specialised services, adapted to migrants' needs are overwhelmingly concentrated in large urban areas, meaning that refugees housed in smaller towns or rural reception facilities are typically less adapted. This urban-rural divide is especially acute for key and vulnerable populations: PLHIV, people on OAT, people with drug-resistant TB, whose treatment requires continuity, specialist oversight, and services that rarely exist outside major cities (Altice et al., 2023).

Q2. Are there documented gaps between formal health entitlements and actual access to care?

The immediate European response to displacement was broadly effective: the activation of the TPD rapidly enabled millions of Ukrainian refugees to access healthcare across member states, and studies confirm that 20 out of 27 EU countries extended coverage broadly equivalent to that of nationals, with access to vaccinations and prescription medications rated particularly well by refugees themselves (Mauer et al., 2025).

Yet, the gap between formal rights and lived reality is substantial and well-documented. The RefuHealthAccess study (Kardas et al., 2025), a cross-national survey of 550 Ukrainian refugees, found that access to chronic condition care was rated worst among 11 evaluated service categories: 41.8% of respondents rated it 'bad' or 'very bad.' The most frequently cited barriers were long waiting times (64.2%), language and information obstacles (55.5%), and out-of-pocket costs (49.1%). Notably, nearly 25% of respondents reported temporarily returning to Ukraine to access services unavailable when needed or unaffordable in their host country. This reflects a structural failure of host health systems, not individual preference.

The qualitative study by Kashnitsky et al. (2026), based on 122 in-depth interviews across France, Georgia, Germany, Estonia, Moldova, and Poland, further documents how refugees with HIV, TB, and opioid use disorder face layered systemic, regulatory, and linguistic barriers that formal entitlements alone cannot resolve. Refugees with HIV described reliance on infectious disease specialists for all referrals due to absent interpreter services, while PWUD frequently concealed their treatment needs out of fear of stigmatisation.

Q3. What is the specific situation for people living with HIV (PLHIV)?

Ukraine has one of the highest HIV burdens in Europe, with heterosexual transmission as the dominant route, structurally distinct from the predominantly MSM-driven epidemics in most Western European host countries. A WHO/ECDC survey found that by March 2023, at least 6,519 Ukrainian refugees were receiving ART across the EU, representing 1.5 per 1,000 registered refugees. Among the 11 countries providing longitudinal data, the number of Ukrainian refugees on ART increased by 74% between July 2022 and March 2023, reflecting rapidly growing demand in

destination countries (Kuchukhidze et al., 2024). A study of Ukrainian PLHIV in Czechia found that 30% switched ART regimens upon arrival, raising concerns about viral suppression and drug resistance (Massmann et al., 2023).

Beyond formal health systems, community-based solidarity networks proved critically important for building trust and linking PLHIV to care, particularly in the earliest and most disorienting phase of displacement. Kashnitsky et al. (2025) document how Ukrainian peer-led organisations and diaspora HIV networks operating transnationally across Germany and Poland functioned as essential intermediaries: they located newly arrived PLHIV through informal channels, provided Ukrainian-language guidance on how to navigate unfamiliar health bureaucracies, redistributed ART in emergency situations, and accompanied refugees to clinical appointments where interpreter services were absent. Crucially, these networks operated on the basis of shared identity, lived experience, and trust, resources that formal health systems, however well-intentioned, structurally cannot replicate. Migrant and refugee-led NGOs such UkrPlusDE, HelpNow, platform similarly provided real-time linkage to care via Telegram, Instagram, and online consultations with Ukrainian-speaking infectious disease specialists, reaching newly arriving PLHIV from Ukraine creating accompanying them to the points of care (UNAIDS, 2022).

Recommendation

- Guarantee uninterrupted ART access regardless of legal status.
- Expand HIV testing and linkage-to-care for newly arrived and long-staying refugees.
- Invest in migrant-sensitive HIV services that account for Ukraine's HIV transmission context.
- Recognize and support community-based migrant-led organizations as important health system components across the EU.

Q4. What are the specific risks for Ukrainian refugees affected by tuberculosis (TB)?

In 2022, TB notifications among Ukrainians in the EU/EEA increased nearly fourfold from a mean of 201 cases (2019–2021) to 780 cases and nearly 20% of all drug-resistant TB cases notified in the EU/EEA were of Ukrainian origin (Stoycheva et al., 2024). Managing MDR/RR-TB is a pressing clinical and public health priority, as treatment courses last 6–20 months and any interruption risks generating further resistance.

A multi-country study found that 71% of TB cases among Ukrainian refugees were concentrated in just three host countries – Germany, Poland and Czechia - underscoring the need for equitable burden-sharing and EU-wide coordination (de Vries et al., 2024). Kashnitsky et al. (2025) document how structural risk factors, overcrowded accommodation, long working hours, poor nutrition, and cold environments create conditions conducive to TB activation and transmission among displaced people.

Positive models exist: Poland, in partnership with WHO and Médecins Sans Frontières, established outpatient treatment for drug-resistant TB with short regimens, a Ukrainian-language TB helpline, and video-supported directly observed therapy (VDOT). WHO Regional Office for Europe facilitated patient data transfer from Ukraine's National TB Programme to ensure treatment continuity for patients who crossed borders mid-treatment (de Vries et al., 2024).

Recommendation

- Systematise TB screening for newly arrived and long-staying refugees.
- Establish cross-border patient data transfer protocols with Ukraine's National TB Programme.
- Invest in telemedicine for MDR/RR-TB management.
- Replicate the Poland–WHO partnership model at EU scale, with dedicated funding.
- Engage civil society and community-led organizations as formal TB care partners for outreach, trust-building, and adherence support.

Q5. What is the situation for people who use drugs, including those on opioid agonist treatment (OAT)?

Ukraine has one of the highest rates of opioid use in Europe, with an estimated 350,000 people who inject drugs, approximately 1.7% of the adult population. OAT (methadone or buprenorphine) is the gold-standard evidence-based treatment for opioid use and a critical HIV prevention tool. OAT must not be interrupted: abrupt discontinuation causes severe withdrawal, relapse, overdose, and increased HIV transmission, a painful lesson learned when Russia's illegal annexation of Crimea in 2014 led to abrupt OAT programme closures (Altice et al., 2023).

Ukrainian refugees on OAT face severe barriers in EU host countries: bureaucratic registration delays lasting weeks to months, geographic inaccessibility of OAT clinics concentrated in large cities, limited OAT-prescribing physicians, stigma-driven self-concealment of treatment needs, and country-specific prohibitions on OAT medication shipment. In Romania, a major transit and hosting country, only five public OAT clinics existed prior to the refugee crisis, serving a country with 16% HIV prevalence among PWID.

Recommendation

- Implement fast-track OAT registration for displaced persons (within 24–72 hours of arrival).
- Expand the geographic distribution of OAT providers and invest in mobile OAT delivery.
- Allow temporary take-home doses to accommodate working schedules.
- Fund healthcare provider training in OAT prescribing for refugee populations.
- Engage civil society, migrant-led peer networks, and harm reduction organizations as formal OAT outreach partners, particularly for PWUD who do not disclose their treatment needs upon arrival.

Q6. What is the current status of the TPD, and what risks does its potential discontinuation pose?

The TPD was formally extended until 4 March 2027 by Council Decision in July 2025, following a European Commission proposal of 4 June 2025. This fifth extension was accompanied by a Council Recommendation on a coordinated transition, urging member states to prepare national legal frameworks for Ukrainians once EU-level protection expires. The Commission explicitly acknowledged that safe and durable conditions for return to Ukraine do not currently exist and that further mass arrivals cannot be excluded.

Civil society organisations have warned that unless work starts now, another one-year extension may become the only option by default (HIAS, 2025). An ECRE working paper (2026) “Transitioning to What?” documented the absence of adequate national legal pathways for the majority of TPD beneficiaries in most member states. Moreover, as of 28 February 2026, the TPD caseload continues to grow reaching 4.40 million beneficiaries, partly driven by a Ukrainian government decree in late

August 2025 permitting men aged 18–22 to leave Ukraine, which triggered a peak in new TPD decisions in autumn 2025 (Eurostat, 2026).

For people on life-sustaining treatments, the March 2027 deadline is not an administrative transition, it might become a clinical emergency. Treatment interruptions for PLHIV cause viral rebound and drug resistance; MDR-TB treatment interruption generates further resistance; OAT discontinuation causes withdrawal symptoms, overdose, and increased risk behaviors leading to a higher risk of HIV transmission.

Q7. What transition mechanisms are needed to protect the right to health beyond March 2027?

The evidence base converges on the following structural requirements for a health-inclusive TPD transition:

- Guarantee of treatment continuity for all TPD beneficiaries receiving treatment for HIV, TB, cancer, OAT, diabetes, or other chronic conditions — established before the TPD expires, guaranteeing access regardless of migration status transition.
- Integration into national health insurance systems as the durable standard for long-staying refugees with chronic conditions (not project-based or humanitarian provision).
- EU-level minimum standards for health transition, embedded in the Council Recommendation, must include an explicit guarantee that no change in migration status, including transition out of temporary protection, may result in the interruption of ongoing treatment for chronic, communicable, or life-threatening conditions. Continuity of care must be legally protected regardless of a person's status at the moment of transition.
- Cross-border coordination with Ukraine's health authorities formalised for TB patient data exchange, ART supply chain management, and OAT continuation.
- Community-based organisations formally integrated into transition planning and co-funded by member states, with multi-year funding commitments extending beyond the TPD's lifetime.
- Systematic data collection on health service use by TPD beneficiaries, disaggregated by condition and population group, to enable evidence-based planning and resource allocation.

Q8. Do receiving countries benefit from hosting Ukrainian refugees, and does investing in their social inclusion risk attracting unsustainable numbers?

The evidence is unambiguous on both counts: hosting Ukrainian refugees generates concrete, measurable gains for receiving societies, above all in healthcare, and the fear that generous policies trigger disproportionate flows toward the most welfare-generous states is empirically unfounded.

Ukrainian refugees represent an exceptional demographic profile — predominantly women of working age, highly educated, with professional qualifications in healthcare, engineering, and education. Their economic contribution has been substantial: in Poland, a UNHCR-commissioned Deloitte study found that Ukrainian refugees raised real GDP by 2.7% in 2024 alone, equivalent to €23.1 billion in additional economic output. Across Europe, Ukrainian migrant employment rates reached 64% of the working-age population by 2024, only 7 percentage points below the host country average. A rigorous econometric study in Czechia found zero negative employment effects for local workers at any education level, gender, or industry (Postepska & Voloshyna, 2025, CEPR VoxEU).

The Healthcare Workforce Dividend

The most directly relevant benefit for health system decision-makers is the integration of Ukrainian health professionals into chronically understaffed national health systems. In Czechia, the number of active Ukrainian healthcare workers reached 2,841 by February 2026, a 55% increase since 2022, including 1,098 physicians, 242 dentists, and over 1,490 nurses. Hospital managers credit them with stabilising a sector long plagued by staff shortages, noting that many bring intensive care and trauma expertise forged under wartime conditions. In Poland, over 2,300 refugee doctors and 1,000 nurses benefited from fast-track work permit procedures. A comparative study of Ukrainian physicians in Germany and Poland found that their integration reinforces the health workforce and helps alleviate physician shortages, while their Ukrainian language proficiency makes them irreplaceable clinical and cultural bridges for co-national patients (Hointza et al., 2025).

This workforce dividend is inseparable from the argument for sustained health investment: Ukrainian health professionals who lose legal status or healthcare access will leave host countries, removing both their labour contribution and their role as trusted clinical mediators for refugee communities with chronic conditions.

Why Welfare Generosity Does Not Drive Destination Choice

A persistent concern is that expanding social and health entitlements will trigger excessive secondary movement toward the most generous welfare states. The actual distribution of Ukrainian refugees directly contradicts this. As of 28 February 2026, Poland hosts 966,595 TPD beneficiaries, a country with more modest social welfare and lower wages than most of Western Europe, while France, with one of the EU's most comprehensive social protection systems, hosts fewer than 56,000: approximately 18 times fewer per capita (Eurostat, 2026). A landmark PNAS study (Adema et al., 2025) directly tested the welfare magnet hypothesis and found that job opportunities, social networks, and language proximity are the dominant determinants of destination choice, with social assistance generosity showing no statistically significant effect across any subgroup tested. Refugees do not cross three borders for better benefits, they settle where they have community, work, and continuity. Harmonising healthcare entitlements upward will not destabilise migration flows; it will preserve four years of hard-won chronic disease management and retain a skilled healthcare workforce EU member states cannot afford to lose.

Q9. What role do community-based and civil society organisations play, and why must their funding be protected?

The evidence consistently shows that community-based organisations (CBOs) and peer networks have been indispensable in bridging the gap between formal entitlements and actual access. Kashnitsky et al. (2025) document how Ukrainian-led NGOs, peer support networks, and community health advocates facilitated ART access through informal redistribution, accompanied refugees to appointments, conducted outreach to PLHIV who had self-excluded from health systems, and served as cultural and linguistic brokers where professional interpreter services were absent. In Moldova and Georgia, civil society organisations with prior experience in Global Fund coordination mechanisms rapidly extended services to Ukrainian refugees, demonstrating the irreplaceable value of pre-existing networks.

These roles are not supplementary, they are structural. In contexts where host country health systems are not migrant-sensitive and where provider training in heterosexual HIV transmission,

MDR-TB, or OAT is limited, CBOs often constitute the only functional pathway to care for the most vulnerable. Yet their funding is overwhelmingly project-based, time-limited, and directly tied to the TPD's existence, meaning that TPD expiry risks dismantling this infrastructure precisely when the transition period demands it most.

Recommendation

- Formalise and fund CBOs as structural partners in national health transition plans.
- Establish multi-year funding commitments for civil society HIV, TB, and harm reduction services.
- Include community and CSO representatives in all governance bodies responsible for TPD health transition planning.
- Recognise peer support as a health intervention in national health accounts and WHO reporting frameworks.

Q10. What are the key messages for EU institutions and national governments?

- Chronic and communicable disease treatment is a non-negotiable right, not a discretionary benefit. TPD transition mechanisms must enshrine health continuity as a legally enforceable standard.
- Variation in healthcare entitlements across member states is a structural injustice. The EU should establish binding minimum health standards for all TPD beneficiaries.
- Key and vulnerable populations (PLHIV, people on TB treatment, people on OAT, LGBTQIA+ refugees, and undocumented individuals) require targeted, population-specific interventions beyond generic refugee health frameworks.
- Language and information barriers are a leading cause of failed access and must be addressed through professional interpreters, Ukrainian-language health materials, and trained cultural mediators in clinical settings.
- Community-based solutions work: peer networks and Ukrainian-led CBOs are cost-effective, trusted, and often the only accessible point of contact for the most excluded populations. Their funding must be safeguarded beyond the TPD.
- Hosting Ukrainian refugees is an economic and health workforce asset, not a burden. Poland, Czechia demonstrated measurable GDP gains, zero displacement of local workers, and critical reinforcement of healthcare staffing.
- The expiration of the directive in March 2027 must trigger health planning now. For people on life-sustaining treatments, a care gap can be life-threatening. Interruptions in medical care can have life-threatening consequences for people on life-sustaining treatment. In the case of infectious diseases, such interruptions also undermine epidemic control and increase transmission risks Proactive, funded planning must begin immediately.

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