

Access to Primary Healthcare by Ukrainian Beneficiaries of Temporary Protection in Rural Communities

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Abstract

Aim

This study aimed to assess the primary healthcare services accessed by Ukrainian refugees in Ireland, their health needs, and consultation outcomes.

Methods

Ballyvaughan Medical Centre had 491 Ukrainians registered for GP services since March 2022. Data on age, gender, comorbidities, consultations, and outcomes were collected over 24 months.

Results

With conscription preventing Ukrainian males aged 18-60 from leaving, the cohort was predominantly female (322, 66%), including children (154, 31.4%), adults (282, 57.4%) and older adults (55, 11.2%). A total of 3,551 consultations were conducted: 1,910 (54%) with GPs, 774 (22%) with practice nurses, 860 (24%) as telephone consultations, and 7 (0.2%) out-of-hours. Hypertension was the most common diagnosis (56 cases, 24%), followed by cardiovascular disease (54, 23.5%), gastrointestinal issues (25, 11%), major depressive disorder (18, 8%), and thyroid disorders (17, 7%). New diagnoses included hyperlipidaemia (33 cases, 40%) and depression (18, 22%). Monthly medications were needed for 167 (34%), and 236 (48%) required acute prescriptions. Hospital visits were provided for 66 (13%) Ukrainians, while 425 (87%) were managed in primary care.

Discussion

The study illustrates the complex health needs of Ukrainian refugees in Ireland and emphasizes the need for culturally and linguistically tailored care to address these health needs.

Introduction

Globally, approximately 13% of the world's population is either a migrant or has been displaced due to conflict, persecution, poverty, or lack of security¹. The UN Refugee Agency defines a refugee as 'a person forced to flee their country due to persecution, war, or violence, fearing persecution based on race, religion, nationality, political opinion, or social group, and unable or afraid to return.'²

According to the Census of Population of Ireland in 2022, 20% of the residents were born outside of Ireland³. This represents over a million people. The biggest increases from 2016 to 2022 were in the number of people born in India, Brazil and Romania. During the year until April 2023, over 80,000 non-Irish citizens moved to Ireland, a 16-year high³.

Since the Russian Federation's full-scale invasion of Ukraine in February 2022, more than 7.6 million Ukrainians have been registered as refugees in European countries⁴. More than 100,000 Ukrainians, primarily women and children, have sought refuge in Ireland⁵. They were designated as Ukrainian beneficiaries of temporary protection, and the Irish government, through the Health Service Executive, recruited Ukrainian and Russian-speaking interpreters, many of whom were refugees themselves, to facilitate consultations with healthcare staff. Many of these interpreters have now been fully integrated into routine general practice.

Refugees and migrants in Europe face health risks due to poor living conditions and barriers accessing healthcare⁶. After arriving in host countries, they encounter challenges such as entitlement to healthcare, language barriers, and discrimination⁶. Research comparing migrant health with host populations in Europe has shown varied findings, with some studies indicating migrants are more disadvantaged overall⁷.

However, limited data exist on how Ukrainian refugees access general practice services in Ireland and what types of health needs they present with in rural settings. This study aims to describe the nature of primary healthcare accessed by Ukrainian refugees in Ireland's Mid-West, identify their healthcare needs, and assess consultation outcomes. The study addresses a gap in the literature regarding the patterns of healthcare utilisation by Ukrainian refugees in a rural general practice setting.

Methods

This is a retrospective observational study conducted at the Ballyvaughan Medical Centre, a hub for the North Clare Primary Care Team in Ballyvaughan, Co Clare, a member of the University of Limerick ULEARN-GP Research and Education Network and part of HSE Community Healthcare Organisation area 3. The core sample included Ukrainian refugees granted temporary protection in Ireland and registered with this facility.

The study period covered 24 months from March 22nd, 2022 to February 22nd, 2024, reflecting that the audit began in February 2024, and all 491 Ukrainian beneficiaries of temporary protection registered with the practice were included in the analysis. The study

period was chosen to cover both the initial and more established stages of refugee settlement.

Data collection involved electronic extraction from patient records via Socrates, with identifiers removed prior to analysis. Data collected included age, gender, comorbidity, consultation type (GP, nurse, other), and outcomes (e.g., treatment, specialist referral, emergency call, lifestyle advice). The variables were selected to capture demographic and clinical dimensions of primary care access, allowing analysis of patient needs, care processes, and outcomes. Quality assurance involved cross-checking a subset of records for consistency and completeness, with data entry independently verified by a second team member to ensure accuracy.

Statistical analysis was conducted to examine relationships and patterns among the collected variables. Descriptive statistics were compiled using standard formulae and analyses were performed using the statistical software packages SPSS (version 24.0) and R (3.6.2).

Results

Demographic data

As expected, with conscription in Ukraine preventing males aged 18 to 60 from leaving the country, the cohort was predominantly female 322/491 (66%), including children 154/491 (31.4%), adults 282/491 (57.4%), and older adults 55/491 (11.2%). Among those aged between 19 and 59 years, there is a noticeable gender disparity, with 200/282 (71%) females compared to 82/282 (29%) males (figure 1).

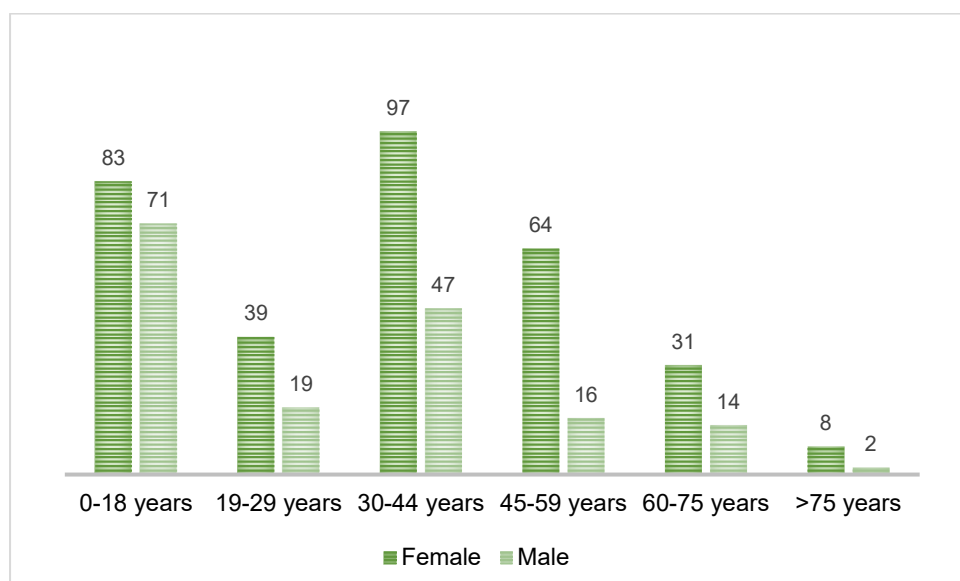


Figure 1. Demographic distribution of Ukrainian refugees by age and gender

Consultations, diagnosis and treatment

The total number of consultations recorded was 3,551, an average of 7 consultations per person. The majority, totaling 1,910 (54%), were in-person consultations conducted by GPs with Ukrainian medical interpreters. Additionally, there were 774 (22%) consultations carried out by practice nurses with Ukrainian translators. A total of 860 (24%) telephone contacts were conducted by Ukrainian interpreters. 7 (0.2%) were out-of-hours GP consultations, provided to address urgent medical needs.

During the study period, a diverse range of diagnoses was recorded. Hypertension emerged as the most prevalent, with 56/229 (24%) cases, followed by cardiovascular disease with 54/229 (23.5%) cases. Hyperlipidaemia was identified in 40/229 (17%) cases, while gastro-intestinal diseases were noted in 25/229 (11%) cases. Major depressive episode was diagnosed in 18/229 (8%) cases, and thyroid disorders were diagnosed in 17/229 (7%) cases (figure 2).

A total of 82/229 (36%) new diagnoses were made during the study period. Hyperlipidaemia emerged as the most common issue, with 33/82 (40%) new diagnoses. Mental health also featured prominently, with 18/82 (22%) new cases of major depressive episode identified. Hypertension was also notably frequent, with 11/82 (13%) new cases. Cancer diagnoses were noteworthy, with 5/82 (6%) new cases, as were thyroid disorders with 5/82 (6%) new diagnosis (figure 2).

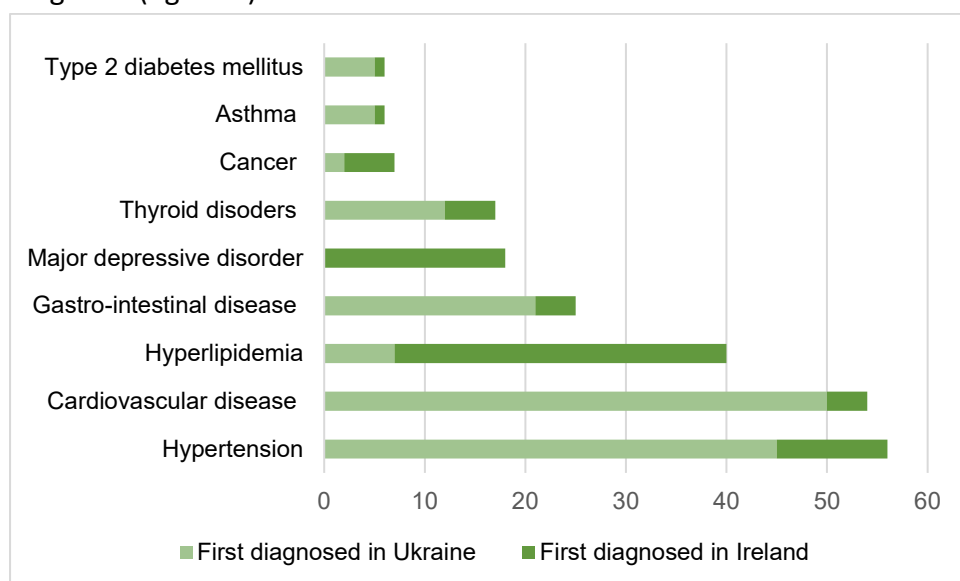


Figure 2. Distribution of diagnoses according to major chronic illness and country in which the diagnosis was first made

The data on prescription patterns reveal notable trends in both repeat and acute prescriptions among patients. For repeat prescriptions, 167/491 (34%) patients were on one or more medications each month. 39/491 (8%) were prescribed three or more medications on a monthly basis, and 20/491 (4%) were on five or more medications every month.

236/491 (48%) patients required at least one acute prescription to address immediate health concerns (e.g., antibiotics for infections, pain relievers for acute pain, or antihistamines for severe allergic reactions). Additionally, 69/491 (14%) needed three or more acute prescriptions, and 20/491 (4%) required six or more acute prescriptions.

Additional examinations and procedures

A total of 187 hospital visits were recorded during the study period, encompassing various types of interactions with hospital services. Of these, 152/187 (81%) were outpatient visits, and 35/187 (19%) were hospital admissions. All hospital visits were provided for 66/491 (13%) Ukrainians, while 425/491 (87%) were purely managed in primary care.

There were 58/95 (61%) referrals made for radiological examinations, 19/95 (20%) referrals were directed towards community services, and 18/95 (19%) were made to other members of the primary care team including physiotherapists, occupational therapists, opticians, etc.

Regarding immunization efforts, a total of 45/154 (29%) children received vaccinations over 24 months. The overall number of vaccinations administered reached 142.

Discussion

This study describes primary healthcare access and consultation outcomes among Ukrainian refugees in a rural Irish general practice over a 24-month period. Ukrainian refugees at a rural GP practice were mainly women, with a near-equal gender ratio among children. Most consultations were in-person GP visits with interpreters, and prevalent diagnoses included hypertension, cardiovascular disease, gastrointestinal issues, major depressive episodes, and thyroid disorders. Among the new diagnoses, hyperlipidemia and major depressive disorder were prevalent. A third of patients required repeat prescriptions on a monthly basis, while nearly half needed at least one acute prescription during the study period. Immunization efforts were mainly focused on children. There were also numerous hospital interactions, mostly outpatient visits, with a smaller number requiring hospital admissions. Out of the Ukrainian patients, the majority (87%) were managed exclusively within primary care, which is vital to prevent higher emergency department visits and hospitalizations, thus controlling healthcare costs.

The Russian Federation's full-scale invasion of Ukraine, triggered a severe humanitarian crisis, resulting in significant migration, primarily of women and children, to European Union countries⁸. A study by Parente et al. (2023) of Ukrainian refugees in an Italian Local Health Authority found that 29.8% were male and 70.2% were female, with a median age of 25 years⁹. This demographic pattern is consistent with findings by Fatyga et al. (2022) in Poland, where most of Ukrainians were women and children¹⁰.

Significantly, 31.4% of the population were children, a particularly vulnerable group in armed conflicts. Unlike adults, children are largely defenseless due to their lack of independence and experience in navigating a conflict-ridden environment. Reports, including those by Awuah et al. (2022), highlight that armed conflicts severely impact children's development, potentially

affecting their future health and well-being¹¹. Additionally, many Ukrainian children may need follow-up care due to missed vaccinations from disruptions in healthcare systems in territories occupied by the Russian Federation. The WHO's external situation report indicates suboptimal vaccination coverage for routine childhood immunizations among Ukrainian children, including critical vaccines like measles and polio¹².

Notably, an almost equal gender ratio was observed only among the children, while less than one-third of the working-age population were men. This gender imbalance is likely due to the legal restrictions, which limit the ability of men aged 18 to 60 to leave Ukraine¹³.

The most frequently diagnosed conditions within this population were hypertension, cardiovascular disease, and hyperlipidemia. In a study by Parente et al. (2023), similar patterns were observed among Ukrainian refugees in Italy, where the most common health issues were related to the circulatory system (50.6%), the endocrine system (24.9%), and mental disorders (6.5%)⁹. These findings align with the general burden of non-communicable diseases, which account for 84% of all deaths in Ukraine, with cardiovascular diseases, diabetes, cancer, chronic respiratory diseases, and mental health disorders being the most prevalent¹⁴.

One major concern within this population is major depressive disorder. War-related tragedies, such as loss, family separation, displacement, and lack of support, significantly impact mental health¹⁵. Ukrainians may experience distress due to war-related trauma, living in the Russian-occupied territories, forced displacement from their homeland, and difficulties in navigating social, and cultural nuances in Ireland, and language barriers¹⁶. Furthermore, frequent exposure to news is associated with increased anxiety and depression, particularly among female Korean-Ukrainian refugees¹⁶. Additionally, mental health diagnoses may be under-reported in Ukrainians due to stigma and fear rooted in the historical misuse of psychiatry during the Soviet era¹⁷.

Another significant health issue in Ukrainians is thyroid disease. Ukraine is a region endemic for thyroid disorders, particularly due to the long-term consequences of the Chornobyl nuclear disaster^{18,19}.

Healthcare needs within the Ukrainian community have progressively shifted from predominantly acute conditions toward a greater emphasis on chronic disease management. Effective management of chronic conditions in primary care is essential to prevent higher costs due to emergency visits and hospitalizations²⁰. The capacity of well-resourced primary care services, including the provision of interpreter support, facilitates the management of most patients entirely within primary care settings; this is demonstrated by 87% of Ukrainian patients having their healthcare needs addressed within this level of service.

Addressing challenges related to communication, such as interaction difficulties and confidentiality concerns, requires enhancing interpreter training and implementing rigorous quality monitoring²¹. Training campaigns for practitioners and involving migrants in interpreter training are impactful, beneficial in postgraduate and ongoing medical

education²². By strengthening the medical capacity to meet the healthcare needs of refugees, host countries can play a proactive role in promoting stability, preventing avoidable health crises, and supporting long-term public health resilience in the context of the war in Ukraine²³. Methodological strengths of this study include use of real-world clinical data across a two-year period and inclusion of multiple clinical variables. However, limitations include its single-site nature, lack of qualitative perspectives, and limited generalisability beyond rural practices with similar demographic profiles. The study also did not capture patients who may not have registered with general practice.

Implications for research, practice and a policy include the importance of proactive chronic disease management and adequate interpretation services in refugee health. Future research should explore patient experiences, service delivery models, and healthcare outcomes across broader and more diverse settings.

In conclusion, this study highlights the role of general practice in providing effective, culturally sensitive care to Ukrainian refugees in Ireland. Sustained investment in primary care infrastructure, interpreter services, and tailored health interventions may help support the well-being of the refugee population and strengthen the health security policies of Ireland.

Declarations of Conflicts of Interest:

Three of the authors (LG, IM and VL) are involved in the delivery of primary care services to Ukrainian refugees at the Centre under study.

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