

“Cash and beyond”

Analysis of extra costs associated with disabilities and disability-specific Social Protection in Ukraine, in the aftermath of the Russian invasion



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List of acronyms

CALP	Cash and Learning Platform
CCD	Collaborative Cash Delivery
CCSS	Community Centres of Social Services
CI/MoE	Confidence Interval/Margin of Error
CSNAP	Central Agency for Social Protection
CVA	Cash and Voucher Assistance
CWG	Cash Working Group
DTM	Displacement Tracking Matrix
FGD	Focus Group Discussion
FSPs	Financial Service Providers
GCA	Government Controlled Areas
GoU	Government of Ukraine
GSR	Good and Services Required
HH	Household
HI	Humanity and Inclusion
HNO	Humanitarian Needs Overview
HRMMU	Human Rights Monitoring Mission in Ukraine
IASC	Inter-Agency Standing Committee
IDPs	Internally Displaced Persons
ILO	International Labour Organization
IOM	International Organization for Migration
IRC	International Rescue Committee
KI	Key informant
KIIs	Key Informant Interviews
MoSD	Ministry of Social Development
MoSP	Ministry of Social Policy
MPCA	Multi-Purpose Cash Assistance
OCHA	Office for the Coordination of Humanitarian Affairs
OECD	Organisation for Economic Cooperation and Development
OHCHR	Office of the High Commissioner for Human Rights
OPDs	Organisations of Persons with Disabilities
SP	Social Protection
SSCCFY	Social Service Centre for children, family and youth
TSNAP	Territorial Agency for Social Protection
TT	Task Team
UAH	Ukrainian Hryvnia
UNCRPD	UN Convention on the Rights of Persons with Disabilities
UNOSAT	UN Satellite Centre
US BHA	United States' Bureau for Humanitarian Assistance
USD	United States Dollars
UXOs	Unexploded ordnance
WGQ	Washington Group Questions
WHO	World Health Organization

Executive Summary

As conflict in Ukraine continues, the gravity of the humanitarian needs of people in areas directly affected by conflict are deteriorating, leading to consider humanitarian assistance and service provision as most urgent and life-saving. Amongst the people affected, households with members with disabilities and/or older persons may experience greater repercussions and socio-economic implications due to the barriers they face in meeting their needs, including accessing basic services and assistance. The trend is further accelerated and exacerbated by the partial or full damage of key social funds and community infrastructures, such as hospitals, schools, and community centres, as well as by the movement limitations imposed by the security context, and by the decline in the number of social workers and professionals (OECD, TT5, 2022). However, to date there is little to no accurate data on the number of persons with disabilities in need of humanitarian assistance, the barriers they face, and the extra direct and indirect costs associated with it (UNPRPD, 2022).

In order to address the data gaps and understand how humanitarian assistance can be more inclusive, the study focused on two core research questions:

- 1) What are the barriers and the enablers to make CVA humanitarian assistance in Ukraine more inclusive of people with disabilities and older persons?
- 2) Is the government's Social Protection (SP) system in the position of continuing to support persons with disabilities, older persons, and their households?

Data collection entailed a mix of secondary sources, quantitative data collected from a randomised sample of households from Humanity & Inclusion's existing caseloads, key informant interviews with experts operating in Ukraine, and Focus Group Discussions with representatives from Organisations for Persons with Disabilities (OPDs).

Data showed that, while almost all assessed households had negative net-income ratio, in spite of the presence of persons with disabilities or older persons in the composition, those with one or more members with disability reported worse gaps. Indeed, costs are not the main barrier to accessing services and core commodities, and it is pivotal not only to provide a top-up to those with heightened risk of vulnerability (approx. 170 USD), but also couple it with service provision, in-kind support, delivery of rehabilitation services and assistive technologies, capacity building for community members, and advocacy sessions. In terms of Social Protection, findings showed that the schemes in Ukraine have remained active following the Russian invasion, accounting for both supplementary income and service provision. The former remained stable throughout the war with minor delays but also with expansion of schemes upon need (e.g., IDP and Conflict-Affected People Emergency Support Housing Allowance Programme), and the latter, in several instances, decreased in either quality, availability, or accessibility. Yet, the needs skyrocketed since before February, and in the current context not even the Social Protection and humanitarian assistance together suffice to meet households' needs. Although this appeared to be true for all households assessed, those with a member with a newly acquired disability caused by a recent traumatic event are falling at the end of the spectrum of capacity to meet needs and cover extra costs linked to the disability status. Those persons and their households are both new to the condition and have not had a chance to adapt to the new situation via accessing functional rehabilitation and/or assistive technology, MHPSS and/or adaptations in their socio-economic environment yet.

It is key to call for more inclusive and comprehensive approaches, to ensure that everyone would have equal access to the specific commodities, services, and, more broadly, assistance they need. It remains to be considered, however, that disabilities-related needs could last a lifetime, and humanitarian work is short-term. Thus, persons with disabilities require more meaningful participation in all spheres of society, and particularly in the development of longer-term solutions in order to ensure continuous access to the resources they need. Nexus now is the core aspect to consider in order to be inclusive

and generate results that can be sustained in the longer-run, together with the strengthening of pre-existing schemes and considerations around adequate values based on the current socio-economic context and availability of services.

Background

As conflict in Ukraine continues, the gravity of the humanitarian situation is clear. People in areas directly affected by conflict are in immediate need of life-saving support, lacking food, energy, utilities, and facing a breakdown in the provision of basic services. They also face the risk of environmental disasters because of proximity to hazardous infrastructure, a risk that extends well beyond conflict-affected areas (REACH Resource Centre, 2022).

Since the Russian invasion of Ukraine, intensive bombing of the country's major cities has resulted in multiple civilian casualties. Hundreds of thousands of people are fleeing violence inside the country or taking refuge in neighbouring countries. According to the latest OCHA reports, in Ukraine there are a total of 17.7M people in need, out of which 13.35 were already reached through cash and voucher assistance (CVA) distributions. About 7M people are currently internally displaced, and 7.4M are currently refugees in neighbouring countries (OCHA Updates, September 2022).

The Human Rights Monitoring Mission in Ukraine (HRMMU) verified, as of September 18th, at least 14,532 civilian casualties. Over half of the civilian casualties (56 percent) continued to be recorded and verified in the eastern Ukraine. HRMMU also stressed that it believes the actual figures are much higher (HRMMU, September 2022).

On top of casualties, particularly concerning is the reported extent of damages to basic infrastructure in the country. The UN Satellite Centre (UNOSAT) reported in Mariupol and Donetsk oblasts about three quarters of the buildings sustained different extent of structural damages, mainly for residential buildings, grocery shops, schools, pharmacies, hospitals and community centres (OECD, TT5, 2022). Indeed, extensive infrastructure damages, disruptions of supply chains, and interruptions to Black Sea shipping have forced Ukrainian businesses to cease activities or relocate away from war zones. In some areas, mainly in the east of the country, up to half of businesses have ceased operations since February 2022 (OECD, TT5, 2022).

Furthermore, the Ukraine Energy Ministry updated on September 20th that, in spite of the continuous work to restore power supplies disrupted by the war, they expect almost one million households and businesses across Ukraine to remain without power, most of which in Donetsk, Kharkivska, and Luhanska oblasts (UNOSAT, September 2022). Moreover, the Energy Ministry and the International Rescue Committee (IRC) raised concerns about the lack of gas supplies, alerting that this gas shortage may further compound Ukrainians capacity to cope with the harsh winter (IRC, 2022). Additionally, aboveground heat pipeline networks are exposed to damage from artillery shelling and air strikes, which could have implications for the preparedness of the heat network for the upcoming winter period (REACH, August 2022).

Overall, the levels of needs assessed by various stakeholders remain clear: priorities are identified as medicines and fuel, CVA, infrastructure repairs, and livelihoods support.

Persons with disabilities and older persons¹ in Ukraine

The UN Convention on the Rights of Persons with Disabilities (UNCRPD) reads “disability is an evolving concept” (UNCRPD, 2006, p. 1); in article one of the Convention, persons with disabilities “include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others” (UNCRPD, 2006, Article 1, p. 4). The CRPD conceptualization looks indeed at the environment in which the persons with disabilities live and the barriers that they encounter as the main source of vulnerability. This is heightened during humanitarian crises, where barriers lead to exclusion, thus increasing the threats and vulnerabilities for persons with disabilities compared to the rest of the population (IASC 2019). While the purpose of the Convention is not to provide a definition, but rather defining a concept,

¹ For the purpose of this study, older persons were defined as anyone aged 60 or above.

WHO reports that conceptualization of disability is “complex, dynamic, multidimensional and contested,” (WHO and World Bank, 2011, p. 3) WHO estimates at least 15 percent of the world population experience disability and 3 to 4 percent experience significant difficulties (WHO, 2011, p. 27-29).

To be noted, however, that there is no accurate prevalence data, and that the registration of persons with disabilities in Ukraine is based solely on medical records: people need to obtain official medical certificates, from recognized institutions, to be able to enter the governmental system of support. This is in contrast with the legal framework provided by the CRPD, which Ukraine has ratified, as noted by OHCHR in its observations from the Committee on the Rights of Persons with Disabilities (OHCHR, 2015, p. 2). The process of registration is guided by Cabinet of Ministers’ Resolution 1317 dated 03/12/2009 and its implementational decrees. This is a process often hindered by physical, financial, and administrative barriers (UN 2021). Three degrees of disability are defined and recognized by the GoU for certification of adults:

- Group I includes people with incapacity for any work and that require constant attendance
- Group II includes people with incapacity for any work but that do not require constant attendance, and
- Group III includes people with incapacity for usual work (Sojka et al., 2022).

A different system is in place for children, where a medical opinion, issued by a dedicated “Medical Advisory Commission”, is produced based on medical records. Children's disability recognition system does not result in assignment to groups (Order of the Ministry of Health 04/12/2001, No. 482).

Indeed, the latest census data and broader assessments lack a disaggregation for persons with disability, which may affect the perception of barriers to accessing available services, specific needs, and overall related socio-economic implications.

To date, there is no accurate data on the number of persons with disabilities in need of humanitarian assistance and the barriers they face. Prior to the escalation of hostilities in February 2022, 2.7 million people were registered in Ukraine as having some kind of disability. According to the website of the Ministry of Social Policy, among the 2.7 million persons with disabilities in Ukraine, 222,300 people are registered in disability group I, 900,800 people are registered in disability group II, and 1,416,000 people are registered in disability group III; additionally 163,900 are children with disabilities (MoSP website). However, there is unclarity around the numbers provided and disability determination. The number is corresponding, according to secondary data, to between 20 and 25 percent of the assessed households to date (IOM, 2022). This would already represent a ten percent increase compared to the data from OCHA from prior to the Russian invasion of Ukraine (HNO, 2022), however, there are no means to test their comparability, sample size, and questionnaire. The estimated numbers increased with the reported needs, particularly considering that persons with disabilities are more likely to remain in their home villages, towns and cities even with conflict ongoing (Mercy Corps, 2022; OECD, TT5, 2022), and may face additional challenges related to the lack of accessible transport, accessible evacuation, lowered availability of social support services, support persons, diminished households’ financial capacities and/or similar (UNPRPD, 2022). This might lead to issues in accessing safe shelters, with access to food, water and sanitation also threatened (OECD 2022). However, there are no up-to-date (after February 2022) reliable figures on the numbers of persons with disabilities, their unmet needs, and barriers encountered.

Additionally, Ukraine has been experiencing a trend of ageing during the recent past. Reasons are to be found in the high ratio of pensioners to working-age citizens (40 percent), low fertility rates, and high levels of outbound emigration. OECD (TT5, 2022) data report that between 70 and 80 percent of elderlies in the country, mostly women, live below the national poverty line, and face challenges in covering their most basic needs.

The current war is driving at-risk groups, including persons with disabilities and older persons into further worsening of their socio-economic situation. A trend which is further accelerated and exacerbated by the partial or full damage of key social funds and community infrastructures, such as hospitals, schools, and community centres, which led to reduced capacities in reaching and assisting the most at risk. Additionally, the decline in the number of social workers and the movement limitations imposed by the situation, especially in occupied oblasts, have an additional negative impact on older persons and persons with disabilities (OECD, TT5, 2022).

In this regard, it is also important to consider that households with persons with disabilities not only face additional monthly costs (e.g., routine healthcare treatments or medication, specialised transportation and its related costs, specific services, etc.), but also have “*indirect costs*”, mainly associated with an overall lower income capacity and level, opportunity cost for caregivers where there are no free or subsidised support provided by social workers, barriers to accessing education or retaining employment, etc. (UNPRPD, 2022). In such circumstances, while CVA, specifically the Multi-Purpose Cash Assistance (MPCA), remains critical to bridge some gaps and meet the most basic urgent needs of a household, to complement to the extent possible with the government assistance provided through the Social Protection programs. However, because of the depreciation of the UAH, high inflation rates, levels of needs of and persons with disabilities and older persons, and overall income losses, it is difficult to understand the current effectiveness of the existing state-programming.

Social Protection in Ukraine

Social Protection schemes in Ukraine are led by the Ministry of Social Policy (MoSP), but are increasingly devolved to regional (Oblast) and district (Rayon) authorities in line with the decentralisation policy of the Government of Ukraine (GoU) (Smusz-Kulesza 2020, Sojka et al. 2022). Under the MoSP, the Central Agency (CSNAP) implements policies and programmes at national level and coordinates services across the country; at district level (Rayon) there is the Territorial Agency (TSNAP), while Community Centres of Social Services (CCSS) and Social Service Centre for children, family and youth (SSCCFY) are active at Hromada level for service delivery. In 2020 (most recent available data) the Ukrainian government spent around 23 percent of its budget on Social Protection (UkrStat 2020), with pensions accounting for more than half of the total expenditures. However, as noted by the UN: “overall lack of transparency, weak targeting and low coverage and quality of support undermines the effectiveness of Ukraine’s Social Protection expenditure in reducing poverty and inequality” (UN 2021).

In 2021, through Cabinet of Ministers’ decree n. 404 of 14/04/2021, the government of Ukraine set up a “Unified Information System of the Social Sphere” (UISSS) to develop a centralised social register and enable online applications of whomever needs assistance (Sojka et al. 2022). UISSS is connected to a portal (DIIA) that allows citizens to submit applications and interact with the state systems in a digital manner. The Government of Ukraine has established the eDopomoga (There is Help) portal as well, with the aims of connecting state, volunteer, and international organisations and facilitation request and provision of assistance to those affected by the Russian invasion (CWG TT5).

According to a recent statement from the Minister of Social Policy, the establishment of the UISSS has proven very practical in ensuring a rapid Social Protection response to the current crisis (MoSP website, September 2022). A centralised data repository with information about the status and needs of persons with disabilities is supposed to exist in Ukraine. The disability data repository has merged, along with other fourteen databases, into the UISSS after its establishment. Disability data, however, were already incomplete in the original databases due to a lack of clear regulation for data collection, non-comprehensive definitions of eligible cases, and the lack of disaggregated data (Smusz-Kulesza, 2020). This still represents a challenge for what it concerns comprehensiveness and accountability of the final combined UISSS, particularly considering that Social Protection benefits in Ukraine are primarily based on medical conditions, age, employment, or residency status, and paid at individual level, not at household level. In fact, most Social Protection schemes in Ukraine use categorical targeting. Among

the former categories, it was common to have disability-related features, mainly related to different transfer values. Accordingly, the main war-related cash-based SP programme, the “IDP and Conflict-Affected People Emergency Support Housing Allowance Programme” has different amounts for persons with disabilities (and children) compared to the rest of the population (CWG TT5).

In regard to Social Protection schemes for persons with disabilities and not related to the conflict situation, the programmes are regulated by the Law of Ukraine “On Fundamentals of Social Protection of Persons with Disabilities in Ukraine” No. 875-XII of 21 March 1991 and Decree of the President of Ukraine “On Measures Aimed at Ensuring Observance of the Rights of Persons with Disabilities” No. 553/2016 of 13 December 2016. According to the law, the category of disability (I, II, III) and the reason for disability are the factors that determine the possibility of registering for Social Protection benefits, as well as the size and duration of the assistance (Smusz-Kulesza, 2020). Three main cash-based Social Protection schemes for persons with disabilities prior to February 2022 are (Gnatenko et al. 2021 in “Sojka et al. 2022”):

- Disability Pension paid to persons registered under all groups (I, II, III) - disbursed to around 456,000 persons (Blin et al. 2022).
- Complimentary caregiver allowance paid to an unpaid caregiver of a person with a Group I disability as part of the government’s Social Protection schemes.
- Social Pension (disability), a mean-tested pension paid to low-income citizens who may have some degree of disability but are ineligible for disability pension or work injury benefit.

Similarly, cash-based schemes for older people follow the same scheme, i.e. Old-age pension, Caregiver allowance - older persons, Social pension - old-age (Gnatenko et al. 2021 in “Sojka et al. 2022”, CWG TT5). A mapping of Social Protection schemes for persons with disabilities is annexed to the report (Annex A).

Since the Russian invasion in February 2022, the Social Protection system in Ukraine seems not only to have remained functional, but to have been able to quickly expand to absorb the emerging and increased needs (Fultz and Arnone, 2022). This could be due to the delivery mechanisms used by the government; the Social Protection benefits are disbursed either through the State Savings Bank of Ukraine (JSC “Oschadbank), or through the post office JSC “Ukrposhta”, which remained fairly functional throughout the Russian Invasion of Ukraine (Blin et al., 2022). To support its humanitarian efforts, the MoSP has set up a “humanitarian account” in the National Bank of Ukraine (NBU) from which it disburses emergency assistance to citizens in need. At the time of writing (November 2022) the MoSP reports having spent 462,536,131 UAH (12,529,697 USD) from this account to support 1,236,921 people (MoSP Dashboard)². In April 2022 the government announced that it would not stop the payments for the whole period of martial law, and one month beyond (World Bank 2022). Overall, in 2021, Social Protection expenditures (not only related to disability) constituted almost 125 billion UAH of the state budget (CWG TT5).

In addition to ongoing programmes, conflict-related schemes, that were either existing following the initiation of the hostilities in 2014 or that have been set up following February 2022, constitute one of the backbones of the government’s aid to Ukrainian citizens. While persons with disabilities affected by the war can access assistance through established Social Protection schemes, the flagship IDP support programme “IDP and Conflict-Affected People Emergency Support Housing Allowance Programme” provide higher transfer values for persons with disabilities. The value is 1,000 UAH higher than for the rest of the population (World Bank 2022, CWG TT5). The IDP shelter programme, as all Social Protection schemes in the country, is funded by the government budget and managed by the MoSP territorial and local structures (Blin, 2022; CWG TT5).

² Access on 25/11/2022, <https://www.msp.gov.ua/content/dashboard.html>

Humanity & Inclusion's response in Ukraine

Handicap International - *Humanity & Inclusion* (HI) works alongside persons with disabilities and vulnerable populations, taking action and bearing witness in order to respond to their essential needs, improve their living conditions and promote respect for their dignity and fundamental rights.

HI is promoting the inclusion of persons with disabilities in Social Protection systems in line with article 28 of the UNCRPD "Adequate standard of living and Social Protection", including the right to mainstream Social Protection schemes and to "ensure access by persons with disabilities and their families living in situations of poverty to assistance from the State with disability-related expenses". However, there is limited global evidence of tried, tested, and operational inclusion mechanisms in Social Protection systems (SPACE, March 2021). HI is working alongside fellow actors responding to the emergency to help implement inclusive humanitarian aid and ensure that populations experiencing the most risk can access vital resources. Inclusive needs assessments and targeting mechanisms can promote better access to people with disabilities and their families in need of core services and commodities to meet their most basic and urgent needs. Inclusion is the act of creating environments in which any individual or group can be and feel welcomed, respected, supported, and valued to fully participate. "Full and effective participation and inclusion in society", is a fundamental principle of the UNCRPD, 2006, Article 3, p. 5. Additionally, "the inclusion of persons with disabilities in Social Protection systems is not only a human rights issue, but also a crucial investment for development that States cannot afford to miss," (UN General Assembly, 2015, V., 87, p. 24)

Inclusive humanitarian action has a twofold scope for field programming that includes both the continuous and consistent mainstreaming of disability-inclusion across the program cycle of humanitarian response, including during preparedness, assessment, design, targeting, distribution, and monitoring, and the targeted interventions specifically aimed at ensuring persons with disabilities have access to specific requirements, such functional rehabilitation or assistive technology (IASC 2019). HI aims to optimise the effect of the assistance towards ensuring achievement of equitable outcomes for persons with disabilities. IASC (2019) identifies four "must-do" actions that provide a solid framework for programming. Those include: Promotion of meaningful participation, Removal of barriers, Empowerment of People with Disabilities, and Disaggregation of data for monitoring inclusion.

HI's emergency response applies the twin-track approach. On one hand, this includes the identification and removal of attitudinal, institutional, communication and environmental barriers in emergency response design, adapting targeting and assistance delivery modalities. On the other hand, HI promotes and implements responses that address the specific requirements of vulnerable households, including households with persons with disabilities and older persons, through the provision of physical and functional rehabilitation services (including the provision of assistive mobility devices such as wheelchairs, canes and walkers), psychosocial support, empowerment and protection related activities, explosive ordnance risk education, and basic needs support through CVA and in-kind distributions, among other initiatives. In order to meet the most immediate needs of vulnerable populations, HI prioritises the distribution of MPCA to ensure full coverage of basic needs and to uphold the dignity and preferences of affected populations.

CVA framework in Ukraine

Since the onset of the war in eastern Ukraine, the use of CVA has been a pivotal component of humanitarian operations in the country, particularly in Government-Controlled Areas (GCA) where markets and financial service providers (FSPs) remained functional. While different clusters advised different possible sectoral CVA approaches, Multi-Purpose Cash Assistance (MPCA), with possible top-ups, has been the most appropriate and frequently used method across the humanitarian community to meet the population's most urgent needs. The determination of a MPCA transfer value for harmonised humanitarian operations has been facilitated by the Cash Working Group (CWG) since 2016 (CWG formed in 2016). As of February 2nd, 2022, the CWG partners endorsed the new transfer

value, and agreed that in case of emergency or rapid response it should cover 100 percent of the income gap. This corresponded to an amount of UAH 2,220 per person per month³, with the recommendations of the Inter-Cluster Coordination Group (ICCG) and Humanitarian Country Team (HCT) for MPCA to be the default modality in GCA for a period of three months, to accompany and reinforce service delivery interventions (Ukraine CWG, February 2022). As of November 2022, MPCA was delivered to over 4.3 million people in 26 Oblasts of Ukraine by 59 humanitarian organisations. The total volume of MPCA assistance, at the time of writing, stands at 930 million dollars (CWG, Multi-Purpose Cash Information Dashboard, accessed 25/11/2022). Humanitarian organisations opted for blanket distribution as the targeting strategy for households in emergency situations (newly displaced, residing in conflict-affected areas, affected by shelling), while setting some basic socio-economic and categorical criteria for longer term support (CWG TT1, August 2022). From the onset of the escalation, most humanitarian agencies have relied on government lists for targeting (CaLP, 2022).

Yet, the war has already inflicted devastating economic and social losses to Ukraine. An estimated 4.8 million jobs have been lost, some 30 percent of pre-war employment. Further military escalation could lead the number of job losses to increase to some 7 million. Thus, the gap analysis for the currently used MPCA transfer value, which was undertaken in August-September 2021, thus months before the Russian invasion of Ukraine on February 24th, 2022, and not revised afterwards, may not be as grounded in the reality of the context as it should. It is possible to assume that, since then, the income levels changed, and that, as a consequence, the transfer value is no longer reflecting the level of needs of the affected population.

A recent report from CALP (August 2022) reported concerns on some key aspects of CVA programming in the Ukraine response. While not mentioning explicitly “people with disability” the report (produced by the Learning Group established under the Ukraine CWG) highlights how the vast use of digital self-registration platforms pose accessibility issues for those with low digital skills. Additionally, the research points towards the issue of ongoing blanket targeting for IDPs, which fails to consider status-specific vulnerabilities - such as disability, including the socio-economic impact of those. Finally, local organisations, which might refer to OPDs as well, were not always involved in supporting local registration of people for humanitarian support, which might have further hindered people with disabilities’ access to aid and support (CALP, August 2022).

On top of the above, just a few resources featuring sections on the topic of inclusivity of CVA in humanitarian settings were developed over the recent years. The concept of inclusive CVA refers to the continuous and consistent mainstreaming of disability across the cycle of CVA activities, including during preparedness, assessment, design, targeting, distribution, and monitoring, with the purpose of optimising the effect of the assistance towards ensuring achievement of equal outcomes. In order to bridge this information gap, HI called for a consultancy to analyse these technical aspects and provide recommendations for both internal programming and for the broader humanitarian coordination, factoring:

1. The need to consider extra expenditures associated with disability status, such as special healthcare and medications, specific food and hygiene items, assistive devices, and home-based care (CBM 2021, IASC 2019, HI 2021, NAPD 2022).
2. The need to assess the impact of different kinds and severity levels of disability on the amount of resources needed (CBM Global Disability Inclusion, 2022), and how this leads to disability-related costs to be very diverse (ILO 2020)
3. The need to factor both direct and indirect costs in the calculation of extra support (HI 2021, ILO 2020, NAPD 2022).

³ The value in USD varied during the response because of the depreciation of the national currency from roughly 74 to 60 USD.

4. The need to assess the potential increase in the income gap (HI 2021, ILO 2020) is strictly connected to the worsening economic conditions and access to livelihoods, coupled with possible increased levels of needs.
5. The need to consider mixed modalities, especially in regard to assistive devices (in-kind) and personalised care (service provision) (CBM 2021, HI 2021). Availability of goods in the market, and specification and type of items needed, are factors that might make CVA not the preferred option. Flexibility of transfer modalities, a key principle that stands for all kinds of CVA interventions, must be embraced as well when delivering CVA to persons with disabilities.

Linkages and collaboration with Social Protection schemes are also crucial in the design and implementation of cash assistance to persons with disabilities.

Methodology

Research questions

Based on what described above, this research aimed to answer the following questions:

- a) What are the barriers and the enablers to make CVA humanitarian assistance in Ukraine be more inclusive for people with disabilities and older persons?
 - i) What are the barriers encountered by persons with disabilities and/or older persons in accessing MPCA?
 - ii) Is the current MPCA transfer value factoring specific needs of older persons and persons with disabilities, resulting in both direct and indirect costs?
 - iii) Is the current transfer value adequate to meet the needs of households with members with disabilities or older persons?
 - iv) What is the difference in need and monthly expenditures of households with and without members with disabilities?
 - v) Are there additional services provided to households with disabilities or older persons or members? And are these provided equally in spite of IDP status?
 - vi) Should there be a top-up to bridge any gap? And if yes, how much? Or if not, what other modalities of assistance should be prioritised or integrated in the broader humanitarian response?

- b) Is the government's Social Protection (SP) system in the position of continuing supporting households with members with disabilities?
 - i) What services are currently available and/or free of charge for people with disabilities and older persons and in Ukraine? And did they remain accessible in the aftermath of the Russian invasion of Ukraine?
 - ii) What is the current eligibility framework for the government SP system?
 - iii) How much is the government currently providing or planning to provide moving ahead as part of the SP scheme?
 - iv) What is the extent, if any, of the gap that could be forecasted for the SP system moving forward?
 - v) How can humanitarian actors support in the short and medium term in bridging this gap?

Each of the above mentioned research questions and sub-questions was addressed through a mixed method of data collection, triangulating findings of the quantitative component with qualitative interviews, focus group discussions, as well as available literature.⁴

Secondary data and literature review

In order to have a more comprehensive understanding of the context and information available prior to the beginning of data collection and minimise the data to be collected in respect of global data protection guidelines, the study included extensive secondary data and literature review. This was facilitated by HI through internal documents regarding ongoing programs and projects in Ukraine, as well as by the information sharing mechanism within coordination bodies, namely: task teams (TTs), Cash Working Group (CWG), Collaborative Cash Delivery Network (CCD), and informal discussion groups. However, while there is extensive literature available on Ukraine, data and reports selected were limited to those produced after the Russian invasion of Ukraine on February 24th, 2022, and particularly for documents regarding implications of the war on older persons and persons with disabilities. This was mainly aimed to gather information on the current conditions, needs, and expenditures of actual and potential affected persons.

Quantitative data collection, household (HH) level survey

In regard to the calculation of disability extra costs, primary data collection focused on both expenditures and actual needs of the assessed population, as limited financial resources may indeed compound people's capacity to spend on healthcare and other needs (Leaving No-one Behind: Building Inclusive Social Protection Systems for Persons with Disabilities pg. 167). This was in line with approaches identified by the Good and Services Required (GRS) method,⁵ and considering the framework provided by the IASC guidelines on inclusive humanitarian action (2019). A total of 242 randomly selected households from HI's existing caseloads were surveyed between October 26th and November 5th using a structured questionnaire⁶ translated in Ukrainian. Because of the location of the assessed households and concerns regarding safety and security of the staff, data collection occurred remotely, via phone calls. Data collection was conducted by six enumerators hired locally and trained in advance by the consultants on quality data collection. The training occurred online with the support of a translator English-Ukrainian, and it addressed general best practices in data collection, rights based approaches, appropriate communication modalities, data protection and consent, the Washington Group Questions, and the tool itself.

In this regard, respondent households are differentiated by the presence of either an older person or a person with disabilities as per the use of an adapted version of the short set of question of the Washington Group (group one), with more than one person either with disabilities or aged above 59 years old (group two), or with neither (group zero). Those in "group two" define whether the increased costs or the reduced income follow a linear or exponential increase, while people belonging to "group zero" serve as a control group for the study. For the purpose of this study, the short set of Washington Group (WG) set was expanded, by adding an "other" components for categorical medical conditions, and by dividing difficulties walking or climbing steps into two categories (paralysis or quadriplegia in one category, and absent or impaired limb in another) to better capture possible consequences of

⁴ A summary of approaches per research question is presented in Annex B.

⁵ An overview of the methods taken into consideration for the purpose of this study, for the calculation of extra costs for disability, can be found in "Considering the Disability related Extra Costs in Social Protection" (ILO et al, 2020), pag.7 <https://www.social-protection.org/gimi/RessourcePDF.action?id=56925>

⁶ Tool can be found here: <https://ee.kobotoolbox.org/x/6ppQL7bi>

escalations and war. No severity level was factored in the analysis for data minimization policies, as they were already assessed by HI.

Table 1: interviewed households, by group

Group	ID	Count	Absolute	Percentage
Group 1 (one person with disability)	1D	77	129	32%
Group 1 (one older person)	1E	52		21%
Group 2 (more than one person with disability or older person)	2	68	68	28%
Group 0 (control group)	0	45	45	19%

The sample size was defined to guarantee sufficient and equitable representation of the three groups (0, 1, and 2, with over half of the respondents falling into group 1 to better assess the implications of the war on persons with disability or older persons), and an overall 90/5 Confidence Interval/Margin of Error on the existing caseload. Incidentally, just a few households from the sub-group 1E (older persons) reported cases of disability, and when they reported any, it was affecting the older person themselves, not other members. In order to have some representativeness of the results, these cases still fell under the sub-group 1E, and the consultants did not create a different subset just for these HHs.

Considering that there may be a correlation in expenditures and net-income ratio for households with an older person or a person with disability, data from the “group one” are, where needed, further disaggregated to investigate similarities or sharp differences across these two pre-identified sub-groups (1D referring to those in group 1 with disability and 1E where those in group 1 are elderly). Same was applied to the sex of the head of household. Yet, due to limited resources, the study did not stratify the sample based on the sex, but rather investigated differences within “group one” with sub-groups 1F and 1M upon need. Furthermore, selected indicators were disaggregated by the Washington Group Question (WGQ) set, in line with Tibble’s suggested comparative approach (2005) to identify differences and gaps between groups and strata.

Geographical areas of the respondents were defined by the sample, and more broadly by HI’s areas of operation in the country. While this approach may limit representativeness on the broader discussion, it enables timely assessments and data turn-around, in order to complement existing CVA revision efforts at country level by coordination bodies, by still providing indicative data.

Data were cleaned and analysed by the consultants in the days following the end of data collection.

Qualitative data collection

For the second objective of the study, the adopted methodology is primarily qualitative, complemented by some of the data collected through the HH survey tool. While secondary data review was conducted to provide the basis of the analysis, especially in regard to the system existing prior to February 2022, the bulk of information was extracted through in-depth Key Informant Interviews (KIIs). These were conducted with both representatives of the humanitarian community and, more importantly, local actors

from the Ukrainian Social Protection sphere, including representatives of OPDs, speaking on behalf of persons with disabilities.

The selection of KIs was guided by both general experiences and knowledge on the topics assessed (i.e. disability, Social Protection, humanitarian CVA), and by the Ukraine-specific relevance of the informant (i.e. local, on-the-ground actors, possibly involved in both the pre- and post-February 2022 operations). Qualitative findings were not weighted, but particular attention was given to answers provided in their respective areas of expertise (i.e., barriers and enablers to accessing resources for OPDs, Social Protection for the National Assembly of Persons with Disabilities and Social Protection specialists, etc.).

Throughout quantitative data collection, the consultants ran in-depth interviews with 27 KIIs,⁷ and two Focus Group Discussions (FGDs) with organisations for persons with disabilities (OPDs). The original list of key informants has also been expanded through a snowball sampling, where respondents were asked to identify at least two or three other people who should be included in the study. Where challenges were faced due to language barriers, the interviews were conducted with the support of an ad-hoc translator (e.g. national actors, organisations of persons with disability, etc.). Findings, suggestions, advice, and perceptions of the respondents have been included in the narrative report as they fit, and aided triangulation of gathered information for better informing conclusions and recommendations.

In regard to the development of messages and external communication, in consultation with HI and selected OPDs, strong evidence based material (two-pager) to be used for external communication has been developed. Additionally, the results will be circulated through solid information sharing at coordination level presenting core key findings, thus in order to facilitate discussion and increase buy-in of the recommendation of the study. Collaboration with OPDs is key to ensure appropriateness, relevance, and strengthen buy-in of the messages and results.

Finally, preliminary findings were presented and discussed in a workshop by the end of data collection and data analysis with relevant stakeholders and affected persons, and then core aspects of the discussion and feedback received were incorporated into the narrative report.

Limitations

This study was conducted with a mixed method approach, accounting for both qualitative and quantitative data collection. The quantitative component, however, because of limited resources, access difficulties, and timeline constraints dictated by broader coordination groups and discussions ongoing, is statistically representative just at HI caseload level. Furthermore, because respondent HHs were sampled randomly based on “group”, and thus the proportion of HHs by age, sex of the head of HH, IDP status, or disability type was not factored in the sampling, there may be demographics characteristics more predominantly present than others. Within the groups, persons with high levels of functional difficulties, or hearing, speech, communication, psychosocial and intellectual difficulties may not be accurately represented as the proportion of persons with physical disability was disproportionately higher than any of the other sub-groups. Furthermore, no individuals currently residing in institutional settings were assessed in this study, as they may have different expenditures and administration processes of their income.

Indeed, all data and findings presented hereby are generalisable to the broader population, but they should be considered **indicative**, and with a bias towards persons with physical disabilities. Moreover, it should be considered that the proportion of IDPs and persons with disabilities does not necessarily

⁷ The consultants ran 20 interviews with a total of 27 people, including social workers, representatives of OPDs, experts and technical advisors, etc.

reflect the reality of the Ukrainian context, as the sample was taken from existing caseload level, and it was thus influenced by HI's targeting criteria and broader mandate.

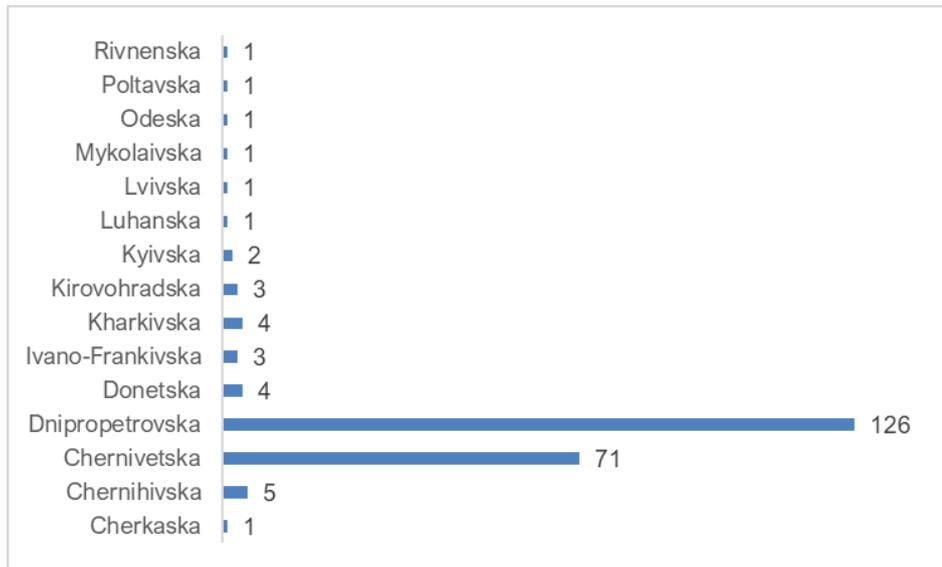
Data collection and interviews were conducted immediately after the October escalations, which may have affected people's perceptions about accessibility of assistance and government-provided services throughout the country. This was factored in the analysis, and followed upon via qualitative interviews.

Finally, it should be factored that the consultants are cash experts, and the limited inclusion and Social Protection technical knowledge may have impacted how questions were asked and analysed. In order to mitigate this lack, all tools were designed in consultation with HI's inclusion, basic needs, and Social Protection specialists in the headquarters.

Key findings

Quantitative data presented below were, with few exceptions, analysed at country-level. In the vast majority of cases, however, respondents were based in either Dnipropetrovska or Chernivetska. A total of 28 respondent households, however, were based in different oblast across the country, after either return or secondary displacement.

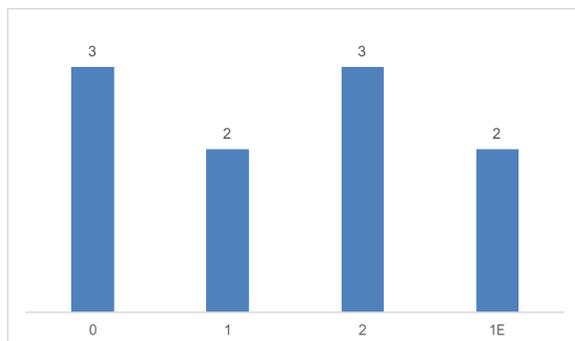
Figure 1: number of respondent HHs, by Oblast



Demographics

Households (HHs) assessed for this study showed a median average household size of 2.6 members, which is in line with the latest country-level analysis.

Figure 2: average HH size, by group

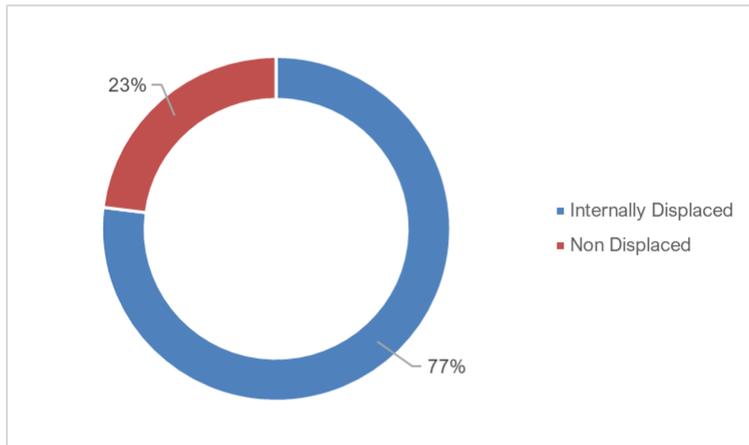


This, reportedly, included both nuclear and extended family members living within the same shelter and sharing resources. In a few cases, the household size was well above this median average (max reported was 13 members) where unaccompanied children were supposedly taken in either temporarily or permanently (with the maximum number of children in the household composition reported as six (against the national average of one)).

As expected following context analysis, 79 percent of the assessed households were female-led⁸, which again corresponds to the latest reports and overall conditions imposed by adult-male conscription. The average age of the respondents, on the full caseload, was 55 years old, with a two-years difference between male headed households and female headed ones (56 and 54, respectively).

⁸ Household in which an adult female is the sole or main income producer and decision-maker. According to the ILO Thesaurus (2005), this could be due to the absence of adult males in the household composition owing to divorce, separation, migration, non-marriage, or widowhood. In few cases, although an adult male is present, the female remains the head of household should the men not contribute to income or decision making processes.

Figure 3: percentage of respondent HHs, by IDP status

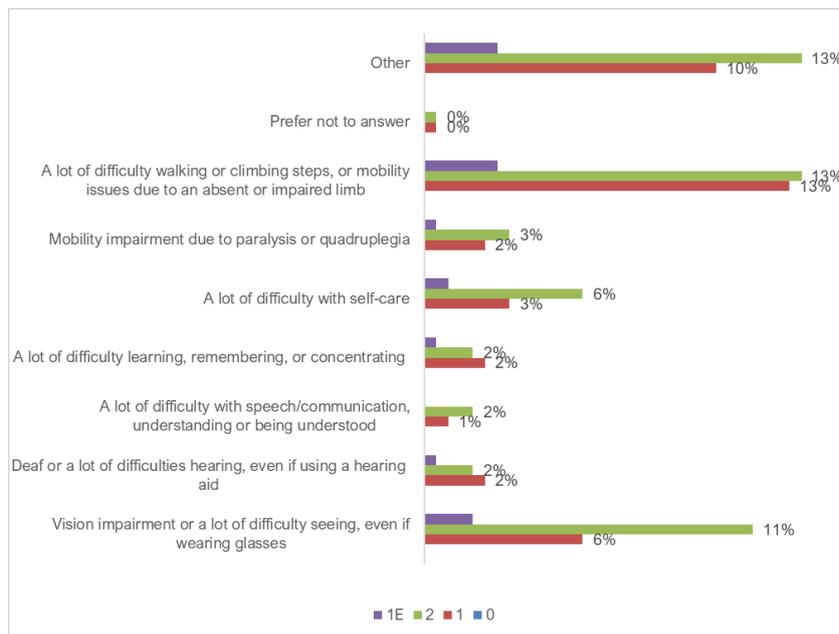


Furthermore, 78 percent of the assessed households are currently internally displaced persons (IDPs).

The proportion of IDP households is in line with recent data, as about half of the respondents were located in Dnipropetrovska (126 HHs), about a quarter in Chernivetska (71 HHs), although, because of the sample conducted based on HI's existing caseloads and their internal targeting criteria, the proportion was higher than the one reported at country level.

Disability status

Figure 4: Percentage of HHs reporting a person with disability, by disability type



Out of the total sample of 242 HHs, a total of 82 respondents (head of HHs) reported having a disability, and 79 HHs (with a partial overlap) reported having at least one member from the HH with a disability, with a maximum reported of three persons within the same HHs and 235 individual disabilities recorded.

As presented in the figure, the most frequently reported types of disability are difficulty walking or climbing steps and mobility issues due to absent or impaired limb (29 percent), other

types of disability not properly captured in the Washington Group Question set (26 percent)⁹, and vision impairment or difficulties seeing even wearing glasses (19 percent).¹⁰

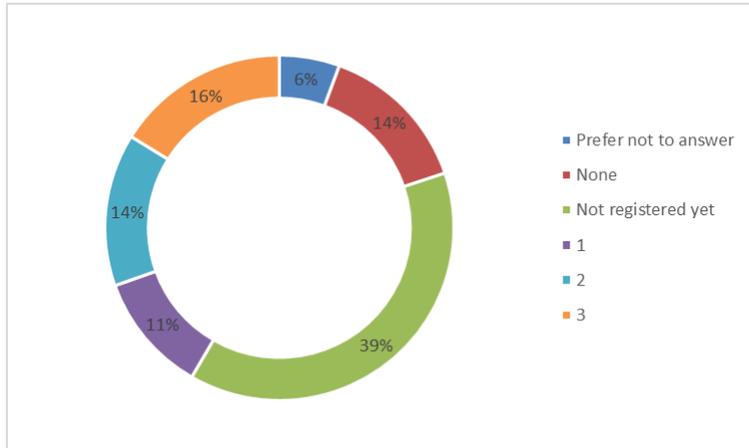
Reportedly, there is fear of the prevalence of persons with physical disability to increase in the upcoming months, which was reported and feared by one key informant (KI 9), due to the presence of unexploded ordnances (UXOs) in conflict active zones. While the 29 percent of persons reporting difficulties walking or climbing steps due to absent or impaired limb does not automatically link to the presence of UXOs or shellings in general, it would be interesting to further investigate the changes in its prevalence at country level once more data will be available. Yet, according to the KIs perceptions and assumptions,

⁹ Reportedly, the percentage of persons reporting a disability not included in the list ("other", 26 percent) refers to persons with a disability that is recognized by the categorical medical approach of the current Social Protection system (e.g., diabetes), but that is not captured in the WGQ.

¹⁰ This is not an actual representation of the proportion of HHs with a member with a disability in Ukraine, as it may have been affected by the sampling based on HI's programming in the country.

the percentage may increase, although some may be just temporary. The Focus Group Discussion with OPDs further confirmed this assumption, with increased presence of persons with temporary or permanent disability in conflict active areas. Indeed, almost all of respondents who reported an absent or impaired limb stated they have not registered their disability yet in the government official system, or, those who did, received a level three (mild cases of severity). Furthermore, it is worth noting that the prevalence of persons with psychosocial difficulties may also increase, as war-related trauma, displacement, losses, and other factors directly linked to the war may play a pivotal role, and these were not properly captured in the analysis.

Figure 5: percentage of HHs, by registration level/status of disability in the Social Protection system



In terms of registration with the national Social Protection system, 41 percent of the HHs who reported having at least one person with disability were registered in the system, falling between category 1, 2, or 3 in almost equal proportion.¹¹ Admittedly, 39 percent of the respondent HHs have not registered yet, and six percent preferred not to answer. Finally, 14 percent reported not being registered at all (either choosing not to or not having necessary documentation to do so).

Investigating this group more closely, 65 percent are IDPs, 61 percent of them are older persons, and in just one case the non-registered disability affected a child aged between 3 and 12 years old. In terms of disabilities, 23 percent reported having a lot of difficulty walking or climbing steps, or mobility issues due to absent or impaired limb, 18 percent reported vision impairment or a lot of difficulty seeing, even if wearing glasses, 5 percent difficulties with self-care, 3 percent respectively hearing difficulties and quadriplegia. However, 50 percent reported “other” disabilities, and it remains to be investigated whether this refers to functional limitations and environmental factors that impair their lives but are not listed in the Social Protection schemes and their application was rejected, due to lack of documentation to prove it, preferences of applying to different exclusive schemes (e.g., retirement or pension) because higher in amount, or for any other reason. Indeed, this may represent a demographic group to closely monitor for further assistance needed in the longer run, should they not have the capacity to obtain the necessary documentation to actually receive Social Protection assistance.

Socio-economic conditions¹²

Considering the overall caseload, the study assessed average levels of income by source, and monthly expenditures by sector. On average, HHs assessed reported earning 9,930 UAH in the 30 days prior to data collection, but with reported expenditures amounting to 11,250 UAH. This left them with a negative net-income ratio of about 1,300 UAH. In line with these findings, several KIs, and more significantly the local organisations of persons with disabilities included in the study, reported that persons with disabilities are generally poorer than the rest of the population. Many pointed out however at differences

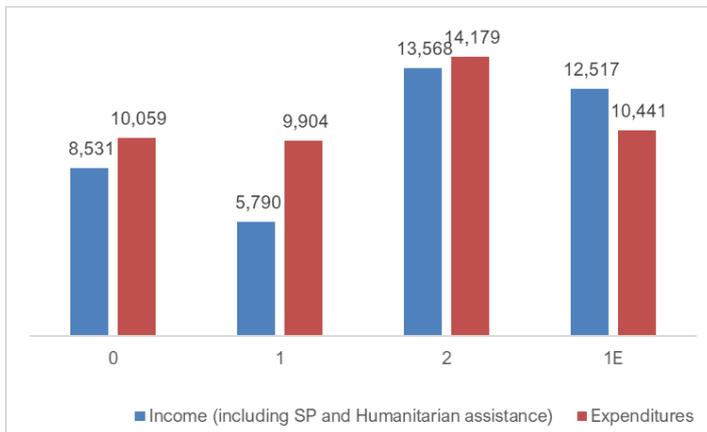
¹¹ The government system categorises disability into three levels of severity (1, 2, and 3), with level 1 being the most severe with highest assistance delivered, and level 3 the least severe.

¹² The survey included a question on how confident about the response provided the respondents were. As the vast majority of them (92 percent) reported being either very or mildly confident, the average numbers presented in this section are mean averages, not median.

based on regions and areas, as well as on displacement status. However, the gap varies when data are disaggregated by group.

When investigating the sources of income, the main considerations occur around the provision of government Social Protection, where in fact households in group 1 receive about 4,000 UAH per month, and households in group 2 receive almost twice as much, likely because of the greater number of persons with disability in the HH, and thus multiple individual assistance received.

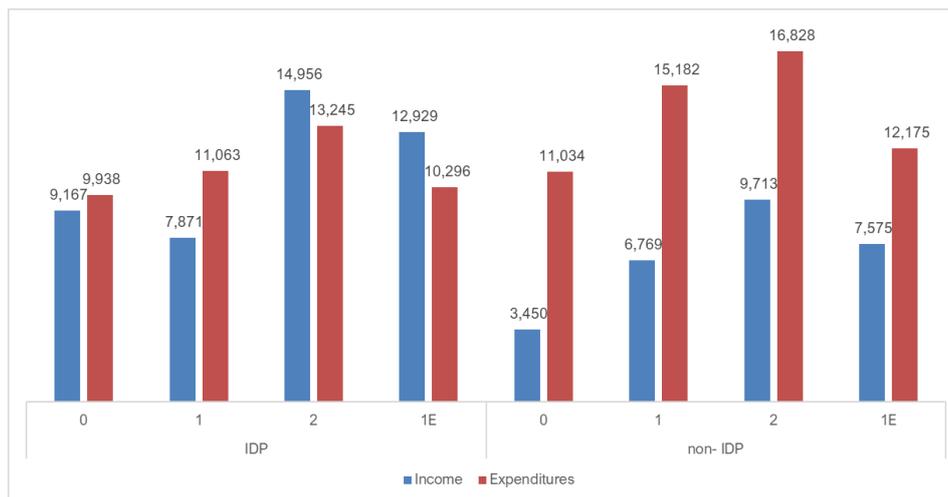
Figure 6: average reported income in the 30 days prior to data collection and monthly expenditures, by group



This justifies the differences between groups. Yet, differences are also noticeable in the amounts received through stable employment and the informal support received from the community and friends. Information gathered through key informants, however, underscored that the majority of persons with disability live below the poverty line (KI 8).¹³ While data point toward a slightly different result, this still raises concerns around the devaluation of the national currency against the current decreased purchasing power of

households in local markets.

Figure 7: average reported income and monthly expenditures in the 30 days prior to data collection, by IDP status and group

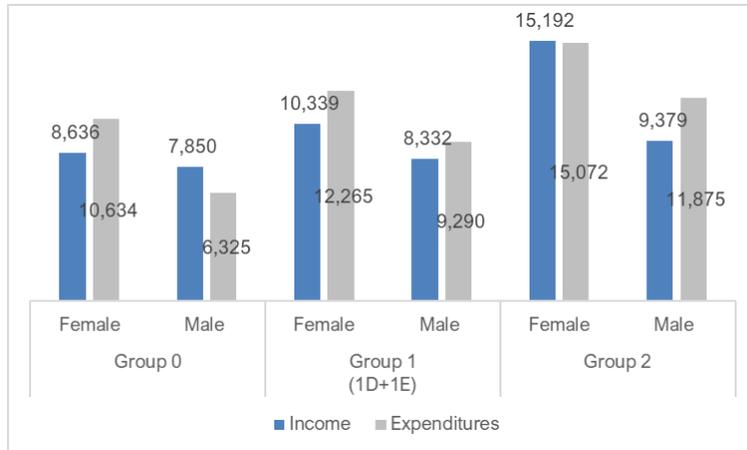


When disaggregating income and expenditure by IDP status, the net-income ratio of IDPs is next to zero, while for non-IDPs the expenditures are nearly double their income. Overall, IDPs have not only the larger Social Protection cash benefits (e.g., IDP and Conflict-Affected People Emergency Support Housing Allowance Programme), but also greater levels of humanitarian assistance (2,675 UAH for IDPs vs. 592 UAH for non-IDPs). It is particularly concerning the difference in income and expenditure when disaggregating by both IDP status and group. It is clear that households that are not displaced had not only significantly less income, but often also higher expenditures. The negative net-income ratio

¹³ Depending on sources, the poverty line may be approximated at 2,500 UAH per person per month, and considering the HH size reported above, on average, households should be just above it (including Social Protection received).

of HHs in group 0 non-IDPs is almost ten times higher than the ones in the same group but displaced. The same is almost three times as high for HHs in the sub-group 1D. Finally, for what it concerns HHs in group 2 and in the sub-group 1E, IDPs have a positive net-income ratio, while non displaced have respectively a negative value of 7,115 UAH and 4,600 UAH. This points toward a gap from both the Social Protection and the humanitarian actors in addressing the needs of those who are either returnees or that never displaced.

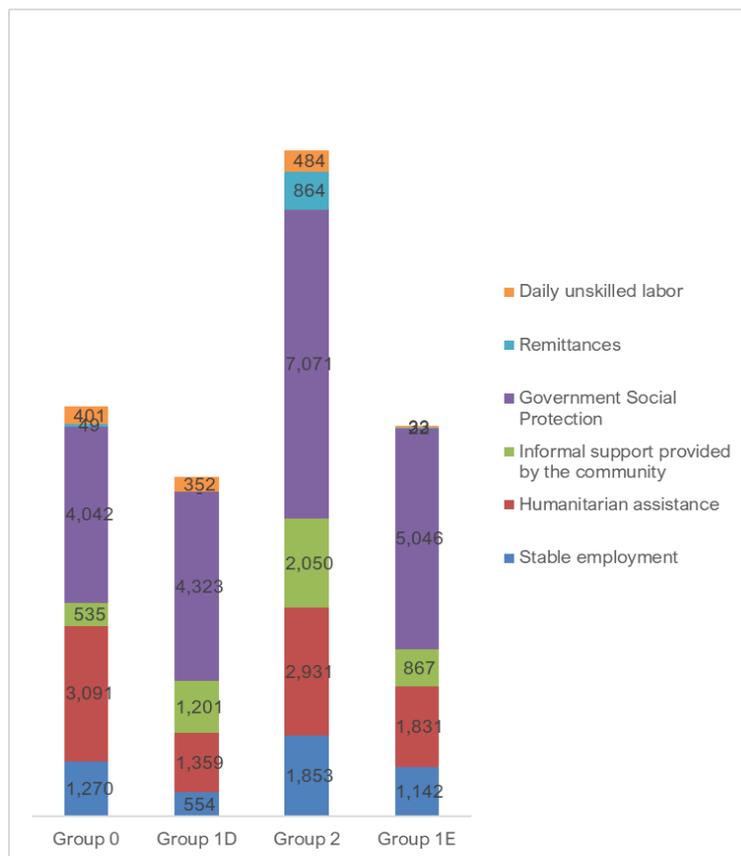
Figure 8: average reported income and monthly expenditures in the 30 days prior to data collection, by group and sex of the head of HH



Solid differences were also noticeable when data are disaggregated by sex of the Head of HH. In fact, across all groups female headed households have higher reported expenditures than male headed ones, with differences ranging between 800 UAH (sub-group 1, older persons) and up to 4530 UAH (sub-group 1D). Interestingly, income was also higher in female headed households, although the difference was not always as sharp as for expenditures,

with the exception of those of group two, where the difference spiked up to 5,800 UAH per month.

Figure 9: average reported income in the 30 days prior to data collection, by source of income



By disaggregating the average monthly reported income by source, it is possible to notice that households in group 2 have greater reported income generated by stable employment, remittance, and daily labour. The component on remittances, sent from abroad, was anecdotally justified by HHs separation, with members without disabilities leaving the country and sending back money to those who stayed behind (KI 16).

While the overall higher income sources may be due to the higher HH size, it could also be driven by higher levels of needs and thus necessity to increase the total monthly income to afford them. For what it concerns the government Social Protection, HHs in group 2 also reported receiving greater support, which is linked to the higher number of members with disability in the household composition.

Interestingly, the informal support provided by the community (e.g., donations), is also significantly higher, or nearly double the one

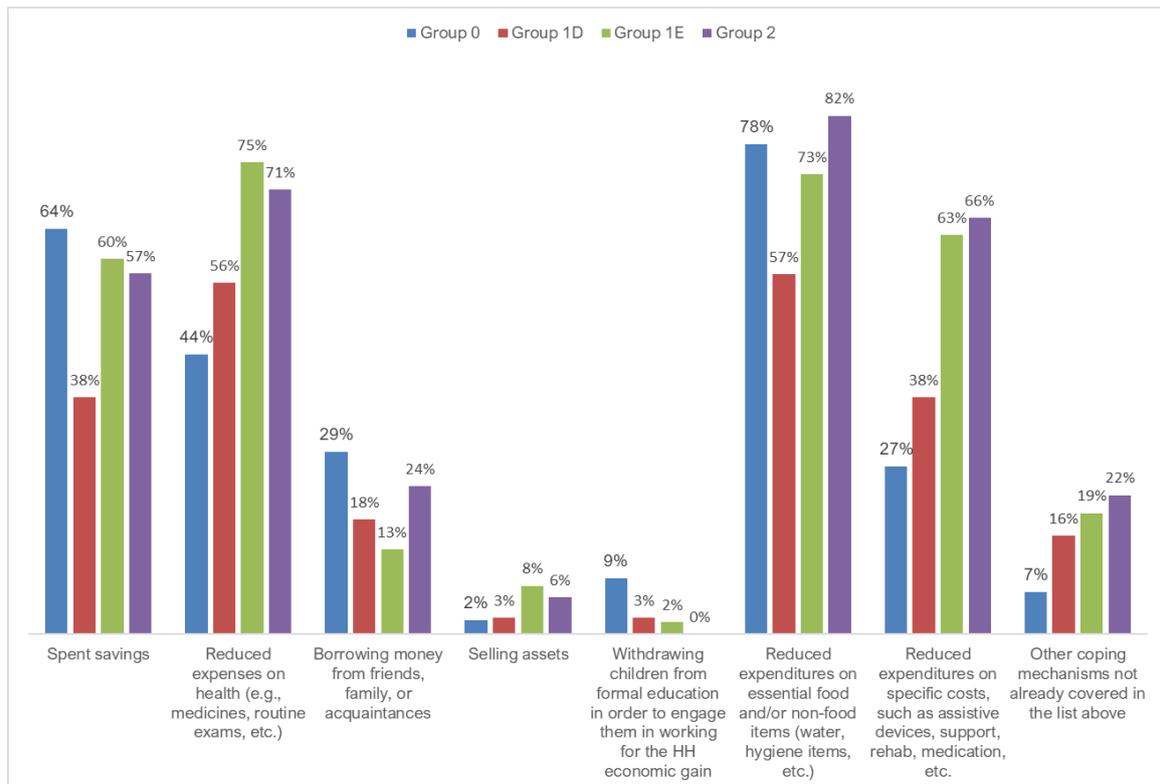
reported by HHs in group 1 (D+E). The different levels of reported humanitarian assistance received are in line with the HH size.¹⁴

Negative coping strategies

Out of the total caseload, 16 percent of the interviewed HHs reported having accrued debt, with a reported average of 12,425 UAH. Whether this is formal debt accrued with a bank or a financial institution or informal from family members or friends, debt remains a very common coping mechanism to deal with continuous negative net income ratio. Together with accruing debt, HHs frequently reported spending their savings. However, it needs to be noted that across all groups, HHs in group 1D tended to resort much less often to this strategy. This can be explained considering that this group had the largest negative income-expenditure ratio among the four, and thus it is plausible to assume that they had less savings to spend. For the other three groups, over a half of the HHs reported adopting this strategy. Yet, over three quarters of the HHs reduced expenditures on core food and non-food items, two thirds reduced expenditures on healthcare and medications, and over half on assistive devices and rehabilitation treatments for those who needed it. As reported by one KI: “People now have to choose whether to buy medicine or firewood to keep warm” (KI 8)

In terms of reduction of health expenses, data showed a linear increase through groups 0, 1D and 2. Additionally, a much sharper increase can be noted through group 0, group 1D, and group 2 in regard to the reduction of health expenses dedicated to disability specific costs. The high percentages for both these indicators of households in group 1E might be justified by the reduced quantity of services in the areas most affected by the conflict, where older people often remained behind.

Figure 10: percentage of HHs that reported using negative coping strategies in the 30 days prior data collection¹⁵, by group



¹⁴ Please, see figure 2.

¹⁵ Currently, Ukraine does not have a contextualised Livelihood Coping Strategy Index (LCSI). For the purpose of this study, the consultants drafted a potential approach to the LCSI for the country, with weighted indicators and thresholds. These are reported in the Annex C.

Considering the severity of the socio-economic implications of each coping strategy on the household's members well-being, and disaggregating by group, it is visible that HHs in group 0 have reported less frequent and less severe coping strategies in the 30 days prior to data collection. Compared to the control group (group 0), group 1 already presented a mild deterioration in terms of use of coping mechanisms, with HHs in the sub-group 1E having worse mechanisms than others. HHs in group 2 reported on average the most severe coping mechanisms, and a more frequent use in the 30 days prior to data collection. However, “*reducing expenses on health, medicines, and pharmacy costs*” (reported respectively by 56 percent of the households of group 1, 75 percent of group 2, and 71 percent of sub-group 1E) and “*reducing expenditures on specific costs such as assistive devices, rehab, medication, and routine treatments*” (used by 38 percent of households in group 1, 63 percent of group 2, and 66 percent of those in sub-group 1E) may have short-, mid- or greater longer-term implications for persons with disabilities and chronic illnesses, as they both compound their overall wellbeing and health status. The use of such strategies not only affects HHs conditions in the short term, but also compounds their resilience capacity in the longer term, which further calls for the need of strong social support, and justifies the different levels of Social Protection received for the latter group.

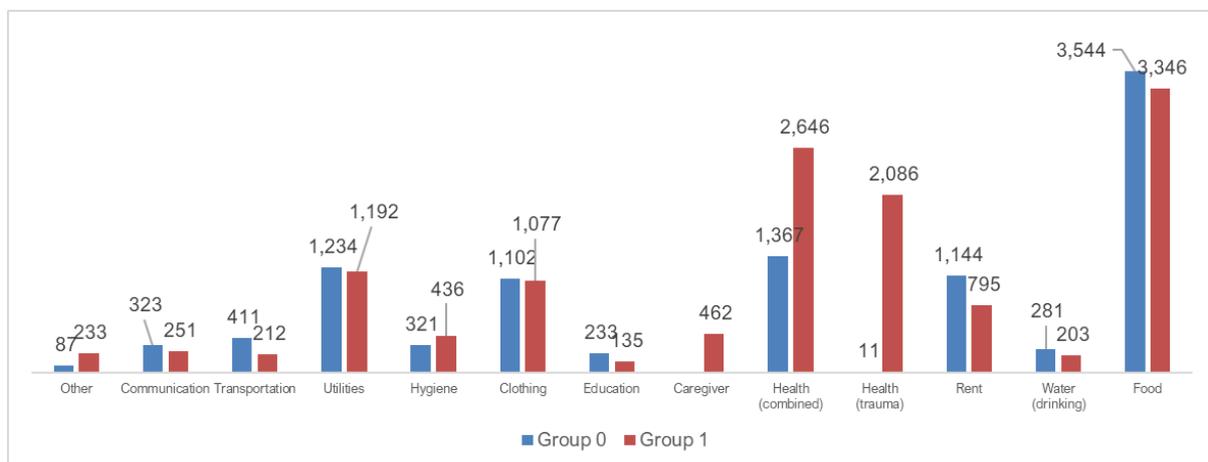
No respondent reported asking money from strangers or begging as a coping mechanism throughout the entire caseload. When running the disaggregation of livelihood coping strategies used in the 30 days prior to data collection by IDP status, the only visible difference was the percentage of non-IDPs being double the one reported by IDPs (13 percent vs. 6 percent, respectively).

No correlation was spotted between use of specific coping strategies and geographical location, age or sex of the head of HH, IDP status, nor group.

Extra costs of disability

Looking into reported monthly expenditures, it appears that healthcare may be the only sectoral expenditures with sharp differences across groups. Specifically, persons in group 1D spend on average an additional 1,279 UAH on healthcare (excluding trauma care) and 2,075 UAH on trauma care compared to the group 0. On the other hand, few key informants had misconceptions about extra costs related to transportation and clothes (KI 6 and 8). Some even suggested differences in the need of making reserves and stocking up on firewood and fuel (KII 8). Data did not show differences in this regard.

Figure 11: Sectoral expenditures in the 30 days prior to data collection, by group 0 and 1



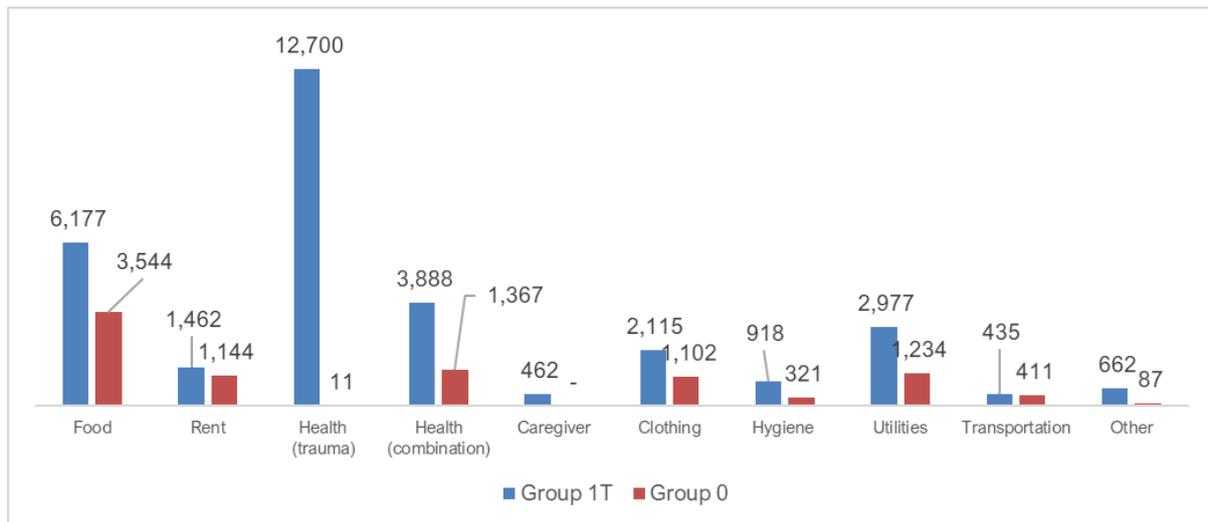
The vast majority of qualitative data supported the findings of the survey. While the vast majority of technical experts, and especially those working directly with disability, suggested that the definition of extra costs is linked to the individual person with disability and his/her environment, there was a general agreement that the cost of healthcare, home care, utilities, transportation for persons with limited

mobility, and specific food requirements would represent extra costs for households with at least one member with disability and/or an older person. In a few cases, people suggested investigating the costs of communication (KI 7) and the possible shelter costs to adapt housing to the deambulation needs of the person with disability (KI 2, 12, 17). In this regard, one key informant (KI 12) pointed toward a clear aspect of extra costs, which is entirely related to how “recent” the disability is and how people are able to cope in the short-term.

For those persons that have a newly acquired disability, whether this may be a direct consequence of the war or something that emerged later on life, it is possible to assume that the first months living with a disability cause unforecasted expenditures to readapt one’s life and ways of conducting daily activities to the new condition, ranging from having to pay someone to do something they used to do by themselves (e.g., cooking) up to having to change some of the furnishing of the house and/or purchase additional assistive devices not provided for free under Social Protection schemes or humanitarian assistance.

In this regard, data show that 36 percent of those in group 1D who reported spending way above average in trauma treatments, which reportedly are for amputations, initial rehabilitations costs, and prosthetics (KI 19), and they have not been registered yet with the national Social Protection system. This 36 percent of group 1, for the sake of analysis and disaggregation, from now on is renamed “1T” as seemingly related to traumatic events that occurred since the Russian invasion of Ukraine. Incidentally, almost all HHs falling into the sub-group 1T are those that reported having a disability related to mobility for absent or impaired limb and that have not registered yet with the national Social Protection System.¹⁶

Figure 12: greatest sectoral expenditures variations between group 0 and the sub-group 1T (those who reported trauma expenditures higher than 1,500 UAH) in the 30 days prior to data collection



This sub-group has total expenditures three times as high as compared to the control group 0 (32,668 UAH vs. 10,058 UAH in the 30 days prior to data collection). While there are minor to no differences in communication, transportation, and water, other sectoral analysis showed sharp variations for this sub-group. The analysis on the costs of newly acquired disabilities confirms their hypothesis, with sharp differences in food (2,633 UAH), rent (322 UAH), a combination of different healthcare costs beside those that are trauma-related (2,521 UAH), the need for a caregiver (462 UAH), clothing (1,013 UAH), hygiene items (597 UAH), utilities (1,743 UAH), and other costs (575 UAH).

To be noted, all HHs within the entire caseload who reported costs related to the need to pay for a caregiver fell under the sub-group 1T, possibly because of the time needed to adapt to the new condition

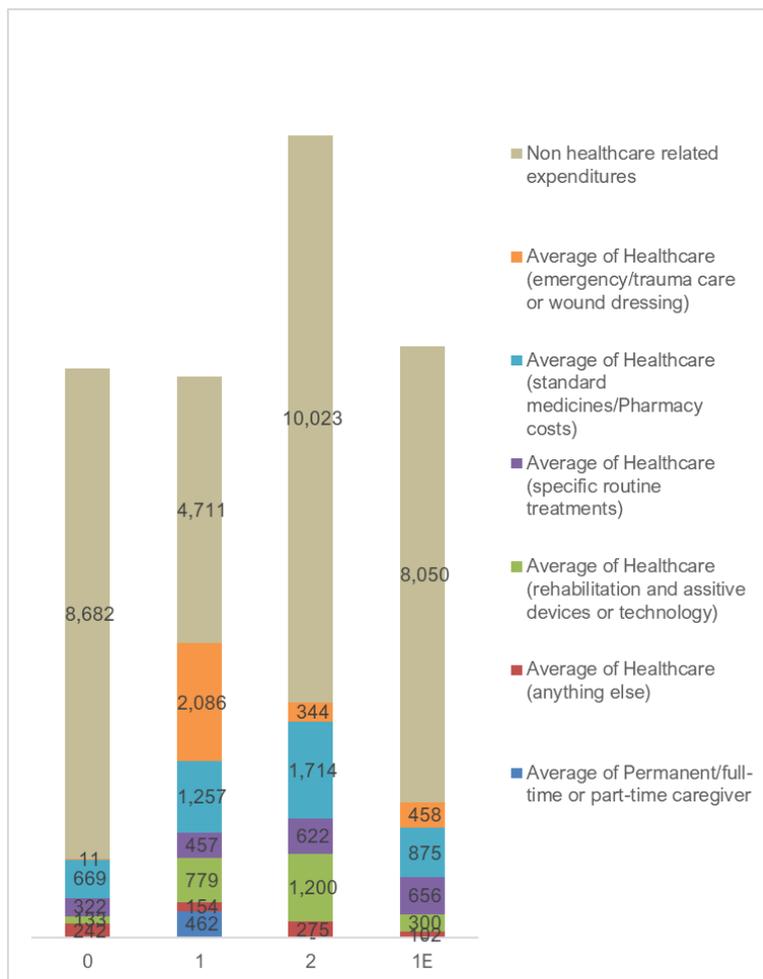
¹⁶ Please, refer to pages 13-14.

in dealing with daily tasks or because they do not have access yet to the subsidised support provided by the Social Protection schemes, which is often linked with the scarce knowledge around governmental disability registration and support system. No HHs in any other group reported the need to pay for a professional to attend the needs of persons with disabilities or older persons within their HH.

The extra costs, reportedly, are associated with the lack of coping mechanisms developed in such a short timeframe. This is likely to be compounded as well by the heavy psychological stress experienced by persons with newly-acquired impairments. In the longer-run, persons with disabilities are likely to establish for themselves alternative methods to deal with daily tasks and needs, but zero to six months may not be a sufficient time frame to allow this to happen.

Additionally, once registered in the government schemes they may receive additional assistance to better bridge this gap. Furthermore, the extra costs are currently coupled with “the lack of resources to run vocational rehab training and overall opportunities for those who are new to this condition, which makes them less likely to re-enter in the job market, and further limits their income sources” (KI 12).

Figure 13: proportion of healthcare related expenditures against total monthly expenditures of the household, by group



Also, it appears that the perception of the costs related to healthcare is inflated, as some guessed that they would amount to about 65 percent of total monthly expenditures (KI 8), which would be close to those reported by group 1 (52 percent), but not by others.

It is core to investigate whether the extra costs presented here are growing linearly or exponentially depending on the number of members in the household with disability.

Data suggest that, for what it concerns healthcare specifically, standard medicines and pharmacy costs, as well as rehabilitation and assistive devices technology costs increase linearly (by about 500 UAH) by the number of persons with disability in the HH (group 0, 1, and 2). For what it concerns routine treatments, the increase was aligned with the ones described above, but with a much smaller difference (200 UAH vs. 500 UAH).

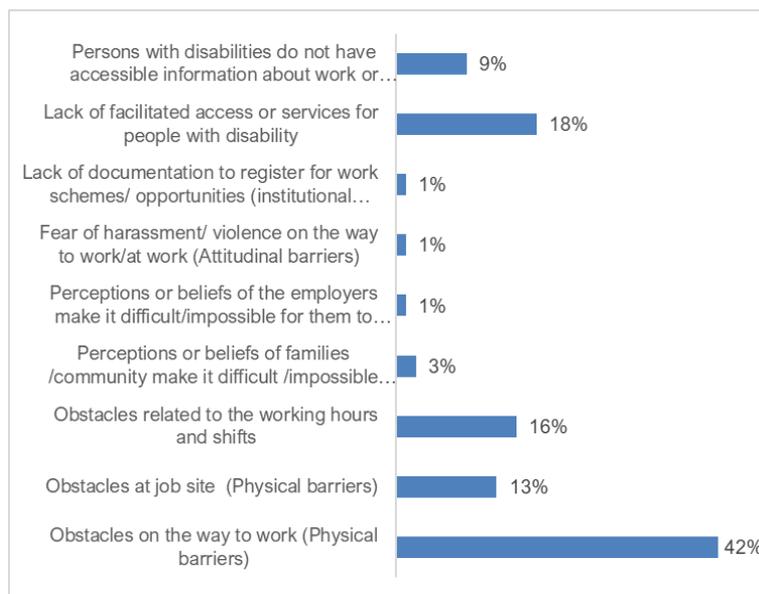
The only group that reported expenditures for a permanent or part-time caregiver belong to group 1, and particularly just those in the sub-group 1T, while other groups and sub-groups did not report such expenditures. Again, this may be due to both the fact that the sub-group 1T has no access to the subsidised support part of the Social Protection Schemes or the fact that they have new injuries or newly acquired disabilities and had not time to adapt to the new condition and need support to conduct daily activities.

For costs not associated with healthcare, group 0 had similar costs to group 1E, indicating that older persons do not have non-healthcare costs on top of standard ones. However, the variations in income may have severely affected these proportions and HHs capacity to spend on different sectors, as often one need may have had to be prioritised compared to others.

However, for older people, during the FGD it emerged that, in areas directly affected by the conflict, issues around documentation might exist due to the lack or the loss of documentation which can lead to extra costs for shelter (cannot be accepted into retirement houses) and for re-issuance of the papers. Additionally, for those officially recognized as persons with disabilities, the renewal process is particularly long and includes additional expenditures. OPDs reported that they are not able to support persons with disabilities in this process.

Some key informants agreed with these findings, but others rather suggested that the different levels of expenditures may be due to a combination of severity of the disability (KII 2), independence and movement capacity (KII 12), level of care provided and available, as well as other personal or interpersonal factors (KII 10).

Figure 14: Reported perceived barriers for persons with disability in earning an income



In this regard, the survey also investigated what are the perceived barriers for persons who have a lot of difficulties in seeing, hearing, walking, communicating, understanding (for reasons other than the language spoken) in earning an income.

Among those who chose to answer this question, 34 percent reported that persons with disability face no additional barrier compared to everybody else. Yet, among those who perceived barriers, the top three reported were physical barriers in terms of transportation and access to the workplace, and issues with work shifts, guessing

that medical visits or long shifts may be difficult to merge.

Barriers

Respondents were also asked to identify barriers concerning accessing the marketplace, healthcare services, and overall leaving the house. For each of the set of barriers, respondents were provided with a list of pre-identified issues that arose from preliminary interviews and literature review. These were also factoring the IOM's displacement tracking matrix (DTM) on Disability Inclusion questionnaires and answer sets, in order to ensure inclusive language and comprehensive answer options.

Figure 15: Top three perceived barriers for persons with disability in accessing the marketplace, and

Figure 16: Top three perceived barriers for persons with disability in accessing the healthcare

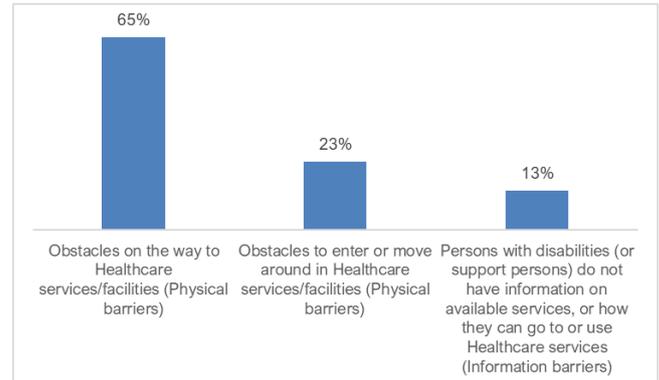
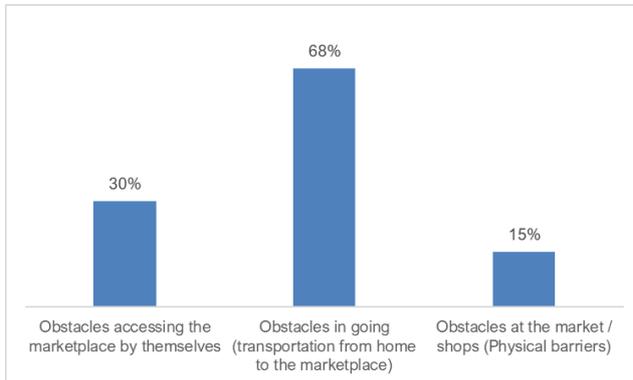
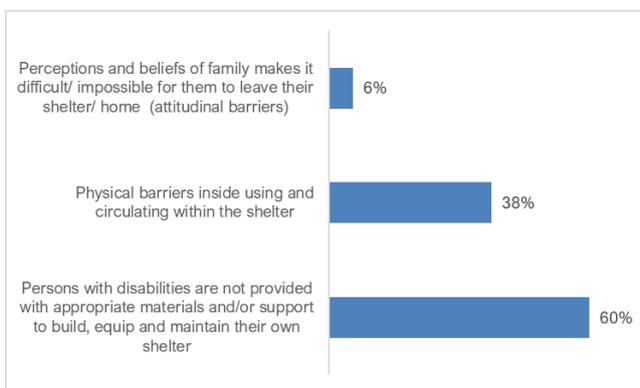


Figure 17: Top three perceived barriers for persons with disability in leaving the house or shelter



From the three charts concerning barriers to access the marketplace, healthcare, and just overall to leave their house, three aspects need to be considered and grouped into broader concepts as core obstacles for persons with disability, namely:

1. transportation and access,
2. access to information, and
3. other people's perceptions and communication capacity.

It is clear that, while data show that transportation does not entail extra costs for persons with disabilities per se, it is reported as a barrier for them to leave the house and access fundamental services and infrastructure in the area, as it is not always available or accessible (KI 1). Remains to be determined whether the transportation-related barriers are due to the availability of accessible means for persons with disabilities or if the issues have much deeper roots (i.e., the accessibility of standard public transportation). Key informants also reported that among social services for people with disabilities, 50 percent discounted tickets for public transport were available (KI 8)¹⁷, but there was no information about the current status of accessibility of public transports for persons with disabilities, and thus whether the discounted tickets would suffice to bridge this gap. In this regard, the MoSP Classifier of Social Services includes transport services for people with disabilities and people with objective barriers in using public transport (service 43/023). A group of KII collectively interviewed (KI 8) however, reported that this service has almost completely stopped, especially in the areas most affected by the conflict.

For what concerns informational barriers, key informants reported possible challenges with the digitalization of social services, as the system is not necessarily accessible by everyone (KI 8, 11, 18),

¹⁷ According to "The Law of Ukraine about the basics of social security for persons with disabilities in Ukraine" art. 38: persons with disabilities of group I and II, and persons accompanying them, can travel for free on city public transports (with the exception of taxis) and are entitled to 50 percent discount on the fare on domestic lines (routes) of air, rail, sea, inland, water, and road transport in the period from October 1 to May 15.

and with the lack of information on the state of infrastructure and services in the current context, and whether centres have safe-rooms (for bombing) accessible by persons with disability (KI 1 and FGD).

Finally, the perception of other HH members, neighbours, community, and possible employers was also considered a barrier by part of the respondents (KI 18). Indeed, while barriers may not constitute a cost per se, *“people need money to overcome the barriers, so the barrier is the extra cost”* (KI 1). This is in line with the UN guidance note on Rights of Persons with Disabilities, stating that extra costs can be minimised by dismantling barriers to participation of persons with disabilities, in education, skills development, enterprise development and employment, as well as poverty reduction and development programmes (UNDG, 2011. pg 14) and they do not result from the disability in itself, but rather from barriers that exclude persons with disabilities and make them dependent instead of independent (UNDG, 2011. pg. 47).

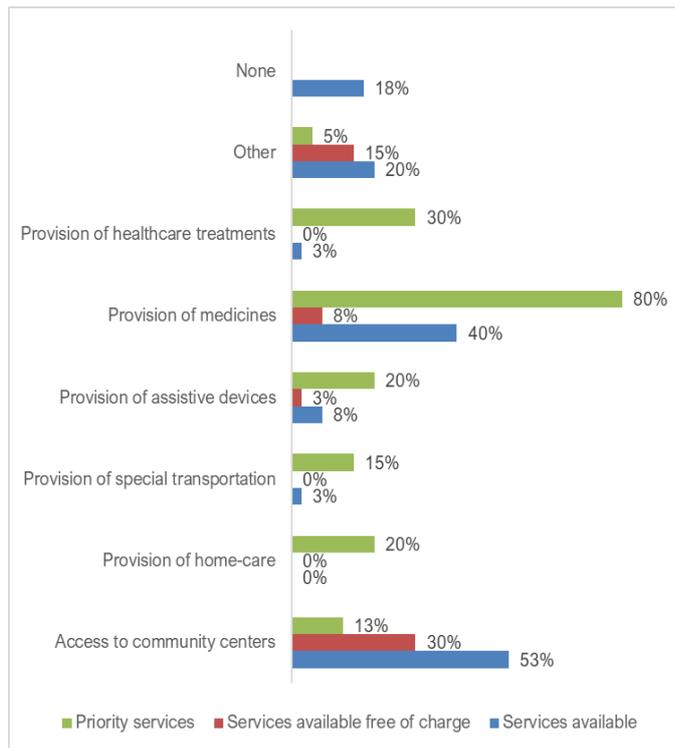
Further barriers that emerged during the FGD concern the availability of readaptation services and devices (e.g., walking with a stick – working with some kinds of software – cooking and self-care). Yet, some of the OPDs provide, upon availability and capacity, such support.

Services

Secondary data and key informants indicated that service provision is generally available, but with differences between urban and rural areas (KI 1) and with overall reduced capacity, quality, and resources at the frontlines and in newly liberated areas, due to the prolonged lack of access by government authorities, and in IDP-receiving areas due to increase in demand (KI 9 and KI 11). Persons with disability receive assistance and when displaced, but those who are either returnees or that never left their homes may be subjected to a number of restrictions of movements due to their mobility issues, issues with accessing centres (e.g., centres do not have safe-rooms), or just reduced quantity and quality of the service provision and home-care (KI 3). The war has also resulted in mass displacement of specialist care professionals who serve people with specific needs in specialist facilities, resulting in severely understaffed facilities, and care professionals who remain at severe risk of burn-out (NVPF, May 2022). In a few cases, social workers are reported working remotely, which compounds their capacity to deliver assistance, and the provision of social services stopped entirely (KI 11). Such a situation was confirmed by the participants of the FGD, specifically in regard to the network of centres for rehabilitation and the availability of social workers. It remains unclear, to date, whether there will be additional funds allocated for hospitals, community centres, or health-worker visiting persons with disability at their homes (KI 8), as well as for Organizations of persons with disabilities (OPDs). Representatives of OPDs reported a continuous lack of funds which severely hampers their capacities to deliver services. KI 8 mentioned that OPDs have received no funds in 2022, and that this trend is likely to continue in 2023. Other OPDs representatives mentioned that public funds are generally not timely and not in line with UAH inflation. Specifically, as mentioned during the FGD, the reduced availability of public social workers in affected areas, either the front-line or IDP-receiving regions, is often linked with increased costs for the household which, when necessary, must find private solutions to assist its members with disabilities, thus effectively sustaining additional costs (FGD participants). This is particularly concerning when considering children with disabilities. Families tend to hand-over the care of children with disabilities to institutions because of needs, financial and human resources-related capacity, and the idea that the state needs to take care of children is still common (KI 12). It is worth noting that the state is indeed responsible, on the basis of its commitment to the CRDP, but only in the best interest of the persons with disabilities, children and adults. Persons with disabilities who are hosted in institutions and hospitals following displacement continue receiving social protection benefits, as the Disability Pension (KI 8).

Considering the sharp differences based on geographical location, data concerning service provisions were analysed by Oblast.

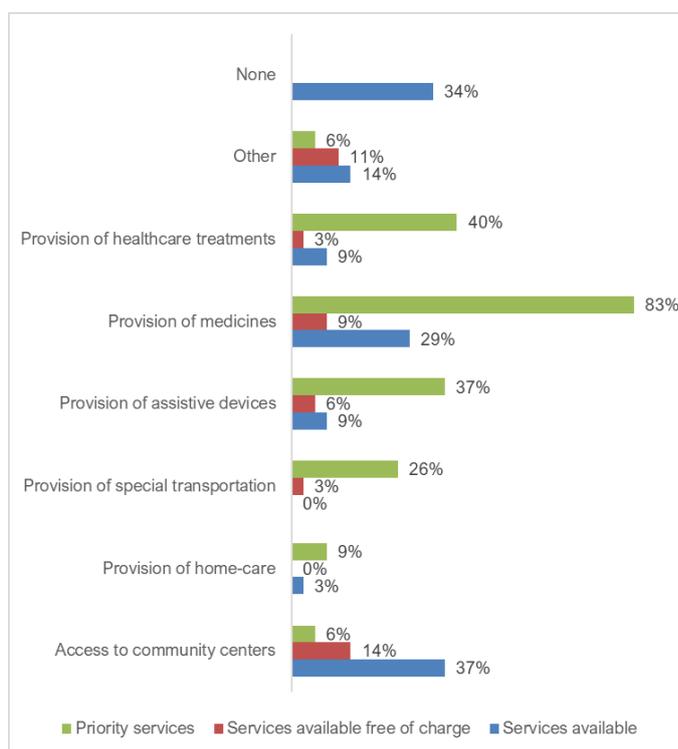
Figure 18: percentage of HHs, by reported service available, free of charge, and urgently needed (or in need to be scaled up), in Dnipro



Provision of medicines, healthcare treatments, home-care, and accessible transportation were the four most frequently reported priorities in Dnipro. The differences in percentage between needed and currently available services indicated that the needs of households with a person with disability or an older person may not be just strictly related to income, but rather a much broader approach. Community centres are widely available, but not as much needed as other more specialised services. Furthermore, 18 percent of the respondents reported that there are no services available in the area where they live. On top of which, 55 percent of the respondents reported that the quantity of the services decreased since February 2022, and 50 percent reported that the quality of the remaining available services deteriorated.

Similar figures in terms of satisfaction with quantity and quality of the assistance are in Chernivska, compared to those reported in Dnipro. Yet, 74 percent of the respondents from this region reported that in the current circumstances, Social Protection and services in the area do not suffice to meet the needs of their HH.

Figure 19: percentage of HHs, by reported service available, free of charge, and urgently needed (or in need to be scaled up), in Chernivetska



In both oblasts the provision of medicines was reported as a priority need. In line with the most recent available data (REACH, JMMI August 2022) many KIs reported the increase of prices as the major issues with the medicines, as well as with other goods and services (KI 4, 8, 9, 11, and 12). One KI (n 12) reported quality as well as a matter of concern.

The sharp differences between the percentage of HHs indicating provision of medicines as a priority and those who reported it is available raised concerns. Across the two oblasts, less than ten percent of HHs reported medicines are provided for free or as part of one of the Social Protection packages, and again this implied that routine medications may undertake part of the income and a core role in priority expenditures. Key informants also suggested that while the government Social Protection provides

discounts or cards to access some drugs and medication for free (e.g., drugs for hypertension, diabetes, etc.), some of these remain difficult to obtain or may require extra expenditures from the HH side (KI 9). Additionally, provision of subsidised medicines specifically for persons with disabilities, which is part of the policies in support of persons with disabilities, was reported as being negatively affected by the conflict (KI 8), particularly closer to the frontlines.

As of the current context, two thirds of the respondents reported that the social services and overall Social Protection system does not suffice to meet their most urgent and basic needs. This has been confirmed by all KIIs prompted on this topic. When disaggregating findings by IDP status, non-IDPs have access to a better range of services (i.e., provision of homecare, provision of special transportation). However, IDPs have greater access to community centres and community level services (48 percent for IDPs vs. 33 percent for non-IDPs).

Additionally, it was reported that some sanatoriums and boarding homes, which used to provide services to persons with disabilities, among others, have been turned into shelters and reception centres (FGD). This is confirmed as well by interviewed experts, in line with REACH findings that 4 and 2 percent respectively of the current shelters used to be sanatoriums and boarding houses, with this number increasing in IDP receiving areas, such as Lviv (10 percent and 9 percent respectively). In regard to Lviv, for example, one participant to the FGD pointed out that the main problem in Lviv is that it cannot sustain another wave of persons with disabilities IDP as there are no more places fit to host them.

It is worth mentioning that different KIIs made references to informal support and assistance and community-level service provision being active across the country, and often representing a significant part of the assistance provided to those in need, including people with disabilities (KI 5, 6, 20). This type of informal support was also reported when it came to the income of the 30 days prior to data collection, where HHs indicated receiving donations from the community members.¹⁸ Reportedly, the informal system refers to neighbours' support, friends and family sharing physical or financial resources, and community members stepping up to provide assistance or covering "caregiver duties", or provide educational materials as well as informal trainings (i.e., persons who speak English teaching English although not qualified teachers) to children so they can continue their education, or even just drive persons with disabilities and older persons upon need and availability (KI 16, 20). As KI 13 mentioned, "to support persons with disabilities we need to reach them in their houses, and that is where national actors are key". It was mentioned, however, that this level of support does not factor trained professionals nor adequate resources, and it relies exclusively on the time volunteered by neighbours when available (KI 15, 16, 20). However, secondary data or literature information and data regarding community level initiatives and informal support services are not available and would need further research.

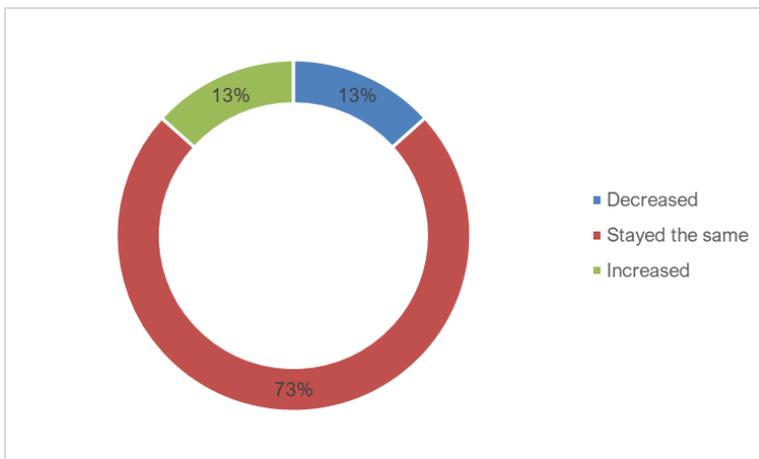
Social Protection provision

Qualitative data collected through both KIIs and FGD, as well as the review of existing literature, overwhelmingly pointed towards the fact that the Social Protection system in Ukraine has been coping well with the escalation of the conflict, especially in regards to the continuation of payments to persons identified as heightened risk of vulnerability and the rapid expansion to new beneficiaries for dedicated programmes - which, as reported by Social Protection experts, is one of the three key functions of the paradigm of Social Protection for persons with disabilities (KI 10). Among other reasons, this can be related to the fact that the Government of Ukraine prioritised Social Protection over other elements and that most of the international aid funds have been directly distributed to the government to support its

¹⁸ Please, refer to figure 8. This is either coming from "Group cash approaches" where humanitarian actors deliver larger sums to informal groups, community representatives, churches, sports clubs, etc. to then be administered and divided across the community members upon need, or from actual donations peer-to-peer. Group cash transfer guidance available [here](#).

Social Protection schemes (KI 6 and KI 7). Furthermore, all KIIs who provided information and opinions on this element, reported that war-related Social Protection schemes have rapidly expanded horizontally, with the inclusion of new beneficiaries, when eligible (KI 3, 5, 6, 7, 17).

Figure 20: percentage of HHs receiving the government Social Protection assistance, by reported variation in the amounts received since February 2022



The expansion has only been internal to the MoSP as the contribution of the humanitarian community through the provision of MPCA is to be considered a top-up for some of the Social Protection beneficiaries (KI 6). According to a variety of documents, the government of Ukraine is obliged to provide Social Protection as per Ukrainian constitution, thus making it impossible to refer lists of people in need to external actors without providing them with the support they are eligible for in the first place (KI 6

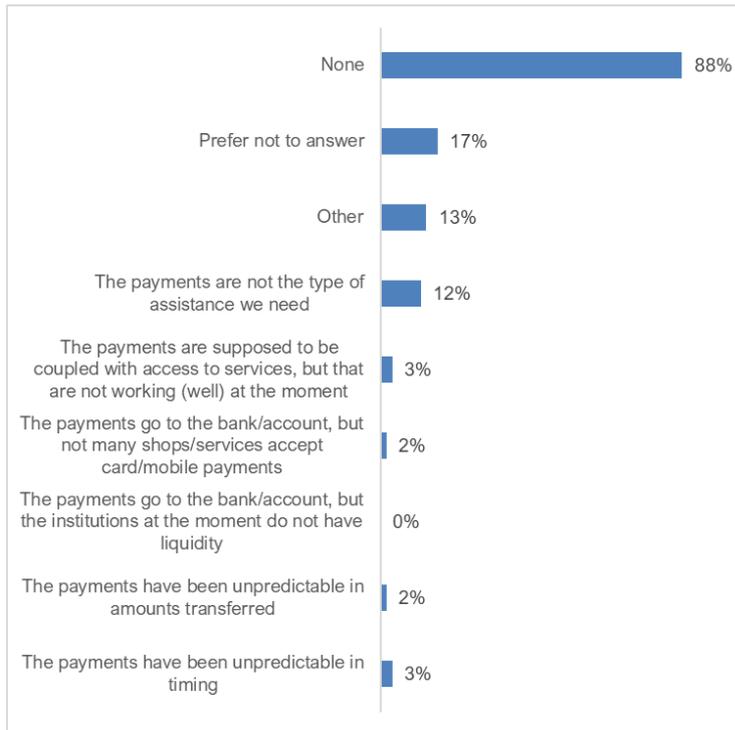
and to CWG TT 5). This implies that HHs that are referred to the humanitarian actors by the MoSP are receiving both Multi-Purpose Cash Assistance and Social Protection assistance as they cannot outsource Social Protection assistance delivery. Yet, in spite of receiving both types of assistance, data on net-income ratio show negative results in the current context. The legislation, however, does not prevent adopting “piggybacking” modalities, where humanitarian actors can use the systems of the Ukrainian Social Protection structure (KI 6 and 7).

Just eight percent of households that were receiving SP assistance prior to February 2022 reported that it discontinued since the Russian invasion, with all of them but one being from Dnipropetrovska. Indeed, this is a unique example in the landscape of humanitarian crises.

Confirming what gathered through qualitative data collection, in terms of amounts received, 73 percent of the respondents that received Social Protection assistance reported that it remained the same throughout the last months, since February 2022. This is a clear sign that cash-based benefits within the Social Protection system have managed to continue operating regularly. Yet, the FGD highlighted that there may be variances based on geographical location, and in conflict active areas there have been some delays or issues accessing the payments. Yet, the overall system remained functional. In terms of ad-hoc Social Protection schemes designed to respond to the needs emerging from the conflict, which are largely cash-based, no significant issues were reported.

Concerning the amounts received, however, it must be noted that, according to both secondary data and KIIs, the calculations and rationale behind most of the the levels of individual assistance provided by the government, including the war-related schemes, are not publicly available (KI 6, 7, and 8), and they vary according to a number of factors. Some of the experts interviewed suggested that they might be based on a basket of goods and services and their costs in the market, while one KI reported that the amounts of pensions for persons with disabilities used to be calculated on the bases of previous work and income. A consequence of this approach is that those with disabilities since childhood receive particularly low amounts, as they do not have any income-earning history (KI 11).

Figure 21: percentage of HHs receiving the government Social Protection assistance, by reported difficulties in accessing, withdrawing, or using the assistance received



Amongst the criticism raised, there were concerns regarding the fact that Social Protection is not meant to cover rental costs (KI 4), compounding the households' capacity to live in a dignified and adequate shelter, the current cost of commodities and the reduced capacity to afford all urgent and basic commodities (FGD), and the external collaboration element, which includes the two-way referral system with humanitarian actors (KI 5, 6, 8, 13).

Specifically, when asked about difficulties in accessing, withdrawing, or using the assistance received, interviewed households that were entitled to Social Protection assistance rarely reported any issue. However, in a few instances, it was mentioned that payments are not the type of assistance the household

actually needed (12 percent), but yet, according to one of the experts interviewed, the government prefers to provide assistance as complementary income (KI 11). This appears to be a timeliest and more cost-effective way of assisting the population, however issues may arise particularly in conflict affected areas, where the increase in demand is not coupled with increased resources and safe access. Interestingly, only three percent of the assessed households receiving Social Protection assistance reported that it should be coupled with other forms of assistance (e.g., service provision) but they are not fully functional at the moment. It remains to be investigated whether the households expected an increase in the amount received considering the current context (i.e., depreciation of the UAH and inflation), or whether the stability of the assistance received by the government suffices to afford what it is intended to cover.

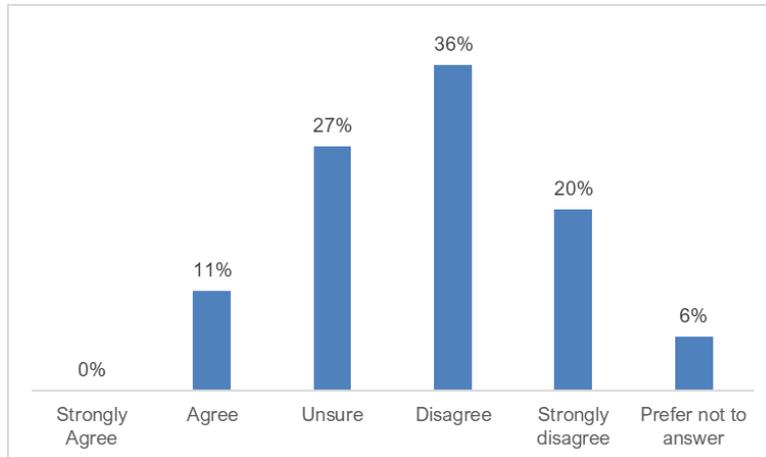
Furthermore, three percent of interviewed households reported that the payments have been unpredictable in timing. While this may be justified by the context, and by the fact that the overall system has been considered shock-responsive and minor delays may be expected, it underlines a communication challenge. Information in this regard have been opposing, with some key informants reporting that the government's communication efforts around Social Protection have been clear and consistent (KI 5), and in other cases reporting inconsistencies in communication channels and messaging, or lack thereof (KI 2).

Additionally, as reported by participants in the FGD, the support of the Social Protection system is limited to those who obtained or still have access to an official disability certificate. For older people and people with specific diseases, the lack of disability certificate excludes them from obtaining the needed assistance. As mentioned by experts interviewed, the categorical nature of Social Protection contributes in fact to the risk of exclusion of vulnerable individuals (KI 6, 8, 12, and FGD participants).

Humanitarian assistance and needs

In spite of humanitarian assistance being aligned with the Social Protection schemes, the perception of MPCA is opposed to what reported about Social Protection. Households assessed and experts interviewed as KIs were almost unanimously in agreement with the fact that the current design of the transfer value for MPCA in Ukraine does not take into consideration the needs of people with disabilities.

Figure 22: percentage of HHs, by response on whether the current humanitarian assistance (UAH 2,200) suffice to meet their basic needs



Some reported as well that the transfer value is the product of a decision to align humanitarian MPCA with existing Social Protection amounts (subsistence minimum) for reasons of quickness of delivery at the beginning of the crisis, but that lack proper understanding and consideration of what is meant to be covered (KI 5 and KI 6). Across qualitative data, the transfer value was described as “non humanitarian” in nature (KI 3),¹⁹ but rather geared towards

poverty alleviation objectives. Additionally, there is no clarity regarding the needs that are meant to be covered by the adopted MPCA transfer value (2200 UAH), as it was calculated based on a broader basket of basic and non- commodities, as per the government Social Protection basket. This was further reflected in the considerations shared by one of the KIs, “*We do not know what it is supposed to be covered with this [government] amount*” (KI 6).

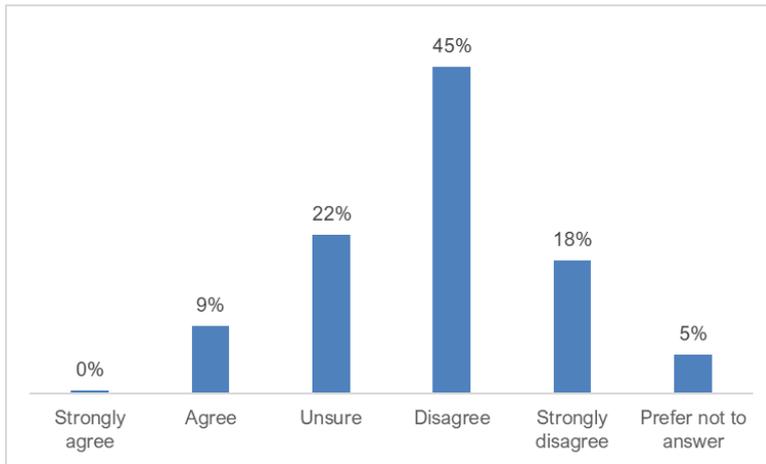
While aligning and coordinating with the government is a pivotal component of humanitarian assistance in the longer-run, the two are reportedly intending to bridge different gaps (i.e., Social Protection for specific needs with supplementary income and longer term, and humanitarian assistance to allow households to live in dignity and afford all their most urgent and basic needs in the shorter-run during or immediately after a shock).

Different KIs reported as well that there is a general lack of data to back any discussion around persons with disabilities from both the government side and proper disaggregation and analysis from the humanitarian end to properly inform inclusive CVA.

The price monitoring run across the country confirmed that the depreciation of the local currency and the overall purchasing power of the households changed people’s capacity to access basic commodities. These financial barriers were confirmed by data, when respondents were asked whether the current humanitarian assistance (2,200 UAH) is appropriate to the current cost of commodities in the local markets.

¹⁹ The current transfer value is not based on a Minimum Expenditure Basket (MEB) and an inclusive gap analysis, as instead recommended by Cash Coordination hubs and technical groups for other large-scale humanitarian crises globally. The current list of commodities amounts to over 200 items ranging from essential needs to hairdressers and chocolate.

Figure 23: percentage of HHS, by response on whether the humanitarian assistance (UAH 2,200) is appropriate to the current cost of commodities in the local markets

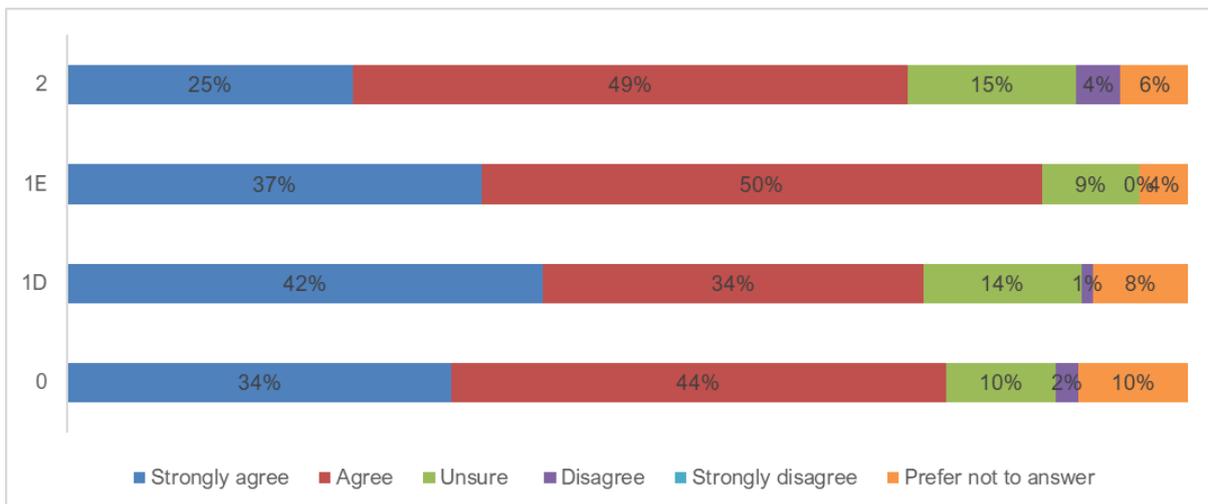


The overwhelming majority disagreed with the statement, and just nine percent agreed.

Furthermore, multiple experts noted that the transfer value defined at the beginning of the crisis has lost part of its purchase power due to inflation and devaluation - from roughly 74 USD²⁰ to 60 USD²¹ (KI 6, 7, and 8). Almost all KIs who have actively engaged with persons with disabilities at different levels reported that the feedback

received is that the amounts are not enough to cover needs, sometimes not even to cover housing alone (KI 11). Indeed, while MPCA is aligned with the government Social Protection, it aims to respond to different needs, and this was suggested to be incorporated into the transfer value analysis.

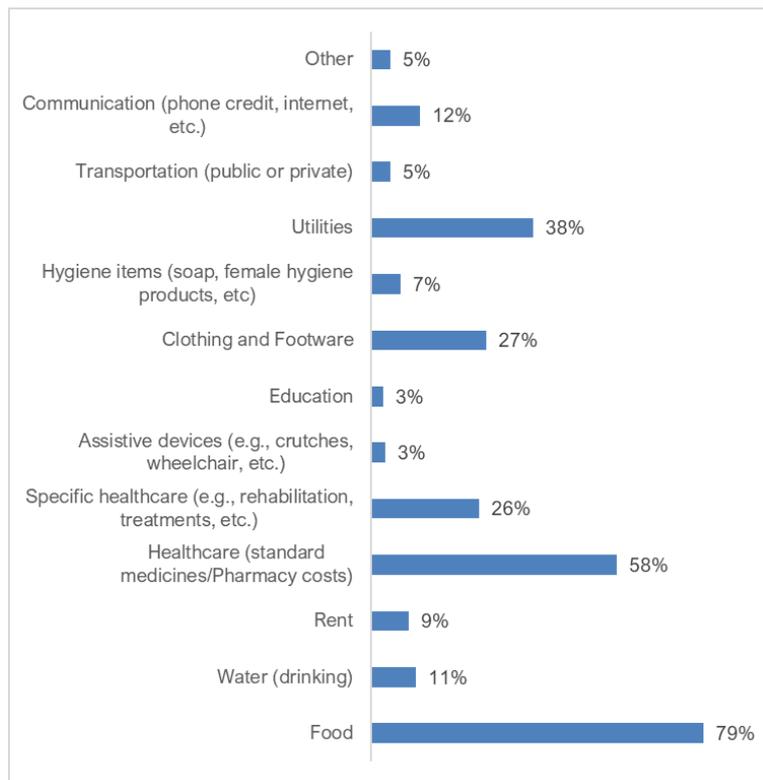
Figure 24: percentage of HHS, by response on whether the humanitarian assistance (UAH 2,200) would require service provision for specific population groups (e.g., older people) as extra/top up, by group



When asked about modalities of assistance to cover disability-specific costs, most KIs indicated cash assistance as an effective modality, but the overwhelming majority pointed out to the need to complement with technically sound in-kind, particularly for specific needs (e.g., prosthetics, orthotics, and prosthesis) and with service provision where services are not available or not enough (KI 1). Overall, all the KIs that provided opinions on this topic pointed to the preference for mixed modalities (KI 1, 3, and 9) and, above all, to the need for case-by-case analysis, considering the extremely individual nature of disability.

²⁰ Exchange rate at 22 February 2022 (2,200 UAH)

²¹ Exchange rate at 12 November 2022 (2,200 UAH)

Figure 25: percentage of HHs by priority needs (top three identified)

It must be noted that the needs of persons with disabilities are diverse from each other as need intersect with age, sex, severity of the disability, environment, and support available to them. These are all key in determining necessities and extra costs (KI 1). Yet, disaggregating needs by group: food, healthcare, utilities, and clothing were by far considered more urgent priorities compared to other sectors.

Over two thirds of HHs, peaking to 98 percent for respondents in group 0, considered food as a top priority. This difference may be matched by the different percentages and reversed proportions in the specific healthcare section, indicating that households with at least one member with disability or older person need to prioritise health

over other pivotal sectors.

For specific healthcare costs (e.g., rehabilitation, treatments, assistive devices), in fact, we see that just seven percent of group 0 considered it among the top three priorities, but the percentage increases to 33 percent for group 1, and 25 percent for group 2. For other components of health, as expected, the prioritisation of standard healthcare and pharmacy increases by group, peaking at 74 percent for group two, which may have the most need of routine drugs and medications. This is in line with what was reported by one KI: “*primary need of medicine, diapers, and special care for people with disabilities*” (KI 4). When running the disaggregation based on IDP status, it can be noted that internally displaced persons had lower specific healthcare needs, such as rehabilitation and treatment (47 percent), compared to non-displaced (22 percent). This might be justified by the larger public and humanitarian provision of such services in IDP-receiving regions. Data showed as well that IDPs more often consider rent and communication as priorities compared to those non-displaced, although the overall percentage remained small (13 percent for rent, and 14 percent for communication).

Similar percentages of HHs amongst all groups considered utilities, including firewood and heating systems, among their top three priorities, recalling the importance of assistance delivery during the winter period. Moreover, the overall percentage of HHs considering clothing and footwear as a priority was actually shifted upward by HHs belonging to group 2 (40 percent) and 0 (38 percent), compared to much lower percentages for those in group 1.

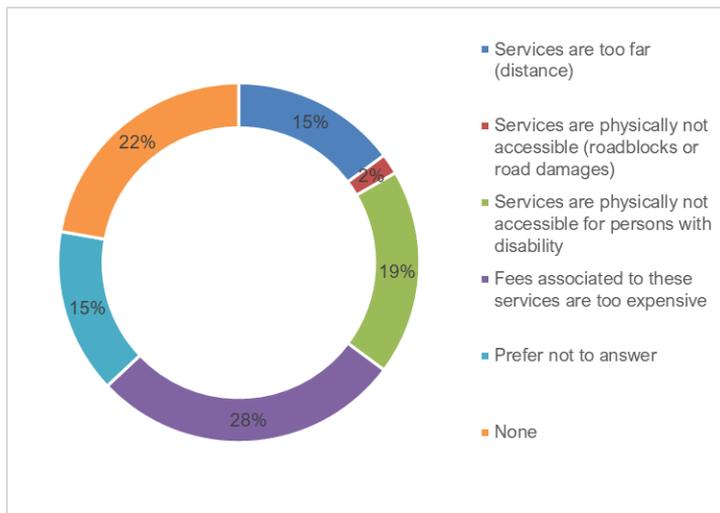
Other sectoral needs were also assessed and disaggregated. Interesting is that in spite of the fact that transportation constituted a barrier or the main barrier to accessing a variety of services, just very few HHs considered it a core priority. Furthermore, 20 percent of HHs in group 0 considered communication among their top three priorities. Finally, education was almost never considered a priority, ranging between two and four percent, by group.

Additionally, 77 percent of the respondents reported preferring assistance to be delivered as cash. This is in line with the cash feasibility assessment produced by the NAPD in the early stages of the Russian

invasion, in which it was reported that all IDPs with disabilities engage with markets to fulfil their daily needs. Majority (80 percent) can buy all or some goods and services themselves and 20 percent are reliant on relatives and caregivers (NAPD 2022).

Such preference matches the opinions of several KIs (KI 1, 3, 8, 9, and 11) who pointed to CVA being the most suitable modality to cover their household’s basic needs. Concerning extra costs embedded in having a member of the household with disability, all of the KI who expressed opinions on this topic pointed to the importance of mixed modalities to cover the multifaceted and subjectively-defined needs of persons with disability.

Figure 26: out of those HHs who reported preferring assistance in other forms than cash only, percentage of reported issues and barriers



Instead, the remaining 23 percent of the respondents stated that assistance should be provided as in-kind and services only, not cash. When investigating the reasons and barriers behind the use of cash, respondents indicated that accessibility of services (financial service providers, banks, marketplaces, community service providers, healthcare centres, etc.) is compounded and that there are associated fees decreasing their purchase power in the markets.

However, respondents also indicated that in-kind may be problematic too, as

it is difficult to transport (21 percent), and distributions are often organised in a way that makes it more difficult for persons with disability to handle (ten percent). Both elements were supported by qualitative data collected through KIs: for example, some indicated that cash might indeed be preferred because it is more portable in case of displacement (KI 11). Others reported that specific food items, which are necessary for people with particular disabilities, are never considered in in-kind distribution of food parcels from humanitarian organisations (KI (1, 8, and 11). Finally, only 46 percent of the respondents reported that they received clear information on what humanitarian assistance is supposed to cover, which highlights a problematic in communication inclusivity from the NGOs’ side. This is further supported by the fact 17 percent of the respondents also stated that information is not shared in ways that can reach and be understood by persons with disabilities (institutional barrier).

Analysis

The data presented above, from both primary and secondary sources, indicate that the Social Protection schemes in Ukraine have remained active following the Russian invasion in February 2022, accounting for schemes including supplementary income and services provision. Yet, since February the context changed dramatically, and a humanitarian intervention was and remains strongly needed. In light of the shock-responsiveness of the government and despite the proactive response of locally-led organisations, gaps identified are mainly affecting service provision and adequacy of the transfers in the current context (i.e., factoring both depreciation of the UAH and inflation). For what concerns cash-based interventions, the predominantly categorical nature of Social Protection schemes has been identified as having potential risks of exclusion for categories of people in need of assistance.

In such context, the role of humanitarian organisations is limited to complementing government initiative with a focus on unmet needs (e.g. MPCA addressing the needs not covered by IDP housing programme) and on those excluded by the categorical eligibility framework, among which are the persons with disabilities who are not officially registered as such.

However, it appears clear that, in the current context and considering the increased levels of needs, humanitarian assistance does not suffice to meet all the most urgent and basic needs of households with an older person or with a member with disability. While this seemed to be true for all households, those with at least one member with disability or an older person most frequently fall at the worse end of the spectrum because of the extra costs associated with their status and the reduced access to income sources and opportunities. Although this is particularly true for those households with a member with disability caused by a recent traumatic event, as they are both new to the condition and have not developed coping mechanisms to deal with it.

The displacement status is reportedly an additional factor affecting the household's capacities to meet its basic needs, specifically for those who either remained in their homes or returned to their areas of origin. This highlights a gap in the provision of humanitarian assistance and Social Protection schemes alike.

The vastly reported negative perception of the appropriateness of humanitarian assistance may be caused by two core drivers, namely: cost of commodities in the markets and decreased purchasing power, and lacking or disrupted access to core services for these groups. While the Social Protection benefits received by these households usually bridge the gap, the context after February 2020 calls for more extensive and comprehensive actions. Observing the negative net-income ratio it is possible to notice that households in group one have a gap at least twice as high as the control group (1,500 UAH for group 0 vs. 4,100 UAH for group 1D). Yet, the more persons receiving Social Protection are in a household, the smaller the gap appears to be (610 UAH for group 2).

Indeed, costs are clearly not the main barrier to accessing services and core commodities. Main barriers reported factor transportation to and from facilities, physical barriers to access, information barriers, and a component on perceptions of either the family or the community. As such, humanitarian assistance alone does not suffice, and in fact over three quarters of respondents reported that it should be coupled with in-kind assistance and service provision upon necessity and/or geographical location.

While it appears that every household, in spite of IDP status, is entitled to similar services and benefits, geographical differences play a pivotal role in Ukraine, particularly for newly accessible areas and oblast still with active conflict. Furthermore, considering that on the one hand cash-based programmes, spearheaded by the Disability Pension, have largely continued delivering without changes in transfer values, and on the other hand, social provision and to a lesser extent in-kind and service provision assistance have been affected both in terms of availability and quality, accessibility remains one of the main barriers to tackle to ensure inclusivity.

Recommendations²²

Acknowledging all data and information gathered, together with implicit suggestions from the interviewed households, it appears clear that, in order to have a more inclusive approach to humanitarian assistance in Ukraine, a mixed modality approach should be prioritised. Indeed, more research and assessments are needed, with disaggregation based not only on the disability status of the head of HH, but also on the presence of persons with disabilities and/or older persons in the HH composition. Where possible, it is advisable to consider a case-by-case approach to ensure the needs of all persons are adequately met, particularly noting the bias in this study towards persons with physical disabilities.

Needs for top-ups

A Protection top up for households with a member with disability or injuries caused recent and traumatic events (i.e., war wounds affecting civilians since February 2022) in spite of whether these are temporary or permanent, particularly in light of considerations around the Minimum Expenditure Basket (MEB) or the standard Multi-purpose Cash Assistance (MPCA) transfer value may not be changed anytime soon. For this subset it would be advisable to top up the standard MPCA with 6,308 UAH (170 USD)²³ monthly for one to three months although a case-by-case analysis to redefine the value based on each individual condition should also be applied through a Protection lens.²⁴ This top up should aim to cover all extra costs associated with the first months coping with the new condition (i.e., food, utilities, clothing, and hygiene items, and not factoring extra medical costs or the provision of a caregiver) and with the specific needs based on the environment they live in and their registration status with the Social Protection schemes. Furthermore, in light of the extent of coverage of the government Social Protection system, it appears that this Protection top-up can be administered at household level, rather than per-capita, with a categorical targeting approach based on the presence of a person with disabilities in the household composition. The Protection top-up would indeed benefit the entire household in meeting the extra costs associated with the newly acquired disability of one of their members, as many of the costs associated are at household level.²⁵ Moreover, it is absolutely necessary to coordinate with the government and local institutions (e.g. CSNAP, TSNAP, CCSS, SSCCFY) to ensure their registration in the Social Protection schemes and complementarity, as disability specific benefits cannot be exclusive (KI 10), but should be coupled with other levels of mainstream assistance upon need.

Beyond cash - Mixed modalities

However, considering that *“there are not two persons with the same disability in the world”* (KI 1), and that *“the decisions on assistance amount and methods should depend on what people need, not the severity of their conditions as the environment and context may provide dissimilar support or barriers”* (KI 1), humanitarian assistance should be as inclusive and adaptable as possible. It is a well-known fact that not all needs can be covered with CVA (e.g., rehabilitation treatments, access to services and infrastructure, etc.), and these needs are recommended to be addressed by integrating CVA with:

1. the provision of in-kind medication in areas where pharmacies are reported poorly stocked,
2. provision of funding and resources for community services or “group cash transfers”, to tackle funding gaps of OPDs and volunteer groups to enhance the local ecosystem of informal support and assistance provision,

²² These recommendations are strictly linked to the findings of the study, and thus apply mainly to HI's operations in Ukraine. Other humanitarian actors may choose to adopt these recommendations too, but further analysis should be considered in order to better understand the individual needs and dynamics of the geographical areas of operations and demographics of the caseload.

²³ Exchange rate at 15 November 2022 (6,308 UAH)

²⁴ For the breakdown of calculations please see Annex D

²⁵ As above.

3. by delivering trainings and services normally provided by OPDs where they are not functional or easily accessible, or providing sub-grants to the OPDs where needed,
4. delivery of technical in-kind and assistive devices (e.g., wheelchairs and other assistive devices) for those households in need or in areas where services of this type are not functioning,
5. training to communities and volunteers to provide informal support in order to ensure they have sufficient means and understanding to provide the best possible help within their availability and capacity,
6. broader baskets of core commodities for those who have difficulties leaving their house.
7. developing a clear referral system or pathway to ensure linking persons with disabilities receiving MPCA to sectoral or specialised services for other unmet needs that they may have (ex. health, education, protection, etc.), and
8. promote better coordination among government and humanitarian actors (i.e., not just aligning transfer values) to ensure complementarity.

All this combined could provide additional benefits to those households with a member in need. In areas where it is already possible to discuss recovery and reconstruction, it would be helpful to reconsider access facilities for basic services and infrastructure, as well as transportation designs, frequency, routes, and inclusivity.

Identified gaps

Additionally, it is recommended to more closely consider those who remained in their homes and the returnees (non-IDPs) with disabilities in the targeting strategies of humanitarian organisations as the analysis of their net-income ratio showed that they have much greater socio-economic needs compared to the IDPs. However, in order to continuously support better inclusivity of humanitarian assistance and rapidly identify needs and barriers, it is recommended to enhance disaggregated and IDP status as well as disability-sensitive data collection across the response.

Communication, advocacy, and sensitization

Finally, strong advocacy and sensitization messages to raise awareness about independence and/or capacity of persons with disabilities across communities, families, and employers may be beneficial. This is also strictly linked to the reported informational barriers, or broader issues with accessing information. It is pivotal to call for more inclusive and comprehensive communication approaches, to ensure everyone would have equal access to the information they need.

Considering the humanitarian focus of the eDopomoga system, and the broader Social Protection schemes, and its large-scale use by humanitarian agencies, it is recommended to review the accessibility of the system by persons with different disabilities in order to ensure proper access and use by everyone in need. This review should also include an active component of outreach to persons with disabilities to provide individual-level support in accessing the system.

Ways forward

Should it become possible to re-discuss and adapt the standard MPCA amount, it is necessary to call for a more inclusive approach. This would entail a revision of the list of commodities themselves, quantities, and current costs in the local markets in main cities, newly accessible areas, frontlines, and conflict active zones.

It remains to be considered, however, that disabilities may be “*forever, while humanitarian work is just short term*” (KI 5) and persons with disabilities require more meaningful participation in all spheres of society, and particularly in the development of longer-term solutions in order to ensure continuous access to the resources they need. Nexus now is the core aspect to consider in order to be inclusive

and generate results that can be sustained in the longer-run, together with the strengthening of pre-existing schemes and considerations around adequate values based on the current socio-economic context and availability of services.

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Annex A

Social Protection mapping

Please, see the attached Excel file.

Annex B

Table 2: methodology used per research question and sub-question

Research Questions		Quant (HH)	KIIs	FGD
What are the barriers and the enablers to make CVA humanitarian assistance in Ukraine be more inclusive for older persons and people with disabilities?	What are the barriers encountered by persons with disabilities and/or older persons in accessing MPCA?	X	X	X
	Is the current MPCA transfer value factoring specific needs of older persons and persons with disabilities, resulting in both direct and indirect costs?	X	X	
	Is the current transfer value adequate to meet the needs of households with older persons or members with disabilities?	X	X	
	What is the difference in need and monthly expenditures of households with and without members with disabilities?	X	X	X
	Are there additional services provided to households with older persons or members with disabilities? And are these provided	X	X	X

	equally in spite of IDP status?			
	Should there be a top-up to bridge any gap? And if yes, how much? Or if not, what other modalities of assistance should be prioritised or integrated in the broader humanitarian response?	X	X	
Is the government's Social Protection (SP) system in the position of continuing supporting households with members with disabilities?	What services are currently available and/or free of charge for older persons and people with disabilities in Ukraine? And did they remain accessible in the aftermath of the Russian invasion of Ukraine?	X	X	X
	What is the current eligibility framework for the government SP system?		X	X
	How much is the government currently providing or planning to provide moving ahead as part of the SP scheme?		X	X
	What is the extent, if any, of the gap that could be forecasted for the SP system moving forward?		X	X
	How can humanitarian actors support in the short and medium term in bridging this gap?	X	X	X

Annex C

Suggested approach to a contextualised Livelihood Coping Strategy Index (LCSI)

In order to better address the analysis on the livelihood coping strategies used by the respondent HHs, the consultants developed a draft LCSI through the use of nine indicators weighted based on the severity of the coping strategy used and its possible socio-economic implications and health-related consequences in the longer-run. Out of the nine indicators, seven were selected from the global recommended list, considering both frequency studies and further thematic quantitative evaluations, and four were added to better reflect the specificity of the study on inclusive MPCA and humanitarian assistance for persons with disabilities and older persons. Where available, literature about coping strategies and protection implications supported the decisions around the indicators selected.

Each of the nine coping mechanisms selected was assigned a severity coefficient based on two possible approaches, one more general, and one more inclusive and sensitive to the different needs and implications that specific coping mechanisms may have on persons with disabilities or older persons. Indicators were then weighted ranging from one to five (where the higher the coefficient, the more severe the implications of using the coping mechanism are). The complete set of indicators is presented in Table below.

Table 3: suggested weighting approach to assessed coping strategies

Indicator	Frequency of use	Option 1 (general)	Option 2 (inclusive)
Spent savings	53%	1	1
Reduced expenses on health (e.g., medicines, routine exams, etc.)	67%	3	5
Borrowing money from friends, family, or acquaintances	22%	2	2
Selling assets ²⁶	5%	2	3
Withdrawing children from formal education in order to engage them in working for the HH economic gain	3%	5	5
Asking money to strangers or begging	0%	4	4
Reduced expenditures on essential food and non-food items (i.e., water, hygiene items, etc.)	77%	4	4
Reduced expenditures on specific healthcare costs (e.g., assistive devices, rehabilitation, medication, caregiver, etc.)	53%	3	5
Other coping	18%	1	1

²⁶ This should be divided into selling non-productive assets (e.g., jewellery), productive assets (e.g., land, house, electronics, vehicles, etc.), and selling assistive devices and medications. If so, they should be weighted 1, 3, and 3 / 5 respectively.

mechanisms not already covered in the list above			
TOTAL POSSIBLE SCORE		25	30

If adopting option 1, on average the caseload would score 8.11 out of 25, with the control group (group 0) falling below average (7.02), and group 2 slightly above (8.78). However, if adopting a more disability inclusive approach in the weighting system, out of 30 possible scores to obtain, group 0 would score 8.47, group 1 10.76, and group 2 11.57, leading to a relative more substantial difference between the group 0 and the scores of HHs with at least one member with disability (group 1 and 2).

Table 4: average score by approach, by group

Group	Average LCSi, option 1 (general)	Average LCSi, option 2 (inclusive)
Group 0	7.02	8.47
Group 1 (D+E)	8.13	10.76
Group 2	8.78	11.57
Total	8.11	10.55

Figure 27: frequency distribution of LCSi (option 2, disability inclusive approach)



Based on the frequency test, suggested thresholds could fall at 6 for “stress”, at 15 for “crisis”, and at 20 for the “emergency” status. This would lead to having 20 percent of the caseload in “crisis” or “emergency”, out of which 7 percent belong to the group 2, 6 percent to the sub-group 1E, and 6 percent to the sub-group 1T.

Please, kindly consider that this indicator is a draft, and would require extensive testing prior to its endorsement. It was purely developed to have a more in-

depth comparative understanding of the severity of coping mechanisms currently used by HH assessed for this study.

Annex D

Breakdown of calculation to estimate the protection top-up

Based on all of the above, the Protection top-up was calculated on additional costs related to essential commodities that HHs falling into the sub-group 1T reported having.²⁷ Indeed, this group would also require delivery of other ad-hoc support beside MPCA and the suggested top-up, as per the table below. The Protection top-up rather aims to cover only those extra costs that KIs indicated due to the buffer months between the trauma and the creation of coping mechanisms to cope with the new condition.

Table 5: breakdown of costs and suggested mean to address them

Sector	monthly Δ ²⁸ UAH	Notes
Food	2,633	Different dietary requirements may be needed for the first months after traumatic events, or even just the need to purchase already-cooked food instead of ingredients (due to difficulties in cooking or standing) may have increased the average cost per month. <u>(FACTORED IN THE TOP-UP)</u>
Rent and shelter	322	Need to adapt furniture or entirely change the residency may have arisen after the traumatic event (e.g., need to live on the ground floor or in buildings with an elevator, need to purchase specific bedding or actual furniture, etc.) <u>(FACTORED IN THE TOP-UP)</u>
Healthcare (beside costs that are trauma related)	2,521	Increased costs in pharmacy, routine visits, check-ups, etc. However, this was not factored in the calculation of the top-up, as they will be covered under insurance and SP scheme once they will enrol, and it can be addressed via in-kind and service assistance provision.
Caregiver	462	As per the narrative above, need to pay for a caregiver (only HHs in the sub-group 1T had a paid professional amongst their monthly expenditures). However, these costs were not factored in the calculation of the top-up, as it could be provided in the form of services, and/or it will be covered by the SP scheme once they will enrol.
Utilities	1,743	Due to the traumatic event and rehabilitation, persons within this sub-group may stay at home longer and need for more constant heating, light, and running water.

²⁷ Please, kindly consider that these are mean averages, and that the costs do not include the 12,700 UAH spent on average only on trauma (healthcare).

²⁸ Δ is the Greek letter Delta, and refers to an arithmetic difference between two values, in this case 1T-0.

		This, reportedly, led to higher costs of utilities. <u>(FACTORED IN THE TOP-UP)</u>
Clothing and non-food items (e.g., blankets)	1,013	Same as per the utilities, there may be additional needs for clothing and blankets. <u>(FACTORED IN THE TOP-UP)</u>
Hygiene items	597	The cost of hygiene items may have increased due to specific needs and supplies to attend to the needs of those with a “new” disability (e.g., specific types of soap, gloves, etc.) <u>(FACTORED IN THE TOP-UP)</u>
Other costs	575	Other and higher costs were reported on average, but these were not factored in the calculation for the top up, as ad-hoc assistance may be needed, and these can be covered under the standard MPCA, their income, or the SP assistance once they will enrol in the system.
TOTAL	6,308 UAH =170 USD.	This represents the sum of the components signed as <u>(FACTORED IN THE TOP-UP)</u> . Yet, as clarified, other needs and extra costs may need to be addressed via provision of in-kind and service assistance, and some will be covered by the appropriate SP schemes once they will enrol and register.