From emergency response to system integration

Health and socio-economic conditions of refugees from Ukraine in Poland (2022–2025)

Statistics Poland (GUS),
World Health Organization (WHO)
and
United Nations High Commissioner for Refugees (UNHCR)

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Abbreviations

CZP – Community Mental Health Centre (Centrum Zdrowia Psychicznego)

DTP – Diphtheria, Tetanus and Pertussis (Whooping Cough) Vaccine

HH – Private households (Gospodarstwa domowe)

GUS – Statistics Poland (Główny Urząd Statystyczny)

MMR – Measles, Mumps and Rubella Vaccine

MHPSS – Mental Health and Psychosocial Support Services

CC – Collective Center (Ośrodek Zbiorowego Zakwaterowania)

PESEL UKR – Polish National Identification Number with Temporary Protection Status

PTSD – Post-Traumatic Stress Disorder

TB – Tuberculosis

UNHCR – United Nations High Commissioner for Refugees

WHO – World Health Organization

Executive summary

Four years after the start of the full-scale invasion of Ukraine, Poland's response has evolved from emergency reception to structured and measurable integration. What began as rapid humanitarian absorption has transitioned into systemic inclusion within national institutions. The evidence presented in this report demonstrates that this transition has largely succeeded.

Between 2022 and 2025, key indicators show sustained stabilization. Healthcare access has consolidated, with nearly all refugees reporting that their medical needs are met. Financial exposure to health costs has declined sharply, reflecting strengthened economic resilience. Labour market participation has increased, mental health functional impairment has fallen by half since the early displacement phase, and vaccination coverage has grown and remains high at the population level. These outcomes are not temporary improvements; they indicate structural integration into Poland's health, labour, and social systems.

The socio-economic profile reinforces this transition. The refugee population is highly educated, language acquisition has advanced substantially, and nearly two-thirds have resided in Poland for more than three years. Integration is therefore no longer transitional but structurally embedded in human capital and residency patterns.

The 2025 survey introduces expanded measurement of mental health conditions and psychosocial service utilization, allowing deeper insight into concentrated structural vulnerability. The findings reveal that vulnerability is no longer spread across the refugee population. Instead, it has become petrified among groups of older, disabled, less educated refugees who stay in collective centers.

Across employment, financial risk protection, vaccination coverage, mental health prevalence, and psychosocial support, differences are observed between refugees living on their own and those who have no other option but to be housed in collective sites. Refugees residing in private households demonstrate outcomes closely aligned with overall stabilization. In contrast, collective center remains associated with significantly worse outcomes: employment is dramatically lower, mental health functional impairment more than three times higher, stress-related conditions substantially elevated — particularly among women — and financial and preventive gaps persist. Although psychosocial service utilization is higher in collective settings, it does not proportionately match the elevated burden.

Poland has demonstrated that large-scale integration into national systems is achievable. The remaining challenge is targeted consolidation. Collective center has emerged as a concentrated pocket of structural vulnerability within an otherwise integrated system.

Poland has built the foundations of integration. The next phase requires precision to secure long-term resilience.

These indicators confirm that integration into Poland's national systems is not temporary or partial. It is real, measurable, and structurally embedded for the majority of refugees.

However, the evidence also reveals a concentrated and persistent vulnerability among refugees residing in collective centers (CC). The right to stay in CC is regulated by the law and predetermines the characteristics of the resident population. At the time when the research was conducted, the population of residents of collective sites was composed primarily of retirees (women over 60 years of age, and men over 65), pregnant women, persons raising a child up to 12 months of age, single parents, persons independently providing care to three or more children, minors placed in foster care and their temporary guardians, adult students under 20 years of age attending full-time post-primary schools providing education or persons directly after hospitalization. The a priori demographic composition of this group, determined by the conditions of eligibility, is an important factor to consider when interpreting the survey results.

Across employment, financial risk protection, mental health, vaccination coverage, access completion and protection indicators, collective center residents (CC) consistently perform worse than refugees living in private households (HH). Employment in the collective centers stands at 28% compared to 72% in private housing. Functional impairment is more than three times higher. Financial burden and cost barriers are markedly elevated. Also the proportion of unvaccinated children is significantly higher.

Poland has successfully stabilized the system at scale. The next phase is not expansion of emergency response, but precision targeting to eliminate concentrated structural vulnerability.

If housing-based inequality is addressed decisively, Poland's transition from emergency management to durable integration can be completed and serve as a European model for medium-term displacement governance within national systems.

Introduction

Since 2022, Poland has undertaken one of the most rapid and large-scale refugee inclusion efforts in Europe. What began as an emergency response has evolved into a structured integration process embedded within national systems – health, labour, education, and social protection.

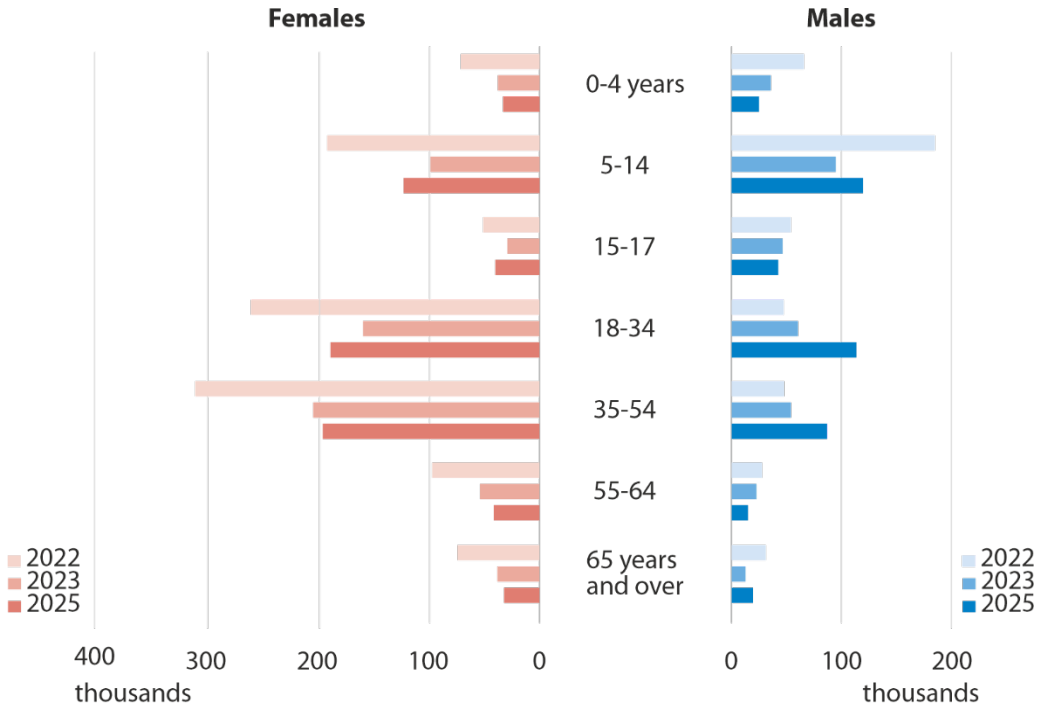
This report provides a three-year evidence trajectory (2022–2025) assessing whether that transition has succeeded, and where structural vulnerabilities remain. The 2025 survey expands analytical depth for the first time, introducing detailed measurement of mental health disorder categories, psychosocial service utilization, and mistreatment experiences. This allows a more precise distinction between system-level stabilization and concentrated structural vulnerability.

The central question is no longer whether the system absorbed displacement. The question now is whether integration is durable, equitable, and aligned with the emerging reality of medium-term residency and settlement. Accordingly, this report focuses on housing modality as the primary structural differentiator shaping integration outcomes in 2025.

From emergency displacement to structural integration (2022–2025)

The demographic profile of refugees from Ukraine in Poland provides the clearest structural signal of transition from emergency displacement to medium-term residency. Changes in age and sex composition between 2022 and 2025 reflect reduced inflow volatility, partial normalization of early crisis imbalances, and consolidation into a predominantly working-age population. Understanding this demographic stabilization is essential for interpreting subsequent trends in labour market participation, service utilization, and long-term integration planning.

Figure 1. Demographic transition of refugees from Ukraine in Poland



Between 2022 and 2025, the refugee population in Poland underwent a clear demographic stabilization. The 2022 profile reflects emergency displacement dynamics: a strongly feminised structure in prime working ages (18–54), particularly visible in the 35–54 cohort (female 311.7 thousand vs male 48.7 thousand), alongside a large concentration of children aged 5–14.

By 2023, the overall age structure narrowed in scale but retained its core features: women continued to dominate working-age cohorts, while the relative weight of children declined compared to 2022. This suggests reduced immediate inflow volatility and early settlement consolidation.

The 2025 overall distribution confirms the emergence of a stable, predominantly working-age population. The demographic center of gravity remains concentrated in the 18–54 age range, with

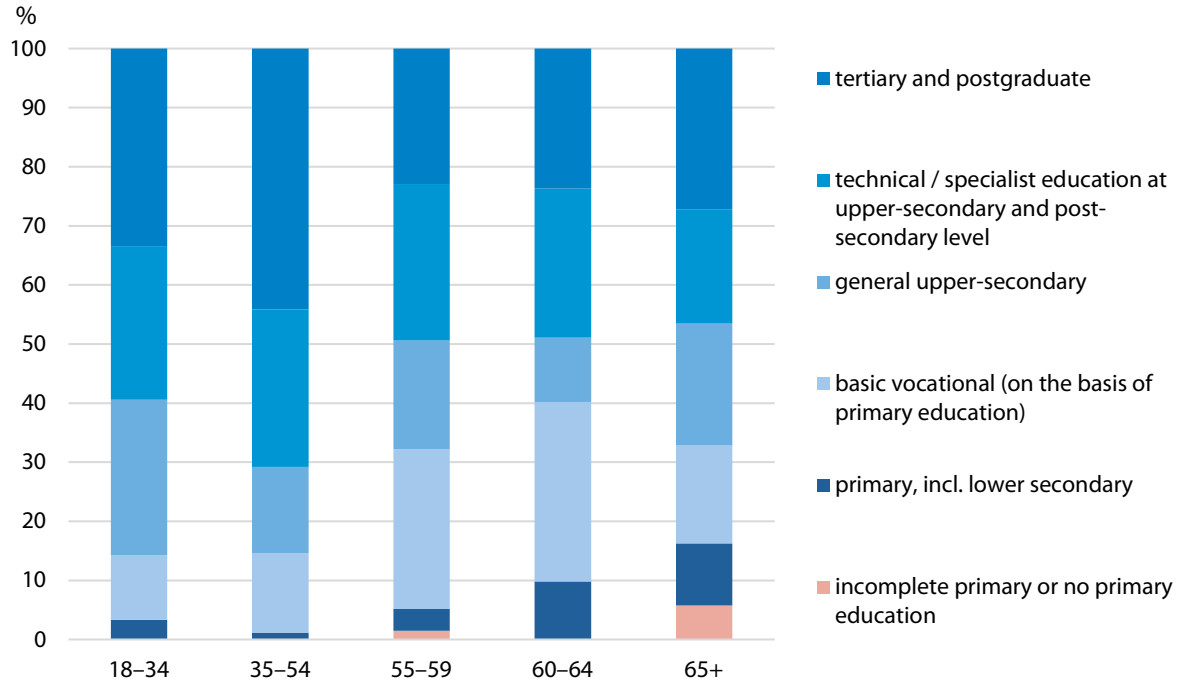
women still forming the majority in these cohorts (e.g., 18–34: 189.3 thousand females vs 113.3 thousand males; 35–54: 196.9 thousand females vs 87.0 thousand males). At the same time, the presence of men in prime working ages increased compared to 2022, indicating partial normalization of the sex imbalance observed during the initial displacement phase. It is important to acknowledge that these shifts were influenced primarily by legal changes in Ukraine related to mobilization and regulations governing the right to leave the country, which contributed to an increase in the number of young Ukrainian men among refugees in Poland. Men aged 18-22 were allowed to leave Ukraine freely (without meeting additional conditions) as of August 2025. Children (5–14) continue to represent a substantial share of the population, while older age groups (55+) remain smaller but persistent across waves.

Overall, the demographic trajectory shows a transition from acute crisis-driven displacement toward a more settled, labour-relevant population structure. The implications for policy are structural: this is no longer a short-term humanitarian cohort but a medium-term resident population with sustained implications for labour markets, education systems, health services and social protection planning.

Socio-economic conditions and settlement dynamics

By 2025, the refugee population in Poland is no longer defined primarily by displacement status but by its integration capacity and settlement trajectory. Education, language acquisition, labour market participation, duration of stay and return intentions together provide a structured assessment of socio-economic consolidation and long-term integration prospects

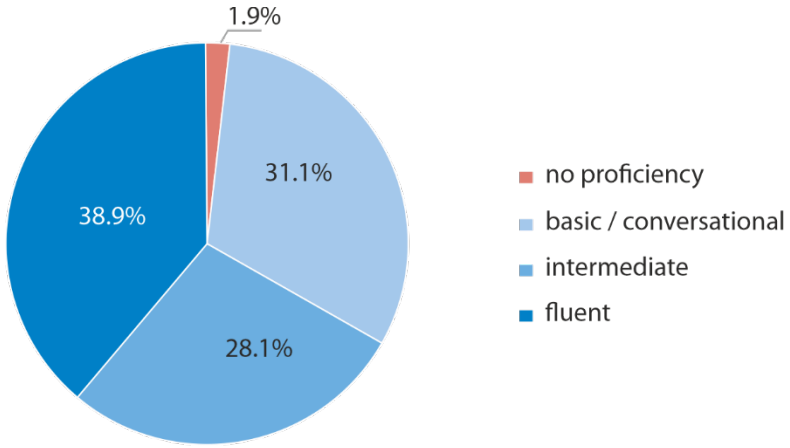
Figure 2. Educational attainment by age group in 2025



Educational attainment is high across prime working ages. The 18–34 and 35–54 cohorts are dominated by upper-secondary, technical/specialist, and tertiary education, indicating substantial human capital relevant for labour market integration. Lower education levels (primary or below) are minimal in younger and middle-age groups.

In older age groups, the distribution becomes more mixed and the share with lower or vocational education increases, alongside a smaller tertiary share-consistent with cohort and education-system effects. The overall implication is that integration constraints are more likely to arise from language, credential recognition and labour market matching than from low educational attainment.

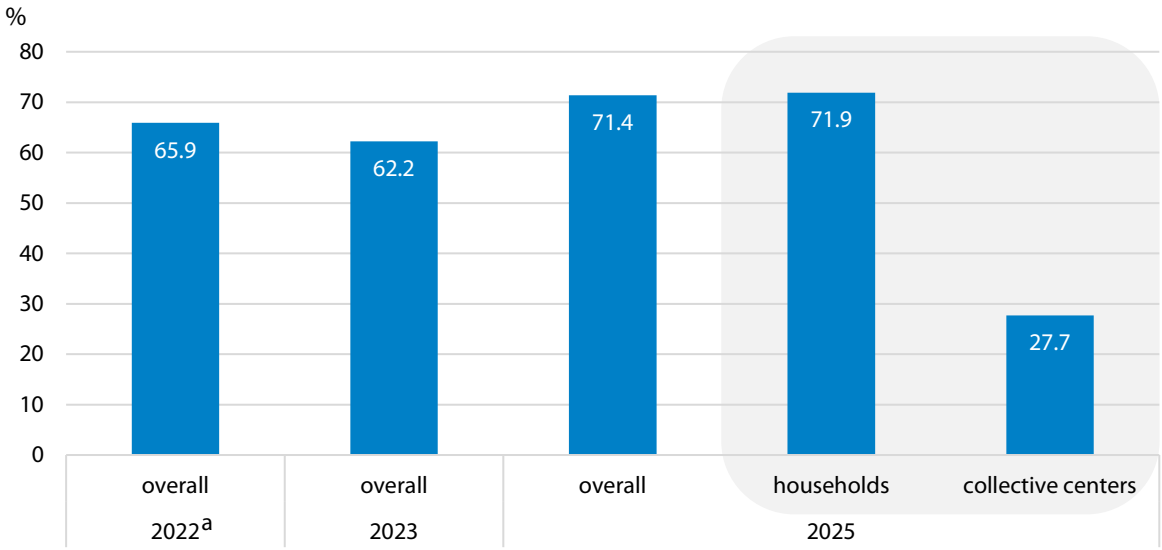
Figure 3. Polish language proficiency among refugees in 2025



Language proficiency among refugees is high. Only 1.9% of respondents report no Polish proficiency. Nearly 39% report fluent command, while 28.1% demonstrate intermediate functional capacity and 31.1% basic conversational ability.

Taken together, roughly two-thirds of refugees now possess intermediate or fluent proficiency. Language is therefore no longer a widespread structural barrier but a differentiating factor influencing labour market quality, occupational mobility, and long-term integration prospects.

Figure 4. Work in Poland overall and by housing



a Refers to people who expressed an intention to work in Poland.

Employment participation among refugees in Poland remains high overall. The employment share rises to 71.4% in 2025, indicating strong labour market attachment at the aggregate level. In 2023 the

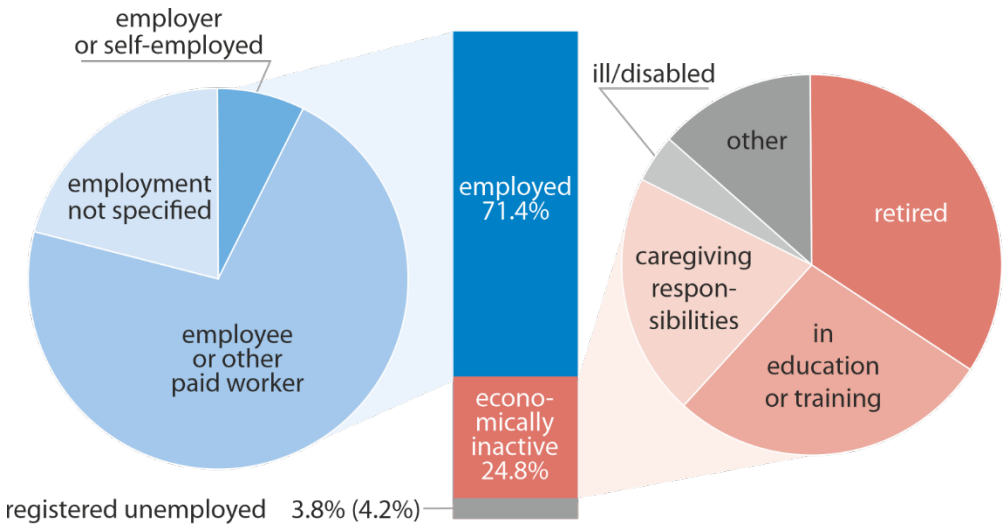
share of refugees who were employed in Poland amounted to 62.2% in 2023 (in 2022, 65.9% of refugees declared their willingness to work in Poland).

However, the 2025 housing disaggregation reveals a pronounced structural divide. Employment among refugees living in private households (HH) reaches 71.9%, closely matching the overall rate.

This divergence is substantial. While the majority population in stable housing appears economically integrated, collective center is associated with markedly lower labour participation.

The policy implication is clear: labour market integration at the national level masks a concentrated pocket of exclusion within collective center. Targeted activation measures, childcare support, and housing transition policies will be critical to closing this structural gap.

Figure 5. Socio-economic status of adult refugees in 2025

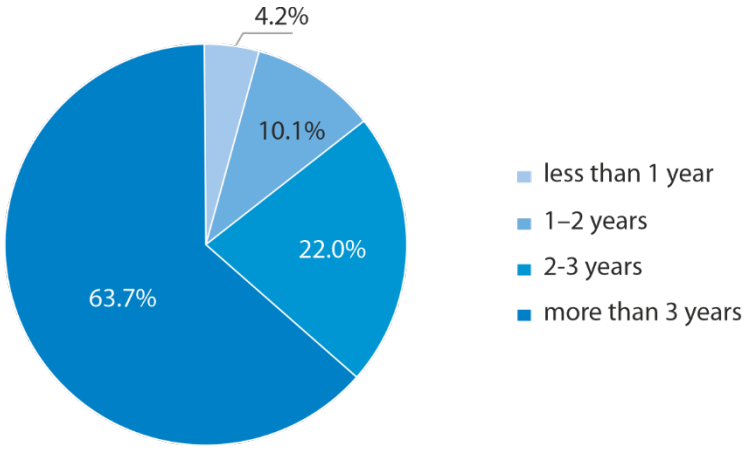


* Percentages given in brackets refer to working age population

Employment and language proficiency move together in a clear gradient. Employment participation is lowest among those with no or minimal Polish and rises steadily as language capacity increases. By 2025, 29.0% of all respondents are both employed and fluent in Polish, compared with only 0.3% employed among those reporting no proficiency.

This pattern indicates that Polish language capability functions as an enabling mechanism for labour market integration, not merely an integration marker. Policy responses that link employment activation with structured language advancement are likely to produce the strongest gains.

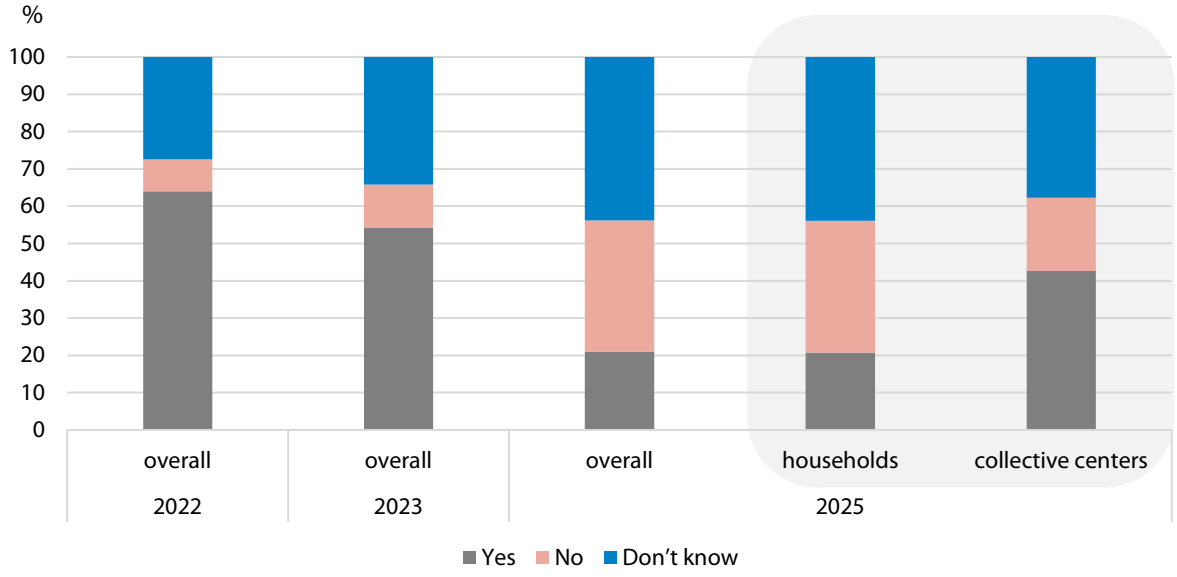
Figure 6. Length of stay of refugees from Ukraine in Poland in 2025



By 2025, displacement has clearly transitioned into medium-term residency. Nearly two-thirds (63.7%) of refugees have lived in Poland for more than three years, and a further 22.0% between two and three years. Only 4.2% report staying in Poland for less than one year.

This residency duration confirms that the refugee population is no longer in an emergency reception phase. The policy lens must therefore shift decisively toward durable integration planning– across labour market participation, education-to-work pathways, language advancement, and long-term service access– rather than short-term humanitarian assumptions.

Figure 7. Intention to return to Ukraine overall and by housing



Settlement expectations shifted sharply between 2022 and 2025. The share intending to return ("Yes") declined from 64.0% (2022) to 54.3% (2023) and then to 20.9% (2025). Over the same period, the share

reporting they do not intend to return ("No") increased to 35.3% in 2025, while uncertainty ("Don't know") rose to 43.8%.

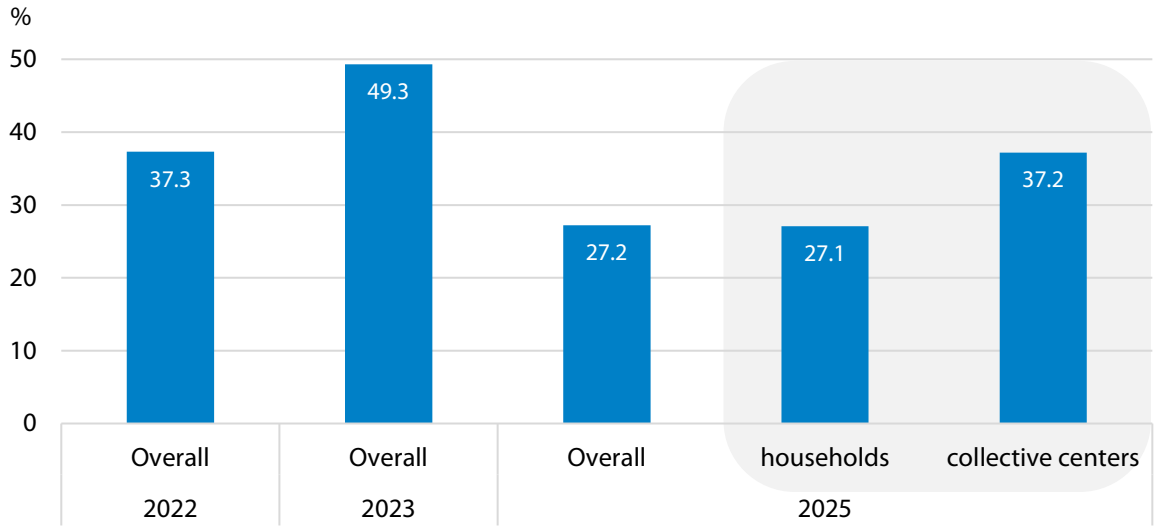
In 2025, the housing disaggregation shows a clear divergence. **Refugees in private households (HH) are less likely to intend to return (20.7%) than those in collective center (CC, 42.6%).** Conversely, **a higher share in HH report no intention to return (35.4%) compared with CC (19.8%).** Uncertainty remains high in both groups (HH 43.9%; CC 37.7%).

The policy implication is that settlement trajectories are strongly patterned by housing conditions. Collective center is associated with higher return intention and lower stated non-return.

Health needs and effective access

Health needs and the ability to effectively resolve them provide a core test of system integration. Beyond overall service coverage, the key question is whether healthcare demand has stabilized over time and whether access is equitably realized across different living arrangements. The following analysis distinguishes between levels of need and the probability of completing care, allowing assessment of both normalization and remaining structural gaps.

Figure 8. Healthcare need in the last month overall and by housing



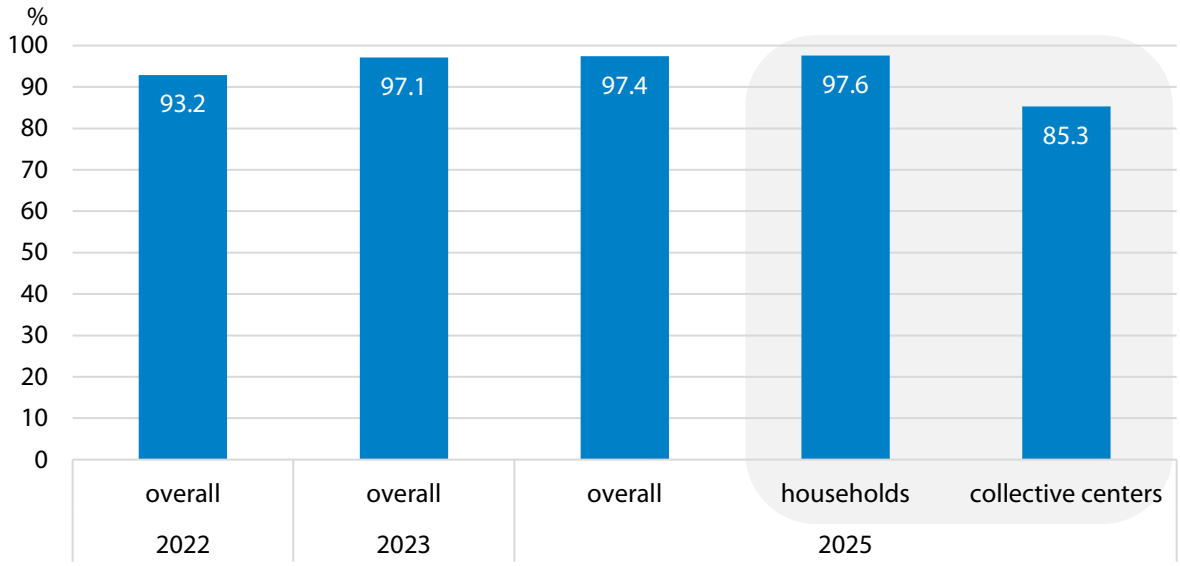
Reported healthcare need fluctuated substantially over time. In 2022, 37.3% of refugees reported needing healthcare in the last month. This rose sharply to 49.3% in 2023, before declining to 27.2% in 2025.

The 2025 distribution shows virtually no difference between housing modalities: 27.1% in private households (HH) and 37.2% in collective center (CC). This indicates that, unlike several other outcome areas in this report, healthcare need itself is not structurally differentiated by housing in 2025.

The temporal pattern suggests a mid-period peak in healthcare demand in 2023, possibly reflecting accumulated unmet need, delayed care-seeking, or stress-related morbidity–followed by stabilization by 2025 at a level substantially lower than in previous waves.

The key policy message from this figure is therefore not inequality, but normalization. By 2025, healthcare need has declined to below 2022 levels and is evenly distributed across housing types. Subsequent figures will show whether access and financial risk protection follow the same equitable pattern.

Figure 9. Access to health care overall and by housing



Effective access to healthcare has improved steadily over time at the population level. The share reporting that they received healthcare increased from 93.2% in 2022 to 97.1% in 2023 and 97.4% in 2025, indicating strong system performance overall[1].

However, the 2025 housing disaggregation reveals a clear equity gap. While full resolution of need reaches 97.6% among refugees living in private households (HH), it falls to 85.3% in collective center (CC), a difference of 12.3 percentage points.

This divergence is analytically important. Healthcare need itself is similar across housing types (Figure 2), yet the probability of resolving that need differs substantially by living arrangement. The issue is therefore not demand, but effective service completion. Collective center is associated with lower realized access despite high overall coverage.

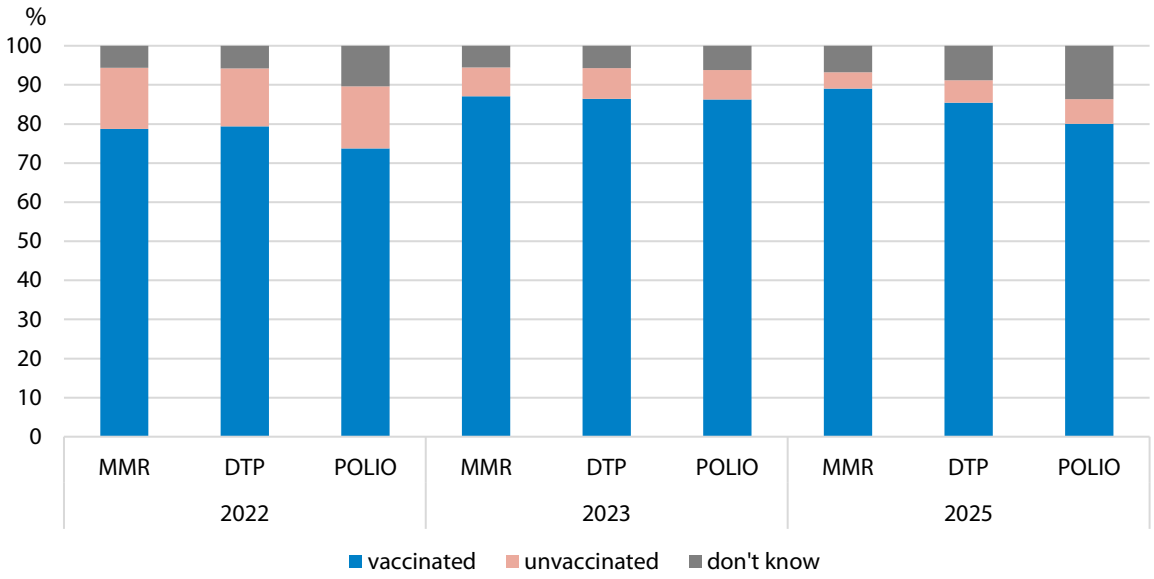
The policy implication is clear: national coverage levels are high, but equitable access requires targeted operational adjustments in collective settings, including service navigation, continuity of care, and medication access.

[1] In 2022 and 2023 respondents reported if they had access to healthcare, only in 2025 it was if they had access to all needed medical services

Vaccination coverage and public health risk

Vaccination coverage provides a critical lens on both system integration and residual public health vulnerability. While aggregate immunization levels reflect successful incorporation of refugee children into Poland's national vaccination programme, disaggregated analysis reveals whether preventive protection is equitably distributed. The following evidence distinguishes between overall stabilization and localized immunity gaps that may pose longer-term public health risks.

Figure 10. Declared vaccination status of children aged 1–4 years



Vaccination coverage improved substantially between 2022 and 2023 across all antigens. MMR increased from 79.9% to 87.1%, DTP from 80.5% to 86.4%, and Polio from 74.7% to 86.3%, reflecting rapid integration into Poland's immunization system following initial displacement.

By 2025, overall coverage remains high for MMR (89.0%) and DTP (85.5%), while Polio stands at 80.1%. However, the 2025 housing disaggregation reveals a pronounced structural divide.

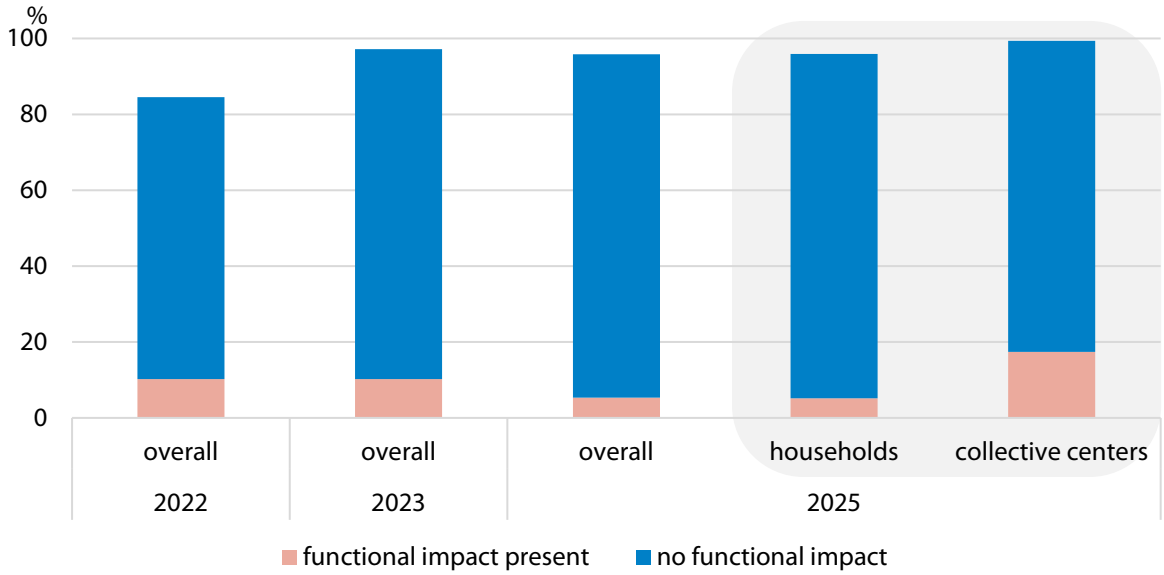
Among refugees living in private households (HH), coverage is strong and closely aligned with overall levels (MMR 89.3%, DTP 85.8%, Polio 80.3%). In contrast, coverage in collective center (CC) is markedly lower across all vaccines (MMR 64.0%, DTP 60.8%, Polio 59.8%).

The policy implication is clear: while aggregate vaccination performance appears robust, collective center represents a concentrated pocket of under-immunization. Targeted catch-up campaigns, on-site vaccination delivery, and improved vaccination tracking systems in collective settings are essential to prevent localized immunity gaps and sustain national coverage goals.

Mental health and psychosocial support

For the first time across survey waves, the 2025 round introduces a deeper and more granular assessment of mental health conditions and service utilization. Beyond functional impairment (tracked since 2022), the survey now measures specific disorder categories and actual use of mental health and psychosocial support services (MHPSS). This expanded lens allows distinction between overall stabilization trends and concentrated structural vulnerability.

Figure11. Mental health functional impairment overall and by housing

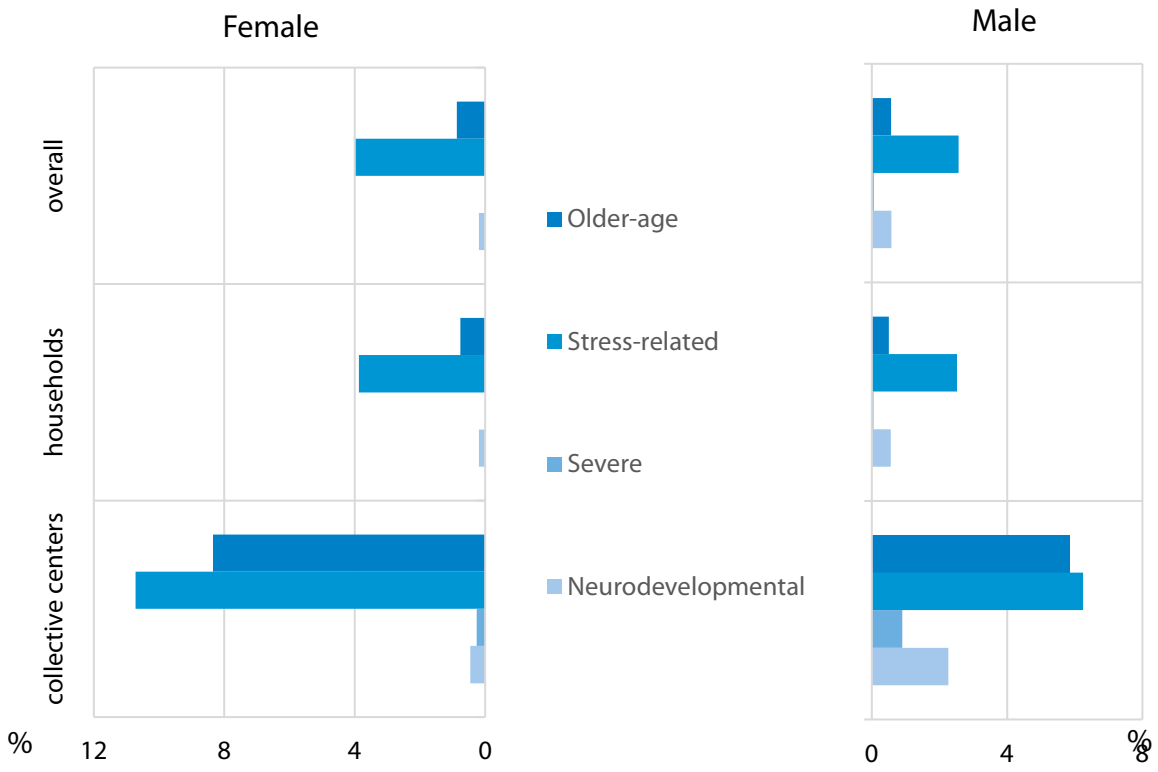


Functional impairment due to mental health conditions declined significantly at the population level – from **10.2% in 2022 and 2023 to 5.3% in 2025**. This confirms overall psychosocial stabilization consistent with broader integration trends.

However, housing disaggregation reveals structural concentration. Functional impairment stands at **5.2% in private households (HH)** but rises to **17.4% in collective center (CC)** – more than three times higher.

The system has stabilized overall, but mental health burden remains spatially concentrated. Collective center functions as a high-risk psychosocial environment within an otherwise integrated population.

Figure 12. Prevalence of mental health conditions among female and male by housing in 2025



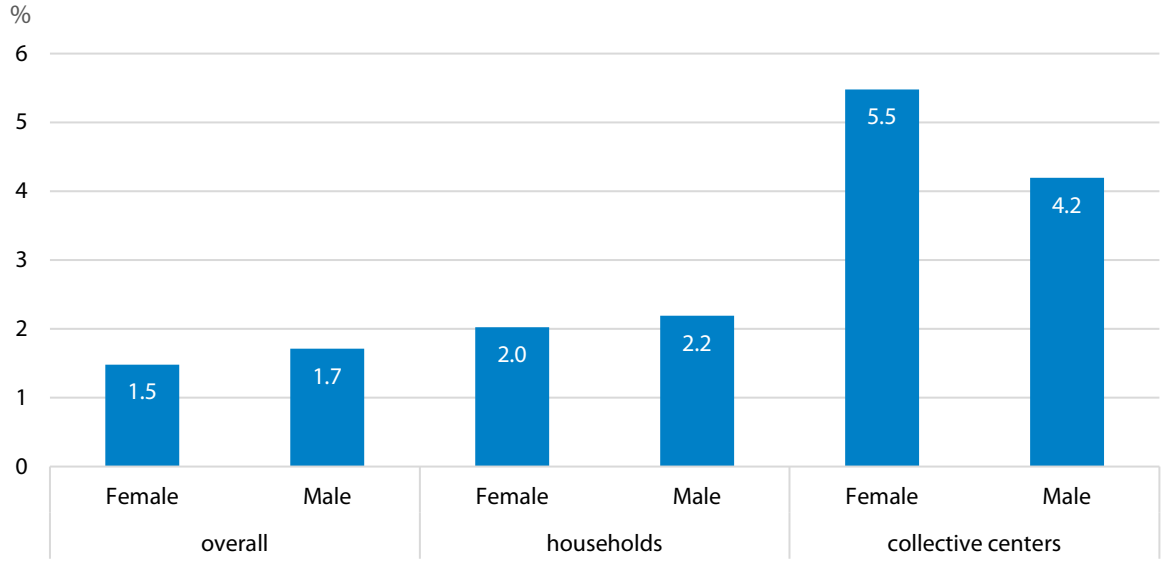
The 2025 disorder breakdown confirms this structural divergence.

Stress-related conditions (PTSD, depression, anxiety) dominate across groups but are markedly elevated in collective center — reaching **10.7% among women and 6.3% among men**, compared with **4.0% and 2.6% overall**, and nearly identical levels in private households.

Older-age related conditions show an even sharper contrast: below **1% in households**, but **8.3% among women and 5.8% among men in collective center**. Severe and neurodevelopmental disorders remain rare in absolute terms but are disproportionately represented in collective settings.

The pattern is consistent across sex and condition type: collective center concentrates psychological vulnerability, particularly among women and older residents.

Figure 13. Use of mental health and psychosocial support services in 2025



Service utilization remains modest overall — **1.5% among women and 1.7% among men** — with nearly identical levels in private households.

In collective center, utilization increases to **5.5% among women and 4.2% among men**, approximately three times higher than in households.

Yet service uptake remains substantially below the prevalence of stress-related conditions in these settings.

Three conclusions follow:

First, Poland has achieved population-level psychosocial stabilization since 2022.

Second, vulnerability is no longer diffuse – it is concentrated geographically and structurally in collective center.

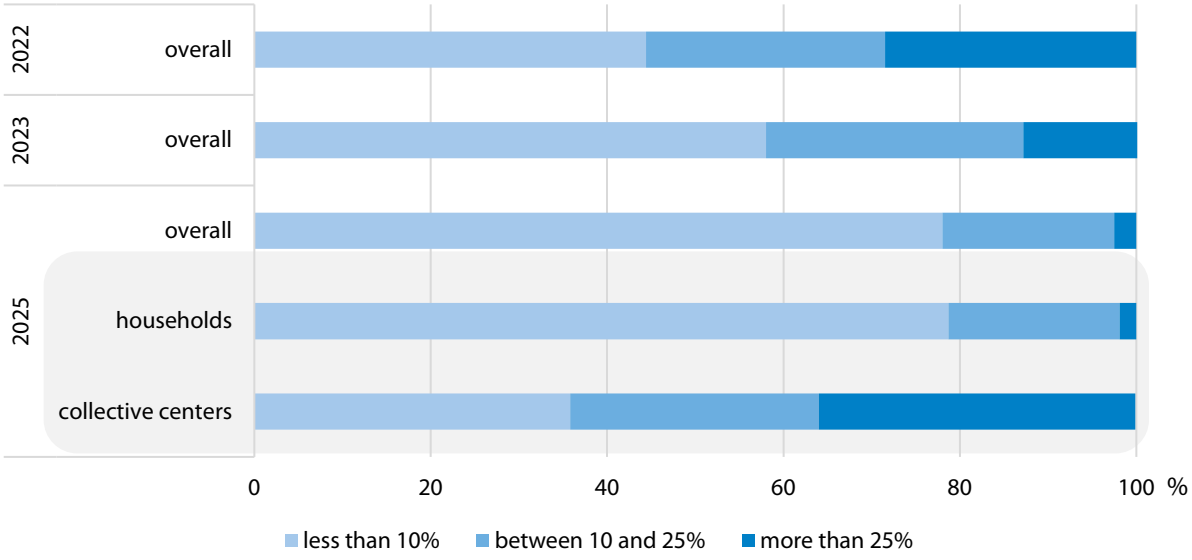
Third, service utilization increases in high-burden settings but remains insufficient relative to need.

The policy implication is clear: MHPSS expansion should not be system-wide. It should be targeted, site-based, and integrated with housing situation. Collective center represents a manageable but high-impact intervention zone where intensified outreach, on-site psychosocial services, and referral pathways could rapidly reduce concentrated vulnerability.

Financial risk protection and barriers to healthcare

Financial risk protection is a central dimension of effective health system integration. Beyond whether care is received, the critical question is whether households are protected from excessive out-of-pocket spending and practical barriers that may discourage care-seeking. The following analysis examines both expenditure burden and reported access constraints, distinguishing between aggregate system performance and housing-based structural differences.

Figure 14. Share of household income/savings spent on healthcare costs overall and by housing



Financial risk protection has improved substantially over time at the population level. The share of refugees spending less than 10% of household income on healthcare increased from 44.4% in 2022 to 58.0% in 2023 and 78.0% in 2025, indicating stronger overall protection against catastrophic health expenditure.

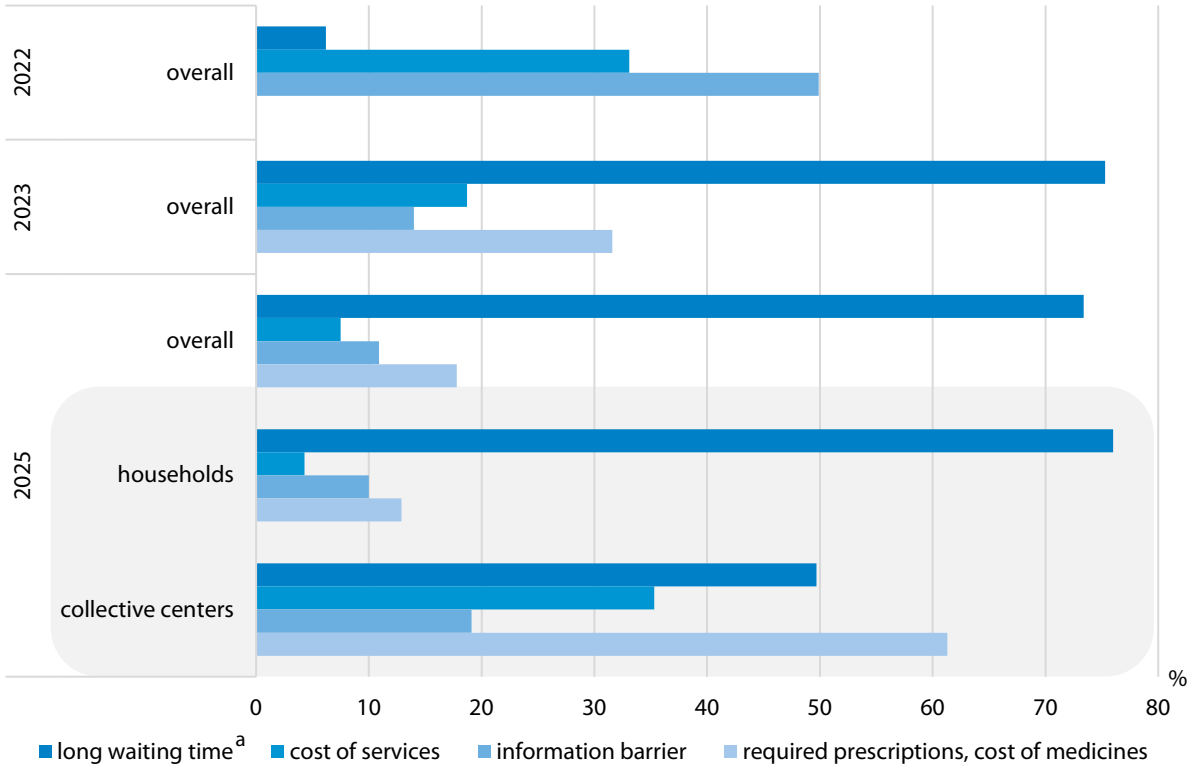
However, the 2025 housing disaggregation reveals a stark divide. While 78.7% of refugees in private households (HH) report spending less than 10% of income on healthcare, this share drops to 35.8% in collective center (CC). Conversely, higher spending categories are disproportionately concentrated in collective center: 28.2% report spending 10–25% of income, and 35.9% report spending more than 25%.

The contrast suggests that improvements in financial risk protection at the aggregate level mask substantial exposure to high out-of-pocket costs within collective center. Financial burden is therefore not evenly distributed but structurally.

The policy implication is clear: broad system-level financial situation has occurred, but targeted financial risk protection measures may be required in collective settings to reduce exposure to high spending and potential care avoidance.

Although aggregate spending patterns suggest strengthened financial protection, self-reported barriers reveal the operational and structural constraints that continue to shape effective access.

Figure 15. Reported barriers to healthcare access overall and by housing



a In 2022 most frequent responses from "other" category, in 2023 and 2025 as separate category.

Reported barriers reveal two distinct access dynamics operating simultaneously in 2025: system-wide capacity pressure and concentrated financial vulnerability.

Long waiting times are the most frequently reported barrier overall (73.4%) and remain high among refugees living in private households (HH: 76.0%). Collective centers (CC) report lower levels (49.7%), indicating that congestion reflects broader system demand rather than a housing-specific constraint. Waiting time is therefore a capacity issue affecting the majority of refugees, not a marginal subgroup.

In contrast, cost-related barriers are sharply concentrated in collective centers. While only 7.5% overall report cost of services as a barrier (4.3% in HH), this rises to 35.3% in CC. The same pattern holds for

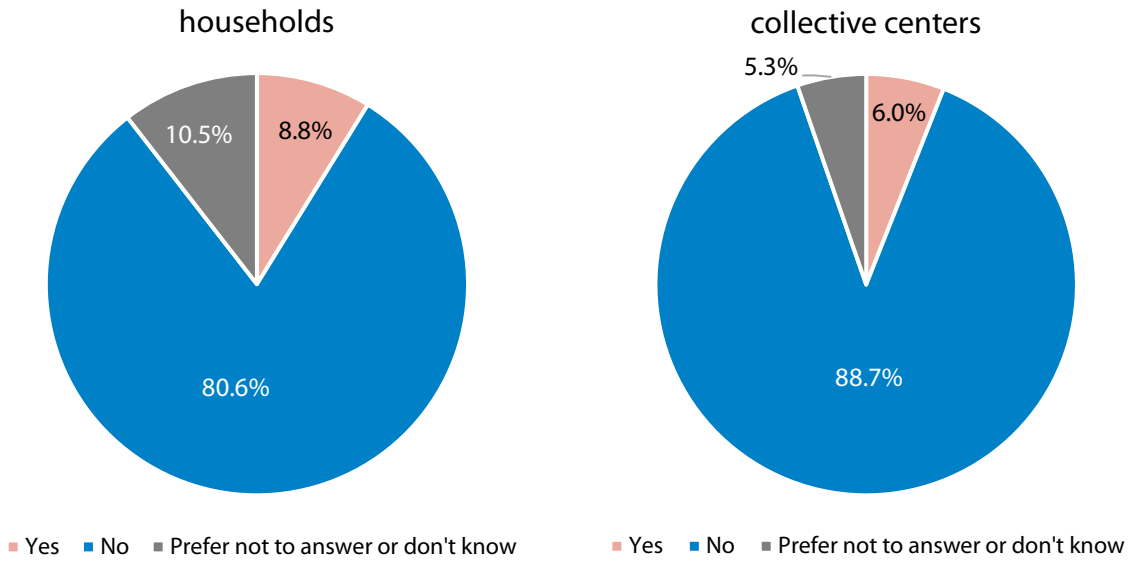
cost of medicines: 12.8% overall and 9.5% in HH, compared with 41.5% in CC. Information barriers follow a similar distribution (19.1% in CC versus 10.0% in HH).

The divergence is structural. Capacity constraints are broadly distributed, whereas financial and informational barriers cluster in collective centers. Effective access is therefore shaped by different mechanisms across housing modalities: system congestion affects most refugees, but exposure to cost and navigation barriers is concentrated in collective settings. Policy responses must accordingly operate on two levels-strengthening overall service capacity while deploying targeted financial protection and service-navigation support in collective centers to prevent cost-related care avoidance.

Social protection and experiences of mistreatment (2025)

Recognizing the importance of this issue for long-term integration, the 2025 survey introduces dedicated measurement for the first time, strengthening the evidence base for targeted policy action.

Figure 16. Reported mistreatment in the last three months in 2025 by housing



The 2025 survey introduces, for the first time, systematic measurement of reported mistreatment within the previous three months. The majority of refugees report no direct mistreatment in both housing settings. However, a clear housing-based difference is visible.

In collective center (CC), reported mistreatment represents a small minority share. In private households (HH), the proportion reporting mistreatment is visibly higher, while the share reporting no mistreatment is correspondingly lower.

Although the overall prevalence remains in single digits, the relative difference between housing modalities is analytically significant.

Mistreatment is not only a protection concern but also an integration signal. Even moderate levels of reported harassment can interact with psychological distress, labour market participation, and settlement intentions. Continued monitoring will therefore be essential to assess whether housing transitions and integration measures are associated with improved perceptions of safety and social cohesion.

Conclusion and strategic policy implications

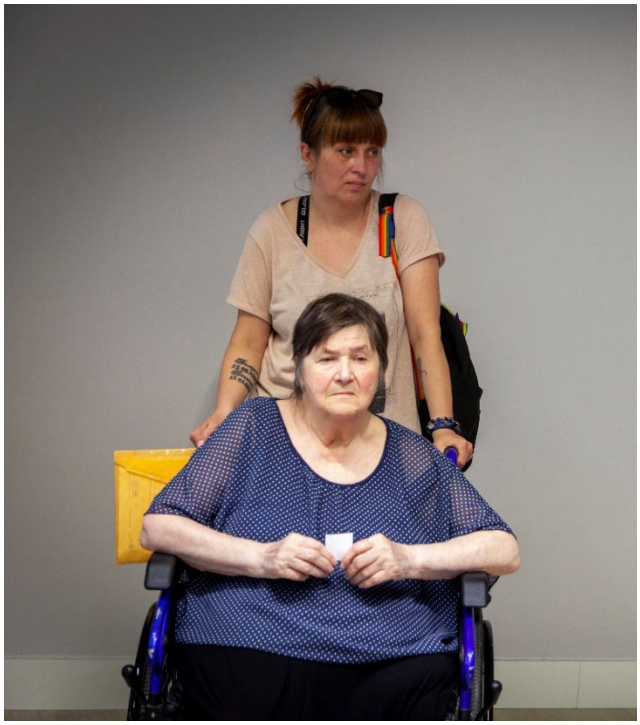
Four years after the onset of the full-scale invasion, Poland's refugee response stands at a decisive transition point. The evidence presented in this report demonstrates that large-scale integration into national systems has largely succeeded. Healthcare access is consolidated, financial risk protection has strengthened, labour participation has recovered, and mental health functional impairment has declined significantly since the early displacement phase. The emergency response has matured into structural inclusion.

Yet integration outcomes are not uniform across living conditions.

The 2025 data – enriched with expanded mental health and psychosocial measurement – reveal a consistent structural pattern. Vulnerability is no longer generalized across the refugee population. It is concentrated in specific environments, most notably collective center.

Across employment, financial burden, vaccination coverage, mental health prevalence, psychosocial service utilization, and reported mistreatment, collective center emerges as a concentrated enclave of risk. Employment levels are dramatically lower. Stress-related mental health conditions are substantially higher, particularly among women. Functional impairment is more than three times that observed in private households. Although service utilization increases in these settings, it does not proportionately match the elevated burden.

This concentration reframes the policy challenge. The issue is no longer system absorption capacity. The issue is targeted consolidation.



Stable, community-based housing is associated with better labour integration, improved psychosocial outcomes, stronger preventive coverage, and greater financial resilience. Collective center, by contrast, are associated with structural exclusion across domains.

The evidence also confirms that the refugee population is structurally embedded in Poland's socio-economic landscape. High educational attainment, significant language acquisition, sustained labour participation, and prolonged residency duration indicate that the integration question is no longer short-term absorption but long-term consolidation.

The strategic priority is therefore clear: intensification site-based activation, health, and psychosocial interventions in the interim. Precision targeting – not broad expansion – is the lever for the next phase.

Poland has demonstrated that rapid inclusion into national systems is possible at scale. The final stage is to ensure that integration gains are durable and equitably distributed. By addressing housing-based structural vulnerability, Poland can consolidate its achievements and establish a long-term model of resilient, system-based refugee integration in Europe.

Annex A. Methodology and analytical framework

A1. Survey tool and research interview questions

Statistics Poland

al. Niepodległości 208, 00-925 Warszawa

Health of refugees from Ukraine[2]

Dear Madam / Sir,

Statistics Poland is conducting an anonymous survey on health and use of health care services by the refugees from Ukraine. All collected data are used for public statistics only and protected according to the law on public statistics. Please answer our questions.

The respondent must have (or have had) PESEL UKR, be at least 18 years old and has lived in Poland for more than one month.

I. Type of interview	**1**	In households	**2**	In collective accommodation establishments	**3**	At the border	

II.1. Respondent's age	*years old*		**II.2. Respondent's sex**	**1**	Female	**2**	Male

II.3. Please give the number of people living together in Poland and jointly maintaining themselves (later refer household) *(if one person - write in „**1**")*		persons

Specification		**under 1 year**	**1–4**	**5–14**	**15–17**	**18–34**	**35–54**	**55–59**	**60-64**	**65 +**
0		2	3	4	5	6	7	8	9	10
Females	01									
Males	02									

III. Please specify your and your household members current status in Poland	**Number of persons** (in the household, incl. the respondent)	**Respon-dent**
Persons registered in the PESEL UKR register		**1**
Persons with temporary residence permit		**2**
Persons with permanent residence permit		**3**
Other status → **Please specify**.....		**4**

[2] This questionnaire has been designed by Statistics Poland in collaboration with **World Health Organisation (WHO)** and United Nations High Commissioner for Refugees (UNHCR).

IV. What is the highest completed level of education of adult members of your household?	**Number of adults (18+)** (in the household, incl. the respondent)	**Respon-dent**
Incomplete primary or no primary education		**1**
Primary, incl. lower secondary		**2**
Basic vocational (on the basis of primary education)		**3**
General upper-secondary		**4**
Technical / specialist education at upper-secondary and post-secondary level		**5**
Tertiary and postgraduate		**6**

V. Which of the following best describes labour market status in Poland that you and other adult members of your household had in the last month? **Each person must be included in one major category and can be included in one subcategory if relevant.**	**Number of adults (18+)** (in the household, incl. the respondent)	**Respon-dent**
Had a job as employer, self-employed person, employee or other paid worker		**1**
• employer or self-employed person (working in own enterprise) registered and paying taxes in Poland		**2**
• employee or other paid worker for whom social security premium was paid in Poland and whose monthly pay was not less than 2333 zloty gross (half of minimum pay officially established by Polish authorities)		**3**
• employee or other paid worker for whom only national health insurance premium was paid		**4**
Unemployed person registered at Labour Office		**5**
• unemployed person who received unemployment benefit last month		**6**
Retired		**7**
• recognised by Polish authorities as retired on the basis of age (60+ women, 65+ men) and retirement documents		**8**
Unable to work due to long-term health issues, disability, war injuries		**9**
• recognised by Polish authorities as a person with disability or a person being treated for war injuries		**10**
Taking care of the household members, incl. persons with disabilities, foster children, infants, etc.		**11**
• recognised by Polish authorities as a caregiver for a person with disabilities or foster child		**12**
• a parent / guardian receiving maternity (or parental) benefit		**13**
Student, pupil, participant of vocational courses / training		**14**
Other situation → **Please specify**		**15**

VI. Which of the following phrases best describes your and your household members communication skills in Polish?	**Number of persons** (in the household, incl. the respondent)	**Respon-dent**
I don't understand Polish at all		**1**
I understand and use only a few words and phrases		**2**
I can understand and use most everyday expressions		**3**
I can understand the essence of clear speech and can write simple texts		**4**
I can understand many complex texts and use the Polish regularly without any issues		**5**

VII. Did you or any of your household members participate in the following forms of education or other group activities conducted in Poland in the last month?	**Number of persons** (in the household, incl. the respondent)	**Respon-dent**
Nursery (children under 3 years old)		**1**
Pre-primary (3-6 years old)		**2**
Primary school (7-14 years old)		**3**
Vocational school (15-18 years old)		**4**
Secondary and postsecondary (15-20 years old)		**5**
Higher education institution, PhD studies (19 y.o. and over)		**6**
Courses preparing for a new job / profession or advancing in own profession		**7**
Polish language courses		**8**
Other free-time group activities in Polish (culture, religion, recreation, hobbies etc.)		**9**
Free-time group activities in Ukrainian / Russian (culture, religion, recreation, hobbies etc.)		**10**
None of the above		**11**

VIII.1. Have you ever been in Poland before 24 February 2022?	**1**	Yes	**2**	No

VIII.3. When did you arrive to Poland for the first time since 24 February 2022?	month	year

VIII.2. Where were you on 24 February 2022 (in the morning)?	
Ukraine	**1**
Russian Federation	**2**
Belarus	**3**
Poland	**4**
Other EU country	**5**
Other country (non-EU)	**6**

VIII.4. From which country did you cross the border to Poland then (first time since 24 February 2022)?	
Ukraine	**1**
Belarus	**2**
Russian Federation	**3**
Other → **Name the country**	**4**

VIII.5. How many times have you travelled from Poland to Ukraine since then?	

VIII.6. Considering all your stays in Poland, how much time (approximately) have you spent in Poland in total? **Enter number of years and months (e.g. 2 years and 3 months)**	years	and	months

VIII.7. Do you intend to return to Ukraine after the end of military operations?	1	Yes	2	No	3	Do not know

VIII**.8. Please specify oblast of your last residence in Ukraine**	

VIII.9. Do you intend to return to Poland (after this trip)? ONLY AT THE BORDER VERSION OF THE QUESTIONNAIRE	1	**Yes → When?**	dd/mm/yyyy
	2	No	

IX. In which region of Poland do you live / have lived last month?

Write in the voivodship number	

X. Type of accommodation you live/lived in Poland last month	
Whole apartment/house, which was rented / owned only by my family	**1**
Collective accommodation coordinated by a voivode office (***Ośrodek Zbiorowego Zakwaterowania***)	**2**
Apartment / shared flat used together with people outside my family / household – paying my share of the rent	**3**
Room / apartment / house which was used for free or only for covering basic costs (water, electricity, etc.)	**4**
Other → **Please specify**.....	**5**

XI.1. Were all adult members (18+) of your household entitled to fully use Polish public healthcare services in the last month?	
Yes, all of them	**1**
Some of them, but not all	**2**
None of the adult members had the right to full access to public health care in Poland → XII.1	**3**
I don't know → XII.1	**4**

XI.2. Which persons had this full access to public healthcare services?

Female		Male		Respondent
18–59	60 +	18–64	65 +	
				YES / NO

PLEASE INDICATE THE ANSWERS REFERING TO ALL HOUSEHOLD MEMBERS IN COLUMNS ACCORDING TO THEIR SEX AND AGE. IN THE LAST COLUMN MARK ANSWERS REFERRING ONLY TO THE RESPONDENT.

XII.1. In the last month, did your household member need health care?	Female				Male				Respon-dent
	0–4	5–17	18–59	60 +	0–4	5–17	18–64	65 +	
Yes									**1**
No → XIII (*If answers regarding all household members are NO*)									**2**
XII.2. What types of health care were needed? (last month)									
Acute illnesses (with symptoms like fever, diarrhoea, cough, etc.)									**1**
Physical traumatic conditions (injuries, burns, wounds, etc.)									**2**
Noncommunicable diseases & chronic illnesses such as:									**3**
• Cardiovascular disease									**4**
• Pulmonary disease									**5**
• Diabetes									**6**
• Renal/kidney disease									**7**
• Cancer									**8**
• Other chronic									**9**
Infectious diseases (influenza, COVID-19, TB, hepatitis, HIV, etc.)									**10**
Mental health problems									**11**
Sexual and Reproductive Health (Ante-natal or post-natal services, safe delivery, etc.)									**12**
Dental health									**13**
Physiotherapy, rehabilitation care, disability support, access to medical devices									**14**
Others → **Please specify**									**15**
XII.3. Related to the above conditions, were you in need of acquiring medicine during your stay in Poland? (last month)									
Yes									**1**
No									**2**
XII.4. Did your household members have access to all needed medical services including medication? (last month)									
Yes → XII.6									**1**
No									**2**
XII.5. What was the reason for the lack of access? (*more than one of the following answers can be indicated)*									
No entitlement to public health services									**1**
Information barrier (e.g. lack of information, language or cultural differences, unclear referral pathways)									**2**
Cost of services for consultations, treatment									**3**
Required prescriptions									**4**
Cost of medication									**5**
Logistics to attend facilities (e.g. transport, accommodation, opening hours, no childcare)									**6**
Long waiting times to receive medical services									**7**
Other reasons (please specify)									**8**
XII.6. If you / your household members used health care services (in the last month) please mention who received them free of charge and for whom the health care was paid from household budget?									
Free medical care									**1**
Paid medical care • Paid **in cash**									**2**
Paid medical care • Paid **by card**									**3**

XII.7. What proportion of your household monthly budget was spent on healthcare-related costs for you and your household members (includes service fees, medication, other treatment costs)?	
Less than 10%	**1**
Between 10 and 25%	**2**
More than 25%	**3**

Complete this question only if there are children aged 1-4 in your household.

XIII. For children in your household aged 1–4 years, have they completed the following vaccinations in accordance *with the Ukrainian immunization schedule*?

MMR (Measles, Mumps, Rubella)	**1**	Yes	**2**	No	**3**	Don't know
DTP (Diphtheria, Tetanus, Pertussis / Whopping Cough)	**1**	Yes	**2**	No	**3**	Don't know
Polio (Childhood Poliomyelitis)	**1**	Yes	**2**	No	**3**	Don't know

XIV.1. During the last month was there anyone in your household member currently so upset, anxious, worried, agitated, angry, addicted, depressed or experiencing mental health e.g. developmental or older age mental problems that it affected the person's daily functioning? *For example, having difficulty getting out of bed, working or going to school, caring for self or for others in the household, or doing daily household activities such as cooking, cleaning, or playing with friends.*	Female				Male				
	0–4	5–17	18–59	60 +	0–4	5–17	18–64	65 +	Respon-dent
Yes									**1**
• How many household members do you think would benefit from the support due to this issue?									**2**
No									**3**

Here, we should be concluding the border crossing version of the questionnaire:

THANK YOU FOR PARTICIPATION IN THIS SURVEY. WE APPRECIATE YOUR CONTRIBUTION TO BETTER UNDERSTANDING OF HEALTH CONDITIONS OF THE REFUGEES FROM UKRAINE IN POLAND.

PLEASE INDICATE THE ANSWERS REFERING TO ALL HOUSEHOLD MEMBERS IN COLUMNS ACCORDING TO THEIR SEX AND AGE.
IN THE LAST COLUMN MARK ANSWERS REFERRING ONLY TO THE RESPONDENT.

XIV.2. Which of the following disorders have affected members of your household? (last month)	Female				Male				Respondent
	0–4	5–17	18–59	60 +	0–4	5–17	18–64	65 +	
Conditions related to older age, incl. dementia, excessive nervousness, fears, depression, anxiety									**1**
Stress related symptoms including PTSD, depression, anxiety									**2**
Schizophrenia, bipolar disorder, or other severe mental disorders									**3**
Disorders due to use of alcohol or other psychoactive substance, addictive behaviours, including gambling, excessive use of electronic devices									**4**
Autism Spectrum Disorder (ASD), other neurodevelopmental disorders, or disorders of intellectual development, (cognitive / linguistic / socioemotional developmental problems of children and youth)									**5**
Other → **Please specify**									**6**
This question refers only to services provided to household members who had health problems meant in questions XIV.1. XIV.3. Has any of the persons mentioned in the previous question used Mental Health or Psychosocial Support Services in the last 12 months in Poland?									
Yes → Who provided this/these service(s)? (*more than one of the following answers can be indicated)*									**1**
• Provided by public sector services (e.g. community mental health centres (CZP), psychiatric hospitals, other mental health services covered by public health insurance; provided in public schools)									**2**
• Provided by NGO/civil society organisations / self-organised peer groups/religious organisations									**3**
• Provided by private services (paid out-of-pocket)									**4**
No									**5**
XV.1. In the past 3 months, have you or any member of your household experienced any mistreatment, discrimination, abuse, or violence while in Poland?									
Yes → What type of mistreatment, abuse or violence was it? (*more than one of the following answers can be indicated)*									**1**
• Physical assault									**2**
• Verbal abuse or harassment									**3**
• Sexual violence or harassment (e.g. unwanted touching, rape)									**4**
• Psychological / emotional abuse (e.g. threats, coercive control)									**5**
• Robbery, theft or confiscation									**6**
• Destruction of personal property									**7**
• Arrest or unlawful detention									**8**
• Labour exploitation (e.g. unpaid wages, unsafe conditions)									**9**
• Trafficking or coercion (e.g. for sex or labour)									**10**
• Gender-based violence (any act based on gender identity)									**11**
• Nationality or race-based mistreatment / violence									**12**
• Other → **Please specify**.....									**13**
No → *End of the questionnaire, if none of the above answers was indicated*									**14**
Prefer not to answer									**15**
Don't know									**16**

Questions XV.2 and XV.3 refer only to the respondent and should be asked only if the respondent has experienced mistreatment (RESPONDENT'S ANSWERS MARK X).

XV.2. Where did the mistreatment or abuse occur?	Physical assault	Verbal abuse or harassment	Sexual violence or harassment	Psychological emotional abuse	Robbery, theft or confiscation	Destruction of personal property	Arrest or unlawful detention	Labour exploitation	Trafficking	Gender-based violence	Nationality or race-based violence	Other
1. In a workplace												
2. In a school or educational setting												
3. At a border crossing												
4. Health care setting												
5. Police or municipal police station												
6. Other public office or institution												
7. In a public open space (street, bus, park, shop)												
8. Online (e.g. social media, messaging apps)												
9. At home												
10. Other → **Please specify**												
11. Prefer not to answer												
XV.3. Who abused or mistreated?												
1. Border guard												
2. Police (state and municipal)												
3. Other personnel of state / municipality incl. clerks, teachers, health care professionals												
4. Aid worker / volunteer of local / intl. charity /UN												
5. Pole, member of the host community												
6. Intimate partner or family member												
7. Other Ukrainian												
8. Unknown individual												
9. Other → **Please specify**												
10. Prefer not to answer												

THANK YOU FOR PARTICIPATION IN THIS SURVEY. WE APPRECIATE YOUR CONTRIBUTION TO BETTER UNDERSTANDING OF HEALTH CONDITIONS OF THE REFUGEES FROM UKRAINE IN POLAND.

A2. Survey methodology

The data presented in this report comes from a survey titled "Health of Refugees from Ukraine in Poland". It was initially inspired by the WHO and, more recently, by the UNHCR, evolving alongside the changing situation of refugees. The primary objective remained constant: to obtain representative data on the health status, access to healthcare, and socio-economic determinants of refugees from Ukraine staying in Poland.

The fieldwork was conducted by Statistics Poland (GUS) interviewers in three distinct waves. The methodology transitioned from an emergency response study-focused on immediate health needs, vaccinations, and migration paths near the Ukrainian border-to a comprehensive national system for monitoring the health and living conditions of long-term refugees.

The distinct nature of the subpopulation residing in collective accommodation centers was addressed by creating a separate sampling frame and adapting the interviewers' fieldwork accordingly. Multilingualism of the questionnaire was a priority from the outset. Furthermore, the study was progressively enriched with new data sources and innovative analytical methods, allowing for increased accuracy (including lower levels of geographical aggregation) and cyclical estimation of results between survey waves.

FIRST WAVE (June-August 2022)

The survey was carried out in 94 reception and aid distribution sites across two voivodeships (Podkarpackie, Lubelskie) along the Polish-Ukrainian border. Participants were adult refugees who came to Poland after 24 February 2022 as a result of Russia's military aggression. Interviewers from Statistical Offices in Rzeszów and Lublin collected 1,800 filled-in questionnaires covering 5,000 people (individuals or small groups traveling together-typically members of one family). Final results were generalized based on: (1) Polish Border Guard data, (2) the Common Population Register (PESEL).

To gain a deeper understanding of health needs and barriers to healthcare access, 35 in-depth interviews (IDIs) were conducted simultaneously.

SECOND WAVE (December 2023)

This survey was conducted across all regions of Poland. Through integration with administrative records and big data from mobile network operators, the results offered insights at the regional level. The use of consolidated administrative data enabled gathering data also by telephone interviews, which required Ukrainian or Russian-speaking interviewers. In collective accommodation centers, data were gathered mostly through self-administered questionnaires (SAQ) supplemented with classical

paper and pencil interviewing (PAPI). In total, over 1,700 questionnaires were collected, covering nearly 4,500 refugees. The questionnaire was extended with questions on accommodation type, employment, and education.

Data generalization utilized consolidated administrative registers via the "signs of life" method. Additionally, survey data regarding out-of-pocket health expenditures were supplemented with information from payment card operator data.

To further explore barriers to healthcare, 30 in-depth interviews were conducted.

THIRD WAVE – RECENT SURVEY (November-December 2025)

The latest survey accounted for the context of newly introduced regulations limiting access to public healthcare and collective accommodation for some categories of the Ukrainian refugees. Consequently, the updated questionnaire included detailed questions on labor market status (defining forms of employment related to health insurance contributions, registered unemployment, retirement, or disability status) as well as being disabled or providing foster care. Following inspiration of the UN partners (WHO, UNHCR) the questionnaire was enriched with a question on limitations in daily functioning related to mental well-being as well as questions on Polish language proficiency and experienced mistreatment, violence, or discrimination.

The sampling frame was significantly improved[3], allowing the survey of refugees in private households to be conducted entirely via telephone (1,324 questionnaires covering 3,258 persons). Notably, the vast majority of these interviews were conducted in Polish.

As for the Ukrainian refugees staying in refugees collective centers, a verified registry of sites was obtained, and a census-style approach was applied in 60 randomly selected centers. Due to lower Polish language proficiency in these sites, data collection involved both direct interviews and the distribution of self-administered questionnaires (in total 1,336 questionnaires covering 2,780 persons). By integrating these survey data and current information on size and structure of the refugee population in these centers the from administrative source, the study provided-for the first time-accurate and representative results describing this vulnerable and hard-to-reach population.

[3] In developing the frame from consolidated administrative data: (1) the **"UKR" status** in the PESEL register was used to identify refugees from Ukraine, i.e. people who fled Ukraine since 24 Feb. 2022 and applied for **temporary protection** in Poland; and (2) the **"signs of life"** method was applied to identify persons actually residing in Poland (selecting those who, in the last year, were employed, received public healthcare, had children in schools, or performed fiscal/administrative activities).

Data from private households and collective centers (in total 2,660 questionnaires on 6,083 people) were generalized in separate but complimentary way accounting for the total number of nearly 1.1 million Ukrainian refugees in Poland

The same as with the 2023 study, the data from the current survey will be calibrated with a small-scale quarterly study on Health of Ukrainian crossing back to Ukraine, mobile network data, and records from the National Health Fund (NFZ) and the e-Health Centre (CeZ). This allows for regular, automated updates between major waves of the survey. Estimated results of refugee health indicators are available via the Health of Refugees from Ukraine in Poland dashboard accessible through the "Experimental" section under "See details".

A3. Tabular data

Table 1. Demographic transition of refugees from Ukraine in Poland

Age group (years)		Females	Males
		No. (thousands)	
2022	0–4	72.0	65.7
	5–14	192.6	183.5
	15–17	51.1	54.0
	18–34	262.0	48.0
	35–54	311.7	48.7
	55–64	97.8	28.9
	≥65	74.2	31.7
2023	0–4	38.2	36.1
	5–14	99.2	94.5
	15–17	29.6	46.9
	18–34	159.6	60.8
	35–54	205.3	54.5
	55–64	54.1	23.8
	≥65	38.2	14.1
2025	0–4	33.6	25.4
	5–14	123.5	118.9
	15–17	40.1	42.8
	18–34	189.3	113.3
	35–54	196.9	87.0
	55–64	41.4	15.6
	≥65	32.2	20.1

Table 2. Educational attainment by age group in 2025

Specification	18–34	35–54	55–59	60–64	65+
	%				
Incomplete primary or no primary education	0.0	0.0	1.5	0.0	5.7
Primary, incl. lower secondary	3.3	1.1	3.7	9.8	10.5
Basic vocational (on the basis of primary education)	10.9	13.4	27.0	30.4	16.5
General upper-secondary	26.4	14.6	18.4	10.9	20.7
Technical / specialist education at upper-secondary and post-secondary level	26.0	26.7	26.5	25.2	19.2
Tertiary and postgraduate	33.4	44.1	22.9	23.7	27.3

Table 3. Polish language proficiency among refugees in 2025

	No Polish Proficiency	Basic / Conversational Polish	Intermediate Polish	Fluent Polish
	%			
Polish language proficiency	1.9	31.1	28.1	38.9

Table 4. Work in Poland overall and by housing

	2022	2023	2025		
	Overall			Households	Collective centers
	%				
Work in Poland [a]	65.9	62.2	71.4	71.9	27.7

a Refers to people who expressed an intention to work in Poland.

Table 5. Socio-economic status of adult refugees in 2025

Labour market status	Percentage
Had a job as employer, self-employed person, employee or other paid worker	71.4
Unemployed person registered at Labour Office	3.8
Retired	8.6
Unable to work due to long-term health issues, disability, war injuries	1.1
Taking care of the household members, incl. persons with disabilities, foster children, infants, etc.	5.1
Student, pupil, participant of vocational courses / training	6.5
Other situation	3.5

Table 6. Length of stay of refugees in Poland in 2025

Time spent in Poland	Percentage
less than 1 year	4.2
1–2 years	10.1
2-3 years	22.0
more than 3 years	63.7

Table 7. Intention to return to Ukraine overall and by housing

	2022	2023	2025		
	Overall			Households	Collective centers
	%				
Yes	64.0	54.3	20.9	20.7	42.6
No	8.6	11.5	35.3	35.4	19.8
Don't know	27.4	34.2	43.8	43.9	37.7

Table 8. Healthcare need in the last month overall and by housing

	2022	2023	2025		
	Overall			Households	Collective centers
	%				
Needed care	37.3	49.3	27.2	27.1	37.2

Table 9. Access to health care overall and by housing

Access to health care	2022	2023	2025		
	Overall			Households	Collective centers
	%				
Access	93.2	97.1	97.4	97.6	85.3

Table 10. Declared vaccination status of children aged 1–4 years

Year		Vaccinated	Unvaccinated	Don't know
		%		
2022	MMR	79.9	15.2	4.9
	DTP	80.5	14.3	5.1
	POLIO	74.7	15.4	9.9
2023	MMR	87.1	7.3	5.6
	DTP	86.4	7.8	5.8
	POLIO	86.3	7.5	6.2
2025	MMR	89.0	4.2	6.8
	DTP	85.5	5.7	8.9
	POLIO	80.1	6.3	13.6

Table 11. Mental health functional impairment overall and by housing

Problems with daily functioning	2022	2023	2025		
	Overall			Households	Collective centers
	%				
Yes	10.2	10.2	5.3	5.2	17.4
No	74.3	87.0	90.5	90.7	82.0
No answer	15.4	2.8	4.1	4.1	0.6

Table 12. Prevalence of mental health conditions among female and male by housing in 2025

Mental health conditions	Overall		Households		Collective centers	
	Female	Male	Female	Male	Female	Male
	%					
Older-age	0.9	0.6	0.8	0.5	8.3	5.8
Stress-related	4.0	2.6	3.9	2.5	10.7	6.3
Severe	0.0	0.1	0.0	0.0	0.3	0.9
Neurodevelopmental	0.2	0.6	0.2	0.6	0.5	2.3

Table 13. Use of mental health and psychosocial support services in 2025

Mental health support	Overall		Households		Collective centers	
	Female	Male	Female	Male	Female	Male
	%					
Use of mental health support services	1.5	1.7	2.0	2.2	5.5	4.2

Table 14. Share of household income/savings spent on healthcare costs overall and by housing

Proportion of income/savings	2022	2023	2025		
	Overall			Households	Collective centers
	%				
Less than 10%	44.4	58.0	78.0	78.7	35.8
Between 10 and 25%	27.1	29.2	19.5	19.4	28.2
More than 25%	28.5	12.9	2.5	1.9	35.9

Table 15. Reported barriers to healthcare access overall and by housing

Barrier	2022	2023	2025		
	Overall			Households	Collective centers
	%				
Long waiting time[a]	6.2	75.3	73.4	76.0	49.7
Cost of services	33.1	18.7	7.5	4.3	35.3
Information barrier	49.9	14.0	10.9	10.0	19.1
Required prescriptions. cost of medicines	–	31.6	17.8	12.9	61.3

a In 2022 most frequent responses from "other" category. in 2023 and 2025 as separate category.

Table 16. Reported mistreatment in the last three months in 2025 by housing

Housing	Yes	No	Prefer not to answer
	%		
Households	8.8	80.6	10.5
Collective centers	6.0	88.7	5.3