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Maternal and Child Health of Internally Displaced Persons in Ukraine: a Qualitative Analysis

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Abstract

The research aimed to describe the subjective health status of internally displaced mothers and children in Ukraine. The study was conducted within the military context in the East of Ukraine started in April, 2014 and lasting till today. As a result of the conflict, a total of 1.75 million IDPs have fled the area. Poor financial and legal state support, income poverty, and the general economic downfall in the country all together contribute to the threats to maternal and child health of IDPs in Ukraine.

This is a qualitative research. The primary data has been collected through semi-structured in-depth interviews with internally displaced mothers of children less than two years old in Ukraine.

The study found that the influence of conflict and displacement experience mostly reflected on mental and psychological health of IDP mothers in Ukraine, while the direct influence on physical health and/or on breastfeeding practices has not been reported. Poor financial conditions, low income (comprising of social assistance mostly) as well as weak state support have been found to contribute to unhealthy household environment and deteriorated nutrition practices of IDP mothers and children in Ukraine. The absence of vaccination country-wide is an alarming issue which needs to be addressed immediately, since it threatens not only the health of the IDP population, but of the host population as well. Such obstacles as bribes enquiry and bad treatment have been identified, though the latter was not common.

Key words: Ukraine, Maternal and Child Health, Sexual and Reproductive Health, IDPs, Conflict, Ukraine, Ukrainian Crisis, Humanitarian Response.

1. Introduction

1.1. Country context

Ukraine is a country located in the Eastern part of Europe. According to the data by State Ukrainian Statistics Agency, Ukraine`s population accounted for 42.8 million permanent residents on September,1, 2015 (Ukrcensus, 2015). The country has the highest mortality rate in Europe. According to the data by State Ukrainian Statistics Agency, the death rate in 2014 was 14,7 per 1000 citizens (Ukrcensus, 2015).

Ukraine has a very high literacy rate of 99.7 %, and its population is well-educated with the university enrollment ratio of 82 % (The World Bank, 2014). However, the possession of high education does not guarantee a well-paid job. Ukraine is famous for its low salaries, and the situation has significantly deteriorated after the political events of 2013-2014, when the national currency dropped by a factor three (from UAN 8 per $ 1 to UAN 24 per $ 1). According to the State Statistics Service of Ukraine, the average salary in the country amounted to 4895 hrn/month (EUR 179, with the exchange rate fixed for this research as UAN 27,3 per EUR 1 as per 11.07.2016).

Social, economic and political transformation following the independence in 1991 had a strong negative impact on population health, resulting in decreased life expectancy of 66,9 years with 10 years of gap of life expectancy between men and women (61,3 and 72,6 correspondingly) (Richardson et al, 2015). Ukrainian health care system is still functioning on the background of the health care system from Soviet Union (Semashko model). Health care services are de jure free to any citizen of Ukraine. De facto, the sector remains hardly under-financed which induces high prevalence of informal payments (HIT, 2015).

Ukraine has an extensive health care infrastructure, which is poorly maintained. Unsatisfactory sanitary conditions are most often found in rural health care facilities (Richardson et al, 2015). Other than that, significant declines in vaccination coverage started in 2014, which has

been evidenced by joint WHO and UNICEF estimates (2016).

1.2. Brief conflict overview

The military conflict in Eastern Ukraine started in April, 2014 from the protests against the newly appointed government in Kyiv, the capital. Active fights have been in place till a ceasefire was signed in February 15, 2015. However, clashes of violent confrontation are still ongoing, with both sides accusing each other of violating the armistice. The northern parts of Donetsk and Luhansk regions are currently under control of Ukrainian government.

1.3. Consequences of the conflict on population displacement

According to OCHA (2016), since the beginning of the armed conflict in Donbass (which includes Donetsk and Luhansk regions), the number of war-induced among civilians were 2,008. This data is incomplete due to the gaps in coverage of certain geographical areas and time periods, as well as due to incomplete and poor reporting (OCHA, 2016).

As per the most recent report from OCHA from March 2016, a total of 1.75 million IDPs have been registered in Ukraine due to the conflict (OCHA, 2016). The government provides poor financial assistance to IDPs as well as little legal support. To provide an illustration: an able-bodied IDP is entitled to 442 UAH (EUR 16,2) of state support per month. For the reference, an average one-room apartment in regions would cost starting from EUR 130 and in the capital city starting from EUR 185 without utility costs. IDP dependents like children or pensioners are entitled to 884 UAN (EUR 32,4 per month). According to an OCHA report (2016), for many IDPs these payments constitute the major or the only source of income.

1.4. Maternal and child health of IDPs in Ukraine

Pregnant women, women with young children and the young children themselves are among

the most vulnerable groups within the population. For women affected by conflict and displaced from their communities the risk of maternal death is especially high. In crisis settings, the access to health services is limited, which raises the risk of newborn death from preterm birth, due to e.g. infection or asphyxia during childbirth s (WRC, 2016). Conflicts also seriously affect child health: most children do not die from weapons directly, but from the preventable diseases which become very common due to the destroyed health systems and further infrastructure (Degomme, Guha-Sapir, 2010). Conflict and displacement also have significant harmful psychological impact on both mothers and children (Akol et al., 2016). However, these issues are often overlooked by traditional measures of humanitarian response, which tend to focus on the provision of basic services, such as food and water, shelter, sanitation and medical emergency (UNFPA, 2015).

So far, more than 215,000 children are internally displaced from the conflict-affected areas in Ukraine. Lack of access to health services, shortage of medicines and poor living conditions are threatening more disease outbreaks among children. According to UNICEF (2016), access to employment, education, and health care represent further challenges to IDPs, and problems have emerged in the provision of food, clothing, and medicines to IDP children.

2. Methods

The primary data were collected through semi-structured in-depth interviews with internally displaced mothers of children less than two years old in Ukraine. The interviews lasted around 30 minutes each and were conducted via Skype and Viber. According to the preferences of respondents, video-call was or was not used. All interviews were recorded with the help of a voice-recording tool. The participant's agreement to record was prior obtained. The recordings were stored safely and have not been disclosed to any third parties.

The intended number of respondents was not pre-determined and the information has been

collected till the point of data saturation, which was reached when the number of interviews equalled 9. The method of Skype-assisted/Viber - assisted interviews has been selected due to the absence of possibility to physically travel to Ukraine due to security issues.

The interviewees were recruited via convenience sampling. There were two starting points of recruitment established represented by the two local NGOs. The inclusion criteria for the interviewees was to be an IDP mother at time of interview (independently if they were formally registered as IDPs with the Ukrainian Ministry of Social Policy or not) of a child aged two and less than two years old. The age limit for a child has been selected with consideration to the duration of the conflict. In spring 2016 (the period of data collection), the Ukrainian conflict reached its second year of duration, which means that respondents were either pregnant or gave a birth to a child after displacement.

International Ethical Standards have been strictly followed: all the potential respondents have received a digital informed consent form and the ethical advice for this study has been obtained from The Ethics Committee of Saint-Luc.

The thematic analysis has been utilized so as to analyse the interviews collected. The use of thematic analysis in health care research has been justified by Rice et al. (1999). Thematic analysis allows to develop a set of codes, domains or themes and to subsequently categorize the data collected.

3. Results

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1) Conflict and Displacement Experience

The direct military actions were among the primary ones mentioned by respondents for leaving home. All the respondents admitted that they did not initially plan to stay displaced for a long period of time, and always had in mind to get back: "*We thought the military actions would not last longer than two weeks, so we planned just to wait till they were over. When it became clear that we would not return home, we tried our luck in Mariupol*" (resp. 4). One respondent mentioned that she and her husband were forced to move due to the risk of her husband being recruited to the so-called separatist army in Donetsk: "*My husband has the age of recruitment to the army, and we did not want him to be recruited, so we moved to save him*" (resp. 6).

The selection of the new place of living has been mostly guided by convenience (having relatives or friends in the new place), and some respondents reported to choose the new place of living for financial considerations: " *In Luhansk, I worked in "Epicenter" (big Ukrainian chain of stores with construction materials), so I hoped to get employed in the "Epicenter" in Brovary*" (resp. 7).

2) Subjective health status of IDP mothers and children

It was initially suggested to the respondents to rank their health status and the health status of their children after displacement on a scale from 0 to 100 and to supplement the estimate with verbal comments. The majority of mothers surveyed reported no or relatively slight changes in theirs and their children physical health after displacement. Some respondents reported slight changes in their physical health, but significant deterioration of psychological health status: "*If you do not take the stress level into account, the health is normal. Fears have still not gone away. I have even asked for psychological help, but the fears are coming back in a month after therapy. Except for the this, everything else is fine*" (resp. 3).

3) Access to health care services

5 respondents out of 9 reported the destruction of health facilities and infrastructure in their home towns, due to which they had to miss the obligatory medical check-ups and tests during pregnancy: "*…Back then, the pharmacies were closed, the shops were damaged. I went to my female consultation to get some paper with my husband, and we actually thought that we would never get back alive because of the explosions and fights. I was not able to do the required medical tests*" (resp. 8).

4) Registration with health care center in the place of displacement

The respondents reported the following procedure of finding health care center on their new place of living: they choose the closest one to their location and applied for the inscription there. Consequently, our sample of respondents did not reveal a problem of geographic inaccessibility of health care centers. On this stage, the problems of enquiries for bribes and the reluctance of providing health care services without the document of IDP registration with the Ministry of Social Policy in Ukraine have been identified: *I asked health care center in Kyiv to register me there. They agreed, but they also asked for 'voluntary financial contribution' amounting to UAN 500 (EUR 20)*" (resp. 5); "*In health care center for adults there they did not treat me well, they were rude. I had otitis, and they denied helping me unless I paid a bribe*" (resp. 5). However, the cases when health services have not been eventually provided were not reported.

5). Quality of health care

The low resourcefulness of the health care organizations and maternity hospitals was clearly reported. In particular, this applied to the conditions of stay in maternity hospitals: problems with electricity and running water, poor nutrition and absence of heating. This can be interpreted as a general poverty of Ukrainian health care system and thus should not apply to the IDP situation specifically. Low quality and poor financing of health care services has been evidenced by the latest

Health Systems in Transition report (2015) as well.

6) Attitudes of the host population in health care organizations

While the evidence notes the biased attitudes of the host population towards the IDPs (enquiries for bribes, denied appointments, unfair treatment etc.) (Ferris et al, 2015), the respondents mostly reported to have been treated well in both health care centers and maternity hospitals: "*When they [health care personnel] knew that we came from Donetsk, they wanted to hug me, they were so caring….. I also found out that in normal practice one has to pay some money annually for female consultations, but they have not even told me about that. The same was the situation in the maternity hospital, they were really caring once they knew I came from Donetsk*" (resp. 6).

However, certain cases of health care professionals asking for bribes once knowing about IDP status were also reported: "*...as soon as I arrived to Kiev I immediately went to health care center which was close to the place we were living in. I asked them to register me there. They agreed, but they also asked for 'voluntary financial contribution' amounting to UAN 500 (EUR 20) since I am an IDP, new here. Of course, I paid, because there was no other way for me*" (resp. 5).

7) Breastfeeding practices

7 out of 9 respondents have reported no breastfeeding disruptions due to their conflict and displacement experience. Moreover, the interviewees were mostly well-informed about breastfeeding duration, with an average duration of exclusive breastfeeding of 6 months (as per WHO guidelines). They have also reported having received advice on breastfeeding from the health care personnel: "*I have been breastfeeding before the 7th month. Then, I slowly started introducing semi-solid food, but I'm still breastfeeding*" (resp. 4). Even more, lactation has been seen by the IDP mothers as a suitable strategy to save on child nutrition and has thus been used as a coping strategy.

8) Nutrition

Significant changes in diet after displacement were reported. Due to lower income while displaced, the respondents reported to be forced to cut consumption of meat, fish, fruits and vegetables: "*Me and my mother, we eat only pasta and grains. Of fruits, we give one apple per day to each child, we cannot afford more. We cannot afford meat at all so we don`t eat it*" (resp. 8); "*We mostly use the storages of grains and macaroni we have received as humanitarian help. I cannot even afford to buy a small piece of fish for my child because it is too expensive for us, even though our doctor guided us to do so*" (resp. 4).

9) Vaccination

An alarming problem of vaccination absence or vaccination delay has been found. This, however, applies not only to IDPs, but to the general population. Significant declines in vaccination coverage started in 2014, which have been evidenced by joint WHO and UNICEF estimates (2016). The process of awaiting for vaccines can take more than one year: "*My child has not received a single vaccine, since they were not available. When my child was 4 months old, they called us and said that BCG vaccine was available. But I have decided to ask a blood check for my child first before the vaccine was administered, and found that the results were out of norm, so we haven`t vaccinated. Now they told us in the health care center that we should wait another year for BCG vaccine*" (resp. 4).

10) Financial State

Social payments constitute the major source of income for the IDP mothers. These payments are low and are not always enough to cover even the basic needs: "*The social payments we receive are those IDPs are entitled for (EUR 32,4 per child and EUR 16,2 per adult), and the state support for the youngest child. The latter is a one-time paid sum of UAN 10,000 (EUR 366,3), and UAN 800 (EUR 32,2) per month until the child reaches 3 years of age. Considering that we have to pay for rent and utilities, this is not enough*" (resp. 3). Due to the pregnancy and the need to take care of a

child, most respondents were not able to work and earn their own money, while all of them noted that husband/partner/father of a child provided certain financial support.

Other than that, it should be noted that much bureaucracy and many delays are involved when it comes to applying to social help: "*Since my husband is not a Ukrainian citizen, they did not give us the financial support for IDPs and denied us. I tried to dispute, but they did not want to negotiate"(resp. 5); "Other than that, there are long delays with social help, for example, our last payment was delayed for 4 months because of bureaucracy"(resp. 4).*

11) Financial coping strategies

Of the coping strategies identified, there are application for humanitarian assistance, use of previous savings and cutting consumption or purchasing of second-hand goods for children. Some respondents noted that they manage to get their clothes and other everyday goods from home to the new place of living, and that allowed them to allocate their income to purchase food and required goods for children. An important role of a community support should also be noted: those more informed respondents created groups in social networks so as to share the information about the humanitarian assistance, possible promotions, privileges etc. The simplification in diet is the most common strategy to get on for mothers. Mothers tend to save on their own nutrition so as to have more money for better nutrition of their kids.

4. Discussion

In this study, we looked at subjective health status of IDP mothers and children in Ukraine. We found that while IDP mothers did not perceive a notable impact of war and displacement on their physical health status and that of their children, they did admit significant deterioration in their psychological health status, suffering from conditions such as stress, depression, anxiety and constant fear. The IDP mothers were found to be well-informed about lactation practices and predominantly did not feel a harmful influence of war and displacement on their ability to

breastfeed.

The study has also grasped the relative poverty of the IDP mothers and their household, independent of their level of education and professional expertise. For example, we found that social financial support, despite being very limited, constitutes the major source of income for the IDP mothers; while paternal support, even if present, is still not enough to cope. It has also been reported that obtaining the social payments is a tough bureaucratic procedure and these payments are often delayed for months, making the IDP mothers and children live on the dire straits. Given these facts, poor financial conditions create an environment potentially risky for the health of IDP mothers and their children. This is directly reflected in deteriorated nutrition practices, with some IDP mothers eating exclusively grains, bread and pasta so as to save money. The majority of the IDP mothers surveyed admitted to having significantly cut consumption of meat, fish, vegetables and fruits for them and their children. The poor financial conditions are also reflected in IDP mothers` avoidance of preventive health care services with mothers trying to make their children 'not to get sick' so there is no necessity to buy medicines and pay for health care services.

The conflict eruption deprived those living in the occupied area from health care services for the last two or three months before fleeing, and thus many reported to have missed obligatory medical check-ups and examinations during pregnancy. After displacement, however, the IDP mothers and children accessed the health care services in the same way as the host population. However, certain cases of enquiries for bribes and maltreatment due to the IDP status have been reported. Even though bribing is a common practice in Ukrainian health care system, 3 respondents reported to have been asked for bribes for registering in the health care center in their new place of living.

Talking about the quality of health care provided to the IDP mothers and children, it cannot be viewed separately from the health care system of the country in general, which is low-resourced and poorly financed. In particular, the study has found that there are huge disruptions of vaccine

procurement in Ukraine.

The study found that among the financial coping strategies utilized by the IDP mothers are cutting consumption of food, stopping to buy such goods as clothes, shoes and hygiene-related items, and applying for humanitarian help. Even though the system of humanitarian assistance is not inclusive and often does not allow families with two parents to apply, even the small donations which the IDP mothers managed to receive were reported to be of a great help

To the best of our knowledge, the theme of maternal and child health of IDPs in Ukraine has not been addressed from an academic perspective so far. The only reports available on the issue are provided by international and local relief organizations. However, the study aligns with the other studies devoted to the maternal and child health in a military context conducted in other countries. In particular, our study found the destruction of health care infrastructure in the occupied areas, which deprived pregnant women from quality health care for several months. This corresponds with previous research by Akol and Weeks (2016) suggesting the lack of antenatal care in war, which increases the risk of anemia, malnutrition and concomitant disease.

It is worth discussing that mothers' perceptions on their own health was not aligned with their reporting of nutritional dietary patterns or that of their children. Given the low consumption of vegetables, meat and fish, a high prevalence of malnutrition could be normative in these settings. It is widely known that suboptimal food dietary intake can cause problems of micronutrient deficiencies (Akol, Weeks, 2016), which often are not easily perceived by mothers. Same applies to child's body weight (Akol, Weeks, 2016). This question cannot be answered from our data but further research should explore the problem of insufficient income and potential implications on the maternal and child nutritional status.

Our study has found the significant deterioration in self-reported psychological state of mothers. This aligns with the findings by Smith et al. (2001) who examined the effects of the war on Balkans on mental health among mothers and children. They found that both mothers and

children showed high levels of post-traumatic stress reactions and increased levels of depression and anxiety. The increased levels of depression, anxiety and post-traumatic stress disorder (PTSD) have been evidenced by Debakumar et al. (2014) who have conducted a comprehensive overview of effects of conflict exposure on maternal and child health, based on the evidence from the conflicts that took part within last 20 years worldwide.

Limitations

There is an evidence that Skype-assisted interviewing can be used on equal footing as face-to-face interviews when there are time and financial constraints, geographical dispersion, and physical mobility boundaries (Janghorban et al., 2014). However, this method of data collection still implies certain limitations. Using Skype and Viber allowed us to contact only those respondents, who had an Internet connection which was good enough to use video-call, as well as a computer/smartphone/tablet with relevant technical specifications. Interview participants also needed to have some technical expertise, which might also have excluded potential participants from the sample. The study was thus unable to identify the most marginalized and poor IDPs, who presumably suffer from the displacement consequences the most.

5. Conclusions

The conflict is still ongoing and it was likely that certain dynamics in maternal and child health status of IDPs would occur. This was, basically, an exploratory/pilot study, which can inspire the subsequent research of a wider scope. The research findings have a potential to serve as an evidence base for the further policy-building and corresponding public health actions. In particular, the recommendations based on the study findings include:

- immediate restoration of vaccines procurement and distribution by the Ukrainian state;
- simplification of the IDP status registration system and subsequent obtainment of financial support by the IDPs without delays;
- launching educational program on the adequate, but at the same affordable dietary intake for IDP

mothers;

- ensuring that humanitarian assistance is distributed more exclusively and the information about its availability is made transparent and noticeable to the IDPs;

- implementation of the tolerance initiatives and projects with the host population to decrease the biased attitudes towards IDPs in Ukraine.

There is a pressing need in the further research on the theme utilizing the quantitative approach as well as wider geographic and time frame. It is recommended to address such themes as sexual and reproductive health and war and post-war induced violence. Further research should also allow hearing the voices of the least privileged populations.