Choosing rural healthcare during the war

Understanding drivers and barriers shaping health workforce engagement in rural Ukraine

November 2025

Abstract

Ukraine's healthcare system faces significant challenges amid ongoing conflict, systemic instability, and rising health needs in underserved rural communities. Strengthening primary healthcare in these rural settings requires understanding what motivates healthcare workers and students to engage in rural practice and what barriers prevent them from doing so. This mixed-methods assessment combined three focus group discussions with a structured survey of 406 respondents across nine regions of Ukraine, including rural and urban healthcare workers and students enrolled in health-related educational programs. Findings revealed ambivalent perceptions of rural practice: while 56% viewed rural healthcare as respected, only 26% saw its good career prospects. Major barriers include low salaries, poor infrastructure, lack of housing, and limited career development, with safety concerns emphasized in conflict-affected areas. Key motivators were largely remunerative (higher salaries (30%), housing support (18%), and transportation assistance (16%)), complemented by professional development opportunities. Respondents valued closer patient relationships and community trust but stressed that these benefits cannot cover systemic gaps. Over 86% agreed that material incentives/ benefits and improved infrastructure would significantly increase willingness to work in rural areas. Strengthening rural healthcare in Ukraine requires a comprehensive approach combining financial incentives, housing, infrastructure, safety measures, and professional support. These findings inform policy recommendations to enhance primary healthcare access and resilience in rural communities during and beyond the current crisis.

Keywords: rural healthcare; primary healthcare; health workforce; health policy; health system strengthening; Ukraine

Suggested citation: Isajlovic M. Choosing rural healthcare during the war: Understanding drivers and barriers shaping health workforce engagement in rural Ukraine. Ukraine: International Rescue Committee (IRC); 2025.

Contents

Aknowledgments

This assessment was conducted by the International Rescue Committee (IRC) Ukraine Health Team. The primary author of this report is **Dr. Marko Isajlovic,** Health Coordinator, with co-authorship and methodological support provided by **Danylo Lopatin**, Senior Health MEAL Officer. We extend our gratitude to **Dr. Tetiana Demidoiva**, Senior Primary Health Manager, and **Dr. Valerii Pantieiev**, Senior Health Partner Support Officer, for their technical contributions to the assessment design, and to **Vladyslav Shaulsky**, Health Program Support Officer, for logistical support throughout the process. Special thanks to **Tamara Kiptenko**, Regional Content and Digital Officer, for visual design and **Bethany Orlikowski**, Senior Partnerships Coordinator, for proofreading and editorial assistance.

We also acknowledge the valuable input from participants of the Validation Workshop held on 14 November 2025 in Kyiv, including representatives from government institutions, academia, healthcare providers, and national and international organizations. Their insights were instrumental in refining the recommendations and ensuring their relevance to Ukraine's health system context.

Finally, we thank all **healthcare workers and students**, who contributed their time and perspectives through surveys and focus group discussions. Their voices form the foundation of this report and its recommendations.

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Abbrevations

ECG	Electrocardiograph
EPHA	European Public Health Alliance
EU	European Union
EURIPA	European Rural and Isolated Practitioners Association
FAP	Feldsher-midwife posts
FGD	Focus group discussion
GBV	Gender-based violence
GP	General practitioner
IRC	International Rescue Committee
mhGAP	Mental Health Gap Action Program
MHPSS	Mental health and psychosocial support
MoH	Ministry of Health
NCD	Noncommunicable disease
NGO	Non-governmental organization
NHSU	National Health Service of Ukraine
PHC	Primary health care
PHCC	Primary healthcare center
SRH	Sexual and reproductive health
UNICEF	United Nations Children’s Fund
USD	United States Dollar
WHO	World Health Organization

Executive summary

This report presents the findings of a mixed-methods assessment conducted to identify motivators, explore challenges, and inform policy directions related to current and future healthcare workers' engagement in rural healthcare settings in Ukraine. The assessment was carried out in the context of ongoing war, systemic health system challenges, and increasing health care needs in underserved rural communities of Ukraine.

Methodology overview

The assessment employed a mixed-methods approach, combining three focus group discussions with a structured survey of 406 respondents across nine regions of Ukraine, including rural and urban healthcare workers as well as students enrolled in health-related educational programs. The methodology was designed to ensure regional and professional diversity and to capture lived experiences, attitudes and assumptions. Stratified random sampling ensured convincing representativeness across rural and urban settings, age groups, and professional backgrounds. Through this combination of qualitative and quantitative methods, the assessment provides a comprehensive picture of how current and future healthcare workers perceive rural practice, what motivates them, and what prevents them from choosing or remaining in rural positions.

Perceptions of rural healthcare work

The assessment revealed a complex and often indecisive set of perceptions regarding rural healthcare work. While more than half of the respondents (56%) agreed that rural healthcare is a respected and important role, only one in four (26%) believed that it offers good career prospects. Social life was not perceived as a major deterrent by most healthcare workers, though students and less experienced professionals expressed greater concern in that regard. Perceptions of safety and quality of life varied considerably: while rural workers often viewed their environments as safer than urban respondents did, uncertainty and neutrality prevailed among those without direct rural experience, particularly students. Level of humanitarian support was viewed inconsistently, with no clear consensus across groups or regions. Importantly, the ongoing conflict has not diminished the overall interest in rural work. Nevertheless, it has deepened the division between experienced healthcare workers who often remain committed despite hardship, and younger professionals who perceive rural areas as insecure and professionally limiting.

Barriers and motivators

The main barriers identified for engaging in rural healthcare settings were low salaries, poor infrastructure, lack of housing, limited career development opportunities and limited digital connectivity. These challenges were consistently reported across professional groups and regions, though their relative importance varied. For example, students prioritized training and career pathways, while rural healthcare workers emphasized logistical issues such as transport and internet connectivity. Safety concerns, particularly in conflict-affected areas, further impacted willingness to work in rural settings. Respondents from frontline regions noted shelling, mined areas, and absence of shelters as primary risks, while others emphasized psychological stress, trauma among patients, and social isolation as main concerns.

Key motivators that would likely increase motivation included higher salaries (30%), housing support (18%), and provision of transportation (16%). Career advancement guarantees and continued professional training were also relevant, especially among younger and less experienced respondents. Many respondents expressed higher motivation because they focused on aspects that provided personal satisfaction, such as closer relationships with patients, community trust, and a quieter working environment. However, they emphasized that these benefits alone cannot compensate for the lack of financial and institutional support.

Professional support and integration

Professional support mechanisms emerged as another crucial determinant of motivation. Less than half of respondents (43%) felt confident in their ability to make independent clinical decisions in rural settings without specialist support. At the same time, there was strong consensus that regular mentoring, access to telemedicine, or opportunities for specialized training would significantly increase readiness to work in rural areas. Access to psychological support and burnout prevention programs for healthcare workers was also seen as important (63%), particularly in regions with high hostilities, like Zaporizhzhia and Sumy.

The most desirable support, however, remains material benefits, with respondents expressing high levels of agreement across all demographics. Over 86% of respondents stated that salary increases, housing provision, and transport assistance would directly influence their willingness to work in rural healthcare. Similarly, over 85% agreed that improved infrastructure and working conditions would make rural work more attractive. These findings confirm that systemic improvements and material incentives are essential to both attract and retain healthcare workers in rural settings.

Willingness to engage and perspectives on improving rural healthcare

When asked about their willingness to accept rural assignments, over one third (36%) of students and urban healthcare workers indicated openness to short-term deployments (≤6 months), while a quarter (26%) stated they would never accept a rural posting, suggesting deeply rooted perceptional and structural barriers. Younger professionals were more open to short-term engagements, whereas older colleagues preferred more stable medium- or long-term engagement.

Regional differences were quite pronounced. Respondents from Zaporizhzhia, Mykolaiv and Odesa showed the highest willingness to engage in rural work, while those from Kharkiv and Kyiv had the highest levels of reluctance. These findings indicate that regional contexts should be considered when designing effective engagement strategies.

Open-ended responses strongly reinforced these quantitative findings and provided further depth to the policy recommendations. Financial incentives were the most frequently cited motivator (63%), followed by housing provision (21%), social benefits (11%), and transportation improvements (8%). Respondents also emphasized the need for better working conditions, modern equipment, professional development opportunities, and viable safety measures.

When asked what the Government of Ukraine should do to support health workforce engagement in rural settings, respondents called for a comprehensive and transparent national policy framework. Key recommendations included increased salaries, housing programs, infrastructure development, professional growth initiatives, and family-inclusive support mechanisms. The importance of safety and security in conflict-affected areas was also highlighted. Recurrent themes included frustration over poor infrastructure, lack of recognition, and excessive administrative burdens. Several respondents linked the quality of health care to broader rural development, stressing that improvements in medical services cannot be achieved in isolation from roads, communication, and economic recovery.

Conclusion

The findings reveal a health workforce that remains deeply committed to serving communities but is constrained by systemic instability, limited career prospects, and insufficient institutional support. Strengthening rural healthcare in Ukraine requires a comprehensive approach that combines financial, infrastructural, and social measures to address both practical barriers and personal perceptions. While financial incentives and housing remain foundational, they must be complemented by reliable infrastructure, safe working environments, and access to essential equipment. Equally important are mentorship and structured training pathways that expose students to rural practice early and position family medicine as a respected and rewarding career choice. Digital solutions, telemedicine, and professional support networks should reduce isolation and enhance confidence, while improvements in childcare and psychosocial support will make relocation viable for healthcare workers and their families. Finally, national campaigns promoting the prestige of rural healthcare and family medicine can help shift perceptions and attract new generations of professionals. Together, these measures can transform rural healthcare into a sustainable and appealing career path, strengthening health system resilience and equity across Ukraine.

Introduction

The importance of primary healthcare in rural areas

Nearly half a century ago, the Declaration of Alma-Ata defined primary health care (PHC) as essential health services based on practical, scientifically sound, and socially acceptable methods that are universally accessible to all individuals and families through their active participation. Today, PHC has evolved into a comprehensive, society-wide approach aimed at achieving equitable health outcomes by delivering services that are aligned to people's needs across all stages of life, within or near their communities.

Strong PHC systems improve public health by addressing root causes of illness and death, as well as reducing costs through prioritizing prevention, early diagnosis, and patient-centered service delivery. Despite progress, many countries still struggle with communicable diseases and malnutrition. At the same time, the global health landscape is shifting toward a rising burden of noncommunicable diseases (NCD), driven by aging populations and lifestyle factors such as poor diet, physical inactivity, and tobacco use. Managing multimorbidity adds complexity to care, further challenged by limited evidence-based guidance, while mental health disorders remain a largely under-addressed global concern.

PHC therefore remains essential for meeting these evolving health needs by integrating prevention, health promotion, and community-responsive services into a multisectoral patient-centered model [1].

Even in high-income countries, the need for PHC remains significant, particularly in rural areas, where populations face different barriers to accessing services. Rural communities often experience higher rates of chronic illness, lower life expectancy, and limited access to qualified healthcare professionals compared to their urban counterparts [2]. To address these gaps, innovative approaches have been implemented globally, including mobile clinics, telemedicine, community health programs, school-based services, and partnerships with non-governmental organizations (NGOs), including faith-based organizations [3].

Despite nearly half of the world's population living in rural areas, only 23% of healthcare professionals work in these communities, creating major gaps in service delivery [4]. This imbalance is widespread but most severe in low-income countries; these countries often face severe shortages of healthcare professionals, as well as higher percentages of people living in rural regions, further exacerbating the strain on already limited health resources [5].

Rural health in Europe

Europe, particularly the European Union (EU), is known for its well-established and relatively equitable healthcare systems, which aim to ensure universal access to basic health services for all [6]. However, the continent is experiencing a significant demographic shift and is facing a rapidly aging population. By 2050, the number of people aged 65 and over will rise by 41%, while those aged 80 and over will nearly double [7]. This places increasing pressure on healthcare systems, especially in terms of managing NCDs, multimorbidity, and long-term care needs [8].

In rural areas of Europe, these challenges are even more pronounced. Rural populations tend to be older than their urban counterparts, often facing additional barriers such as limited mobility, geographic isolation, and reduced access to specialized health care services [9]. These factors contribute to poorer health outcomes, particularly in terms of timely access to critical and quality health care [10].

The situation is further complicated by widespread shortages in the health workforce, a challenge affecting nearly all European countries. These shortages are especially acute in regions with lower standards of living and scattered rural populations, such as Bulgaria, Greece, Slovenia, Croatia, and Slovakia [11]. In response, several initiatives have been launched to improve rural health conditions, including mobile medical units, community-based care models, and rural-proofing of health policies [12].

The shortage of healthcare professionals across multiple functions (doctors, nurses, paramedics, etc.) is estimated to reach 1.8 million by 2030 [13]. This crisis is driven by a combination of factors: aging health workforce, burnout, migration, and poor working conditions. In many countries, over a third of doctors and a quarter of nurses are over age 55, raising concerns about future capacity [14].

The uneven distribution of healthcare professionals has led to the emergence of "medical deserts"[1],particularly in rural and remote areas [15]. Countries like Ireland and the Czech Republic

1 "Medical deserts" are areas where population healthcare needs are unmet partially or totally due to lack of adequate access or improper quality of healthcare services caused by (i) insufficient human resources in health or (ii) facilities, (iii) long waiting times, (iv) disproportionate high costs of services or (v) other socio-cultural barriers.

have conducted studies to better understand how to attract and retain general practitioners (GP) in rural settings. In the Czech Republic, key motivating factors for GP trainees include financial incentives, employment opportunities for partners, and access to quality education for children [16]. Similarly, a study in Ireland found that GP trainees are motivated by work-life balance, family support, and well-supported portfolio careers [17].

To address these challenges, the EU and national governments are investing in health workforce planning, rural medical education, and improved working conditions. The Bucharest Declaration (2023), endorsed by 50 World Health Organization (WHO) European Region member states, calls for urgent political action to protect and invest in health workers across Europe [18].

Rural health in Ukraine

Since independence, Ukraine has been gradually reforming its healthcare system, which was originally based on the centralized Semashko model[2]. Rural healthcare has faced persistent challenges, including infrastructural neglect, under-staffing, and weak legal and financing frameworks, leaving many rural communities without reliable primary healthcare and forcing them to travel to district or regional centers for basic health services [19].

The foundation for rural healthcare policy in Ukraine was laid in 1990 with the Law on the Priority of Social Development of Villages and the Agro-industrial Complex (Law No. 400-XII), mandating state investment in rural social infrastructure. However, the socio-economic crisis of the 1990s led to rural depopulation and deterioration of healthcare facilities. By the mid-1990s, infant mortality was high, life expectancy had fallen to 66.8 years, and access to qualified healthcare professionals was limited. Feldsher-midwife posts (FAP)[3] remained the primary link in rural healthcare, staffed by mid-level practitioners under doctor supervision [20].

One of the first milestones in reform came in 2007, when the “State target program” introduced family practice as the basis for rural primary healthcare, aiming to reorganize FAPs into family medicine clinics in villages with over 1,000 inhabitants [20].

Between 2016 and 2018, Ukraine launched comprehensive healthcare reforms making family doctors the first point of contact, replacing the Soviet-style polyclinic system. The Law on State Financial Guarantees (2017) introduced the principle of “money follows the patient”[4], and the National Health Service of Ukraine (NHSU) was established as the main healthcare fund. The Law No. 7117 “On Improvement of Accessibility and Quality of Healthcare Services in Rural Areas” (2017) allocated 5 billion hryvnas[5] to upgrade rural healthcare infrastructure, including new outpatient clinics, medical transport, and digitalization [21].

In 2018, Order No. 178/24 redefined rural healthcare structures, replacing FAPs with Health Points staffed intermittently by visiting doctors or nurses. Feldsher positions were officially reclassified as “paramedic”[6], and responsibility for rural facilities, including financing, shifted to local communities [21]. In June 2021, President Volodymyr Zelenskyy signed a decree establishing minimum monthly salaries of 20,000 hryvnas for doctors and 13,500 hryvnas for nurses[7], aiming to enhance the prestige of the medical profession and improve retention of healthcare workers in Ukraine [22].

Since the start of the full-scale invasion in 2022, institutional support for strengthening rural healthcare has been limited, leaving many services and patients dependent on humanitarian assistance. Local and international NGOs provide essential care, medications, and mental health support in rural and

2 The Semashko model is a centralized and state-funded healthcare system developed in the Soviet Union, providing universal access to healthcare and emphasizing preventive care, but was ultimately hampered by bureaucratic rigidity, chronic underfunding, and poor adaptability to evolving health needs, resulting in inefficiencies and declining service quality.

3 Feldsher-midwife posts were rural primary healthcare units in the Soviet Union staffed by feldshers (mid-level medical practitioners trained to provide basic diagnostic, therapeutic, and emergency care) and midwives, serving as the frontline of healthcare delivery in rural areas with limited access to doctors.

4 “Money follows the patient” means that healthcare financing shifted from funding institutions to funding services, incentivizing quality care and allowing local governments to adjust salaries and invest in equipment.

5 Approximately 188 million USD in 2017

6 Paramedic focuses more narrowly on prehospital emergency care, stabilization, and transport of patients.

7 In 2021, 20,000 Ukrainian hryvnia was approximately 735 USD, and 13,500 hryvnia was about 496 USD.

conflict-affected areas [21]. Systemic measures to strengthen rural healthcare were largely deprioritized until Presidential Decree No. 483/2024, which introduced measures such as incentives for healthcare workers, housing compensation, medication delivery, pharmacy expansion, and rural-focused medical training. However, this decree raised constitutional concerns regarding separation of powers, as noted by the Centre for United Actions [23].

Despite reforms, legal uncertainty and chronic underfunding persist, undermining service delivery and risking deeper rural health inequalities. Experts warn that without clear regulation and sustainable financing for rural health staffing and infrastructure, reforms may accelerate depopulation trends [20] [21].

Ukraine has been struggling with a shortage of healthcare professionals for over a decade, like other European countries, and this issue has become even more acute since the full-scale invasion. Contributing factors include emigration of healthcare workers and persistent financial constraints within the healthcare system [24][25].

To fill these gaps, family physicians have been required to take on additional responsibilities, such as providing sexual and reproductive health (SRH) services and mental health and psychosocial support (MHPSS). Many were trained under WHO's Mental Health Gap Action Program (mhGAP)[8] to manage common mental health conditions at the primary healthcare level [26][27]. This has placed significant pressure on an already overstretched workforce, particularly in rural communities. The psychological toll on healthcare workers has been severe. One in five medical professionals in Ukraine reports struggling with prolonged war-related stress, including anxiety, depression, and burnout. Many lack effective coping mechanisms, and younger staff are particularly vulnerable [28].

Telemedicine emerged as a potential solution to address capacity shortages in rural areas. The Ukrainian government adopted a telemedicine development strategy in 2023, followed by the Law on Telemedicine (September 2023), which established a legal framework for remote consultations and rehabilitation services. However, implementation requires substantial investment in infrastructure, training, and digital literacy [29][30].

The Ministry of Health (MoH) of Ukraine reports that 2,419 healthcare infrastructure facilities have been damaged or destroyed as of August 2025, with 311 completely ruined, many of these in rural and frontline regions like Donetsk, Kharkiv, Luhansk, Kherson, and Zaporizhzhia [31]. According to the World Bank, the estimated cost to recover and reconstruct Ukraine's healthcare system over the next decade is more than 19.4 billion USD [32].

A multi-sectorial needs assessment (MSNA) conducted by IRC in October 2025 shows that health needs across the assessed regions are marked by critical service gaps and significant access barriers. More than 70% of surveyed households identified health needs as a top priority. Chronic diseases affect 80% of households, while mental health conditions affect 34%. Although 94% of respondents know where their nearest health facility is located, 16% live more than 10 km away (20% in rural areas and 11% in urban areas), with Sumy region being the highest at 29%. Regarding accessibility, 13% consider health facilities inaccessible due to poor service quality (25%), lack of transport (24%), low provider competency (14%), and high costs (8%). Additionally, 53% cannot afford prescribed medicines, mainly due to financial constraints (93%). Interestingly, awareness of the government's 'affordable medicines' program, which provides patients with access to essential prescription drugs at reduced or no cost, stands at 73%, yet 26% remain unaware. Even among those familiar with the program, barriers persist, including limited drug coverage, the absence of pharmacies in rural areas, and infrequent mobile pharmacy visits, often occurring only once a month. Furthermore, shortages of specialists, outdated diagnostic equipment, and the lack of pediatric, maternal, psychological, and palliative care remain a critical gaps. Pharmacy access is absent in many rural settlements, where limited medication availability, high prices, and irregular supply continue to pose major challenges. [33]

8 The WHO's mhGAP aims to scale up care for mental, neurological, and substance use disorders in low- and middle-income countries, emphasizing that with proper support, even in resource-limited settings, millions can recover from conditions like depression, schizophrenia, and epilepsy, and lead normal lives.

Objective

Objective of the assessment

This assessment aims to explore and deepen the understanding of the perceptions, attitudes, and underlying barriers that influence current and future healthcare professionals' willingness to work in rural healthcare settings in Ukraine, all in the context of ongoing full-scale war, economic instability, and heightened health needs among rural communities.

By uncovering these personal and systemic factors, the assessment seeks to inform the development of targeted and context-specific policies that can enhance health workforce engagement in rural healthcare settings, consequently improving health outcomes for these underserved rural communities.

Additionally, the findings and recommendations should inform international actors in the support, design, and implementation of pilot initiatives that are responsive to local needs, rooted in the lived experiences of healthcare workers, and structured to be both effective and sustainable beyond the current crisis.

Methodology

Methodology and methods

This assessment employed a mixed-methods approach, combining qualitative and quantitative data collection to comprehensively explore the challenges and motivators influencing current and future healthcare workers' decisions to engage in rural healthcare settings in Ukraine. The assessments targeted three key groups: rural healthcare workers, urban healthcare workers, and students enrolled in health-related educational programs (medical, nursing, and paramedical).

For the purposes of this assessment, healthcare workers were classified as rural or urban based on the official designation of the settlement in which their facility is located, in accordance with current Ukrainian administrative classifications [34]. Facilities located in legally recognized rural settlements were considered rural, while those in urban-designated areas were classified as urban.

The first phase of data collection consisted of three focus group discussions (FGD) conducted in July 2025, with each involving one of the target groups: rural healthcare workers, urban healthcare workers, and medical students. These discussions provided significant contextual insights into the perceptions, experiences, and barriers associated with rural healthcare work, particularly in the context of ongoing war, economic instability, and systemic challenges. The findings revealed both external structural issues and deeply rooted perception-based barriers that contribute to the reluctance of health workforce to pursue careers in rural areas.

Building on the thematic findings from the FGDs, a structured survey was developed to collect quantitative data from a broader and more diverse sample. This second phase aimed to validate and expand upon the qualitative findings, offering a more specific and statistically convincing understanding of the factors influencing healthcare workforces' engagement in rural areas.

To ensure validity and convincing representativeness, the survey employed stratified random sampling, dividing the population into homogeneous subgroups (strata) and randomly selecting respondents within each. This approach was chosen due to the internal heterogeneity of Ukraine's healthcare system, which varies significantly by professional role, region, and facility type [35]. Stratification helped minimize sampling error and enabled meaningful comparisons across groups.

Strata were defined based on two criteria, allowing the sample to reflect the actual structure of Ukraine's health workforce and account for regional and professional differences:

1. Regional – Kharkiv, Sumy, Dnipro, Zaporizhzhia, Mykolaiv, Odesa, Zakarpattia, Lviv, and Kyiv regions;
2. Professional Category – Medical doctors, nurses, feldshers/paramedics in urban and rural facilities, and students of health-related educational programs (medical, nursing and paramedical).

The selection of regions was based on the following principles:

- Territorial representativeness
- Variation in healthcare system conditions, ranging from frontline to less conflict-affected regions[9].

This selection enabled a comprehensive analysis of health workforce potential and educational needs across diverse contexts, allowing for generalizable conclusions at the national level.

The sample size was calculated to range between 382 and 648 respondents, based on standard social research parameters at a 95% confidence level. The limits were based on statistical calculations ensuring reliability and precision of results for a large general population, with approximately 177,000[10] individuals within this assessment [36].

Using the classic formula for finite populations, the minimum sample size was determined to be 383 respondents (with a 5% margin of error). To enhance precision and allow for deeper subgroup analysis, an extended sample size of up to 654 respondents (with a 4% margin of error) was considered.

After determining the total sample size, a proportional allocation of respondents across the nine regions of Ukraine was conducted based on the distribution of healthcare workers and students in each area, ensuring balanced representation and enabling accurate national-level comparisons.

9 For this assessment, less conflict-affected regions were identified based on lower proximity to the frontline, lower frequency of the attacks/shelling and smaller influx of IDPs.

10 Based on the MoH data, from January 1st 2025, the number represents total number of the target population enrolled in this assessment, including healthcare professionals (medical doctors, nurses and feldshers/paramedics), together with number of students from health related educational-programs

Data collection combined face-to-face and online methods. Trained interviewers conducted fieldwork in Sumy, Kharkiv, Kyiv, Zakarpattia, Mykolaiv, and Zaporizhzhia regions, targeting healthcare workers in both rural and urban facilities. Simultaneously, online surveys were distributed to students and some healthcare workers in remote communities, allowing for the inclusion of participants without requiring physical presence.

All participants involved in both the FGDs and the survey were informed about the purpose and objectives of the data collection prior to their participation. Informed consent was obtained from everyone, ensuring that their involvement was entirely voluntary. The assessment adhered to core ethical research principles, including confidentiality, anonymity, and respect for participants' autonomy. No personal identifiers were collected, and all responses were handled in a manner that protects the privacy and dignity of the individuals involved.

Data Collection Tools

The FGD guide consisted of seven thematic sections with open-ended questions designed to explore motivations, barriers, and attitudes toward rural healthcare work (Annex 1):

1. **Advantages and perceptions** – exploring perceived pros and cons of rural healthcare work, including peer and patient perspectives.
2. **Motivations and incentives** – identifying personal, professional, and systemic factors that could make rural work more attractive.
3. **Conflict and safety** – assessing how the ongoing conflict influences perceptions of safety and willingness to work in rural areas.
4. **Working conditions and practical concerns** – gathering views on operational challenges, including infrastructure, equipment, and digital tools.
5. **Personal and social life** – understanding how family, gender, and social integration affect decisions about rural postings.
6. **Policy, system, and recommendations** – evaluating perceptions of existing policies and collecting suggestions for improvement.
7. **Wrap-up** – providing space for open reflection and additional insights not covered in earlier sections.

FGD findings were analyzed and structured around shared themes across the three groups, including: perceived benefits of rural health work; perceptions among peers; career development and professional growth; impact of conflict and security concerns; incentives for rural work; social integration and personal life factors; and, perceptions of current policy and recommendations.

Based on the FGD findings, the quantitative data collection tool was developed as a structured questionnaire that included a mix of question types (Annex 2):

- Likert scale[11] to measure attitudes and perceptions, formed as positive statements
- Multiple-choice questions to identify key motivators and barriers
- Open-ended questions to capture individual suggestions and reflections

The questionnaire was initially drafted in English, translated into Ukrainian, and pilot-tested with a small group to ensure clarity and logical consistency. It was then adapted into a digital format for broader distribution.

Respondents were first asked to provide basic demographic and professional information, including:

- Professional background: medical doctor, nurse, feldsher/paramedic, or student
- Work location: rural or urban[12]
- Age group: 18–25, 26–35, 36–45, 46–55, 56+
- Gender: male, female, other
- Region of workplace or study: Dnipro, Zaporizhzhia, Zakarpattia, Mykolaiv, Odesa, Kharkiv, Sumy, Kyiv, Lviv
- Years of professional experience: 0 (for students), <5, 5–10, 11–20, >20

11 A Likert scale is a type of rating scale measuring attitudes, opinions, or perceptions by asking respondents to indicate their level of agreement or disagreement with a statement. It provides a range of options, such as "strongly agree," "agree," "neutral," "disagree," and "strongly disagree."

12 This question was excluded for students

The questionnaire was organized into five logically structured sections:

1. **Perceptions of rural healthcare work** – which included statements designed to assess respondents' attitudes toward working in rural communities, including perceived prestige, career prospects, social recognition, safety, and quality of life.
2. **Barriers and motivation** – in which respondents were asked to select up to three key factors (both social and professional) that they considered most influential in their decision to work (or not work) in rural areas.
3. **Conflict and safety** – which explored perceived risks and threats associated with working in frontline or conflict-affected rural communities.
4. **Professional support and integration** – which was worded separately for healthcare professionals and students, examining factors influencing confidence and motivation to work in rural settings. Topics included autonomy in clinical decision-making, access to supervision and mentoring, availability of training and telemedicine, psychological support, financial incentives, and infrastructure quality.
5. **Open-ended questions** – in which respondents were invited to freely express their views on what changes could enhance motivation to work in rural healthcare settings and to suggest actions the government could take to support rural health workforce engagement.

Most responses were collected online using the KoboToolbox platform, which facilitated efficient data collection and automatic aggregation. For participants unable to access the digital format due to technical or organizational constraints, a paper-based version of the survey was provided. All paper responses were subsequently digitized to ensure data completion and integrity.

Following data analysis, a validation workshop was organized with representatives of government institutions, academia, healthcare workers, and national and international NGOs. While not part of the primary data collection, this workshop served as a quality assurance step to confirm the validity of the findings and ensure that stakeholder perspectives were incorporated into the interpretation and recommendations.

Limitations and shortcomings of the assessment

While this assessment provides valuable insights into factors influencing healthcare workers' and students' willingness to engage in rural practice, several methodological and contextual limitations should be noted. These do not diminish the relevance of the findings but clarify the degree to which they can be generalized, particularly given the constraints of conducting assessment during wartime.

The sample was substantial and geographically diverse but not nationally representative as it only covers nine of Ukraine's 24 regions, and reliance on voluntary support and existing networks may have introduced selection bias. Student representation varied significantly by region, and in Zaporizhzhia no students were included due to the closure of some health-related educational institutions, while others remained functional but shifted to online modalities and, for security reasons, were less willing to engage in data collection or survey participation. Due to limited access to certain Lviv health facilities and time constraints in data collection, these sites were not properly captured, resulting in zero urban healthcare worker respondents.

Healthcare facilities were selected based on settlement type, fieldwork accessibility, and the presence of relevant healthcare workers. In each of the nine regions, facility lists were developed with IRC-supported sites, the Health Cluster, partner organizations, and educational institutions, ensuring reliable information and effective cooperation with healthcare staff and students. For rural healthcare workers, the survey focused on primary healthcare facilities (PHCCs, ambulatories, and FAPs). For urban healthcare workers, central district, city, and regional hospitals were prioritized. Data collection was shaped by security concerns, movement restrictions, and disrupted communications, which often required shifting engagement from in-person to online formats. As a result, perspectives from communities facing severe instability may be underrepresented or captured differently compared to those from more accessible regions. Additionally, the survey did not capture key sociodemographic variables such as family status or parenting responsibilities, which could be the important factors influencing willingness to relocate given limited childcare and educational services in rural areas.

Limited number of FGDs and reliance on IRC-linked institutions may have narrowed viewpoints, and self-reported attitudes at one point in time may not predict real-world behavior under changing context. Finally, while the validation workshop provided critical feedback and confirmed overall validity, its participant group was relatively small and may not represent all institutional perspectives.

Future studies should aim for broader sampling, inclusion of additional demographic variables, and longitudinal approaches to track how attitudes evolve over time.

Findings

Overview of respondent demographics

Qualitative data was collected through three FGDs conducted during July 2025 with a total of 23 participants. Two were held in Kharkiv, with rural healthcare workers from Shevchenkove Primary Healthcare Center (PHCC) and students of the Kharkiv National Medical University. The third FGD was held with urban healthcare workers from Sumy Regional Clinical Hospital.

Table 1. Demographic data and representation per region of FGD participants

Region	Group	Participants per gender	Age of participants
Kharkiv	Rural healthcare workers	8 (M-0; F-8)	40-65 y
Sumy	Urban healthcare workers	10 (M-1; F-9)	35-60 y
Kharkiv	Students	5 (M-1; F-4)	22-24 y

Quantitative data collection was conducted from September 8 to October 24, 2025, simultaneously across all sampled regions. A total of 409 individuals were invited to participate in the survey, of whom 406 (99%) provided informed consent and completed the questionnaire. The remaining three individuals declined participation after being informed of the survey's purpose without sharing specific reasons for that decision.

The final sample size of 406 respondents falls within the calculated parameters for convincing representativeness and serves as the denominator for the most percentage-based analyses presented in the report.

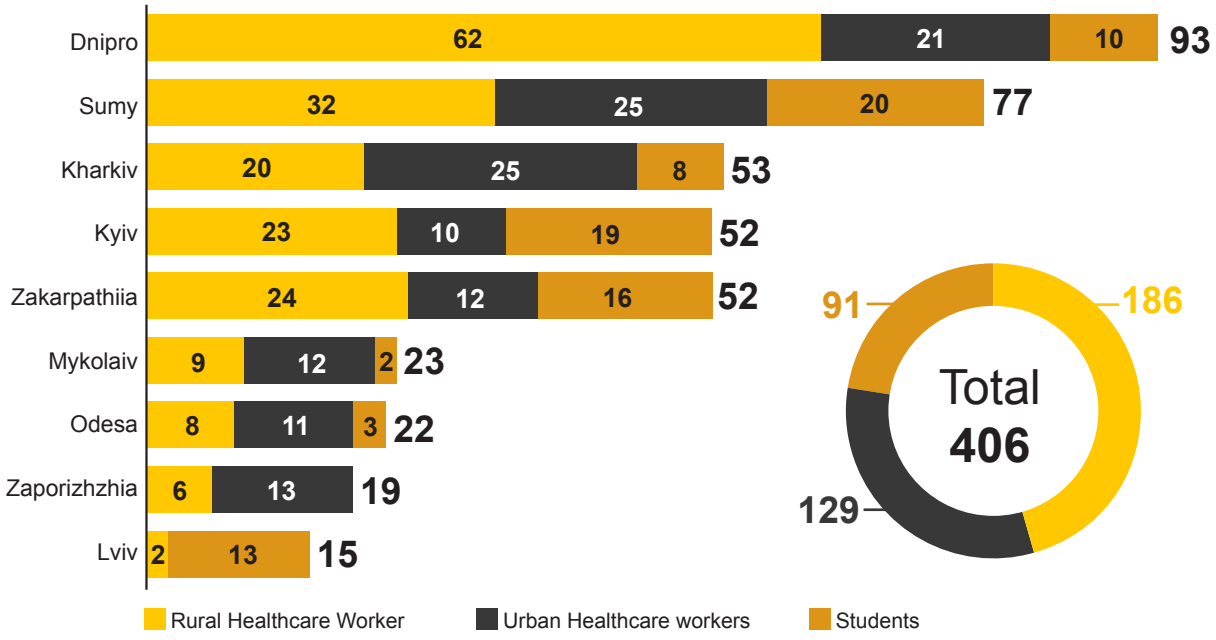
Among the three target groups, the largest proportion of respondents were rural healthcare workers (45.8%), followed by urban healthcare workers (31.8%) and students of health-related disciplines (22.4%). In terms of professional background, nurses represented the largest group (39.4%), followed by medical doctors (29.1%), medical students (18.0%), feldshers/paramedics (9.1%), nursing students (3.9%), and paramedical students (0.5%).

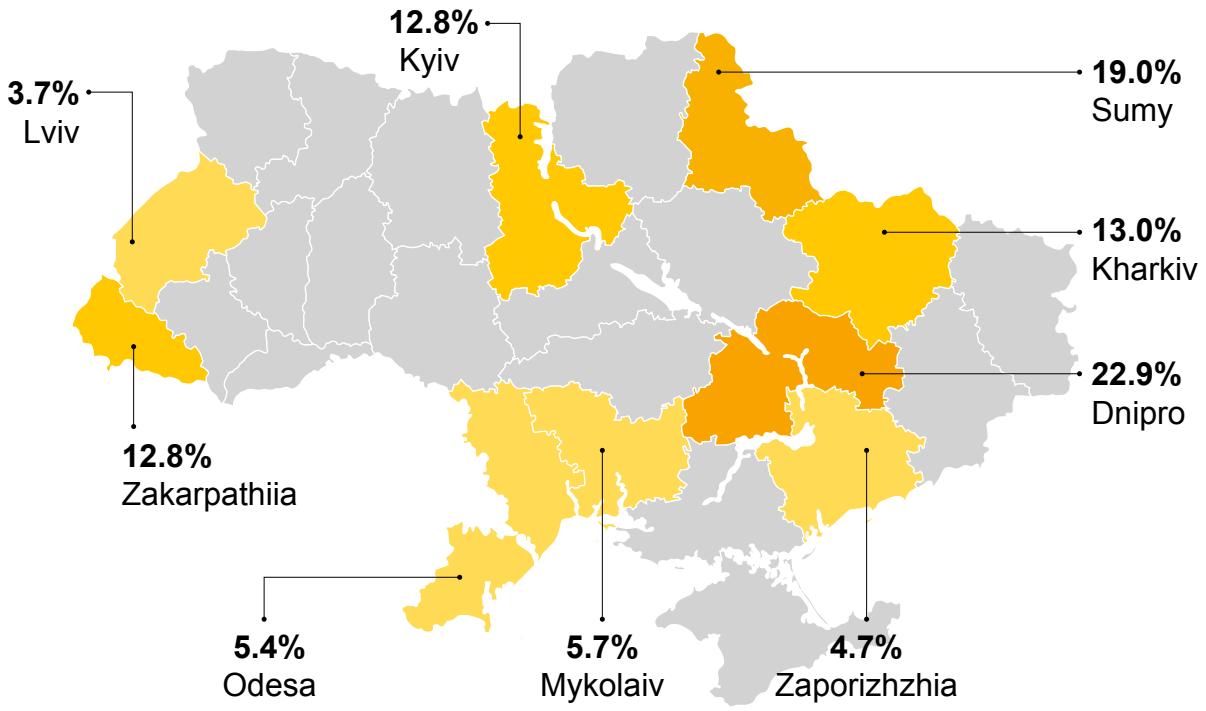
Age distribution was relatively balanced, with the largest group aged 18–25 years (26.4%), followed by those aged 46–55 (21.4%), 36–45 (20.2%), 26–35 (16.7%), and over 56 years (15.3%). Regarding professional experience, the majority of respondents had over 20 years of experience (35.0%), followed by those with 11–20 years (24.9%), no experience - students (22.4%), 5–10 years (9.3%), and less than 5 years (8.4%).

Regionally, the highest number of respondents came from Dnipro (22.9%), followed by Sumy (19.0%), Kharkiv (13.0%), Kyiv (12.8%), Zakarpattia (12.8%), Mykolaiv (5.7%), Odesa (5.4%), Zaporizhzhia (4.9%), and Lviv (3.7%).

In terms of gender distribution, the sample was predominantly female, accounting for 80.0% of all respondents, which reflects the overall gender composition of Ukraine's health workforce.

Table 2. Distribution of three main target groups across Regions, in absolute numbers





General findings

The integration of qualitative and quantitative data enabled a comprehensive understanding of the pros and cons influencing current and future healthcare professionals' engagement in rural healthcare settings. The majority of assumptions and thematic insights identified during the qualitative phase were substantiated by the quantitative data results, reinforcing the overall findings.

FGDs revealed that the lack of motivation to work in rural healthcare is shaped by a range of long-standing and interconnected factors. These include not only financial constraints and security concerns, but also deeper systemic and perception-related barriers, particularly present among urban healthcare workers and medical students. A prominent theme emerging from the qualitative data was the disconnect between the lived experiences of rural healthcare workers and the perceptions held by those outside these communities. Addressing this gap will require not only targeted policy reforms and infrastructure investments, but also a broader cultural and professional rebranding of rural healthcare as a respected and fulfilling career path.

To further explore and validate these findings, the results of this assessment are presented across four thematic areas:

1. Perceptions of rural healthcare
2. Barriers and motivators for engagement in rural healthcare
3. Professional support and integration in rural healthcare
4. Willingness to engage and perspectives on improving rural healthcare

Data for questions utilizing Likert scales were analyzed by grouping responses into positive – "Agreement" (strongly agree and agree), "Neutral", and negative – "Disagreement" (disagree and strongly disagree) categories. Where responses demonstrated a high concentration of strong agreement or disagreement, these trends are highlighted in the presentation of findings.

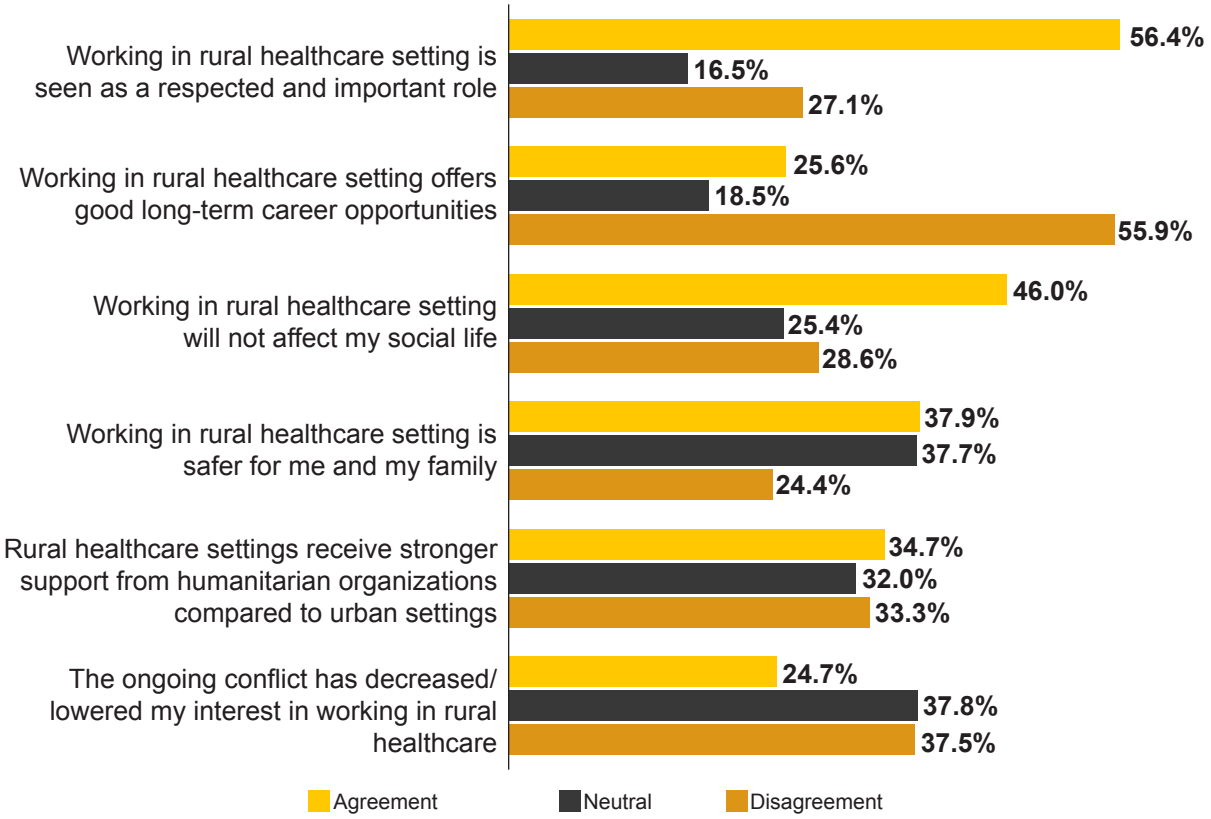
To enhance the depth of analysis, findings were cross-compared across key variables, including professional background, age, years of experience, workplace setting (urban vs. rural), and geographic region. Due to similarities in response patterns and sample size considerations, certain regions were grouped for analytical purposes. For example, Mykolaiv and Odesa were grouped under "South," while Zakarpattia and Lviv were grouped as "West." Furthermore, Zaporizhzhia, despite a smaller sample size, is presented separately in selected findings due to the distinctiveness and consistency of respondent perspectives from that region.

Perceptions

Perceptions of rural healthcare

This section of the assessment explores respondents' attitudes toward rural healthcare through a series of statements designed to assess perceptions of professional respect, career prospects, social life, safety, humanitarian support, and the impact of conflict on motivation. The results reveal a complex and often ambivalent set of views, with some areas showing clear consensus and others marked by uncertainty or divergence across respondent groups.

Table 3. Survey responses on perceptions of rural healthcare



A majority of respondents (56.4%) agreed that working in rural healthcare is perceived as a respected and important role. This opinion was particularly strong among rural healthcare workers (61.8%) and urban healthcare workers (58.9%), while students expressed lower levels of agreement (41.8%). Nurses demonstrated the highest level of agreement across professional categories (65.0%). Regionally, respondents from Sumy (70.0%) and the South (64.0%) were most likely to affirm the statement, whereas respondents from Kyiv showed the highest level of disagreement (51.9%).

In contrast, perceptions of long-term career opportunities in rural healthcare were notably less positive. Over half of respondents (55.9%) disagreed that rural settings offer good career prospects. This view was most prevalent among students (67.1%) and healthcare workers with less than five years of experience (70.5%). However, regional variation was evident, with respondents from the South (51.1%) and Zaporizhzhia (57.9%) expressing more optimism about career development in rural areas.

Regarding the impact of rural work on social life, 46.0% of respondents agreed that working in rural healthcare would not negatively affect their personal lives. This view was similarly held by rural (51.6%) and urban (51.2%) healthcare workers. Nurses (54.4%) and feldshers (70.2%) were particularly likely to agree, as were older and more experienced professionals (57.0% agreement among those with over 20 years of experience). In contrast, only 27.5% of students shared this view, with 40.7% expressing concern that rural work would negatively affect their social life. A similar trend was observed among less experienced professionals, 52.9% of whom disagreed with the statement.

Responses to statements concerning safety, humanitarian support, and the impact of conflict on motivation were more evenly distributed, indicating a lack of consensus. Approximately 37.9% of respondents agreed that rural healthcare settings are safer for themselves and their families, while 37.7% remained neutral. Rural healthcare workers were more likely to perceive rural work as safe

(46.7%) compared to urban professionals (38.0%) and students (19.8%). Notably, 58.2% of students expressed neutrality on this issue, suggesting limited exposure or information. Regional differences were pronounced, with respondents from Zaporizhzhia (78.9%) and the South (57.8%) reporting higher levels of perceived safety, while 67.0% of respondents from Kyiv remained neutral.

Rural healthcare is respected, but not rewarded

Perceptions of humanitarian support in rural areas were divided. While 34.7% of respondents agreed that rural healthcare settings receive stronger support from humanitarian organizations, 33.3% disagreed, and 32.0% remained neutral. Urban healthcare workers were more likely to agree (41.1%), whereas students tended to disagree (41.8%). Among professional categories, feldshers (51.3%) and medical doctors (45.8%) showed the highest levels of agreement. Regional variation was again evident, with respondents from the South (57.8%) and Kyiv (48.0%) expressing stronger agreement, while those from Sumy (46.7%), the West (41.8%), and Kharkiv (41.5%) were more likely to disagree.

Finally, when asked whether the ongoing conflict had decreased their interest in working in rural healthcare, responses were mixed. While 37.8% of respondents were neutral, 37.5% disagreed, indicating that their interest probably had not diminished. Rural healthcare workers were most likely to disagree (48.1%), as were older respondents, with 53.2% of those aged 56 and above stating that the conflict had not reduced their interest.

The findings show that while there is a general recognition of the social value and respect associated with rural practice, significant concerns persist regarding career development, social integration, and safety. The differences in views between professional groups, particularly between experienced healthcare workers and students, suggests that perceptions are shaped not only by individual experience but also by exposure to rural contexts and systemic support structures. Regional differences further underscore the importance of localized approaches in policy and program design.

Barriers and motivators

Barriers and motivators for engagement in rural healthcare

This section explores the personal, professional, structural, and safety-related factors that influence healthcare professionals' willingness to work in rural areas. It examines perceived benefits of rural healthcare work, the most significant challenges, and the incentives that could enhance motivation. Respondents were asked to select the three most important items from a predefined list of ten options for each question. An open-ended "Other" category was also provided to capture additional perspectives not reflected in the listed choices.

Table 4. Summary of top three responses to key questions on barriers and motivators for engagement in rural healthcare

Question	Top three choices
Professional or social benefits you consider most important when working in a rural healthcare setting?	1. Closer connection with patients and community 2. Greater respect and trust from patients 3. Quieter, less stressful environment outside major cities
Challenges you consider most significant for working in rural healthcare?	1. Low salary 2. Poor roads/transport 3. Lack of housing
Benefits or incentives you believe would increase motivation to work in a rural healthcare setting?	1. Higher salary 2. Housing support 3. Transport/vehicle provided
Security or safety risks you consider most significant when working in a rural healthcare setting?	1. Psychological trauma among patients/community 2. Lack of shelters 3. Shelling/proximity to front line

Perceived benefits of rural healthcare work

When asked to identify the most important professional or social benefits of working in rural healthcare settings, respondents most frequently selected a closer connection with patients and the community (22.0%), followed by greater respect and trust from patients (17.4%), and a quieter, less stressful environment outside major cities (13.9%). Additional benefits noted included a lower cost of living (10.3%) and the opportunity to have a direct impact on community health (8.7%).

Across the three main target groups, these top benefits were consistently selected, with minor variations. Students, for instance, placed slightly more emphasis on the quieter environment (17.9%) compared to respect from patients (17.5%). Less experienced healthcare workers highlighted broader clinical exposure and a more diverse clinical-case mix (13.7%) and lower patient aggression (13.7%) as key benefits, alongside the commonly cited community connection. Regional differences were also observed, with respondents from Western regions prioritizing lower cost of living (17.9%), as well as Kyiv (14.7%), while those from the South emphasizing the opportunity to influence public health (16.3%).

Key challenges in rural healthcare work

In terms of perceived challenges, the most frequently selected barriers were low salary (25.4%), poor roads and transport (17.4%), and lack of housing options (11.3%). Outdated equipment and facilities (11.2%) and limited opportunities for career development (10.7%) were also commonly noted.

Rural healthcare workers selected these challenges with higher frequency, particularly low salary (27.2%) and poor roads (20.8%), probably reflecting on their lived experiences. In addition, poor internet and telecommunications infrastructure (8.6%) emerged as a significant concern among rural respondents. Similarly, urban healthcare workers also identified low salary (23.3%) and poor roads (16.8%) as key challenges, though at slightly lower rates. Interestingly, students selected limited career development opportunities (18.3%) and outdated equipment (18.3%) alongside low salary (24.5%), as three main challenges, potentially indicating that future prospects and working conditions are central to their decision-making and motivation.

Experience level also influenced perceptions, with younger professionals prioritizing career development (14.7%), while older respondents (aged 56+) identified conflict-related security risks (9.1%) as a notable

challenge. Regionally, outdated equipment was a prominent choice in Sumy (14.3%), Zaporizhzhia (14.0%), and Dnipro (12.5%), while limited career development was emphasized in the West (17.4%) and Kharkiv (15.1%).

Main motivators for rural healthcare engagement

When asked about incentives that could increase motivation to work in rural healthcare, nearly one-third of respondents (30.2%) selected higher salary as the most important factor. This was followed by housing support (17.7%) and provision of transportation or vehicles (16.3%). Career advancement guarantees (10.8%) and continued professional training (6.6%) were also a frequent choice.

Urban healthcare workers aligned with the overall trend but placed greater emphasis on housing support (22.7%). Rural healthcare workers, on the other side, prioritized transportation support (16.5%) over housing (14.7%), and also chose reliable mobile connectivity (8.8%) and reliable safety (8.6%) as important motivators. Notably, students were the most likely to select higher salary (31.5%), followed by career advancement guarantees (19.4%) and housing support (16.8%). Furthermore, students were the only group to significantly prioritize the possibility of temporary assignments to rural settings (5.5%).

Experience level also shaped the preferences of motivators. Less experienced professionals favored career advancement guarantees (15.7% among those with <5 years of experience), while older and more experienced respondents emphasized reliable safety (9.4% among those with >20 years of experience and 8.1% among those aged 56+). As per the regions, higher salary was the top choice across all areas, with the highest selection rate in Kyiv (32.0%). Kyiv respondents also prioritized housing support (25.6%), while those in Dnipro emphasized reliable safety (10.7%). Career advancement guarantees were particularly important for the respondents in the West (14.9%), Kharkiv (12.0%), and Kyiv (9.6%).

Perceived safety and security risks

The final question in this section addressed the most significant safety and security risks associated with rural healthcare work. Responses were relatively evenly distributed, with psychological trauma among patients and communities (17.6%), lack of shelters (17.5%), and shelling or proximity to the front line (17.0%) emerging as the top concerns. Additional risks included fear due to isolation and lack of immediate support (12.4%) and unstable communication networks (11.4%).

Rural healthcare workers were more likely to choose psychological trauma (21.1%) and lack of shelters (19.9%) as key risks, while urban professionals placed less emphasis on psychological trauma (15.8%) probably due to being exposed to these cases on a more regular basis. Students highlighted fear due to isolation (15.4%) as a major concern. Younger respondents also prioritized fear of isolation (16.2%) as a major concern, whereas older participants (aged 56+) were more concerned about the lack of shelters (25.3%).

Connection matters, but compensation and safety matter more

Regional differences in perceived safety risks were particularly pronounced. Shelling was a major concern in frontline regions such as Sumy (28.1%), Zaporizhzhia (26.3%), and Kharkiv (21.4%), while placing less emphasis on psychological trauma, likely reflecting both proximity to conflict zones and greater familiarity with trauma-related cases. In contrast, respondents from the West (22.4%) and Kyiv (22.4%) prioritized psychological trauma as a key concern. Kyiv respondents also highlighted fear of isolation (19.2%), unstable communication (14.7%), and the presence of violent or antisocial individuals (13.5%) as notable risks. Mined areas were a significant concern in the South (17.8%) and Kharkiv (13.8%), while lack of shelters was frequently noted in Zaporizhzhia (21.0%) and the South (20.0%). Notably, Zaporizhzhia was the only region where a high presence of military personnel (14.0%) was identified as a significant safety concern.

The findings showcase that healthcare workers and students recognize meaningful benefits in rural practice, such as closer community ties and professional respect, but these are overshadowed by systemic barriers including low salaries, poor infrastructure, limited housing, and inadequate career development opportunities. Safety concerns, particularly in conflict-affected regions, and lack of reliable connectivity further reduce willingness to relocate to rural areas. Financial incentives, housing support, transportation, and clear career advancement guarantees emerge as the strongest motivators, alongside measures to ensure safety and improve working conditions.

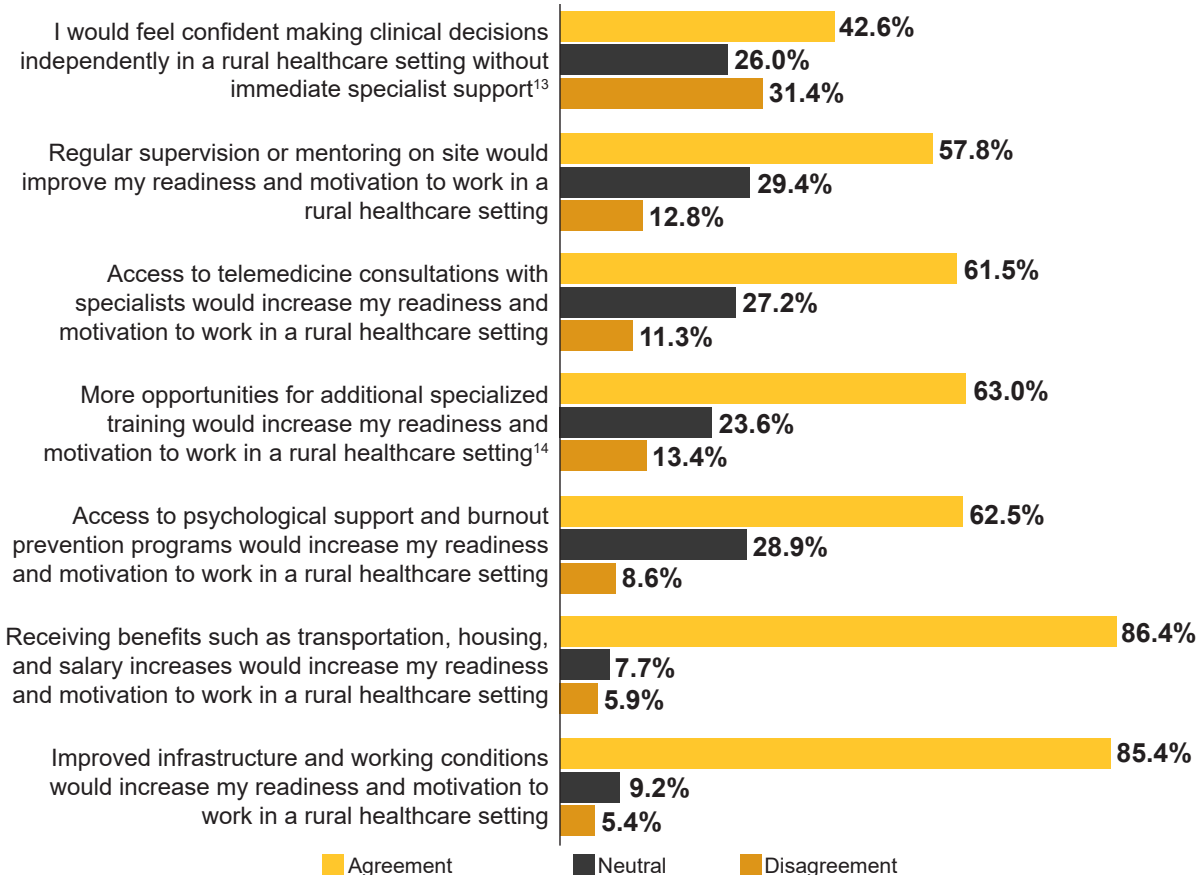
Support and integration

Professional support and integration in rural healthcare

This section explores the perspectives of current and future healthcare workers regarding the systems and resources that support effective practice, retention, and motivation in rural healthcare settings. It assesses both current capacities to work independently in rural environments and the perceived impact of various support mechanisms, such as supervision, telemedicine, training, psychological support, benefits packages, and infrastructure improvements, potentially affecting their professional confidence and long-term engagement.

Respondents were presented with seven positive statements, each framed to assess whether a specific support measure would increase their readiness and motivation to work in a rural healthcare setting. Responses were captured using a Likert scale. While the conceptual structure of the questions remained consistent across respondent groups, the phrasing was adapted to reflect their professional status. For example, students were asked to consider hypothetical future scenarios (e.g., "I would feel confident that, after completing my studies…"), whereas current healthcare workers responded based on their present experiences (e.g., "I would feel confident making clinical decisions…").

Table 5. Survey responses on professional support and integration in rural healthcare



Overall, 42.6% of respondents expressed confidence in making independent clinical decisions in rural healthcare settings, while 31.4% reported lower levels of confidence. Confidence was notably higher among current healthcare workers: urban (55.8%) and rural (53.5%). On the other hand, only 30.8% of students felt confident to independently work in rural healthcare settings, while 41.8% indicated they would not feel confident. Medical doctors reported the highest confidence levels (64.4%), followed by feldshers/paramedics (52.8%) and nurses (47.5%). Confidence increased proportionally with age and years of experience, as expected. Regionally, respondents from Zaporizhzhia (89.0%) and the South (75.0%) reported the highest levels of confidence, while those from Dnipro expressed the lowest (38.5%).

13 For the students, this question was formulated as: "I would feel confident that after completing my studies (internship), I would be able to make clinical decisions independently in a rural healthcare setting without immediate specialist support"

14 For the students, this question was formulated as: "The opportunity for specialized training (course, internship) would increase my readiness and motivation to work in a rural healthcare setting"

A majority of respondents (57.8%) agreed that regular supervision or mentoring on-site would improve their readiness and motivation to work in rural healthcare. This view was consistent across most demographic and professional variables, with a relatively high proportion of neutral responses and minimal disagreement. Younger healthcare workers (aged 23–35) showed particularly strong agreement (69.1%) to this support mechanism. Regionally, the highest levels of agreement were observed in Kharkiv (71.1%) and Sumy (68.4%).

Telemedicine was widely recognized as a valuable tool for enhancing readiness to work in rural settings, with 61.5% of respondents agreeing that access to remote consultations with specialists would increase their motivation. Agreement was highest among rural healthcare workers (66.5%), followed by urban professionals (61.2%) and students (51.7%). Nurses (68.7%) and mid-career professionals (69.0% among those aged 36–45) expressed particularly strong support. Regional differences were minimal, although respondents from Kyiv showed a higher level of neutrality (54.0%).

Opportunities for specialized training were also viewed positively, with 62.9% of respondents agreeing that such programs would enhance their motivation and readiness for rural healthcare work. Urban healthcare workers (68.3%) expressed slightly higher agreement than rural colleagues (65.4%) and students (59.4%). Medical doctors showed the highest level of agreement (68.7%), potentially suggesting a need for targeted training programs tailored to their roles. Younger and less experienced professionals were especially supportive, with up to 79.4% agreement. Regionally, respondents from the West demonstrated the strongest support (86.5%), potentially reflecting existing rural health initiatives in Zakarpattia and a heightened awareness of training needs.

Access to mental health and psychosocial support (MHPSS) was also identified as an important factor in motivating rural healthcare engagement, with 62.5% of respondents agreeing. Agreement was highest among rural healthcare workers (69.2%) and urban ones (66.7%), while students were less convinced (42.9%) and more likely to express neutral views (39.6%), potentially indicating lower awareness of mental health needs in professional practice. Regionally, the strongest support came from Zaporizhzhia (84.1%) and Sumy (77.0%), potentially related to higher level of stressor and lower level of coping.

The highest level of agreement across all statements was related to the provision of financial and material benefits such as transportation, housing, and salary increases, with 86.4% of respondents affirming that these would significantly improve their readiness and motivation to work in rural healthcare. Only 5.9% disagreed to this. Agreement was strongest among rural healthcare workers (91.3%), with 60.0% strongly agreeing. Feldshers showed the highest level of agreement (94.4%) among professions, with no respondents disagreeing. Students expressed slightly lower support (78.0%), but with over half (51.6%) strongly agreeing. Younger professionals (92.6%) were more supportive than older colleagues (82.3%). Regionally, the highest agreement was recorded in the South (97.5%) and Kyiv (93.9%), while Kharkiv showed slightly lower support (77.8%).

Confidence can grow only when proper support systems are established

Finally, 85.4% of respondents agreed that improved infrastructure and working conditions would enhance their motivation to work in rural healthcare. Rural healthcare workers were most supportive (89.7%) to this idea, followed by their urban colleagues (85.3%). Students were less convinced (76.9%), with 17.6% expressing neutrality, which could possibly reflect their limited awareness of current rural infrastructure challenges. Feldshers again showed the highest level of agreement (94.4%) among professions, with no respondents disagreeing. Younger professionals (91.2%) were more supportive than older ones (82.3%).

The findings showcase that confidence to work independently in rural healthcare settings remains limited, especially among students and less experienced professionals, underscoring the need for structured support systems. Respondents strongly endorsed measures such as regular mentoring, telemedicine access, specialized training, and MHPSS as critical for improving readiness and motivation. While financial and material benefits remain the most influential factor, professional integration through digital connectivity and MHPSS are critical additions needed to sustain engagement and reduce isolation.

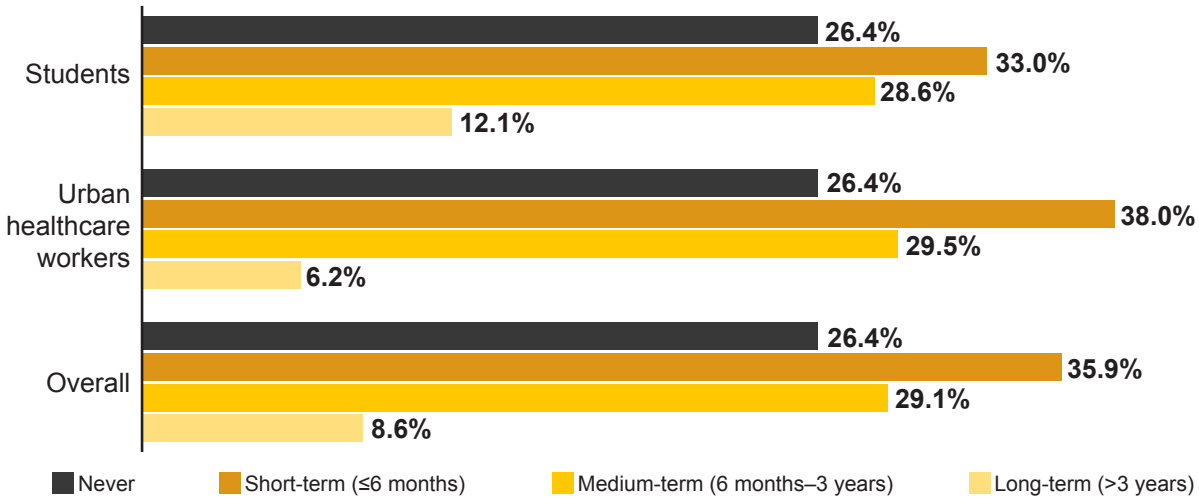
Willingness and perspectives

Willingness to engage and perspectives on improving rural healthcare

This section presents findings from targeted questions and open-ended responses to assess the willingness of non-rural respondents to engage in rural areas and their openness to short-term/long-term deployment. It also explores the motivations behind rural professionals' initial engagement in rural practice and captures respondents' perspectives for actionable recommendations for government and institutional actors seeking to attract and retain healthcare professionals in rural settings.

To better understand the potential for rural workforce engagement, students and urban healthcare workers were asked: **"If you were offered a rural position, what duration would you be willing to accept?"** Responses were relatively evenly distributed, with the largest share (35.9%) indicating willingness to accept a short-term assignment of up to six months. Notably, 26.4% of respondents stated they would never accept a rural posting, suggesting that for a significant portion of the respondents, strong pre-existing attitudes may limit the effectiveness of any incentive-based or other types of engagement programs.

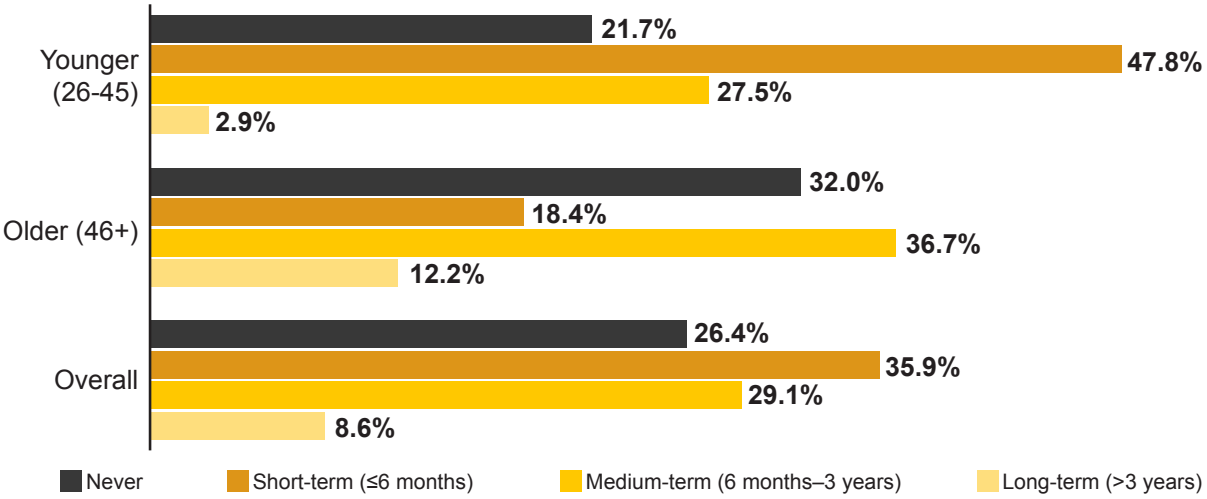
Table 6. Willingness to accept rural positions by duration among students and urban healthcare workers



Students were slightly less inclined to accept short-term assignments (33.0%) compared to urban healthcare workers (38.0%), but more open to long-term engagement (12.1%) also compared to urban healthcare workers (6.2%). This may reflect a degree of openness among students to rural work if appropriate support mechanisms are in place.

Among other professional groups, 50.0% of feldshers/paramedics indicated willingness to accept medium-term assignments (6 months to 3 years), while 48.0% of nurses preferred short-term deployments. Age also played a significant role in shaping preferences: younger respondents (aged 26–45) were more likely to accept short-term assignments (47.8%), whereas older professionals (46+) favored medium-term engagements (36.7%) or expressed unwillingness to ever work in rural areas (32.0%).

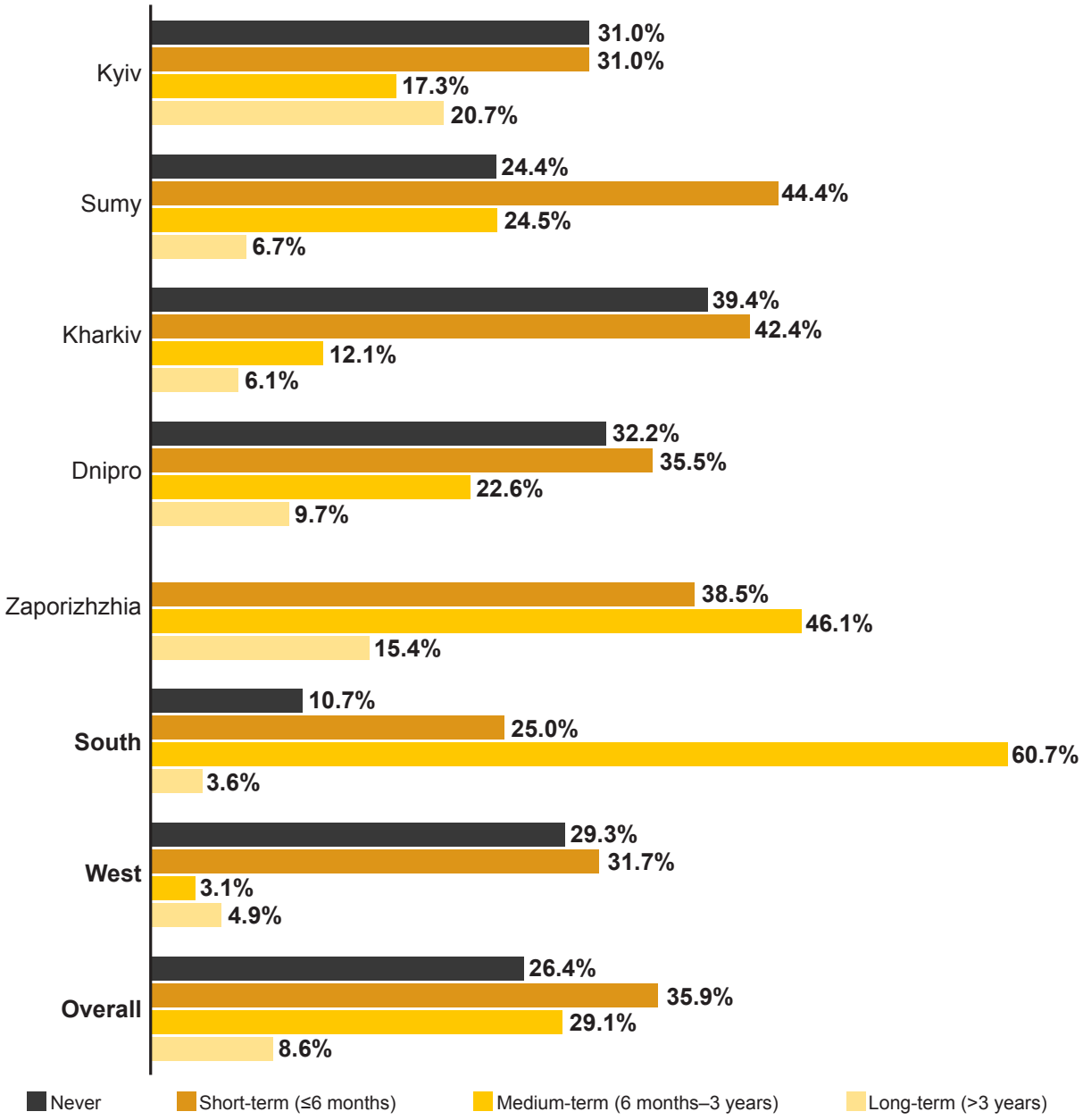
Table 7. Willingness to accept rural positions by duration among younger and older responders



Regional analysis revealed substantial differences in attitudes toward rural postings between different areas. Respondents from Zaporizhzhia and the South demonstrated the highest openness to rural engagement, with no respondents from Zaporizhzhia indicating refusal to ever engage in rural areas. Moreover, 60.7% of the respondents from the South express willingness to accept medium-term assignments. In contrast, Kharkiv (39.4%) and Kyiv (31.0%) had the highest proportion of respondents unwilling to ever accept rural postings. Interestingly, Kyiv also had one of the highest shares of respondents willing to consider long-term engagement (20.7%), suggesting a polarized view within the region.

Sumy and Dnipro showed moderate levels of short-term willingness, while the West had a relatively low share of medium- and long-term engagement.

Table 8. Willingness to accept rural positions by duration across regions



Lastly, we analyzed the views of respondents who stated they would never work in rural healthcare and those open to long-term deployment (over three years).

By cross-referencing this question with the previous section, it was observed that respondents unwilling to work in rural areas expressed stronger disagreement across most statements, with notable deviations from overall averages in several cases. For example, 52.4% responded not being comfortable making independent clinical decisions in rural settings (vs. 31.4% overall), and 69% disagreed that rural work offers long-term career opportunities (vs. 55.9% overall). Only 67.2% agreed that benefits like salary,

transport, and housing would improve motivation (vs. 86.4% overall), and just 63.7% felt infrastructure improvements would help increase motivation (vs. 85.4% overall). This suggests a strong, predetermined negative perception that benefits alone cannot overcome.

Conversely, those willing to work long-term expressed higher agreement on most statements from other sections. Notably, 100% of urban healthcare workers in this group agreed that specialized training would increase motivation, with none disagreeing. Additionally, 94.7% supported infrastructure improvements (vs. 85.4% overall), while 84.2% agreed on benefits like salary and housing (slightly below the 86.4% average). These findings could indicate that long-term willingness is driven more by workplace improvements and training opportunities than by personal benefits.

Rural healthcare workers were asked a question **"Was it your decision to work in a rural setting, or was this due to a governmental program?"**. A majority (64.0%) responded that working in rural healthcare was their personal decision, while 16.7% noted it was due to government-run programs. An additional 10.7% did not recall the reason, and 8.6% selected "other," often citing family ties, place of birth, or lack of alternative employment options. This suggests that personal perceptions of rural work, combined with individual life circumstances, are major factors influencing engagement. These elements should be carefully considered when designing benefit programs aimed at attracting and retaining professionals.

To complement the structured survey, respondents were invited to answer three open-ended questions. These were optional, yet a high response rate was recorded, with 395 participants (97%) providing input for each question, indicating strong engagement and interest in shaping future policy directions.

The first question asked: **"In your own words, what single change would motivate healthcare workers or increase their willingness to work in a rural healthcare setting?"**

The responses overwhelmingly emphasized financial incentives as the primary motivator, mentioned by over 63% of responders. Commonly cited phrases included *"high salary," "salary increase,"* and *"stable payments,"* reflecting the perception that adequate financial compensation is a foundational requirement for rural healthcare engagement, particularly in contexts of high workload and limited resources.

Housing provision emerged as the second most frequently mentioned factor (21%), with respondents highlighting the importance of access to official or subsidized housing. Statements such as *"free official housing or rental compensation"* and *"provide housing for young specialists"* illustrate the role of housing in influencing workplace decisions, especially for early-career professionals.

The third most cited motivators were benefits and social guarantees (11%), including health insurance, pension supplements, and compensation for utilities or transportation. Examples of this include *"more benefits for medical workers who work in the village"* and *"providing discounts on utility payments."*

Approximately 8% of respondents focused on transportation and logistics, particularly the condition of roads and accessibility of healthcare facilities. Suggestions included *"quality road connections"* and *"transport options for patients to higher-level care"*, highlighting that infrastructural improvements are benefiting all, not only healthcare workers.

Other notable themes included the improvement of working conditions and facility infrastructure, with comments such as *"providing modern equipment and heating"* and *"upgrading clinics and hospitals."* Professional development opportunities were mentioned by 4% of respondents, emphasizing the need for internships, advanced training, and rotation between urban and rural institutions. Finally, around 3% of respondents raised concerns about safety and the impact of conflict, with remarks such as *"we need better safety, or at least a shelter."*

The second open-ended question asked: **"In your opinion, what should the Government of Ukraine do to motivate healthcare workers to work in rural healthcare settings?"**

The majority (over 60%) called for the development of a systematic national policy to support rural healthcare professionals. Key suggestions included increasing salaries, offering bonuses, and implementing comprehensive incentive programs. One respondent summarized this sentiment: *"Bonuses, social package, ensuring decent pay for workers."*

Approximately 20% of respondents emphasized the need for housing support, particularly for young specialists, and called for family-inclusive policies. Examples included *"develop a specific benefits program for rural workers," "create a program for integrating the medical worker's family into the local community,"* and *"design an honest program without hidden 'hooks' for future doctors in rural areas."*

Other recurring themes included infrastructure improvements (roads, transport, access to higher-level hospitals), modernization of medical equipment, and the development of professional growth programs (internships, training courses, priority quotas for rural doctors). Several respondents also proposed relocation payments for young specialists and emphasized the importance of safe working conditions, including shelters and security systems.

The third and last open-ended question asked: **"Do you have any additional comments?"**

Although optional, 27 respondents provided additional remarks, offering interesting perspectives on systemic issues and personal experiences. Several comments expressed frustration with staffing policies and the lack of personnel renewal, with one respondent noting that *"older staff are not helping anyone. They just talk nonsense. They go to the market during working hours. They are no longer doctors, they are just there to occupy a place and get salary."*

A health system is only as strong as its rural healthcare

Other responses provided broader reflections on structural challenges, emphasizing that improvements in rural healthcare cannot occur in isolation:

"The quality of medical care should depend on the quality of life in the villages, both from infrastructural and financial support. It is not possible to raise the quality level of any sector independently. There must be progress across all key sectors for rural communities, in order to positively influence the economy and demographic situation in the country."

Recurring concerns included excessive workload, staff shortages, and administrative burdens:

- *"The last reform reduced staff and increased workload. We need a five-day work week to prevent burnout."*
- *"Reduce administrative burden. Medical workers should treat patients, not spend hours on statistics."*

Practical suggestions were also offered, such as utility subsidies, career incentives, and free online training:

- *"The government could provide benefits for utility services."*
- *"Give priority in specializations, internships, residencies for those working in rural communities. Provide them online training for free."*

A notable theme was the perceived devaluation of the profession and lack of respect for healthcare workers:

- *"Nurses are undervalued"*
- *"Medical science is not respected."*
- *"We want recognition equal to European standards."*

Finally, some comments reflected emotional fatigue and hope for peace:

- *"At the moment, the rural medicine is zero. The lack of roads, transport, and communication kills the desire to work in the village"*

The findings reveal a complex landscape of attitudes toward rural healthcare engagement, shaped by personal perceptions, life circumstances, and structural factors. While a significant share of respondents expressed willingness for short-term assignments, long-term commitment remains limited and highly dependent on workplace improvements, professional development opportunities, and supportive policies. Strong negative perceptions among those unwilling to work in rural areas suggest that financial incentives alone are insufficient to overcome entrenched attitudes. Conversely, openness among students and certain professional groups indicates potential for targeted interventions, particularly through early engagement, improved infrastructure, and comprehensive benefit programs. The strategies to attract and retain healthcare professionals in rural settings should combine financial, professional, and social measures.

Validation workshop

Main takeaways from the validation workshop

To review and confirm the accuracy of the findings, the IRC organized a validation workshop on 14 November 2025 in Kyiv. The event brought together representatives from key stakeholders, including government institutions, academia, healthcare providers, and national and international organizations. Specifically, participants included representatives from the Trostyanets City Council, Kharkiv National Medical University, Dnipro Regional Medical Center for Family Health, Tomakivka PHCC, the Student Council of Bogomolets National Medical University, the World Health Organization, the Health Cluster, the national agency "ZDOROVI", the charitable foundation "Fortitude UA", and the International Rescue Committee.

During the workshop, participants had the opportunity to hear the assessment findings firsthand, share their reflections, and engage in discussion around emerging questions. Several critical points were raised and collectively acknowledged. One key limitation identified was the absence of a survey question on respondents' family status. Participants emphasized that having a family, as well as young children, would significantly influence willingness to work in rural areas. Limited access to schools, kindergartens, and other social services in many small communities could serve as a major barrier for healthcare workers considering relocation. There was broad agreement that household and family-related factors are closely intertwined with workforce motivation and should be integrated into future research and policymaking.

Participants also discussed generational differences in career trajectories. Older healthcare professionals noted that, in previous years, they couldn't choose the place of internship, meaning that around half of them would be placed in family medicine and were required to complete a mandatory three-year service in the location where they were posted. Since 2019, this system has been abolished, giving the new generation of doctors significantly more freedom in choosing their specialty. Moreover, graduates after 2022 are no longer obligated to work in the facility where they completed their internship. This means that even if the internship takes place in a rural health facility, the likelihood that a young doctor will remain there is very low. This shift, combined with structural barriers, may further reduce the number of young professionals entering rural practice.

Another significant part of the discussion focused on the future of family medicine. Academic representatives shared that, in the most recent graduation cohort of approximately 300 medical students, only nine chose to pursue internship in family medicine, which is a strikingly low number. This was interpreted as a reflection of how the specialty is perceived: less prestigious compared to fields such as surgery or internal medicine. At the same time, participants agreed that family medicine, particularly in rural settings, remains highly respected due to the level of responsibility, independence, and amount of knowledge required. The perception that the specialty lacks prestige may therefore stem not from the nature of the work but from the high demands, limited support, and challenging conditions faced by family doctors in rural communities.

Overall, the group validated that the findings presented in the assessment are relevant, meaningful, and aligned with the lived experience of professionals working within Ukraine's health system. Participants emphasized the importance of continuing to deepen the understanding of these perceptions to inform more effective and realistic policy development.

The workshop concluded with a collaborative session on shaping the recommendations to be included in the final report. Participants were divided into two groups: one composed of representatives from state authorities and government institutions, and the other of international and local non-profit organizations. Each group drafted recommendations, which were then shared, discussed, refined, and ultimately consolidated into a unified set of proposals for inclusion in the report.

Recommendations

Recommendations for strengthening rural health workforce engagement in Ukraine

Building a sustainable rural health workforce in Ukraine requires a comprehensive approach that goes beyond a single actor action. It must address education, professional support, financial incentives, service delivery models, and the social environment in rural communities. The following recommendations, informed by relevant stakeholders, outline practical steps to make rural practice more attractive and viable.

Build strong training and career pathways to encourage rural practice

Early exposure to rural healthcare during medical education could increase future engagement. Structured rotations in rural facilities should become a required part of undergraduate and postgraduate training, allowing students and young professionals to gain hands-on experience and understand the realities and opportunities of rural practice. Specialized courses should be introduced to prepare healthcare workers for the unique challenges of rural healthcare, including emergency care in resource-limited settings, telemedicine, and autonomous decision-making. Given the decline of interest in family medicine, targeted incentives and career development guarantees should be integrated into training reforms. Mentorship programs pairing new rural practitioners with experienced clinicians can help reduce professional isolation and build confidence.

Strengthen professional support through digital connectivity between rural and urban healthcare workers

Rural healthcare workers often face isolation and limited access to specialist advice. Establishing digital health hubs in rural communities can support teleconsultations, remote diagnostics, and continuous education. National telemedicine platforms, supported by academic institutions and senior clinicians, should enable real-time clinical guidance and medical-case discussions. These platforms should also include structured mentoring and supervision programs to address the confidence gap in independent clinical decisions. Incentives and/or benefits for experts to provide regular remote supervision could create a more connected and supportive professional environment.

Provide competitive incentives and adequate resources to attract and retain staff

Competitive compensation and benefits packages are essential to make rural practice appealing, since salary increases, housing provision, and transport assistance are decisive factors for rural engagement. Salaries for rural healthcare workers should reflect the higher responsibility and resource constraints they face, potentially exceeding urban rates by at least 50%. Access to essential medical equipment, such as portable ultrasound, ECG machines, and basic laboratory diagnostics, should be guaranteed to support autonomous decision-making. Reliable transportation for outreach and emergency response, along with adequate housing and social support for healthcare workers and their families, should be prioritized by local authorities.

Expand flexible and innovative service delivery models to support rural communities

Geographic and demographic challenges in rural areas require adaptable solutions. Mobile multidisciplinary teams operating on predictable schedules can complement rural healthcare workers and provide specialized care. Mobile diagnostic units should support routine screening, early detection, and chronic disease management, reducing the need for patients to travel long distances. Community-based programs, such “as health ambassadors and health secretaries”, can strengthen health education and patient navigation, potentially decreasing the workload for rural healthcare workers and improving the quality of their work and life. These models should be prioritized in conflict-affected regions where safety concerns and infrastructure damage limit access to static facilities.

Strengthen social infrastructure to support rural healthcare workers and their families' wellbeing

Relocation decisions depend not only on professional conditions but also on quality of life. Improving child-related infrastructure, including kindergartens and safe schools, could make rural communities more attractive for healthcare workers with families. Family status could be a critical determinant of willingness to relocate, therefore, policies should integrate family-inclusive benefits such as childcare support, including education. Local governments should play an active role in shaping benefit packages and ensuring that community-level support aligns with the expectations of newly engaged staff. In addition to physical and social infrastructure, accessible, confidential, and free mental health and psychosocial support services should be available for rural healthcare workers and their families to address stress, isolation, and trauma, particularly in conflict-affected areas.

Rebrand rural healthcare to promote prestige and community impact

A comprehensive national and institutional campaign should actively promote the prestige of family medicine and rural healthcare as respected, intellectually demanding, and socially impactful fields. Campaigns must highlight rural healthcare workers' critical role in health system resilience, community wellbeing, and responding to emergencies, making these career paths more attractive and aspirational. These efforts should begin within medical universities to engage students early and reshape perceptions among future professionals and the wider public.

Conclusion

Final conclusions and reflections

This assessment showcases a rural health workforce that remains committed to serving Ukraine's rural communities despite persistent structural, financial, and security-related barriers. While respondents value the close patient relationships, trust, and community connectedness that rural practice offers, these natural motivators are outweighed by chronic challenges, such as low salaries, inadequate housing, poor infrastructure, and limited career development pathways. The war has further intensified safety risks, burnout, and professional isolation, particularly in frontline regions. Students and younger professionals, who represent the future of the health system, express significant uncertainty, noting limited exposure to rural practice, low prestige of family medicine, and lack of institutional support as major deterrents. Without coordinated policy and investment, these attitudes risk deepening rural workforce shortages in the years ahead.

Strengthening Ukraine's rural healthcare system requires bold reforms and investments to make safe, sustainable, and rewarding workplace for committed healthcare workers

Strengthening Ukraine's rural health workforce will require a comprehensive, multi-layered approach that improves both working and living conditions. Competitive compensation, modernized facilities, transportation support, and safer working environments must be paired with structured professional pathways, including rural rotations, mentorship, and expanded telemedicine. Integrating housing support, family-inclusive policies, and psychosocial services will be essential to making rural postings viable for healthcare workers at different life stages. Finally, national efforts to elevate the status of family medicine and redefine rural healthcare as a skilled, impactful, and respected career path can help shift long-standing perceptions. By aligning financial, educational, and systemic reforms, Ukraine can build a resilient rural health workforce capable of supporting equitable access to health care during and beyond the current crisis.

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Annex 1

Focus group discussion (FGD) guide

Title: What Factors influence Health Professionals' Decisions About Working in Rural Ukraine

Participants: This FGD explores the factors influencing decisions to work in rural areas, focusing on final-year medical students and urban-based health professionals. These groups were selected either on the verge of choosing their career path or have already made decisions not to practice in rural settings, offering valuable insights into barriers and motivations.

Estimated Duration: 60–90 minutes

Number of Participants per FGD: 6–8

Introduction

Hello, and thank you for joining this discussion. My name is _____ and I work as a [job title] at the International Rescue Committee. We are conducting an assessment to better understand what factors influence health workers' decisions to work in rural Ukraine, especially given the ongoing conflict.

This discussion should last about an hour. We will not reveal your identity or name. Your participation is completely voluntary, and you may choose not to answer some or all of the questions. You are also free to leave this discussion at any time.

Do you feel comfortable participating in this discussion and answering my questions? With your permission, we would like to record this discussion so that we can accurately reflect on your ideas. Is everyone in agreement? Do you have any questions before we begin?

Informed consent was obtained from the participants: □ Yes □ No

Consent to take notes was obtained: □ Yes □ No

Informed consent for audio/video recording obtained:* □ Yes □ No

* Use audio recording only if it is necessary and it has been determined that the audio recording will not pose a risk to participants or staff.

Before you start, please fill in the following information:

Type of activity:	**Location:**	**Date:**
Identity of the interlocutor/group:	The need for interpretation: □ Yes □ No	
	# of participants:	

(After you have noted the consent and collected all the demographic information, inform the participants that you will begin asking questions. Remember to record both verbal and non-verbal responses (that is, pay attention to statements with more detailed information, etc.) as well as non-verbal consent (such as nodding, and so on))

Section 1: Motivations and Challenges of Working in Rural Healthcare

(Explore what factors or incentives might make rural healthcare work more attractive. Focus on personal, professional, and systemic motivators.)

1. From your perspective, what do you see as some advantages or challenges of working in rural areas?
2. How do you think rural work is perceived by your peers?
3. Has your attitude to the possibility of working in rural areas changed since you started your work/ medical studies? If so, how and why?

Section 2: Motivations and Incentives

(Investigate how conflict influences participants' sense of safety and their openness to rural work in the current and post-conflict environment)

4. What specific changes would make rural work more appealing to you (e.g., salary, housing, professional support)?
5. Are there certain conditions or factors that would make rural work a viable or appealing option for you? If so, for what period might you consider it
6. Do you think rural work can help or hurt your career development? Why?

Section 3: Conflict and Safety

(Gather views on operational challenges in rural settings. Identify perceived gaps in support, equipment, digital tools, and professional collaboration)

7. How has the ongoing conflict influenced your view of working in rural areas?
8. What security or safety concerns do you associate with working in rural areas, especially in conflict-affected zones?
9. Can you reflect on how your thoughts might differ during conflict vs before/after conflict?

Section 4: Working Conditions and Practical Concerns

(Understand how personal life circumstances, gender-specific concerns, and social integration affect decisions about rural postings)

10. If you had to work independently in a rural setting, with limited access to other specialists, how confident would you feel in that situation?
    10.1. What kinds of support or tools do you think would help you manage such a setup?
    10.2. What kind of equipment, facilities, or support would make your work easier in rural settings?
11. How do you think health professionals are perceived by patients in rural communities? Do you believe you would feel respected and trusted if you worked in such a setting? Why?

Section 5: Personal and Social Life

(Assess perceptions of systemic and policy-level support. Encourage practical recommendations that could make rural postings more feasible or appealing)

12. How do personal factors (e.g., family, relationships, children) affect the decision to work in a rural area?
13. Are there specific challenges for people in rural health work? Can you give an example?
14. Do you think you would feel socially isolated or integrated in a rural community? Why?

Section 6: Policy, System, and Recommendations

(Provide space for open reflection or insights that may not have been covered earlier. Invite willingness for follow-up and thank participants for their time)

15. Do you feel existing government programs (like internships, financial bonuses, or housing for rural workers) are realistic and effective?
16. If you could design a program to attract more professionals to rural areas, what would it include?
17. Are there certain rural areas you would be more willing to work in than others? Why?

Section 7: Wrap-Up

18. Do you have any other thoughts that were not covered during our conversation? If so, you can mention them now

Closing

Thank you for sharing your thoughts today. Your feedback is incredibly valuable and will help to inform us how we can better support healthcare professionals and improve rural healthcare delivery. If you have any concerns or want to share something privately, please feel free to speak to us after the session.

Annex 2

Questionnaire

Dear colleagues,

We are conducting a survey to better understand healthcare workers' experiences and perceptions of working in rural healthcare settings. The results will help us build a clearer picture of the current situation and identify common views and challenges.

Participation in this survey is completely voluntary. All responses will be kept strictly confidential, and only a limited number of team members within our organization will have access to the data. No personally identifiable information will be disclosed in any reports or publications.

Would you be willing to participate in this survey?

□ Yes □ No

If No, please tell us why: _____

Background Information

- What is your professional background?

Medical Doctor / Nurse / Feldschers (Paramedic) / Student

- Where do you currently work?

Rural area / Urban area

- If students:

Medical Students / Nursing students / Feldschers (Paramedic) student

- Age:

18-25 / 26-35 / 36-45 / 46-55 / 56+

- Gender:

Male / Female / Other

- Region:

Kharkiv, Sumy, Dnipro, Zaporizhzhia, Mykolaiv, Kherson, Odesa, Kyiv reagion/city, Lviv, Zakarpattia

- Years of professional experience:

0 (for students), <5 / 5-10 / 11-20 / >20

Perceptions of Rural Healthcare Work

- Working in rural healthcare setting is seen as a respected and important role.

Strongly agree/Agree/Neutral/Disagree/Strongly disagree

- Working in rural healthcare setting offers good long-term career opportunities.

Strongly agree/Agree/Neutral/Disagree/Strongly disagree

- Working in rural healthcare setting will not affect my social life.

Strongly agree/Agree/Neutral/Disagree/Strongly disagree

- Working in rural healthcare setting is safer for me and my family.

Strongly agree/Agree/Neutral/Disagree/Strongly disagree

- Rural healthcare settings receive stronger support from humanitarian organizations compared to urban settings.

Strongly agree/Agree/Neutral/Disagree/Strongly disagree

Barriers and Motivations (multiple selection)

From the list below, select the three professional or social benefits you consider most important when working in a rural healthcare setting.

- ☐ Closer connection with patients and community
- ☐ Greater respect and trust from patients
- ☐ Opportunity to have a direct impact on community health
- ☐ Lower patient aggression or conflict compared to urban areas
- ☐ Broader clinical exposure and more diverse case mix
- ☐ Opportunities for leadership or independent decision-making
- ☐ Lower cost of living
- ☐ Support from humanitarian organizations or NGOs
- ☐ Quieter, less stressful environment outside major cities
- ☐ Other (please specify): _____

From the list below, select the three challenges you consider most significant for working in rural healthcare.

- ☐ Low salary
- ☐ Lack of housing
- ☐ Poor roads/transport
- ☐ Poor internet/telecommunications
- ☐ Outdated equipment/facilities
- ☐ Isolation/loneliness (limited social opportunities)
- ☐ Limited opportunities for career development
- ☐ Administrative burden (e.g., electronic system issues)
- ☐ Security risks (conflict-related)
- ☐ Lack of childcare/schools
- ☐ Other (please specify): _____

From the list below, select the three benefits or incentives you believe would increase motivation to work in a rural healthcare setting.

- ☐ Higher salary
- ☐ Housing support
- ☐ Transport/vehicle provided
- ☐ Reliable mobile/internet
- ☐ Mentorship/supervision
- ☐ Continued professional training
- ☐ Career advancement guarantees
- ☐ Reliable safety/security conditions
- ☐ Possibility of temporary assignment to rural healthcare setting
- ☐ Other (please specify): _____

Conflict & Safety

- ▶ The ongoing conflict has decreased/lowered my interest in working in rural healthcare.

Strongly agree/Agree/Neutral/Disagree/Strongly disagree

From the list below, select the three security or safety risks you consider most significant when working in a rural healthcare setting.

- ☐ Shelling/proximity to front line
- ☐ Mined areas
- ☐ Violent or antisocial individuals
- ☐ Lack of shelters
- ☐ Psychological trauma among patients/community
- ☐ Lack of police/firefighters
- ☐ Unstable connection to call for help
- ☐ High presence of military
- ☐ Fear due to isolation (the absence of immediate support or protection)
- ☐ Other (please specify): _____

Professional Support & Integration

Please rate how much you agree with the following statements, considering your work experience and the possibility of working (or continuing to work) in rural areas:

- I would feel confident making clinical decisions independently in a rural healthcare setting without immediate specialist support.

Strongly agree / Agree / Neutral / Disagree / Strongly disagree

- Regular supervision or mentoring on site would improve my readiness and motivation to work in a rural healthcare setting.

Strongly agree / Agree / Neutral / Disagree / Strongly disagree

- Access to telemedicine consultations with specialists would increase my readiness and motivation to work in a rural healthcare setting.

Strongly agree / Agree / Neutral / Disagree / Strongly disagree

- More opportunities for additional specialized training would increase my readiness and motivation to work in a rural healthcare setting.

Strongly agree / Agree / Neutral / Disagree / Strongly disagree

- Access to psychological support and burnout prevention programs would increase my readiness and motivation to work in a rural healthcare setting.

Strongly agree / Agree / Neutral / Disagree / Strongly disagree

- Receiving benefits such as transportation, housing, and salary increases would increase my readiness and motivation to work in a rural healthcare setting.

Strongly agree / Agree / Neutral / Disagree / Strongly disagree

- Improved infrastructure and working conditions would increase my readiness and motivation to work in a rural healthcare setting.

Strongly agree / Agree / Neutral / Disagree / Strongly disagree

Only for medical students and urban healthcare workers

- If you were offered a rural position, what duration would you be willing to accept? (select one)

- ☐ Short-term (≤6 months)
- ☐ Medium-term (6 months–3 years)
- ☐ Long-term (>3 years)
- ☐ Never

Only for rural healthcare workers

- Was it your decision to work in a rural setting, or was this due to a governmental program?

Yes / No / I do not remember

Final remarks

In your own words, what single change would motive healthcare workers or increase their willingness to work in a rural healthcare setting?

In your opinion, what should the Government of Ukraine do to motivate healthcare workers to work in rural healthcare setting?

Any additional comments: _____

The International Rescue Committee (IRC) has been working in Ukraine since February 2022. Together with Ukrainian partners, we strive to best serve people affected by the war. The IRC works in the Odesa, Mykolaiv, Kharkiv, Sumy, Dnipro, Kherson, Zaporizhzhia, and Donetsk regions, supporting communities in major cities and hard-to-reach rural areas closer to the frontlines.

Together with our local partners, we distribute essential basic items, provide cash assistance to families in need, and ensure that children, vulnerable groups and people with special needs are protected. Furthermore, we have been at the forefront of health system recovery and emergency, through a combination of lifesaving mobile medical units, rural health facility rehabilitation, targeted capacity- building initiatives, and community-based physical and mental health, reinforcing overstretched health services in some of Ukraine's most conflict-affected regions.

Since the onset of the full-scale war, through its direct operations and supported partners, we have delivered over 150,000 outpatient consultations and 20,000 mental health and psychosocial support (MHPSS) services. More than 100 health facilities have received critical medical supplies, and over 10 local health organizations have been supported through strategic partnerships and funding.

We are scaling context-sensitive, needs-based health interventions that are both immediate in impact and sustainable in design. Our programs support access to quality healthcare and psychosocial services for conflict-affected communities, particularly elderly, women, persons with disability and mental health conditions in rural and hard-to-reach communities, as well as healthcare workers, social workers and teachers, while contributing to longer-term health system strengthening.

The IRC is continuing its efforts in Europe and the US to match the growing scale of needs of Ukrainians. We have emergency programs in Poland and are also supporting Ukrainian refugees in Poland, Italy, Greece, Germany, and the UK.

Check out our report on State of Health Workforce Mental Health in Ukraine:

Check out our landing page to learn more about IRC's work in Ukraine: