Assessment of barriers to access the health services faced by refugees from key affected groups from Ukraine

Chișinău, 2025

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ABBREVIATIONS

ARV	Antiretroviral treatment
STI	Sexually transmitted infections
IEC	Information, education and communication
HIV	Human Immunodeficiency Virus
TB	Tuberculosis
SW	Sex worker
LGBTQI+	Acronym for lesbian, gay, bisexual and transgender
NGO	Non-governmental organization
PWUD	People who use drugs (any form)
PrEP	Pre-exposure prophylaxis
PEP	Post-exposure prophylaxis
PLHIV	Person living with HIV
UNAIDS	United Nations Agency on HIV/AIDS
UNHCR	United Nations Refugee Agency

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ACKNOWLEDGEMENTS

Study on the Assessment of barriers to access the health services faced by people from key affected groups of refugees from Ukraine in the Republic of Moldova carried out by independent consultants in cooperation with civil society organizations working the health sector and with the technical and financial support of UNAIDS and UNHCR.

The research report reflects the opinion of the authors and does not necessarily represent the views of the donors or any other affiliated organizations.

We would like to express our gratitude to all the institutions, organizations and individuals who contributed to this research, especially representatives of key vulnerable populations, people affected by HIV and tuberculosis. Data collection was carried out with the support of the non-governmental organizations Positive Initiative, Union for Health Equity, Genderdoc-M, Pas cu Pas South Region and AFI Public Association.

Sincere thanks to all the respondents who participated in the study, and we thank them all for their time, involvement, openness, trust, confidence and valuable information provided during the focus group discussions and in-depth interviews.

We are grateful to the experts who reviewed the report and contributed to its finalization.

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EXECUTIVE SUMMARY

Amid the humanitarian crisis generated by the conflict in Ukraine, research was needed to understand and address the specific challenges faced by Ukrainian refugees in the Republic of Moldova (hereafter Moldova) in accessing health services.

This report provides a detailed analysis of the situation of Ukrainian refugees in Moldova, with a particular focus on their access to health services and the barriers they face. The research focuses on vulnerable groups, including people who use drugs (PWID), people living with HIV (PLHIV), the LGBTQI+ community, and people with tuberculosis (TB). This is comprehensive research, including opinions and perceptions provided in focus groups and interviews with representatives of governmental and non-governmental organizations.

Refugees from Ukraine face barriers in accessing health services in Moldova. Among the most common obstacles are the long distance to health facilities, which particularly affects refugees in rural areas, and long waiting times for consultations, both with specialists and family doctors. The need for additional documents such as temporary protection and Ukrainian passports also complicates access to services. High costs for essential treatment and specialized services, such as paid medical consultations and investigations in private clinics, are another significant barrier. Stigmatization and discrimination, particularly for vulnerable groups such as PWUD and PLHIV add an additional layer of difficulty. Language barriers further complicate access to services, especially for those who do not know Romanian language. These barriers not only make access to health care more difficult, but also affect the quality of care received by refugees.

Risk factors in accessing health services include regional and rural disparity, poor financial situation, lack of temporary protection, non-registration to a family doctor, belonging to vulnerable groups, access to specific services (ARV therapies and drug addiction treatment), exposure to violence, and experience of stigma and discrimination. Refugees from the North and South regions of Moldova faced fewer barriers compared to those from the Center region. Also, residents of district centers (rayons) and villages were more likely to experience difficulties compared to those in municipalities.

The study highlights that PWUD and PLHIV groups face the greatest difficulties in accessing health services and are often stigmatized and marginalized. The LGBTQI+ community faces fewer barriers, mainly due to access to services through NGOs or private clinics.

Recommendations from this research include developing innovative solutions to bring health services closer to refugee communities, simplifying administrative and bureaucratic procedures, reducing stigma and discrimination, and ensuring adequate financial and psychosocial support. These measures are essential to address the complex needs of refugees and to give them a real chance for a healthy and safe life in Moldova.

BACKGROUND INFORMATION

The war in Ukraine has triggered the biggest humanitarian crisis in the European region since the end of Second World War. By the end of 2024, more than eight million refugees had fled the war in Ukraine, and around one million of these had arrived in Moldova. Currently, over 130 thousand Ukrainian refugees are in Moldova [1].

In Moldova, foreigners can benefit from several forms of protection provided for by the Law on Asylum in Moldova, one of which is temporary protection [2]. Temporary protection is a legal status granted by EU member states, including Moldova, to persons who must flee the war in Ukraine to neighboring countries. The basic advantage of temporary protection over applying for asylum is its rapidity, i.e. the immediate granting of a legal status to refugees coming from a conflict zone, which recognizes several rights including the right to receive emergency medical care, primary health care and free medical examination on public health grounds, in medical institutions, in accordance with the list of medical services established by the Ministry of Health, as well as access to social assistance measures, financed by international organizations, based on procedures and conditions approved jointly with the Ministry of Labor and Social Protection and the competent authority for foreigners [3].

International research highlights that access to health and social care is becoming a challenge for many displaced people from other countries. Among the barriers or difficulties in accessing health care were listed (1) language barriers, (2) excessive number of documents requested, (3) information gaps on how to access services and (4) types of services available, (5) cultural competence, (6) fear of persecution, (7) systemic problems associated with 'lower status' (the process of transition from an asylum seeker to refugee status). Acute respiratory infections, chronic diseases such as diabetes, cancer, trauma, and infectious diseases (tuberculosis (TB), HIV infection, viral hepatitis) were mentioned as high risk among refugees. Ukraine is listed among the countries with high burden of chronic infectious diseases, such as HIV and TB, especially drug-resistant TB, registering about 30 thousand new cases of TB annually [4].

Since the early days of the war, Moldova has faced a large influx of refugees, including people from at-risk populations, but also at risk of HIV and TB infection [5]. Given the public health priorities of uninterrupted access to prevention, screening, diagnosis, treatment and care of infectious diseases, including HIV and TB, the decision was taken to provide prevention, medical, psychosocial and support services to refugees and to include those at risk in existing prevention, treatment and support programs for both HIV and TB. Over 8 thousand refugees have benefited from NGOs support since their arrival in Moldova [5].

In this context, UNAIDS proposed to conduct a community-based operational study to provide a comprehensive, evidence-based understanding of priority needs and barriers faced by refugees, particularly those at risk, in accessing health services since their arrival in Moldova. The results of the study provide a clearer picture of how displaced people from Ukraine face difficulties in accessing health services.

The results can guide public policies and intervention strategies, helping to develop more effective and accessible programs and services for refugees, and will also underline the importance of cooperation among various medical and social entities to ensure better health protection for refugees and more effective integration into the Moldovan health system. In addition, the results of the study can add valuable knowledge to the literature on access to health services for refugees from at-risk groups, providing useful data and analysis.

METHODOLOGY

Study title

Assessing barriers faced by key refugee populations from Ukraine in accessing health services in the Republic of Moldova

Aim of the study

Analysis of the barriers faced by Ukrainian refugees from at-risk populations in accessing health services in the Republic of Moldova

Objectives of the study

Among refugees from at risk groups PWUD, PLHIV, SW, LGBT, TB, other categories to:

1. describe socio-demographic characteristics
2. describe the transfer procedures
3. describes the health services accessed
4. analyze barriers in accessing health services
5. assess risk factors that might influence accessibility to health services

Quantitative study

Type of study: descriptive, prospective, cross-sectional

Sample size. The study recruited all individuals who met the eligibility criteria. The sample size was 300 respondents interviewed. The target population included refugees from Ukraine temporarily staying in Moldova.

Inclusion criteria: refugee person from Ukraine who:

- are temporarily in Moldova (and have accessed health services on the right bank of the Nistru River)
- accessed at least one of the related health and/or social services on TB, HIV, viral hepatitis
- is mentally competent to give a structured interview based on the questionnaire
- over 18 years of age
- signed informed consent for participation in the study

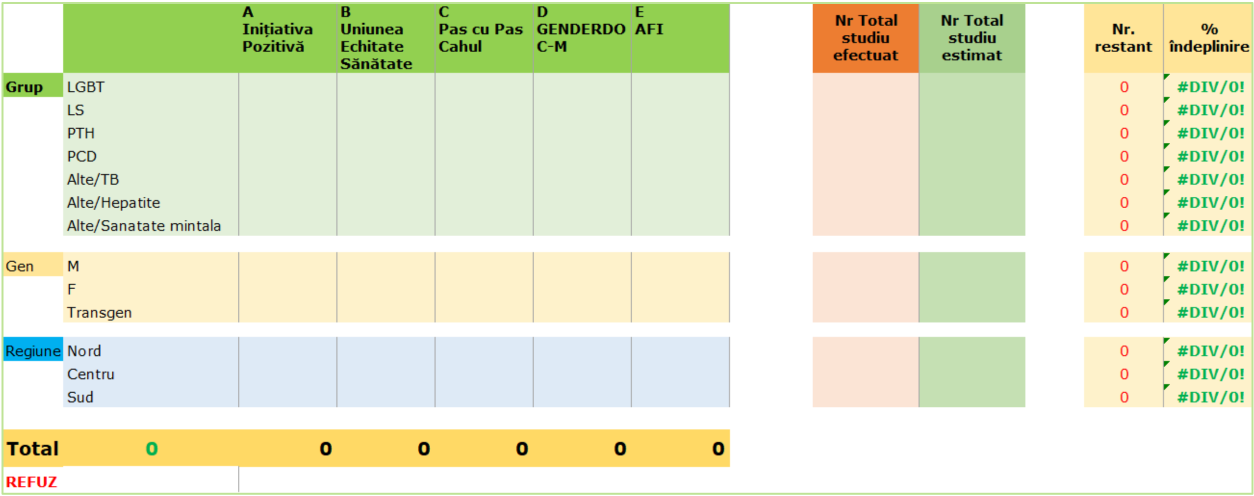
Exclusion criteria: included the vice-versa of the inclusion criteria

Recruitment of respondents

The recruitment of respondents was based on the lists formed at the level of NGOs involved in providing support to Ukrainian refugees from at-risk populations. The recruitment considered the inclusion criteria and the sampling step which included: territorial representation of 25% each for the North and South regions and 50% for the Center region, including the gender proportion. The person who refused participation in the study was replaced by the next person on the list. At enrollment, the respondent was assigned an anonymous unique identifier, which did not allow direct or indirect identification of the person.

Recruitment was monitored online, based on a tool developed in Google docs format, where information on the enrollment of respondents in the study was entered in real time. The monitoring tool allowed the tracking of proportions by group, gender, geographical region, but also percentage enrollment (Figure 1).

Figure 1. Google docs tool used to monitor respondent enrollment in the study, in Ro



		A Inițiativa Pozitivă	B Uniunea Echitate Sănătate	C Pas cu Pas Cahul	D GENDERDO C-M	E AFI	Nr Total studiu efectuat	Nr Total studiu estimat	Nr. restant	% îndeplinire
Grup	LGBT								0	#DIV/0!
	LS								0	#DIV/0!
	PTH								0	#DIV/0!
	PCD								0	#DIV/0!
	Alte/TB								0	#DIV/0!
	Alte/Hepatite								0	#DIV/0!
	Alte/Sanatate mintala								0	#DIV/0!
Gen	M								0	#DIV/0!
	F								0	#DIV/0!
	Transgen								0	#DIV/0!
Regiune	Nord								0	#DIV/0!
	Centru								0	#DIV/0!
	Sud								0	#DIV/0!
Total	0	0	0	0	0	0				
REFUZ										

Questioning respondents

Questionnaire-based interview, developed on the literature review information [5–14] , was used for the interview. The data collection instrument was available in Russian. After pre-testing, the questionnaire was adjusted accordingly. Questioning of respondents was carried out consecutively as follows: contact with the respondent, informing and filling in the questionnaire. Changing the sequence of events was not allowed. The questioning was confidential, in the absence of the third persons.

Qualitative study

Focus groups and individualized interviews. Two focus groups were conducted. The participants in the focus groups were representatives of NGOs that have been involved in or have carried out activities tangential to the provision of support to refugees from Ukraine, as well to representatives of communities of at-risk populations. Individualized semi-structured interviews were conducted with individuals from governmental and non-governmental institutions. Both interviews and focus groups were conducted in accordance with the guidelines developed based on the literature review [5–14].

Data analysis

Quantitative study. The data obtained were subjected to the following methods of analysis: summarization; comparison; forecasting; and veracity determination. The data extracted from the questionnaire were imported into the IBM SPSS Statistics 20 statistical program for analysis. Data analysis was done by generating simple frequencies and cross tabulations. Additional statistical tests were also conducted to identify correlations between variables. Continuous variables were summed as mean (standard deviation). *The Odd Ratio* was used to assess risk factors. The value $p<0.05$ was considered the threshold of statistical significance. Fisher's test was applied in the case of calculations of numbers less than 30. **Qualitative study**. The information collected based on individualized interviews and focus-groups was transcribed in text form: deciphering, transcription and triangulation of the obtained information.

QUANTITATIVE STUDY: RESULTS

GENERAL CHARACTERISTICS

Socio-demographic

The demographic profile of the study sample shows that many respondents were male (56%). The mean age was 39.3± 12 years, while the median age was 37 years. The predominant age group was between 25 and 44 years (65%). The group of young people aged 18 to 24 years accounted for 8.7%, and those aged 65 years and over - 4.3%. The youngest respondent was 18 years old and the oldest - 75 years old. In 39% of the cases the survey participants indicated that they were married or cohabiting, while in 18% of the cases they indicated that they were divorced or widowed, and in 43% of the cases - single (Table 1).

The employment status of the participants varied significantly between the period in Ukraine and the period of stay in Moldova: employed (61% vs. 15%, $p<0.001$), self-employed (16% vs. 23%, $p=0.246$), not employed (10% vs. 58%, $p<0.001$) and other categories (21% vs. 13%, $p=0.158$), respectively (Table 1).

In about half of the cases (51%), the respondents had complete secondary education, and in about a fifth of the cases they had higher education (23%) or incomplete secondary education (19%). A small number of respondents had no education or only primary education (2.7% and 3.3%, respectively,Table 1).

During their stay in Moldova, 26% of respondents mentioned that they had dependents. Of these, they mentioned that they were children under 18 years of age (87%, 69 out of 79), persons over 65 years of age (16%, 13 out of 79), and persons with disabilities (9%, 7 out of 79) (Table 1).

In terms of language knowledge, almost all respondents indicated that they spoke Russian (99%) and Ukrainian (88%). A quarter of the respondents specified that they spoke English (25%) and Romanian (10%) language. Also mentioned knowledge of other languages 7% of the respondents (Table 1).

Table 1.Socio-demographic characteristics of respondents

Features	N (%)
Gender	
Men	168 (56.0)
Women	123 (41.0)
Trans gen	9 (3.0)
Age group	
18-24 years	26 (8.7)
25-44 years	195 (65.0)
45-64 years	66 (22.0)
≥ 65 years old	13 (4.3)
Educational level	
No education	8 (2.7)
Primary	10 (3.3)
Incomplete secondary	56 (18.7)
Full secondary	153 (51.0)
Higher education	69 (23.0)
Employment status (in Ukraine)	
Employee	184 (61.3)
Self-employed	48 (16.0)
Unemployed	30 (10.0)

Features	N (%)
Other	62 (20.7)
Employment status (Moldova)	
Employee	44 (14.7)
Self-employed	70 (23.3)
Unemployed	174 (58.0)
Other	40 (13.3)
Marital status	
Married or cohabiting	117 (39.0)
Divorced or widowed	53 (17.7)
Single	130 (43.3)
Dependents (Moldova)	
Yes	79 (26.3)
No	221 (73.7)
Knowledge of languages	
Ukrainian	265 (88.3)
Russian	296 (98.7)
English	75 (25.0)
Romanian	31 (10.3)
Other languages	21 (7.0)

No answer: educational level (4)
Employment status (Other: pupil, student, retired, disabled, maternity/paternity leave)

During their stay in Moldova, respondents reported a significant decrease in their average monthly income compared to the period in Ukraine (Figure 2).

Figure 2. Average monthly income of respondents in Ukraine and Moldova

In Ukraine, 9.3% of respondents had no income at all, while in Moldova this increased to 30%. The percentage of those with an income of up to €200 also increased from 29% in Ukraine to 40% in Moldova. A third of the respondents (30.3%) indicated incomes between €201 and €500 in Ukraine, while in

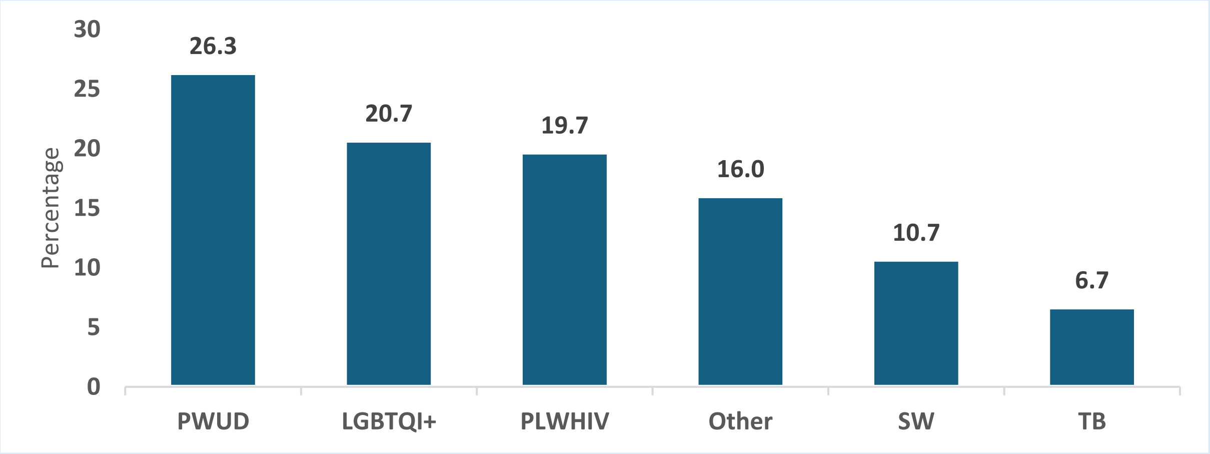
Moldova this percentage decreased to 21.3%. Similarly, the percentage of those with income between 501 and 1000€ decreased from 23.7% in Ukraine to 6.7% in Moldova. Higher incomes of more than 1000€ were reported by 7.7% of respondents in Ukraine and only 2% in Moldova (Figure 2).

Groups and communities

The largest group was people who use drugs (PWID), accounting for 26.3% (79) of all respondents. The next largest group was people living with HIV (PLHIV), with 19.7% (59), followed by the LGBTQI+ community, which made up 20.7% (62) of respondents. Female sex workers (FSWs) accounted for 10.7% (32) of the total, indicating a notable, albeit smaller, presence among the populations studied. The group with the lowest representation was people with tuberculosis (TB), with only 6.7% (20), but this did not diminish their importance in the context of vulnerability (Figure 3).

Note that the PLHIV group included 12 from the PWUD group, one person from the SW group and 11 people from the LGBTQI+ community. Also, in the PLHIV group, two people also identified as LGBTQI+. The category Other included 16% of respondents, these were people who did not identify with a particular group or community, but who had benefited from health services, including harm reduction services (Figure 3).

Figure 3. Groups and communities



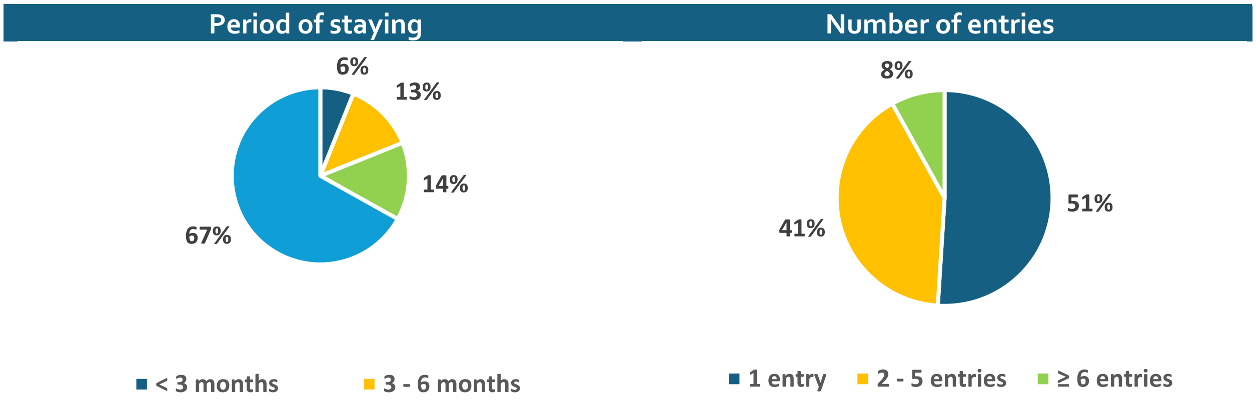
TRANSFER PROCEDURES

Procedures of entering in Moldova

Most of the respondents used biometric passports when entering Moldova, representing 77.7% (233) of the total. The next most frequently used document was the Ukrainian identity card, with 13.0% (39), followed by the non-biometric passport, used by 6.0% (18). The use of other documents was marginal, with the driving license used in 0.7% of cases (2) and the birth certificate in 0.3% of cases (1). Also, 2.3% (7) of respondents entered the country without legal documents.

Survey participants reported various lengths of stay and frequency of entry into Moldova. Most of the respondents (67%, 198) stated that they had been in Moldova for more than one year, while 14% (42) had been in Moldova for between 6 and 12 months and 13% (38) for between 3 and 6 months. Only 6.0% (18) had a stay of less than 3 months. In terms of the frequency of entries, 51% (152) of the respondents had a single entry, 41% (122) had between 2 and 5 entries, and 9% (24) had entered more than 6 times (Figure 4).

Figure 4. Period of staying and number of entries in Moldova



Non-response: period of stay (4), number of entries (2)

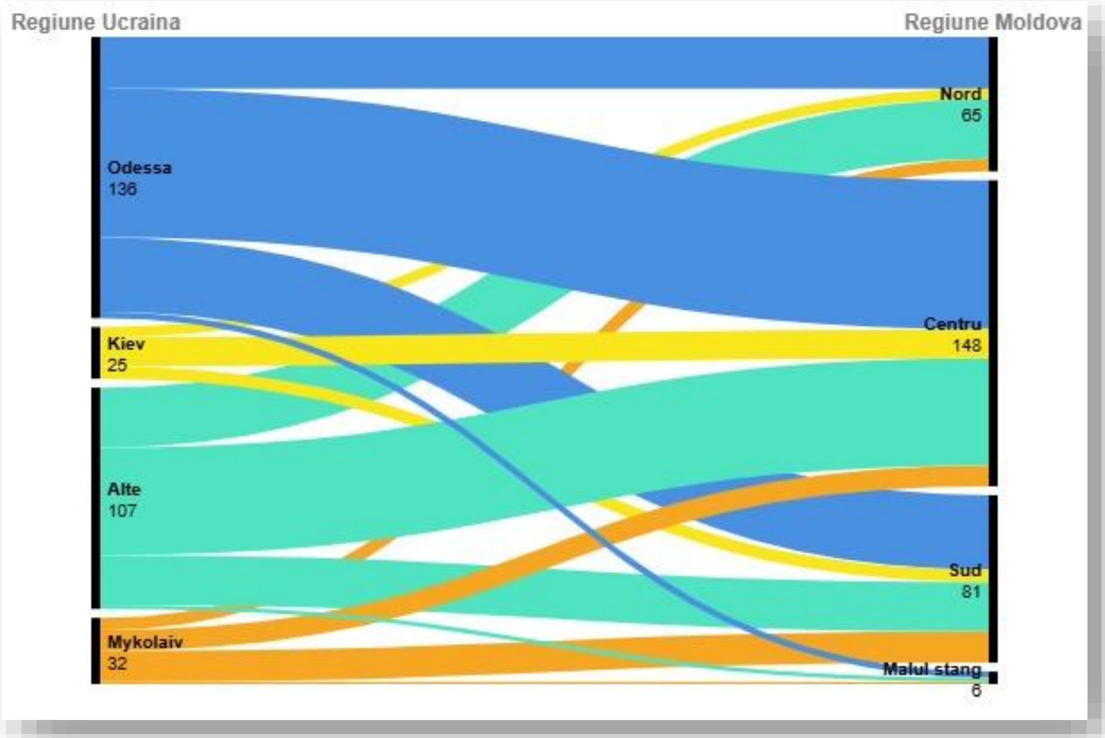
Survey participants came from a variety of regions of Ukraine, with a notable presence from Odessa, Mykolaiv and Kiev. Most respondents, 45.3% (136), were from the Odessa region, with Mykolaiv being the second most common region of origin with 10.7% (32). Approximately 8.3% (25) are from Kiev, the capital of Ukraine. In addition, 6.7% (20) come from Kharkov and 6.3% (19) from Herson. Other regions of origin included Dnipropetrovsk (4.0%), Donetsk (3.0%) and Chernihiv (2.0%). Regions with contributions below 2% were Cherkasy, Chernivtsi, Crimea, Khmelnytskyi, Zhytomyr, Kirovohrad, Luhansk, Lviv, Mohyliv, Ternopil, Vinnytsia and Zaporizhzhia. Some respondents (7) did not specify their region of origin.

In Moldova, respondents' place of residence was diverse, choosing to live in municipalities (64.3%, 193), district centers (26.7%, 80) and villages (9.0%, 27). Chisinau municipality was the most represented, with 46.0% (138). The second most frequent city of residence was Balti municipality, with 17.7% (53). The Cahul and Comrat districts also had a notable presence, with 12.3% (37) and 3.0% (9) respectively. Other districts with a lower presence included Ceadir-Lunga (1.7%), Taraclia (3.0%) and Bender city (1.3%). Districts where respondents with a place of residence below 1% were settled included Anenii Noi, Calarași, Cantemir, Cantemir, Caușeni, Criuleni, Dondușeni, Drochia, Dubasari, Falesti, Floresti, Glodeni, Ocnița, Riscani, Rezina, Singerei, Slobozia, Soroca, Stefan Voda, Straseni, Telenesti, Tiraspol and Vulcanesti.

Looking at the geographical distribution of the respondents, we observe that almost half of them (49.3%, 148) chose to live in the central part of Moldova. The South hosted 27.0% (81) of the participants, while 21.7% (65) settled in the Northern region of the country and 2.0% (6) in the Eastern region of the country.

The figure below illustrates the regions in Moldova where the respondents settled, as well as the regions in Ukraine where they came from. The choice of region of living in Moldova was not influenced by the region of origin in Ukraine, the p-value p=0.252, indicating that there is no statistically significant association (Figure 5).

Figure 5. Distribution of respondents according to the regions in Moldova where they live and the regions in Ukraine where they come from



By the time the study participants arrived in Moldova, they were accommodated in various places, such as refugee centers (93) or in families who hosted them for free (42). Others rented an apartment, house (80) or a room (27), and some chose other types of accommodation (58), such as (with relatives, friends, NGO rehabilitation centers or rent paid from NGO) (Figure 6).

In 37.6% (35 out of 93) of the cases those who initially accommodated in the refugee centers stayed there, while another 39.8% (37 out of 93) rented an apartment or house. The vast majority (95.0%, 76 out of 80) stayed in their initially rented apartments or houses. Also, 63% (17 out of 27) of those who rented a room and 64.3% (27 out of 42) of those who initially lived with families who accommodated them free of charge stayed in the same conditions. What concerns other types of accommodation (with relatives, friends, NGO rehabilitation centers or rent paid from the NGO), 62.1% (36 out of 58) of them remained in these conditions, while 20.7% (12 out of 58) rented an apartment or house (Figure 6).

Statistical tests indicate a significant association between initial place of accommodation and current place of living, suggesting that initial accommodation experiences in Moldova had a significant impact on their current living situation ($p< 0.05$).

Asked whether they plan to leave their place of living in Moldova soon, one third of the respondents (30.6%, 89 out of 291[1]) said that they have such plans. Analyzing the respondents' relocation intentions, the majority (51.7%, 46 out of 89) of those who want to leave Moldova prefer to move to another country. In about one fourth (22.5%, 20 out of 89) of the cases, they want to return to their native region in Ukraine, while others (3.4%, 3 out of 89) intend to move to another region in Ukraine, different from their

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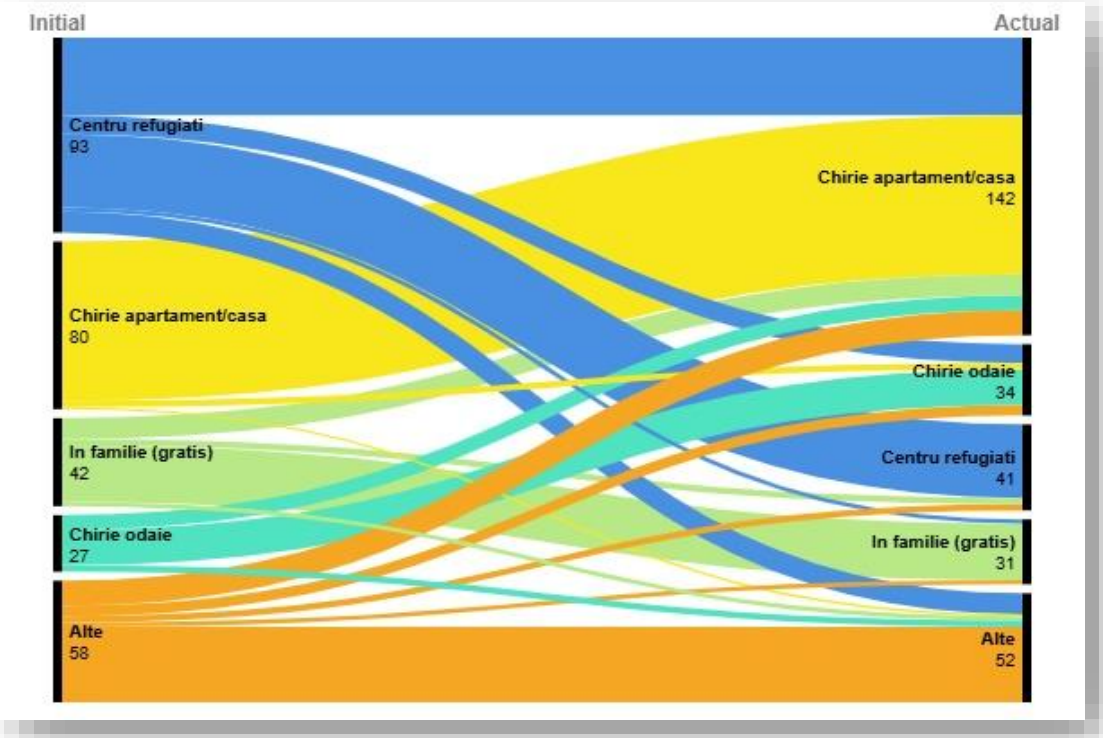
[1] No answer (9)

native one. Every tenth (10.1%, 9 out of 89) is planning to change their place of living to another locality in Moldova, and 12.4% (11 out of 89) of the respondents are not sure whether they want to leave their place of living.

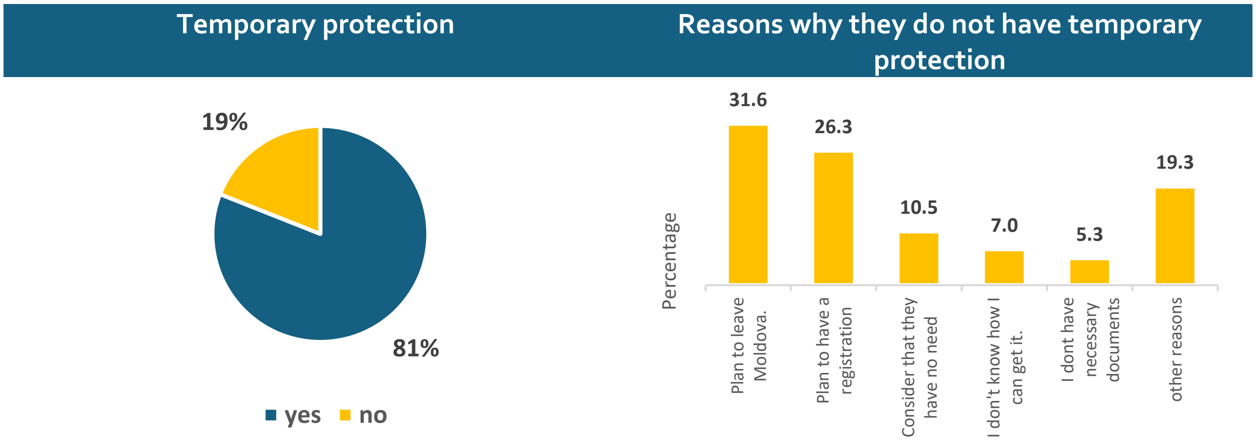
Figure 6. Initial place of accommodation when study participants arrived in Moldova and current place of accommodation



Temporary protection

According to the data collected, a significant majority (81%, 243) of the respondents have benefited from temporary protection. In addition, 19% (57) of the respondents do not have this protection for various reasons: planning to leave Moldova in the near future (18), planning to register (15), consider that they do not need it (6), do not know how to obtain it (4), do not possess the necessary documents (3), other unspecified reasons (11) (Figure 7).

Figure 7. Temporary protection and reasons for not having temporary protection

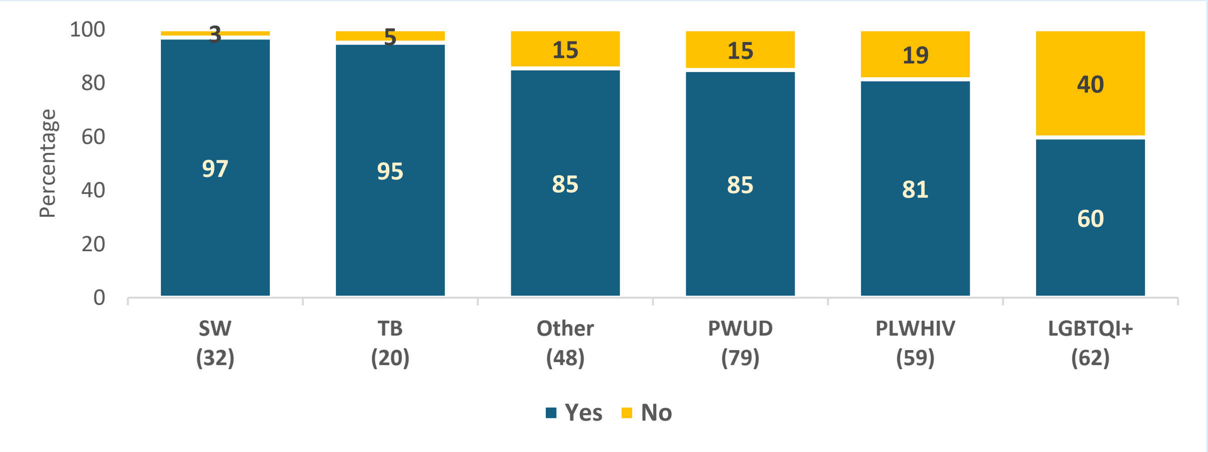

Temporary protection

Reasons why they do not have temporary protection

According to the possession of temporary protection and group (or community) affiliation, it was observed that the SW and TB groups accounted for the highest proportion of people with this status, 96.9% and 95.0% respectively. The PWUD and PLHIV groups reported temporary protection at 84.8% and 81.8%, respectively. In the LGBTQI+ group, only 59.7% of respondents have temporary protection (Figure 8).

The p-value p<0.001 indicates a statistically significant association between belonging to a particular group (or community) and holding temporary protection status, suggesting that belonging to a particular group (or community) has a considerable influence on the likelihood of obtaining temporary protection in Moldova (Figure 8).

Figure 8. Temporary protection in disaggregation by groups and communities



Violence

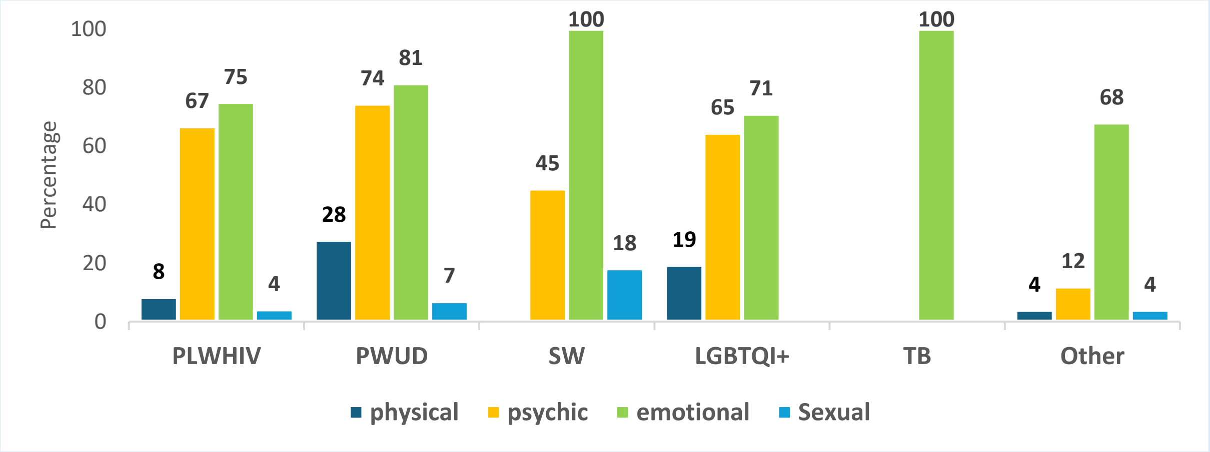
The study analyzed the experiences of violence on the study population after the Russian invasion of Ukraine. Thus, about half (49%, 147) of the surveyed population had been exposed to various forms of violence. In 78.9% (116 out of 147) of the respondents exposed to violence reported experiencing emotional abuse, which is the highest proportion of all forms of violence reported. Mental abuse was mentioned by 51.7% (76 out of 147) of respondents, indicating a high prevalence of mental stress and trauma. In terms of physical violence, 14.3% (21 out of 147) of the respondents stated that they had been victims of this type of abuse. Sexual abuse was indicated in 4.8% (7 out of 147) cases.

The survey results show that 55.8% (82/147) of men, 40.1% (59/147) of women and 4.1% (6/147) of trans gender respondents reported experiences of violence. Statistical tests (p = 0.555) indicate that there is no significant association between gender and violence.

The data analyzed reveals that people with TB were the most vulnerable to violence (13 out of 20). Similarly, PWUD and those in the Group Other had high rates of violence at 54.4% (43/79) and 52.1% (25 out of 48) respectively. The LGBTQI+ community indicated exposure to violence in 50.0% (31 out of 62) cases, highlighting significant vulnerability. In the case of PLHIV and SW, they indicated that they had been victims of violence in 40.7% (24 out of 59) and 34.4% (11 out of 32), respectively.

Of the people with TB who mentioned exposure to violence (13), all were victims of emotional violence. Among PLHIV participants who had been subjected to violence (24), 18 had experienced emotional violence, 16 had been victims of mental abuse, two had been exposed to physical violence, and one to sexual abuse. Among PWUD who mentioned exposure to violence (43), the majority were subjected to emotional (35) and psychological (32) violence, followed by physical (12) and sexual (3) violence. All SW who indicated exposure to violence (11) had been exposed to emotional violence, while five had experienced psychological abuse and two had been victims of sexual abuse. On LGBTQI+ community who were exposed to violence (31), 22 were exposed to emotional violence and 20 to psychological abuse, while six were victims of physical violence. In the Group Other of those subjected to violence (25), 17 were exposed to emotional violence, three to psychological abuse, one each to physical violence and sexual abuse (Figure 9).

Figure 9. Groups and communities according to the type of violence they have experienced



From 21 respondents who mentioned physical violence, 14 indicated that they had been victims of physical violence on the territory of Moldova, 10 specified that the abuse took place in Ukraine, three mentioned that the violence occurred when crossing the border with Moldova, and one stated that he had been a victim of violence on the territory of another country. In terms of aggressors, the data show that 13 of the respondents were victims of physical violence by unknown persons. The police were mentioned as an aggressor by 7 respondents, while family members and border service employees were mentioned by two respondents each.

Regarding mental (psychic) violence (76), 58 of the respondents mentioned that they had been victims of mental violence in Ukraine, while 29 stated that the abuse took place on the territory of Moldova. Also, 14 respondents indicated that the mental violence occurred when crossing the border with Moldova, and one respondent mentioned that the abuse occurred on the territory of another country. The aggressors were unknown persons for 38 of the respondents. Border service employees were mentioned as aggressors by 32 respondents and police by 23 respondents. Family members were indicated as aggressors by 25 respondents, while 5 others preferred not to answer.

Emotional violence was mentioned by 116 of the study participants who had been subjected to abuse in various contexts. The majority (86) of them reported that they had been victims of emotional violence in Ukraine, and 61 that they had suffered emotional abuse while crossing the border with Ukraine. Also, 34 of the respondents stated that this abuse took place on the territory of Moldova. A smaller number of respondents indicated being subjected to emotional violence while crossing the border with Moldova (10) or on the territory of another country (2). In terms of aggressors, the data show that 57 of the respondents were victims of emotional violence at the hands of unknown persons and 52 mentioned border service employees as aggressors. Family members were indicated as aggressors by 29 respondents and police by 17 respondents.

Analysis of the data on sexual violence reveals that seven of the study participants reported experiences of abuse. Most of these incidents occurred in Moldova, where five respondents indicated that they had been victims of sexual violence. Another respondent indicated that the abuse occurred in Ukraine, and one chose not to respond. With reference to aggressors, the data show that two respondents were victims of sexual violence by family members or their partners, and one indicated unknown persons as aggressors. The other four respondents preferred not to answer this question.

During their stay in Moldova, respondents who had been subjected to violence (147) were asked whether they had sought help to report cases of violence while in Moldova. Thus, the majority (55.1%, 81) admitted that they had been victims of violence but did not seek help. In over a third of cases (34.0%, 50) they refferedd to NGOs for support. Respondents contacted the police to report the incidents and sought medical assistance in 2.0% of cases (3 each). In addition, 6.8% (10) chose not to answer this question.

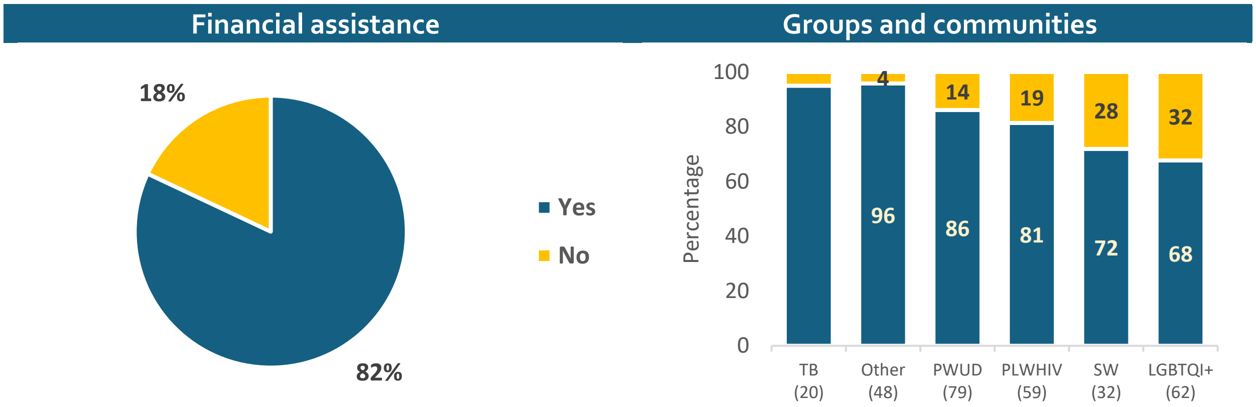
Some respondents (79) had dependents such as children under 18, adults over 65 and people with disabilities. Experiences of violence by their dependents were mentioned by 23 respondents. One respondent indicated that one of their dependents had been a victim of physical violence, 10 respondents reported that their dependents had been subjected to psychological abuse, and 12 respondents specified that their dependents had experienced emotional violence.

ASSISTANCE AND FACILITIES

Financial assistance

Survey participants were asked whether they received financial support for refugees during their stay in Moldova. Out of a total of 300 respondents, an overwhelming majority of 82% (246) confirmed that they had received such financial support. In contrast, about a fifth (18%, 54) stated that they had not received financial support. The reasons why they had not received financial support were varied: they were not registered to receive such support (57.4%, 31 out of 54), did not wish to disclose their personal details (5.6%, 3 out of 54) and did not know that they could receive such financial support (3.7%, 2 out of 54). One respondent (1.9%) said they intended to register for financial aid. In addition, in 25.9% (17 out of 54) of the cases, participants did not specify the reasons (Figure 10).

Figure 10. Financial assistance, including breakdown by groups and communities



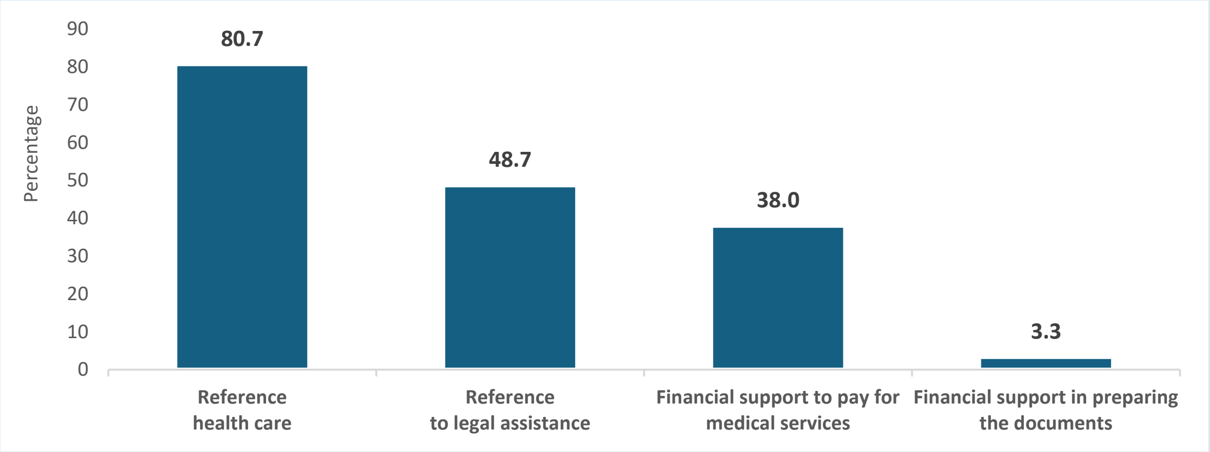
Within groups and communities, the proportion of those who had received financial support varied significantly: people with TB (19 out of 20), PLHIV (81.4%), PWUD (86.1%), SW (71.9%), LGBTQI+ community (67.7%). The Group Other had 95.8% of respondents confirming that they had received financial assistance. Statistical tests revealed a significant association between groups and financial assistance, indicating that belonging to a particular group or community may influence the likelihood of receiving financial support (p=0.001,Figure 10).

Since their arrival in Moldova, survey participants have received various essential goods and products free of charge. Among these, food was the most frequently distributed, reaching 22.7% (68) of respondents. Hygiene products benefited about a fifth (20.7%, 62) of the respondents, while another 11.3% (34) benefited from clothing, bed linen and similar items. In 18.7% (56) cases respondents received medicines, and in 0.7% (2) cases they received medical equipment (wheelchairs, crutches, hearing aids, etc.) Families with children (5.0%, 15) received specific products such as baby food and diapers. In addition, 9.7% (29) of respondents received other types of aid.

Support and facilities provided by NGOs and volunteers

Survey participants benefited from a wide range of services provided by NGOs and volunteers. The most frequently used services were referral and/or accompaniment to medical institutions, which was used by 80.7% (242) of respondents. Also, in 48.7% (146) cases, respondents were referred to legal aid, while in 38.0% (114) cases, they received financial support to pay for medical services (Figure 11).

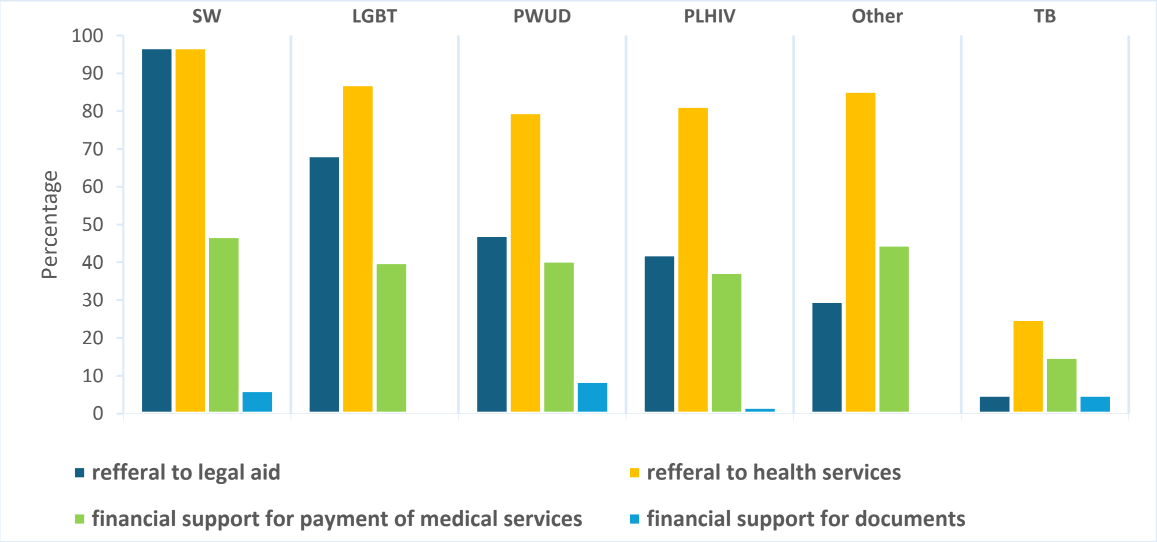
Figure 11. Support and facilities provided by NGOs and volunteers



Services provided by NGOs and volunteers, depending on the groups and communities, illustrate that referral to health care was the most used, with a high percentage of beneficiaries in all groups (Figure 12):

- PWUD benefited mainly from referral to medical institutions (79.7%), referral to legal aid (47.3%) and financial support for the payment of medical services (40.5%).
- The SW group benefited significantly from referral to legal aid (96.9%) and financial support for the payment of medical services (46.9%). In 96.9% of cases, they were referred to medical institutions.
- The LGBTQI+ community mainly benefited for referral to medical institutions (87.1%), financial support to pay for medical services (40.0%).
- The PLHIV group benefited significantly from referral to medical institutions (81.4%), referral to legal aid (42.1%), financial support for the payment of medical services (37.5%).
- People with TB mainly received referral to medical institutions (25.0%) and in 15.0% of cases financial support to pay for medical services.
- The group Other was referred to medical institutions (85.4%), in 29.8% of cases they were referred to legal aid and in 44.7% of cases they received financial support for medical services.

Figure 12. Assistance and facilities provided by NGOs and volunteers, by groups and communities



HEALTH SERVICES

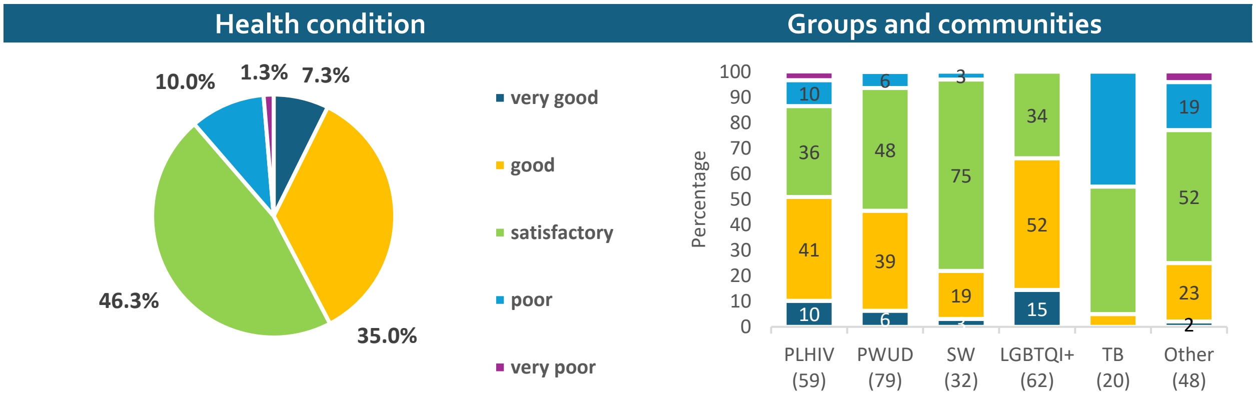
Health condition

The study assessed respondents' perception of their health condition at the time of the survey. They self-assessed their health status for the last four weeks. In 46.3% (139) of the cases, the study participants rated their health condition as satisfactory. A significant proportion, 35.0% (105), considered their health condition as good. In contrast, only 7.3% (22) of respondents rated their health as very good. On the other hand, 10.0% (30) of respondents described their health condition as poor and 1.3% (4) as very poor (Figure 13).

The analysis of health perception by groups and communities revealed significant differences, highlighting the need for individualized approaches. Thus, the SW group had the highest percentage of respondents who rated their health condition as satisfactory (75.0%, 24 out of 32), suggesting an overall positive perception. In contrast, the LGBTQI+ community had the highest percentage of respondents who rated their health condition as good (51.6%, 32 out of 62), indicating a more favorable perception of health status in this group. On the other hand, those in the TB group had the highest percentage of respondents who described their health condition as poor (9 out of 20), highlighting significant health problems in this group. The PLHIV group also had a notable percentage of respondents who rated their health condition as very good (10.2%, 6 out of 59), but also 3.4% (2 out of 59) who described their health as very poor. The PWUD group had a moderate perception of health, with almost half of the respondents (48.1%, 38 out of 79) rating their health condition as satisfactory. A significant proportion (39.2%, 31 out of 79) considered their health to be good, and a small proportion (6.3%, 5 out of 79) reported a very good health condition. However, some respondents (6.3%, 5 out of 79) described their health status as poor and none reported very poor health condition (Figure 13).

Statistical tests (p< 0.001) indicated a significant association between groups and perceived health status, suggesting that belonging to a particular group may influence how respondents perceive their health.

Figure 13. Respondents' perceived health status in the last four weeks before the interview

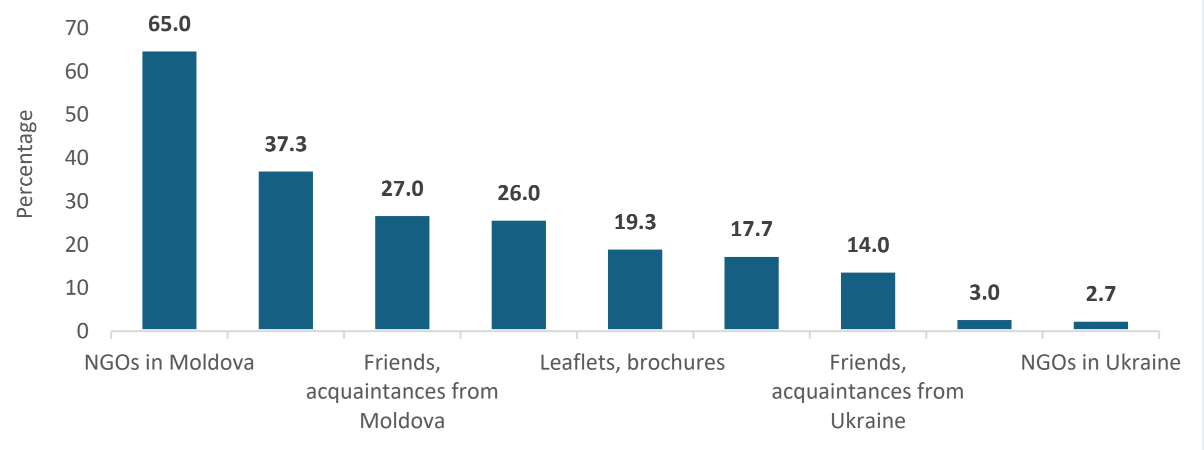

Health condition

Groups and communities

Information sources

In the survey, respondents were asked about sources of information on accessing health services in Moldova. The most common sources of information on accessing health services were NGOs in Moldova (65.0%, 195), followed by information obtained from other refugees in Moldova (37.3%, 112) and from friends or acquaintances in Moldova (27.0%, 81). Social networks were an important source of information for 26.0% (78) of respondents, while leaflets and brochures were used in about a fifth (19.3%, 58) of cases. Information from official Moldovan websites was a source in 17.7% (53) of cases, while official Ukrainian websites were used by only 3.0% (9) of respondents. Friends and acquaintances in Ukraine served as a source of information for 14.0% (42) of the respondents and Ukrainian NGOs for 2.7% (8) of the respondents (Figure 14).

Figure 14. Sources of information on accessing health services



There were significant variations in the sources of information used to access health services between groups and communities.

Moldovan NGOs were the most frequent source of information. Thus, respondents from the SW group relied on these organizations 96.9% (31 out of 32), followed by respondents from the PWUD group (67.1%, 53 out of 79), the LGBTQI+ community (79.0%, 49 out of 62), the PLHIV with (50.8%, 30 out of 59) and the Group Other (56.3%, 27 out of 48), as well as TB people (5 out of 20).

Friends and acquaintances in Moldova were also another important source. TB persons relied mainly on these sources (14 out of 20). This source was relied on in a third of cases by PWUD (30.4%, 24 out of 79) and group Other (29.2%, 14 out of 48), and in about a quarter of cases by PLHIV (25.4%, 15 out of 59). Respondents from the LGBTQI+ community indicated this source in 17.7% (11 out of 62) cases, and in 9.4% (3 out of 32) cases by SW.

Social networks were mostly used by TB people (12 out of 20), followed by those from the LGBTQI+ community (48.4%, 30 out of 62), the PLHIV group (30.5%, 18 out of 59), the Group Other (22.9%, 11 out of 48) and the PWUD group (8.9%, 7 out of 79).

Other refugees from Moldova were an important source for the SW group (71.9%, 23 out of 32), followed by the PWUD group (49.4%, 39 out of 79), the Group Other (29.2%, 14 out of 48) and the LGBTQI+ community (24.2%, 15 out of 62).

The information on official websites in Moldova was mainly used by people from the TB group (10 out of 20), followed by the SW group (28.1%, 9 out of 32), the PWUD group (13.9%, 11 out of 79), the PLHIV group (11.9%, 7 out of 59), the Group Other (20.8%, 10 out of 48) and the LGBTQI+ community (9.7%, 6 out of 62).

Brochures and leaflets also served as important sources of information for people in the TB group (8 out of 20), followed by those in the SW group (34.4%, 11 out of 32), the PWUD group (26.6%, 21 out of 79), the Group Other (20.8%, 10 out of 48), the LGBTQI+ group (8.1%, 5 out of 62) and the PLHIV group (5.1%, 3 out of 59).

Friends and acquaintances in Ukraine were sources of information for the Group Other (35.4%, 17 out of 48), the PWUD group (10.1%, 8 out of 79), the SW group (12.5%, 4 out of 32), the TB group (6 out of 20), the PLHIV group (8.5%, 5 out of 59) and the LGBTQI+ community (3.2%, 2 out of 62).

Information from official Ukrainian websites was less used: people in TB group (1 in 20), PLHIV group (6.8%, 4 in 59), PWUD group (3.8%, 3 in 79), Group Other (2.1%, 1 in 48).

NGOs in Ukraine: the PLHIV group (3.4%, 2 out of 59), the PWUD group (3.8%, 3 out of 79) and the LGBTQI+ community (4.8%, 3 out of 62).

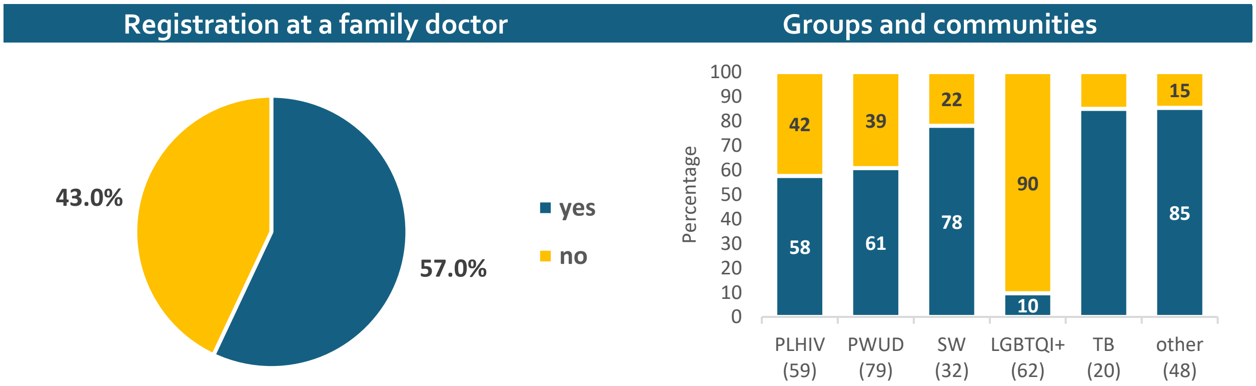
Entry in the family doctor's register

In 57.0% (171) cases respondents mentioned that they were registered at a family doctor in Moldova, but this percentage varied considerably between groups and communities.

The TB and Group Others have the highest registration rates of 85.0% and 85.4% (41 out of 48) respectively, indicating good accessibility to health services. A high percentage of 78.1% (25 out of 32) was also observed among the SW group. The situation is different for the PLHIV and PWUD groups, which have moderate registration rates of 57.6% (34 out of 59) and 60.8% (48 out of 79). In contrast, the LGBTQI+ group has the lowest registration rate of only 9.7% (6 out of 62).

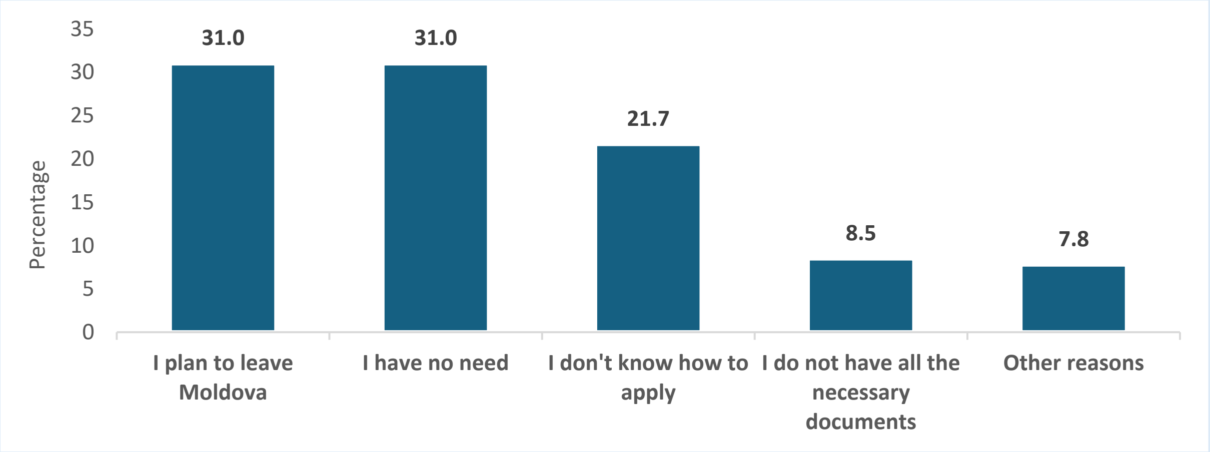
Statistical tests confirm that there is a significant association between group affiliation and the likelihood of being registered with a family doctor ($p<0.001$,Figure 15).

Figure 15. Registration at a family doctor



The survey revealed several reasons why participants were not registered at a family doctor in Moldova. In about one third of the cases, the main reasons were the intention to leave Moldova (31.0%, 40 out of 129) and not considering necessary to be register at a family doctor, however they pay for medical services (31.0%, 40 out of 129). On the other hand, in more than one fifth of the cases (21.7%, 28 out of 129), respondents specified that they are not registered because they do not know the registration procedure. A smaller percentage, 8.5%, did not have the necessary documents for registration. Finally, the remaining 7.8% (10 out of 129) of respondents did not specify why they were not registered (Figure 16).

Figure 16. Reasons for not registering at a family doctor



The analysis by groups and communities revealed a variety of reasons for not registering at a family doctor in Moldova. Thus, 40.0% (10 out of 25) of respondents from the PLHIV group, 39.3% (22 out of 56) of respondents from the LGBTQI+ community, 9.7% (3 out of 31) of respondents from the PWUD group did not consider necessary to be registered at a family doctor. In addition, this reason was also given by some respondents from the Group Other (2 out of 7), but also from the TB group (2 out of 3).

The intention to leave Moldova soon was another common reason, especially among LGBTQI+ respondents (37.5%, 21 out of 56), among PLHIV (28%, 7 out of 25) and PWUD (25.8%, 8 out of 31). Some respondents from the SW group also indicated this reason (4 out of 7).

Lack of knowledge of registering procedures, another reason, observed among the PLHIV group in 28.0% (7 out of 25) cases, among the PWUD group in 29.0% (9 out of 31) cases, but also among the LGBTQI+ community in 21.4% (12 out of 56) cases.

Lack of the necessary documents for registration is another cause highlighted. About a quarter (25.8%, 8 out of 31) of the PWUD group respondents mentioned this, but also one respondent from the PLHIV group (4.0%, 1 out of 25), the SW group (1 out of 7) and the Group Other (1 out of 7).

Trust in the family doctor is an essential aspect of the patient-doctor relationship and significantly influences the quality of medical care. The respondents, registered in the list of family doctors in Moldova (171), were asked to give their opinion on the level of trust in the family doctor they are registered with. In 44.4% (76) cases, respondents specified that they trusted the family doctor, while in 37.4% (64) cases, they were neutral, not having a clear positive or negative opinion. On the other hand, 8.8% (15) of the participants declared full trust in the family doctor, while 8.2% (14) specified a low level of trust or no trust at all (1.2%, 2).

Communication with healthcare providers

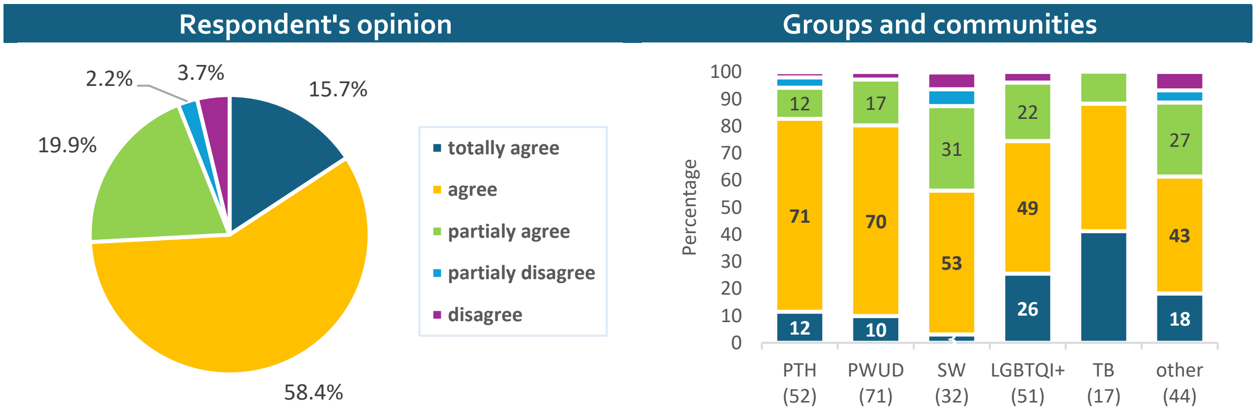
Communication with healthcare providers is essential to ensure the quality of care.

Information on treatment and care options

According to the data, most respondents felt adequately informed about their health care and treatment options (74.1% agree or strongly agree, 198 out of 267[2]), indicating a high level of satisfaction among the study participants.

According to groups and communities, respondents from the PLHIV and PWUD groups were the most satisfied with the level of information from health care providers in 82.7% (43 out of 52) and 80.3% (57 out of 71) of the cases, respectively. The LGBTIQ+ community felt adequately informed in 74.5% (38 out of 51) cases and the SW group in 56.2% (18 out of 32) cases. In addition, most people in the TB group (15 out of 17) were satisfied with the level of information from healthcare providers. In context, respondents' opinions regarding the volume of information from health care providers on treatment and care options varied between groups and communities, confirmed by statistical tests (p=0.009) (Figure 17).

Figure 17. Information from healthcare providers on treatment and care options



Treatment safety information

Analyzing the data on respondents' information on the safety of treatment showed a predominantly positive attitude. The proportion of those who felt that they receive the necessary information (strongly agree and agree) was 72% (190 out of 264 ,[3] Figure 18).

When disaggregated by groups and communities, no significant variations were observed (p=0.281). In context, respondents in the PLHIV and PWUD groups felt best informed about treatment safety in 87.2% (48 out of 55) and 72.9% (51 out of 70) of the cases, respectively. The majority of those in the TB group also felt well informed (13 out of 17). Those from the LGBTQI+ community felt adequately informed in 68.8% (33 out of 48) cases, and those from the Group Other in 61.9% (26 out of 42) cases. In contrast, the SW group felt least informed about treatment safety (59.3%, 19 out of 32) (Figure 18).

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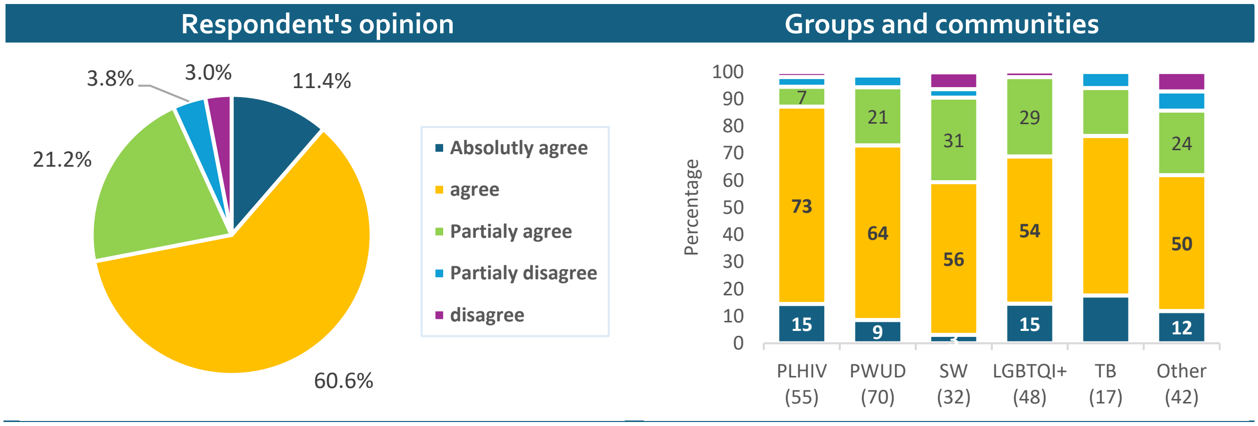
[2] No answer (33)

[3] No answer (36)

Figure 18. Information from healthcare providers on treatment safety



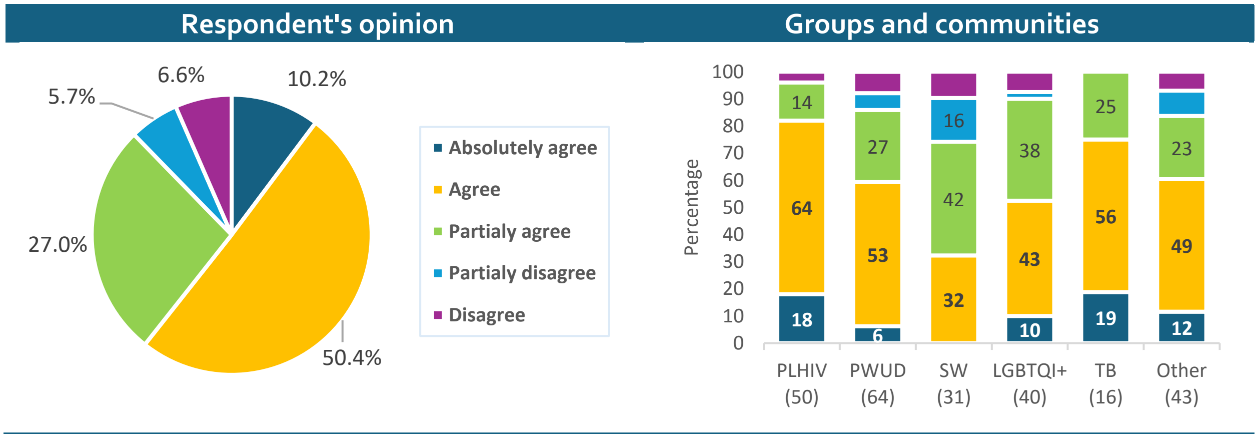
Adapting health care according to needs

Respondents' opinions regarding the tailoring of health care by health care providers to their needs revealed a predominantly positive attitude. The percentage of those strongly agreeing and agreeing with this statement was 60.6% (148 out of 244[4]), indicating a high level of satisfaction (Figure 19).

In most cases, those in the PLHIV and Group Others largely strongly agreed or agreed, in 82.0% (41 out of 50) and 60.4% (26 out of 43) cases, respectively. Most respondents in the PWUD group (59.3%, 38 out of 64) and the majority in the LGBTQI+ community (52.5%, 21 out of 40) also felt adequately cared for, as did those in the TB group (12 out of 16). The SW group felt least cared for (32.3%, 10 out of 31) (Figure 19).

Therefore, respondents' views on whether health care providers adapted health care to their needs varied between groups and communities, confirmed by statistical tests (p=0.026,Figure 19).

Figure 19. Adaptation of health care by service providers depending on respondents' needs



Capturing feedback by healthcare providers

Data on capturing feedback from respondents (through satisfaction surveys or other means) by healthcare providers revealed that the percentage of those who strongly agreed and agreed with this statement was 48.2% (102 out of 212), indicating a moderate level of satisfaction among the study participants.

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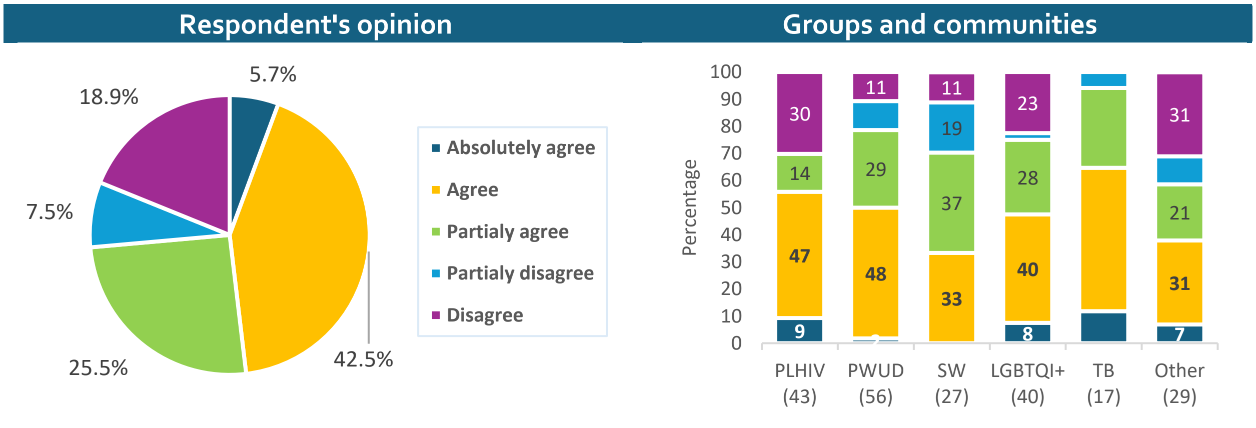
[4] No answer (56)

The study found a high level of satisfaction with the capture of feedback by health care providers among respondents in the PLHIV group at 55.8% (24 out of 43), and those in the TB group (11 out of 17). The PWUD group stood out at 50.0% (28 out of 56), and the LGBTQI+ community at 47.5% (19 out of 40). The SW group registered satisfaction in only one-third of cases (33.3%, 9 out of 27). Thus, the analyzed results show significant variations between groups and communities in dependence on the capture of feedback by healthcare providers (p=0.027,Figure 20).

Figure 20. Capturing feedback by healthcare providers


Respondent's opinion

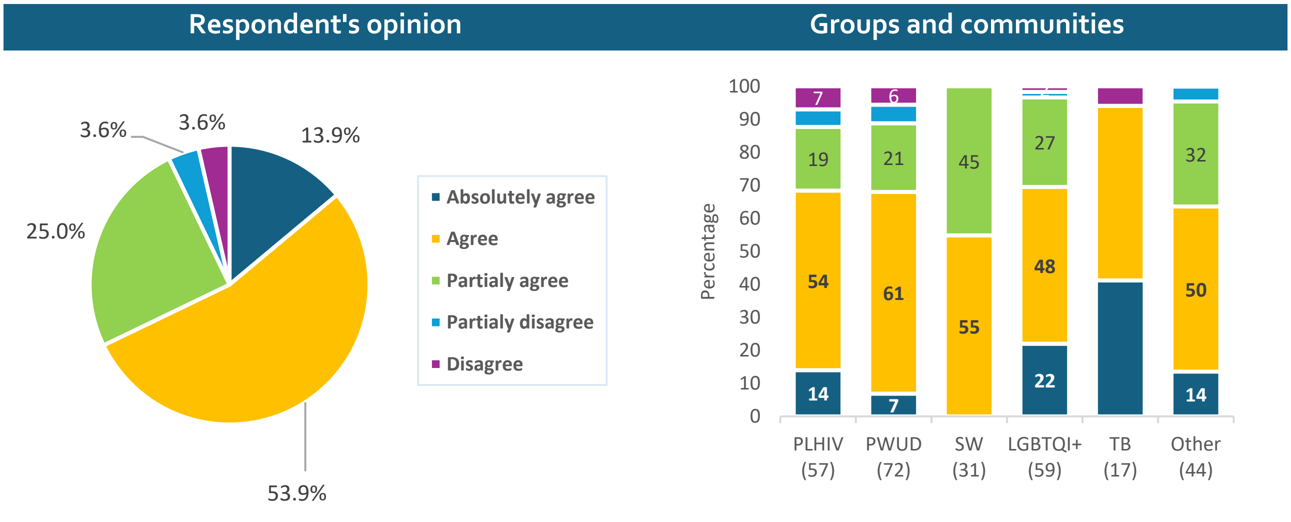
Groups and communities

Time allowed for medical consultation

In most cases (67.8%, 190 out of 280[5]), study participants strongly agreed or agreed that the time given for the medical consultation by health care providers was sufficient (Figure 21).

Most people in the TB group strongly agreed or agreed with this statement (16 out of 17), as well as those in the LGBTQI+ community (69.5%, 41 out of 59). They were followed by respondents from the PWUD group (68.0%, 49 out of 72), the PLHIV group (68.4%, 39 out of 57) and the Group Other (63.6%, 28 out of 44). 54.8% (17 out of 31) of respondents from the SW group mentioned this fact. Thus, statistical analysis confirmed statistically significant differences between groups (p = 0.003,Figure 21)

Figure 21. Time spent for medical consultation by health care providers


Respondent's opinion

Groups and communities

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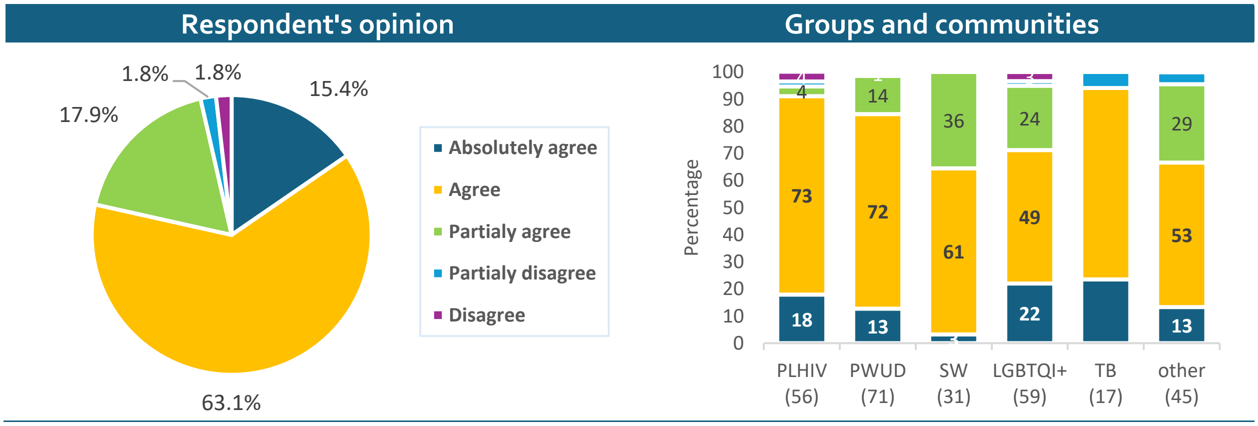
[5] No answer (20)

Confidentiality during the medical consultation

With reference to health care providers conducting medical consultations in a private and confidential manner, the study revealed that 78.5% (219 out of 279[6]) of the respondents supported this statement, strongly agreeing or agreeing (Figure 22).

When disaggregated by groups and communities, 91.1% (51 out of 56) of respondents from the PLHIV group supported this statement, followed by those from the PWUD group (84.5%, 60 out of 71) and the LGBTQI+ community (71.2%, 42 out of 59). Those in the Group Other supported the statement 66.6% (30 out of 45) and those in the SW group 64.5% (20 out of 31). In addition, those in the TB group (16 out of 17) also supported the statement. Thus, the data analysis revealed statistically significant differences between the respondent groups in terms of perceived confidentiality and privacy during medical consultations (p=0.007, Figure 22).

Figure 22. Opinions on respected confidentiality during the medical consultation


Respondent's opinion

Groups and communities

Health status confidentiality

Respect for confidentiality by health care providers is a crucial aspect of health care delivery. Analyzing the data collected, it was observed that most of the study participants (79.5%, 206 out of 259[7]) felt that health care providers respected the confidentiality of their health condition (Figure 23).

However, the level of confidence in health care providers' adherence to confidentiality with respect to individuals' health varied between groups and communities (p=0.010). Thus, all individuals in the TB group (16 out of 16) expressed complete confidence in health care providers' respecting confidentiality. The PLHIV group followed closely, with 90.0% (45 out of 50) of the respondents having a positive attitude, but those in the PWUD group also expressed a high level of confidence, with 88.0% (59 out of 67) of the respondents agreeing or strongly agreeing. In the Group Other, 71.8% (28 out of 39) of respondents expressed confidence in respecting confidentiality, while in the LGBTQI+ community, this was 69.0% (38 out of 55). On the other hand, the SW group had the lowest level of confidence, with only 62.5% (20 out of 32) of respondents agreeing or strongly agreeing that healthcare providers respected their health providers' confidentiality (Figure 23).

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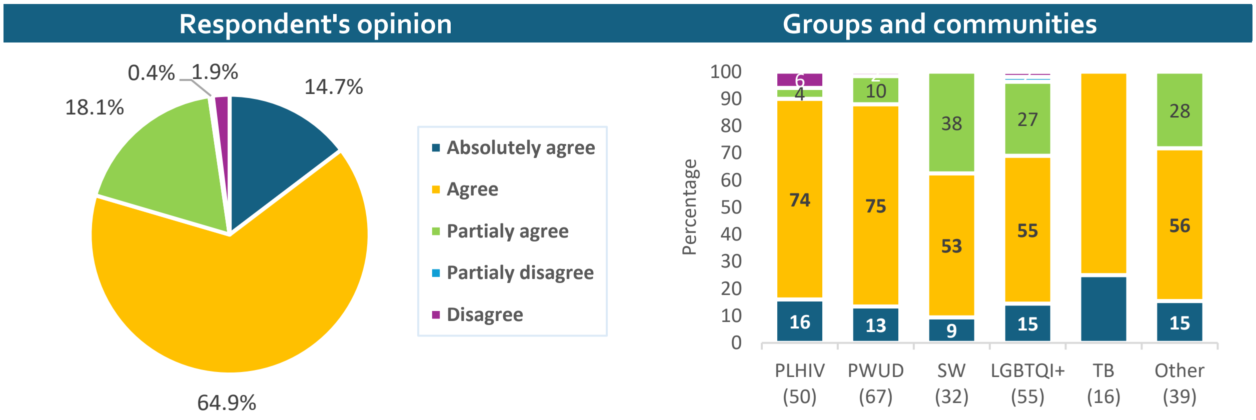
[6] No answer (21)
[7] No answer (41)

Figure 23. Opinions on health condition privacy

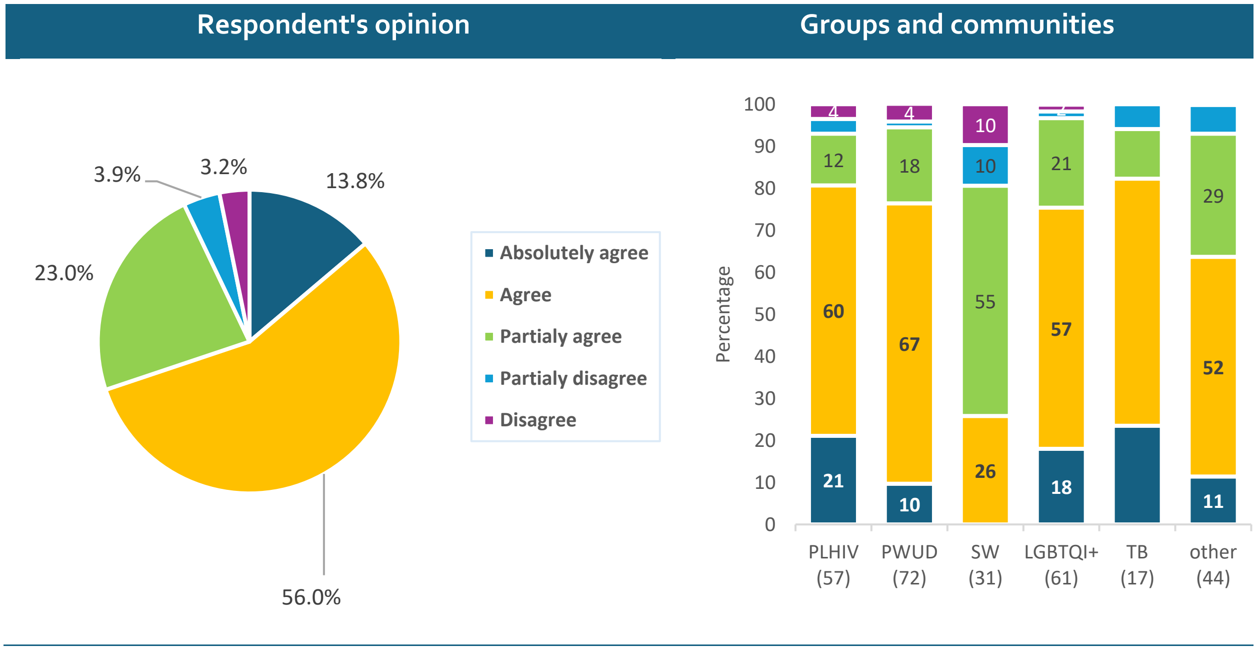


Trust in healthcare providers

The majority of the respondents (69.9%, 197 out of 282[8]) emphasized a trust towards the healthcare providers they interacted with, specifically 13.8% (39) of the respondents strongly agreed and 56.0% (158) agreed with the statement "I trust the healthcare providers I interacted with" (Figure 24).

Respondents in the PLHIV group (80.7%, 46 out of 57) had the highest percentage of trust, followed by those in the PWUD group (76.4%, 55 out of 72). The LGBTQI+ community indicated trust in healthcare professionals in 75.4% (46 out of 61) cases, and those in the Group Other - in 63.7% (28 out of 44) cases. People in the TB group also showed trust in the healthcare providers with whom they interacted (14 out of 17). Those in the SW group had the lowest percentage of trust (25.8%, 8 of 31). Statistical analysis revealed significant differences between groups in terms of trust in the healthcare providers they interacted with (p<0.001,Figure 24).

Figure 24. Opinions on trust in healthcare providers



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[8] No answer (18)

Quality and safety of health services

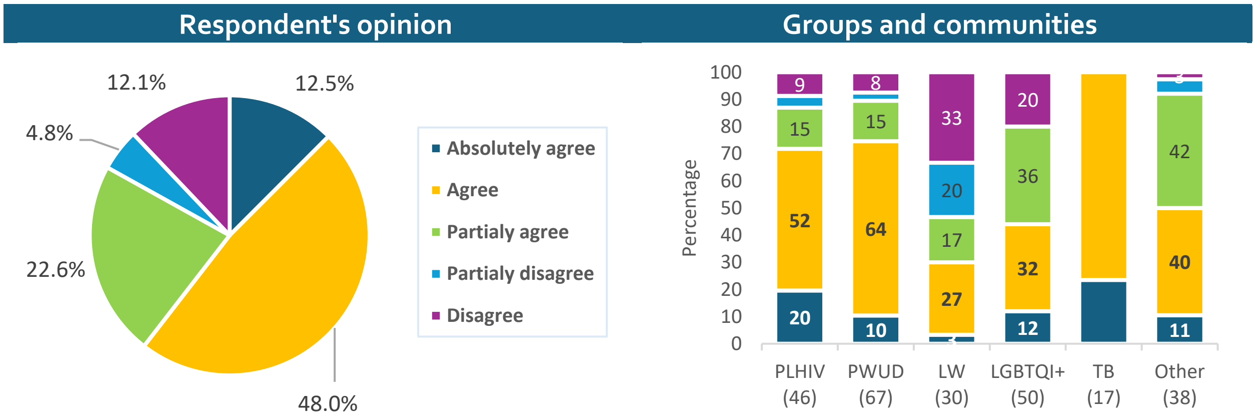
The quality and safety of health services were assessed through various aspects of cooperation and referral.

System of referral and cooperation among health services

The system of referral and cooperation among health services were perceived as effective by 60.5% (150 out of 248[9]) of the survey participants. Specifically, respondents strongly agreed with this statement in 12.5% (31) cases and agreed in 48.0% (119) cases (Figure 25).

Disaggregating by groups and communities, all respondents in the TB group (17 out of 17) claimed that there is a good system of referral and cooperation among health services in Moldova. They were followed by the PWUD group (74.6%, 50 out of 67) and the PLHIV group (71.8%, 33 out of 46). The system of referral and cooperation between health services was good by 50.0% (19 out of 38) of the respondents from the Group Other, 44.0% (22 out of 50) of those from the LGBTQI+ community and 30.0% (9 out of 30) of those from the SW group. These data suggest that perceptions of the effectiveness of the referral system and cooperation between health services varied significantly between groups. The p<0.001 value indicates that these differences are statistically significant (Figure 25).

Figure 25. Opinions on the effectiveness of the referral system and cooperation among health services



Referral system and cooperation between health services and placement centers

Out of the total of 300 respondents, 151 expressed their opinion on the referral system and cooperation between health services and placement centers, which was rated as good in 45% (68) cases or 7.9% (12) of the respondents strongly agreed and 37.1% (56) agreed with this statement (Figure 26).

A good referral system and cooperation between health services and placement centers was considered to be in place by 65.7% (23 out of 35) of the PWUD respondents, 55.1% (16 out of 29) of the PLHIV respondents and 44.5% (8 out of 18) of the group Other respondents. The LGBTQI+ community rated good cooperation in 35.3% (12 out of 34) cases and the SW group in 2 cases out of 24. Only three respondents (3 out of 11) from the TB group expressed confidence in this referral system and cooperation. Thus, the data suggest that the perception of the effectiveness of the referral and cooperation system between health services and placement centers varied significantly between groups (p<0.001,Figure 26).

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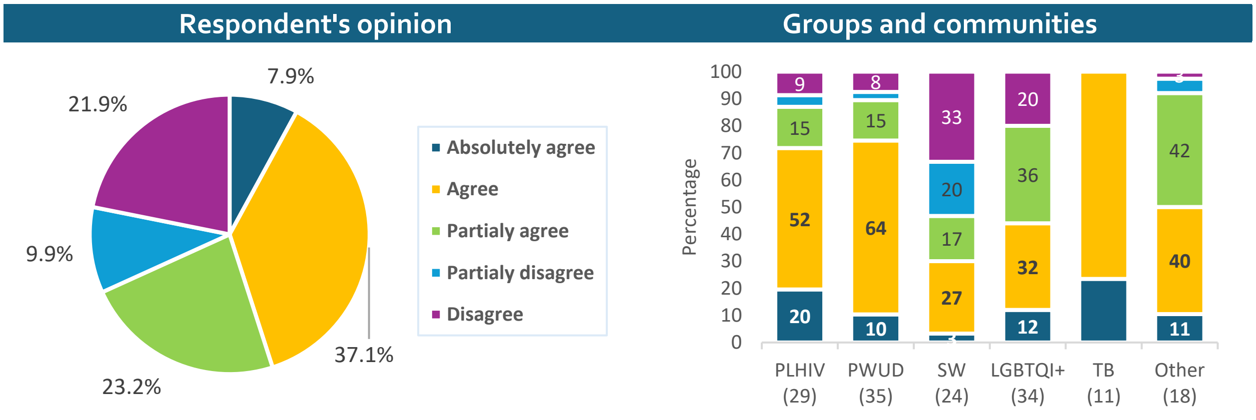
[9] Valid answers (52)

Figure 26. Opinions on the effectiveness of the referral system and cooperation between health services and placement centers


Respondent's opinion

Groups and communities

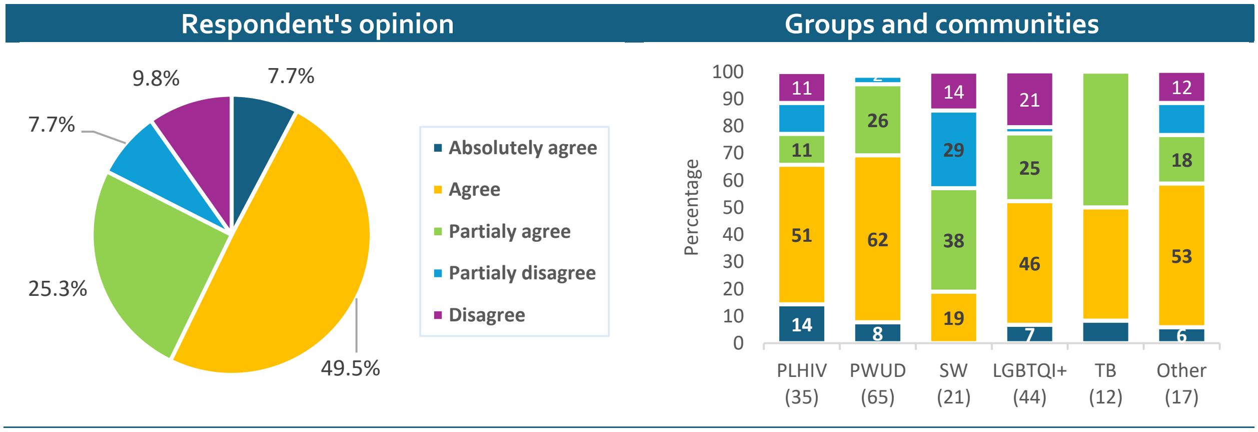
Referral system and cooperation between health and social services

Out of a total of 300 respondents, 194 answered the question on collaboration between health and social services. Out of them, 57.2% agreed that the referral system and cooperation between health and social services is good; 7.7% (15) strongly agreed and 49.5% (96) agreed with the statement.

Analyzing the perception of the collaboration between health and social services in Moldova, by groups and communities, it was observed that 69.2% (45 out of 65) of the PWUD group respondents consider this collaboration as good, and similarly, 65.7% (23 out of 35) of the PLHIV group respondents share the same opinion. Likewise, 58.8% (10 out of 17) of respondents from the Group Other and 52.3% (23 out of 44) of respondents from the LGBTQI+ community felt that there was good collaboration, while only 19.0% (4 out of 21) of respondents from the SW group shared this view. In the TB group, six respondents (6 out of 12) in the TB group support the existence of good collaboration (Figure 27).

The p-value of 0.001 indicates statistically significant between-group variation in perceptions of collaboration between health and social services (Figure 27).

Figure 27. Opinions on the effectiveness of the referral system and cooperation between health and social services


Respondent's opinion

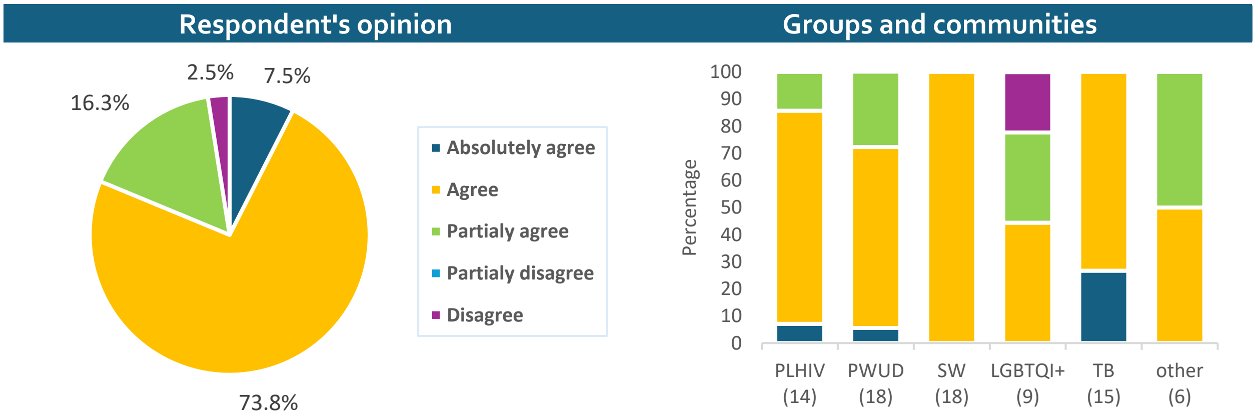
Groups and communities

Referral system and cooperation between health services and NGOs on TB

Evaluation of the referral system and cooperation between health services and NGOs in Moldova in the context of TB services showed a predominantly positive perception. Thus, out of the total of 300 respondents, 80 respondents expressed their opinion on the collaboration between health services and NGOs, and these were the ones who had some tangibility in knowing about the existence of such collaboration. In context, 81.3% (65 out of 80) of the respondents had perceptions of good cooperation.

The analysis by groups showed that there were significant differences in the appreciation of the referral system and collaboration between health services and Moldovan TB NGOs. The TB and SW groups stood out with a good appreciation (15 out of 15 and 18 out of 18, respectively), suggesting complete satisfaction in these categories. In contrast, the PLHIV and PWUD groups indicated mostly but not complete satisfaction (12 out of 14 and 13 out of 18, respectively). The lowest level of good appreciation was in the group Other (3 out of 6) and LGBTQI+ (4 out of 9). These differences are supported by a significant p-value ($p<0.001$), indicating a clear association between the groups and the level of appreciation of the referral system and collaboration between health services and NGOs in the context of TB (Figure 28).

Figure 28. Perceptions on the effectiveness of the referral system and cooperation between health services and NGOs in the context of tuberculosis

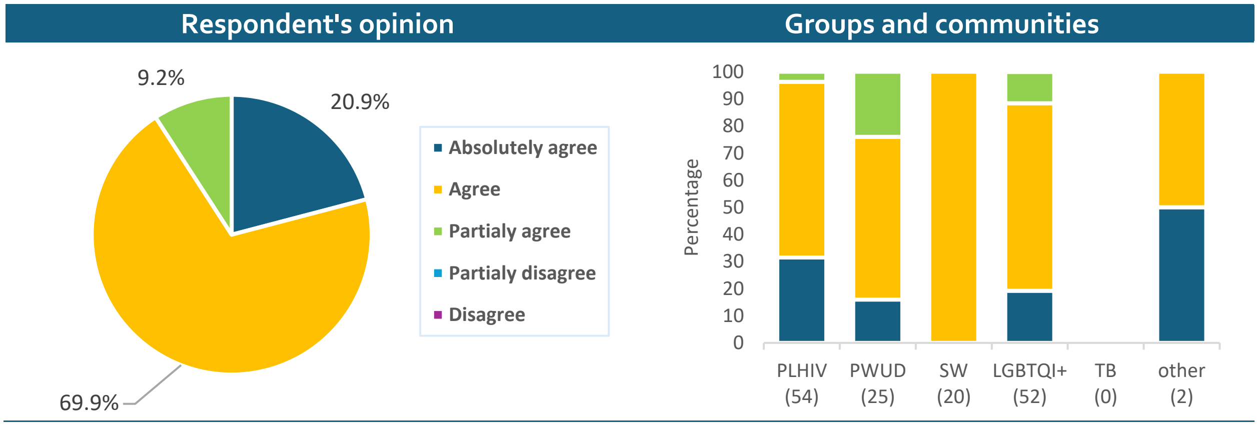


Referral system and cooperation between health services and NGOs in the context of HIV

The survey revealed a significantly positive assessment of the referral system and collaboration between health services and NGOs on HIV services in Moldova. Out of a total of 300 respondents, 153 respondents expressed their opinion on the collaboration between health services and NGOs, and these were the ones who had some tangential knowledge of the existence of such collaboration. Specifically, 90.8% (139) of the respondents consider that this system works well. Of these, 20.9% (32) strongly agreed, while 69.9% (107) agreed. These results suggest high overall satisfaction and a positive perception of collaboration in this area.

Analysis by groups showed that there were significant differences in the appreciation of the referral system and collaboration between health services and NGOs in the field of HIV services. The SW group stood out with a good appreciation (20 out of 20), which suggests about complete satisfaction. The PLHIV group had a good appraisal in 96.3% (52 out of 54) cases, indicating majority satisfaction, and those from the LGBTQI+ community showed a good appraisal in 88.5% (46 out of 52) cases, showing significant satisfaction. On the other hand, the respondents from the PWUD group had a good appreciation (19 out of 25), which showed a lower satisfaction compared to the group Others. These differences were supported by a significant p-value ($p= 0.06$), indicating a clear association between the groups and the level of appreciation of the referral system and cooperation between health services and NGOs in the context of HIV (Figure 29).

Figure 29. Perceptions on the effectiveness of the referral system and cooperation between health services and NGOs in the context of HIV prevention and control



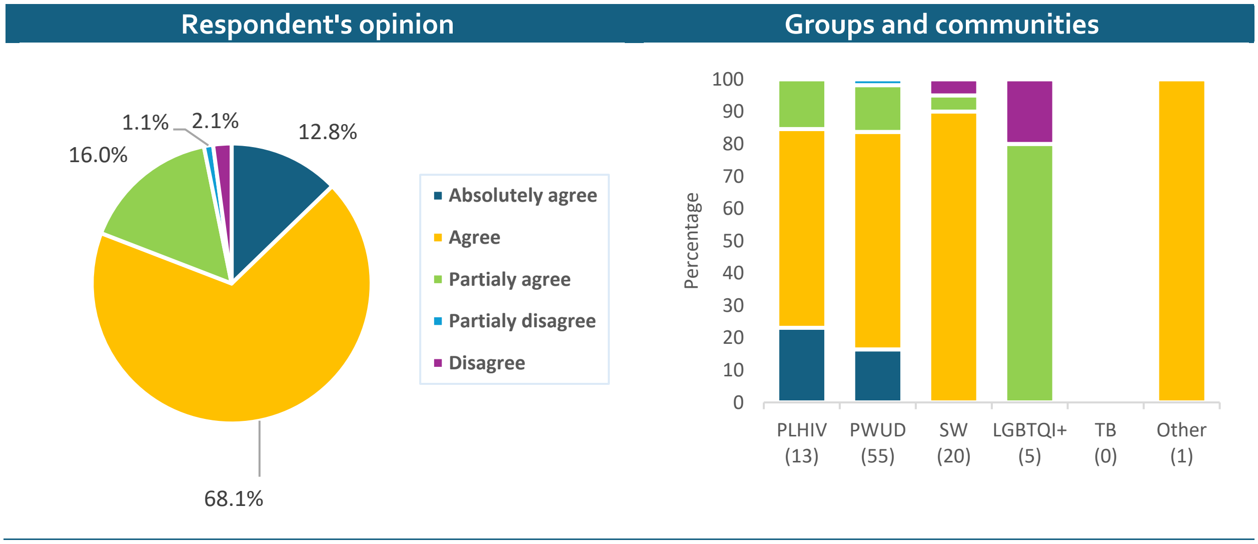
Referral system and cooperation between health services and NGOs on opioid agonist treatment

Of the 300 survey participants, 94 shared their views on the referral system and cooperation between health services and NGOs regarding opioid agonist treatment. The respondents who shared their opinions were those who had some tangential knowledge of such a collaboration. Thus, 80.9% of the respondents (76 out of 94) felt that the system works well. Specifically, 12.8% (12) of the respondents strongly agreed, while 68.1% (64) agreed with this statement. These results suggest high overall satisfaction and a positive perception of collaboration in this area (Figure 30).

Analysis by groups showed a majority satisfaction among respondents in the SW group (18 out of 20), the PLHIV group (11 out of 13) and the PWUD group (46 out of 55). On the other hand, respondents from the LGBTQI+ community indicated a total lack of satisfaction (0 out of 5) (Figure 30).

In this context, the analysis revealed a clear association between the groups and the level of appreciation of the referral and collaboration system regarding opioid agonist treatment (p=0.004).

Figure 30. Perceptions on the effectiveness of the referral system and cooperation between health services and NGOs- on opioid agonist treatment



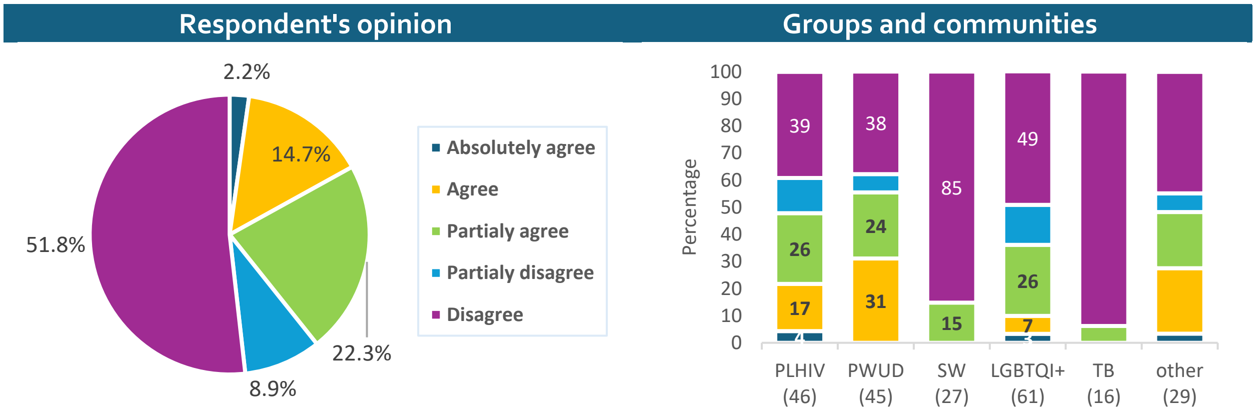
Informed consent for health services available in Romanian language only

In the survey, participants were asked to express their opinion on the availability of informed consent for health services, specifying whether it was given only in Romanian or in other languages

The analysis revealed varied views on the availability of informed consent in Romanian language only. Most respondents (60.7%, 136 out of 224) indicated that this consent was also available in other languages. In contrast, 17.0% (38 out of 224) indicated that it was only available in Romanian, and 22.3% (50 out of 224) had a neutral opinion.

Respondents from the TB group and the SW group stood out with a positive assessment, indicating the availability of consent in other languages in most cases (15 out of 16 and 23 out of 27, respectively). Similarly, respondents from the LGBTQI+ community were positive in 63.9% (39 out of 61) of cases, those from the HIV group in 52.2% (24 out of 46) of cases, and those from the Group Other in 51.7% (15 out of 29) of cases. In contrast, the PWUD group had a positive assessment in 44.4% (20 out of 45), and in about a third of the cases (31.1%, i.e. 14 out of 45) they mentioned the fact that consent was only given in Romanian. These differences are supported by a significant p-value (p<0.001), indicating a clear association between groups and the level of appreciation of the availability of informed consent (Figure 31).

Figure 31. Consent for health services available in Romanian only


Respondent's opinion

Groups and communities

Informed consent for health services also available in Ukrainian language

The provision of informed consent, including in other languages, emphasizes ensuring effective and accessible communication on accessing health services. In the context, 61.4% (162 out of 264[10]) of the survey participants mentioned about the availability of informed consent including in Ukrainian, 15.2% (40 out of 264) indicated that this did not occur, and 23.5% (62 out of 264) had a neutral position on this topic.

Analysis by groups shows significant differences. The availability of consent form, including in the Ukrainian language, was specified in the vast majority of cases by respondents in the TB group (15 out of 17) and those in the PWUD group (82.9%, 58 out of 70). In contrast, the share was lower among respondents in the SW group (67.7%, 21 out of 31), and those in the PLHIV group (65.3%, 32 out of 49). Those from the LGBTQI+ community confirmed this in 41.0% (25 out of 61) cases, and those from the Group Other in only a third (30.6%, 11 out of 36) cases. These differences are supported by a significant p-value (p<0.001), indicating a clear association between the groups and the availability of consent, including in Ukrainian, when accessing health services (Figure 32).

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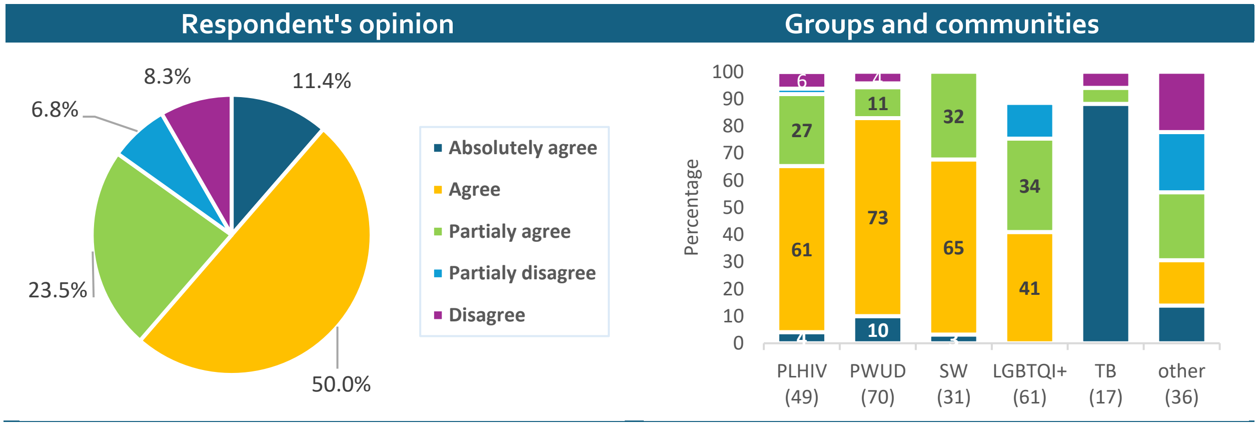
[10] No answer (36)

Figure 32. Consent form for health services available in Romanian and Ukrainian

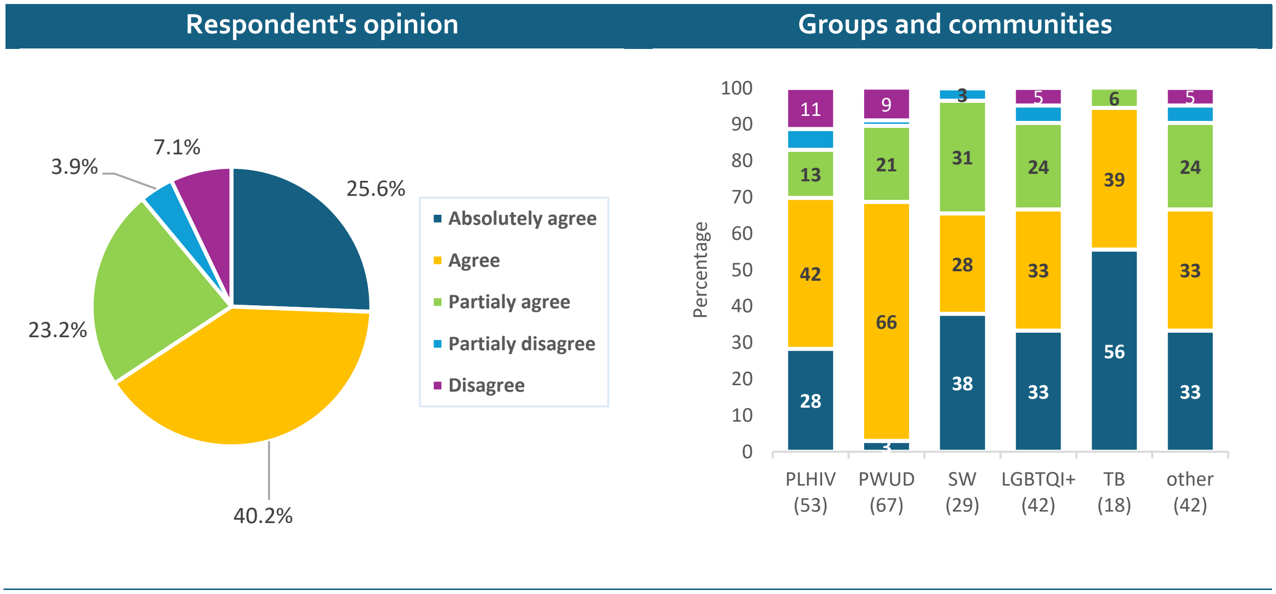


Health care demand in relation to primary health care capacity

Concerning requests for assistance from refugees in relation to the capacity of primary health care to provide these services, 254 of the survey participants gave their views. Most of the respondents, 65.7% (167 out of 254), claimed that the requests for assistance were greater than the capacity of primary health care to provide these services. In 23.2% (59 of 254) cases, respondents were neutral, and in 11.0% (28 of 254) cases, they did not support the statement.

The survey results revealed that virtually all respondents in the TB group (17 out of 18), as well as the majority of those in the PLHIV group (69.8%, 37 out of 53), the PWUD group (68.7%, 46 out of 67) and the Group Other (66.7%, 28 out of 42) supported the idea that the demand for care was greater than the capacity of primary health care. Respondents from the SW group were less convinced of this (19 out of 29), as were respondents from the LGBTQI+ community (44.4%, 20 out of 45). In context, although perceptions varied between groups, most respondents felt that the demand for care exceeded the capacity of primary care. The p-value> 0.001 indicates a statistically significant association between the groups and the responses provided (Figure 33).

Figure 33. Opinions on health care demand in relation to primary health care capacity



Quality and safety of health care

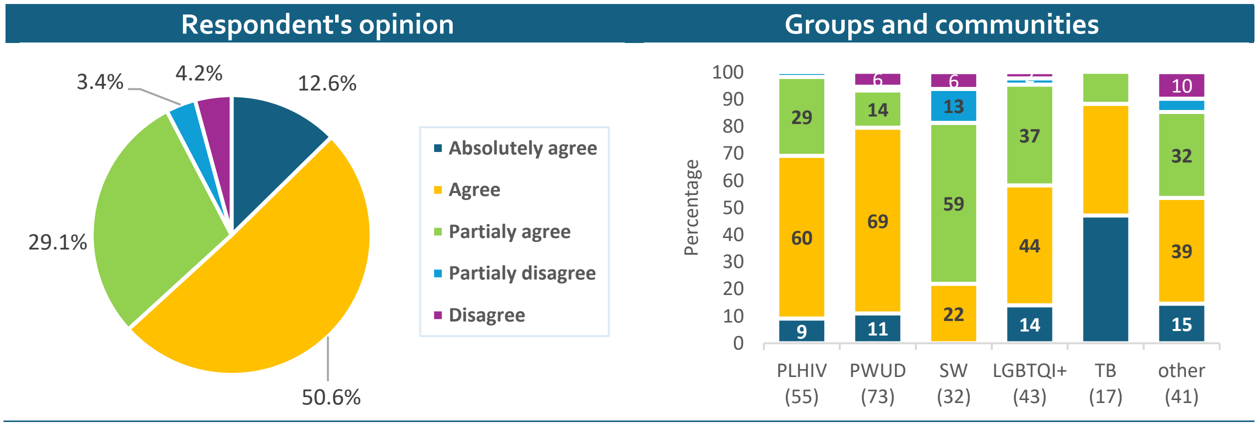
The quality and safety of health care are essential to ensure patient well-being. Safety of care means preventing medical errors and adverse incidents, while quality refers to accessibility, effectiveness and patient satisfaction with the services received.

High quality health care

Of a total of 300 respondents, 261 were asked whether they received good quality care (in line with available standards, guidelines or best practice). Most survey participants (63.2%, 165 out of 261) supported this statement, while about one-third (29.1%, or 76 out of 261) were neutral and 7.7% (20 out of 261) did not support it.

The analysis showed significant differences by groups and communities in their opinion of good quality of care. Respondents in the TB group showed the highest positive appraisal in this regard (15 out of 17), followed by those in the PWUD group at 79.5% (58 out of 73) and those in the PLHIV group at 69.1% (38 out of 55), indicating the majority satisfaction. Survey participants from the LGBTQI+ community supported the statement in 58.1% (25 out of 43) and the Group Other in 53.7% (22 out of 41). Respondents from the SW group had the lowest positive appraisal of 21.9% (7 out of 32), suggesting significant dissatisfaction among this group. These differences are supported by a significant p-value ($p<0.001$), indicating a clear association between the groups and the level of appreciation of the health care provided (Figure 34).

Figure 34. Opinions on whether the health care provided was of high quality



Health care safety

After analyzing the responses, 71.2% (200 out of 281[11]) of the respondents were satisfied with the safety of the care they received. About a quarter (25.3%, 71 out of 281) were neutral and 3.6% (10 out of 281) were not satisfied.

Disaggregating by groups and communities on satisfaction with the safety of health services received, the survey results showed that respondents from the TB group were the most satisfied (16 out of 18). The PWUD group followed with 85.3% (64 out of 75), and PLHIV group was 77.2% (44 out of 57) satisfied. Also indicating satisfied were 67.9% (38 out of 56) of participants from the LGBTQI+ community and 54.5% (24 out of 44) of the Group Other. SW group respondents were the least satisfied at 45.2% (14 of 31). The

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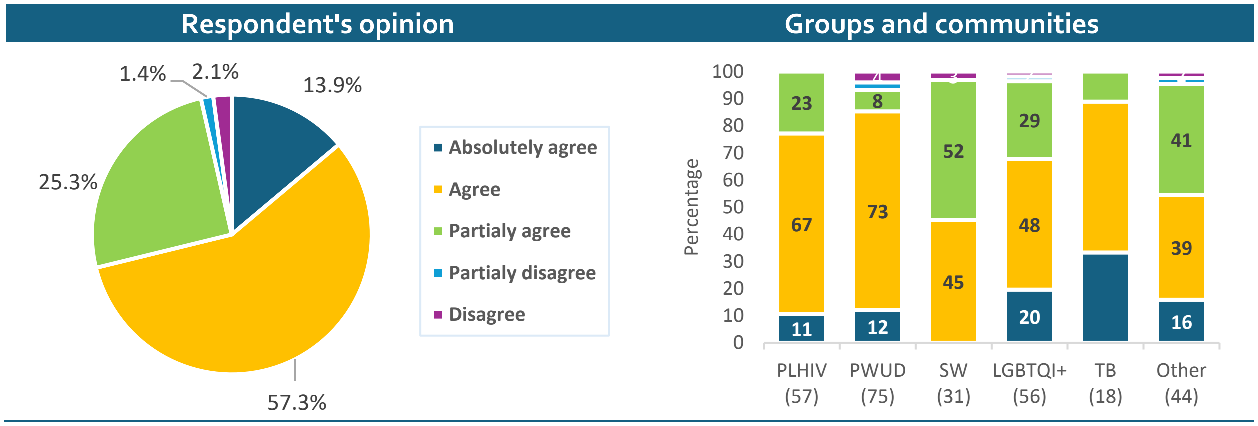
[11] No answer (19)

p-value<0.001, indicating strong statistical significance between groups and satisfaction with the safety of health services received (Figure 35).

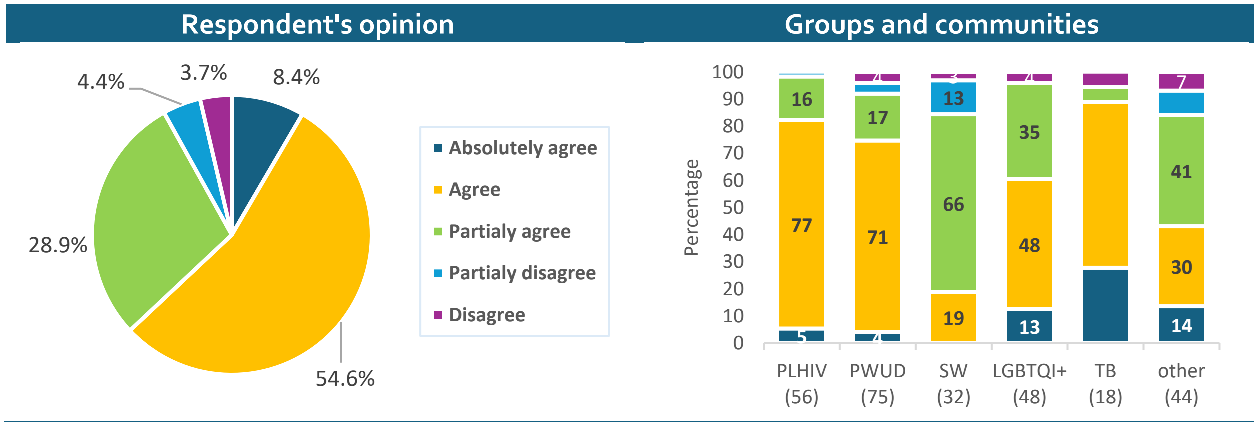
Figure 35. Perceptions on the safety of health care provided



Continuity of health care services

Perceptions of continuity of health care show that 63.0% (172 out of 273[12]) of respondents supported the statement that they were satisfied with the continuity of health care. In about one-third (28.9%, 79 out of 273) of the cases the participants were neutral and in 8.1% (22 out of 273) of the cases they did not support the statement (Figure 36).

Figure 36. Opinions on continuity of care



Most respondents from TB (16 out of 18), PLHIV (82.1%, 46 out of 56) and PWUD (74.7%, 56 out of 75) groups claimed that they were satisfied with the continuity of health care provided. Also, a significant percentage from the LGBTQI+ community (60.4%, 29 of 48) indicated satisfaction. Participants in the Other and SW groups were least satisfied, with 43.2% (19 of 44) and 18.8% (6 of 32), respectively. The p value, p<0.001, indicates statistically significant differences between groups in satisfaction with continuity of care (Figure 36).

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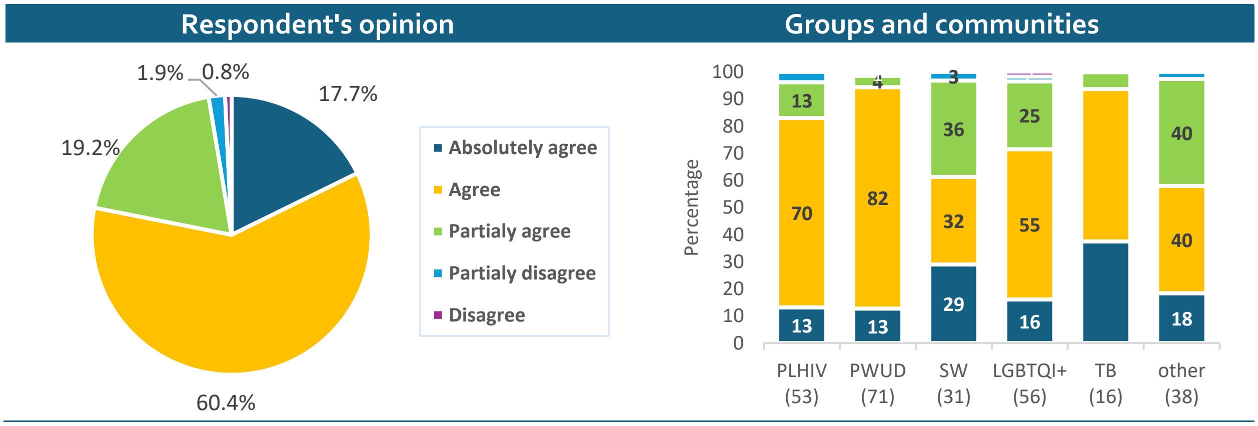
[12] No answer (27)

Referral system and cooperation on support services between health services and NGOs

The results of the survey showed that majority of respondents considered that there was an effective system of referral and cooperation between health services and NGOs on support services, with 78.1% (207 out of 265). About a fifth (19.2%, 51 out of 265) of the survey participants were neutral to this statement, while only 2.6% (7 out of 265) did not support it (Figure 37).

Specifically, the vast majority of PWUD group respondents (94.4%, 67 out of 71) and TB group respondents (15 out of 16) supported this statement. PLHIV and LGBTQI+ respondents considered the existence of a good system in 83.0% (44 out of 53) and 71.4% (40 out of 56) of cases, respectively. On the other hand, those in the SW (61.3%, 19 out of 31) and Other (57.9%, 22 out of 38) groups had the lowest percentages in this regard ($p < 0.001$).

Figure 37. Good referral system and cooperation between health services and NGOs on support services



HARM REDUCTION SERVICES

After analyzing the data collected, most of the study participants (55.0%, 164 out of 298[13]) considered themselves to be at risk of HIV, STI or viral hepatitis B and C. On the other hand, 35.9% (107 out of 298) did not consider themselves to be at risk. In addition, 9.0% (27 out of 298) of the respondents expressed uncertainty about these risks, indicating that they were not sure whether they were exposed.

Most respondents received information and support in HIV prevention and management. Thus, 91.5% (268 out of 293[14]) of respondents stated that they had discussed HIV with an NGO representative, *outreach* worker or *peer counselor*. In addition, the data analyzed demonstrates a high level of awareness of confidential testing possibilities for HIV, with 88.3% (256 out of 290[15]) of respondents indicating that they are aware of places where they can get confidential HIV testing.

With reference to the level of awareness and use of pre-exposure prophylaxis (PrEP), the majority (69.5%, 205 out of 295[16] the participants) indicated that they were familiar with PrEP for HIV. Regarding the use of PrEP, 15.6% (32 out of 205) of the respondents indicated that they had ever used this method of HIV prevention, including during their time in Moldova.

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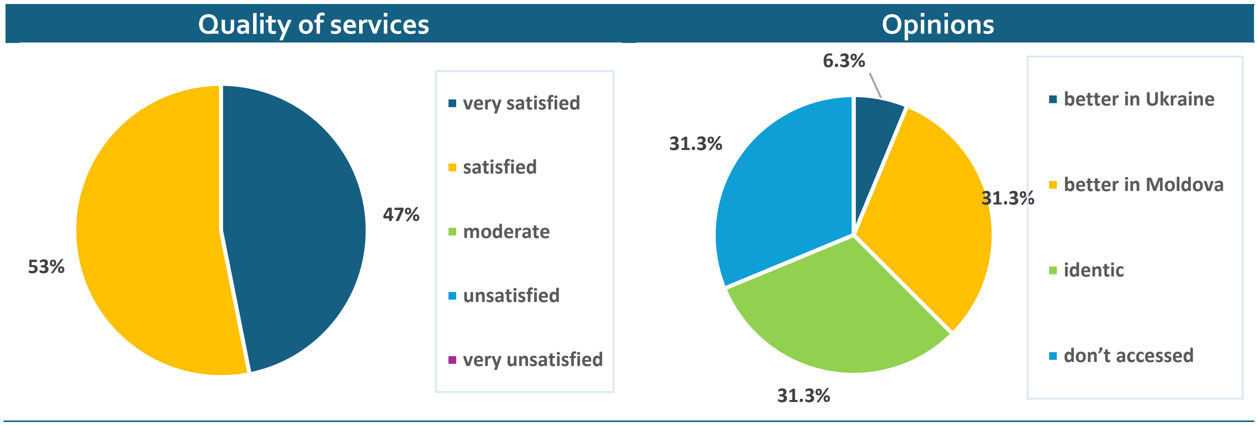
[13] No answer (2)
[14] No answer (7)
[15] No answer (10)
[16] No answer (5)

The survey participants who accessed PrEP services, in 53.1% (17 out of 32) of the cases were satisfied with the services offered in Moldova, while 46.9% (15 out of 32) were very satisfied. In terms of comparison with the services offered in Ukraine, 31.3% of the respondents considered the services in Moldova to be better (10 out of 32) or the same (10 out of 32). 6.3% (2 out of 32) of the participants considered the services in Ukraine to be better. Also, another 31.3% (10 out of 32) of the respondents indicated that they had not used such services in Ukraine and therefore could not compare them (Figure 38).

Figure 38. Respondents' satisfaction and perception of PrEP



In the same context of HIV prevention, the level of awareness and utilization of post-exposure prophylaxis (PEP) among the study population was also assessed. The data collected indicated that the majority (73.1%, 215 out of 294[17]) of the respondents mentioned that they were familiar with PEP for HIV. However, there is a significant segment, 26.9% (79 out of 294), who do not know about this prevention method. That they have ever used PEP, indicated 1.9% (4 out of 215) of the respondents.

The vast majority (94.7%, 284 out of 300) of the survey participants mentioned that they were aware of the existence of harm reduction services in Moldova, and in 87.7% (249 out of 284) of the cases they had accessed them. In context, the survey data allowed to analyze per service, both the knowledge of the existence of the service and its benefit or use (Figure 39):

- 96.1% (273 out of 284) of the respondents (96.1% out of 284) indicated that they were aware of the service for anonymous and voluntary testing for HIV, STI and hepatitis B, C. Of these, 71.7% (196 out of 273) accessed it.
- 40.1% (114 out of 284) of the respondents specified that they were aware of the existence of the free needle exchange service. 48.3% (44 out of 91) of the PWUDs had benefited from this service.
- Knowledge of the existence of information, education and communication (IEC, including training) services was mentioned in 70.8% (201 out of 284) cases and in 79.1% (159 out of 201) cases used them.
- 76.1% (216 out of 284) of the respondents indicated the existence of *free condoms*; 83.3% (180 out of 216) of those who indicated that they were aware of the existence of this type of service have used it.
- about the existence of the *peer-to-peer* service indicated that 56.7% (161 out of 284) of the respondents were aware of it and 52.2% (84 out of 161) of them had benefited from it.
- 39.4% of respondents (112 out of 284) specified existence of the service on opioid agonist treatment; 23.1% (21 out of 91) of PWUDs accessed it.

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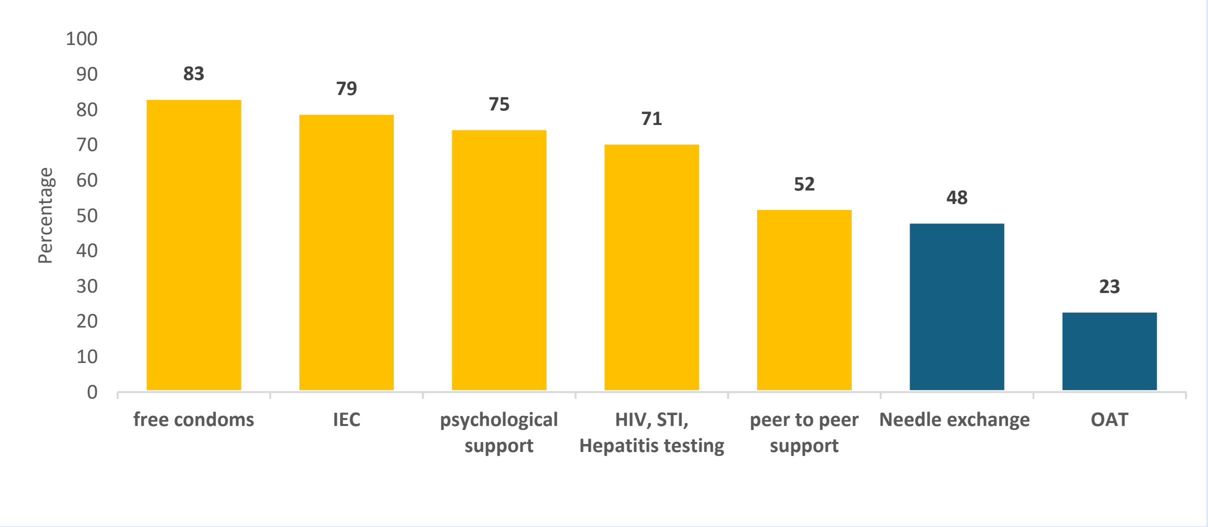
[17] No answer (6)

- indicated that 73.9% (210 out of 284) of the respondents were aware of the existence of the psychological counseling service and 74.8% (157 out of 210) of the respondents had benefited from this service.

Figure 39. Accessed harm reduction services



Analyzing data on the use of harm reduction services in Moldova by groups and communities provides a detailed insight into their preferences and needs (Figure 40).

Survey participants from the LGBTQI+ community who had used at least one harm reduction service (62) reported the highest use of free condoms, with 91.9% (57) of respondents taking advantage of this service. In addition, 87.1% (54) of them had participated in IEC activities, and 85.5% (53) had been tested for HIV, STIs and hepatitis B or C. In addition, 59.7% (37) of them had accessed psychological counseling, and 16.1% (10) had benefited from peer-to-peer services.

Respondents in the PLHIV group who accessed harm reduction services (49) indicated significant use of testing for HIV, STIs and hepatitis B and C (73.5%, 36), as well as free condoms (59.2%, 29). 53.1% (26) of them received counseling and 38.8% (19) accessed peer-to-peer services. In addition, 49.0% of respondents in this group participated in IEC activities (24). Syringe exchange services were accessed in 18.4% (9) cases, and treatment for drug addiction in 6.1% (3) cases, these were respondents from the mixed PLHIV and PWUD group.

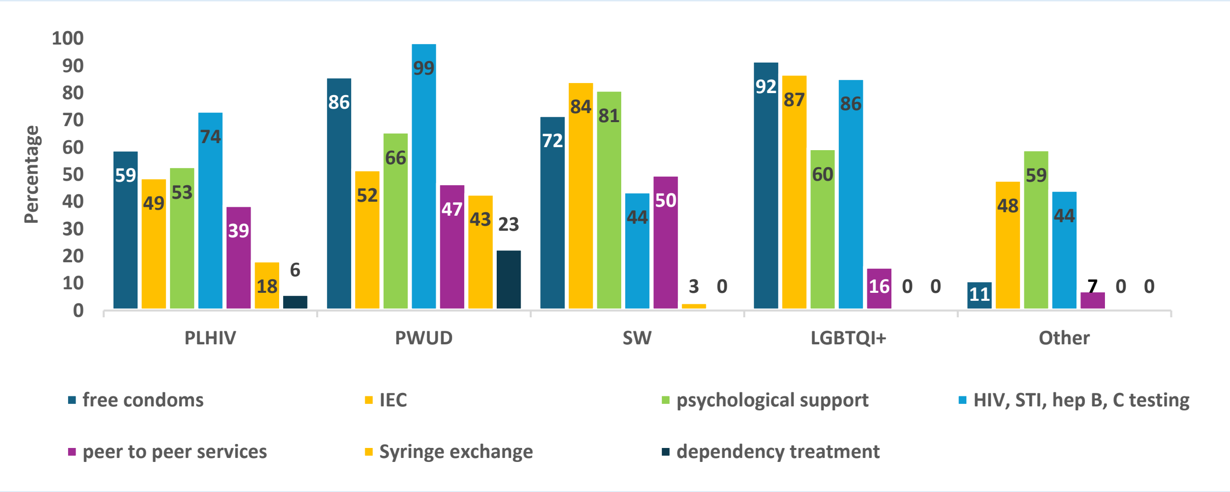
The PWUD group of harm reduction service clients (79) had the highest utilization rate of testing for HIV, STIs and hepatitis B and C, with 98.7% (78) of respondents accessing this service. In addition, 86.1% (68) of respondents received free condoms and 65.8% (52) accessed psychological counseling. In addition, 51.9% (41) of them participated in IEC activities, 46.8% (37) utilized peer-to-peer services, 44 utilized needle exchange services, and 21 received treatment for drug addiction.

Respondents from the SW group who accessed harm reduction services (32) reported a high uptake of IEC activities (84.4%, 27) and psychological counseling (81.2%, 26). 71.9% (23) of them received free condoms, 50.0% (16) accessed peer services, and in 43.8% (14) accessed testing for HIV, STI and hepatitis B and C. In 3.1% (1) cases they used needle exchange services (mixed SW and PWUD group).

The group Others who accessed harm reduction services (27) specified a lower utilization of harm reduction services: accessed psychological counseling (16), testing for HIV, STI and viral hepatitis B, C (12), participated in IEC activities (13), received free condoms (3), received peer services (2).

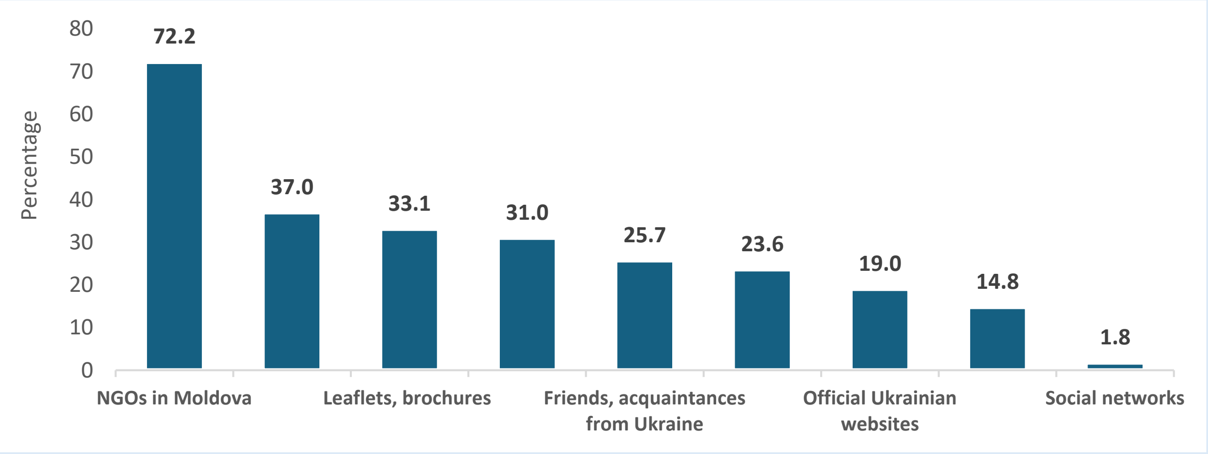
TB group respondents did not access any harm reduction services.

Figure 40. Harm reduction services by groups and communities



Respondents who indicated that they were aware of the existence of harm reduction services (284 people) were asked questions about the sources from which they learned about these services in Moldova. The most common source of information was NGOs in Moldova, with 72.2% (205) of respondents mentioning this source. Ukrainian NGOs were indicated by 37.0% (105) of participants. Friends and acquaintances from Moldova were a source of information for 31.0% (88) of respondents, while friends and acquaintances from Ukraine were mentioned by 25.7% (73). Leaflets and brochures were a source of information for 33.1% (94) of respondents. Moldovan official websites were mentioned in 23.6% (67) cases and Ukrainian official websites were mentioned in 19.0% (54) cases. Other refugees in Moldova were a source of information for 14.8% (42) of participants. Social networks were the least frequent source of information, being mentioned by only 1.8% (5) of respondents (Figure 41).

Figure 41. Sources of information on harm reduction services

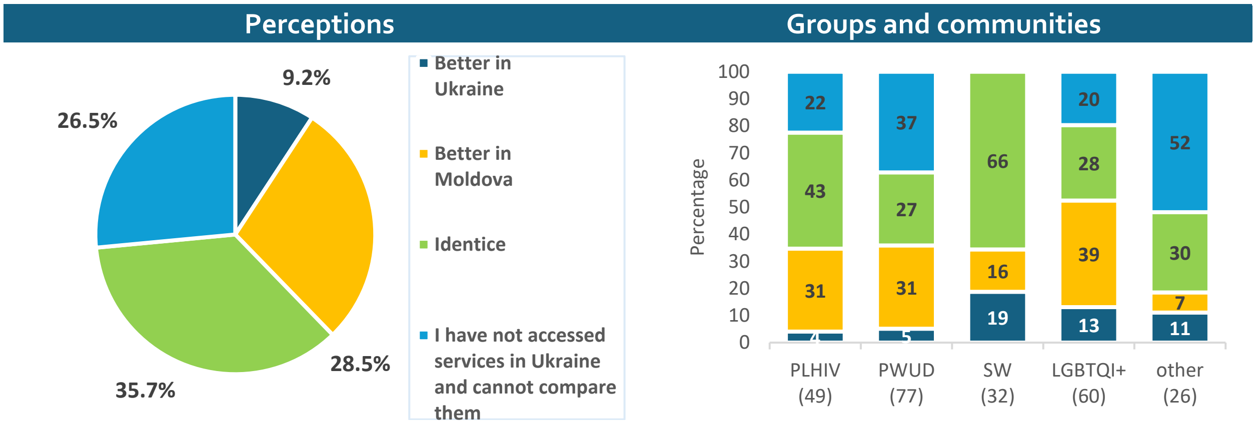


The survey participants who had used at least one harm reduction service in Moldova (249), more than one third (35.7%, 89) considered the services to be identical in both countries. On the other hand, 28.5% (71) rated the services in Moldova as higher quality than in Ukraine. Another 26.5% (66) of the respondents had not accessed services in Ukraine and therefore could not compare them. Finally, 9.2% (23) felt that services were better in Ukraine (Figure 42).

The analysis of data on perceptions of harm reduction services disaggregated by groups and communities showed that the share of those who rated services in Moldova as better ranged from 7.4% (Group Other) to 39.3% (LGBTQI+ community). In addition, PLHIV and PWUD group members rated services in Moldova as better in about one third of cases (30.6% and 30.8%), and SW group members in 15.6% of cases (Figure 42).

18.8% of SW, 13.1% of LGBTQI+, 11.1% of group Other, 5.1% of PWUD and 4.1% of PLHIV respondents felt that these services are better in Ukraine (Figure 42).

Figure 42. Perceptions on the use of harm reduction services



For those who specified that services are the same in both countries, the percentages ranged from 26.9% (PWUD group) to 65.6% (SW group). 42.9% of the PLHIV group respondents considered services to be the same, 27.9% of the LGBTQI+ group respondents considered services to be the same in 27.9% of cases, and 29.6% of the Group Other respondents considered services to be the same in 29.6% of cases.

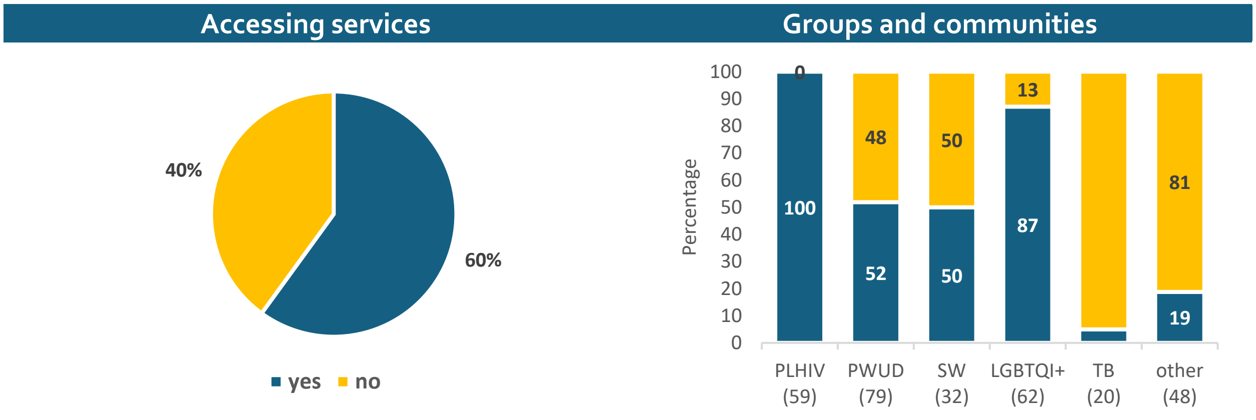
Respondents who mentioned that they have not accessed and cannot compare services in Ukraine ranged from 0.0% (SW group) to 51.9% (Group Other). Respondents from the PWUD group mentioned this in 37.2% of cases, those from the PLHIV group in 22.4% of cases, and those from the LGBTQI+ community in 19.7% of cases (Figure 42).

HIV INFECTION

The analysis of data on the utilization of HIV services in Moldova showed that most of the study participants accessed these services. Thus, in 60.0% (180 out of 300) cases respondents mentioned that they had accessed HIV-related services while in Moldova.

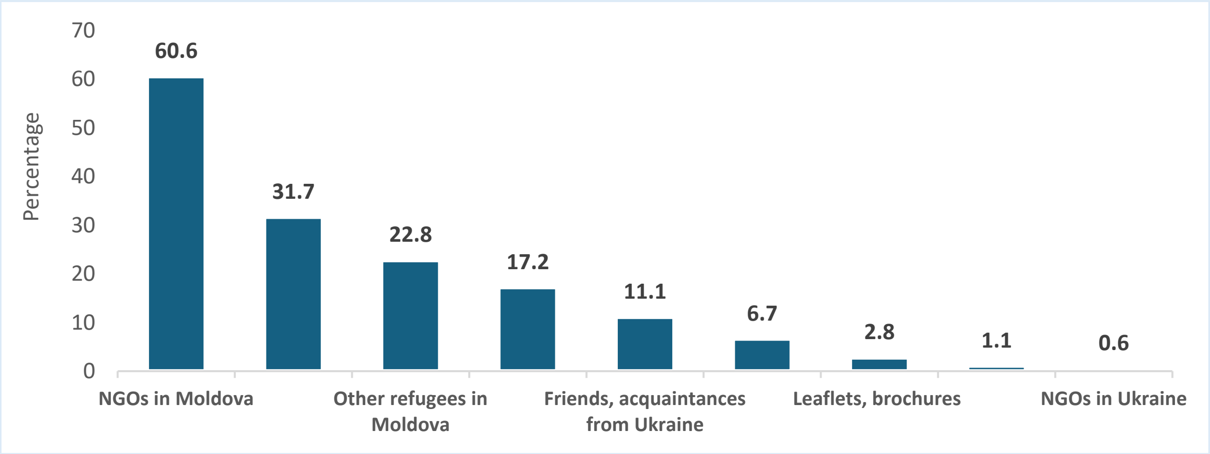
All respondents in the PLHIV group (100%, 59 out of 59) reported accessing HIV services, indicating universal awareness and utilization in this group. The LGBTQI+ community also reported high utilization of HIV services, with 87.1% (54 of 62) of respondents indicating accessing these services. In contrast, respondents in the PWUD and SW group accessed these services 51.9% (41 of 79) and 50.0% (16 of 32) respectively. Respondents from the Group Other accessed HIV services in 18.8% (9 out of 48) cases, and from the TB group, only one respondent accessed these services. The statistical analysis revealed a significant p-value ($p<0.001$), indicating a strong association between the groups and utilization of HIV services (Figure 43).

Figure 43. Access to HIV services, including disaggregation by groups and communities



According to the data collected, most respondents who accessed HIV services in Moldova (180) found out about these services through NGOs in Moldova, representing 60.6% (109) of the total. Social networks were another important source of information, with 31.7% (57) of respondents mentioning them. Other sources were other refugees in Moldova (22.8%, 41), friends and acquaintances in Moldova (17.2%, 31) and friends and acquaintances in Ukraine (11.1%, 20). Official websites in Moldova were used by 6.7% (12) of respondents, while official websites in Ukraine were a source of information for 1.1% (2) of respondents. Leaflets and brochures were mentioned in 2.8% (5) cases and Ukrainian NGOs in 0.6% (1) cases (Figure 44).

Figure 44. Sources of information on HIV services



In the context of the services accessed, most respondents (68.9%, 124 out of 180) accessed testing services, in about one-fifth (18.3%, 33 out of 180) of the cases, they accessed ARV treatment, and in 12.8% (23 out of 180) of the cases they accessed both testing and ARV treatment services.

HIV testing

To test for HIV, the overwhelming majority of participants (91.2%, 134 out of 147) used services offered by NGOs. A very small percentage of respondents turned to their family doctor (2.7%, 4 out of 147) or infectious disease doctor (2.7%, 4 out of 147). Centers for HIV confirmation and ARV treatment initiation were chosen in 2.0% (3 out of 147) of the cases, while private clinics were preferred by 1.4% (2 out of 147) of the participants

The reasons why respondents decided to test for HIV were diverse. In over half of the cases (54.5%, 78 out of 143[18]), respondents did so on their own initiative. Recommendations from doctors influenced a small percentage of respondents (3.5%, 5 out of 143), while recommendations from NGO staff were a determining factor for 42.0% (60 out of 143).

Pre-test counseling for HIV was provided to 63.9% (94 out of 147) of the respondents who accessed testing services. With reference to the information provided upon communication of the HIV test result, the majority of respondents (95.2%, 140 out of 147) specified that they were counseled, and the significance of the result was explained to them in addition to the communication of the result. A very small proportion (1.4%, 2 out of 147) were counseled without having the significance of the result explained to them, and 2.7% (4 out of 147) received only the test result without further explanation. Only 0.7% (1 out of 147) did not understand the significance of the result received.

In the survey, respondents were asked about payments for HIV testing. Of these, four participants (2.8%) mentioned that they had paid for this service, with amounts ranging from 400 to 500 lei, paid at private clinics.

Of the respondents who were tested for HIV infection (147), 2.7% (4) received a recommendation to follow PEP, while another 5.4% (8) mentioned that they did not receive such a recommendation because more than 72 hours had elapsed since HIV exposure, while 91.8% (135) did not require such treatment.

All four respondents who were recommended PEP specified that they had been exposed to HIV during sex. They were recommended PEP for 28 days, which they followed in Moldova.

ARV treatment

They accessed ART services in Moldova 56 of the respondents (or 94.9% of the PLHIV group). In 69.6% (39 out of 56) cases, ART was prescribed by the infection disease doctor from Ukraine, in 26.8% (15 out of 56) cases, it was prescribed by the infection disease doctor from Moldova, and in 3.6% (2 out of 56) the treatment was prescribed by a doctor from a country other than Ukraine or Moldova. Respondents initiated ART in the country where they were prescribed ART.

Study participants who initiated ARV treatment outside Moldova (41) were asked questions about treatment continuity while traveling to Moldova. Of these, eight respondents mentioned that they did not have the necessary number of pills to ensure their therapy during the transfer. Thus, one respondent did not have the necessary pills for less than one week, two respondents for more than two weeks, one respondent for more than three weeks and four respondents for more than one month. Respondents who started ARV treatment outside Moldova (41) were also asked whether they were prescribed the same treatment regimen in Moldova as they were before the transfer. The majority of respondents (78.0%, 32) indicated that they were offered the same treatment regimen, 17.1% (7) did not, and 4.9% (2) did not provide an answer.

Methods of picking up ARV treatment pills were diverse and, in some cases, mixed. In most cases, respondents (92.9%, 52 out of 56) mentioned that they personally picked up their ARV treatment pills from the ARV treatment center, in 5.4% (3 out of 56) cases they were picked up from the ARV treatment center by a family member or friend, and in 19.6% (11 out of 56) cases they were brought to their homes by NGO representatives.

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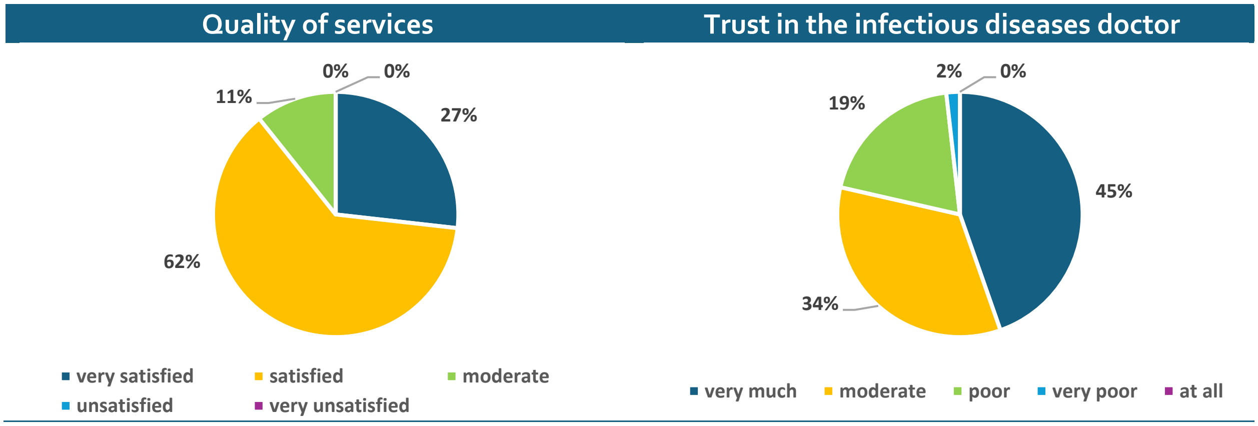
[18] No answer (4)

With reference to adverse effects following the administration of ARV drugs while in Moldova, these were mentioned by respondents in about one fifth of cases (19.6%, 11 out of 56). None of the respondents who experienced adverse effects mentioned having received any treatment for them.

They mentioned that they paid for the services of the infectious disease doctor five of the respondents, the amount paid per service was 100 lei and it was paid from their own financial sources directly to the infectious disease doctor.

Figure 45. Respondents' satisfaction with the HIV services accessed and trust in the infectious disease doctor

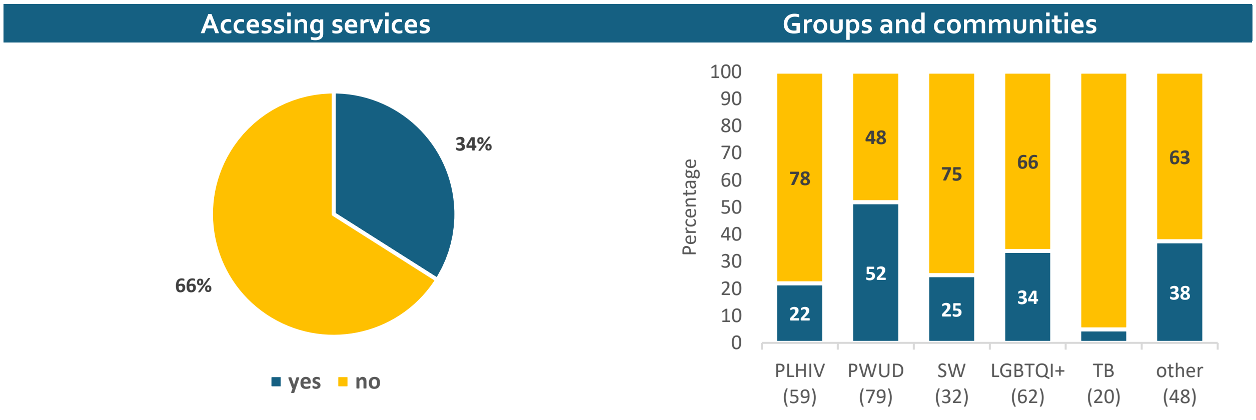


Regarding the respondents' satisfaction with the quality of HIV services in Moldova, the majority (62.5%, 35 out of 56) were satisfied with these services. A significant percentage (26.8%, 15 out of 56) were very satisfied, while 10.7% (6 out of 56) were moderately satisfied. The majority of respondents (44.6%, 25 out of 56) expressed full trust in infectious diseases physicians in Moldova, while 33.9% (19 out of 56) said they had a lot of trust. In addition, 19.6% (11 out of 56) remained neutral, and in 1.8% (1 out of 56) cases they said they had little trust (Figure 45).

VIRAL HEPATITIS B AND C

More than a third (34.0%, 102 out of 300) of study participants accessed services for viral hepatitis (B, C). Depending on the groups and communities, the analyzed results showed that 51.9% (41 out of 79) of the PWUD group respondents indicated that they had accessed such services. Among the Group Other, this percentage was 37.5% (18 out of 48), and among those from the LGBTQI+ community 33.9% (21 out of 62). Also accessing these services were 25.0% (8 out of 32) of respondents in the SW group and 22.0% (13 out of 59) of those in the PLHIV group. Only one TB group respondent accessed such services. Statistical analysis revealed a significant difference between groups in accessing services for viral hepatitis B, C ($p<0.001$, Figure 46).

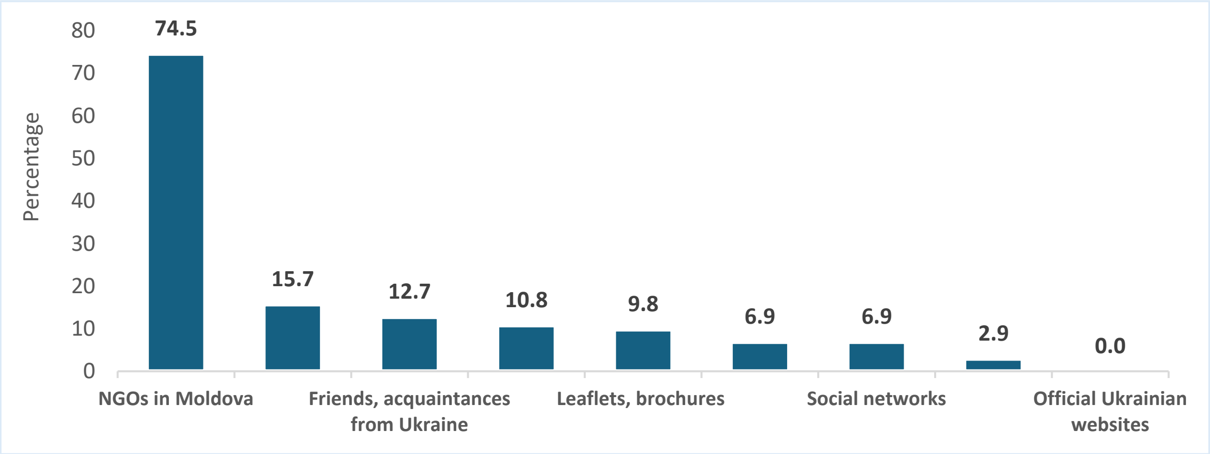
Figure 46. Access to services on viral hepatitis B, C, including disaggregation by groups and communities



In the survey, respondents were asked where they found information on how and where to access services on viral hepatitis (B, C). The results showed that most respondents, 74.5% (76 out of 102), mentioned Moldovan NGOs as their main source of information. Other refugees in Moldova were indicated by 15.7% (16 out of 102) of the respondents, while friends and acquaintances in Ukraine were the source of information in 12.7% (13 out of 102) of the cases (Figure 47).

Friends and acquaintances in Moldova were mentioned in 10.8% (11 out of 102) cases, leaflets and brochures were the source of information in 9.8% (10 out of 102) cases, and official Moldovan websites and social networks were each mentioned by 6.9% (7 out of 102) of respondents. Ukrainian NGOs were mentioned by 2.9% (3 out of 102) of the respondents, while official Ukrainian websites were not mentioned by any respondent (Figure 47).

Figure 47. Sources of information on services for viral hepatitis B, C



With reference to testing for hepatitis B or C while in Moldova, the results showed that the majority (89.2%, 91 out of 102) of those who accessed such services had both tests. In 7.8% (8 out of 102) cases, they only tested for hepatitis B, and in 2.9% (3 out of 102) cases they only tested for hepatitis C. In addition, respondents mentioned that they did not pay for the tests, which were offered free of charge.

Analyzing the results according to groups and communities, it was found that all of the PLHIV group (13 out of 13) and 95.1% (39 out of 41) of the PWUD group performed both tests. Among the LGBTQI+ community, 18 out of 21 respondents performed both tests, in the Group Other 15 out of 18, and in the SW group 6 out of 8. Only two respondents from the SW and PWUD group, one from the LGBTQI+

community and three from the Group Other tested for hepatitis B. As for the hepatitis C test, it was performed by two respondents from the LGBTQI+ community and one from the TB group.

Survey participants were asked about their hepatitis B vaccination status. Thus, 9.4% (9 out of 96[19]) of the respondents indicated that they were vaccinated, 76.0% (73 out of 96) indicated that they were not vaccinated, and 14.6% (14 out of 96) stated that they did not know whether they had been vaccinated or not.

The study also assessed the location of hepatitis B or C diagnosis among study participants. In this regard, they indicated that they were diagnosed in Moldova for hepatitis B in 5.9% (6 out of 102) cases and for hepatitis C in 7.8% (8 out of 102) cases. In addition, some of the respondents indicated that they had already been diagnosed in Ukraine for hepatitis B in 9.8% (10 out of 102) cases and in 7.8% (8 out of 102) cases for hepatitis C. Also, one of the participants stated that he had been diagnosed with hepatitis B in another country.

Respondents with a diagnosis of hepatitis B and/or C were asked whether any doctor (infectious disease specialist or hepatologist) in Moldova prescribed them for the disease. The results showed that in 12.1% (4 out of 33) cases, they were prescribed treatment for hepatitis B, in 15.2% (5 out of 33) for hepatitis C, and in 6.1% (2 out of 33) for both hepatitis B and C.

Regarding hepatitis B treatment, six of the respondents continued treatment started in Ukraine, one continued treatment started in another country and one started treatment in Moldova. Those who started treatment in Ukraine or in another country mentioned that they had the necessary pills with them during the transfer to Moldova, so they did not have any interruptions in treatment.

In order to continue their hepatitis B treatment, five of the respondents who started treatment in Ukraine, or another country had the complete set of drugs with them. Three of the respondents had received the drugs free of charge in Moldova, one mentioned that he had procured the full set of drugs, and two others did not initiate treatment.

Regarding hepatitis C treatment, four of the respondents continued the treatment started in Ukraine and two started it in Moldova. Only one respondent who started treatment in Ukraine had an interruption of 21 days during the transfer to Moldova due to lack of necessary medication, after which he procured it from Moldova. The other three had all the necessary pills with them for the entire duration of treatment. Two of the respondents who started hepatitis C treatment in Moldova procured their set of medicines. In addition, five of the respondents diagnosed with hepatitis C in Moldova did not initiate treatment, two due to lack of necessary documentation and three for financial reasons.

Four of the respondents who indicated that they purchased their set of medicines for the treatment of viral hepatitis B or C indicated different sources of funding: they used their own money (4), borrowed money (3) or paid from refugee financial support (3).

Of the 102 respondents who accessed at least one service for the treatment of viral hepatitis B or C, 88.2% (90) expressed their opinion on the quality of these services. The majority, 59.0% (53 out of 90), were satisfied with the quality of services and 13.1% (12 out of 90) were very satisfied. Some 19.7% (18 out of 90) had a neutral opinion, while 6.6% (6 out of 90) were dissatisfied and 1.6% (1 out of 90) very dissatisfied (Figure 48).

Opinions on the quality of health services for viral hepatitis B and C varied according to respondents' individual experiences. About one-fifth of respondents (20.9%, 19 out of 90) rated services in Moldova as better than in Ukraine, while 4.9% (4 out of 90) considered services in Ukraine to be superior. Also, 43.2%

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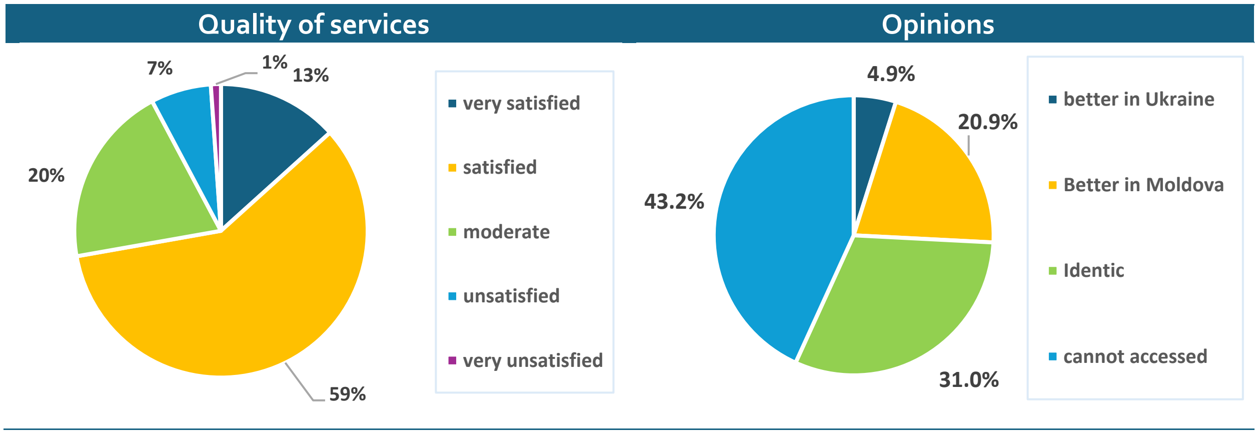
[19] No answer (6)

(39 out of 90) of the respondents mentioned that they had not used services in Ukraine and therefore could not compare them. In addition, 31.0% (28 out of 90) considered the services to be identical in both countries (Figure 48).

Figure 48. Respondents' satisfaction and perception of services accessed in relation to viral hepatitis B, C



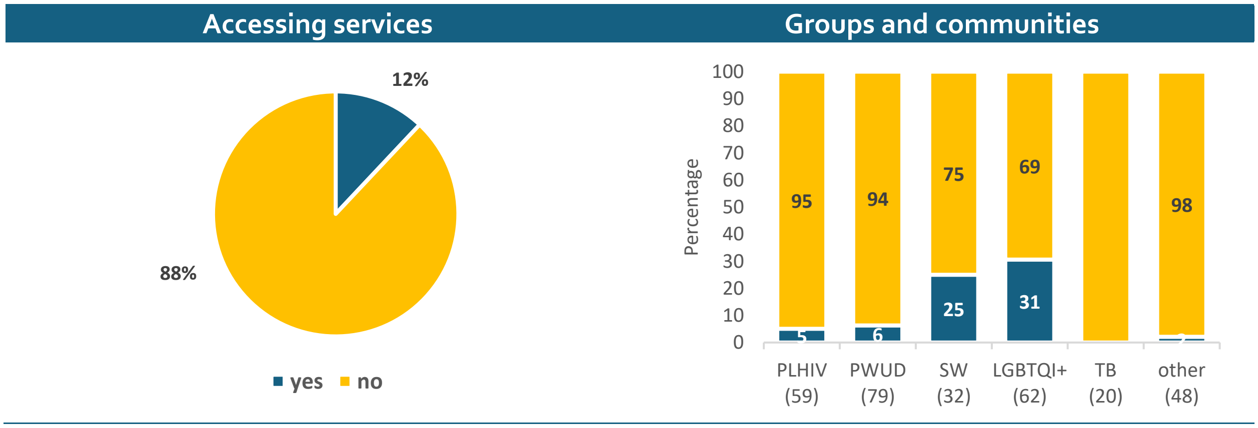
Quality of services

Opinions

SEXUALLY TRANSMITTED INFECTIONS

Of the 300 survey participants, 12.0% (36) accessed STI services. Of the groups surveyed, the highest percentage of respondents who accessed STI services were in the LGBTQI+ community at 30.6% (19 of 62). These were followed by respondents from the SW group at 25.0% (8 out of 32), and the PWUD group at 6.3% (5 out of 79). Those in the PLHIV group accessed STI services in 5.1% (3 out of 59) of cases, and those in the Group Other in 2.1% (1 out of 48) of cases. No respondents in the TB group accessed these services. Statistical analysis revealed a significant p-value (p<0.001), indicating significant differences between groups in accessing STI services (Figure 49).

Figure 49. Access to STI services disaggregated by groups and communities



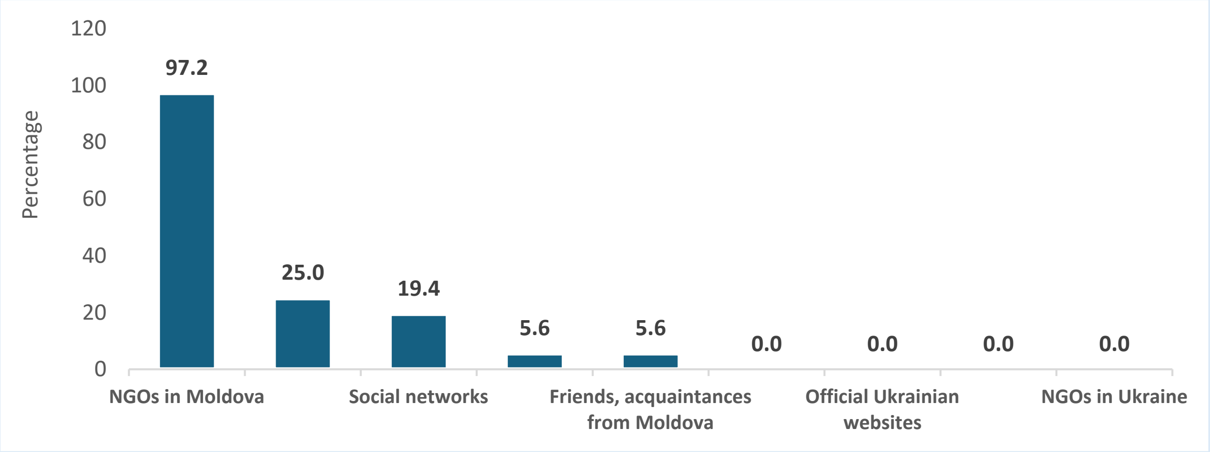
Accessing services

Groups and communities

In the most frequent cases, Moldovan NGOs were the main source of information on STI services, mentioned by 97.2% (35 out of 36) of the participants. Other refugees in Moldova were a source of information for 25.0% (9 out of 36) of respondents. Social networks were mentioned by 19.4% (7 out of 36) of respondents. Leaflets and brochures, as well as friends and acquaintances in Moldova, were each source of information for 5.6% (2 out of 36) of respondents. In contrast, official websites in Moldova and

Ukraine, friends and acquaintances in Ukraine, and NGOs in Ukraine were not mentioned by any of the respondents (Figure 50).

Figure 50. Sources of information on sexually transmitted infections services



Most survey participants who accessed STI health services turned to NGOs. According to the data, 77.8% (28 out of 36) of the respondents indicated that they accessed services offered by NGOs in Moldova. In a quarter of the cases (25.0%, 9 out of 36), they also turned to state institutions such as polyclinics or hospitals. In 13.9% (5 out of 36) of cases, respondents accessed such services in private clinics.

Of the respondents who accessed STI services, 66.7% (24 out of 36) mentioned that they were prescribed treatment for STIs, which they received in Moldova. Only one respondent who received STI treatment was hospitalized, the others received the prescribed treatment on an outpatient basis.

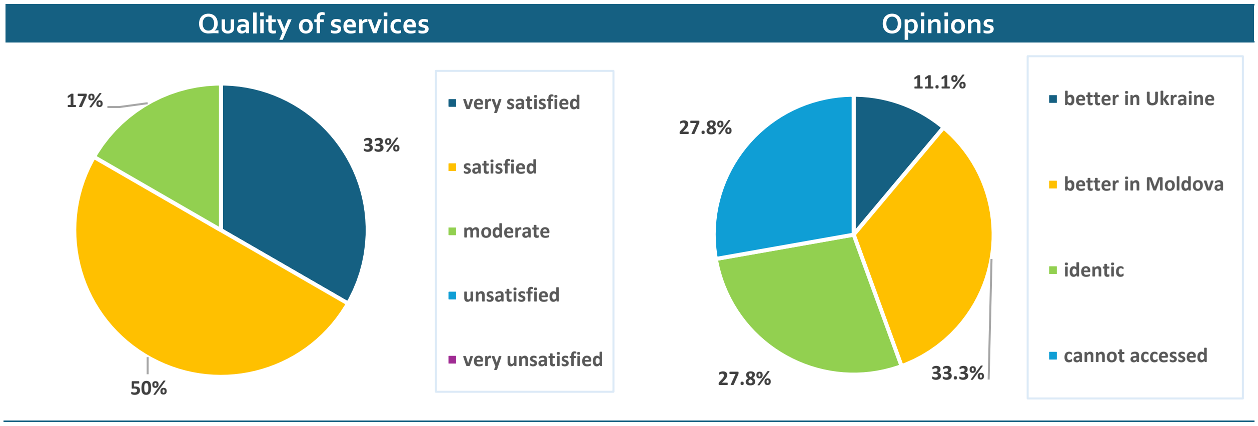
Five of the respondents mentioned that they paid for health services related to STIs (tests and treatment), the amounts ranged from 1000 to 4500 lei, which were paid at private clinics. One respondent mentioned that he paid 400 lei directly to the medical staff. For 13 of the respondents who received treatment for STIs in Moldova, treatment expenses were paid by NGOs. Six others purchased their prescribed drugs from pharmacies.

In context, expenditure incurred for STI-related health services was covered by own financial sources (5), loans (3), financial support provided to refugees (5) or help from friends (1).

Survey participants' level of satisfaction with the quality of STI health services provided in Moldova varied. Most respondents were satisfied or very satisfied with the services they received. According to the data, 50.0% (18 out of 36) of the respondents were satisfied and 33.3% (12 out of 36) were very satisfied. 16.7% (6 out of 36) had a neutral opinion. No respondents were dissatisfied or very dissatisfied with the quality of health services received in Moldova (Figure 51).

Survey participants had varied opinions on STI-related health services offered in Moldova compared to those in Ukraine. According to the data, 33.3% (12 out of 36) of the respondents considered the services in Moldova to be better than those in Ukraine, and in 1.1% (4 out of 36) cases they considered the services in Ukraine to be superior. Some 27.8% (10 out of 36) rated the services as identical in both countries, and in 27.8% (10 out of 36) cases, respondents had not accessed services in Ukraine and therefore could not compare them (Figure 51).

Figure 51. Respondents' satisfaction and perception of health services accessed in relation to sexually transmitted infections



DRUG ADDICTION

One third of the study participants (30.3%, 91 out of 300) indicated that they had ever used drugs (injectable or non-injectable). Respondents who indicated drug use were representatives of the PWUD group (86.8%, 79) and the PLHIV group (13.2%, 12).

A considerable proportion of respondents had a long period of drug use (injecting or non-injecting). Thus, most of the respondents (44.0%, 40 out of 91) mentioned that they had been using drugs for 5-10 years. Also, a significant proportion (26.4%, 24 out of 91) reported using drugs for more than 15 years, while 17.6% (16 out of 91) reported using drugs for 2-4 years. In 8.8% (8 out of 91) cases, they indicated a duration of 11-14 years, and in 3.3% (3 out of 91) they reported use for 1 year.

Regarding the used drugs, 63.7% (58 out of 91) of the respondents stated that they had used non-injecting drugs, including during their stay in Moldova. 56.0% (51 out of 91) of the respondents said that they had ever injected drugs and 49 of them continued to inject drugs, including during their stay in Moldova. In addition, 12 of the respondents who indicated either injecting or non-injecting drug use specified that they had stopped injecting drugs since their stay in Moldova.

A significant proportion of PWID, namely 73.5% (36 out of 49), stated that they had used injecting drugs in the last 30 days. In addition, 10.2% (5 out of 49) reported injecting in the last 6 months and 16.3% (8 out of 49) indicated that they had injected drugs more than a year ago.

The majority of non-injectable substances used in the last 6 months were cannabis, marijuana and hashish at 95%. Other notable substances included amphetamines (55%), new psychoactive substances in powder, crystal or tablet form (60%) and Ecstasy (26%). In terms of injecting drug use, poppy derivatives (shirach) were the most used, with 59%. Other commonly used injecting substances included amphetamines (34%), new psychoactive substances in liquid form (46%) and methamphetamines (29%) (Table 2).

Table 2. Injecting and non-injecting substance use in the last 6 months

Substance name	Consumption non-injectable last 6 months, n (%)	Consumption by injection last 6 months, n (%)
Total	**58**	**41**
Cannabis, marijuana, hashish	55 (94.8)	-
Heroin	3 (5.2)	4 (9.8)
Cocaine	6 (10.3)	2 (4.9)
Amphetamine	32 (55.2)	14 (34.1)
Methamphetamine (VINT)	-	12 (29.3)
Ecstasy (MDMA, MDA)	15 (25.9)	-
Hallucinogenic mushrooms, mescaline	2 (3.4)	-
Ketamine	-	3 (7.3)
Hallucinogenic substance (Lysergic Acid Diethylamide, LSD)	12 (20.7)	-
Derived from poppy	-	24 (58.5)
Dezomorphine, tropicamid	-	-
Methadone, Buprenorphine, Fentanyl, Subutex (illicit)	6 (10.3)	10 (24.4)
Promedol, Phenobarbital, Amobarbital, Tramadol, Morphine, Codeine, Ephedrine, Omnopon, Dimedrol, Amitriptyline, Tranquilizers	11 (19.0)	2 (4.9)
Diazepam, Alprazolam, Rivotril, Clonazepam, Krestin	13 (22.4)	2 (4.9)
Gamma-Hydroxybutyrate (GHB) Gamma-Butyrolactone (GBL)	2 (3.4)	-
NSP in the form of mixtures of smoking herbs with drug-like effects (*chimari, ethnobotanicals, spice, chamomile, rose*)	15 (25.9)	-
NSP in the form of powders, crystals, tablets with drug-like effects (*mephedrone, pentedron, alpha-PVP, salts*)	35 (60.3)	12 (29.3)
NSP in liquid form with drug-like effects	8 (13.8)	19 (46.3)
Other substances (not specified)	14 (24.1)	-

All 41 participants (100%) who indicated injecting substance use in the last 30 days or last 6 months indicated the use of sterile syringes and needles. However, according to the data, 48.7% (20 out of 41) of the respondents indicated that they occasionally used[20] and reused equipment. Also, 43.9% (18 out of 41) indicated that they were injected by someone or injected themselves with pre-filled syringes, without seeing how these syringes were loaded. In addition, 39.0% (16 out of 41) of respondents specified that they had given other people syringes with a dose but without a needle to inject themselves, and that they had occasionally given[21] other people used syringes or needles.

Most respondents (83.7%, 41 out of 49) who indicated injecting drug use mentioned that they know where or from whom they can get new and unused syringes in Moldova. In addition, 83.7% (41 out of 49) of them stated that they can get new and unused syringes when they need them, and 81.6% (40 out of 49) stated that they can get new and unused syringes in the right quantity when they need them. In terms of free access to syringes, 81.6% (40 out of 49) of respondents indicated that they received syringes free of charge.

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[20] In 1%-24% of cases

[21] In 1%-24% of cases

Injecting drug user respondents indicated that they obtained new syringes and needles in Moldova through various sources. The majority (79.6%, 39 out of 49) had benefited from needle exchange programs, while 65.3% (32 out of 49) had purchased them from pharmacies. Also, 40.8% (20 out of 49) received syringes and needles from friends. A smaller number of respondents mentioned other sources: 14.3% (7 out of 49) obtained syringes and needles from medical workers outside medical institutions and 18.4% (9 out of 49) from other drug users. Sexual partners were mentioned by 12.2% (6 out of 49) of respondents, while 4.1% (2 out of 49) obtained new syringes and needles from drug dealers or through street purchases.

The main source of obtaining new syringes and needles in Moldova was the syringe exchange program, used by 68.3% (33 out of 49) of respondents. In addition, 25.0% (12 out of 49) of respondents purchased them in pharmacies. Friends were mentioned as a primary source by 3.7% (2 out of 49) of respondents and sexual partners by 3.0% (1 out of 49) of respondents.

While in Moldova, nine of the respondents specified that they had overdosed to the point of unconsciousness, and eight of them mentioned that they had used *Naloxone* to treat their overdose.

During the time they were on the territory of Moldova, 19.0% (16 out of 84[22]) of the respondents who indicated that they had ever used drugs (injecting or non-injecting) specified that they had sought for consultations with an addiction specialist (narcologist).

According to the data, in 18.7% (17 out of 91) cases, respondents indicated that they are registered with an addiction specialist in Ukraine, and in 6.6% (6 out of 91) cases that they are registered with such a specialist in Moldova. Also, 5.5% (5 out of 91) of the respondents indicated that they are registered with an addiction specialist in both Ukraine and Moldova

The survey highlighted the diversity of respondents' experiences with drug addiction treatment. Thus, according to the data, 25.6% (21 out of 82[23]) of the respondents reported at the time of the interview that they are currently receiving treatment in Moldova to stop drug use. In addition, in 40.2% (33 out of 82) of the cases they reported that they had been in treatment in the past but are currently no longer in treatment. On the other hand, 37.8% (31 out of 82) of the respondents stated that they have never received any treatment to stop drug use.

In the same context, respondents specified that they had received various services to stop drug use. According to the data, 5.5% (5 out of 91) of the respondents indicated receiving outpatient treatment, while 37.4% (34 out of 91) indicated receiving consultations from addiction specialists (therapist or narcologist). Support groups were mentioned by 6.6% (6 out of 91) of the respondents, and in 23.1% (21 out of 91) cases, they mentioned Methadone or Buprenorphine therapy. Also, 5.5% (5 out of 91) of the respondents confirmed that they had received rehabilitation services in specialized centers.

Two of the respondents indicated payments for treatment of drug addiction (anonymous detoxification) in the amount of 10000 and 5000 lei, which they paid officially in the hospital where they received treatment, paid from their own money, including from the financial aid for refugees received in Moldova.

The survey data reflect a generally positive perception of the quality of drug addiction services in Moldova. In this regard, 53 respondents gave their opinion. In one third of the cases (30.3%, 16) respondents were very satisfied, and in more than half of the cases (54.5%, 29) they were satisfied with these services. A smaller percentage, 15.2% (8), indicated that they were moderately satisfied, i.e. neither satisfied nor dissatisfied (Figure 52).

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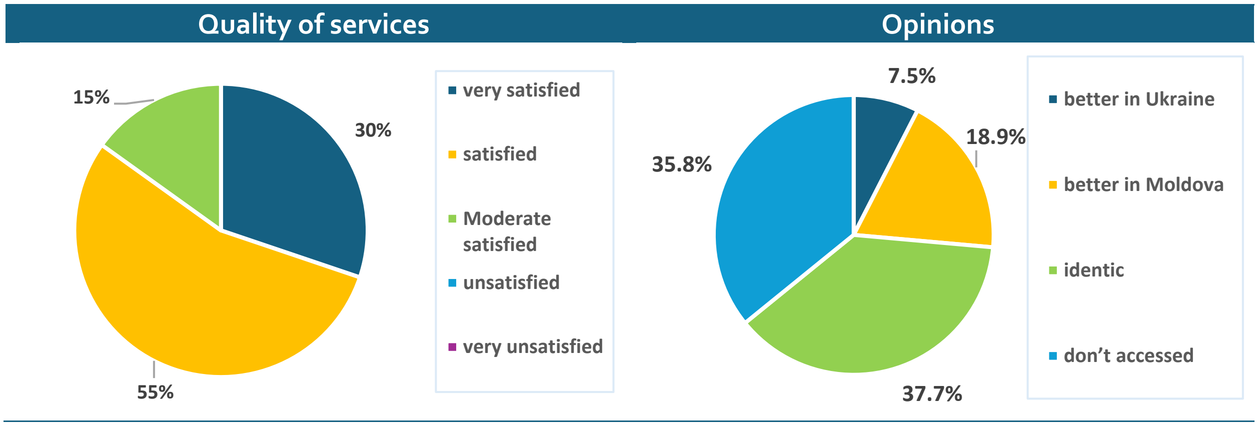
[22] No answer (7)

[23] No answer (9)

Respondents' views on the drug addiction services offered in Moldova and Ukraine varied. In 7.5% (4 out of 53) of the cases, they thought that services were better in Ukraine, while 18.9% (10 out of 53) of the respondents said that services were better in Moldova. A significant percentage, 37.7% (20 out of 53), stated that services are the same in both countries. Also, 35.8% (19 out of 53) of the respondents mentioned that they had not used the services in Ukraine and therefore could not compare them (Figure 52).

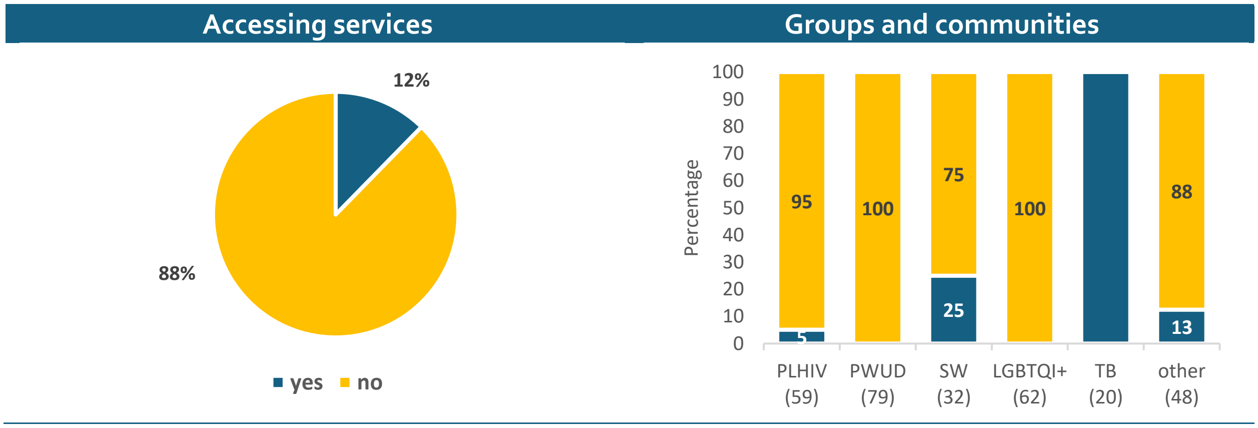
Figure 52. Respondents' satisfaction and perception of drug dependence services accessed



TUBERCULOSIS

Of the total of 300 respondents, 12.3% (37) mentioned that they had accessed TB health services. Depending on groups and communities, all TB group participants (20 out of 20) had accessed these services. A quarter of those in the SW group (25.0%, 8 out of 32) and 12.5% (6 out of 48) in the Group Other also accessed such services. No respondents from the PWUD group and the LGBTQI+ community accessed such a service. Statistical analysis revealed a significant association between groups and TB health service access (p<0.001) (Figure 53).

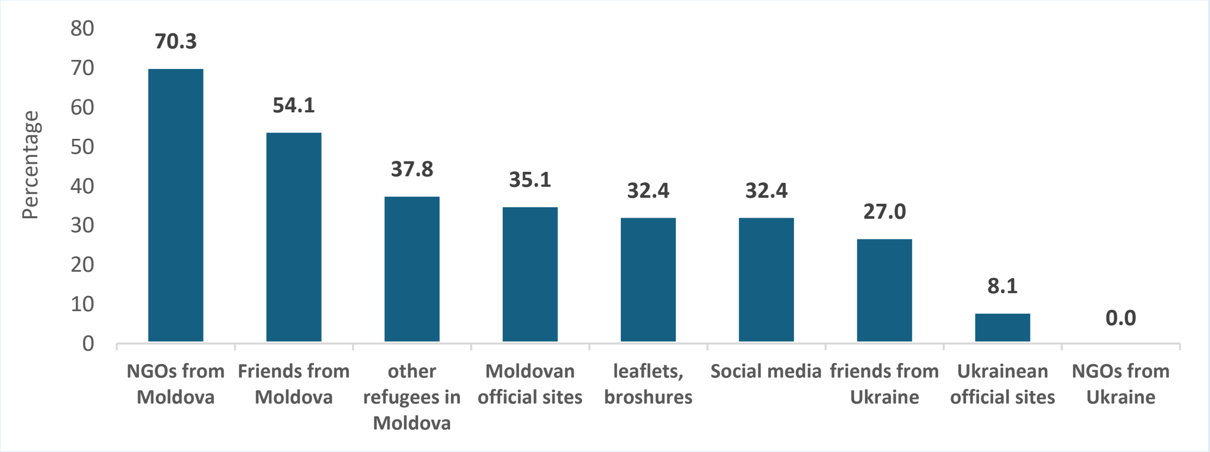
Figure 53. Access to tuberculosis health services disaggregated by groups and communities



In the survey, participants were asked how they found out about how and where to seek assistance for TB health services. Thus, NGOs in Moldova played a crucial role in informing participants, with 70.3% (26 out of 37) of the participants mentioning that they found out about these services through these organizations. Friends and acquaintances in Moldova were an important source of information for 54.1%

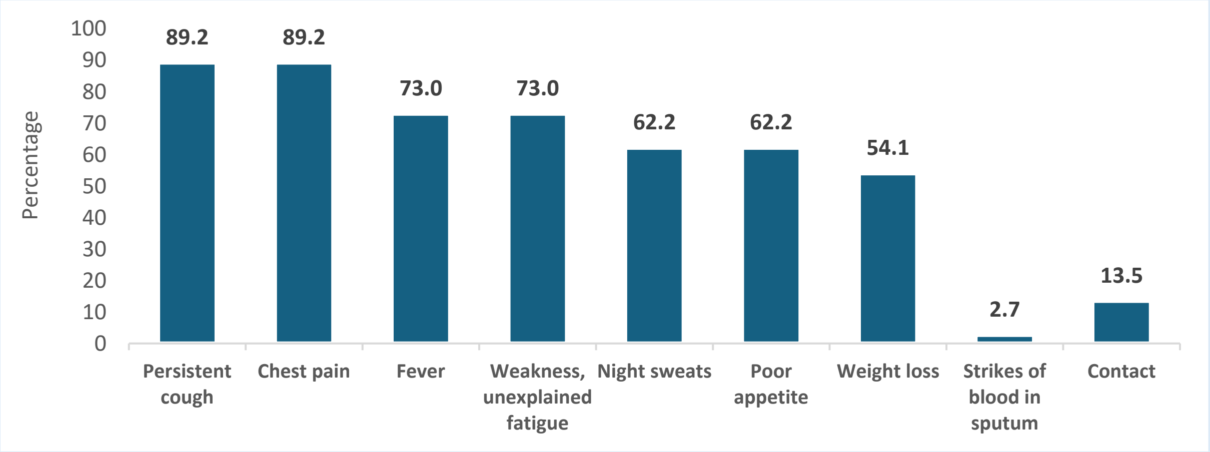
(20 out of 37) of respondents. Other refugees living in Moldova provided useful information in 37.8% (14 out of 37) cases, official Moldovan websites in 35.1% (13 out of 37) cases, and in 32.4% (12 out of 37) cases respondents mentioned that they found the necessary information from leaflets and brochures or used social networks. They received information from friends and acquaintances in Ukraine in 27.0% (10 out of 37) cases, while 8.1% (3 out of 37) of the respondents accessed official Ukrainian websites. No respondent mentioned Ukrainian NGOs as a source of information (Figure 54).

Figure 54. Sources of information on tuberculosis health services



With reference to the symptoms that prompted study participants to seek medical attention, the majority (89.2%, 33 out of 37), mentioned that permanent cough and chest pain were the main reasons for seeking TB health services. High body temperature and unmotivated weakness or tiredness were reported by 73.0% (27 out of 37) of the participants. Night sweats and reduced appetite were mentioned in 62.2% (23 out of 37) cases, and weight loss was an important symptom for 54.1% (20 out of 37) of respondents. In 2.7% (1 out of 37) cases, participants mentioned the presence of streaks of blood in the sputum during coughing. In addition, in 13.5% (5 out of 37) cases, respondents accessed TB services by being in contact with other people suffering from TB (Figure 55).

Figure 55. Symptoms of tuberculosis



The study assessed the time from the onset of the first characteristic TB symptoms until participants sought medical services. Thus, in more than half (54.1%, 20 out of 37) of the cases, respondents reported that they waited between 2 and 3 weeks before seeking medical care. In about a third (27.0%, 10 out of

37) of the cases they sought medical care within a week of the onset of symptoms. A smaller number of respondents, 16.2% (6 out of 37), waited more than 3 weeks before seeking medical help, and 2.7% (1 out of 37) said they waited between 1 and 2 weeks. Reasons for seeking care in more than 3 weeks were fear of investigations and tests (3) and not knowing where to access them (3).

In most cases (91.9%, 34 out of 37) respondents indicated that they sought TB care in state institutions (polyclinic or hospital). In 13.5% (5 out of 37) cases, they mentioned that they turned to NGOs for support in accessing services, and in 5.4% (2 out of 37) cases, they turned to private clinics. They paid for the services, two of the respondents (those who turned to private clinics) and who incurred expenses between 250 and 2000 lei, the payments were made in the hospital billing office from their own financial sources.

The diagnosis of TB was confirmed in 54.1% (20 out of 37) of the cases. Respondents mentioned that they found out their diagnosis within 1-3 days after TB investigations. Of these, 15 were diagnosed with susceptible TB and five with resistant TB. All respondents were hospitalized in specialized inpatient facilities to follow the initial phase of their prescribed antituberculosis treatment. Respondents indicated that they followed their treatment under directly observed treatment (DOT), being supervised by nurses both during hospitalization and outpatient periods. They also went daily to the treatment points (TB cabinets) to pick up their pills, none of the respondents mentioned the use of Video *Supported* Treatment (*VST*) program during their outpatient treatment.

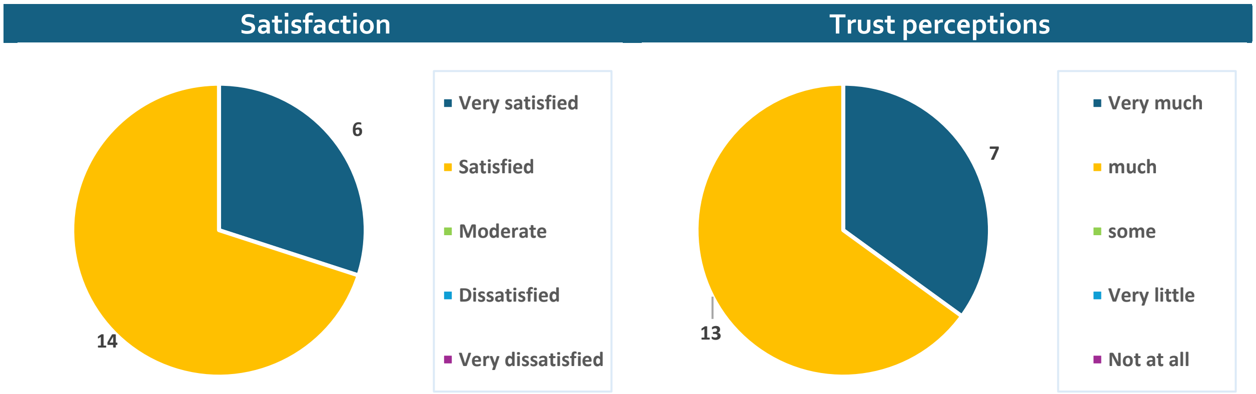
Participants were asked if they experienced any of the side effects during TB treatment. Thus, they mentioned experiencing nausea (20 out of 20), headache (15 out of 20), diarrhea and gastric pain (12 out of 20), muscle or joint pain (11 out of 20), vomiting (8 out of 20), feeling depressed (6 out of 20), skin rash and pruritus (3 out of 20), and decreased vision (2 out of 20). In addition, respondents who experienced side effects specified that they received treatment for side effects during hospitalization.

In terms of support during TB treatment, the study participants mentioned that they received support from social workers (13 out of 20) and psychologists (7 out of 20). All respondents also mentioned that they received support in the form of adherence incentives during TB treatment.

Of the 20 study participants who received TB treatment, ten indicated that they had successfully completed treatment. One participant was assessed with treatment failure and nine others were still on treatment at the time of the interview.

Regarding satisfaction with the quality of TB services accessed, 14 respondents stated that they were satisfied, and six stated that they were very satisfied. Also, 13 participants specified that they had a lot of trust in the doctor who treated them, while another five stated that they had a lot of trust (Figure 56).

Figure 56. Respondents' satisfaction and perception of tuberculosis health services accessed



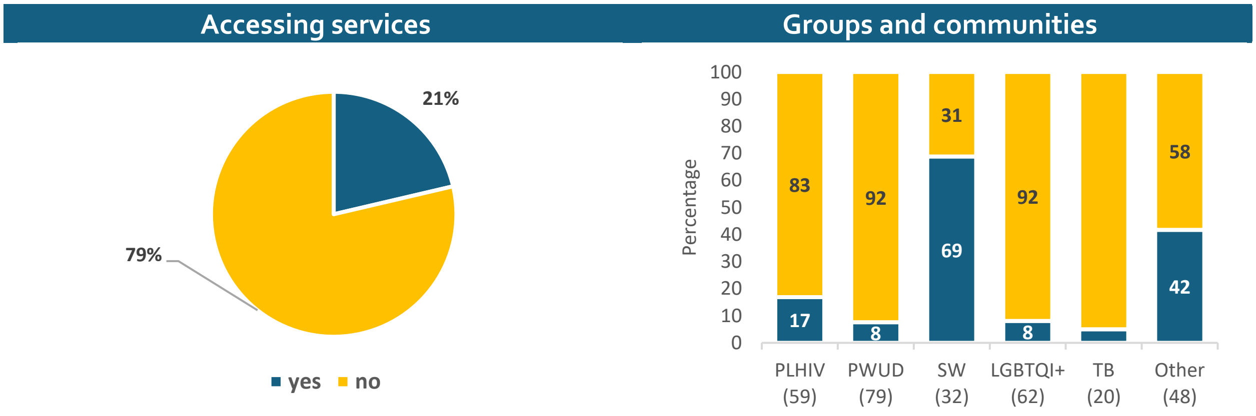
ACUTE VIRAL RESPIRATORY INFECTIONS (AVRI)

Of the total of 300 study participants, 21.3% (64) reported seeking medical attention for acute respiratory infections (AVRI) (Figure 57).

Analyzing in more detail, it was observed that respondents from the SW group had the highest percentage of seeking medical assistance in relation to AVRI with 68.8% (22 out of 32). The Group Other followed with 41.7% (20 out of 48), and those from the PLHIV group with 16.9% (10 out of 59). Respondents from the LGBTQI+ community sought such assistance in 8.1% (5 out of 62) cases, and those from the PWUD group in 7.6% (6 out of 79). Only one respondent from the TB group sought medical assistance for AVRI (Figure 57).

The data show significant between-group variability in seeking medical attention for AVRI ($p<0.001$, Figure 57).

Figure 57. Access to acute viral respiratory infection services disaggregated by groups and communities



Out of 64 respondents who sought medical assistance for AVRI, in 85.9% (55 out of 64) cases, they turned to state institutions (polyclinics, hospitals). 20.3% (13 out of 64) participants mentioned that they also turned to private clinics. The majority (84.4%, 54 out of 64) of the respondents who sought medical assistance related to AVRI had investigations, tests or analyses performed, and in about one third of the cases (27.8%, 15 out of 54) they mentioned that they paid money for some of these services.

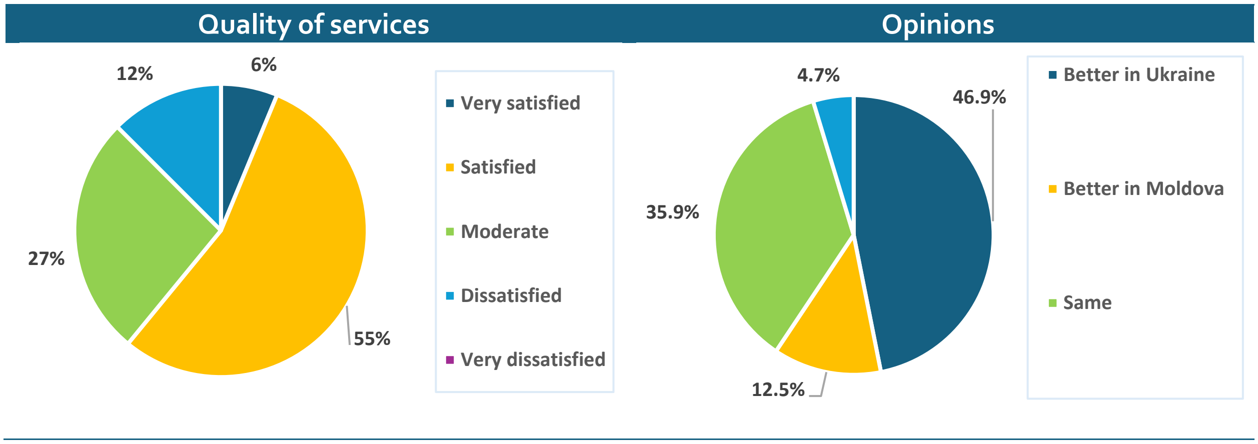
With reference to the amounts paid, the data show considerable variability. Thus, in one out of 14 cases, respondents paid 300 MDL and 400 MDL, respectively. In general, the amounts paid ranged from 300 MDL to 2000 MDL, with a few respondents (2 out of 14) paying 500 MDL and 1100 MDL. This variability suggests differences in the costs of medical services, possibly also depending on the type and complexity of the investigations performed. Regarding the destination of the payments, 25.9% (14 out of 54) of the respondents mentioned that they paid at the hospital or polyclinic cashier, while 9.3% (5 out of 54) stated that they paid directly to the medical staff, data indicating that most of the payments were made through official channels, but there were also cases of informal payments.

Of the respondents who had incurred payments, 25.9% (14 out of 54) indicated that they had used their own savings to cover health costs, and in 7.4% (4 out of 54) cases, they indicated that they had borrowed. In 5.6% each, they received help from relatives and friends (3 out of 54), used financial sources from refugee support (3 out of 54) or the costs for health services were covered by NGOs (3 out of 54).

Survey participants were asked how satisfied they were with the quality of AVRI services offered in Moldova. Thus, in 54.7% (35 out of 64) cases, respondents indicated that they were satisfied with the quality of services, while in 26.6% (17 out of 64) cases, they remained neutral. On the other hand, in 12.5% (8 out of 64) cases, participants stated that they were dissatisfied with the quality of services, while 6.3% (4 out of 64) said they were very satisfied (Figure 58).

Survey participants also expressed their opinions on the perception of the quality of services compared to those in Ukraine. In 46.9% (30 out of 64) cases, the respondents indicated that the medical services related to AVRI are better in Ukraine, while in 35.9% (23 out of 64) cases, they mentioned that the services are identical in both countries. A smaller number of respondents, 12.5% (8 out of 64), specified that medical services are better in Moldova, while 4.7% (3 out of 64) mentioned that they had not used such services in Ukraine and therefore could not make a comparison (Figure 58).

Figure 58. Respondents' satisfaction and perceptions of health services accessed in relation to acute respiratory viral infections

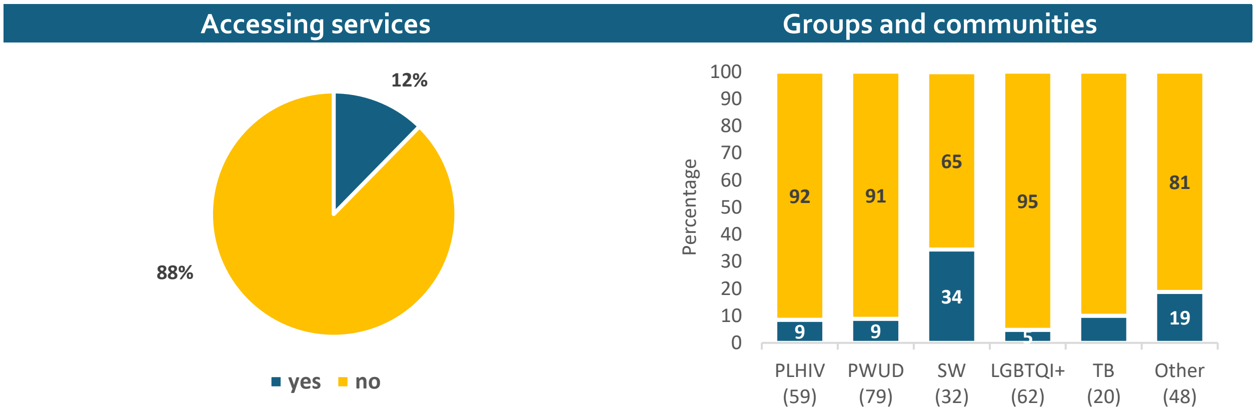


MEDICAL EMERGENCIES

Out of 300 survey participants, 12.3% (37) indicated that they had sought emergency medical care during their stay in Moldova (Figure 59).

The study analyzed the frequency of seeking emergency medical care during the respondents' stay in Moldova, according to groups and communities. The results showed that respondents from the SW group had the highest percentage of those who sought emergency medical care, with 34.4% (11 out of 32) reporting that they needed such services. Respondents in the Group Other sought emergency medical care in 18.8% (9 out of 48) cases, those in the PWUD group in 8.9% (7 out of 79) cases, and those in the PLHIV group in 8.5% (5 out of 59) cases. Respondents from the LGBTQI+ community sought emergency care in 4.8% (3 out of 62) cases, and as for the TB group, two respondents indicated that they sought emergency care. Statistical analysis revealed that there were significant differences between groups in the frequency of seeking emergency medical care (p=0.001) (Figure 59).

Figure 59. Access to emergency health care services disaggregated by groups and communities



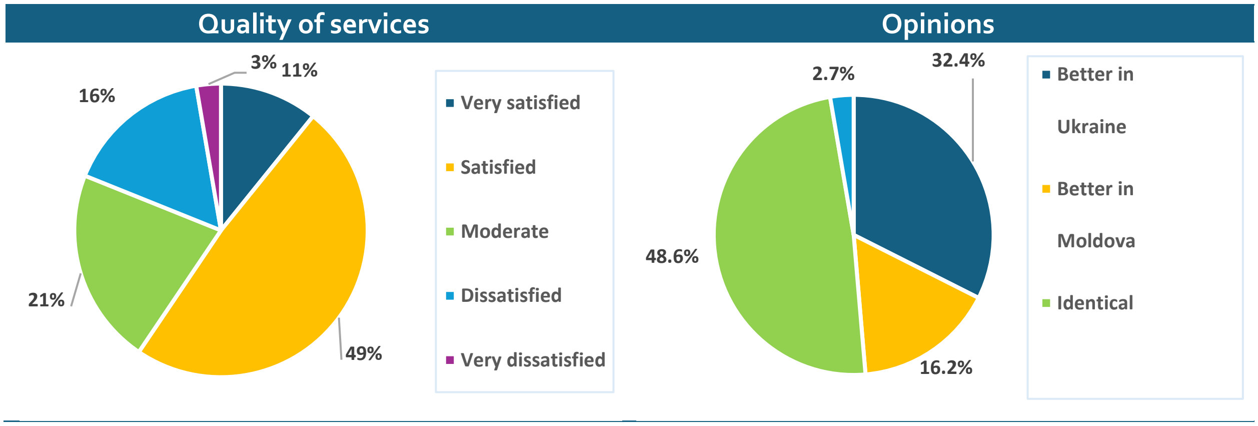
The results showed that the overwhelming majority of respondents, 94.6% (35 in 37), turned to state institutions (emergency departments) for emergency medical care, and 5.4% (2 in 37) turned to a private clinic for such services.

73.0% (27 out of 37) of the respondents reported having undergone various emergency medical examinations, tests and tests. In terms of the costs associated with these services, 8.1% (3 out of 37) reported that they had incurred expenses for these services. Of those who incurred expenses, the amounts ranged from 600 lei to 1000 lei, making payments directly to the hospital cashier. One of the respondents indicated that they incurred expenses from their own financial sources and two others indicated that they paid from loans.

Satisfaction with the quality of services received in Moldova varied. The results showed that almost half of the respondents (48.6%, 18 out of 37) were satisfied with the quality of services, and over a fifth (21.6%, 8 out of 37) were moderately satisfied, indicating that services were acceptable but not exceptional. On the other hand, 16.2% (6 out of 37) of respondents were dissatisfied with the quality of service, and a smaller proportion of 2.7% (1 out of 37) were very dissatisfied. In contrast, 10.8% (4 out of 37) of the respondents were very satisfied with the services they received, highlighting a positive experience with emergency healthcare (Figure 60).

When comparing the services received in Moldova with those in Ukraine, the results showed that almost half of the respondents, 48.6% (18 out of 37), considered that the emergency services in both countries were identical. A significant 32.4% (12 out of 37) said that services in Ukraine were better than in Moldova, and 16.2% (6 out of 37) of respondents thought that services in Moldova were superior to those in Ukraine. A small percentage, 2.7% (1 out of 37), did not use Ukrainian emergency services and therefore could not make a comparison (Figure 60).

Figure 60. Respondents' satisfaction and perception of emergency health services


Quality of services

Opinions

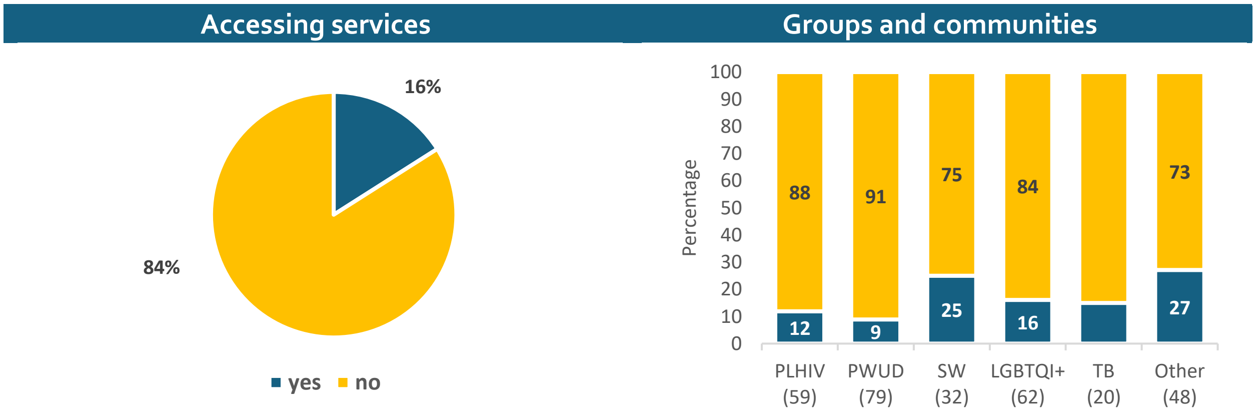
CHRONIC DISEASES

Survey participants were asked whether they sought medical care for chronic diseases. Of a total of 300 respondents, 16% (48 out of 300) indicated that they had accessed health services for such conditions (Figure 61).

By groups and communities, respondents from the Group Other accessed such services in 27.1% (13 out of 48) cases, and those from the SW group in 25.0% (8 out of 32) cases. Of the LGBTQI+ community respondents, 16.1% (10 out of 62) indicated that they had accessed chronic health care services, while 11.9% (7 out of 59) of the PLHIV group respondents and 8.9% (7 out of 79) of the PWUD group respondents had done so. Three of the TB group respondents (3 out of 20) also accessed such services (Figure 61).

Statistical analysis revealed a p-value equal to 0.073. Although this value is close to the significance threshold of 0.05, it does not indicate a statistically significant difference between the groups in terms of seeking health care for chronic diseases.

Figure 61. Access to health services, chronic diseases, disaggregated by groups and communities

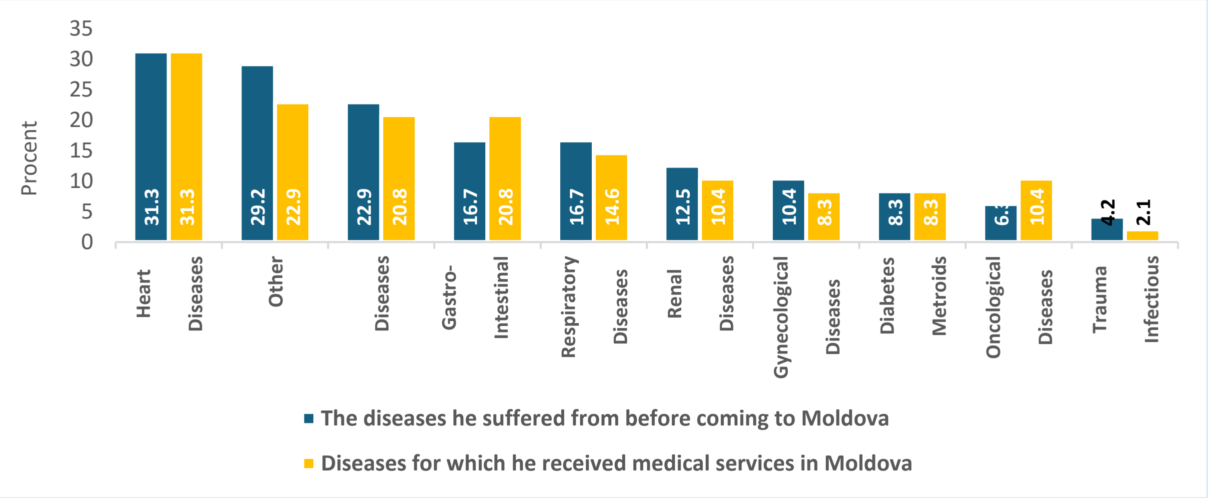

Accessing services

Groups and communities

The study analyzed data on the diseases from which the participants were suffering from before taking refuge in Moldova and the receipt of medical services for these diseases in Moldova. The data fromFigure 62 presents information on the proportion of those who had a specific condition and the proportion of those who received care for this condition, both calculated among respondents who sought medical care for chronic diseases (48). Thus, 31.3% (15, received medical services 15) of the respondents mentioned suffering from heart diseases, gastrointestinal diseases - 22.9% (11, received medical services 10) of the respondents, respiratory diseases - 16.7% (8, received medical services 10) of the respondents, kidney diseases - 16.7% (8, received medical services 7) and gynecological or obstetric diseases - 12.5% (6, received medical services 5) of the respondents. Diabetes mellitus was mentioned in 10.4% (5, received medical services 4) cases, trauma in 6.3% (3, received medical services 5) cases, oncologic diseases in 8.3% (4, received medical services 4), infectious diseases (other) in 4.2% (2, received medical services 1) cases. Other specified diseases were indicated by 29.2% (14, received medical services 11) of the respondents.

These data suggest that, although heart disease was the most common both prior to refuge in Moldova and in terms of medical services received in Moldova, there is a diversity of conditions for which participants sought and received medical care (Figure 62).

Figure 62. Referral for health services in disaggregated by disease



The analysis of the survey participants' preferences in terms of accessing medical services in health care institutions shows that 68.8% (33 out of 48) of the respondents accessed medical services offered by state institutions (polyclinics, hospitals), and in other 54.2% (26 out of 48) of the respondents accessed such services in private clinics.

In more than half of the cases (54.2%, 26 out of 48), respondents specified that they incurred costs for health services accessed in relation to the listed conditions. The average amount paid by the respondents was 5325 lei, the minimum amount indicated was 300 lei, and the maximum amount reached 60000 lei, data reflecting a wide range of expenses incurred by patients for chronic disease care, highlighting both cases of moderate costs and situations of significant expenses.

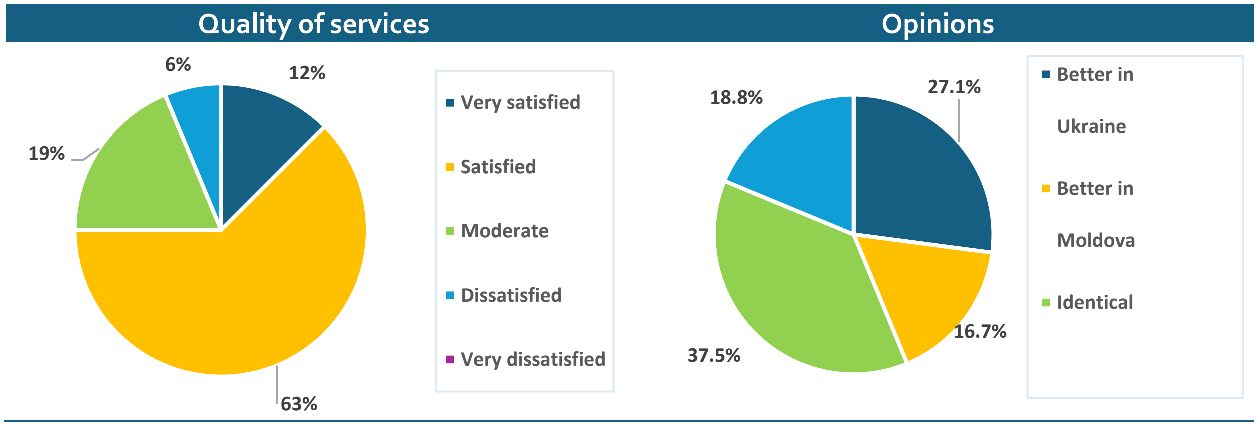
Of the total of 26 respondents who indicated payments, 24 specified that they paid at the hospital or polyclinic cashier. Four of the respondents indicated that they made payments, including to medical staff. In terms of sources of financing for health services related to chronic diseases, 17 of the respondents used their own money to cover their health expenses. Some of them (6) used loans, while others (4) received help from relatives or friends. Also, 8 of the respondents used financial sources from refugee support to make payments. In addition, 11 of the respondents received support from NGOs to cover their health costs.

Survey participants were asked how satisfied they were with the quality of health services provided in Moldova in relation to the chronic diseases they suffer from or for which they have received medical care.

Out of the total of 48 respondents, 12.5% (6) were very satisfied with these services, while 62.5% (30) were satisfied. This represents the majority of respondents, suggesting a high level of overall satisfaction. On the other hand, 18.8% (9) were moderately satisfied, indicating that the services were neither good nor bad for them. Only 6.3% (3) of the participants were dissatisfied with the quality of healthcare services, which represents a small minority (Figure 663).

In terms of comparing health services for chronic diseases between Moldova and Ukraine, 27.1% (13) of the respondents considered that services are better in Ukraine. In contrast, 16.7% (8) stated that services are better in Moldova. A significant 37.5% (18) considered that services are the same in both countries. Also, 18.8% (9) of the respondents mentioned that they had not used health services in Ukraine and therefore could not make a comparison (Figure 663).

Figure 63. Respondents' satisfaction and perception of health services accessed in relation to chronic diseases

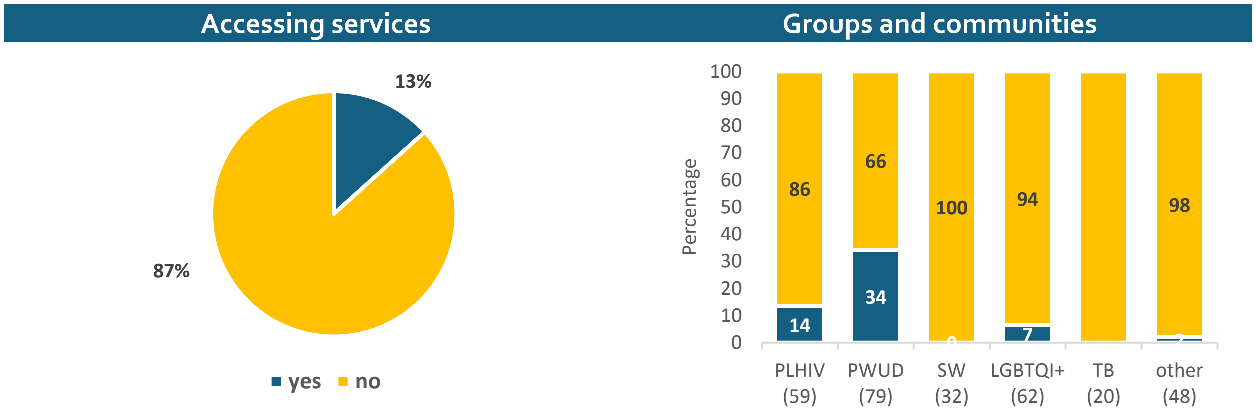


OTHER HEALTH REASONS

Out of 300 survey participants, 13.3% (40) indicated that they accessed health services for health reasons other than those mentioned above. Other reasons included various types of consultations, such as dermatologic, otolaryngologist, urologic, therapist, and hormonal therapies (Figure 64).

Depending on groups and communities, respondents from the PWUD group accessed such services in 34.2% (27 out of 79) cases, followed by those from the PLHIV group (13.6%, 8 out of 59) and those from the LGBTQI+ community (6.5%, 4 out of 62). In the Group Other, 2.1% (1 in 48) of respondents accessed such services. No respondents in the TB and SW groups accessed such services. These data suggest significant variability in service utilization by respondent group ($p<0.001$) (Figure 64).

Figure 64. Access to health services, other reasons, disaggregated by groups and communities


Accessing services

Groups and communities

For services for other reasons, respondents in most cases preferred private clinics (including MedHub Clinic affiliated to the "Positive Initiative" public association), with 87.5% (35 out of 40) of respondents indicating this option. Regarding public institutions (polyclinics, hospitals), respondents accessed these services in 12.5% (5 out of 40) cases. In 95.0% (38 out of 40) cases, the survey participants who requested such services specified that they had any investigations, tests or analyses performed.

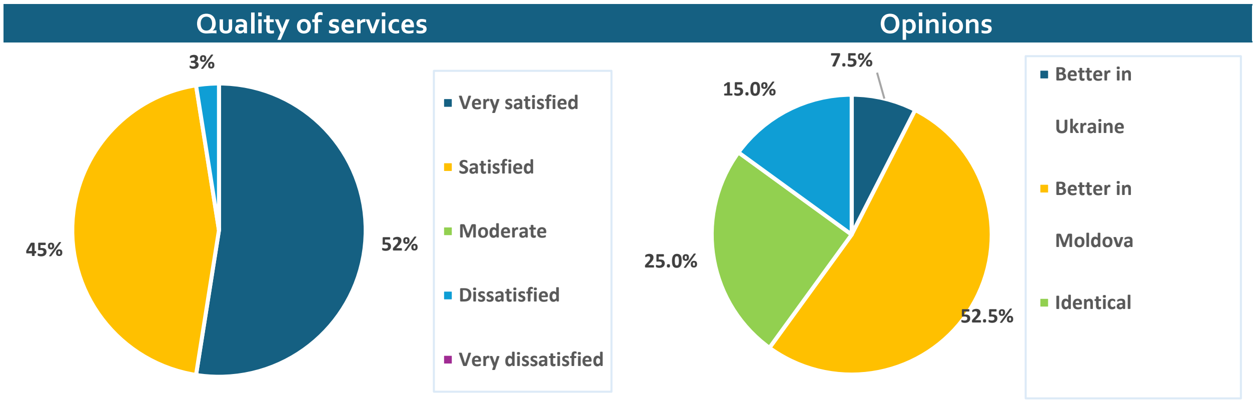
With reference to payments for consultations, including investigations, analyses or tests performed in medical institutions, the survey results showed that 87.5% (35 out of 40) of the respondents indicated that they paid for these services. Of those who paid, 77.1% (27 out of 35) paid amounts of 750 lei, 14.3% (5 out of 35) paid amounts of 1300 lei, and 5.7% (2 out of 35) paid amounts of 300 lei. In 2.9% (1 out of 35) of the cases the payments amounted to 4800 lei. Regarding the destination of the payments, 87.5% (35 out of 40) of the respondents paid in the hospital or polyclinic cashier, while 5.0% (2 out of 40) paid directly to the medical staff.

The source of payments varied: in 87.5% (35 out of 40) cases, respondents specified that they received financial support from NGOs (voucher of 750 lei for therapist consultation and investigations or payments of 1300 lei for hormone therapy). In contrast, in 5.0% (2 out of 40) cases participants indicated that they used their own savings to cover these costs, in 2.5% (1 out of 40) cases, they paid from loans, and in another 2.5% (1 out of 40) cases from financial support to refugees.

The survey data analyzed the satisfaction with the quality of services offered in Moldova, regarding other health reasons for which the respondents turned to the health centers. Thus, it was found that 52.5% (21 out of 40) of the respondents were very satisfied, while 45.0% (18 out of 40) were satisfied. In 2.5% (1 out of 40) cases respondents were dissatisfied with the quality of service (Figure 65).

With reference to comparing health services in Moldova with those in Ukraine, 52.5% (21 out of 40) of the respondents considered the services in Moldova to be better, 25.0% (10 out of 40) considered the services to be identical, and 7.5% (3 out of 40) considered the services in Ukraine to be better. Also, 15.0% (6 out of 40) of the respondents indicated that they had not used such services in Ukraine and therefore could not compare them (Figure 65).

Figure 65. Respondents' satisfaction and perception of other health services accessed

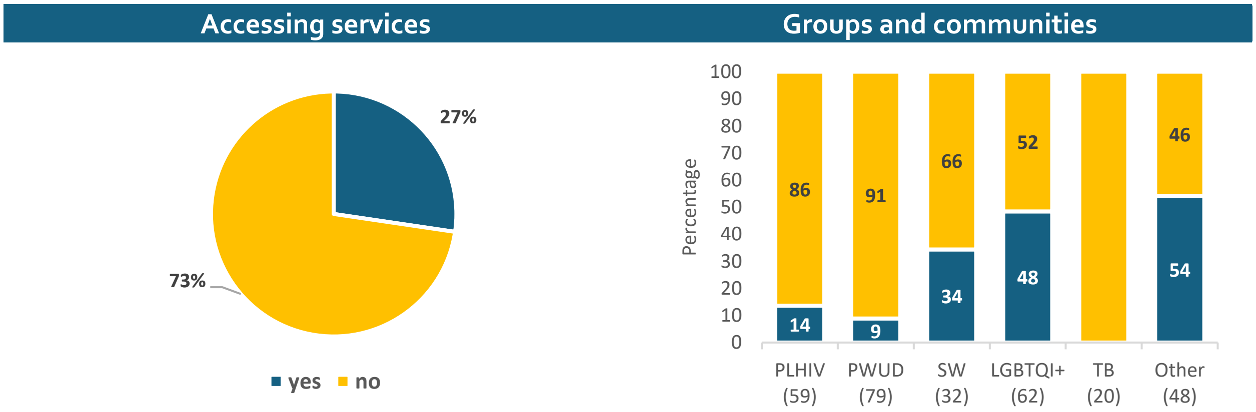


MENTAL HEALTH

Mental health services were accessed in about a third of cases (27.3%, 82 out of 300).

Disaggregating by groups and communities, 54.2% (26 out of 48) of respondents from the Group Other accessed mental health services, followed by respondents from the LGBTQI+ community with 48.4% (30 out of 62). Those in the SW group accessed such services in 34.4% (11 out of 32) cases, while those in the PLHIV group accessed them in 13.6% (8 out of 59) cases. In the PWUD group, 8.9% (7 out of 79) of respondents reported accessing such services, while in the TB group, no respondent (0 out of 20) indicated that they had accessed mental health services. Statistical data indicate a statistically significant association between groups and accessing mental health services ($p<0.001$,Figure 66).

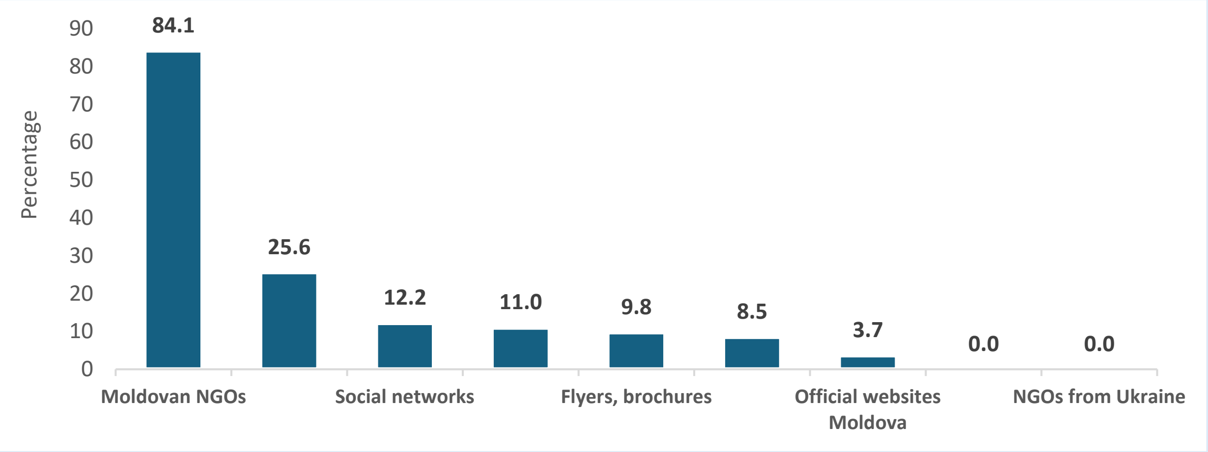
Figure 66. Access to mental health services disaggregated by groups and communities



With reference to how the respondents found out about the mental health services available in Moldova, the results showed that in 84.1% (69 out of 82) cases, they found out about these services through Moldovan NGOs. In one fourth of the cases (25.6%, 21 out of 82) the respondents found out about mental health services from other refugees in Moldova, social networks were a source of information for 12.2% (10 out of 82) of the study participants, while 11.0% (9 out of 82) found out about mental health services through friends and acquaintances in Moldova. Friends and acquaintances in Ukraine were a source of information for 8.5% (7 out of 82) of respondents, while leaflets and brochures were useful for 9.8% (8 out of 82) of respondents. Moldovan official websites were consulted in 3.7% (3 out of 82) cases, while

Ukrainian official websites and Ukrainian NGOs were not mentioned as sources of information for mental health services in Moldova (Figure 67).

Figure 67. Sources of information on mental health services



The survey looked at where respondents turned to access mental health services. Results showed that the majority of participants, 75.6% (62 out of 82), turned to NGOs for mental health support. In more than one fifth of cases (22.0%, 18 out of 82) they consulted a psychiatrist or neurologist in the consultative wards of polyclinics or hospitals, while 15.9% (13 out of 82) consulted their family doctor. As for private medical centers, 13.4% (11 out of 82) of the respondents also chose this option for mental health services. Community mental health centers were attended by 6.1% (5 out of 82) of the respondents, and public mental health centers were chosen by 2.4% (2 out of 82) of the respondents.

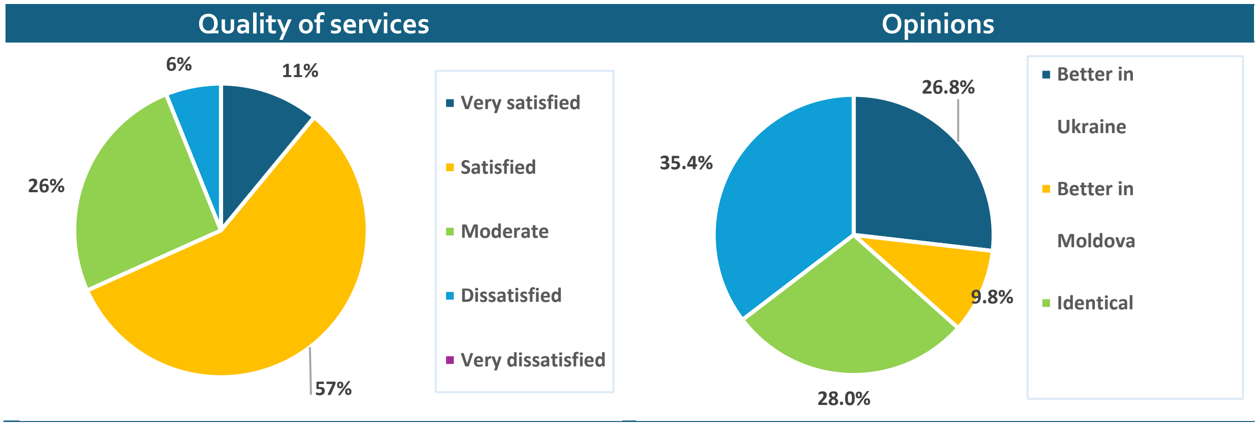
With reference to payments for mental health services, the results showed that 13.4% (11 out of 82) of the respondents paid for psychiatrist (neurologist) consultations and individual psychotherapy, and 6.1% (5 out of 82) of the respondents paid for psychiatrist (neurologist) consultations.

Most frequently (3 out of 16) respondents paid 300 or 1000 lei for the services received. Others (2 out of 16) paid 400 or 500 lei. Other amounts paid were 2700, 4290 and 6000 lei (1 out of 16). Also (3 out of 16) paid 200 lei. Regarding the method of payment, in 12.2% (10 out of 82) of the cases the respondents made payments at the cashier's office of the clinics, and in 7.3% (6 out of 82) they paid directly to the medical staff. Financial sources were own financial resources (10), loans (4), support from NGOs (2).

The results on satisfaction with the quality of mental health services in Moldova showed that in 57.3% (47 out of 82) of the respondents were satisfied with the quality of the services received. In one fourth of the cases (25.6%, 21 out of 82), the participants were moderately satisfied, indicating that the services were acceptable but not exceptional. On the other hand, 11.0% (9 out of 82) of the respondents were very satisfied with the quality of services, indicating a positive experience with mental health care. In contrast, 6.1% (5 out of 82) of respondents were dissatisfied with the quality of services (Figure 68).

The comparison of mental health services in Moldova with those in Ukraine showed that 28.0% (23 out of 82) of the respondents considered that the services are identical in both countries. In 26.8% (22 out of 82) cases, they specified that services in Ukraine are better than those in Moldova, while 9.8% (8 out of 82) of the respondents considered that services in Moldova are superior to those in Ukraine. A significant 35.4% (29 out of 82) did not use mental health services in Ukraine and therefore could not make a comparison (Figure 68).

Figure 68. Respondents' satisfaction and perception of mental health services


Quality of services

Opinions

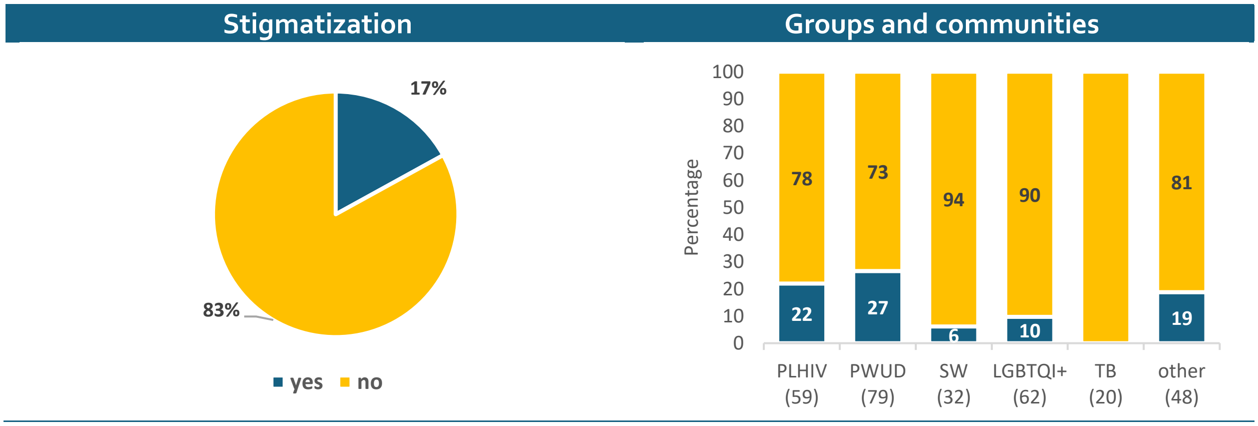
STIGMA, DISCRIMINATION, THE RIGHT TO HEALTH

Perception of stigma

Participants' experience of stigmatization while seeking health care was also analyzed in the study. The results showed that 17.0% (51 out of 300) of the respondents mentioned that they felt stigmatized while accessing health services (Figure 69).

Results on the experience of stigmatization while seeking health care by group and community showed that the PWUD group had the highest percentage of respondents who had experienced stigmatization, with 26.6% (21 out of 79) reporting such experiences. The PLHIV group had a percentage of 22.0% (13 out of 59) mentioning this. Also indicating stigmatization were 18.8% (9 out of 48) of Group Other respondents, 9.7% (6 out of 62) of LGBTQI+ community respondents, and 6.2% (2 out of 32) of SW group respondents. The TB group reported no cases of stigmatization (0 out of 20). Statistical analysis revealed a p-value equal to 0.009, indicating a significant association between groups and experience of stigmatization (Figure 69).

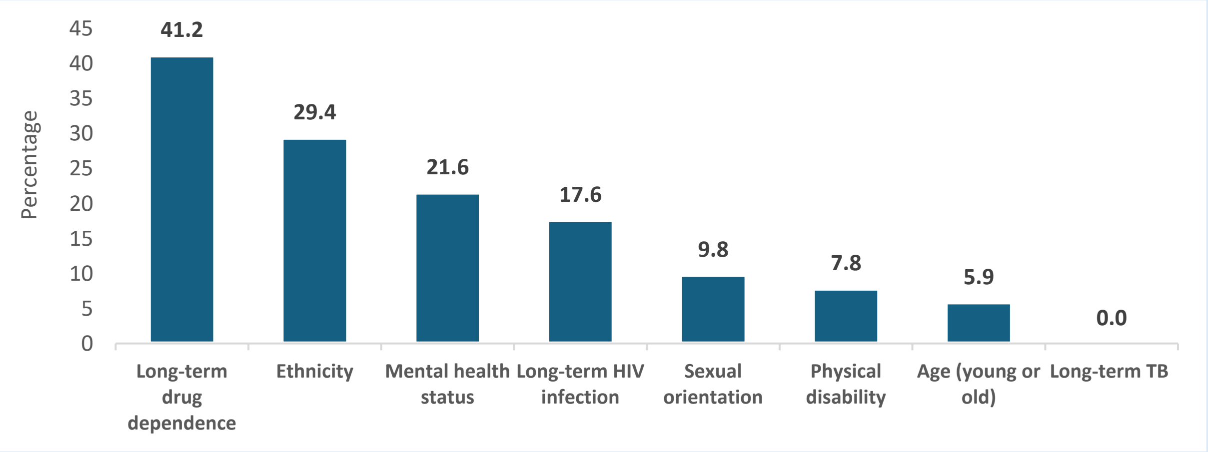
Figure 69. Perception of stigma, including disaggregation by groups and communities


Stigmatization

Groups and communities

Reasons for stigmatization were also analyzed. The results showed that the most common reason for stigmatization was related to drug addiction, with 41.2% (21 out of 51) of respondents reporting such experiences. Another significant reason for stigma was related to ethnicity, with 29.4% (15 out of 51) of respondents indicating this reason. Mental health-related stigma was reported by 21.6% (11 out of 51) of respondents, while 17.6% (9 out of 51) felt stigmatized because of HIV infection. Stigmatization based on sexual orientation was experienced by 9.8% (5 out of 51) of respondents, and 7.8% (4 out of 51) reported stigmatization due to physical disabilities. Lastly, 5.9% (3 out of 51) of respondents experienced stigmatization due to age, whether young or old. No respondents reported stigma due to TB (0 out of 51) (Figure 70).

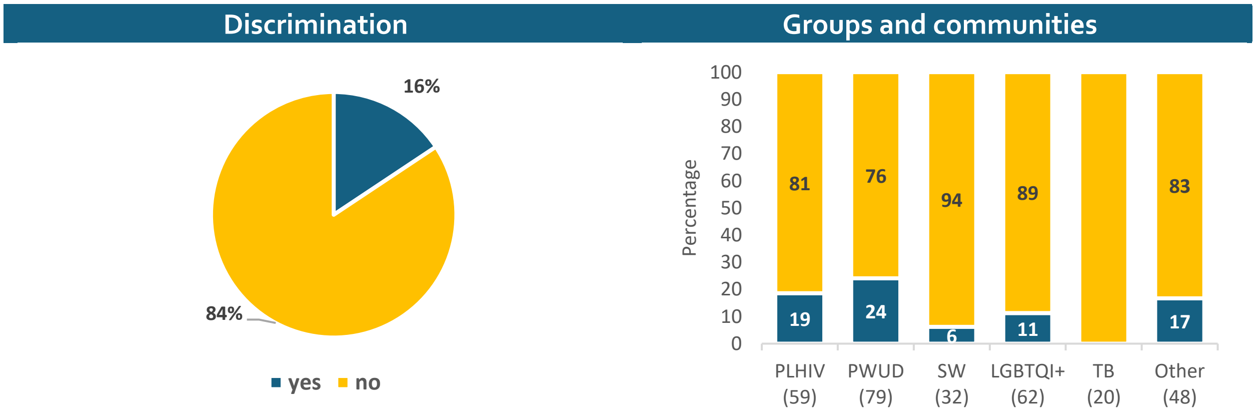
Figure 70. Reasons for perceived stigmatization



Perception of discrimination

The survey results also revealed that 15.7% (47 out of 300) of the respondents indicated that they had encountered some negative experiences, such as discrimination when accessing health services (Figure 71).

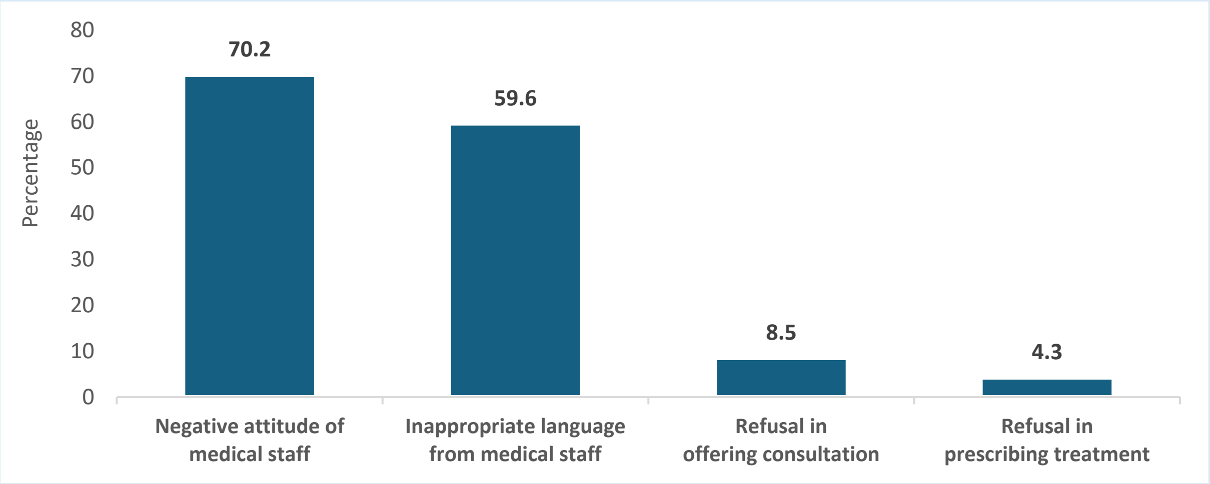
Figure 71. Perception of discrimination, including disaggregation by groups and communities



Data analysis revealed a varied perception of discrimination among groups and communities. Discrimination was perceived in 24.1% (19 out of 79) cases by respondents from the PWUD group and in 18.6% (11 out of 48) cases by respondents from the PLHIV group. Those from the Group Other reported discrimination in 16.7% (8 out of 48) cases and those from the LGBTQI+ community in 11.3% (7 out of 62) cases. In addition, the SW group had 6.2% (2 out of 32) reporting such experiences. The TB group reported no cases of discrimination (0 out of 20). Statistical analysis revealed a p-value equal to 0.044, indicating a significant association between the groups and the experience of discrimination (Figure 71).

The types of discrimination encountered by respondents were diverse: in the most frequent cases the discrimination was related to the negative attitude of medical staff, with 70.2% (33 out of 47) of respondents reporting such experiences. The next most frequently encountered type of discrimination was related to inappropriate language used by medical staff during the provision of health services, with 59.6% (28 out of 47) of the respondents indicating this reason. Some (8.5%, 4 out of 47) of the respondents felt discriminated against when they were refused medical consultations, while others (4.3%, 2 out of 47) experienced discrimination when they were refused medical treatment. These data suggest that although the majority of respondents experienced problems with the attitudes and language of medical staff, there were also cases of refusal to offer consultations or prescribe treatment (Figure 71).

Figure 72. Types of discrimination experienced by study participants



Right to health

According to the survey data, 75.6% (204 out of 270[24]) of the respondents mentioned that the right to health for refugees is respected in Moldova, which represents a clear majority, indicating a positive perception among the participants. On the other hand, 21.1% (57 out of 270) of the respondents considered that it is partially respected and 3.3% (9 out of 270) that it is not respected.

Opinions on the respect of the right to health for refugees in Moldova varied depending on groups and communities. Thus, respondents from the TB group, in the majority of cases (17 out of 18) considered that the right to health is respected, which indicates a very positive perception among this group. Also, 85.7% (24 out of 28) of the SW group respondents, 81.0% (34 out of 42) of the Group Other respondents and 72.4% (42 out of 58) of the PLHIV group respondents considered that the right to health is respected. Those from the PWUD group, indicated positive responses in 71.2% (47 out of 66) cases, and those from the LGBTQI+ community in 69.0% (40 out of 58) cases (Figure 73).

On the other hand, 27.3% (18 out of 66) of the PWUD respondents, 25.9% (15 out of 58) of the PLHIV respondents and 24.1% (14 out of 58) of the LGBTQI+ respondents partially agreed. They considered that the right to health is not respected 6.9% (4 out of 58) of the LGBTQI+ respondents, 7.1% (3 out of 42) of the Group Other and 1.7% (1 out of 58 and 1 out of 66) of the respondents from the PLHIV and PWUD groups. The p-value analysis equal to 0.130 indicates that there was no statistically significant difference

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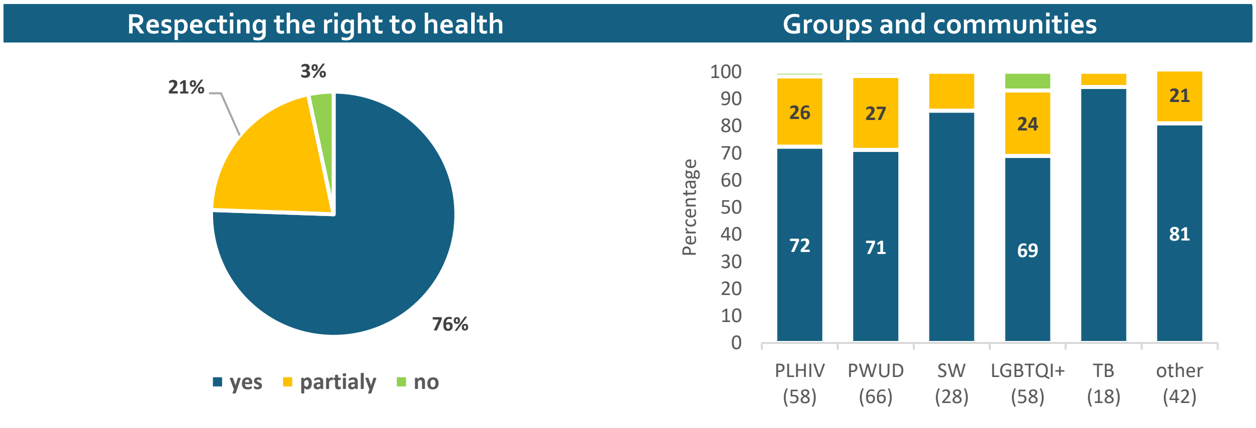
[24] No answer (30)

between groups in terms of perceptions of respect for the right to health, suggesting that perceptions were generally similar between the groups analyzed (Figure 73).

Figure 73. Views on respect for the right to health, including disaggregation by groups and communities



Respecting the right to health

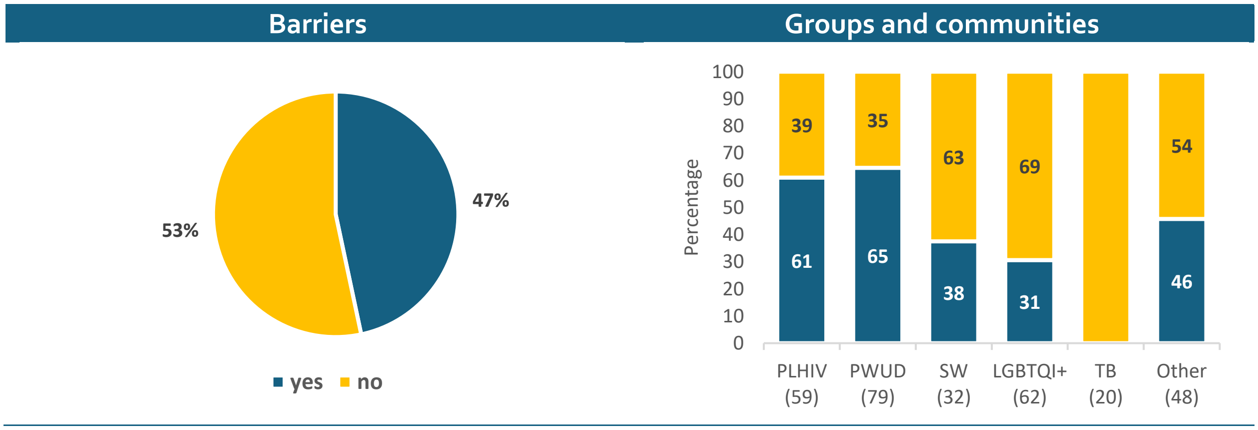
Groups and communities

BARRIERS IN ACCESSING HEALTH SERVICES

Analyzing the data collected on access to health services, the results revealed respondents' perceptions of encountering certain barriers. The barriers mentioned included: distance to centers (health institutions), waiting time at the specialist doctor, waiting time at the family doctor, related to prescribing treatment, accessing services, requesting additional documents, language. Thus, 46.7% (140 out of 300) of the participants encountered some of the mentioned obstacles in accessing certain health services (Figure 74).

Encountering barriers in accessing health services, depending on groups and communities, reveals that the majority of respondents from the PWUD group encountered barriers, with 64.6% (51 out of 79), followed by those from the PLHIV group (61.0%, 36 out of 59) and those from the Group Other (45.8%, 22 out of 48). The SW group indicated encountering barriers in 37.5% (12 out of 32) cases, and those from the LGBTQI+ community in 30.6% (19 out of 62) cases. The TB group reported no barriers (0 out of 20). The p-value< 0.001 indicates about the existence of statistically significant differences between groups and encountering barriers (Figure 74).

Figure 74. Barriers in accessing health services, including disaggregation by groups and communities



Barriers

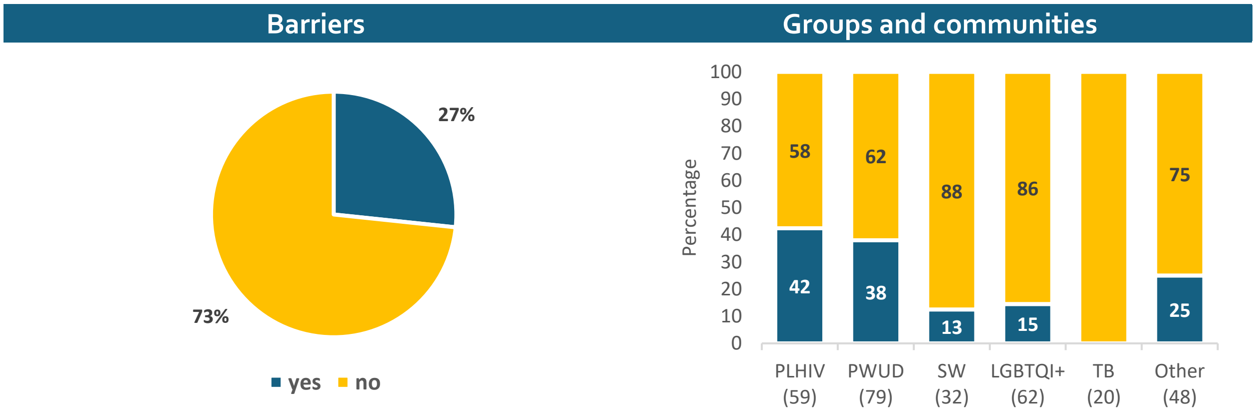
Groups and communities

Distance-related barriers

Distance-related barriers were experienced by 26.7% (80 out of 300) of the respondents, indicating that the centers (institutions) they went to be a long distance from their home. The distance from the place of living to the centers indicated by the respondents was on average 40 km and ranged from 4 km to 120 km.

The majority of respondents in the PLHIV group mentioned that the centers they went to be a long distance from their home, at 42.4% (25 out of 59), followed by those in the PWUD group at 38.0% (30 out of 79). Respondents in the Group Other faced such an obstacle in one fourth of the cases (25.0%, 12 out of 48), and those from the LGBTQI+ community in 14.5% (9 out of 62) of the cases. In the SW group, 12.5% (4 out of 32) of respondents indicated this barrier. Those in the TB group did not mention issues related to distance. In context, the data show that perceptions of distance to centers varied significantly between groups. The PLHIV and PWUD groups experienced the most distance-related difficulties, whereas the TB group reported no such problems. The p-value< 0.001 indicates a statistically significant difference between groups and perception of distance to health service centers (Figure 75).

Figure 75. Distance-related barriers, including disaggregation by groups and communities



Depending on the region of Moldova in which they live, 48.1% (39 out of 81) of respondents from the South region, 21.6% (32 out of 148) of respondents from the Center region and 13.8% (9 out of 65) of respondents from the North region of Moldova faced distance obstacles. Respondents living in the Eastern region of the country (0 out of 6) did not mention distance as an obstacle.

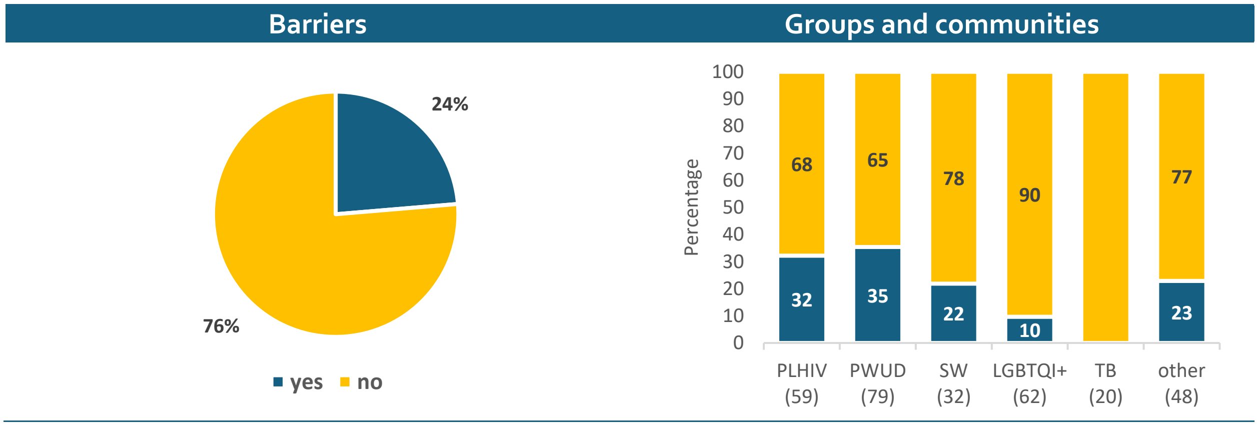
Waiting time barriers

Waiting time at the specialist (specialized doctor)

Concerning the barrier of waiting time at the specialist doctor's office, the results showed that in about one fourth of the cases (23.7%, 71 out of 300) respondents mentioned this problem. The average waiting time at the specialist doctor's door was 30 min, the minimum waiting time was 15 min and the maximum 90 min (Figure 76).

In disaggregation, this type of barrier faced the vast majority of LGBTQI+ community respondents, at 90.3% (56 out of 62). The next highest group was PLHIV, with 67.8% (40 out of 59), followed by PWUD, with 64.6% (51 out of 79). The SW group had 78.1% (25 out of 32), and the Group Other had 77.1% (37 out of 48). The TB group did not indicate waiting time at the specialist as a barrier accessing health services (0 out of 20). Therefore, there is a statistically significant difference between groups in terms of long waiting time at a specialist doctor's office with a p-value of 0.001, indicating that the results are not random and that there is a significant association between groups and waiting time (Figure 76).

Figure 76. Barriers related to waiting time to see a specialist, disaggregated by groups and communities

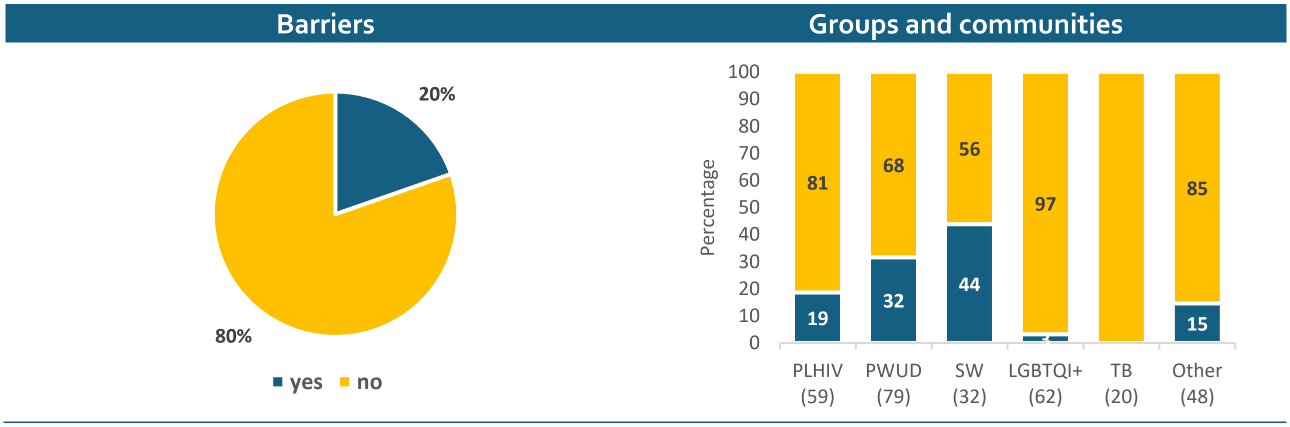


Waiting time at a family doctor

With reference to waiting time at the family doctor's door, about one fifth (19.7%, 59 out of 300) of the respondents indicated that they experienced this problem. The average waiting time at the specialist doctor's door was 25 min, the minimum 15 min and the maximum 60 min (Figure 77).

The vast majority of respondents from the LGBTQI+ community 96.8% (60 out of 62) indicated that they had experienced this barrier. PLHIV group respondents mentioned this barrier in 81.4% (48 out of 59) cases, and Group Other respondents in 85.4% (41 out of 48) cases. The PWUD group recorded 68.4% (54 out of 79) cases and the SW group 56.2% (18 out of 32) cases. No respondents in TB group (0 out of 20) did not mention waiting time as a barrier. The results of the study determined that there was a statistically significant difference between the groups in terms of long waiting time at the family doctor's door, with a p-value less than 0.001, indicating that the results are not random and that there is a significant association between the groups and reported waiting time (Figure 77).

Figure 77. Barriers related to waiting time at the family doctor, disaggregated by groups and communities



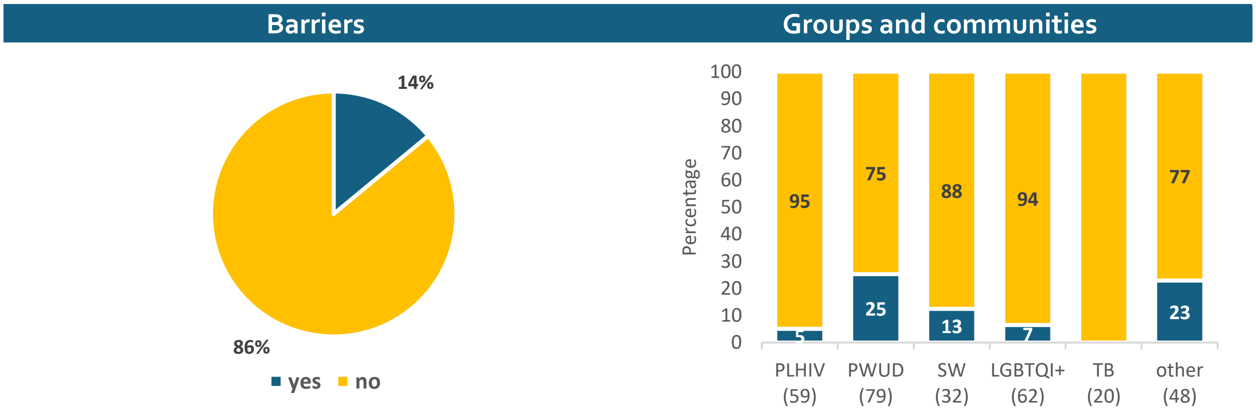
Barriers to accessing treatment

In 14.0% (42 out of 300) of the cases, the study participants mentioned that they faced obstacles related to treatment. The barriers mentioned included the lack of certain medicines in the pharmaceutical network in Moldova, and the availability of medicines in most cases more expensive compared to those available in the pharmaceutical network in Ukraine.

Other obstacles mentioned were the limitations imposed by the temporary protection status, which does not always provide free access to some treatments, affecting patients' ability to receive the necessary care. Problems with prescriptions were also reported, with some respondents mentioning that doctors did not prescribe the necessary medication or that treatment was prescribed late. Another barrier mentioned was costs for treatment, with respondents having to pay for their own medicines and in some cases having to seek help from NGOs to cover costs of treatment.

Depending on groups and communities, respondents from the PWUD group had the highest percentage of respondents indicating barriers to accessing treatment at 25.3% (20 out of 79), followed by the Group Other at 22.9% (11 out of 48). Respondents from the SW group mentioned such barriers in 12.5% (4 out of 32) cases, those from the LGBTQI+ community in 6.5% (4 out of 62) cases, and those from the PLHIV group in 5.1% (3 out of 59) cases. The TB group (0 out of 20) did not mention treatment-related barriers. The analysis determined statistically significant differences between groups and barriers related to accessing treatment (p=0.001,Figure 78).

Figure 78. Barriers to accessing treatment, disaggregated by groups and communities



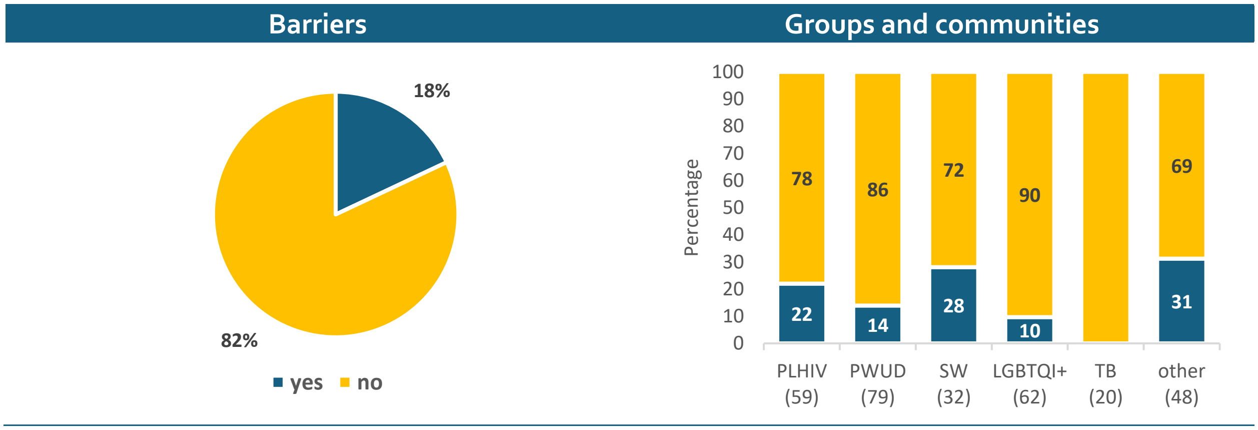
Barriers to accessing services

With reference to the accessibility of services, the survey results revealed that in 18.0% (54 out of 300) of the cases, respondents encountered obstacles in accessing certain services, which were only offered to them for a fee (Figure 79).

One of the most common barriers mentioned were medical consultations offered for a fee, including consultations with an infectious disease doctor, psychologist or neurologist. Other barriers included: costs for general tests, including determination of CD4, hormone tests, COVID-19 tests, mammography, radiologic examination, etc. Respondents also mentioned that they were often referred to private clinics for investigations, which involved additional costs. Another barrier identified was related to dental services, indicating that access to a dentist (medical emergency cases) was difficult due to high costs.

Such obstacles were encountered in about a third of the cases by respondents from the Group Other, with 31.2% (15 out of 48), and by respondents from the SW group, with 28.1% (9 out of 32). Respondents from the PLHIV group indicated such obstacles in 22.0% (13 out of 59) cases, and those from the PWUD group in 13.9% (11 out of 79) cases. Those from the LGBTQI+ community accounted for 9.7% (6 out of 62), and TB group respondents did not indicate encountering barriers related to accessing services (0 out of 20). In context, the study determined statistically significant differences between groups in accessing services (p=0.005) (Figure 79).

Figure 79. Barriers to accessing services, disaggregated by groups and communities

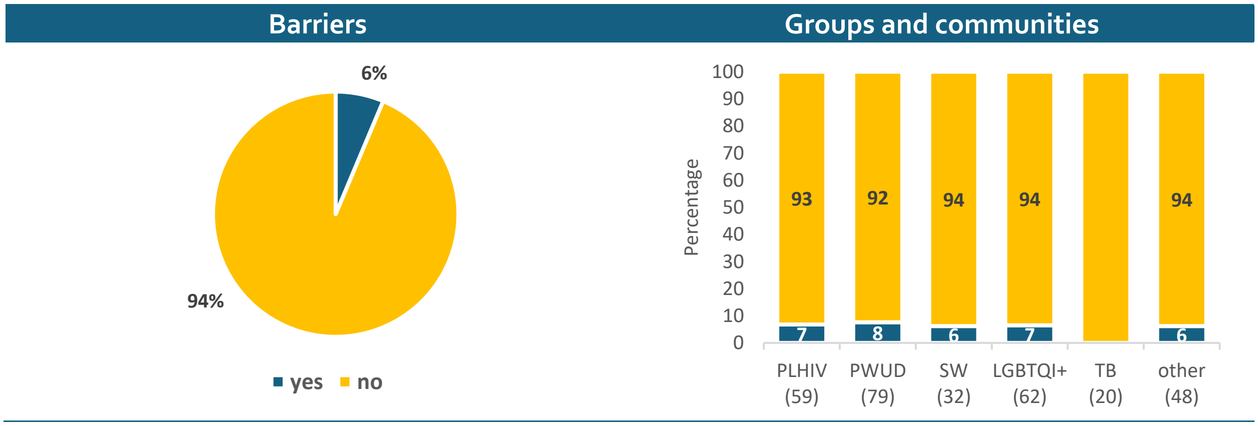


Barriers by requesting additional documents

In 6.5% (19 out of 300) of the cases, the study participants indicated that they encountered obstacles in accessing health services, which were related to the health care providers' request for additional documents. They considered as barriers in accessing health services, when they were required to present temporary protection (but did not have it), to present Ukrainian passport, documents confirming diagnosis or disability (from Ukraine) or results of analysis, tests, dynamic investigations (from Ukraine).

The PWUD group had the highest percentage of respondents who mentioned requesting additional documents, at 7.6% (6 out of 79). The next largest group was the PLHIV group, with 6.8% (4 out of 59), followed by those from the LGBTQI+ community, with 6.5% (4 out of 62). The SW and Group Others each had a percentage of 6.2% (2 out of 32 and 3 out of 48, respectively). The TB group faced no such barriers (0 out of 20). Also, the data analyzed did not yield statistically significant differences between the groups in terms of requesting additional documents (p=0.903,Figure 80).

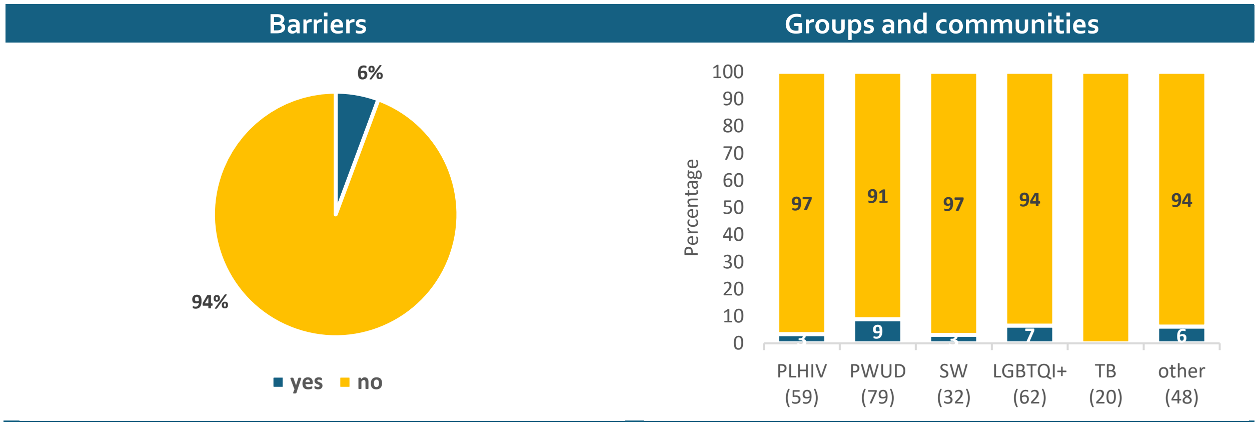
Figure 80. Barriers related to requesting of additional documents, disaggregated by groups and communities



Language barriers

Language barriers were encountered by 5.7% (17 out of 300) of the survey participants. The survey results revealed that respondents from the PWUD group faced language barriers in 8.9% (7 out of 79) cases, and those from the LGBTQI+ community in 6.5% (4 out of 62) cases. Respondents from the Group Other encountered such barriers in 6.2% (3 out of 48) cases, the PLHIV group in 3.4% (2 out of 59) cases, and the SW group in 3.1% (1 out of 32) cases. The TB group faced no language barriers (0 out of 20). Statistical analysis revealed a p-value = 0.583, indicating that there was no statistically significant difference between the groups in terms of language barriers (Figure 81).

Figure 81. Language barriers, including disaggregation by groups and communities



RISK FACTORS ON FACING BARRIERS TO ACCESSING SERVICES

Socio-demographic factors

Data analysis on barriers to accessing health services did not reveal statistically significant differences between the socio-demographic groups analyzed. Although there were variations in the perception of barriers depending on gender, age, educational level and marital status, the p-values obtained (all greater than 0.05) indicate that these differences are not statistically significant. Thus, the socio-demographic factors analyzed did not influence the perception of barriers in accessing health services (Table 3).

Table 3. Socio-demographic factors that might influence access to health services

Name	From	No	OR [IÎ95%]	p-value
Sex				
Men	78 (55.7)	90 (56.2)	0.9 [0.59-1.49]	0.795
Women	59 (42.1)	64 (40.0)	1	
TG	3 (2.1)	6 (3.8)	0.5 [0.13-2.27]	0.621
Age				
≤ 39 years old	82 (58.6)	87 (54.4)	1.2 [0.75-1.88]	0.467
≥ 40 years	58 (41.4)	73 (45.6)	1	
Educational level				
Primary or incomplete secondary	36 (26.3)	38 (23.9)	1.3 [0.67-2.53]	0.433
Complete media education	72 (52.6)	81 (50.9)	1.2 [0.69-2.17]	0.491
Higher education	29 (21.2)	40 (25.2)	1	
Marital status				
Married or cohabiting	61 (43.6)	56 (35.0)	1.6 [0.95-2.62]	0.075
Divorced or widowed	26 (18.6)	27 (16.9)	0.4 [0.73-2.67]	0.388
Single	53 (37.9)	77 (48.1)	1	

With reference to occupational and economic factors the survey data showed that the amount of average monthly income was determined as a significant factor in the perception of barriers in accessing health services. Thus, respondents with no income faced barriers in accessing these types of services, with the highest percentage of 39%. The study estimated that participants in this group were 3.5 times more likely to experience barriers in accessing health services compared to participants with higher income (p=0.007,Table 4).

In contrast, occupational status and the presence of the respondent's dependents did not show statistically significant differences, with p-values greater than 0.05. These results suggest that income plays a crucial role in access to health services, while other socio-economic factors analyzed did not have a significant impact (Table 4).

Table 4. Occupational and economic factors that might influence access to health services

Name	From	No	OR [IÎ95%]	p-value
Employed*				
Employed	23 (16.4)	21 (13.1)	1	
Self-employed	31 (22.1)	39 (24.4)	0.7 [0.34-1.54]	0.523
Other	20 (14.3)	20 (12.5)	0.8 [0.36-1.73]	0.704
Unemployed	66 (47.1)	80 (50.0)	0.7 [0.38-1.48]	0.417
Dependents*				
Yes	42 (30.0)	37 (23.1)	1.4 [0.85-2.38]	0.112
No	98 (70.0)	123 (76.9)	1	
Average monthly income*				
No income	55 (39.3)	35 (21.9)	3.5 [1.38-9.00]	**0.007**
≥ 200 EUR	52 (37.1)	68 (42.5)	1.7 [0.69-4.26]	0.247
201-500 EUR	25 (17.9)	39 (24.4)	1.4 [0.54-3.81]	0.623
≤ 501 EUR	8 (5.7)	18 (11.2)	1	

*Employed (Moldova); Other: pupil, student, pensioner, disabled person, maternity/paternity leave; Dependents (Moldova); Average monthly income (Moldova)

Transfer procedures as risk factor

The analysis of transfer procedures revealed several important aspects related to factors that might influence access to health services in Moldova. In this context, region of residence, place of residence and availability of temporary protection were found to be significant factors that could influence access to health services in Moldova by refugees ($p< 0.05$). The other factors analyzed, such as length of stay, number of entries in Moldova, and receipt of refugee financial assistance, did not appear to have had a significant impact on access to health services ($p> 0.05$,Table 5).

Thus, respondents from the North and South regions were significantly less likely (OR=0.14 and OR=0.15, respectively) to face barriers in accessing health services, which were presented as protective factors. In other words, those living in the Center region were 6.7 [IÎ95%: 3.59-12.86] times more likely than those living in the North region and 6.8 [IÎ95%: 3.26-14.48] times more likely than those living in the South region, statistically significant differences ($p<0.001$) indicating a regional disparity in access to health services (Table 5).

Location in Moldova also influenced access to health services. Participants who indicated living in district centers and villages were more likely (OR=4.8 and OR=17.1, respectively) to experience barriers in accessing health services compared to those living in municipalities. These differences are statistically significant ($p<0.001$), highlighting an urban-rural disparity (Table 5).

Temporary protection was another significant factor. Respondents without temporary protection were 2.5 times more likely to face barriers in accessing health services compared to those with temporary protection, a statistically significant difference ($p=0.002$,Table 5).

Table 5. Transfer procedures as risk factor that might influence access to health services

Name	From	No	OR [IÎ95%]	p-value
Period of stay				
< 12 months	40 (28.6)	58 (36.2)	0.7 [0.43-1.14]	0.159
> 12 months	100 (71.4)	102 (63.8)	1	
Number of entries				
1 entry	78 (55.7)	74 (46.2)	1.4 [0.92-2.30]	0.104
≥ 2 entries	62 (44.3)	86 (53.8)	1	
Living region (Moldova)				
North	53 (37.9)	95 (59.4)	0.14 [0.08-0.27]	**<0.001**
South	23 (16.4)	42 (26.2)	0.15 [0.07-0.30]	**<0.001**
Center	64 (45.7)	17 (10.6)	1	
East (left bank)	0 (0.0)	6 (3.8)	-	
Temporary protection				
Yes	103 (73.6)	140 (87.5)	1	
No	37 (26.4)	20 (12.5)	2.5 [1.38-4.64]	**0.002**
Place of living (Moldova)				
Municipality	61 (43.6)	132 (82.5)	1	
District center	55 (39.3)	25 (15.6)	4.8 [2.71-8.34]	**<0.001**
Village	24 (17.1)	3 (1.9)	17.1 [5.42-73.8]	**<0.001**
Financial assistance for refugees				
Yes	113 (80.7)	133 (83.1)	1	
No	27 (19.3)	27 (16.9)	1.2 [0.64-2.13]	0.652

Violence as a risk factor

Violence in its various forms was found to be a significant factor in the context of accessing health services. Participants who reported having been exposed to violence were twice as likely (OR = 2.2) to experience barriers in accessing health services compared to those who had not been exposed to violence (p = 0.001,Table 6

Physical violence was associated with an even higher likelihood (OR=5.4) of experiencing barriers to accessing health services, the difference is also statistically significant (p=0.001). Psychological and emotional violence were also important factors, with double the odds (OR=2.2 and OR=2.1, respectively) of experiencing barriers to accessing health services compared to people who had not been exposed to such forms of violence. These differences are statistically significant (p=0.005 and p=0.003, respectively) (Table 6).

Table 6. Violence as a risk factor that might influence access to health services

Name	From	No	OR [IÎ95%]	p-value
Violence				
Yes	83 (59.3)	64 (40.0)	2.2 [1.37-3.47]	**0.001**
No	57 (40.7)	96 (60.)	1	
Physical violence				
Yes	17 (12.1)	4 (2.5)	5.4 [1.77-16.43]	**0.001**
No	123 (87.9)	156 (97.5)	1	
Mental violence				
Yes	46 (32.9)	30 (18.8)	2.2 [1.25-3.61]	**0.005**
No	94 (67.1)	130 (81.2)	1	
Emotional violence				
Yes	67 (47.9)	49 (30.6)	2.1 [1.29-3.33]	**0.003**
No	73 (52.1)	111 (69.4)	1	
Sexual violence				
Yes	7 (5.0)	0 (0.0)	-	-
No	133 (95.0)	160 (100)	-	-

Entry in the family doctor's register as risk factor

Family doctor registration was determined to be a significant factor in the context of accessing health services. Participants who did not have a family doctor registration were estimated to be twice as likely (OR = 2.2) to face barriers in accessing health services compared to those who were registered. This difference is statistically significant (p=0.001), suggesting that registration at a family doctor may influence access to health services. Trust in the family doctor does not appear to be a significant factor as the observed differences are not statistically significant (p=0.878,Table 7).

Table 7. Registration and trust in a family doctor as risk factors that might influence access to health services

Name	From	No	OR [IÎ95%]	p-value
Registration with your family doctor				
Yes	94 (67.1)	77 (48.1)	1	
No	46 (32.9)	83 (51.9)	2.2 [1.37-3.52]	**0.001**
Trust in your family doctor				
Yes	51 (54.3)	40 (51.9)	1	
Moderate or a bit	43 (45.7)	37 (48.1)	1.1 [0.60-2.01]	0.878
No				

Confidence in family doctor, among those registered, non-response (1)

Groups and communities

Access to health services can be influenced by various barriers experienced by groups and communities. The study estimated that respondents in the PWUD and PLHIV groups were 2.6 times and 2.1 times more likely to face barriers in accessing health services compared to those not in these groups. These differences were statistically significant (p=0.001 and p=0.020,Table 8).

In contrast, the LGBTQI+ community was significantly less likely (OR=0.43) to experience barriers in accessing health services, suggesting a possible protective effect (p=0.006). On the other hand, the Other and SW groups did not show statistically significant differences in accessing health services (p=0.902 and p=0.362, respectively) (Table 8).

Table 8. Groups and communities in relation to barriers in accessing health services

Name	From	No	OR [IÎ95%]	p-value
PWUD Group				
Yes	51 (36.4)	28 (17.5)	2.6 [1.59-4.63]	**0.001**
No	89 (63.6)	132 (82.5)	1	
LGBTQI+ Community				
Yes	19 (13.6)	43 (26.9)	0.43 [0.23-0.77]	**0.006**
No	121 (86.4)	117 (73.1)	1	
PLHIV Group				
Yes	36 (25.7)	23 (14.4)	2.1 [1.15-3.72]	**0.020**
No	104 (74.3)	137 (85.6)	1	
Group Other				
Yes	22 (15.7)	26 (16.3)	0.96 [0.51-1.79]	0.902
No	118 (84.3)	134 (83.8)	1	
SW Group				
Yes	12 (8.6)	20 (12.5)	0.6 [0.30-1.39]	0.362
No	128 (91.4)	140 (87.5)	1	
TB Group				
Yes	0 (0.0)	20 (100)	-	
No	140 (100)	140 (87.5)	-	

Types of health services accessed and barriers

Access to health services can be influenced by a variety of barriers, depending on the type of services sought. For respondents who accessed drug dependence health services, the study estimated triple odds of experiencing barriers to accessing services (OR = 3.1), statistically significant differences (p<0.001,Table 9).

Double odds of encountering barriers to accessing health services were also estimated for those who accessed ARV treatment services (OR = 2.0) with a statistically significant difference (p = 0.028). In contrast, HIV testing was associated with a significantly lower likelihood of encountering barriers (OR = 0.4, p = 0.001), indicating a protective effect (Table 9).

There were no statistically significant differences in accessing health services for viral hepatitis B and C, STIs, chronic diseases, mental health, medical emergencies or other health reasons (all with p-value greater than 0.05) (Table 9).

Table 9. Types of services accessed in relation to barriers in accessing health services

Name	From	No	OR [IÎ95%]	p-value
HIV testing				
Yes	53 (37.9)	94 (58.8)	0.4 [0.26-0.68]	**0.001**
No	87 (62.1)	66 (41.3)	1	
ARV treatment				
Yes	34 (24.3)	22 (13.8)	2.0 [1.11-3.67]	**0.028**
No	106 (75.7)	138 (86.3)	1	
Viral hepatitis B and C				
Yes	52 (37.1)	50 (31.2)	1.3 [0.80-2.09]	0.329
No	88 (62.9)	110 (68.8)	1	
Sexually transmitted infections				
Yes	11 (7.9)	25 (15.6)	0.5 [0.21-0.97]	0.050
No	129 (92.1)	135 (84.4)	1	
Drug addiction				
Yes	60 (42.9)	31 (19.4)	3.1 [1.86-5.23]	**< 0.001**
No	80 (57.1)	129 (80.6)	1	
Tuberculosis				
Yes	0 (0.0)	37 (21.2)	-	
No	140 (100)	126 (78.8)	-	
Acute viral respiratory infections				
Yes	26 (18.6)	38 (23.8)	0.7 [0.41-1.28]	0.323
No	114 (81.4)	122 (76.2)	1	
Medical emergencies				
Yes	21 (15.0)	16 (10.0)	1.5 [0.79-3.18]	0.219
No	119 (85.0)	144 (90.0)	1	
Chronic diseases				
Yes	21 (15.0)	27 (16.9)	0.8 [0.46-1.62]	0.753
No	119 (85.0)	133 (83.1)	1	
Other health reasons				
Yes	20 (14.3)	20 (12.5)	1.2 [0.59-2.28]	0.775
No	120 (85.7)	140 (87.5)	1	

Name	From	No	OR [IÎ95%]	p-value
Mental health				
Yes	31 (22.1)	51 (31.9)	0.6 [0.36-1.02]	0.069
No	109 (77.9)	109 (68.1)	1	

Stigma and discrimination as risk factors

The study results highlight the significant impact of stigma and discrimination on access to health services. The data indicate that people who have experienced stigmatization are more likely to experience difficulties in accessing health services compared to those who have not experienced stigmatization (OR=42) The p-value $p<0.001$, suggests a highly statistically significant association (Table 10).

Similarly, respondents who reported feeling discriminated against were also more likely to experience difficulties in accessing health services (OR=37, $p<0.001$), indicating a strong and statistically significant association (Table 10).

The results of the study on the perception of respect for the right to health for refugees in Moldova revealed that people who felt that this right is not respected or partially respected were twice as likely (OR=2.2, p=0.007) to encounter barriers in accessing health services (Table 10).

Table 10. Stigma and discrimination as barriers to accessing health services

Name	From	No	OR [IÎ95%]	p-value
Stigmatization				
Yes	49 (35.0)	2 (1.2)	42.1 [11.8-263.1]	**<0.001**
No	91 (65.0)	158 (98.8)	1	
Discrimination				
Yes	45 (32.1)	2 (1.2)	37.1 [10.3-231.9]	**<0.001**
No	95 (67.8)	158 (98.8)	1	
Respecting the right to health				
Yes	86 (67.7)	118 (82.5)	1	
Partial or No	41 (32.3)	25 (17.5)	2.2 [1.27-4.01]	**0.007**

No answer: respect for the right to health (30)

QUALITATIVE STUDY: RESULTS

Following discussions with representatives of key affected communities, members of the TB platform and representatives of the authorities regarding access to essential health services for refugees, the following issues were raised:

- Temporary protected status provides free access to family doctor and pre-hospital emergency care. At the same time, several necessities (such as CD4 examination for PLHIV persons could not be carried out free of charge).
- A major problem in accessing health services was mentioned the long distance, lack of transportation and the cost of traveling to institutions providing health services Inpatient treatment, analysis, laboratory tests, investigations were perceived as difficult to access services conditional on referrals from the family doctor, but also on the availability of places in medical institutions.
- Access to essential services, especially narcological and HIV related services, and medical investigations is uneven and less accessible for people in rural areas. It is similar for other at-risk groups in these localities. The lack of specialized medical staff at district level imposes indirect costs related to travel to the municipalities and a barrier to access and continuity of medical services.
- Refugees from the PWUD group in Ukraine spoke about reduced access to opioid agonist treatment services, including their absence in the private sector. This situation necessitates the need to live in areas where the Opioid Agonist Treatment Program (OAT) is available. In the context of the closure of several temporary refugee placement centers, this leads to high costs for renting accommodation.
- Services for narcology, TB and HIV treatment were considered easily accessible and supported by NGOs. There is also good access to ARV, TB, OAT and other similar treatment schemes used in Ukraine and Moldova. However, for other conditions and chronic diseases, there are differences in the spectrum and cost of treatment, which often leads to regular return to Ukraine to purchase medicines (e.g. for hypertension, diabetes, etc.). Accessibility of free medicines is limited, and additional costs for their purchase are often covered with the NGOs support.
- Specialized medical services, such as dental, mental health and gynecological services, were considered less accessible.
- The frequent use of the services of private institutions has been confirmed, the costs being covered either by the beneficiary or with the support of someone else. The main reason for using these services is the long waiting time for investigations or medical consultations.
- Due to high stigmatization, the LGBTQI+ community is less likely to turn to public institutions, opting more frequently for services offered by NGOs such as GDM and MedHUB. Interruptions in hormonal treatment have been reported due to lack of medication in Moldova or excessively high prices. In Moldova, only one NGO provides support services to this group, including accompaniment to health services and HIV risk reduction services such as community PreP.
- There is a language barrier in accessing services, as official websites are often only available in Romanian, but medical documents are also issued in Romanian. This increases the frequency of requests for information from Romanian-speaking third parties such as NGO members, local friends or other refugees.
- The situation where people in key groups do not want to recognize their belonging of these vulnerable groups, including their HIV status, was mentioned as problematic.

- Refugees from at-risk groups face the same barriers in accessing essential services as the Moldovan population. There is therefore an emerging need to invest in medical infrastructure and equip with modern technologies to increase capacity to respond to the diverse needs of patients, including those from refugee communities.
- The model of health care provision for refugees was implemented by integrating services into the national health system, with the entry point through primary health care and the same mechanisms for accessing services as for the local population. Thus, the access to services through referral and accompaniment of persons at risk groups of refugees from Ukraine was carried out through NGOs, like persons in local risk groups. A rapid communication system with Ukrainian NGOs was established to ensure continuity of services.

In this context, access to health services for refugees from at-risk groups is marked by challenges and inequalities, influenced by factors such as long distances, travel costs, limited access to essential treatment and specialized services, stigma and language barriers. NGOs play a key role in ensuring access to treatment and services, but there is a need for investment in modern medical infrastructure and equipment to meet the diverse needs of patients.

DISCUSSIONS

The study explores the accessibility of health services to PLHIV, PWUD, SW, LGBTQI+, and people with TB and the barriers they face in accessing these services during their stay in Moldova.

Research findings show that people in the PWUD group and those in PLHIV face the greatest barriers in accessing health services. These groups are often stigmatized and marginalized, making it difficult for them to access appropriate health care [15, 16] . The LGBTQI+ community is less likely to face barriers in accessing health services, suggesting a possible protective effect, which could also be explained by the fact that in most cases they access health services through NGOs or in most cases access paid services directly at private clinics.

SW and Group Others did not show significant differences in accessing health services, suggesting that these groups do not face specific barriers. However, it is important to continue awareness-raising and education efforts to ensure an inclusive and respectful health care environment among groups and communities.

The study highlights that access to health services for refugees in Moldova is influenced by a few factors, and refugees may face barriers in accessing health services.

With reference to the socio-demographic factors analyzed, although no statistically significant differences were found, perceptions of barriers varied by gender, age, educational level, occupational status, marital status, and presence of dependents. This suggests that although socio-demographic factors do not directly impact access to health services, they may indirectly influence refugees' perception and experience of accessing health services.

The educational attainment of the respondents in this study is comparable to that of other studies, indicating a high potential for integration into the labor market, provided there are adequate opportunities and recognition of qualifications. However, limited knowledge of the Romanian language could be a barrier, similar to the findings of other research emphasizing the importance of language learning programs to facilitate social and economic integration [17,18].

The results of this study highlight significant changes in the employment status and income of Ukrainian refugees from Ukraine in Moldova. Compared to other similar studies, a common trend of decreasing employment and income rates among refugees was observed, reflecting the difficulties faced in labor market integration in the host countries [17] . The study results highlight the average monthly income of the refugee as a key factor influencing access to health services. Refugees with no or very low income face the greatest difficulties in accessing health services in Moldova. Many refugees cannot afford to pay for medical consultations, treatments and investigations, which prevents them from accessing necessary care. These findings underline the importance of ensuring adequate financial support for refugees so that they can access necessary health services without being burdened by costs. A study in Morocco assessed the government's contribution to financing migrant and refugee health care through free services, mobilizing approximately 5% of the annual budget for primary health care for migrants and refugees, highlighting the need to develop alternative financing mechanisms as health insurance coverage is extended [19] . In this context, there is an emerging need to improve financial support policies and insurance mechanisms to cover medical costs for refugees, thus ensuring their access to quality health services.

The results of the research provide a detailed insight into the transfer procedures and residence experiences of Ukrainian refugees from Ukraine in Moldova, particularly among at-risk populations.

Although in most cases refugees used legal documents to cross borders, there were also cases of illegal transfer.

Most respondents stated that they had been in Moldova for more than 12 months, suggesting relative stability, which is essential for long-term integration and access to basic services. The frequency of multiple entries into Moldova also indicates continued mobility, possibly linked to the search for better living conditions or services or temporary return to Ukraine. On the other hand, one third of the respondents intend to leave Moldova soon, with the majority preferring to move to another country, reflecting uncertainty and the desire to find better living conditions. Relocation intentions are influenced by economic and security factors, similar to those identified in other studies on forced migration [18].

Study participants came from various regions of Ukraine, with a notable presence from Odessa, Mykolaiv and Kiev. In Moldova, the majority chose to live in municipalities, especially in Chisinau and Balti. The geographical distribution reflects a preference for urban areas, where access to services and economic opportunities are greater. The choice of where to live was not influenced by region of origin in Ukraine, suggesting that local factors in Moldova played a more important role in the settlement decision [18].

However, the long distance to health centers is one of the most common barriers in accessing health services. Many refugees must travel long distances to reach healthcare centers, which can be daunting and costly. This problem may also be compounded by the lack of adequate public transportation and refugees limited financial resources. The results of the study show that refugees living in district centers and villages face more difficulties in accessing health services than those living in municipalities [11, 20]. Regional disparities are also highlighted. Thus, refugees living in the North and South regions of Moldova face fewer barriers in accessing health services compared to those in the Center region. In this context, in order to ensure equitable access to health care, it is essential to develop solutions to bring health services closer to refugee communities, including through the implementation of mobile health services[21].

Initial housing experiences have had an impact on the current housing situation of refugees. Those who were initially housed in refugee centers tended to stay there or subsequently rent an apartment or house, which points to the importance of refugee centers in providing a stable starting point for further integration [22].

The majority of respondents were granted temporary protection, which underlines the effectiveness of the support measures implemented by the Moldovan authorities [23]. However, a significant percentage did not obtain temporary protection for various reasons, including plans to leave Moldova, lack of necessary documents or lack of knowledge of procedures.

The availability of temporary protection is another determinant influencing access to health services. Refugees without temporary protection are more likely to face more barriers in accessing health services than those with temporary protection [24,25]. These results suggest the need for information campaigns, as well as improved policies and programs to facilitate access to temporary protection for all refugees, including through the involvement of NGOs and their collaboration with relevant institutions.

The majority of refugees received financial support for refugees, which underlines the effectiveness of the support measures implemented [26]. However, a significant percentage did not receive this support for a variety of reasons, including lack of registration and lack of awareness of the possibilities to benefit from this support. These findings suggest the need for more effective information campaigns and administrative support to ensure access to financial support for all refugees. The distribution of financial assistance varied significantly between groups, with people with TB and those in the group Other benefiting most from this type of support. This variation indicates that belonging to a particular group may influence the likelihood of receiving financial aid, highlighting the need for policies or programs to ensure equity in the distribution of resources.

In addition to financial support, refugees were provided with various essential items such as food, hygiene products and medicines. The distribution of these goods reflects the immediate needs of the refugees and the importance of ensuring access to basic resources to facilitate adaptation and integration into the new environment.

NGOs and volunteers have played a crucial role in providing essential services such as referral or accompaniment to centers (medical facilities), free HIV testing and psychological support. These services were frequently accessed by refugees, indicating a continued need for specialized support. Referral to legal aid and financial support to pay for medical services were also essential to ensure access to rights and health services.

The study revealed a high prevalence of violence among refugees, with almost half of respondents reporting various forms of abuse. Emotional and psychological violence were the most common, indicating a high level of stress and trauma among the study population. People with TB, PWUD and the LGBTQI+ community had the highest rates of exposure to violence, highlighting the vulnerability of these groups. The data show that emotional and psychological violence were predominant, and perpetrators were strangers, family members, border service and police employees [27]. These findings point to the need for protection measures and psychological support for refugees, as well as interventions to prevent violence in all its forms [17]. A worrying aspect is that many victims of violence have not sought help, which may be attributed to a lack of trust in the authorities or lack of knowledge of available resources. NGOs have played a crucial role in providing support, but a concerted effort is needed to encourage reporting of incidents and access to assistance. High exposure to violence and avoidance of help-seeking highlights the need for integrated interventions that address both the security and psychological needs of refugees.

Violence, in its various forms, has also been identified as a factor that could influence refugees' access to health services. Thus, participants who have been exposed to violence, whether physical, psychological or emotional, are more likely to face barriers in accessing health services compared to those who have not been exposed to such experiences. This highlights the profound impact that violence can have on the health and well-being of refugees, further complicating their access to essential health care. Evidence from the literature emphasizes that refugees experience a continuous cycle of trauma and violence that begins before migration and persists after resettlement, with cumulative effects on their health [28].

In the same vein, the study highlights that physical violence is associated with the greatest difficulties in accessing health services [27]. Refugees who have experienced physical violence face significant obstacles, which can be explained by the physical and psychological trauma they suffer, but also by the fear of seeking help due to stigmatization or reprisals because of belonging to certain risk groups. Mental and emotional violence are also important factors influencing access to health services. Refugees exposed to such forms of violence may suffer from anxiety, depression and other mental health problems[29], which affect their ability to seek and access health care. To improve refugees' access to health services in Moldova, it is essential to address violence in all its forms. At the same time, psychosocial support and community efforts remain key factors in facilitating access to health services and improving the health status of refugees.

Stigma and discrimination were highlighted as problems among refugees from at-risk populations [5]. About 17% of respondents reported feeling stigmatized and 16% experienced discrimination when seeking health services. PWUD and PLHIV groups experienced the highest rates of stigma and discrimination. The main reasons for stigmatization included drug addiction, ethnicity and mental health, and the types of discrimination experienced were varied, including negative attitudes of healthcare staff and inappropriate language used by them. A study in France showed that socially disadvantaged populations, including immigrants and refugees, face high rates of discrimination when accessing health services [30]. These findings highlight the need for targeted interventions to reduce stigma and discrimination among refugees through education and awareness-raising among health service providers and the community.

The majority of refugees settled in Moldova consider that their right to health is respected, indicating a generally positive perception. However, there are also refugees who believe that this right is only partially or not respected at all, highlighting gaps in ensuring equitable access to health services [5]. Perceptions vary between groups and communities. For example, the TB group has the most positive perception, while the LGBTQI+ and PWUD groups have less favorable perceptions. The survey of the general population in Moldova showed that perceptions of respect for human rights, including the right to health, vary significantly between different vulnerable groups, highlighting that while there has been progress in respect for human rights, certain groups, such as the LGBTQI+ community and people with disabilities, continue to face significant challenges [31]. These differences highlight the need for specific interventions to address the concerns of each group and to ensure equitable access to health services for all refugees.

Some specific challenges and needs of refugees in relation to health status and access to health services are also highlighted in this study [10]. Respondents' self-assessment of their health status varied considerably between groups; with the majority rating their health as satisfactory or good, with small differences between groups such as people with TB and the LGBTQI+ community indicating more severe health problems. All this underlines the importance of continuous health monitoring and provision of appropriate health services, including in dependence on groups [12].

Family doctor registration is essential to facilitate access to health care, including for refugees. Refugees who are not registered with a family doctor face significant barriers in accessing health services, which underscores the importance of registering with a family doctor [6,8]. The percentage of refugees registered at a family doctor varied considerably between groups, with the highest rates of registration observed among people with TB and the Group Other. In contrast, the LGBTQI+ community had the lowest rate of registration, which may reflect barriers in accessing the health services offered from state institutions.

One of the main reasons why refugees do not register with their family doctor is the intention to leave Moldova in the near future [6]. This suggests instability and lack of certainty among refugees, which prevents them from registering and receiving continuous medical care. Another significant reason is unfamiliarity with the registration procedure. Many refugees are not familiar with the Moldovan health care system and do not know how to register with a family doctor [5] . The lack of the necessary documents for registration is also a significant barrier. Refugees often face difficulties in obtaining the necessary documents for registration, which hinders their access to health services [13]. All this highlights the need for information and education campaigns that clearly explain the steps needed to register and the benefits of registration. NGOs and state institutions need to work together to provide this information in an accessible way and in languages that refugees understand.

Trust in the family doctor is an essential aspect of the patient-doctor relationship and significantly influences the quality of health care [32]. Although the majority of refugees trust their family doctor, there is also a significant percentage who are unclear or do not trust the doctor on whose register they are registered, suggesting the need for continued efforts to build and maintain refugees' trust in the health system and medical professionals.

Refugees accessed a wide range of health services, indicating diverse access to health services, but also reflecting the complex needs of refugees [10, 13]. NGOs in Moldova were the main source of information for accessing these services, followed by social networks and other refugees settled in Moldova, highlighting the crucial role of NGOs in disseminating information and facilitating access to health services. The majority of participants accessed the services offered by NGOs, highlighting the importance of these organizations in supporting refugees.

The survey results reflect a detailed insight into the communication between Ukrainian refugees and health care providers in Moldova, highlighting the importance of effective communication and adequate information in the relationship between patients and health care providers. The majority of refugees expressed a high level of satisfaction with information about treatment options, their safety, and the tailoring of medical care to individual needs. Confidentiality and trust in health care providers were also key aspects appreciated by patients. All these show similar results to the study among refugees, general population [5]. However, the present study found variations between groups and communities in this area, which underlines the need for tailored approaches and greater attention to groups that reported lower levels of satisfaction. The study also revealed other challenges, such as the perception that the demand for health care exceeds the capacity of primary health care in Moldova in the context of refugees [7], particularly evident in the TB, PLHIV and PWUD groups.

Gaps in the availability of informed consent in various languages were also highlighted, emphasizing the importance of this aspect for accessibility and effective communication, as described in the previous study among refugees, where they mentioned the availability of informed consent in Russian or Ukrainian in 58% of cases [5]. Against this background, it is concluded that it is essential to continue efforts to ensure informed consent in the mother tongue or other languages understood by Ukrainian refugees.

The survey revealed varied perceptions of refugees on the quality and safety of health services, as well as on the effectiveness of referral systems and cooperation between different medical and social entities [5]. The majority of refugees from at-risk populations felt that the referral and cooperation systems between health services, shelters and NGOs functioned well, although there were differences between groups and communities, particularly among people from PWUD and SW groups. Thus, it is essential to continue efforts to improve referral systems and cooperation between health services, social services and NGOs in order to ensure integrated and quality care.

Long waiting times for consultations with both specialist and family doctors are a significant barrier to accessing health services [33]. Refugees often face long waiting lists and delayed appointments, which can lead to a worsening of their health. There is a need to improve the efficiency of the scheduling system and to ensure enough medical staff to reduce waiting times and provide timely medical care. The literature emphasizes that refugees in host countries frequently face long waiting times for medical consultations, which can lead to delays in diagnosis and treatment [34, 35].

Requiring additional documentation and language barriers further complicate access to healthcare. Refugees are often faced with excessive bureaucratic requirements and communication difficulties due to language barriers, results also demonstrated in other research conducted in refugee or migrant host countries [7, 20, 36]. Simplification of administrative and bureaucratic procedures and the provision of translators could facilitate communication between refugees and medical staff.

From the analysis of the data collected in the survey, it can be concluded that there is significant awareness and varied utilization of harm reduction services among refugees who have settled in Moldova. For the most part refugees received information and support in HIV prevention and management, and the level of awareness of confidential HIV testing was high. There was also considerable familiarization with pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) for HIV. These findings are supported by others research. For example, a study published by UNAIDS highlights the unique challenges that refugees face in HIV prevention and management, emphasizing the need for access to prevention, treatment and support services [37].

The quality of harm reduction services was perceived as positive, with high overall satisfaction with the services offered in Moldova. However, there were notable differences in perceptions and utilization of services between groups and communities. For example, the LGBTQI+ community and the PWUD group reported the highest rates of service utilization, while the SW and Group Others had lower rates of accessing these services. Thus, continued efforts to inform and educate refugees, strengthen cooperation between medical and social entities, and tailor services to the specific needs of groups and communities could further improve access and quality of harm reduction services, as well as ensure better health protection for refugees and more effective integration into the Moldovan health system.

Access to HIV services in Moldova varied and was influenced by a number of factors, including group and community membership. The PLHIV group demonstrated universal awareness and utilization of HIV services, which underlines the importance of continued information and education for this group. High utilization of HIV services was also observed in the LGBTQI+ community, indicating their good integration into the health system. In contrast, the PWUD and SW groups accessed these services to a lesser extent [38], suggesting the need for specific interventions to improve access and utilization among these groups.

In terms of HIV testing, the majority of refugees used the services provided by NGOs, which underlines the crucial role of these organizations in HIV prevention and management. Reasons for testing varied, but personal initiative and referrals from NGO staff were the main drivers for testing. A study in Uganda showed that refugees' access to HIV testing is influenced by daily survival priorities and circumstances that allow for temporary changes in these priorities [39], while another study emphasized the importance of social support and community efforts for young migrants in accessing HIV services [40].

ARV treatment was accessed by the vast majority of refugees in the PLHIV group, and treatment continuity was ensured [41]. However, there were cases in which refugees did not have sufficient pills to secure their therapy during the period of transfer. Refugees' satisfaction with the quality of HIV services in Moldova was high, with the majority of refugees stating that they were satisfied or very satisfied with these services. In context, a study conducted in Ethiopia showed that the level of satisfaction with HIV treatment and care services is influenced by the waiting time and duration of receiving care [42].

In terms of refugees' access to services for viral hepatitis B and C, the results showed positive aspects such as availability and access to free testing. However, treatment continuity was affected by factors such as lack of necessary paperwork and financial difficulties, which can lead to interruptions in treatment and worsening of health status. The literature confirms that refugees are at higher risk of viral hepatitis B and C and face barriers in accessing immunization, testing and treatment services [43].

Although the majority of refugees accessed services for STIs, the highest percentage of access was in the LGBTQI+ community. The literature emphasizes the importance of rapid and sensitive molecular testing [44]. However, in contrast to the results obtained in the present study, a systematic review highlights the associated stigmatization regarding STI and HIV testing among refugees, which has led to low utilization of testing services [45]. Continued treatment for STIs was influenced by economic factors, with some respondents having to pay for health services and others receiving financial support from NGOs.

The study shows a prevalence of both injecting and non-injecting drug use among refugees in the PWUD group, with varying duration of use. In the majority of cases, they continue to use drugs during their stay in Moldova, underlining the need for continuous and effective interventions. Research findings emphasize that the prevalence of substance use among refugees is influenced by factors such as exposure to trauma, mental health disorders, social and economic inequalities [46], living conditions and social relations [47].

Access to sterile syringes and needles was relatively good, with most PWUD group refugees benefiting from syringe exchange programs or purchasing them from pharmacies [48]. However, occasional use of reused equipment and injecting with pre-filled syringes pose significant health risks to PWID. Treatment for drug dependence was accessed by a proportion of respondents, but its continuation was influenced by economic factors and availability of services [49]. Although the majority of respondents are satisfied with the quality of services offered in Moldova, there are varied perceptions regarding the comparison with services in Ukraine.

TB health services were accessed 100% by those in the TB group. Symptoms that prompted refugees to access TB health services included constant cough, chest pain, fever and unmotivated weakness. In vast majority of cases, refugees sought health care in government facilities and TB diagnosis was confirmed quickly, within 1-3 days. All those diagnosed with TB were hospitalized and underwent treatment under direct observation, which underscores the importance of medical supervision in TB management [14]. However, there were challenges in terms of adverse reactions to treatment especially at the outpatient stage [50]. Support from social workers and psychologists, as well as incentives provided during treatment, played a key role in completing treatment [51, 52].

Access to medical services for AVRI, medical emergencies and chronic diseases varied. The SW group accessed these services most often, followed by the Group Other for medical emergencies and chronic diseases. In most cases, refugees accessed state services. In contrast, some incurred costs either by accessing the services of private clinics or by being offered certain services for a fee. In this context, the variability in the costs of health services and the use of their own savings, loans or NGO help to cover these costs highlights the financial challenges faced by refugees. Literature data highlights that refugees in Iran face significant financial difficulties in accessing health services, despite the existence of a public health insurance program [53].

Mental health services were accessed particularly by the Other and LGBTQI+ groups [54], while the TB group did not access these services at all. Most refugees turned to NGOs for mental health support, and a significant proportion consulted psychiatrists or neurologists in polyclinics. Some respondents incurred costs for mental health services [55], and sources of funding included own financial resources, loans and support from NGOs. Satisfaction with the quality of mental health services in Moldova is generally positive, with the majority of respondents stating that they are satisfied or very satisfied. However, there are also respondents who consider the services in Ukraine to be superior, suggesting the need for continued improvements in the Moldovan mental health system to reach the standards perceived in Ukraine.

Finally, the study highlights the importance of integrated and tailored interventions to address the specific needs of different refugee groups. It is essential to continue awareness-raising and education efforts, to develop solutions to bring health services closer to refugee communities and to ensure an inclusive and respectful health care environment. This will ensure better health protection for refugees and more effective integration into the Moldovan healthcare system.

STUDY LIMITATIONS

In the survey, data were self-reported by respondents, which may be a limitation. This method of data collection may introduce subjective errors as respondents may provide inaccurate or incomplete information.

Another limitation of the study was the clustering of key affected populations, which made it difficult to interpret some results due to the small sub-sample sizes of less than 30 respondents. This may reduce statistical power and limit the generalizability of the results.

CONCLUSIONS

1. **Barriers in accessing health services:** Refugees from Ukraine, especially from key groups face some barriers in accessing health services in Moldova. Among the most common obstacles are the distance to health facilities, long waiting time, the need for additional documents, restricted access to essential treatment and specialized services, stigmatization and language barriers. These barriers not only hinder access to health services, but also affect the quality-of-care refugees receive.
    1.1. **Distance**. Distance-related barriers were significant for 27% of refugees. PLHIV and PWUD groups experienced the most difficulties. Perceptions of distance varied significantly between the regions of Moldova, with refugees settled in the Southern regions most frequently facing this barrier.

    1.2. **Waiting time**. Barriers related to waiting time at the specialist and family doctor were significant for a considerable proportion of refugees. In a quarter (24%) of cases, waiting time at the specialist doctor and in a fifth (20%) of cases, waiting time at the family doctor were specified as problems, mainly affecting the LGBTQI+ community and the PLHIV and PWUD groups.

    1.3. **Limited access to essential treatments**. In 14% of cases, refugees faced obstacles in accessing treatment, including a lack of medicines in the pharmaceutical network in Moldova and higher costs compared to Ukraine. Other barriers included limitations imposed by temporary protection, problems with prescriptions and the need to pay for treatment, sometimes turning to NGOs to cover costs. Most barriers of this type were faced by those from the PWUD, Other, SW, PLHIV groups, as well as those from the LGBTQI+ community.

    1.4. **Access to specialized services**. In 18% of the cases, refugees encountered obstacles in accessing health services, which were only offered for a fee. The most common barriers included paid medical consultations, the cost of tests (including CD4) and investigations in private clinics. Access to emergency dental services was difficult due to high costs. Such barriers were faced in particular by refugees from the Other and SW groups, but also by those from the PLHIV and PWUD groups.

    1.5. **Application for additional documents**. Such an obstacle was faced by 6.5% of refugees, particularly those from the PWUD, PLHIV and LGBTQI+ groups. The documents most often included temporary protection, Ukrainian passport, documents confirming diagnosis or disability, as well as test results from Ukraine.

    1.6. **Language barriers**. Language barriers in accessing health services were experienced by 5.7% of refugees, particularly those from the PWUD group and the LGBTQI+ community.

2. **Risk factors regarding barriers in accessing health services:** regional and rural disparity, economic factors such as poor financial situation, lack of temporary protection, non-registration at the family doctor, group membership, access to specific services such as ARV and drug addiction therapies, exposure to any type of violence, experience of stigma and discrimination.
    - 2.1. **Regional and urban-rural disparity:** Refugees settled in the North and South regions were significantly less likely to experience barriers, while those in the Center region were significantly more likely to experience difficulties. Also, residents in district centers and villages were significantly more likely to face barriers than those in municipalities.
    - 2.2. **The role of the economic factor:** the amount of average monthly income is a significant factor in the perception of barriers in accessing health services. Refugees with no income are 3.5 times more likely to experience difficulties in accessing health services.
    - 2.3. **The role of temporary protection**: the role of temporary protection is crucial in facilitating access to health services, but about one fifth of refugees do not benefit from this protection. Refugees without temporary protection are significantly more likely to face barriers in accessing health services.
    - 2.4. **The role of family doctor registration:** family doctor registration has been shown to be a significant factor in accessing health services and can positively influence access to health services. Refugees not registered with their family doctor are twice as likely to face barriers in accessing health services.
    - 2.5. **Belonging to the risk group**: at-risk populations such as PWUD and PLHIV face the greatest barriers in accessing health services due to stigma and marginalization. In contrast, the LGBTQI+ community face fewer barriers, suggesting a possible protective effect or being a more 'closed' group.
    - 2.6. **Access to specific services:** access to health services is influenced by various barriers, depending on the type of services required. Refugees accessing services for drug dependence treatment were three times more likely to face barriers, and those accessing services for ARV therapy were twice as likely to face barriers. In contrast, HIV testing was associated with a significantly lower likelihood of encountering barriers, indicating a protective effect.
    - 2.7. **Violence.** Violence in its various forms has been shown to be a significant factor in accessing health services. Refugees exposed to violence are more likely to face barriers in accessing these services. Those exposed to physical violence are 5.4 times more likely to experience difficulties, while those exposed to psychological and emotional violence are twice as likely to face such barriers.
    - 2.8. **Stigma and discrimination**: the study found that stigma and discrimination have a significant impact on access to health services. People who experienced stigma or discrimination experienced significantly more difficulties in accessing these services than those who were not exposed to these factors. Also, the perception that the right to health is not respected or only partially respected was associated with a higher likelihood of experiencing barriers in accessing health services.
3. **Communication with health care providers.** Most refugees felt well informed and reported a high level of satisfaction with health care. The PLHIV and PWUD groups were the most satisfied, while the SW group felt the least informed. Information on treatment safety and tailoring care to patients' needs were positively rated. Capturing feedback showed a moderate level of satisfaction, and the

time taken for consultations and respect for confidentiality were well rated, although there were differences between groups.

4. **Quality and safety of health services.** The results underline the importance of a well-structured referral and cooperation system to ensure the quality and safety of health services tailored to the specific needs of different groups and communities.
    4.1. The system of referral and cooperation between health services was considered effective in most cases, especially by the TB, PWUD and PLHIV groups, while the SW and LGBTQI+ groups had a less favorable perception.

    4.2. Collaboration between health services and shelters was rated positively but with variations between groups: the PWUD and PLHIV group felt that there was a good system of referral and cooperation, while the SW and LGBTQI+ groups had a less favorable perception.

    4.3. Collaboration also between health and social services was rated positively by the majority of refugees, especially those in the PWUD and PLHIV groups. The SW group had a significantly lower perception of the effectiveness of this collaboration.

    4.4. The system of referral and cooperation between health services and NGOs was well appreciated in the context of TB and HIV but differed between groups. In the TB context, collaboration was rated as effective, especially by the TB and SW groups. In the context of HIV services, the referral and cooperation system was also well rated, with high satisfaction among SW, HIV and LGBTQI+ groups. However, the PWUD group had a lower appreciation compared to the group Others. In terms of treatment with opioid antagonists, the majority of respondents felt that the system worked well, with the exception of the LGBTQI+ community, who indicated a total lack of satisfaction.

    4.5. **Quality and safety of health care**. In most cases refugees were satisfied with the quality, safety and continuity of health care they received. The TB, PWUD and HIV groups had the highest levels of satisfaction, while the SW group had the lowest positive rating.

5. **NGO support**: The study highlighted the crucial role of NGOs in supporting Ukrainian refugees in Moldova. NGOs provided essential services such as referral and accompaniment to medical centers, free HIV testing, psychological support, legal assistance. They also provided financial support for the payment of medical services and the distribution of essential goods such as food, hygiene products and medicines. These services were frequently accessed by refugees, indicating a continued need for specialized support. NGOs played a key role in facilitating access to health services and ensuring more effective integration of refugees into the Moldovan health system. Collaboration between NGOs and the health system is essential to address the needs of refugees.

RECOMMENDATIONS

1. **Improving access to health services.** It is essential to develop innovative solutions to bring health services closer to refugee communities. Implementing mobile health services could reduce the long distances refugees have to travel to access necessary care. Simplifying administrative and bureaucratic procedures would also facilitate quick and efficient access to health services, removing unnecessary obstacles.
2. **Person-centered approach**. To improve the quality, increase the satisfaction of refugees and increase the safety of health care, there is an emerging need for a people-centered approach, including effective and transparent communication, tailoring care to the individual needs of the person and ensuring confidentiality and safety in all aspects of health care.
3. **Expand access to temporary protection and adequate information**: It is imperative to expand support for accessing temporary protection for all at-risk groups, including PWUD, OAT, SW and the LGBTQI+ community. Information campaigns should clearly explain the procedures for obtaining temporary protection and its benefits and be available in languages known by refugees to ensure access to information for all refugees.
4. **Reducing language barriers**. Reducing language barriers and improving access to health services are key to facilitating refugees' access to health care. Ensuring the availability of medical forms and information in languages known by refugees will remove language barriers.
5. **Combating stigma and discrimination**. Stigma and discrimination are significant barriers to accessing health services for people from at-risk groups. Training health service providers to ensure an inclusive and respectful healthcare environment would help improve people's experience and increase their confidence in the health system. Conduct awareness raising campaigns and activities to reduce stigma and discrimination of refugees, especially those from vulnerable groups (PWUD, PLHIV, SW, LGBTQI+) to promote social inclusion and equal access to services.
6. **Strengthening education and outreach programs**. Continuing outreach and education efforts to inform refugees about registration procedures and their benefits would facilitate access to health care and reduce language barriers.
7. **Ensuring support services**. Providing support and expanding financial assistance programs, as well as increasing the capacity of NGOs to provide support, including legal aid, psychological support and specialized medical services, will ensure that refugees from at-risk groups receive the care and support necessary to maintain their health and well-being.
8. **Psychosocial support and violence prevention**. The implementation of protection measures and psychological support for refugees is crucial to address the profound impact of violence on their health and well-being. Encouraging the reporting of incidents of violence and ensuring access to assistance would help to create a safe and supportive environment for refugees.
9. **Strengthening cooperation between NGOs and health services**. Strengthening cooperation between NGOs and health services is essential to ensure continuity of care and access to specialized services for refugees from at-risk groups (PWUD, PLHIV, SW, LGBTQI+). NGOs play a crucial role in providing support and better coordination between these organizations and formal health institutions can optimize access to health services. Improved referral systems and effective cooperation will significantly contribute to ensuring quality care and adequate response to the complex needs of refugees

10. **Continuous monitoring and evaluation**. Implementing a continuous monitoring and evaluation system is essential to ensure effective access to health services for refugees. These mechanisms will enable new barriers to be promptly identified and addressed, ensuring the quality and effectiveness of interventions. Monitoring and evaluation of the impact of the services provided will facilitate the adaptation of strategies according to the emerging needs of refugees, thus contributing to the continuous improvement of health and support services. These measures are crucial to respond appropriately and flexibly to the challenges faced by refugees, ensuring their access to quality care.

BIBLIOGRAPHY

1. Country - Republic of Moldova [cited 2025 Mar 4]. Available from: https://data.unhcr.org/en/country/mda
2. Law 270 of 18.12.2008 on Asylum in the Republic of Moldova [cited 2025 Mar 4]. Available from: https://www.legis.md/cautare/getResults?doc_id=123117&lang=ro
3. Government Decision 21 of 18.01.2023 [Internet] [cited 2025 Mar 4]. Available from: https://www.legis.md/cautare/getResults?doc_id=135260&lang=ro
4. World Health Organization. WHO releases new global lists of high-burden countries for TB, HIV-associated TB and drug-resistant TB [Internet]. WHO Library Cataloguing. 2021 [cited 2025 Mar 4]. Available from: https://www.who.int/news/item/17-06-2021-who-releases-new-global-lists-of-high-burden-countries-for-tb-hiv-associated-tb-and-drug-resistant-tb
5. Panico C. Report on the assessment of the accessibility of essential health services to refugees in the Republic of Moldova. 2023;1-50. Available from: https://ombudsman.md/wp-content/uploads/2023/10/raportul-avocatului-poporului-privind-evaluarea-accesibilitatii-serviciilor-esentiale-de-sanata.pdf
6. International Organization for Migration. A QUALITATIVE STUDY ON FOREIGNERS' ACCESS TO HEALTH SERVICES IN THE REPUBLIC OF MOLDOVA [Internet]. Available from: https://publications.iom.int/books/qualitative-study-foreigners-access-health-services-republic-moldova
7. Moezzi SMI Moezzi, Etemadi M, Lankarani KB, Behzadifar M, Katebzada H, Shahabi S. Barriers and facilitators to primary healthcare utilization among immigrants and refugees of low and middle-income countries: a scoping review. Global Health [Internet]. 2024 Dec 1 [cited 2025 Feb 24];20(1):75. Available from: https://pubmed.ncbi.nlm.nih.gov/39449084/
8. Davitian K, Noack P, Eckstein K, Hübner J, Ahmadi E. Barriers of Ukrainian refugees and migrants in accessing German healthcare. BMC Health Serv Res [Internet]. 2024 Dec 1 [cited 2025 Feb 25];24(1):1-10. Available from: https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-024-11592-x
9. Republic of Moldova. Tech Assist Reports [Internet]. 2024 [cited 2025 Mar 4];2024(023):1. Available from: https://www.unhcr.org/countries/republic-moldova?gad_source=1&gclid=CjwKCAiA5pq-BhBuEiwAvkzVZRG5MmeXSpzhjGbTyA21cYNhgAHknBRT5GOSZLrxs7nX57ViUspDNRoCA5QQAvD_BwE
10. World Health Organization (WHO). Health service needs and access for refugees from Ukraine. Https:///WwwWhoInt/Docs/Librariesprovider2/Default-Document-Library/Health-Service-Needs-and-Access-for-Refugees-From-UkrainePdf?Sfvrsn=5E8Ad9De_1&Download=True. 2023;(March 2022).
11. Immigrant & Refugee Transportation Exploratory Needs Assessment | 1. Available from: https://irp-cdn.multiscreensite.com/c86a044e/files/uploaded/King County Immigrant and Refugee Transportation Needs Assessment May 2019.pdf
12. UN. Navigating health and well-being challenges for refugees from Ukraine. An Inter-Agency Explor Data [Internet]. 2024;(May). Available from: https://reliefweb.int/report/bulgaria/navigating-health-and-well-being-challenges-refugees-ukraine
13. International Organization for Migration. UKRAINE RESPONSE REPUBLIC OF MOLDOVA ACCESS TO HEALTHCARE SERVICES. 2023; Available from: https://moldova.un.org/en/265748-republic-moldova---access-healthcare-services-refugees-ukraine---annual-report-2023
14. World Health Organization (WHO). WHO releases new report addressing TB among refugees and migrants [cited 2025 Feb 24]. Available from: https://www.who.int/news/item/19-11-2024-who-releases-new-report-addressing-tb-among-refugees-and-migrants
15. Ziersch A, Due C, Walsh M. Discrimination: A health hazard for people from refugee and asylum-seeking backgrounds resettled in Australia. BMC Public Health. 2020;20(1).

16. Karadag Caman Karadag Caman OO. Stigma and Discrimination towards Migrants in Health Care: Ozge Karadag Caman. Eur J Public Health [Internet]. 2015 Oct 1 [cited 2025 Feb 25];25(suppl_3). Available from: https://dx.doi.org/10.1093/eurpub/ckv167.054
17. CPR Moldova. INTEGRATION OF REFUGEES IN THE REPUBLIC OF MOLDOVA AND THE PROTECTION OF THEIR RIGHTS [Internet]. Vol. 15, Αγαη. 2024. Available from: https://cpr.md/wp-content/uploads/2024/02/Studiu_Integrarea-persoanelor-refugiate-în-Republica-Moldova.pdf
18. Norwegian Refugee Council. Enduring hardships : Ukrainian refugees ' realities in Moldova and Poland two years on Comparative analysis of the situation of refugees from Ukraine in Moldova and Poland (April 2024). 2024;(April). Available from: https://www.nrc.no/siteassets/reports/20240416_report_-two-year-mark-research-pl-and-md.pdf
19. Akhnif EH, Mataria A, Belmadani A, Bigdeli M. Migrants and refugees' health financing in Morocco: How much is the hidden contribution of the government through free services? Health Econ Rev [Internet]. 2024 Dec 1 [cited 2025 Feb 25];14(1). Available from: https://pubmed.ncbi.nlm.nih.gov/39589607/
20. Coumans JVF, Wark S. A scoping review on the barriers to and facilitators of health services utilization related to refugee settlement in regional or rural areas of the host country. BMC Public Health. 2024;24(1).
21. Rabiou LM, Oumarou B, Mor D, Abdou M, Ibrahim C, Tamuzi JL. Mobile outreach clinics for improving health care services accessibility in vulnerable populations of the Diffa Region in Niger: A descriptive study. Res Sq [Internet]. 2024 Nov 12 [cited 2025 Feb 24];23(1):1-20. Available from: https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-024-02322-0
22. International Organization for Migration, Housing Ecosystem Assessment and Options for Social and A ordable Housing in the Republic of Moldova [Internet]. Available from: https://moldova.iom.int/sites/g/files/tmzbdl1626/files/documents/2024-12/pub2024-051-l-housing-ecosystem-assessment-moldova.pdf
23. UNHCR. Temporary protection in Moldova [Internet]. UNHCR. 2021 [cited 2025 Feb 23]. Available from: https://help.unhcr.org/moldova/temporary-protection/
24. Chong C. Temporary protection: Its impact on healthcare for Syrian refugees in Turkey. Int Health. 2018;10(4).
25. Komakech H, Orach CG, Atuyambe LM. Sustainability of health services in refugee hosting districts: a qualitative study of health services in three west Nile refugee hosting districts, Uganda. Confl Health. 2023;17(1).
26. UNHCR Cash assistance for refugees in - UNHCR Moldova [cited 2025 Feb 23]. Available from: https://help.unhcr.org/moldova/how-to-find/cash-assistance/
27. Hanwell K, Finnerty F, Richardson D. Asylum seekers' and refugees' experiences of violence and accessing healthcare in the UK: a systematic review. J Public Health (Bangkok) [Internet]. 2025 Jan 23 [cited 2025 Feb 25]; Available from: https://dx.doi.org/10.1093/pubmed/fdaf005
28. Shi M, Stey A, Tatebe LC. Recognizing and Breaking the Cycle of Trauma and Violence Among Resettled Refugees. Curr Trauma Reports [Internet]. 2021;7(4):83-91. Available from: https://doi.org/10.1007/s40719-021-00217-x
29. Due C, Green E, Ziersch A. Psychological trauma and access to primary healthcare for people from refugee and asylum-seeker backgrounds: A mixed methods systematic review. Vol. 14, International Journal of Mental Health Systems. 2020.
30. Rivenbark JG, Ichou M. Discrimination in healthcare as a barrier to care: Experiences of socially disadvantaged populations in France from a nationally representative survey. BMC Public Health. 2020;20(1).
31. UNDP. Perceptions of human rights in the Republic of Moldova. 2018;69. Available from: https://www.undp.org/ro/moldova/publications/perceptii-asupra-drepturilor-omului-republica-moldova-2018
32. Ye T, Xiao W, Li Y, Xiao Y, Xiao Y, Fang H, Chen W, et al. Trust in family doctor-patient relationships: an embeddedness theory perspective. BMC Public Health [Internet]. 2024 Dec 1 [cited 2025 Mar 4];24(1):1-8. Available from: https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-024-20805-1
33. Capodici A, Noci F, Nuti S, Emdin M, Dalmiani S, Passino C, et al. Reducing outpatient wait times through telemedicine: a systematic review and quantitative analysis. BMJ Open [Internet]. 2025 Jan 30 [cited 2025 Mar 4];15(1):e088153. Available from: https://pmc.ncbi.nlm.nih.gov/articles/PMC11784372/
34. Mangrio E, Sjögren Forss K. Refugees' experiences of healthcare in the host country: a scoping review. Vol. 17, BMC health services research. 2017. p. 814.
35. Kang C, Farrington R, Tomkow L. Access to primary health care for asylum seekers and refugees: A qualitative study of service user experiences in the UK. Br J Gen Pract. 2019;69(685):E537-45.
36. Pandey M, Maina RG, Amoyaw J, Li Y, Kamrul R, Michaels CR, et al. Impacts of English language proficiency on healthcare access, use, and outcomes among immigrants: a qualitative study. BMC Health Serv Res. 2021;21(1).
37. UNAIDS, UNHCR. Policy Brief: HIV and Refugees. 2007;28(2002):20-1. Available from: https://www.unaids.org/sites/default/files/media_asset/jc1300-policybrief-refugees_en.pdf

38. Report T. People who use nps/stimulants: basic needs and barriers in access to hiv related medical and social services in moldova.
39. O'Laughlin KN, Rouhani SA, Faustin ZM, Ware NC. Testing experiences of HIV positive refugees in Nakivale Refugee Settlement in Uganda: Informing interventions to encourage priority shifting. Confl Health. 2013;7(1).
40. Li K, Thaweesee N, Kimmel A, Dorward E, Dam A. Barriers and facilitators to utilizing HIV prevention and treatment services among migrant youth globally: A scoping review. PLOS Glob Public Heal. 2024;4(February 2).
41. Mendelsohn JB, Schilperoord M, Spiegel P, Ross DA. Adherence to antiretroviral therapy and treatment outcomes among conflict-affected and forcibly displaced populations: A systematic review. Vol. 6, Conflict and Health. 2012.
42. Abdissa B, Abdissa R, Derega J, Wake SK. Satisfaction of antiretroviral therapy services and its associated factors among adult clients attending antiretroviral therapy in Woliso town, Ethiopia. AIDS Res Ther [Internet]. 2024 Dec 1 [cited 2025 Feb 24];21(1). Available from: https://pubmed.ncbi.nlm.nih.gov/38254208/
43. Saseetharran A, Hiebert L, Gupta N, Nyirahabihirwe F, Kamali I, Ward JW. Prevention, testing, and treatment interventions for hepatitis B and C in refugee populations: results of a scoping review. BMC Infect Dis [Internet]. 2023 Dec 1 [cited 2025 Feb 24];23(1). Available from: https://pubmed.ncbi.nlm.nih.gov/38071291/
44. Hlatshwayo M, Reno HEL, Reno HEL, Yarbrough ML. STI update: Testing, treatment, and emerging threats. Vol. 86, Cleveland Clinic Journal of Medicine. 2019. p. 733-40.
45. Aljadeeah S, Hosseinalipour SM, Khanyk N, Szocs E, Szocs E, Traianou A, Tomas A, et al. Healthcare provision for displaced people in transit: Analyses of routinely collected data from INTERSOS clinics at the Ukrainian border with Moldova and Poland. J Migr Heal [Internet]. 2024 Jan 1 [cited 2025 Feb 23];11. Available from: https://pubmed.ncbi.nlm.nih.gov/39867634/
46. Horyniak D, Melo JS, Farrell RM, Ojeda VD, Strathdee SA. Epidemiology of substance use among forced migrants: A global systematic review. PLoS One. 2016;11(7).
47. Hertner L, Stylianopoulos P, Heinz A, Kluge U, Schäfer I, Penka S. Substance (mis)use among refugees as a matter of social ecology: insights into a multi-site rapid assessment in Germany. Confl Health. 2023;17(1).
48. Aljadeeah S, Kielmann K, Michielsen J, Payedimarri AB, Ravinetto R. Access to medicine among asylum seekers, refugees and undocumented migrants across the migratory cycle: a scoping review protocol. BMJ Open. 2022;12(12):e068917.
49. Dubov A, Basenko A, Dymaretskyi O, Shoptaw S. Impact of the Russian invasion on opioid agonist therapy programs in Ukraine: A qualitative study. Drug Alcohol Depend. 2024;255.
50. Sant´Anna FM, Araújo-Pereira M, Schmaltz CAS, Arriaga MB, de Oliveira RVC, Andrade BB, et al. Adverse Drug Reactions Related to Treatment of Drug-Susceptible Tuberculosis in Brazil: A Prospective Cohort Study. Front Trop Dis. 2021;2.
51. Ciobanu A, Domente L, Soltan V, Bivol S, Severin L, Plesca V, et al. Do incentives improve tuberculosis treatment outcomes in the Republic of Moldova? Public Heal Action. 2014 Oct 21;4:S59-63.
52. Wen S, Yin J, Sun Q. Impacts of social support on the treatment outcomes of drug-resistant tuberculosis: A systematic review and meta-analysis. BMJ Open. 2020;10(10).
53. Amuzadeh-Araei S, Takian A, Jabbari A. Policy analysis of the Universal Public Health Insurance program for Afghan refugees in Iran: a protocol study. J Health Popul Nutr [Internet]. 2025 Feb 21 [cited 2025 Feb 24];44(1):47. Available from: https://pubmed.ncbi.nlm.nih.gov/39985004/
54. Bleckmann C, Golembe J, Kaiser T, Leyendecker B, Busch J. Mental Health and Well-Being of LGBTQ+ Refugees in Comparison to LGBTQ+ Host Country Population. Sex Res Soc Policy [Internet]. 2024 Dec 18 [cited 2025 Feb 25];1-16. Available from: https://link.springer.com/article/10.1007/s13178-024-01064-6
55. Böge K, Karnouk C, Hahn E, Schneider F, Habel U, Banaschewski T, et al. Mental health in refugees and asylum seekers (MEHIRA): study design and methodology of a prospective multicentre randomized controlled trail investigating the effects of a stepped and collaborative care model. Eur Arch Psychiatry Clin Neurosci. 2020;270(1).