



Comprehensive study of needs, obstacles and prerequisites for independent living of older people (aged 50+ and 60+) in Dnipropetrovsk and Kharkiv regions

Contents

1. Executive summary	3
2. Introduction and study context	9
2.1. Population ageing, war and the accumulation of vulnerabilities	9
2.2. Independent living as a matter of rights, choice and dignity	10
2.3. Regional context of Dnipropetrovska and Kharkivska oblasts	10
2.4. Deinstitutionalisation and the development of community-based support	11
2.5. Rationale, purpose and use of the study findings.....	11
3. Conceptual and regulatory framework	12
3.1. Independent living: freedom of choice rather than the absence of assistance	12
3.2. Functional ability and independence	12
3.3. Independent, supported and institutional living.....	13
3.4. Deinstitutionalisation as a systemic transformation	13
3.5. Regulatory framework for the organisation of community-based social services	14
3.6. Role of local authorities and non-governmental organisations	15
3.7. Analytical framework of the study	15
4. Study methodology and limitations	16
4.1. Study design and methodological approach	16
4.2. Geographical coverage	16
4.3. Quantitative survey	17
4.4. Measurement of functional difficulties: Washington Group short set.....	18
4.5. Assessment of functioning in activities of daily living	19
4.6. Focus group discussions.....	20
4.7. Analysis of open-ended responses.....	20
4.8. Desk review	21
4.9. Quantitative data analysis	21
4.10. Qualitative data analysis	23
4.11. Data triangulation	23
4.12. Data quality assurance.....	24
4.13. Ethical principles	24
4.14. Study limitations	25
5. Profile of study participants, health status and functional ability	25
5.1. Socio-demographic profile.....	25
5.2. Self-rated health and chronic health conditions.....	27
5.3. Officially recognised disability status.....	28
5.4. Detailed analysis of the Washington group questions	28
5.5. Independence in performing basic activities of daily living	30
5.6. Use of assistive products.....	31
5.7. Housing safety and adaptation.....	31
5.8. Key findings of the section	31
6. Older people's understanding of independence and independent living	32
6.1. Independence as the right to choose rather than the absence of assistance.....	32
6.2. Personal space, privacy and housing stability.....	32
6.3. Preferred living arrangement if care needs increase.....	33

6.4. Uncertainty about being able to remain independent	33
6.5. Concerns about future care	34
6.6. Financial capacity as a component of independence.....	34
6.7. Mobility, information and safety as conditions for exercising choice	35
6.8. Social connections, participation and a sense of personal value.....	35
6.9. Life satisfaction as an overall reflection of participants' circumstances	35
6.10. Key findings of the section.....	36
7. Principal needs of older people for independent living	36
7.1. Overall structure of needs	36
7.2. Financial stability	37
7.3. Health services and access to medicines	37
7.4. Assistance in everyday life and home-based care	38
7.5. Gap in the availability of home-based support	39
7.6. Rehabilitation and maintenance of functional ability.....	39
7.7. Assistive products and housing adaptations.....	40
7.8. Transport and accompaniment.....	40
7.9. Psychological support and social interaction.....	40
7.10. Information and legal support	41
7.11. Differences in needs between principal subgroups	41
7.12. Key findings of the section.....	42
8. Barriers, inequalities and risks to independent living	43
8.1. Cumulative nature of barriers	43
8.2. Financial barriers	44
8.3. Health status and functional limitations.....	44
8.4. Inaccessibility of the physical environment and transport.....	44
8.5. Security situation and inaccessible protection	45
8.6. Insufficient care and exhaustion of informal caregivers	45
8.7. Information and digital barriers	46
8.8. Institutional fragmentation	46
8.9. Loneliness, social isolation and lack of support.....	47
8.10. Age discrimination and paternalistic attitudes	47
8.11. Specific barriers affecting particular subgroups	48
8.12. Pathway from accumulating barriers to institutionalisation.....	49
8.13. Key findings of the section.....	49
9. Enabling factors for independent living and mapping of support systems	49
9.1. Principal pillars of independent living	49
9.2. Personal resources, skills and income	50
9.3. Family support.....	50
9.4. Friends, neighbours and local mutual-support networks	51
9.5. Social services and social workers	52
9.6. Health services	52
9.7. Civil society organisations and volunteers	52
9.8. Faith communities.....	53
9.9. Assistive products and an accessible environment	53
9.10. Support-system characteristics for particular subgroups.....	54
9.11. Functional map of formal and informal support systems	55

9.12. Required model for coordinating support	56
9.13. Key findings of the section.....	56
10. Ecosystem of formal and informal support for older people	56
10.1. Overall architecture of the support system	57
10.2. Actual providers of everyday assistance	57
10.3. Formal support system	58
10.4. Informal support from family members and immediate social networks.....	59
10.5. Role of civil society, volunteer and faith-based organisations	60
10.6. Principal systemic gaps	61
10.7. Recommended model for coordinating support.....	61
10.8. Summary	62
11. Comparison of living arrangements and regional differences	62
11.1. Analytical structure.....	62
11.2. Own or rented housing.....	63
11.3. Collective sites.....	64
11.4. Transit centres.....	65
11.5. Long-term care facilities.....	66
11.6. Comparative characteristics of living arrangements	67
11.7. Regional differences	68
11.8. Key findings of the section.....	69
12. Deinstitutionalisation: the role of local authorities and non-governmental organisations	70
12.1. Deinstitutionalisation must begin with supporting people in the community	70
12.2. The risk of institutionalisation results from a combination of deficits	70
12.3. Existing regional programmes provide a foundation but require a shared deinstitutionalisation framework.....	71
12.4. Required amendments to local and regional instruments	71
12.5. Minimum package of support for independent living.....	73
12.6. The role of non-governmental organisations	73
12.7. Transformation of different living arrangements	74
12.8. Monitoring reform outcomes	74
12.9. Conclusion.....	74
13. Integrated study conclusions	75
14. Practical recommendations	80

1. Executive summary

The full-scale war has exacerbated the demographic, social and economic challenges associated with population ageing in Ukraine. Internal displacement, destruction of housing and infrastructure, disruption of transport links, contraction of the network of accessible services, and loss of family and neighbourhood ties have disproportionately affected older people. Risks are particularly high for people with disabilities and significant functional difficulties, people aged 80 and over, internally displaced persons (IDPs), people living alone, and residents of temporary and long-term residential settings.

In response to these challenges, a study was conducted to examine the needs, barriers and enabling conditions for the independent living of older people with and without disabilities in Dnipropetrovska and Kharkivska oblasts. The study understood independent living not as a person's ability to live without any assistance, but as the opportunity to choose where and with whom to live, retain control over everyday routines, participate in community life, and receive the necessary support in accordance with their own choices.

The study used a mixed-methods design. The quantitative survey covered 400 older people, with 200 respondents in each of the two oblasts. The sample included 120 residents of owner-occupied or rented housing, 80 residents of collective sites, 80 people interviewed in transit centres, and 120 residents of long-term care facilities. Women accounted for 70% of the sample and men for 30%; approximately 40% of participants had internally displaced person status.

The qualitative component included eight focus group discussions with older women and men, people with disabilities, and internally displaced persons in both oblasts. Legislation, regional programmes and previous research concerning ageing, disability, social and health services, housing support and deinstitutionalisation were also analysed. The integration of quantitative and qualitative evidence made it possible to examine independent living at the individual, service-delivery and systems levels.

The findings describe the study sample and should not be automatically extrapolated to the entire population of Dnipropetrovska and Kharkivska oblasts. Nevertheless, the consistency between the quantitative indicators, focus group evidence and policy analysis makes it possible to identify persistent patterns, groups at heightened risk, and practical areas for intervention.

Overall assessment of the conditions for independent living

The study shows that the vast majority of older people wish to remain in their own homes or another small-scale residential setting where they can preserve their privacy, social ties and control over everyday life. If they were to require continuous support, 58.8% of respondents would prefer to remain at home and receive the necessary assistance. A further 16.3% would prefer to live with relatives, 11.0% would choose supported living, and only 6.0% would prefer a long-term care facility.

These findings demonstrate that the need for care does not in itself mean that a person wishes to relinquish their independence or move into an institutional setting. Independence is primarily determined by the availability of choice, the ability to make decisions, and access to support that compensates for functional difficulties without depriving the person of control over their own life.

"It is support that makes independence possible. If accessible housing, an assistant for a few hours and transport are available, I can decide for myself how to organise my day." [Participant in an FGD with older people with disabilities, Dnipropetrovska oblast]

At the same time, there is a substantial gap between the desire to remain at home and the actual availability of the necessary services. Regular assistance is already required by 35.8% of respondents, while 85.5% are very or somewhat concerned about who will care for them if their health deteriorates.

Financial hardship, chronic health conditions, functional limitations, inaccessible transport and housing, loneliness, and safety risks generally do not operate in isolation but accumulate. Consequently, even a relatively minor deterioration in health, loss of income, withdrawal of assistance from a relative, or damage to housing may result in a sharp decline in independence and create a risk of forced placement in an institutional setting.

The principal problem, therefore, is not a person's age or their need for assistance, but the absence of a timely, adequate and coordinated package of support at their place of residence.

Key findings in figures

Table 1. Preferred living arrangements and future care

Indicator	Percentage of respondents, %
Would prefer to remain at home with support if continuous care were required	58.8
Would prefer to live with relatives	16.3
Would choose supported living	11.0
Would choose a long-term care facility	6.0
Already require regular assistance	35.8
Very or somewhat concerned about who will care for them in the future	85.5

The findings demonstrate a clear preference for receiving support in a familiar living environment rather than institutional care. At the same time, the high level of concern about future care indicates that people lack confidence in the ability of their families, communities and the existing service system to provide the necessary support if their health deteriorates.

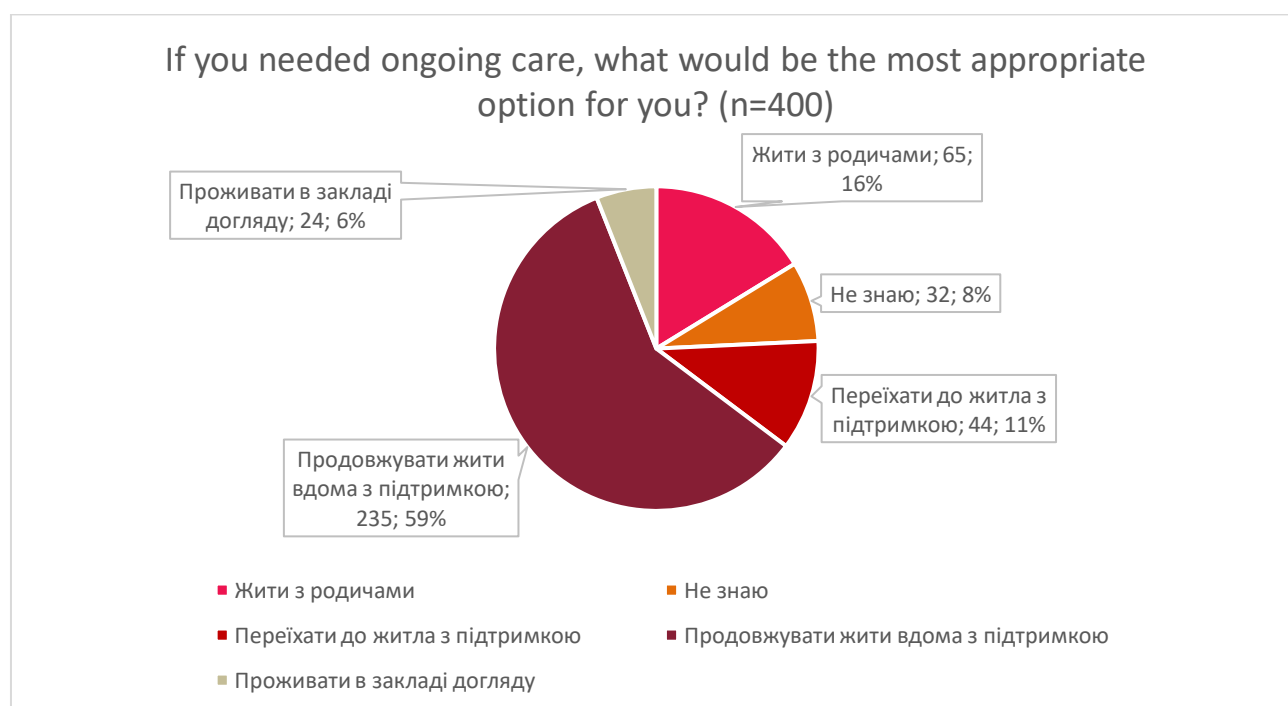


Table 2. Main needs and barriers to independent living

Indicator	Percentage of respondents, %
Require financial support	91.3
Identified the security situation as a factor limiting their independence	79.0

Indicator	Percentage of respondents, %
Identified insufficient financial resources as a factor limiting their independence	77.8
Require medical assistance	66.3
Require access to medicines	58.5
Consider home-based healthcare necessary to remain at home for longer	47.8
Require psychological support to remain at home for longer	29.0
Require home-based care	24.8
Require transport support	21.3

Financial insecurity is the most widespread need and one of the principal factors contributing to the loss of independence. Insufficient income limits people's ability to purchase medicines and pay for treatment, transport, utilities, care and housing adaptations. Financial assistance, however, cannot substitute for unavailable services. Even when a person has some financial resources, they may still lack access to home-based healthcare, rehabilitation, social transport or a qualified caregiver.

The security situation is also a systemic rather than merely contextual barrier. Shelling, transport disruptions, inaccessible shelters, dependence on lifts and electrically powered equipment, and evacuation difficulties directly determine whether a person can continue living independently.

Table 3. Health status and functional difficulties

Indicator	Percentage of respondents, %
Have a chronic illness or long-term health condition	79.3
Rate their health as poor or very poor	32.3
Have significant difficulty in at least one functional domain	27.8
Require regular assistance among people with significant functional difficulties	83.8
Require assistance with activities of daily living among this group	70.3
Rate their health as poor or very poor among this group	71.2
Require housing adaptations among this group	43.2
Rate the accessibility of public places as low among this group	40.5

Significant functional difficulties were defined using the Washington Group Short Set on Functioning as reporting “a lot of difficulty” or being “unable to do” an activity in at least one of six domains: seeing, hearing, walking or climbing steps, remembering or concentrating, self-care, and communication.

The findings show that functional difficulties are among the strongest predictors of the need for assistance from others. Their impact on independence is not inevitable, however: housing adaptations, assistive products, rehabilitation, home-based services, transport and accessible information can substantially reduce a person’s dependence on others.

Table 4. Social connections and everyday support

Indicator	Percentage, %
Live alone	48.5
Always or often feel lonely	24.3
Sometimes feel lonely	35.5
Participated in community activities during the previous six months	21.0
Have no one they can turn to for assistance	14.8
Receive assistance from a social worker ¹	59.6
Receive assistance from an immediate family member ¹	36.3
Receive assistance from a volunteer ¹	23.3
Receive assistance from a neighbour or acquaintance ¹	18.8

Note: ¹ Among the 245 respondents who require assistance regularly or occasionally; multiple responses were permitted.

Almost half of the respondents live alone. Living independently may be a conscious and preferred choice; however, in the absence of a support network, it increases the risk of isolation, delayed access to assistance and crisis-driven displacement. All 59 respondents who had no one to turn to when they needed assistance were living alone.

The findings also show that everyday support is provided through a combination of formal and informal sources. Social workers play a central role, but a substantial share of assistance continues to depend on family members, neighbours and volunteers. Without coordination, support for family caregivers, and a guaranteed minimum package of professional services, this model remains unsustainable

Individual level: choice, functioning and accumulation of risks

At the individual level, independence is determined not only by a person’s health status but by the relationship between their functional capacities and the support available to them. Similar mobility impairments may have very different consequences depending on whether a building has a lift, whether the home is adapted, whether accessible transport is available, and whether the person can receive assistance at home.

On average, each respondent reported three factors limiting their independence. At least three concurrent barriers were experienced by 66.8% of respondents, while 30.0% faced four or more. Among people with significant functional difficulties, 51.4% experienced four or more barriers, compared with 21.8% of other respondents. Among people living alone, the corresponding proportion was 41.8%, compared with 18.9% among those living with others.

This means that the loss of independence generally results not from a single impairment or unmet need, but from the accumulation of interconnected constraints. Financial assistance without transport, medical treatment without rehabilitation, home-based care without housing adaptations, or opportunities for social participation without an accessible physical environment will have only a limited effect.

People aged 80 and over face particularly high risks. Within the study group, 81.3% of respondents in this age category had difficulty moving around outside their homes, and half described these difficulties as very significant or were completely unable to move around outside their homes independently. No respondent aged 80 or over expressed a high level of confidence in their ability to continue living independently over the next five years.

Support for this group must be proactive. Needs assessments, housing adaptations and planning for future care should take place before an acute crisis, hospitalisation or loss of an informal caregiver occurs.

Service-delivery level: fragmented support instead of a coordinated pathway

At the service-delivery level, the study identified a gap between the availability of individual forms of assistance and the system's capacity to build a coordinated package of support around the person. Health, social, rehabilitation, housing, transport and administrative services largely operate as separate systems. Responsibility for coordinating them often falls on the person, their relatives, a social worker or a volunteer.

"The first priority is integrated home-based support: a social worker, a nurse, rehabilitation and respite for the caregiver, all under one plan." [Participant in an FGD with older women, Dnipropetrovska oblast]

The shortage of home-based and mobile services is particularly pronounced. Home-based healthcare was identified by 47.8% of respondents as a condition for remaining at home for longer, psychological support by 29.0%, home-based care by 24.8%, social activities by 22.5%, and transport services by 21.3%.

Older people's independence is supported by several groups of resources: personal economic resources include adequate income, identified by 69.3% of respondents; formal support includes medical services (56.8%) and social services (39.8%); informal support includes assistance from family members (54.8%), friends and neighbours (29.8%); and civil society and humanitarian organisations also play a distinct role (29.3%). These components complement one another, but assistance from relatives, neighbours and volunteers cannot replace guaranteed professional services, particularly when a person requires regular care, medical supervision or rehabilitation.

Family caregivers often simultaneously perform the roles of personal assistant, healthcare coordinator, representative before public authorities, driver and source of financial support. Without training, psychological support and respite services, this model creates a risk of caregiver burnout and the discontinuation of support.

Different living arrangements create different configurations of risk. Living in one's own home is most consistent with people's desire to retain control, but the dwelling may be damaged, inaccessible or remote from services. Collective sites provide basic safety but do not always ensure privacy or offer a pathway towards stable housing. Transit centres perform an important crisis-response function but are not designed for long-term residence. Long-term care facilities may provide round-the-clock assistance but can also restrict choice, privacy and participation in community life.

For older IDPs, the transition from evacuation and initial accommodation to stable housing and long-term support is particularly challenging.

"Once people have been accommodated, responsibility becomes blurred: the administration tells them to contact the community, the community refers them to social services, and social services tell them to collect documents." [Participant in an FGD with older IDPs, Kharkivska oblast]

Systems level: fragmented responsibility and the risk of involuntary institutionalisation

At the systems level, the principal problem is the absence of a unified mechanism combining needs assessment, support planning, financing and monitoring of outcomes. Responsibilities are distributed across social protection, healthcare, housing policy, civil protection and local government systems.

Responsibility for the ultimate outcome—whether a person is able to live safely in the community—nevertheless remains insufficiently defined.

The existing system generally responds only after a crisis has occurred, such as a fall, hospitalisation, loss of housing, sudden deterioration in health, or withdrawal of family care. Preventive risk assessment, early housing adaptations and planning for future support are insufficiently applied.

Under these conditions, institutionalisation may occur not because a person has voluntarily chosen to live in a facility, but because housing, transport, home-based care or family support is unavailable in their place of residence. The transition towards independent living requires not only a reduction in the number of places in institutional facilities but also the development of genuine community-based alternatives: supported living, social rental housing, day care, home-based and mobile services, personal assistance, and support for caregivers.

Civil society, charitable, humanitarian and faith-based organisations partially compensate for gaps in the formal system. They identify people who remain outside the system and provide mobile services, assistive products, legal and psychological assistance, social activities and support for IDPs. Project-based funding and uneven geographical coverage, however, mean that such assistance cannot be regarded as a substitute for guaranteed local services.

Regional and group differences

Application of the WHO ICOPE Implementation Scorecard indicates that most actions at both the service and systems levels remain at an early or initiation stage ([Assessment of the capabilities and readiness of implementation of ICOPE in Ukraine. Research report. HelpAge International, i-APS Ukraine, 2026](#)). Although individual initiatives and pilot practices exist, they have not yet been integrated into a coherent and scalable framework

Table 5. Main regional differences

Indicator	Dnipropetrovska oblast, %	Kharkivska oblast, %
Significant functional difficulties	15.5	40.0
Need for regular assistance	21.5	50.0
Poor or very poor health status	26.5	38.0
Difficulties accessing healthcare services	14.5	32.5

Regional differences should be interpreted in light of the sample composition, particularly the higher proportion of people with functional difficulties in Kharkivska oblast. At the same time, the findings are consistent with the prolonged effects of hostilities, damage to infrastructure, population displacement and increased pressure on local support systems.

Internally displaced persons face a combination of housing instability, loss of familiar services and social ties, documentation-related difficulties, and insufficient coordination following displacement. People with significant functional difficulties have substantially greater needs for regular assistance, housing adaptations and an accessible environment. People living alone are more likely to experience an accumulation of barriers and to lack backup support.

Summary

The study shows that independent living among older people in Ukraine is sustained through a complex combination of personal resources, pensions and other income, family assistance, social and health services, mutual support among neighbours, and assistance from civil society and humanitarian organisations. At the same time, this support system remains insufficiently integrated, uneven and heavily dependent on family resources and the initiative of individual professionals.

The strongest risk factors are the combined effects of insufficient income, deteriorating health, functional difficulties, an inaccessible environment, security threats, and the absence of a person who can provide assistance. Particular attention should be given to people aged 70 and over, people with significant functional difficulties, IDPs, people living alone, and those residing in temporary or institutional settings.

Support is not the opposite of independence. On the contrary, timely, personalised and coordinated assistance is the essential condition that enables a person to preserve choice, privacy, safety and participation in community life.

Strategic implications

The findings indicate the need to move away from isolated cash payments and fragmented services towards a personalised package of support built around each person's needs and choices.

The following areas should be prioritised:

1. Introduce comprehensive assessments of functional, health, social, housing and safety needs and assign one accountable case manager.
2. Expand home-based care, mobile healthcare, rehabilitation and psychological support.
3. Develop training, counselling and respite programmes for family caregivers.
4. Establish social transport services that include assistance from the person's door to the service-delivery location.
5. Finance adaptations to owner-occupied, rented, social and temporary housing.
6. Develop social rental housing, rent subsidies, supported living and other small-scale community-based living arrangements.
7. Introduce individual transition plans for residents of collective sites, transit centres and long-term care facilities.
8. Include older people with functional difficulties in local civil protection, early-warning and evacuation plans.
9. Ensure sustainable financing for non-governmental service providers through social contracting, procurement of services and long-term partnership mechanisms.
10. Require the meaningful participation of older people, people with disabilities and IDPs in the planning, budgeting, monitoring and evaluation of local programmes.

2. Introduction and study context

2.1. Population ageing, war and the accumulation of vulnerabilities

Population ageing in Ukraine is a long-term demographic process; however, the full-scale war has substantially altered the conditions in which people in Ukraine grow older. The destruction of housing and infrastructure, prolonged disruptions to electricity, water and heating supplies, reduced transport connectivity, population displacement and the rising cost of living have exacerbated the challenges already faced by older people. Chronic health conditions, functional limitations and low incomes are increasingly compounded by housing loss, disruption of family ties, social isolation and dependence on humanitarian assistance.

The impact of the war on older people is not limited to direct security risks. Even when a person has not sustained physical injuries or lost their home, their everyday independence may be reduced by the closure of pharmacies and healthcare facilities, shortages of specialists, cancellation of transport routes, inability to access shelters, or suspension of social or rehabilitation services. Under such conditions, a relatively independent person can rapidly become dependent on assistance from others.

The situation is particularly challenging for people with difficulties related to mobility, vision, hearing, self-care, memory or communication. The formal availability of a service does not necessarily mean that a person can use it. A healthcare facility may be open but remain inaccessible because of unavailable transport, a non-functioning lift, a complicated electronic appointment system or information that is difficult to understand. Similarly, the existence of a shelter does not guarantee safety if a person cannot reach it independently.

The challenges experienced by older people are cumulative. Low income limits the ability to purchase medicines or pay for transport; deteriorating health reduces mobility; limited mobility restricts social contact; and social isolation, in turn, reduces the likelihood that a need for assistance will be identified

in a timely manner. The war did not create all these problems, but it has significantly intensified them and made them increasingly interconnected.

2.2. Independent living as a matter of rights, choice and dignity

In this study, independent living is not interpreted as the ability to perform all activities of daily living without assistance from others. A person may use home-based care or receive assistance from relatives, a personal assistant, a social worker or a nurse while retaining their independence, provided that they determine where, with whom and how they live, participate in decision-making, and retain control over the nature of the support they receive.

This approach is consistent with Article 19 of the United Nations Convention on the Rights of Persons with Disabilities, which recognises the right of a person to choose their place of residence, decide where and with whom they live, and have access to the services necessary for living and inclusion in the community. This right does not depend on the level of a person's functional limitations or the intensity of support required. Its implementation requires not only formal freedom of choice but also the availability of genuine alternatives to institutional living.

For older people, independence has several interconnected dimensions: the ability to remain in familiar housing; retain control over everyday routines; manage finances independently or with support; obtain health and social assistance without excessive barriers; maintain relationships with family members and the community; and participate in decisions concerning their own lives. Independence therefore does not mean the complete absence of reliance on others, but the ability to preserve choice, dignity and control when the necessary support is available.

This understanding also avoids dividing people into those who "can live independently" and those who supposedly "need an institution". In many cases, the risk of institutionalisation arises not from a person's condition itself, but from the absence of accessible housing, home-based care, rehabilitation, transport services, assistive products or support for a family caregiver.

2.3. Regional context of Dnipropetrovska and Kharkivska oblasts

Dnipropetrovska and Kharkivska oblasts are among the regions that are both directly affected by the war and host substantial numbers of internally displaced persons. According to Round 22 of the IOM General Population Survey, approximately 3.7 million internally displaced persons were living in Ukraine as of December 2025. The largest number of IDPs was recorded in Dnipropetrovska oblast, which hosted approximately 15% of the total IDP population, followed by Kharkivska oblast with approximately 12%. A substantial proportion of displaced people had been in protracted displacement for more than two years, while Dnipropetrovska and Kharkivska oblasts remained among the primary destinations for new and repeated displacement. [IOM, Ukraine Internal Displacement Report, General Population Survey, Round 22](#)

Dnipropetrovska oblast simultaneously serves as a host region and transit hub while increasingly experiencing shelling and damage to infrastructure itself. Evacuation flows from frontline areas pass through the oblast and include a substantial proportion of older people and people with disabilities. Some remain in transit centres or collective sites, while others attempt to find rented accommodation, stay with relatives or move onward.

Kharkivska oblast combines a large urban centre with communities located closer to areas of active hostilities and regularly affected by security threats, infrastructure damage and workforce losses. For older people, this results in an increased likelihood of repeated displacement, interruption of treatment, loss of established social connections and an inability to obtain necessary assistance regularly.

Living conditions also differ substantially within each oblast. The experience of a person living in a large city cannot automatically be equated with that of someone living in a rural or remote area. Similarly, living in one's own apartment, a collective site, a transit centre or a long-term care facility creates different opportunities for choice, privacy, safety and participation in community life.

The study therefore focuses on the oblast level and does not identify individual communities. This approach protects participant confidentiality, avoids unsupported conclusions about areas with small numbers of respondents, and still makes it possible to identify broader regional patterns.

2.4. Deinstitutionalisation and the development of community-based support

In December 2024, the Cabinet of Ministers of Ukraine approved the Strategy for Reforming Psychoneurological and Other Residential Institutions and Deinstitutionalising Care for Persons with Disabilities and Older People until 2034. The Strategy provides for the creation of legislative and institutional conditions for independent living in the community, the development of social and other services, economic integration, changes in public attitudes, and the gradual reform of the residential institution system. [Order of the Cabinet of Ministers of Ukraine No. 1315-r of 24 December 2024](#)

The first phase of the Strategy's implementation covers 2025–2026 and is intended to establish the legal and organisational foundations necessary for the reform. Subsequent phases provide for changes in financing, development of the service-provider market, training of professionals and expansion of community-based services. The period during which this study was conducted therefore coincides with the initial phase of the reform, when it is particularly important to identify people's actual needs, risks of institutionalisation, and the capacity of local systems to offer alternatives to residential care.

[Government Overview of the Deinstitutionalisation Strategy](#)

The full-scale war has created an additional risk that residential institutions will be used as a rapid solution for evacuated older people, people with disabilities, and those who have lost their housing or have no relatives. Placement in a facility may provide immediate shelter and basic care, but it may simultaneously restrict a person's ability to choose where to live, preserve privacy, maintain social connections and return to life in the community.

Deinstitutionalisation should therefore be understood as more than the reorganisation of the residential institution network. It requires the creation of a system capable of preventing institutionalisation through accessible and supported housing, home-based care, day services, rehabilitation, personal assistance, caregiver support, social transport, and crisis and short-term care. Local authorities have a decisive role, as they assess population needs, plan the network of social services, determine local priorities, and can engage public, municipal and non-governmental providers.

Non-governmental organisations perform a dual role. On the one hand, they directly provide humanitarian, social, psychological, legal and material assistance. On the other, they test new service models, help identify people who remain outside the formal system, strengthen the capacity of local providers, and advocate for the rights of older people and people with disabilities. At the same time, the project-based nature of many such services creates a risk that they will be discontinued when funding ends unless they are integrated into local programmes and budgets.

2.5. Rationale, purpose and use of the study findings

Existing research in Ukraine primarily examines individual aspects of the circumstances of older people, including humanitarian needs, disability, internal displacement, access to healthcare, or the functioning of the residential institution system. Far less evidence is available on how these factors interact and jointly determine a person's ability to remain in the community, make decisions and maintain an acceptable level of autonomy.

There is a particular lack of comparative evidence on the experiences of people living in different settings: their own homes, collective sites, transit centres and long-term care facilities. Regional differences, the role of informal assistance, the contribution of civil society organisations, and the specific changes required in local policy have also not been sufficiently systematised.

The purpose of this study is to develop an evidence-based understanding of the needs, barriers and enabling conditions that determine the ability of older people in Dnipropetrovska and Kharkivska oblasts to live independently, safely and with dignity.

The study combines a quantitative survey of 400 older people, focus group discussions, analysis of open-ended responses and desk research. The sample includes 120 residents of their own homes, 80 residents of collective sites, 80 people staying in transit centres, and 120 residents of long-term care facilities. Approximately 40% of participants are internally displaced persons. This makes it possible to examine not only overall trends but also the experiences of groups living in different housing, functional and social circumstances.

The study findings are intended to serve three interconnected purposes. First, they are intended to inform improvements to the programmes of HelpAge International and its partner organisations, including programmes concerning home-based support, access to services, housing adaptations, social inclusion and caregiver support. Second, they are intended to support advocacy for the development of community-based services and the practical implementation of the deinstitutionalisation reform. Third,

they are intended to inform recommendations to national and local authorities on regulation, financing, intersectoral coordination and monitoring of the situation of older people.

The central research question is therefore not whether an older person can cope with every difficulty independently. Rather, it concerns the conditions, services and forms of support that must be established to enable a person to preserve choice, retain control over their own life, and remain part of the community regardless of age, disability, displacement status or the intensity of their support needs.

3. Conceptual and regulatory framework

3.1. Independent living: freedom of choice rather than the absence of assistance

In this study, independent living is understood as a person's ability to exercise control over their own life and make decisions concerning where and how they live, their everyday routines, use of financial resources, medical treatment, care and participation in community life. Independence does not mean that a person must live alone or perform every activity without assistance. On the contrary, appropriate support may be the principal condition enabling independence.

Article 19 of the United Nations Convention on the Rights of Persons with Disabilities establishes the equal right of persons with disabilities to live in the community, with choices equal to those of others. This includes the right to choose their place of residence, decide where and with whom they live, not be obliged to live in a particular living arrangement, and have access to in-home, residential and other community support services. [United Nations Convention on the Rights of Persons with Disabilities, Article 19](#)

In General Comment No. 5, the United Nations Committee on the Rights of Persons with Disabilities explains that independent living entails the ability to exercise choice and control in all areas of everyday life. The level of a person's functional limitations or the intensity of their support needs cannot justify depriving them of the right to live in the community. Support must respect the person's will and preferences rather than subordinating their life to the convenience of the service provider or an established institutional routine. [General Comment No. 5 on Article 19 of the Convention](#)

Although Article 19 directly concerns the rights of persons with disabilities, its underlying approach is relevant to all older people. Age, deteriorating health or the need for care should not automatically result in the loss of choice, privacy or participation in decision-making. A person who requires assistance with bathing, preparing meals, mobility or taking medication can continue to live independently if support is organised according to their needs and does not deprive them of control over their own life.

Accordingly, independence in this study is not equated with complete functional self-sufficiency. It is defined through a combination of five key elements:

1. The ability to exercise choice and make decisions.
2. Control over the assistance received.
3. Accessibility of housing, services and infrastructure.
4. Maintenance of social connections and participation in community life.
5. Availability of genuine alternatives to institutional living.

3.2. Functional ability and independence

Functional difficulties are an important but not the sole factor determining a person's ability to live independently. Two people with the same mobility impairment may have fundamentally different levels of independence depending on the accessibility of their housing, transport, assistive products, family support and home-based services.

The study therefore distinguishes between:

- health status and the presence of chronic health conditions;
- officially recognised disability status;
- actual functional difficulties;
- the ability to perform activities of daily living;
- the need for assistance from others;
- the availability of the necessary support.

Functional difficulties are assessed across the six domains of the Washington Group Short Set on Functioning: seeing, hearing, mobility, remembering and concentrating, self-care, and communication. These questions make it possible to identify people who may not have officially recognised disability status but experience substantial restrictions on participation in everyday life.

Basic activities of daily living—bathing, dressing, using the toilet, moving around inside the home and eating—are analysed separately. Combining the Washington Group Short Set with the ADL assessment makes it possible to distinguish the presence of functional difficulties from actual dependence in self-care.

The following sections analyse not only the prevalence of functional difficulties but also how they interact with age, gender, region, living arrangement, loneliness, access to services and a person's confidence in their ability to continue living independently over the next five years.

3.3. Independent, supported and institutional living

A person's living arrangement does not in itself determine their level of independence. A person may live in their own apartment but remain effectively isolated because of a non-functioning lift, inaccessible transport, lack of home-based care, or an inability to purchase food and medicines independently. Conversely, living with family members or receiving regular assistance does not necessarily constitute a loss of independence if the person retains the ability to express their own decisions and influence how support is provided.

The following working definitions are applied for the purposes of this study.

Independent living in one's own home means living in a privately owned or rented apartment or house, alone, with relatives or with other people, while retaining the ability to control everyday life and receive the necessary support at home or in the community.

Supported living is a social service that combines housing in the community with individually determined support. Such support may include assistance with self-care, household tasks, communication, management of financial resources, access to services and participation in community life. Supported living must not reproduce an institutional model through collective routines, restrictions on freedom, or staff control over residents' decisions.

Ukraine has adopted the State Standard for the Social Service of Supported Living for Older People and Persons with Disabilities, approved by Order No. 454-N of the Ministry of Social Policy of 8 October 2024. The Standard provides a regulatory foundation for developing supported living as an alternative to institutional care. [State Standard for Supported Living](#)

A collective site is a residential arrangement intended for the temporary accommodation of displaced persons. Its consistency with the principles of independent living depends on the duration of residence, accessibility of the premises, privacy, opportunities to prepare food and receive visitors, access local services, and influence the rules governing communal living.

A transit centre is a short-term place of stay for evacuated or displaced people where the primary purposes are safety, immediate assistance and onward referral. A transit centre is not a form of long-term housing, and an extended stay may deepen a person's uncertainty and dependence.

A long-term care facility is a residential facility in which a person lives permanently or for an extended period and receives care. Collective living is not the sole defining feature of institutionalisation. The determining factors are the extent of the person's control over their own life; their ability to choose their routine, food, social contacts and activities; their access to the community; their privacy; the voluntary nature of their stay; and their ability to change their place of residence.

Institutional characteristics may also exist in a small facility if all residents are subject to a single routine, lack privacy, and cannot independently manage their financial resources, leave the premises or influence the support they receive. By contrast, small-scale housing in the community that provides individualised assistance, freedom of choice and access to mainstream services may be consistent with the principles of supported living.

3.4. Deinstitutionalisation as a systemic transformation

Deinstitutionalisation is not limited to closing or renaming residential institutions. It entails shifting the centre of the support system from the institution to the person and the community. Resources should be directed not only towards maintaining places in residential facilities but also towards creating services that enable people to live in an environment of their choosing.

The Strategy for Reforming Psychoneurological and Other Residential Institutions and Deinstitutionalising Care until 2034 identifies the development of community-based services as one of

the central areas of reform. It covers not only people already living in institutions but also those at risk of institutionalisation because of disability, deteriorating health, housing loss, the absence of a caregiver, or the unavailability of necessary services. [Deinstitutionalisation Strategy until 2034](#)

In the context of this study, deinstitutionalisation encompasses three interconnected areas:

- preventing new cases of institutionalisation;
- creating conditions for people to transition from institutions to community living;
- transforming residential care in accordance with the principles of dignity, autonomy, privacy and individual choice.

Preventing institutionalisation requires the early identification of risks. These may include deterioration in functional status, death or burnout of a caregiver, housing loss, repeated displacement, prolonged hospitalisation, loneliness, lack of income, or inability to obtain assistance at home. If the local system responds only after a crisis has occurred, a long-term care facility often becomes the only available solution.

The key components of deinstitutionalisation therefore include home-based care, home-based healthcare, day care, rehabilitation, personal assistance, social support, supported living, crisis and short-term accommodation, respite services for caregivers, social transport, access to assistive products, and housing adaptations.



3.5. Regulatory framework for the organisation of community-based social services

The Law of Ukraine “On Social Services” establishes the organisational and legal foundations for preventing difficult life circumstances, addressing their consequences, and providing social services in accordance with a person’s individual needs. The Law provides for needs assessments, the development of individual plans, case management, the engagement of providers under different forms of ownership, and assessment of service quality. [Law of Ukraine “On social services”](#)

At the local level, regularly determining the population’s need for social services within a territorial community is critically important. The relevant Procedure, approved by Order No. 130-N of the Ministry of Social Policy of 19 April 2023, requires an analysis of the socio-demographic situation, the size of vulnerable groups, available services, their capacity and unmet needs. [procedure for determining the population’s need for social services in a territorial community](#)

Resolution No. 64 of the Cabinet of Ministers of Ukraine of 14 January 2026 updated the procedure for organising the provision of social services and case management within communities. It strengthens the importance of needs assessments, individual planning and coordination among the actors involved in supporting a person. [Resolution No. 64 of the Cabinet of Ministers of Ukraine of 14 January 2026](#)

An important new component of the regulatory framework is the State Standard for the Social Service of Consultation on the Adaptation of Residential Premises, which entered into force in November 2025. It provides for housing assessments, identification of required adaptations, selection and adjustment of assistive products, training in their use, and the engagement of a multidisciplinary team. The Standard applies not only to people with officially recognised disability status but also to people with limitations in everyday functioning. [State standard for consultation on housing adaptation](#)

The existence of a regulatory instrument does not, however, guarantee that the service is available in practice. To implement it, a community must:

- include the relevant service within the local social service system;
- designate a provider and establish a financing mechanism;
- train or engage appropriately qualified professionals;
- establish referral procedures and inter-agency coordination;
- provide information to the population in accessible formats;
- monitor coverage and quality.

Analysis of local policies must therefore assess not only the formal existence of programmes or service lists but also their budgetary allocations, actual coverage, geographical accessibility, sustainability and responsiveness to the needs of older people.

3.6. Role of local authorities and non-governmental organisations

Local authorities are central to implementing the right to independent living. It is at the local level that needs are assessed, service networks are planned, municipal providers are financed, social contracting is implemented, non-governmental organisations are engaged, and transport, accessibility of public buildings and civil protection are ensured.

To implement the deinstitutionalisation reform, local social protection programmes must move away from the predominantly category-based distribution of material assistance towards planning services on the basis of people's actual functional and everyday needs. Official disability status, age or IDP status should not be the sole eligibility criteria. A person may experience significant difficulties with mobility or self-care without having formally recognised disability status or meeting the formal criteria of a particular programme.

Non-governmental organisations may act as:

- direct providers of social and humanitarian services;
- community partners in identifying needs;
- developers and pilot providers of new support models;
- providers of training and methodological assistance;
- representatives of the interests of older people;
- independent monitors of rights and service quality;
- advocacy partners in reforming local programmes.

At the same time, NGOs should not be expected to compensate indefinitely for the essential functions of the public system solely through short-term project funding. Successful models initiated by civil society or international organisations should gradually be integrated into local programmes, referral pathways and financing mechanisms.

3.7. Analytical framework of the study

A multidimensional framework is used to assess independent living.

Analytical dimension	What is assessed	Main sources
Choice and control	Ability to determine one's place and mode of living, make decisions and retain control over assistance	FGDs; Q30; Q47
Health and functioning	Chronic health conditions, disability, the six Washington Group domains, and ADLs	Q9–Q19; Q22–Q26 of the ADL module
Financial security	Income, financial support, and expenditure on medicines, housing and transport	Q18; Q29; Q34; Q39; open-ended Q44–Q45

Housing and environment	Housing safety, need for adaptations, mobility, and accessibility of buildings and shelters	Q7–Q8; Q33; Q35; Q38
Care and services	Need for assistance, types and providers of assistance, adequacy of support, and access to health and social services	Q19–Q29; Q40–Q43
Social inclusion	Social contacts, community participation, loneliness, discrimination, and availability of someone to turn to for help	Q27–Q32; Q36–Q37
System sustainability	Availability of formal and informal support mechanisms, the role of NGOs, local programmes and regulatory gaps	FGDs; regulatory review; regional programmes

This framework makes it possible to analyse independence not as a personal characteristic, but as the outcome of the interaction between a person's functional capacities and their housing, support, services, community environment and public policy. Limitations on independence should therefore not automatically be attributed to age, illness or disability. In many cases, they result from barriers that can and should be removed through appropriate planning and provision of support.

4. Study methodology and limitations

4.1. Study design and methodological approach

The study employed a mixed-methods design combining quantitative and qualitative methods of data collection and analysis with a desk review of regulatory, programme and research materials. This approach made it possible to assess the prevalence of key needs and barriers, explore participants' own understanding of independence, and explain how individual experiences are connected to service organisation, living conditions and the broader humanitarian and regulatory context.

The study comprised three interconnected components:

1. A structured survey of 400 older people.
2. Eight focus group discussions with older people.
3. A desk review of legislation, regional documents, programme materials and previous research.

Open-ended responses provided by quantitative survey respondents constituted an additional source of qualitative evidence. They complemented the standardised response options with participants' own descriptions of the changes required, the services they considered most important, and problems not otherwise captured by the questionnaire.

The sources were combined for triangulation purposes. Quantitative data demonstrated the scale and structure of the issues examined; FGDs helped explain people's experiences and the mechanisms through which these issues emerged; and the desk review made it possible to relate the findings to statutory responsibilities, regional programmes and the deinstitutionalisation reform.

4.2. Geographical coverage

The study covered Dnipropetrovska and Kharkivska oblasts. Fieldwork was conducted in the communities specified in the Terms of Reference; however, findings are presented only at the oblast level.

Results are not presented for individual communities for three reasons. First, the number of participants in some communities was insufficient to support valid quantitative comparisons. Second, greater geographical detail could have created a risk of indirectly identifying participants, particularly residents of transit centres and long-term care facilities. Third, the primary objective of the study was to identify broader regional patterns rather than assess the performance of individual communities.

Regional comparisons were conducted between Dnipropetrovska and Kharkivska oblasts. They covered needs, barriers, access to services, security risks, social support, functional difficulties and confidence in the ability to continue living independently.

4.3. Quantitative survey

4.3.1. Sample

The quantitative survey involved 400 people aged 50 and over. A purposive quota sampling approach was used. The sample was designed to ensure equal regional representation, the required gender distribution, and the inclusion of different age groups, people with disabilities, internally displaced persons and people living in different residential settings.

Table 6. Quantitative sample profile

Characteristic	Category	Number	Percentage
Oblast	Dnipropetrovska	200	50.0%
	Kharkivska	200	50.0%
Gender	Women	280	70.0%
	Men	120	30.0%
Age	50–59 years	80	20.0%
	60–69 years	160	40.0%
	70–79 years	120	30.0%
	80 years and over	40	10.0%
Living arrangement	Own or rented housing	120	30,0%
	Collective site	80	20,0%
	Transit centre	80	20,0%
	Long-term care facility	120	30,0%
Displacement status	IDPs	160	40,0%
	Other respondents	240	60,0%

The participants' mean age was 66.3 years, the median age was 66 years, and the overall age range was 50–88 years.

The planned gender distribution was fully achieved: women accounted for 70% and men for 30% of the sample. The regional distribution also corresponded to the study design, with 200 respondents in each oblast.

The age distribution corresponded to the planned quotas: 20% of respondents were aged 50–59, 40% were aged 60–69, 30% were aged 70–79, and 10% were aged 80 and over. Results concerning the oldest age group were nevertheless interpreted cautiously. Where relevant, percentages for this group were accompanied by the absolute number of observations, and conclusions were not generalised to all people aged 80 and over without appropriate caveats.

4.3.2. Inclusion criteria

Participants were eligible for inclusion if they:

- were aged 50 or over;
- were residing or temporarily staying in Dnipropetrovska or Kharkivska oblast at the time of the survey;
- were able to provide free and informed consent;
- belonged to one of the defined groups based on their living arrangement;
- agreed to participate in an individual structured interview.

Participation did not depend on officially recognised disability status. This was critically important because functional difficulties may arise before disability status is formally established or may remain formally unrecognised because of complex procedures, insufficient information, security constraints or a person's reluctance to apply for official status.

4.3.3. Survey instrument

The questionnaire covered the following thematic modules:

- socio-demographic profile;
- household composition and living conditions;
- health status and chronic health conditions;
- officially recognised disability status;
- Washington Group Short Set on Functioning;
- assistive products;
- access to health and social services;
- current needs;
- need for care and assistance from others;
- activities of daily living;
- social support and participation in community life;
- loneliness and life satisfaction;
- barriers to independent living;
- factors supporting independence;
- priority changes and services;
- confidence in the ability to live independently over the next five years.

As some question numbers were repeated across different questionnaire modules, variables were identified during the analysis using the full wording of each question rather than the question number alone. This prevented the conflation of, for example, two different sections concerning access to healthcare or questions Q22–Q30 appearing in both the care and ADL modules.

Interviews were conducted individually. Where necessary, interviewers adjusted the pace, repeated questions or ensured that the interview took place in a physically accessible setting. Assistance from a third person was permitted only when necessary for communication and was not allowed to substitute for the participant's own response.

4.4. Measurement of functional difficulties: Washington Group short set

The Washington Group Short Set on Functioning (WG-SS) was used to identify functional difficulties. The instrument covers six basic functional domains:

1. Seeing, even when wearing glasses.
2. Hearing, even when using a hearing aid.
3. Walking or climbing steps.
4. Remembering or concentrating.

5. Self-care, including washing and dressing.
6. Communication, including understanding others and being understood.

The WG-SS is not a medical diagnostic instrument and does not determine a person's legal disability status. Its purpose is to identify people who may be at increased risk of restricted participation in society because of functional difficulties.

A four-level response scale was used for each domain:

- no difficulty;
- some difficulty;
- a lot of difficulty;
- cannot do at all.

The principal WG-SS indicator was constructed using the threshold recommended by the Washington Group. Respondents were classified as meeting the functional criterion for disability if they reported "a lot of difficulty" or "cannot do at all" in at least one of the six domains.

The following indicators were constructed during the analysis:

- the proportion of respondents experiencing difficulty in each domain;
- the proportion experiencing any difficulty, beginning with "some difficulty";
- the principal WG-SS indicator — "a lot of difficulty" or "cannot do at all" in at least one domain;
- the number of domains in which a person experienced difficulty;
- the highest level of severity across the six domains;
- the co-occurrence of multiple functional difficulties;
- the relationship between the WG-SS indicator and officially recognised disability status;
- associations between the WG-SS indicator and age, gender, region, ADLs, need for assistance, access to services, and confidence in future independent living.

The analysis found that 111 of the 400 respondents, or 27.8%, met the recommended WG-SS functional threshold. This indicator was analysed separately from officially recognised disability status, as the two indicators measure different phenomena.

A detailed analysis of all six Washington Group domains is presented in a separate subsection of the findings.

4.5. Assessment of functioning in activities of daily living

An ADL module was used to assess basic activities of daily living. It covered:

- bathing;
- dressing;
- using the toilet;
- moving around inside the home;
- eating.

For each activity, the level of independence and need for assistance were assessed. The responses were used to construct:

- domain-specific indicators for each activity;
- an indicator of the need for any assistance with ADLs;
- the number of activities for which assistance was required;
- an aggregate category reflecting the level of dependence.

The WG-SS and ADL results were analysed together but were not treated as interchangeable. The WG-SS captures difficulties in basic functional domains, whereas the ADL module indicates the extent to which those difficulties affect the performance of specific everyday activities.

4.6. Focus group discussions

Eight focus group discussions were conducted, with four in each oblast. A total of 56 older people participated in the FGDs, with seven participants in each group.

The qualitative sample had the same structure in both oblasts:

Table 7. Qualitative Sample Profile

Participant group	Dnipropetrovsk oblast	Kharkivska oblast	Total participants
Older women	1 FGD / 7 participants	1 FGD / 7 participants	14
Older men	1 FGD / 7 participants	1 FGD / 7 participants	14
Older people with disabilities	1 FGD / 7 participants	1 FGD / 7 participants	14
Internally displaced older people	1 FGD / 7 participants	1 FGD / 7 participants	14
Total	4 FGDs / 28 participants	4 FGDs / 28 participants	56

This design made it possible to compare:

- women's and men's experiences of ageing;
- the experiences of people with disabilities;
- experiences of internal displacement;
- common and divergent themes across the two oblasts.

The FGDs explored participants' understanding of independence, everyday life, needs, access to health and social services, care, barriers, social inclusion, the role of the community and priority changes.

All quotations used in the report were anonymised. Attribution identifies only the participant's gender or the key characteristic of the FGD group and the oblast. The names of specific communities and facilities, as well as personal characteristics that could lead to the identification of a participant, are not disclosed.

4.7. Analysis of open-ended responses

The questionnaire included several open-ended questions:

- Q44—three changes that would most improve the person's ability to live independently;
- Q45—the services most needed by people of the respondent's age in their community;
- Q48—important needs or difficulties not covered by the questionnaire;
- Q49—the respondent's concluding comments.

Responses were cleaned by removing technical entries, missing values and responses without substantive content, such as "no", "none" or a dash. Substantive responses were coded under the following themes:

- financial security;
- healthcare and medicines;
- housing;
- employment and income-generating opportunities;
- social services;
- home-based care;
- transport;
- accessibility;
- psychological support;
- social activities;

- legal assistance;
- safety and an end to the war;
- respect, attention from the state and participation in decision-making.

Open-ended responses were used to explain the quantitative findings and as a source of short anonymised quotations. They were not treated as a separate representative qualitative study.

4.8. Desk review

The desk review covered:

- the United Nations Convention on the rights of persons with disabilities and the international interpretation of the right to independent living;
- Ukrainian legislation governing social services;
- the Deinstitutionalisation Strategy until 2034;
- state standards governing supported living, palliative care and housing adaptation;
- the procedure for determining the population's need for social services within a community;
- regional programmes concerning social protection, support for IDPs, development of social services and accessibility;
- IOM reports on internal displacement;
- studies concerning the needs of people with disabilities and older people;
- research on the institutional care system and deinstitutionalisation;
- previous materials developed by HelpAge International and i-APS Ukraine concerning integrated care.

Regulatory documents were identified through the official Legislation of Ukraine database and the websites of the Cabinet of Ministers of Ukraine, relevant ministries and oblast military administrations. Priority was given to current versions of legislation and other official documents.

The purpose of the desk review was not to assess each community individually, but to identify:

- existing regulatory opportunities;
- the distribution of responsibilities;
- the principal gaps between regulatory requirements and access in practice;
- potential amendments to regional and local programmes;
- the role of NGOs in service development and the deinstitutionalisation reform.

4.9. Quantitative data analysis

The quantitative analysis was conducted in several stages.

Descriptive statistics

Frequencies and proportions were calculated for categorical variables. The mean, median, minimum and maximum were calculated for age and other numerical variables. For multiple-response questions, each response option was analysed as a separate binary indicator.

For multiple-response questions, percentages could sum to more than 100% because respondents were able to select more than one answer. Each chart specifies the denominator used for the calculation, such as:

- all respondents, N=400;
- only respondents requiring assistance;
- only respondents who sought healthcare;
- another relevant subgroup.

Comparative analysis

The principal indicators were compared by:

- oblast;
- gender;
- age group;
- living arrangement, where this could be validly linked to individual responses;
- officially recognised disability status;
- WG-SS indicator;
- level of ADL dependence;
- living alone;
- need for regular assistance.

A confirmed aggregate estimate of approximately 40% was used to describe IDP status in the sample profile. Detailed findings concerning the experiences of IDPs were based primarily on the dedicated FGDs, open-ended responses, comparisons between living arrangements and external IOM data.

For categorical variables, a chi-square test or Fisher's exact test could be applied where the number of observations was small. In addition to statistical significance, the analysis considered the absolute difference between groups, subgroup size and the practical significance of the finding. Where possible, effect sizes, including Cramér's V, were calculated.

Findings concerning small subgroups, particularly people aged 80 and over, were interpreted cautiously. Percentages were accompanied by the absolute number of observations.

Analysis of five-point scales

For questions using response scales from 1 to 5, full distributions were analysed. For selected comparisons, responses were additionally grouped as follows:

- 1–2: low level or negative assessment;
- 3: moderate or uncertain assessment;
- 4–5: high level or positive assessment.

This grouping was applied to satisfaction with services, sense of belonging to the community, accessibility and confidence in future independent living. Mean values were not used as the sole summary measure for ordinal scales.

Multivariable analysis

The principal outcome variable for multivariable analysis was the respondent's confidence in their ability to continue living independently over the next five years, measured through Q47.

For the binary model, responses were grouped as follows:

- 4–5: confident or fully confident;
- 1–3: not confident, rather not confident or uncertain.

Potential predictors included:

- age;
- gender;
- oblast;
- WG-SS indicator;
- level of ADL dependence;
- self-rated health;
- living alone;
- need for regular assistance;
- adequacy of the assistance received;

- loneliness;
- family and community support;
- accessibility of health and social services;
- impact of the security situation.

The model results were interpreted as statistical associations rather than evidence of causal effects. Odds ratios, confidence intervals and the direction of associations were reported. Given the quota-based nature of the sample, the model was used to identify internal patterns within the study group rather than to make population-level predictions for the two oblasts.

4.10. Qualitative data analysis

FGD transcripts were analysed using thematic analysis. The initial codebook was developed on the basis of the study objectives and included the following principal categories:

- understanding of independence;
- needs;
- health and functioning;
- housing;
- care;
- access to services;
- economic barriers;
- physical and information accessibility;
- loneliness and social inclusion;
- safety;
- internal displacement;
- formal and informal support;
- alternatives to institutional care;
- the role of NGOs;
- priority changes.

Inductive subcategories emerging from participants' responses were added during coding. These included hidden needs for assistance, reluctance to become a burden on the family, digital exclusion, instability of project-funded services, loss of social roles, caregiver support, repair of assistive products and accessibility of shelters.

The prevalence of themes in the qualitative material was not converted into percentages. Expressions such as "most FGD participants" were used only when a theme was evident across the majority of groups. In other cases, the report indicates that a theme emerged in particular groups or was especially characteristic of a specific subgroup.

Quotations were selected according to three criteria:

- they clearly illustrated the analytical finding;
- they contained no information that could identify the participant;
- they were not used as a substitute for quantitative evidence concerning the prevalence of a phenomenon.

4.11. Data triangulation

For each key theme, findings from different sources were compared. For example:

- quantitative responses concerning financial needs were compared with open-ended responses and FGD discussions of the cost of medicines and utilities;

- WG-SS and ADL results were compared with accounts of mobility, self-care and accessibility;
- responses concerning the desire to remain at home were compared with themes relating to home-based care, supported living and fear of institutionalisation;
- assessments of social services were compared with participants' accounts of their actual experiences of receiving assistance;
- findings concerning IDPs were compared with data from the dedicated FGDs and IOM reports;
- findings concerning local services were compared with existing statutory responsibilities and regional programmes.

Convergence between findings from different sources was treated as strengthening the evidence base. Divergences were not eliminated mechanically but analysed as potential indications of different subgroup experiences, uneven access to services, or gaps between the formal availability of a service and people's ability to access it in practice.

4.12. Data quality assurance

Before the quantitative dataset was analysed, it was checked for:

- duplicate records;
- values outside permissible ranges;
- missing values in key variables;
- logical consistency between related questions;
- correct coding of multiple responses;
- compliance with the age-based inclusion criteria;
- consistency with the regional and gender quotas.

No complete duplicate records were identified. Key variables—including age, gender, oblast, health status, officially recognised disability status, WG-SS, principal needs, barriers, enabling factors and Q47—were complete for all 400 respondents.

The aggregate distribution by living arrangement was verified against the final fieldwork quotas. Analyses requiring living arrangement to be linked to other individual responses used only verified observations, and the resulting conclusions were additionally checked against the FGD evidence.

The qualitative material was reviewed for consistency with the discussion guide, completeness of thematic sections, and the availability of sufficient context to interpret quotations accurately.

4.13. Ethical principles

Participation in the study was voluntary. Before the survey or FGD began, participants were informed about the purpose of the study, the nature of the questions, confidentiality protections, their right not to answer individual questions, and their right to discontinue participation at any time.

Particular attention was paid to:

- explaining information in an accessible manner;
- allowing sufficient time for participants to respond;
- preventing pressure from facility staff, relatives or other persons;
- protecting the confidentiality of information concerning health, disability, displacement and family circumstances;
- minimising emotional distress;
- allowing participants to take breaks;
- anonymising quotations and findings.

4.14. Study limitations

The findings should be interpreted in light of the following limitations.

Quota-based sample. The sample was neither random nor statistically representative of all older people in Dnipropetrovska and Kharkivska oblasts. The findings describe the experiences of the study participants and support comparisons within the study sample.

Representation of age groups. People aged 80 and over accounted for 10% of the sample, or 40 participants. Findings concerning this group provide important analytical signals but should be generalised with caution.

Aggregate nature of selected indicators. The proportion of IDPs and the final distribution by living arrangement were confirmed at the aggregate level. Consequently, not all quantitative indicators could be fully disaggregated by displacement status or living arrangement. Such comparisons were supplemented with qualitative evidence.

Self-reported data. Information concerning health, functional difficulties, access to services, discrimination, loneliness and life satisfaction was based on participants' self-reports and may have been influenced by recall, expectations and willingness to disclose personal difficulties.

Cross-sectional design. The survey reflects the situation at the time of data collection and does not make it possible to determine causal relationships or changes over time directly.

Security context. Shelling, air-raid alerts, population displacement, transport restrictions and interruptions to the operation of institutions may have affected both access to participants and their responses.

FGD group dynamics. Participants may have refrained from raising sensitive issues or may have agreed with more active members of the group. FGD findings were therefore used to understand experiences and underlying mechanisms rather than estimate the prevalence of particular phenomena.

Absence of community-level comparisons. Because of the small number of participants in some locations, findings were aggregated at the oblast level. This limits the possibility of assessing local differences but reduces the risk of inaccurate or stigmatising conclusions concerning particular communities.

Despite these limitations, the combination of a quantitative survey, FGDs, open-ended responses and a regulatory desk review provides a sufficient evidence base for identifying the principal needs, barriers and enabling conditions for independent living and developing practical programme and policy recommendation.

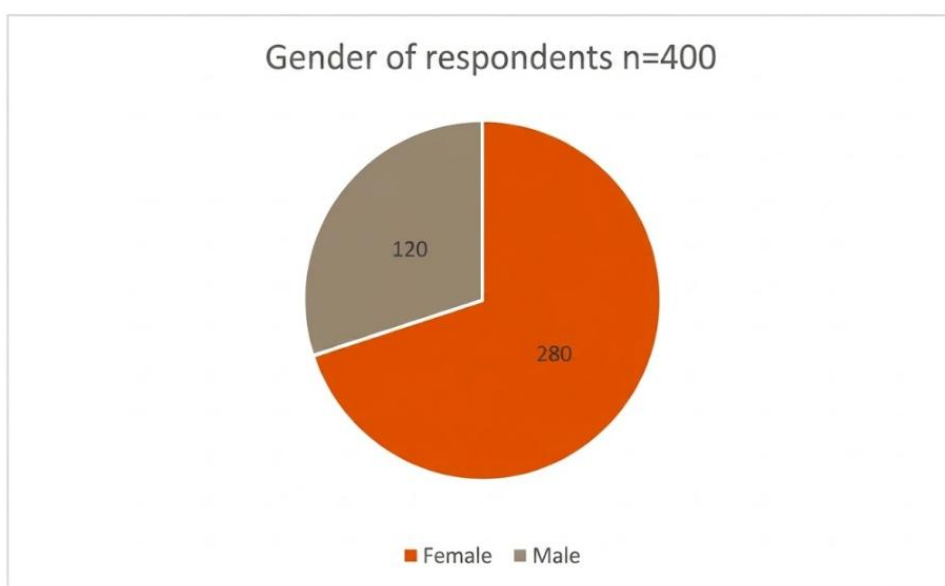
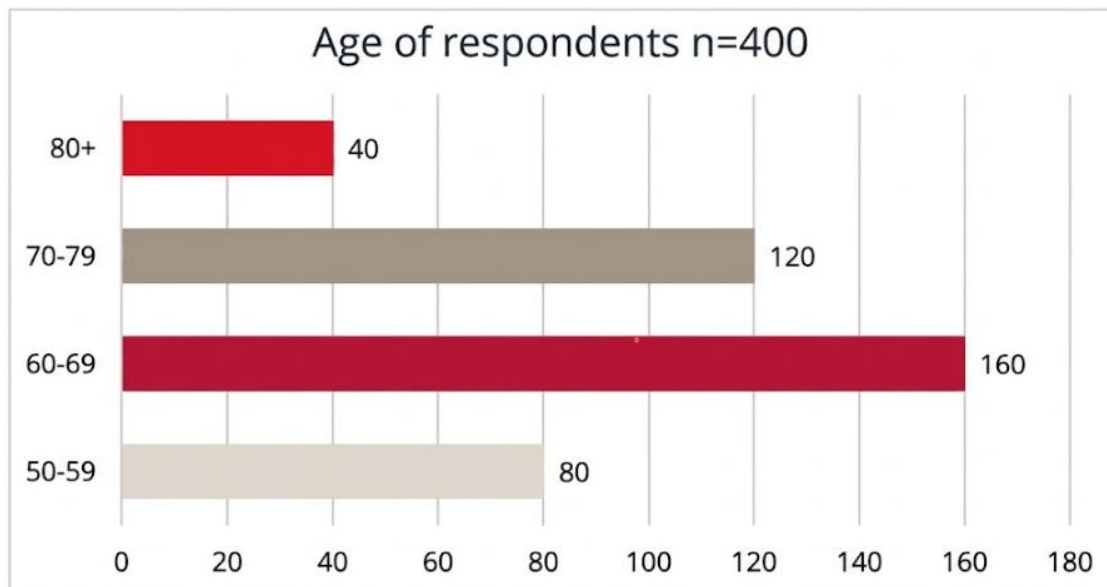
5. Profile of study participants, health status and functional ability

5.1. Socio-demographic profile

The quantitative survey covered 400 people aged between 50 and 88, with 200 participants in Dnipropetrovska oblast and 200 in Kharkivska oblast. The mean age of respondents was 66.3 years, and the median age was 66 years.

The largest age group comprised people aged 60–69: 160 participants, or 40.0% of the sample. A total of 120 respondents, or 30.0%, were aged 70–79; 80 respondents, or 20.0%, were aged 50–59; and 40 respondents, or 10.0%, were aged 80 and over.

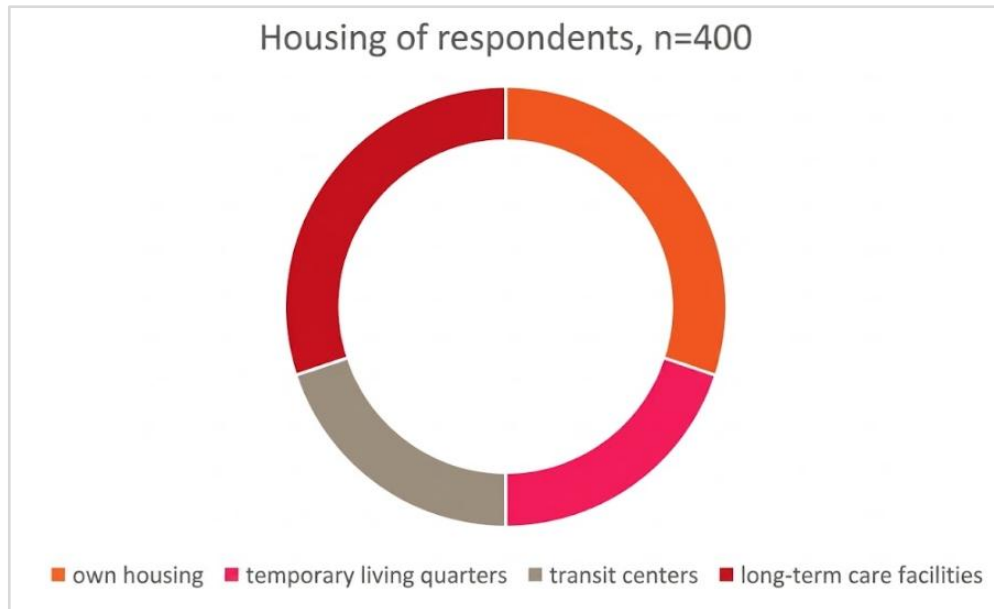
Women accounted for 70.0% of the sample—280 respondents—while men accounted for 30.0%, or 120 respondents. The findings therefore reflect the experiences of older women to a greater extent. At the same time, separate focus group discussions with women and men made it possible to identify gender differences in perceptions of independence, help-seeking behaviour and the use of informal support.



The sample covered four principal living arrangements:

- own or rented housing: 120 people, or 30.0%;
- collective sites: 80 people, or 20.0%;
- transit centres: 80 people, or 20.0%;
- long-term care facilities: 120 people, or 30.0%.

Approximately 40% of study participants had internally displaced person status. Because the exported dataset did not contain a fully verified individual-level variable for IDP status, this figure is used to describe overall coverage but not for quantitative cross-tabulations at the level of individual respondents.



Almost half of the participants reported living alone. “Alone” was selected as the only response by 188 participants, or 47.0%. A further six participants selected it alongside another household arrangement. The broader proportion of people who identified themselves as living alone was therefore 48.5%.

A total of 28.5% of respondents lived with a spouse, 9.0% lived with their children, and 7.5% lived with both a partner and children. In terms of marital status, 42.5% were married, 34.5% were widowed, 16.0% were divorced and 7.0% had never married.

The high proportion of people living alone has direct implications for service planning. In the absence of other household members, even a moderate deterioration in mobility, vision, memory or the ability to perform household tasks may create a risk of unmet needs, social isolation or emergency placement in a care facility.

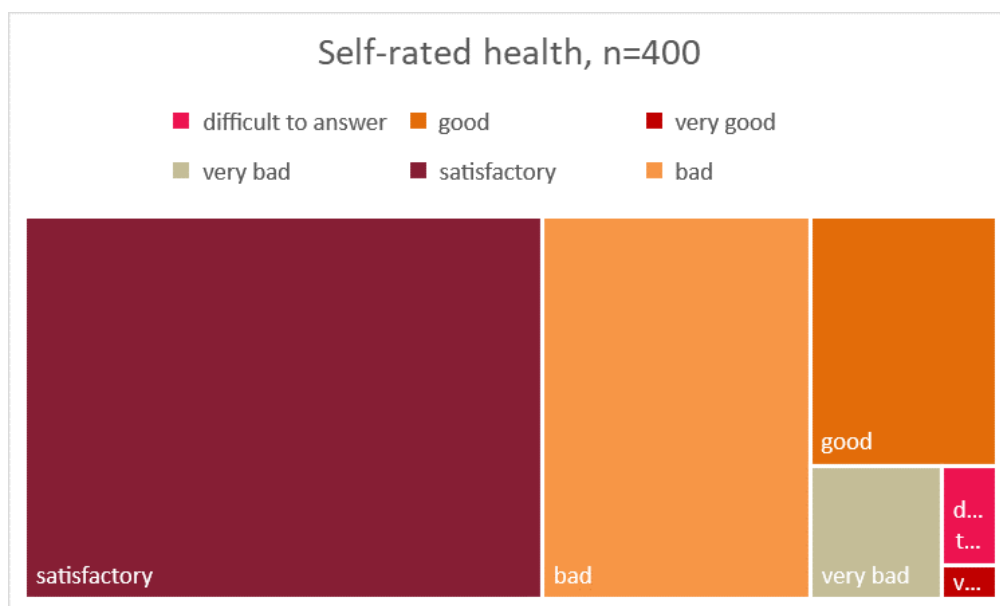
5.2. Self-rated health and chronic health conditions

Only 13.0% of participants rated their health as good or very good. More than half—53.3%—described it as fair, while 32.3% rated it as poor or very poor.

Chronic illnesses or long-term health conditions were reported by 317 participants, or 79.3% of the sample. The most common conditions were:

- cardiovascular conditions or hypertension: 130 people, or 41.0% of participants with chronic health conditions;
- visual impairments: 119 people, or 37.5%;
- musculoskeletal conditions: 79 people, or 24.9%;
- neurological conditions: 69 people, or 21.8%;
- diabetes: 68 people, or 21.5%;
- anxiety, depressive conditions or other mental health concerns: 57 people, or 18.0%;
- hearing impairments: 42 people, or 13.2%;
- respiratory conditions: 41 people, or 12.9%.

As participants could report more than one condition, the percentages sum to more than 100%. The findings indicate a substantial prevalence of multimorbidity, whereby one person experiences several chronic conditions concurrently. Under such circumstances, the need is not limited to an isolated medical consultation but extends to continuity of care, access to medicines, rehabilitation, transport, and coordination between health and social services.



5.3. Officially recognised disability status

Officially recognised disability status was reported by 123 participants, or 30.8% of the sample. A further 23 participants, or 5.8%, were in the process of obtaining formal recognition. A total of 52.3% reported that they did not have officially recognised disability status, while 11.3% preferred not to answer.

Among the 123 participants with confirmed disability status, 52 had a Group II disability, 52 had a Group III disability and six had a Group I disability. A further 13 participants preferred not to disclose their disability group.

Official status is important for access to benefits, social protection, rehabilitation and assistive products. It does not, however, provide a complete picture of the difficulties a person experiences in everyday life. For this reason, the study supplemented official disability status with an assessment of functioning using the Washington Group Short Set on Functioning.

5.4. Detailed analysis of the Washington group questions

5.4.1. Approach to interpretation

The Washington Group Short Set assesses difficulties across six basic functional domains:

1. Seeing.
2. Hearing.
3. Walking or climbing steps.
4. Remembering or concentrating.
5. Self-care.
6. Communication.

Each domain used four response categories, ranging from no difficulty to being completely unable to perform the relevant activity. In accordance with the recommended WG-SS threshold, participants were classified as meeting the functional criterion for disability if they reported “a lot of difficulty” or “cannot do at all” in at least one domain.

Using this threshold, 111 participants, or 27.8% of the sample, met the functional criterion for disability.

At the same time, 328 participants, or 82.0%, reported at least some difficulty in one or more domains. This broader indicator should not be interpreted as the prevalence of disability. Rather, it demonstrates the scale of moderate and potentially progressive functional limitations that may require early intervention.

5.4.2. Distribution of difficulties by functional domain

Functional domain	At least some difficulty	A lot of difficulty or cannot do at all
Walking or climbing steps	65,0%	17,3%
Remembering or concentrating	63,3%	7,3%
Seeing	53,3%	12,5%
Hearing	29,3%	3,5%
Self-care	28,3%	8,8%
Communication	13,5%	3,8%

Difficulties with walking or climbing steps were the most prevalent. At least some difficulty was reported by 260 participants, while 69 experienced a lot of difficulty or were completely unable to walk or climb steps. This directly connects functional ability with the accessibility of housing, transport, healthcare facilities and shelters.

Remembering and concentrating constituted the second most prevalent domain, with 63.3% reporting at least some difficulty. Even when such difficulties do not reach the WG-SS threshold, they may complicate medication management, completion of administrative procedures, use of digital services and comprehension of complex information.

More than half of the participants reported difficulty seeing. A lot of difficulty or complete inability to see was reported by 12.5% of respondents. This requires accessible communication, large print, high-contrast information materials, and opportunities to access services through channels other than digital platforms.

Functional difficulties frequently co-occurred. Two or more domains involving at least some difficulty were reported by 68.0% of participants, while 49.5% experienced such difficulties in three or more domains. A lot of difficulty in at least two domains was reported by 13.0% of the sample, and in three or more domains by 7.3%.

The needs of a substantial proportion of participants therefore cannot be addressed through a single specialised service. The co-occurrence of difficulties related to mobility, vision, memory and self-care requires a comprehensive support plan.

“I can cook, work on a computer and organise things, but I cannot manage the stairs.” [Participant in an FGD with older people with disabilities, Kharkivska oblast].

This quotation illustrates that functional independence depends not only on a person’s condition but also on the characteristics of their environment. An inaccessible entrance or staircase can turn an isolated mobility impairment into effective confinement, even when the person’s other abilities remain unaffected.

5.4.3. Differences by age, gender and oblast

The highest proportion of participants meeting the recommended WG-SS threshold was recorded among those aged 80 and over—56.3% in the preliminary age-disaggregated analysis. The corresponding proportions were 29.2% among people aged 70–79, 27.7% among those aged 50–59 and 20.8% among participants aged 60–69.

The pattern among groups below the age of 80 was not strictly linear. This may be attributable to the sample composition, different living arrangements and the purposive inclusion of people experiencing heightened vulnerability. Nevertheless, the sharp increase among people aged 80 and over clearly signals the need to prioritise proactive outreach to this group.

Among women, 29.6% met the WG-SS threshold, compared with 23.3% of men. This difference should be treated as descriptive, as it may be associated with differences in age composition, living arrangements, life expectancy and willingness to report difficulties.

A marked difference was observed between the two oblasts: 40.0% of participants in Kharkivska oblast met the WG-SS threshold, compared with 15.5% in Dnipropetrovska oblast. This finding should not be interpreted as an estimate of disability prevalence in the populations of the two oblasts. It may reflect the composition of the groups reached, their living arrangements and the purposive inclusion of people

with disabilities. This regional difference should be considered when interpreting other findings and is examined in greater detail in the section addressing regional characteristics.

5.4.4. Relationship between functional difficulties and official disability status

The analysis showed that officially recognised disability status and the WG-SS functional indicator overlap only partially.

Among the 111 participants who met the WG-SS threshold, only 56 had officially recognised disability status. A further 24 reported that they did not have officially recognised disability status, 13 were in the process of obtaining it, and 18 preferred not to disclose their status.

At the same time, 67 of the 123 participants with officially recognised disability status did not meet the WG-SS threshold. This does not mean that they did not have a disability. Legal status may have been established on the basis of conditions or limitations not covered by the six WG-SS domains. Alternatively, treatment, assistive products and support may have meant that they did not report significant current difficulties.

Neither indicator can therefore substitute for the other. Official status is required to establish eligibility for state benefits and guarantees, whereas planning community-based services requires regular functional assessment regardless of whether a person holds a disability certificate or has been assigned a disability group.

5.4.5. Association between functional difficulties and support needs

The functional indicator was strongly associated with the everyday need for assistance:

- among participants who met the WG-SS threshold, 70.3% required assistance with at least one basic activity of daily living, compared with 11.1% of other participants;
- regular assistance in everyday life was required by 83.8% of participants who met the WG-SS threshold, compared with 17.3% of those who did not;
- housing adaptations were required by 43.2%, compared with 13.1%;
- 71.2% rated their health as poor or very poor, compared with 17.3%;
- only 6.3% of participants who met the WG-SS threshold reported high confidence in their ability to continue living independently over the next five years, compared with 24.2% of other participants.

The Washington Group questions therefore do more than describe functional difficulties: they also help identify people at heightened risk of losing the ability to live independently. They should be incorporated into local needs assessments, social service practice, humanitarian support programmes and evacuation planning.

5.5. Independence in performing basic activities of daily living

A total of 110 participants, or 27.5%, required assistance with at least one basic activity: bathing, dressing, using the toilet, moving around inside the home or eating.

The greatest difficulties were reported in relation to:

- bathing: 21.0% required assistance or could not perform the activity;
- moving around inside the home: 16.8%;
- dressing: 11.8%;
- using the toilet: 8.8%;
- eating: 6.3%.

Regular assistance in everyday life was required by 143 participants, or 35.8%. Another, more broadly worded question found that 19.5% required assistance from others regularly and 41.8% required it occasionally. A primary caregiver was available to 28.5% of participants.

The difference between these indicators reflects the fact that regular everyday assistance extends beyond basic self-care to shopping, preparing meals, cleaning, accompaniment to healthcare appointments, obtaining medicines, paying bills and completing administrative procedures. A person may be able to dress and eat independently but remain unable to leave the building, obtain groceries or reach a healthcare facility.

5.6. Use of assistive products

The most commonly used assistive products were glasses, used by 62.8% of participants, and walking sticks, used by 27.8%. Grab rails or other adaptations within the home were used by 19.5%, walking frames by 9.8%, hearing aids by 8.8%, wheelchairs by 8.3%, and prostheses or orthoses by 3.3%.

A total of 61.8% of participants reported having all the assistive products they required. A further 19.3% stated that they did not need such products. Needs were partially met for 15.5%, while 3.5% had none of the assistive products they required. Consequently, 76 people, or 19.0% of the total sample, had a partially or entirely unmet need. Among participants who did not indicate that they required no assistive products, this proportion was 23.5%.

Provision of an individual assistive product does not guarantee its effective use. Individual assessment and fitting, user training, repairs, replacement of consumable components, housing adaptations, and verification that the product enables the person to complete the entire journey to the required service are also necessary.

“Transport to rehabilitation and mobility aids are needed. They give you a walking stick and consider the matter resolved”. [Participant in a men’s FGD, Kharkivska oblast)].

5.7. Housing safety and adaptation

A total of 67.3% of participants reported feeling safe in their homes most or all of the time. However, 23.5% felt safe only sometimes, 8.0% rarely, and 1.3% never. Housing therefore did not provide a consistent sense of safety for almost one-third of the sample.

Housing adaptations were required by 86 participants, or 21.5%. Among people who met the WG-SS threshold, this need was more than three times as prevalent as among other participants: 43.2%, compared with 13.1%.

Housing adaptations may include installing grab rails, removing thresholds, adapting bathrooms, improving lighting, providing an accessible entrance, repairing a lift, or relocating the person to a more accessible floor. For residents of rented and temporary housing, the need to obtain the consent of the owner or facility administration constitutes an additional barrier.

“Adapting rented housing is a problem. The owner does not want the wall drilled to install a grab rail, but without it the bathroom is unsafe”. [Participant in an FGD with older people with disabilities, Kharkivska oblast)].

5.8. Key findings of the section

The participant profile demonstrates the accumulation of interconnected vulnerability factors: a high prevalence of chronic health conditions, living without other household members, functional difficulties, unmet needs for assistive products and inadequate housing adaptations.

People aged 80 and over constitute the group facing the greatest risks. Preliminary age-disaggregated analysis indicated that more than half of participants in this age category met the WG-SS functional threshold; this proportion should be recalculated using the verified age-group denominator before finalisation. The risk of losing independence is not, however, limited to the oldest group. Significant functional difficulties were also identified among people aged 50–79.

Comparison of officially recognised disability status with the WG-SS indicator showed that administrative records do not capture all people experiencing significant functional difficulties. Needs assessments should therefore be based not only on documentation or disability group, but also on what a person can actually do, the support they require and the barriers created by their environment.

Preserving independent living requires the early identification of functional difficulties and the provision of support before they lead to complete dependence or institutionalisation. Priorities include home-based care, rehabilitation, housing adaptations, accessible transport, appropriate assistive products, support for informal caregivers and regular contact with people living alone.

6. Older people's understanding of independence and independent living

6.1. Independence as the right to choose rather than the absence of assistance

The focus group findings show that older people do not equate independence with having to perform every activity of daily living without assistance from others. For them, the central elements of independence are the ability to make their own decisions, retain control over their daily routines, manage their financial resources, choose where to live, and determine what assistance they receive, when they receive it and from whom.

"It does not mean doing everything by myself. It means that I decide when to get up, what to buy and which doctor to see, while support enables me to exercise that choice." [Participant in a women's FGD, Dnipropetrovska oblast]

Support itself is therefore not perceived as dependence. On the contrary, timely and predictable support organised in accordance with the person's will is regarded as a condition for preserving independence. Dependence arises when a person has no alternatives, is forced to adapt to the only available service, or when decisions concerning their life are made by relatives, facility staff or service providers.

"I do not consider assistance to be dependence. Dependence is when you are given no choice or when the service is available only in one facility far from home". [Participant in a men's FGD, Dnipropetrovska oblast].

Participants with disabilities placed particular emphasis on addressing the person directly, allowing sufficient time for them to respond, and ensuring that support does not become a substitute for the person's own decision-making. Physical, sensory or communication difficulties should not automatically be interpreted as an inability to identify or express one's own needs.

For practical service planning, this means that service quality should be assessed not only by whether assistance has been provided but also by whether the person retains control over their own life. A service that formally meets a basic need but deprives the person of privacy, choice concerning the timing or manner of assistance, or the ability to refuse it does not fully comply with the principles of independent living.

6.2. Personal space, privacy and housing stability

Housing was one of the central elements in participants' understanding of independence. They associated it less with legal ownership than with stability, privacy and the ability to control their own space.

In one's own home, important elements include having a key, receiving visitors, preparing food according to one's preferences, keeping personal belongings, and determining one's own routine. At the same time, living in one's own apartment or house does not guarantee genuine independence if the person cannot leave because of stairs, a non-functioning lift, an inaccessible courtyard or unavailable transport.

In collective sites and transit centres, independence is restricted by shared rooms and sanitary facilities, institutional routines, insufficient space for personal belongings, an inability to invite relatives or friends, and uncertainty concerning the duration of residence.

For internally displaced older people, housing independence primarily means protection from repeated displacement. Even a small room may be perceived as a home if the person has the right to remain there, can close the door, and can plan their life at least over the medium term.

"Having a place that I will not be asked to leave in a month. Even one room can be a home if I have the right to stay there". [Participant in an FGD with internally displaced older people, Kharkivska oblast].

For couples and families in which one person has substantial care needs, the ability to remain together is an important component of independence. Placement arrangements that separate couples because they have different levels of support needs are perceived as a loss of control and family life.

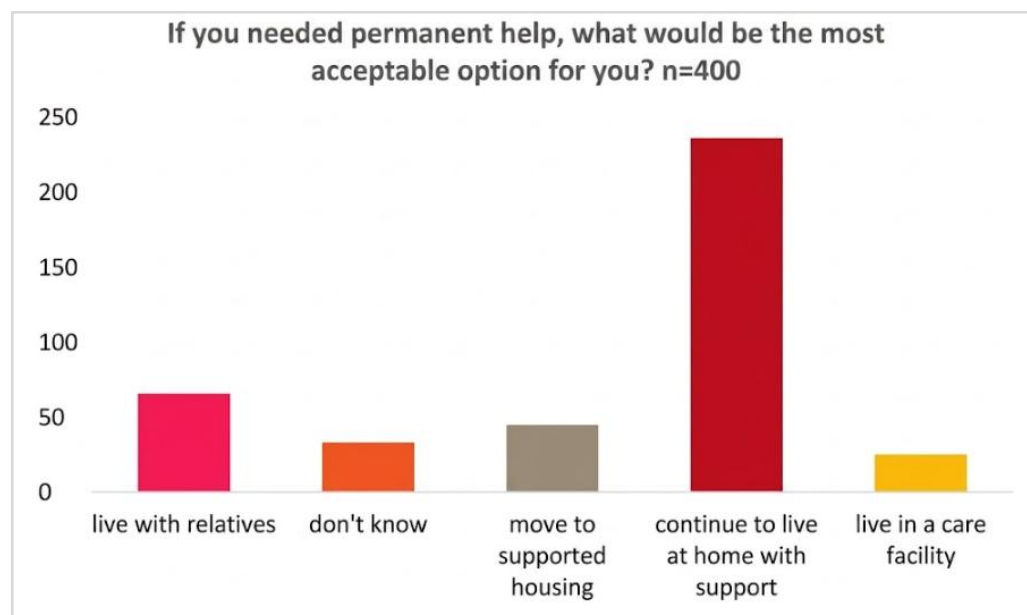
6.3. Preferred living arrangement if care needs increase

The quantitative findings confirm that most participants clearly wish to remain in a familiar environment even if their health deteriorates.

If continuous assistance became necessary:

- 58.8% would prefer to continue living at home with support;
- 16.3% considered living with relatives the most acceptable option;
- 11.0% would choose supported living;
- 6.0% would agree to live in a care facility;
- 8.0% were unable to decide.

At least 85.0% of participants therefore preferred one of the options involving an ordinary or near-ordinary living environment: their own home, living with relatives or supported living.



The low proportion choosing a care facility does not represent a complete rejection of residential support. During FGDs, participants acknowledged that some people may require round-the-clock assistance. Preference was nevertheless given to small-scale, accessible, community-based supported living arrangements that preserve privacy, personal belongings, family connections and the right to determine one's own daily routine.

"I want to remain in my own home, but I do not want to be abandoned. Two home visits a week would give me more freedom than moving into a facility". [Participant in an FGD with older people with disabilities, Dnipropetrovska oblast].

These findings demonstrate that the principal demand is not for a binary choice between complete self-sufficiency and placement in a facility, but for access to a broad continuum of intermediate options: home-based assistance, mobile healthcare, day care, short-term support, respite for caregivers and supported living.

6.4. Uncertainty about being able to remain independent

Despite a clear desire to remain at home, most participants lacked confidence that they would be able to continue living independently over the medium term.

When asked about their ability to live independently over the next five years:

- 49.3% selected the lowest rating — "not at all confident";
- 13.8% selected a rating of 2;
- 17.8% selected a rating of 3;
- 11.8% selected a rating of 4;
- only 7.5% were fully confident.

Overall, 63.0% of participants reported low confidence, corresponding to ratings of 1–2. Only 19.3% reported high confidence, corresponding to ratings of 4–5. The mean rating was 2.14 out of five.

Confidence was particularly low among people with significant functional difficulties. Among participants who met the Washington Group threshold, only 6.3% reported high confidence in their ability to continue living independently over the next five years. The corresponding proportion among other participants was 24.2%.

Preliminary age-disaggregated analysis also indicated substantial differences. High confidence was reported by 31.7% of participants aged 50–59, 24.0% of those aged 60–69 and 7.1% of those aged 70–79. None of the participants aged 80 and over selected a rating of 4 or 5. The proportions by age group should be recalculated using the verified age-group denominators before finalisation.

The gap between preferred and expected outcomes is one of the study's key findings: most people want to remain at home but do not see a sufficiently reliable support system that would enable them to do so.

6.5. Concerns about future care

Low confidence in the future was accompanied by substantial anxiety about who would provide assistance if participants' health deteriorated.

More than half of the participants—53.3%—were very concerned about this issue. A further 32.3% were somewhat concerned. Only 2.8% stated that the prospect did not concern them. Overall, 85.5% experienced substantial or moderate concern about future care.

During the FGDs, participants attributed this concern to several factors:

- children or other relatives live in another region or abroad;
- family members are employed and cannot provide continuous care;
- potential caregivers are themselves older or have health problems;
- families have been separated by the war and displacement;
- available social services do not provide assistance of sufficient duration or intensity;
- participants are unaware of alternatives between family assistance and placement in a facility.

The anxiety is therefore associated not only with possible deterioration in health but also with the absence of a predictable support pathway. People do not know where to seek assistance, whether a service will be available, who will pay for it, or whether they will be able to remain in their own homes

6.6. Financial capacity as a component of independence

For participants, independence included the ability to cover essential expenses and manage their own financial resources. This did not necessarily mean the complete absence of social benefits or humanitarian assistance. Rather, it meant having a predictable income and being able to plan expenditure on housing, food, medicines, transport and utilities.

Participants, particularly IDPs and people aged 50–65, emphasised that dependence on a single benefit, one charitable organisation or a short-term programme did not enable them to plan their lives. For some, continuing to work or having access to age-appropriate employment was not only a source of income but also a means of preserving their social role and sense of usefulness.

"Not being tied to one benefit or one volunteer. Independence means having several sources of support rather than one that is available only by chance". [Participant in a women's FGD, Kharkivska oblast]

Financial independence is particularly closely linked to housing. For IDPs, the ability to pay rent independently or receive long-term housing support means protection from repeated displacement. For owners of damaged housing, financing repairs and receiving practical assistance with carrying them out are critical.

6.7. Mobility, information and safety as conditions for exercising choice

Participants understood independence as the ability not only to remain at home but also to leave it, use services and participate in community life. Mobility, accessible transport and a barrier-free journey are therefore conditions for the practical exercise of choice.

According to the survey, 41.0% of participants stated that moving around outside their homes was sometimes difficult. A further 8.3% considered it very difficult and 1.5% virtually impossible. Half of the sample therefore experienced some level of difficulty moving around outside their homes.

Independence also requires access to understandable information. People with visual, hearing, speech or memory difficulties emphasised the need for information in multiple formats, opportunities to receive written explanations, communicate with a live operator, or seek assistance in person without mandatory electronic registration.

The security situation had an exceptionally strong effect on perceptions of independence. A total of 81.0% of respondents gave a rating of 4 or 5 out of five for the impact of security on their ability to live independently. The mean rating was 4.28.

"I cannot get down to the shelter. My independence now depends on an accessible safe room or assistance with evacuation, not on the strength of my character". (Participant in a women's FGD, Kharkivska oblast)

In wartime, independence includes having a reserve supply of medicines, a charged telephone, access to backup power, the contact details of someone who can provide assistance, and a realistic evacuation plan. Standard advice to proceed to a shelter cannot be implemented if a person is unable to manage the stairs or use transport.

6.8. Social connections, participation and a sense of personal value

Independent living does not mean social isolation. Participants emphasised the importance of having someone to turn to, maintaining contact with relatives, neighbours and friends, participating in community life, and being more than recipients of assistance.

Most respondents maintained regular social contact: 52.5% communicated with relatives or friends every day, while 23.5% did so several times a week. At the same time, 11.0% communicated less than once a week and 1.0% never did so.

A total of 85.3% of participants had someone they could turn to for assistance. However, 59 people, or 14.8%, had no such support. For people living alone, experiencing functional difficulties or residing in unsafe areas, the absence of an emergency contact creates a particularly high risk.

A total of 24.3% of respondents felt lonely often or all the time, while a further 35.5% sometimes felt lonely. Almost six in ten participants therefore experienced loneliness at least occasionally.

Participation in community life was low: only 21.0% of respondents had participated in community activities during the previous six months. A strong sense of belonging to the community, reflected in ratings of 4–5, was reported by 37.3%, while 25.3% gave low ratings of 1–2.

During the FGDs, older people emphasised that they wanted not only to receive assistance but also to share their experience, organise neighbourhood initiatives, work, teach others and participate in planning local programmes. The opportunity to contribute and influence decisions is an important component of independence and dignity.

6.9. Life satisfaction as an overall reflection of participants' circumstances

The mean life-satisfaction rating was 3.0 out of five. Low ratings of 1–2 were given by 31.5% of participants, a rating of 3 by 43.0%, and high ratings of 4–5 by 25.5%.

This finding reflects predominantly precarious rather than uniformly negative circumstances. A substantial proportion of people continue to maintain family and neighbourhood connections, receive some services and adapt to their circumstances. At the same time, the combined effects of security risks, financial instability, deteriorating health and uncertainty about the future prevent most participants from rating their lives highly.

6.10. Key findings of the section

In older people's understanding, independent living comprises eight interconnected components:

1. The right to make one's own decisions.
2. The ability to choose where and how to live.
3. Private and stable living space.
4. Support that assists rather than replaces the person's will.
5. Adequate and predictable income.
6. Physical mobility and accessible information.
7. Safety and an emergency plan.
8. Social connections, participation and opportunities to contribute to the lives of others.

The central issue is the gap between aspirations and expectations. Most participants want to remain at home or in another community-based living arrangement, but 63.0% have low confidence that they will be able to continue living independently over the next five years, while 85.5% are concerned about future care.

Independent-living policy should therefore not require people to cope without assistance. It should create a predictable support system through which people retain choice, control, community connections and dignity even when they have substantial care needs.

7. Principal needs of older people for independent living

7.1. Overall structure of needs

The findings show that older people's ability to live independently is determined not by one individual service but by a combination of financial stability, accessible healthcare, home-based support, safe housing, mobility and social connections.

During the quantitative survey, participants could select multiple current needs. The most frequently identified needs were:

Need	Number	Percentage of sample
Financial support	365	91.3%
Health services	265	66.3%
Medicines	234	58.5%
Psychological support	160	40.0%
Social interaction	118	29.5%
Transport	111	27.8%
Rehabilitation	87	21.8%
Assistive products	52	13.0%
Home-based care	40	10.0%
Assistance with household tasks	36	9.0%
Housing adaptations	20	5.0%

Financial support, health services and medicines had the highest reported prevalence. However, the lower frequency with which home-based care, assistive products or housing adaptations were selected

does not mean that these needs are insignificant. They are concentrated among smaller but particularly vulnerable groups, including people aged 80 and over, people with significant functional difficulties and people living alone.

Comparison of responses across different questionnaire items also reveals hidden or insufficiently recognised needs. For example, only 5.0% identified housing adaptations among their three most urgent needs, whereas 21.5% responded affirmatively when directly asked whether they required housing adaptations. Similarly, 10.0% selected home-based care as a current need, but 24.8% identified it as a condition for remaining at home for longer.

Assessing needs therefore requires more than asking people about their general priorities. It should include a functional assessment, a review of housing conditions and a discussion of specific activities of daily living.

7.2. Financial stability

Financial support was the most prevalent need, identified by 91.3% of participants. When asked which forms of support would enable them to remain in their own homes for longer, 78.5% also selected financial assistance.

Open-ended responses and FGDs showed that financial insecurity manifests in an inability to cover the costs of food, medicines, utilities, transport and housing repairs simultaneously. Pensions or social benefits often cover only basic survival needs and do not enable people to pay for rehabilitation, hearing aids, glasses, assistive products, paid accompaniment or housing adaptations.

*“Medicines. Not just a prescription, but enough money for the full course and the ability to reach the pharmacy. People split tablets in half even though the doctor did not prescribe them that way”.
[Participant in a women’s FGD, Dnipropetrovska oblast]*

Financial needs are not limited to increasing the amount of cash benefits. Participants also identified:

- reimbursement of expenditure on medicines and medical products;
- utility subsidies;
- financing for minor repairs and housing adaptations;
- long-term rental support for IDPs;
- access to suitable paid employment for people aged 50–65;
- free or subsidised transport;
- transparent and stable eligibility rules for benefits.

Financial insecurity is particularly acute for IDPs who must pay rent and for people with chronic health conditions who spend a substantial proportion of their income on treatment.

7.3. Health services and access to medicines

Health services were identified as a current need by 66.3% of participants and medicines by 58.5%. Home-based healthcare was identified by 47.8% as a condition for remaining at home for longer.

During the previous 12 months, 347 people, or 86.8% of the sample, had sought healthcare. Among them, 305 usually or always received the assistance they needed. However, 42 participants received it only sometimes or rarely.

Overall, 23.5% of respondents stated that accessing healthcare was difficult or very difficult. The most prevalent barriers were:

- the security situation: 57.0%;
- queues or long waiting times: 54.5%;
- high cost of services or medicines: 49.0%;
- lack of transport: 28.0%;
- distance to a healthcare facility: 24.0%;
- lack of information: 20.3%;
- unavailability of the required specialists: 17.5%;
- physical inaccessibility of the facility: 8.3%.

Formal access to a family doctor does not resolve the other stages of the healthcare pathway. A person must obtain a referral, arrange an appointment with a specialist, reach the facility, undergo diagnostic procedures, purchase medicines and return for follow-up monitoring.

This pathway is substantially more difficult for people with functional difficulties. Among participants who met the Washington Group threshold:

- 65.8% identified the security situation as a barrier;
- 50.5% identified the high cost of services or medicines;
- 43.2% identified the unavailability of the required specialists;
- 31.5% identified the lack of transport;
- 30.6% identified the distance to the healthcare facility;
- 22.5% identified the physical inaccessibility of the facility.

Among participants without significant functional difficulties, only 2.8% identified physical inaccessibility and 7.6% identified the unavailability of specialists. This demonstrates that the same healthcare system creates disproportionately greater difficulties for people with disabilities.

Priority health-related needs include:

- home visits by family doctors and nurses;
- mobile medical teams;
- access to specialist healthcare professionals;
- uninterrupted access to medicines;
- laboratory tests and basic diagnostic procedures at home;
- coordination of healthcare, rehabilitation and social support;
- transport coordinated with appointment times;
- accessible information concerning treatment and medication use.

7.4. Assistance in everyday life and home-based care

Regular assistance in everyday life was required by 143 participants, or 35.8%. Another question covering both regular and occasional assistance showed that 78 people required it regularly and 167 occasionally. At least 245 participants, or 61.3%, therefore had some need for assistance from others.

Participants most frequently required assistance with:

Type of assistance	Percentage of sample
Financial matters and payment of bills	50,3%
Accompaniment to healthcare appointments	39,5%
Preparing meals	31,5%
Shopping	28,3%
Cleaning the home	26,3%
Emotional support	23,8%
Taking medication	22,5%
Personal hygiene	15,8%
Dressing	6,5%

Among the 245 participants who required assistance at least occasionally, 160 considered the assistance available to them fully or mostly sufficient. For 71 people it was only partially sufficient, while for 14 it was insufficient. Consequently, 34.7% of people requiring assistance did not receive it at a level that fully or mostly met their needs.

A primary caregiver was available to 114 participants, or 28.5%. This was most commonly a social worker, spouse, son, daughter or another relative. Only eight participants had a paid caregiver.

"I do not need continuous care yet. I need assistance twice a week—with shopping, cleaning and accompaniment. If that were available, I could remain at home for longer". [Participant in a women's FGD, Dnipropetrovska oblast].

This reflects the principal demand: not round-the-clock supervision, but flexible assistance with specific activities that the person can no longer perform safely. For many people, a few hours of support each week could delay or entirely prevent placement in a facility

7.5. Gap in the availability of home-based support

Despite the substantial need, home-based care remains insufficiently represented in the structure of social services received. Overall, 70.3% of participants received social services, but they most frequently identified social support, humanitarian assistance or psychosocial support. Only 1.5% selected the formal home-based care service from the relevant list.

In another questionnaire module, however, 81 participants identified a social worker as the person who usually assisted them in everyday life, while 146 included a social worker among their providers of assistance. This may indicate that participants do not always distinguish between home-based care, social support and other forms of assistance. Even accounting for differences in how the terms were understood, the findings indicate the absence of a clear, understandable and sufficiently intensive system of home-based support.

Participants identified the following as conditions for remaining at home for longer:

- financial support: 78.5%;
- home-based healthcare: 47.8%;
- psychological support: 29.0%;
- home-based care: 24.8%;
- social activities: 22.5%;
- transport services: 21.3%;
- day care: 13.0%;
- rehabilitation: 10.5%;
- housing adaptations: 8.3%;
- assistive products: 5.3%.

The structure of required support differed among people who met the WG-SS threshold. Within this group, 53.2% selected home-based care, 54.1% home-based healthcare, 27.0% day care and 15.3% housing adaptations. This confirms the need to distinguish between universal support for all older people and more intensive services for people with significant functional difficulties.

7.6. Rehabilitation and maintenance of functional ability

Rehabilitation was identified as a current need by 21.8% of participants. Among people who met the WG-SS functional threshold, the proportion was 33.3%, compared with 17.3% among the remainder of the sample.

The need for rehabilitation was particularly high among people living alone: 30.4%, compared with 13.6% among those living with other people. This indicates that rehabilitation is not only a health service but also a means of preserving the ability to perform activities of daily living independently.

The preliminary age-disaggregated analysis found that only 6.3% of participants aged 80 and over identified rehabilitation as a current need, although 56.3% met the threshold for significant functional difficulties. The apparent gap may nevertheless indicate low awareness, limited previous experience of rehabilitation services, or a perception that functional decline is an inevitable part of ageing.

The required rehabilitation model should:

- be available not only following hospitalisation or injury;
- focus on maintaining existing functional abilities;
- be deliverable at home or close to the person's place of residence;
- include training in the use of assistive products;
- be combined with housing adaptations;
- provide for reassessment and revision of the rehabilitation plan.

7.7. Assistive products and housing adaptations

Assistive products were identified as one of the most urgent needs by 13.0% of the sample. Among people meeting the WG-SS threshold, this proportion was 32.4%, compared with 5.5% among other participants. Among people living alone, the need was identified by 20.1%, compared with 6.3% among those living with others.

As demonstrated in the previous section, 19.0% of the total sample had a partially or entirely unmet need for assistive products. The problem concerns not only obtaining a product but also ensuring that it meets the person's needs, is properly adjusted, can be repaired, and has replacement batteries or other consumable components available.

"It is not enough simply to provide a prosthesis or walking frame. It must be adjusted, the person must be trained to use it, and repairs must be available. Without follow-up services, the product quickly becomes a piece of furniture". [Participant in an FGD with older people with disabilities, Dnipropetrovsk oblast]

Direct assessment showed that 21.5% of participants required housing adaptations, rising to 43.2% among people with significant functional difficulties. The adaptations most frequently discussed during FGDs included grab rails, removal of thresholds, bathroom adaptations, improved lighting, non-slip flooring, accessible entrances and lift repairs.

Participants also emphasised that providing materials without installation does not resolve the problem. An older person may be physically unable to install a grab rail, repair a roof or replace a damaged window.

7.8. Transport and accompaniment

Transport was identified as a current need by 27.8% of participants, while 21.3% identified transport services as a condition for remaining at home for longer. Even more revealing was the need for accompaniment to healthcare appointments, reported by 39.5%.

The need extends beyond the availability of a vehicle. A person with limited mobility requires a complete accessible journey:

1. Assistance leaving the apartment or house.
2. Assistance managing stairs or an uneven courtyard.
3. Support boarding the vehicle.
4. arrival at an accessible healthcare, rehabilitation or social protection facility, or another location where the necessary service is provided;
5. Accompaniment within the facility.
6. Transport and assistance back home.

"We need social transport that actually arrives and helps the person get downstairs. Simply having a car outside the building does not solve the problem of living on the fourth floor". [Participant in a women's FGD, Dnipropetrovsk oblast]

Transport must be coordinated with the schedules of healthcare appointments, rehabilitation and social services. Otherwise, even a formally available vehicle does not ensure effective access to the service.

7.9. Psychological support and social interaction

Psychological support was identified as a current need by 40.0% of participants and social interaction by 29.5%. These figures were higher among people living alone: 46.9% required psychological support and 33.0% required social interaction.

The preliminary age-disaggregated analysis found that 50.0% of participants aged 80 and over identified psychological support and 37.5% identified social interaction as needs. These figures should be verified using the confirmed denominator of 40 participants. This group also demonstrated the lowest confidence in its ability to continue living independently.

The FGDs showed that psychological support is not always viewed positively because of stigma or the perception that psychological assistance is intended only for people with severe disorders. More acceptable entry points may include social groups, day centres, clubs, shared activities, regular telephone contact and home visits, through which professional assistance can be offered where necessary.

Participants identified the following concerns:

- anxiety caused by shelling and repeated displacement;
- loss of home and familiar social surroundings;
- death or departure of relatives and friends;
- exhaustion of family caregivers;
- loneliness;
- sleep disturbances;
- fear of deteriorating health;
- feeling no longer needed after losing employment or a social role.

Psychological and social support should form part of the independent-living system rather than being treated as an optional supplementary component.

7.10. Information and legal support

Although information and legal services were not included as separate options in the list of principal needs, they emerged consistently in open-ended responses and FGDs.

Participants most frequently required assistance with:

- obtaining or restoring documents;
- applying for pensions, benefits and subsidies;
- IDP status;
- rental agreements;
- compensation for damaged or destroyed housing;
- obtaining assistive products;
- arranging healthcare appointments and electronic referrals;
- paying bills;
- protection from fraud;
- appealing decisions by public authorities.

For IDPs, the need to explain their circumstances repeatedly to different institutions and compile separate document packages for each programme is particularly burdensome. Participants proposed introducing case management through which one accountable person would assist them throughout the entire service pathway.

Information should be provided through multiple channels: by telephone, in person, in printed form, and through social workers, healthcare facilities, places of residence or civil society organisations. A fully digital service model does not meet the needs of a substantial proportion of older people.

7.11. Differences in needs between principal subgroups

Older people's needs are not homogeneous.

People with significant functional difficulties

Compared with other participants, they were substantially more likely to require:

- health services: 83.8%, compared with 59.5%;

- rehabilitation: 33.3%, compared with 17.3%;
- assistive products: 32.4%, compared with 5.5%;
- home-based care: 16.2%, compared with 7.6%;
- assistance with household tasks: 16.2%, compared with 6.2%.

In relation to specific everyday activities, 67.6% required assistance with preparing meals, 61.3% required accompaniment to healthcare appointments, 55.9% required assistance with shopping and cleaning, and 40.5% required assistance with personal hygiene.

People aged 80 and over

The preliminary analysis identified financial support, health services, psychological support, social interaction and home-based care as particularly important for this group. The reported proportions—93.8%, 68.8%, 50.0%, 37.5% and 31.3%, respectively—were calculated using the earlier denominator of 32 participants and should be recalculated using the verified group of 40 before finalisation.

The preliminary data also indicated that the need for home-based care among participants aged 80 and over was almost twice as high as among people aged 70–79 and almost five times as high as among those aged 60–69. These comparisons should likewise be verified after recalculation.

People living alone

Compared with other participants, they more frequently identified a need for:

- health services: 71.1%;
- psychological support: 46.9%;
- social interaction: 33.0%;
- rehabilitation: 30.4%;
- assistive products: 20.1%;
- home-based care: 11.3%.

Regular contact is particularly important for this group because it allows deterioration in health or a crisis to be identified promptly.

Internally displaced older people

According to the FGD findings, their specific needs include:

- long-term and accessible housing;
- protection from repeated displacement;
- private living space;
- restoration of documents and medical records;
- continuity of benefits and medical treatment;
- legal support;
- opportunities to work;
- integration into the host community;
- support in coping with the loss of home;
- access to home-based services regardless of living arrangement.

Regional differences

Financial support was identified more frequently in Dnipropetrovska oblast than in Kharkivska oblast—96.0%, compared with 86.5%—as were medicines: 64.0%, compared with 53.0%.

The need for rehabilitation was reported more frequently in Kharkivska oblast—25.5%, compared with 18.0%—as was the need for assistive products: 19.0%, compared with 7.0%. This difference is consistent with the higher proportion of participants with significant functional difficulties in the Kharkivska oblast subsample.

7.12. Key findings of the section

The principal needs of older people form an interconnected system. Financial assistance without accessible healthcare does not ensure treatment; an assistive product without accessible housing and

transport does not ensure mobility; home-based care without healthcare support does not address complex needs; and the availability of services without accessible information does not guarantee their use.

The study identified five critical gaps:

1. Insufficient financial capacity to cover essential expenditure.
2. Complex and fragmented access to healthcare and medicines.
3. A shortage of flexible home-based and everyday support.
4. Insufficient access to rehabilitation, assistive products and housing adaptations.
5. The absence of integrated case support combining social, health, transport, information and legal services.

To preserve independent living, services must be provided before complete dependence develops. Priority should be given to the early identification of needs and the development of an individual support plan that considers the person's functional status, housing conditions, availability of an informal caregiver, the security situation and the person's own choices.

8. Barriers, inequalities and risks to independent living

8.1. Cumulative nature of barriers

The findings show that loss of the ability to live independently rarely results from a single factor. More commonly, it occurs through the simultaneous accumulation of financial, health-related, functional, infrastructural, security and social barriers.

Participants identified the following factors as imposing the greatest limitations on their independence:

Barrier	Number	Sample proportion
Security situation	316	79,0%
Insufficient financial resources	311	77,8%
Poor health	222	55,5%
Lack of transport	120	30,0%
Loneliness	62	15,5%
Disability	57	14,3%
lack of social support	34	8,5%
Lack of care	28	7,0%
Inaccessible buildings	28	7,0%
Lack of information about services	20	5,0%

On average, each participant identified three barriers. Two-thirds of respondents—66.8%—experienced at least three barriers concurrently, while 30.0% experienced four or more.

Among people who met the Washington Group functional threshold, 51.4% experienced four or more barriers, compared with 21.8% of other participants. Among people living alone, the corresponding proportion was 41.8%, compared with 18.9% among those living with others.

The risk of losing independence is therefore determined not only by the severity of an individual impairment, but also by the number of barriers a person must overcome simultaneously.

8.2. Financial barriers

Insufficient financial resources constituted the second most prevalent barrier after the security situation and were identified by 77.8% of participants. Financial instability restricts people's ability to pay for medicines, food, transport, utilities, rehabilitation, care and housing repairs.

During the FGDs, participants described having to choose continually between several essential expenses. Paying utility bills and purchasing medicines often came at the expense of adequate nutrition, social participation or necessary housing repairs.

"The pension cannot keep pace with prices. First come the utility bills, then medicines, and food has to be bought with whatever remains". [Participant in a women's FGD, Dnipropetrovska oblast]

People with disabilities incur higher actual costs because they may need to purchase or repair assistive products, use specialised transport, pay for accompaniment and obtain additional health services. These costs are not always considered when determining the level of social support.

For IDPs, rent is added to basic expenditure. Unstable payments and short-term assistance programmes prevent people from planning for the future. People aged 50–65 who might otherwise continue working face a combination of age discrimination, health limitations and prejudice associated with their IDP status.

Insufficient financial resources were identified by 80.0% of women and 72.5% of men. This may reflect women's lower pension income, longer life expectancy, greater likelihood of living without a partner, and unpaid care responsibilities for other family members.

8.3. Health status and functional limitations

Poor health restricted the independence of 55.5% of respondents. Among people who met the WG-SS threshold, however, this proportion reached 85.6%, as it did among 86.4% of those requiring assistance with at least one basic activity of daily living.

Disability was identified as a separate barrier by 14.3% of the total sample but by 36.0% of people meeting the WG-SS threshold. The FGD findings indicate, however, that participants often regarded the inaccessibility of the environment, transport, information and services—rather than disability itself—as the principal barrier.

A person may be able to organise their life independently, make decisions and perform most everyday activities, yet remain unable to leave their building because of a single step, a high kerb or a non-functioning lift.

"The physical barrier is the entire journey. One kerb or step renders everything else inaccessible". [Participant in an FGD with older people with disabilities, Kharkivska oblast].

The problem is exacerbated by the absence of regular rehabilitation. Following an exacerbation of a chronic condition, a fall, stroke or prolonged immobility, a person may rapidly lose functions that could have been maintained or partially restored with appropriate support.

8.4. Inaccessibility of the physical environment and transport

The lack of transport was identified as one of the principal barriers by 30.0% of participants. A broader question concerning mobility showed that 50.8% experienced at least some difficulty moving outside their homes. This was very difficult for 8.3% and virtually impossible for 1.5%.

Among people meeting the WG-SS threshold, 85.6% experienced difficulty moving outside their homes:

- 54.1% reported that it was sometimes difficult;
- 27.9% reported that it was very difficult;
- 3.6% reported that it was virtually impossible.

Preliminary analysis found that 81.3% of participants aged 80 and over experienced difficulty leaving their homes, while for half of this group it was very difficult or virtually impossible. These findings should be recalculated using the verified denominator of 40 participants.

Only 6.3% of participants aged 80 and over identified transport as a principal barrier in the preliminary analysis. This may indicate not the absence of a problem but withdrawal from mobility: a person who rarely leaves home may no longer regard transport as an available option.

Inaccessible buildings were identified as a principal barrier by only 7.0% of the total sample. Among people meeting the WG-SS threshold, however, the proportion was 19.8%, while among people requiring assistance with basic activities it was 20.0%.

On a five-point scale assessing the accessibility of public buildings and services, 15.0% of all participants gave low ratings of 1–2. Among people meeting the WG-SS threshold, the proportion was 40.5%, compared with 5.2% among other participants. Accessibility was rated highly by 82.0% of participants without significant functional difficulties, but by only 34.2% of people meeting the WG-SS threshold.

This demonstrates fundamentally different experiences of using the same infrastructure. What is accessible to a person without functional limitations may be entirely inaccessible to a wheelchair or walking-frame user or to a person with a visual impairment.

The transport barrier also connects multiple other problems: without transport, a person loses access to healthcare, social services, banks, administrative services, humanitarian assistance and community life.

8.5. Security situation and inaccessible protection

The security situation was the most prevalent barrier, identified by 79.0% of respondents. A separate assessment showed that 81.0% gave a rating of 4 or 5 out of five for the impact of the security situation on independent living. The mean rating was 4.28.

The impact was high in both oblasts: ratings of 4–5 were given by 82.0% of participants in Dnipropetrovska oblast and 80.0% in Kharkivska oblast. The preliminary proportion among people aged 80 and over was 87.5% and should be verified using the confirmed denominator.

The war creates both direct and indirect barriers:

- damage to housing and infrastructure;
- changes to public transport routes;
- relocation of healthcare facilities;
- reductions in or overloading of personnel;
- disruptions to electricity, water and communications;
- inaccessible shelters;
- absence of individual evacuation plans;
- disruption of family and neighbourhood support networks;
- exacerbation of chronic conditions and psychological exhaustion.

Standard safety recommendations are often impossible to follow for people with mobility impairments. Shelters may be located far away, accessible only by stairs or equipped with inaccessible sanitary facilities. Lifts cease to operate during power cuts, while people who depend on electrically powered medical equipment require backup power.

"The worst combination is an inaccessible shelter and a broken lift. During an air-raid alert, I remain in my apartment knowing that the evacuation plan does not include me". [Participant in an FGD with older people with disabilities, Dnipropetrovska oblast]

Security planning that fails to consider a person's functional status effectively transfers responsibility for survival to the individual and their family.

8.6. Insufficient care and exhaustion of informal caregivers

Lack of care was identified as a principal barrier by 7.0% of the sample. Among people requiring assistance with basic activities of daily living, however, the proportion was 16.4%, while among people meeting the WG-SS threshold it was 12.6%.

The comparatively low overall prevalence conceals the concentration of this problem among people with the most intensive needs. Some participants may also not describe assistance from relatives as “care”, instead regarding it as a family obligation.

FGDs showed that informal caregivers are often older people themselves, have chronic health conditions and receive neither training nor respite services. Consequently, one person’s needs may result in the loss of independence of two family members: the recipient of assistance and the caregiver.

Additional barriers include:

- absence of a replacement caregiver;
- inability to leave the person even for a few hours;
- shortage of hygiene products and equipment;
- lack of training in safely assisting a person to move;
- psychological exhaustion;
- loss of income because continuous care is required;
- absence of crisis support if the caregiver becomes ill.

A policy that assigns primary responsibility to the family does not eliminate the need for services. It transfers that need to the unpaid labour of relatives, most often women.

8.7. Information and digital barriers

Only 5.0% of participants identified a lack of information about services as a principal barrier. Nevertheless, information-related difficulties were a recurring theme in open-ended responses and FGDs.

Barriers experienced by older people include:

- absence of a single source of current information;
- frequent changes to programme rules and eligibility criteria;
- mandatory electronic registration;
- complicated telephone menus;
- small print;
- voice messages without text alternatives;
- videos without subtitles;
- complex administrative language;
- risk of digital fraud;
- absence of opportunities to obtain advice in person or by telephone.

A lack of information was identified by 9.2% of men and 3.2% of women. FGD findings suggest that some men are less likely to seek assistance and may consequently remain outside formal support systems for longer.

“The information barrier is that everything is done through apps. I am afraid of pressing the wrong button and losing money to fraudsters”. *[Participant in a men’s FGD, Dnipropetrovska oblast]*

Digital tools can expand access but should not become the only means of obtaining information or services. Offline and telephone channels must be retained, together with assistance in using digital services.

8.8. Institutional fragmentation

One of the most important qualitative findings concerns the fragmentation of the support system. Health, social, housing, administrative and humanitarian services often operate separately, apply different eligibility criteria and require documents to be submitted repeatedly.

FGD participants described the following institutional barriers:

- the need to contact multiple institutions;
- absence of a unified needs assessment;

- different eligibility criteria in public and humanitarian programmes;
- access depending on registration or place of residence;
- responsibility being shifted between the administration of the place of residence, the community and social services;
- short duration of project-based assistance;
- absence of follow-up after an initial consultation;
- reliance on individual applications rather than proactive identification;
- absence of a transition plan from temporary accommodation to stable housing.

“Once people have been accommodated, responsibility becomes blurred: the administration tells them to contact the community, the community refers them to social services, and social services tell them to collect documents”. [Participant in an FGD with internally displaced older people, Kharkivska oblast]

People with multiple statuses or needs are most affected by fragmentation, including older people with disabilities, IDPs with chronic health conditions, people living alone and family caregivers.

8.9. Loneliness, social isolation and lack of support

Loneliness was identified as a principal barrier by 15.5% of participants and lack of social support by 8.5%. Among people living alone, however, 29.4% identified loneliness as a barrier, compared with 2.4% of those living with others.

People living alone were also more likely to identify:

- poor health: 65.5%, compared with 46.1%;
- lack of transport: 34.0%, compared with 26.2%;
- disability: 18.0%, compared with 10.7%;
- inaccessible buildings: 9.8%, compared with 4.4%;
- lack of care: 8.8%, compared with 5.3%.

Living alone does not always mean an absence of assistance. Some people receive support from children, other relatives, neighbours or social workers. Such support may nevertheless be irregular and unavailable during a crisis.

Proactive identification of people who have stopped leaving their homes, do not seek assistance or have no emergency contact is critical. A system that responds only to applications fails to reach the most isolated people.

8.10. Age discrimination and paternalistic attitudes

A total of 32 participants, or 8.0%, reported experiencing age discrimination during the previous year. A further 14.8% were unable to provide a definitive answer.

Among those reporting discrimination, healthcare facilities, public institutions and public transport were the most frequently identified settings, each selected by 16 people. Social services were identified by 14 participants. As multiple settings could be selected, the total exceeds the number of participants reporting discrimination.

The relatively low level of direct reporting does not necessarily indicate an absence of ageism. During FGDs, participants described situations in which:

- staff addressed relatives instead of the person concerned;
- older age was automatically associated with an inability to work;
- slower speech was interpreted as an inability to understand;
- care arrangements were proposed without sufficient discussion;
- older people's needs were determined without their participation;
- assistance was provided in a humiliating or infantilising manner.

The preliminary finding for participants aged 80 and over is particularly notable: none directly selected “yes”, but 43.8% were unable to answer. This may indicate difficulty recognising discrimination or the normalisation of paternalistic treatment and should be verified using the confirmed denominator.

8.11. Specific barriers affecting particular subgroups

People with disabilities and significant functional difficulties

The following barriers were substantially more prevalent within this group:

- poor health: 85.6%;
- disability as a barrier: 36.0%;
- lack of transport: 32.4%;
- inaccessible buildings: 19.8%;
- lack of social support: 17.1%;
- lack of care: 12.6%.

The central problem is a break in the accessible journey: a nominally available service may remain unreachable because of the person's housing, courtyard, transport, the entrance to the building or inaccessible communication.

People aged 80 and over

Preliminary analysis found that 93.8% identified poor health as a barrier, 75.0% the security situation, 50.0% insufficient financial resources and 37.5% disability. These proportions should be recalculated using the verified denominator of 40 participants.

The preliminary findings also indicated that half of participants aged 80 and over found moving outside the home very difficult or virtually impossible, 43.8% rated public-building accessibility poorly, and none expressed high confidence in their ability to continue living independently over the next five years.

People living alone

This group experiences an accumulation of health, transport and social barriers. Three or more barriers were reported by 75.8%, while 41.8% experienced four or more. Particular risks include the absence of emergency assistance, delayed identification of deteriorating health and social isolation.

Internally displaced older people

According to the FGD findings, the principal barriers include:

- housing instability;
- repeated displacement;
- lack of privacy in collective settings;
- loss of documents and medical records;
- services dependent on registration;
- complicated digital procedures;
- interruption or delay of payments;
- loss of employment;
- disruption of social connections;
- absence of a pathway from temporary accommodation to a long-term solution.

The combination of age, displacement, disability and absence of relatives creates a risk that institutional placement will be proposed immediately, without first examining community-based support options.

Gender differences

Women more frequently identified insufficient financial resources, transport, loneliness, lack of care and inaccessible buildings. Qualitative evidence indicates an additional burden of unpaid care and a greater likelihood of living without a partner in later life.

Men more frequently identified the security situation and lack of information. During FGDs, men discussed reluctance to seek assistance, loss of employment and social roles, and hidden loneliness following the death of a partner.

Regional differences

The security situation, insufficient financial resources and loneliness were identified somewhat more frequently in Dnipropetrovska oblast. Disability, inaccessible buildings, lack of care and lack of social support were more frequently reported in Kharkivska oblast.

Inaccessible buildings were identified by 10.5% of participants in Kharkivska oblast, compared with 3.5% in Dnipropetrovska oblast, while lack of care was reported by 9.5%, compared with 4.5%. These differences are partly associated with the higher proportion of people with functional difficulties in the Kharkivska oblast subsample.

8.12. Pathway from accumulating barriers to institutionalisation

The risk of institutionalisation does not arise only when a person requires continuous medical care. A combination of circumstances often becomes critical:

1. Deterioration in health or functional ability.
2. Inaccessible housing and transport.
3. Insufficient financial resources.
4. Absence of regular home-based assistance.
5. Exhaustion or absence of a family caregiver.
6. A crisis event—a fall, hospitalisation, shelling, housing damage or evacuation.
7. Absence of a rapidly available community-based alternative.
8. Referral to a facility as the only available solution.

In such circumstances, institutionalisation results not from free choice but from gaps in the support system. Preventing it requires early identification of risks, crisis assistance at home, short-term care, family support, housing adaptations and accessible supported-living options.

8.13. Key findings of the section

The principal barriers affecting the sample overall are the security situation, insufficient financial resources and deteriorating health. For people with functional difficulties, people aged 80 and over, IDPs and people living alone, these are compounded by inaccessible environments, transport restrictions, lack of care, information barriers and social isolation.

The accumulation of barriers is the central concern. More than half of people meeting the WG-SS threshold and more than two-fifths of people living alone experience four or more barriers concurrently.

The support system remains predominantly reactive and fragmented. People are expected to find information themselves, contact multiple institutions, demonstrate eligibility for assistance and coordinate different services. For those with limited mobility, visual or memory difficulties, or no informal caregiver, this model becomes a barrier in itself.

Ensuring the right to independent living requires a transition from assessing individual statuses to assessing the person's overall life situation, and from disconnected services to integrated support within the community.

9. Enabling factors for independent living and mapping of support systems

9.1. Principal pillars of independent living

The survey findings show that older people's independence is sustained through a combination of personal resources, income, family and neighbourhood assistance, health and social services, support from civil society organisations and assistive products.

Participants most frequently identified the following enabling factors:

Enabling factor	Number	Percentage of sample
Pension or other income	277	69,3%
Health services	227	56,8%
Family support	219	54,8%
Social services	159	39,8%
Assistance from friends or neighbours	119	29,8%
Civil society organisations	117	29,3%
Personal initiative and skills	110	27,5%
Faith community	65	16,3%
Assistive products	63	15,8%

On average, participants identified 3.4 sources of support. At least three sources were reported by 84.3% of respondents. Independent living is therefore generally sustained not by one source of assistance but by a combination of several resources.

The number of sources identified does not necessarily indicate their adequacy or stability. A pension may be regular but insufficient; family members may provide assistance but live far away; neighbourhood support may be available but not guaranteed; and assistance from a civil society organisation may depend on continued project funding.

The sustainability of independent living depends not only on the availability of support but also on its continuity, substitutability and capacity to respond to changing needs

9.2. Personal resources, skills and income

A pension or other income was identified as an enabling factor by 69.3% of participants. Income enables people to determine their own priorities, pay for housing, food, medicines and transport, and reduce their dependence on irregular assistance.

Personal initiative and skills were identified by 27.5%. This proportion was 45.5% among people aged 50–59 but only 10.8% among those with significant functional difficulties.

The reduced role attributed to personal initiative among people meeting the WG-SS threshold should not be interpreted as an absence of ability or motivation. It reflects environmental barriers and insufficient support. Accessible transport, an assistant, an assistive product or an adapted workplace can restore a person's ability to organise a substantial part of their life independently.

FGDs showed that older people want to remain active by working part-time, sharing professional experience, helping neighbours, volunteering and participating in community initiatives. Such activities simultaneously support income, social connections and a sense of personal value.

"I felt included when I was asked to help in the community kitchen for our neighbours, rather than only being invited to collect an assistance package". [Participant in a women's FGD, Kharkivska oblast]

Programmes for older people should regard them not only as recipients of assistance but also as participants and co-creators of support systems.

9.3. Family support

Family support was one of the three principal pillars of independence and was identified by 54.8% of participants. Satisfaction with family support was rated highly, at 4–5, by 61.8%; 13.5% gave a moderate rating, while 24.8% gave low ratings of 1–2.

Among people living with others, 88.4% identified family support as an enabling factor. Among people living alone, the corresponding proportion was only 19.1%.

Among participants requiring practical assistance at least occasionally, 36.3% identified immediate family members as providers and 21.6% identified other relatives. Among the 114 participants with a primary caregiver, this was most commonly a social worker, spouse, son, daughter or another relative.

Families provide a broad range of assistance:

- financial support;
- shopping and delivery of medicines;
- preparing meals;
- accompaniment to healthcare appointments;
- completion of administrative procedures;
- use of digital services;
- personal care;
- emotional support;
- emergency response.

The study nevertheless identified limitations in the family-based model. Relatives may live far away, be employed, care for children or experience health problems themselves. War and displacement have separated many families. Prolonged intensive care results in caregiver exhaustion, loss of income and deteriorating health.

"The family helps, but the children work and have children of their own. A policy that places everything on the family simply transfers the problem to middle-aged women". [Participant in a men's FGD, Dnipropetrovska oblast]

Family assistance should complement professional services rather than justify denying access to them. Family caregivers require training, advice, assistive equipment, psychological support and respite services.

9.4. Friends, neighbours and local mutual-support networks

Assistance from friends or neighbours was identified as an enabling factor by 29.8% of respondents and by 33.0% of people living alone.

Among participants requiring practical assistance, 18.8% identified a neighbour or acquaintance as a provider. Neighbourhood assistance was particularly important for people living alone: 18.6% selected this option, compared with 4.9% of those living with others.

Neighbourhood networks perform several functions:

- checking on people living alone after attacks;
- delivering water, food and medicines;
- helping with minor repairs;
- sharing information about available services;
- maintaining contact during service disruptions;
- contacting emergency services;
- strengthening a sense of community belonging.

"Our building has a telephone circle: if an air-raid alert lasts a long time or the water supply is interrupted, younger neighbours call the older residents. It is simple, but it makes us feel safer". [Participant in a women's FGD, Dnipropetrovska oblast]

Such networks are flexible and responsive but cannot guarantee professional care. Neighbours also grow older, move away, work or experience difficulties of their own. Communities can support neighbourhood initiatives through coordinators, contact lists, first-aid training, safety protocols and direct links with social and emergency services.

Informal assistance should not involve unsafe tasks or replace the work of qualified professionals.

9.5. Social services and social workers

Social services were identified as supporting independence by 39.8% of participants. The proportion was higher among people meeting the WG-SS threshold—52.3%—and among people living alone—59.8%.

Social workers were the most prevalent providers of practical assistance. Among the 245 participants requiring assistance at least occasionally, 146 people, or 59.6%, identified a social worker. Among those requiring regular assistance, social workers were the primary provider for 81 of 143 participants, or 56.6%.

Their role was particularly prominent among people living alone: social workers were identified by 66.0% of this group, compared with 8.7% of those living with others.

Overall, 47.3% of respondents reported high satisfaction with social services, 38.3% moderate satisfaction and 14.5% low satisfaction. Assessments differed substantially by functional status:

- 50.9% of participants without significant functional difficulties gave high ratings;
- 37.8% of people meeting the WG-SS threshold gave high ratings;
- low ratings were given by 10.7% and 24.3%, respectively.

Social workers constitute a critical pillar of the system, but their capacity is restricted by caseloads, limited time per recipient, a narrow list of authorised tasks and insufficient coordination with health services.

FGD participants emphasised that a brief visit is insufficient for people with complex needs. The intensity of assistance should be flexible, ranging from telephone contact and two hours of household assistance per week to daily visits, healthcare and respite for the family.

9.6. Health services

Health services were identified as a pillar of independence by 56.8% of participants. The preliminary proportions were 75.0% among people aged 80 and over and 61.3% among people with significant functional difficulties. The result for the 80+ group should be verified using the confirmed denominator.

Healthcare facilities received the highest satisfaction rating among the four types of support assessed: 64.8% of participants gave ratings of 4–5. Among people meeting the WG-SS threshold, however, only 35.1% reported high satisfaction, compared with 76.1% of other participants.

Low ratings were given by 32.4% of people meeting the WG-SS threshold but by only 3.5% of participants without significant functional difficulties.

This gap indicates that the healthcare system works better for people who can travel independently, arrange appointments, wait in queues and visit different facilities. People with complex functional needs require:

- home visits;
- mobile medical teams;
- coordination with social workers;
- transport and accompaniment;
- accessible communication;
- management of chronic conditions;
- rehabilitation;
- continuity-of-care plans during attacks and service disruptions.

“It works when the family doctor or social worker informs people directly about changes. When information has to be found through ten different channels, many people miss it”. [Participant in a women’s FGD, Kharkivska oblast]

9.7. Civil society organisations and volunteers

Civil society organisations were identified as supporting independence by 29.3% of respondents. Among the 245 participants requiring assistance, 57 people, or 23.3%, identified volunteers as providers of practical support.

Civil society and humanitarian organisations provide:

- financial and material assistance;
- food and hygiene supplies;
- medicines and assistive products;
- legal advice;
- psychosocial support;
- social activities;
- home visits;
- transport;
- minor housing adaptations;
- information and referrals.

Their strengths include flexibility and an ability to test new models rapidly. They can also reach people who are not registered with social services, support mutual-aid groups and represent the interests of older people.

Project-based assistance, however, is often limited in duration, geographical coverage and eligibility. When a programme ends, a person may lose support around which they have already organised their daily life.

- The optimal model is therefore one in which civil society organisations:
- complement services guaranteed by the community;
- pilot new approaches;
- train personnel;
- support proactive identification;
- ensure the participation of older people;
- transfer successful models into local programmes and budgets.

9.8. Faith communities

Faith communities were identified as a source of support by 16.3% of respondents. Their role was somewhat greater among people meeting the WG-SS threshold—19.8%—and in Kharkivska oblast—18.0%.

Faith communities may provide social contact, emotional and spiritual support, food, clothing, home visits, transport and assistance during crises. They may also be aware of people who do not contact formal services.

Such support is uneven and depends on local resources. Faith-based organisations should be included in local referral mechanisms without being assigned responsibility for professional health or social services.

9.9. Assistive products and an accessible environment

Assistive products were identified as supporting independence by 15.8% of participants. The proportion was 34.2% among people meeting the WG-SS threshold. The preliminary figure for people aged 80 and over was 62.5% and should be verified using the confirmed denominator.

The value of an assistive product depends on the environment. A wheelchair does not ensure independence where there are stairs; a walking stick does not remove the need to repair a pavement; and a hearing aid is ineffective if information is provided only in an inaccessible format.

Assistive products should therefore form part of comprehensive support that includes:

- individual assessment and fitting;
- training;
- maintenance;
- repair and replacement;

- provision of consumable components;
- housing adaptations;
- accessible transport;
- rehabilitation.

9.10. Support-system characteristics for particular subgroups

People with functional difficulties

Independence among this group depends to a much greater extent on external support:

- social services were identified by 52.3%;
- health services by 61.3%;
- assistive products by 34.2%;
- family support by 47.8%;
- personal initiative and skills by only 10.8%.

This group also rates the quality of family, community, social and health support substantially lower. The formal presence of assistance therefore does not always correspond to the intensity, accessibility or quality required.

People living alone

Among people living alone, 69.6% had someone they could turn to for assistance. However, 59 people, or 30.4% of this group, had no such contact. Every participant in the sample who reported having no one to turn to was living alone.

The principal pillars for this group were a pension or other income—72.2%, health services—66.5%, social services—59.8%, neighbours and friends—33.0%, and civil society organisations—28.9%.

People aged 80 and over

Preliminary analysis identified health services—75.0%, social services—62.5%, assistive products—62.5%, income—56.3% and family—43.8% as their principal sources of support. These proportions should be recalculated using the verified denominator of 40 participants.

The overall pattern indicates that after the age of 80, independence becomes increasingly dependent on reliable professional support rather than personal resources alone.

Internally displaced older people

For IDPs, rebuilding a new support network after losing their familiar environment is as important as access to services. Relevant elements include:

- stable housing;
- a case manager;
- a local social worker;
- access to a family doctor;
- legal support;
- mutual-aid groups;
- shared activities involving local residents and IDPs;
- opportunities to work or volunteer.

Support should promote inclusion in the community rather than perpetuate a separate status as a permanent category of “assistance recipients”.

9.11. Functional map of formal and informal support systems

Level of support	Principal actors	Functions	Strengths	Principal gaps
Personal	The individual	Self-care, decision-making, financial management and participation	Preserves autonomy and dignity	Depends on health, income and environmental accessibility
Family	Partner, children and other relatives	Care, shopping, accompaniment, financial and emotional support	Trust and knowledge of the person's routines and needs	Distance, employment, exhaustion and unpaid care
Neighbourhood	Friends, neighbours and local leaders	Emergency contact, deliveries, minor assistance and information	Speed and proximity	Informal nature, lack of guarantees and ageing networks
Community	Mutual-aid groups, clubs, libraries and faith communities	Social contact, inclusion, information and mutual support	Prevents isolation	Uneven availability and physical barriers
Social services	Social workers, territorial centres and social service providers	Care, case support, needs assessment and referrals	Professional expertise and potential regularity	High caseloads, narrow remit and fragmentation
Health	Family doctors, nurses, specialists and rehabilitation teams	Treatment, prevention and management of chronic conditions	Particularly important for older age groups	Transport barriers, waiting times, inaccessibility and weak home-based provision
Social protection	Pension system, benefits, subsidies and local programmes	Financial stability and coverage of basic expenditure	Regularity of established payments	Insufficient amounts, complex criteria and failure to account for additional costs
Civil society and humanitarian	NGOs, charitable foundations and volunteers	Material, legal and psychosocial assistance and pilot services	Flexibility and speed	Project-based duration and uneven coverage
Private	Paid caregivers, private transport, landlords and pharmacies	Paid care and services	Flexibility	Unaffordable costs and absence of uniform standards
Housing	Administrations of residential settings, homeowners' associations and municipal utilities	Safety, repairs, accessibility and emergency response	Direct influence on living conditions	Insufficient adaptation and unclear responsibility for residents

9.12. Required model for coordinating support

The current system contains many individual elements, but they are insufficiently connected. Participants or family caregivers often have to coordinate doctors, social workers, transport, assistive products, benefits and humanitarian assistance themselves.

“There is the doctor, the social service and the rehabilitation product, all separate—and I am the coordinator without any training”. *[Participant in a men’s FGD, Dnipropetrovsk oblast]*

A more effective model would ensure that:

1. The person’s needs are assessed comprehensively.
2. An individual plan is developed with the person.
3. An accountable case manager is appointed.
4. Health and social services are coordinated.
5. Family caregivers receive support and respite.
6. Neighbourhood and volunteer networks have contact with professional services.
7. Information is updated regularly through accessible channels.
8. The plan is reviewed following changes in health, housing or family circumstances.

9.13. Key findings of the section

Independent living is sustained through a combination of income, family assistance, health and social services, neighbourhood networks, civil society organisations, personal initiative and assistive products.

The most sustainable situation is one in which a person has several complementary sources of support. Reliance on one relative, social worker, volunteer or short-term programme creates a risk of sudden loss of assistance.

The family remains a key resource but cannot constitute the entire care system. Social workers are particularly important for people living alone, while health and social services are critical for people with functional difficulties and those aged 80 and over.

People with the greatest needs nevertheless rate the quality of all principal forms of support substantially lower. The primary gap is therefore not the complete absence of individual elements, but insufficient intensity, accessibility, predictability and coordination.

Priority should be given to an integrated model centred on the person, their choices and an individual support plan. Formal and informal resources should complement one another without transferring professional responsibility to families or neighbours.

10. Ecosystem of formal and informal support for older people

The support system for older people encompasses the actors, services and resources that help individuals preserve their autonomy and continue living in the community. It includes national and local social and health services, rehabilitation, support from family members and immediate social networks, and the activities of civil society, charitable, faith-based and volunteer organisations.

The findings show that support is not the opposite of independence. On the contrary, timely and personalised assistance is one of the principal conditions for preserving it. A person may require assistance with mobility, cleaning, preparing meals, taking medication or completing administrative procedures while remaining independent, provided that they determine where and with whom they live, what support they receive and how they organise their everyday life.

10.1. Overall architecture of the support system

The support ecosystem for older people comprises three interconnected levels: formal, informal, and civil society and humanitarian support.

Level of support	Principal actors	Principal functions	Key limitations
Formal	Local authorities, social protection authorities, social services, healthcare facilities, rehabilitation providers, employment services and long-term care facilities	Social benefits, home-based care, healthcare, rehabilitation, provision of assistive products, and housing, transport and administrative services	Fragmented services, complex procedures, insufficient outreach services, weak inter-agency coordination and absence of a single coordinator
Informal	Family members, other relatives, friends, neighbours, local activists and mutual-aid groups	Everyday household assistance, social contact, accompaniment, delivery of food and medicines, assistance with documents and crisis response	Uneven support, caregiver exhaustion, absence of specialised skills, dependence on one person, and shrinking social networks because of displacement
Civil society and humanitarian	Civil society and charitable organisations, volunteers, faith communities, and international and national humanitarian organisations	Material, psychological, legal and information support, mobile services, social activities, advocacy, identification of people at risk, and testing of new support models	Dependence on project funding, limited geographical coverage, unstable financing and insufficient integration with local services

These levels do not operate in isolation. In everyday life, support for an older person generally comprises several elements: a pension or social benefit, assistance from relatives, support from a social worker, access to healthcare facilities, and periodic assistance from civil society or humanitarian organisations.

The involvement of several providers does not in itself constitute an integrated system. Without a designated coordinator, the person or their family must combine different services independently, repeatedly explain their needs to different institutions, collect documents and monitor whether agreed actions are implemented.

10.2. Actual providers of everyday assistance

Of the 400 respondents, 245 people, or 61.3%, required assistance from others with everyday tasks either regularly or occasionally. Social workers were the most frequently identified providers, reported by 146 people, or 59.6% of respondents requiring assistance.

Provider of assistance	Number	Percentage of people requiring assistance, %
Social worker	146	59.6
Immediate family member	89	36.3

Volunteer	57	23.3
Other relative	53	21.6
Neighbour or acquaintance	46	18.8
Paid caregiver	8	4.9
No one	2	0.8

Note: Respondents could identify multiple providers; percentages therefore sum to more than 100%.

The findings demonstrate the central role of social workers in everyday support. In many cases, however, assistance is provided through a combination of social workers, immediate family members, other relatives, neighbours and volunteers.

This model can be relatively sustainable where its participants coordinate their efforts and responsibilities are clearly allocated. It becomes vulnerable when each provider performs only isolated tasks without information about the person's overall circumstances, other available services or long-term support plan.

Among respondents requiring assistance, 15.5% considered the support they received fully sufficient and 49.8% considered it mostly sufficient. However, it was only partially sufficient for 29.0% and insufficient for 5.7%. Approximately one in three people receiving assistance therefore continued to experience partially or entirely unmet needs.

10.3. Formal support system

10.3.1. Social protection and financial support

Pensions, social benefits and other income remain a fundamental resource for independent living. Overall, 69.3% of respondents identified a pension or other income as a factor helping them remain independent.

At the same time, 91.3% reported a current need for financial support, while 78.5% considered financial assistance necessary to remain in their own homes for longer. These were the highest proportions among all needs and potential forms of support examined.

Although pensions, social benefits and humanitarian cash assistance have broad coverage, available income is generally insufficient to cover medicines, food, utilities, transport, rehabilitation, assistive products and care.

Financial support matters not only for meeting basic needs. It directly affects a person's ability to make their own decisions, pay for necessary services and avoid complete dependence on relatives, social workers or humanitarian assistance.

10.3.2. Social services

Social services were identified as supporting independent living by 39.8% of respondents. The most visible element of this system is assistance from social workers, received by 59.6% of respondents who regularly or occasionally required help with everyday tasks.

Social support, however, often focuses on individual household tasks and does not always include:

- comprehensive needs assessment;
- coordination of health and social services;
- housing adaptations;
- support for family caregivers;
- organisation of transport services;
- psychological support;
- social participation;
- regular review of the individual support plan.

Social services received high ratings of 4 or 5 from 47.3% of respondents. This indicates not a complete absence of services, but uneven geographical availability, intensity and responsiveness to individual needs.

Access to comprehensive services remains particularly limited for people with significant functional difficulties, people living alone, IDPs and residents of collective sites. Periodic household assistance alone is insufficient for these groups; they require a coordinated package of social, health, rehabilitation, transport and housing services.

10.3.3. Health and rehabilitation services

Health services were identified as supporting independent living by 56.8% of respondents. High satisfaction with healthcare facilities, reflected in ratings of 4 or 5, was reported by 64.8%.

The need for health-related support nevertheless remains substantial:

- 66.3% had a current need for healthcare;
- 58.5% required medicines;
- 47.8% identified home-based healthcare as support that would enable them to remain at home for longer;
- 21.8% reported a current need for rehabilitation;
- 13.0% required assistive products.

These findings reveal a gap between the general availability of healthcare facilities and access to continuous assistance at the person's place of residence. The principal gap is the absence of an integrated pathway connecting primary healthcare, home visits, care, rehabilitation, medicines and assistive products.

10.3.4. Transport, housing and physical accessibility

Transport services were identified as a condition for remaining at home for longer by 21.3% of respondents. At the same time, 30.0% identified transport as a factor limiting their independence.

Housing adaptations were identified as a necessary form of support by 8.3% of respondents. Direct assessment nevertheless showed a substantially higher need among people with significant functional difficulties: 43.2%, compared with 13.1% among other respondents. This may indicate both the greater needs of this group and the tendency for adaptations to be considered only after a substantial deterioration in functional status.

The accessibility of housing, buildings, public transport, shelters and public spaces should not be treated as a secondary infrastructure issue. It determines whether a person can use a health, social or administrative service even when that service formally exists.

10.3.5. Information, administrative and legal support

Older people receive information about services, benefits and support opportunities from different institutions, volunteers, personal contacts, telephone messages and digital channels. In the absence of a unified information pathway, people frequently have to determine for themselves which institution is responsible for a particular issue.

This problem is particularly pronounced for IDPs, who must simultaneously address housing, registration, social benefits, healthcare, document restoration and access to local services following evacuation.

For people with low digital literacy, visual or hearing impairments or cognitive difficulties, a system based primarily on electronic applications and online information creates additional barriers. Information must therefore be disseminated simultaneously through digital and accessible offline channels.

10.4. Informal support from family members and immediate social networks

Informal support remains one of the principal resources for independent living. Family support was identified as an enabling factor by 54.8% of respondents, while assistance from friends or neighbours was identified by 29.8%. High satisfaction with family support, reflected in ratings of 4 or 5, was reported by 61.8%.

Family members and relatives often perform several functions simultaneously: providing household assistance, purchasing food and medicines, accompanying people to healthcare appointments, delivering care, providing financial support, assisting with documents and communicating with public authorities.

Reliance on family support cannot, however, replace guaranteed social and health services. The principal risks of a family-based model include:

- physical and emotional exhaustion of the caregiver;
- the need to combine care with employment and other family responsibilities;
- absence of professional knowledge and skills;
- disagreements concerning the extent and manner of assistance;
- the older person's dependence on one individual;
- absence of a replacement if the caregiver becomes ill or leaves;
- loss of support because of displacement, mobilisation, death or relatives moving away.

People living alone are particularly vulnerable. They numbered 194, or 48.5% of the sample. Fifty-nine respondents—14.8% of the total sample—had no one they could turn to for assistance. All of them lived alone.

The absence of a contact person does not necessarily mean an immediate need for continuous care. It does, however, substantially increase the risk that deteriorating health, a fall, power cuts, evacuation or another crisis will not receive a timely response. This group requires regular contact, an emergency-response mechanism and a designated responsible professional.

Neighbours and acquaintances are particularly important in meeting urgent everyday needs, including obtaining food and medicines, carrying out minor repairs, providing accompaniment and social contact, and assisting during air-raid alerts. Such support is largely informal, depends on personal relationships and cannot guarantee regular professional care.

10.5. Role of civil society, volunteer and faith-based organisations

Civil society organisations were identified as supporting independent living by 29.3% of respondents and faith communities by 16.3%. Among people requiring everyday assistance, 23.3% received it from volunteers.

Civil society and humanitarian organisations perform several important functions:

- identifying people who remain outside formal support systems;
- providing humanitarian and cash assistance;
- delivering mobile health and social services;
- providing psychological, information and legal support;
- facilitating access to assistive products;
- organising social activities and mutual-aid groups;
- providing digital-literacy training;
- supporting IDPs in moving from transit or temporary accommodation to more stable housing;
- advocating for changes in local and national policies;
- testing supported living, day-care and integrated home-support models.

Civil society organisations may also respond more rapidly to emerging needs, adapt assistance formats and reach people who do not contact public institutions because of physical, information or administrative barriers.

Civil society and humanitarian organisations should not, however, substitute for local social and health systems. Their assistance should complement the guaranteed support package, promote innovation, reach underserved groups, strengthen local providers and independently monitor service quality.

“Mutual-aid groups can provide company and information, but professional care must be guaranteed by the community”. [Participant in an FGD with older IDPs, Kharkivska oblast]

10.6. Principal systemic gaps

Comparison of the assistance available with the support respondents require reveals the following systemic gaps.

1. **Absence of a single coordinator.** People or their families generally have to coordinate social, health, administrative, housing and humanitarian services themselves.
2. **Insufficient services at the place of residence.** Home-based healthcare was identified as necessary by 47.8% of respondents, psychological support by 29.0%, home-based care by 24.8% and transport services by 21.3%.
3. **Gap between needs assessment and actual assistance.** Disability status or contact with social services does not guarantee housing adaptations, rehabilitation, transport, assistive products or care of sufficient intensity.
4. **Excessive burden on families.** Relatives simultaneously act as caregivers, coordinators, drivers, representatives before public authorities and sources of financial support without systematic training, psychological assistance or respite.
5. **Unsustainable humanitarian support.** Volunteer and civil society assistance has substantial reach but is often dependent on the duration of individual projects and is not incorporated into long-term individual support plans.
6. **Absence of continuity between living arrangements.** When a person moves from a transit centre to a collective site, rented housing, relatives' accommodation or a long-term care facility, information concerning their needs and previous assistance may be lost.
7. **Insufficient focus on preventing loss of independence.** Housing adaptations, rehabilitation, assistive products and caregiver support often become available only after a substantial deterioration in the person's condition.

10.7. Recommended model for coordinating support

The optimal system should operate through a single pathway regardless of which institution the person first contacts. The initial point of contact may be a social service, healthcare facility, local authority, collective-site administration, civil society organisation or humanitarian organisation.

The recommended pathway comprises:

1. Initial contact or proactive identification.
2. Comprehensive assessment of functional, health, social, housing, psychological and safety needs.
3. Appointment of a case manager or another accountable coordinator.
4. Agreement with the person on an individual support plan.
5. Development of a service package drawing on formal, informal and community resources.
6. Identification of responsible providers and timelines for each service.
7. Regular review of the plan and assessment of the adequacy of assistance.
8. Development of a contingency plan for deteriorating health, housing loss, evacuation or discontinuation of informal care.
9. Забезпечення збереження та захищеної передачі даних про людину, її потреби й отримувані послуги до відповідальної служби за новим місцем перебування у разі евакуації.

Integrated support pathway for older people



The pathway is cyclical: changing needs trigger reassessment and **revision** of the plan

For people living alone, experiencing significant functional difficulties or lacking someone to turn to, the system should provide proactive monitoring. This may include regular telephone calls or home visits, an emergency alarm button, a backup contact person, a designated social worker and an agreed crisis-response procedure.

Case management should not create an additional administrative layer. Its purpose is to ensure that the person is not left as the sole coordinator of their own support and is not required to engage separately with every institution.

10.8. Summary

The existing support system for older people is multi-component but insufficiently integrated. Its strongest elements are social workers, family support, health services, and assistance from civil society and volunteer organisations.

The greatest gaps concern coordination, home-based and mobile services, housing adaptations, accessible transport, rehabilitation, support for family caregivers, and transitions from temporary or institutional settings to community living.

The principal direction for development should be a shift from isolated forms of assistance towards a personalised support package built around the person's choices. Such a package should combine social and health services, material assistance, accessible housing, transport, rehabilitation, social participation and support from immediate social networks.

11. Comparison of living arrangements and regional differences

11.1. Analytical structure

The study covered four principal living arrangements:

- own or rented housing: 120 participants, or 30.0%;
- collective sites: 80 participants, or 20.0%;
- transit centres: 80 participants, or 20.0%;
- long-term care facilities: 120 participants, or 30.0%.

Because the individual-level variable for living arrangement was incomplete in the exported quantitative dataset, the comparison does not include artificially calculated cross-tabulated percentages. The analysis is based on the confirmed sample structure, FGDs, open-ended responses, field-team observations and desk-review materials.

Living arrangements were compared according to:

1. Choice and control.
2. Privacy.
3. Housing stability.
4. Access to care and healthcare.

5. Safety and physical accessibility.
6. Preservation of family and community connections.
7. Ability to leave the living arrangement.
8. Risk of isolation and institutionalisation.

11.2. Own or rented housing

Advantages

A person's own apartment or house was most frequently associated with independence. The principal advantages included:

- control over daily routines;
- privacy;
- the ability to retain personal belongings;
- the right to receive visitors;
- familiar surroundings;
- established routes to shops, pharmacies and healthcare facilities;
- neighbourhood connections;
- a sense of belonging to the local community.

For most participants, remaining at home meant preserving not only housing but also identity, routines and social history.

Principal risks

Living in one's own home does not guarantee actual independence. An apartment may become a place of isolation if the person cannot manage the stairs, use the lift or cross the courtyard safely. In detached housing, additional problems include heating, water, snow clearance, roof repairs, carrying fuel and substantial distances to services.

Other risks include:

- housing damage caused by attacks;
- high repair costs;
- inability to carry out repairs physically;
- inaccessible bathrooms and entrances;
- risk of falls;
- absence of a shelter;
- power cuts;
- social isolation;
- absence of regular home-based assistance.

In rented housing, a particular problem is the owner's refusal to permit grab rails, removal of thresholds or other adaptations.

Required support

For own or rented housing to remain a genuine independent-living environment, the following are required:

- home-based care and household assistance;
- home-based healthcare;
- mobile rehabilitation;
- minor repairs;
- housing adaptations;
- social transport with accompaniment;
- delivery of medicines and food;

- regular contact with people living alone;
- an individual safety plan;
- support for family caregivers.

Among respondents, 58.8% wanted to remain at home with support even if they required continuous care. Developing home-based and mobile services is therefore the principal means of preventing institutionalisation.

11.3. Collective sites

Advantages

Collective sites provide basic safety following evacuation or housing loss. Their strengths may include:

- availability of a bed, heating and water;
- presence of other people;
- immediate humanitarian assistance;
- access to selected consultations;
- opportunities to receive centralised information;
- mutual assistance among residents.

For a person who has lost their home or cannot return, a collective site is an important crisis-response solution.

Principal risks

The central problem is that temporary accommodation often becomes temporary for an indefinite period. People do not know how long they can stay, where they will move next or who is responsible for finding a long-term solution.

“There are a bed, warmth and other people at the centre. But I cannot plan my day: there are shared sanitary facilities, queues, rules and new arrivals”. [Participant in an FGD with internally displaced older people, Kharkivska oblast]

The principal limitations include:

- insufficient privacy;
- shared rooms and sanitary facilities;
- dependence on administrative rules;
- limited space for personal belongings;
- inability to receive relatives or friends;
- absence of a stable transition plan;
- physical inaccessibility;
- absence of individualised home-based assistance;
- blurred responsibility between the administration and the community;
- limited inclusion in the host community.

The presence of staff or administrators does not mean that care is available. FGD participants reported that social services may assume that a resident’s needs are already met because they live in a collective setting, even when assistance with bathing, mobility, medication or accompaniment is not provided.

Risk of hidden institutionalisation

If a collective site lacks a pathway towards ordinary housing, it may acquire institutional characteristics:

- prolonged collective living;
- lack of control over daily routines;
- dependence on the administration;
- isolation from the community;

- absence of genuine housing alternatives;
- inability to change one's place of residence freely.

The risk is particularly high for people with disabilities, people aged 80 and over, IDPs without relatives and those requiring regular care.

Required support

Every collective site should provide:

- individual needs assessments;
- a case manager;
- access to a social worker and nurse;
- home-based services regardless of the collective living arrangement;
- accessible sanitary facilities;
- opportunities for private space;
- legal assistance;
- a transition plan leading to social rental housing, supported living, residence with family or another option chosen by the person.

11.4. Transit centres

Function of a transit centre

A transit centre performs a short-term crisis-response function. It should provide:

- physical safety following evacuation;
- food, clothing and hygiene supplies;
- an initial health assessment;
- restoration of contact with relatives;
- registration;
- information about available onward options;
- organisation of onward movement.

For older people, the quality of a transit centre is determined not only by the speed of onward movement but also by its ability to consider the person's health, functional ability, care needs and will.

Principal risks

Following evacuation, people may be experiencing stress, physical exhaustion or disorientation. They may not be able to absorb large amounts of information, reconstruct their medication history or make rapid decisions about their preferred living arrangement.

"After the transit centre, everything felt like a fog: documents, a health examination and new people. At the age of 80, it is difficult to tell your story repeatedly to everyone". [Participant in an FGD with internally displaced older people, Dnipropetrovsk oblast]

The principal risks include:

- information overload;
- repeated collection of identical information;
- loss of medical records;
- interruption of treatment;
- unavailability of required medicines and assistive products;
- rushed decisions concerning the next place of residence;
- absence of accessible transport;
- separation of family members or of the caregiver and care recipient;
- referral to a facility solely because no other accessible option is available.

Transit procedures must be adapted for people with memory, visual or hearing difficulties. Information should be repeated, provided in writing in an accessible format, and checked to ensure that the person has understood it.

Required support

A transit centre should ensure:

1. Rapid functional screening.
2. Identification of care and assistive-product needs.
3. Reconstruction of relevant medical information.
4. Continuity of medication.
5. Contact with relatives.
6. Accessible communication.
7. The person's participation in selecting the next living arrangement.
8. Transfer of information to the accountable case manager in the destination community.
9. A follow-up consultation after initial stabilisation.

A transit centre should serve as an entry point into the support system, not a point after which responsibility for the person is lost.

11.5. Long-term care facilities

For this study, this category includes residential homes for older people, institutional care homes, inpatient long-term care units and selected palliative care facilities. These settings differ in size, routines, resident profiles and levels of medical support.

Potential advantages

For people with intensive support needs, facilities may provide:

- continuous staff presence;
- meals;
- heating and basic living conditions;
- assistance with personal hygiene;
- medication supervision;
- contact with other residents;
- reduced pressure on family members.

During crises, a facility may be perceived as the only available option, particularly when a person has lost their home, has no relatives or requires round-the-clock assistance.

Restrictions on independence

The principal risk of long-term institutional living is loss of control over one's own life. This may be reflected in:

- fixed routines;
- collective meals and household arrangements;
- lack of privacy;
- limited choice of staff or co-residents;
- inability to determine when assistance is received;
- weak connections with the community;
- limited participation in decision-making;
- distance from family members;
- gradual loss of everyday skills;
- difficulty leaving the facility.

A 2025 national study of the institutional system found that restrictions on residents' independent activities lead to demotivation and the gradual loss of independent-living skills. The principal reasons for institutional residence also included the absence of housing and community-based services, loss of relatives, and families' inability to provide the necessary support.

Residence in a facility is therefore not always the result of free choice. It may result from the absence of home-based care, accessible housing, supported living or crisis assistance.

This is supported by the survey findings: only 6.0% of participants would choose a care facility as their preferred option if they required continuous assistance.

"If my condition deteriorated, I would want to live in a small accessible apartment with staff on call, rather than in a large facility far from my neighbourhood". [Participant in an FGD with older people with disabilities, Kharkivska oblast]

Security risks

Large facilities face additional wartime risks:

- difficulty evacuating residents rapidly;
- residents' dependence on administrative decisions;
- inaccessible or insufficient shelters;
- absence of individual evacuation plans;
- risk of mass relocation to another facility;
- loss of documents and medical information;
- disruption of contact with relatives.

Moving people from one large institution to another does not constitute deinstitutionalisation, even if the new facility is safer or better equipped.

Required changes

Pending transition to a community-based support system, facilities should:

- assess residents' individual needs and preferences;
- provide the greatest possible privacy;
- maintain self-care skills;
- avoid unnecessarily restricting independent activities;
- maintain connections with family and the community;
- ensure access to independent legal assistance;
- regularly review opportunities for transition to community living;
- maintain individual safety and evacuation plans;
- avoid automatically making decisions on behalf of the person.

11.6. Comparative characteristics of living arrangements

Criterion	Own or rented housing	Collective site	Transit centre	Long-term care facility
Principal function	Permanent residence	Temporary accommodation	Short-term crisis support	Permanent or long-term care
Control over routine	Generally high	Restricted by communal rules	Low because of crisis-response arrangements	Often low because of institutional routines
Privacy	Generally high	Low or moderate	Low	Low or dependent on the facility

Stability	High for owners; lower for tenants or damaged housing	Uncertain	Intentionally short-term	Formally high but dependent on the institution
Access to care	Depends on community services and family	Often fragmented	Initial assistance only	More regular but standardised
Connection with the community	Potentially high	Limited	Minimal	Often weak
Principal risk	Isolation in inaccessible housing	Prolonged temporariness	Inappropriate onward referral	Segregation and loss of autonomy
Priority support	Home-based and mobile services	Transition planning and case management	Safe onward referral	Individualisation and transition to the community

11.7. Regional differences

The quantitative sample was evenly distributed between the two oblasts, with 200 participants in each. The differences identified describe the surveyed groups and should not be interpreted as estimates of prevalence among the entire populations of the oblasts.

Functional status and health

Participants in Kharkivska oblast had a more complex functional profile:

Indicator	Dnipropetrovsk oblast	Kharkivska oblast
Met the WG-SS threshold	15.5%	40.0%
Poor or very poor health	26.5%	38.0%
Chronic health conditions	75.0%	83.5%
Required housing adaptations	16.5%	26.5%
Required regular assistance	21.5%	50.0%
Lived alone	45.5%	51.5%

Particularly substantial differences were observed in significant difficulty with walking or climbing steps—8.0% in Dnipropetrovsk oblast, compared with 26.5% in Kharkivska oblast—self-care, at 1.0% compared with 16.5%, and seeing, at 7.0% compared with 18.0%.

These differences are consistent with the greater need for rehabilitation, assistive products, care and housing adaptations among participants in Kharkivska oblast.

Access to services

In Dnipropetrovska oblast, 85.5% of participants considered access to healthcare very or fairly easy, compared with 67.5% in Kharkivska oblast. Access was difficult or very difficult for 14.5% and 32.5%, respectively.

High satisfaction with the accessibility of community services was reported by 73.5% of participants in Dnipropetrovska oblast and 46.5% in Kharkivska oblast.

A similar difference was observed in assessments of specific support systems:

High satisfaction, ratings of 4–5	Dnipropetrovska oblast	Kharkivska oblast
Family support	70.0%	53.5%
Community support	55.0%	33.5%
Social services	58.5%	36.0%
Healthcare facilities	80.5%	49.0%

Needs and barriers

Financial support, medicines and social interaction were identified more frequently in Dnipropetrovska oblast. Rehabilitation, assistive products and housing adaptations were identified more frequently in Kharkivska oblast.

Inaccessible buildings, lack of care and lack of social support were also reported more frequently in Kharkivska oblast. Qualitative evidence relates this to infrastructure damage, changes to transport routes, power cuts and the greater proportion of participants with functional difficulties.

Insufficient financial resources and loneliness were reported somewhat more frequently in Dnipropetrovska oblast.

Security and perceived future prospects

Despite differences in functional status and access to services, the impact of the security situation was almost equally high: ratings of 4–5 were given by 82.0% of participants in Dnipropetrovska oblast and 80.0% in Kharkivska oblast.

Only 18.5% of participants in Dnipropetrovska oblast and 20.0% in Kharkivska oblast expressed high confidence in their ability to continue living independently over the next five years. Low confidence was reported by 66.0% and 60.0%, respectively.

Even though participants in Dnipropetrovska oblast assessed access to services more positively, they did not feel substantially more confident about their longer-term prospects. Financial, security and health-related risks are likely sufficiently strong to offset the advantages associated with access to individual services.

11.8. Key findings of the section

No living arrangement guarantees independence in itself. The determining factors are choice, privacy, stability, environmental accessibility, adequate support and connection with the community.

Own or rented housing is most consistent with participants' aspirations for autonomy, but without home-based services and adaptations it may become a place of effective isolation. Collective sites provide basic safety but create a risk of prolonged uncertainty and hidden institutionalisation. Transit centres are essential crisis-response points but must ensure functional assessment, continuity of treatment and safe onward referral. Long-term care facilities may provide regular assistance but frequently restrict privacy, choice and participation in community life.

The regional comparison indicates a more complex profile of functional needs and lower assessments of service accessibility in the Kharkivska oblast subsample. Low confidence in the ability to continue living independently is nevertheless characteristic of both oblasts.

Policy should focus not on selecting one universal living arrangement, but on developing a continuum of support ranging from assistance in a person's own home to small-scale supported living and crisis and short-term care. Decisions should be based on the person's will, individual assessment and regular review of their needs.

12. Deinstitutionalisation: the role of local authorities and non-governmental organisations

12.1. Deinstitutionalisation must begin with supporting people in the community

In the context of this study, deinstitutionalisation should not be understood solely as reducing the number of residential institutions or transferring their residents to other premises. Its purpose is to create conditions in which an older person can choose where and how to live, retain control over everyday life, receive the necessary support in the community, and avoid placement in a facility solely because of poverty, disability, loss of housing or the absence of relatives.

This approach is consistent with Article 19 of the [United Nations Convention on the Rights of Persons with Disabilities](#), which establishes the right to choose one's place of residence and to receive the services necessary for living and inclusion in the community. At the national level, the relevant priorities are set out in the [Strategy for Reforming Psychoneurological and Other Residential Institutions and Deinstitutionalising Care until 2034](#) and its operational plan for 2025–2027. The Strategy provides for the development of social services and support for people with heightened needs specifically to enable them to live in the community and prevent institutionalisation.

The study findings confirm that older people are not primarily seeking to avoid assistance, but to receive it without losing their homes, privacy or control over their lives. If continuous support were required, 58.8% of respondents would prefer to remain at home and receive the necessary services. A further 16.3% would prefer to live with relatives, 11.0% would choose supported living, and only 6.0% would prefer to move to a long-term care facility. At the same time, 8.0% were unable to decide, which may reflect both uncertainty about the future and insufficient awareness of alternatives to institutional care.

The strong preference for home-based support coexists with a substantial risk of institutionalisation. Regular assistance with everyday life is already required by 35.8% of respondents, while 27.5% require assistance with at least one basic activity of daily living. Overall, 85.5% are very or somewhat concerned about who will care for them in the future if their health deteriorates. Without an expansion of community-based services, some people currently living independently or with relatives may eventually face what is effectively a forced choice between remaining without the necessary assistance and moving to a facility.

“Older IDPs without relatives are often immediately offered a place in a facility. Rental or social housing with support should be tried first, instead of depriving the person of choice”. [Participant in a women’s FGD, Dnipropetrovska oblast]

12.2. The risk of institutionalisation results from a combination of deficits

Institutionalisation is rarely caused by health status alone. It generally results from the combined effects of several factors: deteriorating mobility, low income, inaccessible housing, unavailable home-based services, exhaustion of a family caregiver, housing instability, and weak coordination between the social and healthcare systems.

According to the survey findings:

- 91.3% of respondents require financial support;
- 66.3% require medical assistance;
- 58.5% require access to medicines;
- 27.8% require transport support;
- 21.8% require rehabilitation services;
- 13.0% require assistive products;
- 10.0% require home-based care;
- 5.0% require housing adaptations.

Among the forms of support that would help respondents remain in their own homes for longer, the most frequently identified were financial assistance, at 78.5%; home-based healthcare, at 47.8%; psychological support, at 29.0%; home-based care, at 24.8%; social activities, at 22.5%; and transport, at 21.3%.

Preventing institutionalisation therefore requires a coordinated package of support rather than a single specialised service. Financial assistance remains critically important, but it cannot substitute for home-based care, medical and rehabilitation visits, social transport, housing adaptations or respite for family caregivers.

The desk review also indicates that, under wartime conditions, institutional placement is frequently used as a rapid response to the loss of housing, evacuation or the absence of family support. Such a response merely transfers a person from one crisis to another if it does not ensure privacy, choice, an individual support plan and a realistic prospect of returning to life in the community.

The groups at particularly high risk include:

- older people with significant functional difficulties;
- people aged 80 and over;
- people living alone;
- IDPs who have lost their homes or have no relatives in the host community;
- families in which care is provided by a single exhausted caregiver;
- residents of collective sites without a long-term housing solution;
- people unable to use transport, shelters and public buildings;
- people without documents, registration or access to information about services.

12.3. Existing regional programmes provide a foundation but require a shared deinstitutionalisation framework

Both oblasts covered by the study have programmes relating to social protection, accessibility, support for IDPs, mental health and the development of social services. These measures are nevertheless implemented through different programmes, budget lines and responsible departments. As a result, a person may receive an individual payment, humanitarian assistance or a medical consultation without receiving a coordinated pathway from the initial identification of needs to stable housing and regular support.

Dnipropetrovska oblast has a [Comprehensive Social Protection Programme for 2025–2029](#) and an [Action Plan for Creating an Accessible Environment for 2025–2026](#). Certain supported-living measures are also included in the regional mental health plan. These instruments provide a regulatory foundation but require coordination across programmes and shared outcome indicators.

In Kharkivska oblast, the [Comprehensive Social Protection Programme for 2026–2030](#) is largely focused on targeted material assistance and support for specific population groups. At the same time, the [Social Services and Psychosocial Support Development Programme for 2023–2027](#) already provides for day care, supported living, social contracting, engagement with civil society and international organisations, and the participation of older people's councils in identifying needs.

The principal gap is therefore not a complete absence of regulatory foundations, but the fact that existing measures have not yet been brought together around a measurable objective: increasing the number of older people who can live safely in the community with the support they require.

12.4. Required amendments to local and regional instruments

The Law of Ukraine [“On Social Services”](#) authorises local authorities to assess the population's needs, plan service networks, finance services and engage non-governmental providers. The [Procedure for Determining the Population's Need for Social Services](#) provides for the systematic collection and consolidation of such data by local social protection authorities. Most of the necessary changes can therefore be implemented through oblast and local programmes, procedures, budgetary decisions and inter-agency protocols without waiting for the entire national reform to be completed.

Local or regional instrument	Required amendment	Practical result
Comprehensive social protection programmes	Include a separate component entitled "Independent Living and Prevention of Institutionalisation among Older People and People with Disabilities"	Shift from predominantly financing payments and maintaining facilities towards financing outcomes for individuals
Oblast reform implementation plan	Adopt a regional plan for implementing the Deinstitutionalisation Strategy, specifying responsible authorities, timelines, budgets and annual indicators	Coordination between social protection, healthcare, housing policy, transport, civil protection and work with IDPs
Procedure for determining the population's needs	Add assessments of functional difficulties, everyday autonomy, housing conditions, caregiver availability, risk of institutionalisation and preferred living arrangements	Identification of needs before a crisis occurs, rather than only after an application for residential care
Local procedure for admission to facilities	Before admission, require documentation of the person's informed wishes and verification of the availability of home-based support, supported living, temporary care and housing solutions	Institutional placement becomes a last resort rather than an automatic option
List of social services and procedures for their provision	Provide home-based care, personal assistance, mobile rehabilitation, day care, respite for caregivers, social transport, supported living and housing adaptations	Establishment of the minimum package of services required for living in the community
Regulations governing collective sites and transit centres	Introduce individual plans for transition from temporary accommodation, appoint a responsible case manager, and ensure that residents retain access to home-based and mobile services	Prevention of temporary accommodation becoming a long-term institution
Housing programmes	Provide social and municipal rental housing, rent subsidies, housing repairs and adaptations, with priority given to people living alone, IDPs and people leaving facilities	Elimination of situations in which people are placed in facilities because accessible housing is unavailable
Transformation plans for residential institutions	Conduct individual assessments of residents, develop transition plans for living in the community, retrain staff, and gradually redirect resources towards community-based services	Transformation of facilities without leaving residents or staff without support
Accessibility and civil protection programmes	Audit the entire journey—from the home to transport, services and shelters—with the participation of people with different impairments, and introduce individual evacuation plans	Safe mobility and the practical ability to access services
Social contracting procedures and local grant competitions	Introduce multi-year or annually renewable financing for non-governmental providers based on clear quality standards	Transformation of short-term NGO projects into stable components of the local system
Regulations governing advisory bodies	Ensure that older people, people with disabilities, IDPs and their representative organisations participate in the preparation of programmes and budgets	Shift from consultation after decisions have been made to joint planning
Programme monitoring procedures	Introduce publicly available indicators concerning independent living, complaints, service quality and transitions from facilities to community living	Assessment of changes in people's lives rather than the number of activities implemented

It is essential that assessments of institutionalisation risk do not become a mechanism for automatically placing people on a "waiting list for a residential facility". Such assessments should trigger early intervention: a home visit, identification of functional and housing needs, advice concerning rights, caregiver support, and the preparation of an individual plan.

12.5. Minimum package of support for independent living

Each oblast should define a minimum package of services that communities must provide independently, jointly with other communities, or through the procurement of services from non-governmental providers. The package should include:

1. Needs assessment and case management by one accountable professional.
2. Home-based care of varying intensity, ranging from several hours a week to daily assistance.
3. Home-based nursing, rehabilitation and palliative care.
4. Social transport and assistance in reaching health, social and administrative services.
5. Respite for family caregivers, together with care-related advice and training.
6. Day care and social activities accompanied by accessible transport.
7. Assistive products, user training, repairs and maintenance.
8. Minor repairs and housing adaptations, including grab rails, ramps, lighting, safe bathrooms and the removal of thresholds.
9. Supported living in small residential units, with a right to privacy and assistance tailored to individual needs. Provision of this service must comply with the [State Standard for Supported Living](#).
10. Legal and information support concerning housing, documents, compensation, benefits and appeals against decisions.
11. Crisis support without mandatory admission to a facility, including temporary care, emergency accommodation and services provided at the person's actual place of residence. The updated [procedure for organising the provision of social services](#) provides for social services to be delivered on an emergency basis.

The package must be available not only to people living in their own homes but also to residents of rented accommodation, collective sites, dormitories and transit centres. A person's living arrangement should not constitute grounds for denying them a home-based or mobile service.

12.6. The role of non-governmental organisations

The study findings indicate that non-governmental and volunteer organisations are already a significant part of the support system. Civil society organisations were identified as a factor supporting independence by 29.3% of respondents. Among respondents who require at least occasional assistance, 23.3% receive it from volunteers.

Within the deinstitutionalisation reform, NGOs can perform seven interconnected functions.

Identifying people who remain outside the system. NGOs can undertake proactive telephone and home-based outreach to people living alone, IDPs, residents of remote areas and people with limited mobility.

Providing and piloting community-based services. These may include home-based support, mobile teams, housing adaptations, mutual-support groups, social transport, day centres, supported living and respite for caregivers.

Connecting humanitarian and long-term support. Material assistance should serve as an entry point for a comprehensive needs assessment rather than mark the end of engagement with the person.

Training local professionals. NGOs can train social workers, healthcare professionals and residential-setting staff in case management, accessible communication, supported decision-making and rights-based approaches.

Legal assistance and monitoring of rights. Particular attention should be given to informed consent to relocation, the right to appeal decisions, privacy, protection from violence, access to documents and the ability to leave a facility.

Participation of older people in policymaking. NGOs can organise accessible consultations, support older people's councils, and facilitate the participation of people with sensory, cognitive and mobility difficulties.

Independent monitoring of the reform. Monitoring should address not only the number of services established or places closed in facilities, but also whether individuals have obtained stable housing, adequate support and genuine control over their everyday lives.

“The authorities must ask older people before programmes are adopted, not afterwards. Civil society organisations can teach communities how to make such consultations accessible”. *[Participant in a women’s FGD, Dnipropetrovska oblast]*

NGOs must not, however, replace the responsibilities of the state and local government. A pilot service financed by a donor should either be integrated into the local system or have a defined plan for handover, co-financing or procurement from the local budget. Otherwise, the end of a project will create another gap in support for people who have already come to depend on the service.

12.7. Transformation of different living arrangements

Each living arrangement requires a distinct but coordinated deinstitutionalisation pathway.

Living arrangement	Principal objective
Owner-occupied or rented housing	Prevent forced relocation through the timely provision of home-based, medical, transport and housing services
Collective site	Provide residents with access to community-based services and develop individual plans for transition to stable housing
Transit centre	Conduct a rapid comprehensive assessment, restore documents, identify care needs, and transfer the case to a specific case manager at the person’s subsequent place of residence
Long-term care facility	Review the needs and wishes of each resident, develop an individual transition plan, and provide alternative housing and support before and after relocation

Collective sites and transit centres must not become institutions simply because people remain there for extended periods. The defining features of institutionalisation are not the name or legal status of a building, but the absence of privacy, a rigid collective routine, inability to make choices about everyday activities, isolation from the community, and the absence of a realistic opportunity to move elsewhere.

12.8. Monitoring reform outcomes

The following indicators should be used to monitor deinstitutionalisation at oblast and local levels:

- the number and proportion of people whose risk of institutionalisation was addressed through community-based services;
- the number of people receiving home-based care, mobile rehabilitation, social transport, day care and respite services;
- the average waiting time for each service;
- the number of supported-living places and the proportion of residents with an individual plan;
- the number of people who have moved from facilities into community living and continue to receive support after six and 12 months;
- the number of collective-site residents who have a plan for transition to stable housing;
- the proportion of decisions concerning admission to a facility for which alternatives were formally considered and documented;
- the number of adapted homes;
- the proportion of recipients satisfied with the adequacy and accessibility of support and the extent to which their choices are respected;
- the number of complaints concerning involuntary placement, inaccessible services, violence or restrictions on privacy;
- the proportion of local programmes prepared with the documented participation of older people and people with disabilities;
- the level of local financing for community-based services compared with financing for residential care.

12.9. Conclusion

The study shows that most older people wish to remain at home or live in a small-scale supported setting rather than move to a long-term care facility. Existing support is nevertheless insufficient to ensure that this preference can always be realised.

The principal task for local authorities is to establish a continuous pathway: early identification of need; comprehensive assessment; an individual plan; a housing solution; home-based, medical and social services; and regular review of the adequacy of support. NGOs can pilot new models, reach hidden groups, provide training and legal assistance, and conduct independent monitoring. The responsibility for guaranteeing services and ensuring their sustainable financing must, however, remain with the state and local government.

The success of deinstitutionalisation should therefore be measured not by the number of facilities reorganised, but by the number of people who have obtained genuine choice, stable housing, the support they require and the opportunity to live safely in the community.

13. Integrated study conclusions

13.1. Independent living means having control over one's life, not living without assistance

The central conclusion of the study is that older people do not equate independence with complete physical self-sufficiency. For them, independent living means being able to decide where and with whom to live, make everyday decisions, manage their own finances, maintain social relationships, and receive assistance without losing dignity, privacy or control.

The need for support does not negate independence. On the contrary, timely and adequate assistance enables a person to continue doing what they are able and wish to do independently. Dependency increases when there is effectively no choice: when accessible transport, home-based care, stable housing, necessary medicines or alternatives to institutional care are unavailable.

Independent-living policies should therefore focus not only on people who are already fully self-sufficient, but particularly on providing the necessary support to those whose functional abilities are gradually declining.

13.2. A substantial gap exists between the desire to remain at home and the actual availability of support

Most respondents would prefer to remain in their own homes even if they required continuous assistance. This option was selected by 58.8% of respondents. A further 16.3% would prefer to live with relatives, while 11.0% would choose supported living. Only 6.0% considered moving to a long-term care facility the most acceptable option.

At the same time, the ability to remain at home is constrained by substantial gaps in access to services:

- 35.8% already require regular assistance with everyday life;
- 27.5% require assistance with at least one activity of daily living;
- 47.8% believe that home-based healthcare would help them remain in their own homes for longer;
- 24.8% require home-based care;
- 21.3% require transport support;
- 10.5% require rehabilitation services at home or in the community;
- 8.3% require housing adaptations;
- 5.3% require assistive products.

This gap creates a risk of delayed institutionalisation. A person remains at home while they or their family can compensate for the lack of services. A deterioration in health, caregiver burnout, or loss of income or housing can, however, rapidly turn a manageable situation into a crisis.

Overall, 85.5% of respondents are very or somewhat concerned about their future care. This reflects not only personal anxiety but also the limited predictability of the support system. People are uncertain whether they will be able to obtain adequate assistance at their place of residence if their health deteriorates.

13.3. Financial support is essential but does not in itself ensure independent living

Financial hardship is the most widespread need and one of the principal barriers. Financial support was required by 91.3% of respondents, while 77.8% identified insufficient financial resources as a factor limiting their independence. Adequate income was identified as a factor supporting independent living by 69.3% of respondents.

These findings reflect the effects of low pensions and the high costs of medicines, utilities, transport, care and housing repairs. People living alone, IDPs, people with disabilities, and households with ongoing treatment or care expenses are particularly vulnerable.

Financial assistance cannot, however, eliminate functional, infrastructural and service-related barriers on its own. Even when financial resources are available, a person may be unable to find accessible transport, a home-care worker, step-free housing or a professional who provides rehabilitation at home. Material assistance must therefore be accompanied by service development rather than used as a substitute for it.

13.4. Health and functional difficulties significantly affect independence but should not automatically lead to institutionalisation

Chronic illnesses or long-term health conditions were reported by 79.3% of respondents, while 32.3% rated their health as poor or very poor. According to the Washington Group Short Set criteria, 27.8% of respondents experience significant difficulty or are completely unable to perform an activity in at least one of the six functional domains.

People with significant functional difficulties are substantially more likely to:

- require regular assistance—83.8%, compared with 17.3% among other respondents;
- require assistance with activities of daily living—70.3%, compared with 11.1%;
- have poor or very poor health—71.2%, compared with 17.3%;
- require housing adaptations—43.2%, compared with 13.2%;
- rate the accessibility of public places as low—40.5%, compared with 5.2%;
- have low confidence in their ability to continue living independently over the next five years.

These differences demonstrate that disability arises through the interaction between a person's functional characteristics and an inaccessible environment. With adapted housing, assistive products, transport, personal support and accessible communication, even a person with significant functional difficulties can retain substantial control over their life.

Officially recognised disability status was reported by 30.8% of respondents. Administrative status and actual functional difficulties are not, however, interchangeable indicators. Reliance solely on a disability certificate or assigned disability group may leave people without support when they already experience significant limitations but have not yet obtained formal status or are still completing the relevant procedures.

13.5. Living alone is both an expression of autonomy and a risk factor

Almost half of the respondents—48.5%—live alone. Living alone should not automatically be treated as a problem: for many people, it is their preferred living arrangement and a means of preserving privacy and control.

Without regular contact, accessible services and a crisis-response plan, however, living alone may increase risks. All 59 respondents who have no one to turn to for assistance live alone. Respondents living alone are also more likely to experience an accumulation of several barriers to independent living.

Loneliness is experienced always or often by 24.3% of respondents, while a further 35.5% experience it sometimes. Only 21.0% had participated in community activities during the previous six months.

A distinction must therefore be made between preferred independent living and social isolation. The objective of support should not be to force a person living alone to move in with relatives or enter a facility, but to establish a safety network comprising regular contact, home visits, emergency-call systems, social transport, neighbour-based support and accessible community activities.

13.6. People aged 80 and over face the highest risk of losing their independence

Among respondents aged 80 and over, 81.3% experience difficulty moving around outside their homes. Half describe these difficulties as very significant or are completely unable to move around outside their homes independently.

No respondent aged 80 or over expressed high confidence in their ability to continue living independently over the next five years. This does not mean that everyone in this age group will require residential care. Rather, the findings indicate the need for support to be planned at an early stage, before a crisis occurs.

People aged 80 and over particularly require:

- proactive needs assessments at home;
- regular health monitoring;
- delivery of medicines and groceries;
- assistance with household tasks;
- social transport;
- housing adaptations;
- mobility products;
- support for family caregivers;
- plans for responding to attacks, evacuation or power cuts.

13.7. Older IDPs face a combination of age-related, housing and administrative barriers

IDPs account for approximately 40% of the sample. The available data do not permit a complete quantitative comparison between displaced and non-displaced respondents across all indicators. FGD evidence nevertheless consistently identifies risks specific to this group.

These include:

- loss of their own housing and familiar social environment;
- prolonged residence under a “temporary” status;
- uncertainty about continued residence in a collective site;
- difficulties with documents, compensation and registration;
- disruption of contact with previous doctors and social workers;
- absence of relatives in the host community;
- inaccessible rented accommodation;
- risk of placement in a facility because no alternative housing solution is available.

For IDPs, independent living begins with housing stability. One-off humanitarian assistance cannot compensate for the absence of a predictable place to live, the right to remain there and the possibility of adapting the dwelling to the person's functional needs.

13.8. The security situation has become a systemic factor affecting independent living

The security situation was identified as affecting independence by 79.0% of respondents. For older people, safety encompasses not only the risk of attack but also the ability to reach a shelter physically, leave an upper floor when a lift is not operating, obtain medicines during an air-raid alert, maintain essential medical equipment and evacuate without interruption to their care.

Safety measures that do not take account of people's functional abilities may be inaccessible in practice. The existence of a shelter in or near a building does not guarantee safety if the person cannot descend the stairs, travel the necessary distance or receive warnings in an accessible format.

Civil protection plans must therefore be integrated with individual social, medical and evacuation support plans.

13.9. Regional differences indicate different levels of accumulated need

In Kharkivska oblast, 40.0% of respondents had significant functional difficulties, compared with 15.5% in Dnipropetrovska oblast. Regular assistance was required by 50.0% and 21.5% of respondents respectively.

High satisfaction ratings were also lower in Kharkivska oblast for:

- health services—49.0%, compared with 80.5%;
- social services—36.0%, compared with 58.5%;
- community support—33.5%, compared with 55.0%;
- family support—53.5%, compared with 70.0%.

Difficulties accessing healthcare services were reported by 32.5% of respondents in Kharkivska oblast, compared with 14.5% in Dnipropetrovska oblast.

These differences should be interpreted cautiously. The Kharkivska oblast sample contains a higher proportion of people with functional difficulties, and some of the differences may therefore be associated with sample composition. Nevertheless, the overall findings indicate a heavier burden on individuals and support systems in Kharkivska oblast, which is consistent with the more prolonged and intensive impact of hostilities.

Regional differences do not mean that the situation in Dnipropetrovska oblast is satisfactory. Substantial gaps in home-based care, transport, housing adaptations, social participation and support for people living alone remain in both oblasts.

13.10. No living arrangement guarantees independence in itself

The study included people living in their own homes, collective sites, transit centres and long-term care facilities. The analysis shows that the quality of a living arrangement is determined not only by the type of premises but by choice, privacy, safety, access to services and the opportunity to change one's housing situation.

A person's own home may support autonomy while also being inaccessible, damaged or isolated from transport and services. A collective site may provide basic safety, but prolonged residence without a transition plan creates dependency and uncertainty. A transit centre is an essential component of crisis

response but should not become a long-term solution. A long-term care facility may provide continuous assistance, but it frequently restricts privacy, choice and control over everyday life.

Policy should therefore assess not only the formal designation of a living arrangement but its actual characteristics:

- whether the person chose the place;
- whether they have private space;
- whether they can determine their daily routine;
- whether they can maintain relationships and receive visitors;
- whether community-based services are accessible;
- whether they can change their place of residence;
- whether they have an individual support plan;
- whether their decisions and legal capacity are respected.

13.11. Formal and informal support are complementary but not interchangeable

Respondents identified income, healthcare, family support, social services, friends and neighbours, NGOs and their own skills as the most important resources supporting independence.

Having several sources of support increases a person's resilience. When family assistance is temporarily unavailable, a social worker, neighbours, volunteers or a mobile team may partly compensate for it. Informal support must not, however, be used as grounds for refusing professional services.

Relatives—particularly women—often provide substantial unpaid care without training, respite or psychological support. Assistance from neighbours and volunteers is important but depends on the goodwill and availability of particular individuals. Professional care, healthcare, rehabilitation and crisis response must therefore be guaranteed by the system.

13.12. Fragmentation of support is the principal systemic gap

Older people require simultaneous interaction with social protection, healthcare, rehabilitation, housing, transport and civil protection systems. At present, these systems generally operate in parallel.

Individuals or their families are required to:

- determine which institution to contact;
- explain the situation repeatedly to different professionals;
- collect documents;
- arrange transport;
- seek non-governmental assistance;
- coordinate health and social services;
- plan future care.

For people with cognitive, sensory or mobility difficulties, this pathway may be virtually impossible to navigate. The central organisational reform should therefore be integrated case management, under which one accountable person coordinates the assessment, prepares the support plan, arranges referrals and verifies whether the person has actually received the necessary services.

13.13. Overall conclusion

Older people's right to independent living cannot be realised through a single programme, payment or service. It depends on a coordinated support ecosystem combining income, housing, health, care, accessibility, safety, social relationships and participation in decision-making.

The greatest threat is not age or disability in itself, but the accumulation of barriers without a timely response. Particular attention should be given to people with significant functional difficulties, people aged 80 and over, people living alone, IDPs and families with exhausted caregivers.

The study demonstrates a clear demand for a transition from a reactive model, which responds to a crisis by referring a person to a facility, to a preventive model that supports them in the environment they have chosen. The key components of this transition should be early identification of needs, integrated case management, home-based and mobile services, accessible housing, caregiver support, sustainable financing, and the mandatory participation of older people in policymaking.

14. Practical recommendations

14.1. Overall approach to implementing the recommendations

The study recommendations are intended to facilitate a transition from a reactive model—in which assistance is provided after a person has lost the ability to live independently—to a preventive model. Under this model, needs are identified at an early stage and support is provided before the absence of care, housing or income results in a crisis or institutionalisation.

All programmes for older people should be based on the following principles:

- respect for the person's choices, will and preferences;
- assessment of individual needs rather than reliance solely on formal status;
- priority for support at the person's place of residence;
- access to services regardless of living arrangement;
- integration of social, health, rehabilitation and housing measures;
- non-discrimination on the grounds of age, disability, IDP status or family circumstances;
- support for family caregivers;
- participation of older people in programme planning and evaluation;
- continuity of support during displacement, evacuation and changes in residence;
- regular monitoring of outcomes for individuals, rather than only the number of services provided.

"The most important thing is not to decide for us. Ask what the person can still do independently and support precisely that". *[Participant in a women's FGD, Dnipropetrovska oblast]*

14.2. Priority recommendations

No.	Priority recommendation	Rationale based on the study findings	Principal responsible stakeholders	Indicative timeframe
1	Introduce integrated needs assessment and case management	35.8% require regular assistance; support remains fragmented	Oblast and local social protection authorities; social and health service providers	0–12 months
2	Expand home-based and mobile services	58.8% prefer to remain at home with support; 47.8% require home-based healthcare	Communities, social service centres, healthcare facilities and NGOs	0–24 months
3	Introduce systematic support for family caregivers	Relatives provide a substantial proportion of care; 85.5% are concerned about future care	Social services, healthcare facilities and NGOs	0–18 months

No.	Priority recommendation	Rationale based on the study findings	Principal responsible stakeholders	Indicative timeframe
4	Develop stable and accessible housing solutions	Housing instability particularly affects IDPs, people living alone and people with disabilities	Oblast and local authorities, housing authorities and donors	1–3 years
5	Expand social transport and accompanying assistance	30.0% identified transport as a barrier; 50.8% experience difficulty moving around outside their homes	Communities, transport operators and social services	0–24 months
6	Establish a housing adaptation programme and ensure full access to assistive products	32.8% do not consistently feel safe at home; people with functional difficulties are substantially more likely to require adaptations	Communities, social protection authorities, NGOs and donors	0–3 years
7	Develop supported living as an alternative to institutional care	11.0% prefer supported living, while only 6.0% prefer a long-term care facility	Oblast authorities, communities, NGOs and non-governmental providers	1–4 years
8	Introduce individual transition plans for people in temporary and institutional settings	Prolonged temporary accommodation creates dependency and uncertainty	Administrations of residential settings, social services and housing authorities	0–18 months
9	Strengthen older people's economic security	91.3% require financial support; 77.8% identified insufficient financial resources as a barrier	Central and local authorities, employment services and NGOs	Ongoing
10	Ensure accessible information and participation in decision-making	Older people experience difficulties with digital procedures and are insufficiently involved in planning	Public authorities, service providers and NGOs	0–12 months
11	Integrate older people's needs into civil protection plans	79.0% identified the security situation as a barrier	Oblast military administrations, communities, the State Emergency Service, and social and health services	Immediately
12	Establish a system for monitoring independent living and institutionalisation risk	Existing administrative indicators primarily measure institutions and service volumes rather than outcomes for individuals	Oblast and local authorities, NGOs and research organisations	0–18 months

14.3. Recommendations for central government authorities

1. Develop a unified inter-agency mechanism for supporting independent living

The Ministry of Social Policy, Ministry of Health, Ministry for Development of Communities and Territories, and other responsible authorities should adopt a coordinated support pathway for older people. It should cover:

- initial identification of needs;
- functional assessment;
- assessment of housing conditions;
- identification of social, health and rehabilitation service needs;
- appointment of an accountable case manager;
- preparation of an individual plan;
- periodic review of the adequacy of support;
- crisis response without automatic referral to a facility.

The assessment should consider not only a diagnosis or disability group but also functional difficulties, ability to perform activities of daily living, housing safety, caregiver availability, social relationships and the person's preferred living arrangement.

2. Finance services according to the principle that "funding follows the person"

Financing should support an individual package of services regardless of whether the provider is a municipal institution, NGO, charitable organisation, individual social service provider or licensed private provider.

A situation in which residential care receives guaranteed financing while home-based care, supported living or respite services depend on short-term projects or residual funding should be avoided.

3. Establish safeguards against unjustified institutionalisation

Admission to a long-term care facility should not be based solely on:

- age;
- disability;
- absence of relatives;
- IDP status;
- loss of housing;
- low income;
- the absence of a service in a particular community.

Before a decision is made, the following alternatives should be formally considered and documented: home-based support, enhanced care, crisis services, respite for the family, supported living, social rental housing, or relocation closer to relatives where this is the person's preference.

4. Strengthen state regulation of supported living and housing adaptations

The practical implementation of state standards should be supported through:

- model local procedures;
- methodologies for calculating service costs;
- requirements for small residential units;
- quality-control mechanisms;
- financial support for communities;
- staff training;
- independent monitoring of residents' rights.

Supported living must not reproduce the institutional model in a smaller building. People must retain privacy, control over their daily routines, access to the community, and the right to change provider or place of residence.

5. Review income and employment policies for people aged 50 and over

Alongside pension and social support, the following should be developed:

- adapted employment;
- short, practical training programmes;
- offline access to employment programmes;
- social enterprise opportunities;
- microgrants without unnecessarily complex digital procedures;
- part-time employment and flexible working arrangements;
- incentives for employers who recruit older workers.

14.4. Recommendations for oblast and local authorities

1. Introduce regional independent-living programmes

Dnipropetrovska and Kharkivska oblasts should adopt a separate independent-living component or subprogramme for older people. These programmes should include:

- a list of target groups;
- an estimate of the number of potential recipients;
- a minimum package of services;
- designated implementing bodies;
- annual budget allocations;
- mechanisms for intermunicipal cooperation;
- engagement of non-governmental providers;
- outcome indicators.

Priority groups should include people with significant functional difficulties, people aged 80 and over, people living alone, IDPs, and people in temporary or institutional settings.

2. Establish a system for the early identification of risks to independence

Social services should proactively identify people who may require support through:

- family doctors;
- social workers;
- mobile teams;
- heads of local administrative districts and community self-organisation bodies;
- pharmacies;
- veterans' and volunteer organisations;
- NGOs;
- administrators of collective sites.

Priority assessments should be offered to people aged 80 and over, people living alone, and people who have experienced hospitalisation, injury, evacuation or the loss of a caregiver.

3. Assign a single case manager

A person with complex needs should have one designated professional who:

- explains rights and available services;
- assists with documentation;
- coordinates social, health and rehabilitation support;
- arranges transport;
- liaises with housing services;

- verifies that assistance has actually been received;
- reviews the plan when the person's circumstances change.

Case management is particularly important for IDPs, people with cognitive difficulties, people living alone and families in which one person provides continuous care.

4. Provide social transport as a basic service

Social transport should provide not only transportation but also assistance from the person's door to the place where the service is delivered. It should include:

- advance booking by telephone;
- regular journeys;
- wheelchair-accessible vehicles;
- assistance with boarding;
- accompaniment to the relevant office or consulting room;
- priority for health and rehabilitation journeys;
- services for residents of collective sites.

5. Establish local housing adaptation funds

Adaptation programmes should cover owner-occupied, rented, social and temporary housing. Funding may be used for:

- installation of grab rails and ramps;
- removal of thresholds;
- bathroom adaptations;
- improved lighting;
- non-slip flooring;
- repairs to doors and windows;
- installation of emergency-call systems;
- backup power for essential equipment;
- minor repairs required for safe living.

Assessments should be conducted in the person's home and with their participation rather than solely on the basis of documents.

6. Support intermunicipal service provision

Smaller communities may lack the resources to establish every necessary service. Appropriate mechanisms include:

- shared mobile teams;
- intermunicipal social transport;
- regional respite services;
- shared day-care centres;
- procurement of services from non-governmental providers;
- oblast co-financing for services covering several communities.

14.5. Recommendations for social and health services

1. Establish integrated home-based teams

Depending on the person's needs, a team may include:

- a social worker;
- a nurse;
- a family doctor;
- a physical therapist or other rehabilitation professional;
- a psychologist;

- social transport;
- an assistive-products specialist;
- a case manager.

Each person should have one coordinated plan rather than several unconnected plans prepared by different institutions.

2. Ensure transitional support following hospital discharge

Discharge following hospitalisation is a critical point at which a person may temporarily lose part of their functional ability. Before discharge, the following should be assessed:

- whether the person can return home safely;
- whether mobility products are required;
- whether housing adaptations are necessary;
- who will provide assistance during the first weeks;
- whether home-based health and rehabilitation visits are required;
- whether the person has medicines and can continue obtaining them;
- whether the absence of temporary assistance creates a risk of admission to a facility.

3. Develop mobile rehabilitation

People unable to reach a rehabilitation facility should not automatically lose access to support. Home-based and outreach formats are required, together with training for the individual and caregiver in safe movement, use of assistive products and fall prevention.

4. Introduce accessible communication

Information about services should be available:

- by telephone, with the option of speaking to an operator;
- in large-print materials;
- in plain language;
- by SMS;
- in text formats for people with hearing impairments;
- in audio formats;
- through home visits;
- through local offline channels.

Providing access exclusively through a mobile application or electronic form creates additional barriers.

14.6. Recommendations for supporting family caregivers

Family caregivers should be recognised as a distinct target group of social policy. Support should include:

- assessment of workload and burnout risk;
- practical care training;
- psychological support;
- legal and social advice;
- regular respite;
- short-term care during a crisis;
- access to assistive products;
- replacement care while the caregiver receives treatment, works or completes administrative procedures;
- opportunities to combine care with employment;
- information about all available services.

Supporting caregivers is also a measure for preventing the institutionalisation of the person receiving care.

14.7. Recommendations concerning housing and different living arrangements

For people living in their own homes:

- provide home-based and mobile services;
- assess housing safety;
- finance adaptations and minor repairs;
- establish regular-contact networks for people living alone;
- provide social transport and emergency-call systems.

For residents of collective sites:

- permit access to home-based social services at the person's actual place of residence;
- assess functional needs;
- ensure accessible sanitation facilities and routes;
- appoint a case manager;
- prepare an individual plan for transition to stable housing;
- prevent automatic referral to a residential institution when the collective site closes.

For people in transit centres:

- conduct an initial health and social assessment;
- identify needs for medicines, mobility products and care;
- restore documentation;
- transfer information to an assigned case manager in the destination community;
- avoid repeatedly interviewing the person without necessity;
- provide assistance in reaching the next place of residence.

For residents of long-term care facilities:

- individually assess each person's wishes, needs and opportunities for transition;
- provide independent information about alternatives;
- develop a plan for transition to the community;
- provide opportunities to trial supported living;
- maintain support after the person leaves the facility;
- conduct follow-up monitoring after three, six and 12 months;
- avoid transferring people to another facility instead of supporting community living.

14.8. Recommendations for HelpAge International and other non-governmental organisations

1. Pilot an integrated home-based support model

A pilot package should combine:

- case management;
- home visits by a social worker;
- basic nursing support;
- mobile rehabilitation;
- psychological support;
- housing adaptations;
- social transport;
- respite for caregivers.

The pilot should assess changes in independence, safety, adequacy of support and the risk of admission to a facility.

2. Establish a programme for transitioning from temporary to stable housing

A programme for older IDPs could include:

- housing case management;
- legal assistance;
- rent subsidies;
- assistance in finding accessible housing;
- adaptation of rented accommodation;
- relocation support;
- connection to social and health services;
- restoration of social relationships in the new community.

3. Strengthen the capacity of local NGOs

Organisations should be supported to:

- register as social service providers;
- implement state standards;
- calculate service costs;
- participate in social contracting;
- introduce safeguards against violence and exploitation;
- ensure confidentiality;
- monitor service quality;
- prepare for financing from local budgets.

4. Link material assistance with long-term support

Every contact made while providing cash, food or other material assistance can be used to identify voluntarily people at high risk of:

- functional decline;
- social isolation;
- absence of care;
- unsafe housing;
- loss of documents;
- institutionalisation.

Further assessment and support should be offered without coercion and without creating any risk that material assistance will be withdrawn if the person declines.

5. Support evidence-based advocacy

HelpAge International and partner organisations can use the study findings to:

- amend oblast and local programmes;
- justify budgets for home-based services;
- advocate for social transport;
- develop supported living;
- introduce respite for caregivers;
- protect the rights of residents of long-term care facilities;
- include older people in recovery and civil protection plans.

14.9. Recommendations for donors and humanitarian organisations

Donors should move from financing isolated short-term activities towards multi-year support for models that can be integrated into local systems.

Priority funding areas should include:

- home-based and mobile services;
- supported living;
- housing adaptations;
- social transport;
- housing solutions for IDPs;
- caregiver support;
- capacity-building for local providers;
- digital and offline case-management systems;
- independent monitoring of deinstitutionalisation;
- participation of organisations of people with disabilities and older people.

Every project should include a sustainability plan involving transfer of the service to a local provider, co-financing, social contracting or inclusion in a local programme.

14.10. Recommendations for information and advocacy work

Advocacy messages should challenge perceptions of ageing, disability and care. Key messages may include:

- needing assistance does not deprive a person of the right to independence;
- institutional care is not an automatic response to age, disability or homelessness;
- home-based support is an investment in dignity, safety and participation;
- family care requires support from the state and community;
- temporary accommodation must provide a pathway to stable housing;
- older people should be participants in programmes, not merely recipients;
- accessibility must be assessed across the entire journey from home to service;
- independent living is a human right, not a reward for physical self-sufficiency.

Communication campaigns should not be conducted exclusively online. Television, radio, telephone helplines, printed materials, pharmacies, healthcare facilities, social workers, community self-organisation bodies and local civil society organisations should also be used.

14.11. Phased roadmap

Stage	Principal actions
Immediate: 0–6 months	Appoint responsible coordinators; establish inter-agency working groups; begin identifying people at high risk; ensure that services reach collective sites; include older people in evacuation plans; design an integrated home-based support pilot
Short-term: 6–18 months	Introduce case management; expand social transport; establish respite services; launch local housing adaptation programmes; approve individual plans for transition from temporary accommodation; commence social contracting
Medium-term: 1–3 years	Scale up home-based and mobile services; establish supported living; expand social rental housing; provide intermunicipal services; integrate independent-living indicators into regional programmes
Long-term: 3–5 years	Transform the institutional care system; redirect part of its financing towards community-based services; ensure sustainable housing solutions; establish a comprehensive system for monitoring transitions from institutional to independent living

14.12. Proposed monitoring indicators

The following indicators are proposed for assessing implementation of the recommendations:

- proportion of people at high risk who have an individual support plan;
- proportion of people who received the required service within the specified timeframe;

- average waiting time for home-based care;
- number of recipients of mobile health and rehabilitation support;
- number of caregivers who received respite;
- number of adapted homes;
- number of people using social transport;
- number of supported-living places;
- number of collective-site residents who moved to stable housing;
- number of people who transitioned from facilities to community living;
- proportion of these individuals continuing to live in the community after six and 12 months;
- proportion of recipients who consider their support adequate;
- proportion of people who report being able to make their own everyday decisions;
- proportion of local expenditure allocated to community-based services;
- number of programmes and regulatory instruments developed with the participation of older people;
- number and nature of complaints concerning involuntary placement, inaccessibility and violations of privacy.

Targets should be established after an administrative baseline has been developed. The principal measure of success should not be the formal number of services created, but whether those services have enabled people to retain choice, safety, dignity and control over their own lives.



Maryna Moroz / HelpAge International

HelpAge International is a global network of organisations advocating for the right of all older people to live dignified, healthy, and secure lives.

Acknowledgements

We would like to extend our special thanks to the older people in Ukraine who generously gave their time to participate in interviews and focus group discussions.

We also express our sincere gratitude to representatives of civil society organisations and government officials who took part in the survey and shared their valuable insights and experiences.

We are grateful to the i-APS team for conducting this research, providing professional expertise, and undertaking thorough work.

This research was made possible through the generous support of the German Federal Ministry for Economic Cooperation and Development (BMZ), Aktion Deutschland Hilft (ADH) and HelpAge Deutschland.

COMPREHENSIVE STUDY OF NEEDS, OBSTACLES AND PREREQUISITES FOR INDEPENDENT LIVING OF OLDER PEOPLE (AGED 50+ AND 60+) IN DNIPROPETROVSK AND KHARKIV REGIONS

Published by
HelpAge International
PO Box 78840
London SE1P 6QR
United Kingdom
Tel: +44 (0)20 7278 7778
Email: info@helpage.org
Website: www.helpage.org
Registered charity no. 288180

Cover photo: Katya Moskaliuk / HelpAge International



HelpAgeinUkraine



@HelpAge



@helpageint/



HelpAge International



helpage

Copyright © HelpAge International 2026

Any part of this publication may be reproduced without permission for non-commercial and educational purposes. Please acknowledge HelpAge International and send us a copy or link.