Examining Barriers to Family Planning Information, Products, and Services Among Ukrainian Refugees and Host Communities in Poland

Findings from Mixed Methods Research to Inform Cash and Voucher Assistance Programming

August 2024

The Women's Refugee Commission (WRC) improves the lives and protects the rights of women, children, youth, and other people who are often overlooked, undervalued, and underserved in humanitarian responses to crises and displacement. We work in partnership with displaced communities to research their needs, identify solutions, and advocate for gender-transformative and sustained improvement in humanitarian, development, and displacement policy and practice. Since our founding in 1989, we have been a leading expert on the needs of refugee women, children, and youth and the policies that can protect and empower them. www.womensrefugeecommission.org.

Founded in 1945 with the creation of the CARE Package®, CARE is a leading humanitarian organization fighting global poverty. CARE has more than seven decades of experience delivering emergency aid during times of crisis. Our emergency responses focus on the needs of the most vulnerable populations, particularly girls and women. CARE works around the globe to save lives, defeat poverty, and achieve social justice. To learn more, visit www.care.org.

The Foundation for Women and Family Planning FEDERA (previously the Federation) is a non-governmental organization fighting for reproductive health and rights. It was established in 1991 as a result of an agreement between five organizations – the League of Polish Women, the Polish Feminist Association, the Pro Femina Association, the Association for Ideologically Neutral State "Neutrum," and the Association of Christian Girls and Women YWCA Poland. In 1999 the Federation was awarded special consultative status with the Economic and Social Council of the United Nations (ECOSOC). FEDERA has been actively fighting for equal opportunities for men and women for over 30 years, protecting the right to conscious parenthood, which includes access to contraception, comprehensive and evidence-based education about human sexuality, the right to high-quality prenatal diagnostics and fetal care, and the right to legal and safe abortion.

The Global Public Health in Emergencies Branch at the US Centers for Disease Control and Prevention provides help to people affected by complex humanitarian emergencies like war, famine, civil strife, natural disaster, genocide, and displacement. Our humanitarian health experts provide support in a variety of subject matters including emergency nutrition, infectious and vaccine preventable diseases, maternal and child health, mental health, non-communicable diseases, and sexual and reproductive health. Work in all of these subject areas is supported by expertise in surveillance, assessments, digital mapping, and coordination. To learn more visit: Emergency Response and Recovery | Division of Global Health Protection | Global Health | CDC

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Introduction

In crisis-affected settings, sexual and reproductive health (SRH) services, including family planning (FP), are lifesaving and the standard of care. The Minimum Initial Service Package (MISP) for SRH—the global standard for SRH response in acute emergencies—includes the prevention of unintended pregnancies as one of six objectives. People affected by crises want and need access to FP, but FP services in crisis-affected settings remain limited and uneven.[1] In host countries, refugee women and girls, including adolescents and those with disabilities, have unmet SRH needs, but face acute barriers to accessing SRH services, including FP.[2]

Refugees often face financial barriers that hinder access to health services, even though services are often intended to be available free of cost in humanitarian settings.[3] Financial barriers may include transportation or childcare costs, or costs incurred when obtaining services through pharmacies and private sector outlets, as national health systems adjust to rapid increases in demand as more refugees enter the country. Financial barriers can be particularly challenging for refugees and displaced people to overcome as they may be limited in where and how they can work. Restrictive policy environments for SRH, such as in Poland, can compound the financial barriers to accessing services, creating more hurdles to access, which can increase both time and money spent.

To meet the SRH needs and fulfill the rights of displaced and crisis-affected women and girls of reproductive age, it is critical to strengthen FP services and pilot innovative approaches to improving FP access and availability in humanitarian settings, for example by providing cash and voucher assistance (CVA) for SRH. CVA for health outcomes, as defined by the Cash Learning Partnership (CALP) Network, is "CVA that is linked to a particular beneficiary or beneficiaries in need of specific healthcare, and which addresses the barriers which they encounter when accessing that care, while incentivizing service use and adherence to treatment."[4] Despite global commitments to scaling up the use of CVA in humanitarian settings, and evidence demonstrating the successful use of CVA in sectors such as food security, the health sector—and specifically SRH—lags behind[5]

Preliminary evidence on integrating CVA into SRH programming shows positive outcomes, with CVA identified as potentially supportive of service uptake, including FP.[6] Evidence also indicates that integrating CVA in SRH programming can address financial barriers to access, such as user fees and transportation fees to health facilities in refugee-hosting countries.[7] Targeted CVA interventions have the potential to lead to improved SRH outcomes, including reducing unintended pregnancy and maternal and newborn death and disability. To date, CVA for SRH has predominantly focused on maternal health services, while FP has been overlooked. A 2020 literature review of existing CVA for SRH interventions in humanitarian settings showed that 6 of 28 studies or interventions targeted FP outcomes, and only 2 did so exclusively.[8]

Effective CVA programming for SRH must be carefully contextualized to reflect the unique opportunities,

1 Sarah Rich and Lily Jacobi. 2021. "Contraceptive Services in Humanitarian Settings and in the Humanitarian-Development Nexus: Summary of Gaps and Recommendations from a State-of-the-Field Landscaping Assessment." Women's Refugee Commission. https://www.womensrefugeecommission.org/wp-content/uploads/2021/03/FP-In-Humanitarian-Settings-In-The-Humanitarian-Development-Nexus_Summary.pdf.
2 "Center and Partners Call on Europe and Broader International Community to Address the Sexual and Reproductive Health Needs of Women and Girls Impacted by the Conflict in Ukraine." 2022. Center for Reproductive Rights. March 16, 2022. https://reproductiverights.org/ukraine-call-to-action/.; Levy, Max G. 2022. "The War in Ukraine Is a Reproductive Health Crisis for Millions." Wired, March 16, 2022. https://www.wired.com/story/the-war-in-ukraine-is-a-reproductive-health-crisis-for-millions/.; Kismödi, Eszter, and Emma Pitchforth. 2022. "Sexual and Reproductive Health, Rights and Justice in the War against Ukraine 2022." Sexual and Reproductive Health Matters 30 (1): 2052459. https://doi.org/10.1080/26410397.2022.2052459.
3 https://airbel.rescue.org/studies/generating-evidence-for-the-use-of-cash-relief-for-health-outcomes/
4 Anna Gorter and Corinne Grainger. 2021. "A 'Stocktake' of CVA for Health Outcomes in the MENA Region Moving from Evidence to Practice." CaLP: The Cash Learning Partnership. https://www.calpnetwork.org/wp-content/uploads/2021/06/CaLP-CVA-for-Health-Outcomes.pdf.
5 "The State of the World's Cash 2023: An Insightful and Authoritative Analysis of Humanitarian Cash and Voucher Assistance Worldwide." 2023. CaLP: The Cash Learning Parternship. https://www.calpnetwork.org/wp-content/uploads/2023/11/The-State-of-the-Worlds-Cash-2023-1.pdf.; "Evidence and Feasibility of Cash and Voucher Assistance for Sexual and Reproductive Health Services in Humanitarian Emergencies." 2020. Royal Tropical Institute, Amsterdam. https://www.kit.nl/wp-content/uploads/2020/11/CVA-for-SRH-in-Humaniarian-Settings-Literature-Review.pdf.
6 "Evidence and Feasibility of Cash and Voucher Assistance for Sexual and Reproductive Health Services in Humanitarian Emergencies." 2020. Royal Tropical Institute, Amsterdam. https://www.kit.nl/wp-content/uploads/2020/11/CVA-for-SRH-in-Humaniarian-Settings-Literature-Review.pdf.
7 "The State of the World's Cash 2023: An Insightful and Authoritative Analysis of Humanitarian Cash and Voucher Assistance Worldwide." 2023. CaLP: The Cash Learning Parternship. https://www.calpnetwork.org/wp-content/uploads/2023/11/The-State-of-the-Worlds-Cash-2023-1.pdf
8 "Evidence and Feasibility of Cash and Voucher Assistance for Sexual and Reproductive Health Services in Humanitarian Emergencies." 2020. Royal Tropical Institute, Amsterdam. https://www.kit.nl/wp-content/uploads/2020/11/CVA-for-SRH-in-Humaniarian-Settings-Literature-Review.pdf.

constraints, and considerations in a given setting, and to ensure it is accessible to diverse members of affected communities. From May 2023 to January 2024, the Global Public Health in Emergencies Branch at the US Centers for Disease Control and Prevention (CDC), CARE International, CARE Poland, and the Women's Refugee Commission (WRC), in collaboration with Federa, undertook a mixed methods study to understand the FP needs of newly arriving Ukrainian refugee women in Poland and to assess the feasibility of using CVA to support access to FP services. Using data collected from a market assessment on FP services and methods, and an FP barrier assessment with Ukrainian refugee and Polish host community women, the findings in this report aim to inform the design, coordination, and funding of future CVA programming for SRH, specifically FP service provision, in the refugee response in Poland.

Assessment Context

Since the Russian Federation military offensive began in February 2022, more than 6 million people have fled Ukraine, with 1.8 million seeking temporary protection in Poland as of August 2024.[9] In response to the significant increase in Ukrainian refugees crossing into Poland, in March 2022 the Polish Parliament passed the Law on Assistance to Citizens of Ukraine in Connection with Armed Conflict on the Territory of that State.[10] This law allows Ukrainians to legally stay in Poland; though provisional, the period of protection has been routinely extended by the Polish government as the war in Ukraine continues. However, rights and benefits for Ukrainian refugees can be revoked if they leave Poland for more than 30 days, and Ukrainians who lived in Poland prior to the 2022 escalation of the conflict are not eligible for the same protections. Under this law, Ukrainian refugees have the right to work and to access social benefits, including health services through the National Health Fund (NHF), on par with Polish citizens.

SRH services are available in Poland through both the national and private healthcare systems. Poland's public healthcare system is financed and organized through a publicly funded institution called Narodowy Fundusz Zdrowia, or the National Health Fund (NHF), which covers healthcare services for citizens and nearly all other residents.[11] The Ministry of Health determines which services are guaranteed and which medicines or medical devices are reimbursable, and patients do not need a referral to seek care from gynecologists and obstetricians. In parallel to the public healthcare system, the private healthcare system operates on a commercial basis. Services are fee-based, but private clinics are regarded as an important complement to the public health care system, where waiting times are long.[12] This dual system can create economic division in accessibility of healthcare, as the cost of private services are often high.[13]

Poland has one of the most restrictive policy environments for SRH and rights in Europe.[14] Access to abortion in Poland has been highly restrictive for over three decades. Currently, legal abortion can be obtained within the healthcare system only if the continuation of the pregnancy threatens the life of the pregnant person or if the pregnancy is the result of a crime.[15] The law also allows physicians in Poland to exercise conscientious objection to providing any healthcare that does not align with their personal beliefs, but only in cases in which care is not lifesaving.[16] Although the government does not collect and report data on the incidence of

9 "Ukraine Refugee Situation." n.d. UNHCR Operational Data Portal. https://data.unhcr.org/en/situations/ukraine.
10 Act of 12 March 2022 on Assistance to Citizens of Ukraine in Connection with Armed Conflict in the Territory of the State. 2022. Journal of Laws 2022. https://www.gov.pl/attachment/fd791ffb-c02b-4e99-b710-e8ed3a9a821b.
11 Kozierkiewicz A, Trabka W, Romaszewski A, Gajda K, Gilewski D. Definition of the "health benefit basket" in poland. Eur J Health Econ. 2005 Dec;Suppl(Suppl 1):58-65. doi: 10.1007/s10198-005-0320-3. PMID: 16258749; PMCID: PMC1388086.; "Healthcare in Poland." n.d. Welcome Point, University of Warsaw. https://welcome.uw.edu.pl/healthcare-in-poland/.
12 Małgorzata Darmas and Julia Wygnańska. 2015. "Monitoring the Availability of Gynecological and Obstetric Services within the National Health Fund in Poland." Rodzić po Ludzku Foundation. https://rodzicpoludzku.pl/raporty/raport-monitoring-dostepnosci-do-uslug-ginekologiczno-polozniczych-w-ramach-nfz-w-polsce/.
13 Krystyna Dzwonkowska-Godula. 2019. "The phenomenon of social inequalities in the area of reproductive rights in Poland – selected issues." Przegląd Socjologiczny 68 (2): 133–57. https://doi.org/10.26485/PS/2019/68.2/6.
14 "European Abortion Laws: A Comparative Overview." 2023. Center For Reproductive Rights. https://reproductiverights.org/wp-content/uploads/2023/09/European-Abortion-Laws-A-Comparative-Overview-new-9-13-23.pdf; European Parliamentary Forum for Sexual & Reproductive Rights. n.d. "European Contraception Policy Atlas - Poland." https://www.epfweb.org/node/745.
15 This broadly covers damage to the foetus or pregnancy because of a criminal act such as rape or incest; Katarzyna K Borkowska, Ewa M. Guzik-Makaruk, and Emil W. Pływaczewski. 2023. "Discussion around the Issue of Punishability of Abortion in Poland." Prawo w Działaniu, no. 53, 7–19. https://doi.org/10.32041/pwd.5301.
16 Justyna Czekajewska, Dariusz Walkowiak, and Jan Domaradzki. 2022. "Attitudes of Polish Physicians, Nurses and Pharmacists towards the Ethical and Legal Aspects of the Conscience Clause." BMC Medical Ethics 23 (1): 107. https://doi.org/10.1186/s12910-022-00846-0.

conscientious objection, there are documented instances of physicians refusing to provide FP services due to their religious beliefs.[17] Pharmacists in Poland do not have the same right to exercise conscientious objection, [18] yet there are no policies that require pharmacies to carry FP methods. This exception has resulted in a network of "pro-life pharmacies" run by members of the Association of Catholic Pharmacists of Poland, that do not offer FP methods.[19] Conversely, there are physicians in Poland who aim to broaden access to FP by providing consultations and prescriptions via telemedicine. Although these telemedicine services are generally available through the private healthcare system and are fee-based, some clinics provide services pro bono.[20]

To obtain any FP method, other than barrier methods such as condoms, clients must get a prescription from a physician.[21] Polish healthcare guidelines indicate that a client should have a consultation with a gynecologist before obtaining a prescription for FP. Prescriptions can be extended for 60 days of use by nurses and up to 180 days of use by pharmacists. However, even with this provision, a client would need to schedule appointments to receive a prescription for their FP method every six months. Under the NHF, the costs of FP services are covered, which includes the cost of insertions and removals of IUDs and implants insertions. In practice, not all public health care facilities provide these services.[22] However, the costs of FP supplies are not reimbursed under the NHF, with the exception of a few brands of combined oral contraceptives (COCs), which are partially reimbursed.[23] Barrier methods, such as condoms, do not require prescriptions and are available over the counter.

In Ukraine, by contrast, abortion is available upon request, with a gestational limit of 12 weeks, and some hormonal contraceptive methods are available without prescription.[24] Prior to the crisis, in 2021, 44.2 percent of all women of reproductive age (15-49 years) in Ukraine were using modern contraceptive methods.[25] Ukrainian women and girls who have been displaced to Poland need continued access to quality SRH services, including FP. Evidence has shown how the legal and policy environment in Poland has restricted access to SRH services for Ukrainian refugees.[26]

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18 Justyna Czekajewska, Dariusz Walkowiak, and Jan Domaradzki. 2022. "Attitudes of Polish Physicians, Nurses and Pharmacists towards the Ethical and Legal Aspects of the Conscience Clause." BMC Medical Ethics 23 (1): 107. https://doi.org/10.1186/s12910-022-00846-0.
19 Krystyna Dzwonkowska-Godula. 2019. "The phenomenon of social inequalities in the area of reproductive rights in Poland – selected issues." Przegląd Socjologiczny 68 (2): 133–57. https://doi.org/10.26485/PS/2019/68.2/6.
20 Sample addresses: https://federa.org.pl/ , https://fundacjajeszcze.com.pl/szukam-pomocy/pilna-pomoc/ , https://jaroslawgornicki.pl/ellaone/
21 ACT of 6 September 2001 Pharmaceutical Law. Journal of Laws from 2008, No. 45, item 271. https://www.gif.gov.pl/download/3/5000/pharmaceuticallaw-june2009.pdf; European Parliamentary Forum for Sexual & Reproductive Rights. n.d. "European Contraception Policy Atlas - Poland." https://www.epfweb.org/node/745.
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23 FEDERA Foundation for Women and Family Planning. 2020. "Interpelation on contraception refund - answer and discussion." April 1, 2020. https://federa.org.pl/interpelacja-refundacja-antykoncepcji/.; Partial reimbursement is provided for: Levomine, Microgynon 21, Rigevidon, Stediril 30.
24 "European Abortion Laws: A Comparative Overview." 2023. Center For Reproductive Rights. https://reproductiverights.org/wp-content/uploads/2023/09/European-Abortion-Laws-A-Comparative-Overview-new-9-13-23.pdf.
25 Track20. n.d. "Ukraine - Projected Trends in mCPR." https://www.track20.org/Ukraine.
26 Center for Reproductive Rights (2023). Care in Crisis: Failures to Guarantee the Sexual and Reproductive Health and Rights of Refugees from Ukraine in Hungary, Poland, Romania and Slovakia. https://reproductiverights.org/ukraine-report-care-in-crisis/.

Methodology

Objectives

The study aimed to understand the FP needs of newly arriving Ukrainian refugee women in Poland and to assess the feasibility of using CVA to support access to FP services to inform the design, coordination, and funding of future CVA programming for SRH, specifically FP service provision, in the refugee response in Poland.

In order to capture both the market and barriers to FP, the study was completed in two phases. The first phase was an FP market assessment, which aimed to capture the market for FP services and products in Poland, including:

- direct and indirect costs associated with obtaining FP services and products;
- product availability;
- quality of FP services and products in two target locations (Warsaw and Przemyśl) across both public and private care; and
- capacity of actors to increase the supply of FP services if a CVA for FP intervention were implemented, and resulted in increased demand for services.

The second phase was a FP barrier assessment, which aimed to explore and document:

- barriers to accessing SRH services, including FP, faced by Ukrainian refugee and Polish host community women living in Warsaw and surrounding areas;
- difference in barriers faced between refugee women and Polish women, and by women with disabilities; and
- possible modalities to reduce barriers and increase the availability and accessibility of FP services and products.

Site Selection

In January 2023, the project team conducted a rapid mapping exercise to select the sites for the assessments. The project team compared 10 cities based on the following criteria:

- distance from the Ukrainian border;
- number of Ukrainian refugee women in the city at the time (as reported by UNHCR, the Refugee Agency);
- size of Polish population;
- estimated international and national funding donated for protection, health and gender-based violence (GBV) programming in the city at the time (reported by UNHCR); and
- number of national NGOs operating in the city that were potential relevant partners for future CVA for SRH programming.

For both the market and FP barrier assessments, the project team targeted respondents in Warsaw and Przemyśl. Warsaw is an urban environment (1,861,975 people) with a large population of Ukrainian refugee women (194,420) at the time of data collection. In contrast, Przemyśl is a rural town (56,802 people) in eastern Poland close to the Ukrainian border, with a significant proportion of Ukrainian refugee women (30,800) at the time of data collection, who were reported to be in transit.[27] Due to challenges in reaching target numbers

27 Karen Hargrave. 2023. "Refugees and Other Migrants in Poland: A Spotlight on City Leadership." ODI: Think Change. February 24, 2023. https://odi.org/en/insights/refugees-and-other-migrants-in-poland-a-spotlight-on-city-leadership/.

during data collection, respondents from Lublin and Rzeszów, also in eastern Poland were later included in the sample for the quantitative survey conducted under the market assessment.

Ethics

For the market assessment, the project team hired Kantar Public in Poland as consultants to conduct data collection and analysis. For the FP barrier assessment, all enumerators had prior experience conducting qualitative interviews and received training from WRC researchers in application of the survey tools and research methodology. Participants and key informants were informed of the study's purpose, risks, and benefits, and were given the opportunity to provide written consent to participate in the study. WRC provided an information sheet to each participant with WRC's contact information and instructions for anonymous reporting channels. Any names mentioned during the qualitative research data collection were deleted during data transcription. All data collected for this report were stored securely on password-protected devices once uploaded and transferred to WRC; data were not shared outside the project team. All recordings made during data collection were subsequently deleted. WRC and CDC staff reviewed all of the collected data for quality assurance.

Data Collection

The project team designed the market assessment. It comprised a desk review of Poland's SRH policy landscape, product and appointment availability, and quantitative surveys and qualitative interviews with physicians who provide sexual and reproductive healthcare, pharmacists, distributors and manufacturers of FP, and nongovernmental organization (NGO) representatives in Poland. Respondents were purposively selected due to their familiarity with the policy environment, FP market and/or FP products and services in Poland. The data collection took place from July to August 2023 and was undertaken by local consultant, Kantar Public.

For the FP barrier assessment, data collection took place from October 2023 to January 2024. WRC designed the FP barrier assessment and Federa and CARE Poland led the data collection support from local enumerators and consultants from Opinia 24. Participants were recruited through contacts with organizations supporting refugee women in Poland, which posted information about participation in the study in aid centers and social media groups frequented by refugee women and Polish women. Using criterion-based sampling, participants were selected if they fulfilled the following:

- displacement status (refugee, asylum seeker or migrant from Ukraine shortly before or after February 2022; or host community member);
- nationality/ethnicity (Ukrainian or Polish);
- age (18-25 or 26-45); and
- disability (without disability or self-identified as having a disability).

The project team developed qualitative interview guides, which contained 17 to 19 questions that covered: barriers to healthcare and FP services, access to humanitarian assistance and financial institutions, and household decision-making related to FP. The guides were developed in English and translated into Polish and Ukrainian. A team of four data collectors conducted interviews in Polish or Ukrainian, based on the interviewee's preference. Each interview took 45–60 minutes, and participants received 99 Polish złoty (PLN), roughly $25 USD, as remuneration.

Across both phases, 120 quantitative computer-assisted personal interviews[28] and 64 qualitative interviews were collected. A summary of participants can be found in Table 1.

[28] Computer-assisted personal interviewing (CAPI) is a method of data collection that involves face-to-face interviews where the interviewer uses a computer, tablet, or mobile phone to record the respondent's answers.

Table 1. Respondent Demographic Characteristics for Market and FP Barrier Assessments

Method	Respondent Breakdown
Quantitative survey	**Market Assessment (n=120):** ***In Warsaw:*** • 25 interviews with physicians providing SRH care • 25 interviews with pharmacists • 15 interviews with representatives of FP manufacturers and distributors and • 16 interviews with representatives of NGOs ***In Przemyśl, Rzeszów, and Lublin:*** • 12 interviews with physicians providing SRH care • 12 interviews with pharmacists • 4 interviews with representatives of FP manufacturers and distributors • 11 interviews with representatives of NGOs
Qualitative interviews	**Market Assessment (n=16):** • 5 physicians providing SRH care in Warsaw • 3 physicians providing SRH care in Przemyśl and Rzeszów • 4 pharmacists in Warsaw • 4 pharmacists in Rzeszów **FP Barrier Assessment (n=48):** • 21 Ukrainian women, 26–45 years old • 1 Ukrainian women, 18–25 years old • 19 Polish women, 26–45 years old • 7 Polish women, 18–25 years old • 7 women with disabilities across all groups

All qualitative interviews were audio-recorded. Audio recordings were anonymized, then transcribed into Polish or Ukrainian and translated into English for analysis.

Data Analysis

Kantar Public led the analysis for the market assessment. WRC led the analysis for the FP barrier assessment with support from the Global Public Health in Emergencies Branch at the CDC. For all qualitative transcripts collected for the FP barrier assessment, analytic memos were created and used to generate the initial findings

and a codebook with deductive and inductive codes. WRC convened a co-analysis workshop with members of the project team to share the initial findings and validate the codebook, using excerpts from a range of transcripts. After the codebook was finalized, the data was coded and analyzed using Dedoose. A team of eight coders, with five primary and three secondary coders, analyzed the FP barrier assessment data; more than 50 percent of transcripts were coded by a first and second coder. The data analysis team met weekly to discuss and resolve discrepancies in coding, and to further refine the codebook.

Findings

In this report, the findings from the market and FP barrier assessment are presented in three sections. The first section outlines the provision of FP services in Poland; it reviews findings from the market assessment on the process to obtain FP in Poland, as well as the availability, accessibility, and quality of FP services and methods. The second section expounds on the utilization of FP services and methods by FP clients, which details findings from the FP barrier assessment, and related data from the market assessment. The third and final section discusses findings from both the market and FP barrier assessments on CVA for FP, including provider and client perspectives on designing a potential CVA for FP intervention in Poland.

Provision of Family Planning Services in Poland: Provider Perspectives

Process to Obtain Family Planning in Poland

In the market assessment, physicians were asked about the process to obtain FP services and methods in Poland. In the qualitative interviews, physicians reported that obtaining an FP method generally required an initial appointment for an examination, including bloodwork and pap smear, followed by a dedicated appointment to prescribe the FP method. However, it was reported that the number of appointments could vary, depending on the provider, the FP method that the client wanted, and whether the client was able to provide a recent medical history. If they had a patient's medical history and recent testing available, physicians stated, for many methods, they could provide the FP method at the first appointment, or via telemedicine.

In the quantitative surveys, physicians similarly reported that obtaining FP methods required one to two appointments on average, depending on the method. However, physicians in Warsaw were less likely to require multiple appointments compared to physicians in the eastern cities, Przemyśl, Rzeszów, and Lublin. For example, physicians in Przemyśl, Rzeszów, and Lublin reported requiring FP clients to attend three appointments, on average, in order to obtain methods such as IUDs, implants, or injections. Physicians in Warsaw reported that they would require FP clients to attend two visits, on average, for the same methods. (See Table 2.)

During the qualitative interviews, physicians stated that a follow-up visit is normally recommended one to three months after the initial prescription, depending on the method; this follow-up appointment could take place via telemedicine. If the client was satisfied with their method, the doctor could issue prescriptions for a longer period.

Nearly all physicians participating in this assessment reported providing same-day prescriptions for emergency contraceptive pills (ECPs) when requested by clients. Most physicians reported that they do not require any testing or examinations to prescribe ECPs and understand that the provision of ECPs is time sensitive. Some doctors mentioned that they provide prescriptions for ECPs via telemedicine. Notably, one doctor in Warsaw reported that there are doctors in Poland who will exercise conscientious objection and decline to provide ECPs for clients.

In June 2024, Poland passed a new law allowing pharmacists to prescribe ECPs without a physician

consultation.[29] Over 100 pharmacies across Poland have joined the program, and participating pharmacies are searchable on the NHF's patient portal. However, this program is elective, and pharmacists are not required by law to provide ECPs without a prescription, thereby potentially limiting widespread access across Poland.

In the qualitative interviews, pharmacists generally reported that they did not play a significant role in counselling clients on FP methods. Pharmacists attributed this to a lack of privacy in the pharmacy, and their perception that clients were embarrassed to discuss FP; however, pharmacists stated that they would answer clients' questions about FP if asked—for example, finding a cheaper substitute for their prescriptions, how to use their method, or possible interactions with other medications. In some cases, pharmacists stated that they would fill prescriptions for Ukrainian refugees that had been issued in Ukraine, if the medication or prescription order was provided.

Table 2. Number of Visits Recommended by Physicians to Prescribe Contraceptives, by Method (N=37)

Contraceptive method	Number of Visits Recommended to Prescribe – Total Sample (N=37), Average (Min-Max)	Average Number of Visits Recommended to Prescribe – Doctors in Warsaw (N=25), Average (Min- Max)	Average Number of Visits Recommended to Prescribe – Doctors in Przemyśl, Rzeszów, and Lublin (N=12), Average (Min-Max)
Copper IUD	2 (1-4)	2 (1-3)	3 (2-4)
Hormonal IUD	2 (1-4)	2 (1-3)	3 (2-4)
Contraceptive implants	2 (1-4)	2 (1-3)	3 (2-4)
Contraceptive injections	2 (1-4)	1 (1-2)	3 (1-4)
Progesterone vaginal ring	2 (1-4)	1 (1-2)	2 (1-4)
Contraceptive patches	1 (1-3)	1 (1-2)	2 (1-3)
Combined oral contraceptive pills (COCs)	1 (1-3)	1 (1-1)	2 (1-3)
Progestin-only pills (POPs)	1 (1-2)	1 (1-1)	2 (1-2)
Emergency contraceptive pills (ECPs)	1 (1-2)	1 (1-1)	1 (1-2)

Note: The averages report here are rounded to the nearest whole number.

Availability of Family Planning Services and Methods

In the market assessment, physicians and pharmacists were asked about the availability of FP appointments and methods in Poland. In addition, availability of FP appointments and methods were queried online through patient portals.

29 Agata Pyka. 2024. "Poland Labels Pharmacies Providing Morning-after Pill without Doctor's Prescription." Notes From Poland. June 11, 2024. https://notesfrompoland.com/2024/06/11/poland-labels-pharmacies-providing-morning-after-pill-without-doctors-prescription/.

Availability of Family Planning Appointments in Warsaw and Eastern Poland

When asked about the availability of appointments, approximately 30 percent of physicians in the quantitative survey stated that patients could expect an appointment within a week of the scheduling date, while 70 percent said it would take up to two to three weeks or more. From quantitative data, only 20 percent of physicians in Warsaw reported offering appointments within a week, whereas 50 percent of physicians in Przemyśl, Rzeszów, and Lublin reported offering appointments within a week. Interestingly, physicians reported their perception that that waiting times for Ukrainian FP clients were slightly shorter than for Polish clients. Around 41 percent of doctors said Ukrainian clients could expect appointments within a week, and nearly 80 percent within three weeks.

In the qualitative interviews, physicians were not concerned about the availability of FP appointments in the Polish market. Physicians generally felt that NHF gynecology appointments were available in a timely fashion, in comparison to the overall system, and therefore easier to obtain than other types of care. Physicians working in both public and private facilities stated that their scheduling processes remained flexible for those who needed to seek care immediately. If necessary, patients would be able to seek a consultation within a few days, and in urgent situations, on the same day. Some physicians mentioned that they were able to facilitate timely access to care through telemedicine, which may not provide a complete examination, but can expedite care for patients with uncomplicated needs. Others mentioned that they retain a pool of in-person appointments available for patients who needed urgent care. Some stated that patients were aware of these available appointments and would simply come to the facility to request an appointment, but that this information was not publicly available.

As part of the market assessment, online research was conducted to gauge the availability of FP services in Warsaw and Przemyśl through the NHF and private care patient portals.[30] Availability of appointments under public healthcare was estimated using the availability listed on the NHF patient portal, https://pacjent.gov.pl/, which provides information on available appointments at NHF clinics. The review showed that, in Warsaw, there were no NHF gynecology appointments available within a week from the research date. However, three appointments were available within two weeks, two within three weeks, and eight within four weeks of the scheduling date. In Przemyśl, no NHF gynecology appointments were available within five weeks of the scheduling date and appointments after five weeks were not included in the analysis. (See **Annex 1, Tables 1 and 2.**)

Similar methods were employed to estimate the availability of FP services under private care using the national private care website, ZnanyLekarz, znanylekarz.pl. In Warsaw, on the same review date, there were dozens of same-day appointments with private care physicians available. In Przemyśl, no private clinic had available schedules listed online—the site only provided contact information for individual clinics. Moreover, the websites for the individual clinics did not provide information on available appointments either.

The differences between physicians' perception and the availability of appointments listed online suggests that physicians, especially in eastern Poland, may underestimate the lack of available gynecology appointments as a major barrier to care. However, it is important to note that, in the quantitative sample, over half of physicians from Warsaw and a majority of physicians in Przemyśl, Rzeszów, and Lublin worked in both NHF and private care clinics. Given this data, it is difficult to discern if physicians reported on their availability of appointments under private care or public care.

Availability of Family Planning Supplies

Based on quantitative surveys and qualitative interviews with pharmacists as well as data queried on the NHF and private care portals, the supply of FP methods in Poland was not disrupted by the crisis in Ukraine. Likewise, in qualitative interviews, pharmacists shared that FP methods were generally available on the Polish

[30] These data were collected on September 21, 2023.

market.

According to the pharmacists who participated in the quantitative survey, the availability of various FP methods was high nationwide, with contraceptive patches, OCPs, ECPs, and male condoms reported being sold by more than 90 percent of participating pharmacists; vaginal rings were sold by 76 percent; contraceptive injections by 51 percent; and IUDs by more than 60 percent of pharmacist survey participants. Implants, female condoms, and diaphragms were the least accessible, with approximately 30 percent of pharmacists reporting selling these methods. Only six respondents declared that in the last three months their pharmacy had run out of stock of any of the hormonal IUD, contraceptive implants, contraceptive patches, COCs or ECPs.

Based on the data from the online prescription portal https://www.gdziepolek.pl/, all FP methods—copper and hormonal IUDs, implants, injections, patches, vaginal rings, COCs, progestin-only pills (POPs), ECPs, male and female condoms, and diaphragms—were reported as available for purchase in country (**see Annex 2**).[31] Most FP methods were available for purchase in both Warsaw and Przemyśl, with the exception of copper IUDs and implants, which were not available at any pharmacies in Przemyśl. Given that both methods were available in country, the lack of availability for copper IUDs and implants in Przemyśl could have occurred due to stockouts. However, these data were collected on one day, which cannot confirm if these methods were available at another time. Based on the number of pharmacies that were listed as sellers, the availability of methods and brands was much higher in Warsaw than in Przemyśl, which is likely due to the number of pharmacies in each location—874 pharmacies in Warsaw and 27 in Przemyśl.

In the market assessment, FP manufacturers and distributers, as well as NGO representatives, were asked about the use of FP methods obtained through informal or unauthorized vendors in Poland. Twenty-five percent of NGO representatives, and roughly 50 percent of FP manufacturers and distributers reported that they believed that some people obtain FP from informal or unauthorized vendors exists in Poland. According to contraceptive manufacturers and distributors, the most common method purchased from informal or unauthorized vendors are ECPs, followed by hormonal pills, patches, contraceptive injections, and copper IUDs. Among FP manufacturers and distributors, obtaining FP methods from an unauthorized or informal vendor was often attributed to barriers related to difficulties in getting to a gynecologist (78%), securing a prescription (67%), or overly restrictive policies governing access to FP (52%).

Accessibility of Family Planning Services and Methods

Cost of Family Planning Services

Under the NHF, the cost of appointments for FP services is covered for clients. In qualitative interviews, physicians reported that there may be costs incurred for preliminary testing to obtain FP methods under the NHF, depending on the type of test, whether it qualifies for reimbursement, and the type of facilities used to process the results.

Under private care, clients pay for both appointments and testing. In the quantitative surveys, physicians were asked about patient costs for FP-related services. On average, physicians reported that an examination or consultation for a prescription would cost 220 PLN, or $52 USD in Warsaw and 196 PLN or $46 USD in Przemyśl, Rzeszów, and Lublin (see Table 3). Physicians in the quantitative survey reported that the cost for testing would be an additional 214 PLN ($50 USD) in Warsaw, or 240 PLN ($57 USD) in Przemyśl.

In qualitative interviews, physicians reported the cost of FP services in a similar price range; one gynecology visit in Warsaw could cost 200 PLN, roughly $50 USD, in addition to a blood test and a pap smear, which could cost up to 100 PLN, roughly $25 USD. In Przemyśl, Rzeszów, and Lublin, physicians reported that the costs could be up to 170 PLN ($43 USD) for a one gynecology visit and 30 PLN ($7.70 USD) for a blood test and pap smear.

When reviewing the price of FP services on Poland's private care portal ZnanyLekarz, znanylekarz.pl, the average price listed for one gynecology visit in Warsaw was roughly 250 PLN ($57.59). The cheapest option

[31] The product availability data was queried on May 29, 2023.

available cost 170 PLN (39.16 USD). In Przemyśl, the average price listed online for a private gynecology visit was about 205 PLN ($47.23 USD); the cheapest option available was also 170 PLN ($39.16 USD). **(**See **Annex 1, Tables 1 and 2.**)

On the private care portal, some clinics also offered same-day in-person appointments to obtain prescriptions for ECPs. The average price for the appointment to obtain ECPs in Warsaw was just under 260 PLN ($59.90 USD), and the cheapest was 150 PLN ($34.56 USD). In Przemyśl, only one clinic offered same-day in-person appointments for ECPs, which cost 50 PLN ($11.52 USD). (See **Annex 1, Tables 1 and 2.**)

Table 3. Average Price of Exam by Type of Examination, in Warsaw and Eastern Polish Cities, Reported by Gynecologists (N= 37)

Type of examination	Warsaw - Average price	Przemyśl, Rzeszów, and Lublin, eastern Polish cities - Average price
An examination or consultation related to obtaining contraception	220.80 PLN ($52.22 USD)	196 PLN ($46.35 USD)
Medical tests related to obtaining contraception	214.40 PLN ($50.71 USD)	240 PLN ($56.76 USD)
Other costs related to obtaining contraception	107.90 PLN ($25.52 USD)	150 PLN ($35.48 USD)

In comparison, physicians' perceptions of the cost of private FP consultations were on par with, if not slightly less expensive than, the average costs of services listed online. The slight differences between the online listed prices and physicians' perceptions imply that physicians have an accurate gauge of the costs of private FP services, albeit their estimates for the costs for examination were slightly under.

In the desk review, data were also collected from websites offering same-day telemedicine appointments to obtain ECPs specifically.[32] These telemedicine websites operate under private care, and provide numerous types of appointments, including FP telemedicine appointments to obtain ECPs. Clients select an appointment based on the type of physician they want to see or the type of medication they require. The price for an FP telemedicine consultation was roughly 80 PLN ($18.92 USD) and the standard price for an ECP prescription was 59.99 PLN ($14.40 USD), which could be available within hours of placing the order.

Cost of Family Planning Methods

In Poland, the NHF does not reimburse the cost of any FP method, with the exception of four brands of COCs, which are partially reimbursed (see **Annex 2, Combined Oral Contraceptive Pills** for more information).[33] Therefore, all FP clients in Poland, regardless of whether they seek public or private care, pay out of pocket for their FP methods.

In the market assessment, the costs of FP methods were assessed through both quantitative surveys and qualitative interviews with pharmacists, as well as a review of the costs for FP methods listed online through the national prescription portals.

[32] Websites included: Receptomat (https://receptomat.pl/), E-Recepty (https://e-recepty.pl/), Lekarz Recepta (https://lekarz-recepta.pl/), ZnanaRecepta (https://znanarecepta.pl/), and HaloMed (https://halomed.pl/).
33 FEDERA Foundation for Women and Family Planning. 2020. "Interpelation on contraception refund - answer and discussion." April 1, 2020. https://federa.org.pl/interpelacja-refundacja-antykoncepcji/.; Partial reimbursement is provided for: Levomine, Microgynon 21, Rigevidon, Stediril 30.

In the quantitative surveys, pharmacists were asked about the estimated prices for FP methods by method (see Table 4). IUDs and implants were the most expensive methods reported by pharmacists, priced on average at 118 to 144 USD and 106 to 149 USD, respectively. The cheapest prescription FP methods, on average, were POPs, priced at approximately 7 USD, followed by COCs, priced between approximately 8 to 10 USD, per pack. Overall, pharmacists in Warsaw reported, on average, higher costs for FP methods than those reported by pharmacists in Przemyśl, Rzeszów, and Lublin, except for four methods: copper IUDs, contraceptive implants, contraceptive injections, and POPs were priced slightly higher by pharmacists in eastern Poland than by pharmacists in Warsaw.

Table 4. Prices for Contraceptives by Method in Poland, as Reported by Pharmacists (N=37)

	Estimates by Pharmacists in Warsaw		Estimates by Pharmacists in Przemyśl, Rzeszów, and Lublin – Eastern Poland	
Method	**Price range**	**Average Price**	**Price range**	**Average Price**
Copper IUD	65.25-745.45 PLN ($16.56-189.2 USD)	247.16 PLN ($62.73 USD)	93.18-326.15 PLN ($23.65-82.78 USD)	279.54 PLN ($70.95 USD)
Hormonal IUD	465.91-652.27 PLN ($118.25-165.55 USD)	566.77 PLN ($143.85 USD)	111.82-465.91 PLN ($28.38-118.25 USD)	465.91 PLN ($118.25 USD)
Contraceptive implants	37.27-726.81 PLN ($9.46-184.47 USD)	420.79 PLN ($106.8 USD)	69.9-652.27 PLN ($17.74-165.55 USD)	587.06 PLN ($149.00 USD)
Contraceptive injections	18.64-46.61 PLN ($4.73-11.83 USD)	34.75 PLN ($8.82 USD)	13.04-93.18 PLN ($3.31-23.65 USD)	44.25 PLN ($11.23 USD)
Vaginal ring	27.97-93.18 PLN ($7.1-23.65 USD)	52.8 PLN ($13.4 USD)	33.53-69.9 PLN ($8.51-17.74 USD)	41.92 PLN ($10.64 USD)
Contraceptive patches	27.97-74.54 PLN ($7.1-18.92 USD)	54.92 PLN ($13.94 USD)	23.29-74.54 PLN ($5.91-18.92 USD)	46.61 PLN ($11.83 USD)
Combined oral contraceptives (COCs)	26.08-60.56 PLN ($6.62-15.37 USD)	37.94 PLN ($9.63 USD)	23.29-93.18 PLN ($5.91-23.65 USD)	31.68 PLN ($8.04 USD)
Progestin-only pills (POPs)	18.64-37.27 PLN ($4.73-9.46 USD)	27.62 PLN ($7.01 USD)	13.04-111.82 PLN ($3.31-28.38 USD)	27.97 PLN ($7.10 USD)
ECPs	51.26-165.87 PLN ($13.01-42.1 USD)	96.33 PLN ($24.45 USD)	41.92-93.18 PLN ($10.64-23.65 USD)	65.25 PLN ($16.56 USD)

Female condom	55.91-85.73 PLN ($14.19-21.76 USD)	63.51 PLN ($16.12 USD)	9.34-37.27 PLN ($2.37-9.46 USD)	19.58 PLN ($4.97 USD)
Male condom	3.74-37.27 PLN ($0.95-9.46 USD)	14.14 PLN ($3.59 USD)	1.85-18.64 PLN ($0.47-4.73 USD)	9.34 PLN ($2.37 USD)
Diaphragm	185.42-223.63 PLN ($47.06-56.76 USD)	207.13 PLN ($52.57 USD)	51.26-325.21 PLN ($13.01-82.54 USD)	158.43 PLN ($40.21 USD)

In the market assessment, the costs of FP supplies listed on the Polish websites were also assessed and included in this analysis.[34] By comparison, the prescription pricing data retrieved from the online portals was similar to what pharmacists reported in the quantitative survey (see Table 5).

Table 5. Minimum and Average Prices of Contraceptives in Warsaw and Przemyśl, by Method, Online Pharmacy Portals,[35] July 2023

Method	Lowest price on the market	Average price across the market
Combined orals contraceptives (COCs, 21 tablets)	5.56 PLN (1.31 USD)	31.03 PLN (7.32 USD)
Contraceptive patches (3 patches)	48.81 PLN (11.51 USD)	48.81 PLN (11.51 USD)
Progestin-only pills (POPs, 28 tablets)	16.83 PLN (3.97 USD)	31.11 PLN (7.34 USD)
Vaginal ring	41.39 PLN (9.76 USD)	52.11 PLN (12.29 USD)
ECPs	34.99 PLN (8.25 USD)	66 PLN (15.57 USD)
Copper IUD	121.57 PLN (28.67 USD)	123.89 PLN (31.59 USD)
Hormonal IUD	597.52 PLN (141.01 USD)	597.52 PLN (141.01 USD)
Contraceptive implants	572.62 PLN (135.13 USD)	572.62 PLN (135.13 USD)
Contraceptive injections	41.02 PLN (9.67 USD)	41.02 PLN (9.67 USD)
Male condom (3 pieces)	3.50 PLN (0.82 USD)	5.80 PLN (1.36 USD)

[34] Prices of prescriptions were randomly selected from the following websites: https://www.doz.pl/, https://www.swiatleku.pl/, https://www.apteka-melissa.pl/, https://gemini.pl/, https://apteline.pl/, https://www.drmax.pl/. The names of the drugs were entered into their search engines and the prices offered there were noted. This procedure was repeated three times. An average was then calculated and placed in the "Average price" column.

[35] Ibid.

Affordability of Family Planning in Poland

During the qualitative interviews, physicians generally noted that FP methods in Poland are relatively expensive, as costs are not reimbursed by the NHF. According to some physicians, costs could be a significant problem for clients. Others felt that the cost of FP methods was not a substantial barrier to care, as less expensive methods were available, and a limited number of OCPs were reimbursable under the NHF.

Some physicians reflected on the economic barriers facing Ukrainian refugees and the difficulties of affording care if refugees had no source of income and had to cover all the costs of living in a foreign country. However, some physicians especially those working in the private sector, perceived newly arriving Ukrainians to be affluent and therefore, less impacted by the cost of FP services and methods in Poland.

Quality of Family Planning Services and Methods

In the qualitative interviews of the market assessment, physicians and pharmacists were asked about their experience working with diverse communities, including Ukrainian refugees, people with disabilities, adolescent girls, Roma communities, and people with diverse sexual orientations, gender identities and expressions, and sex characteristics (SOGIESC). The findings from the qualitative data are summarized below, by demographic group.

Working with Ukrainian Refugees

When queried about their experiencing providing services to Ukrainian refugees, both physicians and pharmacists emphasized that Ukrainian refugees have equal access to the Polish healthcare system, including free services and reimbursements for medicines. While navigating the system could be challenging, providers felt that many refugees manage well, aided by long-standing Ukrainian communities in Poland.

Some care providers acknowledged that Ukrainian refugees encountered difficulties in healthcare due to language barriers, and prescriptions and medical documents that were written in Cyrillic.[36] However, physicians regarded these barriers as surmountable, expressing that Ukrainians could acquire Polish language skills quickly through classes, communicate with their physician in English as a third, shared language, seek out a Ukrainian or Ukrainian-speaking physician, or use an in-person or web-based translator. One physician stated that he typically refers Ukrainian patients to Ukrainian-speaking colleagues for care.

Working with People with Disabilities

During the qualitative interviews, physicians and pharmacists shared that they had limited experiences working with clients with disabilities, but a few noted their barriers to care, overall. Some physicians recognized that their offices were narrow and not completely accessible for those with mobility impairments. Others noted that they often required assistance in transferring a patient with mobility impairment to the exam table or holding the patient in place at the time of the examination. In these instances, they typically relied on support persons accompanying the client for assistance. Physicians also mentioned challenges providing counselling to FP clients with disabilities. One provider expressed that in some cases, it could be difficult to identify methods that would not interact with other medications being taken by the client.

Similarly, during their qualitative interviews, pharmacists discussed challenges related to accessibility, and counselling clients with disabilities. Some pharmacists stated that clients with disabilities faced structural barriers in pharmacies—such as narrow hallways and doors—and required tailored instructions or needed a support person to receive information on how to use their FP method.

However, in the qualitative interviews, several providers also expressed potentially harmful beliefs and practices for providing FP services to clients with disabilities. One physician stated that the barriers facing clients with disabilities were less about the healthcare system, and instead the product of social isolation; they

[36] The Cyrillic alphabet is a writing system used for over 50 languages, including Russian, Ukrainian, Belarusian, Bulgarian, and Serbian.

expressed their belief that people with disabilities would be less likely to be in romantic or sexual relationships and need FP. Another physician expressed biases about people with disabilities' ability to self-administer some FP methods. A pharmacist also stated during their qualitative interview that they do not know how clients with disabilities cope and function in their daily lives.

In the quantitative survey, nearly all physicians and pharmacists from Warsaw reported their perception that there were no barriers to care for clients with disabilities in their practice, 100 percent and 88 percent, respectively. For those in Przemyśl, Rzeszów, and Lublin, 75 percent of physicians and 25 percent of pharmacists reported that there were no barriers to care in their practice for those with disabilities; the rest reported they could identify some barriers, or that they did not know if clients with disabilities faced any barriers to care.

Working with Adolescent Girls

In the qualitative interviews of the market assessment, most physicians and pharmacists had experience working with adolescent girls (under 18). All physicians stated they comply with the legal requirement to have a caregiver present for any child's healthcare examinations. However, some gynecologists noted they allow exceptions to this rule in certain cases. While most physicians also expressed that the obligation to have a guardian present can raise barriers and limit access to gynecological care for adolescents, only two stated that this policy should change. Many physicians expressed that sexual education in schools was limited and insufficient, and that adolescents were receiving misinformation about SRH online. When queried as to adolescents' preferred FP methods, physicians reported that adolescents typically requested prescriptions for OCPs, which physicians attributed to a lack of knowledge on other FP methods and the popularity of OCPs in social circles and on the internet.

Pharmacists' interactions with adolescent girls were largely limited to filling prescriptions. Some pharmacists mentioned in their qualitative interview the need for a caregiver was a barrier to FP services for adolescents, and that expressed their perception that adolescents exhibit either reluctance to speak about FP or "overconfidence" on what type of FP method they want to use—most popularly OCPs—when seeking FP methods.

Working with Roma Communities

In the market assessment, physicians and pharmacists were asked about their experience working with Roma communities. The Roma people are ethnic minorities in both Ukraine and Poland and often experience marginalization due to their ethnicity.

In the quantitative survey, 38 percent of physicians reported that clients from the Roma community faced some barriers to accessing SRH care, which they identified as language, cultural, or financial barriers. In the qualitative interviews, only one physician shared any experience working with Roma clients. Notably, he expressed his opinion that it was difficult to deliver services because of language barriers, and his perception that Roma clients had lower literacy levels. He also expressed potentially harmful biases about members of the Roma community as described below.

> **"[Talking about Roma clients]** ***These are patients who are very often late for appointments. These are patients who can call a dozen times and ask about the same thing. Well, it also happened that a patient's husband came in intoxicated for an appointment. They make arguments at the reception desk, they argue."***
>
> - ***Gynecologist from Warsaw***

Working with Individuals with Diverse Sexual Orientations, Gender Identities and Expressions, and Sex Characteristics (SOGIESC)

In the quantitative survey, a majority of physicians overall (73 percent) reported working with clients with diverse SOGIESC. Only 17 percent of physicians from Przemyśl, Rzeszów, and Lublin reported they had worked with clients with diverse SOGIESC. When asked in qualitative interviews of the market assessment, both physicians and pharmacists reported limited experiences working with clients with diverse SOGIESC. Among those who worked with clients with diverse SOGIESC, physicians reported that these clients rarely sought out FP services. Overall, physicians expressed their belief that clients with diverse SOGIESC received quality care, regardless of their orientation or identities, and that they did not face particular barriers. However, research does show that clients with diverse SOGIESC do experience barriers to healthcare, including FP services, globally.[37]

During qualitative interviews, pharmacists also reported that they had limited experience serving clients with diverse SOGIESC. Few pharmacists expressed that serving clients with diverse SOGIESC was not different from serving heterosexual, cisgender clients. Some pointed out that pharmacies typically do not have private spaces for pharmacists to consult with clients and noted that this could be a potential barrier for those with diverse SOGIESC. However, pharmacists stated that clients with diverse SOGIESC rarely inquired about the availability of contraception.

Utilization of Family Planning: Ukrainian Refugee and Polish Host Community Perspectives

As part of the FP barrier assessment, 22 Ukrainian refugee and 26 Polish host community women were interviewed to understand the barriers they face when accessing FP care in Poland. The findings from those in-depth interviews are reported below, in two sections, based on their relevance to the FP market. The first section presents supply-side factors that impact uptake of FP among Ukrainian refugee and Polish host community women, such as barriers to availability, accessibility and quality of FP services and methods in Poland. The second section presents findings related to demand-side factors from both the market and FP barrier assessment, which covers how Ukrainian refugee and Polish host community women prioritize FP, their knowledge of FP services and methods, attitudes toward FP, financial barriers to healthcare and FP, specifically, as well as strategies to improve their access to good quality FP services.

Supply-Side Factors

Barriers to Availability

In discussing barriers to FP services, several Ukrainian refugee and Polish women discussed Poland's restrictions on abortion as a barrier to SRH care in Poland. Many of these respondents expressed that these restrictions were an infringement on women's rights, and some respondents shared concerns about being able to access safe abortion care in Poland if they needed it. Ukrainian women explicitly connected Poland's abortion restrictions to a general stigma around FP in Poland. Some respondents, both Ukrainian and Polish, stated that they would leave Poland, or seek services outside of the formal health system, if they needed abortion care.

37 Cemile Hurrem Balik Ayhan et al. 2020. "A Systematic Review of the Discrimination Against Sexual and Gender Minority in Health Care Settings." International Journal of Health Services: Planning, Administration, Evaluation 50 (1): 44–61. https://doi.org/10.1177/0020731419885093.; Hayley Conyers et al. "Barriers and Facilitators to Accessing Sexual Health Services for Older LGBTQIA+ Adults: A Global Scoping Review and Qualitative Evidence Synthesis." Sexual Health 20, no. 1 (February 2023): 9–19. https://doi.org/10.1071/SH22144.

> ***"Yes, it's a huge barrier. A big gynecological barrier in terms of women. And in terms of my rights. What if I don't want to get pregnant? For example, me and my husband have decided we don't want any more children. Why can't I go and get that pill or do that [abortion]? Things I can normally do in Ukraine, in a medical institution."***
>
> ***- Ukrainian refugee woman with disabilities***

Barriers to Accessibility

Prescription Requirements

Several Ukrainian women discussed barriers to accessing FP care, such as needing an appointment or a prescription for contraceptives. Most Ukrainian women generally regarded FP methods and services as being less readily available in Poland than in Ukraine, especially for hormonal contraceptive methods. Both OCPs and ECPs are available in Ukraine without a prescription. They also found the Polish healthcare system to be more difficult to navigate than Ukrainian healthcare due to appointment and prescription requirements, longer wait times for appointments, or difficulties with language. Several Ukrainian women expressed their frustrations with needing appointments for blood testing and pap smears to obtain FP methods; in Ukraine, testing services can be obtained directly from private laboratories; respondents cited this as another barrier to accessing adequate SRH care.

Many Polish women also regarded the need for appointments and prescriptions as barriers to FP services, given the number of steps needed to obtain an FP method. For some Polish women, these requirements were more onerous due to the lack of timely appointment availability under public care, which could prolong the process to obtain an FP method. Moreover, several Polish women noted that the combination of appointment and prescription requirements for FP methods and limited same-day appointment availability significantly diminished the accessibility of ECPs under the NHF.

Language Barriers

A majority of Ukrainian women discussed language as a barrier to seeking health services, including FP. Many Ukrainian women discussed strategies to navigate these barriers, including seeking out Ukrainian- speaking providers; having translators present during their appointments; learning Polish; and in one case, having a Polish-speaking family member provide support. However, identifying and securing an appointment with a Ukrainian-speaking provider required additional time and effort under both the public and private healthcare systems. Without it, Ukrainian women stated they could be placed with Polish-speaking physicians, with whom they would still consult as they needed to receive care. Some Ukrainian women reported feeling embarrassed for not understanding Polish when seeking healthcare or reported that language barriers made it challenging to navigate the Polish healthcare system, resulting in inadequate care. Others noted that language barriers resulted in an inability to use their benefits, and confusion around disability and refugee status. One woman expressed that some refugees were hoping that their displacement would be short-lived, and learning Polish was not a priority as they expected that they would return to Ukraine soon.

> ***"We must understand that some Ukrainian women who found work here, don't return home, and still don't learn the language. I constantly tell the girls that it shouldn't be like that. Even if you return to Ukraine, live in Ukraine, but learning the language won't hurt…One colleague has been living here for a year and a half, attended courses, but it's clear she just sat there and thought about when she would return home…So, I think there is a language barrier, but it depends a lot on women who often think, 'I'll be back soon.'"***
>
> - ***Ukrainian refugee woman with disabilities***

Logistical Barriers to Healthcare for Ukrainian Refugee and Polish Women

Ukrainian refugee women cited long wait times as the most common barrier to accessing healthcare. Wait times referred both to the need to wait for several months for an available appointment to see a physician and long waits on the day of their appointment. Notably, all respondents were referring to the NHF when discussing wait times as a barrier. Care in Ukraine, by comparison, was regarded as much more timely, where clients were able to schedule appointments online, and see a physician in a matter of days.

> ***"[P]ublic health care services have very long queues. I don't know who has the time for that. I have a job, and I have two children. I am also studying at the university. I rent a flat. So, unfortunately, I have no time for that. Visiting a private clinic is expensive for me. That is why I will only see a doctor when there is an emergency. Not otherwise."***
>
> - ***Ukrainian refugee women without disabilities***

Ukrainian refugee women reported that long wait times were particularly onerous for people with pre-existing conditions, new health concerns, or experiencing emergencies, which often required specialized care. They also mentioned other logistical barriers, such as the need to obtain childcare in order to attend an appointment and a lack of child-friendly healthcare spaces; a lack of clinics in their area; and the distance required to travel in order to receive care. For some Ukrainian women living in smaller towns outside of Warsaw, travelling to and from appointments could take an hour or more. One Ukrainian woman mentioned that healthcare clinics in Ukraine typically had child rooms, where children could stay while parents consulted with physicians, whereas in Poland, children were left to wait in corridors. If a clinic was far away, and at-home childcare was not available or affordable, attending appointments became difficult.

Many Ukrainian refugee women discussed general difficulties in navigating the Polish healthcare system. Respondents discussed a number of processes that posed challenges, including registration to receive healthcare, registration for refugee status and benefits, and applying for disability status and benefits. Some Ukrainian refugee women mentioned difficulty discerning if clinics were public or private, or if their care would be covered under their refugee status. Others reported that the referral process for specialized treatment was complicated, with respondents describing experiences where they were referred to the wrong provider, or where the provider they were referred to did not have availability for months. These challenges in navigating the healthcare system were often compounded by language barriers and long wait times, as well.

> ***"Despite knowing Polish well and being raised here during the first stage of my life, I still don't understand the local system. It would be good if someone explained, for example, 'when you go to a gynecologist, you make an appointment, go through some free examinations,' but I don't know where to get such information. You just don't understand if it's paid or free; there is no such information."***
>
> - ***Ukrainian refugee woman with disabilities***

Polish women also cited long wait times as the most common barrier to accessing healthcare, referring again to both the need to wait for several months for an available appointment and long waits on the day of their appointment. Some Polish women also described the distance to clinics as a barrier, where preferred physicians or clinics were not near their home or work—one Polish woman regarded this as the norm. Other Polish women mentioned the need for childcare as a potential barrier, but many of these women were able to secure paid childcare or rely on their support systems—partners, parents, siblings, friends, etc.—to watch their children during their healthcare visits. One woman mentioned that her insurance was able to pay for her childcare, thereby removing it as a barrier.

Financial Barriers to Family Planning and Healthcare

Cost as a barrier to general healthcare or FP in Poland varied among Ukrainian women in the sample. Overall, most Ukrainian refugee women mentioned costs of care as a barrier for general healthcare, FP care, or both in Poland. They said that costs for general health services in the private system were much higher in Poland than in Ukraine, particularly because they were earning much less in Poland. Despite this, many Ukrainian women reported electing to use private care to circumvent wait times in the NHF, leaving Ukrainian women to choose between expensive care or timely care.

Some Ukrainian refugee women described their personal experience of cost as a barrier to FP services. One Ukrainian refugee woman described her experience trying to identify a highly rated gynecologist, only to learn later that the cost of the consultation was too expensive because the pricing structure was unclear. Another elected not to proceed with obtaining FP when confronted with the consultation charge of 250 PLN ($62 USD), stating that it was too expensive given her income and she did not have time to wait in long queues under the NHF. Like costs for general healthcare, private FP services in Poland were considered to be much costlier than in Ukraine.

Other Ukrainian women expressed that cost would be a barrier for those with lower socio-economic status but did not mention it as a barrier for themselves. Among these women, several said that cost as a barrier varied depending on the method, and how much a woman prioritized FP. A few Ukrainian refugee women did not see cost as a barrier at all. One woman stated that the use of contraceptives depended on its necessity alone, and that cost was not a factor.

A majority of Polish women also felt that cost was a barrier to general healthcare, specifically for private healthcare and for medications that were not reimbursable under the NHF. Several Polish women reported seeking private services to avoid wait times and other barriers encountered when seeking NHF services if they could afford to do so. Some Polish women regarded private care as too expensive to ever use, while others mentioned that they sometimes used private care, but only if they needed care much sooner than they could access it in public services. A few women also discussed challenges in paying for medications, given the limited and changing medications that were reimbursable under the NHF.

Regarding access to FP services, nearly all Polish women also reported that cost was a barrier. Most Polish women did not mention that cost was a barrier for them personally, but regarded it as a barrier for others: those who had low incomes, who may need to seek services at a private facility to obtain care as soon as

possible; for certain FP methods like IUDs, which have a large cost upfront; or other hormonal contraceptive methods, which cost much less for one prescription, but would compound over time. However, a few women stated that they were not sure what the estimated costs to obtain FP services were to begin with.

Several Polish women reported that cost was a barrier to FP for them personally; they could not afford certain methods, like IUDs, or had previously spent a lot of money on securing FP methods, beyond purchasing condoms. As previously mentioned, many women discussed logistical barriers to obtaining FP services, including the need to have multiple appointments or tests, and the need to obtain childcare and transportation—all of which have cost implications or could result in a client needing to take off work, further compounding the barrier posed by the cost of the service itself.

> ***"Well, you know, [contraceptives are] not cheap, not every woman would agree to it. For example, getting an IUD installed. And if it's about pills, you have to remember to take them every day. In my case, I saved money for three or four months to be able to afford [an IUD]. Because, for me, it's expensive. I'll say that from one salary, it would be difficult for me to do this."***
>
> ***- Polish woman without disabilities***

Only a few Polish women reported that they did not think cost posed a barrier to FP services, with one woman stating that the average Polish woman would be able to afford FP, and another expressing that having the financial means to afford FP was a matter of prioritization.

Barriers to Quality

A majority of Ukrainian women mentioned poor quality of care under the NHF in their interviews. Notably, respondents discussed quality of care in relation to a range of health services, not only FP and SRH. Specific issues cited included receiving different diagnoses in Poland than in Ukraine; lengthy referral processes; disrespectful or negative attitudes on the part of providers; and receiving ineffective treatment. Some Ukrainian women mentioned instances in which Polish healthcare providers did not recognize medical conditions that they were diagnosed with in Ukraine, or diminished their severity, because their provider did not consider their medical histories. For example, one woman was denied necessary prescriptions for a chronic condition. A few women also stated that consultations were short, and providers did not adequately answer questions. One woman described a visit where her physician quickly prescribed medication without an examination, which did not treat her health issue. Some Ukrainian women also discussed how the poor quality of care compounded with challenges navigating the Polish healthcare system, recounting experiences where they were referred to doctor after doctor, without any immediate resolution or treatment plan. In a few cases, respondents reported receiving care that did not treat their medical concern.

> ***Respondent: "To be honest, the experience varied. In some cases, it was good, while in others, it wasn't. Some doctors told me that I wasn't really disabled, that I had made it up. Even though I've been using a wheelchair since birth. I don't know how to walk at all. It was very strange for me to hear that here in Poland. They didn't provide me with any help at all, [they] just said they can send me on rehabilitation."***
>
> ***Moderator: "Sorry to hear that. Was that a public or private doctor?"***
>
> ***Respondent: "It was an [NHF] doctor."***
>
> ***- Respondent was a Ukrainian refugee women with disabilities***

Polish women also described poor quality of care as a barrier to general healthcare, especially for care provided under the NHF. Polish women mentioned many of the same issues with quality of care as Ukrainian refugee women: physicians who did not listen, consultations that were short, treatments that did not work, and disjointed and inefficient care. Polish women were much more likely than Ukrainian women to discuss quality of care as a barrier.

> ***"I used NHF services before, but now that I earn better, I don't want to wait, so I turn to private services...It's the attitude towards the client and better problem resolution in private healthcare. I had some unpleasant situations with the NHF. Not everything could be done during one visit, and they tried to impose additional examinations. I had the impression that they were trying to push additional things onto me."***
>
> - ***Polish woman without disabilities***

Regarding FP care specifically, many Polish women also faced deterrence or refusal to provide FP methods from healthcare providers. For some, these experiences of physicians denying care came firsthand, where they were not able to receive FP services because their physician exercised conscientious objection; several others had heard about experiences like this from members in their community. The ability of healthcare providers to decline to provide FP services sowed distrust of the public system among all Polish women who mentioned this as a barrier. In many of these instances, Polish women switched to private healthcare where they paid more for consultations but did not encounter this barrier.

> ***"In my personal opinion, it's challenging to have that trust...Because it's difficult to talk to an unfamiliar doctor since they may have a different view and could be against what I need. For example, if I go to him for "morning-after" pills or talk about abortion, and he opposes it, it's challenging to talk to such a doctor."***
>
> - ***Polish woman without disabilities***

Demand-Side Factors

Prioritization of Family Planning

In the FP barrier assessment, both Ukrainian Refugee and Polish women were asked about the importance of SRH services, and of FP services in particular.

Among Ukrainian refugees, nearly all respondents described SRH services as being important, citing the importance of annual exams, cancer screenings, or the need to manage specific reproductive health conditions. Notably, several Ukrainian women reported that they had deprioritized seeking routine SRH services after relocating to Poland, due to barriers in easily accessing care or other pressing concerns, such as children's emerging health issues.

Only some Ukrainian women expressed that access to FP was important to them, and that they had sought or were seeking FP services. However, half of the Ukrainian women in the sample reported that FP was not a priority, stating that their partners remained in Ukraine while they were living in Poland, or they were single with no current sexual partners.

> ***"We have many women here at my workplace and their husbands stayed in Ukraine, so I can feel that they miss their sex life. They sometimes want to go to the border to arrange a meeting, because they miss each other very much[.] But the men are at the front, [and] they don't get leave.[…]I know many friends who are at war now. There are very few women who have come to Poland with their men."***
>
> *- Ukrainian refugee women without disabilities*

Among Polish women, nearly all respondents described SRH as important; Polish women cited similar concerns to Ukrainian women, including the importance of annual exams, screening for reproductive cancers, and receiving care for existing conditions. Some Polish women also stated that FP was also not relevant for them as they did not have sexual partners or long-term relationships, and were not using FP.

In the qualitative interviews of the market assessment, both physicians and pharmacists perceived that Ukrainian refugee and Polish women had similar FP needs, though pregnancy services were the primary focus. Physicians and pharmacists stated that contraceptive use among Ukrainian refugees were low, which they attributed to a lack of need because they were traveling without their partners or perceptions that Ukrainian women were more accepting of pregnancy at a younger age compared to Polish women.

However, in the quantitative survey, 92 percent of physicians in Warsaw also reported they perceived an increase in Ukrainian patients requesting FP services. In eastern provinces, this was noted to a lesser extent, with 42 percent of doctors mentioning they had not noticed any change in demand for FP services.

Family Planning Knowledge

Knowledge of the Polish System

Several Ukrainian refugee women expressed knowledge gaps on accessing FP services and methods in Poland. When asked about how they would access FP methods, some stated that they had no idea on the matter. Others stated they were unsure and shared incorrect information—that they would go directly to the pharmacy, that they did not need a prescription, or that the NHF would reimburse the cost of their FP method.

Knowledge gaps on accessing FP in Poland were more common among Ukrainian refugee women who stated that they did not need any FP methods at the time. Several of these women shared incorrect pathways to accessing OCPs, said that they did not know how to access OCPs, or that they knew some methods required prescriptions and appointments with physicians but were not sure which ones. Some Ukrainian women who had no need for FP reported that they had never heard of ECPs; others had heard of it but were not clear on its use or how to obtain it.

By comparison, Ukrainian women who expressed a need for FP were more knowledgeable about FP. Nearly all the women in this group had heard of ECPs and some knew that ECPs would require an appointment with a physician and a prescription in Poland. However, there were a few Ukrainian women who reported needing FP methods, who were unsure of how to access ECPs in Poland or believed it could be obtained at a pharmacy without a prescription, again demonstrating gaps in knowledge on the Polish healthcare system.

Interestingly, several Polish women also mentioned knowledge gaps on accessing FP in Poland as a barrier. For some Polish women, these were barriers they faced themselves—not knowing the cost of FP methods or services, such as the costs of appointments in Poland. Other Polish women described knowledge gaps on accessing FP as a barrier to care for Polish society at large, created by the lack of education and, at times, dissemination of misinformation on FP topics.

Knowledge of Emergency Contraceptive Pills (ECPs)

During the qualitative interviews in the FP barrier assessment, both Ukrainian refugee and Polish women were asked about their knowledge on ECPs specifically.

Most Ukrainian refugee women had heard of ECPs, though only half of these women knew how to access them in Poland; the other half were mostly unsure of how to access ECPs in Poland. A few were confused about whether they were taken before or after intercourse or how long after intercourse they should be taken. For example, one Ukrainian woman expressed the belief that ECPs needed to be taken within 6-12 hours after intercourse to be effective. However, several Ukrainian refugee women had never heard of ECPs before the interview.

Most Polish women in the sample were knowledgeable or somewhat knowledgeable about ECPs. Nearly half of the Polish women reported that they knew about ECPs, how they worked, and how to access them in Poland. Many others had heard of ECPs but were either confused about how they worked as a contraceptive, had misinformation about how they were used, or were not sure how to access them. Only a small number of Polish women had never heard of ECPs and were not interested to learn more..

Myths and Misperceptions

Some Ukrainian refugee women shared misperceptions about SRH and FP services during their interviews. One respondent reported that she believed having more than one abortion could be life-threatening. Another expressed concern that the FP methods available in Poland differed significantly from those in Ukraine and should therefore be carefully considered. Others shared that they believed IUDs could only be used by people who had already given birth, and that hormonal contraception could damage organs or lead to the development of cancer.

Similarly, some Polish women expressed misperceptions about SRH and FP services. Like Ukrainian refugee women, a few believed IUDs were only for people who had already given birth. Others thought that OCPs could cause cancer or organ damage, or that ECPs were harmful for women.

Attitudes about Family Planning

Social Stigma

A few Ukrainian refugee women cited social stigma as a barrier to accessing FP. Ukrainian women felt, given Poland's restrictive abortion laws and strong religious influence, that Polish attitudes about FP created a barrier to access. A small number of Ukrainian women also discussed the potential embarrassment of purchasing or inquiring about FP as a barrier, which one woman felt was exacerbated by language barriers. A few other Ukrainian women mentioned that some religious and cultural barriers in Ukraine could also prevent women from accessing FP, depending on their family's views. Moreover, for Ukrainian women who reported during their interview that they did not need FP, social stigma was a commonly cited potential barrier, in particular.

Many Polish women also discussed how social stigma was or may be a barrier to accessing FP in Poland, particularly in rural communities. Some Polish women shared that small towns and villages tended to oppose contraception due to strong ties to religion. In addition, some women noted that clients seeking FP in rural regions may know the physicians or pharmacists they are consulting, which would decrease client anonymity and increase the chances of being stigmatized, given the size of these communities. One respondent shared an instance where someone they knew chose to seek FP services outside of their town to avoid stigma from their community, after experiencing judgement from a physician during a consultation. Several Polish women also expressed that sex, in general, was a taboo topic in Polish communities, making SRH and FP taboo by extension. This was despite the fact that many Polish women shared that they learned about SRH and FP in grade school; they reflected that these conversations were not taken seriously, and the quality of sexual education was subpar.

Preferred Methods of Contraception

A large majority of Ukrainian women reported that condoms were their preferred contraceptive method, due to its ubiquity, low price, and ability to be purchased without prescription. After condoms, many women cited OCPs and IUDs as preferred methods among themselves and their communities. The majority of Polish women also reported preferring condoms, citing similar reasons, followed by OCPs and IUDs. However, both Ukrainian and Polish women also mentioned that they hesitated to choose IUDs due to the high initial cost.

Both Ukrainian and Polish women mentioned hesitation or dislike for specific FP methods. Some stated they would not opt for hormonal contraceptives due to perceived side effects such as weight gain and disruptions to their hormonal cycle. A small number of Ukrainian and Polish women also discussed concerns about other methods, such as patches and spermicidal gels, which they regarded as less effective methods.

In the quantitative survey of the market assessment, physicians and pharmacists were asked about preferred FP methods among Ukrainian and Polish clients, including any differences between methods requested versus sold. From their perspective, preferences between the two populations were largely the same, with products most frequently asked about overlapping with those most often purchased. Physicians and pharmacists reported that OCPs and hormonal IUDs were the most preferred FP methods among the populations they served.

In qualitative interviews, physicians reported that COCs, and to a lesser extent, POPs, were very popular because of their ease of use, the ability to discontinue them easily, and their relative affordability as compared to other methods. Often used, but less popular, were IUDs. Physicians also stated that IUDs were recommended for older women who have already given birth and some adhered to the previously widespread belief that they should not be used by women who had never given birth. Others considered IUDs to be outdated. In some cases, the cost of an IUD was regarded as being comparable or cheaper than hormonal contraceptive pills over the same duration of use. However, no physicians mentioned that IUD insertion services are reimbursed by the NHF as a benefit for clients. According to physicians, IUDs were less popular among women due to the high initial cost and lack of flexibility in comparison to OCPs.

> ***"This is about the one-time large cost that the patient has to pay. Of course, I emphasize that on the scale of using a particular IUD, the annual cost of having it comes out lower or comparable to the pill."***
>
> \- ***Gynecologist from Warsaw***

Coping Mechanisms to Family Planning Barriers

Throughout the interviews, both Ukrainian refugee and Polish women discussed the various ways they circumvented barriers to FP and general healthcare. As mentioned, many Ukrainian refugee women stated that they used private care instead of public care in Poland in order to overcome wait times or issues with quality of care under the NHF. Private care in Poland was often timelier, and for some, higher quality care, compared to NHF, which was considered overburdened and under-resourced.

"I can say that everything was unclear. Where to go, what to do, long queues, unclear where to register. So when I first approached a gynecologist here, I found a private clinic where the doctor could communicate in English. That's why I found a private clinic because it was unclear how it works through the [NHF]"

- *Ukrainian refugee woman without disabilities*

"After a month, I was invited to the oncology center. I brought all my medical documents and tried to talk to the doctor. He didn't want to listen to me. He had one goal: to do a biopsy on me, but I know I don't need it. He said that I shouldn't argue with him and should do the biopsy. So I refused the biopsy. He was very dissatisfied. After that, I turned to a private doctor. I really liked him. He reviewed all my medical documentation from Ukraine and compared it with the examinations I underwent in Poland. He said that nothing had changed, and I had nothing to worry about. He reassured me, and I went home."

- *Ukrainian refugee woman with disabilities*

Findings from the assessment identified strategies that Ukrainian refugee women employed to access FP care that could put them at-risk. Many Ukrainian refugee women mentioned that they had returned to Ukraine or would return to Ukraine in order to avoid barriers in the Polish system to receive FP care or other general healthcare. Given the barriers to FP care and Poland's restrictive abortion laws, Ukrainian refugee women regarded FP in Ukraine as easier to navigate and more accessible, despite the ongoing war, and would pick up medications or schedule healthcare visits while they were returning for days at a time. A few Ukrainian women also mentioned bringing contraceptives, like OCPs or ECPs, with them during their relocation, or asking their friends to do so when they were relocating to Poland.

"Before arranging the supply from Ukraine, I checked if I could buy them at a pharmacy here. They told me they were by prescription, so I understood that I first needed to see a gynecologist. I just don't know if the gynecologist can prescribe them for an extended period, or if I'll have to see him more often... Before organizing their supply, I thought about how to buy them here. The system turned out to be more complicated, so we decided it was simpler to get them from Ukraine."

- *Ukrainian refugee woman without disabilities*

Many Polish women also expressed that they used private care to overcome wait times or issues with quality of care under the NHF. For Polish women, using private care to avoid public care was employed specifically with FP care to avoid repeating prior experiences with providers who would deter them from using or refuse to provide certain FP methods in the NHF, or negative perceptions gleaned from others who had such experiences. In some cases, Polish women, or others close to them, would schedule appointments under the NHF if they had time to wait, but for urgent appointments would select private care. Others did not select care under the NHF unilaterally, as they now had the means to afford private care and did not want to encounter any of the barriers associated with public healthcare. A few Polish women talked about accessing hormonal contraceptives or ECPs with physicians online through telemedicine. This option was especially favorable for one Polish woman who needed ECPs immediately but was not able to receive care because her clinic was not open on the weekend.

A small number of Polish women also mentioned strategies to access FP services that could put them at risk. One Polish woman shared in her interview that her friend had an at-home abortion, which resulted in severe complications.

Several Ukrainian women shared positive experiences with Polish healthcare. For general healthcare, these

experiences were often coupled with factors that circumvented the barriers described above: a few women discussed the ease of communicating with their provider because they had translators during their visit or were able to see Ukrainian- or Russian-speaking physicians; another woman shared that, though the queue was long for public healthcare, the quality of care she received was satisfactory. With regard to FP, the quality of care was also not diminished by the barriers they experienced, where some participants rated it as comparable to, or in one case, better than Ukraine's, without specific reference to public or private care.

Despite the barriers to quality care, a majority of Polish women also shared positive care experiences in their interviews. Roughly half of them attributed their positive experience to the quality of private care or to recommendations they received about physicians in the public system. A handful of these stories were tied to previous experiences of poor-quality care in the public system, and thus adding to the number of examples where clients used private care to avoid barriers and negative experiences in the public system.

Cash and Voucher Assistance for Family Planning

One objective of this assessment and the findings therein were to inform the design, coordination, and funding of future CVA programming for FP service provision in the refugee response in Poland. In both the market and FP barrier assessments, respondents were asked about the utility and potential design of a CVA intervention to improve access to FP in Poland for both Ukrainian refugee and Polish communities. In addition, Ukrainian refugee and Polish women were asked about aspects of their finances, such as access to financial institutions, financial challenges, and household decision- making processes, which could be used to better inform the design of a future CVA for FP program. The findings on these topics are collated in the section below.

Access to Financial Institutions and Financial Challenges

In Poland, Ukrainian refugees are granted Universal Electronic Population Registration System (PESEL) identification numbers when they register for refugee, or "UKR," status. Under the PESEL system, Polish citizens and Ukrainian refugees are treated as equals in every way. As a result, the Polish government provides Ukrainian refugees equal access to social assistance as Polish citizens. On arrival in Poland, Ukrainian refugees with "UKR" status are entitled to a one-time cash transfer of 300 PLN ($70.95). They can also apply for other benefits available to Polish citizens, including an additional 800 PLN ($197.54) per month for each child, childbirth benefits (one-time payment of 1,000 PLN, or $236.50), family benefits, disability benefits, or subsidies for a child's stay in a daycare center.

During the interviews, Ukrainian refugee women were asked about their access to financial institutions as well as financial challenges they faced in Poland. Several mentioned that, with their documentation, they and others in their community were able to open bank accounts in Poland. However, many expressed difficulties with and confusion about banking in Poland; several women stated that individuals with "UKR" status were unable to secure loans at all through their bank in Poland, because they did not have a residence card, which is a requirement for loan eligibility. However, one woman mentioned that, in applying for a residence card in Poland, she feared lost access to benefits that she received under her "UKR" status due to a lapse in renewal but did not know if she would still receive those benefits as a resident.

> ***"Recently, we have had a bit of a turbulence in this benefit [under our UKR status]. I was applying to get a residence permit. And I didn't know that a new application was required [to reinstate the UKR benefit]. I lost the UKR status in November. So I haven't received the benefit since November and I'm not sure if the money is going to be lost or not. Because I now have the residence permit."***
>
> *- Ukrainian refugee woman without disabilities*

Other Ukrainian refugee women also expressed difficulties in navigating the Polish welfare benefits system. A few shared that they were not sure what benefits were available under the "UKR" status. Two Ukrainian refugee

women mentioned difficulties in understanding Polish disability benefits. For one, her chronic health condition qualified her for disability status in Ukraine; however, this designation was not recognized in Poland and her application for disability status was denied twice, although she was unclear as to why. For another, her child is disabled and despite being able to secure their disability status in Poland, she was not able to receive financial assistance for her child because of how the paperwork was submitted. This lack of financial knowledge among Ukrainian refugees in Poland impacted clients' abilities to access necessary and available financial support.

Some Ukrainian refugee women mentioned that their salaries were much lower since moving to Poland, with a small number of respondents expressing that they were underemployed in Poland, meaning that they were not working in positions that used their full skillset. For example, one woman shared that she was working as an assistant in a kindergarten in Poland, but in Ukraine, she was an engineer. She was not able to work as an engineer in Poland because she could not afford the fee to have her diploma validated. Several Ukrainian refugee women described experiences in which they attempted to register to receive financial assistance, either through state assistance or programs or via international organizations, but were not able to do so. In some cases, the respondent's income was too high to qualify; in other cases, respondents did not know why they did not qualify.

Household Decision-Making about Finances

When designing CVA interventions, it is best practice to evaluate financial decision-making dynamics within households to gauge any risks in providing assistance. Both Ukrainian and Polish women were asked about the dynamics of decision-making, especially for expenditures related to women's health and FP in their household or among households in their community.

Most Ukrainian refugee women stated that they typically made decisions on FP alone, whether partnered or not partnered. The remainder stated it was a joint decision between them and their partner. Only one woman mentioned that her boyfriend typically takes care of decisions on purchasing contraceptives, because they use condoms, which he would purchase. Nearly all Ukrainian women said that the dynamics of decision-making were not particularly divided by gender but rather informed by the preferences of the couple or the family.

Many Polish women reported that they made decisions about women's health and FP alone, whether they were with partners or without, as well. Some Polish women mentioned that these decisions are made jointly between them and their partners. Only two women stated that their partner handles purchasing decisions on FP, because their preferred FP method was condoms, which their partner would purchase.

Designing Cash and Voucher Assistance for Family Planning: Provider Perspective

As part of the market assessment, quantitative and qualitative data collection with physicians, pharmacists, manufacturers and distributors of FP products, and NGO representatives included questions on the feasibility of delivering CVA for FP in Poland. Across these stakeholder groups, respondents were generally supportive about the potential to deliver CVA for FP programming in Poland.

FP method manufacturers and distributers described the Polish contraceptive market as competitive (47%), restricted by legislation (37%), and priced inappropriately (16%) overall. Suggestions for improvement included changes in existing laws, specifically the "conscience clause" and the requirement for prescriptions, major changes in government policy to permit broader reimbursement for contraception, and education and outreach activities.

In the quantitative assessment, over 80 percent of NGO representatives surveyed agreed that CVA could assist in accessing FP, given its use by various organizations to support refugees and people in need, including United Nations and other specialized agencies. In qualitative interviews, many doctors and pharmacists felt that if assistance was provided for FP, it should be targeted to those with lower socio-economic status and should extend beyond Ukrainian refugees to Polish women.

Designing Cash and Voucher Assistance for Family Planning: Client Perspectives

During qualitative interviews, Ukrainian refugee women were asked if they had experience receiving CVA of any kind in Poland. Nearly all Ukrainian women reported that they had received some form of CVA after arriving in Poland. A number of organizations were cited as providing assistance, including the UN, the Red Cross, Help for Ukraine, and Caritas Poland. The type and amount of CVA received varied based on the purpose of the assistance, ranging from vouchers to one-time payments of 100 PLN ($25 USD) to monthly payments of 800 PLN ($202 USD). Women in the sample used their assistance to cover a myriad of necessities: rent, groceries, vaccines, medications, and children's glasses. When queried as to whether the amount of cash assistance they received was adequate to cover basic needs, responses varied—likely reflecting the variation in the amount of money different respondents received.

A small number of Ukrainian refugee women encountered barriers to receiving CVA, however. One woman shared an experience where her friend was notified that there would be some assistance distribution, but when she arrived, she was told that she did not qualify for support as there were others who had greater need. This experience led her friend to stop seeking assistance all together as she felt "stupid" for requesting aid.

Ukrainian and Polish women were asked about their perspectives on whether CVA could be used to improve their access to SRH services in Poland. Both Ukrainian and Polish women agreed that CVA could support women to access SRH services, including FP. Notably, twice as many Polish women as Ukrainian women stated that they would benefit from CVA for FP services specifically. Several Polish women advocated that this support be available to vulnerable populations, such as adolescent girls, women in abusive partnerships, and those who are low-income.

Preferred Methods for Delivering CVA

Women in the sample were also asked about their preferred methods of receiving CVA. Most Ukrainian refugee women mentioned that payments by card are most convenient for their lifestyles and that cash transfers to a debit card would be suitable to receive CVA. One woman shared a negative experience using cards, however; while using a card to pay for items, she was unable to use the funds in their entirety because the card had a minimum balance that needed to be maintained in order to make payments.

BLIK[38] was another popular method of receiving assistance among Ukrainians. Many Ukrainian women reported having received assistance through BLIK before. However, a few women did mention difficulties in using mobile transfers for CVA. For one woman, the payment was delayed for several days; another did not receive the payment at all. One woman stated that BLIK was not a preferred method because she did not have a Polish bank account or bank card.

Some Ukrainian refugee women recommended vouchers or in-kind assistance to ensure funds would be used for FP. Others noted that providing vouchers for specific facilities or providers could help Ukrainian women more easily navigate the health system. Conversely, several women mentioned that they would prefer to choose their own physician.

Ukrainian women in the sample were very mixed on if they preferred to receive cash. For some, cash was a safe and common method of CVA. There was little to no risk in carrying large amounts in Poland and sometimes, having cash on hand was a necessity. For others, cash posed some risk or inconvenience; some women in the sample were not comfortable in carrying cash, felt that it was difficult to pay with, or that it was hard to keep track of.

For Polish women in the sample, the preferred methods of CVA differed slightly from those of Ukrainian women. Cards were a common method of payment in everyday life, and therefore many respondents recommended using cards to provide CVA. Several Polish women recommended that CVA should be provided through vouchers or e-vouchers to ensure that the assistance was not misused outside of its intended purpose. Reimbursements for FP or in-kind assistance were also popular recommendations. Similar to Ukrainian women,

[38] BLIK is a payment system in Poland that allows users to make instant payments and withdraw cash using only the user's standard mobile banking app.

there were many mixed opinions on cash as a method of support, given factors related to safety and convenience.

Recommendations for CVA for FP programming

Ukrainian and Polish women shared a variety of perspectives and recommendations for how CVA for FP programming should be designed to meet their SRH needs and priorities, and promote access to and uptake of FP.

Most Ukrainian refugee women not only wanted education on FP methods but also information on how to navigate the Polish healthcare and benefits system, in conjunction with CVA for FP. A few mentioned that CVA for FP could be coupled with organized groups to visit a healthcare facility and receive care. Some Ukrainian refugee women suggested online or digital engagement to share information about FP as well.

> ***"I think [informational sessions on FP] wouldn't be very useful because this is a kind of thing that requires time. And people who are traumatized find it hard to absorb such information...I think it would be more helpful to have information videos or billboards rather than gatherings of people to listen to a lecture."***
>
> - ***Ukrainian refugee woman without disabilities***

Nearly all Polish women recommended that a CVA for FP intervention be coupled with education on FP and sexual and reproductive health and rights (SRHR), overall. Many Polish women strongly recommended education campaigns to combat myths and misperceptions in Polish society about FP and sex; they felt that CVA alone would not be enough to deter unwanted pregnancies. Some Polish women recommended workshops, either online or with an organization in Poland. Others recommended spaces for free one-on-one counselling with trusted sources to learn more about FP and SRHR in a private setting, given how taboo this topic can be for some in Polish society.

> ***"Especially since sexual education in Poland is hopeless and lousy, especially in smaller towns and villages. If contraception was available for a very small fee or was completely subsidized, then I think it would make things easier for many women. We wouldn't have unwanted children. I think such a subsidy would be positive, but it has to go with sexual education."***
>
> - ***Polish woman without disabilities***

Ukrainian refugee and Polish women were also asked their sources of FP information and the best ways to reach their communities for this type of programming. Many Ukrainian refugee women expressed that the best way to reach the Ukrainian refugee community about FP was on social media or messaging apps, such as Facebook, WhatsApp, Viber, and Telegram. Through groups on social media, Ukrainian refugee women were sourcing information not only about how to navigate living in Poland in general, but also healthcare, specifically. Several women mentioned that they research independently online, and therefore a website would be best. Others recommended that information on this topic should be shared via physicians or NGOs.

Most Polish women in the sample stated that they typically found information about FP from researching online, through social media, or speaking with physicians. Several mentioned examples of organizations that had done outreach campaigns to disseminate information on contraception.

Discussion

In this assessment, the Global Public Health in Emergencies Branch of the CDC, CARE International, CARE Poland, WRC, and Federa undertook a mixed methods study to identify and understand the FP needs of Ukrainian refugee women in Poland, assess the availability and accessibility of FP services, and explore the feasibility of using CVA to support access to FP as part of the ongoing refugee response in Poland. Across the assessment, findings indicate that while FP services are generally available, they may not be easily accessible, with both Ukrainian and Polish women facing a range of barriers to accessing services. In discussing the potential of CVA interventions, respondents in the assessment supported CVA for FP programming as a strategy to alleviate these barriers and improve access to FP in Poland.

The findings from clients, providers, and desk reviews demonstrate that FP methods are widely available and that the market has remained stable despite the ongoing war in Ukraine. However, mixed interpretations among providers about appointment and testing requirements for FP methods limit full access to FP for many.

Physicians generally felt that wait times for NHF appointments were manageable, especially for those who could take advantage of walk-in appointments. However, not all FP clients have the time and resources that allow them to take advantage of walk-in appointments, and not all clients may be aware of the availability of walk-in appointments. Additionally, when compared with data on the availability of appointments through the NHF patient portal—wait times to obtain appointments were generally longer than estimated by providers, particularly in Przemyśl, Rzeszów, and Lublin. Similarly, there was variation in the cost of FP services, including consultations and testing, among physicians. Physicians acknowledged that the costs associated with services could be prohibitive, particularly as the NHF does not cover the cost of FP services or supplies, with the exception of several brands of OCPs.

Assessment data indicates that provider knowledge, attitudes, and practices significantly affected the availability and accessibility of FP services. Clients were required to consult a physician in order to receive a prescription, but the number of appointments a client is required to attend ranged from one to three, depending on the method and individual provider preferences. Urban and rural providers were inconsistent in their requirements for the number of visits; the examinations, testing, and number of visits required, as described, were not consistent with WHO guidelines on FP service delivery.[39] Barriers to services, including costs, compound with each additional appointment required. Additionally, physicians in Poland can exercise conscientious objection, and decline to provide FP services. Providers in Przemyśl, Rzeszów, and Lublin generally required more appointments before providing a prescription than providers in Warsaw, indicating that barriers for FP clients may be amplified in rural areas.

When asked to discuss their experience providing services to diverse clients, including adolescents, people with disabilities, people with diverse SOGIESC, and members of the Roma community, providers generally acknowledged that these clients face unique and heightened barriers to FP services. Adolescents in Poland are required to have a caregiver present when receiving health services, which can be particularly limiting for SRH services, and providers expressed that there was a lack of comprehensive sexual education for adolescents. For Ukrainian adolescents living in Poland, what limited sexual education may be available in school is further hindered by barriers to enrolling in Polish schools and continuing in-person education.[40]

Notably, there were discrepancies between quantitative and qualitative data from providers about the accessibility of services for people with disabilities. Despite nearly all physicians from Warsaw, and 75 percent of physicians in Przemyśl, Rzeszów, and Lublin surveyed in the quantitative assessment reporting that there were no barriers to care for clients with disabilities in their practice, qualitative data revealed that clients with

[39] WHO. 2016. Selected practice recommendations for contraceptive use, Third edition 2016, https://www.who.int/publications/i/item/9789241565400

40 CARE International, International Rescue Committee, Save the Children Poland, and Triangle. "Out of School: Assessment on Barriers to School Enrollment for Ukrainian Refugee Adolescents in Poland," 2024. https://www.care.org/wp-content/uploads/2024/02/Out-of-School-Report_en-1.pdf.

disabilities encounter inaccessible facilities, and biases and negative attitudes from providers.

FP clients with disabilities should receive client-centered, rights-based counselling that supports volunteerism and client choice when selecting an FP method. The provider statements from the qualitative interviews highlight biases that potentially impact the quality of FP services that individuals with disabilities in Poland receive. Additionally, the data from the quantitative survey suggest gaps in providers' knowledge about barriers that clients with disabilities face when accessing care in Poland. Given that clients with disabilities face issues with accessibility and quality of care worldwide, it is unlikely that there are no barriers to care for clients with disabilities in Poland. Failure to recognize healthcare barriers for clients with disabilities may impede physicians and pharmacists from providing equitable care for this client population.

Providers described limited experiences providing care to people with diverse SOGIESC, and members of the Roma community. One physician interviewed expressed biases and negative attitudes towards members of the Roma community—although the majority of respondents did not report having experience providing care to members of the Roma community. However, survey data from providers reported that members of the Roma community faced linguistic, cultural, and financial barriers to SRH services.

Physicians and pharmacists expressed that refugees had access to health services, including FP, equal to Polish citizens. Although respondents acknowledged that refugees might face some barriers—for example, language barriers—most felt that refugees were able to manage. However, provider perceptions did not align with the personal experiences of many Ukrainian refugee women.

Both Ukrainian and Polish women perceived significant barriers to accessing FP services, citing the need for appointments and prescriptions. Ukrainian women reported that FP and SRH services were much more accessible in Ukraine, and both Ukrainian and Polish women discussed abortion restrictions in Poland as a barrier to SRH services, including FP. Notably, numerous Polish women described experiences in which providers discouraged them from seeking FP, or in which they were denied FP—in clear contrast to providers' perception that the conscientious objection clause was not a notable barrier.

Both Ukrainian and Polish women discussed concerns about the quality of care provided by the NHF, including for FP, with Ukrainian women largely expressing that they felt the quality of care they received in Ukraine was better than that in Poland. Ukrainian women also described the NHF as being challenging to navigate, citing lack of clarity as to whether services were under public or private care, difficulty obtaining appointments, long wait times, challenges obtaining referrals for specialized care, and language barriers. Among both Ukrainian and Polish respondents, some reported that they did not know how to access FP services or were unsure as to whether appointments and prescriptions were required. Again, women's self-reported experiences contrasted with doctors' perceptions that it was relatively straightforward to schedule timely appointments, that refugees were able to navigate the health system, and that language barriers were not a significant challenge for refugees.

Both Ukrainian and Polish women discussed cost as being a barrier to FP, including the cost of FP methods under the NHF, and the cost of services under private care. Findings from the market assessment show that the cost of FP methods could range from 17 PLN ($4 USD) a month for POPs up to a one-time payment of 600 PLN ($141 USD) for IUDs. For private care services, the cost of an FP consultation was 200 to 250 PLN on average, and the cost of testing to obtain an FP method was 40 to 240 PLN ($10 to $60 USD) on average, depending on the number and types of tests needed for a specific FP method. Overall, FP services under private care could cost up to 490 PLN ($126 USD), excluding the cost of the FP method.

The cost for FP methods or private care services came in addition to the associated costs of transportation and childcare, particularly if multiple appointments were required. It is likely that these barriers would be amplified in rural areas, where providers may require more appointments, and where facilities and pharmacies may be farther away.

To address the challenges to obtaining FP in Poland, Ukrainian women and Polish women discussed a range of

strategies to access FP. Both Ukrainian and Polish women discussed seeking private services, despite the cost; Polish women were particularly likely to discuss seeking private services to mitigate barriers posed by provider practices, like requiring multiple appointments or conscientious objection, and to ensure they received a higher quality of care. Several Ukrainian women reported bringing FP methods, including ECPs, with them from Ukraine when going to Poland, or returning to Ukraine to obtain FP methods and SRH services, where they felt it was more accessible. Like Ukrainian women, Polish women also considered accessing abortion outside of Poland, if necessary.

Although Ukrainian refugee women and Polish women expressed that accessing SRH services is a priority for them, several Ukrainian women reported that they had deprioritized seeking SRH services due to barriers to care. Notably, half of Ukrainian respondents expressed that FP was not a priority, largely because they were separated from their partner as a result of the conflict.

Cash and Voucher Assistance for Family Planning in Poland

Despite the lower demand for FP among some Ukrainian refugee women, respondents in this assessment felt that FP services and methods could be more accessible in Poland. Across providers, NGO representatives, and Ukrainian and Polish women, there was consensus that a CVA intervention could address some of these barriers and promote access to and uptake of FP services in Poland.

Findings from the assessment reinforce that Ukrainian refugee women—and Polish women—face barriers to accessing FP, and SRH services more broadly. Respondents consistently discussed the costs of seeking services as a key challenge, including the cost of appointments, especially under private care, and obtaining a method, which is not reimbursed by NHF, as well as attendant expenses for transportation and childcare. These challenges may be particularly acute in rural areas and are compounded for refugee women who may be unemployed or underemployed. Moreover, refugee women discussed challenges registering for humanitarian assistance, and the overall availability of assistance for Ukrainian refugees is waning as the conflict persists.

CVA for FP interventions has the potential to address these barriers to FP facing both Ukrainian refugees and Polish communities. Data from the market assessment indicates that the FP market in Poland can absorb the increased demand for FP services and products.

Both Ukrainian and Polish women expressed that a CVA program should address women's SRH needs more broadly, allowing women to prioritize services—including FP—to meet their needs. Similarly, both Ukrainian and Polish women emphasized that it would be important for CVA for FP programming to include activities to promote accurate SRH knowledge and address myths and misperceptions, with many respondents expressing that the availability of SRH information was limited in Poland.

Due to the limitations of the sample, this assessment does not sufficiently investigate the barriers to FP specific to diverse communities, such as adolescent girls, people with diverse SOGIESC, and members of the Roma community. More research is needed to identify and understand these barriers and future CVA for FP interventions should be designed to address the unique needs of diverse communities in Poland.

Challenges and Limitations

For both the market assessment and the FP barrier assessment, the project team faced challenges in data collection and struggled to reach target numbers for the sample.

The market assessment used a purposive sampling method to recruit participants for interviews. A stakeholder mapping was conducted to identify the diversity of actors needed for the market assessment in only two cities, Warsaw and Przemyśl. However, during data collection, there was significant difficulty in recruiting gynecologists and pharmacists as many declined to participate. The project team was unable to meet the target number of participants after reaching out to nearly all of the gynecologists and pharmacists located in Przemyśl. As a result, the sample criteria expanded to include participants from Lublin and Rzeszów as part of

the sample.

For the barrier assessment, the target sample was 60 participants. However, the final analytical sample only included 48 participant interviews. Respondents aged 18–25 were under-represented for both Ukrainian and Polish communities, which could be attributed to the social stigmas and overall reticence to discuss FP or topics related to sex for both Ukrainian and Polish women. Therefore, the barriers to FP for younger women cannot be discussed effectively within this assessment, as they likely had different experiences and perspectives from the older women represented in this sample. Similarly, no respondents in the sample were under 18, which limits the analysis in discussing barriers for adolescent girls. Additionally, some interviews were removed from the analysis due to the quality of the data collected or poor translations from Polish or Ukrainian to English, which was done for the analysis process. Some interviews were also removed from the analysis, as it was determined that some respondents did not meet the sampling criteria based on the meta-data collected.

Conclusion

FP is an essential component of primary health care, and good quality services, including the full range of methods, should be available and accessible—including for communities affected by displacement and crises. During armed conflict, provision of FP services and methods may be limited and uneven, resulting in unmet SRH needs for displaced communities. Since the Russian military offensive began in 2022, millions of Ukrainians have been seeking temporary protection in Poland. Poland has one of the most restrictive policy environments for SRHR in Europe. Access to FP services and methods differs substantially between Poland and Ukraine. As Ukrainians continue to relocate to Poland, it is imperative to ensure their access to FP services and methods and prior evidence indicates that CVA intervention may support FP uptake for displaced communities.

To inform future CVA for FP programming in Poland, this assessment explored the availability, accessibility and quality of service and methods in the FP market as well as barriers that Ukrainian refugee and Polish host community women encountered when seeking FP in Poland. Findings from this assessment demonstrated that, although the availability of FP methods remains stable despite the ongoing war in Ukraine, both Ukrainian refugee and Polish women experience many barriers to access and quality of FP services and methods. Low availability for appointments leading to lengthy wait times, poor quality of care, and lack of reimbursement of FP supplies significantly diminished access to FP under Poland's public health care system. These barriers were compounded by others unique to Ukrainian refugees, such as language barriers, lack of knowledge on navigating the Polish system, and financial challenges. For Polish women, social stigma and knowledge gaps limit demand for FP. Moreover, findings from the market assessment also showed that physicians and pharmacists providing FP services and methods in Poland were largely unaware of the barriers to access and quality faced by FP clients, suggesting additional barriers related to quality of care.

Ukrainian refugee and Polish women used services outside of Polish public care to circumvent these barriers and access good quality FP services and methods. Clients turned to private care, which had higher quality of services and more appointment availability than public care. However, the associated costs of private care placed additional financial burden on both Ukrainian refugee and Polish women when accessing FP. Many Ukrainian refugee women felt that FP was more accessible in Ukraine than under public or private care in Poland, and several women sourced FP methods from Ukraine, either returning to the country to receive services or requesting community members to bring methods for them in transit to Poland. These strategies undertaken by Ukrainian refugee and Polish women to access FP further underscored the salience of the barriers to FP care in Poland.

The findings from this assessment not only identified the challenges of seeking FP care in Poland; they also elucidated how a CVA for FP intervention could address these barriers to care and support uptake of FP. CVA for

FP programming could allow Ukrainian and Polish women to purchase longer-acting methods, which were costlier than preferred short-acting methods like condoms, or to seek private care to access good quality services in a timely fashion. With dedicated CVA for FP, Ukrainian refugee women could also be encouraged to prioritize their SRH and FP needs by alleviating the burden of costs during this period of financial strain. CVA could allow Ukrainian women who source FP methods from Ukraine to transition to more sustainable pathways of FP access in Poland.

Both clients and providers supported the idea of CVA for FP, especially for Ukrainian refugees, and low-income Polish women. Ukrainian refugee and Polish women also recommended that CVA should be provided alongside informational campaigns on SRHR, and FP specifically, to fill knowledge gaps on FP methods and accessing FP in Poland. Future CVA for FP programming in Poland should consider the findings in this report to inform program design and adequately address the FP needs of Ukrainian refugee and Polish host communities. However, more research is needed to better understand FP needs and barriers of diverse communities that should be included in CVA for FP programming, such as adolescent girls, people with diverse SOGIESC, and members of the Roma community.

For Ukrainian refugee and Polish women, the barriers identified in this report are significant deterrents to accessing and using FP services and methods in Poland. To ensure access to quality FP services that meet SRH needs, it is imperative to address these barriers, especially as the conflict in Ukraine continues. With the findings from this assessment, CVA for FP programming may be a promising path forward to increase uptake of FP in Poland and improve SRH outcomes for both Ukrainian refugee and host communities in Poland.

Want to learn more? In May 2024, the project team held an action planning workshop in Warsaw, Poland with SRHR and CVA stakeholders to discuss the initial results of the study and identify factors that facilitate and hinder access to FP in Poland. Read the **recommendations and next steps** developed in the workshop in our **learning brief**.

Acronyms and Abbreviations

COC	Combined oral contraceptive pills
CVA	Cash and voucher assistance
ECP	Emergency contraceptive pills
FP	Family Planning
IUD	Intrauterine device
NGO	Nongovernmental organization
OCP	Oral contraceptive pills
PLN	Polish złoty
POP	Progestin-only pills
SOGIESC	Sexual orientation, gender identity and expression, and sex characteristics
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
USD	United States dollar

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Annexes

Annex 1: Availability and Cost of Services - Data from Desk Review

As part of the market assessment, online research was conducted on September 21, 2023 to gauge the availability of and cost of FP services in Warsaw and Przemyśl through the NHF and private care patient portals. Availability under public healthcare was estimated by the availability and cost of care listed on the NHF patient portal, https://pacjent.gov.pl/, which provides information on available appointments at NHF clinics. The availability and cost of FP services under private care was estimated using similar information listed on the national private care website, ZnanyLekarz, znanylekarz.pl. Data was collected for availability and cost of FP services in both Warsaw and Przemyśl, as presented below in Tables 1 and 2, respectively.

Table 1. Availability of Services in Warsaw

	Number of clinics with available appointments in 7 days	Number of clinics with available appointments in next 14 days	Number of clinics with available appointments in next 21 days	Number of clinics with available appointments in next 28 days	The cheapest service available*	The average price*
NHF Gynecology Appointment	0	3	2	8	Free of charge	Free of charge
Private Care Gynecology Appointment	>100	>100	>100	>100	170 PLN ($39.16 USD)	245.66 PLN ($56.59 USD)
Private Care Telemedicine Appointment	>100	>100	>100	>100	90 PLN ($20.73 USD)	178.80 PLN ($41.19 USD)
Private Care Pap Smear Appointment	>100	>100	>100	>100	50 PLN ($11.52 USD)	85.83 PLN USD 19.77
Private Care Emergency contraception (Same-day) Appointment	32	-	-	-	150 PLN ($34.56 USD)	258.42 PLN ($59.53 USD)

Note: * These prices were calculated based on the first 42 search results available.

Table 2. Availability of Services in Przemyśl

	Number of clinics with available appointments in 7 days	Number of clinics with available appointments in next 14 days	Number of clinics with available appointments in next 21 days	Number of clinics with available appointments in next 28 days	The cheapest service available*	The average price*
NHF Gynecology Appointment	0	0	0	0	Free of charge	Free of charge
Private Care Gynecology Appointment	No data in internet sources	No data in internet sources	No data in internet sources	No data in internet sources	170 PLN ($39.16 USD)	204.83 PLN ($47.19 USD)
Private Care Telemedicine Appointment	No data in internet sources	No data in internet sources	No data in internet sources	No data in internet sources	150 PLN ($34.56 USD)	160 PLN ($36.86 USD)
Private Care Pap Smear Appointment	No data in internet sources	No data in internet sources	No data in internet sources	No data in internet sources	30 PLN ($6.91 USD)	40 PLN ($9.21 USD)
Private Care Emergency contraception (Same-day) Appointment	1	-	-	-	50 PLN ($11.52 USD)	50 PLN ($11.52 USD)

Note: * These prices were calculated based on the first 42 search results available.

Annex 2: Availability of Contraceptive Methods

The data here were collected from a desk review of publicly available websites conducted on May 29, 2023. Information on product availability was drawn from https://www.gdziepolek.pl/, which contains data from 13,336 pharmacies in Poland, including 874 pharmacies in Warsaw and 27 in Przemyśl. Column "Availability in the country" reflects the percentage of pharmacies that carried the product nationally. Columns "Przemyśl" and "Warsaw" reflect the number of pharmacies in Warsaw and Przemyśl that listed online that they carried the product.

Copper IUDs

Given the low availability in pharmacies, it is likely that clients purchased copper IUDs from online sources.

	Product name	Availability in the country	Przemyśl – Number of pharmacies	Warsaw – Number of pharmacies
1.	Copper TCu 380A			
2.	Meringer UT380™			
3.	Nova T 380 Cu380Ag	1%	0	6

Hormonal IUDs

	Product name	Availability in the country	Przemyśl – Number of pharmacies	Warsaw – Number of pharmacies
1.	Jaydess	not available		
2.	Kyleena	14%	0	40
3.	Levosert	5%	0	6
4.	Levosert Easy	not available		
5.	Mirena	26%	2	54

Implants

	Product name	Availability in the country	Przemyśl – Number of pharmacies	Warsaw – Number of pharmacies
1.	Implanon NXT	2%	0	2 pharmacies

Injections

	Product name	Availability in the country	Przemyśl – Number of pharmacies	Warsaw – Number of pharmacies
1.	Depo-Provera	29%	1	45

Vaginal rings

	Product name	Availability in the country	Przemyśl – Number of pharmacies	Warsaw – Number of pharmacies
1.	Adaring	34%	0	82
2.	Circlet	not available		
3.	Contraseton	not available		
4.	Ginoring	38%	0	>100
5.	Mirgi	1%	0	0
6.	NuvaRing	52%	2	>100
7.	PolaRing	26%	1	63

Contraceptive patches

	Product name	Availability in the country	Przemyśl – Number of pharmacies	Warsaw – Number of pharmacies
1.	Evra	88%	3	>100

Combined oral contraceptive pills

Partially reimbursed by the NHF

	Product name	Availability in the country	Przemyśl – Number of pharmacies	Warsaw – Number of pharmacies
1.	Levomine	24%	0	24
2.	Microgynon 21	1%	0	1
3.	Rigevidon	75%	2	>100
4.	Stediril 30	25%	2	28

Not reimbursed by the NHF

	Product name	Availability in the country	Przemyśl – Number of pharmacies	Warsaw – Number of pharmacies
1.	Aidee	51%	0	95
2.	Angiletta	0	0	0
3.	Artilla	23%	0	37

4.	Astha	2%	0	9
5.	Asubtela	29%	0	83
6.	Ativia	61%	3	>100
7.	Atywia Daily	58%	2	>100
8.	Axia	55%	2	>100
9.	Axia Conti	64%	1	>100
10.	Axia Forte	37%	1	76
11.	Axia Forte Plus	23%	0	61
12.	Axia Plus	26%	0	58
13.	Belara	89%	3	>100
14.	Belara CONTI	not available		
15.	Bonadea	40%	2	83
16.	Clormetin	not available		
17.	Daylette	60%	1	>100
18.	Dessette	not available		
19.	Dessette Forte	not available		
20.	Dionelle	31%	0	89
21.	Dorin	20%	1	67
22.	Drosfemine	10%	1	22
23.	Drosfemine forte	10%	0	16
24.	Drosfemine mini	10%	0	20
25.	Drovelis	81%	2	>100
26.	Elin	35%	2	65
27.	Estmar	not available		
28.	Femoden	20%	0	58

29.	Harmonet	49%	2	>100
30.	Hastina 21	14%	0	50
31.	Hastina 21+7	12%	1	51
32.	Hastina 24+4	19%	0	74
33.	Jeanine	62%	1	>100
34.	Kontracept	43%	1	>100
35.	Lesine	25%	0	44
36.	Lesinelle	36%	0	77
37.	Lesiplus	27%	1	59
38.	Leverette	31%	1	76
39.	Levomine mini	18%	0	37
40.	Liberelle	35%	2	73
41.	Lindynette	not available		
42.	Logest	38%	2	>100
43.	Lydisilka	not available		
44.	Madinette	35%	2	94
45.	Marvelon	36%	1	94
46.	Mercilon	40%	1	>100
47.	Midiana	38%	2	87
48.	Milvane	0%	0	0
49.	Mywy	44%	2	81
50.	Naraya	42%	1	>100
51.	Naraya Flex	not available		
52.	Naraya Plus	42%	2	>100
53.	Nobabelle	not available		

54.	Nobabelle Daily	not available		
55.	Novynette	80%	2	>100
56.	Orlifique	63%	2	>100
57.	Ovulastan	14%	1	55
58.	Ovulastan Forte	9%	0	29
59.	Qlaira	89%	2	>100
60.	Regulon	57%	0	>100
61.	Seasonique	16%	0	37
62.	Sibilla	not available		
63.	Sidretella 20	51%	2	>100
64.	Sidretella 30	45%	2	86
65.	Sylvie 20	45%	2	92
66.	Sylvie 30	40%	2	80
67.	Symbella	7%	0	10
68.	Teenia	12%	1	37
69.	Varel	not available		
70.	Varenelle	Internet	0	1
71.	Velbienne mini	31%	0	89
72.	Vibin	70%	3	>100
73.	Vibin mini	70%	2	>100
74.	Vines	86%	1	>100
75.	Vixpo	53%	2	>100
76.	Yasmin	77%	2	>100
77.	Yasminelle	78%	2	>100
78.	Yaz	76%	2	>100

79.	Zoely	29%	1	>100

Progestin-only oral contraceptive pills

	Product name	Availability in the country	Przemyśl – Number of pharmacies	Warsaw – Number of pharmacies
1.	Azalea	26%	0	62
2.	Cerazette	62%	2	>100
3.	Desirette	not available		
4.	Dessette mono	16%	1	15
5.	Lemena	9%	0	26
6.	Limetic	85%	2	>100
7.	Ovulan	17%	1	54
8.	Symonette	19%	1	26
9.	Slinda	68%	2	>100

Emergency contraceptive pills

	Product name	Availability in the country	Przemyśl – Number of pharmacies	Warsaw – Number of pharmacies
1.	Eginilla	not available		
2.	ellaOne	77%	2	>100
3.	Misstala	not available		
4.	Ulipristal Aristo	not available		
5.	Escapelle	76%	2	>100
6.	Halyone	not available		
7.	Livopill	28%	2	60
8.	Ramonna	not available	0	0