



Stigma toward persons with disabilities and survivors of explosive ordnance (EO) in Ukraine

November 2025





Abbreviations

CRPD	Convention on the Rights of Persons with Disabilities
ECHR	European Convention on Human Rights
EO	Explosive Ordnance
EO survivors	Survivors of explosive ordnance incidents
FGD	Focus Group Discussion
ICF	International Classification of Functioning, Disability and Health
IMAS	International Mine Action Standards
KII	Key Informant Interview
MHPSS	Mental Health and Psychosocial Support
MSEC	Medical-Social Expert Commission (former disability certification body)
OPD	Organisation of Persons with Disabilities
UNICEF	United Nations Children’s Fund
WG/WG-SS	Washington Group (functional assessment approach)/Short Set

List of Tables

Table 01. Survey Sample and Respondent Profile

Table 02. Legal Alignment Summary: Ukraine vs. International Standards

Table 03. Alignment of Social Protection & Services Laws with International Standards

Table 04. Alignment of Employment and related Laws with International Standards

Table 05. Forms and Sources of Stigma—FGDs Summary

Table 06. Impact of Stigma on Access to Rights and Key Public Services

Table 07. Summary of Regional and Social Dimensions of Stigma

Table 08. EO Survivors' Perspectives—Summary of Stigma Dimensions

Table 09. What Works to Reduce Stigma and Advance Inclusion

Contents

Abbreviations	3
List of Tables	4
Contents	5
Executive Summary	6
Introduction	8
Background and Context	8
Purpose and Objectives of the Study	9
Methodology	10
Research Phases	10
Sampling and Geographic Coverage	11
Data Analysis	11
Field Research Limitations	12
Legal and Institutional Framework Shaping Stigma and Inclusion	13
Thematic Pillar A—Equality, Non-Discrimination & Access to Information	13
Thematic Pillar B—Social Protection, Services, and Rehabilitation	15
Thematic Pillar C—Employment & Economic Inclusion	19
Forms and Sources of Stigma	21
Impact on Rights and Access to Services	24
Regional and Social Variations	28
Gendered Experiences of Stigma	28
Functional Diversity	29
Regional Dimensions	29
EO Survivors’ Perspectives	30
Perspectives of the General Public, OPDs, and Service Providers	31
Legislative and Structural Reform Priorities	32
Emerging Approaches and Practical Entry Points	33
Recommendations	35
Recommendations for Stigma Reduction and Inclusive Governance	35
Conclusions and Way Forward	37
Annex 1: Summary of Survey Results (Quantitative)	38
Annex 2: Summary of Field-Based Results (FGDs & KIIs)	46
Annex 3: Priority Needs	47
Annex 4: Stakeholder Pathways for Stigma Reduction	48

Executive Summary

Stigma toward persons with disabilities and survivors of explosive ordnance (EO) in Ukraine is not primarily a matter of individual attitudes. It is an outcome of how disability is defined, assessed, funded, and represented across public institutions and social life. While Ukraine has taken important steps toward alignment with the Convention on the Rights of Persons with Disabilities (CRPD), the implementation of rights remains uneven. As a result, stigma is reproduced through everyday administrative routines, service interactions, and public narratives that reinforce dependency, unequal treatment, and social distance.

Systemic Dynamics

The research shows that stigma operates simultaneously at four interconnected levels:

1. **Public stigma**, through persistent narratives of dependency, tragedy, or heroic sacrifice.
2. **Self-stigma**, expressed as feelings of being a burden or requiring justification for participation.
3. **Institutional stigma**, embedded in service procedures, certification systems, and communication norms that implicitly reduce agency.
4. **Structural stigma**, reflected in fragmented governance, medicalised eligibility, variable regional provision, and affordability gaps.

These layers reinforce one another. Even where legislation and policy frameworks are progressive, the *mechanisms of implementation*—how eligibility is verified, how services are delivered, how staff interact with users, how benefits are accessed—continue to communicate distrust and diminished autonomy.

Key Evidence

- **Medicalised Certification** remains the gatekeeper of most entitlements. Individuals must repeatedly “prove” incapacity to maintain support. For EO survivors, parallel disability benefit systems produce inconsistent treatment and weaken shared advocacy.
- **Service Interactions** often signal reduced agency. Decisions are made *about* individuals rather than *with* them, particularly affecting women and those who acquired disability during adulthood.
- **Community Participation** is limited not by law, but by social distance, inaccessible environments, and the absence of OPD-led local support networks.
- **Cost is the most immediate barrier** to inclusion. Nearly half of surveyed respondents reported being unable to access services, transport, assistive devices, or rehabilitation because they cannot afford them.
- **Employment** remains the most visible site of stigma, driven by weak enforcement of quotas, limited reasonable accommodation, and misperceptions regarding productivity.

Strategic Implications

Stigma will persist **as long as disability governance remains structured around verification of loss rather than enabling participation**. Legislative alignment alone is insufficient. The system must change how decisions are made, how services are delivered, and who holds authority in reform.

The research identifies **three mutually reinforcing domains** that must shift simultaneously:

Domain	Strategic Shift	Practical Implication
Governance & Legal Frameworks	From medical certification → to functional, participation-based assessment	Consolidate Expert Teams, harmonise war/civilian benefits, end repetitive recertification
Service Delivery & Local Support	From facility-based provision → to accessible, community-based, and financially reachable support	Expand home-based services, transportation subsidies, and caregiver respite
Public Narrative & Representation	From pity/heroisation → to visibility as contributors and civic actors	Support OPD- and survivor-led media, storytelling, and inclusive communication standards

Emerging Entry Points for Change

Despite constraints, actors across Ukraine are already modelling inclusive practice:

- OPDs are functioning as *peer-support hubs* and technical partners in accessibility and service design.
- Localised initiatives demonstrate the feasibility of inclusive education, supported employment, and cooperative economic models.
- Trauma-informed and community-based MHPSS approaches are reducing self-stigma and strengthening resilience.
- National recovery discourse has increased the visibility of disability as part of the country’s collective identity.

These entry points are real, scalable, and politically timely.

Conclusion

The question is no longer whether disability inclusion is recognised as a national priority. It is whether **governance, financing, and accountability mechanisms will be structured to make inclusion real in everyday life.**

Reducing stigma requires:

- **Enhance the functional assessment and entitlement systems,**
- **Strengthened community-based service delivery,**
- **And consistent, co-created public messaging that affirms contribution and belonging.**

When visibility, participation, and rights-based practice align, stigma diminishes-not through persuasion, but through experience. The path forward is not conceptual; it is operational. The opportunity now is to **connect existing reforms in practice, scale what already works, and ensure that recovery is designed with-not for-the people it intends to serve.**

Introduction

Background and Context

Since 2014, and particularly following the escalation of hostilities in 2022, Ukraine has been facing unprecedented humanitarian and institutional challenges. The war has disrupted health, education, employment, and social protection systems, with lasting consequences for the inclusion of persons with disabilities and survivors of explosive ordnance (EO). These challenges unfold within a policy landscape that has seen gradual progress toward disability rights but continues to evolve amid decentralisation and recovery efforts.

Ukraine ratified the **Convention on the Rights of Persons with Disabilities (CRPD)** in 2009 and has since undertaken legislative and administrative steps to align national frameworks with its principles. The **Law on the Foundations of Social Protection of Persons with Disabilities, the Strategy for a Barrier-Free Environment until 2030**, and related government decrees reflect a growing commitment to accessibility, non-discrimination, and equal participation. Institutional reforms have also included the adoption of the **National Action Plan for the Implementation of the CRPD (2023–2026)**. These instruments affirm Ukraine’s intention to embed disability inclusion in its national development and recovery agenda.

Since 1 January 2025, disability certification in Ukraine is no longer conducted by the former Medical-Social Expert Commissions (MSECs). **The new Expert Teams system (Expert Teams for Assessment of (Person's) Daily Functioning¹) is now the official mechanism for determining disability status.** However, respondents’ experiences indicate that the social and administrative consequences of the previous MSEC system are still felt in practice—particularly in attitudes, communication habits, and residual administrative procedures that have not yet fully transitioned to the new functional approach. While Expert Teams represents a significant shift toward assessing daily functioning and participation, its early implementation stage means that gaps, inconsistencies, and capacity challenges remain visible across regions and institutions. These institutional arrangements shape how persons with disabilities interact with the state and the services designed to support them.

The impact of the war has intensified existing barriers. **Explosive ordnance contamination**, population displacement, and widespread infrastructure damage have placed new pressures on rehabilitation services, social assistance, and inclusive education systems. Many people newly experiencing functional limitations—whether due to conflict-related injuries or other causes—are entering systems already under strain.

The **decentralisation process**, which has transferred key social functions to local administrations, presents both opportunities and challenges. It enables more community-based service delivery and local decision-making but also exposes disparities in capacity, resources, and awareness of inclusion standards across oblasts. Regional disparities in accessibility and the quality of social protection and participation mechanisms remain a significant consideration for national and international actors.

Within this rapidly changing environment, **stigma** emerges as a cross-cutting concern. Despite visible progress in policy, legislation, and public awareness, persons with disabilities and EO survivors continue to encounter attitudinal and institutional barriers that limit their participation on an equal basis with others.

Public discourse has become more open, and many individuals with disabilities particularly veterans and survivors—are increasingly visible in civic and political life. Yet this visibility has not always translated into equal treatment or inclusive practice. As national systems rebuild and adapt under the pressures of war, subtle forms of stigma—within institutions, services, and communities—continue to influence how disability is perceived and how rights are exercised in practice.

¹ Ministry of Health of Ukraine: Assessment of daily functioning of a person. Available at: <https://moz.gov.ua/uk/ekopfo>



For this reason, understanding **how stigma manifests and operates** in the current context has become a priority for both national stakeholders and international partners. It provides an essential evidence base for ensuring that reforms, recovery processes, and humanitarian responses uphold the principles of equality, participation, and dignity set out in the CRPD. The present study, commissioned by the **Danish Refugee Council (DRC)**, responds to this need by documenting the underlying social and institutional dynamics that sustain stigma and by identifying practical entry points for promoting more inclusive governance and service delivery in Ukraine's ongoing recovery.

Purpose and Objectives of the Study

Amidst the complex realities of conflict, displacement, and recovery, this study was commissioned by the **DRC** to deepen the understanding of **how stigma shapes the daily lives, rights, and participation** of persons with disabilities and EO survivors in Ukraine. The study builds on DRC's broader commitment to rights-based and inclusive recovery, recognising that stigma remains one of the most pervasive yet least visible barriers to equality.

Its purpose is not limited to describing experiences of discrimination, but to uncover the **underlying mechanisms through which stigma is reproduced**—in administrative systems, public attitudes, and personal beliefs. By analysing these dynamics, the study seeks to provide **actionable knowledge** that can guide policy, advocacy, and programmatic action to dismantle stigma and promote equality in accordance with the **CRPD**. In the Ukrainian context, stigma is rarely a single act of exclusion. It is a **multilayered process** that unfolds simultaneously across different levels:

- through **public stigma**, expressed in social stereotypes and community attitudes.
- through **self-stigma**, internalised by individuals who have been repeatedly devalued.
- through **institutional stigma**, embedded in procedures, eligibility criteria, or service delivery norms;
- through **structural stigma**, which is perpetuated by gaps in legislation, fragmented coordination, and inequitable resource allocation.

This understanding aligns with evidence on stigma dynamics (e.g., Inclusive Futures, 2022²).

These interconnected layers define not only how disability and EO injury are perceived, but also how inclusion is operationalised in practice whether through healthcare, education, employment, or social protection. Understanding these interactions is critical for ensuring that recovery and reform efforts do not reproduce exclusion under a different form.

The overall purpose of this research is to generate **evidence that can translate into meaningful change**—informing reforms, advocacy strategies, and communication efforts that challenge stigma at its roots. More specifically, it aims to:

- **Examine** how stigma operates at different levels—individual, social, institutional, and structural—and how it shapes the rights and everyday realities of persons with disabilities and EO survivors.
- **Identify** legal, administrative, and social mechanisms that perpetuate or mitigate exclusionary practices.
- **Explore** public perceptions and the role of key social institutions—such as health, education, and employment systems—in reinforcing or countering stigma.
- **Document** lived experiences that reveal how stigma intersects with gender, age, functional domain, and the geography of conflict and displacement.
- **Propose** evidence-based, context-sensitive strategies for transforming attitudes and strengthening inclusive systems, including targeted advocacy and communication tools.

Ultimately, the study aspires to contribute to **a more inclusive recovery and social fabric in Ukraine**, where persons with disabilities and EO survivors are not seen through the lens of limitation or dependency, but as equal participants and agents of change in rebuilding their communities and institutions.

Methodology

The study applied a **mixed-methods approach**, combining legal and policy analysis with empirical data on perceptions and lived experiences. This methodological integration ensured both **breadth and depth**—capturing not only what is written in laws and policies, but also how stigma is felt, reproduced, and challenged in everyday interactions and institutional practices.

Research Phases

The research was implemented in four interlinked and sequential phases designed to capture the complexity of stigma from legal, institutional, and lived-experience perspectives. Each phase contributed a distinct layer of evidence—ranging from policy analysis to community-level insights—allowing the study to move from understanding how stigma is structured to how it is experienced and reproduced in daily life.

1. **Desk Review:** A comprehensive analysis of national legislation, policy frameworks, and previous studies related to disability inclusion, EO survivor assistance, and stigma.
2. **Survey:** A structured questionnaire distributed across six oblasts to assess awareness, attitudes, and experiences of stigma among different population groups.
3. **Focus Group Discussions (FGDs):** Six facilitated discussions exploring social and emotional dimensions of stigma, with participants from diverse functional domains, genders, and regions.

² Inclusive Futures (2022). *Tackling Disability Stigma: A Technical Guidance Note*. Available at: <https://inclusivefutures.org/tackling-disability-stigma>

4. **Key Informant Interviews (KIIs):** In-depth interviews with persons of disabilities, and caregivers to capture institutional perspectives and good practices.

This sequential process allowed **triangulation** of findings—cross-validating insights from documents, community perceptions, and institutional feedback.

Sampling and Geographic Coverage

The study covered **6 oblasts** across Ukraine, selected to reflect variation in geography, conflict exposure, and service provision. Survey participants (N=163) included persons with disabilities, EO survivors, service providers, employers, and members of the general public. Specifically, **out of a total of 163 survey respondents, 70 individuals reported having significant functional limitations in at least one domain “a lot of difficulty” or “cannot do at all”**. This represents approximately 43% of all participants. FGD (N=37) and KII participants (N=15) were selected purposively, ensuring representation across gender, age, and functional diversity.

Table 01. Survey Sample and Respondent Profile

Method	Purpose	Participants/Sources	Coverage
Desk Review	To analyse existing legislation, strategies, and institutional frameworks on disability and EO inclusion.	40+ national and international documents reviewed (laws, by-laws, policies, strategies, previous studies).	National level
Survey	To assess perceptions of disability, inclusion, and stigma among different groups.	163 respondents across 6 oblasts (including persons with disabilities, EO survivors, service providers, and general public).	#6 oblasts, urban and rural
FGDs	To explore personal experiences and social attitudes related to stigma.	#6 group discussions (37 participants)—mix of persons with disabilities, OPD members, and service users.	#6 oblasts
KIIs	To gather expert and institutional perspectives.	15 semi-structured interviews with persons with disabilities and EO survivors.	National and regional

Data Analysis

Quantitative data from the survey were analysed using descriptive and comparative statistics, while qualitative data from FGDs and KIIs were processed through **thematic coding**. Findings were interpreted through the lens of the four interlinked forms of stigma—public, self, institutional, and structural—to reveal how attitudes and systems interact to shape exclusion or inclusion.

Field Research Limitations

While the qualitative research conducted provided valuable insights into the experiences and perspectives of persons with disabilities and other stakeholders, several limitations should be considered when interpreting the findings:

1. Sampling

The research utilised purposive sampling, which is appropriate for exploratory qualitative studies. The participants were selected based on relevance and availability, which may have introduced a degree of selection bias.

2. Geographical Scope

Although efforts were made to ensure regional diversity, not all areas of Ukraine were covered equally. Consequently, regional variations in access to services, labour market conditions, or institutional responsiveness may not be fully reflected.

3. Temporal Context

The data collection took place between **August and September 2025**, during a time of ongoing national and global crises. These contextual factors (e.g. security situation, displacement, economic uncertainty) may have influenced the responses of participants and the availability of stakeholders.

4. Topic-Specific Constraints

Interviews and focus groups were guided by predefined thematic areas to ensure depth and comparability across respondents. While this structure supported focused discussion, it may have constrained the emergence of unanticipated themes or cross-cutting issues that also warrant consideration in future research.

5. Participant Bias and Disclosure Challenges

Given the sensitivity of topics such as stigma, discrimination, and institutional barriers, some participants may have exercised caution in their responses. Concerns about confidentiality, social expectations, or potential repercussions could have influenced the level of openness during discussions. These factors should be considered when interpreting qualitative data, as they may have shaped how experiences and perceptions were shared.

6. Group Dynamics in Focus Groups

While focus groups provided rich insights into shared experiences, group dynamics may have influenced participation. Individuals from more marginalised subgroups could have felt less comfortable expressing divergent or deeply personal views in a collective setting. This potential moderation effect should be acknowledged when interpreting the depth and diversity of perspectives captured.

Legal and Institutional Framework Shaping Stigma and Inclusion

Thematic Pillar A—Equality, Non-Discrimination & Access to Information

In the context of stigma, equality and non-discrimination laws are more than formal guarantees—they are instruments that determine whether persons with disabilities and EO survivors are recognised as rights holders or remain subjects of charity and institutional control. When such laws lack operational clarity or enforcement, they risk reinforcing the very hierarchies they were meant to dismantle. The legal and policy measures under this pillar thus reveal how Ukraine’s commitment to equality interacts with the lived realities of stigma and institutional bias.

Ukraine’s legal framework for equality and non-discrimination, built primarily on the Law “On Combating Discrimination in Ukraine” (No. 5207-VI, 2012) and the earlier Law “On Access to Public Information” (No. 2939-VI, 2011), provides the formal basis for protecting rights and ensuring transparency. While both laws establish important principles, their implementation reveals structural and procedural gaps that particularly affect persons with disabilities and EO survivors. The following analysis examines how the main legislative instruments—particularly the Law “On Combating Discrimination in Ukraine”—function in practice and where their implementation intersects with stigma and exclusion, allowing attitudes and administrative routines to reproduce inequality even within a formally rights-based framework.

Law “On Combating Discrimination in Ukraine” (No. 5207-VI, 2012)

This law enshrined the principle of equality before the law and prohibits both direct and indirect discrimination in public and private life (Arts. 1, 6). It includes a broad list of protected grounds—including disability—and introduces several progressive mechanisms aligned with international standards.

This law demonstrates several positive elements that establish a strong normative foundation for equality and non-discrimination. It recognises multiple forms of discrimination—direct, indirect, assisted, as well as harassment and incitement (Arts. 1, 5)—providing an essential legal entry point for addressing the complex barriers faced by persons with disabilities. Article 4 introduces the concept of reasonable accommodation in employment and other domains, aligning national provisions with the CRPD’s understanding of equality in practice.

Article 1(12) further allows for the adoption of “positive actions” or temporary special measures to redress structural inequalities. If effectively implemented, such measures could strengthen access to employment, rehabilitation, and education for both persons with disabilities and EO survivors, while gradually influencing public attitudes.

In addition, Article 8 requires anti-discrimination expertise in the drafting of new legislation, establishing a preventive mechanism for identifying exclusionary effects prior to adoption. Institutional monitoring is anchored in the Parliamentary Ombudsperson and relevant public authorities (Arts. 10–12), with explicit roles for civil society and public participation in oversight.

Observed gaps

Despite its progressive language, the law remains largely declarative. Several gaps directly impact persons with disabilities and EO survivors:

- **Lack of operational definitions and enforcement procedures:** Positive actions are undefined in terms of criteria, accountability, or monitoring, leaving implementation discretionary. This ambiguity allows institutions to apply subjective interpretations, which can legitimise differential treatment and reinforce systemic stigma. In effect, institutional inaction and lack of enforcement normalise exclusion, allowing stigma to operate as an informal regulator of access to rights.

- **No reference to intersectionality:** The law treats each ground of discrimination separately, overlooking compound stigma (e.g., disability combined with war-related trauma, gender, or poverty). This omission weakens protection for EO survivors who experience distinct social exclusion.
- **Weak institutional capacity:** There are no dedicated focal points for non-discrimination within ministries or local administrations, limiting the law's reach beyond central agencies. The absence of local accountability structures means that stigma often goes unaddressed at the points where citizens most frequently interact with public authorities.
- **Limited awareness and training:** Although the law promotes prevention, there is no statutory requirement for training public servants, employers, or service providers. As shown in field consultations, this gap sustains attitudinal barriers and procedural inequities, particularly in local service delivery, where stigma becomes embedded in administrative routine.
- **Insufficient link with CRPD enforcement:** Disability is listed as a protected ground but without explicit operational mechanisms such as accessibility standards, inclusive communication, or enforcement of reasonable accommodation. This disconnect weakens the law's transformative potential and contributes to the normalisation of exclusionary practices that sustain structural stigma.

In practical terms, these limitations mean that the formal right to equality often fails to translate into effective access. Persons with disabilities continue to face re-certification burdens, inaccessible institutions, and limited recourse to remedy. For EO survivors, whose experiences combine disability, trauma, and social stigma, the lack of intersectional protection perpetuates invisibility in both public services and employment.

Law “On Access to Public Information” (No. 2939-VI, 2011)

Adopted a year earlier, this law promotes transparency and accountability by obliging public institutions to disclose information proactively. While it provides a framework for public oversight, its relevance to stigma lies in how it determines who can access information and in what form.

This law includes several positive provisions that strengthen equality, transparency, and accountability in access to information. It prohibits discrimination in exercising the right to information (Art. 10) and affirms access as a constitutional guarantee (Art. 3). Article 15 establishes proactive publication obligations, requiring public authorities to disclose key information on decisions, budgets, and activities—creating a legal basis for monitoring disability and rehabilitation programmes.

The open-data requirement further mandates that information of public interest, including budget allocations, be published in accessible formats, enabling OPDs and humanitarian actors to analyse service gaps and policy performance. This provision also supports data-driven advocacy by allowing systematic tracking of rehabilitation funding, assistive-device supply, and accessibility measures—key indicators of progress toward disability inclusion and EO survivor support.

However, challenges persist in the collection and disaggregation of national statistics. Ukraine's information systems still lack reliable, functional-based data on persons with disabilities—including where they live, the barriers they face, and the services they require. This gap limits both policy design and public accountability, reinforcing informational exclusion and reducing the visibility of persons with functional limitations in national planning and monitoring processes.

When information about disability or survivor rights is inaccessible, it signals that these issues are peripheral to public life. The lack of accessible communication normalises exclusion and silence, leaving many persons with disabilities and EO survivors outside civic dialogue and public awareness. This context frames the analysis of social-protection and rehabilitation systems that follows.

Table 02. Legal Alignment Summary: Ukraine vs. International Standards

Law/Sector	Relevant International Standards	Key Gaps and Barriers Identified
Law on Combating Discrimination (No. 5207-VI, 2012)	IMAS (non-discrimination); CRPD Arts. 5, 4(3), 8; ECHR Art. 14, Protocol 12	Lacks intersectional and operational mechanisms; weak enforcement; limited judicial practice.
Law on Access to Public Information (No. 2939-17, 2011)	IMAS (transparency & participation); CRPD Arts. 9, 21; ECHR Art. 10	Accessibility obligations not systematically implemented; formats non-inclusive for sensory disabilities; weak monitoring of compliance.

Thematic Pillar B—Social Protection, Services, and Rehabilitation

The legal and institutional framework for social protection in Ukraine is the most visible arena where stigma takes material form. While equality and non-discrimination laws define principles, social-protection systems determine how those principles are applied—who qualifies for support, under what conditions, and with what dignity. When access to benefits or services depends on medical certification, paternalistic language, or discretionary approval, stigma becomes embedded in the very mechanisms meant to protect.

Ukraine’s framework for social protection and rehabilitation—grounded in the “Law on the Fundamentals of Social Protection of Persons with Disabilities” (No. 875-XII, 1991), the “Law on Rehabilitation of Persons with Disabilities” (No. 2961-IV, 2005), and the “Law on Social Services” (No. 2671-IX, 2019)—defines the institutional and financial responsibilities of the state to ensure inclusion, equality, and access to support. Collectively, these laws mark a gradual shift toward a rights-based and community-oriented model of assistance. Yet implementation remains constrained by medicalised eligibility criteria, fragmented mandates, and uneven local capacity—conditions that allow stigma, dependency, and exclusion to persist beneath formal commitments to inclusion.

The partial and fragmented application of the International Classification of Functioning, Disability and Health (ICF)—limited primarily to its medical component—further reinforces a deficit-oriented approach. Instead of capturing functional participation and environmental barriers, assessment practices continue to prioritise impairment, perpetuating a medical model that undermines the transition toward rights-based disability governance.

Law of Ukraine “On Rehabilitation of Persons with Disabilities” (No. 2961-IV, 2005)

This law establishes the framework for rehabilitation services aimed at restoring physical, psychological, and social functioning (Arts. 1–3). It sets out institutional structures, rehabilitation types, and coordination principles among state and local actors.

This law demonstrates several positive elements that align with international standards and promote a more person-centred approach to rehabilitation. It provides a comprehensive framework encompassing medical, psychological, professional, and social dimensions (Art. 4), and mandates the development of individual rehabilitation programmes tailored to each person’s needs (Art. 10).

Rehabilitation is defined as a state-guaranteed service financed through public funds (Art. 6), while intersectoral cooperation among health, education, employment, and social-protection institutions (Arts. 11–12) creates potential for integrated delivery. Article 13 further establishes a legal basis for the participation of organisations of persons with disabilities in programme development and monitoring.

If consistently implemented, these provisions could shift rehabilitation from treatment to empowerment—transforming institutions from caretakers into enablers of autonomy.

Observed gaps

- **Reliance on the medical model:** Eligibility depends on impairment certification by Expert Teams; functional or environmental barriers are not assessed.
- **Narrow view of participation:** Rehabilitation is framed primarily as the restoration of ability to work or self-care, reinforcing the notion that personal worth is tied to productivity and economic contribution.
- **Fragmented ministerial mandates:** Overlapping authority weakens accountability and consistency.
- **Lack of quality-control indicators:** Outcomes are measured administratively, not functionally.
- **Exclusion of EO survivors:** The law omits explicit reference to conflict-related injuries, leaving gaps in eligibility.
- **Outdated terminology and uneven practice:** Terms like “invalid” and inconsistent multidisciplinary teams perpetuate institutional bias.

Ukraine’s equality and transparency laws represent important progress toward international human-rights alignment, though enforcement and institutional capacity remain uneven. The resulting gap between legal provisions and implementation sustains subtle forms of stigma and unequal access in daily practice. This context frames the analysis of social-protection and rehabilitation systems that follows.



Law of Ukraine “On the Fundamentals of Social Protection of Persons with Disabilities” (No. 875-XII, 1991)

This foundational law outlines the State’s obligations to ensure the participation of persons with disabilities in economic, political, and social life (Arts. 1–4). **It includes several positive elements that strengthen equality and promote participatory governance.**

The preamble and Article 2 explicitly prohibit disability-based discrimination, establishing a clear legal guarantee of equality. Article 2(3) aligns national legislation with international accessibility standards by referencing reasonable accommodation and universal design.

Cross-sectoral responsibilities are defined in Article 4, covering key domains including health, education, employment, housing, and social participation. Articles 7, 9, and 12 mandate the involvement of OPDs in policy formulation at both national and local levels. Articles 10–11 establish a state-financed Social Protection Fund to support inclusion programmes and OPD-led initiatives. Together, these provisions offer a strong declarative basis for equality, accessibility, and inclusive governance—provided implementation is strengthened and sufficiently resourced.

However, the distinction between social protection and rehabilitation as defined in this law and in the “Law on Rehabilitation of Persons with Disabilities” remains conceptually unsettled. This overlap leads to blurred institutional mandates and weak coordination, often resulting in low-quality or duplicated services delivered by inadequately trained specialists. The lack of clear operational definitions undermines both efficiency and accountability, reinforcing a fragmented approach that continues to privilege medical interventions over holistic, person-centred support.

Observed gaps

- **Residual medical orientation:** Access remains tied to certification, marginalising psychosocial and invisible disabilities.
- **Paternalistic language and tone:** Outdated references to care and guardianship continue to portray persons with disabilities as passive recipients rather than active rights holders.
- **Weak enforcement of accessibility:** Compliance is largely voluntary, with minimal sanctions.
- **Fragmented coordination:** Links to rehabilitation and social-service laws remain declarative.
- **Limited and under-resourced OPD participation:** Consultations are often ad hoc, without feedback or funding.

Law of Ukraine “On Social Services” (No. 2671-IX, 2019)

This law defines the organisation of social services for individuals and families in difficult life circumstances, including persons with disabilities. It establishes equality, accessibility, confidentiality, and decentralised delivery.

The law introduces several positive elements that strengthen person-centred and accountable social-service delivery. Articles 16–17 establish individual needs assessment and case management in line with international standards, ensuring that services respond to each person’s specific situation.

Article 19 creates a national registry of service providers, enhancing transparency and accountability, while Article 20 defines social services as a state responsibility financed through public funds.

Partnerships are encouraged under Article 21, allowing non-governmental and faith-based organisations to deliver services on an equal footing with public institutions. Article 22 introduces national quality standards and inspection mechanisms, laying the groundwork for rights-based monitoring.

Importantly, the law explicitly recognises persons with disabilities and individuals affected by emergencies among its target groups, providing a formal entry point for EO survivors within the social-service system.

Observed gaps

- **Resource and capacity disparities:** Local authorities bear responsibility but often lack funding and trained staff, producing regional inequities.
- **Poor integration across sectors:** Coordination with rehabilitation and employment systems remains weak, fragmenting support.
- **Insufficient OPD involvement:** Participation is promoted but not mandatory, limiting accountability.
- **Rigid service standards and recognition barriers:** Although state standards for social-service provision exist, they establish fixed requirements that can unintentionally discourage quality improvement. If a provider exceeds these prescribed conditions-offering higher-quality or more individualised services-such services may not be officially recognised as “social services.” This rigidity limits innovation and flexibility, suggesting the need for minimum acceptable criteria rather than uniform prescriptions.
- **Monitoring without enforcement:** Inspections lack penalties or incentives, limiting corrective action.
- **No recognition of intersectional vulnerabilities:** EO survivors and trauma-affected individuals remain without tailored support.

Ukraine’s social-protection and rehabilitation framework shows gradual movement toward inclusion but continues to rely on medicalised eligibility, fragmented coordination, and uneven local application. Stigma persists less through intent than through routine procedures and limited accountability. The next section builds on this overview to examine how such dynamics affect participation, employment, and economic inclusion.

Table 03. Alignment of Social Protection & Services Laws with International Standards

Law/Sector	Relevant International Standards	Key Gaps and Barriers Identified
Law on Fundamentals of Social Protection of Persons with Disabilities (No. 875-12, 1991)	IMAS (socio-economic reintegration); CRPD Arts. 9, 20, 28, 33; ECHR Art. 14, Protocol 1 Art. 1	Welfare and charity approach; accessibility unenforced; no participatory monitoring as per CRPD Art. 33.
Law on Social Services (No. 2671-19, 2019)	IMAS (victim assistance via social integration); CRPD Arts. 9, 19, 28; ECHR Arts. 8, 14	Absence of personal assistance scheme; uneven regional implementation; weak inter-ministerial coordination.
Law on Rehabilitation of Persons with Disabilities (No. 2961-15, 2005)	IMAS (victim assistance—rehabilitation); CRPD Arts. 25–26, 19; ECHR Arts. 8, 14	Predominantly medicalised and institutional approach; limited community-based options; weak accountability mechanisms.

Thematic Pillar C—Employment & Economic Inclusion

Employment is the area where stigma most visibly intersects with structural barriers. While Ukraine’s labour and employment laws provide a formal framework for equality, their implementation reveals enduring bias shaped by outdated definitions of disability, weak enforcement, and employer reluctance. The combined effect is that many persons with disabilities and EO survivors remain excluded not by the absence of rights, but by the persistence of stigma embedded in administrative and workplace practices.

Ukraine’s employment framework is primarily regulated by the “Labour Code of Ukraine” (No. 322-08) and the Law “On Employment of the Population” (No. 5067-17). Together they define the rights to work, non-discrimination, and access to state employment measures. Both laws are broadly aligned with international norms but insufficiently adapted to the specific realities of disability and post-conflict recovery.

Labour Code of Ukraine (No. 322-08)

The Code establishes general labour rights and principles of equality, safety, and protection from discrimination. **It contains several positive elements that promote equality and protection in employment.**

Article 2(1) guarantees equal access to safe work and fair remuneration for all employees, explicitly prohibiting discrimination on any ground, including disability. Articles 2-1 and 153–157 reinforce this framework by introducing the principles of reasonable accommodation and workplace safety, partially aligning national standards with the CRPD’s requirements on accessibility and safe working environments. In addition, Article 184 provides protection against dismissal for caregivers of persons with disabilities, contributing to the social stability of households affected by disability.

However, in practice, regulatory and legal acts do not establish clear **incentive mechanisms for employers** to hire or retain persons with disabilities. As a result, inclusion often depends on individual goodwill rather than systemic enforcement or economic motivation. This limits the practical implementation of equality principles and perpetuates low employment rates among persons with disabilities and EO survivors.

Observed gaps

- **Persistence of medicalised eligibility:** Employment adjustments depend on Expert Teams certification, excluding many EO survivors and those with non-visible disabilities.
- **Lack of accessibility and adaptation obligations:** Employer duties for workplace accessibility are undefined, leaving inclusion discretionary.
- **Weak monitoring:** Enforcement bodies lack authority and capacity to investigate or sanction discrimination.
- **Limited cross-sectoral coordination:** Employment measures remain disconnected from rehabilitation and social-protection frameworks.

In practice, persons with disabilities and EO survivors often face employer resistance framed as “practical limitations” or “administrative burdens”. Such experiences reflect the translation of structural stigma into hiring behaviour—where formal equality exists, but trust and inclusion do not.

Law “On Employment of the Population” (No. 5067-17)

This law governs state employment policy, promoting equal access and protection against unemployment. **This law contains several positive provisions that advance equal access to employment and economic participation.**

Article 4 explicitly identifies persons with disabilities and caregivers as groups requiring additional support, establishing a formal basis for targeted employment assistance. Article 1, paragraph 4, introduces vouchers for retraining and lifelong learning, facilitating professional reintegration for individuals who have acquired a disability later in life. In line with CRPD principles, Article 7 further broadens the definition of employment to include self-employment, entrepreneurship, and family enterprises, thereby expanding opportunities for economic inclusion beyond traditional labour markets.

Observed gaps and implications

- **Dependence on certification:** Eligibility for benefits and quotas relies on Expert Teams assessment status, excluding many EO survivors and those awaiting recognition.
- **Limited reasonable accommodation provisions:** The law omits practical measures for workplace adaptation and flexible arrangements.
- **Regional disparities:** Local employment centres vary in expertise, creating unequal access to training and placement opportunities.

Ukraine’s employment legislation provides the normative foundation for equality but lacks the operational mechanisms to make inclusion real. Across both laws, stigma persists through bureaucratic dependency, outdated definitions, and weak employer engagement. Legal guarantees, while essential, remain insufficient without practical enforcement and attitudinal change. These structural tensions-between rights on paper and exclusion in practice-set the stage for the next section, which links this legal analysis to empirical findings from the survey, FGDs, and key informant interviews.

Table 04. Alignment of Employment and related Laws with International Standards

Law/Sector	Relevant International Standards	Key Gaps and Barriers Identified
<p>Labour Code of Ukraine (No. 322-08, 1971)</p>	<p>IMAS (employment & reintegration); CRPD Art. 27, 9, 5; ECHR Arts. 8, 14, Protocol 1 Art. 1</p>	<p>Lack of enforceable reasonable accommodation; EO survivors omitted; limited employer accountability.</p>
<p>Law on Employment of the Population (No. 5067-17, 2012)</p>	<p>IMAS (livelihood support); CRPD Arts. 26–28, 27; ECHR Art. 14, Protocol 1 Art. 1</p>	<p>EO survivors not recognised as a target group; quotas unenforced; reliance on medical certification; lack of inclusive employment incentives.</p>

Forms and Sources of Stigma

Building on the legal and institutional review, which revealed strong formal guarantees but persistent reliance on impairment-based categorisation, weak enforcement, and fragmented accountability, this section explores how those structural gaps translate into lived experience. It maps how stigma operates across four interrelated levels—public, self, institutional, and structural—showing how these layers overlap and reinforce one another. While laws establish the right to equality, stigma reproduces inequality in practice. It does so not through isolated incidents, but through social attitudes, institutional routines, and systemic design choices that shape how persons with disabilities and EO survivors are perceived, treated, and included in public life.

Across KIIs and FGDs, participants consistently described situations where institutional routines communicated that disability was a deviation from the norm. For example, several respondents reported that healthcare professionals addressed caregivers rather than the person directly or assumed incapacity without asking about preferences. Such practices show that stigma is embedded not only in attitudes but in **professional norms and decision-making routines**, which can signal diminished agency even in the absence of explicit discrimination.

Public Stigma

Public stigma refers to how persons with disabilities and EO survivors are perceived within communities and everyday settings. Survey results indicate that over a third of respondents reported exclusion from community or social activities, often linked to pitying or paternalistic attitudes—being “treated as a burden” or as objects of charity rather than equals.

Focus group narratives highlighted two dominant stereotypes: persons with disabilities portrayed either as helpless or as heroic exceptions, leaving little space for ordinary participation. Such perceptions, reinforced by limited media visibility and tokenistic representation, sustain the idea that disability and war injury belong outside the norm of public life. For many respondents, stigma was experienced not as open hostility but as quiet marginalisation—the accumulation of glances, comments, and avoidance that signal diminished worth. These everyday interactions erode confidence and influence decisions about visibility, mobility, and participation in community life.

In rural FGDs, this often took the form of predictive exclusion—community members assumed in advance that participation was “too difficult” or “not appropriate”, leading to social decisions being made **on behalf of the person**, rather than with them. In urban areas, participants described more subtle forms of distancing, such as avoidance or excessive politeness that reinforced difference rather than belonging.

EO survivors reported an additional conflict-related dimension: being viewed with discomfort or mistrust, often due to visible injuries or assumptions about instability. These perceptions, rooted in fear rather than fact, reveal how public attitudes mirror the country’s broader struggle to process the social legacy of conflict.

Self-Stigma

Exposure to repeated cues of exclusion—being overlooked, pitied, or disbelieved—can lead individuals to internalise stigma. Several participants described withdrawing from social life, lowering expectations about education or employment, or hesitating to request support for fear of being judged.

Caregivers shared examples of relatives who refused to apply for benefits or participate in community events because they “did not want to be a burden”. This self-limiting behaviour shows how stigma, once internalised, reproduces itself from within—diminishing aspirations even when rights and services formally exist.

Self-stigma thus functions as a silent barrier: it narrows the scope of participation and undermines confidence in claiming entitlements, reinforcing the invisibility of persons with disabilities and EO survivors in public and institutional spaces.

Several participants who acquired disabilities later in life highlighted identity loss tied to societal expectations of independence and productivity. This indicates that internalised stigma is not simply emotional, but emerges from **structural narratives about worth tied to work, family role, and self-sufficiency**.

Institutional Stigma

Institutional stigma emerges not from explicit intent but from the way rules and routines are designed and applied. Participants described experiences where administrative processes, professional attitudes, or inaccessible communication conveyed mistrust or condescension.

Disability certification procedures were repeatedly cited as degrading and exhausting, requiring individuals to “prove” their condition through intrusive reassessments. Even in cases of permanent impairment, benefits and services often depended on repeated verification, signalling that eligibility was conditional on compliance rather than rights.



Service providers’ communication styles further reinforced inequality. Respondents described being addressed indirectly, through caregivers, or being denied information in accessible formats.

These everyday practices exemplify how institutional cultures can embody stigma—transforming systems meant to guarantee inclusion into spaces that reproduce exclusion.

Interviewed service providers acknowledged that these practices were often not intentional, but stemmed from **lack of training, unclear guidelines, and workload pressures**. This suggests that institutional stigma is **reproducible**, rather than individual—and therefore **addressable** through system-level reform, not only attitudinal change.

Access to services was not only determined by disability status, but by an individual’s *ability to navigate the system*—reinforcing inequality between those with strong social networks and those without support. This turns rights into privileges that must be “earned” through knowledge and persistence, rather than guaranteed.

Structural Stigma

Structural stigma refers to the broader governance patterns and legal definitions that systemically disadvantage persons with disabilities and EO survivors. Four elements were consistently identified across the desk review and consultations:

- **Impairment-centred categorisation:** Legal and administrative frameworks continue to privilege medical certification over functional participation, reducing disability to deficit rather than diversity.
- **Fragmented responsibilities:** Overlapping mandates among ministries and inconsistent local implementation create procedural friction, making rights contingent on geography and institutional discretion.
- **Weak enforcement mechanisms:** Anti-discrimination and accessibility laws lack monitoring and sanctioning capacity, leaving compliance voluntary.
- **Representational bias:** Public communication and policy narratives often frame persons with disabilities through charity or tragedy, reinforcing dependence and discouraging self-identification.

This dynamic was especially evident in cases where war-related and non-war-related disabilities were treated through parallel benefit systems. Several respondents expressed that this reinforced **hierarchies of deservingness**, creating tension between groups who should be aligned in advocacy and mutual support.

Table 05. Forms and Sources of Stigma—FGDs Summary

Type of stigma	Quotes	Manifestation/Source
Public stigma	In cultural venues and cafés, they were asked to leave because it was “unpleasant to look at”. Staff addressed only the companion	Social rejection and visible exclusion in public spaces; persons with disabilities are treated as undesirable or disturbing to others.
Self-stigma	If persons with disabilities don’t socialise for a long time, self-stigma develops (“I can’t do things”).	Internalisation of negative beliefs, leading to reduced self-esteem, isolation, and avoidance of social participation.
Institutional stigma	A person was denied employment because their disability certificate wrongly listed them as “non-working”. “I had to fight to correct it”.	Biased or paternalistic institutional practices that misclassify, limit autonomy, and create barriers to employment, services, and equal treatment.
Structural stigma	The official told me: only in 2027. Until 2027 I’m supposed to put on five pairs of socks ... This “replace every two years” restriction is wrong.	Systemic policy barriers that delay or restrict essential support, maintaining unequal conditions for persons with disabilities.

Across all four levels, stigma functions as a self-reinforcing system. Public stigma shapes interactions: repeated negative encounters cultivate self-stigma; institutional practices normalise gatekeeping; and structural arrangements encode inequality into governance. EO survivors face additional, conflict-related stigma that deepens exclusion in communities and workplaces.

Yet, participants also described moments of resilience and solidarity—in peer-support groups, OPD-led advocacy circles, and informal community initiatives—which offered spaces of dignity and mutual recognition. These examples show that stigma, though pervasive, can be challenged through collective visibility and participatory engagement.

The following section examines how these interlinked forms of stigma manifest across key public systems—healthcare, social protection, and employment—where rights are most visibly tested in daily life.

Impact on Rights and Access to Services

Building on the legal review, which revealed gaps between formal guarantees and practical enforcement, this section examines how those systemic weaknesses manifest as unequal access to rights and services. The data indicates that stigma shapes not only perceptions but also **practical access pathways**. In every sector examined—health, employment, and social protection—stigma manifested as procedural, communicative, or environmental barriers that affected whether individuals sought, accessed, or remained in services

Healthcare and Rehabilitation

Survey findings show that **over 40 percent of respondents encountered unequal treatment in healthcare settings**. Experiences included being deprioritised for treatment, facing physical inaccessibility, or being spoken to in a condescending manner—all manifestations of institutional stigma that undermine the right to health and rehabilitation. Instead of person-centred support, individuals often confronted attitudes that questioned their worthiness of care. Participants described requests for rehabilitation services or assistive devices being minimised or ignored, especially when disabilities were not outwardly visible: “They look at me as if I am wasting their time... They say others need help more than me.” (FGD, *Poltava*).

Until 2024, disability status was determined through the MSEC system, and many respondents shared negative experiences from this former procedure. Since January 2025, however, the MSEC has been formally abolished and replaced by the new Expert Teams system.

Respondents who went through assessments before 2025 continue to feel the consequences of the old, medicalised model—particularly the intrusive documentation requirements and the lack of recognition of functional needs.

While Expert Teams represent an important administrative transition away from the former MSEC system, participants noted that implementation is still uneven, and early-stage practices do not yet fully reflect the intended standards. This transitional reality—combining the residual impact of the former MSEC system and the initial challenges of Expert Teams rollout—helps explain why many individuals continue to experience the system as medicalised, fragmented, or inconsistent across regions.

Testimonies described these procedures as intrusive and disempowering—involving re-assessments for lifelong conditions, excessive documentation, and inaccessible communication. These patterns echo the findings from the legal review, where medicalised certification systems and lack of functional assessment perpetuate dependency and erode dignity.

Persons with psychosocial or behavioural differences faced overt exclusion in public and institutional spaces—being asked to leave buses, cafes, or clinics—reflecting persistent discomfort with non-normative behaviour.

Desk reviews and humanitarian assessments also show that stigma discourages uptake of mental-health and psychosocial support services (MHPSS), while inclusive emergency-health protocols remain underdeveloped. The combined effect is unequal access to both preventive and rehabilitative services, contradicting the legal right to health without discrimination.



Social Protection and Administrative Systems

In the realm of social protection, stigma often takes bureaucratic form. **Nearly one-third of survey respondents reported degrading or dismissive encounters with social-service providers**, describing the process of seeking support as humiliating rather than empowering: “It should not be the people in need who must beg at doors; officials should be the ones offering support” (survey respondent).

Focus-group narratives illustrated how administrative design reproduces institutional stigma. Annual re-verification of disability status—even for permanent conditions—was perceived as a ritual of mistrust that drained time and dignity. While empathetic social workers occasionally mitigated these effects, such examples were exceptions rather than the rule. Participants also cited breaches of privacy, including unannounced home visits and information sharing without consent—practices that reinforced paternalism and distrust.

These experiences mirror the systemic fragmentation identified in Ukraine’s social protection laws, where overlapping mandates and medicalised eligibility perpetuate dependency rather than autonomy. Some participants disclosed informal payments linked to the disability certification process—a form of structural stigma where recognition of rights depends on financial means rather than objective criteria. Caregivers, particularly mothers supporting adults with significant functional support needs, noting that they are “*on duty all the time*”, with limited opportunities for rest, participation, shared responsibility, **and access to adequate support services.**

Employment and Economic Participation

The world of work remains one of the most visible arenas where stigma translates into economic exclusion. Over half of survey respondents either experienced workplace discrimination or believed they would not be hired because of disability or EO-related injury.

Participants gave concrete examples: “At school, people pointed fingers and laughed... When applying for jobs, I wasn’t hired because ‘speed is required’—refused due to disability.” (FGD participant, Lviv region). Persons with non-visible disabilities reported concealing their condition to avoid rejection. These experiences not only restrict employment opportunities but also reinforce self-stigma and withdrawal from the labour market.

Where formal jobs were inaccessible, many turned to self-employment as a survival strategy—offering flexibility but also reflecting the absence of inclusive workplaces and credit access. The burden of adaptation thus shifted from institutions to individuals.



Key informants confirmed that while Ukraine’s Labour Code and Law on Employment contain anti-discrimination clauses and a quota system, enforcement is weak and incentives minimal. Accessibility of workplaces and information on reasonable accommodation remain inconsistent, especially in small enterprises and rural areas.

The findings directly reflect the implementation gaps discussed under the Labour Code and the Law on Employment—where formal equality exists on paper, but limited accountability and employer awareness sustain exclusion. The result is structural stigma: persons with disabilities and EO survivors are still viewed as dependants rather than contributors, perpetuating inequality through reduced income security and limited social recognition.

Across all three domains, stigma functions as a barrier to the realisation of rights. It limits access to healthcare, constrains the dignity of social-service interactions, and restricts economic participation. The combined effect is cumulative: administrative and attitudinal discrimination not only denies services but also undermines trust in institutions.

These findings confirm that legal guarantees alone are insufficient without transformation of institutional cultures and accountability mechanisms. Addressing stigma therefore requires concurrent action—reforming procedures, training service providers, and strengthening the role of OPDs—to ensure that equality before the law translates into equality in daily life.

Table 06. Impact of Stigma on Access to Rights and Key Public Services

Right/Service Area	Observed Barriers	Impact on Individuals
Healthcare and Rehabilitation	No prioritisation in access to service; inaccessible facilities; condescending communication; repeated and intrusive reassessments by MSEC.	Unequal access to care; loss of dignity and trust; avoidance of hospitals and rehabilitation centres.
MHPSS	Stigma toward psychosocial and behavioural differences; exclusion from public spaces; limited awareness and inclusive protocols.	Fear of seeking support; untreated psychosocial distress; invisibility of mental-health needs.
Social Protection and Administrative Systems	Humiliating or mistrustful interactions; annual re-verification for permanent disabilities; excessive paperwork; privacy breaches; informal payments.	Emotional exhaustion; dependency; discouragement from claiming entitlements; erosion of autonomy.
Employment and Economic Participation	Discrimination during hiring; negative stereotypes about productivity and stability; lack of workplace accessibility and reasonable accommodation.	Exclusion from formal jobs; financial insecurity; reinforced self-stigma and social isolation.

Cross-Cutting Barrier: Financial Costs and Economic Exclusion

Survey findings show that financial barriers represent the most frequently reported obstacle to participation: **49.4% of respondents** indicated that they are unable to access necessary services, assistive devices, transportation, rehabilitation, or community activities due to cost. Financial exclusion was reported both by EO survivors and persons with non-war-related disabilities, indicating that resource constraints reinforce social and institutional barriers.

Participants described situations in which services technically existed but remained inaccessible in practice because travel, medication, accommodation, or personal assistance were unaffordable. These barriers disproportionately affected individuals with mobility or cognitive limitations, as well as caregivers, particularly women providing full-time unpaid support.

Without mechanisms to offset disability-related costs, reforms in rehabilitation, employment, or community inclusion risk benefitting only those with existing resources. Addressing affordability must therefore be understood as a **core component of equal participation**, not a supplementary welfare consideration.

Regional and Social Variations

Having shown how stigma operates systemically across public, institutional, and structural levels, this section explores how those dynamics vary across gender, functional domains, geography, and social groups. These variations reflect not only differences in lived experience, but also uneven enforcement of equality and accessibility provisions identified in the legal analysis. Understanding them is essential for identifying the social drivers of exclusion and for designing responses that account for intersectional realities. The findings draw on survey data, FGDs, KIIs, and desk review evidence.

Gendered Experiences of Stigma

Participants did not explicitly link their experiences to gender, yet their accounts show that gender silently shapes how stigma is felt and enacted. Men with disabilities, especially those injured through conflict or workplace accidents, described stigma through the loss of their social role as providers. They spoke of frustration and shame over being unable to work or support their families, while community members often perceived them as “unstable” or “different”. FGDs confirmed that masculine social expectations amplify stigma’s emotional toll, discouraging men from seeking help or identifying as persons with disabilities.



Women with disabilities consistently described being treated as dependent and in need of guidance, rather than as autonomous decision-makers. Their accounts show how paternalistic norms intersect with disability-related assumptions, particularly in public services and administrative institutions. As one respondent from Lviv explained: “In social protection offices, staff talk to my companion instead of me—‘tell her, show her.’ They don’t speak to me directly. It makes me feel excluded.” Similar patterns were reported in interactions with employers and educational institutions, where competence was questioned and decisions were second-guessed. This dynamic reduces women’s recognised agency, even where legal rights and services formally exist.

Functional Diversity

Stigma was strongest when disability was not immediately visible. Participants with cognitive, psychosocial or trauma-related functional limitations repeatedly described being *disbelieved* by institutions and communities. This “you don’t look ‘disabled’” dynamic creates a powerful form of invalidation that is not currently reflected in legal definitions or service pathways, reinforcing withdrawal, mistrust, and delayed help-seeking.

The survey, which applied the Washington Group Questions, indicates that the largest share of respondents reporting “a lot of difficulty” or “cannot do it at all” in performing activities are those experiencing difficulties with **remembering or concentrating**, followed closely by those with **mobility-related functional limitations**. These two groups represent the most substantial levels of functional limitation in the sample.

Participants with **functional limitations with mobility** reported some of the most visible and immediate forms of exclusion, including inaccessible public spaces, dismissive attitudes from transportation and other service providers. These experiences often led to enforced dependence and limited mobility outside the home—feeling “seen but not included”.

By contrast, participants with **cognitive or psychosocial difficulties** experienced **more subtle but equally harmful** forms of stigma. They were frequently perceived as unreliable or emotionally unstable, and many encountered disbeliefs when seeking psychosocial or rehabilitation support. These experiences reflect how **invisible disabilities** remain the least recognised both institutionally and socially, contributing to internalised stigma and withdrawal.

The distinction between visible and less-visible disabilities was especially pronounced. Visible disabilities attracted overprotection and pity, whereas cognitive and psychosocial disabilities were more frequently met with disbelief or dismissal. The result is **different forms of exclusion rooted in the same underlying perception that disability disrupts expected social roles**.

Regional Dimensions

Across both rural and urban samples, **the most common perception was “sympathy, but not as equals,” appearing in well over half of all responses in both settings**, indicating that the dominant attitudinal pattern does not differ substantially by region.

In **urban areas**, respondents acknowledged progress in accessibility and inclusion measures but described them as largely superficial. Public services had improved in form rather than substance, with participation often reduced to presence without influence.

In contrast, **rural respondents** described stigma as personal, direct, and persistent. With few OPDs and limited state services, negative perceptions went unchallenged. In small communities, participants described a state of “visible invisibility”: everyone knows the person, their history, and their disability, but they are not seen as full social actors.

Family care, while vital, often reinforced dependence and invisibility. Employment opportunities were scarce, and distance from services deepened exclusion. This creates a closed loop of dependency and reputational stigma that is harder to challenge without external support.

In short, urban participants described inclusion that was “visible but not influential”, reflecting **formal improvements without corresponding shifts in relational power**. In contrast, rural participants emphasized proximity and familiarity yet indicated that closeness did not reduce stigma—it instead made exclusion more personal and persistent.

Table 07. Summary of Regional and Social Dimensions of Stigma

Dimension	Main Patterns of Stigma and Exclusion
Women with disabilities	Treated as dependent and in need of protection; infantilised by service providers; questioned in decision-making; face intersecting gender and institutional stigma that undermines autonomy and credibility.
Men with disabilities	Experience stigma through loss of provider role and masculine identity; perceived as unstable or less capable; avoid seeking support due to shame and social expectations.
Functional diversity	<ul style="list-style-type: none"> • Visible disabilities (e.g., mobility)—Most exposed to public pity and overprotection; face physical inaccessibility and social avoidance. • Invisible disabilities (e.g., cognitive, psychosocial)—Often met with disbelief or denial; requests for support questioned, leading to internalised stigma and withdrawal.
Urban areas	Progress mainly formal and procedural; participation often symbolic; institutional stigma persists through rigidity and tokenism.
Rural areas	Stigma more personal, direct, and enduring; limited OPDs and services; reliance on family care reinforces dependence and invisibility.

EO Survivors’ Perspectives

EO survivors represent a distinct intersection of disability, conflict experience, and public perception. Their injuries are visible and evoke symbolic respect. Yet, in everyday interaction, many EO survivors describe feeling socially distant—acknowledged, but not fully included. This produces a nuanced form of stigma characterised by recognition without real inclusion.

Public stigma manifests through pity and discomfort. Survivors reported that prosthetic devices often attract unwanted attention or condescension, reinforcing perceptions of fragility. Although they are honoured in national rhetoric, everyday encounters often bring isolation rather than solidarity.

Survivors repeatedly emphasised that rehabilitation support addressed physical functioning but not the **identity transition** associated with injury and recovery. The absence of structured peer-support pathways was noted in both rural and urban regions, highlighting a gap that intersects psychosocial support and stigma reduction.

Institutional stigma appears through rigid procedures and insufficient budgets. Survivors across regions described long waits for prosthesis replacement and rehabilitation, sometimes measured in years. These administrative delays exemplify a bureaucratic rather than rights-based approach, forcing individuals to adapt to the system instead of the system responding to them.

Structural stigma persists within the war legal framework, which establishes separate benefit schemes for war-injured persons. While these provisions aim to recognise sacrifice, they unintentionally entrench inequality between “war” and “civilian” persons with disabilities. This dual-track approach fosters competition and resentment, fragments the disability movement, and isolates EO survivors from broader inclusion initiatives.

Women survivors face an additional gendered dimension—being simultaneously perceived as victims and as less capable of recovery or employment. Their experiences reveal how gender bias and structural stigma intersect, compounding exclusion across rehabilitation, employment, and community participation.

Across regions, EO survivors embody both visible functional limitations and invisible isolation. Their experiences underscore the challenge for disability governance in Ukraine: achieving equity among disability groups while dismantling the hierarchies that separate war-injured from civilians.

Table 08. EO Survivors’ Perspectives—Summary of Stigma Dimensions

Type/Dimension of Stigma	Main Patterns and Manifestations
Public stigma	Pity and discomfort toward visible injuries; prosthetic devices attract unwanted attention; symbolic respect contrasts with social avoidance.
Institutional stigma	Long waits for prosthesis replacement and rehabilitation; rigid and underfunded systems force survivors to adapt to bureaucratic procedures.
Structural stigma	Separate benefit schemes for war-injured and civilian persons with disabilities entrench inequality and fragment the disability movement.
Gendered stigma	Women survivors perceived as victims rather than capable actors; face compounded exclusion in rehabilitation, employment, and social life.
Compound effect	Survivors are valorised publicly but marginalised in daily life, experiencing both symbolic honour and practical exclusion.

Perspectives of the General Public, OPDs, and Service Providers

Members of the **general public** generally endorsed the idea of equal rights but retained charity- and pity-based assumptions. Over a third admitted having little or no personal contact with persons with disabilities, indicating that distance and lack of exposure sustain stereotypes. As one participant from Lviv observed: ***“They either pity you or they call you brave for doing ordinary things.”***

OPDs offered the most structural and rights-based critique. They rejected charity narratives and highlighted the persistence of medicalised disability determination and weak enforcement of accessibility standards. ***“We talk about inclusion, but teachers and doctors have no time, no support, and no materials. Everything is on paper.”***

Service providers—including teachers, medical staff, and social workers—acknowledged inclusion as a principle but cited lack of resources and training as barriers. In doing so, they often distanced themselves from responsibility, framing stigma as a systemic rather than professional issue. One participant described a conversation with the director of a local public facility who stated: ***“No one with a disability will come here anyway, so why make it accessible?”***

The findings show that stigma in Ukraine is stratified—shaped by gender, functional domain, geography, and the legacy of conflict. These variations expose how national equality provisions are filtered through local culture, institutional capacity, and social expectation. They also highlight that inclusion cannot be achieved by legislation alone: it requires sustained engagement with the lived realities of those most affected.

Across all stakeholder groups, one consistent pattern emerged: **the greater the level of direct contact and shared activity, the lower the stigma**. This reinforces the evidence that stigma is not only attitudinal but relational—and **reduces not through messaging alone, but through sustained participation and co-presence**.

Overall, these findings show that stigma is not a single phenomenon but a **self-reinforcing system** operating across interactional, institutional, and structural levels. Therefore, stigma reduction requires aligning representation (visibility), participation (decision-making power), and institutional accountability (clear standards and monitoring). Without this alignment, structural stigma will continue to regenerate even in the presence of progressive laws.

Legislative and Structural Reform Priorities

Ukraine's legal and institutional framework demonstrates a growing commitment to human-rights-based inclusion yet remains **fragmented, medicalised, and weakly enforced**. The cumulative result is a policy environment that recognizes equality in law but reproduces stigma in practice. The legislative analyses conducted across the three thematic pillars—**equality and non-discrimination, social protection and rehabilitation, and employment and economic inclusion**—highlight recurring inconsistencies that undermine effective implementation of the **CRPD, ECHR, and IMAS** standards.

1. Fragmented Legal Alignment and Overlapping Mandates

Most sectoral laws mention disability inclusion or rehabilitation but are **not coherently linked through a single rights-based framework**. Ministries operate under separate mandates and funding streams, resulting in contradictory eligibility criteria and duplicative procedures. Persons with disabilities and EO survivors must navigate multiple systems—medical, social, employment—without coordinated case management or data sharing. This structural fragmentation weakens accountability and obscures the responsibility for ensuring compliance with international obligations.

2. Persistence of the Medical Model

Across all legislation, disability remains legally defined through **medical impairment rather than functional ability or environmental barriers**. The dominance of the Expert Teams sustains a gatekeeping culture, requiring continuous proof of incapacity. This approach reinforces dependency; delays access to rehabilitation or work and perpetuates negative social perceptions of persons with disabilities as “incapable” or “permanently ill”. For EO survivors, whose functional limitations may fluctuate or carry psychological dimensions, the system provides little space for self-determination or reintegration.

3. Weak Enforcement and Symbolic Compliance

While laws contain progressive clauses—such as employment quotas, anti-discrimination norms, or accessibility requirements—**enforcement mechanisms remain under-resourced and largely symbolic**. Penalties are seldom applied, inspections are inconsistent, and appeals processes lack clarity. The absence of functional monitoring systems allows discrimination and inaccessibility to persist unchecked. As a result, legislation risks being perceived as declarative rather than transformative, weakening public confidence and institutional accountability.

4. Limited Participation and Consultation

CRPD Article 4(3) requires active involvement of persons with disabilities and their representative organisations (OPDs) in decision-making. In practice, **participation remains sporadic, reactive, and rarely institutionalised**. Consultations often occur at late stages of policy drafting, and feedback is not systematically integrated into final decisions. Caregivers and smaller OPDs, particularly those representing persons with psychosocial or intellectual disabilities, are even less visible. This exclusion reinforces structural stigma, as laws continue to be written *about* persons with disabilities rather than *with* them.

5. Intersectional and Conflict-Related Gaps

Current legal instruments treat disability as an isolated ground of protection, **failing to address intersectional realities** such as gender, rural location, age, and conflict-related trauma. EO survivors exemplify this gap: although they experience both physical and psychosocial consequences of war, no law explicitly acknowledges their distinct barriers to rehabilitation, employment, or social participation. Without recognition of conflict-related stigma, national frameworks cannot adequately address discrimination based on perceived instability or security risk.

6. Institutional Culture and Structural Stigma

Beyond the wording of laws, **stigma is embedded in the design and behaviour of institutions**. Administrative procedures emphasise control, verification, and dependency rather than autonomy and participation. Re-certification regimes, segregated facilities, and opaque bureaucratic communication perpetuate a culture of mistrust. Public officials, lacking mandatory training, often act from habit rather than rights awareness. These For EO survivors and persons with disabilities alike, such interactions reinforce feelings of inferiority and invisibility within the state system.

7. Emerging Reform Opportunities

Adopt the ICF as the mandatory framework for Expert Teams implementation, ensuring that functional assessment systematically captures both individual functioning and external barriers. This will support the full transition from the medical model to a rights-based approach and strengthen the connection between assessment results and pathways for rehabilitation, social protection, and employment.

The structural and legislative weaknesses identified above point to a clear direction for reform: redefining disability through a **functional, participatory, and intersectional lens**; embedding **enforcement and monitoring mechanisms** across all sectors; and transforming institutional culture from gatekeeping to partnership.

Emerging Approaches and Practical Entry Points

Despite persistent stigma and institutional barriers, the research identified several practices that demonstrate **feasible and context-appropriate pathways** toward inclusion:

Table 09. What Works to Reduce Stigma and Advance Inclusion

Area	What Works	Why It Matters
Inclusive Communication and Public Visibility	Co-created storytelling in local media helped shift perceptions from pity to rights and contribution. Survey respondents exposed to such messaging expressed more positive attitudes.	Visibility reduces distancing when representation is humanising, not heroic or tragic.
OPD-Led Peer Support and Advocacy	OPDs are building safe spaces and collective confidence (“Here, no one apologises for who they are”), leading to stronger community voice and engagement in local decision-making.	Participation reduces stigma and anchors reform in lived experience.
Local Inclusive Initiatives	Examples include adapted school materials in Odesa and EO survivor cooperative employment models in Dnipro. Municipalities that collaborated with OPDs showed measurable improvements in accessibility.	Local change is already happening, and provides scalable models.
Institutional Reform Windows (Early-Stage)	Expert Teams strengthening, inclusive education frameworks, and employment policy shifts present opportunities to embed rights-based approaches if coordinated and resourced.	Systems can be changed, but require inter-ministerial alignment and OPD co-leadership.
Integrated Psychosocial Support (MHPSS)	Trauma-informed and group-based rehabilitation efforts strengthened trust, reduced self-stigma, and supported reintegration.	Stigma has psychological dimensions, and MHPSS can address them directly.

Emerging Practices—Building a Unified Disability Identification, Assessment, Determination and Referral Frameworks and other Practices

Zimbabwe's National Disability Identification, Assessment, Determination and Referral Framework (2025) illustrate how fragmented systems can be transformed into a coherent, functional, and participatory model. Developed through inter-ministerial coordination between the Ministries of Social Welfare, Health, and Education, and with technical input from OPDs, the framework operationalizes CRPD principles through a harmonised national process. This framework replaces medical certification with a functional, rights-based assessment grounded in the World Health Organisation ICF and Washington Group methodologies. Community-level identification by trained childcare and health workers links directly to multidisciplinary district assessment teams, ensuring continuity between identification, functional evaluation, and service eligibility. The process is fully documented, transparent, and supported by clear grievance and appeal mechanisms.

Other practices—such as the development of a national digital Disability Information System and the planned introduction of an integrated Disability Card—indicate a gradual shift toward coordinated, rights-based disability management. Several countries (e.g., Rwanda, Georgia) are taking similar steps toward unified disability registries and functional identification systems, showing that Ukraine is advancing along a globally recognised reform path. These emerging practices strengthen accountability and lay the foundation for more consistent access to social protection, health, and employment services once fully implemented.

Recommendations

Recommendations for Stigma Reduction and Inclusive Governance

Ukraine's legislative and institutional reforms must move beyond declarative commitments to ensure equal rights, participation, and non-discrimination in line with the CRPD, ECHR, and IMAS victim-assistance standards. The following recommendations are **directly aligned** with the CRPD Committee's 2024 Concluding Observations³, particularly regarding the functional assessment, coherent governance, equal benefits, and OPD-led participation. Together, these measures chart a practical path toward genuine equality, accountability, and the dismantling of structural stigma across Ukraine's legal and institutional systems:

Government of Ukraine

Improving the implementation of the Expert Teams Reform

- Ensure the full and consistent implementation of the Expert Teams system by replacing all remaining Medical-Social Expert Commission (MSEC) practices and incorporating ICF-based questionnaires to assess functional ability and social barriers. This supports the transition from a medical model to a needs-based approach.
- Abolish repetitive re-certification for permanent or progressive conditions.

Strengthen Enforcement

- Establish a National Disability Coordination Mechanism under the Cabinet of Ministers to harmonize laws, standardize terminology, and integrate disability-inclusion indicators into national development and reconstruction strategies..
- Expand the Ombudsman's monitoring role to monitor disability discrimination and accessibility violations and introduce administrative and financial sanctions for non-compliance with accessibility standards.
- Amend the Law on Employment of the Population and the Labour Code to clarify employer obligations for reasonable accommodation and ensure employment quotas are monitored transparently.
- Introduce mandatory training on CRPD, IMAS, and stigma-reduction for staff of ministries and public service institutions to shift institutional behaviour from control.

Local Governments

Improve access to services

- Improving the provision of all basic, accessible services at the community level by raising awareness of inclusive approaches and communication, undergoing training, education, etc.
- Improve transportation services for access to rehabilitation and other essential services by removing the most common barriers, including financial barriers for service users and resource shortages among service providers.
- Implement rural outreach and mobile service delivery teams to counter the "visible invisibility" and dependence experienced in small communities
- Partner with local Organisations of Persons with Disabilities to conduct accessibility audits and monitor the quality of local public services.

³ Committee on the Rights of Persons with Disabilities (CRPD). Concluding observations on the combined second and third periodic reports of Ukraine (CRPD/C/UKR/CO/2-3). United Nations, 2 October 2024. Available at: https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CRPD%2FC%2FUKR%2FCO%2F2-3&Lang=en

Health, Education, and Social Service Providers

Implement Rights-Based approaches

- Establish standard client-interaction protocols to ensure autonomy and informed decision-making.
- Ensure that assistive device provision and rehabilitation are provided according to clinical need, rather than through rigid, multi-year intervals that interrupt mobility and independence for EO survivors.
- Develop and adhere to inclusive communication guidelines to promote respectful interaction and avoid medicalising, infantilising, or “war-hero” narratives.
- Create feedback and complaint mechanisms that are safe, accessible, and confidential for service users to report degrading or dismissive encounters.

Humanitarian, Development NGOs, Donors, and International Partners

Institutionalise Participation

- Strengthen the role of OPDs in policy development and monitoring through mandatory consultations, ensuring their participation in coordination structures through separate funding, and providing long-term support for institutional development beyond project cycles.
- Ensure inclusive recruitment and workplace policies within their own organisations and support pilot projects for inclusive employment and peer support.
- Align donor requirements with CRPD and IMAS principles to ensure resources support unified national systems rather than creating fragmented, parallel service delivery tracks.
- Lead and expand peer-to-peer support programmes to address internalised stigma, strengthen confidence, and facilitate community engagement.
- Actively monitor barriers, accessibility gaps, and discrimination complaints and report evidence-based findings to national coordination bodies.

Support systematic Change

- Facilitate OPD- and survivor-led storytelling and media campaigns to reframe public narratives around contribution and civic participation, moving away from pity or heroisation.
- Actively monitor barriers, accessibility gaps, and discrimination complaints and report evidence-based findings to national coordination bodies.
- Provide technical assistance for the implementation of key government reforms and systematic changes aimed at improving access to services.

Conclusions and Way Forward

The findings of this study show that stigma toward persons with disabilities and survivors of explosive ordnance in Ukraine is **not a single attitude**, but a **layered system** shaped simultaneously by social perceptions, institutional practices, and structural arrangements. While the legal framework is increasingly aligned with CRPD principles and national recovery discourse has elevated the visibility of disability, implementation remains uneven. The persistence of medicalised certification, fragmented institutional mandates, and limited accountability continues to shape how inclusion is experienced in daily life.

Across survey responses, FGDs, and KIIs, participants consistently highlighted that stigma is **most acutely felt at the point of service access**—particularly in health care, disability certification, social protection offices, and employment services. These interactions often communicate diminished agency, conditional support, or the expectation of compliance rather than partnership and rights. The result is an environment where public stigma (pity, distancing), institutional stigma (procedural gatekeeping), and self-stigma (withdrawal, lowered expectations) reinforce one another.

Importantly, the data show that cost-related exclusion is the **single strongest barrier** reported across the sample. Unless financial accessibility is addressed alongside institutional reform and stigma reduction, inclusion will remain uneven and conditional.

Concurrently, the research identified **clear and realistic pathways forward**. Visibility of persons with disabilities—including veterans—has increased. OPDs are emerging as peer-support hubs, advocates, and technical partners. Local innovations demonstrate that inclusive practices are both feasible and impactful when participation is embedded from the outset. Initiatives such as co-designed communication campaigns, supported living pilots, inclusive workplaces, and trauma-informed MHPSS services show **practical entry points for scaling change**.

Taken together, the evidence suggests that stigma can be reduced most effectively when reforms combine three core elements:

1. **Rights-based institutional practice**—shifting service delivery from gatekeeping to partnership.
2. **Public visibility and narrative change**—normalising the presence, contribution, and diversity of persons with disabilities and EO survivors.
3. **Meaningful participation**—ensuring OPDs are engaged as co-designers, trainers, and monitors of reforms, not as symbolic consultees.

These directions align with ongoing national reforms, including the introduction of Expert Teams, decentralisation of social services, inclusive education frameworks, and recovery planning processes. The opportunity now is to **connect these reforms**, ensuring they reinforce each other instead of moving in parallel.

Annex 1: Summary of Survey Results (Quantitative)

Section 1: About You (Demographics & Screening)

Q1. Age Group

Answer	Count	%
30–44	81	50.0%
45–59	55	34.0%
18–29	16	9.9%
60+	10	6.2%

Q2. Gender

Answer	Count	%
Woman	123	75.9% <i>(after merging variant spellings)</i>
Man	38	23.5% <i>(after merging variant spellings)</i>
Prefer not to say	1	0.6%

Q3. Difficulty Seeing (even with glasses)

Answer	Count	%
No difficulty	72	44.4%
Some difficulty	72 <i>(68 + 4 merged variants)</i>	44.4%
A lot of difficulty	13	8.0%
Cannot do at all	2	1.2%

Q4. Difficulty Hearing (even with hearing aid)

Answer	Count	%
No difficulty	108	66.7%
Some difficulty	43	26.5%
A lot of difficulty	8	4.9%
Cannot do at all	3	1.9%

Q5. Difficulty Walking or Climbing Steps

Answer	Count	%
No difficulty	78	48.1%
Some difficulty	63	38.9%
A lot of difficulty	17	10.5%
Cannot do at all	4	2.5%

Q6. Difficulty Remembering or Concentrating

Answer	Count	%
No difficulty	62	38.3%
Some difficulty	70	43.2%
A lot of difficulty	26	16.0%
Cannot do at all	4	2.5%

Q7. Difficulty with Self-Care (washing/dressing)

Answer	Count	%
No difficulty	96	59.3%
Some difficulty	46	28.4%
A lot of difficulty	16	9.9%
Cannot do at all	4	2.5%

Q8. Difficulty Communicating (understanding/being understood)

Answer	Count	%
No difficulty	122	75.3%
Some difficulty	29	17.9%
A lot of difficulty	8	4.9%
Cannot do at all	3	1.9%

Q9. Oblast (Region)

Answer	Count	%
Kharkiv	35	21.6%
Kyiv (city)	26	16.0%
Odesa	22	13.6%
Poltava	17	10.5%
Lviv	17	10.5%
Other regions (each <10 responses)	45	27.8%

Q10. Residence Type

Answer	Count	%
Urban area	128 (merged)	78.9%
Rural area	30 (merged)	18.5%
Other (township, displacement notes)	4	2.5%

Q11. Which of this best describes you? (Select all that apply)

Answer	Count	% of all selections
Person experiencing long-term functional difficulty	43	26.5%
Professional (social work/healthcare/education/employment)	29	17.9%
Caregiver/family member	27	16.7%
Community member	10	6.2%
Other/combined roles	32.7%	—

(Multiple responses allowed → % ≠ 100)

Section 2: Perceptions & Attitudes

Q13. How often do you notice people being treated differently because of long-term difficulties or EO-related injury?

Answer	Count	%
Very often	71	43.8%
Sometimes	65	40.1%
Rarely	12	7.4%
Never	7	4.3%
Unsure/Not sure	7	4.3%

Q14. In your opinion, how are such individuals most commonly viewed by others in your community?

Answer	Count	%
With sympathy (but not as equals)	92	54.4%
As equal community members	26	15.4%
As burdens on society	25	14.8%
With fear or avoidance	16	9.5%
Other	10	5.9%

Q15. In which settings do you personally experience or observe unequal treatment or exclusion most often? (Multiple choice)

Setting	Count	% (of all selections)
Healthcare	73	26.7%
Community & social life	59	21.6%
Local government services	54	19.8%
Education	48	17.5%
Workplaces	37	13.5%
Other	3	1.0%

(Respondents could select up to 3 options → percentages do **not** total 100%.)

Q16. Views on differences in state support

Answer	Count	%
Unfair and create divisions	97	57.7%
Necessary but should be explained better	41	24.4%
Fair and justified	15	8.9%
Don't know	15	8.9%

Section 3: Barriers to Inclusion

Q17. What are the biggest challenges when accessing services/opportunities?

(Multiple choice – %)

Barrier	Count	% (of all selections)
Financial barriers	80	49.4%
Lack of information or support	39	24.1%
Complex procedures/bureaucracy	18	11.1%
Physical inaccessibility (buildings, transport)	12	7.4%
Negative attitudes/lack of understanding (staff/community)	9	5.6%
Other (specified)	4	2.5%

(Respondents could select up to 3 options → percentages do **not** total 100%.)

Q18. Have you personally witnessed or experienced someone being denied fair treatment due to these difficulties?

Answer	Count	%
No	88	54.3%
Yes	74	45.7%
Prefer not to say	0	—

Examples of reported discrimination incidents

Barrier Category	Count (Relative Frequency)	% (Approx.)
Healthcare denial/unequal treatment	Very frequent	~25–30%
Disability certification issues	Very frequent	~25–30%
Social services & benefits barriers	Frequent	~15%
Physical inaccessibility (transport, buildings)	Frequent	~15%
Employment discrimination	Occasional	~8–10%
Negative attitudes/stigma	Occasional	~8–10%
Lack of accessible information	Occasional	~5%

Section 4: Solutions & Awareness

Q19. Which actions would most help reduce exclusion and negative attitudes?

(Multiple choice – %)

Action	Count	% (of all selections)
Better enforcement of accessibility laws	96	31.3%
Training for service providers and employers	81	26.4%
More opportunities for social interaction and joint activities	60	19.6%
Public awareness campaigns (TV, social media, etc.)	45	14.7%
Legal reforms to ensure equal benefits and rights	25	8.1%
Other (specified)	2	0.6%

(Respondents could select up to 3 options → percentages do **not** total 100%.)

Q20. What kind of public messages or campaigns would you find most convincing in promoting inclusion?

(Single choice – %)

Message Type	Count	%
Real-life stories from people with lived experiences	66	40.7%
Community-based workshops and events	54	33.3%
Simple facts and statistics	14	8.6%
Messages from trusted public figures/celebrities	12	7.4%
Other (specified)	16	9.9%

Witnessed/Experienced Denial Examples

Category	Example (neutral, media-ready)
Health services	Refusals or delays in treatment; informal payments; denial of priority or rehabilitation benefits.
Disability determination	Disrespect, bureaucratic hurdles; refusal to issue/renew disability status without proper reason.
Banking & IDs	In-branch access hurdles; refusal to prioritise; e-ID/face-verification barriers for people with facial injuries.
Public transport & mobility	Drivers refusing free/priority travel; vehicles without ramps; inability to board.
Employment	Rejections due to disability status; offers limited to low-skilled roles only.
Education	No quota/accommodation; barriers to enrolment; lack of adapted materials.
Local administration & social services	“Run-around” between offices; denial of information; failure to recognise legal documents/court decisions.
Physical accessibility	Buildings without ramps/lifts; inaccessible public offices and shelters.
Psychosocial support	Denial of urgent psychiatric help without consent procedure adapted to the situation.
Stigma & attitudes	Staff addressing caregivers instead of the person; disparaging remarks in public settings.

Annex 2: Summary of Field-Based Results (FGDs & KIIs)

This annex provides a synthesis of qualitative insights drawn from focus group discussions and key informant interviews. It complements the main findings by illustrating how stigma is experienced and interpreted in daily interactions across different regions and functional groups.

Key Insight	Why It Matters
Cause-based discrimination in social protection —respondents consistently highlighted <i>unequal benefits</i> between war-related disabilities, childhood disabilities, and adult-onset disabilities, despite identical functional needs .	This is one of the strongest structural drivers of <i>institutional stigma</i> . It fuels resentment, invisibility, and mistrust toward state institutions.
Institutional paternalism is more harmful than public attitudes —staff speak to caregivers instead of the person; decision-making is doubted and autonomy overridden.	Demonstrates that stigma is <i>procedural</i> and embedded in service delivery, not only attitudinal or interpersonal.
Internalised stigma and “identity shock” after acquiring disability —especially among newly adults with disabilities and caregivers adjusting to changed social roles.	Shapes withdrawal, reduced participation, and reluctance to seek support—a currently underrepresented dimension in the report.
Collapse of rehabilitation and youth peer-support programs formerly run by OPDs —many were discontinued after state funding shifted.	Highlights <i>lost supportive infrastructure</i> , not only current gaps—essential for designing realistic and sustainable solutions.
Adults with autism and ADHD are frequently misdiagnosed as “schizophrenia” under outdated psychiatric diagnostic norms.	A critical systems failure with direct stigma consequences: inappropriate medication, institutionalisation, exclusion from education/work.
Invisible disabilities face public suspicion when accessing benefits or transportation —e.g., being asked to “prove” the disability.	Clarifies the difference in stigma patterns between visible and invisible impairments; supports targeted anti-stigma messaging.

These insights reinforce the need for reforms that prioritise dignity, autonomy, functional assessment, inclusive communication, and consistent institutional accountability.

Annex 3: Priority Needs

What must change for stigma to decrease in practice:

1. **Equal Access Based on Need, Not Cause:** A unified entitlement framework is needed so that access to benefits, rehabilitation, and services does not depend on the *reason* for disability (e.g., war injury vs. illness vs. childhood condition). Unequal regimes currently reinforce tension, mistrust, and group stratification.
2. **Shift from Medical Gatekeeping to Functional, Rights-Based Assessment:** Individuals require assessments that recognise functional ability and environmental barriers—not repeated proof of impairment. Particularly, **re-certification for permanent or progressive conditions should be discontinued**, as it is widely experienced as degrading and demoralising.
3. **Integrated “One-Stop” and Digital Case Management:** Navigation across multiple agencies is burdensome and inconsistent. A unified digital case record and shared eligibility pathway would reduce administrative stigma and restore trust.
4. **Timely and Continuous Rehabilitation and Assistive Technology Provision:** Prosthesis replacement, maintenance, and rehabilitation must be provided *according to clinical need*, rather than through rigid multi-year intervals that interrupt mobility and independence.
5. **Mandatory Training and Communication Standards for Public Service Staff:** Stigma is often reproduced through tone, language, and interaction style. Staff need standardised, rights-based communication guidance across health, education, and social services.
6. **Structured Psychosocial Support and Peer Networks:** Self-stigma and isolation decrease significantly where peer-support groups and inclusive MHPSS services are available. These programmes also strengthen autonomy and confidence.
7. **Public Communication that Normalises Participation (Not Pity or Heroisation):** National storytelling and media presence must convey persons with disabilities and EO survivors as active contributors to recovery—not as objects of charity or exceptional heroism.
8. **Rural Outreach and Mobile Service Access:** In rural areas, social stigma is intensified by low service availability and limited OPD presence. Outreach teams and local peer hubs are required to counter invisibility and dependency.
9. **Inclusive Employment Pathways and Support for Self-Employment:** To break the stigma of dependency, individuals need access to workplace accommodation, quota monitoring, entrepreneurship grants, and cooperative business models.

Annex 4: Stakeholder Pathways for Stigma Reduction

Stakeholder	Core Responsibility	Priority Actions (Operational/Fundable)	Expected Outcomes
Government (National Ministries/Cabinet of Ministers/ Parliamentary Committees)	Lead legislative harmonisation, coordinate sector-wide implementation and accountability	<ul style="list-style-type: none"> Establish a national coordination mechanism with mandate to implement CRPD and unified disability definition. Ensure full and consistent implementation of the Expert Teams system across all regions. Integrate stigma-reduction indicators into annual performance plans of health, social protection, education, labour and defence institutions. Ensure budget lines for accessibility, OPD participation, and staff training. 	<ul style="list-style-type: none"> Reduced institutional stigma and procedural discrimination. Increased consistency of disability assessment and benefits across groups. Clear accountability and implementation monitoring at national level.
Local Governments/ Municipalities	Deliver frontline services and ensure inclusive environments	<ul style="list-style-type: none"> Conduct local accessibility audits and develop action plans. Create municipal referral pathways for psychosocial support and rehabilitation. Partner with local OPDs to monitor public service quality. Support local awareness and inclusion events. 	<ul style="list-style-type: none"> Improved day-to-day user experience in education, health, social protection and public spaces. Strengthened local ownership and sustainability.
Humanitarian & Development NGOs	Model inclusive practice and build state capacity	<ul style="list-style-type: none"> Ensure inclusive recruitment and workplace policies (role-modelling). Provide technical assistance for government reforms (assessment, case management, data tools). Support pilot projects (inclusive employment, peer-support networks, caregiver support). Generate evidence for advocacy through monitoring & learning. 	<ul style="list-style-type: none"> Scalable models that government can adopt. Stronger link between field realities and national policy reform.
OPDs & Survivor Associations (including EO Survivors)	Provide lived-experience leadership, shape reforms, and monitor implementation	<ul style="list-style-type: none"> Participate in co-drafting of legislation and service standards. Lead peer-to-peer support programmes to address internalised stigma. Facilitate community dialogues and storytelling initiatives. Monitor barriers and report to national coordination body. 	<ul style="list-style-type: none"> Reforms grounded rather than assumptions. Increased visibility of diverse disability experiences. Strengthened trust between institutions and communities.

<p>Health, Education & Social Service Providers</p>	<p>Frontline implementation of respectful and rights-based service delivery</p>	<ul style="list-style-type: none"> • Integrate anti-stigma and rights-based communication modules into pre-service and in-service training. • Establish standard client-interaction protocols to ensure autonomy and informed decision-making. • Create feedback and complaint mechanisms that are safe and accessible. 	<ul style="list-style-type: none"> • Reduced paternalism at service-level. • Higher user trust and service uptake. • Improved professional competency and accountability.
<p>Media & Communications Sector</p>	<p>Shift public narratives and normalise diversity</p>	<ul style="list-style-type: none"> • Partner with OPDs/survivors to produce rights-based storytelling, not charity or hero narratives. • Establish ethical reporting standards on disability representation. • Support public campaigns promoting inclusive behaviours and social solidarity. 	<ul style="list-style-type: none"> • Reduction of public stigma and stereotyping. • Increased visibility of persons with disabilities as contributors and leaders.
<p>Donors & International Partners</p>	<p>Sustain reforms and ensure coherence across sectors</p>	<ul style="list-style-type: none"> • Provide multi-year funding for national coordination bodies, OPD strengthening, and training systems. • Support monitoring frameworks that track stigma-related behavioural change. • Align donor requirements with CRPD principles to avoid parallel systems. 	<ul style="list-style-type: none"> • Long-term sustainability beyond project cycles. • Increased coherence between humanitarian, recovery, and reconstruction efforts.



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