



European partnership for  
health, equity & wellbeing

# EuroHealthNet Country Exchange Visit

– Improving the health of highly vulnerable populations

Host: Institute of Preventive Medicine, Environmental and Occupational Health,  
Prolepsis

24-25 November 2025, Athens



On 24–25 November 2024, EuroHealthNet, in collaboration with the Institute of Preventive Medicine, Environmental and Occupational Health – [Prolepsis](#), hosted a Country Exchange Visit (CEV) in Athens, Greece. This event brought together representatives from national and regional public health institutes, and municipal authorities across Europe to discuss effective approaches for improving the health and wellbeing of highly vulnerable and marginalised populations, including Roma communities, migrants and refugees, homeless people, and other groups experiencing severe exclusion.

Participants explored the complex structural, social, and economic determinants that contribute to the extreme marginalisation of certain groups. They exchanged experiences on national and local models designed to improve the situation and health of these groups, with a particular focus on participatory and community-based approaches. The CEV offered a platform to discuss how public health authorities can better involve marginalised communities in service design, decision-making processes, and how cross-sector collaboration can create more inclusive health systems.

Throughout the visit, attendees heard from experts at Prolepsis about ongoing efforts to enhance access to healthcare, strengthen social protection, and reduce poverty among highly vulnerable groups. They also took part in field visits, including to a Roma settlement in the broader Athens region and to an open day centre for homeless people in the district of Piraeus, gaining first-hand insights into living conditions, barriers to care, and the role of local organisations in providing essential support.

The visit falls within EuroHealthNet’s contract agreement with the European Commission’s DG Employment, Social Affairs and Inclusion programme of the European Social Fund Plus (ESF+). The meeting was moderated by Ingrid Stegeman, Programme Manager at EuroHealthNet. Representatives from ten EuroHealthNet member organisations took part. This report summarises the programmes, activities, and key discussion points from the visit and is prepared by Lina Papartyte, Practice Platform Coordinator at EuroHealthNet.



Image 1: Country Exchange Visit participants

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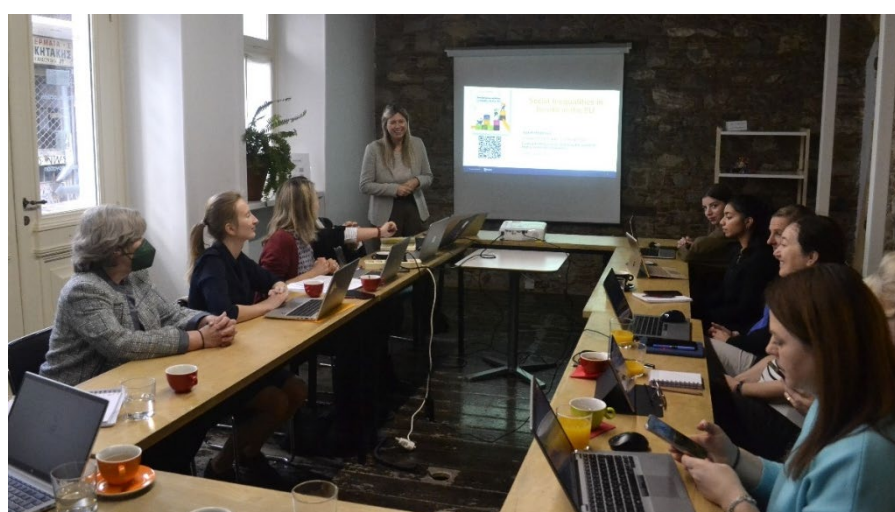


Image 2: Afrodit Veloudaki, Prolepsis, welcoming Country Exchange participants

# 1

## Setting the scene: understanding health inequalities and policy responses

The meeting was opened by Athena Linos, Founder of the Prolepsis Institute and Member of the Hellenic Parliament, Afroditi Veloudaki, Managing Director of the Prolepsis Institute, and Ingrid Stegeman, Programme Manager at EuroHealthNet. Together, they welcomed participants and set the tone for two days of reflection and exchange.

In their opening remarks, they underlined the urgency of strengthening support for populations experiencing the greatest disadvantage, noting that the world is not changing in favour of marginalised groups. They emphasised that women, children, and families living in vulnerable conditions often bear the heaviest burden of inequality, making it essential for public health systems and governments to prioritise their rights, wellbeing, and access to services.



Image 3: Athena Linos, Prolepsis

All three speakers stressed that meaningful progress requires solidarity, coordinated action, and strong collaboration across sectors and across Europe. They highlighted the long-standing role of EuroHealthNet as a “family” of public health organisations that, for decades, has facilitated valuable learning, exchanges, and joint work across Member States.

### Social inequalities in health in the EU

*Ingrid Stegeman, Senior Programme Manager, EuroHealthNet*



Image 4: Ingrid Stegeman, EuroHealthNet

Ingrid Stegeman opened the Country Exchange Visit with a [presentation \(PPT\) of findings from EuroHealthNet’s report on social inequalities in health \(SIH\) in Europe](#), drawing on data from the 2014 and 2024 rounds of the European Social Survey (ESS). She highlighted that gaps in health and wellbeing between socio-economic groups remain large and are, in many countries, widening. This reflects that our societies are not delivering on common values like equity, which can undermine other policy priorities, such as resilience, preparedness, growth and innovation. Ingrid noted that Surveys like the ESS do not capture data on highly vulnerable groups. However, analyses of ESS data still provide valuable context for understanding broader socio-economic trends in health. These trends are relevant because individuals in vulnerable situations tend to be most adversely affected by negative developments.

Using data from 17 countries, Ingrid showed that one in three adults in Europe reports poor health, with striking national variations (from 17% in Ireland to nearly 50% in Lithuania). Poor mental health affects an average of 13% of adults, with the lowest rates in the Netherlands and the highest in Lithuania. Across Europe, people in lower education and occupational groups are twice as likely to report poor physical and mental health than those in the higher groups.

On the drivers of health inequalities, the ESS data show that chronic diseases have risen over the past decade, particularly in countries with greater social and economic inequality. This increase has occurred despite declines in smoking and alcohol use and modest improvements in physical activity. At the same time, unhealthy diets, inadequate housing, unpaid care burdens, and childhood hardship are all becoming more prevalent. Financial strain remains the strongest single predictor of poor health. For mental health, key determinants include employment status, job control, and working conditions, pointing clearly to the need for cross-sectoral action.

Factors most strongly associated with these inequalities include financial strain, high BMI, limited job control, experiences of childhood adversity, and smoking, illustrating the cumulative effects of disadvantage across the life course.

Turning to solutions, she emphasised the need to:

- **Strengthen equity-focused health systems**, capable of monitoring inequalities with granularity and ensuring equitable access to care. Health systems cannot in and of themselves reduce health inequalities and address the needs of highly vulnerable populations, but they can improve their role they can play, through a stronger emphasis on equity.
- **Apply proportionate universalism** - designing universal services delivered at a scale and intensity proportionate to need, complemented by targeted interventions where necessary.
- **Advance cross-sectoral approaches** addressing housing, employment, education, and commercial determinants of health and to ensure more wholistic models of support and to avoid that people fall through the cracks of siloed service provision.
- **Invest in trust-building, culturally sensitive approaches**, such as link workers, mediators, peer supporters, and participatory models, particularly critical for working with Roma communities, migrants, and homeless populations.



- **Promote a whole-of-government shift toward wellbeing** as other measures of progress, alongside economic growth.

Ingrid highlighted that upcoming EU initiatives like the [Anti-Poverty Strategy](#), [Affordable Housing Plan](#), and [Cardiovascular Health Plan](#), offer promising opportunities to embed health equity at the centre of policymaking. Achieving this will require aligning objectives, linking funding to equity indicators, and conducting distributional impact assessments to ensure policies benefit those most in need.

Ingrid linked these findings to the core theme of the Country Exchange Visit. The structural drivers of SIH are even more pronounced among highly vulnerable groups such as Roma communities, migrants, homeless populations, and people facing substance-use challenges. These groups are in a perpetual cycle of systemic discrimination, which makes it difficult for them to meet their basic needs, which generates further discrimination. Holistic, right based approaches are required to break this cycle, to live up to common European values and strengthen resilience and prosperity.

## 2 Work in Greece

### Health and care challenges for Roma communities: Proposed solutions & Lessons learnt

*Dr. Dina Zota, Psychologist, Director of Educational Strategy Development & Health Promotion, Prolepsis Institute*

Dina Zota provided an [in-depth overview](#) (PPT presentation) of Prolepsis Institute's long-standing work with Roma communities in Greece, focusing on the persistent barriers to health and wellbeing and the approaches that have proven most effective in addressing them. While interventions engage the wider community, Roma women and girls are the primary target group, given their central role in within families and communities, acting as key multipliers of health knowledge. However, many face intersecting barriers: low educational attainment, limited health literacy, early marriage and adolescent pregnancy, and restricted access to health and social services. Engagement with men is limited but growing, particularly around preventing early pregnancies and engaging young fathers.



*Image 5: Dina Zota, Prolepsis*

## Education as a turning point

Findings from Prolepsis' participatory research show that most Roma women have only completed primary school. Many express regrets at not continuing their education, linking schooling to independence, employment, and the ability to support their families. Importantly, parents consistently express a strong desire for their children, particularly daughters, to complete secondary education and secure better professional opportunities. Enhancing school attendance and preventing dropout were identified as critical determinants for long-term health and social integration.



Image 6: Picture from the Prolepsis project archive

## Empowerment programmes for Roma women and girls

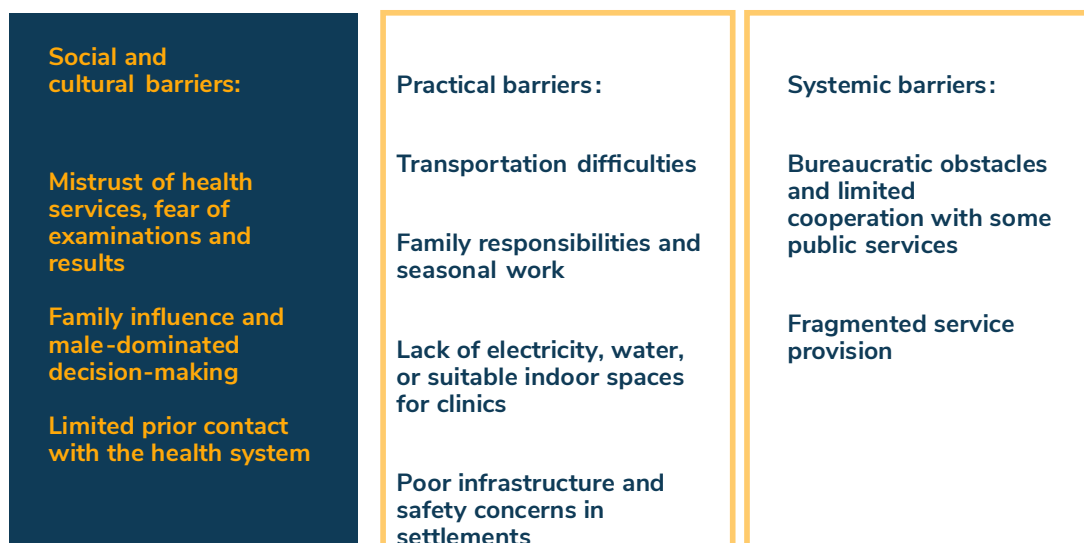
Prolepsis implements several multi-year initiatives aimed at empowering young Roma women in matters of health, prevention, and human rights. One such project (2022–2024) involved the development and delivery of training modules on gynaecological health, vaccinations, smoking, and nutrition. A key innovation was testing a dual model of delivery: health professionals as trainers versus trained Roma women themselves.

The evaluation showed that both approaches improved knowledge, but Roma trainers generated slightly greater gains, illustrating the value of community-led education. All materials used simple language, visual tools, and culturally appropriate content to support understanding.

## A Comprehensive Health Promotion and Disease Prevention Programme

Another major initiative titled Improving the Health of Roma Women in Greece (2022–2025) aimed to improve Roma women's health through a combination of educational sessions and on-site screening services, including Pap tests, mammograms and gender-neutral HPV vaccination. Activities were delivered through mobile clinics or in collaboration with local public health services. These activities targeted health issues identified through participatory research as priorities for Roma women and families.

Dr Zota described several categories of barriers:



### Lessons learnt and recommendations

Dina Zota emphasised that trust takes time and depends on a continuous presence, follow-up, and on-site engagement rather than one-off activities. Trust and participation increased when Roma women, mediators, and female health professionals were actively involved.

Dina Zota concluded with a series of recommendations derived from participant feedback and project experience:

- Engage local stakeholders and Roma community leaders early and consistently
- Use simple, visual, culturally tailored materials
- Employ experiential learning approaches
- Work closely with older Roma women, who hold strong influence
- Provide practical incentives (e.g. hygiene items, food vouchers, children's toys) to facilitate participation
- Deliver services on-site whenever possible to eliminate logistical barriers and offer transportation solutions when this is not possible.

Overall, she highlighted that sustained presence, cultural sensitivity, and meaningful involvement of Roma women and community partners are essential for improving Roma health and reducing inequalities.

## Addressing health disparities: migrants and refugees in the Greek context

Vasiliki Radaïou, Social Epidemiologist, Program Manager, Prolepsis Institute

Vasiliki Radaïou provided an [overview \(PPT presentation\)](#) of the health challenges faced by migrants and refugees in Greece, highlighting how national migration policies, structural barriers, and daily living conditions shape health outcomes for these populations. Her presentation focused on lessons learned from Prolepsis' work in camps, urban settings, and community centres, and on approaches that have proved most effective in supporting access to healthcare.



Image 7: Vasiliki Radaïou, Prolepsis

### A restrictive system that deepens vulnerability

Vasiliki began by setting out the current migration context in Greece, characterised by criminalisation of irregular migration, pushbacks, and deterrence-focused policies. As of 2025, more than 35,000 refugees and migrants had newly arrived, including over 13,000 on the islands of Crete and Gavdos. At the time of the presentation, 27,496 asylum cases were pending at first instance, with 13,148 people still waiting, sometimes up to two years, for their asylum interview.

The Closed Controlled Access Centres (CCACs), where many asylum seekers are housed, as Vasiliki Radaïou described are:

- overcrowded and unsanitary conditions.
- minimal privacy.
- low-quality food distributions (replacing residents' ability to cook for themselves).
- isolation from cities and services.
- heightened levels of internal violence, particularly among teenage boys.
- increased risks of harassment and sexual violence for women.
- insufficient provision for people with disabilities or special needs.

Recognised refugees face significant barriers to integration: despite legal status, two-thirds remain unemployed, often unable to access Greek language classes, banking, or documentation systems. "The system," Vasiliki noted, "seems almost designed to make people fail."

## Building trust in a system perceived as hostile

Under these conditions, trust in institutions and health services is extremely low. Many migrants do not believe that public authorities have their best interests at heart, making health engagement particularly challenging.

Vasiliki highlighted that taking care of one's health is rarely a priority when individuals are preoccupied with survival—finding food, safety, housing, or income. Traditional health promotion messages therefore fail unless tailored to the lived realities of people.

## Capacity building for health professionals

A major component of Prolepsis' work involves strengthening the skills of health professionals—many of whom feel unprepared to serve multicultural and multilingual populations. Training covers, cultural competence, effective collaboration with interpreters and cultural mediators, understanding the social and legal determinants affecting refugees, and awareness of trauma-informed approaches.

Vasiliki highlighted that creating glossaries of essential medical terms, flashcards, and other simple communication tools has significantly improved dialogue around vaccination, screening, and chronic disease management.

## Participatory and community-based approaches

Vasiliki stressed the importance of involving migrants and refugees directly in programme design and implementation. A series of small, community-based events, particularly those that engage women, have been especially effective. These events create safe, familiar spaces for dialogue and acknowledge participants' contributions (even small gifts were offered as recognition). Several women subsequently reported meaningful behavioural changes, such as improved awareness of second-hand smoke, better understanding of violence, or more proactive health-seeking behaviour.

## Tools and EU-supported initiatives

Prolepsis has contributed to and implemented several European projects aimed at improving health literacy, vaccination uptake, and professional capacity:

- **RIVER-EU**: educational initiatives to improve HPV and MMR vaccine uptake in underserved communities; in Greece, school-based science fairs proved especially engaging for children and families.
- **AcToVax4NAM**: repository of tools, glossaries, conceptual frameworks for vaccination communication.
- **Mig-Health Apps**: training migrants and refugees to use digital tools related to health and addiction support.
- **EU Mi-Care**: training curricula for professionals working at the intersection of mental health, psychosocial support, and migration.

Vasiliki concluded by emphasising that health interventions cannot succeed in isolation of the broader environment. When policies focus on deterrence rather than protection, and when day-to-day survival is uncertain, health becomes secondary. The most effective strategies - built on trust, cultural competence, participation, and empathy - are those that acknowledge this reality.

## COVID-19 response and lessons for reaching highly marginalised populations

*George Stamatis, Member of Parliament and General Rapporteur on Roma at the Council of Europe*

George Stamatis presented an account of Greece's efforts to vaccinate two of the country's most marginalised groups during the COVID-19 pandemic: Roma communities and people experiencing homelessness. His reflections highlighted both the practical and societal challenges encountered, as well as the strategies that ultimately proved successful.

### Mapping: the starting point

When the national vaccination campaign began, a major challenge lay in identifying where people lived and how many individuals required support. Homeless populations in Athens, Thessaloniki and Patras were mapped through shelters and outreach organisations, while Roma communities were spread across approximately several hundred sites. Mr. Stamatis emphasised that logistical preparation: mapping, identifying leaders, and coordinating with NGOs, was a critical first step.

### Vaccination results among homeless populations

Despite initial hesitation, the results among the homeless population were impressive:

- 87% of homeless people in major cities were vaccinated
- No deaths among homeless people due to COVID-19 were recorded
- A combination of shelter-based vaccination, outreach workers, and a message of "you decide about your health" proved effective
- Recruitment of translators helped address barriers faced by migrants experiencing homelessness
- Uptake was higher among women than men

## Vaccination in Roma Communities

In Roma settlements, where over 20,000 people live, vaccination uptake reached around 72%, with no deaths among vaccinated Roma. Yet major challenges needed to be overcome. Roma communities carry the weight of intergenerational trauma, stemming from centuries of persecution—including segregation, forced sterilisation, and widespread discrimination. Many believed the state wanted to harm or “exterminate” them.



### Key strategies that worked

#### 1. Bringing services directly to settlements

Over 70 mobile vaccination units were deployed. Ensuring short, accessible, on-site opportunities was essential—expecting Roma people to travel was unrealistic.

#### 2. Focusing on women and girls

Women were more likely to vaccinate, more open to discussion, and, as mothers, able to influence vaccination decisions for children.

#### 3. Engaging trusted community figures

A turning point was identifying Roma leaders, influential elders, and religious figures to communicate messages in culturally relevant ways.

#### 4. Using digital ambassadors and influencers

The government launched a targeted TikTok campaign featuring, popular athletes, religious leaders, trusted community voices, local Roma and Muslim opinion leaders. This approach led to a measured 13% increase in vaccination uptake.

## 5. Understanding the roots of distrust

Mr. Stamatis stressed that the health system must acknowledge its own stereotypes. Many medical students and health professionals hold biased views about Roma people. Real change requires training, cultural competence, and a willingness to “go to them,” not expect them to enter a system they do not trust.

# 3

## National policies and strategies across Europe

The Country Exchange Visit in Athens provided a valuable platform for a roundtable discussion among representatives of EuroHealthNet member organisations on the health challenges faced by highly marginalised groups, including Roma communities, migrants and refugees, and people experiencing homelessness. Participants shared emerging trends in their countries, examples of promising initiatives, and persisting barriers that hinder progress.

### 3.1 Austria

*Represented by Marion Weigl, Austrian Health Promotion Fund*

Despite a traditionally strong social support system, several groups continue to face poverty, social exclusion, and barriers to accessing health and care services. Recent budgetary pressures have led to cuts in social and health services, disproportionately affecting vulnerable groups, especially migrants.

Austria has generated valuable insights through participatory research with Roma communities, distinguishing between autochthonous Roma and Roma with migrant backgrounds. These findings have informed the [Austrian Early Childhood Interventions Programme](#), which provides home visits for families living in difficult circumstances. The programme has demonstrated sufficient flexibility to allow small but important adaptations to better meet the needs of Roma families. For example, initial contact should not be limited to home visits but may be more effective when offered in neutral, mutually agreed spaces, as families often experience fear or distrust. Building trust gradually is essential before entering private homes. Identifying areas where home visitors can provide rapid, practical support early on also helps make the benefits of the programme tangible. As a result of this research, an additional training module was developed for home-visiting staff, with a focus on cultural sensitivity, addressing stereotypes, and strengthening teams' capacity to engage with families from diverse backgrounds.

In the field of migrant health, a promising approach is led by the Austrian National Public Health Institute, which works in a participatory manner with migrants to co-develop accessible health information. This work aims to strengthen health literacy, particularly the skills needed to navigate the Austrian health system.

Another positive example is the Housing First approach, which is currently implemented in seven of Austria's nine federal states. Supported by the Ministry of Social Affairs, the programme has improved access to stable housing for people experiencing homelessness. A key added value is the peer-support component in Vienna, where people with lived experience of homelessness are trained and employed to support others entering housing and related support services.

## 3.2 Kent County, England

*Represented by Nirosha Dissanayake, The Health and Europe Centre / Kent County Council*

The update from England highlighted trends across the country's nine regions, home to a population of 66 million, with a particular focus on the Southeast, Kent County. A key concern is that life expectancy has been decreasing for the past two years, reflecting deepening inequalities across several population groups.

Nirosha described a range of highly vulnerable populations, each facing distinct but overlapping health and social challenges:

- People experiencing homelessness, who have a 30-year shorter life expectancy than the general population and face extremely high burdens of chronic disease. Suicide rates among homeless are nine times higher than among the general population.
- Adults with multiple disadvantages, estimated at over 50,000 nationally, often experiencing combinations of substance dependence, severe mental ill-health, violence, and frequent contact with the criminal justice system.
- Individuals on probation, who often face fragmented service pathways and severe health inequalities.
- Roma communities, who face structural barriers, discrimination, and low access to services.
- Coastal communities, where life expectancy is 10–12 years lower than the national average, a trend also highlighted in recent Marmot reviews.

Several good practices exist across England. The Housing First model, though not currently implemented in Kent, has shown strong impacts in stabilising housing and improving long-term health outcomes. Locally, the MEAM (Making Every Adult Matter) coordinator model assigns a dedicated coordinator to each district to help connect adults with complex needs to appropriate health, social, housing, and justice services. This approach aims to reduce fragmentation and ensure more holistic support.

However, substantial challenges persist. Stigma and discrimination remain key barriers to accessing services. National and local campaigns have sought to reduce stigma, but participants emphasised the continued need for systemic efforts. Digital exclusion is becoming increasingly problematic, as many NHS services and communications now operate digitally. People experiencing homelessness often lack stable access to phones or the internet, creating new obstacles to care.

The need for gender- and age-appropriate services was stressed, as demographic patterns shift. Increasingly, people aged 50–60 are becoming more vulnerable to drug-related deaths, compared to the previously dominant group aged 40–50, requiring tailored responses.

The region also hosts significant asylum seeker populations, particularly near Dover. Many new arrivals are boys aged 16–18, often with no vaccination history and increased risk of infectious diseases such as tuberculosis, dengue, and malaria. They are housed in asylum seeker hotels, where access to health services is inconsistent. While homeless individuals can legally register with a general practitioner (GP) without a fixed address, in practice lack of an address remains a major barrier, preventing GP registration and use of digital health portals.

### 3.3 Germany

*Represented by Elke Hackländer, German Federal Institute of Public Health*

Germany, with almost 84 million inhabitants (December 2025) across 16 federal states, is facing a growing set of challenges related to marginalised populations and widening health inequalities. Homelessness continues to rise, including among women, a trend linked to hidden homelessness, housing insecurity, mental health challenges, drug use, and lack of health insurance. Germany's system still leaves some groups uninsured.

Migrant and refugee populations, from both EU and non-EU countries, experience pronounced inequalities and are often overrepresented in precarious living and working conditions. Recent years have also seen a noticeable increase in older male migrants and refugee women, each with specific support needs related to health status, caregiving responsibilities, labour market participation, and access to social and health services. These needs are not always adequately addressed by existing systems, which are often insufficiently adapted to linguistic, cultural, and legal diversity.

In this context, Germany places increasing emphasis on early childhood as a critical window for reducing long-term health inequalities. National initiatives such as the Early Childhood Support Programme (Frühe Hilfen) aim to strengthen families facing multiple social and psychosocial stressors from pregnancy onwards. By combining health, social, and family support services at the local level, these approaches seek to promote healthy development, parental empowerment, and equal life chances from an early age.

Data on Roma communities remains incomplete: Germany does not officially collect ethnicity-based statistics but estimates range from 70,000 to 300,000. Many come from Bulgaria, Romania, Hungary and Ukraine, and substantial proportion face low literacy levels. The absence of systematic, disaggregated data limits evidence-based planning and makes it difficult to monitor inequalities or assess the effectiveness of targeted interventions.

A cross-cutting governance challenge lies in the distribution of responsibilities across federal, state, and municipal levels. Promising initiatives, particularly community-based and peer-led approaches, which are known to work well, frequently lack long-term funding. As a result,

successful practices often remain project-based and locally confined, despite their demonstrated effectiveness.

To support action on the ground, Germany has established long-standing national support structures for health equity. The Cooperation Network on Health Equity (Kooperationsverbund Gesundheitliche Chancengleichheit) plays a key role in strengthening municipal capacities, facilitating knowledge exchange, and promoting evidence-informed, community-based health promotion for socially disadvantaged groups. By focussing on good practice, participation, and intersectoral collaboration, the network contributes to improving the quality, reach, and sustainability of local interventions.

Germany has set out a policy framework, including the 2015 National Prevention Strategy and the National Strategy to Prevent Homelessness by 2030. However, implementation gaps persist, and better alignment between sectors is needed to transform policy ambitions into practical improvements for vulnerable groups.

### 3.4 Riga City, Latvia

*Represented by Inga Solovjova and Katerina Žiga, Riga City Council*

Riga is home to a diverse population of approximately 600,000 people, including 47% Latvians, then significant Russian and Belarusian-speaking communities, and an estimated 6,000–7,000 Roma residents. Over 12,000 low-income residents in Riga receive municipal support, highlighting the scale of socio-economic vulnerability.

Riga's public health and social policies are closely aligned with national strategies, with the municipality primarily responsible for administrative coordination, procurement, and commissioning of health-promoting and social welfare activities. A wide range of services are available to support marginalised groups:

- Homeless services include both shelter and a day centre, offering primary health care, psychosocial support, and assistance to Ukrainian civilians displaced by the war.
- A Housing First pilot (2024) supported 24 individuals in transitioning from homelessness into stable accommodation, demonstrating promising results.
- Soup kitchens, serving over 600 meals daily, remain an important safety net for people in chronic deprivation.
- For people with disabilities, the municipality provides specialised transportation services to ensure access to medical care, education, and employment.
- Families with children with complex needs also receive municipal assistance, particularly those dealing with mobility challenges or neurodevelopmental disorders.

- Harm reduction services are delivered through long-standing mobile units, offering needle exchange, condom distribution, and support from social workers and psychologists. Many staff have worked in these roles for over 15 years, contributing to strong trust within the communities they serve.

A notable new initiative is a youth-focused sexual and reproductive health service, offering midwife consultations, information on contraception, and access to free hygiene products for adolescent girls and young couples. This reflects growing recognition of the need for tailored youth-friendly approaches.

## 3.5 Netherlands

*Represented by Elise Disselhorst, National Institute for Public Health and the Environment*

Health in the Netherlands has improved overall, but major inequalities persist. People with low education live around five years shorter and spend 14 more years in poor health; those with low income live eight years less, with 21 years in poorer perceived health. Addressing these gaps is complicated by broader societal pressures, including housing shortages, refugee inflows, climate change, and rising living costs, alongside fragmented funding streams and short-term financing.

Despite these challenges, the Netherlands has a long tradition of work in this field. [Pharos](#), the national expertise centre on health inequalities, has supported action for more than 30 years. Several accredited lifestyle interventions effectively target vulnerable groups, such as “Precaution” (VoorZorg), “Moving Works” (Bewegen Werkt), “Feel Good” (Voel je goed).

There is also a national political commitment to reducing health inequalities, reflected in a broad set of initiatives. The [Healthy and Active Living Agreement \(GALA\)](#) launched in 2023, focuses on health inequalities at the municipal level, aiming to stimulate intersectoral collaboration. Another initiative, Wellbeing at School, led by the [Trimbos Institute](#) and [Pharos](#), aim to reduce health inequalities and ensure equal opportunities for students within educational settings.

Other important programmes include the National Liveability and Safety Programme, *GezondIn*, *Promising Start*, *Growing Up in a Promising Environment (OKO)*, the Neighbourhood Smoking Approach, and the Health Literacy Alliance. Knowledge-sharing across the country continues to expand. An overview of effective interventions for people with a low socioeconomic status is available through the [national database](#).

Looking ahead, opportunities include a stronger focus on healthy childhoods; deeper involvement of affected residents in designing solutions; applying a consistent Health in All Policies approach; focus placed not only on local projects, but also on structural national measures; and strengthening the resilience and self-confidence of vulnerable populations.

## 3.6 Poland

Represented by Katarzyna Lewtak, National Institute of Public Health NIH – National Research Institute

### Ukrainian refugees

Poland has faced significant public health challenges following the outbreak of war in February 2022, with a large influx of refugees, predominantly women, children, and older people, arriving in the country. Over 12 million border crossings and more than 1.6 million individuals registered under temporary protection by mid-2023. A large share were women and children, many of whom required urgent medical care, vaccinations (notably MMR and polio), tests, or support for interrupted chronic treatments.

Poland implemented one of the most inclusive healthcare policies in Europe, granting Ukrainian refugees access to healthcare at the same level as Polish citizens from March 2022. This allowed children to be included in the national immunization program, and no outbreaks of vaccine-preventable diseases were reported.

The inclusion of Ukrainian physicians to serve refugee patients proved highly effective, as they could communicate in the same language and guide Polish medical staff. Training for Polish doctors and nurses was necessary to navigate communication barriers and ensure understanding of refugee entitlements. More than 1,000 prevention and health-promotion activities for refugees are recorded annually in the national [Profibaza system](#).

Refugees generally did not live in camps, instead residing with Polish families or independently, which made it challenging to track and ensure follow-up for interventions such as the second dose of vaccination.

### People experiencing homelessness

The 2024 national count recorded 31,042 people experiencing homelessness, numbers that have remained stable for years but with a rising share of women and older adults. Chronic diseases, mental health problems, substance use, untreated injuries, and lack of health insurance are common. Many rely on shelters or stay in non-residential public spaces, facing stigma, fragmented services, and barriers to formal healthcare.

Approximately 100 prevention and health-promotion activities for people experiencing homelessness are recorded each year, in the ProfiBaza system, which is far fewer than for the refugee populations. Community-based organisations therefore play a vital role. A notable example is Fundacja Ambulans z Serca in Warsaw, which provides low-threshold medical aid through street outreach, shelter clinics, psychological support, and medical transport. In 2023–2024 alone, the volunteer team delivered hundreds of on-the-spot medical interventions and engaged medical students to expand capacity. Their street-medicine model helps bridge the gap for individuals excluded from primary care and demonstrates the importance of mobile, trust-building services.

## 3.7 Scotland

*Represented by Omotomilola Ajetunmobi, Public Health Scotland*

Scotland faces some of the widest health and social inequalities in the UK, affecting approximately 5.5 million people, of whom around 10% were not born in the UK. Child poverty and homelessness remain major concerns for the government, and tackling these issues is central to current policy action.

Homelessness is a major policy focus, particularly following COVID-19. Applications for homelessness support are rising, with around 40,000 applications annually. Scotland has robust policies, including the Housing Act 1997 and subsequent legislation, and has established groups in 2017 and 2020 to develop action plans addressing homelessness.

Many people experiencing homelessness had significant contact with the health system in the years preceding their homelessness, highlighting the need for early intervention. The profile of those affected is changing, with increasing numbers of refugees and migrants requiring housing and support.

Some of the local initiatives that provide crucial support:

- [Simon Community Scotland](#)
- [Cyrenians](#)
- [Street Soccer Scotland](#) offers recreational activities while helping participants reintegrate into society.
- [Glasgow City Mission](#) delivers tailored services to meet the immediate and longer-term needs of homeless individuals.

### Challenges and Gaps

While Scotland has strong policies and effective programs, gaps remain in implementation and coordination. Challenges include:

- Fragmented services, especially in rural areas, where individuals may not have access to the same support.
- Data limitations: While numbers are collected, they may not capture the full picture. Anecdotal evidence suggests that people “fall through the cracks” when services are uncoordinated.
- Policies often rely on quantitative data, which may not fully reflect individuals lived experiences.

Efforts are underway to link data across sectors and ensure stories are incorporated into policymaking.

## Collaboration and innovation

Partnerships, such as [Collaboration for Health Equity in Scotland \(CHES\)](#) aim to play a key role in driving coordinated action on inequalities. CHES strengthens national and local efforts to improve health, wellbeing, and equity by combining data-driven insights with local experience. The collaboration aims to identify the most impactful interventions and provide support in closing the gap between policy intent and real-world outcomes.

## 3.8 Wales

*Represented by Kerry Bailey, Public Health Wales*

Wales has a strong foundation for advancing health equity, with devolved control over both health and housing and a long-standing commitment to social justice. As a recognised [Marmot nation](#), Wales works under the principles of the [Well-being of Future Generations Act 2015](#), requiring all public sector bodies to contribute to a fairer, more sustainable society. Around half of the Welsh budget is allocated to health, and the NHS operates on a free-at-point-access model governed by seven health boards.

A major step forward has been the development of a national programme for Health Inclusion [Fair For All - Primary Care One](#) to share good practice, develop and deliver education for receptionists and clinicians in all primary healthcare settings as well as a framework for education for those in specialist inclusion health settings. There was also a first Health Inclusion Summit (2025), during which the Minister for Health launched a national blueprint for improving access to care for all underserved populations. The blueprint emphasises trust, continuity, and co-production with communities, now embedded as core principles across services.

Data and evidence remain key challenges. Health data on marginalised groups such as Roma families, migrants, refugees, people experiencing homelessness, sex workers, and those on probation are incomplete, as many are not registered with a GP despite the fact that no ID is required to do so. To address this, Wales works closely with probation services, asylum and refugee support organisations, and third-sector partners to build more accurate insight. National data dashboards and inclusion lead for all vaccination programmes strengthen oversight and responsiveness.

Service delivery varies across Wales. Rural areas often face the greatest barriers. However, inconsistent funding results in services appearing and disappearing, limiting continuity of care. At the same time, Wales has seen rising homelessness, migration, and substance use, heightening pressures on inclusion health services.

Close collaboration with the third sector is essential, with charities providing outreach, trust-building, and culturally appropriate support. Training initiatives— including anti-stigma programmes and expanded pharmacy training—aim to ensure that frontline staff are prepared to deliver equitable, dignified care.

# 4

## Site visits

### 4.1 Shedia Home, a solidarity and social innovation hub

Shedia is Greece's only street paper, sold in Athens and Thessaloniki by vendors who come from socially excluded groups, including people experiencing homelessness, long-term unemployment, or deep poverty. The model provides dignified, immediate income while helping people reconnect with society.

During the site visit, participants had lunch at Shedia Home and learned directly from Mr. Christos Alefantis (Editor in Chief & Founder of Sxedia) about how the organisation operates in practice: how people who were formerly homeless gain employment, how the street-paper system works, and how Shedia fosters a sense of dignity, purpose, and belonging.

Shedia Home functions as a vibrant multi-purpose hub: a café, social-enterprise shop, workshop venue, cultural space, and distribution point for the magazine. Its core mission is to empower people facing extreme social exclusion by offering training, employment, and pathways to social and economic reintegration.

A distinctive feature of Shedia's work is its commitment to environmental and social innovation. Unsold or returned copies of the street paper are not discarded but upcycled through the "Shediart" programme into handmade design objects and everyday goods. These workshops provide meaningful, skill-building employment for people living below the poverty line, while promoting sustainability and creativity.



Images 8: Shedia entrance and workshop

## 4.2 Praksis – Open Day centre for homeless people in Piraeus

During the exchange visit in Athens, our group had the opportunity to spend an afternoon at the offices of [Praksis](#) – an Open Day Centre for Homeless People in Piraeus, a place that quietly sustains dignity, hope, and human connection for some of the city’s most vulnerable residents. Founded in 2004 through a collaboration with the Region of Piraeus, the centre operates with a simple but powerful mission: to offer free, accessible, and respectful support to anyone in need - no conditions, no exceptions. At the same time, Praksis’ work is carried out under significant uncertainty, as the organisation relies largely on short-term EU project funding alongside limited national support, with no guarantee of continuity from one funding cycle to the next. Despite this instability, the centre continues to provide essential services, highlighting both the resilience of civil society organisations and the structural fragility of support systems for people experiencing homelessness.

Ms Ioanna Tampaki, Sociologist, Member of the Social Service team & the Praksis EU Programs Sector and Mr. Michalis Tsiblakos, Financial Administrator of EU Programs welcomed us warmly, guiding us through a space where people could rest, watch TV, or simply escape the heat. The centre runs separate hours for men and women, allowing everyone to feel safe and comfortable. We learned that every day, between 90 and 100 people come here to take a hot shower, refresh with clean clothing, and enjoy a small snack or drink. Even individuals who technically have housing, often without electricity or running water, rely on the centre for washing and hygiene.

As beneficiaries arrive, Praksis creates a personal file, recording their health, documentation status, and social needs, all handled with strict respect for GDPR standards. The staff approach each person holistically, helping them navigate identity papers, social insurance, medical referrals, and any urgent concerns. Many visitors face long delays in accessing shelter placements, even when their documents are fully in order.



Image 9: CEV Participants visiting Praksis

Some other centres of Praksis, have a social pharmacy where medications are provided free of charge with a prescription. We also learned about the on-site and mobile medical services: general practice, gynaecology, dentistry, mental health support, and infectious disease testing. Their mobile unit travels across the region offering free STI, hepatitis, and HPV testing, as well as harm-reduction supplies and street outreach.

The team spoke openly about the changing face of homelessness in Piraeus. Unlike Athens, where refugee populations, particularly Syrian and African communities, form a large share of those in need, Piraeus sees more Greek, Bulgarian, Albanian, and Romanian individuals, often men, though women with children also come in.

Beyond immediate care, the centre invests in pathways out of homelessness. They offer job counselling and support people in returning to education or training. One initiative, Generation New Agriculture, provides practical experience in agriculture and tourism, with the ambition to train 300 people by 2027. Another programme, Home and Employment, works with municipalities and NGOs to secure long-term housing and jobs. For young adults transitioning out of shelters, the independent living project offers up to 18 months of support to develop autonomy and life skills.

Despite their wide network of services, staff expressed the difficulty of operating in a context where Greece lacks comprehensive, up-to-date data on homelessness. Efforts to map the situation in 2013, 2017, and the upcoming 2025 survey highlight how urgently accurate information is needed. Several ongoing projects, including ComeHome and FindHR aim to build better datasets, algorithms, and digital tools to guide individuals toward stable housing.

### 4.3 Roma Community centre and Roma settlement in Halandri



Image 10: Participants visiting Roma settlement, Halandri

During our visit to the Roma Community Centre and settlement in Halandri, we were welcomed by Mr. Konstantinos Efthymiou, Deputy Mayor for Social Solidarity of the Municipality of Chalandri. Mr Konstantinos Paiteris, President of the Greek Roma Mediators Association also participated in the visit and shared valuable experience. His work focuses on empowering Roma mediators, particularly women, and improving access to education, health services, and social welfare through national and European-funded projects. Mediators play a crucial role: they inform, guide, and bridge the gap between Roma communities and public services.

No two Roma settlements are the same. The settlement in Halandri, established in 2015, is home to 37 permanent residents. Many residents face major barriers to accessing running water, social and healthcare services, leading to very low life expectancy; of more than 2,000 Roma in the area, only eleven people are over the age of 70. Low literacy, poverty, lack of documents, and limited access to specialised care create a cycle of disadvantage. Preventive health concepts, such as prenatal care or postpartum support, are often unfamiliar, yet desperately needed.



Image 11: Participants at Roma Community Centre, Halandri

The community centre provides education sessions, health promotion, and support for navigating services. Trust is key: Roma mediators ensure that women and children feel safe enough to participate, which is essential for improving health literacy and early detection of risks. A local paediatrician works closely with mothers, teaching them how to recognise danger signs in infants. Many women cope with stress by overusing psychiatric medication, while men often turn to alcohol or drugs. Cultural norms around contraception, early marriage, and sterilisation also contribute to health vulnerabilities.

We learned that over 2,000 Roma residents in the area lack legal documents, even though they are entitled to have them, as Greek citizens. This created significant barriers during the pandemic: unlike undocumented migrants and refugees, undocumented Roma could not obtain temporary social security numbers, despite being Greek citizens. Cases of disrespect and mistreatment of Roma women during childbirth were also shared, highlighting the need for training among health professionals.

The municipality of Halandri has taken steps to support urban integration, moving families from unliveable settlement conditions into private housing, a project costing around one million euros. Most Roma people do not want to live in settlements and would prefer to be integrated into society but do not get the opportunity. However, dismantling settlements remains complex, as central government approval is required but there is no official criteria around this; it is a political choice, and political alignment can influence decisions. Meanwhile, European funding that supports community centres like this one will be phased out next year. The trust that has taken over 20 years to build between the community and the centre will also be lost as municipalities cannot sustain staffing and services alone.



Image 12: Participants at Roma Community Centre, Halandri

Housing, employment, education, and health form a hierarchy of needs that is difficult to address when discrimination persists. Many Roma families are refused rental housing simply because of their identity. Children do not attend public schools regularly because they are for example discriminated against for being dirty but are obliged to live in settlements where it is hard to access running water. Without education, health literacy remains low; and without running water and awareness of good hygiene and other health-related habits, avoidable illness becomes common.

The Roma in this region identify as Greek Gypsies, not as a minority group. Their culture is deeply woven into Greek history, dating back to the Byzantine era, and most are devout Orthodox Christians. Yet despite this long-standing presence, structural inequalities persist.



Image 13: Visiting Roma Settlement in Halandri

The visit highlighted a clear message: programmes work when they become policy, and sustainable improvements require government investment, continuity of staff, and strengthened cross-sector collaboration. Young people, through education and changing expectations, offer the most promising path toward long-term transformation.

# 5

## Concluding discussion and next steps

The closing discussion of the Country Exchange Visit brought together reflections from across the two days, highlighting common challenges, shared principles of effective practice, and areas requiring further action. Participants agreed that the issues discussed whether homelessness, poor health among Roma communities, barriers faced by migrants and refugees, or gaps in service access, stem fundamentally from poverty and structural disadvantage. Addressing stigma, strengthening coordination, and ensuring accountability emerged as central themes.

### Addressing poverty and reducing stigma

Participants emphasised that many of the barriers faced by highly vulnerable groups are rooted in poverty, and that stigma continues to limit access to health and social services. Examples such as the *Diatrofi* school nutrition programme, whose impact has been independently evaluated by Deloitte, demonstrating both social and economic benefits, show the value and cost-effectiveness of investing in interventions that break cycles of deprivation. Such evidence can help build political and public support for investing in marginalised communities.

### Shared barriers and cross-country similarities

Despite national differences, participants recognised significant similarities in the obstacles faced by marginalised groups across Europe. These include distrust of institutions, inconsistent access to services, fragmented governance and services, and gaps between national, regional, and local systems. A recurring concern was the fragmentation of and lack of continuity in services, with programmes often ending due to funding cuts or political shifts or reliance on limited duration project grants. It was also difficult across countries to have a good understanding of extreme vulnerability, since these are the groups that often fall through the cracks of the system and are not counted.

Participants from several countries noted that while public health organisations can help alleviate the worst effects of poverty, the underlying drivers require structural action and political commitment. The question of accountability, who is ultimately responsible for ensuring that excluded communities receive equitable care, was raised repeatedly.

### Improving governance, coordination, and participation

Much of the discussion focused on the need for better multi-level governance and alignment between national and local authorities. Several participants stressed the importance of one-stop services, clear referral pathways, and continuity of care. Others highlighted the need for more meaningful participation, including the employment of community members, such as Roma mediators, as part of programme design and delivery. There is scope for improved governance at EU level, to encourage and enable governments to invest EU-level funds to reduce poverty and promote social inclusion in a more coordinated way to embed structural change, rather than fragmented, time-bound and piecemeal initiatives.

Participants reflected on examples from Scotland to illustrate why homelessness receives sustained policy attention there, including strong statistical monitoring, and efforts to understand “what works” through principles such as trust-building, person-centred support, and cross-sector collaboration.

### **The role of narrative, communication, and storytelling**

There is a need to bring the stories of lived experience into policymaking. Participants agreed that communication, how issues are framed and whose voices are amplified, is central to reducing stigma and securing political will. Training community members, frontline workers, and mediators in communication and public speaking was highlighted as a practical, impactful strategy that empowers communities and strengthens advocacy.

### **Collaboration, value creation, and the role of business**

The discussion also touched on broader systemic approaches, including models that involve businesses and private actors in long-term community investment, drawing on examples from the US<sup>1</sup>. Participants noted that demonstrating the value (not only profit) of investing in resilient, healthy communities, could support sustainability in Europe as well. Approaches such as the Collaboration for Health Equity in Scotland, which apply the Marmot Principles to drive system-wide transformation, and the "Making Every Adult Matter" programme in Kent, England were highlighted as promising examples of cross-sector collaboration that build shared purpose and depoliticise action.

## **Next steps**

### **Recommendations for EU, National, Regional, and Local Policy Makers for Improving the Health and Wellbeing of Highly Vulnerable Populations, like Roma and Homeless people.**

#### **Acknowledge deep structural disadvantage**

- Roma and homeless populations remain the only groups in Europe experiencing absolute rather than relative poverty. For Roma people, centuries of discrimination have generated systemic exclusion and deep mistrust toward institutions. Policies must explicitly recognise this background, as it underpins the challenges these groups face and should inform efforts to address them.

#### **Embed training and awareness across sectors**

- Make education on marginalised groups, stigma, discrimination and on effective outreach strategies (e.g., vaccination drives through community

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<sup>1</sup> This paper provides a broad overview: Khullar D and Chokshi DA (2020). Moving to action on place-based health. JAMA. (please see link <https://jamanetwork.com/journals/jama/fullarticle/2761627>)

This paper provides an example of implementing a strategy (where businesses identify shared values of investing in place): Taylor LA and Nichols LM (2024). [Insights From Implementation Of A Community-Based Model For Collaborative Public Good Investing](#). Health Affairs. 43 (1): 72-79

health programmes and behavioural insights) a mandatory part of pre- and post-graduate training for health and social care professionals.

- Provide similar learning opportunities for policy makers and encourage direct engagement, through visits, dialogue, and co-design, with highly vulnerable communities. Embed evidence of how investing in targeted, holistic models of care benefits communities and economies in such training programmes.

#### **Strengthen universal basic services through proportionate universalism**

- Enhance the provision of universal basic services, such as housing, electricity, clean water, education, and health care, while applying a “proportionate universal” approach that directs additional resources and attention to where they are needed most, through targeted programmes and initiatives.
- Institutionalise targeted initiatives like outreach programmes for vulnerable groups by embedding them into mainstream policy frameworks, to secure sustainable funding, ensure continuity, strengthen institutional capacity and maintain trust.
- Support comprehensive, integrated models such as *Housing First* or the *Making Every Adult Matter* coordinator model (Kent, England) that provide a single point of access to a range of services for individuals with or facing vulnerability. Such models help to reduce access barriers for individuals while tackling multiple dimensions of exclusion. Develop such models and interventions collaboratively with affected communities to build trust, increase effectiveness, and promote long-term sustainability.

#### **Promote joined-up commissioning**

- Ensure sustainable financing of initiatives to support vulnerable populations through joint commissioning. This engages different sectors in planning and buying services together instead of separately to achieve common goals and combine their budgets to fund shared solutions, avoiding duplication and gaps.

#### **Engage the private sector in place-based initiatives and impact investments**

- Motivate businesses to co-invest in local, place-based solutions, for example employ homeless people or Roma, that create shared social and economic value for communities. This could be achieved through for example impact investments, or funding from private investors or social funds that expects returns not just in money, but in long-term societal benefits like job training programs that get people off benefits permanently.

#### **Expand the evidence base for long-term, integrated interventions**

- Strengthen evidence on vulnerable populations like Roma and homeless people and non-documented migrants through anonymous, service-based data collection. This enables targeted health and social care while safeguarding political misuse.

- Improving the evidence base matters because better data allows precise targeting of scarce funds to high-need areas and addressing root issues like untreated mental health early to cut emergency hospitalisations and welfare costs. Targeted care stabilises communities and reduces the societal burden of “unseen” health and social costs benefiting everyone by, for example, limiting long-term dependency.
- Continue to build and disseminate evidence on the cost-effectiveness and social impact of holistic, preventive, and long-term approaches that address structural causes rather than symptoms.

### Next steps for the EuroHealthNet Partnership:

- EuroHealthNet has been contributing to consultations in relation to the [EU Anti-Poverty Strategy](#), highlighting the need to recognise the links between poverty, social exclusion and health. The Strategy should therefore incorporate the need to reduce health inequalities, through a systemic approach. We will follow-up on the design of the Strategy and its implementation, in collaboration with bodies like the [Nobody Left Outside](#) coalition.
- EuroHealthNet also call for the EU Anti-Poverty Strategy to be embedded in the annual European Semester process and will monitor whether and how the Country Specific Recommendations deriving from this process will address poverty and social inclusion and orient countries towards taking systemic and sustainable approaches to reduce these.
- EuroHealthNet will also call for a substantial increase and ringfencing of funds to address the root causes of poverty in the future Multi-Financial-Framework that is currently being negotiated at EU-level.
- We will follow up on the implementation of the [European Affordable Housing Plan](#) that was launched in December 2025, as the EU's first comprehensive framework to combat the housing crisis, and calls that it places stronger focus on excluded populations, in follow-up measures. EuroHealthNet will also explore and engage with relevant initiatives in relation to the EU's [new Anti-racism strategy](#) and the [European Social Economy Action Plan](#).
- As part of our work, we will work over the next four years to help amplify the voices of highly vulnerable populations, to tell their stories.
- EuroHealthNet will also continue to identify and share best practice in relation to joined-up models of health and care, joint commissioning and impact investments. We will gather and disseminate evidence on the cost-effectiveness of such actions, over the long term, to encourage further uptake of such approaches across Europe.

# EuroHealthNet

European partnership for [health, equity & wellbeing](#)



**Our mission is to help build healthier communities and tackle health inequalities within and between European States.**

EuroHealthNet is a not-for-profit partnership of organisations, agencies and statutory bodies working on public health, promoting health, preventing disease, and reducing inequalities.

EuroHealthNet supports members' work through policy and project development, knowledge and expertise exchange, research, networking, and communications.

EuroHealthNet's work is spread across three collaborating platforms that focus on practice, policy, and research. Core and cross-cutting activities unite and amplify the partnership's activities.

The partnership is made up of members, associate members, and observers. It is governed by a General Council and Executive Board.

[EuroHealthNet.eu](https://eurohealthnet.eu)

[Health-inequalities.eu](https://health-inequalities.eu)

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