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When Ageing Meets Poverty:

Life in the Rural Areas of the Region of Western Greece

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«While poverty persists, there is no true freedom.»

— *Nelson Mandela*

Introduction

Poverty is a multifaceted phenomenon that often remains hidden in rural and remote areas. It is measured in the European Union using objective criteria that allow for comparisons at both national and regional levels, and is not limited solely to the financial situation of an individual or household[1]. It has a direct impact on living conditions, health, education, financial and emotional security, as well as an individual's overall well-being, consequently leading to social exclusion.

In 2025, 27.5% of Greece's population (2.797.000 people) were at risk of poverty or social exclusion, whilst severe material and social deprivation rose from 14.0% in 2024 to 14.9%[2]. Poverty amongst older people in Greece is gradually worsening, with the rate rising to 20.9% in 2025, compared with 18.8% in 2024 and 17.6% in 2023. The corresponding rate for children aged 0–17 stood at 22.8% in 2025, marking an increase of 0.4 percentage points[3]. In recent years, despite the significant role played by pensions and social transfers in reducing the risk of poverty[4], financial vulnerability amongst older people continues to worsen, as the scope for supplementing their income remains limited, a situation which often leads to a deterioration in their health.

According to the World Health Organization[5], poverty significantly affects people's health and general well-being, as it is linked to unsafe living conditions, inadequate nutrition, limited access to preventive and healthcare services, as well as increased psychological stress, which adversely affects mental health. Specifically, health risks increase when housing conditions are inadequate or unsafe and when the living environment fails to meet hygiene standards, particularly where there is insufficient access to clean drinking water and adequate sanitation facilities. One factor taken into account when assessing the risk of poverty is severe material and social deprivation. This indicator reflects the proportion of the population which, for financial reasons, is unable to secure at least 7 out of the 13 goods, services or social activities considered essential for a decent standard of living[6].

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[1] Data are collected at national and annual level by the national statistical offices of each Member State and form the basis for EU statistics on income and living conditions (EU-SILC) and the at-risk-of-poverty or social exclusion rate (AROPE) for the total population.
Eurostat, EU-SILC and ECHP Surveys: Income and Living Conditions Statistics (Luxembourg: European Commission, 2024), https://ec.europa.eu/eurostat/databrowser/view/ilc_pnp1__custom_8792030/default/table?lang=en.

[2] Hellenic Statistical Authority, Risk of Poverty or Social Exclusion 2025: Survey on Income and Living Conditions of Households (EU-SILC), Press Release (Piraeus: ELSTAT, 19 March 2026).

[3] ELSTAT, Risk of Poverty or Social Exclusion 2025.

[4] Hellenic Statistical Authority, Risk of Poverty or Social Exclusion 2025.

[5] World Health Organization, Equity, Social Determinants and Public Health Programmes (Geneva: World Health Organization, 2010).

[6] Eurostat, "Living Conditions in Europe — Poverty and Social Exclusion," Statistics Explained, 2025, https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Living_conditions_in_Europe_-_poverty_and_social_exclusion.

Another parameter is living in households with very low labour intensity, that is, households where adults (aged 18–59) have worked for less than 20% of their total potential working time during the previous year[7]. To capture the economic and social vulnerability of older people in this study, factors such as employment history, educational background, health status and living in rural or remote areas were also taken into consideration.

Poverty and social vulnerability are not distributed evenly across the population, but are influenced by intersecting factors that can accumulate and reinforce one another. Place of residence, age, housing conditions, health and disability status, as well as access to work and essential services, exacerbate existing inequalities. In the context of this study, the following dimensions of socio-economic vulnerability are of particular importance.

Dimensions of socio-economic vulnerability

Geographical dimension: The geographical dimension constitutes a significant factor in social and economic vulnerability. Residents of rural and remote areas often face greater distances to essential services, limited mobility and unequal access to social and health services[8]. The European Commission also noted in 2026 that, in Greece, people living in rural and remote areas are among the groups particularly at risk of poverty and social exclusion, whilst significant regional inequalities in access to social services persist[9]. This study adopts this spatial distinction as its central axis of analysis, focusing on rural and remote communities in the Region of Western Greece, where the effects of poverty are compounded by limited access to services, geographical isolation and other forms of social inequality.

Age dimension: The economic vulnerability of older people remains significant. According to the most recent data cited in this study, the risk of poverty for older people in Greece rose to 20.9% in 2025, compared with 18.8% in 2024 and 17.6% in 2023. This trend highlights the need to strengthen social protection, particularly for people facing a combination of low income, health problems, care needs or geographical isolation[10].

Housing and financial vulnerability: The cost of housing is a particularly important aspect of financial pressure in Greece. In 2024, 28.9% of Greece's population lived in households where total housing costs exceeded 40% of disposable income, the highest

[7] Hellenic Statistical Authority, Risk of Poverty or Social Exclusion 2025.

[8] Theodosia Anthopoulou, Maria Partalidou, Sofia Nikolaidou, and Glykeria Stamatopoulou, "Poverty and Housing Precariousness in Rural Areas under the Lens of Social Resilience: Revealing Societal Implications of Lived Experiences of Rural Poverty," Societal Impacts 6 (2025): 100119, doi: 10.1016/j.socimp.2025.100119

[9] European Commission, 2026 Country Report—Greece, Commission Staff Working Document SWD(2026) 208 final (Brussels, 3 June 2026).

[10] Hellenic Statistical Authority (ELSTAT), Population at Risk of Poverty or Social Exclusion: Survey on Household Income and Living Conditions, Year 2025 (Piraeus: ELSTAT, 19 March 2026), Table 7.

proportion among EU Member States[11]. The housing cost burden is particularly acute for low-income households and must be considered in conjunction with energy poverty, housing quality and access to basic infrastructure, as 19.0% of the population reported being unable to keep their home adequately warm[12].

Employment and economic insecurity: People living in rural areas often face inadequate infrastructure and limited access to services, as well as limited employment opportunities for the younger population. Furthermore, in rural areas, incomes rely heavily on seasonal agricultural activities, which can exacerbate economic insecurity.

Disability: Disability can affect people at every stage of their lives, including those of working age. In the poorest and rural communities in particular, limited infrastructure, inadequate access to services and barriers in the physical and social environment can exacerbate the inequalities experienced by people with disabilities and restrict their access to employment, healthcare and social participation.

Demographic challenges: Another characteristic of many rural areas is demographic decline, as a significant proportion of the younger population moves to urban centres or abroad in search of employment and better professional or educational opportunities. Population decline and low population density, combined with long distances to essential services and limited economic and job opportunities, contribute to a set of structural and socio-economic challenges that can aggravate the economic and social vulnerability of rural communities, including those in Western Greece.

Selected key figures:

- In 2024, 33.1% of the population in rural areas of Greece was at risk of poverty or social exclusion, compared with 25.4% in small towns and suburbs and 23.8% in cities, a difference of approximately nine percentage points between rural and urban areas[13].
- At regional level, in 2025, 27.9% of the population of Western Greece was at risk of poverty or social exclusion, a figure slightly higher than the 27.5% for the country as a whole[14]. The aggregate regional figures, however, also include the urban population of Patras and therefore underestimate the conditions prevailing in the rural and mountainous communities of the Region, on which this study focuses.
- The economic vulnerability of Western Greece is also linked to long-term transformations in the local labour market. In the wider Patras area,

[11] Eurostat, "SDG 1 — No Poverty," Statistics Explained, 2026, section "Access to Housing and Health Care."

[12] Eurostat, Inability to Keep Home Adequately Warm — EU-SILC Survey, online data code ilc_mdes01, 2026, https://ec.europa.eu/eurostat/databrowser/.

[13] Eurostat, Key Figures on European Living Conditions – 2025 Edition (Luxembourg: Publications Office of the European Union, 2025), 'People at risk of poverty or social exclusion, by degree of urbanisation', data for 2024.

[14] European Commission, 2026 Country Report – Greece, Commission Staff Working Document SWD(2026) 208 final, 3 June 2026, Annex 18, Table A18.1, "Key regional indicators (at NUTS 2 level) for Greece".

deindustrialisation during the final decades of the 20th century was accompanied by the closure of major industrial plants and the loss of jobs, thereby affecting the structure of the local economy and employment[15].

- Significant population decline in Western Greece. The 2021 census showed a 5.4% decline since 2011, with a further decline projected for the coming years[16].
- In recent years, extreme weather events and the wider impacts of climate change have created additional challenges for local communities in Western Greece, particularly those whose economic activity depends to a significant extent on agriculture and livestock farming[17]. Severe storms, floods and recurring wildfires during the summer months result in significant damage to agricultural production, losses of crops and livestock, and damage to homes and infrastructure, further amplifying the economic and social vulnerability of the population. A typical example is the wildfires of August 2025 in the municipalities of Patras and Western Achaea, which caused extensive damage to crops, agricultural and livestock holdings, property and infrastructure. For numerous families and producers, this damage amounts to a loss of income, productive capacity, and financial and housing security[18].

Mental health and poverty

Mental health is a key factor in quality of life and healthy ageing[19]. Conditions such as depression and anxiety may have an adverse impact on people's overall well-being, particularly when they co-occur with social and financial difficulties. European data[20] show that factors such as poverty, low income, precarious employment, inadequate housing conditions and social isolation are associated with a deterioration in mental health and the onset of symptoms of depression and anxiety. The prolonged financial crisis in Greece, with the subsequent reduction in pension benefits and income,

[15] Apostolos Palaiologos, 'Industry and the labour movement in Patras during the 20th century: Transformations in the Context of the Metapolitefsi (1974–1990)' (doctoral thesis, University of Ioannina, 2024).

[16] Hellenic Statistical Authority, Results of the 2021 Population and Housing Census Concerning the Country's Permanent Population (Piraeus: ELSTAT, 2023), https://www.statistics.gr.

[17] Constantinos Antonopoulos, Nikos Koutsias, Vagelis Papadakis, Dimitrios Vitsas, Galateia Katsi, and Ileanna Diamantopoulou, Down to Earth: Environmental Risks Related to Depopulation and an Ageing Population in Rural Areas — Regional Report Year 1: Western Greece (Interreg Europe / University of Patras, 2024), https://www.interregeurope.eu/sites/default/files/2024-02/Western%20Greece%20%20Regional%20Report%20Year%201.pdf.

[18] BBC News, "Wildfires in Western Greece Cause Extensive Damage to Farming," BBC News, 2025, https://www.bbc.com/news/articles/cwy5dqxd0z1o.

[19] Greece has one of the highest overall rates of depression amongst EU populations, including older people. For the general Greek population, see Eurobarometer, Mental Health Factsheet (FL 530) (European Commission, 2023), https://europa.eu/eurobarometer/surveys/detail/3040.

[20] European Commission, European Health Interview Survey (EHIS): Harmonised Mental Health Data Across EU Member States (Eurostat Microdata, 2024), https://ec.europa.eu/eurostat/web/microdata/european-health-interview-survey.

combined with social isolation during the Covid-19 pandemic[21], acted as stressors for older people. Inadequate and unevenly distributed access to mental health services in rural areas constitutes an additional burden, intensifying existing inequalities, particularly for people living in poverty[22].

The role of Co2gether in the study of poverty in Western Greece

Co2gether, an NGO based in Patras working to strengthen social cohesion, reduce inequalities and support vulnerable people, has developed the initiative 'Life Visits', an internationally recognised innovative practice at local, national and European level. Through this initiative, free home-based services are provided, mainly to older people, in collaboration with municipal social services. The multidisciplinary team behind 'Life Visits' comprises, amongst others, a gerontologist, a nurse, a social worker, a home care worker, a psychologist and a lawyer specialising in human rights, and provides personalised home-based interventions as well as activities within the local community. In this way, Co2gether has established a strong presence in Western Greece, with the contribution of professionals and volunteers[23], primarily supporting people living in rural and remote areas who face heightened economic and social vulnerability, with a particular focus on older people.

More specifically, Co2gether provides older people with specialised services, aiming to promote their health, independence and, more generally, improve their quality of life. Through home-based interventions and community-based activities, it offers a comprehensive assessment of each individual's gerontological vulnerability and specific needs, in order to develop a personalised and holistic support plan. At the same time, it offers cognitive enhancement programmes that help to maintain and strengthen cognitive functions, as well as providing mental and emotional support, utilising therapeutic recreation tools that promote wellbeing, social participation and psychological resilience among older people. Furthermore, nursing services are provided and pharmaceutical counselling, aimed at safe health management, the correct administration of medication and support for both the beneficiaries themselves and their carers. The intervention is complemented by legal and administrative advice and guidance, which includes information on rights and social benefits, support in gathering supporting documents and submitting applications, as well as liaison with the relevant public and social services. In this way, the support is tailored to the actual needs of each beneficiary.

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[21] Loukia Moustakopoulou et al., "Exploring Loneliness, Fear and Depression Among Older Adults During the COVID-19 Era: A Cross-Sectional Study in Greek Provincial Towns," *Healthcare* 11, no. 9 (2023): 1234, doi: 10.3390/healthcare11091234.

[22] Vaios Peritogiannis and Christos Lixouriotis, 'Mental health care provision for older people in rural Greece: unmet needs', Journal of Neurosciences in Rural Practice 10, no. 4 (2019): 721–24, https://doi.org/10.1055/s-0039-3399603.

[23] The number of volunteers varies depending on the month and the activities; over 120 people are officially registered. See Co2gether, 'Our volunteers', https://co2gether.gr/οι-εθελοντές-μας/.

Long-term socio-economic changes, demographic decline and the impacts of extreme weather events have placed an additional burden on certain communities in Western Greece. In particular, with regard to extreme weather events, the consequences of climate-related disasters are exacerbating the socio-economic vulnerability of the region's inhabitants. Devastating floods and wildfires have caused significant damage to homes, crops and farms, affecting families and individuals who rely primarily on agriculture and livestock farming for their income.

In response to the growing needs of the local community, and particularly the food insecurity faced by vulnerable individuals and families, Co2gether has developed partnerships with local authorities, social organisations and private enterprises. In this context, the Food Bank of Western Greece was established on Co2gether's initiative; it collects and redistributes food and hygiene products free of charge to vulnerable households living in conditions of poverty and/or isolation, with the support of major supermarket chains, local businesses, sponsors and volunteers. Through this initiative, Co2gether contributes to addressing food insecurity and reducing the risk of hunger among people and households experiencing poverty, social exclusion and isolation.

Study Sample

The study was carried out amongst residents of the Regional Units of Achaea, Elis and Aetolia-Acarnania, with a focus on rural and remote areas of Western Greece. Participants were identified through Co2gether's network of partnerships with local organisations and social services in eight municipalities and met predefined criteria for economic vulnerability. Specifically, the sample included individuals with a disposable monthly income of less than 600 euros, whether they lived in their own home or, in the case of rented accommodation, had less than 600 euros per month remaining after paying rent. The majority of participants were recipients of welfare or social benefits, whilst a large proportion of them received the Minimum Guaranteed Income (MGI) and/or other benefits administered by the Organisation for Welfare Benefits and Social Solidarity (OPEKA), such as housing allowance, disability benefits and the social solidarity allowance for uninsured older people[24]. Eligibility for these benefits is based on specific income, asset and social criteria and, consequently, provides an objective indication of the financial and social vulnerability of the population studied. Although many participants were receiving some form of social benefit, Co2gether provided systematic support primarily to individuals and households with the most acute and complex needs.

Consequently, the sample was not based solely on participants' self-identification as 'poor', but consisted of individuals with a documented very low income and, primarily, of recipients of social and welfare benefits based on official eligibility criteria. This strengthens the study's ability to capture the living conditions and needs of a population experiencing objectively documented economic and social vulnerability.

[24] The Organisation for Welfare Benefits and Social Solidarity (OPEKA) administers, amongst other things, the Guaranteed Minimum Income, the housing allowance, disability benefits and the social solidarity allowance for uninsured elderly people. There are no systematically published data that would allow for a direct comparative assessment of the number of beneficiaries per Regional Unit for all years covered by the study.

The initial sample consisted of 448 participants. Given that not all participants answered all the questions, the number of valid responses varies across the variables. For this reason, each analysis specifies the corresponding number of participants (N) for whom data were available.

Among the 339 participants for whom data on place of residence were available, 74.0% resided in Achaea, 13.6% in Elis and 12.4% in Aetolia-Acarnania. Overall (N = 448), 65.2% were women and 34.8% were men. The mean age was 59.0 years (SD = 16.3), whilst the median age was 60 years. Among the 431 participants with available age data, 44.1% were aged 60 years and over, and 55.9% were under 60 years of age. The age threshold of 60 years was adopted in accordance with the World Health Organization's definition of older adults. All participants provided informed consent prior to completing the questionnaire[25].

Variable	**Category**	**N**	**%**
Regional Unit (N = 339)	Achaea	251	74.0
	Aetolia-Acarnania	42	12.4
	Elis	46	13.6
Gender (N = 448)	Men	156	34.8
	Women	292	65.2
Age	Mean age (SD)	59.0 (16.3)	
	Median (interquartile range)	60.0 (49–69)	
Are you aged 60 or over? (N = 431)	No	241	55.9
	Yes	190	44.1

In addition, the study aimed to provide a broader picture of the conditions and factors affecting their daily lives. In particular, the participants' housing conditions and, more generally, their living environment were examined in order to identify needs and potential interventions to improve their quality of life. The geographical proximity and accessibility of essential public and social services, particularly health services, were also taken into consideration.

Research Process

Co2gether collaborated with the municipal social services in the Regional Units of Achaea, Aetolia-Acarnania and Elis, and, in particular, with social workers, programme managers, staff from the 'Help at Home' programme and Community Centres. Data collection began in April 2023 and was completed in July 2025.

Participants were members of households already registered with municipal social services as being at risk of poverty. The eligibility criteria for receiving food or other material support, as defined by these services, include, inter alia, unemployment, low pension income, inadequate housing conditions, chronic illness and disability.

[25] For the purposes of this study, older people were defined as those aged 60 and over. This definition is consistent with the terminology used by the World Health Organization in the context of monitoring healthy ageing. See World Health Organization, World Report on Ageing and Health (Geneva: World Health Organization, 2015).

Participants were approached in two ways. Municipal staff who were already supporting the households and had established a relationship of trust with them facilitated the beneficiaries' initial contact with the Co2gether team by accompanying Co2gether staff on the first visit and making the introduction. Following the initial visit, the assessment of the households and their enrolment in the Co2gether support programme, the team was able to carry out visits without being accompanied by the municipalities' social services staff. Additionally, six households were identified directly by Co2gether staff and volunteers during the visits and were enrolled in the programme following an assessment.

It is worth noting that participation was entirely independent of the provision of material assistance. Specifically, participants were explicitly informed, both verbally and in written form, that refusing to take part or withdrawing from the study at any stage of the process would not result in the cessation of material support. Given that the research involved health data, which constitute a special category of personal data under Article 9(1) of the General Data Protection Regulation (GDPR), the processing was based on the participants' explicit consent, in accordance with Article 9(2)(a).

Individuals referred to Co2gether via the social services of the local authorities were enrolled in the intensive monitoring programme, with visits taking place every two months or monthly, depending on the needs of each beneficiary. The interventions began in April 2023 and continue to this day.

Among the households that joined the programme, two refused to accept food aid from the outset and five withdrew from it later on, stating that they associated it with a sense of stigma. This finding is consistent with the literature, indicating that social stigma hinders the uptake of food support[26]. The written consent provided by participants during their first visit covered their participation in the programme's follow-up visits for a period of one year. Consent could be freely withdrawn at any time without affecting the receipt of food aid or other forms of support. Following the consent process, the questionnaire was completed by the Co2gether team during the home visit. During the first year of implementation, the questionnaire was administered in paper form, whilst an electronic version was subsequently developed and used.

Responses relating to housing conditions were cross-checked against direct observations made by the Co2gether team during the home visit. The observations covered, inter alia, the presence of a heating system, the condition of the bathroom and kitchen, the presence of basic household appliances, connection to the mains water supply, as well as factors relating to the safety and accessibility of the home, such as ease of access to the entrance and the presence of potential fall hazards, including slippery floors.

[26] Kingsley Purdam, Elizabeth A. Garratt, and Arpana Esmail, "Hungry? Food Insecurity, Social Stigma and Embarrassment in the UK," Sociology 50, no. 6 (2016): 1072–1088, doi: 10.1177/0038038515594092; Kayleigh Garthwaite, Hunger Pains: Life Inside Foodbank Britain (Bristol: Policy Press, 2016); Manos Matsaganis, Horacio Levy, and Maria Flevotomou, "Non-Take-Up of Social Benefits in Greece and Spain," Social Policy & Administration 44, no. 7 (2010): 827–844, doi: 10.1111/j.1467-9515.2010.00744.x; Eurofound, Access to Social Benefits: Reducing Non-Take-Up (Luxembourg: Publications Office of the European Union, 2015).

The study used a purposive sample comprising individuals who were already registered with or had been referred by municipal social services and who, for the most part, were recipients of public financial or social support. As a result, the sample does not represent the entire population of Western Greece, but aims to reflect the living conditions and needs of a socially vulnerable group.

The questionnaire focused on the following topics:

- The existence and type of care or support received by the beneficiaries,
- Household size,
- Housing conditions, including, amongst other things, the size of the dwelling, heating, basic facilities and utilities, and the presence or absence of domestic or other animals,
- The accessibility of the dwelling,
- Access to health, social care and other essential services.

A key objective of the study was to identify needs and problems within the home environment and to examine possible interventions that could be implemented to improve safety, accessibility, independence and, in general, the living conditions of the beneficiaries.

In total, 54.8% of participants were beneficiaries of the Fund for European Aid to the Most Deprived (TEBA), a social assistance programme providing food and basic material support to people experiencing severe material deprivation. The proportion of TEBA beneficiaries was higher among participants under the age of 60 (72.0%) and lower among those aged 60 and over (35.2%). Among participants who were not TEBA beneficiaries, 63.3% were spouses of pensioners, with the proportion reaching 88.5% among those under 60 and 45.8% among those aged 60 and over. Overall, 39.5% of participants were married, whilst 70.8% had children.

The median number of people living in the household was 2 (range: 1–3). For participants aged under 60, the number was slightly higher, at 3 people (range: 2– 4), whilst for those aged 60 and over it was 2 (range: 1–2). Correspondingly, 73% of participants under 60 who had children lived with at least one of them. At the same time, for participants aged 60 and over, this proportion was lower, at 36.4% (overall, 54.9% of those with children lived with at least one of them). Among those who had children but did not live with them, 87.1% reported receiving visits from their children, with once a week being the most frequently reported frequency (33.9%).

Furthermore, 27.6% of participants had a caregiver: 24.5% were cared for by a family member and 3.1% by a professional caregiver. Among participants under the age of 60, 16.3% had a caregiver, with 15.8% receiving care from a family member and 0.5% from a professional. Among those aged 60 and over, the corresponding proportion was 41.2%, with 34.7% cared for by a family member and 6.5% by a professional caregiver. For participants under 60, the family caregiver was most commonly another relative (58.1%), and in 72.4% of cases the caregiver spent more than 8 hours per day in the home. Among participants aged 60 and over, the family caregiver was more commonly a child of the care recipient (38.6%), and in 78.2% of cases the caregiver remained in the home for more than 8 hours per day. In both age groups, professional caregivers

generally provided support for fewer than 8 hours per day (100% among participants under 60 and 66.7% among those aged 60 and over).

Thus, the findings highlight an inverse relationship between the need for and the availability of informal care. As can be observed, although the need for support more than doubles among people aged 60 and over, the proportion living with their children falls from 73.0% to 36.4%, without a corresponding provision of professional care services, which supported just 6.5% of these individuals.

Finally, the mean disability percentage for people under the age of 60 was approximately 16%, whilst for those aged 60 and over it was 20%. A slow but gradual increase in disability with age is evident in the results of this study, with a faster rise observed among those aged over 75. Only 12 people in the study reported receiving support from a paid professional caregiver, usually those living in urban centres, and the recipients were usually people with disabilities under the age of 65, who covered the cost of care through public financial support.

The 'Help at Home' service provided support on a weekly basis, mainly with personal hygiene and shopping for food and other essentials, to people aged 65 and over. This age threshold meant that participants aged 60–64 were not eligible for the service, despite the support needs identified among this age group.

Limitations of the study

This study has certain limitations that must be assessed when interpreting the findings. Firstly, a purposive, rather than a random, sample was used. Most participants were already registered with or had been referred by municipal social services and met criteria for economic or social vulnerability. Therefore, the sample is not representative of the total population of Western Greece, and the results cannot be generalised to the entire population of the Region. Rather, the study aims to provide a detailed picture of the living conditions and needs of a population facing heightened economic and social vulnerability.

Furthermore, the recruitment of participants took place largely through Co2gether's network of partnerships with social services and local organisations. Accordingly, it is likely that individuals experiencing similar conditions of vulnerability but who remain outside the scope of social services and existing support mechanisms are under-represented.

The number of available observations varied across the variables, as complete data were not available for all participants across all questions. For this reason, the results are presented with the corresponding number of valid observations (N) where necessary. Moreover, some data are based on the participants' own reports and may be influenced by factors such as recall bias or subjective judgement. However, specifically with regard to housing conditions, the responses were supplemented by direct observation of the domestic environment by the Co2gether interdisciplinary team.

Finally, the overall sample included both people aged 60 and over and younger participants. Consequently, the conclusions specifically concerning older people are

based on the corresponding sub-group of the sample and on comparisons between the two age groups. Among the participants for whom age data were available, 44.1% were aged 60 and over.
Despite the above limitations, the study provides important primary data from a population that is often under-represented in general population surveys, as data collection took place directly in the participants' home environment.

Housing conditions and accessibility

Overall, 54.4% of dwellings were built before 1978 (49.8% for those under 60 and 59.9% for those aged 60 and over). The majority of dwellings were located within a built-up area, with the corresponding percentages standing at 69.6% and 80.3% in both age groups. The median floor area of dwellings was 65 square metres (range: 42–90) and the majority were detached houses (78.1%), with a higher proportion among those aged 60 and over (83.3% compared with 73.6% among those under 60).

With regard to home safety, safety railings were present in 64.1% of dwellings (62.9% for those aged under 60 and 65.1% for those aged 60 and over). In contrast, accessibility of the home showed a more significant difference, as 77.2% of the homes of people aged 60 and over were classified as easily accessible, compared with 61.7% for those under 60 years of age.

Figure 1 A 67-year-old widower shows the condition of the house in which he lives with his two sons and which he cannot afford to renovate. He speaks with emotion about the religious icons that adorn his home and that, for him, are symbols of faith and hope.

When examining the differences observed in housing conditions between the two age groups, it is worth noting that people aged 60 and over were more likely to live within a settlement and in older dwellings.

The homes of people aged 60 and over were reported to be more easily accessible than those of participants under 60. This difference may be related either to the original

characteristics of the home or to modifications that had been carried out to improve its accessibility and safety.

Figure 2 Where the effects of time meet the hardships of everyday life, every makeshift solution bears witness to the effort to keep a home functioning with the limited resources available.

Diagram showing the year of construction of the dwelling.

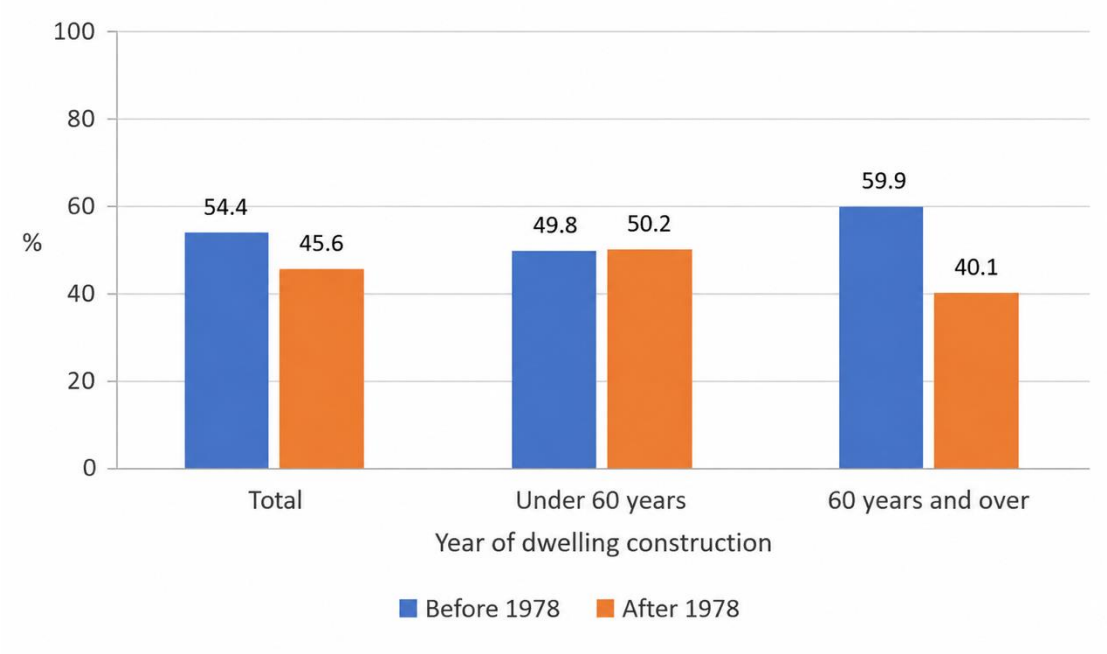


Figure 3 In a mountain village with just 40 residents, Co2gether provided the necessary materials and supported an older couple facing serious challenges, including alcohol-related problems and cancer, in improving their living conditions and maintaining their home.

Kitchen, bathroom and heating

The condition of the homes in which respondents lived was also reflected in the lack of basic facilities and household amenities. A particularly significant finding was that 59 participants (13.2%) did not have a cooker, with this proportion reaching 20% among those under the age of 60, compared with 5.8% among those aged 60 and over. This finding raises concerns about their ability to prepare meals and adequately meet their

dietary needs. Nevertheless, the majority of participants had an electric cooker (70% overall), including 64.6% of those under 60 and 75.7% of those aged 60 and over.

Figure 4 The old appliances, worn-out cupboards and deteriorating walls suggest a daily life marked by deprivation and poverty, visibly reflected in the condition of the kitchen.

Figure 5 The old gas hob and the abandoned house without electricity reflect the particularly adverse living conditions of an older man with mental health problems living in Western Greece.

Furthermore, the proportion of people without basic electrical appliances was high, standing at 35.9% (45.8% and 23.1% for the two age groups respectively). The lack of basic household appliances, such as a fridge, is a significant indicator of material deprivation and can directly affect the safe storage and preservation of food.

Figure 6 The home of an older couple living on a single low pension. The couple live in one room, which serves simultaneously as a living room, kitchen and bedroom, while the fireplace is also used for cooking.

As regards heating methods, the wood-burning stove was the most frequently mentioned (29.5% overall, 34.7% among those under 60 and 21.5% among those aged 60 and over). A fireplace was used by 22.9% of the total sample, with a significantly higher frequency amongst those aged 60 and over (33.9%). Besides, 7.5% of participants had no means of heating at all. Overall, 54.9% described the available heating as inadequate, a figure that rose to 61.1% among those under 60 and stood at 47.4% among those aged 60 and over.

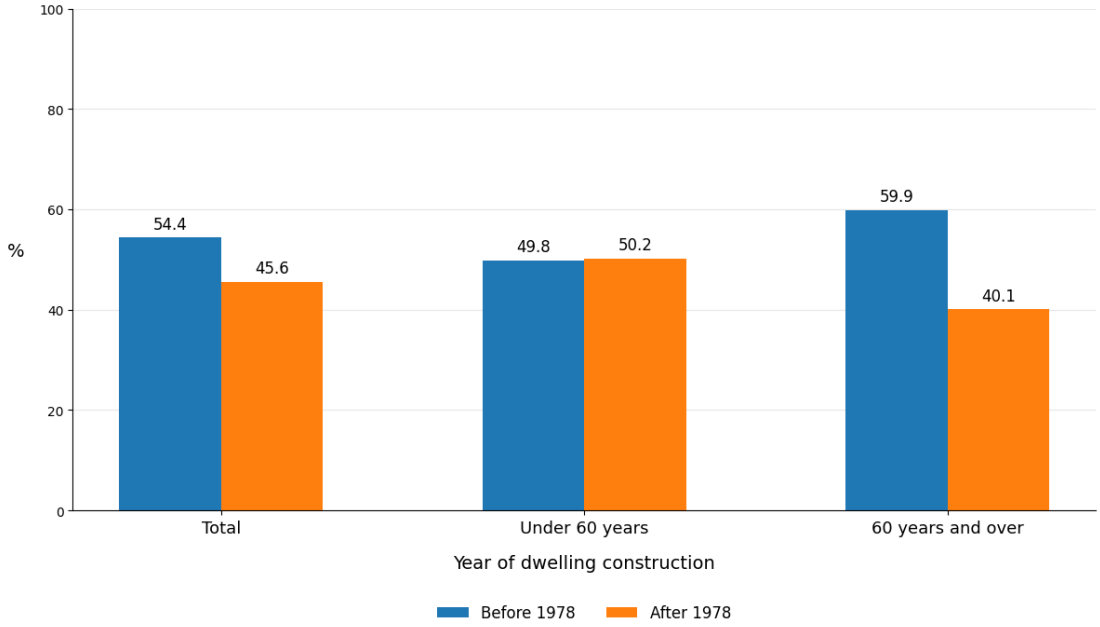
The inability to heat one's home adequately is one of the most widespread indicators of material deprivation in Greece. According to Eurostat data published in 2026, 19.0% of the Greek population reported financial difficulties in keeping their home adequately heated, which is the highest percentage in the EU, alongside Bulgaria. It is noteworthy that the corresponding EU average stands at 9.2%[27].

In addition, 44.8% of participants in the study considered the method used to heat their home to be unsafe. A notable difference was observed between age groups, with the proportion reaching 51.2% among participants under the age of 60, compared with 32.1% among those aged 60 and over.

[27] Eurostat, Inability to Keep Home Adequately Warm.

Figure 7 A makeshift barrier designed to prevent children from approaching the hot surfaces of the stove, in a home where three generations live together.

Diagram of basic heating methods



Water supply and sewerage

A particularly significant finding was the complete absence of sanitary facilities. More specifically, 16.5% of participants (61 people) did not have a bathroom in their home, with this figure rising to 23.0% among those under 60 and falling to 7.7%among those aged 60 and over. Among those who did have one, 43.5% had a shower and 40.0% had a bath tub.

As regards the condition of the available sanitary facilities, 52.1% were recorded as being in good condition (49.8% among those under 60 and 56.2% among those aged 60 and over), whilst 47.9% were assessed as being in fair or poor condition. Poor condition was more common amongst those under 60 (32.2% compared with 19.7%).

Taking these two findings together, more than half of the households in the sample lived in accommodation either without a bathroom or with one in fair or poor condition. Combined with the 13.2% who did not have a cooker, these figures highlight a lack of facilities considered essential for decent living conditions.

Figure 8 Outdoor toilet facilities belonging to a 65-year-old man, consisting solely of a toilet bowl and without access to running water.

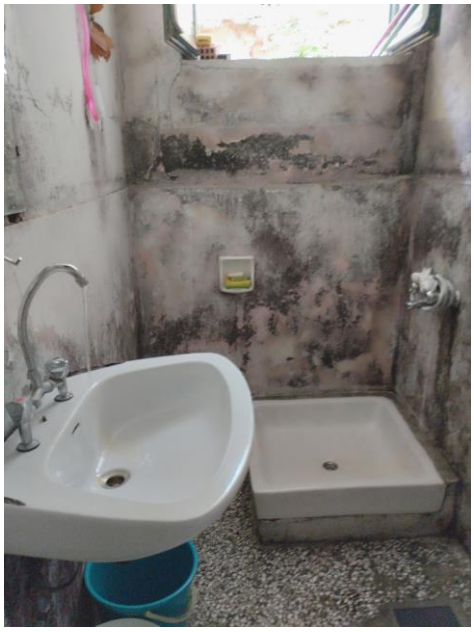


Figure 9 A bathroom showing clear signs of damp and mould, significant damage and conditions that make it difficult to maintain adequate hygiene.

The overwhelming majority of participants who answered the relevant question (99.7%) had access to water via the local water supply network. As regards sewerage, an external cesspit was the most common arrangement among beneficiaries under the age of 60 (43.8%), while an internal cesspit was most common among those aged 60 and over (40.3%). The lack of a connection to a sewerage network is an indicator of poor sanitary conditions. Differences in the location of sanitation facilities play a critical role in the daily lives of older people, as the use of outdoor facilities and the subsequent need to move outside the home can increase the risk of a fall, particularly in dim light or adverse weather conditions.

Figure 10 The particularly precarious living conditions of an 80-year-old man with a disability who lived alone in a makeshift, isolated dwelling without running water and access to basic services.

Figure 11 The 80-year-old man with a disability was found in critical condition due to severe malnutrition and required admission to the University General Hospital of Patras. Co2gether provided comprehensive support by securing suitable rental accommodation, contributing to the rent, and ensuring that his new home was fully furnished and ergonomically adapted to his needs. He also received daily meals and ongoing social support. In addition, support was provided to help him rebuild relationships with his family. Co2gether continued to support him on a regular basis throughout the remainder of his life.

Health and poverty

Physical Health

People living in poverty consistently experience poorer health outcomes, reflecting the combined effects of multiple factors, including income, educational attainment, access to healthcare services, and socially patterned health behaviours. Smoking is one example of a health behaviour that is strongly shaped by social and economic conditions.

In this study, 42.2% of respondents were smokers, with a marked age-related difference: 53.5% among those under 60 years of age, compared with 26.3% among those aged 60 and over. The literature has linked the higher prevalence of smoking among people on low incomes to two main factors. The first is more frequent exposure to stressful living conditions, combined with limited resources to cope with them,[28] while the second concerns barriers to accessing relevant health and support services[29]. Research also suggests that the likelihood of smoking increases when multiple forms of social vulnerability, such as unemployment, poverty and disability, are experienced simultaneously[30]. Such overlapping vulnerabilities were also common among participants in the present study.

Moreover, deteriorating health makes timely and easy access to healthcare services particularly important. Notwithstanding, such access is often limited in rural, remote and economically disadvantaged areas. An examination of participants' access to healthcare services revealed considerable difficulties, particularly among those living in hard-to-reach areas. Overall, 63% of respondents reported having a family doctor, including 61.2% of those under 60 years of age and 64.7% of those aged 60 and over. The healthcare facility most frequently used for medical care was the Health Centre, reported by 48.4% of participants overall, 51.4% of those under 60 and 44.1% of those aged 60 and over. Most participants, irrespective of age, travelled to healthcare facilities by private car (53.5% overall; 57.9% among those under 60 and 47.6% among those aged 60 and over). Notably, 30.8% of participants aged 60 and over required someone to accompany them when travelling to access healthcare services, compared with 9.2% of those under 60.

As far as vaccination is concerned, a total of 81.3% of respondents reported having received at least one of the vaccines examined, with similar proportions in both age groups (80.9% among those under 60 and 81.5% among those aged 60 and over). Analysis by vaccine type, however, reveals notable variations. By vaccine type, higher

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[28] Annika Theodoulou et al., "Differences in the Effectiveness of Individual-Level Smoking Cessation Interventions by Socioeconomic Status," Cochrane Database of Systematic Reviews 2025, no. 1 (2025): CD015120, doi: 10.1002/14651858.CD015120.pub2.

[29] Els C. van Wijk, Lorraine L. Landais, and Janneke Harting, "Understanding the Multitude of Barriers That Prevent Smokers in Lower Socioeconomic Groups from Accessing Smoking Cessation Support: A Literature Review," Preventive Medicine 123 (2019): 143–151, doi: 10.1016/j.ypmed.2019.03.029.

[30] Rosemary Hiscock, Linda Bauld, Amanda Amos, Jennifer A. Fidler, and Marcus Munafò, "Socioeconomic Status and Smoking: A Review," Annals of the New York Academy of Sciences 1248, no. 1 (2012): 107–123, doi: 10.1111/j.1749-6632.2011.06202.x.

rates were recorded among participants aged 60 and over for influenza (58.9% compared with 29.9% for those under 60), pneumococcal disease (33.2% compared with 19.5%), Covid-19 (64.2% compared with 53.1%) and herpes zoster (13.7% compared with 0%). In contrast, people under 60 presented a higher rate of vaccination against tetanus (38.6% compared with 17.4% for those aged 60 and over).

This pattern is further reflected in the high prevalence of chronic conditions within the sample. Overall, 74.8% of participants reported having a chronic condition, with the proportion rising to 92% among those aged 60 and over, compared with 61.9% among those under 60. The particularly high prevalence of chronic conditions amongst older participants highlights the increased need for continuous health monitoring, timely and accessible healthcare, and coordinated support, especially for individuals simultaneously facing financial and social difficulties.

Figure 12 An older woman living on a low pension, who has lost three of her five children, speaks with a municipal social worker during a home visit by the Co2gether team.

Mental health

As previously noted, addressing mental health needs in rural and remote areas of Western Greece remains a significant challenge. The mental health and wellbeing indicator used in the survey was the participants' score on the Generalised Anxiety Disorder Scale (GAD-7). Scores on the scale range from 0 to 21, with higher scores indicating a higher level of anxiety. In this sample, the mean score on the scale was 8.9 (SD = 4.6). For participants aged under 60, it was 8.6 points (SD = 4.7), whilst for participants aged 60 and over, it was 9 points (SD = 4.3). The two age groups did not

show a statistically significant difference in GAD-7 scores ($p = 0.340$)[31]. The Cronbach's alpha was 0.85, indicating good internal consistency of the scale in this particular sample.

In the initial validation of the scale, scores of 5, 10 and 15 were proposed as cut-off points for mild, moderate and severe anxiety, respectively. With regard to symptom severity, 14.0% of participants reported minimal anxiety symptoms, 45.4% mild symptoms, 30.3% moderate symptoms and 10.3% severe symptoms. A broadly similar distribution was observed across the two age groups. Among participants under 60 years of age, the corresponding proportions were 16.7%, 44.2%, 30.0% and 9.2%, while among those aged 60 and over they were 11.4%, 48.4%, 29.9% and 10.3%, respectively. Overall, approximately four in ten participants (40.6%) reported moderate or severe anxiety symptoms.

At the same time, 28.4% of respondents aged 60 and over reported experiencing social isolation, compared with 19.9% of those under 60. This is a particularly important finding, given the association of social isolation with loneliness, psychological distress and poorer overall well-being, particularly in later life.

When examining specific symptoms and difficulties related to mental health and well-being, sleep disorders were the most frequently reported problem, accounting for 52.7% of the total sample (47.7% among those under 60 years of age and 60.0% among those aged 60 and over). Anxiety was reported by 31.7% of participants (31.1% and 33.7% respectively), whilst 29.7% reported fatigue (23.7% and 37.9% respectively). Weakness was recorded in 23.2%, social isolation in 23.0% and unspecified psychosomatic problems in 20.3% of the sample.

Available Greek studies provide evidence of a high prevalence of sleep disorders amongst older people. Sleep disorders are associated with factors such as chronic conditions and depressive symptoms[32]. In a study of an urban population of 250 individuals aged 60 and over, who were members of the Municipality of Larissa's Open Care Centre for Older People (KAPI), the prevalence of insomnia stood at 39.2%[33]. In a subsequent study of a similar population in Larissa, the rate stood at 40.5%[34].

It should be noted that suicidal thoughts were reported by 4.0% of the total sample, with the rate rising to 5.4% among those under 60 years of age and to 1.6% among those aged 60 and over. By contrast, 34.4% of the total sample did not report any of the

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[31] Robert L. Spitzer, Kurt Kroenke, Janet B. W. Williams, and Bernd Löwe, "A Brief Measure for Assessing Generalised Anxiety Disorder: The GAD-7," Archives of Internal Medicine 166, no. 10 (2006): 1092–1097, doi: 10.1001/archinte.166.10.1092.

[32] Efstratios Christodoulou et al., "Depression Is Associated with Worse Health-Related Quality of Life, Lower Physical Activity Levels, and Inadequate Sleep Quality in a Greek Elderly Population," Psychology, Health & Medicine 28, no. 9 (2023): 2486–2500, doi: 10.1080/13548506.2023.2221446.

[33] Konstantinos Tsaras et al., "Predictors of Depression and Insomnia in Community-Dwelling Elderly People: A Cross-Sectional Study of Their Bidirectional Relationship," Cureus 13, no. 3 (2021): e13965, doi: 10.7759/cureus.13965.

[34] Konstantinos Tsaras et al., "The Effect of Depressive and Insomnia Symptoms on Quality of Life Among Community-Dwelling Older Adults," International Journal of Environmental Research and Public Health 19, no. 20 (2022): 13704, https://doi.org/10.3390/ijerph192013704.

specific symptoms examined. This proportion was higher among respondents under 60 years of age (41.1%) than among those aged 60 and over (26.3%).

For all participants who reported suicidal thoughts, Co2gether's immediate support and referral procedure was activated. In each case, Co2gether informed and coordinated with the relevant social and health services and, where appropriate, facilitated access to psychiatric assessment and subsequent follow-up. When required, the organisation also covered the cost of specialist support and the beneficiary's transport to the appropriate healthcare facility or professional. The intervention extended beyond the initial referral and included ongoing follow-up and liaison with the relevant services.

Figure 13 The home of an older man experiencing mental health difficulties, which had significantly affected his ability to maintain a clean and hygienic living environment.

Conclusions

This study highlights that poverty in Western Greece is a multidimensional phenomenon that affects all aspects of an individual's daily life, including housing conditions, health, autonomy, access to essential services and opportunities for social participation, rather than being merely an economic issue. For a significant proportion of participants, particularly older people and those living in rural and remote areas, different forms of vulnerability overlap and interact, creating complex and mutually reinforcing forms of social exclusion and inequality. The findings reveal inadequate housing conditions, insufficient or unsafe heating, limited access to basic facilities and, in some cases, living conditions that compromise personal safety and the ability to live with dignity. At the same time, chronic health conditions, mental health difficulties, disability, limited support networks and residence in remote and underserved areas contribute to increased needs for support and care.

Place of residence emerges as a particularly important determinant of access to essential services and support. Long distances, limited service availability and mobility difficulties can turn even basic needs, such as travelling to a healthcare facility or Health Centre, accessing social services, or obtaining essential goods and food, into significant daily challenges.

The study's findings therefore highlight substantial inequalities in the effective enjoyment of fundamental human rights among certain population groups. These include the rights to health, safe and sufficient water, adequate housing, social protection and an adequate standard of living. These rights are universal, inherent and inalienable: they belong to every person by virtue of being human and cannot be taken away. They must therefore be respected, protected and fulfilled without discrimination on the basis of age, gender, disability, place of residence, socioeconomic status or any other characteristic.

Hence, tackling poverty in rural and remote areas cannot be limited solely to income support. A comprehensive and coordinated approach is required, linking social protection with healthcare and mental health support, improved housing conditions, accessibility, transport, food security and support for informal caregivers. Furthermore, interventions must be tailored to the specific needs of rural communities and reach those individuals who, due to age, disability, isolation or financial hardship, face greater barriers to accessing available services themselves.

Co2gether's experience in the field demonstrates the importance of early identification of needs, home-based and personalised holistic approach, and close cooperation between social services, health professionals, local authorities and civil society organisations. Such approach can contribute significantly to identifying and supporting vulnerable individuals, who would otherwise remain outside the reach of formal support systems and face persistent barriers to the effective exercise and enjoyment of their fundamental human rights.

Proposed immediate measures

1. Targeted energy and housing improvements for economically vulnerable households

The findings regarding inadequate and unsafe heating, dilapidated housing conditions and the lack of basic infrastructure highlight the need for targeted interventions to improve energy efficiency and carry out minor home repairs. Priority should be given to low-income households, older people, persons with disabilities and other socially vulnerable groups who may lack the financial means to improve their living conditions independently.
Such interventions could include improvements to heating systems, insulation and energy efficiency, repairs addressing safety and hygiene concerns, and the provision of essential household infrastructure where this is lacking.

Responsible and collaborating bodies:

- Ministry of Environment and Energy
- Ministry of Social Cohesion and Family
- Regions and Municipalities
- Civil society and non-profit organisations, where appropriate

2. Coordinated action on housing, energy poverty and health

Housing conditions, the ability to adequately heat the home, and health are closely interconnected and should not be addressed in isolation. A coordinated referral and intervention mechanism is needed so that, when an individual or household facing multiple and overlapping needs is identified, a comprehensive assessment can be carried out and a personalised support plan developed. Such a plan may include measures to improve housing conditions and energy efficiency, accessibility and safety adaptations, as well as referrals and links to healthcare, mental health and social care services.

Responsible and collaborating bodies:

- Ministry of Environment and Energy
- Ministry of Health
- Ministry of Social Cohesion and Family
- Regions and Municipalities
- Health Centres, mobile health units and mental health services
- Civil society organisations, where appropriate

3. Strengthening prevention and primary healthcare in rural and remote areas

The high prevalence of chronic conditions and the difficulties reported in accessing healthcare services highlight the need to strengthen prevention, early detection and continuous health monitoring in rural and remote communities. This requires stronger primary healthcare services, regular preventive health outreach, mobile health units and improved capacity of local Health Centres to respond to the needs of geographically isolated populations.

Responsible and collaborating bodies:

- Ministry of Health
- Regional Health Authorities
- Health Centres and mobile health units
- Regions and Municipalities

4. Strengthening home-based care and support for informal caregivers

The high prevalence of chronic conditions, mobility limitations and restricted access to professional care highlight the need to strengthen home-based health and social care services. At the same time, family members and other informal caregivers should be

supported through counselling, practical training, psychosocial support and respite care services.

Responsible and collaborating bodies:

- Ministry of Health
- Ministry of Social Cohesion and Family
- Regions and Municipalities
- 'Help at Home' services
- Civil society and non-profit organisations

5. Integrating mental health support into social and home-based care

The high prevalence of anxiety symptoms, social isolation and other indicators of psychological distress highlights the need for systematic screening, early identification and timely referral. Comparative international evidence indicates that Greece continues to face significant gaps in the provision of mental health services, particularly in prevention and mental health promotion[35]. The use of validated screening tools, combined with clear referral pathways and protocols linking social and home-care services with mental health professionals, can help identify and support individuals who might otherwise remain outside the reach of formal mental health services.

Responsible and collaborating bodies:

- Ministry of Health
- Health Centres and mental health services
- Regions and Municipalities
- Social services
- Civil society organisations

6. Local initiatives for digital inclusion and access to public services

The increasing digitisation of public, health and social services can create additional barriers for older people, people with limited digital skills and residents of rural and remote areas. Local digital inclusion programmes, combined with practical in-person support, are needed to facilitate access to healthcare, social protection, benefits and public administration services.

Responsible and collaborating bodies:

- Ministry of Education, Religious Affairs and Sports
- Relevant lifelong learning and adult education bodies

[35] Konstantinos Kotsis et al., "The State of Mental Health in Greece: An International Comparative Analysis Using Data from the Global Mental Health Countdown 2030," International Journal of Social Psychiatry 71, no. 4 (2025): 757–69, https://doi.org/10.1177/00207640241303029.

- Regions and Municipalities
- Open Care Centres for Older Persons (KAPI)
- Community Centres and social services
- Civil society organisations

Key message

Civil society plays a crucial role in identifying, reaching and supporting people who often fall outside the reach of existing services. However, the scale and complexity of the needs identified in this study exceed what can be addressed through isolated interventions or purely charitable responses.

A cross-sectoral public policy approach is therefore required, addressing poverty, housing, health, mental health, care and access to services in an integrated manner rather than as separate issues, with particular attention to people experiencing multiple and overlapping forms of vulnerability.

Addressing poverty cannot be limited to meeting basic survival needs. It must ensure the conditions necessary for every person to live with dignity and to effectively exercise and enjoy the full range of their human rights.

Appendix A – detailed tables

Age, marital status, care and disability

Variable	Category	Total N	Total %	Under 60 N	Under 60 %	60 YEARS AND OVER N	60 YEARS AND OVER %
TEBA beneficiaries	No	177	45.2	59	28.0	107	64.8
	Yes	215	54.8	152	72.0	58	35.2
If not TEBA beneficiaries	Pensioners	65	36.7	7	11.5	58	54.2
	Spouses of pensioners	112	63.3	54	88.5	49	45.8
Marital status	Widowed	67	17.5	7	3.6	58	34.3
	Divorced	78	20.4	43	21.9	30	17.8
	Unmarried	86	22.5	59	30.1	26	15.4
	Married	151	39.5	87	44.4	55	32.5
Total people living in the household	Mean (SD); Median (interquartile range)	2.5 (1.6); 2 (1–3)		3.0 (1.8); 3 (2–4)		2.0 (1.1); 2 (1–2)	
Children	No	121	29.2	72	33.8	41	22.3
	Yes	293	70.8	141	66.2	143	77.7
Children living at home	Do not live at home	132	45.1	38	27.0	91	63.6
	Living together	161	54.9	103	73.0	52	36.4
Visits by children	No	17	12.9	6	15.8	10	11.0
	Yes	115	87.1	32	84.2	81	89.0
Frequency of Children's Visits	Every day	24	19.4	4	10.8	20	23.8
	Every week	42	33.9	13	35.1	27	32.1
	Every month	24	19.4	11	29.7	13	15.5
	Less frequently	34	27.4	9	24.3	24	28.6
Do you have a caregiver?	No	275	72.4	164	83.7	100	58.8
	Family caregiver	93	24.5	31	15.8	59	34.7
	Professional caregiver	12	3.1	1	0.5	11	6.5
If the caregiver is a family member	Child	31	34.1	8	25.8	22	38.6
	Relative	38	41.8	18	58.1	19	33.3
	Neighbour	1	1.1	0	0.0	1	1.8
	Friend	6	6.6	2	6.5	4	7.0
	Spouse	15	16.5	3	9.7	11	19.3
If the caregiver is a family member	Fewer than 8 hours	16	18.4	7	24.1	8	14.5
	More than 8 hours	66	75.9	21	72.4	43	78.2
	Outside the home	5	5.7	1	3.4	4	7.3
If the caregiver is a professional	Fewer than 8 hours	5	71.4	1	100.0	4	66.7
	More than 8 hours	2	28.6	0	0.0	2	33.3
	Outside the home	0	0.0	0	0.0	0	0.0
Disability percentage (%)	Mean (SD); Median (range)	18.2 (32.1); 0 (0–20)		16.2 (30.4); 0 (0–0)		20.0 (33.8); 0 (0–50)	

Description of housing conditions

Variable	Category	Total N	Total %	Under 60 N	Under 60 %	60 YEARS AND OVER N	60 YEARS AND OVER %
Year of construction	Before 1978	242	54.4	120	49.8	112	59.9
	After 1978	203	45.6	121	50.2	75	40.1
Location	Within a settlement	328	73.7	167	69.6	151	80.3
	Outside built-up areas	117	26.3	73	30.4	37	19.7
House area (numeric value), Arithmetic mean (SD), Median, interquartile range	Mean (SD); Median (interquartile range)	67.8 (41.5); 65 (42–90)		66.5 (47.5); 63 (40–90)		69.2 (32.4); 65 (50–85)	
Number of rooms (excluding bathroom)	1	83	19.0	57	23.8	26	14.3
	2	88	20.1	42	17.6	42	23.1
	3	125	28.6	72	30.3	47	25.8
	4	88	20.1	41	17.2	43	23.6
	5	45	10.3	25	10.5	19	10.4
	6	8	1.8	3	1.3	5	2.7
Type of dwelling	Detached house	342	78.1	173	73.6	155	83.3
	Flat	96	21.9	62	26.4	31	16.7
The house comprises	Ground floor	333	97.4	170	98.3	149	96.1
	Basement	8	2.3	4	2.3	4	2.6
	Upper floor	68	19.9	37	21.4	30	19.4
Which of these are habitable?	Ground floor	318	93.0	161	93.1	144	92.9
	Basement	16	4.7	7	4.0	8	5.2
	Upper floor	59	17.3	31	17.9	28	18.1
Protective guardrails	No	160	35.9	89	37.1	66	34.9
	Yes	286	64.1	151	62.9	123	65.1
Access to the entrance	Easy	307	68.8	148	61.7	146	77.2
	Difficult	139	31.2	92	38.3	43	22.8
Yard/Balcony	No	29	6.5	13	5.4	14	7.4
	Yes	416	93.5	227	94.6	174	92.6

Kitchen, bathroom and heating

Variable	Category	Total N	Total %	Under 60 N	Under 60 %	60 YEARS AND OVER N	60 YEARS AND OVER %
Cooker	No	59	13.2	48	20.0	11	5.8
	Electricity	312	70.0	155	64.6	143	75.7
	Petrogaz	65	14.6	31	12.9	31	16.4
	Both	10	2.2	6	2.5	4	2.1
Lack of basic electrical appliances	No	282	64.1	129	54.2	143	76.9
	Yes	158	35.9	109	45.8	43	23.1
Heating	Fireplace	101	22.9	35	14.6	63	33.9
	Oil-fired stove	13	2.9	8	3.3	5	2.7
	Gas stove	26	5.9	15	6.3	11	5.9
	Wood-burning stove	130	29.5	83	34.7	40	21.5
	Fan heater	12	2.7	3	1.3	8	4.3
	Radiators	87	19.7	41	17.2	41	22.0

	Electric heating element	88	20.0	42	17.6	44	23.7
	Natural gas	3	0.7	2	0.8	1	0.5
	Air conditioning	81	18.4	41	17.2	38	20.4
	No heating	33	7.5	20	8.4	11	5.9
Heating	Adequate	188	45.1	89	38.9	91	52.6
	Inadequate	229	54.9	140	61.1	82	47.4
Heating safety	Safe	122	55.2	63	48.8	57	67.9
	Unsafe	99	44.8	66	51.2	27	32.1
Bathroom	No	72	16.5	55	23.0	14	7.7
	Shower	190	43.5	96	40.2	88	48.4
	Bath	175	40.0	88	36.8	80	44.0
Bathroom condition	Good	222	52.1	116	49.8	100	56.2
	Moderate	87	20.4	42	18.0	43	24.2
	Poor	117	27.5	75	32.2	35	19.7
Type of water supply	Well	1	0.3	0	0.0	1	0.6
	Local water supply network	387	99.7	215	100.0	163	99.4
Drainage	Connection to the sewerage network	53	32.9	23	28.8	28	38.9
	Domestic cesspit within the house	52	32.3	22	27.5	29	40.3
	Domestic cesspit outside the house	56	34.8	35	43.8	15	20.8

Health status

Variable	Category	Total N	Total %	Under 60 N	Under 60 %	60 YEARS AND OVER N	60 YEARS AND OVER %
Do you smoke? (N = 446)	No	258	57.8	112	46.5	140	73.7
	Yes	188	42.2	129	53.5	50	26.3
Does anyone else smoke in the house apart from you? (N = 446)	No	248	55.6	109	45.2	133	70.0
	Yes	198	44.4	132	54.8	57	30.0
Do you have a family GP? (N = 416)	No	154	37.0	85	38.8	65	35.3
	Yes	262	63.0	134	61.2	119	64.7
The doctor IS (N = 409)	Private	110	26.9	55	25.0	53	29.9
	Hospital doctor	101	24.7	52	23.6	46	26.0
	Health Centre	198	48.4	113	51.4	78	44.1
How do you get to the nearest medical centre?	On foot	104	23.7	62	25.8	39	21.1
	By public transport	51	11.6	35	14.6	14	7.6
	Accompanied	80	18.2	22	9.2	57	30.8
	Unaccompanied	9	2.1	5	2.1	4	2.2
	By taxi	57	13.0	23	9.6	34	18.4
	By private car	235	53.5	139	57.9	88	47.6
Distance by road from the Health Centre	Near	249	56.3	131	54.4	113	60.8
	Far	193	43.7	110	45.6	73	39.2
Distance by road from the	Near	227	52.9	127	53.1	92	52.0

Regional Medical Centre							
	Far	202	47.1	112	46.9	85	48.0
Have you been vaccinated? (N = 439)	No	82	18.7	46	19.1	34	18.5
	Yes	357	81.3	195	80.9	150	81.5
Vaccines	Tetanus	129	28.8	93	38.6	33	17.4
	Flu	187	41.7	72	29.9	112	58.9
	Pneumococcal	113	25.2	47	19.5	63	33.2
	Covid-19	261	58.3	128	53.1	122	64.2
	Herpes zoster	27	6.0	0	0.0	26	13.7
Chronic condition (Yes)	Yes	330	74.8	148	61.9	173	92.0

Anxiety and stress

Measure	Total	Under 60	60 YEARS AND OVER
Generalised Anxiety Disorder (GAD-7) – Mean (SD); Median (interquartile range)	8.9 (4.6); 8 (6–12)	8.6 (4.7); 8 (6–12)	9.0 (4.3); 8 (6–12)

Anxiety level

Level	Total N	Total %	Under 60 N	Under 60 %	60 YEARS AND OVER N	60 YEARS AND OVER %
Minimal	61	14.0	40	16.7	21	11.4
Mild	198	45.4	106	44.2	89	48.4
Moderate	132	30.3	72	30.0	55	29.9
Severe	45	10.3	22	9.2	19	10.3

Mental health symptoms and difficulties

Symptom	Total N	Total %	Under 60 N	Under 60 %	60 YEARS AND OVER N	60 YEARS AND OVER %
Sleep disorder	236	52.7	115	47.7	114	60.0
Weakness	104	23.2	45	18.7	57	30.0
Anxiety	142	31.7	75	31.1	64	33.7
Social isolation	103	23.0	48	19.9	54	28.4
Lack of interest	68	15.2	36	14.9	29	15.3
Reduced concentration	41	9.2	18	7.5	22	11.6
Suicidal thoughts	18	4.0	13	5.4	3	1.6
Reduced appetite	46	10.3	19	7.9	26	13.7
Feelings of inadequacy	45	10.0	26	10.8	17	8.9
Fatigue	133	29.7	57	23.7	72	37.9
Unspecified psychosomatic problems	91	20.3	49	20.3	38	20.0
None	154	34.4	99	41.1	50	26.3

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