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Health promotion and homelessness – findings from ProfiBaza on public health interventions in Poland (2021–2024)

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Abstract

Introduction and Objective. Homelessness constitutes a challenge for public health (PH) as people experiencing homelessness (PEH) face marginalization, barriers to healthcare and social support, as well as diverse health needs that remain insufficiently addressed. Since immediate survival needs among PEH often supersede health concerns, community-based health promotion (HP) interventions are crucial for reducing health inequities within this disadvantaged population. The aim of the study is to determine the scale and scope of HP interventions targeting PEH implemented in Poland.

Material and Methods. The analysis covers 2021–2024 data on PH interventions delivered in community settings in Poland by local government units and health system institutions, obtained from ProfiBaza – a national registry of health promotion and disease prevention (HPDP) programmes managed by the National Institute of Public Health NIH-NRI.

Results. Between 2021–2024, among 21,944 HPDP interventions aimed at people at risk of social exclusion, only 163 specifically targeted PEH, which included: mental health support (38.0%), shelter provision (31.9%), reintegration programmes (26.4%), street outreach (17.8%), health education (14.7%), harm reduction (12.9%), meal provision (12.9%), healthcare services (11.0%), vaccination and screening (11.0%), distribution of essential clothing/hygiene products (11.0%), medical equipment (5.5%), Housing First interventions (1.8%), staff training (1.8%), and crisis interventions (1.2%), with only 1.2% of interventions targeting PEH solely in rural vs. 59.5% in urban settings.

Conclusions. PEH are at a high risk of being left behind; therefore, multisectoral approaches to address their health challenges, along with HP initiatives that provide practical support and are underpinned by appropriate regulation and sustainable funding, are essential.

Key words

health promotion, health services, homelessness, disease prevention, public health interventions, health programmes, people experiencing homelessness

INTRODUCTION AND OBJECTIVE

Homelessness is a global major challenge for public health, characterized by unmet health needs among people experiencing homelessness (PEH) and a substantial strain on social, healthcare, and economic systems. A homeless person is defined as:

> a person who does not reside in a residential premises as defined by the regulations on tenant rights protection and municipal housing resources, and is not registered for permanent residence under population registration regulations, as well as a person who does not reside in a residential premises and is registered for permanent residence in a premises where living is not possible [1].

According to the 2024 National Research on the Number of Homeless People (led by the Ministry of Family and Social Policy), 31,042 individuals are recorded as PEH in Poland, of whom men comprise 80.1%, although recent trends indicate a growing proportion of women (from 16.4% [2019] to 19.9% [2024]). The majority (78.6%) are accommodated in institutional facilities, whereas 21.4% in public or non-residential spaces. Geographically, homelessness is concentrated in the Northern (23.6% of PEH), Southern (19.8%), and North-Western (18.3%) macro-regions. Most PEH hold Polish citizenship (90.1%), with a smaller proportion of Ukrainian nationals (5.6%) [2].

Although PEH face a wide range of health challenges, they often remain a marginalized and hard-to-reach group in the context of health promotion and disease prevention (HPDP) interventions. During the COVID-19 pandemic, PEH were considered one of the most at-risk groups [3]. PEH have a life expectancy about 17.5 years shorter than the general population, mainly due to poor healthcare access – over 50% homeless respondents, according to the Repka study, could not

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recall their last GP visit [4, 5]. Harsh living conditions increase vulnerability to weather-related threats; hypothermia-related deaths are 13 times more common among the homeless [4]. Malnutrition, chronic illnesses, substance abuse, violence, and accidents further exacerbate health disparities and marginalization. All those factors may result in a large dependency on emergency departments and extended hospital stays for ambulatory care sensitive conditions, thus exacerbating the economic burden on the healthcare system, as most of the PEH lack health insurance [5].

Due to the complex determinants of homelessness, including individual characteristics and experiences, as well as social, economic, and cultural factors influencing this phenomenon, interdisciplinary and systemic public health measures incorporating a health promotion (HP) approach are needed [6, 7].

In Poland, providing assistance to people in vulnerable situations, including PEH, is a state responsibility regulated by law, with the Social Welfare Act of 2004 constituting the primary legal framework, complemented by the long-standing 'Overcome Homelessness. Assistance Programme for the Homeless', which supplements the statutory responsibilities of local governments [1, 8]. About 50 NGOs collaborate with authorities to provide housing, medical, and social support [9]. Research consistently shows that PEH face multidimensional barriers to healthcare, psychological support, and access to essential resources [3, 10, 11].

In recent years, HP has increasingly prioritized a coordinated approach to populations in vulnerable situations, emphasizing behavioural modification through targeted community-level interventions. Modern approaches to HP focus not only on lifestyle, risk factors, and preventive health behaviours, but also on broader societal concerns of the environment and public policy. One of the main goals of HP is to achieve equity by reducing health inequalities and ensuring that everyone has an equal opportunity to reach their full health potential, regardless of social position. The implementation of this concept is carried out through recommended strategies, including building healthy public policy, creating supportive environments, developing personal skills, strengthening community actions, and reorienting health services. HP addresses socio-economic determinants of health and engages multiple sectors to support vulnerable populations, particularly individuals at risk of poverty, social exclusion, and adverse health outcomes [12]. Due to the lack of safe shelter or a home, the fundamental determinant and prerequisite for health, PEH experience deprivation in social and health-related needs [3, 13, 14]. HP strategies and HP programmes aimed at improving the health of PEH should be adapted to the local needs and possibilities of individual countries and regions, taking into account differing social, cultural, and economic systems [15].

There is limited evidence on HP interventions for PEH implemented by local government units and health system institutions in Poland as part of their public health responsibilities, and little is known about how to make these interventions more effective in addressing the needs of PEH. The aim of the study is to address the existing knowledge gap by systematically analysing HP interventions delivered as part of public health tasks to address PEH health and social needs in Poland, with particular attention to their structure, regional distribution, and changes in implementation from 2021–2024.

MATERIAL AND METHODS

This retrospective cross-sectional study was based on data on HP interventions for adult PEH implemented in Poland between 2021–2024, including characteristics of the organizers and programmes (target population, time and location/region, duration, and types of HP activities), obtained from the ProfiBaza system. This system, managed by the National Institute of Public Health NIH-NRI, serves as an electronic platform for collecting information on implemented HPDP interventions in Poland, including activities targeting vulnerable populations such as PEH or migrants. This reporting obligation applies to health institutions (e.g., ministries, the State Sanitary Inspection, research institutes, and organizational units of uniformed services) as well as local government units at all administrative levels.

Interventions were categorized by the European Federation of National Organizations working with the Homeless, resulting in a matrix of homelessness services [11] (Fig. 1). This typology categorizes homelessness services within a two-dimensional matrix based on whether they are housing-focused (centred on placement in housing) or support/non-housing-focused (aiming to achieve 'housing readiness'), and on the intensity of the support provided, which can be either high or low [11]. These collectively form a continuum of care from crisis intervention to long-term reintegration, offering a framework for evaluating public efforts to address homelessness.

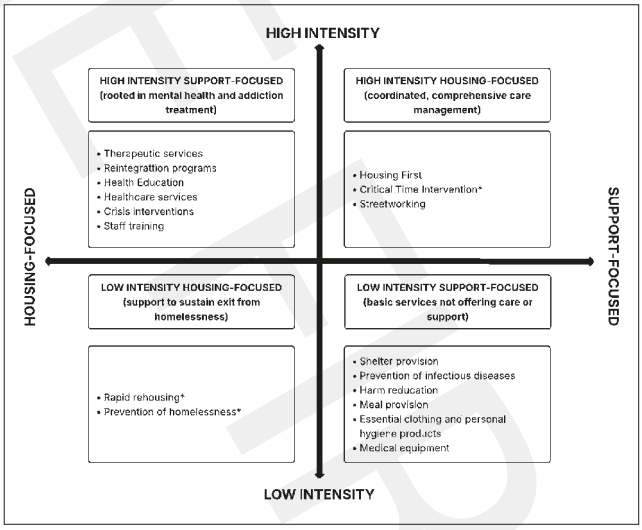

Figure 1. Classification of interventions aimed at supporting PEH based on FEANTSA Typology on Homelessness Strategies [11]

*such strategies were not present in our data set

As the ProfiBaza system does not collect personal data, the approval of a Bioethics Committee was not required for this study.

Collected data (aggregated numbers and percentages) were analyzed using descriptive statistics methods with SPSS 29.0 package. Using 2024 National Research on the Number of Homeless People data [2], the rate of HP interventions per 1,000 adult PEH was calculated for each macro-region (NUTS-1 unit) and year. In the cartograms, the data were grouped using the natural breaks method.

Table 1. Health promotion activities delivered to PEH in Poland (2021–2024)

Characteristics	2021		2022		2023		2024		Total	
	n	%	n	%	n	%	n	%	n	%
Type of intervention owner										
Local government units (LGUs)	7	100.0	51	91.1	50	92.6	44	95.7	152	93.2
Health system institutions	0	0.0	2	3.6	1	1.9	2	4.3	5	3.1
National Health Fund	0	0.0	3	5.4	3	5.6	0	0.0	6	3.7
Territorial scope of intervention										
Local	7	100.0	55	98.2	53	98.1	45	97.8	160	98.2
Nationwide	0	0.0	1	1.8	1	1.9	1	2.2	3	1.8
Duration of interventions										
Less than 12 months	3	42.9	21	37.5	17	31.5	15	32.6	56	34.4
The whole year (12 months)	4	57.1	27	48.2	25	46.3	21	45.7	77	47.2
More than 12 months	0	0.0	8	14.3	12	22.2	10	21.7	30	18.4
NUTS macro-region										
Central	0	0.0	3	5.4	4	7.4	6	13.0	13	8.0
Southern	4	57.1	9	16.1	10	18.5	4	8.7	27	16.6
Eastern	0	0.0	5	8.9	4	7.4	2	4.3	11	6.7
North-Western	2	28.6	20	35.7	17	31.5	13	28.3	52	31.9
South-Western	0	0.0	3	5.4	5	9.3	4	8.7	12	7.4
Northern	0	0.0	8	14.3	7	13.0	10	21.7	25	15.3
Mazovian Province	1	14.3	8	14.3	7	13.0	7	15.2	23	14.1
Target group – gender										
Men	0	0.0	3	5.4	3	5.6	6	13.0	12	7.4
Women	0	0.0	1	1.8	1	1.9	2	4.3	4	2.5
Regardless of gender	7	100.0	52	92.9	50	92.6	38	82.6	147	90.2
Target group – place of residence										
Urban	7	100.0	32	57.1	30	55.6	28	60.9	97	59.5
Rural	0	0.0	1	1.8	1	1.9	0	0.0	2	1.2
Regardless of place of residence	0	0.0	23	41.1	23	42.6	18	39.1	64	39.3
Type of health promotion activity*										
High intensity, Non-housing focused	3	42.9	35	62.5	34	63.0	30	65.2	102	62.6
• Therapeutic services (mental health support)	3	42.9	16	28.6	22	40.7	21	45.7	62	38.0
• Reintegration programmes	3	42.9	16	28.6	14	25.9	10	21.7	43	26.4
• Health education	1	14.3	12	21.4	6	11.1	5	10.9	24	14.7
• Healthcare services for PEH	1	14.3	6	10.7	7	13.0	4	8.7	18	11.0
• Crisis interventions	1	14.3	1	1.8	0	0.0	0	0.0	2	1.2
• Staff training	1	14.3	1	1.8	0	0.0	1	2.2	3	1.8
High intensity, Housing focused	0	0.0	18	32.1	6	11.1	8	17.4	32	19.6
• Streetworking	0	0.0	17	30.4	5	9.3	7	15.2	29	17.8
• Housing First	0	0.0	1	1.8	1	1.9	1	2.2	3	1.8
Low intensity, Non-housing focused	6	85.7	36	64.3	30	55.6	26	56.5	98	60.1
• Shelter provision	4	57.1	17	30.4	16	29.6	15	32.6	52	31.9
• Prevention of infectious diseases	1	14.3	8	14.3	7	13.0	2	4.3	18	11.0
• Harm reduction	0	0.0	9	16.1	6	11.1	6	13.0	21	12.9
• Meal provision	2	28.6	6	10.7	6	11.1	7	15.2	21	12.9
• Essential clothing and personal hygiene products	1	14.3	5	8.9	5	9.3	7	15.2	18	11.0
• Medical equipment	1	14.3	4	7.1	3	5.6	1	2.2	9	5.5
Low intensity, Housing focused	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Total	7	100.0	56	100.0	54	100.0	46	100.0	163	100.0

* Bolded rows indicate the number of health promotion activities, including at least one activity from a given FEANTSA category; they are not the sum of the subcategories, as activities may span multiple subcategories

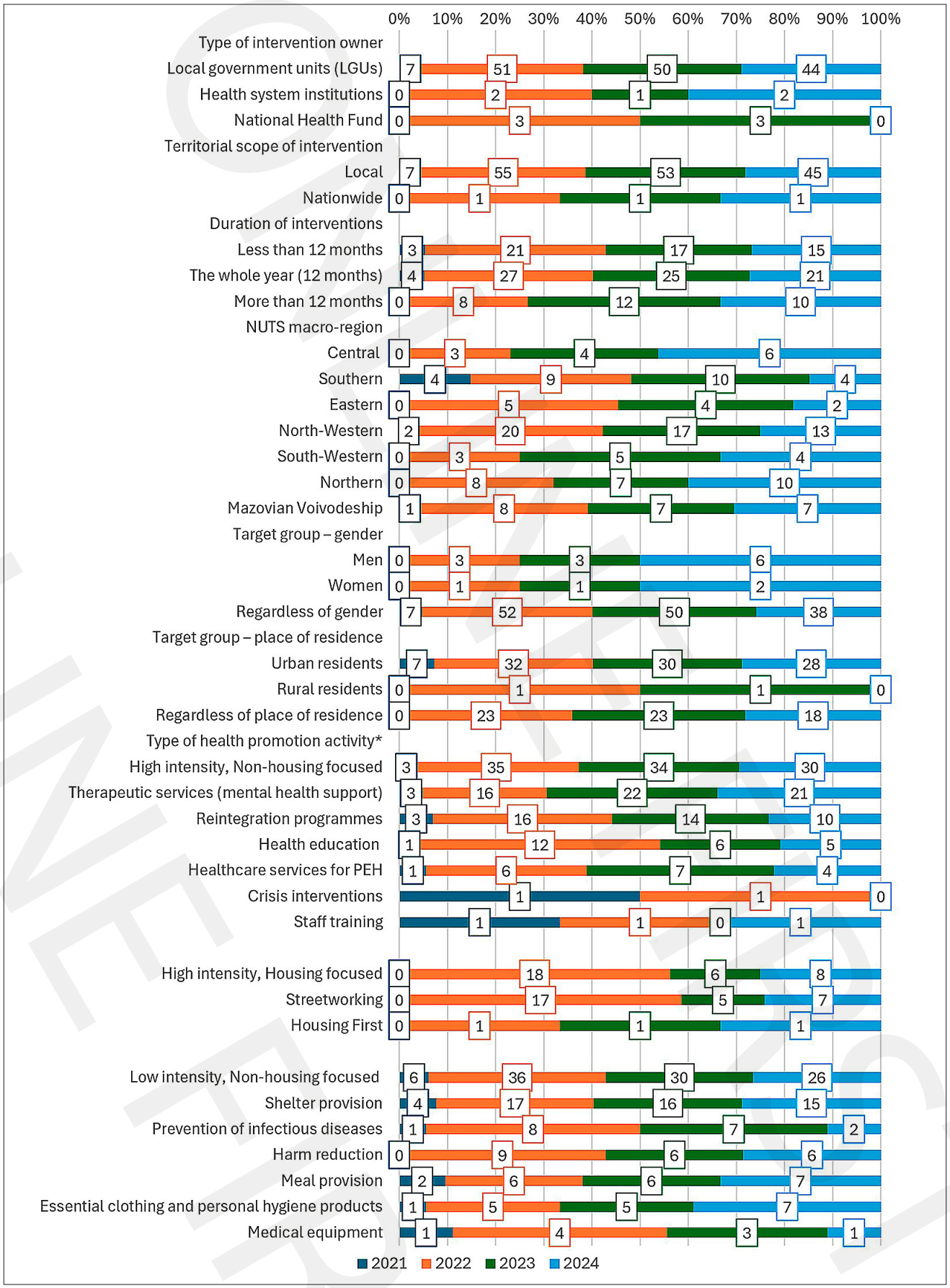

Figure 2. Health promotion activities delivered to PEH in Poland (2021–2024)

* Response categories are not mutually exclusive (percentages do not sum to 100.0%)

RESULTS

Analysis revealed that between 2021–2024, only 163 programmes registered in the ProfiBaza system, targeted PEH, representing less than 1% of the 21,944 programmes aimed at individuals at risk of social exclusion. In 2022, the number of implemented HP interventions increased sharply from 7 to 56, followed by only a slight decline in subsequent years. Data on HP activities provided to PEH in 2021–2024 are presented in Tables 1–2, and Figures 2–3.

Most of the analysed interventions were implemented by local government units (93.2%), with only a small proportion carried out by the National Health Fund (3.7%) and health system institutions (3.1%). Short-term activities were most common, with 47.2% implemented for exactly 12 months, 34.4% lasting less than 12 months, and only 18.4% classified as long-term, multi-year interventions.

Between 2021–2024, HP interventions targeting PEH were most frequently reported in the North-Western macro-region (31.9%), followed by the Southern (16.6%) and Northern regions (15.3%), whereas the Eastern region accounted for the lowest proportion of interventions (6.7%).

An analysis of the needs for HP interventions (assessed by the PEH number in each macro-region) and the corresponding response (assessed by number of interventions per 1,000 PEH), revealed clear regional disparities. During the study period, the North-Western region demonstrated the most favourable outcome, with 2.38 interventions per 1,000 PEH, followed by capital region – the Mazovian Province with 1.69. The South-Western region exhibited the weakest results, as moderate needs were met with a low number of programmes (0.92), while in the Northern region, high needs were not matched by a sufficient number of interventions (0.95) (Tab. 2, Fig. 3).

Analysis of programme distribution also revealed an urban-rural disparity. Only 1.2% of programmes were implemented exclusively for PEH in rural areas, compared with 59.5% in urban areas, while 39.3% were delivered regardless of place of residence.

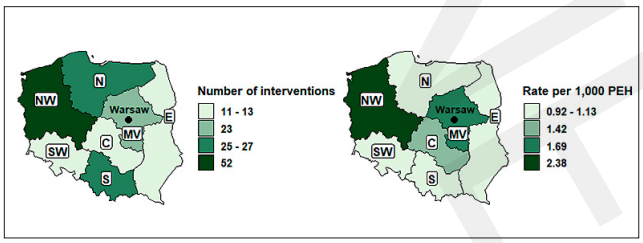

Figure 3. Health promotion interventions among PEH in Poland by macro-region (NUTS-1): Total number of interventions and rates per 1,000 PEH, 2021–2024

Across 2021–2024, high-intensity, non-housing-focused activities accounted for the largest share of FEANTSA-categorized HP interventions (62.6%). The primary types included therapeutic services, such as mental health support (38.0%), reintegration programmes (26.4%), and health education (14.7%). Healthcare services for PEH were relatively infrequent (11.0%), while crisis interventions (1.2%) and staff training (1.8%) were the least reported.

The second most common category comprised low-intensity, non-housing-focused activities (60.1%), mainly shelter provision (31.9%), harm reduction and meal provision (12.9% each), infectious disease prevention (11.0%), essential clothing and hygiene products (11.0%), and distribution of medical supplies (5.5%). High-intensity, housing-focused programmes constituted the third most frequently reported category, including street outreach activities (17.8%) and Housing First interventions (1.8%). No low-intensity, housing-focused activities were reported during the analysis period.

A clear shift in intervention trends was observed between 2021–2024. Initially, shelter provision was most prevalent (57.1% in 2021), but by 2023–2024, therapeutic services had become the leading intervention (rising from 40.7% to 45.7% in 2024), consistently surpassing shelter provision. Reintegration programmes remained an important component throughout, while crisis interventions and staff training declined and were ultimately not reported.

DISCUSSION

International studies indicate that PEH face disproportionately poor health, including substance use disorders and chronic conditions, which are further exacerbated by socio-economic barriers and limited access to healthcare, resulting in unmet health needs [3, 16–18].

This study identified a significant lack of support programmes, delivered as part of public health tasks, specifically targeting PEH. Among nearly 22,000 initiatives addressing underserved groups, fewer than 1% were directly focused on this population, which reveals a substantial gap in the support system and insufficient recognition of the specific needs of PEH within social and health policies. The limited number of programmes may be attributed to policymakers' prioritization of other social issues and limited awareness of the scale and nature of homelessness, often perceived as less urgent than other forms of social exclusion, such as unemployment or disability. Additionally, the limited political and social representation of PEH, combined with challenges in reaching this population, further impedes the

Table 2. Health promotion needs and implemented interventions among PEH in Poland by macro-region (NUTS-1 unit), 2021–2024: number of adult PEH, number of interventions and rates per 1,000 PEH

NUTS macro-region	No. of adult PEH (2024)	No. of interventions					Rate per 1,000 PEH				
		2021	2022	2023	2024	Total 2021–2024	2021	2022	2023	2024	Total 2021–2024
Central (C)	2296	0	3	4	6	13	0	1.31	1.74	2.61	1.42
Southern (S)	5974	4	9	10	4	27	0.67	1.51	1.67	0.67	1.13
Eastern (E)	2525	0	5	4	2	11	0	1.98	1.58	0.79	1.09
North-Western (NW)	5451	2	20	17	13	52	0.37	3.67	3.12	2.38	2.38
South-Western (SW)	3268	0	3	5	4	12	0	0.92	1.53	1.22	0.92
Northern (N)	6606	0	8	7	10	25	0	1.21	1.06	1.51	0.95
Mazovian Province (MV)	3398	1	8	7	7	23	0.29	2.35	2.06	2.06	1.69

development and implementation of effective support around HP interventions. Geographic dispersion and exclusion from formal social structures complicate efforts to provide targeted assistance [15].

Efforts to address homelessness should consider its diverse forms and the specific needs of PEH [15]. Not all countries have integrated strategies or dedicated public funding for services targeting homelessness. Interventions are often interconnected, with some supported by government funding and others managed by charities, NGOs, or faith-based organizations [15, 19, 20].

In European Union countries, the most common interventions are low-intensity, support-focused strategies that primarily address the immediate survival needs of rough-sleeping PEH, rather than providing housing [11]. The findings of the current study indicate that almost one-third of interventions involved providing emergency shelter, primarily through night shelters, homeless shelters, and day centres. This approach is consistent with strategies adopted in other EU countries, for instance, the Czech Republic provides emergency shelters to nearly 50,000 PEH, while France's 'Reception, Accommodation, Integration' model focuses on immediate, tailored support, predominantly through temporary accommodation. The United Kingdom, by contrast, is shifting towards greater use of temporary supported housing rather than emergency shelters [11]. Meal provision constituted approximately one in eight interventions in the present study. In Poland, nearly 500 mobile meal provision points are primarily run by NGOs and faith-based organizations (e.g., Caritas or Brother Albert), whereas in The Netherlands and Denmark, meal services are limited and generally concentrated in major urban centres [3, 11]. Greater emphasis should be placed on integrating low-intensity, support-focused interventions with educational and employment support, as exemplified by Les Restos du Cœur in France, which combines unconditional food aid through balanced food parcels and hot meals, delivered in city centers and in the streets, with educational activities [21].

In Poland, the most frequently identified category of interventions for PEH comprised therapeutic services, particularly psychological counselling (38.0%), followed by reintegration programmes (26.4%), which are classified as high-intensity, non-housing-focused services, even though they often focus on stabilizing housing conditions. This approach emphasizes preparing PEH to become 'housing ready' rather than offering immediate relief from homelessness. The integrated strategy, known as the Critical Time Intervention model, combines intensive psychological support with measures to stabilize housing and social circumstances [22].

There is an increasing agreement that high-intensity, housing-focused services, such as Housing First (HF) programmes, should be prioritized. However, the current study identified only three interventions consistent with the Housing First approach, highlighting its limited use in Poland in the context of public health tasks, as well as in the EU. Although a 2024 survey found that 87% of EU Member States include HF in their strategies, it remains one of the least frequently implemented interventions [19]. The HF model asserts that stable housing is the essential first step in addressing homelessness, and that housing access is not contingent on treatment compliance or abstinence. Although the exact number of HF programmes is unknown, this model has been widely adopted in North America, Europe, Australia, and New Zealand [20]. A systematic review and meta-analysis found that HF increases the likelihood of sustained exits from homelessness by about 2.5 times compared to traditional methods. Access to independent housing also results in a 37% reduction in emergency department visits and a 24% reduction in hospitalizations, generating significant healthcare cost savings [23]. Even in countries with broad HF adoption, such as the UK, Denmark, and France, these strategies co-exist with low-intensity, support-focused interventions [11].

Street outreach is another form of high-intensity, housing-focused strategies. In the current study, 17.8% interventions used this form of support to connect people sleeping rough to other services, providing advocacy, information, case management, and food. This form of support is widely used across the EU and is especially important in Hungary, where sleeping rough was criminalized in 2018 [11].

Low-intensity, housing-focused support strategies were absent in this study, a pattern similar to that observed in other EU countries. Rapid rehousing serves as an immediate intervention or prevention strategy for homelessness, with examples in the UK, France, and Ireland, supporting transitions into the private rental sector [11].

The presented study also identified disparities in access to support between urban and rural areas. Only 1.2% of interventions targeting PEH solely in rural settings, indicating limited access for PEH in these areas, where the problem is less visible, and often inadequately recognized by institutions. A primary reason could be the concentration of assistance providing institutions and NGOs in cities, which allow easier access to social infrastructure, qualified personnel, and opportunities to collaborate with institutional and social partners, thereby increasing the efficiency of support activities [24]. In rural areas, homelessness often takes less visible forms, such as living in highly inadequate housing, makeshift shelters, or temporary household sharing. This so-called 'hidden homelessness' leads to underestimation of the problem's scale and insufficient institutional response [25]. According to FEANTSA, in rural settings, there is often no emergency accommodation, forcing PEH to sleep rough. For example, in Bludenz (Austria), the nearest emergency accommodation is located 20 kilometers from the city. On the other hand, in Svendborg (Denmark), there are programmes utilizing more sophisticated strategies, such as Critical Time Intervention [11]. It is also important to acknowledge that various forms of support in rural areas are often provided to larger groups, rather than exclusively for PEH.

Limitations of the study. Several significant limitations must be considered when interpreting the study's findings. ProfiBaza contains only interventions delivered as part of public health tasks reported by local governments and selected health sector institutions, whereas NGOs, which play an important role in supporting PEH, are not subject to mandatory reporting. Therefore, under-reporting of interventions cannot be excluded. ProfiBaza currently provides data on HPDP interventions targeting PEH only for 2021–2024, reflecting the reporting cycle and the platform's implementation for underserved populations in 2021. Data comparability and classification may be affected by heterogeneity in programme definitions and the inclusion of PEH-related activities within broader social inclusion

initiatives without explicit identification. Limited access to primary project documentation and the absence of outcome data may have resulted in incomplete identification of interventions and preclude assessment of their effectiveness, limiting interpretation beyond intervention provision.

A key strength of this study is that HPDP interventions are reported by all local government units in Poland, as well as major health sector institutions, whose contribution to health promotion and disease prevention in Poland is highly significant.

CONCLUSIONS

The study indicates that public support programmes for PEH are insufficient, and from a strategic and political perspective, this population lacks the means to form cohesive structures to represent their interests. It is recommended to empower PEH to participate in decision-making processes and collectively represent their interests in the design and implementation of public policies and support programmes.

Raising awareness of the consequences and costs of homelessness among society and decision-makers from various sectors, allocating more resources to medical, social, and reintegration support, is crucial for developing effective PEH assistance models and better public policies.

Programmes aimed at promoting health among the homeless should combine practical support with educational components, considering the hierarchy of health and social needs, specific housing environments, and the ways in which PEH may seek health care.

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