REDUCING ACCESS INEQUALITIES IN PRIMARY HEALTHCARE FOR SOCIALLY SIGNIFICANT DISEASES AT CB AREA'S DEPRIVED COMMUNITIES

Interreg Greece-Bulgaria

EQUAL2HEALTH

European Regional Development Fund

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Deliverable 4.1.1. On-going evaluation of short-term results on health of Thess pilot action community population

PROJECT

EQUAL2HEALTH

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1 Introduction

The Equal2Health project with the title "Reducing access inequalities in primary healthcare for socially significant diseases at CB Area's deprived communities" was designed and implemented in the framework of the 2nd Call for Proposals of the Interreg V-A Cooperation Programme "Greece - Bulgaria 2014-2020" and specifically, within Priority Axis 4 "A Socially Inclusive Cross-Border Area" and in the Investment Priority 9a. "Investing in health and social infrastructure which contribute to national, regional and local development, reducing inequalities in terms of health status, promoting social inclusion through improved access to social, cultural and recreational services and the transition from institutional to community-based services".

The general objective of the Equal2Health project is to reduce health inequalities in the cross-border area and to contribute to diverting a significant volume of health care services from hospitals to primary care facilities and indirectly manage to provide better health coverage to remote and/or socially excluded communities by:

- protecting (medical exams) citizens (especially socially vulnerable groups) from socially sensitive diseases,
- promoting health prevention and "health literacy" on deprived communities for better understanding and benefiting from primary health care services, and
- fostering supportive environments for healthy lifestyles.

The main activities were implemented in the Region of Central Macedonia in Greece and in the Smolyan District (South-Central Region) in Bulgaria, covering a wide part of the Programme eligible area.

2 Mapping of the monitoring system and presentation of the objectives, the assessment indicators and those involved in the the process

2.1 Scope of the Chapter

The current section is analysing the overall system for the monitoring of the project, the project targets that are linked with the programme indicators, as well as the relevant people involved in the process.

Specifically, the first paragraphs of the chapter include the presentation of the project idea, objectives, actions and results, aiming to understand further the context and the special characteristics of the project.

Following, the next paragraphs include the presentation of the project monitoring system and the involved parties, with particular focus on project outputs and indicators.

2.2 The Overall Concept of the Equal2Health project

Equal2Health is the acronym name of the project with the title "Reducing access inequalities in primary healthcare for socially significant diseases at CB Area's deprived communities". The Greece - Bulgaria cross-border area includes some of the most deprived and isolated communities, especially in the mountainous and rural regions of both countries.

This fact is manifested by rising poverty and high unemployment rates, particularly amongst two types of social groups or else vulnerable groups (such as disabled people and elderly) and professionally and financially challenged groups (women, youth, long term unemployed, below poverty line households and other special social groups). Amongst those groups, the Roma in particular, whose marginalized population is estimated at 45,000 people (32,000 living in Bulgarian and 13,000 residing in Greek regions respectively), encounter a high risk of social exclusion and inequalities in health access.

Particularly, these cross-border areas record a high ratio of inequalities in a health standpoint. These inequalities are related to the availability of health infrastructures, the low and difficult accessibility in the existing health structures, the medium to low quality of health services, and many other difficult to overcome socio-economic issues that are stemming primarily from the poverty of people, the linguistic and cultural discriminations and gender-based stereotypes. These barriers are often embedded even in the way in which clinical practice is conducted. These health inequalities represent a waste of human potential and a huge potential economic loss.

Especially in the low-income parts of the cross-border area, within the project, there is the opportunity to reorient existing health services towards primary care and prevention and to improve the health of affected communities.

2.3 Objectives and Outputs of the Equal2Health project

The project's general objective is to mitigate or eliminate these health inequalities in these specific cross-border areas by protecting citizens from socially sensitive diseases, promoting

health prevention, adopting supportive people-centric environments for healthy lifestyles, and encouraging health innovation. Many stakeholders are target groups and benefit from the project, such as the deprived and isolated communities, Medical Staff, and the Regional & National Health Authorities.

The Project focuses on the following two general categories of diseases:

a) Main non-communicable diseases (NCDs) that – according to the WHO (World Health Organization) - are the world's "biggest" killers: mainly cardiovascular diseases (including cholesterol), chronic respiratory diseases, and diabetes. From these two, up to 40% of the global population has been affected.

b) Psychiatric (mental) diseases: Positive mental health is a state of well-being in which the individual realizes his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully, and can contribute to his or her community. Unfortunately, statistics present that worldwide the mental disorders affect one in four people.

Both above categories of diseases are related to deprivation, poverty, inequality, and other social and economic determinants of health.

The Project's approach to offering solutions to the above problems was the establishment of the joint "Observatory Equal2Health for socially significant diseases" in the cross-border area population with specific interest on deprived (areas at-risk of poverty), isolated (mountainous, rural areas with limited access to primary health care units) and marginalized (e.g., ex-drug addicts, Roma, etc.) communities. The "Observatory" provided:

- Medical exams (primary health services) on vulnerable populations for specific diseases (in the Observatory and on-the-spot in deprived/ isolated areas with a Mobile Unit).
- Awareness and Information campaigns on deprived communities for preventive medical examination of the socially significant diseases and "prevention through a healthy lifestyle".
- Establishment of an "Open Network" between various stakeholders such as Medical Staff, Local & Regional Authorities, Hospitals, and Primary Health Care Units, Regional & National Health Authorities, Civil Society, etc. for exchanging:
  - Know-how on the specific diseases (e.g., presentations-trainings from Psychiatric & Cardiology Partners): causes, treatments, prevention, etc.
  - Proposal-ideas between the stakeholders to reduce the barriers of equal access to the primary health care system for specific deprived and isolated communities.

Expected short and medium/long-term results of the Equal2Health project

The expected short and medium/long-term results of the project are:

- Support access to good healthcare and information in those regions (target CB areas) where services are underdeveloped or for those disadvantaged and marginalized groups with an accessibility deficit (e.g., low educational level, low or no income, etc.)
- Identify main causes of health inequalities (connecting specific diseases with socio-economic inequalities factors) and alleviate or mitigate the health low level-indicators in disadvantaged and marginalized communities through pilot and random medical examinations, training, and mobilization of main relative to the health issues stakeholders, social and health agents and mediators, health services providers, decision-makers, etc.

- Promote a healthy lifestyle and early intervention programmes for people from groups with increased vulnerability to mental disorders.
- Bring innovations to the care and health systems - through policy recommendations and action plans - to improve patients' health literacy and empowerment, to promote adherence to prevention, treatment, and proper follow-up care.
- Induce positive impact on the prevention of diseases in disadvantaged communities contributing to the decrease of sickness incidents to be treated by secondary health services.
- Enhancement of the capacity-building of the medical personnel through research, training, transferring know-how, and good practices between the two countries and their medical staff at isolated and deprived areas, especially on dealing with specific diseases and patients from various vulnerable and marginalized groups.
- Enhancement of Public Authorities and other Stakeholder's capacity on developing -and/or improving the existing- policies and actions plans in compliance with the EU relevant strategies/programmes for the "equality in health" and with the World Health Organization's Action Plans for the examined diseases (mental &Cardio/diabetics).

Implementation of the Equal2Health project

The project has been structured on 6 Work Packages (WP):

WP 1. Management and Coordination, including Activity and Financial Reporting and Meetings.

WP 2. Publicity and Dissemination

1. Production of communication material and tools for raising awareness about the specific diseases and the significance of the prevention
2. National Conferences in Programming area (2 in Bulgaria and 2 in Greece)
3. Workshops & Scientific events in the Programming area (3 in Greece and 3 in Bulgaria)
4. Webpage & Social networks (FB, Twitter, etc.)

WP 3. Establishment of an "Observatory of health inequalities for socially significant diseases" with its headquarters in Greece and its antenna offices in Bulgaria.

The "headquarters" are located in the Psychiatric Hospital of Thessaloniki, Greece, and the "Antenna Offices" are in Smolyan and Devin, Bulgaria.

The scope of the structure is to act as the "Observatory of socially significant diseases" for the cross-border area population with a specific interest in deprived (areas at-risk of poverty), isolated (mountainous, rural areas with limited access to primary health care units), and marginalized (e.g., ex-drug addicts, Roma, etc.) communities which are the communities with the highest inequalities in health.

The "Observatory" provides the following services and activities:

i. Analysis of the CB area's current situation including relevant strategies, policies, programmes, previous relevant action plans and results, available statistical data, and health indicators, as well as development and collection of data and health inequalities indicators by age, sex, socio-economic status, and geographic dimension.

ii. Basic medical examinations for the reference diseases, mainly cardiovascular diseases (including cholesterol), chronic respiratory diseases and diabetes, psychiatric diseases/depression, and headaches.
iii. Raising awareness campaign for preventive medical examination as well as "prevention through a healthy lifestyle."
iv. Establish of an "Open Network" between various stakeholders such as Medical Staff, Local & Regional Authorities, Hospitals and Primary Health Care Units, Regional & National Health Authorities, Civil Society, etc. The Network has be elaborated through an "open platform-dialog" (webpage, Conferences, workshops, etc.) for exchanging:
    - Know-how on the specific diseases (e.g., presentations-trainings from Psychiatric & Cardiology Partners): causes, treatments, prevention, etc.
    - Proposal-ideas between the stakeholders to reduce the barriers of equal access to primary health care system for specific deprived and isolated communities.
v. Two (2) Mobile Units fully equipped for medical examinations as well as for the promotion of prevention and healthy lifestyle in the CB Area with often visits various villages of the CB area (1 in Greece: Hospital Papanikolaou – Psychiatric Unit and 1 in Bulgaria, Hospital Devin).

WP4. Pilot implementation on deprived & isolated communities

Two pilot actions in two (2) communities with different characteristics concerning the inequalities in access to primary health care services were implemented:

the 1st in Greece: Roma community at Diavata – Thessaloniki (deprived & marginalized community) and

the 2nd in Bulgaria: area of Municipality Devin (deprived & isolated mountainous and rural communities)/ Scientific Support on medical exams (telemedicine & on the spot visits by the "Diagnostic Centre Aleksandrovska," Sofia)

The following services and activities were provided:

i. Medical Examinations on specific selected diseases. During the project's implementation, scheduled follow-up examinations of persons at high risk were regularly conducted in order to check the improvement or not (e.g., every six months).
ii. Awareness events and consultation for a large portion of selected communities improve patients' health literacy on healthy lifestyle, preventive medical examinations, adherence to the recommended treatment (take the pills), proper follow-up care, etc.
iii. Training and transfer of knowledge and skills to selected persons (around 5) from each community to act as "Mediators" to help the local population of their local community proper use of healthcare services to promote health prevention and disseminate – promote healthy nutrition and life of style. This activity was crucial for the project's success because activities directed at local communities have a greater impact when stakeholders and persons from their communities are directly involved in the implementation.
iv. Analysis of the current health situation of the community's population. On-going evaluation and identification of short-term results of the pilot actions on community health (relevant to the examined diseases), to analyse the barriers to equal access to the primary health care system of the specific deprived-isolated communities.

WP5. Valorisation and Policy Recommendations

Valorisation and Policy Recommendations are aimed via:

1. Impact Assessment of the project
2. Recommendations on policies, programmes, and action plans for dealing with inequality in health for deprived communities and prevention of the examined diseases (BG RHI Fund)

2.4 Monitoring system and actors involved

The quantitative data for the evaluation was collected internally during the implementation of the project from the staff that was involved in the Observatory and Pilot actions. The data includes visits to Medical Doctors per month as well as a number of social characteristics of the beneficiaries.

In particular, the data included the following:

- Visits per specialty
- Visits per months
- Visits per trip
- Gender of the beneficiaries
- Education attainment
- Employment Status
- Marital Status
- Number of children
- Place of Residence
- Rom descent

A number of other medical history specific data were also monitored such as:

- Substance use
- Type of substance used
- Underlying conditions
- Use of other prescription drugs

The above, while they are very useful concerning the impact to the health of the patients are not relevant within the scope of the project and were not included in the analysis.

It must also be noted that the project lacked a comprehensive and unified system of monitoring. This led to important information gaps and discrepancies, a major limitation to the analysis of the impact in general.

Beneficiaries of the Equal2Health project

General Hospital of Thessaloniki "G Papanikolaou" - PHT, Unit Psychiatric Hospital of Thessaloniki (Lead Beneficiary)

The Psychiatric Hospital Unit of Papanikolaou Hospital in Thessaloniki consists of a Special Hospital with extended activity in providing services in the specialty field of mental health, both within the Network of Community Services operating in the regional unit of Thessaloniki and also with its function as an educational institution. On 01/01/2013, when working under a single command, affiliated Hospitals: Thessaloniki General Hospital "G.Papanikolaou" and

"Psychiatric Hospital of Thessaloniki," are now independent and unified Public Entity under the name "General Hospital of Thessaloniki "G.Papanikolaou". The Psychiatric Unit supervises three Mental Health Centres, two guest houses, four boarding, and a child guidance centre. In addition, it has five sections of short hospitalization, one of which is directed by the Medical School of Aristotle University. Also, it acts in the field of training, addressing addictions and employment in patients Cooperative Therapeutic Units. Furthermore, it has implemented many European programs in the dependency field of de-institutionalization, etc. such as:

a. "Cross Border Actions for the proper diagnosis and stigma elimination in epilepsy (EPILEPSY SPECTRUM)" (Cooperation Programme “Greece-Bulgaria 2007-2013”)
b. “Local Action plan for social inclusion of ex-drug-users” (Operational Programme Human Resources).

Cardiology Society of Northern Greece (Partner Beneficiary 2)

Cardiology Society is a scientific association with more than 500 members/cardiologists. Aiming in the enlightenment and development of cardiology in North Greece, they are actively involved in preventing and treating cardiovascular diseases and striving to improve its members' scientific and professional conditions.

Intermunicipal Agency of Western Countryside of Thessaloniki “Nefeli” (Partner Beneficiary 3)

The Intermunicipal Agency of Western Countryside of Thessaloniki was set up in 1995. It is a company of the three Municipalities of the Western Countryside of Thessaloniki (Delta, Chalkidona, and Oreokastro). It has implemented the EU-funded project "Centre for the Social & Health Support of Roma and Vulnerable Groups in Settlement Agia Sofia of Municipality of Delta" and many other projects relative to social & health issues.

Regional Health Insurance Fund (RHIF) – Smolyan (Partner Beneficiary 4)

RHIF-Smolyan is a territorial structure of the National Health Insurance Fund providing administrative services to citizens and communication with partners and other institutions. Also, it is responsible for the construction and maintenance of modules and registers, according to the single integrated information system and supervising all requirements of applying European regulations/EEC/governing health insurance issues. Furthermore, RHIF participates in projects for increasing the efficiency of human resources in the administrative structures in education and health for the entire region.

Multispecialty Hospital for Active Treatment Devin JSC (Partner Beneficiary 5)

Multispecialty Hospital for Active Treatment Devin JSC carries out many medical activities, including internal medicine, surgery; neurological diseases; paediatrics, imaging diagnostic; and a clinical laboratory. The Hospital is specialized and divided into two medical diagnostic structures "Clinical Laboratory" and "Imaging diagnostics." In addition, the Hospital operates in the research field by conducting serious research, such as screening for latent flowing diabetes in the population of 45 -65 years in obese people and consultation about recreational and reproductive health relevant to project activities.

Diagnostic and Consulting Centre "Aleksandrovska" Ltd (Partner 6)

Diagnostic - consultative centre "Alexandrovska" is a highly specialized patient care unit with a wide range of medical services and highly technical experts and participate in significant clinical researches as a Randomadizired, double-blind, confirmatory test to evaluate the efficacy, safety, and immunogenicity of MSB 11022 compared approved in the EU - Hamira in subjects with severe chronic plaque psoriasis, reducing the risk of major thrombotic vascular events in patients with symptomatic peripheral arterial disease undergoing revascularization procedures of the lower extremities - which are linked with project objectives.

2.5 Outputs and Indicators of the Equal2Health project

The main delivered outputs of the "Equal2Health" project are:

1. One (1) joint "Observatory Equal2Health for socially significant diseases" in the cross-border area population, located in the premises of Psychiatric Unit of Papanikolaou Hospital in Stavroupoli, Thessaloniki. The Observatory has been equipped with new equipment for the main socially significant diseases: cardiovascular, respiratory, diabetes, psychiatric and neurologic. Besides it is easily accessible and target socially vulnerable groups for medical exams and consultation. In Smolyan, in the premises of the Regional Health Insurance Fund has been also located one "antenna office" mainly for administrative actions (data, indicators, planning, etc.)
2. Two (2) Mobile Units (1 in the Observatory in Greece, 1 in the Devin Hospital in Bulgaria) to provide medical exams and prevention awareness campaigns in the whole cross-border area.
3. Two (2) Pilot Actions' implementation on deprived & isolated communities (1 in the Roma community of Diavata Thessaloniki, 1 in the mountainous/rural, remote area of Devin Municipality in West Rhodopi mountain). The Hospital of Devin has been also equipped with new relevant medical equipment, while these pilot actions provided valuable results on the health of the specific communities (exams, prevention) and conclusions and recommendations for action plans and policies.
4. Awareness campaign to the main target population and Medical Staff and Authorities.
5. Policy recommendation on reducing health inequalities and dealing with the common and socially significant diseases.

The outputs contribute to the achievement of the specific objective of the programme as well as to the accomplishment of its output and result indicators:

- Number of health care institutions reorganized, modernized, or re-equipped: 2 (Devin Hospital & Psychiatric Unit of Papanikolaou in Thessaloniki (Programme's target 12).
- Population covered by improved health services: 100.000 for the Observatory estimation on Thessaloniki, Serres & Sandanski persons from deprived communities and 10.000 around Devin Municipality = 110.000. Additionally, the 2 Mobile Units will provide basic medical exams in most of the cross-border areas (which are not considered health services as they are not permanently accessible). Target of this action= 632.000.

Programme result indicators are:

Annual visits to secondary/tertiary healthcare (decrease by 56.178) / Project Contribution = 5.500 visits (5% of Population covered by improved health services of the project = 110.000 X 5%)

Equal access to health is an important EU policy, which recently has been prioritized, and by now, so little progress has been achieved. The project has already contributed substantially to National compliance with EU relevant policies and priorities with its research and recommendations.

3 Assessment of the pilot action juxtaposed with the initial planning of the project, the programme objectives and EU Health Policies

3.1 Scope of the Chapter

The current section is analysing and evaluating the pilot action with regards to the scope and objectives of the Interreg V-A Cooperation Programme "Greece - Bulgaria 2014 - 2020, as well as relevant EU Health policies.

Towards this end, the chapter presents the specific characteristics of the Programme and the intervention area, as well as the EU 2016-2020 Health Policy Priorities.

Lastly, the pilot action is assessed based on its contribution to the respective objectives.

3.2 Interreg V-A Cooperation Program "Greece - Bulgaria 2014 -2020

3.2.1 The cross-border (CB) area of Greece and Bulgaria

Taking as the fact that the Greece-Bulgaria cross-border area is the eligible area of the homonymous Interreg Cooperation Program, it covers an area of 40,202 km^2 having a total population of 2.7 million inhabitants. At the same time, it includes 4 NUTS II Regions and 11 NUTS III Regional Units III[1].

Table 1 The area of the Interreg V-A Cooperation Program "Greece - Bulgaria 2014 – 2020"

	Region	**Regional Units**
Greece	Eastern Macedonia and Thrace Region	Drama | Evros | Kavala | Xanthi Rodopi
	Central Macedonia Region	Thessaloniki | Serres
Bulgaria	South-Central Region	Smolyan | Haskovo | Kardzhali

[1] The Nomenclature of Territorial Units for Statistics (NUTS) was developed by Eurostat aiming to provide a unified and uniform analysis of territorial units to produce regional statistics in the European Union.

	Southeast Region	Blagoevgrad

In addition, being the south-eastern non-island region of the European Union (EU), the Greek-Bulgarian border region borders Turkey to the east and the Republic of Northern Macedonia to the west. It is located between three seas: the Black Sea, the Mediterranean, and the Adriatic-Ionian Sea.

The residential structure of the area is characterized by the existence of ten cities of medium-large size (over 50,000 inhabitants) where 38.2% of its population lives and 25 small cities (between 10,000-50,000 inhabitants).

It has a well-developed road network with the EGNATIA ROAD along the Greek cross-border area with important vertical axes for its connection with the Bulgarian cross-border site:

- Thessaloniki - Serres - Promachonas (Bulgaria – Pan-European Corridor IV)
- Ardanio - Ormenio (Bulgaria – Pan-European Corridor IX)
- Komotini - Nymfea - Greek-Bulgarian Borders (Bulgaria – Pan-European Corridor IX)
- Xanthi - Echinos - Greek-Bulgarian Borders (Bulgaria)[2]

Regarding the economy of the cross-border area, it is considered one of the poorest areas in the EU, with the Gross Domestic Product (GDP) per capita below 50% of the average of the EU countries. At the same time, large internal inequalities also characterize it. In particular, the

[2] https://www.egnatia.eu/en/projects/kathetoi-axones/oi-kathetoi-axones-kai-h-simasia-tous/

cross-border regions of Bulgaria show a much lower level of economic growth (below ¼) than the corresponding regions of Greece.

Compared to the European Union of 28, the economy of the Greece-Bulgaria cross-border region is more agricultural, less industrial, and more dependent on services. However, even in this sector, it presents great heterogeneity, with the Greek cross-border area being less agricultural and industrial and more service-oriented.

According to the diagnostic analysis presented in the Operational Program Interreg V-A Greece-Bulgaria 2014-2020, in terms of the dominant economic sectors, the peripheral units of the cross-border area could be categorized as follows:

Table 2 Dominant economic sectors by regional unit

Regional Units	Dominant economic sectors
Blagoevgrad | Haskovo	Industry and Trade
Smolyan | Kirdzhali	Industry and Agriculture
Evros | Drama | Thesaloniki	Public Administration and Industry
Xanthi | Rodopi	Public Administration and Agriculture
Kavala | Serres	Industry and Public Administration

Although, the CB area currently maintains important research facilities, which are not significantly collaborating or with the business community. It also includes similar productive systems, presenting important opportunities for coupling entrepreneurship initiatives with innovation and further room for cooperation. The critical mass of research centres and other academic structures is located in Thessaloniki with the following fields of excellence: biotechnology, advanced production systems for chemical processes, energy, environmental technologies, information processing, virtual reality, security, health care services, etc.

Finally, lower-level roads are at various stages of disrepair (especially on the Bulgarian part) making **interconnections difficult and reducing mobility, especially in the mountain ranges**. At the same time, several Egnatia vertical axes, as agreed in the Transnational Agreement between Greece and Bulgaria in 1998, are still missing or under construction (such as the connection of II-86 to the Greek transport system) motorways on the Bulgarian part are incomplete.

3.2.2 Cross-border area's social exclusion, inequalities, poverty, and discrimination

The CB area presents considerably higher than EU28 percentages of the population at risk of poverty or social exclusion (**3-4 times higher**). The principal reason for the large divergence is the relatively higher long-term unemployment rates and the higher share of people living in low work intensity and low-income levels. Concerning the latter, the percentage of people living in

areas with low work intensity has been rising since 2010 in Bulgarian and Greek territories. The large number of people undergoing poverty and social exclusion in the CB area is also attributable to various vulnerable groups such as minorities, internal migrants, asylum seekers, and foreign persons under subsidiary protection. The higher risk of poverty and social exclusion among these groups is primarily connected to long-term unemployment and economic inactivity.

The rising incidence of poverty has various social outgrowths, one of which is deteriorating public health conditions. Even though the CB area enjoys the availability of basic health care resources (e.g., hospitals and doctors) at levels near, or even better in several cases, than the EU28 average, the average life expectancy is lower than EU28 levels epidemiological indicators record higher values. Overall, Greek districts have manifested higher life expectancy than Bulgarian districts in the past. Still, since poverty forces more people to resort to hospital care (**more than a 20% increase has been documented in Greece after 2010**), it appears that Greek districts may be more **at risk of deteriorating health care conditions** shortly, thereby lowering overall public health levels in the CB area.

CB area health status indicators have not been satisfying for a long time despite the adequate levels (in terms of quantity) of healthcare infrastructure, indicating a lack of effectiveness and proper spatial distribution of such resources. Moreover, the rise of poverty in the CB area now exerts raised pressure on health care systems.

Improving their effectiveness is of paramount importance. At the same time, economic slowdown and disinvestment prevent many CB area inhabitants from gaining access to healthcare services (uninsured civilians). The rise of poverty in the CB area places vulnerable groups with a significant presence in the CB area - at increased risk of peril. Supply gaps are yet a reality in the border zone or buffer area, causing the expansion of health service networks across the border priority attention. Moreover, service delivery reformations are needed to transform traditional healthcare delivery into primary care, optimizing the enrichment of health services – local health systems, healthcare networks, health districts – to health and equity while responding to the growing expectations for better health performance. Especially in the low-income parts of the CB area, the opportunity exists to reorient existing health services towards primary care to improve the health of affected communities.

3.3 The Reasoning and Objectives of the Programme

According to the Interreg V-A Cooperation Program "Greece - Bulgaria 2014 – 2020 “Greece-Bulgaria 2014-2020”,

> *“the health status indicators in the cross-border area have not been satisfactory for a long time, despite the satisfactory levels (in terms of quantity) of healthcare infrastructure in the area, indicating a lack of effectiveness and proper spatial distribution of such resources. The rise of poverty in the cross-border area now exerts increased pressure on health care systems, while it also places vulnerable groups (which have a significant presence in the CB area) at increased risk of peril. At the same time, economic recession and disinvestment prevent many CB area inhabitants from gaining access to healthcare services (uninsured civilians). Health inequalities in the CB area are shaped by the inequalities in availability,*

access and quality of services, by the financial burden these impose on people, and even by the linguistic, cultural and gender-based barriers that are often embedded in the way in which clinical practice is conducted. Supply gaps are still a reality in the border-zone or buffer area, making the extension of health service networks across the border a priority concern. Further, service delivery reforms are needed to transform conventional healthcare delivery into primary care, optimizing the contribution of health services – local health systems, health-care networks, health districts – to health and equity while responding to the growing expectations for better health performance. Especially in the low-income parts of the CB area, the opportunity exists to reorient existing health services towards primary care, to improve the health of affected communities".

Based on the above, the Programme under PA 9a - Investing in health and social infrastructure which contributes to national, regional and local development, reducing inequalities in terms of health status, promoting social inclusion through improved access to social, cultural and recreational services and the transition from institutional to community-based services supports projects in order to improve access to primary and emergency health care (at isolated and deprived communities) in the CB area.

In particular, the programme supports actions concerning:

- The development of common cross-border plans and principles for the provision of high-quality health care services and the joint treatment of health risks,
- The acquisition of new / upgrading of existing medical equipment of health care facilities in the cross-border area,
- The exchange of good practices for upgrading the knowledge of human resources in the efficient provision of health services as well as the successful handling of emergencies and emergencies.

3.4 EU Health Policies

EU countries hold the primary responsibility for organising and delivering health services and medical care. EU health policy therefore serves to complement national policies, and to ensure health protection in all EU policies.

Towards this end, the European Commission's Directorate for Health and Food Safety (DG SANTE) supports the efforts of EU countries to protect and improve the health of their citizens and to ensure the accessibility, effectiveness and resilience of their health systems. This is done through various means, including by:

- Proposing legislation
- Providing financial support
- Coordinating and facilitating the exchange of best practices between EU countries and health experts
- Health promotion activities

Therefore, the EU promotes investments on health considering it as a mean to achieve smart, sustainable and inclusive growth. This takes the form of:

- Promoting effective, accessible and resilient health systems
- Investing in health through disease prevention and health promotion
- Fostering health coverage as a way of reducing inequalities and tackling social exclusion.

To support these investments, the EU provides several instruments for co-financing and in particular:

- The Health Programme that provides funding to projects on health promotion, health security and health information.
- The Horizon 2020 research programme that supports projects in areas such as biotechnology and medical technologies.
- EU cohesion policy that supports investments in health in EU countries and regions.
- The European Fund for Strategic Investments, supporting strategic needs.

In general the EU actions in the public health area are mainly linked to incentives and cooperation measures. The European Commission has an important supporting role to play, providing guidance and tools to promote cooperation and help national systems operate more effectively. Actions focus on the following challenges:

- Achieving greater cost-effectiveness
- Competitiveness together with safety
- Tackling emerging global threats such as antimicrobial resistance
- Evidence-based policy making
- Addressing the risk factors of non-communicable diseases
- Promoting vaccination

3.4.1 The DG Health & Food Safety Strategic Plan 2016-2020

According to the Strategic Plan, a number of challenges need to be addressed to promote Health in the EU Area. In particular, as the Strategic Plan 2016-2020 points out:

> *"The consequences of the economic crisis and the austerity measures dictate a different prioritisation of Commission's spending plans to that which has been set out at the beginning of the current financial framework. They require not only an adaptation of policy deliverables at DG level, but also mean that DGs are asked to deliver more and better with less financial and human resources. Such efficiency gains can be achieved, but not without identifying negative priorities. Similarly, as pressure on public spending in Member States continues to grow, their delivery on the common priorities becomes increasingly difficult.*
>
> *This situation, coupled with the migration and refugee crisis, has brought to light warning signals of a diminishing sense of solidarity among Member States put into question the very essence of the European project. In such a context, the essential role of the Commission and every one of its DGs is to show very clearly that there is added value for the Member States and their citizens in joint EU action. In contribution to this, DG SANTE will focus its efforts on the range of issues outlined below, in order to successfully tackle the key challenges of better cost effectiveness and efficiency, of delivering both safety to citizens and competitiveness to the economy, and of tackling global threats, all of this based*

on sound evidence, and taking place in a sensitive environment with numerous sector interests." p.5

More in particular, the challenges identified for the 2016-2020 period are:

- Achieving greater cost-effectiveness
- Safety versus competitiveness
- Safety versus competitiveness
- Evidence-based policy making
- Evidence-based policy making

While the Strategy is organized as follows:

General objective 1: A new boost for jobs, growth and investment in the EU

- Specific objective 1.1: Better preparedness, prevention and response to human, animal and plant health threats
- Specific objective 1.2: Safe and sustainable food and food production systems
- Specific objective 1.3: Cost-effective health promotion and disease prevention
- Specific objective 1.4: Effective, accessible and resilient EU healthcare systems
- Specific objective 1.5: Increased access to medical expertise and information for specific conditions
- Specific objective 1.6: Effective, efficient and reliable controls

General objective 2: A deeper and fairer internal market with a strengthened industrial base

- Specific objective 2.1: Effective EU assessment of medical products and other treatment
- Specific objective 2.2: Stable legal environment and optimal use of current authorisation procedures for a competitive pharmaceutical sector and patients' access to safe medicines
- Specific objective 2.3: Common Member States' tools and methodologies used for EU health systems performance assessments

General objective 3: A balanced and progressive trade policy to harness globalisation

- Specific objective 3.1: Increased EU influence in international fora
- Specific objective 3.2: A balanced agreement with the US on pharmaceutical products and in SPS area

3.5 Evaluation of the pilot action concerning the initial targeting of the Equal2Health project, the objectives of the Programme, and the EU policies for health

Taking into consideration the above it is evident that the project interventions in general, as well as the pilot specifically are in line with the objectives of the Programme and the EU policies.

3.5.1 Synergies with the EU Policy

As far as EU Policies are concerned, the synergies are based on the SP 1. Specific Objective 1.4: Effective, accessible and resilient EU healthcare systems and Specific Objective 1.5: Increased access to medical expertise and information for specific conditions.

The project is working complementary to supporting the Health Care Systems of the two countries providing access to vulnerable communities. This is especially true also in the case of S.O. 1.5 since the core of the project is to provide medical expertise and information for specific conditions to the vulnerable population.

3.5.2 Synergies with Interreg V-A Cooperation Programme "Greece - Bulgaria 2014 - 2020 "Greece-Bulgaria 2014-2020"

The Project and the pilot actions are in full accordance with the objectives of the Interreg V-A Cooperation Programme "Greece - Bulgaria 2014 – 2020 "Greece-Bulgaria 2014-2020", and they address in particular:

- IP 9a - Investing in health and social infrastructure which contributes to national, regional and local development, reducing inequalities in terms of health status, promoting social inclusion through improved access to social, cultural and recreational services and the transition from institutional to community-based services
- Specific Objective 8. To improve access to primary and emergency health care (at isolated and deprived communities) in the CB area

The above is expected since the Programme was approved by the Managing Authority. Nevertheless, it should be stressed that the pilot is also in accordance with S.O. 8 Improving access to primary and emergency health care (at isolated and deprived communities) in the CB area.

In particular, focusing in the local Roma population allies also with the overall scope of the Programme, as well as the IP that focus on Health. Moreover, as it was presented above health inequalities are strongly linked with a lower socioeconomic status. Therefore, a population like the Roma, is under a triple level of health threats since:

- It resides in an area
  - of low performance in Health indicators
  - of high unemployment and low performance in macroeconomic indicators
- It consists a marginalised group.

3.5.3 Other Synergies

In addition to the above, the project contributes to the EU2020 strategy and especially to the "inclusive growth" objective by promoting "access for all" to health care. Furthermore, in February 2013, the Commission adopted the Staff Working Document (SWD) "Investing in health" (as part of the Social Investment Package - SIP), which presents health as a value in itself and as a "growth-friendly" investment.

It recommends investing in three key areas:

1. health systems sustainability,
2. people's health as human capital,
3. reducing health inequalities (contributes to social cohesion and breaks the vicious spiral of poor health contributing to, and resulting from, poverty and exclusion).

The SWD "Investing in Health" recommended the use of structural funds in health for:

- It invests in health infrastructure that fosters a transformational change in the health system, particularly reinforcing the shift from a hospital-centred model to community-based care and integrated services.
- They improve access to affordable, sustainable, and high-quality healthcare to reduce health inequalities between regions and give disadvantaged groups and marginalized communities' better access to healthcare.
- Marginalized communities obtain better access to health care.

The project is in line with Regulation No 282/2014, which establishes the third multi-annual programme for Union action in the field of health for the period from 1 January 2014 to 31 December 2020.

Last but not least, the project is in line with:

- National Health Strategy,
- National & Regional Strategy, for Reducing Poverty and
- EU Regional Operational Programmes (GR: Central Macedonia & East Macedonia & Thrace, BG: Regional Operational) and specific the 9a Investment Priorities.

4 Methodological Approach

4.1 Scope of the Chapter

The current section is presenting the methodological approach for the evaluation of the impact of the project.

4.2 Overall Approach

The starting point in planning any public intervention is to identify a problem that needs to be addressed. Given that there will always be a number of real or perceived needs, the decision to address unmet needs is the result of a deliberate social process ("political decision"). It is part of this process also to determine the direction of the desired change and sometimes the desired state in which it is to be achieved (goal). A public intervention often aims at more than one result.

The intended result is the specific dimension of well-being and progress for people that motivates policy action, i.e. what is intended to be changed, with the contribution of the interventions designed.

Having identified needs and a desired result does not mean that the public intervention has been fully designed. Different factors can drive the intended result towards or away from the desired change. A policymaker must analyse such factors and decide which ones will be the object of public policy. In other words, an intervention with a certain intervention logic must be established. The project designers must clarify which of those factors they want to affect. The specific activity of project leads to outputs.

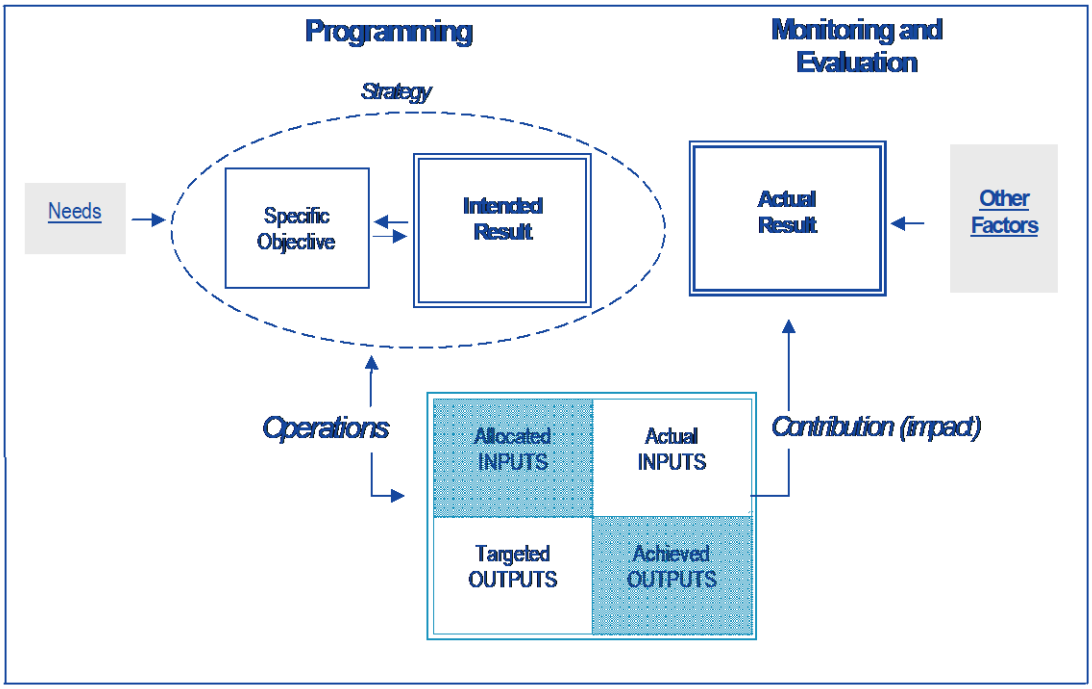
The intention to change the situation in a certain region, for a sector or group of people (potential beneficiaries) is the core of the project. However, projects often cannot support all persons that are concerned by a problem. In most cases, only some potential beneficiaries will become actual beneficiaries.

It can be useful to illustrate an intervention graphically by a logical framework. Such a stylised representation of a programme should reflect that an intervention can lead to several results and that several outputs can lead to these changes. Equally, it can be useful to differentiate the result(s) by affected groups and time horizons.

The following graph illustrates the reasoning of a programme, but it can be adapted to express the main logic behind the planned interventions of a project. What should be noted that there could be a difference between the allocated/planned inputs and the actual inputs committed in the implementation, as well as the planned outputs and the achieved outputs.

For this reason monitoring and evaluation is crucial.

To monitor means to observe. Monitoring of outputs means to observe whether intended products are delivered and whether implementation is on track.



While evaluation examines, the difference between the situation before and after the public intervention, but does not equal the effect of public intervention, since there are also underlying factors affecting the results of the programme.

Impact is the change that can be credibly attributed to an intervention. "Effect of an intervention" or "contribution of an intervention" are alternative expressions for this idea.

To disentangle the effects of the intervention from the contribution of other factors and to understand the functioning of a programme is a task for impact evaluation. Two distinctive questions are to be answered:

- Did the public intervention have an effect at all and if yes, how big – positive or negative - was this effect. The question is: Does it work? Is there a causal link? This is the question counterfactual impact evaluations aim to answer.
- Why an intervention produces intended (and unintended) effects? The goal is to answer the “why and how it works?” question. To answer this question is the aim of theory-based impact evaluations.

4.3 Theory Based Evaluation

While counterfactual based evaluation are the state of the art concerning the evaluation of projects and programmes, they are difficult in implementation since they require big data sets and in most cases ex-ante development of Monitoring and Evaluation systems that would allow statistical methods to be employed. Therefore in this particular case a Theory Based Evaluation is being employed.

The importance of theory-based impact evaluations stems from the fact that a great deal of other information, besides quantifiable causal effect, is useful to policy makers to decide what policy to implement and to be accountable to citizens. The question of why a set of interventions produces effects, how, for whom and under what conditions, intended as well as unintended, is

as relevant, important, and equally challenging, if not more, than the "made a difference" question. This approach does not mainly produce a quantified estimate of the impact, it produces a narrative. Theory-based evaluations can provide a precious and rare commodity, insights into why things work, or don't and under what circumstances. The main focus is not a counterfactual ("how things would have been without") rather a theory of change ("did things work as expected to produce the desired change"). The centrality of the theory of change justifies calling this approach theory-based impact evaluation.

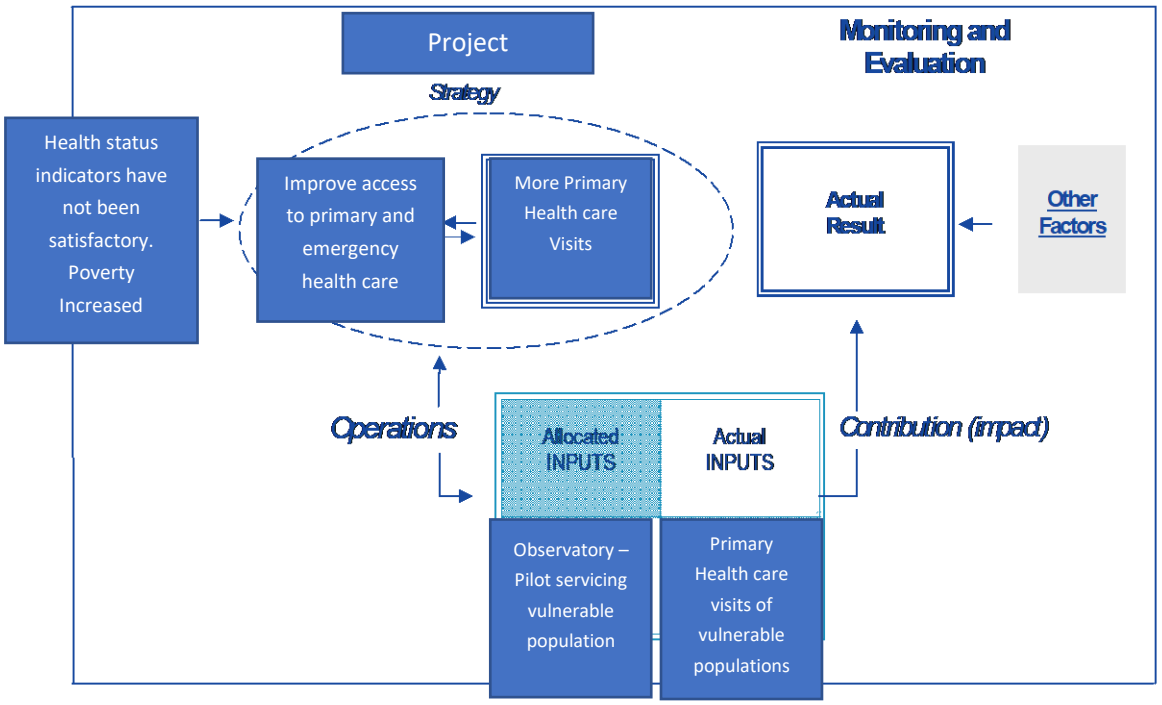
Typical methods include literature reviews, administrative data analysis, case studies, interviews and surveys in order to reconstruct and verify the intervention logic. Often mentioned approaches are realist evaluation, general elimination methodology, contribution analysis and participatory evaluation. A good evaluation of this type will always be open to flag up unintended effects. Such effects and the understanding of their mechanisms can be as important as the intended intervention logic.

4.4 Operationalization of the Methodology

Based on the above as well as on the background of the project and the programme that was presented in the previous sections of the document, the following diagram illustrates the project intervention in the above framework.

The main actions/operations that contribute to the overall Specific objective of the programme is the operations of the "Observatory" and the pilots that could alleviate some stress from the Health care systems in the CBA.

The monitoring of the outputs and the impacts of the project are the focus on the current deliverable and are tackled in the following sections.



5 Sampling of the end beneficiaries of the pilot action and inteviews with project key figures

5.1 Scope of the Chapter

The current section is presenting the sources of data concerning the impact analysis of the pilot action, focusing both in primary and secondary quantitative and qualitative data.

5.2 Primary Data Sources

The impact assessment of the pilot action was based on a series of quantitative and qualitative data, following the guidelines for such project evaluations.

5.3 Sampling of the end beneficiaries of the pilot

Since the project had a monitoring system in place for the pilot action collecting adequate information for the assessment no sampling of end beneficiaries was needed. On the contrary a in depth interview had to be conductes with the Project Manager & Supervisor/Scientific Manager.

Overall the assessment was based on a number of quantitative and qualitative data, following the relevant guideline. The data are presented below.

5.3.1 Data collected during the project implementation

The quantitative data for the evaluation was collected internally during the implementation of the project from the staff that was involved in the Observatory and Pilot action. The data includes visits to Medical Doctors per month as well as a number of social characteristics of the beneficiaries.

In particular, the data included the following:

- Visits per specialty
- Visits per months
- Visits per trip
- Gender of the beneficiary
- Education attainment
- Employment Status
- Marital Status
- Number of children
- Place of Residence
- Rom descent

A number of other medical history specific data were also monitored such as:

- Substance use
- Type of substance used

- Underlying conditions
- Use of other prescription drugs

The above, while they are very useful concerning the impact to the health of the beneficiaries are not relevant within the scope of the project and were not included in the analysis.

It must also be noted that the project lacked a comprehensive and unified system of monitoring. This led to important information gaps and discrepancies, a major limitation to the analysis of the impact in general.

5.4 In depth interviews with key implementation figures

An in-depth interview took place with the project manager of the LP in order to evaluate in greater detail:

- the implementation of the actions
- the problems that might have occurred
- the limitations that took place in order to achieve the outputs
- the perceived outputs
- the follow up actions
- the management issues that arose
- the impact of unexpected risks and especially the pandemic

The interview took place on line through the zoom platform. The evaluator took notes and the analysis was based in those.

5.5 Secondary Data Sources

The evaluator took into consideration a number of secondary data in order to assess the implementation of the project. Most of these data concern documents that are directly linked with the project, though also documents linked with the wider scope of the project were considered. The following sections present the relevant secondary documents that were used for the evaluation.

5.5.1 Project documents

The evaluator took into consideration all the relevant project documents and in particular:

- The application form
- The Justification of Budget
- The Project reports

5.5.2 Programme documents

The evaluator took into consideration all the relevant programme documents and in particular:

- The programming document
- The indicators methodological note

- The Annual Implementation reports

5.5.3 Other relevant documents

The evaluator took into consideration other relevant documents that are linked with the project this included:

- The national strategy for social inclusion
- The regional strategy for social inclusion
- The Regional Observatory of Social Inclusion Reports
- The Regional Operational Programme Programming Document

6 Quantitative and Qualitative Data Analysis

6.1 Scope of the Chapter

The current section is presenting the data analysis, focusing both in primary and secondary quantitative and qualitative data.

6.2 Analysis of quantitative data

The following section presents the analysis of the quantitative data that were collected by the monitoring system of the project itself. The relevant data include:

- Visits in the Observatory
  - Per month
  - Per specialization
- Visits in trips
  - Per month
  - Per specialization
- Visits in the pilot
  - Per month
  - Per specialization
- Social Data from the Observatory and trips visits
  - Medical Insurance
  - Place of residence
  - Gender
  - Employment Status
  - Education
  - Marital status
  - Number of Children

6.2.1 Visits in the Observatory

The overall visits to the observatory were 795 based on the data provided and they spanned from October 2018 to February 2020.

In general, the peak period was between the 10th and 17th month of the observatory with the busiest month in total was the 14th month since the initiation of the observatory (11/2019) with overall 70 visits.

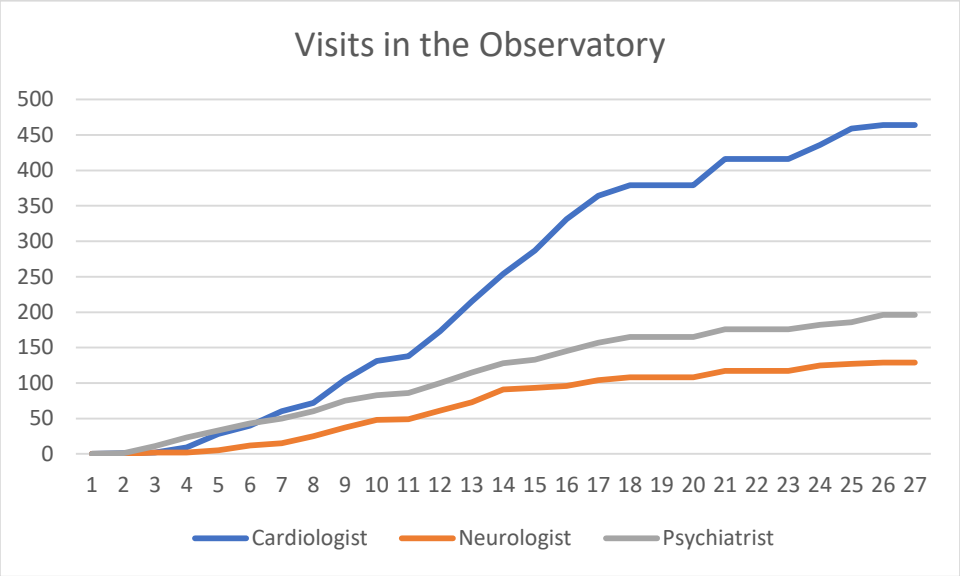


Figure 1 Visits in the Observatory

Most visits concerned the cardiologist with almost 60% of the visits. Twenty-five percent of the visits were done to a psychiatrist and the rest 16 percent to a neurologist.

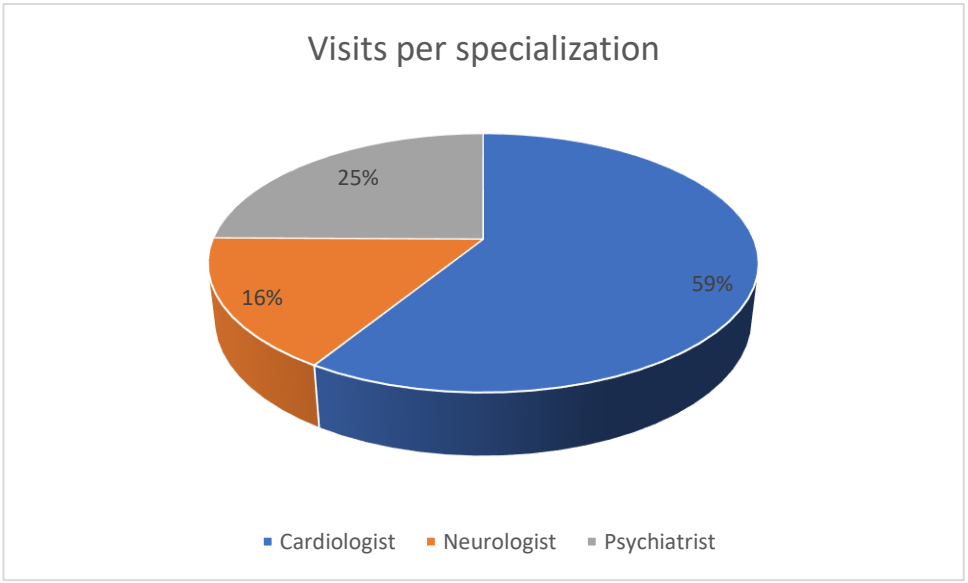


Figure 2 Visits per specialization (Observatory)

6.2.2 Visits in the Trips

The overall visits in the trips were 215 based on the data provided and they spanned between October 2019 to January 2020.

In general, the 1st trip was the most successful with 50 overall beneficiaries, with the 5th close to it with 49 .

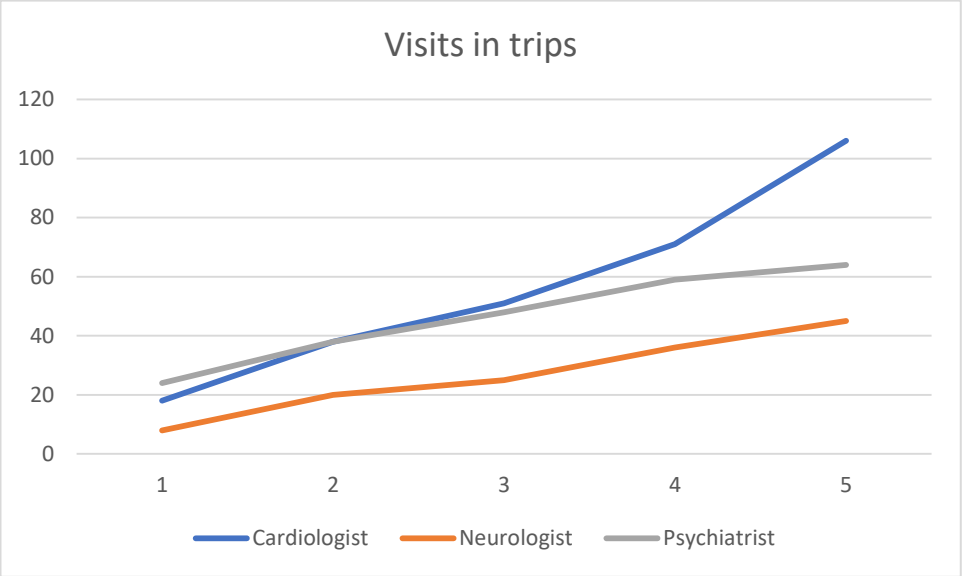


Figure 3 Visits in trips

Most visits concerned the cardiologist with almost 49% of the visits. Thirty percent of the visits were done to a psychiatrist and the rest 21% to a neurologist.

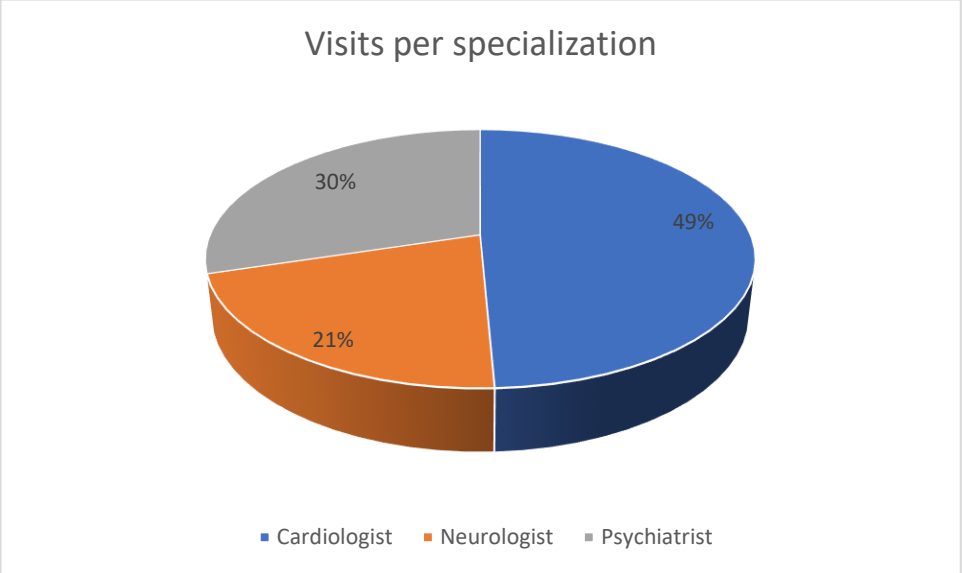


Figure 4 Visits per specialization (Trips)

6.2.3 Visits in the Pilot

The overall visits in the pilot were 537 based on the data provided and they spanned from November 2019 to March 2020.

In general, the visits followed a stable course without important changes in the number of visits. That said the most successful month was the 3rd month is the initiation of the pilot (January 2019) with an overall of 70 visits.

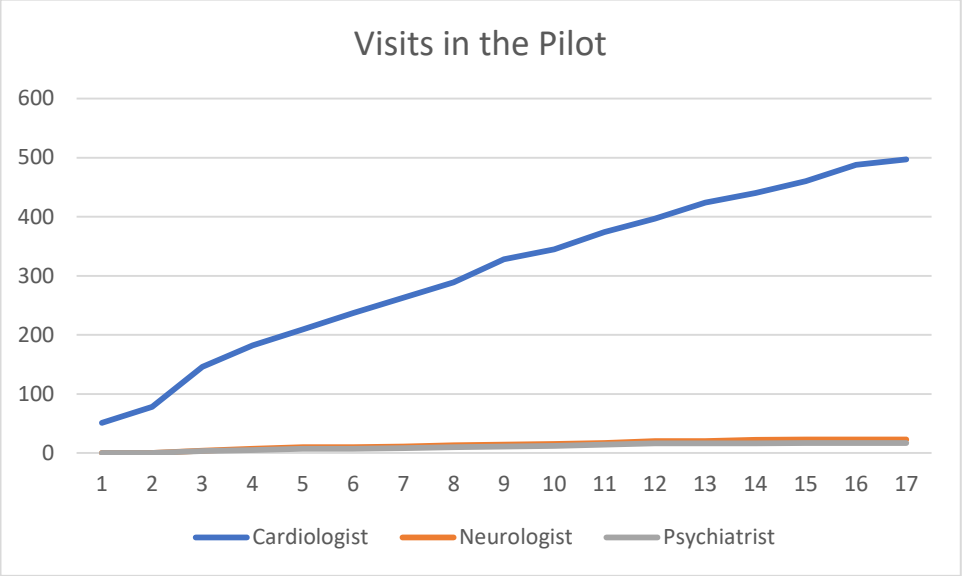


Figure 5 Visits in the Pilot

Most visits concerned the cardiologist with more than 90% of the visits. Three percent of the visits were done to a psychiatrist and the rest 4% to a neurologist.

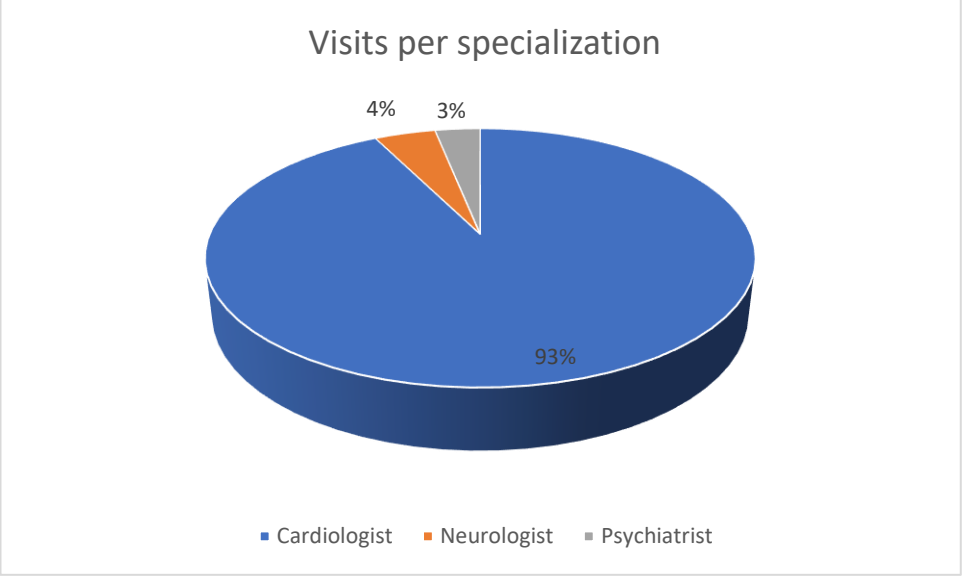


Figure 6 Visits per specialisayion (Pilot)

6.2.4 Social Data from the Observatory and trips visits

The following section presents the available social data of those that visited the observatory and were checked during the trips. A number of data concerning the medical history of the beneficiaries are not presented since they are not relevant with the pilot evaluation.

6.2.4.1 *Medical Insurance*

The greatest part of those that visited the observatory were insured (80%). A small part were uninsured (8%) with a 13% of cases with no available data.

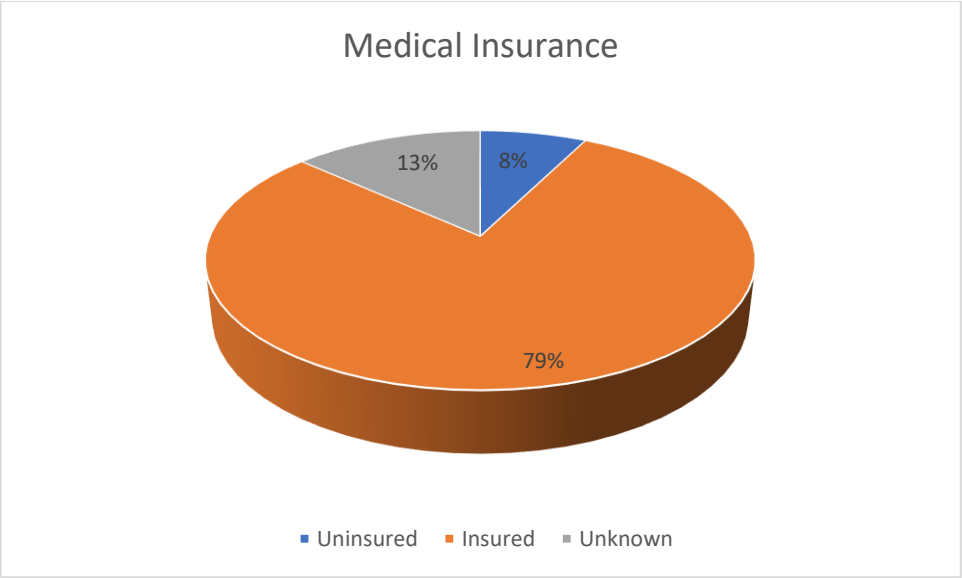


Figure 7 Medical Insurance

6.2.4.2 *Place of residence*

The greatest part of the cases were living in the Regional Unit of Thessaloniki (80%) and moreover in an Urban setting. A small part resided in The Regional Unit of Serres (8%) where the trips took place. One percent were cases coming from other Regional Units, a handful of cases were living abroad. Lastly 3% of the cases did not provide data for residence.

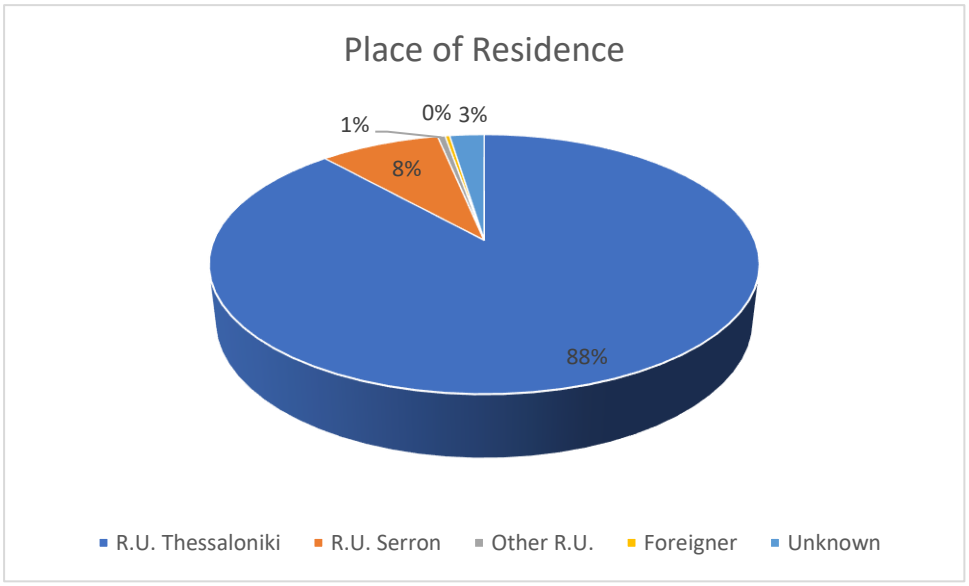


Figure 8 Place of residence

6.2.4.3 Gender

The majority of the cases were male (60%) with the rest 40% being female. No cases were included in other, either because the monitoring did not include such a category, or because none of the cases opted for this option.

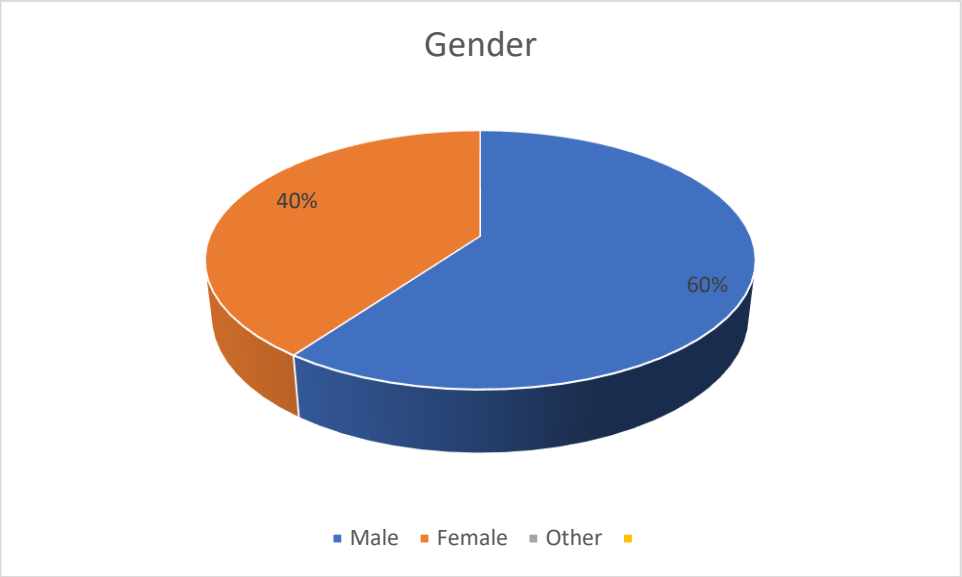


Figure 9 Gender

6.2.4.4 Employment status

The majority of the cases were unemployed (65%) with 25% being employed. The rest of the cases 9% were inactive and were mainly pensioners.

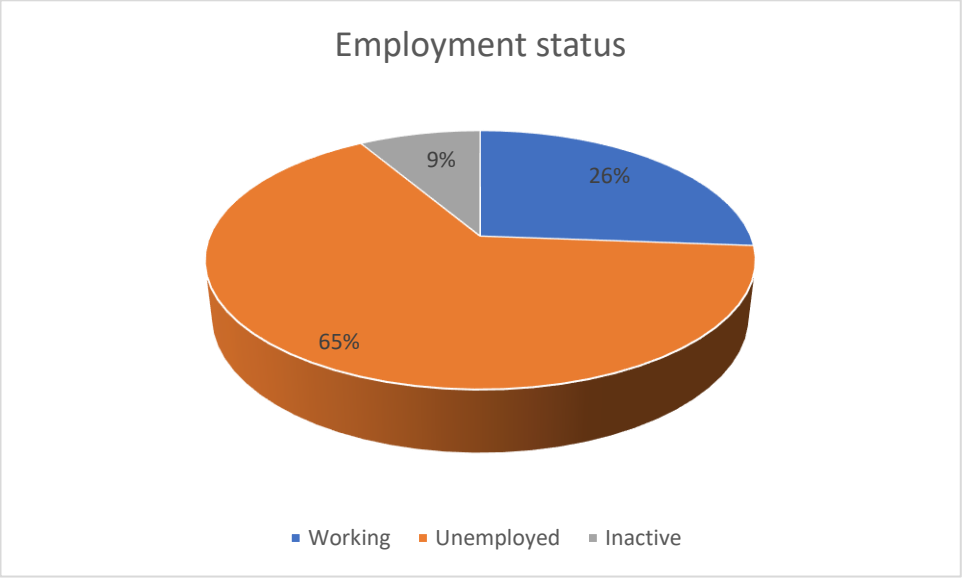


Figure 10 Employment status

6.2.4.5 Educational Attainment

The majority of the cases finished Elementary of Special School (44%) with an extremely high percentage of 39% not having any education. Only 17 percent has finished the compulsory education and higher (Junior high school 12%, High School 4%, University 1%).

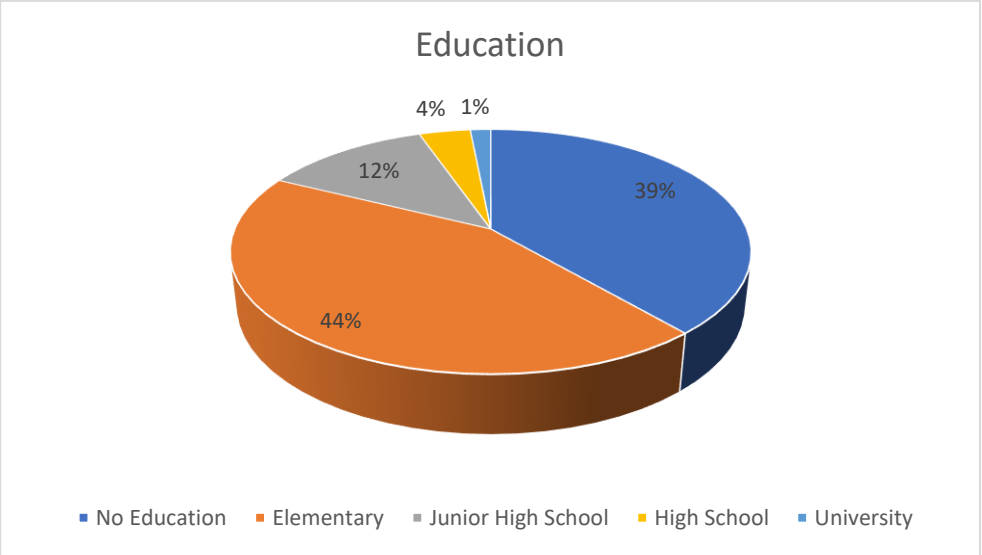


Figure 11 Education

6.2.4.6 Marital Status

The majority of the cases were single (59%), but a significant 35% of the cases were married. A small number of cases (4%) were divorced, while a handful of cases were widowers.

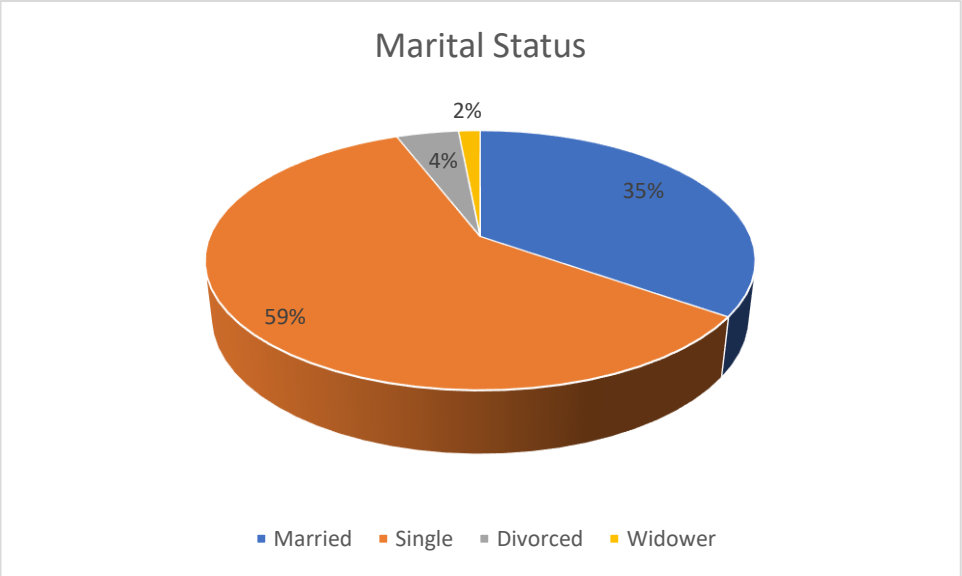


Figure 12 Marital status

6.2.4.7 Number of Children

The majority of the cases did not have any children (28%) with an additional 35% having one or two children. Nevertheless, an important 27% of cases had 3 or more children and a handful of cases had 7, 8 and 9 children. It must be noted that marital status is not directly linked with having children, with a significant number of cases being single but having children.

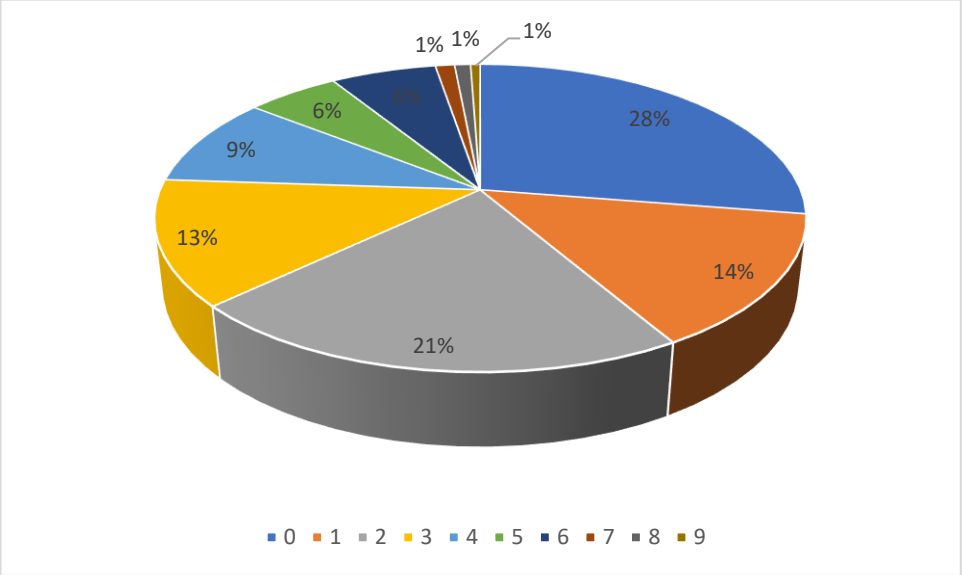


Figure 13 Number of children

6.2.4.8 Roma population

The majority of the cases were Roma people (70%) therefore belonging in a vulnerable group, in addition with the usual unfavourable social and economic conditions.

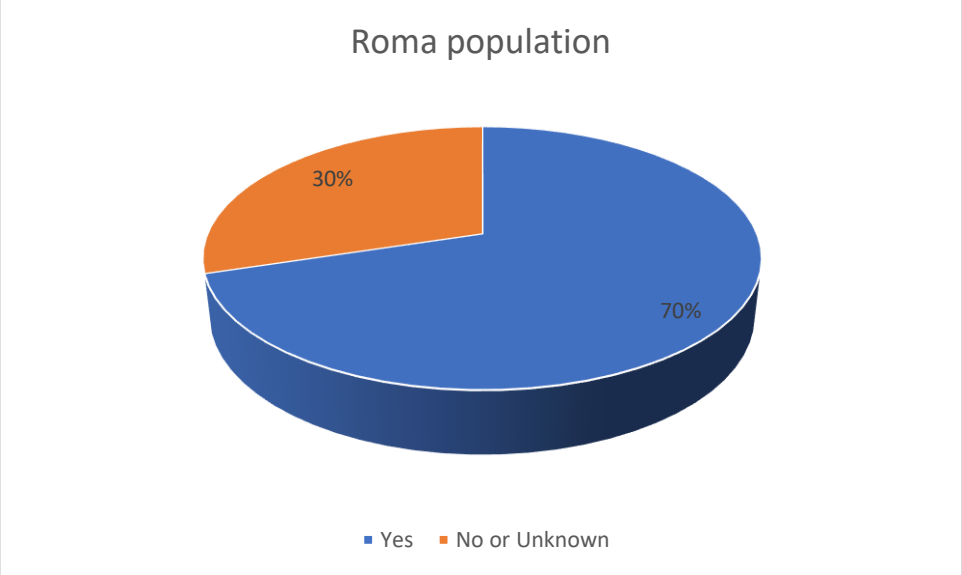


Figure 14 Roma population

6.2.4.9 Unitary Cost

The following table present the available data from the monitoring of the project, both in terms of output indicators and financial data from all 3 Greek partners and computes the unitary cost per visit (1547 visits in total).

Table 3 Unitary cost

Overall Cost (Euros)	Relevant WPs	Unitary Costs
301.586,96	WP3 & WP4	193,7 euros/visit
323.848,57	All WP	207,9 euros/visit

It should be noted that the unitary costs presented above only include beneficiaries of actual visits and do not include the beneficiaries that were informed about prevention. Therefore the overall unitary cost, based on all the beneficiaries, is expected to be lower.

6.3 Analysis of qualitative data

The analysis of the qualitative data was based on the notes that were taken by the evaluator during the in depth interview and are organized in the following 4 categories:

- Planning and Scope
- Implementation
- Monitoring and Impact
- Sustainability and continuation

6.3.1 Planning and Scope

The planning and scope of the project was to support vulnerable populations that do not have easy access to primary and proactive health care focusing in three important specialties:

- Cardiology
- Neurology
- Psychiatry

In Greece, the focus of the project was linked with Roma people through the Pilot but also people in extreme poverty or in threat of poverty and social exclusion (Unemployed, Elderly etc.). The planning was solid based on the needs of the CBA and is still valid today.

6.3.2 Implementation

The implementation followed the initial planning to a great extent and the relevant actions have been implemented as planed focusing in all vulnerable populations.

To increase the outreach the project staff communicated with flyers and leaflets with

- Urban Health Centres
- Municipalities

- Mental Health Centres
- Community Centres
- Psychiatric Hospital and General Hospitals
- 3rd and 4th Health Districts
- and other relevant institutions.

The actions included the presence of an MD, a nurse and the scientific responsible of the project. For example the observatory was operational Monday to Thursday between 3-10pm with alternating specialties.

Based on the assessment of the beneficiaries the MDs would reference them to

- General Hospitals
- Mental Health Centers
- Emergency care unit

Nevertheless, the implementation of the project faced several hurdles and to some extent the project underperformed. The main aspects are presented in the following section.

6.3.2.1 Management issues

The staff and the project manager were not familiar with all the necessary process for the management of the project that has led to important difficulties with the implementation. In addition to the above the LP is an institution with important bureaucracy issues, due to some extent with the way that is organized.

The project manager reported that there is a significant amount of knowledge accumulated after the implementation.

6.3.2.2 Implementation of main actions

A number of hurdles made the implementation more difficult than expected mainly due to

- the underlying conditions of the vulnerable populations and especially the Roma Population
- the COVID pandemic

Underlying Conditions

There are number of underlying conditions that posed hurdles to the implementation. Concerning the relevant lower need for the specialties of Psychiatry and Neurology the PM explained that

In the case of the Neurologist is linked with high specialization of the field and the need to reference someone to a neurology, while this is not the case in Cardiology.

In the case of Psychiatric there are two basic underlying factors that are linked with the relative underperformance of visits to a psychiatrist are:

- The perceived stigma of Mental Health issues
- The perceptions of Roma people concerning mental health issues that in many cases disregard low impacts mental disorders.

Moreover, the Psychiatric Hospital also covers a big part of the current needs.

COVID Restrictions

The COVID pandemic has created a lot of hurdles in the implementation due to the lockdown measures.

While the needs increased the access to the services was restricted in General creating a number of issues to the project as well. Based on the assessment of the project staff mental health patients have not been able to follow up with their treatment, leading to relapses.

At the same time some of the project actions were restricted. Out of the 15 visits planned only 5 took place since COVID restrictions did not allow for the implementation of siuch actions. The measure also led to fewer visits in total and the cancelation of several communication actions.

6.3.3 Monitoring and Impact

As it is expected due to the limited implementation of the actions the impact of the project was also restricted to some extent. Nevertheless, it should be said that according to the PM the overall impact has been up to satisfactory levels especially taking into consideration aspects such as:

- Identifying the population needs
- Identifying groups that are in need of such services
- Referencing and specialized care of beneficiaries
- Access to specialized care

6.3.4 Sustainability and continuation

The PM reported that the Observatory continues to be operational and is expected to be operational under the sustainability actions of the project. Currently the Oupatient Units of (psychiatry, neurolgy ans cardiology) and the Neurophysiology Laboratory have taken over.

Moreover, the network that was developed is still operational and there is a functional reference pathway. In this sense the Observatory works as entrance point to specialized healthcare.

7 Capitalization of the pilot action

7.1 Scope of the Chapter

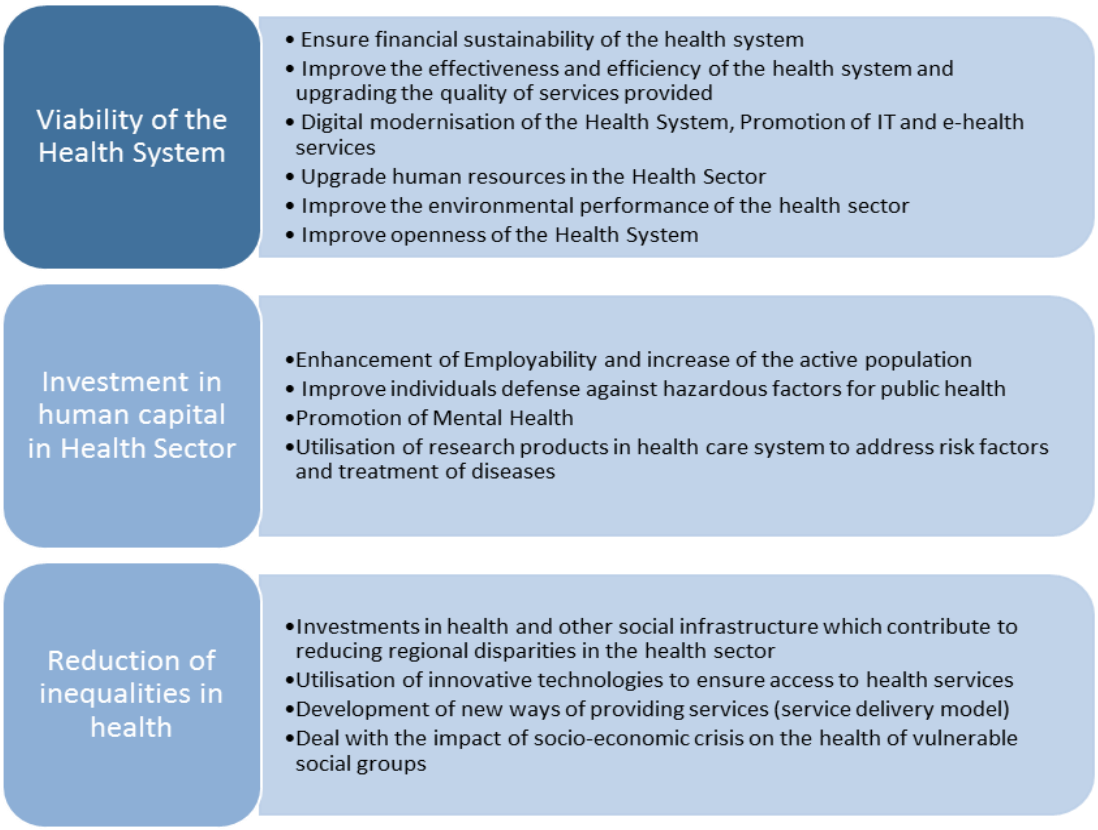
The current section presents the main elements regarding the utilization of pilot action results.

7.2 Capitalization Actions

Now that Equal2Health project has reached the end of its implementation, apparently partners, medical, administrative staff and experts involved have acquired important experience in project management and implementation of transnational projects with the use of EU and national funding.

Besides, the operation of the Observatory in combination with the antenna offices, the mobile units operation and the implementation of the pilot activity could be used as the basis for the further development of permanent or project-based services to the same target groups or a greater number of vulnerable groups with relevant needs.

In order to achieve the above all interventions should be incorporated under a specific framework of intervention in a metropolitan and/or regional level. The following diagram elaborates on the Pillars and Specific characteristics that interventions should take into consideration to be seamlessly incorporated under an overall planning.



8 Continuation of the action and know-how transfer

8.1 Scope of the Chapter

The current section presents suggestions for continuing the action and transferring know-how.

8.2 Strategies and Programmes compatible for Know-how tranfers

The project has a strong linkage with the Social inclusion policies on a national, regional and local level. In particular the project has important synergies with following strategies:

- Naitonal Social Inclusion Strategy
- National Strategy for the Social Inclusion of Rom people
- National strategy for third country nationals
- Regional Strategy for Social Inclusion
- Regional Action Plan for the Inclusion of Rom People
- Thessaloniki Resilience Startegy

Addtionally, the project has strong ties with the Operational Programmes that are fudning the respective policies and especially the Regional Operaitonal Programme of the Regions of Central Macedonia and Eastern Macedonia and Thrace (both ERDF and ESF parts).

Lastly, the project could develop linkes and transfer good practices with projects that are funded today through the AMIF and will be funded in the next programming period through the ESF+.

From all the above strategies and programmes the most relevant and readily accessible are projects for Good Practices Transfer are the Community Centers and Local Health Units that are funded through the Regional Operational Programmes (ESF).

8.3 Good Practices Transfer with Community Centers

Takng into consideration the above analysis, as well as the analysis of the implementation of the project, we consider that the best option for Good practices transfer is through the Communicty Cented with which the project has already established a link.

Community Centers have proved to be important pillars of Social Inclusion Policies as well as screening centers for the identification of needs. Community centers include a psychologist in their staff which can work as a first level screen to further reference people in need to the project. While, currently there is no staff in Community Centers to cover other needs (cardiology, neurology), since there is an overall needs' assessment in Community centers in order for the beneficiaries to get the relevant benefits, they can be an important alternative entry point for vulnerable people.

Therefore the link of the project with the Community Centers is the most valuable element as far as impact is concerned. To this end the evaluator suggests the institutional connection of Community Centers with health care providers and in particular Urban and Rural Health Cents and Organisms that act as "Observatories" in order to increase outreach and better identify the

needs of the population. In this was observatories can be much more efficient in “recruiting” the people in need of specialized health care.

9 Conclusions and lesson's learned

9.1 Scope of the Chapter

The current section presents the main conclusions and lessons from the implementation of the project.

9.2 Conclusions

The Conclusions are presented focusing on the following pillars

- Planning
- Implementation
- Monitoring
- Impact

Planning

The project is covering an important need that exists in the CBA area. Nevertheless, is not strongly linked with the main focus of the IP which is to promote access to primary and emergency care. In this sense the project supports vulnerable populations though not in the identified needs of the programme.

Based on the above there is discrepancy and a gap in the theory of change of the project.

Implementation

The implementation of the project was problematic mainly due the underlying conditions and the COVID pandemic. If the lockdown measures were not in effect the implementation of the project would be much more successful.

That said the overall implementation in assessed as satisfactory taking into consideration all the relevant limitation factors.

Monitoring

It must be said the project developed an internal monitoring scheme that was more elaborated than just accounting for the beneficiaries of the project and should be complemented for this.

That said the project's monitoring system left a lot of room for improvement. The system was not unified and did not necessarily served the needs of evaluation.

Impact

Despite all the difficulties for the implementation the project had an important impact in the targeted groups. It is the opinion of the evaluator that more lasting effects will be linked with the development of a network of institutions to support these needs and to a lesser extent with the direct impact of the actions.

Nevertheless, the gaps between the programme scope and objectives and the projects scope and objectives are expected to lead into a lower impact in the result indicators than was originally expected.

10 Litterature

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