Social Policy Issues

ISSN: 1640-1808
E-ISSN: 2719-7328

4/2025 vol. 71

Problemy Polityki Społecznej

Faculty of Political Science
and International Studies
University of Warsaw

Published thanks to the support of the University of Warsaw under the Excellence Initiative – Research University programme and the Faculty of Social Science and International Studies

ISSN 1640-1808
e-ISSN 2719-7328

PUBLISHING PARTNER
Scholar Publishing House Ltd.
ul. Obożna 1, 00-340 Warsaw, Poland
phone: + (48) 22 692 41 18; e-mail: info@scholar.com.pl
www.scholar.com.pl

Corresponding address:
Nowy Świat 67, room 110
00-927 Warszawa
Tel./fax 0-22 826-66-52
www.problemypolitykispolecznej.pl; problemy.ps@uw.edu.pl

The reference version of the journal is the online version

Contents

Editorial for Issues 3 and 4

These days, social policy toward rural areas has been facing challenges that are difficult to compare with any previous period. Rural Europe – particularly in our region – has found itself at the very centre of overlapping processes: depopulation and ageing, structural transformations, climate change, widening service inequalities, the redefinition of social ties, and, in the case of Ukraine, also the consequences of war and the immense tasks linked to rebuilding local communities. These processes no longer constitute the backdrop of social policy – they actively shape it, influencing its scope, pace, and possible directions, while simultaneously revealing where existing public policy instruments have become obsolete.

The idea for this special issue arises directly from this diagnosis. We aimed to shift the perspective: to move away from viewing rural areas as spaces of deficit and toward recognising them as ones where the systemic tensions of contemporary welfare states become most visible – and as territories where new responses may emerge, more integrated and territorially sensitive, taking into account economic, institutional, environmental, and cultural factors simultaneously. The articles collected in these two volumes fulfil this intention exceptionally well: despite differences in themes and research approaches, they share a common sensitivity to inequalities rooted in space, institutions, and local structures.

In their particularly important article "Ensuring spatial inclusion of the socio-economic development of urban-rural formations of Ukraine", Ella Libanova and Ihor Bystriakov demonstrate that space is one of the key conditions of social inclusion. Ukraine's post-war reconstruction requires – not only infrastructure investments, but above all – a new way of thinking on the relationships among segments of the territorial system: the interdependence between city and countryside, between core and periphery, between local institutions and national reconstruction policy. A similar logic reappears in the article by Kamil Glinka and Barbara Panciszko-Szweda, "Childcare accessibility for children under 5 years of age across the urban and rural areas. Lessons from Wałbrzych district", where the accessibility of childcare services becomes a litmus test of local governments' and public service systems' ability to ensure equal opportunities regardless of residence. In an analogous way, though in a different policy field, Jan Neugebauer, Marek Vokoun, Ivana Lovětínská, and Jiří Rotschedl in "Access to healthcare services for vulnerable populations in the Czech Republic" show that the geography of healthcare is becoming one of the major factors differentiating health opportunities.

The second important theme linking these analyses is structural exclusion. It is this precisely – rather than poverty or lack of employment alone – that determines the situation of rural residents most strongly. In their article, "Anticipation of female labour supply in rural area of Ukraine: A microsimulation approach", Volodymyr Sarioglo and Anton Kuranda demonstrate that womwen's labour market participation in rural areas depends primarily on the availability of care and transport services, rather than on individual choices. Viktor Borshchevskyi and Julia Tsybulska in "What is the impact of social isolation of internally displaced persons in rural communities? Implications for Ukraine's recovery" emphasise that the isolation of internally displaced persons does not stem from social tensions, but from the overload of local institutions and the lack of coordination in service provision. These studies show that rural exclusion is above all institutional: it is the product of insufficiently dense service networks, dispersed responsibilities, and inadequate integration of public actions.

In this context, the need to depart from narrow sectoral thinking in public policy becomes particularly clear. Rawia Naoum's article "Education and healthcare policies to alleviate inequalities: The case of MENA countries" proves that educational and health inequalities are tightly intertwined – and that public policy can be effective only when it operates simultaneously on multiple levels: education, healthcare, social services, and spatial planning. Similar insights appear in the work of Libanova and Bystriakov, as well as in Stanisława Golinowska's reflections in "Health in social policy and social problems in health policy", where the lack of cooperation between social and health policy is presented as a mechanism generating systemic injustice – felt most strongly in peripheral regions.

Equally important is the theme of institutional capacity – of the state and of local communities. The articles reveal that the effectiveness of social policy in rural areas depends not only on funding or central-level decisions, but also – and perhaps above all – on the quality of local institutions, their embeddedness, networks of cooperation, and capacity for self-organisation. In "Sustainable production models in rural Galicia: Environmental challenges in community forest management", María Gabriela Miño and Raimundo Elías Gómez show that community-based resource management models can foster resilience and sustainability when they operate based on social trust, local knowledge and shared responsibility. This dimension – the relationship between the state and the community – emerges as key to understanding future directions in social policy.

All these texts are united by a conviction that we must rethink the relationship between urban and rural areas. In a world where the flows of people, services, resources, and information are increasingly intense and multidirectional, a non-hierarchical, networked perspective becomes essential. Ukraine, where urban–rural systems are undergoing a dramatic transformation, highlights this need with particular clarity. However, analogous processes are visible in Poland, the Czech Republic, Spain, and the MENA region. Rural areas are no longer "outside" the system – they are an integral part of it, and, in many domains, they are the spaces where the earliest symptoms of change and the first consequences of public policies' inability to adapt become visible.

Taken together, the two volumes lead to an overarching conclusion: rural areas are a laboratory for the future of social policy. It is there that the effects of demographic, environmental, institutional, and economic shifts become visible most rapidly. It is there that the need for service integration, institutional cooperation, and strengthening of local resources is most apparent. It is there that we can observe how the state functions – or fails to function – and how local communities compensate for its weaknesses. It is there, too, that the innovation potential emerges: new models of care, new forms of community governance, and new mechanisms of intersectoral coordination.

We, therefore, warmly encourage you to read both special issues. Not because they offer interesting case studies – though they do. Not because they present a cross-national overview of actions – though they do. They are worth reading because they create a shared map of problems, experiences, and possible solutions, allowing rural areas to be seen not as peripheries, but as one of the key arenas where the future of social inclusion and social justice – both in Europe and beyond – will be decided. It is an essential read for anyone who wishes to understand the direction in which social policy should evolve in times of profound transformation – and the crucial place that contemporary rural areas occupy within it.

Sławomir Kalinowski
Ruta Śpiewak

Problemy Polityki Społecznej. Social Policy Issues 2025, 71(4): 1–22
https://doi.org/10.31971/pps/214248

Submitted: 2025-06-09/Accepted: 2025-11-14

Stanisława Golinowska[1]

ORCID: 0000-0002-6812-5972
Institute of Labour and Social Studies – IPiSS, Warsaw,
Institute of Public Health, Jagiellonian University –
Collegium Medicum, Kraków

Health in social policy and social problems in health policy

Abstract

Recent changes in Poland's classification of scientific fields and disciplines (2018, 2022) have impacted the organisation of research institutions and the direction of studies, particularly in the social and health sciences. Unlike the natural sciences, which rely on stable classifications, the social sciences and humanities deal with complex and evolving subjects, making rigid frameworks problematic.

This article argues that recent classification reforms, particularly concerning the social and health sciences, disrupt cognitive processes, weaken institutional coherence, and hinder the formulation of rational social and health policies. The argument focuses on one crucial dimension of the issue: the marginalisation of integrative approaches that connect social and health concerns. This limitation adversely affects public governance and the effective design of real-world interventions in both domains.

Given the intrinsic overlap between social and health issues in public policy, interdisciplinary research and action are essential. However, current academic administrative practices – including the proliferation of narrow specialisations and the continual emergence of new subfields – discourage genuine interdisciplinarity, despite official declarations to the contrary. Alarmingly, these trends persist with minimal resistance from the academic community, even as their negative consequences are acknowledged.

[1] **Corresponding author:** Stanisława Golinowska, Institute of Labour and Social Studies (IPiSS), Warsaw; email: stellag@onet.pl

The reflections presented in this article stem from the author's research across the fields of health policy (including public health) and social policy. The text is organised into three sections: health-related issues, social policy, and the intersection of the two. The article concludes with reflections and recommendations aimed at scholars and policymakers in both the social sciences and humanities, as well as the health and natural sciences.

Keywords: public health, social policy, evaluation of scientific activity, organisation of science

Introduction

In recent years (2018, 2022), we have witnessed modifications to the nomenclature of fields of science and scientific disciplines in Poland, as well as the introduction of new classifications[2]. This activity did not remain without impact on the organisation of institutions and research teams, as well as on the directions of research undertaken, and consequently on the development of science in general. This applies to a lesser extent to the exact sciences (hard sciences), where concepts and classifications are more stable. They more clearly convey specific contents of phenomena, processes, and activities. In the field of social and human sciences, we are dealing with incomparably greater diversity and variability. The subject of interest for these sciences, namely humanity, communities, and societies, resists universal organisation despite the vast amount of philosophical and generally methodological work, along with carefully conducted reviews and classifications, still only bringing closer to the full clarity of the comprehensive picture.

In this article, I argue that the classifications of fields of science and scientific disciplines made in recent years in relation to social and health issues disrupt cognitive processes, weaken the institutional order, and do not promote the adoption of rational social and health policy. In the argumentation presented in this article, I focus on one dimension of the problem exclusively – the limitation of approaches that connect social and health issues, and the consequences of this for good public governance, and consequently for the proper shaping of the real sphere in both areas.

The coexistence of social and health issues in both health and social policy requires interdisciplinary research and action. Meanwhile, current practices in organising and administering science involve introducing narrow specialisations (fragmenting disciplines), in creating new directions and fields, and consequently discouraging a multidisciplinary approach despite declarations of its necessity. These practices do not encounter strong resistance from scientific communities, despite describing flaws and indicating harm[3].

---

[2] Regulation of the Minister of Science and Higher Education of September 20, 2018 (Journal of Laws item 1668) and Regulation of the Minister of Education and Science of October 11, 2022 (Journal of Laws of 2022 item 2202) regarding fields of science and scientific disciplines as well as artistic disciplines.

[3] Among others in Resolution No. 26/2022 of the Main Council of Science and Higher Education dated July 6, 2022.

The considerations presented in this article are the result of reflections that encompass and connect conclusions derived mainly from the research I conducted in both health policy (including public health) and social policy (Golinowska, 2018; Golinowska & Tambor, 2020; Golinowska, 2022; Golinowska, 2024).

The text is divided into three parts: (1) health problems, (2) social problems, and (3) the connection between both topics throughout the life course and in places of living. It concludes with considerations and recommendations addressed to academic communities and policymakers of both groups of disciplines, social sciences and humanities, as well as health sciences and natural sciences, and more broadly, to scientific communities that participate in or influence state regulations concerning the functioning of science.

1. The social dimension of health

When the subject of definition and classification is health, we encounter exceptionally complex problems. Health is a common issue across many disciplines and fields: social and economic sciences, medical sciences and health sciences, as well as natural sciences, which is reflected in the slogan "health in all policies" (Ståhl et al., 2006). The approach that combines requires the creation of common categories, uniform definitions, and appropriate systemic organisational solutions, which is still missing.

Health is also defined in relation to different entities described from the perspective of health status. On one hand, to individuals (people exposed to health risks and sick individuals), on the other hand, to populations and society, and thirdly, to all of nature: humans, animals, and plants. In the first case, we refer to medical sciences, which provide knowledge about the ethology of diseases and their treatment methods, and in the next two cases, we additionally refer to natural and social sciences, which recognise the impact of natural and social environmental conditions (in their continuous variability) on people health condition (population health) as well as that of animals and plants (one health).

A common category for defining health-related matters of individuals and populations is **health protection**. This term has been adopted in Poland as institutionally encompassing the entirety of health matters for both individuals and populations, in both preventive and therapeutic actions.

The health of the population in preventive actions related to the population in specific structures (socio-economic and geographic-ethnic) is the subject of **public health** interest.

Public health has been forging its way as a discipline in the science and practice of public actions for about five decades now. This is an exceptionally difficult path, as it goes against contemporary trends. They focus on solving the problems of individuals; people threatened by a specific disease and those who are ill ("patient in the spotlight," patient at the centre of attention). In diagnosis and therapeutic actions, references relate to a specific organ and its functioning, deviating from the norm. Medical specialities have developed, including cardiology, oncology, diabetology, orthopaedics, etc. What is often overlooked in this process is the patient, as the focus is mainly on the

malfunctioning organ. For this reason, a new trend in medicine, namely, holistic medicine, emerged, which encompasses the patient rather than their sick parts.

Public health requires a comprehensive view of the multitude of factors that shape health and pose threats to it, not only for individual human beings but for populations in their multidimensional structure and dynamic changes. The COVID-19 pandemic halted the trend of devaluing (neglecting) public health, which had visible successes concerning infectious diseases (vaccinations!). Meanwhile, the health of the population remains at risk due to the increase in chronic diseases (sometimes referred to as social or lifestyle diseases) and external threats arising from environmental degradation and climate change, as well as behavioural reasons, i.e., an increase in stress-inducing, aggressive, violent, and forceful behaviours.

Considering the social dimension of health in medical and life sciences research is not obvious. Cognitive interest in health and its care usually arises in connection with illness. The need for constant health care, even when pain is absent and no illness or accident is requiring life-saving intervention, is not widely recognised, and actions that promote disease prevention are insufficiently valued. History shows that public actions concerning health care, undertaken by public authorities (local, state, and international) aimed at the general population, were taken for two main reasons.

On one hand, due to the emergence of epidemics or other mass health problems. Public actions were based on identifying the causes of infections (dirty water, impurities, miasma, lack of personal hygiene) and taking actions that resulted from scientific discoveries in biology and medicine, which involved identifying bacteria, viruses, or other pathogens and applying measures.

On the other hand, public authorities began to influence health by improving the living conditions of society due to the need to keep the population in good condition; men for military reasons (the health of soldiers) and women for the "quality" of children and the need to care for them. Public concern for health during the period of industrialisation was supported by labour movements and the activities of trade unions, as well as the paternalistic attitude of employers interested in increasing work efficiency and social peace.

The increase in prosperity and the development of new medical technologies, leading to significant progress in the treatment of infectious diseases, have contributed to the rise, largely in the average life expectancy lived in good health. Infectious diseases broke out in areas distant from the main economic centres of the world, and thanks to successes in their treatment and prevention, they were quickly extinguished. The importance of public health decreased, and consequently, efforts in this field were limited.

Meanwhile, new challenges have emerged for public health. In countries with growing prosperity, health threats primarily arise from the expansion of non-communicable chronic diseases, known as lifestyle diseases[4], the emergence of epidemics of new infectious diseases, and the neglect of social and ecological health determinants.

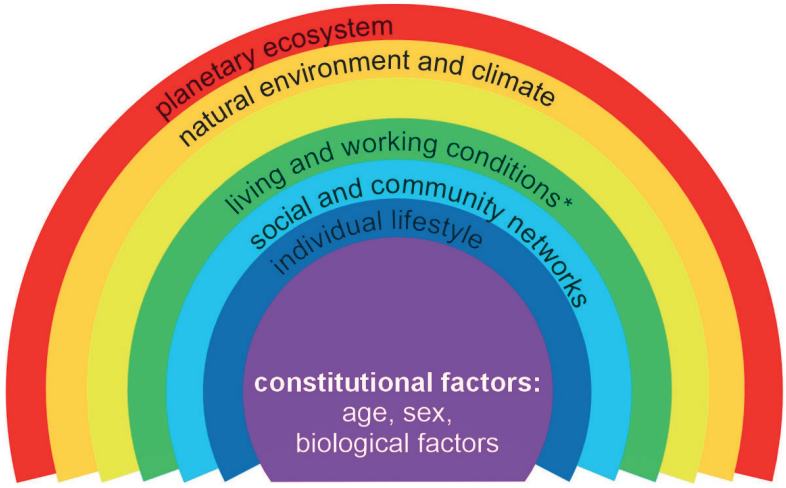
[4] The category of "lifestyle diseases" (and lifestyle medicine) narrows the scope of the issue by relating the matter to individual behaviours rather than to the system that promotes it.

1.1. Health determinants

The Minister of Health and Social Services of Canada, Marc Lalonde, published a report on the health of Canadians in 1974 – A New Perspective on the Health of Canadians (1974), highlighting the importance of social and environmental determinants of health for the population and individual citizens, which are equally important (if not more important) than the biological characteristics of humans and the quality of healthcare. His concept, outlined in the form of what is referred to as **health fields**, contributed to a new perspective on public health, where the health status of the population is determined by activities in many areas of people's lives, and not just progress in the treatment of diseases.

The complexity of the impact of various factors on health has been presented in the form of diagrams (graphs), also showing the ranking of health determinants. The concept most frequently cited today is that of Goran Dahlgren and Margaret Whitehead (1991), prepared for the European WHO Division. The authors presented it in the form of a graphic called the rainbow of health. Biologically described people (age, gender, and genes) primarily influence their health through their individual lifestyle, and then through relationships with people in their immediate surroundings (family and local social network). Only after that do living conditions and social institutions, including health services, become important. On the outer ring, we have more general factors of living conditions: socio-economic (level of welfare and its social distribution), cultural (values, tradition, norms), and environmental. In the health rainbow model (see below), two additional circles are drawn. In one, environmental health and climate are distinguished, excluding them from the set of general socio-economic and cultural factors, and in the next circle, global health factors are introduced, including the planetary ecosystem.

Figure 1. The Rainbow Model of Health



Source: Dahlgren & Whitehead, 1991.

1.2. Ecological-social model of health

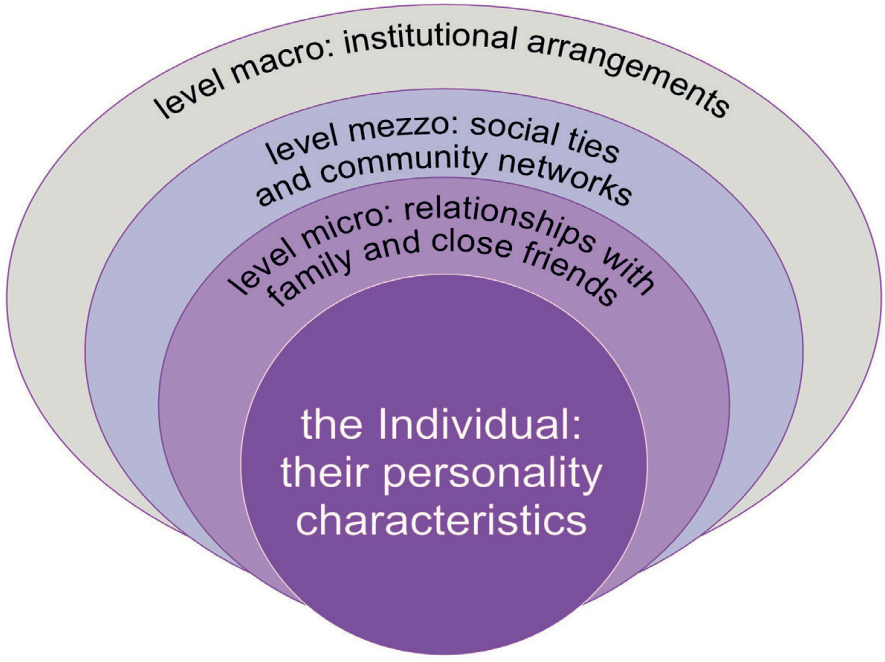
Alongside the findings related to health determinants, research deepening their specific types within the framework of scientific workshops of individual social sciences disciplines, primarily psychology and sociology, was developed.

In the field of social psychology, the ecological-social model of health was developed. It was presented by Urie Bronfenbrenner (1979), an American developmental psychologist who, as early as the 1970s, analysed and published works on human development in ecosystems and over time (in the chronosystem). By introducing the adjective "ecological" into the category of development, he was not only referring to the natural environment but more broadly to the social environment, which in contemporary times is also a product of human activity.

Environmental factors constitute a category of **environmental health**, which considers the impact on health of such factors as clean air, access to drinking water, uncontaminated land, safe food production, and safe living conditions.

Social factors are considered to have their variability throughout a person's life. Bronfenbrenner's concept is illustrated by a nest diagram (see below), which is extended (new circles are added) with development. In the last circle of the nest, we have a system of public institutions with legal regulations as well as media and political influence.

Figure 2. The ecological and social model of human development



Source: Based on the concept of ecological human development by Bronfenbrenner (1989).

The influence of society on health is the subject of the developing sociology of health and illness. This field initially developed alongside public health, both in the environment of social sciences and medical sciences[5]. Its full recognition came from medical research on human susceptibility to currently dominant diseases (cardiovascular, cancer, and diabetes), indicating that in the aetiology of these diseases, a social factor is also present. Considering a wide range of social variables became the basis of what is referred to as social epidemiology[6]. Over the years, social factors were grouped, classified, and assigned to specific diseases. Scholars who organised and classified these factors were Bruce Link and Jo Phelan in 1995. The social factors recognised as fundamental were presented in the handbook by Lisa F. Berkman and Ichiro Kawachi (2000).

Australian social epidemiologist Zahid Ansari and his collaborators developed a classification of variables grouped into three categories: (a) institutional factors used officially and in statistics, such as education, profession, income, origin, religion, and place of residence; (b) factors characterising communities, e.g. social networks and support structure, participation in community life, civic and political engagement, trust in people and institutions, tolerance of diversity, altruism, crime, domestic violence, and unemployment; (c) psychosocial risk factors, e.g., lack of or non-participation in a social network, low self-esteem, self-efficacy, depression, tensions, loss of a sense of security, loss of a sense of control, entitlement, chronic stress, social isolation, anger/hostility, (in)coping, as well as expectations (Ansari et al., 2003).

1.3. Anthropocentrism and one health

The consideration of the distinct circle of natural environment and climate factors in the health rainbow model was influenced by studies that allow us to observe, experience, and measure their impact. They were included in scientific facts about the health impact. This turned out to be problematic, as contrary to the threatening natural phenomena to humans due to their disturbances and transformations, ideological arguments gained strength, supporting the philosophy and belief in anthropocentrism, i.e., the conviction of man as the ruling centre of the universe, who can "make the earth submissive to him without fear that this is happening against the will of God".

In the philosophical debate, in which representatives of biological sciences and other earth and natural sciences also participated, the central role of humans was confirmed, but **as a destroyer, not as a source of natural harmony**. The thesis is even formulated that humans have caused an ecological crisis on such a scale that they have changed the Earth's ecosystem, leading to the formation of the Anthropocene, the geological epoch of humans (Gałuszka, 2021). As part of the discourse, the interpretation began to change, from a normatively understood role of humans in the universe (they can build and destroy) to a limited role that arises from human rights – the right to a clean environment and health.

---

[5] Recognition and identification of socio-economic factors affecting health emerged simultaneously from both the medical and social environments, from reports from experienced doctors and nurses, as well as social workers.

[6] John Cassel (1976) is considered the initiator of social epidemiology.

As for the environmental issues and the role of humans in interacting with the environment, there is also the topic of "one world – one health", a concept linking the health of humans, animals, and plants as interdependent, immersed in a global ecosystem. The idea of one health is represented by the graphic presented below.

Each of these three groups of life in one world is negatively affected by air and water pollution, deforestation, loss of biodiversity, and climate change. In the world of humans, health is threatened by reduced food security and an unhealthy diet, as well as excessive mobility through modern means of transport (airplanes, cars, etc.) and due to conflict-generating inequalities.

Figure 3. "One health" concept

Source: ISGLOBAL figure, as modified by the author.

The world of plants is being destroyed by contaminated and depleted land due to the intensity and monoculture of agricultural practices, exploitative logging, climate change, and natural disasters, fires, hurricanes, and floods. The world of animals is threatened, on one hand, by the reduction of wild animal species, and, on the other, by intensive farming for the nutritional needs of humans and animals in the food chain. The interactions occurring in the biologically imbalanced worlds have additional destructive consequences.

The slogans and calls for global unity and health began to be proclaimed with greater intensity upon recognising the sources of new infectious diseases, particularly, the occurrence of epidemics and pandemics of viral diseases in the 21st century: SARS (Severe Acute Respiratory Syndrome), bird flu, Ebola in West Africa, Zika virus in the Americas, MERS-CoV (Middle East Respiratory Syndrome coronavirus), and recently the COVID-19 pandemic. They drew attention to the transmission of infections from wild animals to humans.

Along with the export of food and the movement of people, animal-origin viruses spread to humans in many places simultaneously. Global interdependencies became

evident, encompassing the entirety of the natural world, animals and humans in every corner of the earth[7].

As knowledge accumulated, the idea of "one health" started to be promoted. A close collaboration was declared among institutions dealing with agriculture and food (FAO), animals (World Organisation for Animal Health – OIE), health (WHO), and the environment (UNEP), and a plan of action was established.

The process of further accumulating knowledge may slow down due to the influence of both traditional ideologies regarding the place of man in the ecosystem and interest groups of large corporations and the oligarch class, which amass enormous fortunes from the destructive extraction and exploitation of the earth's resources and its nature.

2. Health in social policy

By the subject of social policy, I refer to the needs and the so-called social questions or problems[8]. The category of social problems originates from the period of the Industrial Revolution. It involves pointing out the troubling issues of human existence that require intervention; the need for assistance from a wide range of different institutions, from family through numerous social organisations to local, state, and international.

The main social problems, such as poverty, unemployment, poor working conditions, homelessness, also included health-threatening behaviours (health risks), particularly alcoholism and drug addiction. Kazimierz Frieske addressed these recent issues in his works (1984, 1987) as new social problems, although alcoholism had a long history (Daszyńska-Golińska, 1905[9]).

The subject of social policy in the context of health is, therefore, the social consequences of "unhealthiness" (poor health, disability) and risky health behaviours that affect the individual and collective living conditions of people. The aim of social policy from a health perspective is to mitigate these effects and assist affected individuals in living normally and in a socially integrated manner, without discrimination, exclusion, or isolation.

In the history of social policy, the approach to sick, oppressed, and disabled people has come a long way. The norms of human community responses to health issues were shaped by religions, resident communities, labour unions, paternalistic employers, and finally, the state and international organisations.

An undeniable achievement on this path was sickness insurance (or health insurance), which created conditions for treatment and recovery by financing the costs of absence from work and covering the costs of treatment and rehabilitation[10].

---

[7] For example, an agreement has been signed within the framework of WHO to improve surveillance of infectious diseases transmitted from animals to humans and to support the development of integrated public and veterinary health systems.

[8] In English, it translates to the category of social problems or social questions, in German it is Sociale Frage, and in Dutch – *sociale vraagstuk*.

[9] Pioneering research and work by Zofia Daszyńska-Golińska on the health, social, and economic dimensions of alcoholism in Polish lands at the turn of the 19th and 20th centuries (in Galicja) is presented by Tomasz Kamiński (2012).

[10] This refers to what is called tertiary prevention – actions taken after treatment: improving the body, preventing complications, and monitoring the process of recovery.

A milestone in considering social conditions and the consequences of ill health was the creation of equal rights and the treatment of people within human rights. This resulted, among other things, in the UN Convention on the Rights of Persons with Disabilities (in the 21st century).

The voice of people with disabilities currently leads to the development of various forms of support and assistance, as well as openness towards individuals with limited abilities, enabling them to live actively and integrated within society (Masłyk, 2019).

Social policy in the context of health has increasingly focused on actions directed towards the elderly. As people age, their health deteriorates, which is indeed a natural phenomenon, but it is currently being modified. As mentioned earlier, when the standard of living increased and the living conditions of people improved (hygiene, adequate nutrition, protection against cold and heat, limiting excessive physical effort, protection against aggression, and accidents), there was also progress in the treatment of diseases, extending human life.

The main area of social policy actions towards older people is concerned with income security (pensions and retirement benefits). As a result, income poverty among the elderly ceased to be the dominant type of poverty. Social insurance also covered the costs of medical services for the older population[11].

The ageing process, which increases the number of elderly people in welfare state countries, has led to the political empowerment of seniors (a large and growing electorate). This undoubtedly improves their material situation, but not necessarily their health. Healthy ageing is primarily influenced by access to health and social services, and a less lonely life.

In social policy, there was essentially no space for actions aimed at the health of the population, based on the conscious need to care for it. The concept of caring for health, maintaining and nurturing it, was born within public health as health promotion. Since the announcement of the Ottawa Charter (in 1986), this concept has been present in significant documents and reports from the World Health Organisation (WHO), which have become a guide for developing international and national actions, before the disease manifests itself and medicine begins to struggle with it using its knowledge, technologies, and professional staff. Health promotion started to be incorporated into health education programmes in schools and universities, and it also became the focus of many non-governmental organisations and social movements for healthy living. New professions emerged, health educator, health promoter, or prevention specialist.

In promoting a healthy lifestyle, the danger of developing a new ideology called healthism has arisen. Robert Crawford, an American sociologist from Washington University, in an essay dated 1980, suggested that the middle class in the USA demonstrated health-promoting behaviours in daily life, which fostered the development of products for monitoring physical activity (e.g., counting daily steps) and an appropriate diet (e.g. counting calories and/or nutrient content).

[11] Even in the USA, there is a special public health insurance system for people aged 65+ (Medicare).

Crawford also attributed a moral significance to this, drawing attention to the creation of self-disciplining, entrepreneurial individuals striving to maximise control in daily life marked by uncertainty. Over time, he noticed in this behaviour an element of neoliberal ideology (Crawford, 2006), which is also focused on the development of the marketisation of healthcare and the development of individual health care concerns in the context of efforts to establish public health protection to the necessary extent. Healthism in the USA has hindered the pursuit of social reforms in the name of freedom and individual responsibility for health.

Social policy, by limiting the subject of its interest in relation to population health, inadequately appreciated the problem of health inequality (Marmot, 1996; 2000; Wilkinson & Marmot, 2003). Meanwhile, a characteristic and consequence of the new form of capitalism (neoliberalism) was increasing inequality.

Health inequalities in European countries (Central and Eastern European countries, including Poland), documented based on mortality and morbidity indicators and considering three main risk factors: smoking, alcohol consumption, and an unhealthy diet, contributed to the formulation of the thesis about what is called the paradox of welfare countries with a developed welfare state (Mackenbach, 2002, Wilkinson & Pickett, 2009). The interpretation of this "paradox" suggests that health inequalities do not yield to compensatory redistribution efforts through traditional welfare state tools, such as income and in-kind benefits. The growing importance at present is attributed to intangible variables associated with the process of limiting (closing) intergenerational vertical social mobility, which leads to achieving a higher social position. It would mean that health inequalities are entrenched in the population, weakening its life potential, diminishing social engagement, trust, and social mobility. They correlate with dysfunctions in family and public life, an increase in addictions, mental disorders, violence, and crime.

Addressing health inequalities has taken the form of a social movement initiated by Michael Marmot (2000), who believes that there is nothing worse in societies than inequalities in health. In this context, we must state that social and health policy, within its institutional framework, does not take on the challenge essential for improving people's condition and motivation to care for their individual biological and social development, one of the effects of which has been the ongoing lack of improvement in average life expectancy for several decades. This trend, as Marmot demonstrates in his works, has its roots in social exclusion, beginning in early childhood (2015).

3. Combining health and social issues

The integration of both spheres of human life: health and social well-being can take place in two ways: (1) based on the life course perspective or (2) places of residence (settings). These are not mutually exclusive approaches. With each phase of life, specific places of everyday presence are associated. Both approaches reflect the socio-ecological model of health, providing an opportunity for a systematic understanding of all health and social issues in their multidimensional reality.

3.1. Health and social problems from the perspective of the life course

The perspective of the life course has been institutionalised against the backdrop of human biological development (Kohli, 2023) with a division into periods: caregiving (early human development), education, active work, and retirement.

Several types of social policies have been identified, which concern social issues of population groups by age: addressed to children, youth, young adults and older adults, and seniors. The extraction of phases (stages) during life, based on the psychophysical development of a person, generally aligns with the public tasks required at various stages of human life. It can be proven that the welfare state influences the course of life through a differentiated approach to subsequent life stages and by modelling transitions between them (Kohli, 2023).

Life course epidemiology was developed (Wagner et al., 2024), demonstrating that the effects of poor living conditions and lack of healthcare accumulate over a lifetime. Relevant specialities emerged in the medical sciences, such as paediatrics, family medicine, and geriatrics.

The differences observed around the world in the occurrence of various stages of life and the social policies addressed to them reflect the influence of specific natural, cultural, and institutional factors that organise the education system, labour market, and social security. However, this does not change the universal concept.

Social policy aimed at children, taking health into account, includes the living conditions of the mother during pregnancy, the living and family situation in the early period of the child's life, and the quality of care in childhood. The unfavourable influence of living, behavioural, and environmental factors occurring in the early stages of life affects the emergence of diseases in later stages, such as late adulthood and old age. The explanation of this phenomenon is based on hypotheses about many different causes, the occurrence of which may take place even during the prenatal period.

Another theory emphasises what is called the **critical phases of the life course**. In addition to the earliest period, attention is drawn to the **adolescent period**. Adolescence and the social demands associated with reaching adulthood led to educational problems and health risks. In recent decades, social policy has begun to pay more attention to children and youth[12], along with specific health disorders related to the earlier onset of biological maturation and the intensification of behaviours harmful to health, including the use of new psychoactive substances (the so-called "legal highs") and drugs, the practice of non-medical body modification, the use of diets that disrupt food intake, addiction to social media and computer games, or various forms of gambling[13]. During the COVID-19 pandemic, mental disorders among young people intensified due to isolation and the introduction of remote education.

---

[12] Many longitudinal studies have already been conducted around the world, allowing for the observation of phenomena in the same cohort of the population. The United Kingdom leads in these studies. Since 1985, international cross-sectional studies (HBSC) of 15-year-olds have been organised, to which Poland joined in 1990.

[13] The beginning of the accumulation of health threats during adolescence, if not interrupted later in life, becomes a dominant cause of the development of the most serious chronic diseases (cardiovascular, cancers, respiratory, and metabolic diseases) in the future.

On the road to adulthood, there is a stage referred to as **emerging adulthood** (Halfon et al., 2018). It is also characterised as critical due to the uncertainty of the future in both personal and social terms. In response to the sensitivity of young people to the massive changes they are undergoing, for which they were not adequately prepared, there has arisen a need to create new types of interventions and social support. In traditional public policies, there were programmes supporting entry into the labour market, situated either in the education sector or within the responsibilities of employers, but also in the system of special schools, if there were serious health problems and risky behaviours.

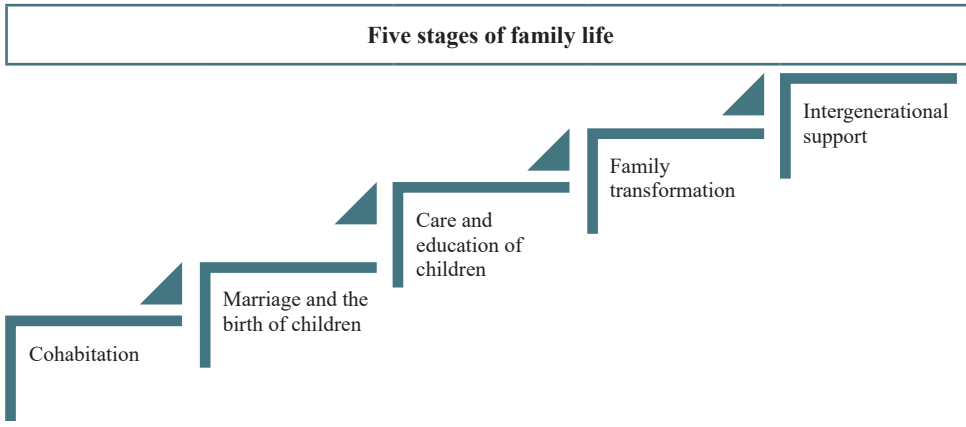
The phase of adulthood is most often defined by a person's ability to function in society and to fulfil the expected social roles associated with this stage of life, linked to the five golden events, also known as the big five. They are: completing education, starting regular work, leaving the family home, entering a relationship, and the birth of offspring (Settersten, 2007).

The adult phase, which is a time for starting one's own family, is the axis of a distinct **family policy**. However, family policy is not a field that has been developed only recently. It was formulated in the 19th century; however, it was based on a different model of family functioning, namely, the model of a single breadwinner family. The state's tasks were limited to income support and protection of the breadwinner of the family under the labour law when children arrived.

Currently, over a century later, the tasks of the state's family policy are more complex. They are based on a different model of the family, which is the employment of both partners and in the context of the changing structure of families in terms of formation (Daly et al., 2023; Bahle, 2023).

The diagram below illustrates the typical stages of family development in Western culture.

Figure 4. Five stages of family life



Source: Daly (2023, p. 15).

As a result of the dynamic demographic changes of the post-war decades (from the baby boom phase to the 21st century), characterised by a systematic decline in fertility, the state's family policy has included goals related to halting this decline. The considerations and actions encompassed the connections between three issues: women's employment, the family model, and the type of welfare state institutions.

Family policy that would simultaneously respect the equal rights of women and men in the labour market as a dimension of generally accepted gender equality in the public sphere, as well as partnership in the family (in the private sphere), with investment in the development of pro-family welfare state institutions, despite declarations and promotions (especially in European countries), are still difficult to achieve in practice. The problem is the denial of causal relationships between changes in each of the three mentioned areas. Therefore, the social policy of many countries around the world (including Poland) implements what is referred to as conservative family policy that goes against the rights and aspirations of women and is accompanied by limited development of health and social services related to childcare, allowing parents to balance their professional activities with family life.

The next phase in the life course – **late adulthood** – does not arouse significant interest in public policy, including social policy. Nevertheless, in this phase, problems related to social limitations arise, e.g., the inability of previously acquired professional skills to keep pace with the needs of the modern labour market, both in new technologies and work organisation. The institutions designated for continuing education often lack the support in appropriate regulations and sufficiently effective actions. In this area, numerous private training and education organisations operate; however, they respond more to the targeted demand of the strongest employers than to the needs of employees adjusted to their potential and life circumstances.

Interest in health issues in late adulthood is sometimes publicly stimulated through voluntary participation in public health (e.g., screening) programmes[14]. Participation in voluntary screening programmes is generally low. This does not bode well for the effectiveness of the prevention of dominant chronic diseases, especially in critical periods of life. It provides access to preventive examinations only for those individuals who are characterised by what is called health literacy.

Demographic changes involving the accelerated process of population ageing have directed social policy attention to the situation of **older people**. The first institutional problem was determining the age that could be considered the beginning of old age. In social policy, this boundary is usually associated with the moment of **retirement**. In northern welfare countries, the period of professional activity in the labour market is generally subject to systematic extension, while in others, it is significantly more difficult[15].

---

[14] In Poland, there is a programme called "Prevention 40 Plus", which allows for free screening tests and will be extended to the entire adult population starting from the age of 20 in 2025.

[15] In Poland, we have a situation that significantly deviates from the trends observed in other welfare state countries. Two characteristics have influenced this: (a) the disregard for equality in the period of professional deactivation by gender (women can retire 5 years earlier; at the age of 60, while men at age 65), (b) the withdrawal from the phased programme of raising the retirement age for both genders to 67 years.

The shifting of employees' rights to the so-called state of rest (de facto setting an institutional boundary for old age) has resulted in traditional social policy losing interest in health during old age, focusing instead on combating poverty. The proposed slogan of **healthy ageing** (Behr et al., 2023) has become a subject of attention primarily in public health, formulated in WHO programmes (Rudnicka et al., 2020).

As part of national social policies, the so-called **senior policy** was formulated. Its hallmark was emphasising activity as a continuation of the existing course of life. First, extending professional work, and if not, engaging in social-cultural and sports-recreational activities in the local environment (European Union, 2022).

The extraction of senior policy in Poland was more of an expression of the "victory" of a politically significant group of the population (a growing electorate) that has the strength and assets to ensure its well-being in the period of an "early" old age[16].

Senior policy brings undeniable benefits primarily to groups that are more active after retirement, relatively younger and aware of the health needs of an ageing organism. As part of the senior policy, the task of addressing the issue of long-term care in the final stage of a person's life is not being undertaken for now. In Poland, the burden of long-term care is mainly borne by families. Some individuals rely on social assistance facilities or private centres when they do not have the necessary resources. In the absence of a universal long-term care system, dependent old age becomes a dramatic period.

Meanwhile, in welfare countries, interest in social policy regarding the issues of elderly people has increased due to their progressing dependence as life expectancy continues to rise, making care and nursing services necessary (Comas-Herrera et al., 2025). In several countries around the world, long-term care systems have been established as part of social insurance (Germany, Japan, South Korea, the Netherlands) (Rothgang et al., 2021).

3.2. Settings

Another theoretical approach to integrating social and health issues, compared to the life course approach, as reflected in social policy and health care practice, is the concern for health in everyday living environments. The concept of health in settings where people spend their daily lives was articulated in texts written in connection with the preparation of the Ottawa Charter, justifying the concept of health promotion. It is written there that "Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love" (WHO, 1986).

A healthy setting for daily living has become the subject of analyses and public health programmes (Tyszko, 2024). As part of this approach, research is being conducted to determine and control the conditions of daily life in terms of health, to what extent these conditions are safe and not harmful to health. These actions include cities, villages, and other local places, homes, workplaces, schools, universities, cultural and entertainment venues, hospitals, care facilities, prisons, etc. Health in places of

[16] For the agricultural population, ideas for creating what is called care farms in the countryside have been formulated (Wojciechowska-Solis et al., 2023).

residence is the main approach in health promotion (WHO, 1998; Paton et al., 2005).

The history of research and interventions related to health threats in settings began during the times of intense industrialisation. It encompassed factories and workers' homes, leading to the development primarily of **occupational medicine** and the institutionalisation of activities termed **occupational safety and health** (OSH). Over time, other health-related specialities emerged in healthcare settings, such as school hygiene, road safety, health protection in agriculture, and military medicine. Within the framework of the WHO, definitions and standards have been developed for places recognised as healthy (WHO, 1998). At the same time, it was established that poor living conditions exert a negative impact on health when:

- they occur for a long time (time factor);
- the quality of the place in terms of physical aspects is dangerous to health, as the place and objects are made of harmful materials, the space is limited (crowding), there is improper ventilation, no access to daylight, and no access to greenery;
- there is a lack of available places to meet biological needs: toilets, showers, and laundry facilities, and seating areas;
- there is no health-safe (with supervision of sanitary standards) and economically accessible places to eat meals outside home;
- there is no safety on the roads[17]: sidewalks and pedestrian crossings, when speed limits are not respected and when the quality of motor vehicle transport is insufficient.

Safety and health standards of settings have been incorporated into building law regulations in the areas of residential and public utility construction, sanitary equipment in educational and care facilities, road safety, and working conditions subject to labour law.

In the case of the workplace, health and social issues are particularly interconnected and are fundamentally important in a person's life, as they last the longest. The analyses and regulations encompass both the conditions and the effort (load) of work adjusted to age, gender, and work ability, as well as the methods of managing work, and the relationships between supervisors and employees, as well as among employees. Phenomena such as bullying, mobbing, staffing, sexual harassment, and violence currently pose as frequent threats to psychosomatic health, as workplace accidents and the occurrence of occupational diseases. These issues are being studied and analysed within the framework of established occupational medicine, which contributes its findings to occupational safety and health regulations (OSH).

In a young market economy (such as the Polish economy), the enforcement of legal regulations in the field of working conditions and relations is not a strong point of the functioning quality. This is facilitated by the general approval for deregulation, which has gained strength in the neoliberal trend of market system development.

[17] The National Road Safety Programme in Poland was developed only in 2013.

4. Final considerations (discussion) and conclusions

In the institutional (regulatory, administrative, and financial) sphere of the welfare state, we are dealing with the separation of social questions and health.

In each of the two fields, there are additional divisions. In healthcare, on one hand, we deal with a separate area of health concern (health promotion and prevention), and on the other hand, with the area of disease treatment (medicine). Medical treatment, in turn, is subject to an increasingly deeper division into specialisations. Appealing for a holistic approach is highly ineffective and does not change separatist tendencies.

In the area of social policy, we have problems that are positioned separately within the disciplines of social sciences (economics, law, sociology, social psychology, and political science). Additionally, institutional divisions are used in sectoral, territorial (national, regional, local) structures, in state administration (ministries in governments), as well as according to political directions, which can differentiate separate systems of social values and represent distinct goals and interests. In the real sphere, the relationships and dependencies between social situations and health conditions, which also consider the perspective of consequences (over time), are so numerous and complex that their systemic and holistic grasp hinders and even prevents the effectiveness of public interventions undertaken. As a result, segmental actions burdened with the resignation from providing people with achievable goods are more effective.

Overall, in a situation of increasing tendencies to divide and simultaneously technological possibilities to deepen research in selected areas, a combined approach is an action "against the current". To overcome this, what would be needed are broad cognitive horizons and acceptance of collaborative connections. In addition, it is necessary to create appropriate institutional tools that enable the management of separately functioning areas of social and health affairs. The literature on this topic indicates three types of integration methods in public management: integration, coordination, and the so-called networking (a network of contacts and cooperation) (Bache & Flindres, 2004; Osborne, 2010; Golinowska & Tambor, 2020).

Integration means the functioning of one institution for both types of matters. For instance, one ministry at the government level, such as social and health policy, or at the local government level, similarly – one department.

Coordination is based on formalised cooperation between separately managed social and health institutions. At the governmental level, many countries then establish an additional institution for coordinating both fields (Golinowska et al., 2024).

Networking organisations are voluntary institutions that come together to cooperate in the framework of periodic ventures (joint ventures). They are often motivated to cooperate by creating extra public funds (at the international, national, and local levels) that finance multidisciplinary projects. Social networks complement formal institutions, and in social and health issues, they are an essential element of the social convoy theory (Tobiasz-Adamczyk, 2024). Social networks are rated positively because they create social capital (Lin, 2001). One could argue that they are building bridging institutional capital, analogous to bridging social capital in Robert Putnam's concept (Putnam, 2000).

The most effective and democratic methods seem to be coordination tools. However, one of the persistent institutional problems, even in wealthy Northern countries with developed welfare state institutions, is the deficiencies in coordination according to the principles of good public governance. In practice, we are dealing with "silos" and tendencies to reinforce them, and even to further fragment them. One of the reasons is the functioning of the political sphere, which favours the division of spoils (appointing positions according to merits in winning elections).

Other coordination difficulties are also significant. These include the organisation of public life in vulnerable institutional structures: without the establishment of lasting rules, bridging social capital, or appropriate qualifications among those in management.

The challenges of contemporary times, requiring innovative, effective, and global actions, indicate an urgent need to develop multidisciplinary approaches and cooperation among various activities in their real conditions and many contexts. An example is the development of activities within the life sciences. We have a multidisciplinary approach here, encompassing biological, medical, and technical sciences as well as sectoral partnerships (private and public) for practical actions in the field of new technologies applied in diagnostics and personalised medicine.

An important, if not the most important, foundation of effective coordination within the principles of good governance is **the proper organisation of scientific institutions**. Meanwhile, both social policy and health issues are often placed in an inadequate or random manner, devastating the meaning and development of both fields. For example, social policy in Poland has been integrated into political science, focusing on the study of the "struggle for power" toolkit, offering social programmes to candidate parties, investigating their support, and forecasting winners.

Health policy and public health have been incorporated into what is known as health sciences, which focus on preparing personnel for practical skills in allied medical professions: nursing, midwifery, physiotherapy, and emergency medical services, pushing aside the issues of public health and the systemic formulation of health policy tasks[18]. On the other hand, public health is the science of the conditions for healthy living of people in their dynamically changing natural and social environment. The practical dimension of public health is, therefore, related to shaping the environment and behaviours within that environment. This is a different area of issues than those covered in academically organised health sciences.

[18] This solution was proposed by Lesław Nieborój, a bioethicist; a graduate of the Pontifical Academy of Theology in Kraków and subsequently an academic teacher at the Silesian School of Health Sciences (Nieborój, 2014).

References

Ansari, Z., Carson, N.J., Ackland, M.J., Vaughan, L., & Serraglio, A. (2003). A public health model of the social determinants of health. *Sozial- und Präventivmedizin*, *48*(4), 242–251. DOI: 10.1007/s00038-003-2052-4

Bache, I. & Flinders, M. (2004). *Multi-level governance*. Oxford University Press. Bahle, T. (2023). Family policies in long-term perspective. In M. Daly *et al.* (Eds.), *The Oxford handbook of family policy over the life course*. Oxford Academic. https://doi.org/10.1093/oxfordhb/9780197518151.013.6

Behr, L.C., Simm, A., Kluttig, A., & Grosskopf, A. (2023). 60 years of healthy aging: On definitions, biomarkers, scores and challenges. *Ageing Research Reviews*, *88*, Article 101934. https://doi.org/10.1016/j.arr.2023.101934

Berkman, L.F. & Glass, T. (2000). Social integration, social networks, social support and health. In L.F. Berkman & I. Kawachi (Eds.), *Social epidemiology* (2nd ed.). (158–162). Oxford University Press.Bronfenbrenner, U. (1979). *The ecology of human development*. Harvard University Press.

Bronfenbrenner, U. (1989). Ecological systems theory. In R. Vasta (Ed.), *Annals of child development*. (187–249). Jessica Kingsley Publishers.

Cassell E.J. (1976). Illness and disease. Th e Hastings Center Report, 6(2): 27–37.

Comas-Herrera, A., Cyhlarova, E., Govia, I., Rajagopalan, J., & Feng, Z. (2025). Financing of long-term care. In J. Cylus, G. Wharton, L. Carrino, S. Ilinca, M. Huber & S.L. Barber (Eds.), *The care dividend*. (158–202). Cambridge University Press.

Crawford, R. (1980). Healthism and the medicalization of everyday life. *International Journal of Health Services*, *10*(3), 365–388. https://doi.org/10.2190/3H2H-3XJN-3KAY-G9NY

Crawford, R. (2006). Health as meaningful practice. *Health*, *10*(4), 401–420. https://doi.org/10.1177/1363459306067310

Dahlgren, G. & Whitehead, M. (1991). *Policies and strategies to promote social equity in health: Background document to WHO – Strategy paper for Europe*. Institute for Future Studies.

Daly, M. Pfau-Effinger, B., Gilbert, N., & Besharov, D.J. (Eds.). (2023). *The Oxford handbook of family policy over the life course*. Oxford Academic. https://doi.org/10.1093/oxfordhb/9780197518151.001.0001

Daszyńska-Golińska, Z. (1905). *Alkoholizm jako objaw choroby społecznej*. Towarzystwo "Eleuterya".

Dzwonkowska-Godula, K. (2016). Stosunek młodych ludzi do własnego zdrowia a ideologia healthismu. *Acta Universitatis Lodziensis. Folia Sociologica*, *58*, 25–46. https://doi.org/10.18778/0208-600X.58.02

European Union. (2022). *The European Union social policy on older people in the light of the deinstitutionalisation of social services*. V&R Unipress.

FAO, UNEP, WHO, & WOAH. (2022). *One Health joint plan of action (2022–2026): Working together for the health of humans, animals, plants and the environment*. https://doi.org/10.4060/cc2289en

Frieske, K.W. (1984). *Pijaństwo: interpretacje problemu społecznego*. Instytut Wydawniczy Związków Zawodowych.

Frieske, K.W. & Sobiech, R. (1987). *Narkomania. Interpretacje problemu społecznego*. Instytut Wydawniczy Związków Zawodowych.

Gałuszka, A. (2021). Antropocen w ujęciu geologicznym. *Filozofuj*, *5*(41), 9–10.
Golinowska, S. & Tambor, M. (2020). *O łączeniu spraw zdrowotnych i społecznych w przebiegu życia*. Wydawnictwo Naukowe PWN.
Golinowska, S. (2018). *Modele polityki społecznej w Polsce i Europie na początku XXI wieku*. Fundacja Stefana Batorego.
Golinowska, S. (2022). O zmianach polityki społecznej w Polsce. Od przełomu wieków do współczesnych wyzwań. *Polityka Społeczna*, 1, 10–22.
Golinowska, S. (Ed.). (2022). Public health institutions: Functions and types. In S. Golinowska (Ed.), *Public health: The social and ecological dimension*. Wydawnictwo Naukowe Scholar.
Golinowska, S., Badora-Musiał, K., & Kowalska-Bobko, I. (2024). Public health institutions: Functions and types. In S. Golinowska (Ed.), *Public health: The social and ecological dimension*. (835–852). Wydawnictwo Naukowe Scholar.
Gordon, J.S. (1982). Holistic medicine: Advances and shortcomings. *Western Journal of Medicine*, *136*(6), 546–551.
Halfon, N., Forrest, C.B., Lerner, R.M., & Faustman, E.M. (Eds.). (2018). *Handbook of life course health development*. Springer.
JPA Health. (2023). *One world, one health: Exploring the connectability between human, animal and environmental health*. https://jpa.com/wp-content/uploads/2023/11/one-world-one-health-nov-2023.pdf
Kamiński, T. (2012). Zofii Daszyńskiej-Golińskiej socjologiczne badania alkoholizmu. *Roczniki Historii Socjologii*, *2*, 133–146.
Kawachi, I. & Berkman, L.F. (2014). Social capital, social cohesion and health. In L.F. Berkman, I. Kawachi, & M. Glymour (Eds.), *Social epidemiology.* (74–190). Oxford University Press.
Kickbusch, I. & Gleicher, D. (2012). *Governance for health in the 21*st *century*. World Health Organization.
Kohli, M. (2023). Theorizing the relationship between the welfare state and the life course. In M. Daly et al. (Eds.), *The Oxford handbook of family policy over the life course*. Oxford Academic. https://doi.org/10.1093/oxfordhb/9780197518151.013.8
Lalonde, M. (1974). *A new perspective on the health of Canadians*. Government of Canada. http://www.phac-aspc.gc.ca/ph-sp/pdf/perspect-eng.pdf
Link, B.G. & Phelan, J. (1995). Social conditions as fundamental causes of disease. *Journal of Health and Social Behavior*, Special Issue, 80–94.
Mackenbach, J.P. et al. (2002). Socioeconomic inequalities in health in Europe: An overview. In J.P. Mackenbach & M.J. Bakker (Eds.), *Reducing inequalities in health: A European perspective*. (3–24). Routledge.
Marmot, M. (1996). The social pattern of health and disease. In D. Blane, E. Brunner, & R. Wilkinson (Eds.), *Health and social organization: Towards a health policy for the 21*st *century*. (42–67). Routledge.
Marmot, M. (2000). Multilevel approaches to understanding social determinants. In L.F. Berkman & I. Kawachi (Eds.), *Social epidemiology*. (349–367). Oxford University Press.
Marmot, M. (2006). Social causes of social inequalities in health. In S. Anand, F. Peter, & A. Sen (Eds.), *Public health, ethics and equity*. Oxford University Press.
Marmot, M. (2015). *The health gap: the challenge of an unequal world*. Bloomsbury Publishing.

OECD. (2017). *Preventing ageing unequally*. OECD Publishing. http://dx.doi.org/10.1787/9789264279087-en

OHHLEP. (2021–2023). *One Health High Level Experts Panel annual reports 2021, 2022, 2023*. FAO, United Nations Environment Programme, World Health Organization & World Organisation for Animal Health.

Osborne S.P. (2010). *The new public governance. Emerging perspectives on the theory and practice of public governance*. Routledge.

Paton, K., Sengupta, S., & Hassan, L. (2005). Settings, systems and organization development: The eHealthy Living and Working Model. *Health Promotion International*, *20*(1), 81–89. DOI: 10.1093/heapro/dah510

Putnam, R. (2000). *Bowling alone: The collapse and revival of American community*. Simon & Schuster.

Rothgang, H., Fischer, J., Sternkopf, M., & Doetter, L.F. (2021). *The classification of distinct long-term care systems worldwide: The empirical application of an actor-centered multi-dimensional typology* (Working Paper No. 12). SOCIUM, SFB 1342.

Rudnicka, E., Napierała, P., Podfigurna, A., Męczekalski, B., Smolarczyk, R., & Grymowicz, M. (2020). The World Health Organization (WHO) approach to healthy ageing. *Maturitas*, *139*, 6–11. https://doi.org/10.1016/j.maturitas.2020.05.018.

Settersten, R.A. Jr. (2007). The new landscape of adult life: Road maps, signposts, and speed lines. *Research in Human Development 4*(3–4), 239–252. https://doi.org/10.1080/15427600701663098

Ståhl, T., Wismar, M., Ollila, E., Lahtinen, E., & Leppo, K. (Eds.). (2006). *Health in all policies: Prospects and potentials*. Ministry of Social Affairs and Health. http://ec.europa.eu/health/archive/ph_information/documents/health_in_all_policies.pdf

Szatur-Jaworska, B., Rysz-Kowalczyk, B., & Petelczyc, J. (2021). *Perspektywa cyklu i biegu życia w polityce*. Wydawnictwo Elipsa.

Tambor, M. (2024). The health of young adults. In S. Golinowska (Ed.), *Public health: The social and ecological dimension*. (290–302). Wydawnictwo Naukowe Scholar.

Tobiasz-Adamczyk, B. (2024). Social networks and health status. In S. Golinowska (Ed.), *Public health: The social and ecological dimension*. (563–576). Wydawnictwo Naukowe Scholar.

Tyszko, P. (2024). Health in the settings of everyday life: Foreword. In S. Golinowska (Ed.), *Public health: The social and ecological dimension*. (367–370). Wydawnictwo Naukowe Scholar.

Wagner, C., Carmeli, C., Jackisch, J., Kivimäki, M., van der Linden, B.W.A., Cullati, S., & Chiolero, A. (2024). Life course epidemiology and public health. *The Lancet Public Health*, *9*, e261–e269.

Whitman, D. (2024). *The second fifty: Answers to the 7 big questions of midlife and beyond*. W.W. Norton & Company, Incorporated.

WHO. (1986). *The 1st International Conference on Health Promotion, Ottawa, 1986*. http://www.who.int/healthpromotion/conferences/previous/ottawa/en/

WHO. (1999). *Healthy living: What is a healthy lifestyle?* World Health Organization, Regional Office for Europe. https://iris.who.int/handle/10665/108180

WHO. (2002). *World report on violence and health*. https://www.who.int/publications/i/item/9241545615

WHO. (2022). *One Health*. https://www.who.int/health-topics/one-health

Wilkinson, R. & Marmot, M. (2003). *Social determinants of health: The solid facts*. International Centre for Health and Society; World Health Organization Regional Office for Europe.

Wilkinson, R. & Pickett K. (2009). *The Spirit Level. Why More Equal Societies Almost Always Do Better*. Penguin Books Ltd.

Wojciechowska-Solis, J., Martínez Cortijo, F.J., & Ruiz-Canales, A. (2023). Social entrepreneurship in rural areas: Opportunities for the development of care farms. *Acta Scientiarum Polonorum. Oeconomia*, *22*(3), 61–71.

Woleński, J. (2021). Czy antropocentryzm jest ważny? *Filozofuj*, *5*(41).

Wróblewski, M. (2016). Nowe szaty healthismu. Self-tracking, neoliberalizm i kapitalizm kognitywny. *Acta Universitatis Lodziensis. Folia Sociologica*, *58*, 7–25. DOI: https://doi.org/10.18778/0208-600X.58.01

Zhou, X.-N., Xiaokui, G., & Zhang, X. (2025). *Global One Health Index Report 2022*. Springer. https://doi.org/10.1007/978-981-97-4824-2

Problemy Polityki Społecznej. Social Policy Issues 2025, 71(4): 1–27
https://doi.org/10.31971/pps/209708

Submitted: 2025-01-24/Accepted: 2025-08-19

Rawia Fuad Naoum[1]

ORCID: 0009-0001-0930-8744
Faculty of Business and Economics, University of Pécs, Hungary

Education and healthcare policies to alleviate inequalities: the case of MENA countries

Abstract

This paper explores how education and healthcare policies can reduce ongoing inequalities in the Middle East and North Africa (MENA). We focus on different types of inequality, particularly educational disparities and healthcare access gaps, and examine how social policies in these areas have affected these issues. Using a comparative literature review approach, this study covers a policy-oriented analysis of inequality in education and healthcare across MENA. Drawing on recent data and research, it evaluates the effectiveness of various reforms and programmes. The findings suggest that while economic growth has generally improved living standards in the region, the distribution of these gains remains highly uneven, with persistent gaps between affluent and marginalised groups. Policies that target education and healthcare are crucial for closing these gaps: investing in quality education and expanding access to healthcare can increase social mobility and fairness. The paper offers a set of coordinated policy suggestions – including expanding educational opportunities for disadvantaged populations and improving healthcare financing and coverage – to reduce inequalities. Ultimately, a comprehensive social policy framework, guided by human capital theory and social determinants of health, is vital for promoting inclusive development in the MENA countries.

Keywords: economic growth, social policies, education policies, healthcare policies, MENA region

[1] **Corresponding author:** Rawia Fuad Naoum, Faculty of Business and Economics, University of Pécs, Rákóczi, 7622, Pécs, Hungary; email: rawiahnaoum@gmail.com

1. Introduction

The Middle East has long struggled with inequality, which hinders development and causes social and political unrest. Historical development policies in many Arab countries, especially during the 1960s to 1990s, aimed to promote fairness through broad social transfers, public-sector employment, and infrastructure investments. These efforts created a post-independence "social contract" that spread the benefits of growth more evenly (World Bank Group, 2016). Activism has also played a key role in addressing development issues. Bayat (2002) discussed how grassroots movements drive social change in the Middle East, suggesting that such activism is essential to achieving fairness and justice. These efforts have led to significant improvements in human development: for example, illiteracy rates in the Arab region have been cut in half, and average years of schooling have risen from about 1.3 to nearly 7 since the 1960s (ESCWA, 2019). Health indicators have also improved, with child mortality decreasing and life expectancy increasing alongside higher incomes and expanded public services (Khawaja et al., 2008).

Despite this progress, disparities continue to exist. Studies show that health improvements remain closely linked to socioeconomic conditions, highlighting that poorer communities still fall behind on key health outcomes (Boutayeb & Serghini, 2006). Income inequality in the MENA region is among the highest in the world (Alvaredo et al., 2018; Assouad, 2020), with extreme wealth concentrated among a few and a large portion of the population living in poverty. Additionally, various factors such as political instability, conflict, corruption, and weak governance often worsen these inequalities. According to Al-Shawarby et al. (2019), although there has been progress in human development, inequality remains a major issue in the Arab region. It has been identified as a significant factor in the uprisings of 2011. The World Bank describes this phenomenon as the "Arab inequality puzzle" (Devarajan & Ianchovichina, 2017; Ianchovichina et al., 2015; World Bank Group, 2016). Such an uneven distribution of wealth and opportunity has been linked to social unrest and political instability in the region. Therefore, reducing inequality through more equitable social policies is essential for sustainable and inclusive development.

Multiple forms of inequality are of concern in this study. *Income inequality* refers to an unequal distribution of income and wealth across the population – for instance, the fact that the top 10% of income earners in the Middle East capture an estimated 64% of total income (Alvaredo et al., 2018), leaving a very small middle class and a large low-income population. *Educational inequality* denotes disparities in access to quality education and in educational attainment among different groups (such as between urban and rural communities, or between wealthy and low-income families) (Aiston & Walraven, 2024). Despite increased school enrolment, large gaps remain in the MENA region in terms of who benefits from education, with marginalised groups often achieving lower literacy and schooling levels. *Healthcare access inequality* involves uneven availability and quality of healthcare services and outcomes (Abatemarco et al., 2024). For example, differences in infant mortality or life expectancy between rich and poor areas, or between those with private health coverage and those relying solely

on strained public health systems. These dimensions of inequality are interrelated and often mutually reinforcing: income disparities can lead to unequal educational and health opportunities, which in turn perpetuate income inequality across generations.

This paper aims to explore the various strategies and policies that have been implemented to reduce inequalities in the MENA region. Using a comparative literature review approach, this study conducts a policy-oriented analysis of inequality in education and healthcare across MENA. We will begin by providing an overview of the causes and implications of regional disparities and examining the challenges and opportunities associated with these efforts. We will also highlight successful examples of education and healthcare reforms, policies, programs, and initiatives aimed at reducing inequalities in different countries in the region. In doing so, we will offer recommendations for future action, highlighting the importance of a comprehensive and coordinated approach to addressing inequality in the MENA region.

2. Methodology

This study adopts a qualitative, desk-based review of secondary sources, drawing on peer-reviewed academic articles, policy briefs, and institutional reports published between 2008 and 2024. The selection process focused on materials examining education and healthcare policies in Middle East and North Africa (MENA) countries, with explicit links to reducing inequality in income, education, and healthcare access. Relevant sources were identified through targeted searches in databases such as Scopus, Web of Science, and Google Scholar, supplemented by reputable institutional repositories, including the World Bank, UNESCO, and WHO. Search terms combined keywords related to inequality ("income inequality," "educational inequality," "healthcare access"), the MENA region, and specific policy interventions (e.g., "cash transfer programmes," "health insurance reform," "refugee education policies").

Inclusion criteria required that studies or reports: (1) Address at least one form of inequality (income, educational, or healthcare) in the MENA region; (2) Provide empirical findings, policy evaluations, or evidence-based analysis; (3) Offer details on implementation strategies or measurable outcomes of the policies discussed. The analysis synthesised evidence thematically, focusing on policy design, implementation, and impact on inequality. Where possible, country-specific examples were compared to highlight similarities, divergences, and contextual factors influencing success or limitations.

3. Literature review

3.1. Theoretical background

Understanding the dynamics of inequality and the impact of social policies in MENA requires a grounding in both empirical literature and relevant theoretical frameworks. Three conceptual perspectives guide this review. First, human capital

theory (Becker, 1964) posits that education is a form of capital; greater investments in schooling improve individuals' knowledge, skills, productivity, and earning potential, which should, in theory, foster economic growth and reduce income inequality as more people can participate in high-skill, high-wage activities. Becker's seminal work linked the accumulation of education and skills to increased labour productivity, framing education as an investment that yields both private and social returns (Marginson, 2019; Li et al., 2017). However, the MENA region presents a paradox where significant educational gains, particularly in enrolment and completion rates, have not translated into commensurate economic opportunities for all (Scarrone, 2021; Assaad, 2014). This "education–employment mismatch" is well-documented in the region, with structural constraints in labour markets limiting the potential of human capital investments to reduce inequality (ESCWA, 2021).

Second, the social determinants of health framework emphasise that health inequalities are not solely the result of biological or healthcare factors but are primarily shaped by broader social and economic conditions, such as income, education, housing, and gender equity, under which people are born, live, and work (Marmot et al., 2008). This framework, developed through global public health research, has been applied in MENA studies to show how disparities in education, gender norms, and rural–urban divides influence both health access and outcomes (El-Zanaty & Way, 2009). In contexts of political instability or conflict, social determinants such as displacement and loss of livelihoods further exacerbate health inequities (El-Jardali et al., 2021). These findings imply that improving health equity in MENA depends not only on healthcare delivery but also on cross-sectoral strategies addressing poverty, education, housing, and social protection.

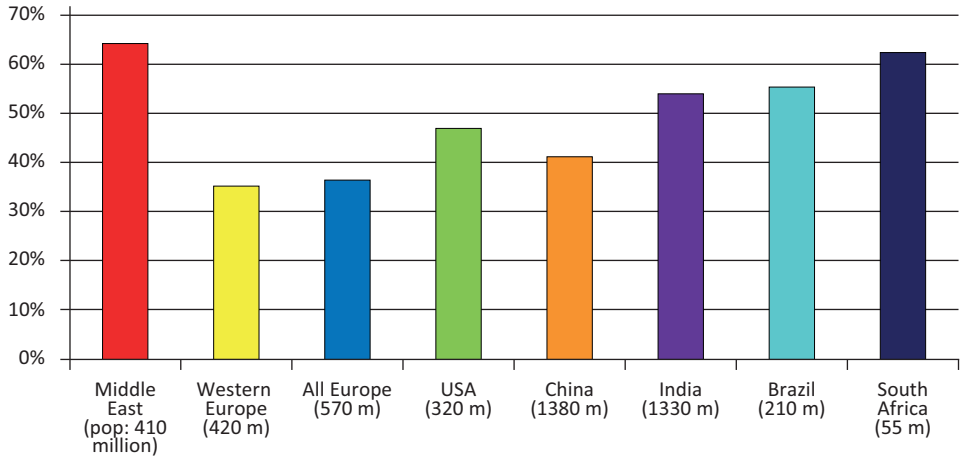
Third, welfare regime models (Esping-Andersen, 1990) analyse how social policy systems and state intervention – ranging from universal welfare states to minimal safety nets – create different inequality outcomes. Although MENA countries do not fit neatly into traditional Western welfare state categories, the region's "social contract" model historically involved providing subsidised goods, public sector jobs, and free education and healthcare in exchange for political stability (Devarajan & Ianchovichina, 2017; Cammett & Diwan, 2019; Karshenas et al., 2014). This approach resembled elements of a "state-led welfare" system but has faced challenges due to fiscal pressures, population growth, and structural adjustment policies (Karshenas et al., 2014). The decline of subsidies and reductions in public sector employment have contributed to increased inequality and public dissatisfaction, while targeted social assistance programmes have shown mixed results in addressing structural inequalities (Silva et al., 2013). Recent research indicates that MENA's welfare structures are now evolving, with hybrid models emerging that blend residual safety nets with market-oriented reforms, often widening inequality gaps if not accompanied by redistributive policies (Loewe et al., 2021).

These theoretical lenses – human capital, social determinants, and welfare regime/social contract – will be employed to analyse the literature on economic inequality and social policy in the MENA region, with particular focus on how education and healthcare policies interact with broader structural, political, and economic forces.

3.2. Economic growth and income inequality in MENA

A key question in development economics is how economic growth impacts inequality. In the MENA region, this relationship has been complicated and sometimes counterintuitive. On one side, economic growth can increase average incomes and decrease poverty; on the other side, without fair distribution, growth may skip over poorer groups, thus widening income differences. The MENA region's recent history illustrates this tension.

Figure 1. Top 10% income share, Middle East versus other countries[2]



Source: Alvaredo et al., 2018.

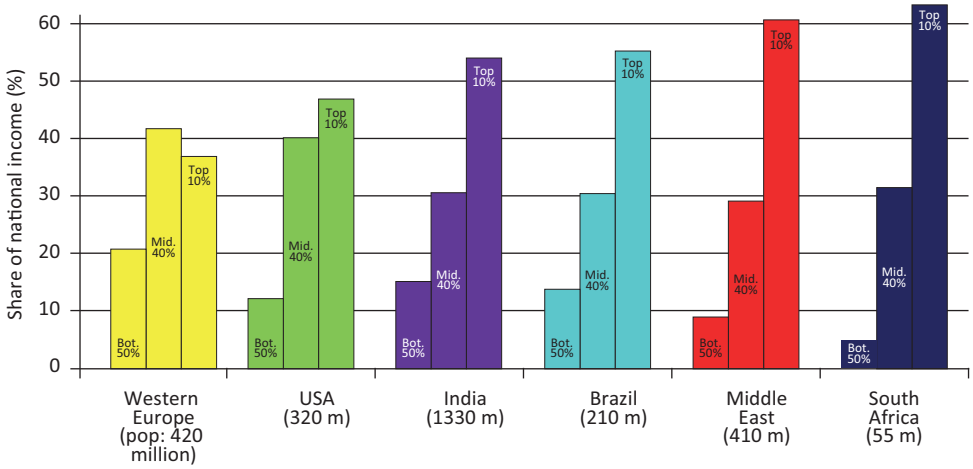
For instance, the region experienced periods of robust growth (during oil booms or post-2000 economic liberalisation), yet inequality remained stubbornly high or even increased in many countries. According to benchmark estimates by Alvaredo et al. (2018), the top 10% of income earners in the Middle East receive around 64% of total income, making the region one of the most unequal globally Figure 1 and Figure 2. The Middle East has a dual social structure, with a highly wealthy group at the top and a much larger group with minimal income (Figure 2).

This statistic reflects a highly skewed income distribution with a small wealthy elite and a broad base of low-income populations, and only a thin middle class. By comparison, in many Western countries the top 10% capture 30–50% of income, making the Middle East an outlier in inequality. One structural driver of this inequality is the unequal distribution of natural resource wealth. Oil-rich Gulf countries, while

[2] National income distribution among adults (before taxes and transfers, excluding pensions and unemployment insurance). Refined projections based on a synthesis of updated survey, fiscal, wealth, and national accounts information. Equal-split series (married people's income is split in half). Recent years (2012–2016) are included.

comprising a small fraction of MENA's population, account for a large portion of regional income, for example, Gulf nations in 2016 made up only 15% of the MENA region's population but nearly 50% of its total income (Assouad et al., 2018). This geographic concentration of wealth creates a stark contrast between high-income oil exporters and other countries. Even within individual countries like Egypt, Tunisia, and Jordan (which are not major oil exporters), significant income disparities exist due to factors such as urban–rural divides, labour market dualism (Assaad, 2014; Assaad et al., 2022), and uneven access to quality education and jobs (AlAzzawi & Hlasny, 2020).

Figure 2. Global distribution of the bottom 50%, the middle 40%, and the top 10%



Source: Alvaredo et al., 2018.

The literature provides mixed evidence on whether growth has reduced or worsened inequality in MENA. Some scholars argue that periods of growth in the region did little to benefit the poor because the gains mainly went to those who were already better off. For example, Cingano (2014) remarks that while economic growth generally raises average living standards, it can increase income inequality if the benefits are not shared widely. In societies with weak redistribution policies or where job growth is concentrated in high-skill sectors, growth may expand the income gap (Cingano, 2014). Ncube et al. (2014) similarly suggest that the very high initial levels of inequality in MENA have weakened the poverty-reducing effects of growth – meaning that even when GDP rises, the poorest groups see only slight improvements because wealth remains concentrated at the top. Conversely, other analysts note that in some MENA countries, moderate declines in inequality have happened alongside growth, often where deliberate pro-poor policies were implemented. Overall, the link between growth and inequality in MENA is complex and depends on specific contexts. Countries' experiences vary: for example, Tunisia under President Ben Ali pursued

neoliberal economic reforms that led to periods of growth but also coincided with rising social disparities and strain on the middle class (Görmüş & Akçalı, 2020). By the late 2000s, frustration over this imbalance helped spark protests. In Jordan, economic stagnation coupled with rising living costs in the 2010s resulted in higher poverty rates despite earlier growth, partly due to external shocks like the Syrian refugee influx (ESCWA, 2022). Egypt's growth in the 2000s also did not significantly reduce poverty or inequality; the country entered the 2011 revolution with a sense that crony capitalism had enriched a few while many struggled (Aziz, 2015; Ibrahim, 2021; Verme et al., 2014).

A key insight from the literature is that the distribution of growth benefits is vital. If growth is paired with effective redistributive measures – such as progressive taxation, social safety nets, job creation in inclusive sectors, and investments in public services – it can promote equity. Without these, growth might simply widen existing inequalities. The World Bank (2016) has warned that unchecked disparities in MENA undermine social cohesion and economic stability. High inequality is viewed as one factor behind political unrest, as shown by references to an "Arab inequality puzzle," where standard measures like household survey-based Gini coefficients appeared moderate, but perceptions of injustice and extreme wealth concentration fuelled uprisings (Devarajan & Ianchovichina, 2017). In hindsight, it was not just how much economies grew, but who benefitted from the growth that shaped sociopolitical outcomes. This highlights a central point: inclusive growth is essential to reduce inequality. Inclusive growth involves expanding economic opportunities for all societal groups and ensuring marginalized populations – such as the rural poor, urban slum residents, women, and youth – are not left behind. Countries like Egypt, Tunisia, and Jordan need to diversify their economies away from rent-based and elite-controlled sectors, improve governance and transparency, and strengthen labour markets to absorb educated youth (Malik, 2017). It also requires linking growth strategies with strong social policies – particularly in education and healthcare – that can promote equality of opportunity.

Importantly, accurate assessment of inequality in MENA is hindered by data limitations. Income and wealth data are often incomplete; high-income individuals are underrepresented in household surveys, and some countries lack recent surveys or national accounts data detailing distribution (Alvaredo et al., 2018). For instance, reliable tax or income records are scarce in many MENA countries, especially in the Gulf. This makes it difficult to precisely measure inequality levels and trends through new research (e.g., Assouad, 2020; Moshrif, 2022) using tax data and other methods confirms the extreme concentration of income and wealth. Despite these challenges, recent literature generally agrees that inequality – in income and access to services – is a critical issue in the MENA that growth alone will not resolve without deliberate policy action. Addressing inequality in the MENA region requires a comprehensive approach that includes effective social policies, strong governance, and improved access to education and healthcare. The complex relationship between economic growth and inequality highlights the need for such multifaceted strategies.

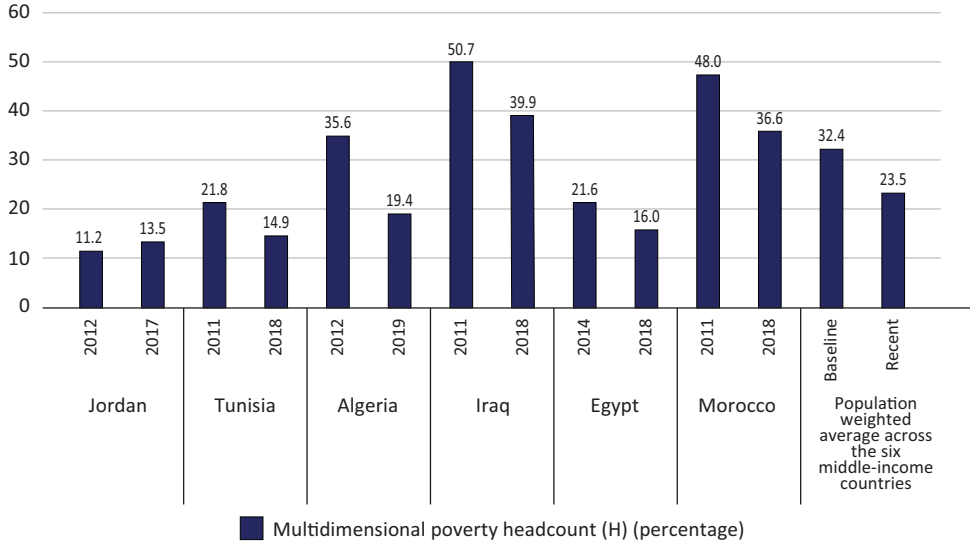
3.3. Social policies, education, and healthcare in reducing inequality

In order to ensure that all members of society have access to the resources they need to feel safe and secure, social policy addresses structural inequalities and issues related to healthcare (Donkin et al., 2018; Marmot et al., 2008); housing (Desmond & Gershenson, 2016); education, and labour market (Bailey et al., 2017; Egede et al., 2024; Egede & Walker, 2020). Therefore, social policy should ensure equitable access to essential resources such as healthcare, housing, education, and employment opportunities. It addresses key societal challenges, including poverty, unemployment, and demographic changes, to enhance human security and well-being. Effective social protection systems have demonstrated the potential to reduce poverty and income inequality significantly through targeted interventions (Pouw & Bender, 2022). Empowering marginalised groups and encouraging their active participation in political, economic, and social spheres are critical components of poverty reduction strategies. Comprehensive policies must expand access to social protection mechanisms and foster a more equitable distribution of wealth and income (Omar & Inaba, 2020; Pouw & Bender, 2022).

The Second Arab Multidimensional Poverty Report by ESCWA (2022) comprehensively analyses poverty trends across six Arab middle-income countries (MICs): Jordan, Tunisia, Algeria, Iraq, Egypt, and Morocco. Using the Multidimensional Poverty Index (MPI), the report highlights both improvements and persistent challenges in addressing poverty. Figure 3 shows a significant decline in poverty headcount ratios in most countries between 2011 and 2019. Algeria achieved the largest reduction, decreasing from 35.6% in 2012 to 19.4% in 2019, followed by Egypt, which reduced poverty from 21.6% in 2014 to 16.0% in 2018. However, Morocco had the highest poverty rate, with 36.6% of its population affected in 2018. Jordan experienced an increase in poverty, rising from 11.2% in 2012 to 13.5% in 2019, driven by economic stagnation and the impact of the Syrian refugee crisis.

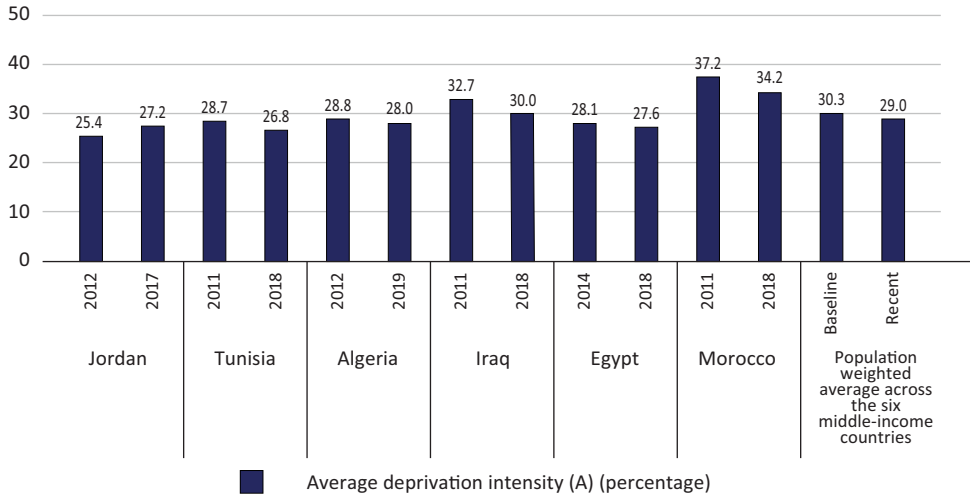
Despite reductions in headcount ratios, Figure 4 shows that the average deprivation intensity among the poor remained high. Morocco exhibited the highest deprivation intensity, which only slightly declined from 37.2% in 2011 to 34.2% in 2018, while Algeria and Tunisia stabilised at around 28–29%. The population-weighted average deprivation intensity across all six countries stagnated at 29.0%, indicating persistent challenges in improving living standards among the poor. While macroeconomic policies and growth patterns set the stage for income distribution, social policies in areas like education and health are key tools for governments to combat inequality in the long run. Improving access to quality education and healthcare services can enhance labour productivity and provide equal opportunities for all citizens (Awad, 2020; Khondker, 2024). Education and healthcare are often termed "egalitarian investments" because they build human capabilities and can level the playing field for disadvantaged groups. However, the mere existence of schools and clinics is not enough – the quality, inclusiveness, and targeted support within these systems determine whether they actually mitigate inequality or inadvertently reinforce it.

Figure 3. Multidimensional poverty headcount ratio in Arab middle-income countries over time



Source: United Nations Economic and Social Commission for Western Asia (ESCWA), 2022.

Figure 4. Average deprivation intensity among the poor in Arab middle-income countries over time



Source: United Nations Economic and Social Commission for Western Asia (ESCWA), 2022.

In the MENA section, education and health indicators have improved substantially over decades, yet inequalities within these sectors remain pronounced. This section reviews the state of educational and health inequalities in our focus countries (and the region more broadly) and evaluates the social policy measures aimed at alleviating those inequalities.

4. Education policies

Education is both a fundamental right and a critical determinant of socio-economic mobility. The MENA countries have made great strides in expanding education over the past half-century – literacy rates are up, gender gaps in enrollment have narrowed in many cases, and millions more children attend school now than in the past. However, educational inequality persists in several forms: disparities in access to schooling (especially secondary and higher education) between different regions and income groups, differences in school quality and learning outcomes, and a growing divide in opportunities for graduates. These educational disparities contribute to income inequality by affecting who can obtain the skills for higher-paying jobs.

One notable episode underscoring education's role in inequality was the Arab Spring of 2011. The uprisings that swept Tunisia, Egypt, and other Arab countries were driven in part by the educated youth feeling economically and politically marginalised. Rapid expansion of formal education in the MENA countries resulted in a large cohort of young graduates who faced limited job opportunities, a phenomenon referred to as the "education paradox" (Campante & Chor, 2012; Scarrone, 2021). In Tunisia and Egypt, for example, university graduates experienced unemployment rates far above those of less-educated workers, contrary to what human capital theory would predict. Frustration grew as educated individuals could not translate their qualifications into decent employment, fueling a sense of inequity and wasted potential (Grinin & Korotayev, 2022). Data illustrate this challenge: in Tunisia, the unemployment rate for university graduates was about 30% in 2020 (OECD, 2022b), and in Egypt it was reported at 36% in 2020 (ESCWA, 2021). In Jordan as well, unemployment among those with a bachelor's degree or higher reached roughly 27% in 2020 (Scarrone, 2021). These figures are strikingly high and point to structural issues – economies not creating enough high-skill jobs, and education systems not aligning with labour market needs. The result is a perception of **inequality of opportunity**: even with equal educational attainment, young people from less affluent backgrounds or outside elite networks struggle to secure good jobs, while those with connections or privilege fare better (Assaad et al., 2019). This dynamic can entrench upper and lower classes even among the educated, undermining the equalising effect education is supposed to have.

Other aspects of educational inequality in the MENA region are access and quality gaps at the primary and secondary levels, often correlated with geography and socioeconomic status. Rural and remote areas typically have fewer schools, higher dropout rates, and lower quality of instruction compared to urban centres. For instance, prior to the Syrian civil war, around two-thirds of secondary-school-aged youth in Syria were enrolled in school; that number plummeted due to conflict

(Kolstad, 2018). In Iraq, deep inequalities in educational attainment exist, with girls, rural children, and the poor far less likely to complete schooling (Muslah & Abbas, 2023). Iran also contends with challenges in ensuring equal access to secondary education, where disparities are evident across different regions and among various socio-economic groups (Salehi-Isfahani et al., 2013). Even in more stable countries like Egypt, Tunisia, and Jordan, rural districts and poorer communities lag behind in terms of indicators such as secondary school completion and student learning outcomes.

Social and cultural factors also play a role: across the region, girls' education has improved dramatically, yet in some traditional communities, they still face more barriers to schooling (early marriage, conservative norms) than boys. Jordan and Tunisia stand out as positive examples in certain respects – both have achieved near gender parity in basic education. Jordan, for example, reached equal enrolment of boys and girls in primary education as early as 1980, and today female registrations even slightly exceeds male enrolment in secondary and tertiary education; by 2021, adult female literacy in Jordan was over 97% (World Bank Group, 2022). Tunisia has made progress likewise: by 2014, its gross secondary enrolment rate for girls was 84% (slightly higher than for boys at 80%), indicating narrowing gender gaps (OECD, 2017). Bahrain has achieved the highest gender parity in the Gulf Cooperation Council (GCC) after the UAE, ranking as the first globally in literacy rate and educational attainment, as reported in the Global Gender Gap Report 2023 (World Economic Forum, 2023). These successes result from sustained political commitment and investment in girls' education. However, pockets of inequality remain – often within countries. In Tunisia, rural interior regions lag behind the coastal areas in educational outcomes (Kim, 2019). In Jordan, despite high female education rates, social norms and labour market conditions result in low female labour force participation, posing a different kind of inequality challenge (Bouri, 2023; Robbin, 2022).

Region-wide data highlight persistent educational gaps. According to UNICEF, over one-third of adolescents aged 15 to 17 in MENA are out of school, and girls make up just over half of this out-of-school group (UNICEF, 2019). Many of these adolescents are from poor families who may prioritise basic survival over schooling or from communities where secondary schools are not easily accessible. When schooling is available, there are often quality disparities between public and private institutions. Wealthier families can afford private schooling or tutoring to boost their children's success, whereas poorer families must rely on under-resourced public schools. Research has found that private tutoring – effectively a shadow education system – is widespread in parts of the MENA countries and tends to exacerbate inequality. For example, a study of five MENA countries (Egypt, Algeria, Lebanon, Morocco, and Tunisia) revealed that households with higher income and education are much more likely to invest in private tutoring for their children, which in turn improves academic performance (Fakih et al., 2022). Children from lower-income families generally cannot afford these extra lessons, potentially widening achievement gaps. Socioeconomic status (SES) is a strong predictor of student performance in MENA, as elsewhere: more affluent students have access to books, a conducive learning environment, and additional support, leading to better outcomes (Heyneman, 1997;

Tan, 2024). By contrast, low-SES students often face limited access to quality education and may start falling behind early in primary school. These early gaps can compound, resulting in markedly different educational and life trajectories for rich and poor children. In Egypt, studies have shown an education divide between the rich and the poor youth, though some recent evidence suggests that the gap may be narrowing there, while widening in other countries like Jordan (Rizk & Hawash, 2020). Indeed, Rizk and Hawash (2020) describe the MENA region as facing an educational crisis characterised by stagnating quality and widening inequalities in opportunities.

To tackle educational inequality, the MENA governments have implemented various policy interventions. Many of these aim at *expanding access* and *improving equity* in schooling. For instance, recognising the urban–rural divide, introducing policies to build more schools in underserved areas, recruiting and training teachers to serve in remote regions, and providing incentives for families to keep children (especially girls) in school. A critical strategy has been the use of conditional cash transfers (CCTs) and other social protection programmes to support education. Egypt's "Takaful and Karama" programme is an illustrative example (World Bank Group, 2024). It provides cash transfers to vulnerable low-income households, conditional on children's school attendance and health checkups. This programme, launched in 2015, has grown to reach over 4.6 million households as of late 2023, with women comprising 74% of the primary recipients (World Bank Group, 2024). By easing the financial burden on poor families and directly incentivizing education, such transfers have shown promise in reducing wealth disparities and improving educational access (Rizk & Hawash, 2020; World Bank Group, 2024). Early evaluations suggest increased enrolment and attendance among beneficiary children in Egypt, indicating that CCTs can help level the playing field for poor students.

Beyond financial incentives, policy recommendations from researchers and international agencies emphasise *systemic educational reforms* to address inequality. These include:

1. *Improving schooling infrastructure and quality in marginalized areas* – providing better school access, training teachers, and enriching curricula to create a more inclusive educational environment. Such measures are essential to bridge the gender gap and promote equitable educational attainment across the region (Awad & Al Ali, 2024). The examples of such activities include constructing secondary schools in rural districts so that distance is not a barrier, deploying well-trained teachers and providing them incentives (housing, bonus pay) to teach in remote or low-income communities, and updating curricula to be relevant and inclusive (UNICEF, 2021).
2. *Early childhood education* – expanding access to preschool can mitigate developmental gaps before children even enter primary school, particularly benefitting children from disadvantaged backgrounds (Kallas et al., 2022).
3. *Addressing gender disparities* – even where enrollment is near equal, ensuring that girls do not drop out due to marriage or safety concerns requires community engagement and possibly providing girls with safe transportation or sanitary facilities at schools (Assaad et al., 2018; UNICEF, 2019).

4. *Vocational and technical training* – as a complement to academic education, strengthening technical and vocational education as well as training (TVET) programmes can provide youth (especially those not pursuing university) with market-relevant skills, improving their employment prospects. This can be crucial in countries like Tunisia and Egypt where a large number of university graduates compete for a limited number of formal jobs; expanding vocational pathways can reduce the pressure and better match labour market needs (OECD, 2022b).
5. *Governance and accountability in education* – ensuring that resources invested in education yield results requires monitoring and evaluation. Some MENA countries have begun instituting stronger performance management in schools and universities (Cosenz, 2022; Omar & ElBastawissi, 2022), which can help identify failing schools and direct support accordingly.
6. *Decentralising education* to local or institutional levels – allowing for more responsive and adaptable education systems (Powell-Davies, 2015). For example, Saudi Arabia has made strides in engaging the private sector to play a pivotal role in education reform, ensuring that educational systems align more closely with labour market demands and societal needs (Algassem & Hassan, 2024).
7. *Strengthening partnerships* between educational institutions and industries (Algassem & Hassan, 2024), where building these connections enables the development of curricula that meet the demands of the modern workforce (Billett & Seddon, 2004). By involving industry stakeholders in curriculum design, educational systems can equip students with skills that are directly applicable to job markets (Alagaraja et al., 2014; Billett & Seddon, 2004; Algassem & Hassan, 2024).
8. *Performance management* in education is also a critical area for reform. Establishing systems that ensure accountability and drive continuous improvement is essential for achieving high-quality education (Cosenz, 2022; Omar & ElBastawissi, 2022). Such practices demonstrate how monitoring and evaluation frameworks can ensure reforms deliver tangible results.

Education is both a cause of and a solution to inequality in MENA. When access to quality education is unequal, it reproduces social stratification. Nevertheless, when effectively reformed and supported by social policies (like cash transfers and targeted investments), education can become a great equaliser, enhancing equality of opportunity. Encouragingly, research by Krafft et al. (2019) shows signs of a decreasing trend in inequality of opportunity in education and income in countries such as Tunisia, Egypt, and Jordan in the 2010s, suggesting that sustained policy focus can yield improvements. Still, the education gap remains a "growing challenge" (Rizk & Hawash, 2020) and will require continued attention to ensure that gains in enrolment translate into truly equitable outcomes in learning and employment.

5. Healthcare policies and inequality

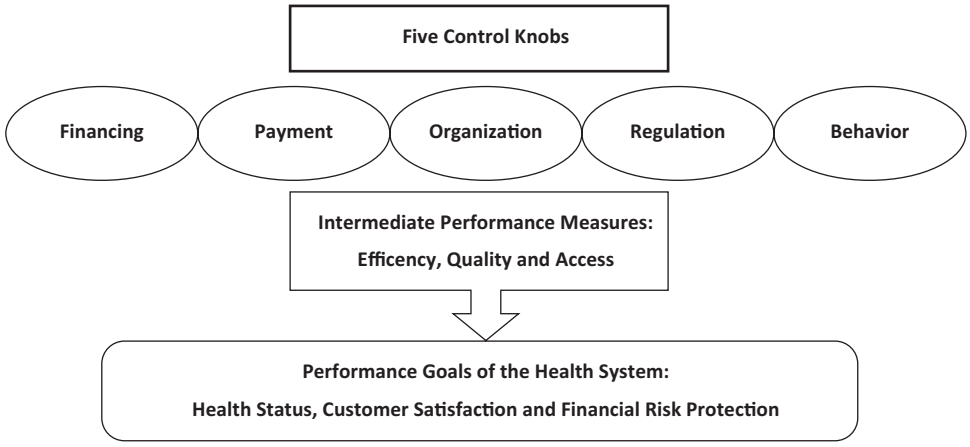
Like education, healthcare is a pivotal arena for social policy in the fight against inequality. Health inequality in the MENA region often manifests as disparities in access to healthcare services and in health outcomes (such as life expectancy, maternal/

child mortality, or the prevalence of diseases) between different socioeconomic groups and regions (Katoue et al., 2022). Factors such as income, insurance coverage, urban vs. rural location, and even nationality (e.g. citizens vs. refugees or migrant workers) can influence one's access to quality care (Katoue et al., 2022).

Broadly, according to Katoue et al. (2022) and Mate et al., (2017), the MENA countries' health systems can be categorised by income level. Low-income countries (like Yemen, Djibouti, and Sudan) struggle with minimal healthcare infrastructure. High-income Gulf states offer extensive health services (often free or heavily subsidised for citizens) funded by oil wealth, though they rely on migrant healthcare workers and sometimes disparities between citizens and expatriates exist. Egypt, Tunisia, and Jordan fall into the middle-income category, where health systems have made significant strides, nevertheless, they still exhibit coverage gaps and resource constraints. For instance, Tunisia has a long-standing contributory health insurance scheme (CNAM) that covers over 80% of the population. The country's health system is predominantly public, with more than 80% of hospital beds in the public sector, yet the private sector employs the majority of health professionals and absorbs most advanced medical technology (WHO, 2024). Public facilities, especially in rural areas, are often overburdened and suffer from medicine shortages and limited operating hours, leading many to turn to private providers perceived as higher quality (WHO, 2024). Egypt's healthcare system is a mix of public and private providers; the government operates a large public system, but due to resource limitations, patients often face issues like shortages of medicines, overburdened hospitals, and high out-of-pocket (OOP) expenditures for medications and private consultations. Indeed, high OOP spending is a major contributor to health inequality – when people must pay a large share of healthcare costs directly, the poor may delay or forgo care, leading to worse health outcomes (Biltagy & Hamdi, 2024). In Egypt, as of the 2010s, households paid a considerable portion of health expenses out of pocket, disproportionately affecting the poor (Pande et al., 2017). Jordan's health system is somewhat stronger, achieving near-universal immunisation and low child mortality. The country's routine immunisation program is highly effective – there are currently no reported cases of polio, attesting to the strength of its vaccination infrastructure and public health commitment (Department of Statistics (DoS) Jordan & ICF, 2023). UNICEF data from 2017 confirm that over 95% of children are vaccinated, with infant and child mortality consistently declining (UNICEF, 2017). Yet, the influx of Syrian refugees over the past decade has placed substantial pressure on public health services. Jordan's early policy of granting refugees' access to public healthcare – initially free of charge – was subsequently revised; in 2018, Syrian refugees were required to pay 80% of the foreigner rate for services, with exceptions for maternity and child health (Muhieddine et al., 2022). This shift has strained both refugee populations, who now face financial barriers, and the overall health system, which must stretch finite resources across citizens and displaced groups. Given the limited fiscal resources available, it is essential to have a firm political commitment to implement rigorous and consistent reforms that cater to the population's health needs to address the challenges encountered by the healthcare systems in the MENA region (Yazbeck et al., 2017).

To improve health equity, MENA governments have pursued various health sector reforms and policies. A key concept guiding many of these reforms is the WHO's health system framework (as articulated by Katoue et al., 2022; Roberts et al., 2008, and the World Bank's Flagship Framework). This framework, as shown in Figure 5, identifies several functions of a health system – including financing, payment, organisation, regulation, and behaviour – and suggests that reforms in these areas can enhance the system's performance goals: improved health outcomes, financial protection, and citizen satisfaction.

Figure 5. Visual of the elements of the flagship framework



Source: Katoue et al., 2022.

In practice, this means countries are trying to:

1. *Improve health financing and coverage*, for example, by expanding insurance schemes or government funding to achieve universal health coverage (UHC), so that people are protected from catastrophic health costs (Asbu et al., 2017).
2. *Enhance service delivery* – such as investing in primary healthcare, integrating services, and improving infrastructure in underserved regions (Katoue et al., 2022).
3. *Reform payment systems* – shifting how providers (hospitals, doctors) are paid to incentivise quality and efficiency (moving away from fee-for-service toward bundled payments or performance-based payments) (Hanson et al., 2022).
4. *Strengthen regulation and accountability* – to ensure quality of care and to manage issues like corruption or the phenomenon of dual practice (where doctors work in both public and private sectors, potentially undermining their commitment to public patients) (Hoogland et al., 2022). Table 1 shows some concrete examples from the literature illustrating these efforts.

Table 1. Examples of health policy reforms and lessons in the MENA countries

Reform area	Country & reference	Policy/intervention	Key findings & lessons learned
Expanding insurance coverage	Saudi Arabia (Al-Mazrou et al., 2017)	Mandatory health insurance for expatriate workers, provided by private employers	Expanded insurance coverage to previously uninsured groups; boosted the private insurance market
	Egypt	New national law aiming for universal coverage in phases	Expected to expand access gradually, though funding and the implementation of remaining challenges. Shows that phased approaches can build momentum toward UHC in middle-income contexts.
	Jordan (MOH initiatives, 2015–2020)	Expanded public insurance schemes to more citizens	Coverage improved but gaps remain, especially for refugees and informal workers. Highlights the need to pair insurance with sustainable financing and service expansion.
Provider payment reforms	Lebanon (Khalife et al., 2017)	Reform of hospital contracting: standardised admission criteria, automated billing, and mixed public–private contracting	Improved efficiency, reduced billing irregularities, and strengthened accountability. Shows payment reform can free resources for underserved areas.
Regulating workforce practices	Palestine (Alaref et al., 2017)	Policy experiment banning dual practice (public + private work by doctors)	Outright ban risked losing specialists to private jobs or emigration. Suggests flexible policies (incentives, higher public wages, regulated private practice) are preferable to outright bans. Egypt and Jordan face similar rural workforce shortages.
Targeting disadvantaged groups	Egypt (Pande et al., 2017)	Diagnostic tool to identify underserved groups and evaluate system goals	Found gaps in rural areas, high out-of-pocket costs, and poor quality in public facilities. Targeted interventions (family health model, subsidies for the poor) are critical.

Source: Author's own illustration, derived from the literature review.

The literature stresses that *political commitment and adequate funding* are vital to advance health equity (Yazbeck et al., 2017). Middle-income MENA countries often operate under tight fiscal constraints, especially post-2011 with slower growth and, in Jordan's case, refugee-related expenses. Health reforms, therefore, need to be efficient and evidence-based. International comparisons show that the MENA nations have room to increase health spending efficiency and reallocate expenditures towards preventive and primary care (Asbu et al., 2017). Preventive public health measures (like vaccinations, maternal health programmes, and disease prevention campaigns) can yield large equity gains by disproportionately benefitting the poor (who rely on

public services more). There is also a call in the literature for *integrating social determinants of health into policy* – meaning that health ministries should work in tandem with other sectors like water and sanitation, housing, and education, since improvements in those domains will lead to better health outcomes and narrow health gaps (Donkin et al., 2018; Marmot et al., 2008).

Despite numerous initiatives, challenges remain in all three focus countries. Common issues include: persistently high out-of-pocket expenditures (e.g., buying medicines or seeing specialists privately due to inadequacies in the public system), which disproportionately burden the poor; variable quality of care, where wealthier individuals can access high-end private hospitals while low-income families may only have understaffed clinics; and urban-centric resource allocation, with capital cities enjoying the best hospitals (Pande et al., 2017). Moreover, systematic evaluation of health reforms is limited – as noted by Katoue et al. (2022), more research and published literature on health system changes in the MENA region are needed. Without rigorous evaluation, it can be hard to know which interventions work best for reducing inequalities.

Improving health equity in the MENA countries requires making their health systems more *inclusive, accessible, and resilient*. This involves increasing coverage (financial protection) so that no one is impoverished by medical bills, improving the availability and quality of services in marginalised areas, and continuously adapting policies as new challenges emerge (Braithwaite et al., 2017). The COVID-19 pandemic, for instance, tested MENA health systems and highlighted gaps in public health infrastructure (OECD, 2022a). Going forward, these countries will need to invest in both the *"hardware"* of healthcare (facilities, technology, supply chains) and the *"software"* (health workers, management, financing schemes) with an eye toward equity.

The next section will offer specific policy recommendations drawing on the aforementioned analysis, focusing on education and healthcare strategies to alleviate inequality.

6. Conclusion and recommendation

The MENA region has high-income inequality, with extreme wealth concentrated among a few and many living in poverty. Economic growth can reduce inequality, but the distribution of benefits is crucial. In the MENA region, high levels of income inequality can hinder economic growth's ability to alleviate poverty, particularly among marginalised groups. Addressing regional disparities requires a comprehensive approach that tackles root causes like weak governance, limited access to education and healthcare, and a lack of economic diversification. This paper explores strategies and policies to reduce inequality in the MENA region, highlighting successful examples and challenges. A comprehensive approach is recommended, focusing on education and healthcare policies to promote sustainable development and improve well-being. While evidence suggests that high inequality can hinder economic growth, this may only apply to some income levels in different countries (Topuz, 2022). These strategies aim to promote

a more equitable distribution of opportunities and outcomes, thereby mitigating income inequality and fostering inclusive development.

*Education policy strategies – alleviating educational inequality***.** Governments should prioritise reforms that equalise educational opportunities for all children, regardless of their socio-economic background or gender. The following actions are recommended:

- *Expanding access in underserved areas*. Investing in building and upgrading schools in rural and low-income urban areas, and ensure they are equipped with sufficient teachers and learning resources. Improving infrastructure (e.g., safe classrooms, sanitation facilities) and providing transportation or boarding where needed will help bring more children, especially girls, into secondary education (Rizk & Hawash, 2020; World Bank Group, 2024).
- *Improving the quality of education for disadvantaged groups*. Deploying well-trained teachers to high-need schools, offering professional development focused on inclusive teaching practices, and adapting curricula to be culturally relevant and skills-oriented. Smaller class sizes and remedial support (tutoring, mentoring) should target students who are falling behind. Introducing monitoring and evaluation systems in schools can help track learning outcomes and hold schools accountable for closing achievement gaps (Cosenz, 2022). In addition, decentralising education management – giving local schools and communities more control and flexibility – can make schooling more responsive to local needs (Omar & El Bastawissi, 2022; Powell-Davies, 2015).
- *Strengthening technical and vocational education.* To address the education-employment mismatch, expand technical and vocational education and training (TVET) programmes that equip youth with market-relevant skills (OECD, 2022b). Updating vocational curricula in partnership with industries and providing apprenticeships or on-the-job training can improve the employability of graduates (Algassem & Hassan, 2024).
- *Targeted financial support and incentives***.** Scaling up social protection programmes that directly support education for the poor. Conditional cash transfer programmes (like Egypt's Takaful and Karama) should be continued and refined, and similar initiatives expanded in Tunisia and Jordan, to alleviate the immediate costs of schooling for low-income families (World Bank Group, 2024). Scholarships, free textbook programs, school meal programmes, and stipends for girls or children at risk of dropping out are all tools that have proven effective worldwide in keeping disadvantaged children in school (Banerjee et al., 2015). These not only increase enrolment but also improve completion rates for margnlised groups.
- *Promoting gender equality in education.* Close the remaining gender gaps by addressing socio-cultural barriers. This includes community awareness campaigns on the importance of girls' education, enforcement of laws against child marriage, and initiatives such as girls' mentorship programmes. Providing a safe school environment (with adequate sanitation facilities and measures against harassment) and recruiting female teachers in conservative areas can encourage girls' attendance (UNICEF, 2021). Additionally, incorporate gender sensitivity into the curriculum to challenge stereotypes. *Political commitment is essential* – high-level advocacy and consistent policy emphasis on female education have shown results in countries

like Jordan and Tunisia, and must continue to ensure gains are not reversed (Bouri, 2023; Kim, 2019; Robbin, 2022).

*Healthcare policy strategies – advancing health equity***.** To reduce health access inequalities and ensure social justice in healthcare, the following policy actions are recommended for the MENA governments and health systems:

- *Moving toward universal health coverage.* Establishing or expanding health insurance schemes so that all individuals have financial protection and access to essential health services. This can involve subsidised public insurance for low-income populations, integrating fragmented insurance programmes into a unified system, and, where feasible, mandating employer or government contributions for coverage (Al-Mazrou et al., 2017). Jordan and Tunisia, which already have broad insurance networks, should work on covering any remaining uninsured and including services that are often paid out-of-pocket (like medications or dental care) in the benefit package. Egypt's recent steps toward a Universal Healthcare Insurance Law should be accelerated and adequately funded. Reducing out-of-pocket expenditures is critical – no one should be impoverished or forego treatment due to healthcare costs (Biltagy & Hamdi, 2024; Pande et al., 2017).
- *Enhancing primary healthcare and rural health services.* Invest in primary health care infrastructure, especially in underserved rural and peri-urban areas. Strong primary care acts as the frontline for prevention and early intervention, benefitting the poor who rely on public clinics. Strategies include building more local health centres, deploying community health workers, and mobile clinics, and ensuring consistent supply of medicines and basic equipment. Family health practice models (as recommended by Pande et al., 2017 for Egypt) can provide comprehensive care at the community level, addressing common ailments, maternal-child health, and health education. A robust primary care system improves health outcomes and reduces the burden on hospitals, thereby improving equity.
- *Improving quality of care through system reforms.* Implement provider payment and hospital management reforms to incentivise quality and efficiency in the health system. For example, transition from fee-for-service models (which can lead to over-treatment for those who can pay and under-treatment for those who cannot) to capitation or performance-based payments in public insurance, encouraging providers to focus on outcomes (Hanson et al., 2022). Invest in training for healthcare professionals, accreditation systems for hospitals and clinics, and stronger regulatory oversight to ensure minimum quality standards. Lebanon's experience with hospital contracting reform and quality measures (Khalife et al., 2017) provides a roadmap for using contracts and accreditation to raise standards. Quality improvement particularly benefits lower-income patients who cannot afford to pay for better private care – it narrows the gap between public and private service outcomes.
- *Address healthcare workforce challenges.* To ensure equitable access, policies must distribute health workers more evenly and keep them in the public system. This can include providing incentives (financial bonuses, housing, career development opportunities) for doctors and nurses to serve in rural or low-income urban areas, thus countering the urban concentration of providers. Regulate dual practice by

developing clear guidelines or requiring a minimum commitment in public hospitals before private practice is permitted, rather than outright bans which may drive talent away (Alaref et al., 2017). By improving salaries and working conditions in the public sector, countries can reduce the "brain drain" of medical professionals and encourage them to serve domestic needs.

- *Strengthening preventive and public health programmes.* Inequalities in health are often rooted in differences in exposure to risks and in health-related knowledge. Governments should expand programmes like immunisations, nutritional support, clean water and sanitation projects, as well as health education campaigns targeting disadvantaged communities. For example, increased outreach for maternal and child health in poor areas can dramatically reduce mortality gaps. Public health interventions (such as anti-tobacco campaigns or diabetes prevention initiatives) should focus on lower-income and high-risk groups who might lack access to information or early screening. This approach aligns with the social determinants of health framework, tackling upstream factors that cause ill health among the disadvantaged (Marmot et al., 2008). Such preventive measures are cost-effective and equity-enhancing.
- *Continuous monitoring and adaptive reform.* Finally, health systems should become more *flexible and responsive* to emerging challenges. This involves setting up robust data collection and evaluation mechanisms to monitor the impacts of any health reform on different population groups. For instance, when new policies (like a co-pay or a service delivery reform) are implemented, data on utilisation by income quintile or region should be analysed to ensure the poor are benefitting. If unintended consequences are detected (such as reduced access for the poor or loss of medical personnel from public facilities), mid-course corrections must be made. Governments are encouraged to support research on health system performance and equity (Katoue et al., 2022) and to pilot programs before scaling up. Building evidence base specific to the MENA region – through academic studies and public reporting – will help policymakers design effective and sustainable health reforms.

Reducing inequality in the MENA countries is an achievable but complex goal. Some experiences in the MENA region highlight that targeted social policies in education and healthcare can significantly improve opportunities. When a poor rural girl can complete quality schooling and grow up healthy with access to medical care, her chances to participate in the economy and society greatly increase. With millions of such individual gains, national inequality measures will also improve. However, social policies alone do not work in isolation; they must be part of a broader framework of inclusive growth and good governance. This includes sound macroeconomic management, job-creating economic strategies (to ensure educated youth have employment prospects), and anti-corruption measures to ensure resources reach their intended targets. Strengthening institutions and accountability is essential so that programmes like cash transfers or school reforms are implemented transparently and effectively. Ultimately, an integrated approach is necessary, a combination of education reforms, healthcare improvements, social protection, and economic inclusion policies, all tailored to each country's specific context. By adopting such a comprehensive strategy, MENA countries can better address the structural inequalities that have long

hindered their development. The policy recommendations provided here, grounded in both theoretical insights and empirical evidence, serve as a roadmap toward more equitable and just societies in the region.

7. Study limitations

One central area for improvement in studying the relationship between economic growth and inequality in the MENA region is the scarcity of literature and research on the topic. Similarly, resources for implementing educational reform policies in the area are limited, and recommendations for reform need a solid, evidence-based approach. Although healthcare reforms and systems have been implemented in the MENA region, it is difficult to draw concrete conclusions about their impact due to the limited availability of data and evaluation. Another limitation is that the challenges of addressing inequality in the MENA region vary from one area to another, making it challenging to develop generalisable recommendations. Context-specific solutions are required to tailor policy interventions and strategies to the specific challenges faced by different areas.

References

Abatemarco, A., Aria, M., Beraldo, S., & Collaro, M. (2024). Measuring health care access and its inequality: A decomposition approach. *Economic Modelling*, *132*, 106659. https://doi.org/10.1016/j.econmod.2024.106659

Aiston, S.J. & Walraven, G. (2024). A *re*-view of educational inequalities. *Educational Review*, *76*(1), 1–12. https://doi.org/10.1080/00131911.2023.2286849

Alagaraja, M., Kotamraju, P., & Kim, S. (2014). A conceptual framework for examining HRD and NHRD linkages and outcomes. *European Journal of Training and Development*, *38*(4), 265–285. https://doi.org/10.1108/EJTD-01-2013-0009

Alaref, J., Awwad, J., Araujo, E., Lemiere, C., Hillis, S.A., & Özaltin, E. (2017). To ban or not to ban? Regulating dual practice in Palestine. *Health Systems & Reform*, *3*(1), 42–55. https://doi.org/10.1080/23288604.2016.1272980

AlAzzawi, S. & Hlasny, V. (2020). *Vulnerable employment of Egyptian, Jordanian, and Tunisian youth: Trends and determinants* (WIDER Working Paper No. 2020/166). United Nations University World Institute for Development Economics Research (UNU-WIDER). https://doi.org/10.35188/UNU-WIDER/2020/923-5

Algassem, F. & Hassan, A. (2024). Challenges facing TVET in Saudi Arabia and road map to reform. *International Journal of Vocational Education and Training Research*, *10*(1), 15–26. https://doi.org/10.11648/j.ijvetr.20241001.13

Al-Mazrou, Y., Al-Ghaith, T., Yazbeck, A.S., & Rabie, T.S. (2017). How labor laws can transform health systems: The case of Saudi Arabia. *Health Systems & Reform*, *3*(1), 26–33. https://doi.org/10.1080/23288604.2016.1272982

Al-Shawarby, S., El Tawila, S., El-Majeed, E.A.A., Gadallah, M., Milanovic, B.L., & Verme, P. (2019). *Inside inequality in the Arab Republic of Egypt: Facts and perceptions across people, time, and space*. World Bank. http://documents.worldbank.org/curated/en/70767

1468247494406/Inside-inequality-in-the-Arab-Republic-of-Egypt-facts-and-perceptions-across-people-time-and-space

Alvaredo, F., Assouad, L., & Piketty, T. (2018). Measuring inequality in the Middle East 1990–2016: The world's most unequal region? *Review of Income and Wealth*, *65*(4), 685–711. https://doi.org/10.1111/roiw.12385

Asbu, E.Z., Masri, M.D., & Kaissi, A. (2017). Health status and health systems financing in the MENA region: Roadmap to universal health coverage. *Global Health Research and Policy*, *2*(1). https://doi.org/10.1186/s41256-017-0044-9

Assaad, R. (2014). Making sense of Arab labor markets: The enduring legacy of dualism. *IZA Journal of Labor & Development*, *3*(1). https://doi.org/10.1186/2193-9020-3-6

Assaad, R., Hendy, R., & Salehi-Isfahani, D. (2019). Inequality of opportunity in educational attainment in the Middle East and North Africa: Evidence from household surveys. *International Journal of Educational Development*, *66*, 24–43. https://doi.org/10.1016/j.ijedudev.2019.02.001

Assaad, R., Krafft, C., & Salemi, C. (2022). Socioeconomic status and the changing nature of school-to-work transitions in Egypt, Jordan, and Tunisia. *ILR Review*, *76*(4), 001979392211414. https://doi.org/10.1177/00197939221141407

Assaad, R., Krafft, C., Roemer, J., & Salehi-Isfahani, D. (2018). Inequality of opportunity in wages and consumption in Egypt. *Review of Income and Wealth*, *64*, S26–S54. https://doi.org/10.1111/roiw.12289

Assouad, L. (2020). *Inequality and its discontents in the Middle East*. Carnegie Endowment for International Peace. https://carnegieendowment.org/research/2020/04/inequality-and-its-discontents-in-the-middle-east?lang=en&center=middle-east

Awad, A. (2020). Which contributes more to economic growth in the MENA region: Health or education? An empirical investigation. *Journal of the Knowledge Economy*, *12*, 1119–1133. https://doi.org/10.1007/s13132-020-00662-0

Awad, A. & Al Ali, W. (2024). Removing barriers to quality education in the MENA region. *Stanford Social Innovation Review*. https://ssir.org/articles/entry/removing_barriers_to_quality_education_in_the_mena_region?

Aziz, S.F. (2015). Bringing down an uprising: Egypt's stillborn revolution. *Connecticut Journal of International Law*, *30*(1).

Bailey, Z.D., Krieger, N., Agénor, M., Graves, J., Linos, N., & Bassett, M.T. (2017). Structural racism and health inequities in the USA: Evidence and interventions. *The Lancet*, *389*(10077), 1453–1463. https://doi.org/10.1016/S0140-6736(17)30569-X

Banerjee, A.V., Hanna, R., Kreindler, G., & Olken, B.A. (2015). Debunking the stereotype of the lazy welfare recipient: Evidence from cash transfer programs worldwide. *SSRN Electronic Journal*. https://doi.org/10.2139/ssrn.2703447

Bayat, A. (2002). Activism and social development in the Middle East. *International Journal of Middle East Studies*, *34*(1), 1–28. https://www.jstor.org/stable/3880166

Becker, G.S. (1964). *Human capital: A theoretical and empirical analysis, with special reference to education*. National Bureau of Economic Research.

Billett, S. & Seddon, T. (2004). Building community through social partnerships around vocational education and training. *Journal of Vocational Education & Training*, *56*(1), 51–68. https://doi.org/10.1080/13636820400200245

Biltagy, M. & Hamdi, M. (2024). Public health expenditure and household poverty: Case study of Egypt. *Future Business Journal*, *10*(7). https://doi.org/10.1186/s43093-023-00295-0

Bouri, C. (2023, September 19). Women's labor-force participation in the Middle East. *Think Global Health*. https://www.thinkglobalhealth.org/article/womens-labor-force-participation-middle-east

Boutayeb, A. & Serghini, M. (2006). Health indicators and human development in the Arab region. *International Journal of Health Geographics*, *5*(1), 61. https://doi.org/10.1186/1476-072X-5-61

Braithwaite, J., Mannion, R., Matsuyama, Y., Shekelle, P., Whittaker, S., Al-Adawi, S., Ludlow, K., James, W., Ting, H.P., Herkes, J., Ellis, L.A., Churruca, K., Nicklin, W., & Hughes, C. (2017). Accomplishing reform: Successful case studies drawn from the health systems of 60 countries. *International Journal for Quality in Health Care*, *29*(6), 880–886. https://doi.org/10.1093/intqhc/mzx122

Cammett, M. & Diwan, I. (2018). *The political economy of the Arab uprisings*. Routledge. https://doi.org/10.4324/9780429492747

Campante, F.R. & Chor, D. (2012). Why was the Arab world poised for revolution? Schooling, economic opportunities and the Arab Spring. *Journal of Economic Perspectives*, *26*(2), 167–188. https://doi.org/10.1257/jep.26.2.167

Cingano, F. (2014). *Trends in income inequality and its impact on economic growth* (OECD Social, Employment and Migration Working Papers). OECD Publishing. https://doi.org/10.1787/5jxrjncwxv6j-en

Cosenz, F. (2022). Developing performance management systems in higher education institutions. In *Managing sustainable performance and governance in higher education institutions: A dynamic performance management approach* (pp. 37–84). Springer International Publishing. https://doi.org/10.1007/978303099317-7_2

Desmond, M. & Gershenson, C. (2016). Housing and employment insecurity among the working poor. *Social Problems*, *63*(1), 46–67. https://doi.org/10.1093/socpro/spv025

Devarajan, S. & Ianchovichina, E. (2017). A broken social contract, not high inequality, led to the Arab Spring. *Review of Income and Wealth*, *64*(1), S5–S25. https://doi.org/10.1111/roiw.12288

Donkin, A., Goldblatt, P., Allen, J., Nathanson, V., & Marmot, M. (2018). Global action on the social determinants of health. *BMJ Global Health*, *3*(Suppl. 1), e000603. https://doi.org/10.1136/bmjgh-2017-000603

Department of Statistics (DoS) Jordan & ICF. (2023). *Population and family health survey 2023: Summary report* (pp. 1–20). https://dhsprogram.com/pubs/pdf/SR288/SR288.pdf

Egede, L.E. & Walker, R.J. (2020). Structural racism, social risk factors and COVID-19 – A dangerous convergence for Black Americans. *New England Journal of Medicine*, *383*(77). https://doi.org/10.1056/NEJMp2023616

Egede, L.E., Walker, R.J., & Williams, J.S. (2024). Addressing Structural Inequalities, Structural Racism, and Social Determinants of Health: a Vision for the Future. *Journal of General Internal Medicine*, *39*, 487–491. https://doi.org/10.1007/s11606-023-08426-7

El-Jardali, F., Bou-Karroum, L., & Fadlallah, R. (2020). Amplifying the role of knowledge translation platforms in the COVID-19 pandemic response. *Health Research Policy and Systems*, *18*(58). https://doi.org/10.1186/s12961-020-00576-y

El-Zanaty, F. & Way, A. (2009). *Egypt demographic and health survey 2008*. Ministry of Health and Population. https://dhsprogram.com/pubs/pdf/fr220/fr220.pdf

ESCWA. (2019). *Rethinking inequality in Arab countries*. United Nations Economic and Social Commission for Western Asia. https://digitallibrary.un.org/record/3880343?ln=en&v=pdf

ESCWA. (2021). *Youth employment dynamics in Egypt: Challenges and opportunities*. United Nations Economic and Social Commission for Western Asia. https://www.unescwa.org/sites/default/files/pubs/pdf/youth-employment-dynamics-egypt-challenges-opportunities-policy-brief-english.pdf

ESCWA. (2022). *Second Arab multidimensional poverty report*. United Nations Economic and Social Commission for Western Asia. https://www.unescwa.org/sites/default/files/pubs/pdf/second-arab-multidimensional-poverty-report-english.pdf

Esping-Andersen, G. (1990). *The three worlds of welfare capitalism*. Polity Press.

Fakih, A., Haimoun, N., & Sleiman, A. (2022). What drives demand for private tutoring in the Middle East and North Africa region? Evidence from a youth survey. *African Development Review, 34*(2), 268–279. https://doi.org/10.1111/1467-8268.12626

Görmüş, E. & Akçalı, E. (2020). Variegated forms of embeddedness: Home-grown neoliberal authoritarianism in Tunisia under Ben Ali. *Journal of International Relations and Development*, *24*, 408–429. https://doi.org/10.1057/s41268-020-00196-7

Grinin, L. & Korotayev, A. (2022). The Arab Spring: Causes, conditions, and driving forces. In J.A. Goldstone, L. Grinin, & A. Korotayev (Eds.), *Handbook of revolutions in the 21st century: The new waves of revolutions, and the causes and effects of disruptive political change* (pp. 595–624). Springer International Publishing. https://doi.org/10.1007/978-3-030-86468-2

Hanson, K., Brikci, N., Erlangga, D., Alebachew, A., De Allegri, M., Balabanova, D., Blecher, M., Cashin, C., Esperato, A., Hipgrave, D., Kalisa, I., Kurowski, C., Meng, Q., Morgan, D., Mtei, G., Nolte, E., Onoka, C., Powell-Jackson, T., Roland, M., & Sadanandan, R. (2022). The *Lancet Global Health* Commission on financing primary health care: Putting people at the centre. *The Lancet Global Health*, *10*(5), 715–772. https://pmc.ncbi.nlm.nih.gov/articles/PMC9005653/

Heyneman, S.P. (1997). The quality of education in the Middle East and North Africa (MENA). *International Journal of Educational Development*, *17*(4), 449–466. https://doi.org/10.1016/S0738-0593(97)00022-9

Hoogland, R., Hoogland, L., Handayani, K., Sitaresmi, M., Kaspers, G., & Mostert, S. (2022). Global problem of physician dual practices: A literature review. *Iranian Journal of Public Health*, *51*(7), 1444–1460. https://doi.org/10.18502/ijph.v51i7.10079

Ianchovichina, E., Mottaghi, L., & Devarajan, S. (2015). *Inequality, uprisings, and conflict in the Arab world*. World Bank. http://documents.worldbank.org/curated/en/303441467992017147/Inequality-uprisings-and-conflict-in-the-Arab-World

Ibrahim, S. (2021). The dynamics of the Egyptian social contract: How the political changes affected the poor. *World Development*, *138*, 105254. https://doi.org/10.1016/j.worlddev.2020.105254

Kallas, C., Foda, H., Rosbe, H., Robinson, J.P., & Elliott, M. (2022, May 19). *3 insights on expanding the impact of early learning opportunities in Jordan*. Brookings. https://www.brookings.

edu/articles/3-insights-on-expanding-the-impact-of-early-learning-opportunities-in-jordan/

Karshenas, M., Moghadam, V.M., & Alami, R. (2014). Social policy after the Arab Spring: States and social rights in the MENA region. *World Development*, *64*, 726–739. https://doi.org/10.1016/j.worlddev.2014.07.002

Katoue, M.G., Cerda, A.A., García, L.Y., & Jakovljevic, M. (2022). Healthcare system development in the Middle East and North Africa region: Challenges, endeavors and prospective opportunities. *Frontiers in Public Health*, 10. https://doi.org/10.3389/fpubh.2022.1045739

Khalife, J., Rafeh, N., Makouk, J., El-Jardali, F., Ekman, B., Kronfol, N., Hamadeh, G., & Ammar, W. (2017). Hospital contracting reforms: The Lebanese Ministry of Public Health experience. *Health Systems & Reform*, *3*(1), 34–41. https://doi.org/10.1080/23288604.2016.1272979

Khawaja, M., Dawns, J., Meyerson-Knox, S., & Yamout, R. (2008). Disparities in child health in the Arab region during the 1990s. *International Journal for Equity in Health*, *7*(1). https://doi.org/10.1186/1475-9276-7-24

Khondker, H.H. (2024). Social inequality in the MENA region. In *Springer eBooks* (pp. 1–17). https://doi.org/10.1007/978-3-030-97417-6_94-1

Kim, S. (2019). *Preliminary study on regional inequalities in Tunisia: Demography of Tunisia in the early 20th century*. https://www.ide.go.jp/library/English/Publish/Reports/InterimReport/2018/pdf/2018_2_40_013_ch03.pdf

Kolstad, K. (2018). *Accessing education in the midst of the Syria crisis*. Norwegian Refugee Council. https://www.nrc.no/news/2018/april/accessing-education-in-the-midst-of-the-syria-crisis/

Krafft, C., Assaad, R., Nazier, H., Ramadan, R., Vahidmanesh, A., & Zouari, S. (2019). Estimating poverty and inequality in the absence of consumption data: An application to the Middle East and North Africa. *Middle East Development Journal*, *11*(1), 1–29. https://doi.org/10.1080/17938120.2019.1583493

Li, H., Loyalka, P., Rozelle, S., & Wu, B. (2017). Human capital and China's future growth. *Journal of Economic Perspectives*, *31*(1), 25–48. https://doi.org/10.1257/jep.31.1.25

Loewe, M., Zintl, T., & Houdret, A. (2021). The social contract as a tool of analysis: Introduction to the special issue on "Framing the evolution of new social contracts in Middle Eastern and North African countries." *World Development*, *145*, 104982.

Malik, A. (2017). Rethinking the rentier curse. *Revue Internationale de Politique de Développement*, *7*, 41–57. https://doi.org/10.4000/poldev.2266

Marginson, S. (2017). Limitations of human capital theory. *Studies in Higher Education*, *44*(2), 287–301. https://doi.org/10.1080/03075079.2017.1359823

Marmot, M., Friel, S., Bell, R., Houweling, T.A., & Taylor, S. (2008). Closing the gap in a generation: Health equity through action on the social determinants of health. *The Lancet*, *372*(9650), 1661–1669. https://doi.org/10.1016/S0140-6736(08)61690-6

Mate, K., Bryan, C., Deen, N., & McCall, J. (2017). Review of health systems of the Middle East and North Africa region. In *International encyclopedia of public health* (pp. 347–356). https://doi.org/10.1016/B978-0-12-803678-5.00303-9

Moshrif, R. (2022). *Income inequality in the Middle East*. World Inequality Lab. https://wid.world/document/income-inequality-in-the-middle-east-world-inequality-lab-issue-brief-2022-06/

Muhieddine, D., Farhat, T., Ibrahim, S., Al-Yahya, M., Al-Sheyab, N., Zeng, W., Halasa-Rappel, Y., Jarawan, E., Diab, J., Hashoush, M., & Fouad, F. (2022). *The Big Questions in Forced Displacement and Health: Jordan Country Report* (pp. 1–93). UKaid, UNHCR & World Bank Group. https://www.publichealth.columbia.edu/sites/default/files/media/documents/2023-03/jordan_v3-compressed_1.pdf

Muslah, A.F. & Abbas, N.F. (2023). Gendered social-interactional contexts in educational institutions in Iraq. *Journal of Ethnic and Cultural Studies*, *10*(2), 191–202. https://www.jstor.org/stable/48728407

Ncube, M., Anyanwu, J.C., & Hausken, K. (2014). Inequality, economic growth and poverty in the Middle East and North Africa (MENA). *African Development Review*, *26*(3), 435–453. https://doi.org/10.1111/1467-8268.12103

OECD. (2017). *The pursuit of gender equality*. OECD Publishing. https://doi.org/10.1787/9789264281318-en

OECD. (2022a). *Navigating beyond COVID-19: Recovery in the MENA region* (pp. 1–117). OECD Publishing. https://doi.org/10.1787/48300c64-en

OECD. (2022b). *OECD economic surveys: Tunisia 2022*. OECD Publishing. https://doi.org/10.1787/7f9459cf-en

Omar, M.A. & Inaba, K. (2020). Does financial inclusion reduce poverty and income inequality in developing countries? A panel data analysis. *Journal of Economic Structures*, *9*(37). https://doi.org/10.1186/s40008-020-00214-4

Omar, O. & El Bastawissi, I.Y. (2022). Bringing the SDGs to life by 2030: Best practices in higher education within the Middle East region. In L. Filho, I.R. Abubakar, R. da Silva Pretorius, & K. Tarabieh (Eds.), *SDGs in Africa and the Middle East region* (pp. 1–26). Springer International Publishing. https://doi.org/10.1007/9783030912604_21

Pande, A., El Shalakani, A., & Hamed, A. (2017). How can we measure progress on social justice in health care? The case of Egypt. *Health Systems & Reform*, *3*(1), 14–25. https://doi.org/10.1080/23288604.2016.1272981

Pouw, N. & Bender, K. (2022). The poverty reduction effect of social protection: The pros and cons of a multidisciplinary approach. *The European Journal of Development Research*, *34*, 2204–2223. https://doi.org/10.1057/s41287-022-00505-5

Powell-Davies, P. (2015). *Education reform and improvement in MENA*. British Council. https://www.britishcouncil.org.eg/en/symposium/thought-pieces/education-reform-and-improvement-mena

Rizk, R. & Hawash, R. (2020). Education gap and youth: A growing challenge in the MENA region. *RePEc: Research Papers in Economics*, *790*. https://www.econstor.eu/handle/10419/228341

Robbin, Z.H. (2022). *Women's labour force participation and COVID-19 in Jordan*. Middle East Institute. https://www.mei.edu/publications/womens-labor-force-participation-and-covid-19-jordan

Roberts, M., Hsiao, W., Berman, P., & Reich, M. (2008). *Getting health reform right*. Oxford University Press. https://doi.org/10.1093/acprof:oso/9780195371505.001.0001

Salehi-Isfahani, D., Hassine, N. B. & Assaad, R. (2013). Equality of opportunity in educational achievement in the Middle East and North Africa. *The Journal of Economic Inequality*, *12*, 489–515. https://doi.org/10.1007/s10888-013-9263-6

Scarrone, N. (2021). *The education paradox in the Southern and Eastern Mediterranean – Youth, human capital and transition to work*. IEMed. https://www.iemed.org/publication/the-education-paradox-in-the-southern-and-eastern-mediterranean-youth-human-capital-and-transition-to-work/

Silva, J., Levin, V., & Morgandi, M. (2013). *Inclusion and resilience: The way forward for social safety nets in the Middle East and North Africa*. World Bank.

Tan, C.Y. (2024). Socioeconomic status and student learning: Insights from an umbrella review. *Educational Psychology Review*, *36*(4). https://doi.org/10.1007/s10648-024-09929-3

Topuz, S.G. (2022). The relationship between income inequality and economic growth: Are transmission channels effective? *Social Indicators Research*, *162*(3). https://doi.org/10.1007/s11205-022-02882-0

UNICEF. (2017). *Situation analysis of children in Jordan 2017: Summary*. UNICEF. https://www.unicef.org/jordan/media/506/file

UNICEF. (2019). *Over one third of adolescents aged 15 to 17 are out of school across the Middle East and North Africa*. https://www.unicef.org/mena/press-releases/over-one-third-adolescents-aged-15-17-are-out-school-across-middle-east-and-north

UNICEF. (2021). *Situational analysis of women and girls in the Middle East and North Africa*. https://www.unicef.org/mena/reports/situational-analysis-women-and-girls-middle-east-and-north-africa

United Nations Office for the Coordination of Humanitarian Affairs. (2019). *Regional report*. https://menawomenandgirlsanalysis.org/

Verme, P., Milanovic, B., Al-Shawarby, S., El Tawila, S., Gadallah, M., & El-Majeed, A.A. (2014). *Inside inequality in the Arab Republic of Egypt*. World Bank. https://www.worldbank.org/content/dam/Worldbank/egypt-inequality-book.pdf

WHO. (2024). *Understanding the private health sector in Tunisia* (pp. 1–70). World Health Organization, Regional Office for the Eastern Mediterranean. https://applications.emro.who.int/docs/9789292743581-eng.pdf

World Bank Group. (2016). *Poverty and shared prosperity 2016: Taking on inequality*. World Bank Publications. https://www.worldbank.org/en/publication/poverty-and-shared-prosperity-2016

World Bank Group. (2022). *Jordan: Literacy rate from 2007 to 2021, total and by gender*. https://www.statista.com/statistics/572748/literacy-rate-in-jordan/

World Bank Group. (2024). *Cash transfers incentivize social change for women and girls in Egypt*. https://www.worldbank.org/en/news/feature/2024/03/07/cash-transfers-incentivize-social-change-for-women-and-girls-in-egypt

World Economic Forum. (2023). *Global gender gap report 2023*. World Economic Forum. https://www.weforum.org/publications/global-gender-gap-report-2023/

Yazbeck, A.S., Rabie, T.S., & Pande, A. (2017). Health sector reform in the Middle East and North Africa: Prospects and experiences. *Health Systems & Reform*, *3*(1), 1–6. https://doi.org/10.1080/23288604.2016.1272984

Problemy Polityki Społecznej. Social Policy Issues 2025, 71(4): 1–27
https://doi.org/10.31971/pps/214249

Submitted: 2025-04-28/Accepted: 2025-11-14

Viktor Borshchevskyi

ORCID: 0000-0002-1868-4434
Department of Public Management, Ukrainian Catholic University, Ukraine
Department of Spatial Development, State Institution
"Institute of Regional Research named after M.I. Dolishniy
of the National Academy of Sciences of Ukraine", Ukraine

Julia Tsybulska[1]

ORCID: 0000-0001-8038-8233
Department of European Integration, Institute of Rural and Agricultural
Development, Polish Academy of Sciences, Poland

What is the impact of social isolation of internally displaced persons in rural communities? Implications for Ukraine's recovery

Abstract

This article explores the institutional and socio-economic dimensions of social isolation among internally displaced persons (IDPs) in rural territorial communities (rural hromadas) of Ukraine during 2022–2023. Framed by historical institutionalism and the social capital/integration literature, the analysis draws on focus group discussions with the IDPs in rural western Ukraine. It identifies key causes of isolation, including cultural differences, infrastructural challenges, and institutional dysfunctions such as communication gaps, lack of employment opportunities, and opaque access to

[1] **Corresponding author:** Julia Tsybulska, Department of European Integration, Institute of Rural and Agricultural Development, Polish Academy of Sciences, Nowy Świat 72, 00-330, Warszawa, Poland; email: tsybulska.yulia@gmail.com

documents and services within thin service networks. The article reveals how IDPs often face subtle forms of exclusion despite the absence of direct hostility, contributing to a decline in human and social capital in host communities. We argue for an integrated approach that includes closing the communication vacuum, strengthening community engagement through local initiatives, and launching joint educational programmes for IDPs and residents. We also emphasise participatory mechanisms, digital inclusion initiatives, and low-cost community-building activities. These measures are crucial for preventing the long-term institutionalisation of social isolation during recovery and reconstruction and for enabling the successful integration of IDPs into the social and economic life of rural Ukraine. In policy terms, linking and bridging ties – together with dependable institutional access – emerge as practical levers to reduce isolation and support rural recovery.

Keywords: rural communities, social isolation, internally displaced persons, post-war recovery, historical institutionalism

Introduction

The institutional phenomenon of social isolation has been known in economic science since the second half of the 20th century. We distinguish social isolation – an objective lack of social contacts and participation – from loneliness, a subjective perception of being isolated (Beller & Wagner, 2018). We analyse isolation across household, community, and institutional settings, drawing on social capital and integration accounts that emphasise bonding, bridging, and linking ties (Putnam, 2000; Szreter & Woolcock, 2004; Ager & Strang, 2008). Its impact became particularly relevant and even acquired a global dimension due to the COVID-19 pandemic from 2019 to 2022. Most countries worldwide introduced quarantine restrictions, which led to the emergence of various problems associated with increased social isolation for certain groups of residents and, in some cases, entire social strata. The most affected categories of citizens in this regard were individuals from so-called "risk groups", including pensioners, cancer patients, diabetics, and people with cardiovascular diseases. In many countries, support programs were specifically aimed at mitigating the issue of social isolation among vulnerable populations. Global responses to isolation during COVID-19 (e.g., home-delivery schemes for seniors, remote social services) are relevant here only as a contrast: they addressed health-related isolation, whereas wartime displacement in Ukraine generates institution – and place-dependent isolation tied to documentation, services, and mobility in rural settings. Researchers have also noted the worsening issue of social isolation among other groups, such as homeless individuals (Nóżka, 2024, p. 10), for whom staying outside shelters and other crowded places proved to be safer than participating in various socialisation programmes.

However, these aspects of social isolation largely receded into the background following the large-scale Russian invasion of Ukraine in early 2022. Since then, at least in the Ukrainian context, this issue has taken on new dimensions and more complex institutional meanings. The war led to the displacement of a large number of people

from combat zones to safer regions of Ukraine, as well as to neighbouring European countries and the EU in general. In many cases, this was accompanied by social isolation not only of individuals and families but also of entire social groups among refugees and internally displaced persons (IDPs), i.e., people displaced within a country's borders in line with the UN usage.

After 2022, the financial dependence of Ukraine's territorial communities (decentralised local-government units formed through the 2014–2020 reform; when referring specifically to rural units we use "rural hromadas"), increased significantly, particularly in rural ones. A significant share of subsidies was directed toward supporting IDPs, leading some local residents to view displaced persons as competitors for financial aid. According to Zaiats et al. (2024), rural communities also demonstrated higher per capita budget expenditures and higher spending on education and culture compared to urban areas. At the same time, social isolation of IDPs stems from objective factors, mainly difficulties in securing housing, employment, and acceptable living conditions. Research shows that the employment rate among IDPs is 10% lower than among the local population, whereas before the 2022 invasion, 60% of those now displaced had jobs, compared to 50% in host communities today, according to Malynovska and Yatsenko (2024).

In Ukraine's current context, the social isolation of IDPs results from both objective conditions and subjective factors, contributing to a decline in social and human capital in host – especially rural – communities. Here, "social capital" refers to connections among people, including networks and the associated norms of reciprocity and trust, which enable coordination and cooperation for mutual benefit (Putnam, 2000). This highlights the need for effective mechanisms to address the issue. The article aims to identify the key drivers of social isolation among IDPs in rural communities and outline priority strategies for overcoming it in the context of recovery and reconstruction. We approach IDP isolation as a "wicked problem": causes are interlocking (housing, employment, documentation, distance), stakeholders have conflicting incentives (hosts, local authorities, IDPs), evidence is incomplete in wartime, and interventions shift the problem rather than "solve" it once-and-for-all. This warrants a theoretically anchored, place-sensitive analysis and modest, testable implications.

We investigate social isolation among internally displaced persons (IDPs) in rural Ukrainian communities in 2022–2023 (post-February-2022 displacement) and draw out implications for national recovery. Framing the analysis with historical institutionalism and with research on social capital and integration, we trace how path-dependent gatekeeping and thin service networks heighten isolation, and how linking and bridging ties, together with dependable access to documents and services, can counter it.

This study is situated at the intersection of three strands: research on IDP integration; the social isolation and loneliness literature; and rural, place-based development that examines distance and "thin" service networks in low-density areas. This focus on rural hromadas connects our argument to current debates in refugee studies, social policy, and rural studies. Existing work concentrates on urban reception contexts, uses heterogeneous measures of "isolation", and rarely examines rural IDPs in Ukraine. As a result, we know less about how institutional access and social ties

interact under rural constraints such as long distances and thin service networks (Ager & Strang, 2008; Strang & Quinn, 2019; Williams et al., 2022; Pickering et al., 2023; IOM DTM, 2023; IOM DTM, 2025; Zhang & Dong, 2022).

Grounding the analysis in historical institutionalism, we link long-run legacies to the displacement shock after 2022 in rural communities and specify a place-based mechanism in which institutional access and bridging and linking ties shape isolation. We draw on qualitative evidence from focus group discussions with IDPs in rural western Ukraine and conclude with pragmatic, context-bound suggestions that follow from the analysis.

Empirically we analyse experiences from 2022–2023 in rural hromadas of western Ukraine. References to 2014–2021 serve only to situate policy and reception dynamics, while the brief discussion of the Soviet period provides historical background that motivates the theoretical lens rather than evidence within the analysis window. Because rural settings are often more closed and conservative with thinner infrastructure, the problem can intensify there (Fyshchuk & Kolesnik, 2024; Chitea & Dona, 2018). The article first sets the historical and institutional context, then examines institutional and socio-psychological aspects of IDP isolation during the war, including local-government integration challenges and host-community concerns, and finally outlines mechanisms suited to rural hromadas with a view to recovery and European-integration priorities.

Literature review

Researchers in the field of social and socio-economic issues have long noted a close relationship between citizens' social activity and their economic success. Numerous studies have shown that people with sufficiently diversified social connections – regularly communicating with friends, colleagues, business partners, and like-minded individuals – tend to find suitable jobs more easily. According to Cherry (2023), they also tend to be more successful in entrepreneurship and are less likely to suffer from depression and various psychological dysfunctions compared to those who lack social self-realisation and emotional support from their surroundings. This aligns with integration frameworks in refugee studies that foreground social connections as central to well-being and economic participation (Ager & Strang, 2008; Strang & Quinn, 2019).

Over time, the term "social isolation" has become widespread in scientific literature. However, it remains primarily a subject of study in sociology and psychology, while economists have paid much less attention to it. Nevertheless, in the economic domain, the manifestations of social isolation can have the most destructive societal impact. Psychological problems of an individual or group requiring social support or psychotherapy are one thing, but systemic manifestations of individual issues related to social isolation that spill over into the economic sphere are quite another. Modern history provides numerous examples of industrial accidents, technological disasters, traffic incidents, financial crises, and business failures caused by this seemingly inconspicuous phenomenon. Consistent with this, meta-analytic evidence shows a robust negative association between perceived social support and loneliness across contexts,

underscoring the public-health and economic salience of connectivity (Zhang & Dong, 2022).

Social isolation can take various forms, each with different causes and consequences. Two primary types are distinguished. First, physical isolation, occurring when an individual cannot interact with others due to health conditions or spatial constraints, as seen among elderly people with mobility issues, hospital patients, or individuals with disabilities. Second, psychological isolation, where individuals, despite being surrounded by others, feel lonely and disconnected due to a lack of understanding, close relationships, or experiences of rejection. This phenomenon, as noted by Urbas (2024), is particularly dangerous, as over time it can lead to memory and concentration issues, workplace conflicts, and deviant behaviour in society. In empirical work, isolation is operationalised via network size and diversity, validated loneliness scales, and participation in associations – measures that link directly to labour-market search frictions and team productivity (Ager & Strang, 2008; Strang & Quinn, 2019).

Key indicators of social isolation identified by researchers include withdrawal from social activities, ignoring family or corporate traditions, spending most of the day alone, reluctance to communicate with close ones and colleagues, loss of business contacts, lack of trust, destruction of long-standing relationships, growing latent intolerance and hostility, feelings of alienation and loneliness, and unhealthy reactions to external stimuli like loud noises, bright lights, or laughter, as identified by Widłak (2024). These indicators are also used in displacement settings to track exclusion risks among uprooted populations.

The Evolutionary Theory of Loneliness (ETL), as discussed by Beller and Wagner (2018), explores the adaptive functions of loneliness, aiding short-term survival but causing detrimental long-term effects in the modern world. ETL places the social level of organisation at the centre of studies on the human brain and behaviour, arguing that the social world's centrality stems from both social and biological processes shaped by evolutionary forces long before humans appeared. While ETL focuses on adaptive mechanisms, policy-relevant literatures in refugee and social policy studies emphasise how institutions can either buffer or amplify isolation through access to services, documentation, and legal remedies (Krakhmalova, 2022).

Social isolation remains a complex global public health issue, as highlighted by a 2023 Gallup study (Tulane University, 2020) based on over 100,000 participants across 142 countries, which revealed that nearly a quarter of the global population felt "very lonely" or "fairly lonely", meaning over a billion people worldwide lack social connection. In parallel, conflict-related internal displacement has reached record levels globally, which magnifies isolation risks in affected communities (IDMC, 2024).

The problem is particularly acute in rural areas, where interpersonal communication is less intense than in cities. Traditional conservatism and the dominance of agricultural production methods further limit opportunities for alternative communication and economic mobility. Evidence from rural studies documents both elevated risks and promising, community-based responses in low-density areas (Williams et al., 2022; Kelly et al., 2019).

In many ways, social isolation is a de facto element of rural life compared to urban areas, due to lower population density and greater physical distance between

residences. According to Pickering et al. (2023), rural residents, across various race and ethnicity divisions, are more at risk of loneliness than their urban counterparts and face disadvantages in access to social services and social capital, particularly among older adults. These disadvantages include thinner service networks and higher mobility costs that can entrench isolation, especially for older and low-income households (Williams et al., 2022).

Another important aspect is the intensification of factors exacerbating social isolation during wars and military conflicts. For example, Graham (2022) notes that approximately half of US veterans report feeling they do not belong in society after separation from military service, often experiencing social isolation despite familial support. Similar patterns of non-belonging and strained social ties are widely discussed in the refugee-integration literature (Ager & Strang, 2008; Strang & Quinn, 2019).

Older adults are often unable to flee from conflict and remain alone, without family or support, including access to medicine and food. They are especially vulnerable during outbreaks of violence, unable to shelter from danger. Research by HelpAge (2022) after the 2014 conflict in Ukraine highlights the specific risks older people face during escalations, such as separation from family and resulting social exclusion. A striking 96% of older respondents reported conflict-related mental health issues.

The social isolation of forced migrants and internally displaced persons (IDPs) is also a critical issue during war. They bear a double psychological burden: the loss of home and way of life, and the loss of livelihoods and social ties with colleagues and business partners. In Ukraine, legal-institutional analyses show how policy design and court practice shape IDPs' agency, entitlements and risks of exclusion (Krakhmalova, 2022).

Research in Ukraine reveals a consistent pattern of social isolation among internally displaced persons (IDPs), marked by loneliness, anxiety, and emotional exhaustion, regardless of location. Cultural disconnection plays a key role – war-induced shifts in social norms create alienation in native communities, while adapting to new cultural settings in host areas presents its own challenges. IDPs are also more vulnerable to stigma, bias, and anxiety in social interactions (Tsybuliak et al., 2024). Recent displacement-tracking analyses likewise foreground social cohesion, trust, and perceived fairness as determinants of integration trajectories (IOM DTM, 2023; IOM DTM, 2025).

Evidence from other conflict-affected settings shows similar mechanisms with context-specific manifestations. In Colombia, internal displacement produces sizeable and persistent labour-market penalties and scarring, including higher unemployment, greater informality, and slower earnings recovery, even in receiving cities. (Calderón-Mejía & Ibáñez, 2015; Ibáñez et al., 2022). In Nigeria, studies document large gaps in rights protection and access to healthcare among IDPs, with high burdens of infectious disease and barriers to care in camp settings (Ekezie et al., 2021; Acha-Anyi, 2024). In Syria, research highlights severe obstacles to healthcare for the IDPs within a fragmented system, contributing to excess mortality and poor treatment outcomes in high-need areas (Abbara et al., 2022). These cross-country findings qualify our claims and help delineate the external validity of results from rural Ukraine.

Beyond historical and psychological drivers of social isolation in rural Ukraine, recent studies stress the importance of sustainable development, poverty reduction, and access to services. Łuczak and Cermakova (2024) propose a framework for assessing territorial development, emphasising regional policy's role in strengthening social cohesion. Kalinowski et al. (2025) highlight multidimensional poverty in rural Poland, showing that limited access to healthcare, education, and transportation intensifies social exclusion and obstructs integration. Taken together, this supports a place-based policy approach that pairs social protection with investments in transport, healthcare and education in low-density areas (Williams et al., 2022; Kelly et al., 2019).

Thus, the issue of social isolation of IDPs in Ukraine's rural territorial communities – now in the third year of war – is relevant not only in applied terms but also theoretically and methodologically. It requires a comprehensive analysis and justification of effective institutional mechanisms for its mitigation. Our analysis is, therefore situated within current debates in top scientific discussions in refugee studies, social policy, and rural studies (e.g., Journal of Refugee Studies, Social Policy and Society, Journal of Rural Studies).

The analysis draws on two main theoretical strands. First, historical institutionalism explains how inherited rules and routines generate path dependence; legacies of gatekeeping or defensive withdrawal can persist under new shocks, with change often occurring through layering and conversion rather than abrupt replacement (Pierson, 2000; Mahoney & Thelen, 2012; Thelen, 1999; North, 1990). Second, the social capital/integration literature distinguishes bonding ties (within-group) from bridging (across groups) and linking ties (to public authorities and services); bridging and linking ties are especially important for access, opportunity, and trust in new settings (Putnam, 2000; Ager & Strang, 2008; Szreter & Woolcock, 2004). Therefore, we read rural isolation as an interaction between historical gatekeeping routines (HI) and the structure of ties plus institutional access. Our empirical section explores these expectations qualitatively using FGD evidence of post-February-2022 displacement.

Research methodology

The methodological framework of this study is based on the theory of institutional economics, taking into account the fundamental postulates of human and social capital theories. In particular, it relies on the contributions of economic scholars regarding methods and tools for analysing institutional dysfunctions in the context of their impact on transaction costs in different types of economic systems, including rural economies. The key principles of institutional analysis are also applied to identify characteristic interrelations between various groups of economic agents in rural territorial communities of Ukraine. This has made it possible to identify the impact of institutional distortions caused by the social isolation of IDPs on the economic development of the studied communities, including the post-war recovery phase of their economies. The study's empirical window is 2022–2023 (post-February-2022 displacement), with contextual references to 2014–2021; the primary setting comprises rural hromadas in western Ukraine.

Guided by historical institutionalism and the social capital and integration perspective, our codebook tracked three domains: legacy gatekeeping and path dependence; institutional access (documents, services, decision channels); and types of ties (bonding versus bridging and linking). This allowed us to trace historical-institutionalist mechanisms in participants' narratives (e.g., boundary work – "capsularisation" – as gatekeeping; improved administrative access as conversion that reorients local routines). These are working expectations suited to qualitative inquiry, not claims of general causality.

The socio-empirical aspect of this research is based on the methodological framework of sociology, using specialised approaches that form the theoretical, methodological, and procedural-instrumental foundation for empirical studies of social processes. Specialised sociological theories ("middle-range theories"), as described by Verbets (2007), focus on identifying specific manifestations of general sociological laws within defined spatial and temporal contexts. They translate general methodological principles into the language of concrete sociological research to ensure reliable characteristics of the object and serve a prognostic function by enabling the formulation of scientific hypotheses.

The sources of informational materials for studying the outlined problem included publications by scholars and experts specialising in the research subject. Additionally, analytical materials developed by specialised institutions studying rural economy issues and the institutional development of social systems in crisis situations were used. These materials particularly focused on eradicating the prerequisites and factors that contribute to the social isolation of various categories of citizens, including forced migrants.

We use exploratory qualitative evidence from focus group discussions (FGDs) with internally displaced persons (IDPs) residing in five territorial communities in Lviv region (oblast) – Yavorivska, Pustomytivska, Stryiska, Horodotska, and Drohobytska. Fieldwork took place between July 2023 and January 2024. The study was implemented under the project "Synergy of Cross-Sector Partnerships for Integrating Relocated Business into the Community's Economic Space" by the Agency for Local Economic Development of Yavorivshchyna. Recruitment was purposive via local social services and IDP coordinators; eligibility: adults (18 years or older), IDP status (formal or de facto), current residence in a locality within the listed communities. We conducted five FGDs (one per community) with approximately 10–15 participants each (total $\approx$ 50–75). Sessions lasted 60–120 minutes, were facilitated by trained moderators; detailed notes were taken and, where consented, sessions were audio-recorded. Analysis followed thematic coding with a shared codebook; quotes are anonymised. As a non-probability qualitative design, findings are not statistically generalisable.

To complement FGD themes, the team also held ten semi-structured in-depth interviews with managers of relocated enterprises operating in the same five communities (approximately 45–75 minutes) and convened a closing community forum (approximately 50 participants); these materials inform context but are not the primary unit of analysis here. A small structured questionnaire (up to roughly 70 forms across sites) was used descriptively to prompt discussion; any reported shares indicate theme salience across FGDs rather than population estimates. Data were stored as facilitator notes and, where consented, audio files; the internal project report is on file

with the implementer and not publicly released. Participation was voluntary with informed consent and anonymisation, in line with the implementer's ethics guidance.

Evolution of the problem of social isolation in rural territorial communities of Ukraine: the "collective farm period" and the post-totalitarian context

This section provides historical context (pre-1991 and early post-totalitarian legacies) to motivate a historical-institutionalist reading of today's rural dynamics; it does not extend the empirical window beyond 2022–2023 (post-February-2022 displacement).

Rural hromadas in Ukraine have inherited entrenched institutional remnants – rooted in the Soviet planned economy and its routine social isolation – that still shape village relations. The issue was largely ignored under the collective-farm system and after 1991, and even the 2014–2016 territorial reform offered no conceptual reassessment; instead, unresolved isolation complicated decentralisation, especially in rural areas. In historical-institutionalist terms, these legacies reflect path dependence and change via layering and conversion rather than abrupt replacement (Pierson, 2000; Mahoney & Thelen, 2012; North, 1990). From the start of Soviet rule, social isolation became built into rural life in Ukraine. Different groups experienced it in alternating waves, and although its forms shifted, it remained a constant feature of the centralised planned system.

In the 1920s, the Bolsheviks brought the "Red Terror" to Ukrainian villages, followed by mass collectivisation and the isolation of so-called "kulaks", wealthy peasants capable of running efficient individual farms (today we would call them farmers). Many were executed, deported, or branded as enemies, and prosperous peasants thereafter concealed their assets to avoid ostracism, an early and enduring form of social isolation. Researchers note that as early as 1919 the Bolsheviks launched mass repressions: revolutionary tribunals and commissions monopolised violence, targeting affluent peasants, the rural intelligentsia, and clergy, and carrying out uncontrolled executions (Seredynskyi, 2020). Unable to flee, many members of the rural elite withdrew into a "social underground", one of the harshest forms of isolation.

Later, this problem significantly intensified and became more complex with the onset of mass collectivisation. One of the main slogans of collectivisation was the "Liquidation of the Kulaks as a Class". In this regard, a special resolution of the Central Committee of the All-Union Communist Party (Bolsheviks) was adopted on January 30, 1930, titled "On Measures for the Liquidation of Kulak Households in Areas of Complete Collectivisation". According to this resolution, all kulak households were divided into three categories ("Kolektyvizatsiya ukrains'koho sela", 2012):

1. Economically strong households belonging to active opponents of collectivisation (their owners were to be "isolated" in prisons and labour camps);
2. Economically stable households whose owners did not resist collectivisation (they, along with their families, were exiled, mostly to Siberia);
3. Relatively strong and stable "middle-peasant" households that did not resist (the social isolation of their owners was carried out by granting them small land plots outside the newly created collective farm areas).

Despite official claims of "victorious" collectivisation, resistance persisted among nationally conscious Ukrainians, wealthy peasants, the rural intelligentsia, and national minorities – especially Polish and German communities. Branded by the Soviet government as centres of petty-bourgeois resistance, these areas experienced especially brutal collectivisation and persecution, peaking in the late 1920s and early 1930s (Yakubova, 2004).

This policy, which targeted 10%–20% of Ukrainian peasants – mainly effective farmers, rural intelligentsia, and clergy – with persecution and social isolation, triggered even deeper problems. The brutal destruction of traditional rural life, intensified by repression and misanthropic Bolshevik policies, culminated in one of the greatest tragedies of the 20th century – the Holodomor of 1932–1933.

This genocidal policy targeted the national identity and deeply rooted individualism of Ukrainian peasants, which conflicted with Bolshevik ideology. As documented by the Holodomor Museum (2024), it was implemented through legalised violence and mass killings of those who tried to leave collective farms or reclaim property (livestock, tools, grain). The regime then banned peasants from owning grain or livestock and even from gleaning abandoned harvest remnants; violations carried up to ten years' imprisonment with confiscation or execution. Special brigades searched homes and seized grain, enforcing terror through physical and psychological abuse.

The moral trauma of the Holodomor and its precursor, collectivisation, lodged deeply in Ukrainians' collective subconscious and was transmitted across generations. Even after independence, many rural households kept dried bread, salt, sugar, and barrels of lard "for a rainy day". Authorities and self-styled "progressive" circles stigmatised such prudence as "vestiges of kulak mentality", "anti-people attitudes", or "stinginess", fostering palpable alienation and, at times, social isolation.

After World War II, another layer of social dysphoria was added to this issue. Alongside the "kulak descendants", other groups were labelled as "alien elements" in Ukrainian villages: "fascist collaborators", "Bandera remnants", and "descendants of police officers", terms used indiscriminately to describe nearly all villagers who had lived under the occupation.

As in the 1930s, a new wave of repression followed after World War II. Thousands of families were deported, and rural intellectuals were barred from their professions. The 1947 famine, driven by food seizures and repression, deepened social isolation in villages. It also ingrained fear of the authorities and distrust among villagers – anyone could be betrayed for hiding even a crust of bread.

The famine of 1946–1947 was triggered by a combination of extreme drought, post-war devastation, and a shortage of male labour for cultivating land. Adding to this was the cessation of food supplies from the United States under the Lend-Lease programme. According to the Ukrainian Institute of National Remembrance (2021), the Soviet government, eager to demonstrate the superiority of communism, prioritised grain exports to drought-stricken Eastern European countries. To fulfil unrealistic state quotas – over 360 million poods of grain from Ukraine to Moscow – grain was confiscated not only from collective farms but also from private households. A large portion of the collected grain rotted in storage facilities but was not redistributed to

the starving population. Stalin's "Law on Five Ears of Grain" still applied, threatening even children with labour camps for gleaning. In desperation, people ate goosefoot, acacia blossoms, mallow, sparrows, and even mice.

All this bred latent intolerance toward the authorities and their most zealous enforcers, often outsiders, especially ethnic Russians known in Western Ukraine as "osvoboditeli" ("liberators"). A deep divide emerged between party-economic elites and the rural majority; in some villages it hardened into unspoken norms that discouraged marriage with members of the "alien" administrative milieu.

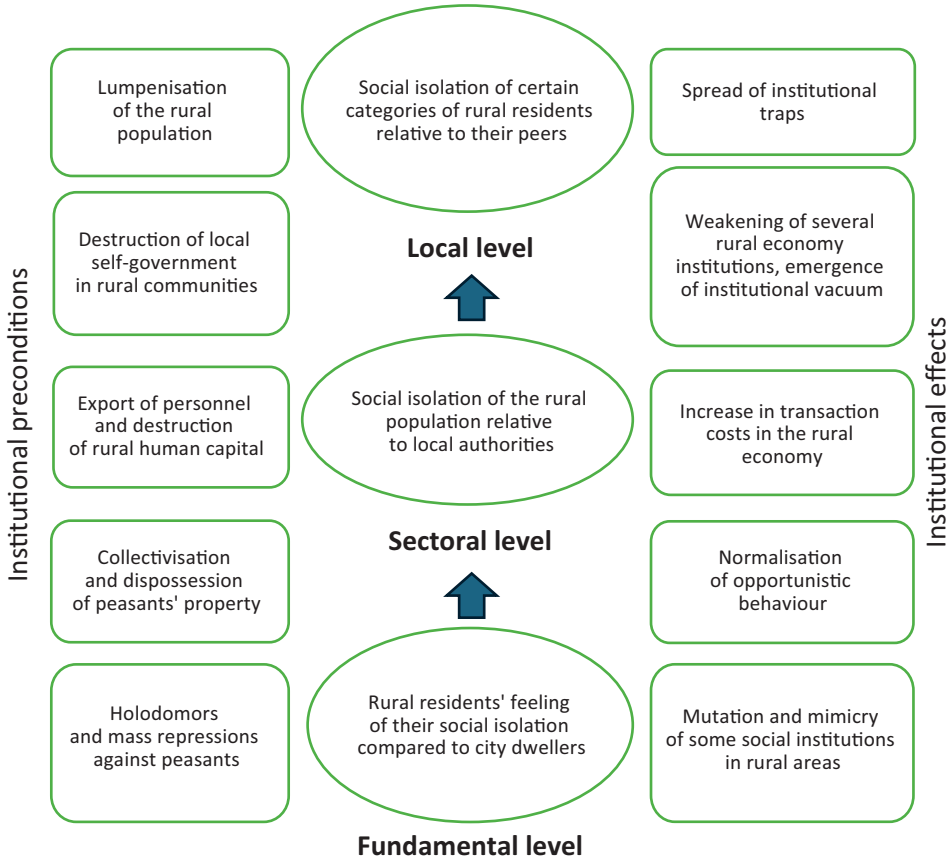
To some extent, this process was reciprocal. Soviet authorities deeply distrusted Ukrainian peasants, effectively keeping them in a state of serfdom. Until the 1970s, rural residents were denied passports, binding them to collective farms. At age 16, they were automatically enrolled as farm workers and needed special permission to leave their villages. Only in 1976 did they begin receiving passports, yet even then, employment in cities required official documentation from the farm administration (Pyvovarov, 2024).

All this effectively institutionalised social isolation of peasants as state policy, reinforced daily by the stereotype of the "backward villager". Even when rural residents moved to cities as students, factory workers or officials, they encountered subtle suppression and open discrimination, epitomised by "limita," the Soviet system of residential quotas that restricted rural migrants' urban rights. "Harmless" jokes, patronising kindness and condescending remarks were common. These patterns, internalised in self-perception and everyday mental habits, entrenched a lasting sense of separation from the societal mainstream.

Scholars of Soviet life have described a peculiar social phenomenon known as "out-being", "un-realness", or "self-obliteration". It refers to a state in which individuals, while formally complying with ideological requirements, effectively withdrew from official life, retreating into social niches beyond political control. Large segments of the rural population deliberately avoided political and social engagement, forming communities of "their own". Official discourse was seen less as false than irrelevant; instead of "conscious builders of communism", isolated enclaves pursued a "normal life", mimicking required rituals (parades and communal labour days) without conviction. The world split into "ours" and "others" – activists, the nomenklatura, dissidents, and criminals (Lakinsky & Kulchynsky, 2021). The term "ours" recurs in late-socialist memoirs and persists in independent Ukraine, often signalling distance from the official state position.

Thus, in Ukrainian social tradition, the rural community evolved alongside the entrenchment of a three-tier institutional system that shaped and perpetuated social isolation as an inherent attribute of rural life. In HI terms, these are durable "rules and routines" whose effects persist via reproduction and conversion into contemporary practices (e.g., boundary-making, gatekeeping, defensive withdrawal), thereby shaping today's reception of newcomers. Layering means adding new rules on top of existing ones, while conversion repurposes existing rules toward new goals (Mahoney & Thelen, 2012). The various forms of social isolation that developed in rural communities over time can be schematically illustrated in Figure 1.

Figure 1. Forms of social isolation prevalent in rural territorial communities of Ukraine (evolutionary context)



The most common negative institutional effects resulting from the described destructive socio-economic processes and political phenomena include the mutation and mimicry of rural social institutions (family, local government, cooperation, private property, etc.); the entrenchment of opportunistic behaviour among peasants (mainly in passive forms – lower labour productivity, deviant behaviour, ignoring or covertly sabotaging government decisions, falsification); increased transaction costs in the rural economy, leading to highly inefficient collective farm operations; the weakening of several rural economy institutions and the emergence of an institutional vacuum (especially regarding intermediary organisations, infrastructure, and qualified personnel training); as well as the spread of institutional traps such as barter settlements, bribery, corruption, and counterfeit production. We refer to these as "lock-ins" (locally stable equilibria that are costly to exit), consistent with HI accounts of path dependence (Pierson, 2000).

Character of social isolation in rural territorial communities of Ukraine and the IDPs in current conditions

Two complementary lenses guide the analysis: historical institutionalism, which traces how path-dependent routines, gatekeeping and defensive withdrawal (retreat from wider engagement into familiar in-group routines) persist (Pierson, 2000), and the social capital and integration literature, which highlights the role of linking and bridging ties, together with clear institutional access to documents, services, and decision channels, in reducing isolation in rural hromadas.

All the institutional effects mentioned, which accompanied the process of entrenching social isolation in the Ukrainian rural society over decades, led to the transformation of social isolation into a kind of inherent institutional characteristic of all rural territorial communities in Ukraine. It manifested most noticeably in those communities whose socio-economic development was influenced by agricultural monoculture and their distance from urban agglomerations. This phenomenon became especially pronounced during the initiation and implementation of the administrative-territorial reform in Ukraine (2014–2021), reaching its peak after the large-scale Russian invasion.

In this context, the main institutional factors contributing to the spread of social isolation in Ukrainian rural communities included institutional traps (corruption trap, shadow economy trap, barter transaction trap, and the self-fulfilling pessimistic expectations trap) and the vacuum of important institutions (primarily the lack of regulatory legal acts and unwritten rules regulating interactions between rural residents, local self-government bodies, state authorities, civil society institutions, and businesses). These factors were further aggravated by the opportunistic behaviour (strategic self-interest under weak enforcement) (Williamson, 1985) of rural residents and local elites (manifested in resistance to reforms, information concealment, and even sabotage of management decisions), as well as by institutional dysfunctions such as the mutation and mimicry of institutions, particularly within civil society and local governments.

For example, institutional traps, which still pose one of the greatest threats to the rural economy, evolved mainly due to illicit benefits gained by small but influential local interest groups. This not only reduced the efficiency of using available natural, human, and financial resources in rural territorial communities but also stimulated the spread of various forms of social isolation.

Thus, institutional traps formed the basis for the emergence of a specific form of social isolation among some peasants, such as group or "clan" self-isolation. This mainly concerned corruption, barter, or illegal institutional traps. Their participants tended to isolate themselves from the rest of the rural society, grouping mainly among themselves. This fostered a cautious or even unfriendly attitude towards outsiders, including members of other clans, although informal "non-aggression pacts" were often established. Other community members had little influence and were forced to tolerate the situation.

Outsiders (or "newcomers") threatened participants in institutional traps by risking disruption or information leakage. Urban incomers, researchers, project staff, and

foreign experts often faced "blocking" isolation – a preventive practice allied to clan self-isolation – where they were tacitly or openly "capsuled" away from everyday rural life. Sometimes this appeared hospitable (tours, invitations to public events) yet kept them from the community's real processes; when they sought deeper access, clan brokers mobilised residents to resist and press for their departure. We use capsularisation to mean boundary-making and gatekeeping closure that restricts cross-group interaction (Lamont & Molnár, 2002), and social blocking to mean informal or administrative access barriers for newcomers.

Loyal-type social isolation usually affected temporary visitors to rural communities, such as experts, foreign guests, or relatives visiting from cities. In contrast, "aggressive capsularisation" targeted outsiders seeking to integrate into the local institutional environment – investors, candidates for local government positions, or those aiming for employment in communal enterprises, healthcare, education, or cultural institutions. In social-capital terms, such closure suppresses bridging and linking ties that otherwise could reduce isolation and improve access to services and jobs.

With the appearance of IDPs, they were perceived as "suspicious outsiders" and risked falling into the same "capsulation" trap of social isolation – either of the loyal type (if they declared intentions to migrate abroad, move to another, usually urban, community, or return home after the war) or of the aggressive type (if they attempted to start a business or find permanent work locally, especially in government bodies).

The empirical references in this section draw on our 2022–2023 focus group discussions (FGDs) with IDPs across five rural communities in Lviv region (plus a small supplementary questionnaire and a closing forum used for context). Where shares are mentioned, they indicate relative salience across FGDs and are not population estimates.

FGD findings (2022–2023, five rural communities in Lviv region) show that, despite attention from local authorities, many displaced persons did not perceive genuine interest in cooperation from the local population or businesses. Participants frequently reported poor information about employment options, retraining, and the host community's culture and economic traditions. Support was experienced mainly as material and household assistance rather than integration, so many IDPs did not plan to remain in host communities, preferring to return home after the war or to move to cities in search of better opportunities.

Unlike traps rooted in illegalisation and corruption, the institutional trap of self-fulfilling pessimistic expectations operates through the internalisation of destructive forecasts, not the pursuit of illicit gains. Rather than "capsulating" outsiders, participants adopt opportunistic behaviour to minimise perceived risks such as rising unemployment, inflation or poverty. As a result, "carriers of threat", including IDPs, face isolation via ignoring, concealment of essential information, the creation of informational barriers and the spread of information asymmetries. Those least known to trap participants are most exposed, which makes IDPs particularly vulnerable. We treat this as an expectations-driven lock-in: defensive behaviour becomes self-reinforcing unless countered by trusted linking ties and clear institutional access.

The systemic effects of the self-fulfilling pessimistic expectations trap, contributing to the deepening of social isolation of IDPs in rural territorial communities of Ukraine,

as outlined by Borshchevskyi (2014), can be summarised as follows: widespread demoralisation caused by poverty, hardship, and war-related disruptions; loss of belief in the possibility of personal well-being; consolidation of social pessimism and a sense of hopelessness; proliferation of deviant behaviours (e.g., alcoholism, theft, idleness); internalisation of the notion that "social activity causes problems"; growing distrust toward those who hold different views; and marginalisation and exclusion of "alternative" social elements, including IDPs.

Another important factor contributing to the social isolation of IDPs in rural communities has been the long-standing institutional mutations and mimicry of key institutions. These include the erosion of local self-government's core functions, the motivational distortion of civil society organisations, and dysfunctions within the business sector. Instead of genuinely supporting IDP settlement and integration, some actors merely simulate activity – civil society efforts often remain superficial, limited to the scope of grant-funded initiatives, while local authorities and businesses tend to see IDPs more as a burden than a potential resource.

For example, research among Ukrainian IDPs revealed that in rural territorial communities, they often sense a lack of genuine engagement from local authorities in addressing their needs (Integration of internally displaced persons in host communities, 2023). Some respondents also reported excessive bureaucracy in administrative procedures, while cooperation with civil society organizations is frequently perceived as passive and ineffective.

It is also important to note that the prolonged hostilities in Ukraine – and their expected social and economic consequences for rural areas (e.g., damage to energy infrastructure, demographic decline, inflation, rising prices, mobilisation, and casualties) – intensify the destructive effects of institutional dysfunctions contributing to the social isolation of IDPs in rural communities.

For instance, in everyday conversations and even expert discourse in rear regions, narratives increasingly place blame on IDPs for their own hardships. This is often linked to the perception that residents of occupied or frontline regions had supported pro-Russian parties, and fled rather than defending their homes. Such views only deepen the divide and hinder the integration of IDPs, especially in rural areas.

In this context, it is particularly worth mentioning the traumatic social experience of Ukrainian village residents, which has become ingrained in their institutional memory. Such psychological experiences often resurface in critical situations, making IDPs especially vulnerable to the effects of these historical projections. First, many IDPs are Russian-speaking, which may provoke caution among predominantly Ukrainian-speaking rural populations. Second, they come from regions historically associated with repressive or authoritarian forces that brought suffering to peasants in central and western Ukraine. Third, cultural and mental differences between IDPs and local residents often require the latter to step out of their comfort zone – something particularly difficult in conservative rural settings. As a result, it is often easier for communities to distance themselves from newcomers, pushing them into social isolation rather than working toward integration.

Some rural communities are now so depleted that they struggle to meet even basic needs. Assistance is often delivered on a "take what you are given" basis, without

regard to actual needs, and forced migrants are increasingly seen as a burden rather than a resource. Community activists also note low social activity and weak job search among IDPs; in some places fewer than 1% are registered with employment centres even after three years without work. Support, therefore, narrows to material aid, fostering dependence on subsidies, fatigue among hosts, and growing alienation. In such conditions, the drivers of isolation intensify (Stelmakh, 2024). By contrast, where rural administrations establish clear channels to services such as documents, employment centres, and retraining, and involve IDPs in local councils or volunteer initiatives, participants report lower isolation and more frequent bridging contacts.

Another interesting social phenomenon that emerged in this context is the transfer of the objective spatial division of people, which existed before the war, into subjective social alienation within the same rural territorial communities. People meet in the streets, shops, hospitals, schools, and on public transport, even live nearby, yet remain mentally in different regions, separated by an invisible distance. The IDPs, even without much contact with one another, often form a distinct social group with its own psychological orientations, visible in politics, leisure, work, religion, parenting and daily routines. Feeling out of place, they drift into social isolation, which in rural settings is reinforced by the absence of established IDP networks that could ease loneliness and counter alienation.

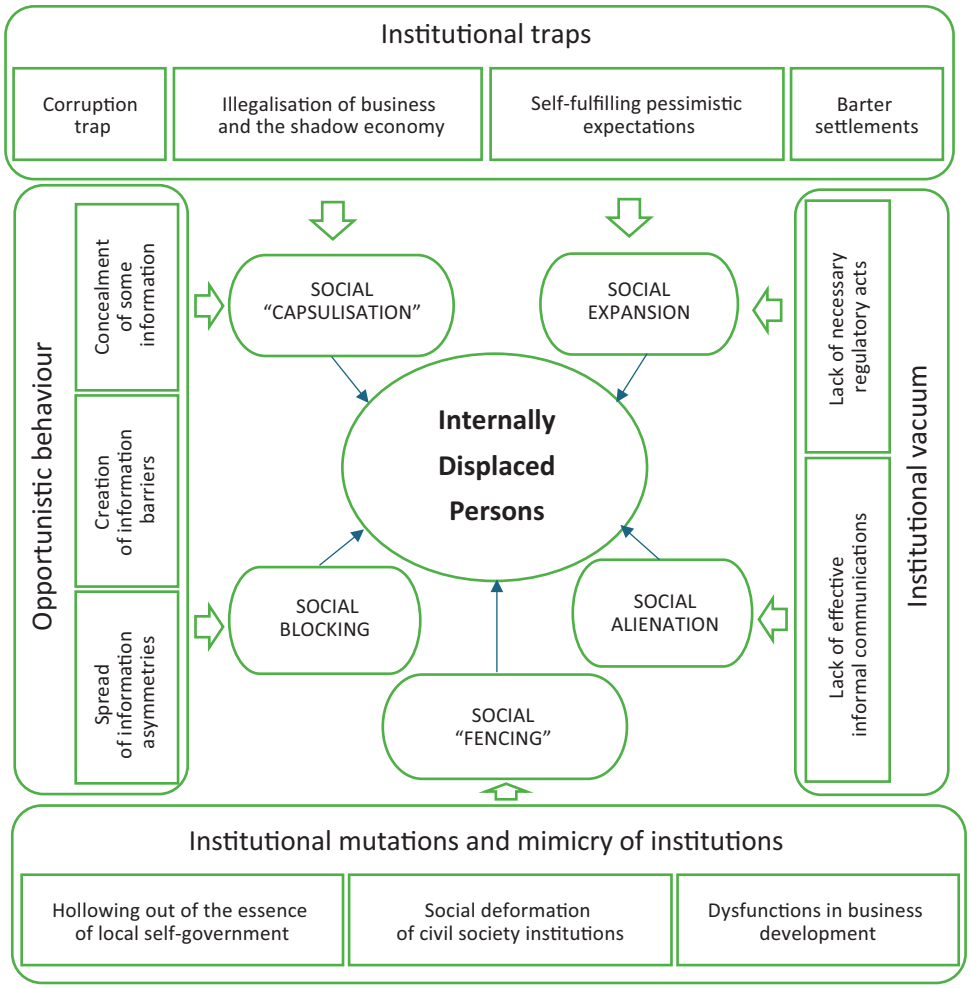
In summary, the main factors and forms of the spread of social isolation of IDPs in rural territorial communities of Ukraine in the current conditions are depicted in Figure 2.

Thus, the main preconditions for social isolation of IDPs in contemporary rural territorial communities of Ukraine include institutional dysfunctions related to the closed nature of host communities, pessimistic expectations shared by both IDPs and local residents, opportunistic behaviour on both sides, and low motivation among local authorities, businesses, and civil society actors. Another factor is the limited social activity of many IDPs. In rural areas – more conservative and less financially capable than urban ones – social isolation often negatively affects the psychological well-being of IDPs, causing depression, loneliness, a loss of optimism, and reduced engagement. These communities also offer fewer employment opportunities, poorer living conditions, and limited access to transport, mobile networks, and the internet. As a result, many IDPs seek alternatives elsewhere, which in turn hampers their integration and deepens isolation. In such a context, social isolation becomes institutionalised and begins to reproduce itself. Consistent with our framework, isolation is highest where historical gatekeeping persists and institutional access is opaque; it is mitigated where linking and bridging ties and reliable service channels are present.

Social isolation of the IDPs in rural territorial communities of Ukraine: factors of rooting and mechanisms for overcoming it

We interpret the patterns below through historical institutionalism (HI), which highlights path-dependent gatekeeping and defensive withdrawal, and through the social capital and integration lens, emphasising how linking and bridging ties, together

Figure 2. Main factors and forms of the spread of social isolation in rural territorial communities of Ukraine



with clear institutional access to documents, services, and decision channels, reduce isolation in rural hromadas.

The described models of social isolation of IDPs in rural territorial communities of Ukraine are still in the early stages of development, although their institutional roots stretch deep into historical traditions. It is important to accurately identify the key systemic effects that contribute to this process, in order to prevent social isolation from becoming a stable and self-sustaining phenomenon. Otherwise, it could gradually generate complex negative consequences across economic, socio-political, humanitarian, and security dimensions, potentially limiting the future opportunities for the post-war recovery and sustainable development of rural territorial communities.

In HI terms, such effects may harden into local "lock-ins" unless offset by inclusive routines and cross-group ties.

One of the main aspects to consider is the administrative and managerial dimension. For rural territorial communities of Ukraine, the arrival of the IDPs was largely unplanned, requiring local authorities to address new organisational challenges, find additional funding for social services, and solve housing and employment issues for IDPs. At the same time, the burden of responsibilities increased. Furthermore, as noted in the Integration of internally displaced persons into territorial communities' study (Novikova et al., 2018), the situation often created preconditions for rising social tensions, especially as opportunities for the local population to access education, healthcare, and utilities diminished. Where rural administrations clarified access points (one-stop windows, documented procedures) and involved IDPs in consultative bodies, participants reported lower perceived isolation – consistent with the role of linking ties.

Given the described trends, there is a justified concern that ignoring this problem may lead to the emergence of dangerous phenomena in the near future. First, there is the risk of further degradation of the social capital of rural territorial communities. Alongside existing demographic challenges, mental-psychological and socio-political problems would gradually accumulate. Particularly alarming is that these issues may develop latently at first, but could manifest acutely within a few years.

Furthermore, the security aspect will remain crucial in decision-making at the level of rural territorial communities. The escalation of social conflicts, provoked by the consequences of social isolation of IDPs and other groups, could undermine social cohesion. This would affect sensitive areas such as property distribution, business diversification, civil society development, the quality of governance, and democratic practices. Ignoring the problem may also lead to a significant decline in community governability, particularly concerning property use, land allocation, and power distribution.

For example, in Lviv region, controversies arose around investors – former pro-Russian deputies who relocated businesses from Kharkiv. They were criticised for refusing to cooperate with local authorities and for importing large numbers of workers from the east, potentially harming social processes in host communities. Activists warned that, if this ended badly in small rural localities, even locals could soon face social isolation, while oligarchic relocated firms might use "arriving" IDPs to push their representatives into local self-government and reshape governance. Local entrepreneurs also reported unhealthy lobbying by central and regional authorities in favour of the newcomers, which they saw as violating fair competition. In some communities, radical protests occurred (Bundz, 2022). Such episodes, if unmanaged, can reinforce boundary-making and deepen isolation.

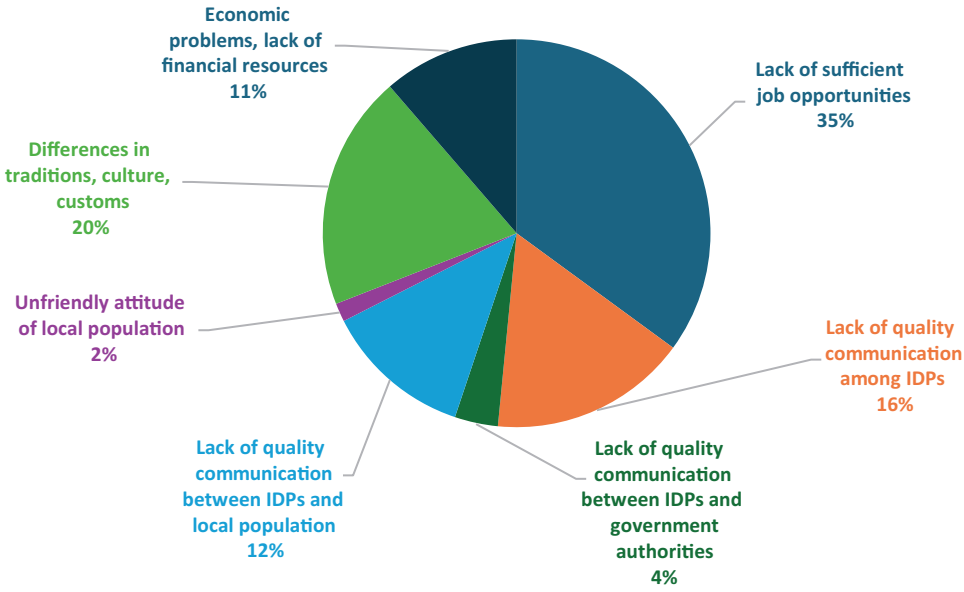
If we return to the main problems accompanying the social isolation of IDPs in rural territorial communities of Ukraine, the most important issue is the lack of sufficient job opportunities and low financial capacity. This is reflected in the low welfare of rural residents and, in some cases, their poverty.

Also noteworthy are several so-called "communication" problems, which are caused by the inability of local authorities to effectively manage information and gaps

in the development of information infrastructure (primarily regarding access to quality mobile communication and the internet). In the social-capital perspective, both constraints suppress bridging contacts (with employers, associations) and weaken linking channels to services, reinforcing isolation.

Thus, based on exploratory qualitative evidence from focus group discussions (FGDs, non-probability sample) held in five rural territorial communities of Lviv region (Yavorivska, Pustomytivska, Stryiska, Horodotska, Drohobytska) in 2023, nearly 70% of participants highlighted insufficient job opportunities in the community, and over 60% pointed to various "communication" problems (Figure 3). Our primary material comes from FGDs with the IDPs (not one-to-one interviews); any percentages in the text indicate the relative prominence of themes across groups rather than population estimates.

Figure 3. Main factors causing the problem of social isolation of IDPs in rural territorial communities of Ukraine (according to the survey results)



Thus, the main factors of social isolation of IDPs in rural territorial communities of Ukraine include:

- Lack of sufficient job opportunities, which forces IDPs to search for jobs in neighbouring cities or even in regional centres, often 20–30 or even 50 km away from their temporary residence, thus limiting their ability and desire to integrate into the host rural community – as a result, they remain relatively distant from its problems and real interests (limits bridging ties to local employers and weakens attachment);
- Presence of cultural barriers, which complicates the process of social integration of IDPs into the host rural communities; the situation is worsened by the limited

opportunities to obtain information about the community and its culture and historical traditions, especially considering that communication with local residents is not sufficiently active, including through the centralized relocation of IDPs mostly in budget institutions or remote rural settlements (sustains boundary-making and what participants described as "capsularisation");

- Lack of quality communication among IDPs themselves partially caused by the shortage of targeted efforts in this direction by local authorities, and partially by the mental characteristics of the IDPs themselves, who do not feel a particular need to group together in new places of residence: some expect support from local authorities, others independently search for work or a new place to live, while others work remotely with clients with whom they have maintained business contacts (bonding ties often remain elsewhere, while local bridging and linking ties fail to develop).

Notably, the IDPs almost never reported overt ill-will from local residents or authorities (about 2% of responses). This suggests that isolation is driven primarily by institutional and organisational factors such as opaque access, thin service networks, and limited bridging and linking opportunities rather than by explicit hostility. The Summary that follows synthesises practical mechanisms that flow from this diagnosis while retaining Table 1 as a compact reference.

Summary: practical implications for rural hromadas

This section collates practice-oriented implications that remain secondary to the analysis. The recommendations align with our historical-institutionalist reading, which emphasises reducing path-dependent gatekeeping, and with the social capital and integration lens, which emphasises strengthening linking and bridging ties and institutional access in rural hromadas.

The first priority is to close the communication vacuum. IDPs often lack convenient opportunities to connect both with one another and with local authorities. Creating accessible internet platforms, leisure centres, coworking spaces and shared public areas can provide low-barrier entry points for contact. Engagement in public councils, business associations and civil society bodies within host communities should be encouraged. Local-history walks, joint volunteering and community events can further strengthen social ties and expand linking and bridging connections to employers and service providers.

The second priority is targeted education and skills provision. Joint programmes for the IDPs and local residents in digital and financial literacy, entrepreneurship, marketing, international partnerships, fundraising and community leadership can reduce capability gaps. Funding should come from state institutions and local authorities, complemented by business partners and international donors. Simple co-design and light follow-up (e.g., mentoring or job-matching) help consolidate gains.

The third priority is the use of "tactful encouragement" tools – light-touch behavioural nudges that lower entry costs and normalise participation. This includes social technologies, gamification and advocacy for necessary social transformations. It

is important to involve practitioners from the public sector, business, universities and research centres, particularly those with strong experience and partnerships in the EU. The three priorities above are operationalised in Table 1.

Table 1. Mechanisms for overcoming the social isolation of IDPs in rural territorial communities of Ukraine (operationalises three levers: fill the communication vacuum; build skills; use tactful encouragement)

Proposed mechanisms	Priorities and directions for overcoming social isolation of IDPs		
	Filling the communication vacuum	**Educational and training work**	**Tools of "tactful encouragement"**
Institutional	Development of intersectoral partnerships with the involvement of IDPs	Implementation of special educational programmes for IDPs	Creation of coworking spaces and creative hubs for IDPs
Administrative and managerial	Creation of IDP councils within local self-government bodies	Involving vocational education institutions in the retraining of IDPs	Implementation of nudge technologies: social inhibition, group synergy
Informational and communicational	Organisation of regular communication events with the participation of IDPs	Conducting advocacy campaigns among the local population	Creation of local social networks and databases for IDPs
Financial	Funding programmes for informing IDPs about job opportunities, etc.	Funding training programmes for IDPs, payment for trainers' services	Grants for IDPs aimed at their better integration into the community
Socio-psychological	Organisation of joint leisure activities for IDPs and local residents (sports games, etc.)	Conducting educational tours of the community for IDPs, excursions, tourist hikes	Gamification of the social integration process for IDPs (quizzes, competitions, tournaments)

Given the long-term development prospects, including the post-war recovery of rural territorial communities, priority should be given to informational-communication and socio-psychological mechanisms for overcoming IDP social isolation. Special attention should focus on advocacy campaigns for local residents and businesses (highlighting the benefits of cooperation with IDPs), as well as on organising educational tours, excursions, and hikes for IDPs. These activities can be combined with gamification elements such as quizzes, competitions, tournaments, and joint sports events to normalise everyday contact and reduce boundary-making.

Quality funding for IDP social integration programmes is crucial, including informing about job opportunities, retraining, and conducting workshops (financial mechanism supported by institutional and administrative-managerial tools). Additional

synergy can be achieved through creating coworking spaces, creative hubs, and clubs for IDPs, especially for youth, and implementing over-technologies (behavioural design and nudge-based approaches) to enhance social integration.

To implement these changes effectively, the administrative and managerial mechanisms of rural territorial community development in Ukraine should be modernised. As argued by Borshchevskyi, Tsybulska and Chemerys (2024), shifting from bureaucratic routines to project-management approaches can broaden funding sources for integration activities and remove factors that sustain isolation, including institutional legacies, weak intersectoral cooperation and decision-making inertia. A simple results frame – tracking participation in events, taking up services and documents, and local job placements by IDPs – can help administrations iterate and scale what works.

Conclusions

The problem of social isolation in rural territorial communities of Ukraine has deep socio-psychological and historical roots. It has been evolving and entrenching itself over a long period, largely due to numerous institutional deformations that negatively impacted the development of Ukrainian villages and their social capital. These deformations were especially prominent during the era of the command-administrative economic system and were driven by political repression, forced collectivisation, artificially induced famines, and the resulting catastrophic socio-psychological consequences for rural residents and their way of life.

Given this, the problem of social isolation in rural territorial communities of Ukraine evolved throughout the 20th century, taking on increasingly new forms and methods of entrenchment. Even after the collapse of the totalitarian Soviet system, it did not lose its relevance. Indeed, in the context of Ukraine's restoration of independence, social isolation became a kind of response to new political processes and challenges. During the economic realities of the transitional period, characterised by mass privatisation and the distribution of former state property, the creation of new rural territorial communities, the formation of local self-government bodies, the development of market infrastructure in the countryside, and the arrival of private investors and their foreign partners interested in investing in Ukraine's rural economy, new institutional factors for the spread of various forms of social isolation emerged.

Thus, the Russian military expansion in 2014, as well as its second phase, which began with the large-scale invasion in 2022, took place against the backdrop of the well-known and long-standing problem of social isolation in Ukrainian villages. As a result, the appearance of a significant number of IDPs and their relocation to rural communities in central and western Ukraine from regions near the combat zones naturally accompanied the fact that these people often fell within the scope of the institutional phenomenon of social isolation.

The main manifestations of this isolation were: social "capsularisation" (or "locking" of IDPs in a limited circle of social contacts), social expansion (manifestations of various forms of pressure on IDPs from the local population through differences in customs, household behaviour, or culture), social blocking (denial of IDPs access to

certain sectors of the local economy, usually the development of their own businesses or entry into government institutions), social alienation (residents of host communities tolerate IDPs but do not accept them as "their own," causing IDPs to feel like "outcasts" and generating feelings of ostracism), and social "fencing" (when residents of host communities close themselves off in their own social circles, leaving IDPs with a very limited scope for establishing social contacts).

The main factors contributing to the spread of social isolation of IDPs in rural territorial communities of modern Ukraine include: numerous economic problems reducing the quality of life of the local population, creating a lack of job opportunities, and weakening the financial capacity of communities; cultural differences between IDPs and residents of host rural communities, which generate psychological and customary barriers; and insufficiently developed communication among IDPs themselves, caused both by objective difficulties (the specifics of their spatial settlement, gaps in communication infrastructure) and subjective ones (lack of desire to communicate with other IDPs or expectation of soon leaving the host community and changing their social environment).

These results have conceptual consequences. The findings support a historical-institutionalist reading of rural isolation: long-run routines of gatekeeping and defensive withdrawal persist as path-dependent constraints in today's displacement setting. At the same time, the evidence refines the social capital and integration perspective by showing that in low-density, service-thin environments it is linking and bridging rather than bonding ties, together with dependable access to documents and services, that most consistently reduce isolation. Conceptually, we specify how rural gatekeeping appears on the ground (informal boundary work similar to "capsularisation") and identify improving institutional access as a practical lever similar to conversion in historical institutionalism (repurposing existing routines toward openness).

These findings should be interpreted as indicative rather than definitive. Evidence derives from five FGDs with IDPs in rural western hromadas (2022–2023; non-probability sample). Reported "shares" reflect the relative salience of themes across groups and are not population estimates. Participants were recruited purposively via local services; self-selection may over-represent more engaged or better-informed IDPs, and social desirability may colour accounts of interactions with authorities and hosts. The design is cross-sectional with limited triangulation (supplementary IDIs with managers of relocated enterprises and a closing community forum inform context but are not the primary evidence). Our analytical labels (e.g., "capsularisation," "social blocking") are theory-informed and require further operational validation. The geographic focus on low-density western rural settings and wartime fluidity limits statistical generalisation; our aim is analytic generalisation and transferability to similar contexts.

Looking ahead, several lines of inquiry follow. Future work should combine representative surveys with embedded FGDs and IDIs across rural and small-town settings (west, centre, and east) to test prevalence; follow cohorts over time to track networks, service access and labour reintegration; link administrative data (social protection, employment services) with transport and service geographies to quantify access frictions; run quasi-experimental or pragmatic trials (e.g., one-stop desks,

transport vouchers, time-bounded coworking) to assess effects on isolation and jobs; map networks to distinguish bonding versus bridging and linking ties and their wellbeing correlates; and pursue comparative rural cases beyond Ukraine (e.g, Colombia, Nigeria, and Syria) to test how historical legacies condition integration pathways.

Finally, practical implications are collated in the Summary to keep recommendations clearly subordinate to the analysis; in brief, addressing isolation requires coordinated institutional, administrative-managerial, informational-communication, financial and socio-psychological measures. Special attention should be paid to "tactful encouragement" tools (such as over-technologies, coworking spaces, creative hubs and advocacy initiatives), closing information gaps, and sustained educational work, including retraining IDPs and deepening their knowledge about host communities, their culture and traditions.

References

Abbara, A., Rayes, D., Ekzayez, A., Jabbour, S., Marzouk, M., Alnahhas, H., & Fouad, F. (2022). The health of internally displaced people in Syria: Are current systems fit for purpose? *Journal of Migration and Health*, *6*, 100126. https://doi.org/10.1016/j.jmh.2022.100126

Acha-Anyi, P. (2024). Unmasking the human rights needs of internally displaced persons: A case of Nigeria. *International Journal of Migration, Health and Social Care*, *20*(4), 682–699. https://doi.org/10.1108/IJMHSC-02-2023-0016

Ager, A. & Strang, A. (2008). Understanding integration: A conceptual framework. *Journal of Refugee Studies*, *21*(2), 166–191. https://doi.org/10.1093/jrs/fen016

Beller, J. & Wagner, A. (2018). Loneliness, social isolation, their synergistic interaction and mortality. *Health Psychology*, *37*(9), 808–813. https://doi.org/10.1037/hea0000605

Borshchevskyi, V. (2014). Вплив інституційних дисфункцій на ефективність використання соціально-економічного потенціалу розвитку сільських територій. *Regional Economy*, *3*, 149–161.

Borshchevskyi, V., Tsybulska, J., & Chemerys, V. (2024). Governance priorities for the post-war development and European integration of rural local communities in Ukraine. *Studies in Agricultural Economics*, *126*(2), 75–83. https://doi.org/10.7896/j.2876

Bundz, Yu. (2022). Хліб із колорадською стрічкою: як на Львівщину переїхав бізнес "регіонала". NTA. https://www.nta.ua/public/hlib-iz-koloradskoyu-strichkoyu-biznes-eksregionala-na-lvivshhyni

Calderón-Mejía, V. & Ibáñez, A.M. (2015). Labour market effects of migration-related supply shocks: Evidence from internal refugees in Colombia. *Journal of Economic Geography*, *16*(3), 695–713. https://doi.org/10.1093/jeg/lbv024

Cherry, K. (2023). *The impact of social isolation on mental health*. Verywell Mind. https://www.verywellmind.com/the-impact-of-social-isolation-on-mental-health-7185458

Chitea, L. & Dona, I. (2018). Modernization and socio-economic development of the Romanian rural area: 1995–2016 evolution. In *Agrarian economy and rural development – Realities and perspectives for Romania: 9th edition of the International Symposium*

(pp. 89–95). The Research Institute for Agricultural Economy and Rural Development (ICEADR). https://www.econstor.eu/handle/10419/205089

Колективізація українського села. Голодомор 1932–1933 рр. Реферат. (2012). OSVITA. UA. https://osvita.ua/vnz/reports/history/33631

Ekezie, W., Myles, P., Murray, R.L., Bains, M., Timmons, S., & Pritchard, C. (2021). Self-reported diseases and associated risk factors among camp-dwelling conflict-affected internally displaced populations in Nigeria. *Journal of Public Health*, *43*(2), e171–e179. https://doi.org/10.1093/pubmed/fdaa114

Fyshchuk, Y. & Kolesnik, D. (2024). Людина шукає собі те місце роботи, яке її влаштовує". На Хмельниччині зменшується кількість населення в селах. Suspilne Khmelnytskyi. https://suspilne.media/khmelnytskiy/658114-ludina-sukae-sobi-te-misce-roboti-ake-ii-vlastovue-na-hmelniccini-zmensuetsa-kilkist-naselenna-v-selah

Graham, E. (2022). *Combating social isolation and loneliness among veterans after separation from military service*. Syracuse University, Maxwell School of Citizenship & Public Affairs. https://www.maxwell.syr.edu/research/lerner-center/population-health-research-brief-series/article/combating-social-isolation-and-loneliness-among-veterans-after-separation-from-military-service

HelpAge. (2022). *Ukraine: Older people face abandonment and isolation as conflict with Russia intensifies*. HelpAge. https://www.helpage.org/news/ukraine-older-people-face-abandonment-and-isolation-as-conflict-with-russia-intensifies/

Історія Голодомору. (2024). Holodomor Museum. https://holodomormuseum.org.ua/istoriia-holodomoru/

Ibáñez, A.M., Moya, A., & Velásquez, A. (2022). Promoting recovery and resilience for internally displaced persons: Lessons from Colombia. *Oxford Review of Economic Policy*, *38*(3), 595–621. https://doi.org/10.1093/oxrep/grac014

Internal Displacement Monitoring Centre. (2024). *2024 Global report on internal displacement*. IDMC/NRC. https://www.internal-displacement.org/global-report/grid2024/

Інтеграція внутрішньо переміщених осіб у приймаючих громадах. (2023). INFLUENCE GROUP. https://www.vplyv.org.ua/wp-content/uploads/2023/06/Звіт-фокус-групи.pdf

International Organization for Migration, Displacement Tracking Matrix [IOM DTM]. (2023, December). *Social cohesion and public trust*. https://dtm.iom.int/dtm_download_track/59851?file=1&type=node&id=32476

International Organization for Migration, Displacement Tracking Matrix [IOM DTM]. (2025, February). *Displacement and social cohesion in Ukraine*. https://crisisresponse.iom.int/sites/g/files/tmzbdl1481/files/appeal/documents/UKR_IOM_Displacement%20and%20Social%20Cohesion%20in%20Ukraine_February%202025.pdf

Kalinowski, S., Łuczak, A., & Szczygieł, O. (2024). *Ubóstwo ubogich. Obszary deprywacji potrzeb beneficjentów pomocy społecznej*. Wydawnictwo Naukowe Scholar; Wydawnictwo Naukowe IRWiR PAN.

Kelly, D., Steiner, A., Mazzei, M., & Baker, R. (2019). Filling a void? The role of social enterprise in addressing social isolation and loneliness in rural communities. *Journal of Rural Studies*, *70*, 225–236. https://doi.org/10.1016/j.jrurstud.2019.01.024

Krakhmalova, K. (2022). Security, social policy, agency and work of the courts in relation to Ukrainian internally displaced persons. *Social Policy and Society*, *23*(3), 687–702. https://doi.org/10.1017/S1474746422000446

Lakinskyi, E. & Kulchynskyi, R. (2021). «Останнє радянське покоління»: безглузді ритуали, «общєніє» і «внєнаходімость». Як мертва мова розвалила СРСР. TEXTY.ORG.UA. https://texty.org.ua/articles/103815/ostannye-radyanske-pokolinnya-bezhluzdi-rytualy-obshyeniye-i-vnyenahodimost-yak-mertva-mova-rozvalyla-srsr/

Lamont, M. & Molnár, V. (2002). The study of boundaries in the social sciences. *Annual Review of Sociology*, *28*, 167–195. https://doi.org/10.1146/annurev.soc.28.110601.141107

Łuczak, A., Cermakova, K., Kalinowski, S., Hromada, E., & Mec, M. (2025). Measurement of sustainable development and standard of living in territorial units: Methodological concept and application. *Sustainable Development*. https://doi.org/10.1002/sd.3366

Mahoney, J. & Thelen, K. (2012). *Explaining institutional change: Ambiguity, agency, and power*. Cambridge University Press. https://doi.org/10.1017/CBO9780511806414

Malynovska, O. & Yatsenko, L. (2024). Social consequences of forced internal displacement of population in Ukraine. *Problems of Modern Transformations. Series: Economics and Management*, *11*. https://reicst.com.ua/pmt/article/view/2024-11-07-01/2024-11-07-01

North, D.C. (1990). *Institutions, institutional change and economic performance*. Cambridge University Press. https://doi.org/10.1017/CBO9780511808678

Novikova, O., Antoniuk, V., Pankova, O., et al. (2018). Інтеграція внутрішньо переміщених осіб у територіальні громади: діагностика стану та механізми забезпечення. National Academy of Sciences of Ukraine, Institute of Industrial Economics. https://iie.org.ua/wp-content/uploads/2018/11/mono_vo_2018_da_compressed.pdf

Nóżka, M.A. (2024). The everyday lives of street homeless people in the context of welfare initiatives during the COVID-19 pandemic. *Social Policy Issues*, *67*(4), 1–19. https://doi.org/10.31971/pps/188710

Pickering, J., Wister, A.V., O'Dea, E., & Chaudhury, H. (2023). Social isolation and loneliness among older adults living in rural areas during the COVID-19 pandemic: A scoping review. *BMC Geriatrics*, *23*, 511. https://doi.org/10.1186/s12877-023-04196-3

Pierson, P. (2000). Increasing returns, path dependence, and the study of politics. *American Political Science Review*, *94*(2), 251–267. DOI: https://doi.org/10.2307/2586011

Putnam, R.D. (2000). *Bowling Alone: The Collapse and Revival of American Community*. Simon & Schuster. DOI: https://doi.org/10.1145/358916.361990

Pyvovarov, S. (2024) 50 років тому селяни в СРСР уперше отримали паспорти, до цього вони понад пів століття були кріпаками при колгоспах. Як це було (багато архівних фото). *Babel*. https://babel.ua/texts/34878-sorok-p-yat-rokiv-tomu-selyani-v-srsr-upershe-otrimali-pasporti-do-cogo-voni-ponad-50-rokiv-buli-kripakami-pri-kolgospah-yak-ce-bulo-bagato-arhivnih-foto

Seredynskyi, O. (2020). Червоний терор на Миколаївщині у 1919 році. *State Archive of Mykolaiv Region*. https://old.archive.mk.ua/pubonsite/1017-pub-chervony-teroor-myk-1919.html

Stelmakh, O. (2024). Громади не можуть підтримувати переселенців лише гуманітарною допомогою. *Public space*. https://www.prostir.ua/?news=hromady-ne-mozhut-pidtrymuvaty-pereselentsiv-lyshe-humanitarnoyu-dopomohoyu

Strang, A.B. & Quinn, N. (2019). Integration or isolation? Refugees' social connections and well-being. *Journal of Refugee Studies*, *34*(1), 328–353. https://doi.org/10.1093/jrs/fez040

Szreter, S. & Woolcock, M. (2004). Health by association? Social capital, social theory, and the political economy of public health. *International Journal of Epidemiology*, *33*(4), 650–667. https://doi.org/10.1093/ije/dyh013

Thelen, K. (1999). Historical institutionalism in comparative politics. *Annual Review of Political Science*, *2*, 369–404. https://doi.org/10.1146/annurev.polisci.2.1.369

Tsybuliak, N., Popova, A., Lopatina, H., & Suchikova, Y. (2024). In a stranger's house: Social isolation of internally displaced people in Ukraine during wartime. *Human Affairs.* https://www.degruyter.com/document/doi/10.1515/humaff-2024-0027/html?srsltid=AfmBOopzzGzuR9rZB0ckw4iUzvg1CyZPAC7EcaaVI0JbCQrM3Snb51Ua

Tulane University. (2020). *Understanding the effects of social isolation on mental health*. https://publichealth.tulane.edu/blog/effects-of-social-isolation-on-mental-health

Ukrainian Institute of National Memory (2021). «Голод після Перемоги»: до 75-річчя масового голоду 1946-47 років УІНП презентував історичний ролик. https://uinp.gov.ua/pres-centr/novyny/golod-pislya-peremogy-do-75-richchya-masovogo-golodu-1946-47-rokiv-uinp-prezentuvav-istorychnyy-rolyk

Urbas, D. (2024). Jakie są skutki izolacji społecznej na zdrowie psychiczne? *PolFamilia.Psychologia*. https://polfamilia.org.pl/jakie-sa-skutki-izolacji-spolecznej-na-zdrowie-psychiczne/

Verbets, V. (2007). Методологія та методика соціологічних досліджень. RSU, Institute of Social Studies.

Widłak, M. (2024). *Izolacja społeczna. Jej oznaki i konsekwencje*. PSYCHE TEE. https://psychetee.pl/2024/07/23/izolacja-spoleczna-jej-oznaki-i-konsekwencje/

Williams, T., Lakhani, A., & Spelten, E. (2022). Interventions to reduce loneliness and social isolation in rural settings: A mixed-methods review. *Journal of Rural Studies*, *90*, 76–92. https://doi.org/10.1016/j.jrurstud.2022.02.001

Williamson, O.E. (1985). *The economic institutions of capitalism*. Free Press.

Yakubova, L. (2004). СУЦІЛЬНА КОЛЕКТИВІЗАЦІЯ В СЕЛАХ ЕТНІЧНИХ МЕНШИН 1930-1935. *Problems of Ukrainian History: Facts, Judgments, and Searches*. http://history.org.ua/JournALL/pro/11/17.pdf

Zaiats, T., Romaniuk, S., Kraievska, H., Diakonenko, O., & Sova, O. (2024). Priority areas for the formation of capable territorial communities in Ukraine. *Agricultural and Resource Economics*, *10*(1), 145–148.

Zapędowska-Kling, K. (2022). The COVID-19 pandemic in Poland: Implications for senior policies. *Social Policy Issues*, *56*(1), 61–82. https://doi.org/10.31971/pps/150203

Zhang, X. & Dong, S. (2022). The relationships between social support and loneliness: A meta-analysis and review. *Acta Psychologica*, *227*, 103616. https://doi.org/10.1016/j.actpsy.2022.103616

Problemy Polityki Społecznej. Social Policy Issues 2025, 71(4): 1–22
https://doi.org/10.31971/pps/216569

Submitted: 2025-06-11/Accepted: 2026-01-08

Kamil Glinka[1]

ORCID: 0000-0002-4983-9697
Institute of Political Science, University of Wrocław, Poland

Barbara Panciszko-Szweda

ORCID: 0000-0003-3480-3189
Faculty of Political Science and Administration, Kazimierz Wielki University in Bydgoszcz, Poland

Childcare accessibility for children under 5 years of age across the urban and rural areas. Lessons from Wałbrzych district

Abstract

The question about the potential differences between the town/city and the countryside becomes important in relation to such a specific type of social service as childcare. These are the services whose accessibility can play the role of a factor in local development. Therefore, the paper aims to illustrate the state of accessibility to childcare for children up to 5 years of age in a comparative approach covering urban and rural areas. To achieve this aim, a set of research methods and techniques is used (elements of comparative analysisand document analysis supported by statistical data). The study on the accessibility of nurseries, children's clubs, and kindergartens covering the district under the discussion leads to the conclusion that the level of this accessibility, regardless of whether we are talking about the physical dimension (A1),

[1] **Corresponding author:** Kamil Glinka, Institute of Political Science, University of Wrocław Koszarowa 3, 51-149, Wrocław, Poland; email: kamil.glinka2@uwr.edu.pl

qualitative dimension (A2), or economic dimension (A3), shows differentiation in the division into urban and rural municipalities. Due to the lack of detailed, specialist documents adopted at the strategic level, this statement refers to the operational level, which consists of the activities of entities providing care, i.e., nurseries, children's clubs and kindergartens operating in the eight municipalities in question.

Keywords: urban area, accessibility, rural area, childcare, Wałbrzych

Introduction

Accessibility is one of the most important dimensions of contemporary social policy, regardless of its sectoral area or level (local, regional, national) in question. The belief in the importance of accessibility for meeting collective social needs is reflected in the practice of functioning of many institutions, also in Poland. One should agree with Agnieszka Kanior and colleagues, who, placing the problem of accessibility in the context of the functioning of public cultural institutions, state: "In Poland, over the past few years, authorities introduced legal, organisational, and financial changes to support the implementation of accessibility. These changes have affected the functioning of many public entities, including state, and local government (…) institutions" (Kanior et al., 2024, p. 2). Raising the level of accessibility to social services is taking on a paradigmatic character, implementing the postulate of purposeful and coordinated action by public policy actors (see: Sroka, 2009; Zybała, 2012; 2013). In other words, the implementation of standards defined at the level of legislation not only national but also EU (Act, 2019; European Union, 2021; European Commission, 2025) allows us to assume that citizens are becoming beneficiaries of the growing level of accessibility of social services of diversified sectoral provenance. The accessibility of social services divided into cities and countrysides is a problem that can be observed at the local level and is of interest not only to researchers but also to practitioners[2].

The question about the potential differences between the city and the countryside becomes important in relation to such a specific type of social services as childcare (see: Tietze & Cryer, 1999). These are the services whose accessibility can play the role of a factor in local development. This is determined by the impact of this accessibility on the professional activity of parents and guardians of children and, consequently, on the development opportunities of local self-government units in which these parents and guardians live and/or work. As it results from the reports of the Committee for Economic Development (CED), the relationship between the accessibility of childcare and the level of local development is strong (CED, 2019).

Referring to official data, it can be stated that the issue of differences between urban and rural areas is current and significant. The scale of the disproportion is revealed by studies on the accessibility of childcare not only in Poland, but also in the European Union (Eurodice, 2025) and the USA (Malik et al., 2018; Davis et al., 2019).

[2] It is assumed that the terms city/town and countryside and urban areas and rural areas are synonymous.

Taking the above into account, it can be stated that the issue is current and requires analysis on a micro scale as Wałbrzych district in question.

The aim of the paper is to illustrate the state of accessibility to childcare for children up to 5 years of age in a comparative approach covering urban and rural areas. Taking into account not only the current research on this issue but also, and perhaps above all, extensive and complex empirical material relating to the functioning of entities providing childcare services in Poland, it was decided to focus on the accessibility of nurseries, children's clubs, and kindergartens in one district – Wałbrzych district. This is a district that, due to its wealth (relatively low level of income per capita) and structure (presence of both urban and rural municipalities), creates an interesting area of research in terms of explanation. The reflection on the accessibility of nurseries, children's club and kindergartens in the Wałbrzych district, which is a kind of laboratory of socio-economic challenges during the systemic transformation period (see: Przybyła, 2015; Glinka, 2014) as well as crisis period (see: Glinka et al., 2025), allows us to answer the question raised above about the potential differences between the city and the countryside.

Public policy, and in the analysed case – local social and (to a limited extent) educational policy is a theoretical perspective of the paper (cf. Daly, 2003). The local self-government administration is a main actor of this policy. Adopting the rational choice paradigm, the authors of the paper analyse the activities of the local self-government administration of the municipalities of the Wałbrzych district, the aim of which is to meet the collective needs and expectations of citizens in terms of the accessibility of childcare (see: Hausner, 2001; 2008; Sroka, 2009; Zybała, 2012; 2013; Mazur, 2014; Szarfenberg, 2016; cf. Moran et al., 2006; Sabatier, 2007; Howlett, 2011; Weimer & Vining, 2011; Dye, 2014). The authors' attention is focused on both the strategic and operational level of these activities. It should be emphasised that there is a perspective of the local self-government administration as an organiser of childcare (cf. Glinka, 2021; 2023), and not of parents and guardians of children or other actors (e.g., non-governmental organisations involved in childcare in question).

Literature review. Childcare accessibility in the perspective of sector-oriented public policy

Access to social services is an important component of the quality of life, a determinant of the daily functioning of individuals in both formal (workplace) and non-formal (leisure, recreation) settings. In accordance with the sectoral approach developed in the Anglo-Saxon trend, appropriate to public policy, it reflects the level of satisfaction of the diverse and changing over time needs of citizens and is a kind of the guarantor of a decent prosperous life. In Poland, in accordance with the provisions of the Act of 19 July 2019 on the implementation of social services by social service centres, the catalogue of social services includes activities in the field of, among others: pro-family policy, family support, foster care system, social assistance, promotion and health protection, support for people with disabilities, public education, culture, physical culture and tourism, stimulating civic activity, or counteracting unemployment

and professional and social reintegration (Act, 2019, art. 2). The accessibility of childcare, which is the subject of the analysis, is an issue that should obviously be linked to the social services indicated by the legislator.

The reflection devoted to the critical view of the accessibility of a specific social service, and in the analysed case – accessibility to childcare – requires not only defining the concept of access, but also indicating the most objective criteria for its measurement. Penchansky and Thomas treat access as: "a concept representing the degree of 'fit' between the clients and the system" (1981, p. 129), at the same time distinguishing its five basic dimensions: availability, accessibility, accommodation, affordability, and acceptability. As Penchansky and Thomas argue, availability refers to the relationship between the scope and type of available services and the scope and type of clients' needs. Accessibility is the relationship between the location of service provision and the place of residence/stay of clients (including the need to take into account the transport possibilities that clients have). The third dimension – accommodation – concerns the relationship between the system of organising the service (including working hours, methods of making appointments) and the ability of clients to adapt to the established rules. Affordability, in turn, is the affordability of the price and the relation of the price to the quality of the service provided. The last of the distinguished dimensions, namely, acceptability, includes the relations between the characteristics of service providers and the attitudes of customers (Penchasky & Thomas, 1981). Taking on the difficult task of expanding and updating the researchers' approach, Emily Saurman (2015) supplements the catalogue defined by them with a sixth dimension. It is awareness, meaning the channels of communication (transferring data, information and opinions) of customers about the services used.

Taking the above into account, it can be assumed that while access is the possibility of using something (e.g., childcare as a social service), availability means the state in which this something (the aforementioned childcare) is available. Moseley (1979) defines accessibility: "as the degree to which someone or something is 'get-at-able'". John Farrington and Conor Farrington (2005) emphasise that accessibility refers to the level of life opportunities and is a necessary condition (although not the only one) for effectively "fighting" the phenomenon of social exclusion, which takes both institutionalised and non-institutionalised forms. Zbigniew Taylor emphasises the importance of the geographical dimension of accessibility, at the same time pointing out the fact that it refers to "(…) proximity, ease of spatial integration or potential contacts with functions" (1999, p. 12). Monika Stanny, Andrzej Rosner and Łukasz Komorowski (2023, p. 35) draw attention to the role of space (i.e., distance) and travel time in this context. Mikko Tervo and his team (2013) focus on the impact of the development of a given space on the ability of individuals to reach entities that provide social services. A similar position is presented by Karst Geurs and Jan Ritsema van Eck (2001, p. 200). According to the researchers, accessibility is "the amount of effort for a person to reach a destination".

The accessibility of childcare for children up to the age of 5 is a subject of interest for researchers representing various scientific disciplines, which is reflected in the diversity of approaches and concepts presented in the literature. In addition to research conducted by lawyers and administrative specialists, it is worth emphasising

the achievements of economists, sociologists and political scientists who study the barriers to childcare (see: Abrassart & Bonoli, 2015; Lee & Ha, 2022), the forms of this care (see: Anderson & Mikesell, 2017), or the effectiveness of programmes and social initiatives focused on this care (see: Farfan-Portet et al., 2011; Alexiadou & Stadler Altmann, 2020; Subocz, 2019). The accessibility of childcare is also part of the practice of international organisations (e.g., European Union, Council of Europe, Organisation for Economic Co-operation and Development), which publish reports and expert studies (European Commission, 2025b; Council of Europe, 2025; OECD, 2025).

It should be emphasised that the European Union treats access to early childhood education and care (ECEC) as a right belonging to EU citizens. Highlighting its importance, Akvile Motiejunaite (2021) advocates the introduction of an ECEC condition indicator which consists of: integrated management, guaranteed places in the facility, the level of education of staff and the development of a guide to the educational process based on European and international guidelines. Irina Abankina and Liudmila Filatova (2018) believe that the accessibility of childcare is determined primarily by the number of places in facilities and the financial possibilities of parents. At the same time, they draw attention to the importance of the perception of facilities by parents and all those involved in the care process, their motivation, assessments of physical and mental barriers. Equally valuable conclusions can be drawn from analyses, the authors of which examine accessibility by comparing the number of available places in facilities with the number of children per parent and/or guardian (Bassok et al., 2011). Research on accessibility provides interesting insights into which actors take into account the distance that must be travelled in order to access care from the nearest facility providing appropriate services (Davis et al., 2019).

An increasingly important trend in research on the accessibility of childcare includes analyses focused on its spatial (locational) conditions. These are studies that examine accessibility either in urban areas (see: McLean et al., 2017; Moussié, 2021; Alm & Forsberg, 2023; Cordero-Vinueza et al., 2023; Pennerstorfer, et al., 2024; Kang & Hwang, 2024), or in rural areas (see: Atkinson, 1996; Davis & Weber, 2001; Halliday & Little, 2001; Morrissey et al., 2022), or comparative studies that consider similarities and differences in institutionalised childcare in urban and rural areas (see: Atkinson, 1994; Miller & Vortuba-Drzal, 2013; Gordon & Chase-Lansdale, 2001; Maher et al., 2008; Bucaite-Vilke, 2021; Agyekum et al., 2023; Crouch et al., 2024). As Astrid Pennerstorfer and her colleagues argue, the accessibility of this type of care in cities is a function of the activity of public administration, including local self-government, which implements specific programmes and initiatives (2024). As Vivianna Cordero-Vinueza and her team claim, accessibility is such a complex category that it should be placed in a significantly broader context of creating appropriate conditions for childcare, a certain positive climate related to this care, which translates into legal, financial, and logistical solutions implemented in the city (2023). It is hard to disagree with the results of Taryn's research who, together with his colleagues, proves that the accessibility of childcare in rural areas is correlated with the financial support that entities providing such services receive from the central budget, regardless of whether

they are run by local self-government administration or private or social entities, e.g., non-governmental organisations (Taryn, 2022).

The search for differences and similarities between urban and rural municipalities of the Wałbrzych district means that this paper certainly fits into the trend of research on the accessibility of childcare that takes into account its spatial (locational) conditions. This issue is important because, as Katie Beck and Marie Kaune note, the accessibility and standard of childcare in rural areas are usually worse than in urban areas, although not always, as evidenced by the research on the accessibility of this type of social services in densely populated metropolitan areas (2025). In Polish reality, the local self-government administration is an actor responsible for providing childcare, regardless of whether we are talking about urban or rural areas (see: Kurowska & Szczupak, 2016; Stolińska-Pobralska, 2012). It is this administration, guided by economic calculation and the need to meet the collective needs of citizens, which takes actions to ensure its accessibility.

Research design

Taking into account the legal and organisational conditions of care for children up to 5 years of age in Poland, the study covered such forms of care as indicated in the Act of 4 February 2011 on the care of children up to 3 years of age and the Act of 14 December 2016 – Education Law. These are (1) nurseries, (2) children's clubs, and (3) kindergartens.

As mentioned, the concentration on the Wałbrzych district has a twofold justification. It is not only the level of its wealth resulting from the systemic transformation process (manifested by the closure of mines and heavy industry plants and the liquidation of state-owned farms), but also its spatial and administrative diversity.

Firstly, it should be emphasised that the Wałbrzych district is a particularly interesting example of the functioning of a local self-government unit, which, as a result of the collapse of the bipolar division of the world after 1989, is facing numerous economic and social problems. Therefore, it could serve as a laboratory for changes and challenges in the field of social policy, including childcare for children under 5 years of age. The Wałbrzych district is, alongside the Śrem and Wrocław districts, by far the poorest rural district in the Lower Silesian Voivodeship. In the ranking of the wealth of voivodeships in Poland, it ranks relatively far away, 241st in Poland (out of 314 positions) with income per capita at the level of PLN 968.57. The scale of the disproportion between the Wałbrzych district and the richest districts is reflected in the fact that in the case of the latter, the level of this wealth is at least twice as high[3]. The low level of income makes the issue of providing childcare particularly important. As a result, it seems to be a factor that does not facilitate the childcare accessibility for children under 5 years of age.

[3] The highest in the ranking for 2023 were: Człuchów district (PLN 2,154.20), Przysucha district (PLN 2,043.64) and Opatów district (PLN 1,971.00) (Wspólnota, 2023).

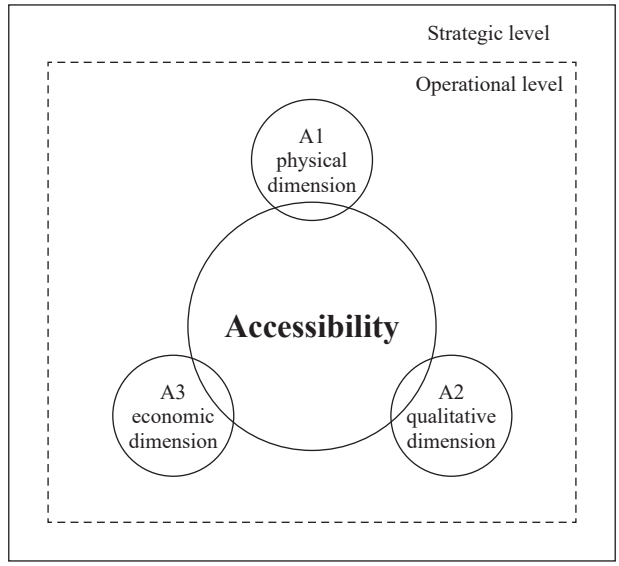
Secondly, within the administrative boundaries of Wałbrzych district, there are both urban municipalities (Boguszów-Gorce, Jedlina Zdrój, and Szczawno-Zdrój) and rural municipalities (Czarny Bór, Stare Bogaczowice, and Walim). Urban-rural municipalities (Głuszyca and Mieroszów), which are an intermediate variant between urban and rural areas, were also included in the study. In total, these are eight municipalities which create an area diversified in terms of the location of entities providing social services related to childcare.

Placing the paper in the stream of research whose authors emphasise the importance of territorial differentiation of public services (urban areas *versus* rural areas), a hypothesis was formulated according to which the level of accessibility of childcare in nurseries, children's clubs, and kindergartens in urban municipalities is higher than the level of this accessibility in rural municipalities. Writing about accessibility, the authors take into account its three dimensions (see: Figure 1):

1. Physical accessibility (A1) understood through the prism of the very fact of functioning of entities providing childcare in nurseries, children's clubs, and kindergartens and the number of children who potentially require such care;
2. Qualitative accessibility (A2), which includes the hours of operation of entities providing childcare in nurseries, children's clubs, and kindergartens and the provision of care for children with disabilities;
3. Economic accessibility (A3) defined through the prism of fees for childcare in nurseries, children's clubs, and kindergartens.

The hypothesis is accompanied by the following research questions: (1) Do all dimensions of childcare accessibility differentiate urban and rural municipalities to the same extent? (2) If the extent of this differentiation is varied, which dimension or dimensions of accessibility play a key role in this respect?

Figure 1. Dimensions of accessibility of childcare for children up to 5 years of age



Each of the three dimensions is the subject of analysis conducted on two levels. The first (strategic) includes documents (strategies, plans, programmes, etc.) devoted to childcare which are prepared by the local self-government administration of the municipalities studied. The second (operational) level consists of specific activities carried out by the entities subordinate to these administrations – nurseries, children's clubs, and kindergartens. The combination of the two levels provides a possible full picture of the socially-oriented local policy.

According to the adopted approach, accessibility has a broad meaning and is not limited to its understanding that focuses on minimising or eliminating barriers for people with disabilities or other deficits, e.g., cognitive ones (see: Goering, 2015). The hypothesis can be said to be positively verified when the "advantage" of urban municipalities over rural municipalities includes most of the accessibility variants: A1, A2, and A3. The hypothesis was verified using several research methods and techniques, primarily elements of comparative analysis and document analysis (Della Porta, 2008) and a diverse set of source materials which are: strategic documents, official websites of municipalities, official websites of nurseries, children's clubs, and kindergartens and primary schools, accessibility declarations and the data provided by the Central Statistical Office. The authors analysed the indicated sources in terms of the availability of data that they used in the comparative analysis. The data was obtained from three types of documents that municipalities are obliged to make publicly available (see: Table 1). The analysis was focused on, firstly, the very fact of developing (or not) the document, and secondly, their main assumptions relating to forms of care for children up to 5 years of age. Accessibility declarations (all public institution have to publish on their websites information regarding the current accessibility of their buildings and services for people with special needs, however, not all institutions have such declarations) were additionally taken into the account.

The way of defining the accessibility of childcare adopted for the purposes of the paper, due to its multidimensionality, allows for the most comprehensive illustration of the differences and similarities that can be observed between urban and rural municipalities. It fills (partially) the gap in research on local public policy focused on childcare, providing evidence of the existence of disproportions in the accessibility of this care in the district which, as a result of systemic transformation, is facing the problem of social exclusion (Zakrzewska-Półtorak, 2010).

Analysis. In search of differences in the Wałbrzych district

Strategic level

As mentioned, the first level of analysis includes currently in force (in 2025) official regulations (strategies, programmes, plans, etc.) that define the goals, directions, and forms of local social and (partly) educational policy. As it results from the analysis of the data presented in Table 1, strategic management concerns all municipalities, both urban and rural ones.

Each municipality has a strategy for solving social problems, which results from the obligations imposed on local self-government administrations by the Act of 12 March 2004 on social assistance (Ustawa, 2004). These strategies do indeed address the issue of childcare for children up to 5 years of age, but only in a general, limited way. A few municipalities (Jedlina Zdrój and Szczawno-Zdrój) have made an effort to prepare other documents devoted to family support and/or the provision of social services (in Jedlina Zdrój these are two documents, in Szczawno-Zdrój – one). However, the issue of access to childcare for children up to 5 years of age is only presented in them fragmentarily. It is, therefore, difficult to treat these documents as separate specialist documents devoted to this accessibility. Even though development strategies include threads devoted to childcare it is also difficult to treat them, generally, as separate, specialised strategic documents (see Table 1)[4].

Table 1. Childcare for children up to 5 years of age in the municipalities of the Wałbrzych district – strategic documents

Municipality	Strategic document (specialised strategy)	Strategic document (development strategy of local government unit)
Boguszów-Gorce*	Yes	Yes
Jedlina Zdrój*	Yes * 3	Yes
Szczawno-Zdrój*	Yes * 2	Yes
Głuszyca**	Yes	Yes
Mieroszów**	Yes	Yes
Czarny Bór	Yes	Yes
Stare Bogaczowice	Yes	Yes
Walim	Yes	Yes

Source: Own study based on the data provided by the offices of the surveyed municipalities: Boguszów-Gorce (2025), Jedlina Zdrój (2025), Szczawno-Zdrój (2025), Głuszyca (2025), Mieroszów (2025), Czarny Bór (2025), Stare Bogaczewice (2025), Walim (2025). An asterisk (*) indicates urban municipalities, two asterisks (**) – urban-rural municipalities. No marking indicates a rural municipality.

While attempting to explain the causes of deficits, it should be noted that all municipalities are relatively small local self-government units that do not have extensive organisational and personnel resources, and such resources are usually responsible for developing strategic documents. One can also risk a statement that the problem of childcare for children up to 5 years of age is not treated as an issue that requires the development of a separate document. For this reason, the accessibility of childcare, regardless of the analysed dimension (A1, A2, A3), does not really fit into the framework of properly understood strategic management.

[4] To sum up, the analysis covered strategies for solving social problems, other documents devoted to family support and/or the provision of social services as well as development strategies of local government units in question. In total, 19 documents were examined.

Operational level

In order to achieve the main objective of the paper and to verify the research hypothesis, the authors verified first the physical dimension of the accessibility of nurseries, children's clubs, and kindergartens providing care services within the administrative boundaries of the eight studied municipalities (A1). As indicated, this dimension consists of entities providing these services in relation to the number of children living in the studied municipalities (see: Table 2).

Table 2. Children aged 0–6 years in the municipalities of the Wałbrzych district divided into urban municipalities and rural municipalities

	Urban municipalities			Rural municipalities			Total	Total	Total
Municipality / Age	0–3	3–5	6	0–3	3–5	6	0–3	3–5	6
Boguszów-Gorce	256	332	108	–	–	–	256	332	108
Jedlina Zdrój	58	99	35	–	–	–	58	99	35
Szczawno-Zdrój	75	107	44	–	–	–	75	107	44
Głuszyca	86	119	43	20	51	23	106	170	66
Mieroszów	59	71	30	39	34	24	98	115	54
Czarny Bór	–	–	–	94	146	53	94	146	53
Stare Bogaczowice	–	–	–	69	113	38	69	113	38
Walim	–	–	–	93	117	48	93	117	48

Source: GUS 2024.

It is worth mentioning that nursery care (clubs, daycare providers, nannies, and financially supported care provided by grandparents) and preschool care are actually separate forms of childcare, which, of course, do not change the fact that they can be analysed together. However, the authors of the paper are aware of these obvious and well-recognised differences. It should be emphasised that, for example, the development dynamics of both of them can vary, which could related to the fact that, in the case of the youngest children, parents are able to take paid leave, and nursery care often only be applicable and used when the child turns one.

As it results from the analysis of the data presented in Table 3, there are 5 nurseries and children's clubs in the Wałbrzych district. These two are in urban municipalities (Boguszów-Gorce, Jedlnia Zdrój), other two in rural-urban municipalities (Głuszyca, Mieroszów – importantly, they are located in towns), and one in a rural municipality (Stare Bogaczowice). The disproportion between the urban areas and rural areas is clear in this case. It is noteworthy that in two rural municipalities (Czarny Bór and Walim) there is no entity providing care services for children up to 3 years of age. It is also worth emphasising that a private nursery, i.e., one that is not run by local self-government administration is the only nursery operating in a rural municipality. The analysis of the total number of children up to 3 years of age allows for similar conclusions. Taking into account the data from 2024, it should be noted that it is 315 in rural municipalities and 537 in urban municipalities. Comparing these numbers with

the number of places offered proves that in urban areas the level of "saturation" of care in nurseries and children's clubs is much higher than in rural areas.

Table 3. Accessibility of nurseries and children's clubs in the municipalities of the Wałbrzych district – physical dimension (A1)

Municipality	Number of public nurseries/ children's clubs	Number of private nurseries/ children's clubs	Number of places taken/number of places available
Boguszów-Gorce*	1	0	58/72
Jedlina Zdrój*	1	0	22/34
Szczawno-Zdrój*	0	0	0
Głuszyca municipality**	1	0	35/45
Głuszyca (town)	1	0	35/45
Mieroszów municipality**	1	0	24/30
Mieroszów (town)	1	0	24/30
Czarny Bór municipality	0	0	0
Stare Bogaczowice municipality	0	1	16/25
Struga	0	1	16/25
Walim municipality	0	0	0

Source: Own study based on data from websites of entities, reports on the condition of municipalities, accessibility declarations. An asterisk (*) indicates urban municipalities, two asterisks (**) – urban-rural municipalities. No marking indicates a rural municipality. Gray refers to the eight municipalities studied.

Disproportions are also revealed by the analysis of the data included in Table 4. There are 17 kindergartens in the Wałbrzych district: 9 in urban municipalities, three in urban-rural municipalities (mainly in towns, with the exception of Sokołowsko) and five in rural municipalities. The vast majority of kindergartens are public kindergartens, i.e., those supervised and run by local self-government administration. The total number of kindergarten places in urban municipalities is 702, while the number of children entitled to use this form of care is 725 (in 2024). This means that almost every child living in urban municipalities is provided with kindergarten care. The situation is clearly different in urban-rural and rural municipalities. It turns out that only 604 children were provided with places in kindergartens (compared to 920 children who lived in the surveyed rural municipalities in 2024).

Table 4. Accessibility of kindergartens in the municipalities of the Wałbrzych district – physical dimension (A1)

Municipality	Number of public kindergartens	Number of private kindergartens	Number of places available
Boguszów–Gorce*	3	1	372
Jedlina Zdrój*	1	1	138
Szczawno–Zdrój*	1	2	192
Głuszyca municipality**	1	0	130
Głuszyca (town)	1	0	–
Mieroszów municipality**	2	0	168
Mieroszów (town)	1	0	–
Sokołowsko	1	0	–
Czarny Bór municipality	1	0	100
Czarny Bór	1	0	–
Stare Bogaczowice municipality	0	2	83
Stare Bogaczowice	0	1	–
Struga	0	1	–
Walim municipality	2	0	123
Dziećmorowice	1	0	–
Walim	1	0	–

Source: Own study based on official websites of kindergartens, reports on the condition of municipalities and declarations of accessibility. An asterisk (*) indicates urban municipalities, two asterisks (**) – urban-rural municipalities. No marking indicates a rural municipality. Gray refers to the eight municipalities studied.

The assessment of the second dimension of accessibility, the qualitative dimension (A2), concerns the duration of care services and the adaptation of entities providing these services to the needs of people with disabilities.

Considering the service provision time, it should be emphasised that no significant differences were identified between urban and rural municipalities. Entities, both nurseries and children's clubs, and kindergartens, are open on average between 6:00 and 17:00, from Monday to Friday (see: Table 5, Table 6). Therefore, the implementation of the care standard is characteristic of this type of entities, not only in the Wałbrzych district in question, but also in many other local self-government units in Poland. However, it should be remembered that residents of rural municipalities usually commute to work in the town/city, which means that they need more time to return to the municipality and pick up their child from the facility. For that reason, it can be assumed that in many cases the actual time of childcare is shorter due to the commuting time to and from the nursery or kindergarten which must be taken into account.

Nurseries and children's clubs operating in urban municipalities are much more often adapted to the needs of children with disabilities. These are 3 out of 4 entities. A similar disproportion concerns kindergartens and kindergarten departments at primary schools. Those located in urban municipalities are often more adapted to the

needs of people with disabilities than those operating within the boundaries of rural municipalities (see: Table 5, Table 6). Not in every instance the provision of adaptations is full, in many cases entities providing care services are only partially adapted to the needs of people with disabilities. Nevertheless, even after taking this fact into account, the advantage of kindergartens operating in urban municipalities over kindergartens operating in rural municipalities, is noticeable.

According to the adopted assumption, the essence of the third dimension of accessibility, namely, economic accessibility (A3), is determined by the amount of fees paid for the care and educational services provided. The data presented in Table 5 prove that all nurseries and children's clubs in the Wałbrzych district charge fees for care services. Significantly, these fees are higher on average in nurseries and children's clubs located within the administrative boundaries of rural municipalities than in the case of those operating in urban municipalities.

Table 5. Accessibility of nurseries and children's clubs in the municipalities of the Wałbrzych district: economic (A2) and qualitative (A3) dimensions

Municipality	Number of entities (total)	Opening hours	Adaptation to the needs of children with disabilities (Yes/No)	Amount of fee (in PLN)
Boguszów-Gorce*	1	6.30–16.30	Yes	1800,00
Jedlina Zdrój*	1	6.00–16.00	Yes	1300,00
Szczawno-Zdrój*	0	–	–	–
Głuszyca municipality**	1	–	–	–
Głuszyca (town)	1	6.00–16.00	No	2850,00
Mieroszów municipality**	1	–	–	–
Mieroszów (town)	1	6.00–16.00	Yes	1850,00
Czarny Bór municipality	0	–	–	–
Stare Bogaczowice municipality	1	–	–	–
Struga	1	6.00–17.00	No	1600,00
Walim municipality	0	–	–	–

Source: Own study based on official websites of nurseries and children's clubs, reports on the condition of municipalities and declarations of accessibility. An asterisk (*) indicates urban municipalities, two asterisks (**) – urban-rural municipalities. No marking indicates a rural municipality. Grey refers to the eight municipalities studied.

Considering the care provided by kindergartens, it should be noted that in public kindergartens it is free for five hours a day (Table 6). For each additional hour of care, as well as for meals used by children, a fee is charged. It is worth noting that the amount of these fees is similar in both urban and rural municipalities[5].

[5] It should be noted that there are objective problems in obtaining data on the costs of childcare in kindergartens, exceeding the 5 hours required by law. For this reason, this data is not included in Table 5.

Table 6. Accessibility of kindergartens in the municipalities of the Wałbrzych district: economic (A2) and qualitative (A3) dimensions

Municipality	Number of public kindergartens	Opening hours	Adaptation to the needs of children with disabilities (Yes/ No/Partially)	Amount of fee
Boguszów–Gorce*	4	6.45–16.30 6.00–16.30 6.00–16.30 5.30–17.00	No Partially Partially Yes	Free care Free care Free care 450,00
Jedlina Zdrój*	2	7.00–16.00 5.30–16.30	No No	Free care 350,00
Szczawno–Zdrój*	3	6.30–16.30 6.00–17.00 7.00–17.00	Partially Yes Yes	Free care 460,00 480,00
Głuszyca municipality**	1	–	–	
Głuszyca (town)	1	6.00–16.30	Partially	Free care
Mieroszów municipality**	2	–	–	
Mieroszów (town)	1	5.30–16.00	Partially	Free care
Sokołowsko	1	7.00–16.00	No	Free care
Czarny Bór municipality	1	–	–	
Czarny Bór	1	7.00–16.00	Partially	Free care
Stare Bogaczowice municipality	2	–	–	–
Stare Bogaczowice	1	6.00–17.00	No	No data available
Struga	1	6.00–17.00	No	No data available
Walim municipality	2	–		
Dziećmorowice	1	6.30–16.30	Yes	Free care
Walim	1	6.30–16.30	No	Free care

Source: Own study based on official websites of kindergartens and primary schools, reports on the state of municipalities and accessibility declarations. An asterisk (*) indicates urban municipalities, two asterisks (**) – urban-rural municipalities. No marking indicates a rural municipality. Gray refers to the eight municipalities studied.

Discussion and conclusions

The analysis of the accessibility of childcare for children up to 5 years of age covering the Wałbrzych district leads to the conclusion that the level of this accessibility, regardless of whether we are talking about the physical dimension (A1), qualitative dimension (A2), or economic dimension (A3), shows differentiation in the division into urban and rural municipalities. Due to the lack of detailed, specialist documents adopted at the strategic level, this statement refers to the operational level, which consists of the activities of entities providing care, i.e., nurseries, children's clubs, and kindergartens. The formulated hypothesis can be confirmed, although not fully, because the "advantage" of urban municipalities over rural municipalities, concerns the physical dimension (A1) in full, and only partially the qualitative dimension (A2), and economic dimension (A3). Regardless of the degree of positive verification of the hypothesis, the obtained results correspond in at least several points with the results of the findings relating to a larger scale.

According to the report of the Supreme Audit Office, only 25% of children up to 3 years of age can count on a place in a children's club or nursery. Moreover, in over 45% of municipalities, and these are mostly rural municipalities, there is not a single facility of this type (NIK, 2024, p. 9). Other conclusions accompany the analysis of the accessibility of kindergartens. As it results from the data of the Central Statistical Office, the percentage of children aged 3–6 using preschool education is at the level of 96.1%, which indicates an incomparably larger number of facilities providing services, both public and private ones (GUS, 2024, p. 16). In most cases, these are kindergartens operating within the administrative boundaries of towns and cities. Of the total number of 76,276 branches, 49,785 branches operate in towns and cities, while 26,491 branches – in countrysides (GUS, 2024a). Relating these data to the situation in the Wałbrzych district, one may be tempted to say that the dividing lines between the urban areas and rural areas are noticeable. The identified disproportions, which correspond to national data and fit into the aforementioned trend of research on childcare taking into account the importance of spatial (location) conditions, lead to the formulation of at least several conclusions.

Firstly, one can make a very cautious assumption that the development and adoption by local self-government administrations of separate specialist documents regulating the issue of childcare (strategic level) could affect the level of accessibility of this care. Research shows that professional strategic management can be a factor that dynamises and increases the scope of the activities carried out at the operational level (cf. Hausner, 2001).

Secondly, while the lack of clear differences in the scope of childcare time in nurseries, children's clubs, and kindergartens may be treated as the implementation of the postulate to provide this care in such a way as to enable parents and guardians to be professionally active, the disproportions regarding adaptations to children with disabilities are an expression of a different approach implemented by entities providing care in nurseries, children's clubs, and kindergartens in urban and rural municipalities. The differentiation of the qualitative dimension of accessibility (A2) related to adaptations may also indicate the efficiency of local self-government administrations,

which are able to obtain appropriate financial resources for the adaptation of nursery and kindergarten buildings (which is the case in urban municipalities), or for various reasons do not make such efforts, or make them insufficiently (as confirmed by the example of rural municipalities).

Thirdly, the relatively low level of differentiation in the accessibility of preschool care in the economic dimension (A3) is the result of the legal and organisational solutions in force in Poland. As mentioned, children up to the age of 5 are provided, children with 5 hours of free preschool care, regardless of whether the entity providing such a service operates in urban or rural areas. In the case of care provided by nurseries and children's club, such solutions are lacking. This deficit translates into differences between the urban areas and rural areas. The costs of care for children up to the age of 3 are noticeably higher in rural municipalities. This also confirms the thesis about the decisive influence of local self-government administration as the initiator and implementer of local sectoral policies on the accessibility of key social services.

The fourth conclusion, and this is a conclusion referring to further research on the accessibility of childcare for children up to 5 years of age in the Wałbrzych district, refers to the strategies for dealing with accessibility deficits implemented by local self-government administrations (as care organisers) and parents and guardians of children (as beneficiaries of care). In this case, it is research taking into account a dual perspective (local self-government administration versus parents and guardians of children) based on the analysis of empirical material, e.g., structured interviews. This is a direction that allows for an in-depth and multi-factorial illustration of the opinions, motivations and actions of organisers and beneficiaries of, as has been proven, a clearly diversified childcare system in Poland.

The fifth conclusion concerns the recommendations addressed to self-governments' administrations responsible for ensuring the childcare accessibility for children under 5 years of age. Regardless of whether we are talking about local self-government administration operating in urban or rural areas, it is necessary to emphasise the need to increase financing for childcare for children up to 5 years of age and to cooperate, where possible and justified, with external entities (private and social) that can provide such care. It seems that, given the objective financial and organisational deficits that affect the functioning of districts such as Wałbrzych, appropriately planned childcare is essential. Such programming requires the development and adoption of specialised strategic documents, which, even when they exist, do not always meet the criteria of professionalism.

References

Abankina, I. & Filatova, L. (2018). Accessibility of pre-school education. *Educational Studies Moscow*, *3*, 216–246. https://doi.org/10.17323/1814-9545-2018-3-216-246

Abrassart, A. & Bonoli, G. (2015). Availability, cost or culture? Obstacles to childcare services for low-income families. *Journal of Social Policy*, *44*(4), 787–806. https://doi.org/10.1017/S0047279415000288

Agyekum, M.W., Yeboah, S.B., Dzradosi, C., Ofosu-Ampong, K., Quaye, M.O., & Donkoh, C. (2023). Rural–urban differentials in early childhood education and child development: Evidence from Multiple Indicator Cluster Survey (MICS) in Ghana. *PLOS Global Public Health*, *3*(8), e0002171. https://doi.org/10.1371/journal.pgph.0002171

Alexiadou, N. & Stadler Altmann, U. (2020). Early childhood education research in Europe: Contexts, policies and ideas. *Education Inquiry*, *11*(2), 89–93. https://doi.org/10.1080/20004508.2020.1736795

Alm, A.F. & Forsberg, H. (2023). Even in preschools: Analysing the preschool and neighbourhood segregation gap in Swedish municipalities. *European Sociological Review*, *39*(5), 677–691. https://doi.org/10.1093/esr/jcad004

Anderson, S. & Mikesell, M. (2017). Child care type, access and quality in rural areas of the United States: A review. *Early Child Development and Care*, *189*(11), 1812–1826. https://doi.org/10.1080/03004430.2017.1412959

Atkinson, A.M. (1994). Rural and urban families' use of child care. *Family Relations*, *43*(1), 16–22. https://doi.org/10.2307/585137

Atkinson, A.M. (1996). Rural mothers' evaluation of the strong and weak points of child care. *Journal of Research in Rural Education*, *12*(2), 83–91. https://jrre.psu.edu/sites/default/files/2019-08/12-2_7.pdf

Bassok, D., Fitzpatrick, M., & Loeb, S. (2011). *Disparities in child care availability across communities: Differential reflection of targeted interventions and local demand* (CEPA Working Paper). https://cepa.stanford.edu/sites/default/files/Bassok_Fitzpatrick_Loeb_Disparities%20in%20Child%20Care%20Availability_Draft_April%202011.pdf

Beach, B.A. (1995). What do we know about rural child care: An overview of issues. *Journal of Research in Rural Education*, *11*(2), 114–122. https://jrre.psu.edu/sites/default/files/2019-08/11-2_2.pdf

Beck, K. & Kaune, M. (2025). *Early childhood development and cities*. https://urban95academy.org/new-publication-early-childhood-development-and-cities/

Boguszów-Gorce. (2025). *Oficjalny serwis Miasta Boguszów-Gorce*. https://boguszow-gorce.pl/

Bucaite-Vilke, J. (2021). Family choices on welfare and territorial disadvantages: The perception of the child care services approach in urban and rural areas. *SAGE Open*, *11*(3). https://doi.org/10.1177/21582440211032641

Cordero-Vinueza, V.A., Niekerk, F., & van Dijk, T. (2023). Making child-friendly cities: A socio-spatial literature review. *Cities*, *137*, 104248. https://doi.org/10.1016/j.cities.2023.104248

Council of Europe. (2025). *Children's rights*. https://www.coe.int/en/web/children

Crouch, E., Hung, P., Benavidez, G., Giannouchos, T., & Brown, M.J. (2024). Rural–urban differences in access to care among children and adolescents in the United States. *The Journal of Rural Health*, *40*(1), 200–207. https://doi.org/10.1111/jrh.12769

Czarny Bór. (2025). *Strategia rozwoju*. https://bip.czarny-bor.pl/dokumenty/menu/38

Daly, M. (2003). Governance and social policy. *Journal of Social Policy*, *32*(1), 113–128. https://doi.org/10.1017/S0047279402006840

Davis, E.E. & Weber, R.B. (2001). The dynamics of childcare subsidy use by rural families in Oregon. *American Journal of Agricultural Economics*, *83*(5), 1293–1301. https://doi.org/10.1111/0002-9092.00281

Davis, E.E., Won, F.L., & Sojourner, A. (2019). Family-centered measures of access to early care and education. *Early Childhood Research Quarterly*, *47*(2). https://doi.org/10.1016/j.ecresq.2018.08.001

Della Porta, D. (2008). Comparative analysis: Case-oriented versus variable-oriented research. In D. Della Porta & M. Keating (Eds.), *Approaches and methodologies in the social sciences: A pluralist perspective* (pp. 198–222). Cambridge University Press.

Dye, T.R. (2014). *Understanding public policy*. Pearson Education Limited.

ECD. (2019). *The link between child care and the economy*. https://www.earlyyearsnc.org/2019/02/07/the-link-between-child-care-and-the-economy/

Eurydice. (2025). *Wczesna edukacja i opieka*. https://eurydice.eacea.ec.europa.eu/pl/eurypedia/poland/dostepnosc-placowek

European Commission. (2025a). *European accessibility act*. https://commission.europa.eu/strategy-and-policy/policies/justice-and-fundamental-rights/disability/union-equality-strategy-rights-persons-disabilities-2021-2030/european-accessibility-act_en

European Commission. (2025b). *European education area: Quality education and training for all*. https://education.ec.europa.eu/education-levels/early-childhood-education-and-care

European Union. (2021). *Strategy for the rights of persons with disabilities 2021–2030*. https://op.europa.eu/en/publication-detail/-/publication/3e1e2228-7c97-11eb-9ac9-01aa75ed71a1/language-en

Farfan-Portet, M.I., Lorant, V., & Petrella, F. (2011). Access to childcare services: The role of demand- and supply-side policies. *Population Research and Policy Review*, *30*(2), 165–183. https://doi.org/10.1007/s11113-010-9184-z

Farrington, F. & Farrington, C. (2005). Rural accessibility, social inclusion and social justice: Toward conceptualisation. *Journal of Transport Geography*, *13*, 1–12. https://doi.org/10.1016/j.jtrangeo.2004.10.002

Geurs, K.T. & Ritsema van Eck, J.R. (2001). *Accessibility measures: Review and applications. Evaluation of accessibility impacts of land-use transportation scenarios and related social and economic impacts*. RIVM Report, Urban Research Centre, Utrecht University.

Glinka, K. (2014). Zarządzanie wizerunkiem dużego miasta na przykładzie Wałbrzycha. *Ogrody Nauk i Sztuk*, *4*, 506–515. https://doi.org/10.15503/onis2014.506.515

Glinka, K. (2021). The biggest Polish cities in response to the first wave of the COVID-19 pandemic: The perspective of municipal self-government administration. *Przegląd Politologiczny*, *21*(2), 47–69. https://doi.org/10.14746/pp.2021.26.2.4

Glinka, K. (2023). *Przeskalowanie urban governance. Doświadczenia miast wojewódzkich w Polsce*. Wydawnictwo Naukowe Scholar.

Glinka, K., Cabada, L., Klimovský, D., & Soós, E. (Eds.). (2025). *Urban responses to the COVID-19 pandemic: Perspectives of the Visegrad Group countries*. Routledge. https://doi.org/10.4324/9781003634003

Głuszyca. (2025). *Kierunki strategii rozwoju. Plan rozwoju lokalnego*. https://www.bip.gluszyca.pl/kierunki-strategii-rozwoju-plan-rozwoju-lokalnego/5673

Goering, S. (2015). Rethinking disability: The social model of disability and chronic disease. *Current Reviews in Musculoskeletal Medicine*, *8*(2), 134–138. https://doi.org/10.1007/s12178-015-9273-z

Gordon, R.A. & Chase-Lansdale, P.L. (2001). Availability of child care in the United States: A description and analysis of data sources. *Demography*, *38*(2), 299–316. https://doi.org/10.1353/dem.2001.0016

GUS. (2023). *Opieka nad dziećmi w wieku do 3 lat w 2023 r.* https://stat.gov.pl/obszary-tematyczne/dzieci-i-rodzina/dzieci/opieka-nad-dziecmi-w-wieku-do-lat-3-w-2023-roku,3,11.html

GUS. (2024a). *Opieka i wychowanie w roku szkolnym 2023/2024*. https://stat.gov.pl/obszary-tematyczne/edukacja/edukacja/oswiata-i-wychowanie-w-roku-szkolnym-20232024,1,19.html

GUS. (2024b). *Opieka i wychowanie w roku szkolnym 2023/2024: Informacje sygnalne*. https://stat.gov.pl/obszary-tematyczne/edukacja/edukacja/oswiata-i-wychowanie-w-roku-szkolnym-20232024,1,19.html?contrast=default

GUS. (2024c). *Ludność. Stan i struktura ludności oraz ruch naturalny w przekroju terytorialnym w 2024 r. (stan w dniu 30.06)*. https://stat.gov.pl/obszary-tematyczne/ludnosc/ludnosc/ludnosc-stan-i-struktura-ludnosci-oraz-ruch-naturalny-w-przekroju-terytorialnym-w-2024-r-stan-w-dniu-30-06,6,37.html

Halliday, J. & Little, J. (2001). Amongst women: Exploring the reality of rural childcare. *Sociologia Ruralis*, *41*(4), 423–437. https://doi.org/10.1111/1467-9523.00192

Hausner, J. (2008). *Zarządzanie publiczne*. Wydawnictwo Naukowe Scholar.

Hausner, J. (Ed.). (2001). *Studia z zarządzania publicznego*. Wydawnictwo Akademii Ekonomicznej w Krakowie.

Howlett, M. (2011). *Designing public policies*. Routledge.

Jedlina-Zdrój. (2025). *Strategie i programy*. https://jedlinazdroj.eu/miasto/strategie-i-programy.html

Kang, E.J. & Hwang, M.H. (2024). Diagnosing communities' childcare friendliness: Case studies of two South Korean cities. *Children's Geographies*, *22*(6), 878–897. https://doi.org/10.1080/14733285.2024.2397736

Kanior, A., Pluszyńska, A., Grabowska, A., & Czyczyło, A. (2024). Accessibility implementation in public cultural institutions: An opportunity or a legally imposed necessity? *Problemy Polityki Społecznej. Social Policy Issues*, *67*(4), 1–23. https://doi.org/10.31971/pps/173429

Kurowska, A. & Szczupak, K. (2016). Zmiany w dostępie do usług opieki nad dzieckiem poniżej trzech lat w polskich gminach i popyt na te usługi. *Prace Naukowe Uniwersytetu Ekonomicznego we Wrocławiu*, *456*, 180–191. https://doi.org/10.15611/pn.2016.438.11

Lee, H.Ch. & Ha, M.K. (2022). A study on the development of childcare environment in urban low-rise residential areas based on child-friendly city. *Journal of the Architectural Institute of Korea*, *38*(12). https://doi.org/10.5659/JAIK.2022.38.12.25

Maher, E.J., Frestedt, B., & Grace, C. (2008). Differences in childcare quality in rural and non-rural areas. *Journal of Research in Rural Education*, *23*(4), 1–13. https://jrre.psu.edu/sites/default/files/2019-08/23-4.pdf

Malik, R. & Schochet, L. (2018). *A compass for families: Head Start in rural America*. Center for American Progress. https://cdn.americanprogress.org/content/uploads/2018/04/09071311/RuralHeadStart-report-final-.pdf

Mazur, S. (Ed.). (2014). *Współzarządzanie publiczne*. Wydawnictwo Naukowe Scholar.

McLean, C., Naumann, I., & Koslowski, A. (2017). Access to childcare in Europe: Parents' logistical challenges in cross-national perspective. *Social Policy & Administration*, *51*(7), 1367–1385. https://doi.org/10.1111/spol.12242

Mieroszów. (2025). *Strategia rozwoju lokalnego kierowanego przez społeczność na lata 2023–2027*. https://mieroszow.pl/strategia-rozwoju-lokalnego-kierowanego-przez-spolecznosc-na-lata-2023-202729/

Miller, P. & Vortuba-Drzal, E. (2013). Early academic skills and childhood experiences across the urban–rural continuum. *Early Childhood Research Quarterly*, *28*(2), 234–248. https://doi.org/10.1016/j.ecresq.2012.12.005

Moran, M., Rein, M., & Goodin, R.E. (2006). *The Oxford handbook of public policy*. Oxford University Press.

Morrissey, T.W., Allard, S.W., & Pelletier, E. (2022). Access to early care and education in rural communities: Implications for children's school readiness. *RSF: The Russell Sage Foundation Journal of the Social Sciences*, *8*(3), 100–123. https://doi.org/10.7758/RSF.2022.8.3.04

Moseley, M.J. (1979). *Accessibility: the rural challenge*. Methuen.

Motiejunaite, A. (2021). Access and quality of early childhood education and care in Europe: An overview of policies and current situation. *IUL Research Open Journal of IUL University*, *2*(4), 64–80. https://doi.org/10.57568/iulres.v2i4.190

Moussié, R. (2021). Childcare services in cities: Challenges and emerging solutions for women informal workers and their children. *Environment & Urbanization*, *33*(1), 117–130. https://doi.org/10.1177/0956247820987096

Neumeier, S. (2016). Accessibility to services in rural areas: The example of petrol service provision in Germany. *disP – The Planning Review*, *52*(3), 32–49. https://doi.org/10.1080/02513625.2016.1235877

NIK. (2014). *Rozwój systemu opieki nad dziećmi do lat 3, w tym realizacja programu „Maluch+". Informacja o wynikach kontroli*. https://www.nik.gov.pl/kontrole/P/23/034/

NIK. (2019). *Zapewnienie przez gminy opieki przedszkolnej*. https://www.nik.gov.pl/plik/id,20566,vp,23193.pdf

OECD. (2025). *Early childhood education and care*. https://www.oecd.org/en/about/programmes/early-childhood-education-and-care-ecec.html

Penchansky, R. & Thomas, J.W. (1981). The concept of access: Definition and relationship to consumer satisfaction. *Medical Care*, *19*, 127–140. https://doi.org/10.1097/00005650-198102000-00001

Pennerstorfer, A., Pennerstorfer, D., & Neumayr, M. (2024). Unequal access to childcare in cities: Is equal public funding sufficient? *Urban Studies*, *62*(4), 647–664. https://doi.org/10.1177/00420980241258298

Przybyła, K. (2015). Zmiany poziomu życia w Wałbrzychu na tle większych miast Dolnego Śląska. *Studia Miejskie*, *19*, 121–129.

Sabatier, P.A. (2007). *Theories of the policy process*. Westview Press.

Saurman, E. (2015). Improving access: Modifying Penchansky and Thomas's theory of access. *Journal of Health Services Research & Policy*, *21*(1), 36–39. https://doi.org/10.1177/1355819615600001

Sroka, J. (2009). *Deliberacja i rządzenie wielopasmowe. Teoria i praktyka*. Wydawnictwo Uniwersytetu Wrocławskiego.

Stanny, M., Rosner, A., & Komorowski, Ł. (2023). *Monitoring rozwoju obszarów wiejskich. Etap IV: Dekada przemian społeczno-gospodarczych*. Fundacja Europejski Fundusz Rozwoju Wsi Polskiej; Instytut Rozwoju Wsi i Rolnictwa PAN.

Stare Bogaczowice. (2025). *Strategia rozwoju gminy*. https://www.starebogaczowice.ug.gov.pl/gmina/strategia-rozwoju-gminy

Stolińska-Pobralska, N. (2012). Publiczno-prawny charakter instytucjonalnej opieki nad dzieckiem trzyletnim w Polsce. *Pedagogika Rodziny*, *2*(3), 115–125.

Subocz, E. (2019). Wczesna edukacja i opieka nad dzieckiem jako wyzwanie dla polityki społecznej z perspektywy Unii Europejskiej. *Problemy Wczesnej Edukacji*, *1*(44), 103–113. https://doi.org/10.26881/pwe.2019.44.10

Szarfenberg, R. (2016). Polityka publiczna – zagadnienia i nurty teoretyczne. *Studia z Polityki Publicznej*, *3*, *1*(9), 45–75. https://doi.org/10.33119/KSzPP.2016.1.1

Szczawno-Zdrój. (2025). *Plany, programy i strategie*. http://um.szczawnozdroj.ibip.wroc.pl/public/?id=38590

Taryn, W., Scott, W., & Allard, P.E. (2022). Access to early care and education in rural communities: Implications for children's school readiness. *RSF: The Russell Sage Foundation Journal of the Social Sciences*, *8*(3), 100–123. https://doi.org/10.7758/RSF.2022.8.3.04

Taylor, Z. (1999). *Przestrzenna dostępność miejsc zatrudnienia, kształcenia i usług a codzienna ruchliwość ludności wiejskiej*. Polska Akademia Nauk, Wydawnictwo Continuo.

Tervo, M., Kotavaara, O., Antikainen, H., & Rusanen, J. (2013). Accessibility analysis of public services in rural areas under restructuring. *Nordia Geographical Publications*, *42*(2), 39–55.

Tietze, W. & Cryer, D. (1999). Current trends in European early child care and education. *The ANNALS of the American Academy of Political and Social Science*, *563*(1), 175–193. https://doi.org/10.1177/000271629956300111

Walim. (2025). *Prawo lokalne*. https://bip.walim.pl/?c=69

Weimer, D.L. & Vining, A. (2011). *Policy analysis: Concepts and practice*. Routledge.

Wspólnota. (2023). *Najbogatsze samorządy w 2023 r. Ranking dochodów per capita*. https://wspolnota.org.pl/fileadmin/news/RANKINGI/Ranking_nr_15-2024_Zamoznosc_samorzadow_MAIL.pdf

Zakrzewska-Półtorak, A. (2010). Problemy rozwoju Wałbrzycha i ich znaczenie dla rozwoju województwa dolnośląskiego. *Biblioteka Regionalisty*, *10*, 263–273. https://dbc.wroc.pl/Content/35006/Zakrzewska-Poltorak_Problemy_Rozwojowe_Walbrzycha_i_Ich.pdf

Zybała, A. (2012). *Polityki publiczne. Doświadczenia w tworzeniu i wykonywaniu programów publicznych w Polsce i w innych krajach*. Krajowa Szkoła Administracji Publicznej. https://ksap.gov.pl/ksap/sites/default/files/publikacje/polityki_publiczne.pdf

Zybała, A. (2013). *Państwo i społeczeństwo w działaniu. Polityki publiczne wobec potrzeb modernizacji państwa i społeczeństwa*. Difin.

Legal acts:

Act (2019). Directive (EU) 2019/882 of the European Parliament and of the Council of 17 April 2019 on the accessibility requirements for products and services.

Ustawa (2004). Ustawa z dnia 12 marca 2004 r. o pomocy społecznej, Dz. U. 2024, poz. 1283 (z późn. zm.).

Ustawa (2011). Ustawa z dnia 4 lutego 2011 r. o opiece nad dziećmi do lat 3, Dz. U. 2024, poz. 338, 743, 858.
Ustawa (2016). Ustawa z dnia 14 grudnia 2016 r. – Prawo oświatowe, Dz. U. 2024, poz. 737, 854, 1562, 1635, 1933.
Ustawa (2019). Ustawa z dnia 19 lipca 2019 r. o realizowaniu usług społecznych przez centra usług społecznych, Dz. U. 2019, poz. 1818 (z późn. zm.).