The determinants of health and the health needs across excluded Roma enclaves in Slovakia

Andrej Belák

Zdravé regióny

EURÓPSKA ÚNIA
Európsky sociálny fond
Európsky fond regionálneho rozvoja
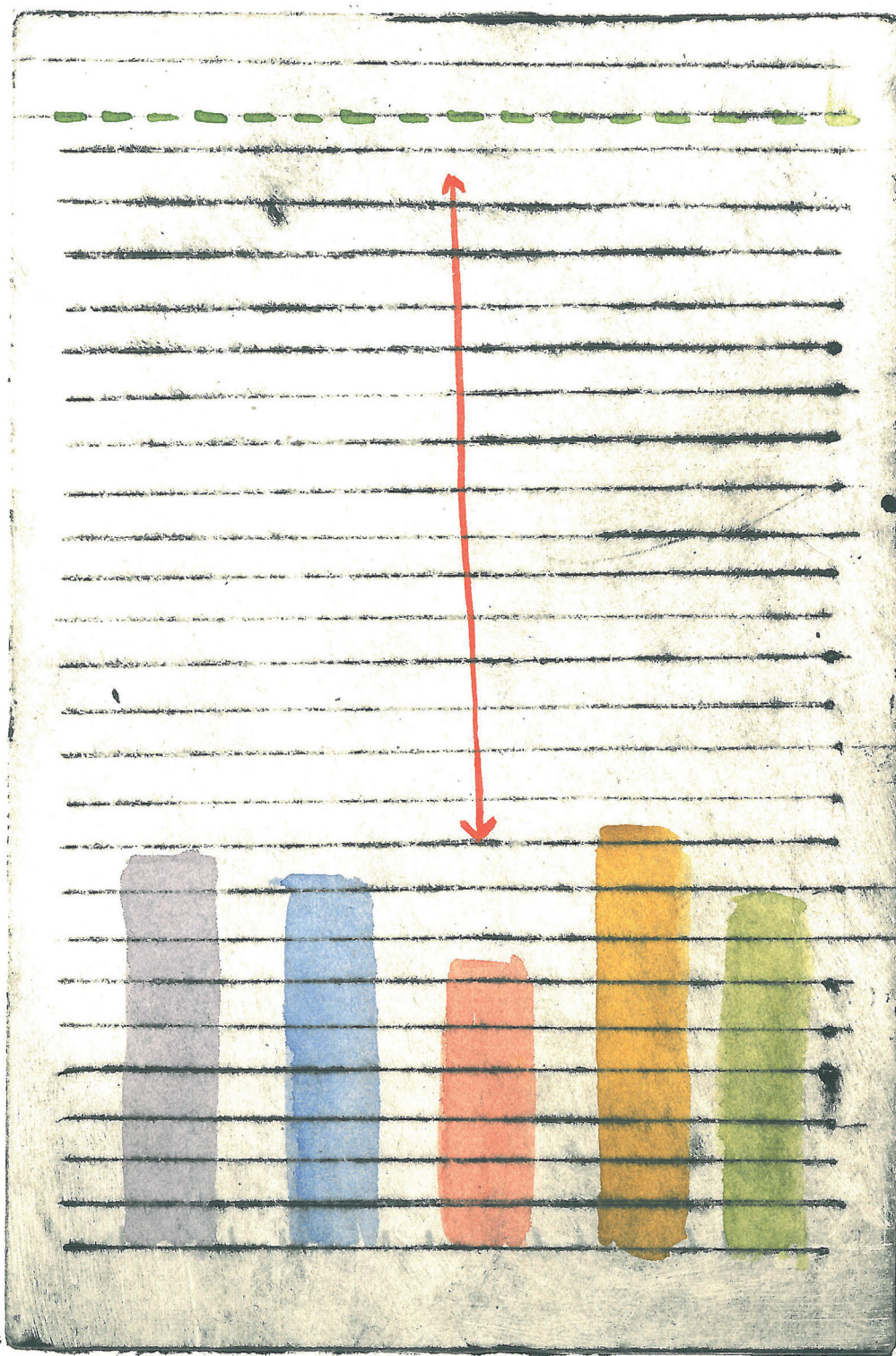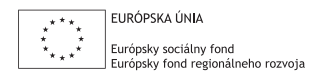
OPERAČNÝ PROGRAM
ĽUDSKÉ ZDROJE

The determinants of health and the health needs across excluded Roma enclaves in Slovakia

Final report from the initial phase of the impact evaluation and health needs assessment across target locations of the National Project Healthy Communities 2A

Andrej Belák

Contents

Key terms and abbreviations used

1
Related terminological guideline by the Slovak Government's Office of the Plenipotentiary for Roma communities (2018) defined the marginalized Roma communities as "Roma communities living predominantly in concentrations (excluded) and suffering from systematic disadvantages in the areas of education, employment, housing and health." At the same time, the material emphasizes that the term does not regard a place, but a group of people.

CENSUS – The first step of the NP HC initial impact evaluation phase (carried out in 2019), consisting in a complete population census and a households and household amenities census across excluded Roma enclaves in the target locations of the project and in the control locations of the NP HC impact evaluation.

Control locations of the NP HC impact evaluation – Municipalities with excluded Roma enclaves in which the HPAs have not yet been active and which were included in the initial impact evaluation phase of the NP HC as a control group.

Determinants of health – All circumstances that significantly affect health status at the population level, traditionally divided into specific groups according to the nature of the circumstances (such as biological factors, environmental factors, lifestyle, socio-political context, etc.)

Determinants of health at the community level – Domains of social determinants that can be positively influenced through the fieldwork of HPAs and HPACs: A) Health-related practices, B) Psychological burden, C) Material conditions, D) Health care services access and E) Social position and opportunities.

ESF – European Social Fund

Excluded Roma enclave – A residential enclave whose population has a significant predominance of people who identify (also) as Roma and occupied also by so-called excluded (marginalized) Roma.[1]

Follow-up phase of the impact evaluation – Quantitative assessment of the level of determinants of health in the target locations of the NP HC and the in the control locations of the NP HC impact evaluation for the (originally, prior to the COVID-19 pandemic planned for 2022, now postponed to 2026).

Health needs assessment – Determining the extent to which it is necessary to improve the current health determinants level(s) in specific locations in order to significantly improve the health environment and (consequently) the health status of their inhabitants.

Health promotion assistant (HPA) – Field worker of the National Project Healthy Communities (NP HC) providing educational, mediation and assistance services in the area of health on a daily basis directly in one or several excluded Roma enclaves targeted by the project (some HPAs cover several smaller excluded Roma enclaves and some larger

excluded enclaves require coverage by several HPAs). At the time of completion of the initial evaluation phase (project phase 2A), the NP HC project employed a total of 262 HPAs across 255 municipalities.

Health Promotion Assistants Coordinator (HPAC) – Manages a group of HPAs serving in a specific geographic area (coordination area). At the time of completion of the initial impact evaluation phase (project phase 2A), the NP HC project employed 24 HPACs, with one HPAC managing the work of 11 HPAs on average.

Healthy communities – An original collaborative intervention model in the field of health promotion and prevention focused on excluded Roma enclaves through continuous educational, mediation and assistance work of community field workers coming directly from the target enclaves. Originally developed in the Slovak non-profit sector and gradually adopted by the central state administration.

Household – A group of people sharing a common housing space, eating together and preferring common housing (typically a nuclear family).

HR – Healthy Regions, a state contributory organization of the Ministry of Health of the Slovak Republic managing and implementing the NP HC since 2017.

Initial phase of the impact evaluation – Quantitative assessment of the initial levels of the determinants of health within the target locations of the NP HC and in the control locations of the NP HC impact evaluation for the period 2019–22, implemented in 2019 (project phase 2A).

MoH – Ministry of Health of the Slovak Republic

National Project Healthy Communities (NP HC) – A national project financed from the ESF through which, since 2017, the Healthy Regions (HR), a contributory

organization of the Ministry of Health of the Slovak Republic, has managed, operated and developed the intervention model Healthy Communities.

OP HR – ESF Operational Programme Human Resources

OPRC – Slovak Government's Office of the Plenipotentiary for Roma communities

REPRE-assessment – The second step of the NP HC initial impact evaluation phase (carried out in 2019), consisting in structured interviewing in samples of excluded Roma households representative for specific NP HC target or control locations.

Specific health needs profile – Diagram illustrating the basic components and sizes of the health needs of an excluded Roma enclave (or enclaves) in a given location (or group of locations) regarding a specific subgroup of health determinants (such as material conditions).

Summary profile of health needs – Diagram illustrating the size of health needs of an excluded Roma enclave (or enclaves) in a location (or group of locations) for all five main domains of social determinants of health at the community level (A – E).

Target locations of the NP HC – Municipalities with excluded Roma enclaves in which the HPAs of the NP HC project operate. At the time of completion of the initial impact evaluation phase (project phase 2A), the NP HC covered a total of 450 excluded Roma enclaves in 255 target locations.

The level of determinants of health – The extent to which setups of community-level health determinants identified in an excluded Roma enclave (or enclaves) do not present risky environment according to current biomedical criteria; in most cases expressed as the share of households from the considered enclaves that are not exposed to critical risk values for selected indicators of determinants of health.

Summary

[1] https://zdraveregiony.eu/

This report describes the results and methods of the first **detailed quantitative assessment of the determinants of health across excluded Roma enclaves in Slovakia** as well as the first **comprehensive assessment of the health needs in these enclaves**. Both assessments were carried out on behalf of *Healthy Regions* (HR), a state contributory organization of the Ministry of Health of the Slovak Republic (MoH), for the purposes of the *National Project Healthy Communities* (NP HC). The NP HC aims at systematic improvement of the extremely poor health status of people living in excluded Roma enclaves via community health work. The NP HC is financed mostly by European Structural and Investment Funds via its Operational Programme Human Resources.[1]

Purposes of the assessments

[2] According to a contract between P. J. Šafárik University and the HR contributory organization. The research team members and their roles are listed on page 197.

The main purpose of the assessment of the determinants of health, conducted in 2019, was to provide **initial data necessary for the evaluation of the NP HC's impact** over the period 2019–2022. The follow-up assessment of this evaluation was originally scheduled for the end of the given period, but later postponed to 2026 due to the COVID-19 pandemic. The main purpose of the health needs assessment, based on the results of the initial assessments of social determinants, was **to determine what is needed to improve health in the Roma enclaves** targeted by the NP HC. The research on which both assessments were based was performed by a researcher team from the Faculty of Medicine of Pavol Jozef Šafárik University in Košice (UPJŠ) led by the author of this report.[2]

Conceptual approach to the the impact evaluation

[3]
Even though all of these requirements might seem ordinary, meeting them all at once is quite rare with respect to excluded Roma in Slovakia, even within projects of a much smaller scale. Designing effective interventions at the community level without initial data regarding individual communities is practically impossible. Yet, except for some basic data delivered by the so-called "Atlases of Roma communities" (2004, 2013, 2019), no related surveys representative for larger geographic areas (including academic studies) have thus far attempted to provide complex data more specific than county averages. Designing interventions without prior consultation of the targeted people is not legitimate. However, in reality this principle only gets thoroughly applied exceptionally, including in cases when such a principle is formally declared.

The assignment for the initial quantitative assessment of the determinants of health across the targeted Roma enclaves included a pioneering combination of requirements regarding both the assessment's outputs and methods. The outputs were required to include data covering all kinds of determinants of health relevant according to previous expert knowledge – thus, they had to be theoretically comprehensive. Next, they were required to be of immediate use for the NP HC, especially with respect to individual municipalities – that is, they were supposed to be practical at the community level. Finally, the outputs were required to have been obtained and presented in a manner explicitly sensitive regarding the rights and views of the residents of the excluded enclaves – they had to be ethical.[3]

In response to the requirements and utilizing the extraordinary related capacities of the NP HC itself[4], the UPJŠ implementation team opted for a **radically collaborative approach to the research: both the NP HC management and the residents of the targeted excluded Roma enclaves were continuously engaged** in the specification of research objectives and focuses, in the preparation of research procedures, in carrying out the field work and in the finalization and interpretation of the research results.
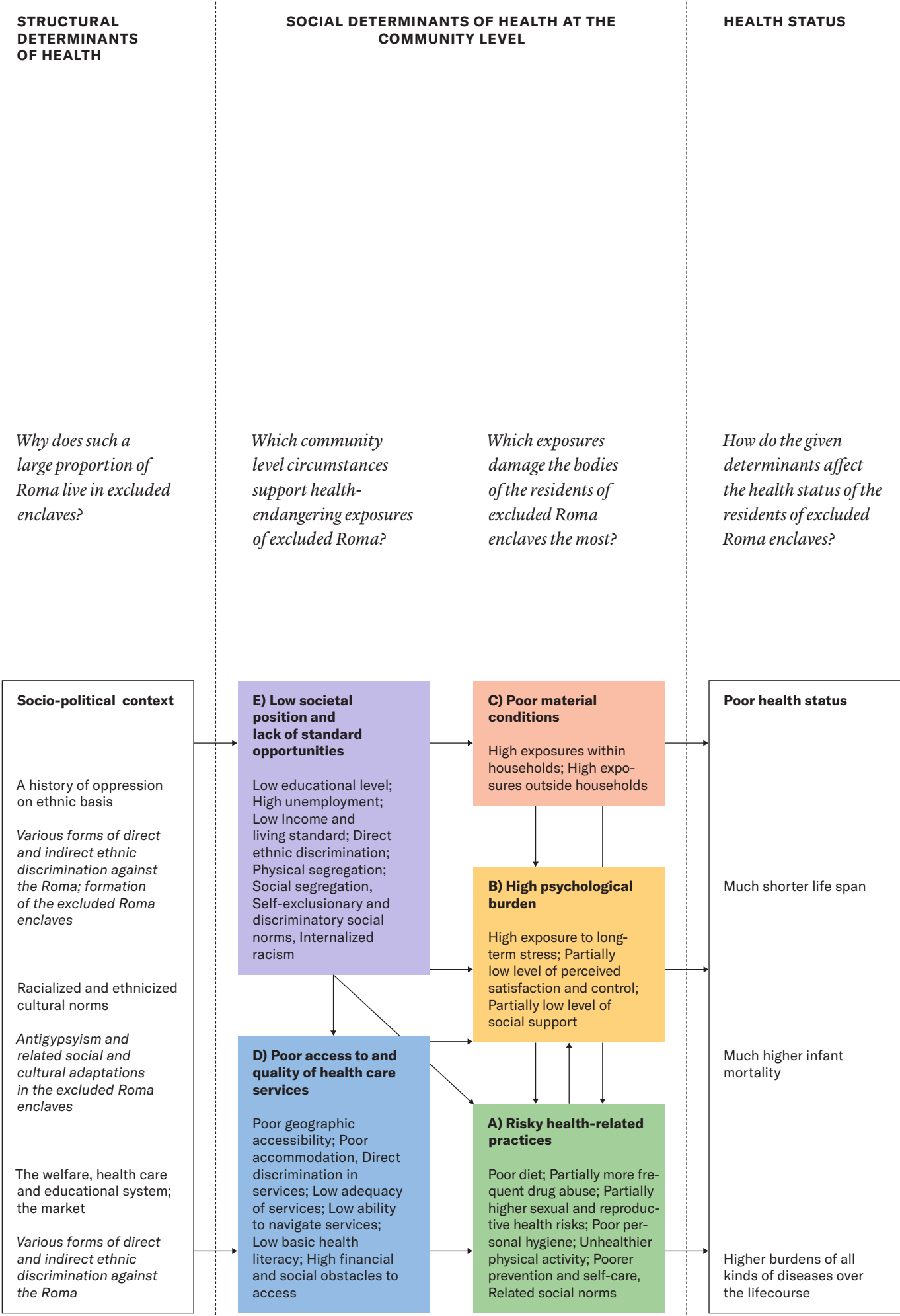
Impact evaluation methods

[4]
At the time of the assessments, the NP HC daily provided outreach, mediation and assistance directly in approximately 3/4 of all excluded Roma enclaves in Slovakia. The majority of the involved field workers came from the targeted enclaves themselves and most of them also continued living there. In both respects, the NP HC seems quite extraordinary in a Europewide context (see e. g. Belak et al. 2017).

The selected research approach enabled the UPJŠ research team to first devise **an original tool for quantitative assessment of the level of determinants of health across excluded Roma enclaves**. The tool design was carried out in 2018. It started with a systematic review of related scientific literature and followed with an intense qualitative research phase in four distinct target locations of the NP HC. Next, it consisted in the gradual sorting, selection and partial adaptation of specific standard assessment methodologies. All these steps were directed according to the idea that the resulting toolkit needed to be instrumental for assessment in a **standardly fast, yet more comprehensive, practical and ethically sensitive way**.

The final assessment toolkit consisted of an original set of

standard specific indicators and an original sequence of standard procedures for determining the values for the given indicators in the given environment using NP HC field workers' capacities. Through its indicators, the tool focused in particular on the following 5 domains of determinants of health: **A) Health-related practices, B) Psychological burden, C) Material conditions, D) Health care services access and E) Social position and opportunities**. Figure 1 shows the more detailed contents of each of the groups, their expected roles with respect to the health status of excluded Roma in Slovakia, and their determinants as well as their mutual interactions. Based on this preliminary theoretical framework, the above listed domains of determinants can be collectively considered as **determinants of health at the community level**.

Fig. 1 →
Determinants of the poor health status of excluded Roma in Slovakia, emphasizing (in colour) all five domains of determinants assessed at the community level (originally based on WHO 2015)

| STRUCTURAL DETERMINANTS OF HEALTH | SOCIAL DETERMINANTS OF HEALTH AT THE COMMUNITY LEVEL | HEALTH STATUS |

Why does such a large proportion of Roma live in excluded enclaves?

Which community level circumstances support health-endangering exposures of excluded Roma?

Which exposures damage the bodies of the residents of excluded Roma enclaves the most?

How do the given determinants affect the health status of the residents of excluded Roma enclaves?

Socio-political context

A history of oppression on ethnic basis

Various forms of direct and indirect ethnic discrimination against the Roma; formation of the excluded Roma enclaves

Racialized and ethnicized cultural norms

Antigypsyism and related social and cultural adaptations in the excluded Roma enclaves

The welfare, health care and educational system; the market

Various forms of direct and indirect ethnic discrimination against the Roma

E) Low societal position and lack of standard opportunities

Low educational level; High unemployment; Low Income and living standard; Direct ethnic discrimination; Physical segregation; Social segregation, Self-exclusionary and discriminatory social norms, Internalized racism

D) Poor access to and quality of health care services

Poor geographic accessibility; Poor accommodation, Direct discrimination in services; Low adequacy of services; Low ability to navigate services; Low basic health literacy; High financial and social obstacles to access

C) Poor material conditions

High exposures within households; High exposures outside households

B) High psychological burden

High exposure to long-term stress; Partially low level of perceived satisfaction and control; Partially low level of social support

A) Risky health-related practices

Poor diet; Partially more frequent drug abuse; Partially higher sexual and reproductive health risks; Poor personal hygiene; Unhealthier physical activity; Poorer prevention and self-care, Related social norms

Poor health status

Much shorter life span

Much higher infant mortality

Higher burdens of all kinds of diseases over the lifecourse

Impact evaluation procedure

The initial quantitative assessment of determinants of health commenced in March 2019 with a **total census of the residents, buildings and selected material conditions** (CENSUS) **in 450 excluded Roma enclaves** in the territory of the 255 target municipalities covered by the NP HC. Based on the data from this survey, the sizes of the representative samples of households were calculated for each of the municipalities covered by the NP HC (the average size of the total sample per municipality was 62 households; the largest consisted in a total of 198 households).

Next, beginning in July 2019, **more than 13,500 structured interviews** were carried out **covering all the remaining indicators** in samples of households personally recruited in the excluded enclaves according to the given sampling plan (REPRE-assessment).

For the purposes of mutual comparison of changes over the entire evaluation period (2019–2022), starting in October 2019, the CENSUS and subsequent REPRE-assessment were carried out in an **additional 34 municipalities with 38 excluded Roma enclaves** never previously covered by the NP HC (an additional 1,199 interviews). For the geographical distribution of the NP HC and the control locations, see map in Figure 2 and the list of municipalities in ANNEX A.

Fig. 2
Municipalities targeted by the NP HC and/or the assessments (for further details regarding individual locations see list of municipalities in Annex A)

× Eligible locations at present not covered by NP HC
○ NP HC locations – no assessments
◖ NP HC locations – CENSUS only
● NP HC locations – CENSUS and REPRE-assessment
▲ Control locations of the NP HC impact evaluation
▬ Districts with NP HC field work present

Impact evaluation results

The main results of the initial impact evaluation assessment summarize the situation in the excluded Roma enclaves for each of the municipalities included in the research. At this level of detail, the results consist of over 380 numbers for most of the 255 municipalities included, i.e. **nearly 100 000 quantitative data entries**.[5]

Approx. 3/4 of these data describe the very determinants of health at the community level. The remaining 1/4 of the data describe other circumstances useful for the NP HC or for its evaluation: the size and composition of the excluded enclaves' population, coverage of the municipalities included by the NP HC and various other services, the public infrastructure of the municipalities outside the excluded Roma enclaves, etc.

5
At its most detailed level, the research consists of even substantially more information, e.g., figures describing each of the dozens of households included in the representative samples individually and data regarding individual excluded enclaves from numerous municipalities where there were several such enclaves. These more detailed data can be used in the future for more nuanced analyses, e.g., of possible interactions between individual parameters of the assessed determinants of health.

Each of the numbers pertaining to determinants of health describes the local status of a specific parameter commonly used by experts as an indicator of a specific aspect of health determinants. Each number assigns to the given place a specific value from a range of values covering related variability existing across the targeted excluded enclaves. More specifically, the majority of these results describe **what share of excluded Roma households** in the given municipality was **subject to specific extreme health risks**. The rest of the results describe **to what extent the population of the excluded enclaves in the municipality was subject to specific risks as a whole** (including through several binary variables, e.g., risk present or not present for the whole population). The structure of all the main results is presented in Table 1.
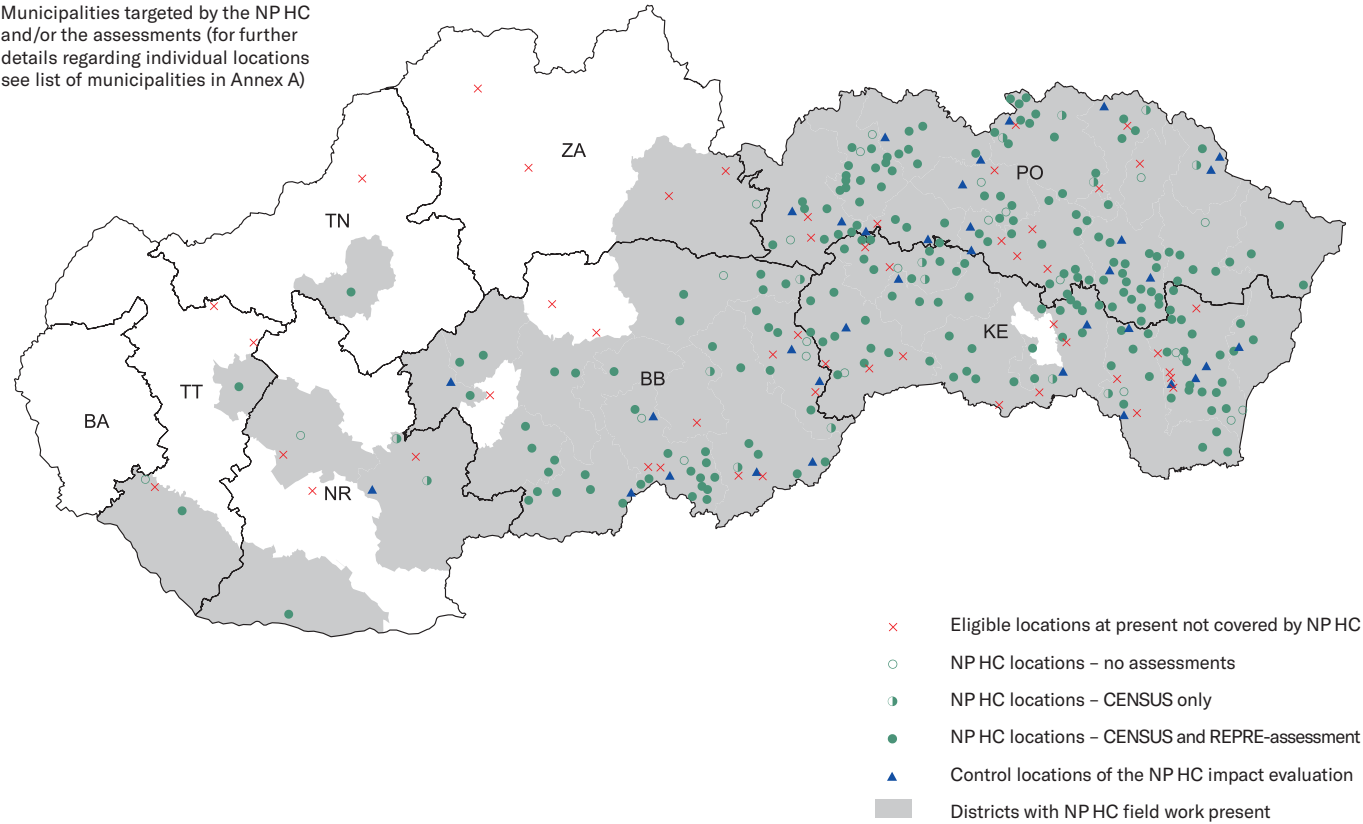
Conceptual approach to the health needs assessment

Expectations regarding the outputs and methods of the health needs assessment were equally challenging as those for the impact evaluation assessment: they were required to be theoretically comprehensive, immediately practical for the NP HC and explicitly ethical. In other words, the assessment's outputs were expected to include all known kinds of causes behind the poor health status of excluded Roma but at the same describe related needs with an emphasis on deficits down to the level of the hundreds of individual municipalities covered by the NP HC. In addition, the outputs were expected to have been attained and to be presented in a manner explicitly congruent with the rights and views of the targeted excluded residents.

To meet these requirements, the UPJŠ research team **relied mostly on the knowledge and results obtained within its previous initial impact evaluation assessment of the determinants of health** across the enclaves. The review of the scientific literature preceding the initial impact evaluation assessment provided information regarding all known causes of the poor health status of excluded Roma in the country (Figure 1). The results of the initial evaluation assessment provided data on deficits at the level of individual municipalities. Finally, the initial qualitative exploration, carried out previously as part of designing the initial assessment toolkit, together with further engagements of the NP HC's field workers, provided information on the related views and preferences of the residents of the excluded enclaves.

Tab. 1
Structure of the main results of the
initial evaluation assessment for
each of the included municipalities

RESULTS REGARDING DETERMINANTS OF HEALTH AT THE COMMUNITY LEVEL

301 indicators covering 5 main domains of health determinants at the community level:

E) Social position and opportunities

6 Subgroups of determinants, 66 indicators:

Education level	Employment	Incomes and standard of living	Direct ethnic discrimination and physical segregation	Social exclusion	Self-exclusionary and discriminatory social norms
12	10	11	12	11	10

D) Health care services access

6 Subgroups of determinants, 58 indicators:

Geographic accessibility	Direct discrimination in services	Inadequacy of services	Ability to navigate health care services	Basic health literacy	Financial and social obstacles
6	13	9	11	8	11

C) Material conditions

2 Subgroups of determinants, 48 indicators:

Exposures within households	Exposures outside households
29	19

B) Psychological burden

3 Subgroups of determinants, 25 indicators:

Stress	Coping with stress	Social support
11	6	8

A) Health-related practices

7 Subgroups of determinants, 104 indicators:

Diet	Drug abuse and dependencies	Sexual and reproductive health	Personal hygiene	Physical activity	Prevention	Related social norms
22	22	8	6	10	14	22

+ ADDITIONAL RESULTS

4 Subgroups, 81 indicators:

Socio-demographics	Coverage by NP HC field work	The municipality outside segregated Roma enclaves	Coverage by other services
43	13	15	10

Health needs assessment methods and procedure

The health needs of the excluded Roma enclaves targeted by the NP HC were determined through **a comparison of the results from the previous quantitative assessments of the determinants of health in the given enclaves with values describing situations that would be ideal** according to contemporary medical and public health recommendations. The results gained in the impact evaluation assessment thus served as both theoretically comprehensive and practically meaningful input regarding the current levels of health risks in the excluded enclaves. Drawing on these results, the UPJŠ research team first identified indicators for which any of the included enclaves appeared to have faced exposures critical for health from a biomedical perspective (202 of the initial assessment's 301 indicators). Next, the ideal situations were determined for each individual indicator, according to current clinical and public health recommendations. Finally, preliminary health needs were determined for all the given indicators and for all the locations as **the differences between the current real values and the values describing the ideal situations**.
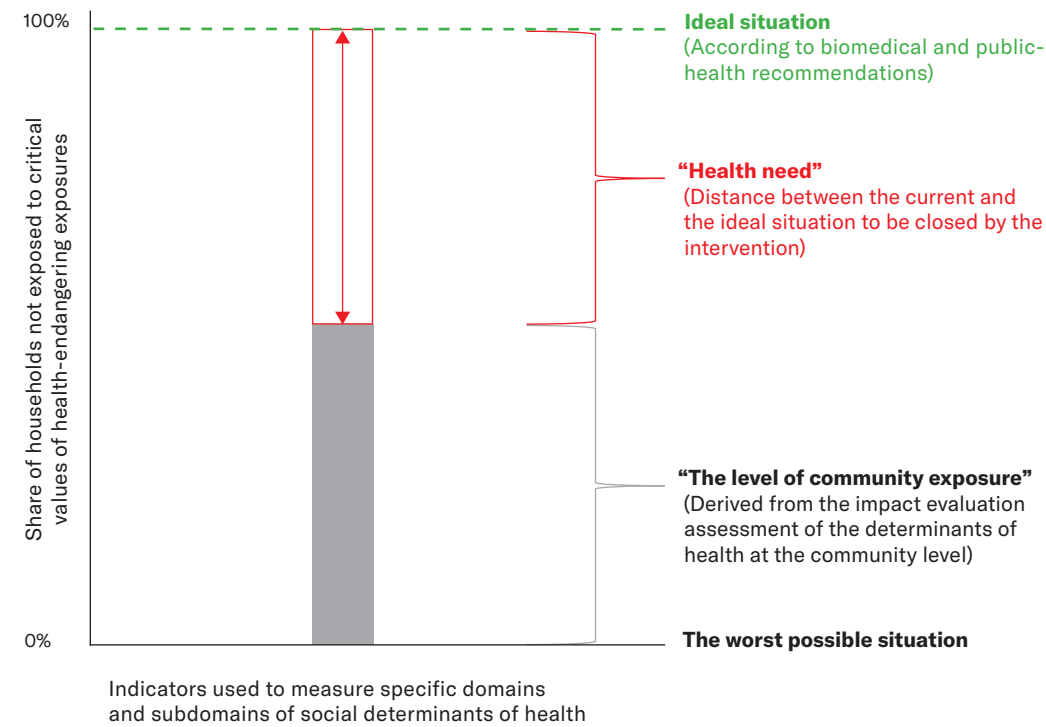
The preliminary health needs, i.e., needs critical according to biomedical criteria, were subsequently reviewed for eventual discrepancies with related views of the residents of the excluded Roma enclaves according to related previous findings of the UPJŠ team and experienced NP HC Roma fieldworkers. Based on this critical revision, the identified health needs were classified as either **needs that are ethically non-problematic or needs that are ethically disputable**. This distinction is emphasized in the results and recommendations section of the report.

Health needs assessment results

In general, the results of the health needs assessment describe **how far the determined current health exposures are from the respective non-critical levels within each of the included segregated Roma enclaves**. All indicators used to assess the current levels of exposure were derived directly from the previous evaluation assessment of the community determinants of health. Consequently, for most of the indicators the needs assessment was expressed through the proportions of households facing certain exposure levels. Since the main use of the needs assessment was to setmeaningful intervention goals for thelong term, situations in which no households would be subject to critical values of exposure were defined as the ideal states. In turn, the results of the needs assessment describe the size of the health needs through the **share of excluded Roma households that were subjected to critical levels of health exposures**. For a schematic summary of the nature of the needs assessment results and how they were derived from the previous evaluation assessment of the local determinants of health, see Figure 3.

Fig. 3
The nature of the health needs assessment results and their relationship with the results from the previous impact evaluation assessment of determinants of health at the community level

Ideal situation
(According to biomedical and public-health recommendations)

"Health need"
(Distance between the current and the ideal situation to be closed by the intervention)

"The level of community exposure"
(Derived from the impact evaluation assessment of the determinants of health at the community level)

The worst possible situation

Share of households not exposed to critical values of health-endangering exposures

100%

0%

Indicators used to measure specific domains and subdomains of social determinants of health

Main outputs from the assessments

Presentation of all the main results from both assessments (initial impact evaluation and health needs) for all individual municipalities in the form of text would be too extensive, tedious, and to a great extent also unethical. Publishing some of the results could contribute to further stigmatization of the particular excluded Roma enclave's residents or even of entire municipalities.[6] Presentation of the results of both assessments in this report are therefore limited to **averages across larger geographical units, explanations of all indicators used** and **summaries and examples of the overall variability of the results**.

Nevertheless, the collaborative approach used enabled a transgression of all the above limitations via a parallel output – **an interactive electronic database**. Although formally secondary, this output contains all the main results of both assessments in full; i.e., it provides numbers for all the indicators used and needs identified for almost each of the included 255 municipalities. Moreover, as the database itself was created step-by-step in close cooperation with NP HC management, it also includes prearranged analytical and visualizing tools.[7]

6
For example, information suggesting a certain status of hygiene or regarding illegal provisory connections to public infrastructure.

7
An Excel database with pre-programmed macros e.g. for easy creation of visual comparisons, analyses and charts for any municipalities or combinations of municipalities included in the research.

General Findings

Both assessments were carried out primarily to deliver information regarding individual municipalities that would be practical for the NP HC project. However, the overviews of the main results of both assessments presented in this report show that the acquired data carries a lot of new more broadly relevant

information. On one hand, the results support all previous general knowledge about the determinants of health and health needs in the excluded Roma enclaves in Slovakia. On the other hand, they considerably extend the previous knowledge, especially with a new level of detail.

As for the supporting side, the results of the assessments strongly corroborate that a **maximum of half of Slovak Roma live in excluded Roma enclaves** (the CENSUS in the target municipalities of the NP HC and the control locations of the evaluation counted 191,519 excluded Roma citizens in total). Next, the results show that **substantial parts** of this population are **exposed to critical levels of health-endangering exposures**. Also, the results confirm that such exposures r**esult in an extremely poor health status of the population** (e.g., the number of people over 60 years old makes up only 5% of the overall population).

As for extensions of previous knowledge, the basic descriptive analyses used for this report already allow for adding the following:
· Considerable shares of populations in excluded Roma enclaves are exposed to critical healthendangering exposures **across the country and across all domains of determinants of health at the community level**.
· **Which enclaves** are subject to **what critical value**s for **which indicators** of health-endangering exposures
· Despite relatively small differences in most average values for larger territories (e.g., comparing counties), **there are considerable differences between individual excluded Roma enclaves**

in many specific health exposures and needs between individual municipalities even within the scope of relatively small geographical areas.
· **Low health literacy** of the residents of the excluded Roma enclaves – the determinant of health most traditionally addressed by the NP HC – indeed belongs **among the most critical aspects of health-related capabilities** in the excluded Roma enclaves
· However, despite the extremely poor availability of all related means and preconditions (e.g., infrastructure, income, education, services access), the majority of the residents of excluded Roma enclaves manage to keep most of their **health-related practices outside critically risky levels in most other respects**.
· Most residents of the enclaves **are constantly exposed to environmental hazards both indoors and in public spaces**.
· Apart from geographic distance, significant shares of the enclaves' residents **face many problems with accessing health care services**, especially in terms of their organization and quality, **including ethnic discrimination**.
· There are **considerable differences in how different excluded Roma understand and experience their situation**, including between residents of excluded enclaves subjected to very similar other living conditions.

Report use and contents

This report was designed primarily as a basic guide regarding what both assessments have delivered for the NP HC. However, the report also presents the **first detailed comprehensive overview of the determinants of health and health needs across the majority of excluded Roma enclaves in Slovakia**.

The following parts of the report cover:
Part I – Overview of the results of the initial impact evaluation assessment of the determinants of health
Part II – Overview of the results of the health needs assessment
Part III – Summary of the methods used for both assessments
Part IV – General overview of results and recommendations for both NP HC and beyond

PART I
Overview of the initial impact evaluation phase results

Introduction

Main focus of the overview

The initial impact evaluation assessment provided numerical data on the determinants of health in the particular excluded Roma enclaves across Slovakia. These data represent the main results of the initial impact evaluation assessment. Due to over 200 hundreds of included municipalities (with more than 400 excluded Roma enclaves), a large number of result types (more than 380 indicators) and the ethical sensitivity of many of them (the risk of stigmatization of individual enclaves or whole municipalities), the full publication of the main results in textual form was not possible. Therefore, for the purposes of this report, the following overview of the results has been created.[1] The overview has been compiled in such a way as to enable readers to gain a comprehensive picture of the following:

- **Excluded Roma enclaves included in the results**
- **Determinants of health covered by the results**
- **Usual health effects of the determinants covered by the results**
- **Indicators used in the evaluation assessment of the determinants**
- **Accuracy of the results**

The following passages of the introduction address these issues individually.

1
The complete results were submitted to the research sponsor, HR, simultaneously in the form of an interactive electronic database.

Excluded Roma enclaves included in the results

The initial impact evaluation assessment focused on two groups of municipalities with excluded Roma enclaves. The first group consisted of 255 municipalities with 450 excluded Roma enclaves, where the field workers of the NP HC 2A worked on a daily basis – target locations of the NP HC. The second group consisted of 34 municipalities with 38 excluded Roma enclaves, where the field workers of the NP HC have not yet been active – so-called Control locations of the NP HC impact evaluation. Complete lists of the municipalities forming both groups can be

Overview of the initial impact evaluation phase results

found in ANNEX A. In the vast majority of municipalities from both groups, the impact evaluation assessment took place by means of a full census of the population, buildings and household amenities (CENSUS) as well as structured interviews on other health determinants (REPRE-assessment); see Table I.1. Therefore, the evaluation assessment results testify **mainly about the situation in the NP HC 2A target locations and in the control locations of the project evaluation** (a total of more

than 400 excluded Roma enclaves across Slovakia). The evaluation assessment results, however, can also be considered as representative for all most deprived Roma enclaves in the Košice, Prešov and Banská Bystrica regions, as the covered group of enclaves includes the absolute majority of all local excluded enclaves identified in the particular regions (approximately 3/4) and favouring the level of deprivation as a criterion in the selection. (See ANNEX A and Figure 2).

Group of included municipalities	In how many municipalities did the CENSUS take place?	In how many municipalities did the REPRE-assessment take place?	Numbers of structured REPRE-interviews in households
NP HC target locations	232/255	214/255	13 500
Control locations of the NP HC impact evaluation	34/34	33/34	1 199

2
Results for municipalities outside the Košice, Prešov and Banská Bystrica regions – "NP HC regions NR TN TT" – are summarized together, as these are geographically and socio-economically distant municipalities with regards to the given regions and because NP HC operates in only a few municipalities of the given regions as well as only for a short time.

All the results, can be found in the overview always summarized separately for all the following specific groups of municipalities with excluded Roma enclaves (in order to bring possible differences into view, especially geographical ones):
· **"NP HC locations together"** – results for all municipalities where the NP HC 2A operated
· **"NP HC KE region"**, **"NP HC PO region"**, **"NP HC BB region"**, "**NP HC regions NR TN TT"** – results for all municipalities from the given regions or groups of regions where

the NP HC 2A operated
· **"Control locations"** – results for all municipalities where the NP HC 2A has not yet operated[2]

Basic data related to the population of excluded Roma enclaves involved in the results of the initial evaluation assessment can be found in the first chapter of the overview, entitled "Population of the excluded Roma enclaves". The data are also presented in this subchapter summarized for various selections of municipalities.

Determinants of health covered by the results

The results of the impact evaluation assessment cover five domains of determinants of health at the community level, as defined by the conceptual model on causes behind the poor health status of excluded Roma (see Figure 1 and part III). In particular, the following domains of determinants are concerned: **A) Health-related practices, B) Psychological**

burden, C) Material conditions, D) Health care services access and E) Social position and opportunities.

There is a separate chapter devoted to each of the domain of determinants, divided into thematic subchapters, in the overview. For reasons of clarity, the chapters are differentiated through colour variation,

following the colour patterns in the conceptual model (Figure 1): A B C D E. In the thematic subchapters, readers will find summaries of the impact evaluation results related to the groups of interrelated

indicators: e.g., "Diet" represents a subchapter within the chapter "A) Health-related practices", and the indicators included here together describe the aspects related to food availability and quality.[3]

Usual health effects of the determinants covered by the results

3
The classification of conditions and indicators into the given groups and their names were both inspired mainly by the academic literature. This classification, however, also reflects certain shifts, for reasons of taking into account several practical criteria. For example, only indicators that were assumed to be reliable in the given environment by selected procedures were included, and they were combined into groups, which were assumed to be possible to intervene together in relation to them within the capacities of the NP HC. The names of all groups were adapted in order to be immediately recognizable even for the field workers of the NP HC with no professional qualification.

The initial conceptual model of the initial impact evaluation assessment (see Figure 1) schematically illustrates the five main domains of health determinants involved and how they tend to influence health status (also) in the environment of excluded Roma enclaves. At the expense of some simplification, it can be concluded that the **domains of determinants** A B and C represent circumstances that can damage or protect the human body, especially **directly** (so-called exposure in epidemiological terminology). **Domains of determinants** D and E

on the other hand, represent determinants damaging the human body, in particular indirectly, via the previous groups of determinants (so-called social determinants of health in epidemiological terminology).

Readers will find brief summaries of specific known effects of individual groups of determinants on health status – in general and possibly also specifically in the environment of excluded Roma enclaves – in short editorials preceding respective individual subchapters of the results overview.

Indicators used in the evaluation assessment of the determinants

4
Following a radically collaborative approach to research. The tools, procedures and research process are discussed in detail in part III.

The initial quantitative assessment of the determinants of health was performed using a research tool, which was developed for this purpose directly by the UPJŠ research team. The development of the tool was based on indicators and procedures traditional in academic research but adapted and combined in a new way in cooperation with the sponsor and people from the target population according to their knowledge and requirements.[4] The final assessment tool consisted of an **original set of more or less common indicators** and an **original sequence of more or less common procedures** for determining values in the given environment with the help of the NP HC field workforce. The groups and numbers of indicators used by the assessment tool

to measure levels for individual domains of determinants (A – E) (a total of more than 380 indicators) are summarized in Table 1. In the first step of the assessment (CENSUS), the values mostly for context indicators and indicators of the level of material conditions (determinants group A) were determined by means of a complete census in the field (data on the population of the enclaves, adjacent municipalities, etc.). In the second step of the assessment, (REPRE-assessment), the values were determined mainly for indicators of the remaining health determinants (groups B – E), through structured interviews among the samples of households from the excluded Roma enclaves, which were representative in regards to the individual municipalities included.

In the overview of the results, readers will find more detailed information on the individual indicators employed and related assessment procedures summarized in the lists entitled "Additional information on the data regarding ...". In these lists, corresponding with the tables presenting the very results via simple codes, the following information are always given (see also illustrative List I.1):

Indicator code – the code of the given indicator, which is also marked in the results table (capital initial letters indicate domains of determinants, numbers indicate the order of the relevant tables with results in the report, and lower-case letters indicate the columns in these tables).

Interpretation – A detailed specification of what exposure(s) do the values for the given indicator(s) describe (including the method of calculation in the case of mathematically derived values).[5]

Research documentation link – specification of the step through which the assessment values were obtained for a given indicator (CENSUS or REPRE-assessment) and reference(s) to items in the research documentation (the research documentation constitutes ANNEX B of the report).

Indicator quality – estimated overall reliability of data obtained for the given indicator (Category A or B; see the following section for details).

indicators with recorded problems – with 'I' denoting none, 'II' denoting less than three, and 'III' denoting more than three. At the same time, the degree of representativeness of the samples collected and the response rate in the locations (lower rates further reduced the overall quality of the data) were considered. In the second classification, three quality grades were assigned to individual indicators. The decisive criterion in this case was the **number of locations where problems arose in the collection or analysis of respective data** – 'A' denoting in no location, 'B' denoting in less than three locations and 'C' denoting in more than three locations.[6]

Only results from locations with the overall data quality I or II and only for indicators with the overall data quality A or B were included in the presented overview. The final classification of individual municipalities (also with data on the response rate within them) can be found in ANNEX A. The overall quality of the individual indicators is indicated directly in the overview, in the lists with additional information to results for individual thematic subchapters (see also illustrative List I.1). Why specific indicators were classified as B quality indicators and what this may mean for their accuracy can be found directly in the overview of the results – in the short editorials for the relevant thematic subchapters.

List I.1 Illustration – Additional information regarding results on n X group of determinants X

Indicator code	Interpretation	Research documentation link(s)	Indicator quality
X99a	Presence rate indicator...: Indicates the share of municipalities with enclaves...	CENSUS, Record sheet HPAC n. 1	B
X99b	Presence rate indicator of...: Indicates the proportion of REPRE household samples, where...	REPRE, Record sheet HPAC n. 2 (question n. ...)	A
X99c	Level indicator...: Indicates the proportion of households, where...	CENSUS, Record sheet HPAC n. 1	A

Accuracy of the results

During data acquisition in the field, there were various complications for specific indicators and locations, especially organizational, personnel and procedural. In the case of some locations and indicators, other problems were identify also upon the analysis of the obtained data. These complications warn against possible inaccuracies in the results. In order to completely exclude the most serious of such inaccuracies and with the aim of drawing attention to the less serious ones, all the obtained data were **further classified into different quality categories** according to the

nature and degree of complications observed in data acquisition or analysis. There were two parallel classifications: one aimed at determining the degree of difficulties recorded for entire locations and the second aimed at determining the degree of difficulty recorded regarding individual indicators.

In the first classification, to each of the municipalities where the research was carried out, we assigned one of three grades describing the overall quality of the data obtained for it. Grades were assigned to locations mainly according to the **number of**

Presentation of the results

Readers will find the results for individual domains of determinants A – E and related indicators presented in the respective chapters and subchapters of the overview **through uniformly structured tables and graphs.** The tables (see illustrative Table I.2) present the average values found for individual indicators for different selections of municipalities. Most of them **present the average shares of excluded Roma households** in which the given selection of municipalities was or was not affected by a specific circumstance critical to health, as defined by the

given indicator. For example, "the average percentage of households where someone has been suffering from hunger for a long time in the last year [level indicator] in control locations [selection of municipalities]". The second most common type of data presented is the percentage of municipalities with excluded Roma enclaves, in which all excluded Roma households were exposed to certain critical circumstances, e.g., the percentage shares of municipalities in which all excluded households are without the selected infrastructure.[7]

Tab. I.2 Illustration – The method of presenting the resulting numerical data for particular indicators

X99	a	b
	indicator name	indicator name
NP HC locations together	Percentage of households or enclaves	Percentage of households or enclaves
NP HC **KE region**	...	...
NP HC **PO region**	...	...
NP HC **BB region**	...	...
NP HC **regions NR TN TT**	...	...
Control locations together	...	...

These are 24 coordination areas, each of which includes an average of 11 municipalities with excluded Roma enclaves where the field work of the HPAs is coordinated by one coordinator (HPAC). The summaries of the values referred to in graphs type 2 and 3 as "CONTROL:" do not include the values for the coordination area, but for the control locations of the impact evaluation.

Included graphs (see illustrative Graphs I.1–3) describe the variability of more detailed results which is "hidden" behind many of the aggregate averages given in the result tables. All types of the included graphs line up the values from the smallest to the largest. The type 1 graph sorts all values obtained for included individual locations side by side. Type 2 and 3 graphs rank the average values for larger territorial units, so-called coordination areas.[8] Type 1 and 2 graphs also indicate the commonness of particular values using percentiles.[9] The type 3 graph shows values representing several indicators together. It was included in cases where direct comparisons of indicators could be interesting for various reasons.[10]

Graph I.1
Illustration – Graph type 1
Percentage of households where… (X99b); NP HC locations together

25th percentile
50th percentile
90th percentile

Sorting of values per location
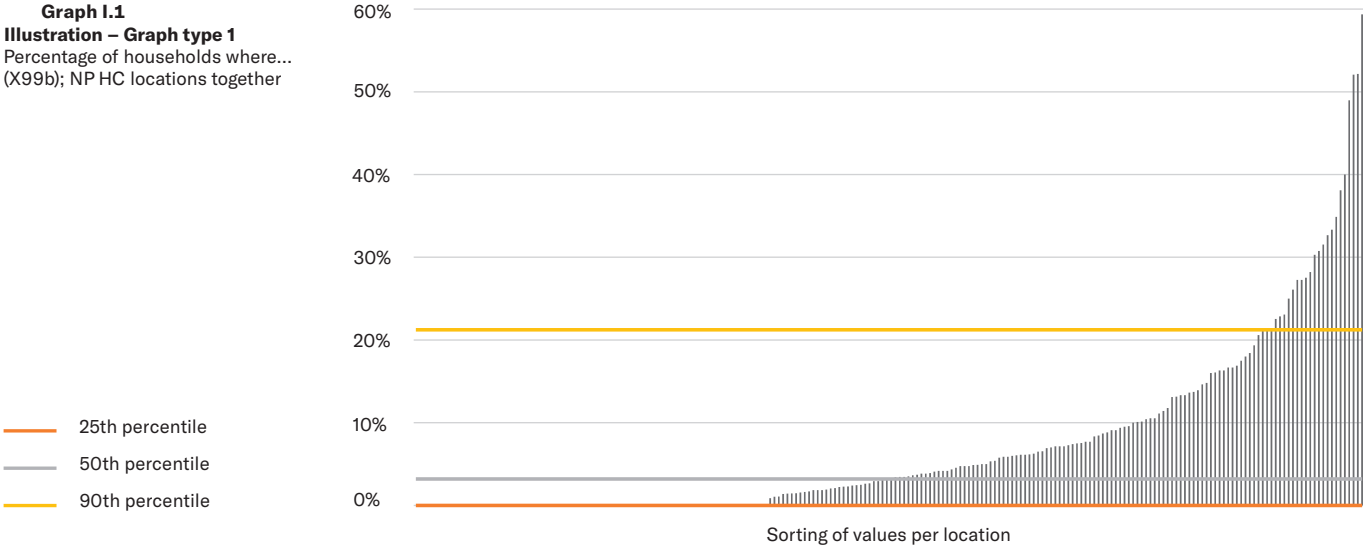
Graph I.2
Illustration – Graph type 2
Percentage of households where… (X99a); averages for individual coordination areas
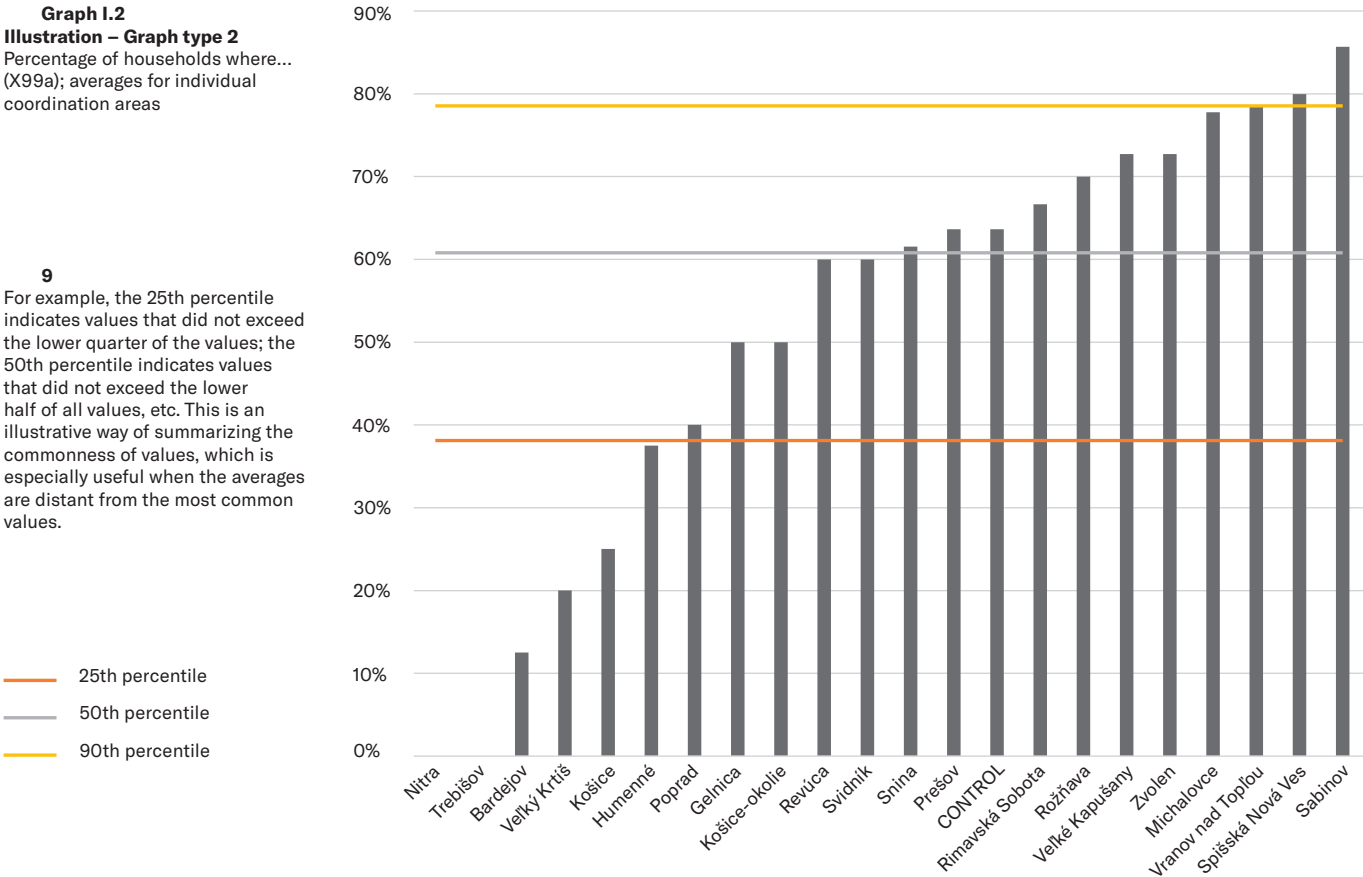
9
For example, the 25th percentile indicates values that did not exceed the lower quarter of the values; the 50th percentile indicates values that did not exceed the lower half of all values, etc. This is an illustrative way of summarizing the commonness of values, which is especially useful when the averages are distant from the most common values.


25th percentile
50th percentile
90th percentile

Graph I.3
Illustration – Graph type 3
Percentage of municipalities with enclaves where… (X99d), or … (X99e); averages for the NP HC 2A coordination areas

10
Due to lack of space, the graphs were included only for selected indicators. The inclusion of any graph generally means that the detailed results for the given indicator(s) can be considered as either extremely interesting in the context of previous findings or extremely varied. The inclusion of type 2 or 3 graphs in particular means that the detailed results for the given indicators have shown a considerable diversity across the coordination areas, indicating their possible variability according to geographical areas. The inclusion of the type 1 graph means that the detailed results for the given indicator did not show a significant diversity between coordination areas, but they showed a significant diversity between individual municipalities (indicating a variability independent from the geographical areas).
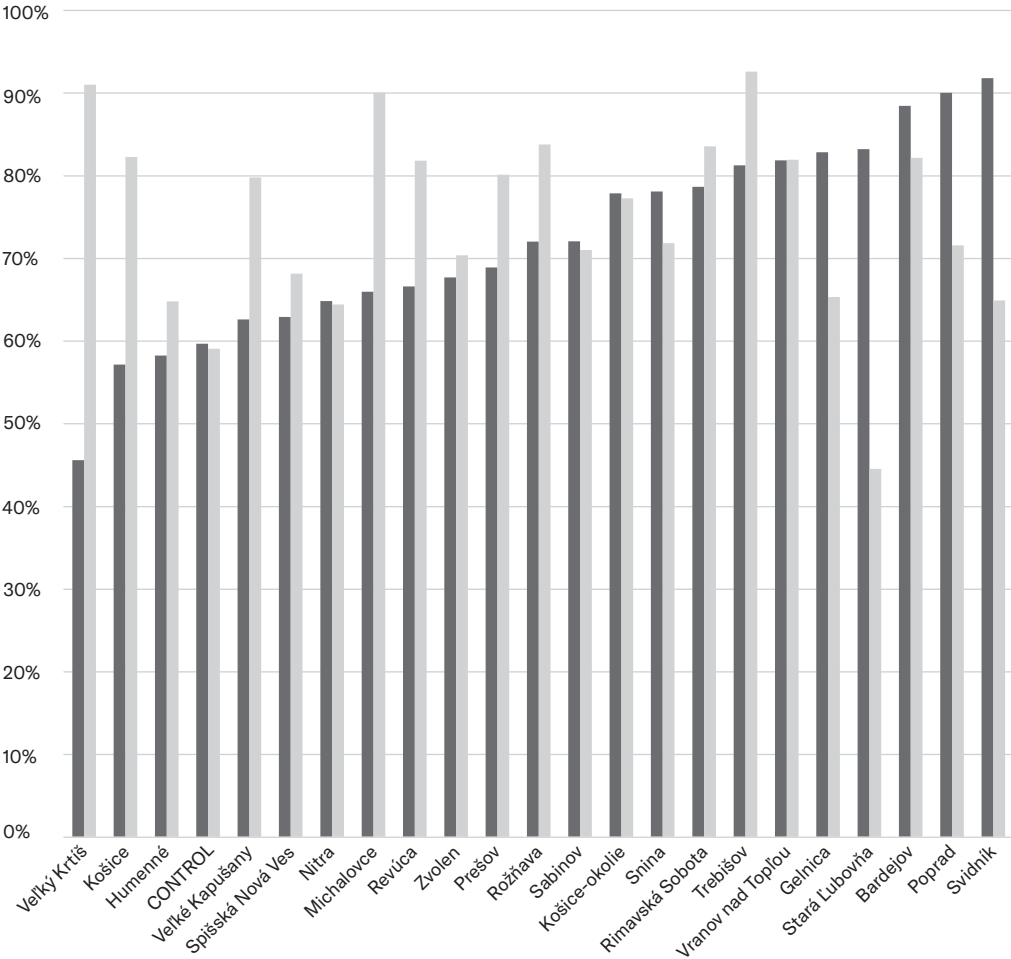
Conclusion: Guidelines for easy reading and interpretation of the results overview

· Short editorials related to the individual subchapters contain brief reminders of the biomedical importance of included factors for health status.
· The groups of indicators to which the individual subchapters are devoted represent groups of determinants of health that are addressed or mean to become addressed in the future by NP HC through related types of interventions.
· The results tables summarize the results for individual indicators (columns a, b,…) and listed groupings of municipalities with excluded Roma enclaves (rows)
· The results in the rows reflect the NP HC locations together; the results in NP HC

KE region row, the NP HC PO region row and the NP HC BB region row can be considered as values representative for all excluded Roma enclaves in the respective regions
· The results in the rows referring to the NP ZK TT, TN, NR and Control locations can be considered as representative only for the specifically included enclaves (see the lists of municipalities in ANNEX A)
· The wording of the indicators in the tables adheres to the natural language that was used in the field survey. Expert interpretations are always given at the end of each section in the lists entitled "Additional information to the results

on…"; these lists also indicate the overall quality of the data for the given indicators and references to respective items in the survey questionnaires administered via structured interviewing
· The results presented in the overview were compiled only from data for indicators of A or B quality and only for locations with the overall quality of data I or II
· The graphs are included mainly for the indicators for which the observed values showed great variability and they describe this variability and its distribution.

· For the purposes of the overview, the results were compiled from detailed data representative of more than 200 individual municipalities (with more than 400 excluded enclaves) and can be considered representative of all excluded Roma enclaves in the Košice, Prešov and Banská Bystrica regions; results from municipalities in other regions can be considered representative only for the included municipalities (lists of the municipalities included can be found in ANNEX A)

The population in excluded Roma enclaves

The population data summarized in this chapter – summaries of values for basic demographic indicators describing excluded Roma enclaves in various samples of municipalities with such enclaves – do not belong among the results of the initial impact evaluation assessment as such, as they do not provide direct information on health determinants in the enclaves. However, these results are significantly complementary to the assessment because they describe the subjects exposed to the given determinants at the time of the survey. Several of the presented demographic data – e.g., average age, the shares of populations in individual age categories or the distribution of the values of the highest age for individual locations – also indirectly summarize how the levels of health determinants from previous periods in the given enclaves are currently reflected in the poor health of the local population. The most basic of the presented demographic data were obtained through a direct and complete census in the field (CENSUS). Additional and more detailed data were obtained through questionnaires (administered via structured interviews) in samples of households representative of excluded Roma enclaves in the individual municipalities included in the research (REPRE-assessment). None of the surveys experienced problems for any of the indicators included in the overview (whether conceptual, related to field data acquisition or upon analyses). The presented overview thus represents a brief summary of the thus far most accurate (and most detailed) demographic data on the inhabitants of excluded Roma enclaves in our country.

028

PART I

Overview of the initial impact evaluation phase results

029

PART I

Overview of the initial impact evaluation phase results

O1	a	b	c	d	e
	Total number of inhabitants of excluded Roma enclaves	Total number of households in excluded Roma enclaves	Number of municipalities included	Number of excluded Roma enclaves included	Average number of excluded Roma enclaves per municipality
NP HC locations together	**183 602**	**31 731**	**255**	**450**	**1.8**
NP HC **KE region**	69 410	11 705	82	126	1.5
NP HC **PO region**	77 938	14 229	110	174	1.6
NP HC **BB region**	28 650	5 186	54	122	2.3
NP HC **regions NR TN TT ZA**	7 604	611	9	28	3.1
Control locations together	7 909	2 017	34	38	1.1
Eligible locations not covered by the NP HC[1]	14 565	?	49	73	1.5

O2	a	b	c	d	e	f
	Average population in the segregated Roma enclaves in a municipality	25th percentile population in the segregated Roma enclaves in a municipality	50th percentile population in the segregated Roma enclaves in a municipality	75th percentile population in the segregated Roma enclaves in a municipality	Lowest population in the segregated Roma enclaves In a municipality	Highest population in the segregated Roma enclaves in a municipality
NP HC locations together	**720**	**287**	**517**	**945**	**36**	**4 212**
NP HC **KE region**	846	311	523	1 159	36	4 212
NP HC **PO region**	709	262	568	962	48	2 990
NP HC **BB region**	531	263	425	685	56	2 586
NP HC **regions NR TN TT ZA**	845	307	386	1 210	247	2 363
Control locations together	233	138	221	286	52	656
Eligible locations not covered by the NP HC[1]	297	135	258	442	34	930

Total population of excluded Roma enclaves (O1a) per individual NP HC 2A coordination areas

— 25th percentile
— 50th percentile
— 90th percentile
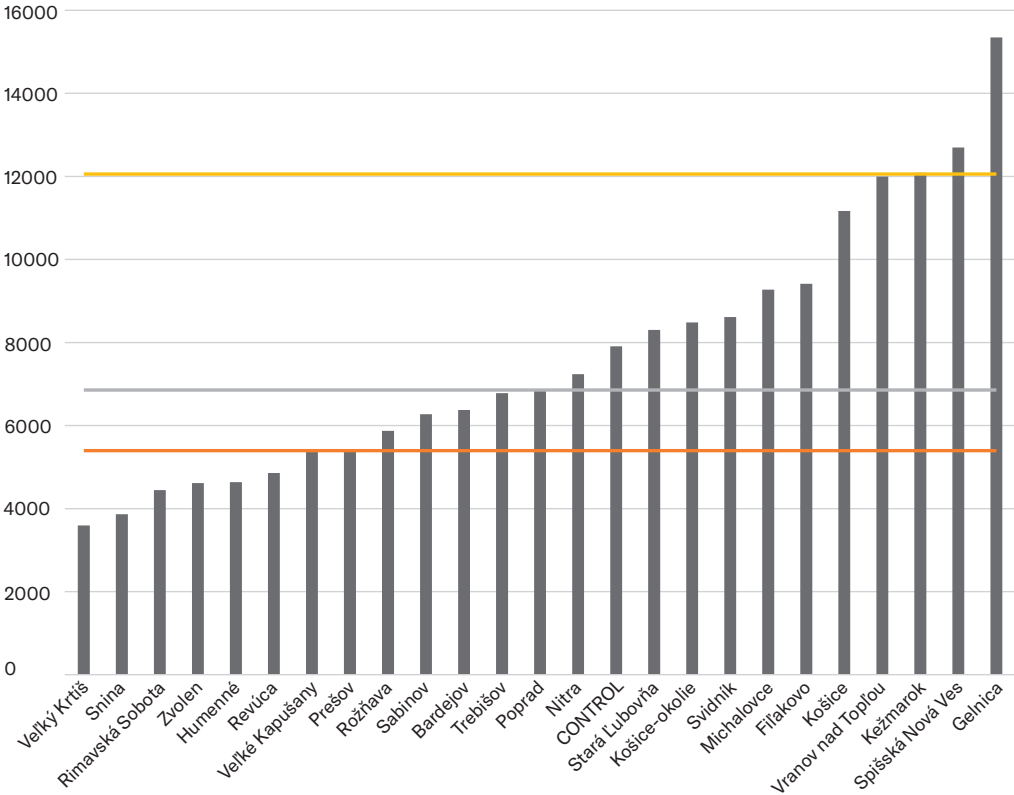
Average population in the excluded Roma enclaves (O2a) in particular coordination areas of the NP HC 2A

— 25th percentile
— 50th percentile
— 90th percentile

Overview of the initial impact evaluation phase results

Overview of the initial impact evaluation phase results

O3	a	b	c	d
	Share of excluded Roma in the population of the municipality	Number of town municipalities with excluded Roma enclaves	Number of village municipalities with excluded Roma enclaves	Percentage of town municipalities with excluded Roma enclaves
NP HC locations together	**35.0%**	**125**	**325**	**27.8%**
NP HC **KE region**	37.8%	31	126	24.6%
NP HC **PO region**	36.1%	26	174	14.9%
NP HC **BB region**	31.8%	50	122	41.0%
NP HC **regions NR TN TT ZA**	6.8%	18	28	64.3%
Control locations together	27.0%	1	38	2.6%

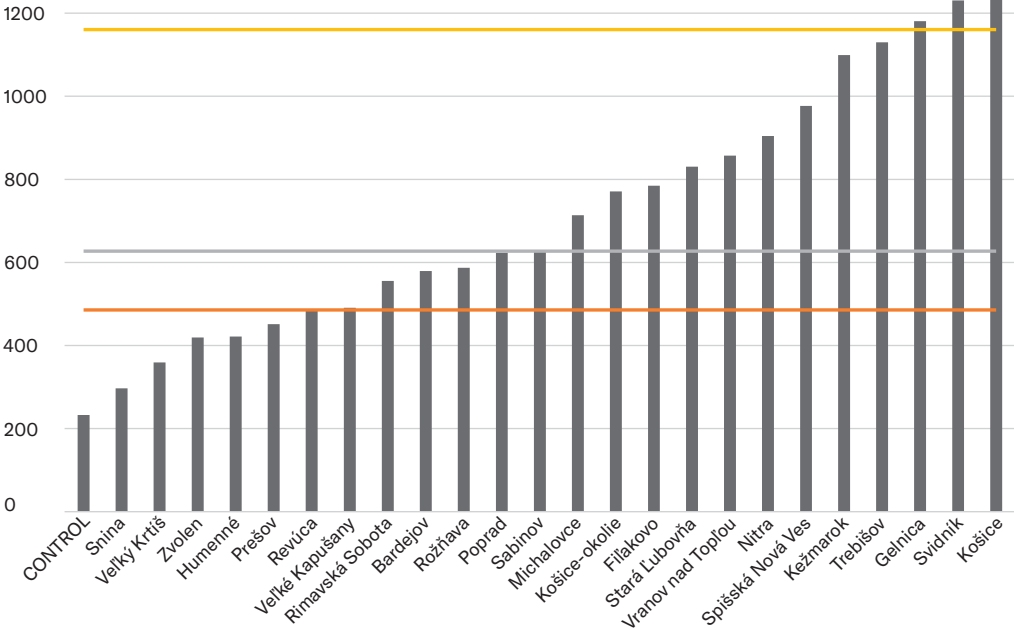| O4	a	b	c	d	e	f
	Approximate number of children (aged up to 18) in the Excluded Roma enclaves	Approximate number of adults (aged 18–59) in the excluded Roma enclaves	Approximate number of elderly (aged 60 and above) in the excluded Roma enclave	Approximate percentage of children in the excluded Roma enclaves	Approximate percentage of adults in the excluded Roma enclaves	Approximate percentage of elderly in the excluded Roma enclaves
NP HC locations together	**82 254**	**90 516**	**10 833**	**44.8%**	**49.3%**	**5.9%**
NP HC **KE region**	31 790	33 456	4 234	45.8%	48.2%	6.1%
NP HC **PO region**	35 774	37 566	4 598	45.9%	48.2%	5.9%
NP HC **BB region**	10 772	15 528	2 321	37.6%	54.2%	8.1%
NP HC **regions NR TN TT**	3 460	3 832	319	45.5%	50.4%	4.2%
Control locations together	3 559	3 686	664	45.0%	46.6%	8.4%
Eligible locations not covered by the NP HC	6 525	7 181	859	?	?	?

Share of excluded Roma in the population of the municipality (O3a) in the individual NP HC 2A coordination areas

- 25th percentile
- 50th percentile
- 90th percentile

O5	a	b	c	d
	Approximate average age of men in the excluded Roma enclaves	Approximate average age of women in the excluded Roma enclaves	Approximate percentage of men in the total population of the excluded Roma enclaves	Approximate percentage of women in the total population of the excluded Roma enclaves
NP HC locations together	**24.8**	**25.4**	**48.5%**	**51.5%**
NP HC **KE region**	23.6	24.1	49.9%	50.1%
NP HC **PO region**	25.4	25.6	48.2%	51.8%
NP HC **BB region**	25.6	26.7	47.3%	52.7%
NP HC **regions NR TN TT**	24.0	26.5	46.5%	53.5%
Control locations together	24.9	25.0	48.2%	51.8%

Overview of the initial impact evaluation phase results

Overview of the initial impact evaluation phase results

Approximate percentages of male population of the excluded Roma enclaves in the given age

O6	a	b	c	d	e
	percentage of boys in the age category <2	percentage of boys in the age category 2–9	percentage of boys in the age category 10–17	percentage of men in the age category 18–59	percentage of men in the age category 60+
NP HC locations together	**1.5%**	**10.2%**	**8.9%**	**25.6%**	**2.3%**
NP HC **KE region**	1.6%	12.0%	9.6%	24.5%	2.2%
NP HC **PO region**	1.5%	9.7%	8.7%	25.9%	2.4%
NP HC **BB region**	1.4%	8.7%	8.0%	26.7%	2.5%
NP HC **regions NR TN TT**	1.8%	10.5%	9.4%	22.2%	2.5%
Control locations together	1.1%	9.4%	8.8%	25.4%	3.0%

Approximate percentages of female population of the segregated Roma enclaves at the given age

O7	a	b	c	d	e
	Percentage of girls in the age category <2	Percentage of girls in the age category 2–9	Percentage of girls in the age category 10–17	Percentage of women in the age category 18–59	Percentage of women in the age category 60+
NP HC locations together	**1.5%**	**10.3%**	**9.0%**	**27.8%**	**2.9%**
NP HC **KE region**	1.6%	11.6%	9.7%	24.9%	2.3%
NP HC **PO region**	1.5%	9.8%	8.8%	28.9%	2.8%
NP HC **BB region**	1.4%	9.1%	8.2%	30.1%	3.9%
NP HC **regions NR TN TT**	2.2%	12.2%	8.5%	26.8%	3.8%
Control locations together	1.8%	10.5%	9.3%	27.2%	3.5%

The highest current ages of men in the excluded Roma enclaves covered by the NP HC 2A

Data ranking according to the relevant locality

- 25th percentile
- 50th percentile
- 90th percentile

034

PART I

Overview of the initial impact evaluation phase results

035

PART I

Overview of the initial impact evaluation phase results
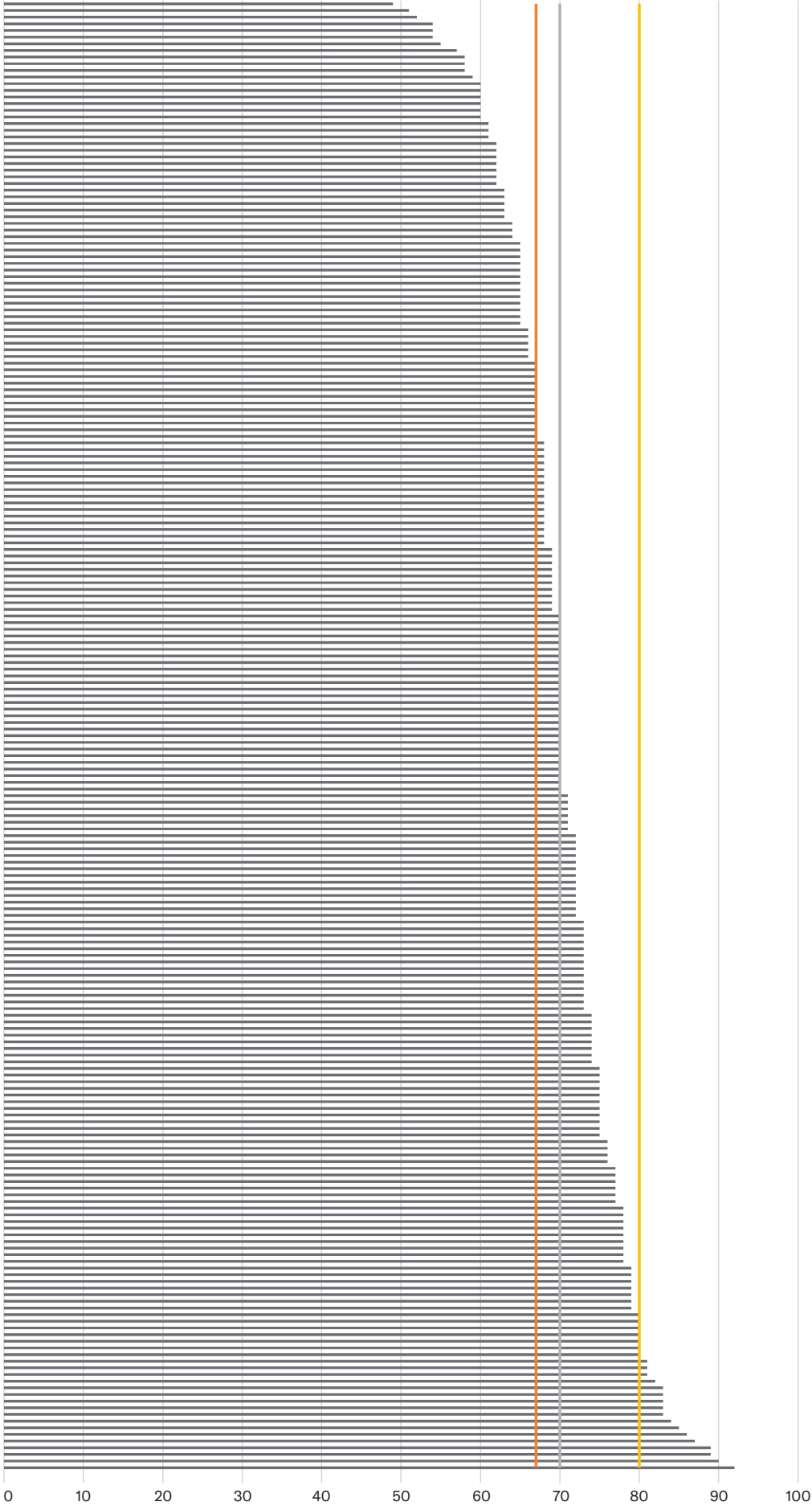
Highest current ages of women in the excluded Roma enclaves covered by the NP HC (2A)

Data ranking according to the relevant locality

— 25th percentile
— 50th percentile
— 90th percentile
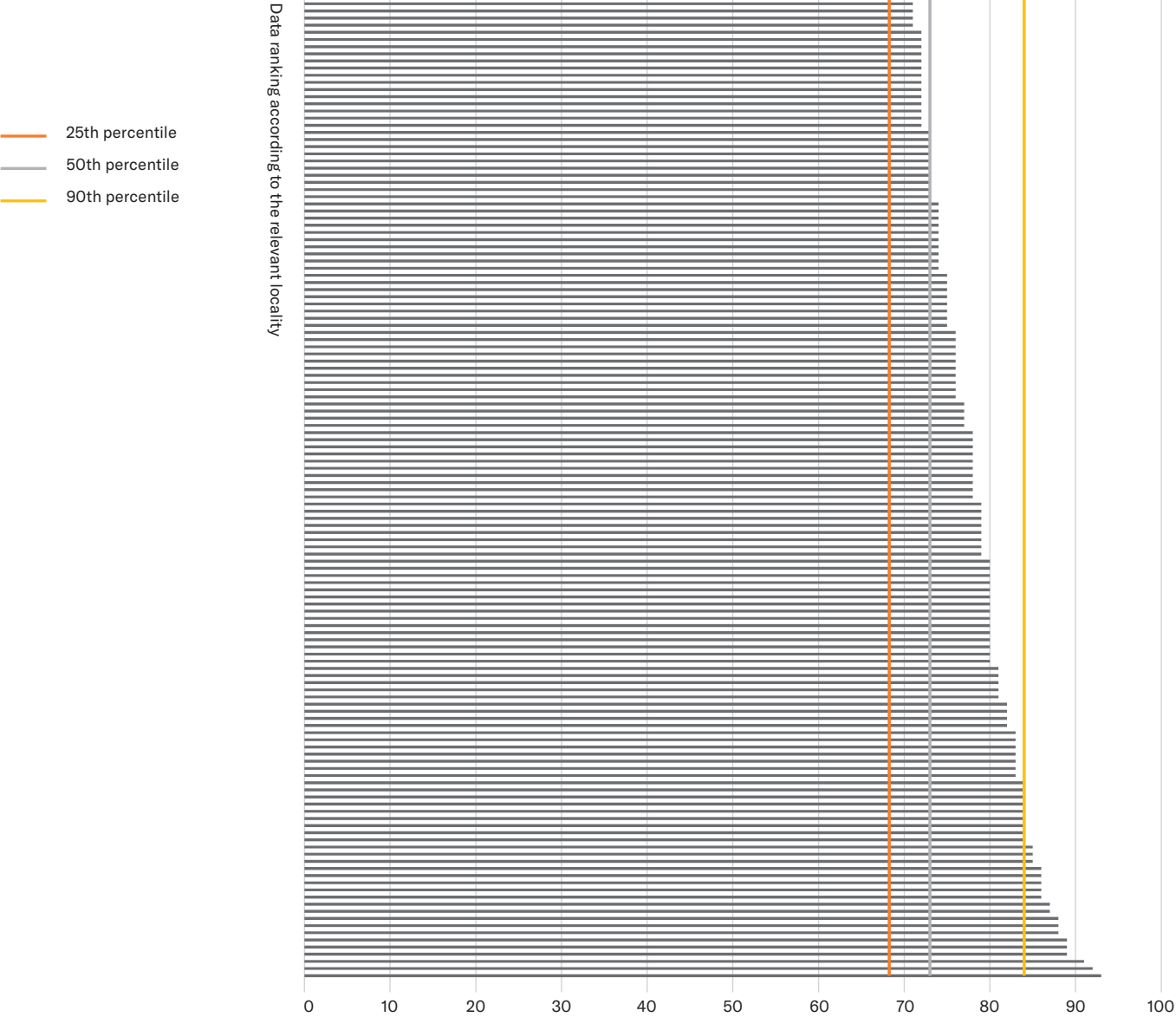
O8	a	b
	Approximate percentage of the population in the excluded Roma enclaves who do not consider themselves as Roma	**Approximate percentage of the population in the excluded Roma enclaves who do not identify themselves with their gender assignment**
NP HC locations together	**0.8%**	**0.9%**
NP HC **KE region**	0.5%	0.9%
NP HC **PO region**	0.9%	0.8%
NP HC **BB region**	1.3%	1.0%
NP HC **regions NR TN TT**	0.9%	1.8%
Control locations together	0.8%	1.0%

Additional information to population data	Data	Interpretation	Items in research documentation	Indicator quality
	O1a	Indicates the population in the excluded Roma enclaves in the given municipality selection	CENSUS, Record sheet HPA n. 1 → HPAC form n. 1.	A
	O1b	Indicates the number of households in the excluded Roma enclaves in the given municipality selection	CENSUS, Record sheet HPA n. 1 → HPAC form n. 1.	A
	O1c	Indicates the number of municipalities with excluded Roma enclaves in the given municipality selection	CENSUS, HPAC form n. 1.	A
	O1d	Indicates the number of excluded Roma enclaves located in the given municipality selection	CENSUS, HPAC form n. 1.	A
	O1e	Indicates the number of excluded Roma enclaves in the given municipality selection per municipality; 1d/1c	N/A	N/A
	O2a	Indicates the population of the excluded Roma enclaves in the given municipality selection per municipality; 1a/1c	N/A	N/A
	O2b	25 % of the values indicating the population of the excluded Roma enclaves in the given municipality selection not exceeding the given value	CENSUS, Record sheet HPA n. 1 → HPAC form n. 1.	A
	O2c	50 % of the values indicating the population of the excluded Roma enclaves in the given municipality selection not exceeding the given value	CENSUS, Record sheet HPA n. 1 → HPAC form n. 1.	A
	O2d	75 % of the values indicating the population of the excluded Roma enclaves in the given municipality selection not exceeding the given value	CENSUS, Record sheet HPA n. 1 → HPAC form n. 1.	A

Overview of the initial impact evaluation phase results

Overview of the initial impact evaluation phase results

Data	Interpretation	Items in research documentation	Indicator quality
O2e	Indicates the lowest number of inhabitants of the excluded Roma enclavesin the given municipality selection	CENSUS, Record sheet HPA n. 1 → HPAC form n. 1	A
O2f	Indicates the highest number of inhabitants of the excluded Roma enclaves in the included municipalities	CENSUS, Record sheet HPA n. 1 → HPAC form n. 1.	A
O3a	Indicates the approximate proportion of the total population of the given municipality selection made up of the inhabitants of the excluded Roma enclaves; 1a / the sum of the population numbers in the included municipalities according to the official websites of the municipalities	CENSUS, Record sheet HPA n. 1 → HPAC form n. 1. + Form HPAC n. 1.	A/?[2]
O3b	Indicates the number of excluded Roma enclaves located in the given selection of municipalities with a total population of over 5,000	N/A	N/A
O3c	Indicates the number of excluded Roma enclaves located in the given selection of municipalities with a total population of up to 5,000	N/A	N/A
O3d	Indicates the proportion of the excluded Roma enclaves represented by the enclaves in municipalities with a total population of over 5,000	N/A	N/A
O4a	Indicates how many people aged below 18 lived in the excluded Roma enclaves	CENSUS, Record sheet HPA n. 1 → HPAC form n. 1.+ HPAC form n. 1	A/?[3]
O4b	Indicates how many people aged 18 to 59 lived in the excluded Roma enclaves	CENSUS, Record sheet HPA n. 1 → HPAC form n. 1. + HPAC form n. 1.	A/?[3]
O4c	Indicates the proportion of the population aged over 59 in the excluded Roma enclaves	CENSUS, Record sheet HPA → n. 1 HPAC form n. 1. + HPAC form n. 1.	A/?[3]
O4d	Indicates the proportion of the population aged below 18 in the excluded Roma enclaves; 1a/4a	CENSUS, Record sheet HPA → n. 1 HPAC form n. 1. + HPAC form n. 1.	A/?[3]
O4e	Indicates the proportion of the population aged 18 to 59 in the excluded Roma enclaves; 1a/4b	CENSUS, Record sheet HPA → n. 1 HPAC form n. 1. + HPAC form n. 1.	A/?[3]
O4f	Indicates the proportion of the population aged over 59 in the excluded Roma enclaves; 1a/4c	CENSUS, Record sheet HPA n. 1. → HPAC form n. 1. + HPAC form n. 1.	A/?[3]
O5a	Indicates the average age of persons included in the REPRE samples of households with attributed male sex	REPRE, Record sheet HPA n. 2. (1)	A
O5b	Indicates the average age of persons included in the REPRE samples of households with attributed female sex	REPRE, Record sheet HPA n. 2. (1)	A
O5c	Indicates the proportion of the population from included REPRE samples of households made up of persons with attributed male sex	REPRE, Record sheet HPA n. 2. (1)	A
O5d	Indicates the proportion of the population from included REPRE samples of households made up of persons with attributed female sex	REPRE, Record sheet HPA n. 2. (1)	A

Data	Interpretation	Items in research documentation	Indicator quality
O6a–e	Indicate the proportion of the population in the included REPRE samples of households made up of people in the given age ranges with attributed male sex	REPRE, Record sheet HPA n. 2. (1)	A
O7a–e	Indicate the proportion of the population in the included REPRE samples of households made up of people in the given age ranges with attributed female sex	REPRE, Record sheet HPA n. 2. (1)	A
O8a	Indicates the proportion of the population in the included REPRE samples of households made up of people who "did not consider themselves Roma"	REPRE, Record sheet HPA n. 2. (1)	A
O8b	Indicates the proportion of the population in the included REPRE samples of households made up of people who "felt like a different (than attributed) gender"	REPRE, Record sheet HPA n. 2. (1)	A

A Health-related practices

Diet

1
A thorough assessment of the actual effects of individual norms on individual practices will only be made possible by subsequent in-depth analyses. However, we present both types of results (for practices and preferences, or norms) in a direct comparison in the passage devoted to diet in order to illustrate the intuitiveness as well as the complexity of mutual relations of this kind. Data on preferences and norms that are likely to condition other health-related practices are summarized together in the last section of the chapter related to practices.

The following results provide information on the levels of dietary deficiency and related practices. An insufficient diet causes reduced functioning of the immune system, growth problems, acute problems of the digestive tract, various mental problems, including behavioural disorders, and many other systemic health problems.

The dominant dietary habits in a given social environment are always determined by related social norms, too. The dietary survey therefore also focused on determining the degree of presence of related preferences.[1]

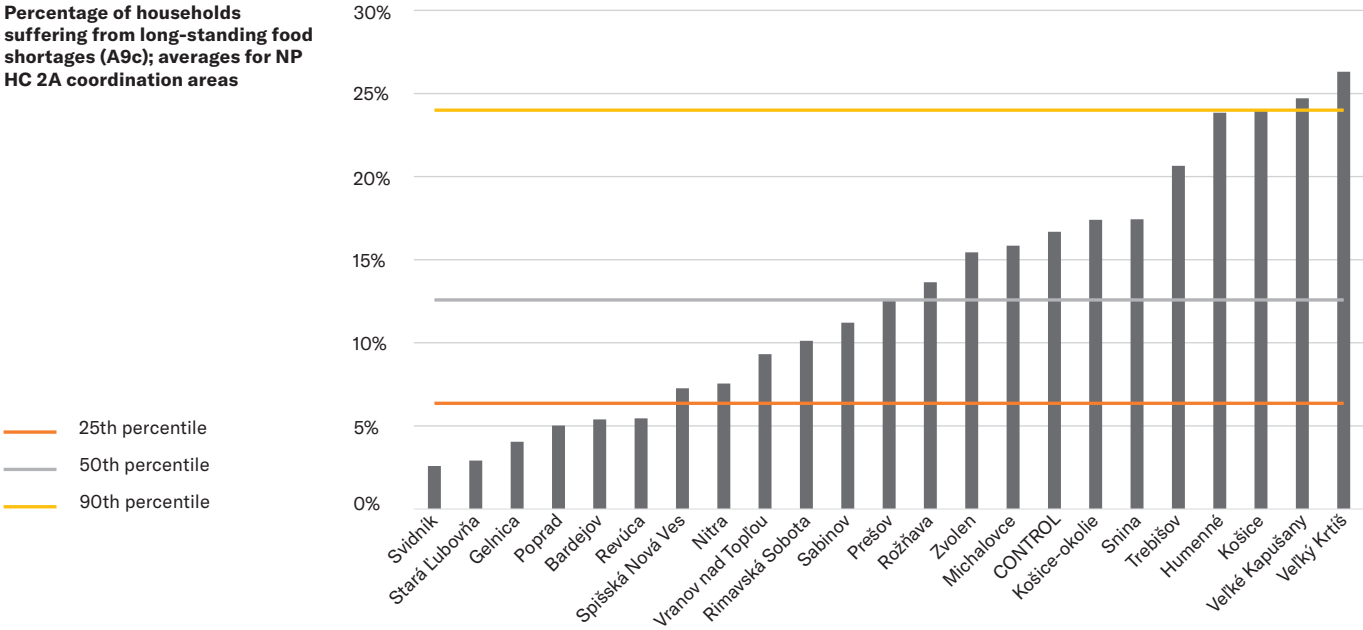The accuracy of the data on dietary deficiencies, based on the knowledge of the administrators (A9a–b), varied from location to location, in particular depending on the size of the individual excluded enclaves – for enclaves with more than 500 inhabitants, presented figures are less accurate. No problems were noted for the other indicators.

Overview of the initial impact evaluation phase results

A9	a	b	c
	Qualified estimates of the percentage of households where the individuals regularly go to sleep hungry because there is nothing to eat at home	**Qualified estimates of the percentage of households where the food consumed also includes food from waste bins**	**Percentage of households containing individuals who have suffered from a long-standing lack of food or hunger this year**
NP HC locations together	**7.5%**	**2.7%**	**13.5%**
NP HC **KE region**	8.6%	3.5%	17.7%
NP HC **PO region**	6.3%	1.2%	9.6%
NP HC **BB region**	9.0%	5.1%	15.6%
NP HC **regions NR TN TT**	0.6%	0.6%	7.6%
Control locations together	9.5%	6.0%	16.7%

Percentage of households where the following food is consumed during the week following a payday/payment of benefits…

A10	a	b	c	d	e	f	g
	raw fruits / vegetables every day	**raw fruits / raw vegetables not at all**	**dairy products every day**	**dairy products not at all**	**meat or charcuterie every day**	**starchy foods every day**	**sweets or sweetened beverages every day**
NP HC locations together	**21.5%**	**13.9%**	**23.8%**	**8.6%**	**34.3%**	**30.6%**	**30.0%**
NP HC **KE region**	18.1%	17.0%	20.3%	10.0%	35.5%	30.0%	29.6%
NP HC **PO region**	26.4%	11.1%	27.7%	7.5%	35.2%	33.8%	31.5%
NP HC **BB region**	16.4%	13.8%	20.7%	8.3%	29.6%	25.4%	25.6%
NP HC **regions NR TN TT**	22.4%	17.7%	28.8%	8.4%	32.3%	21.2%	43.1%
Control locations together	14.1%	10.7%	16.3%	5.1%	23.2%	20.3%	19.0%

Numbers of households where the food consumed also included food from waste bins in the individual NP HC 2A locations

25th percentile
50th percentile
90th percentile

Data ranking according to the relevant location

Percentage of households where the following food is consumed during the week preceding a payday/payment of benefits…

A11	a	b	c	d	e	f	g
	raw fruits / vegetables every day	**raw fruits / raw vegetables not at all**	**dairy products every day**	**dairy products not at all**	**meat or charcuterie every day**	**farinaceous foods every day**	**sweets or sweetened beverages every day**
NP HC locations together	**16.1%**	**26.7%**	**18.6%**	**18.4%**	**27.6%**	**28.2%**	**24.0%**
NP HC **KE region**	14.7%	29.6%	16.6%	20.7%	28.5%	28.2%	24.1%
NP HC **PO region**	19.6%	23.5%	22.4%	16.7%	29.2%	31.9%	25.5%
NP HC **BB region**	10.6%	27.8%	13.6%	18.0%	22.1%	21.4%	19.1%
NP HC **regions NR TN TT**	11.6%	31.3%	16.0%	15.3%	24.5%	9.3%	31.8%
Control locations together	8.4%	27.5%	10.1%	16.2%	13.2%	18.3%	11.7%

Percentage of households suffering from long-standing food shortages (A9c); averages for NP HC 2A coordination areas

25th percentile
50th percentile
90th percentile

Eating preferences: Percentage of households where the majority of members would prefer to eat…

A12	a	b	c	d
	more raw vegetables and fruit	**less charcuterie and meat**	**fewer sweets and drink fewer sweetened beverages**	**fewer farinaceous meals**
NP HC locations together	**51.6%**	**31.2%**	**30.9%**	**28.5%**
NP HC **KE region**	54.0%	31.4%	30.3%	28.2%
NP HC **PO region**	53.4%	31.3%	30.7%	28.0%
NP HC **BB region**	43.3%	32.9%	35.1%	31.6%
NP HC **regions NR TN TT**	40.6%	13.3%	11.7%	18.0%
Control locations together	48.3%	20.5%	20.0%	19.3%

PART I

Overview of the initial impact evaluation phase results

PART I

Overview of the initial impact evaluation phase results

Shares of households where people would like to consume more raw vegetables and fruits (A12a) and shares of households with people who think that others in the enclave would find this strange (A12a); averages for NP HC 2A coordination areas

- A12a – personal preferences
- A13a – given preferences "strange"
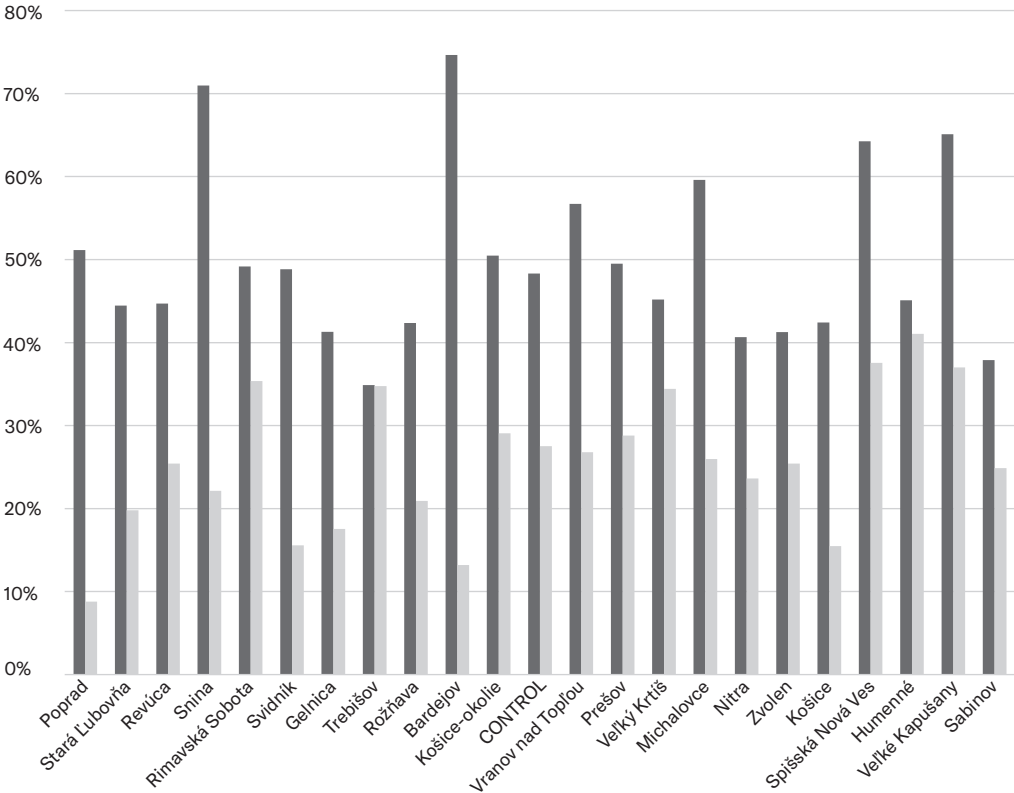
Proportions of households that do not consume raw fruits and vegetables at all in the week following (A10b), and preceding a (A11b) payment/benefits; averages for coordination areas of NP HC 2A

- A10b – following the
- A11b – preceding the

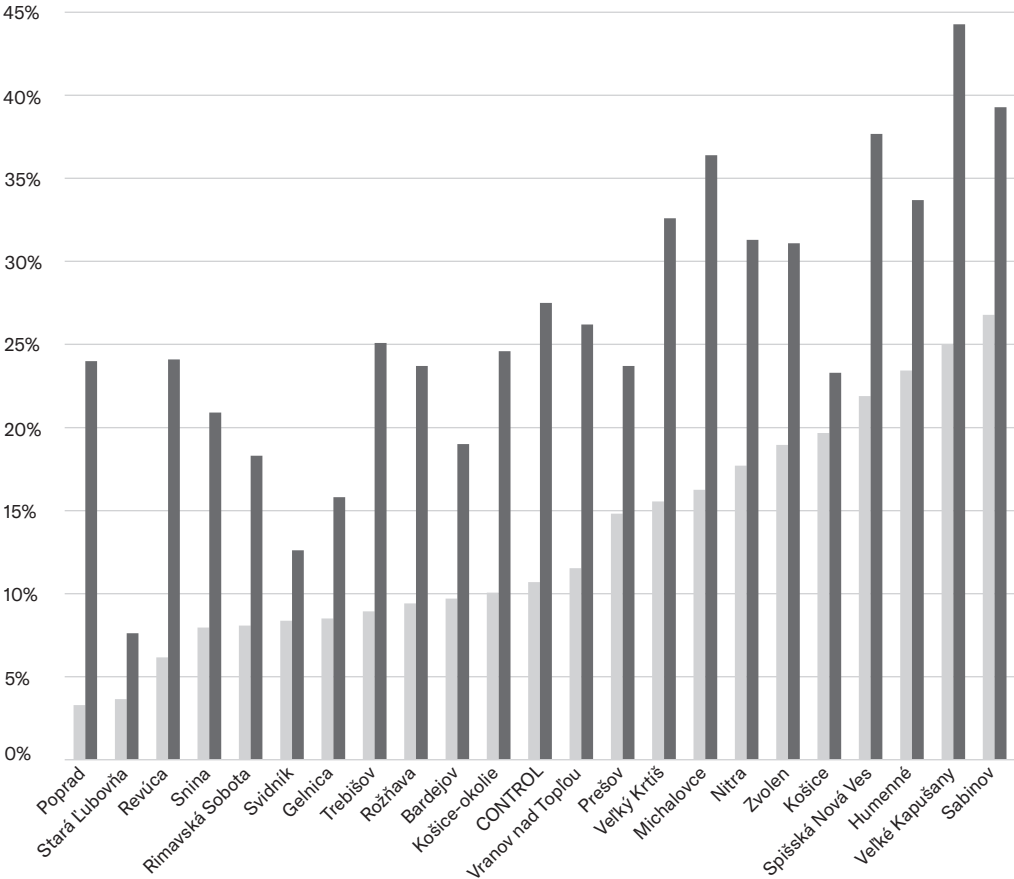| A13	a	b	c	d
	more raw vegetables and fruit	less charcuterie and meat	fewer sweets and drink fewer sweetened beverages	fewer farinaceous meals
NP HC locations together	**26.1%**	**29.2%**	**24.9%**	**25.4%**
NP HC **KE region**	28.3%	31.4%	24.7%	26.0%
NP HC **PO region**	23.5%	27.4%	23.3%	23.6%
NP HC **BB region**	28.1%	27.5%	27.9%	26.7%
NP HC **regions NR TN TT**	23.6%	43.4%	38.7%	40.1%
Control locations together	19.8%	24.0%	18.1%	20.6%

Additional information to the dietary information

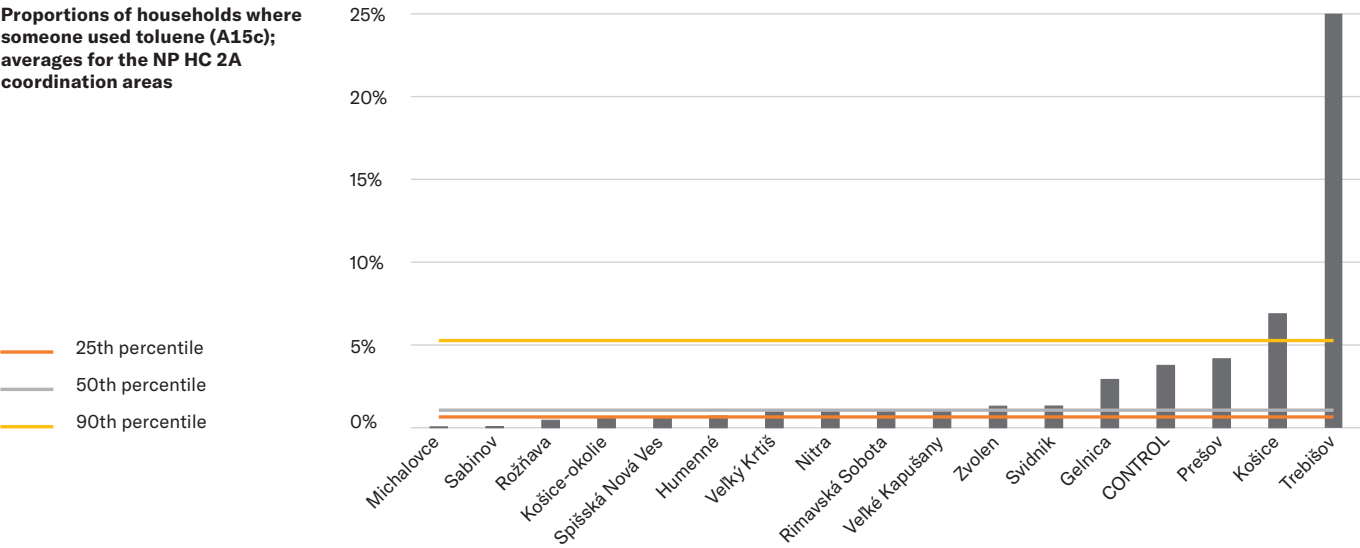| Data	Interpretation	Items in research documentation	Indicator quality
A9a	Dietary deficiency rate indicator: This gives estimates of the number of households "in which people sometimes go to bed hungry because there is nothing to eat at home" out of the total number of households in the considered enclaves (O1b) to the knowledge of the administrators	CENSUS, HPAC form n. 1	B
A9b	Indicator of the presence of food shortages: Provides estimates of the number of households "where food was also consumed from waste bins" out of the total number of households in the considered enclaves (O1b) to the knowledge of the administrators	CENSUS, HPAC form n. 1	B
A9c	Indicator of the presence of food shortages: Indicates the proportion of REPRE samples of households where "someone has suffered for a long time this year from lack of food or hunger"	REPRE, Record sheet HPA n. 2 (2)	A
A10 a–g	Indicators of the level of healthy consumption, or unhealthy diet: Indicate the shares of REPRE samples of households where "the week AFTER a payment/benefits" the given type of food is consumed in the given frequencies	REPRE, Record sheet HPA n. 2 (12)	A
A11 a–g	Indicators of the level of healthy consumption or an unhealthy diet: Indicate the shares of REPRE samples of households where the representatives "in the week BEFORE a payment/benefits" indulged in a given type of food at the given frequencies	REPRE, Record sheet HPA n. 2 (13)	A
A12 a–d	Indicators of the degree of presence of preferences regarding a healthy or unhealthydiet: Indicate the shares of REPRE samples of households where "most people would like to eat" more or less of the given types of food	REPRE, Record sheet HPA n. 2 (14)	A
A13 a–d	Indicators of the degree of presence of social norms regarding a healthy or unhealthy diet: Indicate the proportions of REPRE samples of households with people according to whom "others in the community would find this strange"	REPRE, Record sheet HPA n. 2 (14)	A

Drug abuse and dependencies

Taken together, the following results indicate the levels of presence of substance abuse, gambling, and related addictions. Overuse of addictive substances in the long term negatively threatens not only medical health, but also health in a broader sense – mental well-being, personality and family and social relationships. The direct health consequences of long-term substance abuse include, in particular: a significantly increased risk of respiratory, cancer, cardiovascular, neuro-motor and mental illnesses or crises that directly threaten life, including major injuries.

Since any personal dependencies in the given environment carry a considerable social stigma, it was not feasible to determine the degree of their presence or the degree of presence of related practices for most indicators (except A14 a–d) through direct questions within the interviewed households. Even with the indicators that the administrators initially considered not to be particularly sensitive (e.g., the number of people who only tried substances in the given households), in many locations no direct answers could be obtained eventually. Many administrators doubted the accuracy of the data obtained – according to the personal experience of the majority, there was a deliberate underestimation by the respondents. The alternative of qualified estimates based on direct experience of the administrators themselves provided additional data of fluctuating accuracy, particularly with regards to more sensitive indicators (15, 16), for the enclaves, where the given administrators themselves did not live for a long time, and in enclaves of over 500 inhabitants.

Shares of relevant households where…

A14	a — an adult smokes more than once a week (cigarettes or other tobacco products)	b — an adolescent smokes more than once a week (cigarettes or other tobacco products)	c — an adult drinks alcohol every day or almost every day	d — an adolescent drinks alcohol every day or almost every day	e — an adult gets drunk at least once a week (qualified estimate)	f — an adolescent gets drunk at least once a week (qualified estimate)
NP HC locations together	**82.7%**	**20.3%**	**16.7%**	**2.6%**	**21.8%**	**2.1%**
NP HC **KE region**	78.5%	19.8%	16.2%	3.3%	18.2%	2.0%
NP HC **PO region**	83.1%	20.8%	16.0%	1.9%	23.1%	2.5%
NP HC **BB region**	88.4%	20.3%	20.5%	3.3%	26.8%	1.5%
NP HC **regions NR TN TT**	95.5%	15.3%	8.6%	0.0%	7.4%	0.0%
Control locations together	82.3%	20.4%	10.7%	0.9%	17.4%	0.8%

Qualified estimates of the shares of relevant households where…

A15	a — an adult is using toluene	b — an adolescent is using toluene	c — somebody is using toluene	d — an adult is using meth	e — an adolescent is using meth	f — someone is using meth
NP HC locations together	**1.6%**	**1.3%**	**2.0%**	**0.7%**	**0.3%**	**0.8%**
NP HC **KE region**	1.4%	2.3%	2.8%	0.3%	0.3%	0.1%
NP HC **PO region**	1.5%	0.6%	0.9%	0.4%	0.2%	0.2%
NP HC **BB region**	2.8%	0.8%	2.9%	3.5%	0.7%	3.7%
NP HC **regions NR TN TT**	1.6%	0.0%	1.0%	3.4%	0.0%	0.1%
Control locations together	1.4%	1.6%	3.8%	0.2%	0.0%	1.7%

Proportions of households where someone used toluene (A15c); averages for the NP HC 2A coordination areas

Legend:
- 25th percentile
- 50th percentile
- 90th percentile

X-axis labels: Michalovce, Sabinov, Rožňava, Košice-okolie, Spišská Nová Ves, Humenné, Veľký Krtíš, Nitra, Rimavská Sobota, Veľké Kapušany, Zvolen, Svidník, Gelnica, CONTROL, Prešov, Košice, Trebišov

Overview of the initial impact
evaluation phase results

Overview of the initial impact
evaluation phase results

Left column

Proportions of households where an adult has tried toluene, methamphetamine or herb (A16d); averages for individual NP HC 2A coordination areas

- 25th percentile
- 50th percentile
- 90th percentile
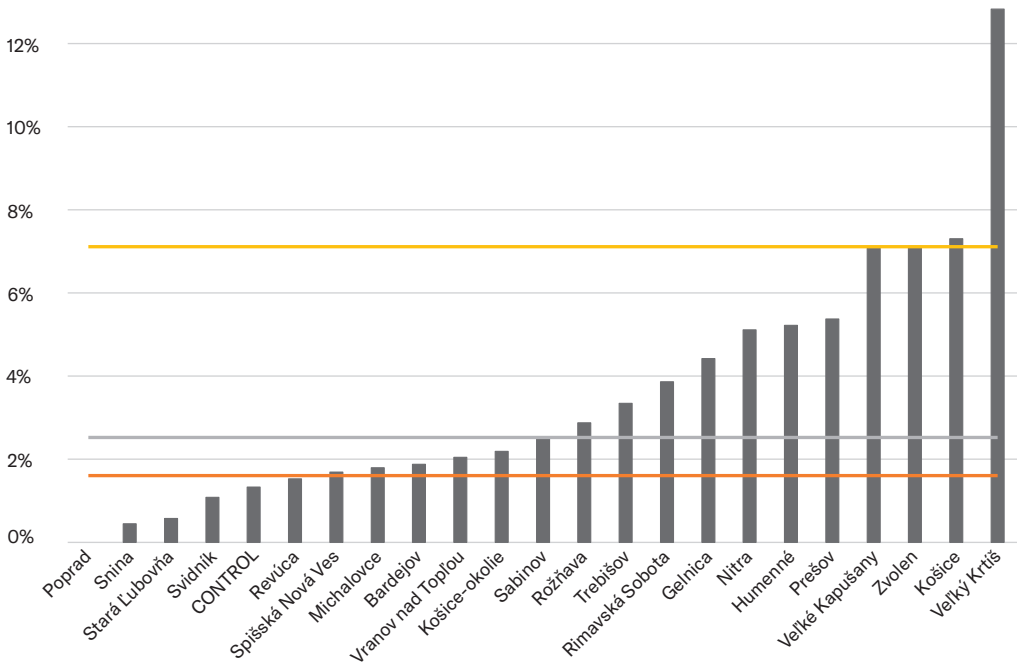
Proportions of households where an adult was regularly taking some psychiatric drugs (A17a); averages for individual NP HC 2A coordination areas
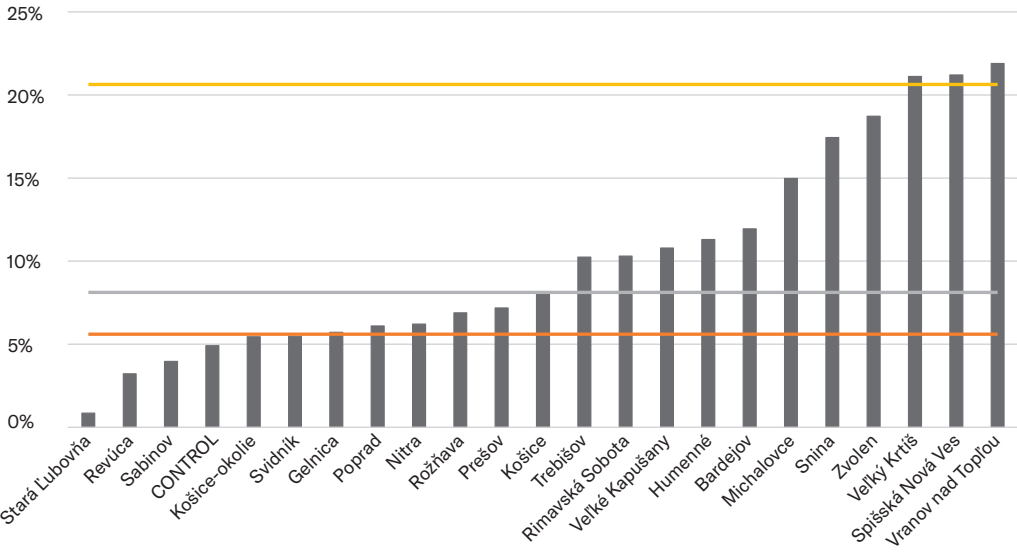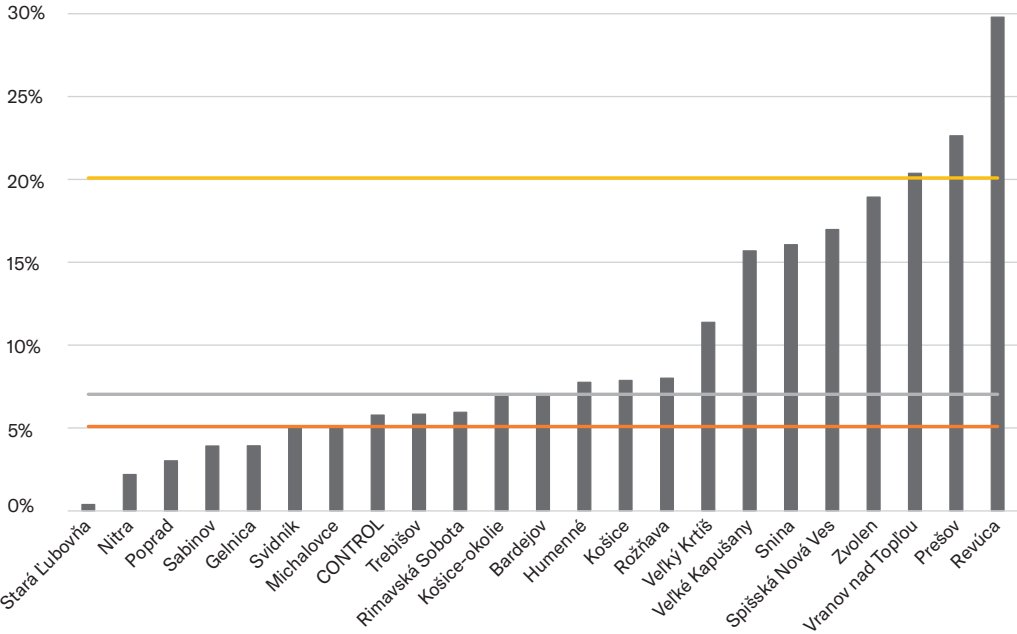

- 25th percentile
- 50th percentile
- 90th percentile

Shares of households where an adult regularly plays on slot machines (A17d); averages for individual NP HC 2A coordination areas

- 25th percentile
- 50th percentile
- 90th percentile

Right column

Shares of relevant households where…

A16	a	b	c	d	e
	an adult is using herb *(qualified estimate)*	an adolescent is using herb *(qualified estimate)*	someone is using herb *(qualified estimate)*	an adult has tried toluene, meth or herb	an adolescent has tried toluene, meth or herb
NP HC locations together	**0.7%**	**0.3%**	**0.9%**	**3.4%**	**2.2%**
NP HC **KE region**	0.4%	0.3%	1.2%	3.8%	3.4%
NP HC **PO region**	0.3%	0.1%	0.3%	2.0%	0.9%
NP HC **BB region**	3.8%	1.1%	2.0%	6.1%	3.6%
NP HC **regions NR TN TT**	1.2%	0.0%	0.1%	5.1%	0.0%
Control locations together	0.1%	0.2%	1.1%	1.3%	0.8%

Qualified estimate of the share of relevant households where…

A17	a	b	c	d
	an adult is regularly taking psychiatric medications	an adolescent is regularly taking psychiatric medications	an adult regularly plays slot machines	an adolescent regularly plays slot machines
NP HC locations together	**10.6%**	**1.3%**	**10.2%**	**1.3%**
NP HC **KE region**	9.1%	1.5%	7.0%	0.6%
NP HC **PO region**	10.9%	1.0%	12.3%	1.7%
NP HC **BB region**	13.0%	1.6%	12.4%	1.8%
NP HC **regions NR TN TT**	6.2%	3.3%	2.2%	0.0%
Control locations together	4.9%	0.6%	5.8%	1.8%

Additional information on substance abuse and addiction data

Data	Interpretation	Items in research documentation	Indicator quality
A14 a–d	Indicators of the presence of tobacco and alcohol abuse or nicotine and alcohol addiction: Indicate the shares of REPRE samples of households where someone was taking the given addictive substances in the given way	REPRE, Record sheet HPA n. 2 (34)	A
A14 e–f	Indicators of the presence of tobacco and alcohol abuse or nicotine and alcohol addiction: Indicate the share of the REPRE samples of households that was taking the given addictive substances in the given way according to the knowledge of the administrators	REPRE, Record sheet HPA n. 2 (part HPA)	B
A15 a–b, d–e	Indicators of the presence of tobacco and alcohol abuse or nicotine and alcohol addiction: Indicate the share of the REPRE samples of households that was taking the given addictive substances in the given way according to the knowledge of the administrators	REPRE, Record sheet HPA n. 2 (part HPA)	B

Data	Interpretation	Items in research documentation	Indicator quality
A15 c, f	Indicators of the presence rate of substance abuse: Indicate the estimates of the number of households where someone was taking the addictive substances in the given ways according to the knowledge of the administrators and relates them to the total number of excluded households in the considered enclaves (O1b)	CENSUS, HPAC form n. 1	B
A16 a–c	Indicators of the presence rate of substance abuse: Indicate the share of the REPRE samples of households that was taking the given addictive substances in a given way according to the knowledge of the administrators	REPRE, Record sheet HPA n. 2 (part HPA)	B
A16 d–e	Indicators of the presence of experimentation with given addictive substances: Showing the proportions of REPRE samples of households in which someone experimented with the given addictive substances in a given way	REPRE, Record sheet HPA n. 2 (34)	A
A17 a–b	Indicators of the degree of overuse of psychotropic drugs: Indicates the share of REPRE samples of households where someone regularly took psychotropic drugs to the knowledge of the administrators	REPRE, Record sheet HPA n. 2 (HPA part)	B
A17 c–d	Gambling presence indicators: Indicates the share of REPRE samples of households that regularly played on slot machines according to the knowledge of the administrators	REPRE, Record sheet HPA n. 2 (HPA part)	B

Sexual and reproductive health

Together, the following results indicate the level of presence of sexual and reproductive practices which usually significantly increase or decrease the risk of spreading sexually transmitted diseases, development disorders in children and health or social problems in the life trajectories, mostly of women.

Given the sensitivity of the topics, according to all the stakeholders involved, it was not feasible to acquire respective values through direct questioning for any of the indicators included. The values were therefore determined exclusively based on direct experience and the knowledge of local administrators about the individual enclaves or families included in theREPRE samples. On the other hand, as this is an area where the concerned administrators often directly assist residents of excluded enclaves in cooperation with local health professionals, they generally considered their estimates to be accurate. Qualified estimates of administrators should be less accurate only in cases (significantly less frequent) where the administrators were men, for enclaves where the administrators themselves did not live for a long time and for enclaves with more than 500 inhabitants.

Qualified estimates of the number of households where…	A18	a	b	c
		there are people who sleep with more than one partner over the same time period	a child was born to an adolescent parent in the last year	there are parents who are secondary or close relatives
	NP HC locations together	**4.2%**	**2.8%**	**7.7%**
	NP HC **KE region**	4.7%	5.7%	10.4%
	NP HC **PO region**	3.5%	1.3%	6.5%
	NP HC **BB region**	5.3%	1.2%	6.3%
	NP HC **regions NR TN TT**	0.8%	0.4%	0.8%
	Control locations together	3.4%	4.5%	6.4%

Qualified estimates of the number of households where…	A19	a	b	c	d	e
		an adult woman has undergone an abortion	an adolescent woman has undergone an abortion	an adult is taking hormonal contraception	an adolescent is taking hormonal contraception	a woman has an implanted uterine device
	NP HC locations together	**9.5%**	**0.5%**	**2.7%**	**0.4%**	**12.9%**
	NP HC **KE region**	8.4%	0.6%	2.2%	0.5%	8.4%
	NP HC **PO region**	9.5%	0.3%	2.8%	0.0%	16.6%
	NP HC **BB region**	12.8%	0.6%	3.8%	1.4%	14.0%
	NP HC **regions NR TN TT**	1.5%	1.7%	0.0%	0.0%	3.8%
	Control locations together	5.2%	0.0%	6.6%	0.3%	8.5%

Proportions of households where an adult woman has undergone an abortion (A19a); averages for individual NP HC 2A coordination areas

— 25th percentile
— 50th percentile
— 90th percentile
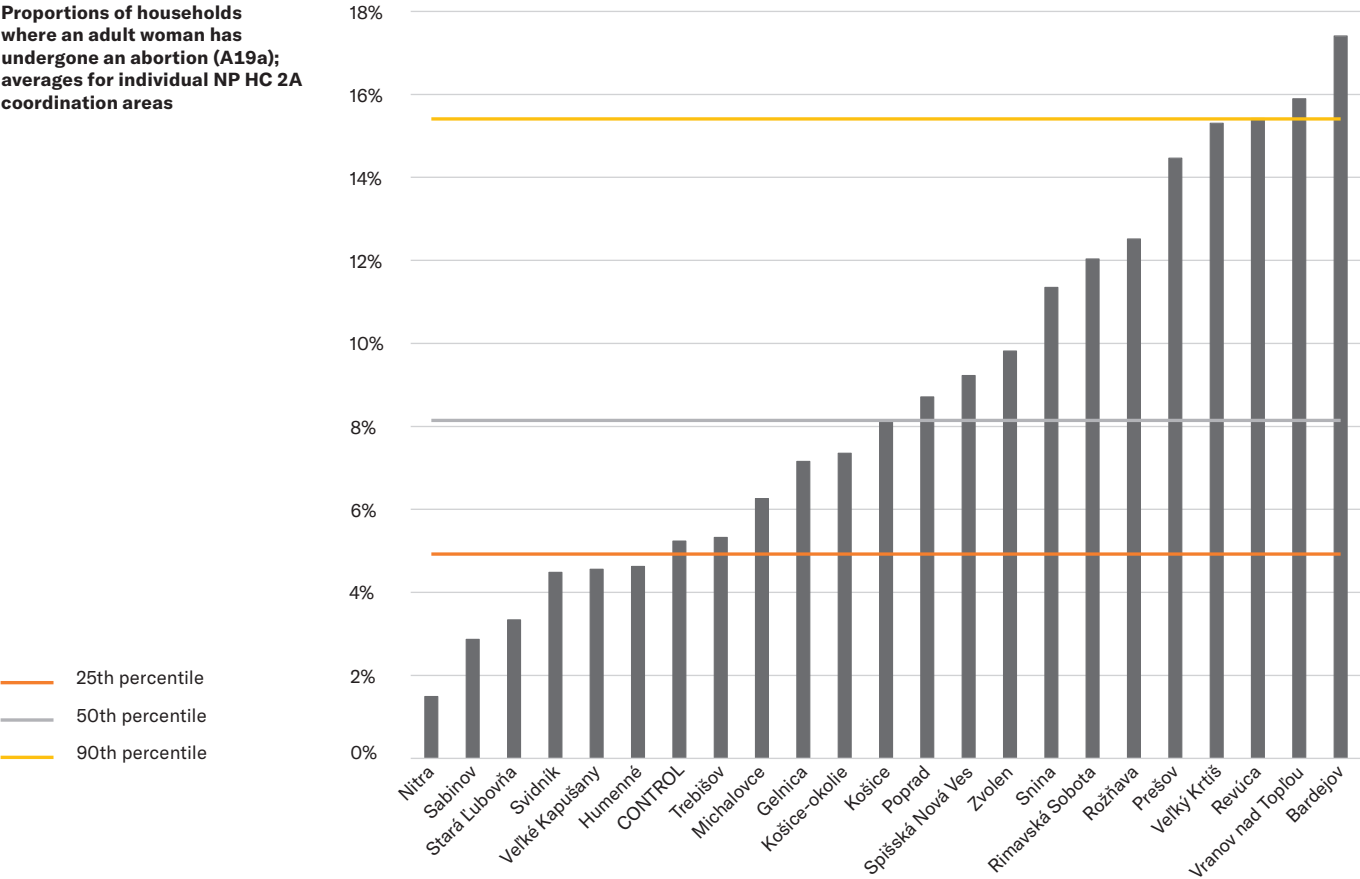
Proportions of households where a woman has an intrauterine device (A19e); averages for individual NP HC 2A coordination areas

— 25th percentile
— 50th percentile
— 90th percentile

Data	Interpretation	Items in research documentation	Indicator quality
A18 a–c	Indicators of the degree of presence of health-risky sexual practices: Indicate the estimates of the number of households where the practices occur to the knowledge of the administrators and relate to them to the total number of excluded households in the considered enclaves (O1b)	CENSUS, HPAC form n. 1	B
A19 a–e	Indicators of the presence of practices that tend to protect the reproductive health of girls and women: Indicate the share of REPRE samples of households where the listed practices occurred according to the knowledge of the administrators	REPRE, Record sheet HPA n. 2 (HPA part)	A

Personal hygiene

Together, the following results indicate the degree of (non) presence of home body care practices, especially cleanliness in the medical sense, which significantly reduces the risk of infectious and parasitic diseases and the development of non-infectious skin and dental diseases. Non-compliance with dominant social standards of personal hygiene is also associated with a strong social stigma, which significantly supports the processes of social exclusion, including reducing the access to and quality of health care services.

A strong stigmatization of the so-called "lower standards" of personal hygiene makes it impossible to reliably ascertain the presence of specific related practices through direct questions. Related values were therefore determined based on the direct experience and knowledge of administrators about the given locations and consulted families. However, according to the administrators their estimates were generally only approximate, and their accuracy was lower for the enclaves where the administrators themselves did not live for a long time and with increasing population numbers.

Proportion of excluded Roma households where children take a bath once a week or less (A20b); shares in individual NP HC 2A locations

- 25th percentile
- 50th percentile
- 90th percentile

Data ranking according to the relevant location
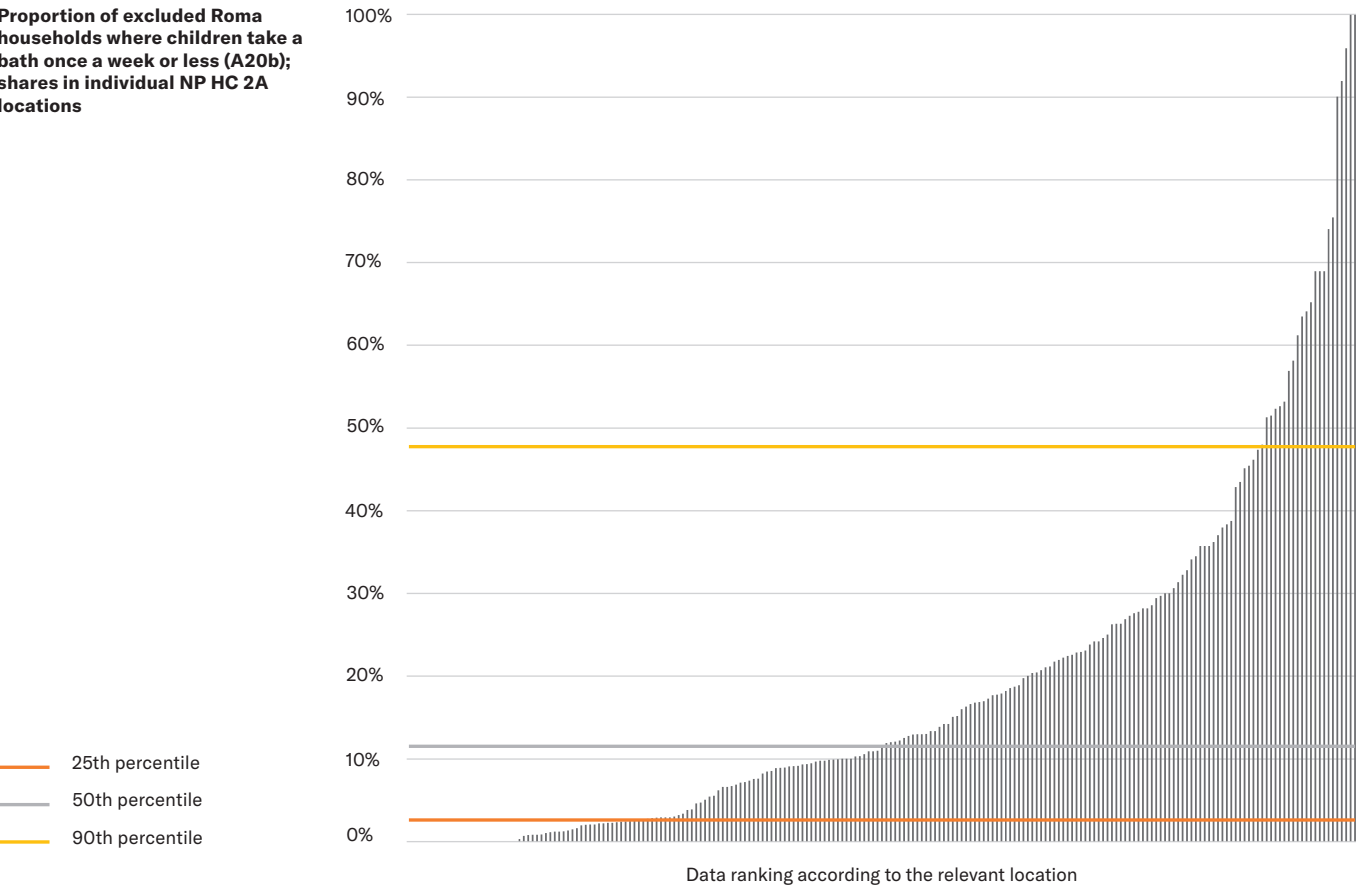
Proportions of excluded Roma enclaves where fleas, lice or scabies are a common problem (A20d); shares in individual NP HC 2A locations

- 25th percentile
- 50th percentile
- 90th percentile

Data ranking according to the relevant location
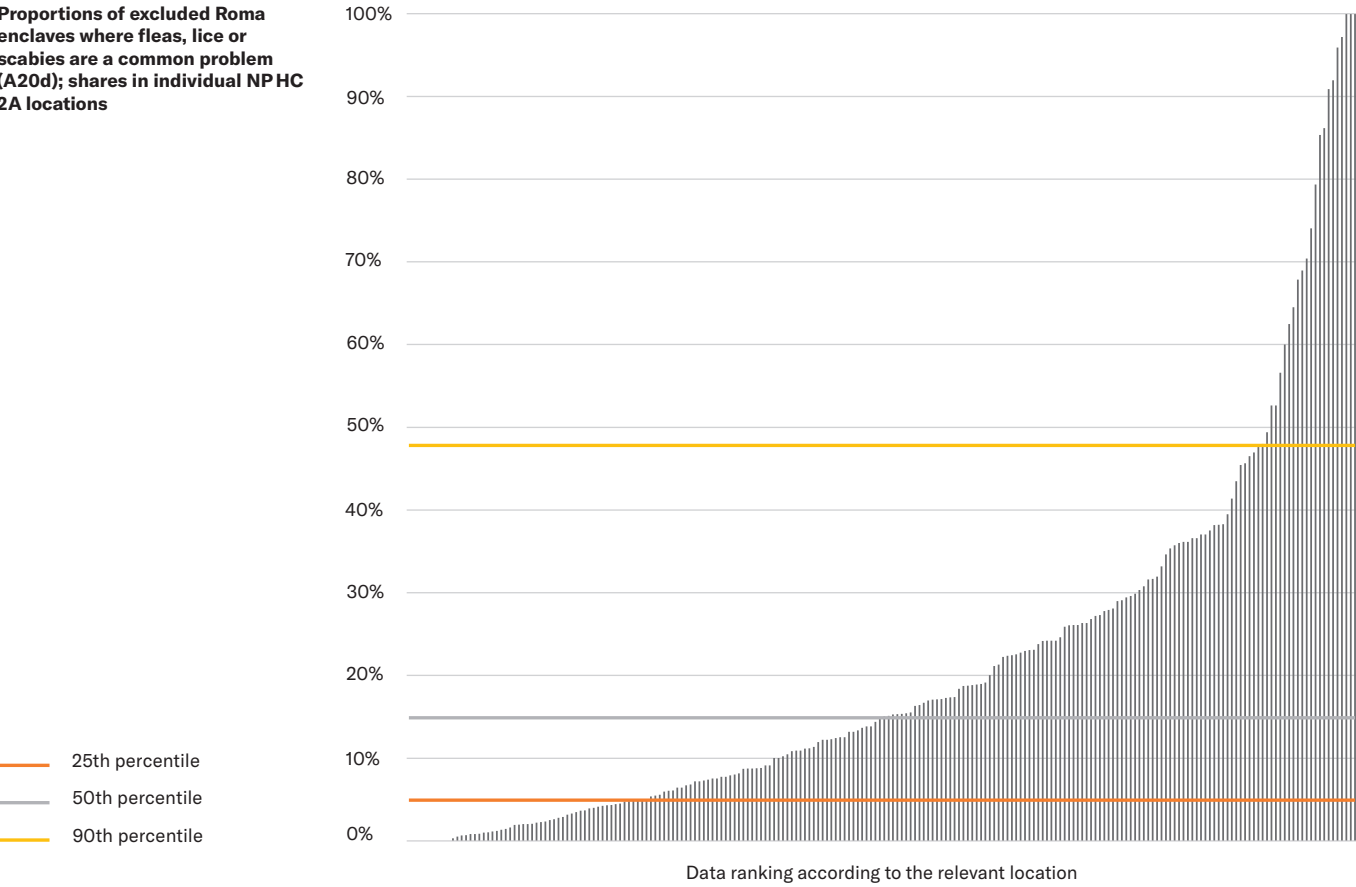
Qualified estimates of the numbers of households, where…

A20	a	b	c	d	e	f
	The adults do not wash their hands with soap every day	The children only have a bath once a week or less	There are adults who do not brush their teeth daily	lice, fleas, or scabies are a common problem	bed bugs, cockroaches or rodents are common	roundworms, nematodes or other parasitic worms have occurred in the last year
NP HC locations together	**16.4%**	**16.8%**	**26.2%**	**19.1%**	**16.9%**	**4.9%**
NP HC **KE region**	18.2%	17.9%	29.4%	20.2%	14.7%	8.6%
NP HC **PO region**	13.9%	14.9%	24.1%	20.7%	18.7%	3.0%
NP HC **BB region**	20.1%	20.8%	27.4%	15.3%	19.2%	1.9%
NP HC **regions NR TN TT**	0.7%	0.7%	1.2%	0.8%	1.2%	0.7%
Control locations together	24.5%	26.1%	34.7%	26.8%	17.3%	6.0%

Additional information to personal hygiene data

Data	Interpretation	Items in research documentation	Indicator quality
A20 a–c	Indicators of the presence of so-called basic hygienic practices: Indicate the estimates of the number of households where to the knowledge of the administrators the given hygienic standards were not observed, relative to the total number of excluded households in the considered enclaves (O1b)	CENSUS, HPAC form n. 1	B
A20 d–f	Indicators of the degree of presence of parasitosis or pests indicating non-compliance with the so-called basic hygiene standards in the households or in the community: Indicate the estimates of the number of households where, according to the administrators' knowledge, the above phenomena occurred, relative to the total number of excluded households in the considered enclaves (O1b)	CENSUS, HPAC form n. 1	B

Physical activity

Taken together, the following results indicate the level of presence or absence of physical activity practices which are key to the prevention of civilization diseases in particular – vascular and metabolic heart diseases, including obesity and diabetes, musculoskeletal disorders, cancer and mental illnesses – but also injuries.

No problems were noted for any of the indicators included (whether conceptual, related to fieldwork or analyses).

Page 056

Proportions of households where an adolescent does physical exercises or practices sports in an unorganized manner at least once a week (A21d) or regularly in larger groups in an organized manner (A21b); averages for NP HC 2A coordination areas

■ A21d – in an unorganized manner
▫ A21b – in an organized manner
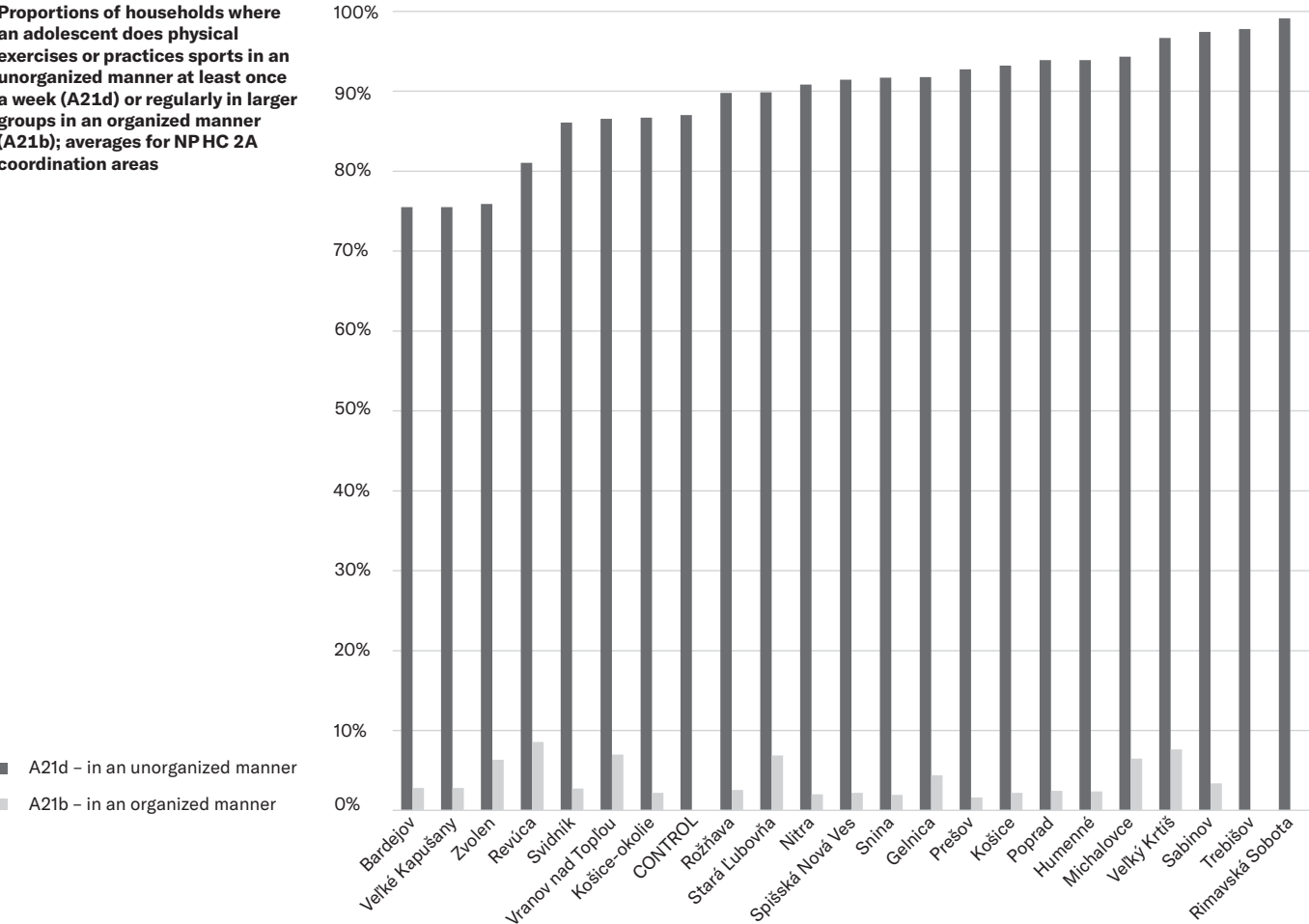
Proportions of households where an adult has suffered serious injuries in the last year at work related to the household (A23a); averages for NP HC 2A coordination areas

— 25th percentile
— 50th percentile
— 90th percentile

Overview of the initial impact evaluation phase results

Page 057

Proportions of households where…

A21	a	b	c	d
	someone regularly plays sports alone (organized activities)	someone regularly plays sports in larger groups (organized activities)	an adult exercises or does sports at least once a week (unorganized activities)	an adolescent exercises or does sports at least once a week (unorganized activities)
NP HC locations together	**2.0%**	**4.0%**	**78.4%**	**89.1%**
NP HC **KE region**	1.6%	4.7%	79.6%	90.0%
NP HC **PO region**	1.4%	2.8%	80.0%	88.7%
NP HC **BB region**	4.2%	5.5%	71.2%	88.0%
NP HC **regions NR TN TT**	0.9%	2.2%	86.8%	90.9%
Control locations together	2.1%	3.2%	74.6%	87.1%

Proportions of households where…

A22	a	b	c	d
	an adult is not willing to exercise or do any physical activity	an adolescent is not willing to exercise or do any physical activity	an adult watches TV, plays computer games or mobile phone games for more than 2 hours a day in total	an adolescent watches TV, plays computer games or mobile phone games for more than 2 hours a day in total
NP HC locations together	**10.0%**	**4.8%**	**54.7%**	**39.2%**
NP HC **KE region**	8.9%	4.5%	57.3%	39.0%
NP HC **PO region**	10.9%	5.5%	53.0%	42.1%
NP HC **BB region**	10.5%	4.2%	58.4%	35.3%
NP HC **regions NR TN TT**	3.7%	0.9%	13.3%	18.4%
Control locations together	12.0%	4.5%	65.4%	43.6%

Proportions of households where…

A23	a	b
	an adult has suffered a serious injury while working around the house or in the household in the past year	a teenager suffered a serious injury during the last year while working around the house or in the household
NP HC locations together	**4.7%**	**1.7%**
NP HC **KE region**	5.7%	1.7%
NP HC **PO region**	4.6%	1.8%
NP HC **BB region**	3.4%	1.8%
NP HC **regions NR TN TT**	1.1%	0.0%
Control locations together	6.0%	0.5%

Overview of the initial impact evaluation phase results

Data	Interpretation	Items in research documentation	Indicator quality
A21 a–d	Presence rate indicators for external physical activities: Indicate the proportions of REPRE samples of households in which people did sports to a given extent	REPRE, Record sheet HPA n. 2 (29)	A
A22 a–b	Indicators of the lack of healthy physical activity: Indicate the proportions of REPRE samples of households in which there were people who generally avoided any physical activity deliberately	REPRE, Record sheet HPA n. 2 (34)	A
A22 c–d	Indicators of the degree of presence of sedentary behaviour or lack of healthy physical activity: Indicate the proportions of REPRE samples of households where an unhealthy rate of sedentary behaviour was common	REPRE, Record sheet HPA n. 2 (34)	A
A23 a–b	Indicators of the degree of presence of non-economic work habits or non-economic environment: They show the proportions of REPRE samples of households where, during routine work in the home environment, the given people have suffered injuries requiring medical treatment in the last year	REPRE, Record sheet HPA n. 2 (34)	A

Prevention

Taken together, the following results provide evidence on the level of presence of various preventive practices, including the early detection and appropriate treatment of a wide range of the most common health problems.

No problems were noted for any of the indicators included (whether conceptual, related to fieldwork or analyses).
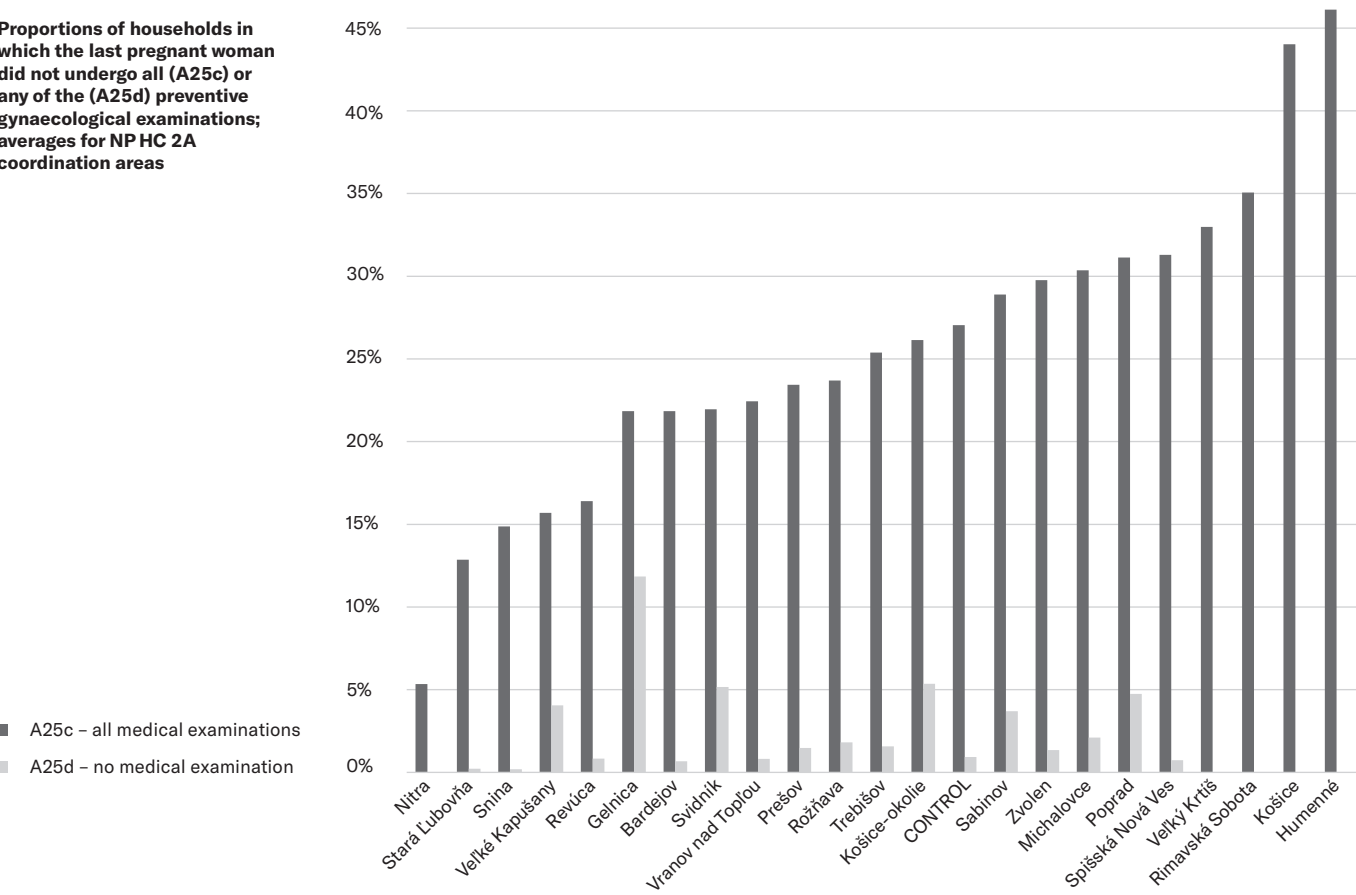
Proportions of households where a child has not yet undergone some of the compulsory vaccinations (A25a); averages for coordination areas NP HC 2A

35%
30%
25%
20%
15%
10%
5%
0%

— 25th percentile
— 50th percentile
— 90th percentile

Rožňava, Nitra, Sabinov, Veľké Kapušany, Veľký Krtíš, Bardejov, Michalovce, Zvolen, CONTROL, Poprad, Košice-okolie, Vranov nad Topľou, Snina, Revúca, Rimavská Sobota, Prešov, Spišská Nová Ves, Humenné, Košice, Svidník, Gelnica, Trebišov, Stará Ľubovňa

A24	a	b	c	d	e	f
	an adult has not undergone a preventive examination by a general practitioner in the last 2 years	a child has not undergone a preventive examination by a general practitioner in the last 2 years	an adult has not undergone a free preventive examination at the dentist	a child has not undergone a free preventive examination at the dentist	an adult woman has not undergone a free preventive gynaecological examination in the last year	a girl has not undergone a free preventive gynaecological examination in the last year
NP HC locations together	26.4%	8.4%	39.6%	15.1%	33.2%	8.8%
NP HC **KE region**	26.6%	7.7%	36.1%	13.5%	29.8%	6.1%
NP HC **PO region**	28.9%	9.2%	43.4%	16.3%	38.1%	9.9%
NP HC **BB region**	21.7%	8.8%	39.5%	15.8%	30.6%	12.6%
NP HC **regions NR TN TT**	12.7%	1.4%	21.0%	11.4%	11.6%	0.0%
Control locations together	18.1%	6.9%	34.0%	12.0%	25.2%	4.1%

A25	a	b	c	d
	a child has not yet undergone some of the compulsory vaccinations	an adult has not undergone the mandatory tetanus vaccination	the last pregnant woman did not undergo any preventive examination by a gynaecologist	the last pregnant woman did not undergo all preventive exams at gyanecologist
NP HC locations together	12.9%	18.5%	2.6%	25.6%
NP HC **KE region**	13.6%	16.7%	3.3%	28.4%
NP HC **PO region**	15.0%	22.3%	2.2%	23.3%
NP HC **BB region**	7.6%	14.7%	2.2%	27.7%
NP HC **regions NR TN TT**	3.0%	1.1%	0.7%	5.3%
Control locations together	10.4%	10.2%	0.5%	27.0%

Proportions of households in which the last pregnant woman did not undergo all (A25c) or any of the (A25d) preventive gynaecological examinations; averages for NP HC 2A coordination areas

- ■ A25c – all medical examinations
- ▫ A25d – no medical examination

(x-axis: Nitra, Stará Ľubovňa, Snina, Veľké Kapušany, Revúca, Gelnica, Bardejov, Svidník, Vranov nad Topľou, Prešov, Rožňava, Trebišov, Košice-okolie, CONTROL, Sabinov, Zvolen, Michalovce, Poprad, Spišská Nová Ves, Veľký Krtíš, Rimavská Sobota, Košice, Humenné)

Additional information on prevention data

Data	Interpretation	Items in research documentation	Indicator quality
A24 a–f	Indicators of the rate of use of specific preventive health services: They indicate the proportions of REPRE samples of households where the given people did not undergo the given types of preventive examinations	REPRE, Record sheet HPA n. 2 (34)	A
A25 a–d	Indicators of the rate of use of the specific preventive health services: They indicate the proportions of REPRE samples of households where the people in question have not yet undergone the given types of compulsory vaccination	REPRE, Record sheet HPA n. 2 (34)	A

Related social norms

[2]
Except preferences and social standards for diet, which have been already covered separately in the above section on dietary practices, to illustrate common relationships between the norms and the practices.

The following results together indicate the degree of presence of attitudes and norms prevailing throughout the enclaves, which in the given social environment tend to contribute to the adoption of the above-mentioned riskier or less risky health-related practices.[2]

Due to the sensitivity of some risky practices from the point of view of the inhabitants of excluded Roma enclaves, related values were determined indirectly. The representatives of the addressed households were supposed assess what attitudes and norms prevailed in their neighborhoods. However, data were not obtained at all because local respondents refused to discuss the given topics. On the other hand, the indicators themselves can be considered reliable wherever the respondents did not refuse to answer (the presented data are informative for individual locations, but they are less accurate for larger geographical units).

Proportions of households according to which others in the community…

A26	a like it when someone tries to quit smoking	b dislike it when a pregnant woman smokes	c like it when someone does not want to drink alcohol	d dislike it when a pregnant woman drinks alcohol	e do not like frequent women drunkenness	f do not like frequent men drunkenness
NP HC locations together	69.3%	69.4%	68.5%	78.6%	79.4%	77.3%
NP HC **KE** region	66.3%	65.1%	66.0%	76.4%	77.3%	75.0%
NP HC **PO** region	63.6%	63.1%	62.9%	73.4%	74.6%	72.3%
NP HC **BB** region	58.9%	58.8%	57.1%	67.6%	69.4%	67.4%
NP HC regions **NR TN TT**	60.5%	68.6%	61.5%	74.9%	75.5%	70.5%
Control locations together	62.3%	66.7%	60.8%	72.0%	71.2%	69.3%

Proportions of households according to which the others in the community…

A27	a like it when someone does not want to play slot machines	b do not like the regular use of psychiatric drugs	c do not like it when someone tries to live healthy in order to not get sick	d do not like it when someone tries to exercise regularly	e do not like it when someone is careful at work
NP HC locations together	66.4%	52.4%	10.8%	5.6%	7.3%
NP HC **KE** region	64.1%	48.3%	9.3%	6.9%	7.6%
NP HC **PO** region	61.3%	47.3%	8.6%	6.5%	7.0%
NP HC **BB** region	56.4%	44.8%	7.1%	5.1%	5.4%
NP HC regions **NR TN TT**	57.2%	54.3%	12.6%	12.7%	11.2%
Control locations together	60.6%	46.8%	8.4%	5.3%	5.8%

Proportions of households according to whose representatives the others in the location do not like it when a person tries to live a healthy life in order not to get sick (A27c); in individual NP HC 2A locations

25th percentile
50th percentile
90th percentile
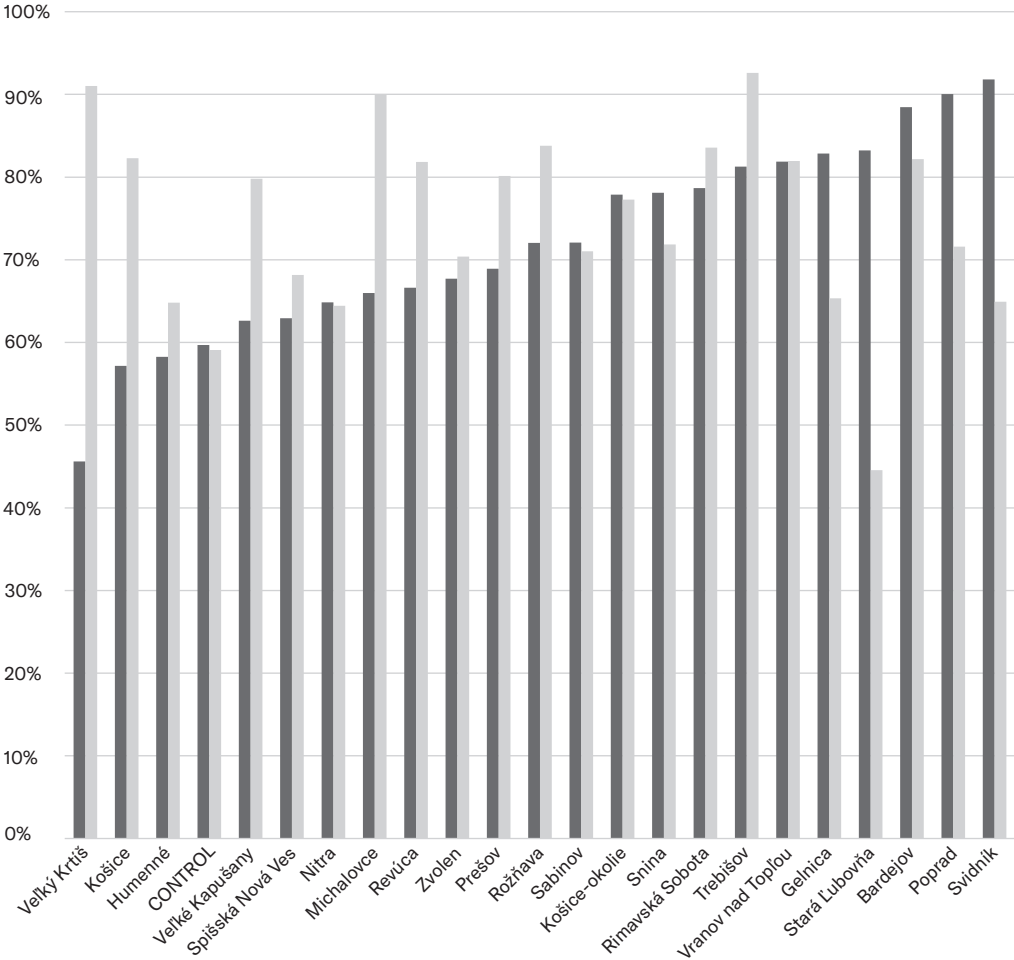
Data ranking according to the relevant location
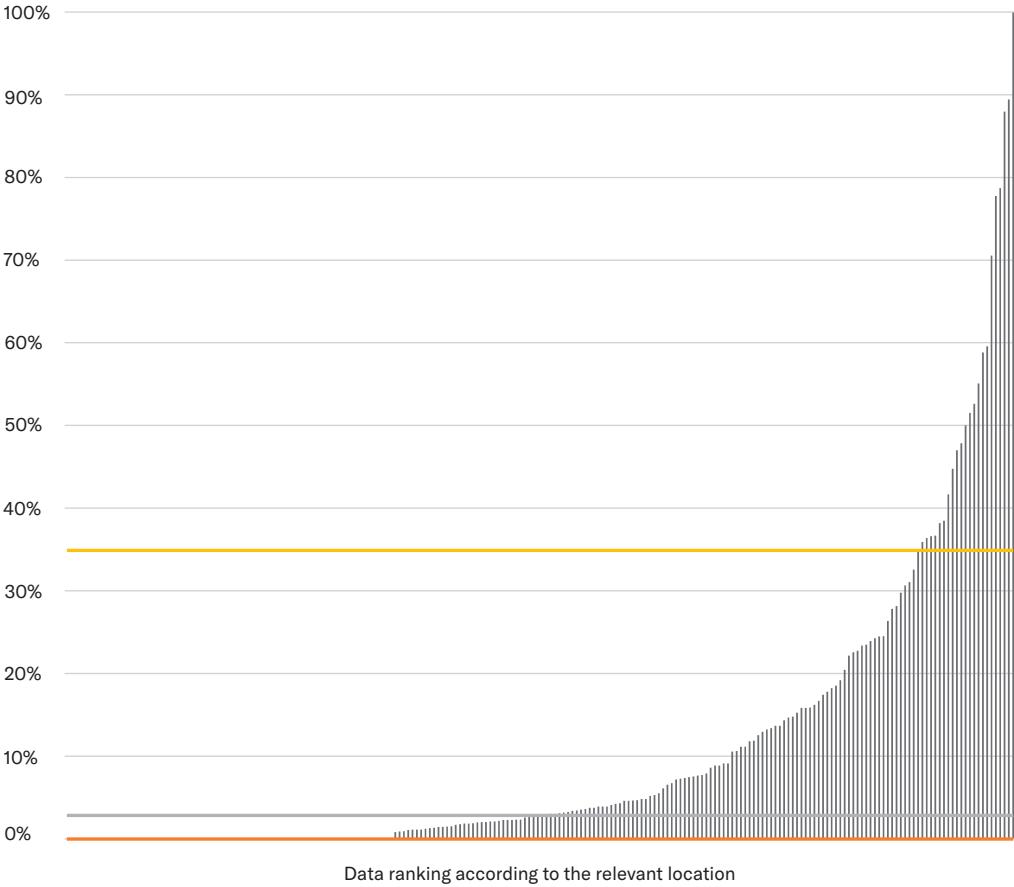
Proportions of households according to whose representatives the others in the enclave do not like it when single men (A28a) or women (A28b) switch sexual partners; averages for NP HC 2A coordination areas

A28a – when men
A28b – when women

Overview of the initial impact evaluation phase results

Proportions of households according to which the others in the community…

A28	a	b	c	d
	dislike it when single men switch sexual partners	dislike it when single women switch sexual partners	dislike prostitution (for money)	do not like sex as a reward (rewards other than money)
NP HC locations together	70.2%	73.5%	78.1%	77.8%
NP HC **KE region**	66.3%	69.4%	73.9%	73.3%
NP HC **PO region**	64.1%	67.0%	72.1%	71.6%
NP HC **BB region**	59.7%	62.8%	69.0%	68.7%
NP HC **regions NR TN TT**	64.9%	64.4%	69.8%	69.8%
Control locations together	59.7%	64.9%	72.1%	72.8%

Proportions of households according to which the others in the community…

A29	a	b	c	d	e	f
	do not like using condoms when making love	do not like the use of hormonal contraception	dislike when someone has an intrauterine device	do not like it when someone fails to children	do not like it when someone becomes a single mother	do not like it when someone undergoes an abortion
NP HC locations together	18.0%	25.1%	16.2%	45.4%	39.4%	47.7%
NP HC **KE region**	17.3%	21.5%	13.9%	42.2%	35.8%	41.3%
NP HC **PO region**	16.6%	18.4%	12.2%	40.1%	33.7%	39.6%
NP HC **BB region**	15.5%	13.0%	8.9%	36.0%	30.9%	35.9%
NP HC **regions NR TN TT**	13.5%	15.5%	12.8%	44.3%	23.0%	44.4%
Control locations together	14.1%	19.2%	15.5%	43.4%	35.6%	41.7%

Overview of the initial impact evaluation phase results

Data	Interpretation	Items in research documentation	Indicator quality
A26 a–f	Indicators of the presence of negative attitudes regarding addiction-promoting practices: They indicate the proportions of REPRE samples of households according to which the attitudes prevailed in the community	REPRE, Record sheet HPA n. 2 (15)	A
A27 a–e	Indicators of the presence of negative attitudes regarding preventive practices: They indicate the proportions of REPRE samples of households according to which the attitudes prevailed in the community	REPRE, Record sheet HPA n. 2 (15)	A
A28 a–d	Indicators of the presence of negative attitudes towards practices that may increase the risk of sexually transmitted diseases and related threats to reproductive health: They indicate the proportions of REPRE samples of households according to the representatives of which the given attitudes prevailed in the community	REPRE, Record sheet HPA n. 2 (15)	A
A29 a–f	Indicators of the presence of negative attitudes regarding practices that may increase sexual and reproductive health, especially for women: They indicate the proportions of REPRE samples of households according to which the attitudes prevailed in the community	REPRE, Record sheet HPA n. 2 (15)	A

B

Psychological burden

Stress

Together, the following data indicate the degree of presence of circumstances that in the given environment tend to cause people stress, especially in the long term, but also cause them psychological trauma. Long-term stress significantly contributes to the development of mental and chronic diseases, especially cancer and cardiovascular diseases, but also metabolic disorders. Psychological trauma can cause behavioural or personality disorders in individuals and lead to social conflicts or isolation, associated with other negative consequences for health in general. In addition, higher levels of stress and frequent psychological trauma tend to increase the presence of various risky behaviours in populations (e.g. substance abuse, as such behaviour is an effective means of coping with excessive psychological stress in the short term).

No problems were noted for any of the indicators included (whether conceptual, related to fieldwork or analyses). However, some administrators have expressed concern that for stressors whose presence in the home may be perceived as stigmatizing (e.g. lack of food or physical violence), the data obtained may partially underestimate the real situation.

064

PART I

Overview of the initial impact evaluation phase results

065

PART I

Overview of the initial impact evaluation phase results

Proportions of households in which someone has been worried for a long time this year about the following:

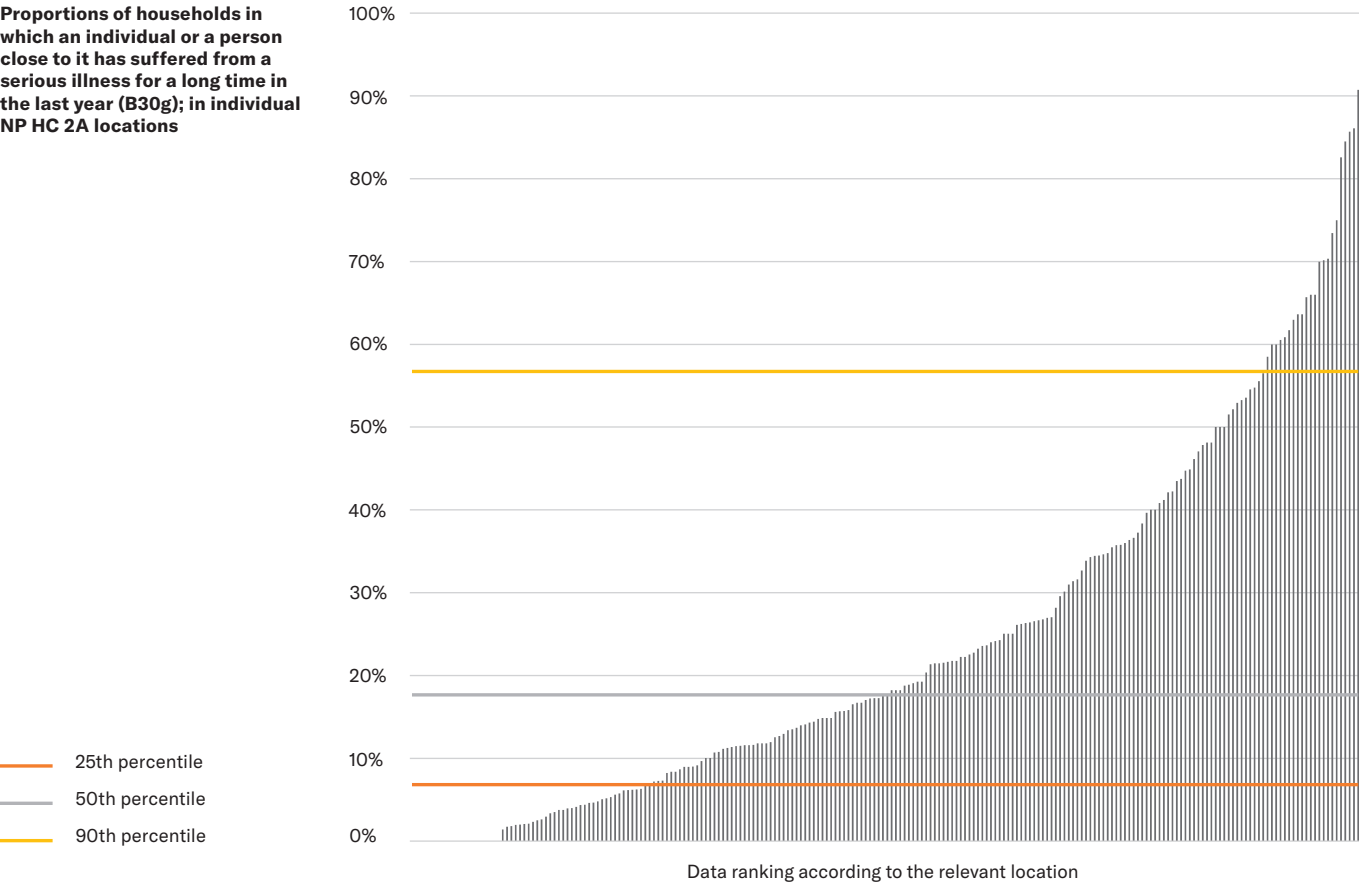| B30	a	b	c	d	e	f
	loss of dwelling/ forced move	lack of food/ hunger	removal of children	debts	cold in the household	criminal prosecution, imprison-ment of a close person
NP HC locations together	**10.1%**	**13.5%**	**4.4%**	**37.6%**	**23.9%**	**10.7%**
NP HC **KE region**	12.7%	17.7%	4.8%	34.4%	26.5%	12.5%
NP HC **PO region**	5.0%	9.6%	2.8%	32.8%	16.5%	7.3%
NP HC **BB region**	15.4%	15.6%	7.3%	56.7%	34.9%	15.4%
NP HC **regions NR TN TT**	29.5%	7.6%	4.4%	30.9%	39.3%	11.7%
Control locations together	10.8%	16.7%	3.1%	41.9%	18.8%	8.7%

B30	g	h	i	j	k
	serious disease of oneself or of a close person	quarrels or fights in the household	disputes outside the household	discrimination against oneself or against a close person	long-term absence of a family member
NP HC locations together	**24.8%**	**10.8%**	**12.1%**	**12.9%**	**8.7%**
NP HC **KE region**	23.0%	9.6%	10.9%	16.6%	8.1%
NP HC **PO region**	23.5%	7.6%	9.5%	8.4%	8.2%
NP HC **BB region**	31.4%	20.6%	21.8%	17.0%	11.9%
NP HC **regions NR TN TT**	25.7%	15.8%	5.7%	9.5%	2.8%
Control locations together	19.8%	7.2%	7.9%	12.2%	7.3%

Proportions of households in which an individual or a person close to it has suffered for a long time from a serious illness (B30g); averages for individual NP HC 2A coordination areas

— 25th percentile
— 50th percentile
— 90th percentile
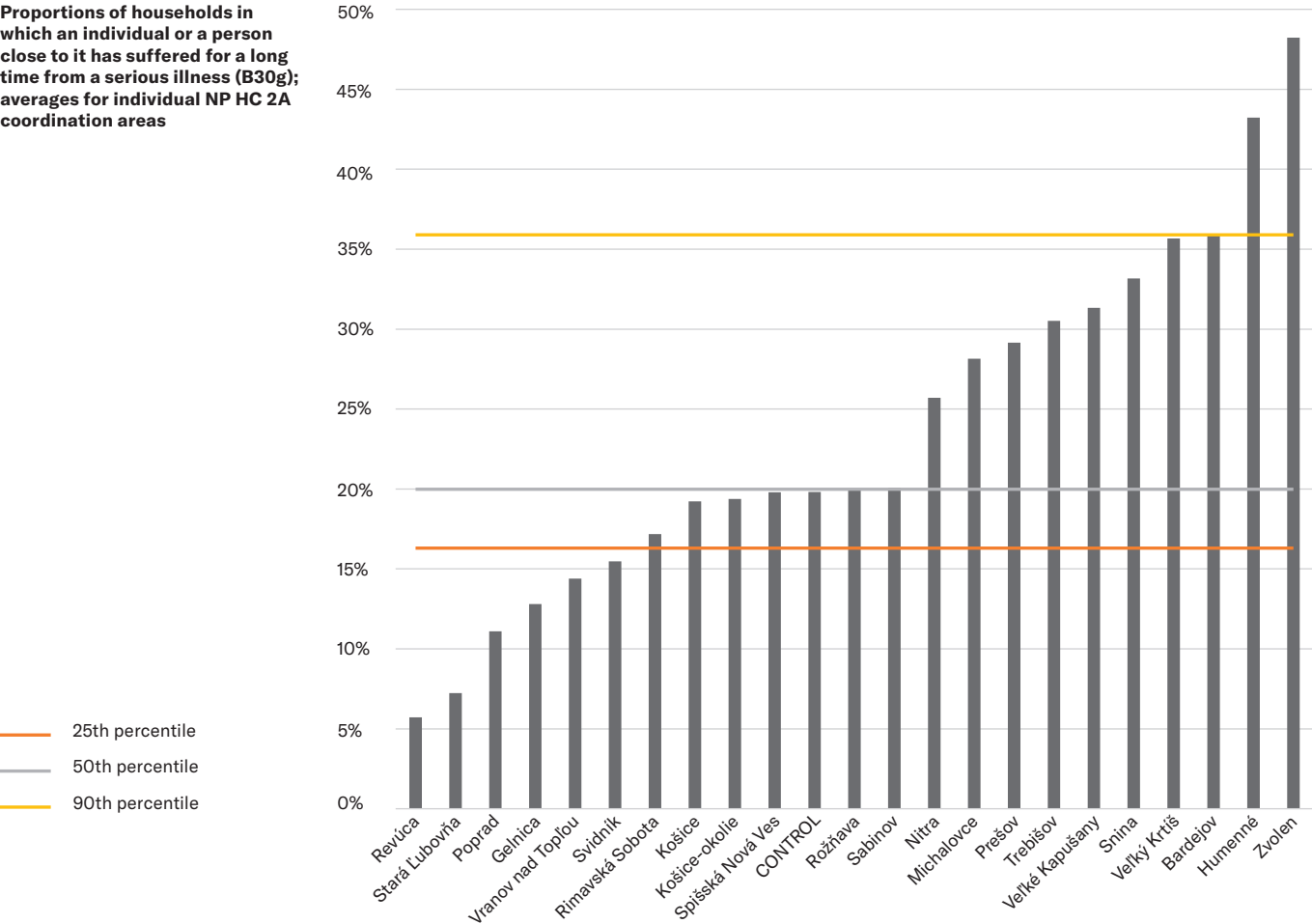
Proportions of households in which an individual or a person close to it has suffered from a serious illness for a long time in the last year (B30g); in individual NP HC 2A locations
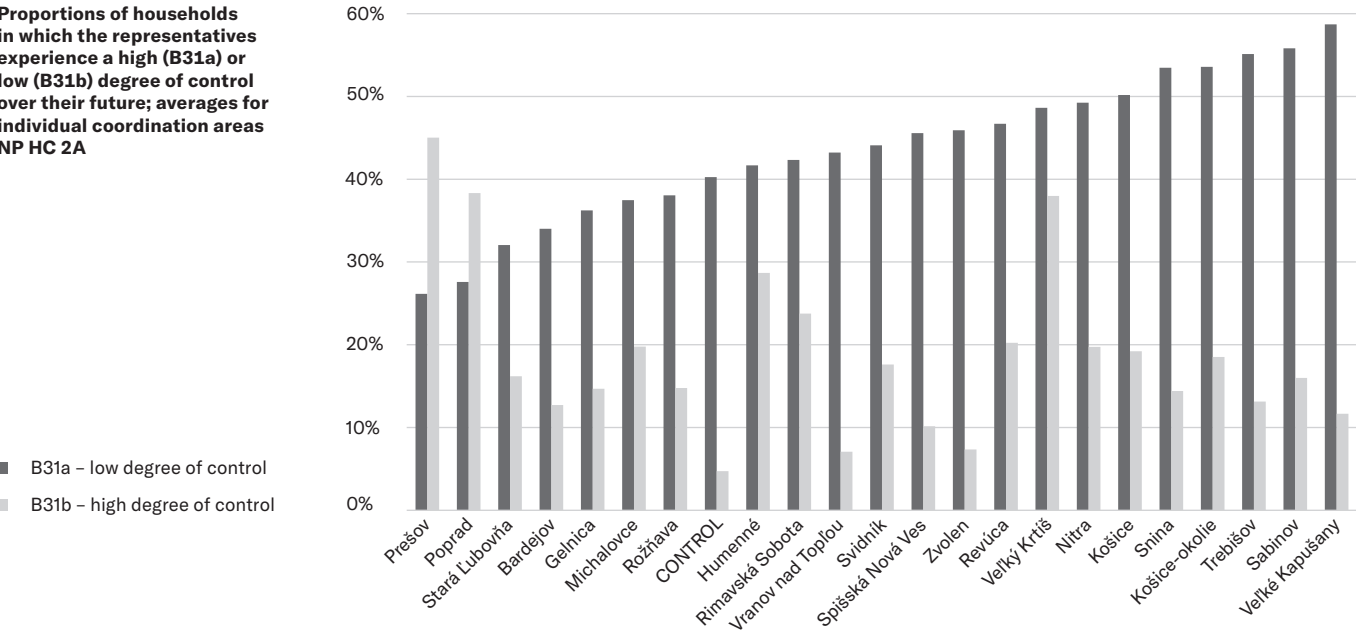

— 25th percentile
— 50th percentile
— 90th percentile

Data ranking according to the relevant location

Experienced level of control over one's own future – proportions of households, in which residents see their future options as follows:

B31	a	b
	"we have almost no possibility to improve anything" or "we only have few options for something to improve"	"we have opportunities to improve a lot" or "most things mainly depend on us"
NP HC locations together	43.9%	19.2%
NP HC **KE region**	44.7%	18.5%
NP HC **PO region**	41.8%	21.6%
NP HC **BB region**	47.1%	15.0%
NP HC **regions NR TN TT**	49.3%	14.8%
Control locations together	40.3%	11.6%

Taken together, the following data provide evidence of the presence of common ways of coping with stress that are not immediately harmful to health – including social support – and of the overall success rate of coping with psychological stress. The absence of healthy ways of coping with stress increases the negative health effects of the presence of stressors in the population and tends to increase the presence of risky behaviour.
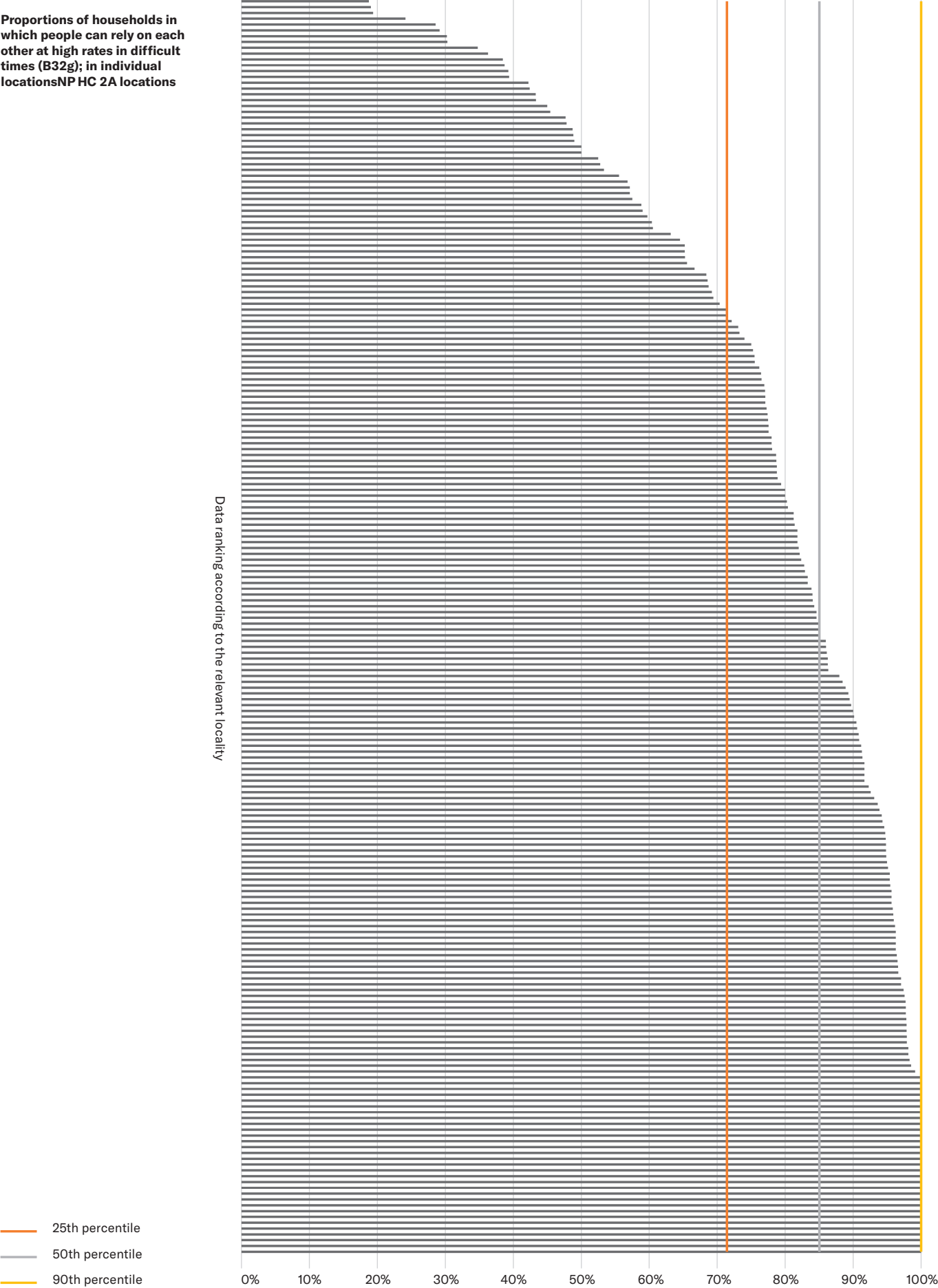
No major conceptual problems or problems associated with data collection or analysis were noted for any of the indicators included. However, according to some administrators, the degree of absence of selected aspects of social support may have been partially underestimated by some respondents in cases where such absence is perceived as a social failure (e.g. absent forms of social support within the family; B32).

Proportions of households in which the representatives experience a high (B31a) or low (B31b) degree of control over their future; averages for individual coordination areas NP HC 2A

- ■ B31a – low degree of control
- ▨ B31b – high degree of control

(Bar chart categories, left to right: Prešov, Poprad, Stará Ľubovňa, Bardejov, Gelnica, Michalovce, Rožňava, CONTROL, Humenné, Rimavská Sobota, Vranov nad Topľou, Svidník, Spišská Nová Ves, Zvolen, Revúca, Veľký Krtíš, Nitra, Košice, Snina, Košice-okolie, Trebišov, Sabinov, Veľké Kapušany)

Shares of households evaluating the available social support in the family as follows:
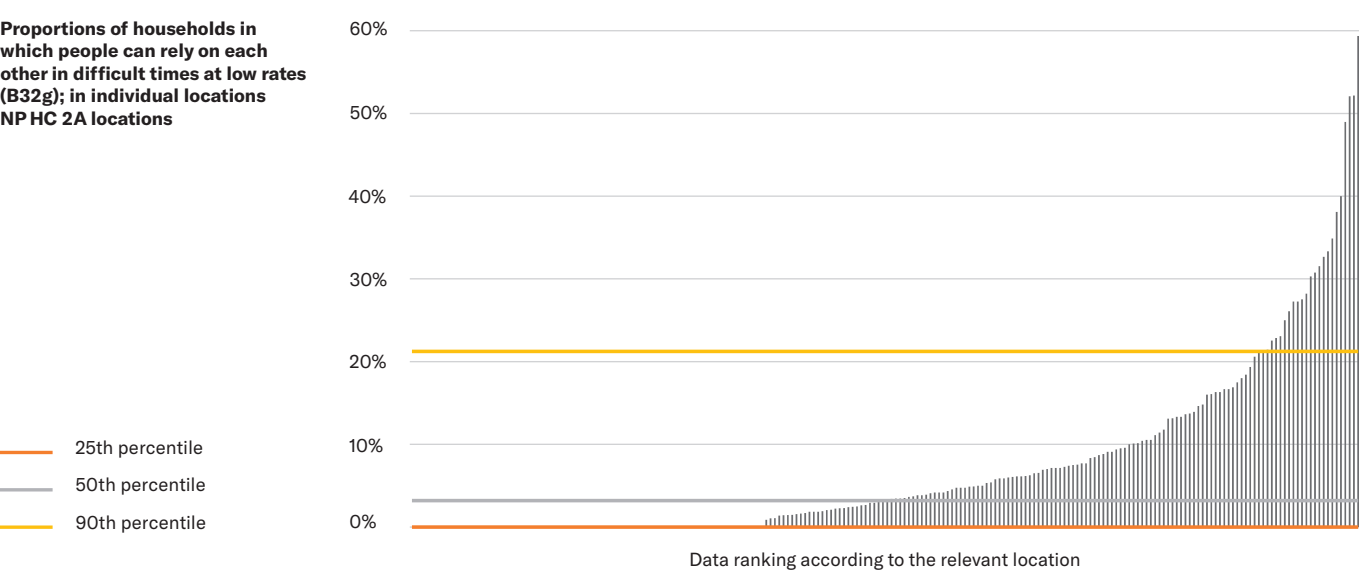
B32	a	b	c	d
	"in our family, we support and help each other:" "yes, always" or "mostly"	"in our family, we support and help each other:" "rarely" or "no, never"	"we do talk about problems in our family:" "yes, always" or "mostly"	"we do talk about problems in our family:" "rarely" or "no, never"
NP HC locations together	77.3%	7.9%	74.6%	9.2%
NP HC **KE region**	77.4%	7.8%	74.7%	9.1%
NP HC **PO region**	79.1%	6.8%	76.6%	8.2%
NP HC **BB region**	72.8%	10.3%	69.9%	11.4%
NP HC **regions NR TN TT**	75.8%	13.7%	72.5%	14.0%
Control locations together	72.1%	5.7%	69.2%	6.8%

B32	e	f	g	h
	"in our family we can come to an agreement and make decisions together:" "yes, always" or "mostly"	"in our family we can come to an agreement and make decisions together:" "rarely" or "no, never"	"in difficult times we can rely on each other:" "yes, always" or "mostly"	"in difficult times we can rely on each other:" "rarely" or "no, never"
NP HC locations together	72.9%	9.8%	79.2%	7.5%
NP HC **KE region**	72.3%	9.3%	79.1%	6.8%
NP HC **PO region**	75.2%	8.5%	82.2%	6.3%
NP HC **BB region**	69.0%	13.1%	72.7%	11.1%
NP HC **regions NR TN TT**	70.4%	16.2%	73.0%	12.7%
Control locations together	70.1%	6.9%	75.4%	6.2%

Additional information to the stress data

Data	Interpretation	Items in research documentation	Indicator quality
B30 a–k	Indicators of the degree of presence of given stressors in households: Indicate the share of REPRE samples of households in which circumstances were perceived as psychologically burdensome for a long time in the last year.	REPRE, Record sheet HPA n. 2 (2)	A
B31 a–b	Indicators of the degree of control over one's own future: Indicate the share of REPRE samples of households in which they perceived their possibilities regarding satisfaction in the future as sufficient or restricted (categories formed by the extremes of the 5-point scale).	REPRE, Record sheet HPA n. 2 (5)	A

068

PART I

Overview of the initial impact evaluation phase results

069

PART I

Overview of the initial impact evaluation phase results

Proportions of households in which people can rely on each other at high rates in difficult times (B32g); in individual locationsNP HC 2A locations
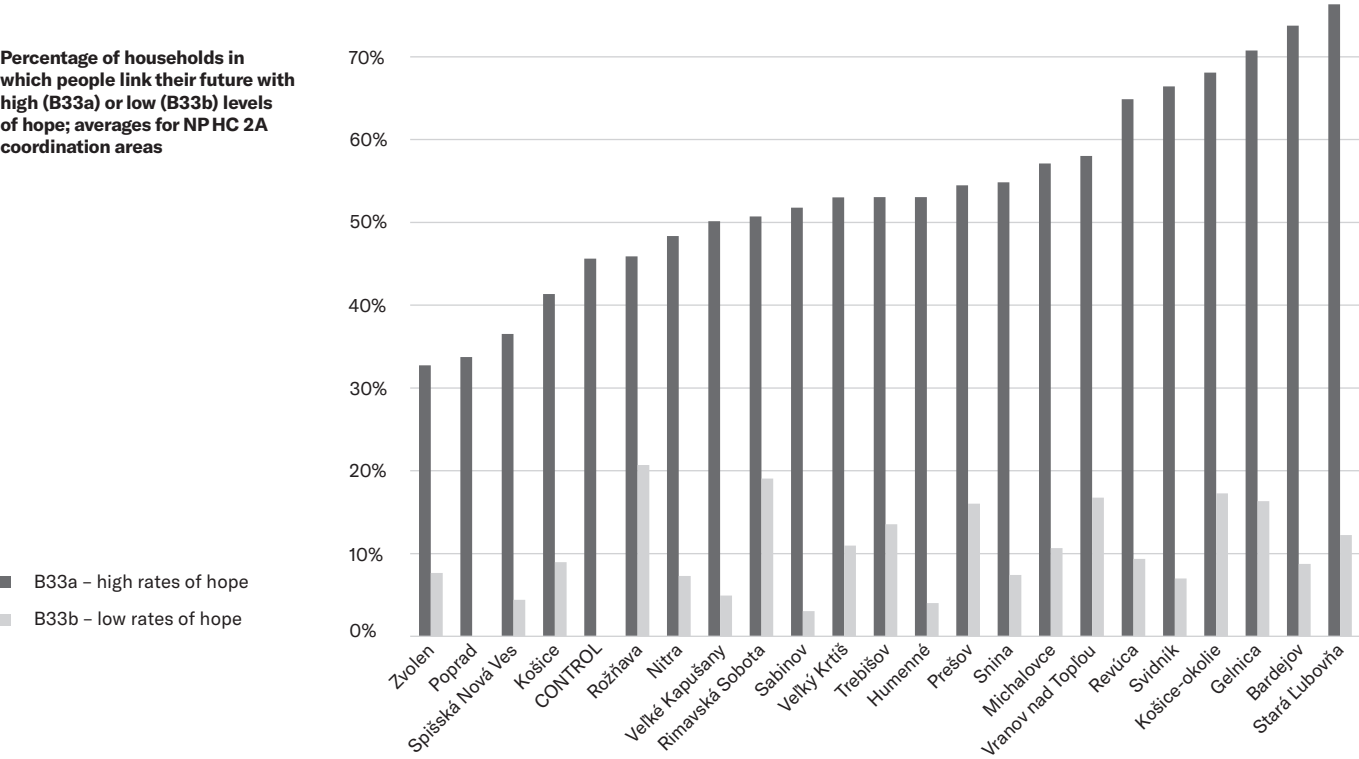

Data ranking according to the relevant locality

- 25th percentile
- 50th percentile
- 90th percentile

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Proportions of households in which people can rely on each other in difficult times at low rates (B32g); in individual locations NP HC 2A locations

60%
50%
40%
30%
20%
10%
0%

- 25th percentile
- 50th percentile
- 90th percentile

Data ranking according to the relevant location

Hope – shares of households, which rate their hopes regarding future satisfaction as follows:	B33	a	b
		"we believe it will get better" or "we hope it gets better"	"we fear it will get worse" or "it is clear to us that it will get even worse"
NP HC locations together		**54.3%**	**11.5%**
NP HC **KE region**		52.9%	12.7%
NP HC **PO region**		58.4%	9.5%
NP HC **BB region**		47.4%	13.1%
NP HC **regions NR TN TT**		48.4%	19.0%
Control locations together		45.6%	15.1%

Percentage of households in which people link their future with high (B33a) or low (B33b) levels of hope; averages for NP HC 2A coordination areas

70%
60%
50%
40%
30%
20%
10%
0%

- B33a – high rates of hope
- B33b – low rates of hope

Zvolen, Poprad, Spišská Nová Ves, Košice, CONTROL, Rožňava, Nitra, Velké Kapušany, Rimavská Sobota, Sabinov, Veľký Krtíš, Trebišov, Humenné, Prešov, Snina, Michalovce, Vranov nad Topľou, Revúca, Svidník, Košice-okolie, Gelnica, Bardejov, Stará Ľubovňa

Overall satisfaction –
proportions of households that
rate their overall satisfaction as:

B34	a	b
	"the best possible" or "good"	"bad" or "the worst possible"
NP HC locations together	39.7%	12.7%
NP HC **KE region**	36.6%	16.4%
NP HC **PO region**	47.4%	8.7%
NP HC **BB region**	27.8%	15.2%
NP HC **regions NR TN TT**	34.1%	12.9%
Control locations together	29.2%	17.3%

Proportions of households
where people rate their overall
satisfaction as high (B34a) or
low (B34b); rates are averages
for NP HC 2A coordination areas

■ B34a – high satisfaction rates
□ B34b – low satisfaction rates
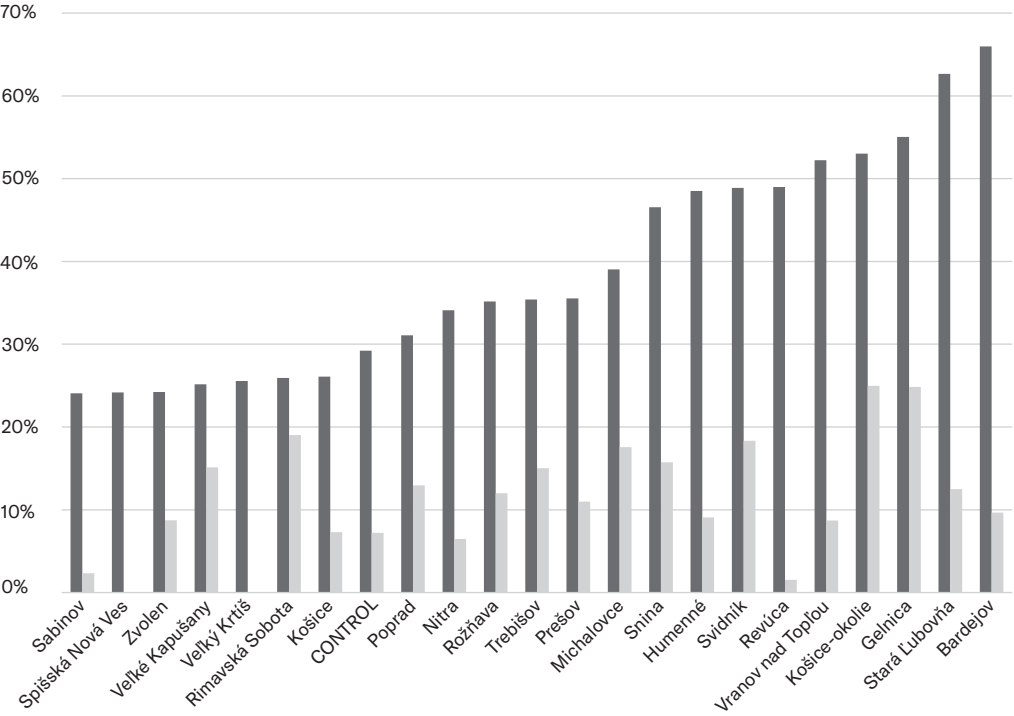
Additional information to data
on social support and stress
management

Data	Interpretation	Items in research documentation	Indicator quality
B32 a–h	Indicators of the degree of presence of specific aspects of social support in the family: They indicate the share of REPRE samples of households in which people perceived the presence of given aspects of social support as high or low (categories formed by the extremes of 5-point scales).	REPRE, Record sheet HPA n. 2 (7)	A
B33 a–b	Indicators of the success rate of social support in the family in relation to psychological burden: They indicate the share of REPRE samples of households in which people perceived their hopes of satisfaction in the future as high or low (categories formed by the extremes of 5-point scales).	REPRE, Record sheet HPA n. 2 (4)	A
B34 a–b	Indicators of the degree of success of social support in the family and in the community in relation to psychological burden: They indicate the share of REPRE samples of households in which people perceived overall satisfaction as high or low (categories formed by the extremes of 5-point scales).	REPRE, Record sheet HPA n. 2 (3)	A

Material conditions

Exposures within households

Taken together, the following data indicate the presence of circumstances that directly harm or endanger health indoors within the home environment. This is a traditional group, diverse in the nature of individual circumstances and their effects. High housing density, especially in connection with the absence of basic household infrastructure, increases the risk of the spread of infectious and parasitic diseases but can also contribute to higher stress from overpopulation. Households without insulation expose their inhabitants to temperature instability and extremes, which increases the burden on the immune system and the risk of physical crises (e.g. heart attacks). The unavailability of (standard) household electricity connections and the associated burning of wood (or solid waste) increases exposure to toxic substances and the risk of developing chronic respiratory diseases, including cancer (this also applies to smoking in households), as well as the risk of injuries and burns. The absence of standard water and sewage connections and th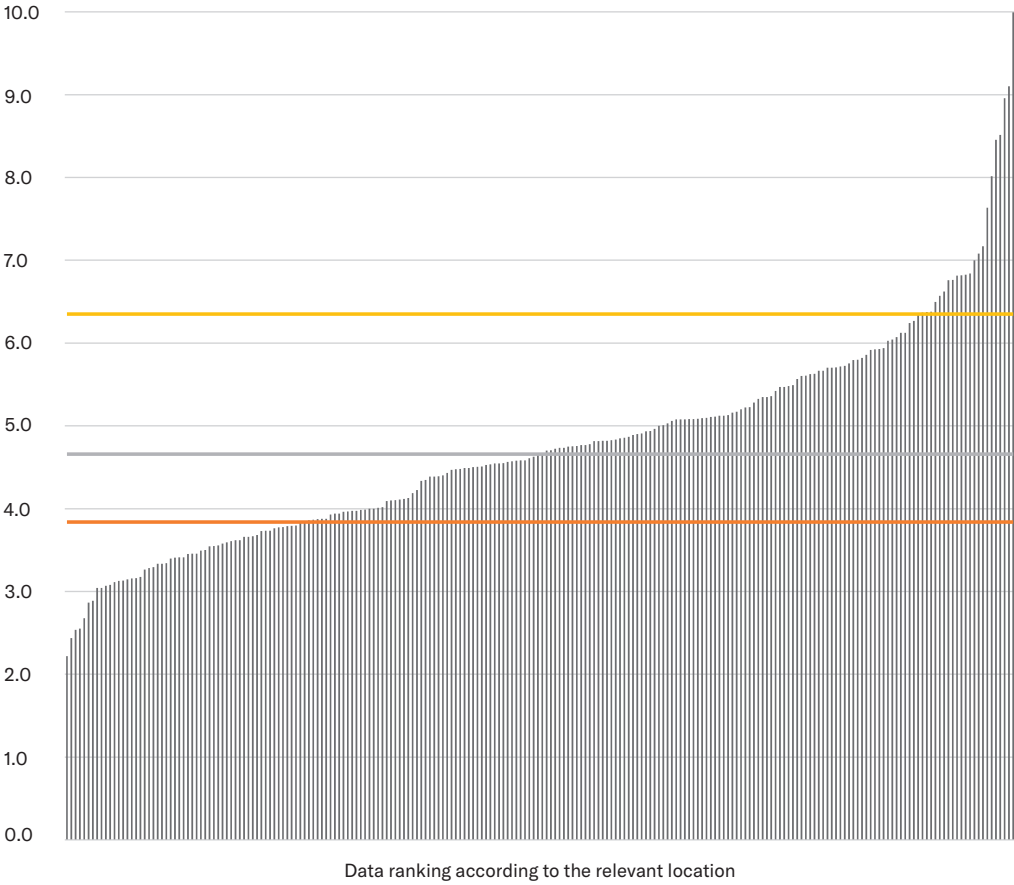e unavailability of other standard personal hygiene facilities increase the incidence of related infectious and skin diseases, parasitoses, digestive problems, as well as musculoskeletal problems (the need for continuous carrying of heavy loads). At the same time, the more difficult conditions for compliance with the hygienic standards common outside the excluded Roma enclaves also make a significant contribution to the stigmatization and segregation of the local population, including within the health care services.

Data for most indicators were obtained through a full census directly in the enclaves (some were supplemented by additional data from the REPRE samples of households) and can therefore be considered accurate, with the exception of a few extremely large locations (above 1500 inhabitants). When data on population (C35) were collected, there were ambiguities in the REPRE samples regarding the classification of individual rooms as rooms by residents and administrators – these data are less accurate.
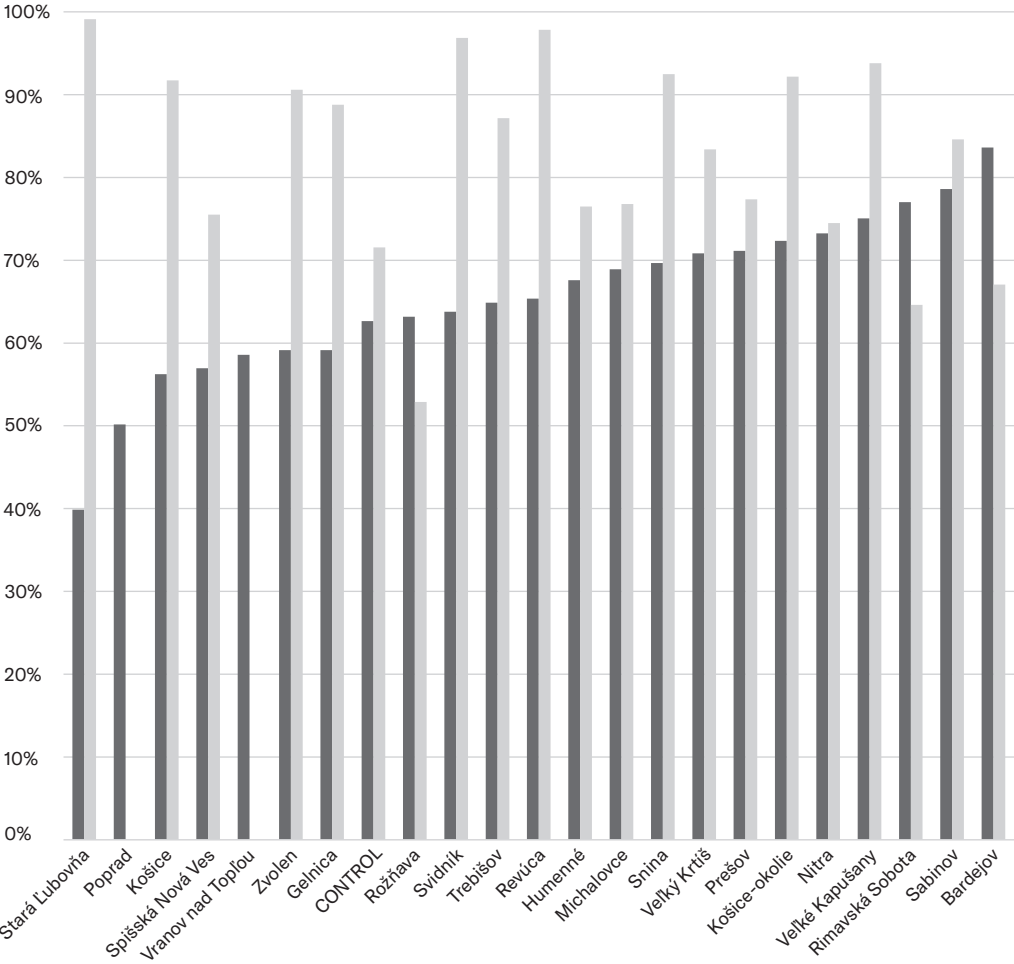
Population in the households

C35	a	b	c	d
	The average number of household members	The average number of adult household members	Average number of separate rooms per household (except kitchen)	Average number of people per single room
NP HC locations together	**4.6**	**2.6**	**1.9**	**2.4**
NP HC **KE region**	4.8	2.6	1.8	2.6
NP HC **PO region**	4.8	2.7	2.1	2.4
NP HC **BB region**	3.7	2.2	1.5	2.4
NP HC **regions NR TN TT**	4.3	2.4	1.4	3.2
Control locations together	4.5	2.6	2.0	2.3

Pollutants and risks in households –share of households…

C36	a	b	c	d	e	f
	insulated	where people normally smoke inside	where there is heating with wood	where people cook on wood	with an electricity connection	with a legal and functional electricity connection
NP HC locations together	**30.1%**	**65.0%**	**82.4%**	**69.9%**	**87.6%**	**62.8%**
NP HC **KE region**	24.8%	65.6%	79.7%	71.5%	85.6%	58.1%
NP HC **PO region**	36.7%	65.4%	84.2%	71.4%	90.2%	63.9%
NP HC **BB region**	23.6%	62.3%	85.9%	67.6%	86.2%	67.3%
NP HC **regions NR TN TT**	20.9%	73.3%	52.9%	25.0%	74.9%	76.1%
Control locations together	21.6%	62.7%	91.8%	81.1%	86.8%	70.6%

Average number of household members (C35a); in individual locations NP HC 2A locations

25th percentile
50th percentile
90th percentile

Data ranking according to the relevant location

Proportions of households in which smoking is normal inside the building (C36b) and which are heated by wood (C36c); averages for NP HC 2A coordination areas

C36b – smoking inside
C36c – wood heating

Overview of the initial impact evaluation phase results

Overview of the initial impact evaluation phase results

Shares of households with an electricity connection (C36e) or with legal electricity connection (C36f); averages for NP HC 2A coordination areas

- C36e – any connection
- C36f – legal connections
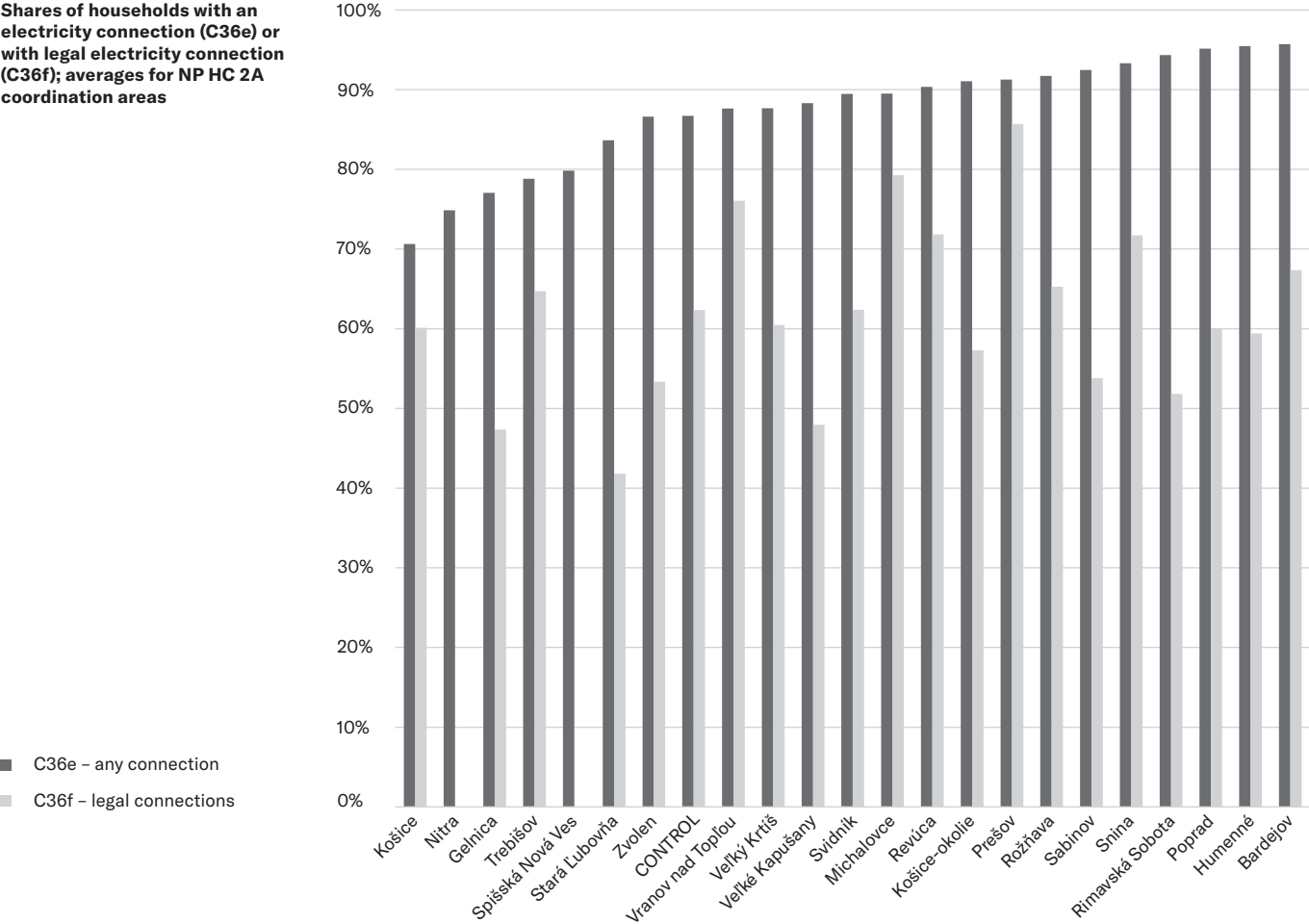
Proportions of households with a functional flush toilet (C36j) or with a functional connection to a sewer (C36k); averages for areas NP HC 2A coordination

- C36j – flush toilet
- C36k – connection to the sewer
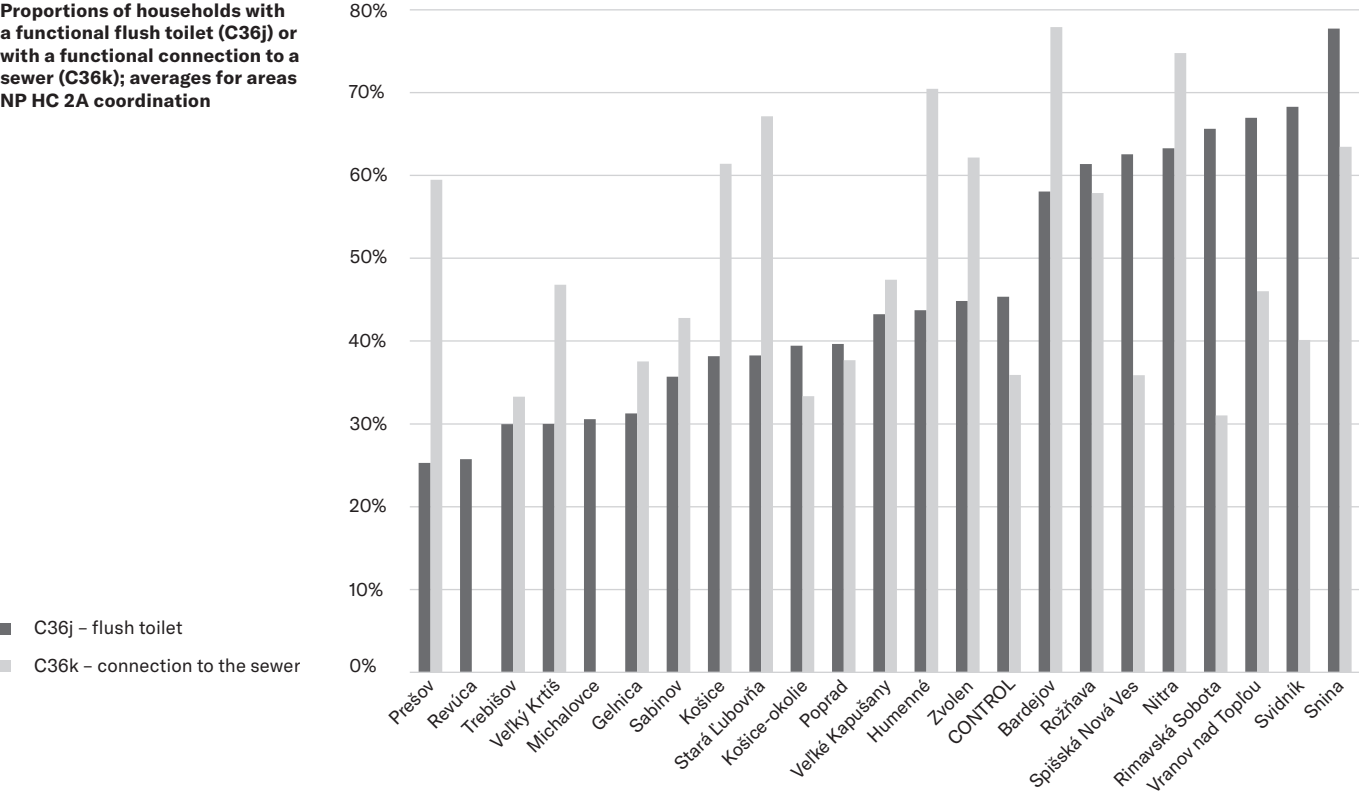
Proportions of households with a legal and functional water connection (C35a); in individual NP HC 2A locations

- 25th percentile
- 50th percentile
- 90th percentile

Data ranking according to the relevant location
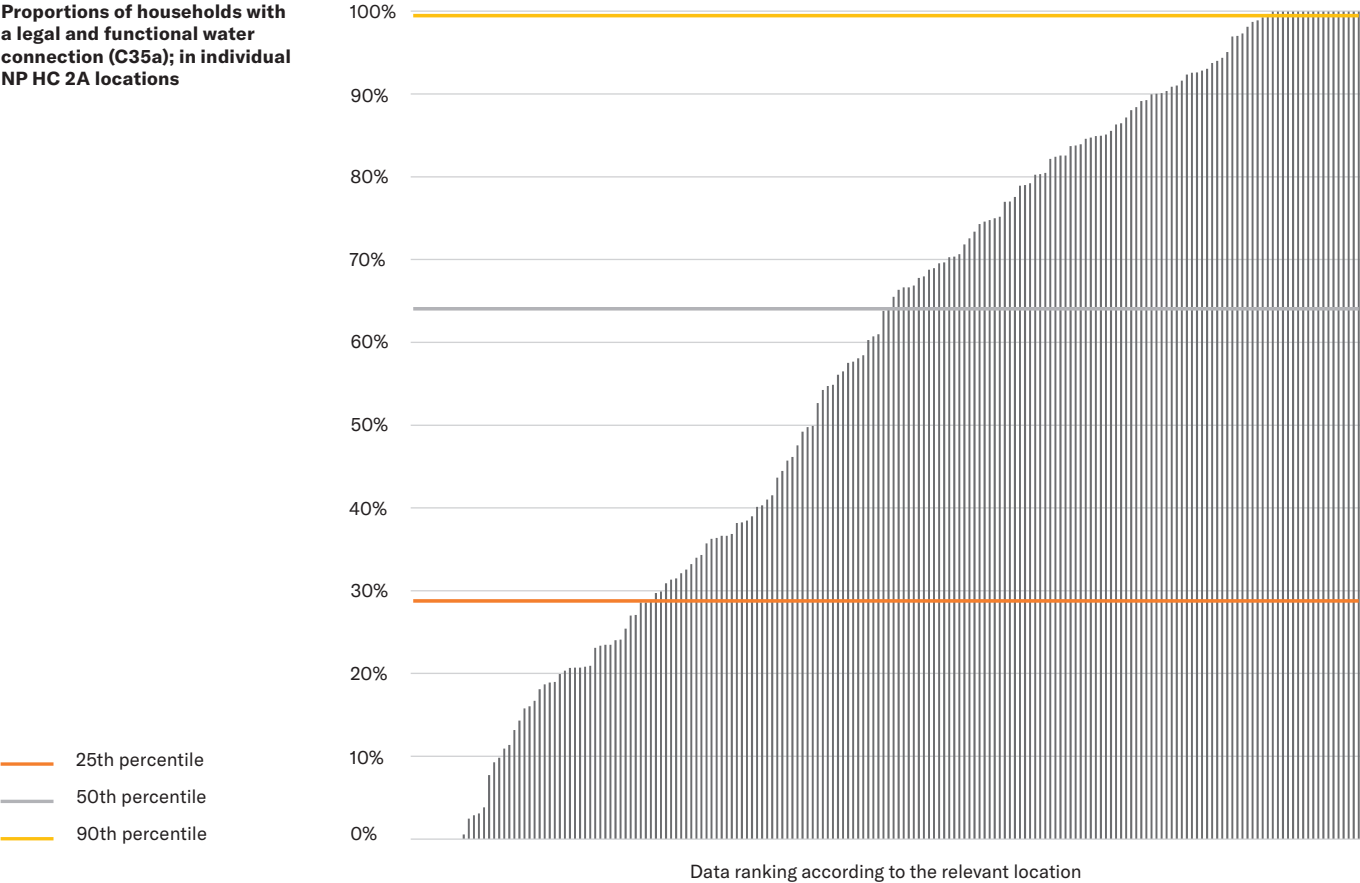
Additional information to material conditions in households

Data	Interpretation	Items in research documentation	Indicator quality
C35 a–b	Household size indicators: They indicate the average number of people in the REPRE samples of households	REPRE, Record sheet HPA n. 2 (1)	A
C35c	Indicator of functional size of dwellings: Indicates the average number of given rooms in the use of one household in the REPRE samples of households	REPRE, Record sheet HPA n. 2 (30)	B
C35d	Household population occupancy rate indicator: Indicates the average number of people per single room (excluding the kitchen); C35a/35c	REPRE, Record sheet HPA n. 2 (2)	B
C36a	Indicator of the rate of exposure to temperature instability and extremes in dwellings: Indicates how part of the households of the REPRE samples lived in dwellings with thermal insulation	REPRE, Record sheet HPA n. 2 (30)	A
C36b	Exposure rate indicator from tobacco combustion: Indicates how many households of the REPRE samples were normally exposed to smoke from tobacco combustion directly in the dwelling	REPRE, Record sheet HPA n. 2 (30)	A
C36 c–d	Indicators of exposure to pollutants from wood burning: Indicates which shares of the households did not heat with radiators or heaters or did not cook using electricity or gas	CENSUS, Record sheet HPA n. 1 → Form HPAC n. 1	A

076

PART I

Overview of the initial impact evaluation phase results

077

PART I

Overview of the initial impact evaluation phase results

Data	Interpretation	Items in research documentation	Indicator quality
C36e	Indicator of the degree of exposure to health risks associated with the unavailability of electricity: Indicates which parts of the households of the REPRE samples had a connection to electricity in dwellings at that time	REPRE, Record sheet HPA n. 2 (30)	A
C36f	Indicator of the degree of exposure to health risks associated with the unavailability of standard electricity connections in households (possibly also risks associated with non-standard electrical connections etc.): Indicates which parts of households did not have functional and legal connections to electricity in dwellings at the time	CENSUS, Record sheet HPA n. 1 → Form HPAC n. 1	A
C36g	Indicator of the degree of risk of consumption of rotten food: Indicates which parts of households did not have the means to effectively cool food at the time	CENSUS, Record sheet HPA n. 1 → Form HPAC n. 1	A
C36h	Indicator of the degree of exposure to health risks associated with the unavailability of safe water in households: Indicates which parts of households did not have functional and legal connections to water in dwellings at the time	CENSUS, Record sheet HPA n. 1 → Form HPAC n. 1	A
C36 i–k	Indicators of the degree of unavailability of standard equipment facilitating the safe performance of personal hygiene: Indicates which parts of households did not have the given room equipment at a given time	CENSUS, Record sheet HPA n. 1 → Form HPAC n. 1	A

Exposures outside households

Taken together, the following data show, on the one hand, the level of availability of public infrastructure that enable or facilitate the reduction of exposure to pollutants and risks within households. On the other hand, they indicate the level of exposure to harmful circumstances or risks in the public space of the enclaves. The unavailability or dysfunction of the sewerage system significantly increases the risk of spreading infectious diseases, especially of the digestive tract. The presence of landfills in public spaces is associated with the occurrence of rodents and parasites in households; it also increases the risk of accidents, especially for children, and may also represent increased exposure to toxic substances. The presence of environmental risks endangers the health and lives of the population in various ways from exposure to toxic or carcinogenic substances (e.g. in the vicinity of industrial plants or landfills)

through an increased risk of accidents (e.g. in the case of the proximity of high-voltage power lines or unstable slopes) to the spread of infectious diseases and a direct threat to life (e.g. in the event of floods). The unavailability of functional roads increases the risk of accidents and reduces the availability of routine services, including the availability of timely emergency medical care.

As far as the accuracy of the indicators is concerned, they were all based on field surveys by administrators directly in the enclaves concerned and therefore can generally be considered accurate. Exceptions are indicators of the presence of landfills and other environmental risks (C40–41), for which there were more frequent ambiguities during data collection regarding the classification of specific cases by administrators.

Overview of the initial impact evaluation phase results

Enclave access to water

C37	a	b	c	d
	Proportion of municipalities with enclaves with a functional public water supply with the technical possibility of connecting the dwellings in the enclaves	Number of municipalities with enclaves where no household has a water connection	Number of municipalities with enclaves without any sources of drinking water in the enclaves	Number of households without a water connection
NP HC locations together	80.9%	10	2	14 802
NP HC KE region	88.2%	1	0	5 546
NP HC PO region	68.7%	9	2	6 546
NP HC BB region	93.9%	0	0	2 397
NP HC regions NR TN TT	100.0%	0	0	313
Control locations together	78.8%	1	1	955

Access to water in the enclaves

C38	a	b	c	d
	Average number of continuously functional and free public resources of drinking water	Average number of continuously functioning paid public sources of drinking water	Average number of households without a water connection to a public source of drinking water	Average number of households without a water connection to one free public source of drinking water
NP HC locations together	0.9	0.1	81	93
NP HC KE region	0.8	0.2	83	99
NP HC PO region	1.0	0.0	80	83
NP HC BB region	0.8	0.2	68	89
NP HC regions NR TN TT	0.0	0.5	0	0
Control locations together	0.5	0.1	50	60

Overview of the initial impact evaluation phase results

Total numbers of households without a functional and legal connection to water (C37d) in individual NP HC 2A coordination areas

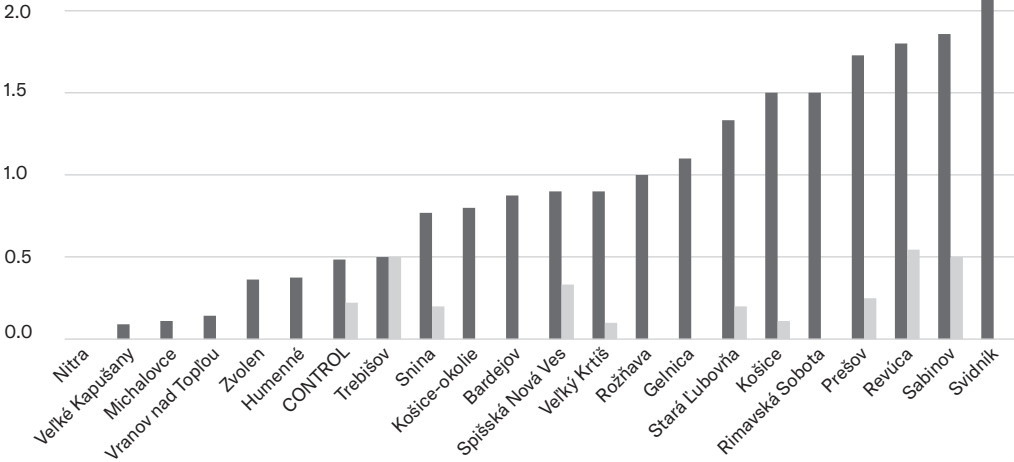- 25th percentile
- 50th percentile
- 90th percentile
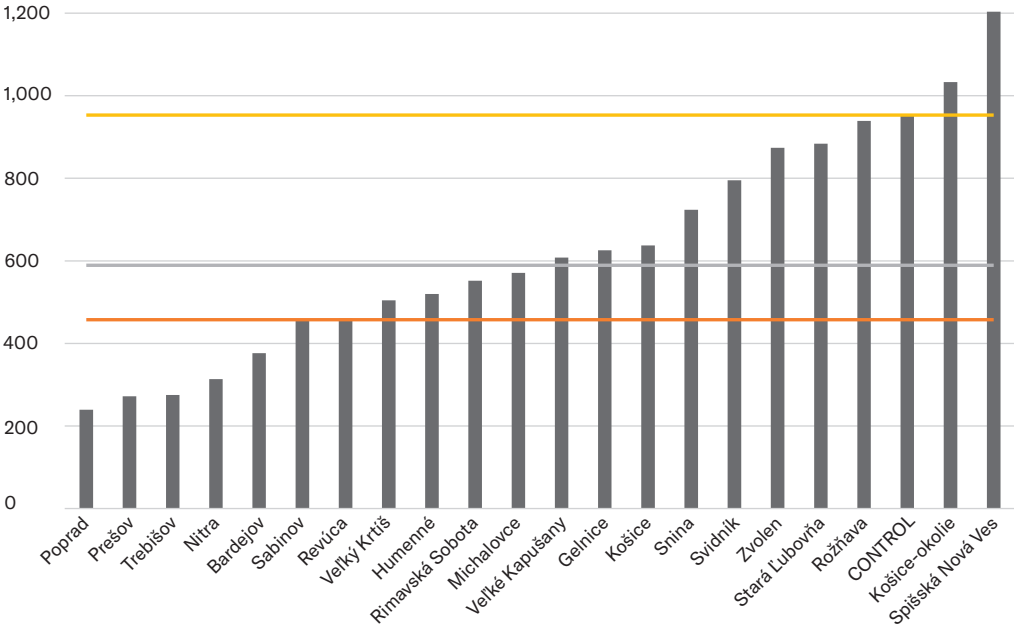
Numbers of continuously functional and free public sources of drinking water (C38a), or for a fee (C38b); averages for NP HC 2A coordination areas
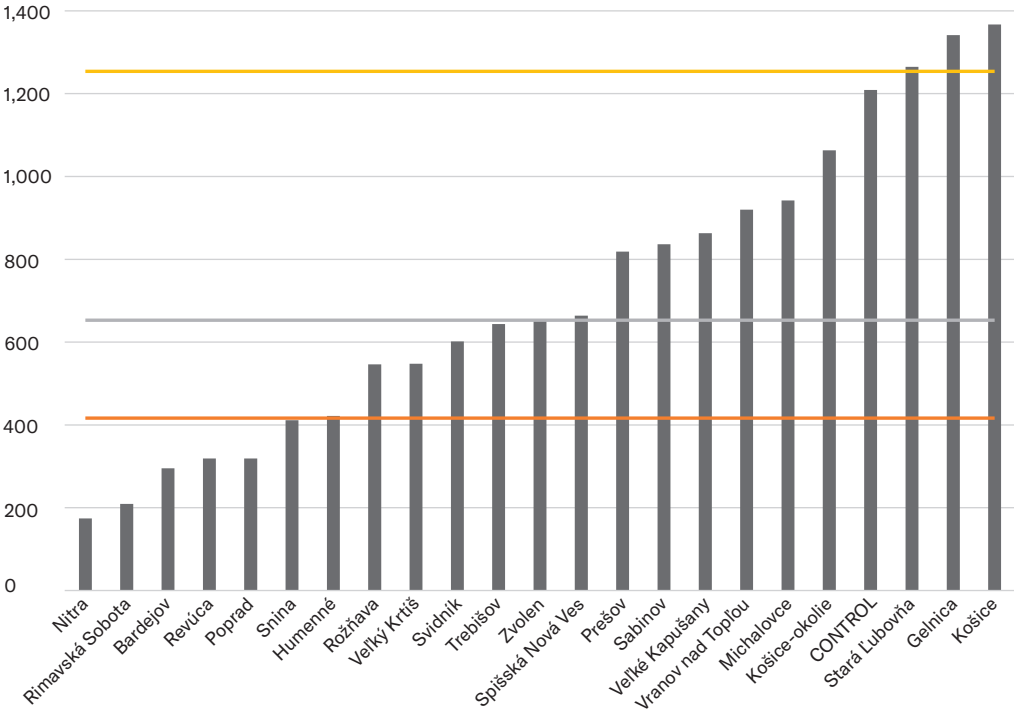

- C38a – free
- C38b – paid

Total numbers of households without a functional and legal connection to a sewerage system (C39c) in individual NP HC 2A coordination areas

- 25th percentile
- 50th percentile
- 90th percentile

Overview of the initial impact evaluation phase results

Access to a sewer	C39	a	b	c
		Proportion of municipalities including enclaves with functional public sewerage and technical possibility of connecting dwellings in enclaves	Number of municipalities with enclaves where no household from the enclave has a connection to a sewerage system	Total number of households without a sewerage connection
	NP HC locations together	67.0%	32	15 226
	NP HC KE region	66.2%	15	7 072
	NP HC PO region	69.9%	14	6 121
	NP HC BB region	57.6%	3	1 859
	NP HC regions NR TN TT	100.0%	0	174
	Control locations together	60.6%	3	1 209

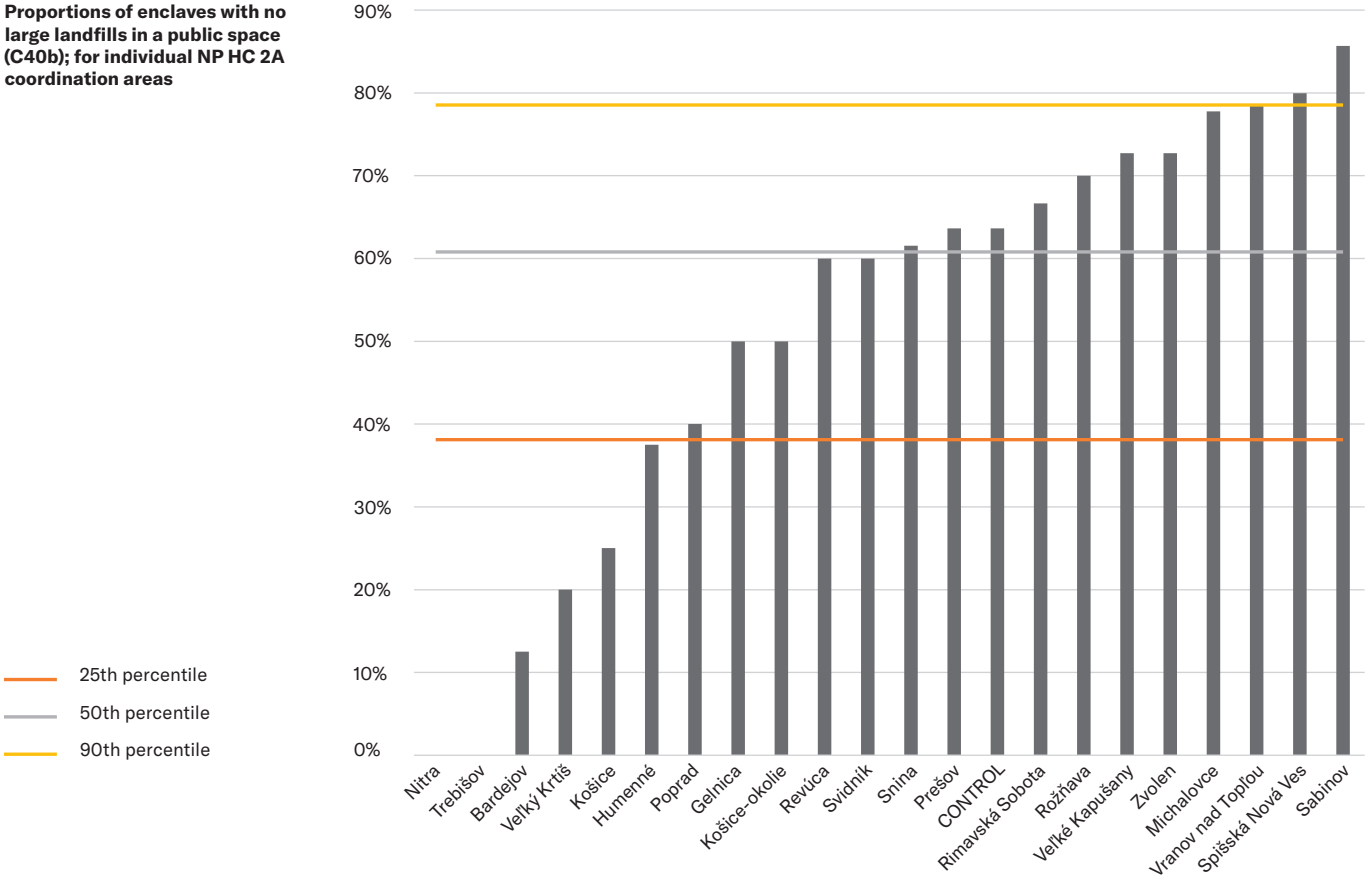| Landfills	C40	a	b	c	d
		Average number of larger landfills in enclaves per municipality with enclaves	Proportion of municipalities with enclaves without larger landfills in the enclaves	Average number of public garbage containers provided by the municipality in the enclaves with landfills	Average frequency of removal of large-capacity containers in half a year in the enclaves with landfills
	NP HC locations together	0.9	58.0%	2.5	4.2
	NP HC KE region	1.0	57.4%	3.3	4.5
	NP HC PO region	0.8	63.9%	1.9	2.6
	NP HC BB region	0.8	51.5%	2.6	5.2
	NP HC regions NR TN TT	2.5	0.0%	0.8	12.3
	Control locations together	0.5	63.6%	2.2	2.4

Other exposures – proportions of municipalities with enclaves where…	C41	a	b
		the residents are exposed to environmental risks	untreated animals move freely
	NP HC locations together	36.7%	93.5%
	NP HC KE region	25.0%	91.0%
	NP HC PO region	51.8%	96.3%
	NP HC BB region	15.2%	93.9%
	NP HC regions NR TN TT	100.0%	75.0%
	Control locations together	33.3%	90.3%

Overview of the initial impact evaluation phase results

Enclave roads

C42	a	b	c
	Share of municipalities with enclaves in which there are functional roads with a solid surface	**Average length of non-functional sections of local and enclave access roads (m)**	**Total length of non-functional sections of local and enclave access roads (km)**
NP HC locations together	**96.3%**	**228**	**43**
NP HC **KE region**	89.7%	312	21
NP HC **PO region**	94.0%	158	13
NP HC **BB region**	97.0%	263	9
NP HC **regions NR TN TT**	100.0%	0	0
Control locations together	78.1%	291	8

Proportions of enclaves with no large landfills in a public space (C40b); for individual NP HC 2A coordination areas

- 25th percentile
- 50th percentile
- 90th percentile

Bar chart x-axis labels: Nitra, Trebišov, Bardejov, Veľký Krtíš, Košice, Humenné, Poprad, Gelnica, Košice-okolie, Revúca, Svidník, Snina, Prešov, CONTROL, Rimavská Sobota, Rožňava, Veľké Kapušany, Zvolen, Michalovce, Vranov nad Topľou, Spišská Nová Ves, Sabinov

Overview of the initial impact
evaluation phase results

Additional information to data on exposures outside households

Data	Interpretation	Items in research documentation	Indicator quality
C37a	Indicator of the degree of availability of household water connections: Indicates the part of enclaves for which there was a technical possibility to connect most households to drinking water sources	CENSUS, HPAC form n. 1	A
C37b	Indicator of total availability of household water connections: Indicates the number of enclaves where no household was connected to a source of drinking water	CENSUS, Record sheet HPA n. 1 → Form HPAC n. 1	A
C37c	Indicator of total availability of household water connections: Indicates the number of enclaves where no household was connected to a source of drinking water (C37c) and at the same time no public source of drinking water was available (C38a–b)	N/A	A
C37c	Indicator of total availability of household water connections: Indicates the total number of households in enclaves that did not have functional and legal water connections	CENSUS, Record sheet HPA n. 1 → Form HPAC n. 1	A
C38a	Indicator of the level of exposure to health risks associated with the unavailability of safe water in the community: Indicates how many drinking water sources were continuously functional and available (except of short-term disturbances) for the inhabitants of the enclave free of charge	CENSUS, Form HPAC n. 1	A
C38b	Indicator of the level of exposure to health risks associated with the unavailability of safe water in the community: Indicates how many drinking water sources were continuously functional and available (excluding short-term disturbances) to the inhabitants of the enclave for a fee	CENSUS, Form HPAC n. 1	A
C38 c–d	Indicators of the degree of exposure to health risks associated with the unavailability of safe water in the community: Indicate the number of households without their own connections that shared drinking water on average, one public source of drinking water (c) or a public source of drinking water free of charge (d); $(1-36h) * 1b / (38a + 38b)$ or $(1-36h) * 1b / (38b)$	N/A	A
C39a	Indicator of the degree of availability of household connections to sewerage: Indicates the part of the enclaves for which there was a technical possibility to connect most households to a functional sewer	CENSUS, Form HPAC n. 1	A
C39b	Indicator of total availability of household sewerage connections: Indicates the number of enclaves where no household was connected to a functional sewer	CENSUS, Record sheet HPA n. 1 → Form HPAC n. 1	A
C39c	Indicator of the total availability of household connections to the sewerage system: Indicates the total number of households in the enclave with no functional sewerage connections	CENSUS, Record sheet HPA n. 1 → Form HPAC n. 1	A
C40a	Indicator of the degree of exposure to waste in the public space (and the lack of standard waste containers): Indicates how many average number of landfills in the enclaves that would require large-capacity containers, per municipality with enclave	CENSUS, Form HPAC n. 1	A

Overview of the initial impact
evaluation phase results

Data	Interpretation	Items in research documentation	Indicator quality
C40b	Waste exposure rate indicator in the public space (and lack of standard waste bins): Indicates the proportion of locations with no landfills defined as landfills in public spaces, the disposal of which would not be possible without the use of large-capacity containers or similar techniques	CENSUS, HPAC form n. 1	A
C40c	Waste exposure rate indicator in public space (and lack of standard waste bins): Indicates the number or large containers on average provided by municipalities in locations with enclaves with large public space landfills	CENSUS, HPAC form n. 1	A
C40d	Waste exposure rate indicator in the public space (and lack of standard waste bins): Indicates how many times on average in the last half-year the municipalities have transported full large-capacity containers from the locations with enclaves with large public space landfills	CENSUS, HPAC form n. 1	B
C41a	Indicator of the level of exposure of the population to environmental risks: Indicates in what proportion of the enclaves were settlements close to environmental risks, such as flood zones, landslide areas, large landfills, close proximity to industrial production plants or high-voltage substations and poles	CENSUS, HPAC form n. 1	B
C41b	Zoonosis risk indicator: Indicates what proportion of the sites were enclaves in which humans normally came into contact with free-moving animals that were not inspected and treated by veterinarians	CENSUS, HPAC form n. 1	A
C42a	Enclave access rate indicator for car transport: Indicates the proportion of municipalities with enclaves with functional roads with a paved surface	CENSUS, HPAC form n. 1	A
C42b	Enclave access rate indicator for car transport: Indicates the length of local and access roads (in metres) that was impassable for ambulances on average per one locality	CENSUS, HPAC form n. 1	A
C42c	Enclave access rate indicator for car transport: Indicates the length of local and access roads (in km) that was impassable for ambulances together for all enclaves included	CENSUS, HPAC form n. 1	A

Health care services access

Geographical accessibility of health care

Together, the following data provide an indication of the physical accessibility of the geographically closest basic health care facilities for the population of the considered excluded Roma enclaves. With the reduction in the number of available medical facilities, their use is d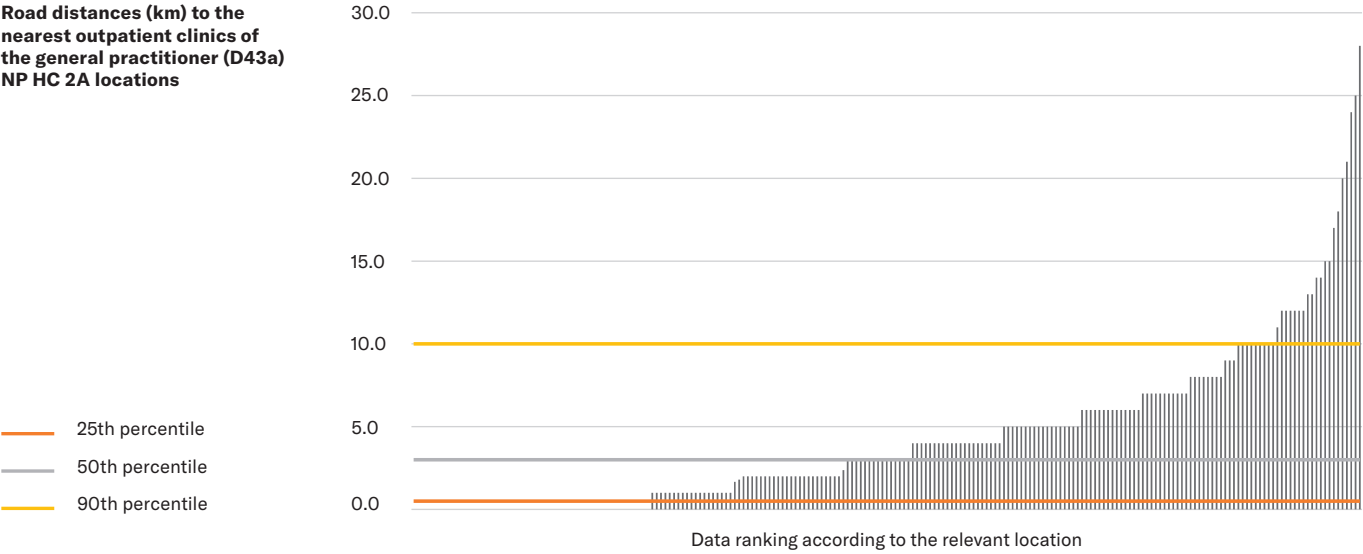eclining sharply, which contributes significantly to less effective or absent medical treatment, but also hinders prevention and convalescence.

For the included indicators, no problems were recorded, whether conceptual, related to field data collection or analyses.

084

PART I

Overview of the initial impact evaluation phase results

085

PART I

Overview of the initial impact evaluation phase results

Distances from the enclave to the nearest medical facility (km)

D43	a	b	c	d	e	f
	General practitioner's clinic	Paediatrician's outpatient clinic	Dental clinic	Adult emergency	Children's emergency	Pharmacy
NP HC locations together	**4.5**	**6.0**	**7.3**	**17.2**	**19.3**	**6.4**
NP HC **KE region**	3.9	5.3	6.7	19.3	22.1	7.6
NP HC **PO region**	5.2	6.8	7.4	14.8	14.8	6.1
NP HC **BB region**	4.0	5.8	8.4	20.5	26.7	5.1
NP HC **regions NR TN TT**	4.0	4.0	4.0	4.0	4.0	4.0
Control locations together	5.1	5.2	6.4	14.9	15.3	5.8

Functional distances to the nearest centres (municipalities with inpatient care)

D44	a	b
	Number of public transport connections in the morning	Number of public transport connections in the afternoon
NP HC locations together	**7.8**	**8.8**
NP HC **KE region**	8.8	9.3
NP HC **PO region**	6.4	7.9
NP HC **BB region**	9.7	10.6
NP HC **regions NR TN TT**	2.8	5.5
Control locations together	8.5	9.4

Road distances (km) to the nearest outpatient clinics of the general practitioner (D43a) NP HC 2A locations

— 25th percentile
— 50th percentile
— 90th percentile

Data ranking according to the relevant location

Road distances (km) to the nearest paediatrician's outpatient clinic (D43b) or paediatric emergency room (D43e); averages for NP HC 2A coordination areas

■ D43b – clinics
☐ D43e – emergency
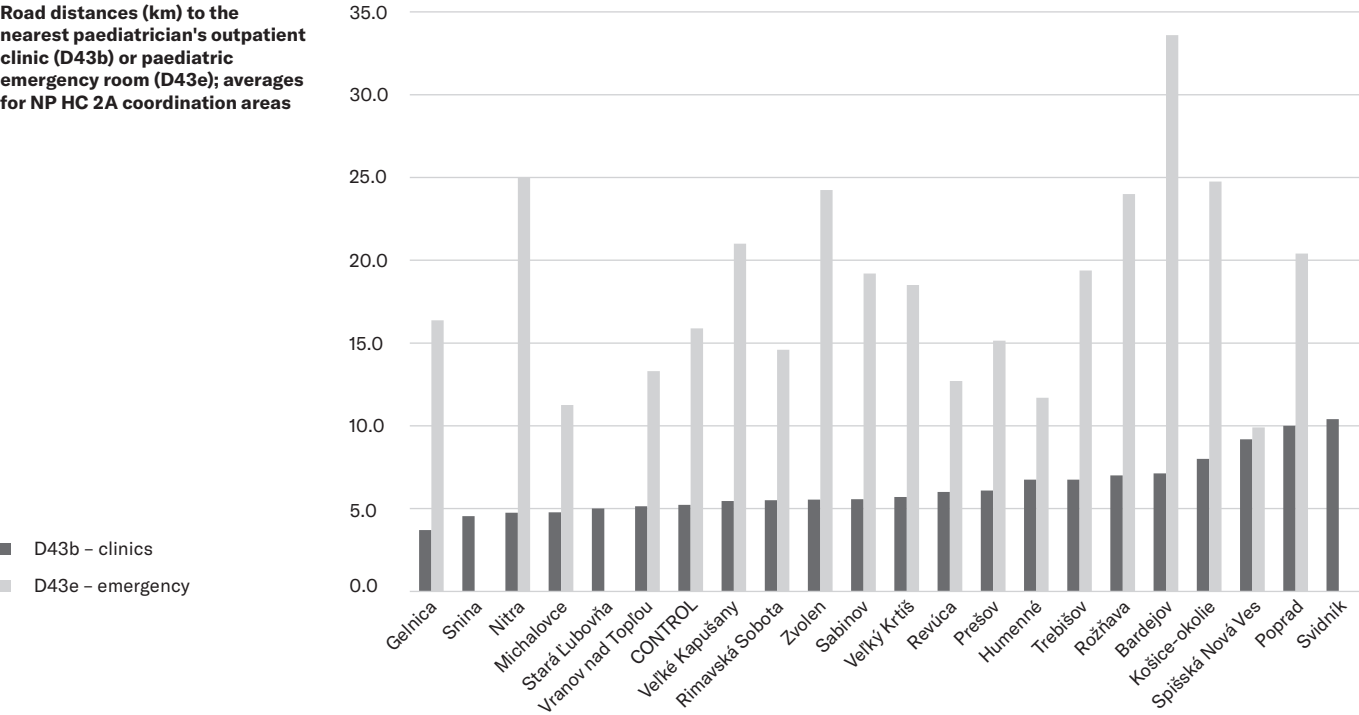
Number of morning public transport connections to the nearest centres (D44a); averages for individual NP HC 2A coordination areas

— 25th percentile
— 50th percentile
— 90th percentile

Additional information on
geographical accessibility data
for health care services

Data	Interpretation	Items in research documentation	Indicator quality
D43 a–f	Indicators of spatial distance of basic health care services: Indicate the average road distances from the enclaves in a given municipality to the nearest given type of medical facilities in kilometres.	CENSUS, Form HPAC n. 1	A
D44 a–b	Indicators of functional distance of basic health care services: Indicate the number of public transport connections on working days from municipalities with enclaves to the nearest centres defined as municipalities with medical facilities with beds, in the periods 5:00 – 12:00 (a) or 12:00 – 21:00 (b).	CENSUS, Form HPAC n. 1	A

Discrimination in health care services

1
According to the performed focus groups with HPAC and pilot evaluation assessments with administrators, by "discrimination" the inhabitants of excluded Roma enclaves generally understand ethnic discrimination – associated with their Roma ethnicity.

Taken together, the following data provide evidence about the degree of (ethnic) discrimination in health care services as experienced by users of the health care facilities involved. Frequent experience of discrimination is a serious long-term stressor and at the same time a significant contributor to the avoidance of environments where such experiences take place – in this case causing less frequent use of the given care services. Perceived ethnic discrimination also strongly suggests a relatively lower quality of service provision.

For the perceived discrimination indicators included (D46), no problems were noted during the initial evaluation assessment (whether conceptual, related to field data collection or analysis).[1]

Proportion of households where someone has experienced discrimination in the last year:

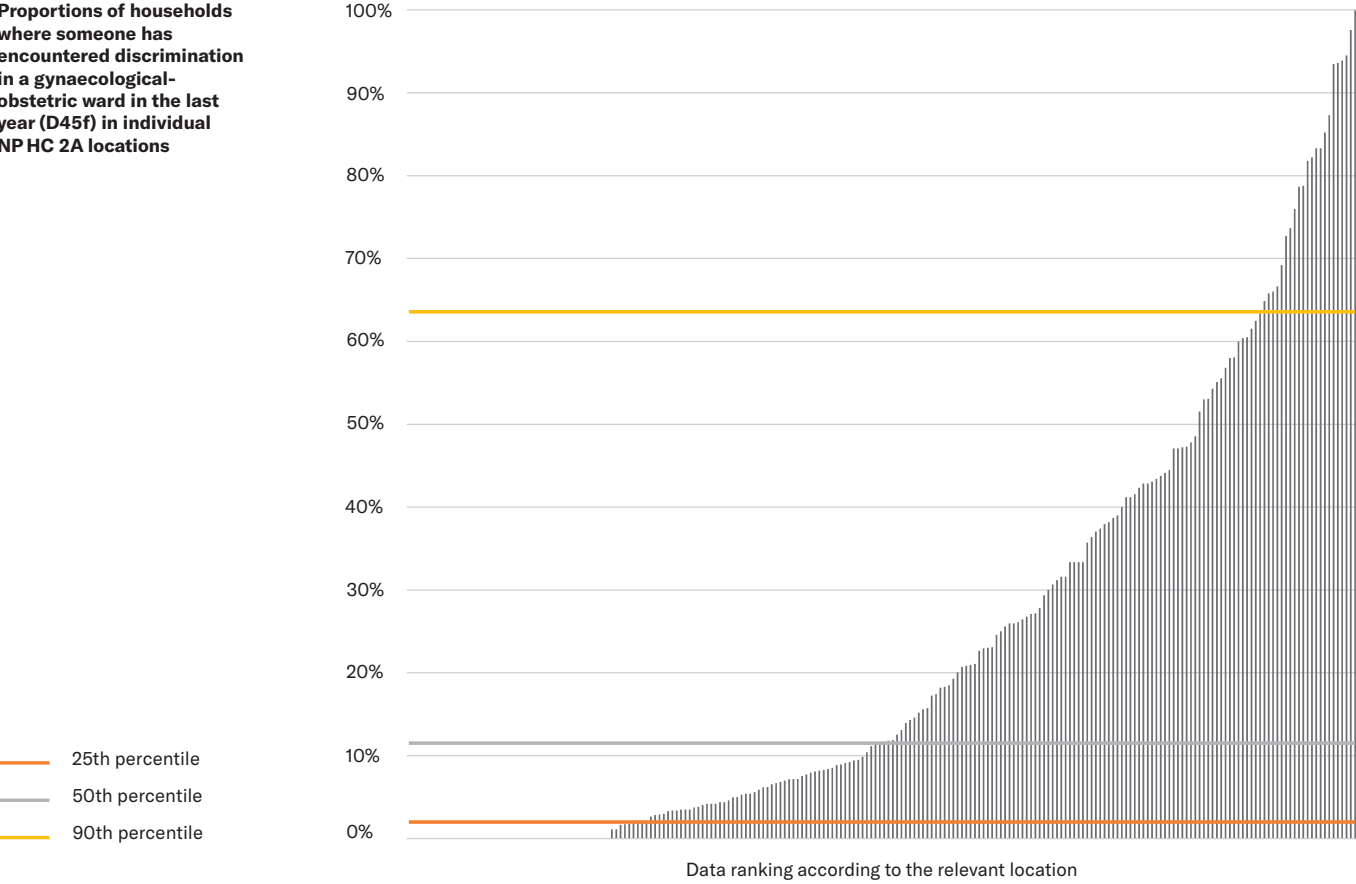| D45	a	b	c	d	e
	in a general practitioner's office	in a general practitioner's clinic	in a dental clinic	in a pharmacy	in an ambulance
NP HC locations together	**16.0%**	**14.2%**	**12.5%**	**11.4%**	**18.2%**
NP HC **KE region**	15.9%	13.9%	11.7%	11.6%	18.3%
NP HC **PO region**	17.5%	15.5%	13.2%	12.1%	20.5%
NP HC **BB region**	14.4%	12.8%	13.6%	10.7%	13.8%
NP HC **regions NR TN TT**	2.3%	2.2%	0.7%	0.3%	4.3%
Control locations together	9.8%	8.9%	6.3%	8.1%	11.6%

D45	f	g	h	i	j
	in a gynaecology-obstetrics ward	in a gynaecologist's office	in a children's ward	in an isolation ward	in another ward or other outpatient clinic
NP HC locations together	**25.1%**	**15.2%**	**21.0%**	**14.8%**	**18.6%**
NP HC **KE region**	24.6%	15.9%	19.8%	15.4%	20.2%
NP HC **PO region**	27.9%	15.9%	25.4%	16.8%	19.8%
NP HC **BB region**	22.3%	13.8%	15.1%	10.4%	14.1%
NP HC **regions NR TN TT**	1.2%	0.3%	1.2%	0.6%	1.9%
Control locations together	14.0%	10.4%	12.0%	9.8%	11.3%

Number of cases per municipality with enclaves where in the last six months:

D46	a	b	c
	the called ambulance did not come to the enclave	a rescuer in the enclave refused to enter a household	a doctor refused to accept a resident of the enclave as a patient
NP HC locations together	**1.9**	**5.6**	**2.0**
NP HC **KE region**	1.3	7.6	1.3
NP HC **PO region**	2.9	5.8	3.4
NP HC **BB region**	0.5	1.5	0.2
NP HC **regions NR TN TT**	0.5	0.3	0.3
Control locations together	0.5	1.1	0.3

Proportions of households where someone in the last year has experienced discrimination in a general practitioner's office (D45a) or in the ambulance services (D45e); averages for NP HC 2A coordination areas

■ D45a – general practitioner
▨ D45e – ambulance
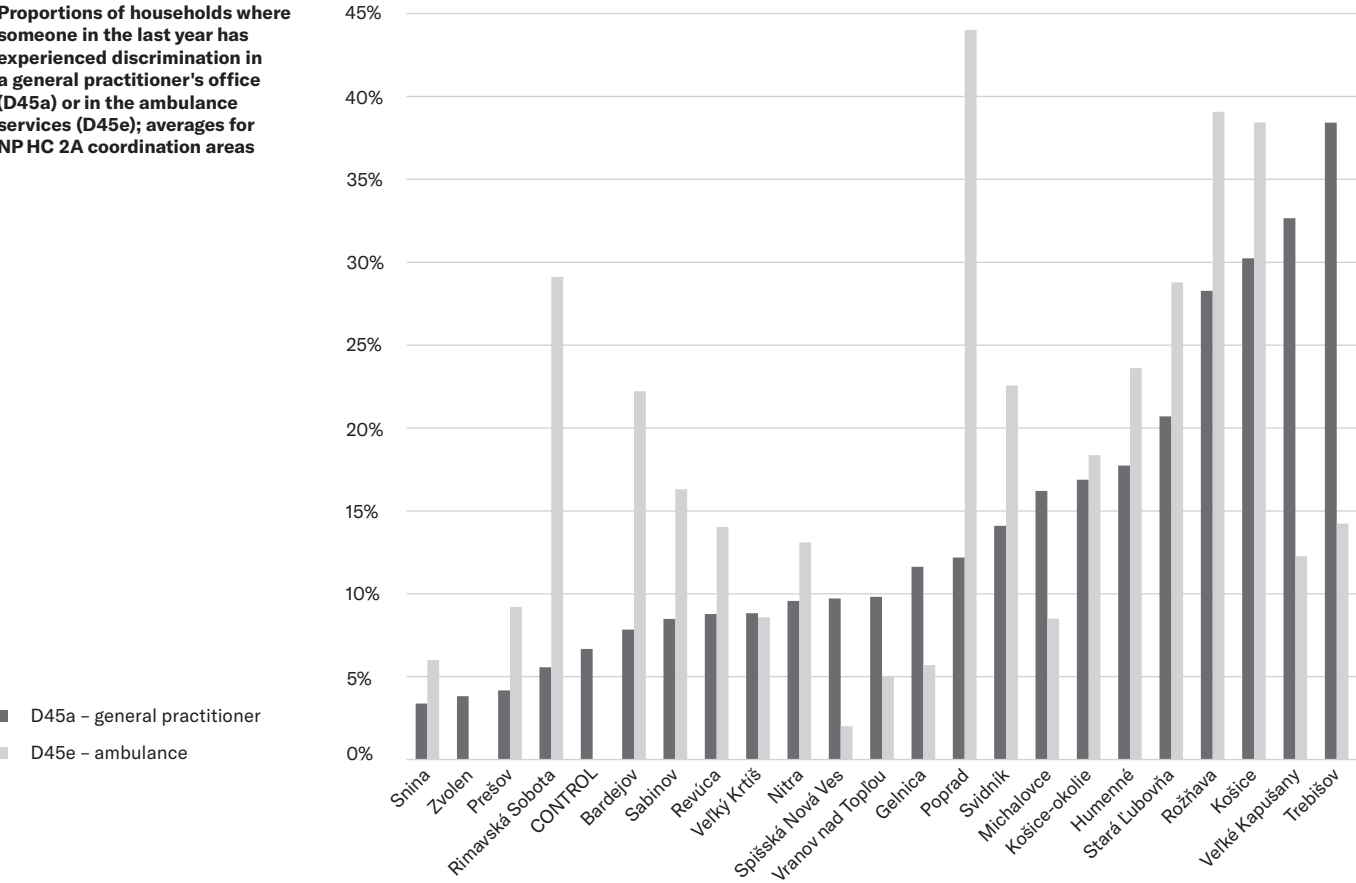
Proportions of households where someone has encountered discrimination in a gynaecological-obstetric ward in the last year (D45f) in individual NP HC 2A locations

— 25th percentile
— 50th percentile
— 90th percentile

Data ranking according to the relevant location

Data	Interpretation	Items in research documentation	Indicator quality
D45 a–j	Indicators of the degree of ethnic discrimination experienced in health care services: Indicate the shares of REPRE samples of households where over the past year someone has encountered discriminatory behaviour in care facilities due to Roma or presumed Roma origin.	REPRE, Record sheet HPA n. 2 (11)	A
D46a	Indicator of the degree of presence of ethnic discrimination in the form of refusal to provide services to the inhabitants of excluded Roma enclaves: Indicates how many times in the last six months, on average, an ambulance did not come to an enclave in an village on demand.	CENSUS, HPAC form n. 1	B
D46b	Indicator of the degree of presence of ethnic discrimination in the form of refusal to provide services to inhabitants of excluded Roma enclaves: Indicates how many times in the last six months, on average, in an enclave in the given municipality, one of the ambulance personnel refused to enter a household to see a patient.	CENSUS, HPAC form n.1	B
D46c	Indicator of the degree of presence of ethnic discrimination in the form of refusal to provide services to the inhabitants of excluded Roma enclaves: Indicates how many times in the last six months, on average, a doctor has refused to accept a resident of a given enclave as a patient.	CENSUS, HPAC form n. 1	B

Inadequacy of health care services

Together, the data presented indicate the degree of real usability of physically available services from the perspective of the patients. Elements of care services that are perceived by patients as inadequate significantly reduce the use of these services, regardless of their level of physical availability.

For the included indicators, no problems were recorded at the initial evaluation assessment, (whether conceptual, related to field data collection or analyses).

D47 Proportion of households where people tend not to deal with health problems with medical professionals because:	a it is difficult for them to get to the medical professionals	b they are afraid of a doctor's reproach	c they have had bad experiences with the behaviour of doctors and nurses	d they have troubles securing childcare	e they do not believe in the ability of doctors and nurses
NP HC locations together	25.0%	39.7%	24.4%	12.7%	23.9%
NP HC **KE region**	26.3%	38.3%	25.7%	13.4%	26.5%
NP HC **PO region**	22.4%	42.8%	23.9%	12.0%	21.3%
NP HC **BB region**	29.3%	36.9%	24.8%	14.1%	26.3%
NP HC **regions NR TN TT**	21.4%	21.6%	11.4%	7.1%	11.3%
Control locations together	28.9%	33.4%	15.2%	10.3%	19.1%

D47	f are afraid of pain during an examination or procedure	g waiting times at local health facilities are long	h they don't like to stay hospitalized longer	i they are ashamed of health professionals
NP HC locations together	63.0%	69.8%	62.7%	20.4%
NP HC **KE region**	62.6%	68.0%	61.6%	21.2%
NP HC **PO region**	64.0%	71.0%	61.4%	21.5%
NP HC **BB region**	63.6%	72.3%	68.6%	18.1%
NP HC **regions NR TN TT**	42.6%	55.7%	56.0%	4.3%
Control locations together	52.5%	58.8%	52.9%	22.6%

Percentage of households where people avoid medical professionals because they do not believe in their abilities (D47e) or they fear hospitalization (D47h); averages for NP HC 2A coordination areas

- D47e – they do not believe in the ability
- D47h – concerns about hospitalization
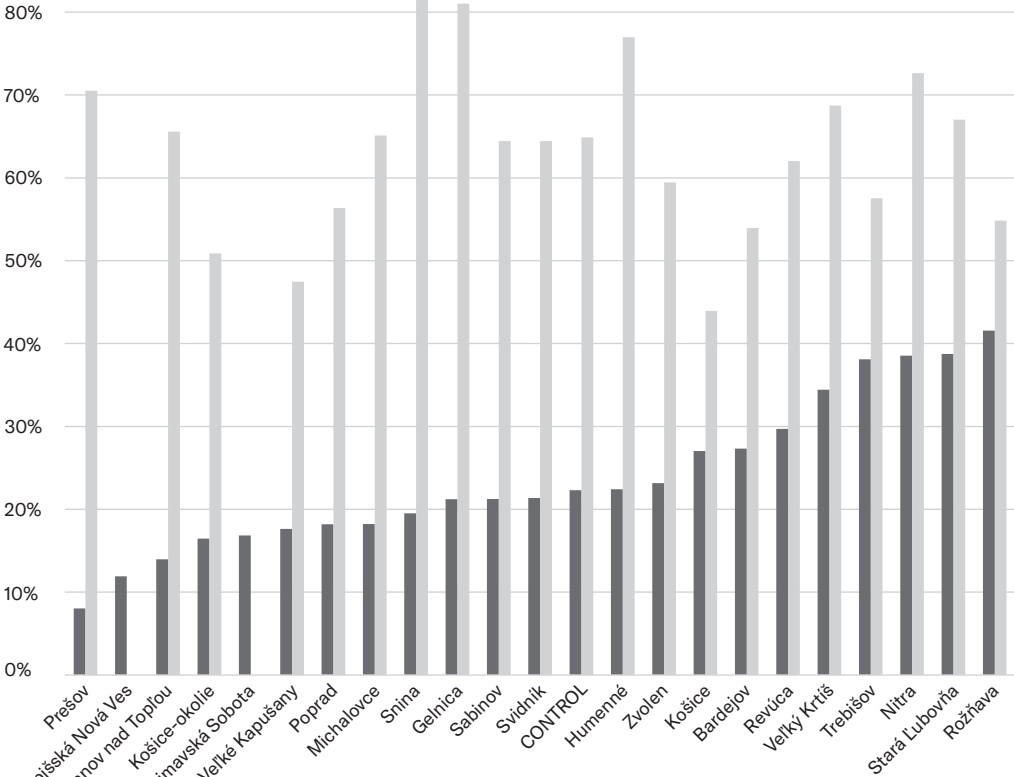
Shares of households in which they avoid solving problems with health care staff because they are ashamed of them (D47i) in individual NP HC 2A locations

- 25th percentile
- 50th percentile
- 90th percentile

Data ranking according to the relevant location

Overview of the initial impact evaluation phase results

Overview of the initial impact evaluation phase results

Data	Interpretation	Items in research documentation	Indicator quality
D47 a–i	Indicators of the degree of adequacy of physically available health care services from the users' point of view: Indicate the shares of REPRE sample households, where people tend not to solve health problems with health professionals because they do not like given aspects of the given services.	REPRE, Record sheet HPA n. 2 (10)	A

Ability to navigate health care services

Taken together, the following data indicate the level of patients' ability to independently seek the necessary types of services and care. It presents an important element of the patients' health literacy with regards to the health system. At the same time, it provides additional information on the adequacy of the components of the health system with respect to the given patients. These aspects significantly affect the extent and effectiveness of the use of those health care services that are physically available and otherwise acceptable to patients.

For the included indicators, no conceptual or analysis problems were noted during the assessment. However, according to the experience of the administrators concerned, many respondents tended to overestimate their abilities and degree of independence due to social desirability. The relevant data can therefore be considered as overestimating the actual current capabilities of the inhabitants of the considered enclaves.

Proportions of households for which it was unmanageable to be scheduled for a medical examination by phone (D48a) or to read and understand how to take medication (D48g); averages for NP HC 2A coordination areas

- ■ D48a – making an appointment for medical examination
- ▢ D48g – package leaflet
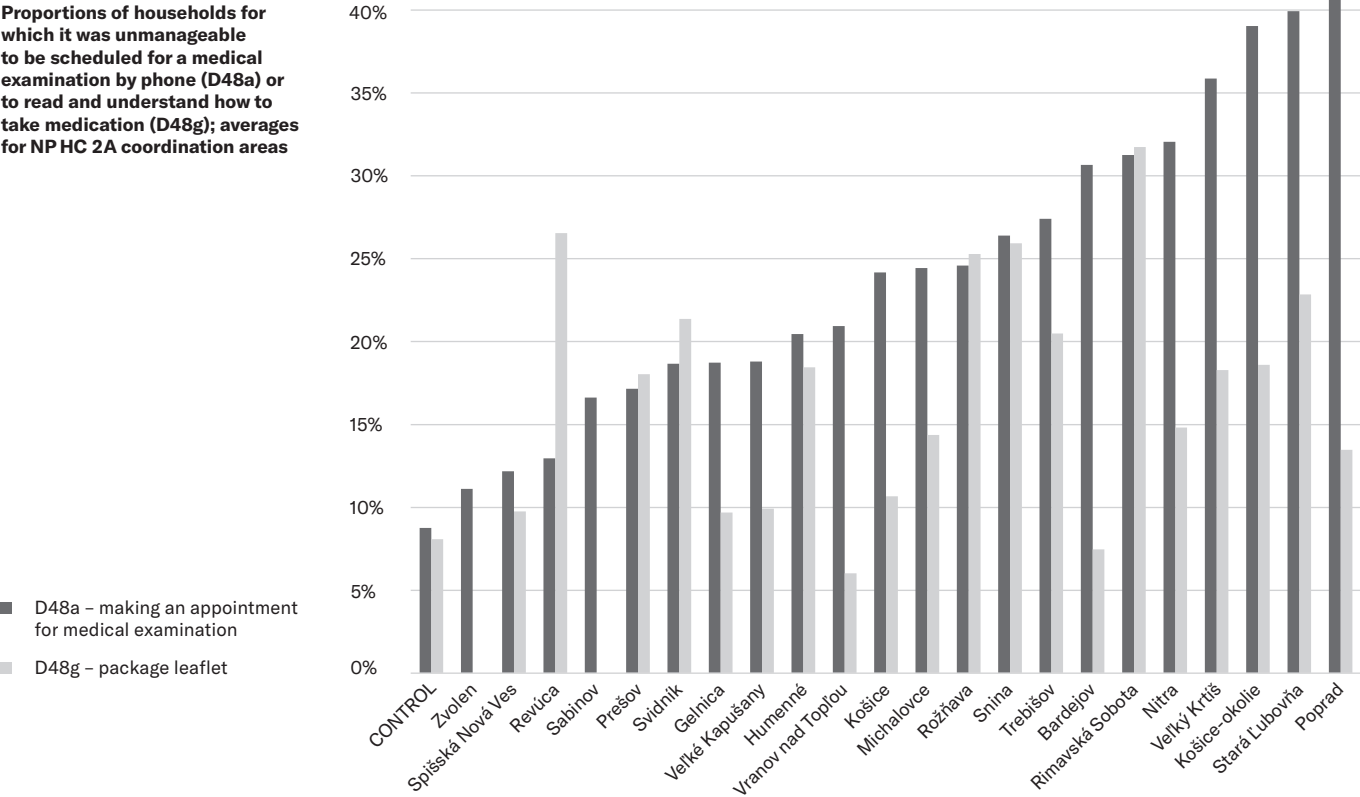
Proportions of households where the following was unmanageable without aid:

D48	a arrange an appointment with the appropriate doctors by phone	b find the appropriate department in the right hospital	c make sure doctors understand their health problem correctly	d answer doctors about what they ask	e understand and remember how medicines should be taken according to the doctors	f understand and remember what doctors recommend regarding lifestyle
NP HC locations together	25.6%	19.5%	14.9%	12.3%	15.0%	17.8%
NP HC **KE region**	27.9%	19.7%	16.6%	13.5%	16.9%	19.8%
NP HC **PO region**	24.8%	20.5%	14.3%	12.5%	15.2%	18.5%
NP HC **BB region**	24.9%	17.9%	14.0%	10.7%	12.0%	13.8%
NP HC **regions NR TN TT**	8.5%	5.6%	5.5%	2.2%	3.9%	3.6%
Control locations together	14.2%	13.1%	12.8%	10.6%	11.1%	12.5%

D48	g read and understand how to take medications	h fill in the necessary papers at the doctor's	i get the prescribed medications	j handle insurance problems	k get a medical transport (not an ambulance)
NP HC locations together	17.7%	30.8%	10.6%	32.2%	33.4%
NP HC **KE region**	21.1%	33.5%	10.8%	34.4%	36.8%
NP HC **PO region**	17.2%	30.9%	11.1%	31.2%	34.8%
NP HC **BB region**	13.1%	25.7%	9.6%	31.4%	25.7%
NP HC **regions NR TN TT**	5.1%	24.4%	4.0%	21.8%	9.5%
Control locations together	13.5%	23.3%	10.3%	22.7%	18.9%

Data	Interpretation	Items in research documentation	Indicator quality
D48 a–k	Indicators of the level of health literacy in the field of navigation through health services: They show the shares of REPRE samples of households in which people were unable to perform the above with regard to the given health services without assistance.	REPRE, Record sheet HPA n. 2 (8)	A

Basic health and health care literacy

Taken together, the following data provide information about the level of those elements of health literacy that are key to the effective use of physically available and acceptable health care services (in particular the ability to identify and describe health problems and related circumstances) and to the effective prevention and treatment of health problems at home.

As low personal literacy presents a social stigma in the given environment, it was risky to rely solely on direct assessment of the level of one's own literacy. The level of literacy in this area was therefore determined via a knowledge mini-test for the main respondent. The test included offering multiple choices regarding biomedical concepts and procedures that can be considered critical.

Proportions of households where the most competent member responded correctly to all (D49a) or none (D49b) of the basic questions about the structure and functions of the human body; averages for NP HC 2A coordination areas

- D49a – all answers correct
- D49b – no answer correct

Overview of the initial impact evaluation phase results

Proportion of households where The most competent member:

D49	a answered correctly all the basic questions asked about body parts and organ functions	b did not answer correctly any of the basic questions regarding body parts and organ functions	c answered correctly all the basic questions asked about disease prevention	d did not answer correctly any of the fundamental issues concerning disease prevention
NP HC locations together	**24.0%**	**7.4%**	**1.2%**	**11.4%**
NP HC **KE region**	23.8%	8.7%	0.6%	13.0%
NP HC **PO region**	23.3%	6.7%	2.0%	9.7%
NP HC **BB region**	24.8%	7.3%	0.4%	11.9%
NP HC **regions NR TN TT**	34.1%	2.7%	0.0%	17.3%
Control locations together	22.0%	12.4%	0.0%	17.9%

D49	e answered correctly all the basic questions asked about supportive home treatment	f did not answer correctly any of the basic questions about supportive home treatment	g answered correctly all the basic questions asked about a new-born's nutrition	h knew how to call an ambulance correctly
NP HC locations together	**54.0%**	**9.5%**	**0.4%**	**74.6%**
NP HC **KE region**	48.7%	11.2%	0.1%	73.2%
NP HC **PO region**	57.3%	8.5%	0.7%	77.4%
NP HC **BB region**	59.2%	8.5%	0.0%	69.8%
NP HC **regions NR TN TT**	33.0%	7.7%	0.0%	80.4%
Control locations together	30.2%	17.0%	0.0%	63.1%

Overview of the initial impact evaluation phase results

Proportions of households where the most competent member answered all questions regarding home treatment (D49e) correctly in individual NP HC 2A

25th percentile
50th percentile
90th percentile

Data ranking according to the relevant location
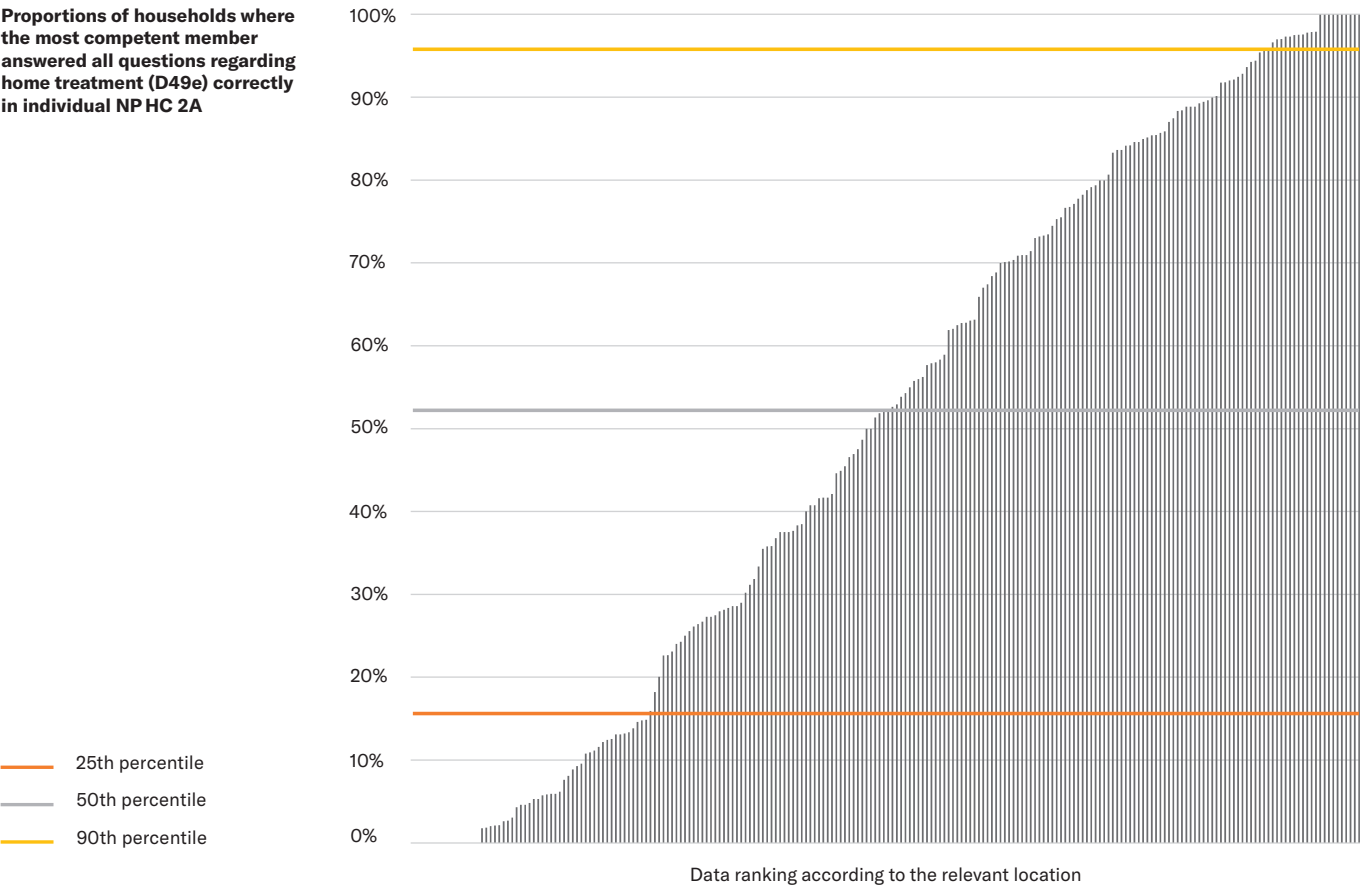
Additional information to data on basic health and health care literacy

Data	Interpretation	Items in research documentation	Indicator quality
D49 a–h	Health literacy indicators on basic biomedical concepts and procedures: Indicate the shares of REPRE samples of households where the most competent member (the main respondent) knew or was not able to choose the biomedically correct options in all cases for the given thematic area of questions from 4 options.	REPRE, Record sheet HPA n. 2 (1627)	A

Financial and social obstacles

Taken together, the following data point to barriers to accessing physically available and otherwise acceptable health care services, which for households of excluded Roma enclaves result directly from their very low social status (e.g. absolute poverty and substandard household facilities) and from related preferences and societal norms.

No problems were noted for the indicators included, with the exception

of a few specific indicators of overall literacy and health motivation (D52), which were identified by the HPAC consultants and administrators as overly sensitive. Here, a survey with direct questions was replaced by estimates based on the direct experience and observations of local administrators, and the accuracy of the resulting data may be lower in the given enclave (in relation to individual enclaves, especially depending on their increasing size and the length of the administrator's tenure).

Financial and related barriers – proportions of households that tend not to solve health problems with medical professionals because they:

D50	a do not have enough money for transportation	b do not have enough money for medicines	c have a health insurance debt	d are missing related documents
NP HC locations together	**34.9%**	**38.6%**	**14.5%**	**9.5%**
NP HC **KE region**	37.7%	40.4%	14.1%	8.1%
NP HC **PO region**	32.4%	35.8%	12.4%	10.5%
NP HC **BB region**	37.3%	43.0%	21.0%	10.3%
NP HC **regions NR TN TT**	21.1%	29.5%	10.4%	6.1%
Control locations together	33.4%	36.4%	15.4%	10.4%

Related social standards – Proportions of households that tend not to solve health problems with medical professionals because they:

D51	a prefer to recover at home in their own way	b are afraid of detection of other unexpected diagnoses	c end to wait until the health problem goes away itself	d a partner obstructs the doctor's visit
NP HC locations together	**17.9%**	**69.1%**	**30.0%**	**7.2%**
NP HC **KE region**	17.0%	67.2%	27.3%	6.0%
NP HC **PO region**	15.7%	71.2%	29.2%	7.3%
NP HC **BB region**	25.7%	69.8%	38.6%	9.9%
NP HC **regions NR TN TT**	14.6%	53.0%	22.8%	1.2%
Control locations together	17.2%	58.2%	27.8%	7.1%

Proportions of households that tend not to solve health problems with medical professionals because they:

D52	a show a lack of interest in their own health	b cannot estimate the severity of the problem	c show reluctance to change their lifestyle in the recommended way
NP HC locations together	**25.6%**	**28.8%**	**31.4%**
NP HC **KE region**	17.8%	22.1%	21.5%
NP HC **PO region**	27.8%	32.7%	37.2%
NP HC **BB region**	35.6%	33.1%	38.2%
NP HC **regions NR TN TT**	30.0%	30.0%	26.4%
Control locations together	30.3%	31.1%	36.6%

098

PART I

Overview of the initial impact evaluation phase results

099

PART I

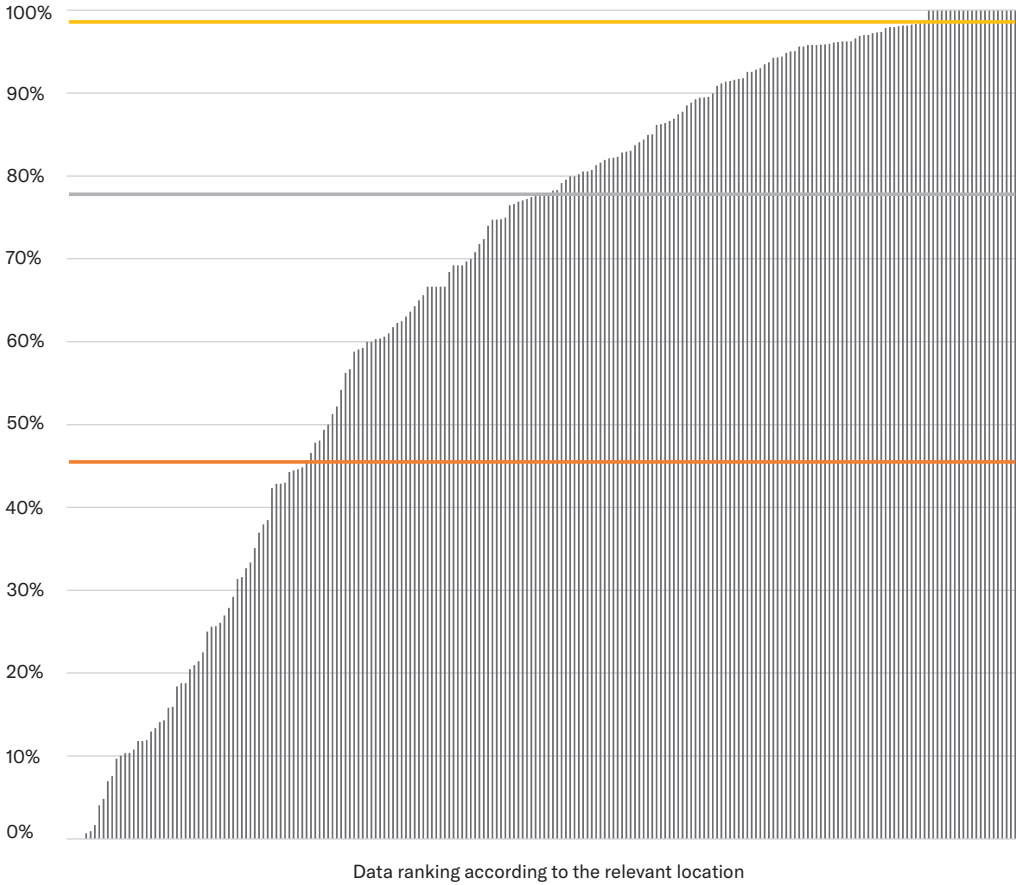Overview of the initial impact evaluation phase results

Proportions of households that do not solve their health problems with medical professionals because they do not have enough money for transport (D50a) or for medicines (D50b); averages for NP HC 2A coordination areas

- D50a – money for transportation
- D50b – money for medicines
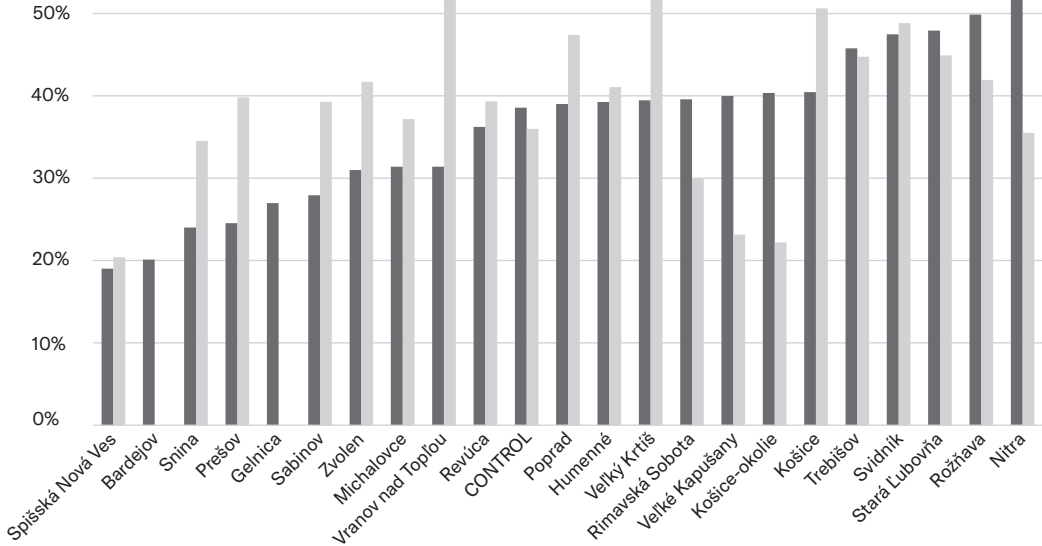
Proportions of households in which they do not solve health problems with medical professionals due to fear of detection of other unexpected diagnoses (D51) in individual NP HC 2A locations

- 25th percentile
- 50th percentile
- 90th percentile

Data ranking according to the relevant location

Proportions of households that do not solve their health problems with medical professionals because they have a health insurance debt (D50c) or they lack the necessary documents (D50d); averages for NP HC 2A coordination areas

- D50c – insurance debts
- D50d – missing documents
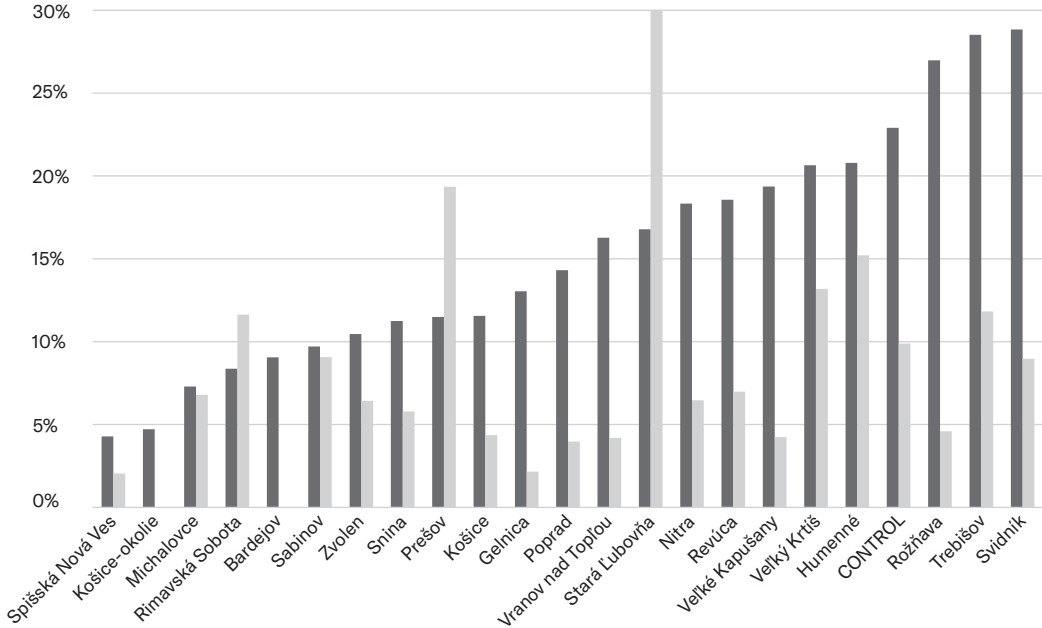
Proportions of households in which they do not solve health problems with medical professionals because of their partner's obstruction (D51d) in individual NP HC 2A locations

- 25th percentile
- 50th percentile
- 90th percentile

Data ranking according to the relevant location

Data	Interpretation	Items in research documentation	Indicator quality
D50 a–d	Indicators of the level of financial and infrastructural barriers to access to healthcare services: Indicate the proportions of REPRE samples of households which are used to not addressing their health problems with medical professionals, as they are limited by financial and related barriers.	REPRE, Record sheet HPA n. 2 (10)	A
D51 a–d	Indicators of the level of social barriers in access to health care services: Indicate the proportions of REPRE samples of households which are used to not addressing their health problems with health professionals because they are limited by local preferences or social norms.	REPRE, Record sheet HPA n. 2 (10)	A
D52 a–c	Indicators of overall literacy and motivation regarding health: Indicate the proportions of REPRE samples of household which are used to not addressing their health problems due to given limitations, according to the related direct experience and knowledge of administrators.	REPRE, Record sheet HPA n. 2 (HPA part)	B

E

Social position and opportunities

Education level

The following figures together indicate the level of formal education. The length of formal education in the long run affects health before all via types of employment, related income levels, health literacy and related health practices. Reflecting previous findings regarding education of marginalized Roma, the selection of indicators focuses on capturing the presence and length of both the regular formal education and the so-called "special" forms of education – intended for variously disadvantaged children.

Analyses of data from dozens of locations revealed numerous logical discrepancies between data on the demographic composition of individual households and data on the education of their members for specific demographic categories. According to the relevant HPACs and administrators consulted, this was probably due mainly to problems with the respondents' understanding and ascription of certain categories of education. The given indicators of the level of education must therefore be interpreted with this in mind. However, data from locations where such problems were frequent were not included in the presented summary – the presented results can thus be considered accurate at the level of summaries for larger geographical units.

Proportion of households where:

E53	a	b	c	d	e	f
	any child aged 3–5 years attends kinder-garten	any child aged 6–15 years attends an elementary school for children with special needs	anyone attends a "practical secondary school" (follow-ing a "special needs"elemen-tary school)	anyone attends a high school without a high school diploma	anyone attends a high school with a high school diploma	anyone attends a university
NP HC locations together	**30.6%**	**12.2%**	**1.4%**	**7.0%**	**2.5%**	**1.6%**
NP HC **KE region**	29.3%	10.3%	1.7%	7.9%	2.3%	1.7%
NP HC **PO region**	31.7%	11.2%	1.1%	7.4%	3.1%	1.8%
NP HC **BB region**	31.3%	14.4%	1.3%	4.8%	1.7%	1.0%
NP HC **regions NR TN TT**	27.5%	44.1%	2.5%	1.6%	0.7%	0.3%
Control locations together	23.9%	7.7%	1.1%	6.7%	2.8%	0.6%

Proportion of households where:

E53	g	h	i	j	k	l
	the highest completed level of edu-cation is a "special needs" elementary school	the highest completed level of education is an elementary school	the highest completed level of education is a practical secondary school	the highest completed level of education is a high school without a high school diploma	the highest completed level of education is a high school with a high school diploma	the highest completed level of education is a university degree
NP HC locations together	**17.2%**	**74.7%**	**0.6%**	**20.7%**	**3.3%**	**0.5%**
NP HC **KE region**	14.2%	77.7%	0.4%	18.1%	3.0%	0.5%
NP HC **PO region**	15.7%	71.0%	0.9%	23.7%	3.9%	0.5%
NP HC **BB region**	22.9%	75.7%	0.4%	20.6%	2.9%	0.3%
NP HC **regions NR TN TT**	50.5%	89.9%	1.0%	6.4%	2.6%	0.0%
Control locations together	7.8%	78.5%	0.1%	18.7%	2.1%	0.6%

Proportions of households where someone attends a "special needs" elementary school (e53b) in individual NP HC 2A locations

25th percentile
50th percentile
90th percentile

Data ranking according to the relevant location

Proportions of households where the highest completed level of education is primary school (e53h) or secondary school without a diploma (e53j); averages for NP HC 2A coordination areas

E53h – primary school
E53j – high school without diploma

Overview of the initial impact evaluation phase results

Overview of the initial impact evaluation phase results
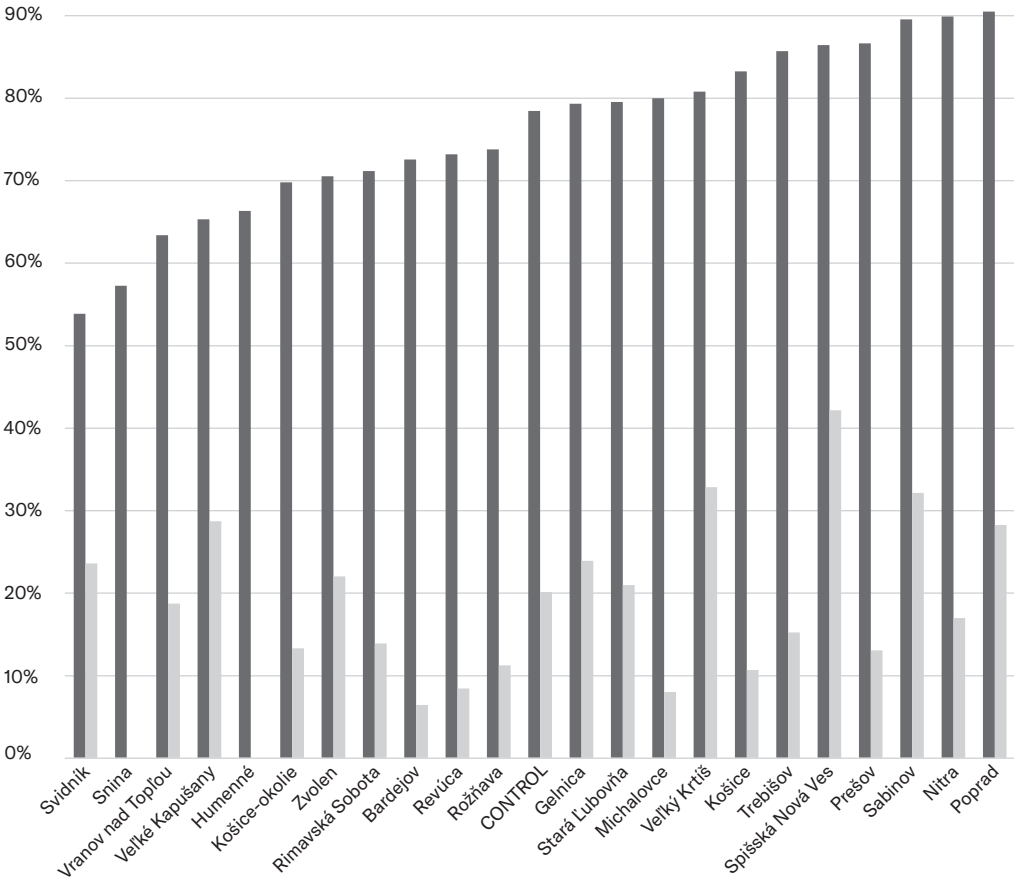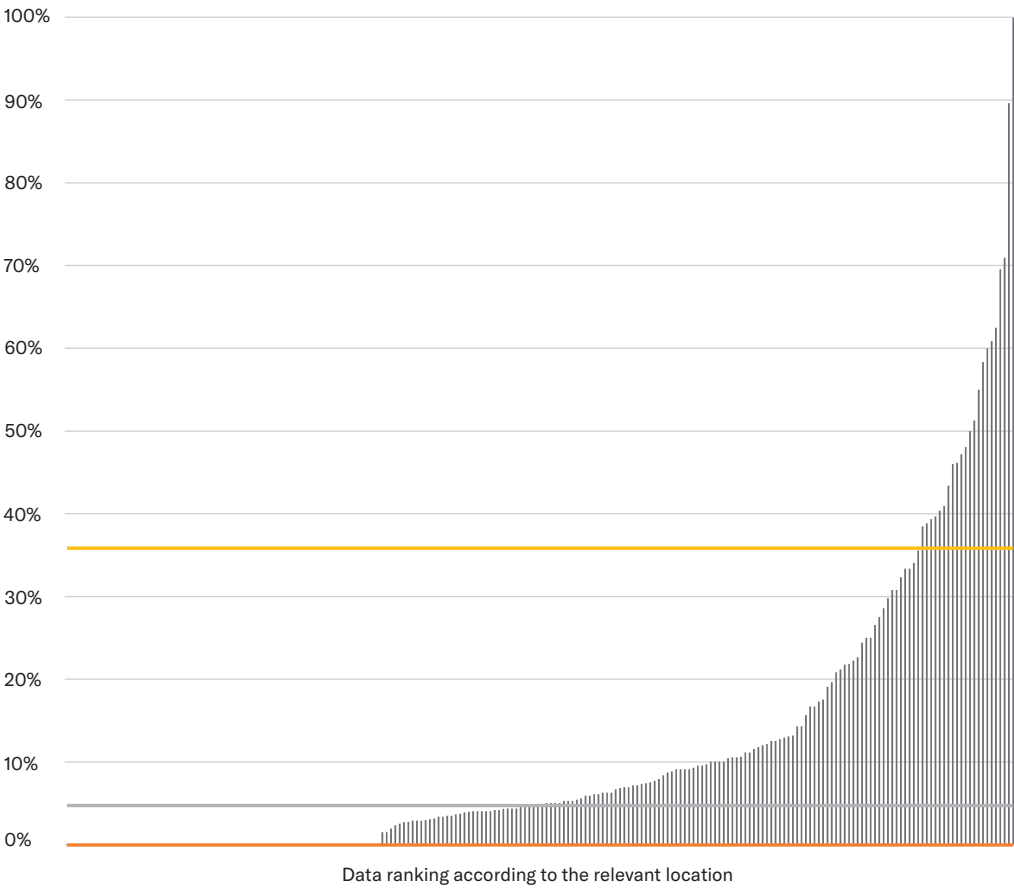
Proportions of households where the highest completed level of education is a secondary school with a diploma (e53k) or university degree (e53l); averages for NP HC 2A coordination areas

- ■ E53k – high school with a diploma
- ▨ E53l – university

(bar chart x-axis categories, left to right:)
Trebišov, Spišská Nová Ves, Poprad, Sabinov, Gelnica, Veľký Krtíš, Košice, Veľké Kapušany, CONTROL, Prešov, Zvolen, Nitra, Svidník, Humenné, Bardejov, Michalovce, Rožňava, Rimavská Sobota, Stará Ľubovňa, Vranov nad Topľou, Revúca, Košice-okolie, Snina
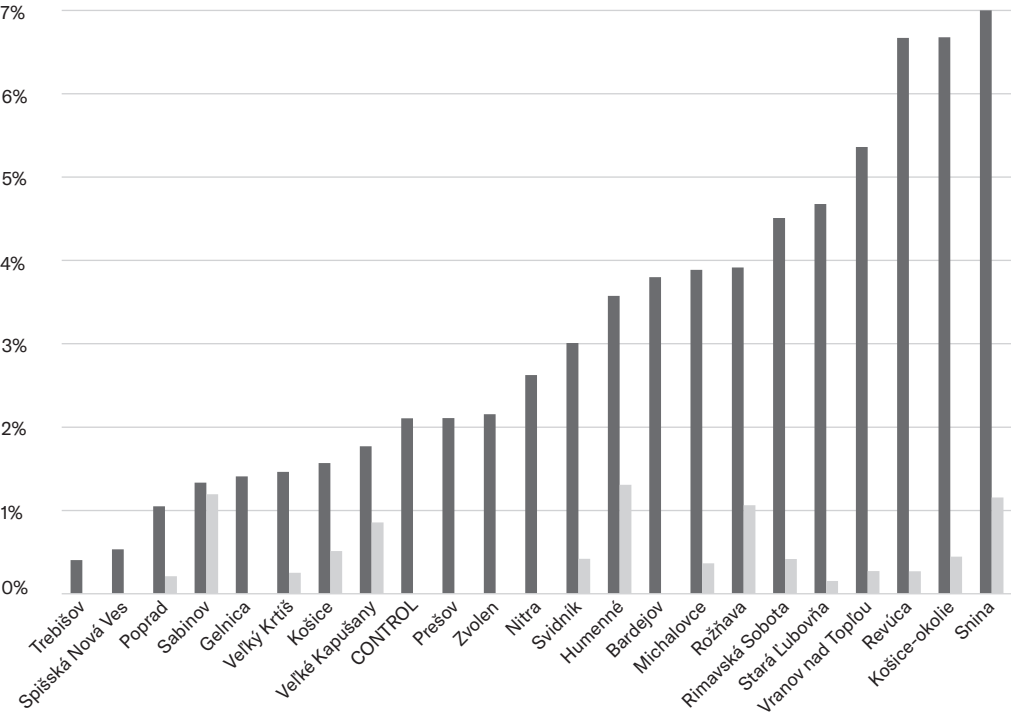
Additional information on education data

Data	Interpretation	Items in research documentation	Indicator quality
E53 a–j	Indicators of formal education levels: Indicate which proportions of REPRE samples of relevant households met the given educational level criteria.	REPRE, Record sheet HPA n. 2 (1)	B

Employment

Together, the following data show employment and unemployment rates of various kinds. Employment generally affects health mainly through the nature of working conditions (from the nature of material exposures to the types and rates of physical activity or injuries) and the level of current income (significantly affecting material conditions, but also health-related practices). In the long term, employment also significantly affects overall mental health (e. g., via the perceived level of control on the job, but also via the symbolic social status associated with specific professions, etc.). Unemployment, especially long-term unemployment, has a negative impact on mental health in particular. It indirectly affects health also through poorer material conditions and riskier practices due to low incomes and alternative subsistence activities.

For the included indicators, no problems were recorded at the initial evaluation assessment, whether conceptual, related to field data collection or analyses.

Proportion of households where:

E54	a someone has a regular income from employment or a business	b a woman has a regular income from employment or a business	c someone is on maternity leave	d someone takes care of a child or another person in substitute family care	e someone is working within "activation employment" program
NP HC locations together	40.1%	14.4%	12.6%	8.1%	29.6%
NP HC **KE region**	32.0%	10.6%	16.3%	9.1%	32.6%
NP HC **PO region**	45.8%	15.8%	11.8%	8.2%	32.3%
NP HC **BB region**	42.3%	17.6%	8.2%	5.6%	19.5%
NP HC **regions NR TN TT**	42.9%	20.2%	4.1%	11.6%	6.0%
Control locations together	37.5%	13.6%	7.2%	5.5%	24.3%

Proportion of households where:

E54	f people mostly work occasionally	g someone regularly commutes to a workplace located outside the district	h someone has lived or is living abroad for more than a year	i someone is long-term unemployed	j no one does any work
NP HC locations together	36.8%	18.9%	6.7%	32.7%	20.1%
NP HC **KE region**	41.8%	16.5%	10.6%	33.2%	23.6%
NP HC **PO region**	30.1%	21.7%	5.0%	32.8%	16.0%
NP HC **BB region**	41.4%	16.6%	3.2%	31.9%	22.0%
NP HC **regions NR TN TT**	50.2%	23.5%	3.6%	29.2%	30.8%
Control locations together	42.7%	18.9%	5.3%	38.5%	23.4%

Overview of the initial impact evaluation phase results

Overview of the initial impact evaluation phase results

Proportions of households where someone has a regular income from employment or a business (e54a) in individual NP HC 2A locations

— 25th percentile
— 50th percentile
— 90th percentile

Data ranking according to the relevant location
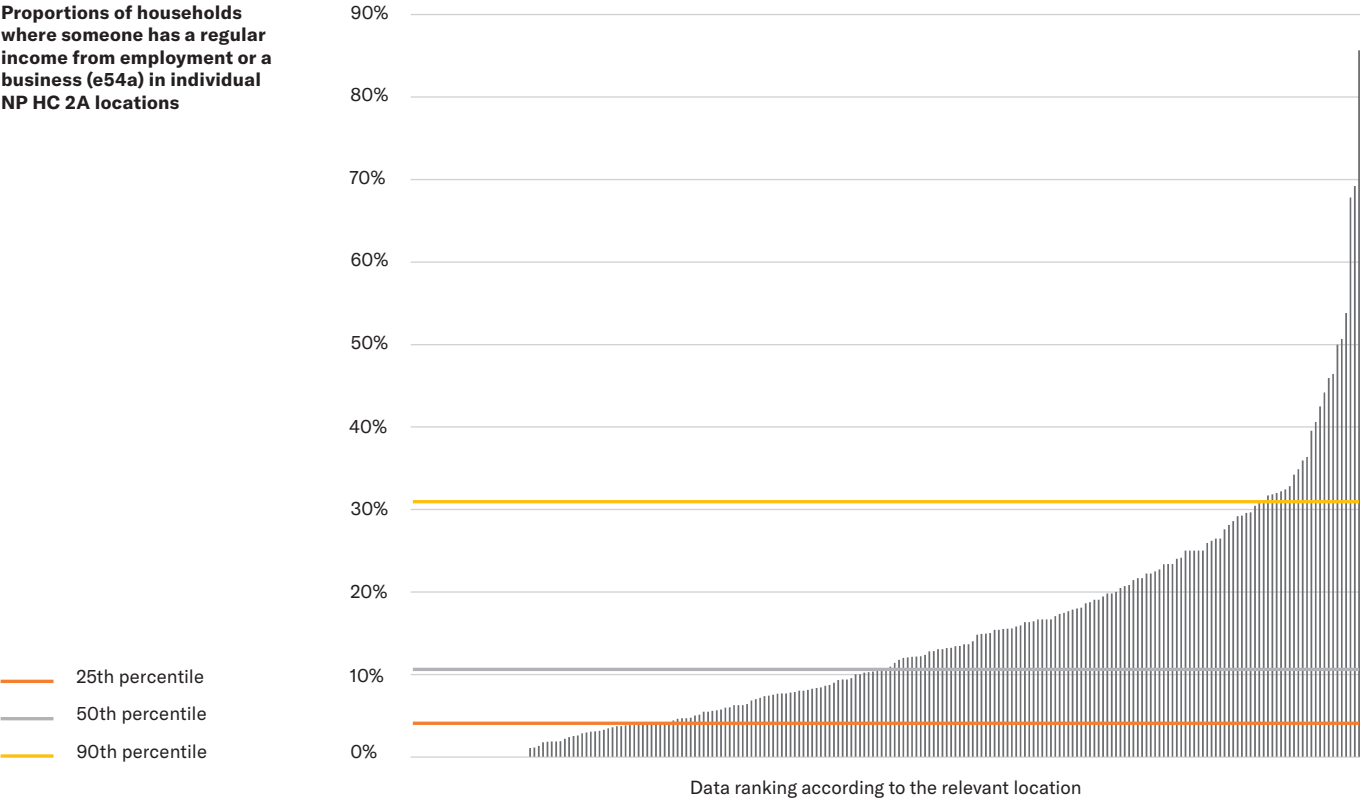
Proportions of households where someone is long-term unemployed (e54i) or someone does not work (e53l); averages for NP HC 2A coordination areas
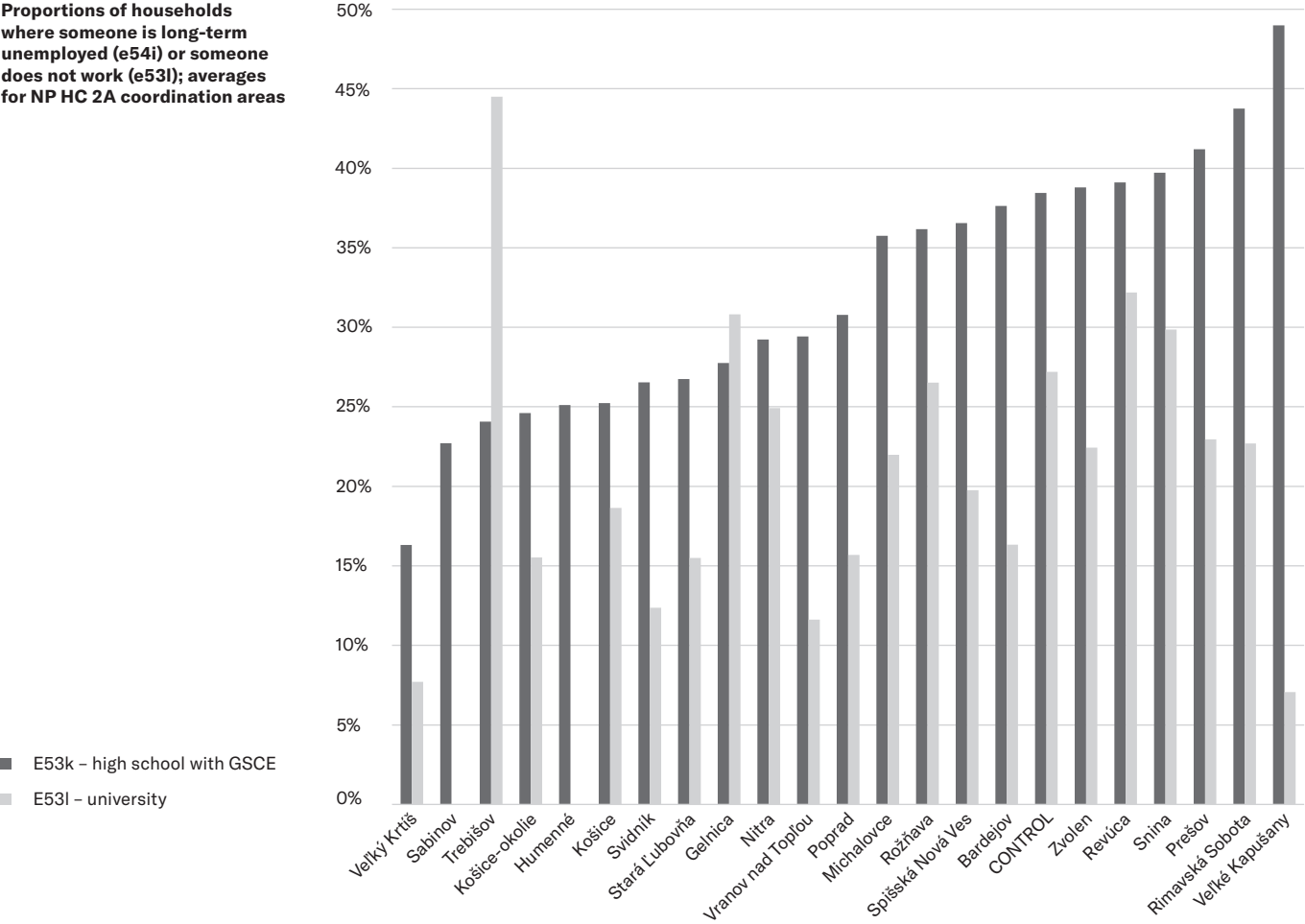
■ E53k – high school with GSCE
▢ E53l – university

Data	Interpretation	Items in research documentation	Indicator quality
E54 a–j	Indicators of employment levels: Indicate the proportions of REPRE samples of households concerning the given characteristics of employment or unemployment.	REPRE, Record sheet HPA n. 2 (31)	A

Incomes and standard of living

Together, the data presented provide evidence of income levels and living standards, with an emphasis on various aspects of the poverty that is common in the described social environment. Income levels and living standards in general affect health, specifically through the level of material conditions and the risk of health-related practices. In addition, at absolute poverty levels, it is significantly more difficult to secure any livelihood without the simultaneous development of alternative social strategies or lifestyles, which are often referred to as social pathologies – partly because they have direct negative effects on health (informal work, crime, prostitution, substance abuse, etc.).

During the initial phase of the assessment, some data on income (E55a and E55b) and some data on the level of housing (E57a–b) appeared to be problematic in terms of data collection in the field. First, because the respondents considered the information to be private and strategically valuable (especially in the most common cases where administrators presented the respondents' neighbours); second, because administrators also encountered a large number of borderline and more difficult to assess cases, including due to lack of precise information on the part of the respondents. However, the data included in the summary can be considered telling for the larger geographical areas concerned.

E55	a	b	c
	Average legal monthly net income per household (EUR)	Average legal monthly net income per household member (EUR)	Share of households in the income poverty zone
NP HC locations together	**511**	**81**	**90.2%**
NP HC **KE region**	461	69	98.3%
NP HC **PO region**	585	82	78.3%
NP HC **BB region**	450	99	100.0%
NP HC **regions NR TN TT**	468	85	100.0%
Control locations together	548	103	100.0%

Proportion of relevant households where:

E56	a	b	c	d	e	f
	someone was granted the status of a household in material need	someone is receiving unem-ployment benefits	someone is benefiting from a retirement pension	someone is benefiting from an invalidity pension	an adult has no income	they fail to set aside any savings from their monthly income
NP HC locations together	**52.6%**	**4.1%**	**13.1%**	**15.5%**	**17.2%**	**20.5%**
NP HC **KE region**	50.1%	3.8%	11.6%	13.3%	17.4%	17.0%
NP HC **PO region**	47.7%	4.4%	14.9%	15.9%	19.5%	28.6%
NP HC **BB region**	63.3%	4.6%	11.7%	18.8%	10.1%	9.9%
NP HC **regions NR TN TT**	100.0%	2.1%	15.8%	19.2%	27.7%	1.1%
Control locations together	48.1%	2.2%	12.1%	14.8%	14.3%	12.0%

Proportions of households below the income poverty line (e55c) or with recognized material deprivation status (e56a); averages for NP HC 2A coordination areas

- E55c – income poverty
- E56a – state of material deprivation
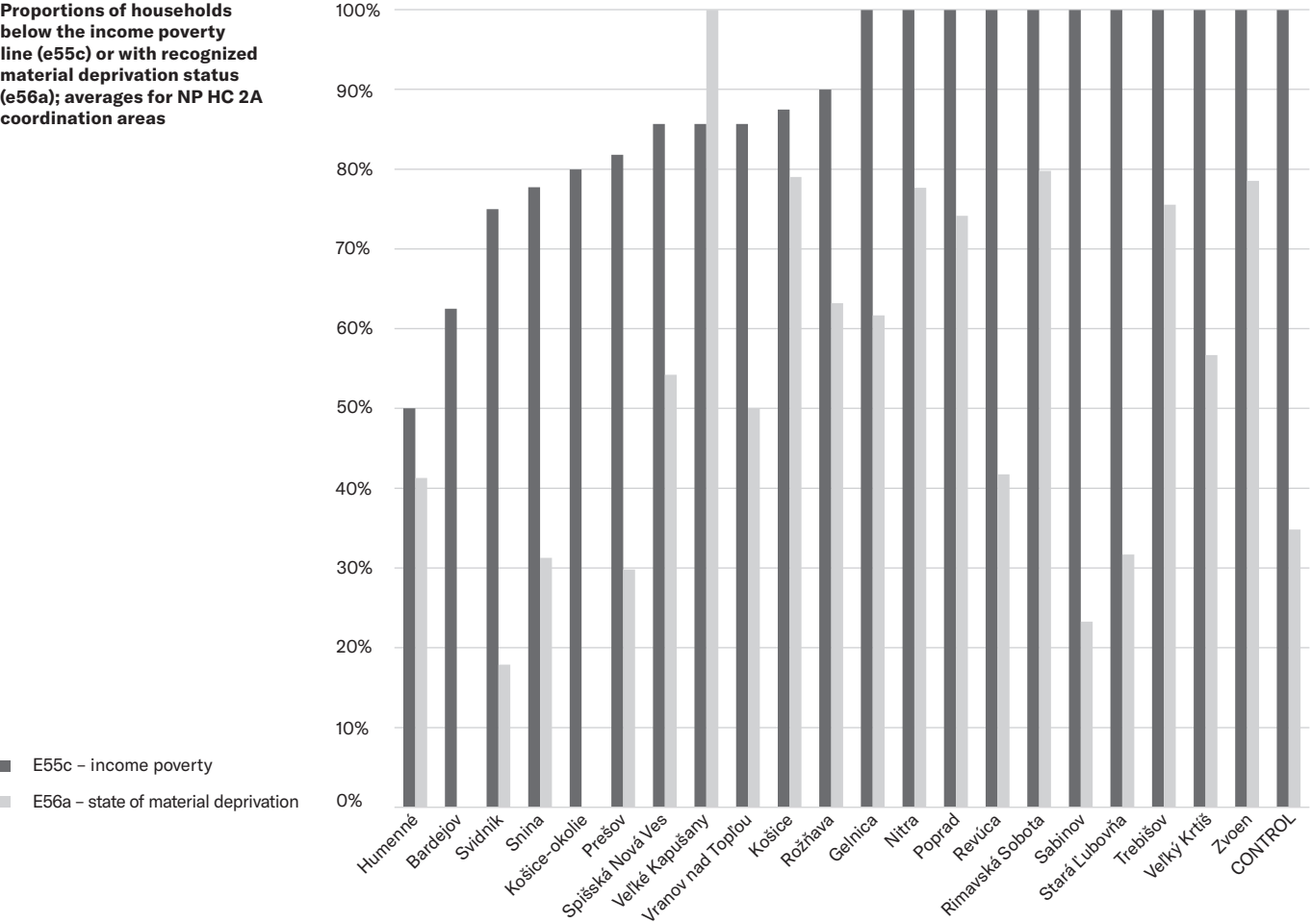
Proportions of households where someone receives a retirement pension (e56c) or an invalidity pension (e56d); averages for NP HC 2A coordination areas

- E56c – retirement pensio
- E56d – invalidity pension

Overview of the initial impact evaluation phase results

Overview of the initial impact evaluation phase results
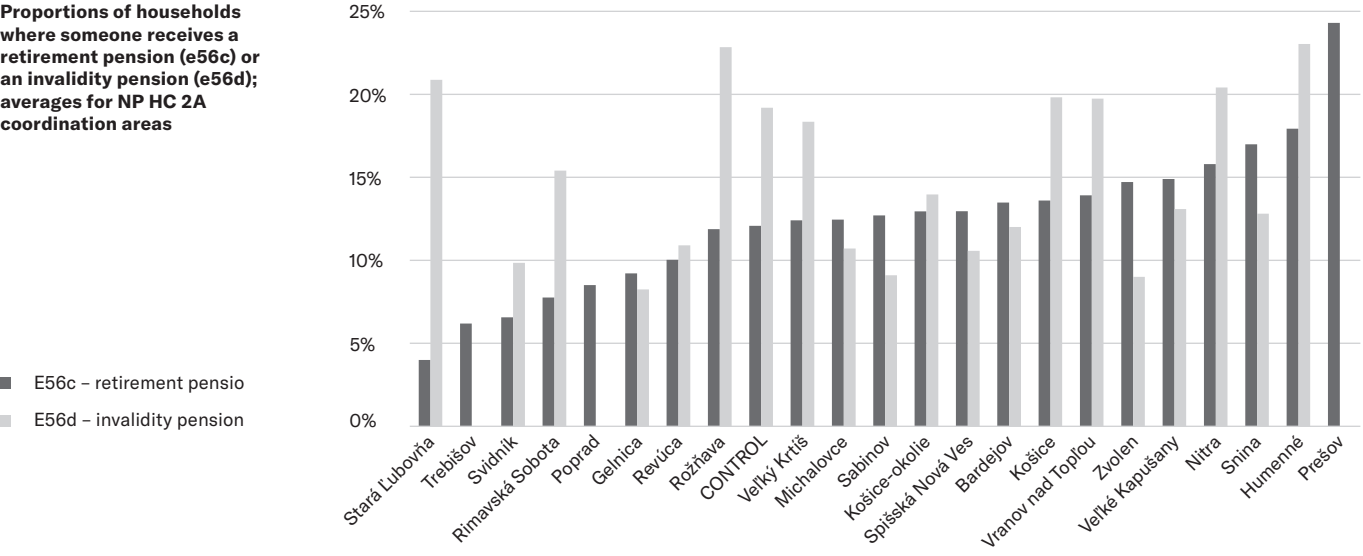
Proportion of households which:	E57	a	b	c	d	e
		have to pay rent	can immediately lose housing	live in shacks, transportable buildings or another substandard housing	have a car	have a washing machine
	NP HC locations together	**30.4%**	**31.5%**	**12.6%**	**32.4%**	**67.9%**
	NP HC **KE region**	32.8%	30.7%	12.5%	30.5%	63.6%
	NP HC **PO region**	28.8%	30.1%	14.0%	37.0%	71.7%
	NP HC **BB region**	22.1%	36.1%	10.6%	24.6%	66.6%
	NP HC **regions NR TN TT**	91.5%	36.9%	0.0%	35.0%	71.9%
	Control locations together	47.4%	16.6%	12.4%	35.5%	68.6%

Shares of households that may immediately lose housing (e57b) in NP HC 2A individual locations

Data ranking according to the relevant location

— 25th percentile
— 50th percentile
— 90th percentile
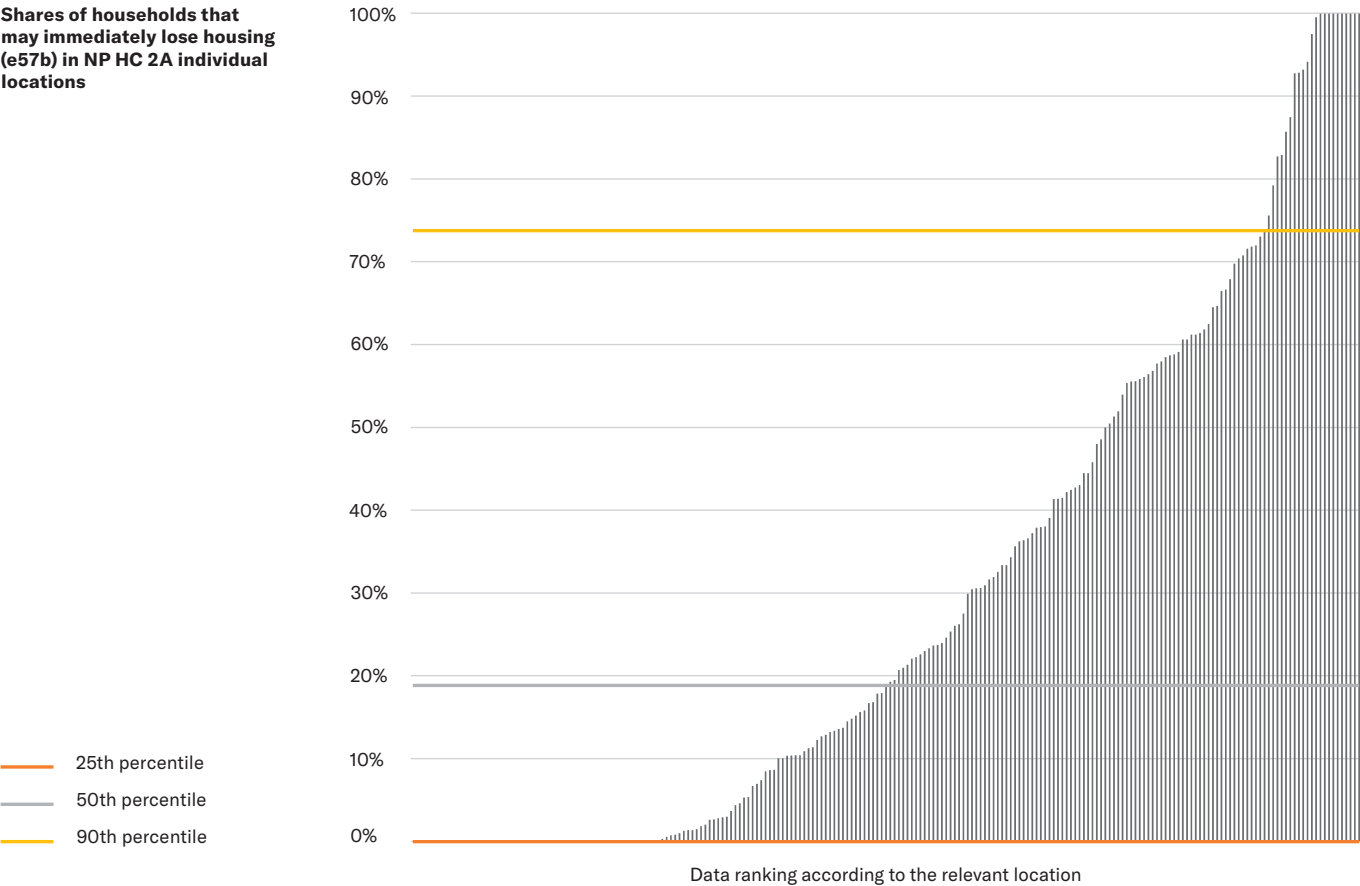
Additional information on income and standard of living data

The income poverty line in Slovakia in 2018 for complete households with two children (2 adults + 2 children up to 14 years) (Statistical Office of the Slovak Republic)

Data	Interpretation	Items in research documentation	Indicator quality
E55a	Income level indicator: Indicates the average net income in euros of a household in the REPRE samples available for a month.	REPRE, Record sheet HPA n. 2 (32)	B
E55b	Income level indicator: Indicates the average net income in euros of household in the REPRE samples available per household member: E55a/E35a.	N/A	B
E55c	Living standard: Indicates the proportion of REPRE household samples with a net monthly income of up to € 783.[1]	N/A	B
E56 a–f	Revenue indicators: Indicate the proportion of REPRE samples of households covered by the given income characteristics.	REPRE, Record sheet HPA n. 2 (33, 31)	A
E57a	Cost and standard of living indicator: Indicates the proportion of REPRE samples of household which did not live on their own property.	REPRE, Record sheet HPA n. 2 (33)	A
E57b	Indicator of living standards and risk of loss of housing: Indicates the proportion of households threatened by the immediate loss of current housing for legal reasons (long-term rent debts, buildings to be demolished, housing without the owner's permission, housing in non-legalized buildings, etc.).	CENSUS, Record sheet HPA n. 1 → Form HPAC n. 1	B
E57c	Indicator of standard of living through the material level of the dwelling: Indicates the proportion of households in the lowest standard buildings.	CENSUS, Record sheet HPA n. 1 → Form HPAC n. 1	A
E57 d–e	Indicators of living standards through household equipment levels: Indicate the proportions of households with the given equipment available.	CENSUS, Record sheet HPA n. 1 → Form HPAC n. 1	A

Direct ethnic discrimination and physical segregation

Taken together, the following figures indicate the degree of direct ethnic discrimination in everyday life, on the one hand, as experienced by the inhabitants of the considered enclaves outside of health care facilities, on the other hand, as reflected in local social rules. A frequent experience of discrimination is a serious long-term stressor and contributes significantly to the avoidance of environments where such experiences take place.

Related avoidance subsequently exacerbates the degree of social exclusion, including less efficient use of available public services. Perceived ethnic discrimination also indicates a generally low quality of service provision, which has similar negative effects as direct ethnic discrimination.

For the included indicators, no problems were recorded, whether conceptual, related to field data collection or analyses.
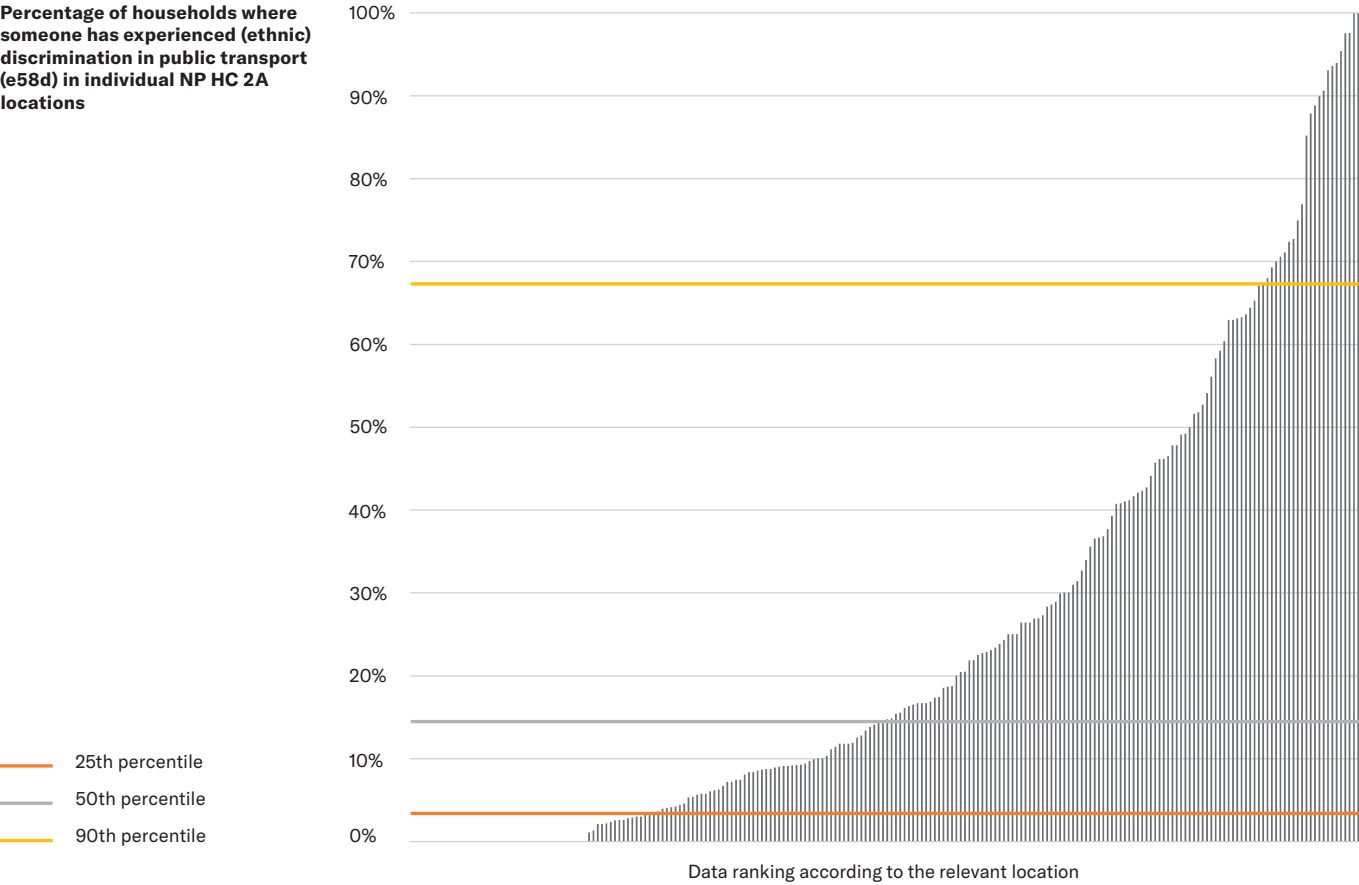
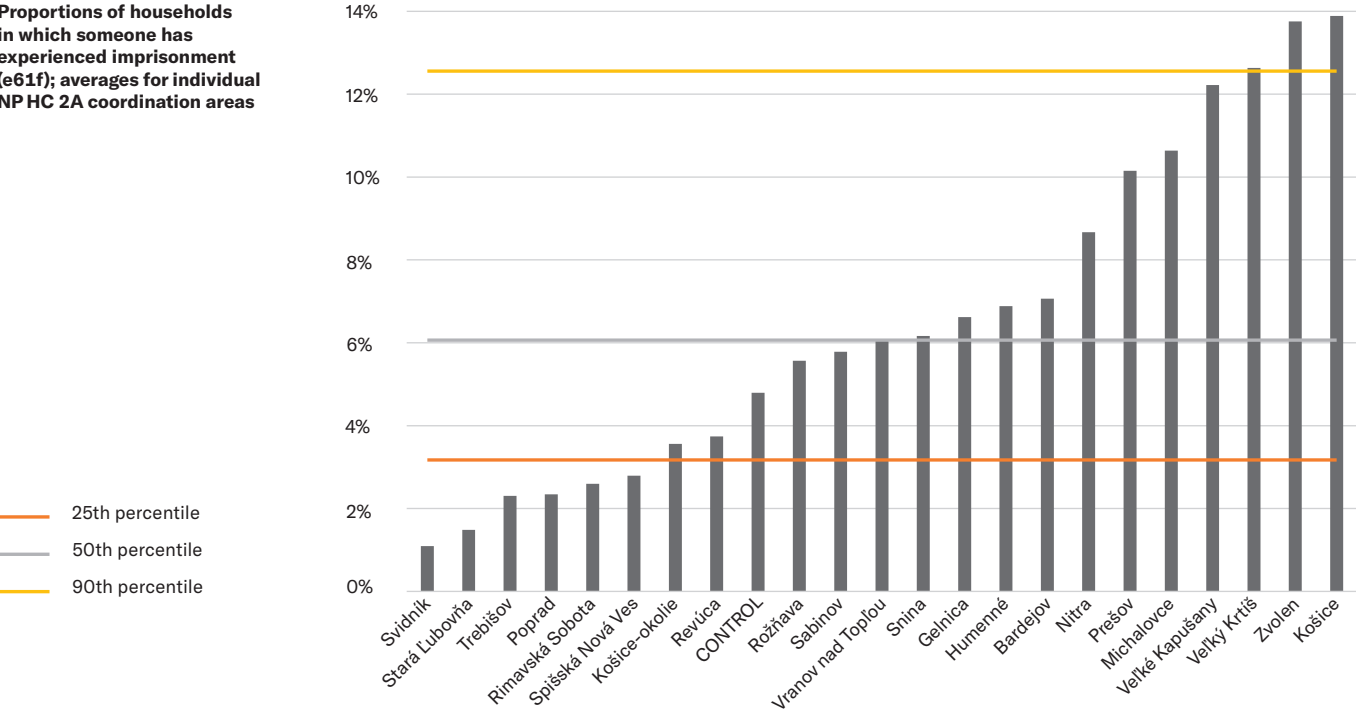| E58	a	b	c	d	e
	at school	in a store	at the office	in public transport	in an establishment
NP HC locations together	23.2%	24.5%	27.3%	24.7%	23.3%
NP HC KE region	20.5%	25.2%	29.2%	23.1%	22.1%
NP HC PO region	26.2%	25.7%	26.9%	27.7%	25.0%
NP HC BB region	22.7%	21.9%	25.0%	23.0%	23.3%
NP HC regions NR TN TT	9.6%	8.6%	20.7%	3.5%	6.8%
Control locations together	18.5%	20.5%	27.2%	26.3%	24.1%

Proportions of locations which have:

E59	a	b	c
	segregated schools or classes	segregated waiting rooms or reserved times when only Roma can walk in	establishments (restaurants, pubs, etc.) refusing to let people from the enclave in
NP HC locations together	69.1%	3.5%	29.7%
NP HC KE region	79.1%	6.0%	32.8%
NP HC PO region	72.7%	2.9%	30.4%
NP HC BB region	48.5%	0.0%	21.9%
NP HC regions NR TN TT	0.0%	0.0%	25.0%
Control locations together	39.4%	0.0%	24.2%

Overview of the initial impact evaluation phase results

Percentage of households where someone has experienced (ethnic) discrimination in public transport (e58d) in individual NP HC 2A locations

- 25th percentile
- 50th percentile
- 90th percentile

Data ranking according to the relevant location

Proportions of enclaves where excluded schools or classes (e59a) or bars or restaurants that do not allow the population of the enclaves (e59c) are located; averages for NP HC 2A coordination areas

- E59a – excluded education
- E59c – non-admission to bars or restaurants

Overview of the initial impact evaluation phase results

Data	Interpretation	Items in research documentation	Indicator quality
E58 a–e	Indicators of the degree of ethnic discrimination experienced outside health care services: They indicate the shares of REPRE samples of households where someone in the last year has encountered behaviour in given environments or situations that he felt discriminatory due to Roma or presumed Roma origin.	REPRE, Record sheet HPA n. 2 (11)	A
E59 a–c	Indicators of the degree of ethnic discrimination institutionalized through segregation rules: Indicate the proportions of enclaves, where the given discriminatory rules have been introduced.	CENSUS, Record sheet HPAC n.	A

Social exclusion

Taken together, the following data indicate the degree of indirect discrimination practices of other local (mostly non-Roma) residents that tend to make it difficult or impossible for residents of the excluded Roma enclaves to access standard out-of-enclave opportunities and the degree of "success" of these practices in terms of their immediate negative consequences. Persistent practices of exclusion, in addition to a variety of adverse health effects through all other groups of health determinants (see previous groups of determinants), also contribute to the development and adoption of alternative, often self-excluding and less healthy social strategies, norms and preferences on the part of those excluded.

For the included indicators, no problems were recorded at the initial measurement, whether conceptual, related to field data collection or analyses.

Proportion of locations where the following occurs:

E60	a	b	c	d
	municipal, city deputies or mayors living in the excluded enclave	refusals to sell, rent or allocate real estate to people from the excluded enclave	unofficial money-lending	attempts to buy votes of people from the enclave
NP HC locations together	**40.8%**	**54.1%**	**78.0%**	**68.5%**
NP HC **KE region**	38.8%	50.7%	80.6%	78.6%
NP HC **PO region**	53.3%	51.9%	74.0%	64.0%
NP HC **BB region**	21.2%	60.6%	81.8%	66.7%
NP HC **regions NR TN TT**	0.0%	100.0%	75.0%	25.0%
Control locations together	30.3%	36.4%	51.5%	51.5%

Proportion of relevant households where:

E61	a	b	c	d	e	f
	someone attends a school where most children are non-Roma	someone has colleagues who are non-Roma or live among non-Roma	someone works as a civil servant	someone attends an art school, youth organizations, a sports club or hobby groups	someone has lived or is living in an institution for more than a year	someone has personal experience with imprisonment
NP HC locations together	**27.3%**	**31.8%**	**3.5%**	**9.3%**	**2.5%**	**7.2%**
NP HC **KE region**	21.8%	24.4%	4.5%	9.2%	2.0%	8.2%
NP HC **PO region**	28.5%	34.9%	3.0%	7.4%	1.9%	5.4%
NP HC **BB region**	35.1%	38.2%	3.0%	14.6%	4.7%	9.3%
NP HC **regions NR TN TT**	31.3%	44.1%	1.8%	5.8%	5.1%	8.7%
Control locations together	26.3%	26.3%	1.9%	8.3%	1.9%	4.8%

Proportions of enclaves with representation in the municipal council (e60a) or with attempts to buy electoral votes (e59d); averages for NP HC 2A coordination areas

Legend:
- ■ E60a – representation in municipalities
- ▨ E60d – buying votes

X-axis categories: Košice-okolie, Nitra, Poprad, Zvolen, Humenné, Prešov, Spišská Nová Ves, Veľký Krtíš, CONTROL, Revúca, Rožňava, Bardejov, Gelnica, Rimavská Sobota, Vranov nad Topľou, Sabinov, Košice, Michalovce, Trebišov, Svidník, Snina, Stará Ľubovňa

---
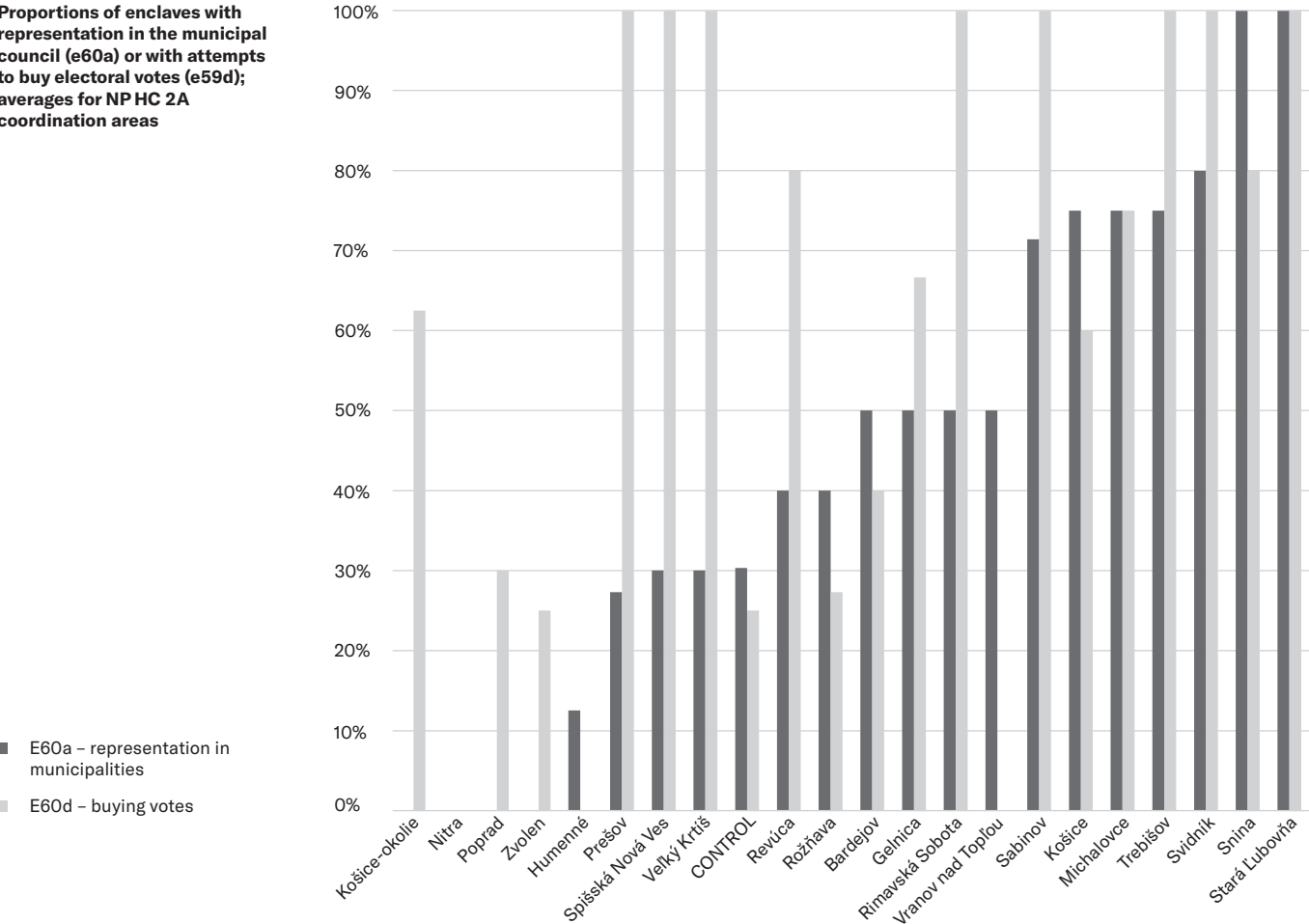
Proportions of households in which someone has experienced imprisonment (e61f); averages for individual NP HC 2A coordination areas

Legend:
- — 25th percentile
- — 50th percentile
- — 90th percentile

X-axis categories: Svidník, Stará Ľubovňa, Trebišov, Poprad, Rimavská Sobota, Spišská Nová Ves, Košice-okolie, Revúca, CONTROL, Rožňava, Sabinov, Vranov nad Topľou, Snina, Gelnica, Humenné, Bardejov, Nitra, Prešov, Michalovce, Veľké Kapušany, Veľký Krtíš, Zvolen, Košice

Data	Interpretation	Items in research documentation	Indicator quality
E60a	Indicator of the degree of social exclusion through the degree of political participation at the municipal level: Indicates the share of municipalities with enclaves with no member of the municipal council living in the enclave.	CENSUS, Record sheet HPAC n. 1	B
E60b	Indicator of the degree of social exclusion through the degree of presence of discriminatory practices of spatial segregation: Indicates the share of municipalities with local inhabitants preventing the spatial desegregation of housing.	CENSUS, Record sheet HPAC n. 1	A
E60c	Indicator of the degree of social exclusion through the degree of unavailability of ordinary financial services: Indicates the proportion of enclaves with the lack of legal financial services compensated by illegal alternative financial services.	CENSUS, Record sheet HPAC n. 1	A
E60d	Indicator of the degree of social exclusion through the degree of illegitimacy of political representation: Indicates the proportion of enclaves in which attempts were made to abuse the social exclusion rate of the population for corruption in the last parliamentary or regional elections.	CENSUS, Record sheet HPAC n. 1	B
E61 a–e	Indicators of the level of social exclusion through the degree of participation of the population of the enclave in social activities with people outside the enclave: Indicate the shares of relevant households to which the given characteristics of participation in social activities apply.	REPRE, Record sheet HPA n. 2 (29)	B

Self-exclusionary and discriminatory social norms

Together, the data obtained provide evidence on the extent of the presence of personal preferences and social norms that support the relatively low social status and segregation of the inhabitants of excluded Roma enclaves and the extent of the presence of discriminatory norms – both within the enclaves. Self-exclusion preferences and standards have an indirect but serious negative impact on health by helping to establish and maintain relatively low levels of all other health determinants in enclaves. Discriminatory preferences and norms within enclaves have a negative impact on the psychological aspects of the health of the groups of people whom specific forms of discrimination target.

For the included indicators, no problems were recorded at the initial measurement, whether conceptual, related to field data collection or analyses.

Self-exclusion social norms: proportion of households according to which others in the community do not like:

E62	a	b	c
	when someone tries to live or lives completely like non-Roma	when someone is involved in politics (candidacy for the municipal council, etc.)	when someone is studying in high school or college
NP HC locations together	**21.1%**	**14.4%**	**10.0%**
NP HC **KE region**	20.5%	14.9%	9.7%
NP HC **PO region**	23.2%	16.3%	12.4%
NP HC **BB region**	15.7%	9.1%	4.8%
NP HC **regions NR TN TT**	31.2%	11.1%	7.9%
Control locations together	17.7%	8.1%	11.9%

Internalized racism: Proportion of households where people believe that Roma children would be able to do the same as non-Roma if they had the same opportunities and support:

E63	a	b
	"yes, even more, they are more skillful by nature" or "there would certainly be many that yes"	"certainly there would be few who do" or "certainly not, they are not naturally good at such things"
NP HC locations together	**60.7%**	**11.5%**
NP HC **KE region**	60.3%	12.7%
NP HC **PO region**	58.3%	9.5%
NP HC **BB region**	67.1%	13.1%
NP HC **regions NR TN TT**	64.3%	19.0%
Control locations together	52.2%	15.1%

Discriminatory social norms: proportion of households according to which others in the community do not like:

E64	a	b	c	d	e
	violence between partners	when a man is beating "his own" wife	when parents are beating "their own" children	homosexuality	when a man is involved in housework and child care
NP HC locations together	**78.5%**	**82.2%**	**83.1%**	**67.2%**	**5.4%**
NP HC **KE region**	74.0%	77.2%	79.1%	62.8%	5.8%
NP HC **PO region**	85.1%	89.3%	89.4%	75.7%	5.4%
NP HC **BB region**	72.0%	75.5%	76.6%	57.6%	3.4%
NP HC **regions NR TN TT**	74.6%	77.0%	74.7%	44.9%	13.8%
Control locations together	72.2%	74.5%	76.1%	59.8%	4.9%

Overview of the initial impact evaluation phase results

Proportion of households where they feel social pressure not to live as non-Roma (e62a), in individual NP HC 2A locations

- 25th percentile
- 50th percentile
- 90th percentile

Data ranking according to the relevant location
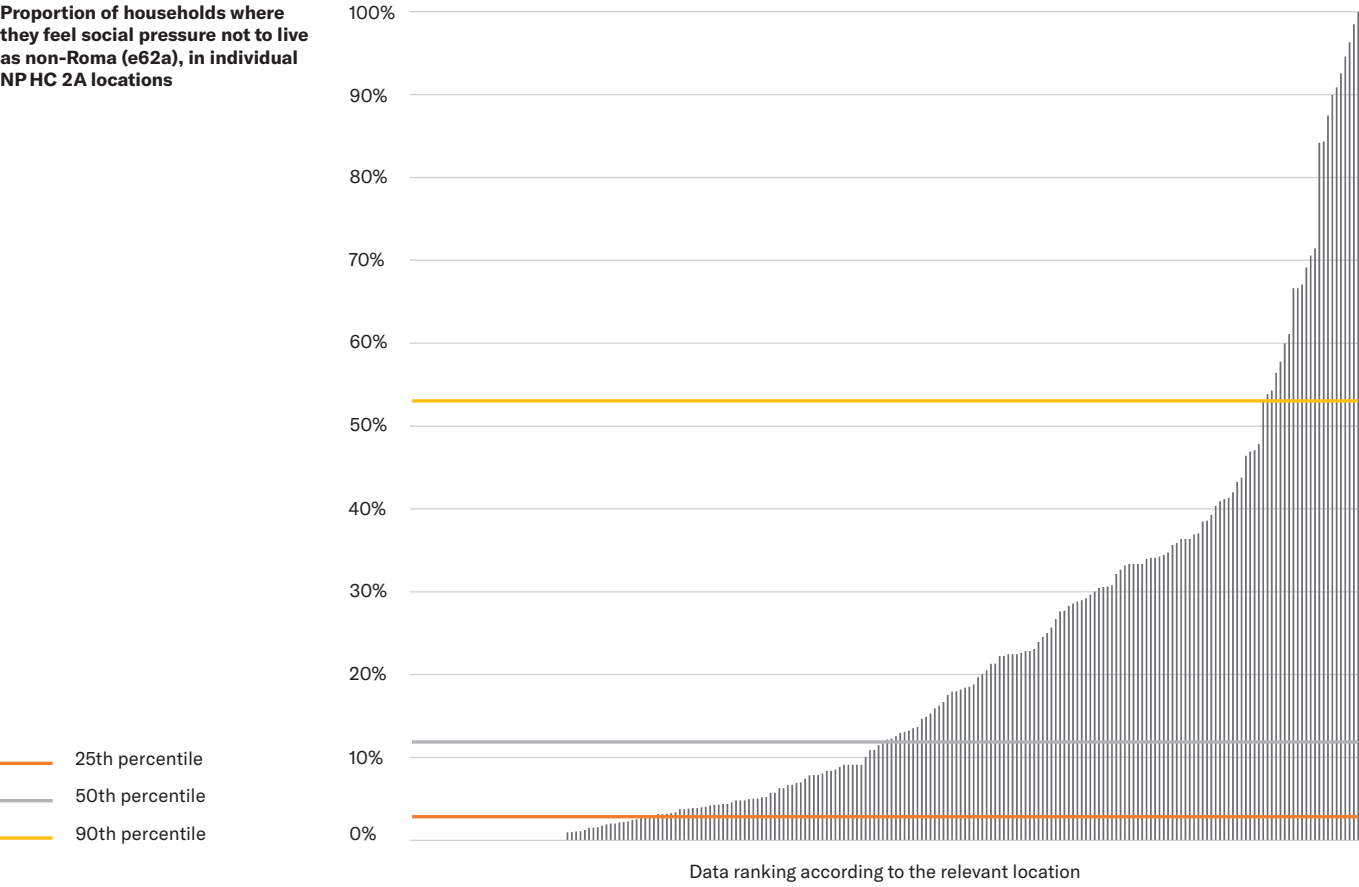
Proportions of households in which they believe in lower congenital capacities of Roma children (e63b), in individual NP HC 2A locations

- 25th percentile
- 50th percentile
- 90th percentile

Data ranking according to the relevant location

Overview of the initial impact evaluation phase results
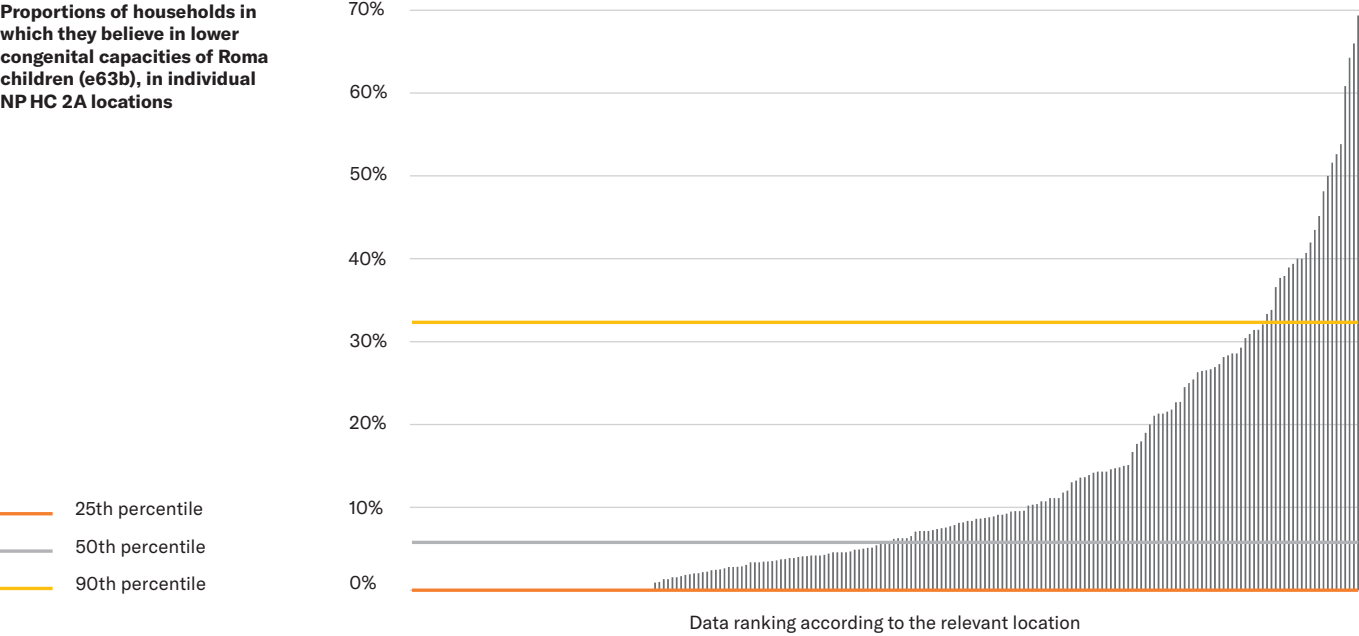
Proportions of households where people feel social pressure against violence between partners (e64a) or men's violence against "their own" wives (e64d); averages for NP HC 2A coordination areas

- ■ E64a – violence between partners
- ▢ E64b – beating "their own" women
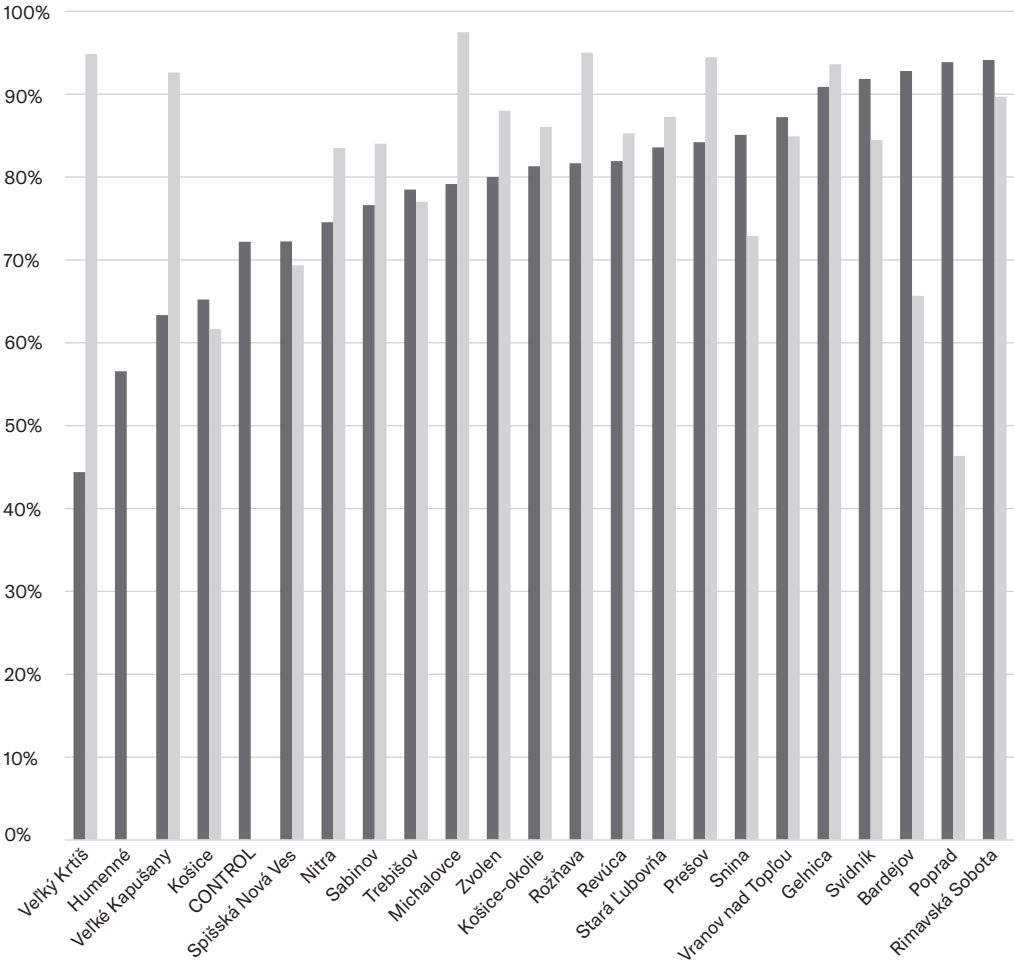
Data	Interpretation	Items in research documentation	Indicator quality
E62 a–c	Indicators of the degree of presence of self-exclusionary personal preferences and social norms: Indicate according to which proportions of REPRE samples of households the given activities facilitating inclusion in the given enclaves were mostly considered unpopular.	REPRE, Record sheet HPA n. 2 (15)	A
E63 a–b	Indicators of the presence of internalized anti-Roma racism: Indicate the proportions of REPRE samples of households where Roma children were supposed to have larger or smaller innate capacities in contrast to non-Roma children.	REPRE, Record sheet HPA n. 2 (6)	A
E64 a–e	Indicators of the degree of presence of discriminatory standards: Indicate the proportions of the REPRE samples of households, according to which the given forms of discrimination or emancipation were considered mostly unacceptable by others in the enclave.	REPRE, Record sheet HPA n. 2 (15)	A

Overview of the initial impact evaluation phase results

PART II
Overview of the health needs assessment results

Introduction

Main focus of the overview

The health needs assessment was based on the main results from the initial impact evaluation phase that examined social determinants of health in excluded Roma enclaves served by the NP HC across Slovakia (see part I). As in the case of the impact evaluation, thus, the publication of the full main results of the health needs assessment in text form was not possible for several reasons. The results individually cover hundreds of municipalities (with more than 400 excluded enclaves) and a wide range of needs (through hundreds of indicators), many of which are ethically sensitive (carry the risk of stigmatization of individual enclaves or entire municipalities). For the purposes of this report, the following overview was developed from the main results of the needs assessment.[1] The overview was compiled in such a way as to enable readers to gain a comprehensive picture regarding the following aspects of the needs assessment:

- **Which excluded Roma enclaves were covered by the results?**
- **What health needs were covered by the results?**

The following passages of the introduction address these aspects individually. After the brief general answers, they explain where in the text of the summary readers will find related more detailed information.

1
The complete results of the health needs assessment were submitted to the research sponsor, the HR, in the form of an interactive electronic database.

Excluded Roma enclaves covered by the results

Since the health needs assessment was based on the results of the initial evaluation phase, its results, too, testify mainly to the situation in the two groups of municipalities included in the evaluation: **the target locations of the NP HC and the control locations of the project evaluation.** Thanks to the numbers and spatial distribution of the included municipalities and excluded Roma enclaves

(a total of more than 400 enclaves across Slovakia), the results can be considered as **representative for all excluded Roma enclaves of the Košice, Prešov and Banská Bystrica regions** (see ANNEX A).

Readers will find the results summarized for all the following groups of municipalities with excluded Roma enclaves:

• **"NP HC locations together"** – results for all municipalities where the NP HC 2A operated

• **"NP HC KE region", "NP HC PO region", "NP HC BB region"** – results for all municipalities where the NP HC 2A operated in the given regions

• **"Control locations"** – results for all municipalities where the NP HC 2A has not operated yet

The basic sociodemographic data on the population concerned can be found in the first chapter of Part I, entitled "The population in excluded Roma enclaves".

Health needs covered by the results

Health needs were defined for the purposes of NP HC as **deficiencies in terms of social determinants of health at the community level, the improvement of which is necessary for a substantial improvement of health status** of the population of excluded Roma enclaves.[2] The needs categories in the assessment mirror the subgroups of social determinants of health used for the initial evaluation phase assessment, i.e., needs in the areas of: **A) health-related practices B) psychological burden, C) material conditions, D) health care services access and E) social position and opportunities.** The individual needs were determined via comparisons of the current levels of social determinants of health within the concerned excluded Roma enclaves with ideal levels. The sizes of individual needs were determined as **the quantitative differences between the then real and the ideal values**, in units of the given indicators for the given determinant of health.

To construct the health needs, only those indicators of health determinants levels were used

for which the values established during the initial impact evaluation phase were critical for health from a biomedical perspective (202 out of 301 indicators). With regard to the long-term goals of the NP HC, in the case of most indicators as ideal were chosen situations in which no excluded Roma enclaves would be exposed to critically risky values. Most of the specific results of the needs assessment describe health needs as deficiencies in health determinants that need to be addressed in individual municipalities. The extent of the deficiencies is in most cases expressed as the **proportion of excluded Roma households that were exposed to critical levels of the given health determinants at the time**. In turn, for most health needs a situation in which no excluded Roma enclaves would face related critical exposure levels would be considered to be a fulfilment of the needs. For an illustrative summary of how the health needs of the enclaves were derived from the results of the initial impact evaluation phase assessment, see Figure II.1.[3]

Share of households NOT exposed to critical values of health endangering exposures

100%

Ideal situation
(According to biomedical and public health recommendations)

"Health need"
(Distance between the current and the ideal situation to be closed by the intervention)

"The level of community exposure"
(Derived from the impact evaluation assessment of the determinants of health at the community level)

0%

Worst possible situation

A specific health determinants level indicator
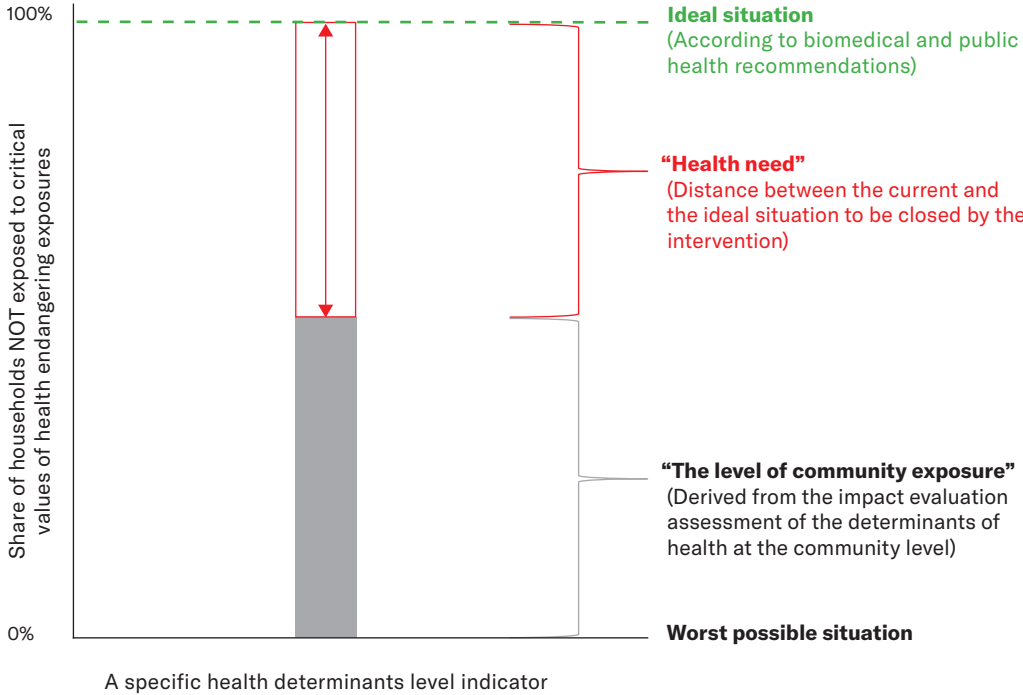
In the overview, readers will find the results of the needs assessment presented mainly through **two types of graphs**, called **health needs profiles**, and showing average results for specific selections of municipalities (NP HC locations together, control locations and NP HC locations specifically in the KE, PO and BB regions). The introductory graphs, summarizing the results for all NP HC locations together, are always accompanied by tabular overviews of the numerical values which the graphs show, for better illustration. Both types of graphs – **summary profile** and **sub-profile** – are simple bar graphs based on the diagram in Figure II.1. They enable an intuitive display and comparison of sizes and different types of determined health needs for individual municipalities or any group of municipalities with excluded Roma enclaves (see also illustrative Graphs II.1–2).[4]

The graphs differ from each other in the level of detail:

Summary profiles – represent the most abstract summaries of the results of the needs assessment. For the given selections of municipalities, they summarize the results for all 5 areas of health determinants at the community level. Each column in these graphs summarizes, by

means of an average, more detailed data on the size of needs for a whole group of health determinants area (A – E).

Sub-profiles – represent summaries in a more specific and detailed way. They always focus on only one area of health determinants. In addition to displaying the average of more detailed data on the size of the needs for the whole given area (first column), they also show the averages of the sizes of needs for individual sub-areas by which the given field is defined (other columns). Thus, the sub-profiles represent an illustrative "unpacking" of the averages displayed in the individual columns of the summary profiles.

The first chapter of the overview presents summary profiles of health needs for selected groups of municipalities. The following chapters present the sub-profiles of health needs for the same selections of municipalities – a separate chapter is devoted to each of the area of needs, A – E. The last chapter focuses on the demonstration of significant differences in needs between municipalities with excluded Roma enclaves within small areas, through an example of a comparison of the needs of two specific municipalities with excluded Roma enclaves from the Košice-okolie district.

5
Definitions of indicators and values found for them during the initial evaluation assessment can be found in part I, devoted to the summary of the results of the initial evaluation assessment (see coding – e.g. E99b).

In the chapters devoted to individual areas of needs (A – E), readers will find tables summarizing the data from which the values of the size of health needs were derived (see illustration Table II.1). The table always shows for each needs area:
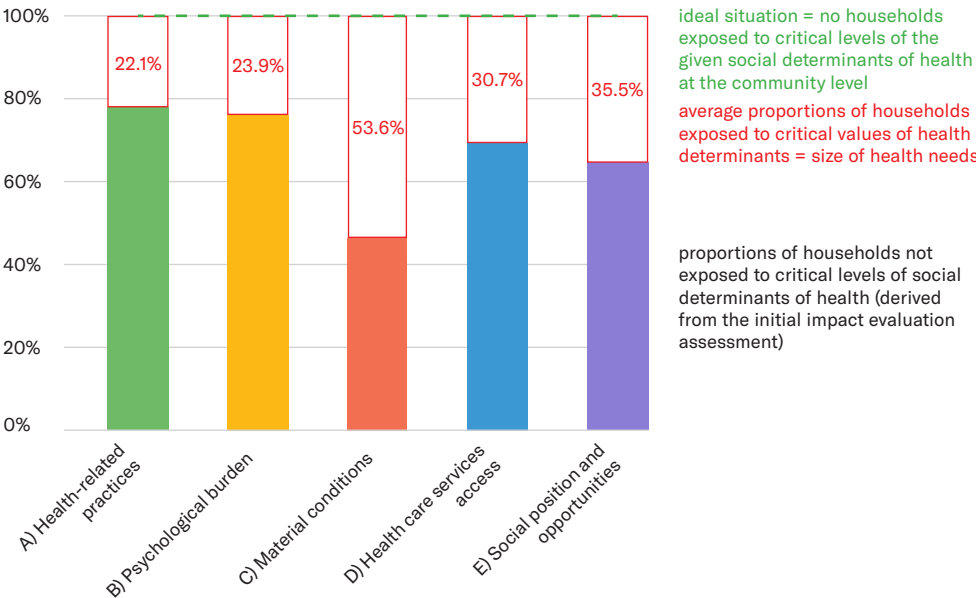
· the group of indicators of the level of health determinants which the given needs were based on[5]
· which values were used as ideal situation in terms of risk exposure for the given indicators (used to derive the magnitude of the given health needs)

Summary profiles of health needs

Tab. II.1
Illustrative table –
Indicators of the levels of health determinants and values of the relevant ideal conditions used to derive the magnitudes of the relevant health needs

Indicator group	Health determinants indicators	Ideal state value
Indicator group 1	Indicator X96a Indicator X97c Indicator X99b ...	No households exposed... All households have... Average value of indicator X99b up to... ...
Indicator group 2	... ...	... ...

Graph II.1
Illustration – Summary health needs profile: NP HC Target locations together

ideal situation = no households exposed to critical levels of the given social determinants of health at the community level

average proportions of households exposed to critical values of health determinants = size of health needs

proportions of households not exposed to critical levels of social determinants of health (derived from the initial impact evaluation assessment)

Summary table for all target NP HC locations together:

Areas of social determinants of health or areas of health needs	A) Health-related practices	B) Psychological burden	C) Material conditions	D) Health care services access	E) Social position and opportunities
Current proportions of households outside the critical level	78.2%	76.2%	46.3%	69.4%	64.3%
Size of health needs	21.8%	23.8%	53.7%	30.6%	35.7%

Graph II.2
Illustration – Health needs sub-profile of: A) Health-related practices
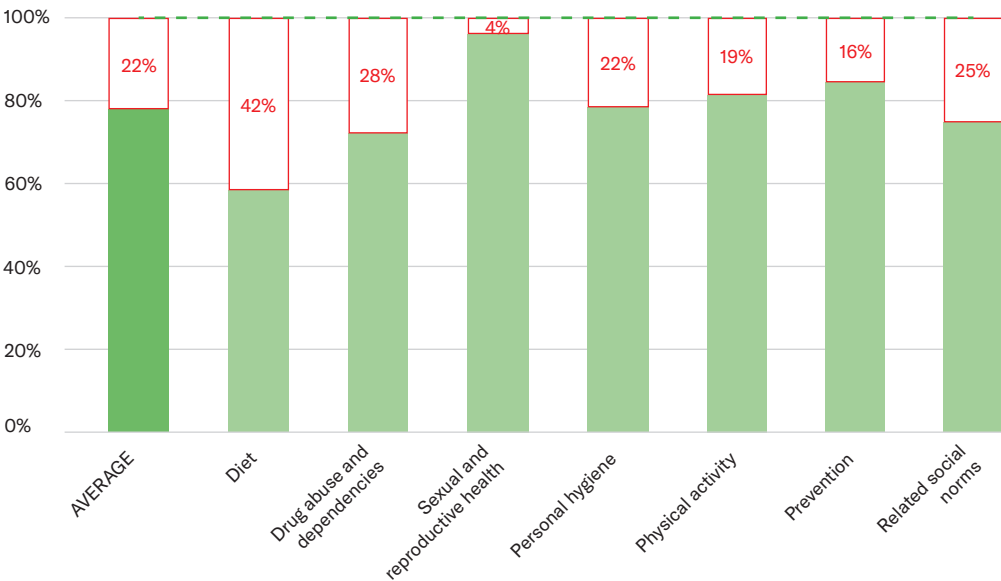
Summary profile: NP HC target locations together

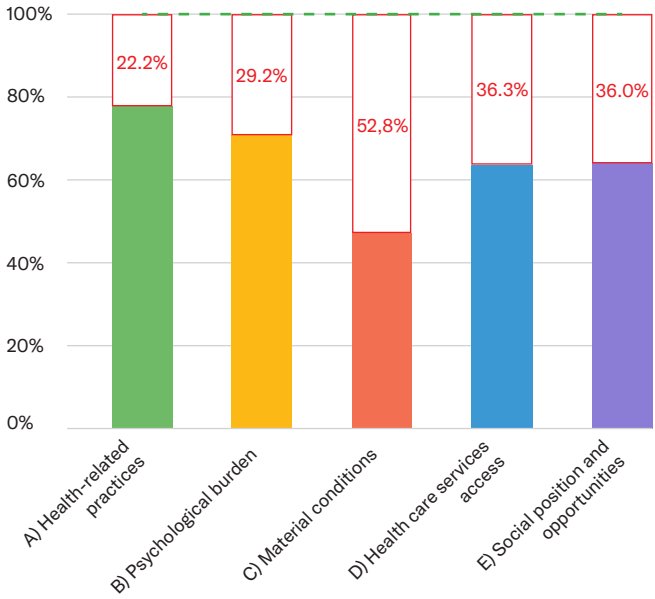**Summary profile: Control locations of the initial evaluation assessment**

	A) Health-related practices	B) Psychological burden	C) Material conditions	D) Health care services access	E) Social position and opportunities
	21.8%	26.2%	56.5%	29.0%	34.3%

Summary profile: NP HC localities in the Prešov region

	A) Health-related practices	B) Psychological burden	C) Material conditions	D) Health care services access	E) Social position and opportunities
	21.9%	20.7%	54.0%	30.8%	34.3%

Summary profile: NP HC localities in the Košice region

	A) Health-related practices	B) Psychological burden	C) Material conditions	D) Health care services access	E) Social position and opportunities
	21.9%	24.8%	54.6%	33.5%	36.9%

Summary profile: NP HC localities in the Banská Bystrica region

	A) Health-related practices	B) Psychological burden	C) Material conditions	D) Health care services access	E) Social position and opportunities
	22.2%	29.2%	52,8%	36.3%	36.0%

Needs related to health-related practices

Sub-profile: control locations of the evaluation

Values related to the sub-profile for all NP HC target locations together:

Indicator groups	AVERAGE	Diet	Drug abuse and dependencies	Sexual and reproductive health	Personal hygiene	Physical activity	Prevention	Related social norms
Current proportions of households outside the critical level	78.2%	58.2%	72.3%	96.2%	79.5%	81.5%	84.5%	74.8%
Size of health needs	22%	42%	28%	4%	20%	18%	15%	25%

Sub-profile: NP HC localities in the Košice region
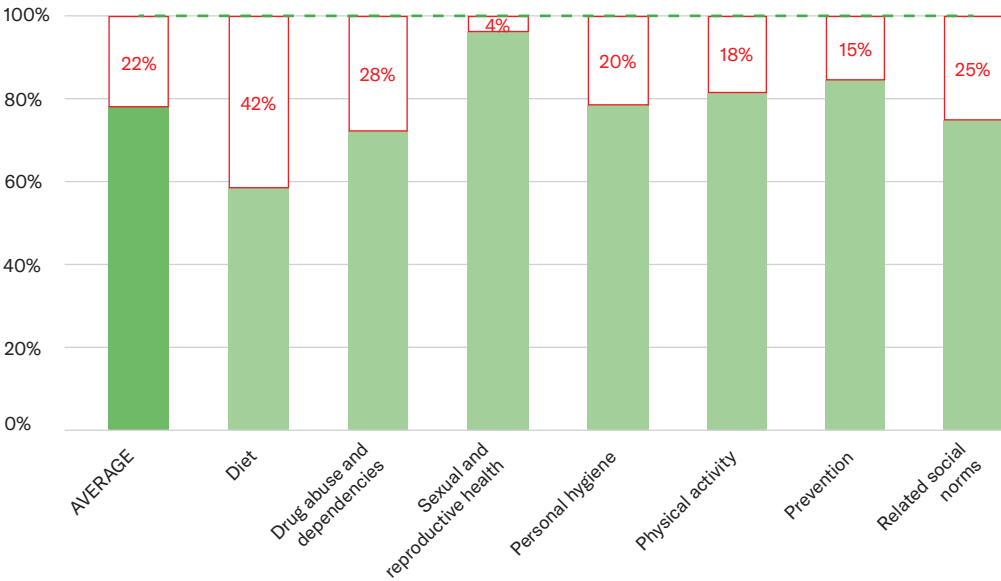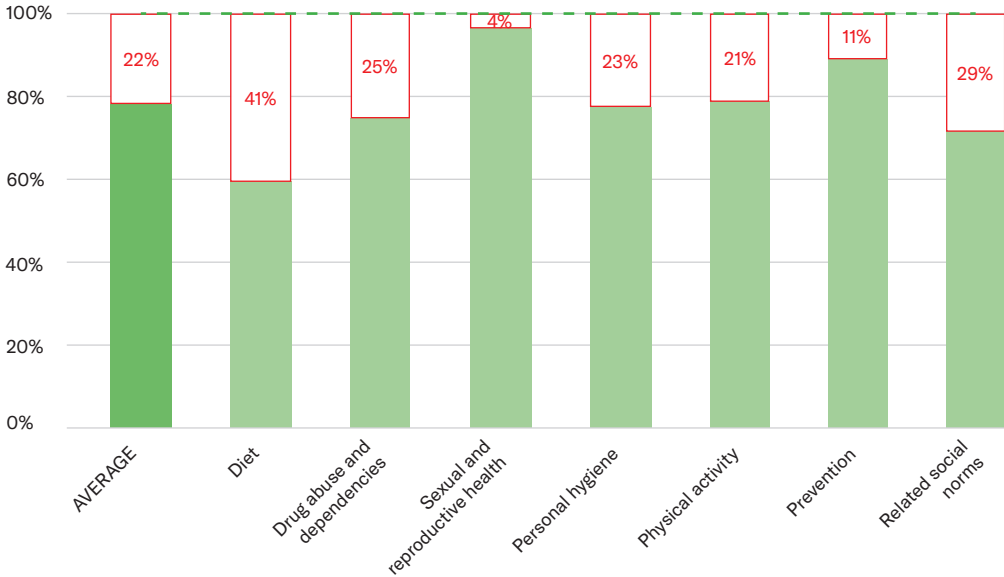
Sub-profile: NP HC locations together

Sub-profile: NP HC localities in the Prešov region

Needs related to psychological burden
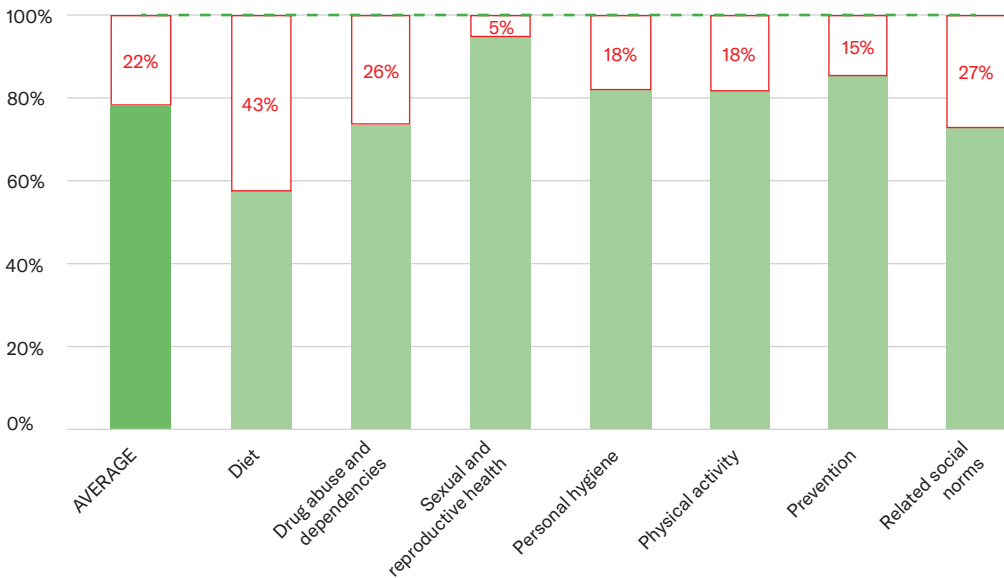
Sub-profile: NP HC localities in the Banská Bystrica region
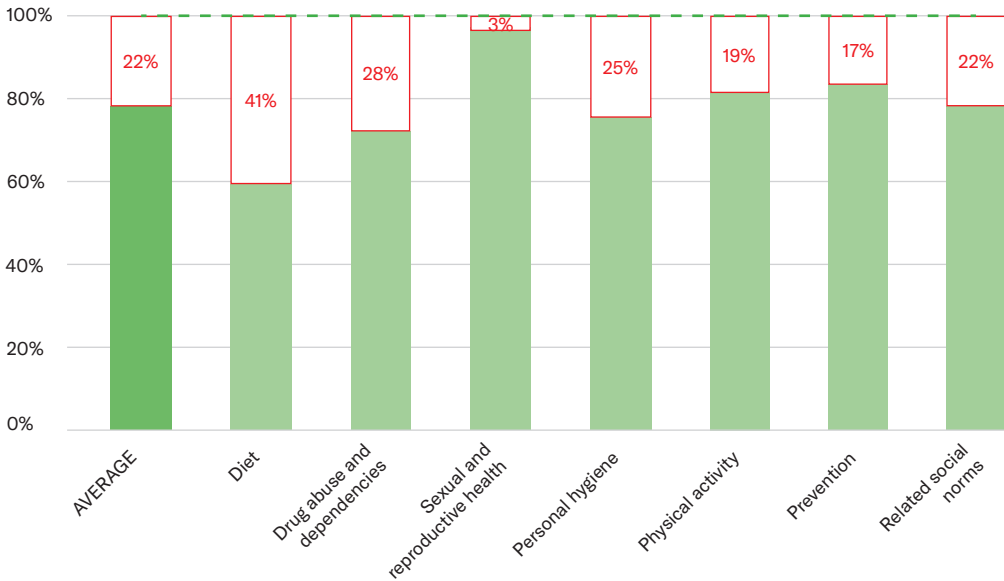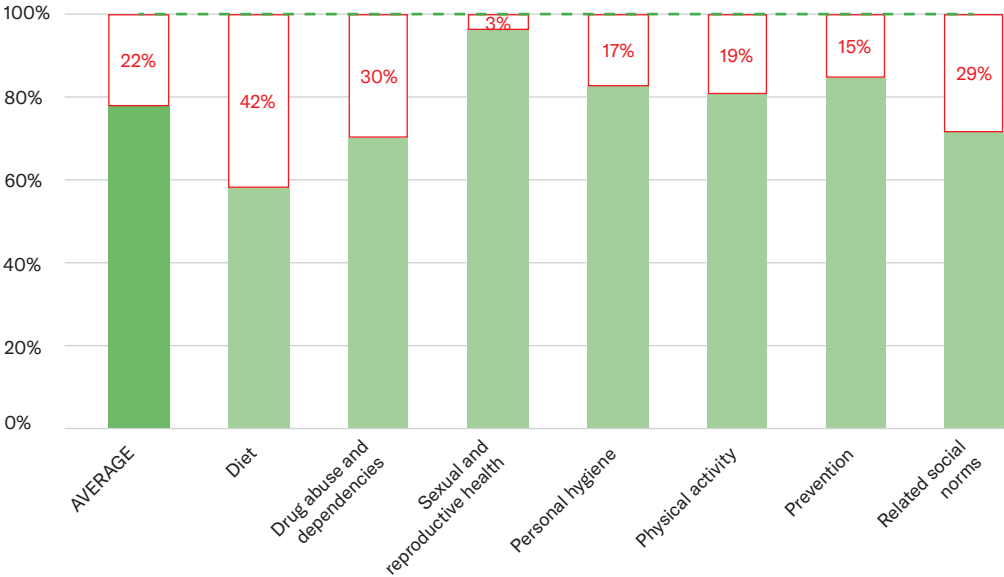
Tab. 1
Needs related to health-related practices – Indicators of social determinants of health included and the values of the relevant ideal situations used to derive the size of the needs

Indicator group	Indicators of the social determinants	Ideal situation value
Diet	A10a	Applies to 100% of households
	A10d–e,g	Applies to 0% of households
	A12a–c	Applies to 100% of households
	A13a–c	Applies to 0% of households
Drug abuse and dependencies	A14a–d	Applies to 0% of households
	A15a–f	Applies to 0% of households
	A17a–d	Applies to 0% of households
Sexual and reproductive health	A18a–c	Applies to 0% of households
	A19b	Applies to 0% of households
Personal hygiene	A20a–f	Applies to 0% of households
Physical activity	A21c–d	Applies to 100% of households
	A22a–d	Applies to 0% of households
	A23a–b	Applies to 0% of households
Prevention	A24a–f	Applies to 0% of households
	A25a–d	Applies to0% of households
Related social norms	A26a–i	Applies to 100% of households
	A27a–c	Applies to 0% of households
	A28c–d	Applies to 100% of households
	A29b–c,f	Applies to 0% of households

Values related to the sub-profile for all target NP HC locations together:

Indicator groups	AVERAGE	Long-term stress	Coping with stress	Social support
Current proportions of house-holds outside the critical level	76.2%	77.4%	67.4%	83.7%
Size of health needs	23.8%	22.6%	32.6%	16.3%

Sub-profile: NP HC locations together
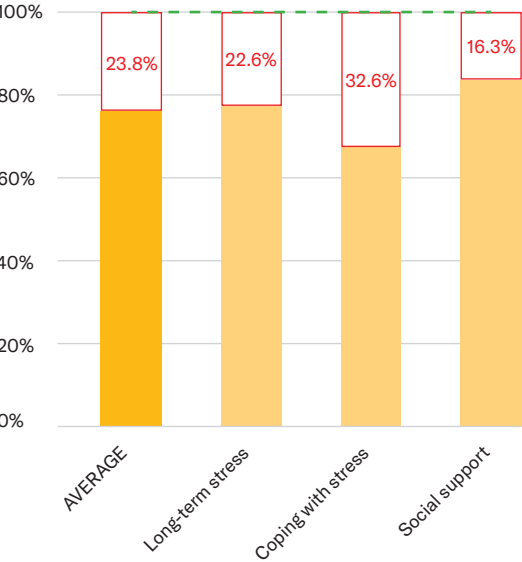
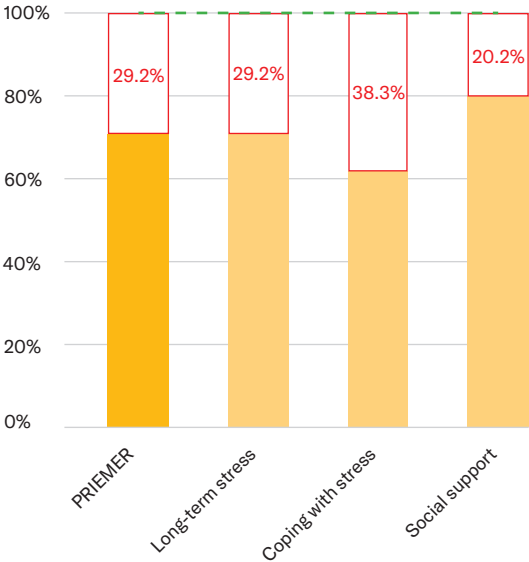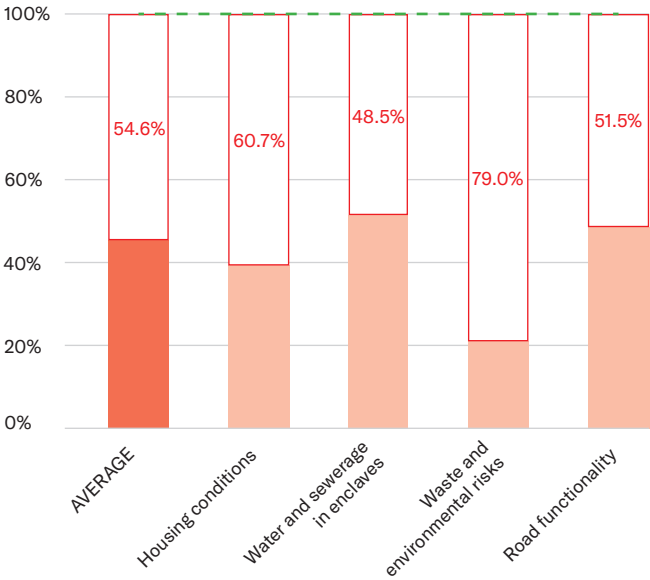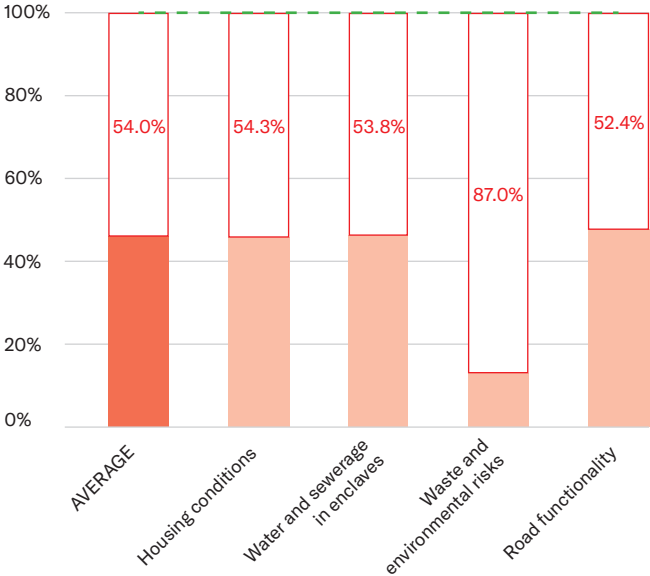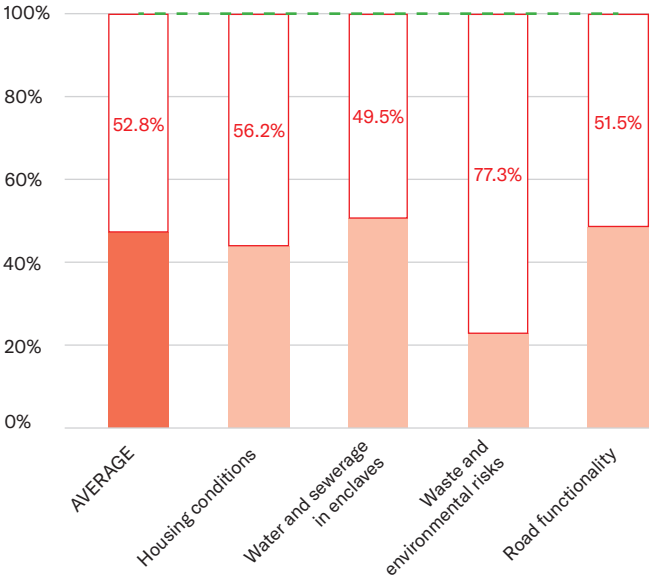**Sub-profile: control locations of the evaluation**
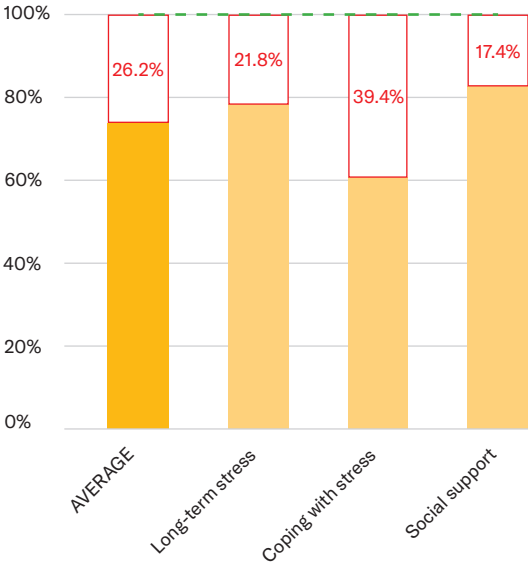
Partial profile: NP HC localities in the Košice region
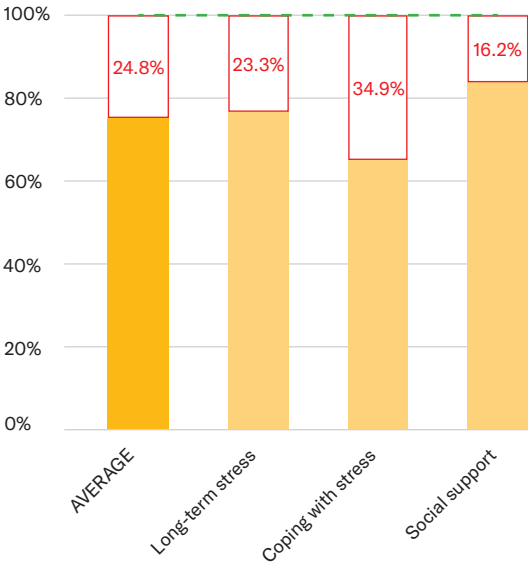
Sub-profile: NP HC localities in the Prešov region
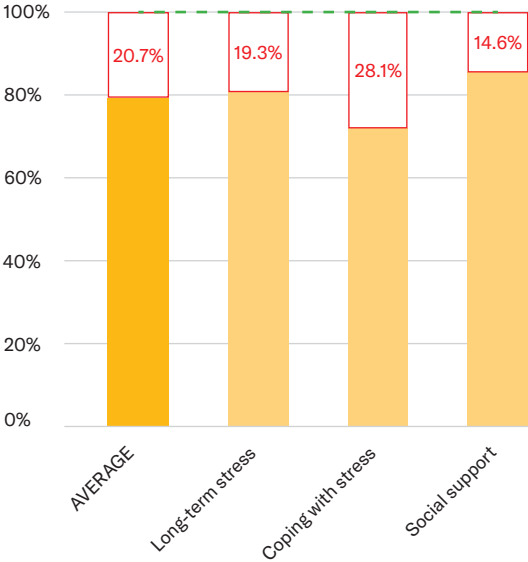
Sub-profile: NP HC localities in the Banská Bystrica region

Tab. 1
Needs related to the psychological burden – included indicators of social determinants of health and values of the respective ideal situations used for observation of the size of needs

Indicator group	Indicators of the social determinants	Ideal situation value
Long-term stress	B30a–k	Applies to 0% of households
	B31a	Applies to 0% of households
	B31b	Applies to 100% of households
Coping with stress	B33a	Applies to 100% of households
	B33b	Applies to 0% of households
	B34a	Applies to 100% of households
	B34b	Applies to 0% of households
Social support	B32a,c,e,g	Applies to 100% of households
	B32b,d,f,h	Applies to 0% of households

Needs related to material conditions

Sub-profile: control locations of the evaluation

Values to the sub-profile for all target NP HC locations together:

1
Initial evaluation assessment category "conditions outside of the dwelling" were divided into specific categories "Water and sewerage in the settlement", "Waste and environmental risks" and "Road Functionality" to illustrate in more detail.

Indicator groups	AVERAGE	Housing conditions	Water and sewerage in enclaves[1]	Waste and environmental risks[1]	Road functionality[1]
Current proportions of house-holds outside the critical level	46.3%	43.3%	49.3%	17.4%	48.1%
Size of health needs	53.7%	56.7%	50.7%	82.6%	51.9%

Sub-profile: NP HC localities in the Košice region
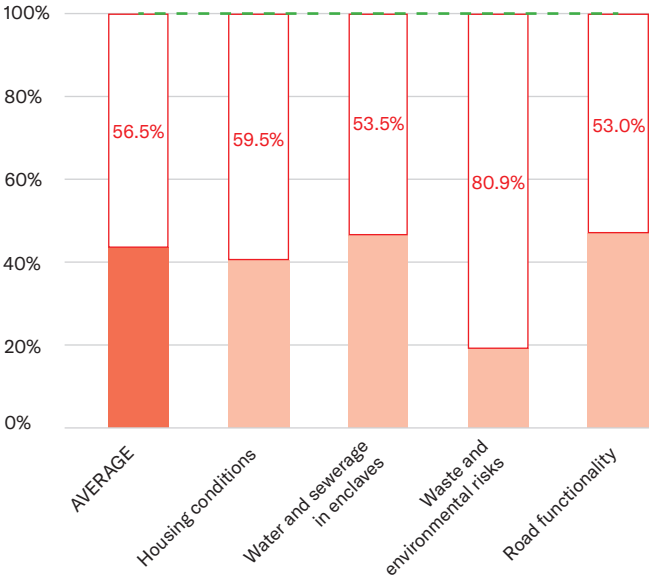
Sub-profile: NP HC locations together

Sub-profile: NP HC localities in the Prešov region

Needs related to health care services access

Sub-profile: NP HC localities in the Banská Bystrica region

Tab. 1
Needs related to health care services access – Indicators of the social determinants of health included and the values of the respective ideal situation used for deriving the size of the needs

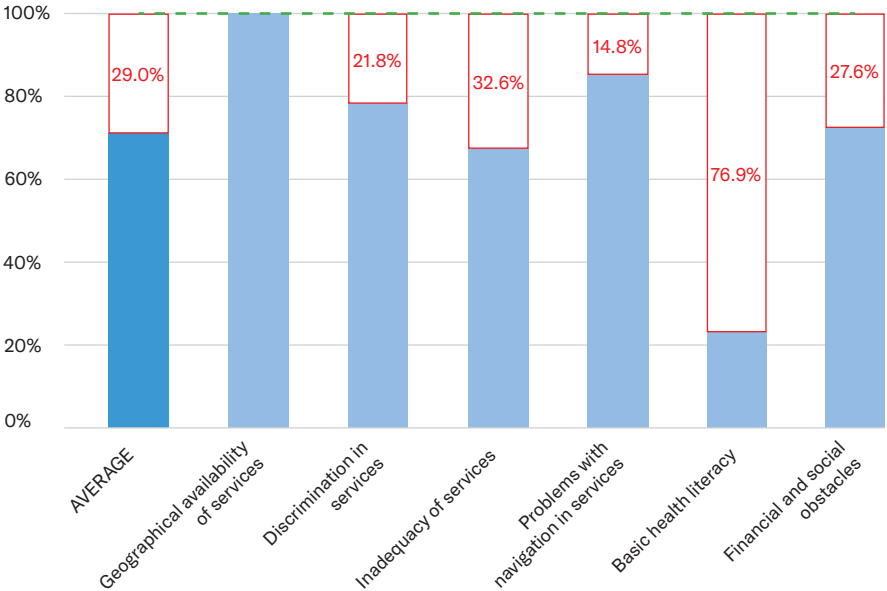| Indicator group	Indicators of the social determinants	Ideal situation value
Housing conditions	C35d	2 or less people per room
	C36a,f–k	Applies to 100% of households
	C36b-d	Applies to 0% of households
Water and sewerage in enclaves	C38c	5 or fewer households not connected to one public source of drinking water
	C37a	Applies to entire enclaves
	C39a	Applies to entire enclaves
Waste and environmental risks	C40a	0 public landfills in the enclaves
	C40d	6 or more removals of large-capacity containers from the enclaves in half a year
	C41a	0 environmental risks in the enclaves
	C41b	Does not apply to the entire enclave
Road functionality	C42a	Applies to entire enclaves
	C42c	0 km of non-functional roads

Values related to the sub-profile for all NP HC target locations together:

| Indicator groups	AVERAGE	Geographical availability of services	Discrimination in services	Inadequacy of services	Problems with navigation in services	Basic health literacy	Financial and social obstacles
Current proportions of house-holds outside the critical level	69.4%	100.0%	72.4%	62.0%	79.1%	30.8%	72.0%
Size of health needs	30.6%	0.0%	27.6%	38.0%	20.9%	69.2%	28.0%

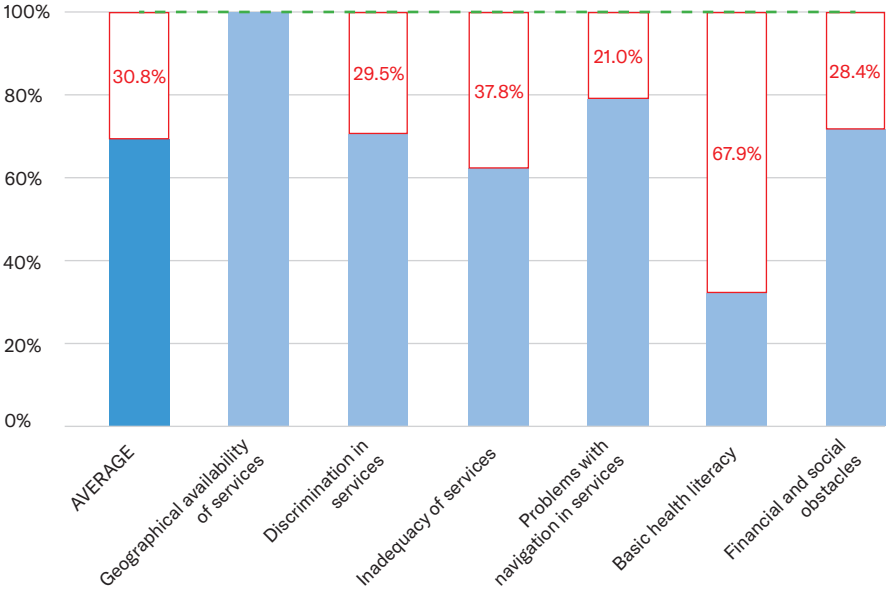**Sub-profile: NP HC locations together**
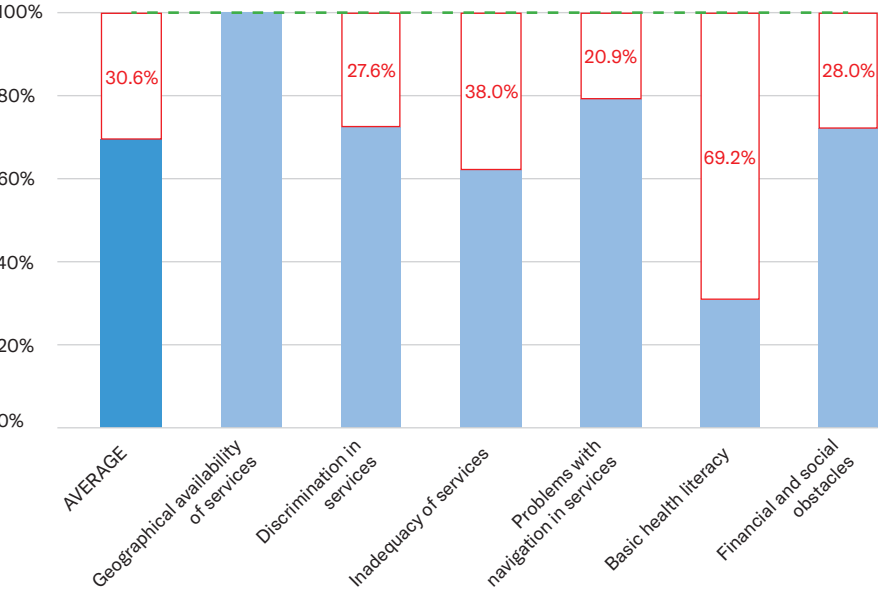
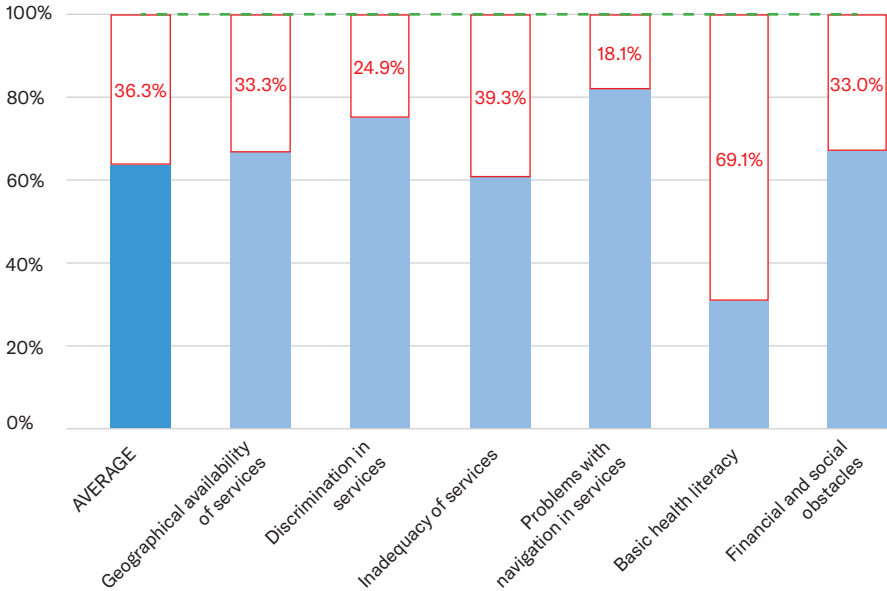**Sub-profile: control locations of the evaluation**

Sub-profile: NP HC localities in the Košice region
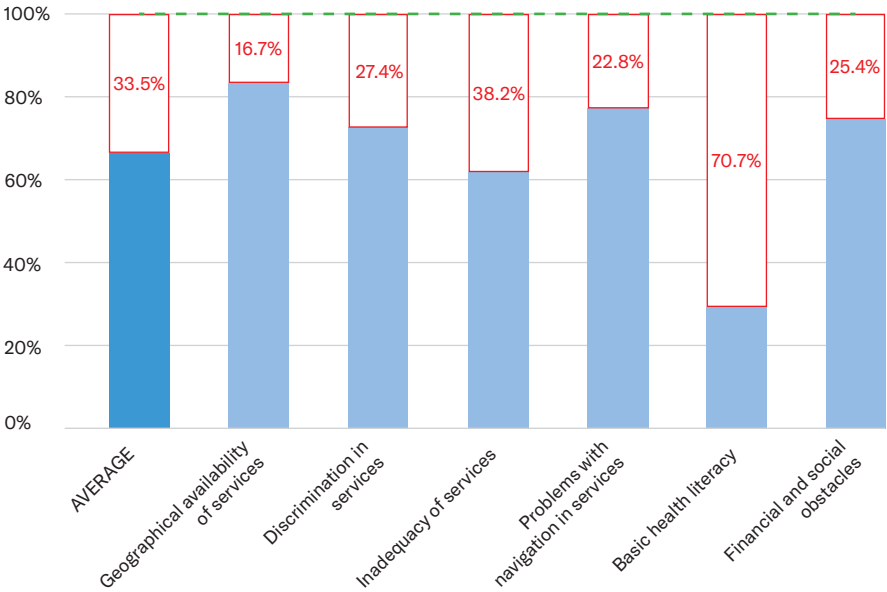
Sub-profile: NP HC localities in the Prešov region

Sub-profile: NP HC localities in the Banská Bystrica region

Tab. 1
Needs related to health care services – Included indicators of the social determinants of health determinants and values of the relevant ideal situations used to derive the size of needs
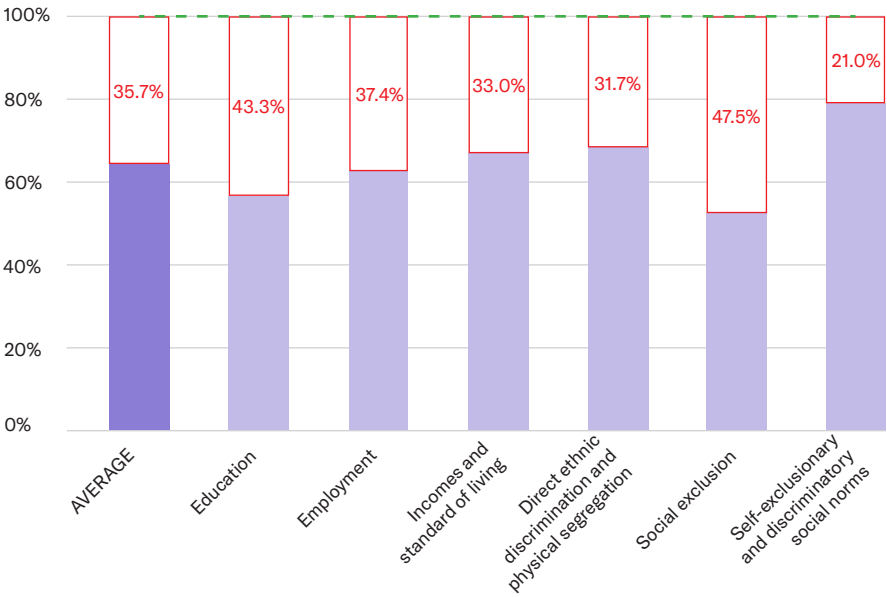
Indicator group	Indicators of the social determinants	Ideal situation value
Geographical availability of services	D43a–f	Distance up to 20 km (included)
Discrimination in services	D45a–j	Applies to 0% of households
	D46b	0 rejections
Inadequacy of services	D47a–j	Applies to 0% of households
Problems with navigation in services	D48a–k	Applies to 0% of households
Basic health literacy	D49a,c,e,g–h	Applies to 100% of households
Financial and social obstacles	D50a–d	Applies to 0% of households
	D51a–d	Applies to 0% of households
	D52a–c	Applies to 0% of households

Needs related to social position and opportunities

Sub-profile: control locations of the evaluation


Values related to the sub-profile for all NP HC target locations together:

Indicator groups	AVERAGE	Education	Employment	Incomes and standard of living	Direct ethnic discrimination and physical segregation	Social exclusion	Self-exclusionary and discriminatory social norms
Current proportions of households outside the critical level	64.3%	56.7%	62.6%	67.0%	68.3%	52.5%	79.0%
Size of health needs	35.7%	43.3%	37.4%	33.0%	31.7%	47.5%	21.0%

Sub-profile: NP HC localities in the Košice region
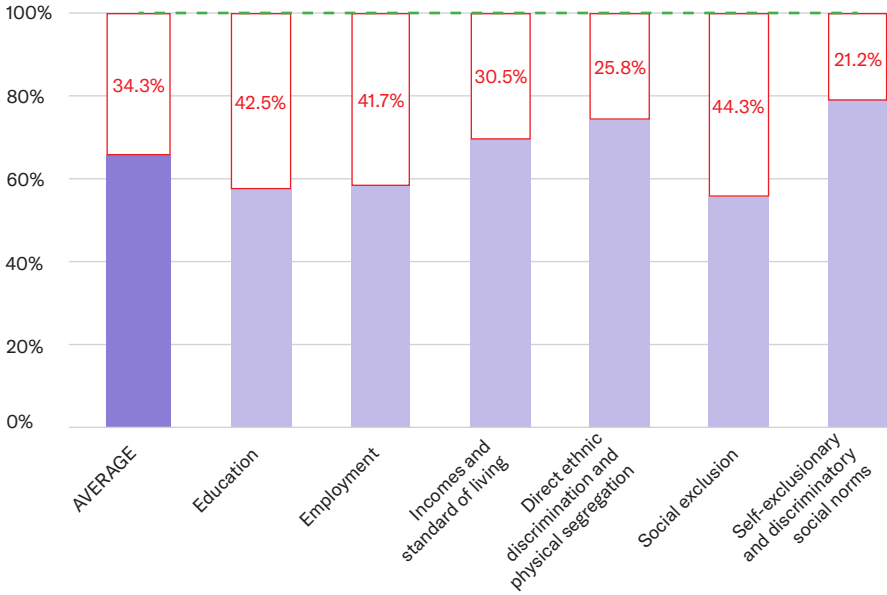
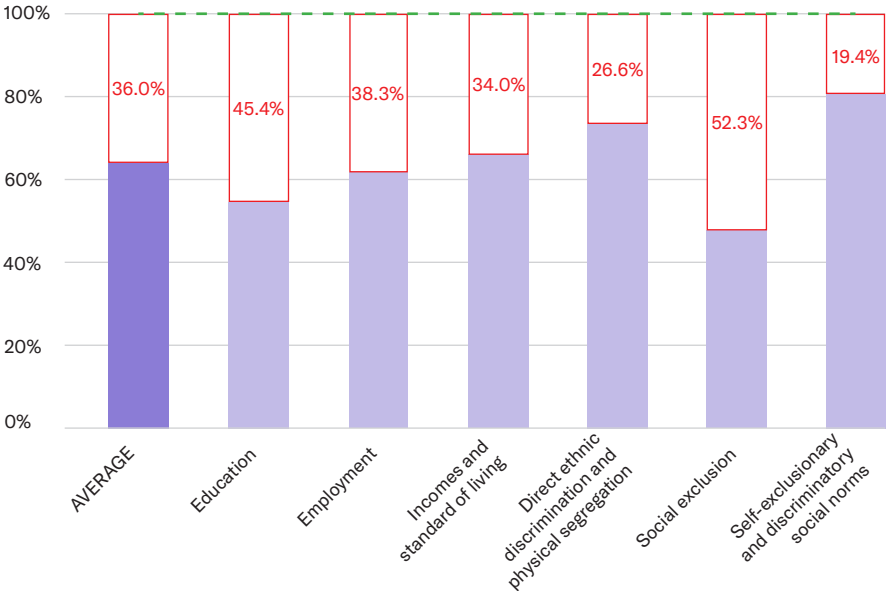**Sub-profile: NP HC locations together**

Sub-profile: NP HC localities in the Prešov region

Sub-profile: NP HC localities in the Banská Bystrica region

# Example of the diversity of individual locations

Tab. 1
Needs related to health care services access – Included indicators of the social determinants of health and values of the relevant ideal situations used for deriving the needs sizes

Indicator group	Indicators of the social determinants	Ideal situation value
Education	E53a	Applies to 100% of households
	E53b	Applies to 0% of households
	E53g–h	Applies to 0% of households
Employment	E54a	Applies to 100% of households
	E54f,i–j	Applies to 0% of households
Incomes and standard of living	E55c	Applies to 0% of households
	E56a,e–f	Applies to 0% of households
	A9a	Applies to 0% of households
	E57b–c	Applies to 0% of households
	E57e	Applies to 100% of households
Direct ethnic discrimination and physical segregation	E58a–e	Applies to 0% of households
	E59a–c	Does not apply to the entire enclave
Social exclusion	E61a–b	Applies to 100% of households
	E61e–f	Applies to 0% of households
	E60a	Applies to entire enclaves
	E60b–d	Does not apply to the entire enclave
Self-exclusionary and discriminatory social norms	E62a–c	Applies to 0% of households
	E63b	Applies to 0% of households
	E64a–c	Applies to 100% of households
	E64d–e	Applies to 0% of households

Summary profile: Municipality X in the Košice-okolie district
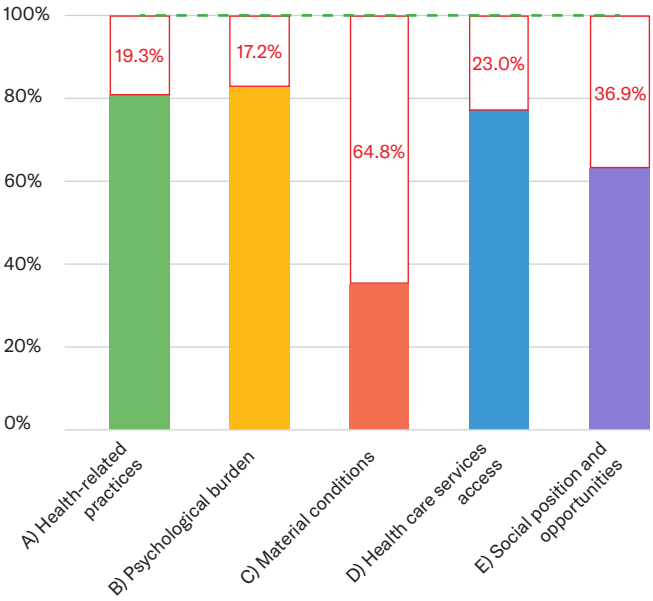
Summary profile: Municipality Y in the Košice-okolie district
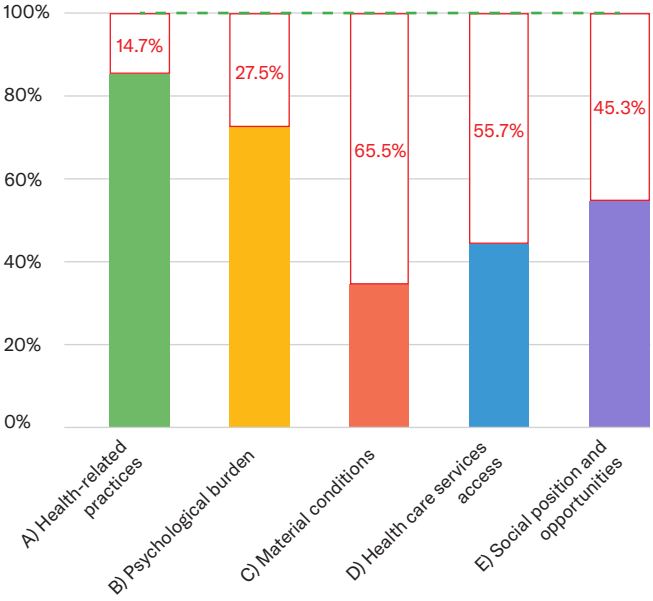
Sub-profile A:
Municipality X in the
Košice-okolie district

Sub-profile B:
Municipality Y in the
Košice-okolie district

Sub-profile A:
Municipality Y in the
Košice-okolie district

Sub-profile C:
Municipality X in the
Košice-okolie district

Sub-profile B:
Municipality X in the
Košice-okolie district

Sub-profile C:
Municipality Y in the
Košice-okolie district

150

PART II

Overview of the health needs assessment results

151

PART II

Overview of the health needs assessment results

**Sub-profile D:
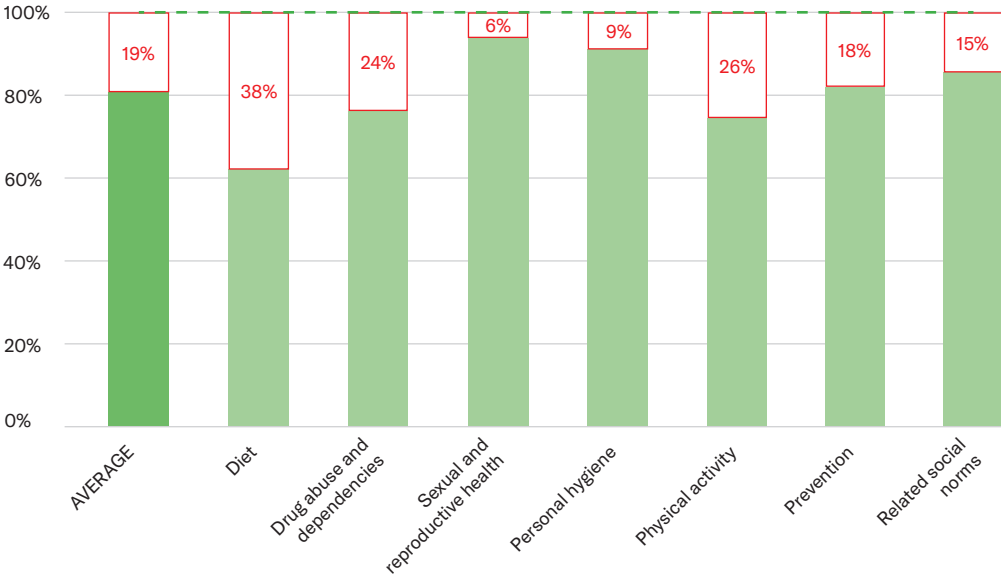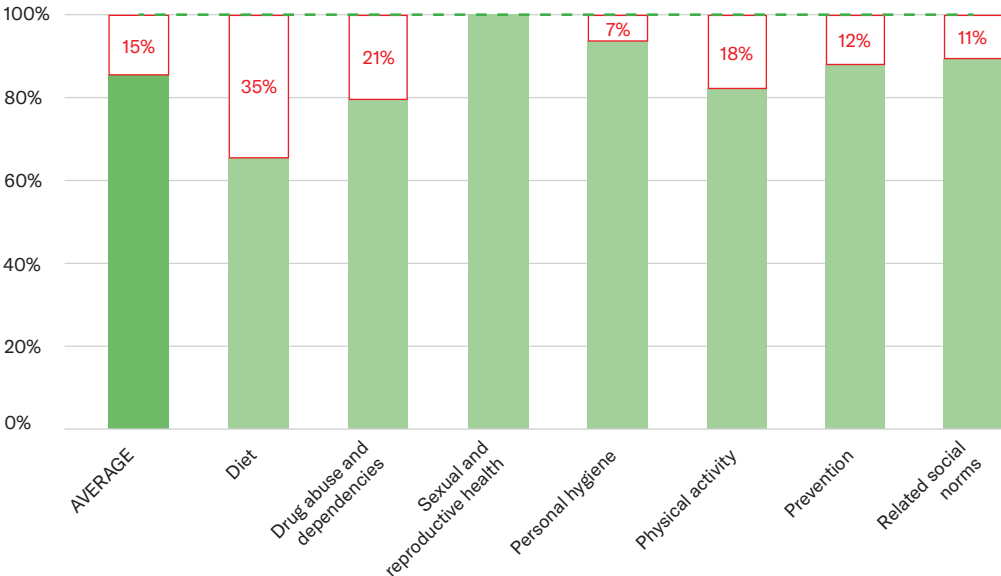Municipality X in the
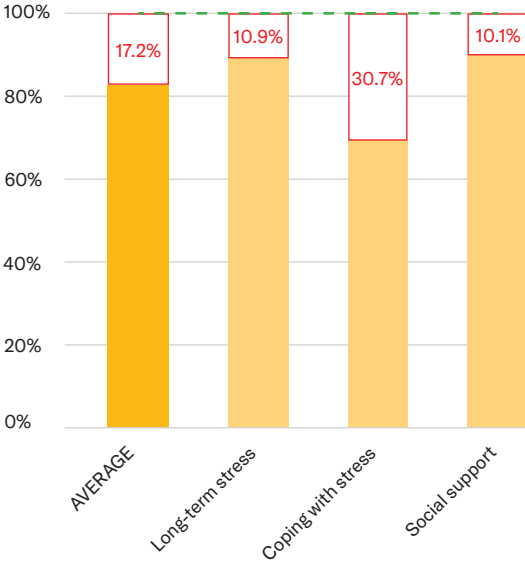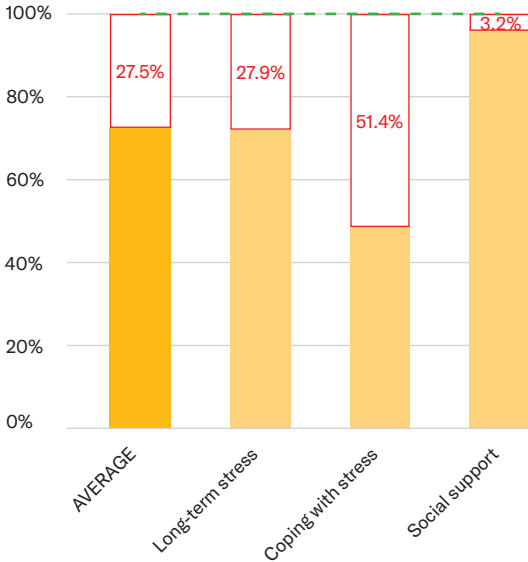Košice-okolie district**

**Sub-profile E:
Municipality X in the
Košice-okolie district**
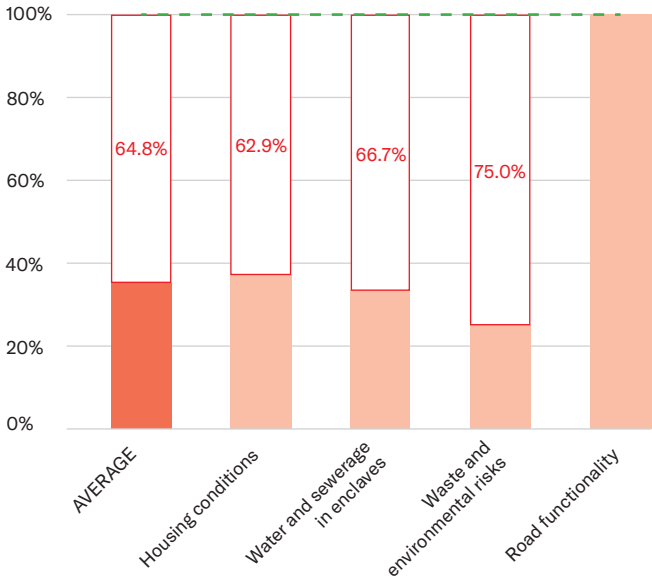

**Sub-profile D:
Municipality Y in the
Košice-okolie district**

**Sub-profile E:
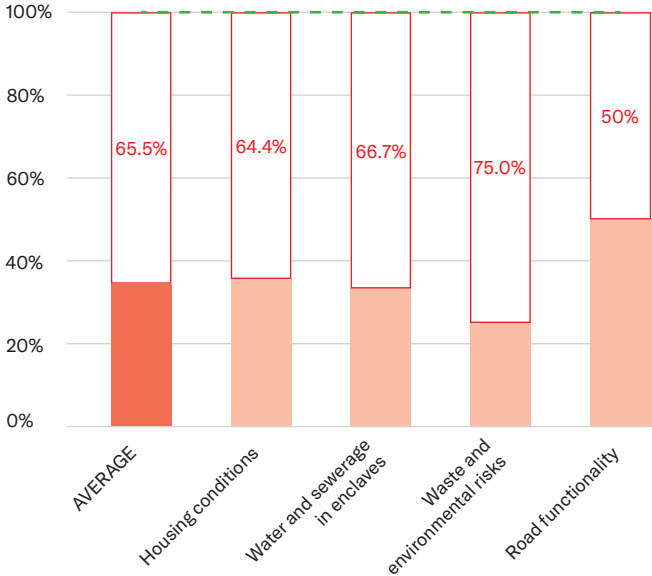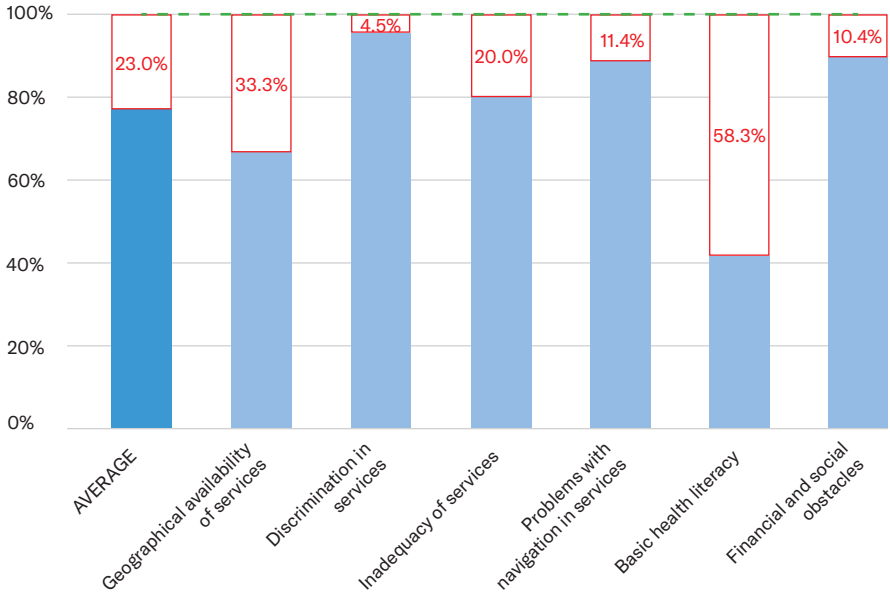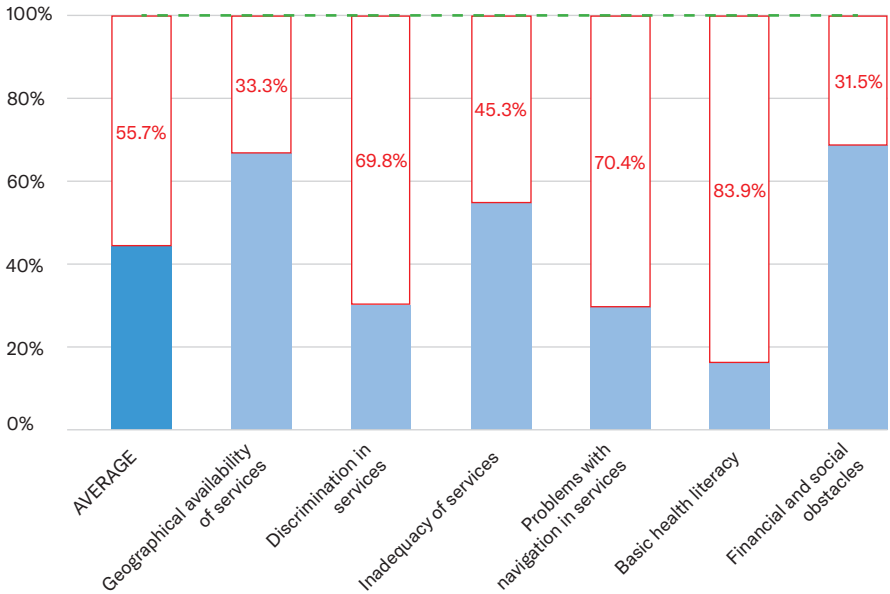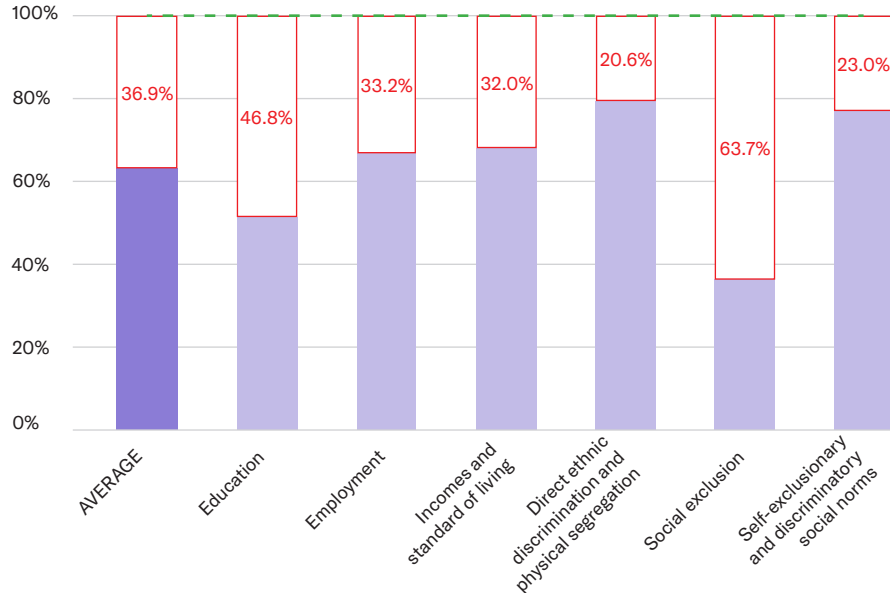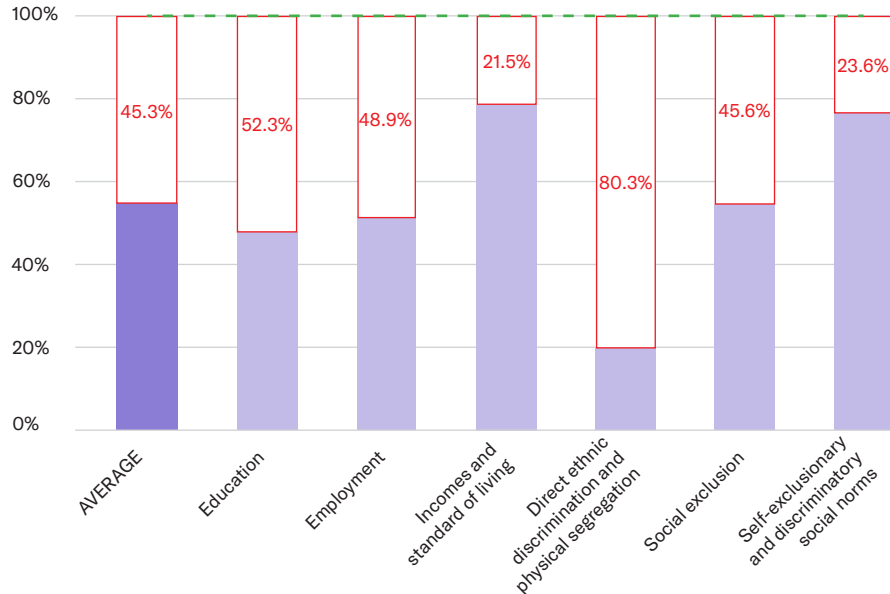Municipality Y in the
Košice-okolie district**

PART III
Methods

Impact evaluation methods

The impact evaluation methodology was guided primarily by its main purpose, which was to provide the input data needed to evaluate the success of the NP HC over a period of time. Following a brief summary of the evaluation framework, this chapter describes the design of the evaluation assessment tools and the course of the initial evaluation assessment. The section concludes with a discussion of the reliability of the evaluation toolkit and the accuracy of the obtained results.

Why did the impact evaluation require an assessment of the determinants of health?

1
A detailed presentation and justification of the chosen approach to the evaluation itself was published in the report Methodology of Impact Assessment of the National Healthy Communities Project from 2018. Within the framework of the fulfilment of the UPJŠ contract – 247/2018, this was the first part of the output from the implementation: "Tasks B – Development of the methodology for initial evaluation and implementation and initial evaluation assessment of the impacts of the NP HC 2A on the social determinants of health in marginalized Roma communities involved in the NP HC 2A".

Evaluating the success of any project can theoretically be considered at different levels: at the level of fulfilling the main purpose, at the level of achieving specific goals set for that purpose, and at the level of fulfilling specific activities planned to achieve the set goals [1–3]. The main purpose of the NP HC is to contribute to the elimination of steep inequalities in health status among the inhabitants of excluded Roma enclaves and the general population in Slovakia by improving the health status of the first group. To this end, the project has set itself the goal of improving the setups of determinants of health in these enclaves. The project tries to fulfil the set goal through health education, mediation and assistance work in selected communities. Therefore, the corresponding possible levels of evaluation of the success of NP HC are the following: The extent to which the NP HC contributes to the elimination of differences in health status between the inhabitants of excluded Roma enclaves and the general population in Slovakia; the extent to which the NP HC improves the setups of social determinants of health in the given enclaves; the extent to which the NP HC provides education, mediation, and assistance in the planned way in the given enclaves.

The evaluation of success of the NP HC exclusively at the level of fulfilment of the main purpose or evaluation only at the level of fulfilment of the planned activities in the given case were not suitable levels of evaluation. According to the assignment, the evaluation of the NP HC aimed at helping the state administration answer not only whether, but also through which

2
See the contracting authority's requirements for complexity and practicality, formulated in the *UPJŠ Contract – 247/2018*. These requirements reflect that from the point of view of state administration, the NP HC presents primarily a pilot of a systemic solution (see, for example, the project application for the NP HC 2A).

3
At the same time, it would be a mere doubling of standard internal evaluations of the project implementation regularly carried out by the NP HC managers.

4
One of the requirements for the evaluation by the contracting authority was the inclusion of economic aspects, i.e., evaluation of NP HC-cost-effectiveness and a cost-benefit analysis. Evaluation of the project at the level of fulfilment of its objectives is also compatible with this requirement. Indeed, individual aspects of the determinants of health are associated with specific impacts on health and healthcare. However, by definition, both types of analysis will only be possible at the end of the evaluation.

processes the project presents an effective tool for eliminating the targeted health inequalities.[2] Evaluation of the NP HC solely according to the degree of fulfilment of the main purpose of the project (improvement of health status) by definition could not answer the second question. Moreover, such an assessment would not be possible due to two major practical obstacles. The first is that data on health inequalities between the inhabitants of excluded enclaves and other populations are still not collected systematically in Slovakia [4] and that their creation *de novo* within the project would not be possible due to financial, legislative and logistical constraints. The second obstacle is the fact that a substantial part of the evaluated activities of the NP HC aim at prevention, whose positive effects on health status in many respects requires much longer periods to develop (e.g. the later onset of diseases of civilization in the population due to a healthier lifestyle). Evaluation of the NP HC solely according to the extent to which the planned activities are carried out would be practically possible, but it would bring no information regarding its impact in terms of fulfilling its objectives or main purpose (improving the social determinants of health and health status, respectively).[3]

The evaluation of the success of the NP HC according to the degree of fulfilment of the set goals – the size of its contributions to the improvement of the determinants of health at the community level – presents the most appropriate level of evaluation for several reasons. First of all, it is theoretically a very convincing measure of potential usefulness also with regard to the main purpose of the project, i.e., improvement of the health status in the excluded Roma enclaves. According to all previous findings, the substandard health status of the inhabitants of excluded Roma enclaves is a direct consequence of the persistence of deficient setups of health determinants at the community level across the enclaves. Also, focusing the evaluation on this level also makes it possible to evaluate the contributions and usefulness of the individual procedures through which the project seeks to fulfil the main purpose. Finally, although the determinants of health represent a similarly wide and varied set of elements as health status, their evaluation is not as demanding logistically as obtaining data related directly to biomedical health status (it does not require, for example, a highly qualified staff, expensive equipment and is not limited by so many strict legislative barriers).[4]

How will it be possible to determine the contributions of the NP HC to the improvement in terms of health determinants?

No project takes place independently from other events. One of the basic problems in evaluating the success of any project is therefore to convincingly determine which changes it has caused and which are not related to it (the so-called attribution problem) [1, 5, 6]. Even reliably measured improvements in setups of health determinants in all target communities of the NP HC for the evaluated period would not necessarily represent the consequences of the work of this project. Such development could be also caused, for example, by a combination of widespread changes in the health or social care system (context) and the effective operation of other helping professions in the same locations (so-called confounders).

The method of evaluation that solves these problems most convincingly is the so-called counter-factual impact evaluation, i.e., evaluation of impact using a control [1, 5, 6]. The basic approach of such an evaluation is to compare the development in the places where the evaluated activities took place (in the so-called target or experimental group) with the development in similar places where the evaluated activities did not take place (in the so-called control group).
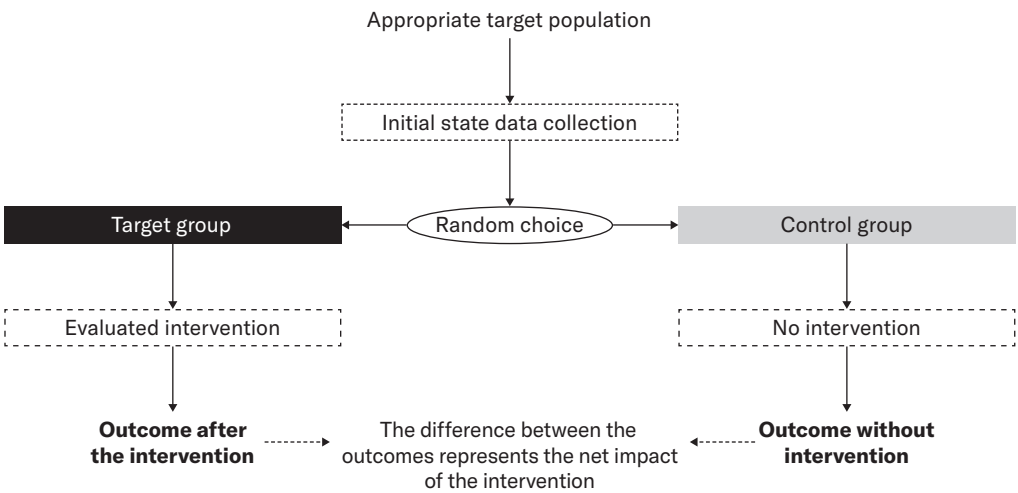
5
The counter-factual approach had for the above reasons been required also by the contracting authority – see the contracting authority's requirements regarding reliability (UPJŠ Contract – 247/2018).

6
Information from the current management of NP HC. In addition, other circumstances that can be considered randomizing, such as administrative decisions to include some locations among the target locations for historic reasons, influenced the initial selection. In terms of evaluation theory, the used design thus can be best classified as a natural experiment with elements of randomization due to administrative errors (EUC 2012).

The high persuasiveness of such an approach to evaluation consists in its intuitive assumption that the development in the control group shows well what would have happened to the target group if it had not been affected by the evaluated activities, because both groups are substantially the same in all other respects.[5]

The UPJŠ evaluation team opted for a specific counter-factual design called natural experiment. In general, the most convincing counter-factual evaluation designs are those where the relevant places for evaluation of the activity are selected in advance and on a random basis (so-called randomized experiments; see Figure III.1). In the given case, however, only the control group could be selected in advance, because the selection of locations in which the NP HC operates (target groups) had already taken place in the past (in the period 2014–16) and was formally non-random.

Fig. III.1
Scheme of a randomized experimental study (amended from EUC 2012). If any of the compared groups cannot be selected in advance and at random, it is a so-called natural experiment.

The accuracy of determining the contributions of the evaluated activities in the natural experiment is lower compared to a randomized experiment in cases where the method of selecting both groups could significantly influence the results of their mutual comparison. The original selection of the NP HC locations could theoretically have such influences. As communities with greater health needs were originally to be selected as target locations of the NP HC, only locations with significantly more favourable initial setups of health determinants could remain available for the control group of the evaluation. This difference could theoretically partially reduce the informative value of group comparisons, for example, because in the less disadvantaged control locations, it could be more difficult to achieve changes of the same magnitude with the same activity at the same time as in the more disadvantaged locations of the target group.

However, additional information obtained upon the evaluation preparation showed that, despite the deliberate choice of "only" a natural experiment, the significance of the final evaluation will, in fact, be closer to that of randomized trials. Field data from the search for control locations (see the locations selection procedure below) and a comparison of the actual levels of social determinants of health in the target and control locations of the NP HC during the initial evaluation phase (see Part I) showed that in the original selection of the project target locations (from 2014), many locations with extremely poor levels of social determinants of health probably "slipped through". The exact degree of randomness in the original selection of target locations according to this criterion cannot be traced back from this finding. However, the main reason for non-compliance with the originally established systematic procedure was that it could, in fact, only work with highly mediated and inaccurate inputs regarding the then levels of health determinants in the locations (others did not exist at the time);[6] thus, considerable randomness can be expected in relation to the focus of this evaluation.

The overall approach of the impact evaluation methodology: radically collaborative research

7
For details on the Healthy Regions' requirements, see UPJŠ Agreement – 247/2018.

8
In the context of the region, compare e.g. with Mušinka et al. 2013, UNDP 2011, or EU-SILC surveys.

9
https://zdraveregiony.eu/

In addition to the unambiguity requirement described above, the choice of specific assessment procedures was most influenced by requirements for the complexity, reliability, practicality and ethical aspects of the methodology and the output of the evaluation. The output was to include statistically reliable data on all types of health determinants that appear to be biomedically relevant (reliability and complexity). At the same time, it was to be immediately usable for the NP HC, especially at the level of each of the hundreds of target municipalities of the project (practicality). Finally, the output was to be obtained and compiled consistently respecting the rights and preferences of the inhabitants of the excluded Roma enclaves which the NP HC targets (ethics).7

All these requirements are fully in line with the general international guidelines for similar research [1, 6]. However, research that would respond to all these recommendations at the same time is, in fact, still not common at all, not even in academic literature [7–9]. Due to the high logistical complexity of a truly comprehensive approach across a large number of locations, most similar research tends to be narrowed down to more specific topics (e.g. selected health determinants) or only to obtaining general values for relatively rough indicators across larger geographical units (for example, regional averages of a small number of indicators covering individual thematic areas).8
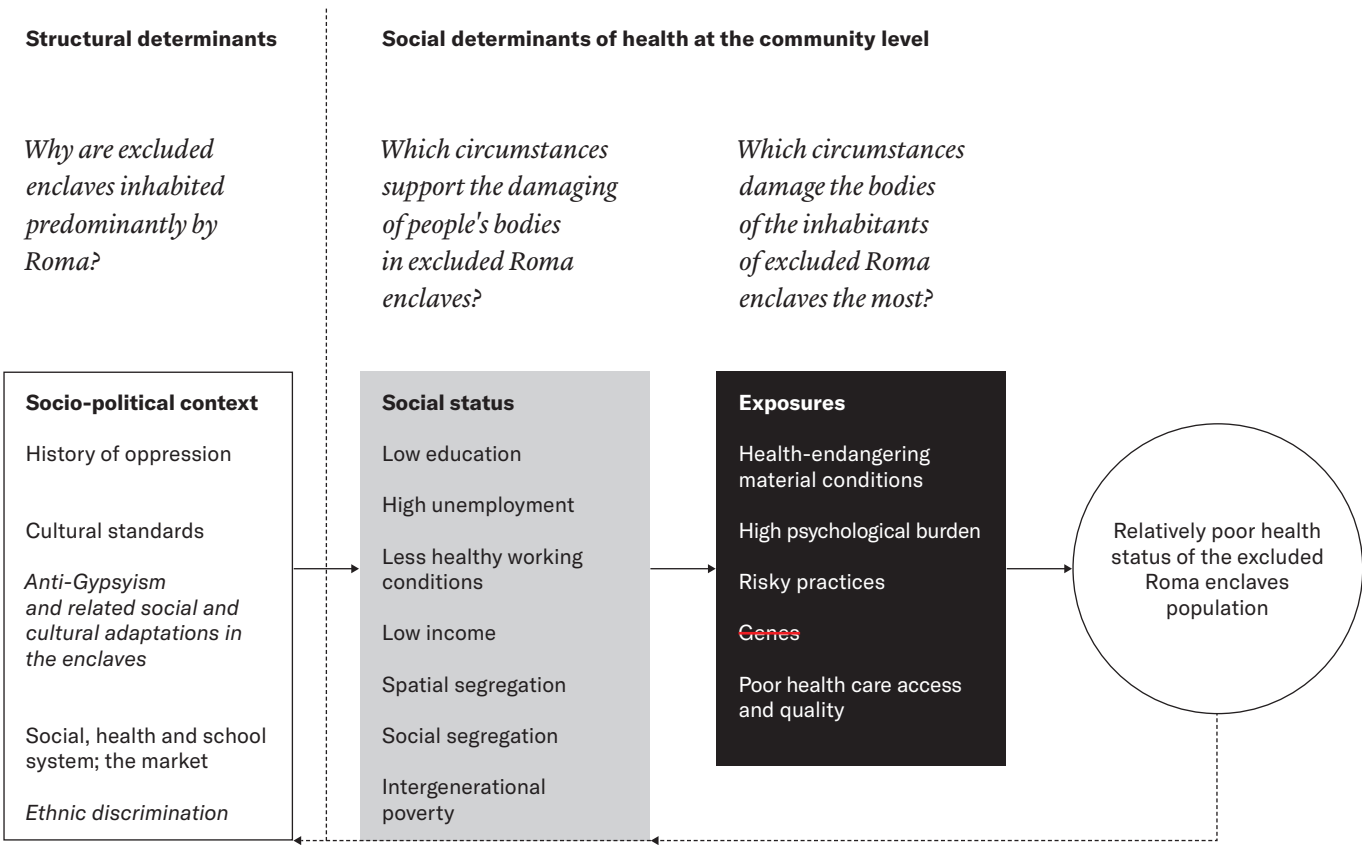
Thanks to the exceptional embeddedness of the NP HC fieldworker personnel within the targeted excluded population, the UPJŠ research team could attempt to replace lacking successful methodological templates with the development of original procedures using a radically collaborative approach to research [10–14]. More than 90% of the almost three hundred employees of the NP HC come directly from the target enclaves of the programme, where they not only work on a daily basis within the project, but also continue to live.9 The collaborative approach invited also these employees of the NP HC to directly help solve any methodological ambiguities and dilemmas using their detailed know-how and personal interest related to themselves being inhabitants of the targeted excluded Roma enclaves.

How were specific determinants of health selected as relevant for the evaluation?

Fig. III.2 →
Community level determinants of health in excluded Roma enclaves in Slovakia and their structural determinants

Figure III.2 summarizes the initial theoretical assumptions of UPJŠ research team regarding the causes of substandard health in excluded Roma enclaves in Slovakia. These assumptions were compiled gradually, combining scientific literature and previous empirical experience as described below. The diagram specifically shows:

· determinants assumed by the UPJŠ research team before the evaluation as significantly affecting the health in the excluded Roma enclaves in Slovakia,
· the groups into which the team divided these determinants for practical reasons,
· the causal relationships assumed between the groups of determinants compiled.

Structural determinants	Social determinants of health at the community level		
Why are excluded enclaves inhabited predominantly by Roma?	*Which circumstances support the damaging of people's bodies in excluded Roma enclaves?*	*Which circumstances damage the bodies of the inhabitants of excluded Roma enclaves the most?*	

Socio-political context

History of oppression

Cultural standards

Anti-Gypsyism and related social and cultural adaptations in the enclaves

Social, health and school system; the market

Ethnic discrimination

Social status

Low education

High unemployment

Less healthy working conditions

Low income

Spatial segregation

Social segregation

Intergenerational poverty

Exposures

Health-endangering material conditions

High psychological burden

Risky practices

~~Genes~~

Poor health care access and quality

Relatively poor health status of the excluded Roma enclaves population

The initial, most general assumptions were taken from the World Health Organization's Framework for the Social Determinants of Health Inequalities (WHO CSDH Framework) [15, 16]. This theoretical framework represents one of the most comprehensive and illustrative reviews of knowledge from epidemiological studies regarding the circumstances most often contributing to health inequalities between larger groups of people, especially in the industrial world. The UPJŠ team took over from the framework its breadth of coverage (what can be considered as health determinants), the traditional divisions of the determinants (e.g. distinction into structural and intermediary determinants) and the assumptions about the likely relationships between individual groups of determinants (e.g. relationship of dominance: social norms → social status → exposure, with feedbacks).

In addition, the research team drew on recent summaries of previous knowledge about the causes of major ethnic health inequalities [17-21]. From this literature, assumptions regarding the negligible influence of heredity (differences in the frequencies of health-relevant genes) and the significant impact of direct and indirect racism and ethnic discrimination were adopted.

The general assumptions merged in this way were consequently compared with the findings from the previous, especially academic, research on selected determinants affecting the health of the excluded Roma enclaves in Slovakia and the wider region. Based on this comparison, preliminary theoretical assumptions were supplemented by several elements, which can also be found in these international recommendations and reviews, but they are not as emphasized, because they are not present everywhere (e.g. phenomena such as spatial segregation or cultural adaptations to racism).

The resulting abstract selection (Figure III.2) was subsequently subjected to additional in-depth discussions on its validity and sufficienc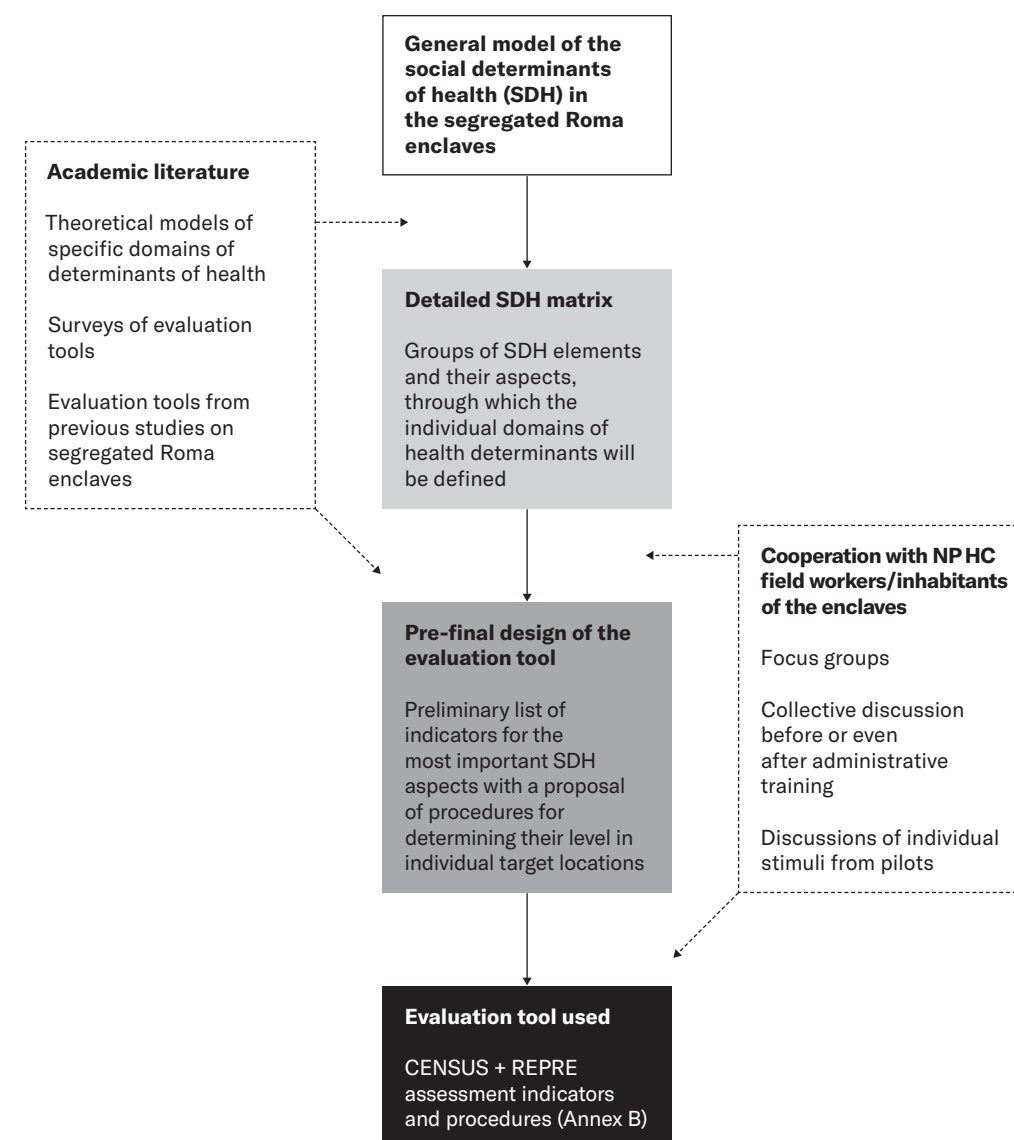y in relation to the situation in the excluded Roma enclaves in Slovakia as part of a dedicated qualitative research phase carried out in 2019. This research did not lead to further adjustments to the initial model.

How were specific aspects and indicators of the selected health determinants identified as most relevant for the evaluation?

After previously identifying the domains of health determinants whose level needed to be measured, the framework had to be supplemented at a more detailed and practical level (operationalized). The procedure used to solve these issues is schematically summarized in Figure III.3.

Based on the source literature, the research team compiled preliminary sets of properties through which the given groups are usually most often defined and assessed. The team elaborated this more detailed theoretical template into a "matrix of social determinants of health in the excluded Roma enclaves", see Table III.1.

Fig. III.3
Diagram of the collaborative process of the evaluation toolkit development

Academic literature

Theoretical models of specific domains of determinants of health

Surveys of evaluation tools

Evaluation tools from previous studies on segregated Roma enclaves

General model of the social determinants of health (SDH) in the segregated Roma enclaves

Detailed SDH matrix

Groups of SDH elements and their aspects, through which the individual domains of health determinants will be defined

Cooperation with NP HC field workers/inhabitants of the enclaves

Focus groups

Collective discussion before or even after administrative training

Discussions of individual stimuli from pilots

Pre-final design of the evaluation tool

Preliminary list of indicators for the most important SDH aspects with a proposal of procedures for determining their level in individual target locations

Evaluation tool used

CENSUS + REPRE assessment indicators and procedures (Annex B)

Health and health care

The most common health problems in the excluded enclaves (infectious diseases, parasitoses, chronic diseases, injuries, congenital malformations)
· Prenatal care
· Neonatal care, infants and toddlers (0–3 years)
· Preschool and school child care (up to 15)
· Adolescent and adult health care (over 15)
· The most common causes of death

Health care services access
· Equipment and accessibility of medical facilities (real availability of the outpatient clinic, of a general practitioner and a paediatrician, emergency room, hospitals, emergency services, dentist)
· Financial availability of services (transport fees, recipes, services)
· Trust in doctors
· Problems with insurance and documentation

Health literacy
· Knowledge of prevention and basic health care in the home environment
· Ability to navigate the health system
· Motivation for prevention and health care
· Social support for prevention and health care
Non-medical health care practices

Lifestyle and risky practices

Nutrition
· Common diet
· Preferred diet
· Hunger

Unhealthy physical activity
· Hard physical work
· Avoiding physical activity

Drugs
· Smoking, alcohol
· Psychotropic drugs and other drugs

Unhealthy sexual and reproductive practices
· Multiple sexual partners
· Unprotected sex
· Marriage of biologically close relatives
· Contraception
· Premature pregnancy and abortions

Material conditions and resources

Housing quality
· Types of dwellings
· Heating and cooking
· Water in the household
· Overcrowding
· Toilets
· Parasites and rodents
· Electricity
· Waste management

Public space and infrastructure
· Legality/illegality of dwellings
· Waste management
· Presence of landfills
· Access roads
· Public water sources

Social capital
- Acquaintances in the village
- Acquaintances at offices
- Solidarity network in relation to health

Violence
- Domestic violence
- Fights

Biological aspects

Community demographics
- Population
- Proportion of people over 60
- Proportion of children under 15
- Average number of children per couple

Genetic influences
- Confirmed hereditary diseases

Psychosocial factors

- Transient stressful situations
- Persistent stressors
- Coping strategies

Social environment of the community

Socio-economic position/poverty
- Unemployment rate
- Types of employment
- Amounts and sources of income
- Educational profile
- Types of schools attended
- Functionality of education

Living standard
- Household indebtedness
- Legal status of dwellings
- Household equipment
- Car ownership

Social pathologies
- Presence and character of usury
- Presence and nature of prostitution
- Presence and character of gambling
- Rate and types of other crime
- Incarceration rate

Sex roles
- Differences in the duties and life trajectories of men and women
- Differences in health and health-related practices between men and women
- Perspectives on non-heteronormative sexuality

Migration
- Presence, rate and types of migration

Discrimination and racism

Manifestations of racism and discrimination in personal contact and in institutions
- Conflicts and segregation in medical facilities
- Conflicts and segregation in schools
- Conflicts with the police
- Conflicts and segregation in other public institutions and in public space

Internalized racism
- Self-underestimation
- Self-exclusion preferences

Socio-political context

Social policies
- Functioning of social welfare services
- Functioning of intervention projects

Legislation
- Problematic laws

This more detailed selection of theoretical assumptions was subsequently subjected to in-depth discussions about their validity and adequacy via dedicated qualitative research phase. This research took place from May to October 2018 at four geographically and socially rather distinct NP HC locations (Rudňany, Trebišov, Litava and Nový Komárnik).

Research in each of the selected places consisted mainly of in-depth interviews about what and how significantly affected the health status of the inhabitants in the given excluded Roma enclaves. The interviews were conducted with representatives of local people, who were expected to have extensive related direct knowledge due to their place of residence and/or jobs. Specifically, these were mainly inhabitants of the enclaves, municipal authorities, social workers, physicians, psychological counselling staff, teachers and staff of the regional public health authorities (RPHA). The theoretical SDH matrix served as a basis for the final structured parts of the interviews (Table III.1).[10]

Based on the findings of the research, the theoretical matrix of the SDH was narrowed down to the most relevant aspects of individual groups of health determinants and subsequently served as a template for the preliminary design of the quantitative assessment instrument itself. First, those elements from the original theoretical matrix of theSDH the effects of which on health were considered to be relatively insignificant across the given diverse locations and agents were excluded (e.g. the occurrence of confirmed hereditary diseases). Subsequently, for the remaining list of significant elements and their specific aspects the measurement standards used in general [9, 22–28] or directly in relation to excluded Roma enclaves were adopted to propose a preliminary assessment tool – sets of indicators and questions to determine respective values. This template was then further adapted according to the findings of previous qualitative research so that on one hand they better corresponded to specific types and ranges of aspects present in excluded enclaves and on the other hand to become more intelligible

for lay administrators, to increase their appropriateness for the social settings and research design.

The thus obtained preliminary assessment tool was then further modified according to suggestions and recommendations of NP HC field workers via several rounds of trial use and critical discussions. This collaborative process as well as further fine-tuning of the instrument aimed at increasing its accuracy also though gradual reduction of the number and complexity of the assessment procedures proposed. Following general recommendations for participatory research on health inequalities [11, 13, 29], the collaborative finetuning included: several days of detailed thematic discussions (focus groups) with selected HPACs; detailed collective discussions, comments and suggestions from all HPACs before and after trial uses (piloting) as part of regional HPA administration training; numerous additional discussions of written and telephone suggestions of individuals from across NP HC organization, and field trials of the administration of the tool final version (cognitive interviews).

Especially during the collaborative "tuning" (validation) of the evaluation tool, the UPJŠ research team had to solve a number of dilemmas regarding the extent to which to adapt standard assessment procedures according to suggestions from NP HC field workers and the team's previous research experience in excluded Roma enclaves. Insistence on standards offered a more convenient path (shortening the lengthy collaborative process and avoiding personal responsibility for the unconventional nature of the adjusted procedures), but in the opinion of all stakeholders seemed to significantly reduce the ability of the assessment tool to evaluate many essential features accurately (or at all). The research team therefore chose the path of customization of standard solutions for most of the dilemmas. The specific advantages and disadvantages of the first and second approaches in the most fundamental dilemmas considered are presented in Table III.2.[11]

10
The procedures, course and other results of this research are summarized in more detail in the Report on the Fulfilment of Tasks and Partial Output from Field Research for the NP HC 2A from 2018.

11
The table also shows the implications of the individual methodological decisions for the possibilities of statistical verification of the accuracy and reliability of the resulting tool – see the conclusion of the chapter for a summary of these aspects.

12

Tab. III.2 →
An overview of relative advantages and disadvantages of the traditional and the used methods

Methodological task	Traditional procedure	Advantages	Disadvantages
Indicator selection and the corresponding procedure for determining the respective values in the enclave	Selection of an item from a standard set of research questions	Better comparability of the results with findings for a given indicator from research from other places	Inability to measure non-standard but locally significant aspects and ranges of values (e.g. standardly unrecorded levels of education, (un)employment status, etc.) → Lower usefulness of results
	Customizing of the item from a traditional set or creation of an item based on qualitative research and collaboration with NP HC field workers	Ability to measure non-standard, but locally significant categories and ranges of values → higher usefulness of results	Worse comparability of results with findings for a given indicator from surveys from other places
Selection of indicator groups to measure a property level	Use a complete standard set of items	More information about the property Better ability to verify the reliability of individual assessment of the level of the same property (e.g. within one household) by comparing related responses (internal consistency tests)	Higher number of detection items in the tool → greater complexity of administration and measurement error, eventually pressure to exclude indicators of other properties due to feasibility
	Selection of the most important items from the traditional set (or sets) based on qualitative research and collaboration with NP HC field workers	Lower number of detection items in the tool → less complex administration and evaluation error; increased feasibility to include more indicators of other properties	Less information about the property Worse ability to verify the reliability of the individual assessments of the same property (e.g. for one household) by comparing related answers (internal consistency tests) → verification of measurement reliability possible only through subsequent evaluations (test-re-test measurements)
Choice of administration language	Formulations from standard sets of questions	Immediate comparability with findings from other research	Lower intelligibility of the survey procedure on the part of administrators and survey respondents → greater complexity of administration and inaccuracy of assessment or more ambiguity regarding the meaning of the findings
	Formulations from standard sets of questions adapted on the basis of qualitative research and collaboration with NP HC field workers	Higher intelligibility of the survey procedure on the part of administrators and survey respondents → less complex administration and inaccuracy of assessment or less ambiguity regarding the meaning of the findings	For comparison with the results of standard surveys, it is necessary to translate the items and possibly also verify the identity of the items being compared (criteria or concurrent criteria validity tests).
Selection of survey administrators	Selection of formally qualified and experienced administrators who do not live in target and control enclaves	Faster administration training Lower risk of local personal interests influencing results	Lower ability to judge and contradict falsehood and inaccuracy of answers, greater distrust on the part of respondents and less personal interest in the accuracy of findings → greater complexity of administration and inaccuracy of assessment or more ambiguity regarding the meaning of the findings Lower feasibility of additional specification of findings or verification of their meanings
	Selection of formally less qualified and relatively inexperienced administrators living (constantly working) directly in the target and control enclaves	Greater ability to assess and dispute the accuracy of answers and less distrust on the part of respondents → less demanding administration and inaccuracy of assessment, or less ambiguity regarding the meaning of the findings Regarding practical research questions, greater personal interest of administrators in the accuracy of the survey Increase in the qualification and standardization of knowledge and procedures of NP HC field workers regarding health determinants High feasibility of additional specification of findings or verification of their meanings	Longer administration training Greater risk of local personal interest influencing results → The need for independent administration control
Approach to administration training	Direct training of administrators	Immediate quality control of training → less diversity of administration procedures and error → greater initial accuracy of detection or less ambiguity regarding the meaning of individual findings	Greater difficulty and longer total training time
	Training of administrators through their superiors (NP HC coordinators)	Possibility of simultaneous training of a sufficient number of administrators for all target locations	Less direct control of training quality → greater variety of administration procedures and error → Necessity of continuous control and adjustment of administration quality or clarifying
Choice of administration procedure	One-time administration	Faster results	Impossibility to adapt to the findings from previous phases → lower accuracy or more ambiguity regarding the meaning and significance of individual findings
	Administration in steps	Ability to adapt the adequacy of the procedures of later phases according to the findings of previous phases → higher accuracy or less ambiguity regarding the meaning and significance of individual findings	A longer process

What did the evaluation tool consist of and how was the evaluation carried out?

Tab. III.3 →
Summary of elements of the evaluation tool used

The process of collaborative development described above provided an original tool for detailed assessment of the setup and levels of health determinants across excluded Roma enclaves. The tool combines direct field survey with a full census of selected items (hereinafter referred to as the CENSUS) and subsequent structured interviewing regarding remaining items in samples of households representative for individual enclaves (hereinafter referred to as the REPRE assessment)[12]. The main elements of the instrument and their functions are summarized in Table III.3. Readers will find the relevant individual items in ANNEX B.

Tool element	Function of the element	Included groups of health determinants and other indicators	Procedure	Related documentation
Administration training	To ensure sufficient administrators to record the values for all selected indicators in all the enclaves of the target and the control groups	All	Training of NP HC coordinators (HPAC) for administration by the UPJŠ researcher team	All documentation for CENSUS and REPRE-assessment
		All	Training of health promotion assistants (HPA) for administration by trained HPACs	All documentation for CENUS and REPRE-assessment
		All	Recruitment and training of administrators for control group enclaves by the NP HC coordinators and the UPJŠ researcher team	All documentation for CENUS and REPRE-assessment
CENSUS	To ensure recording the values of those indicators that can be easily verified via direct observation during the visit to the enclave, i.e. based on a direct field survey	Selected aspects of material conditions, selected aspects of access to health care, size and composition of the population, related parameters of adjacent municipalities	HPAC fill in the electronic form based on structured interviews with HPA and own field survey	HPAC form no. 1
			HPA complete census of buildings, inhabitants, households and household amenities – recording values during a field visit	HPA record sheet no. 1
Selection of REPRE households	Ensure that the findings are representative for each location as part of the REPRE assessment	N/A	Calculation of minimum numbers of households into REPRE assessment samples for all locations (UPJŠ research team according to data for individual locations from the CENSUS)	N/A
REPRE-assessment	To ensure recording the values of those indicators that cannot be easily verified via direct observation during the visit to the enclave, based on administration via structured interviews in samples of households representatives for the given enclaves	Indicators for all remaining groups of health determinants: Health-related practices, material conditions, access to health care, psychological burden, social position and opportunities	HPA randomly addresses households according to the UPJŠ team instructions (minimum number of households for 6 categories) and conducts interviews in them with the members therein considered most competent regarding health-related issues	HPA record sheet no. 1

How were the target and the control locations selected and to what outcome?

The impact evaluation included as the target group the vast majority of all locations in which an NP HC (HPA) health promotion assistant was to work continuously in 2019, see Figure III.4. The planned long-term presence of an HPA made the location a suitable candidate for the target group, because all evaluated health promotion activities of the HPA (but also related supporting activities of HPAC) are bound by the long-term presence of the HPA. Selection of all locations that qualify in this way – instead of the standard selection of only a representative sample of such locations – resulted from two unusual

13
This above-standard requirement was intended to ensure the utility of the results, as opposed to the usually sought average figures for larger geographical units, which are essentially inapplicable for intervention practice in specific locations.

14
Of the 262 suitable enclaves, a final complete assessment was not performed in 23. These were enclaves without currently sufficient coverage of HPA due to long-term work disability, termination, short period of operation, etc.

15
The ideal of two locations for the coordination area was based on the limit of 48 control locations due to limited personnel and financial capacities for the research.

research circumstances. On the one hand, there was a request from the contracting authority for practical results in relation to individual enclaves.[13] On the other hand, there was exceptionally intensive coverage of enclaves from the project, which made it possible to address such a requirement through the involvement of a workforce directly in each target location of the project.[14]
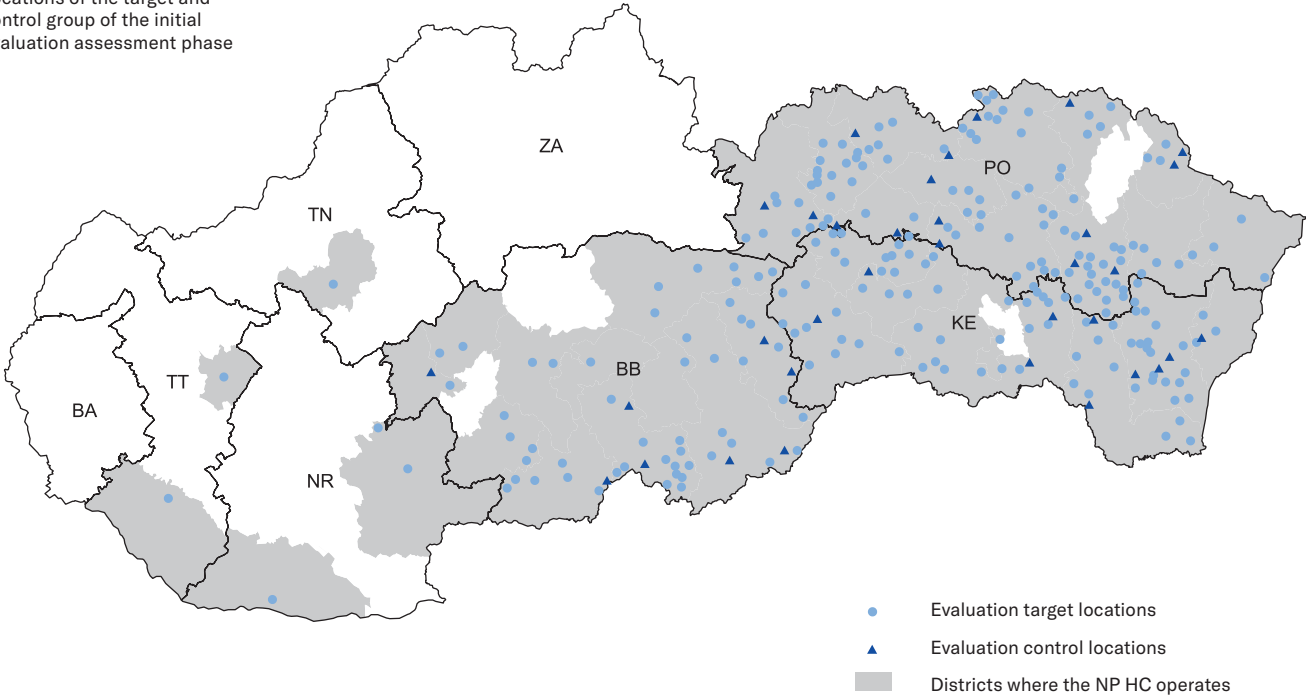
Within the practical limitations of the research, the UPJŠ team selected 34 control locations, lead by two sets of criteria. First, the greatest similarity of each control location with as many target locations as possible. Second, the most even coverage of the whole area of operation of the NP HC. The similarities of the locations were to enable the most accurate determination of the effects of the NP HC for as many individual target locations as possible. The even coverage should support the impact evaluation of the NP HC as a whole. An overview of the specific criteria according to which the control locations were selected, including the justifications and the information sources on which the selection relied, is shown in Table III.4.[15]

Tab. III.4
Justification criteria and sources of information for the selection of control locations
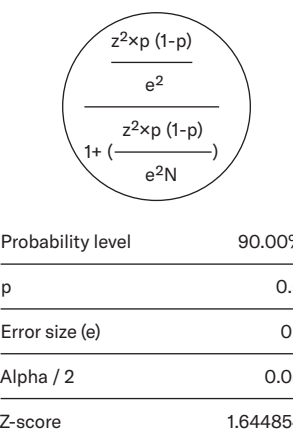
Criterion	Reason (s)	Source of information
The need for HPA in the given locality	Ensuring similarity in health determinants with target NP HC locations	Consultation with HPAC and HPA from the given geographical area
HC never worked in the locality	Ensuring the absence of evaluated activities in the control group	NP HC management
At least 200 inhabitants in the exuded Roma enclave	Ensuring similarity in health determinants with most NP HC target sites + reduction of the effects of chance on the results	Consultation with HPAC + preliminary results of the Atlas of Roma Communities 2019
Possibility to hire an administrator with good access to the given enclaves	Ensuring feasibility of valid assessment in the locality	Consultation with HPAC and HPA from the given geographical area
2 locations per 1 NP HC coordination area	Ensuring good coverage of geographical areas within the scope of NP HC	Consultation with HPAC + preliminary results of the Atlas of Roma Communities 2019

Fig. III.4
Locations of the target and control group of the initial evaluation assessment phase

- Evaluation target locations
- Evaluation control locations
- Districts where the NP HC operates

How did the initial impact evaluation assessment procede?

$$\cfrac{\cfrac{z^2 \times p\,(1-p)}{e^2}}{1 + \left(\cfrac{z^2 \times p\,(1-p)}{e^2 N}\right)}$$

Probability level	90.00%
p	0.5
Error size (e)	0.1
Alpha / 2	0.05
Z-score	1.644854

The CENSUS in the target locations has been running since March 2019 and included 410 excluded Roma enclaves in the territory of 232 municipalities, which at that time were covered by the NP HC (for details, see ANNEX A). The data obtained were based on direct visits by HPA and HPAC in the enclaves. This was a gradual, complete census of the assessed aspects for all individual buildings present in the given locations.

Recruitment of households for the subsequent REPRE-assessments was carried out by HPA according to instructions prepared in advance by the UPJŠ team. Recruitment instructions were developed on the basis of analyses of sociodemographic data for the relevant locations from the previous CENSUS. The instruction for each location determined the minimum numbers of households for different types of households according to material equipment and social status, so that the result would be samples of households representative of individual locations. This stratification of households was based specifically on a combination of two CENSUS indicators: the type of building in which the household resides (brick family house, apartment building or shack, or portakabin) and the presence or absence of a legal and functional water connection in the household. Thus, in theory, there could be a maximum of 6 different groups of households in one location: households in apartment buildings with a water connection, or without water connection, households in brick family houses with or without a connection, and households in shacks or Portakabins with or without a connection.[16]

The REPRE-assessment in the target locations commenced in July 2019. It consisted of structured interviews conducted by HPA according to the relevant documentation (ANNEX B) with members of households of the representative samples. During the interviews, the administrators addressed the members they considered to be the most competent on health issues, following a consultation directly within the household. The interviews covered all aspects of health determinants not covered by the CENSUS and lasted in one household 1–2 hours. In the target group, structured interviews of the REPRE-assessment were carried out in a total of 13,520 households.

In 34 control locations (38 excluded Roma enclaves without NP HC presence), both phases of the initial impact evaluation assessment (CENSUS and REPRE-assessment) were carried out within approximately two months from October 2019. Initial impact evaluation assessment in the control locations (see ANNEX A) was implemented by external administrators with a good access into the selected enclaves, proposed by the regional NP HC coordinators. The structured interviews were conducted as part of the REPRE-assessment here in 1,199 households.

What do we know about the overall accuracy and reliability of the developed assessment tool?

Due to the unconventionality of the assignment and logistical constraints, the NP HC impact evaluation tool could not be validated using standard academic procedures. Thorough preliminary checks of accuracy by comparison with results of other evaluations (statistical tests of external validity) were not possible, because in most respects these were the first assessments of their kind (for most of the included aspects, previous surveys did not aim at representativeness at the individual location level). Thorough accuracy checks by comparing alternative results within the performed measurement (statistical tests of internal validity) were not possible, because the breadth of the research scope (5 diverse areas of health determinants at the community level) did not allow most aspects to be measured simultaneously in several ways. Finally, the required emphasis on collaborative procedures, which is logistically and time-consuming, did not allow consistent preliminary estimates of inaccuracies by repeated subsequent measurements in the same locations (nested test-retest studies).

Therefore, the UPJŠ team tried to ensure the greatest possible reliability of the measuring instrument with the approach recommended for evaluation in previously unresearched areas – emphasis on obtaining and taking into account the most detailed qualitative information about the object of interest and the evaluation situation [22, 30, 31]. The UPJŠ team tried to ensure the accuracy of the instrument itself through collaborative development of individual components of the instrument with administrators and representatives of the target population (see the "tuning" phase of the instrument described above), including cognitive checks (discussions of the adequacy of pilot use results etc.). The appropriateness of the instrument administration was ensured by numerous both random and targeted field inspections carried out during the administration, on the one hand, by the HPAC, and on the other hand by the staff of the UPJŠ research team (representatives of the team checked randomly selected aspects of administration in at least two locations of each of the 24 coordination areas of NP HC).

Given the above mentioned, the available partial external comparisons of results obtained and some additional circumstances, the initial impact evaluation assessment tool can be provisionally considered as exemplarily reliable in the context of research for governance purposes. As for the results of the conceptually unproblematic CENSUS (direct observations of easily verifiable facts), no findings obtained are in direct conflict with the results of other similar surveys from the period (e.g. Atlas of Roma Communities 2019, EU SILC MRK 2019). The REPRE-assessment results also show consistency with previous findings (in this case, especially from narrower academic studies – see Belak 2019). Overall, the above-standard adequacy of the tool in the case of REPRE-assessment is also signalled by an extremely low number of rejections during administration (average response rate up to 94%; for details at the level of individual locations, see ANNEX A). Further, relatively small deviations between many observed averages for larger geographical units, despite the considerable overall variability between locations (see part IV), indicates the same use of the tool by many different administrators. At the same time, the collaborative development of the tool brought about exceptional assessment accuracy, in the practically most important sense – thanks to it, most findings can be interpreted unambiguously, because their meanings were also consulted in detail from the point of view of the respondents [22, 32].

What do we know about the accuracy of specific results?

Upon data acquisition, for specific indicators and locations there were also various complications, especially organizational, related to personnel and procedural. Other complications were also noted in some locations and indicators upon the analyses of the obtained data. These complications generally warn against various possible inaccuracies in the related specific results. In order

to completely exclude the most serious of possible inaccuracies and to draw attention to the less serious ones, all data obtained were compiled into different quality categories according to the nature and degree of the observed complications in their acquisition and analyses before compiling the here presented summaries of the main measurement results. These are two parallel classifications. The first focuses on determining the degree of complications recorded for entire locations, the second on determining the degree of complications encountered by individual indicators.

In the first classification, each of the municipalities in which the research was carried out was assigned for both phases of collection (CENSUS and REPRE-assessment) one of the three degrees defining the overall quality of the data obtained (I–III). Degrees were assigned to locations mainly according to how many indicators in the enclaves had any problems recorded during the fieldwork administration phase. At the same time, however, account was taken of the degree of representativeness of the samples collected and the response rate in the given locations:

Location quality I – No problems encountered during inspections or analyses, required minimum numbers

achieved for all types of households in the sample, response rate above 85%

Location quality II – Problems encountered during inspections or analyses regarding a maximum of 3 specific parameters, response rate above 85%

Location quality III – Problems encountered during inspections or analyses regarding more than 3 specific parameters

In the second classification, one of three reliability degrees were assigned to the individual indicators (A–C). The decisive criterion in this case was the number of locations that encountered problems in collecting or analysing the given type of data:

Indicator quality A – no problems recorded either during inspections or analyses

Indicator quality B – problems recorded during inspections or analyses in less than a quarter of all locations

Indicator quality C – problems recorded during inspections or analyses in more than a quarter of all locations

Methodological recommendations for future needs assessments

· Verification and eventual corrections of the individual results of potentially lower quality (locations II – III and indicators B – C); e.g. during collaborative design of related interventions planned based on the assessment results

· Additional formal determination of the reliability for individual elements of the assessment tool; e.g. through test-retest studies in selected locations

Health needs assessment methods

Overall approach to needs assessment

The requirements for the outputs and the procedure for determining what the target excluded Roma enclaves needed to improve in regard to health were as demanding and pioneering as in the initial impact evaluation assessment of the level of health determinants in these enclaves.[17] They were expected to be statistically significant (reliability), theoretically exhaustive (complexity), immediately usable within the capacities of the NP HC at the level of the individual municipalities (practicality) and sensitive to the target population (ethicality). Judged by state-of-the-art theoretical standards of needs assessment, such requirements were on one hand rather progressive – especially with their radical emphasis on democratism, holism and practicality in defining health needs themselves. On the other hand, they appeared almost utopian, especially due to related considerable conceptual and logistical complexity [11, 13, 29, 33–35].

17
See UPJŠ Agreement – 247/2018

However, in this case it was possible to utilize the already available comprehensive knowledge and results obtained during the previous initial impact evaluation assessment. The review of previous findings preceding the initial impact evaluation assessment provided information on all known causes of poor health in excluded Roma enclaves in Slovakia (Figure 1 in the Summary). The results of the evaluation assessment itself (see Part I) provided data on the deficiencies in the setups of determinants of health across the excluded enclaves down to the level of individual target locations covered by the NP HC project. Finally, the initial qualitative phase of the assessment tool design, as well as the collaborative procedures and selected results of the initial impact evaluation assessment, provided information on the views of the inhabitants of the excluded enclaves regarding the found biomedically defined deficiencies.

How were the health needs constructed?

The UPJŠ implementation team first preliminarily defined the health needs

of the excluded Roma enclaves for the purposes of the NP HC as deficiencies

Fig. III.5
Graphical representation of the applied theoretical relationship between the assessed determinants of health and health needs
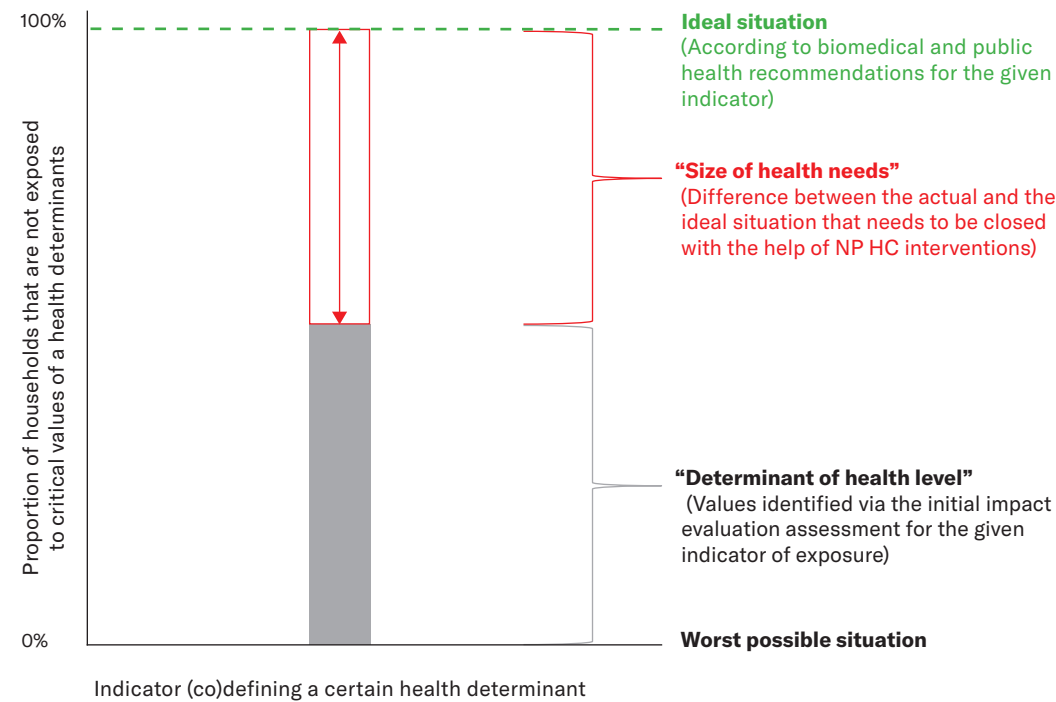
in the local health determinants at the community level. The deficiencies were to be identified by comparing current levels of health determinants in given enclaves with levels ideal from a biomedical point of view. Next, the findings from the initial impact evaluation assessment were used as a theoretically exhaustive and practically meaningful overview of the current health determinants' levels in the enclaves. All indicators for which the identified values were not clearly critical for health from a biomedical perspective (99 out of 301 indicators) were excluded. The actual sizes of the preliminary, biomedically defined health needs were determined for all given indicators and for all locations where the respective values were measured as the differences between the established actual values and the values describing ideal states according to current biomedical and public health recommendations [15, 36] (see Figure III.5).

The assessed needs were to serve primarily to guide the interventions of the NP HC. Therefore, in the case of most indicators, situations in which no excluded Roma households would be exposed to respective critical values were chosen as ideal situations. Most of the results of the needs assessment describe health needs

as shortcomings that need to be addressed at the level of the individual enclaves. More specifically, they describe the extent of these shortcomings as the proportions of the excluded Roma enclaves which were at that time exposed to critical levels of selected health determinants.

The thus constructed preliminary health needs – exposures critical from a biomedical perspective – were then compared with the UPJŠ team's and NP HC field workers' knowledge regarding related views and attitudes of the inhabitants of the target excluded Roma enclaves (discussions with the HPAC, HPA and management of the NP HC 2A). Based on this review, the preliminary needs were subsequently broken down into ethically non-problematic and ethically questionable constructs of needs. The report emphasizes this distinction through the related recommendations for NP HC practice (Part IV). Unhealthy social norms were specifically identified as ethically controversial, as were preferences regarding health-related behaviours (especially regarding personal hygiene, sexuality and reproduction) and social norms and preferences promoting social exclusion (in particular internalized racism and the preference for spatial segregation).

References

1. Bauman, A. and D. Nutbeam, *Evaluation in a nutshell: a practical guide to the evaluation of health promotion programs.* 2013: McGraw Hill.
2. Goodyear, L., et al., *Qualitative Inquiry in Evaluation: From Theory to Practice.* Vol. 29. 2014: John Wiley & Sons.
3. Scriven, M., *Types of evaluation and types of evaluator.* American Journal of Evaluation, 1996. 17(2): p. 151–161.
4. Belák, A., *Segregated Roma and health policies: ethical and practical contradictions [Segregovaní Rómovia a zdravotné politiky: etické a praktické rozpory],* in *Čierno-biele svety. Rómovia v majoritnej spoločnosti na Slovensku,* T. Podolínska and T. Hrustič, Editors. 2015, VEDA Ústav etnológie Slovenskej akadémie vied: Bratislava
5. EUC, *Design and commissioning of counterfactual impact evaluations. A practical guidance for ESF managing authorities.* 2012.
6. WHO, *Evaluation in health promotion: principles and perspectives, in WHO Regional Publications European Series.* 2001.
7. Kaplan, G.A., *What's wrong with social epidemiology, and how can we make it better?* Epidemiol Rev, 2004. 26: p. 124–35.
8. Krieger, N., *Epidemiology and the people's health: theory and context.* 2011, New York: Oxford University Press. x, 381 pages.
9. Garthwaite, K., et al., *Desperately seeking reductions in health inequalities: perspectives of UK researchers on past, present and future directions in health inequalities research.* Sociology of Health & Illness, 2016. 38(3): p. 459–478.
10. Fals Borda, O. and M.A. Rahman, *Action and knowledge: breaking the monopoly with participatory action-research.* 1991: Apex Press.
11. Minkler, M. and N. Wallerstein, *Community-based participatory research for health: From process to outcomes.* 2011: John Wiley & Sons.
12. Schulz, A.J., et al., *A community-based participatory planning process and multilevel intervention design: toward eliminating cardiovascular health inequities.* Health Promotion Practice, 2011. 12(6): p. 900–911.
13. Wallerstein, N.B. and B. Duran, *Using community-based participatory research to address health disparities.* Health promotion practice, 2006. 7(3): p. 312–323.

14. Belák, A., et al., *How Well Do Health-Mediation Programs Address the Determinants of the Poor Health Status of Roma? A Longitudinal Case Study.* International Journal of Environmental Research and Public Health, 2017. 14(12): p. 1569.

15. WHO, *Review of social determinants and the health divide in the WHO European Region: final report.* 2013, WHO Regional Office for Europe: Copenhagen. p. 188.

16. WHO, *A conceptual framework for action on the social determinants of health, in Discussion Paper Series on Social Determinants of Health, 2.* 2010, World Health Organization: Geneva.

17. Dressler, W.W., K.S. Oths, and C.C. Gravlee, *Race and ethnicity in public health research: Models to explain health disparities.* Annual Review of Anthropology, 2005. 34(Oct): p. 231–252.

18. Gravlee, C., *How race becomes biology: Embodiment of social inequality.* American Journal of Physical Anthropology, 2009. 139(1): p. 47–57.

19. Diez Roux, A.V., *Conceptual approaches to the study of health disparities.* Annual review of public health, 2012. 33: p. 41–58.

20. Phelan, J.C. and B.G. Link, *Is racism a fundamental cause of inequalities in health?* Annual Review of Sociology, 2015. 41: p. 311–330.

21. Bailey, Z.D., et al., *Structural racism and health inequities in the USA: evidence and interventions.* The Lancet, 2017. 389(10077): p. 1453–1463.

22. McDowell, I., *Measuring health: a guide to rating scales and questionnaires.* 2006: Oxford University Press, USA.

23. Ibrahim, S. and S. Alkire, *Agency and Empowerment: A Proposal for Internationally Comparable Indicators.* Oxford Development Studies, 2007. 35(4): p. 379–403.

24. Berkman, L.F., I. Kawachi, and M.M. Glymour, *Social epidemiology.* 2014: Oxford University Press.

25. Moore, S. and I. Kawachi, *Twenty years of social capital and health research: a glossary.* Journal of Epidemiology and Community Health, 2017. 71(5): p. 513–517.

26. Levesque, J.-F., M.F. Harris, and G. Russell, *Patient-centred access to health care: conceptualising access at the interface of health systems and populations.* International journal for equity in health, 2013. 12(1): p. 18.

27. Batterham, R., et al., *Health literacy: applying current concepts to improve health services and reduce health inequalities.* Public health, 2016. 132: p. 3–12.

28. Hicken, M.T., et al., *Racial inequalities in health: Framing future research.* Social Science & Medicine, 2018. 199: p. 11–18.

29. Cargo, M. and S.L. Mercer, *The value and challenges of participatory research: Strengthening its practice*.* Annu. Rev. Public Health, 2008. 29: p. 325–350.

30. Flyvbjerg, B., *Five misunderstandings about case-study research.* Qualitative inquiry, 2006. 12(2): p. 219–245.

31. Gravlee, C.C., *Research design and methods in medical anthropology.* A companion to medical anthropology, 2011: p. 69–91.

32. Taherdoost, H., *Validity and reliability of the research instrument; how to test the validation of a questionnaire/ survey in a research.* How to Test the Validation of a Questionnaire/Survey in a Research (August 10, 2016), 2016.

33. Kelly, M., J.E. Powell, and N. Bartle, *Health needs assessment.* 2015.

34. Ross, J.A., *Participatory needs assessment.* The Canadian Journal of Program Evaluation, 2006. 21(1): p. 131.

35. Leung, M.W., I.H. Yen, and M. Minkler, *Community based participatory research: a promising approach for increasing epidemiology's relevance in the 21st century.* International journal of epidemiology, 2004. 33(3): p. 499–506.

36. Šašinka, Nyulassy, and Badalík, *Vademecum medici.* 6 ed. Vademecum medici. 2003, Martin: Osveta. 2252.

PART IV
Findings and recommendations

Findings

The initial impact evaluation assessment and needs assessment were to provide information practical from the perspective of the NP HC, i. e. on individual excluded Roma enclaves. However, already the above results overviews show that the data obtained also provide a wealth of new general information. By this information, the previous general knowledge about excluded Roma enclaves in Slovakia was confirmed and further expanded.[1]

What do the results confirm?

1
Due to its unprecedented detail and representativeness, the data obtained can also be used to explore entirely new, deeper general knowledge, such as causal relationships between different types of determinants or their aspects.

With regards to the confirmatory information, the data obtained clearly document the following:

· **A maximum of half of Slovak Roma** live in excluded Roma enclaves (the CENSUS counted 191,519 inhabitants in the NP HC target locations and in the control locations of the impact evaluation)

· A significant part of the population of these enclaves is exposed to **critical levels of various health determinants** (see the sizes of the identified health needs)
· This exposure is **rather negatively reflected in the health status** of the population of the enclaves (see, for example, the low proportions of people over 60 of the total population)

How do the results expand the existing knowledge?

With regards to the expansion of knowledge, the data obtained provide, for the first time, convincing evidence of the following:

· Significant proportions of the population of a **vast majority of excluded Roma enclaves** in Slovakia are exposed to critical levels of **all types of health determinants at the community level**. (see variances of values for all examined groups of health determinants across regions)
· **Which enclaves** are exposed to **critical levels of which specific health determinants** at the community level (see, for example, the rankings of values for individual locations in type 1 graphs)

- Despite the similarities of most of the average results for larger geographical areas (see, for example, comparisons of the size of needs by region), there are **significant differences** between individual excluded enclaves, even **within relatively small areas** (see, for example, comparisons of the values between coordination areas)
- **The low level of health literacy** of the inhabitants of excluded Roma enclaves (the determinant on which NP HC interventions have traditionally focused) **presents one of the most critical aspects** of their health-related practices
- Despite very unfavourable circumstances – especially social isolation and poverty, substandard material conditions, low health literacy and high psychological burden – **large portions of the population** of excluded Roma enclaves **manage to keep their own risk behaviours outside critical levels** in most respects (see e.g. most substance abuse or sexual and reproductive health indicators)

- Most households in most excluded Roma enclaves are **permanently exposed to varied environmental exposures and other immediate health risks** directly in the dwellings, as well as in the public space of the enclave (see especially the distribution of the rates of absence of basic infrastructure in households and public infrastructure)
- Except for the physical availability of facilities, large portions of the population face **various problems with most aspects of access to health services**, especially in terms of their organization and quality, **including the presence of ethnic discrimination**
- There are **significant differences in the understanding and experience of the same health determinants** between the inhabitants of excluded Roma enclaves, even within individual enclaves (see, for example, differences in the levels of concern when comparing large geographical units with similar material conditions).

Recommendations

General recommendations on health promotion in excluded Roma enclaves

[2]
This recommendation is based on extensive critical feedback, mainly from participating Roma in all phases of the research. In general, they pointed to the widespread open resistance of many residents to interventional approaches that target unhealthy personal preferences, social standards and behaviour without proper consideration or addressing of the fact that such preferences, norms and behaviours are for the most part directly or historically related to the reduced availability of standard living opportunities and services for excluded Roma.

It is already clear from the presented basic overviews of the results of the initial impact evaluation and needs assessment that a **substantial improvement of health** in the excluded Roma enclaves in Slovakia **will not be possible without effective measures and interventions across all assessed domains of health determinants.**

With regards to the domains of determinants that measures and interventions in general have so far focused on the most – health-related practices and access to health care – the following emphases can generally be recommended on basis of the carried-out assessment:

- Improving health through better **health-related practices** on the part of the enclave population would require: increasing the availability of quality food and potable water within dwellings; reducing the overall psychological burden; and replacing personal preferences and social standards that promote unhealthy eating habits and unhealthy ways of coping with stress (especially smoking), with healthier alternatives
- However, personal preferences and social norms related to unhealthy behaviour were found to be very diverse, even within individual enclaves, and the inhabitants of the enclaves often associated them with their ethnic or gender identity. The given area must thus be considered **ethically and practically very problematic** – it is desirable to limit related interventions to sensitive information sharing regarding medical risks and to critical discussions on the possibility that local unhealthy preferences and standards could be a consequence of long-term social exclusion, certainly when approaching people without access to standard infrastructure and with respect to the most intimate topics, such as personal hygiene and sexual and reproductive health[2]

· Addressing the issue of **health care access** needs to focus on all aspects of the organization and quality of physically available services, including the elimination of common direct ethnic discrimination, but also on very low level of health literacy of the services' users (mainly through effective measures and interventions to increase access to quality public education)

Regarding the domains of health determinants to which no measures and interventions have been addressed so far within the framework of health promotion in the excluded Roma enclaves in Slovakia, the following can be generally recommended:

· Improving **material conditions** in the enclaves: provision of standard public infrastructure and functional connections to it for individual households and eliminating possible local sources of other environmental risks (removal of landfills, strengthening of banks, etc.)
· Improving **social opportunities**: eliminating direct and indirect forms of discrimination and segregation of the enclave population by other local people and local institutions in all areas of services, including the labour market; in the case of the presence of personal preferences or social norms, supporting self-exclusion on the part of the inhabitants of the enclaves (e.g. personal preferences of segregation or the presence of internalized racism[3]), it is desirable to sensitively open critical discussions with the targeted people about the possibility that their preferences and norms may represent the immediate or historical consequences of segregation and exclusion
· Reducing the overall **psychological burden**: raising the level of material conditions, improving social status (including the elimination of all forms of ethnic segregation and discrimination) and improving those organizational and qualitative aspects of available health care services that constitute access barriers (including all forms of ethnic discrimination)

Given the considerable variability of health needs profiles across the enclaves, it is further desirable to design, plan, implement and evaluate **any interventions directly in relation to individual enclaves and based on a solid knowledge of local setups of root causes, including local preferences.**

Recommendations for the NP HC

Based on ongoing discussions with NP HC management and HPAC, within the current project capacities the above general recommendations could be most effectively taken into account as follows:

· **Retaining the capacity of health promotion assistants (HPA)** primarily for daily **educational, mediation and assistance work** on behalf of individual families and in relation to the domains of health needs they have addressed so far: health-related practices, health care access and psychological burden
· **Adjusting the emphasis in the work of HPA** as follows:

a) a proactive **priority focus** on increasing the health literacy of the population of the enclaves, especially in terms of basic information on health and the effective use of health care services,
b) persistent, but **reduced activity** in terms of personal assistance with health care access problems and **increasing the emphasis on the educational function** of such assistance (perform only at the request of health professionals or residents and with an effort to ensure the prospect of independence on both sides going forward)
c) provide psychosocial support to the population **only in serious individual cases**

· **Focusing the work of coordinators (HPAC)** exclusively on the supervision and support of the HPA work (prevent using HPAC management capacities for development activities, etc.) and the introduction of long-term **individual HPA work plans for individual locations** based on the needs profiles of the respective locations (adaptation of the overall focus, selection of interventions and setting specific goals directly according to the current state of needs and their local root causes)
· Staff **training adjustments** to take account of the above changes in intervention practices, ideally proposed in cooperation with the representatives of the staff concerned, and **linking of the training with the sectoral education system**, especially in the field of public health (in cooperation with the relevant departments at the Ministry of Health and the Ministry of Education)
· **Development and piloting of a new intervention role focused on** those domains of health determinants that the project has previously not dealt with systematically – **material conditions, health care services quality**, and selected aspects of the social status and opportunities of enclave inhabitants; the new role could be organizationally similar to that of an HPAC but would focus on the given community-level aspects according to the respective needs identified in individual locations and would operate in parallel with the HPAC
· **Development and piloting of a new level of intervention at the central level** focused on **structural determinants** of health that cannot be influenced at the community level – within the Ministry of Health, intersectoral and in relation to other actors and the public (e.g. proactive data collection and analysis of the local health-significant impacts of structural settings and measures in the project locations and related suggestions to the relevant responsible state actors)
· **Setting up a more clear mutual communication and cooperation model with other actors** covering identified needs in the excluded Roma enclaves, especially with Regional Public Health Offices and with other national projects (clear division of tasks, communication rules and coordinated intervention procedures)

Research team

UPJŠ

Mgr. Andrej Belák, PhD
Concept, logistics, field research, database creation, analyses, final report writeup

Mgr. Daniela Fiľakovská Bobáková, PhD
Consultations on the concept and quantitative aspects, field research

Doc. Mgr. Zuzana Dankulincová Veselská, PhD
Consultations on the concept and quantitative aspects

Ing. Ivana Borysová & Ing. Jarmila Frištiková
Concept consultations, financial and administrative management, logistics, emotional support

MUDr. Ingrid Babinská, PhD, MPH
Consultations on epidemiological and public health aspects

Ing. Lucia Bosáková, PhD
Consultations on economic aspects

Mgr. Shoshana Chovan
Field research

External collaborators

Mgr. Jan Ort
Consultations on the concept and qualitative aspects, field research

Mgr. Tomáš Hrustič, PhD
Consultations on qualitative aspects, field research

Mgr. Zuzana Jarošová
Consultations on geographical aspects, preparation of maps, emotional support

Mgr. Eva Mazárová
Field research

Mary Balážová
Ancillary works for data processing and analysis

187

ANNEX A
Overview of included enclaves

Legend

- ×   Unoccupied NP HC eligible locations
- ○   NP HC locations – research did not take place
- ◑   NP HC locations – only CENSUS took place
- ●   NP HC locations – CENSUS and REPREassess
- ▲   Control locations of the impact evaluation
- ▨   Districts covered by NP HC
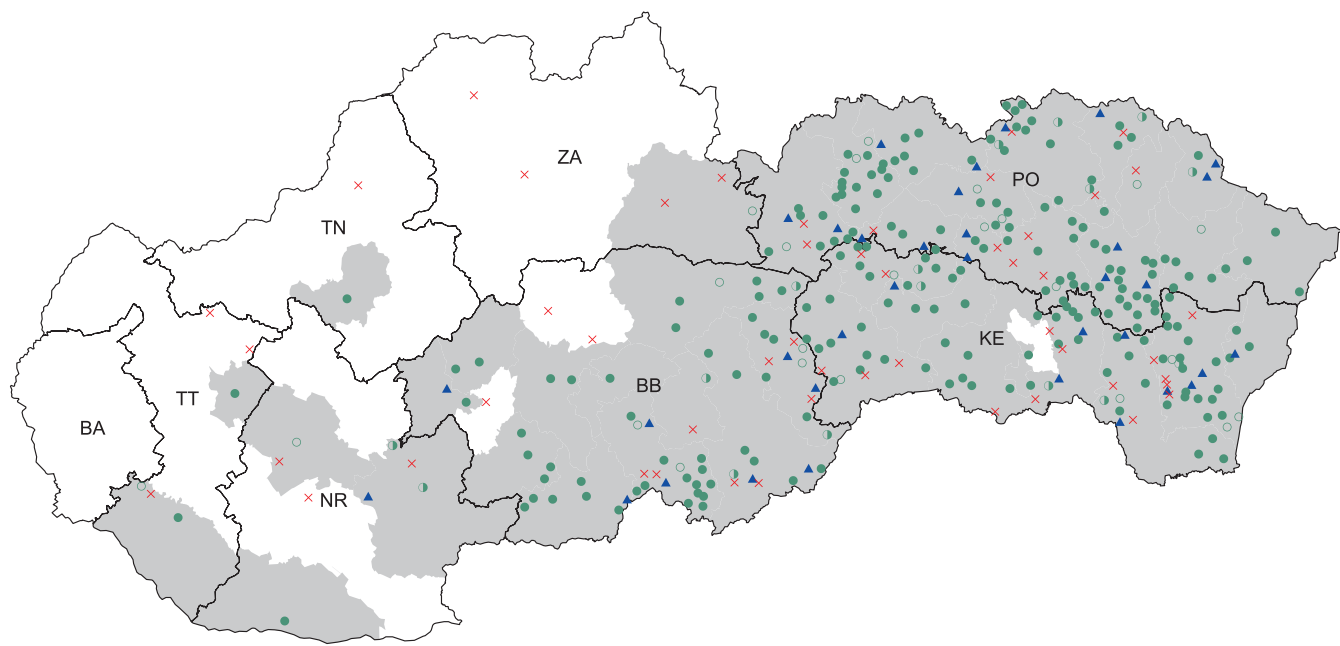
I)   # NP HC 2A Target locations

Municipality	NP HC (2A) coordination area/Other	District	Region	CENSUS			REPRE-assessment		
				Data quality	Number of people in excluded enclaves	Number of excluded enclaves in the municipality	Data quality	Number of households in the sample	Response rate
Arnutovce	Spišská Nová Ves	SN	KE	I	233	1	II	42	100.0%
Bačkov	Trebišov	TV	KE	I	270	1	I	46	100.0%
Bánovce nad Bebravou	Nitra	BN	TN	II	569	3	I	63	94.0%
Banské	Vranov nad Topľou	VT	PO	I	800	1	I	53	100.0%
Bardejov	Bardejov	BJ	PO	I	1432	1	II	54	100.0%
Batizovce	Spišská Nová Ves	PP	PO	I	618	2	II	74	100.0%
Belina	Fiľakovo	LC	BB	III	536	1	II	27	90.0%
Bidovce	Košice-okolie	KS	KE	I	330	1	II	42	77.8%
Bijacovce	Gelnica	LE	PO	I	181	1	I	22	100.0%
Biskupice	Fiľakovo	LC	BB	III	694	1	II	58	96.7%
Blatné Remety	Michalovce	SO	KE	I	430	1	II	53	100.0%
Boliarov	Košice-okolie	KS	KE	I	667	2	II	62	63.9%
Bôrka	Rožňava	RV	KE	I	396	3	II	53	68.8%
Brekov	Snina	HE	PO	I	156	1	II	22	84.6%
Brezno	Zvolen	BR	BB	I	1358	5	II	126	100.0%
Brzotín	Rožňava	RV	KE	I	478	2	I	69	86.3%
Bušince	Veľký Krtíš	VK	BB	I	765	1	I	49	100.0%
Bystrany	Gelnica	SN	KE	I	4212	2	II	164	97.0%
Bystré	Humenné	VT	PO	I	479	1	II	65	76.5%
Bzovík	Zvolen	KA	BB	I	165	1	II	30	100.0%

Municipality	NP HC (2A) coordination area/Other	District	Region	CENSUS Data quality	Number of people in excluded enclaves	Number of excluded enclaves in the municipality	REPRE-assessment Data quality	Number of households in the sample	Response rate
Čakanovce (LC)	Fiľakovo	LC	BB	III	984	1	II	38	100.0%
Čaklov	Vranov nad Topľou	VT	PO	I	1113	1	I	110	100.0%
Čaňa	Košice	KS	KE	II	441	2	N/A	N/A	N/A
Čelovce	Veľký Krtíš	VK	BB	I	227	1	II	48	100.0%
Cerovo	Veľký Krtíš	KA	BB	I	104	1	I	22	95.7%
Červenica	Košice-okolie	PO	PO	I	743	2	I	79	98.8%
Chmeľov	Prešov	PO	PO	I	165	1	I	19	100.0%
Chminianske Jakubovany	Svidník	PO	PO	I	2796	4	II	77	88.5%
Chrásť nad Hornádom	Spišská Nová Ves	SN	KE	I	277	1	N/A	N/A	N/A
Čičarovce	Veľké Kapušany	MI	KE	I	36	1	II	11	100.0%
Čičava	Snina	VT	PO	I	715	2	II	69	90.8%
Čierna nad Tisou	Veľké Kapušany	TV	KE	I	506	2	II	67	95.7%
Čierny Balog	Zvolen	BR	BB	I	629	4	II	81	100.0%
Cigeľka	Bardejov	BJ	PO	I	466	1	II	56	100.0%
Detva	Zvolen	DT	BB	I	731	4	I	80	100.0%
Divín	Fiľakovo	LC	BB	III	356	1	III	41	100.0%
Dlhé nad Cirochou	Snina	SV	PO	I	48	1	II	12	80.0%
Dobšiná	Rožňava	RV	KE	I	1142	2	II	107	74.8%
Doľany-Roškovce	Gelnica	LE	PO	I	545	1	I	57	100.0%
Dolná Ždaňa	Zvolen	ZH	BB	I	56	1	II	9	100.0%
Drahňov	Trebišov	MI	KE	I	370	1	II	8	100.0%
Drienov	Prešov	PO	PO	I	263	1	I	46	100.0%
Drienovec	Košice	KS	KE	I	929	1	I	101	91.8%
Družstevná pri Hornáde	Košice-okolie	KS	KE	I	563	1	II	49	100.0%
Fiľakovo	Fiľakovo	LC	BB	III	2586	5	II	64	88.9%
Fiľakovské Kováče	Fiľakovo	LC	BB	III	300	1	II	22	84.6%
Frička	Bardejov	BJ	PO	I	197	1	II	26	100.0%
Fričovce	Prešov	PO	PO	I	226	1	I	43	100.0%
Gelnica	Gelnica	GL	KE	I	292	4	I	48	94.1%
Gemerská Poloma	Rožňava	RV	KE	I	257	1	II	31	100.0%
Gemerská Ves	Revúca	RA	BB	I	512	3	III	74	93.7%

Municipality	NP HC (2A) coordination area/Other	District	Region	CENSUS Data quality	Number of people in excluded enclaves	Number of excluded enclaves in the municipality	REPRE-assessment Data quality	Number of households in the sample	Response rate
Giraltovce	Sabinov	SK	PO	I	727	1	II	93	100.0%
Hanušovce nad Topľou	Vranov nad Topľou	VT	PO	I	910	3	I	78	100.0%
Hencovce	Vranov nad Topľou	VT	PO	I	206	1	II	29	100.0%
Hermanovce	Prešov	PO	PO	N/A	528	2	N/A	N/A	N/A
Hlinné	Vranov nad Topľou	VT	PO	I	987	1	I	66	81.5%
Hlohovec	Nitra	HC	TT	II	247	5	II	34	100.0%
Hniezdne	Stará Ľubovňa	SL	PO	II	124	1	III	22	84.6%
Hnúšťa	Rimavská Sobota	RS	BB	I	792	8	II	96	88.9%
Hodejov	Rimavská Sobota	RS	BB	I	797	6	N/A	N/A	N/A
Hodruša Hámre	Zvolen	ZC	BB	I	91	3	I	21	100.0%
Holiša	Fiľakovo	LC	BB	N/A	290	1	N/A	N/A	N/A
Holumnica	Stará Ľubovňa	KK	PO	II	599	5	II	60	96.8%
Hrabušice	Spišská Nová Ves	SN	KE	I	982	2	I	88	100.0%
Hranovnica	Poprad	PP	PO	II	1471	2	N/A	N/A	N/A
Hrušov (VK)	Veľký Krtíš	VK	BB	I	110	1	II	26	96.3%
Humenné	Humenné	HE	PO	I	1041	1	II	117	88.6%
Huncovce	Kežmarok	KK	PO	I	1068	1	III	95	95.0%
Iľany	Stará Ľubovňa	KK	PO	II	676	4	II	60	92.3%
Iňačovce	Michalovce	MI	KE	I	196	1	I	26	100.0%
Jakubany	Stará Ľubovňa	SL	PO	II	763	3	I	96	96.0%
Jánovce	Spišská Nová Ves	PP	PO	I	944	1	I	45	81.8%
Jarovnice	Svidník	SB	PO	II	2990	2	II	132	81.5%
Jasov	Košice	KS	KE	I	1610	1	II	87	73.1%
Jastrabie nad Topľou	Vranov nad Topľou	VT	PO	I	101	1	I	16	100.0%
Jelšava	Revúca	RA	BB	N/A	1317	2	N/A	N/A	N/A
Jurské	Stará Ľubovňa	KK	PO	II	921	3	II	48	92.3%
Kamenica nad Cirochou	Humenné	HE	PO	I	225	1	I	40	80.0%
Kamenná Poruba	Vranov nad Topľou	VT	PO	I	766	1	I	70	100.0%
Kapušianske Kľačany	Michalovce	MI	KE	N/A	350	1	N/A	N/A	N/A
Karná	Snina	HE	PO	I	123	1	I	24	100.0%

Municipality	NP HC (2A) coordination area/Other	District	Region	CENSUS Data quality	Number of people in excluded enclaves	Number of excluded enclaves in the municipality	REPRE-assessment Data quality	Number of households in the sample	Response rate
Kecerovce	Košice-okolie	KS	KE	I	2033	3	II	143	74.1%
Kežmarok	Kežmarok	KK	PO	I	556	1	II	39	92.9%
Klenovec	Rimavská Sobota	RS	BB	I	516	5	II	68	86.1%
Kokava nad Rimavicou	Rimavská Sobota	PT	BB	I	300	5	N/A	N/A	N/A
Kolačkov	Stará Ľubovňa	SL	PO	II	401	2	II	49	90.7%
Komárno	Nitra	KN	NR	II	1210	8	I	81	96.4%
Košice Luník IX	Košice	KE	KE	II	2492	2	II	30	75.0%
Košické Oľšany	Prešov	KS	KE	I	342	1	I	55	100.0%
Kosihovce	Veľký Krtíš	VK	BB	I	156	1	I	35	97.2%
Kozárovce	Nitra	NR	NR	II	254	1	N/A	N/A	N/A
Krajná Bystrá	Svidník	SK	PO	I	291	2	N/A	N/A	N/A
Kráľ	Rimavská Sobota	RS	BB	II	282	1	II	44	100.0%
Kráľovce	Košice-okolie	KS	KE	I	304	1	I	46	93.9%
Kráľovský Chlmec	Veľké Kapušany	TV	KE	II	1438	3	I	122	96.8%
Krásnohorské Podhradie	Rožňava	RV	KE	I	959	1	II	99	67.3%
Krásny Brod	Humenné	ML	PO	I	96	1	N/A	N/A	N/A
Krišovská Liesková	Veľké Kapušany	MI	KE	II	72	2	II	14	82.4%
Krížová Ves	Kežmarok	KK	PO	I	1416	1	III	95	86.4%
Krompachy	Gelnica	SN	KE	I	1662	1	II	81	100.0%
Krupina	Zvolen	KA	BB	I	146	3	II	23	100.0%
Kružlová	Svidník	SK	PO	I	461	3	I	47	90.4%
Kučín	Snina	BJ	PO	I	141	1	II	27	93.1%
Kurov	Bardejov	BJ	PO	I	214	1	II	24	100.0%
Kuzmice	Trebišov	TV	KE	I	299	1	N/A	N/A	N/A
Ladomirová	Svidník	SK	PO	I	424	1	II	43	89.6%
Laškovce	Michalovce	MI	KE	N/A	510	1	N/A	N/A	N/A
Lastovce	Veľké Kapušany	TV	KE	I	691	1	II	50	100.0%
Leles	Veľké Kapušany	TV	KE	II	335	2	II	45	100.0%
Lenartov	Bardejov	BJ	PO	I	733	1	I	58	100.0%
Lesíček	Prešov	PO	PO	I	243	1	II	28	100.0%
Lesné	Humenné	MI	KE	I	40	1	I	7	100.0%
Letanovce	Spišská Nová Ves	SN	KE	II	868	1	II	39	100.0%

Municipality	NP HC (2A) coordination area/Other	District	Region	CENSUS Data quality	Number of people in excluded enclaves	Number of excluded enclaves in the municipality	REPRE-assessment Data quality	Number of households in the sample	Response rate
Levice	Nitra	NR	NR	II	386	2	N/A	N/A	N/A
Levoča	Spišská Nová Ves	LE	PO	I	579	2	II	32	61.5%
Lipany	Sabinov	SB	PO	N/A	800	1	N/A	N/A	N/A
Liptovská Teplička	Poprad	PP	PO	I	463	2	II	32	86.5%
Litava	Zvolen	KA	BB	I	215	1	II	35	100.0%
Lomnička	Stará Ľubovňa	SL	PO	II	2361	7	II	110	97.3%
Ľubica	Kežmarok	KK	PO	I	645	1	II	32	84.2%
Lučenec	Veľký Krtíš	LC	BB	I	527	2	I	36	81.8%
Lukov	Bardejov	BJ	PO	I	238	1	II	26	100.0%
Magnezitovce	Revúca	RA	BB	N/A	250	2	N/A	N/A	N/A
Malá Domaša	Snina	VT	PO	I	196	1	II	33	84.6%
Malčice	Veľké Kapušany	MI	KE	I	685	1	II	49	96.1%
Malcov	Bardejov	BJ	PO	I	402	1	N/A	N/A	N/A
Malý Slavkov	Kežmarok	KK	PO	I	396	1	III	22	81.5%
Malý Slivník	Prešov	PO	PO	I	739	1	I	75	100.0%
Marhaň	Sabinov	BJ	PO	I	180	1	N/A	N/A	N/A
Markušovce	Spišská Nová Ves	SN	KE	N/A	2921	1	N/A	N/A	N/A
Medzev	Košice	KS	KE	I	1129	1	I	116	89.2%
Medzilaborce	Humenné	ML	PO	I	909	3	III	62	78.5%
Michalovce	Michalovce	MI	KE	I	1245	1	II	65	100.0%
Mirkovce	Košice-okolie	PO	PO	N/A	945	2	N/A	N/A	N/A
Mníšek nad Hnilcom	Gelnica	GL	KE	I	789	2	I	93	100.0%
Modrý Kameň	Veľký Krtíš	VK	BB	I	305	1	I	60	100.0%
Moldava nad Bodvou	Košice	KS	KE	I	1658	2	II	104	86.7%
Muráň	Revúca	RA	BB	I	393	1	II	49	94.2%
Muránska Dlhá Lúka	Revúca	RA	BB	I	424	1	II	56	91.8%
Nacina Ves	Humenné	MI	KE	I	535	1	I	54	87.1%
Nálepkovo	Gelnica	GL	KE	I	1394	5	III	107	100.0%
Nitra	Nitra	NR	NR	N/A	1900	5	N/A	N/A	N/A
Nižný Hrabovec	Snina	VT	PO	I	113	1	I	23	85.2%
Nižný Tvarožec	Bardejov	BJ	PO	I	258	1	I	27	100.0%
Nižný Žipov	Trebišov	TV	KE	N/A	579	3	N/A	N/A	N/A

				CENSUS			REPRE-assessment		
Municipality	NP HC (2A) coordination area/Other	District	Region	Data quality	Number of people in excluded enclaves	Number of excluded enclaves in the municipality	Data quality	Number of households in the sample	Response rate
Ochtiná	Rožňava	RV	KE	II	317	1	II	40	100.0%
Ondavské Matiašovce	Snina	VT	PO	I	268	1	II	34	94.4%
Ostrovany	Sabinov	SB	PO	I	1482	1	I	135	100.0%
Parchovany	Vranov nad Topľou	TV	KE	I	287	1	I	36	100.0%
Pašková	Revúca	RV	KE	I	226	1	I	41	100.0%
Pavlovce nad Uhom	Michalovce	MI	KE	I	1802	1	II	93	100.0%
Pečovská Nová Ves	Sabinov	SB	PO	I	655	1	I	95	100.0%
Petrová	Bardejov	BJ	PO	I	641	1	III	70	100.0%
Petrovce nad Laborcom	Humenné	MI	KE	I	245	2	I	23	100.0%
Plešivec	Revúca	RV	KE	N/A	96	2	N/A	N/A	N/A
Podhorany	Stará Ľubovňa	KK	PO	II	1181	5	I	122	95.3%
Pohorelá	Poprad	BR	BB	I	208	1	II	39	88.6%
Polomka	Poprad	BR	BB	N/A	595	3	N/A	N/A	N/A
Poprad	Poprad	PP	PO	I	519	1	II	54	91.5%
Poráč	Gelnica	SN	KE	II	270	1	N/A	N/A	N/A
Poša	Humenné	VT	PO	II	368	1	II	25	45.5%
Prešov	Prešov	PO	PO	I	944	1	I	85	100.0%
Radzovce	Fiľakovo	LC	BB	III	1187	1	III	61	100.0%
Rakúsy	Kežmarok	KK	PO	I	2547	1	III	126	86.3%
Rankovce	Košice-okolie	KS	KE	I	732	1	I	70	87.5%
Raslavice	Sabinov	BJ	PO	I	428	1	I	67	100.0%
Ratková	Revúca	RA	BB	I	356	1	II	51	100.0%
Ražňany	Sabinov	SB	PO	N/A	300	1	N/A	N/A	N/A
Rejdová	Rožňava	RV	KE	I	240	1	II	36	55.4%
Revúca	Revúca	RA	BB	I	968	2	I	88	89.8%
Richnava	Gelnica	GL	KE	I	1857	1	II	83	100.0%
Rimavská Seč	Rimavská Sobota	RS	BB	I	517	6	I	72	100.0%
Rimavská Sobota	Rimavská Sobota	RS	BB	I	898	3	II	81	77.9%
Rimavské Janovce	Rimavská Sobota	RS	BB	I	340	1	I	44	100.0%
Roštár	Rožňava	RV	KE	I	353	1	II	57	91.9%
Rožkovany	Sabinov	SB	PO	I	151	1	II	33	100.0%

				CENSUS			REPRE-assessment		
Municipality	NP HC (2A) coordination area/Other	District	Region	Data quality	Number of people in excluded enclaves	Number of excluded enclaves in the municipality	Data quality	Number of households in the sample	Response rate
Rožňava	Rožňava	RV	KE	I	954	2	II	103	82.4%
Rudňany	Gelnica	SN	KE	I	2039	5	I	120	100.0%
Ruská	Michalovce	MI	KE	N/A	130	1	N/A	N/A	N/A
Ružiná	Fiľakovo	LC	BB	N/A	306	1	N/A	N/A	N/A
Sabinov	Sabinov	SB	PO	I	936	1	I	110	100.0%
Sačurov	Vranov nad Topľou	VT	PO	I	1070	1	I	98	100.0%
Šamudovce	Michalovce	MI	KE	I	361	1	I	49	100.0%
Šarišská Poruba	Prešov	PO	PO	I	278	1	I	32	100.0%
Šarišská Trstená	Prešov	PO	PO	I	116	1	II	14	100.0%
Šarišské Jastrabie	Sabinov	SB	PO	I	613	1	II	51	100.0%
Šávoľ	Fiľakovo	LC	BB	III	651	1	II	35	94.6%
Sečovce	Trebišov	TV	KE	I	1308	1	I	94	100.0%
Sečovská Polianka	Vranov nad Topľou	VT	PO	I	422	1	I	43	91.5%
Šíd	Fiľakovo	LC	BB	III	945	1	III	40	88.9%
Slavkovce	Veľké Kapušany	MI	KE	I	309	1	II	34	100.0%
Slavošovce	Rožňava	RV	KE	I	775	1	II	96	94.1%
Slovenská Ves	Kežmarok	KK	PO	N/A	287	1	N/A	N/A	N/A
Slovenská Volová	Humenné	HE	PO	I	156	1	I	26	83.9%
Smižany	Spišská Nová Ves	SN	KE	I	1710	1	II	86	85.1%
Snina	Snina	SV	PO	I	1304	2	II	97	82.9%
Sobrance	Michalovce	SO	KE	II	1164	1	II	72	94.7%
Sokoľany	Košice	KS	KE	I	440	1	II	50	90.9%
Soľ	Vranov nad Topľou	VT	PO	II	1135	1	II	101	100.0%
Spišská Nová Ves	Spišská Nová Ves	SN	KE	II	2017	5	I	130	92.9%
Spišské Vlachy	Gelnica	SN	KE	I	307	2	II	27	100.0%
Spišský Štiavnik	Poprad	PP	PO	I	1232	1	II	105	77.8%
Stakčín	Snina	SV	PO	I	292	1	II	38	79.2%
Stará Ľubovňa	Stará Ľubovňa	SL	PO	II	968	5	II	54	94.7%
Stráne pod Tatrami	Kežmarok	KK	PO	I	1506	1	III	88	89.8%
Strážske	Snina	MI	PO	I	120	1	II	17	89.5%
Stropkov	Svidník	SP	PO	N/A	1198	4	N/A	N/A	N/A

Municipality	NP HC (2A) coordination area/Other	District	Region	CENSUS			REPRE-assessment		
				Data quality	Number of people in excluded enclaves	Number of excluded enclaves in the municipality	Data quality	Number of households in the sample	Response rate
Šumiac	Poprad	BR	BB	I	461	1	III	29	93.5%
Švedlár	Gelnica	GL	KE	II	506	1	III	21	29.2%
Sveržov	Bardejov	BJ	PO	I	81	1	I	10	100.0%
Svidník	Svidník	SK	PO	I	455	2	II	38	90.5%
Svinia	Prešov	PO	PO	I	1326	1	II	100	100.0%
Svit	Spišská Nová Ves	PP	PO	I	316	1	II	34	94.4%
Telgárt	Poprad	BR	BB	I	552	2	N/A	N/A	N/A
Toporec	Kežmarok	KK	PO	N/A	1376	2	N/A	N/A	N/A
Tornaľa	Revúca	RA	BB	II	315	1	N/A	N/A	N/A
Trebišov	Trebišov	TV	KE	II	3954	1	I	184	100.0%
Trenč	Veľký Krtíš	LC	BB	I	426	1	I	63	100.0%
Trhovište	Michalovce	MI	KE	I	1415	1	II	68	97.1%
Tuhrina	Prešov	PO	PO	I	244	1	I	48	100.0%
Turňa nad Bodvou	Košice	KS	KE	I	492	2	II	57	73.1%
Ubľa	Snina	SV	PO	I	122	1	II	20	90.9%
Úbrež	Michalovce	SO	KE	I	405	1	II	48	100.0%
Vaľkovňa	Poprad	BR	BB	I	233	1	II	30	75.0%
Varhaňovce	Košice-okolie	PO	PO	II	837	1	II	82	84.6%
Važec	Liptovský Mikuláš	LM	ZA	N/A	368	1	N/A	N/A	N/A
Vechec	Vranov nad Topľou	VT	PO	I	1472	2	I	113	100.0%
Veľká Ida	Košice	KS	KE	II	1981	2	II	95	90.5%
Veľká Lomnica	Kežmarok	KK	PO	I	1952	1	III	93	78.8%
Veľká Nad Ipľom	Veľký Krtíš	LC	BB	I	257	1	I	40	100.0%
Veľké Blahovo	Nitra	NR	NR	II	307	2	I	52	100.0%
Veľké Dravce	Fiľakovo	LC	BB	III	581	1	II	20	83.3%
Velké Kapušany	Veľké Kapušany	MI	KE	II	607	3	I	46	90.2%
Veľký Krtíš	Veľký Krtíš	VK	BB	I	717	1	I	49	100.0%
Vikartovce	Poprad	PP	PO	N/A	755	1	N/A	N/A	N/A
Vítkovce	Spišská Nová Ves	SN	KE	I	261	1	N/A	N/A	N/A
Vranov nad Topľou	Vranov nad Topľou	VT	PO	I	1081	4	I	78	98.7%
Vrbnica	Michalovce	MI	KE	I	579	1	N/A	N/A	N/A
Vrbov	Kežmarok	KK	PO	I	341	1	III	21	84.0%

Municipality	NP HC (2A) coordination area/Other	District	Region	CENSUS			REPRE-assessment		
				Data quality	Number of people in excluded enclaves	Number of excluded enclaves in the municipality	Data quality	Number of households in the sample	Response rate
Vtáčkovce	Košice-okolie	KS	KE	I	623	1	I	58	85.3%
Výborná	Stará Ľubovňa	KK	PO	II	311	5	I		100.0%
Vydrník	Spišská Nová Ves	PP	PO	I	972	1	II	56	100.0%
Žalobín	Snina	VT	PO	I	262	1	II	50	87.7%
Zámutov	Vranov nad Topľou	VT	PO	I	1647	1	I	112	100.0%
Žbince	Michalovce	MI	KE	I	687	1	II	61	96.8%
Zborov	Bardejov	SK	PO	I	1710	6	N/A	N/A	N/A
Zbudské Dlhé	Humenné	HE	PO	N/A	544	1	N/A	N/A	N/A
Žehňa	Košice-okolie	PO	PO	I	704	1	I	72	82.8%
Žehra	Gelnica	SN	KE	I	1295	2	II	102	83.6%
Zemplínska Teplica	Veľké Kapušany	TV	KE	I	376	1	II	48	96.0%
Zemplínske Kopčany	Veľké Kapušany	MI	KE	I	343	1	I	56	100.0%
Žiar nad Hronom	Zvolen	ZH	BB	I	378	2	I	51	100.0%
Zlaté Klasy	Dunaská Streda	DS	TT	N/A	2363	1	N/A	N/A	N/A
Zvolen	Zvolen	ZV	BB	I	656	10	I	71	100.0%
Zvolenská Slatina	Zvolen	ZV	BB	I	189	5	II	37	100.0%

	CENSUS			REPRE-assessment			
Number of municipalities	Number of districts	Quality I + II	Number of people in excluded enclaves	Number of excluded enclaves	Quality I + II	Number of interviews	Average response rate
255	38	96%	183 602	450	92%	13 500	92.7%

II) Eligible locations not covered by the NP HC 2A

Municipality	District	Region	Population in the excluded enclaves[1]	Number of the excluded enclaves in the municipality[1]
Banská Bystrica	BB	BB	488	5
Banská Štiavnica	BS	BB	284	1
Beniakovce	KS	KE	115	1
Bracovce	MI	KE	285	1
Buzica	KS	KE	273	3
Cabaj-Čápor	NR	NR	215	1
Chmiňany	PO	PO	604	1
Chyžné	RA	BB	34	1
Dlhé Stráže	LE	PO	181	1
Drnava	RV	KE	189	2
Egreš	TV	KE	190	3
Falkušovce	MI	KE	?	?
Gerlachov (BJ)	BJ	PO	232	1
Gortva	RS	BB	398	3
Horovce	MI	KE	40	1
Hrčeľ	TV	KE	701	2
Hrochoť	BB	BB	160	1
Hronské Kosihy	LV	NR	75	1
Jelšovec	LC	BB	267	1
Jovice	RV	KE	216	1
Kapišová	SK	PO	145	1
Komjatice	NZ	NR	196	2
Krušinec	SP	PO	?	?

Municipality	District	Region	Population in the excluded enclaves[1]	Number of the excluded enclaves in the municipality[1]
Lascov	BJ	PO	182	1
Licince	RA	BB	505	2
Liptovský Mikuláš	LM	ZA	930	5
Markovce	MI	KE	761	1
Milpoš	SB	PO	73	1
Nesluša	KM	ZA	135	1
Nový Život	DS	TT	500	1
Panické Dravce	LC	BB	?	?
Petrovany	PO	PO	453	2
Poltár	PT	BB	358	2
Prašník	PN	TT	64	1
Pribylina	LM	ZA	400	1
Ratnovce	PN	TT	98	1
Rokycany	PO	PO	894	2
Rozložná	RV	KE	153	1
Sady nad Torysou	KS	KE	332	1
Seňa	KS	KE	321	1
Sirk	RA	BB	300	1
Širkovce	RS	BB	527	3
Spišská Teplica	PP	PO	520	1
Spišské Bystré	PP	PO	308	2
Spišské Tomášovce	SN	KE	600	4
Sučany	MT	ZA	258	1
Teplička	SN	KE	115	1
Trnava pri Laborci	MI	KE	48	1
Veľký Šariš	PO	PO	442	1

[1] Data from the draft of the *Atlas of Roma Communities 2019*

Number of municipalities	Number of districts	Population of the excluded enclaves	Number of excluded enclaves
49	26	14 565	73

III) Control locations of the NP HC 2A impact evaluation

Municipality	District	Region	CENZUS Data quality	Number of people in excluded enclaves	Number of excluded enclaves in the municipality	REPRE-zisťovanie Data quality	Number of households in the sample	Response rate
Budkovce	MI	KE	I	237	1	I	26	100.0%
Bunkovce	SO	KE	I	130	1	I	22	100.0%
Čabalovce	ML	PO	I	52	1	II	12	100.0%
Čakanovce (KS)	KS	KE	N/A	378	1	N/A	N/A	N/A
Chanava	RS	BB	II	186	1	I	44	100.0%
Hrabské	BJ	PO	I	348	1	II	40	100.0%
Hucín	RA	BB	I	237	1	II	44	81.5%
Jesenské	RS	BB	I	314	1	I	53	100.0%
Kačanov	MI	KE	I	251	1	I	34	100.0%
Kravany	TV	KE	I	136	1	I	22	100.0%
Kyjov	SL	PO	II	190	1	II	30	75.0%
Lovinobaňa	LC	BB	N/A	303	3	N/A	N/A	N/A
Lubeník	RA	BB	I	288	1	I	61	92.4%
Lučivná	PP	PO	I	281	1	II	34	77.3%
Michaľany	TV	KE	I	262	1	II	40	95.2%
Muľa	VK	BB	I	300	1	I	49	100.0%
Nižná Myšľa	KS	KE	I	362	1	I	45	100.0%
Nižná Slaná	RV	KE	I	421	1	II	58	63.0%
Palín	MI	KE	I	253	1	I	39	100.0%
Palota	ML	PO	I	66	1	I	9	100.0%
Podolínec	SL	PO	II	113	1	II	30	78.9%
Rapovce	LC	BB	N/A	474	2	N/A	N/A	N/A

Municipality	District	Region	CENSUS Data quality	Number of people in excluded enclaves	Number of excluded enclaves in the municipality	REPRE-assessment Data quality	Number of households in the sample	Response rate
Roztoky	SK	PO	I	185	2	I	27	100.0%
Rudlov	VT	PO	I	221	1	I	24	100.0%
Sedliská	VT	PO	I	242	1	I	33	100.0%
Šindliar	PO	PO	I	135	1	I	26	100.0%
Skrabské	VT	PO	I	209	1	I	27	87.1%
Spišské Podhradie	LE	PO	I	112	1	I	23	100.0%
Spišský Štvrtok	LE	PO	I	656	1	II	65	100.0%
Švábovce	PP	PO	I	220	1	I	27	84.4%
Torysa	SB	PO	I	457	1	I	57	100.0%
Viťaz	PO	PO	II	190	1	I	21	100.0%
Žarnovica	ZC	BB	I	144	1	I	30	93.8%
Zavadka	GL	KE	I	171	1	I	23	100.0%

CENSUS Number of municipalities	Number of districts	Quality I + II	Number of people in excluded enclaves	Number of excluded enclaves	REPRE-assessment Quality I + II	Number of households in the sample	Average response rate
34	20	100%	8 524	38	100%	1 199	94.5%

ANNEX B
Research documentation

Information about the excluded enclave(s) in the municipality (name of the municipality):

Distances from the excluded community to the nearest medical facilities (in kilometers):

- · General practitioner's clinic ____km
- • Children's clinic doctor ____km
- · Dental clinic ____km
- • Emergency for adults ____km
- · Emergency for children ____km
- • Pharmacy ____km

Presence in the enclave at the time of investigation (circle):

Free public sources of drinking water operating 24 hours a day?[i]	YES NO
Public sources of drinking water for a fee functional 24 hours a day?[ii]	YES NO
A functional municipal water supply that households in the enclave could connect to?[iii]	YES NO
A functional municipal sewer that households in the enclave could connect to?	YES NO
Is it possible to connect households to the electricity network?[iv]	YES NO
Functional public lighting (street lamps)?	YES NO
Functional hard surface roads in the enclave?[in]	YES NO
A functional access road from the village to the enclave?	YES NO
Enough of regular small household waste containers?[vi]	YES NO
Cameras monitoring public spaces in the enclave?	YES NO
The possibility for households to connect to high-speed Internet?	YES NO
Circumstances exposing households to environmental risks?[vii]	YES NO

If present, indicate for the given enclave:

- · Number of free public drinking water sources operating 24 hours a day ____
- ⃞ Number of public sources of drinking water for a fee operating 24 hours daily ____
- · Total length of non-functional sections of local and access roads (in meters)[viii] ____m
- • Number of larger landfills in the enclave[ix] ____
- · The number of large-capacity garbage containers in the enclave ____
- ⃞ How many times were large-capacity containers emptied in the last half-year? year? ____
- · Number of cameras monitoring public spaces in the enclave ____

How many field workers work in the enclave in the long term?[x]

- · Field social worker ____
- ⃞ Municipal civil order services ____
- · Civic patrols ____
- ⃞ Community centers workers ____
- · Missionaries ____
- ⃞ NGO workers ____

Administrator: Date:

Information about the excluded enclave(s) in the municipality (name of the municipality):

Approximately, how many households are there in the enclave in which...

... a child was born to teenage parents in the last year[xi]	____
... there are people who sleep with more than one partner at the same time	____
... are parents who are second degree or close relatives[xii]	____
... sometimes people go to bed hungry because there is nothing to eat at home	____
... people also consume food from waste containers	____
... adults at home do not wash their hands with soap every day	____
... children bathe only once a week or less	____
... there are adults who do not brush their teeth daily	____
... lice, fleas, or scabies are common	____
... bugs, cockroaches or rodents are common	____
... roundworms, worms or other parasites have occurred in the last year	____
... someone inhales toluene	____
... someone uses the "herb" drug	____
... someone uses meth	____
... someone is addicted to slot machines	____

Are the following present in the given enclave (circle)?

Unofficial money lending?	YES NO
Segregated schools or classes?[xiii]	YES NO
Segregated waiting rooms, or reserved days and times when only Roma can visit?	YES NO
Businesses (restaurants, pubs, etc.) not allowing people from the enclave?	YES NO
Representation of the enclave in the municipal council (MPs or mayors living in the enclave)?	YES NO
Buying the electoral votes of people in the enclave?[xiv]	YES NO
Refusal to sell, rent or assign real estate to people in the enclave?	YES NO
Do people daily meet with freely moving untreated animals (dogs, cats...)?	YES NO

How many times has it happened in the given enclave in the last HALF of a year

- · an ambulance didn't arrive to the enclave following a proper call? ____
- ⃞ ER staff refused to enter the households? ____
- · a physician refused to accept a patient from the enclave? ____

[i]Pumps or faucets with drinking water without regular shutdowns and with functional equipment paid for by the municipality
[ii]Pumps and faucets with drinking water without regular shutdowns and with functional equipment paid for by the residents of the enclave
[iii]A provider's pipeline in close proximity to the enclave's dwellings that locals could connect to
[iv]Provider poles in close proximity to the enclave dwellings for locals to connect to
[in]Asphalt or concrete surface in a condition that allows rapid emergency services to pass through
[vi]Containers for family houses ("KUKA" containers) and apartment buildings, NOT large-capacity containers
[vii]Proximity to floods, landslides, community landfills, high voltage poles, industrial plants or landfills, etc.
[viii]Approximately how long sections of roads would need to be repaired so that cars can be used to and from the site without problems
[ix]Piles of trash that would require a high-capacity dumpster to clear
[x]The total number of employees of organizations regularly spending time in the enclave (at least 2 times a month), including unskilled workers (cleaners in community centers, etc.)
[xi]There were problems with the law in the household, because one of the parents is not yet 15 years old
[xii]Cousin
[xiii]There are classes in the school where only children from the enclave go, or when only such children go to the whole school (including in the case of municipalities where the majority inhabitants or all inhabitants are Roma)
[xiv]In the last parliamentary or municipal elections

Administrator: Date:

Record sheet for (circle 1): apartment buildings / brick family houses / shacks   Municipality:

Building no. (own numbering):	1	2	3	4	5	6	7	8	9	10	...	...	...	...	...	...	...	...
Number of households (individual families) in the building																		
How many households do not have to pay rent?																		
How many households are at risk of losing their housing immediately?																		
Number of children younger 18																		
Number of adults 18-59																		
Number of adults older 60																		
How many households in the building heat with radiators or gas?																		
...cook using electricity or gas?																		
...have legal and functional water connections?																		
...legal and functional electricity connections?																		
..functional flush toilet?																		
... bathroom?																		
... functioning refrigerator or freezer?																		
... working washing machine?																		
... functional sewer/septic tank?																		
...use a car?																		

Filled in by the administrator: Signature: Date:

EXPLANATORY NOTES to the CENSUS Record sheet HPA n. 1.

Building no. – number of the building that you choose yourself (NOT street number and the like)

Number of households in the building – the number of individual families in the given building (individual family = a group of people who eat together and who would like to have their own housing)

How many households do not have to pay rent? – The number of households in the given building, from which for housing no one asks for rent (they only pay for energy, water, etc.)

How many of the households are at risk of losing their housing immediately? – The number of households in a given building that could lose their housing because they do not have the necessary housing documents in order (building permits, ownership documents, lost documents, etc.)

Number of children younger 18 in the building – The total number of children in that building

Number of adults 18-59 in the building – The total number of adults in the building who are older 17 and younger 60 years

Number of adults older 60 in the building – The total number of adults in a given building

How many households in the building heat with radiators or gas heaters – Number of households in the given building, which heat with radiators or gas stoves (we assume that the others heat burning wood)

...cooks using electricity or gas – The number of households in a given building that cook using exclusively electric or gas appliances (we assume that the others burn wood)

...have legal and functional water connections – The number of households in the given building that have functional and legal water connections (they did not connect themselves)

...have legal and functional electrical connections – The number of households in the given building that also have functional and legal electricity connections (they did not connect themselves)

...have a functional flush toilet – The number of households in a given building that have a functional flushing system toilet (flushes and is connected to a functional sewage system)

... a bathroom – The number of households in a given building that have a room reserved as a bathroom

... a functional refrigerator or freezer – The number of households in a given building that have a functional refrigerator or freezer

... a working washing machine – The number of households in a given building that have a working washing machine

... a functional sewer/septic tank connection – The number of households in a given building that have functional sewer or septic tank connection (they could connect a flush toilet)

... use the car – The number of households in a given building that regularly use any of their own cars (including unregistered cars and regardless of holding a driver's license or purchase contract)

208

ANNEX B

CENSUS – HPA Record sheet No. 1
Research documentation

209

ANNEX B

CENSUS – HPA Record sheet No. 1
Research documentation

Left page (210)

SUMMARY OF BASIC INFORMATION FOR INTERVIEW PARTCIPANTS

What is going on? A survey, in the form of interviews in households, organized by the Faculty of Medicine of PJ Šafárik University in Košice for the needs of the Healthy Communities project. Exact title of the research: "Impact evaluation and health needs assessment across target locations of the National Project Healthy Communities 2A".

Why should I participate? By answering our questions, you will help us find out more about what needs to be changed to improve health in communities like yours. It is important for us to know what influences health in similar places, how people perceive it, what they would need to improve their health, and so on. This information will help us fight to improve health in places like yours.

Should I worry? This questionnaire is anonymous. This means that your answers will remain confidential and only researchers will see your questionnaire. No one else will be able to see your answers. Therefore, your name is not written on the questionnaire. The health promotion assistant will fill the form according to your interview answers. The assistants are bound by confidentiality, which means that they must not reveal to anyone else what you talked about while filling out the questionnaire and how you answered the questions. Your data will only be used according to your informed consent. It protects both you and us legally from any possible abuse. At the same time, the consent will allow us to contact you again in three years and ask for an interview about what has changed.

If you do not wish to fill in the questionnaire, you do not have to. If you don't feel like answering any of the questions, you can skip them and move on – for us, it's better to have questions unanswered than to have them answered falsely.

How to answer? You will help us the most if you try to answer each question honestly and truthfully. Listen carefully to each question and answer it as honestly as you can. It is not a test, there are no right or wrong answers.

The most suitable answers will be marked by a cross in the appropriate box: ☒

The answer can also be a number entered into a box (number of people, etc.):

Mistakes can be corrected like this: ■ ☒

Whom can I contact with further questions? The employees of the Institute of Health Psychology of the Medical Faculty of PJ Šafárik University in Košice, who are responsible for the research:

Andrej Belák: andrej.belak@upjs.sk; 0919 XXX XXX

Daniela Fiľakovská: daniela.filakovska@upjs.sk

Right page (211)

1. **For everyone who lives in this household, indicate the gender, school, age, etc.:**

	Feels to be a man (or boy) Mark one option with a cross	Feels to be a woman (or girl)	Feels to have a different gender	Is how many years old? Write the number	Does not consider themselves to be Roma	Was present during the conversation	The highest schools they completed? Use the numbers from the table below	What schools do they attend now? Use the numbers from the table below
1	☐	☐	☐		☐	☐		
2	☐	☐	☐		☐	☐		
3	☐	☐	☐		☐	☐		
4	☐	☐	☐		☐	☐		
5	☐	☐	☐		☐	☐		
6	☐	☐	☐		☐	☐		
7	☐	☐	☐		☐	☐		
8	☐	☐	☐		☐	☐		
9	☐	☐	☐		☐	☐		
10	☐	☐	☐		☐	☐		
11	☐	☐	☐		☐	☐		
12	☐	☐	☐		☐	☐		
13	☐	☐	☐		☐	☐		
14	☐	☐	☐		☐	☐		
15	☐	☐	☐		☐	☐		
16	☐	☐	☐		☐	☐		
17	☐	☐	☐		☐	☐		
18	☐	☐	☐		☐	☐		
19	☐	☐	☐		☐	☐		
20	☐	☐	☐		☐	☐		

no. 1. No school/nursery	no. 5. Graduated from secondary school / college with a teaching certificate	no. 4. Special-needs elementary school
no. 2. Kindergarten	no. 6. Completed high school/gymnasium/college with high school diploma	no. 8. University
no. 3. Elementary school	no. 7. Practical school (after elementary school)	

2. Was someone in the household worried about the following during this year? | Yes | No

	Yes	No
That they will lose the roof over their head or be forced to move?	☐	☐
Lack of food or hunger?	☐	☐
Taking away of children?	☐	☐
Debts?	☐	☐
Cold in the home (long-term problems with heating)?	☐	☐
Prosecuting or imprisoning of someone close?	☐	☐
Serious illness of someone close?	☐	☐
Big arguments or fights in the home?	☐	☐
Serious disputes with people outside the household, for example with distant family or neighbors?	☐	☐
Discrimination against yourself or a loved one?	☐	☐
Long-term absence of a household member due to work?	☐	☐

3. How would you evaluate the overall life satisfaction in your household?

The best possible	Good	Neither good nor bad	Bad	The worst possible
☐	☐	☐	☐	☐

4. How would you evaluate the overall hopes for improving satisfaction in your household?

We believe it will get better	We hope it gets better	It's hard to predict how it will be	We fear it will get worse	It is clear to us that it will get worse
☐	☐	☐	☐	☐

5. How do people in your household see their options regarding future satisfaction?

We have almost no possibility to improve anything	We have few opportunities to improve anything	Some things depend on us, some don't	We do have opportunities to improve many things	Most things mainly depend on us
☐	☐	☐	☐	☐

6. Would Roma children be able to do the same as non-Roma children if they had the same opportunities and support?

Yes, even more, they are smarter by nature	There would certainly be many who would	Hard to say	There would certainly be few who would	Certainly not, they are naturally not as gifted
☐	☐	☐	☐	☐

---

7. Try to honestly evaluate how it is in your home with the following

	Yes, always	Mostly	Sometimes yes, sometimes not	Rarely	No, never
In our family, we support and help each other	☐	☐	☐	☐	☐
In our family, we know how to talk about problems	☐	☐	☐	☐	☐
In our family, we can agree and make joint decisions	☐	☐	☐	☐	☐
In difficult times, we can rely on each other	☐	☐	☐	☐	☐

8. How difficult or easy is it for you to do the following?

	It is easy	It can be done, but it's not easy	It cannot be done without the help of another person
Make an appointment with the right doctors by phone	☐	☐	☐
Find the right department in the right hospital	☐	☐	☐
Make sure the doctors understand your health problems correctly	☐	☐	☐
Answer the doctors what they want to know	☐	☐	☐
To understand and remember how medicines should be taken, according to the doctors	☐	☐	☐
Understand and remember what doctors recommend regarding lifestyle	☐	☐	☐
Read and understand how to take which medicines	☐	☐	☐
Fill in the necessary papers at the doctors	☐	☐	☐
Take out prescription drugs	☐	☐	☐
Handle insurance issues	☐	☐	☐
Arrange transport to medical facilities (not by an ambulance)	☐	☐	☐

9. Last time a women in the household was pregnant, did she go for regular monthly check-ups with a gynecologist?

Yes, she went regularly	☐
She went several times, but missed some	☐
She didn't go even once until she went to give birth	☐
We don't know / we don't remember	☐

2

3

10.	The usual reasons in your household why health problems do not get resolved with doctors...	Yes	No
We prefer to treat ourselves at home in our own way (herbs, healers, magic, etc.)		☐	☐
It's hard for us to get there		☐	☐
We are afraid of the doctor's reproaches after a long-term failure to address the health condition		☐	☐
We don't have enough money for transportation to the doctor		☐	☐
We don't have enough money for prescription drugs		☐	☐
We have health insurance debt		☐	☐
Missing documents (documents, insurance card, medical records, applications)		☐	☐
We have bad experiences with the behavior of doctors and nurses		☐	☐
We have a problem ensuring childcare		☐	☐
We do not believe in the abilities of our doctors and nurses		☐	☐
We fear of pain during the examination or procedures		☐	☐
Long waiting times in medical facilities are long		☐	☐
Fear of discovering new diagnoses		☐	☐
Reluctance to stay hospitalized longer in the hospital		☐	☐
We prefer to wait until the health problem passes by itself		☐	☐
The life partners prevent a visit to the doctor		☐	☐
Shyness in front of health professionals		☐	☐
Other, fill in		☐	☐

11.	Has anyone in this household encountered discriminatory behavior in the past year?	Yes	No
At school		☐	☐
In the shop		☐	☐
At the office		☐	☐
On a bus or train		☐	☐
In a business (restaurant, bar, cafe, hotel...)		☐	☐
At the general practitioner's office		☐	☐
At the pediatrician's office		☐	☐
At the dental office		☐	☐
In the pharmacy		☐	☐
In the gynecology and obstetrics department of the hospital		☐	☐
In the gynecologist's clinic		☐	☐
In the children's ward of the hospital		☐	☐
In the infectious department in the hospital		☐	☐
In another department in the hospital or in another clinic		☐	☐
From the emergency services		☐	☐

4

12.	How often you can enjoy the following food in the week AFTER pay / benefits	Every day	Several times	At all
Raw fruit (apple, banana, orange, etc.)		☐	☐	☐
Raw vegetables (tomatoes, peppers, lettuce, etc.)		☐	☐	☐
Dairy products (milk, yogurt, cheese, etc.)		☐	☐	☐
Cold cuts (salami, sausage, ham, etc.)		☐	☐	☐
Meat (schnitzel, roast chicken, pasta with meat, etc.)		☐	☐	☐
Flour dishes (pasta, gnocchi, dumplings, pancakes, pancakes, etc.)		☐	☐	☐
Sweets (candies, chocolates, etc.)		☐	☐	☐
Sweet drinks (cola, raspberry, energy drinks)		☐	☐	☐

13.	How often you can enjoy the following food in the week BEFORE pay / benefits	Every day	Several times	At all
Raw fruit (apple, banana, orange, etc.)		☐	☐	☐
Raw vegetables (tomatoes, peppers, lettuce, etc.)		☐	☐	☐
Dairy products (milk, yogurt, cheese, etc.)		☐	☐	☐
Cold cuts (salami, sausage, ham, etc.)		☐	☐	☐
Meat (schnitzel, roast chicken, pasta with meat, etc.)		☐	☐	☐
Flour dishes (pasta, gnocchi, dumplings, pancakes, pancakes, etc.)		☐	☐	☐
Sweets (candies, chocolates, etc.)		☐	☐	☐
Sweet drinks (cola, raspberry, energy drinks)		☐	☐	☐

14.	Do you think that...	Yes	No
Would most people in this household like to eat more raw vegetables and fruits?		☐	☐
Would most people in this household like to eat less cold cuts and meat?		☐	☐
Would most people in this household like to eat less sweets and drink less sugary drinks?		☐	☐
Would most people in this household like to eat less floury foods?		☐	☐
Would eating more raw vegetables and fruits be considered strange by other families in the enclave?		☐	☐
Would eating fewer cold cuts and less meat be considered strange by other families in the enclave?		☐	☐
Would eating less sweets and drinking less sugary drinks be considered strange by other families in the enclave?		☐	☐
Would eating less floury foods be considered strange by other families in the enclave?		☐	☐

5

15. How do you think people in the enclave take..
(HPA only reads the questions, does not offer answers - chooses them from the options then according to the answers)

	They like it (mostly)	They don't like it	They don't care
When someone is studying in high school or college	☐	☐	☐
When someone is trying to quit smoking	☐	☐	☐
When someone doesn't want to drink alcohol	☐	☐	☐
When someone doesn't want to play slot machines	☐	☐	☐
When someone tries to exercise regularly	☐	☐	☐
When someone is careful at work (avoids risk, uses gloves, warms up, etc.)	☐	☐	☐
Using condoms when making love	☐	☐	☐
When a pregnant woman smokes	☐	☐	☐
When a pregnant woman drinks alcohol	☐	☐	☐
Frequent drunkenness in women (problems with speech, walking, vomiting or memory loss)	☐	☐	☐
Frequent drunkenness in men	☐	☐	☐
When men change sexual partners when they are single	☐	☐	☐
When women change sexual partners when they are single	☐	☐	☐
Prostitution (for money)	☐	☐	☐
Sex for reward (rewards other than money)	☐	☐	☐
Regular use of psychiatric medications	☐	☐	☐
Fights between partners	☐	☐	☐
When a man beats his wife	☐	☐	☐
Beating of own children	☐	☐	☐
Homosexuality	☐	☐	☐
When someone can't have children	☐	☐	☐
When someone under the age of 15 has a child	☐	☐	☐
Single mothers	☐	☐	☐
Artificial termination of pregnancy (abortion)	☐	☐	☐
Taking hormonal contraception (birth control pills)	☐	☐	☐
When someone has an intrauterine body ("dana")	☐	☐	☐
When someone tries to live so as not to get sick at all	☐	☐	☐
When a man participates in housework and child care	☐	☐	☐
That someone is engaged in politics (e.g. running for municipal elections)	☐	☐	☐
When someone tries to live or lives completely like the non-Roma	☐	☐	☐

6

In the following section, mark all the answers that you think are correct.

16. Could you show me the approximate location of the kidneys, ovaries and heart on your body? (According to what they showed, HPA will choose the correct answer)
- ☐ They knew everything
- ☐ Something they knew, something they didn't
- ☐ They knew nothing

17. What are the kidneys for?
- ☐ They cool the body
- ☐ They clean the blood and make urine
- ☐ They speed up the digestion of food
- ☐ We do not know

18. What are the ovaries for?
- ☐ They purify the uterus
- ☐ Sperm are formed in them
- ☐ Eggs are formed in them
- ☐ We do not know

19. What is the heart for?
- ☐ It pumps blood throughout the body
- ☐ It is the center of feelings
- ☐ Drives muscle movement
- ☐ We do not know

20. How can jaundice be prevented?
- ☐ Sufficient vitamins in the diet
- ☐ Regular hand washing with soap
- ☐ Regular exercise
- ☐ We do not know

21. How can high blood pressure be prevented?
- ☐ Regular exercise
- ☐ A diet rich in sugars and fats
- ☐ Avoiding stress
- ☐ We do not know

22. When and how is it necessary to start treating the increased body temperature in children at home?
- ☐ Above 37 °C, cold compresses on the forehead
- ☐ Above 39 °C and give fever medicines (paralen or nurofen)
- ☐ Above 37 °C and give fever medicines (paralen or nurofen)
- ☐ We do not know

7

Research documentation

217   ANNEX B   **REPRE – HPA Record sheet No. 2**
Research documentation

23.   How to properly treat diarrhea at home?

☐ A little brandy and no liquids
☐ Dry food and plenty of fluids
☐ Lots of vitamin C and fruit tea
☐ We do not know

24.   How can roundworms be prevented in children?

☐ Vaccination of children
☐ Deworming of animals
☐ Regular hand washing with soap
☐ We do not know

25.   How can colds be prevented in children?

☐ Training and appropriate dressing outside
☐ Strong heating in the home
☐ Sufficient vitamins in the diet
☐ We do not know

26.   How to correctly call the emergency services

☐ Call 155, give your name, the address of incident, and describe who has what problem
☐ Call 158, state your social security number and what long-term illness the person has
☐ Call 155, give your address, name and ask for quick help
☐ We do not know

27.   What should be child up to 6 months fed apart from breast milk?
(you can check multiple options)

☐ Artificial milk
☐ Plain milk powder
☐ Sweetened water
☐ Tea without sugar
☐ Regular food
☐ Cow milk
☐ Pure water without sugar
☐ Tea with sugar
☐ Water from potatoes, pasta and the like
☐ No need to give anything

28.   What do you think about breastfeeding?
(you can check multiple options)

☐ Breastfeeding is important for the proper nutrition of the baby
☐ It doesn't make much difference whether the baby is breastfed or formula fed
☐ If a woman has breast milk, she should breastfeed her baby
☐ It is useless to breastfeed a baby for too long
☐ Breastfeeding is good for the relationship between mother and baby
☐ If a woman doesn't want to, let her not breastfeed
☐ Breastfeeding calms the baby
☐ Formula is more nutritious than breastfeeding

29. Is there someone in this household who...	Yes	No
Does regularly go to work outside the district?	☐	☐
Does go to a school where most of the children are non-Roma?	☐	☐
Does have colleagues who are non-Roma or live among non-Roma?	☐	☐
Does work as an official at a state office (municipal office, employment office, social or health insurance office – NOT activation works, project jobs, etc.)?	☐	☐
Does or has lived abroad for over a year?	☐	☐
Does or has lived in an institution for mor e than a year (in a children's home or in a reformatory – re-education center)?	☐	☐
Does have personal experience of imprisonment, or is in prison?	☐	☐
Does regularly engage in collective sports (for example, for a football club)?	☐	☐
Does regularly do individual sports (for example, boxing for a club)?	☐	☐
Does attend art school (musical instrument, singing, art, dance, etc.)?	☐	☐
Does attend children's or youth organizations (e. g. Boy Scouts)?	☐	☐
Does attend an interest activity group (needlework, young mothers' club, etc.)?	☐	☐
Does regularly attend church events or groups (e.g. mass, choir)?	☐	☐
Is non-religious?	☐	☐

30.	Yes	No
Does this household have heating?	☐	☐
Does this household have a working electrical connection (any kind)?	☐	☐
Is smoking common in this household also indoors?	☐	☐
Does your household receive housing allowance?	☐	☐
Do you manage to put some money aside every month?	☐	☐
How many separate rooms (bedrooms, living room) do you use in addition to the kitchen?		

8

9

218   ANNEX B

REPRE – HPA Record sheet No. 2
Research documentation

219   ANNEX B

REPRE – HPA Record sheet No. 2
Research documentation

31. How many people in this household (specify number)...	Men/boys	Women/girls
Do have regular income from a permanent job or business?		
Do have irregular income from odd jobs/chores?		
Do receive an activation allowance?		
Do receive an incentive allowance (after employment)?		
Do receive unemployment benefits (within six months of losing his permanent job)?		
Do receive a retirement pension (also early)?		
Do receive a disability pension (even a partial one)?		
Do receive an allowance for a child in substitute family care?		
Do receive carer's allowance?		
Do receive a scholarship?		
Do take care of widows/orphans?		
Do receive rent (money from rent)?		
Do receive maternity benefits?		
Do receive parental allowance?		
Are long-term unemployed (more than a year)?		
Do have no income (not even social benefits, children are also counted)?		
Do have other regular income (such as from foundations)? Please indicate which....................................		

32. Total regular legal household income per month (excluding chores, gifts, loans...) (state the amount in euros)	€
33. How many material-needs benefits does this household receive? (indicate the number of granted benefits per person)	

10

34. How many people in your given household (insert number of people)...	Men	Women	Boys	Girls
Do smoke purchased cigarettes more than once a week?				
Do smoke other tobacco products more than once a week (rolled tobacco, pipe, staves)?				
Have tried the "herb" drug?				
Have tried to inhale toluene?				
Have tried meth?				
Do not exercise or play sports even once a week?				
Avoid physical activity (for other than health reasons, for example they don't like to walk, etc.)?				
Do watch TV, play on the computer or play with their phone for more than 2 hours a day?				
In the last year, suffered a serious injury while working around the house or household (including injuries while carrying water, wood; NOT at work or on a chore; the injury required medical treatment)?				
Have not had a preventive check-up with a general practitioner (children older three years and adults) in the last 2 years?				
Have not had a free preventive check-up at the dentist in the last year?				
Have not had a free preventive check-up with a gynecologist (women only) in the last year?				
Did not go to the doctor for a procedure in the last year when they were invited?				
Have not yet completed any of the mandatory vaccinations (only children)?				
Have not yet received the mandatory tetanus vaccination (adults)?				

11

HPA fills in **separately**

How many people in this household...(indicate the number or, if you do not know, put a cross in the "don't know" box)	Men	Women	Boys	Girls	I do not know
Do drink alcohol every day, or almost every day?					☐
Do get drunk at least once a week (problems with speech, walking, vomiting or memory loss)?					☐
Do regularly take psychiatric medication?					☐
Do use herb?					☐
Do use toluene?					☐
Do use meth?					☐
Do play slots?					☐
Have had an artificial termination of pregnancy (abortion)?					☐
Do use hormonal contraception?					☐
Do have an intrauterine body ("dana")?					☐

Reasons for avoidance of solving serious health problems in the given household...	Yes	No
Total lack of interest in one's own health	☐	☐
Misunderstanding the seriousness of the problem	☐	☐
Reluctance to change lifestyle in the recommended way	☐	☐

12

Record of instruction and informed consent Regarding the participation in the research "Impact evaluation and health needs assessment across target locations of the National Project Healthy Communities 2A"

The main goal of the research is to map the current health needs for the purposes of the Healthy Communities National project and at the same time to clearly evaluate the effects of health interventions in the targeted marginalized Roma communities. For this purpose, we will ask research participants to fill in an anonymous questionnaire. The research is carried out by the Faculty of Medicine of PJ Šafárik University in Košice within the framework of contract UPJŠ-247/2018.

All data provided by research participants will be anonymous and will be subject to Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data, which repeals Directive 95/46/EC (General Data Protection Regulation) (hereinafter referred to as "GDPR") and the Act on the Protection of Personal Data and the Amendment of Certain Acts (Act No. 18/2018 Coll.). Contact information such as name, surname, date of birth, residence and telephone number are necessary for the possibility of contacting the research participants within the next three years exclusively for the purpose of re-filling the questionnaire and will be stored in a separate database. The answers of the research participants will not be provided to each other or to any third party,

With my signature, I confirm the following (circle as appropriate):

Yes No I was provided with all the necessary information and had the opportunity to ask questions regarding this research. Any questions have been answered. I am aware that my participation in this study is anonymous and voluntary.

Yes No I agree to participate in the study "Impact evaluation and health needs assessment across target locations of the National Project Healthy Communities 2A ".

Yes No I made the decision freely, without coercion, with full awareness, at the same time I declare that I am not deprived of the capacity for legal actions to any extent. I acknowledge that I can freely revoke this informed consent at any time.

In ...., on ....
Signature of the respondent

Consent of the person concerned (respondent)

....
Name, surname, date of birth, place of residence,

Yes No I agree to the processing of my personal data according to Art. 6 and Art. 7 GDPR in the scope of name, surname, date of birth, place of residence for the purpose of managing the respondents involved in the research. This consent can be withdrawn in writing at any time, and the withdrawal of consent does not affect the legality of the processing of personal data based on consent before its withdrawal. I am aware that the provision of personal data, as well as the granting of consent to their processing, is voluntary. The processed data will be archived and disposed of in accordance with the applicable legal regulations of the Slovak Republic.

In ...., on ....
Signature of the respondent

I personally gave the appropriate instructions to the respondent and recorded his/her consent to participate in the research: ....

In ...., on ....
Administrator's signature

This record is part of the research documentation.

The determinants of health and the health needs across excluded Roma enclaves in Slovakia

Final report from the initial phase of the impact evaluation and health needs assessment across target locations of the National Project Healthy Communities 2A

FSC FORESTS FOR ALL FOREVER   PEFC

How many people live in which excluded Roma enclaves? How many of them do not consider themselves to be Roma? What is the life expectancy in the specific excluded Roma enclaves? What proportions of households in the specific enclaves are also dependent on food from waste containers? How many people have been troubled by the imprisonment of a loved one? How do people in the enclaves perceive their satisfaction, their future and their ability to influence it? What are the shares of households where they do not have electricity connections, a flush toilet or a bathroom? How many serious environmental risks are there per enclave? How many households commonly face ethnic discrimination and in which health care settings? In which enclaves do rescue workers not enter households? What portion of enclaves has no representation in the local council? In which municipalities are there attempts to buy ballots, to not let people into businesses and to segregate children in schools? In what proportions of households in specific enclaves do people believe that Roma children innately have fewer abilities than non-Roma children?

Zdravé regióny

EURÓPSKA ÚNIA
Európsky sociálny fond
Európsky fond regionálneho rozvoja

OPERAČNÝ PROGRAM
ĽUDSKÉ ZDROJE