RIVER-EU Reflections

Working Within Roma Communities in Slovakia

Funded by the European Union

Educational Handout

Reading time: ca. 15 mins

About this Resource

This SEKI educational handout was developed as part of the RIVER-EU project (EU Horizon 2020, 2021–2026). It is intended for junior-to-mid-level healthcare professionals — including doctors, nurses, immunisation program officials, and public health workers — and is available on the SEKI.EU learning platform.

It draws on a recorded expert interview conducted as part of the RIVER-EU project's knowledge-sharing initiative, and the insights presented here are designed to remain relevant well beyond the project's lifetime.

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1. Introduction

RIVER-EU (Raising Immunisation Rates for Vulnerable populations in Europe) was a European Union Horizon 2020 research and innovation project that ran from 2021 to 2026. Its central mission was to understand and address the structural, cultural, and informational barriers that prevent marginalised and vulnerable communities from accessing routine immunisation — and to translate those insights into practical interventions that healthcare systems can adopt and sustain.

One of the project's most compelling case studies comes from Slovakia, where a dedicated team – **Prof Daniella Filakovska Bobakova**, Faculty of Medicine, Pavol Jozev Safarik University, Kosice, Slovakia and **Doctor Tana Grauzelova and colleagues** from Healthy Regions, an allowance organisation of the Ministry of Health, Bratislava, Slovakia - worked to bring HPV (Human Papillomavirus) vaccination to marginalised Roma communities — populations that had historically been left out of preventive healthcare conversations entirely.

This handout captures the lessons, strategies, and lived experience of that work. It is designed to sit permanently on the SEKI.eu learning platform, ensuring that the knowledge generated during RIVER-EU continues to educate and inspire healthcare professionals long after the project's formal conclusion.

Learning Objectives – by the end of this handout, you will be able to:

- Describe the HPV vaccination policy context in Slovakia and how it has evolved
- Identify the key barriers to vaccination faced by marginalised Roma communities
- Explain the Roma Health Mediator model and how it was deployed in the RIVER-EU intervention
- Apply evidence-based, community-centred principles to your own practice when working with underserved populations
- Reflect on how trust, informed dialogue, and consistent messaging shape immunisation outcomes

2. Meet the Team

The Slovakia component of RIVER-EU was led by two specialists whose complementary expertise — academic research and frontline community work — proved to be one of the intervention's greatest strengths.

Prof. Daniela Filakovska Bobakova

Role: University professor, researcher and social epidemiologist

Daniela brings academic expertise in **health inequities and social epidemiology**, with a particular focus on how structural and social factors shape health outcomes in vulnerable populations. Her work bridges the world of research evidence and practical public health, and within RIVER-EU she provided the theoretical grounding and study design for the HPV vaccination intervention in Slovakia.

Her motivation is deeply rooted in the principle that *preventive healthcare is a right, not a privilege* — and that marginalised communities deserve the same quality of health information as anyone else.

Dr. Tana Grauzelova

Role: Field coordinator, Healthy Regions (Organization Health Regions), Roma health mediator program

Tana works on the ground with **Roma health mediators** across Slovakia through the organisation Healthy Regions. Her role involves training, supporting, and coordinating community health workers who serve as trusted bridges between Roma communities and the formal healthcare system.

Tana's experience is built on years of direct community engagement, and she emphasises the irreplaceable value of collaboration between researchers and field workers. As she put it: *It's important to bring the real benefits for clients.*

Key Insight: The pairing of a university-based social epidemiologist with community-embedded health facilitators was not incidental — it was strategic. In addition, Academic rigour without community trust achieves little; community reach without evidence risks doing harm. Together, Daniela and Tana modelled what genuine co-design looks like in public health.

3. Understanding the Target Community

3.1. Who Are Marginalised Roma Communities in Slovakia?

Roma people represent one of Europe's largest ethnic minority groups, and Slovakia is home to a significant Roma population — estimates suggest between 7% and 9% of the total population, though figures vary. Within this group, marginalised Roma communities — those living in segregated settlements, often in conditions of poverty with limited access to education, employment, and public services — face compounding health disadvantages.

These communities are not homogeneous. They are diverse in language, culture, and degree of integration with mainstream Slovak society. However, common structural conditions create shared vulnerabilities:

- Limited or no access to reliable health information
- Geographic and logistical barriers to reaching healthcare facilities
- Historical and ongoing experiences of discrimination in healthcare settings
- Lower levels of formal education, which can make navigating health systems more difficult
- Poverty and economic precarity that deprioritises preventive care

3.2. Historical Exclusion from Preventive Healthcare

Preventive healthcare — particularly vaccination programs — has historically not reached these communities in a meaningful way. As Daniela explained during the interview:

> *Health information about HPV vaccination had not reached marginalised Roma communities in Slovakia, making it important to introduce the topic there.* — ***Prof. Daniela Filakovska Bobakova***

This is not simply a communication failure. It reflects decades of systemic exclusion — programs designed for and tested on majority populations, with insufficient attention to how they would reach communities on the social and geographic margins. The result is a significant health information gap that compounds existing disparities in cancer incidence, cervical health outcomes, and access to screening.

Cervical cancer — one of the key diseases prevented by HPV vaccination — disproportionately affects women in lower-income communities with less access to screening. In Roma communities, personal experience with cervical cancer among family members was, paradoxically, one of the factors that made the topic resonate once it was introduced — communities were not indifferent to HPV; they simply had never been given the information.

4. HPV Vaccination in Slovakia: Policy Context

4.1 A Timeline of Change

Understanding the policy landscape is essential for any healthcare professional working on immunisation in Slovakia. The evolution of HPV vaccination policy mirrors a broader European shift towards recognising HPV as a public health priority — but the journey has been gradual.

Period	Policy Status	Implications
Pre-2018	Voluntary; individuals paid out-of-pocket	Significant financial barrier; low uptake in low-income communities
2018 onwards	Free national vaccination programme for boys and girls aged 12–14, delivered through paediatricians	Removed cost barrier; widened eligibility to include boys; expanded reach through primary care
RIVER-EU era (2021–2026)	Active outreach to marginalised communities; city-organised vaccination dates	Structural support for hard-to-reach groups; increased rates in previously underserved populations

Important Context: The shift to free HPV vaccination in 2018 was a critical enabler — but it was not sufficient on its own. Cost had been a barrier but so had awareness. Marginalised communities did not automatically benefit from the policy change without active, targeted outreach. This is a lesson that applies far beyond Slovakia: **universal policies do not automatically produce universal outcomes.**

4.2 A Unique Prevention Opportunity

One aspect of HPV vaccination that the team found particularly powerful in community conversations was its unique positioning in the prevention landscape. As Daniela noted, HPV vaccination prevents cancer — not merely an infection. This framing made it highly accessible, even to community members with limited prior health literacy:

> *The unique aspect of HPV prevention — preventing cancer rather than treating an infection — made it an accessible topic for communities with limited health information.* — ***Prof. Daniela Filakovska Bobakova***

This insight has direct implications for how healthcare professionals should frame HPV vaccination conversations, particularly with communities who may be

unfamiliar with the virus itself, but who understand, often viscerally, the devastation of cancer.

5. Key Barriers to Vaccination

The RIVER-EU team in Slovakia identified a nuanced set of barriers — some expected, some surprising. Understanding these is essential for anyone working on immunisation outreach with similar communities.

5.1 Information Gaps

The most fundamental barrier was simply that communities had never received clear, accessible information about HPV or the vaccine. This was not scepticism or refusal — it was absence. Once information was provided in a respectful, understandable format, community members engaged actively and with genuine curiosity.

5.2 Stigma and Sensitive Messaging

One of the most delicate challenges was how to introduce HPV vaccination without making Roma communities feel they were being singled out or stigmatised. Tana described this with care:

> *We emphasised the need for sensitive communication about the vaccination being available to all, not just Roma people.* ***— Dr. Tana Grauzelova***

This is a critical lesson. Any outreach program targeting a specific community must be careful not to inadvertently reinforce the idea that the intervention is for them because they are a problem. The message must be: *This is available to everyone — and we are making sure it reaches you too.*

5.3 Trust Deficits

Decades of discrimination and paternalism within healthcare settings have left deep traces. Roma communities have often experienced healthcare interactions as coercive, dismissive, or disrespectful. Building genuine trust — not just compliance — required a fundamentally different approach.

5.4 Logistical and Structural Barriers

- Distance from healthcare facilities and limited access to transport
- Work schedules that make daytime appointments difficult
- Uncertainty about entitlements, documentation requirements, and costs

- Fragmented or inconsistent messaging between community educators and healthcare providers

5.6 Initial Hesitancy Among Professionals

Interestingly, some hesitancy also existed on the provider side — concerns about whether targeting marginalised communities for vaccination constituted appropriate prioritisation, or whether it risked stigmatisation. The team's experience ultimately showed that with thoughtful framing, these concerns could be addressed. As Daniela noted, people in the communities showed "genuine interest once the topic was introduced, often having personal experiences with cervical cancer in their families" — demonstrating that demand existed; it simply needed to be met with appropriate supply of information and access.

6. The Intervention: What the RIVER-EU Team Did

6.1 The Roma Health Mediator Model

The cornerstone of the RIVER-EU Slovakia intervention was the deployment of Roma health mediators — community members, often women, who were trained to serve as trusted connectors between their communities and the formal healthcare system. This model, developed and refined by Healthy Regions, is built on a simple but powerful premise: people trust people who are like them, who know their lives, and who have no authority to coerce them.

Health mediators are not doctors or nurses. They are community insiders who can have frank, informal conversations about health topics in a way that a clinic visit rarely allows. Their role in the HPV vaccination project was to:

- Provide accessible, accurate information about HPV and the vaccination programme
- Answer questions honestly and without pressure
- Help community members navigate the healthcare system to access vaccination
- Serve as a consistent, familiar point of contact over time

6.2 Training the Mediators

Before any community engagement took place, the health mediators themselves were thoroughly trained. This was essential: mediators needed to feel confident answering difficult questions, to understand the science at an appropriate level, and to know how to handle sensitive topics — including concerns about side effects, fertility, and whether the vaccine was "really" free.

Training was designed to be collaborative and respectful of mediators' existing community knowledge, treating them as professionals with expertise in their communities, not simply as messengers for medical information.

6.3 Educational Sessions in the Community

Organised educational sessions were held within communities — not in clinical settings. This was a deliberate design choice. Meeting people in their own spaces, on their own terms, was fundamental to reducing the power imbalance that often characterises health outreach.

Sessions were conversational rather than didactic. The goal was never to tell people what to do, but to give them the information they needed to make a genuinely informed decision. As the team emphasised:

> *The focus was on creating informed conversations rather than pressure to vaccinate. — **Prof. Daniela Filakovska Bobakova***

6.4 Consistent Messaging Between Community Workers and Healthcare Providers

A crucial — and often overlooked — element of the intervention was ensuring that the messages delivered by health mediators were aligned with what community members heard from doctors and nurses. Inconsistent information between trusted community educators and clinical staff can erode trust rapidly. The team worked to ensure that healthcare providers in the area were aware of the outreach being done and could reinforce the same messages in clinical encounters.

Key Design Principle: Community-based outreach and clinical care must speak with one voice. When a health mediator tells a mother that the vaccine is safe and free, and then the paediatrician confirms the same, trust compounds. When messages contradict, it collapses.

7. What Worked & Key Insights

7.1 Listening Over Pressure

Perhaps the single most important finding from the Slovakia intervention is that **listening worked better than persuading**. The team approached communities not as resistant populations to be convinced, but as curious individuals who deserved good information. The result was striking:

Building trust through listening and providing information without pressure was key to success.

This runs counter to some instincts in public health outreach, where there can be pressure to "close the deal" — to leave every interaction with a commitment to

vaccinate. The RIVER-EU Slovakia experience suggests that respecting autonomy and offering genuine informed choice actually increases uptake over time, because it builds the trust foundation on which further engagement can occur.

7.2 Genuine Community Curiosity

Contrary to assumptions about apathy or hostility, the team found that community members were **genuinely curious and engaged** once the topic was introduced. Many had direct personal experience with cervical cancer — in mothers, aunts, or neighbours — and this gave the HPV vaccination conversation immediate personal relevance.

People showed genuine interest once the topic was introduced, often having personal experiences with cervical cancer in their families. — **Daniela**

7.3 Vaccination Rates Exceeding the General Population

The results were not just encouraging — they were remarkable. In the pilot study group, HPV **vaccination rates exceeded those of the general Slovak population**. This outcome challenges deficit-based assumptions about marginalised communities and demonstrates clearly that when appropriate, respectful, and well-designed outreach is provided, underserved populations can and do respond.

Standout Result: HPV vaccination rates in the RIVER-EU Roma community pilot group **exceeded those of the general population in Slovakia.** This is not just a success metric — it is a powerful argument for investing in targeted, community-centred outreach as a standard component of national immunisation strategy.

7.4 Working *With* Communities - Not *For* Them

The team repeatedly emphasised a philosophical distinction that shaped every aspect of their work: they were working *with* communities, not *for* them. This meant:

- Adapting approaches based on community feedback rather than imposing a fixed protocol
- Treating community members as active participants in their own healthcare decisions
- Valuing the expertise of mediators and community members as essential to program design
- Remaining flexible and responsive throughout the intervention period

8. Sustainability & Institutional Impact

8.1 Beyond the Project: Ongoing Roundtables

One of the most significant markers of success for RIVER-EU Slovakia is that the work did not end when the project period ended. The intervention built enough

momentum and credibility that Daniela and Tana — and the broader Healthy Regions network — have been invited to participate in high-level stakeholder roundtables involving the Ministry of Health, NGOs, and other key actors in the Slovak health system.

These roundtables represent the institutionalisation of a community-centred approach — the formal recognition by policymakers and system leaders that the Roma Health Mediator model works and deserves to be scaled and sustained.

8.2 Advocating for the Mediator Model

Daniela and Tana continue to advocate actively for the sustainability of the Roma Health Mediator model, pushing for ongoing program funding and upscaling. Their presence at high-level meetings ensures that the community perspective remains visible in policy discussions — and that the results achieved through RIVER-EU are not treated as a curiosity, but as evidence for systemic change.

8.3 Training the Next Generation of Mediators

Tana continues the training of additional Roma health mediators in HPV prevention and vaccination across all regions in Slovakia — extending the geographic reach of the approach and ensuring that the cadre of trusted community connectors continues to grow.

8.4 Academic-Community Partnership as a Model

The collaboration between Daniela's university research expertise and Tana's community field work is itself a model worth documenting and replicating. The success of RIVER-EU Slovakia was not achieved by either party alone. Their ongoing joint participation in stakeholder roundtables sends a clear message to the system: research and community practice are most powerful when they stay connected.

Replicability: The Roma Health Mediator model, as deployed in RIVER-EU Slovakia, offers a transferable framework for other countries and communities. Its core elements — trusted community connectors, non-coercive education, consistent messaging, and sustained institutional advocacy — are not Slovakia-specific. They are universal principles of equitable public health practice.

9. Practical Tips for Healthcare Professionals

Whether you are a GP, a paediatric nurse, an immunisation program coordinator, or a public health officer, the lessons from RIVER-EU Slovakia translate directly into actionable guidance for your work with marginalised or underserved communities.

9.1 In the Clinic

1. **Frame HPV vaccination as cancer prevention, not infection management.** This language is more accessible, more relevant, and more likely to resonate with individuals who may have personal or family experience with cancer.
2. **Never assume apathy.** Marginalised communities are not inherently reluctant to vaccinate — they are often simply under-informed. Curiosity is your ally. Make time for questions.
3. **Confirm that vaccination is free** and clearly explain eligibility criteria. Uncertainty about cost and entitlement is a significant practical barrier that can be easily addressed with direct, clear information.
4. **Create an environment where questions are welcome** — without judgment and without time pressure. A patient who feels rushed or dismissed is unlikely to return, let alone to recommend the service to their community.
5. **Align your messaging with community educators** if outreach programs are active in your area. Contradictions between community workers and clinical staff erode trust. Seek consistency.

9.2 In Community Outreach

1. **Go to where people are** — community centres, settlements, familiar spaces — rather than expecting them to navigate unfamiliar clinical environments for initial information-sharing.
2. **Invest in trusted intermediaries.** If your organisation does not already work with community health mediators or health promoters from within the target community, advocate for this. It is not an optional add-on — it is often the difference between reach and irrelevance.
3. **Use inclusive language in all communications.** Avoid framing vaccination campaigns in ways that could signal that a community is being targeted because of a deficit or risk. Lead with universality: "Available to everyone — and we want to make sure you have access too."
4. **Listen more than you speak** in community educational sessions. Understand what people already know, what concerns they have, and what experiences shape their views before delivering information.
5. **Document and share your results,** however small the scale. The RIVER-EU Slovakia team's participation in national roundtables was made possible because they had evidence. Good community health practice, rigorously documented, becomes the evidence base for policy change.

9.3 In Program Design

1. **Build in flexibility from the start.** Rigid protocols often fail in community settings. Design for adaptation based on feedback and treat mid-course adjustments as a sign of a responsive program, not a failure of planning.
2. **Pair academic or institutional partners with community-embedded organisations** from the outset. This is not just good ethics — it is good methodology. Community partners bring knowledge that cannot be obtained through desk research.

3. **Plan for sustainability before the project ends.** Funding cycles are short; community trust takes years to build. Design handover, transition, and advocacy strategies from day one.

10. Reflection Questions

These questions are designed for use on SEKI.eu in self-directed study or group discussion. Take time to consider them honestly — the most valuable learning often comes from the moments where we recognise the gap between what we intended and what communities experienced.

10.1 For Individual Reflection

1. Think of a recent interaction where a patient or community member seemed disengaged or resistant to a health recommendation. Looking back, what might have been driving that response? How might the RIVER-EU Slovakia approach have changed that interaction?
2. What assumptions do you hold — consciously or unconsciously — about marginalised communities and their relationship to healthcare? Where do those assumptions come from, and how might they affect your practice?
3. The RIVER-EU team achieved HPV vaccination rates in a marginalised Roma community that exceeded the general population. What does this result challenge about conventional narratives in public health?

10.2 For Group Discussion

1. The Roma Health Mediator model relies on community members — not clinical professionals — as the primary agents of health education. What are the opportunities and risks of this approach? How can healthcare systems support and protect community health workers?
2. Consistent messaging between community educators and healthcare providers was identified as a key success factor. In your current context, how aligned is the information provided in community outreach with what patients hear in clinical settings? What would it take to improve alignment?
3. Daniela and Tana emphasised working with communities, not for them. What does genuine co-design look like in your professional context? What would need to change in your organisation or system to make this possible?
4. The project's success contributed to ongoing institutional engagement at the Ministry of Health level. How can frontline healthcare professionals contribute to policy advocacy, even without formal research roles? What role does documentation and storytelling play?

Acknowledgements and Disclaimers

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