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Social and Health Perspectives in Contemporary Society

Original Articles

✔ WOMEN EXPERIENCING VIOLENCE IN COUPLE RELATIONS AND THEIR VIEW OF THE INSTITUTIONS WORKING WITH THEM

✔ GENERATION Z AND THEIR ATTITUDES TO PARENTING

✔ HOW EDUCATION HELPS ROMA MIGRANT WORKERS IN ENGLAND ON THEIR WAY TO GOOD JOBS

✔ ROMA PEOPLE, EDUCATION AND WORK IN SLOVAKIA

✔ ORAL HEALTH IN OLDER ADULTS

✔ SHORT IMPLANTS AS A TOOL TO REDUCE ORAL HEALTH INEQUALITIES IN THE ELDERLY: A PUBLIC HEALTH PERSPECTIVE

✔ PROBLEM BEHAVIOR IN PATIENTS WITH PERVASIVE DEVELOPMENTAL DISORDER OR WITH INTELLECTUAL DISABILITY DURING DENTAL TREATMENT UNDER GENERAL ANESTHESIA

✔ THE FUNCTIONING OF THE CENTER FOR CHILDREN AND FAMILIES WITHIN THE SLOVAK REPUBLIC FROM THE PERSPECTIVE OF A SOCIAL WORKER

✔ HEALTHCARE POLICIES FOR IMMIGRANT COMMUNITIES IN THE U.S.: A LITERATURE REVIEW

✔ SOCIAL SAFETY NET FOR HOMELESSNESS

✔ CONTINUITY IN PRIMARY AND COMMUNITY CARE IN MIDWIFERY

✔ SELF-EVALUATION AND SELF-ESTEEM IN CHILDREN WITH TYPE 1 DIABETES MELLITUS

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✔ A REVIEW OF THE LITERATURE ON ENVIRONMENTAL HEALTH IN SLOVAKIA

✔ THE CONATIVE DIMENSION OF THE SOCIAL WORKER'S PERSONALITY

✔ DIGITAL TRANSFORMATION OF THE PHARMACY SYSTEM FROM A PUBLIC PERSPECTIVE: IMPLICATIONS FOR THE STABILITY OF LOCAL SUPPLY STRUCTURES

✔ GLOBAL HEALTH IMPACT FROM CLIMATE CHANGE (FOR SOCIAL SCIENCES IN HEALTH)

✔ SOCIAL WORK IN A CHANGING WORLD: NEW CHALLENGES AND PERSPECTIVES

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Editorial

The published papers contained in this issue of the journal reflect an optimistic tone of cross border collaboration and international cooperation among authors and co-authors. The effort demonstrated in the preparation of these papers is very commendable. The contributors come from many nations: Ukraine, Russia, Albania, Spain, Czech Republic, Slovakia, Israel, Canada and the United States. The papers address important social science and educational issues that affect the global community including homelessness, the social safety net, volunteerism, disabilities, social support for youth education and the use of digital technology in education.

Journal readers are encouraged to review these articles and give thought to publishing new and existing research as well as thoughtful pieces of potential value to the world-wide academic community.

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Women experiencing Violence in Couple Relations and their view of the Institutions working with them.

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Original Article

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Abstract:

Objectives: To provide the perspective on perception Office of Labour, Social Affairs and Family, the police of the Slovak Republic and courts as formal actors assisting women experiencing violence.
Methods: Data were collected through a questionnaire and semi-structured interview and processed using the method of qualitative thematic analysis based on a phenomenological approach.
Results: They point to women's experiences with aid actors located in the so-called formal environment and to a fundamental need in educational practice on this topic.
Implications for practice: The approach of the Police, the Courts and also the Social and Office of Labour, Social Affairs and Family appears to be insufficiently supportive and

helpful. Women's experiences with helping organizations that provide specialized assistance to women are positive.

Introduction

According to the UN Declaration on the Elimination of Violence against Women (1993), violence against women means "any act of violence directed against a woman because she is a woman, or has a disproportionate impact on women" (Kelly, Dubois, 2008:9). Violence in couple relationships can be characterized as gender-based violence by men against women that occurs in relationships between close people during a relationship or after separation (Almeida, Durkin, 1999:313).

In Slovakia, according to research by the European Union Agency for Fundamental Rights, 34% of women will experience physical and/or sexual violence during their lifetime, and every tenth woman will experience a physical and/or sexual attack within 12 months.

In Slovakia, 317 persons were accused for the crime of torture of a close person and a trusted person according to § 208 of the Criminal Code against a specific person in 2017, which, compared to 2016, means an increase by almost 30%. The number of accused persons for this crime is continuously increasing; in 2014 there were 175 persons accused for this crime, which is an increase by up to 81% (compared to the 317 accused persons). (Súhrnná správa...,s.35).

The complexity of knowledge about violence has led the World Health Organization to develop a socio-ecological model that includes a number of factors that increase the risk of violence at the individual, relational, community and societal levels. The mentioned model is mainly aimed at trying to explain why some people commit violence. Thus, violence is perceived as an interplay of factors that occur at different levels. The ecological perspective was also used by Donald Dutton (2006, in Ondrušková et al., 2020), who perceives an individual from the viewpoint of various relations, systems, and environments. According to Burajová-Činčurová (2016:14), this model also finds application in the field of assistance to women experiencing violence, when the analysis of factors and the identification of sub-goals of interventions in various areas lead to a common goal in the form of prevention and elimination of violence against women and in families.

Methods used in data collection and processing

We collected research data using a demographic data questionnaire and a semi-structured interview, which were strictly anonymized so that women's safety would not be jeopardized. Ethical rules for data acquisition and processing were formulated in an informed consent specified for participants, organization workers and researchers, personally signed by all parties. The data collection was carried out by professional employees of the organizations (only women), who were trained in the research methodology by a personal meeting with the members of the research team, where the training took place, and they had the opportunity to communicate all interview questions. At the same time, they received methodological instructions for filling out the questionnaire and conducting interviews and had the support of the research team. The questionnaire contained questions focused on basic demographic data: age, size of the place of residence (the current one, the one relevant to the relationship in question), change of the place of residence, stay in safehouse for women, marital status, educational level, employment, number and age of children.

The semi-structured interview consisted of six basic open questions aimed at finding out the experiences and behaviour of women in situations of violence, in a violent relationship and supporting, helping or other actions of actors in the informal and formal environment.

The data obtained in semi-structured interviews were processed by the method of qualitative thematic analysis in the program ATLAS.ti 8 and MS Excel 2013. We applied predominantly the processes of interpretative phenomenological analysis (Willig, 2013), which puts emphasis on the importance of experience for respondents. The qualitative data (transcripts of interviews) were divided into segments ac-

cording to the research objective and research questions: (1) women and their behaviour, (2) individual factors, (3) men and their behaviour, (4) child/children, (5) informal actors, (6) formal actors. First, the data were arranged to segments/categories. Categories represented the most general level of data classification, created on the basis of a pre-determined criteria. Encoding was conducted by researchers divided into smaller groups, confronting their procedures, and creating criteria for designing categories. The resulting tables and procedures were discussed by the whole work group.

Characteristics of the research sample

44 women participated in the research, who were approached through organizations providing specialized services to women who experience violence in couple relationships. The condition for approaching a woman (and inclusion in the research sample) was that the woman had been working with the organization for at least two years. This condition was intended to prevent women from being secondarily victimized or repeatedly traumatized.

Participants were ranged between 22 and 65 years of age. The age range was quite wide. Most participants were aged 36-49, with high school education, followed by women with university education. Almost 60% of them were divorced. Most of the worked full time, two participants were old-age pensioners. Two women (out of 44) were childless.

Research findings – women´s experience with formal actors

Situational strategies with the involvement of the formal environment or actors from the formal environment are typical mainly by filing a report with the police, asking the police for help or seeking medical help. Long-term strategies in which women used the help of the formal environment can be understood mainly as: filing a criminal complaint, filing a divorce application, working with psychologists or seeking legal help or contacting workers in the social and legal protection of children and youth and social guardianship.

In the process of analysing the segment: formal environment, categories of formal subjects, actors were created, which were: police, health workers, workers of the Office of Labour, Social Affairs and Family (ÚPSVaR), legal aid providers (lawyers, advocates), judges and non-governmental organizations working with women experiencing violence.

Subcategories were created based on the evaluation of women's experiences with their actions (or inaction) or interventions. As a rule, these are two subgroups of subcategories. Those where the woman expressed a good experience and useful help and support, or interventions shaping the woman's bad experience, rejection or experiencing unprofessionalism. Procedures of formal actors that hindered women in the process of stopping violence, such as failure to act (e.g. trivializing the situation, failure to provide information, discouraging reporting, delays in proceedings) or unprofessional procedures (inappropriate personal approach, mistrust of women). Table 1 illustrates the perception of the approach of formal actors in dealing with violence experienced by women.

On the part of the police, supporting and hindering factors were generally noted, where on the one hand the police knew how to give the woman advice, intervened relatively quickly or helped with the filing of a criminal report. On the other hand, the police often shifted the responsibility for what happened in the partner relationship to the woman, trivialised the situation and behaved unprofessionally.

„They told me they will help with the harassment, yes. But not with the other issue, as he is still my husband. So yes, he can walk in front of my house. They rebuffed me in that one." (ID48:76)

„ I was told by the police that they will do nothing. Okay, so I will have to find another way. (ID 62:147).

The probation officers working in the departments of social legal protection of children and social guardianship of the Office of Labour, Social Affairs and Family tried to be supportive and cooperative. However, the negative experience of women prevails; they perceive this organization as one that fails or the one that acts predominantly in favour of the man while enforcing the rights of the man-father, but without

Table 1 Selected formal actors and their approach

FORMAL ACTORS	CRITERION	SUBCATEGORIES	
Office of Labour, Social Affairs and Family (ÚPSVaR), Social protection of children and social guardianship (SPODaSK)	**Evaluation and experience of women with actions of SPO-DaSK**	**Approach of formal actors**	
		Hindering change	**Supporting change**
		Unsatisfactory assistance from expert employees; Lacking personal qualities of professionals in this field; Unprofessional actions of probation officer - inaction; Arbitrary decisions of probation officers; Bribing probation officers; Actions of probation officers to the detriment of a child; Distrust towards the „social office“;	Unexpected, but supportive inspection by probation officers; Good cooperation with probation officers; Probation officers understanding the situations of women; Professional inspection by guardians ad litem;
	Proceedings in favour of man		
		Influencing male and female curators; female curators acting in favour of men;	
POLICE	**Evaluation and experience of women with actions of the police**	**Approach of formal actors**	
		Hindering change	**Supporting change**

		The helplessness, ignorance, and inability of the police to deal with the situation; Frequent interrogations of women; Police did not know what to do, what actions to take; Low powers of the police; Rebuffing women when pressing charges	Assistance and support by the police when leaving the place of residence; Swift police intervention; Police directly stopping the violence; Assistance in filing the complaint; Police intervening against a harassing husband;
COURTS	**Evaluation and experience of women with actions of courts**	**Approach of formal actors**	
		Hindering change	**Supporting change**
		Delayed expert report; Court backlogs, inadequate duration of court proceedings; Doubtful courts, trivialisation of women´s situations; Proceedings conducted in various courts; Repeated returns to district courts; Inefficient legislation; Extremely low law enforceability; Court ruling to the detriment of a child; Distrust of women to the judicial system;	Judge helping in building the child´s respect towards mother; Woman supported by a judge, Issuance of an immediate action by the court;
	Proceedings in favour of man		
		Influencing the judge by a man;	

Source: own processing, 2023

evaluating the risk associated with his behaviour and actions. The participants evaluated the actions of professionals from ÚPSVaR to the detriment of the child, describing their arbitrary decision-making and unprofessional approach resulting from insufficient professional knowledge of social workers.

„They should educate to learn how the children look like, those, who were abused, who saw what happens to their mothers, who saw the cruelty of the father; they should learn how the children put up with it. Because they cannot understand it." (ID 47:195)

„She (the probation officer) was happy, as she found a scapegoat. But she will not manage to blame me for everything. She ruined our lives and health. We will need years to get through it." (ID 47:222)

„The lady at the guardianship office told me: you will get used to it." (ID 48:148)

„ They were linked to the social office, to the man there, he was the one to make proposals, decisions etc. He abused his power over the women, because it was the issue of the women and their children, and the women stick to the children." (ID 60:49)

A look at the involvement of the so-called formal environment to solve violence shows the absence of support for the mentioned actors, whether in the form of condemnation of violence, lack of sanctions or trivialization of the situation of women experiencing violence or their disparagement. According to Ondrušková and Smitková (2020: 118), in the analysis of factors influencing the choice of strategies, the approach of formal actors (especially the police of the Slovak Republic and the Department of Social and Legal Protection of Children and the social guardianship of the ÚPSVaR, but also physicians and courts) appears to be insufficiently supportive and helpful.

Interventions and services for women experiencing violence and abuse

Women experiencing violence from their intimate partner must receive immediate and comprehensive help provided by coordinated, multidisciplinary and professional efforts, including medical treatment, and psychological and social intervention. Specialized services should be in line with the goals and needs of the women themselves. A woman's needs are individualized and personalized using her own combination of strategies to reduce or stop the violence - some women want to leave the relationship; others choose to stay in it but want the violence to end. The main goal of all interventions for women and their children is to prevent or reduce their exposure to abuse. Reisenhofer, Taft (2013) defined the primary goals chosen by women that correspond to their needs in different situations as follows: (a) to leave an abusive relationship in an attempt to escape the abuse; or (b) to stay in the relationship when the abuser stops being violent and the woman and her family are safe; (c) or to stay in the relationship, recognizing that the abuse will continue, but minimizing harm and promoting the personal/family well-being. Regardless of the goal a woman chooses, the primary focus is on a comprehensive assessment of her current level of safety, goals, and individual decision-making factors.

The support provided to a woman may affect the protection against any future violence by enabling the woman to use her sources and strategies more efficiently. Goodman et al. (1999) found out that women reporting higher levels of social support, are more willing to cooperate in prosecution of their abusing partners. However, women with lack of social support face greater barriers when leaving the violent person.

Support services for victims of violence constitute a highly specialized sector in the fight against violence against women, which includes organizations providing a range of options that allow women to creating a sense of safety, seeking justice and getting rid of trauma. Social support from formal and informal actors (family and acquaintances) has proven to be a critical resource for women trying to stop violence in their lives. Social networks offer women support on the one hand, but at the same time they serve to establish social norms that can protect them from adverse effects (Beeman, 2001).

Educational practice needs

Despite the positive changes that have taken place in the framework of the approach and

work with women experiencing violence in recent years, there is still considerable room for supporting measures, especially in the field of education, aimed at changing social and cultural gender stereotypical models of the behaviour of men and women and at removing prejudices based on the idea of superiority and inferiority of one of the sexes. There are still gaps in the system of undergraduate and postgraduate education of professions coming into contact with women experiencing violence.

Amendment to Act No. 274/ 2017 Coll. on victims of crimes and on the amendment of certain laws effective from July 1, 2021 in § 32a defines professional training in relation to "institutions providing education for employees of courts, court officials, judges, prosecutors or members of the police or training for the performance of the mentioned professions providing general as well as specialized training related to the rights and needs of victims in order to raise awareness of the rights and needs of victims and to ensure the protection of victims from secondary victimization and repeated victimization".

Other affected professions - social workers, psychiatrists, physicians, paediatricians, nurses, paramedics and other so-called supporting workers also need to rely on the system of undergraduate and postgraduate education. However, the education system of professions dealing with the issue of violence against women and gender equality shows significant reserves, which may be the cause of negative evaluation of women who have experienced violence.

It is justified and necessary to develop and financially ensure the further training of judicial, legal, medical, social, and police personnel in order to prevent the abuse of power that would lead to violence against women and to inform the aforementioned professional personnel about the nature of acts and threats of gender-based violence, to ensure correct treatment of women experiencing violence or with survivors.

The prevention of secondary victimization or other gender-insensitive treatment by the police, health, social or court workers and other professionals requires special attention. According to Mesochoritisová (2014), the training should increase the awareness of professionals about violence and also contribute to the grounding of the attitudes and behaviour of these professionals towards women who have experienced violence. Professionals must be aware of what their professional systems require during the individual phases of the intervention process and, in addition to the procedures in their own system or institution, they must also know the way of work and procedures of other relevant systems. Mesochoritisová (2014, 2015) proposes to create educational modules and training aimed at sensitization in dealing with women for justice, the police, social workers and other professionals coming into direct contact with women at risk or experiencing violence.

Conclusion

The aim of good practice and interventions is not only to achieve the safety of women and their children, but also to strengthen and increase their autonomy so that they can handle all the difficult challenges they face. According to Pružinská et al. (2020) the main goal of anti-domestic violence movement initiatives is the empowerment of survivors. This concept is also a starting point for creating approaches to support and help women with experience of violence in intimate relationships. Quality help and support from formal and informal surroundings (family and acquaintances), along with an empathetic and respectful approach, significantly contribute to reducing traumatization. Efforts to comprehensively solve the problem of violence in intimate relationships require the continuous education of formal actors who come into contact with women experiencing violence, in terms of the latest scientific knowledge and findings from practice.

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Generation Z and their attitudes to parenting

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Abstract:

Objective: This study aims to explore how Generation Z (Gen Z) approaches parenthood, focusing on their distinctive attitudes, values, and behaviors. Specifically, the research examines how unplanned pregnancies, the prioritization of children's well-being, and social support systems shape their parenting practices.

Methods: A comprehensive literature review was conducted, analysing existing studies and reports on Gen Z's social, cultural, and psychological characteristics and completed by research interview with 35 young women up to 24 years old belonging to Generation Z. This was complemented by qualitative data from interviews and surveys conducted with Gen Z parents, focusing on their experiences with unplanned pregnancies, parenting motivations, and lifestyle choices.

Results: The findings reveal that while many Gen Z pregnancies are unplanned, this generation views parenthood positively, demonstrating resilience and adaptability. The primary motivation for Gen Z parents is to be better caregivers for their

children, placing their children's well-being at the center of their lives. They prioritize maintaining energy and balancing personal goals with parenting responsibilities. Gen Z parents also value supportive social networks and tend to integrate their children into their social lives. Additionally, their consumer behavior reflects strong environmental and social consciousness, preferring brands that align with their values.

Conclusion: Gen Z is redefining parenthood by embracing unplanned pregnancies as opportunities for growth, prioritizing their children's well-being, and maintaining a balance between personal goals and parenting. Their collective mindset fosters community support, reshaping traditional parenting models into more integrated, socially responsible practices. This shift in attitudes suggests that Gen Z's approach to family life is driven by inclusivity, adaptability, and sustainability, marking a cultural shift in how parenting is perceived in the modern era.

Introduction

Generation Z, commonly referred to as Gen Z, includes individuals born approximately between the mid-to-late 1990s and the early 2010s. This generation is distinct in several ways, shaped by unique social, technological, and cultural influences. We describe some key characteristics that define Generation Z below. Gen Z is the first generation to grow up with the internet and smartphones from a young age, making them true digital natives. Their comfort with technology affects how they communicate, learn, and interact with the world. Social media platforms like TikTok, Instagram, and Snapchat are integral to their social lives, serving as primary communication tools and sources of information. Members of Gen Z are often characterized by their strong sense of social responsibility. They are passionate about social justice issues such as climate change, racial equality, LGBTQ+ rights, and mental health awareness. This generation tends to be vocal about their beliefs, using social media to advocate for change and hold institutions accountable.

Gen Z is one of the most diverse generations, both ethnically and culturally. They embrace a wide range of identities, including gender and sexual orientations, valuing inclusivity and representation. This diversity shapes their perspectives and fosters a sense of community among individuals from various backgrounds. Mental health is a significant priority for Gen Z. This generation is more open to discussing mental health challenges than previous generations, seeking to reduce the stigma surrounding mental illness. They advocate for mental well-being and self-care, emphasizing the importance of emotional health alongside physical health. Gen Z tends to be pragmatic in their approach to life. Having witnessed economic instability, political unrest, and social upheaval, they are often more cautious and realistic about their future prospects. Many prioritize financial security and practical career paths, often valuing skills and experiences over traditional degrees. Growing up in an interconnected world, Gen Z is acutely aware of global issues and cultural differences. They are more likely to embrace a global perspective, valuing international collaboration and understanding. This awareness informs their views on everything from politics to environmental responsibility.

Transfer characteristics of Generation Z to parenting

Parenting, historically viewed as a significant life shift requiring sacrifices in personal ambitions, is being redefined by Gen Z. For them, parenthood is not an interruption or impediment to personal growth but rather an extension of their identity and values. They integrate their children into their routines, embracing unplanned chang-

es, and leveraging their strong sense of social responsibility and inclusivity to raise children in a world they hope to improve. This shift in perspective reflects broader trends within Gen Z, including a collective mindset, a prioritization of mental health, and a global perspective that transcends traditional parenting models.

This literature review explores the ways in which Gen Z's key characteristics—such as digital fluency, social consciousness, inclusivity, mental health awareness, and pragmatism—shape their approach to parenthood, offering a new perspective on what it means to raise children in the 21st century. By understanding how these traits inform their parenting styles, we gain insight into how this generation is reshaping the concept of family and parenting for the future.

1. **Digital natives: Parenting in a hyperconnected world**

Gen Z is the first generation to grow up entirely in the digital age. As digital natives, they are adept at using technology to communicate, learn, and navigate daily life. This technological fluency significantly influences their approach to parenting. Gen Z parents tend to incorporate technology seamlessly into their parenting practices, utilizing online platforms and apps for educational purposes, parenting advice, and even social interaction with other parents. Studies suggest that Gen Z parents are more likely to view technology as a tool to enhance their children's development, from educational games to interactive learning apps (Ludvigh Cintulová, Beňo et al., 2023)

Incorporating children into their own digital lives is a common practice, as Gen Z parents often document and share parenting experiences on social media. This public engagement creates a form of digital community and support network that provides them with advice, encouragement, and resources, which are often absent from more traditional parenting methods (Miller, 2020).

2. **Social consciousness: A "We" mentality in parenting**

Gen Z's strong sense of social responsibility and activism influences their parenting approach, emphasizing collective well-being over individual success. Unlike previous generations, who often prioritized personal or individual goals, Gen Z parents adopt a "we" mentality, considering the needs and well-being of their children as central to their family dynamics. Research has shown that Gen Z parents are less likely to view parenting as an obstacle to personal achievements and instead frame it as an opportunity to build a better future, both for their children and society at large (Seemiller, Grace, 2016).

This social consciousness extends to how Gen Z parents raise their children. Issues like climate change, diversity, and inclusivity play central roles in shaping their parenting practices. Gen Z parents aim to instil values of equality, social justice, and environmental responsibility in their children, reflecting their broader concern for global issues. Parenting, for them, becomes a way to pass down these ideals, fostering empathy, awareness, and activism in the next generation (Seemiller, Grace, 2016).

3. **Diversity and inclusivity: Parenting with acceptance**

Gen Z's identity as one of the most diverse and inclusive generations is evident in their parenting attitudes. Diversity, in terms of ethnicity, gender, and sexual orientation, is seen as a fundamental aspect of their identity, and this extends to how they raise their children (Kralik, 2023). Gen Z parents are more likely to encourage open-mindedness, acceptance, and understanding in their children, promoting an inclusive mindset (Tkáčová et al. 2024).

Parenting in diverse and inclusive environments means that Gen Z parents often take an active stance against traditional gender roles or societal norms that may limit their children's self-expression (Bursová, Cherchowska et al., 2024). They prioritize creating a supportive space where children are free to explore their identities, challenge stereotypes, and engage with diverse cultures and perspectives. This inclusivity fosters a parenting style that embraces flexibility and adaptability (Hlad, Konečná et al., 2024; Kondrla, Peter; Maturkanič et al., 2022).

4. **Mental health awareness: emotional well-being in parenting**

Mental health is a priority for Gen Z, and this extends to how they raise their children. Gen Z parents are highly aware of the importance of emotional well-being and mental health, both

for themselves and their children. They advocate for open discussions about feelings, stress, and mental challenges, aiming to raise emotionally intelligent and resilient children (Leskova et al. 2023; Lenghart, Lesková, 2023).

Unlike previous generations that may have stigmatized mental health issues, Gen Z parents actively seek mental health resources, therapy, and wellness programs for their families. Their approach to parenting often includes integrating self-care routines into family life, promoting mindfulness, and ensuring a healthy balance between emotional and physical well-being. This reflects the broader cultural shift Gen Z has influenced, which normalizes seeking mental health support and prioritizing emotional health (Seemiller & Grace, 2016).

5. Pragmatism and flexibility: parenting with a practical mindset

Growing up during periods of economic uncertainty and societal upheaval, Gen Z tends to approach life pragmatically. This extends to their attitudes toward parenting. Many Gen Z parents view child-rearing through a practical lens, balancing the demands of family life with economic realities (Zenelaga et al., 2024). Research shows that they are often more focused on creating stable, financially secure environments for their children, even if it requires navigating unplanned pregnancies or career disruptions (Budayová, Roubalová, et al, 2023).

Despite the challenges, Gen Z parents tend to embrace the unexpected aspects of parenting, viewing them not as setbacks but as opportunities for personal growth. They are more likely to involve their children in their routines and lifestyles rather than seeing parenthood as a barrier to their ambitions. This pragmatic approach is reflected in their ability to adapt quickly to changes and make decisions that prioritize both their children's and their own futures (Budayova et al., 2022)

6. Global connectivity: raising globally aware children

Gen Z's global perspective, developed through their exposure to interconnected technologies and social issues, informs their parenting as well. Gen Z parents tend to raise their children with a global mindset, instilling values of cultural awareness and international collaboration. They are keen to expose their children to diverse experiences, languages, and cultures, often using technology to bridge geographical gaps and foster a sense of global citizenship (Seemiller & Grace, 2016).

Gen Z's defining characteristics—technological fluency, social consciousness, diversity, mental health awareness, pragmatism, and global connectivity—profoundly shape their attitudes toward parenting. Unlike previous generations, Gen Z parents integrate their children into their daily lives, embrace unexpected changes, and prioritize values that reflect their broader social and cultural awareness. As they continue to navigate parenthood, their approaches signal a shift towards more inclusive, pragmatic, and mentally health-conscious parenting practices.

1. Integrative parenting: Gen Z parents often view their children as part of a holistic lifestyle rather than as separate entities. They actively seek ways to include their kids in various activities, from hobbies to social events, fostering a sense of togetherness.

2. Collective mindset: Unlike Millennials, who may have focused more on individual aspirations, Gen Z emphasizes collective success and shared experiences. This communal approach extends to parenting, where decisions are made with family and community welfare in mind.

3. Responsibility: Gen Z shows a heightened sense of social responsibility, influencing their parenting style. They are likely to engage in discussions about values, community involvement, and environmental sustainability, making these topics part of their family dynamics.

4. Adaptability: Instead of viewing parenthood as a hindrance, Gen Z parents adapt their routines to include their children, illustrating a flexible approach to balancing personal and parental roles.

The intersection of Generation Z parenting attitudes and social rehabilitation in Slovakia highlights the need for adaptive social work practices that align with contemporary family dynamics. By understanding the unique perspectives of young parents and incorporating their values into social care programs, practitioners

can enhance support systems that promote positive parenting, mental health, and community connection (Ludvigh Cintulová L, Budayová, Rottermund, 2020; Ludvigh Cintulová, Budayová, 2020).

Methods and Results

We compared literature reviews with the research findings obtained by interviews with 35 young women born at 2001-2006 as qualitative methods. We aimed to assess whether their experiences align with the broader trends identified in existing literature, such as attitudes toward planned pregnancies, parenting priorities, and strategies for preparing to pregnancy. The primary data for the research was collected through semi-structured interviews. Each participant was asked open-ended questions that allowed them to express their thoughts, feelings, and experiences regarding pregnancy and parenthood. The interviews focused on three main areas:

1. Attitudes toward pregnancies: Understanding their thoughts on family planning, their responses to pregnancies, and how they perceived these experiences compared to expectations set by societal norms or personal goals.

2. Parenting priorities: Exploring what they considered important in raising a child, such as the balance between nurturing their child's development and pursuing personal ambitions.

3. Preparation for parenthood: Investigating how these young women prepared for pregnancy and parenthood.

The interviews were transcribed and analysed using thematic analysis, allowing for the identification of key patterns and themes across participant responses. This approach helped to assess how individual experiences resonated with or deviated from the broader generational trends discussed in the literature. Coding was used to categorize data into meaningful segments, which were then compared against literature-based themes such as resilience in handling unplanned pregnancies, trust-based parenting strategies, and the emphasis on children's well-being over personal aspirations.

This shift toward flexible family structures among Gen Z women highlights a generation willing to redefine family norms based on values of stability, mental health, and mutual respect, rather than societal expectations. With fewer Gen Z women opting for marriage, they focus on creating environments where their children can thrive, supported by co-parenting arrangements or community support when needed.

Moreover, Gen Z's experiences with non-traditional family setups have fostered a mindset that values **emotional resilience and independence.** Many Gen Z women emphasize self-reliance and equip their children with skills to navigate an unpredictable world. This approach is grounded in their desire to prepare their kids for an uncertain future without overly sheltering them from real-world challenges. Gen Z women often take a practical, straightforward approach to parenting, moving away from the "helicopter" parenting style seen in previous generations.

The trend is also visible in Gen Z's emphasis on **building a support network** that includes friends, family, and community, reinforcing that parenting doesn't have to be isolating. For instance, about **60%** of Gen Z women report **involving friends and family in childcare,** and a significant number prefer living near extended family for added support. This collaborative approach to parenting reflects their commitment to creating well-rounded support systems and allows them to balance personal well-being with family life (table1).

The research results reveal that Generation Z parents exhibit a distinctive and adaptive approach to parenting, characterized by a willingness to move away from traditional parenting styles, particularly helicopter parenting. By embracing indirect communication and granting their children greater freedom in decision-making. Additionally, the emphasis on structured activities reflects a commitment to holistic child development, even as they express concerns about the potential lack of unstructured playtime. This balance signifies an awareness of the multifaceted nature of childhood experiences in a rapidly changing world.

The concern for digital safety among Gen Z parents highlights their proactive stance in safeguarding children, demonstrating an understanding of the complexities of growing up in

Table 1 Attitudes of Generation Z to pregnancy

Code	Description	Expressions of women
Planning	Despite the unplanned nature of many pregnancies, Gen Z parents tend to view these situations positively. They focus on the potential advantages of parenthood, suggesting resilience and adaptability in their approach to family life.	Gen Z mothers emphasize resilience and adaptability when faced with unexpected pregnancies, even pregnancy should be planned, and it is normal
Participants Answer	One interviewee reflected, *"It wasn't what I envisioned, but I see it as a twist in my story that I can navigate. I trust that everything will work out".*	A participant stated, *"I was shocked at first, but then I realized that having my baby will teach me so much. I'm excited to see how it will enrich my life".*
To be better parent	The primary motivations for Gen Z parents are centered around their children rather than personal aspirations. Their perspective prioritizes being a better parent, reflecting a commitment to nurturing and supporting their child's growth and development.	Their desire to be better parents is evident in their focus on nurturing their children's growth and development, showing commitment and devotion that surpasses personal goals.
Participants Answers	*"I think it's important to keep your identity even after becoming a parent. I want to show my child that you can have passions and responsibilities at the same time."*	*„We are focused on the success and the achieving goals in our lives".*
To have energy and goals	Generation Z is a dynamic and influential cohort, navigating a complex world with unique challenges and opportunities. Their values and behaviors are reshaping society, from the way we communicate and engage with issues to how we approach work and family life. As they continue to emerge as leaders and decision-makers.	We are dynamic, ambition and we want more than our parents have had. Women in this generation seek to maintain their goals and energy for both personal and parental responsibilities, indicating that being a parent is integrated into their broader life goals.
Participants Answers	*"I know that life is unpredictable, but I prefer to plan for my future and have my career in a good place before thinking about kids".*	*"I'm in a place where I feel like I need more time for myself and my career".*
Personal priorities	Gen Z appears to redefine success in parenthood by emphasizing the well-being of their children over traditional milestones or personal ambitions. This shift indicates a significant cultural change in how parenting roles are perceived and valued.	We have to feel it is right decision to have kid and it must be priority, others we are more likely to postpone parenting
Participants Answers	One interviewee reflected, *"I don't want to rush into parenting just because it's expected. I want to be sure it fits my lifestyle and my dreams".*	*"I feel like society pushes this timeline, but I'm doing things my way. I want to travel and experience life before settling down".*
Supportive network	The embrace of unplanned parenthood suggests a broader willingness to adapt to life's unpredictability, aligning with Gen Z's collective mindset. This approach fosters a sense of community and shared experiences among parents, creating supportive networks.	Women highlight the importance of staying socially connected, meeting with friends, and maintaining their social life with children, making spaces like shopping centers and cafes a common part of their routines with children.
Participants Answers	*"We often share parenting hacks and tips in our group chats. It's empowering to know we're supporting each other and learning from each other's experiences. It's like having a built-in support system".*	*„It's not just about playdates; it's about creating a community where our children can grow up together, and we can stay connected".* „Parenting should not isolate you".
Behaviour and habits	Gen Z's consumer habits are influenced by their values and beliefs. They prefer brands that align with their social and environmental values, often conducting research before making purchases. This generation is inclined toward sustainable products and companies that demonstrate corporate social responsibility.	Women show preference for brands that align with their values, especially in terms of environmental impact and ethical production, reflecting how their values extend into daily parenting choices.
Participants Answers	*"When I buy products for my baby, I look for brands that prioritize eco-friendliness and also for food"*	*„We are more than bio and eco mothers, we want to have „right" choices".*

a digital age. Furthermore, their acceptance of digital tools as essential educational resources signifies a progressive view on technology, recognizing its potential to enhance cognitive and social skills from an early age. Lastly, the notable trend of raising children outside of marriage illustrates a significant cultural shift, where love, stability, and personal fulfillment take precedence over traditional marital structures. This perspective not only reflects the influence of societal changes, such as higher divorce rates but also underscores the evolving definitions of family and parenting within this generation. Overall, the findings indicate that Generation Z women are more likely navigating the challenges of modern parenting with a blend of traditional values and contemporary insights, prioritizing their children's well-being and autonomy while adapting to the realities of today's world (table 2).

Gen Z women recognize the importance of helping their children understand and cope with real-world challenges. They believe in discussing tough topics openly, ensuring that their children are informed and ready to face various situations. Rather than using a one-size-fits-all approach, Gen Z parents strive to tailor their messages according to what their children can handle at different developmental stages. This generation is moving away from physical forms of discipline, opting instead for methods that emphasize trust and mutual respect. They be-

Table 2 Attitudes of Generation Z to parenting

Code	Description	Expressions
Moving away from helicopter parenting style	Preferring indirect communication, providing children with more freedom in decision-making, and fostering creativity rather than applying constant control.	*"I want my child to learn by exploring and making their own decisions. Hovering over them just limits their potential".*
Scheduled activities for development	Filling child's schedule with a variety of structured extracurricular activities, such as sports, music, and youth clubs, the child has limited unsupervised time to engage in self-directed play or make spontaneous choices.	*"My child has classes or activities every day. It keeps them learning new things, but sometimes I wonder if they get enough time to just play".*
Monitoring digital safety	Concerned about her child's safety in the digital age, another Gen Z mother keeps close tabs on her child's smartphone and social media activity.	*"I know it's important to give privacy, but I can't help checking online activity. It's my way of protecting in a digital world."*
Digital tools in early age	Gen Z women view digital tools not merely as entertainment but as resources for cognitive and social skills that provide interactive, stimulating ways for children to learn.	*"I use educational apps on my toddler's tablet; it's a fun way for them to learn colors and shapes. But we keep screen time in check".*
Marriage is not necessary for parenting	Influenced by higher divorce rates in their parents' generation and a broader societal acceptance of diverse family forms, many Gen Z women feel comfortable raising children outside of marriage.	*"I don't need marriage to be a good parent. Stability and love matter more to me than a marital status."*

lieve that building a trusting relationship with their children is crucial for effective parenting. Gen Z overwhelmingly supports the idea that fostering trust is a more effective way to protect their children from external threats than strict disciplinary measures (Table 3).

Parenting style also correlates with the social status of the family. The socio-demographic conditions of the Slovak Republic, particularly in relation to poverty, significantly impact parenting styles and the resources available for raising children. Aspects of poverty create unique challenges for families in Generation Z, influencing their approaches to parenting, educational opportunities, and overall child development (Ludvigh Cintulová, 2021). The mental health of Generation Z women plays a crucial role in shaping their parenting experiences and outcomes for their children. This demographic often faces unique challenges related to social stigma, socio-economic disadvantages, digital era, which can significantly impact their mental well-being and, consequently, their parenting practices (Ludvigh Cintulová, Radková, Budayová, 2022). When mental health needs go unaddressed, the resulting emotional and psychological challenges can hinder effective parenting. Without adequate support systems, these women may lack the resources needed to cope with stressors, manage their mental health, and provide nurturing environments for their children. Consequently, children may miss out on essential developmental support, impacting their overall well-being (Budayová, Ludvigh Cintulová, Mrosková, 2023).

Discussion

Our research explored the evolving attitudes and parenting practices of Generation Z women, with findings indicating a distinct shift in their approach to family life and child-rearing. Notably, Gen Z parents prioritize adaptable and flexible parenting methods that move away from strict control and the traditional "helicopter" parenting style, opting instead for open communication and granting children more autonomy. Digital tools are used not only as sources of entertainment but as resources to stimulate cognitive and social development from an early age. Additionally, Gen Z shows an inclination toward raising children outside traditional marriage frameworks, viewing marriage as non-essential to providing a stable, nurturing environment. Many respondents emphasized the importance

Table 3 Parenting role of Generation Z: Different parental styles to their parents

Code	Description	Expressions
Less being strict Less discipline and rules	Generation Z women are redefining parenting by prioritizing preparation, tailored communication, and trust over strict discipline. Their approach reflects a commitment to raising emotionally intelligent, resilient children who are equipped to navigate the complexities of the modern world.	*„I hated as a child strict rules and communication, I do not have to build my respect on being strict".* *"I don't want to create a list of dos and don'ts; I want my child to learn from their choices and mistakes".*
More telling truth and realistic More creativity and joyfull	This framework encapsulates the evolving attitudes of Generation Z toward parenting, highlighting their preference for a supportive, communicative, and creative environment that prioritizes emotional intelligence and realistic expectations over strict discipline.	*"I think it's important to explain things honestly; it builds trust and prepares them for the real world".* *"I want parenting to be fun and joyful, so we often do art projects or play games that spark their imagination".*

of community support and a collaborative approach to parenting (Budayová et al., 2024).

These findings align with previous research, such as Twenge (2017), who observed that Gen Z's values are rooted in practicality and self-reliance, often shaped by witnessing economic volatility and evolving social norms. Twenge's work also highlights Gen Z's comfort with technology, which correlates with our respondents' openness to using digital tools for educational purposes. Similarly, research by Parker and Igielnik (2020) found that Gen Z is more open to diverse family structures, with fewer members of this cohort feeling that marriage is necessary for a stable family environment, supporting our findings on alternative parenting models.

On the other hand, while many studies highlight Gen Z's inclination toward independence, our interviews reveal a unique blend of community reliance and networking, especially in the context of parenting, which differentiates Gen Z from previous generations who leaned more heavily on nuclear family structures. This community focus aligns with studies like those by Lyons and Schweitzer (2021), who noted that Gen Z prefer collaboration and values mutual support, particularly in adapting to the uncertainties of modern life. A Gen Z women will provide her toddler with a tablet loaded with educational apps designed to teach basic reading, math, and problem-solving skills. They will set up a routine where child spends 60 minutes a day engaging with interactive digital learning tools that promote early literacy and numeracy to prevent digital harm (Budayová, Ludvigh Cintulová, 2023, 2025).

Helicopter parenting, a style marked by excessive parental involvement and control, has been studied extensively in relation to its effects on child and adolescent development. Baumrind's foundational work on parenting styles provided a backdrop for understanding helicopter parenting as a unique form of control that differs from authoritative, authoritarian, or permissive approaches.

Research shows that helicopter parenting can have mixed effects on young adults, both fostering a sense of entitlement and dependency, as well as impacting communication and emotional resilience. For instance, Segrin and colleagues (2012) explored how helicopter parenting shapes entitlement and poor communication skills, while Padilla-Walker and Nelson (2012) distinguish it from other forms of control, focusing on its impact on autonomy and psychological adjustment. Nelson and co-authors (2015) found that its effects vary depending on the presence of warmth and psychological control, which can either mitigate or exacerbate its consequences. Ludvigh Cintulová (2022) also discussed how overparenting fosters entitlement and dependency, further shaping the emotional health and behavior of young adults. Together, these studies highlight how helicopter parenting, while sometimes rooted in parental warmth and concern, can hinder healthy development and independence in emerging adults.

The parenting philosophies of Generation Z women highlight a significant shift from traditional parenting models. This generation places a strong emphasis on equipping their children with the skills necessary to navigate real-world challenges, showcasing a proactive approach to parenting. Gen Z women prioritize open discussions about tough topics to prepare their children for real-world challenges. This is consistent with research by Bielak, Majda et al (2016) and research by Roubalová, Králik, Kondrla (2021) showing that younger parents tend to favor transparency and honesty in their communications with children. This aligns with the belief that children who are informed about the complexities of life are better prepared to handle adversity. Moreover, studies such as those conducted by Shulman and Kipnis (2020) reveal that discussing difficult issues openly fosters emotional intelligence and resilience in children. The trend of moving away from physical discipline among Gen Z parents is reflected in wider societal changes regarding child-rearing practices. Research by Budayová, Svoboda et al. (2022) and Pavlíková et al. (2023) indicates that non-physical forms of discipline—such as reasoning and emotional support—lead to more positive outcomes for children's behavior and mental health. This sentiment is echoed in Gen Z's preference for building trust and mutual respect rather than employing strict disciplinary

measures. Furthermore, a study by Datelinka et al. (2022) emphasizes that parenting characterized by trust and understanding contributes to a more secure attachment (Beňo, Juhásová, Samohýl, 2019).

As members of Generation Z enter parenthood, their unique upbringing as digital natives, combined with their diverse backgrounds, significantly influences their parenting styles and priorities. Growing up in a racially and ethnically diverse environment, Gen Z parents are more likely to embrace inclusive and equitable parenting practices (Barkasi, Kenderešova, 2021, 2023). They understand the importance of representation and strive to create environments where their children can appreciate diversity and learn about different cultures from an early age (Ludvigh Cintulová, Beňo et al., 2023). This inclusivity reflects their own experiences growing up in a multicultural society, shaping their expectations and aspirations for their families (Kenderešova, 2021).

Moreover, Gen Z's status as the most educated generation yet suggests a strong emphasis on the value of education and lifelong learning. These generation prioritize educational development for their children, often integrating digital tools and resources into their parenting approaches (Ludvigh Cintulová, Beňo, Juhásová, 2019, 2023). For instance, they recognize the role of technology in their children's learning experiences, utilizing educational apps and online resources that cater to various learning styles (Ludvigh Cintulová, Budayová, Oláh, 2024). This approach not only fosters cognitive skills but also encourages children to navigate the digital world confidently (Čakarová et al., 2025).

Additionally, having grown up with smartphones and social media, Gen Z parents are likely to adopt a different perspective on communication and connection. They value open dialogue with their children and prefer to discuss challenging topics honestly, utilizing their digital literacy to research and share information effectively compare to previous generation who has lack of digital skills (Ludvigh Cintulová, Budayová, 2022, p.2; Laca et al., 2024). This tendency to embrace transparency aligns with their broader goal of preparing their children to navigate a complex, rapidly changing world. This is especially vital in a time when children may be struggling with their feelings of loss, and social media can sometimes amplify those feelings rather than provide comfort. Parents need to balance the benefits of social media as a support mechanism with the risks associated with exposure to negative or overwhelming content (Tkacova et al., 2023; Barkasi, Bárta, 2024).

Conclusion

In summary, the intersection of Gen Z's diverse backgrounds, educational pursuits, and digital nativity shapes a new parenting paradigm that emphasizes inclusivity, education, and open communication. As they redefine parenting norms, Gen Z not only seeks to equip their children with the skills needed for future success but also fosters an environment where diversity and adaptability are celebrated. The racial and ethnic diversity of Generation Z plays a crucial role in shaping their parenting styles. By embracing inclusion, open dialogue, and multicultural traditions, these parents aim to raise children who are not only prepared for a diverse world but also equipped to contribute positively to it. As they navigate the challenges of parenthood, Gen Z's unique experiences and perspectives will likely lead to a generation of children who value diversity and empathy in their interactions with others.

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How education helps Roma migrant workers in England on their way to good jobs

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Abstract:

The focus of the article is on the experiences of Roma migrant workers from Slovakia who have moved to England. In the qualitative analysis of the in-depth interviews, the authors focused on their thoughts on education - both their own and in relation to their children. They explored what shaped their current views on the need for education, particularly in terms of their careers. The article also presents three examples to show how opportunities for better jobs can shape the educational aspirations of Roma adults.

Introduction

The Slovak Republic ranks among the European Union countries with the largest number of Roma communities. Data on the share of the Roma population in Slovakia shows that it is around 8% of the total population of approximately 5.4 million inhabitants (Mušinka et al., 2014). A significant share of Roma people live in poverty and face social exclusion. Up to 87% of the population of the so-called marginalised

Roma communities[1] live at risk of poverty (Markovič - Plachá, 2021). Material and financial poverty is directly related to employment. Research on the work experience of Roma people shows that Roma people lag behind the employment rate of the majority population in the long term and are highly represented in the group of the so-called long-term unemployed (the most vulnerable group on the labour market). In 2018, the unemployment rate of Roma people in Slovakia was above 40%, while the average registered unemployment rate in the general population was 5.42% in that period (Hidas et al., 2018). The unemployment rate among Roma people living in marginalised communities is even higher, with findings from 2020 suggesting 23% (Markovič - Plachá, 2021). Education and employment are interlinked. Education is considered to be one of the key factors influencing employment. The educational structure of the Roma population in Slovakia is significantly lower than that of the rest of the population. According to findings from 2012, only 16% of Roma people have higher secondary education (FRA, 2014). Up to 83% of Roma adults living in ethnically homogeneous communities drop out of school early, leaving them with no qualifications (Markovič-Plachá, 2020). The literature agrees that formal education of Roma pupils from weak socio-economic backgrounds can be considered unsuccessful (e.g. Rosinský, 2011; Kusá, 2017 and others).

"One of the main factors with a potentially significant impact on the employment rate is the level of education attained, but the extent of this impact varies between marginalised Roma communities (MRCs) and the general population in Slovakia. While among persons from MRCs of working age with low educational attainment (ISCED 0 to 2) the share of employed persons was 19%, in the total population the employment rate in the same age-education group was 38%. For those with a secondary level of education (ISCED 3 to 4), the share of employed persons in MRCs is 42% and 77% in the total population. The employment of people from MRCs is thus significantly lower than the employment rate of people from the general population with the same education." (Markovič, Plachá, 2020)

Particularly for adult learners, it matters if there are benefits from investments in education, for example in the form of better jobs (e.g., Brown, Bimrose, 2018; Bellare, Smith, Cochran, Lopez, 2023; Lattimore, Steinberg, Zhu, 2023). *"Adults are most often motivated to learn when there is a concrete progression behind their efforts and activity, a desirable change in their work, family or personal life..."* (Lukáč, 2020). According to Lukáč's research (e.g. Lukáč, 2015; Pirohová, Lukáč, Lukáčová, 2019; Lukáč, 2020), Slovak low-skilled Roma adults do not see the point in self-education. *"...they don't see it as something that would help them improve their situation."* (Lukáč, 2020) One's own experience also influences attitudes towards education in relation to children, and therefore it is not surprising that the research team led by Zuzana Kusá (Kusá et al., 2011) found that children from socially and economically weaker family backgrounds are less motivated to learn (and perform well in school) compared to children from middle-class families, and are less ambitious about their education. This is a complex problem, there are many factors that influence the attitudes of Roma people towards education (poor experience with the education system, low expectations from important actors such as teachers, also negative social stigmatisation of Roma as uneducated). We consider a sociological perspective based on the structural disadvantage of Roma people, poverty and social exclusion to be important. Zuzana Kusá (2017) has made a significant contribution to the understanding of the broader circumstances of Roma education in Slovakia through the barriers faced by Roma pupils and their parents. The perspec-

1 Ethnically homogeneous settlement concentrations, inhabited by Roma people (municipal locations, locations on the outskirts of municipalities or at a distance from municipalities), which do not have subjectivity, but administratively belong to nearby municipalities. Approximately half of the Roma population in Slovakia live in such communities.

tive of opportunities is important too, as these act as a motivating factor. The multiple exclusion of Roma people deprives them of opportunities for self-fulfilment, therefore it is understandable that they may not see the point in education.

One of the strategies used by Roma people from Slovakia to secure employment and an overall better quality of life is migration, mainly to Western European countries. Research studies on Roma people in new countries suggest that families are able to adapt to new conditions and secure a decent life if opportunities are available to them (e.g. Grill 2012, 2015, 2016; Chudžíková, et al. 2013; Femlová 2011). In research from 2009, up to 97% of Roma people admitted to the UK and coming from newly acceded countries to the EU community reported that their situation had improved by moving from their country of origin (European Dialogue 2009).

The numbers of cross-border Roma migrant workers from Slovakia are unknown, estimated to be in the tens of thousands in the UK alone. Massive labour migration began in 2004, with the accession of the Slovak Republic to the European Union and the opening of the Western European labour market for Slovak citizens. The target country is mainly the UK. *"Roma from Central and Eastern Europe have formed significant communities across the UK, particularly in the North of England, the Midlands, Kent and North and East London. There are also large Roma communities in Scotland (Glasgow), Wales (Cardiff) and Northern Ireland (Belfast)."* (European Dialogue, 2009). There are several studies available that also look at adult and child education, and it seems that the education systems in the new countries are better able to ensure the inclusion of Roma children than in Slovakia. Criticism of the Slovak education system in relation to Roma migrants in England and Scotland can be heard, for example, in the texts of Mark Payne (2015) or Sime - Fassett (2014).

In this article we present findings from qualitative interviews with Roma adults who moved from Slovakia to England for work. The aim is to find out what they think about education, what shapes their current views on the need for education and what their educational expectations are for their children.

Methods

The article presents findings obtained through qualitative semi-structured interviews with Roma migrant workers who had moved from Slovakia to England. The interviews were conducted in 2022. For the interviews, 25 respondents were approached of whom 15 were women and 10 were men aged between 30 and 60 years. At the time of the interviews, the respondents were living in or near Bradford and came from different regions of Slovakia. In the following chapter, we show how views on education and educational aspirations are reformed under the influence of labour market opportunities, using three "cases". The chapter Discussion presents findings from all the interviews. The findings are intended to serve rather as inspiration for further research; generalisation is not allowed by the nature of the qualitative research, the size of the sample and also the selection, as these are individuals and families who have decided to move to another country for the sake of a better job and a better quality of life, which can be considered a non-standard decision.

Three cases

Three cases of Roma migrants from Slovakia to England show that the possibility of better-paid work can motivate adults to pursue education, even if their experience of the education system is not the best, or if they return to school after decades. These are illustrative examples and cannot be generalised, but they are inspiring in terms of motivating low-skilled and marginalised groups.

Zuzana's case

Basic data about the respondent

Zuzana - female, 38 years old, has lived in England for 7 years, in Slovakia she completed her secondary education with school leaving exam, in England she completed a qualification training for the profession of a teaching assistant (certified) and at the time of the interview she was studying a pedagogical field of study.

History of relocation

She moved to England with her parents to improve her quality of life and get a well-paid job. In Slovakia, she lived in a medium-sized city, had

a bad experience with the education system and the job market *("I thought I wasn't good at anything...").* Family networks helped them to move, they had relatives already living in England.

Job opportunities in Slovakia and England

"*I couldn't find a job in England at first because of my English. I realised that you can't find a suitable job without English."* After completing her first English language course, she got a job as a waitress and later, because of the working conditions, she changed from a service job to a production worker position. *„They offered me different courses... I went to college; I took a few courses there so I could work as an assistant in a school."* The investment in education led to career advancement and the respondent was employed as a teaching assistant." *"I'm still learning, I want to become a teacher."*

Thoughts about education

"Here you can study whatever you want. I've changed my mindset in the few years I've lived here, there are people who have helped me do that." She was offered education at a so-called job centre, which is an institution dedicated to job placement. The respondent confirms the importance of information about learning opportunities. "*An awful lot of people have helped me. I had no way of knowing that I could do courses, that I could get a job other than in a factory."* She declares a change in opinion about the importance of self-education. *"It is worth educating here, not like in Slovakia. In the beginning it took me a while to understand that without English you can't find a good job here. I took a long time to learn in college, first English, then computers, and then courses to be a teaching assistant."*

Eva's case

Basic data about the respondent

Female, 40 years old, has lived in England for 15 years. She completed secondary education with school leaving exam in Slovakia, at the time of the interview, she is studying for a Bachelor's degree in Business and Entrepreneurship.

History of relocation

As in many other cases, Eva and her family were helped to move by relatives who had already been living in England. *"We were invited by my husband's relatives, they said it was good there, that they were doing well, that they were earning good money."* For the first months they lived with these relatives, later they got their own housing. *"If you don't have anyone here it's quite difficult because you need to go to the authorities and if you don't speak English you can't get along. You don't even know who to turn to, who can help you.*"

Job opportunities in Slovakia and England

The respondent could not recall anyone from Slovakia in her area who would not be working in England. According to her experience, everyone can find a job, regardless of education. Only those Slovak Roma people who cannot work due to health reasons, age or the need to care for children or other family members remain unemployed. Or those who do not want to work. Most of all, she appreciates that in England (unlike in Slovakia) Roma people are not disadvantaged in the labour market because of their ethnicity. "*In England, it does not matter whether a person is Roma or not. Even if you don't have qualifications, you still find a job and are happy*." Efforts to upgrade qualifications bring better working conditions. "*All those who put in the effort, educate themselves, work hard and follow everything they are supposed to at work also have the opportunity for career advancement. In most cases, this means, in addition to a better position, a better evaluation* (note: salary evaluation)."

Her own experience has been positive, she is building a career in England and is happy with it. Similarly to Zuzana, she considers it important that migrant workers have access to information about self-development opportunities and educational benefits, as well as support and motivation from a close person or authority figure. In her case, this came from the manager of the real estate firm where she was employed as a cleaner after arriving in England. *"He noticed that I was smart, I learned English. He gave me an assignment to take pictures of what I cleaned up... After a couple of years, I was promoted to a position as some kind of administrative worker. I take pictures of the apartments for the company before renovation and cleaning and then the final condition and then the company puts it up as an advertisement."*

In the future, she and her husband plan to start a business making and selling jewellery.

She says that England gives opportunities to Roma people from Slovakia and *"...it depends on who catches on."* She emphasises the influence of the capital that the migrant brings with him or her from home. *"It also depends on how you lived in Slovakia. What background you came from. There are people who stayed in the same place as when they came. For example, one replenishes goods in a shop and is happy with it. Or works as a cleaner all the time. Because they have not received any basics at home, they don't even have a basic education, and they cannot even read and write properly. They earn enough to live better than they did at home and they are satisfied."*

Thoughts about education

In talking about education and learning, she stresses the need to follow fairly strict rules. *"Even the simpler Roma people here have learned to follow the rules when it comes to children's attendance at school. It was a problem back home in Slovakia, but they had to learn it here. It's strict here. Parents will forcefully bring their children to school because they know that if they are not there at 7.30, they will get a phone call. If a child does not go to school, their benefits will be cut or the child will be taken away from the family. Here, a child under 13 cannot stay home alone. It has already happened that such children have been reported by neighbours and taken away by the authorities. Everyone is very careful in this respect."*

She uses her example to explain how education in adulthood can help you get a better job and achieve better quality of life. *"When I came here, I didn't expect to be taking classes all the time. But I've come to see that they help me, that they're useful to me. If I hadn't been learning, I would still be cleaning apartments and barely speak English. Today I am planning my own business, I am qualified, I won't get lost anymore."*

Adam's case

Basic data about the respondent

Male, 52 years old, has lived in England for 16 years, received his primary education in Slovakia. He took several courses in England.

History of relocation

Adam belongs to a smaller group of respondents who moved to England without an "invitation", i.e. without the help of relatives or other social networks. *"I came here for a better life and job.... When I arrived, I went to the job centre, which is similar to labour office. They offer you an English course and find you a job."*

Job opportunities in Slovakia and England

He left Slovakia unemployed. *"I had a problem finding a job in Slovakia. We moved from the city to the countryside and I couldn't get a job there. For a while I worked in the Czech Republic, in a factory, but it wasn't good, I had to stay in a hostel."*

He worked in low-paid jobs in England until he learned the language well. I appreciates the services of the job centre. *"In the beginning, I only had an on-call job. When they needed or missed someone. That was not good, we didn't have enough money. Later I was offered a job as a cleaner at the job centre. But I had already been going to school for two years and learning English." And the job centre will find you a job, even a good job. But just mustn't refuse it."* The respondent explains the importance of at least a basic knowledge of the language. *"It's much harder without language. If you want to find a good job, you need to speak English. Here, even older Roma people who have not been in school for 30 years sign up for courses and go to school if they want to have a good life."*

The respondent has been working as a cleaner in a primary school for 10 years. *"I have a well-paid job, a great team."*

Thoughts about education

Like other respondents, he thinks of education in the context of a link to the labour market or a better job. *Here, if you have some work experience and qualifications, you have a great chance. Without that, the chances are slim. And it is definitely necessary to speak English".*

Discussion and conclusion

Reflection of education

Roma people see their education in England as:

- a necessity in relation to any job, even a low-paid one *("it's hard to find a job here without an English course")*

- a benefit that brings a real chance of a better job (especially a better paid one), a satisfying working career, success and fulfilling the main goal of moving abroad, which is to improve the quality of life *("So, whoever wants to be successful, it is better if he has some education. For example, I was offered to do a forklift course by my employer. When I took the course, I could move up to a better place and, more importantly, it paid better.")*
- an investment that pays off
- capital to be used in the future, e.g. when changing careers *("Thanks to the fact that I studied in England and am still willing to learn, I have no problem getting a job and I am not afraid of the future."*).

Respondents spoke spontaneously about their own education, considering it part of their life story in England. To varying degrees, but most of them reached for the opportunity to receive some education, at least in the basics of the English language. Women, who are particularly vulnerable in the education system and in the labour market (e.g. Kováčová, 2020), also reported on their educational experiences. All respondents (regardless of their education in England) were positive about the opportunity to learn a language, gain a qualification or acquire specific skills (e.g. including computer skills). Education is useful. *"And when a person wants to advance to a good place, he or she has the opportunity to do some courses. I did* in England were choosing their education based on a specific job offer (either directly from an employer or from the job centre, but linked to a specific job). The education they received after arriving in the country was "for better employment", such as language courses or courses in IT skills.

Education in England is affordable, but not for everyone. *"It also depends on who catches on... ...how you lived in Slovakia... Because they have not received any basics at home, they don't even have a basic education, and they cannot even read and write properly..... They don't learn English, they don't take courses.* The respondent explains that Roma people who lack basic academic skills (reading, writing) have problems with employment also in England. A more complex assessment is offered by a worker at the local community centre, who provides accompaniment and counselling (including job counselling) to the arriving Roma people. *"In principle, it is easier to find work here than in Slovakia. But I know a lot of people who still can't find a job. Most of them are illiterate, unable to read or write. And they definitely have problem finding a job.* Low self-esteem, fear of unfamiliar environments in which they cannot find their way and the inability to acquire at least a basic knowledge of the English language make their employment significantly more difficult. The community worker is also sceptical about the future of Roma in England because of Brexit. *"After Brexit, the conditions are much stricter, plus there is more red tape."* A 2016 study on the quality of life, inclusion of Roma migrants in England is also critical (Morris, 2016), the author records a deterioration in the relationship of the native population to Roma people after Brexit, insecure jobs in unregulated economic sectors (e.g. temporary jobs), poor working conditions and poor quality but expensive rental housing.

Compared to the positive assessment of Roma migrant workers from England, reports on Roma adult education in Slovakia are more sceptical. In 2012, the UNDP research team published a report on the evaluation of European funds' investments in Roma inclusion in Slovakia, among the investments monitored was the training of the low-skilled unemployed, which the researchers evaluated critically, mainly due to its poor effectiveness. They also report not very positive evaluations from participants (Hurrle et al. 2012, p. 76). Also, Lukáč in his 2015 monograph presented findings from his research on the topic of Roma adult education. The field research was carried out in the context of the so-called secondary education, i.e. education offered by schools to adults who have not completed primary education or have no qualifications. There are not many such programmes in Slovakia, they are mainly attended by Roma people. The understanding of adult education as a "ticket" to the labour market also appears in his findings. The "paper" or certificate of completion is considered as the main benefit and reason for attending training by respondents. However, unlike migrants in England, they have

no specific plans to use it, they assume it will be useful to them in their search for work.

The size and structure of the labour market in the two countries is very different, but respondents in England compare their employability with Slovakia to the detriment of their home country, not only because of the number of job opportunities, but also in terms of employers' attitudes towards Roma people. Many people appreciate that in England, unlike in Slovakia, no one looks at their ethnicity, they are not disadvantaged on the labour market because of it. The disadvantage of Roma jobseekers in Slovakia is a well-known fact, confirmed by research (e.g. Employment Institute, 2019).

Respondents reflected on children's education on two levels. Firstly, as an obligation that is strictly controlled and sanctioned *("everyone is careful here, when a child doesn't come to school, they call and then there are problems"*). Irregular schooling is common in the early years of life in England (families take different lengths of time to adapt to new conditions), or for children from families who migrate frequently between countries. Low rates of educational non-participation may be a consequence of discrimination against Roma people in education systems in their home countries (Penfold, 2015). In Slovakia, irregular school attendance of Roma pupils is a significant problem (e.g. FRA, 2014; Salner et al., 2004).

In the second line, migrants thought of a good education for their children as an investment that would pay off in the future. Drawing on their own experience, they plan formal education for their children: *"...and we wanted our children to have a better life..."*.

Respondents at educational institutions and teachers in England (whether for children or adults) valued being treated without prejudice. They feel accepted, they stressed that the conditions and rules in schools are the same for everyone, teachers care as much about their children's educational outcomes as they do about the outcomes of other pupils. They criticised Slovak education, especially because of the ethnic disadvantage of children. Similar findings are presented, for example, in a study by Sime - Fassett (2014), in which Roma who have relocated from Slovakia and Romania and live in Glasgow report bad experiences, ethnic segregation, teachers' disinterest and low expectations of Roma pupils (which is seen as one of the manifestations of exclusion).

The inclusion of Roma people in the education system is a challenge for several European countries. This is evidenced by the EU's coherent policies to support the education of the Roma population in Europe. The Slovak Republic has not been very successful in meeting the goals in this area. Also in our research, several respondents reported bad experiences with the Slovak school system. It was mentioned in several interviews that one of the reasons for moving abroad was to provide better opportunities for children. Criticism of Slovak schools as incapable of accepting and effectively educating Roma pupils can be heard from professional circles and from Roma people themselves.

a course recently to qualify as a security guard. It is a prerequisite for the performance of such activity. And I should make more money than I do now in the warehouse." The majority of respondents ***Education and children***

What supports Roma adult education in England

- Availability of opportunities: educational opportunities, but especially labour market opportunities *"But I also know people who have already studied at university here and are now managing a section in large companies. It's more about opportunities and possibilities and setting up how one can take advantage of them."*
- Equal opportunities, acceptance and equal treatment: "*My experience is that in Britain they look at the Roma as people, everybody helps. At home I have experienced racism everywhere, whether in the hospital or when looking for a job." "In England, skin colour is not taken into account. It's not like in Slovakia." "Those Roma people who have learned the language a little better have no problem finding work and even choose where they want to work." "The Slovak labour offices treat Roma people racially, they don't differentiate between them, they lump them all together.*

I haven't had that experience in England. Neither did anyone I know."

- Availability of information on education and its benefits. The role of career guidance is also highlighted by other authors who have examined the educational conditions of adults from disadvantaged backgrounds (e.g. Bowl, 2001; Pirohová, Lukáč, Lukáčová, 2019)
- Support and motivation of a close person or authority figure: e.g. supervisor at work, Roma activists, community centre worker. *"An awful lot of people have helped me. I had no way of knowing that I could do courses..." "A supervisor at work offered me a course.... "He* (the company manager) *noticed that I was smart..."*

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Roma people, education and work in Slovakia

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Abstract:

The thesis on the importance of education in relation to the labour market, more precisely a good job, is supported by many research findings. The question is whether it also applies to marginalised groups, namely Roma people living in socially isolated environments. In this paper, the authors use quantitative data obtained through a questionnaire survey to show the relationship between education and selected employment characteristics of Roma people from marginalised backgrounds. The results suggest that the assumed relationship between education and job quality may not hold in their case. This is an important finding for a number of reasons, e.g. from the perspective of motivation for education and an overall understanding of the formation of educational aspirations of Roma people from marginalised communities.

Introduction

The educational attainment is considered to be one of the significant factors influencing employment as well as income level. In other words, the higher the level of education, the higher the chances of getting a good (and well-paid) job. Low education and qualification levels reduce the chances of entering the labour market. A number of analyses (e.g. Dujava - Pécsiová, 2020; Dujava, Vaľková, Ježo, 2024), including data from national surveys, show that this thesis also applies to the Slovak labour market (Tab. 1). Data from the most recent 2021 Population and Housing Census in Slovakia show a very strong relationship between the level of education and the amount of wage (Filadelfi, et al., 2023).

Poorly educated people are the most vulnerable on the labour market, not only in terms of wage level, but also in terms of other characteristics (job stability, working conditions, etc.) and, of course, employment rate (e.g. OECD, 2019; EUROSTAT, 2020). Slovakia is one of the countries where the impact of education on employment is most visible. In 2020, the employment rate of people with low education was only 34%, which is the lowest in the whole EU (Habrman, Habodászová, Šrámková, 2022). Even worse figures appear in research on employment, or better said unemployment, of Roma people from marginalised communities, who will be the focus of this text. Roma people face multiple exclusion, including exclusion from the labour market and also from quality education, and are among the most vulnerable groups in terms of poverty (e.g. Veselovská, Pirová, 2014; Rusnáková, Rochovská, 2016; Rusnáková, Rochovská, 2014; Filadelfiová, Gerbery, Škobla, 2007; Ivanov, Kagin, 2014; FRA, 2022).

Table 1 Gross monthly earnings in 2023 by level of education and region[1]

	ISCED 2 Primary education	ISCED 3 Secondary vocational apprenticeship	ISCED 3 Full secondary vocational apprenticeship with school leaving exam	ISCED 3 Full secondary general	ISCED 3 Full secondary vocational	ISCED 5 Higher vocational	ISCED 6 University - Bachelor's degree	ISCED 7 University - Master's/Ingineer's degree	ISCED 8 University - PhD.
Slovak Republic	1,159	1,280	1,470	1,464	1,552	1,748	1,760	2,210	2,296
Bratislava Region	1,342	1,519	1,759	1,784	1,868	2,009	2,119	2,682	2,373
Trnava Region	1,274	1,293	1,517	1,426	1,526	1,476	1,749	2,079	2,264
Trenčín Region	1,206	1,313	1,441	1,397	1,492	1,655	1,612	2,022	2,524
Nitra Region	1,155	1,219	1,389	1,367	1,462	1,671	1,605	2,014	2,033
Žilina Region	1,129	1,310	1,488	1,382	1,500	1,666	1,640	2,036	2,308
B. Bystrica Region	1,032	1,193	1,364	1,284	1,419	1,691	1,606	1,944	1,958
Prešov Region	921	1,112	1,258	1,246	1,356	1,704	1,521	1,782	2,028
Košice Region	1,000	1,193	1,363	1,323	1,529	1,710	1,679	2,034	2,423

[1] Most Roma people live in the Prešov and Košice Regions, followed by the Banská Bystrica and Nitra Regions.

Source: Statistical Office of the Slovak Republic

Roma people in Slovakia

According to the mapping of Roma communities carried out in 2013, an estimated 400,000 Roma people in Slovakia live in various types of ethnically homogeneous settlement concentrations as well as in spatial integration with the majority population (Mušinka et al., 2014). Segregated communities are considered to be the most at risk, with approximately 70,000 Roma living there according to data from 2013. In addition to the aforementioned mapping, data on the living situation of Roma households is also provided by the UNDP research (2007; 2012) and a number of other research studies, all of which agree that Roma people are among the population groups most affected by poverty and social exclusion (Džambazovič, Jurásková, 2002; FRA, 2012). According to the results of a national survey in 2020, up to 87% of households in Roma communities are at risk of poverty, 52% face severe material deprivation, 58% live in substandard housing (Markovič - Plachá, 2021). The poor living conditions[2] in which people live in these communities directly determine their life chances, life strategies and labour market opportunities (e.g. Rusnáková et al., 2011).

The handicap of Roma people in the labour market is a complex set of factors, among them the very belonging to an ethnic minority (e.g. Ayala and Rodriguez 2007; Carlsson and Rooth, 2007; Darity and Mason, 1998; Li, 2010; Lajčáková et al., 2017 and others). The other factors include gender (Roma women are particularly vulnerable), employment history, poor access to important services in marginalised settings, education and qualifications. The educational structure of the Roma population is significantly worse than that of the majority population. More than 18% of Roma people have not even completed primary education, almost 60% have only primary education, almost 5% graduated from a primary school for children with special needs and less than 0.5% have an education higher than ISCED 3 (Filadelfiová et al., 2012).

The fact is that a significant proportion of Roma people in Slovakia are excluded from the labour market, with only less than a quarter of them working. Although Roma employment has been increasing in the last decade, it is still estimated to be less than half of the employment rate of the majority population (Hidas et al., 2022). It is important to note that employment does not necessarily mean breaking the cycle of poverty and a pathway to improved quality of life. For a significant number of employed Roma people from marginalised communities, high job instability and high volatility (short-term or seasonal jobs), employment in so-called precarious jobs (low wages, unfavourable working conditions) and less protected employment contracts (e.g. temporary work agreements, etc.) are typical (Hidas et al. 2018; Lajčáková et al. 2017)

The question addressed in this paper is whether education is among the factors that influence the employment (employment rate, selected characteristics of employment) of Roma people. That is, whether the relationship between the level of education and the quality of employment discussed in the introduction applies also to Roma people.

Methods

The following parts of the paper present data obtained from two related scientific projects, APVV No. -17-0141 and VEGA No. 1/0886/21, carried out in the years 2021-2023. The authors of this paper use data from a questionnaire survey conducted on a sample of 805 Roma adults (in total for both projects, the items that were included in both questionnaires are analysed). In the context of the topic of this paper, these data were analysed mainly within the framework of the first-named project (VEGA), which focused on examining educational inequalities and educational aspirations of Roma people.. The research in the project was conceived more broadly, combining several questionnaire surveys (mainly in Slovak schools) and qualitative interviews. The selection was based on selected

[2] One in fourteen households in marginalised Roma communities has no electrical wiring, and in approximately one in seven households the wiring is inadequate. Fewer than half of households have a functional public sewerage system and one third of households in marginalised Roma communities have no plumbing (Grauzelová, Markovič, 2018).

demographic indicators (gender, age, position in the labour market) and also on the basis of the established typology of the geographical distribution of the Roma population in relation to the majority population (spatial integration, spatial segregation). The paper mainly presents the findings obtained from a sample of 314 employed Roma people .

In relation to the topic of the paper, the data on the educational structure of the respondents is important: 64.09,% of the respondents have primary education; 25.71% have secondary education without school leaving exam, 7.70% have secondary education with school leaving exam and 2.48% of the Roma people have university education. The education of the subgroup of employed Roma people is better. Here, people with primary education make up 47.13%, secondary education without school leaving exam31.21%, with school leaving exam16.24% and university graduates 5.41%. In any case, the educational structure of the respondents is better than in the FRA surveys and in other surveys mentioned in the introductory chapters of the paper. The explanations may be both the sample selection - the presented researches included Roma people living in spatial integration with the majority (in contrast to several researches that surveyed only Roma from ethnically homogeneous communities) and also the trend of improvement of Roma education.

In the following section, the paper will focus on the analysis of employment rates, wage level and subjectively assessed job satisfaction in relation to Roma education. The aim is to find out whether there is a relationship between the educational attainment and the above mentioned job characteristics.

Results

Education seems to help Roma people get jobs. The table below shows that there is a higher employment rate among the better educated respondents. The distribution is statistically significant.

Education is an important factor in relation to job stability, which is an important job characteristic. The following table presents the employment history of employed respondents in our sample. The distribution of their responses by education is statistically significant, indicating that education has an impact on job stability.

Secondary school graduates with school leaving exam and university graduates have mostly been employed continuously since leaving school, with the highest share of continuous workers among secondary school graduates with school leaving exam (higher than among university graduates). When combining those who have been employed consistently with respondents who have mostly been employed than unemployed since leaving school, secondary school graduates with school leaving exam rank first; in this group, all respondents chose one of these two options. The second place was taken by university graduates (94.12%), the third by secondary school graduates without high school

Table 2 Employment rate by education

	Education							
Are you currently employed?	**primary education**		**secondary education without school leaving exam**		**middle education with school leaving exam**		**university education**	
	n	%	n	%	n	%	n	%
Yes	150	29.07%	109	52.66%	51	82.26%	17	85.00%
No	366	70.93%	98	47.34%	11	17.74%	3	15.00%
Total	516	100.00%	207	100.00%	62	100.00%	20	100.00%

Table 3 Employment history of working respondents

	Education							
What is your employment history, from finishing school up to now?	**primary education**		**secondary education without school leaving exam**		**middle education with school leaving exam**		**university education**	
	n	%	n	%	n	%	n	%
I have been employed continuously since leaving school	38	26.20%	25	36.76%	40	86.96%	12	70.59%
I have been mostly unemployed	39	26.89%	14	20.59%	0	0.00%	1	5.88%
I have been mostly employed	63	43.44%	27	39.70%	6	13.04%	4	23.53%
I have not been employed yet	4	2.75%	1	1.47%	0	0.00%	0	0.00%
I don't know, I don't remember	0	0.00%	1	1.47%	0	0.00%	0	0.00%
This is my first job	1	0.65%	0	0.00%	0	0.00%	0	0.00%
Total	145	100.00%	68	100.00%	46	100.00%	17	100.00%

exam (76.46%), followed by primary school graduates (69.64%).

In the following characteristics, the importance of education is fading. It is not related to the length of current employment, job mobility, type of job contract, satisfaction with wage and only partially with wage level.

Table 4 shows the length of respondents' current employment by their educational background. The highest shares across all education groups are in the under 12 months category, followed by the 13 to 36 months category (except for secondary school graduates, where the second highest share was in employment lasting more than 5 years), and the third highest share in almost all education groups is in the more than 5 years category. While among Roma people with primary and secondary education without school leaving exam the percentage differences between the 0-12 months category and the more than 5 years category are relatively high, (e.g. 49.32% of Roma people with primary education have been working up to 1 year and only 13.51% of them have been working in their current job for more than 5 years), among secondary school graduates with school leaving exam and univer-

Table 4 Length of current employment by education

If you are currently employed, for how long?	Education							
	primary education		secondary education without school leaving exam		middle education with school leaving exam		university education	
	n	%	n	%	n	%	n	%
0-12 months	73	49.32%	42	42.86%	18	35.29%	7	41.18%
13-36 months (1-3 years)	40	27.03%	26	26.53%	11	21.57%	5	29.41%
37-60 months (3-5 years)	15	10.14%	15	15.31%	9	17.65%	1	5.88%
More than 5 years	20	13.51%	15	15.31%	13	25.49%	4	23.53%
Total	148	100.00%	98	100.00%	51	100.00%	17	100.00%

Table 5 Commuting to work

How often do you commute to work?	Education							
	primary education		secondary education without school leaving exam		middle education with school leaving exam		university education	
	n	%	n	%	n	%	n	%
Daily	98	66.22%	71	72.45%	27	52.94%	14	82.35%
Less frequently than once a month	4	2.70%	3	3.06%	3	5.88%	0	0.00%
Weekly	23	15.54%	5	5.10%	6	11.76%	3	17.65%
Once a month	23	15.54%	19	19.39%	15	29.41%	0	0.00%
Total	148	100.00%	98	100.00%	51	100.00%	17	100.00%

sity graduates the more than 5 years group is more strongly represented and the share of those working 0-12 months is lower. However, the differences are not statistically significant and it can be concluded that the relationship between the educational attainment and the length of current employment has not been demonstrated. Interestingly, with the exception of secondary school graduates without school leaving exam, the least represented across all education groups is the 37-60 months category.

Even in the case of commuting, there are no statistically significant differences among Roma people with different education.

Table 5 shows the responses of Roma people to the question *"How often do you commute to work*?". The highest share of those working close to home (daily commuting) is among people with university education, followed by secondary school graduates without school leaving exam, then respondents with primary education and secondary school graduates with school leaving exam. The highest share of labour migrants is among Roma people with secondary education with school leaving exam (47.05%), the largest part of them commuting to work in monthly intervals. Commuting once a month was also chosen by the largest number of labour migrants with secondary school education without school leaving exam (19.39%), 27.55% of Roma people in this group migrate for work. Of the respondents with primary education commuting to work (33.78% of the total number of employed Roma with primary education), the same number of respondents travel once a week as once a month (15.54%).

Information about the type of employment contract is important for job security. The following table shows what kind of employment relationships Roma people have with their employers. Again, the differences between people with different education level are not statistically significant.

The highest share of Roma people in all education groups have their employment relationship confirmed by a full-time employment contract. For university graduates (note the total number of respondents is not high) it is up to 88.24% and the rest combine self-employment with part-time employment. The second highest share of peo-

Table 6 Type of employment

	Education							
If you are currently employed, which of the following applies to you? (more answers possible)	**primary education**		**secondary education without school leaving exam**		**middle education with school leaving exam**		**university education**	
	n	%	n	%	n	%	n	%
Full-time employment contract	66	44.59%	66	67.35%	31	60.78%	15	88.24%
Self-employment	45	30.41%	23	23.47%	17	33.33%	0	0.00%
Part-time employment contract	5	3.38%	0	0.00%	3	5.88%	0	0.00%
Other form: e.g. temporary work	27	18.24%	7	7.14%	0	0.00%	0	0.00%
Part-time employment and temporary work	5	3.38%	0	0.00%	0	0.00%	0	0.00%
Self-employment and part-time employment	0	0.00%	0	0.00%	0	0.00%	2	11.76%
Work contract for weekends	0	0.00%	2	2.04%	0	0.00%	0	0.00%
Total	148	100.00%	98	100.00%	51	100.00%	17	100.00%

Table 7 Monthly wage

	Education			
What is your net monthly wage?	**primary education**	**secondary education without school leaving exam**	**middle education with school l eaving exam**	**university education**
Average wage	EUR 560.83	EUR 792.30	EUR 840.71	EUR 731.21
Wage median	EUR 500	EUR 640	EUR 700	EUR 697.50

Table 8 Satisfaction with wage

	Education							
How satisfied are you with your wage? (marks as in school)	**primary education**		**secondary education without school leaving exam**		**middle education with school leaving exam**		**university education**	
	n	%	n	%	n	%	n	%
1	63	42.57%	18	18.37%	9	17.65%	5	29.41%
2	36	24.32%	30	30.61%	19	37.25%	5	29.41%
3	45	30.41%	48	48.98%	23	45.10%	7	41.18%
4	4	2.70%	2	2.04%	0	0.00%	0	0.00%
5	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Total	148	100.00%	98	100.00%	51	100.00%	17	100.00%
Average	1.94		2.35		2.78		2.10	
Median	2		3		2		2	

ple employed with a full-time contract is among secondary school graduates without secondary school exam, followed by secondary school graduates with secondary school exam, and the lowest share of people employed with a full-time contract is among Roma people with primary education. With the exception of university graduates, full-time employment is followed by self-employment. Among Roma people with primary education, the difference between full-time employment and self-employment is the lowest (full-time 44.59% and self-employment 30.41%)

The distribution of wage levels by education is highly significant in the general population in Slovakia (Tab. 1). The following table shows the situation in the group of respondents to our research.

Even in the case of employed Roma people, the differences in wages by education are statistically significant. However, if we take a closer look, we find that wages rise with education only after secondary education without school leaving exam. Beyond that, the growth is less significant, with even the average wage

and median wage being higher in the group of secondary school graduates with school leaving exam than in the group of university graduates. 9 out of 14 university graduates who responded to the question about jobs reported that they work in positions that do not require a university degree (e.g., administrative worker, stock clerk, community centre assistant, sales clerk). This may be one possible explanation for the lower average wage in this group. In any case, it is true (also when compared to the average of the general population in Slovakia) that Roma people carry out lower paid jobs, education influences the wage only after secondary education without school leaving exam, university-educated Roma work mainly in the social sphere, and a large part of them do jobs requiring only lower education.

In the last table we look at satisfaction with wage by education.

When it comes to satisfaction with wage, there are no significant differences between the education groups. Overall, it can be stated that employed Roma people are rather satisfied with their wages regardless of the level thereof and their educational background. The median shows that secondary school graduates without school leaving exam are the most critical of their pay (median 3), in all other groups the median is 2.

In 2022, a job satisfaction survey was performed among Slovak employees (regardless of their ethnicity). An exact comparison is not possible as different methodology was used, but the figure is interesting. In 2022, as many as 53% of respondents were not satisfied with their wages (this year falls within the period of our survey collection) (Trend, 2022).

Discussion and Conclusions

The argument of poor motivation is often used in relation to the educational attainment of Roma residents of marginal and poor communities. In the literature we can find claims that education is not a value for Roma people, that they do not consider it important enough to invest effort and time in it (Turzák, Turzáková, 2013). Especially in the sociological literature, the prevailing perspective emphasises the impact of poverty and social exclusion and the human rights approach to addressing the lower educational level of Roma (e.g. Kusá, 2017; Culenová et al., 2024), which is shared by the authors of this text. The barriers that Roma people have to overcome in their path to education are well identified, they are structural in nature and the solution is not on their shoulders or in their power. Labour market disadvantages seem to be part of it.

The prospect of a well-paid job occupies an important place in the mosaic of motivation to learn, especially for adults, but adults play a key role in motivating children. The results of our analysis suggest that the Slovak labour market does not offer equal opportunities to educated Roma people. For most of the employment characteristics analysed, the educational attainment does not play an important role. According to our findings, education helps Roma people to enter the labour market, but it is not related to the wage level. It affects wage up to secondary school, but for higher education the wage growth is no longer statistically significant. In other words, in terms of wage, Roma people only need to obtain secondary education without school leaving exam.

Education is not related to respondents' satisfaction with wage, nor does it affect the type of employment contract, the length of current employment, job mobility or commuting. The average wages of university-educated Roma people in our sample are lower than the average wages in the general population, partly because they work in lower-paid spheres (social services, education) and also because they work in jobs where university education is not required.

The labour market disadvantages of educated Roma people have deep roots and are the result of a combination of several causes (poor availability of better paid secondary and higher education and better paid jobs in regions more populated by Roma, ethnic disadvantage of Roma people in the labour market, based, for example, on employers' distrust in their skills and morale, etc.).

Wage and overall good work are not the only arguments in support of education, but they are important for work motivation. Especially when it comes to disadvantaged groups who have to put in more effort to attain education.

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Oral Health in Older Adults

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Abstract:

Overall health is not just something that older adults possess; unfortunately, it is also intricately linked to oral health as well. Physiologic and pathologic changes of the oral cavity are associated with aging and the effect of chronic disease and poly pharmacy. Current medical advances in preventive dentistry have been unable to overcome the barriers to optimal oral health due to aging, especially among people requiring care. This study explores the status of oral health among older adults, the effect of multi morbidity, and the effect of preventive strategies on reducing the outcome in dental care. Methods included utilization of measurable data from clinical examinations supported with surveys of oral health status, resilience, and healthcare utilization done in cross-sectional analysis. All this that dental care access is not the same and that prevention programs must be designed differently. Considering the risks associated with oral disease and facilitating the ability to lead a quality of life, oral health should be integrated into public health interventions that support complete medical care in the aging populations.

Introduction

Maintaining oral health is very important for overall healthy aging, especially as people age. Physiological changes, multi morbidity, and the side effects of medication make seniors and younger ones more vulnerable to oral diseases with increasing age (Dietrich et al., 2017). Progress towards prevention of oral disease and associated systemic diseases in the older population is poor, despite improvements in dental care. Many of those in urgent need of institutional or home care among older adults have limited access to dental services. Despite many studies proving that individuals with care dependency receive lower numbers of dental examinations, the importance of oral health in contributing to conditions such as diabetes, cardiovascular diseases, and cognitive decline is increasingly being identified. This study investigate the oral health status of older adults and seeks to determine the key risk factor associated with oral diseases and makes recommendations regarding the improvement of the existing preventive dental strategies.

Materials and Methods

Study Design

This is a retrospective cross-sectional study to determine the oral health of older people, both community-dwelling and institutionalized elderly people. The cross-sectional approach was selected as it is efficient for determining the state of oral health as it stands and looking for correlation with multi morbidity and other health factors (Humphrey et al., 2008). Unfortunately, the drawback associated with this design is that causality cannot be established. Cross-sectional studies are useful to identify patterns and disparities, but they offer no insights about how oral health changes over time or the outcome of interventions over a long period of time (Liu et al., 2019). By including both independent and institutionalized seniors, a comparison of types of living environments is possible, an important aspect to determine the effect of healthcare access and support systems on oral health outcomes (Polzer et al., 2012). However, to not miss selection bias, it is important to note that willingness and ability to participate probably meant that the most vulnerable individuals, with severe mobility limitations or cognitive impairment, were probably not included. However, the study is limited but offers a comprehensive picture of health conditions among aging populations; areas that should be studied in the future as well as be given policy intervention.

Participants and Data Collection

The study had recruited 161 people aged 65 and older, both independent and care-dependent. While the sample size will be sufficient to detect some significant trends, it may not be fully representative of the whole elderly population due to the vast socioeconomic and health-related factors that can impact oral health (Ide et al., 2016). Dentition status, periodontal health, and the presence of oral diseases like caries and mucosal conditions were assessed through clinical examinations (Lafon et al., 2014). In addition, a structured quantitative survey was administered for self-reported data on oral hygiene practices, usage of health care, and perceptions of health. However, self-reported data is crucial in that it gives an idea of an individual's behaviors and experiences, and although beneficial, their validity is inherently infiltrated with bias in terms of recall and error in elderly participants with cognitive decline (Seitz et al., 2016). This serves to strengthen the study by including both clinical assessments in the form of objective measures of oral health and using survey data as well. One excludes this is reliance on single-point assessments that didn't note differences in health status or dental care behavior changes.

Statistical Analysis

The descriptive statistics were used to analyze the data to describe the oral health status and to identify important trends of the study population. Differences between groups, especially between community-dwelling and institutionalized seniors, were compared using ANOVA (Analysis of Variance). This statistical method can help statistically detect change in oral health status as a function of changing environment but is not confounded by other known variables, specifically socioeconomic status, education level, or previous dental care access (Indukar et al.,

2016). Furthermore, relationships between multi morbidity, oral health status, and resilience levels were investigated to establish significant ones. Correlation analysis can pinpoint important relationships but does not mean causation, so it is important to consider the findings. The use of a statistical approach for studying the study's results serves to give a certain basis for understanding the oral health disparities, but more in-depth multivariate analysis may reveal deeper analysis of the interaction between more than one of the contributing factors. Since aging-linked health issues are substantially complex, future studies should use regression models to control confounders and further dissect the causal paths in more detail.

Results

Oral Health Status

Substantial disparities in the oral health status of independent seniors compared to those in need of institutional care were present in the clinical examination. As compared to older adults residing in the community, the residents of long-term care facilities had significantly higher rates of periodontal disease, tooth loss, and dental caries (Institut der Deutschen Zahnärzte, 2014). This result corroborates previous work that suggests institutionalized people generally receive less than optimal oral health care because of a variety of systemic and logistic barriers.

Table 1 presents an overview of the study population, including total sample size, gender distribution, and mean age per group.

The most concerning observation was the high prevalence of periodontal disease within institutionalized seniors. This group had markedly more periodontitis with more individuals with advanced attachment loss and more individuals with deep periodontal pockets (Schwarz & Schulze, 2022). The higher prevalence of periodontal disease seen in elderly institutionalized individuals may be related to inadequacy of oral hygiene practices, lack of professional dental care, and cumulative effects of systemic health conditions (Jockusch et al., 2021). Our analysis confirms these findings, as periodontal disease severity was significantly higher in Group C compared to Groups A and B ($p < 0.001$).

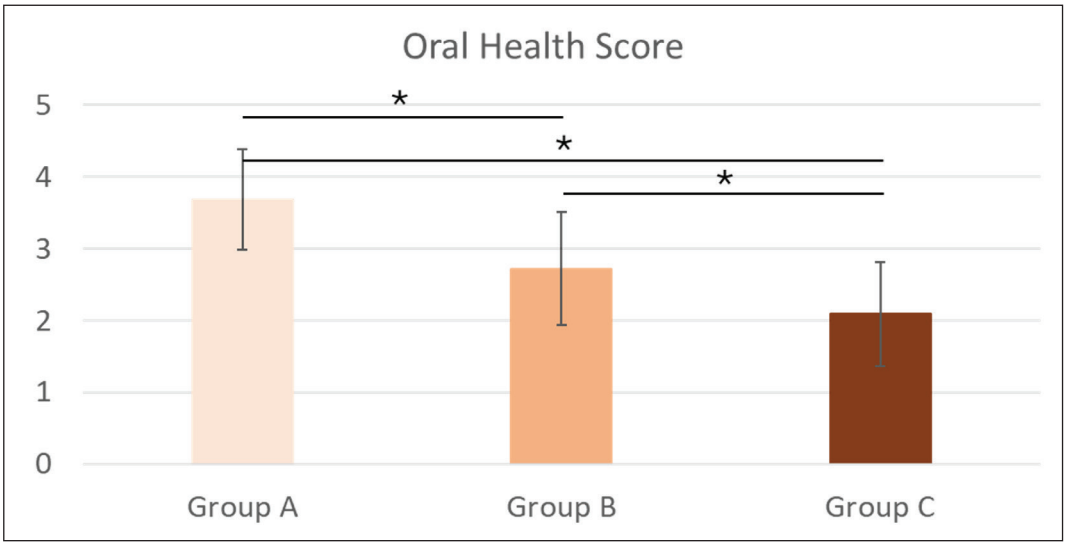
The biggest problem was tooth loss; more than one-third of seniors placed in an institution were edentulous or partially dentulous. Age-related tooth loss is expected, to some degree; the discrepancies between the two groups likely indicate that there is a failure in preventive strategy and prompt dental intervention among long-term care residents (KZBV & GKV-Spitzenverband, 2019). We are reinforcing the need for targeted dental care programs as a result of the loss of natural dentition, which is possible and can lead to nutritional deficiencies, compromised chewing efficiency, and diminished quality of life.

Older adults in institutional care also had a high prevalence of dental caries and quite a lot of people had untreated decay (Ziller et al., 2021). There was a particular exhibition of root caries because of root surfaces being exposed as a result of age-related gingival recession and

Table 1 Sociodemographic characteristics of the study population (n=161)

total (n)	gender		age (years)	
	male	female	mean	SD
GROUP A (lives in own household without external support)				
52	24	28	**75,33**	3,67
GROUP B (mobile care service regularly comes to the home)				
54	26	28	**77,24**	4,54
GROUP C (lives in an inpatient care facility)				
55	23	32	**82,33**	5,07

Figure 1 Oral Health Status by Group (Group A: independent living, Group B: mobility-assisted, Group C: institutional care. Significant differences (*) were observed between all groups; p<0,05; n=161)



an inability to remove plaque (Brauckhoff et al., 2009). This trend was most likely due to the lack of preventive fluoride applications and professional cleanings in care facilities. To quantify overall oral health status across the three groups, an Oral Health Score was used. This score considers the number of remaining teeth, the condition of teeth, and periodontal health. The scale ranges from 1 (very poor) to 5 (very good). Figure 1 illustrates the significant differences in oral health status between the three groups, highlighting disparities in caries prevalence and periodontal health based on the Oral Health Score.

In addition, a considerable number of the institutionalized seniors possessed removable prostheses and exhibited many signs of ill-fitting dentures, mucosal irritation, and denture-related stomatitis. The importance of gaining functional and comfortable oral function and care is underscored by these findings. They highlight the urgent need for better denture maintenance programs in long-term care facilities.

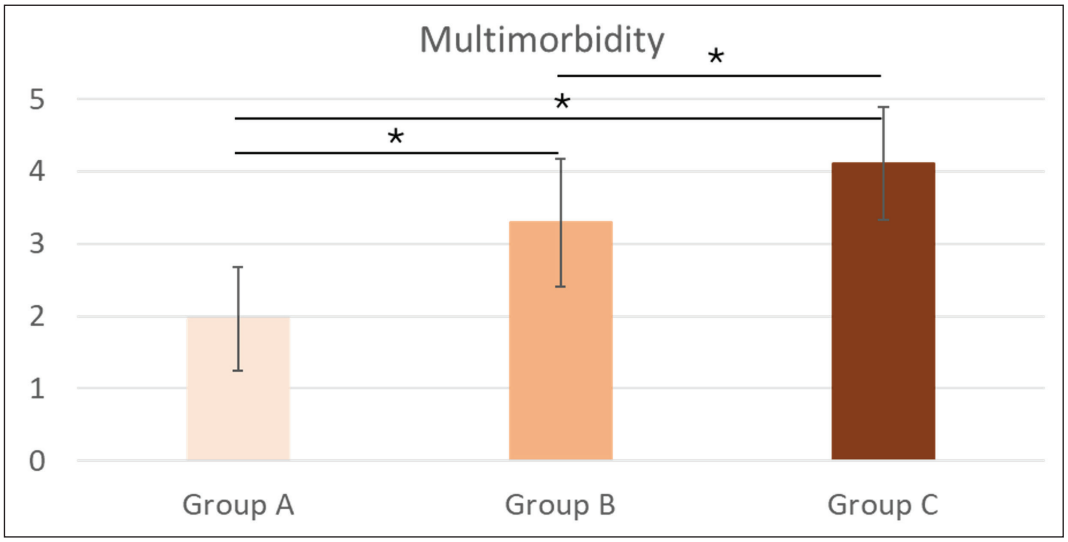
Multi morbidity and Oral Health

The research found a tight relation between multi morbidity and oral health deterioration, as was expected between systemic diseases and oral conditions (Chávez et al., 2022). Older people with chronic medical problems, which included diabetes, cardiovascular disorder, and dementia, had higher rates of periodontitis, oral infections, and poorer dental status. However, the deterioration of the oral cavity seems to further be exacerbated by the presence of multiple chronic diseases, suggesting that there is a key linkage between systemic and oral health.

Our data confirm these findings, showing significant differences in multimorbidity among the three groups. To quantify multimorbidity, a Multimorbidity Score was used, which categorizes individuals based on the number of chronic conditions they have. The scale ranges from 1 (no chronic disease) to 5 (four or more chronic diseases), including conditions such as diabetes, heart failure, and hypertension. Figure 2 illustrates the distribution of multimorbidity across the three study groups, with institutionalized seniors (Group C) showing the highest burden of chronic diseases.

Specifically, diabetes mellitus became an important determinant of oral health outcomes. Distinctions they found in periodontal health involved distinctly higher levels of probe depths for probing depths, better attachment for attachment loss, and greater gingival inflammation in diabetic participants than in no diabetic partici-

Figure 2 Multimorbidity by Group (Group A: independent living, Group B: mobility-assisted, Group C: institutional care; significant differences (*) were observed between all groups; p<0,05; n=161)



pants (Chebib et al., 2021). Furthermore, these findings help to bolster existing evidence for the fact that diabetes compromises periodontitis through impaired immune response, deregulated inflammatory mediators, and impaired wound healing. Also, many diabetic participants reported having dry mouth (xerostomia), a common side effect of the disease and its pharmacological management.

Xerostomia increases the risk of oral infection and mucosal irritation and renders it difficult to maintain oral health. In our study, the prevalence of xerostomia was significantly higher among participants with multimorbidity scores of 3 or higher, suggesting a strong link between chronic disease burden and salivary dysfunction. Poorer oral health outcomes were also found to be associated with cardiovascular diseases being hypertension and coronary artery disease. The conditions associated with these conditions were also more prevalent among those with periodontitis and tooth loss, most likely related to underlying inflammatory processes and the effects of cardiac medications on the oral environment (Curtis et al., 2021). For instance, some antihypertensive drugs are known to cause gingival overgrowth, slowing oral hygiene attempts and significantly increasing the risk for periodontal infections. It was also found that cardiovascular patients often have a reduced ability of the immune system—something always praiseworthy—and indeed such patients often suffer from reduced healing after dental procedures.

Maintaining oral health also proved another huge challenge with dementia. The greatest cases of neglected oral hygiene, an extreme amount of plaque accumulation, and the lack of treatment of dental diseases were seen in individuals who had cognitive decline (Campbell et al., 2020). Our results indicate that participants with dementia tended to have higher plaque accumulation and more untreated dental conditions compared to those without cognitive impairment. Trends suggest that cognitive decline may be associated with poorer oral hygiene and less frequent dental care. Inadequate oral hygiene could be performed by many participants with dementia independently, and their caregivers had inadequate training to provide assistance. In addition, behavioral problems and resistance to dental interventions had hampered efforts to provide such oral health care to this population. This is seriously worrying in view of new research indicating that periodontal disease may be involved in dementia due to systemic inflammation and bacteremia.

Preventive Measures and Utilization of Dental Services

Independent seniors turned out to utilize preventive dental care to a vastly different extent in that they visited their routine dental visits and did their hygiene much more often than those living in institutions (D'Aiuto, Orlandi, & Gunsolley, 2013). The most striking difference in how preventative care is used, particularly, is alarming in that it exacerbates our country's systemic inability to bring vulnerable populations to the gate to be able to provide preventive services.

Independent seniors were more likely to continue visiting a dentist on a regular basis and to go through a professional cleaning, as well as utilize preventive measures like fluoride treatment and interdental cleaning (D'Aiuto, Gable, et al., 2017). In this group, many participants had a long-standing connection to their dentists and permitted them to routinely monitor their oral health and to act promptly. However, the institutionalized seniors had several obstacles to mitigate their lack of access to prevent social care. Reduced utilization of dental services was due to transportation difficulties, limited financial resources, and, in general, lack of prioritization of dental health in long-term care facilities.

The finding that so few of the institutionalized individuals were being routinely checked by the dental department was, perhaps, the most worrying (Ogawa et al., 2017). Oral health screening programs in nursing homes were not systematic, and many residents relied on reactive treatment approaches, either due to severe pain or acute infections, rather than preventive treatment approaches, because such programs were not sought. The result was often crisis-driven care that resulted in unnecessary extractions and the start of untreated diseases and, as a consequence, an increase in oral health decline.

Caregiver support was related to shaping oral health outcomes. Maintaining oral hygiene was more independent for those seniors living in the community and more dependent for the institutionalized seniors. Caregiver-provided oral hygiene care was very variable, with some facilities having structured oral health protocols and others without any formal training programs (Patel et al., 2021). This lack of standardized caregiver training on oral hygiene best practices gave rise to inconsistent care quality and pointed to the need for education efforts to improve support for oral health among long-term care settings.

Discussion

Integration of Oral Health in General Healthcare

The findings from this study indicate that oral health should be included within healthcare systems and mainstream care frameworks for older people (Mirwald & Foltin, 2023; Al-Nasser & Lamster, 2020). Clearly, systemic conditions that are associated with oral health need to be more interdisciplinary and not just dental health on its own. Older adults should have regular oral health assessments as part of routine medical check-ups, and physicians and geriatric specialists should help identify oral health risks more actively. Furthermore, such collaboration may also aid early detection of oral conditions and, in general, improve the quality of health within general populations that are aging.

Addressing Barriers to Dental Care

The other crucial problem that this study brings to light is the extensive unused dental services within the institutionalized seniors. To address these barriers, mobile dental services, home-based dental care program expansion, and enriched caregiver training initiatives are required. Financial constraints also present a significant challenge, which necessitates the implementation of policy reforms to subsidize dental care for older adults and include dental care coverage in public health care (Besimo & Besimo-Meyer, 2017). Additionally, it can involve a growing number of seniors and their caregivers becoming more proactive in terms of their dental care.

Policy Recommendations for Preventive Strategies

It is known that except from injuries, exposition to external risk factors starts onset and development of disease (Foltin, 2020). Crucial role in Public health and dentistry plays both

building health literacy of whole population and risk factor elimination or minimalization. Policymakers need to ensure that oral health promotion is given the same status as other public health promotion of older adults. The key to improving the dental health outcomes of residents of long-term care facilities is increasing funding for preventive dental programs, mandating oral health screenings in such facilities, and training of oral hygiene for caretakers through structured training (Borgnakke et al., 2015). Oral diseases should also be emphasized as systemic diseases, and dental care should be a preventive, not an emergency, healthcare issue. However, because managing oral diseases requires a more long-term cost mitigation, healthcare systems can proactively adopt strategies to prevent the costs from being long-term.

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Short Implants as a Tool to Reduce Oral Health Inequalities in the Elderly: A Public Health Perspective

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Abstract:

Existing research evidence about the elderly people in Germany and other European countries revealed that oral health especially in relation to income variation and access to dental care is still wanting. Thus, SDIs represent a conservative and relatively inexpensive solution for the edentulous elderly patient, who requires teeth just for simple functions; no extensive surgical procedures are necessary. In light of this, the study will undertake a systematic evaluation of SDIs in relative to their clinical effectiveness, cost-effectiveness, and patient satisfaction based on randomised controlled trials, cohort studies and policy documents. Findings indicate that SDIs are therapeutic models with high efficacy rates and also found to enhance functional capacity and quality of life of the patients without compromising any standard practices for all the patients requiring dental care services. These approaches

may also help in relation to cost containment and access to enhance equity in oral health and health among the elderly people when they are included in national health systems.

Introduction

A component of health that cannot be overlooked is that of oral health and especially that of the elderly. In Germany and other European countries, an issue, which constantly challenges the healthcare institutions is the high percentage of the aging population that would need all specialized dental care. Socio-economic disparities, unequal distribution of access to health care, and inadequate funding in dental care worsen oral health inequalities. As a result of economic constraint, many elderly population in many European countries requiring dental prosthetics cannot afford quality prosthesis hence affecting their oral function and overall health. Such conditions as edentulism and severe periodontal diseases, are still common in the elderly affecting mastication function, communication and psychological well-being. For instance, people living with cardiovascular conditions and diabetes should also ensure that they seek professional dental care, which underscores the importance of affordable and efficient dental care services. Dental implants have proven to be the most effective method of dental restoration, and are more functional and cosmetically preferred as compared to conventional dentures (Shahdad, 2024). The importance of implantological procedures in dentistry in glance are disused previously (Schmidt-Breitung, 2022, Muller at all.). In table 1 we compare basic parameters of Regular implants vs SDI.

In this paper, we highlight the characteristics of short dental implants (SDIs) as a solution to the aforementioned challenges. Due to their ability to simplify surgical procedures and mitigate the need for bone boosts, SDIs increase the options for accessibility and the affordability factor. This paper aims at dissecting the potentials of short implants in reducing oral health inequalities in Germany and Europe specifically the efficiency, possibility and consequences in elderly care.

Materials and Methods

In this paper, the following aspects of short implants in elderly patients: clinical effectiveness, cost-utility and patients' satisfaction have been discussed based on a systematic review of the current literature. Source identification involved articles that were RCTs, cohort studies, and meta-analyses, which were published be-

Table 1 Comparison of Basic Parameters: Regular Implants vs. Short Dental Implants

Parameter	Regular Implant	Short Implant (SDI)
Diameter	~3.5–5.0 mm	~4.0–6.0 mm
Length	>10 mm	⩽8 mm
Minimum bone tissue quality requirements for safe implantation	Good to excellent	Moderate to good
Reconvalescence time required after bone drilling and implant insertion	Several months (3–6)	Shorter (often <3 months)
Surgical invasiveness	Often requires bone augmentation	Generally avoids bone grafting
Clinical success rate	>90%	>90% (comparable in many studies)

tween 2015 and 2024. Searches of databases like Pub Med, Cochrane library and Google Scholar were made using terms such as "short implants", "elderly oral health", "edentulism treatment" and "health inequalities". These consist of policy reports from Germany and the European Union, as well as regional and national health statistics, to evaluate its receivability as well as its integration into public health policies (Sengupta et al., 2024). To make sure that no significant research was left unnoticed, inclusion criteria were developed for the systematic review regarding SDIs success rate, biomechanical property, patient satisfaction, and economical viability of SDIs in elderly patients. Studies that could not provide statistical analysis results or that have not made a clear distinction between implants and SDIs were excluded. Considerably more focus was made on samples originating from Germany and Europe to obtain a regional approach to healthcare policies, healthcare reimbursement, and clinical guidelines related to SDIs (Brown et al., 2024).

In accordance with PRISMA, (Preferred Reporting Items for Systematic Reviews and Meta-Analyses), a selection protocol was followed. Titles and abstracts were checked for relevancy, and the full text assessed according to predetermined criteria. Specific measures sampled in the analyzed studies entailed survival rate, complication rate, and costs in relation to conventional implants and other prostheses. Quantitative research included patient self-reported experiences, perceived quality of life, and practitioners' insights into SDI implementations in geriatric dentistry (Campbell-Montalvo et al., 2022). In addition, the existing national and European strategic policies of public health were scrutinized to understand the level of adoption of SDIs in the healthcare context. Interviews with the German Federal Ministry of Health (Bundesministerium für Gesundheit) and the European Commission on oral health programs gave an understanding of the current activity and reimbursement legislation and policies (Gerlinger, 2024). Additional data was also collected through interviews of dental practitioners and public health professionals to gather their perceptions and experiences with SDI practie. This methodological research approach provides a strong foundation for the assessment of SDIs against the background of oral health inequalities in Germany and Europe (Shellard et al., 2022). These findings will be useful to policymakers, healthcare decision-makers, and dental practitioners for SDI implementation in public health settings.

Results

Recent studies have shown that SDIs provide equal efficiency rates (over 90%) to that of regular-length implants; this is also valid in the case of low bone density (Ganji et al., 2023). It eliminates the need for additional procedures such as bone augmentation and consequently brings down time, cost, and the risks associated with the operations. This is especially important in Germany and other European countries where complex dental procedures may not be fully covered by public health insurance, thus important alternatives with favourable costs have to be provided to patients of this age. As observed, elderly patients with low income, and those with coexisting medical conditions, can also benefit immensely from SDIs techniquereflect ownership of lesser procedural risks. Since the population in Europe is growing older and conditions like osteoporosis and diabetes are quite usual, SDIs seem to be a useful solution for patients to avoid extensive bone grafting surgery. The findings of clinical studies on SDIs in Germany and other European countries further suggest strong osseointegration, a lower frequency of peri-implantitis, and a high level of patient satisfaction, thus emphasizing the practicality of the concept in the field of geriatric dentistry (Forbes-Haley, 2022).

More importantly, cost comparison shows that SDIs are cheaper than conventional implants, which makes them an option within the publicly funded health systems within Europe. In Germany, statutory health insurance reimburses partial costs of dental implants (GKV) but copayment might be a concern especially for elderly patients (Schwendicke and Bombeck 2023). Because SDIs are less invasive and generally require less costly implants, they may reduce surgical and material costs and thus enhance the availability of implant-supported prosthodontic care. Health economic assessments sug-

Table 2 Summary of Results

Key Aspect	Findings
Clinical effectiveness	SDIs show high success rates (>90%) even in patients with low bone density
Surgical advantages	Avoidance of bone augmentation, reduced procedural risks, shorter chair time
Cost efficiency	Lower material and surgical costs; suitable for partial reimbursement within public health systems
Patient benefits	High satisfaction, improved oral function, aesthetics, nutrition, and psychosocial well-being
Accessibility	Suitable for elderly patients with low income and comorbidities; less invasive than standard implants
Public health implications	Potential to reduce health inequalities and improve access within statutory health insurance systems
System-level advantages	Time-saving in clinical workflows; useful for public dental services with limited resources
Educational relevance	Increasing incorporation into dental training and continuing education programs

gest that the use of SDIs could help containing future health costs and reduce the prolonged stays at the dentist for denture modifications and treatment of problems that could otherwise arise from ill-fitting dentures. Perceived benefits embrace enhanced oral function, smile appearance, and overall quality of life, thus reaffirming patient reports as crucial in fighting oral health inequalities in elderly populations (Nascimento et al., 2023). Several elderly people noted increased confidence, better nutrition caused by efficient chewing, and good psychology after receiving SDIs (Martínez-García et al., 2023). These improvements are also congruent with the goals of the European Union the overall goal of enhancing active and healthy aging.

Furthermore, in terms of the placement of SDIs, the simplified design of those presented here needs less clinical time and shorter chair times than clinical worked models, making them especially useful to busy public dental services in Germany and other EU countries (Dutta, 2024). Less time-consuming approaches help to decrease waiting lists, increase clinic output, and improve access to dental health services for elderly people. Additionally, educational activities that prepare individuals for dentistry careers, as well as postgraduate education programs, also focus on SDI methods as the future dental practitioners should be able to offer this treatment. The outcomes demonstrate that SDIs can contribute significant improvements in oral health inequalities for elderly people (Bai et al., 2024). Due to their considerable efficacy, relatively low costs, and low invasiveness, they are a valuable instrument in public health intervention programmes in Germany and Europe. The following conclusions and recommendations can be drawn for policy debate on including SDIs in national health insurance systems to increase equal access to dental care services among frailer seniors. In table 2 we summarize our results.

Discussion

Another factor that remains a concern is the rising elderly population in not only but also in

other European countries: oral health issues and equal access to dental care remain crucial problems (Aida et al., 2022). As millions of elderly people are at high risk of edentulism and other oral care demands, they require effective, affordable solutions to address the gap in services. To date, significant improvement in dental technology has not changed the fact that most elderly patients cannot afford dental implants from a financial and/or procedural standpoint (Watanabe, 2024). SDIs have proven to be another potential option that can potentially improve reliability and cost efficiency, better yet, if included in state health care programs. Germany is no exception to this, being a European country with a growing elderly population that is in need of dental services. A large number of senior citizens have a limited income and governments offer them limited health care benefits; therefore, they cannot afford costly dental treatment. This is due to the high costs of the conventional fixtures, long surgical procedures, and even longer periods of healing after the treatment. SDIs, on the other hand, is a less invasive approach that does not entail high costs of treatment while being highly effective. Easy to implant and require low complications or adverse effects during operations that are well suited for geriatric patients who may have other illnesses that make them ineligible for implant surgeries (Mosaddad et al., 2024).

Expanded SDI coverage in Germany and across Europe could significantly enhance access in connected national health insurance plans (Faye et al., 2024). Germany's statutory health insurance system – Gesetzliche Krankenversicherung (GKV) offers extensive medical and dental care but restricts the coverage for traditional dental implants where patients are expected to self-fund the procedure. Thus, if policymakers pursue the reimbursement of SDI within the framework of public health insurance, they could eliminate the financial obstacles and promote access to oral health care. Sweden and the Netherlands are other European countries that have included dental implant treatments in their healthcare systems, thus providing a benchmark for Germany. Another key factor that must be addressed in order to encourage the broader use of SDI is the question of training programmes that would be required by personnel in the dental field (Rosario Michel et al., 2023). Although the process of SDI placement may be less intricate compared to conventional implants, there is crucial education required to facilitate proper implementation. More emphasis should be made on including SDI techniques in European dental education programmes for increasing usage in elderly patients with fixed bone structures or limited financial means. Therefore, there is need for implementation of Continuing Education programs and workshops for dentists to enhance them in delivering sdI in a professional manner.

However, the following challenges need to be discussed to enhance the possibility of these SDIs. An important limitation is the uncertainty of research on the long-term outcomes of SDIs in elderly patients (Mele et al., 2022). Nevertheless, further longer-term research is required to determine the long-term success rates, patient satisfaction, and other factors related to oral health. European cooperation may be particularly effective in generating clinically sound data that would help to substantiate the use of SDI in routine clinical practice. However, there are several limitations in the use of SDIs namely they may not be efficient in people with severe bone resorption (Joo et al., 2023). Unlike traditional implants that necessarily involve surgical treatment of the bone to reinforce the anchorage, SDIs work with the bone. In situations where there is considerable bone resorption, patients may require either zygomatic implants or other forms of prosthesis (Brennand Roper et al., 2023). German and European dental associations should invest more effort into studying hybrid cases where SDIs have been used together with other bone augmentation techniques to expand its usage (Padil et al., 2022).

Education of the public and the patients is also an important aspect of SDI implementation. Various surveys and questionnaires indicate that a large number of elderly patients are not even aware of the other implant options and therefore still believe that dental rehabilitation can be very costly and difficult (Jayachandran, 2022). Given these developments, national or European-wide campaigns should be launched to raise aware-

ness of SDIs, emphasize the benefits of their usage and special value for the elderly. Involving many stakeholders such as dental practitioners, healthcare providers, and policymakers, SDIs need to be recognized as standard modalities (Farina and Cirillo 2024). Future policy imperatives should focus on extending application of SDIs as key elements of both German public health initiatives and overall EU healthcare systems. Specific policy recommendations should include extending the access to SDIs through statutory health insurance programs, funding research on medium- and long-term outcomes, increasing access to dental training, and raising awareness (Da Cunha et al., 2023). With these interventions, Germany and other European nations will be able to make giant leaps in the reduction of oral health inequalities for elderly patients and maintain access to quality treatment care.

Conclusion

In conclusion, it is evident that short dental implants are vital in managing oral health inequalities targeting the elderly in Germany and throughout Europe. With the growing population of elderly people, availability of adequate and reasonable dental care is a crucial aspect. SDIs are effectively a real and potential way to minimize the risk of extensive surgical procedures; especially how helpful they are for elderly patients with lower bone density or other comorbidities. Their cost structure is also compatible with the statutory health insurance in Germany and other European health policies that are geared towards provisioning affordable basic medical procedures. It is recommended that increasing the use of SDIs can be facilitated for dentists by integrating them into national reimbursement programs and offering academic training. Since dental care is only partially reimbursable by public insurance, more subsidies or increased reimbursement for SDIs could help close such gaps so that lower-income elderly people get proper dental services. In terms of a wider European context, the integration of SDIs aligns with the EU focus on preventive care and patient-oriented approach in treatment that will enhance the oral health of those countries within the union. Future efforts should be directed towards the dissemination of awareness programs, cooperation with various faculties, and more tangible clinical studies pertaining to the lasting effects of SDIs. By removing both financial and structural obstacles, SDIs can play a key role in the improvement of the condition of older people and further development of efficient and readily available healthcare systems in Germany as well as the whole EU.

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Problem behavior in patients with pervasive developmental disorder or with intellectual disability during dental treatment under general anesthesia

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Abstract:

People with pervasive developmental disorder (PDD) or intellectual disability (ID) are very vulnerable and disadvantaged when visiting a healthcare facility as patients. They do not have their daily needs and rituals fulfilled and feel threatened. We present the professional community with a qualitative research report to determine whether the implementation of a personality trait questionnaire for patients with PDD or ID will bring to light the individual needs of the patient and enable a perioperative healthcare team to apply an individual approach during the introduction to general anesthesia.

Introduction to the issue

Problem behavior is characterized as "culturally abnormal behavior" that is so intense, frequent, or persistent that it can seriously threaten the physical safety of a given person or others (Emerson, 2008). Problem behavior is an umbrella term that includes a variety of behaviors that can affect the psychological and behavioral characteristics of an individual. Such behaviors include aggression, aggressiveness, impulsivity, ADHD, avoidance of instructions, meltdowns, being emotional, mood and affect disorders, hyperactivity, and destructiveness. Although these behaviors may occur separately, they are often exhibited in a combination in people with different psychological or behavioral problems (**Čadilová**, **Žampachová**, 2012). They often occur together, and co-occurrence with PDD is possible in up to 85% of patients. The comorbidity of such disorders increases the problems in the areas of behavior, attention, and adaptation (Thórová, 2016). More than half of patients have problem behaviors severe enough to require strategies to manage them (**Čadilová**, **Žampachová**, 2012).

Visiting a healthcare facility for dental treatment that requires general anesthesia can be an extremely stressful and frustrating experience for patients with PDD or ID. The unfamiliar surroundings, pain, separation from loved ones, and the interruption of rituals and established routines often cause anxiety, resistance, and difficulty cooperating, which can make the entire treatment process very difficult. This situation is a real challenge for healthcare professionals and requires a high level of empathy, communication skills, and a willingness to react flexibly to patients' individual needs.

Hypothesis and research objectives

A personalized approach to the patient is an essential element of quality healthcare, especially for patients who have difficulty cooperating or whose behavior is not easy to predict. Understanding a patient's personality traits not only allows healthcare professionals to better tailor their communication and approach, it also helps to minimize stressful situations, reduce the risk of problem behaviors, and increase the effectiveness of the care.

We began our research with the hypothesis that the personality trait questionnaire we designed would enable the better identification of individual patient needs and contribute to the development of sustainable strategies that would enhance collaboration and make the work of healthcare professionals easier. The aim was not only to gain deeper insight into the factors influencing patient behavior, but more importantly to provide a practical and applicable tool that would lead to long-term improvements in the care of non-cooperative or anxious patients.

Methodology and procedures

In order to achieve this objective, it was necessary to independently and objectively map the current practices of the perioperative team when caring for these patients and to capture all variations of problem behaviors. We conducted this process both before and after the implementation of the personality trait questionnaire. Our own roles also changed during the research process - first we acted as observer-participants and tried to understand the reality of care without actively intervening. Only subsequently did we move into the role of participant-observers, meaning we actively intervened and engaged in providing care. This change allowed us to look at the same problem from different perspectives and to better understand what factors influence the daily reality of both healthcare professionals and patients.

This approach not only gave us the opportunity to better understand the dynamics of care, but we were also able to observe how the introduction of the new tool was reflected in practice and how healthcare professionals responded to changes regarding their approach to patients. We recognize that changing our position and actively engaging in care may have raised ethical questions about the extent to which we influenced the studied phenomena and reality. However, this approach was necessary in order to achieve change in the real situations being studied, or at least to show that such change is possible.

Data analysis

The approach in our research was not purely phenomenological, but rather an interpretative

phenomenological analysis (IPA). While traditional phenomenology aims to capture the lived experience without external interpretation as objectively as possible, in our case we actively entered into the process of analysis as researchers and made the lived experience meaningful (Hendl, 2005). The aim was not only to describe the reality as it is lived by healthcare professionals and patients, but also to interpret it in the context of the wider healthcare system and organizational processes of care. This meant that we not only documented the participants' experiences, we also looked for deeper meaning, connections, and possible implications for practice.

Our personal beliefs, attitudes, and interpretations that we entered into the research with played a key role in obtaining a deeper understanding of the lived experiences of the individuals studied (**Čermák** et al., 2013). This approach not only allowed us to better understand the reality of perioperative care for patients with PDD or ID, it also aided us in proposing specific measures to optimize it. The small size of the research sample, which is typical for IPA, allowed for a more detailed and careful study of individual cases and deeper insight into the experiences of healthcare professionals and patients (Smith & Osborn, 2015).

Ethical aspects of the research and pilot testing of the patient personality trait questionnaire

The research was performed on the perioperative care of patients with PDD and ID, and it required strict compliance with ethical standards. The study was approved by the ethics committee of the University Hospital Olomouc and by the management of the respective clinics. Key experts from the perioperative team (anesthesiologists, dentists, nurses) agreed with the research. Patients' legal guardians were provided with detailed information, and their participation was based on written consent. The possibility to withdraw at any time was guaranteed without any impact on the healthcare. All data were anonymized and securely stored. A patient personality trait questionnaire was then created as part of the study with the aim of tailoring perioperative care to individual needs. Its content was consulted with anesthesiology experts and subsequently pilot tested on four patients. Based on the feedback from healthcare professionals, the questionnaire was modified for easier use and to better reflect specific patient behaviors. Thanks to these measures, the survey was conducted transparently and safely, with respect to patients, their families, and healthcare professionals. Ethical approval, the consent of guardians, the anonymization of data, and pilot testing of the questionnaire ensured the validity of the results and their practical applicability.

Research population

By selecting a population of patients with pervasive developmental disorder (PDD) or intellectual disability (ID), it was not our intention to present this group as a homogeneous group, but rather to bring attention to a specific problem that its members may repeatedly encounter during their lives.

The research population consisted of six patients who were unable to receive dental treatment without general anesthesia.

Data collection

Data were obtained through unbiased observation of the entire perioperative care process of patients with PDD or ID during their dental treatment. We collected video recordings, photographs, and audio recordings to capture all events in the operating room, including the behavior, actions, and decision-making of all members of the perioperative team. In addition, we took field notes and extracts from documentation to capture as wide a range of information as possible. The records were transcribed verbatim and converted into narrative descriptions to make the texts legible and understandable. These narratives were subsequently entered into the Atlas.ti software.

Atlas.ti 8 software

Atlas.ti is a qualitative analysis software that enables the efficient organization, coding, and systematic processing of text, image, and audio-visual data. Unlike automated analyti-

Figure 1 Research population

Case study no.	Name	Age (years)	Diagnosis
1	Jiřinka	47	Severe Cerebral Palsy, Intellectual disability
2	Pavlík	26	Down syndrome
3	Pája	16	Cerebral palsy
4	Anetka	18	Atypical autism, intellectual disability
5	Péťa	47	Cerebral palsy
6	Filip	27	Cornelia de Lange syndrome, profound intellectual disability

cal tools, it does not interpret data or assign meaning through hidden algorithms. Its main contribution is to support researchers' analytical work - making it easier to work systematically with data, code it, create relationships between categories, and visualize connections.

Using sequential coding and categorization, we obtained a more comprehensive view of the representation of individual phenomena and were able to observe patterns in the data that might have remained hidden during manual processing. Atlas.ti thus does not offer ready-made interpretations, but greatly facilitates the analysis and organization of data, leading to a deeper understanding of its structures and connections.

The first phase of research: key theme identification

The analysis of the texts began with a careful interpretative reading of the first three case studies (Jiřinka, Pavlík, and Pája), which described the situations before the application of the personality trait questionnaire. Each of these patients brought a unique perspective to the perioperative care of people with PDD or ID.

The aim was not only to observe general patterns of behavior, but more importantly to identify factors influencing the quality of care, patient cooperation, and the effectiveness of the healthcare team. Key extracts were systematically coded, allowing for rapid data comparison and a deeper understanding of the dynamics of patient behavior and the responses of healthcare professionals. Recurrent or associated codes were then grouped into overarching themes that served as the basis for deeper analysis and strategies to improve the care of difficult-to-care for or uncooperative patients.

These topics are essential for clinical care practice:

1. Negative Behavior - Identifying patterns of non-cooperation, defensive reactions, or patient resistance helped us to understand what situations are most challenging for healthcare professionals and how to minimize their impact.
2. Negative emotions - Fear, frustration, or aggression can significantly affect the process of perioperative care. Understanding these emotions is key when choosing the right approaches and techniques to work with a patient.
3. Positive emotions - It was also important to note moments when patients showed calmness, trust, or cooperation. These findings helped us to understand what factors positively influence their comfort and feelings of safety.
4. Accompaniment - The presence of a loved one or assistant plays a crucial role in minimizing

patient stress and facilitating their adaptation to the hospital environment.

5. Teamwork - Coordination among healthcare professionals and the way they communicate and share information among team members has a direct impact on the smooth flow of treatment and the overall outcome of care.

The second phase of research: The active implementation of change

In the second phase of the research, we analyzed cases after the introduction of the personality trait questionnaire. In this phase we were no longer just passive observers, but we actively participated in the modification of the care. The information from the questionnaire allowed us to inform the perioperative team about the specific needs of the patients in a targeted manner and tailor the care to the patient's individual reactions. To minimize stress and promote patient cooperation, we modified the communication between the healthcare professionals, the patient, and the patient's companion. We also recommended limiting the number of people in the operating room, regulating lighting, and reducing noise-factors that can significantly affect patients with PDD and ID. When planning care, we took into account patients' sensitivity to touch, handling, cannulation, and contact with an inhalation mask. We also paid attention to the prevention of self-harm and strategies for coping with stress reactions.

The analyzed cases (Anetka, Péťa, and Filip) were coded and classified into previously created categories, just like in the first phase. This phase not only allowed us to validate the effectiveness of the questionnaire, but also to better understand the key factors in the perioperative care of patients with pervasive disorders.

Results from the first phase of research

The analysis of case studies 1, 2, and 3 showed a prevalence of negative emotions, in particular, uncooperativeness, determination, fear, and unexpected insults. The dominant negative behaviors included shouting, defiance, and running away. Although health professionals tried to perceive patients individually, their personality traits were only taken into account by the empathetic team members based on their personal interest. There was a lack of a systematic approach in standard procedures that led to misunderstandings, especially when trying to establish contact. Critical situations occurred when medical staff touched patients, attempted to place patients on the operating table, applied a face mask, cannulated a venous line, or when patients were separated from a close person. These moments often provoked physical reactions from patients that complicated the procedures. The team's work showed major weaknesses in organization and preparation. The most common codes were physical management of the patient, uncertainty, a lack of information, and improvisation. The team approached patients reactively, without a premeditated plan. There was a lack of systematic preparation, the healthcare professionals did not know the patient, and they had no information about the patient's personality traits, all of which led to random decisions. Nevertheless, they tried to respond empathically to the emotional state of the patients and their companions. In addition to reassuring the patients' companions, they tried to respond to the needs of the patient himself/herself. In the category of Accompaniment, the most frequently occurring codes were uncertainty, passivity, and non-cooperation. The people accompanying the patients often did not understand the situation, were not encouraged to cooperate, and their insecurity was exacerbated by the patient's behavior.

Results from the second phase of research and a comparison with the first phase

The analysis of case studies 4, 5, and 6 showed a major shift in the dynamics of patient behavior. Although fear persisted, it did not escalate into negative behavior - codes such as non-cooperation, defiance, or running away no longer appeared. A new phenomenon was benign self-harm, which patients used as a coping mechanism to deal with emotional distress. There were significant changes in the Teamwork category. Key codes included team interplay, awareness of health professionals, and a well-thought-out care plan, which led to better organization and the elimination of ineffective improvisation. Healthcare professionals were

informed in advance about patient specifics, allowing them to work with greater confidence and minimize their negative reactions. In the category of Accompaniment, the code of cooperation and interplay dominated. The accompanying persons were actively involved in the process, facilitating the work of the health professionals and creating a positive impact on the patients. A new element was the emotional expressions of the companions, especially tears as a natural reaction to tense situations.

The comparison of the first and second phases of the research clearly showed that the individual approach to patients in perioperative care resulted in significant changes. Instead of uncertainty, improvisation, and negative emotions, the dominant emotions were awareness, interplay, and cooperation. The personality trait questionnaire provided healthcare professionals with key information about patients that minimized stress, reduced negative behaviors, and enabled more effective care planning. Additionally, the companions became active partners, reducing the need to physically immobilize the patient.

These results confirm that targeted changes in the approach and systematic measures can not only substantially improve the patient experience, but also the efficiency and work quality of the healthcare team. The implementation of structured and individualized care therefore leads to greater professionalism, respect for patients, and safer perioperative care.

Discussion

Domestic and international studies confirm that a properly adjusted individual approach can turn a stressful procedure into a safe and calm process. Our study provides a practical solution that facilitates this approach and makes it effectively applicable in practice.

A study by Wittenberg (2016) showed that systematic preparation of the child for the operating room - either at home or during hospitalization the day before - significantly reduces his or her stress, as well as the stress of parents and healthcare professionals. This model is undoubtedly effective, but difficult to implement in practice. Our study shows that a similar effect can be achieved through another process - the targeted use of a personality trait questionnaire, which immediately provides healthcare professionals with information about a patient's individual needs. Instead of complicated preparations, it is thus sufficient to take a short amount of time to adapt the approach to the patient, leading to a similarly positive effect. The importance of parental involvement in perioperative care was highlighted by Lewis et al. (2015), who came to a clear conclusion - parents are an invaluable source of information for healthcare professionals, and their active participation is crucial for the child to better cope with the procedure. Our case studies confirm that when parents and other accompanying persons are perceived as active partners of healthcare professionals, there is a significant change in the dynamics of care. Patients are calmer and less defiant, and the treatment process is smoother. This approach doesn't require any costly measures - just professional and empathetic communication that enables parental involvement.

Similarly, the topic of how to approach patients with PDD or ID was addressed by Anderson (2016), who highlighted the issue of anonymity in healthcare. Her research shows that these patients often perceive the hospital environment as cold and impersonal, which only exacerbates their stress and uncooperativeness. However, our study shows that this problem is avoidable. If healthcare professionals actively communicate with the patient's companion, show empathy, and ensure that the whole team is informed, the atmosphere of perioperative care can be fundamentally transformed. This approach not only makes the work of healthcare professionals easier, but more importantly increases the patient's feeling of safety and cooperation.

The importance of parent presence in the operating room was highlighted in an interview for Respekt magazine (2020) by the head of the children's department at Havířov Hospital, Hynek Canibal. He emphasized that this is a fundamental step towards humanizing healthcare. Although this approach is still being introduced in some departments, our study confirms it as a key factor in reducing patient stress. In addition, we

have gone one step further in our research - not only have we confirmed the positive effect of the presence of a close person, we have also shown that if the companion is actively involved in collaborating with healthcare professionals, their role goes beyond just psychological support and becomes an important element in ensuring the process of the whole procedure goes smoothly.

A summary of the key principles of care for patients with PDD is presented in the expert paper by Jelínková et al. (2021). The authors highlight the importance of an individual approach, the presence of a close person, and clear communication. However, their paper does not offer a specific procedure when it comes to applying these principles in practice. This is the contribution of our study - we provide a comprehensive system that can identify the patient's needs, set up an effective collaboration with the companion, and optimize the organization of the healthcare team's work.

When looking at all the studies mentioned above, a clear trend is confirmed – an individual approach, staff awareness, and cooperation with the patient's companion are crucial for successful perioperative care. Our study shows that these objectives can be achieved by using a simple but effective system that allows for the quick identification of patient needs and tailored care, without the need for complex and financially demanding programs.

Conclusion

Changing established rituals and not having needs fulfilled can cause significant stress for patients with PDD or ID. If these changes are not adequately managed, the stressful hospital environment can trigger defense mechanisms, such as aggression, self-aggression, or complete withdrawal into oneself. Our study showed that the right approach prevents these negative reactions from happening. Individual care, respect for the patient's individuality, and open communication are not only signs of humanity but also signs of true professionalism. Quality healthcare is not just about professional qualifications and technical precision, but about combining professionalism with empathy and understanding. Each step towards a personalized approach increases the safety, comfort, and success of care, all of which also strengthen the patient's trust in the healthcare system. Based on the positive results of the research and feedback from the perioperative team, the patient personality trait questionnaire was adopted by the University Hospital Olomouc through its Quality Department and included in the standardized pre-operation documents. This step allows it to be systematically used in clinical practice, leading to an increase in the quality and individualization of perioperative care for patients with PDD or ID. The standardization of the questionnaire in preoperative preparation allows for more effective identification of patient needs and the adaptation of procedures by healthcare professionals, minimizing the risk of problematic behavior and increasing the comfort of patients and the entire perioperative team.

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The functioning of the Center for Children and Families within the Slovak Republic from the perspective of a social worker

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Abstract:

The company consistently monitors and ensures compliance with the rights of the child, ensures the protection of the child necessary for his well-being, healthy development and growth, and respects his best interest. The Ministry of Labor, Social Affairs and Family of the Slovak Republic characterizes the goal of the measures as follows: "The basic goal of measures of social and legal protection of children and social guardianship is to provide necessary assistance to families so that children can grow up in the care of their parents." If this goal cannot be achieved, other legal options and aspects of care come into play, which are used until the situation in the

family improves. This option is the placement of the child in the Center for Children and Families, which will ensure a healthy environment for the child's development and benefit. In the presented study, we focus on these centers and their basic functioning, as well as on the basic aspects of child upbringing.

Institutional care versus deinstitutionalization

Based on and in line with the global trend of systematically eliminating the prevailing model of institutional segregated care, which was provided to those who were long-term dependent on the help of another person, such as persons with severe disabilities, the elderly, children in foster care, and replacing it with a model of community services and measures of social guardianship in the natural social environment of the community, the Government of the Slovak Republic, by its Resolution No. 761/2011 of 30 November 2011, approved the Strategy for the Deinstitutionalization of the System of Social Services and Foster Care in the Slovak Republic. Such a change in the model is both one of the objectives of the EU policy in the field of social inclusion and disability and is also part of the Slovak Republic's commitments in the international human rights agenda. These are:

- The European Disability Strategy 2010-2020,
- European social guidelines for the transition from institutional to community-based care,
- Tools for using structural funds for the transition from institutional to community-based care,
- The United Nations Convention on the Rights of Persons with Disabilities and the Optional Protocol to that Convention,
- UN Convention on the Rights of the Child,
- European Social Charter.

The development of the National Action Plan for the Transition from Institutional to Community-Based Care in the Social Services System for 2012–2015 (hereinafter referred to as the "National Action Plan for DI") was one of the basic tasks of the Strategy for the Deinstitutionalization of the Social Services and Alternative Care System in the Slovak Republic (hereinafter referred to as the "DI Strategy"). Both the DI Strategy and the National Action Plan for DI were prepared with the help of a broad working group of experts in the field of social services and alternative care. (MPSVR, 2016). "The basic objective of the National Action Plan for DI was to support the deinstitutionalization of the social services system by implementing pilot projects and creating additional support mechanisms in legislation, financing and organization of the DI process." (MPSVR SR, p. 3).

The main principles that guided the pilot phase of the DI social services system were:

- respect for human rights,
- demedicalization ,
- self-realization,
- self-help,
- self-advocacy /advocacy,
- removing barriers,
- examples of good practice,
- cross-sectional approach.

According to WHO, an institution is "any setting in which persons with disabilities, seniors or children live together outside their family; an environment where people do not have control over their own lives and daily activities." (MPSVaR In: World Health Organisation , The World Bank. World report on disability , 2016, p. 8).

The main features that characterize institutional culture:

- depersonalization – insufficient respect not only for personal property, but also for signs and symbols of one's own uniqueness and humanity,
- rigid, stereotyped and routine activities – fixed time, structure of activities, lack of respect for personal needs,
- flat-rate treatment and professional procedures – social service recipients are worked with en masse, without respecting not only their privacy but also their individuality,
- social distance and paternalism – different status of staff and clients,

- segregation from the local community – the location of the social services facility is eccentric, distant from the local community, and services are concentrated in one place,
- learned passivity – passive behavior of social service recipients that they have acquired and their helplessness,
- underdeveloped social relations. (MPSVaR In: Report of the Ad Hoc Expert Group on the Trasition from institutional to Community - based Care , European Commission, 2016).

Institutional care provides social services, which include:

- their recipients are isolated from the wider society and forced to live together,
- they have no power over their lives and the decisions that affect them,
- is the tendency to prioritize the requirements of the organization itself over the individual needs of individual recipients of social services (MPSVR, 2016).

Deinstitutionalization is based on a fundamental value-based change in the relationship to people who are dependent on the help of society. It represents a process of change (transformation) of the system, form, structure, and content of social services, which is manifested in a departure from the model of traditional care that was applied in classic facilities with an institutional culture. It moves from a passive model to an active model that requires a change in the approach to clients, especially by respecting them as individuals and holders of rights. (MPSVR, 2016). Oláh et al. (2008, p.240) characterized deinstitutionalization as "an influential trend in contemporary social work that promotes, in all cases where possible, non-constitutional forms of care that are easily accessible to the client and do not tear the client out of their natural environment, i.e. care provided within the community."

The overall transition was based on the following recommendations of the DI Ad-hoc Group Report:

- respecting the rights of beneficiaries and their involvement in decision-making processes,
- prevention of institutionalization,
- creating community services,
- closing institutions,
- limiting investments in original institutions,
- human resources development,
- efficient use of resources,
- quality control,
- holistic (comprehensive) approach,
- continuous awareness raising. (MPSVR, 2016, p. 10).

The amendment to Act No. 305/2005 Coll. on the social and legal protection of children and social guardianship on 1 January 2019 brought about significant legislative changes. The biggest change concerned the transition of children's homes, crisis centres and resocialisation centres into a new type of multifunctional facility called the Centre for Children and Families (CDR). This involved the transformation of spatial conditions, personnel structure, educational conditions and economic conditions. If a home transformed into separate groups is compared with a boarding school type, at first glance the transformed homes appear more advantageous. When it comes to the quality of housing, project design, functionality of premises, equipment, the position of separate groups is almost unshakable. (Škoviera , 2006). Škoviera (2006, p.74) offers us another perspective, namely, "if we add a standard home environment to the comparison pair and choose as a criterion what can be called the "truthfulness" of the environment (we understand it as the relationship between what the environment really is and what it is declared to be externally), the outcome in favor of family types is not so clear." The author explains his statement:

- A true home is a home without any need to declare it outwardly, it is defined by the emotional and legal relationship between parent and child,
- The boarding school declared itself to be an alternative solution, but did not create the illusion of a real home.
- The so-called family type - if aspirations are to replace a real home - only creates the illusion of a real home.

Empirical verification of the functionality of deinstitutionalization

The purpose of the survey we conducted was to determine the general public's view of the Centers for Children and Families, what knowl-

edge the public has about its functioning, the nature of the services provided, its clientele, and whether they perceive the legislative changes from 2019, especially the transformation of former children's homes into Centers for Children and Families. We asked them specific questions that gave them the opportunity to express their views on the topic, and the method used was a questionnaire.

We set the following hypotheses:

Hypothesis No. 1: We assume that the public thinks that children who grew up in Centers for Children and Families are unable to start a family and live an organized family life because they did not grow up in a classic family environment and did not have a role model.

Hypothesis No. 2: We assume that the public believes that children of Romani origin are overrepresented in Centers for Children and Families than children of non-Romani origin.

Hypothesis No. 3: We assume that the public believes that children who leave the Center for Children and Families are sufficiently prepared for life and can integrate into society without major problems.

Hypothesis No. 4: We assume that the public believes that parents maintain contact with a child in a CDR that has been taken away from them.

Organizational requirements for the survey

When working with the questionnaire, we used Survio . It is an online platform for creating questionnaires. It works on the principle of an online service and includes tools for distributing and comprehensively analyzing questionnaire responses. When choosing a research method, we were interested in the advantages that the questionnaire offers as one of the quantitative research methods, for example:

- **anonymity** – in our case, anonymity was in terms of the answers to the questions in the questionnaire. The sample we addressed were respondents we know personally, but the questionnaire was filled out anonymously, without personal contact and without knowing which of the respondents had filled out the questionnaire at all,
- **time to think** – the time period for completing the questionnaire was from 09/2023 to 10/2023, however, the time the respondent devoted to completing it was personal,
- **number of respondents** – a large number of respondents can be addressed.

We mainly used closed questions in the questionnaire, mainly to eliminate reluctance to complete the questionnaire if the respondent assessed the question as too open. We formulated the questions in such a way that they had a clear answer, either in the form of yes / no or where the respondent could choose from three or more specific answers.

The questionnaire began with 3 identification questions, where respondents indicated their age, gender, and education, thus obtaining basic demographic data. Respondents then answered 19 questions. As mentioned, we avoided leading questions so that the data obtained would not distort the survey results.

In total, we addressed 310 respondents, creating groups that we excluded from the survey sample:

- children and youth under 18 years of age
- CDR employees
- other interested persons in this issue
- children placed in CDR

In our case, the questionnaire was completed by a larger number of women than men, in the ratio of 71.5% women and 28.5% men, namely 143 women and 57 men. The selection was not targeted, but random. The largest representation was in the age category 35-44 years, namely with a number of 72 respondents, which is 36% of the total number. The second most numerous group was the age category 18-24 years, with a number of 38 respondents, i.e. 19.0% of the total number. By 2%, exactly 17.0%, the age categories 25-34 and 45-54 years were also placed in third position, identically with the number of respondents 34. The smallest group of respondents was the age group 55-64 years with a number of 22 and a ratio of 11.0% of the total number.

When determining the level of education, the respondents provided the following data. The largest number of respondents was represented by those who graduated from a secondary vocational school and completed their studies with a high school diploma. The number of respondents with

a high school diploma was 86, i.e. 43.0% of the total number of respondents. This was followed by respondents with a second-level university degree, in the number of 40, the percentage is 20.0% of the total number of respondents. This was followed by respondents with a secondary vocational school without a high school diploma, in the number of 25 respondents, 12.5% of the total number. The next group, with a number of 20 respondents and a 10.0% representation, were respondents with a 1st-level university degree. There were 17 respondents with a high school diploma, i.e. 8.5% of the total number. The penultimate group consisted of respondents with a primary school degree, in the number of 12, the percentage is 6.0% of the total number. We also mentioned the possibility of using the other group, which the respondents did not use.

Table 1 Did you know that since January 1, 2019, the name Center for Children and Families has been used and the original name Children's Home has been discontinued?

ANSWER	ANSWERS	SHARE
yes	66	33.0%
no	134	67.0%

Table 2 Children placed in the Center for Children and Families (CDR)

ANSWER	ANSWERS	SHARE
orphans	76	38.0%
half-orphans	35	17.5%
they have both parents	89	44.5%

The table refutes the myth that there are only children in CDR who do not have parents. As they were called in ancient times - orphanages. As many as 89 respondents, or 44.5% of the total number of respondents, chose the answer that the children have both parents. The answer orphans was chosen as an option by 76 respondents (38%) and a total of 17.5%, or 35 respondents, think that children in CDR are half-orphans.

Table 3 Contacting children by biological family is permitted

ANSWER	ANSWERS	SHARE
allowed anytime	105	52.5%
only allowed a few times a year	61	30.5%
not allowed at all	34	17.0%

From the above table, we learned from the answers of our respondents that more than half of the total number of 200, namely 105 respondents, which is 52.5%, think that the biological family can visit the child at any time. Of course, court orders, agreements with the CDR on visits, etc. must also be taken into account. 61 respondents (30.5%) are convinced that children can only be visited a few times a year. The rest of the respondents, numbering 34, a percentage of 17.0%, were inclined to answer that children are not allowed to visit at all.

Research part

By asking the question *Did you know that since January 1, 2019, the name Center for Children and Families has been used and the original name Children's Home has been discontinued?* we were investigating whether the public had noticed the changes effective from January 1, 2019. 67% of respondents (134 respondents out of 200) missed the change. The remaining 66 respondents (33%) did not miss the change,

Table 4 Do you think that children are sufficiently prepared for real life after leaving CDR and can integrate into society without major problems?

ANSWER	ANSWERS	SHARE
yes	43	21.5%
no	157	78.5%

Our hypothesis No. 3 is also related to this question: We assume that the public thinks that children who leave the Center for Children and Families are sufficiently prepared for life and can integrate into society without major problems.

As the table shows, 157 respondents think that the problem occurs when integrating into society (78.5%), only 43 respondents out of 200 think the opposite (21.5%).

Table 5 Do you think the statement that the majority of children in CDR are of Roma origin is true?

ANSWER	ANSWERS	SHARE
yes	122	61.0%
no	78	39.0%

This question was very important for us because it is the basis of our hypothesis. 61% of respondents answered that the statement is true, 39% disagreed with the statement.

Hypothesis No. 2: We assume that the public believes that children of Romani origin are more represented in Centers for Children and Families than children of non-Romani origin.

Table 6 Do you think that children who leave the CDR are able to start a family and live an organized family life, despite the fact that they did not grow up in a classic family environment and did not have a role model?

ANSWER	ANSWERS	SHARE
yes	180	90.0%
no	20	10.0%

This question was key for us because it is linked to hypothesis no. 1: We assume that the public thinks that children who grew up in Centers for Children and Families are not able to start a family and live an organized family life because they did not grow up in a classic family environment and did not have a role model. So far, the biggest difference between the two answers is because 180 respondents, 90%, chose yes, and 10% of the total number, which is 20 respondents, chose no.

Table 7 Do the biological parents from whom the child was taken maintain contact with the child in the CDR?

ANSWER	ANSWERS	SHARE
yes, often	11	5.5%
less often	172	86.0%
they don't contact their child at all	17	8.5%

Another key question related to hypothesis #4: We assume that the public believes that parents maintain contact with a child in the CDR who has been taken away from them.

We offered 3 possible answers to the question we asked. There were also striking differences in the answers. The answer "less often" was chosen by 172 respondents out of 200 (86%), the answer " they do not contact their child at all" was chosen by 17 respondents (8.5%), and the answer "yes, often" was chosen by a total of 11 respondents (5.5%).

but it cannot be said that they actually use it and whether they do not continue to use the old name Children's Home, which has been used longer in terms of time and is more ingrained in the public's memory. It is also not possible to deduce from these answers that the respondents who noticed the change also understand the content change (merger of functions, etc.).

Discussion

Table number 6 in the study is related to hypothesis number 1, where we gave respondents the opportunity to choose from two answers. In the entire questionnaire, only for this question was there such a striking difference in the distribution of votes, namely 90%: 10%. 180 respondents answered that children after leaving the CDR are able to start a family and live an organized family life, despite the fact that they did not grow up in a classic family environment and did not have a role model. Our hypothesis was **not confirmed** . We claimed that the public thinks that children are not capable of this.

Hypothesis number 2 is linked to table number 5 in the study, which we asked the public and reads as follows: "In your opinion, is it true that the majority of children in CDR are of Roma origin?" We assumed that the public has the opinion that children of Roma origin are more represented in the Centers for Children and Families than children of non-Roma origin. As an answer option, they could choose between yes and no. 122 respondents, that is, 61% of the total number, think that there are more children in CDR of Roma origin and only 78 respondents (39%) disagreed with this statement. This means that our assumption was **confirmed.**

In the third hypothesis, we investigated whether the public thinks that children after leaving the Center for Children and Families are sufficiently prepared for life and can integrate into society without major problems. The questionnaire clearly shows that 157 respondents, which is 78.5%, do not think that children are ready for real life after leaving the CDR and will be able to integrate into society, which is why they answered no. Out of a total of 200 respondents, only 43 trust children. In percentage terms, this is only 21.5% of the total number of respondents. We can therefore conclude that hypothesis no. 3 is **unconfirmed.**

In the last hypothesis, which reads as follows: "We assume that the public believes that parents maintain contact with the child in the CDR that was taken away from them.", table number 7 was linked. Respondents could choose from three answers. The first answer was yes, which was chosen by 11 respondents. The answer less often was chosen by 172 respondents, which represents 86% of the total number of respondents. The last option, the answer that they do not contact their child at all, was chosen by

17 respondents. This leads to the only conclusion: the hypothesis is **unconfirmed.**

Hypothesis No. 1 – is unconfirmed – we assumed that the public thinks that children are not capable of starting a family and living an organized family life because they did not grow up in a classic family environment and did not have a role model – the public's answer was yes, they are capable of it (90%),

Hypothesis No. 2 – is confirmed – we assumed that the public has the opinion that children of Roma origin are more represented in the Centers for Children and Families than children of non-Roma origin - the public's answer is yes, the majority of children are Roma (61%),

Hypothesis No. 3 – is unconfirmed – we assumed that the public thinks that children after leaving the Center for Children and Families are sufficiently prepared for life and can integrate into society without major problems - the public's answer is no, (78.5%),

Hypothesis No. 4 – is unconfirmed – we assumed that the public believes that parents maintain contact with a child in the CDR who was taken away from them - the answer "yes, often" was chosen by only 5.5% of respondents.

Conclusion

If we compare the answers to hypothesis number 1 and 3, where the public answered that children are not able to integrate into society after leaving the CDR (78.5%), on the other hand, they will be able to start a family and live an organized family life (90%), this is at least a bit contradictory, because we think that a person who cannot integrate into society also has a problem with finding a life partner and thus starting a family. We must admit that these children often come from an environment that was not ideal for their development (neither physical, nor psychological, nor social) and it leaves a mark on them. Not everyone can process traumatic events so quickly, if they can process them at all. Our goal and mission is to work with the child and his family, to eliminate shortcomings, problems and complications so that the child can return to his own biological family. But while they are in the CDR, we try to make their stay as similar as possible to that at home.

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Healthcare Policies for Immigrant Communities in the U.S.: A Literature Review

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Abstract:

Objective: The objective of this paper is to review healthcare policies that influence access, coverage, and delivery of care for immigrant communities in the United States, and to identify inclusive policy strategies.
Design: Narrative review of recent literature and policy reports.
Participants: This review synthesizes findings from federal and state-level studies examining immigrant health coverage, focusing on legal residents and mixed-status families.
Methods: Sources were selected from PubMed, ASPE, KFF, and Commonwealth Fund databases, exploring Medicaid and CHIP access, ACA exclusions, state waivers, and culturally responsive models.
Results: Immigrants continue to face gaps in insurance eligibility and care utilization, though state-level innovations and

community-based approaches show promise. Policy frameworks that prioritize equity, confidentiality, and affordability enhance access.

Conclusion: Inclusive healthcare policy requires multi-sector collaboration and evidence-based reforms that recognize the diverse needs of immigrant populations.

Introduction to Immigrant Health Policy Landscape

There are over 44 million immigrants in the United States, and they are an integral component of the country's population and workforce (ASPE, 2023a). They are not provided with any healthcare services although they contribute to the country. These differences are not just a socioeconomic issue, but as a federal and state regulatory policy issue regarding who is to be qualified for public health care coverage through Medicaid, Medicare, and ACA Marketplace plans (KFF, 2024). The result is one of overall variability and random unfairness of access.

Whereas citizens must negotiate a monolithic system of access to care based on residence, immigrants must negotiate a patchwork system of access to care based on state, immigration status, income, and family status. This review is specifically interested in how healthcare policy structures those experiences. It's examining how federal restraint, state innovation, and community interventions open or close doors to care, and making policy recommendations for establishing a more equitable, sustainable health system for immigrant communities.

Federal Policy Frameworks

1. Medicaid and CHIP Eligibility

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) fundamentally reorganizing immigrant eligibility for federally funded public programs, including Medicaid and the Children's Health Insurance Program (CHIP). Legally present immigrants, with very few exceptions, are not eligible for federally funded Medicaid in their first five years here under PRWORA (ASPE, 2023a). Excepted individuals such as refugees, asylees, and veterans are covered, but it is nevertheless a major barrier for millions of immigrants.

Other states cover this gap with state dollars, most notably for pregnant women and children. To illustrate, CHIPRA Section 214 authorized states to offer lawfully present immigrant children and pregnant women coverage without waiting, which over half of the states have done (KFF, 2024). But coverage is not always applied consistently, and many immigrants are left without coverage or in the dark as to whether they are eligible for coverage.

2. Affordable Care Act (ACA) and Marketplace Access

The ACA more radically expanded health coverage to Americans through insurance products than ever before in our history, but immigrants (especially those without any permanent legal status) were blocked from purchasing benefits in ACA Marketplaces (KFF, 2024). Lawfully present immigrants also have restrictions on eligibility along and many do not know their rights because of complicated rules related to every situation and concerns over the potential consequences of being illegal. The 2019 "public charge" rule, which penalized use of public benefits in immigration and also charged for it, chilled the immigrants even the legally eligible beneficiaries (ASPE, 2023b). While the rule would later be rescinded, it created a residual fear that discourages immigrant enrollment in the public health programs.

In mixed-status families (where children are U.S. Citizens and parents are undocumented), the risk of exposing immigration status information at home led to declines in enrollment in ACA and Medicaid programs (KFF, 2024). Federal policy affects not only eligibility, but also individual perceptions of safety in receiving care, especially among those who are most vulnerable.

State-Level Innovations and Waivers

1. State-funded Insurance Expansions

In response to the federal restrictions on health care access, some states have developed policies to provide health care access to their immigrants using state funds only. There is no state in the United States currently as ambitious in this direction as California has been. In 2016, California established the Medi-Cal program which covers income eligible residents 0-26 years old, and age 50 and older regardless of immigration status. Beginning in 2024, they will expand to all low income California residents, making this one of the largest health care access programs in the United States (Commonwealth Fund, 2024).

The state of Illinois has similar policies under the Health Benefits for Immigrant Seniors and Adults programs and applicants 42 or older who are denied federal aid can receive free or low-cost health care services. Illinois' policies are mirroring New York's Essential Plan which is a public insurance option for all many noncitizen residing in New York State, including those with temporary protected status (KFF, 2024). States are paving a way to cover populations excluded from federally funded programs and creating more equitable systems for differing populations.

2. Section 1332 and 1115 Waivers

States can apply to obtain waivers about certain provisions established in the ACA, through Section 1332, in order to alter ACA requirements and possibly experiment with new coverage programs. While states have not submitted waiver applications specifically to cover noncitizens, experts feel that the 1332 waiver framework can offer states paths to blaze new trails in coverage expansion without having to wait for legislation to be enacted at the federal level (Urban Institute, 2022).

Medicaid's Section 1115 waiver provides even further states flexibility to develop demonstration projects for testing new types of delivery systems and payment models. For example, states have used these waivers for enhanced integration of care and transformation of access to behavioral health services, and from a broader standpoint in relation to social determinants of health and displacement in systems. Oregon's 1115 waiver is specific to service delivery to varied communities while using community-based care models and can also simply be used to cover immigrant populations (ASPE, 2023a).

The waivers, while flexible, will require federal approval, and there must be sufficient political will on the state side to allow for the waiver application process to unfold, which will limit applicability in communities with less progressive leadership. Even with both limitations, they can be instrumental in advancing immigrant-inclusive health reform efforts, and without significant and contingent delays waiting for the Federal Congress to act.

Administrative and Systemic Barriers

Even when immigrants are legally eligible to access care, circumstantial barriers to care often remain. Language barriers are some of the most common barriers. While there are federal civil rights laws which require interpretation services to be available for patients that do not speak or understand English, many facilities do not offer interpreting services consistently, leading to miscommunication and medical errors, as well as poor experiences for patients (PubMed ID: 17848435).

Documentation requirements can create another barrier to access care. Applications for insurance or various assistance programs usually require several different types of documents that prove identity, income, and residence, and the immigrant population often lacks the required documents, or it would not be within their interests to disclose. The results are long delays in care, avoidance of services, and worsening conditions.

Finally, the barriers to accessing technology-based tools, like online enrollment portals or telehealth, are magnified for immigrant populations due to their language or literacy levels, or sophisticated technology gaps. Barriers to accessing resources are compounded, especially for older adults or those that are new to the health system, which is associated with lower rates of preventive care and increased visits to the emergency room (ASPE, 2023a).

Community-Based Models and Local Programs

In many immigrant-populated areas, access to health care is made a reality not by federal or state policy, but a local initiative and community-based organizations. Community Health Centers (CHCs) and Federally Qualified Health Centers (FQHCs) resources for their underserved populations that serve immigrants. Community Health Centers and Federally Qualified Health Centers must provide services no matter a patient's ability to pay and provide an essential access point for preventive services, chronic disease management, and maternal health (ASPE, 2023a).

A great example is the Program of All-Inclusive Care for the Elderly (PACE) at On Lok provides home-based, culturally tailored services to the aging immigrant population in San Francisco. PACE includes healthcare services, nutrition, and social services into one package to this aging population (San Francisco Chronicle, 2024). PACE will keep an elderly immigrant out of a nursing home, or some other intuitional settings and routine and preventable care tends to reduce costs.

Community health workers (CHWs), often hired from inside the communities in which they serve, also can be agents of change. CHWs serve as cultural and language navigators for immigrant patients who may be unfamiliar with a health system dominated by a different culture or a different language, helping with how to move through the health system, manage chronic conditions, and understand rights and services (KFF, 2024). Evidence supports that organizations that hire a CHW staff have significantly better adherence to care plans and increased trust in providers (PubMed ID: 37096601).

Grassroots strategies are effective in reaching marginalized people who may initially be skeptical of government institutions or nonmainstream medical systems. Funding is inconsistent, and commonly reliant on grant funding, which forces many of these programs to think about sustainability and the ability to scale when securing grant funding is an ongoing issue hospice must grapple with. At a minimum, there exists a need for allocated funding to sustain publicly funded CHCs, CHWs and mobile health that can help ensure equitable access to health care to immigrants, by geography and legal status.

Implications of COVID-19 Policy Shifts

The COVID-19 pandemic exposed the vulnerabilities of multiple groups in the U.S., and immigrant groups were particularly vulnerable during this time. While many immigrants—particularly those who worked within essential frontline jobs in food processing, elder care, and delivery—were classified as essential workers, many lacked accesses to healthcare, sick leave, or any semblance of protective equipment (PubMed ID: 40102373). Due to their work, these groups were at a higher risk of exposure with very few protections.

In this moment of a publicly declared emergency and temporary public health measures, some initiatives were taken to expand access. For example, emergency Medicaid funding was established to provide coverage for testing and treatment of COVID-19 for all individuals, regardless of their immigration status. Similarly, federally funded vaccination programs were rolled out with no requirement for proof of insurance or immigration status (ASPE, 2023b). While only for the duration of the emergency, these types of policies demonstrated that it is possible to provide comprehensive public health services to the public in emergency situations.

A small number of states undertook additional measures. California, for instance, established multilingual hotlines and mobile vaccination units directed at immigrant communities. Non-profit organizations mobilized in various cities, distributing masks, food, and public health information in Spanish, Mandarin, Arabic, and other languages (Commonwealth Fund, 2024). Not only did these additional measures help to reduce the incidence of the disease, but they also illustrated the effectiveness of cultural competency in outreach.

With the end of the COVID-19 public health emergency in 2023 and the elimination of many temporary measures, access for many, particularly as it relates to undocumented immigrants, has been rolled back to pre-pandemic levels and they have again been subjected to exclu-

sions excluding them from many medical and other social benefits. The fact that even a small set of measures could be adopted in the face of extraordinary death, illness, and social disease, demonstrates how tenuous inclusion can be when tied only to temporary exceptions and not to conditions and policy changes that can enact fundamental reform that is sustained over time.

Gaps, Challenges, and Areas for Reform

Although state-sponsored expansions and temporary pandemic policies have existed, there remain serious inequities for immigrant populations receiving healthcare. The key issue remains that many immigrants, especially new arrivals, are still not eligible for federally funded health coverage such as Medicaid and ACA subsidies (ASPE, 2023a). These exclusions limit their access to care they require and reinforce existing health inequities long term.

The geographic inconsistency further increases the gap. Immigrants who reside in states that provide protections, such as California, or progressive states such as New York may have access to inclusive insurance through state funding, while immigrants in states having protections that are entirely excluded from access to care. The nationwide fragmentation of health coverage is driven more by states than need (KFF, 2024) based solely on zip codes.

Another significant emergence is that immigrants still do not have access to culturally and linguistically appropriate care. Many immigrants have difficulty interacting with healthcare providers, and in many instances, providers did not receive cultural competence training. Even in instances where interpreters are required, they are sometimes improperly employed, or unavailable, resulting in miscommunication and care of lesser quality (PubMed ID: 17848435).

Mental health is an under-addressed component of immigrant health policy. Immigrants are often at a higher risk for mental health problems because of trauma, familial separation, work stressors, and acculturative stress. Even when immigrants need culturally sensitive accessible care, availability is extremely limited, especially for non-English speaking immigrants (PubMed ID: 37096601).

Another barrier is the absence of data to inform the design of policies. Public health datasets often do not include sufficient demographic detail—including indicators such as immigration status, language preference, or time since arrival—what makes it challenging to design programs to meet specific needs or subsequently evaluate the effectiveness of the program once delivered (ASPE, 2023b).

Policy Recommendations

We're creating a collective vision for a more equitable, inclusive, and efficient health system for immigrant communities in the U.S. The following policy recommendations are drawn from evidence and successful examples from states and communities:

- Expand publicly funded health insurance coverage to all residents with income-qualifying status regardless of immigration status; states like California have already begun substantial improvements to coverage for their residents (Commonwealth Fund, 2024).
- Streamline applications and decrease the documentation and other barriers to health care access by adopting presumptive eligibility models, providing translated materials, and utilizing online application tools.
- Create and improve culturally competent and linguistically concordant care delivery models through new and improved access to professional interpreters in clinical settings (PubMed ID: 17848435) and increased education about delivering culturally competent care by providers.
- Support, engage, and refer immigrants for primary care services through increased funding for community outreach and in community health workers, mobile clinics, and organizations that are already reaching vulnerable populations, with existing community partnerships (PubMed ID: 37096601).
- Use federal waivers, including Section 1115 and 1332, to trial your integrated, inclusive health models suitable for immigrant communities. This is especially important in states that are willing to be creative (Urban Institute, 2022).
- Assure that patient confidentiality is assured and declare that health data will not be re-

leased to those agencies that enforce immigration laws; this is a critical step toward restoring confidence in public programs, specifically for the immigrant population.
- Better data collection of immigrant populations and sub-populations is needed to heighten evidence-based policy making. Disaggregating is needed to better serve more diverse use populations (ASPE, 2023a).

Together these program and policy reforms may address access, quality, and equity in health care for immigrant communities, while bolstering public health and eliminating costs across the system.

Conclusion

The complex interplay of federal exclusions, differing state policies, and structural barriers continues to shape the lived healthcare experiences of immigrant communities in the US. While state-based programs for inclusion and model sites for local community-based care have great promise, there are still meaningful gaps against access and utilization. The COVID-19 pandemic demonstrated what is possible in terms of an agile, equitable, inclusive, coordinated healthcare response and how fragile and often temporary policies can be in extending access to immigrant communities without transformational change.

This literature review suggests that informed and deliberate immigrant-inclusive healthcare policies can and should be created on the state level to consider equity, access for all, and dignity. Expanding access to publicly funded coverage, removing paperwork and documentation, investing in culturally competent care, and ensuring confidentiality are all important steps in the right direction. And most importantly, healthcare policy needs to see immigrant communities as fundamentally linked to the nation's economic contribution and social fabric—because immigrant health is national health.

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Social Safety Net for Homelessness

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Abstract:

The main objective of this study is to identify and analyse the social safety net in relation to the problem of homelessness. We also point out the factors that influence the potential emergence of such a problem, which affect both homeless persons and their immediate environment. The study addresses the basic objectives of the social safety net and the attitude of local residents towards homeless people. The safety net is often the last chance, while the goal of homeless people is to avoid falling into deep misery and poverty. The most effective help for the homeless individuals can be granted by social services and in facilities especially designed for this particular group.

Methods. The current study has a dual, theoretical and empirical, dimension. From an empirical-quantitative standpoint, the research was conducted with the help of 332 respondents living in the city of Prešov, Slovakia. Theoretically, we investigate the relationship between the issue of homelessness in the aforementioned city, the attitudes of local residents, and the financial aspect of the social services involved. We analysed the connection between the respondents' gender and their opinion on the usefulness of services provided for the homeless. In the final part, we check our working hypotheses using the the social safety net provided by Prešov's Archdiocesan Charity.
Conclusions and discussion. We conclude the study by raising the awareness concerning the topic at hand. Second, we claim that there is no statistically significant connection between the gender of the respondent and their opinion regarding the usefulness of social services. Neither is there a statistically significant connection between the respondent's place of residence and the financing of social services from the city budget.

Introduction

Průdková and Novotný (2008) define homelessness as a social phenomenon preceded by various processes and behaviours which lead to the loss of life security, background and social exclusion. At the same time, however, they point out that this situation is influenced by individually different factors, either objective or subjective. Further, homelessness affects all areas of human life: social, psychological, financial, physical, etc. From a societal perspective, it is primarily a way of life characterized by insufficient or no shelter (Ludvigh Cintulová et al., 2023).

Beňová and Matiaško (2018) present a three-dimensional approach to the definition of homelessness. This approach was first introduced by Leilani Farha, the UN Special Rapporteur on the right to housing. The first dimension focuses on the absence of a home. Home is understood from a material and social viewpoint. It means a minimally adequate housing facility, wherein conditions are created for the creation or maintenance of family relationships and participation in community life (Kondrla et al., Slobodova Novakova, 2024). The second dimension refers to the stereotype in the perception of homelessness. This results in the systematic discrimination and social exclusion of the homeless. This dimension recognizes that not having a home creates a social identity which in turn leads to the discrimination and stigmatization of the homeless. As to the third dimension, it connotes the fact that homeless people strive for survival and dignity. These individuals are holders of basic human rights and freedoms. In addition, there exist other definitions of homelessness in the professional literature, which analyse this phenomenon from several different angles. In its turn, this fact encouraged the European Union to look for a more unified understanding (Beňová, 2008). Specifically, *"the European Observatory on Homelessness (EOH), which was established by the European Federation of National Organisations Working with the Homeless (FEANTSA), has produced the ETHOS European Typology of Homelessness and Housing Exclusion after several years of research."* (Matoušek, 2013, 56).

Social safety net

The guarantor of the social safety net in Slovakia is the state itself. The state can provide financial and material assistance (Hamarová, 2024; Králik, 2024), guarantee income, or provide other forms of assistance if they are more advantageous to the citizen in question. Moreover, the social safety net treats many adverse social situations in which citizens may find themselves. It has a humanitarian and formal character. Traditionally, it is formed by dedicated organizations and its main target group are citizens

who have found themselves in material need (Budayová, 2024, Vaľko et al., 2024). In solving the social pathology of homelessness, the social safety net has an irreplaceable position. Radičová argues that without a permanent source of income, which can be provided through benefits from the social safety net, we cannot change the position of the homeless in society (Matoušek, 2013). Matoušek (2005) defines a social safety net as a system of state-guaranteed social security which integrates social insurance, social support and social assistance. Thanks to it, citizens should not fall into a state of destitution even in times of social transformation or economic crisis. However, Radičová (2024) and Fila (2024) hold that social safety nets do not take into account that some citizens may fall into poverty at a higher rate than others, and so, such networks work only if they cover citizens who have no other option for solving their dire material situation.

Regarding the functions of the social safety net, they are, according to Dudová et al. (2018, 72), as follows:

- provision of a certain level of protection to socially dependent citizens;
- ensuring a minimum income for the economically active population through the guarantee of a minimum wage;
- ensuring a minimum income for socially dependent families or citizens by determining the minimum level of subsistence and the minimum level of old-age pension;
- implementation of employment policy through active and passive systems;
- provision of institutional social care;
- implementation of the so-called valorization, i.e., the adjustment of wage and social income according to the increasing costs of living.

That said, the social safety net can be understood as consisting of three separate pillars: social insurance, state social support, and social assistance. These pillars give rise to a distinct assistance network meant for citizens who find themselves in emergency situations. Their goal is to prevent these citizens from falling into poverty by guaranteeing them an income at the minimum subsistence level (Ondrušová, 2009; Kondrla, Repar 2017).

Factors of homelessness

Homelessness has a multifaceted nature. Like other socio-pathological phenomena, its cause can be a risky behaviour or such phenomena as poverty, unemployment, addiction, prostitution, domestic violence, crime, delinquency, etc. The professional community, therefore, tends to examine the causes of homelessness from a bio-psycho-social perspective. In this regard, one can divide the causes into endogenous and exogenous (Matoušek. 2005). Endogenous factors include innate (or biological) factors that are genetically determined. Likewise, psychological factors are directly related to personality development. Exogenous factors mean a long-term stay in a toxic environment, which can be a family or peer groups. Here we can also include negative influences that occur in prisons, re-education centres, orphanages (Matoušek, 2007, Árpová, Árpová, 2024).

In practice, one can divide the causes of homelessness into subjective and objective. Objective causes are those that an individual cannot influence through their own behaviour, be that positive or negative. Included here are primarily the social policies of the state, for instance, employment, housing, or family policies. Another possible cause is the overall perception of homeless people and the attitudes of others towards them (Králik, 2023).

Concerning the subjective causes, they can issue from individuals' abilities, traits, temperament, character, or age, but also from families and other social groups (Mátel, Schavel, 2011, 38). Hroncová and Kraus (2006) divide these causes into four groups:

- Material: personal debt or the loss of property, housing, employment, or financial security;
- Relational: the breakdown of the family through divorce or other disruptions, the cause of which may be, among others, social pathologies such as alcoholism, sexual abuse.
- Personal: physical illness or disabilities. To this list, Vágnerová (2008) and Máhrik (2024) add various mental illnesses, personality disorders, or psychic impairment due to drug abuse. Homeless people often become mentally ill and after being released from hospitals, they are not always capable of acquiring an

independent life. Hence, the increased risk of social failure due to tendencies towards illegal behaviour, addiction to psychoactive substances, and non-compliance with prescribed treatments.
- Institutional: prison inmates, people released from rehabilitation homes or orphans (Hroncová, Kraus, 2006).

Árpová (2023) and Tomová, Árpová (2023) argue that these objective and subjective causes or factors should not separated from each other. They also highlight the social skills of the individual, deemed essential for the effective resolution of crisis situations. Social skills are conditioned by the high demands and expectations of society, they comprise socio-economic factors, as well as the individual shortcomings of the homeless. The absence of such skills leads to the inability to meet the demands of our current, complex society or to resolve situations such as unemployment, losing one's house, divorce (Budayová, 2024b, Ludvigh Cintulová, 2019), and even global pandemics (Khalid, Pavlikova, et al., 2024). This inability usually leads to the loss of material and relational resources, doubled by the rejection across the entire society (Matoušek, 2008).

Draganová (2006) states that the most common cause of homelessness is the loss of employment, which accounts for 23%; followed by divorce - 20%; leaving the family - 11%; release from prison - 11%; poor life management - 3%; and, leaving other institutional facilities - 2%. Only 7% of homeless people freely and deliberately decided to become homeless, but in their case, we must take into account personality factors such as psychological disorders.

From the viewpoint of society, the perception of homelessness has been theorized in two different ways. One set of theories finds fault with the homeless person, claiming that the victim is also the culprit. Here, the person who finds oneself on the street is considered fully responsible for one's situation, being blamed for being an alcoholic, deviant, vagrant, etc. Since the perception of a homeless person in this case is not at all favourable, the supporters of this view are not inclined to help in the form of alternative permanent housing and the like (Ludvigh Cintulová, Budayová, 2024).

The second theory states that a person becomes homeless because of some failure or incapacity, however, we cannot assign any personal responsibility for this condition. Moreover, scholars argue that providing minimal assistance to the homeless is insufficient in solving the problem (Bursová et al., 2024; Leskova, Haburajová, 2023).

We should also mention that solutions can occur through the use of new technologies and especially media (Tkácová et al., 2023a), which offer constant presence and participation (Pavlikova et al., 2023), huge amounts of information (Leka et al. 2024; Tkácová, 2022), although often with deceptive content containing elements of manipulation (Králik, 2024; Tkácová et al., 2024), which can lead to overload and a decline in the ability to effectively address everyday challenges (Tkácová et al., 2023b), and ultimately also to exacerbating socio-pathological phenomena.

Empirical findings

Concerning the findings of our empirical research, we should start by saying that we analysed the attitude and behaviour of the outside population towards the homeless, as well as this population's view of social service networks for the homeless, their financing plans from the city budget, and the willingness to increase either the quality of these services or their allocated sums.

Our explicit objectives have been:
- To determine the residents' attitude in the city of Prešov towards the issue of homelessness within the limits of the city.
- To examine residents' views about the financing of social services in the city of Prešov.

Our working hypotheses have been: Hypothesis No. 1

H0: There is no statistically significant connection between the gender of the respondent and their opinion on the usefulness of services provided by the Archdiocesan Charity for the homeless.

H1: There is a statistically significant connection between the gender of the respondent and their opinion on the usefulness of services provided by the Archdiocesan Charity for the homeless.

Hypothesis No. 2

H0: There is no statistically significant connection between the respondent's residence and their consent to the financing of social services from the city budget.

H1: There is a statistically significant connection between the respondent's residence and their attitude to the financing of social services from the city budget.

Out of a total of 339 questionnaires, we excluded invalidly completed questionnaires and included 332 validly completed questionnaires. The questionnaire return rate is 97.9%.

Table 1 Respondent's gender

	n	%
Man	80	24,1
Woman	252	75,9
Together	**332**	**100,0**

Source: own processing

The table shows that 332 (100.0%) respondents participated in the online survey in the city of Prešov. Out of these, 252 (75.9%) were women and 80 (24.1%) were men. Based on the numbers above, it can be concluded that women were more interested in completing the questionnaire than men.

Table 2 Respondent's dwelling type

	n	%
Apartment building	304	91,6
Family house	28	8,4
Total	**332**	**100,0**

Source: own processing

Out of a total number of 332 (100.0%) respondents, the majority lived in apartment buildings, more exactly, 304 (91.6%) respondents; 28 (8.4%) respondents lived in family houses.

Question In your opinion, is the network of social services for the homeless provided by the Archdiocesan Charity beneficial?

Table 3 Social services of the Archdiocesan Charity

	Men	Woman	Together
Beneficial	44	124	168
Somewhat beneficial	27	105	132
Somewhat unbeneficial	5	11	16
Unbeneficial	4	12	16
Total	80	252	332

Source: own processing

To verify hypothesis no. 1, we divided the respondents into men and women. The table shows that 252 women answered the question. Out of these, 124 deemed beneficial the network of social services for the homeless provided by the Archdiocesan Charity of Prešov, whereas 105 women considered it rather beneficial. 12 respondents described the network as unbeneficial, while 11 respondents as rather unbeneficial. Of the 80 men who answered this question, 44 described the network of social services for the homeless provided by the Archdiocesan Charity of Prešov as beneficial, and 27 as rather beneficial. The opposite opinion was expressed by 9 men. A total of 332 respondents answered this question, of which 168 respondents described the network of social services for the homeless provided by the Archdiocesan Charity of Prešov as beneficial and 132 respondents as rather beneficial. The opposite opinion was expressed by 16 respondents, who described the network in question as rather unbeneficial and unbeneficial.

Question In your opinion, should the Archdiocesan Charity increase the number of clients and services?

Table 4 Increasing the number of social services and clients of the Archdiocesan Charity

	Men	Woman	Together
Yes	29	102	131
Probably yes	38	113	151
Probably no	6	25	31
no	7	12	19
Together	80	252	332

Source: own processing

In order to verify hypothesis no. 1, we divided the respondents into men and women according to their gender. The table shows that 252 women and 80 men answered the question. Of the total number of women, 113 chose the option rather yes and 102 the option yes. The opposite opinion was voiced by 25 women who chose the option rather no and 12 women opted for the answer no. Of the total number of men, 38 marked the option yes and 29 marked the option rather yes. On the contrary, 7 men marked the option no and 6 men marked the option rather no, thereby expressing disagreement with the increase in the number of clients and services. A total of 332 respondents answered this question. Of the total number of respondents, 151 answered rather yes and 131 answered yes. Disagreement with the increase in the number of clients and services was expressed by 31 respondents who marked the option rather no and 19 respondents who marked the option no.

Question Do you agree that part of the social services for the homeless in the city of Prešov be financed from the city budget?

Table 5 Financing of social services by the city of Prešov

	Apartment building	Family house	Total
Agree	109	14	123
Try to agree	116	7	123
Try to disagree	46	5	51
Disagree	33	2	35
Together	304	28	332

Source: own processing

To test hypothesis no. 2, we divided the respondents into two groups, namely: respondents living in apartment buildings and respondents living in family houses. The table shows that the questionnaire was submitted by 304 respondents who stated that they live in an apartment building. Out of these, 116 respondents stated that they tend to agree that part of the social services for the homeless in the city of Prešov should be financed from the city budget. 109 respondents living in an apartment building marked the option I agree. On the contrary, the option, I tend to disagree, was marked by 46 respondents and 33 respondents disagreed. The question was also answered by 28 respondents living in family houses. Out of this number, 14 respondents agreed that part of the social services for the homeless in the city of Prešov should be financed from the city budget, while 7 of them tended to agree. The opposite opinion was voiced by 5 respondents who tended to disagree, while 2 respondents disagreed completely. A total of 332 respondents answered this question. Out of them, 123 agreed or rather agreed that part of social services for the homeless in the city of Prešov should be financed from the city budget. The opposite opinion was expressed by 51 respondents who rather disagreed, and 35 who completely disagreed with the financing in question.

Question Should the city of Prešov stop financing social services provided for the homeless?

Table 6 Cancellation of financing of social services by the city of Prešov

	Apartment building	Family house	Total
Yes	30	2	32
Probably yes	34	2	36
Probably no	114	10	124
No	126	14	140
Together	304	28	332

Source: own processing

In order to verify hypothesis no. 2, we divided the respondents into two groups, namely: respondents living in an apartment building and respondents living in a family house. The table shows that the questionnaire was submitted by 304 respondents who stated that they live in an apartment building. Of this number, 126 respondents disagreed and 114 rather disagreed with the statement that the city of Prešov should stop financing social services for the homeless. The opposite opinion was held by 34 respondents who rather agreed and 30 respondents who agreed with the statement that the city of Prešov should stop financing social services provided for the homeless. The question was also answered by 28 respondents who live in a family house. Of this number, 14 respondents disagreed and 10 rather disagreed with the idea of stopping the financing of the social services in question. On the contrary, 2 respondents rather agreed and 2 agreed with stopping the financing of social services for the homeless. A total of 332 respondents answered this question, of which 140 disagreed and 124 rather disagreed with the idea of stopping the financing of social services provided for the homeless. On the contrary, there were 36 respondents who rather agreed and 32 who agreed.

Results

Regarding hypothesis No. 1, we claim that there is no connection between the gender of the respondent and their opinion on the usefulness of services provided for the homeless by the Archdiocesan Charity. To gather information, we deliberately selected a church institution from all possible providers of social services for the homeless. The residents of Prešov did not discriminate against such an institution and rather recognized its benefits in solving the social pathology of homelessness. Thus, we recommend that the Archdiocesan Charity increase its communication with the residents of Prešov to obtain new sponsors and volunteers for the provision of said social services.

In order to verify hypothesis no. 1, we subjected the values in the tables to X_2 with the following result:

Table 7 Verification of hypothesis no. 1

	Table 3	Table 4
Chi square	1,815	2,438
P- value	0,986	0,965
Significance level	0,10	0,10
Level 8 with 95% probability		

Source: own processing

Based on the results of the X_2 test shown in Table No. 7, we confirm the null hypothesis. We can state that at the significance level of 0.10, there is no statistically significant connection between the respondent's gender and his opinion on the usefulness of the network of services provided for the homeless. Based on the p value p=0.965, we found out with what probability the null hypothesis was confirmed. Level 8 probability 95%.

Based on the confirmation of the null hypothesis No. 2, we claim that there is no connection between the respondent's residence and their consent to the financing of social services from the city budget, despite the differences in the opinions of these two groups on the causes of homelessness. As a result, we suggest that all city districts participate in the financing of providers of social services for the homeless in

the city of Prešov, regardless of the number of homeless people in any given district.

Verification of hypothesis No. 2

H0: There is no statistically significant relationship between the respondent's residence and his/her consent to financing social services from the city budget.

H1: There is a statistically significant relationship between the respondent's residence and his/her attitude to financing social services from the city budget.

To verify hypothesis no. 2, we subjected the values in tables 5 and 6 to X_2 with the following result:

Table 8 Verification of hypothesis no. 2

	Table 5	Table 6
Chi square	3,042	1,050
P- value	0,932	0,998
Significance level	0,10	0,10
Level 8 with 95% probability.		

Source: own processing

Based on the results of the X_2 test shown in Table No. 8, we confirm the null hypothesis. We can state that at the significance level of 0.10, there is no statistically significant relationship between the respondent's place of residence and his/her consent to financing social services from the city budget. Based on the p value p=0.998, we found out with what probability the null hypothesis was confirmed. Level 8 probability 95%.

Our second objective was to examine the attitudes of the residents of Prešov towards the network of social services for the homeless within the city of Prešov. Our conclusion is that the vast majority of Prešov residents agree with the expansion of the network of social services in all city districts. The results provided by the questions reveal that the majority of the residents of Prešov disagree with the statements that the network of social services services for the homeless provided by the city of Prešov is sufficient. Rather, the respondents considered the entire network of social services for the homeless in the city of Prešov to be insufficient.

Our last objective was to examine the attitudes of the residents of Prešov towards the financing of social services in the city of Prešov. Here, we found that the majority of the residents of Prešov agree with the financing of social services for the homeless from the city budget. At the same time, the residents of Prešov agreed with the increase in the financing of social services for the population group in question. At the same time, we found that the majority of the residents of Prešov do not agree with the cessation of financing of social services for the homeless in the city of Prešov. Rather, they do not consider the current financing of the social services in question to be sufficient.

Based on the present findings, here are our practical recommendations to the city of Prešov:

- improve public information about homelessness in the city of Prešov;
- inform the public about available social services for the homeless in the city of Prešov and the results of individual providers' activities with respect to the relevant services;
- regularly inform the public about current social service projects for the homeless, including their evaluation;
- create an up-to-date map of social services for the homeless in the city of Košice;
- increase the number of beds in individual service facilities for the homeless;
- ensure social services for the homeless in all city districts;
- inform the public about specific financing of social services for the homeless in the city of Prešov;
- the city of Prešov should review the financing of social services for the homeless in the city of Prešov and consider increasing it.

Conclusion

The social safety net is often the last resort against absolute poverty, ensuring the receipt of funds in times of threat or financial incapacity due to various life situations (Janáčková, 2024). The financial loss which threatens the standard of living, is associated with various life situations, be they deliberate – e.g., retirement, birth

of a child – or unplanned. These can cause a sudden loss of income or an increase in expenses.

Social services provided by public or private providers have proven to be effective in combating homelessness. This is confirmed by both directors and social workers who provide assistance to the homeless in Košice. Our facilities are fully staffed - year-round. Social services for the homeless are often the last resort before living on the street. Providing accommodation, personal hygiene facilities, or hot meals are invaluable in trying to deal with this social predicament.

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Continuity in Primary and Community Care in Midwifery

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Abstract:

Aim: To identify factors that influence the implementation of the midwife-led model of continuous care and to find out the interest of Czech and Slovak midwives and women in such care.
Design: Quantitative research
Methodology: Research conducted using a standardized questionnaire method from September 2022 to January 2023. The selection of respondents was deliberate, 320 Czech and 131 Slovak midwives and 521 Czech and 162 Slovak women. The data were evaluated in Excel statistics.
Results: Midwives in both countries consider the lack of support from the state and health insurance companies, inadequate legislation and the negative attitude of gynaecologists to be significant obstacles. In both the Czech and Slovak Republics, women have a comparable interest in community care, while Czech midwives with up to 20 years of experience showed more interest.
Conclusion: The vision for changing the status quo is to de-

velop a model of continuity in midwifery, strengthen the political environment, and support the integration of community midwives into the health care system that women are interested in.

Introduction

Continuity of care is a concept that is based on primary care. It involves care over time by the same provider for a specific person rather than for an entire population (Bradford et al, 2022). It is considered to be one of the main attributes of quality of care within health care services. The continuity model in the community includes the delivery of counselling, antenatal, postpartum care to women and families, individual education and the participation of a midwife at the birth that the woman has chosen (Michel-Schuldt et al, 2020). This form of complex care of the woman and child faces many challenges in providing services. It requires a degree of flexibility, travel needs, legislative adjustments in training, professional competencies and integration of maternity services into the health care system. Despite evidence and positive policy developments that enable continuity of care in midwifery, organisational changes are slow or absent in many countries (Renfrew et al, 2014). In the Czech Republic (the CR) and the Slovak Republic (the SR), continuous primary and community care provided by midwives is delivered on a limited scale. There has been a significant reduction in the number of visits to pregnant women and mothers after childbirth by midwives, although the length of hospital stay has been reduced from 7.3 days to 3.6 days in the Czech Republic and 4.0 days in the Slovak Republic, and the number of hospital beds has decreased from 10.9 to 4.4 thousand in the Czech Republic and from 5.4 to 2.4 thousand in the Slovak Republic. (Health Yearbooks of the Czech Republic and Slovakia for the period 1991-2020) There are several reasons that explain this problem. These include a lack of understanding of how midwifery models work, how they can be implemented in different situations, the low status of midwives in relation to doctors and their dominance. Midwifery is often not considered an autonomous profession (Sandall, et al, 2001; P. ten Hoope-Bender et al, 2016). In both countries, the position of midwives in the community care system is not defined in an exact way. The services provided by midwives are covered to a small extent by health insurance. In the Czech Republic there are 194 registered independent workplaces where midwives independently provide continuous care, but the procedures must be indicated by a gynaecologist. In Slovakia, licensed midwives, of which there are ten, can provide specific health care during pregnancy and after childbirth, without a doctor's indication, for those pregnant women who are insured with the health insurance company UNION. Women who are pregnant for the first time have little idea of what midwives can do in independent practice. Their main source of information comes from their own experience of midwifery during childbirth. To improve the coordination of primary and secondary care, which is largely ignored, and the services of midwives in the community, which are not very visible, often remain silenced, there is a need to increase multidisciplinary training, revise the system of financial reimbursement for maternity services provided, and improve the promotion of the role and services led by midwives (Zadoroznyj et al, 2000; Schölmerich et al, 2014). Despite the barriers and obstacles, the midwife-led model of continuous care is associated with lower rates of interventions during labour, analgesia, episiotomy, amniotomy. Women report higher levels of satisfaction with care, feeling safer, less stressed, more respected (Walsh 2021; Sandall 2013; Forster et al 2016). The continuity of care helps to develop a trusting relationship with the mother and family, improves communication, and increases efficiency and accountability for services provided. This enables the midwife to identify problems, behavioural changes and needs of the mother and baby early during community or home visits (Bowers et al, 2015).

Aim: The aim of the study was to identify factors that influence the implementation of

midwife-led community-based continuous care and the interest of midwives and women in this form of care in the Czech and Slovak Republics.

Methodology: we conducted the study from September 2022 to January 2023.We used a questionnaire method to collect empirical data in two language versions: in Czech and Slovak for midwives and women. The items in the questionnaire assessed sociodemographic indicators: place of practice, age, education, experience, and parity for women. We used the Likert scale to assess the respondents' opinions and barriers to continuous community care. We analyzed legislation, financial evaluation, time flexibility, counseling, accompanying mothers during childbirth, and gynecologists' attitudes towards midwifery services. For women, we analyzed awareness and satisfaction with midwifery services. We purposively sampled the respondents in the research population, where the criterion for midwives was the implementation of midwifery practice and willingness to complete the questionnaire, and for women the criterion was willingness to complete the questionnaire and age more than 18 years. 320 (8% of the total number of 3700 midwives) Czech and 131 (7% of the total number of 1800 mid-

Table 1 Provision of primary and community care (PCC) in midwifery in the Czech Republic

Provision of PCC	abs.p.	rel.p.	length of practice			
			up to 5yrs.	6-20 yrs.	21-35	36 and more
PCC is provided as a private practice	98	30,6%	19	38	26	15
PCC is provided as an occupation	102	31,9%	23	32	35	12
I don't provide PCC, but I'm interested	75	23,4%	43	15	12	5
I don't provide PCC and I'm not interested	45	14,1%	8	19	15	3
Czech midwives in total	320		93	104	88	35
		100%	29,1%	32,5%	27,5%	10,9%

Table 2 Provision of primary and community care (PCC) in midwifery in the Slovak Republic

Provision of PCC	abs.p.	rel.p.	length of practice			
			up to 5yrs.	6-20 yrs.	21-35	36 and more
PCC is provided as a private practice	10	7,6%	0	2	6	2
PCC is provided as an occupation	68	51,9%	21	24	15	8
I don't provide PCC, but I'm interested	36	27,5%	21	12	2	1
I don't provide PCC and I'm not interested	17	13,0%	9	2	4	2
Slovak midwives in total	131		51	40	27	13
		100%	39,0%	30,5%	20,6%	9,9%

wives) Slovak midwives participated in the research survey. The second sample consisted of 521 women from the Czech Republic and 162 women from Slovakia. The questionnaires were distributed through professional organizations in Slovakia Slovak Chamber of Nurses and Midwives, in the Czech Republic Czech Chamber of Midwives, and for women through women's organizations.

Data analysis

Data collection was conducted electronically via the internet platform "Survio", which fully ensures anonymity and protection of respondents' personal data in accordance with the Declaration of Helsinki. The collected data were evaluated by descriptive and inferential statistics using Microsoft Excel 2010. For descriptive statistics, we calculated absolute frequencies (f) and relative frequencies (%), arithmetic mean (AM) values, standard deviations (SD), median (Mdn), minimum (min) and maximum (max) values. Statistical tests were performed at the significance level $\alpha = 0.05$ ($^*p < 0.05$) using the Chisquare test ($\chi 2$). To test the population mean, we used the Z test statistic.

Results

In the group of midwives, the greatest number of midwives with a bachelor's degree in midwifery were represented, 210 (65.6%) in the Czech Republic, 88 (67.2%) in Slovakia, 104 (32.5%) with 6 to 20 years of work experience in the Czech Republic and 51 (39.0%) with 5 years of work experience in Slovakia. In the female population, second births were the most represented, with 241 (46.3%) in the Czech female population and 67 (41.3%) in the Slovak female population. The age structure was most represented between 31 and 40 years, with 284 (54.5%) in the Czech female population and 88 (54.3%) in the Slovak female population. In Table 1 and Table 2, we present the provision of primary and community care in midwifery in both countries in relation to the length of experience.

In the Czech Republic, 98 (31%) midwives have an independent private practice and in the Slovak Republic only 10 (8%) respondents have an independent private practice. Midwives most often provide the above care if they are employed. Czech midwives mainly provide individual counselling 94(48%), courses for

Table 3 Czech and Slovak midwives - Interest in providing primary and community care

Primary and community care	ČR n=320		SR n=131	
	abs.p.	rel.p.	abs.p.	rel.p.
a) is provided as an independent full-time private practice	29	9,1%	1	0,7%
b) is provided as a part-time private practice while working in a hospital, clinic or school	69	21,5%	9	6,9%
a+b) is provided as an independent private practice	98	30,6%	10	7,6%
c) is provided as a full-time employee	71	22,2%	63	48,1%
d) is provided as a part-time employee	31	9,7%	5	3,8%
c+d) is provided as an employee	102	31,9%	68	51,9%
e) is NOT provided but I consider providing it if the legislative and financial conditions are modified	75	23,4%	36	27,5%
f) is not provided and I don´t consider providing it	45	14,1%	17	13,0%
a-f) in total	320	100%	131	100%

pregnant women 80 (41%), continuous care 71(36%), antenatal care 62 (31%) and visiting service 57 (29%). Slovak midwives reported similar items when providing care: providing individual counselling 51 (39%), continuous care 49 (37%), courses for pregnant women 27(21%) and care during delivery in the maternity ward 24 (18%). However, Czech midwives are more interested in primary and community care compared to Slovak midwives, as shown by the result of the test statistic $Z = 2.78$. Statistically significant difference $p = 0.00535$, $p < 0.05$ was confirmed. 95% CI confidence interval ranges <0.0135; 0.0777> . Both groups of respondent midwives are mainly not interested in physiological home birth in CR 100 (76%) compared to SR 125 (63%), in physiological home birth in maternity house in CR 80 (61%) compared to SR 70 (35%), and in exercise for pregnant or postpartum women in CR 49 (37%) compared to SR 86 (44%). Midwives are not interested in these activities regardless of years of clinical practice. Similarly, women reported the least interest in midwife-led home births. This was 106 (20.4%) in CR and 37 (22.8%) female respondents in SR. Younger Czech midwives with up to 20 years of experience are more interested in providing primary and community care than older Czech midwives with 21 years of experience. The result of the test statistic $Z = 4.7945$. Confi-

Table 4 Barriers - midwives in the Czech Republic

Barrier	Female respondents' answer		Rating scale				
	abs.p.	rel.p.	None	Rather small	medium	Rather large	large
inadequate legislation	237		3	11	74	138	94
		74,1%	0,9%	3,5%	23,1%	43,1%	29,4%
insufficient support from the state, health insurance companies	253		3	11	49	140	117
		79,1%	0,9%	3,5%	15,3%	43,7%	36,6%
negative attitude of gynaecologists	209		6	32	91	118	73
		65,3%	1,9%	10,0%	28,4%	36,9%	22,8%
insufficient education	99		26	82	116	72	24
		30,9%	8,1%	25,6%	36,3%	22,5%	7,5%
external barriers	798		38	136	330	468	308
		62,3%	3,0%	10,6%	25,8%	36,5%	24,1%
lack of interest of midwifes	62		11	86	137	70	16
		19,4%	3,5%	26,8%	42,8%	21,9%	5,0%
financial uncertainty	143		7	49	107	112	45
		44,7%	2,2%	15,3%	33,4%	35,0%	14,1%
greater responsibility	101		7	56	130	82	45
		31,6%	2,2%	17,5%	40,6%	25,6%	14,1%
inconsistency of midwives	123		7	73	108	99	33
		38,4%	2,2%	22,8%	33,8%	30,9%	10,3%
internal barriers	429		32	64	482	363	139
		33,5%	2,5%	20,6%	37,6%	28,4%	10,9%

dence interval 95% CI ranges <0.0509; 0.1213>. The same result was shown for respondents in the Slovak Republic, where younger midwives are more interested in providing the above care, test statistic result Z = 5.724, 95% confidence interval CI ranging <0.1154; 0.2355>. Based on the results, we found that women mostly would be interested in community midwifery services, 270 (51.8%) in CR and 94 (58%) in SR. Only 58 (11.1%) women in the Czech Republic and 21 (13.0%) women in the Slovak Republic would not be interested in the services of midwives. Most women in the Czech Republic would be interested in counselling for physiological pregnancy by a midwife 351 (67.4%), and in exercise for pregnant and postpartum women 279 (53.5%). In Slovakia, women expressed interest in postnatal visit service 110(67.9%), in birth guidance by a midwife in a healthcare facility 85 (52.5%). The results of the study show that women in CR are more interested in the activity, however, midwives in CR show the lowest level of interest in the activity, which is exercise for pregnant or postpartum women. Respondents rated which barriers and obstacles affect the delivery of primary and community care provided by midwives. Overall, Czech midwives reported external barriers 798 (62%) more often than internal barriers 429 (33.5%), compared to Slovak midwives who rated external barriers also as more significant 302 (58%) than internal barriers 222 (42%). Those midwives from the Czech Republic who provide primary and community care as private practice rated external barriers (legislation, state support, health insurance companies, negative attitude of gynaecologists, lack of education) 254(64.5%) as stronger compared to internal barriers 117(29.8%). Table 4 provides an overview.

Discussion

Studies point in particular to the lack of standardisation of primary and community midwifery, a precisely defined scope of practice, and criteria for practical training in community midwifery qualification and specialisation (Renfrew et al, 2014; de Jonge et al, 2015). As a result of the change in the specific role of community midwives, there is an inaccuracy within the definition of continuous community care, not reflecting the changes in the scope of practice that current community midwifery requires. Sherratt (2013) cites the problem that education is mostly based on theory and lacks real and relevant practical experience. Full mastery of the competencies needed to assist a woman during pregnancy, birth and the six months of labour can only be gained through a reasonable amount of experience in the clinical area under the supervision of experienced community midwives and doctors. The difficulty in educating midwives for community care is to provide practice in a community environment that meets the needs of pregnant women. Pregnant women are not always satisfied with the professional support they receive from midwives during the care they are offered because the support does not match their actual needs. Therefore, the services provided by midwives should be based on the interest of women and not only on the interest of midwives. Because a positive birth experience can have the effect of boosting a woman's confidence, improving the bond between her baby, the preference for the way of the next birth. In contrast, women who experience inadequate support before becoming pregnant are at greater risk of negative birth experiences, are more likely to experience fear of childbirth in subsequent pregnancies, which may lead to requests for caesarean sections in future births (Bäckström et al, 2022; Hendrych-Lorenz, 2019). The International Confederation of Midwives and the WHO (2017, 2006) have highlighted the difficulties in providing primary and community care in midwifery in many countries around the world, particularly in terms of legislation, creating an environment for practice, education, monitoring and evaluation of midwives' work. However, the strategies recommended by international organisations have been met with resistance from many national governments due to the increase in care provided by gynaecologists (Vermeulen et al, 2019). Barriers at the macro level, inequitable models of financing between doctors and midwives result in interpersonal conflicts at the micro level. Therefore, most of the barriers to the development of primary and community care come from less favourable rela-

tionships between midwives and gynaecologists. In some situations, midwives may actually pose a certain threat to the obstetrician-gynaecologist, which in many countries is mainly based on the model of payment for procedures, the scope of midwives' competence, and the possible competition for participation in childbirth. Models of financing contribute to the exclusion of midwives from primary community care, discourage collaboration and encourage competition (Munro et al, 2013; Darling et al, 2023). Schölmerich (2014) highlights the need for improving coordination and interprofessional communication in the continuum of information shared not only between midwife and obstetrician, but also between primary and secondary care. The key barriers to interprofessional collaboration are reported to be strong hierarchical structures, fragmentation of care, lack of respect, trust and lack of clarity about responsibilities and authority. Midwives perceive their work environment as stressful with a high risk of conflict. Professional dissonance, caused by inconsistencies in communication, coordination mechanisms and professional ethics, is considered a central cause of tension (Smith, 2015; Aquino et al, 2016; McFarland et al, 2020; Hansson et al. 2022). The heterogeneous professional basic understanding of childbirth, its redefinition into a disease that requires specialist care that can only be provided in hospitals, has caused a loss of autonomy for midwives. Evidence shows that health systems that lack midwives have higher rates of unnecessary interventions, higher economic costs and inequalities in care provision. These aspects can reinforce feelings of demarcation between professional groups of midwives and doctors and inhibit a common vision of care (Reiger, 2008; Reiger et al, 2009; de Jonge et al, 2015; Behruzi et al, 2017; McFarland et al, 2020). In order to implement midwifery care that is focused on women and their families, it would be constructive to adopt a statement of the value of this care, supported by groups of providers, health policy makers and health insurers (Fontein-Kuipers et al, 2018). Both women and midwives today face the challenges of a prevailing care delivery system characterized by a lack of 'person' time, limited space for decision-making, hierarchical and medicalized care, and weaknesses in practical community-based midwifery education that override the core competencies of midwives (Lohmann et al, 2018). A limit to the paper is the lower number of responses from midwives and women respondents in both countries, which was due to reluctance to answer the questions. The online questionnaire website was viewed by 976 midwives in CR, 320 (32.8%) completed valid questionnaires, in CR 131(51.6%) of 254 midwives completed the questionnaire. In the second set from CR, 1292 women viewed the questionnaire and 521 (40.3%) completed the questionnaire, in CR 162 (32.0%) of 507 women completed the questionnaire.

Conclusion

Based on the results obtained, we conclude that there is a need to modify the primary community care system based on the actual needs of women and to provide conditions for functional, comprehensive and accessible midwifery services. Educations, regulation through legislation, licensing and effective management of the midwifery workforce are important dimensions of health policy that require attention. The vision is that primary care in a community midwifery setting, close to the woman and her family, can be provided by a community midwife, providing a seamless transition to other continuing care with a multidisciplinary approach when needed.

Conflict of interest

The authors declare no conflict of interest.

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Self-evaluation and Self-esteem in Children with Type 1 Diabetes Mellitus

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Original Article

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Abstract:

Background: Diabetes mellitus (DM) is the most common endocrine disease in childhood. The treatment of the disease is complex and includes lifestyle modification, self-monitoring, insulin administration, and regular physical activity. After starting school, children gradually become aware of their differences from their peers, which together with other factors can affect their self-evaluation. Hence, in the present study we focused on the influence of self-evaluation on the degree of

compensation in children with type 1 DM.
Methods: The sample consisted of 64 parents of 6-12-year-old children regularly treated in the Diabetology Outpatient Clinic of the Children's Diabetes Centre. To obtain the data, a self-assessment questionnaire was used; to verify hypotheses, the statistical methods were used: the chi-square test (verifying the relationship between nominal data and verifying the differences between the compared groups); the Student's t-test (comparison of mean values); and the F-test (comparison of variances).
Results: The relationship between children's difficulties at school and occurrence of acute complications was found out in the sample in the present study. The relationship between difficulties at school and frequency of hospitalisations of children with type 1 DM was confirmed.
Conclusions: The present study suggests there is a relationship between difficulties of children with DM in school environment and occurrence of acute complications or hospitalisations of children with DM. Thus, nursing interventions should be aimed at improving self-esteem to achieve the desired compensation of DM.

Introduction

Diabetes mellitus (DM) is defined as a group of metabolic diseases characterised by hyperglycaemia caused by absolute or relative deficit of insulin. The disease can be manifested in any age. The highest incidence in our population is recorded between 9-14 years of age. There has been an increase in the incidence in children from birth to five years of age (1). Diagnosis of the disease brings significant changes to children's lives. The changes influence the children's daily routine significantly, and children are also affected by more frequent separation during hospitalisations, isolation from their peers, and changes in relationships with peers. School-age children with type 1 DM gradually start to compare themselves with their peers and realise they are different, which may influence their self-evaluation (2).

Self-evaluation, as a concept, was defined for the first time by an American psychologist William James in his book "Principles of Psychology", which is considered the first American textbook of psychology by professionals. James characterises self-evaluation as a certain self-image that allows us to appreciate or not appreciate who we are, what we do and what we achieve (3).

Zelina (4) states that self-evaluation is a result of comparing oneself and pronouncing a "judgement" about self, how a person perceives oneself as good or bad, wise or unwise, etc.

Self-evaluation develops and changes continually throughout a person's life. In general, it is high in childhood and decreases significantly with the beginning of adolescence. It is affected by multiple factors including family support, parents' education, economic factors, peer relationships, age, growth, and development (5). However, children's self-evaluation also relates to the fact how their opinions are accepted and how their roles at home or school are perceived (6).

In the present study we focused on identification of effects of self-evaluation on compensation of DM in children.

Sample and Methods

A questionnaire method was used to obtain relevant data about the studied phenomena. We filled in the questionnaire in cooperation with children's parents. The sample included 64 parents of 6-12-year-old children with type 1 DM. The exclusion criteria were insulin pump treatment in the child and an intercurrent disease. The respondents' willingness to participate and

anonymity were respected when filling in the questionnaires. The response rate was 100 %. Statistical methods of quantitative research were used, and the data were statistically processed. To verify the hypotheses, we used various types of statistical tests. The chi-square test was used to verify the differences between the compared groups. To compare cardinal data, we used the F-test, and to compare variances, and the Student's t-test was used to compare mean values. We found out the relationship between the cardinal variables by calculating the correlation coefficient and testing for the nullity of the correlation coefficient.

Results

To find out effects of self-evaluation on compensation of diabetes, we asked the respondents about self-evaluation of their children, and the parents' relationships to their diabetic children.

We analysed the relationship between the parents and their children, and the extent of cooperation between them. The parents were asked

Table 1 Cooperation with children

Cooperation with children		
	N	%
Very good	31	48 %
Rather good	27	42 %
Rather bad	6	9 %
Bad	0	0 %
Total	64	100 %

Table 2 Attitudes towards complying with the treatment regimen

Attitudes towards complying with the treatment regimen					
	Yes		No		Total
	Number	%	Number	%	
Cautions	57	89 %	7	11 %	64
Excessive protection	19	30 %	45	70 %	
Reasoning the decisions	58	91 %	6	9 %	
High requirements	25	39 %	39	61 %	

Table 3 Supporting children's self-evaluation

Supporting children's self-esteem		
	M	SD
Adequate work	3.58	0.79
Being critical towards the child	3.36	0.91
Blaming for failures	3.33	0.77
Criticism of work, not the child	3.30	0.78
Respect	2.59	1.30
Esteem	2.44	1.33
Attention to success	0.98	1.12

to choose one option rating their cooperation with their children.

Almost half of the parents, 31 (48 %), stated that their cooperation with their children was very good. Another group, almost the same size, of the respondents, 27 (42 %), rated their cooperation with their children as rather good. Six (9 %) parents considered their cooperation with their children to be rather bad than good. None of the parents rated cooperation as bad.

Regarding cooperation between the parents and their diabetic children, very good or good atmosphere prevailed between them in their families (Table 1).

We asked the parents which attitudes they used in the attempt to comply with the treatment regimen. They were asked to choose if they preferred each attitude or not.

We found out that the parents, in their attempt to comply with the treatment regimen in their diabetic children, preferred reasoning their decisions, as stated by 58 (91 %) respondents. Almost the same number of the respondents, 57 (89 %), used cautions too. Approximately one third of the parents admitted they also used not very suitable methods in their attitudes towards their diabetic children. Too high requirements for their children were reported by 25 (39 %) respondents; and 19 (30 %) parents protected their children excessively (Table 2).

Children's self-evaluation is significantly affected by their health. They may feel different from other children or even excluded from others because of their disease. Therefore, we were interested in how the parents supported their children's self-evaluation.

The parents from the sample stated most frequently that they gave their children adequate work (M = 3.58). However, we perceive certain shortcomings in the parents in supporting self-evaluation in children with type 1 DM. They largely stated they were critical towards their children and blamed them for their failures. On the other hand, they often did not realise that

Table 4 Children's difficulties

Children's difficulties		
	M	SD
Anger outbursts	2.55	1.37
Self-deprecating	2.17	1.24
Difficulty talking about the disease	1.56	1.31
Sensitive reactions to criticism	1.47	1.38
Child's isolation	1.44	1.41
Child's sadness	1.22	1.32
Does not give an opinion	1.06	1.34

Table 5 Difficulties at school

Difficulties at school		
	Mean	Deviation
Excessive fatigue	1.63	1.34
Difficulties concentrating	1.20	1.24
Rejecting afterschool groups	0.97	1.32
Rejecting common activities	0.81	1.41
Difficulties learning	0.64	1.37
Criticism from teachers	0.45	1.38
Non-acceptance by classmates	0.31	1.31

positive evaluation was important for children. They paid very little attention to children's success (M = 0.98). Showing respect (M = 2.59) and esteem (M = 2.44) towards the child was not a matter of course either. We also studied whether parents' support for their child's self-esteem changed with age (Table 3). We compared the answers about children's age with the answers about support for children's self-esteem. We found out that age of the child with type 1 DM and support of self-evaluation by parents had strong correlation between the studied characteristics. The correlation coefficient was negative (r = - 0.33); thus, it is indirect correlation. It means that the parents supported their children's self-evaluation less as the children got older.

In addition to usual activities that are expected from healthy children, children with type 1 DM must also cope with activities related to compliance with the diabetic regimen. It can cause negative pressure that is manifested by various difficulties. Therefore, we asked the parents which difficulties were manifested in their children and to what extent.

The parents rated anger outbursts as the most frequent difficulty in the children with type 1 DM. The average rating of the degree of this difficulty was 2.55, which can be interpreted as moderate to high level of difficulty. Self-deprecating (M = 2.17) was also a very frequent phenomenon in the children. The children had difficulty talking about their disease to a moderate degree (M = 1.56). Similarly, the difficulties were manifested in sensitive reactions to criticism (M = 1.47), or child's isolation (M = 1.44). According to the parents, sadness and not giving an opinion (M = 1.22 – 1.06) caused the slightest difficulties from the offered options (Table 4). Higher standard deviations were in all the studied items. It suggests that children's difficulties varied. Furthermore, we examined if there was a relationship between age and manifestations of difficulties in children. We compared the answers about children's age and the answers about manifestations of difficulties in children. We verified the validity of relationships by the test for the nullity of the correlation coefficient.

The relationship between age and occurrence of difficulties in children was found out by the statistical tests. Thus, in general, we can state that difficulties occur more often in older children than in the younger ones.

Besides the difficulties that are manifested primarily by behaviour towards close persons in family, or friends, children can experience difficulties at school too. Therefore, in the questionnaire we asked about difficulties that children experienced most frequently at school or among peers.

The parents stated that most of the difficulties at school occurred in their children only to a small extent. According to our findings, excessive tiredness (M = 1.63) caused the largest difficulties to children. Difficulties concentrating (M = 1.20) followed. Rejecting common activities and rejecting afterschool groups by children (M = 0.81 – 0.97) occurred less frequently. Difficulties learning, criticism from teachers, and non-acceptance by classmates (M = 0.64; 0.45; 031) occurred in the smallest extent.

As in the assessment of children's difficulties, higher values of standard deviations are observed also here. Thus, it means that difficulties

Table 6 Relationship between occurrence of school difficulties and hospitalisations of children

Occurrence of school difficulties		
Hospitalised for inadequate compensation		Without hospitalisations for the stated reasons
Mean	7.77	3.04
Variance	18.69	13.04
Number	13	51
T stat	4.05	
T crit	2.00	T stat > T crit
p-value	0.000145	p-value is very low

of the diabetic children at school also occurred in various extents.

We tried to find out if the occurrence of difficulties in school environment related to more frequent hospitalisations due to inadequate compensation of diabetes in individual children. We used the respondents' answers to the questions where the parents stated to what extent their diabetic children experienced difficulties at school and the answers about the reasons for hospitalisations. In the sample, 38 children were hospitalised in the previous year. The parents stated the most frequent reasons for hospitalisation: diagnosis of the disease (17 %); inadequate compensation (16 %); and ketoacidosis (11 %).

We processed the answers to those questions as entering data for the Student's t-test.

The differences in the compared groups are very large and cannot be attributed to random effects. The test results confirm that difficulties at school occurred in the group of the children hospitalised for decompensation much more frequently than in the second group. We found out there was a relationship between the number of hospitalisations due to decompensation in the children and their difficulties at school. Thus, we also focused on detecting a relationship between children's difficulties at school and occurrence of acute complications in the previous two years. We compared the answers from the question about the extent to which the diabetic children experienced difficulties in the school environment and the answers about types of acute complications experienced by the children in the previous two years.

We found out moderate correlation (r = 0,475) between children's difficulties at school and occurrence of complications. The relationship between children's difficulties at school and occurrence of acute complications in the sample was confirmed.

Discussion

Vlachioti et. al. (6) pointed out that parents' education has also influence on self-evaluation in children with type 1 DM. Several studies implied that family plays an important role in compliance with treatment in diabetic children in all stages of development. The family that provides support in coping with a disease relates to a higher level of self-esteem in the child. Furthermore, it was proved that children have higher self-evaluation in the period after being diagnosed because in that time they are supported by the education process and get necessary family and social support. Also, the present study implies there is a relationship between children's age and support for self-esteem provided by parents. We found out that the parents paid less attention to supporting self-evaluation in older children than in the younger ones.

We also studied a relationship between age and parents' attitudes towards complying with the treatment regimen. No relationship was found out in this case.

Several authors studied the impact of the chronic disease on self-evaluation in children. The objective of the study by Vlachioti et. al. (6) was to evaluate negative effects of diabetes on self-evaluation in children and young people. The group of 144 patients with DM was compared with the group of 136 healthy children. The study authors found out that self-esteem in diabetic children was primarily affected by age, level of physical activity, and family support. However, the analysis of the data obtained by them showed that self-evaluation in the children with DM did not differ from self-evaluation in the healthy children. Similarly, Boeger, Seifge and Roth (7) found out that self-evaluation in the young people with type 1 DM and the young adolescents did not differ significantly.

Hoare and Mann (8) studied self-esteem and behavioural disorders in children with chronic diseases. The sample included 8-15-year-old children. The first group consisted of 64 children with epilepsy; the second group consisted of 91 children with type 1 DM. Their study implied that the children with epilepsy had lower self-evaluation and more behavioural disorders than the diabetic children.

In the present study, we asked the parents what difficulties their children experienced at school or among peers. We focused on the existence of a relationship between difficulties at school and children's hospitalisations because of complications. We compared the group of children who were hospitalised because of inadequate compensation with the group of chil-

dren who were hospitalised for other reasons (for example: hospitalisation for diagnosis of DM) or children who were not hospitalised at all. We found out the group of patients hospitalised for decompensation experienced difficulties at school much more often than the children in the second group. Furthermore, the relationship between children's difficulties at school and occurrence of acute complications was confirmed.

Children in younger school age have sufficiently developed cognitive skills to be able to understand their diseases. Furthermore, they start to realise their difference from their peers. In this period, children often compete and try to achieve success both in and out of school. If children fail, it can affect their self-evaluation. Children's failures can be caused by multiple factors such as tiredness, frequent absence from school because of hospitalisations, or insufficient concentration (2).

Based on their study, Pek et al. concluded that children with type 1 DM had higher self-evaluation in the period after being diagnosed because in that period children were supported by the education process and got necessary family and social support (8).

Therefore, it seems important to continuously educate children so that they can understand "what is happening to them". Individual education is an ideal choice because it allows nurses to focus on specific needs of children and their families (9). Information can also be supplemented by various brochures or books (2). Telenursing could also be an effective tool for supporting and educating children with DM. Providing nursing care, telenurses use systems that allow monitoring data about patients and their physiological parameters (for example: glucose levels). Also, they can use telephone or video consultations to solve nursing problems that arise during the management of diabetes (for example: how to administer insulin correctly, and many others) (10). Furthermore, it is suitable to include children in all activities. Family and peer support groups also have irreplaceable roles (2).

Conclusions

The occurrence of acute complications and frequency of complications in children with type 1 DM is related to children's difficulties at school. Therefore, it is necessary to focus on supporting children and their parents through education sufficiently so that their occurrence is reduced to minimum. Education should be directed in support of modern trends in treatment of children with type 1 DM, the possibility of using telemonitoring, and consultations with physicians and nurses (11) to achieve maximum compensation of DM.

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The Influence of the Dark Triad Traits on the Motivation to Succeed Among Students Under Martial Law in Ukraine

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Abstract:

In recent decades, researchers around the world have been actively studying the impact of personality traits on management, career, leadership, and interpersonal relationships. Of particular interest is the role of the so-called "dark" traits, which are traditionally associated with manipulation and unethical behavior, but can also contribute to the achievement of ambitious goals. And in today's world, where competition for resources, career opportunities, and social influence is constantly intensifying, the motivation to succeed often involves the use of strategies typical of people with high Dark Triad

scores. In this regard, our study investigates the influence of the Dark Triad trait construct on the motivation to succeed among students of higher education institutions under martial law in Ukraine.

Methods: To test the hypotheses, we used Pearson correlations and the hierarchical regression method with statistical significance testing. This is a universal statistical test that is widely used to identify predictors.

Results: After analyzing the results, we found a systematic, positive, and statistically significant effect of one of the Dark Triad traits (narcissism) on success motivation. However, we did not find a statistically significant effect of the other two Dark Triad traits on success motivation.

Conclusion: The hypothesis about the significant influence of the Dark Triad traits on success motivation was partially confirmed in the case of subclinical narcissism. This allows us to conclude that self-esteem, the need for recognition, demonstrativeness, and belief in personal uniqueness, inherent in the narcissistic type, play a leading role in shaping success orientation. The results obtained are of both theoretical value for further study of motivational mechanisms and practical importance, in particular, in the areas of management, pedagogical counseling, professional selection, and psychoprophylaxis.

Introduction

Modern society views success as one of the key values that determines professional fulfillment, social status and personal well-being. It is conventionally posited that success results from a combination of perseverance, innate ability, sustained effort, and a high level of emotional intelligence.. Without diminishing the importance of these really important traits, in this study we would like to draw attention to the impact on success motivation of certain personality traits that have been attracting more and more attention from experts around the world in recent decades. We will talk about the personality construct of the Dark Triad, which combines three such "dark" traits as subclinical psychopathy, subclinical narcissism, and Machiavellianism (14) and the impact of this construct on the motivation to succeed.

Narcissism is defined as a combination of a grandiose but at the same time vulnerable self-image, excessive focus on achieving success, a need for admiration from others, a desire for self-actualization, and difficulties in building and maintaining interpersonal relationships due to a lack of trust and empathy (1).

Psychopathy, in turn, is characterized by impulsivity, reduced empathy and anxiety, lack of guilt, emotional coldness, conviction of one's own superiority, and a parasitic lifestyle, often accompanied by deviant or criminal behavior.

Machiavellianism is characterized by a proclivity to manipulate and exploit others as a means of attaining personal objectives. People with a high level of this trait usually hold three key attitudes: a belief in the effectiveness of manipulative strategies in social interactions, a cynical outlook on human nature, and a belief that expediency is of higher value than moral norms (22).

Combined together, these traits form a special type of psyche that primarily manifests itself as self-interest, aggression, and ruthlessness.

Most previous studies have focused on the negative effects of the Dark Triad (7; 25). However, there are cases where a high level of Dark Triad traits in combination with other factors (intelligence, physical attractiveness) can help

a person gain leadership positions. For example, a study (26) shows that individuals with high Dark Triad scores are quite successful in managing their self-image, which ultimately allows them to build a successful career. In some situations, people with high Dark Triad traits can demonstrate strategic advantages, especially in highly competitive environments or where circumstances require quick decision-making (16).

Given that success encompasses more than just career advancement and represents a broader, multifaceted construct, it is pertinent to reference research examining the perceived attractiveness of men exhibiting Dark Triad traits from the perspective of female evaluators. (5). The study revealed that male individuals exhibiting elevated levels of Dark Triad traits were evaluated as significantly more attractive by the participants. Even when the study participants consciously recognized that they were looking at people with high levels of the Dark Triad traits, they still rated them as more attractive. In addition, some studies have examined the relationship of individual components of the Dark Triad to career growth and success (i.e., salary, status, and job satisfaction (26).

However, to our knowledge, no studies have analyzed whether and to what extent the Dark Triad traits influence success when conceptualized as a broad and generalized concept. Consequently, success as a socio-psychological phenomenon may reflect not only the negative but also the potentially adaptive aspects of the Dark Triad.

Against the background of the above, the present study aimed to extend research on personality and success by, first, investigating whether narcissism, psychopathy, and Machiavellianism exert differential (i.e., both negative and positive) effects on an individual's motivation for success. Second, we assessed which components of the Dark Triad exert a more substantial and reliable influence on success motivation. This approach allowed us to determine the relative predictive validity of each Dark Triad trait in this context.

It is important to note that the majority of the studies referenced are predominantly based on Western samples. Given the cultural differences between Western contexts and Ukraine, it remains unclear whether the findings from these studies can be directly applied to Ukrainian populations. Therefore, one of the additional questions posed in the current study was whether statistically significant conclusions could be drawn using Ukrainian research samples, taking into account the unique cultural characteristics of the region. Another important issue of this study is to determine the levels of expression of the components of the Dark Triad of Personality (SD3) among students under martial law in Ukraine in comparison with the corresponding indicators in samples of students from Germany and the United States, which allows us to identify culturally and situationally determined features of social and psychological adaptation.

Given that such studies are hardly ever conducted in Ukraine, this issue is of great interest to us, as we are also considering the possibility of further studying and testing it in the Ukrainian context.

Success as a socio-psychological phenomenon

Success is a multifaceted socio-psychological construct that reflects both personal aspirations and social expectations. In psychology, it is seen not only as the achievement of an externally recognized goal, but also as a subjective experience of self-realization, satisfaction, and social recognition (6). From the point of view of social psychology, notions of success are shaped by cultural norms, social stereotypes, and reference groups that define standards of "successful" behavior. Individual perceptions of success are closely related to self-esteem, achievement motivation (19), ambition level, and social context, including expectations of family, professional environment, and the broader cultural milieu. Success also has a normative function, setting benchmarks for social comparison and identification in the social hierarchy. Thus, success is a dynamic socio-psychological phenomenon in which personal values, social evaluations, and cultural models interact. Its achievement or lack thereof has a significant impact on emotional well-being, social status, and overall life satisfaction (6).

Narcissism and success

We hypothesize that narcissism is positively related to success through motivational tendencies to get ahead and succeed, as well as through a higher desire to prove one's worth. For example, Elliot & Thrash (10) concluded that at least some components of narcissism are positively related to achievement orientation. Moreover, in situations related to success, narcissists demonstrate strong emotional reactions and use them as an additional source of self-improvement (e.g., subjective sense of success) (3; 23).

In addition, research has shown that narcissists are highly effective in creating a positive impression, especially in selection situations (4; 26), which can help them get a more prestigious job. This can also be explained by beliefs in the high self-efficacy of narcissists (20). Ultimately, since narcissists are assumed to have higher levels of self-efficacy beliefs, a higher drive to prove their worth, and can present themselves more effectively, they are more focused on achieving success.

Hypothesis 1: Narcissism is positively elated to success motivation

Psychopathy and success

Psychopathic personality traits, such as impulsivity, emotional superficiality, and lack of guilt, are associated with a reduced level of corporate responsibility, which in turn can negatively affect individual performance in the professional environment (9). Among the personality characteristics of the Dark Triad, psychopathy is the most significant negative predictor of professional performance (22).

Despite the predominantly negative impact of psychopathic traits on professional performance, some studies have suggested potential mechanisms through which psychopathy may be associated with higher rates of career success. In particular, some individuals with severe psychopathy may demonstrate outward attractiveness, extroverted charisma, and confidence, which contributes to their perception as effective leaders or managers. In this context, researchers have found a positive relationship between antisocial tendencies, which partially overlap with psychopathic traits, and achievement of higher positions and financial results (2; 27).

However, despite such arguments, most empirical studies provide convincing evidence that psychopathy is usually associated with lower objective (e.g., income, job status) and subjective (e.g., career satisfaction) success. Impulsivity, negative affectivity, and social coexistence disorders are the main factors that determine this relationship.

Hypothesis 2. Psychopathy is negatively related to success

Machiavellianism and the motivation to succeed

Machiavellianism has a long tradition of research in the context of success and leadership. This is because the key traits of individuals with a pronounced Machiavellian type of behavior (a tendency to manipulate, use other people, and think strategically) can be effectively implemented in positions and roles that involve authority. Despite the fact that the presence of Machiavellian tendencies is associated with lower loyalty to the organization, reduced commitment to the team and leadership (28), and negative perceptions from subordinates (24), these personality characteristics can contribute to achieving leadership positions.

It is also noted that individuals with high levels of Machiavellianism are often inclined to career-oriented professions, particularly in the fields of law and management, where they can exercise control and influence, as well as due to their own initiative and confidence. They seek power and have a strong motivation to achieve status (17). It has also been found that, unlike individuals with high levels of psychopathy, individuals with pronounced Machiavellianism are more likely to use socially acceptable soft power strategies: demonstrating charm, attractive appearance, humor, compromise, mutually beneficial exchange, building alliances, and using compliments (12). These approaches are less confrontational, which reduces the risk of negative consequences in the medium and long term, thereby contributing to objective career success.

With regard to career success, the evidence

remains less conclusive. Despite their potential effectiveness in achieving professional goals, individuals with high levels of Machiavellianism tend to report lower levels of job satisfaction. This may be due to increased expectations of reward, control, and influence that are not always realized to the desired degree. However, it is worth noting that individuals with high levels of Machiavellianism, even when seeking greater influence and control, may subjectively perceive themselves as successful in their career due to achieving a prestigious or influential position.

Hypothesis 3: Machiavellianism is positively correlated with success motivation

Materials and method

The study was conducted online. This was due to the restrictions caused by martial law, as well as the peculiarities of organizing the educational process, which took into account the safety of the participants (lack of heating and, in some places, electricity, air raids, etc.).

The sample consisted of 175 students and teachers of educational and professional programs in Psychology, Management, Mathematics, Information Technology, and Economics from higher educational institutions of Ukraine. The chosen areas of study have a common feature - a professional orientation to human interaction, which can manifest the features of the Dark Triad. It should be noted that the main idea was also to form a sample in which the bulk of respondents would be approximately the same age (18-25), since the characteristics of the Dark Triad construct can change both under the influence of personal and professional growth (including the influence of the surrounding professional environment) and under the influence of age-related changes. Nevertheless, these changes themselves aroused some research interest, so no age restrictions were included in the study design.

Measurement

Motivation to achieve success

As an instrument for studying the motivation to succeed, the Ehlers' questionnaire (8) was chosen, which is a well-known tool for assessing the level of motivation of individuals to succeed in various fields of activity, which has become popular in psychological research due to its simplicity and effectiveness.

The methodology consists of 41 questions or statements to which the respondent must answer "yes" or "no," which allows us to assess the level of success motivation. It is a self-assessment, meaning that respondents independently evaluate their own reactions and behavior in various life situations. A high level of motivation to succeed is often associated with ambition, activity, desire to achieve high results, and the ability to overcome difficulties. The answers to the questions are compiled to form the success motivation (ELRS).

The Dark Triad

To examine the Dark Triad as a holistic construct, the present study employed the Short Dark Triad (SD3) assessment methodology. (14). According to the authors of the methodology, the features of the Dark Triad are similar in their manifestations (and therefore correlate), but at the same time, each of them contributes to socially unacceptable behavior (and therefore, these are three relatively independent features). Its peculiarity is that it allows simultaneously identifying the presence and degree of certainty of all three components of the Dark Triad: Machiavellianism, psychopathy, and narcissism in a normal (non-clinical) population. The questionnaire consists of 27 questions, 9 questions for each component. The respondent is asked to answer these questions on a 5-point Likert scale (answers range from "1. Strongly disagree" to "5. Strongly agree"). The final result is presented for each of the three scales separately, so the Dark Triad is represented in our study: Machiavellianism (SD3_M), Narcissism (SD3_N), Psychopathy (SD3_P).

The NPI Narcissism Inventory

The NPI-16 (*Narcissistic Personality Inventory-16*) is a shortened version of the larger NPI-40, designed to assess the level of grandiose narcissism in the general population (1). It consists of 16 pairs of statements, where the respon-

dent chooses the one that best matches his or her views or behavior. This questionnaire also allows to analyze the structure of this component in more detail: leadership/authority (NPI_LA), superiority/arrogance (NPI_SA), and self-absorption/self-satisfaction (NPI_SS).

Analytical approach

All variables were standardized before the analysis to ensure comparability of beta coefficients across all regression models. Two main analytical strategies were used:

1. Pearson correlations: Bivariate correlations were calculated to examine the relationships between all measured variables (N = 175).
2. Hierarchical regression:

- Model 1: SD3 traits (Machiavellianism, narcissism, psychopathy) as predictors of the ELRS
- Model 2: NPI-16 subscales (Leadership/Authority, Superiority/Arrogance, Self-Absorption/Self-Capture) as predictors of ELRS

Results obtained

Correlation analysis

Pearson's bivariate correlations revealed systematic patterns of relationship between Dark Triad traits, narcissism components, and achievement motivation (Table 1), and its "temperature" version is shown in Figure 1. The correlation matrix revealed differentiated relationships between specific narcissistic traits and achievement motivation.

Correlation with motivation to success (ELRS)

- ELRS ↔ NPI_LA ($r = 0.409$, $p < .001$): Leadership-oriented narcissism is positively correlated with achievement motivation, supporting theories of "adaptive" narcissism.
- ELRS ↔ SD3_N ($r = 0.344$, $p < .001$): Narcissism from SD3 correlated with motivation to succeed, although the relationship was somewhat weaker than that of NPI_LA.

Hierarchical regression analysis

Model 1 The predictive role of Dark Triad (SD3) traits

The first hierarchical regression model examined the predictive power of the Dark Triad traits in terms of influencing the motivation to succeed (ELRS). The regression equation was statistically significant: $F(3, 171) = 8.50$, $p < .001$ (Table 2).

Key findings from Model

The only significant predictor was SD3_N (narcissism): $\beta = 0.33$, $SE = 0.076$, $t(171) = 4.34$, $p < .001$, which shows a positive and statistically significant effect on the ELRS, indicating that individuals with more pronounced narcissistic traits have higher levels of motivation to

Table 1 Correlation matrix of the Dark Triad traits, narcissism subscales, and motivation to succeed

Variable	1	2	3	4	5	6	7
1.NPI_LA	---						
2.NPI_SA	---	---					
3.NPI_SS	.456***	.447***	---				
4.SD3_M	-.015	---	---	---			
5. SD3_N	.551***	---	.672***	.273**	---		
6.SD3_P	---	---	---	.511***	---	---	
7. ELRS	.409***	---	.288***	---	.344***	.110	---

Notes. N = 175. Only significant and theoretically relevant correlations are shown. NPI_LA = Leadership/Authority; NPI_SA = Superiority/Arrogance; NPI_SS = Self-Absorption/Self-Satisfaction; SD3_M = Machiavellianism; SD3_N = Narcissism; SD3_P = Psychopathy; ELRS = Effort-Leadership-Results Scale (motivation to succeed).

**p < .01. ***p < .001.

succeed. The other predictors were either insignificant or not significant.

Notes: In the ANOVA (Type I SS), SD3_M (Machiavellianism) showed little significance ($p = .011$) when entered first, but its effect was absorbed by SD3_N (narcissism).

Model 2 The predictive role of the NPI-16 narcissism subscales

The second hierarchical regression model examined the three factor components of the NPI-16: Leadership/Authority (NPI_LA), Superiority/Arrogance (NPI_SA), and Self-Absorption/Self-Satisfaction (NPI_SS). This model provided a more detailed assessment of how specific narcissistic tendencies are related to success motivation. The regression equation was statistically significant: $F(3, 171) = 13.08$, $p < .001$ (Table 3).

Key findings from Model 2

The only significant predictor was NPI_LA ($\beta = 0.37$, $SE = 0.079$, $t(171) = 4.66$, $p < .001$), while other predictors were either insignificant or not significant. Thus, it is Leadership/Authority that has a statistically significant and strong impact on ELRS and accounts for 89.7% of the explained variance in the model.

Comparison of severity levels by components of the Dark Triad

The data obtained in our study, as well as data from studies in Germany (18) and the United States (13; 11; 15) are presented in Table 4.

Figure 1 „Temperature" correlation matrix

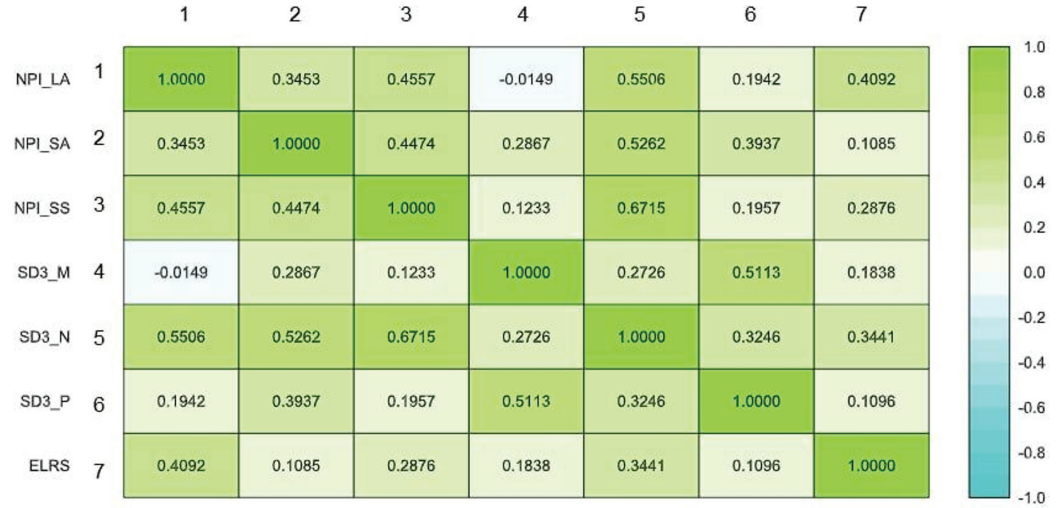

Table 2 Hierarchical regression analysis: Dark Triad traits as predictors of motivation to succeed

Predictor	β	SE	T	p	95% CI	SS	% of variance
SD3_N	0.330	0.076	4.34	<.001	[0.18, 0.48]	16.24	73%
SD3_M	0.125	0.084	1.50	.136	[-0.04, 0.29]	5.88	26%
SD3_P	-0.062	0.085	-0.72	.471	[-0.23, 0.11]	0.46	1%

Notes. N = 175. Dependent variable: Standardized ELRS (motivation to succeed). All predictors are standardized. SD3_N = Narcissism; SD3_M = Machiavellianism; SD3_P = Psychopathy; SS = Sum of Squares. Model results: $F(3, 171) = 8.50$, $p < .001$; Adjusted $R^2 = .115$; Residual standard error = 0.941.

Discussion

Theoretical and empirical implications

This study analyzes the relationship of Dark Triad personality traits with success motivation among mostly young people studying at different universities in Ukraine. An important contribution of the study is the simultaneous examination of all three Dark Triad traits in relation to this relationship. Narcissism turned out to be the only Dark Triad trait that has **a systematic, statistically significant, and positive effect on success motivation**. This may be due to the narcissistic personality's characteristic tendency to self-enhancement, demonstrativeness, and need for recognition, which stimulates the desire to achieve high results. However, a more detailed analysis of the narcissism dimensions revealed that this relationship is mostly driven by the Leadership/Authority component (NPI_LA, $\beta = 0.37$), which supports the concept of "adaptive narcissism" in achievement contexts. Psychopathy and Machiavellianism did not show a significant relationship with achievement motivation, which may indicate that the underlying destructive traits are not determinants of socially adaptive achievement motivation

We also proved that in the context of studying the Dark Triad traits, the existing cultural differences between Ukraine and Western countries do not affect the effectiveness and statistical significance of the sample when applying the correct models. In general, the study extends previous work on the impact of the Dark Triad traits on certain areas of human life not only in the geographical and cultural sense, adding Ukrainian samples to Western ones, but also in the sense of analyzing this impact on success as a broader socio-psychological phenomenon. Thus, our study makes a significant contribution both to the field of management and business and to the field of holistic personality research.

A comparative analysis of the average values of the Dark Triad components among students in Ukraine, which is in martial law, with those in peaceful countries turned out to be quite interesting. For example, the levels of psychopathy and narcissism were even lower than other indicators, but the level of Machiavellianism was the highest.

Despite the results, their interpretation requires some caution. In particular, it was unexpected that Machiavellianism did not demonstrate a statistically significant positive relationship with success motivation. One possible explanation for these results may be that the sample under study mostly did not have a suffi-

Table 3 Hierarchical regression analysis: NPI-16 subscales as predictors of success motivation

Predictor	β	SE	T	p	95% CI	SS	% of variance
NPI_LA	0.367	0.079	4.66	<.001	[0.21, 0.52]	29.14	89.7%
NPI_SS	0.161	0.083	1.94	.053	[-0.002, 0.32]	3.13	9.6%
NPI_SA	-0.090	0.078	-1.15	.252	[-0.24, 0.06]	0.21	0.7%

Notes. N = 175. Dependent variable: Standardized ELRS (motivation to succeed). All predictors are standardized. NPI_LA = Leadership/Authority; NPI_SS = Self-absorption/Self-satisfaction; NPI_SA = Superiority/Arrogance; SS = Sum of Squares. Model results: $F(3, 171) = 13.08$, $p < .001$; Adjusted $R^2 = .172$; Residual standard error = 0.910

Table 4 Comparison of the levels of expression of the Dark Triad traits among students

Component	Germany(18)	USA(13)	USA(11)	USA(15)	This study
SD3_M	3.12	2.99	2.36	2.90	3.65
SD3_N	3.45	3.38	3.29	2.91	3.08
SD3_P	2.89	2.16	2.12	2.16	2.10

cient level of professional experience necessary for the full manifestation of the predicted individual psychological tendencies in the context of career trajectory.

Conclusion

The results of the study

The theoretical significance of this study is manifested primarily in three key areas.

First, our findings offer a new perspective on the relationship between Dark Triad traits and success motivation in the context of Ukrainian culture and the current martial law. Against the backdrop of previous empirical evidence that Dark Triad traits influence emotional and social aspects of behavior, our study extends the understanding of these relationships in the context of the impact on the motivational domain of the individual. We confirmed the results of existing studies that the Dark Triad has a positive predictive effect on career achievement (12), extending them to motivation to succeed in general. However, the only statistically significant positive predictor of this effect was narcissism (or rather, its leadership/authority component), which differs from previous studies in which Machiavellianism was also a predictor. Summarizing, the results of this study reveal certain discrepancies with the findings of Western elections. This allows us to take a fresh look at the existing research and opens up new directions for further empirical research in this area.

Second, this study is the first in the Ukrainian scientific context to offer a differentiated analysis of the relationship between individual Dark Triad traits and success motivation. It complements and extends previous research that has predominantly focused on the relationship between success and more general constructs of dark personality based on a combination of traits from the Big Five model, rather than focusing on the specific components of the Dark Triad - narcissism, psychopathy, and Machiavellianism.

Third, the increased level of Machiavellianism compared to peaceful countries may be a reaction to the threat and uncertainty inherent in martial law. In crisis situations, the value of strategic thinking, pragmatism, and interpersonal manipulativeness increases as a means of self-preservation or adaptation to instability. The lowest level of psychopathy may seem paradoxical, but in times of war, social cohesion and moral responsibility can suppress manifestations of ruthlessness or impulsivity. This may also be the result of increased mobilization of pro-social attitudes and collective ethics aimed at survival. Therefore, in our opinion, these patterns may indicate **adaptation to stressful conditions through strategic behavior, but without cruelty**, which is consistent with high social solidarity and moral mobilization in Ukrainian society.

Implications for practice

The findings regarding the impact of Dark Triad traits on achievement motivation hold substantial practical significance across multiple domains, including management, human resource practices, and educational settings.

First, the positive impact of narcissism on the motivation to succeed has been found to allow a new interpretation of the role of this trait in management processes. In particular, in a highly competitive environment, individuals with a moderate level of narcissism can be effective drivers of result-oriented change. Managers can take this into account when assigning roles in teams, creating motivational strategies, or developing leadership development programs. At the same time, it is important to control excessive manifestations of narcissism that can lead to conflicts, authoritarian management style, or neglect of team interaction.

Secondly, the results obtained can be used in the processes of recruiting personnel, assessing the potential of candidates and forming a personnel reserve. In particular, knowledge of the relationship between narcissism and the motivation to succeed can be useful in assessing leadership potential or career development. On the other hand, the absence of a significant influence of Machiavellianism and psychopathy on achievement motivation gives grounds for a cautious attitude towards individuals with high scores on these traits, especially in the context of teamwork, corporate ethics, and long-term organizational effectiveness. In HR practice, this can be realized through the use of appropriate

psychodiagnostics techniques (in particular, SD3) in the formation of a psychological profile of employees.

Thirdly, in the education system, the results of the study can be useful for career guidance, psychological support for students, and the development of their motivational sphere. The knowledge that only narcissism correlates with the motivation to succeed can help in individualizing approaches to stimulating achievement, as well as in identifying potential leaders among students and pupils. It is also advisable to include the topic of psychological characteristics of achievement motivation in training programs and courses on personal development.

In general, the results of the study can serve as a basis for building evidence-based practices of human resource management, leadership development, and improving the effectiveness of educational programs.

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A Review of the Literature on Environmental Health in Slovakia

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Original Article

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Abstract:

Objective: This study provides a literature review on the issue of environmental health in Slovakia
Methods: As of December 31, 2024, we have generated a list of publications within the WOS database for the topic "environmental health in Slovakia". The publications were subsequently classified into groups of indicators designed according to the methodology of the WHO (1999). Publications had to meet a basic criterion, namely the interaction of the environment with human health.
Results: From the 214 publications generated by the WOS database, 70 publications did not meet the criterion of the

presence of environmental interaction with human health. Although 144 publications were categorized into indicator groups, they dealt with environmental health only marginally. **Conclusion:** Almost no attention is paid to the topic of environmental health in Slovakia. We therefore call for continuous monitoring of data and their continuous processing.

Introduction

Good health allows us to live a full life. An individual's health status is influenced by a range of factors, including lifestyle (Viallon et al., 2024), access to healthcare (Gulliford et al., 2002), socioeconomic status (Barakat & Konstantinidis, 2023), and environment (Harting et al., 2014), which directly affect a person's life.

In the face of an ever-changing world, it is essential to study the impact of the environment on human health, not only physical health but also mental health. Environmental health is key to protecting public health and well-being (Birnbaum & Jung, 2011, Petrovič et al . 2023). It encompasses a wide range of areas that assess water, soil, and air pollution, the presence of toxic substances in the environment, and radiation. Climate change and noise also have a major impact on health. These factors affect the human body to varying degrees.

Environmental factors influence disease incidence and mortality worldwide. The most vulnerable populations are children, the elderly and low-income communities (EEA, 2024). However, demonstrating such impacts is difficult and mostly requires detailed and long-term research on the affected sample of people.

Studying environmental health helps to better understand how the environment affects human health, thereby identifying risk factors. It helps to develop effective strategies to prevent disease and reduce mortality, and technologies to protect and improve the environment, thereby improving the health of the population. Environmental health research is interdisciplinary, incorporating knowledge not only from the natural sciences but also from the humanities, applied and interdisciplinary sciences. Research varies in scale from local to global studies covering a wide range of areas.

There are many outputs and publications addressing environmental health issues. A review of the available literature from the WOS database provides an important overview of available publications on environmental health. Such an overview is important for understanding the complex interactions between the environment and human health.

Our study was conducted as a Literature Review Study of the Web of Science database, which is a valuable source of information for researchers, students, and professionals in various scientific disciplines. The study reviews existing research in the field of environmental health in Slovakia, identifies key findings, and assesses the current state of knowledge about the relationships between people and their environment in the form of publications. It also tracks the level of monitoring of the impact of the environment on human health and, conversely, how anthropogenic activities affect the quality of the environment in Slovakia.

Materials and Methods

Publications were searched in the Web of Science database on the topic "Environmental health in Slovakia" as of 31. December 2024. 214 publications were retrieved. By reading the abstracts of all publications, we identified key areas, on the basis of which we provisionally classified them into groups based on the WHO (1999) "Environmental Health Indicators: Profiles and Examples" methodology. The latter contains profiles of indicators that are related to environmental health and are applicable at all levels, from local to international. Following the WHO (1999) methodology, we have selected the following groups:

1. Access to safe drinking water
2. Air pollution
3. Food safety
4. Hazardous/toxic substances
5. Non-occupationl health risks
6. Occupational health risks

7. Radiation
8. Sanitation
9. Shelter
10. Socio-demographic context
11. Solid waste management
12. Vector-borne diseasess

Since the WHO (1999) methodology recommends the creation of new groups of indicators according to available data and needs, we created new groups of indicators following the steps in this methodology:

13. Noise
14. Human influence on environment and health
    As we state in the introduction, given the ever-changing world, it is essential to study the impact of the environment on human health, not only physical but also mental health. We are therefore adding to the group of indoctors:
15. Mental health
    Although the 2030 Agenda is not legally binding, the implementation of its goals by individual countries has been considered crucial in recent years. We have therefore set up a group to address this issue:
16. Agenda 2030
    The basic criterion for sorting WOS publications into groups was that the topic of the publication must address the environmental linkage of diseases. As several publications did not meet this criterion, we created a group of publications that could not be classified into our selected groups:
17. Discarded publications
    Within each group, we assessed the number of included publications, which was used to evaluate and identify potential trends and gaps in research in each area of environmental health. This approach allowed us to better analyze the current state of knowledge on environmental health and to identify deficits in research in the areas.

Results

A search of the Web of Science database related to studies on environmental health in Slovakia generated a total of 214 publications. Although the publications show the interaction of human health with the environment, the concrete term of "environmental health" is not mentioned in any of them. From all publications, 70 (33.02%) did not meet the criteria for inclusion of publications in the environmental health indicator groups.

144 publications met the criteria for inclusion of publications in the environmental health indicator groups, which represents 66.98% of the publications. The largest number of publications dealt with Hazardous/toxic substances (36 publications) and Human influence on environment and health (24 publications) (Figure 1). This was followed in frequency by publications dealing with Food safety (18 publications), Air pollution (18 publications) and Socio-demographic context (17 publications). Fewer than 10 publications were assigned to the groups Agenda 2030 (8 publications), Noise (7 publications), Access to safe drinking water (5 publications), Occupational health risks (4 publications), Vector-borne diseases as well as Radiation (3 publications in each group) and Solid waste management (1 publication). For the WHO (1999) Non-occupational health risks, Sanitation and Shelter groups of environmental health indicators, we did not identify any publications from Slovakia. We also did not identify any publications within our Mental health group.

Toxic Substances and Hazardous Wastes

We allocated four indicators to the group of Toxic Substances and Hazardous Wastes: (1.) Areas contaminated with toxic substances by a major source of pollution, (2.) Impact of toxic substances on human health, (3.) Land management with contaminated soil, and (4.) Management of contaminated water bodies.

We assigned 18 publications for the indicator of *Areas contaminated with toxic substances by a major source of pollution* (Table 1), 9 publications to the indicator of *Land management with contaminated soil*, 4 publications to the indicator of *Management of contaminated water bodies,* and 3 publications to the indicator of *Impact of toxic substances on human health*.

Human impact on environment and health

We allocated five indicators to the group of Human Impact on the Environment with Human

Health Impacts: (1.) Energy and human health, (2.) Forest management effects on air quality and human health, (3.) Green infrastructure development, (4.) Impacts of mining on human health, (5.) Impacts on soils and human health, and (6.) Impacts of water pollution on human health.

We assigned 8 publications to the indicator of *Impacts of water pollution on human health* (Table 2), 6 publications to the indicator of *Forest management effects on air quality and human health,* 4 publications to the indicator of the *Impacts on soils and human health*, 3 publications to the indicator of the *Impacts of mining on human health*, 2 publications to the indicator of the *Energy and human health,* and 1 publication to the indicator of the *Development of green infrastructure*.

Food safety

We allocated two indicators to the group of Safe Food: (1.) Consumption of food quantity and (2.) Monitoring of chemical hazards in food.

We assigned 17 publications to the indicator of *Monitoring of chemical hazards in food* (Table 3) and 1 publication to the indicator of the *Food consumption quantity.*

Air pollution

We allocated four indicators to the group of Air pollution: (1.) Air pollutants from the combustion of solid fuels, (2.) Air pollutants in urban areas, (3.) Air quality management with human health impacts, and (4.) sources of indoor air pollution. We assigned 8 publications to the indicator of the *Indoor air pollution sources* (Table

Figure 1 Percentual representation of publications in individual groups of indicators for environmental health as of December 31, 2024 (Source: Web of Science).

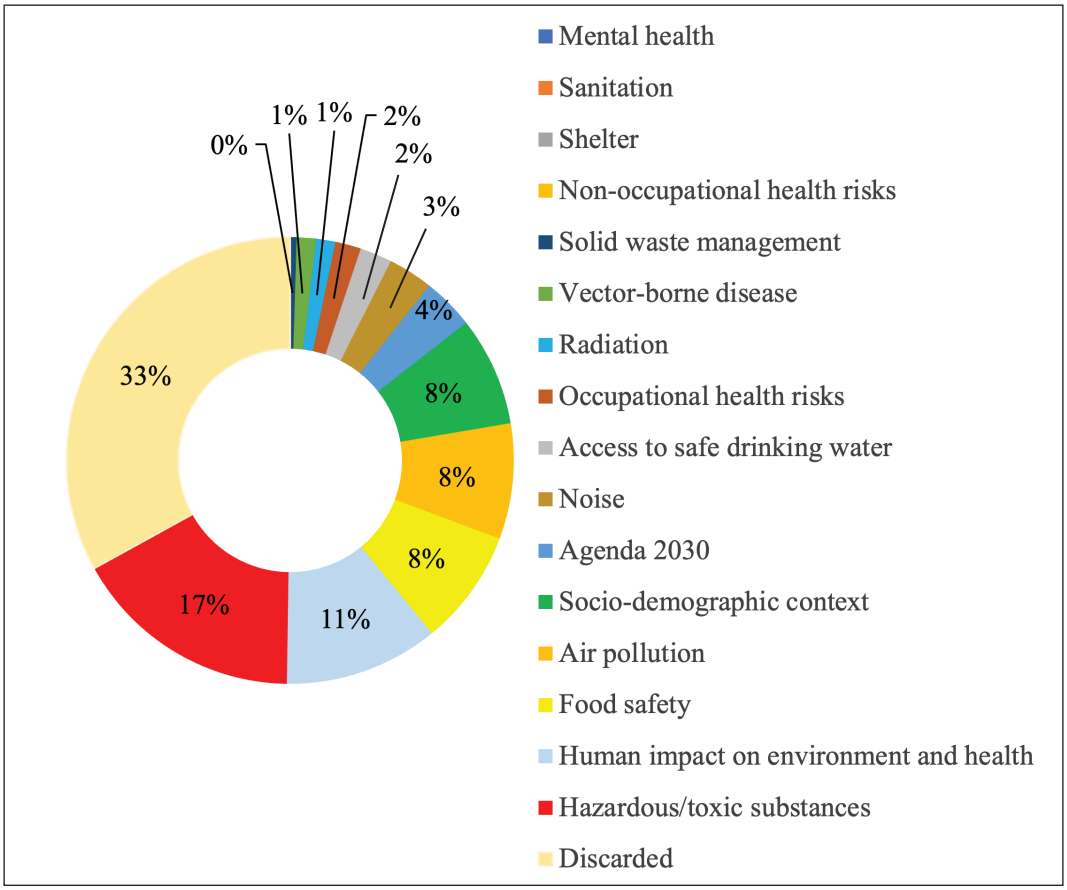


Table 1 Assignment of publications to individual indicators for Toxic Substances and Hazardous Wastes

Areas contaminated with toxic substances by a major source of pollution	
Arsenic in the human body based on urine samples	Ranft et al. (2003)
Bacterial diversity of PAH-contaminated soil	Puškárová et al. (2013)
Impact of PCBs on health status, particularly in newborns and young children	Plíšková et al. (2005); Hovander et al. (2006); Jan et al. (2007); Langer et al. (2007); Park et al. (2007, 2009); Wimmerová et al. (2015); Mondal et al. (2022); Hertz-Pieciotto et al. (2003); Urbanetz et al. (2024)
Pollution from industry	Rapant et al. (2006); Sanciova (2015); Arvay et al. (2017); Mitterpach et al. (2017); Andras et al. (2012)
Prevalence of pesticides in humans	Petrik et al. (2006)
Land management with contaminated soil	
Antimony in sediments in a contaminated area	Zhao et al. (2023)
Assessment of mercury, chromium and nickel accumulation from mining soils in nettle	Hiller et al. (2021)
Determination of mercury in potatoes and soil	Musilova et al. (2017)
Impact of geological contamination on public health	Rapant et al. (2009a,b)
Monitoring of heavy metals in soils and berries	Fedorková et al. (2023)
PCB and PAH assessments	Hiller et al. (2015); Drimal et al. (2016)
Radon measurement in dwellings	Mojzeš et al. (2017)
Management of contaminated water bodies	
Heavy metals in surface waters	Singovszka et al. (2020)
Impact on human and animal health of toxic cyanobacteria	Mališová et al. (2021)
Radon measurement in caves	Ambrosino et al. (2020)
Water pollution on heavy metals and its effects on fishes	Brazova et al. (2012)
Impact of toxic substances on human health	
Blood lead levels in children	Hrubá et al. (2023)
Presence of BFR substances in organisms	Slamecka et al. (2012); van der Schyff et al. (2023)

Table 2 Assignment of publications to individual indicators for Human impact on environment and health

Impacts of water pollution on human health	
Antibiotics in wastewater	Ng et al. (2023)
Application integrated with GIS as a decision support tool for the management of potentially polluted sites as well as for overall water management	Lánczos (2009)
Cyanobacteria growth on water reservoir	Onderka (2007)
Environmental impacts of water management structures	Zeleňáková et al. (2017a)
Evaluation of sludge water using bacteria	Perháčová et al. (2022)
Point sources of water pollution	Sabo et al. (2014)
Water features in urbanized environments with recreational use	Virtudes et al. (2018a,b)
Forest management effects on air quality and human health	
Air purity differences in forests of European countries	Kovac (2016)
Assessment of atmospheric cadmium deposition in forests	Bohdalkova et al. (2020)
Change in forest condition in relation to industrial transformation	Main-Knorn et al. (2009)
Forest quality in relation to sustainable development	Ozkaya & Erdin (2020)
Heavy metals in beech forest soils	Qiu et al. (2022)
Monitoring of air pollution effects on forests	Oszlányi (1997)
Impacts on soils and human health	
Assessing and proposing options for soil revitalization	Huttmanova et al. (2015)
Diversity of microorganisms in contaminated soils	Fazekaš et al. (2018), Fazekašová et al. (2021)
Effect of genetically modified maize on the genetic diversity of rhizosphere bacteria	Ondreičková et al. (2014)
Sorption and desorption of acetochlorine in soil samples	Hiller et al. (2009)
Impacts of mining on human health	
Assessment of the impacts of coal mining on health	Skvarekova & Kozakova (2012)
Potential of uranium deposits in Slovakia	Šofranko et al. (2020)
Risk of environmental burdens	Sevcikova et al. (2021)
Energy and human health	
Assessment of the effects of the thermal power plant on the environment	Zeleňáková et al. (2017b)
Sustainable use of nuclear waste	Labor & Lindskog (2014)
Green infrastructure development	
Development of green areas and green infrastructure	Belčáková et al. (2019)

4), 6 publications to the indicator *Air pollutants in urban areas,* 3 publications to the indicator of the *Air quality management with impact on human health,* and 1 publication to the indicator of *Air pollutants from solid fuel combustion.*

Socio-demographic context

We included six indicators in the group of Socio-demographic context: (1.) Health habits, (2.) Human well-being, (3.) Non-working dependent population, (4.) Population growth in relation to health, (5.) Poverty, and (6.) Vulnerable populations.

We assigned 6 publications to the indicator of *Non-working dependent population* (Table 5), 4 publications to the indicator of the *Human well-being,* 2 publications to the indicator of *Health habits,* 2 publications to the indicator of *Population growth in relation to health,* 2 publications to the indicator of *Vulnerable populations,* and 1 publication to the indicator of the *Poverty*.

Agenda 2030

We included one indicator in the group of Agenda 2030: (1.) Implementation of Agenda 2030, Goal 3 Quality of health and life. We assigned 8 publications to this indicator (Table 6).

Noise

We included four indicators in the group of Noise: (1.) Consequence of high noise intensity on human health, (2.) Excessive noise from restaurants, (3.) Excessive noise from the workplace, and (4.) Excessive noise in urban settlements.

We assigned 3 publications to the indicator of *Excessive noise in urban settlements* (Table 7), 2 publications to the indicator of the *Consequence of high noise intensity on human health,* 1 publication to the indicator of *Excessive noise from restaurants*, and 1 publication to the indicator of *Excessive noise from the workplace.*

Access to safe drinking water

We included two indicators in the group of Access to safe drinking water: (1.) Drinking groundwater quality, and (2.) Waterborne diseases.

We assigned 4 publications to the indicator of *Drinking groundwater quality* (Table 8), and 1 publication to the indicator of the *Waterborne diseases.*

Table 3 Assignment of publications to individual indicators for Food safety

Monitoring of chemical hazards in food	
Dangerous fungi in wine growing areas	Mikušová et al. (2010)
Hazardous toxic substances in meat	Lauková et al. (2000); Lukáčová et al. (2015); Slamecka et al. (2017); Silva et al. (2022)
Impact of mining activities based on heavy metal concentrations in vegetables	Musilová et al. (2022)
Mercury content in mushrooms	Jančo et al. (2021), Árvay et al. (2022), Čeryová et al. (2022)
Milk and feed analyses in relation to hazardous substances	Tunegova et al. (2016), Pšenková et al. (2020); Almásiová et al. (2023); Almášiová et al. (2024)
Safety of fish consumption focusing on mercury and PCB content	Borosová et al. (2014); Desvignes et al. (2017)
Wheat diseases	Blikova et al. (2012)
Food consumption quantity	
Reduction of meat consumption in Poland and Slovakia	Borusiak et al. (2022)

Occupational health risks

We included one indicator in the group of Occupational health risks: (1.) Exposure to hazardous workplaces.

We assigned 4 publications to this indicator (Table 9).

Radiation

We included three indicators in the group of radiation: (1.) Cosmic radiation, (2.) Cumulative radiation dose, and (3.) X-rays in health care facilities.

We assigned 1 publication to the indicator of *Cosmic radiation* (Table 10), 1 publication to the indicator of the *Cumulative radiation dose,* and 1 publication to the indicator of *X-rays in health care facilities.*

Vector-borne diseases

We included one indicator in the group

Table 4 Assignment of publications to individual indicators for Air pollution

Indoor air pollution sources	
Concentrations of airborne bacteria and moulds	Górny & Dutkiewicz (2015)
Improvements in energy efficiency of air exchangers	Földváry et al. (2017)
Indoor air quality in older buildings	Vilčeková et al. (2023)
Indoor air quality in Roma settlements	Majdan et al. (2020)
Indoor air quality in schools	Meciarova et al. (2017)
labour productivity in relation to air quality	Vilčeková et al. (2015)
Presence of particulate matter indoors	Vilčeková et al. (2013); Burdova et al. (2016)
Air pollutants in urban areas	
Chromosome research in relation to air pollution	Beskid et al. (2007)
Correlation between meteorological parameters and particulate matter concentrations	Pekdogan et al. (2023)
Determination of particulate matter concentrations in urban environments	Sarkan et al. (2023)
Exposure to odorous substances	Drimal et al. (2010)
Monitoring the operation of a coal-fired power plant	Thornton et al. (2003)
Worsened emission situation	Krokusova et al. (2013)
Air quality management with impact on human health	
Building design in relation to air quality	Senitkova & Tomcik (2010)
Measures in municipalities aimed at reducing air pollution in Poland and Slovakia	Czuba (2020)
Tobacco quality control and tobacco harm	Willemsen & Nagelhout (2016)
Air pollutants from solid fuel combustion	
Environmental impact of coal combustion emissions and cancer incidence	Bencko et al. (2009)

of Vector-borne diseases: (1.) Spread of vector-borne diseases.

We assigned 3 publications to this indicator (Table 11).

Solid waste management

We included one indicator in the group of Solid waste management: (1.) Solid municipal waste disposal.

We assigned 1 publication to this indicator (Table 12).

Shelter, Sanitation, Non-occupational health risks and **Mental health** - publications from Slovakia are absent.

The time line of publications generated by the WOS database dates back to 1993. The fol-

Table 5 Assignment of publications to individual indicators for Socio-demographic context

Non-working dependent population	
Children's rights for a healthy environment	Lux (2023)
Impact of tobacco smoke on pregnant women and children	Argalášová et al. (2017); Sevcikova et al. (2018)
Increase in the retirement age	Polackova (1999)
Quality of life of people over sixty	Kowalczyk et al. (2024)
Respiratory health of children	Rimarova (2015)
Human well-being	
Evolution of quality of life	**Oláh et al. (2020)**
Impact of the environment on people's health in selected countries	Streimikiene & Vveinhardt (2015)
Influence of factors on the blood pressure of schoolchildren	Rimarova & Frank (2014)
Traveling to school	Brindley et al. (2023)
Health habits	
Health disparities among people in Europe in relation to health habits	Mackenbach (2014)
Purchase of organic food as one of the health habits	Janska et al. (2023)
Population growth in relation to health	
Health status in Roma settlements	Bartosovic (2016)
Quantification of regional differences in mortality influenced by selected environmental factors	Gavurova & Toth (2019)
Vulnerable populations	
Pollutant-induced infant mortality	Schoeters et al. (2011)
Prevalence and elucidation of the causes of anencephaly in Slovakia, the Czech Republic, and Germany	Risova et al. (2024)
Poverty	
Social status in marginalized communities	Krizovsky & Drotarova (2015)

lowing publication was created in 1997. More than 10 publications per year have been published since 2012 (Figure 2).

Discussion

One of the biggest factors in human health is the environment (Herman, 2014). Underlining this importance, the United Nations entities issued a joint statement in 2021 recognizing the "right to a safe, clean, healthy and sustainable environment" for all people (UNEP, 2021). In 2016, WHO released a report entitled "Preventing disease through healthy environments: A global assessment of the burden of disease attributable to environmental risks", estimating how much of global disease could be prevented by modifying the environment. There are more than 12 million deaths globally each year attributed to unhealthy environments according to the Office of Disease Prevention and Health Promotion (WHO, 2016)

Environmental health is therefore one of the most important parts of public health. Public health experts have long recognized that the environments where people live have health consequences at both the individual and community

Table 6 Assignment of publications to individual indicators for Agenda 2030

Implementation of Agenda 2030, Goal 3 Quality of health and life	
Analysis of the national policy of Poland and Slovakia on energy efficiency in the context of the 2030 Agenda	Małajowicz et al. (2023)
Development of the banking sector in the context of meeting the objectives of the Agenda	Bayar et al. (2023)
Environmental burdens and challenges	Majerník et al. (2019), Lieskovska et al. (2020)
Green growth of the economy	Majerník et al. (2017)
Implementation of EU directives	Jurickova (2002)
Implementation of health risk management in the SEA process and sustainable development	Zeleňáková & Zvijaková (2011), Sanciova (2016)

Table 7 Assignment of publications to individual indicators for Noise

Excessive noise in urban settlements	
Assessment of railway noise	Pultznerova et al. (2018)
Impact of noise on the health of inhabitants living in cities	Kuzmova et al. (2017)
Noise-induced sleep disorders in Central Europe	Ristovska & Lekaviciute (2013)
Consequence of high noise intensity on human health	
Assessment of noise exposure to pupils	Filová et al. (2020)
Relationship between noise levels and health	Panulinova et al. (2016)
Excessive noise from restaurants	
Public awareness of the danger of noise from restaurant facilities	Jeram et al. (2013)
Excessive noise from the workplace	
Environmental noise from mining operations in Slovakia	Rovňák et al. (2023)

levels (Kent State, 2024). People who live in a healthy environment may enjoy the positive health effects of their living conditions (Roberts et al., 2022). In contrast, those who don't live in a healthy environment may face a higher risk of chronic diseases and other health hazards that decrease life expectancy.

Environmental hazards such as air and water pollution, lack of access to healthy foods, and exposure to the toxic by-products of industrial and agricultural production are among the environmental risks that can significantly influence human health and well-being (Kent State, 2024).

The monitoring of ambient environmental conditions is essential to environmental management and regulation (Biber, 2013). However, effective monitoring is subject to a range of institutional, political, and legal constraints, constraints that are a product of the need for monitoring to be continuous, long lived, and well matched to the resources being studied.

Several authors point to the issue of data collection for environmental health (Nisbet, 2007;

Table 8 Assignment of publications to individual indicators for Access to safe drinking water

Drinking groundwater quality	
Estimation of health risks from groundwater contamination	Rapant & Krčmová (2007)
Groundwater contamination and human health	Backman et al. (1998), Schmidt et al. (2017)
Relationship between arsenic in groundwater and cancer incidence	Kričković et al. (2022)
Waterborne diseases	
Effect of hardness of water on the cardiovascular system	Rapant et al. (2019)

Table 9 Assignment of publications to individual indicators for Occupational health risks

Exposure to hazardous workplaces	
Exposure of incinerator workers to waste incineration ash	“
Impact of chromium and asbestos on lung cancer incidence and risk factors in the workplace	Fabiánová et al. (1997), Halasova et al. (2005), Gergelová et al. (2006)

Table 10 Assignment of publications to individual indicators for Radiation.

Cosmic radiation	
Influence of solar, geomagnetic and cosmic activity on human physiological parameters	Mavromichalaki et al. (2021)
Cumulative radiation dose	
Cumulative effect of sunlight and arsenic in relation to skin tumors in Hungary, Romania and Slovakia	Surdu et al. (2014)
X-rays in health care facilities	
Slavic gene mutation and X-rays	Chrzanowska et al. (2023)

Doremus, 2008). Many people ask whether we can reliably and efficiently obtain the necessary environmental data for regulation and control (Elzinga et al., 2001; Biber, 2011)?

Ongoing development and implementation of empirically based systematic review methods are required in environmental health to ensure transparent and timely decision making to protect the public's health. According to the Suttorn et al. (2021), systematic reviews produced more useful, valid, and transparent conclusions compared to non-systematic reviews, but poorly conducted systematic reviews were prevalent. The uptake of systematic reviews in environmental health is advancing, but the standards by which the methods are applied have been somewhat variable (Whaley et al., 2021). According to these authors (Whaley et al., 2021), new questions are arising such as "how systematic are reviews in environmental health?" and "do systematic reviews in environmental health result in more transparent and reliable reviews than traditional expert-based, narrative reviews?"

A systematic review in the field of environmental health has not yet been prepared for Slovakia. However, there are systematic reviews at the European level, e.g. A systematic review of water, sanitation and hygiene among Roma communities in Europe: Situation analysis, cultural context, and obstacles to improvement (Anthonj

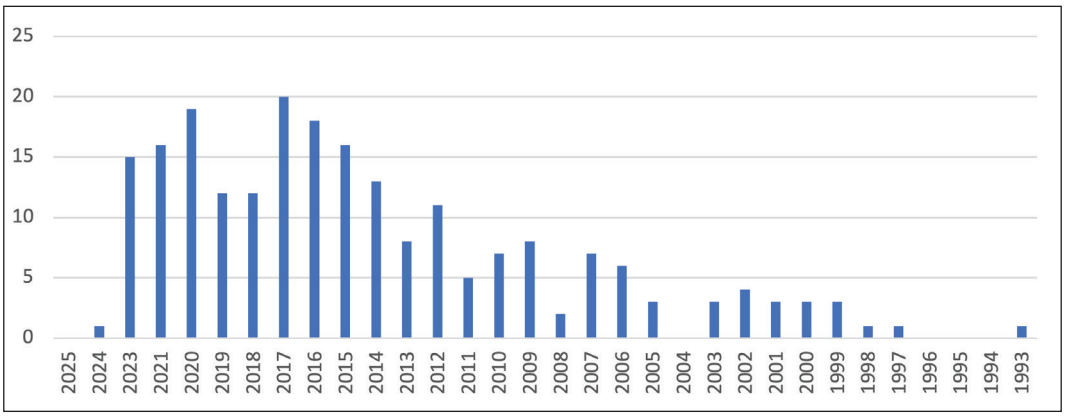
Table 11 Assignment of publications to individual indicators for Vector-borne diseases

Spread of vector-borne diseases	
Faecal bacterial flora of deer with special attention to potential pathogens and anaplasmosis transmitted to humans by infected ticks	Gnat et al. (2015)
Occurrence of enterococci in cow manure	Lauková et al. (2019)
Pathogens transmitted by ticks to humans	Karshima et al. (2023)

Table 12 Assignment of publications to individual indicators for Solid waste management

Solid municipal waste disposal	
Health impacts of landfilling and waste incineration in Italy, the United Kingdom and Slovakia	Forastiere et al. (2011)

Figure 2 Time line of publications generated by the WOS database for the topic "environmental health in Slovakia"



et al., 2020) or at the level of more countries, e. g. Physical activity of children and adolescents from the Czech Republic, Hungary, Poland, and Slovakia: A systematic review (Kantanista et al., 2021)

In an effort to obtain more information about environmental health in Slovakia and to collect data for the field of environmental health, we focused on publications in the WOS database as of December 31, 2024. The oldest publication in the database was published in 1993, which would mean that the authors have been dealing with the issue of environmental health in Slovakia for only the last 28 years. Unfortunately, this oldest publication (Badalik et al., 1993, Supplementary Material) is devoted to the topic New trends in postgraduate health education in Slovakia: first experiences of the School of Public Health in Bratislava. The publication does not meet the criterion of interaction of health and the environment. Another publication was published in 1997 (Oszlányi, 1997), where the author deals primarily with the health of forests and environmental pollution in Slovakia, but also mentions the impact on people's health. Another publication in the field of environmental health in Slovakia comes from 2012, while the authors wrote the most publications in 2023.

We consider the fact that none of the publications deals with the health of the environment comprehensively to be problematic. There are no publications from the continuous data collection of selected indicators throughout Slovakia. All publications are only marginally related to environmental health. For the indicator groups of sanitation, shelter and non-occupational health risks, WOS did not generate any publications. We encourage professionals to also focus on mental health. We hypothesized that the WOS database would contain publications describing the interactions of mental health and the high mountain landscape, which is a hot topic abroad.

Conclusion

The review study provided a comprehensive overview of knowledge on various environmental health factors from the territory of Slovakia available in the Web of Science database. For the topic "environmental health in Slovakia", the WOS database system generated 21 publications as of December 31, 2024. Groups of factors influencing environmental health were selected based on the methodology and recommendations of WHO (1999).

Despite the fact that the system searched for 214 publications after entering the topic "environmental health", we excluded 70 publications (33.02% of them) after a more detailed study because they did not meet the basic criterion – the association of diseases with the environment. The remaining publications could be classified into the indicator groups Hazardous/toxic substances (25%), Human influence on environment and health (16.67%), Food safety (12.50%), Air pollution (12.50%), Socio-demographic context (11.81%), Agenda 2030 (5.56%) over Noise (4.86%), Access to safe drinking water (3.47%), Occupational health risks (2.78%), Radiation and Vector-borne diseasess (2.08%) and Solid waste management (0.69%). For some groups of environmental health indicators, no publications from Slovakia have been published in the WOS database so far (Non-occupational health risks, Shelter, Sanitation and Mental health).

Within one group of indicators, the Human influence on environment and health and Socio-demographic context groups were assessed for 6 indicators each (Figure 3), the Hazardous/toxic substances, Air pollution and Noise groups for 4 indicators each, Radiation for 3 indicators, the Food safety and Access to safe drinking water groups for 2 indicators each, and the Agenda 2030, Vector-borne diseasess, Occupational health risks and Solid waste management groups for 1 indicator each.

We observed a complete absence of publications for 4 groups of environmental health indicators, namely Non-occupational health risks, Shelter, Sanitation and Mental health.

Acknowledgement

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Figure 3 Groups of indicators and their associated environmental health indicators in Slovakia (according to WHO, 1999)

Group of indicators	Indicators
Human impact on environment and health	1. human activities in forests with an impact on air 2. impacts of human activities on land with implications for human health 3. mining with impacts on human health 4. energy with human health impacts 5. impacts of human activities on water with implications for human health 6. development of green infrastructure
Sociodemographic context	1. population growth in relation to health 2. non-working dependent population 3. poverty 4. vulnerable populations 5. health habits 6. welfare
Air pollution	1. air pollutants from the combustion of solid fuels 2. air quality management with impact on human health 3. sources of indoor air pollution 4. air pollutants in urban areas
Toxic Substances and Hazardous Wastes	1. management of land with contaminated soil 2. management of a contaminated water body 3. an area contaminated with toxic substances by a major source of pollution 4. toxic substances in the human body
Noise	1. excessive noise in the workplace 2. excessive noise from restaurants and night-time establishments 3. excessive noise in urban settlements 4. the effect of high noise intensity on human health
Radiation	1. cumulative radiation dose 2. cosmic rays 3. X-rays in medical facilities
Access to safe drinking water	1. diseases from water 2. drinking groundwater quality
Food safety	1. monitoring chemical hazards in food 2. consumption of food quantity
Agenda 2030	1. meeting the objectives of the health agenda
Occupational health risks	1. exposure to hazardous workplaces
Solid waste management	1. disposal of municipal solid waste
Vector-borne diseases	1. spread of vector-borne diseases in Slovakia

types of Slovak landscape from the early prehistory to the present.

Author´s Contributions

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Ethical Issue

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No

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The Conative Dimension of the Social Worker's Personality

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Original Article

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Abstract:

Objective: The aim of the research is to identify the essential conative attributes of the social worker's personality necessary for the practice of the profession, as they encourage effective interaction with social work client. At the same time, to find out the perception important social worker will qualities by university students of social work in the line of acceptance of professionalism, prosociality and motivation to apply themselves.
Design: Qualitative analysis, focus groups method.
Participants: The research sample consisted of four focus groups, together 30 undergraduate full-time bachelor's and external master's students Faculty of Social Sciences, Institute of Social Work and Social Policy, University of St. Cyril and Methodius in Trnava.
Methods: We applied guided group discussions, using focus groups as the data collection method.

Results: The intention was to identify a key aspect for the development positive character dispositions of the helping professional. The results of the qualitative analysis confirmed the necessity of high internal motivation for prosocial behaviour. Focus groups participants reported that interest in the profession of social worker is preferably associated with an internal motivation to help others. The intrapersonal disposition is individual, authentic and non-transferable. Results identified motivation and self-regulation as essential conative dimensions.

Conclusion: Create educational module for university students of social work to support the conative dimension of personality. The conative dimension of a social worker's personality plays a fundamental role in provided intervention quality. It is necessary to continuously develop and empower motivation to positive will qualities through social-psychological trainings, webinars, supervision meetings.

Introduction

The conative dimension of personality represents that part of personality which relates to willpower, goal-directed action, decision-making and motivation to act. It is actually an aspect of the psyche, influencing the individual's initiative, guiding and maintaining behaviour in order to achieve selected goals. Will means the range of psychological qualities and processes that lead to the achievement of goals, especially when one needs to overcome barriers in order to gain them. This is crucial for the social worker. Positive dispositions of the conative dimension of personality are associated with individual qualities such as patience, goal-orientation, responsibility, perseverance, decisiveness, initiative, consistency, principle, self-control, self-esteem, independence, creativity, bravery, and the ability to complete tasks, among others (Kopecká, 2011).

The aim of this paper is to reflect on the conative dimension of the helping professional's personality and emphasize the necessary character qualities needed for a successful helping intervention. We perceive the conative dimension of personality primarily in attributes such as motivation, goal-orientation, endurance, and self-regulation. Motivation has a major influence on behavior, specifically external motives, identified as impulses, e.g., reward, recognition, and internal so-called incentive motives, which include self-actualization, personal growth. Motivation naturally encourages a person to act. In addition, the helping professional should have a sense of purpose so that he or she is able to set goals and work systematically towards them. Furthermore, endurance, that demonstrates his resilience to barriers, the ability not to give up in the face of partial failures. An important feature of the helping professional in social work is self-regulation in the sense of control of emotions and behaviour. Equally essential is to act independently and make decisions without accepting external pressure. In principle, the conative side of personality should express a balance between spontaneity, impulsivity and decisiveness in planning, decision-making and action. This is the privileged capital of the helping approach that stabilizes the client.

We are based on the scientific knowledge that not only inborn genetic factors, but also the environment significantly contribute to the formation of personality (Thorová, 2015).

Allport (1937) say the personality of an individual is the mode of adjustment or survival that results from interaction of his organic cravings (segmental drives) with an environment both friendly and hostile, through intermediation of a plastic and modifiable nervous system. Therefore, education has a formative influence on personality development, not excluding undergraduate preparation for a profession, while we

consider as relevant a person's continuous interest in self-assessment. The ability to self-reflect is an essential component of social worker personality preparation. This dimension is fulfilled in social psychological training in self-knowledge and communication skills. We formulated the research problem as follows: University students of social work perceive the importance of forming the conative side of personality in significantly unclear outlines in the perspective of meaning.

Methods and selected theory

The basic method of the qualitative research, focus groups discussion was used. We were doing content analysis data that we gathered through focus group discussions. We used method of searching and labelling relationships. It means when participants put certain selected phenomena in context. We say about shared product of the participant and the researcher (Masaryk, 2021). The researcher is not a disinterested observer but a key instrument of analysis.

In the transcribed focus group interviews, we used open coding to systematically search for themes, differentiate attitudes, narratives and emotional frames. By thematically decomposing the text, we selected categories that we interpreted in relation to the research topic (Hendl, 2016). Participants were asked open-ended questions designed to gain their opinions according to selected discussion line and categories. We recorded the frequency of narratives and words with concrete feature towards the topic.

A broad-spectrum theory differentiation of personality characteristics usually recognizes several dimensions in which they are identified in external manifestations of behavior. A dimension of intelligence expressed in the cognitive processes of perception, imagination, thinking. The vitality of behaviour and feeling is characterised by temperament, the key point being the strength and dynamics (speed and rhythm) of psychomotor reactions. The specific dimension of personality is the will as an authentic disposition of man, the evolutionary highest form of behavioural regulation. It is associated with human character as a complex of external manifestations of personality, actions and patterns of behavior (Nakonečný, 2015).

Zelina (2004) notes Royce's theory of personality, which distinguishes sensory-motor, cognitive and affective systems, and a style-value system. The last one is the least genetically, but much more environmentally and educationally primarily determined. In other words, external control regulates human behaviour.

The basic research concept focuses on the conative dimensions of personality as the will-related ranges of an individual. They relate to aspects of life associated primarily with goal-directed action and motivation. Conativity (from Lat. conatus - effort, trying) refers to an individual's ability to initiate, regulate, and maintain behavior in order to achieve certain goals.

First topic in goup discussion was selection the crucial conative dimensions of personality as a basic professional qualities social worker There were selected categories:

- *Motivation (internal, external),*
- *Intentionality* and *goal-orientation*,
- *Endurance* and *self-regulation*,
- *Autonomy* - a measure of independence in decision making and the ability to direct one's own behavior according to internal principles.
- *Behavioral energization* - the intensity and dynamism with which an individual performs actions (e.g., proactivity vs. passivity).

In this perspective, the structure of the focus group discussions had fixed in several lines.

- Conative dimensions as will ranges of the individual.
- Character qualities as a part of the helping professional's entity.
- Identified indicators of the conative dimension.
- Perception of the conative dimensions, character features as a necessary disposition of an erudite social worker.

The helping character entity

Human character significantly determines creativity, axiologization (values, attitudes), but especially all motivation to achieve goals. Zelina (2003) suggests that helping behaviour should

be *expressive* (hiding nothing) *adaptive*, but also *alimentary* (traditional, habitual) and *appetitive* (searching, exploration of experience). Character is formed by natural predispositions, but also by education, values or by experiences.

Allport (1937) points out: Traits are only covenient names to types or qualities of behavior which have elements uncommon. They are not psychological entities but rather categories for the classification oh habits. Character qualities are stable and long-term personality features, that influence behaviour, decision-making and interpersonal relationships. They are divided into four basic groups: *moral features*, *social features expressing relationships with other people*, *work features*, and *personality features expressing relationships with oneself*. In this context, we created the following codes:

1. *Moral qualities* - are usually expressed in relation to values and ethical rules. Research paticipants selected: Honesty, Responsibility, Fairness, Solidarity - willingness to help others, altruism, Humility - modesty, awareness of one's own limits.
2. The *social characteristics* - expressing mainly the relationship to other people. Informants included: Empathy, Sociability, Tolerance, Assertiveness, Patience.
3. About *work qualities* we talked in the context of the relationship to work and duties. Participants named Endurance, Discipline, Responsibility, Precision, Creativity.
4. *Personal qualities to oneself* - express the relationship to self. Were selected Self-esteem, Self-control, Courage, Optimism, Adaptability (cf. Hall, Lindzey, 1999; 2002, Čerešník, 2025).

The determination of will action

By describing the personality structure of the social worker, we base on the theory of personality features "The Big Five" - Extraversion (liveliness), Neuroticism, Conscientiousness, Openness to Experience, Agreeableness (Costa, McCrae, 1985; Deary, Matthews in Armstrong, 2009).

In this sense we reflected on the desirable will attributes necessary to successfully practice. The conative dimension of a social worker's personality is associated to motivation, will and purposeful activity in professional activity. It naturally influences approach to work, ability to cope difficult situations and to help clients effectively.

Research informants in focus group discusions selected the most necessary key *conative dispositions of a social worker. There were*:

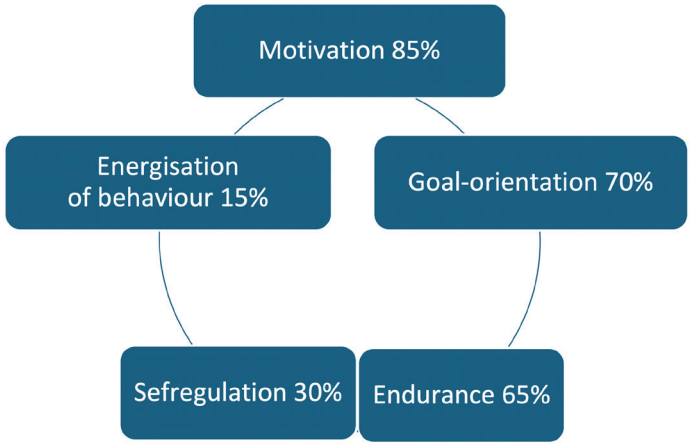
- *Internal motivation* - the need to help others, to improve their life situation.
- *Empathy* and *engagement* - the ability to empathize with the client's situation, without projecting, to actively participate in problem solving.
- *Endurance* and *resilience* - coping with frustration and persevering to achieve positive outcomes despite obstacles.
- *Self-discipline* and *responsibility* - ability to organize work responsibilities, be a reliable partner to clients.
- *Adaptability* and *flexibility* - ability to adjust to changing conditions, respond to individual client needs.
- *Teamwork* - willingness to work with colleagues, other professionals to achieve best results.
- *Ethical values and integrity* - acting in accordance with moral rules, emphasis on fairness, respect for human dignity

Especially in social work, the professional has to expect with overcoming external barriers as well as internal conflicts. The formation conative dimension of a social worker's personality is important in relation to effective and long-term work in this profession. It helps to maintain a balance between personal involvement and professional limits. Determination of will action means that each person's behavior is not random, but is influenced by a variety of factors. Primarily refers to the processes of making decisions and carrying out goal-oriented actions.

Results

Motivation, goal-orientation and endurance were identified in the in all focus groups as essential personality dimensions necessary for the practice of the profession.

Graph 1 The most perceived conative dimensions – ranges



(Source: author's own processing)

They perceived motivation as the most important conative dimension, determined by internal or external factors that encourage individuals to act (e.g., self-actualization, achievement, social recognition). They considered personal beliefs about one's own disposition to help to be essential. The impulse is a strong sense of helping others, founded on the desire to give a helping hand to people in difficult life situations. Also a sense of solidarity and justice. Therefore, we agree with the statement (Slastan et al., 2004), that social worker as advisor helps clients get insight into their attitudes, feelings and ways negotiations. However, personal experience also plays a significant part in motivation if one has gone through difficult life situations oneself, has seen a loved one struggle with psycho-social problems.

We share Hvozdik's (1986) claims that personality formation is actually more or less the shaping of motivational lines and levels, the formation of life goal and the search for the meaning of life. Another important conative dimension is represented by purposefulness or intentionality. Based on the focus group discussions, the ability of the helping professional to set goals and work systematically to achieve them is essential. In addition, participants identified endurance and self-control. They identified it with the social worker's key ability to overcome barriers and regulate impulsive behaviour in favour of long-term goals. In addition, autonomy and self-regulation are also desirable. However, there is a danger that the social worker's decision-making and ability to autonomously manage own behaviour will be affected by interactions with individuals or social groups exposed to significant pressure of society. As a last key dimension, focus group participants included behavioral energization. That is, the engagement with which the Helping person undertakes activities (proactivity vs. passivity), intensity, and dynamism.

Naturally from presented conative dimensions, individual will characteristics are key. In this sense, focus group participants as essential selected a conative quartet individual quality: moral qualities, social qualities, work qualities, and qualities expressing a relationship with the self. Research participants highlighted a significant relationship between character qualities and required skills in a social worker.

Discussion and conclusion

The advantage of qualitative research investigation is the generation of new hypotheses, new understanding, and the creation of theory. The regularity of the data that we have gathered are a guarantee of validity (Masaryk, 2021).

According to the research study *'Conative Dimension of Attitude: An Investigation on Student Influencing Stimuli in Decision-Making*

Processes', among the physical, psychological, social and virtual factors that influence students' decision-making in choosing a university, the influence of virtual factors on students' decision-making resonates the most (Lixandru, Măiță, Shuleski, 2024). In the context of our research reflection, the interest in study social work is primarily associated with internal motivation. Virtual and marketing appeals had only a partial influence on their decisions.

Honzák (2022) points out that members of the helping professions invest much more in their work than just knowledge and skills. They invest a part of their personality. Especially co-

Table 1 Perception of character qualities as necessary dispositions of an erudite social worker

Personality features of the conative dimension	Participants bachelor level undergraduate education/ full-time form	Participants bachelor level undergraduate education/ external form	Participants Master's level undergraduate education/ full-time form	Participants Master's level undergraduate education/ external form
Moral qualities	X	X		
Social characteristics	X	X	X	X
Working qualities			X	
Relationship to oneself				X

(Source: author's own processing)

Table 2 Perceptions of specific social worker character qualities

Personality qualities that need social worker	Necessary skill/ frequency/ **almost always**	Necessary skill/ frequency/ **often**	Necessary skill/ frequency/ **sometimes**	Necessary skill/ frequency/ **rarely**
Patience	X			
Goal-orientation	X			
Responsibility		X		
Endurance	X			
Decisiveness		X		
Initiativite			X	
Consistency			X	
Essentiality		X		
Self-regulation		X		
Autonomy		X		
Creativity			X	
Bravery				X

(Source: author's own processing)

native dimension. Working with people and their sufferings is more demanding than working with non-living material. Empathy along the lines of sharing the client's story and emotions is expected. Reflection that requires authentic personality characteristics of the helping person. The client's surrendered pain may be half, but it should be added that the other half remains in social worker.

Leskova, Mahrik, Janiga (2024) in this sense say, that the human need for acceptance and love is a fundamental and enduring aspect of the human experience, persisting throughout the lifespan.

The conative dimension of personality relates to will, motivation, goal-orientation and the tendency to act. It is a willful extension that corresponds to how one approaches actions, decisions, and problem solving. Conative qualities are different from the cognitive (thinking) and affective (emotional) aspects of personality.

We have created essential social-psychological educational modul, that is need for involment in study programme. It would prepare social work students continously encourage to gain knowlede about themselves. The basic aim of the module is to include training in psychosocial eduacational area. Selected the most repeated narratives from research informants:

Motivation – *„We think, that is needed an internal or external force that stimulates behavior and decisions. The most important element in relation to the social work profession. "*

Willpower and self-discipline scored lower in the focus group participants' ratings. However, this was mainly because, of the qualities offered, goal-orientation more significantly expressed the helping intervener's priority in the sense of goal setting and systematic orientation. Research informants share:

The initiative – „It is necessary the ability to act and take professional responsibility without the requirement for external impulses. Sensitively guiding the client, courage and decisiveness. Quick and effective decisions. "

Endurance – „We perceive as a great disposition, willingness to continue to act despite barriers and failures. "

Autonomy – „Social worker must possess the ability to act independently without the need for continuous guidance. "

Adaptability – „Necessity to handle difficult situations. Flexibility to adapt to new situations and challenges. "

Berry (2009) points out that conative dimension of personality is often studied in work psychology. Most often in the context of motivation and self-development, as they are closely connected to an individual's efficiency and effectiveness. We can say it depends from a special individual conative mechanism that plays an important role in the formation of a psychologically personality resilience. Is the consciousness of self-efficacy, the subjective idea of one's own ability to control and manage one's own life. This is a key element of a mature personality.

Self-efficacy beliefs are associated with successful coping with difficulties and stress, health-enhancing behaviors, and better handling of cognitive tasks (Thorova, 2015).

Blatný and Plháková (2003) indicate that the conative component of personality is closely connected with self-regulation, i.e. the ability to control one's behaviour, emotions and thoughts in order to achieve goals. The results of the research study confirmed that participants' reactions to their own human behaviour can be material or evaluative. Material ones motivate the individual, for example, to engage in activities would not otherwise do or would prefer to avoid them. In the case of interest in the social work profession, the evaluative reaction, which is just associated with self-regulation, is particularly exposed. It brings the satisfaction of maintaining certain human and social standards and one's own self-esteem.

Used content analysis through focus goups in social-psychological optics reflects finding the so-called ideal identity in the personality of the help person. It is characterized by a deep understanding of one's own person, flexibility, an active approach to life, a perception of one's own effectiveness and resilience to social pressures. Aimed narratives showed: *„Social workers need positive self-perception, communication skills, self-confidence, the ability to make realistic plans, and an interest in new and professional experiences predetermine the development of the*

helping professional. "So the results of our research study concerning the appropriate conative dispositions of a social worker can be identified with Jung's personality typology. The personality need have some preferences. Relationship to other people, disposition to gather, convenient evaluate informations and make decisions base on understanding (Armstrong, 2009).

We agree with statement Svatošová (2011) that te helping professional has to own himself. We think its necessary to achieve this elementary conative level for encouraged prosocial guided helping action. In addition group discussions evaluted the basic imperativ about specific conative dimension erudite social worker: *„The most important is avoid a restrictive relation with the client! "In* intervention engagement of social worker, should apply the principle of moderation. The extremes of compulsive helping packaged in self-offering for the client, taking responsibility for solving his own problems, as well as a superficial helping exposure, are a manifestation of a low coefficient of the conative dimension of personality. Moderation is a fundamental character quality in professional engagement, accompanied by a continuity of erudite and pro-social action. At the same time the helping professional must focus on the self in order to be able to use all the positive dimensions of one's own existence (personality entity) for the client. Moderation leads the helping professional to apply help in a balanced measure in the right way.

From this reason is important to enhance the hours of practical education in confrontation with the client of social work. Trainings aimed at self-awareness, self-regulation and endurance. This is an essential element in the development of the ability to regulate one's own behaviour with a helping accent towards the social work client. In addition, informal team building and burnout prevention programs are important in support mental health, also volunteering activities that help internal setting for long-term work in the helping professions.

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Digital Transformation of the Pharmacy System from a Public Perspective: Implications for the Stability of Local Supply Structures

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Abstract:

Objective: This study examines how the digital transformation of the pharmacy sector—especially through telepharmacy, e-prescriptions, and AI-based systems—affects public health equity and the stability of local pharmaceutical supply structures, with a focus on the German context within the European Union.
Design: Mixed-methods policy analysis
Methods: A combination of systematic literature review, policy and regulatory analysis, and qualitative case studies from both urban and rural areas in Germany. Key documents included the Digital Healthcare Act (DVG), EU policy frameworks such as the European Health Data Space (EHDS), and national strategies from France and Poland. Thematic analysis was applied to identify major cross-cutting themes such as regulatory fragmentation, access disparities, and the evolving role of pharmacists.

Results: The digital transformation has significantly improved efficiency and access in urban centers through innovations like e-prescriptions and online pharmacies. However, rural areas suffer from inadequate digital infrastructure and limited digital literacy, leading to inequitable access. Regulatory fragmentation across EU member states further complicates implementation. While AI-driven systems enhance supply chain efficiency, they also introduce cybersecurity risks and threaten the existence of traditional local pharmacies, particularly in underserved regions.

Conclusion: Digitalization offers major benefits to pharmaceutical care but risks undermining public health equity and the resilience of local supply systems if not accompanied by inclusive infrastructure investment and harmonized regulation. To safeguard access and sustainability, especially in rural areas, targeted policy measures are needed—ranging from broadband expansion and GDPR support for small pharmacies to workforce training and funding for hybrid service models. A cohesive EU-level approach, combined with national investments like Germany's Gigabit Strategy and Pharmacy Future Act, will be essential to ensure that digital transformation strengthens rather than erodes local health systems.

Introduction

The increasingly growing technology is driving a massive change in the worldwide pharmacy sector, redefining prescription, dispensation, and drug management. The shifting patient needs and technological innovation drive this revolution in the European Union, particularly Germany. Germany has a Digital Healthcare Act (Digitale-Versorgung-Gesetz, DVG), which defines how digital instruments, such as e-prescriptions, telepharmacy, and artificial intelligence (AI)-driven record-keeping, are incorporated into the pharmacy sector (Maass, 2023). While the advancements have increased the efficiency of drug administration, they adversely affect the stability of local pharmaceutical supply models, causing inequitable access to medical services. Approximately 18,000 community pharmacy establishments in Germany serve as critical touchpoints and frontline healthcare systems (ABDA, 2024). Technological developments may disrupt the role of local pharmacies in connecting patients with healthcare services in rural and underserved regions where pharmacies are the sole medical access point. These stores may be left behind because of inadequate digital infrastructure and lower adoption rates. This paper examines the effect of digitalization on public health equity and supply chain resilience, focusing on Germany's experience as a European leader in healthcare innovation.

Theoretical Framework

The digital transformation of the pharmacy sector represents a paradigmatic shift in healthcare delivery that extends beyond technical innovation to broader public health concerns such as equity, resilience, and system fragmentation. Grounded in the frameworks of digital public health and health system resilience, this paper analyzes digitalization not only as a technological process, but also as a complex sociopolitical phenomenon with far-reaching implications for regional accessibility and structural justice (Maass, 2023; Yadav, 2024).

A central theoretical lens guiding this analysis is the concept of health equity in digital infrastructures, which posits that the availability and design of digital tools must support all population groups equally to avoid widening existing disparities (Bulaj et al., 2024; Kroenert & Bertsche, 2024). The application of telephar-

macy, e-prescriptions, and AI-powered logistics tools has undoubtedly improved efficiency in urban regions. However, these gains are offset by persistent structural barriers in rural areas, where gaps in broadband infrastructure and limited digital literacy restrict equitable access (European Commission, 2023; Eckert, 2024).

Moreover, the resilience of local supply systems is increasingly viewed through the lens of centralized versus decentralized care models. While AI-driven inventory tools and robotic dispensing systems offer logistical advantages, they can simultaneously endanger the operational viability of rural pharmacies, which serve as essential local care hubs (Burk et al., 2024; ABDA, 2024). This tension raises questions about the long-term sustainability of local pharmaceutical services within a rapidly digitizing system, especially in socioeconomically weaker regions.

Another relevant theoretical strand involves the shifting professional roles within healthcare in response to digital innovation. Pharmacists are increasingly expected to assume extended responsibilities, including patient counseling, chronic disease monitoring, and public health interventions. Yet, this expanded role is challenged by unequal access to training and technological resources, particularly in rural and underfunded settings (Maass, 2023; Marangwanda, 2024).

Finally, the regulatory and cybersecurity landscape introduces additional theoretical complexity. The lack of harmonized telepharmacy regulations across EU member states exemplifies regulatory fragmentation, which hinders cross-border interoperability and exacerbates systemic vulnerabilities (Stoumpos et al., 2023; Odenbach-Wanner, 2023). Additionally, the growing reliance on centralized data systems intensifies exposure to cyber threats, raising urgent questions about the balance between innovation and risk in public digital health (Traynor, 2024; Graf et al., 2024).

Taken together, these interrelated dimensions underscore the importance of integrating public health theory, health equity, and systems resilience into the conceptual framing of pharmacy digitalization. This framework informs the subsequent analysis of the empirical findings presented in this study.

Methodology

This research employed a mixed-methods design to investigate how digitalization affects the pharmacy sector, with a special focus on public health equity and supply resilience in Germany. This approach was preferred because it integrates quantitative and qualitative data to offer a detailed comprehension of the problems and prospects of digital transition in the pharmacy industry. The investigator performed a systematic review of peer-reviewed articles, industry reports, and policy publications to obtain information regarding e-prescriptions, AI-driven technologies, and telepharmacy. The key sources examined included the Digital Healthcare Act (Digitale-Versorgung-Gesetz, DVG), European Health Data Space (EHDS) initiatives, journals on health policy, infrastructure, policy development, and cybersecurity, and reports from the European Commission and ABDA (Federal Union of German Associations of Pharmacists). In addition, case study projects in rural Germany, such as Bavaria, were examined to evaluate the efficiency of digital tools in underserved regions. Finally, the researcher conducted a regulatory and policy analysis, in which a comparative assessment was performed to compare frameworks across the EU. The key regulatory models that were examined include Germany's DVG, France's Health Innovation 2030 plan, and Poland's e-Health Strategy, enabling the study to establish interoperability and fragmentation challenges within the union.

Data was analyzed qualitatively, with thematic analysis as the primary approach. This method, whose stages include data familiarization, initial codes generation, themes searching, themes reviewing, themes definition and naming, and production of the results section, allowed the researcher to determine recurring themes in the publications. The major themes that were extracted included inequitable access, regulatory fragmentation, and the shifting roles of pharmacists. The case study findings were coded and examined to obtain information regarding the successes and failures of digital pharmacy architectures in urban and rural settings. Although the mixed-methods approach enabled this study to obtain a comprehensive

understanding of digitalization has affected the pharmacy sector in the EU, it has limitations, including heavy dependence on secondary data limiting the depth of insights into specific local contexts, underrepresentation of data on rural areas because of limited reporting and structural changes, and the increasingly changing nature of digital technologies implies that some results may be updated with the emergence of new developments.

Results

In summary, the digital transformation of the pharmacy sector in Germany and across the EU has introduced far-reaching changes that impact not only pharmaceutical service delivery, but also public health structures and regulatory stability. This section presents the key findings of the study and is structured around three core dimensions: First, we examine how digital innovations—such as e-prescriptions, telepharmacy, and AI-driven systems—are reshaping pharmacy operations and infrastructure. Second, we assess the public health implications of these changes, with particular attention to access, equity, and the resilience of local supply structures. Finally, we address the broader challenges and risks associated with digitalization, including regulatory fragmentation, infrastructure gaps, and cybersecurity vulnerabilities. Together, these aspects reveal both the transformative potential and the structural tensions that accompany the digital evolution of pharmacy systems.

Digital Transformation in the Pharmacy Sector

E-Prescriptions

Electronic medication prescription is a critical development in the digital pharmacy systems, with Germany passing the mandatory e-prescription requirements. This advancement is managed by Gematik, streamlining the medication process to reduce errors and improve patient convenience (Hareem et al., 2023). Compared to the paper-based system, e-prescriptions allow healthcare providers to share patients' prescription records with pharmacy computers electronically, decreasing medication faults and instances of callbacks by pharmacists for clarification (Lösch et al., 2022). Similarly, this method has improved the clinical practice workflow, boosted patient contentment and compliance, and decreased paperwork and related mistakes in handwritten notes. Nonetheless, Alhur et al. (2024) claim that e-prescription is associated with challenges, including delayed adoption because of interoperability issues between different healthcare structures and limited access among elderly patients and those who lack digital knowledge, negatively influencing healthcare equality. Regardless of these challenges, the increasing technological adoption in Europe, which is driven by the European Health Data Space (EHDS), will make e-prescriptions the standard across the region.

Online Pharmacies and Telepharmacy

Other developments that have changed the pharmacy landscape include online pharmacies and telepharmacy. Germany recorded a 30% increase in online pharmacies in 2022, allowing patients to conveniently order drugs from home at affordable prices (Almeman, 2024). This model has been supported by reliable internet access in the country. However, it threatens the brick-and-mortar pharmaceutical stores in rural areas, which have started to record declining foot traffic – most people order medicine online (Kroenert & Bertsche, 2024). Conversely, telepharmacy allows patients to consult healthcare providers remotely and acquire drugs, possibly sustaining pharmacy services in underserved areas. Mekurianew Kelkay (2024) performed pilot research in rural Bavaria and demonstrated telepharmacy's efficiency in enhancing medication access among community members. However, this development can only be successful if patients willingly adopt new technologies and the digital structure is robustly developed in rural and isolated communities.

Automation and A-Driven Systems

Automation and AI-driven systems, including robotic dispensing mechanisms, have revolutionized pharmacy processes in urban sectors. These systems automate drug sorting and packaging in large pharmacies, decreasing human

mistakes and increasing medication prescription and management efficiency (Yadav, 2024). Because these technologies require enormous financial investments, their adoption in smaller facilities is limited. Furthermore, AI technologies significantly change drug supply chain operations by decreasing wastage and maximizing stock levels through historical data analysis and demand prediction capabilities (Burk et al., 2024). Nonetheless, they depend on centralized data systems, which are susceptible to cyberattacks, the occurrence of which may disrupt the supply chain processes.

Public Health Implications

The digital transformation of the pharmacy sector has positive and negative effects on healthcare systems' access, equity, and resilience. The positive implications of these tools include enhanced efficiency and patient convenience. Conversely, they are associated with challenges concerning care access equity and supply chain resilience that must be addressed from their seamless adoption in the local sector.

Access and Equity

While automated pharmacy structures, including telepharmacy and e-prescriptions, can enhance healthcare and medication service access, their benefits are unevenly distributed in local and underserved communities. For example, while the German government advocates for the mandatory roll-out of e-prescriptions to streamline medication access, the implementation is only concentrated in urban centers, such as Berlin and Munich (Lösch et al., 2022). Rural towns with poor digital infrastructure, such as Mecklenburg-Western Pomerania, have low adoption rates. According to Bulaj and colleagues (2024), 23% of rural German cities lack dependable broadband access, negatively affecting e-prescription utilization. Similarly, while the EU's EHDS aims to harmonize health systems and structures across member nations, there are disparities in digital preparation between states, such as developed Germany and less advanced Bulgaria and Romania, further increasing health disparities (European Commission, 2023). These regions require ongoing investment in technological infrastructures to ensure equitable access to digital pharmacy systems in urban and rural areas.

Supply Chain Resilience

Healthcare facilities and pharmacies optimize their supply chains through digital tools, including AI-driven inventory management. While this advancement allows pharmaceutical firms to eliminate and reduce waste, it is associated with centralization risks and causes rural pharmacy closures, potentially destabilizing local supply systems (Yadav, 2024). For example, Germany has adopted centralized technological mechanisms, including TI-Connect (Telematikinfrastruktur), to improve its healthcare efficiency. However, they increase dependency on digital frameworks, which are vulnerable to cyberattacks. The negative effect of this overreliance on digital systems is demonstrated by a breach of North Rhine-Westphalia hospital networks in 2022, which disrupted drug distribution (Traynor, 2024). Moreover, the increased presence of online pharmacies and automation tools fostered the closures of rural stores in Germany, with approximately 500 rural pharmacies closing between 2020 and 2023 (ABDA, 2024). The closures left many communities without access to medications, destabilizing the welfare of regions with limited transportation options and a high presence of older citizens.

Shifting Roles of Pharmacists

The increasing digital transformation of the healthcare sector has changed the role of pharmacists from drug administration and dispensation to health management and counseling. This transition ensures enhanced patient care; nevertheless, it causes challenges to workplace education and resource distribution. According to Maass (2023), 60% of German pharmacists complain of limited training in applying digital tools, such as electronic prescriptions. The skill gap prevents these professionals from harnessing the potential of digital technologies to improve patient care and increases disparities between rural and urban pharmacies (Marangwanda, 2024). Although the expanded pharmacists' role, facilitated through digital tools, en-

ables them to perform activities such as chronic disease management and distribution of tests during pandemics such as COVID-19, it demands additional training and resources, which are scarce in rural settings.

Cybersecurity and Data Privacy

Cyber attackers target digitalized pharmacy systems, adversely affecting public health. To decrease these occurrences, the General Data Protection Regulation (GDPR) imposes strict requirements for pharmacies when handling patient data. These impositions, such as ensuring privacy and confidentiality of information, create administrative burdens for small stores, as proved by Graf et al. (2024), who determined that 40% of German pharmacies in rural settings struggle to meet the GDPR requirements. In addition, criminals may target these digital systems, disrupting operations and affecting patient care outcomes. For example, the cyberattacks on the North Rhine-Westphalia hospital networks and a 2021 attack on German pharmacy chains adversely affected service delivery for days, with personnel resorting to the traditional handwritten record-keeping method, which is non-reliant and error-oriented (Traynor, 2024). These incidents underscore the need for robust cybersecurity measures, which rural pharmacies may not afford because of a lack of financial capabilities and poor architecture.

Challenges and Risks

Regulatory Fragmentation

The European Union lacks harmonized policies on cross-border services, such as telepharmacy, complicating the implementation of digital pharmacy systems. Firstly, the region has divergent national regulations (Marangwanda, 2024). For example, the digital policies between Germany and France differ, yet they are members of the EU. While Germany has enacted the Digitale-Versorgung-Gesetz, which promotes telemedicine practices, France has adopted a dissimilar Health Innovation 2030 plan that advocates for AI-driven healthcare solutions (Stoumpos et al., 2023). Furthermore, Poland has an e-Health Strategy that emphasizes electronic health records. The distinct goal fragmentation of these digitalization plans prevents interoperability and cooperation among EU nations. Similarly, they hinder the success of EU initiatives, such as the EHDS (Odenbach-Wanner, 2023). Moreover, the EU has a cross-border healthcare directive to facilitate access to healthcare services across its states (Hareem et al., 2023). Nevertheless, different telepharmacy regulations in member states, such as Italy, restrict the online supply of prescription drugs. These variances affect the implementation of the EU's directive.

Digital Infrastructure Gaps

Rural areas in Germany have less developed digital architecture, which prevents the adoption of mechanized pharmacy systems. For example, while urban areas boast strong broadband access, rural regions have unreliable access (Kroenert & Bertsche, 2024). Germany implemented the Gigabit Strategy 2025 program to increase internet connectivity (Eckert, 2024). Nonetheless, regions, including the Harz Mountains and parts of Brandenburg, have undependable broadband access because of low-capacity transmission technologies. This poor internet connectivity prevents approximately 23% of rural Germans from leveraging electronic prescription technology (Eckert, 2024). Similarly, the European Union implemented the EU's Connectivity Toolbox to address regional structural indifferences (European Commission, 2023). However, the implementation of this program has been slow in Eastern Europe, with broadband coverage in nations such as Romania remaining below the average. The delayed execution and progress of the EU connectivity initiative restricts the application of digital pharmacy systems in rural EU areas.

Cybersecurity and Data Privacy Risks

The increasing automation and digitalization of drug prescription and supply systems elevate susceptibility to cyberattacks and have implications for the privacy of patients' data. These vulnerabilities caused the GDPR to impose strict rules on how people handle patient data, such as creating strong encryption systems (Europe-

an Commission, 2023). Small pharmacies' low financial access prevents them from developing a robust security fabric; thus, the GDPR's regulations pose administrative burdens for them. A study by Hareem (2023) determined that rural area pharmacies struggle to comply with GDPR. Besides, digital pharmaceutical tools are exposed to malware attacks, which may affect their operations and patients' access to care (Traynor, 2024). The ransomware attack on German pharmacy chains and similar incidents in Ireland's health service delayed medication prescriptions for days. These incidents can be prevented through a robust cybersecurity framework, which, unfortunately, small pharmacies in local areas may not be able to afford.

Discussion

This project synthesized current publications and policy developments to offer comprehensive insights into how digitalization reshapes pharmacy systems in the EU. Digital advancements in the pharmaceutical sector, including e-prescription, have improved efficiency and care accessibility. However, these developments have introduced challenges, such as internet security risks and architecture disparities, adversely affecting equitable access, especially in rural regions. These concerns can be addressed when EU governments reconcile their policies, prioritize digital structure investment in rural locations, and sustain local pharmacy frameworks. Implementing these strategies will enable member states, including Germany, to harness the benefits of digital enhancements and protect the healthcare systems' resilience. These initiatives require a partnership between nations and the EU that is dedicated to inclusivity and equity during policy implementation. The evolution of the pharmacy sector requires prioritization of vulnerable populations in underserved areas, allowing the EU to become a leader in developing a digitalized pharmacy framework that improves public health and sustains the stability of local supply models.

The fragmented fragmentation within the EU's digital technology infrastructure requires a comprehensive and coordinated solution. For example, the region should harmonize by increasing EHDS coverage and aligning national regulations (European Commission, 2023). The EU should have regional standardized electronic prescription formats and telepharmacy rules. The member states should align their digitalization strategies with those of the EU's Cross-Border Healthcare Directive (ABDA, 2024). In addition, Germany can accelerate its Gigabit Strategy 2025 to mitigate the poor digital architecture issue. This suggestion can be achieved by securing more funding from the EU and altering its rollout plan to prioritize connectivity in rural areas (Eckert, 2024). Moreover, resources from the EU4Health and Digital Europe programs can support structure expansion in rural areas (European Commission, 2023). These initiatives will allow Germany to support universal access to digital pharmacy services.

Other recommendations to address the concerns include strengthening cybersecurity and data privacy, supporting workforce training, and sustaining local pharmacy models. Firstly, Germany can offer GDPR support by establishing regional hubs in rural areas to ensure compliance among small pharmacies (Burk et al., 2024). Secondly, the EU nations should revise their healthcare training curricula to incorporate AI-driven systems and telepharmacy education (Kroenert & Bertsche, 2024). Lastly, Germany can prevent local pharmacy closures by availing financial incentives, such as grants and subsidies, through its Pharmacy Future Act (Apothekenzukunftsgesetz) (Maass, 2023). These strategies will ensure the safety of local pharmacies' digital frameworks, ensure the personnel is trained on these advanced models, and prevent their closures because of delayed adoption and lack of funding.

Conclusion

The digital transformation of the pharmacy sector offers major benefits to pharmaceutical care but risks undermining public health equity and the resilience of local supply systems if not accompanied by inclusive infrastructure investment and harmonized regulation. To safeguard access and sustainability, especially in rural areas, targeted policy measures are needed—ranging from broadband expansion and GDPR sup-

port for small pharmacies to workforce training and funding for hybrid service models. A cohesive EU-level approach, combined with national investments like Germany's Gigabit Strategy and Pharmacy Future Act, will be essential to ensure that digital transformation strengthens rather than erodes local health systems.

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Global Health Impact from Climate Change (For Social Sciences in Health)

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Original Article

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Abstract:

The phenomenon of climate change is impacting the plant with notable effect. Polar ice is melting, ocean levels are rising, daily temperatures are increasing, forest fires are burning longer and destroying more residential areas, and urban air quality levels are deteriorating. At the same time, human health is experiencing the effects of exposure to changing climate. Research has indicated that extreme climactic conditions can shorten life expectancy and impact cardias, respiratory and mental health as well as facilitating the spread of some infectious diseases. The health related impacts of climate change merit serious attention in the patient and provider communities.

Introduction

Climate change is a global reality. February and March 2024 were the warmest of those months globally. (The Guardian, 2024). The physical evidence is readily apparent and the era of climate change skepticism should be in the past. Along with the physical manifestation of climate change should come the realization that human health is also impacted by climate change.

With climate variability and change, there are increased health risks impacting quality of life at the individual level. Population health is also impacted by weather variability. A wide range of climate-sensitive health outcomes are related to altered weather patterns, heatwaves, wildfires, floods and droughts, water quality and food insecurity. Without proactive outcomes to measure climate change, the burden of disease will increase. Climate change impacts food and water security through its impact on agriculture, food, health, biodiversity loss, soil degradation, land use and fresh water depletion.

Climate change poses a global challenge resulting in increased prevalence of acute and long term diseases. Changing patterns of infectious diseases are noted along with vector borne diseases. Some climate-sensitive infectious diseases include malaria, dengue fever, Lyme disease, West Nile virus and diarrhea diseases.

According to the World Health Organization (n.d.) environmental health „is concerned with preventing disease, death and disability by reducing exposure to adverse environmental conditions and promoting behavior change. It focuses on the direct and indirect causes of disease and injuries and to resources inside and outside the healthcare system to help improve health outcomes.“ The United Nations (n.d.) has formulated 17 Sustainable Development Goals (SDGs) in working with the global community related to a 2030 global agenda. Some SDGs have a very direct link to climate change and health:

- Goal 6: clean water and sanitation
- Goal 7: Affordable and clean energy
- Goal 13: Climate action

Each of these goals has specific targets and activities. These goals impact health directly. For example, the third leading cause of death in low and middle income countries is COPD. Climate change has an enhancing effect on the poorest countries in food production and food supply. The effects of climate-sensitive change can be studied by level of impact at three levels: household, the community, or globally. Furthermore, there are cost effective ways of reducing the global burden of environmental health problems.

Discussion

According to the US National Oceanic and Atmospheric Administration (NOAA) (2021), indications of climate change are: an increase in global temperature of 1ºc from 1901 to 2020; a rise in sea level of 3.2mm per year since 1993; shrinkage of glaciers depth by more than 60 feet since 1980, a shrinkage of the area covered by Arctic sea ice of approximately 40% since 1979; an increase of atmospheric carbon dioxide of 25% since 1958 and earlier snow melt compared to long-term averages.

The Environmental Protection Agency (EPA) (2019) reports that in the month of July 2019 alone, Greenland lost over 197 billion tons of water from melting ice sheets. In the same report, the agency quoted the New York Times (December 12, 2018) as asserting that extreme rainfall, and the extreme lack of it, affects untold numbers of people, taxing economies, distrupting food production, creating unrest and prompting migrations

The EPA indicated that „it is extremely likely (>95%) that human activities have been the dominant course of that (global) warming“. The EPA claims that „Human activities have contributed substantially to climate change through greenhouse gas emissions and reflexivity or absorption of the sun’s energy.“

According to the National Institute of Environmental Health Sciences (NIEHS) (2021):

Climate change impacts human health in both direct and indirect ways. Extreme heat waves, rising sea levels, changes in precipitation resulting in flooding and droughts, and intense hurricanes can directly cause injury, illness and even death. The effects of climate change can also indirectly affect health through alterations

to the environment. For example, worsening air pollution levels can have negative impacts on respiratory and cardiovascular conditions. Changes in temperature and rainfall can alter the survival, distribution, and behavior of insects and other species that can lead to changes in infectious diseases.

Writing in the open access journal PLOs Climate, Amit Roy claims that „the cost of climate changes may take six months off the average human life span.“ (Public Library of Science, 2024). According to the World Health Organization (WHO) (2023) approximately 3.6 billion people are residing in areas „highly susceptible to climate change“. The WHO also estimates that between 2030 and 2050 climate change will cause an additional 250,000 deaths annually from undernutrition, malaria, diarrhea and heat stress alone. Asia Today (2024) estimates that climate change will cause four million deaths in 2024.

In a report entitled „Addressing climate change and health in the Europe and Central Asia region,“ the WHO (2024) states:

Climate change is one of the greatest threats to human health worldwide, and the risks are on the rise. It threatens the essential ingredients of good health- clean air, safe drinking water, nutritious food supply and safe shelter- and has the potential to undermine decades of progress in health, globally, regionally, nationally and locally.

In Africa, Opaku, Filho, Hubert et al (2021) surveyed health professionals in six countries (Ghana, Nigeria, South Africa, Namibia, Ethiopia and Kenya) and found that 93 persent of respondents indicated that climate change had been experienced in their country. Respondents indicated their belief that inadequate resources existed to combat climate change and that there was a need to improve the skills of health professionals.

The study pointed to extreme weather events in Africa which have resulted in an increase in malaria and other „vector-borne“ diseases. Drought and its impact on food production and food supply has also been cited (ibid).

Irfan (2012) looked at differences between the ages of death and life expectancy due to temperature extremes in Australia. He cited research by Adrian Barnett of Queensland University of Technology in Australia who looked at temperature-related fatalities in the city of Brisbane over an eight year period. In looking at deaths on days when the temperature dropped to 10 degrees celsius or rose to 30 degrees Celsius, Barnett determined that the deaths in Brisbane resulted in a reduction in expected life years for both men and women

Peters and Schneider (2020) assessed the impact of cold and heat on myocardial infarctions for two time periods: 1987-2000 and 2001-2014. They noted that in the earlier period, myocardial infarctions were brought on by „cold exposures only“. During the second period they observed „significant effects of temperatures less 18ºc on the risk of myocardial infarction.“ They wrote that the increased risk was „attributable to the greater vulnerability to cardiovascular disease of individuals with Type 2 diabetes mellitus or hypertension.

Jacobsen, Khiew, Duffy et al (2022) noted that „climate change-related cardiovascular disease is mediated by air pollution, increased ambient temperatures, vector-borne disease and mental health disorders.“

The American Lung Association (n.d) cautions:

Climate change creates conditions, including health and stagnant air, which increase the risk of unhealthful ozone levels. Ground level ozone, often called smog, forms in the atmosphere when gases emitted from sources like smokestacks and tailpipes mix in the air. Hotter weather and stagnant air create conditions that make ozone more likely to form.

The association also cautions that climate change can increase the level of allergens:

As temperatures rise, plants produce more pollen, increasing ragweed and other allergens…. Warmer temperatures also allow allergens to flourish in new regions and for allergy seasons to last longer.

According to Jacobsen et al, solastalgia „refers to the distress that is produced by environmental change while climate anxiety refers to the typical anxiety symptoms such as obsessive thinking, insomnia and panic attacks related to the global climate crisis and the threat of environmewntal disaster.

In addressing the mental health impact of climate change, the Commonwealth Fund (2023) states that experiencing an extreme weather event can be „traumatizing." The Fund states that:

The destruction, loss and displacement people experience can sometimes lead to an array of mental health problems, from anxiety and feelings of helplessness to depression, post-traumatic stress disorder (PTSD) and suicidal thoughts.

The Fund also states that those at higher risk of experiencing mental health issues resulting from climate change are people of color, the homeless, young children and older adults.

Conclusion

Weather and climate disasters are increasing death rates and impacting all regions of the world. Aside from the actual natural disasters, there are latent implications and effects. Environmental risk impacts occur at different levels and require different adaptive strategies to mitigate adverse effects. The key essential latent health issues are: the lack of safe water and sanitation, poor access to hand washing facilities, household air pollution and ambient particulate matter pollution. Efforts are needed to reduce water disease especially diarrhea and parasitic diseases.

All health systems and organizations have a responsibility to address climate change health related issues by mobilizing the community and implementing sustainable initiatives. The importance of SDGs must be realized and embraced to collectively impact climate-sensitive health problems. Disaster and climate related health have an impact on the economic stability of healthcare providers and systems. There are impacts on workforce employment, ED use, hospitalization rates, length of stay (LOS), supply chain management, drugs, medical devices, ventilator usage, IV bags and microchips. There are opportunities to effect meaningful change in the healthcare system and community through sustainable and resilience interventions. Some examples include increasing the need for accurate information based on science, improved health literacy, addressing concerns over conflicts about resources, and changes in health policy. There is a cost to be paid for inaction and measurable benefits to taking action. There will be interactions between climate and migration patterns, demography, socioeconomic factors and ethical concerns. Health protections are needed along with strong efforts at prevention strategies and preparedness strategies.

When discussing climate related health changes, adaption and mitigation can be transformational. Adaptation „is a process of adjustment to actual or expected climate change and its effects. In human systems, adaption seeks to moderate or avoid human or exploit beneficial opportunities." (Eli & Hess, 2024). Concrete examples include providing the workforce with climate resilience knowledge, health information system, risk management, adequate financing to limit indirect health effects, and mental health services as needed. Adaptation can involve modifying existing systems, creating early warning and response systems, early outbreak detection. As noted by Berry, Enright, Shumake-Guillemat, et.al. (2018) „Key approaches to understanding and managing the health risks of climate change include conducting vulnerability, capacity, and adaptation assessments and developing the health component of national or regional adaptation plans. Increasing public awareness is an essential strategy along with the use of implementation science. Finally, hospitals and health systems are positioned to „effectuate positive and widespread change" to impact the effects of climate change. (Wade, 2023).

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Social Work in a Changing World: New Challenges and Perspectives

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Original Article

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Introduction

Holistic Perspectives on Social Work, Education, and Human Well-Being

A prevailing consensus in academic discourse emphasizes the need for a holistic approach to social work and healthcare—one that integrates physical and mental health, community engagement, and social services into a cohesive framework. This journal embraces a complementary methodology, where research papers with distinct yet interconnected focal points collectively present a more comprehensive understanding of these critical matters. This approach not only broadens the discourse but also illuminates a resurgence of interest in the role of spirituality as a fundamental element in enhancing human well-being and fostering resilience (1,2).

By weaving together research from multiple disciplines, this issue aims to provide deeper insights into the evolving landscape of social work and health, underscoring the importance of innovative strategies and ethical considerations

in shaping policies and practices that uphold human dignity and social justice.

The Human Focal Point

In contemporary society, the field of social work is confronted with challenges that encompass policy frameworks, economic transformations, and the diverse needs of individual clients. These challenges necessitate multidisciplinary approaches and innovative solutions (3). Within this intricate ecosystem, the human being occupies a central and exclusive position. This is not only as the catalyst for its own development and the initiator of sustainable growth, but also as the ultimate objective of all endeavours aimed at its empowerment, healing, and meaningful development (4). The ability of a society to address the challenges it currently faces, which are evident across all continents, cultures and political-economic formations, is contingent on the presence of healthy individuals and functioning social entities.

The recent global Covid19 pandemic, which has brought new phenomena in social work that require increased attention (5), is just one example of the challenges that have confronted the world in recent years. This crisis has underscored the critical need for adaptive policies, interdisciplinary collaboration, and sustainable support systems to address emerging social vulnerabilities and inequalities (6). A pivotal aspect of this transformation is the increasing integration of digital tools in social support, particularly within the realm of mental health. Digital platforms have become indispensable for fostering connection and emotional expression, highlighting the necessity of incorporating technology into contemporary social work practices (7). However, the growing reliance on digital engagement also presents significant challenges. As social work continues to intersect with digital environments, a nuanced understanding of both the advantages and limitations of online interactions is essential for the development of effective and equitable support strategies across diverse populations (8). Beyond the pandemic, other global crises—including the California wildfires, economic fluctuations in major world economies, and geopolitical tensions arising from conflicts in such as in Ukraine—have further exacerbated social instability.

These external factors, which are beyond the control of the individual, have resulted in a multitude of psychosocial consequences, which have most frequently been observed to escalate within the family unit (9).

Paradigm Shifts

Considering the contemporary global challenges that we are currently facing, there is an imperative for a rethinking of leadership. Given that these issues extend well beyond a narrow ecological horizon, it is essential to anticipate a new mode of leadership (10). It is not unrealistic to expect that soon, hitherto unrecognized social turbulences and issues may emerge that will confront us with social work challenges that we have not yet had the opportunity to encounter and that have not emerged from a generally accepted understanding of anthropological metanarrative (11,12). Diverse naturalistic conceptions of understanding the world – particularly in the sense of strict determinism according to Hawking (13) – are confronted with novel challenges arising from the social welfare context of adolescents and healthcare for the long-term ill, thereby unveiling fresh possibilities for interpreting observed social phenomena, especially in the context of solipsistic trends in contemporary consumer culture (14). Consequently, it is imperative that social workers have access to new knowledge, digital technologies, modern strategies and innovative practices that reflect the dynamics of social reality (15).

The Implementation of Spirituality in Social Work and Holocaust Education

Recent research and empirical evidence suggest that effective social interventions must be grounded in multidisciplinary collaboration and long-term sustainability. The relationship between social work and spirituality has garnered increasing attention in academic circles, reflecting its significance as a vital component of a holistic approach to practice. Spirituality influences values, ethics, and the overall framework for assisting clients, making it an essential element of social work (16, 17).

Human spirituality is an integral aspect of social work values, encompassing a range of beliefs about what is considered meaningful and forward-looking within the field (18). These beliefs encompass general principles regarding the nature of a just society and the values that foster sustainable quality of life from birth to death. For individuals experiencing a life crisis—whether short-term challenges like burnout or long-term struggles such as homelessness—effective intervention cannot solely focus on practical issues. Instead, it must provide comprehensive social support that addresses the spiritual dimension of their existence (19, 20,21).

Moreover, incorporating Holocaust education into this framework adds a critical layer of understanding. The lessons of the Holocaust emphasize the importance of empathy, resilience, and the acknowledgement of shared humanity in social work practice. By integrating the principles of Holocaust education, social workers can deepen their understanding of the historical and social contexts that shape individual experiences of trauma and resilience. This integration not only enriches the spiritual discourse within social work but also fosters a greater commitment to social justice and human rights (22,23,24).

Ultimately, a holistic approach that encompasses spirituality and Holocaust education equips social workers with the tools to support clients more effectively, recognizing that healing and empowerment extend beyond the material aspects of life to include the spiritual and emotional dimensions as well (25, 26, 27).

Conclusion

Social Work, Healthcare, and the Enduring Lessons of the Holocaust

The fields of social work and healthcare are deeply rooted in an outlook of resilience, healing, and hope. Social workers engage with individuals' narratives to devise solutions, provide crucial assistance, and guide them toward a path of recovery. In doing so, they become bearers of hope—drawing upon an understanding of the past while equipping individuals with the tools to navigate present challenges. Philosophically, it is in the present that the foundation for a meaningful future must be laid, built upon an unwavering commitment to human dignity and the capacity for renewal.

As we mark the 80th anniversary of the Holocaust, we must recognize how history shapes our moral and professional responsibilities (28). The Holocaust, an unparalleled atrocity, forced humanity to confront the depths of cruelty but also revealed the remarkable resilience of the human spirit. From despair emerged the will to survive, and from devastation arose a renewed sense of purpose. This transformation serves as a powerful metaphor for the work of social workers and healthcare professionals—helping individuals reclaim agency, restore hope, and rebuild their lives even in the face of profound suffering (29).

Today, in the face of rising antisemitism and the persistence of hatred, the lessons of the Holocaust are more relevant than ever. The fight against antisemitism is not only about remembering the past but about shaping a just and humane future. As Israel's Ambassador to Slovakia, H.E. Eitan Levon, poignantly stated at the February 26, 2025, funeral of Shiri, Ariel, and Kfir Bibas, "They deserve not to be forgotten." His words underscore the urgent need for education and moral clarity, especially as some Western nations struggle with the ethical imperative of condemning terrorism.

In this spirit of education and remembrance, Dr. Rivka Rosenberg from Bar-Ilan University recently visited Nitra (as part of the Erasmus+ program) to deliver groundbreaking workshops and lectures on the intersection of performing arts and emerging technologies in Holocaust awareness. Her presentation highlighted the use of *Whistle: My Mother Was Mengele's Secretary*, an award-winning play that explores themes of trauma, survival, and moral reckoning. By integrating 21st-century tools such as augmented reality (AR), virtual reality (VR), and artificial intelligence (AI), Dr. Rosenberg demonstrated how immersive storytelling can foster deeper engagement and understanding, especially among younger generations (29).

This innovative approach bridges the past with the future, ensuring that Holocaust education remains dynamic, relevant, and impactful.

By harnessing the power of technology and artistic expression, educators and activists can combat historical distortion, counter Holocaust denial, and inspire meaningful dialogue. Dr. Rosenberg's work exemplifies the critical role that creative and digital methodologies play in preserving memory and reinforcing the imperative of "Never Again." It is through such initiatives that we not only honor the past but actively shape a future where history's darkest lessons serve as a beacon for justice, humanity, and hope.

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