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Original Articles

Editorial

Responsibility of Academia for Combating Poverty and Social Pathology - Adapting Agenda 2030 in Social Work and Health

Important intervention against malnutrition/diseases is prevention of social pathology. Apart from the UN (Agenda 2030); UN-related activities (UN AIDS, UN DP); World Food Program (WFP); Food International Organisation (PAO); World Bank; Academia also plays an important role in decreasing poverty and preventing economic migration.

Agenda 2030 which followed Millennium Development Goals gives responsibility for malnutrition and communicable disease related deaths between developing countries and developed countries. Importantly, intervention against malnutrition/diseases is prevention of social pathology. Apart of the UN (Agenda 2030); UN-related activities (UN AIDS, UN DP); World Food Program (WFP); Food International Organisation (PAO); World Bank; Academia also plays an important role to decrease poverty and prevent economic migration. The aim of this editorial is to identify examples of Academia in various continents investments to education, health and social services as information which is functioning in real time/life/reality.

Examples of Social Work and Health Intervention in Various Academia Settings. From "real life/real time" social work and health intervention examples Table 1 shows examples from 10 countries from four continents. Those are only examples to facilitate other universities to develop extramural Programs in developing countries. However, the amount of contributions generated by universities in the EU, SAE, USA, Canada represent only 5-10% in comparison to World Bank and Philanthropic Foundations (Bill & Melinda Gates Foundation, etc.). This low proportion should be increased mainly in Sub-Saharan Africa to prevent the inflow of large numbers of African refugees, at least partially; to create better educational possibilities (e.g. for free for the best students, or accessible solutions for majority). Education and health care/social work investments have been decreasing investments to manage social pathology (police, prison, etc.) in most EU countries. Importantly, even the slight support of education and health in SSA led to a decrease in illegal migration to the EU in 2017 in comparison to 2010 – 2015.

As seen from above mentioned examples, East European universities following examples from the USA and the EU, active at least 50 years, may be effectively implemented to joint strategy; decrease the threatening *Brain Drain* to the EU; increase the retention of good students and health care workers (HCW) in house to work for their own country. In addition, former East Europe (EE) has to pay back the investment, given by the EU to their university system from 1990 - 2019.

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Few words from the Editors-In-Chief

This journal brings authentic experiences of our social workers, doctors and teachers working for the International Scientific Group of Applied Preventive Medicine I-GAP Vienna in Austria, where we have been preparing students for the social practise over a number of years. Our goal is to create an appropriate studying programme for social workers, a programme which would help them to fully develop their knowledge, skills and qualification. The quality level in social work studying programme is increasing along with the growing demand for social workers.

Students want to grasp both: theoretical knowledge and also the practical models used in social work. And it is our obligation to present and help students understand the theory of social work as well as showing them how to use these theoretical findings in evaluating the current social situation, setting the right goals and planning their projects.

This is a multidimensional process including integration on many levels. Students must respect client's individuality, value the social work and ethics. They must be attentive to their client's problems and do their best in applying their theoretical knowledge into practice.

It is a challenge to deliver all this to our students. That is also why we have decided to start publishing our journal. We prefer to use the term 'clinical social work' rather than social work even though the second term mentioned is more common. There is some tension in the profession of a social worker coming from the incongruity about the aim of the actual social work practice. The question is whether its mission is a global change of society or an individual change within families. What we can agree on, is that our commitment is to help people reducing and solving the problems which result from their unfortunate social conditions. We believe that it is not only our professional but also ethical responsibility to provide therapeutic help to individual and families whose lives have been marked with serious social difficulties.

Finding answers and solutions to these problems should be a part of a free and independent discussion forum within this journal. We would like to encourage you – social workers, students, teachers and all who are interested, to express your opinions and ideas by publishing in our journal. Also, there is an individual category for students' projects.

In the past few years there have been a lot of talks about the language suitable for use in the field of the social work. According to Freud, a client may be understood as a patient and a therapist is to be seen as a doctor. Terminology used to describe the relationship between the two also depends on theoretical approach. Different theories use different vocabulary as you can see also on the pages of our journal.

Specialization of clinical social work programmes provides a wide range of education. We are determined to pass our knowledge to the students and train their skills so they can one day become professionals in the field of social work. Lately, we have been witnessing some crisis in the development of theories and methods used in clinical social work. All the contributions in this journal are expressing efforts to improve the current state. This issue of CWS Journal brings articles about social work, psychology and other social sciences.

Michael Olah
Peter G. Fedor-Freybergh
Edition of the journal

Foster Care as a Form of Support to Dysfunctional Families – Theoretical Views and Social Work Research Perspectives

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Original Article

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Abstract:

The authors explore the complexities of foster care and analyze it as a form of support to dysfunctional families within the framework of today's social work research and practices. They take into account various socio-legal aspects of foster care and examine its socio-legal evolution. In the course of their analysis, the authors examine differences,

as observed by social work researchers in implementation of foster care worldwide, and in selected countries. Finally, the authors identify research trends in the area of foster care support from social work perspectives and provide respective key examples of research studies.

Introduction

Many children have been reported to be exposed to abuse and psychopathology as it frequently occurs in dysfunctional families, i.e. a family where relationships between members are not conducive to emotional and physical health; where some conditions such as sexual and physical abuse, alcohol and substance addiction, delinquency and behavior problems; extreme aggression; eating disorders are observed and legally confirmed. In such situations, foster care is believed to be an ideal solution to provide temporary emotional and developmental stability to the affected children. However, there has been extensive research conducted to prove that alternative care arrangements may also lead to or aggravate already existing children's interpersonal and social impairment.

The foster care might be socio-ethically understood in two ways. Its positive meaning implies that foster care should offer stabilizing roles to dysfunctional families' victims such as children or other family members affected by family dysfunctions. Its negative meaning demonstrates today's societal dysfunctions related to social identity misperceptions observed amidst members of dysfunctional families as well as a broad spectrum of defeat of today's politico-social orders in delivering and nurturing the protection of a family as a social value, which should be recognized not only in theory but in practice as a bedrock of a socially healthy society.

The most representative social work literature which has dealt with issues related to foster care gradually started to appear in 1966, initially in the United Kingdom. Most scientists who analyzed foster care themes to 2005 considered the then existing literature a non-homogenous group. As of 2005 until present - a considerable growth of scientific interest has been observed in the areas of socio-psychological and social development of children, satisfaction of their needs and challenges connected to the roles of foster parents. At present, the subject matter literature is considered to be substantial and homogenous. It combines research achievements in the disciplines of sociology, psychology, social work, development studies, law studies concentrated on exploration of the following themes: 1) intergenerational aspects of foster care, including early motherhood experiences and transmission of distresses connected to child abuse, neglect and domestic violence; 2) impacts of foster placement on foster children and foster parents; 3) relations between economic poverty limitations of birth parents and foster care arrangements; 4) education and social development of foster children; 5) socio-psychological development of foster children, foster parents and their relations; 6) child protection themes.

Socio-legal framework for foster care, major definitions and key research efforts

Over last years, the fact sheets concerning dysfunctional families' victims, particularly children, indicates that dysfunctional family remains a serious global and social problem. In 2010, worldwide it was estimated that 143 million children remained separated from their birth families, out of which

– 95% were subdued to family foster care. In turn, in 2017, UNICEF assessed that out of 80% children world population circa 2.7 million between the ages 0 and 17 lived in foster and residential care settings. It has been acknowledged that many children in foster care settings experienced a feeling of great loss, maltreatment, other complex trauma and behavioral problems.

Legally binding and non-binding internationally recognized arrangements are crucial for national and transnational connotation of foster care; its domestic legal and socio-cultural evolution. The United Nations Convention on the Rights of Child's Article 27 stipulates that every child has the right to "a standard of living adequate for the child's physical, mental, spiritual, moral and social development" and its parents are responsible to "secure within their abilities and financial capabilities, the conditions of living necessary for the child's development". Furthermore, the Article 18 of the Convention declares that "parents or, as the case may be, legal guardians, have the primary responsibility for the upbringing and development of the child". In line with the Article 20 of the Child Convention, in case of parents who find themselves unable to perform these duties, national authorities may decide to remove their children and place them in alternative care settings upon determination of stressors' appearance such as parents' mental and physical health problems, occurrence of domestic and community violence, substance abuse by parents, stigma or other emergencies, e.g. a parental death..

In November 2009, in order to reinforce efforts to promote family reunification and provide clear worldwide definitions of so-called "alternative care" associated concepts, the United Nations issued non-legally binding Guidelines for the Alternative Care of Children. The Guidelines draw upon Western European and European Union's legally binding standards concerning alternative care specify that alternative care might have two forms: formal care and informal care. "Formal care" is understood as "all care provided in a family environment which has been ordered by a competent administrative body or judicial authority and all care provided in a residential environment, including in private facilities, whether or not as a result of administrative or judicial measures." All formal care services delivered by the State and non-State actors such as Non-Governmental Organizations as well as private and faith agencies, organizations are meticulously specified to avoid activities' duplications. Whereas, "informal care" is defined as "any private arrangement provided in a family environment, whether the child is looked after on an ongoing or indefinite basis by relatives or friends (informal kinship care) or by others in their individual capacity at the initiative, his/her parents or other person without this arrangement having been ordered by an administrative or judicial authority or a duly accredited body".

It must be stressed that the worldwide alternative care literature refers, as the United Nations do, to two main genres of alternative care: family based and out-of-home/ not in the home of a family. Within the family based arrangements, the literature distinguishes two types of care: 1) "kinship care" i.e. "family based within the child's extended family or with close friends of the family known to the child, whether formal or informal in nature" and 2) "foster care" which means "situations where children are placed by a competent authority for the purpose of alternative care in the domestic environment of a family other than the children's own family, that has been selected, qualified, approved and supervised for providing such care". The competent authority hereby means the State Authority at national, regional or local level, or

a Non-Governmental Organization in countries without formal care where care mechanisms are poorly developed. Subsequently, not family-based out-of-home placements comprise: 1) "residential care" settings which are group settings; safety and emergency care; short- and long-term care group homes such as for example orphanages or other care institutions; Buddhist Monk Pagodas, Muslim madrasas, boarding schools; 2) supervised independent living arrangements usually provided for children who have reached adolescent age.

Foster care, unlike adoption, is not perceived as a permanent relationship as its arrangements are bound to offer temporary, short-term nurture or training; however it might result in a long-term friendship. Researchers indicate that foster parents, unlike adoptive parents, are motivated not by a wish to formally enlarge their family but to provide a temporary family-like assistance. Although, the socio-legal alternative care related literature provide for definitions of various alternative care settings as outlined above, real-life differences in foster care services models between countries have been underlined by the research community. For example, in Georgia, South Africa, the Russian Federation and Ukraine, foster care might include so-called guardianship and kinship foster care arrangements which encompass monitored and sanctioned formal care settings conducted by statutory organs where children are raised by kin, relatives or friends.

Regional and national cultural history and traditions have molded contemporary norms and regulations of child welfare worldwide. In Central and Eastern Europe as well as in the former Soviet Union of the 20th Century, there was a strong practice of residential care placements of children who were considered a social problem. In many African and Arab cultures, the care and upbringing of a child is still seen as a responsibility of parents, their extended family and community, as it was the case in pre-colonial times, while in European cultures residential care arrangements are yet used rather commonly.

Of note in this respect, are worldwide and regional comparative research which commenced to be conducted in recent years. In 2017, a group of researchers led by S. Chaitkin on behalf of SOS Villages International issued a study for the European Commission which compared alternative care, including foster care arrangements in Asian, African and Latin American countries and in-depth in 6 countries - most populated in the world - Nigeria and Indonesia, with modest population - Chile and Ecuador, and with smaller population - Nepal and Uganda. The factor of religion type as well as poverty rate was taken into account while performing the research. Chile and Ecuador are predominantly Christian; Nepal's religion is predominantly Hinduism, less Buddhism. Nigeria is religiously reported to function as a split between Christianity and Islam, Islam is acknowledged to be the main religion of Indonesia, while Uganda is 85% Muslim and 15% Christian. The study stressed that religion was a driving force in all selected countries and it had entirely determined their alternative care arrangements.

The study resorted to the use of semi-structured interviews with 244 locally-based informants, field visits and web-searched engines. It displayed that informal care arrangements "are by far the most prevalent form of alternative care arrangements" and the use of residential care settings "outstrips that of formal family-based placements such as foster care".

The researchers admitted that data on alternative care arrangements were inadequately collected and analyzed by the selected states, while supervision and monitoring mechanisms of care arrangements

were deficient. It was also demonstrated that poverty was not the main reason to place children in alternative care, while sending children to so-called religious schools in Indonesia, Nigeria, Nepal and Uganda was well perceived and often practiced within these societies. The report indicated that a small percentage of children held in residential care such as religious schools had no living parent. The study revealed that kinship foster care was widely used in these countries, while formal foster care, i.e. taking a stranger's child had been rarely socially accepted and had been treated as a western imposition.

Apparently, 27% children who remained in alternative care in Indonesia came from families where domestic violence occurred. In Nigeria, domestic violence was a key factor for informal and formal foster care arrangements. The authors' study stressed that broadly in Africa and Asia abuse, exploitation, including sexual and neglect were not major reasons for alternative care placements, but it contrast, these factors played significant roles in Latin American countries. Armed conflicts in countries such as Nepal and Nigeria were also important causes to place children in alternative, including foster care arrangements. The study finally stated that formal foster care arrangements lacked national funding which were available in European, western sphere's countries.

Another study which is treated as significant for the recent comparative worldwide research in the area of foster care mechanisms and arrangements is the Baltic Sea States Regional Report dated as of 2015. The report was prepared through a desk review of national, regional and international literature, official data and statistics were collected through a survey of the research group in alternative care. The report covered the following countries: Denmark, Estonia, Finland, Germany, Iceland, Latvia, Lithuania, Norway, Poland, the Russian Federation and Sweden. Data indicated that there was a total population of 302, 314 children under the age of 18 years old in alternative care in all Baltic Sea States and that all countries resorted to the use of residential care and formal foster care settings.

The ration of family-based versus residential care arrangement ranged from 47% family-base care in Germany to even 88% in Norway. On regional average, 58% placements were family-based. In most countries, more than 50% of children who remained in foster care settings were deprived of parental care. The highest percentage of children in alternative care – 2.3% were in Latvia, while the smallest – 0.85% in Sweden. For example in Poland, 74% of children remained in family-based care with 26% in residential care; in Norway 64% were in family-base care and 36% in residential care. Researchers underlined that the alternative mechanisms varied a little between countries, while economic, demographic and ethnicity factors were determined as not decisive for introduction and implementation of respective alternative care models.

The authors' report found that in most cases, monitoring, supervision and implementation mechanisms for alternative care were highly developed and duly organized. The applicable laws in the selected countries were regulated by general civil codes; laws on social services; social protection; labor market; child welfare; child protection; and children's rights laws. A high degree of law fragmentation was reported in all countries. This led to creation of multi-faceted machineries of various mandates and responsibilities which, as researchers confirmed, was a common practice in other Western European states. The study revealed that the causes for the removal of children from their birth families were complex and wide-ranging: 1) parents were unwilling or unable to provide care to their children due

to illness, mental health issues, substance abuse; 2) parents exerted physical, sexual and psychological violence on their children; 3) parents found it socio-economically difficult to raise children; 4) parents left their home country and were not willing to come back.

Additional Social Work Perspectives

In order to further explore the issue of foster care, including how it may indeed contribute to social development and stabilization of dysfunctional families, the following key themes need to be taken into account: 1) intergenerational transmission of foster care; 2) educational efforts aimed at foster care children; 3) improvement of socio-emotional relations between foster children, their birth parents and foster parents. The child protection associated topics would play hereby a cross-cutting role that should be present in all three above mentioned themes. The research findings and social work practice in the area of intergenerational transmission of disadvantages such as foster care and child abuse confirm that an overrepresentation of children of foster care alumni in the foster children group is frequent. In accordance with social learning theory, children observe parents' negative/positive reactions and behaviors. If parents' behavior is rationally verbalized, there is a high probability that their children would consider it a regular norm. Subsequently, children tend to multiply these behaviors, imitate them, particularly once they become parents, they might also perceive foster care as a solution to their family problems. Similarly, Social Attachment Theory indicates that parental behavior is transmitted onto their children, including negative behavior styles which actually are replicated in child's behavior once she/he becomes a parent regardless of the fact that a memory of a particular negative behavior is actually incoherent. The resource perspective theory also suggests that foster care alumni experience difficulties transitioning into adulthood and later parenthood on the grounds of a lack of social and personal resources.

Substantial research results in intergenerational transmission of foster care were accomplished by Danish researchers who studied intergenerational transmission of foster care in Denmark. In Denmark, similarly in other European countries, a risk of foster care placement in pre-school years is 1.5%; 3% in teenage years, while for example the latter in the United States stands at 5%. Researchers in the research sample of the 1977 cohort took into account 30,379 women out of whom 5.2% experienced foster care as children as well as their children and their fathers – the final sample consisted of 15,213 parents whose majority experienced foster care in teenage years. The research revealed that 7% of children had mothers from the foster care alumni while only 1% of children had their mothers with no foster care experience. The researchers used a regression model to examine parent-child associations in foster care.

An extensive research study which focused on educational efforts for foster children was recently issued by a group of British researchers. It outlined the evolution of the legal British system and British Social Work practice; took stock of achievement of foster children's education; called for innovation practices. The researchers proved that education for children in care has been recognized by the socio-legal systems in Britain as important but still lacked integration in placements and schools and that the children needed to be granted education which encompassed two elements: a broadly based social development and an education focused on performance. They recalled that children in public care accounted for less than 1% of the population under the age

of 18 years old in Britain; whereas nearly 45% of young people aged 5-17 years old who were looked after by local authorities, including in foster care, were reported to suffer from mental and conduct disorders, anxiety, depression and hyperactivity. Approx. 70% of children in care in England have been assessed as having special educational needs. The study also called on Social Workers to undergo training on the educational needs of children in care; be aware of the legal entitlements of children in foster care to efficiently protect their rights as this has not always been the case. The study is considered as evidence-based informal guide for those who professionally on a daily basis deal with foster care themes.

An exhaustive study issued by Dutch and Norwegian researchers covering the third foster care research theme - the improvement of socio-emotional relations between foster children, their birth parents and foster parents might be given as a recent research example. The study concentrated upon psychosocial needs of children in foster care and the impact of sexual abuse. It appeared that there was a limited knowledge on needs prioritization and lived experiences of foster children. For the purpose of the study, AQ Methodological study was conducted with 44 youth aged 16-28, out of which 15 reported to have been sexually abused in their childhood. By-person Factor Analysis allowed forming groups of respondents, while qualitative interpretations showed differences and similarities between the groups. The study revealed that groups identified that following needs as their priorities: safety, self-esteem, self-actualization and belonging.

Conclusion

The research performed in the area of foster care support to dysfunctional families' social stabilization cover a wide spectrum of themes, including intergenerational; educational; psychosocial; socio-economic aspects. Both research oriented on selected countries' situations as well as comparative studies analyzing several countries' socio-legal realities in foster care provide an important perspective for Social Work that should be further explored, researched and turned into practice by Social Work Curricula depending on socio-legal and socio-cultural regional and domestic contexts. Legal and Social Work Practitioners should further recognize major points and findings which have been identified by the research community in the domain of foster care including efforts which national authorities should undertake to reunite children with their birth parents whenever possible as well as to focus on child care reforms which should strengthen family cohesion values.

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Spectrum of Humanitarian Assistance Interventions in Acute Physiotherapy and Nursing Refugee Health Unit (Original research)

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Abstract:

Background

A new refugee wave, however much less populated, has been observed after major exodus of Syrian and Iraqi victims of war, reaching about 40% in 2017 of the original reports in 2016-2018. The aim of this short communication was to describe the spectrum of required humanitarian assistance for migrants and refugees from the Middle East transiting Bosnia to the Schengen spaces of Slovenia and Italy.

Patients and Methods

We have actively searched for "wild type" refugee or migrant camps in North Bosnia and analyzed types and spectrum of interventions provided by our field team, which consisted of one Doctor, two Nurses and one Social Worker. We have served around 50-100 patients a day.

Results

The commonest nursing and physiotherapy diagnosis was known - PTSD (posttraumatic stress syndrome) - due to war events; loss of relatives; insecurity of travel results and asylum process procedures; and represented 80 percent and more of all presentations, in addition to other somatic disorders.

Conclusions

Complex and quality Health and Social Care is highly demanded in this populations, mainly due to the complex conditions and PTSD. Organized action and cooperation between NGOs, Academia, Health Care students, Social Workers, etc. and local governance bodies in a divided state should be mandatory, however achievement is not always easy.

Introduction

A new refugee wave, however much less populated, has been observed after major exodus of Syrian and Iraqi victims of war, reaching about 40% in 2017 of the original reports in 2016-2018. Also, the Mediterranean route from Turkey to Greece by boats has been ameliorated and only about 40,000 migrants (armed conflict refugees) has been detected on the inner border of Greece. Many of those migrants were hosted in the EU (Greece, Cyprus, Bulgaria) rushed via the Balkan borders, paradoxically out of the EU, to Serbia and Bosna, rushing again to the EU and Schengen space in Croatia and Slovenia, Austria and Italy. From about 30,000 of such double-migrants, about 10,000 are still stuck in Bosnia in acute and very provisional shelters organized as "wild" refugee camps, moving with huge mobility within Bosnia and Herzegovina to escape from local authorities. The aim of this short communication was to describe the spectrum of required humanitarian assistance for migrants and armed conflict refugees from the Middle East transiting Bosnia to the Schengen spaces of Slovenia and Italy.

Patients and methods

Upon recommendation of Bosnian Journalists and Police Officers, we actively searched for "wild type" refugee or migrant population based camps in North Bosnia near the Croato-Slovenian border which is also the Schengen outer border. Several

camps were created and subsequently abandoned or destroyed by migrants themselves before escaping to woods and local pathways. One such mobile temporary camp has been discovered by our Nursing and Physiotherapy team transiting Bosnia on their return trip home from their Greek Base near Saloniki. Two Nurses created the team joined later with one Tropical Doctor, one Pharmacist and one Social Worker/Auxiliary Nurse), serving daily for 50- 100 patients. The Spectrum of interventions was recorded and analyzed. Medications, transport of the staff food, supplies and logistics was organized via the St Elisabeth Program for Refugees and Migrants from the base in Veroia and Alexandria, about 60 km from the borders.

Results and discussion

The spectrum of interventions related to the spectrum of diseases in war victims of refugee crisis is in Table 1. Nursing diagnosis found 120 cases with respiratory symptomatology of respiratory tract lower infection (LRTI). For example, from lower RTI complaints and symptoms, the majority were confirmed as 25 pneumonia cases – 8 being severe - probably due to unprotected camping in wild nature. Scabies was commonest as far as skin and soft tissue infections are concerned caused most probably by long travel, since some families walked over 500 km within a month. Commonest Nursing and Physiotherapy diagnosis was PTSD (post-traumatic stress disorder) due to war events; loss of relatives; insecurity of travel results and asylum process procedures; and represented 80% and more of all presentations, in addition to other somatic disorders. (3, 4)

Conclusions

In conclusion, analyzing the spectrum of Nursing interventions in war related migrants and refugees before war conflicts from mainly Syria, Iraq and Afghanistan, respiratory tract infections followed by skin and soft tissue infections and infected trauma (police dog related bite wounds, beating sequellae) in 80% accompanied with PTSD are a daily bread in a Mobile Health Care Unit in North Bosnia, searching for "double crossing" migrants from Greece to the Schengen space of Central EU. Organized action and cooperation between NGOs, Academia, Health Care Students, Social Workers, NGOs, like MSF, SEUC, etc. and local governance bodies in a divided state is mandatory, however not always easy.

Table 1: Spectrum of Major Health/Social Pathogens at presentation in Physiotherapy/ Wound Unit at a Temporary Refugee Camp in Northern Bosnia

Total cases	522
Refugees	510
Auxiliary Local Staff	12
Foreign Humanitarian Staff	3
Outpatient Dept. Presented	151
Respiratory Tract – upper	31 (20%)
Respiratory Tract – lower (pneumonia)	11 (6.7%)
Caries Dental uncomplicated	12 (9%)
Caries Dental complicated (osteomyelitis, gingivitis, abscess)	8 (8.5%)
Wound (SSTI/Scabies + SSTI)	71 (47%)
Scabies only	24 (18%)
Psychotrauma (PTSD)	150

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Diarrhoea Patients in Sub-Saharan Africa with Low School Performance and Social Status: Relationship with Chronic Intestinal Parasitosis (Short communication)

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Original Article

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Abstract:

The occurrence of *enteric parasites (geohelminths* – GH) in developing countries is high. Studies on prevalence or incidence of GH are one of the possibilities to focus the attention of the health care politics to this particular problem. The aim of this study was to assess the prevalence of GH in a rural areas of Rwanda, Burundi, and South Sudan, all countries after huge social changes, eg. civil war or genocide within last 30 years. Low school performance is a result of chronic anemia related to GH.

Introduction

The occurrence of enteric parasites (*geohelminths* – GH) in developing countries is high. Studies on prevalence or incidence of GH are one of the possibilities to focus attention of health care politics to this particular problem. The aim of this study was to assess the prevalence of GH in a rural areas of Rwanda, Burundi, and South Sudan, all countries after huge social changes, such as civil war or genocide within the last 30 years. (1) Low school performance is a result of chronic anemia related to GH.

Patients and Methods

Monthly reports on GM incidence in three rural hospitals (Outpatient Departments) in clinics in Rwanda (Bigugu), Burundi (Gasura), and Mapuordit (South Sudan) have been analyzed from March 1st 2017 till Feb 2018 in patients with signs and symptoms of intestinal infection. Stool samples taken in plastic caps were examined by microscopy after adding KOH + H_2O saline (Kato-Katz Method) and centrifuged within 30 minutes (native microscopy) with a trained medical technician.

Results and Discussion

Analysis of 884 stool samples was performed with 37% of these were positive. The commonest pathogens were *Entamoeba histolytica* (47.3%), *Ascaris lumbricoides* (17.22%), and *Giardia intestinalis* (11.83%). Slight environmental differences between three Sub-Saharan African countries have been observed, however, they were insignificant, e.g. 54% of positive samples were in females (who are predominantly preparing food), as well as in those older than 16 years of age (adults), also not significant ($p > 0,05$) probably due to deworming programs in children. *Intestinal parasitosis* due to consumption of folic acid, iron, and B12 vitamin are responsible for so-called "consumption" anemia, responsible for worse school performance in countries with poor access to clean water due to socially/economically instable environments after conflicts (genocide 1982 - 2010) or famine, with destruction of hygienic infrastructure and water supplies (1,2).

Conclusion

Intestinal parasites are a major cause of anemia in developing countries worldwide, mainly in Sub-Saharan Africa and South-east Asia. Anemia is directly responsible for low school performance of children/adolescents/mothers, where apart of *parasitosis* of the gut (GH) malaria and post-partum bleeding contributes to anemia, many times powered by malnutrition or religion-related diet with less iron, B12 vitamin, folic acid, D vitamin, cobalt, and other key elements for *hematopoiesis*. Therefore, large campaigns against soil-transmitted helminths (STH or GH) and deworming programs with twice a year *albendazole* (+*praziquantel*) are supported

by philanthrops, such as Melinda and Bill Gates, World Bank (to combat malaria, HIV, TB, and diarrhea). However, investments to environmental health and clean water supply, within 2030 Sustainable Development Goals agenda are crucial as social work and health intervention.

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Case Study of a Neglected Child as One of the Forms of CAN

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Original Article

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Abstract:

Based on the findings of UNICEF which focuses on long-term and systematic help for children, there are 50 million children who are exposed to physical and psychological abuse. Unsuitable treatment of children brings a whole raft of problems which have to be addressed on the psychological, educational, legal and nursing levels. In this paper, the authors present a case study of a child hospitalized in a ward of older children and adolescents who showed typical signs of neglect.

The term CAN Syndrome (Child Abused and Neglected Syndrome) began to be used in the 1990s. There are several definitions of CAN Syndrome in the current literature. One of them is a definition that emphasizes that it is a *"conscious or unconscious act of a person responsible for the care of a child under the age of 18 which threatens the healthy development or even damages the health of the child."* (Kovac 2009 p 34). One of the forms of CAN Syndrome is **neglect of a child**. We understand this term as referring to any insufficiency of care for the child which threatens or causes a serious deficiency in its development. Physical neglect is understood as not satisfying the child's physical needs. This includes, according to the Council of Europe's Health Committee, failure to provide adequate nutrition, clothing, shelter, healthcare or protection from harm. Most adults do not neglect children intentionally. Neglect usually results from an inability to plan or an ignorance of what is suitable child care. The **forms of neglect include**: non-satisfaction of the child's physical needs; inadequate and irregular nutrition; bad or no hygiene; inadequate cleanliness; quality of dress with regard to weather; particularly leaving small children without proper supervision; insufficient medical care including neglect for prevention; frequent absences from school.

The behavioral indicators of a child who is neglected include: health problems; chronic tiredness, apathy; paleness; gauntness; self-destructive tendencies; low self-esteem; running away from home; delinquency; theft; begging; consumption of alcohol and/or drugs. A neglected child feels frustration and that depresses them. Unfavorable factors have a negative impact on the child's physical and psychomotor development. Physical neglect results in failure and can lead to the death of the child. Emotional neglect and psychological deprivation involve poor satisfaction of basic mental, emotional and social needs and can lead to Deprivation Syndrome in childhood.

The Consequences of CAN Syndrome

The seriousness of the consequences depends on the extent of the destructive forces of the cruelty, abuse and neglect of the child and whether this is short-term or long-term. The ***degree of ability of the victim to defend themselves*** is also important. It is tragic when it leads the victim to break down, shatters their identity establishing lasting feelings of helplessness, dependent slavish submission and loyalty to the aggressor stemming from fear of even greater suffering that could follow if the victim did not try to appease the aggressor in every way possible. The consequences are very serious and one should not underestimate them because they affect the rest of the psychological, physical and social development of the child. The psychological and moral deficit within them deepens. Their character is significantly disturbed. At school they have worse results and can fall in with a "bad crowd". In adulthood, there are more conflicts with the law and crime. If the aggression is removed in childhood, the risk of crime in adulthood will be reduced. Girls do not get into conflict situations with the law more often than others. Their aggressive behavior in childhood is subsequently manifested in adulthood in cruel behavior towards their own children. Hromkova, 2006.

The Role of Nursing in Preventing CAN Syndrome

Children who have been subjected to cruelty, abuse and neglect carry long-term injuries that are the basis of many mental illnesses, addictions, social maladaptation, asocial and antisocial behavior, criminality. It is more effective to avoid and prevent

the recurrence and repetition of this problem by treating and assisting children who are already marked by violence. Early and effective assistance can prevent the adverse consequences of the violence. Prevention of CAN Syndrome involves family rehabilitation as one of the main forms of therapy. It means behavioral influence on the family and its members in the direction of preserving or restoring it. The Council of Europe's recommendation in this respect is to *"establish a system of effective prevention, reporting, verification, investigation and evaluation, interventions or treatment and monitoring of cases of child abuse and cruelty on a multidisciplinary basis, which will also specify the role and responsibilities of the various agencies concerned."* (Dunovsky 1995 p 76). Past experience and expert literature show that prevention is the guiding idea of any attempt at correction. The prevention of CAN Syndrome is based on three components: **primary, secondary** and **tertiary prevention**. Although the division of prevention into primary, secondary and tertiary is seen as unusable and is no longer recommended today because in practice the components are overlap-ping and complementary on a theoretical level this division will help us to clarify the issue.

The role of **primary prevention** is to prevent the onset of CAN Syndrome and, if possible, to prevent it before it happens. In particular, it is targeted at the general public and as it is a child-related Syndrome, it is also focused on children, parents and educators of children, professionals and public officials. It attempts to strengthen good relationships in families, promote education for the safety of affected children, ensure the teaching of sex education in schools, provide courses for teachers and social workers, pediatricians working in hospitals and outpatient clinics, and support conferences and seminars to discuss this topic. *"Primary prevention according to the WHO means to prevent the occurrence of a negative social phenomenon, to suppress it immediately at its origin."* (Dunovsky 1995 p 103).

Secondary prevention depends on the early diagnosis of CAN Syndrome and on collaboration between pediatricians, teachers, psychologists and social workers. The first step is to actively search for risk groups and risky life situations, where abuse is most common. The second step is to target these groups of people and situations in order to minimize the risk of CAN Syndrome. The main task **of tertiary prevention** is to prevent and minimize the risk of repetition of bad behavior towards children. It includes a diagnostic element (defining the extent of the harm to the child); a protective element (preventing further contact of the child with the perpetrator); a therapeutic element (eliminating the negative consequences to the child using therapy). Matejcek takes the view that primary prevention is general and does not need to be differentiated. Secondary prevention largely overlaps with the therapeutic treatment of children. It has its specific goals and processes. Tertiary interventions only relate to the consequences of harm (Matejcek 1995 p 340).

Case Description

On 9.11.2017 the Clinic of Pediatrics, Department of Older Children and Adolescents, admitted a 7-year old child referred by the pediatrician's surgery for hospitalization for **impetigo in the area of the auricles**, ***causus socialis*.** The child had been treated repeatedly during 10/2017 with antibiotics - Cedrox, Ospamox without improvement in the condition. The primary care doctor had supposed **failure to properly give antibiotic treatment by the family**.

Personal History: Child of 3rd physiological pregnancy, delivery in term, in hospital, birth weight 2,500 g / 47 cm, breast-fed

up to 5 months, eats everything without restrictions, vaccinated according to the vaccination schedule, psychomotor development: walks alone from one year of age, 9/2014 - *Bronchopneumonia lobaris, Bronchitis acuta, Ascaridosis, Pediculosis capitis; 8/2016 Pyelonefrititis acuta, Bronchitis acuta diffusa, Tonsillopharyngitis acuta, Ascaridosis; 9/2016 Bronchopneumonia*,

Family History: The mother and father are healthy, unemployed, number of siblings: 5, the younger brother (4 years old) has bronchial asthma, the others are healthy, grandmother survived stroke. Mother and father smoke, live in a "shanty" cottage, drink water from the stream.

Catamnesis: At admission the child was alert, afebrile, weight 16 kg, height 105 cm- the child was *hypotrophic* (percentile 4), BT: 36.8 °C, BP: 80/55 mm Hg, Breathing: 13/min. Upon admission the following test were ordered: FW, CRP, blood test + diff, glycaemia, urea, creatinine, mineralogram, urine CH+S, swabs from nose, throat, rectum. ***Nails short, dirty, hair unkempt, presence of lice in the part of the head with hair, scabies, unkempt, neglected appearance, speech clear, incomprehensible,.*** On both sides of the auricles from the inside and outside, in the nose, on the chest and on the back and on both upper limbs there was a presence of scabies, in the ears and nose lesions with *secondary impetiginisation* and wetting.

Medical Diagnoses: Contact impetigo; *Scabies* with *secondary impetiginisation. Tonsillar hypertrophy; Pediculosis capitis; Hypotrophy.*

Therapy: ½ FR 500 ml, sulfur paste for skin, Framykoin ung / twice daily / diet for larger children no. 13, dietary intake by mouth, problem with food intake – eats ¼ of food.

During five days of hospitalization was administered medicines as per the doctor's orders. Fucidin creme 1x15g, Fenistil gto 1x 20ml gtt, Vermox tbl 6x 100 mg 1-0-1, H2O2 0.3% 3g. Examinations performed: ENT, dermatology, swab from skin of affected area.

Evaluation of Results with Focus on Pathology: FW 50/77, Leu 11.87, HGB 121. Due to *Pediculosis capitis* delicing was performed on the child. Sulfur paste was applied, the child was bathed in Hypermanganese, therapy administered + Biseptol 2x ½ tbl,.

Analysis and Interpretation

During our observations, we identified serious shortcomings in hygiene, eating and speech development as a means of communication. The hygiene standard of the child is low. She is experiencing problems of *Pediculosis capitis*, *scabies* and *impetigo*. The child does not have basic hygienic habits: does not cooperate with showering; cannot clean her teeth independently; does not wash her hands after using the toilet; refuses to eat hot food, only one ¼ of each serving - one reason for which may be the presence of *ascarididae* in the digestive system. She does not have the right weight for her age that a well-fed child should have. According to expert studies, the average weight and height of a girl in the 6th year of life is 21.5 kg and 120 cm. The mother was repeatedly warned by a general practitioner about inconsistently administering antibiotics. For this reason, the child's condition worsened, leading to hospitalization. We tried to get her to cooperate, but there is a language barrier; the child does not know the basics of the Slovak language. This is a child who is about to begin the 1st year of elementary school and one of the criteria of maturity for school is knowledge of the language in which the child will be educated. The history shows signs of delayed development and recurrent episodes of child hospitalization are present. The child was pale, crying and

restless during her stay. Physical examination did not show atypical findings on the skin.

The child also comes from a socially backward multi-child family where the risk of occurrence of CAN Syndrome according to the literature is higher. *Hypotrophy* in the child, considering the low social and economic status of the family, is related to failure to provide adequate nutrition, regular meals and healthcare. Due to the fact that the child has been repeatedly hospitalized over a period of a whole year, the parents show an interest in the child's health and thus the recurrence of illness in the child does not have to occur deliberately, but most of the time the disease will reoccur because of the inability or lack of knowledge of how provide adequate child care and due to neglect for prevention.

All the facts observed indubitably indicate that this is a case of a neglected child. This conclusion is also based on the information in the statements of several authors of the literature, for example, according to Supinova 2013 unfavorable factors in a family with a low social position have a negative impact on the psychomotor development of the child. Veleminsky 2009 described Deprivation Syndrome in neglected children, coupled with poor satisfaction of basic mental, emotional and social needs. The tearfulness and restlessness in the observed child may be a sign of this Deprivation Syndrome.

Despite the fact that we know the social background of the family to which the child returns, as stated by Skodacek 2015, it was difficult for the nurse to ensure adequate prevention. As the poor living conditions and the poor health situation of the Roma population is a widespread social problem requiring more systemic solutions, appealing to and educating the parents to improve the living conditions of the child, seemed to be a problem. In cooperation with the general practitioner, we could only emphasize repeatedly to the mother the need to improve the personal hygiene of the child and other family members. Preventive measures to maintain better health of the child were explained to her, especially during the winter months (layering of clothing, maintaining the right temperature), she was informed about diseases due to poor water and diet.

Discussion

From the child's history we found out that the child lives in a large family with low social and economic status, which may be one of the reasons for the neglect of the child. According to Caputova 2000 the worsened state of health of Roma children is also due to the fact that in Roma communities there are more cases in which the state of health of the child is caused by the neglect of parental care. Family is a significant determinant that influences the development of the personality of the child. It is primarily about the quality of family relationships and their ability to fulfil basic functions (economic, socializing, biological, emotional). According to Ondriova *et al* 2014, mothers from Roma communities have worse health care, more frequent incidence of smoking and alcoholism, poor housing conditions increasing the risk of stress and interpersonal conflicts. According to health statistics, their children have a lower birth weight.

One problem in poorer families is eating habits, or rather, the lack of certain dietary elements (e.g. protein, fruit). Alongside the material deprivation, a serious problem is the unhealthy diet in regard to calories, which are particularly important for children. These children often have a tendency towards malnutrition. A child that eats too little suffers from lack of appetite, low weight, and growth lag may also show other warning signals that point to inadequate nutrition: the child is not interested in its

surroundings; can often be irritated; avoids eye contact; does not reach developmental milestones at the same age as other children.

According to the findings of Kovac *et al* 2009 children from poorer families tend to have complications from prenatal development, they are often born with low birth weight, with health complications, have more frequent injuries in their childhood; they are more often hospitalized than children of families with higher socio-economic status. The poor lifestyle of some members of the Roma community, often associated with unhealthy eating, alcoholism, tobaccoism, overcrowded housing, poor hygiene habits etc., have a significant impact on the increased incidence of some, especially infectious diseases. Some of the most common diseases that have been seen and are still seen in some Roma communities are *scabies*, *infectious respiratory diseases, tuberculosis, meningococcal meningitis, hepatitis type A and B, dysentery, salmonellosis*, *ascariasis*, fleas, bed and hair lice or other parasitic insects.

It is also worth mentioning that the upbringing of children of families living in such an environment is less favorable for the development of the personality of the child. Parents are less sensitive to the special abilities of their children and consider it less important to support them in their development. Fischer and Skoda 2009 claim that a large proportion of six-year-olds are not ready for successful study of the first school year. These children come from broken families, from an environment with low social and educational motivation, are socially isolated, lonely, nobody pays attention to them, plays with them or speaks to them. As a result, the child lags behind in development and also fails at school. According to Padysakova 2006 it is natural that the child does not consider education and school to be important if the family itself does not understand education as a positive value and one of the most important input for the future for its child if it does not show interest in the child's school work. Matejcek 2008 claims that Roma children do not have hygienic habits and do not speak the language they will be taught in. They come to school unprepared and hungry, and find themselves in an environment that is foreign to them.

Conclusion

For the healthy development of a child, it is essential that the basic needs of the child are met, otherwise deprivation occurs. The environment in which a child grows up plays an important role in the formation of the personality of an individual. Pemova, Ptacek 2016. A child has the right to grow up in a family where they are given love, security, safety and the necessary conditions for their healthy physical, mental and social functioning. If one of these aspects is compromised, the growth and development of the child is threatened.

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Migration and Women Left Behind: Challenges and Constraints

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Abstract:

Migration is the phenomenon that is widely recognized and practiced for various reasons. The migration of the head of the family in pursuit

of work often gives rise to problems in the family. The stress and strain that resulted from the husband's absence cause many women to become ill or to leave their homes. Families in Pakistan are experiencing this phenomenon which is caused by the absence of male members of the adult figures. This study aims to explore the challenges faced by left behind women. For this purpose the Qualitative Method was adopted to get in-depth insights and broader views of the topic. Semi-structured interviews also were taken. The data was gathered through Purposive sampling techniques from the metropolitan areas of Quetta City. This study explores that left behind women and families face numbers of challenges at different levels. They face loneliness, overwork, insecurity, sadness, stress; innumerable frustrations in social issues. Government should provide more technical job opportunities to the people to stop this chain of migration.

Introduction

The act of movement from one country to another country is called emigration. Anyone who moves permanently to another geographic region of the same country and all who move permanently to another country can be defined as migrants (J.R. Weeks 1985). The definition of migration can be confounded by the fact that such activity (changing residence) is carried out by people under varying legal and socio-political circumstances (J.R. Weeks 1985). History of mankind is replete with examples of people migrating from one country to another country either for permanent settlement or for a short duration in search of better social and economic life. This kind of social shoving and jostling is seen in Pakistan as extremely miserable and detrimental. (Rauf Zafar 2004).

Ask most educated Pakistanis today what they want for their future you will find a large number will say to settle down in America. Pakistani's, especially the professionals, have been leaving the country at an alarming rate in the last three decades seeking opportunities and benefits outside the country. Pakistani society is spoiled due to: mental stress; poor economy; corruption; terrorism; unemployment; lack of self-dignity; law and order situations; poverty; insecurity; bribery; bomb explosion; suicide bombing; deficiencies of ethical values; political instability. The youth is migrating towards other countries because of these pervasive situations. While the development of any country educationally and economically always depends on each youth, the youth faced such overwhelming conditions will abandon that country. The large number of these Pakistanis belongs to the computer technology profession. In last few years, they recieved many chances to get visas through different computer firms and went away forever (Ikuomola 2015). These caused very critical effects on the economy of Pakistan because foreign and local investors were not interested to invest their money here; that here everything is possible; anything could happen and be demolished anytime. Here the Supreme Court could be attacked anytime. (Mehmood Zaman 2000)

The migration flow of high qualified professionals started in 1990's and today it is on peak. The most despondent fact is that today is that those who leave Pakistan have left it forever; no one wants to live here (Mehmmod Zaman, 2000). Australia is encouraging our Doctors, Nurses, computer experts

and scientists for permanent emigration. According to the Australian High Commission, every year they give permanent emigration to 700 with our families (Oishi, 2002). Some European countries like Spain, Germany, and Ireland also give permanent emigration to Pakistanis. Spain gives emigration to only computer technology experts. Ireland gives emigration to cooks, butchers, nan-Bai's and other skilled laborers.

Another factor fueling frustration is that the system here in Pakistan is that talent is not properly rewarded. In foreign countries, talent is rewarded on *WHAT YOU DO, NOT WHO YOU KNOW!* (Karam Ilahi, Sara Safdar 1994). History of mankind is replete with examples of people migrating from one country to another country either for permanent settlement or for a short duration in search of better social and economic life. In the remote past, this was contrary to historical migration when there were few checks on the movements of people leaving one country for another owing to the reason of better quality of life. But the present migration between countries is not open-ended. There are strong state interventions usually in the form of statutory and regulatory measures both in the country of origin and destination of migrants. However, historians have typically addressed migration as a symptom of economic change, and said very little or nothing at all about the problems of ethnicity and the changing identity of migrants that have resulted overtime. The interest of sociologist in migration, on the other hand, largely revolved around the problems of 'race' relations within Western economies which have been the final destination of migrant streams. (S. Akbar Zaidi, 2006)

Problems Associated with Migration

The migration of the head of the family in pursuit of work often gives rise to problems in the family. Changing values and norms do not always keep pace with economic and socio-cultural development and traditional concept of honor and disgrace. Segregations of the sexes proves difficult to break through. (Hussain Ahmad Siddiqui 2002).

The stress and strain that resulted from the husband's absence cause many women to become ill or to leave their homes. Newly married women, who have been childless, return to their parents. Illness is the culturally accepted form of protest by the weak and occurs particularly among women who already have children and for whom running away is a feasible alternative.

Migrant workers abroad frequently involve separations of families which is socially disruptive at home and which contributes to the rise of prostitution and homosexuality. (James M. Rubenstein, 1983).

Families in Pakistan face numbers of serious challenges at different levels due to lack of male members of the adult figures. Youngsters and women left behind are in the position in which they have to react more particularly to which they are accustomed to.

Literature Review

Several studies have been conducted on migrants and their left behind families. Among various consequences of migration loneliness is by far the leading problem followed by the added responsibilities. The most alarming issue is the emotional and psychological strain that most of the women underwent in the absence of their husbands. (Devasahayam, 2010).

There are only a few studies focusing on the challenges of individual women who have been left behind; otherwise most of the studies have taken into consideration the overall family left behind. There are several pull factors which effect the migration of people. These pull factors are associated with the place of destination including employment opportunities at the destination.

To be successful in all favorable conditions, migration results must include steps towards the wellbeing of the left behind wives and children, too. (Chapagain 2015).

Left behind women face psychological strains when the migrant husband leaves them at the place of origin. Wives feel lonely and sexually disturbed in the case of new marriages. Consequently, some couples experienced conflict and emotional distance, divorce, and extra marital affairs while others oppositely develop stronger emotional ties with other women during their separation. (Farooq & Javed 2009)

Research Methodology

Qualitative mode of data technique was adopted to carry out this study. The purpose of adopting this type of technique was to get in-depth interviews and close observations. The data was collected through interview guides, and semi-structured interviews. The interviews were taken from 16 left behind women in different areas of Quetta City. The universe of the study was Quetta City and Purposive sampling technique was used to select those female respondents.

Research Questions

The study consist of two main research Questions:

What challenges are faced by women left behind?

What can be the solutions to overcome these challenges?

Results

In-depth interviews were taken from 16 left behind women. Researcher narrated the responses of the interviews. Results shows that left behind women face multi-dimensional problems including: overwork; loneliness; lack of security; sadness; lack of security in terms of marriage; frustration; stress; innumerable frustrations in social issues.

In the absence of husband left behind women feel burdens of responsibilities caused by unmanageable situations. There are also cases of husbands that after gaining money don't go straight back to their family when they return home but instead live with their new spouses.

The children, who are often caught in the middle, suffer enormous psychological and emotional distress when their mothers start badmouthing their fathers, which lead children to lose respect for their fathers. They have to look after the children; send them to school; take care of their activities; run their household affairs like buying daily household materials; doing the jobs which were formerly done by male members. This process and load of work leads towards physical and mental fatigue; this stress proceeds further when they see that the coming generation is becoming delinquent; has alien values, moral ethics and poor family affairs. Their educational level decreased day by day because all the aspirations and temptations are centered on the activity to ultimately flow abroad.

The tensions, worries, and miseries are there because the other half is missing. This may cause some sexual deviance on the part of women here and the men abroad. What will happen to the families may a person may ask? But will the track these families are following lead to destruction, emptiness and future barren cultural values and traditional practice. Deciding to live abroad and leaving your family behind is not an easy thing to do. It will have to be a family decision. It's not just the money that you have to count, but the entire wellbeing of the family members.

Discussion

The present study intended to explore the problems and challenges of left behind women of Quetta City. During data collection the researcher observed that the main reason for migration in males was to earn

good money and improve quality of life. Therefore, most of the researchers consider migration an opportunity for individuals to earn significantly for the well-being of left behind family members. (Biao, 2007)

According to current study, when their husbands are migrants, most females suffer from many psychological problems including: isolation; depression; lack of confidence; feeling lonely; loss of family life; face more responsibilities; see adverse effects on the children education; increased anxiety for communications (Hondagneu 1999).

Further, the findings show that left behind women are very curious about their children's studies and feel doubly sad about the absence of their fathers. One report by a women's federation highlighted the fact is left behind children have: poor academic performance; high school drop-out rates; problems in socialization and other psychological development (Biao 2007).

The major findings of this study by researchers disclosed effects on left behind women as those women face numerous social and psychological challenges. The present study was conducted in Quetta City of Balochistan, Pakistan.

Recommendations

The following recommendations are suggested to settle the problem:

Ensuring welfare of the families left behind, and ensuring social and economic re-integration of return migrants so they can start their own earning means in the country. Economic and social problems, political and security reasons, and better standard of life were some of the reasons forcing people to migrate to other countries. So the government should increase employment opportunities; establish political and security stability; offer a better standard of life.

NGO's should launch a campaign to alert the government about the problems and issues of left behind women and their families. They should support left behind families economically till the government takes any steps for their betterment.

Conclusion

Migration has been a constant in the history of Pakistan. From its inception, its people have been moving in migratory waves. This migration of people started with the moving of millions of people from India into Pakistan when the two nations gained their independence from British colonial rule. Muslims moved to Pakistan in hopes of a better life, not just economically but socially and religiously as well. The study set out to explore the challenges for left behind women. Left behind women face psychological strains when the migrant husbands leave them at the place of origin. The wives feel lonely and sexually disturbed in the case of new marriages. Consequently, some couples experienced conflict and emotional distance, divorce, and extra marital affairs while others oppositely develop stronger emotional ties with others during their separation. This research can be helpful nationally and internationally to study and overcome the challenges for left behind women and their families.

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The Level of Satisfaction of the General Public with Health Care Provided by Their General Practitioner

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Abstract:

In this article authors describe research aimed to determine the level of satisfaction of the lay public with health care provided by outpatient practitioners. The authors have set one main objective and five sub-objectives and 5 working hypotheses. A basic set of respondents were 300 randomly approached Slovak citizens. This article analyses the results of this survey - its findings. In the end of the article are proposed several recommendations for practice.

Introduction

Primary health care is the coordinated and complex health and social care provided by health workers at the first contact of people with health systems based on a long-term continuous approach to the individual. It is a set of activities related to health promotion, prevention, examination, treatment, rehabilitation and nursing care. These activities are provided as close to the patient's own environment as possible and respect his bio-psycho-social needs. The key medical discipline of primary care is universal (practical) medicine.

Characteristics of care in general (clinical) medicine:

- **Universality**: solves unsorted health problems of the population, regardless of age, gender or other characteristics of the person concerned; must be easily accessible with minimum delay.
- **Continuity**: focuses more on the person than on the disease based on a long-term relationship between patient and doctor.
- **Comprehensively**: provides integrated care in health promotion, disease prevention, rehabilitation and treatment.
- **Coordination**: informing patients about appropriate health care; the manner of its optimal use providing patient's consultation with a specialist.
- **Cooperation**: General Practitioners work with other health and social care providers.
- **Family Orientation**: addresses the incidence of disease in the family (hereditary dispositions).
- **Community Orientation**: addresses the health problems of the population living in the community; cooperation with other professionals from fields other than Health (Hanzlíková et al. 2004).

Primary health care must be organized so that it is accessible by each citizen. It must be based on the density and size of the physician's network perimeter. Size of physician's circumference (rather number of clients) should be set so that the 8-hour ambulance doctor could provide the care to his patients. The ideal circuit should have 1,500 patients with tolerance, given the geographic and demographic conditions in 1,800 patients aged 18 years.

The role of primary care physicians is:

- Basic early diagnosis of diseases.
- Monitoring and follow-up of major chronic diseases, especially in patients with advanced diseases of civilization.
- Prevention implemented in the form of preventive examinations including vaccinations.

Objectives of the survey

Main objective: To determine the level of satisfaction among the general public

with the overall healthcare provided by General Practitioner.

Sub-objectives:

1. Find satisfaction with the availability of primary health care to citizens.
2. Find satisfaction with the provision of information by health professionals.
3. Find satisfaction with approach of Doctors and Nurses to patients.
4. Obtain an overview of the citizens' awareness of preventive examinations and vaccinations.
5. Identify citizens' views on treatment and outpatient facilities.

Working hypotheses

H1 We assume that for respondents, in evaluation of satisfaction of care by their GP not only medical expertise but also approaches by Doctors and Nurses to patients and communication

with them is important.

H2 We assume that respondents will not be satisfied with providing of information about their state of health, examinations and treatment.

H3 We assume that respondents will have enough information about the possibilities of preventive examinations and vaccinations, from GP and also from other sources, and that they follow preventive examinations.

H4 We expect that the majority of respondents would not change their GP because they are in his care for a long time and are satisfied with his care, availability and tactful approach.

H5 We assume that for the satisfaction rating, clean and neat environments of ambulance and waiting areas as well as equipment are very important.

Characteristic of respondent sample

Number of respondents: 300 - men and women in the age group 20 to 80 years. Respondents were randomly asked to complete the questionnaire.

Research methods

As the principal research method was a questionnaire of our own design where we asked for subjective personal opinions of the respondents. This questionnaire survey was anonymous.

The following areas were covered in the questionnaire we used:

- Introduction of a questionnaire containing demographic data.
- Closed questions where respondents selected answers from the submitted alternatives.
- Semi-open questions were offered closed answers to which it was possible to add open-ended comments.
- Our respondents did not use open response options, they used only offered alternatives.

Analysis of demographic data

Overview of age in three age groups and gender of respondents are presented in the following table.

Age group	Men/n	Women/n	%
20 - 40 years	20	40	20%
40 - 60 years	80	70	50%
60 - 80 years	50	40	30%
N	150	150	100%

Analysis of the questionnaire responses

1. How long have you been in the care of your practical (district) Doctor?

Years of care	n	%
0 - 5 years	60	20%
5 - 10 years	60	20%
More than 10 years	180	60%
N	300	100%

2. What are your most frequent reasons for visits to your GP?

Answers	n	%
I go when I have a medical problem	150	50%
Only in case of any acute illness (viral illness) that cannot handle in my own	70	23%
If I need to prescribe medicines I am taking for a long time	60	20%
For purposes of preventive examinations	20	7%
I do not visit the doctor at all	0	0%
N	300	100

3. Are you generally satisfied with the care provided by your GP?

Answers	n	%
Satisfied	240	80%
Partially satisfied	60	20%
Rather dissatisfied	0	0
If dissatisfied, please specify why	0	0
N	300	100%

4. What do you consider as the most important when assessing satisfaction with your GP?

Answers	5.	%
Expertise of doctor	160	53.3%
Humane approach of doctor to patients	130	43.3%
Age of doctor	0	0%
Whether it‘s a male or female doctor	10	3.3%
If other reasons please specify	0	0
N	300	

5. Did your Doctor provide you enough information about free preventative examinations and vaccinations which under the current legislation you have been entitled to?

Answers	20-40 years/n	40-60 years/n	60-80 years/n	%
Yes, sufficiently	0	100	90	63.3%
Only partially	20	0	0	6.6%
I have more information from another sources	40	50	0	30%
N	60	150	90	100%

6. If in the previous question you indicated that you obtained more information about what you as a patient you are entitled from other sources, indicate from which one:

Answer	n	%
TV, radio	60	20%
Magazines	20	6-6%
Family	30	10%
Friends	0	0%
Internet	20	6.6%
N	130	43%

7. Do you visit your medical practitioner for preventive examinations?

Answer	20-40 years/n	40-60 years/n	60-80 years/n	%
Yes, regularly	20	20	0	13.3%
Irregularly	10	100	0	36.6%
I do not	30	30	90	50%
N	60	150	90	100%

8. Did your Doctor provide you with enough information about the necessity and content of all examinations he prescribed you?

Answer	n	%
Yes, completely	270	90%
Partially	30	10%
Insufficiently	0	0%
N	300	100%

9. Do you feel that this information was presented clearly enough?

Answer	n	%
Yes, completely	250	83.3%
Only partially	20	6.6%
No, there were too many medical terms	30	10%
N	300	100%

10. Did your Doctor give you the opportunity to express agreement or disagreement with the examination or treatment?

Answer	n	%
Yes	210	70%
No	0	0%
I left it on the doctor	90	30%
N	300	100%

11. When prescribing new medications or changing medications, did the Doctor point to the possible adverse effects as well as the surcharge for the medicaments?

Answer	n	%
Yes, ever	200	66.6%
Sometimes	100	33.3%
No, never	0	0%
N	300	100%

12. How would you evaluate approach of Nurses to patient in the office of your doctor?

Answer	n	%
Very good	230	76.6%
Good	70	23.3%
Bad	0	0%
N	300	100%

13. Did the Nurse explain before each performance what she will do?

Answer	n	%
Yes, ever	240	80%
Sometimes	60	20%
No, never	0	0%
N	300	100%

14. Did Nurse and Doctor respect you when you explained your problems and did they respect your privacy during examinations?

Answer	n	%
Yes, ever	300	100%
Sometimes	0	0%
No, never	0	0%
N	300	100%

15. How would you evaluate the communication between you, the Doctor and Nurse?

Answer	n	%
Very good	100	33.3%
Good	180	60%
With problems	20	6.6%
Bad	0	0
N	300	100%

16. Are the cleanliness and equipment in ambulance and waiting areas important when evaluating your satisfaction?

Answer	n	%
Yes, definitely	270	90%
I do not know	30	10%
No	0	0%
N	300	100%

17. Is the neatness of Nurses and Doctors in the ambulance important when you assess your satisfaction?

Answer	n	%
Yes, definitely	240	80%
I do not know	40	13.3%
Not at all	20	6.6%
N	300	100%

18. Are areas of waiting room and ambulance of your doctor adapted for wheelchair access?

Answer	n	%
Yes	100	33.3%
Partially	50	16.6%
I do not know	140	46.6%
No	10	3.3%
N	300	100%

19. Are you satisfied with the length of office hours of your doctor?

Answer	n	%
Yes	210	70%
I do not know, I do not care	80	26.6%
No, I am not	10	3.3%
N	300	100%

20. Do you use the option of ordering at a specific time for a fee?

Answer	n	%
Yes	20	6.6%
No	210	70%
I do not know about this option	70	23.3%
N	300	100%

21. Have you ever thought about changing your GP?

Answer	n	%
Yes I thought about it	20	6.6%
I have not thought about it	40	13.3%
I am satisfied with my doctor	240	80%
N	300	100%

22. What would be the reasons that might lead to a decision to change your General Practitioner?

Answer	n	%
Doubts about the expertise of the doctor	110	36.6%
Dissatisfaction with medical approach	140	46.6%
Failure to provide sufficient information	50	16.6%
Doubts about the expertise of nurse	0	0%
Dissatisfaction with the approach of nurse	0	0%
Unsuitable environment of ambulance & waiting areas	0	0%
Alternatively, indicate the other	0	0%
N	300	100%

Evaluation of working hypotheses

Based on analysis of data collected from respondents, we came to the following conclusions:

H1 *We assume that for respondents, in evaluation of satisfaction of care by their GP not only medical expertise but also approaches by Doctors and Nurses to patients and communication with them is important*.

Hypothesis 1 **was confirmed**. For 53% of respondents for evaluating satisfaction in medical expertise is important and for 43% of respondents a human approach of physician to the patient. The ratio between expertise and approach is essentially balanced. This hypothesis was verified at the beginning of questionnaire and at the end in the last questions where we came to the same results with small variations. Regarding communication with health professionals, respondents evaluated it 60% as good and as very good perceived by only 33.3% of respondents. **The reasons which lead respondents to this evaluation could be the subject of further research.**

H2 *We assume that respondents will not be satisfied with providing of information about their state of health, examinations and treatment.*

Hypothesis 2 **has not been confirmed**. 90% of respondents said that their Doctor had sufficiently informed them about all aspects of examinations and treatment, and for 83.3% of the respondents, this information was sufficiently clear. Even 70% of respondents in the questionnaire said that the doctor allowed them to express agreement or disagreement with the prescribed examinations and treatment. For information on adverse reactions to prescribed medications and supplementary payment, 66.6% of respondents said that they were always informed and 33.3% of respondents sometimes. **80% of respondents said that before the intervention the Nurse explained to them what is going to happen and 20% of respondents said they were instructed only sometimes.**

H3 *We assume that respondents will have enough information about the possibilities of preventive examinations and vaccinations, from GP and also from other sources, and that they follow preventive examinations.*

Hypothesis 3 **has not been confirmed**. As regards the information provided by Doctors, they are sufficient for 63.3% of respondents. It is interesting that this is only in respondents in the age group 40-60 years (33.3%) and 60-80 years (30%). 6.6% of respondents aged 20-40 years said they were partly informed by the Doctor and 30% of respondents said they have more information from other sources. These respondents are in the age groups 20-40 and 40-60 years. This information about awareness cannot be evaluated according to age because we do not have the same number of respondents in all age groups. On the question of information from other sources, 13 respondents and 20% of them answered that they have much information from television and radio, 10% received information from the family and the same proportion of 6.6% were provided with this information from the internet and magazines. The worse situation among respondents is regarding preventive examinations because 50% do not attend them, 36.6% irregularly and only13.3% regularly. These results are not affected by the age of respondents, as there is small representation of younger respondents between them for which these preventive examinations are of utmost importance.

H4 *We expect that the majority of respondents would not change their GP because they are in his care for a long time*

and are satisfied with his care, availability and tactful approach.

Hypothesis 4 **was confirmed**. Overall satisfaction with the care of their General Practitioner was expressed by 80% of surveyed respondents and 80% expressed their satisfaction with it in Question 21 about the change of Practitioner. 100% of respondents also reflected satisfaction with the approach of Nurses and Doctors regarding examinations and confidential communication. The length of office hours suits 70% of respondents.

H5 *We assume that for the satisfaction rating a clean and neat environment of ambulance and waiting areas as well as equipment are very important.*

Hypothesis 5 **was confirmed**. When evaluating satisfaction for 90% of respondents, cleanliness of ambulance facilities and waiting room was of importance for them. Even the neatness of Nurses and Doctors is important to 80% of respondents. Only 33.3% of respondents expressed satisfaction with disabled access into ambulances, 16.6% reported partial access and 46.6% could not assess whether the ambulance and waiting room areas allow it. Only 3.3% replied that they are not facilitated for it.

Recommendations for Practice

Based on the information we have acquired in our research we can conclude that the public is satisfied with the care of Practitioners. The results showed that our Doctors and Nurses should improve their communicating with patients. In the future, more of these problems could be addressed in other research which would be focused on communication with patients. In our study we have actually not identified what mistakes our medics are doing.

Pleasing is the finding of sufficient informing of our public about performances and treatment and it is certainly necessary to pay attention to it in the future because ignorance may cause mistrust of public to Health Care Workers.

I would be more appealing for our Doctors, and also Nurses, closer adherence to preventive examinations, particularly among young people, because now diseases are so widespread in civilization which are in time detected, monitored and treated to have a greater percentage of successful treatment.

There should be a place for even better communication with patients and also decoration of waiting room with posters and reading. To improve access for people with disabilities for care by a General Practitioner, improvement of those areas and waiting rooms is necessary. In conclusion it should be stressed that an empathetic approach, helpfulness, good communication, sufficient awareness and, of course, certainly the expertise of Doctors and Nurses, are judgmental factors of satisfaction with the care our society provides in primary care through the Outpatient Practitioners. Despite financial shortages in our health, we also must think about the technical equipment of clinics to provide care on a certain professional level, but also to increase patient comfort while in the waiting room and during examinations.

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Women's Political Deprivation: A Natural Selection or Cultural Injustice The Case of Pakhtun Society, Pakistan

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Abstract:

Politics is considered men's business; the people with riches and plenty of time. However, it is more vital for the vulnerable segments of Society, to commit them in changing the environment that affects their lives. The current study was conducted concerning cultural barriers toward women's political participation in *Pakhtun* Society, collecting the data from a sample of 320 women councilors using a questionnaire/ interview schedule. SPSS 20, was used for univariate and bivariate analysis, applying chi-square test for possible association. This study revealed that social structure has a phenomenal role in women's least participation in politics in *Pakhtun* Society. Inferences of the statistics discovered that the main cultural hindrances to women's political participation include: lack of power and authority; stereotypical image; heavy domestic burdens; strong patriarchy; lack of women's choices; women's association with family honor.

On the basis of the findings, this study recommends the role of civil Society in highlighting the significance of women's participation in politics. Similarly, the role of mass media and timely implementation of government policies are highly significant in this regard.

Introduction

Constituting almost half of the total world's population, women are claimed to be not dealt equally with men in many respects including politics (Aslam 2002). Due to gender rights movements and widespread awareness the developed countries portray a better position in context of women's rights (Ibrahim 2005). However, poor developmental indicators can be observed in emerging countries which show vast gender gaps (Omvedt 2005). The Inter-Par-liamentary Union (IPU) (2017) revealed that the global female political participation ratio is 22.5% indicating a lack of female representation in the political process due to the hold of traditionalism and socio-economic factors. Kazmi & Quran (2005) believed that two reasons behind low participation are women's illiteracy and socio-economic hurdles.

Omar (2015) argued that women's political empowerment is a precondition for socio- economic, political development and social security. Studies reveal that women's disem-powerment is caused by inflexible socio-cultural environments sponsored by religious manipulation, patriarchy and economic dependency (Naz 2011). Similarly, misunderstood folk wisdom and cultural norms have considered women a delicate gender who cannot shoulder political responsibilities even in the majority of societies (Khan 2011). Similarly, sidelining women from political responsibilities is due to normative structure; economic dependency; religious misinterpretation (Shaheed, 2009). In most countries, women have been given nominal representation in political institutions, governance and decision making bodies (Kittilson 2006). Roza, (2010) believed that the role of political parties is not supportive to women's participation because they are framed by male dominated social setup and institutions.

Studies have indicated that women are deprived of political participation and governance in most societies due to their biological make-up and illiterate status (Bari

2009). As claimed by Ali & Akhtar (2012), the reason behind these deprivations are cultural norms, traditions and conventional folk arrangements perpetuating these theories across generations. Similarly, UNDP (2005) explores that due to such continuous negligence in political affairs women have least understanding of political processes. Research suggests that democratic values can be streng-thened when there is maximum participation of both genders in main stream activities (Stein 1997). Contrarily, in most of societies due to structural barriers, women are discouraged from participating in decision making, casting votes or contesting in elections (Bose & Rossi 1983).

Based on hypothetical understanding of biological differences in majority of societies, the household is considered the women's world; public activities are men's realm (Prince 2005). Naturally equipped for procreation and nourishment, women are considered fit for such domestic responsibilities whereas men's ability to leave their children for long periods are more likely to become engaged in outside activities e.g. hunting and fighting (Rustagi 2000). However, the advent of household technology has made things easier and able to be managed without any concern for muscular power.

Since their childhood, women in the developing world have low status, fewer rights, less opportunities and rare benefits that have lifelong effects (Rizvi, 1980). Female children are taught at a very early age to accept blame; anger; abuse; any other limitations within the family. Similarly, discrimination in food, dress, education, health care, marriage choice and inheritance is common in majority of the Cultures including *Pakhtun* Culture (Population Census 1991). Adams (1997) remarked that girls are married young at age 15 or less, due to their temporary status at their father's home. This young age again has negative impact upon gender relations in the marriage union; marital relations; perpetuates low status in relation to men (Prince 2005).

Devlin & Elgie (2008), believed that due to historical dominancy of patriarchy in societies all institutions are male dominated where men outnumber women and hence their representation is affected on all platforms. In some parts of Palistan, especially *Pakhtun* Society, women are still prevented from casting their vote (Aziz & Abdullah 2012). Research studies show the majority of contemporary societies are latently or manifestly patriarchal (Lockard, 2007), a social system where men dominate primary roles in social; political; economic; religious spheres (Malti-Douglas 2007). A study conducted by Aalberg & Jenssen (2007) explains that traditionally men are considered more gifted and prudent than women. Similarly, male politicians are expected to be more intelligent, trustworthy, popular and convincing. Similarly, Popkin (1991) believed that women are commonly considered more conventional and traditionalistic than men. In fact, voters use known beliefs to support a particular gender according to the prevailing public opinion (Thomas 1997). However, the role of public offices and political institutions is of prime import to address gender biasness; distribution of powers; recognition of gender equality in Culture; knowledge; production; opinion building (Skalli 2011). From given discussion, it is evident that in many societies women are negatively portrayed affecting public and political participation.

Study Argument

As in numerous societies of the world, *Pakhtun* family structure is basically patriarchal in nature. This leads to several structural and functional restraints in Society to hinder women from partici-pation in public at individual (education, jobs, business) and collective levels (party, meetings,

entrepreneurship and groups), as well. However, these structural and functional limitations need to be changed at both levels: individual and collective for the betterment of Society (Bari 2005). The target area of this study is traditional *Pakhtun* Society which has been managed under the conventional and customary law commonly known as *Pakhtunwali* (*Pakhtun codes of conduct*) (Naz 2011, Khan 2011). In *Pakhtun* Society, gender has been the major source of: division of labor; socio-cultural roles; religious; economic; political opportunities. In this context gender is sidelined in politics and empowerment due to sex segregation. Reasons behind this abstention are: low literacy; no roll in decision making processes; patriarchy; religious misconception; economic dependency; male dominancy (Ali, Fani, Afzal, & Yasin 2010).

Development is a holistic approach where all segments of Society act collectively to participate in socio-economic and political uplifting (Saleem 2010). Researchers, like Banting in her study (2003) in Afghanistan, concluded that *Pakhtunwali* (*Pakhtun code of conduct* and *Pakhtun way of life*) consider women as their honor and protect her from physical or vocal harm. Thus, she is prevented from public exposure and is strictly limited to home. This marginalization compels women to live under the culturally defined rules of *Pakhtunwali*: centuries old customs; socio-cultural constraints; blatant misappropriation of religion (Banting 2003). The situation is further aggravated by the reluctance of affirmative action to mitigate exploitation of women or encourage empowerment of women (Reyes 2002).

Similarly, Aslam (2002) opined that under representation of women in political spheres is due to the masculine hold over the power and economic resources which is the running wheel of all their worldly affairs. Likewise, all social and formal institutions are masculine and the socialization process of the study area reinforce patriarchy and male dominance (Basu 2005). Nevertheless, cultural and social values and misinterpreted folk wisdom explain women as a delicate sex who could not shoulder political burdens. Thus in third world countries including Pakistan, political affairs are mostly explained by male dominated religious, social, cultural environments and hence inclusion of women in politics is restricted (Khan 2011).

In addition, lack of financial resources hampers the decision making powers of women in family and community. At the most physical level, bearing and rearing children are considered to be the main hindrance to women's entry into the public domain (Aderinwale 1997). Most importantly this segregation has been justified by the misuse of religion. For example, the *Purdah* system (veil) has been considered an impediment to the simple act of casting a vote or their candidature (Shaheed 2009). Rural areas, especially PATA and FATA, portray a worse picture where codes of life are traditional and thus assign more powers to men in the hierarchy of Society (Noreen & Musarrat 2013). The major source of stratification in *Pakhtun* Society is gender which in many cases lead to gender discrimination female subordination; little economic freedom (Ali *et al.* 2010). It has been further elaborated that women have been allotted secondary status that deprive them from political and economic affairs (Naz 2011, Khan, 2011).

The institutional dominance of men and socialization processes further reinforce male dominancy (Basu 2005). Similarly, lack of infrastructure; unavailability of educational facilities; social conduct; poverty; general perceptions are against female education (Sheikh, 2009). This is why in some parts of the country, especially *Pakhtun* Society, women are still prevented from casting votes (Aziz & Abdullah, 2012). It is

therefore summarized that the base of all the discri-mination against women is the normative structure which define the statuses of genders and allocate roles in the Society. However, the advent of modern technology has filled the gap for requirement of physical power to do public activities. Similarly, least presence of women in educational, economic and religious institutions affect women's political participation.

Materials & Methods

The current study is framed under a quantitative approach where the data was analyzed through the *Statistical Package for Social Sciences* (SPSS) 20. Univariate analysis was conducted for frequencies and percentages. To test possible association between variables, bivariate analysis was conducted through chi-square test at 0.05 level of significance. The universe of this study remained 7 districts of Malakand Division, Khyber Pakhtunkhwa, Pakistan. A sample of 320 women councilors in the district council, tehsil council, union council and village council were interviewed through questionnaire and interview schedules. To decrease sampling error, propor-tional representation technique was adopted, as given in Table-1 below which shows the total number of women representatives in Malakand Division is 1,871 local government councilors.

A sample of 320 was selected according to Sekaran & Bougie (2016) Table for sample selection for the given sample frame. Hypotheses of the study are as under:

H_0: *Pakhtun* social structure has no association with women's participation in politics.

H1: *Pakhtun* social structure has significant association with women's participation in politics.

Table 1: District wise proportional allocation of the sample

District	Stratum Population	Stratum Sample
Chitral	217	38
Dir Upper	263	44
Dir Lower	421	73
Swat	328	56
Shangla	230	39
Buner	228	38
Malakand	184	32
Grand Total	1,871	320

Sample Frame: 1,871 Sample size: 320

Formula: $\frac{\text{Population of Stratum} \times \text{Sample Size}}{\text{Total Population}}$

Univariate Analysis

Univariate analysis in this study is composed of frequencies and percentage Tables. The results in this chapter have been discussed under three sections. Section I reveals discussion on 'Demographic Profile'; Section II '*Pakhtun* Social Structure'; Section III 'Women's political participation'. Detailed discussion is given below.

Section I: Demographic Profile

This section is an important indicator toward the social, economic and psychological representation of the respondents and their thinking preferences. In the study the demographic profile is composed of: age wise distribution; literacy ratio; marital status; professional status. The following Table 2 guides us further in the mentioned regard: Table 2 displays age wise distribution of the sample respondents. It is apparent from the data that out of 320 (100%) respondents, 118 (36.9%) were in the range of ages 25-35 years; 152 (47.5%) were ages 36-45 years; while 50 (15.6%) were ages 46 years and above. The Table showed that majority of the respondents were in the age group 36-45 years which is a group of mature and well experienced people. The second major age group 25-35 indicates that a majority of the respondents are educated youth serving as representative in the local government. Similarly, among the total 320 (100%); 234 (73.1%) a significant majority is married. It has been noted that married women are more trusted to take part in the activities outside home especially in politics (Lieb & Thistle 2005). Similarly, 73 (22.8%) are single while, a minimum number 13 (4.1%) are separated as divorced or widowed.

Table 2: Age, Marital Status, Educational Status, Family Type, Occupation of Respondents

Statement	Frequency	Percentage
Age of the respondents		
25-35	118	36.9
36-45	152	47.5
Above 46	50	15.6
Total	320	100
Marital status of the respondents		
Married	234	73.1
Single	73	22.8
Separated	13	4.1
Total	320	100
Educational status of the respondents		
Illiterate	119	37.2
Metric	121	37.8
Bachelor	55	17.2
Master	25	7.8
Total	320	100
Family type of the respondent		
Nuclear	102	31.9
Joint	201	62.8
Extended	17	5.3
Total	320	100
Occupation of the respondent		
Housewife	252	78.8
Own business	44	13.8
Employee	24	7.5
Total	320	100

Table 2 further illustrates literacy ratio and educational level of the respondents. Out of the total 320 (100%), 119 (37.2%) were illiterate; 121 (37.8%) were matriculate; 55 (17.2%) had bachelor degrees; 25 (7.8%) were master degree holders. These statistics depict that literacy ratio is not satisfactory among the women involved in the political process. However, these are politically conscious families who are well educated and allow their women to participate in public spheres like education and politics.

The specified Table-2 further shows the family type of the respondent which elucidates that majority 201 (62.8%) are coming from joint family system; 102 (31.9%) belongs to nuclear family; 17 (5.3%) belong to anextended family system. Majority of the respondents belong to a joint family system where women have maximum responsibility at home in *Pakhtun* Society and are prevented from engaging in public activities (Aziz & Abdullah, 2012).

The Table further explores that a vast majority of the respondents are housewives 252 (78.8%); 44 (13.8%) have their own businesses; only 24 (7.5%) are formally employed.

This shows that women are not allowed to participate in the public sphere. Due to low literacy women in the target area their participation in employment is also quite low.

Section II: Pakhtun Social Structure

Normative structure or social structure have an important role in social arrangement of institu-tions and norms which are followed by individuals in Society. By social structure we mean the regularities in life which is quite consistent in different societies (Crothers & Charles, 1996). Social structure is varying according to the context which can take the form of macro (overall system of socio-economic stratification); meso (social network ties between individuals and organization); micro (norms and behavior of an individual in social system)(Merton, 1938).

The following Table-3 will show the structural barriers toward women participation in politics.

Table 3: Pakhtun Social Structure

Statement	Frequency	Percent
Least Power with Women in *Pakhtun* Society		
Agree	247	77.2
Disagree	55	17.2
Neutral	18	5.6
Total	320	100
Stereo-typical Image of Women in *Pakhtun* Society		
Agree	250	78.1
Disagree	52	16.3
Neutral	18	5.6
Total	320	100
Gender Segregation in Pakhtun Society		
Agree	250	78.1
Disagree	52	16.3
Neutral	18	5.6
Total	320	100
Limitation of Women to Homes in *Pakhtun* Society		
Agree	258	80.6
Disagree	49	15.3
Neutral	13	4.1
Total	320	100
Strong Patriarchic system in Family		
Agree	258	80.6
Disagree	46	14.4
Neutral	16	5.0
Total	320	100
Women are fit for domestic chores only		
Agree	248	77.5
Disagree	52	16.3
Neutral	19	5.9
Total	320	100
Strict Purdah System (Veil) as a Barrier		
Agree	272	85.0
Disagree	37	11.6
Neutral	11	3.4
Total	320	100
Women's Participation in Politics is a Threat to Men's Honor		
Agree	246	76.9
Disagree	62	19.4
Neutral	12	3.8
Total	320	100
Women's Participation in Politics is a Threat to *Pakhtun* Traditions		
Agree	273	85.3
Disagree	36	11.3
Neutral	11	3.4
Total	320	100
Lack of Freedom to Make a Choice		
Agree	261	81.6
Disagree	45	14.1
Neutral	14	4.4
Total	320	100

The above Table-3 demonstrates that out of the total 320 (100%): a high majority 247 (77.2%) are of the view that *Pakhtun* social structure hinder women to participate in politics; 55 (17.2%) disagreed with this statement; while 18 (5.6%) remained neutral. Khan (2011) believes that cultural values and misinterpreted folk wisdom consider women a delicate gender who could

not shoulder power and political responsibilities.

Table-3 further revealed that 250 (78.1%) agreed that women are stereotyped in *Pakhtun* Culture; 52 (16.3%) disagreed; 18 (5.6%) remained neutral. Aalberg & Jenssen (2007) explain that men are generally considered more popular, gifted and prudent. Similarly, Popkin (1991) believed that women are commonly considered more conventional because of religious and cultural stereotyping against women (Ibrahim 2005).

Table-3 further displays that out of the total 320 (100%): a vast majority 250 (78.1%) believed that women are segregated from main stream public activities; 52 (16.3%) disagreed; 18 (5.6%) were neutral. Sattar (2012) found that segregation of women from main stream public activities is a violation of basic human rights.

Table-3 shows that out of 320 (100%): 258 (80%) opined that there exists a common notion in Pakhtun Society that 'women are either for home or for grave'; 49 (15.3%) disagreed; 13 (4.1%) remained neutral. Basu, Amriyta, Jayal, Naraja Gopal, & Yasmin (2003) believed that societies with strong patriarchy make it difficult for women to compete in the open arena against powerful men. This way their interests are getting more suppressed than properly addressed.

Table-3 further discloses that out of the total 320 (100%): a strong majority 258 (80.6%) agreed that a strong patriarchic system has been the obstacle in women's political participation; 46 (14.4%) disagreed; while 16 (5.0%) remained neutral. Aslam (2002) argued that women's under representation in political spheres is due to the masculine hold over power and economic resources. Likewise, social and formal institutions reinforce patriarchy and male dominance (Basu 2005).

Table-3 revealed that out of the total 320 sample: 248 (77.5%) believed that in *Pakhtun* Society women are considered fit for domestic chores only; 52 (16.3%) disagreed; 19 (5.9%) remained neutral. Researchers have concluded that women in the rural setup face major problems in their due rights because of poverty; lack of access to land; unemployment; illiteracy; heavy domestic workload (International Alert Report 2012).

Table-3 confirms that out of the total 320 (100%) respondents: 272 (85.0%) agreed with the statement that women are debarred from politics due to the strict *purdah* system; 37 (11.6%) disagreed; 11 (3.4%) remained neutral. Shaheed (2009) believed that the undue and strict Purdah system (veil) is considered an impediment to the simple act of casting vote and candidature.

Table-3 further explains that out of the total 320 (100%): 246 (76.9%) agreed that women are not allowed into politics because they are considered a threat to *Pakhtun* honor (*ghairat*); 62 (19.4%) disagreed; 12 (3.8%) remained neutral. In a patriarchal system the normative structure maintains a strict moral and honor code for women while the women have to abide by strict cultural practices to preserve their chastity and not to defame the family (Khan 1999).

Table-3 explains that out of 320 (100%): 273 (85.3%) are of the view that in *Pakhtun* Culture women participation in politics is considered a threat to *Pakhtun* traditions; 36 (11.3%) disagreed; 11 (3.4%) remained neutral. Studies reveal that *Pakhtun* Society has been managed under the conventional and customary law commonly known as *Pakhtunwali* (*Pakhtun codes of conducts*) (Naz 2011 Khan, 2011). Gender has been the major source of division of labor; socio-cultural roles; religious; economic; political opportunities in *Pakhtun* Society. Thus, women are sidelined in the politics and decision making process (Ali *et.al* 2010).

Table-3 further illustrates that out of the total 320 (100%): 261 (81.6) were of the view that women are not allowed to make a choice in voting and contesting election

but to follow the men, 45 (14.1%) disagreed, 14 (4.4%) remained neutral. Studies explain that, the notion of women empowerment also has a contribution to individual choice of selection (Basu *et al.* 2003).

Discussion of the given Table-3 revealed that nothing else affect women participation in politics more than the prevailing patriarchic system which would never allow women to get a position of power. Similarly, women are deliberately segregated from main stream activities by the dominant men in the Society especially in Khyber Pakhtunkhwa. In addition, negative stereo-typing of women as least intelligent and unproductive has negatively portrayed the stature of women. Also, women's association with family honor and the Pakhtun codes are among the hard barriers for women to overcome. Even their choice in spouse selection has also been curtailed and parents especially father decision has to be obliged.

Section III: Women's Political Participation

Women constitute about half of the world population but have traditionally been discriminated in many aspects of life including politics (Aslam 2002). Currently, developed countries are nonetheless in a better position to address gender issues due to women's movements and widespread awareness (Ibrahim 2005). On the contrary, developing countries still experience gender gaps which manifest themselves in poor developmental indicators (Omvedt 2005).

Table 4: Women's Political Participation

Statement	Frequency	Percentage
Pakhtun Social Structure & Women's Participation in Politics		
Agree	270	84.4
Disagree	28	8.8
Neutral	22	6.9
Total	320	100
Women's Economic Dependency & Political Participation		
Agree	265	82.8
Disagree	31	9.7
Neutral	24	7.5
Total	320	100
Mass Illiteracy & Women's least Interest in Politics		
Agree	277	86.6
Disagree	25	7.8
Neutral	18	5.6
Total	320	100
Weak & Deficient Policies & Women's Political Participation		
Agree	264	82.5
Disagree	27	8.4
Neutral	29	9.1
Total	320	100
Masculine Interpretation of Religion & Women's Deprivation		
Agree	272	85.0
Disagree	26	8.1
Neutral	22	6.9
Total	320	100
Women's Nominal Representation in Political Parties		
Agree	276	86.3
Disagree	27	8.4
Neutral	17	5.3
Total	320	100

The above Table-4 displays that out of the total 320 (100%): 270 (84.4%) agreed that *Pakhtun* social structure is not supportive to women's political empowerment; 28 (8.8%) disagreed; 22 (6.9%) were found neutral. Khan (2011) believes that cultural values and misinterpreted folk wisdom consider women a delicate gender who could not shoulder power and political responsibilities.

Table-4 further ascertains that 265 (82.8%) agreed that dependence of women on men economically in *Pakhtun* Culture sideline women from power and authority; 31 (9.7%) disagreed; 24 (7.5%) remained

neutral. Welle & Heilman (2007) believe masculine popular Culture customs; traditions; laws; policy procedures provide little opportunities for women to take a lead. Women thus remain dependent on men economically, in decision making and in politics.

Table-4 further tells us that out of the total 320 (100%): 277 (86.6%) agreed that mass illiteracy in female leads to least understanding of the political system; 25 (7.8%) disagreed; 18 (5.6%) remained neutral. Karl (2001) identifies the main obstacles to women's participation in politics as their low education, illiteracy; lack of access to information; low socialization.

Table-4 explains that out of the total 320 (100%): 264 (82.5%) agreed that enactment of proper policies for mainstreaming women in politics are deficient; while 27 (8.4%) disagreed; 29 (9.1%) remained neutral. Kingdon (1984), observes that lack of rational policies hinder promotion of gender equality in politics. Prudent policies by professionals are more important than any method and technique of empowernent.

Table-4 elucidates that out of the total 320 (100%): 272 (85.0%) agreed that male dominated religious institutions stop women from participation in public activities including politics; 42 (13.1%) disagreed: 21 (6.6%) remained neutral. It is commonly understood that non-participation of women in politics is obstructed by three distinct but interconnected variables: social structure; economic disadvantages; religious miss interpretation (Shaheed, 2009).

Table-4 ascertains that out of the total 320 (100%); 276 (86.3%) agreed that women are not included in political parties; 27 (8.4%) disagreed; 17 (5.3%) remained neutral. Roza (2010) understand that political parties influence the whole political milieu, yet they too are shaped by the patriarchic system.

It is evident from the above discussion that in addition to structural barriers the economic dependence of women are always at the disposal of men in each and every decision including politics. Similarly, illiteracy not only affects their life at home but also the public sphere of women as well. Besides, timely legislation and implementation in the real sense is important. This way, the rights of the women can be safeguarded and will eventually eradicate all sorts of discrimination against her. The role of political parties to streamline women in politics is of utmost significance.

Bi-Variate Analysis

Social structure includes every phenomenon in Society from larger system to individual behavior and therefore its role is of prime importance in the behavior and attitude of the individual living in Society. Cross cultural studies reveal that women are disempowered because of the problems ordained in the rigid socio-cultural conditions backed by religious misappropriation; economic dependency; male dominated values (Naz, 2011).

Table 5: Impacts of Pakhtun Social Structure upon Women's Political Participation

Statements In *Pakhtun* social structure:	**Response**	**Women's Political Participation**			
		Agree	**Disagree**	**Neutral**	**Statistic**
Women have no power/authority which leads to least participation in politics	Agree	225(77.9%)	22(81.5%)	0(0%)	=21.284 =0.000
	Disagree	48(16.6%)	5(18.5%)	2(50%)	
	Neutral	16(5.5%)	0(0%)	2(50%)	

Stereo-typical image of women is a cause of least participation in politics	Agree	228(78.9%)	22(81.5%)	0(0%)	=21.683 =0.000
	Disagree	45(15.6%)	5(18.5%)	2(50%)	
	Neutral	16(5.5%)	0(0%)	2(50%)	
Gender segregation from main stream activities is a cause of least participation in politics	Agree	225(77.9%)	21(77.8%)	2(50%)	=4.259 =0.372
	Disagree	51(17.6%)	6(22.2%)	2(50%)	
	Neutral	13(4.5%)	0(0%)	0(0%)	
Women are for home or grave, a common notion hinders women from politics	Agree	228(89.4%)	35(70%)	13 (86.7%)	=21.107 =0.000
	Disagree	20(7.8%)	6(12%)	1(6.7%)	
	Neutral	7(2.7%)	9(18%)	1(6.7%)	
Strong patriarchic system in family hinders women from active role in politics	Agree	226(77.9%)	22(81.5%)	0(0%)	=21.285 =0.000
	Disagree	47(16.6%)	5(18.5%)	2(50%)	
	Neutral	16(5.5%)	0(0%)	2(50%)	
Women are considered fit for domestic chores only, not politics	Agree	224(77.9%)	22(81.5%)	0(0%)	=21.283 =0.000
	Disagree	49(16.6%)	5(18.5%)	2(50%)	
	Neutral	16(5.5%)	0(0%)	2(50%)	
Strict Purdah in *Pakhtun* is a barrier to women's participation in politics	Agree	245(84.8%)	24(88.9%)	3(75%)	=3.702 =0.448
	Disagree	35(12.1%)	1(3.7%)	1(25%)	
	Neutral	9(3.1%)	2(7.4%)	0(0%)	
Women's political participation is a threat to men's honor (Ghairat) which restrict them	Agree	226(78.2%)	19(70.4%)	1(25%)	=11.201 =0.024
	Disagree	51(17.6%)	8(29.6%)	3(75%)	
	Neutral	12(4.2%)	0(0%)	0(0%)	
Participation of women in politics is considered a threat to *Pakhtun* traditions	Agree	249(86.2%)	21(77.8%)	3(75%)	=2.532 =0.639
	Disagree	30(10.4%)	5(18.5%)	1(25%)	
	Neutral	10(3.5%)	1(3.7%)	0(0%)	
Lack of freedom to choose & act by her choice is a cause of least participation in politics	Agree	222(87.1%)	33(66%)	9(60%)	=18.395 =0.001
	Disagree	16(6.3%)	8(16%)	3(20%)	
	Neutral	17(6.7%)	9(18%)	3(20%)	

Table-5 provides us the bivariate analysis of the first independent variable, *Pakhtun* Social Structure and its association with the dependent variable of Women's Political Participation.

The chi-square value (21.284) having a highly significant 'p' value (0.000) shows that least power and authority given to women in *Pakhtun* Culture affect women's participation in politics. Khan (2011) believes that cultural values and misinterpreted folk wisdom consider women a delicate gender who could not shoulder power; political duties; responsibilities.

Table-5 further provides chi-square value (21.683) having a highly significant 'p'(0.000) which shows that there is a strong association between the stereotypical image of the women in *Pakhtun* Society and their political participation. Aalberg & Jenssen (2007) explain that men are generally considered more gifted; intelligent; trustworthy; convincing than women. Similarly, Popkin (1991) believed that women are commonly considered more conventional and traditional.

The next part of the Table-5 indicates the chi-square value (4.259) which gives the 'p' value as (0.372) which is non-significant. The results showed that there is no association between the two variables. Thus gender segregation in mainstream activities is said to have no association with women's political participation.

Similarly, the chi-square value (21.107) having 'p' value as (0.000) is highly significant and hence a strong association between the variables exist. The sample respondents considered that as a common notion woman in *Pakhtun* Society are considered fit "for home or for grave" as a common maxim. Karl (2001) argued that the main obstacle to women's participation in politics are cultural stereotypes. Similarly, women are considered fit for domestic works only (Ibrahim, 2005).

In the next row the chi square value (21.285) which gives the 'p' value (0.000) is highly significant again and thus signify that in the strong patriarchic system women are not allowed to participate in public activities like politics which is men's job. Societies with strong patriarchy make it difficult for women to compete against the powerful men (UNRISD 2005). Aslam (2002) opined that the under representation of women in the political spheres is due to the masculine hold over the power and economic resources.

Similarly, a chi-square value (21.283) carries 'p' value (0.000) which is highly significant and hence the association between the two variables exist. It signifies that women in *Pakhtun* Society are considered fit for domestic chores only. Women are bound to domestic responsibil-ities and the physically strong men who are able to leave their children for a long time are more likely to become engaged in outside activities e.g. hunting and fighting (Rustagi 2000).

Table-5 further elucidated the chi-square value (3.702) with 'p' value (0.448) is non-significant and hence the strict *purdah* system has no significant effect upon women's political participation according to the sampled respondents. However, the Purdah system (veil) has been considered an impediment to the simple act of casting a vote and their candidature (Shaheed, 2009).

The next part of Table-5 explains the chi-square value as (11.201) with 'p' value as (0.024) which is significant and hence a relation between *ghairat* (men's honor) and women's political participation exists. The *Pakhtun* normative structure maintains strict moral and honor code for women to preserve her chastity and not to dehonor males of the family (Khan, 1999).

The next row of the Table-5 gives Chi-square value (2.532) with 'p' value (0.639) which is again non-significant and hence there is no association between the variables. Thus, women's participation in politics is not considered a threat to *Pakhtun* traditions.

Table-5 further reveals the chi-square value (18.395) with 'p' value (0.001) which is highly significant. The value explains that women are not free to make their choices which is strongly affecting women's participation in politics. The results are verified by studies which explain that the notion of women's empowerment also has a contribution to individual choice of selection what one considers valuable (Basu *et al* 2003).

The above interpretation revealed that out of ten statements in independent variable '*Pakhtun* Social Structure', only 3 are

non-significant and 7 variables are highly significant which shows significant association between variables. Thus, the null hypothesis H_0 is rejected and H1 is accepted. To sum up the whole discussion it is decided that *Pakhtun* social structure significantly affects women's participation in politics.

Conclusions

This study attempted to probe constraints to women's participation in politics in *Pakhtun* Society through assuming independent variable; socio-cultural hurdles to women's political participation. The study findings revealed that the social structure of the Society engender the individual since childhood where girls are trained for domestic chores which include caring, washing, cooking. Similarly, girls are considered emotional; less intelligent; least productive. This attitude leads toward her secondary status and over dependence upon men in food; maintenance; health; mobility; politics. However, women's least participation in politics negatively affect the deve-lopment of women and children. It is interesting to add here that modern democratic states are welfare oriented and thus women's virtues are more suited for socio-economic development; education; health; art; literature; mother and child care.

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Development of Unemployment of the Roma Minority in Selected European Countries

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Abstract:

Objective: The article is aimed at analyzing the degree of unemployment of the Roma minority in selected European countries.
Design: Synoptic study.
Participants: Research data acquired from specialized databases for 1990-2018.

Methods: Meta-analysis.
Results: The results show the lack of availability of data on the target set in most European countries, except for post-communist countries. The unemployment of the Roma minority has no relation at all to the general unemployment; it is always many times higher; it is primarily related to the exclusion of the Roma. Slight variation in the unemployment development can be seen in individual years.
Conclusion: In the first place, unemployment in segregated localities must be dealt with. This article is aimed at analyzing the degree of unemployment of the Roma minority in selected European countries. It is a meta-analysis of existing studies and reports. We used specialized databases as a source and focused on data from 1990 to 2018. For the Slovak Republic, we also found predictive data for the development of the Roma unemployment.
Studies dealing with the Roma minority are often qualitative and their results are limited to stating that the degree of Roma unemployment is higher than that of the majority population without stating any specific numbers. Additionally, many countries consider monitoring of the Roma minority as an ethnically separated group as an ethically and politically inadmissible thing. Therefore, differing data on their socio-economic situation are completely absent. If we want to deal with the unemployment of the Roma we must first allow for the fact that in most countries it is a population significantly affected by social exclusion and by related pathological phenomena. It is therefore necessary to distinguish the Roma who live in some form of segregated settlement (e.g. socially excluded localities in the Czech Republic or Slovak settlements of the Roma); from the Roma who are integrated or assimilated in the company. For example, Cada (2015) states that the unemployment in excluded localities oscillates between 80-85% even in regions where the general unemployment is below the national average. That means that the degree of Roma unemployment does not correspond with the development of the labor market in the given country. The Roma constitute one of the most endangered groups in the labor market not just because of social exclusion.

The Roma participating in the labor market often carry out works of short-term, seasonal character (Davidova *et al* 2010); men are involved more than women (Kajanova *et al* 2015). Cernusakova (2017) speaks of "invisibility" of Roma work. The reason consists in the fact that a great part of the Roma work without any employment contract, in an informal labor market; in highly unstable socially uncertain; often physically hazardous jobs.

The causes of Roma unemployment are dealt with by a number of authors. The causes include a combination of factors such as discrimination in the labor market and in public discourse in general (Gabal, Cada, Snopek 2008); decreasing number of qualified jobs (Mares, Sirovatka, Vyhlidal 2003); low education or qualification in Roma populations (O'Higgins, Ivanov 2006). Sajgalikova, Copus (2017) and Swietek (2013) and other authors see a problem primarily

in intergenerational unemployment. If the family lacks working models the child considers such situation a standard. However, the main cause of low unemployment consists in high indebt-edness and the related wage deductions that may play a demotivating role (Trlifajova, Hurrle, Kissova 2014). Thus the Roma pass to the illegal labor market that provides fast and certain earnings. Fuzesi *et al* (2008) sees a cause in their bad health condition.

Hirt and Jakoubek (2006) state that the inferior position of the Roma in the labor market has many other interacting causes: additionally to the above stated, they mention insufficient motivation to work resulting from the structure of large Roma families, mutual loans, etc. One of the few studies carried out directly with employers (Stankova 2014) showed that employers consider the situation of the Roma in the labor market as unfavorable. But they see responsibility on the Roma side due to their low qualifications. In their opinion, the problem should be addressed by the government and by society, but only to a limited degree. Neumanova (2008) emphasizes the importance of supported employment, professional and pre-professional consulting within a study of the Roma population and within the employment office.

In post-communist countries, Roma employment dramatically dropped in connection with the change of the political regime when the labor market transformations affected primarily unqualified persons and members of minorities (Fuzesi *et al* 2008).

Table 1 below shows the degree of Roma unemployment in available data. The most data including predictive statistics were available from Slovakia. In early 21st Century, the highest unemployment was reported from Bulgaria but it showed the strongest decrease in the course of time. On the contrary, the lowest unemployment could be seen in Hungary where it rapidly decreased as well. Slighter forms of decrease can be seen also in other countries, but with different year-on-year variations which were not caused by changes in national labor markets or by essential interventions. According to our hypotheses, they constitute methodical distortions. Variations in the results of individual studies can be seen for example in Slovakia where the outputs of different authors for the same year sometimes differ by more than 15%. We also consider it interesting that Romania that has the highest percentage of Roma population shows a considerably lower percentage of unemployed Roma than other analyzed countries.

Table 1: Degree of Roma unemployment in selected countries and its development in the course of time

Year	Country	Degree of Roma Unemployment	Source
2000	Czech Republic	46.3%	(Sirovatka 2003)
2005	Czech Republic	70.0%*	(Malan, Shreedhar 2007)
2008	Czech Republic	11.7%	(Czech Government 2009)
2011	Czech Republic	39.0%	(Czech Government 2012)
1997	Slovakia	78.0%*	(OECD 2004)
2000	Slovakia	84.8%*	(Sirovatka 2003)
2000 - 2005	Slovakia	78.2%*	(Marcincin, Marcincinova 2009)
2002	Slovakia	83.0%*	(OECD 2004)
2004	Slovakia	67.0%*	(Hidas *et al* 2018)

2005	Slovakia	73.1%*	(Filadelfiova, Gerbery 2012)
2006 - 2010	Slovakia	65.4%*	(Marcincin, Marcincinova 2009)
2011	Slovakia	70.0%*	(Messing 2014)
2011 - 2015	Slovakia	62.6%*	(Marcincin, Marcincinova 2009)
2012	Slovakia	73.0%*	(Stefancova 2014)
2016	Slovakia	55.0%*	(Hidas *et al* 2018)
2016 - 2020	Slovakia	62.6%*	(Marcincin, Marcincinova 2009)
2017	Slovakia	41.0%*	(Hidas *et al* 2018)
2000	Hungary	56.5%*	(Sirovatka 2003)
2011	Hungary	50.0%*	(Messing 2014)
2015	Hungary	28.3%*	(KamaraOnline 2016)
2000	Bulgaria	80.0%*	(Sirovatka 2003)
2010	Bulgaria	59.0%*	(Flanagin 2014)
2011	Bulgaria	40.0%*	(Messing 2014)
2000	Romania	76.9%*	(Sirovatka 2003)
2010	Romania	50.0%*	(Flanagin 2014)
2011	Romania	33.0%*	(Messing 2014)
2011	Romania	51.0%*	(Ionescu, Banu 2015)
2012	Poland	90%*	(Swietek 2013)

* Roma population aged 15-64 years from segregated localities

Conclusion

The results of our analysis show that primarily the unemployment in segregated localities must be urgently addressed. In other cases, Roma unemployment is higher than that of the non-Roma population, but the difference is not so sharp. The main causes of unemployment of the minority seem to consist primarily in social exclusion, not in ethnicity as such. A unified methodology for measuring of the degree of unemployment would contribute to deeper understanding of the issue in question.

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Mother and Child Anti-malnutrition Programs as a Part of Mission of European/Christian Values. An Example from Muhuroni Kenya and Condi in Burundi (Research note)

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Abstract:

The Anti-malnutrition Program (AMP) is the most successful program that has been introduced in Sub-Saharan Africa to reduce malnutrition in mothers and children suffering from starvation and irreversible damage to their psychosocial development.

Introduction

Large natural disasters such as migrant crisis in Myanmar, tsunami in Indonesia, earthquake in Haiti offers opportunity for humanitarian help. In 2018, famine looms across 13 countries in Africa and the Middle East. At least 2.5 million kids are still confronting starvation. (3)

Anti-malnutrition programs launched in 1990s when RUTF (ready to eat therapeutic food) and special milk formulas for fighting malnutrition were introduced for the first time saving millions lives. They are, in fact, the most successful programs introduced to Sub-Saharan Africa to reduce malnutrition in mothers and children suffering from starvation and irreversible damage to their psychosocial development. (1,2) An overview of AMP in SSA as a part of the Mission of European Christian Values is presented.

Overview of anti-malnutrition programs in Africa

An overview of anti-malnutrition programs in 6 Sub Saharan African countries operated by anti-malnutrition staff of Tropic team of St. Elizabeth University in Kenya, South Sudan, Uganda, Burundi, Lesotho, and Rwanda is described. Programs are operating since 1999 (Kenya); 2000 (S. Sudan); 2004 (Uganda); 2008 (Burundi); 2010 (Rwanda) providing milk powder ("Milk for Mothers and Children") - Muhoroni and Nairobi, general food (wheat) Malindi, Nairobi, for pregnant women in Gordhim (S. Sudan), meat for children ("Goat for taskforce") (Tab 1).

Table 1: Overview of anti-malnutrition programs as example of mission of European values

	S. Sudan	Kenya	Uganda	Lesotho	Burundi	Rwanda
General AMP (children)	+	+	-	-	+	+
General AMP (mother & children)	+	+	-	-	-	-
Gen. food for pregnant	+	-	-	-	-	-
Meat program ("goat taskforce"	-	-	+	-	+	-
"Milk for children and mothers" program	-	+	-	-	-	-
Vitamins + elements for mothers	+	+	-	+	-	-

Conclusion

Anti-malnutrition programs are crucial for mother and child's health and school prosperity in Sub-Saharan Africa where about 40 million children and mothers are starving. Apart of the World Bank, Global Fund and FAO (Rome) NGOs in all EU and US should meet together.

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Refugees after Long Distance Migrating and Camping: Secondary Wound Infection Etiology and Management (Original research)

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Abstract:

Refugee and migrant health issues are still of major concern in Greece, Italy and other countries of the Mediterranean area. The aim of this study is to compare etiology of wound infections in two groups - illegal migrants and refugees; those traveling by foot and camping in nature via BiH to Croatia, Slovenia and Austria (Group A) versus those crossing the sea from the Turkish coast to Lesbos Island (GR).

Introduction

Migrant and refugee health are major concerns within the European Union since Sept. 2015 until now. This is because from Sept. 2015 to March 2016, 1.1 million refugees and migrants (RM) crossed the Turkish/Greek border and migrated via the Balkan Route to Germany, Scandinavia, Austria and other Western EU destinations. Those migrants in the first wave had been transported by trains and buses from Athens across Greece through Thessaloniki and Idomeni border posts to Serbia, Croatia, Hungary or Slovenia. Our Refugee and Migrant Health Teams have offered health assistance to more than 917,000 migrants within the last 3 years, where the majority traveled only l-3 weeks. After the Idomeni border post had been closed legal migration was stopped. However, smaller numbers of illegal migrants were continuing their path to the Western EU by foot, hiking and camping in free nature from April to October 2016, 2017, 2018; several thousand of RM have been backed up in Macedonia (FYROM), Kosovo, Albania (AL), Bosna and Herzegovina (BiH). Commonest complication after hundreds of miles of hiking and camping in sub-standard situations in free nature are a variety of wounds and in children pneumonia. (l.2)

The aim of this study is to compare etiology of wound infections in two groups illegal migrants and refugees, those travelling by foot and camping in nature via BiH to Croatia, Slovenia and Austria (Group A); versus those crossing the Mediterranean Sea from Turkish coast to Lesbos Island (GR).

Patients and Methods

Two groups of migrants, 61 in total, 1 negative culture from wild camp (ICRC) at the Bosnian/ Croatian Border, and 1 on the Turkish/Greek border (the regular UNHCR Camp Lesbos); both with 30 wound infections were cultured; swabs from wounds analyzed for etiology and antimicrobial resistance and tested in National Ref Lab of Antimicrobial Resistance in Nitra; at the Slovak Tropical Institute in Bratislava; or the Institute of MC at Comenius University School of Medicine. Both groups were also compared concerning antimicrobial with local or systemic therapy given to refugees and migrants.

Results and Discussion

Both groups showed similar etiology concerning gram-positive organisms. However, differences in gram-negative rods: the proportion of *S. aureus* and *Str. pyogenes* as major wound pathogens were similar, the proportion of MRSA among *S. aureus* was between 20-40% which is much higher than in host populations. Concerning gram-negaive rods, after 1,000 km trail hiking and free nature camping those from Bosna had more *Enterobacteriaceae* and

Ps. aeruginosa, but those traveling a short time via the Mediterranean Straits between Lesbos and the Turkish coast had more marine organisms (ABBA-*Acinetobacter baumanii* and non aeruginosa *Pseudomonas spp (P.stutzeri, P.fluorescens, P.putida, P (B) cepacia), Leclercia adecarboxylata,, Aeromonas salmonicida, Stenotrophomonas maltophilia*).

Table 1 shows significant differences (p o.0123) in proportion of gram-positive cocci (*S. aureus Str. pyogenes*) in favor of IRC Bosna) versus more marine organisms at the UNHCR Camp Lesbos island. Our previous observations for mainland Greece in 2017 (1, 2) also have shown more marine organisms from the respiratory tract and skin swabs in physio, and gym and other sports facilities in UNHCR Veria and Alexandria Camps due to the high proportion of "sailing" migrants and refugees. The sea environment was more frequently represented in respiratory tract colonizers, and in the current study also in wound pathogens or colonizers (1.2).

Conclusions

Migrants and refugees sailing from Turkey to Greece are concentrated in Lesbos UNHCR Camp and have significantly more gram-negative microorganisms including marine species such as non *aeruginosa Pseudomonas (P.putida, P.(B)cepacia, P.fluorescens, P.stutzeri, A.salmonicida etc*.) in comparison to those in Bosna after hiking and marching thousands of kilometers in the Balkan woods, who present more frequently with human classic pathogens such as *S.aureus and Str.pyogenes*. Resistance to *betalactamas* in *S.aureus* varied between 20-40% which is higher than in host populations. Also, the spectrum of *Candida spp* yeast wound colonization and/or infection was different non-albicans *Candida spp* were more frequent among refugees from the sailing group in contrast to *C.albicans*, which was prevalent among hikers in Bosna.

Table 1: Etiology of wound isolates from Refugees and Migrants in Lesbos UNHCR Camp (GK). Comparison to mainland (BIH)

A) Classic human pathogens:	**# of isolates (GK)**	**# of isolates (BIH)**
S. aureus total	6	21
MRSA	2	7
MSSA	4	14
S. pyogenes	3	1
Enterobacteriaceae	5	3
B) Marine & environmental organisms		
Ps. aeruginosa	5	8
Acinetobacter	2	4
Non aeruginosa Pseudomonas spp	2	16
Other (*Aeromonas salmonicida, Leclercia decarboxylata)*	0	2

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Investment to Joint Academia Programs in Developing Countries – One of Effective Social Investment to Prevent Social Pathology Related to Illegal Migration (Letter)

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Abstract:

Various study programs have been introduced in US, EU and Japan to attract talented students. However, majority of them does not return back to their domicile country. More effective seems to be to prevent illegal migration of young people to expert university programs to developed countries.

To the Editor

Illegal migration from Sub-Saharan Africa causes major social pathology such as unemployment, homelessness, shortage of food supplies and health care. Therefore, preventive strategies to decrease illegal migration should be supported on both sides of Mediterranean, in the EU and Africa. In addition, the age spectrum of migrants to the EU has a prevalence of young males from 40-60%, who are looking not only for jobs and health care, but also better education (1). The initiative of Erasmus-Members, an EC Program inviting students from developing countries to study 1-2 year in the EU was partially misused by the recipient students - more than 50% of them completed their study in the EU and never returned to the domicile country. E.g. from 16 Kenyan students of Public Health hosted in 2000-2010 by Trnava University, only 1 returned back. Therefore, opening the branches of foreign universities of SSA and SEA were more effective. Examples of most successful joint programs are in following Table 1. And are run by prestigious universities in USA and UK. However, Central European Universities have also special positions for opening programs in Sub-Saharan Africa and South East Asia. The position originates from history - many students completed Central European Universities during previous "communistic" periods 1950 - 1990 and currently many of them are in influential positions in government or universities leadership in China, Vietnam, Cambodia, Laos, Mongolia, Afghanistan, Ethiopia, Chad and other left-oriented countries in 1950-1990. Finally, language capacity of students in SEA is rapidly improving and the majority of Sub-Saharan African countries offer English or French as a second official language; another protective factor for opening EU university branches in Sub-Saharan Africa such as was successfully done in Thailand, Hong Kong, China, Philippines, Malaysia, Singapore, Taiwan, Korea and other SEA region.

Table 1: Examples of successful University branches in Sub-Saharan Africa and SE Asia

Oxford - Mahidol Trust	Mahidol Univ. Bangkok Thailand
Imperial College UK	National University of Singapore
UCLA Los Angeles	National University of Taiwan
Harvard University School of PH	Chulalongkorn University of Bangkok
Kings College London	University of Malaysia Kuala Lumpur
Kampala Makerere University	Mc Gill University Toronto
Kakuma UNHCR Refugee Camp Kenya	Emory University School of Public Health, Atlanta

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Prevention of Anemia in Pregnant Women after Periodic Deworming with Albendazol and Praziquantel (Review)

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Abstract:

The Aim of this research was to assess the effect of preventive administration of anti-parasitic drug against anemia during pregnancy in Kenyan pregnant women in St. Lesley Clinic in Eldoret, within 10 years

after introducing the strategy of two administration of albendazole and praziquantel during their pregnancy check up in the beginning of 2nd and 3rd trimester.

Introduction

Anaemia is the leading cause of maternal mortality after delivery in Sub-Saharan Africa and is responsible for majority of maternal and neonatal deaths.(1) The Aim of this research was to assess the effect of preventive administration of anti-parasitic drugs against anemia in pregnancy in Kenyan pregnant women in St. Lesley Clinic in Eldoret, within 10 years after introducing the strategy of two administration of albendazole and praziquantel during their pregnancy check up in the beginning of 2nd and 3rd trimester. Several studies have been published on the positive effect of IPT with sulfadoxine-pyrimethamine against malaria related anemia (1,2) but not on PT.

Major Causes of Maternal Anemia in Developing Countries

Malnutrition

Malnutrition is the major cause of anemia both in mothers and children in Sub-Saharan Africa caused by reduced uptake of elements, which are mandatory for *erythropoesis* (folic acid, iron, cobalt, vitamin B6, B12, etc.). Therefore to combat malnutrition and anemia is one of the millennium development goals and 2030 agenda by WHO.

Dietary customs

Vegetarians are especially common in several South Asia countries (India, etc.) Reduced in-take of meat proteins may cause vitamin B12 and iron mild to severe anemia especially when combined with malnutrition and malaria. Affordability of proteins is questionable in Sub-Saharan Africa too, especially in countries with famine, such as South Sudan.

Malaria

In Sub-Saharan Africa malaria is the leading cause of both mother and child anemia is due to one or more hemolytic effects.

AIDS and Chronic ID (TBC)

Consumption of elements and blood cells by ARV or other drugs for chronic infections as well as bone marrow suppression during antiretroviral chemotherapy for HIV/AIDS may contribute to anemia. Prophylactic *co-trimoxazole* and AZT in ART may cause severe anemia and thrombocytopenia.

Geohelminth Parasites

Consuming B12 (Hookworm – A. duodenale) and proteins (*Ascaris*, *Trichuris*, *Taenia* spp.) infection with g*eohelminths* may contribute, especially in malaria endemic countries, to severe anemia. Therefore, an administration 2x in pregnancy during regular check up (2nd and 3rd trimester) combination of albendazole and praziquantel.

Conclusion

Periodic deworming, food programs where needed and anti-parasitics administration decrease significantly anemia in pregnancy.

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Competencies of Midwifery Graduates in Kenya, Slovakia, Hungary and Czech Republic: Do We Want to Replace Obstetrics? (Short communication)

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Abstract:

The EU and USA and some SEA countries having enough physicians, do not need to share doctor's duties/competencies, however, countries with lack of qualified doctors such as Sub-Saharan Africa (apart of

RSA) and some places in rural Latin America need midwifes to assist with complicated births including caesarean section. (1-3) The aim of this short communication is to present competencies of midwives and nurses in various parts of the world, where Tropic team members are providing care to patients.

Introduction

Several papers have been published in recent years of the competencies of various paramedic occupations including midwifery and nursing. The EU and USA and some SEA countries are currently having enough physicians, so they do not need to divide doctor's duties and competences, however, countries with lack of qualified doctors such as Sub-Saharan Africa (apart of RSA) and some places in rural Latin America need, for example, midwives to assist with complicated births including caesarean section. The aim of this short communication is to present competences in various parts of the world where the Tropic team runs their health care projects.

Methods

Forty-one (41) Kenyan students of community health, 30 students in nursing program from Czech Republic, 31 from Slovakia and 20 from Hungary have participated on this research on competences of nurses and midwifery aid statistically compared with y2 test and Fisher's exact test. $P < 0,05$ were considered as significant.

Results and Discussion

As seen in Table 1, Kenyan students of community health/social work program have been significantly better informed/showed better knowledge on competencies of midwiferies and nurses in comparison to Slovak ($p < 0,02$) and Czech nursing students ($p < 0,01$), or Hungarian social work students ($p < 0,01$).

These results are indicating conservativism and misknowledge of the role of nurses worldwide. (1) WHO Guidelines for paramedic treatments are for the majority of residents unknown (Tab 1.); what has been already published on CEE/V4 health students and doctors. (2)

Table 1: Knowledge of competencies of midwives and nurses according to WHO guidelines.

Countries:	HU	CZ	SK	Kenya	P
Number of respondents	20	30	31	41	
Type of study	Social Work	Nursing	Nursing	Community Health	
Midwifery competencies					
- Birth alone	0	6*	6*	*41	*0.02
- C section	0	0	0	40	0.01
Nursing competencies					
- Physical exam	1	*1	2	*41	*0.01 *0.02
- Drug prescription and/or administration	0	0	0	39	0.001

Conclusion

The level of education and global thinking as well as orientation in international health in students of health and social sciences in Slovakia, Czech Republic and Hungary is weak and needs improvement as well as better education in health sciences.

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Improved Adherence to ART in Children – Orphans with AIDS Results in the Decreasing Occurrence of Tuberculosis (Research paper)

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Abstract:

Tuberculosis (TB) is one of the most frequent opportunistic infections in children with HIV in South-East Asia (SEA) together with *candidiasis*

and *Herpes Zoster* (HZV). After immunity re-constitution due to antiretroviral therapy (ART), occurrence of OI in AIDS decreased rapidly, including TB.

Introduction

Orphans with AIDS and their improved adherence to therapy and decreasing the incidence of TB in a full board Pediatric HIV Facility in Cambodia have been observed for the last 15 years. Opportunistic infections (OI) are the major cause of mortality in children and adults with AIDS. Tuberculosis (TB) is one of the most frequent OI in children with HIV in South-East Asia (SEA) together with *candidiasis* and *Herpes Zoster* (HZV). After immunity constitution due to antiretroviral therapy (ART) occurrence of OI in AIDS decreased rapidly, including TB. After 15 years of directly observed (DO) ARV therapy, only 1 case of TB among 40 children with AIDS occurred.

Patients and Methods

Sputum samples/blood from 31 children in an orphanage sheltering children with AIDS in Phnom Penh were undergoing Gene X-pert test for presence of latent TB infection. Gene X-pert was approved by WHO as a PCR point-of-care testing method for detection of MTB within 1 hour instead of 30 - 60 days. All children received ART for 2 - 12 years.

Results

Despite 10 children having a history of TB for the past 12 years, due to highly active antiretroviral therapy (HAART) all TB cases were cured after 6-0 months of combination of RIF+INH+PZA, Gene X-pert test was negative in all 31 children despite 4 having a recurrent history of TB within 6 months, all were receiving anti-TB therapy (3-4).

Table 1: Decrease of TB among orphans with AIDS receiving ART for 2 – 12 years.

	With AIDS	Without AIDS
Number of Children	31	4
Past History of TB	10	0
Current History of TB	4	0
Radiology Positive	4	0
Gene-Xpert Positive	0	0

Conclusion

Orphanages as a closed environment with community programs are protective against non-adherence to ARV in children. Proper intake of ART prevents from major OI including TBC, what has been documented by a new PCR based quick point of care test X-pert, which is also a method reliable in tropical and remoted settings.

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The Importance of Holistic Approaches to the Patient in the 21st Century Medicine (Ars curandi - art of healing)

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Original Article

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Abstract:

This paper is based on the empirical experience of the general practitioner/primary carer, but the principles of practice have been described in the last decades in many articles and monographs. It may be seen that the presented subject is highly current, not only theoretical but with the necessity of implementation in practice. In addition to familiar terminology, we present some new terms and key words that describe the situation in practice: fragmentation of medical knowledge;

holistic approach; patient reduction; eternal patient; PC doctor; gnostic approach; accepting physician vs. direct approach. In the end, we ask a few questions, and their response in favor of a patient and medicine appears to be a priority.

Holistic Approach to the Patient

Medicine in the 21st Century suffers from the fragmentation of medical knowledge and so the situation is that even the patient is fragmented: no longer on organ systems but on individual organs or even on parts of organs. This situation is progressing. The drug for a given condition is an holistic approach to the patient, and hence to integrate a fragmented patient.

Part of an holistic approach to the patient (certainly not exhaustive) is the reconciliation of physical, mental, social, spiritual status of patient and a question of time. If one of these modalities is omitted, the patient will still not feel comfortable, and we will not be able to talk about the treatment, but only about the symptomatic partial solution.

Another worthy question is associated with the sentence *salus aegroti suprema lex* - the patient's health is the highest law. What does health mean? What is the goal of a doctor? Is it possible to define the concept of health?

For example, an 86-year-old patient with *coxarthrosi*s of the fourth degree, with severe *hypacusis*, walks with the care of his nurse and encourages younger and healthier friends to move more.

Or an 80-year-old patient with a few years of infaust disease - stomach cancer with a breakthrough in the environment, after resection of the stomach and a large part of the intestine with MTS diffusely is full of enthusiasm; he thanks for every care, is communicative and looks forward to the future.

In contrast, young patients, for example, with dyspeptic difficulties that are neither health-threatening nor life-threatening, are of functional origin but subjectively experienced as severe. Who is healthy and who is sick? Even young people are patients in true sense of the word because they lack something.

In practice, we see that the notion of health as defined by the WHO as a feeling of complete mental, physical and social well-being is inapplicable. It is reached almost by nobody. However, is this the goal? Wanting a patient to embrace this definition can be frustrating for both patient and Doctor.

We can see, therefore, that a different approach, like holistic, but which displaces medicine into *ars curandi* – a healing art, cannot be used either. Art, however, is beyond the scope of financial evaluation. At a time when everything can be bought, manufactured, obtained, it may be for the patient unexpected to get something extra: we could call it the principle of access. For patients who do not have the opportunity to fulfill the WHO definition of full health, this "something extra" can be the drug they benefit from. It is this "extra" that becomes the principle - the art that heals.

Social Aspect

The social status of the patient takes into account the environment as documented, for example, in a hygienic hypothesis. In general, a significant increase in allergic or atopic diseases in the industrialized world occurred between the 1960s and 1970s with growth progressions during the 1980s and 1990s. Prevalence in developing countries was 2-3%, on the other hand 20-40% in

developed countries. The rapid transformation of the environment and lifestyle did not allow the human immune system to adapt to these changes and reduced exposure to childhood illnesses indicates that it has contributed to an increased occurrence of incidence and prevalence of autoimmune and allergic diseases.

However, the financial solvency of the patient is also significant. We know that patients do not even take a drug they cannot afford. In some cases, it is necessary to cooperate with the environment, especially with the patient's family when mnestic functions are altered or other more severe disabilities are involved. A young newly diagnosed schizophrenic patient after her second hospitalization had to be integrated into a therapy group. However, the group she attended was cancelled. Mother suffers from severe depression; she is disabled with a cardiac rhythm disorder so has a permanent pacemaker implant. In the household she lives with a husband who is almost immobile and in the past had tortured the family. The daughter was sexually abused by her father; the son in adolescence was repeatedly prosecuted; two other children are problematic. Mother does not have energy to look for a new therapy group for her daughter so we took care of the search at our ambulance and informed the mother and the patient about possibilities.

Mental aspect

The mental aspect of the overall approach involves patient compliance: verbal intervention is often required; the patient much better accepts medication when she/he is properly instructed with its benefits explained.

We do not underestimate pharmacological or other professional attitudes, and erudite health assessment always has a priority role. But often, we count on a few encouraging words with an understanding as an additional drug to the combination in addition without interactions with pills. A middle-aged woman after a particularly serious *tentamen suicidii* suffered with bipolar disorder. Then her 20 year-old daughter suffered from leukemia and after bone marrow transplant died. Subsequently, after the daughter's death, the patient's husband had a bladder cancer and is post-mortem. At that time, an undiagnosed disorder was found in her 6 years old granddaughter: her face deformed and she had to undergo dozens of corrective operations. Even though she lives in another town, this woman has built trust in some Doctors including us and has regular prescription drugs. Here, just inserting a prescription without verbal intervention would be a neglect of the duty. An important role is played in the relationship between Doctor and patient. The concept of a Family Doctor who recognizes generations and has the ability to create confidence in the course of continuous care is coming into the foreground.

It is important for the doctor to trust the treatment and prescribe it congruently - according to his conviction. With the need to use electronic media, a new phenomenon arises - a "doctor hidden within a PC"; the computer becomes a barrier; eye contact disappears; the interview is structured according to the computer diagrams.

In primary care, we often encounter incomplete patient awareness from specialist outpatient clinics. For example, an educated, assertive lawyer, overworked, frustrated by having to take care of children because of her husband's absence had several times changed jobs; had *SVT paroxysms* solved by radio-frequency ablation. She was anxiously tuned, but ambitious and very active. Recently, she suffered from polymorphic difficulties, repeatedly on APS (urgent ambulance or emergency first aid) given *anxiolytics venous*. She has been overly

repeatedly treated by specialists, but no one has ordered her to undergo psychotherapy, nor teach her about the psychosomatic etiology of her difficulties. An holistic approach in this case presupposes knowledge of the patient's situation; courage to inform her fully and with tact; willingness of the Doctor to take antagonism. The first response of the patient was: "I'm normal! I do not need psychotherapy!" After the interview, she admitted a visit to the psychotherapist. If the patient, despite indications leading to the necessity of psychotherapeutic intervention, which is still perceived as stigmatizing in Slovakia, is repeatedly treated in specialized outpatient clinics the patient becomes chronic and frustrated and the so called "eternal patient" is formed.

Poor or incomplete information from patient outpatient clinics undermines the Doctor of first contact. A patient with a *nephrotic syndrome* who was diagnosed postpartum at our clinic, while at least one or two specialists overlooked her difficulties during and postpartum. She was informed by a nephrologist that if she wished to attend a lecture before starting treatment, with the argument that dialysis centers are all over the country, she could. It has been a great deal of effort to convince the patient and her husband that she is seriously threatened, that, even in histological and laboratory findings, her condition is so serious that she needs to avoid a group of people and tostart treatment immediately.

A patient with overturned and recurrent *phlebothrombosis* was repeatedly reminded by phone that his INR values were insufficient and hence should be promptly present to initiate concomitant therapy by LMWH and oral coagulants and to repeat the blood taking again. The patient vehemently argued that hematology, even if he had bad values, never had been a problem for him.

On the contrary, we appreciate the collegiality of cardiologists, internists and other specialists who are collegiate, accept our opinion and cooperate for the benefit of the patient. A 50-year-old woman appeared in our ambulance visibly exhausted, indicating palpitations that started when climbing the stairs. In the *auscultation*, *tachycardia* was diagnosed, instantaneous ECG was detected in our ambulance where *SVT paroxysm* was detected at a frequency of 120/min; subsequently she had a sinus rhythm at a frequency of 70/min. The cardiologist promptly responded by telephone intervention, examined the patient with our ECG and recommended RFA in a specialized ambulance.

For more complicated and untreatable conditions, the physician must manage his own therapeutic frustration. There are a large number of patients who suffer from *polymorphic* pains with only temporary relief, although it is stated that any pain should be treated in practice it is often not possible. For example, patients have *polyvalent allergy* to analgesics or gastric complaints, do not tolerate treatment of higher grade by analgesic patches as they have drug interactions and so on. At that time, word support is often helpful for the patient at least looking for a "new" solution; making sure he can come anytime.

In medicine today an "gnostic" principle dominates. Doctors heal only on the basis of knowledge and forget that there is an holistic principle - the art of healing. As the patient's personality goes beyond schematics, statistics and knowledge, structures that reduce him to numbers, we meet with reduced thinking and a "reduced patient" while the rule says that the person is always more than a prejudiced and learned scheme.

Physical aspect, spiritual aspect, and the question of time

The physical aspect of the holistic approach is perhaps the most commonly used it being the "daily bread" of doctors, i.e.

erudition of a doctor at the level of knowledge and skills (of course, besides knowledge, relational competence is also necessary, etc.). However, using only this last option makes doctors craftsmen.

The spiritual dimension, for example, in the field of reproductive medicine, attempts to maintain fertility in women who wish to have more children than is generally considered "normal". Often curettage is proposed in the early stages of pregnancy with the fetuses often ejecting themselves or after medication. A physician who does not need to share a similar belief as a patient can become "accepting", not directive, and accessing the patient's wishes until her health is compromised.

We have experience with a case of a woman who, by accepting access to spontaneous abortion in the 1st trimester, did not undergo curettage; she cleansed spontaneously and later has multiple family. On the contrary, we have experience with a woman who is almost on the edge of a fertile period after 40; she repeatedly underwent curettage 6 times until the immunological cause of the inability to become pregnant was detected. Today she undergoes treatment with the expectation of pregnancy.

Or a woman with a mild coagulation disorder in the sense of *thrombophilia* was proposed to be sterilized after the second child which she did not accept and has 4 healthy children without complications.

Knowing to have an accepting approach, considering a reasonable consideration of patient needs and requirements, requires the doctor's erudition as well as generosity. It seems like time has worked against us. An holistic approach is extremely demanding, but there are a lot of patients. However, the correct use of the above-mentioned eruditions that lead to holistic approaches can only be used within rationally defined time, not under its pressure.

Discussion

One paper cannot fully embrace holistic approaches to patients which opens up further questions arising from the continuous care of people whose needs are constantly changing. Currently, depersonalization is present in Slovakia in connection with the application of some new laws (e.g. the Privacy Act). The open question is, for example, how to apply this law so that the person will not be devalued. Similarly care for sick, handicapped, immobile patients remains a question that we have not been dealing with. A very special category is socially disadvantaged citizens - *casus socialis*, who are marginalized in normal outpatient clinics and so there are often no possibilities for doctors to treat them fully. This issue would merit a series of papers and discussion by a wider professional public, welcoming patients' insights to correct the paternalist approach of a doctor to the patient that has long been sustained in our society.

Finally, questions arise whether the WHO definition of health is achievable or is it a frustrating ideal? Is it necessary to meet requirements to make the patient feel good? Is it possible to define health without an holistic view of the person? There is a large group of patients who despite complex efforts remain ill. How to watch the disease? We add in this discussion words of French writer G. Flaubert: "Pearl is an oyster disease and yet something extremely rare. Pain is like self-improvement, it is more intense and full of insight into our soul and reality. "

Conclusion

As a result of fragmentation of medical knowledge, patient fragmentation occurs. The drug is an holistic approach to the patient which is the art of healing - *ars curandi*. An holistic approach has several aspects, such as: social, mental, physical, spiritual, the question of time. The WHO definition

of health is in practice inoperable and limiting. Health is a highly subjective hardly standardizing concept. The doctor may be accepting or directing. He can treat patients with reduction and gnostically or generously. As a result of reduced access a "reduced patient" arises. Due to incomplete information, because it is in some cases more convenient, an "eternal patient" is repeatedly treated in specialist outpatient clinics. The doctor can try to establish eye contact and human contact or hide behind a PC. Time is a rare commodity and often forces doctors to restrict themselves to craft performance without an overall assessment of the patient's condition. The patient is more than numbers, statistics and knowledge - this great variability resulting from the uniqueness of a human being who cannot be embedded in numbers can lead to therapeutic frustration that the doctor cannot tolerate.

Breaking Dogmas in Midwifery and Physiotherapy in Central Europe in Maternal and Neonatal HIV Medicine (Letter to editor)

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Abstract:

Textbooks and book chapters used for education in OBG in CEE in Czech Republic and Slovakia are full of unacceptable false dogmas on HIV positive women and neonates. An urgent educational campaign should be introduced, so that medical students and doctors in specialization training get state of the actual updated information on HIV and pregnancy, including ARV and other treatment possibilities.

To the Editor

Since 1990, when HAART was introduced in therapy of HIV infection, mortality decreased from 4.5 million (1997) to 1.7 million (2017). Textbooks and book chapters used for education in OBG and physiotherapy in CEE in Czech Republic and Slovakia are full of false dogmas on HIV positive women and neonates. (1.3) An urgent rapid educational campaign should be introduced for medical students and doctors in specialization training, which will include state of the actual updated information on HIV and pregnancy. The aim of this letter is to inform the healthcare staff about the dearth of knowledge on mortality and treatment options of AIDS, especially when deadly disease has changed for "chronic" disease.

Table 1 informs about unacceptably bad knowledge of doctors trained for specialization by opinion leaders in V4 in comparison to Kenya. In CEE (Slovakia, Czech Republic, Hungary, Poland) the doctors often get wrong information about AIDS as "untreatable" and ultimately "fatal" disease with "100% mortality" within 10 years, and other basic misleading information. Therefore, educational campaign in medical students and students of midwifery and nursing has to be initiated in V4 (2) to change this unacceptable and shameful state.

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Table 1: Correct answers of physicians – MD in CEE/V4 (SK, CZ, HU, PL) versus Kenya on HIV/AIDS in pregnancy. Correct answer (16, 20).

	SK	CZ	HU	PL	KENYA
1. What is MTCTP in pregnant with HIV?	25%	12.5%	25%	12.5%	90%
2. Is HIV treatable disease?	75%	100%	75%	50%	100%
3. What is HAART?	6.25%	0%	6.25%	0%	100%
4. What is the transmission rate for MTC in 2010-2015? (1-3%)	0%	6.25%	6.25%	6.25%	80%
5. What is the mortality for AIDS after ART?	12.5%	25%	25%	25%	100%

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We prefer to use the term 'clinical social work' rather than social work even though it is less common. In the profession of clinical social work, there clearly is some tension coming from unclear definitions of competence of social workers and their role in the lives of the clients; the position of social work in the structures of scientific disciplines especially in cases where people declare themselves to be professionals even though they have no professional educational background. These are only few of the topics we would like to discuss in the CWS Journal.

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