No. 1, Vol. 13, 2022

Editor-in-chief: Prof. DDr. med. Dr. habil Claus Muss Ph.D.

Including: Social Work, Humanitary Health Intervention, Nursing, Missionary Work

CLINICAL SOCIAL WORK
AND HEALTH INTERVENTION

international scientific group of applied preventive medicine I - GAP vienna, austria

Quality of life in pre and during covid pandemia

Original Articles

ISSN 2076-9741/Online ISSN 2222-386X/Print

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Impact factor
1. november 2019
1,21
Subscription rates 2022, Vol. 13, No.1
Open Access Journal
Additional Information on Internet:
www.clinicalsocialwork.eu

The journal works on the non-profit basis. All the published Articles are charged 300 EUR/USD with standard range wich cannot be exceed.

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Editorial

Utilizing COVID-19 Vaccine Diplomacy

Source: Clinical Social Work and Health Intervention *Volume: 13* *Issue: 1*
Pages: 6 – 8 *Cited references: 5*

CSWHI 2022; 13(1): 6 – 8; DOI: 10.22359/cswhi_13_1_13 © Clinical Social Work and Health Intervention

Abstract:

Vaccine diplomacy has become a significant consideration in the global effort to distribute Covid-19 vaccines from wealthier developed nations to poorer developing countries. Based upon a review of the secondary source literature, it appears that while vaccine diplomacy is expected to result in an increase in the quantities available for export, some pragmatic considerations may impede the effort to transport and administer the vaccine in less developed countries.

Author's Biography

Prof. Costello is the assistant program director for the online MHA Degree program at the University of Scranton. He is a retired health care executive of a health system with two hospitals and a large multi-specialty physician practice. He has been teaching at the University of Scranton for 49 years.

Key Words

COVID-19 Vaccines, Vaccine Diplomacy

Introduction

With the rapid spread of the Omicron and Delta variants of COVID-19 worldwide public health specialists are increasingly stressing the importance of vaccination in slowing infection, hospitalization and death rates resulting from the viruses. However, since the vast majority of vaccines are produced in larger, more developed nations there is growing concern that ample quantities of vaccines are not reaching less developed countries where vaccination rates remain relatively low.

Vaccine diplomacywould seem to offer a promising means for the international community to balance the supply of COVID-19 vaccines so as to provide adequate supplies to meet population needs. Hotez (2014) defined vaccine diplomacy as;

> "almost any aspect of global health diplomacy that relies on the use or delivery of vaccines and encompasses the important work of Gavi, the Vaccine Alliance, as well as elements of the WHO, the Gates Foundation and other important international organizations"

Vaccine Diplomacy as International Cooperation

The concept of vaccine diplomacy predates the discovery of the COVID-19 virus and the subsequent development of the vaccines used to fight the viral infections. The prolific spread of the virus and its variants has led several prominent authorities to call for international cooperation in fighting the spread. Gupta (2021 writes:

> "This is why we each have an obligation to make sure we help prevent outbreaks in distant lands. In an ideal scenario, the most vulnerable to a disease would be vaccinated first no matter where they live. Instead we find ourselves vaccinating a person every second in wealthy countries while some countries haven't received any vaccines at all. As of

> Spring 2021, the vast majority of all vaccines have gone to high-income countries (reflecting 16% of the world's population) while less than 1% have gone to the low-income tier."

Hotez (2021) writes further:

> "Vaccine diplomacy offers an approach and way of thinking to solve a pressing problem. We urgently need new vaccines to combat the return or emergence of diseases arising in the Anthropocene. Beyond the actual vaccines themselves, vaccine diplomacy offers a tactic to address urgencies that grow out of the framework for international scientific cooperation and collaboration, especially in times of conflict or political instability… We will need to invoke vaccine diplomacy for combating COVID-19"

In September 2021, Zhaohui Su and colleagues published the results of a narrative literature review which they had conducted. Citing limited research on vaccine diplomacy in light of vaccine empathy, the authors defined the distinction between vaccine empathy and vaccine diplomacy in writing:

> "Vaccine empathy is an individual or a nation's capability to sympathize with other individuals or nations' vaccine wants and needs, whereas vaccine diplomacy is a nation's vaccine efforts that aim to build mutually beneficial relationships with other nations ultimately."

Vaccine Diplomacy in Practice

How do individual nations engage in vaccine diplomacy? What definitive measures can producing nations take to facilitate the distribution of vaccines to nations in need?

The major COVID-19 vaccine producing nations and regions are the US, India, the UK, Russia, China and the European Union. These parties engage in COVID-19 vaccine diplomacy by utilizing a combination of practices.

- Contracting to sell to other nations directly or to sell to Covax, a part of Gavi, the international Vaccine Alliance which works to direct vaccine supplies to poorer countries.
- Donating COVID-19 vaccines to other nations and to Covax.
- Increasing the production of vaccines. As of late 2021, global manufacturers had produced nearly 11 billion doses (ibid).

The push toward COVID-19 vaccine diplomacy has encountered some practical difficulties which may have slowed global distribution to some degree.

1. As production has increased in larger nations, domestic demand has, in some instances, impeded global export to developing countries. Since many of the vaccine producing nations financed the development of the COVID-19 vaccines, political considerations may have kept early production within the borders of those countries.
12. Some producing nations such as the US and India imposed temporary restrictions on COVID-19 exports in order to meet their nations domestic needs.
13. Pricing appears to have caused some problems in vaccine diplomacy efforts with poorer nations citing concern of affordability.India, as an example, has committed to producing low-cost COVID-19 vaccines (Sharun and Dhama, 2021).
4. Some potential recipients of COVID-19 vaccines have expressed preference for the most efficacious vaccines, thereby hampering some diplomacy efforts.
5. Vaccine hesitancy, as witnessed among some segments of the US population, has also been observed in some poorer nations, thereby further complicating efficient distribution and vaccine administration.

Conclusion

Certain factors would seem to indicate that larger quantities of COVID-19 vaccines will soon become available to poorer nations due to COVID-19 vaccine diplomacy. Some of the perceived obstacles to vaccine export are expected to resolve in the near future.

With 11 billion doses produced worldwide in calendar year 2021, distribution to poorer, less developed nations increased in the last six months of the year. Some of the larger vaccine manufacturers claim that early production difficulties have been resolved and that large volumes could be shipped to many poorer nations, assuming those nations have the infrastructure needed

to handle and administer the doses (Roland & Schwartz, 2021).

The very concept of vaccine diplomacy for COVID-19 vaccines seems to have received greater global acceptance. By the end of 2021, Covax had shopped more than 800 million doses with more than half donated by wealthy countries. A Gavi official said that donations were never part of the original Covax plan, meaning that more than 400 million doses come at no cost to the organization (ibid).

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The Contribution of Community Centers in the Elimination of Socio-Economic Problems of Family

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Source: Clinical Social Work and Health Intervention *Volume: 13* *Issue: 1*
Pages: 9 – 14 *Cited references: 4*

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Keywords:

Community Work. Community Development. Social Services. Social Worker.

Publisher:

International Society of Applied Preventive Medicine i-gap

CSWHI 2021; 13(1): 9 – 14; DOI: 10.22359/cswhi_13_1_01 © Clinical Social Work and Health Intervention

Abstract:

Community Centers have for marginalized groups, their integration into society, and eliminationof socioeconomic problems its justification. Community Centers are implemented as an institutional facility that provides: primary programs; responsive lectures; discussions aimed at preventing socio-pathological phenomena. Prevention is focused on all target groups and all ages.This is a task that is accomplished through direct contact with specific people in a community who find themselves in an unfavorable social situation. And, right, the center is a place for them where they can turn to people who will try to help them so that they can help themselves. At the same time, the Center is the place of active workforRoma who help people who need this help and also presentation of individual activities of the Center for Majority, to Majority on Minority is very important.

Introduction

Current problems of many families living in our company require more comprehensive and more systematic approaches.Approacheswhich offer community work through the implementation of Community Centers within the context of § 24d Z. z. Social Services Act.Community Centers are mainly created thanks to the support of the Ministry of Labor, Social Affairs and Family, and the Ministry of the Interior. Community Centers offer various programs responsive to current socio-economic problems and communitity needs. It is a sort of challenge for the need for resolving marginalized Roma communities. However, it must also be pointed out that the justification forCommunity Centers is also in a broader context and also in sites of marginalization. The reasons are mainly lifestyle, urbanization, working pace, as well as some social isolation of certain populations.

To eliminate socio-economic problems in communities, Community Centers and projects implemented with youth to avoid unwanted forms of behavior is significantly contributed. It is primarily on unorganized youth projects providing leisure activities in low-threshold centers and clubs. The low-threshold program for children and adolescents can be an important activity in solving socioeconomic problems but also in solving social delinquency.Especially at work that uses specific programs, these practices focus on specific socio-pathological phenomena and seek to minimize the negative effects and risks of these phenomena.(1)

The Community Center cooperates with local governments and off-road social workers. Together, they participate in the goal to make a poor social situation of people - social isolation -resolved and transformed into social inclusion. The aim of the Community Center is to help clients break the earlier circle of social exclusion, limit possible ways of failure and help them to start living with a positive direction (4).

In Slovakia, the Community Center is a social service for crisis intervention enshrined in Act 448/2008 on Social Services with clearly and relatively strictly stated content, target groups and more implicit objectives.

The disadvantage of the formulated definition of Community Center is less space to support and building the internal potential of communities, through the detection of their needs and in particular, participation in the creation, decision on the objectives of the Community Center and fulfill the form of concrete activities. Although in community work, a generally accepted access from bottom - up is declared in key documents for Community Centers (Community Center standards , Methodology for Community Centers) these must be linked to the applicable legislation setting out the "boundaries" within which the Community Center can operate.(2).

Another problem that Community Centers face on a daily basis in practice is insufficiently processed community social work, which everyone explains in their own way. Thus, also within the management organizations - donors, various clashes arise, which fundamentally change community work and often have a conflict with current legislation.Despite these problems, we want to map the contribution of Community Centers in eliminating the socio-economic problems of families. Within the main goal, we have set partial goals, which are:

- find out what socio-economic problems most often occur with clients of the Community Center,
- find out which social service clients of the Community Center most often use
- find out which target group most often visits the Community Center,
- find out what methods of work community workers use,
- find out what activities aimed at preventing socio-economic problems are implemented in the Community Center.

We chose employees of Community Centers as a research sample. Using the questionnaire method, we sent out 150 questionnaires via the Internet aimed at ascertaining the opinions of the participants on the justification of Community Centers in eliminating socio-economic problems.

Our research sample consisted of erudite experts (professional guarantors, professionals of Community Centers and employees of Community Centers) of various ages with different lengths of professional experience in the field of social work.

The vast majority of participants had experience in community work for more than 5 years (the practice was mostly implemented through national projects). As part of the first research

goal, we found with what social problems clients most often turn to the Community Center. Clients' problems are broad-based: 26% of Community Center workers said it was unemployment and a problem in finding a job, where clients need assistance in writing resumes, job applications, finding vacancies or communicating with a potential employer. 23% of participants stated that clients turn to the Community Center with financial problems, where clients are provided with financial advice, advice to increase financial literacy, assistance in communicating with the executor, etc. 19% of Community Center staff said clients turn to a Community Center when they have health problems. Here, community workers provide interventions when ordering for professional examinations and mediate communication with doctors. Alternatively, they address the neglect of vaccination in children and dissemination of awareness in the field of health and hygiene. Subsequently, we found: that clients have problems with housing (27% of employees), and 5% other problems. We can see from the results of the research, that clients turn to the Community Center with various problems that they cannot handle on their own and require professional intervention.

Participants stated that in deprived regions, the social and economic problems of citizens are among the most serious social problems. Unemployment is linked to economic problems, so helping the unemployed is one of the most useful concrete help a Community Center can provide. Participants stated that they provide clients with: advice on finding a job; organize various discussions with potential employers; carry out various activities to support the development of job skills; social, legal and health counseling; search for new jobs; consultation and preparation of the long-term unemployed to get a new job.

Community staff explain to clients the benefits of employment, alert clients to compliance with rules and behavior at work, and maintain contact with the employer. Community Center employees regularly communicate with employers about how the client behaves at work and what shortcomings need to be remedied.Participants also stated that daily work with the target group in the Community Center is: very demanding; requires patience; tenacity; perseverance; empathy; communication skills; time spent in the field in all weathers. They often communicate directly with law enforcement authorities. Clients are provided with assistance with repayment calendars so that clients can gradually get rid of debts.

Providing social counseling is based on the needs of clients. Participants stated that they approach each client individually and provide advice that is diverse. In this open-ended question, participants had the opportunity to answer at their own discretion. Participants stated that in deprived regions, the social and economic problems of citizens are among the most serious social problems.

Unemployment is linked to economic problems, so helping the unemployed is one of the most useful concrete help a Community Center can provide. Participants stated that they provide clients with advice: on finding a job; organize various discussions with potential employers; carry out various activities to support the development of job skills; social, legal and health counseling;search for new jobs; consultation and preparation of the long-term unemployed to get a new job.

Community workers explain to clients the benefits of employment, alert clients to compliance with rules and behavior at work, and maintain contact with the employer. Community Center employees regularly communicate with employers about how the client behaves at work and what shortcomings need to be remedied. Participants stated that all interventions provided to clients in case of economic problems are in agreement with the client. The client himself is looking for ways to solve the problem. They often communicate directly with law enforcement authorities. Clients are provided with assistance with repayment calendars so that clients can gradually get rid of debts.

Providing social counseling is based on the needs of clients. Participants stated that they approach each client individually and provide advice that is diverse. The Community Center, as an institutional facility, primarily provides primary programs responding to the current pressing issues and needs of the local community.

We asked the participants what methods and techniques of community work are more implemented by them. 40% of respondents stated that they provide individual help and support, social

counseling, individual mentoring and tutoring and others; 29% that they are support the development of groups; motivational discussions for young people; skills training for the unemployed; 31% that there are methods for community support and development, networking, awareness activities. Community Centers carry out their activities in a diverse environment.

In another researchquestion, we asked the participants in what form they provide more interventions, social counseling to clients of the community center. 68% of respondents stated that they provide clients with outpatient professional assistance in the Community Center; 32%

of more respondents provide assistance in their natural environment in the field.They found which activities implemented in the Community Center clients prefer the most. 61% of participants stated that they are sports and cultural activities; 26% stated that clients prefer educational activities; 13% hobby activities; 16% educational activities such as lectures or discussions on the topic.

The mission of the Community Center is to provide comprehensive social and community services and through these services to contribute to the social integration of socially excluded groups at the local and individual level. Community Centers provide their clients with: social counseling; assistance in exercising rights and legally protected interests, assistance in preparing for school attendance and school teaching and accompanying a child to and from a school facility, preventive activity, leisure activities. In the research, we found that the clients of the Community Center most often use the social counseling service provided to them in the community center, as well as crisis intervention. 68% of the surveyed respondents stated that they provide clients with outpatient professional assistance in the Community Center. Clients also prefer hobby activities that are carried out in Community Centers, especially sports and cultural activities.

In the research, we found that clients most often turn to the Community Center with problems with housing, employment and financial problems. Participants stated that in the Community Center, interventions are provided to clients on the basis of agreement with the client and they themselves actively participate in solving their problem.

Participants in the research stated that the most common socio-pathological phenomenon among clients is unemployment and related poverty, homelessness and alcoholism among clients. 36% of participants in the research observed socio-economic problems in socially excluded groups.

As we found in the research, the Community Center is visited by various target groups. However, 46% stated that it is the most frequently marginalized group of the population. We found that clients also visit the Community Center during the COVID 19 pandemic under strict hygiene measures. Community Center staff spread awareness in Roma communities about preventive measures. The research showed that clients ask for individual help and support, social counseling, individual mentoring and tutoring and more.

37% of participants in the research stated that clients most often require the provision of social counseling when solving their social problems. The purpose of social counseling is: to reduce the risks caused by social exclusion; conflicting social conditions; lifestyles and at the same time improve the social skills and social mobility of clients; support social integration of clients families and communities; prevent; mitigate;eliminate negative effects of socio-economic problems. The purpose of social counseling is: to reduce the risks caused by social exclusion; conflicting social conditions; lifestyles; and at the same time improve the social skills and social mobility of clients; support social integration of clients, families and communities, prevent, mitigate and eliminate negative effects of socio-economic problems.

Participants stated that the organization of discussions with experts and thematic workshops significantly contributes to the elimination of socio-pathological phenomena. Short-term and long-term activities are aimed at children and young people in order to prevent social pathology and dangerous behavior.

Behavior

In the research, we found that activities in the Community Center are more implemented to reduce the incidence of socio-pathological phenomena and risk behavior in children and adolescents. 61% of participants stated that they use sports and cultural activities. The purpose of pre-

vention and activation activities is to prevent adverse situations and to support the social integration of children, young people and adults through incentives, education, activation and voluntary services.

The Community Center can be implemented through the following activities and programs.

In our research, we found that in addition to personal work with clients and the provision of social counseling, the Community Center also provides clients with space and wider self-realization, leisure activities and education. The research showed that the staff of Community Centers actively work with children from socially disadvantaged backgrounds with preschool children. With children, they implement programs on various topics such as oral hygiene; bullying; decency; human trafficking; prevention of abuse on the Internet; preparation for parenthood; addiction; AIDS; and many other topics.

They organize regular meetings for seniors, always on a different topic. The activity of a social worker also focuses on research showed that the staff of Community Centers actively work with children from socially disadvantaged backgrounds with preschool children. The prevention of socio-pathological phenomena in children and adolescents.For children and youth, there are regular leisure activities and circles with different focus - sports, culture, art, education.

In her research, Citterbergová investigated the occurrence of educational activities in the Community Center. The aim of the research tasks was to find what specific educational activities are carried out in Community Centers for Roma children; to find the frequency of individual activities. Through the research, the author found that the most common is the preparation for teaching, then the circle activity, followed by leisure activities and preventive programs. The aim is to motivate children to go to school regularly to prepare honestly for school. Social and educational workers try to highlight the value of education for Roma children, as most of their parents have an opposing view of education. We found in the research that community workers in the Community Center are dedicated to children and youth, preschool children are reserved in the morning and are preparing to enter school. Leisure activities and clubs are provided for children. All circles, discussions and lectures for children are held in order to prevent socio-pathological phenomena.

In our research, we found that the most common group visiting a Community Center is the marginalized Roma community. Field research also confirms that communication and cooperation with Roma families is mainly developed through national projects funded by the European Union, which are related to field social work and Community Centers. A similar approach seems to be applied in national projects focused on community work and client-oriented field social work. According to Rosinský, Matulayová and Rusnáková (2015), the evaluation of the National Project of Community Centers brought findings that the most frequently implemented activities were educational activities for children and youth which the employees of the Center consider to be the most important output of the project. Community workers and other professionals working with Roma families need: continuous professional development including training to break down prejudices; to better understand the historical; linguistic; cultural and social environment; and the initial situation of Roma communities.

Insufficient understanding and communication between Roma and non-Roma living in the same community, who have different cultural and social backgrounds, often leads to stereotypical views as to why Roma families do not participate in community or community activities or services.In our research, we found that 93% of participants receive regular training for professional growth. The Office of the Plenipotentiary of the Government of the Slovak Republic for Roma Communities is an advisory body of the Government of the Slovak Republic, which in accordance with the statute has competence to perform tasks aimed at resolving Roma community issues, implementing systemic measures to improve the position of Roma communities and their integration into society.

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Social Work in the Context of the COVID-19 Pandemic

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Pages: 15 – 20 *Cited references: 9*

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Keywords:

Covid-19. Pandemic. Social Work. Public Health. Education. Social Care Facilities.

Publisher:

International Society of AppliedPreventiveMedicine i-gap

CSWHI 2021; 13(1): 15 – 20; DOI: 10.22359/cswhi_13_1_02 © Clinical Social Work and Health Intervention

Abstract:

The coronavirus (aka COVID-19) pandemic has paralyzed the whole world and society as such has found itself in a health, social and economic spiral. We have come to discover how the helping professions – including social work – are undersized, undervalued and marginalized, and yet virtually essential for our survival as a society. This means that there is a growing need for a systemic reform not only in the field of social work, but also in education focused on the helping professions.

Due to the ongoing COVID-19 epidemic, opportunities are being sought for the use of social workers in the field of support provided to healthcare strategies, but also the strategies in the field of social work itself. In the field of healthcare – in addition to medical staff in the residential healthcare facilities and first contact facilities – various specialized departments, such as infectology, pneumology, epidemiology, clinical microbiology, tropical medicine, pharmacology and others, are being actively involved in the process to manage the pandemic. Psychology and social work should be part of the above cooperation. Following the outbreak of the epidemic in our country, the Ministry of Health developed a standard procedure for rapid guidance of the clinical

management of pediatric and adult patients infected with coronavirus (Šuvada, Jarčuška, 2019), which was intended for medical staff providing health- care. This material is primarily intended for the healthcare professionals who provide healthcare to patients hospitalized with severe and acute respiratory infections. A certain risk in the creation of this material was that this procedure was based only on the currently available knowledge, which at that time did not encompass a comprehensive clinical image of the disease, its transmission and duration.

The working group consisted mainly of doctors, nurses, laboratory technicians, and even practitioners in the field of ethics, but it contained no support professionals, psychologists (let alone clinical) or social workers who could contribute to the topic with their holistic approach to treatment and patient care, which the authors of the text build on. This narrowing is also interesting because at least one of the co-authors is a professor in the field of social work.

The above standard procedure is unilaterally focused on the somatic aspects of the presented issues, which are understandably prioritized in the times of a pandemic, but even a crisis such as this one cannot make us neglect the psychological, social and spiritual needs of patients. Inadmissible simplifications appear in the text due to the exclusion of supporting scientific disciplines. Nurses cannot provide psychological counseling because they are not qualified to work professionally with panic, fear and anxiety in the patients as per the expectations in the Standard Procedure of the Ministry of Health of the Slovak Republic. Paradoxically, the doctors don't expect the nurses to perform specialized medical procedures.

The history of the current coronavirus pandemic can be traced to the several cases of hitherto unexplained pneumonia, which appeared in the Chinese city of Wuhan in December 2019. These cases were linked to the exposure to the local seafood market. The cases were confirmed as an acute respiratory infection caused by a coronavirus, and the disease started to transmit from person to person (Perlman, 2020). The most likely hosts for SARS -CoV-2 in the wild are bats (Zhou, 2020). The SARS and MERS viruses were not a complete novelty to the professional public, and experts had identified and described them as early as in 2004. However, it took some time to identify their etiological context and define the relevant procedures. The number of cases without contact with animal hosts had increased dramatically not only in China, but also in Hong Kong, Taiwan and Macau. On March 5, the first confirmed cases were reported in Italy and later in the neighboring European countries. By October 2021, altogether 4,913,115 COVID-19-related deaths had been recorded. There are currently 241,409,221 confirmed cases in 221 countries and territories.The mortality rate is still being assessed.

Patients with pneumonia infected by COVID - 19 have become the central source of infection. Respiratory aerosols have been the main route of transmission, but transmission is also possible through body contact (Zhou, 2020). Based on a rapid epidemiological research, the incubation period of the infection was 3 to 14 days. The clinical signs of the early mutations included fever, symptoms of influenza, signs of pneumonia in the imaging examinations, and low white blood cell or lymphocyte counts. Trips to places with permanent transmission, contact with patients with a fever or respiratory symptoms, groups of possible carriers (means of transport, mass events, medical or social facilities) were all considered an epidemiological risk.

The first anti-epidemiological measures were issued by the Chief Hygienist of the Slovak Republic on 3.3.2020. This decree mandated the application of quarantine measures 14 days after the last contact with the infected; identification of his/her social contacts, which included the monitoring of symptoms typical for the coronavirus infection; the decree also prohibited social contacts and travel and it mandated a quarantine at home, in the hospitals or quarantine centers. The decree was primarily focused on the patients with life-threatening diagnoses, people over the age of 65, and it defined the rules for avoiding high-risk areas. The preventive measures included: population testing; isolation of at-risk and positive individuals; gradual vaccination; disinfection of at-risk environments; preference and support for work from home/home office; government measures to minimize the spread of the epidemic (shuttering schools, facilities and establishments providing services; ban on public meetings, cross-border travel; imposition of curfews with

the above exceptions; ban on travel between counties; etc.). The above psychological support was disproportionately limited to interests and education.

The whole society, and the world at large, has found itself in a health, social and economic collapse. Thus, individuals who have tested positive for SARS-CoV-2, or have been tested for airway or blood homogeneity with SARS-CoV-2, have been confirmed as positive (WHO, 2020). The various emerging mutations in the United Kingdom, Brazil, South Africa and India posed significant trouble because they were to some extent resistant to the then prevention and treatment, and were characterized by rapid spread and higher mortality rates. The emergence and spread of mutations significantly complicates prevention and treatment, and especially so today.

The close contacts of confirmed cases play an important role in tackling the situation. The close contacts are people who live, study and work with a confirmed case. This group also includes medical staff, caregivers and social workers who care for or treat the patient. This also includes the co-patients or clients who have been in contact with a confirmed case.

Preventive and control measures must be applied when patients enter the hospital, or when symptoms appear in the clients residing at home or in the residential social care facilities. Standard preventive measures include: hand hygiene; use of PPE; protection against contact with blood body fluids and secretions of the patient to minimize the direct risk of infection.

COVID-19 affects people in various ways. Most infected have mild to moderate symptoms and recover without hospitalization. The disease has the following clinical symptoms in the course of its development:

- Asymptomatic disease.
- Disease without significant complications – fever, cough, sore throat, swelling of the nasal mucosa, malaise, headache, muscle pain, nausea, fatigue, loss of taste or smell, skin rash, or other non-specific symptoms.
- Mild pneumonia - mild course of pneumonia, difficult breathing, rapid breathing.
- Severe pneumonia – high fevers, severe respiratory distress.
- Acute respiratory distress syndrome – worsening respiratory symptoms, chest obstructions, collapse of the lungs or lung lobe, enlarged lymph nodes.
- Sepsis – a life-threatening condition with organ failure in response to infection, low oxygen saturation, acceleration of cardiac function, decreased diuresis, increased sweating, mental disorders.
- Septic shock – persistent hypertension despite intravenous fluid replenishment.

Treatment includes: isolation of the infected patients at home or in a facility; bed rest; monitoring of vital functions; adequate energy and fluid intake; supportive treatment; adequate pharmacotherapy (although there is no specific drug treatment available yet). Patients with severe development are placed in medical facilities (capacity permitting), oxygen therapy is used (if a sufficient number of devices are available), and laboratory monitoring also plays an important role. The hygiene of workers who are in contact with the patients or clients (hand hygiene, gloves, coats, drapes, eye protection) is a prerequisite for an effective approach. The healthcare professionals should be registered and monitored.

In addition to medical staff, hospitals also allow social workers to operate on their premises. We have already mentioned that health and disease also have a social dimension; social factors are part of the etiology of a disease and pathogenesis; qualified professionals in the field of social work should participate in the treatment process.

Despite the fact that professional statements and publications present the need for an holistic approach, practical experience differs significantly from these public presentations. The social field is marginalized in the healthcare system, and various alternative options for substituting qualified social workers were sought. Without argumentative support, it was assumed that this issue would be handled by medical staff; and it was expected especially from nurses who are not qualified for this job.

Abroad, where social work in healthcare has a long tradition, there are “clinical social workers” who have the necessary competencies to function in the healthcare system and in a professional team. Certain types of our healthcare facilities sporadically open the position for “social workers” in the context of the Decree of the Ministry of Health of the Slovak Republic of 14

December 2012 no. 09780-OL-2012 (pp. 283 - 285), but this position does not appear in the matrix of medical professions. However, the number of these employees per client does not correspond to the needs of intervention social work and their role is often reduced to administration and communication with external social services.

During the Covid pandemic, social workers in residential healthcare facilities have been involved in managing the critical situation in hospitals also because of staff shortages. Some medical staff have become infected with Covid and many workers are in quarantine. In an overload situation, social workers do not focus centrally on work with individual patients, and according to their statements, there is: much less space for informing the patient; discussing the disease and treatment; helping the patients to adapt to the new situation; helping them cope with uncertainties, worries, anxiety, supporting the positive attitude to treatment; preparing the patients for discharge; etc. The current situation does not allow for direct cooperation with the patient's family and wider social environment, as these persons are prevented from entering the medical facilities. Social workers are therefore available where the current situation in the hospital requires it.

The situation in residential social care for various target groups of clients is even more complicated. Seniors in the social care homes are most at risk of contracting Covid. There are many clients diagnosed with Covid-19 in these facilities, there is no contact medical care personnel at the bedside, and the medical staff only consists of nurses who are aided by other professions in the time of crisis. The clients' basal needs are covered by the bedside nurses.

According to the Maslow's pyramid of needs (1968), nursing care should take precedence over traditional, professional methods of social work. It was necessary to create isolated enclosed zones for the infected in the facilities. Despite adhering to the principles of prevention and hygiene, many contact workers in the facilities became infected and the facilities had to operate with reduced numbers of workers. However, there was open space for professional interventions by social workers. The facilities were closed and the clients lost personal contact with their families and the social environment. The clients were struck by minimal social contacts, frequent contact with the death of other clients, and unclear strategies, measures and prognoses. The clients exhibited an increased level of anxiety, fear and tensions. They needed somebody at their side who would listen, understand their situation, provide them with relevant information and support them in a threatening situation.

The support provided to clients, motivation boost for the infected clients to actively participate in treatment and an active approach to prevention for uninfected clients was an important contribution of social workers in this context. The uncertain and traumatic situation in social facilities fuels an atmosphere of dissatisfaction and misunderstandings and reduces the control of affective behavior and aggressive communication.

In regular supervision, social workers have noted an increasing number of conflicts between the clients, but also between the clients and staff. They are looking for ways to participate effectively in resolving the misunderstandings and conflicts and use effective strategies and techniques. One of the important tasks of social workers was to create a positive atmosphere in the facilities, support cooperation at all levels and ensure telephone or online communication between the clients and their families.

Social work in the area of field and social care was also specific for this period. A field social worker works in two central environments. The open environment is typical for work on the street and in low-threshold facilities, and field work is also carried out in the clients' families. Social workers state that the alternation of in-person and online communication with the clients is one of the hallmarks of this period. In contact care, it is necessary to follow all hygienic principles and protect oneself against infection by masks, respirators or shields. Social workers provide the clients on the street with the necessary protection, and by doing so they also protect themselves.

The structure of the presented and solved social problems changes to a certain extent in the context of the Covid situation and limiting measures when working in families. The isolation and closed-up nature of the family: supports the emergence of "cabin fever"; tensions in families increase; rate of aggressive manifestations; outright aggression and verbal and brachial violence is becoming ever so frequent. Experts are more

often confronted with;increased consumption of alcohol and other drugs; the number and level of addictions in the online space is on the rise. The current situation has also greatly influenced the conflict between work and family (Greenhaus, Beutell, 1985). We could map out how the pandemic has affected the social system, but that is more of a social policy issue.

The solutions for this crisis were also provided by social education. When staff shortages in social care facilities reached a critical level, the facilities turned for help to higher education institutions where social workers were being prepared. Often, these included the workplaces where the students of social work take up their practice. The teachers contacted the students; explained the critical situation to them; informed them about the needs of these workplaces; emphasized the voluntary aspect of their work; and some students indeed provided active assistance to these facilities. Later, the Ministry of Labor, Social Affairs and Family of the Slovak Republic responded to the need for cooperation between social education and social services. The departments of social work also responded to the call of the Ministry of Education of the Slovak Republic regarding the assistance in the education of pupils, especially from socially disadvantaged environments. The students of social work were also involved in these activities and helped to cope with the complicated situation in education.

During the pandemic, the work of social workers in healthcare was also restricted by the home office work mode of the officials from institutions such as regional self-governing units (VÚC), municipal offices, and the Office of Labor, Social Affairs and Family (ÚPSVaR). Everything takes longer – including the assessment of reliance on social services. When visits are forbidden, this makes communication with relatives more difficult. In the first wave in Spring 2020, the stakeholders mostly communicated over the phone or by email. The situation turned for the better in the Spring of 2021: the relatives could visit the social workers in their offices, and the social workers mediated the meetings with the clients with the permission of the Chief Physician or Senior Consultant in the more difficult cases. Furthermore, they dealt with the placement of patients in social services facilities (ZSS), mostly with an immediate effect. As the numbers of clients in the facilities decreased, they even managed to house them faster than before the pandemic, in cooperation with a homeless shelter and a dormitory.The situation turned for the worse during the state quarantine when the clients had to be relocated, which was nearly impossible. At that time, they also asked colleagues from other hospitals for help and advice, but they all had the same problem and could not find the solutions.

A Memorandum of Cooperation was signed between the Ministry of Labor, Social Affairs and Family of the Slovak Republic (MPSVR SR), Association of Social Work Educators and the relevant universities providing education in the field of social work, which aims to ensure the preparedness of the Ministry of Labor, Social Affairs and Family for the pandemic of acute respiratory diseases, determination of the tasks for the Ministry of Labor and other organizations under the responsibility of this Ministry in preparation for the pandemic, and mutual cooperation to provide voluntary assistance and support to the clients of social care facilities by students of accredited Social Work study fields.

Social work educators - as conveyors of professional knowledge, skills, attitudes and values (Amadasun, 2020) - are professionally bound to expedite action to conduct and disseminate research about **(1)** social workers' response to protecting their client systems or service users from the COVID-19 pandemic, **(2)** coping strategies of service users (e.g. of older adults, women, resource-deprived households) amid the inaccessibility to medical care in most developing regions around the world, and **(3)** our interventions for families undergoing loss - which could be of relatives, parents or any other loved ones or of socioeconomic or material loss due to the pandemic. By engaging in research, the profession would be creating a vast reservoir of literature that could be fundamental (directly or suggestively) in dealing with future challenges.

Vaccination is the most effective way to control the current COVID-19 pandemic. To this end, the Ministry of Health (Ministry of Health of the Slovak Republic) has prepared a vaccination strategy that combines proposals for implementation of the strategy developed by the expert sections of the Ministry of Health of the Slovak Republic; the working group to implement vac-

cination on the basis of the mandate given by the Pandemic Commission of the Slovak Republic; as well as documents by experts in the field of infectology and epidemiology of the Slovak Republic. There are two basic types of vaccines against Covid-19. The so-called vector vaccines, e.g. Oxford/AstraZeneca COVID-19 vaccines, and mRNA vaccines, e.g. Pfizer/BioNTech or Moderna, which are – following subsequent clinical trials - recommended for children aged 5-18 years in addition to the adult population.

EU leaders have identified the mutations of the new coronavirus to be an increasing problem. Although there are positive signs of a good response of some vaccines to known variants according to doctors and scientists, the situation should be monitored. The Indian variant, also known as delta, is currently the most widespread mutation.

Bridging the crisis situation in the context of the Covid-19 pandemic and social work is a completely new phenomenon in the field of social work. For this reason, we tried to map the first experiences of social workers involved in these processes and monitor the current situation regarding the possible cooperation between the Ministry of Health, Ministry of Social Affairs and Ministry of Education.

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Linking COVID-19 with Suicide: Suggestions for Future Research

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Original Article

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Source: Clinical Social Work and Health Intervention *Volume: 13* *Issue: 1*
Pages: 21 – 26 *Cited references: 31*

Reviewers:

Jirina Kafkova
MSF, Freetown, SL
Selvaraj Subramanian
SAAaRMM, Kuala Lumpur, MY

Keywords:

Suicide. COVID-19. Future Research.

Publisher:

International Society of Applied Preventive Medicine i-gap

CSWHI 2021; 13(1): 21 – 26; DOI: 10.22359/cswhi_13_1_03 © Clinical Social Work and Health Intervention

Abstract:

COVID-19 has impacted the world socio-economically. Unemployment, poverty, social stigma, social isolation, domestic violence and mental illnesses are the notable social issues related to COVID-19 pandemic. Framed under a review based approach, the current study searches for the link between COVID-19 pandemic and an increased vulnerability to suicide across the globe. Linking the current situation with researched determinants of suicide shows that COVID-19 pandemic is exacerbating various socio-economic and psychological causes of suicide. In near future or even during the pandemic, suicide will be a key challenge for the public health sector across the globe. Besides, future research suggestions are given in light of the discussion in order to provide an impetus to researching the impact of the COVID-19 pandemic on suicide.

Background of the Study

There is quite a history of virus outbreaks. The most notable are the Spanish flu in 1918-1919 which spread across the globe (Tsoucalas, Kousoulis and Sgantzos, 2016); Middle East Respiratory Syndrome (MERS) in 2012 in Saudi Arabia (WHO, 2019); Severe Acute Respiratory Syndrome (SARS) in 2002-2003 in China (WHO, 2013). Similarly, recently in December, 2019 another virus started affecting humans in Hubei Province of China and more specifically in Wuhan city. The current outbreak of the virus leads to COVID-19 disease among humans. By May 09, 2020, 20:33 GMT, there are 4,080,173 laboratory confirmed corona virus cases throughout the world. United States of America, Spain, Italy, China, Russian and United Kingdom are the mostly affected countries. 1,425,211 infected persons have recovered and 279,282 died (see Worldemeter for timely updates).

COVID-19 is one of the ongoing pandemics whereby researchers are in continuous efforts to know about the virus e.g. its origin, structure, spread, death and recovery rates, and most importantly cure. The whole world has been affected socio-economically due to the pandemic of COVID-19. Suicide is also a global social phenomenon. Suicide prevails throughout the globe with different rates and causes. The causes of suicide are always socio-economic and psychological. The current pandemic is also important in this regard. Thereby, this study is an effort to link the exacerbating determinants of suicide associated with COVID-19.

Methodology

This is a review article. To produce link between suicide and COVID-19 pandemic, an extensive search for literature has been done. For example, the current news about the pandemic and situation of COVID-19 has been studied and cited particularly the socio-economic impacts of COVID-19 which are already researched as determinants of suicide. The approach was systematic whereby databases such as EBSCO host, Sociological Abstract, WoS and PubMed were searched. The most relevant studies were hand searched and sampled for this study.

Results and Discussion

Linking Determinants of Suicide with COVID-19

Unemployment and COVID-19 and Suicide

The pandemic of COVID-19 brought abrupt lockdowns throughout the globe within few months. Lockdowns have significant economic impact. BBC reports that 1 among 5 households are in hunger in United States of America whereas 20.5 million got unemployed (BBC Urdu, 7th may, 2020). In Italy the unemployment rate increased to 11.2% in 2020 from 9.9% as noted in 2019 (Statista Research Department, 2020). Amaro (2020) mentions the economic situation in Spain that the unemployment rate had surged from 13.2% to 20.8% in April, 2020 due to the situation created by COVID-19.The situation is more worrisome for poor and developing countries. Inamdar (2020) reported that 122 million individuals became unemployed in April, 2020 in India due to situation created by COVID-19. Latif (2020) reported that Pakistani labor is in trouble due to COVID-19. About 75% of the work force in Pakistan is labor. Rana (2020) asserts that approximately 18.5 million individuals were going to be unemployed in Pakistan in May, 2020 due to lockdown. For developing and poor countries the situation further worsens as a matter of fact that a considerable number of people of such countries in developed countries. As COVID-19 being a pandemic is affecting the developed world as well so those overseas employed people are suffering as well leading to further economic problems at their place of origin. For instance, Abbas (2020) explains the situation of Pakistan by arguing that Pakistan is going to be affected by COVID-19 like a doubled edged sword. On one side, it will increase the unemployment in the country as well as the overseas labor is also losing their jobs; therefore, it is inevitable that the rate of poverty will increase significantly.

It is evident from the bulk of studies that economic difficulties play a significant role in suicide related behaviors ranging from suicidal ideation to suicide attempt. In this regard, for example, Blakely, Collings, Atkinson (2003) and Preti (2003) asserted that there is significant causal relationship between unemployment and suicide. Further, Boseley (2015) wrote an article in *The Guardian* and revealed that approximately

45,000 suicide related deaths occurs globally due to unemployment. Besides, notably Kawohl, Nordt (2020) more recently argued that mental health is under threat due to COVID-19 because of the economic crises it produced, and in the coming few months suicide rates are going to raise as a result of wide spread poverty and unemployment across the globe.

Isolation, Lack of Social Support and COVID-19 and Suicide

So far, there is no cure for COVID-19 (WHO, 2020); however, plenty of trails are undergoing to search for possible treatment. Preventive measures have only proven to be effective only to limit the number of new infections. Strategy for it are lockdown, isolation, limiting social contact as recommended by WHO and CDC (WHO, 2020; CDC, 2020).

Self-isolation, quarantine and the standard precautions from medical professionals may lead to a lack of social support and that too in an illness in which one is uncertain. This may lead to stressful situations triggering mental illness which are correlated with suicidal behaviors. Endo, Nishida (2017) found that social isolation is one of the key determinants of suicidal ideation and self-harm among adolescents. Further, a comprehensive review article by Calati*et al* (2019) concludes that social isolation is significantly associated with suicidal behaviors. Social isolation exacerbates: stress; feeling of loneliness; anxiety; lack of sharing of stressors with near ones leading to an increased risk of developing suicidal behaviors. Kawohl,Nordt (2020) point out the importance of technology to maintain social bonds in order to relieve stressful situations but predicts that still the suicide rates with go up during and soon after the pandemic.

Social Stigma and COVID-19 and Suicide

BBC Urdu reported on May 09, 2020 that:

"....Prime Minister of Pakistan Imran Khan showed worry about the response of people even medical community towards individuals infected by the Corona Virus...."

Confrontation of social stigma is one of the leading problems arising as COVID-19 is intensifying throughout the globe. In this connection, UNICEF and WHO have published guidelines to deal with it. The guidelines explain that stigma has been confronted by many people, communities and even religious groups reported across the globe including: discrimination; stereotypes; labelling; separate treatments; even loss of status. As the disease is new and unknown therefore social stigma prevails across certain communities regarding it. Social stigma is impacting the individuals (e.g. there emotional status, hate, increase in stress, fear of rejection, intensifying depression and other mental illness) as well as communities, even people are hiding the symptoms of the illness if they are having it (UNICEF and WHO, 2020).

Warrell (2018) asserts that social stigma play a significant role in suicide. Social stigma contributes to suicide in many ways, for example: fear of social rejection labelling (e.g. name calling); discrimination; and stereotyping lead to emotional traumas and stresses which are linked with suicide. Khan, Naz, Khan (2017) also pointed out that labelling is an important contributing factor to suicide.

Domestic Violence and COVID-19 and Suicide

There are confirmed reports that the incidents of domestic violence have increased during COVID-19 pandemic. The causes are multifaceted, for example, loss of employment, long stays at home and disagreements at home due to poverty and stress are leading to domestic violence. Bogart (2020) illustrates that cases of domestic violence have increased in Canada during COVID-19 pandemic. With regard to Pakistan, Agha (2020) reports that lockdown has certainly increased domestic violence in Pakistan; however, the majority of them go unreported due to lack of proper a legal system, lack of awareness about rights, etc.

Clay (2014) found that individuals confronting domestic violence (particularly intimate partner violence) have atwo fold increase risk of suicidal ideation compare to people not confronting such violence. Additionally, the study also shows that multiple suicide attempts are also common among victims of intimate partner violence. In addition, more recently Brown, Seals (2019) conducted a comprehensive study on domestic violence and suicide. The study found that many suicide cases are result of prolonged confrontation of domestic violence.

Mental Illness and COVID-19 and Suicide

The Center for Disease Control and Prevention and the World Health Organization are alarmed about mental health issues resulting from COVID-19 pandemic. Mental health issues resulting from the pandemic are multifaceted. 1st, fear and anxiety are common which are obvious in any pandemic (CDC, 2020). 2nd, self-isolation and social isolation (loneliness) lead to stress (Campagne, 2019). 3rd, people with chronic health issues (e.g. cardiovascular diseases, diabetes, chronic lung problems etc.) are at increased risk of developing serious illness from leading stress and anxiety (Turner, 2000). 4th lockdowns, closure of industry and markets has led to higher rates of unemployment and widespread poverty leading to stress and depression (Institute for Work and Mental Health, 2009). 5thand most importantly, people who have been infected are in isolation whereby they are: in a fight between life and death; they lack the physical support of close ones; they fear of dying without seeing close ones; thoughts about family and kids and so many other issues exacerbates pre-existing mental illnesses as well as leading to new mental health issues.

Mental health is an extremely important aspect of any suicidal inquiry. Bachmann (2018), and Bradvick (2018) point out that mental health is a significant aspect in any suicide related behavior. Discussing more specifically anxiety is a mental disorder (WebMD; Rector *et al*., 2008). Nepon*et al* (2011) found that anxiety disorders increase the risk of developing suicidal behaviors. Endo, Nishida (2017) found that social isolation is one of the key determinants of suicidal ideation and self-harm among adolescents. Further, a comprehensive review article by Calati*et al* (2019) concludes that social isolation is significantly associated with suicidal behaviors. Social isolation exacerbates: stress; feeling of loneliness; anxiety; lack of sharing of stressors with near ones leading to an increased risk of developing suicidal behaviors. Turner; Kelly (2000) found that chronic illnesses are significantly associated with mental health issues. For example, modern health care facilities have prolonged the life of people with chronic illnesses; however, the quality of mental health is often ignored. People with chronic illnesses often have mental illnesses which raise the question that had the medical advancement also provides people with better living in case of chronic illness. Gurhan*et al* (2019) argues that the risk of depression increases 4 times in people with chronic illnesses leading to 2 fold increased risk of suicidal ideation as well.

Conclusion

So far the available information on COVID-19 shows that the pandemic has impacted the globe socio-economically. The key socio-economic issue includes: lockdowns; closure of industry and markets (leading to widespread unemployment and poverty); social isolation; social stigma (for the affected individuals, families and communities); an increase in incidents of domestic violence; exacerbated pre-existing metal health problems and is developing mental health issues among individuals recently.

Previous research shows that unemployment and poverty, social isolation, social stigma, domestic violence and mental health problems are significantly associated with suicide. Therefore, keeping in view the current situation created by COVID-19 and previous research predicts that there will be an increase in suicide in near future and even during the pandemic if it prolongs for a few more months.

Future Research

This article is mere a link between the situation created by COVID-19 and previous research on suicide; however, its main purpose is to highlight the importance of the issue, and the focus required by the researchers in the near future. Some suggestions for future research are:

- Assessing the stress levels in people recovered from COVID-19 and assessing them for any suicidal ideation. This research can be done by researchers from their communities, and relatively samples are easily available throughout the globe.
- Assessing the stress levels among people with chronic illnesses and linking it with suicidal ideation.
- Researching for stress and difficulties in life of those who got unemployed particularly people of developing countries whereby the states cannot asses such people.
- Rejection, discrimination or labeling of those who have been infected, and assessing stress and suicidal ideation among such individuals.

- The effects of quarantine on the mental health of individuals infected and assessing suicidal ideation in near future among them.
- Researching about the role of technology in keeping isolated or quarantined persons in contact with closed ones. It should be researched whether it has relieved stress or not? And most importantly, its role in preventing suicidal ideation should be assessed.

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Participatory Approach in the Work of a Social Worker with Homeless People

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Source: Clinical Social Work and Health Intervention *Volume: 13* *Issue: 1*
Pages: 27 – 36 *Cited references: 11*

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Keywords:

Homelessness. Participation. Social Worker. Social Work with Homeless People.

Publisher:

International Society of Applied Preventive Medicine i-gap

CSWHI 2021; 13(1): 27 – 36; DOI: 10.22359/cswhi_13_1_04 © Clinical Social Work and Health Intervention

Abstract:

The research study is focused on the participatory approach in the work of a social worker with homeless people. The participatory approach emphasizes the involvement of service users in decision-making processes that directly affect them within the service, organization or within society as a whole. This approach is based on the concepts of recovery and empowerment and on the partnership concept of cooperation between the social worker and the service user. The research part deals with the application of this approach in practice, specifically in an organization that works with homeless people.

Introduction

Homelessness has existed since the beginning of human society - as the first example of this negative social phenomenon, we can mention exclusion from the community, when a particular person has lost his or her relationship with his or her group or tribe. The concept of homelessness etymologically comes from the word home, the

meaning of which is not limited to the roof over your head, but also includes social background or family and the wider community, love and acceptance, security and privacy "To be homeless, to have nowhere to go, to have no one to confide in with one's worries, suffering, pain, protest, frustration, means loneliness, the burden of isolation, the pain of exclusion, leading to despair and self-destruction" (Hradečtí, 1996, p. 36).

The definition of homelessness as the absence of a home is too simplistic and obscures the fact that it is far from just a loss of housing but a much deeper and more complex problem, mostly involving more negative phenomena such as: family breakdown; job loss; indebtedness; various psychological and social pathologies. the most visible of which are various types of addictions and crime (Průdková a Novotný, 2008, p. 11-12). It is a deep life crisis, the result of total failure in an individual's life.

The aim of the empirical research study is to find the answer to the main research question –

How do the social workers of a charity in the Prešov Region perceive the functioning of the participatory method in their daily practice?

At the beginning we will explain the basic theoretical background - concepts that are significantly related to the topic. Subsequently, we describe the methodology used in the research. We outline research strategy, data collection techniques and other important aspects of research. We also set a goal and partial research questions. The last part is devoted to the analysis and subsequent interpretation of the obtained data. In the end, we answer the main research question and consider possible recommendations for practice.

Theoretical Basis

The issue of participatory approach in social work is a new phenomenon that is used in practice. The concept of participation has different contents in different contexts. For the purposes of this study, the term participation can be defined as the participation of users of social services in the planning, coordination and evaluation of services, leading to the empowerment of these users and also to improving the quality and efficiency of services provided. (Beresford a Croft, 1993). In a narrower, individual sense, this term can be understood as a partnership approach of a social worker to the client (Davies, 2002, p. 90). More generally and simply, participation means the degree of participation of individuals and groups in decisions that directly affect them (Davies, 2000, p. 355). The author of Schuring (2015) generally distinguishes between horizontal and vertical participation.

Vertical or public participation is the participation of citizens in political decision-making processes, from the right to vote and the ability of citizens to express themselves on political events, through the requirement of expertise in the preparation of specific projects and delegations, for example, social services into the hands of non-profit organizations, to the cooperation of all stakeholders in the preparation of a specific law (eg the law on subsidies for housing development and on social housing) and state support for self-help civic projects (eg the national project *Support for Partnership and Dialogue in the Field of Participatory Public Policy Making*).

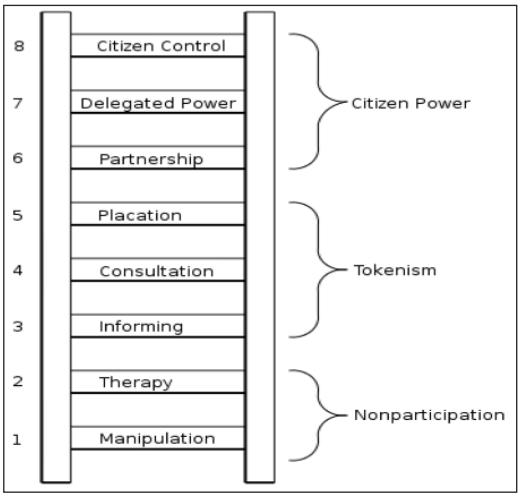
Horizontal participation is the involvement of disadvantaged groups of citizens in the life of society, the equal rights of their voice in society and the support of their own activities, leading to social inclusion and social cohesion. Social work deals with this type of participation in particular. „Participationis sustainable only if we involve all groups of people, not just people like us or with whom we get along well" (Schuringa, 2015).

„Promoting participation at the lowest levels (involvement in the life of the local community or local organizations promoting their interests), horizontal participation is, according to previous experience, a suitable tool for opening imaginary doors to vertical participation, influencing the system at higher levels - municipal, regional, national or European" (Adams, 2008, p. 41). The very participation of users of social services is based on two main approaches (Bandit, 2015). The first is the consumerist approach, it points to the user, i.e. the client who becomes a customer and has a choice. His satisfaction is a measure of service quality. Involving users in improving service quality is a logical part of this approach (Mačkinová, 2010). Another approach is democratic and rooted in the idea of community planning. It therefore has a deeper human rights dimension, it is based on the principles of equality and power sharing.

The most well-known division of participation levels, the so-called participation ladder,

comes from Arnstein (1969). The ladder consists of 8 rungs, from the lowest to the highest participation rate (Figure 1). The author places the first 2 levels, manipulation and therapy, in the category of non-participation. From the point of view of delegating power, this would be powerlessness. The other 3, information, consultation and involvement, are referred to as tokenism, i.e symbolic power. Only the last three rungs, „Partnership, delegated power and civil control, according to the author, they have an empowering potential, it therefore refers to them as civic influence or civil power" (Gojová, 2016, p. 20).

Figure No. 1 Participation ladder (Arnstein, 1969)



The issue of participatory approach in social work is relatively new, and therefore the long-term intention of social work is to apply this approach more often in the practical field using individual methods with different gages of social work not only with homeless people. The author Bandit (2015, p. 82) writes that „It is necessary to create methodologies and instructions for effective involvement of users in various services. User participation and involvement should become an integral part of good practice in social work. Such a need is also related to the clear need to develop reflective and anti-oppressive social work and to enshrine the principles of cooperation, participation and empowerment in ethical codes of social work."

Methodology – Research Design

To answer the main research question: *How do the social workers of a charity in the Prešov Region view the functioning of the participatory method in their daily practice?* In the study, we used a qualitative method that allowed us inductive insight into the issue. The research was carried out using the technique of semi-structured interview and the method of data interpretation thematic analysis. According to Hendl (2016), this is a middle ground, which is characterized by a defined purpose, a certain outline, but also the flexibility of the whole process of obtaining information. The unit of research was to find out how charitable organizations practicing a participatory approach in social work with homeless people work. The survey unit was selected social workers of a charity in the Prešov Region. The intentional selection method was used to select the conversation partners. The selection criterion was experience with a participatory approach. Data were obtained through interviews, represented by 4 social workers - field social workers. The analysis of the obtained data was performed using thematic analysis, which is part of the process of identification and organization of topics in qualitative data (Braun a Clarke, 2012).

To answer the main research question, partial research questions were used, which were based on the research concept. The partial research questions were therefore determined as follows:

1. *What are the challenges of a participatory approach from the point of view of the organization's*
   social workers?
2. *What is the benefit of a participatory approach from the point of view of social workers?*

This research study maintained the ethical principles of the research and that all participants were informed about the purpose of the interview and to maintain the anonymity and anonymity of the organization that wanted it.

Results

First, we focused on the individual questions of the interview, which serve as support points for us in the verification - thematic analysis. During the thematic analysis of the interviews, we found 24 topics that are closely interconnected. We tried to sort them so that they logically follow

each other, and we divided them into three categories. The structure of the research results is therefore the following Figure 2.

Figure 2 Category of topics

Social Workers
Social center
Challenges and obstacles obstacles
Beginning
Qualifications
Work
Sense
Basic support
Social work
Space to engage
Tailor-made services
Rules and prohibitions
Passivity
More and more
Aggression – conflicts
Team support

We called the first category of topics **social workers**. This is the main pillar of the participatory approach in the research study, and it is essential that it touches on the very beginnings of the organization.

Beginning – three social workers stated that it all started as part of a university study in the field of Social Work. The respondent was approached by acquaintances a few years ago during the holidays to volunteer at the time of Advent for the homeless. *„They came up with the idea of selling Christmas punch, honeysuckle at Christmas markets and so on*." The respondent perceived the offer as an opportunity to gain practice and experience something new. Together with other people, he became involved in volunteer work.

Qualifications: The interviews showed that all social workers in the organization have a university degree in Social Work and only one social worker has not completed II. degree of higher education. Respondent No. 1 was originally employed in the organization through the Labor Office of Social Affairs and the Family: *„And then I was actually paid out of the employment office first, so they applied for my position, but it was only for some two years or for how long.The management also wanted me to complete a master's degree in social work."* Respondent No. 2 has experience with the Office of Labor and Social Affairs and the Family. This respondent was contacted about a year ago, with the offer of a social worker in an organization dedicated to the homeless where they meet the requirements for inclusion, and can hire me later. *„Actually, at the beginning, the management offered me - they told me that then they would choose 2 of us, to whom they would offer cooperation. And with the proviso that if someone wants to work as a social worker somewhere in another organization, they will get a recommendation."* Other respondents worked as social workers or field social workers with a professional classification in the field of Social Work.

Work: Respondent No. 3 told us about the very beginnings of social work in the organization:*„Then actually another project after that was something like ... field work and community work*". It started with field social work carried out by field social workers with the support of others from the team. Initially, it was a few hours a week: *„There were about four of us, somehow we always went in pairs for two hours in the field in a week."* This was joined by the original social center, which was only open for one afternoon a week: *„On Tuesday, the center was just open there, so you could not only wash your clothes and stuff, but most importantly probably call and just do the things you don't do outside for work and stuff."* Respondent No. 2, after getting acquainted with the work and went through training, was also offered work in pairs in the field. *„After training, I went to the field with a colleague and it was a challenge to help people on the homeless street as a field worker. That attracted me."* Later, the current social center was opened and since then there is almost no time left for field social work: *„At first we went more into the field, now as the social center was created, it moved to the social center and the terrain decreased a bit. Which is probably a shame, but I hope it gets back to the old norms until it's a little better organized here."* Accompaniments are currently the most used accompaniment of field work, as commented by respondent No. 4: *„Pe-*

ople (...) go to the labor office as an escort and the like, but (...) they are less looking for new necessary places, new people, there is simply no time for that.“ Respondent No. 1 states: *„Accompanying is a toy, but establish communication so that it is something (...),I was scared at first, but a colleague always helped me.“* This aspect of communication was mentioned by all respondents in the interview.

Sense: All the field social workers talked about them enjoying their work and fulfilling them.As respondent No. 3 says: *„As far as housing is concerned, I can't secure my own housing, I haven't moved a step further at all, but I only have a job ... I got a job that I enjoy.“* Respondent No. 2 spoke about the fact that, in addition to working in a social center, he now deals with primary prevention in schools within the framework of socio-pathological phenomena - addiction. *„I want to help the children, too. I want the children not to be addicted.“* Another respondent is a representative of an organization in the field of social housing, in cooperation with the city council, i.e. the social field. One of the respondents comments: *„So I try to do things that I enjoy and that make sense. And especially what I studied here.“*We called the second category of topics *the* ***social center.*** We have included in this category both the provision of basic services to homeless people and activities beyond the scope of regular services and ways of involving clients in the running of the organization.

Basic support: Clients are provided with basic support: food, hygiene, clothing, the opportunity to wash things, make phone calls, keep things.These services were described by respondent No. 2: *„So that they can take a bath, so that they can wash the laundry, so that they don't have to wash it anywhere in their hands“*, and *„when they need the clothes, they can choose it here, otherwise we always have some supplies here for the most necessary cases.“* He also explains that food is served and that clients have hot food almost every day of the week: *„Through the project, hot food is provided for homeless people. Meals are provided only on request, this means that homeless people get free hot concentrated soup (bread / pastries, hot soft drink), so we are de facto providing food aid to people.“* And respondent No. 4 speaks, another service is the possibility to call: „*If someone needs to call the authorities, so we'll lend them a business phone,*" and adds that lockers are also available to act as a locker for things: *„So they can go to those lockers (...) so they can take those things,*" *and* "*they just didn't have to take everything with them.“*

Social work: As we have already mentioned, an important job of social workers in a social center is social work. Respondent No. 1 lists the basic tasks: *„We are actually looking for accommodation, we arrange ID cards, birth certificates“* and is supplemented by respondent No. 2: *„We mediate those contacts with services that are professional, need help, need advice on how to proceed when they are in debt, in domestic violence and so on (...).“* Respondent No. 3 also talks about accompaniments: *„We actually do escorts ... I don't know ... to the employment offices, if the person has to go outside the Prešov Region, then we are able to go with him outside the region and accompany him there, if he has problems with that*", and explains the importance of accompaniments: *„This also applies to escorts to the doctor, because homeless clients often have a problem with this, if you report that they are actually homeless, they do not treat them very nicely. So it's probably better if they have someone there who ..., who they can lean on. And the fact is that it is enough to say that I am a field worker, and the client will say that she wants me to be there, and the clients are viewed differently.“* And he adds: *„It really happened to me many times that they were suddenly more accommodating to the client (...).That just a few words are really enough, (...) and it works.“* Respondent No. 4 currently described how he, accompanied by the client, managed to arrange material need benefits: *„So I've been struggling with this for a year, and now we've solved it all ...“*

Space to engage: All activities of the social center are planned together with the clients, who either design them themselves, or at least participate in their form, if they want. Respondent No. 2 describes it as follows: *„If anyone wanted, could, for example, give an example, beading or something, he would come to us, he would say that he would like to take courses here, for example,if there is interest, then definitely yes, clients actually try, even if it is possible, to get money (...), the client would definitely not do it for free (...),now here we have designed sewing courses“*, and sums it up in words: *„Actually, al-*

most anything is de facto possible here. We connect social rehabilitation and the development of work skills with the educational process." Respondent No. 1 states basically the same thing: „No matter what request they come up with, there is room (...), it's up to them, we will provide all the material and other necessary things", and adds: *„Something goes slower, like the sewing workshop."*

Tailor-made services: Even the space of the community center is co-created by the clients according to their ideas, as stated by respondent no. 1: *„Here, as the rooms are, the clients have actually adjusted them as much as they like them, as they need them, as it suits them"* and is supplemented by respondent No. 3: *„Originally we didn't want to have beds here, but because they actually came and really wanted to, they're just here (...) and they can just rest here all day."* According to respondent No. 2, clients participate in decision-making processes, including the operation of the community center: *„There are often meetings here now where they actually express their opinion on what they would like to change or what they are happy with, and I think those suggestions can usually be fulfilled, or that they will simply be accommodated, because ... Well, that's what it's about, well."* Joint community meetings are held about once a month, always as needed, whether by employees or clients: *„They can also take advantage of the fact that they can tell for themselves,"*says respondent No. 4, adding*: „Now it's about once every fortnight."* Respondent No. 3 comments similarly: *„Just when it's needed and it's graduating."* Respondent No. 2 describes the course of meetings: „*We're talking to them about how they're here, what they'd like differently. If we have any new information we want to tell them, then we'll tell them, too."* Respondent No. 1 also described the course of the meetings: *„Mostly like clients talking, then someone who wants to say something is called, then of course they shout over each other, but that can be regulated."* Respondent No. 2 also explains that it is appropriate to evaluate clients for active participation: *„You can invite these people to a meeting and then just give them something for it, (...) because otherwise they might go to work, instead of participating in something here ... Maybe from the beginning it is not as important for them, (...) and even maybe to offer them something for it (...) that strikes me as a good motivation."* He further emphasizes the importance of mutual communication: *„I think that's also very important, like getting constant feedback from those people all the time, like what they would like differently, or when ... just talking about it, when it doesn't work, when something doesn't work, then it's like having the discussion, having the dialogue."* He adds: *„It's mutually beneficial."*

Rules and prohibitions: Another thing in which the clients of the social center actively participate is, according to respondent No. 1, the creation of rules: *„We also created rules together so that ... they too can participate."* The respondent further states that the social center has set only 3 basic rules from the beginning: *„Without drugs, without alcohol and not aggression" and the rest is completed together with clients: „These are like the basics, then we just try to create those rules at various regular meetings with those clients."* Respondent No. 2 specifies that the condition for entering the community center is not sobriety, but alcohol or drugs may not be used directly in the center: *„Actually, the clients here ... they can come here in a slightly drunk state, they can't be aggressive*, and actually the same with drugs. *So they can't drink here before us, and they can't use the drugs here, yeah*." And he emphasizes: „If there is some kind of aggression, some kind of violence, then the client is expelled, and then he decides whether ... according to that ... according to the situation, well. *He is usually told to leave the social center and the next day to come, that we can talk about it, or there are various alternatives."* Respondent No. 3 compares this with other services which solve a gross violation of the rules by preventing the use of the service or prohibiting it: *„They're used to bringing wine, if I bring it there, I'll get a ban on entry. We keep debating with them here, don't be silly, like, don't drink it here , and he emphasizes that the worker in particular must lead by example to other clients: „I always try to say, as clients ... like let's not make our addictions (...) much public. It is then stupidly said (...) do not drink here when I have beer in the fridge."* A dále uvádí, jak porušení pravidel řeší: *„Instead of prohibitions, I just use it as a sentence, just go think for four days if you want to spend that time here with us or not."* Clients also say that they

are reluctant to approach the ban: *„We are very careful with the ban“ and that he tries to solve everything in a good way*. Gradually, there are more and more rules that prove necessary, as stated by respondent No. 3: *„We imagined from the beginning that it would work differently, that it would be so looser, but experience shows us that it can't be so looser, that there simply has to be some rules here*.“

We called the third category of topics **challenges and obstacles**. We are referring to the challenges faced by social workers by clients, as well as the obstacles to client participation.

Passivity: The passivity and independence of many clients is another challenge for social workers. Respondent No. 1 states it as follows: *„It really sometimes takes a long time before the relationship and trust and so on are formed, and the person may need to move somewhere further or get involved in the organization more*.“ He also states that this is a long-standing habit of users of social services: *„A person is used to (...) the rules that give him clear boundaries, you don't have to have a choice for yourself, and if you just don't have a choice for those 15 years, you're also used to it, you can't actually choose*.“ This inability of clients employs social workers at the expense of social work: *„Then you really seem to end up that day washing and running from A to Z and actually doing very little social work*.“ According to respondent No. 2, this problem can be called dependence on social services: *„I always say that in those 25 years we have become addicted to social services here*. According to him, people who do not have any higher goals in life are subject to this addiction: *„The social support is enough for me, I have food everywhere here, so ..., he just wants to live, to live well, happily, just like ... he really is, in those 10, 15 years ... you will learn to live in that environment so much that it is already a natural environment for them* ". To the question whether the passivity cannot be a manifestation of resignation in an unsolvable life situation, respondent No. 3 answers: *„Because I think there are people like there who can't really be elsewhere, because they have bans everywhere because of something, so it's that there are enough of those clients, even if there's chaos, even though there's a lot of noise and swearing, and so on. , so I think they did quite a bit of work on themselves*.“

More and more: A similar problem, related to living in permanent insecurity and using social services, is the habit of taking as much as possible from everything, because one never knows when one will be in need. Respondent No. 1 explains this on the example of clothing: *„People on the street are used to surviving and don't think they should take one sweatshirt and there will be another 20 tomorrow and I can do it here in peace and I don't have to worry that someone will take my sweatshirt, but they'd better take 4 sweatshirts, because they just don't know how it will go*.“ He also states, on the example of hygiene packages, that such situations lead to confusion: *„You get something as if you sold it, be it shampoo. I don't care, it's his, so why judge him. But then, so that he doesn't come again and say: I want for a friend, I want for my mom, I want for my grandmother, for my aunt, and suddenly there just starts to be such a mess*.“ In his own words, he would like everyone to take only what they really need, and not have to approach the allocation: „*I want it to work so that (...) the moment I just don't have toothpaste, I'll just come, look, there's toothpaste there, yeah, we have*.“ Respondent No. 2 sees progress: *„I think it's pretty much better. As if they understood that if they came to us, they would not always get much*.“ And sometimes the feeling, as the respondent said: *„The more they get, the more they want. Furthur more, more and more*.“ Another social worker, respondent No. 4, sees this from a vantage point: *„It will really take an awful long time, because I know that 25 years have been set up for it here, and maybe just like we're definitely doing it stupidly, we have to do better“* and optimistically adds: *„It will be better, it will just take Langer.“*

Aggression - conflicts: Aggressive and conflicting client behavior is another challenge for social workers. Respondent No. 3 talked about the fact that someone just doesn't like anyone. Direct quote from a social worker from the experience of homelessness in the field: *„Because there may be people on the street who don't like them, so I try to explain to them that it's okay that you don't have to be nice, but try to respect each other. I'll explain it to them (...) and you don't have to attack right away, because you just don't like someone*.“

Team support: Respondents said that their work is psychologically demanding: *„The parti-*

cipatory approach is really challenging," says respondent No. 1 and gives a specific example: „Even if you ask those people what they would be interested in and then try to come up with something with them, then maybe they just won't come up with the activity, (...) it's also demotivating." The respondent emphasizes the importance of maintaining motivation: *„The motivation, well ... I think it's important to just look for ways to just make it work. And with small steps, as if you don't really have high expectations."* Respondent No. 2 also stated that direct work with clients is very demanding: *„There's a lot going on that day, and now that it's too much for you, it's not funny at all."* And that you need to work on yourself all the time: *„We should probably learn to work with it a little bit better, because we have to give a little bit of respect, but some calm respect, and we should learn to control our emotions more."* The respondent emphasizes the importance of supervision, as well as rest: *„Then it is important that there is some kind of supervision that we do not like at all, because you speak, you speak, not everyone seems to like to speak and in fact understands it as if it were whole, kind of (...). Let it be rather a relaxation, rest, trip."* According to another respondent, meetings and supervision should be more frequent: *„I would give more meetings (...) and more supervision. So that we really seem to say some things in meetings which one receives from those clients, and it is simply directed to our team, for example."*

Conclusion

Finally, we will try to answer the main research question:

How do the social workers of a charity in the Prešov Region perceive the functioning of the participatory method in their daily practice?, by answering two sub-research questions.

The first sub-question was: ***What are the challenges of a participatory approach from the perspective of the organization's social workers?*** The interviews clearly show that a participatory approach in social work with the homeless requires great motivation and patience, both for workers and service users. A participatory approach is a long-term, challenging and essentially never-ending task. It very much depends on the recovery phase of the individual, while each individual has a different pace of recovery, which depends on many factors: length of stay on the street, health and mental condition, motivation... It would be interesting to find out to what extent the length of stay on the street affects the speed of recovery. Every homeless person needs a lot of patience and respect from social workers.

Interviews have also shown that street experience leads to the acquisition of certain anti-social behaviors such as ruthlessness towards others, the need to gain a lot for oneself at every opportunity, long-term aggression, a tendency to increase self-esteem by exalting oneself, or even criminal behavior. These problematic phenomena lead to the need to create stronger rules. However, the participatory approach is beneficial in that these rules are developed gradually in cooperation with users of the service. However, problematic behavior also disrupts relationships, both with social workers and between individual users.This creates constant tension and compromises the safety of the space. For workers, a patient and non-judgmental approach to some individuals can be a big challenge.

„Dependence on social services" proved to be an important obstacle in the participatory process. The frequent habit of homeless people to the status of the recipient of assistance, conditioned by the fulfillment of given tasks, keeps these people in subordination, passivity and inability to make independent decisions and manage their lives. This problem is certainly not the fault of social workers, but rather the result of the overcrowding of these services and the need to focus on covering the most basic needs of clients at the expense of continuous individual or community work. Moreover, this passivity or resignation usually has deeper roots, dating back to before pre-homelessness. In any case, this is a major challenge for a participatory approach.

The second partial research question was: ***What is the benefit of a participatory approach from the point of view of social workers?*** A participatory approach is, in essence, a bottom-up approach - its principle is to give people the space to define for themselves what they need and to be the main actors in their own empowering process. However, they also need a large amount of support and suitable conditions for this. The first condition is to ensure security - while maintaining the highest possible degree of freedom - and to satisfy

basic needs. Furthermore, a partnership approach is important, which leads to increasing the self-confidence of homeless people, to strengthening self-confidence, which are necessary conditions for one to find the strength to change and take one's own destiny into one's own hands.

Also, the possibility of self-choice and self-formulation of what I need and what I would like to achieve can lead to disruption of passivity and resignation. A person performs a role better if he chooses it of his own free will than a person whose role has been entrusted to him or forced by someone else. A person who "accepts the task", who enjoys the task and makes sense for it, has a much greater motivation to complete it. Such an approach also leads to an increase in self-worth, has a strengthening effect and therefore long-term sustainable results.

Respondents emphasized the importance of being able to empathize with homeless people and understand behaviors that may seem negative to employees. This understanding and insight are a huge benefit and a strength of social workers. Social workers can also be a motivation for others, a good example of what a homeless person can achieve. Above all, however, their work has an invaluable benefit for them. They were able to use that space and that support to get from the hopeless and humiliating situation of a homeless person who receives the help of others to the position of a helper. They were given the opportunity to use their unfortunate experience for the benefit of others and thus give it a certain meaning. They are real experts on homelessness and learn not to be ashamed of their experience. They receive the necessary support and awards from colleagues, not to mention an adequate financial evaluation. And their position is a constant challenge for them to move on, whether for work or "just" personally.

The participatory approach is, on the one hand, highly individualized, "human-oriented", "tailor-made". On the other hand, it is an important pillar of working with the community, which can lead to the fulfillment of the highest goal - self-help. As all interviews have shown, a community center can become a substitute home for many people, safe, welcoming and open at the same time. The community center enables and even supports the creation of an emotional relationship with the given space and with the people who inhabit it, regardless of whether they are employees or clients.Social workers are aware that a participatory approach to working with homeless clients is challenging in practice. Nevertheless, individual social workers see progress, either in the form of obtaining housing or work, or in the form of a "mere" change in behavior or approach to oneself and others.

The question that has accompanied us since the beginning of the interest in the topic of participatory approach in social work with the homeless and which remains unanswered is: ***How could a participatory approach be introduced in organizations providing social services to a huge number of homeless people?***I believe that this is possible, thanks to the example of the British organization St. Mungo's, which is a comparatively large colossus, yet is a role model in a participatory approach. Even from the interviews themselves, however, it turned out that such success does not arise by itself, but is, on the one hand, the result of many years of work and experience - in the case of St. Mungo's is 40 years of experience - and on the one hand it is conditioned by the development of the whole society that deals with social services.

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Life Satisfaction of Holocaust Survivors

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Original Article

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Source: Clinical Social Work and Health Intervention *Volume: 13* *Issue: 1*
Pages: 37 – 44 *Cited references: 13*

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Keywords:

Holocaust. Survivors. Health. Life Satisfaction

Publisher:

International Society of Applied Preventive Medicine i-gap

CSWHI 2021; 13(1): 37 – 44; DOI: 10.22359/cswhi_13_1_05 © Clinical Social Work and Health Intervention

Abstract:

Objective: Find out the impact of the Holocaust trauma on life satisfaction of alive Czech survivors, and to compare it with a control group of respondents.
Design: Prospective study
Participants: The total number of respondents in the study was 130. The exposed group consisted of 65 Czech Holocaust survivors (average age 88.5 years), control group of 65 Czech seniors (average age 88 years).

Methods: The article presents a quantitative research assessing the life satisfaction of survivors using the standardized Life Satisfaction Questionnaire by Fahrenberg et al. (1986) on a main group, and compares it with a control group. A non-parametric test for two selections (Mann – Whitney) at a significance level of 0.05 was used to test the hypotheses.
Results: In spite of wide spectrum of the Holocaust effects, the exposed group shows higher or the same satisfactionin the most of the monitored areas compared to the control group (Health Me 4 vs. 3, p – 0.000; Workand employment Me 6 vs. 5, p – 0.000; Financial situation Me 6 vs. 4, p – 0.000; Leisure time Me 4 vs. 4, p – 0.002; Marriage and partnership Me 2 vs. 0, p – 0.284; Own self Me 4 vs. 3, p – 0.000; Sexuality Me 3 vs. 3, p – 0.879; Friends and acquaintances Me 5 vs. 4, p – 0.002; Housing Me 5 vs. 4, p – 0.000; Overall life satisfaction Me 5 vs. 4, p – 0.001). On the contrary, they are less satisfied in the area Children (Me 4 vs. 5, p – 0.016).
Conclusions: The research displays integration of hardiness and vulnerability, lust for life and the ability of man to live and survive in extreme conditions and still feel a joy of life.

Conflict of interest

All the authors declare that the research involved in the article and the publication of the article were carried out without having any business, financial or other relations and/or circumstances that could be considered as a potential conflict of interest. At the same time, all the authors declare that there is no conflict of interest related to this article or its review.

Introduction

It´s been only 76 years since the World War II and the Holocaust ended. Those who have gone through the walls of Jewish ghettos or concentration camps are still living among us. They are live pictures of horrors that almost none of us can even imagine. Their fates even these days feel with monstrosity, fear and suffering. Along with it the questions forward:

”How these people could have survived and lived in the places where others were dying?“

”Is it really possible, after all those horrors, to come back to ordinary life and find meaning in it again?“

”To feel joy?“

In April 2020 the Jewish Holocaust survivors' database contained approximately 450 clients who were receiving social services in the Czech Republic supported by grants provided by the international organization Claims Conference. Actual number of Czech Holocaust survivors may be even higher, since not each survivor belongs to a Jewish community or organization associating concentration camps prisoners, active combatants, hidden children, and so on. In spite of dealing with relatively small number, it´s still probable that among clients/patients who we care of in the terrain, ward or hospital beds sphere, these people may be present.

Searching for relations between various traumas and health or life satisfaction is in the center of gravity of researchers from numerous fields, such as psychology, medicine, nursing, social work, sociology, economy, and others. Causal relation between Holocaust trauma and survivors´ health condition was supported by foreign studies by researchers from areas with high concentrations of Jewish refugees from Europe (the United States of America, Australia, and Israel). Joining the studies creates a bio-psycho-social-spiritual model of Holocaust effects that presents not only the effects of this tragedy on the stated health dimensions, but also points to survivors´ attitudes towards life, health, disease, and additionally to transgenerational trauma transmission. Researchers detect causes such as insufficient nutrition, extreme stress, insufficient and health threatening hygiene, life and work conditions, and guards' brutality in work or concentration camps. (1, 2, 3, 4, 5, 6)

For a very long time, this causality was not in the focus of researchers´ interest in the communist countries of Europe. In the West, victims of the Third Empire racist laws were recognized as victims of Nazism and racial anti-Semitism, and thus they were in the focus of research seeking to help this victim group. In the countries under the Soviet influence the situation was more difficult. Returnees from concentration camps, shelters or forced emigrations would often on a long-term basis face various anti-Semitic attacks. This was the main reason why survivors refused to talk about their experiences. The taboos about the life in concentration camps or Jewish ghettos were breached by the regime change in 1989. Holocaust research in the post-communist countries was delayed for more than 40 years compared to the Western block. After the effects on survivors´ health were scientifically supported, researchers´ interest started focusing on the area of life quality, well-being and survivors´ coping strategy. (5, 7)

The aim of the presented study was to find the impact of Holocaust trauma on life satisfaction of living Czech survivors, and to compare it with a control group of respondents.

The respondent set and methods of research inquiry

To find the life satisfaction of Holocaust survivors the quantitative research design using a questionnaire method was selected. As a proper tool, the standardized Life Satisfaction Questionnaire (LSQ) was chosen, originating in 1986 as a part of a research project aimed on psychological and medical recovery of patients suffering from heart and blood circulation diseases. Representative LSQ testing was carried out in Germany in 1995 by Schumacher, Laubach & Brähler on a group of 3,047 inhabitants aged from 14 to 92, and created the necessary empiric basis for scale analysis and norms creation. Reason for selecting the LSQ as a proper tool in Holocaust survivors is that it mentions individual evaluation of past and current life conditions, and future perspectives. The questionnaire enables capturing of individual satisfaction in various life areas, and its comparison with representative norms. (8) The further reason for the questionnaire selection was the reflection of the evaluated areas from the found research using the Evidence-based-practice method. It means the questionnaire offered the possibility to quantify life satisfaction in the areas where Holocaust effects on health were assessed.

The currently used version of the standardized LSQ contains 10 scales where each scale consists of 7 statements for which respondents select their evaluation on a 7-point scale ranging from ”very dissatisfied“ to ”verysatisfied“. The higher score means higher satisfaction in given areas. Individual scales relate to: satisfaction with their own health (further referred to as HEA), satisfaction in marriage or partnership (MAR); satisfaction with their own self (OWS); satisfaction with work and employment (WAE), satisfaction with leisure time (LET), satisfaction with friends and acquaintances (FRA), satisfaction with their own children (CHIL); satisfaction with sexuality (SEX); satisfaction with financial situation and housing (FIN and HOU). The resulting score of scales (HEA, FIN, LET, OWS, SEX, FRA, HOU) is overall satisfaction (SUM). Life satisfaction is meant as individual judgment of past and current life conditions and of future perspectives, and comparison to representative norms. Since in the representative inquiry many respondents failed to fill in the areas Work and Employment, Marriage and Partnership, and Relationship to their Own Children, to achieve the total score of life satisfaction only the sum of 7 remaining scales was used. (8)

Respondent testing requires test material (a questionnaire) and evaluation form. Respondents must have a command of the Czech language. Test instructions are stated in the beginning of the test. Filling in the questionnaire takes respondents from 5 to 10 minutes. LSQ is evaluated as a sum of individual answers in each of 10 scales. LSQ items and scales are basically polarized so that higher values represent higher life satisfaction. LSQ – SUM is computed as a sum of 7 scales HEA, FIN, LET, OWS, SEX, and FRA values. As it´s been previously mentioned, WAE, MAR, and CHIL scales data are not included in the overall value. Should the scale contain more than one unanswered item, the scale is not evaluated. In case of more than 7 unanswered items in a whole LSQ, the evaluation is not recommended. The standard dealing with unanswered items is following: more than one answer missing in a scale, the respective scale value will be re-

placed with missing data. Apart from WAE, MAR and CHIL scales, also the overall value LSQ – SUM is replaced with missing data. In case of more than 7 answers missing in a whole questionnaire, all the test values are replaced by missing data, it means the questionnaire is excluded from the research. Missing value is replaced with expected value, so that it would be possible (with reservations) to utilize norm values. The expected value is estimated from available item values of the scale: scale value = scale items average x number of items in a scale (rounded). Initially, the rough scores of individual scales are logged into the evaluation form, and then the respective stanine values (ST1-ST9) are searched in the norm charts, which are subsequently graphically displayed. (8)

To select an exposed group of respondents, so a called selection inquiry was carried out. All the Jewish communities in the Czech Republic were addressed for cooperation. Positive responses were sent from Jewish Communities (further referred to as JC) in Prague, Brno, Ostrava, and Karlovy Vary, where subsequently the research intent and data collection methods were presented by a social department managing worker. After receiving consents to carry out the research, it was initiated on 1st December 2016. In that time, the estimated number of Holocaust survivors in the area of the Czech Republic counted to 650, according to employees of the Federation of Jewish Communities. The selection of the exposed group ofrespondents was intentional.

Pre-conditions for inclusion into the research were – a respondent is a Holocaust survivor and lived all his post war life in the area of Czechia, Moravia or Silesia; a respondent is cognitively able to fill in the questionnaire (value of the Clock Drawing Test is 4-5); a respondent is willing to fill in the questionnaire (signs informed consent).

The questionnaires were mostly presented during JCs social events where this group of people meets. Those who showed interest in being included into the research, were given the questionnaire to fill in. 56 respondents were engaged in the cooperation. Other 6 respondents consented to the cooperation after they had been addressed by a social worker who visits survivors in the social environment of their homes. The researcher knew 5 respondents personally and asked to fill in the questionnaire in their home environment. The last 7 were addressed by a social worker in a social care facility which was established by the Jewish Community Prague, and designated for Holocaust survivors. It means we were dealing with respondents living in an institution. The total number of respondents of the exposed group who filled in the questionnaire was 74. The number of sufficiently filled questionnaires that could have been included in the research, was 66 (89.2% utility). Firstly, the respondents filled in the informed consent. Then the research author carried out the Clock Drawing Test with a respondent, and in case of the test physiological value (the value was reached by all the addressed), it came to filling in the LSQ questionnaire which was amended with significant data (a variable value) – a type of experience (a Jewish ghetto, concentration camp, shelter, internment camp, or a combination of these).

To prove the relation between the Holocaust trauma and survivors´ life satisfaction, it was necessary to select a control group. When selecting a control group, the main principles of the control group selection were followed – that is to keep to the maximum possible comparability (full comparability in the critical descriptive indicators) with the monitored group in all characteristics apart from the monitored factor (exposition). If there is no association between exposition and life satisfaction, then the life satisfaction would have to be the same in the both, basic and control group.

Due to a relatively small number of the exposed group respondents, the selection of the control group was made by so called pair selection (matching), where a selected respondent was assigned with a control – a person corresponding in advance stated demographic variables – age, sex, education, family status, social status, place where a respondent lives, who he/she lives with, need/no need of health or social help. The aim was to select the most similar persons as controls, who differ from the exposed group only in the exposition to the risk factor (a Holocaust trauma), thus creating a mirror image set in given characteristics.

With regard to the demographic data of the exposed group, the following subjects were addressed for cooperation in the selection of the control group – the Senior Club and the Univer-

sity of the Third Age auditors as an alternative to the exposed group of respondents, who were addressed during cultural and educational events. A retirement home was selected as an alternative to the Social Care home Hagibor, and a home care agency as an alternative to the respondents who receive care from Jewish Communities in their home environment. All these subjects are located in the Pardubice region. Addressing of respondents and course of research in the control group were made absolutely identically as in the exposed groups. Both the control group and the exposed group consisted of 66 respondents, and were identical in the given demographic indicators, except a Holocaust trauma experience.

Analysis and data presentation

The Microsoft Excel and Statistica were used to elaborate the data. Firstly, the analysis was made regarding the control and the exposed group, and after that differences in the exposed group were examined – according to the type of experience.

The Normality test was carried out in all the groups. Since the hypothesis that the selection comes out of the normal distribution was rejected in the overwhelming number of cases, nonparametric tests (Mann-Whitney Test and Kruskal-Wallis Test) were used to test the hypotheses. Generally it can be stated that in the most monitored parameters there were found differences between the control and the exposed group, and also within the exposed group. Apart from some exceptions, there are no differences among individual categories. The hypotheses were tested on 5% significance level.

Basic demographic characteristics of the exposed group respondents are presented in Table 1, and for the control group in Table 2. Table 3 contains an overview of the both respondents' group descriptive characteristics. Table 4 shows an overview of the Mann-Whitney Test results used for zero hypothesis testing (H_0 - There is no statistically significant difference between the exposed and the control group).

It´s evident from the Table 4, that in the most life satisfaction evaluation items we reject zero hypothesis, claiming there´s no statistically significant difference between the groups. In 8 items of the Life Satisfaction Questionnaire – HEA, WAE, FIN, LET, OWS, FRA, HOU, and LSQSUM, the respondents from the exposed group are statistically significantly more satisfied. On the contrary, they are less satisfied in the area CHIL. There is no difference in satisfaction in MAR and SEX items.

After the individual life satisfaction items had been evaluated and compared to the control group results, the hypothesis verifying the difference in life satisfaction within the exposed group in relation to a Holocaust trauma came to the surface (H_0 – There is no statistically significant difference between the individual experience types). Differences in life satisfaction items in the Holocaust survivors in relation to a war experience type (a shelter, Jewish ghetto, internment camp, or a concentration camp) was detected through the Kruskal-Wallis Test. According to the test results, we can claim that a war experience type has no influence on the life satisfaction evaluation in the mentioned items, see Table 5.

Discussion

Life satisfaction is a basic component of the comfort. There are researches documenting that satisfaction with one´s life is an inevitable part of individual mental and physical health through all the age categories. The research presented here aimed to find out about Holocaust trauma effect on life satisfaction of living Czech survivors, and to compare it with life satisfaction of the control group of respondents. This relationship hasn´t been verified by domestic researchers yet.

The relationship between subjective evaluation of health and life satisfaction has been evaluated e.g. by authors Šolcová and Kebza (2006), who based on their own research inquiry have declared that subjective health might be saturated by life satisfaction or personal comfort. The authors in the research agree on the existence of positive and robust relationship between the two variables. Further they claim that the relationship between health and life comfort is bilateral; that life satisfaction is a crucial part of one´s subjective health. (9)

To evaluate life satisfaction of the Holocaust survivors a quantitative research design was used. As a research tool served standardized Life Satisfaction Questionnaire by authors Fahrenberg *et al*. (1986) used on a group of 66 survivors, and on a control group consisting of 66 respondents,

too. To test the hypotheses the nonparametric test for two selections (Mann – Whitney) at 0.05 significance level was used. The exposed group displays higher life satisfaction in most of the monitored areas compared to the control group(Health Me 4 vs. 3, p – 0,000; Work and employment Me 6 vs. 5, p – 0,000; Financial situation Me 6 vs. 4, p – 0,000; Leisure time Me 4 vs. 4, p – 0,002; Marriage and partnership Me 2 vs. 0, p – 0,284; Own self Me 4 vs. 3, p – 0,000; Sexuality Me 3 vs. 3, p – 0,879; Friends and acquaintances Me 5 vs. 4, p – 0,002; Housing Me 5 vs. 4, p – 0,000; Overall life satisfaction Me 5 vs. 4, p – 0,001). On the contrary, they are less satisfied regarding the area Children(Me 4 vs. 5, p – 0,016). As it was mentioned in the qualitative part, the number of the survivorsdidn´t manage to have children. Those who did have them, frequently imposed high demands on their education. A number of survivors´ descendants emigrated, and only keep online contact with their parents. There is no difference in satisfaction in Marriage and partnership, and Sexuality items. Life satisfaction in the survivors´ group is unaffected either by gender or type of a war experience. The presented study results are surprising with regard to the evidence of wide range of Holocaust trauma effects on the physical, mental, social and spiritual health of survivors which has been proved by several domestic and foreign researches. The higher life satisfaction of the survivors might also be originating in the so called coping strategy that was created by most of the survivors in an effort to survive. (10, 11)

The life satisfaction issue was dealt by some of the foreign studies coming out of the areas with the high concentration of Jewish refugees. The results of foreign researches focusing on the learning of life satisfaction are similar to our study results Longitudinal study of authors Bachner, Carmel *et al*. (2018) The Paradox of Well-Being and Holocaust Survivors presents similar results as here presented research. The authors report higher life satisfaction in Holocaust survivors (n=295) towards a control group (n=340). (12) Authors of the research Aging of Holocaust Survivors: Discrepancies between Subjective and General Health in the Greater Tel Aviv Area on the sample of 107 survivors and 107 respondents in a control group draw attention to the lower evaluation of subjective health of survivors [F (2,211)= 4,18, p<0,05] connected with lowered life quality. The life satisfaction score is higher in survivors, though.

Conclusion

According to ”Evidence-based practice“, the Holocaust negatively affected survivors´ health in its bio-psycho-social-spiritual dimension, and additionally their attitude to life, health, disease, and moreover, it has a transgenerational character. However, the presented research confirms that in spite of the above mentioned effects the life satisfaction of the Holocaust survivors in the Czech Republic is higher compared to the rest of the senior population. The research displays integration of hardiness and vulnerability, lust for life and the ability of man to live and survive in extreme conditions and still feel a joy of life.

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Table 1 Demographic characteristics of the exposed group of respondents

Gender		Age		Education				Status			Employment		Household			Need of social assistance		Type of war experience				
♂	♀	♂	♀	P	MV	C	U	M	D	W	P	WP	LA	LS	I	YES	NO	HP	G	IC	CC	COMB
23	43,0	79-93	71-95	4	12	31	19	12	10	44	58	8	37	23	6	40	26	28	15	1	1	21

Table 2 Demographic characteristics of the control group of respondents

Gender		Age		Education				Status			Employment		Need of social assistance	
♂	♀	♂	♀	P	MV	C	U	M	D	W	P	WP	YES	NO
23	43,000	78-91	71-92	4	12	31	19	14	10	42	58	8	40	26

Footnotes of table 1, 2.

P - PRIMARY, **MV** -MODERN VOCATIONAL, **C** - COLLEGE, **U** - UNIVERSITY
M - MARRIED, **D** - DIVORCED, **W** - WIDOW/ER
P- PENSIONER, **WP** - WORKING PENSIONER
LA- LIVES ALONE, **LS** - LIVES WITH SOMEONE, **I** - LIVES IN INSTITUTION
HP - HIDING PLACE, **G** - GHETTO, **IC** - INTERNMENT CAMP, **CC** - CONCENTRATION CAMP, **COMB** - COMBINATION

Table 3 Overview of descriptive characteristics of the exposed and control groups

Items of LSQ	average	median	mode	lower quartile	upper quartile	standard deviation
HEA	4,40/**3,40**	4,00/**3,00**	4,00/**4,00**	3,00/**3,00**	5,00/**4,00**	1,78/**0,92**
WAE	6,75/**5,23**	6,00/**5,00**	6,00/**5,00**	6,00/**4,00**	8,00/**6,00**	1,75/**1,47**
FIN	5,45/**4,20**	6,00/**4,00**	6,00/**4,00**	4,00/**4,00**	7,00/**5,00**	1,97/**0,85**
LET	4,48/**3,69**	4,00/**4,00**	4,00/**4,00**	3,00/**3,00**	6,00/**4,00**	1,83/**0,95**
MAR	2,69/**2,15**	2,00/0,00	0,00/0,00	0,00/**0,00**	5,00/**5,00**	2,91/**2,64**
CHIL	4,03/**5,09**	4,00/**5,00**	6,00/**6,00**	2,00/**4,00**	6,00/**7,00**	2,63/**2,12**
OWS	4,43/**3,45**	4,00/**3,00**	4,00/ **multiple**	4,00/**3,00**	5,00/**4,00**	1,73/**0,90**
SEX	3,03/**2,88**	3,00/**3,00**	3,00/ **multiple**	2,00/2,**00**	4,00/**4,00**	1,42/**0,98**
FRA	4,72/**4,09**	5,00/**4,00**	4,00/**4,00**	4,00/**3,00**	6,00/**5,00**	1,55/**0,95**
HOU	5,45/**4,48**	5,00/**4,00**	5,00/**4,00**	5,00/**4,00**	7,00/**5,00**	1,69/**1,08**
LSQ-SUM	4,49/**3,60**	5,00/**4,00**	5,00/**4,00**	3,00/**3,00**	6,00/**4,00**	1,82/**1,13**

Table 4 Summary of Mann-Whitney test results

Items of LSQ	Test criterion value	p-value
HEA	3,772	0
WAE	4,772	0
FIN	4,786	0
LET	3,058	0,002
MAR	1,072	0,284
CHIL	-2,407	0,016
OWS	4,04	0
SEX	0,152	0,879
FRA	3,055	0,002
HOU	3,971	0
LSQ-SUM	3,307	0,001

Table 5 Summary of Kruskal-Wallis test results

Items of LSQ	Test criterion value	p-value
HEA	1,889	0,596
WAE	4,161	0,245
FIN	4,139	0,247
LET	4,089	0,252
MAR	3,357	0,340
CHIL	1,849	0,604
OWS	2,255	0,521
SEX	1,316	0,725
FRA	1,107	0,775
HOU	7,601	0,055
LSQ-SUM	1,565	0,667

The issue of homeless young people

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Original Article

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Source: Clinical Social Work and Health Intervention *Volume: 13* *Issue: 1*
Pages: 45 – 54 *Cited references: 24*

Reviewers:

Zofia Szarota
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Keywords:

Homelessness. Young People. Social Exclusion. Social Work. Social Services.

Publisher:

International Society of Applied Preventive Medicine i-gap

CSWHI 2021; 13(1): 45 – 54; DOI: 10.22359/cswhi_13_1_06 © Clinical Social Work and Health Intervention

Abstract:

This paper is devoted to the issue of homeless young people. At present, homelessness is a global problem with an increasing number of young people, who got on the street for various reasons. Homelessness itself can be understood as a complex generalized social failure of an individual. It is a social category of people who are clearly poor, living on the margins of society and characterized by their specific way of life, which puts them on the margins of society on the basis of their inability to participate in the quality of life and disrespect for the requirements of the majority society. The aim of the article is to

present issues related to the phenomenon of homeless young people and understand the reasons and causes of their social degradation which led to their unfavorable social situation. Only appropriately applied social work can stop or reduce the number of young people living on the streets, and help them successfully reintegrate into the majority society.

Introduction

After 1989, when there were many revolutionary changes in the political and economic establishment in Czechoslovakia, the transition from a paternalistic state to a predatory capitalist system affected almost every citizen. Like any change, this transition required some adaptation. However, not every individual was able to cope with the situation. In Eastern Europe, begging as a phenomenon became fully apparent after the fall of the communist regime in the early 1990s. Even in the Czechoslovak Republic, we began to meet beggars and homeless people on the streets of larger cities. We know from historical sources that this phenomenon has occurred in our territory before, but under the rule of the communist establishment it was covered up or completely taboo. Unfortunately, the growing number of homeless people is currently on the rise and has recently affected more and more young people (Pavelkova 2014).

Homeless People

Homelessness is a complex phenomenon where it is not just a missing of shelter (Vagnerova *et al*. 2014). In general, it is a social category of people who are clearly poor, living on the margins of the majority society and characterized by their specific way of life, when behaviours and habits stand outside the majority society and do not fulfil its principles and customs. As stated by Hradecky et al. (2007), homelessness is conditioned by three basic factors. He ranks among them the fact that an individual has a place to live that is suitable for living, whether he has any legal certainty to this place with space for his private life. With the loss of his home and his social exclusion, he gets to the margins of society; there is a change in its value and normative system and its lifestyle. According to Prudkova and Novotny (2008), these changes are reflected in all areas of life:

- Loss of professional position and associated legal access to finance and the resulting economic self-sufficiency
- Exclusion from the family community, disruption of relationships with close people and the disintegration of the social network
- Reduced lifestyle and increased dependence on the support of charities, begging and garbage searching or criminal activity

Based on life on the street, an individual goes through a process of de-socialization (Vagnerova, Csemy, Marek 2014). Their marginalization combined with homelessness also brings social stigmatization because the majority society considers life on the streets to be a clearly negative deviation from the norm. For most people, it is evidence of social pathology and they take a negative and condemning attitude (Marek, Strnad,Hotovcova 2012). Causes of homelessness (Hradecky*et al*. 2007) can be divided according to the factors that lead to this phenomenon into objective and subjective. The first of them are affected, for example, by the social policy of the state and social legislation, and are reflected, for example: in respect for human rights; in respect for the law; equal opportunities for all citizens; in the education of citizens; the possibility of employment; in social protection; in security in old age and disease; employment of young people; xenophobia; ethnic problems; emigration; etc. Subjective factors are influenced: by individuals themselves; their families; different social groups or communities their dispositions and abilities; the temperament of a homeless person; his age; education; etc.

They can be viewed from a material point of view (housing, employment, tragic events in the family, property conditions, unexpected events in society, floods, etc.); in terms of the collapse of relationships in the family or community with its subsequent failure; or with regard to the problems in the personality itself (mental retardation, mental or physical disease, independence, loneliness, disability, alcohol or drug addiction, social immaturity, ethnic differences). Situations arising after release from hospitals, institutions, prisons or after reaching adulthood from ethopedic(criminal be-

havior) facilities often also contribute to subjective factors. According to Hradecka and Hradecky (1996, 34), homelessness is not a question of individual choice, as it would be easy to state.

Sociologists claim that the "homeless" phenomenon is part of a social process, a consequence of continuous social and economic forces leading to social structures (labor market, housing market, social security as a state measure, education, family structures); it therefore relates to the general standards and conditions of the company as such. Nowadays, as we know some examples from the literature on socially disadvantaged families, where the position in society has been passed on to the next generation, most people are not born as homeless but become them during their lives. What can happen in a person's life to get from a relatively well-off family to the bottom of society? According to Janebova (1999), two things must happen: 1) A certain event leads a person from a well-established track (e.g. loss of employment, death of a loved one, nervous breakdown, severe divorce, domestic violence, sexual abuse by relatives or just a banality such as a broken leg). These and similar situations occur in the lives of many people, but of course, according to the author, not everyone becomes homeless on their basis. Another factors must work together to do this, and that is the absence of a helping hand from someone close to you. If a person receives help, support, facilities or temporary housing at such a difficult time, he can clearly move away from the way of life of the homeless. Otherwise, if he is rejected by all and is left alone with his problems without a helping hand, she or he is more likely to eventually become homeless. According to Janebova (1999) before becoming homeless, he suffers three stages of loss:

- Loss of family support - Family members provide resources and advice in solving problems (material and spiritual support). If family support is missing or weakened, the individual turns to friends.
- Loss of friend support - is as critical as loss of family support. The most strongly felt is the loss of psychological support and the gradual decline of contacts, which further slowly leads to the isolation of the individual.
- Loss of community support - National communities are made up of public institutions and social services organizations. However, the resources provided by the community are not always adequate to prevent the loss of home. Help is also often inappropriate for people with a volatile address. Those who will not be helped by the rescue social network, that is the product of the community become homeless.

As Janebova (1999) further points out, this third stage is the starting point for the path to chronic homelessness.From the point of view of presentation to the public, Hradecka and Hradecky (1996, 36) divide homeless people into 3 categories. The group, which is most visible in public, is described as homeless by the obvious. It includes people living on the streets, railway stations, looking for accommodation in dormitories or asylums. They make up only a part of people without permanent residence (according to the Nadeje survey, only 3 people without permanent residence out of 11 usually sleep in dormitories;2 in inadequate flats;5 in public places, 1 in a squat). As early as 1991, a photo with text from the Budapest railway station was documented in National Geographic Magazine in an article on life in post-communist states by author Szulc (1991), where the miserable way of refugees from Romania and the former USSR to sleep can be seen.

Janebova (1999) places a group of people who are not seeking the help of public or charitable services among the hidden homeless. They thus escape the attention of these organizations and are not subsequently included in any homeless censuses as well as people seeking help and accommodation from friends even if only for a shorter stay. This group often travels and changes their temporary refuges, but with the arrival of winter, even these individuals take refuge in various dormitories. In our opinion, the most represented group of homeless people, which I. Hradecky (1996) calls as potential homeless people, belongs to people living in uncertain housing conditions (family or personal problems, risk of not keeping or losing an apartment) and also people waiting to be released from various institutions, prisons or to leave an ethopedic facility (from ethopedic facilities it is about 350 young individuals per year). The number of homeless people is increasing from year to year and recently as already mentioned, there are more and more young people among them.

Numbers of homeless people in the Czech Republic

In 2019, in the Czech Republic under the auspices of the Research Institute for Labor and Social Affairs in Prague and under the leadership of Nesporova the team conducted a census of homeless people. Based on this census, the estimated total number of homeless people in the Czech Republic was 23,830, of which 2,600 were under 18 years of age. Persons living outside and in dormitories were included in the census (ETHOS category - without roof), and also people in asylum, halfway houses, municipal hostels, prisons and medical facilities, in accommodation facilities for women and municipal hostels (category ETHOS - without a flat). People sleeping outside or in dormitories accounted for the largest share (54.0%). Men have a significant predominance among homeless people. They make up 80% of the number of people who sleep outside or in a dormitory. The gender ratio changes in shelter, where 30% of women, 38% of men and 32% of children live. Most homeless people were counted in the Moravian-Silesian Region, a total of 3,541 people. The capital city of Prague had almost the same number of people. Large cities are an opportunity for anonymity, so they are a frequent refuge for the homeless. On the other hand, the fewest homeless people were counted in the South Bohemian Region - 774 homeless people here. The total number of adults in the Zlín Region was 1,032; the total number of children was 105. As for the average age, the oldest population was the Zlín Region together with the Olomouc Region; here the average age was about 50 years. The youngest average age, 45 years, was formed by the population of homeless people in the Ustinad Labem Region. The largest part of people without a roof in the Czech Republic therefore consists of a middle-aged category, aged 40 to 65 years. Homeless people, aged 18-29, accounted for 10%, 1,114 people. However, based on its experience, Nadej estimates the number of homeless people at up to 20%, of which a third are women (an increase compared to the older generation). The average age of these people is 22.7 years and the average time spent on the street is 2.4 years (Marek 2018). However, as the census of such persons is difficult, the numbers and estimates are really different. According to a survey by the Ministry of Labor and Social Affairs of the Czech Republic (Evaluation of the survey of homelessness solutions in municipalities with extended powers in 2015) the estimate of homeless people was more than double compared to the most recent census. The number of homeless people at that time was estimated at 65.8 thousand and up to 119,000 people were at risk of losing their homes. As not all homeless people use social services, or belong to the group of so-called hidden homeless people, estimating the number of such people can be problematic and skewed by these factors.

Young People without Home

A significant part of the homeless community is made up of young people under the age of 26 (Vagnerova*et al*. 2014). According to a study by Darbyshire and colleagues (2006), about half of the homeless fall into this age group. Thus, homelessness affects a large number of young people. This is a widespread social problem that has a rising trend (Feantsa 2013). In most European countries, young people aged 18-29 represent between 20% and 30% of the total homeless population. Feantsa defines homelessness of young people as: "*Youth homelessness occurs where an individual between the ages of 13 and 26 is homeless, or lives in an uncertain or inadequate environment without a parent, family member or other legal guardian*". However, the age limit determining this period varies in different organizations or countries (Feantsa 2020).

Young adulthood can be referred to in psychological terms by various names and also defined in different age periods. Langmeier,Krejcirova (2006) define the period of young adulthood as early adulthood, ranging in age from 20 to 25-30 years. Its main characteristic is the consolidation of the adult's identity, identification with his role, specification of personal goals. It is also an effort to gain independence from parents, find a partner, or start your own family. At the same time, during this period, there is a preliminary choice of profession and

a gradual acquisition of responsibility in the profession. It is considered important in the period of young adulthood to set long-term specific goals and start living your own independent life. Equally important in this period of life is the acquisition of economic independence.

Vagnerova (2000) defines the period of young adulthood at the age of 20-35 years. She considers independence: relative freedom of one's own decisions and behaviors; associated with responsibility in relation to other people; responsibility for one's actions and decisions to be the most important features of adulthood. An adult is expected to have some responsibility, acceptance of responsibilities, adherence to standards. Of course, this development is different for all people and has various priorities. In the case of homeless young people, who have problems providing basic needs at all, it is, of course, difficult to consider a career or starting their own family. On the other hand, there is the very transition to adulthood and personal maturity where we see: homelessness as an alternative to life; when there is a deliberate refusal to accept responsibility;adhere to standards. It can be a period of so-called psycho-social moratorium, i.e. the period in which an individual postpones entry into adulthood; avoids commitment. Young homeless people are unable or are refusing to enter adulthood. Life on the streets can then be a manifestation of freedom, a rebellion, it can be a search for one's own identity (Marek, Strnad,Hotovcova 2012).

Specifics of homelessness of young people

Homeless young people are a separate group that requires a different approach (Vagnerova, Csemy, Marek 2014). Some young homeless people e.g. they refuse to use social services for the homeless, as they are also visited by older homeless people (Marek, Strnad,Hotovcova 2012; Cerna 2019). According to Marek, Strnad,Hotovcova (2012) the thinking and behavior of younger homeless people varies, and meeting the older generation can sometimes cause tension. Research in 2009 conducted by Tompset, Fowler,Torro, which task was to find the differences between homeless adolescents (13-17 years), younger homeless people (19-34 years) and older homeless people (35-78 years) showed several differences. Although street time spent by homeless young people tends to be shorter than that of older adults, they have experienced a higher rate of recent stress events. This suggests that although this period is shorter, they may experience more chaos in this episode of life. In early adulthood, younger adults have to deal with a number of challenges: gaining independence: studying at university; gaining employment; establishing important partnerships. It turns out that this age group also experiences higher levels of stressors in the homeless population. In terms of mental health, younger adults showed higher levels of hostility and paranoid symptoms than other age groups (Tompset, Fowler, Torro 2009; Skodova 2021).

The difference is also in the feeling of loss in the family background. Unlike older homeless people, they do not lose the built background, but only the background in which they were brought up, and they did not choose this background. Thus, homeless young people may not perceive the feeling of loss as strongly as older homeless people. The same is true of the loss of existing roles and social status which older homeless people can endure worse (Marek, Strnad,Hotovcova 2012).

Alcohol and drug abuse rates were the same compared to the elderly. Alcohol abuse affected 50.6% of younger and 56.5% of older homeless people. Drug abuse accounted for 47.4% of younger adults and 56.3% of older adults (Tompset, Fowler,Torro 2019).

Causes of homelessness of young people

Breakdown or dysfunction of the family is often the cause of young people's homelessness.We could divide young homeless people into so-called throwaway, i.e. people who were thrown out by their own family runaway, i.e. people who left the family themselves (Marek, Strnad,Hotovcova 2012). Compared to the older homeless, younger adults report almost twice as much experience with family abuse and neglect (Burt 2007). Young homeless people also run away from their homes, often before they finally take to the streets - almost a quarter say so (Vagnerova, Csemy, Marek 2014).

The risk group are people brought up outside the family, leaving the children's home or other institutional facility. Young adults leave home unprepared and without additional social support, have no one to turn to which increases the risk of failure (Marek, Strnad,Hotovcova 2012).

Vagnerova, Csemy, Marek (2014) divided the reasons for leaving the street into several categories some of which may overlap. These are certain life trajectories that require a different approach in the reintegration process but also pre-

vention. The categories include: excessive drug or alcohol use; inability or unwillingness to work systematically; a combination of behavioral disorders and unwillingness to work; mental illness. Excessive drug or alcohol use is clearly a possible trigger or accelerator how they end up on the street. The result is an inability to manage work, the high cost of procuring drugs leads to an inability to pay bills or to accumulate debt.

Such a person then easily loses his job and is fired from the rent or hostel, or from home. The inability or unwillingness to work systematically usually manifests itself in childhood and in relation to school. People are described as reckless, irresponsible and lazy. They tend to take advantage of the family and end up on the streets if they run out of patience. With an irresponsible approach to fulfilling obligations, also related to the relationship with the school, also includes e.g. lower educational attainment which makes it difficult to applications in life.

According to Vagnerova, Csemy, Marek (2014), people with a combination of behavioral disorders and unwillingness to work are often burdened with debt problems as well as misdemeanors and criminal activity. There are thefts and fraud. They obtain their money illegally. This type of behavior can be supported by the negative influence of the family and later the community of such people. As the above authors state, mental illness can be the cause of homelessness. Depressed and anxiety disorders; suicidal behaviors; post-traumatic stress disorder; schizophrenia; other psychotic disorders occur in homeless young people. A person suffering from a mental illness may then have a problem maintaining a long-term job or permanent social contacts.

Other causes of homelessness can include sexual minority membership and a different sexual orientation (Skodova 2021). According to various studies, identification with the sexual minority ranged from 6 to 35% of young homeless people (Burt 2007). A different sexual orientation can cause a conflict with a family that is not willing to accept such a thing. Sucha person may then feel unaccepted by their own family and stigmatized, which of course increases the risk of going in the street to live.

Feantsa (2013) also talks about barriers to housing affordability. According to Eurostat data for 2012 (in Feantsa 2013), about 50% of young people aged 18 to 29 who suffer from poverty (income below 60% of the median) passes on more than 40% to pay for housing. Some of the factors that contribute to their increasing vulnerability in the housing market are: low income; rising unemployment; limited access to benefits; inaccessible mortgage financing; an inaccessible rental market. It can be concluded that going to the streets is caused by various factors, whether unsuitable family background, as well as the personality characteristics of the individual, which contribute to this social decline. It can be an accumulation of several factors at the same time (Feantsa 2013; Skodova 2021).

Alternative to street life

Young homeless people like to say that they have chosen life on the streets voluntarily and that they enjoy such a life. The street is a place of freedom where they do not have to follow the rules, e.g. own parents. The impulse can be not finishing school, conflicts with a parent's new partner, or different ideas about their future. Young adults sometimes feel that the contradictions are too great and leave the family background. Street life can also be a manifestation of belonging to various subcultures such as punk or hip hop. Such a life then represents a rebellion against the system. They do not want to identify with the role of the homeless so consider it their choice. They may be referred to as "street children" or "squatters" (Marek, Strnad, Hotovcova 2012).

Life in squat is mainly associated with the punk and hard-core subculture. This form of housing is understood as a form of political protest, a meeting place for activists or members of the counterculture(Piotrowski 2011). It can be an attempt to define an autonomous space in which individuals decide for themselves and also to define themselves against functioning in a capitalist society (Klinika 2021).

According to Reeve (2011) a squat is an abandoned building or land that individuals are occupying without the owner's consent. The buildings are usually in poor condition having no water, electricity or heating. Problematic roommates who pose a risk of theft and the like can also be uncomfortable. However, a squat still represents a roof over your head and a relatively stable place (Vagnerova, Csemy, Marek 2014). Some squats

function as communities where even small concerts, workshops and similar events are organized. Living on the streets, especially in squats, can also be a response to the lack of affordable housing for young people.

Young adults who want to become independent can also choose this way (Skodova 2021).

Of course, it is necessary to distinguish when life on the street in a squat is a personal choice and in the form of a certain protest and when it comes to necessity in response to home loss (Reeve 2011). However, young homeless people have to deal with the fact that they can be expelled from the squat at any time, as this is not a legal form of housing in our territory, Vagnerova, Csemy, Marek add (2014).

Social services

Social services, according to Act no. 108/2006 Coll., include social counseling, social care services and social prevention services. Homeless people are most affected by social prevention services. These help to prevent: the social exclusion of people at risk of social crisis; living habits; way of life leading to a conflict with society; a socially disadvantaged environment; the threat to their rights; legitimate interests of the crime of another natural person. The aim of social prevention services is to help people overcome their unfavorable social situation and to protect society from the emergence and spread of undesirable social phenomena (§54). Social prevention services for the homeless include: shelters; low-threshold day centers; dormitories; field programs; halfway houses; social rehabilitation services.

The main goal in social work with homeless people is their return to society, taking into account the specificities of this minority and maintaining an individual approach. These are the client's natural environment; his mentality; subjective causes of homelessness; public attitudes; impacts on the family and others (Pavelkova 2014).

The providing of social services for the homeless is handled by the state administration, self-government, as well as non-profit organizations and churches. As Pavelkova (2014) points out, the non-profit organizations are mainly the Salvation Army, Nadeje, Czech Catholic Charity, the New Space, Emauzy of the Czech Republic, Diakonie, Samaritan and several others, to a lesser extent.

Outreach and low-threshold social services

Outreach and low-threshold social services are most accessible to homeless people. These are services that they can usually use anonymously and where they are not bound by anything. Under outreach services, according to Act no. 108/2006 Coll., On social services, we mean services that are provided in the client's natural environment. This means that the social worker contacts the client on the street, in the squat, or in other places where the homeless person lives. It can also be a pre-arranged meeting at the place of residence if the person is still at risk of losing their home. Within the outreach social services, help is provided in the exercise of rights; corrective interests; procurement of personal affairs (§ 61, 2c). The advantage of outreach social services is that they have a chance to contact people who would otherwise be outside the system of such social services, for example, they would not visit a daily low-threshold center. Outreach services can also catch people who are unable to contact other social services through their health, such as disability and consequent inability to move (Act no.108/2006 Coll., On social services 2020).

Low-threshold social services for the homeless include day centers and dormitories. Day center, according to Act no.108/2006 Sb., On social services, contains the following basic activities: help with personal hygiene or providing of conditions for personal hygiene; providing of food or help in security of food; assistance in exercising rights; legitimate interests and procurement of personal affairs.

In the day center, clients can usually use a sanitary facility such as a shower, or have their clothes washed and dried. This option is becoming a great help for people who, despite living on the street, for example, are employed and can take care of their appearance. The providing of food is usually ensured thanks to food collections and food banks which further distribute food among specific social service organizations. Someday Centers have a dedicated kitchen for clients, where they can bring their own food and prepare meals. In addition to providing for basic needs, social counseling is important in the day center. Clients can find about their entitlement to

social contributions, pension or other financial benefits.

Help in processing documents and escorts to the office are often used (here there is a connection between the day center and outreach work). The day center also usually mediates contacts to offices, hostels, shelters or potential employers in the area. While staying at the center, clients must follow the internal rules of the facility, such as not drinking alcohol which some clients may have a problem with (Act no.108/2006 Coll., On social services 2020). Dormitories, according to Act no.108/2006 Coll., On social services provides help in personal hygiene or the secure of conditions for personal hygiene and the providing of overnight stays. Overnight stays are usually charged a small amount. Clients use the dormitory only at night leaving this facility during the day. The exception occurred during a state of emergency during the corona pandemic crisis, when clients were allowed to use the dormitory during the day, on the basis of a resolution of the Government of the Czech Republic on the providing and organization of the providing of social services for the duration of the emergency (Act. no.108/2006 Coll., On social services 2020).

Residential services

In the reintegration of homeless people, residential social services should provide a sufficient basis for independence, respectively the transition to a higher level facility (from the asylum home to the halfway house, to the social apartment, etc.), in cooperation with a social worker. An individual plan is usually created with the client and active cooperation is expected from him. The stay in the facility is limited by a certain period (usually around one year), after which the client should leave the facility. However, it often happens that clients remain at the same level of reintegration and do not move further after leaving the facility (Vagnerova, Csemy, Marek 2014). We can thus meet, for example, clients who have only repeatedly used their stay in an asylum for several years.

Halfway houses usually provide residential services for people under the age of 26 who, after reaching the age of majority, leave school facilities for institutional or protective education, possibly for persons from other child and youth care facilities, and for persons who are released from imprisonment or protective treatment. The way of providing social services in these facilities is adapted to the specific needs of these people.

According to §58, Act no.108/2006 Coll., the service includes activities such as the provisionof accommodation, mediation of contact with the social environment, social therapeutic activities and assistance in exercising rights, legitimate interests and procurement of personal affairs.

In asylum house, the level of living comfort is lower; clients share a room with several people.

In halfway houses, the level increases.Clients usually have a separate room. However, based on increasing the comfort of accommodation, the requirements for the client and his cooperation also increase (Vagnerova, Csemy, Marek 2014). Of course, homeless people often use commercial hostels as well.

Conclusion

This article provides information about homeless young people. Having a home, background and a stable roof over your head is one of the basic needs of a person. Its absence is a problem that affects all aspects of an individual's life and affects the area, both personal and professional, economic or health. In the Czech Republic, the issue of homeless young people is not given much attention. Based on this fact, we have tried to expand our knowledge about this phenomenon which has a growing tendency and represents a serious social problem. Only a detailed analysis of the problems of young homeless people can detect the extent and causes of the social decline of homeless young people. Only properly applied social work with this social subculture can stop or reduce the number of young people living on the streets and help with their successful reintegration back into the majority society.

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Urinary Incontinence as a Significant Health and Social Problem of Women

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Original Article

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Source: Clinical Social Work and Health Intervention *Volume: 13* *Issue: 1*
Pages: 55 – 62 *Cited references: 12*

Reviewers:
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Keywords:
Urinary Incontinence. Classification. Epidemiology. BMI.

Publisher:
International Society of Applied Preventive Medicine i-gap

CSWHI 2021; 13(1): 55 – 62; DOI: 10.22359/cswhi_13_1_07 © Clinical Social Work and Health Intervention

Abstract:

The issue of urinary incontinence is the most commonly discussedissue in the field of urology and urological nursing. It occurs all over the world. 45% of the population suffers from it. An average time from the onset of the first symptomsuntil the visit to the doctor's is 3 years.It occurs at any age, regardless of gender, still women suffer from it more often and the prevalence of affected female-patients increases with age. However, at present, as an exception that proves the rule, we are increasingly often encountering this problem in younger people. This disease affects every area of patients´ lives. Social, professional and private life are all being subordinated to this issue, which significantly affects the comfort and quality of life.

Urinary incontinence

Urinary incontinence is a very delicate problem, it is a "complaint of any involuntary loss of urine". Urinary incontinence is currently defined as involuntary leakage of urine. Urinary incontinence belongs to the group of lower urinary tract dysfunctions (1). As soon as some element of the entire urinary system does not work as it is supposed to, urinary incontinence can occur. The most commonly used classification according to ICS is:

- Urethral urinary incontinence: urge, stress, mixed, reflex, ischuriaparadoxa.
- Extra-urethral urinary incontinence: congenital, acquired (fistulas) (2).

Stress incontinence occurs in situations when, as a result of a certain happening or activity, the pressure in the abdominal cavity rises to such an extent that the bladder cannot resist. On the other hand, urge incontinence is manifested by an inability to stop urine leakage or by an overwhelmingneed to urinate. Some women have experience with mixed incontinence, when they experience symptoms of stress as well as of urgent nature, usually one of which is predominant. Another and less common type of urinary incontinence is overflow incontinence, in which the bladder does not empty completely and urine leaks spontaneously while the bladder is being gradually filled. There are also other types of incontinence, but they are rare and occur as a result of a certain abnormality of the excretory system (3). All of these types of urinary incontinence are characterized according to symptom, cause, and evidence. For most patients, urinary incontinence is one of the last taboos of medicine. An untreated form of urinary incontinence turns into a chronic form and thus causes patients not only health problems, but also serious mental and social problems (4).

Epidemiology of urinary incontinence in Slovakia and abroad

The age of the population is increasing and, along with this gratifying development, the incidence of some diseases and conditions -urinary incontinence including - is increasing. In its annual report from the 7th Global Incontinence Forum, GFI Forum 2018 reported the percentage distribution of the incontinence-affected population on each continent.The largest number of affected population is in Europe with 9.9%, followed by North America 9%, Asia 8.4%, South America 8.2% and Africa 7.2%. Urinary incontinence affects men and women of all ages, but most often the elderly. 25% of people over the age of 60 and 55.6% of people aged 80 and over suffer from this disease.A 2012 survey conducted by the Incoforum in collaboration with Dicio Agency pointed out that incontinence affects a large population, not just the patients themselves. As many as 89% of respondents were familiar with the concept of incontinence. However, only 2/3 of the population actually perceivedinformation about this problem. Surprisingly, up to 15% of those who suffer from this condition do not seek help at all.Prof.Svihra, a leading expert in the field of urology, says that: incontinence significantly reduces the quality of life; brings feelings of shame; inferiority; frustration; can even lead to depression (5). According to the analysis of INFOSTAT from 2018, it is assumed that Slovakia is going to be one of the fastest aging countries in the European Union. The Demographic Research Institute states that by 2040, 540,000 men and 680,000 women over the age of 70 will live in Slovakia, and thus the number of incontinent people will increase to 900,000 (6).This will result in a high increase in health and social care costs. According to epidemiological estimates, there are 160,000 women living in Slovakia with moderate to severe urinary incontinence. The overall prevalence of urinary incontinence in the Slovak Republic is 25% which indicates that the estimated number is about 530,000 women: 220,000 women do not use any incontinence aids; 180,000 women use at least one pad or diaper a day. At the estimated consumption, about 60 million pieces of pads or diapers per year should be used in Slovakia. Urinary incontinence is caused or exacerbated by age, parity and obesity.Prevention of urinary incontinence is also an important task.Prevention is a method of protection that minimizes risks in the first stages of danger or threat (7).

Research objectives

- Finding out the degree of incontinence that most often affects women
- To verify what factors affect the presence and degree of urinary incontinence in women.

Methods of data analysis

Our research sample consisted of deliberately selected respondents. In the descriptive part of the research, we used the tools of descriptive statistics. We processed the obtained data using the Microsoft Office 2017 spreadsheet.All the women had the opportunity to participate, whether it was nurses, auxiliary medical staffand, of course, patients. We tested the hypotheses with inductive statistics tools. In the hypotheses, with correlation coefficient,we verified the degree of stress, urge as well as of the overflow incontinence in relation to the age and weight of the respondents. We made a decision on the significance of differences based on the calculated p-value and the significance level of 0.05.

Demographic data

82 women took part in the research. Their age distribution is shown in Table 1 Age of the respondents. The youngest respondent was 19 years old, the oldest 70 years old. The average age of the respondents was 40.37 years. The most numerous age group consisted of respondents in the age category of 41 to 50 years, with 26 (31.7%) women. The least represented group wasthe age category of 60 and over, with 4 women, they accounted for 4.9% of the sample.

Table 1 Age of the respondents

Age of the respondents	number	%
Up to 30 years	20	24.4%
31 -40 years	23	28%
41 -50 years	26	31.7%
51 -60 years	9	11%
60 years and over	4	4.9%
Total	82	100%
Average	40.37	

In the questionnaire, we determined the height and weight of the respondents and based on these data, we calculated the BMI index and then evaluated it according to the BMI classification. We found that withBMI below 18.5, 7.4% of therespondents hadweightlower than normal.40.7% of the respondents had normal weight, i.e.their BMI was in the range of 18.5 to 24.9. 32.1% of the participating women were overweight (BMI from 25 to 29.9). Based on BMI values, 13.6% of the respondents hadclass 1 obesity; 2.5% had class 2 obesity; 3.7% had class 3 obesity.

Table 2 Weight evaluation

Weight evaluation		Number	%
Underweight	BMI <18,5	6	7.4%
Normal weight	BMI 18,5-24,9	33	40.7%
Overweight	BMI 25,0–29,9	26	32.1%
Class 1 obesity	BMI 30,0–34,9	11	13.6%
Class 2 obesity	BMI 35,0-39,9	2	2.5%
Class 3 obesity	BMI >=40,0	3	3.7%
Total		81	100%

Incontinence rate in women

The degree of incontinence is assessed mainly according to subjective symptoms - urine leakage in normal life situations. Therefore, we determined the presence of urine leakage as well as its amount during various activities. Based on the answers, we divided the respondents into 4 groups.The first group consisted of women who do not suffer from stress incontinence, the other groups included women with the corresponding degree of stress incontinence. 20.7% of the respondents had no problems with urine leakage. According to our findings, 31.7% of the participating women had occasional problems, especially when coughing, sneezing ordoingsimilar physical activities. Stage 2 stress incontinence affects 35.4% of the respondents and stage 3 affects 12.2% of the respondents.

Table 3 Degree of stress incontinence

Degree of stress incontinence	Number	%
None	17	20,7%
Stage 1	26	31,7%
Stage 2	29	35,4%
Stage 3	10	12,2%
Total	82	100,0%

Another type of incontinence is urine leakage when the bladder is full, also called an overflow incontinence. 34.1% of the participating women do not have this problem at all. Exactly half of the respondents rarely experience this problem. At the same time, 40.2% of those women stated that in such situations they would only leak a few drops and 9.8% would leak a medium amount of urine.With a full bladder, 12.2% of the participating women leak urinemore often. Out of them, 3.7% state that it is only a drop, in 6.1% the amount is medium and in 2.4% the amount is more than 30 ml. The other 3.7% of the women always have a problem with overflow with a full bladder. 1.2% of them leak a medium amount and 2.4% leak a lot of urine - over 30 ml.

Table 4 Full bladder urine leakage

Frequency/ amount	none	very little- drops	medium – up to 30 ml	a lot – over 30 ml	total
Never	34.1%				34.1%
Rarely		40.2%	9.8%		50%
More often		3.7%	6.1%	2.4%	12.2%
Always			1.2%	2.4%	3.7%
Total	34.1%	4.9%	17.1%	4.9%	100%

Another type of incontinence is urge incontinence. In the questionnaire, we asked the respondents how often they felt a sudden and intense urge to urinate, which is a typical symptom of urge incontinence. Approximately a quarter of the respondents (25.6%) said it did not happen to them at all. Almost half of the respondents (48.8%) admitted that it happened to them rarely. More often experience it 18.3% of the participating women and very often 7.3% of the respondents.

Table 5 Urge incontinence

Sudden and intense urge to urinate	Number	%
Never	21	25.6%
Rarely	40	48.8%
More often	15	18.3%
Very often	6	7.3%
Total	82	100%

Hypothesis verification

After the descriptive part, we will focus on verifying the hypotheses using inductive statistics tools.

Hypothesis 1: *We assume that there is a statistically significant association between women's age and urinary incontinence*.

Consideringrelevantitems,we determined the degree of stress, urge and overflow incontinence. To verify the first hypothesis, we calculated and verified the correlation coefficient between age and the type of incontinence. The results are shown in Table 6.

Table 6 Correlation between age and incontinence

Correlations			
Age			
Spearman'srho	Stress incontinence	Correlation Coefficient	.222
		Sig.(2-tailed)	.045
		N	82
	Overflow incontinence	Correlation Coefficient	.185
		Sig.(2-tailed)	.096
		N	82
	Urge Incontinence	Correlation Coefficient	.018
		Sig.(2-tailed)	.876
		N	82

The correlation coefficient between age and *stress incontinence* is 0.222. This positive value expresses a direct, but only slight dependence of the variables. Thus, it can be said that the degree

of stress incontinence increases with agevery slightly. However, the p-value of 0.045 is below the significance level. Therefore, we evaluate this dependence as statistically significant. In the second type - *the overflow incontinence* - the correlation coefficient is slightly lower. It reaches a value of 0.185. There is a slight direct relationship between age and this type of incontinence. However, the p-value of 0.096 is above the significance level. Therefore, this dependence has not been confirmed, it is not statistically significant. For the *urge incontinence*, the correlation coefficient is 0.018. This value is very close to zero, so there is no dependence between the variables. The p-value of 0.876 is much higher than all the common levels of significance. *Hypothesis 1 was confirmed in stress incontinence. There is a direct link between age and stress incontinence. Older women generally have higher rate of stress incontinence.*

Hypothesis2: *We assume that there is a statistically significant association between overweight and incontinence in women.*

In this hypothesis, we verified the degree of stress, urge and overflow incontinence in relation to possible overweight in women. We evaluated overweight, obesity or normal healthy weight using BMI. The calculated correlation coefficients and the corresponding p-values are displayed inTable 7.

Table 7 Correlation between overweight and incontinence

Correlations			
Age			
Spearman'srho	Stress incontinence	Correlation Coefficient	.336
		Sig.(2-tailed)	.006
		N	82
	Overflow incontinence	Correlation Coefficient	.274
		Sig.(2-tailed)	.013
		N	81
	Urge Incontinence	Correlation Coefficient	.142
		Sig.(2-tailed)	.206
		N	81

The correlation coefficient between BMI and *stress incontinence* is 0.336. This value is in the interval of the middle direct connection of the variables. It is therefore true that the degree of overweight or obesity slightly increases the likelihood of incontinence in women. The corresponding p-value of 0.006 confirms the statistical significance of this correlation. In the second type of incontinence, *the overflow incontinence*, the correlation coefficient is slightly lower. It reaches the value of 0.274.This value also indicates a slight direct relationship. The p-value of 0.013 is also below the significance level of 0.05. Thus, again, the interrelationship is statistically significant. For *theurge incontinence*, the correlation coefficient is 0.142. This positive value again means a direct connection. However, the corresponding p-value of 0.206 indicates that this is only a trivial, insignificant relationship.There is a slight direct relationship between age and this type of incontinence. However, the p-value of 0.096 is above the level of significance. Therefore, this dependence has not been confirmed, it is not statistically significant.

Hypothesis 2 has been confirmed for stress incontinence and overflow incontinence. The relationship withoverweight is direct. Generally, obese and overweight women suffer more often from stress incontinence and overflow incontinence than other women.

Discussion

Urinary incontinence is not only a health problem, but also a serious psychological and social problem causing various limitations in professional and social life, and it also has an impact on the financial and sexual areas of one´s life. The World Health Organization (WHO) estimates that approximately 5-8% of the population in all countries of the world suffer from urinary incontinence.As thisissue presents a global, societal, hygienic, and economic problem, we investigated the factors that affect urinary incontinence in women. 82 women took part in the research. Their age distribution was as follows: the youngest respondent was 19 and the oldest was 70 years old. The average age of the respondents was 40.37 years.The most numerous age group consisted of respondents in the age category from 41 to 50 years, in this age category there were 26 (31.7%) women. The least represented was the

age categoryof 60 and over, with only 4 women that accounted for 4.9% of the sample. Considering that we have linked overweight / obesity to urinary incontinence, we were also interested in this anthropometric data.Based on height and weight, we calculated the BMI index of the respondents: We then evaluated this index according to the BMI classification. The results showed that 7.4% of the participating women hadweight under the normal weight with BMI below 18.5. 40.7% of the respondents had normal weight, i.e. BMI in the range from 18.5 to 24.9. 32.1% of the women were overweight (BMI from 25 to 29.9).According to BMI, 13.6% of the respondents had class 1 obesity; 2.5% had class 2; 3.7% had class 3 obesity.

In our research, we determined the degree of stress, urge and overflow incontinence. Our results show that, *stress incontinence* affects 79.3% of the respondents. The author Marencak also states that about 20% of women around the age of 45 suffered from stress incontinence. The incidence of this condition is increasing in older age groups. Urinary incontinence affects a significant percentage of women aged 20–80, while on average 25–27.6% of Slovak women suffer from urinary incontinence (8).

Another type of incontinence is urinary incontinence when the bladder is full, a so-called overflow incontinence.Exactly half of the respondentsexperience this only rarely. At the same time, 40.2% of those women stated that in such situations they would only leak a few drops and 9.8% would leak a medium amount of urine. With a full bladder, 12.2% of the respondents leak urine more often. 3.7% of them state that in these situations it was only a drop, in 6.1% the amount was medium and in 2.4% the amount was more than 30 ml.The other 3.7% of the women always have a problem with overflow with a full bladder. 1.2% of them leak a medium amount and 2.4% leak a lot of urine - over 30 ml.

Another type of incontinence is *urge incontinence*. In the questionnaire, we asked the respondents how often they felt a sudden and intense urge to urinate, which is a typical symptom of urge incontinence. Almost half of the respondents (48.8%) admitted that it happened to them rarely. More often experienced it 18.3% of the participating women and very often 7.3% of the respondents.Burgio*et al*. published an epidemiological research paper on the incidence of urge incontinence. The research was carried out in 1972. It monitored the incidence of urinary incontinence in geriatric patients. An estimated prevalence in 15 - year - old women is 5%; in 60 year old women it is 72%.

The first study on the prevalence of urinary incontinence in women in Central Europe was conducted in Austria.The prevalence reached 26.3%,with an estimated number of 850,000 incontinent women out of a total of 3.2 million women over the age of 18 (8).

From the point of view of social work, it is desirable to provide specialist counseling to people with incontinence and to show them directlyto a financial contribution for increased hygiene-related expenses compensation (10).We tested the hypotheses, the degree of stress, urge and overflow incontinence in relation to the age and weight of the respondents using a correlation coefficient. There is a positive value between the age of the respondents and *stress incontinence*, which expresses a direct, but only slight dependence of the variables. Thus, it can be said that the degree of stress incontinence increases with agevery slightly.However, the p-value of 0.045 is below the significance level of 0,05. Therefore, we evaluate this dependence as statistically significant.

In the second type - *the overflow incontinence* - the correlation coefficient is slightly lower. It reaches a value of 0.185. There is a slight direct relationship between age and the second type of incontinence– *the overflow incontinence*,however, the p-value of 0.096 is above the significance level. Therefore, this dependence has not been confirmed, it is not statistically significant. For the *urge incontinence*, the correlation coefficient is 0.018. This value is very close to zero, so there is no dependence between the variables. The p-value of 0.876 is much higher than all the common levels of significance.

Hypothesis 1 was confirmed in stress incontinence. There is a direct link between age and stress incontinence. Older women generally have higher rate of stress incontinence.The prevalence of stress incontinence in women has been a subject of several studies in Europe. In France, the prevalence of stress incontinence is between 17% -28%; in Italy 4.6% -16.6%; in Spain 13.5% - 17.8%; in England it ranges from 24.5% -27.5%.

The prevalence of stress incontinence is very low in men: for example, 0.2% in Italy; 0.7% in Spain (10).

In the upcoming years,it is estimated that the number of incontinent patients in Europe will increase from 54 to 57 million. Similar development is expected for overactive bladder (OAB). In the future,anincrease in aging population by25%is expected and therefore the number of incontinent female-patients will increase, too (11). The correlation coefficient between BMI and *stress incontinence* is 0.336.This value is in the interval of the middle direct connection of the variables. It is therefore true that the degree of overweight or obesity slightly increases the likelihood of incontinence in women. The corresponding p-value of 0.006 confirms the statistical significance of this correlation. In the second type of incontinence, *the overflow incontinence*, the correlation coefficient is slightly lower. It reaches the value of 0.274.This value also indicates a slight direct relationship. The p-value of 0.013 is also below the significance level of 0.05. Thus, again, the interrelationship is statistically significant. For *urge incontinence*, the correlation coefficient is 0.142. Again,this positive value means a direct connection. However, the corresponding p-value of 0.206 indicates that this is only a trivial, insignificant relationship.There is a slight direct relationship between age and this type of incontinence. However, the p-value of 0.096 is above the level of significance. Therefore, this dependence has not been confirmed, it is not statistically significant.

Hypothesis 2 has been confirmed for stress incontinence and overflow incontinence. Generally,obese and overweight women suffer more often from stress incontinence and overflow incontinence than other women.

Due to those facts, it is necessary to:

- offer women suffering from urinary incontinence an opportunity to obtain information (leaflets, brochures, literature, contact information of experts in the field of urology, psychology),
- recommend appropriate incontinence products according to the type of urinary incontinence, given that different devices are needed for each type of incontinence.

It is necessary to give them the opportunity to try them and to provide advice on disposable absorbent incontinence products (incontinence pads, pants, diapers, mats),

- recommend weight loss to obese patients based on their general condition, as obesity has been proved to increase the risk of urinary incontinence;
- organize effective training for nurses who come into contact with an incontinent patient - in genecology , urology, general practitioners' outpatient clinics, etc.,
- organize conferences and professional events, ensure active professional participation in congresses,
- promote publicationsin professional and lay literature and magazines.

Conclusion

Urinary incontinence is a widespread and expensive health problem. It is associated with a significant burden on a woman. It causes problems tothe women at all levels of their lives. Urinary incontinence puts a certain burden on the whole society, not only on the affected woman. The medical care for such women entails high economic costs for medications and compensatory aids. These costs are covered by public health insurance. The care also includes the costs of rehabilitation treatment. This treatment can be very beneficial in the first stage of urinary incontinence and it is not too financially limiting. Nowadays, we have more options for the treatment of incontinence, but first and foremost it is important that the woman is being treated. In Slovakia there is also a civic patient association called *InkoFórum*. It is a voluntary, independent patient organization focused on helping people suffering from incontinence (7).The association is the only patient platform in Slovakia that is being invited to join the working groups at the Ministry of Health. Thanks to this membership, we can actively shape the health policy in Slovakia. We have become a member of WFIP - the World Federation of Incontinent Patients. From this federation we receive interesting suggestions that help improve lives of patients with urinary incontinence.

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The Nature of the Misinformation before and during Covid 19 (case study of Slovakia)

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Source: Clinical Social Work and Health Intervention *Volume: 13* *Issue: 1*
Pages: 63 – 76 *Cited references: 76*

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Keywords:

Misinformation. Social Media. Society. Youth Generation. Conspiracy Websites.

Publisher:

International Society of Applied Preventive Medicine i-gap

CSWHI 2021; 13(1): 63 – 76; DOI: 10.22359/cswhi_13_1_08 © Clinical Social Work and Health Intervention

Abstract:

This article presents an outline of theoretical background followed by a presentation of our own research which aims to identify the most common misinformation in the period before the pandemic and in the period of the so-called first and second wave of Covid 19 in Slovakia. The research method was a qualitative content analysis of the most read conspiracy web portals in the period before the pandemic, and separately also during the pandemic. The result of the research is the identification of key topics that determined the character of the most watched conspiracy media in Slovakia in the two monitored periods. The article points to a negative phenomenon which, in our opinion, is "lost" in heated discussions about fears of the presence of misinformation in public space. It is a fact that during Covid 19, the time spent in the Internet environment increased radically, especially in the group of today's young peo-

ple. The study expresses concern that extending the time of young people on the Internet has exacerbated new forms of pitfalls that can make a significant contribution to making the younger group an even more vulnerable group as a result of the increase in online misinformation.

Introduction

Although misinformation is almost as old as humanity itself, the huge potential of fake news on the Internet, where millions of web users can create and, above all, share messages of a diverse nature, is only appreciated and seen in recent years. This is related to the increase in false information (Bakir, McStay, 2018; Bradshaw, Howard, 2018; Levy, 2017; Fitzpatrick, 2018), which became more and more shared and credible (Vosoughi *et al*., 2018) and thus contributed to the manipulative nature of the Internet, new media and especially social networks (Infosecurity.sk, 2020; Mitro, 2020; Biznar, 2021; Baum *et al*., 2020).

For almost two years now, communication and content evaluation in relation to health information has become a major challenge worldwide. The highlight of this challenge is health misinformation, defined in general, as any health-related claim of fact that is false due to a lack of scientific evidence (Wang, *et al*., 2019; Scherer, *et al*., 2021). Moreover, in parallel with the Covid 19 pandemic, an information pandemic is infiltrating social media. Thus, while true information helps to mitigate the pandemic-led crisis, false information may intensify it. Cambridge Dictionary introduces the term "infodemic" (i.e., information pandemic) as a situation, in which a lot of false information is being spread in a way that is harmful (Cambridge Dictionary, 2020). According to World Health Organization, infodemic represents a combination of terms "information" and "epidemic", and refers to a wild and widespread dissemination of both accurate and inaccurate information about an epidemic Covid 19 (World Health Organization, 2020a). Thus, infodemic means the very hard effort to find trustworthy sources as well as reliable a responsible guidance during corona crisis. In World Health Organization's situation report is stated that term "infodemic" was coined to make categorization of some common features of rumors, stigma, fake news and conspiracy theories during public health emergencies which is related to the increasing number of conspiracy websites, conspiracy contents and its impact on public health worldwide (World Health Organization, 2020b).

The phenomenon of an ever-increasing number of misinformation (and especially misinformation about health) in the public online as well as offline space can be perceived as particularly dangerous in vulnerable groups, especially seniors, children and adolescents (European Commision, 2021; Unicef, 2020; Martellozzo, 2021; Ngamije, 2021; Crabbe, Flood, 2021; Stoilova, 2021; Ngamije, 2021). The latter is the subject of our interest in this study.

Although the hallmark developmental changes of adolescence can begin before age 10 and persist after age 19 (in some literature to age 25) (Graham, Kahn, 2020), adolescent is defined in this article as a young person ages 15-19 years old, i.e., a person whose current status is high school student.Adolescents are the subject of our interest in our own research because youth's time on the Internet has increased most during Covid 19 (Warc, 2020). The aim of our own research is to identify the most common misinformation in the period before the pandemic and during the pandemic in connection with SARS-CoV-2 in Slovakia. The research of misinformation in two separate time intervals is more closely focused on the most common fake news and hoaxes in the area of the most read conspiracy media and represents a pilot study, including its own methodology, created on an ad hoc basis.

Covid 19 and related research about the nature of the misinformation

Since misinformation is a powerful entity in society and co-creators of social culture at the time of the Covid 19 pandemic, in addition to the visible misinformation-conspiracy war in which they participate in the media space (i.e., so called infodemic), they also have a demonstrable impact on ordinary people. The influence of misinformation on a person, his character or health is not doubted by experts. According to the BBC, misinformation greatly affects human health because

it "undermines public health reports." The nature of the misinformation in relation to Covid 19 also affects the mental health of the individual and society as a whole (BBC, 2020; Al-Zaman, 2021; Coleman, 2020; CBC News, 2021). The nature of the misinformation in relation to Covid 19 also affects the mental health of the individual and the whole society (Fraser *et al*., 1999; Rajkumar, 2020; Xiao, Torok, 2020). Chou *et al*. (2018) takes the view that misinformation about health on social networks can encourage people to use drugs and other toxic substances. Zandifar, Badrfam (2020) as well as Xiang *et al*. (2019) talk about an increase in stress and mental illness, especially depression. Jusko (2021) considering about the increasing of loneliness and Rajkumar (2020) as well as Xiao, Torok (2020) suggest a clear link between misinformation and anxiety. Budayova, Cintulova (2021), Rasskazova *et al*. (2020) or Tkacova *et al*. (2021) are researching the impact of current pandemic on the mental health and well-being, and Radi *et al*. (2021) think even further, talking about the late psychosocial consequences of pandemics.

Other experts point out that the fear caused by misinformation also affects consumer behavior (e. g., the purchase of personal protective equipment is increasing (Addo, *et al*., 2020; BBC, 2020); the purchase and use of over-the-counter medicines (Chan *et al*., 2021; Cuan-Baltazar *et al*., 2020), etc.). Experts therefore agree that misinformation in the media space can have a life-threatening effect. Let us add, finally, that false news and hoaxes also have an impact on the increase of racism, antisemitism, stigmatization of persons or groups, including of other forms of risky behavior (Ippolito *et al*., 2020; Smith *et al*., 2020), and thus also affect the character of the whole society. For the reasons just mentioned, the mass spread of conspiracy media raises relevant questions about their socializing and dissocializing impact on recipients.

The nature of the misinformation in the context of Slovakia

Over the past 5 years, the list of conspiracy websites in Slovakia has grown from an original 90 to an alarming 210, i.e., increased by 120 conspiracy sites which can be consider as negative or even an alarming phenomenon (Dennik N, 2017). Increased number of conspiracy sites and theirs contents might be also one of the main reasons why Covid 19, as it appears today in false reports and hoaxes, polarizes the Slovak public in relation to its government or in relation to science and scientific institutions and, as follows from the opinion of the Slovak Police, it represents a "dangerous tool that has the potential to negatively and fatally affect the lives of the population" (Ministry of the Interior of the Slovak Republic, 2020).

Another alarming finding is, that up to 56% of Slovaks believe in conspiracy theories, which is the most among the countries of Central and Eastern Europe, which, together with Slovakia, were part of recent representative research (Globsec, 2020). The conclusions of further research follow up on these findings and point out that Slovaks' credibility in relation with misinformation is closely related to shortcomings in education; Experts talk in particular about the lack of incentives that would encourage pupils and students to increase their critical thinking in education (O médiách.com, 2020). On the contrary, the fact that almost 70% of Slovaks, in addition to misinformation media, regularly watch serious news newspapers and web portals can be considered good news (Transparency International Slovakia, 2020). Thus, we can see that the inclination of the audience to conspiratorial information, on the other hand, is balanced by the efforts of the recipients to stick to a certain established recognized mainstream in society.

Finally, in the context of theoretical background and recent research findings, the paper continues with the presentation of the research part. Based on the back-gathering of fake news and hoaxes before the Covid 19 period and separately during the corona crisis, the aim of our own research is to identify the most common conspiracy topics (i.e., misinformation) and to provide several other observations and examples in connection with the findings.

Methods

Objective of research

Many similar features can be seen on fake news and hoaxes, such as their engaging processing; attractive headline; both represent a shocking message; contain an emotional request for help; have a strong graphic representation; etc. Despite

our relatively small differences, we will distinguish in the paper between fake news and hoaxes on the basis of their basic characteristics, i.e., fake news is intentionally misleading information intended to obtain an advantage for the originator (such as damage to the name of a person or financial gain from advertising), while hoaxes are intentionally false information (often very emotional to alarming) that inherently encourages further dissemination (such as vaccination hazard reports) (Radio Regina, 2021).

With the intention of talking about intentionally false information in relation to Covid 19 in the online environment (focusing on fake news and hoaxes), we present the research in two separate time intervals.

The aim of the research is:

1. Analysis of media content of conspiracy websites before so-called coronary crisis;
2. Analysis of media content of conspiracy websites during Covid 19.

The nature of research

The time frame of the first part of the research is the interval from June 1, 2019 to December 31, 2019, when the Chinese office of the World Health Organization was officially informed about the outbreak of the disease (Islam *et al*., 2020).The time frame of the second part of the research represents an equally long period, which was limited to 1 January 2021 - 30 July 2021. With the intention of meeting two research objectives, qualitative content analysis of texts published on selected conspiracy web portals is proving to be a suitable research method. The research file, examined through content analysis, represents a total of 80 texts. Design of the research represents a pilot study, including its own methodology created ad hoc. The research design is shown in Table 1.

Research sample

We will examine the nature of fake news and hoaxes separately in two research files: 1) On the most read conspiracy web portals before the corona crisis and 2) on the most read conspiracy web portals during the first and second waves of the corona crisis (Transparency International Slovakia, 2020). The list of investigated conspiracy sites is shown in Table 2.

Table 2 Description of the research file subjected to content analysis

Phase of the research	Name of the conspiracy medium	Number of examined texts
1st Phase	Slobodnyvysielac.sk	10
	Domacaliecba.sk	10
	Radynadzlato.sk	10
	Zem a Vek	10
2nd Phase	Hlavné správy	10
	Zem a Vek	10
	Slobodný vysielač	10
	Infovojna	10

The study consists of two research questions:

Q1: What are the most common topics of fake news and hoaxes on conspiracy sites before the pandemic?

Q2: What are the most common topics of fake news and hoaxes on conspiracy websites during a pandemic?

Data collection

We consider content analysis of 80 randomly selected texts from 8 researched conspiracy web pages as appropriate research technique to make inferences by interpreting and coding textual material. Although the coding is identifying several

Table 1 Design of the qualitative research

Research phase	Aim of the research	Time interval of the research
1st Phase	Content analysis of the most read conspiracy	(June 1, 2019 – December 31, 2019) web portals before the corona crisis
2nd Phase	Content analysis of the most read conspiracy	(January 1, 2021 – July 30, 2021) web portals during the corona crisis

important characteristics (e.g. the frequency, space, direction or intensity), we have chosen only research of the main message of content of researched texts (Clootrack, 2021) that maps the main intention in which the content appears (e. g., denying science, alleviating the situation, negativism, emphasizing emotions, etc.)

Data analysis

Within Q1, the coding took place in a total of eight categories. We noticed, what authors of conspiracy content say about world Jewry, about the Roma, about America, about supranational institutions such as the UN, NATO or the EU, how they assess the issue of migration, the consequences of the convention called the "Global Pact on Refugees", etc. Identification of the most discussed categories (i.e., fake news and hoaxes) among research texts before corona crisis are presented in the "results" section.

Similarly, within Q2, the coding took place in a total of 8 categories. We noticed what the authors of the conspiracy contents discussed during the pandemic. The identification of topics represents the following: presence of opinions and attitudes against vaccination; topics focusing on pro-Russian propaganda; negativism in relation to international institutions; emphasizing negative emotions in relation with current situation; promoting unapproved medicinal products; etc. The most discussed categories (i.e., topics of fake news and hoaxes) within the examined articles are presented in the "results" section.

Results

Based on the retrospective collection of reports before the Covid 19 period and separately during the corona crisis, it was possible to identify the most common topics processed by conspirators in the form of fake news or hoaxes.

Q1: The most common topics of fake news and hoaxes on conspiracy websites before the pandemic

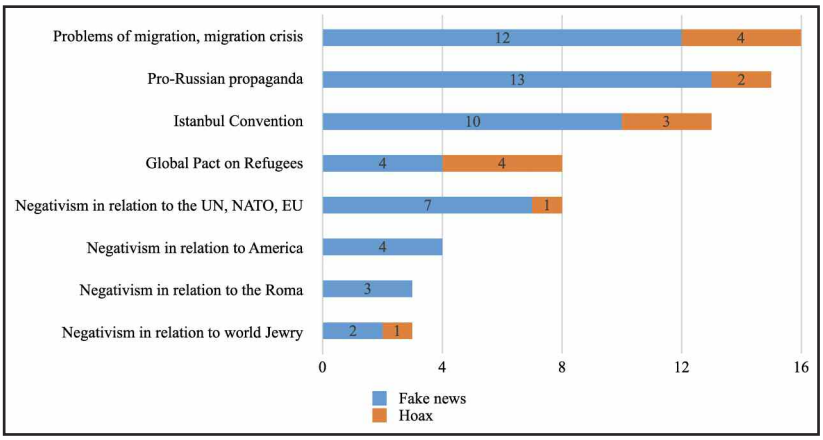
Our own research of 80 randomly selected misinformation texts before the period of the corona crisis, which we examined using content analysis on four of the most widely read conspiracy websites at the time, yielded several interesting findings. The eight most common topics processed by conspirators in the form of fake news or hoaxes in the selected period before the pandemic are presented in Graph 1.

As we can see in Graph 1, researched conspiracy media deal mainly with three topics:

(1) Migration - so-called the migration crisis is an international, primarily humanitarian and political crisis that has been taking place in Europe since 2014;

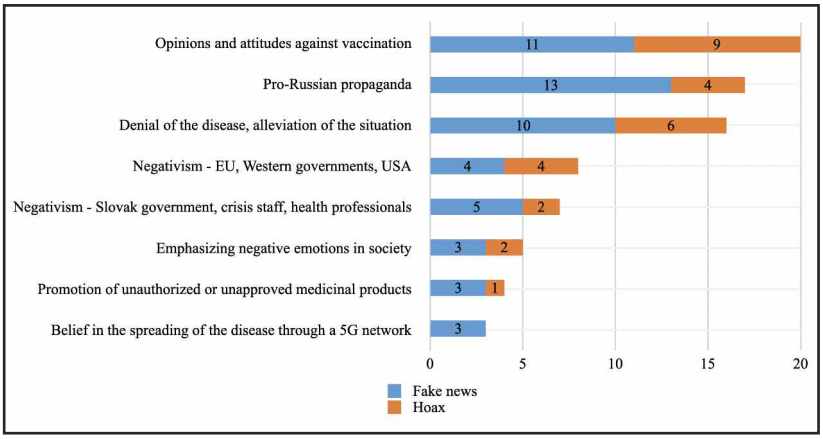
(2) Istanbul Convention - the basic goal of the so-called The Istanbul Convention makes a clear link between achieving gender equality and eliminating violence against women. Its brief goal is to create a Europe without violence against women and without domestic violence. The public discussion has been running since the second half of 2017;

(3) The Global Pact on Refugees - Slovakia, like Austria, Hungary, the Czech Republic or the USA, has rejected the so-called The UN Migration Pact and the so-called The Global Pact on Secure, Managed and Legal Migration, signed in December 2018 by representatives of more than 150 countries at a conference on migration in



Graph 1 The most common topics of fake news and hoaxes before the pandemic (selected time period)

Graph 2 The most common topics of fake news during a pandemic (selected time period)



Morocco. In both cases, it is a global agreement within the UN for international cooperation on migration (European Parlament, 2018).

In the period before the Covid 19 pandemic, other topics of conspiracy websites are negatively portrayed contributions about the UN, NATO, the EU, America, world Jewry or the Slovak Roma.Articles with the character of fake news or hoaxes in the period under review are also significantly related to pro-Russian propaganda. We recorded information about: the achievements of Russian science and technology (Russian armaments, Russian military equipment, discoveries of space); the spread of Pro-Putin propaganda (glorification of the President of the Russian Federation) or the designation of Ukraine as the aggressor who provoked and launched a military operation against the (pro-Russian) Luhansk and Donetsk Republics.

Q2: The most common topics in fake news and hoaxes on conspiracy websites during a pandemic

In the case of research into the nature of Fake news and hoaxes during the Covid 19 pandemic, we examined also a total of 80 texts using content analysis, which were published on the four most read conspiracy web portals. Graph 2 shows the 8 most common topics with the character of fake news or hoaxes in the observed period during a pandemic.

In connection with the pandemic, the content of conspiracy websites consists mainly of false reports presenting opinions and attitudes against vaccination. Thus, "mysterious Russian agency" is associated with anti-vaccination topics (Reynaud, 2021). In addition, creators of conspiracy contents to opinions against vaccination, attempt to legitimize concepts such as "Devil's plan" (i.e., vaccination), "chipping", "covid criminals", geopolitical "holy war", "data hell" (for example in connection with population morbidity data), etc. A large number of hoaxes are also associated with vaccination on the conspiracy sites studied. In the context of vaccination, these are hoaxes that aim to present the vaccine in various negative contexts, i.e., as a tool to blackmail people or watch people. In addition, hoaxes also evoke a kind of demonization of vaccination (e. g., fear of infection in the presence of vaccinated people; posters with the text "no entry of vaccines to protect pregnant women"; hoax about being attacked by bees, etc.).

The second most common category is "pro-Russian propaganda" in which conspirators create content with the intention of undermining Slovaks' confidence in "Western" vaccines. Among the frequent fake news in connection with pro-Russian propaganda during the pandemic we also include texts emphasizing the achievements of Russian scientists in the fight against Covid 19; indicating the US rivalry with the Russian Federation (e. g., in the form of a "victorious" conversation between a Russian journalist and the US Ambassador); etc. Pro-Russian narratives also existed in the form of hoaxes during the Covid 19 period; e. g., Russian video of fake corpses (in fact, it is behind the scenes footage of a Russian music video), which was used to amplify 'hoax' narrative on the pandemic.

Other categories of fake news include topics that completely deny the disease, or facilitate re-

ports of a pandemic and the number of victims, i.e., alleviated of the situation. Covid 19 hoaxes contain nonsense and misleading ideas about the virus or its treatment. Treatment for Covid 19 is interpreted in the form of various guaranteed recipes and prevention tips against infection.

During the period under review, there was also fake news about the pharmaceutical conspiracy or conspiracy of world governments (especially the governments of Western countries in the context of the EU and America). Similarly, hoaxes have repeatedly questioned the European Union and its assistance to member states in the fight against coronavirus. It can be stated that negativism in relation to the EU is a category that existed in the period before Covid 19 and persists among conspirators even during a pandemic.

Further, in our research we confirm fake news that are questioning the competencies and regulations of the Slovak government and questioning the work of health professionals.

There are claims on social networks whose authority among users grows on the basis of the statement "it is secret information from a friend from the crisis staff". Among the hoaxes, there are relatively frequent statements in this category that the state knows about many things in connection with the coronary crisis, but is silent from the citizens, and even conceals the information. In this context, hoaxes can be described for example through "secret" reports on preparations for the total isolation of Slovaks, hoaxes on the transport of the disease by train or the transmission of the virus by so called chemtrails.

A popular method of fake news creators during the pandemic is to emphasize negative emotions (misinformation associated with distrust, frustration) and false information that has the power to affect emotions (e. g., "Covid will end when you put the drape down"). Further, emotional hoaxes are often associated with Covid 19 to create fear. An example is the claim that Covid 19 is a biological weapon or hoax that coronavirus testing is a covert method of introducing infection into the human brain and the like. Let us add that in this context, theories about a hidden "enemy": appearing in various contexts; destroying our society; killing people through a pandemic; frequent personalities depicted in hoaxes are G. Soros (world domination through Covid 19); or B. Gates (vaccine as a tool for chipping people).

Finally, it is possible to identify fake news in the Slovak media space, the aim of which is to promote unauthorized or unapproved medicinal products (e. g., ivermectin) or to spread the idea of the spread of the disease through a 5G network. Let us add that, compared to the period before corona crisis, the volume of false reports in relation to Jews and Judaism, Roma and migrants is declining. These topics can, as can be seen, be neglected at the expense of the main topic which is a pandemic, and sub-topics that are closely related to it (vaccination, anti-pandemic measures, specific kinds of negativism etc.).

Discussion

The aim of the research was the content analysis of 80 texts, which took place in two separate groups. The first research group consisted of the most read conspiracy media in the period before the pandemic and the second group consist of the most read conspiracy media during the pandemic (Transparency International Slovakia, 2020). The result of our own research is the identification of topics that determined the character of the most watched conspiracy media in Slovakia in the two monitored periods.

Perhaps the most surprising finding is the marked change in conspiracy themes that dominated the pre-pandemic and pandemic periods. While, for example, the issue of migration was one of the dominant conspiracy links before the Corona crisis, it is marginalized during a pandemic. During a pandemic, however, the activity of conspirators grows, for example, in connection with topics aimed at negative evaluation of the work of health professionals.

We also consider to be interesting the relatively constant volume of topics we have confirmed in connection with pro-Russian propaganda. This topic is one of the key topics of conspiracy websites in both monitored periods, i.e., conspiracies in favor of Russia have maintained their status quo for a long time, as the volume of these reports is virtually the same before and during the corona. The same findings are repeatedly confirmed by experts (Euractiv, 2021; About media.com, 2021; Infosecurity.sk, 2021; Novotny, 2020). In addition, the effects of pro-Russian propaganda on the audience are also

confirmed by research by the Slovak non-profit organization GLOBSEC. In April this year, it was found that Slovaks perceive Russia as a strategic partner (and a victim of Western states) rather than a threat for Slovakia or other states in Europe (Standard editorial, 2021).

According to us, the findings of our research point to a new phenomenon which we believe is "losing" in heated discussions about fears of the presence of misinformation in public space. First of all, it is necessary to realize that during Covid 19, the time spent in the Internet environment increased radically, especially in the group of today's young people. However, while Generation Z used media and social media on a daily basis for education, communication or leisure activities, it was also exposed to the risk of conspiratorial websites and their contents. Based on our research findings, we see that respondents from the media are in principle affected by completely new content (with the exception of 2 themes that persist, i.e., pro-Russian narratives and, to a lesser extent, criticism of the EU). The problem is that the Slovak school system does not reflect the new conspiracy contents, or reflects them only a little (Dennik N, 2017; Kacinova, 2018; Globsec, 2020; O médiách.com, 2020; Trend.sk, 2020; TASR, 2021).

According to Kacinova (2018), the issue of education in Slovakia, aimed at developing the ability of pupils and students to detect misinformation in the content of school education, is still insufficient. The topic of misinformation and conspiracy media is not even explicitly mentioned in any thematic unit of the teaching of focal subjects in Slovak schools and it can be implicitly seen only marginally, as part of other topics in compulsory education. In addition, the author points out that building media literacy is partly trained for students of Slovak schools only in the context of print media, i.e., new media and social media are on the fringes of educational topics in both explicit and implicit levels. For this reason, too, we consider topics related to misinformation as compulsory educational topics that need to be incorporated into current educational curricula and standards. The topicality of the situation is confirmed by our research, which points not only to the presence of diverse conspiracy content in the pre-pandemic period (we identified 8 most common topics), but also new conspiracy content (we identified 8 most common topics) and their growing number, which can be seen on Slovakia (Urad verejneho zdravotnictva Slovenskej republiky, 2021; Startit Up, 2020; HN Slovensko, 2020; Trend.sk, 2020; TASR, 2021; Kacmar, 2021), worldwide (Nyilasy, 2019; Tsfati *et al.,* 2020; Benkler *et al.,* 2018; Fletcher *et al.,* 2018; Jang *et al.,* 2019).

Finally, we consider the reliability of researched data as an important part of the research process. To know if the data is reliable, we checked the validity and reliability of researched data and tested of the codes that have been designed during our research. Clear presentation of research findings after completing the content analysis in an article format that can be understood by the recipients was final goal of present study.

Conclusion

This article introduced the issue of the existence and increase of misinformation (with a closer focus on fake news and hoaxes) in the space of social media, that expanded and enriched existing links between people on the one hand, and become an essential communication tool for creating and disseminating fake news, misinformation, disinformation, hoaxes and propaganda on the other side.

Based on the retrospective collection of reports before the Covid 19 period and separately during the corona crisis, it was possible to identify the most common topics processed by conspirators in the form of fake news or hoaxes and to provide several other observations and examples. The research method was qualitative content analysis.

In relation with our research findings, we see that young respondents in our research sample are affected not only by older (and partly analyzed and explained) but also completely new conspiracy contents. In connection with these findings, we formulate several challenges, which in our opinion call for acute solutions:

(1) The advent of social media platforms in 1997 has radically changed the way how people consume daily information and form their opinions. The current challenge is the issue of media literacy (e. g., low media literacy, insufficient critical thinking, the presence of cognitive prejudices, etc.) in terms of the abil-

ity of pupils and students to detect misinformation (and other kinds of false information) in Slovakia. Slovak experts also talk about the lack of skills within media literacy (Globsec, 2020; O médiách.com, 2020; Dennik N, 2017; Trend.sk, 2020; TASR, 2021).

(2) Education focusing on the ability of pupils and students to detect misinformation in Slovakia is a relatively new topic in schools and, according to Kacinova (2018), it is moreover not yet anchored in the content of school education. The challenge is to include topics related to past and present misinformation, conspiracy media and the fight against misinformation in the educational content of compulsory subjects as soon as possible.

(3) Insufficient understanding of the educational potential of digital technologies which could be a helpful solution to the ongoing infodemic also seems problematic, i.e., a visible misinformation-conspiracy war in society and in the media. A suitable solution may be, for example, the use of mobile applications with an educational character that would support the development of critical thinking of young people. In short, the current challenge is to find effective and attractive ways how to build the immunization of the young individual from the negative effects of misinformation.

(4) Negatively can also be seen as a lack of regulation of social media content, despite the efforts of large social networks and companies (Google, Amazon, Apple, IBM, Microsoft, and so on), which coordinated various unethical efforts related to Covid 19, including the fight against misinformation (Overly, 2020). Their positive initiatives, such as eliminating misinformation about Covid 19 on Instagram, strengthening the position of scientific institutions through online data tools, or supporting global health organizations through free online advertising (Jin, 2020; Shu, Shu, Shieber, 2020) are respectable only if they stimulate further action to combat online lies within the online world. The problem is, that social media platforms only partially respond to suggestions from fact-controllers (Brennen *et al*., 2020).The current challenge is to find effective societal tools to strengthen the protection of recipients.

(5) The Internet environment seems impersonal to many people giving the impression that it is not real and that practically everything can be used in it. This leads users to the idea that everything is allowed in the online space and that they do not have to be held responsible for their behavior or opinions (unfortunately, in a sense, due to the lack of Internet regulation which we talk about above). The challenge is to lead young people to personal responsibility, i.e., to find ways how to build responsibility of the young and active "creators" of new online contents.

(6) The Covid 19 pandemic has come to dominate the media, both domestically and abroad. Alongside increased attention on the pandemic, has come the viral spread of fake news (in relation with pandemic) online. For almost 2 years now, communication and content evaluation in relation to health information has become a major challenge worldwide. The culmination of this challenge is misinformation about health; we mean the consequences that misinformation about health have in society and in individual decisions of individuals (the findings of relevant research about consequences of misinformation into individual we pointed out in the theoretical part of this paper). Similar concerns are expressed by experts. They are convinced that if a person receives news from social media, they are more likely to believe in misinformation about coronavirus conspiracies, risk factors and preventive treatment (Baum *et al*., 2020). In this situation, we believe that governments have a key role to play here in providing detailed, clear and transparent official information that crowds out false reports. In our opinion, available and reliable official information is crucial to curbing false and, to varying degrees, harmful information.

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Stigmatization by Nurses towards Mentally Ill People

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Original Article

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Source: Clinical Social Work and Health Intervention *Volume: 13* *Issue: 1*
Pages: 77 – 84 *Cited references: 19*

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Keywords:

Stigma. Mental Illness. Nurse. Mental Health.

Publisher:

International Society of Applied Preventive Medicine i-gap

CSWHI 2021; 13(1): 77 – 84; DOI: 10.22359/cswhi_13_1_09 © Clinical Social Work and Health Intervention

Abstract:

Background: People with mental illness face two major problems at the same time. The first is the disease itself which they must learn to live with and to manage all its symptoms. The second, often more serious problem, is the presence of stereotypes and prejudices which are the result of insufficient knowledge about mental illnesses and their misunderstanding. The aim was to explore the current state of stigmatization by nurses towards mentally ill people.

Methods: In this quantitative exploratory research we used an existing questionnaire (the Opening Minds Scale for Health Care Providers) with randomly selected nurses who treat mentally ill patients.

Results:A significant difference in the degree of stigmatization with respect to the age of the nurses was not found. However,

in terms of the overall assessment, specifically in the domain of attitudes, the rate of stigmatization was higher among younger respondents. Nurses with shorter professional experience proved a lower degree of stigmatization than nurses with longer professional experience.

Conclusion: It is expected that the rate of mental illnesses will increase. Therefore, we recommend continuing to pay increased attention to destigmatization within the education of and developing more destigmatizing initiatives among nurses.

Introduction

Advances in neuroscience, technology, and sophisticated research have greatly improved the understanding of mental disorders, but there are psycho-social aspects that exacerbate the healing process and overall recovery. This set of factors includes prejudice anddiscrimination, which we refer to as stigma (Wahl, 2012). Stigma is most often defined as a mark of disgrace or infamy; a stain or reproach, as on one's reputation (Kučukalić, Kučukalić, 2017). Stigma can be a reason for refusing to seek help, for even up to 2/3rdof the total number of patients. Untreated mental illness makes a person likely to face long-term individual difficulties which contributes to the disability of the patients. As a result of these facts, mental illness is a burden on public health. Initiatives to reduce stigma are unsatisfactory, though we consider them key to finding the help needed in time (Kaushik *et al*., 2016). Mentally ill people still have trouble living a full life without prejudice, stigma or discrimination. There is evidence of a link between low levels of mental health literacy, negative attitudes towards people with mental illness and a reluctance on the part of the patient to seek help from people who believe that the patient may have a mental disorder (Thornicroft *et al*., 2007). Stigmatization impairs diagnosis, treatment and the results of treatment. Addressing stigma is the basis for providing quality health care and achieving optimal health. Future investments in reducing the degree of stigma should be aimed at mentally ill patients or mentally ill healthcare professionals at the individual level and structural level of stigma (Nyblade *et al*., 2019; Egbe *et al*., 2014).

It is necessary to fundamentally change the attitude of the professional and lay public in relation to mental illness. We will only achieve change by talking openly about mental illness and the problems associated with it. We will not make this topic taboo or trivialize it. Research shows that patients are also stigmatized by people from the ranks of healthcare professionals, including psychiatrists. In a study conducted by Kochański and Cechnicki, they found that psychiatrists, despite their education and professional mission, present similarly stigmatizing attitudes towards the mentally ill as the general population. Increasing the health literacy of professionals about mental illness is proving a necessity (Kochański, Cechnicki, 2017). Training in the right approach to the mentally ill and professional training can lead to less stigma among professionals about mental health care (Mötteli *et al*., 2019). 6 approaches to stigma reduction are described: education; protest; contact-based education; legislative reform; advocacy; stigma self-management (Arboleda-Flórez, Stuart, 2012). In addition to destigmatizing the attitudes of experts, the key challenge in this area is the personal attitude of the mentally ill person and individual destigmatizing self-assessment (Corrigan, Rao, 2012).

Through anti-stigma programs, psycho-education of patients and families about disorders and treatment options, we can give them: an active role in their treatment; restore their dignity, self-confidence and quality of life; reintegrate them into society (Bravo-Mehmedbašić, Kučukalić, 2017).

Materials and Methods

Design

This quantitative explorative research is mapping the level of stigmatization by nurses of mentally ill patients, and aiming to explore the differ-

ences of mentioned levels between selected categories of nurses.

Instrument

The main objective of our research is to map the current state of stigmatization by nurses towards mentally ill people and to observe how socio-demographic characteristics affect the degree of their stigmatization. In this work, we used an existing psychometrically tested questionnaire- the *Opening Minds Scale for Health Care Providers (OMS-HC)* (Kassam *et al*., 2012; Modgill *et al*., 2014). We addressed a larger number of respondents with a questionnaire in a short time. The individual items of the questionnaire are systematically arranged and clear, which is a positive for the respondents in terms of ease and time required to complete it. The questionnaire represents an easy and clear method of analysis and interpretation of the obtained data. OMS-HC was created to measure stigma in the population of health care providers. It takes the form of a self-report in which a person evaluates their attitudes and the intentions of their behavior towards people with mental illness. The questionnaire consists of a series of items. The respondent can choose one of the answers:

I strongly agree; I agree; I don't disagree either; I disagree; I strongly disagree. Each item is assigned a score from 1 to 5. A high score indicates that there is a more stigmatizing attitude. The full OMS-HC contains 20 items, the score of which can range from 20 (least stigmatizing attitude) to 100 (most stigmatizing attitude). More often, however, a 15-point questionnaire is used that has better results for reliability. With a 15-point questionnaire, the score can range from 15 (least stigmatizing attitude) to 75 (most stigmatizing attitude). The whole questionnaire is divided into 3 subscales. Items 9 ,10 ,11 ,12 ,13 ,15 require reverse coding in the analysis. The questionnaire is divided into 3 domains.

Sampling

Our respondents were nurses who most often treat and care for mentally ill patients within their professional work. Inclusion criteria were: nurses working on the department of psychiatry; the department of trauma surgery; the department of geriatrics and internal medicine; the department of anesthesiology and intensive care. Exclusion criteria were: nurses working in departments other than those mentioned above. We collected empirical data in the period from December 2018 to January 2019. The total number of randomly selected respondents was 89.

Statistical Analysis

We used relevant tests to test hypotheses, specifically Student's t-test and ANOVA. Important data are the value of statistical significance (p), which must be less than 0.05 (5%) for significance to be confirmed, and the values of the Mean (M) and the differences between the individual items of the variables.

Results

Demography

The largest age group of respondents was up to 35 years, with 40.4% (n = 36), slightly fewer between 35-55 years- 37.1% (n = 33), and the fewest in the group aged 55 years and above- 22.5% (n = 20); 42.7% (n = 38) of respondents stated that they had from 10 to 30 years of experience, slightly fewer had less than 10 years, specifically 41.6% (n = 37); respondents with 30 and more years- 15.7 % (n = 14) of the total sample. In the monitored group of nurses, most respondents worked in psychiatric departments, specifically 30.3% (n = 27), and the fewest, 20.2% (n = 18), worked in the anesthesiology and intensive care departments. Respondents working on the department of geriatrics and internal medicine made up 27% (n = 24) of the sample, and a fewer respondents were working in the department of trauma surgery- 22.5% (n = 20).

Means and Differences

Table 1 describes the statistical parameters and testing of Hypothesis 1 which assumes that younger nurses will have a statistically significantly lower rate of stigma towards mentally ill people. The first part of the table describes the results of the ANOVA test (F) and the statistical significance of the results (p) together with the specific number of respondents and the average of their answers. The second part of the table gives specific differences in averages of stigmatization and compares the level within different age categories. Based on the data from the first part of the table we do not record statistical sig-

nificance between the individual age categories for the degree of stigmatization by respondents. The first and second parts of the table report the highest values for the difference between respondents under the age of 35 and from 35-55 years in terms the overall evaluation of stigmatization in domain 1, with the first group scoring higher.

We state that there is no statistically significant difference and Hypothesis 1 was not confirmed. We add that overall, younger nurses have a lower rate of stigma towards mentally ill people than older nurses. Specifically in the attitude domain, younger nurses scored higher than older ones, so stigmatization is higher in younger nurses.

Table 2 presents the statistical parameters and test of the hypothesis that nurses with longer experience will have a statistically significantly lower rate of stigma towards mentally ill people. The first part of the table describes the results of the ANOVA test (F) and the statistical significance of the results (p) together with the specific number of respondents and the average of their answers. The second part of the table lists specific differences in average stigmatization and compares levels between individual categories of length of practice. Based on the data from the first part of the table, we do not record statistical significance in the comparison of individual categories of length of practice in the degree of stigmatization in respondents. The second part of the table gives information about the highest value of the difference between respondents with from 10-30 years and over 30 years of experience, both in terms of the overall assessment of stigmatization and specifically in all three domains.

We state that there is no statistically significant difference and Hypothesis 2 was not confirmed. We add that nurses with shorter professional experience have a lower degree of stigma towards mentally ill people than nurses with more professional experience.

Discussion

The aim of our work was to map the current state of stigmatization by nurses towards mentally ill people and to observe how socio-demographic characteristics affect the degree of stigmatization by them. We chose age and length of practice as socio-demographic characteristics, i.e. independent variables. In connection with the selected independent variables, we developed 2 hypotheses based on the available literature, the veracity of which we tested using appropriate statistical methods.

A total of 89 nurses (100%) participated in our research. The education of nurses was also diverse, most nurses had higher education as their highest completed level of education (n = 47; 52.8%), followed by nurses whose highest completed level of education was higher vocational education (n = 18; 20.2%) , there were slightly fewer nurses whose highest completed level of education was a master's degree (n = 16; 18%) and the nurses whose highest completed level of education was secondary education were least represented (n = 8; 9%). If we compare length of practice and the highest level of education achieved, we come to the conclusion that participation in our research was, to the highest degree, nurses with up to 10 years' experience and university education of the 1st degree (n = 28). It is also evident from the obtained data that almost all the less experienced nurses have completed a university degree, while more experienced nurses (over 30 years of experience) achieved the secondary education as their highest level of education. Also, nurses in the generation between 10 and 30 years of experience have mostly achieved a master's degree.

The age of nurses was the first independent variable (socio-demographic characteristic) whose influence on the degree of stigmatization we observed. We assumed that younger nurses would display a statistically significantly lower rate of stigma towards mentally ill people. Although the results of our research did not show statistical significance, they showed differences in the degree of stigma between different age categories of nurses. In the overall evaluation, the lowest scores were from nurses aged 35-55 years (M 41.8182), followed by nurses aged under 35 years (M 44.2778) and the highest degree of stigmatization was found in nurses aged 55 years and older (M 44.7000). In domain 1 – attitudes, the largest difference was between nurses under 35 (M 17.3056) and nurses aged 35-55 (M 16.0909). In domains 2 – publicizing / seeking help and domain 3 - social distance, the most significant differences were between nurses aged 33-55 (M 12.6970; M 13.0303) and nurses aged

Table 1 ANOVA test of the Hypothesis 1

Domains	F	Sig.(p)	n/Mup to 35 y	n/M35-55 y	n/M55 y and over
Questionnaire total	1.745	0.983	36/44.28	33/41.8182	20/44.70
Domain 1	0.983	0.378	36/17.31	33/16.09	20/16.95
Domain 2	1.961	0.147	36/13.67	33/12.70	20/13.80
Domain 3	0.563	0.572	36/13.301	33/13.03	20/13.95

Dependent variable	(I) age	(J) age	DifferenceM (I-J)	Sig.(p)
Questionnaire total	up to 35	35-55	2.46	0.255
		55 and over	-0.42	0.970
	35-55	up to 35	-2.46	0.255
		55 and over	-2.88	0.258
	55 and over	up to 35	0.42	0.970
		35-55	2.88	0.258
Domain 1	up to 35	35-55	1.21	0.355
		55 and over	0.36	0.935
	35-55	up to 35	-1.21	0.355
		55 and over	-0.86	0.685
	55 and over	up to 35	-0.36	0.935
		35-55	0.86	0.685
Domain 2	up to 35	35-55	0.97	0.207
		55 and over	-0.13	0.978
	35-55	up to 35	-0.97	0.207
		55 and over	-1.10	0.229
	55 and over	up to 35	0.13	0.978
		35-55	1.10	0.229
Domain 3	up to 35	35-55	0.28	0.927
		55 and over	-0.64	0.734
	35-55	up to 35	-0.28	0.927
		55 and over	-0.92	0.544
	55 and over	up to 35	0.64	0.734
		35-55	0.92	0.544

Table 2 ANOVA test of the Hypothesis 2

Domains	F	Sig.(p)	n/Mup to 10 y	n/M from 10 to 30 y	n/M30 y and over
Questionnaire total	2.439	0.093	37/44.24	38/41.84	14/45.79
Domain 1	1.431	0.245	37/17.27	38/16.03	14/17.50
Domain 2	1.440	0.243	37/13.51	38/12.89	14/14.07
Domain 3	0.954	0.389	37/13.46	38/12.92	14/14.21

Dependent variable	(I) experience	(J) experience	Difference M (I-J)	Sig.(p)
Questionnaire total	up to 10	from 10 to 30	2.40	0.238
		30 and over	-1.54	0.721
	from 10 to 30	up to 10	-2.40	0.238
		30 and over	-3.94	0.123
	30 and over	up to 10	1.54	0.721
		from 10 to 30	3.94	0.123
Domain 1	up to 10	from 10 to 30	1.24	0.304
		30 and over	-0.23	0.978
	from 10 to 30	up to 10	-1.24	0.304
		30 and over	-1.47	0.400
	30 and over	up to 10	0.23	0.978
		from 10 to 30	1.47	0.400
Domain 2	up to 10	from 10 to 30	0.62	0.497
		30 and over	-0.56	0.734
	from 10 to 30	up to 10	-0.62	0.497
		30 and over	-1.18	0.255
	30 and over	up to 10	0.56	0.734
		from 10 to 30	1.18	0.255
Domain 3	up to 10	from 10 to 30	0.54	0.728
		30 and over	-0.75	0.713
	from 10 to 30	up to 10	-0.54	0.728
		30 y and over	-1.29	0.371
	30 and over	up to 10	0.75	0.713
		from 10 to 30	1.29	0.371

55 and over (M 13.800; M 13.9500). From the above data, despite the lack of statistical significance, it follows that nurses in lower age categories stigmatize the mentally ill slightly less than nurses in the highest age category.

In 2017, Wang *et al*. performed a randomized cross-sectional study involving 395 healthcare professionals. Its aim was to identify risk factors that may contribute to the stigmatization of the mentally ill. The study showed that one of the risk factors is old age, as older healthcare professionals showed significantly higher levels of stigmatization than younger ones (Wang *et al*., 2017). The opposite conclusion was reached by Ewalds-Kvist *et al*. (2013) who used different types of scales to assess attitudes, openness and social distance towards mentally ill people. The study included 2,391 respondents. It was shown that with increasing age, openness, positive and pro-integration attitudes towards people with mental illness also increase in direct proportion, i.e. the level of stigma decreases with age (Ewalds-Kvist *et al*., 2013).

Another variable monitored in relation to the degree of stigmatization was the length of practice of nurses. Based on an overview of foreign research, we assumed that nurses with longer experience will have a statistically significantly lower rate of stigma towards mentally ill people. However, our research yielded different findings. In the overall evaluation, nurses with a length of experience of 10 to 30 years showed the lowest rate of stigmatization (M 41.8421), followed by nurses with a length of experience of up to 10 years (M 44.2432) and nurses with a length of experience over 30 years displayed the highest levels of stigmatization (M 45.7857).

The categories of nurses were placed in the same order in the individual monitored domains - attitudes, publication / search for help and social distance. Although there was no statistical significance between the categories, we can state that nurses with less professional experience showed a lower level of stigmatization towards mentally ill people than more experienced nurses. In 2015, Chiu–Yueh *et al*. published the results of their study which they carried out on a sample of 180 nurses in Taiwan. The aim of their study was to examine the factors influencing the attitudes of nurses towards people with mental illness. The study clearly showed that nurses with longer experience show significantly lower levels of stigmatization than nurses with shorter experience. This fact is also related to the fact that nurses with longer experience have more clinical experience with mentally ill people (Chiu□Yueh *et al*., 2015). Kluit *et al*. (2011) also argue that lack of knowledge and short professional experience are associated with more negative attitudes and behavior towards mentally ill (Kluit *et al*., 2011).

Conclusions

Based on our findings, we state and emphasize the need for destigmatization in relation to the mentally ill not only among the general public but also in the professional community. The need to increase health literacy in the field of mental illness seems to be just as important compared to other lifestyle and life-threatening diseases. As reported by Janoušková *et al*. (2019) a practical example of a suitable intervention is the anti-stigmatization exercises of medical students during the psychiatric module of education (Janoušková *et al*., 2019). Contact with people with mental illness during the remission period has a destigmatizing effect. Equally important is communication with people with mental illness by health professionals as words can have a stigmatizing effect (Helmchen, 2013). Given the evolution of demography in the European region and the growing number of mental illnesses, the issue of destigmatization is highly important.

Conflict of interest

There was no conflict of interest in this study.

The contribution was made with the support of VEGA project No 1/0433/20 entitled: Factors of formal and informal care in the system of long-term care.

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Influence of Oncological Disease on Patientęs Life Quality

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Original Article

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Source: Clinical Social Work and Health Intervention *Volume: 13* *Issue: 1*
Pages: 85 – 89 *Cited references: 15*

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Keywords:

Oncological Disease. Healthcare. Quality of Life. Psychosocial Support.

Publisher:

International Society of Applied Preventive Medicine i-gap

CSWHI 2021; 13(1): 85 – 89; DOI: 10.22359/cswhi_13_1_10 © Clinical Social Work and Health Intervention

Abstract:

At present, despite of many prevention programs, the incidence of cancer still increases in Slovakia. Breast cancer is the most frequent cancer diseases. The number of new diagnostic patients has increased tangentially. This is the reason, why we have decided to find out about women with this diagnosis and their psychosocial problems after surgery. General healthcare about women with cancer disease contains therapeutic, preventive, and nursing care. It is necessary to focus our attention also on social relationships and quality of life during and after surgery. In the treatment of these women, it is important to know that their psychical reactions depend on: premorbid per-

sonality; level of education; social relationship; value orientation; previous experiences with medical stuff; information about their diseases. Psychological support of women is important in every phases of diseases. Postoperative phase is the most important, because this is the moment when women lost their expression of femininity and the physicians and nurses are the first who can help them. Emphasis put on satisfaction of psychological and social needs help women in their treatment process and aims to mitigate more quickly with this change and fight with disease.

Introduction

At present, despite many prevention programs, the incidence of cancer still increases in Slovakia. It is especially important for women after surgery to take care of social relationships and quality of life during and after treatment. Oncological disease interferes for the whole woman. It doesn´t interfere only in her physical health, but also in the psychical and social areas of her life. This is the reason why it so important that oncological treatment must be oriented toward whole women (1).

Psychosocial support

In the treatment of oncological patients, it is important to know that their psychical reactions depend on their: premorbid personality; level of education; social relationship; value orientation; previous experiences with medical stuff and information about their diseases. Psychological support of women is important in every phases of disease. The postoperative phase is the most important, because this is the moment when women lost their expression of femininity. The needs of women after surgery and after determination end diagnosis are changed. Priorities of women in postoperative phase are complicated and they prefer:

- encouragement, support, and safety
- toleration, respect, and adequate help
- positive news from surroundings
- respect to new daily mode and to other changes in the reason of disease
- compassion
- understanding, especially to transient emotional lability
- naturalness in communication: conformity between face expression and word contents
- need of touching is higher– it is very individual, some women don´t like touching

The role of communication

Communication is an important means by which to find the way to a patient, especially to a patient with cancer. To communicate withwomen it is important: to avoid underestimation(2); to avoid superiority;to avoid self-righteousness;to be age appropriate. Psychical trauma and disruption of self-assurance are more pronounced in women whose social background is inadequate. Their complex oncological treatment is complicated and protracted. Results show that women who were in social isolation had higher risk of mortality. When the women are standing face to face to their own mortality and must handle requirements for getting her grounding again as before surgery, she must reconsider her priorities and values in life (3).

Women talk with physician about these psychosocial problems:

- different kinds of worries
- fear about the future
- helplessness and confusion
- confrontation with their own death mortality
- hopeless and loss of faith
- loss of activities
- social isolation
- threat of social identity and own value *(4)*

Strategies for solutions

Physicians are those, who must show a right way to patients, encourage and motivate them to a better way of life. They must suggest possible strategies for managing these problems for example:

- active managing
- planning of other activities
- acceptance of disease and change of body look
- religiosity and spirituality
- using of emotional support
- self-relaxation

- sense of humor
- emotional ventilation *(5)*

These strategies influence the entire quality of women´s life. Women are influenced by their personality, age, abilities of daily activities, satisfaction of daily things, degree of suffering connected with annoying symptoms or distress. Evaluation of life quality has an important role in daily decision making. Levels of evaluation of life quality in which change of life quality is in progress are:

- physical contentment: can be disturbed with pain and other accompanying symptoms of disease, discomfort by using *epithesis,* that is according to the Harper Collins English Dictionary 12th Ed. 2014 is surgery or an orthopedic modification to a deformed extremity.
- psychical contentment: can be negative influenced by pain, fear of surgery and risk of death, restriction in connection with hospitalization, fear of the family or household, possible economic consequences of incapacity for work.
- relationship to myself: insufficient acceptation of anatomical and physiological changes.
- relationships to other people: women shy away from the other people because of problems and fear of unpleasant situations.
- relationships in family: can be disturbed because of load and claims which relate to nursing of ill member of family *(6)*

Discussion

The concept "quality of life" was for the first time used at the beginning of 20th century regarding of material support for the lower social class. Then we saw this term in post-war USA (President Johnson) when it described the situation in which a many times normal economic increase is not serving the higher satisfaction of people, but it increases only their requirements. From the 1970s this term is used for differentiating people´s needs, differentiatiingof own life feeling from material security.

At this time, the term is used in scientific social-economic studies. People´s life cannot be described only with objective parameters (especially economics), but it is necessary to include concrete social coherences and relations. Economic aspects are the most important at a concrete level, later this economic status is not in direct proportion with quality of life. On a basic level, we can understand the term "quality of life" as the consequences, which are working together. We can divide these factors in two basic forms: objective and subjective:

1) subjective factors come out from human emotionality
2) objective factors are characterized as a fulfilment of social status, material conditions and physical health *(7,8)*

In a healthcare system, the assessment of life quality comesfrom aWHO definition of health: health is not only absence of disease, but also physical, mental, and social contentment. Quality of life from a medical view is not only the health condition, but how this condition influences an individual, his/her possibilities, desires and fulfilment of life aims ***(8)***.

Today, the quality of life is the one of the most important parameters in approach to patients. Physicians are interested about patients; how the concrete treatment process influences the quality of life. In medicine, monitoring of life quality shifts into psychosomatic and physical health. It is implemented new term "health related quality of life". In praxis, it means, that clinically verifiable parameters of treatment processes are evaluated: also information's about physical, mental condition and its subjective perception of processes (perception of pain, fatigue, anxiety etc.) ***(9)***.

From this point of view, results for monitoring of life quality in medicine (especially in oncological patients) is importantand the parameters of how the treatments aggravate this quality of life. So, it is important to evaluate treatment processes only from clinical results, but also its influence for quality of life. Measurement of life quality is important information for physicians which they don´t have from clinical practice.

There are many specific approaches for analyzing the quality of life. They are oriented about disease or its phase. The importance of research in life quality formation of oncological patients has been documented by the *European Organization for Research and Treatment of Cancer*. It is necessary to say that there are many problemsin measurement of life quality. It is exceedingly difficult to decid how this quality life must be and represented as a standard. The effort to measure quality of life in respect to what choice of treatment is the right step. Against the past when

only objective results of treatment were mentioned, in last years are psychosocial aspects of health loss are mentioned. Especially for oncology patients must be the monitored influence of disease and treatment on physical and mental condition; on its social, family and work life. Every treatment process is evaluated not only from quantitative aspect (how long?), but also from qualitative aspect. To know, how the patient survived is an important factor in present oncology. In relation to health and disease, we can talk about health related quality of life. The quality of life gives some degree how disease and treatment (consequences of treatment) allow to live a life which is satisfactory***(10)***. This way understanding of life quality is identified by two characteristics:

1. Multidimensionality– quality of life describes some spheres:
   – physical disorders (pain, fatigue)
   – functional ability (ability to do ordinary activities)
   – psychological- social (mood, depression, anxiety)
   – social (relationships in family, social status, financial situation)
   – existential and spiritual (sense of life, hope, forgiveness)
2. Subjectivity – expressed reality from a different view as same things by different people.

In modern medicine, the correct practice is expressed by evidence of its effectiveness ***(11)***. The most valid are comparative studies systematically evaluating the influence of oncological treatment not only from quantity, but also quality done for the first time in 1948 by American oncologist, Professor David A. Karnofsky. Karnofsky used a scale from 0% to 100% for assessment of the entiire functional ability- performance status. Performance status of 100% meant full health; personal status of 0% meant death. Functional ability of a patient was evaluated by a physician. At the beginning of the 1980, another shift in evaluation of oncological treatment influence was noted by Professor Walter O. Spitzer. Spitzer´s index of quality was multidimensional, but physician evaluated all effects, too. Many studies prove, that patient´s evaluation of their situation is diametrically different from physician's. Patients with the same performance status can be different in the degree of influence of their social function.

Today, especially,questionnaires are used in clinical studies. Despite this, they can be used in practice as ,"a leash", for structural talk with patients. but we must not to forget that quality of life is subjective and the information from a group of questionnaires cannot be applicd for easchindividual patient ***(12)***.

Patients with advanced breast cancer had lower quality of life because of changed body image. Many authors mentioned that side effects of treatment influenced quality of life depending on individual circumstances, type of cancer and its treatment ***(13).*** One from many programs is called OSCAR. This one can improve patients´ quality of life with an advanced degree of cancer and with a bad prognosis. Its role is to increase medical literacy and have participation on planning the therapy with continuous support care ***(14)***. Today, there are many approaches for development and evaluation of navigation programs for cancer patients. One of them is project called ONKOLOTSE from the Saxon Cancer Society. It includes certificated nurses, psychologists, and social workers who are in contact with cancer patients about 20 times per year. Evaluation of this project is oriented tothe number of hospitalizations and psychical stress. Nurses from non-profit organization *Group Health* contact patients every week by phone and meet with them personally at least one time per this period. The aim of nurses is to develop strategies, which are oriented on difficulties and quality of patient life ***(15)***. Program OSCAR was developed for patients with the aim to offer one-year regular support in the matters of the cancer. It is a useful supplement for existing structures such as social services offered by hospitals which solve actual needs after discharge from hospital. Improvement of continuity and building the patient´s competences is important for cancer patients in the fragmental healthcare system. Further, there are necessary appropriate medical structures and contractual frameworks to ensure a low threshold approach to palliative care and counseling support. Experiences collected in OSCAR should bring results for other chronic somatic diseases which relate to serious physical and mental problems in patients and their relatives (***14***).

Conclusion

The treatment of pain caused by cancer is a critical question in medical care for patients. All medical workers must ensure that all the patients get early and adequate education and care. It is necessary to develop measures for useful managing of symptoms and for improving quality of life. Fundamental problems are management of symptoms and need of usingstrategies which help patients to have a better feeling of control over the disease and its treatment.

Women with breast cancer need help in psychical and social areas. It is exceedingly difficult to cope with disease when women don´t have the proper background; suffer from fear; inattention to surroundings. Also, diagnosis of cancer has influences on quality of marital, partner and family relations. Results show that optimism helpspatients better get through diseases. General evaluation of global quality of life cannot substitute for more concrete evaluation of working domains and symptoms.

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The Markers of Cardiovascular Risk in the Roma in Western Slovakia

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Original Article

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Source: Clinical Social Work and Health Intervention *Volume: 13* *Issue: 1*
Pages: 90 – 93 *Cited references: 17*

Reviewers:
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Keywords:
Nutrition. Cardiovascular Markers. Roma. Vitamin B12.

Publisher:
International Society of Applied Preventive Medicine i-gap

CSWHI 2021; 13(1): 90 – 93; DOI: 10.22359/cswhi_13_1_11 © Clinical Social Work and Health Intervention

Abstract:

Introduction and aim: Nutritional studies point to the importance of the quality of food consumed in the pathogenesis of cardiovascular disease before the total amount of food consumed. The aim of the study was to evaluate the cardiovascular risk of Roma in western Slovakia on the basis of selected markers.

Materials and methodology: In our study, we determined the following parameters: total cholesterol, triacylglycerols, homocysteine, vitamin B9 and vitamin B12 in 320 probands aged 20-60 years.

Results and discussion: In the Roma population, we found a significant decrease in vitamin B9 and a significant increase in vitamin B12 compared to the majority population.

Conclusion: The Roma population consumes little fruit and vegetables, which was confirmed by low concentrations of

folic acid. Based on the findings, more effective education in the field of diet and eating habits should be developed which would be used in primary prevention in the Roma population.

Introduction and Aim

Cardiovascular diseases are among the most common and serious diseases in humans. More than half of the population over the age of 40 suffers mainly from heart and vascular diseases. Lifestyle factors, including nutrition, play an important role in the etiology of cardiovascular disease. In 2013, the WHO agreed with all Member States on global mechanisms to reduce the burden of preventable non-communicable diseases. The plan aims to reduce premature deaths from non-communicable diseases by 25% through 9 voluntary global targets by 2025. Two of the global targets directly focus on the prevention and control of cardiovascular disease, which is the global cause of mortality (1).

The Roma are the largest ethnic group in Europe, with an estimated population of 10-12 million (2). According to the data of the Atlas of Roma Communities from 2019, it is estimated that the total number of persons of Roma origin is 440,000 inhabitants of Slovakia which is 8.06% of the total population of the country (3). The larger Roma community lives in 804 municipalities and towns in Slovakia and smaller groups in 373 other municipalities. They are concentrated mainly in the south and east of Slovakia. A large part of the Roma declare their Slovak and Hungarian nationality.

The aim of our study was to evaluate the cardiovascular risk of Roma in western Slovakia by determining selected markers.

Material and Methods

The study group consisted of a randomly selected and subjectively healthy population in the age range of 20 - 60 years. Probands came from western Slovakia and were divided into two groups: majority and Roma (Tab.1). Blood pressure, weight, height and BMI were measured for each proband. Blood was collected in the morning on an empty stomach after standard food intake in the previous days before collection. Total cholesterol and triacylglycerols were determined in serum by standard laboratory methods using a Vitros 250 automated analyzer (Johnson & Johnson, USA). Vitamin B9 and B12 were determined in the serum of the Elecsys 2010 Immunoassay test (Boehringer). Total homocysteine was determined in plasma by high performance liquid chromatography (HPLC method) using fluorescence detection (4). The lifestyle of the probands was evaluated in the form of a frequency questionnaire, in which the nutritional regime was also evaluated. Student's t-test was used for statistical evaluation of the data.

Results

The study had the same number of probands in both groups, with the same age range and mean age. Also, the blood pressure in both monitored groups was within the recommended reference values (Table 1).Favorable lipid values were measured in both groups, although triacylglycerols in the Roma population approached the risk limit of the recommended values (Table 1).Concentrations of homocysteine, which is an indicator of cardiovascular disease, are the same in both groups. Vitamin B9 and B12 are important for the proper regulation of homocysteine in the body. Vitamin B12 concentrations are significantly higher in the Roma compared to the majority group, but both groups have concentrations in the reference range. Vitamin B9 concentrations are significantly reduced in the Roma, ie they have a high deficit in the Roma population (Table1).

Discussion

With growing knowledge about lifestyle, the basic lifestyle of all people is changing. Based on national strategies, great attention is paid to development in the field of health care. Long-term high blood pressure causes serious illnesses, such as stroke, heart and kidney disease (5,6,7). In view of the rapid development of the aging population and eating habits, it is increasingly important to prevent the occurrence of hypertension (8,9). Despite different lifestyles and eating habits, we did not find any difference between the majority and minority populations in our study.

Scientific studies declare that the consumption of animal fats, which contain cholesterol and

Table 1 The group characteristics, concentrations of selected markers of cardiovascular risk

	Majority group	Roma
n	160	160
age range (y)	20-60	20-60
average age (y)	40.50 ± 1.13	39.46 ± 0.96
BMI (kg/m^2)	24.54 ± 0.35	28.95 ± 0.42
systolic pressure (mmHg)	120.57 ± 1.80	132.59 ± 2.30
diastolic pressure (mmHg)	73.15 ± 1.20	83.27 ± 1.50
total cholesterol (mmol/l)	5.01 ± 0.03	5.09 ± 0.04
triacylglycerols (mmol/l)	1.52 ± 0.02	1.81 ± 0.02
homocystein (µmol/l)	9.80 ± 0.40	10.32 ± 0.60
vitamin B9 (µmol/l)	18.61 ± 0.91	9.41± 0.86
vitamin B12 (µmol/l)	295.52 ± 15.00	382.41± 16.00

The results are expressed as mean ± SEM

saturated fatty acids, causes hypercholesterolemia in the body, while unsaturated fatty acids which are the source of plants, have a cholesterol-lowering effect (10). Consumption of a high-fiber diet is a prevention of the risk of cardiovascular disease (11). The hypocholesterolemic effect of fiber is explained by the binding to bile acids and the increase in fecal sterol excretion. Fermentation of soluble fiber produces short chain fatty acids that inhibit cholesterol synthesis in the liver. Whole grains, legumes, fruits, vegetables and various types of nuts are very good sources of fiber (12,13).

Vitamin B12 is absent from plant foods; bacteria in the lower part of the small intestine are its only source in subjects with exclusive consumption of plant foods (14). Vitamin deficiency can have many adverse health consequences: folate "flap" in the methylation cycle; deterioration of DNA biosynthesis; pernicious anemia; increased atherogenic homocysteine in the blood; neural tube defects (15). Consumption of dairy products and eggs, meat intake provides a better ability to meet the needs of vitamin B12 for the body (14,16). One of the many functions of vitamin B12 is its involvement in the metabolism of homocysteine, which has atherogenic properties. Homocysteine is a sulfur amino acid that is metabolized in two ways by B-group vitamins - remethylation (requires vitamin B9 and B12), which converts homocysteine back to methionine, and transsulfurization (requires vitamin B6), which converts homocysteine to cysteine and taurine (17). In vitamin B12 deficiency, the remethylation cycle is inhibited and HCy is not degraded to methionine.

Conclusion

Concentrations of several selected markers of cardiovascular risk are more favorable in the majority population compared to the Roma, which is a consequence of a more suitable composition of the diet which is rich in fruits and vegetables. Based on the findings, more effective education regarding eating habits should be developed, which would be applied in primary prevention in the Roma population.

Conflict of Interests

The authors declare that there is no conflict of interest in connection with the published article.

Financial or Grant Support

This publication was created by the research project "The Center of Excellence in Environmental Health", items code: 26240120033.

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Health Care for Refugees and Asylum Seekers in the Setting of Refugee Camps at Europe's Entry Points

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Original Article

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Source: Clinical Social Work and Health Intervention *Volume: 13* *Issue: 1*
Pages: 94 – 99 *Cited references: 6*

Reviewers:

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Keywords:

Community Work. Community Development. Social Services. Social Worker.

Publisher:

International Society of Applied Preventive Medicine i-gap

CSWHI 2021; 13(1): 94 – 99; DOI: 10.22359/cswhi_13_1_12 © Clinical Social Work and Health Intervention

Abstract:

St. Elizabeth University, Bratislava, and its Tropic team has had an active participation in refugee and migrant humanitarian aid since 2015. In the beginning, it was mainly providing health care in the border areas of Hungary, Serbia, and Slovenia, which represented transit points on the route to Western European final destinations. The uncontrolled influx of fleeing people (mainly Syrians at that time) was stopped in March 2016. The diplomatic EU-Turkey deal and subsequent closure of Balkan borders resulted in an extensive humanitarian catastrophe when

thousands ended up stranded in Greece. Since then, the members of St. Elizabeth's Tropic team operate in affected Greek areas. At first, the University had its presence in the northern part of mainland Greece, which later moved to Lesbos Island. Cooperating closely with the Greek Ministry of Health as well as with multiple non-governmental non-profit organizations registered in Greece. The Topic team focuses on refugee health care inside as well as outside the Greek refugee camps.

Dear editor,

The medical team (established by Professor Vladimir Krcmery, founder of the University of Health Care and Social Work in Bratislava -St. Elizabeth's University) also has been moving along with the unprecedented influx of refugees since 2015. After Hungary, Serbia, and Slovenia, St. Elizabeth's University - in cooperation with the Greek Ministry of Health - opened field clinics in two refugee clinics in northern Greece. This was a reaction to a humanitarian catastrophe in Idomeni, a village on the Greek-Macedonian border, more than 14,000 people became stranded when the Balkan borders closed.[3]. The permission to operate field clinics was granted by the Greek Ministry of Health in May 2016. After two years on the Greek mainland, the medical team moved to the refugee-overwhelmed island of Lesbos. The infamous refugee camp "Moria" was initially established as a registration and identification center (RIC). In cooperation with other medical-oriented NGOs, St. Elizabeth's team has been providing health care, wound care as well as social work and logistics since. Members of the medical Tropic team and volunteers with different medical backgrounds in subspecialties such as General, Tropical Medicine, Infectious Disease, Emergency Medicine, Gynecology, Ophthalmology, Pediatrics, Dermatology, and Dentistry have all taken turns in their participation in refugee camps. Paramedics with emergency medicine and wound care training were also an invaluable part of the team. Apart from medical members, there were also University workers and students from Mission and charity section, as well as medical students. St. Elizabeth's team was present in Moria even during a catastrophic fire in September 2020. This fire utterly terminated the existence of the Moria camp on Lesbos Island. The consequence was another humanitarian disaster that not only left 12,000 roofless but also made them face a lack of food, potable clean water, all under the setting of a raging Covid-19 pandemic.

Immediately after the destructive fire, St. Elizabeth's team alongside partners from local NGOs and the Greek Ministry of Health began providing medical and nursing care to unaccompanied minors (UAMs) - a group of vulnerable refugees, all under the age of 18. Subsequently, all UAMs were evacuated from Lesbos Island to the Greek mainland. In that critical time, the team also focused on providing food and water for people stranded on the streets hopelessly waiting for the resolution to this horrendous situation.

The establishment of a new, temporary refugee camp "RIC Kara Tepe/Mavrovouni" located nearby the capital of Mytilene meant not only a new, more challenging environment but also stricter daily rules for all inhabitants of the camp and outside the camp [1].

St. Elizabeth's team has been participating in a program supported by the Greek Ministry of Health EODY support. Currently, St. Elizabeth's team cooperates with the NGO Eudaimonia Medical Services (EMS), which is one of the few NGOs who possess ISO certificates for quality management of the below-listed health services. Some of them are provided with the direct support of St. Elizabeth's University. EMS provides:

- Interpreter services via translators in languages: Greek, English, Farsi, Dari, Pashtu, Arabic, French, Lingala, Portuguese, Italian, Somali, Urdu, and other dialects as needed to ease the transcultural communication not only in the RIC Maurovouni field clinics but also for the Social Medical Center and the only governmental hospital in Mytilene.
- Case management project covers not only medical care but also transportation, arrangement of accommodation, and improvement of living conditions for vulnerable camp inhabitants (patients with chronic pain, and those with poor

prognosis - advanced cancer stages, severe burns, war injuries, etc.) .
- costs for diagnostics and complex workups that are being ordered based on physician recommendations. Some examples are MRI, CT, X-rays, ultrasounds, blood tests, and subspecialty medical appointments, etc. These are not always covered by the Greek public health care system.
- Costs of medication and medical equipment for vulnerable refugee population based on Greek doctors' recommendations. These patients for various reasons do not have access to health insurance for foreigners or so-called PAAYPA which would normally cover these expenses.
- Most of the above-listed services are currently connected with transportation to and from the hospital and if requested also with proof of negative COVID-19 test.
- Crucial items based on requests from the hospital, remaining flexible and adaptive to unexpected situations.

Discussion

By the end of 2020, there were 82.4 million forcibly displaced people globally. This represents 1% of the world's population, which is quite a sad milestone. Discussions about rising numbers of forcibly displaced people have become a crisis topic even in 2016, when statistics showed approximately 65.6 million people displaced.[2]. While various analyses talk about numbers only, it goes without saying that each one of these numbers carries a heart-breaking story of an individual: real human beings who abandoned literally everything they had to give themselves and their families a chance for a better life and safety, and yet, somewhere in this journey lost their dignity.

International conflicts, climate change, civil wars, ethnic fighting, and insufficient protection of vulnerable individuals lead millions towards the dangerous journey from Turkey to EU borders [2]. Entry points to the EU were created at multiple borders representing multiple migration routes. The busiest route led from South-eastern Europe and the Mediterranean Sea. In 2019 the crossing through the Aegean Sea became the most used entry point for refugees and asylum seekers in Europe. The dynamics, extent, and intensity of the vast movement of people seeking international protection were constantly changing, increasingly affecting Europe and its politics [2].

Lesbos, camp RIC Moria after the catastrophic fire in September 2020. In the camp with a capacity of 3 100 people, more than 20 000 refugees were living and 12 000 shortly before the fire.

Source: M. Jackulikova, September 2020

After the EU-Turkey Deal was signed and came into effect in March 2016, the number of refugees on the islands of the Aegean Sea rapidly dropped and trended downward until 2017. In 2017 there were 62,000 refugees/asylum seekers in the whole of Greece, with one-third (20,000) in the Aegean area. Another peak in the refugee influx in Greece was experienced in 2018. By 2019, there were 59,726 recorded new arrivals and in 2020 15,696 migrants/refugees entered Greece which represented a 78.9% drop compared to 2019.[1].

Below-listed arrival data in 2020 was strongly affected by the COVID-19 pandemic as well as numerous reported practices of "push-backs" on the Greek-Turkish border in the Aegean Sea. Another notable milestone was the Greek emergency legislative decree formed in March 2020 that suspended the Greek asylum process as a reaction to the Turkish government's announcement that Turkey will no longer hinder refugees from entering Greece and the European Union [1].

All of these changes had a vast impact on life, living conditions, and health care accessibility and other crucial services in the RIC refugee camps on the islands in the Eastern Aegean and elsewhere. In December 2020 there were 28,356 people with refugee status in the Greek mainland; 17,005 in Eastern Aegean. The overcrowded camps, with a lack of access to basic services including health care, limited availability of sanitary facilities, violence, and insufficient security measures during 2020 further represent noticeable safety risks. Asylum seekers' mental health has suffered even more as a result of COVID-19 restrictions in RIC camps. The homelessness and misery that hit refugee applicants have been reported regularly throughout 2020. Anew Greek law that entered into force in March 2020 generated high risks of homelessness for asylum seekers as they were forced to leave initially assigned accommodation within 30 days from the date when the international protection/refugee status was granted [1].

Lesvos, camp RIC Mavrovouni / Kara Tepe 2, temporarily built after a devastating fire in Moria.
Source: M. Jackulikova, September 2020

The healthcare accessibility for refugees and asylum seekers in Greece persistently faces enormous challenges [5].One particularly hard-hit group is vulnerable persons. Interestingly, in 2020, the time between arrival to the island and application processing shortened which along with the poor quality of medical and psychosocial screening upon arrival raised serious questions about whether the refugees underwent important vulnerability screening at all [5].

Another issue is the lack of interpreters and cultural mediators in the majority of health care institutions (hospitals, social clinics, etc.). Only a few are capable of providing translation services [5]. Free access to public health care and medication is granted by Greek law L 4368/2016. This law applies also to individuals without social insurance, vulnerable socioeconomic groups, as well as asylum seekers, and their family members. Despite theoretically favorable Greek legislation, access to medical care, in reality, has become a struggle due to an evident lack of resources for both foreigners and locals.

The Greek public health care sector has been under tremendous pressure and does not possess the capacity to cover all health care needs. This is further supported by the impact of the 10-year financial crisis and saving economical measures on Greek health care [4]. To access Greek public health care one needs a so-called "A.M.K.A": a social security number that became impossible to obtain for all asylum seekers due to a general refusal of particular public personnel to provide AMKA to asylum seekers. In 2019 the Greek law regulating international protection (Article 55) incorporated changes that made access to health care, diagnostic measures and medication more difficult for asylum seekers [5]. AMKA was substituted by a temporary health insurance system for foreigners, the so-called PAAYPA system. This is a temporary social security number,that is automatically submitted with an asylum application form and provides access to medical care. Asylum application rejection automatically also means the deactivation of PAAYPA.

On the other hand, in case of its approval, it would be supposedly stepped up to AMKA [3]. The complicating factor is that the access PAAYPA program depends on complete registration and ongoing relevant procedural delays, the extent and the time needed for unregistered asylum applicants with a police record. The situation becomes serious when the applicant loses the right to stay in Greece by getting a second rejection of their asylum case as PAAYPA becomes invalid too. The rejection also implies a vulnerable population, who oftentimes undergo the asylum process without being legally recognized as vulnerable as mentioned before [5]. Concretely speaking, vulnerable people are those patients with chronic and palliative diseases, war injuries, and oncological diagnoses who are left without any support from the Greek health care system given the economic constraints of their chronic health care conditions.

Conclusion

This report briefly summarizes St. Elizabeth's activities and humanitarian work focused on refugee/asylum seekers' health care amid the ongoing European migration crisis.Special attention is dedicated to Greece which has been visibly hit by the migration crisis and where the health care access is complicated for foreigners as well as for locals. Health care delivery therefore still requires support from third parties and international donors. For illustration, the results of the 2020 asylum process have been listed. Out of the total number of second-degree decisions, the majority (63%) experienced rejection [1]. In other words, 63% of asylum applicants lost their right to temporary health insurance (PAAYPA). Eudaimonia Medical Services as well as St. Elizabeth University help refugees in such a situation and flexibly react to the refugee needs and guarantee their basic right to health care.

The COVID-19 pandemic still represents an ongoing challenge, a so-called "prolonged crisis situation" for refugees and asylum seekers. The crisis and refugee environment being complicated by the COVID-19 pandemic and vice versa, just as before the catastrophic fire in September 2020, which resulted in another humanitarian disaster.

Most of the European countries refuse to accept refugees and consider the migration crisis as non-existent; however, the opposite is true. The St. Elizabeth's Tropic team and worldwide humanitarian actions focused on help for those in need have never been more necessary than in the present moment.

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No. 1, Vol. 13, 2022

Editor-in-chief: Prof. DDr. med. Dr. habil Claus Muss Ph.D.

CLINICAL SOCIAL WORK
AND HEALTH INTERVENTION

Indexed by:

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Journal DOI 10.22359/cswhi

Issue DOI 10.22359/cswhi_13_1

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