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✓ LABOR MIGRATION OF UKRAINIANS AND ITS IMPORTANCE FOR DEVELOPMENT OF FAMILY RELATIONS AND SOCIAL SPHERE OF UKRAINE

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Health Promotion and Education as prevention of social pathology: A global Millennium Goal

Health promotion and education is an organic part of health intervention and a valuable bridge between Health and Social Work. Several diseases as well as many risk factors for social pathology are directly linked to under-education, illiteracy and absence of general overview not only among public, but surprisingly among Health Care and Social Work students.

Under-education and absence of health promotion is responsible for the spread of many communicable diseases such as HIV/AIDS and other sexually transmittable diseases. Among non-communicable epidemic disorders, absence of education in social and health sciences is responsible for under nutrition in Sub-Saharan Africa and South East Asia, as well as in some areas of Latin America. Under-education is sometimes a consequence of cast systems, religious, gender, economic and/or racial discrimination resulting in several social and health pathologies, not just in marginalized communities (refugees, migrant women with minors, homeless, etc.) surprisingly not only in developing (low resource) but also in developed countries.

Therefore, education in Social Sciences (Social Work, Sociology, Psychology) and health subjects (Medicine, Nursing and Physiotherapy for elderly and chronical ill. Midwifery for women and minors should be an organic part of education not only in schools of healthcare and in arts educational programs, but at least for first year as a part of universal baccalaureate of letters, health sciences, arts, and even in Natural and Technical Sciences,. Graduates of colleges independently of completed program, arts or sciences, are faced on a daily basis of the worldwide consequences of under-education even illiteracy as a part of economic, racial, gender, religious discrimination and isolation. Lack of education in health and social sciences may be considered as root(s) of social pathology especially such as in borderline age groups, minors, youth and elderly, vice versa as deadly synergy for global health and social welfare.

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Slim Physique Image for Female: Discovering its Socio-psychological Outcomes

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Abstract:

Our world view is guided by the physical world, our knowledge, experiences and our perceptions and beliefs. While shaping our world view in the age of globalization, media through its presentations is one of the powerful elements. Body image is an important part of one's life, as having a positive body image can lead to a happier and satisfied life while a negative body image can lead to a damaging behavior. Media's effects on people particularly women have caused many problems such as on health, which has been a recent topic for many scholars. The discussion which is dominating is either it has positive effect such as obesity or its cause or its negative effect such as thin ideal bodies preferable for women. Further, this has created many social, emotional, psychological and health issues. This study is important in many ways especially in terms of disclosing those factors that influence women to adopt to an ideal body described in the media. There are researches conducted on the topic however; there are very limited amount of researches conducted in Pakistan especially in Balochistan. This study is unique in its nature because it reveals the health issues associated with negative body images.

Introduction

There is increasing concern about the negative impact of ultra-slim models commonly used in advertising on women's body satisfaction, as evidenced in the recent Journal of Social and Clinical Psychology special issue on body image. The body size of glamorous models is often more than 20% underweight (Abbott, Barber, 2011). This widening gap between larger actual body sizes and the cultural obsession with an ultra–thin body size has been blamed for women's "normative" experience of body dissatisfaction, and it is this gap which is made salient to women every time they are exposed to thin ideals in the media. Yet, in contrast to the numerous demonstrations that exposure to ultra–thin media models has a negative effect on many women, there has been comparatively little systematic investigation of the moderators, the when and who, and even less of the mediators, the why and how, underlying this effect (Grogan, 2012).

Body Image is defined as the person's own judgment of their appearance and beauty. These words were first used by G. Gerbner, an Austrian neurologist and psychoanalyst. He mentioned about the perception of body image in his book on how people sense their own bodies and what people think their body should be (Gerbner, 1998). The understanding of an individual about their body image can differ from society's standard. However, ideals around it can affect a person's perception of their body image including socio-cultural influence; influence of media; peer appraisal. (Alexandra, 2013)

An individual's understanding of their body image affects their emotions, acknowledgment, and self-esteems (Alexandra, 2013). Body image perception can differ among gender groups as well as people from various ethnicities will have different perception of their body image. Body dissatisfaction was found to be more common

and felt more intensely in women, though men were also clearly affected by body dissatisfaction (Alexandra, 2013). Several health disorders, including eating disorders, are more common among females as compared to males. The latter seem to be affected more by cultural norms and peer pressure. There are various causes that can be associated with negative body image perception that in return lead to certain changes in a person's performance and sometimes can be damaging. Some of the main factors that effects body image development are as follows:

Influence Of Media On Body Image

Media is regarded as the most influential element in shaping and influencing body image in today's world. In early childhood media inspires indirectly, as the child regards his/her parents, family members or teachers and societal members as their role model. These nominated people are directly affected by media in the case of body image. Media also effect body image directly, as the child grows to youngster. As it is the age of body consciousness media presents the role model for society and portrays it time and again. This direct contact with media influences an individual's body image and body perception directly and most of the time produces negative impact (Franko, Roehrig, 2011).

1. Culture and Body Image

Individuals have strong contacts with society. Prevailing culture of a society has deep impact on the development of body image. Culture sets the norm and value of beauty so these valuations of beauty influence body image. Culture may have both positive and negative impacts on body image which is subject to the nature of the society and its modes of production and interaction. Media is also associated with cultural values in the modern times. This study assesses to what extent cultural values are under the influence of media regarding body image (Abbott, Barber, 2011).

2. Peer Pressure

The word peer can be used as nobles or role models. Role models indirectly exert pressure on individuals as the individuals set their own role model through their exposures. Is it important how the individual set its role model? Is the process subjected to the influence of parents, family, culture or media? Most of the time in this modern word, role models are set under the instructions of media. Thus, peers may also have both negative and positive impacts on body image (Carlson, 2002).

3. Other Psychological Stressors

Psychological stress is a common phenomenon when the process of comparison begins. The exposure of individuals leads for setting role models that lead to the process of comparison. Individuals setting of role model is subjected to exposure. During exposure the individual gets inspired by someone's personality, workings, position or any other characteristic. In the case of inspiration, the individual is subjected to follow the set role model. While following the role model the individual intentionally or unintentionally compares his/herself to the role model. With a process of comparison in any way leads to the physical comparison, which ultimately influences body image of the individual. Most of the time it produces negative impact on body image and directly leads to psychological stress (Breitkop, Littleton, Berenson, 2007).

Literature Review

When women are asked directly how exposure to images of slim women affects them they tend to respond negatively. However, when the self-report questions are less obviously connected to the slim body images, women are more likely to be positive

or self-enhancing pattern-controlled eaters. They are more concerned with their size and shape and thus are more devoted to comparing themselves with slim models. Because exposure to the images was incidental to

the alleged purpose of the study, the Research has shown that the need to achieve physical attractiveness puts considerable pressures on female.

The effect of slimness-promoting media has been the statement that all women return to slim-body images in the same way. Individual differences that may moderate the relation between media exposure and body image are often ignored (Botta, 1999); for example, that body displeasure as a result of encountering slim-body images should be confined to those who approve the slim ideal. A recent series of studies supports the idea that not everyone reacts to slim-body images in the same way. In fact, some women feel better about their appearance after looking at slim women.

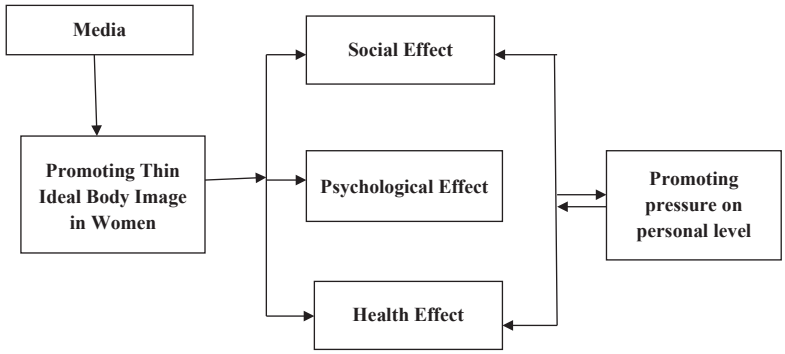
Unrealistic media images of leanness also present ideals that appear to be achievable to the average woman, and that these images promote the misunderstanding that the slim woman body size represents the standard body weight that women should try to rival. One of the societal causes of this cultural concern is the media and the ultra-slim standards the media represent as the ideal, feminine body image. These images are presented to females during the entireness of their lifetimes. This continuous experience to idealistic, female body ideals can promote body displeasure, which can contribute to depression, and ultimately, eating disorders. The researchers found that beauty is the core feature of femininity as portrayed by the media and the core factor in the attractiveness stereotype of women. Social values about women and beauty promote a risk factor for developing an eating disorder. Social pressure to be slim is practiced by many women and young girls. Women and their beauty have been found that overweight girls and women experience significant social pressure, as well as including teasing about weight, perception, and blame. The slim ideal body has been constructed by society and by the media and women and girls is expected to conform to it (Striegel-Moore and Smolak, 2000).

Cultural messages that idealize slim woman body images promote an increase in weight concerns in women. The slim female body image as the societal standard for women prompts girls to view physical appearance as a vital element in cultivating their positive self-esteem (King and Tsiantas 2001).

Development of body image is a lifetime process. The experiences that we have and the feedback that we receive about our bodies from other members of society influence the way we perceive our bodies. These experiences and emotions we receive as children and adolescents about our appearance have an important impact on the formation of our body images. According to researchers, since 1959 the societal standard for the ideal, female body image has increasingly promoted slimness (King and Tsiantas, 2001).

Research Objectives

1. To analyze the slim or lean Ideal body image.
2. To explore the social effects of slim body on women's confidence and self-esteem.
3. To identify the psychological effect of body images on women.



Conceptual Framework

Our world view is guided by the physical world, our knowledge, experiences and our perceptions and beliefs. Media is one of the powerful elements while shaping our world view in the age of globalization, through its presentations. Today's media is promoting thin ideal body image which in most of the cases has negative impact on individual body image, especially for women. Beside this media is also influencing the cultural values regarding body image, that ultimately exerting pressure on individual.

However, with the promotion of the thin ideals media is affecting women psychologically, socially, and also their health. The role of media and its impacts on women are being discussed in the coming parts of this research.

Research Methodology

This part of the study discloses the procedure of selecting simple themes for the study; an explanation of the themes involved in the research; the composition of the measuring instrument used in the study. This research is qualitative in nature. For this reason a theoretical framework is developed with the help of established theories which were already discussed in a previous part of this study. In first instance this part of the study explains the research design for this study.

Research Design/Universe and Sampling:

Research design enables researchers to study any phenomena in a proper way. The nature of this study is qualitative, so qualitative research was being used as a research design. To complete this study in a proper way, I opted for the development of a unique research design based on previous research techniques. For this purpose a self-originated framework was designed with the help of theories, questioners and a study guide for focal group discussions. The research design of the current study is guided by previous research done in different parts of the world, including selected universe of the study; measurement tools; the process of data collection.

For maximum information, the research opted to select educated females in the society of Balochistan. Researcher therefore opted to select the main city of Balochistan, Quetta which is the junction of all cultural values and ethnicities of the province. 15 female respondents of three main universities were taken as the universe of the study. Three of the main public sector universities were selected as the universe of this research for the collection of data. These are University of Balochistan (UoB), Balochistan University of information technology and Management Sciences (BUITMS) and Sardar Bahadur Khan Women's University (SBK).

A purposive sampling is being used for selection of the true representation of the universe. Purposive sampling is the sampling tool which is used in qualitative research for the selection of respondents in a universe. In this sampling, the researcher selected respondents who are more related with the research topic and conveniently available.

This non-probability research is used for abetter understanding and analysing of data with the help of the thematic analysis method. In the analysis of the data, the researcher subjected the collected information to the theoretical aspects of the study.

Results And Discussions

The information revealed in this study is in accordance established by the previous chapters of this research. These findings are given below.

The demographic information revealed that body image is affected by the ethnic origin of individual and it differs from one place to another. In short body image is associated to ethnicity and place in Balochistan subjected to the nature of geography and climate.

The study revealed that as in other parts of the world women's body image is effected by: media, peers, parents and family and culture.

Parental influence produces both positive and negative impacts on girl's body image. In rural areas parental influence produces positive impacts due to encouragement of stronger body culture while in urbanized society parent's influences girls to follow their slim attitudes which negatively affect girl's body image.

There exists a complex relation; regarding women's body image among Media, Peers and Cultural values in the society of Balochistan.

The cultural values in Balochistan are inspired by media and show convergence to the media's propagated slim body image.

The cultural values again shows dual impacts on women body image. Those exposed to media produced negative impacts on women's body image, while the values which are not exposed to media produces positive impacts on body image.

Peer's response toward women's body look is under the influence of both cultural values and media, which produced negative impacts on girl's body image.

Media is regarded as the most influential factor regarding body image as it shapes parental, family and peer perceptions regarding body image which ultimately shape cultural values of society.

Exposition of women to media produces negative impacts on girl's body image. Media is propagating the ideals of slim body in unhealthy ways, resulting negative body image.

The negative impacts of the influencing factors of slim ideal body image produces negative impacts on women's confidence and self-esteem. These negative impacts produce different health issue for women.

Eating disorders are one of the major health problems that are caused by negative impacts of body image include *anorexia nervosa*, *bulimia nervosa* and *compulsive overeating*.

Distorted body image which includes body *dysmorphic disorder* and *depression*, is also caused by negative impacts of body image.

The negative impacts of body image also caused psychological problems for women in Balochistan.

The above findings are the main explorations of this research which allows discussion in light of the literature.

One of the respondents said:

"Today's media is powerful as it also affects the lives and ways of living of our cultural elite. Once media inspires elite culture, these cultural values are being fol-

lowed by the common people either in connection with media or with cultural elite."

Another female said:

"Without any doubt Media is a most effective element for propagation of ideals of slim body. Our parents are inspired by the values set by media

and forcing us to follow these ideals. Women's dress and lifestyle are also dominated by the propagated values of media, which ultimately shape our cultural values, which in return inspires peers and families. Thus it is media that is the root factor regarding the ideals of the slim body."

She added that:

"*Before connection with media I had no idea of beauty but by reading the fashion magazines I got the idea regarding looking beautiful".*

"*Our society is inspired by media and our cultural values are dominated by men in all respects. Thus the wishes of men are being accepted in our society without reason. Men are inspired by media whom opted slim body as values of beauty that is why they are looking for thin and slim bodies regardless of their skills".*

She further narrated that:

"She always tried to look like her. Here it is important that she is comparing herself with her peer and she is being influenced by peers with negative results."

The Focus Group Discussion verified through the respondent's statement:

"*I always remain worried regarding my height and weight when I appeared in any gathering or passing people in my way".* She further added that *"due to concern of weight I always try to avoid public gathering and even sometimes special occasions like marriages and other cultural tasks".*

Conclusion

Body Image can be defined as the person's own judgment of their appearance and beauty. Body image comprises how people sense their own bodies and what people think their bodies should be or look like. An individual's understanding about their body image can differ from society's standard. However, the environment itself can affect a person's perception of their body image including socio-cultural influence, influence of media and peer appraisal.

This study concludes that under peer pressure selected through exposure of media, cultural values (adopted under the propagated ideals of media), family and media had affected women's self-esteem negatively. The media's portrayal of thinness as a standard of female attractiveness is thought to play a determining role in women's contentious relationship with their bodies by pressuring them to lose weight and be thin.

Including eating disorders, *Body Dimorphic Disorder (BDD),* body image, a person's perceptions, thoughts, and feelings about his or her body, are not limited to the visual characteristics of the person, but also take into consideration his or her state of health, skills, and sexuality.

However, the study summarizes that women's body image is affected by peers, family, cultural values and media. The impacting factors producing negative body image led to different body issues that include: body disorder, eating disorder, psychological problems and negative self-esteem. For these reasons this research recommends the following steps to be taken.

Recommendations

Like other parts of the world, research studies must be conducted to further investigate the issue of negative body image and its associates in Balochistan.

Parental influence produces both positive and negative impacts on girl's body image. Parents must be guided regarding the positive side of the fuller body and its benefits,

so as to produce positive impacts on girl's body image.

The cultural values in Balochistan are inspired by media and show convergence to the media's propagated slim body image. Thus is important to propagate positive impacts of the old existing fuller women's body to sustain a positivity of the culture regarding women's body image.

Media in Balochistan is required to project the prevailing body image of the rural areas of Balochistan, in order to provide space for the culture and to counter the ultra slim ideals of women's body image.

Peer response toward women's body look is under the influence of both cultural values and media which produce negative impacts on girl's body image. Thus family, cultural values and media are required to help children to acceptance of peers with fuller bodies.

Media is regarded as the most influential factor regarding body image as it shapes parental, family and peer perceptions regarding body image which ultimately shape cultural values of the society. Thus media is required to project fuller body images of women and counter ultra-slim ideals of women's body image.

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Labor Migration of Ukrainians and its Importance for Development of Family Relations and Social Sphere of Ukraine

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Original Article

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Abstract

This article discusses the essence and the present state of migration in Ukraine. It investigates the migration trends in Ukraine and analyzes the destinations and age groups of Ukrainian labor migrants. The imperfection of a domestic statistical base and consequence of increased scales of international labor migration is parsed. The main socio-economic causes of labor migration and their consequences for the economy of Ukraine are revealed. The article also analyzes the main outcomes of migration of one of the family members for marital relations and relations between parents and children, considers the problems of social orphanhood or the so-called "euro orphanhood " as well as problems of care for the elderly as a consequence of the departure of children abroad. The economic substantiation of the influence of the outflow of labor resources on the sphere of social security, the state and peculiarities of functioning of Ukrainian Medical Institutions is provided.

The peculiarity of the development of the world economy in the 21st century is its globalization, which manifests in the free flow of capital, material and labor resources. The globalization of production; the strengthening of the interdependence of national economies; as well as, as a consequence, the emergence and continual development of the international labor market that covers the flows of labor resources crossing the national borders lead to labor migration of Ukrainian citizens.

The attempt to develop the economy in Ukraine did not lead to a solution to the problem of real improvement of living conditions of the population and the growth of demand for labor. Most indicators of socio-economic development indicate an increasing impoverishment of the Ukrainian people. The employment opportunities in Ukraine's formal labor market are insignificant, and, in addition, employment in the state sector does not guarantee prosperity and does not meet the needs of the reproduction of the workforce of the worker.

Objective

The objective of the article is to study the state of external migration processes in Ukraine; analysis of factors; determination of factors of external labor migration of the population; their consequences for the social sphere and family relations in Ukraine.

Design. The article consists of considering the following issues: **1.** The main tendencies of labor migration in Ukraine. **2.** The reasons for the employment of Ukrainians abroad, their positive and negative consequences. **3.** The impact of labor migration on marital relations, as well as the relationship between parents and children. **4.** Consequences of increasing the scale of labor migration for the state of the social sphere and social security of the country. **5.** Problems of elderly care as a consequence of the departure of children abroad.

Participants: labor migrants from Ukraine, especially the category which have families and children.

Methods of research: for the development of this scientific work we used methods of the system approach, system, economic and statistical analysis and comparison. Much of the information provided by the article was obtained through numerous sociological surveys of labor migrants, as well as the observation of separate groups of families in which there are labor migrants. Currently, Ukraine is one of the largest provider countries of labor resources in Europe and is among the top ten donor countries. The development of external migration processes in Ukraine is associated with low wages in all sectors of the economy, an increase in compulsory part-time employment and unemployment, as well as the spread of poverty and a high level of property segregation of the population [1, p.35-39]. The main causes of international labor migration from Ukraine are:

- search for sources of improvement of the economic situation by raising wages and additional income;
- insufficient number of jobs in the country;
- search for a better life and working conditions abroad
- search for the greatest and best opportunities in the social sphere, especially in medicine, education, pensions, and the like;
- lack of prospects for professional development and career growth;
- instability of the political and economic situation in the country;
- unfavorable conditions for doing business and widespread corruption in all spheres of social, political and economic life

All the reasons presented lead to an increase in the processes of external labor migration from Ukraine, especially with regard to young qualified personnel [2, p. 148-152]

According to the Center for Economic Strategy, the total number of the Ukrainian population who participated in labor migration in the period from 2015 to 2017 is 4 million people. (That is, about 16% of the working population).

The general trend of Ukrainian migration is now its "circular" nature: citizens leave, earn money abroad and return to spend them at home. Therefore, at the same time, not all labor migrants are abroad, but about 2.6-2.7 million people.

We can specify which countries are the most common among labor migration from Ukraine: Poland - 40.76%, Russian Federation - 17.81%, Hungary - 10.45%, Moldova -7.41%, Belarus -5.95% Slovakia - 3.23%, Romania - 2.94%, Turkey - 2.31%, Egypt - 1.51%, Germany - 1.26%, United Arab Emirates - 0.59%, Israel - 0.56%, Italy - 0.5%, Austria – 0.46%, Greece -0.44%, other countries -3.84%. According to the age category of labor migrants, this phenomenon is typical for people of more mature age - about 71% of all labor migrants aged 18-44 years, an average of 34 years. Labor migration from Ukraine is also characterized as a long-term phenomenon, since the majority of migrants leave Ukraine for a considerable period of time [3].

The negative consequences of labor migration include: depopulation of the country's total population; deterioration in the quality of upbringing of children in families of migrant workers (social orphanhood or the problem of another lost generation); disintegration of families; the outflow of the best labor potential of Ukraine; crime and corruption; political aspects; migrant workers are mainly employed in jobs that do little to improve their skills or acquire the skills necessary for future productive activities in their homeland. The positive effects of labor migration include: increasing the solvency

of families of migrant workers; promoting the formation of a middle class in Ukraine; receipt of additional funds in the budget of Ukraine; reducing the burden on the labor market; prolonged stay in developed countries contributes to the formation of the experience of modern economic management; market consciousness; the assimilation of values and norms of a civilized society among labor migrants[4, p.23].

In our article, we will look at precisely the negative impact of migration on the social sphere and family relations, which has already become an essential attribute of labor migration. The majority of labor migrants have from one to three children, children remain for one of the parents, for the older generation, neighbors, or simply for themselves. As a result of a long break in family ties, very often the antisocial behavior of a parent left with the children leads to alcoholism, debauchery, domestic violence (including sexual violence), and eventually to the actual cessation of the existence of a family that was considered to be the foundation of the security of the nation and the state.

Labor migration expands opportunities for professional realization and career growth, contributes to increasing incomes and, accordingly, improving family welfare. However, these material achievements provoke a narrowing; transformation of its other functions the implementation of which is much more complicated. Unique social and psychological functions of the family; psychological support and mutual assistance; the removal of emotional stress; the realization of most individual needs cannot be fully carried out at a distance through communication tools; in conditions of intensification of social processes the acceleration of the rhythm of life are especially important. Such functions as mutual social control, social protection are not fully implemented. Under the conditions of demographic aging; the importance of the functions of caring for and caring for elderly family members who need instrumental assistance increases; their implementation is questionable. The main, most important functions of the family, which are necessary at all stages of the development of society, are the subdivision, socialization and the material maintenance of children. External migration, as a rule, improves the conditions for the material maintenance of children, however, there is a significant risk of underperformance and deformation of the reproductive and educational function. There is a risk of not giving birth in the case of a long-term absence of one of the spouses; deterioration due to this relationship; their instability; emotional alienation; misunderstanding and the like. Especially negative impact is a long separation of parents and children, because “fatherhood at a distance” which is sometimes defined as transnational paternity/motherhood, changing forms of interaction between parents and children give rise to a whole complex of psychological, pedagogical, emotional problems, and is a significant risk of full socialization´of the child.

Modern means of communication create opportunities for new forms of communication, education, care for parents and children, but this only partially compensates for the lack of direct, live communication. So, a transnational family, on the one hand, testifies to the deformation and even destruction of traditional forms of family ties; lack of fulfillment of a number of important functions; on the other hand, indicates the adaptive capabilities of the family institution; its ability to adapt to new social processes transforming forms of family ties. The family institute, being quite stable, has a certain flexibility, the ability to adapt to new conditions [5, p. 50-56].

In the conditions of mass labor migration in modern Ukraine, transnational families are becoming more common. The positive impact of the work of one family member abroad is the undoubted improvement of the material condition of the family: in the conditions of poverty of a large part of Ukrainian families, primarily families with children, the receipt of funds from a migrant worker allows the solving of some economic problems, including ensuring decent material conditions of keeping children. According to the results of the modular sample survey on labor migration conducted by State Statistics in January-June 2017, 45% of households received material assistance from abroad, assessed their level of welfare as below average, and 43.8% considered themselves to the poor and the very poor. So the receipt of funds ($1100-1500) is a significant material support. The majority of households receiving assistance from abroad, receive it from one of the spouses (husband or wife), adult children and even other relatives, is a definite evidence of the preservation of the traditional Ukrainian family solidarity, mutual help of generations in a new, "distance" form. The family "delegates" one of its members to solve their economic problems (housing, education, treatment, formation of insurance savings), including to improve the living conditions of children. The main motive of labor migration is to improve the quality of life of the family, especially for children investment in their education. However, solving economic issues at the same time such a family carries numerous problems and risks - by marriage, the socialization of children, the loneliness of the elderly. One of the most acute problems of the Ukrainian family for a long time is the instability of marriages and the high level of divorce. According to several selective surveys, more than half of labor migrants are married both among those whose emigration is short-term (up to twelve months) and among those who have been abroad for a long time. The prolonged absence of one of the spouses in one form or another necessarily affects a relationship contributing to alienation, misunderstanding and reduction of common interests.

If one of the parents works abroad, the children are brought up in single-parent families, the specifics and risks of which are well known. However, if both parents are absent, or a labor emigrant is a mother who raises a child herself (the proportion of divorced and widowed women is high among such women: according to the last selective survey, every third woman), then socialization of children occurs in extremely unfavorable, distorted conditions. Such children are sometimes called "euro orphans" or "children left behind." These children need special pedagogical and psychological approaches as they are emotionally vulnerable and have a significantly higher level of anxiety compared to children from complete families [6, p. 98-103].

External labor migration is one of the factors that significantly increases the risk of loneliness

of the elderly. The problem of loneliness of the elderly is one of the challenges of our time; in the conditions of increasing aging of the population it is exacerbated in all countries. In modern Ukraine, according to sample polls, the overwhelming majority of the elderly (men and women) sometimes or permanently need help in doing household chores, and this need increases with age because for health reasons, the ability to self-service and homework is reduced. The problem is exacerbated by significant gender differences in mortality, average life expectancy and gender characteristics of marriage behavior. Older women living alone in the household are primarily at risk of neglect and lack of help. The traditions of

family mutual help between the generations in the country are quite strong: the majority of the elderly receive help and care from their adult children, grandchildren, or other relatives, if necessary, and receive material assistance, including from children of migrant workers. However, the possibilities of instrumental support, care depend on the form of residence, the distance between relatives, and labor migration allows increasing financial assistance to elderly parents, however, it changes forms, sometimes limits communication, and makes direct care and care impossible [7, p. 113-117].

In the human rights context at the international level, priority is given to the reunification of migrant families, primarily parents and children, in the host country. It is important for Ukraine that this reunion takes place at home, in our country. A number of researchers include children of migrant workers in the category of social orphans, but in our opinion, a more flexible, targeted approach is needed in this issue: how long parents are absent; how they maintain contact with their child; the family in which the child is at the time of their absence; the conditions of her maintenance and upbringing - that is, to come not from the status of the child, but from the real conditions of his life. However, one should understand that only creation of comfortable conditions for life and education of children in Ukraine - safety, ecology, quality of social infrastructure, etc. - will be a powerful argument for parents in solving the issue: to return children to their homeland or take them abroad to the country of their employment. The process of demographic aging affects practically all spheres of society's life both at the level of individuals and households as well as of the population as a whole. Due to the natural and migratory contraction of the number of young people, Ukrainian society is losing its potential for development. On the other hand, the growth of the proportion of older people in the structure of the population causes an increase in demand for appropriate types of support; services provision for the elderly; pensions; medical services. There is a shift in social spending towards passive support for older people and an appropriate reorientation of social policies. According to estimations, based on national social security accounts, the total expenditures that are sent to support elderly people in Ukraine already account for about 65% of the total expenditures on social protection of the population. And on the basis of existing demographic trends, these costs will continue to rise, creating significant pressure on society [8, p.203-206].

Changes in the age structure of the Ukrainian population are due to natural demographic aging (mainly due to low birth rates, which has been observed for quite some time), as well as to the significant scale of migratory losses of the active population, including through labor migration. As a result, the burden on pensioners on the working-age population is even greater, and the ratio between the number of contributors and the number of pensioners deteriorates. Now in the pension system of Ukraine there are 11,700,000 pensioners and only 12,800,000 payers of contributions, that is, 100 pensioners account for 91 pensioners. Based on current trends, in the middle of the century this ratio could reach almost 120 pensioners per 100 payers. The social consequences of this may be the spread of poverty among retirees, social rejection of the elderly, and the deepening of the conflict between the generations.

Unfortunately, neither economic nor demographic forecasts indicate prospects for improving the situation. As a result, the burden on pensioners on the working-age

population is even greater, and the ratio between the number of contributors and the number of pensioners deteriorates [9].

In addition to the problem of pensions, the growth in demand for services for the elderly is equally important. The Ministry of Health states: every fifth person of elderly people is over 60 years old and lives lonely; every tenth cannot serve himself; 5-6% of pensioners are chained to lust. According to the State Statistics Service, at the beginning of 2017, 1,200,000 senior citizens were identified to be in difficult life circumstances and needed social services: more than 400,000 needed social services at home; 360,000 in social adaptation departments; almost 100,000 - in social and medical services; 9,000 - in stationary departments for permanent or temporary residence. About 300,000 senior citizens require the provision of targeted monetary and in-kind supplementation. Ukraine has an extensive network of social service institutions for senior citizens which provide a range of social services covering all major aspects of the life of an elderly person. In the end of 2016, 65 residential homes for elderly and persons with disabilities functioned in Ukraine; 27 resorts for war and labor veterans; 3 special residential homes; 664 territorial centers for social services (social services) in which there were 2,465 departments. According to Ukrainian League for the Development of Palliative and Hospice Aid, in 2016, there were 7 hospices in Ukraine, two centers and 60 independent departments of palliative care. Most of these institutions are public. In addition, according to the Ministry of Health, in 2015, the country had 25 budget year-round resorts for adults of the MOZ344 structure.

At the same time, the problem of the functioning of this network is quite complex, since it concerns the satisfaction of the diverse specific needs of the elderly. Recent studies have identified an insufficient number of certain types of social service institutions for senior citizens in the country. Thus, according to estimates made on the basis of the survey "Older men and women in Ukraine: living conditions and social well-being", the needs of the elderly in social services are not satisfied by 20.5%. The question of the adequacy of social welfare institutions for the elderly in rural areas remains difficult. As a rule, social services and territorial centers of social services are located in regional centers and serve villages and small towns of the district center. In villages and small towns such institutions are often absent. At the same time, the distance between settlements can be quite significant, and in combination with the inadequate development of transport infrastructure, situations arise in which it is difficult for social workers to reach the recipient in order to provide relevant services.

An extremely acute problem in Ukraine is the lack of hospices and palliative care units for seriously ill and elderly people. There is a big gap between the need for hospice beds and their actual number. According to the calculations of international experts, the need for hospice beds is 4-5 times higher, and an even greater number of patients in the terminal stage of the disease need hospice care at home. In this regard, there is a need for government support for the poor elderly people with limited physical ability and insufficient financial resources. As a rule, the problem lies not only in the financing of such services, but also in the provision of nursing staff. Although there are no official statistics on foreign labor migration in the specialty (an assessment of their number requires special study), a certain part of Ukrainian doctors and nurses currently work in other countries on a permanent or temporary basis. On the

other hand, the facilitation (due to the visa-free regime) of internship opportunities or study abroad, the higher mobility of medical workers (provided they are set to return to Ukraine) is a powerful factor in human development [10].

Conclusion

In order to minimize negative influence of external migration on the Ukrainian family, primarily on children, it is necessary that educational institutions, social services take into account the specifics of the families of migrants in their activities, provide timely pedagogical and psychological assistance, acted in close cooperation with local communities and non-governmental organizations. According to experts, this particular group of children should definitely be included in the target group for psychologists and social workers. The specifics of the current socio-economic situation in the country necessitate the search for answers to the social, financial and economic challenges of population aging, as well as the concentration of efforts to support the most vulnerable groups of the population. The policy of long-term care under such conditions should be combined: along with the development of alternative forms of in-patient care, measures should be introduced to support family forms of care (including foster families) and volunteer activities. But it should be understood that solving the problems of social support of the elderly and counteracting their social isolation lies not only in the plane of passive support, but also depends on how successful the policy of maintaining active longevity, the activation of persons of older age groups, creation of conditions for the full use of their capacity in various spheres of life-affairs. I also need to overestimate the role of the older generation in society. We must move from perceiving these people as inactive and dependent on the formation of the image of active participants in social development.

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Do Midwifes Represent Risk of "Stealing" Patients from OBG Physicians? Not in Low and Middle-income System

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Abstract:

Several new paramedical disciplines has been introduced in new EU member states within the last 20 years, such as midwifery, nursing, physiotherapy, dental technician etc. and concern was observed in discussions if those disciplines are not replacing qualified physicians such as OBG, neurologists, dental surgeons. Another concern was published when critically assessing their curricula during national accreditation processes.

Global Health Environment

Starting with midwifery, more than half of WHO member states had midwifery organically included in their health system. After World War II, Europe, Ukraine and Russia have had excellent experience with so called *Feldsherr-Acoucher Specialists* originating from French and German military experience in late 18th and 19th centuries. Those specialists were active and competent, especially in areas of weak healthcare infrastructure and were more than capable in deliveries countrywide in the last 70 years. The study programs still exist in many Eastern European universities.

Outside of Europe, apart of Latin America, midwifery in Africa and Asia is traditionally a capable discipline to achieve at least two of the millennium goals: to decrease neonatal and decrease maternal mortality in developing countries.

For example, in Ethiopia, every midwife is able to perform caesarean section after 3 years of training. Within last 50 years, this second highest population country in Africa has substantially decreased maternal and neonatal mortality.

Conclusions

Jealousy of physicians including OBG doctors in the EU is understandable due to historic and logistic fact of sufficient number of doctors, but is no longer tolerable. First, we can still see countries in Europe and outside of the EU e.g. Bosnia & Herzegovina, Moldova, Albania, approaching the EU but having unacceptable high neonatal and maternal mortality rates. Second, due to low numbers of OBG specialists in Sub-Saharan Africa and Southeast Asia, midwifery professionals are our only hope in the everlasting battle against neonatal and maternal mortality worldwide.

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Facebook and Propaganda: Following Politics on Facebook and its Impact on Political Behaviors of Youth

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Original Article

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Abstract:

Facebook is an application used globally, and is probably the most utilized application for political discussions. In developing countries like

Pakistan whereby literacy and education levels are so low such social media are often misused. In most instances, people are unaware of the ethical usage of such applications. Framed under qualitative research design, this study aims to describe Facebook as a tool for political propaganda and vested political interests. A total of 400 samples (200 from Punjab and 200 from Sindh) were selected through stratified random sampling. A five level questionnaire was designed relevant to the objectives and research questions of the study whereas the information has been analyzed quantitatively including descriptive and inferential statistics. Findings show that young people in Punjab, Pakistan are greatly exposed to political contents on Facebook which affects their political behaviors.

Facebook was made non-exclusive to the world in Sept, 2006. Since then, it has evolved into something far more universal than its competitors. It is surely not the only social medium tapping in on an inexhaustible pool of chatty, enthusiastic, largely young user base. Rather it is the social media giant. For now, Facebook remains a go-to place for modern users of social media and its success is unsurpassed. Many physical gestures and face to face communications have been replaced by likes, messages, comments and friend requests. This digital age has sped up our communication and opened up a world of infinite choices. Usage of social media and Facebook and translation of online participation into political actions and voting trends was studied in the 2008 US election and it was found that people who participated in political debates and expressed political affiliation online were likely to participate in real life activities, etc. (The Express Tribune, 2013).

Usage of social media by politicians

A cross-sectional study where 88 students of college level were researched showed that Facebook and Twitter accounts managed by politicians affected the voting intentions of the sampled students. The accounts were managed by politicians in order to convey their political messages including contents such as speeches, political gatherings information, photos of political activities, etc. Following these accounts were found to be significant in molding the voting behaviors of the sampled students (Hellweg, 2011). A study conducted in Romania concluded that during elections politicians utilized social media in order to convey their political messages which altered and guided young minds in many ways. The social media worked in positive as well as negative ways. However, exploitations of political emotions was the most note-able one (Lupascu, 2012). Propaganda conveyed through Facebook is almost always directed to use good words for wrong purposes particular when used by politicians. A meta-analysis indicated that good words were projected in a manner that meant presenting opposing people negatively. It was also evident that the majority of sampled individuals were unaware of the use of such words for presenting others negatively and were influenced by the good words while not considering the negative impact of the words about the opposing people (ŞUTIU, 2015).

In the modern era it is a fact that social media including Facebook has played a significant role in many political scenarios. For instance, in Ukraine, Facebook and Twitter brought revolution. Similarly, the political situations in Egypt and certain Arab countries

are directed by Facebook and Twitter. Besides, Facebook was a source of communicating war scenes from Afghanistan to the global community by American soldiers (Ibrahim, 2015). Another key dimension of social media usage by politicians is its mediation through intelligence. The conflicts are old but the mechanisms of mediating people is new in nature through Facebook. Globally, politicians are active in using social media to activate their followers against their opposition by sharing information regarding them and sensitizing their followers by highlighting the time to take action and even the places to take actions (Treverton & Miles, 2014).

Study Argument

Social media is a powerful tool in the modern world. It is utilized in each and every sphere of life including education, health, business, entertainment, communication and similarly politics as well. Political parties, leaders and political workers utilize social media in order to convey their messages, information, news and political debates to the public whereas the public follows political parties, leaders and gets political news and information through social media particular Facebook and Twitter. The utilization and usage of social media for the mentioned political purposes have positive as well as negative implications. Among the negative implications, one is propaganda. For example, politicians cleverly play with minds of people to mold their attitudes and opinions about others through such an easy means. With regard to Pakistan the trend by politicians of utilizing social media has emerged. More and more political parties and leaders are communicating with the public through social media especially Facebook. The political attitudes of young people are significantly affected by the politicians through propagandas which are carried out by targeting others through words, symbols, pictures, memes and character assassination (Statista, 2015).

Objectives Of The Study

To create a profile of young users of Facebook following political parties and leaders

To investigate into the role of political propagandist in playing with young minds

To observe the role of Facebook in changing political attitudes of young users

Research Questions

What is the extent of consumption of political content on Facebook by university students at different levels?

What is the extent of attitudinal change caused by exposure to political propaganda campaigns on Facebook?

What is the extent of change in political behavior lead by the consumption of political contents on Facebook?

Hypotheses

H_1: More the reliance on Facebook for political information, more the political opinion will be influenced.

H0: There is no relation between the consumption of political acebook content and attitudinal change.

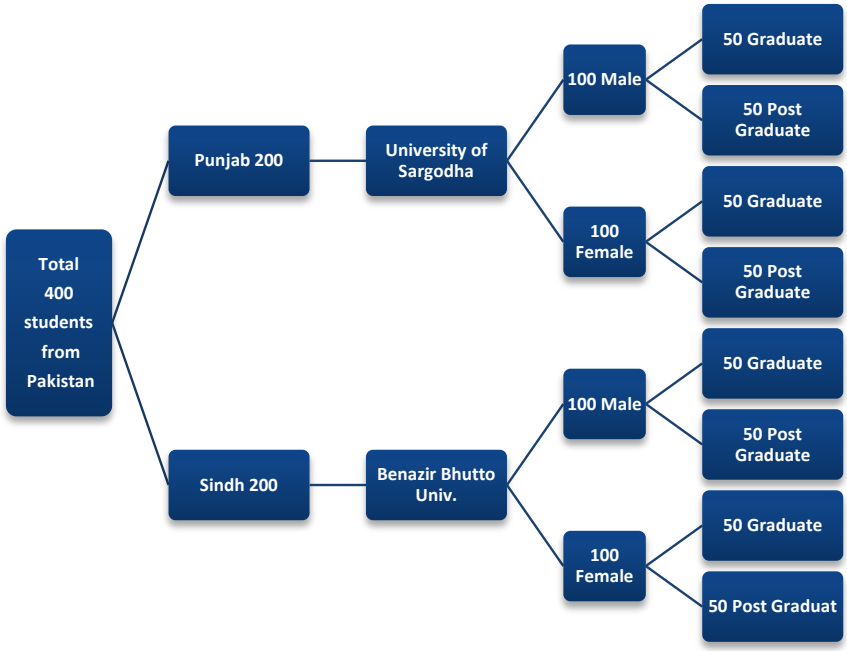
Research Methodology

Survey design was adopted for the study and a questionnaire was the major tool developed on Likert Scale.

Sampling Technique

Randomization technique was used to collect data from a sample frame of 400 students in equal number of male and female, graduate and under graduate students of two randomly selected universities from Punjab and Sindh Provinces of Pakistan.

The following chart explains sampling technique:



Questionnaire Construction

The questionnaire was designed in accordance to the mental depth and verbal capacity of the selected population. English was chosen to be the language of communication.

Data Analysis

Descriptive Information

In terms of targeting character of opposing leaders through social media 53% respondents replied with *to some extent* while 44% *to greater extent*; 22% and 76% respondents replied with *to some extent* and *to greater extent* with that political parties and leaders' talks about policies of opposing parties and leaders through social media. However, 55% of respondents marked to *not at all* against the statement that political leaders post jokes

Table 1: Elements of Political Propaganda by Political Parties and Leaders

Statements	Not at all	To some extent	To greater extent
Political parties and leaders targets character(s) of opposing parties and leaders	3 %	53 %	44 %
Political parties and leaders talks about policies of opposing parties and leaders	2 %	22 %	76 %
Political leaders post jokes about opposing leaders	55 %	42 %	3 %
Political parties and leaders post memes of opposing leaders and parties	75 %	21 %	4 %
Political leaders exaggerates the wrong doings of the opposing leaders	7 %	66 %	27 %
Politicians discuss over the personal issues of opposing leaders	63%	25 %	12 %

about opposing leaders; whereas 42% marked *to some extent*. Similarly, a majority i.e. 75% of respondents opted for *not at all* against the statement that political parties and leaders post memes of opposing leaders and parties while 21% respondents replied with *to some extent*. Further, 66% and 27 % of respondents respectively stated that political leaders exaggerate the wrong doings of the opposing leaders. Lastly, 63% of respondents marked *not at all* against the statement that politicians discuss over the personal issues of opposing leaders while 25% and 12% replied with *to some extent* and *to greater extent*.

Inferential Statistics

Regression Analysis

Table 2: Model Summary [b]

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.763[a]	.582	.581	. 659

Predictors: (Constant), Extent of reliance on Facebook for political information

Dependent Variable: Extent of change caused in previous political attitudes by political contents on Facebook

Predictors: (Constant), Extent of reliance on Facebook for political information, How much Facebook is used

While testing the hypotheses through linear regression analysis, the value of R is found to be 0.763 and R square is 0.581 that is fairly closer to +1 indicating a positive correlation between independent and dependent variables. Significance level of 95% is achieved in the ANOVA Test. Value of Beta is 0.763 (closer to +1 instead of -1) and 0.000 (significant) that also indicates that the independent variables are creating causal effect on the dependent variable. Hence the 95% confidence level is achieved to accept the alternate hypotheses and reject the null hypotheses and the results can be generalized to the whole population. There is a positive correlation between the extent of exposure to political posts on Facebook and change in political attitudes. There is also a positive correlation between reliance on Facebook political contents and change in political attitudes.

Table 3: ANOVAa

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	481.289	2	240.644	553.946	.000[b]
	Residual	346.231	797	.434		
	Total	827.520	799			

Dependent Variable: Extent of change caused in previous political attitudes by political contents on Facebook

Table 4: Coefficientsa

Model		Unstandardized Coefficients		Standardized Coefficients	T
		B	Std. Error	Beta	
1	(Constant)	.639	.061		10.403
	How much Facebook is consumed	.768	.025	.763	31.108
	Extent of reliance on Facebook for political information	.000	.020	.000	.011

Discussion

Facebook is one of the dominant social media services used around the world. Political parties and leaders use it to communicate with the public and their followers and thereby is a means of political propaganda. This study shows that political leaders and parties target the characters of opposing leaders and parties, post jokes and memes about opposing leaders and parties, and exaggerate the wrong doings of opposing parties, etc.

There is an evidence that young people in Punjab, Pakistan follow political parties and leaders through Facebook, and greatly depend on political information through Facebook. This is because they are greatly exposed to political contents on Facebook. Besides, the inferential statistics also show that exposure and reliance of information through Facebook molds and alters the political behavior and attitudes of young people in Punjab, Pakistan. These findings are in line with the studies of Dagona, Karick, & Abubakar (2013), Ibrahim (2015), Smith (2011), Suiti (2015), Hellweg (2011) and the The Express Tribune (2013).

Conclusion

This study investigates the role of Facebook in spreading political propaganda and affecting political behavior of young people. The study has been conducted in Punjab, Pakistan. Randomize sampling technique has been utilized and data has been analyzed statistically including description and inferential statistics.

This study concludes that there are various elements of political propaganda on Facebook including posting memes and jokes against opposing parties and leaders; exaggerating there wrong doings; character assignation of opposition; etc. It is evident that young people in Punjab, Pakistan are greatly exposed to political contents on Facebook which affects their political behaviors.

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An Analysis of Community Perceptions Towards Migration, Economic Development and Family Well-Being in Khyber Pakhtunkhwa Pakistan

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Abstract:

The research study is a critical analysis that examines the perceptions of migrants towards economic development in the District Dir Lower Khyber Pakhtunkhwa Pakistan. The analysis has been made on both original field research as well as extensive review of literature to contextually prove how migration is affecting the economic progress of the society. Similarly, the literary debate is confounded through field data and primary data collected through in-depth interviews from 60 migrants' households purposively selected along with observation and focus group discussion. Overall, a qualitative research design is utilized and the narration and explanation of the various dimensions of migration and economic development has been performed from the field information with the support of secondary information. Results of the study conclude that migration is a major source of sending remittances that positively affect families, reduce poverty, increase income level, support family well-being and enhance the living standards of dependents.

The Study Background

The change that has been found in the last few years is the increase in the ratio of migratory advancement. Beside many restrictions, the migrating people continue to seek economic opportunities abroad (Alonso, 2011). The United Nations has estimated that for the year 2010, 214 million migrants made up 3% of the world population residing in countries other than their origin. However, it has been recorded from various studies that such a percentage seems very low compared to the overt and covert impact of migration i.e. the socio-cultural, economic and political as well as with respect to families left behind, and bring economic progress as well as being a great source of development (Haas, 2007a, Ellerman, 2005, Alonso, 2011).

Studies have clearly emphasized the economic issues and particularly the remittances which are mainly responsible for economic development, poverty reduction and well-being of those households (Ellerman (2005). Literature review and discussion conclude that migration for employment and labor is a major source of economic development in underdeveloped nations and such migration and remittances have impact on the reduction of poverty; allocation of income; disparities; exchange rates; is playing a pivotal role in individual and family wellbeing.

The Study Rationale

The current study is about people's perception with respect to migration and economic development that has been brought through remittances sent back by migrants to their recipient households. It is a fact that the nature and aspect of migration is dependent upon behavior of the migrants toward income decisions taken by migrants and their families (Reza, 2005). Migration of household members and their earnings improve the economic and social status of the family (Arif, 2004). Thus the current study looks into the perception of the migrant households regarding their remittances sent to their native homes and how such remittances increase the status of families in terms of poverty reduction, investment and family well-being.

Objectives in the context of the Study:

Major objectives are:

1. To study the magnitude of people's perceptions regarding migration and poverty alleviation.
2. To know public perceptions regarding migration and household income and facilitation.
3. To judge the perception of people toward increases in investments and monetary benefits.

Plan of Work and Procedural Methodology

The nature of the study is qualitative based upon the interpretation, enumeration of data in the form of textual confirmation and explanation (Bogdan & Biklen, 1982). However, field data as obtained and recorded is thus finalized to results and the pattern linked with both primary and secondary data for producing theory (Roney, 2000). The data gained through interviews, case studies etc. is analyzed in the form of narration, description as well as decimation with proper coding in a systematic manner (Wolcott, 1994). The field information has been obtained from 60 informants (in a survey during one month) in face to face conversation using an interview guide as a tool. Household selection was made through purposive sampling technique and a link has been established between the field data and theoretical stances of social and economic scientists.

Major Research Findings And Discussion Over Findings

On Migration, Remittances And Poverty Reduction

Among the positive changes that migration might have brought in countries is the reduction of community poverty and especially of migrant families. The field data also support the available literature and most of the respondents were of the opinion that migration labor is one of the major sources of sending remittances to support families. Such remittances increase the standard of life of the people to a greater extent as supported by a majority of participants. One of the extracts from an interview reports that: "*Previously, our family members have not had enough resources to live a standard living prevalent in the area. They were deprived of material goods and facilitation services for most of the available services. In other words, we were all in a kind of complex for being deprived and not of equal standing with community members……(R-S5).*

Concerning poverty reduction and family assistance through migration, obtained information indicate that family assistance has enormously increased in families where one or more family member is out of the country for work. In such assistance, the demand for money, family expenses, purchasing power, and surplus money availability has been observed and supported by a major cohort of respondents. Concerning surplus money, a respondents enthused: *"Yah; I have much more surplus i.e. in my bank account, loans given to people and even at home. I also have two cars, one tractor to work in my own fields and I am generous in supporting my family members for every occasion (including marriage, health, food, shelter, education, health, etc.). Surely, all this was not possible a decade ago…..(R-E17)".*

With regard to various forms of assistance, the respondents perceive that social assistance has been increased enormously to cover their basic needs with particular reference to women's poverty reduction and education of children of migrants. Parents have obtained maximum facilitation in the form of education, health and even recreation while a change has been found

in *facilitation in terms of household management; water utilization; fuel and gas consumption; clothes and ornamentation; expenses for marriage and other arrangements; access to health and education as well as markets etc..(R.J34)".*

Similarly, the housing pattern and level of facilitation during house construction and decoration was also observed and analyzed and most of the people perceive that migrants are currently residing in their own houses, which to them previously was a dream. The majority of migrants have cement houses and even have purchased land for future purposes as well. The houses are linked with guest rooms or *hujras* for foreign guests with modern and well sophisticated facilities. Families have their own cars or other transportation facilities available whereas such facilitation was impossible before migration. As narrated by a person: "*Yes of course, cemented house and to have my own house was really a dream for me and my children. I am thankful to Almighty Allah for giving me a house, will facilitated in all aspects. I am self- sufficient in transportation, land and many of the requirements of life. Indeed, this was impossible if I hadn't migrated abroad for work……(R-W11)*. The analysis and discussion thus extracted that poverty of the migrant families have been reduced to a maximum level and most of the families have sufficient facilities of life.

Migration And Increase In Family Income

Family members utilize their income for food items, health related issues, clothing, education of the young generation as well as saving for future activities. Most of the people perceive that the expenditures incurred through labor migration have significantly increased the expenses of households, particularly of women on their dressing, clothing and buying ornamentation and utensils. Besides, an increase has been found in the amount of food expenses, buying clothes and even health and medication along-with children's education as stated by a respondent. *"I can observe a major change in the pattern of life in my family. Comparatively, females are spending more on clothes, visiting families and buying ornamentation (gold) as they are in competition with neighboring relatives. The usual expenses of family are now in lacks as compared to a few years ago when our elders were spending hundreds on such expenses…. (R-T55).*

Participants perceive that previously luxuries were rarer whereas after migration such focus has been intensified. Most people perceive that male members who are working abroad are specifically concerned with their children's education and mostly they want to send their children to private schools to attain quality education being more expensive as stated by a person: *"I remember that the cooking of second type of food item was considered as luxury in my family, but today no such care is taken for second or third dishes and even fruits and cold drink with a meal is the usual pattern of services at lunch or dinner. Our children are preferring private schools on the demand of the parents and there is competition among family members for such schools (R-A-60)".*

Information and its analysis thus conclude that the buying power and capabilities of the majority of family members have been increased to a major extent and further, such remittances had improved the housing expenses, purchasing power, and expenses on education as compared to houses where no such remittances are received.

Migration, Remittances And Increasing Investments

From the analysis, it is obvious that household services and purchasing power

has been enormously increased and participants agreed upon the notion that income resources and their utilization has been increased and chances for investment are also increased manifold in the locality as narrated by a respondent. *"I personally wonder how enormously investments on purchasing land, building markets, installing petrol pumps, opening shops etc. have been increased in the area. Lots of facilities i.e. educational institutions, health care centers, shopping malls, trade centers, and other daily life facilitation has been doubled or even manifold in the past five or six years (R-J28).*

Most of the migrants are interested in initiating their own small scale businesses, search for jobs, construction of markets and plazas, and many times people are open to invest money in construction of housing schemes. Data shows that people of the migrant families and households have enhanced their productive capacity through investments while an increase has been observed in production of material goods in such families as noted. "*I am investing more on constructing market and buying land for establishing centers. Today, I am more stable and richer than my brothers and family members by owning multiple markets and centers which are income generation sources for me and my family…(R-S21).*

Analysis also shows that most migrants are interested in purchasing agricultural land or even investing to irrigation and agricultural productivity. Besides, migrants families have more chances for increase in trade and other economic activities with respect to the non-migrants families in the area and such people have more control over valuable goods and information about production, demand and supply items, policies and prevailing conditions in the country or abroad.

Migration And Household Welfare

Analyzing the field information with respect to migration and family wellbeing, most of the participants are of the opinion that the majority of the migrant families are well facilitated with respect to availability of food, access to health facilities, access to education and other basic needs. Families of migrants have more concern regarding family well-being, education, health, and future planning with regard to family and young ones as narrated by a participant. "*I have almost spent more than 25 years outside my homeland and I have earned millions of rupees but I wish that my children shall get better education to support themselves and my labor shall bring some fruit in future … (R-D30).*

Similarly, most of the respondents were of the opinion that migration has positive impact with many factors responsible for education and its development including sending children to school, decreases in drop-out, and mostly, the importance of education in the area. Parents in such families are more stressing upon academic performance and grade achievements and are more focusing on children's study hours and utilization of time. Analysis confirms that most of people have an improved health conditions whereas the migrant households found open access towards improved health-care facilities i.e. doctors, hospitals, daycare centers and even to medical practitioners. Further, migration and remittances have improved children's overall health condition because such families have awareness with respect to healthy diets, food, and health and other services and the utilization of such services have positive health outcomes as narrated by a field respondent. "*Today we are all aware of our children's health, food requirements, and even to provide them all the health care as well. I myself took my children to a special-*

ist doctor and I even spend a lot of money on it. Sometime, even for a very little health issue, we visit the best doctor in the area or in the country. .(R-U59).

Extracted from the analysis that families and households left behind are getting more facilitation as compared to non-migrant families in terms of food, health, clothing, education and even recreation. The majority of people view that migration and remittances are a compulsory aspect of family well-being and the remittances have improved welfare of children, aged people and even girls and women in the area.

Summary and Conclusion

Analyses indicate that a major chunk of migrants living outside their own country and sending money back have observed a shift in their social and economic as well as personal relationship to the rest of society. In an analysis of the poverty component, migration has been the major contributor to reduce poverty as well as in many cases have increase family incomes; expenses on buying food items, health facilitation, clothes and other things have increased enormously and have thus changed the life style of the migrants to a greater extent. Migration has brought many changes in the family structure; role of family members; even in the decision-making process of the family. Extra money has improved the life expectancy and then has increased the purchasing power of the family to a maximum extent to have markets, land, education, recreation facilities and even extra cash in the banks accounts. Similarly, there has been an enormous increase due to migration in the form and services related to health, family and educational facilitation to the larger extent. It is thus concluded that that migration and remittances are pivotal in family economic as well as social development of the area.

Policy Recommendations And Future Research Indicators

It is recommended that migration has damaged the moral and value system; absence of social control towards kids and their activities; habit of extravagancy has been created; issues of psychological nature; care for children has been reduced which needs attention of the policy makers.

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Comparison of Ordinary Medical Care Centers/Partnerships and Practice Clinic in Germany

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Medical Care Center. Usual MCC/ Partnership. Practice Clinic. Exchange of Services. German Medical Assembly. Diagnosis Related Group (DRG). Medical Care Practice. Reimbursement of Budget Overruns. Improved Cooperation.

Key message:

Managing, controlling and (re-)designing businesses within the system of medical care has become an extremely challenging task. In our paper we analyze the differences between main organizational forms of outpatient care - medical care centers/partnerships and practice clinic model.

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Abstract:

Objective: Politicians are not the only ones who view medical care centers (MCC) as a model for the future. Even physicians often believe that they are better off with such type of care. However, legal and tax expert Dr. Müller-Kern warns that this is not always true because profits do not increase for every partner and some even experience losses in revenue. This is because disciplines such as strategic planning, marketing, organization theory, quality management or project management run parallel to each other in classical business administration. This is how these disciplines are still taught in schools and universities today.
Aim: Managing, controlling and (re-)designing businesses within the system of medical care has become an extremely challenging task. It is thus better to analyse beforehand whether it is really worthwhile.
Results: In a comparison between the standard MCC/partnership and the practice clinic model, one can see that these are very different structures. Of interest are structures where both forms can be integrated within a single enterprise.
Conclusion: Classic business management, which is based primarily on principles such as linearity, stability and deduction, is less and less capable of answering the burning questions of today's corporate governance. The structure of the German MCC is an excellent type for the medical field and has a very good prospect the next years.

Introduction

Aspects of the Medical Care Center/ Partnership

Due to the establishment of enterprises, the salaried physician is considered a co-entrepreneur for tax purposes according to German legislation (Clause 15, § 1, No. 2 of the UStG - Income Tax Act) [1]. Besides the fact that he or she receives income tax-related profit shares and no wages, in terms of VAT (value added tax), the relationship between the MCC (medical care center) partnership and the co-entrepreneurial physician employed should be assessed on the basis of characteristics of the exchange of services within the corporate relationship. The result of the VAT assessment of service relationship depends on whether the physician is effectively self-employed and paid a special rate (fee) or if the service provided by him or her is compensated on the basis of profit and loss. A special rate always exists if the partner receives a fee on a non-share basis. For example, a special rate exists even if the partner receives a percentage of sales for his or her functions (2).

Essentially, it can be assumed that the physician practices independently because in this case the partner is not subordinate to the enterprise, rather co-determines how

the enterprise is handled together with the other shareholders [BFH (*Bundesfinazhof* - Federal Finance Court) 7.12.78, and BStBl (*Bundessteuerblatt* – FederalTax Sheet) II 79, 356)] (3,4). If the partner-physician provides services to the MCC partnership and these services are only compensated through a profit-sharing percentage independent of services provided, he or she is not considered an entrepreneur. He or she does not engage in taxable transactions and may not bill the enterprise separately for any VAT in connection with his or her services. If he or she does account for VAT for this, he or she owes the corporation pursuant to law - Clause 14, § 3 of the UStG (1). In the absence of entrepreneurial status, the physician may not deduct (5).

Regardless of his or her functions for the MCC partnership, the physician may be considered an entrepreneur if the physician effectively works for him or herself with the intent to generate income in addition to his or her functions for the MCC. If the physician provides services to the MCC from his own entrepreneurship without receiving a special rate for doing so, these services may be taxable as fictitious services in return for payment pursuant to law - Clause 3, § 1b of the UStG or other fictitious services pursuant to Clause 3, § 9a of the UStG. (1, 6)

In the service relationship between the MCC partnership and salaried physician who is not also a partner, the same regulations apply as those for a salaried physician at an MCC corporation. Against the backdrop of the physician's salaried employment, income tax excludes a VAT service relationship between these parties.

If a self-employed contract physician and an MCC partnership come together to form a joint practice without affiliating under company law, an exchange of services exists between these parties that is subject to VAT. This corresponds to the exchange of services between an MCC corporation and a contract physician. Here too, VAT liability exists on the basis of the exchange of services, which supersedes that between the MCC partnership and the patient (6, 7).

Dual system for consultants

In Germany, healthcare is provided both through independent medical practitioners in their own practices (or in a group practice) and in hospitals. This means that a dual system exists in relation to consultants. So there are independent ear, nose and throat practitioners who are self-employed, and ear, nose and throat practitioners who work as employees within a hospital (7-10). This formulation creates the impression that this is something special. In fact, a number of countries have independent GPs who are the first point of call for patients, but no independent consultants. If the GP believes that a consultant should take a look at the ear, he or she sends the patient to hospital and not to an independent colleague. Hospitals do not immediately provide beds for such patients, as they have outpatient departments for such cases. This means that hospital doctors treat both inpatients and outpatients. To this extent the dual system for consultants is unusual.

Organizational forms

There is a series of different organizational forms (8,12) within outpatient care. A practice is described as a solo practice where there is just one doctor (with support staff) in it. A group practice is made up of multiple doctors who, however, invoice separately. A partnership practice is made up of multiple doctors who invoice together. Doctors who together run a laboratory and share the costs but invoice separately are described as a "collaborative laboratory". In the case of an "equipment-sharing practice", doctors share high-cost equipment. A practice clinic

offers independent practitioners with a hospital affiliation the infrastructure of a hospital so that these practitioners can lease beds, equipment and staff in order to be able to operate within a hospital.

The term "medical center" relates primarily to the real estate; i.e. a medical center offers independent practitioners practice rooms under one roof with other practitioners. This says nothing as to the degree of cooperation between the practitioners. Some medical centers organize on a joint basis (as for example the disposal of medical waste – "Not in the normal waste bins please!"), or purchase from the operator of the medical center, right up to practices that are closely interconnected, where the waiting room and staff are shared so that the boundaries with a group practice are flexible.

Medical care practices (abbreviated as "MVZs" in German) on the other hand offer outpatient care in a range of areas and occupy a special place in the care of outpatients. A medical care practice can be set up as a corporation and can employ practitioners. Any service provider can incorporate the practice. This is particularly attractive for hospitals, which are responsible for setting up about one third of all medical care practices. These enable hospitals to better use their capacity to the full and also to refer patients to themselves via the MCC (in the inpatient department). This of course means that hospitals are then competing with those who, up until now, have made referrals to them – the independent practitioners in the local area – and must be prepared for the independent practitioners to recommend other hospitals to their patients (8, 11).

The advantage of the Diagnosis Related Group (DRG)

In the age of Diagnosis Related Groups (DRGs), identical prices are paid for identical services. This means that, given the same regional average base case and the same DRG, a center offering a full range of healthcare and one offering basic and regular care will achieve the same yield regardless of their costs structure. Germany's independent practitioners generate between 70 to 90% of their income from services that have been taken over from the statutory health insurance fund (8, 12, 13). About 70 million German citizens are insured through the statutory health insurance fund (9, 12) according to Federal Office of Statistics (6). This makes it the largest health insurance group in Germany by some distance (12), according to Statutory Health Insurance (*GKV-Spitzenverband*) '(12). It is funded on the contributions principle. This means that insurance payments are funded from contributions received in the same year. If we ignore for the moment the fund law aspects and look for a suitable everyday definition, then an MCC is in fact a larger medical practice in which multiple independent practitioners with different specialties operate together. Some MCCs also have non-medical service providers available, such as physiotherapists and those offering remedial gymnastics and outpatient support services. All this happens in shared spaces at a single location.

Apart perhaps from the names and signage, it would be difficult for a patient to recognize from outside whether this is a medical center, a larger partnership practice or an MCC.

However, significant differences exist compared with traditional practices. If one carries out a closer analysis of an MCC's structure in terms of the law governing funds and compares it with traditional solo or group practices, then considerable differences become evident. While in traditional practices independent practitioners operate on a self-employed basis, an MCC is fundamentally a different construct.

Within the structure of an MCC

- different forms of incorporation are possible (e.g. GbR [a German company constituted under civil law] or GmbH [a German limited liability company] etc.),
- it is possible for there to be outside owners,
- partners may operate as doctors or not,
- there is significant scope in terms of regulating succession
- medical "seats" under fund law (accreditations) may lie both with the partners and with the MVZ (the company)
- professional management is (generally) necessary and sensible.
- Health policy environment and general statutory framework

In 2004, the legislator made a fundamental change to the general framework of outpatient care for those covered by statutory health insurance when it first allowed the "medical care practice" form of incorporation under fund law and initiated a dramatic change in the way independent practitioners carry out their profession. The buzz words are the 'opening-up of the markets' and 'increased competition'.

Two laws regulate the activity of MCCs in outpatient care. The management board will be familiar with the content of these laws, as they define the basis and scope of its operations and tasks:

- Statutory Health Insurance Modernization Act ("GMG") in late 2003
- Panel Doctor Law Amendment Act ("PDLA Act") in early 2007

Panel Doctor Law Amendment Act

A further opening-up of the market (going beyond the licensing of MCCs) was undertaken by the legislature in the (*Vertragsarztrechtsänderungsgesetz*) German Panel Doctor Law Amendment Act of 2007. Its substantive contents are the licensing of local and regional group practices, the possibility of partial licenses and affiliated practices as well as the extended employment opportunities for doctors. In addition, the legislature made it possible for medical service providers to be remunerated directly via a direct contractual relationship with health insurance funds. In the context of the "direct contracts", it has become possible to bypass the Panel Doctor Associations "*kassenärztliche Vereinigungen*" or "KV" of GPs treating members of a health (Panel Doctor insurance scheme.) as the organization arranging settlement of payments. The boundaries between inpatient and outpatient care have also been designed to be flexible.

The provisions of the Panel Doctor Law Amendment Act ("PDLA Act") approved by the German Bundestag on 27 October 2006 in a second/third reading have applied since 1 January 2007 and continue to do so. This law affects, among other things, the amendments to the draft professional regulations for psychotherapists already adopted at the 7th German Psychotherapists' Conference in Dortmund on 13 January 2006, and opens up the latter's application to professional work within statutory health insurance. At the same time, the primary objectives of the new statute consist of ameliorating regional care issues by relaxing the law governing forms of incorporation and making these more flexible, as well as designing panel psychotherapy services in a way that is more efficient and hence more competition-based.

In particular, in view of the growing competition pressure from medical care practices (MCCs) an extension of the organizational and commercial forms of incorporation open to individual panel psychotherapists has been announced. It was also intended to remove ambiguities in relation to the conditions precedent to the setting-up of MCCs. The extent to which these goals were implemented within the area of

psychotherapy is intended to be set out and commented on below.

The most important new regulations concern

- the retirement age for those working as panel psychotherapists,
- the age limit for access to work as a panel doctor,
- the appointment of psychotherapists with no numerical limit in open and restricted planning areas,
- work elsewhere (secondary business premises/setting-up of branches),
- local and regional group practices (partnership practice),
- partial licenses,
- second jobs at a hospital and
- the regulations governing the MCC (4, 12).

In license-restricted areas the existing owners of practices or their heirs no longer have a free choice as to a panel practice's successor, and are not free simply to negotiate the purchase price with the latter. This applies in any case where there is no successor available who has a license covering the restricted area in which the practice to be transferred is located.

Specifically in the context of a successor appointment process, the panel doctor's position must then be put out for tender by the panel doctor association and filled by the licensing committee with an applicant who is to be selected "using its proper discretion" (13)**.** The legislator has formulated the successor appointment process in a way that is by no means comprehensive. When making the resulting necessary interpretation of the statutory provisions, one has to take into consideration the fact that the successor appointment process was also introduced in order to make it possible for the owner of a panel practice to realize its commercial value and thereby to preserve the fundamentally protected acquired rights of the panel doctor in restricted areas (7, 15).

Despite numerous attempts to achieve comparability between hospitals in terms of medical standards, for patients there remains a lack of transparency as far as the hospitals market is concerned. But in order to be able to give their consent, patients need information (8, 15). For individual cities such as Berlin and Hamburg as well as for regions such as the Rhine-Ruhr Area, clinic guides are in place or are being prepared. But to date, these relate only to a small selection of conditions. The same applies to quality reports which clinics have for years been obliged to publish. For the medical laity (i.e. for virtually all patients), their information content is rather small, however, as they are aimed at the "Diagnosis Related Groups" (DRGs) that are crucial for payment settlement (9, 16).

For the independent doctor, budgeting means that his/her services are subject to a fixed financial framework. He/she receives a standard volume of work so that within a set period a billable volume of panel-doctor services are to be paid for at the prices included in the Euro Fee Regulation [*Euro-Gebührenordnung*] and applicable to the doctor or doctor's practice." (8, 9, 12, 14).

Comparison of MCCs and practice clinics

The following figure (Fig 1) shows a comparison between the standard MVZ/ partnership and the practice clinic model.

If we regard the setting-up or operation of a medical care practice ("MCC") as a process that has to clear certain obstacles, then the specific funding issues are normally not discussed in the initial phase of such a project. In some MCC projects this can lead to problems which can subsequently be extremely costly to remove. Thus establishing the legal form of the

Figure 1: Comparison of MVZs and practice clinics

	MCCs	Practice clinics
Legal form	GbR [a German company constituted under civil law] / partnership	GmbH [limited liability company]/AG [company limited by shares]
Number of employees	40	double-digit
Average no. of patients a day	40-100	30-80
Doctors employed	2-5	4-8

Source: (9)

MCC early on can have long-term consequences for subsequent project-funding options (9, 12, 13)

Independent practitioners' grounds for selecting the form of cooperation within an MCC are broadly categorized:

- the exercise of their profession within an employee/employer relationship (in the case of doctors willing to set up a business, this may be in preparation for their becoming self-employed),
- the possibility of flexible working hours,
- provision for old age through the sensible disposal of the practice,
- the future investment potential,
- the realization of economies of scale,
- the realization of economies of scope,
- the possibility of agreeing mutual reimbursement of budget overruns,
- joint marketing,
- professional management,
- a good starting position for integrated care contracts,
- market strength when competing with other practitioners, special interest groups and hospitals,
- improved cooperation with other healing professions and with the inpatient sector.

From the point of view of a hospital, the setting-up of an MCC facilitates improved cooperation with the outpatient sector:

- the achievement of additional income via MCC profits,
- the improvement of the competition situation compared with competitors in the inpatient sector,
- the restructuring and extension of a hospital's range of services on offer to date,
- increased cooperation with independent practitioners for the purpose of improving patient care.

The circle of those service providers who are entitled to set up practices extends far beyond independent practitioners and hospitals. The personal, commercial and competition-related reasons set out should again be seen here against the background of the relevant starting position for the service provider, e.g. in the cases of pharmacists, healthcare professionals, psychotherapists, pension funds and rehabilitation facilities. The basic starting point here is the improvement of the market and sales situation through closer integration with medical services provision and a greater emphasis on service at the patient level (9, 12, 17).

Procedural improvement

The professions are becoming increasingly specialized – which sometimes means problematic new points of intersection for patients. This tends to lead to further fragmentation of patient care and of the roles of the professions. However, disruptions in care and unnecessary waiting times do not result only from the pressure to rationalize and reduce costs but also from the fact that measures could be better coordinated (9, 12, 17).

Conclusion

In a comparison between the standard MCC/partnership and the practice clinic model, one can see that these are very different structures. Of interest are structures where both forms can be integrated within a single enterprise.

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Opinions of Caring Professionals on Satisfying of Spiritual Needs in Palliative Care

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Abstract:

We have identified healthcare professionals as assessing spiritual needs, comparing respondents' answers and finding differences. The investigated sample contained 447 respondents (nurses and other people delivering health care service). We used the anonymous SNAP questionnaire method. The data obtained were processed using one-dimensional

descriptive statistics. We have statistically tested the hypotheses of our research using inductive statistics in IBM SPSS Statistics 20 (Statistical Package for Social Sciences). For the influence of independent variables on dependent variables, one-factor scattering analysis in the form of a One-Way ANOVA test was used as part of the parametric tests. To determine the correlation coefficient we used a parametric test in the form of a Bravais-Paerson Test.

According to the answers, the average score in the domain of psychosocial needs was 3,24922 and in the spiritual needs domain 3,22836. In assessing the relationship between gender, age, occupation, practice, religion, and spiritual judgment, we have been shown to have a linear relationship. We are proposing to continuously increase and supplement the knowledge of health professionals by attending seminars and training on spiritual needs and current trends in their assessment.

Introduction

Human life can be seen as a set of events that are closely interconnected; that change and influence people throughout their lives until death. However, the dying period and death continue to be a taboo in society today. Men are the only living creatures aware of their mortality, which is accompanied by anxiety, fear and uncertainty. The 21st century with its rapid development in the field of medicine has also contributed significantly to a negative perception of life. As people lost contact with primary events of life, they got a false feeling that death doesn't concern them. Care for a dying person is a very responsible and demanding job. The process of dying means decompensation, gradual weakening and emotional pain.

In situations where the treatment is ineffective, palliative care seems to be one of the humane alternatives. The purpose of palliative care is to ensure for those who, unfortunately, can no longer be helped by modern medicine, at least high-quality of their last moments of life. Satisfaction of needs also contributes to adequate quality of life of the terminally ill. In addition to biological needs, spiritual needs also dominate in the life of a dying person.

Palliative Care

Palliative care has indivisible medical-social inter-sector dimension, and that is why we are here also looking for ways of its meaningful implementation in the services for the individuals reliant on social assistance. This is a modified definition of palliative care by the World Health Organization from 2002: "Palliative care is understood as an approach that improves quality of life of the patients and their families facing the problems associated with life threatening illness by means of prevention and relief from pain, achieved through assessment and treatment of pain and other problems of physical, psychosocial and spiritual nature" (Frankl, 2010). This is achieved through its early detection, correct and perfect assessment, treatment of pain and other physical, psychosocial and spiritual problems (Munzarova, 2005, p. 61-62). A palliative approach respects all needs of a dying person which are significantly different from those of a patient with a favourable diagnosis. Family is an important part of this. It can effectively help the patient, particularly with the emotional state. However, family also needs care and receives this care during the end of life assistance of the patient as well as after patient's death (Haskovcova, 2000, p. 36-37).

Spiritual Care

Humans are bio- psycho- social- spiritual beings. Besides natural needs, humans have the need for the supernatural, because they are spiritual beings. Definition and specification of the word spirituality is difficult, as spiritual dimension is not based on rational thinking and cannot be strictly proved. Spirituality is the object of study of several fields: philosophy, theology, psychology, social work, **nursing**... Its interpretations in the mentioned fields are different.

In philosophy, spirituality refers to the existential attitude of a person, overall experience related to the transcendence sphere which can be religious or non-religious (Strizenec, 2005).

In theology, it includes belief in God, a higher power (Hamer, Copeland, 2003). In relation to psychology of personality, spiritual dimension of a personality transcends mundane life and opens to formation of characteristics such as love, responsibility, foresight, wisdom, serenity and nobility. In **nursing**, the most comprehensive definition is the one by Farsky *et al*. (2010, p.34) ... „*spirituality is a universal dimension of the human existence, and it reflects experience and expression of the human spirit in a unique and dynamic process. Spirituality integrates, develops and strengthens a person, family, community, and enables and gives strength for finding of a meaning and purpose in life, finding of hope, forgiveness, even in the time of crisis, illness or expectation of death. Culture, religiosity or historical context are not conditions to religiosity, but they might affect how spirituality of a person, family, community is manifested externally in everyday life".*

Spiritual needs are a part of human personality, they are classified in the category of higher needs. They are divided into three basic areas, which are:

- needs related to self-awareness (need for hope, love, purpose and meaning of life, etc.),
- needs related to others (need for forgiveness, acceptance of the loss of love, respect from others, etc.),
- needs related to the absolute (need for certainty of God existence, belief, etc.).

In the provision of nursing care, assessment is a complex bio-psycho-social-spiritual evaluation of the patient; respects all particularities of age; focuses on the needs that have been modified or added due to age and illness. The needs are identified using formal (questionnaires, structured interview); informal tools (patient observation, verbal and non-verbal communication); as well as information about perception of the illness by the relatives.

Obtaining of spiritually history is also important- most frequently through a discussion about one´s belief and life values (Buck, McMilan, 2012). Spiritual needs may not always be associated with life satisfaction, but sometimes with anxiety, and can be interpreted as a patient's desire for spiritual well-being. The need for peace, health and well-being are universal human needs and are particularly important for patients with long-term illnesses (Kober, 2015).

In order to identify spiritual needs of a patient, the nurse should have long-term contact with the patient and form a relationship of trust with the patient. In the environment of the Slovak Republic, in practice we most frequently use informal tools - we obtain the information through dialogue and observation. A dialogue on these subjects usually takes place only after the nurse has gained the trust of the patient and the patient is sure that he/she is understood.

Clinical assessment of spiritual aspects of a patient focuses on identification of impaired or non-functional spirituality, the reasons for which are related to self-image and self-evaluation. It is necessary to identify patient's

concerns, reasons for those concerns, and how we can help the patient cope with them. A valuable source of information can be observation of patient's behaviour. Whether the patient prays before meals or at another time; frequent feelings of sadness; whether the patient has sleeping problems; speaks inappropriately; expresses anger". "What have I done to deserve this?" Sudden change of routine, of patient's behavior, tells us about patient's spiritual distress. Attention must be paid particularly to expressions of self-blame and to understanding of the illness as punishment. Of importance is also information about patient's goals and expressions of belief. When assessing religiosity, mature attitude can be indicatively defined as full acceptance of the content of a religious belief and action based on that belief.

We identify support systems and their importance for the patient. We also focus on the relationship of patients with their fellow patients, nurses and other medical professionals.

The assessment also includes information about the current medical condition. We evaluate whether the illness is acute or chronic; the stage of the illness; its prognosis. Of high importance is to assess patient's informedness; expectations; emotional state; patient's interpretation of the illness. We also assess patient's own activities and options in dealing with the difficult situation. We also focus on obtaining information about the patient's experience and on expressions of moral distress and conflict.

Assessment of Spiritual Needs in Clinical Practice

In the previous text we presented the possibilities of assessment of spirituality and spiritual needs in terminally ill patients. We wanted to know how medical workers in **the Slovak Republic and the Czech Republic** see the spiritual needs of patients, how much the patients need help and what differences are there in respondents' assessments.

Methodology and Description of the Research Sample

The empirical study was carried out in the form of applied research in medical care facilities. The research was carried out in the period of 2016 - 2017. On the basis of the established objectives, we chose the empirical method of data collection – questionnaire **The Spiritual Needs Assessment for Patient (SNAP)** constructed by R.K. Sharma. (Sharma, 2012), which made it possible to objectively illustrate the reality of the studied indicator. The questionnaire was distributed on-line via links on one Slovak and one Czech website. The research sample consisted of 447 respondents.

We processed the collected data into an MS Excel 7.0 spreadsheet and we carried out first level classification. When analysing the research data, as the first step we processed the collected data using the method of one-dimensional descriptive statistics (one way ANOVA). After the classification we calculated the absolute and the relative frequency and we created frequency spreadsheets for the observed indicators. The statistical processing was carried out using inductive statistics. For further processing of the collected statistical data and its subsequent use in verification we used other statistical methods, such as: analysis of variance, correlation, multiple range analysis, t - statistical test, ANOVA. For the actual calculation and presentation of the results in this work we used statistical software Statistica in the version X.

Research Sample

The research sample consisted of 447 respondents providing care for patients in a medical care facility at the time of the research. Of the total number of respondents in the research

sample, the most represented group, with respondent number of 400 (89.46%), was the group of female respondents. Male respondent number was 47 (10.49%). Of the total number of the respondents, 84.34% (377) were nurses. Other medical professionals were represented in the research sample in the number of 15.66% (70), of which the largest representation was that of paramedical personnel 6.26% (28). The largest representation of 183 (40.55%) was that of nurses and medical professionals in the age category of 35-44. The largest representation of 144 (32.21%) was that of nurses and medical professionals with experience of 10-21 years. Of the entire research sample of 447 respondents, 342 (76.51%) claimed to be religious. Other characteristics of respondents are in the tables 1-3.

Table 1: Age of respondents

Age category	absolute number n	percentage %
25-34	127	28.43
35-44	**183**	**40.55**
45-54	105	23.55
55-64	32	7.47
Total number	**447**	**100**

Table 2: Length of respondents' professional experience

Length of professional experience	absolute number n	percentage %
less than 5 years	60	13.42
5-9 years	69	15.44
10-21 years	**144**	**32.21**
22 to 31 years	115	25.73
over 31 years	59	13.20
Total number	**447**	**100**

Table 3: Religion of respondents

Religion	absolute number n	percentage %
religions	**342**	**76.51**
non-religions	49	10.96
atheists	16	3.58
agnostics	5	1.12
No response	35	7.83
Total number	**447**	**100**

Result Analysis

The results obtained in the questionnaire are demonstrated in the form of table. The individual questionnaire items were answered by all 447 respondents. The variation range of the answers was from the maximum of 4 to the minimum of 1 (4= a lot, 3= a little, 2= little, 1= not at all).

In the domain of psycho-social needs we were interested in patients' need for assistance. The respondents' answers in the individual items were in the range from 4 (patient needs help a lot) to 1 (patient doesn't need help at all), the highest average number 3.4 (patient needs help a little) was found when asking about sharing of thoughts and feelings with friends and family and about concern for the family, which indicates strong attachment of patients to their friends and family. More detailed description in Table no. 4.

Table 4: Psychosocial needs n 447

	average	SD	maximum	minimum	variance	absolute deviation	SD
A	3	3	4	1	0.70	0.6	0.84
B	3.1	3	4	1	0.66	0.6	0.81
C	3.3	3	4	1	0.51	0.6	0.71
D	3.4	4	4	1	0.52	0.6	0.72
E	3.4	4	4	1	0.51	0.6	0.72

Legend: a- connection with other patients with the same illness, b- relaxation and stress management, c- learning to cope with sadness, d- sharing of thoughts and feelings with friends and family, e- concern for the family

In the domain of spiritual needs, the answers were in the range from 4 (patient needs help a lot) to 1 (patient doesn't need help at all). We found that patients need a little help with looking for meaning in the illness experience, with looking for hope and overcoming fear, where the highest average value was 3.5 (patient needs help a little to a lot). A more detailed description of the individual items is in Table no. 5.

Table 5: Spiritual needs n 447

	average	**SD**	**maximum**	**minimum**	**variance**	absolute deviation	**SD**
a	3.5	4	4	1	0.47	0.6	0.68
b	3.5	4	4	1	0.44	0.6	0.66
c	3.5	4	4	1	0.42	0.6	0.65
d	2.9	3	4	1	0.67	0.6	0.82
e	3	3	4	1	0,70	0.6	0.83
f	3.1	3	4	1	0.68	0.6	0.83
g	3.2	3	4	1	0.45	0.6	0.67
h	3.3	3	4	1	0.63	0.7	0.79
ch	3.4	4	4	1	0.58	0.7	0.76
i	3.4	3	4	1	0.49	0.6	0.70
j	3	3	4	1	0.72	0.6	0.85
k	3.,2	3	4	1	0.78	0.7	0.89
l	3	3	4	1	0.75	0.6	0.86

Legend: a- looking for meaning in the illness experience, b- looking for hope, c- overcoming fear, d- personal meditation or prayer, e- relationship with god or something bigger than myself, f- becoming closer to the community which shares your spiritual beliefs, g- coping with any kind of pain, h- meaning and purpose of life, ch-death and dying, i- looking for peace, d- correction of old conflicts, pain, family grudges or grudges between friends, j- looking for forgiveness, k- making decisions about the treatment that are in accordance with your spirituality and religious belief.

In Table no. 6 we present the score in the psychosocial and the spiritual domain. We found that the average answer in the domain of psychosocial needs was 3.24922 and the median answer value was 3.33 (patient needs help a little). The answers were in the range from 1 (patient doesn't need help at all) to 4 (patient needs help a lot). The average answer was 3.22836 and the median answer value was 3.30, patient needs help a little.

Table 6: Needs – score n 447

Needs	average	SD	maximum	minimum	variance	absolute deviation	SD	Median
Psycho-social	3.24922	3.4	4	1	0.31	0.45562	0.56	3.33
Spiritual	3.22836	3.31	4	1	0…2	0.448767	0.56	3.30

On the basis of the statistical processing of the results we present how sex, age, occupation, experience and religion are mutually related in the assessment of patients' spiritual needs. When comparing the assessments of patients' needs we examined whether there is a statistically significant relationship between assessment of patients' needs and the individual variables. For the identification of the relationship we used Bravais-Pearson correlation coefficient. This correlation coefficient is the degree of strength of linear statistical dependency of two numeric variables. We set the statistical significance level to 0.01 error probability and we used it to compare the achieved statistical significance. We found that there is a statistically significant relationship ($P<0.05$) between sex and age of the respondents and between religion and the length of experience. Statistically significant relationship ($P<0.01$) exists between sex and occupation, length of experience and religion, between length of experience and sex, age and occupation. The score of assessment of psychosocial needs and the score of spiritual needs showed a significant relationship ($P<0.01$) (Table no. 7).

Discussion

The purpose of palliative care is to ensure the highest possible quality of life; to respect and protect dignity of terminally ill patients; to thoroughly base the care on wishes and needs of the patients as well as to protect and respect the patient's family. Good quality care must include complex perception and satisfaction of needs of patients and their families. Palliative care includes not only medical care provided by a doctor, but also provision of nursing care, rehabilitation, mental health care, spiritual care and social counseling (Sláma *et al.*, 2007).

Spiritual care should be a lot more conscious and purposeful part of the role of a large assistance team (Faull et al., 2012).

The main objective of the work was to examine how medical professionals in the context of nursing care assess spiritual needs of the patients. Assessment is a complex bio-psycho-social-spiritual evaluation of the patient, it respects all particularities of age and it focuses on the needs that have been modified or added due to age and illness. It requires a long-term contact with the patient and establishment of relationship of trust. Hermann (2007) states that nurses/medical professionals must recognize the importance of spirituality and religiosity for the patient, and only assessment of specific spiritual needs can lead to planning of interventions for their satisfaction.

We found that, within the psychosocial domain of spiritual needs, what patients need the

Table 7: Relation with the categorizing items (Pearson Correlation) n 447

		Sex	Age	Profession	Practice	Religion	Score A	Score B
Sex	Pearson	1	-.114 *	.228**	-71**	145**	-.70	-.72
	Sig.		.015	.000	.000	.002	.138	.128
Age	Pearson	-.114 *	1	-.008	.656**	.018	.036	.052
	Sig.	.015		.868	.000	.97	.444	.275
Profes-sion	Pearson	.228 **	.008	1	-.161**	-.009	-.035	-.033
	Sig.	. 000	.868		.001	.854	.462	.481
Practice	Pearson	-.171 **	.656 **	-.161**	1	.114*	.037	.043
	Sig.	.000	.000	.001		.016	.430	.365
Religion	Pearson	.145 **	.018	-,009	.114*	1	-.068	-.079
	Sig.	.002	.697	.854	.016		.148	.094
Score A	Pearson	-.070	.036	-.035	037	-.068	1	.600**
	Sig.	.138	.444	.462	.430	.148		.000
Score B	Pearson	-.072	.052	-.033	.043	-.079	.600* *	1
	Sig.	.128	.275	.481	;365	.094	.000	

Legend: ** Correlation is significant at the 0.01 level (2-tailed).
* Correlation is significant at the 0.05 level (2-tailed).

most help with is sharing of ideas and feelings with their friends and family and concern for the family (average answer 3.4), which indicates strong attachment to friends and family. The total average number in the psychosocial needs domain was 3.24922, the answer median value was 3.33. For the patient it is important to have social contact, support, interest by the personnel, adequate communication and information (Lukackova, 2012). Quality assistance can be provided by someone who is ready for this role, who has an understanding of their own mortality (Moraucikova, Lazarova, 2015).

With regard to assessment and satisfaction of needs in the spiritual needs domain, patients need a little help to a lot of help with looking for meaning in the illness experience, with looking for hope and with overcoming of fear (the average of 3.5). The average answer was 3.22836 and the median answer value was 3.30. When patients need to create the conditions for coping with matters of their inner world and they cannot do it on their own, we must help them. To call the person they need - sometimes it is friends and family, sometimes a spiritual teacher or a mental health specialist. An accompanying priest helps with his presence and listening. He reflects the values he supports in his own life (Hatokova et al., 2009). A dying person with fulfilled spiritual needs and resolved spirituality is poised and has a peace of mind, has no conflicts with others, is able to accept the pain and suffering, has come to terms with death and exudes harmony and hope (Malikova, 2011).

In the process of disease and dying, staff and patients are brought into interaction. In

today's modern nursing care, high emphasis is placed on the quality of care provision and humanization (Andrasi *et al.,* 2017). In order to be able to effectively identify patient's spiritual needs, medical professionals need to have sufficient experience and relatively good basic knowledge in the field of psychology, ethics, communication and theology as well as personal interest in people. There is a statistically very significant relationship between sex and occupation, length of experience and religion, between length of experience and sex, age and occupation. The score of assessment of psychosocial needs and the score of spiritual needs also showed a very significant relationship (Table no. 7)

Assessment in palliative nursing care is a systematic and continuous collection of data of patients (family, friends) with a terminal, time-limited illness, their ability to carry out everyday activities, the effect of pain and other symptoms on satisfaction of biological, psychosocial and spiritual needs, patient's (family's) expectations and support possibilities. It must be continuous and dynamic in view of the patient's condition, progress of the illness and sudden changes, age, current medical condition, personal characteristics, value preferences, social background of the patient (of the family and friends) (Nemcova, 2013). According to Svatosova (2012), a situation may occur where it is too late and we are the only witnesses to patient's spiritual distress, terror and fear of the end.

Conclusion

In the same way as birth, dying is also an integral part of our life. We must realize that dying doesn't only affect biological aspect of life, but also psychological, social and spiritual dimension of a person.

Palliative patient care has recently undergone big changes which respect the natural needs of patients. Our aim was not to judge the work of the nurses and of other medical professionals at the patient care department, but to support improvement of the quality level of assessment and satisfaction of spiritual needs as part of the care. On the basis of the research results, studied publications and our own experience, we would like to propose to continuously increase and expand the knowledge by attending seminars and training on the topics of spiritual needs and taking of spiritual history, to provide information related to current trend development in the assessment of spiritual needs, and to consider financing of courses on accompanying of a dying person organized for nurses and other medical professionals.

Our behavior and the overall approach play a significant role in the quality of a dying patient's last day's experience. Apart from being professionals, we are also people, and those coming to us, apart from being patients, are people too.

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The Same Question: Are Migrants from the Middle East to Greece Carriers of Resistant Bacteria? In 2015, the Answer was No, but in 2019 it is Yes (Letter to editor)

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Abstract:

In 2015, the surveillance cultures from respiratory tract and wounds in migrants and refugees to Greece showed only few strains of multi-resistant bacteria. In 2019, about 33-40% of all isolates were multi-resistant to several antimicrobial agents, however the majority of refugees in 2015 (90%) were from Syria and Iraq, but in 2019 the majority are from Afghanistan (40%) and Sub-Saharan Africa (60%). Longer travel, bad travel and housing conditions following by frequent respiratory and intestinal infections cause overuse of oral and OTC (over the counter) antibiotics resulting in resistance (MRSA ESBL but also KPC).

To the Editors,

In 2016, two papers in Clinical Social Work and Health Intervention (1,2) showed that cultures obtained from migrants from Turkey to Greece and transiting in UNHCR Camps in Greece (Alexandria, Veria) showed an absence of resistant bacteria like MRSA or ESBL. Only less than 5% available ATB were resistant to the migrants (1,2).

Therefore in the summer of 2019 we performed random screening of respiratory and wound isolates of those arriving at the new (2016) UNHCR camp on Lesbos Island in Greece. Results showed a very different situation in phenotypes of isolated bacteria.

While in 2015, MRSA (Methicillin resistant *S. aureus*) and ESBL-producing multi-resistant *E. coli* and *Enterobacteriace*, and *Pseuromonas aeruginosa* and Acinetobacter baumanii (PA and ABBA) were exceptional and represented less than 10% of isolates. *Candida* was the commonest isolate. In 2019, the commonest isolates were *Moraxella catarrhalis* (all ampicillin resistant (MOCCA); followed by ESBL (extended spectrum betalactamase producing); *Enterobacteriaceae*, including two KPC producing pan-resistant EC and ABBA. In addition there was a dramatic decrease of Candida spp and an increase of multi-resistant *S. aureus* and Enterobacteriaceae. This phenomenon was observed in isolates from 2019 with an increase representation of so called marine or environmental pathogens such as *Stenotrophomonas maltophilia, Aeromonas hydrophila, S.gallinarum* - all related to soil and water exposure during long migrations.

Trying to explain this dramatic change which may have great impact in 2020 on screening policy, again need to search for MR bacteria in addition to HIV HBV HCV and TB. We analyzed the origin of refugees and migrants and time (distance) of travel. Data on travel and nationality in 2019 in contrast to 2015 showed that while in 2015 more than 90% were from Syria and Iraq, in 2019, majority (about 75%) are

Tab 1: Comparison of ATB resistant phenotypes in respiratory and wound isolates from refugee camps in Greece in 2015 (Veria, Alexandria) versus 2019 (Lesbos)

Organism type	2015(Veria,Alex)	2019(Lesbos)	significance P
No of isolates tot	101	98	ns
MOCCA AMP-R	12	21	0.045
MRSA multi R	4	8	0.041
MSSA suscept	12	6	
H.influenzae	6	1	
S.gallinarum	0	4	
StrPyogenes ERYR	2	5	
Enteriobact ESBL	1	2	
Enterobac.Sucept	16	8	
Candida spp	21	1	0.0002
Ps aeruginosa	5	4	ns
Acinetobacter spp	2	4	ns
Str pneumoniae	8	1	
Streptococcus NP	8	10	
marine org.	0	4	0.045
other/negatives	4	19	

from Afghanistan and Sub-Saharan Africa, where the spectrum of infections is very different, and the distance and the duration of travel is significantly longer.

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Suicide and Society: The Sociological Approach

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Abstract:

Suicide is a worldwide issue with an increasing trend. Suicidal behavior and tendency to this behavior are becoming a part of postmodern humanity. This paper focuses on an analysis of the issue of suicide based

of sociological theories of suicidal behavior. These we divide based on the most influential work devoted to this issue *Suicide* from Émile Durkheim. The common denominator of the above mentioned authors is that they have conceived suicide as a social phenomenon conditional to the level of social integration of individuals to society. We work with a hypothesis that suicide is an individual act which is carried out as a result of social factors and that suicide can be studied as a social phenomenon.

Various transformations in modern society today offer the main context in which to study the phenomenon of suicide. These transformations affect all areas of social life: culture; politics; values; lifestyle; consumption models; stratification; education; mobility. There is not a single area exempt from the transformation processes linked with modernization, globalization, and transition from the communist system to the post-communist one. The Europe of today has been experiencing considerable turbulence extending to all aspects of social life. Regardless of the political situation dominated by the political elite exercising rather vulgar and despotic forms of democracy, we are predominantly interested in processes within the cultural and religious subsystems of society. We consider these subsystems to be pillars of stability and integrity of society as a whole. Therefore, every attack to weaken cultural and religious capital leads directly to the disintegration of the whole system. The nature of the second demographic transition has brought profound changes in value orientations and moral attitudes of today's society. In the microspace of an individual it has become increasingly difficult to create one's own identity; answer fundamental existential questions; or create a meaningful horizontal and vertical world of relationships and coherent support system. Instead of an individual's identity being formed in the process of primary and secondary socialization, it is often deformed, having been influenced by de-socialization of family, school or peer environments. Mesospace of a community life has also suffered consequences caused by the lost community (*Gemeinschaft*) and modernization processes of the industrial and post-industrial society (Kardis, 2012).

Sociological Theories of Suicide

With the evolution of sciences in the Modern Age interest in suicides shifted from the religious and philosophical positions to the humanitarian sciences and medicine. Since 19th century we can talk about factual research of suicide in Europe. With development of sociology scientists stopped looking at suicide as an individual (psychological) phenomenon but as a phenomenon which resulted from interaction of the individual and his or her social environment. Since the 1970's interest of sociologists has been renewed but by the end of century research shifted to the field of medicine and general health (Douglas, 2015). Sociologists Wray, Colen and Pescosolid consider Durkheim's *Le Suicide Etude de Sociologie* from 1897 to be a fundamental work of sociological interest in suicide. Based on that work they divide research of suicides to three chronological periods:

- Pre-Durkheim's approach
- Durkheim's work
- Post-Durkheim's approach (Wray, Colen, Pescosolido, 2017).

This paper used this approach in analyzing of sociological approach towards suicides.

Pre-Durkheim's Approach

American Sociologist Richard Sennet claims that the view of the modern world on suicides is the result of Durkheim's work, but there had to be other concepts upon which Durkheim built his work. By the end of 19th century European intellectuals dealt with issues of rising suicide on national levels. They found this was because of the breaking bonds with the agrarian way of life and the rise in one's personal freedom. (Veit, 2017). I will devote this chapter to understanding of suicide in works of Italian Psychiatrist Henry Morsellini and first president of Czechoslovakia Republic Tomas Garrigue Masaryk.

In 1882 Morselli published his work *Suicide: An Essay on Comparative Moral Statistics*, in which he analyzes statistics of suicidal behavior in Europe and United States since beginning of 19th century. He concludes that the number of suicides increases faster than geometrical progress of natality and mortality. It is interesting that as a psychiatrist he was looking for causes of suicide in society that surrounds a person but he refused any psychological base for suicidal behavior. Into his thesis he applied *Social Darwinism* and survival of the fittest - modern man *fights* with his mind but modern age may confuse a person's judgment and that's when he feels weak and abnormal. Morselli claimed that suicide was a social-physiological phenomenon and not pathologic because it is part of society from birth. As prevention of suicidal behavior Morselli proposed development of correct thoughts which will help us reach our goal in life and reconsolidation of moral character (Wray, Colen, Pescosolido, 2017).

Except for political events Tomas Garrigue Masaryk was interested in sociological studies: In 1878, in Wien he vindicated his habilitation thesis *Suicide as a Social Mass Phenomenom.* It was his first scientific work and its aim was an analysis of suicide from sociological and religious-ethical points of view. Masaryk had seen a connection between an increase of suicide and crisis of modern society and claimed that suicide as a work of education, progress and secularization. Masaryk understood suicides in relation to happiness and unhappiness in human life hence it is the result of losing one's purpose of life and is a manifestation of desperation. Masaryk also worked with Darwin's theory of natural selection where mentally weaker individuals are losing the social *fight*. When dealing with the relation between religiosity and suicide Masaryk maintained the opinion that there was a higher number of suicides among Catholics than Lutherans. Masaryk saw a result in more liberal attitude of Lutherans towards modern age than strict Catholicism. As a tool of prevention for suicidal behavior Masaryk proposed a return to a religious life (Masaryk, 2002).

Durkheim's Work

Sources of Durkheim's philosophy can be found in philosophies of Rousseau, Montesquieu and in theories of August Comte. But Durkheim's work is special because his theoretical knowledge has been applied by him in sociological practice and thanks to this the develop-ment of this scientific discipline occurred. The practical side of sociology is elaborated in his work *The Rules of Sociological Method* where he denotes the term *social fact*:

"Therefore these are forms of dealing, thinking and feeling that have remarkable character that they exist outside of individual consciousness. These forms of actions or

thinking don't just exist outside of individual but they are also gifted with imperative and suppressive power with which they intrude themselves upon him whether he wants it or not. Stress is an important sign of these phenomenaand proof of this is that it manifests itself right when I attempt to resist." (Durkheim, 1926, p. 36).

Social facts are different opinions, approaches, attitudes, tendencies in society that influence humans with different intensity; while some direct him towards family life others can make him commit suicide.

As we have mentioned earlier, in 1897 Durkheim published *Le Suicide* in which he specified his theoretical knowledge from *The Rules of Sociological Method*. He offered the hypothesis that even if suicide seemed like an individual phenomenon it was the result of an impact of social facts hence collective factors. His publication was supported by extensive statistical data of suicidal behavior in Europe and proved that suicide was the result of social background of a given country. Based on his research he defines four types of suicide according to an individual's integration to the society.

"At each moment of its history, therefore, each society has a definite aptitude for suicide." (Durkheim, 1951, p. xlv)

The first type of suicide according to Durkheim is *egoistic suicide* which we talk about when a human is not able to integrate him or herself into a society or a group. Durkheim points out specific examples of how collectively lived religiosity significantly reduced levels of suicide. Religion had a beneficial impact not because of the specific nature of religious conceptions. Religion protects humans against self-destruction via tenets of protection and respect of one's own life but the most important feature here is society. Society advocates a collective state of mind, supports the existence of faith and mutual practices. The stronger collective values are the stronger protection of tenets was hence protection of life. But the very contents of tenets are secondary. Integration of a person to society and awareness of collective life are important in prevention of suicidal behavior (Durkheim, 1951). Nowadays, a sad example of egoistic suicide are victims of cyber harassment who are humiliated and subsequently suppressed of social life with peers via social networks. The feeling that they don't belong anywhere is obstructing them to talk about their problems with an adult (or any other competent authority) and the only solution they see to social suppression is suicide (The Roadrunner Theorist, 2017).

As the old saying goes "*too much of a good thing" the* same rule applies to the level of integration of humans to society. If she or he was bonded to a group in very unhealthy way and her or his existence only had meaning in connection with the group social pathologies occurred. In our case the result is *altruistic suicide*. A person was so hinged on the group that he was willing to take his own life for the group (Durkheim, 1951). As an example we can mention Sect Davidian or Peoples Temple (Vojtisek, 2010). We will work with the term altruistic suicide in the next chapter where I discussed closer Islamic suicide bombers.

The third type of suicide is called by Durkheim *anomic* which originates as the result of the decay of social values and norms in a given society. This violation of social harmony was manifested by crisis or prosperity one way or the other the result was loss of clear rules for lives of individuals. A person did not know how to behave; what rules to follow; feelings of desperation occurred. Suicide was the result of feeling of being left by society which makes no sense to him (Durkheim, 1951). Anomia also occurred in society as a result of natural catastrophes

after which a person lost literally everything and is not able to start again. Even if the society itself did not change a person's living environment and sub-sequential view of the world was devastated. An example can be the study of the *Centrum for Mental Health and Welfare* in Japanese city Sendai which was built three years after the devastating earthquake in Japan in 2011 (Sendai city mental health and welfare center, 2017).

The last type of suicide, according to Durkheim, is *fatalistic suicide* which he saw was caused in a society which oppresses individuals with too strict rules. That individual had the feeling of powerlessness because he knew he could not change any order of society by his actions and therefore chose the last fatal act (Durkheim, 1951).

Post-Durkheim's Approach

Sociological study of suicides continued after Durkheim's work and in 1930 French Sociologist Maurice Halbwachse published the study *Les causes de suicide* deepening Durkheim's conclusions. In 1933, Luise Dublin introduced a significant statistical work

To be or Not to be: a study of Suicide. In 1947, Dr, Gabriel Deshaiese denied sociological determinants in his paper *Psychologie du suicide*. He defined mental illnesses as a main cause of suicide. Ten years later, American Psychiatrist Donald Jackson connected psychological and social determinants as factors of suicidal behavior in the same way as Andrew Henry and James Short do in their study *Suicide and Homicide: some economic, sociological and psychological aspect of aggression* (1954). In 1968, Austrian Psychiatrist Walter Pöldinger published the study *Die Abschatzung der Siuzidalitat* where with help of statistical data (Wray,Colen, Pescosolido, 2017). He analyzed the issue of suicide from sociological, medical and psychological views.

In present millennium suicides entered into popular literature through the work of French Journalist Martin Monastier in the book *History of suicides* which presents comprehensive publication of willing death in history of humanity. The most up-to-date comprehensive scientific publication was published in 2013 at the conference *Suicide in Eastern Europe, Commonwealth of Independent States, and the Baltic countries: Social and Public Health Determinants.*

How objective can sociology be under the influence of totality?

I can't describe that objectively. The fact is that in his 1969 article *Developmental Tendencies of Czech Sociology* published in the *Czech Sociological Magazine* at the end Karel Gall says:

"It is understandable that for Marxist Sociology that is based on the philosophy of dialectic materialism idealistic philosophical conceptions cannot be relevant which Czech sociology depended on- with the exception of few Marxist Sociologists." (Galla, 2017)

Sociological Magazine published a review of the book *Suicidality in Czechoslovakia from a demographic and sociological perspective* by Ladislav Růzicka which stated that in Czechoslovakia there were two forms of suicide data *Demographic Statistic* and *Ministry of Health*. In the article, the Reviewer concludes that *"even in Soviet Union techno-economical and subjective aspects theft occurred."* (Potuzil, 2017). We must acknowledge to our comrades that they even admitted the possibility of the existence of suicide in the Soviet Union. Even though we must count with propagandistic adjustment of data of suicide in the countries with Communist Governments.

The most available statistical source of suicides in Slovakia after the creation of

the Slovak Republic is the National Centrum of Health Information. Relating to scientific studies in 1994 Czech Psychologist Josef Viewegh published *Suicide – a Psychologist's Perspective* and subsequently in 1996 *Suicide and Literature* in which he is views suicide in terms of centuries and adds samples of historical literatures. In 2001, Hana Vykopalova published *Socio-pathological Phenomena in Modern Society*. A significant work is the monography *Suicidality in the Population of the Czech Republic in the Period of Social Transformation* published by the Charles University in Prague containing valuable demographic and statistic indicators.

In 2007, a paper *Suicidal Behavior* was published by Clinical Psychologist Jana Kocourkova and Psychiatrist Jiri Koutek. Their research focused on the clinical view of suicidal behavior but they also gave therapeutic steps of prevention of this pathologic phenomenon in society. The topic of suicide reached research of science of religion in bachelor thesis of Anna Melanova from *Institute of Science of Religion of Masaryk University* in Brno. Her paper *Suicide in the Ancient and Medieval Christianity from a Theological Perspective* from 2011 analyzed sources of the Christian view on suicide; the view on noble death; views of the fathers of Church on suicide.

Suicide is a worldwide issue with an increasing trend. 28 countries of the world do have in process national strategies of suicide prevention that are focused mainly on prevention in the sphere of Mental Health. For suicide prevention to be successful there must be inter-disciplinary cooperation which includes medical and social situation of people. In the context of Slovak Society, desocialization takes on various forms and has many expressions within social, political, and cultural environments. A prime example of Slovak desocialization is the disintegration of the family. Sociological surveys confirm that the social disintegration in present day Slovakia reflects an ever-increasing secularization, and family life illustrates this truth in many ways. Three important examples are 1) the increased availability and effectiveness of contraceptives, 2) the weakening of informal cooperative norms which create social capital, and 3) the decrease in the number of marriages. These indicators attest that the disintegration of family life is a consequence of the shift in values toward a postmodern, individualistic culture. It is quite troubling that Slovak Society – not to speak of Western societies at large – has succumbed to postmodern ideals in which the values of individualism take precedence over the values of altruism (Fforde, 2010).

The Anomic Society in which we live individualizes and a person can choose who he or she is going to be and where will each belong in the pluralism of ideas. Since nothing is right nor wrong there is no table point in the time of crisis. Suicidal behavior and tendency to this behavior are unfortunately becoming part of postmodern humanity. Despite that in Slovak Society the taboo exists towards suicides there is no common discussion and suicides are pushed to the edge of interest and are being called *mad men*.

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For the Definition of the Methodology of Nursing Education

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Original Article

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Abstract:

This paper addresses the competencies of clinical nursing educators that are necessary to form and develop the set of knowledge and skills key to successfully performing this role. For the purpose of this paper, attention is focused on the important link of competence assessment and teacher performance evaluation with the introduction of a qualification framework in tertiary education institutions, where educational outcomes are characteristically oriented towards the student. The fol-

lowing is a presentation of our own quantitative research, which was carried out in the form of a self-evaluation questionnaire survey of 71 respondents - graduates of the certified course at the 2nd Faculty of Medicine and at the Motol University Hospital, and 38 respondents who completed the certified course in other accredited facilities. In terms of knowledge and skills, the self-evaluation of mentors has produced positive results. Mentors feel well prepared to perform their roles and apply the required knowledge and skills in practice. At the same time, there were differences discovered in the ability to implement certified courses that were supported by either a pedagogical mentoring model or a supportive mentoring model. This paper also includes selected results of the questionnaire survey, which can become an empirical basis for a wider debate on the concept of mentoring in the Czech Republic, and thus for the adjustment of relationships and competencies related to mentoring in nursing, as well as for further improvement of the educational programs of all types. The purpose of this paper is to point out the necessity of educational outcomes, which results from the considerable variability of certified courses.

Introduction

In the last 25 years, we have seen a number of changes throughout society that affect the nursing profession and its professional training. Currently, however, valid legislation requires that students be prepared to participate in the provision of specialized and highly specialized nursing care. A key task in the field of education is to educate a Nurse who is able to actively put theoretical and practical knowledge and skills into practice. It is also necessary to prepare graduates for postgraduate and lifelong education in health care.

The current model of practical nursing training, which largely consists of direct nursing apprenticeship by an educator who is the source of knowledge for students, is inadequate and ineffective because it is to a large extent limited by the ability of educators to reach the appropriate level of specified knowledge and skills in several clinical disciplines at the same time so that nursing practice can be carried out at the highest possible professional level, especially in faculty-type health care facilities where highly specialized diagnostic, treatment and nursing care is provided. The earlier model of practical training limits its content to basic nursing care; which is inadequate due to the current requirements for graduates of the qualification study; thus is essential that nurses with appropriate clinical specialization are provided with practical training. For nursing, it is also true, as stated by Matulnik (2009, p. 13), that: *"Science is understood to mean: an institutionalized human activity aimed at the methodical creation of a system of new truthful knowledge, of individual realms of reality, which is expressed in specific terminology and whose purpose is to describe, explain and predict phenomena in given study areas. Theoretical scientific knowledge gained through cognitive activities and achievement through methodical work. It is a multidisciplinary subject with a theoretical basis and practical application."* It is an integral part of the healthcare system, not only in the Czech Republic, but also around the world.

Custom text

Key Competencies of Mentors

According to the academic dictionary of foreign words, the term competence refers to the assumptions (i.e. knowledge and skills) or the ability to handle a specific function, activity or situation. When formulating the intent of an educational program for the training of mentors of clinical nursing apprentices, we established the following general educational objectives:

- build, in nursing students, competence in the fields of pedagogy and psychology for the qualified performance of the mentoring position of clinical practice for nurses and midwives - for successful prognosis, implementation and evaluation of the educational process in the students' professional practice;
- Deepen the pedagogical and psychological thinking about the phenomena of educational reality for a deeper understanding of the causes, the course and consequences of pedagogical and life situations and for more qualified decision making in the educational field;
- Contribute to autonomy, creativity and flexibility in pedagogical work. Contribute to the integration of new theoretical knowledge with past experience in the field of practical teaching from the experience of those who participated as students.

With these goals in mind, we tried to specify the learned competencies of our course participants so that we can accurately develop the content of the individual educational units and subjects included in the certified course. In this context, we analysed not only available literature related to mentor competence (eg Ayfer and Hatice, 2008 or Jowett, 1994 and others). Literary analysis did not provide us with specific information about mentor competencies and their structure. For this reason, we used the basic structure of educator competencies, which is described in Průcha (Prucha, 1997) and we have modified and supplemented the individual areas of competence.

We also drew from current knowledge of the given problem which some authors point to of the important link between the assessment of competences and the assessment of performance of teachers. For example, Pabian (2012), highlighted in his study the direction of research on learning and educating in tertiary education forms the central concept of "educational approach". He believes that since its inception in the mid-1970s, it has obviously become the most comprehensive and most important research area in the field, notably by giving straightforward key concepts, as well as sustained theoretical development from **"educational approaches"** to complex models of relationships between teaching to educate all the way to **"educational outcomes."** (Pabian, 2012, p. 48, 72)

According to Pabian, the area of education is defined primarily by **descriptors** illustrating **educational outcomes** that in a standardized form express the objectives of education and also reflect the common theoretical, methodological, philosophical and value basis of the given field of education. Educational descriptors translate loosely formulated descriptions of learning areas into the category of expected **educational outcomes** - knowledge, skills and other skills (competencies) of graduates, in accordance with national descriptors of the qualification framework.

It focuses on:

- Expertise in the given field (specification of factual and theoretical knowledge and level of understanding of the graduate of the main field);

- Professional skills (specification of research, artistic or other practical practices applying the expertise of a given level).

(National Qualification Framework for Tertiary Education in the Czech Republic, 2012).

Recommendations on educational policy according to Hnilic and Pabian (2012), and therefore also the purpose of the national qualification framework, clearly describe the knowledge, skills, and general competencies that students acquire in individual programs/fields of study and tertiary education. The goal is to be transparent, clear, and understandable for all students. The National Qualification Framework is the starting point for the creation of study programs and majors at universities and educational fields. This framework focuses only on the learning outcomes of a particular curriculum, i.e. the expected knowledge, skills and competence of graduates. The National Qualification Framework is implemented mainly for the following reasons:

- Experience with the introduction of qualification framework in various countries shows that it contributes to focus on the content of education rather than meeting formal criteria and as a result leads to an improvement in the quality of studies. These countries include the United Kingdom, Germany, the Netherlands, Norway, Denmark, Ireland, and non-European countries such as Australia, New Zealand, South Africa and Hong Kong;
- "on the basis of the obligations of the Czech Republic arising from the Bergen Communiqué of Ministers responsible for Higher Education (Commitment of the Bergen Communiqué requires the existence of the NKR and its "self-certification" over the overarching framework of qualifications for the European Higher Education Area - QF-EHEA) and from the Recommendations of the EU Counc of 23 April 2008 ". (Hnilica, Pabian, 2012, p. 18)

Educational outcomes

Educational outcomes represent a generic term for knowledge and skills, as well as general competencies that students have to acquire in a given field of study or subject. Every study branch and every one of its subjects have educational outcomes: that is what we expect students to learn during their studies. When we document these expectations we will acquire

a characteristic of the field and its subjects, which is extremely comprehensible to existing and potential students, as well as to employers. Students simply find out not only what they are they will learn during the course of their studies, but also what will know upon the completion of their degree - potential employers will know as well. This is the base reason why educational outcomes are also required for accreditation.

For Example: The Student Knows How:

- To explain the principles, methods and procedures of individual nursing activities to pediatric and adult patients;
- To respect the age, individual wishes and other peculiarities of clients/patients in providing nursing care;
- To perform nursing tasks for both pediatric and adult patients in standard and urgent care.

The educational outcomes express what a graduate of a study branch or a student can explain, evaluate, design, assemble etc. after completing the subject. During writing, we do not focus on what we do as an educator (our idea of what we are going to teach students), but what students and graduates will be able to do after graduation.

A common problem is that we often ***write about something other than what a student or graduate should be able to do when they leave school:***

For example:
The student will learn about the basic historical development of the field of study.

This formulation describes the course of the education, not the eventual output; it is necessary to re-formulate the statement, for example:
The student is able to characterize the three main historical stages in the development of the field of study.

With this stated output, it is clear to students what is expected of them in the final exam of the subject, and it is equally clear to new teachers, when they take over the lectures from someone else, what exactly to test, and **we also write about knowledge and skills very generally**: for example: *The Student knows the principles of professional ethics.*

The knowledge and skills of students, or the professional competencies of nurses, are divided into basic, specialized and highly specialized according to the basic functions that a general nurse performs and are based on current legislation in the Czech Republic.

Objective of the empirical study:

The aim of the empirical survey was; using an anonymous questionnaire to analyse the competencies of mentors in clinical nursing practice; focusing on the implementation of the individual stages of the educational process; to assess the extent to which the certified course for the preparation of mentors of clinical practice contributed to acquiring and deepening the knowledge and skills necessary for optimal practical training in the stated stages of the education process; to compare the results of self-evaluation of key competencies in CK graduates for the preparation of mentors from different health sectors with different accredited educational programs.

Methodology

The anonymous questionnaire of our own design was used to obtain the information necessary to achieve the objectives. During the design of the questionnaire, maximum attention was paid to the singular nature and clarity of each question. Through the questionnaire, the following information was collected from individual respondents:

- Information about the respondent
- A set of questions about planning and teaching
- A set of general questions
- A set of questions about the knowledge of the mentor
- A set of questions about other professional requirements

Organization of the study

The questionnaire survey was conducted at the end of the Summer Semester of the academic year 2013. The research was carried out in two stages. In the first phase, the questionnaire was assigned to mentors at the Second Medical Faculty of the Charles University in Motol, during January and February 2013. The first phase questionnaire was distributed in printed form to all 93 mentors/mentors. By the end of March 2013, 75 completed questionnaires were received. The return on questionnaires (80.65%) was above expectations. After evaluating checkpoints in completed questionnaires, the three questionnaires were discarded for disbelief and one questionnaire was discarded due to the non-completion of all items. For the survey, a total of 71 questionnaires were used. Of the total number of mentors of the 2nd Medical Faculty of Charles University

and Motol, 76.34% participated in the survey. Participants in the first stage survey are the A group of respondents.

The second phase of the survey took place in September 2014. A total of 232 active mentors and mentors were contacted through accredited facilities (the Faculty of Health Studies at UWB in Plzeň, Regional Health, Shareholder Company Ústí nad Labem and the Faculty of Public Policy in Opava) and asked to fill in an electronic version of a questionnaire placed

on the website of the 2nd Faculty of Medicine in Prague. Of the total number of 232 mentors contacted, the questionnaire, even after several urgent reminders, was completed by only 46 respondents. The return rate was only 19.83%.

Characteristics of the respondent group

The survey was completed by general nurses and midwives, performing mentorship activities in the conduct of clinical nursing practice for university students, who in the years 2012 - 2013 completed a certified training course for mentors in clinical nursing practice in one of the accredited facilities in the country. Based on the different types of training in the certified course, respondents were divided into two groups: **Group A** (n = 71) consisted of interviewees who had special professional competence to pursue mentoring in the same courses, i.e. in courses at the Motol University Hospital or at the Second Medical Faculty of Charles University. The second Group B (n = 38) consisted of respondents who have acquired special expertise in other accredited institutions (FZS UWB in Pilsen, FZV University of Ústí nad Labem and in FVP SU Opava).

Selected results of the investigation

A key part of our own research was analysis of the development of pedagogical and didactic competencies of mentors obtained through a certified course in relation to selected activities in the specific phases of practical training. From this analysis we can judge the effectiveness of the certified course because this analysis represents progress in the knowledge and skills of the mentors before the certified course and after passing it. The average values of the Gamma Correlation Coefficients are lower for the Group A respondents than for the B respondents. Thus, it can be concluded that the certified mentor training course developed the Group A respondent's knowledge and skills more than in the case of the B respondents. From this we can gather that all calculated values of the Gamma Correlation Coefficient are in the positive range, and it can be stated that the passing of the course, in any case positively influenced, more than less, the knowledge and skills of mentors, or at least did not deteriorate it (especially in group B). Although, in most cases, better results can be found in the presented results for Group A than B respondents, statistically significant differences were found for only two items and *"I have sufficient knowledge of the educational program that is being carried out at the faculty"* (p = 0, 0208) and in the less significant item *"I have the skills to orient in societal changes"* (p = 0.0168). In both these questions, better results were found for group A. In the group B respondents, slightly better results of self-evaluation on statements focusing on mentor behavior were found in practical training with a focus on access to and communication with students, for example on the statements:

- As a mentor, I lead students to a responsible approach to the profession;

- As a mentor, I encourage and help to critical think about the profession;
- As a mentor, I behave as with a colleague, as a partner;
- As a mentor, I behave proactively;
- As a mentor, I effectively collaborate with the student and develop his or her interest in a particular skill;
- I believe that my student assessment strengthens, encourages, and motivates me towards further improvement and development.

Discussion

What is the Qualification Framework good for?

Recommendations for Educational Policy, according to Hnilic and Pabian, proposes defining the legal basis of the Qualification Framework; its binding nature; its forms; its management; possibilities for change; its guaranteeing its support.

The Education Policy Recommendation therefore seeks to systematically support the implementation and proper use of the Qualifications Framework at the highest level of universality. It is therefore clear that the main addressee of this recommendation is the Ministry of Education, Youth and Sports, which oversees and administers the Czech Educational System. However, even if the legal anchoring and management of a qualification framework at the national level is primarily addressed to the Ministry of Education, the Ministry of Education, Youth and Sports cannot proceed completely independently to other interest groups (particularly the Accreditation Commission and Academic Representation). For this reason, the recommendations for educational policy are of course also intended for tertiary education institutions and other bodies involved in the tertiary education process in the Czech Republic.

The other two recommendations are based primarily on the experience of pilot implementation of the national qualification framework and their end-users are primarily institutions of tertiary education, i.e. higher and upper vocational schools:

- Recommendations for school directors are formed from recommendations for tertiary education institutions when introducing Qualification Framework
- Educator recommendations deal with educational outcomes and help those who develop educational outcomes at the field of study and subject levels.

It should be stressed that both these recommendations, particularly for tertiary education institutions, are very closely interrelated. The School Leadership Recommendation is intended to help create an appropriate environment for the establishment of a Qualification Framework at the institutional level. Teacher recommendations should be a practical tool in making educational outcomes at the program, discipline, and subject level.

The general issue of Qualifications Frameworks is dealt with in the study of Allais, Raffe, Young, particularly the distinction between two types of Qualifications Frameworks: the first, the reform of education, and the second about the transparency of the existing education system. (Allais, Raffe, Young, 2009)

Undoubtedly, Bergan's study, a theoretical study on the problems of qualifications and Qualification Frameworks has made a major contribution to the topic, with particular emphasis on the importance of these issues in the area of European higher education. (Bergan, 2007). Furthermore, according to Chakroun it is important to note that the final conclusion, i.e. the framework and processes, its implementation, cannot be

transferred to other countries; it is always necessary to create their own form of implementation. In addition, he argues that the pedagogical potential of educational outcomes can only be fully exploited in close conjunction with learning and evaluation. (Chakroun, 2010)

Conclusion

Past attempts at reform such as unifying mentor training in a single certified course are halfway solutions and the original goal is only partially fulfilled since it does not exactly define the educational outcomes, i.e. what a mentor of clinical practice should be familiar with and know, in that the portfolio, from which specific pedagogical - didactic competencies originate, to which this survey was devoted. The content analysis of the training programs of certified courses for mentor training carried out in 2010-2014 shows a great variability in content and extent of mentor preparation. The current "unified" curriculum issued by the Czech Ministry of Education while firmly defining the scope and general content of education does not precisely define the educational outcomes, which (although to a lesser extent than before) allows a variable approach to the implementation of courses in various accredited institutions.

Although the results of our own survey carried out in our mentor group were positive we feel there is a need for the continuous and systematic development of competencies, i.e. knowledge and skills of nurses who are mentoring students as a necessary and essential contribution to the quality of the educational process of our students. In this sense, we perceive the interdependence of **educational outcomes,** in both education and evaluation for more learners to permanently acquire the targeted complex knowledge and skills, as a necessary element for improving the work of not only the academic staff of our workplace, but also of the mentors of clinical nursing apprenticeships and the students themselves.

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Voices of Gender Discrimination: A Feminist Stylistic Analysis of Khaled Husseini's A Thousand Splendid Suns

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Original Article

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Abstract:

This paper is an attempt to investigate feminist stylistic analysis about various voices of gender discrimination in Khaled Hosseini's A Thousand Splendid Suns 2007. It unveils the female characters' attempts of resistance to such discriminatory practices and their underlying ideologies. The novel
is a chronological narration of the Afghan people beset by their domestic and socio-political issues. However, gender discrimination (or sex-

ism) against the Afghan women at the domestic, social and institutional levels is a dominant thematic issue. The major characters in the novel provide a strong base for various causes of the issue, and their subsequent implications of gender discrimination in different ethnic, ideological and institutional backgrounds. The study highlights not only the linguistic resources, but also the social and institutional underpinnings of gender discrimination. It reveals that the linguistic resources for gender discrimination include attributive, dehumanizing, belittling, oppressing and sexist terms and expressions.

Introduction

Current studies on gender and language are interdisciplinary as they cross boundaries of linguistics into women/gay studies, literature and social sciences (Sunderland, 2006). Gender discrimination (or sexism) is a social practice of discrimination realized in language use that works against women on the basis of gender differences. Van Dijk, (2005, p. 2) views sexism as "domination of women by men and on the basis of constructed gender differences." Sexism is viewed at the discursive, cultural and socio-cognitive dimensions as attitudes and beliefs of sexism are shared and shaped by sexist discursive encounters. Lazar (2007) considers gender as an ideological social structure, causing people's dichotomy into men and women based on their sexual differences, which, further, leads to men's domination over women. Mills (2008) does not view 'sexism' as an exclusively individual practice of discrimination in language use. Rather, she adds that major social and institutional forces of power asymmetry also play their pivotal role in producing and promoting sexist attitudes and practices. She looks at sexism linguistically and pragmatically.

Gender Discrimination: A Critical Overview

Patriarchal society provides a base for gender discrimination. Inequality and injustice in gender relations are the results of the existing dominant perceptions about gender dichotomy and gender ideology. Lazar (2007) explains and extrapolates that "social structures of patriarchy systematically privilege men as a social group, and disadvantage, exclude, and disempower women as a social group" (Lazar, 2007, p. 145). For her, overt "forms of gender asymmetry or sexism, traditionally, have included exclusionary gate-keeping social practices, physical violence against women, and sexual harassment and denigration of women" (Lazar, 2007, p. 148). Multi-dimensional study of sexism leads Mills (2008) to argue that it is realized directly or indirectly at the individual and institutional levels. For her, overt sexism can be explored in language use directly through the analysis of linguistic markers or "presupposition, which has historically been associated with the expression of discriminatory opinions about women, which signals to hearers that women are seen as an inferior group in relation to males" (Mills, 2008, p. 11). Sexism is diverse, pragmatic, depending upon the contexts of its usage/practice. According to her, sexism is an intentional practice in language use which can be declared as sexist through the analysis of language use and/or its context. Her views reveal the local and social model of sexism in their specific and general societal contexts. These sexism and levels are related to each other has been called

sexism on the individual level, while partly affects the institutional sexist attitudes, behaviors, and etc. She (like Lazar (2007) acknowledges the role of patriarchal structures in gender discrimination. For, Lazar and Kramarae, (2011), the asymmetries of gender, and power are causes of gender discrimination. Direct or overt realization of sexism is rare in the social, and political institutions on account of feminist movement and campaign. For Eckert (1989), the traditional gender ideology dichotomizes people into men and women on account of the so-called perceived gender roles and disparities.

Eckert (1989) has offered more complicated operation of gender for gender oppression as compared to other forms of oppressions. According to Allen (2009), the Foucaultian concept of subjection is a central topic in Butler's works. Domination and subordination are the integral elements of subjection as a form of power. In Allen's view (2009, p. 300), the approach of post-structuralism not only examines "the relationship between gender difference and relations of dominance and subordination (as second-wave feminists attempted to do as well), it also suggests that the category of gender, itself, is power-laden, that it can serve as a mechanism of exclusion." Allen refers to Butler, (1995) who argues that "Identity categories are never merely descriptive, but always normative, and as such, exclusionary" (cited in Allen, 2009, p. 300). Eckert (1989) sheds light on how women are more status-conscious than men, but he supports the argument that "women are more status-*bound* than men" (1997, p. 217; italics in original).

There are diverse ways used by men and women for struggling to establish their social status and identity. The mentioned struggle over status is more explicit and vivid in cases of their isolated gender roles and their challenged gender identities. It is, generally, suggested that women, who are powerless, should build and recognize their due status through language (Eckert, 1989). Shabir's (2018) work on *A Thousand Splendid Suns* reveals the root causes of gender discrimination in Afghanistan. He concludes that there are socio-cultural (e.g. gender stereotyping, patrilineality, patrilocality, conservative and traditional mindset and ideology); economic (poverty, especially women's economic dependence on men); political (e.g. instability of and mismanagement in judiciary and political system; the rise of Taliban and Mujahedeen); ideological (extremist, sectarian and ethnic ideologies); geo-political (e.g. foreign aggression in Afghanistan due to its geo-political significance) factors involved behind gender discrimination.

Theoretical and Analytical Perspective: Lazar's Version of Feminism

The feminist approach to critique gendered discourses is considered both as a theory and practice (method). It was introduced by Lazar (2005). Similarly, this approach was also effectively adapted

by Sunderland (2004) and Lehtonen (2007) for studying children's fiction and children's fantasy fiction respectively. Lazar's feminist approach seeks egalitarianism, social justice, emancipation and transformation of/for feminine gender. Its emergence is "a timely contribution to the growing body

of feminist discourse literature, particularly in the field of gender and language" (Lazar, 2007, p. 144).

Lehtonen sheds light on how Lazar's version of feminism is applicable to the analysis of novels in these words: "fictional

texts are a form of language use – although a highly specialized one – and a site where gendered identities are discursively constructed, there is no reason *per se* why feminist linguistic analysis could not deal also with fictional texts" (Lehtonen, 2007, p. 3; italics in original).

The prime objective of this approach is to study "discourses which sustain a patriarchal social order – relations of power that systematically privilege men as a social group, and disadvantage, exclude, and disempower women as a social group" (2007, p. 145). Social emancipation, egalitarianism and empowerment of women are some of the aims of this approach.

Unlike this, social theory views gender identity as social relation(s) among the subjects in certain contexts wherein gender is determined in social relations. Butler's (1990, p. 25) non-essentialist or anti-foundationalist view of gender sees gender as "culturally constructed; hence, gender is neither the causal result of sex nor as seemingly fixed as sex." According to her, gender is not subject of a deed or a set of universal attributes. Rather, it is performative. Gender is considered as a discursive performance that is expressed in an ongoing interaction wherein the subjects emerge as a result of that performance (Butler, 1990). She adds that "There is no gender identity behind the expressions of gender; that identity is performatively constituted by the very "expressions" that are said to be its results" (1990, p. 25). Her focus is more on the deed or performance than the doer of that deed. Lazar argues that "overt forms of gender asymmetry or sexism, traditionally, have included exclusionary gate-keeping social practices, physical violence against women, and sexual harassment and denigration of women. Such overt manifestations of power . . . remain a reality for women in many societies, even where there is legislation against blatant gender discrimination" (2007, p. 148).

Research Method for Data Analysis: Feminist Stylistics

It is pertinent to argue that Sara Mills's (1995) feminist stylistics is a viable research method for exploring various layers of explicature and implicature of gendered discourses in their textual and social contexts. Feminist stylistics is an amalgamation of stylistics (as a research method) and feminism (as a theory). Feminist stylistic analysis at the phrase/sentence level is related to the semantic and pragmatic analysis of various phrases and syntactic structures used in a discourse. At this level of analysis, the analyst investigates certain phrases (e.g. ready-made phrases and metaphoric phrases); patterns of transitivity; presuppositions; sexist jokes/humors; sentences expressing certain ideology. Analysis at this level focuses on the explicit and implicit meanings of the language used to depict characters/roles, fragmentation of the female body (through words and images) with male focalization (representation of the female as an object for the male gaze), various schemata, e.g. sexist schemata, drawn upon to represent women.

Data Analysis and Discussion

The entire analysis of discourses on gender discrimination in "*A Thousand Splendid Suns" exposes* gender discrimination against Mariam and Laila by Rasheed and the Mujahideen in restrictive patriarchal system. Nevertheless, Mariam was also othered by her father and her stepmothers. Her *harami ('illegitimate')* gender (identity) was a source and emblem of shame on their honor and identity. '*Harami*' was a title addressed to Mariam at the domestic and social levels. Nana, her mother, in anger and frustration also used to address her as

a **"clumsy little *harami*"** (Hosseini, 2007, p. 3). Having experienced the odds and adversities of life, Mariam understood that '*harami*' means **"an illegitimate person who would never have legitimate claim to the things other people had, things such as love, family, home, acceptance"** (2007, p. 4). It is another example of discrimination when Jalil (Mariam's father) and his wives hold Nana solely responsible for forcing Jalil for an unlawful sexual intercourse. She voices her complaint against this sort of discrimination thus: **"This is what it means to be a woman in this world"** (2007, p. 6). Nana, further, voices gender discrimination through her expressions: **"Like a compass needle that points north, a man's accusing finger always finds a woman. Always;"** and **"To Jalil and his wives, I was a pokeroot. A mugwort. You** [Mariam], **too"** (2007, p. 7).

Feminist stylistic analysis of the selected passage/lines at the phrase/sentence and discourse levels (2007, p. 26) reveals that Jalil's family excluded Mariam, and discarded her as a root. Nana's view was true in addressing Mariam in these words: **"A man's heart is a wretched, wretched thing, Mariam. It isn't like a mother's womb. It won't bleed, it won't stretch to make room for you";** and that **"when I'm gone, you'll have nothing. You *are* nothing!"** (2007, p. 26). Another instance of deceitful discrimination against Mariam is when she was forced into a premature marriage after her mother's suicide. Jalil's family did not allow Mariam to get her education whereas her half sisters were not only educated, but also not asked to marry Rasheed. Feminist stylistic analysis of passage/lines (2007, pp. 44-45) at the phrase/sentence and discourse levels exposes the clever and planned way of Jalil's wives to get rid of her as a cursed burden on them. This burden was depicted in these words: **"*As you are now to us*" (2007, p. 45)**. Feminist stylistic analysis also shows Rasheed's vilely sexist language and attitude for his wives. He used to treat them as his workers, slaves and lust-gratifying tools. He also set an example of discrimination between Mariam and Laila based on their sexuality and appearance. His address to Mariam was **"a *dehati*," "a village girl," a girl** below the level of a villager (2007, p. 199). He considered her as **"a good worker, and without pretensions" (**2007, p. 199).

Applying feminist stylistic analysis at the word level on the selected words reveals how Rasheed used to address Mariam as a 'Volga,' an old-fashioned car and Laila as a 'Benz,' a new brand car. Rasheed commented on their appearance thus: **"If she were a car, she would be a Volga"** and **"you, on the other hand, would be a Benz. A brand-new, first-class, shiny Benz"** (2007, p. 199). Rasheed's overt sexism is realized through his address to Laila as **"the queen, the *malika,"*** and asking Mariam to serve her in a better way. His overt sexism is exposed in these words: **"one does not drive a Volga and a Benz in the same manner"** (2007, p. 200). Feminist stylistic analysis of the passage/lines (2007, pp. 215-216) spotlights Laila's denial to Rasheed's offer for sex, and how Rasheed rushes angrily into Mariam's room, and how he blames and beats her badly with a leather belt. The scandalous scene focuses on how Mariam was afraid of Rasheed's masochistic power abuse and devilish discrimination against her through the narrator's voice: **"Over the years, Mariam had learned to harden herself against his scorn and reproach, his ridiculing and reprimanding. But this fear she had no control over"** (2007, p. 215). Aziza was also an illegitimate child, and Rasheed showed a dastardly and inhuman attitude to her. Rasheed snubbed her vilely thus:

"Get off my heels!", he snapped, making a shooing motion with his gun. "Stop following me! And you can stop twirling your wrists like that. I'm not picking you up. Go on! Go on before you get stepped on" (2007, p. 227). The Afghan Mujahideen used to maintain order. However, their biased law usually favored men, and the same order was abused as a weapon for discriminating against women. When they tried to flee from Rasheed's prison house of betrayed injustice and cruelty, they were without their '*mehram.'*

Another exhibition of the Taliban's gender discrimination is that when a young Talib beats Laila with a radio antenna accompanied by his sexist language: **"I see you again, I'll beat you until your mother's milk leaks out of your bones"** (2007, p. 286). Observing Laila's immanent death at the hands of Rasheed, Mariam killed him. Afterwards, Laila requests her not to surrender to the Taliban and to escape to a protected place in Pakistan, but she disagrees with her by discursively exposing the Taliban's sexism in her voice: **"When they** [the Taliban] **do, they'll find you as guilty as me. Tariq too"** (2007, p. 318). Overt sexism of the Taliban against the imprisoned women is derisively dotted in voice of the narrator as the Talib guards **"leered in, with their inflamed eyes and wolfish smiles, that they muttered indecent jokes to each other about them"** (2007, p. 321). Feminist stylistic analysis of a passage (2007, p. 329) demonstrates how the discourse-producer shows his sympathy for Mariam, who was executed by the Taliban. His remark of irony strikingly reveals his perspective of resistance against the sexist Taliban: **"It was not so bad, Mariam thought, that she should die this way. Not so bad. This was a legitimate end to a life of illegitimate beginnings"** (2007, p. 329).

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Application of PedsQLTM Questionnaires to the Evaluation of Quality of Life in Families with Children with Selected Diagnoses

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Abstract:

The evaluation of the quality of life is an important component of considering biopsychosocial situations in children suffering from chronic diseases.

Design: Pilot study
The sample group and methods: Children with diagnoses Diabetes Mellitus, Autistic Spectrum Disorder (ASD), Attention Deficit Hyperactivity Disorder (ADHD) and Cerebral Palsy (CP) were monitored together with their parents. The control group comprised ten healthy children and their parents. PedsQL questionnaires, marked PedsQL 4.0, PedsQL 2.0 – family module, were employed. The so called survey questionnaire was used for the quantitative research. The qualitative research was implemented with the help of a semi-structured dialogue with parents. The statistical processing was based on non-parametric Kruskal-Wallis Tests/for independent sampling) and Wilcoxon Test (paired comparison).
In all the tests, the significance level (α) of 0.05 was chosen. The qualitative research was processed by the Atlas.ti program with establishing 600 open codes and with origination
of nine categories.
Conclusion: Differences in the score axis in five groups of respondents resulted in refusing the zero hypothesis H0, i.e. the results were different throughout the questionnaires. The results of five paired subgroups demonstrated that there were most frequent differences between controls and subgroups of children with autism and ADHD. Results of the qualitative research are summarized in the section Results. PedsQL™ questionnaires were applicable to all the families. Children with the autistic spectrum disorder encountered problems with the PedsQL™ questionnaire – they were unable to complete the questionnaire and they did not understand the questionnaire scale.

Introduction

"WHO defines Quality of Life as individualsZ perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns." (The WHOQOL …, p.1).

The PedsQL 4.0 questionnaire, generic module includes a total of 23 questions (Varni, 2001). PedsQL 4.0 questionnaires have four subscales: Physical health, emotional health, social activities and school activities (Baloun, Velemínský, 2018). The Paediatric Quality of Life Inventory™ (henceforth PedsQL™) comes from James W. Varni (Varni, 2004; Varni *et al*., 2003). *"The PedsQL is a valid, reliable, flexible (applicable in the community, in schools*

and in pediatric practice) and multidimensional tool (it consists of 4 subscales – physical, emotional, social function and function in school) measurement of the quality of life" (Gurková, p. 167). There are total of 34 mod-

ules of PedsQL questionnaires (Cheng *et al*., 2016).

The PedsQL 4.0 questionnaire is a generic module comprising total of 23 questions divided into four areas (physical health and activities, emotional health, social activities and school activities) (Varni, 2017). This questionnaire has been translated into 109 world languages (ePROVIDE, 2018). The questionnaire is divided by age categories of children (aged 2-4 years, aged 5-7 years, aged 8-12 years and aged 13-18 years) (Burešová *et al.,* 2008).

Methods and Sample Group Characterization

The sample included 4 types of diseases – Diabetes Mellitus, Autistic Spectrum Disorder (henceforth ASD), Attention Deficit Hyperactivity Disorder (henceforth ADHD) and Cerebral Palsy (henceforth CP). Each category of diseases included five children with their parents. The control group included 10 healthy children with their parents. In the course of the research, the completely anonymous nature of the study was adhered to; numbers were assigned to communication partners, under which they completed the questionnaires.

The research was divided into three parts. In the first part, the parents completed the basic questionnaire, aimed at identification data on the child and family – age, diagnosis, completeness of the family, financial background of the family, etc. In the second part, in the course of personal meetings, children and their parents completed PedsQL™ questionnaires. The third part was a semi-structured interview with the parents. In the course of the interview, we presented questions, for example that focused on the questionnaire comprehensibility; life story; child diagnosis; course of the treatment; taking advantage of social services.

In the quantitative part, 4 types of PedsQL questionnaires were used - we were the first authors using the generic PedsQL 4.0 questionnaire completed separately by children and by their parents. A further questionnaire used was the PedsQL 2.0 - family module. This module was completed by parents twice – firstly in terms of the last seven days and secondly with respect to the last month. In the PedsQL 4.0 questionnaire, three scales are evaluated: score of physical health; score of psychosocial health; total score (Varni, 1998). In the questionnaire PedsQL 2.0 – family module, the "quality of life in relationship with the health condition" (Health-Related Quality of Life, HRQL); score of the family function; total score were evaluated. In each group, 12 tests were implemented in total of 5 children and 5 parents from each group of diseases and in 10 healthy children and their parents.

A comparison of the score achieved in groups of diseases monitored was provided because of a not normal distribution of the group based on non-parametric Kruskal-Wallis Tests (for independent sampling) and Wilcoxon Tests (paired comparison) (Vargha, Delaney, 1998). The significance level chosen (α) was of 0.05 in all the tests.

The third part of the research was implemented by a qualitative data analysis, particularly by an open coding. The interviews were recorded by a Dictaphone and subsequently literally rewritten. More than 600 codes were obtained by open coding, which were then categorized, and this resulted in 9 categories. Some of categories are accompanied by graphical outputs, which were processed in the ATLAS.ti 8 software program (Friese, 2014). The advantage of this program is that it may be used not only for classing the data but also for graphical processing, which made it possible to accompany the research results by appropriate schemes. The choice of informants for interviews was particularly implemented by using the snowball method and

partially by aimed intentional choice depending on the child diagnosis.

Results

Results from the quantitative part of the research

The following principal categories were obtained based on the analysis of the data obtained:

- **Identification data**
- **PedsQL™ questionnaire**
- **Diabetes**
- **ASD**
- **Combined handicaps**
- **ADHD**
- **Social support**
- **Material support**
- **Life with child´s handicap**

Identification data

Table 1: Gender representation of respondents

The sample of 20 children, in which the quality of life was investigated by using PedsQL™ questionnaires included total of 8 girls and 22 boys.

Male	22; 73 %
Female	8; 27 %

Source: Original research

Table 2: Age representation of respondents

	Age (years)
average	11.2
modus	13
median	11

Source: Original research

The age range was delimited immediately at the beginning of the research and we choose children and adolescents aged 5 to 18 years. This age category was chosen with respect to questionnaires which are divided depending on the child age.

Table 3: Type of school/education

Type of school/education	Number of respondents
Kindergarten	4; 13 %
Primary school – degree 1	13; 44 %
Primary school – degree 2	8; 27 %
Secondary school	4; 13 %
Teaching at home	1; 3%

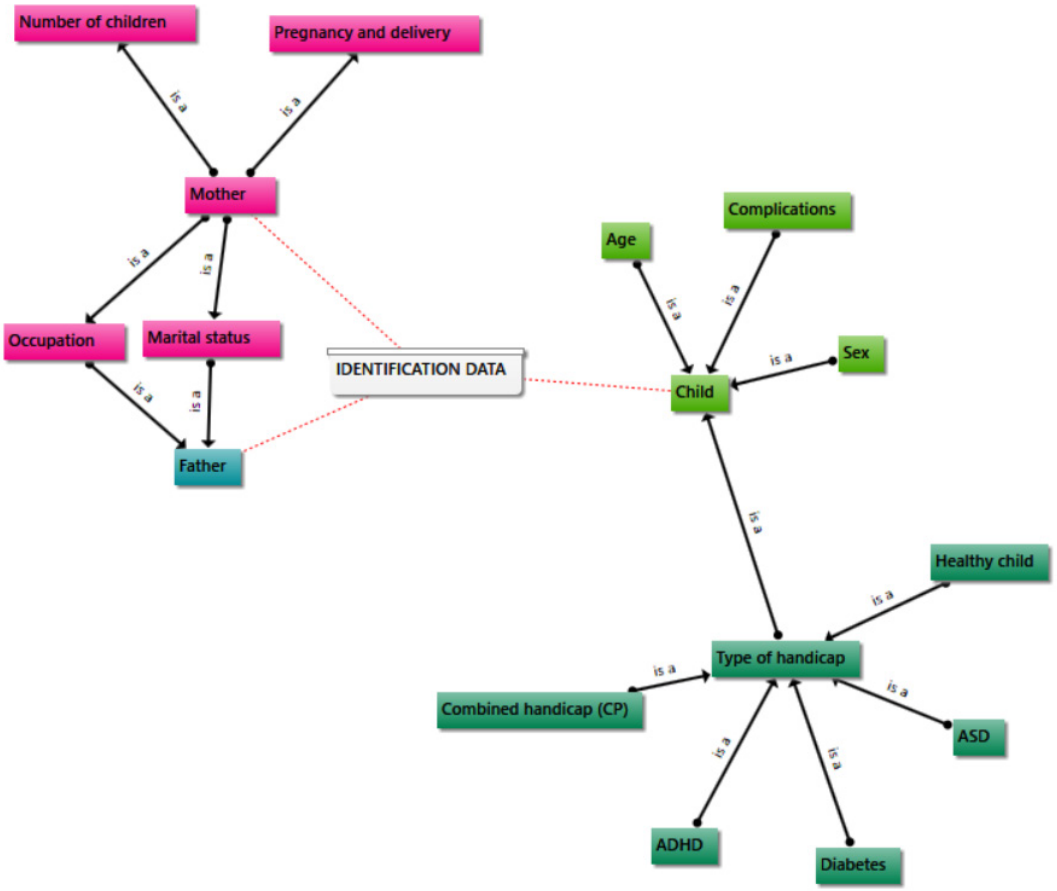
Source: Original research

In children and adolescents, information about the school type (degree) attended was accumulated. Most children attended the primary school. These were the classic type of primary schools as well as special schools.

A total of 30 informants participated in the research, who had a handicapped child. As to their marital status, they were either married or in a partnership relationship with the child´s father or with another partner. As to the occupation of the mothers, it is to mention that most of them returned back to the occupation or were on the maternity leave. Taking care of the child was a full time work in three informants only, and in one case, the father took the care of the child. Most fathers have their permanent jobs and were in the bond of marriage.

The children's age ranged between 5 and 18 years and boys were prevalent as to the sex. In the sample studied, we tried to equally cover all the diagnoses established, i.e. ADHD, ASD, combined handicap and diabetes. The complications of handicaps were diverse.

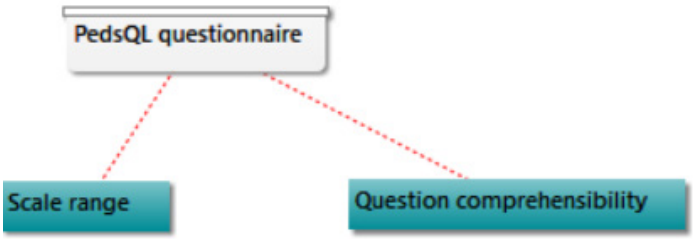
Scheme 1: Identification data



Source: Original research

PedsQLTM questionnaire

Scheme 2: PedsQL questionnaire



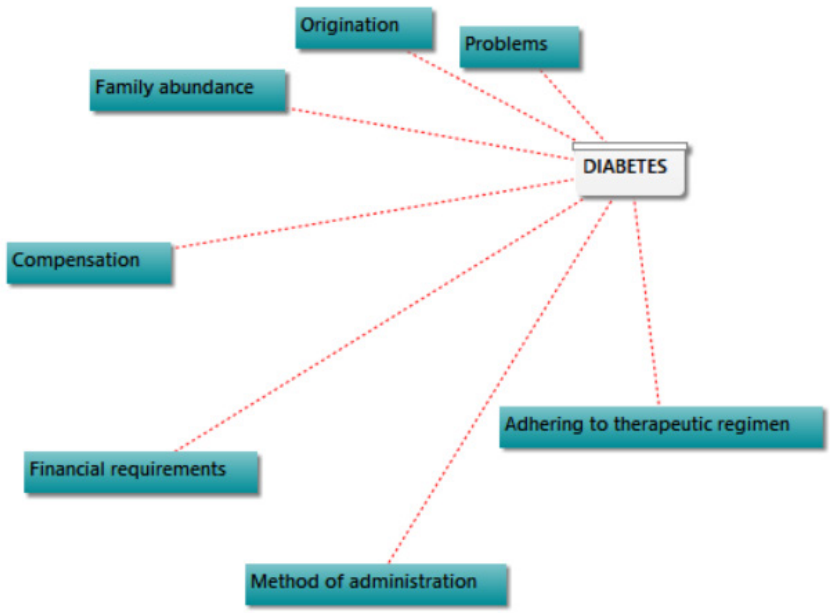
Source: Original research

Most informants reported that the questions in the questionnaire were well comprehensible, only some of them mentioned moderate unclearness or facts that some questions or responses were vague and too general. The scale range was mostly sufficient, but within the framework of interviews, the informants also proposed that the scale should be reduced to three points in the future, which could facilitate completing of the questionnaire.

but also by using an insulin pump and newly also with the help of a special sensor which provides information about the actual sugar level in the blood based on information technologies. However, this is also associated with financial requirements as mentioned by informants whose children have the sensor. A considerable advantage of the sensor is, however, the fact that it is possible to avoid night hypoglycemic conditions as reported by in-

Diabetes Mellitus

Scheme 3: Diabetes



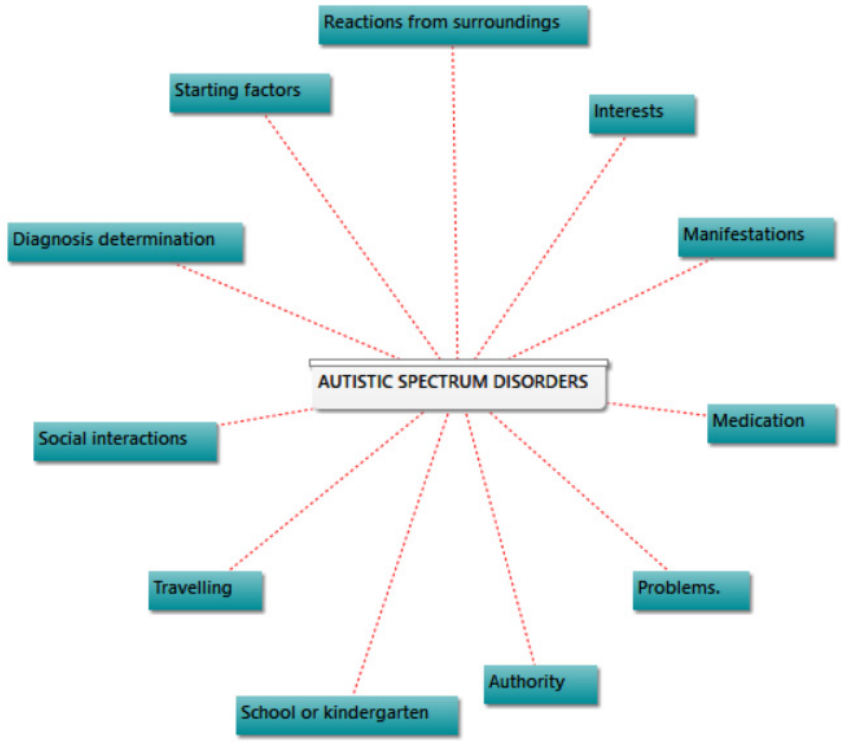
Source: Original research

Type I Diabetes Mellitus was developed in different periods from the toddler age to the older pupil age and the positive family anamnesis occurred only in two families who submitted to the interview. The necessary insulin administration is most frequently implemented with the use of an insulin pen

formant R13. However, children otherwise principally adhere to the therapeutic regimen, though if the informants pointed out failures and bargaining from time to time. This was associated with problems such as taking meals, multiplication of insulin doses or stress.

Autistic Spectrum Disorders

Scheme 4: ASD



Source: Original research

Autistic Spectrum Disorders are a very specific diagnosis manifested in a different way in each particular individual. However, based on the communication by informants, the shared manifestations can be considered as fits of temper associated with aggression from time to time; adhering to stereotypes; anxiety; contrastingly hyperactivity. The starting factor is usually a disturbance of rituals, stress, presence of many humans or fatigue. The reactions of the surroundings to manifestations of the child were mentioned by informant R11, who complained about inadequate reactions and considerable misunderstanding in the school or making the problem light in the hospital. In most children, the social interactions are disturbed. They frequently tend to stay beyond the collective and any crowd of people is difficult for them.

Based on communications by the informants, the diagnosis was most frequently identified at the pre-school age of the children and first manifestations were observed by mothers as soon as at the suckling or toddler age. The children from the research sample attend special or practical school; only the son of informant R11 attends the common type of the school with the help of assistants. The favored activity of children is travelling – they enjoy travelling based on information from their mothers. Interest in technical things, such as trolleybus, telephone or computer is mentioned. Lego is also of interest but every child has also his/her specific hobby, as for example the son of informant R27 enjoys following the

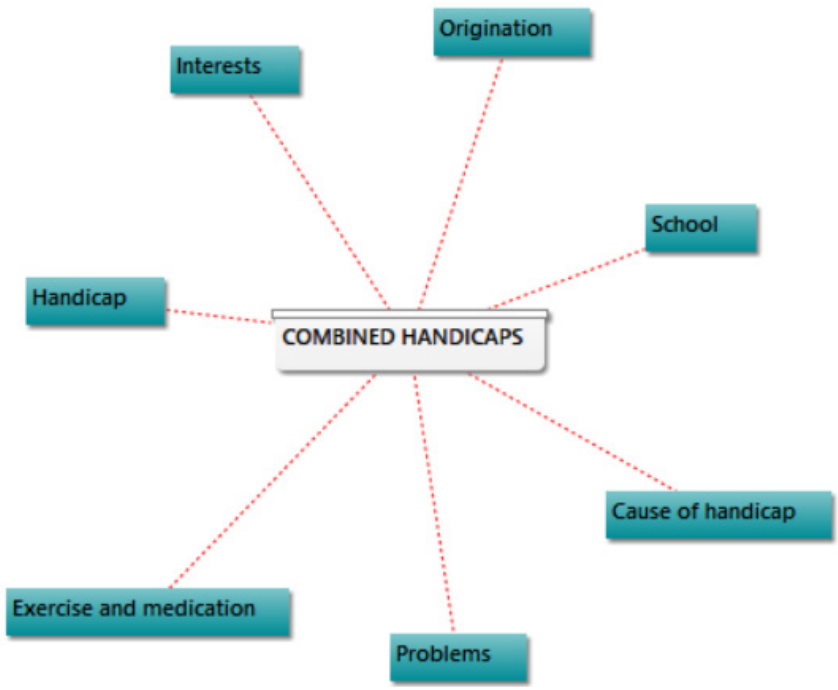
construction of superhighways and inspects milestones.

This diagnosis in the children is, however, associated with different problems as for example with society; problems associated with the rhythm of the child such as refusal or stereotypes in food; sleeping problems; sensitivity to sounds; problems with the locomotor activity; considerable moodiness; alternation of worse and better periods.

the children, the handicaps originated prenatally or perinatally. In the case of the perinatal development, these were problems in the course of the delivery with origination of hypoxia or in association with an incorrect conduction of the delivery. In one of the children, the prenatal origination was affected by cerebral aneurysm. Combined handicaps are also associated with many problems. Informants mentioned health as well as social problems

Combined handicaps

Scheme 5: Combined handicaps



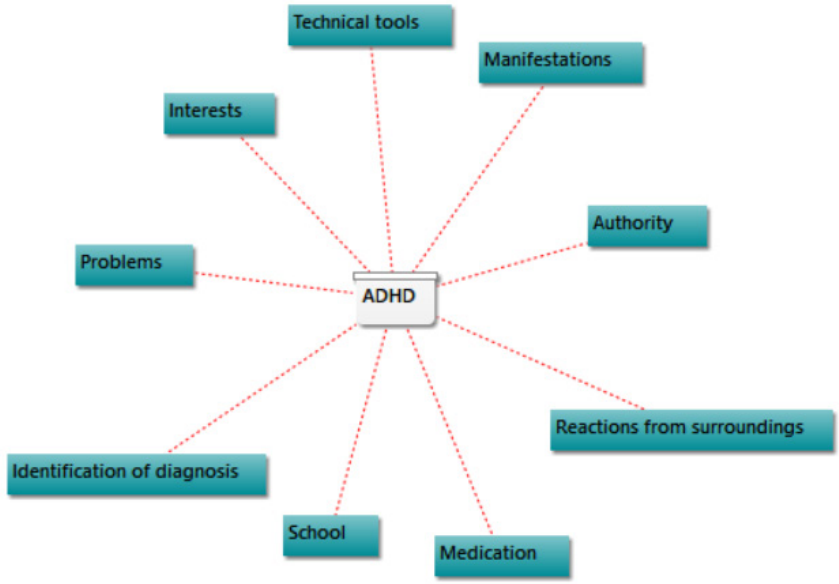
Source: Original research

In our research sample, these were physical handicaps, most typically based on Central Palsy and other types of handicaps. They were mostly a matter of a combination of the spastic form of Cerebral Palsy and mental retardation, epilepsy or sensory disorders. In all – either problems with breathing or being an object of ridicule and thirst for the inclusion into the collective.

Given the diagnosis, all the children were supposed to exercise the Vojta Method. The children attend normal or special schools.

ADHD

Scheme 6: ADHD



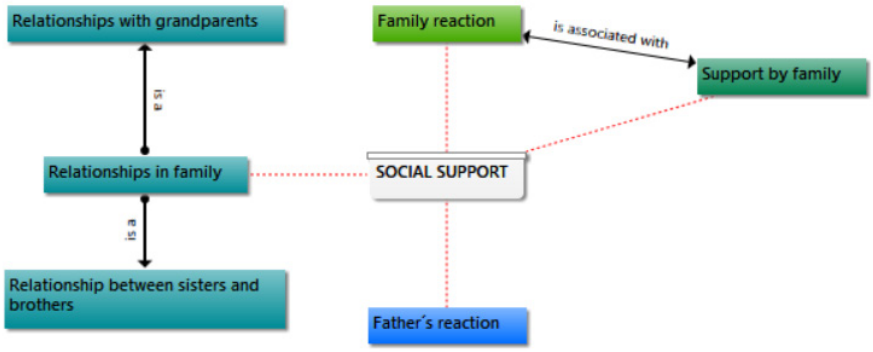
Source: Original research

Attention disorders syndrome is a further diagnosis characterized by different symptoms. However, it is very frequently accompanied by absent mindedness; aggression; fits of temper; hyperactivity which were mentioned by informants in their answers. The children frequently use a medication, particularly Ritalin. The informants mentioned misunderstanding from the surroundings and tendency of the society to provide mothers with "well intended advice" how to raise the child.

In children, the diagnostics was implemented at pre-school age. All children of the informants from the sample studied attend the normal schools, either independently or with the help of a pedagogic assistant or personal assistant in the case of the son of informant R26. Technical tools are also frequently employed, such as mobile telephone or tablet and "clever" books. As to the problems, the informants mostly mentioned problems with sleeping, hypersensitivity or disorders in recognition of reading text and dyslexia. Very diverse interests of children were reported, but sport was mentioned frequently.

Social support

Scheme 7: Social support

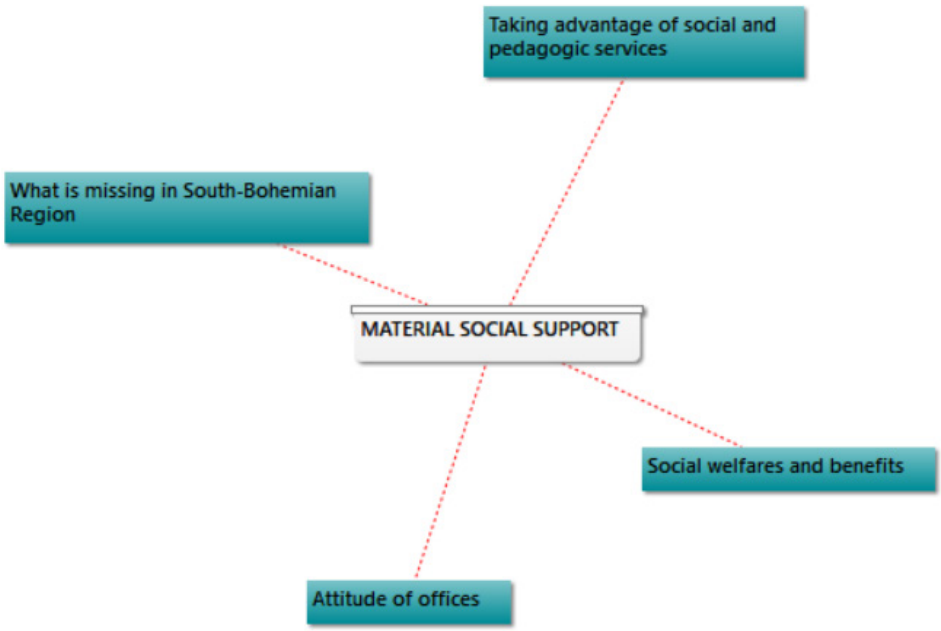


Source: Original research

Help and support by the family is an important part of the life, particularly of the life of a mother having children with handicaps. In the case of mothers of children in the sample examined, the reaction of the father was entirely positive, in spite of the fact that for the fathers it was difficult to reach reconciliation with the handicap and in some cases, they saddled the mother exclusively with the care and child raising. However, one of fathers has not yet reached the reconciliation with his son´s handicap and refuses the diagnosis. On the other hand, informant R33 exclusively takes care of his daughter. Reactions by the family were also rather positive, however, but in certain cases, the wider family is not informed about the handicap, since they would not be able to understand the family and its special requirements. Problems with the reconciliation were also encountered in the case of grandparents. In other cases, informants first met understanding, reproaches or advice how to raise the child. However, there is a positive fact that none of the grandparents completely rejected the grandchild and most of them tried to help and facilitate the family life. If there was a another child in the family, then relationships between sisters and brothers were entirely reported as good.

Material support by society

Scheme 8: Material support by society

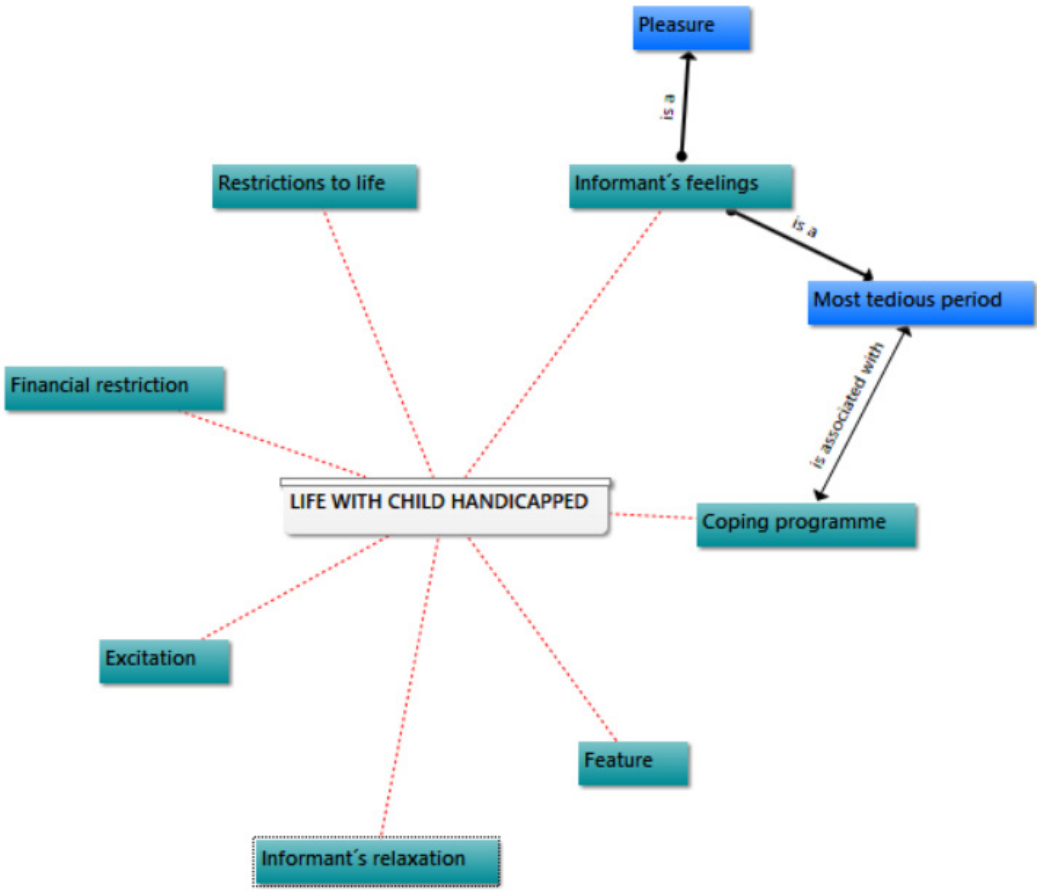


Source: Original research

In terms of the material social support, social welfare and various social or pedagogic services were mostly employed. This was most frequently a contribution to taking care to varying extents. In certain cases, families also took advantage of the ZTP or ZTP/P card or contribution to mobility or special tools. All the informants, who mentioned the services in the interview, took advantage of some of the wide offering of social and pedagogic services, e.g. Auticentrum, Apla, Arpida, Rolnička or pedagogic-psychological consulting institutions and special pedagogic centers. If the informants mentioned the attitude from offices, then they considered it entirely positively with reservations by informants R15 and R16 only. Different opinions were encountered as to the question of what services are missing in the South-Bohemian Region. In mothers of children with autistic spectrum disorders, wishes were, however, repeatedly expressed, concerning the possibility of relieving services for autistic children or of more free time activities for them. Informant R11 would like to have more services in small towns and villages and informant R18 would appreciate enhanced possibilities of work opportunities on the open as well as protected labor market. However, two informants have not yet felt a lack of services or other activities in the South-Bohemian Region.

Life with handicapped child

Scheme 9: Life with handicapped child



Source: Original research

Child handicaps bring a considerable mental burden and it is mostly necessary to cope with this situation. Almost all the informants, who mentioned this theme in the interview, passed a coping program. Only informant R3 rather felt an alleviation, and in informants R1 and R11, the process of reconciliation has ever been underway. In accordance with facts mentioned by informants, the most complicated period of their life concerned just the reconciliation process associated with the diagnosis and new regimen of life. Other frequent problems were the realization of a diagnosis of fatality or fear of the extent of the handicap. For certain parents, understanding of child´s symptoms and problems with healthcare personnel were, however, considerably tedious. Information was frequently repeated that informants are pleased by children having good moods and successes; quiet days; recreation trips; personal interests. According to their words, agitation contrastingly occurs in the case of misunderstanding by the society; child's disease: stress; lack of sleep. Some

informants also are agitated by fits of temper or loudness by their children. In interviews informants frequently expressed their fear of the future. This most typically resulted from the fear of providing care in the future.

The child´s handicap is frequently associated with restrictions to the life and sometimes financial restrictions as reported by the informants in their information. If they pointed out restriction to the child's life, these were mostly cases of social isolation, more worries and loss of friends. However, in some of them, these problems involved a recapitulation of life; pleasure resulting from small successful events; change in considering values of life. However, there are also informants who did not feel any restrictions to life. As far as the financial restrictions or financial problems were concerned, impossibility of finding a quality occupational role with respect to taking care of the child; insufficient financial means for providing the family existence; dependence on social benefits; lack because of only one income in the family were most frequently reported.

Results of the quantitative part of research

Differences in scores achieved between five groups of respondents (4 diseases + healthy control group) were evaluated for both subscales together with the total score in every questionnaire. A total of 12 tests were thus implemented in five children and five parents from each disease category with the use of three types of PedsQL, with evaluation of the total score and subscales (see Table 1). All the zero hypotheses were refused – in all the (sub)scales, the groups were different one from another in the quality of life.

Two types of PedsQL were evaluated: generic type 4.0 (completed by 5 parents and 5 children in each category) and 2.0 type family module – evaluated only by parents for the last week and last month. The total score and two

Table 1. Results of comparing scores achieved in subgroups studied (Kruskal-Wallis test)

Questionnaire - variant	Respondents	(Sub)Scale	P-value
PedsQL 4.0 Generic Core Scale	Children	Physical Health Summary Score	0.001
		Psychosocial Health Summary Score	0.003
		Total Score	0.001
	Parents	Physical Health Summary Score	0.002
		Psychosocial Health Summary Score	0.002
		Total Score	0.002
PedsQL 2.0 Family Impact Module last month	Parents	HRQL Summary Score	0.005
		Family Functioning Summary Score	0.006
		Total score	0.002
PedsQL 2.0 Family Impact Module last week	Parents	HRQL Summary Score	0.004
		Family Functioning Summary Score	0.024
		Total score	0.002

So called omnibus hypothesis was tested.

subscales, i.e. physical health and psychosocial health were evaluated. In all the tests, the zero hypothesis H0 was refused, which means that different results were obtained in all the groups of data. The quality of life was thus different.

Paired comparisons by diagnoses

Results of paired comparisons for five subgroups are shown in **Figs. 1-4**. Most distinct differences were found between the control subgroup (healthy children) and subgroup of children with autism and ADHD.

Fig. 1. Boxplot of the scores in the PedsQL 4.0 Generic Core Scale for children – a) Physical Health Summary Score, b) Psychosocial Health Summary Score, c) Total Score. Similar symbols (e.g. #, $, ≠) depict significant differences between the two respective groups.

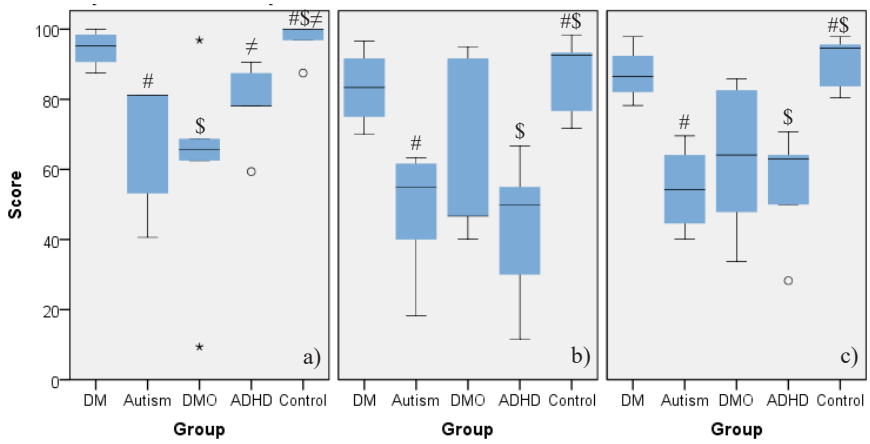


Fig. 2. Boxplot of the scores in the PedsQL 4.0 Generic Core Scale for parents – a) Physical Health Summary Score, b) Psychosocial Health Summary Score, c) Total Score. Similar symbols (e.g. #, $) depict significant differences between the two respective groups.

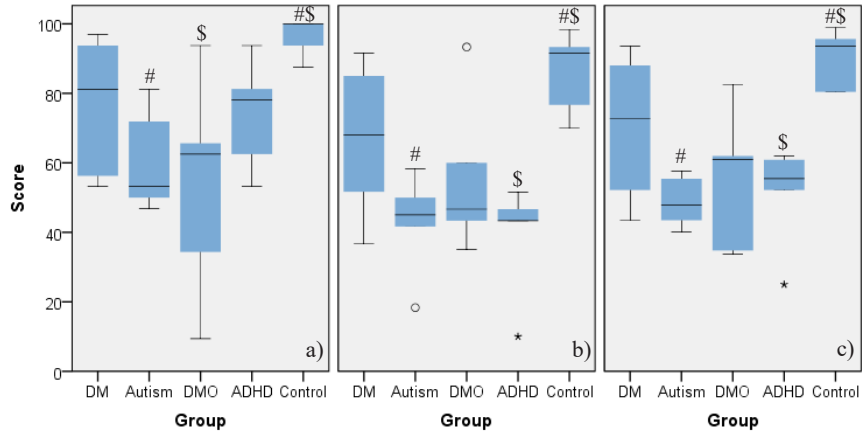


Fig. 3. Boxplot of the scores in the PedsQL 2.0 Family Impact Module for last month – a) HRQL Summary Score, b) Family Functioning Summary Score, c) Total Score. Similar symbols (e.g. #, $) depict significant differences between the two respective groups.

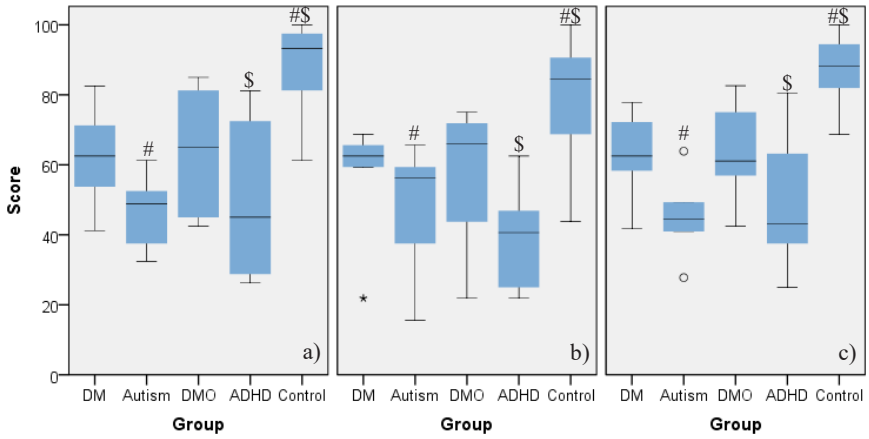
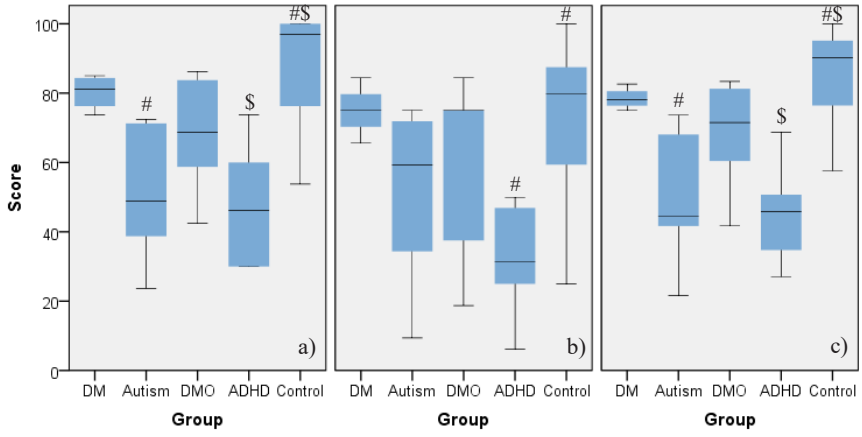


Fig. 4. Boxplot of the scores in the PedsQL 2.0 Family Impact Module for last week – a) HRQL Summary Score, b) Family Functioning Summary Score, c) Total Score. Similar symbols (e.g. #, $) depict significant differences between the two respective groups.



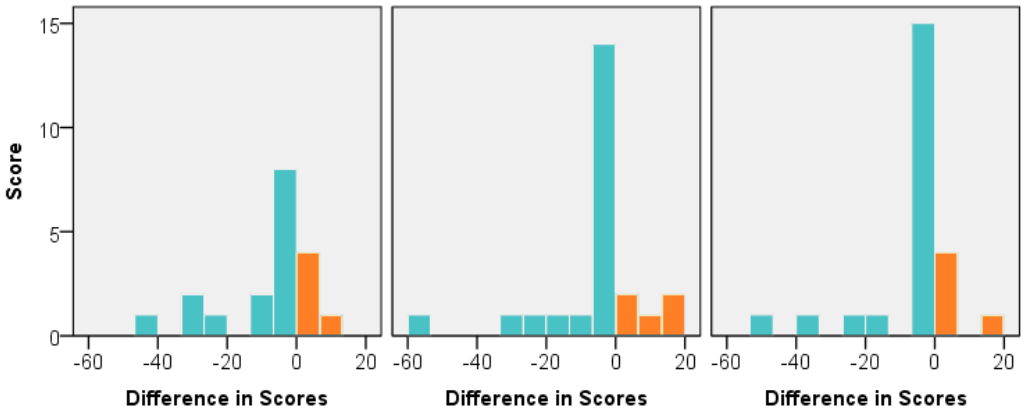
Paired comparison of scores in children and parents

It was possible to compare opinions within the framework of each pair child – parent while saving the anonymity of respondents. Results of the statistical evaluation obviously document a prevalence of higher scores in children, which means that children considered the parameters examined more positively than their parents (Table 2, Graph 5). In the scale of the physical health, a better score in children was found in 14 cases; agreement between children and parents was observed in 10 cases; better score in parents was found in 5 cases. Within the scale of the psychosocial health, children presented better evaluations 19x; evaluation in children and parents were in agreement 5x; a higher score was achieved by parents 5x.

Table 2. Results of comparison of scores achieved in children and parents (Wilcoxon Test)

Questionnaire	(Sub)Scale	P-value
PedsQL 4.0 Generic Core Scale	Physical Health Summary Score	0.016
	Psychosocial Health Summary Score	0.013
	Total Score	0.004

Figure 5. Differences between the scores of children and their parents in the questionnaire PedsQL 4.0 – a) Physical Health Summary Score, b) Psychosocial Health Summary Score, c) Total Score. Negative scores depict higher children's score compared to their parents', i.e. better quality of life perception by children. Note: zero differences (similar scores of children and parents) are not shown.



Conclusions

In 12 tests of PedsQL 4.0 and 2.0 questionnaires, the zero hypothesis was refused and thus, there were differences between values of the quality life among all the groups examined.

In the paired comparison of results of the quality life according to questionnaire PedsQL, the most distinct difference was found between the group of healthy children and group of children with ADHD and autism.

Results of the paired comparison of children with parents document a higher score in children, which means that children consider their quality of life more optimistically compared to their parents.

Children with Diabetes Mellitus have different opinions and there are differences between the quality of life as completed in questionnaires by the child and parent. This results from the fact that the children do not consider their disease as a problem. The reason for this is where the parents of children with Diabetes Mellitus provide essentially everything instead of their children – computing units, supervising regular and balanced food, monitoring sugar levels in the blood, etc.

Anchored theory

1. The combination of mental handicap, epilepsy and attention disorders is most frequently encountered.

2. Tedious financial requirement in Diabetes Mellitus associated with purchasing sensors.
3. Fits of temper and aggression hard to manage in children with autism. Tedious taking of care on the part of parents.
4. Problems in the school, in the community of children, retardation, social failure, misunderstanding by surroundings.
5. Taking care by mother, absence on the part of fathers and grandparents in the care.
6. Lack of facilities, particularly in small towns, missing possibility of occupational inclusion in protected workshops.

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