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Issue: Emerging Problems in Medicaly and Socialy Vulnerable and Disadventaged Patients Groups

Original Articles

✓ THE INFLUENCE OF AN ORGANIZATION ON STRATEGIES TO HANDLE EMOTIONS OF SOCIAL WORKERS WORKING WITH VULNERABLE CHILDREN IN THE CZECH REPUBLIC

✓ ANALYSIS OF SELF-SUFFICIENCY FOR SENIORS

✓ INTERVENTION OF NATIONAL ECONOMIES TO HEALTH AND SOCIAL SECURITY: ANTIBIOTIC POLICY AS AN EXAMPLE OF EU SOLIDARITY WITH MIGRATION CRISIS OR SOCIAL PATHOLOGY? (NOTE)

✓THE SIGNIFICANCE OF ANTHROPOMETRIC INDICATORS IN THE PREDICTION OF ABDOMINAL OBESITY IN OBESE PATIENTS

✓ CHRONIC HEPATITIS C – IN RISK GROUPS IN EASTERN EUROPE: A GLOBAL PUBLIC-HEALTH PROBLEM

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✓ EDUCATION HARMONIZATION IN NURSING AND SOCIAL WORK AS RESPONSE TO VULNERABLE PATIENT/CLIENT GROUPS IN THE NEW CANDIDATE MEMBER STATES – SOLIDARITY FROM EUROPEAN UNION (NOTE)

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Some remarks from the visiting editor

Emerging Problems in Medicaly and Socialy Vulnerable and Disadventaged Patients Groups

The number of handicaped and both medicaly and socialy vulnerable patients and dients, within EU and outside of Europe is ncreasing. This „Christmas“ issue brings miltidisciplinary appreach is to the solidarity with this emerging problem:

Czech authors focus social work with vulnerable children and their families (1).

Hungarian, Austrian and Greek group of researcher focus on consumption of antiinfective drugs in the victims of international refugee and the migrant crisis (3).

Interdisciplinary team form Bosna / Herzegovina analyses self sufficiency capaticies in seniors / elderly clients (2).

Psychosocial intervention as prevention of among humanitarian staff is reperted by on international group.

A single experts submitted original research on health and social stigma in obese chronicaly ill individuals (4).

Risk groups and risk behaviours within social pathology in Central and Eastern Europe infected with Hepatitis C is reviewed by Ukrainian and Russian study group (5).

Professional sportwomen and their place and problems in civil society is dissuessed within group of authors from Pakistan (6).

Two Kenyan scientist analyses of risk factors for acquisition of new HIV/AIDS infected in Kenyan couples (7).

A group of Greek, Slovak, Czech, Hungarian and Albanian authors discucc the burden of healthcare stigmalisation in illegal migrants to Lesbos, Greece and sothern Balkan countries (8-9).

Philosophy and the need of harmonisation in education in nursing and social work as solidarity from western / northen EU is highlighted by nursing experts from Austria, Serbia. (10).

Finally, one of the largest cohorts of homelless population from Slovak capital is described in the last article of social and nursing HCW (11).

All papers have a common pipeline. Solidarity with vulnerable patient and client population. Not only because this is a Christmas issue of CSW.

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The Influence of an Organization on Strategies to Handle Emotions of Social Workers Working with Vulnerable Children in the Czech Republic

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Original Article

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Abstract:

OBJECTIVE: The objective of our research was to understand the influence of an organization on the strategies to handle emotions of social workers working with vulnerable children.
DESIGN: The research was carried out using a qualitative research strategy.
PARTICIPANTS: The research participants were 30 field social workers working with vulnerable children and their families (27 men and 3 women). The average length of practice was 7 years; the minimum length of practice for an informant to be included in the research was 12 months.
METHODS: The research included 30 in-depth interviews with the informants thematically oriented on emotions and their functioning in the practice of social work with vulnerable children. The data was analyzed using grounded theory of A. Clarke.
RESULTS: Setting rules for expressing emotions has an influence in an organization on the creation of positive/negative strategies to handle emotions.
CONCLUSION: Emotions in social work are of a very complex and interactive nature and they are not addressed enough either in the practice or in the research of social work.

Introduction

In social work, theoreticians and practitioners lead discussions whether emotions belong to social work. Such discussions are often based on perception of duality of emotions and sense; where emotions are perceived as "*personal, feminine, and irrational*", thus not belonging to the practice of social work (Knott, Scragg, 2016). References to the rationality of social work can imply the necessity of elimination of human elements, such as emotions, from the personality of a social worker which results in highly unrealistic expectations (Grant, Kinman, Alexander, 2014). D´Cruz *et al*. (2007) state that social workers, in accordance with these expectations, are imposed with high requirements on self-control as a professional skill, particularly handling negative emotions and the art of handling positive emotions.

Numerous authors agree on the fact that emotions cannot be separated from social work and that they are its inherent part (see e.g. Sheppard, Charles, 2015). D´Cruz *et al.* (2007) summarize the above-mentioned by stating that emotions are part of social worker's equipment which enables them to better understand a given situation and execution of this profession.

The practice of social work, of course, arouses emotions in social workers as social workers witness emotionally tense situations which bring emotional reactions to them (Dore, 2016). A frequent phenomenon in social work is meeting people who need a certain support of the workers when handling their own (strong) emotions (Ikenbuchi, Rasmunssen, 2015). The execution of social work is then emotionally demanding in cases when social workers work with vulnerable children or experience clients' traumatic events, such as a loss of someone close (Grant, Kinman, Alexander, 2014). Stanley, Bhuvaneswari (2016) add that social work is a highly stressful profession due to working with people in stressful life events such as home violence; experience

with crime; loss of habitat; etc. and their complexity still rises.

Each organization has own unwritten rules for expressing emotions. The fact how employees adjust their emotioal expression according to these norms is called emotional labor. Brotheridge & Lee (2002) define emotional labor as a control of workers' public expressions of emotions in a way to be in accordance with the organization's rules of expressing emotions. Thanks to emotional labor, emotions are expressed in a suitable way at a suitable moment and suppressed in all other cases. In the context of the above-mentioned, the objective of our research is to understand the influence of an organization on strategies to handle emotions of social workers working with vulnerable children.

Emotional Labor in organization's context

In organizations of health and social care, employees are expected, within the context of emotional labor, to handle their emotions (Grandey, Chuen Foo, 2011). The workers are expected to work emotionally in the sense of expressing their interest, worries, sympathies, and suppressing their frustration and anxiety. This can lead to alienation from own self, non-authenticity, and emotional exhaustion (Vannini, Franzese, 2008). Workers are made to suppress their anger and respond to clients' negative emotions positively, thus they have to pretend their emotional expression (Diefendorff, Richard, Yang, 2008). Expressing emotions in health and social professions is viewed as unprofessional (Lewis, 2005). An individual is then caught balancing between authenticity and acceptance by other people (Vannini, Franzese, 2008).

In contemporary social work, there are two phenomena regarding emotional labor in organizations. They concern: **a)** bureaucratization of emotions: emotional labor in organizations can slip to their bureaucratization when organizations, using their structures, processes, procedures, rules and regulations, help participants in interactions in distorting, manipulating, redirecting and neutralizing emotions (Ruch, Turney, Ward, 2018); **b)** creation of unclear and unuttered rules to express emotions in organizations of social work. This often leads to workers' tension between their own experience of emotional practice and possibilities of its expression. It further leads to stress, non-congruence, and identity confusion of the worker. Another experience related with the creation of unclear and unuttered rules of expressing emotions in organizations is the feeling of *"breaking rules without knowing them"* (Barlow, Hall, 2007).

Related to the above-mentioned, it is necessary to state three specific facts of field social work with vulnerable children and their families **a)** social work is carried out in *"jungle of regulations"*, i.e. directives and regulations given both by legislation and given organizations; **b)** social workers often perceive that these regulations are imposed from above by people who do not know anything about field social work; *c)* social work in the Czech Republic has low prestige and social workers working with vulnerable children and their families are often perceived as *"toothy aunts"* who try to take children away from families (see, e.g., Gojova, Glumbikova, 2015; Glumbikova, Vavrova, Nedelnikova, 2018).

Research methodology

The research was realized using a qualitative research strategy due to our intention to understand the subject perspective and to get an insight into organization's influence on strategies for handling emotions of social workers working with vulnerable children. The research included 30 in-depth in-

terviews thematically focused on emotions and their functioning in the practice of social work with field social workers working with vulnerable children and their families. The selection of the communication partners (CP) took grounds in targeted criteria selection with the following criteria*:* a) *realization of field social work with vulnerable children*[1]*;* ***b)*** *length of practice minimum of 12 months;* ***c)*** *voluntary participation in the research. The research involved 27 women and 3 men; the average length of practice was 7 years. The minimum length of practice was 1.5 years and the maximum length of practice was 35 years. The data was analyzed using the grounded theory by A. Clarke. In particular, we preformed open coding, intentional coding, and axial coding, which lead to the creation of categories.* Then we created positional maps, which graphically depict partakers' positions or phenomena in relations to the cross-section of (identified) factors affecting these positions (Clarke *et al.,* 2018). The research was held in compliance with the Ethical Principles in Human Research (APA, 2010). Every communication partner provided informed consent: every communication partner was also familiarized with research objectives; participation in the research was voluntary; researchers committed themselves to keep confidentiality. Regarding the data limits, it is necessary to reflect possible social desirability in the communication partners' expressions, which can be characterized as a degree of preparedness to answer questions in a way the partaker believes the researcher (society respectively) expects or wishes.

Research results: Data analysis and interpretation

The crucial point for the communication partners to set the strategies of work with emotions was setting rules for work with emotions in the organization. The communication partners distinguished two characteristics of organization's rules, which they considered important for setting their own strategies to handle emotions. The first was (un)clarity of the rule and the second was strictness versus freedom of the rules.

Social workers often spoke about the **lack of clear rules** in the organization (existence of unclear rules respectively) for expression of emotions. Thus, there are situations when the workers do not know when and how they can express emotions, which lead to the fact that they do not express emotions at all (and within their group feeling, it only strengthens this strategy), or they express them but in secret or in places where *"no one can hear or see them"*; because "*one has to let it out sometimes"*. According to the communication partners, unclear rules often lead to the fact that they do not express emotions at work and they take them home, which *"can interfere into their partnership"*. *"In our organization, it is not clear with the emotions, I feel it that everyone rather keeps them inside… we're kind of iron men, we have to withstand everything… of course, we let it out sometimes… when I cannot go on any more, I go to the toilet and cry there."* (CP16)

Setting **clear rules**, on the other hand, led to a certain feeling of safety and the creation

[1] These organisations function in a regime of Social activation services for families with children as defined in Section 69 of the Act No. 108/2006 on Social Services are as follows: *"Social activation services are outpatient or outreach services in nature provided to persons of retirement age or to persons with disabilities at risk of social exclusion. The service according to ... contains the following basic activities: a) Mediation of contact with the social environment, b) Social therapeutic activities, c) Assistance in the exercise of one's rights, legitimate interests and personal affairs."*

of safe environment where the workers can express their emotions without being afraid of irrespective or even condemning approach from their colleagues "*Well, I think that we respect each other here, each personality and we also know what, how and where to do… it gives us certain safety…"* (CP3)

The second characteristics of an organization's rules which influenced the strategies of expressing emotions was **strictness versus freedom** of expressing emotions. Communication partners pointed out that where the rules for expressing emotions are too **strict**, there is too limited space, limited by time or place in a way that is hardly reachable for the workers in moments when they really need it. *"Social work is an arduous profession, full of emotions… I can't give those emotions a command… I can't say to myself to feel delightfully next Tuesday after a meeting with a client when I have supervision."* (CP30) On the other hand, **more freedom for the rules** was related with the amount of (informal) support by colleagues in a moment when the workers needed it. *"We have it set so… when somebody comes from the field and needs support, they get it… we have a habit that when someone comes and needs to spill their guts, it would be impolite to say no… it's an unwritten rule… to listen to each other, discuss… nothing formally set, it just works here like that."* (CP28) Setting more freedom of rules created certain open space at the workplace for the workers to verbalize emotions. In relation to the freedom of rules, the workers pointed out that rules and restrictions for expressing emotions are necessary in organizations as a worker cannot be emotional, i.e. expressing emotions uncontrollably. On the contrary, a worker must handle emotions in social work so that they, worker and client, reached the objectives of their cooperation. *"We can't just collapse or be hysterical… it's rather about using emotions to work with a client to achieve what we want."* (CP30).

Concerning the strategies to handle emotions, the communication partners' narratives distinguished two variables determining those strategies. It concerns their (non-) adaptivity in relation to the achievement the objectives of the cooperation with a client and their focus inside or outside. **Adaptivity** was described by the communication partners in terms of strategies to handle emotions in a way that would lead to positive results both of the client and the worker. Adaptive strategies were typical for being aware of emotions, their acceptance, verbalization, and authentic expression of own feelings. *"To accept that I feel positive emotions as well as those negative ones which influence me… to learn how to handle them, accept them, name them, talk about them… to keep own identity… just to be in harmony."* (CP2) **Non-adaptivity** of emotions was related with the opposite of adaptivity. It concerned a denial of emotions and unauthentic self-control leading to a gap from client's relationship and inability to process own emotions. *"I try to keep this distance… not to express emotions in front of a client… not to show any weakness… just to keep authority at any price..."* (CP6)

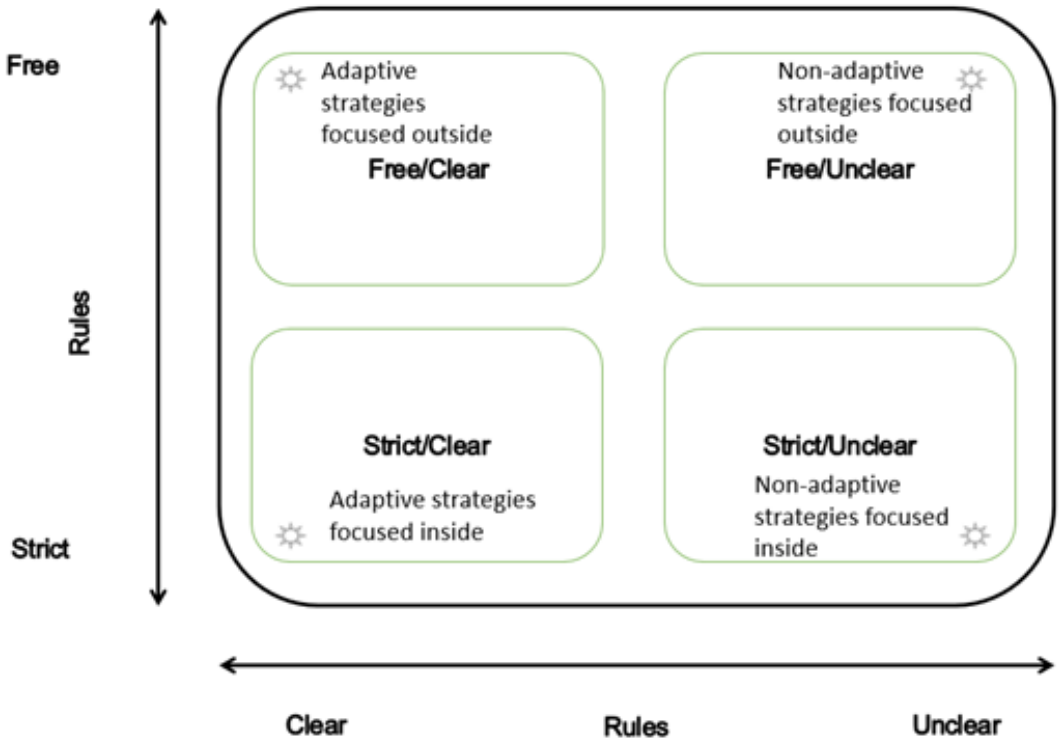
The focus of the strategies to handle emotions inside or outside divided the strategies into those when a worker keeps his/her **emotions inside** and deals with them repeatedly or denies them directly. *"If you want or not, you've got to think about it all the time. Just see, when I brush my teeth… it just goes over in my head what happened what didn't, what might be done, so I think it's not possible not to think about it*." (CP11) **Strategies** to handle emotions **focused outside** were often a result of a long-term frustration with a subsequent need of catharsis or the need of current ventilation of emotions. The manifestation of such strategies was bursting into tears or verbal

aggression. Expression of these emotions was mainly done outside interaction with a client although sometimes directly in it, which social workers described that (*"it just slipped out"*). *"One tries to be professional, but sometimes the emotion is so strong that one says it impolitely or just raises voice more than necessary."* (CP8).

The above-mentioned characteristics of an organization's rules and strategies to handle emotions led to the creation of a positional map of using strategies to handle emotions in relation with an organization's setting of rules.

istence of mutual respect. **Strict and clear rules** lead to the use of adaptive strategies focused inside, where social workers have clearly defined place and time to express emotions, e.g. in a form of supervision. The social workers, according to their narratives, have safe space for the creation of strategies to handle emotions and possible ventilation of emotions, but they often accumulate emotions and think about the possibilities to solve the situation in order to be able to ventilate them just at these occasions. **Free and unclear rules** lead to the use of non-adaptive strategies focused

Fig. 1: Use of strategies to handle emotions in relation with the organization's setting of rules



Source: Own construction.

Free and clear rules lead to the use of adaptive strategies focused outside. It primarily concerns informal sharing and providing of mutual support between colleagues, when the workers perceive the existence of mutual respect. **Strict and clear rules** lead to the use of adaptive strategies focused inside, where social workers have clearly defined place and time to express emotions, e.g. in a form of supervision. The social workers, according to their narratives, have safe space for the creation of strategies to handle emotions and possible ventilation of emotions, but they often accumulate emotions and think about the possibilities to solve the situation in order to be able to ventilate them just at these occasions. **Free and unclear rules** lead to the use of non-adaptive strategies focused outside, i.e. to the state when social workers do not know how and when expressing emotions is acceptable. Strategies to handle emotions are then quite diversified. Most frequently, there is uncertain (by place,

time, and intensity) ventilation of emotions and bringing emotions home. **Strict and unclear rules**, however, led to the use of non-adaptive strategies to handle emotion, which were focused inside, when a worker still reflects on emotions or, on the contrary, totally suppresses them and keeps distance from any relationship with a client.

Conclusions and discussion over results

The positional map presents certain ideal models to handle emotions, which social workers variously combine in the practice of social work in accordance with the dynamism of the profession practice (legislative context of social work, particular target group, client's situation, time, etc.). Nevertheless, it can be said that setting of organization's rules to use the strategies to handle emotion is pre-featured in a certain way. The research results also showed that the most problematic, in relation to the setting of an organization's rules to handle emotions, is a certain lack of clarity of these rules, which results from tabooing of social workers' emotions when emotions are perceived as something *"unprofessional"* and social workers are expected to suppress or not to show emotions at their workplace at all (similarly see, e.g., Lewis, 2005; Grant, Kinman, Alexander, 2014).

Communication partners' narratives also revealed that emotions are immanently present in social work and social workers need certain leadership from the organization as well as space for their expression in order to prevent burn-out syndrome as well as compassion fatigue (which are common in the practice of social work) (similarly see, e.g., Dore, 2008 or Vannini, Franzese, 2008). Organizations should therefore use a combination of various tools to support adaptive strategies to handle emotions of social workers, such as supervision, education, mentoring, team meetings, or other tools of creating (informal) space for sharing emotions with colleagues (see, e.g., Diefendorff, Richard, Yang, 2008).

The objective of this paper was met. Nevertheless, emotions of social workers in field social work with vulnerable children and their families are a highly complex and dynamic issue which deserves more attention from the researchers' side.

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Analysis of Self-Sufficiency for Seniors

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Abstract:

Background. Performance falls in old age and the onset of chronic diseases is developing a series of malfunctions and consequently there is impaired self-sufficiency and dependence.
Objective. The aim of this work was to determine how perceived self-sufficiency and quality of life among seniors in the institutional facilities.
Methods. We selected in this work a sample of 386 probants with standardized questionnaire surveyed the relationship of self-sufficiency and quality of life of the seniors population. Based on statistical comparisons, using Mann-Whitney Test.
Results. We found poorer self-sufficiency (gross score in the score 11, 65) in geriatric patients compared with residents in facilities for the elderly (gross score in the score 8, 92). Our study confirmed a clear dependence on the level of self-sufficiency and quality of life of seniors ($p < .001$). ADL test has being identified in the region of Presov from the group of 1,028 seniors 65 years and older 149 probants who completed the test insufficiently.
Conclusions. Recommendations contained in the ADL tests, balance tests and others are part of a comprehensive geriatric assessment. The quality of life of seniors is an important indicator of their care.

Introduction

Prolongation of human life is associated with higher morbidity and functional disability (1). For dizabilite is an important measure of residual sovereignty (2). Self-sufficiency of the individual is conditioned by two factors: functional state of the environment and demands. Many individuals with severe disabilities are fully self-sufficient in quality high-end housing (lift, central heating, kitchen equipment, communication and availability below). Or barrier-free environment but dependent in harsh environments (1, 3).

The East Slovakia Region is one of the economically underdeveloped areas across the European Union. This status is reflected in the health and social fields. Social services are inadequate in terms of quality and scope, institutional care is limited, senior financial options are restricted (4). These aspects mainly influence the the quality of life and the senior population.

Increasing age and the presence of chronic diseases influence the whole series of functional defects what makes self-sufficiency worse and develops the dependence of handicapped individuals (5). Self-sufficiency can be easily detected by I-ADL Test (Instrumental Activity of Daily Living) that is already insufficient at an early state of functional defect; in the following period the absence of basic daily activities comes along with what we find out from the ADL Test (Activity of Daily Living) (6).

Aim of research

The aim of this research was to evaluate the proportion of relation quality of life from the self- sufficiency in basic daily activities of patients hospitalized in geriatric departments and residents in facilities for the elderly. We supposed that the level of self-sufficiency of geriatric patients and residents in facilities for the elderly statistically differs and is an important factor of

their subjective evaluation of their own life quality.

Methodology of Research

Altogether 204 patients of Geriatric Department of Faculty Hospital J. A. Reiman Presov and 182 residents of Facility for the elderly in Presov (Slovakia) took part in survey. The whole sample contained 386 respondents. In our survey we used causal – comparable research. For selecting individual components we used in research the method of gaining the information with the help of two batteries of standardized tests – test of self-serving daily activities ADL (Barthel Test standardized self-judging scale that finds out the level of managing self-serving activities performed daily; the value of Crombach alpha of used method moved between the interval of 0,8217 – 0,9122 for individual items). For statistical comparison of surveyed groups we used the test for two independent selections of the Mann–Whitney Test. This unparametrical method enabled us to find out statistically the major differences between the groups in researched parameters.

Results

The senior population assessed their quality of life, especially in terms of the perception of their health status. Therefore we were interested in the representation of the largest health problem in the study groups (Table 1).

The graphic view is clear that the severity of priority health problems are heart disease (65 geriatrics patients and 36 seniors). This is connected with the fact that cardiovascular disease can „keep“ the primacy in the prevalence of disease in Slovakia. The high representation of musculo-skeletal system in this age group (61 geriatric´s pacients and 50 seniors) confirms our assumption that mobility is a major domain of quality life of geriatric patients and seniors. We also investigated the perceptions of quality of life in both groups. Here are the results of the examination of significant differences between the groups in overall quality of life (Table 2).

We can conclude from the above results ($p < .001$) that in the population group for senior citizens is manifested a gross score significantly higher overall quality of life associated with a health group than in geriatric patients. We see cause that unlike residents in facilities for seniors dominated in geriatric patients actual health complications and unresolved possibilities of life perspective (who will take care of them after their release, the rate of self-sufficiency, etc.).

Table 1 Comparison of the biggest health problem

	Geriatric patients	Facility for seniors
Cardiac disease	**65**	**36**
Foot pain	**61**	**50**
Other problems	**96**	**78**

Table 2 Statistical results of surveys differences in the value of the gross score WHOQOL – BREF found in the Mann – Whitney Test.

	Geriatric patients		Facility for seniors		
The variable	**M**	**SD**	**M**	**SD**	**Z**
The gross score	74,32	15,46	85,08	11,37	- 7,371***

We list the results of surveyed groups in self-sufficiency according to ADL Test. The values are evidently different in all tested items – toilette, food income, dressing, appearance, mobility and bathing (Table 3).

From the results in Table 1 it is obvious that there is a major dependence of level of self- sufficiency from the life quality of seniors ($p < .001$). On the basis of stated facts we can say that the correlative relationships of both groups among evaluated parameters have comparable power and direction.

Discussion

The stated results prove our supposition that increasing deficit of self-sufficiency causes the decline of life quality of geriatric patients and of residents in facilities for the elderly. That means that their correlative relationship is negative.

In our research we found that the diminished self-sufficiency (rough score with ADL Test, score 11, 65) with geriatric patients in comparison to residents of facilities for elderly (rough score with ADL Test, score 8, 92). Our results proved that the less self-sufficient are especially hospitalized geriatric patients in comparison to clients of institutions for seniors. Self-sufficiency is another important trait elderly people cherish. Self-sufficiency will, in time, give an elderly person self-confidence while self-confidence leads to an increased feeling of self-worth. Self-worth is being defined as: "the sense of one's own value or worth as a person", leading towards an increased mental health and greater sense of purpose in life (4). The elderly can feel like they are a burden to the household they share with younger generations, especially if they are suffering from disabilities preventing them from active participation in the household. Other elements potentially contributing to this feeling include but are not limited to a financial burden; occupying space in a small living area; requiring a lot of time and effort. The feeling of being a burden on family members causes stress as well as feelings of unhappiness. The *Committee on a National Agenda for the Prevention of Disabilities* (NAPD) conceptualized a model for disability; which contains a person´s physical or mental limitations; in interaction with physical and social barriers in the environment; prevent the person from taking equal part in the normal life of the community (22). That is why within care giving and rehab care we stimulate the patients into active participation on recovery regime instead of position of passively accepting help (20).

ADL Test should be the main functional test for disclosing self-sufficiency (or lack of it) with geriatric patients and support of their self-sufficiency should be the domain of geriatric care givers. Positive tasks can play various compensation aid gadgets for

Table 3 Statistical results of search of differences between both groups found out by Mann – Whitney Test

	Geriatric patients		Institutions for seniors		
Parameter	M	SD	M	SD	Z
Toilette ADL	2,00	1,36	1,48	0,97	- 4,264***
Food income ADL	1,66	1,05	1,16	0,41	- 5,283***
Dressing ADL	1,83	1,12	1,25	0,52	- 5,557***
Appearance ADL	2,02	1,10	1,61	0,81	- 3,658***
Mobility ADL	2,64	1,45	2,33	1,48	- 2,541**
Bathing ADL	2,08	1,08	1,63	1,02	- 2,541***
ADL rough score	11,65	5,82	8,92	3,53	- 4,885***

Table 4 Summary ADL test result

Barthelovej Test (women and men)								
Age	65-69 a.	70-74 a.	75-79 a.	80-84 a.	85-89 a.	Over 90 a.	Together %	Together numb.
Sumar of prob.	347	306	178	132	44	21		1028
n% of number	34%	30%	17%	13%	4%	2%		
over 80 p.	330	280	151	88	23	7	85,5%	879
80-61 p.	12	12	17	19	11	4	7,3%	75
60-41 p.	2	5	4	17	2	2	3,1%	32
40-0 p.	3	9	6	8	8	8	4,1%	42
% over 80 p.	95%	92%	85%	67%	52%	33%		
% 80-61 p.	3%	4%	10%	14%	25%	19%		
% 60-41 p.	1%	2%	2%	13%	5%	10%		
% 40-0 p.	1%	3%	3%	6%	18%	38%		

increasing self-sufficiency of patients in all its areas (8). For maintaining the adequate physical capabilities it is necessary to provide for seniors various mobility activities by the form of every day exercises and common mobility programs. Equally important is the psychical support of seniors who are from the point of their age and functional conditions always a risk group for medicine and care giving (1, 7).

Other authors identified the ADL Test (Activity of Daily Living according to Barthel's) in the Region of Presov from the group of 1,028 seniors 65 years and older 149 respondents who completed the test insufficiently (10, 19). After the approval of these 149 respondents there were home conditions were evaluated according to the questionnaire prepared by Tideiksaar (with medium modification). Up to 42 (22%) subjects had bad and inadequate home conditions. It is well known that the quality of home conditions for patients with insufficient abilities to carry out routine daily activities determines the need of home or institutionalized care. The 1,028 respondents were assessed with the consent of the ability to perform normal daily activities according to the ADL Test. Table 4 shows the summary results of the test on ADL Test respondents examined.

The vertical columns are the age zone (after 5 years), horizontal columns are the results, which reached probands (in absolute terms and percentage terms). The last two vertical columns show summary results of the Test. A full score achieved by the Bartel Test is 100 points. According to the literature the easy default value of 61 points or more was deemed a moderate disturbance obtaining 41 to 60 points and 40 points suffer from severe and less (9, 18).

Recommendations contained in the ADL Tests, Balance Tests, and others are part of a comprehensive geriatric assessment (8, 10). Decreases with age and physical ability and consequently appear as attribute dependence together with an increasing risk of disability, frailty and injuries. The patient has the right to a functional signaling to resolve their biological, psychological and social needs. Alternative versions for hospital signaling could be personal property for the elderly at home and in the social facilities. Service emergency care is provided on a contractual basis and the precondition of fixed telephony in the home client that is secure signaling (placed on the wrist or neck) and pushes the button, as appropriate (11, 12). In the literature we did not encounter the assessment of housing conditions in the elderly with functional deficits. Nemeth *et*

al found (in research) that 22% of the functionally disabled elderly had poor housing conditions (10). In Linz (Austria) in the 61-70 group, 70% reported annual (at interview) very good housing conditions; 23% satisfactory; only 7% of poor housing conditions, for self-sufficient seniors (13). The efforts of family members to take care of his old functionally disabled member (as it was in our group) lives a burden. Already 30 years ago Gressner, Nestor Slovak gerontology asked for these families increased care and pointed out the necessity of overprotection for these selfless caregivers (12).

Conclusion

Prohaska *et al* made important observations in the elderly and he assessed the reasons for their action of negative factors on physical activity and the consequences of their deterioration. He found that the lowest levels of physical activity often present lower socio-economic status individuals (14). Physical dependence can be tested for seniors with ADL and IADL Tests. In several foreign sources in other studies nursing is a recommended functional status questionnaire (FAQ) (15, 16). Seniors at home show a higher degree of self-sufficiency as seniors living in social facilities. This is confirmed by Cagankova *et al* research implemented in Zlin in the sample of 200 seniors aged over 80 years (17). According to research Nemeth in order to determine disability in Presov was statistically the greater female population is represented as an independent (in the group of moderate, depending on the level of $p < 0.01$). Expected life of the elderly population of our century requires maintaining an active life and help prevent disability (4, 21). Nursing interventions can prevent disability for older people.

Author contributions:

AH: manuscript writing, literature search, critical review of the manuscript; LM: literature search, critical review of the manuscript; AO: literature search, critical review of the manuscript; DM: critical review of the manuscript; SA: critical review of the manuscript.

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The authors state that there are no conflicts of interest regarding the publication of this article.

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Intervention of National Economies to Health and Social Security: Antibiotic Policy as an Example of EU Solidarity with Migration Crisis or Social Pathology? (Note)

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Abstract:

Antibiotic consumption and policies are of great concern in Europe, mainly due to the growing ATB resistance and failure of ATB therapy. The aim of this note is to interprete the correlation between ATB consumption and resistance to ATB in 30 European (EU) European Economic Area (EEA) countries and search for the influence of state economies (eg. GDP, health expenditures etc.) to the ATB consumption. As result of solidarity and patients behavior.

Introduction

Increasing life expectancy worldwide is a positive economic and social phenomenon in high-income countries and is caused within last 50 years by decreasing mortality on both communicable and non-communicable diseases. Vaccines and antibiotics are major factor in decreasing mortality related to infectious diseases. However, increasing ATB consumption is reported on both – hospital and nationwide levels.(1) Is ATB consumption the only driver of increased ATB resistance? Is high ATB-consumption on national level the major cause of ATB resistance or just a consequence of migration (2,3) patients behavior, education and/or social situation? (3,4,5) The aim of this note is to interpret the correlation between ATB consumption and resistance to ATB in 30 European (EU) European Economic Area (EEA) countries and search for the influence of state economies (eg. GDP, health expenditures, migration, social pathology etc.) to the ATB consumption.

Methods

Data on ATB consumption and resistance were extrapolated from the ESAC study group (1) and data on GDP and health expenditures from 30 EU/EEA countries from the Global Burden of Diseases published in Eurostat 2018 and The Lancet 2019 were compared.

Results and Discussion

Consumption and resistance data from all 30 EU/EEA countries are to be found in tables 1 to 4. Out-of-pocket spending and %GDP in particular countries were compared in 4 groups according to level of consumption and resistance.

Correlation was found in 60% of countries (n=18), rest of the countries showed no correlation between consumption and resistance of ATB.

16 countries with high ATB-R (more than 20% mean ATB-R rate). 10 of them (60%) has also high ATB consumption, mainly in Southern and Eastern Europe. Romania has also the highest resistance rates (45.9%) followed by Slovakia, Greece, Bulgaria and Italy. However there were also countries in this group with low ATB-consumption and high resistance rates (Czech Republic, Hungary, Slovenia, Latvia, Lithuania, Estonia). Countries with low resistance rates, 8 of 14 countries, showed correlation with consumption and resistance, (mainly Scandinavian countries). In France, UK, Ireland and Belgium high consumption is not

accompanied with high resistance rates. Explanation for this 60% consumption can be found in economy and financing of healthcare and discussed as a interesting phenomenon, which may explain this non-correlation. Countries with high resistance and consumption (group A) showed also high percentage of out of pocket spending on healthcare (28-32% vs. 13-14%). Countries with high ATB consumption but low resistance (group C) vice-versa showed significantly higher investments to healthcare (8-9% of GDP vs. 6.0-6.1% p=0.045) than in the countries with low consumption, but high ATB-R (group B). Differences are also in the spending on healthcare per capita, in group B it was on average 1400-1650USD and in group C 5500-7500USD.

Conclusions

There is a partial correlation between ATB-resistance and consumption of antibiotics in EU/EEA. 60% of European countries, which have high ATB consumption, have also high ATB-resistance and countries with low consumption tend to have low resistance rates too. However, there is also correlation between out of pocket expenditure on healthcare and high consumption of ATB and investments to healthcare per capita also correlates to low ATB-R rate, possibly due to more resources spent to hospital hygiene, surveillance and preventive programs for ATB resistance due to charges of social pathology (migration, detention, patient behavior) and social policy, of particular state (4-5)

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The Significance of Anthropometric Indicators in the Prediction of Abdominal Obesity in Obese Patients

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Abstract:

Objectives: Obesity is a chronic progressive disease representing a significant health hazard and serious economic problem. As an independent risk factor it contributes to increased cardiovascular and oncologic morbidity and mortality. The IDEA study conducted in the Slovak Republic in 2017 reports that every other inhabitant in Slovakia suffers from an abdominal type of obesity. Therefore, anthropometric indica-

tors are recommended in the process of screening for early identification of the abdominal type of obesity.

Aim: The aim of the study is to determine the evaluation significance level of chosen anthropometric indicators for early abdominal obesity prediction.

Methods: Empiric data were ascertained by standardized anthropometric methods. We evaluated waistline, WHR, VFA, weight, height and BMI in relation to sex. The In Body 230 device was used to measure the body impedance, and the questionnaire to ascertain somatic indicators. Our research was conducted with 201 male and 301 female respondents aged between 20 and 65. The choice of respondents was purposive and we followed all essential ethical principles for research data collection. Respondents had provided their written consent to research data collection and were provided with instructions regarding anthropometric measurements and informed about its results. The data collection took place in Zvolen and Banska Bystrica in 2018 as a part of the project "Get rid of your excess weight". Empiric data were processed with the SPPS 22.0 statistical program. We used descriptive statistics, calculated Pearson´s correlation coefficient r with the corresponding determination coefficient r^2. We applied Fisher´s transformation r-z to draw a comparison between correlation coefficients.

Results: Abdominal obesity was determined in 77.1% of male and 88% of female respondents using waistline measurements. We could identify 55.2% abdominally obese male and 98% abdominally obese female respondents using WHR index measurements. Visceral fat over the standard level was determined in 93.5% male and 92% female respondents. The intersection of the waistline measurement values, WHR index and visceral fat over the standard level determined 54.7% abdominally obese male and 82.7% abdominally obese female respondents. According to WHO classification, BMI between overweight and 3rd-grade obesity could be determined in our respondents.

Conclusion: For abdominal obesity identification, it is necessary to take index WHR and visceral fat values into account in relation to sex. The anthropometric factors, e.g. BMI and WHR, waistline and WHR, waistline and VFA were higher in men than in women. Anthropometric adiposity indices are assessed as effective for clinical practice in the process of overweight and obesity monitoring.

Introduction

Obesity is a serious chronic multi-factorially induced disease characterized as an illness and at the same time as a risk factor contributing to the development of other diseases. Obesity is accompanied by accumulation of an excessive amount of fat in relation to muscles, age, height and sex. It is considered the second most common risk factor for premature death.

This disease is a result of genetic predisposition, and behavioral and environmental factors interaction *(*Hainer *et al*. 2011; WHO 2003, 2009; Richens, Lavander 2010; Mat-

ulnikova 2012, 2013). This phenomenon has an increased tendency in developed and developing countries and is slowly getting pandemic. According to WHO, the number of obese people in 1995 was 200 million worldwide, and in 2000 it was 300 million. The number increased to 700 million obese people over 15 in 2015. More than a billion adults and 10% of children are overweight or obese. By using different classification for diverse ethnic groups, the number of people suffering from this disease goes up to 1.7 billion (WHO 2010; Kunesova *et. al.* 2016).

The waistline is a very important predictor of health-related conditions and mortality connected to obesity. Abdominal obesity is related to a higher risk of death. Relative risk is more significant in the young in comparison to the elderly, and in people with lower BMI in comparison to the ones with higher BMI. Epidemiologic studies conducted in European countries and in North America specialized in population´s waistline evaluation ascertained the fact that waistline represents more sensitive lifestyle change indicator than BMI which, however, can be influenced by the season of the year in a significant way (Visscher, Seidell 2004; Hainer *et al*. 2011; Krahulec *et al*. 2013). The increase of 2.7cm in male waistline and 4.3cm in female waistline was detected in the Finnish population between the years 1987 and 2002 (15 years). The increase was not conditional on education in both sexes; however, the highest values were detected in people with primary education. BMI did not change significantly in the above mentioned period (Lahti – Koski *et al.* 2007). The increase of an average waistline adjusted to the respondents' age was ascertained by comparing the data of American population in the years 1988 – 1994 and 2003 – 2004, particularly, 96.0 to 100.4cm in man and 89 to 94cm in women. The prevalence of abdominal obesity adjusted to respondents' age increased from 29.9% to 42.4% in men, and from 47% to 61.3% in women between the years 1988 and 2004. Very similar data were gained in China where the figures showed the increase of waistline from 77.1 to 82.9cm in men, and from 75.8 to 78.9cm in women between the years 1993 and 2006. At the same time, the prevalence of abdominal obesity increased from 17.9% to 42.5% in men, and from 28.8% to 46.9% in women. In China; there were 42.5% of men and 46.9% of women suffering from abdominal obesity in the year 2006 (Beydoun, Wang 2009; Hainer *et al.* 2011). The Slovak version of the IDEA study with 4,085 patients (1,624 men – 39.8%, 2,461 women – 60.2%) conducted in the Slovak Republic stated high prevalence of abdominal obesity in the SR. The study shows

that every other adult inhabitant has a raised intraabdominal fat volume. The obesity was ascertained in every third woman (34.7%) and in every fourth man (27%). The prevalence of main risk factors for serious diseases as hypertension, hyperlipidemia and diabetes mellitus increased along with an increased waistline (Dukat *et.al*. 2007; Matulnikova *et al.* 2010, Krahulec *et al*. 2013).

Methods

The representative sample consisted of 502 respondents (40% male, n = 201, 60% female, n = 301) aged between 20 and 65. The choice of respondents was purposive and we followed all the essential ethical principles for the research data collection. Respondents had provided their written consent to research data collection and were provided with instructions regarding anthropometric measurements, and informed about its results. The data collection took place in Zvolen and Banska Bystrica in May 2018 as a part of the project "Get rid of your excess weight". Empiric data were ascertained using standard anthropo-metric devices and

recorded into the structured indicator sheet. Clinical parameters were ascertained with the bioelectrical impedance method. We were ascertaining the portion of excess weight and obesity in monitored population according to WHO classification of Body Mass Index – BMI. We calculated BMI from body height and body weight. BMI in men in the monitored group of respondents was between 24.5 and 61.3. The average BMI was 33.718 (SD = 6.24). BMI in women was between 22.2 and 56. And the average BMI was 32.99 (SD = 5.97). According to WHO Body Mass Index classification 1% of male respondents had normal body weight (n = 2); 26.9% of male respondents had an excess weight (n = 24); 41.3% of male respondents had 1st-grade obesity (n = 83); 19.4% of male respondents had 2nd-grade obesity (n = 39); 11.4% of male respondents had 3rd-grade obesity (n = 23). In the group of female respondents, according to WHO Body Mass Index classification 2% of female respondents had normal body weight (n = 6); 34.2% of female respondents had an excess weight (n = 103); 35.9% of female respondents had 1st-grade obesity (n = 108); 15.3% of female respondents had 2nd-grade obesity (n = 46); 12.6% of female respondents had 3rd-grade obesity (n = 38). Having the same BMI, women have a higher ratio of fat than men, and older individuals have a higher ratio of fat than younger individuals. The negative aspect is that the BMI values may not correlate with the adipose tissue accumulation level as body weight is taken into account when calculating BMI. The body constitution itself (particularly ratio and distribution of muscular and adipose tissues) is not reflected in BMI. This was the reason why our abdominal fat metering was based on the waistline metering using tailor's tape measure in the horizontal position in between lower margin of the last rib and the ridge of ilium bone at the end of a natural expiration. Waistline measured this way best correlates with the visceral fat amount and the risk of cardiovascular conditions. As for the clinical parameters, we measured respondents´ actual body height (± 0.5cm) using the altimeter Trystom (Czech Republic). The Bioelectric Impedance method based on the body resistance, more precisely body conductivity, measurement by means of current flow of low frequency (500mA) and high frequency (50 kHz) was used to ascertain body composition parameters as body weight, body water, body fat percentage, BMI, WHR, fat and muscles segmental evaluation and the amount of visceral fat. This method takes better conductivity of fatless body mass in comparison to fat issues acting as insulator into account. In Body Biospace 230 device was used. When measuring, the correction in connection to sex, body weight and body height of a respondent was made. The acquired data were analyzed with a personal computer and the body composition analysis was made with specializ ed software. We evaluated acquired indicators in relation to sex. Persons with an implanted artificial pacemaker, electronic implants, after bariatric surgery, with endocrine obesity, active sportspeople, people with normal BMI and pregnant women were excluded. The empiric data were processed with the statistical program SPPS 22.0. We used descriptive statistics, calculated Pearson´s correlation coefficient r with the corresponding determination coefficient r^2. We applied Fisher´s transformation r-z to draw a comparison between correlation coefficients.

Results

The average male waistline was M = 113.72cm (SD = 14.09cm). Minimal value was Min = 87cm and maximal value was Max = 164cm. 77.1% of men (n = 155) were diagnosed with abdominal obesity (waistline > 102cm). The average female waistline was M = 101.76cm (SD = 134.31cm). Minimal value was Min = 79cm and maximal value was Max = 149cm. 88% of wom-

en (n = 265) were diagnosed with abdominal obesity (waistline > 88cm). The average WHR value in men was M = 1.02 (SD = 0.11) in the range 0.42 and 1.75. According to this index, abdominal obesity (WHR > 1) was identified in 55.2% men (n = 111). The average WHR value in women was M = 0.99 (SD = 0.07) in the range 0.71 and 1.2. Abdominal obesity (WHR > 0.85) was identified in 98% women (n = 295). Visceral fat in male respondents varied from 55.2cm^2 to 299.4cm^2. The average value was M = 148.96cm^2 (SD = 44.75cm^2). Based on this index, abdominal obesity was identified in 93.5% of men (n = 188). Visceral fat in female respondents varied from 67.9cm^2 to 278.8cm^2. The average value was M = 150.1cm^2 (SD = 39.72cm^2). Based on this index, the abdominal obesity was identified in 92% of men (n = 188). In the intersection of all the 3 indicators showed presence of abdominal obesity in 54.7% of male respondents (n = 110) and in 82.7% of female respondents while BMI varied from overweight to the 3rd-grade obesity in both sexes. Studying connections between 4 indicators of overweight and obesity showed statistically significant positive relation (p < 0.001) among BMI, waistline, WHR index and visceral fat (the combination of all pairs). Acquired correlation coefficients can be found in Table 1 below.

We could determine a closer relation between BMI and WHR in men when comparing the measurement of the correlation coefficient in men and women. BMI explains 43.3% of WHR variance in men and 13.18% of WHR variance in women (Z = 4.46, p = 0.000). Also, the closer relation between waistline and WHR (Z = 3.06, p = 0.002) was determined in men than in women. Waistline explains 37.7% of WHR variance in men and 16.73% of WHR variance in women. Finally, the closer relation between waistline and visceral fat (Z = 2.46, p = 0.014) was determined in men in comparison to women. In this case, waistline explains 47.33% of the visceral fat variance in men and 30.25% of the visceral fat variance in women. The value of visceral fat in women ranged between 67.9cm^2 and 278.8cm^2. An average value was M = 150.1cm^2 (SD = 39.72cm^2). According to this index, abdominal obesity was identified in 92% of women (n = 188).

Discussion

Fat distribution is an important indicator of the risk determination of overweight and obesity. Waistline measurement can identify a twice as high prevalence of people suffering from abdominal obesity as obesity criteria according to BMI (Barakova, 2009 Matulnikova, Mizerska 2019). BMI does not evaluate the ratio of active body weight to body fat. This can result in an incorrect and erroneous interpretation in personal weight

Table 1: Pearson´s correlation coefficient for overweight and obesity indicator pairs.

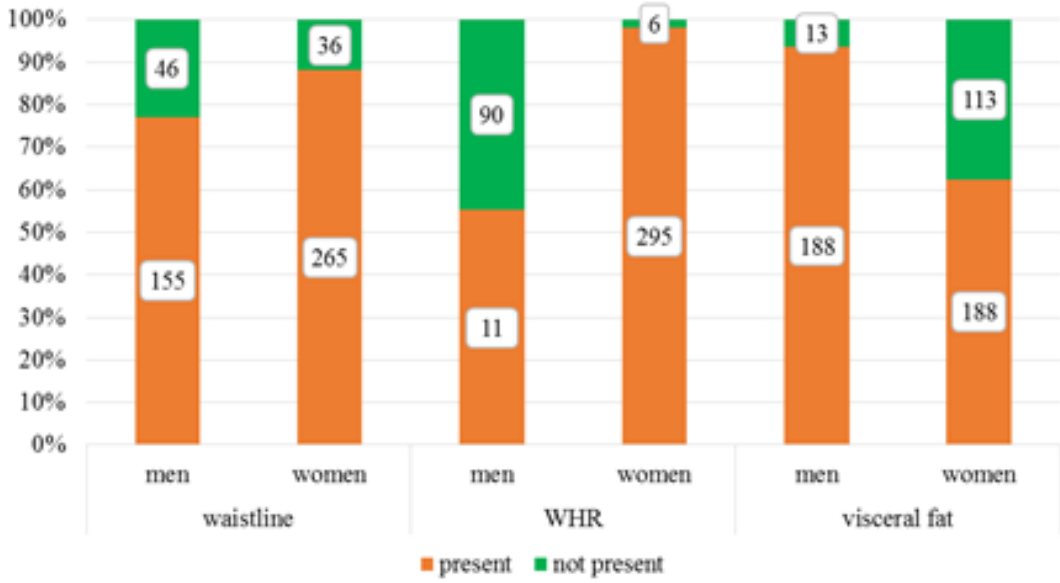
		Waistline	r^2	WHR	r^2	VFA	r^2
BMI	Men	0.619**	0.383	0.658**	0.433	0.890**	0.792
	Women	0.554**	0.307	0.363**	0.132	0.884**	0.781
waistline	Men			0.614**	0.377	0.688**	0.473
	Women			0.409**	0.167	0.550**	0.303
WHR	Men					0.684**	0.468
	Women					0.594**	0.353

** $p < 0.001$; r^2 – coefficient of determination

categorization. A person may be categorized as obese according to BMI in consequence of higher muscle mass, however, not in connection with body fat. Similarly, erroneous interpretation is possible with normal BMI index when a person´s muscle mass ratio is low but the body fat ratio is high. This is characteristic for so-called hidden obesity. The overweight or obesity evaluation solely according to BMI index is not sufficient and reliable. The accurateness and reliability of BMI calculation might also be influenced by more factors necessary to take into consideration, e.g. age and sex.

ures 0.7; this can be seen as one of the factors decreasing the value of anthropometric indicators in prediction. In NEMESYS study, the prevalence of abdominal obesity and metabolic syndrome was monitored in 10,300 Slovak outpatients. Abdominal obesity was ascertained in 65.9% of patients, where 72.6% were women and 56.6% men. The highest abdominal obesity prevalence was proved in the fifth and sixth decennium (Lietava *et al*. 2008, Krahulec *et al.* 2013). In clinical practice, the use of anthropometric indicators is recommended to the evaluation of fat deposition and abdominal obesity

Chart 1 Presence of abdominal obesity in men and women based on 3 indicators



Waistline highly correlates with BMI and abdominal obesity correlates with insulin resistance and with other metabolic syndrome factors. The waistline is a simple anthropometric indicator which correlates best with intra-abdominal fat tissue volume and with the commencement of complications (Dukat *et al.* 2007; Kalousova, Kunesova, 2008). Kunesova (2016) states the volume of visceral or intra-abdominal fat correlates with anthropometric indicators, however, the correlation coefficient is in around fig-

risks. These simple and non-invasive methods are considered suitable and important for screening program implementation. In daily clinical practice waistline measurement represents a simple tool for screening and examination.

Conclusion

The aim of prophylactic strategies is to decrease the prevalence of overweight and obesity in the whole population by creating an anti-obesogenic environment. Interven-

tion programs make use of cognitive-behavioral approaches and they are focused mainly on diet adjustment, active movement and health hazard identification. The identification of risk population and early overweight and obesity diagnostics in primary step are included in prophylactic programs. Diagnostic values of anthropometric factors are considered effective adiposity factors. They can act as important predictors for abdominal obesity, however, age, sex and the morbidity of the monitored population must be taken into consideration.

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Chronic Hepatitis C – in Risk Groups in Eastern Europe: a Global Public-health Problem

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Original Article

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Abstract:

Hepatic diseases are the sixth most common cause of death in the European Union. The World Health Organization has adopted a global strategy to eliminate viral hepatitis as a serious public health threat by 2030. Approximately one quarter of patients with CHC (chronic hepatitis C) has developed cirrhosis of the liver. It is a precancerosis with a high risk of developing hepatocellular carcinoma. From an epidemiological point of view, injection drug use (IDU) is the most significant way of transmitting HCV infection. Patients with an increased risk of transmitting HCV infection, active IDUs, homosexuals with risky sexual practices, women planning to conceive, patients undergoing hemodialysis and prisoners should all be treated in preference. This population of patients is threatened by an addiction itself as well as by infections, repeated reinfections or mixed infections, concomitant mental disorders or diseases, and multiple associated disorders. To the fulfilment of the WHO strategy on HCV elimination/eradication would certainly contribute a nationwide screening in individual European countries and active collaboration with general practitioners who could treat patients with HCV by themselves - that is, without help of specialists, with pan-genotypic drugs.

Introduction

The most common public health priorities within the European Union include: environmental health, addictions, chronic diseases, care for the elderly, health inequalities. Public health priorities in the Slovak Republic include especially environmental health, non-communicable diseases occurring on a mass scale and addictions (1).

Hepatic diseases are the sixth most common cause of death in the European Union (Eurostat data). **Along with metabolic diseases** (NAFLD - non-alcoholic fatty liver disease, NASH - non-alcoholic steatohepatitis), **viral liver diseases are considered to be the most frequently occurring liver disease** (2, 3).

The World Health Organization has adopted a global strategy to eliminate viral hepatitis as a serious public health threat by 2030. This strategy covers both, hepatitis B (HBV) and hepatitis C (HCV). Its goals include a 90% reduction of consequences and a 65% reduction of mortality due to HBV/HCV by 2030.

Worldwide prevalence of HCV infection (hepatitis C) is about 2% in the normal population. Worldwide, about 150 million people are infected with hepatitis C virus. Every year, approximately 350-700,000 people die for causes related with HCV infection (4).

The highest prevalence of HCV is traditionally reported in Egypt, where it reaches 15%. Eastern European countries report

a prevalence up to 3.5%, US 1.68%.

In developing regions, HCV infection is still spreading due to an existing huge reservoir of infection with asymptomatically infected people without diagnosis or treatment. At the same time, developing countries have an inadequate blood donation testing system; a low level of using single-use medical devices which contributes to hepatitis C spreading. Migration of infected people from developing countries brings the risk of transmission.

Chronic hepatitis C (CHC) is a precancerosis with a high risk of developing hepatocellular carcinoma. In Slovakia, an epidemiological study found that the prevalence of anti-HCV antibodies in adults over 15 years was 1.52%, with chronic infection confirmed by evidence of virus replication in 0.67% (5). It accounts for over 30,000 chronically infected patients, out of which, according to the number of reported diseases, only a minor part was diagnosed. Similar data on underdiagnoses of viral hepatitis have also been reported in other countries which highlights the need for active screening of this infection.

HCV is transmitted by ***parenteral*** routes. Prevention is an extremely important part of the health care and it should focus on people infected with HCV as well as on people with risky behaviours. Primary prevention aims to a reduction of the risk of getting the HCV infection and its transmission to other people; **secondary prevention** deals with reducing the risk of liver damage in HCV positive individuals (6). Table no. 1 lists the risk factors for the transmission of HCV infection.

From an epidemiological point of view, intravenous drug use is the most significant way of spreading HCV infection. According to the epidemiological data analysis, around 10 million intravenous drug users (IDUs) worldwide were anti-HCV positive. There are about 2.3 million infected IDUs in Eastern Europe, about 2.6 million infected IDUs in Eastern and South East Asia, China

Tab. 1 Risk factors for the transmission of HCV infection

High risk of transmission:
- **Anamnesis of intravenous drug use**
- Contaminated blood, blood products or organs transplanted before year 1990
- Imprisonment
- Needle stick or sharp injuries
- Performances (e.g. injection administration, vaccination, surgery, transfusion, rituals) including a repeated use or sharing of contaminated tools in countries with a high HCV prevalence
- Non-sterile contaminated tattoos or piercing
- Repeated hemodialysis
- Sharing personal items contaminated with blood of HCV infected person (e.g. razor blades, manicure scissors, toothbrushes)
- Sharing contaminated intranasal cocaine tools
- HBV infection
- HIV infection
- Children whose mothers are infected with HCV
- Undiagnosed liver disease
Moderate risk of transmission:
- Sexual partner with HCV infection
- Frequent change of sexual partners
- Sexually transmitted diseases including HIV and lymphogranuloma venereum

reports 1.6 million, Russia 1.3 million and the US 1.5 million infected IDUs.

Approximately 70-80% of all infected IDUs are infected with HCV during the first year of drug addiction (7). Transmission between the IDUs is not only linked to contaminated injecting instruments. Other personal items related to the preparation of the drug solution for injection (filters, spoons) are also a source of transmission (8, 9).

In 2016, in the Slovak Republic, 237 cases of CHC (morbidity 4.4/100,000 inhabitants) were reported to the Regional Public Health Offices, representing a decrease of 25.9% compared to 2015. Diseases occurred in all regions of the SR with a maximum in the Banska Bystrica (6.1), Trencin (5.8) and Trnava (5.5) Regions. The lowest morbidity was reported in the Presov (2.4), Kosice (3.0) and Zilina (3.7) Regions.

Diseases were reported mostly in age groups above 15 years. One case occurred in the age group of 5-9 years. The highest morbidity occurred in the age group of 25-34 years, in which 82 persons (morbidity 9.8/100,000) got ill and in 35-44 year olds with 58 cases (morbidity 6.6).

In patients epidemiological anamneses were found: 97 x intravenous drug application, 25x healthcare facilities, 12x transfusion, 18x tattoo, 1 x piercing, 84x cause was not found (10).

Providing adequate health care to people who use injection drugs is very specific. This population of patients is threatened by an addiction itself as well as by infections, repeated reinfections or mixed infections, concomitant mental disorders or diseases, and multiple associated disorders. These are often the so-called marginalized patients, socially stigmatized and isolated (1, 11).

Successful diagnosis and treatment of viral hepatitis in drug addicts unconditionally requires effective collaboration and functional interconnection of not only health care professionals, but of the wide range of professionals and institutions involved in the care of this patient - social workers, volunteers working within governmental and non-governmental organizations, self-help groups and foundations, family members and friends of the drug addicts (1).

In the Western world, about 25-30% of people infected with HIV have chronic HCV infection. There is a higher prevalence in Southern and Eastern Europe compared to Northern and Western Europe, as well as is in larger cities where it rises to 50-90%. The need for CHC (chronic hepatitis C) treatment in co-infected persons is greater than in those with CHC infection alone. Progression of liver disease is much faster in people with HCV/HIV co-infection (twice the risk of developing liver cirrhosis). Deaths related to liver disease are the second most common cause of death in HIV-positive patients. Successful HCV treatment can also improve tolerability of antiretroviral (HAART) therapy by reducing the risk of hepatotoxicity (12, 13).

Chronic hepatitis C is **not spread** by sneezing, coughing, water, food, sharing dishes or cups, hugging. People with HCV infection should not be discriminated at work, nor isolated from visiting schools and pre-school facilities. **Acute infection** occurs as a mild illness, often without icterus or even asymptomatically. Therefore, the number of reported cases is only a fraction of the actual number of new cases. There is also a problem to reliably distinguish acute cases from chronic hepatitis C (14).

Chronic hepatitis C, which develops in about 80% of cases, goes on for a long time without symptoms or with minimal symptoms (its course can mimic influenza - fatigue, lassitude, pain in the muscles and joints, loss of appetite, rarely occurs vomiting, raised temperature).These symptoms are usually attributed to other causes, as well as is a possible increased aminotransferase activity, which often only slightly

exceeds the upper limit of physiological values (15).

Approximately one quarter of patients with CHC has developed cirrhosis of the liver. Assumptions say that the proportion of patients with CHC in the stage of liver cirrhosis will increase dramatically. Estimates talk about more than a third of patients. In the US, about 37% of patients will have hepatitis C in the stage of cirrhosis in 2020.

However, CHC may also occur without increased or with just intermittently increased ALT activity. Therefore, the screening of anti-HCV in individuals who belong to any of the risk groups, even if they have normal ALT activity (1, 15), is fully justified.

In some countries, in addition to persons who are or have been at risk of being infected with hepatitis C virus, screening recommendations also involve anti-HCV testing in age groups where epidemiological surveys revealed the highest number of infected people. According to epidemiological data, in Slovakia it currently refers to persons between the ages of 50 and 60 years. It would be appropriate to target the screening activities on this group as well (3).

HCV positive patients: must not donate blood, organs, tissues or sperm; must not share with other people sharp tools that could potentially be contaminated with blood (e.g. razor blades, manicure scissors, toothbrushes); should cover open wounds and scratches to prevent people from coming in contact with their blood; should avoid having tattoos and piercing done in unprofessional salons. HCV positive people should inform their sexual partners about the disease and use barrier protection. A sexual partner of a HCV positive person should have the antibodies to HBV (hepatitis B), HCV and HIV infection examined. Patients with HCV infection should completely eliminate consumption of alcohol (due to worsening of the liver fibrosis progression), avoid other hepatotoxic substances, including the so-called "plant products".

Studies of the natural history of the disease have found that in 55-85% of people with acute hepatitis C it develops into chronicity. Spontaneous excretion of the virus is more common in infected children and young women than in people who have developed acute hepatitis at a higher age. The risk of CHC progression into cirrhosis of the liver is 5-25% over the period of 25-30 years.

Factors associated with the progression of liver damage in chronic HCV infection include: a) transmission of infection in higher age (the risk increases after the age of 40-45); **b)** alcohol consumption over 50 g per day (16); **c)** obesity and liver steatosis for any other reason; **d)** co-infection with HBV and/or HIV; **e)** higher degree of liver damage (F2 - fibrosis of level 2 and higher). To evaluate the alcohol intake, usually the dose of pure alcohol – ethanol – is being calculated. Studies have manifested that a daily intake of ethanol between 30-50 g is an amount that proves to worsen the course of chronic HCV infection as it accelerates the progression of liver fibrosis. Daily marijuana use also has negative effects on the course of CHC (17). On the contrary, drinking coffee (more than 2 cups a day) has a positive effect on the liver (18).

CHC can also cause ***extrahepatic manifestations*** including mixed cryoglobulinaemia, type II and III. The main manifestation is systemic vasculitis, which is clinically manifested as palpable purpura, joints pain and arthritis, fatigue, peripheral neuropathy and glomerulonephritis. Most people with essential mixed cryoglobulinemia are infected with CHC. Since early symptoms of cryoglobulinemia may include simple proteinuria and renal dysfunction without actual symptoms of cryoglobulinaemia or liver disease, all people with proteinuria and cryoglobulinemia should be screened

for CHC even if they have no clinical and/or biochemical manifestations of liver disease. Symptomatic cryoglobulinemia is an indication for the treatment of HCV, independently of the degree of liver disease (19).

Other extrahepatic manifestations of CHC include: hematologic malignancies (B-cell non-Hodgkin lymphoma: B-NHL), renal failure, depression, cognitive impairment, dermatological diseases (hyaline, porphyria cutanea tarda), thyroid disorder, type 2 diabetes mellitus, rheumatic diseases and cardiovascular diseases.

The goal of CHC treatment is to cure HCV infection in order to: prevent HCV-associated liver diseases and extrahepatic manifestations including necroinflammation, fibrosis, cirrhosis, decompensation of cirrhosis, hepatocellular carcinoma (HCC), severe extrahepatic manifestations and deaths; improve the quality of life and eliminate the stigma; to prevent further transmission of HCV infection (20). Eradication – curing the HCV infection will help patients improve survival, prevent development of complications and allow regression of fibrosis even in an advanced stage of liver disease.

Until 2011, pegylated IFN (interferon) and ribavirin combination therapy could have been considered the gold standard in CHC treatment. Success of the treatment was relatively low. In the treatment of the HCV genotype 1 (which is the most common genotype in Europe and in our country) the sustained virological response was less than 50%.

A disadvantage of interferon-based treatment of CHC was, in addition to relatively low efficacy, a relatively long duration of treatment (usually 48 weeks of treatment), complicated dosing regimens and the need to monitor the virologic response during treatment. This treatment was also accompanied by frequent adverse effects and for some groups of patients (e.g. patients with decompensated cirrhosis) it was contraindicated.

In 2011, first two new molecules (telaprevir, boceprevir) from the group of directly acting antivirals were registered for genotype 1. These new molecules were used in triple therapy in combination with pegylated interferon and ribavirin, resulting in an increase in treatment success to approximately 63-75%.

A development of other drugs from a group of directly active antiviral agents brought new prospects for CHC treatment. These are new molecules that interfere with the replication cycle of hepatitis C virus. According to the mechanism of action we divide them into 3 groups: NS3 / 4A protease inhibitors; NS5B polymerase inhibitors; NS5A protein inhibitors.

The most recent trend in CHC treatment is the use of several direct-acting antivirals without IFN, so called interferon-free or IFN-free regimens. These treatment regimens have resulted in: an increase in treatment efficacy to over 90% of the sustained virologic response, efficacy on several or all HCV genotypes, an increased safety of treatment and a significant decrease in adverse effects; shortening of the treatment regimens from standard 48 weeks to 12 weeks; simplified dosing; simplified patient monitoring during treatment; unified treatment regimens. In most patients, after successful antiviral treatment there is an overall improvement in their health independently of the degree of liver damage (21, 22, 23).

However, after completing the CHC treatment, increased attention should be given to patients who had advanced liver fibrosis or cirrhosis prior to beginning the treatment, who had started treatment in a higher age and who had a high body mass index (BMI). In these patients the degree of hepatic impairment should be monitored by non-invasive methods (hepatic fibrosis may persist).

Achieving a sustained virological response (SVR) reduces the risk of decompensated cirrhosis, but does not completely eliminate the risk of HCC (hepatocellular carcinoma). In these patients, we need to perform HCC surveillance every 6 months.

The introduction of non-interferon-based therapy into practice has also brought the need to monitor drug interactions between new direct-acting antiviral drugs and other drugs that the patient is taking: e.g.statins, fibrates, cardiovascular drugs, immunosuppressants, antiretrovirals and others. It is necessary to be careful when modifying the dose or administering new drugs during antiviral treatment of CHC, and consult a specialist in these cases.

Patients with an increased risk of transmitting HCV infection, active IDUs, homosexuals with risky sexual practices, women planning to conceive, patients undergoing hemodialysis and prisoners should all be treated in preference. After successful treatment, patients should be informed about the possible HCV reinfection if they continue with risky activities.

According to WHO, the main obstacles to the implementation of the strategy for viral hepatitis elimination are: low percentage of diagnosed persons (about 20%) and high prices of antiviral drugs (24, 25, 26). The largest drug-price barrier is emerging in middle-income countries, e.g. in Brazil, China, Colombia, Mexico, Kazakhstan or Turkey. **WHO plans to prepare and implement a global system for monitoring the viral hepatitis elimination process** (27).

To the fulfilment of the WHO strategy on HCV elimination/eradication would certainly contribute a nationwide screening in individual European countries and active collaboration with general practitioners who could treat patients with HCV by themselves - that is, without help of specialists, with pan-genotypic drugs. Specialists would deal with the more serious cases of HCV infection in various centers (ineffective HCV treatment, presence of coexisting diseases, suspicion of advanced fibrosis through non-invasive tests: FibroScan ≥ 10 kPa or FibroTest> 0.58). The French Hepatology Society also inclines toward this view. A real-world example of functioning CHC treatment is Australia, where the annual number of treated patients exceeds their options of treatment by specialists (28, 29).

If we do not implement the screening programs at present, in 2 or 3 years patients with CHC already diagnosed will be cured, but on the other hand, many undiagnosed CHC patients will remain in the population. Without facilitating access to treatment and active collaboration with general practitioners, swift eradication of HCV from the population will not be possible in our conditions.

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Challenges Faced by a Sports Woman in Pakistani Society

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Original Article

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Abstract:

In many societies sports are considered as an inappropriate activity for women as it is traditionally associated with masculinity. The aim of this study is to critically analyze the social issues and challenges of

sportswomen in Pakistan. Non-probability sampling for data collection was used and for this purpose, snowball sampling and purposive sampling techniques were applied. The interview schedule is utilized as a tool where 210 sportswomen were approached and had structured and unstructured interviews for having knowledge about their personal qualities and skills of sportswomen. The results of this study highlights that due to social norms, values, customs, culture, myths, traditions, unstable economic conditions and erroneous religious women outlook are not able to participate in sports activities while, sports activities can provide a channel to educate women about their communal, legal and physical rights along with productive and reproductive rights.

Introduction

The current scenarios of developing nations, the human capital is weak as underdeveloped nations are spending less on education and health then how could they spend for entertainment purpose. In addition, mostly societies are traditional and have different gendered expressions for male and female. So, these socially constructed roles create gender disparities in all segments of life, however in that long list of discriminations I have observe a little circle of women who are playing sports. Later I searched more about specific sportswomen sample, which was a difficult part of research, but that time I saw women sports federation which developed huge interest for the researcher to observe their lifestyle and social status in existing societies. On that basis, objectives and research questions were designed to gauge the actual status of sportswomen in Pakistani society.

In developing world the concept of women and sports not fully establish, it still needs further exploratory because of the changing socio-economic status of the women in the world. Whereas if we look up for previous researches on women and sports, international researches have been found so far, and elaborated that in Iran traditional beliefs of gender segregation have been changing for instance under strict veiling policies, women are playing sports after seeing other female athletics as role model in such scenario parents confidence restored and sending female children to various sports including judo, karate, taekwondo, shooting, mountain climbing and rowing.

On the other hand if we look up on India's situation, it is a secular state there are no problem of veil or any other social restriction but problem for women in sports are differing from other countries as females use to play from their early school and college but later they have to give up, because non-availability of play grounds, coaches or mentors, and of course the equipments or goods required for specific games. Due to the reason male in sports are recognized, even fantasized in the world but female's inclusion is at inborn stage (Sengupta, 2018). Similarly, Pakistan is also a male dominant society and facing sexual division in all segments of the society, so this paper aims to acknowledge the role of sportswomen in the society as females found playing various sports; this research is highlighting the role of patriarchy and male dominant factors on lives of sportswomen.

It is further finding the barriers including attire and costumes, sexual harassment, hierarchy, and also analyzing the role of media. These mentioned factors are observed to acknowledge the social status of sportswomen in Pakistani society. However, it is observed that in developed nation that fe-

males who are playing sports are more confident and have high self-esteem. As women are involved in sports related activities from childhood, because of the reason they have good physique and higshest psychological wellbeing and free from all sort of depressions. If we practice sports for women in Pakistan women become more empowered, their personality enhance, better health, and of course stable financially. Women in sports activities are marginal in Pakistan; the government should provide incentives to sportswomen in order to encourage females for playing sports to become strong in the society.

Literature Review

After inception of Pakistan in 1947, politics and economy were the major focused areas for the development. Later sports and Olympics had begun momentum in the country, so this was the time where women were only the spectators of sports. However, few females were playing at school or college levels, all sports related activities were halted and strictly forbidden for women in Pakistan during the Martial Law regime (1977-1986) (Asian Development Bank, 2007).

It is concluded that there are few widely known positive role models of sports women are present in the world. According to (Waqar, 2018) the lack of known role models, female participation has not been increasing with faster pace, as social media is also keeping Pakistan's youth specially young females away from sports. In Pakistan very limited women become in the position of role models and coaches in sports, for instance coach (Sabiha Azhar), Football (Sadia Shaikh & Fouzia Naz) but in individual sports (badminton, tennis, martial art) not a single female recognized as famous coach in present scenario of Pakistan. Recently, we have found one example Sara Mansoor (tennis player) announced as first tennis coach in Pakistan. Besides all social, religious and economic problems the brave Pakistani young sportswomen Raheela Zameen (footballer) has the honor to become a first female South Asian coach of a professional men's team but still there are lack of opportunities, as they do not enter in the field of sports while, they proved their determination and showed that their passion for sports is not less than that of men. In this regard, government and sports departments should promote the participation of women in sports and provide them space to explore their talents because sports activities will helpful in promote peace and harmony in the region (Jazbey, 2018).

Moreover, if we talk about current female players, Sana Mir and Javeria Khan have been known as number one in bowling and booker berth in the ICCI Women's World T20 in 2018, this triumph also uplift the status women players but also represented a good picture of Pakistani society at international level (The Nation, 2018). Another example, a two-time Academy Award winner Sharmeen Obaid-Chinoy's latest collaboration with HBO SPORTS (A private TV Channel) for a documentary on 'STUDENT ATHLETE', which has been nominated for the 2019 NAMIC Vision Awards by National Association for Multi-Ethnicity in Communications. The awards recognize original programming of the documentary that reflected lives, spirit and contributions of people of color that best reflects the ethnic and cultural diversity of the viewing audience. The film making on sports subject shows that now researchers director or film makers are working on the subject to display hided segments of the society on motion picture in order to increase the audiences for encouraging women and sports related activities.

Methodology

Research is followed by snowball sampling technique of non-probability sampling. The researcher has used structured and semi-structure interview techniques in the study. Almost questions are open ended to find out the basic obstacles of the society which hinder the women to participate in sports activities. The tool of measurement is simple chi-square technique used by researcher. The sample of the study is comprised of 210 sports women, to approach these women, various sports federation visited to get sports women respondents for collecting primary data.

ciety. Similarly, if we look up on sports related activities among men and women, so it is considered that women are inferior to men and cannot compete equivalent to men due to lower strength and speed. Whereas, it is medically explained that women have greater flexibility, body mass with fats and small body size which would highly advantageous while play sports. It can be said that women can perform much better as good as men for instance in running series; synchronized swimming; in horse racing; or even can prove themselves footballs game and rugby. It is regarded as people have created a mind sets.

Social, Religious and Economical Issue of Sports Women in Pakistani Society.

Federation's Name	Number of Sample
Pakistan Cricket Board	35
Pakistan Hockey Federation	27
Pakistan Football Federation	23
Pakistan Tae Kwando Martial Art Federation	15
Pakistan Table Tennis Federation	10
Pakistan Badminton Federation	13
Pakistan Squash Federation	03
Chess Federation of Pakistan	05
Athletics Federation of Pakistan	29
Sind Women Swimming Association	26
Pakistan Tennis Federation	05
Pakistan Golf Federation	02
Alpine Club of Pakistan (Mountain Climber)	02
Pakistan Weight Lifting Federation	03
Pakistan Scuba Diving Association	02
Indus Scuba Pakistan	10

Results And Discussion

Pakistan has very unique geography with having various cultures and traditions, which exists in form of sub-societies. However, the beliefs are saturated from one society to another society because of associated myths. The myths are prevailing since ages due to lack of education and socio-cultural misleading behaviors and trends in the so-

According to the available facts, at school and colleges levels funds allocations are very limited and in such scenario male students enrolled more as compared to female students. This is the point when discrimination started and spent funds unequally among both the sexes. In fact in Pakistani society, patriarchs believed that issues on women in sports are irrelevant and have no importance

rather academician or researchers should focus on labor force participation and political empowerment. So, this the point where the researcher had brainstormed that sports and athletes can have positive role in women's leadership development in almost all segments, which could definitely enhance their social status.

The findings of the existing paper revealed significant, strong relationship among sports activities and socially constructed values, myths, tradition and culture. Although the Pakistani women are very strong, tough, active and talented as other women's of the world, but these societal attitudes create the obstacles for women participation in sports activities. According to previous researches it was marked that the lower participation of women in sports is only because of associated myths that women cannot play, considered bad whereas; majority of sportswomen in the current research informed that culture and tradition is not obstacle but close relatives and male dominancy in family structures are mainly held responsible for this discrimination (Javed, 2014;Burch et al, 2014, McKay, 2013; Berberick, 2010).

It is also a ground reality that women participation has been increased as compared to the past years but situation remain same as societies still do not consider sports as an activity for women. Sport is a very prominent social institution in almost all the societies around the world it conventionally connected with masculinity while, many western sociologists and feminists declared that sports emulate the society, the shimmering values, myths, customs and social norms of the society. It works for progressive society whereas, the present societies categorically classify sports as feminine or masculine, but still we see that all sports are considered to be for men specifically. Many feminist social theories determined that gender discrimination in sports is very common while a myth is, women lose their femininity and their physical appearance and resembles like men. These kind of believing paradigms are creating hurdles in sportswomen lives and further discourage female youth to become a sports person.

Gender balanced global sports report finds out, that only cricket is raising their profile by increasing sponsorship opportunities, ground audiences and TV coverage in Australia, England, Wales and India since last decade (Bailey, 1993). Pakistan and South Africa are also included in this list, and it is also observed that female cricketers who are financially stable have a sound position to play sports professionally throughout the year as compared to other individual and team events. Sports can help Pakistani women to get empowered and will also help in personality building along with controlling health issues and last but not the least will bring economic stability among women. While interviewing sportswomen, shared that they feel themselves insecure because the society does not take women into decision making process in any of event or life occurrence. However; sport is a healthy activity which provides grounds for ideological thinking and for developing better gender relations. Research findings showed that it is very important to aware the society about the health benefits of the sport activities and its importance in developing healthy society and for leading a healthy life.

Meanwhile, scholars explored that women can change their state by their own, through breaking all social barriers while urged concerned government departments to provide them basic necessities for example education, technical and vocational trainings, strengthen labor force in order to make themselves dominant in the society as men, then it is expected that mind sets could be changed especially of parents, families,

schools, colleges, teachers and administrators of that particular area or region (Devi, 2017). It is observed by Indian researchers that while female players taken trainings under coaches or mentors, they faced harassments, as misbehaved and many have been caught in love affair. It can be said that such scenario restricting female to get into sports, as there are many cases in which female player terminated from tournaments instead of culprits i.e. coaches (Ahmad, 2015).

Pakistani government need to revise their policies regarding women's sports, because some individual sports need immediate action for their stability. Women in sports activities are marginal in Pakistan, which is already elaborated above in detail, i.e. due to the variety of factors they get fewer chances for participating fully and independently in sports. A strong sports system supports positively and holds women equitably, is essential for empowerment of Pakistani women in sports. As a developing country and global economic environment, it is informed by women respondents, "We are ready for the highly competitive workplace and can change family life through sports." To evaluate the status of sports women in the society, this study aims to explore the concept of women and sport by comparing the social barriers and the status of women in the society.

In fact, it is the responsibility of the sports federation, federal and provincial governments to give incentives and benefits to women/girls for participation in national and international sport events. These institutions are also responsible for providing experienced female coaches, complete medical facility, and positive competitive environment and job opportunities to sportswomen in a way to secure their futures. Whereas, it is observed, there is a scarcity of playgrounds and clubs specifically for women in Pakistan. Society as well as parents does not allow their daughters to play with men at any stage and any sports, because mingling with men is not considered unethical. Though, government does not take any positive action for the improvement of women's sports, there must be proper policy making for sportswomen to promote sport culture among women. It is unveiled by the women players that government should provide protection to women against gender discrimination, ethnicity, and prevailing class system in the society to promote women in sports.

Conclusion

Pakistani sports women have much potential than other sports women in the world. They are iconic in the women's sports world. Unfortunately, they face many social and cultural problems to show their talent in the world. Results reflecting that society have to be changes to decline the pathetic social structure of Pakistani society, which decline the position of women in the society by all means including sports because sports activities boost up the women physically, mentally and psychology. The role of women in policy making as well as in decision making process is not seen anywhere so the future of sports women in Pakistan seems very insecure. Sport is a healthy activity which provides grounds for ideological thinking and for developing better gender relations. Research findings clearly describe that it is very important to aware the society about the health benefits of the sport activities and its importance in developing healthy society and leading a healthy life. More researches have to be done in future in this regard which bring insight about the sport activity and aware the society about the significance of sports in building a positive and healthy environment.

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A Study on the Factors that Predisposes Couples to new HIV Infection: A Case-study of Mary Immaculate Voluntary Counseling and Testing (VCT) Centre, Nairobi-Kenya

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Original Article

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Abstract:

Minimizing the spread of Human Immunodeficiency Virus (HIV) is one of the primary goals of any public health system. Couple testing is one of the strategies that is widely used in achieving this goal. In our study we sought to determine factors that predispose couples to acquiring HIV. Secondly, we also wanted to quantify the amount of risk of HIV infections couples were willing to tolerate when initiating new sexual relationships.

This study was done at the Mary Immaculate VCT Center Nairobi, from 2012 to 2018. A total of 360 couples was recruited into the study using systematic random sampling technique. A couple comprised of two persons of opposite gender who came for VCT services. In this study we observed that only 45.3% of the respondents engaged in sexual affairs within marriage compared 54.73% who did not. We also observed that the mean age difference within couples was 2.4 years and those who had an age difference of 3-5 years were more likely to engage in pre-marital sex. In addition, we also found that that 86.1% of the couples had engaged in sexual affairs without knowing the HIV status of their partner(s).

We conclude that most couples were engaging in premarital and extramarital sex than in marital sex. Sex outside marriage is a risk factor that contributes to acquisition and spread of HIV. An average of 2.4 years was the age difference preferred by most study couples. Age difference is a factor that facilitates transmission of HIV from one generation to another. We also concluded that most couples in this study preferred having sex first before knowing their HIV status. This is a risky practice that facilitates new acquisition of HIV infection.

Introduction

Vertical and parenteral transmissions are the two modes through which individuals acquire HIV. The former refers transmission of HIV virus from mother to child during pregnancy and labor while the latter refers to transmission that involves contact with HIV contaminated body fluids such as blood, semen, vaginal fluids and human breastmilk (Horvathova, *et al.,* 2011, Shahum, A et al. 2017). HIV in these body fluids can be transmitted to another person through body cuts/pricks with sharp objects that are contaminated, sexual contact with infected individuals, and blood transfusion. Transmission of HIV through transfusion is nowadays very rare due to stringent blood screening procedures. Parenteral mode of transmission accountants for a large proportion of new HIV cases especially among Female Sex Workers (FSW); Men who have Sex with Men (MSM); People Who Inject Drugs (PWID); Individuals with casual partners and Monogamous partnership (Zara, Sharmistha, Vesga, & Marie-Claude, 2014) .

There is a worrying trend being reported by most public health surveillance tools in regions where HIV is endemic. In these regions, cases of people who have been newly infected with HIV continue to be reported on a yearly basis. For instance, according to the Kenya HIV Estimates Report released in

2018, the national HIV prevalence rate was estimated at 4.9% with at least 52,800 people having been newly infected in the year 2017. Out of this figure, 44,800 were adult older than 15 years while 8,000 were children below 14 years (Ministry of Health, 2018). Based on prevalence rates of HIV, we were more interested in understanding factors that make people to be newly infected with HIV. Secondly, we also wanted to quantify the amount of risk of HIV infections couples were willing to tolerate when initiating new sexual relationships.

2. Methods

2.1 Study Population and Procedure

This research was carried out at the Mary Immaculate VCT Center, in Nairobi, Kenya. Respondents to this research were couples of opposite genders who had voluntarily sought VCT services in this center. They were recruited voluntarily into this study after giving their consent. A systematic random sampling technique was used in enlisting them into this study. This involved picking every 5th couple who had been served in the VCT. The research interview was only done after they had received their VCT services and were on their way home. This study was done for a period of 6 years, between 2012-2018. Within this period a total of 360 couples were enlisted into the study. A couple comprised adults of opposite gender.

2.2 Research Design and Data Collection

This research employed a case-study design, where only couples of opposite genders who had voluntarily sought VCT services were enrolled into the study. Couples who were below the age of 18 years were also excluded from the study. A structured questionnaire was used in collecting data from the respondents. Research assistants were also trained before being allowed to collect data.

2.3 Statistical Analysis

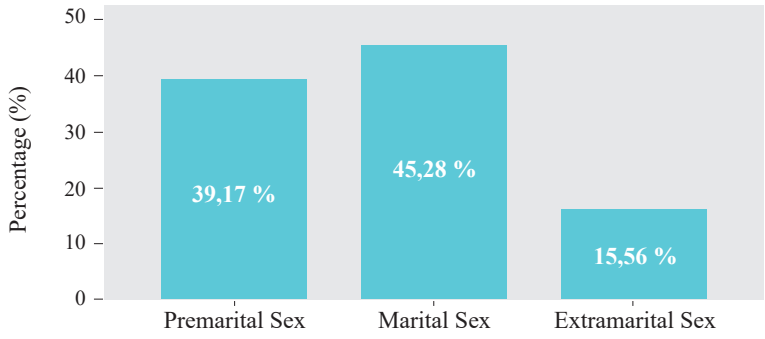
This study applied chi square test in conducting inferential statistics while descriptive statistics were also analyzed using mean and tabulation of frequency. The results of the study were presented in form of tables and figures. A two-sided p value of < 0.05 was set as the threshold for statistical significance.

3. Results

3.1 Distribution of Couples According to their Sexual Behavior

Majority of the couples observed (45.28%) in the study were engaging in marital sex, 39.17% of the couples were engaging in premarital sex while 15.56% were engaging in extramarital sex.

Fig. 1: Distribution of Couples According to their Sexual Behavior



3.2 Distribution of respondents according to age differences

Table: 1 Distribution of respondents according to age differences

Age difference	Frequency	Percentage	Mean	Median	Mode
0-2 years	115	31.9	2.4	2.0	1
3-5 years	112	31.1			
6-8 years	54	15			
9-11 years	36	10			
12 and more	43	11.9			
Total	360				

On average most couples prefered partners who were either ± 2.4 years olders than themselves. 31.9% prefered patrners with an age difference of ± 2 years while 11.9% of preferred partners who were either below or exceeded them with more than 12 years.

Table 2: Crosstabulation of couples sexual behavior and age differences

Sexual behavior	Age differences within couples (years)					
	0-2 N (%)	3-5 N (%)	6-8 N (%)	9-11 N (%)	12 & above N (%)	Total
Premarital sex	47 (33.3)	51(36.2)	19(13.5)	9 (6.4)	15(10.6)	141
Marital Sex	53(32.5)	45(27.6)	28 (17.2)	19 (11.7)	18 (11.0)	163
Extramarital sex	15(26.8)	16 (28.6)	7 (12.5)	8 (14.3)	10 (17.9)	56
Total	115(31.9)	112 (31.1)	54(15)	36 (10)	43 (11.9)	360

$X^2 = 8.727, P=0.366$

Couples who had an age difference of 3-5 years were more likely to engage in premarital and extramarital sex while those who had an age difference of 0-2 years were likely to engage in marital sex.

86.1% of the couples preferred having sex prior to knowing HIV status of their sexual partners while to 13.9% preferred to go for a HIV test prior to having sex. Thus, risk of exposure to HIV was at 86.1%.

Table 3 Risk of exposure to HIV

Sexual Behavior	Couples sexual intercourse Prior to visiting VCT		
	Yes N (%)	No N (%)	Total
Premarital Sex	109 (77.3)	32 (22.7)	141
Marital Sex	159 (97.5)	4 (2.5)	163
Extramarital Sex	42 (75.0)	14 (25)	56
Total	310 (86.1)	50 (13.9)	360

$X^2 = 32.7, P=0.00$

Discussion

HIV prevalence rate or rather the number of people who are newly infected with HIV per year has been of great concern, not only to policy makers but also to practitioners as well. The concern has always been on identifying factors that predispose couples to acquiring HIV. Some of these factors we studied in this research were patterns of sexual behavior, age differences between partners forming a couple and amount of risk of infection couples were willing to tolerate when initiating new sexual relationships. We also examined quantity of risk of HIV exposure couples were willing to tolerate before engaging in sexual activities.

In this study, we identified three patterns of sexual behaviors that were common among couples; premarital sex, marital sex and extramarital sex. We defined premarital

sex as a type of sexual relationship that involves vaginal penetration before marriage. It is mostly preferred by young unmarried people aged 15 to24 years. They mostly engage in this type of sexual relation mainly as a way of conforming to peer pressure, gaining sexual pleasure and in some cases as a mode of gaining material goods such as money (Pouline, 2007; Kobor, *et al.,* 2007). In addition, this type of sexual relation maintained by young people is usually of short duration and in some situations, it may involve a series of multiple partners. Multiple partners has been considered as a high risk factor for unplanned pregnancies, illegal abortions, psychosocial problems and acquisition of sexually transmitted infections including HIV, especially when condoms are either not used correctly and/or consistently (Santelli, Nancy, Richard, Amita, & Laurie, 1998; Behnam, *et al*., 2016; Kumar, Dandona, Kuma, & Dandona, 2011). In our study we found that 39.2% of the respondents were engaging in premarital sex. This finding shows that young and unmarried people were not abstaining from sexual activities as being advocated by most policy makers.

A similar result was found by Finer (2007) in the United States where at least 75% of their respondents were engaging in premarital sex. Several psychological, economical, socio-cultural, and biological factors have been identified as factors that push young people to premarital sex. Psychological factors including alcohol and drug abuse have been known to lower decision-making abilities of those under their influence especially when making judgements about safer sex. Economic factors especially poverty has disempowering effects on those living under it. In the context of HIV and couples, poverty lowers the ability of the partner from lower socio-economic backgrounds from bargaining for safer sex. Young people who normally engage in premarital sex are usually in their late teenagerhood and early adulthood. These two stages of development are normally characterized by rapid hormonal and emotional changes. These rapid changes may make young people to engage in premarital sex with multiple partners so as to satisfy their emotional needs. Having multiple sexual partners may predispose them to acquiring HIV (Santelli, Nancy, Richard, Amita, & Laurie, 1998).

We also examined marital sex, a type of sexual behavior where sex is only performed within the institution of marriage. This form of sexual behavior carries least amount risk of HIV infections if performed exclusively within the marital institution. This is especially true if both partners tested negative before their first sexual encounter and have remained faithful to each other. In our study we observed that 45.3% of respondents were engaging in sexual activities within the marriage.

The 3rd pattern we examined was extra-marital sex, where married people were engaging in sexual activities outside marriage. In our study we found that at least 15.6% of the respondents were engaging in extra-marital affairs. We attributed this finding to the fact that extra marital relationships are normally short lived and that some partners resort to it as a way of revenging

on a cheating partner. According to Ashley (2014), multiple sexual partners is the underlying driver for high HIV infections rates in regions where the infection is epidemic. This is because multiple sexual partners are more likely to engage in sexual activities during asymptomatic phase of the HIV infection. The infected individual may then in turn pass on the virus to their unsuspecting and sometimes faithful marital partner. Extra-marital sex also provides the avenue through which HIV is spread from one region to another, especially when marital partners are in long distance relationships. A person in a long-distance relationship

may pick up the virus in one region and pass it on to his/her partners who live in another region (Kalavska, *et al*., 2015; Kafkova & Kimuli, 2015).

Other aspects of sexual behavior we examined was age differences among sexually active couples. Most studies have found age differences among couples in intimate relationships to be a factor that contributes to acquisition and spread of sexually transmitted infections such as HIV (Joost *et al,* 2018). Various models including the widely used STI model have been advanced in explaining how age differences among couples lead to the acquisition and spread of infectious diseases (Easterly *et al*, 2018; Herdics et al. 2017). In our study we observed that 31.9% of the respondents were in sexual relationships with someone who was either ± 2 years older than themselves. Other respondents (68.1%) chose sexual partners who were either younger or older than them with a margin of three or more years. We speculate that age difference did not only influence their choices of sexual partner but also contributed to the transmission of HIV. This is because most societies have social norms that are too lenient on promiscuous men compared to women. A promiscuous man may be given heroic titles such as 'a womanizer' while a woman may be labelled with demeaning and shameful titles such as 'harlot', 'slut', 'hoe' 'prostitute' among many other offensive adjectives. This leniency may predispose men to a higher risk of being exposed to HIV virus. Thus, we can assume that HIV prevalence for men picks at old age compared to women (Roxanne, Hens, & Delva, 2018; Enright & Rowland, 2018). Since, men prefer to marry or have sexual relationships with younger heterosexual partners, they may end up passing on HIV virus to younger women who in turn it passes it to younger men. This is because as men age their sexual drive also diminishes while that of their heterosexual younger partners reaches climax. This may force younger women married to old men to engage in casual sexual relationships with younger men in order to satisfy their sexual desires. In short, older men look for younger women for long term relationships while older women look for younger men for short term relationships. In addition, older partners are always the alpha of these relationships, i.e. they always determine or have the last word in what happens in these relationships. Thus, the younger partner may find it difficult to negotiate for safer sex such as use of condoms or going for HIV tests. This may explain how HIV is passed from one generation to another.

The last aspect of sexual behavior we examined was amount of risk of HIV infection couples were willing to tolerate when initiating new sexual relationships. More specifically we wanted to know whether our study couples took time to know HIV status of their partners before engaging in sexual activities. In our study we found that 86.6% of the respondents had had sex prior to knowing HIV status of their partners. This risk may even be elevated by the fact that infants who acquired HIV during pregnancy and labor process in the early 90s, are now in their early adulthood. In the 90s, Antiretroviral drugs (ARV) which helps in reducing chances of transmitting HIV from mothers to their children, were not readily available in most public hospitals. Thus, a significant proportion of infants were infected with virus during labor and pregnancy. This heightens the risk of HIV acquisition among those who engage in premarital sex without knowing status of their sexual partners (Mikolasova, G et al. 2018).

Conclusions

We conclude that more couples were engaging in premarital and extramarital sex

than marital sex. Sex outside marriage is a risk factor that contributes to the spread of HIV. Age difference

of 2.4 years was the most preferred by the couples. Age difference is a factor that facilitates transmission of HIV from one generation to another. We also concluded that most couples in

this study preferred having sex first before knowing their HIV status. This is a risky practice that facilitates new acquisition of HIV infection.

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Spectrum of Communicable Diseases in Lesbos Island UNHCR Refugee Camp

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Abstract:

Introduction: Refugee and Migrant Health Programmes in EU react on Migrant and refugee crisis (1) from middle East armed conflict to EU .The aim of this study was to asess the spectrum of communicable diseases among migrants to UNHCR camp on Lesbos island.
Metods: Open study was performed in 2019 to assess the frequency and proportion of ID among migrants and refugees to Greece.
Results: In 1-6/2019 among 9601 patients, 2138 patients with CD were diagnosed. Respiratory tract ID were in 1335 cases, SSTI in 493, UTI/STI in 136, GIID in 183 cases. No case of TB was detected, HN only 0,4%.
Conclusion: Despite the fact that one fourth of all patients at refugee camp in Lesbos island had infectious diseases, HIV was exceptional and no case on TB was detected. No outbreaks reported.

Introduction:

One of emerging issues in EU is still migrant/refugee crisis Refugee and Migrant Health Programmes in EU react on Migrant and refugee crisis (1) from middle East armed conflict to EU (2). The aim of this study was to away the spectrum of communicable diseases among migrants to UNHCR camp on Lesbos Island.

Methods:

Open study was performed in 2019 to assess the frequency and proportion of ID among migrants and refugees to Greece. Occurence of particular diseases was analysed

Results:

Among 9,601 patients who presented themselves at the OPD Health Centre at Lesbos UNHCR Camp (about 60% refugees from Afghanistan, Syria, Sub-saharan Africa and 2238 (23%) had infectious diseases diagnosis (ID CD). Majority had RTI 1335, followed by SSTI/wounds 493. Surprisingly, only very few cases were HIV positive (0,4%) or had HBC/HCV. Zero cases of confirmed TB were detected, similarly to data from camps on Greek mainland. Also WHO and UNHCR was reputing few cases of documented TB, HIV or malaria to Greece from Turkey in 2015-2018 (1,4)

Conclusion:

Despite the fact that one fourth of all patients at refugee camp in Lesbos island had infectious diseases, HIV was exceptional and no case on TB was detected. No outbreaks reported. Low occurence of HIV, BHC, HCV is due to prevalence of mus-

Table 1: Occurence of communicable diseases among refugees in Lesbos Island Camp UNHCR in 1-6/2019

Total No. of patients	9601
No. of patients with communicable diseases	2238 (23%)
Respiratory tract infections	1335
Skin and soft tissue infections / wounds	493
Gastrointestinal	183
Urogenital	136
Rare: chicken pox (32), HIV (4), HCV (1), TBC (0)	

lim population migrating from Syria and Afghanistan to Greece, and this population usually presents much lower incidence in HIV and other STD than southeast Asia or subsaharan Africa. Minimal occurence of TB is because there is no avaiable screening simple method in migrant and refugee health avaiable overall prevalence in Syria, Iraq and most ME countries is below 50/100 000. Lane what is lower than in many host countries.

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Changing Spectrum of Migrants entering Greek Refugee Camp 2019 in Comparison to 2015/2016. (Psychological and social challenge) (Letter to The Editor)

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Original Article

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Abstract:

Spectrum of migrants to EU is changing. The aim of this letter is to assess the necessary change of psychological and social attitude to the new wave of migrants. Table 1 shows changes of the spectrum of the nationality of migrants to Lesbos UNHCR. Situation has substantially changed within last 3 years, when in 2015 and 2016 Syrian and Iraqui refugees were prevalent .In 2019 Afghaistan and Sub-Saharan Africa are in more than 50% of all residents of the Camp. Therefore psychological, social and medical approach must be modifyed from previous operations.

To the editors:

Spectrum of migrants to EU is changing. Previous studys from Greece, Slovenia, Bosna and other Balcan countries in 2015-2018 showed majority of Sirian and Iraqui nationals (1-5). The aim of this letter is to assess the necessary change of psychological and social attitude to the new wave of migrants. Table 1 shows changes of the spectrum of the nationality of migrants to Lesbos UNHCR Refugee camp Moria. The change of the spectrum significantly (more African and Afghani migrants) is a signal for a change of screening and operational policy.

Table 1: Changes of nationality of Migrants in 2019 comparing to 2016.

Country	2016	2019
Syria	1	3
Iraq	2	6
Afghanistan	4	1
Other ME	3	4
SS Africa	6	2
Other	5	5

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5. UNITED NATIONS HIGH COMMISION FOR REFUGEES ANNUAL REPORT (2018) UNHCR , New York, 2019, 206 pp.

Education Harmonization in Nursing and Social Work as Response to Vulnerable Patient/Client Groups in the new Candidate Member States – Solidarity from European Union (Note)

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Abstract:

According to the European Union (EU) Legislature within 10 years of association and full integration Central and Eastern European countries entering EU since 1998 have had to harmonize their university educational system; including the rules of education in nursing and social work due to the huge shortage of social and health care workers HCW. The second wave of enlargement happened after 2001 in South Eastern European region and the last is planned for 2020-2025. Newer member states such as SK CZ with old member countries such as AT, DE, IT and UK shall help to facilitate this harmonization process also for Serbia, Montenegro and Albania as soon as possible so that their nurses and social workers shall be integratable in EU labor Market.

Introduction

According to the European Union (EU) Legislature within 10 years of association and full integration Central and Eastern European countries entering EU since 1998 have had to harmonize their university educational system; including the rules of education in nursing and social work due to the huge shortage of social and health care workers HCW. The second wave of enlargement happened after 2001 in South Eastern European region and the last is planned for 2020-2025. Newer member states such as SK CZ with old member countries such as AT,DE,IT and UK shall help to facilitate this harmonization process also for Serbia, Montenegro and Albania as soon as possible, so that their nurses and social workers shall be integratable in EU labor Market. (1-2)

Actual state of harmonization

Equal levels of education among health care workers and social work specialists is mandatory to facilitate the labor market specially in the time of the rapid increase of elderly clients and patients in Scandinavia, UK and Western EU member states. The *Bologna Magna Charta Universitarum*, known as the *Bologna Process* may serve as one of the key documents as it is accepted by most old and new member states. However, inequities exist. Table 1 shows examples of both institutional and regional help and cooperation in Eastern Europe by current newer and also future member states in the process of negotiation (Montenegro, Northern Macedonia, Albania, Serbia). Unfortunately, another group of European countries including Moldova, Belarus and Ukraine are still in so called orphan status of this harmonization despite the labor market for social work specialists and nurses being

urgently needed to facilitate this process. (1-2)

Future challenges

A functioning example may be adapted e.g. from Scandinavia and the UK where Sweden, Finland and the UK took over the patronage of the education system in Baltic region in former three USSR Republics (Estonia, Latvia, Lithuania) seconded by Poland. Another positive example is the interregional cooperation between Austria and Germany and Czech Slovak and Hungarian Universities, especially when many of them were founded by Monarchs from previous German or Austro Hungarian consortia without language barriers.

A third example is the support of Italy to Slovenia, Croatia and Montenegro. In addition, Poland and Hungary showed increasing activity within University cooperation in Ukraine, and Slovakia and Hungary in Serbia. However, Bosna and Herzegovina and Moldova are unfortunately still more and less abandoned looking for stronger alignment despite no or few language or political barriers existing. Surprisingly, more active approaches are seen in Georgia, Armenia and Azerbaijan to or from Turkish and USA Universities.

Conclusions

In conclusion, the need for social workers and nurses in the EU is huge but language, cultural, historic and educational barriers of many of the above mentioned countries play negative roles in labor market in health and social care. The result of this barrier and lack of harmonization with the *Bologna Process* and EU educational regulations, as well as previous political isolation are undoubtedly negative prognostic factors in the harmonization process. Little progress has been observed also due to the unwillingness to change the internal teaching and research environments in the Universities in Eastern Europe. The request for External Accreditation and Institutional evaluation to ENQUEA and other peer reviewing (accreditation) bodies from Eastern and Southern European Universities is not increasing (3). What shows is either too much respect for Western Universities (top 10 are from UK and FR and G. In the Top 100 there is only one from Eastern Central Europe). Probably it is more likely the unwillingness to change the totalitarian/communist style of working, teaching and research modes. These days we celebrate 30 years of the collapse of iron curtain and Berlin Wall. Those barriers were destroyed physically, however in many former Eastern European and Southern EU (Balkan) countries, still strongly persist in thinking, behavior and direction modes, in many (majority?) Universities in both new member state countries and even more in countries-in-process or countries-in-negotiation.

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Table l: Examples of functioning models of West-East and North-South cooperation in education in social work and nursing - Bologna Process implementation

NORTH EAST
Supporting Universities:
Finland, Sweden, UK
Supported Universities
Estonia, Lituania, Latvia,

WEST to EAST
Supporting Universities
Germany, Austria,
Supported Universities
Czech Rep, Slovakia, Slovenia, Hungary

SOUTH to EAST
Supporting Universities
Italy Switzerland
Supported Universities
Croatia, Montenegro, Albania Kosova

CENTRAL to EAST
Poland Slovakia Hungary
Supported Universities
Ukraine, Serbia

So called ORPHAN countries,
North Macedonia, Bosna and Herzegovina, Moldova

Analysis of 9,896 Homeless Patients within an Urban Area in 2014 – 2019 – Social Pathology Leading to Poor Health

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Abstract:

Introduction: Homeless populations in EU and USA presents an increasing demographic. Social pathology includes substance or alcohol abuse, family and unemployment distress, and several other factors resulting to poverty and homelessness.
Patients and Methods: The purpose of this study was to analyze the spectrum of both communicable and non-communicable diseases in two different urban environments: Large metropolitan area (BA) versus small regional town (NZ); one with 500,000 and other with 50,000 population.
Results: Between January 2014 to December 2019, 9,896 homeless patients in Bratislava and 299 in Nove Zamky were analyzed for the spectrum of communicable and non-communicable disieases. Commonest ID had seasonal occurrence; respiratory tract infections (RTI) in November to March, and gastrointestinal from June to September.
Conclusion: Vaccination of all homeless should be considered to prevent RTI TB, HIV, HCV in shelters

Introduction:

Large inequities in Europe and SE Asia as well as in Latin America resulted from at least two emergencies in social pathology: internal (homelessness) and external (migrant and refugee crisis). Homeless populations in the EU and the USA presents an increasing demographic. Social pathology includes substance or alcohol abuse, family and unemployment distress, and several other factors resulting in poverty and homelessness. Special concerns are in tuberculosis (TBC) and Hepatitis B, C and AIDS (1-3). The aim of this research is to assess the occurrence of patients at two outpatient departments of Homeless Health Posts in a large urban versus local urban setting, capital versus district cities.

Patients & Methods

Several health posts and one hospital serve the homeless population in Bratislava and Nove Zamky. The purpose of this study was to analyze the spectrum of both communicable and non-communicable diseases in two different urban environments: large metropolitan area (BA) versus small regional town (NZ); one with 500,000, the other with 50,000 population.

Results & Discussion

Table 1 shows increasing dynamics of the total number of patients among the homeless population among 9,986 patients in 6 years in Bratislava and 299 in Nove Zamky. Respiratory tract infections were

responsible for more than 50% of all visits (511 & 150 – 50.2 vs 50.1%).

Conclusion

Vaccination of all homeless should be considered to prevent hepatitis, TBC and influenza, and PH control for shelters is essential. Staff should be prevented from burnout syndrome (2). Suprisingly, no case of TB apart of 1 case was noted in 2014 – 2019.

Table 1. Annual occurence of CD/NCD

2014	2015	2016	2017	2018	2019	Total
1,387	1,411	1,635	1,711	1,831	1,911	9,986

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Psychosocial and Medical Intervention before Emergency Travel in Humanitarian Workers – How early is not too late?

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Abstract:

A number of humanitarian and health care workers have to start their mission immediately, especially if professionals on-call, or members of international health and/or social intervention bodies such as UNHCR, MSF, WHO. This communication focus on questions seeking possible answers on preparation including psychosocial orientation and vaccination before an emergency travel of humanitarian staff to conflict areas.

To the editors:

In last Issues of Med. Horizon journal and CSW several papers on preparation of international staff of social workers and health care volunteers have been published mainly from the area of mediterranean refugee crisis.(1-4) Here we descibe our experience in preparation of humanitari staff travelling after short advice(acute humanitarian travel), as a complex holistic psychosocial and mediacal as well as logistic issue.

As first step we do imediate travel and pre travel advice, when announcing emergency travel, just after the logistic information and after the preliminary agreemant of the potential traveller, who is either volunteer or professional health care or social worker. This is not necessary in routine humanitarian staff operating years and in persons who do not travel first time.Itis important to give a structured advice, sometimes necessary partially through skype or phone)just giving a balanced overwiew of risks and benefits, and should be performed by psychologist or experienced social worker.(1-2)

Second phase ,day 2-3(until short notice travel)medical advice and logistic pre travel conucellig is necessary , however should be done by experienced nurse or doctor, or puiblic health petrsonell,ideally by those have been in this area previously, or working in similar team.This advice should be focused on emergence vaccination,analysis of comorbidities of traveller including their medical history, which is in young or student volunteers fortunmately short and simple(90 percent are previously healthy individuals, however dissimulation on psychotic disorders or type I diabetes may occure in psychological dialogue)

Table 1 Experience and reccomendations on emergency Vaccination/infection prophylaxis for humanitarian social workers or health care staff for short term noticed travel Infectious

Disease	Areas of concern	Intervention
Cholera endomicity	Yemen, Haiti	Oral cholera Vaccine, effective in 48-72h
Ebola homorrhagic fever	DR Congo	VSV Vaccine partially active in 72h
Yellow Fever	Angola, DR Congo	YF Vaccine, single dose part, active in 96h
Hepatitis AB	All subsaharan Africa, SE Asia	3 doses, 1st dose in 2w
Falciparum malaria	Subsaharan Africa, SE Asia	No vaccine avaiable, only chemo, prophylaxis, Doxycycline 100 m 1 day before travel. Have ready Co Artem (or other artemisin-comb) for standby therapy

Third phase is financial and logistic orientation(information on airtravel details, luggage limitations,information on sanitation water and housing specially during catastrophes)

Finally we present a simple table on possibilities or indications for emergency or short noptice travel vaccinations/ID prophylaxis, usually used by our humanitarian staff within last years

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