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Source: Michael Olah

Devastation Consequences of Pandemia and War Conflicts in Health and Social Security

Original Articles

✔DEVASTATION CONSEQUENCES OF PANDEMIA AND WAR CONFLICTS IN HEALTH AND SOCIAL SECURITY

✔DENTAL ANXIETY – PSYCHOLOGICAL AND PHYSICAL FACTORS AS TRIGGERS

✔THE IMPACT OF THE PANDEMIC COVID 19 ON ADOLESCENT'S SPORTS PERFORMANCE IN CZECH REPUBLIC

✔SPREADING TERRORISM, MILITANCY, AND RADICALIZATION IN MALAKAND DIVISION KHYBER PAKHTUNKHWA PAKISTAN: AN ANALYSIS OF THE ECONOMIC FACTORS

✔THE INTEGRATIVE FRAMEWORK MODEL ON STRESSES AND RESOURCES IN THE TEACHING PROFESSION ACCORDING TO CRAMER ET AL. FROM THE PERSPECTIVE OF ADULT AND FURTHER EDUCATION WORKERS IN WORK WITH REFUGEES

✔IMMIGRATION TO THE USA: CURRENT OPINIONS ON THE UKRAINE AND LATIN AMERICA COUNTRIES

✔NEW TRENDS IN THE FIELD OF SOCIAL REHABILITATION OF PEOPLE WITH DISABILITIES

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✔VOLUNTEERING OF STUDENTS OF HELPING PROFESSIONS IN PANDEMIC TIMES AT THE FACULTY OF SOCIAL SCIENCES AND HEALTH CARE, CPU IN NITRA, SLOVAKIA

✔THE WAR IN UKRAINE AND THE PARTICIPATION OF ST. ELIZABETH UNIVERSITY OF HEALTH AND SOCIAL WORK IN HELPING AT BORDER CROSSING POINTS

✔THE BENEFIT OF PROFESSIONAL PARENTHOOD FOR THE CHILD

✔IMPLEMENTING NURSING STANDARDS IN CARE MAPS FOR BREAST CANCER PATIENTS

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Editorial

Devastation Consequences of Pandemia and War Conflicts in Health and Social Security

D. West (Daniel J. West)[1], V. Krcmery (Vladimir Krcmery)[2]

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This current issue of *Clinical Social Work and Health Intervention*(1) reflects to some extent on two previous issues of this interdisciplinary Journal dealing within the last 2 years with two groups of catastrophic effects on civil society, social security, healthcare and finally to economics worldwide

1. Pandemic, declared by WHO and most states authorities worldwide, due to the potentially deadly virus COVID-19, may be followed by another endemic disease e.g. zoonotic influenza, monkey pox and hepatitis X.

2**.** At least four War conflicts: Azerbaijan versus Armenia; Yemen versus Saudi Forces; Afghanistan versus NATO; and recently the Russian Federation & Belarus versus Ukraine.

Most articles, studies, notes and letters react on the pandemic and armed conflicts and terrorism since they all appeared about 2 years, in an acute way of tragic consequences. However, we see articles from Pakistan, Czech Republic, Slovakia, Ukraine, USA, Germany, Greece, revealing even more tragic consequences: destroying mental health and social systems in an economic ways; long covid; post-covid syndromes; and war related destruction of infrastructure (health social services, their operations and financing).

Those long-term or chronic consequences of armed conflicts, (e.g. war, terrorism, etc.) in combination with huge economic losses in productivity of employees with chronic or long covid syndromes, associated with pandemic of mental health (20% of those after covid) lost their work ability, not generating even social security funds or health insurance operations; 40% of victims of war suffer post traumatic stress syndrome) may result in panworld economic social health depression for years. The contributing authors indicate ways out of

this *curculus vitiosus*: either we stop conflicts, and take pandemic lessons immediately, or we have to change our lifestyle and accept major limitations on food consumption, transport habits and shortages in fuel and other energy supplies. With devastating health consequences...and two subsequent pandemics-famine in Sub-Saharan Africa and pandemic of mental health worldwide... the first way out is much simpler, effective and health social security friendly...

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1. Long Term Consequences of catastrophies-war and pandemia - to health and social security. Clinical social work and health intervention. Vol.12.2022.3.3-73.

Dental Anxiety – Psychological and Physical Factors as Triggers

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Original Article

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Abstract:

While focusing on the terms dental anxiety, phobia, and fear, they are considerably common, but they are different in their circumstances. However, a difference has been noted between the terminologies. When challenged with a menacing dental issue, dental fear is a response to a familiar danger involving a "fight-or-flight" reaction meant to respond to stimuli[1]. On the contrary, dental anxiety (DA) is a response to unfamiliar danger where an individual exhibits a negative attitude towards dental treatment[2]. In contrast, dental phobia is primarily similar to fear, but it is much stronger because the "fight-or-flight" reac-

[1] Deva Appukuttan, Strategies to manage patients with dental anxiety and dental phobia: literature review, Clinical, cosmetic and investigational dentistry, 8 (2016): 36.

[2] Lingli Wu, and Xiaoli, Gao, Children's dental fear and anxiety: exploring family related factors, BMC Oral Health 18, #100 (2018): 1.

tion happens when one thinks or is reminded about the situation[3]. There are 3 categories of dental phobias based on their intensity[4]. Dental anxiety is popular with the general population and is the least intense, mild odontophobia. When the issue becomes moderate, it becomes dental fear or moderate odontophobia. Finally, a severe case is considered rare and can be challenging to manage - dental phobia.

Introduction

DA is among the problems that affect different societies, becoming a worldwide public health concern, and has been identified as the fifth most prevailing reason for anxiety[5]. DA is ubiquitous as many people encounter various degrees of anxiety, mainly when they are about to experience a definite dental process, be operated on, and have not experienced it before. Furthermore, those with dental phobia will evade dental care regardless of whether they face a physical problem or a psychological challenge that turns out to be immense[6]. This means that DA result in dental care avoidance. DA patients regularly delay or evade dental treatment by turning down appointments. Consequently, this results in a vicious circle leading to a higher pervasiveness and seriousness of dental disease to co-found with impeded dental appointments owing to the disease[7].

Causes of dental anxiety (DA)

One of the leading psychological and physical causes of DA is traumatic experiences in childhood which in many cases result in lifetime severity of DA[8]. If an individual experienced dental pain in their childhood, they are likely to actively respond to any such pain due to the presence of historical but fresh memories. Additionally, DA can also be indirectly acquired from indirect sources like perceiving how others behave. This might be from relatives, close friends, or even strangers acting negatively toward dental stimuli. It can also be caused by a mutual negative reflection of DA drawn from media and society. Research has shown that this indirect learning aspect for some individuals has an ultimate effect on inducing phobia[9]. It has been identified that a sizeable percent of DA is acquired from external negative experiences.

Dental decay is highly associated with excessive pain. Apparently, pain is the primary cause of anxiety[10]. Due to the excruciating pain that some patients undergo, they fear that even the painless dental procedures will add more pain[11]. An aching tooth usually becomes worse when touched. Therefore, they will try to evade dentists and settle on their pain rather than seeking intensified ones.

Furthermore, the formula of dentists, such as being cold and being in control of a character, might have a significant psychological influence on anxiety, worsening their fear. The challenging part is that DA leads to low cooperation among the

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patients when they visit dentists, resulting in more resources and time, as well as unpleasant experiences[12]. The pain caused by a dentist seems to be sometimes caring but leads to psychological anxiety. The perceived reflections from professional dentists forecast the evasion behavior in anxiety because the negative images depress an individual further into evading an appointment to attend the dentist to get the benefit of dental care[13]. Studies have already confirmed that the most fear-evoking stimuli are related to invasive stimuli like surgical operations, compared with the minor anxiety-evoking stimuli of noninvasive. This indicates that the phobia may be personal and supported by definite items which may generalize, where the general event collectively prompts anxiety.

According to studies, children with DA have long-term effects on their lives and may be hard to relieve. DA has been identified to have an intense impact on daily life, affecting sleep and an individual's social behavior patterns, having dental phobia incriminated as its precursor. This defines a ferocious cycle of anxiety and has been confirmed by various studies[14]. The reasons that make the level of DA in children more complicated include dentists' appearance, clinic environment, and the instrument used. Dentists who do not encourage, show care and sympathize with their patients also contribute to DA's escalation because patients do not feel relaxed in their presence[15]. Behavioral demonstrations such as crying, evading dental treatment and screaming reduce the efficacy of dental health services. Several behaviors are used to tackle DA in children such as positive reinforcement, productive communication, and modeling, resulting in improved children's treatment management[16]. The lack of these techniques intensifies DA among children. The behavioral management challenges are associated with dental factors such as earlier negative treatment occurrences, drilling, injections, indicating negative psychological loads.

Far from longer anxiety experiences from childhood, DA is also triggered by the specific dentists who care for childhood patients and have been regularly blamed for the developed anxiety of the same patient in adulthood. This indicates the significance of successful and encouraging early contact with dentists as a leading factor in reducing DA. Reportedly, DA has been increasing due to the quantity and quality of dental treatment experienced by children between 9-12 years[17]. Studies showed that DA is the main factor that results in the experience of unconvinced dental treatment in youth which showed almost 22% of the total. According to the studies, aspects related to the degree of DA in teenage between 13-18 years showed that the higher DA experienced, the lower confidence they usually have in the dental staff and exploitation of dental care[18]. The individual level of the emotional burden of visiting dental care was also noted to affect DA negatively. Specifically, DA experienced during teen years has also been confirmed to affect present oral health status and adulthood and old age.

Embarrassment has also been noted as another trigger of DA, mainly for adults. Adults patients seem to experience DA when they have lapsed on oral hygiene or delayed dental appointments[19]. Personal space is another trigger to DA, where

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most individuals feel uncomfortable with people trespassing on their personal space. It has also been confirmed that these patients feel uncomfortable when someone places instruments near their mouths[20]. Apart from dentist experiences, some individuals might have other mental challenges and ultimately expect something disastrous to occur during the treatment. This has been identified as the main reason why most people carry over their controls which results in worse dental health, mainly in teeth loss, deep cavities, poor teeth service, and maybe leading to periodontosis, reducing the well-being and quality of life[21]. There are categories of factors that lead to DA, such as psychological comorbidities which means an individual may have some mental problems. An excellent example is an individual diagnosed with anxiety may also have depression, generalized anxiety, social anxiety, or multiple comorbidities[22]. This means that such comorbidities may influence the diagnosis and treatment of dental problems.

Dentists' handling of the patients also elicits fear in patients: potential causes of anxiety are fear of choking and drowning, seeing blood, and fear of injections[23]. The inclined lying of the patients while being treated upsurges the affection of frailty and lack of control. When seated in the dentist's chair with their mouths wide open, patients cannot see what the dentist is doing[24]. Additionally, the dentist engages patients' mouths in an intrusive way in an area that can be considered a personal space[25].

In surgical involvement like extractions, patients are unaware of the used technique and know nothing about what to expect. This proves that the unknown is one of the factors resulting in DA. Reportedly, this DA trigger has nothing to do with teeth. A patient who fears injection or seeing blood will experience such anxiety whenever they are about to engage in such treatments. Since dental treatment, particularly the extraction of teeth, will result in injections to initiate numbness and blood will be shed, anxiety sets in.

Situational or environmental factors associated with the dental clinic also trigger DA. Sensory triggers are pivotal in aggravating anxiety[26]. Some of these triggers are sensory-motors that have high-frequency vibrations; visuals such as needles; auditory sounds from turbines; olfactory which is the smell of the dental materials although currently materials used in treating dental problems have been improved.

Another trigger is the waiting room atmosphere, where photos or pictures without neutral topics reinforce patients' anxiety. Similarly, environmental factors that affect patients include unpleasant odor. Ideally, there are two common types of factors that are related to pain perception. One is situational factors, and the other is individual factors[27]. In situational factors, these are narratives that we hear from others and the exact situations of pain appearance. The fear of situations has been ranked fourth, after injuries, height and snakes[28]. Individual factors are the previous pain experiences, where patients tend to postpone appointments for dental control due to this.

Irreversible pulpitis is an enlarged medical situation that entails spontaneous and impetuous pain. Such pain may prompt patients with pulpitis to seek emergency dental care. Yet, fearing pain during and after being treated may cause DA in patients delaying treatment[29]. The treatment for

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[27] Kauther, 1.

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irreversible pulpitis is endodontia therapy, which is claimed to be physical and psychological distress for patients. Alternatively, one may seek aromatherapy to reduce dental pulp inflammation pain[30]. The endobontia therapy procedure contains injection, root canal, cleaning, and obturation provoking DA in patients.

When seeking dental treatment, some patients may also experience embarrassment particularly if their state of health is poor. Experiencing dental odor, some individuals will feel ashamed of themselves and feel that they cannot open their mouths to have their teeth extracted[31]. Bad breath is highly associated with low self-esteem. Essentially, people with halitosis (bad breath) tend to have poor social and relationship skills because they fear talking openly to others[32]. They feel discomfort smiling, laughing, or speaking before others because other people will perceive them negatively. When they are about to visit the dentist, the same anxiety engulfs them.

Addressing DA to seek Dental Care

Since DA limits dental care, different approaches are required to break the existing barriers and help patients to access care. It has been identified that DA makes patients evade care, a behavior that leads to health deterioration. Thus, implementing strategies that encourage patients to feel comfortable with dental care is indispensable for perfect oral hygiene.

As indicated, unsympathetic dentists provoke DA[33]. On the other hand, encouraging and caring practitioners usually sooth patients as they feel relaxed. Patients need to be assured that everything will be okay. Patients who might have experienced DA resulting from their childhood or past experiences also need assurance that current treatment will be different[34]. Nonetheless, dentists' assurances can psychologically and dramatically change the situation. Dentists need to develop good relationships with patients by being supportive, compassionate, and professional[35]. Apart from previous experiences, communicating with the dentist also helps patients who feel anxious when they lose control or when they feel that their personal space (mouth) has been encroached on[36]. When the dentist communicates about the procedure to use and answers any arising questions beforehand, the patient can feel comfortable with the process. For young children, a parent can act as a source of moral support and assurance by reinforcing the dissapatiance of anxiety[37]. Dentists can also use pain-relieving approaches to ensure that pain has been alleviated during treatment.

Aromatherapy intervention reduces anxiety and pain. As a cost effective and safe treatment option, different plants are used in this approach, including lavender[38]. Research has confirmed that patients who have been engaged in aromatherapy experienced a reduced mood, alertness, and anxiety[39]. Lavender aromatherapy has also reduced pain and anxiety among children. When administered as inhaled or a nebulizer, it gets into the nasal mucosa, leading to the limbic system where it boosts the psychological pathway[40]. This ap-

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[40] Ibid., 118

proach can also be critical to patients with irreversible pulpitis because it will help manage pain. To be effective, aromatherapy can be induced before the patient visits the dentist.

To address embarrassment due to halitosis, the patient can be trained on the best methods to improve oral hygiene. Dentists are willing to recommend different approaches that patients can embody so that they can address halitosis[41]. Additionally, several treatment options are available for bad breath to ensure that the patient improves breath before they engage in other dental treatment services[42].

Conclusion

Undeniably, DA has been regarded as a global health problem and ultimately leads to patients' devastating dental health. Examining DA triggers can help address it in a bid to improve dental care. Some of these triggers include: poor past experiences; experiences from close people; unsympathetic dentists; poor oral health; pain perception; lack of control; encroachment of personal space; environmental factors such as clinic odor. These triggers act as barriers to dental care access. Since dental care is part of the larger public health, understanding how to address these triggers can be effective. The dentist needs to engage in a positive relationship by demonstrating compassion and support to patients erasing any negative experiences. Additionally, children can accompany their parents or close friends who can assure them that the process is well. Dentists should also communicate with the patients before treatment to improve awareness of the procedure. Aromatherapy has also been termed as an effective solution to pain and anxiety management. Finally, oral health can address bad breath to eliminate DA.

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The Impact of the Pandemic COVID 19 on Adolescent's Sports Performance in Czech Republic

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Original Article

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Abstract:

Background: During the COVID-19 pandemic, free movement, leisure activities and sports, both competitive and elite, were restricted by measures against the spread of the infection. The study aimed to evaluate the impact of the restric-

tions on the performance of Czech adolescent competitive athletes.

Methods: The sample of the retrospective study comprised 125 participants (41 girls, 84 boys). The initial examination, the mean age of the entire sample was 15.5 ± 1.2 (median 16.0) years; 16.0 ± 1.2 in girls and 15.5 ± 1.2 in boys, respectively. All participants were examined during regular preventive sports health checks from September to November 2019 and a year later. The examination consisted of a complete medical history and physical examination, anthropometric measurements (height, weight and body mass index [BMI] calculations) and maximal exercise testing on a leg cycle ergometer, ECG and blood pressure recordings. The response variables in regression models were power output (W/kg) and MET.

Results: In the entire sample, as well as in the boy and girl subgroups, body height, weight, BMI, BMI percentile and power output were significantly increased in 2020 compared to 2019, yet with a statistically significant reduction in both power output per kilogram of body weight and metabolic equivalent (MET). In 2020, the relative power output dropped by 0.13 W/kg and MET by 0.6. There was no statistically significant predictor of changes in relative power output and MET identified in regression models, including no significant impact of the sport type. There were no significant differences in results between genders.

Conclusions: Performance and anthropometric parameters, specifically power output per kilogram of body weight and MET, worsened in the sample of adolescent male and female athletes.

Introduction

During just a few months, the COVID-19 pandemic has caused a global public health crisis with psychological, social and health consequences. In 2020, the global coronavirus disease (COVID-19) pandemic, caused by severe acute respiratory syndrome coronavirus 2, produced major changes to social behavior including restrictions on free movement, leisure activities and sports, both competitive and elite. Compared with adult COVID-19 patients, the number of pediatric patients was lower with milder symptoms and better prognosis.[1,2,3]

On 11 March 2020 after the virus infected more than 381,000 people in 195 countries, the World Health Organization declared COVID-19 to be a global pandemic.[4] On the same day, preventive measures to contain the spread of the disease including restrictions on free movement, leisure activities and sports, both competitive and elite were adopted. Coronavirus disease has been shown to have direct and indirect effects on human health and social life like social isolation; loss or risk of loss of income and livelihood; economic unrest; increased alcohol and drug use; intimate partners and family violence; reduced physical activity; intellectual stimulation.[5]

With schools and sports grounds being closed, children's leisure activities were significantly limited until 24 May 2020 when the ban was lifted. With regard to the worsening epidemiological situation, the measures were reintroduced; once again, schools, indoor and, later, outdoor sports grounds were closed. Thus, leisure, high competitive and school sports activities of Czech children were limited in 2020. Subsequently, a detraining effect may be expected, associated with reduced physical condition and specific performance[6] as well as other negative metabolic and morphological and functional changes.[7]

Physical activity is a basic biological mani-

festation and need in human life. Globally, progressive technological development, urbanization, car-oriented urban and rural design have reduced common mobility habits and options. The overall amount of physical activity, in particular its habitual component decreases even though the genetic makeup of individuals, and thus their need for movement, remain unchanged. Hypokinetic disease and sedentary lifestyle are increasingly encountered in childhood. Physical activity is one of the most important sources of personal, social and economic development that contributes significantly to the quality of life.[8,9]

Physical inactivity is described as one of the biggest public health problems of the 21st century.[10-12] It is defined as an activity that does not consume sufficient muscle energy.[13] Physical inactivity is one of the main risk factors for noncommunicable diseases, ranking 14th in the world and 11th in high-income countries.[14]

The aim of this study was to evaluate the influence of the lockdown due to the COVID-19 and preventive restrictions on performance of Czech adolescent competitive athletes, by comparing anthropometric and performance parameters measured in 2019 and 2020.

Materials and methods

Study design and sample

A retrospective, non-interventional, non-randomized, non-blinded, uncontrolled study was performed. The sample comprised 125 children and adolescents (41 girls, 84 boys). Outdoor athletes prevailed over the indoor ones (73.6% vs. 26.4%). Participants involved in team and individual sports were present equally in the study sample (48.8% vs. 51.2%). The mean age at initial examination was 15.5 years (median 16, SD 1.2). All participants were examined during regular preventive sports health checks conforming to the Czech legislation (Decree No. 391/2013 Coll.) between September and November 2019. Only athletes examined a year later, in 2020, who did not interrupt their training due to illness or injury between the two health checks were enrolled. The examination consisted of a complete medical history and physical examination, anthropometric measurements (height, weight and body mass index [BMI] calculations) and maximal exercise testing on a leg cycle ergometer (Ergoselect 100P, Ergoline, Bitz, Germany). ECG recordings were made with BTL-08 LC ECG (BTL Industries Ltd., UK). The studied parameters were maximum power output (Wmax, or W per kg of body weight) and metabolic equivalent (MET).

The study was approved by the Ethics Committee of the Faculty of Medicine, University of Ostrava (No. 18/2021). All participants (or their parents) signed informed consent forms.

Statistical analysis

Data were analyzed using IBM SPSS Statistics version 22 (Armonk, NY: IBM Corp.). Numerical variables were assessed with descriptive statistical methods (mean, median, SD). To determine statistical significance of differences between the 2 years, genders and subgroups, the chi-square test and the Wilcoxon test were used. Forward stepwise logistic regression and linear regression were applied to evaluate predictors for changes in power output per kilogram of body weight and changes in MET, as response variables, and the other numerical variables. The level of statistical significance was set at 5%.

Results

Sample characteristics

Basic characteristics of the entire sample are shown in Table 1. In the entire sample, as well as in the boys and girls, body height, weight, BMI and power output were significantly increased in 2020. Table 2 presents changes in the studied characteristics between the two years. Both power output per kilogram of body weight and MET statistically significantly reduced between the study year in the entire sample. However, for genders, this was proven only for boys; in girls, the reduction was insignificant. The type of sport performed by study participants did not statistically significantly relate to the change in power output per kilogram of body weight and the change of MET between the study years. Indoor athletes experienced a mean reduction in relative power output of 0.2 ± 0.72 W/kg, while outdoor athletes of 0.11 ± 0.86 W/kg ($p = 0.592$). A reduction in MET of 0.99 ± 2.79 in indoor athletes and 0.42 ± 3.02 in outdoor athletes was noted ($p = 0.345$). Athletes training individual sports decreases in their relative power output by an aver-

age of 0.08 ± 0.92 W/kg, while team athletes deteriorated by 0.19 ± 0.74 W/kg (p = 0.464). The same athlete subgroups decreased in their MET by 0.56 ± 3.12 and 0.59 ± 2.84 (p = 0.955).

Predicting changes in power output

Both logistic and linear regression analysis (in the entire study sample and in the gender subgroups separately) did not identify any statistically significant predictor of changes in both power output per kilogram of body weight and MET.

Discussion

In the COVID – 19 pandemic restrictions on free movement, leisure activities and sports critically influenced our lifestyle habits. Numerous studies from many countries and regions around the world have analyzed the consequences of quarantine on our health, with diverse outcomes depending on the adherence to a specific diet pattern and physical activity schedule. The study of changes in the lifestyle of the Spanish University Population[15] shows that 36.3% of Spanish students increased their physical activity this results are similar, although higher, to those reported by Rodríguez-Pérez et al.[16], Di Renzo *et al*.[17] and somewhat lower than those found by Celorio-Sarda *et al*.[18], contrary to those of Romero-Blanco *et al*.[19] who found that all groups increased their physical activity.

The results of our study show that between 2 health checks, performed at a one-year interval, the participants increased their mean height, body weight, BMI and power output, but reduced their power output per kilogram of body weight, irrespective of gender. Reduced power output per kilogram of body weight was positively associated with age. The greatest reduction in power output was observed in children aged 14-16 years.

The participants increased their body weight. No reduction in BMI percentiles was noted; conversely, BMI percentiles increased, mainly in boys. Nikolaidis & Karydis, who analyzed the effect of age on body composition in competitive male adolescent soccer players (aged 12-21 years), showed a positive association between age and fat mass, fat-free mass, and a negative association with body fat.[20]

Moreover, they found that a typical gain in the mean BMI value per year was 0.42 kg/m2 within age category 12-21 years. The Czech Republic's Report Card on physical activity for children And youth, part of the Active Healthy Kids Global Alliance global effort, shows that 62% of adolescents participate in organized sport and physical activity programs, with participation in such leisure time activities being associated with better physical and mental health.[21] It may therefore be assumed that it was restrictions on these activities that contributed to performance reduction. In childhood, apart from organized sports activities, leisure time, habitual activities including active transportation to school are of key importance.

In Denmark, where nearly two-thirds of adults use cycling as a means of transport, bike riders were found to have an 8% higher level of fitness. The number of Czech children choosing active forms of transport to school (walking, cycling) has steadily decreased. In 2011, Czech adolescents were 2.7 less likely (OR = 0.365, p <0.001) to use active transportation to school than in 2001, as shown by Dygryn *et al*. in a study of 6,236 participants. Between 2001 and 2011, the proportion of adolescents using active transportation to school decreased from 49.1% to 21%.[22] In this age category, long-term restricted school attendance may result in failing to meet the recommended amount of walking. Boys and girls aged 6-12 years should take at least 15,000 and 12,000 steps a day, respectively.[23] Previous studies indicate that healthy behaviors have complied more beneficially during structured days (e.g. school days) as compared to unstructured days (during vacations or on weekends). This is supported by data showing the importance of structured institutions and organizations (schools, sports clubs) for children's and adolescents' sports activities.[24-28] A physical activity-friendly school environment is associated with lower risk of obesity and a positive youth development-based sports mentorship program improved healthy adolescents' mental well-being, psychological assets, physical fitness and physical activity levels.[29,30]

In their cross-sectional study determining performance level of 200 elite youth hockey players aged 13-17 years, Leiter *et al*. found that aerobic fitness increased to a lesser extent at older ages, with a significant increase in maximum power output between the ages of 13 and 14 years as well as between 14 and 15 years, but an insignificant increase between the ages of 15

and 16.[31] This is consistent with the present study showing the greatest increase in absolute power output in children aged 13 years or younger a smaller increase in those aged 14 to 17 years and the smallest increase in adolescents aged 17 years and older.

Despite the undeniable importance of restrictive measures, such as movement limitations, social distancing or school closures, for containing the COVID-19 pandemic, epidemiological studies have demonstrated a negative impact of certain measures on health through worsening of cardiometabolic parameters in various populations throughout the world. In Europe, an example may be a study of 2,447 Lithuanian adults by Kriaucioniene *et al*. showing that due to COVID-19, one-third of the participants gained weight, negatively changed their dietary patterns and reduced their physical activity.[32] Similarly, Bhutani *et al*. reported increased mean weight (n = 727) resulting from only several months of lockdown in the United States.[33] Studying a population of Greek children and adolescents (n = 397), Androutsos *et al*. showed that during the COVID-19 lockdown, children's/ adolescents' BMI (in 35%), sleep duration and screen time increased, while their physical activity decreased.[34] In a study of 41 Italian children aged 13 years with obesity, Pietrobelli revealed that during the COVID-19 lockdown, time spent in sports activities decreased by 2.30 hours a week; sleep time increased by 0.65 hours a day; screen time increased by 4.85 hours a day; a number of meals eaten per day increased by 1.15.[35] A relationship between too much time spent in front of the screen and poor eating habits has been reported in adolescent girls.[36]

In most countries, epidemiological data have confirmed a dramatic increase in the prevalence of obesity at the time of the pandemic, especially in the young population. The reason was physical inactivity, poor eating habits, sedentary lifestyle.[37,38] Physical inactivity and obesity have also become increasingly important factors in mental illness.[38]

However, the literature focusing on the impact of anti-epidemic measures on children is still scarce. We have not found other studies dealing with the effect of the measures on performance characteristics such as power output. From a public health perspective, it is therefore essential that during restricted school attendance, parents, with state support, provide their children with adequate physical activity, we have focused on the possible health gains originating from that.

Conclusions

However, it is too early to conclude the impact of the COVID-19 pandemic on children's sports performance. We demonstrated, after months of restrictive measures, a statistically significant increase in their body weight and BMI while their power output per kilogram of body weight and MED dropped. The results of the logistic regression analysis as well as the results of the multiple linear regression analysis in the whole group, or separately in the group of girls or boys, did not show any significant predictor of performance worsening between both study years. Therefore, we suggest that restrictions introduced to limit the spread of the virus had detrimental effects on various lifestyle components, especially in young populations. This resulted in augmented levels of physical inactivity and sedentary behaviors and a reduced time spent in play outdoors or sport practices. The sedentary lifestyle during the pandemic of COVID 19, low physical activity, and the media such as the internet, television, radio, the press and others affect the lives of young people can influence them. These findings should be reflected when planning further epidemic measures and the benefits of physical activity need to be emphasized in national programs to prevent the burden of non-communicable diseases. High vaccination coverage of the adolescent population should be supported to prevent not only their weight gain but also performance decline originating from reduced physical activity connected to the restrictive measures.

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Conflict of interest

The authors certify that there is no conflict of interest regarding the manuscript.

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Table 1 Basic characteristics of the entire sample in both years of the study (in girls; boys)

Characteristic	Year 2019		Year 2020		P-value (Wilcoxon test)
	Mean ± SD	Median	Mean ± SD	Median	
Height (cm)	172.1 ± 8.9 (166.9 ± 5.8; 174.6 ± 9.1)	172.0 (167.0; 177.0)	175.6 ± 8.3 (168.6 ± 6.2; 178.2 ± 7.3)	175.0 (169.0; 179.0)	<0.001 (<0.001; <0.001)
Weight (kg)	62.5 ± 11.7 (59.9 ± 10.1; 63.8 ± 12.2)	61.2 (58.0; 63.1)	67.3 ± 11.2 (62.5 ± 9.0; 69.6 ± 11.4)	66.0 (62.3; 68.5)	<0.001 (<0.001; <0.001)
BMI (kg/m2)	21.0 ± 2.8 (21.5 ± 3.2; 20.7 ± 2.6)	20.7 (21.2; 20.4)	21.9 ± 2.7 (22.0 ± 2.9; 21.8 ± 2.9)	21.7 (21.8; 21.7)	<0.001 (0.001; <0.001)
Power output (W)	272.2 ± 65.4 (228.2 ± 50,2.0; 293.8 ± 61.2)	270.0 (220.0; 180.0)	286.3 ± 71.0 (236.3 ± 61.5; 310.8 ± 62.2)	290.0 (230.0; 310.0)	<0.001 (0.029; <0.001)
Power output per kg (W/kg)	4.40 ± 0.83 3.88 ± 0.85; 4.66 ± 0.69)	4.39 (4.04; 4.46)	4,27 ± 0.88 (3.8 ± 0.97; 4.5 ± 0.75)	4.18 (3.83; 4.46)	<0.001 (0.112; <0.001)
MET	17.4 ± 2.8 (15.3 ± 3.2; 18.5 ± 2.4)	17.4 (15.5; 18.5)	16.9 ± 3.2 (14.9 ± 3.0; 17.8 ± 2.8)	16.8 (14.4; 18.4)	<0.001 (0.076; <0.001)

SD, standard deviation; BMI, body mass index; MET, metabolic equivalent

Table 2 Changes in mean values of studied variables between 2019 and 2020

Variables	all	boys	girls
N	125	84	41
Height (cm)	3,0 ± 3.5	3.6 ± 3.8	1.7 ± 2.1
Weight (kg)	4,8 ± 4.4	5.9 ± 4.5	2.6 ± 3.2
BMI (kg/m2)	0.9 ± 1.1	1.08 ±1.05	0.52 ± 1.05
Power output (W)	14.1 ± 28.1	17.0 ± 28.5	8.2 ± 26.6
Power output per kg (W/kg)	-0.13 ± 0.45	-0.16 ± 0.45	-0.07 ± 0.46*
MET	-0.6 ± 1.9	-0.7 ± 1.9	-0.4 ± 1.9*

BMI, body mass index

* statistically insignificant difference

Spreading Terrorism, Militancy, and Radicalization in Malakand Division Khyber Pakhtunkhwa Pakistan: An Analysis of the Economic Factors

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Original Article

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Abstract:

The current study is to analyze the causes of militancy, terrorism, and radicalization where multifarious factors are contributing towards spreading such behavior. However, the study is delimited to focus on the economic factors, including poverty, unemployment and other such factors that lead towards militancy, terrorism, and radical behavior in society. The field information was collected from 200 respondents using purposive sampling technique with stratified approach from 3 strata of the society including businessmen, teachers and clergy

or religious class of age 20 and above. The data was collected through a structured interview schedule, and the analysis was made in the form of tables, discussion and the findings have been verified through chi-square test. The findings show that militancy, terrorism, and radicalization have their roots in deep rooted poverty, unemployment, and lack of other life facilities in the area. The study suggests proper planning for provision of jobs, equal distribution of resources among people and provision of life facilities to the masses.

The Study Background

The spread of militancy, radical behavior and terrorism can be linked to the incident of January 13, 2006, when the CIA (Central Intelligence Agency) fired various missiles on *Damadola, a village in the Bajawar Agency, killing 82 innocent students (*Gul, S. & Royal, Katherine M., 2006). Since then, Pakistan witnesses a rise in the religious extremism, cross boarder terrorism, and militant attacks with gradual increase towards radicalization accompanied by multiple forms of political violence, brutality, occurrence of suicide bombings across country (Bari, 2009). Similarly, change in occurrence of terroristic incidents perpetrated through some organizations and bombings at government installations, places of public interests, worship, and even kidnapping for ransom has been found at large (Abbas, 2007) which also threatened the state machinery through organized mechanism and challenged the government's writ in Khyber Pakhtunkhwa Province (Aftab, 2008). Militancy, terrorism, and cross border attacks have added greatly to the destruction of the socio-economic and political stability of the country whereas its foundation can be traced back to the Soviet-Afghan War (1979-1989). Further, being an Islamic and neighboring country to Afghanistan, a continuous tension exists on the Pakistani side of the border due to the Afghan *Jihad* since the 1980s and then the US led war in Afghanistan against Al-Qaeda sine 9/11 (Abbas, 2011).

Studies have shown that Militancy, terrorism, and radicalization in Pakistan is due to the Afghanistan War (Michael, 2007) however, the seed of militancy and extremism had been there due the fragile social condition, poverty, illiteracy of the masses, economic deprivation, religious extremism, unemployment, ignorance, lack of good governance, and social injustice in the society (Ali, 2010). Similarly, the study of Khan (2009) has linked terrorism with easy access to arms, ammunition, marginalization of rurality, social injustice, and governance issues at large in the country. Accordingly, the volatile geopolitical situation and the poverty of the nation has contributed to the occurrence of terrorism in the country (Nasir & Hyder, 1988) while the mass deprivation from modern facilities, access to education, health, technology, communication and even access to food has thus created a sense of inferiority among the population (Ali, 2010). Further, the international agenda and some interventions cannot be excluded for creating uncertainty in the region, however the inside domestic socio-economic structures and other issues must be examined carefully in effective way for combating terrorism, extremism, and insurgency in Pakistan (Murphy & Malik, 2009). The current study is thus an attempt cover the economic forces that practically turned into havoc as has been witnessed during the past a few years and which cause or at least contribute to the present wave of terrorism, militancy, and radicalization scenario of the country.

Study Purpose and Rationale

Pakistan has been confronted with several challenges for its survival during the last few years. The increasing poverty, economic degradation, and the cross-border attacks, suicide bombing, militancy etc. have made people's lives miserable. Pakistan's Economic Survey (2010) reported that 24% of people are living below the line of poverty. And the country will be facing a rise of population from 180 million to 256 million by 2030. Currently, the economic unrest has been on the rise while 55% of the population have no access to education, food, standard of life, health, and the country has been 125th on the World Index of Human Development (UNDP's Report, 2010). Corruption, economic stagnation,

political instability, and inflation have rotted down the country's economic and political base (Pakistan Economic Survey 2010).

Pakistan is dependent on foreign aid, and thus foreign public debt has risen to more than $9.743 trillion (The Daily Dawn, May 2011). A large segment, particularly the poor, and neglected strata of society have become exhausted and frustrated with their lives within the country leading to a sense of relative deprivation, exploitation, and oppression, resulting in the emergence of anti-state sentiments. Similarly, the intense wave of foreign aggression in the neighborhood in the 21st century, has been another factor that added to the country's existence and perpetuation. The Global War on Terror (GWOT), and the incident of 9/11 disastrously impacted Pakistan's strategic and security scenarios. Several intense military operations were initiated against militants in FATA and Swat Districts and still the scenarios must wait to come to an end (PIPS, 2011). The politically motivated targeted killings and sectarian violence punctuated the security landscape not only in tribal areas and Malakand Division but have also spread to other parts of the country. According to Government of Khyber Pakhtunkhwa (2009) report which mainly demonstrates the post-military operation scenario, presents a very bleak socio-economic picture of Malakand Division. Similarly, the Center for Public Policy Research (2010) in its report *District Swat; Socio-economic Baseline and Displacement Impact*, also depicts Swat as being in a state of continuous socio-economic and political decline. In this context, the current study has been organized to look into the problem from certain fresh angles by exploring the possible linkage between militancy, terrorism and radicalization and the socio-economic situation haunting the area in particular and the whole society in general.

Purpose of the Study

The main purpose of the current study is to know the role of economic factors, community deprivation, poverty of the masses in spreading militancy, terrorism, and radical behavior i.e. extremism in Swat District.

Study Hypothesis

H0: There is no association between poverty, unemployment, and economic deprivation with the spread of militancy, terrorism, and radicalization in the region

Plan of Work and Procedure

This study has both qualitative (descriptive) and quantitative (explanatory) approaches as per the requirements of the collected data; its analysis; relation with secondary data. This study has been conducted in *Mingora (Swat)*. However, the population of the region is unknown and only male population has been made the jurisdiction of the study. The population has been divided into 3 feasible strata and through stratified random sampling 200 respondents was collected from the strata of 'occupation': business, teacher and clergy classes through purposive sampling procedure i.e., 118 from business class; 45 from teacher class; 36 from religious or clergy class. An Interview Schedule has been utilized in the current study as a tool of data collection which describes as a name of a survey research questionnaire when a telephone or face to face interview is used. The structured interview schedule comprises close ended questions including optional answers that provide an adequate range of options to the respondents for easy selection of the factors mentioned. A total of 200 interview schedules were filled from the selected categories and further analyzed in the form of tabulation, discussion/explanation and presentation with statistical test i.e. the chi-square test has also been applied on the collected information for the purpose of authenticity and accuracy. To test the validity of the data, the hypothesis given was operationalized and the association of the poverty, unemployment, economic distribution etc. verified with the spread of militancy, terrorism, and radicalization in the region.

Data Presentation, Results and Discussion

Age and Gender related Information

Only the age and gender of the respondents have been analyzed in the current study to show the level of maturity, age limit of the population, physical, psychological, and social processes associated with the data processing. The table below, illustrates categories of various age groups, i.e., C1, C2, C3, C4 and C5 which signify age limits of 20-24, 25-29, 30-34, 35-39 and 40

and above respectively whereas 51 respondents being (25%) belong to the age category C1, i.e. 20-24 years which is also the second major age group within the population sample; 26 respondents being (13%) belong to C2, i.e. 25-29 years; 15 respondents (7.5%) were of the age group C3, i.e. 30-34 year (See table-1).

Table 1 Age and Gender of Respondents

Categorie	Age Limits	Gender		F	%	C.P	Mean	Median	Mode
		Male	Female						
C1	20-24		-	51	25.0	25.0	3.07	4.00	4
C2	25-29		-	26	13.0	38.0			
C3	30-34		-	15	7.5	45.5			
C4	35-39		-	77	38.5	84.5			
C5	40 & above		-	31	15.5	100			
CT	**Total**	**200**		**200**	**100**				

The table further demonstrates the majority of the age group, which is C4, i.e. 35-39 years within the population sample and which accounts 77 (38.5%) out of the total sample size. Moreover, 31 (15.5%) belong to the age category C5, i.e. 40 years and above, and which stood to be the second major age category within the whole sample population. Furthermore, the table also shows Gender which exempt the female gender from the study through cultural justification and access to the respondents. Consequently, all the respondents, i.e. (100%) in the study are male and no female has been accessed to be interviewed or questioned in this regard

Socio-Economic Dimensions of Militancy

In the study, a glimpse of the economic condition of the area has carefully been taken and which supposedly has a cause-effect relationship with the militancy, terrorism and radicalization menace. The table statistically highlights mandates from the respondents for each of the supposed economic aspects of the mainstream economy of the area and has been examined and which is found considerably unsatisfactory. In the larger whole of the respondents' views regarding the deteriorated economic condition of the area, 31 respondents,15.5% agreed to the notion that average income/household ranges below Rs.5000/= in the area. In addition, investigation into the sources of income of people in the area has also been done in terms of conceptualizing it as a separate and independent variable/aspect of the economy. Society struggles to offer many and diverse sources of income to its members (Nasir & Hyder, 2003). Pertaining to the sources of income in the area, the study does not provide encouraging results, again (13%). Another aspect of the economy and which was conceptualized in terms of an independent variable i.e. employment opportunities. The data obtained 40 (20%) more or less corresponds with Ali (2010) findings which conveyed a very sad picture of the employment situation of the country in general and the area in particular. Moreover, the study assessed the prevalent economic condition in the area in terms of the budgetary allocation to it, the extent of which necessarily determines the overall development of any area. Pakistan's growth rate, according to official analysis has spiraled up (Pakistan Economic Survey, 2009-10), yet it's still not up to the mark, the national assembly passed 3259 billion budgets on June, 2010. Some provinces' share, mainly Sindh, Baluchistan and Khyber Pakhtunkhwa, is too meager, for instance, the total Share of Khyber *Pakhtun*khwa, from 1974 to 2009, according to Revenue Sharing Formula, NFC award (2009) is 14.62%. This budgetary allocation to KP is further devastating when it comes to consider the intense wave of Militancy and social disruption from 2007 to 2010, and probably until now. The federal

budget, announced on June 5, 2010, did not surprise anyone. No one expected that it would provide any significant economic relief to ordinary people, although official circles maintain that it is the best possible budget under the current difficult economic situation (Haq, 2010-11:67). The data collected in this study also conveys the very same situation in terms of severe budgetary discrimination with the area in particular. 23 (11.5%) of the respondents are of the view that the area is discriminated in terms of budgetary allocation. (See Table-2)

Table 2 Economic Profile of the Region

Categorie	Statements	F	%	C.P	Mean	Median	Mode
C1	Income ranges below 5000 per month	31	15.5	15.5	4.05	4	3
C2	No or less avenues of income	26	13	28.5			
C3	No or less employment opportunities	40	20	48.5			
C4	Meager budgetary allocation	23	11.5	60			
C5	State's negligence of the region	18	9.0	69			
C6	Unrestrained population growth based on culture and religion	23	11.5	80.5			
C7	Discouragement of women employment	25	12.5	93			
C8	Agricultural adversity	14	7.0	100			
CT	**Total**	**200**	**100.**				

Another dimension of the economy which has been assessed and quantified in the current study is the "State's Negligence of area", one aspect of which has been discussed in monetary terms i.e. budgetary allocation. In addition to the budgetary discrimination or meager allocation, the area, according to the data being collected (9%, see the table above), has considerably been deprived of the state's attention in terms of holistic and sustainable socio-economic developmental strategies and policies for it. Population growth, if it exceeds the real national income increase, hinders a national development (Nasir & Hyder, 2003), is yet another problem (verified by 11.5%), which adds to the already existing misfortune and economic adversity of the area. Another key dimension of the economy of the area being assessed in the study is the situation of women's employment. Women constitute almost half of the population of any area, and have strong intervention in socio-economic and communal life (Naz, 2009). Most recent studies i.e. (Naz *et.al*, 2011) offer calculated insights regarding women's participation in recognized and paid economic chores of the region. A number of factors i.e. patriarchy, long standing tradition like Purdah, *Pakhtun* code of conduct, Family honor and male dominancy are responsible for the lack of women's employment (Naz, & Khan, 2011). The current study more or less corresponds findings of the previous studies being done in the area as 25 (12%) of respondents opine that women employment is harshly discouraged in the region. Moreover, Pakistan in general and the region in particular are agriculture dependent, yet the situation of agriculture is disappointing too. For instance, 14 (7%) maintain that the region is faced with severe agricultural adversity (See Table-2).

Economic Adversity and Militancy

The table under discussion elaborates the relationship between the economic adversity in the region which directly or indirectly leads to the emergence of militancy, terrorism and radicalization. Also, the specific conditions and their ultimate consequences have been sorted out in terms

of categories ranging from C1 to C7. C1 connotes a particular adverse economic phenomenon, e.g. low income, the supposed ultimate consequence of which is "a sense of relative deprivation" which, with the combination of some other factors leads to militancy and chaos in the society. A relatively considerable number of views 25 (12.5%), in this regard approve the notion that low income outgrows a sense of relative deprivation, which in one way or the other results in militancy. Secondly, the emergence of another specific condition i.e. social segregation and mutual integration of the underprivileged classes in the society has been associated with militancy which has also been supported by the same number 25 (12.5%) of views. Another viewpoint, which also stands to be an unavoidable data set16 (8%), (See table-3), anti-state grouping based particularly on economic miseries, for example poverty, unemployment or low income begins to develop in the society. Such groups then go on struggling for their economic prosperity or at least the compensation of their economic suffering even at the cost of waging an armed protest against the state (See Table-3).

Table 3 Economic Adversity and Militancy

Categorie	Statements	F	%	C.P	Mean	Median	Mode
C1	Low income develops a sense of relative deprivation	25	12.5	12.5	3.68	3.0	3
C2	Segregation of the underprivileged classes	25	12.5	25			
C3	Development of Anti-state grouping	16	8	90.5			
C4	Affiliation of the poor within-state groups	35	17.5	69.5			
C5	Sense of hatred & opposition against the economic order	26	13	82.5			
C6	Alienation/Radicalization of unemployed manpower	54	27	52			
C7	Strengthening of anti-state groups by a high population input	19	9.5	100			
CT	**Total**	**200**	**100**				

The table also highlights another significant data set 35 (17.5%), pertaining to the affiliation of the poor with anti-state groups. The term poor is implied here to include all those who suffer economic deprivations as is elaborated by the conventional definition of poverty. In this specific context, it doesn't however point to those having low income, or are unemployed which is highlighted in one of the proceeding categories e.g. alienation of the unemployed manpower 16 (8%). Another category which receives, though not major, yet significant mandate 26 (13%) which in a broader context points to a general alarming phenomenon, e.g. sense of hatred and opposition against the economic order which if strengthens would result in a so called revolution as had been the precursor of any revolution throughout human history (Ritzer, 2001). A major data set 54 (27%), however reveals a very frightening portrait of an economic adversity e.g. the deterioration of our moral framework and the emergence of social barriers to individual fulfillment lead inevitably to what social scientists call i.e. Alienation/Radicalization of the unemployed manpower. The final category, which points more to a social phenomenon e.g. high population growth, turns to a problem if not well managed and maintained economically. This high population input is then maneuvered by the existing anti-state groups. For example, 19 (9.5%) respondents opine that anti-state groups recruit and manipulate an unmanaged high population

input for their own causes and interests (See Table-9).

Emergence of Militants in Relation with Poverty & Unemployment

The table under discussion amasses data regarding the emergence of anti-social or alienated groups in the region based on poverty and unemployment which contribute to waging militancy in the area while the preceding table represents data concerning a strong association to such groups by members having certain socio-economic backgrounds. By referring back to Table 3, in which majority 54 (27%), respondents argue that poverty and unemployment result in the emergence of radical or revolutionary groups in the society which eventually strike against the existing socio-economic order of the society as also strengthened by Ali (2009) findings in his study of militancy and socio-economic problems of Pakistan. The second major data set 37 (18.5%) as represented in Table 4 regarding respondents' opinion that such socio-economic problems lead to the emergence of revolutionary groups in the society. Such poor and unemployed people then find solace in struggle and slogans for revolution. Other variables in the Table include dacoits, arms mafia, smugglers, wage killers, Drug mafia and gangsters having received consents 22 (11%), 32 (16%), 6 (3%), 15 (7.5%), 20 (10%) & 27 (13.5%) respectively (See Table-4).

Table 4 Emergence of Militants in Relation with Poverty & Unemployment

Categorie	Groups	F	%	C.P	Mean	Median	Mode
C1	Dacoits	22	11	11	4.52	4.00	2
C2	Radical	41	20.5	31.5			
C3	Gangster	32	16	47.5			
C4	Smugglers	6	3	50.5			
C5	Wage killers	15	7.5	58			
C6	Drug mafia	20	10	68			
C7	Arms mafia	27	13.5	81.5			
C8	Revolutionaries	37	18.5	100			
CT	**Total**	**200**	**100**				

Justification for Illicit Economic Activities

According to the data accumulated in the table below, a majority 44 (22%) of respondents argued that militants carry out such acts on the basis of their claim that it is their religious obligation to establish *Sharia* and for this objective to be achieved striking against the existing political order by any means is morally fair. The second major pool 31 (15.5%) of respondents view regarding militants' justification of their acts is that the state expresses no concern or pays attention to the region which is responsible for their economic downtroddeness and misery. Other major data set in the table, and which obviously have no link with religious zeal are the state's corrupt economic and political order which receives 28 (14%) approval from respondents. Another such purely economic justification is also represented in the Table being poor and the neglected, favored by 27 (13.5%) respondents (See Table-13).

Table 5 Justification for Illicit Economic Activities

Categorie	Statements	F	%	C.P	Mean	Median	Mode
C1	On the basis of being poor and the neglected	27	13.5	13.5	4.08	4.00	6
C2	Due to lack of state's concern and attention	31	15.5	29			
C3	On the basis of claims of Equal rights on resources as khans/landlords have	24	12	41			
C4	Due to State's corrupt economic and political order	28	14	55			
C5	Supporting large families and no or less legal income sources	22	11	66			
C6	On the basis of Religious obligation to establish Islam	44	22	88			
C7	On the basis of Being unemployed	24	12	100			
CT	**Total**	**200**	**100**				

Moreover, two other bases, which militants justify for their actions and which have also been pointed to by Anwar *et.al* (2002), in their study of Landlessness and Rural Poverty in Pakistan, are the unequal distribution of land and unemployment. Interestingly, the two grounds, in the current study also have received equal mandates from the respondents 24 (12%) each (See Table 5). Building on the discussion a little further, militants justify their actions on the basis of Maliks/Khans and landlords' oppression, and their demand for equal share in resources of the region. The last but necessarily significant ground as favored by 22 (11%) respondents is militants' complain of having large families and no or less legal means to sustain them, that's why they indulge into illicit and immoral activities (See Table 5).

Major Findings and Verification of Hypothesis

Analysis of the information describes that poverty, economic dependency, illiteracy and lack of economic justice in the region remain dominant forces in spreading militancy, terrorism and radical thoughts among the people. Poverty as one of first and foremost determinant of violence and Militancy in the region having a series of aspects or variables and has been to conceptualize its consequences in varying terms. Most of the population ranges below Rs.5000 PKR and the given the current state of inflation, the said amount is considerably inadequate to fulfill even the least of life necessities. Further, lack of avenues of income in the region which has been affirmed by quite significant data remain another dominating factor in creating the restless. Information and analysis show that economic/monetary sponsoring of the poor masses by anti-state organizations in terms of employment, money, economic support further remain consistent for supporting the militants, as well as terrorism in the region while the spread of radical and anti-state thoughts cannot be ignored in this regard. Besides, some acute social problems, mainly poverty along with others, contribute to the development of militant or anti-social groups in the society and such groups includes radicals, revolutionary, and dacoits and the emergence of such militant grouping in the society is the outcome of the condition prevailed. Similarly, the deteriorated socio-economic scenario in the hypothesis is 'unemployment', which has been discovered frequently as positive while scanning the data being gathered. Majority of the data support the existence of unemployment problems in the region linking unemployment and militancy and the economic adversity and militancy, specifi-

cally focuses one of consequences of economic misfortune in 'employment terms and economic adversity in terms of unemployment results in the alienation/radicalization of the unemployed manpower thus leading to militancy. Such scenario has also been strong association with the emergence of militant groups', highlights such groups of various sorts of dacoits, radicals, gangsters, drug mafia, etc. being emerged as products of unemployment and poverty and such groups become members of such militant groups in the locality. With respect to the mentioned observations and analysis of different variables in different Tables along with the strong support of respondents and the application of Chi-Square test, the hypothesis has been proved as valid and authentic. The result of the applied test clearly shows that the dependent variable "militancy, terrorism, radicalization is strongly affected by the independent variables in relation to the prevailing socio-economic backdrop of the country in general and the region in particular. The value of chi-square test is P=.000**<.05, with the Chi-square value $\chi 2$ = 35.083 and the degree of freedom value D.f. =6, shows highly significant association among the independent and defendant variables. In light of results of the test, demonstrating a very positive correlation among the variables, the hypothesis stands to be correct and proved.

Conclusion and Recommendation

Causes of militancy are multifarious; however, the study was delimited to focus the socio-economic factors that contribute much to the prevalence of the terrorisms and militancy in the country in general and in the region. Basic purposes of the study were to establish the militancy and terrorism narrative in economic terms to systematically unveil the economic factors that may lead to the emergence of violent behavior in the society. Economic factors e.g. poverty, unemployment, low income level, unequal distribution of wealth and low life standards were found to have extremely dismal status in the region and have an igniting role in promoting aggressive, violent and antagonistic behavior. A detailed and careful analysis of findings of the study as a whole, demonstrates a positive correlation between the independent and the dependent variable (militancy and terrorism) being accumulated in hypotheses of the study. Thus, it concluded that poverty, economic dependency, lack of facilities in the region were assumed to be the major causes of militancy, terrorism and producing anti-state behavior. In addition, the unemployment, low income and high inflation in the region in particular and the whole country in general have been major causes of alienation, rebellion against the existing political order and in extreme cases militancy and creating violence in the locality. The study thus recommends that employment opportunities to reduce poverty as well as facilities of daily life need to be provided on priority basis to the people.

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The Integrative Framework Model on Stresses and Resources in the Teaching Profession According to Cramer et al. from the Perspective of Adult and Further Education Workers in Work with Refugees

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Abstract:

Cramer et al. (2018) found in their integrative framework model on stress, resources and consequences of teacher stress that teachers are mentally stressed. In their contribution, published in 2018, they establish an integrative framework model for stress and strain in the teaching profession on the basis of existing theories and models. The author of this thesis researches adult education workers who work with refugees as part of their educational work. The following research question is asked: Can the Cramer et al. transfer the modeled connections between stress, resources and stress to adult educators who work with refugees? For this purpose, the answers from interviews with 12 employees of adult education are subjected to a structuring qualitative content analysis and included under

the Cramer et al. the personal and professional stresses, resources and consequences of stress mentioned are subsumed. As a result, the Cramer et al. modeled relationships between stress, resources and stress are also transferred to adult educators who work in the professional field of training and further education for refugee adults.

Introduction and presentation of the framework model

Cramer *et al*. (2018) state in their *Integrative Framework Model on Stress, Resources and Consequences of Teacher Stress* that teachers are psychologically highly stressed. Many studies exist on this subject which are characterized by diverse theories and models as well as conceptual imprecision (Cramer *et al*., 2018: 1). In their 2018 paper, they justify an integrative framework model of stress and strain in the teaching profession based on existing theories and models. In this way, they discuss existing research findings in an orderly manner and validate their framework model at the same time. In doing so, they distinguish between stress, resources and the consequences of stress in personal and professional terms. In this way, they integrate existing individual theories, models and studies each with its own focus. In this way, Cramer *et al*. construct a structured overview that "[...] contributes to a conceptual and conceptual sharpening of the field. " (Cramer *et al*., 2018: 1). Thus, they accumulate the interrelationships of existing research in a condensed form and offer an occasion to identify existing research gaps on the basis of their contribution and to initiate further research.

The author of this paper is researching adult education workers who work with refugees as part of their educational work. The question now arises as to whether the relationships between stress, resources and strain modeled by Cramer et al. can be transferred to adult educators who work with refugees.

In their work, Cramer et al. focus "[...] on a complete representation of all conceivable resources in order to be able to sufficiently model the empirical function of resources. " (2018: 6) They see the commonality of the different models presented in the fact that stresses increase the probability of strain and the potential effects are mitigated by available resources. They define 'personal stresses' as dispositions, biographical events and physical as well as mental illnesses. These are generally irreversible; can be objectively assessed; their stress potential is proven.

Figure 1 Own illustration with modifications based on Cramer et al., 2018: 14.

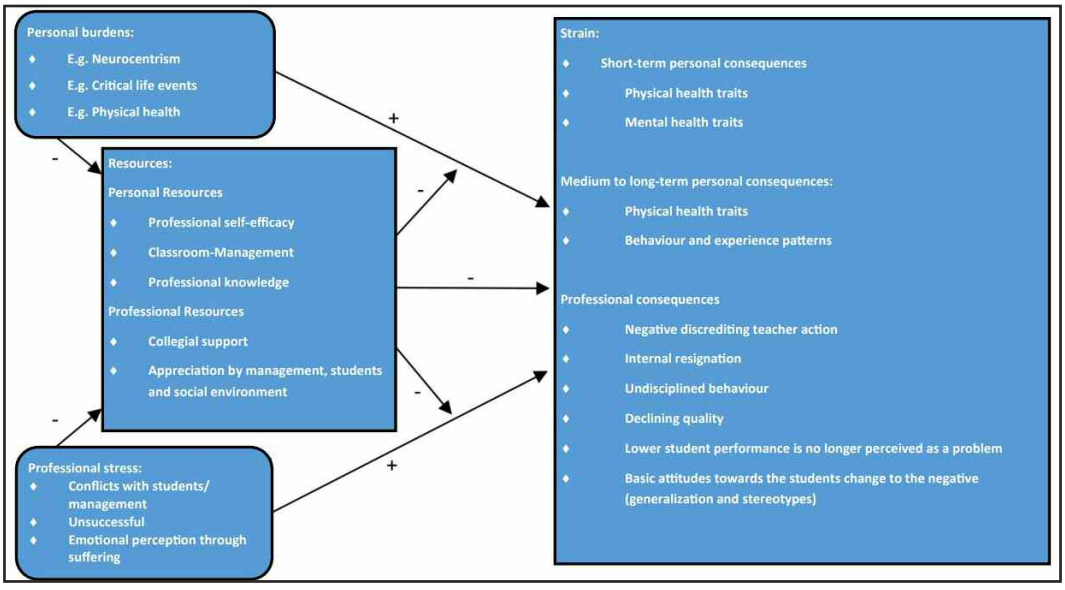


Fig. 3 Personal & occupational stresses, resources & stress consequences

	Terms	Subject (Example Variable)	Function and characteristics
Personal variables	Personal burdens	Dispositions, biographical events, illnesses (e.g. depression)	Source of stress often irreversible; detectable or diagnosable, tied on person, regardless of job characteristics
	Human resources	Professional knowledge, self regulatory skills, beliefs, motivational orientations (e.g. self-efficacy)	Moderators or mediators; cognitively represented, diagnosable often refer to activity
	Personal consequences (short-termed)	(Psycho)-physical stress reactions (physical, behavioural, cognitive, emotional) (e.g. high blood pressure)	Mostly short-term and reversible; diagnosable; bound to a person, often triggered at work
	Personal consequences (medium/ long-termed)	Individual consequences of stress (e.g. burnout)	Symptoms of burnout; unfavourable patterns of behaviour and experience; only conditionally reversible; diagnosable
Profession variables	Profession burdens	Characteristics of the workplace and the activity (e.g. disrupted lessons)	Source of stress; can be determined objectivity; affect all teachers, are sub-individual
	Profession resources	Support and appreciation experienced at work (e.g. collegial support)	Mostly moderators, some mediators; subject to subjective perception; are record as a self-certification; not cognitively represented, conditional
	Profession consequences	Medium and long-term consequences of stress for work, teaching and school (e.g. less efficiency of teaching)	Individual (e.g. teacher actions) and inter-individual (e.g. teaching quality; only conditionally reversible; measureable

Source: (Cramer et al.,2018: 8)

The 'occupational stresses' are objective characteristics of the workplace and the job (e.g. class size; amount of teaching commitment; difficult pupil behavior; teaching per se; work organization). Both types of stress can lead to strain. According to Cramer et al. stress arises from 'personal' and 'professional' stress. Both can exist separately but can also interact.

The following table by Cramer et al. (2018: 8) shows the delineation of personal and occupational characteristics and of stress, resources and strain consequences based on the discussion of theories and models presented above. These serve as a starting point for developing the integrative framework model presented above.

Object of research, research question and methodology

The research object of this work is adult educators who are involved in the further education of refugee adults. In 2018-2019, the author selected people who work with refugee adults (e.g. in language courses, integration projects, counseling) and who have a pedagogical, adult education or further education degree. The spectrum was deliberately kept broad to ensure that people from diverse areas of education and training would come forward for a guideline interview. The plan was that these education professionals would be able to provide information about their everyday work and their views on: motivations; stressors; coping strategies; experiences of meaning. An information letter was prepared to recruit the interview partners. This was sent by email to potential actors and institutions in refugee aid in the Rhine-Main Region. The project was also made known verbally. There were 18 responses, but 4 people were not involved in adult education but in practical support for refugees. There were two cancellations.

In the following, the interviewees are briefly introduced in the selected profile[1] :

[1] The subjects were deliberately anonymized.

1 Ms G.: employed, asylum coordinator, political scientist, DaF teacher, 38 years of age.
2 Ms B.: voluntary, secondary school teacher, integration teacher, 59 years of age.
3 Mr B.: honorary, banking economist, retired trainer, 69 years of age.
4 Ms W.: voluntary, PhD in German studies, language teacher, 75 years of age.
5 Ms S.: employed, B. Sc. physiotherapy, M.A. adult education, Headmistress of physiotherapy school, 50 years of age.
6 Mr B.: employed, M.A. Anthropology, employee Bildungswerk, 53 years of age.
7 Ms N.: voluntary (refugee work), employed, B.A. nursing pedagogy, head of rescue service school, M.A. adult education, 32 years of age.
8 Ms T.: employed, M.A. Marketing, language teacher, 33 years of age.
9 Ms F.: employed and voluntary, teacher nursing, M.A. adult education, 58 years of age.
10 Ms D.: employed, 1st service examination in education, DaF teacher, 70 years of age.
11 Mrs O.: voluntary, primary school teacher, VHS teacher, 68 years of age
12 Mr R.: civil servant, police teacher, graduate administrator, coordinator of interculturalv competence/diversity management, 34 years of age.

After transcription, the interviews were analyzed using qualitative content analysis in order to draw conclusions about motivators; stressors; coping strategies; the experience of meaning of adult educators in refugee work (see appendix).

The aim of the present study is to answer to what extent a connectivity of the integrative framework model of Cramer *et al*. can be established for the field of those working in adult education with refugees. To this end, the following research question is posed:

Can the relationships between stress, resources and strain modeled by Cramer et al. be transferred to adult educators working with refugees?

For this purpose, the employees' answers are again subjected to a structuring qualitative content analysis and subsumed under the personal and occupational stresses, resources and stress consequences mentioned by Cramer *et al*.

Results

Based on the above table by Cramer *et al*. (cf. 2018: 8), the results from the interviews with adult educators are presented below.

Evaluation of personal variables

The results of the personal variables are presented below:

Table 1 Personal variables

Personal variables	Example variable	Variables from the interviews
Personal burdens	z. e.g. illnesses, biographical events	Age-related physical problems, illness
Personal resources	z. e.g. professional knowledge, beliefs	motivational factor intercultural competence, joy of teaching, curiosity, realization of ideals, values and maxims of action, humor and serenity, exchange with friends and family, promotion of own resilience- and use of relaxing activities
Personal consequences (short-term)	z. E.g. (psycho-)physical stress reactions (e.g. high blood pressure)	Short-term (psychological) states of arousal such as anger,rage, emotional participation in the refugees' experience
Personal consequences (medium/long-term)	Individual consequences of stress(e.g. burnout)	Physical and psychological stress, frustration, resignation

Evaluation of occupational variables

After evaluation, the following results emerged for the area of occupational variables:

Table 2 Occupational variables

Occupational variables	Example variable	Variables from the interviews
Occupational stresses	Characteristics of the workplace and the activity (e.g. disturbed teaching)	Cultural differences, different norms & values of refugees, poor pay, lack of skilled workers, institutional difficulties (e.g. funding, bureaucracy), lack of professional support, lack of volunteers
Professional resources	Support and appreciation experienced in the workplace	Support, exchange with colleagues
Professional consequences	Medium & long-term consequences of stress for professional activity (e.g. teaching)	Frustration, employees leave the occupational field

Conclusion

After evaluation, the following can be determined in the area of personal stresses; the stresses mentioned by Cramer *et al*., such as illnesses or age-related physical problems, can also be recognized among the adult educators. The personal resources of the interviewees consist of joy in teaching; exchange with relatives or friends; development of resilience. Short-term personal consequences are expressed in anger and resentment as well as sympathy for the fate of the refugees; in the medium and long term, psychological and physical stress as well as frustration and resignation arise. According to the interviewees, professional stress is caused by cultural differences; the shortage of skilled workers; a lack of funding or bureaucracy; a lack of professional support. Professional resources are generated from the support and exchange within the college. Finally, in the area of occupational consequences there is a change of occupational field by employees as well as long-term frustration mentioned above.

In summary, the relationships between stress, resources and strain modelled by Cramer *et al*. can thus also be transferred to adult educators who work in the professional field of education and training of refugee adults.

In a further research project, the author will use quantitative research instruments to investigate stress and coping strategies of this professional group using a specially developed quantitative survey instrument. Here, too, the integrative framework model mentioned above will serve as a starting point.

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Immigration to the USA: Current Opinions on the Ukraine and Latin America Countries

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Abstract:

The U.S. stands in solidarity with our allies in NATO and European Countries regarding the Ukrainian invasion and war atrocities. The vast majority of Americans support efforts to help Ukrainian people during this Russian military invasion. It is a well-known fact that large communities of Ukrainians live in the U.S. and have American citizenship. Immigration from the Ukraine to the U.S. has existed for decades. Americans support lawful immigration from other countries into the U.S. Overall, more Americans approve than disapprove of President Biden's response to this Russian invasion and humanitarian crisis. There is bipartisan support for limited U.S. intervention but a plurality of Republicans think the U.S. should be doing more in providing Ukraine with military support. There needs to be a balance between avoiding a larger military conflict with Russia and increasing economic pressure.

A recent Gallup poll shows that 85% of Americans have an unfavorable opinion of Russia and 62% of Americans holding a favorable opinion of the Ukraine. The Biden Administration recently announced that the U.S. will welcome up to 100,000 Ukrainians and other displaced people fleeing the conflict in the Ukraine. The U.S. strongly supports defending our NATO allies and letting the Ukraine join NATO.

There are consistent findings across various polls (CNN, Reuters, Newsweek, etc.) that Americans favor action to: help Ukrainians defend themselves; providing financial aid; providing weapons; sending troops to NATO members in Eastern Europe; imparting severe economic sanctions on Russia. Recently several leading Jesuit Colleges and Universities announced plans to recognize the leadership of Ukrainian President Volodymyr Zelensky by conferring honorary degrees.

Refugees from Latin American countries continue to enter the U.S. According to boarder authorities, the number of encounters in January 2022 was 154,745 and February 164,973 along U.S. borders. Venezuelans continue to seek and be granted political asylum. The U.S. Centers for Disease Control & Prevention are now allowing asylum for unaccompanied child migrants. Threats of violence, drought, government corruption, gang activity and high homicide rates continue to drive increased numbers of people from "Northern Triangle" countries of Central America: Honduras, Guatemala, and El Salvador. Other refugees arrive at the U.S. border from Nicaragua, Panama, Costa Rica, Belize. Total immigration to the U.S. from Central America totaled 3,782,000 people in 2019. So far this year a record number of people have arrived at the U.S. / Mexico border in search of protection. The good news is that Mexican and US foreign development agencies are working together to address causes of migration. Current data suggests that poverty, lack of education and job opportunities, gang violence, political instability and corruption cause migration, especially in young people. The Mexican Agency for International Development Cooperation (Amexied) and the United States Agency for International Development (USAID) have targeted Guatemala, Honduras, and El Salvador with new programs to mitigate migration. The 2022 U.S. budget for humanitarian aid to Latin America and Central America totals $228,354,621 USD. The majority of funding will go to Mexico to address humanitarian needs at the U.S. / Mexican borders. The Department of Homeland Security reports 7,100 migrants are crossing into the U.S. per day at the U.S. / Mexican border and most refugees are seeking asylum fleeing persecution. Other Ukrainians are entering the U.S. at the Mexican borders Central and South American countries into Mexico.

World leaders are condemning the war crimes and atroscities cities against civilians in the Ukraine. NATO countries have opened their borders to approximately 4 million Ukrainians, almost all women and children, who have fled the Ukraine since the Russian invasion. The U.S. remains committed to European countries and NATO in addressing war crimes and atrocious acts against children, women, the elderly, poor and marginalized people. Americans support and embrace: lawful immigration; helping people seeking political asylum; addressing global humanitarians crises. The U.S. is taking on new efforts to: address global inequities; poverty, complex humanitarian emergencies; environmental health. Millions of U.S. dollars in humanitarian aid have already been sent to countries surrounding the Ukraine to help with the refugee crises.

New Trends in the Field of Social Rehabilitation of People with Disabilities

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Abstract:

The present article draws on the results of research that explored the role of complex rehabilitation and its individual components; the effectiveness of social rehabilitation in the integration of people into society; feedback from clients on how they evaluate their cooperation with rehabilitation workers in selected facilities; as well as feedback from rehabilitation and social workers on how they evaluate their cooperation with clients. The research took place from May 2020 to March 2022. The first group of respondents comprised 360 clients of rehabilitation centers, social and occupational rehabilitation centers and physiotherapy-rehabilitation departments in Slovakia, specifically Bratislava and Trencin.

The second group of respondents consisted of 30 rehabilitation and social workers employed in these facilities. This research employed quantitative and qualitative research strategies. The

conducted research also highlighted the importance of the creation of complex theoretical and empirical bases concerning social rehabilitation and its role in the integration of people with disabilities into society. The results of the research have also shown the need to raise professional awareness of the importance of complex rehabilitation and its modern trends and, last but not least, the need to improve the level of professional education in the field of complex rehabilitation and social rehabilitation. The results obtained from the research can be used to develop analyses that will form the basis for additional relevant and helpful research in the field of trends in social rehabilitation and improvement of the possibilities of their application.

Introduction

Social rehabilitation refers to a series of activities aimed at achieving independence for people with disabilities. Its purpose is to help these people develop specific abilities by strengthening their habits when carrying out normal activities in the context of their full integration into society. Social rehabilitation depends on a large number of individual factors, abilities, needs, and motivation of the disabled person. Each client, therefore, requires an individual approach and action on the part of the social worker. Social rehabilitation plays an important role not only for people with disabilities but also for their family members and friends. It contributes to: maintaining self-sufficiency; gaining a sense of self-worth and dignity; greater life satisfaction; security and safety; and promotes privacy, stability, trust, confidence, communication, and interpersonal contacts. It also helps the disabled overcome psychological barriers that prevent the emergence of positive motivation to persevere and strive during the rehabilitation process and to integrate as fully as possible into society at all levels (8). These factors result in greater physical and psychological independence of disabled persons from their immediate environment. The conducted research aimed to map the extent to which social rehabilitation helps disabled persons integrate into society.

Methods

The present article examined the role of complex rehabilitation and its individual components, the effectiveness of social rehabilitation in regard to the integration of the disabled into society, the feedback of clients on how they evaluate the cooperation with rehabilitation workers in selected facilities, and the subsequent determination of how rehabilitation and social workers evaluate the cooperation with clients. The research took place from May 2020 to March 2022 in rehabilitation centers, social and occupational rehabilitation centers and physiotherapy-rehabilitation departments in Slovakia, specifically in Bratislava and Trencin. Quantitative and qualitative research strategies were used in the presented research.

The first group of respondents comprised 360 clients of the aforementioned facilities. To participate in the research, participants had to have a musculoskeletal disorder, have spent at least 2 years rehabilitating in the aforementioned facilities, and be aged from 20 to 71 years.

The second group of respondents consisted of 30 rehabilitation and social workers working in these facilities. In order to participate in the research, they had to have been actively employed in the rehabilitation facilities for at least 2 years and be aged 20 years or older.

Clients, as well as rehabilitation and social workers, were approached based on their having met the aforementioned criteria. Both groups provided written consent to the processing of personal data for the purposes of the research and they were reminded that their participation in the research was voluntary and anonymous. The relevance of the research is confirmed by the research report, which records the aforementioned ethical requirements. Prior to the research, both groups of respondents were provided with information about its objectives and possible presentation.

The aim of the research was summed up by the following research question:

How are the benefits and effectiveness of social rehabilitation perceived by clients and rehabilitation and social workers?

For the first group, quantitative research was conducted using a 23-point standardized questionnaire with open-ended questions. Induction, deduction, comparison and also statistical processing were used in the processing.

For the second group, the research took place via a semi-structured interview that lasted an average of 45 minutes. The data was analyzed through content analysis under the supervision of the research administrator.

Results and Discussion

The research yielded the following results:

Respondents from both groups agreed in their assertions that it is important to remember that new data is acquired constantly during the research and in implementation of social rehabilitation trends for clients with disabilities or those who suffer from musculoskeletal injuries, both in the research and in the implementation of the social rehabilitation itself. This provides professionals with the opportunity to confront this data and then apply it in practice.

Health is of essential importance. It determines the quality of life and is the basis for physical and mental capacity. Defining the concept of health and the search for its essence is related to the relationship between the physical and spiritual nature of man. This essence must also be borne in mind in the context of major technological advances in society, such as artificial intelligence (AI) (2).

Artificial intelligence is currently used in medicine and the healthcare sector for many purposes, including diagnosis through non-invasive AI diagnostic systems (2). However, these systems do not absolve the relevant doctor of ultimate responsibility for patient care (2) and can help improve healthcare provision in relation to aspects of social as well as complex rehabilitation. "It is also important to highlight how AL/ML technologies can be used" (2) to provide a new perspective on the medical as well as the psychological state of social and complex rehabilitation clients, even in the event of pandemics similar to COVID-19 (2).

The issue of disability and associated social rehabilitation has been the subject of numerous studies over the years, providing self-reported research findings regarding the rehabilitation of people with disabilities and their subsequent integration into society. The findings of these studies also show that the process of social rehabilitation can be experienced differently, either positively or negatively. For example, the hope of improved health, reintegration into the labor market, a sense of belonging and opportunities for active social participation in the workplace all contribute to a positive experience. On the contrary, a negative experience can be caused by, for instance, a lack of encouragement, support, guidance or counseling opportunities in the workplace as well as exclusion from the labor market (5).

Disabilities affect important aspects of life and their significant impact can also be seen in the ability to engage with other people; in the ability to enter the job market; in the feeling of being useful to society. In the aforementioned research, these aspects were clearly present in the answers of the first group of respondents. Clients reported that physically they suffer most from musculoskeletal disorders, then by injuries, post-traumatic conditions and, last but not least, disabilities. The most severe form of disability is the most common among the respondents.

Physical activity is a very important aspect of respondents' health. The importance of physical activity is also highlighted by several studies carried out directly in Slovakia, such as the 2021 study by the authors Paulik, Plskova, Kacmarikova, Ochaba. This study provided up-to-date information on the prevalence of insufficient physical activity among Slovaks by gender and age (7). It also highlighted the significant decline in performance and physical activity among Slovaks and emphasized the benefits of physical activity in some important national programs (7).

In relation to insufficient physical activity and performance, respondents often mentioned how affected they are by this lack of physical activity. For example, when visiting rehabilitation facilities, they sometimes have to be accompanied by a family member or friend. In the respondents' opinion, this contradicts the idea of post-rehabilitation self-sufficiency.

Clients also reported that they are restricted in other areas such as getting dressed, hygiene, shopping, and housework. Social ties are also very important to the respondents, especially

with the circle of friends who visit them. These social ties enable them to participate in social life, such as going to the theatre, concerts, galleries or traveling if their health permits.

Respondents also said that they had difficulty dealing with the three waves of the pandemic. The pandemic worsened their health and, in terms of social rehabilitation, has made their options to integrate into society more complicated. In relation to the previous waves and periods of the COVID-19 pandemic, as confirmed by experience and the research carried out so far, it is essential to highlight the importance of providing various options of professional support, including in the event of grief over losing one's loved ones due to the pandemic (10) "regardless of whether the grief from the mourning is complicated or not" (10). This also applies to this group of respondents.

Experience and research also show that "the most vulnerable group during the pandemic is the elderly" (1). "In terms of their age and health, they are the most vulnerable to the effects of the pandemic" (1). This also applies to this group of elderly respondents. Some of the respondents were experiencing rumination as a result of the pandemic. Many studies have also shown that "rumination can cause a variety of emotional disorders" (9). Therefore, it is also important to establish how respondents of this group perceive social support. As is generally known, "social support is associated with a positive self-image, self-acceptance, hope, love, and contentment, which reduce stress and generally provide individuals with opportunities for self-fulfillment and growth" (3). It is also "one of the strongest driving forces and is a precursor to successful and easy coping with confrontation during a period when people are struggling" with a certain type of adversity (3). "It reduces levels of depression, improves the quality of life, and is also the most effective and stable prerequisite to compliance with instructions" given by rehabilitation and social workers (3).

The research findings showed that the respondents need individual and anticipated social support the most. "The feeling of being socially supported as confirmed by this group of respondents also leads to a higher number of positive changes which is called post-traumatic growth (11). The importance of social support, feelings of self-efficacy, and dispositional optimism as potential predictors of post-traumatic growth which is confirmed by many kinds of research from other scientific fields, continue to be the subject of numerous studies, yielding different results (11). Practical experience shows people with disabilities continuously "need stronger social support from families, friends," (11), healthcare, rehabilitation, social workers and significant others (11).

Quality of life is one of the most commonly used terms in the medical field. Thus, the provision of healthcare in this context has a purpose to the extent to which it positively affects the patient's life. In the case of respondents participating in the aforementioned research, their quality of life revolves around mobility. The most frequently reported problems of the clients were related to mobility. These problems resulted from their disability, injury, or musculoskeletal pain. Therefore, assistive devices used to increase their mobility are an important part of their lives. They also reported that procedures such as exercise, massage, magnetotherapy, electrotherapy, gas injections, hydrotherapy, or physical training were beneficial in improving their mobility.

Clients also reported that they appreciated the empathetic approach of the rehabilitation workers and their willingness to explain the procedure. Clients also positively evaluated the erudite approach of the rehabilitation workers and the fact that their work fulfills them. They also reported that the motivating approach of the rehabilitation and social workers was very important to them. According to the clients' statements, they noticed the motivating approach of the rehabilitation and social workers, for example, by: helping them be able to help themselves first and not depend on other people; building the feeling that this will make them self-sufficient or at least partially self-sufficient; praising them; smiling; saying nice things, appreciating them; encouraging and giving them the confidence and the courage to believe that their condition will improve with regular and diligent rehabilitation; encouraging them to aspire to be as independent as possible; reinforcing the feeling that they are undergoing rehabilitation to feel better; encouraging them not to get worse. As a result of this motivation, clients' overall perception of the rehabilitation process with workers was positive.

In terms of the effectiveness of social reha-

bilitation in integrating people with disabilities into society, clients reported that their current health significantly improved compared to a year earlier. They attributed this improvement to the comprehensive rehabilitation that helped them better integrate into society and increase their independence.

The clients reported that an important factor in the integration of persons with disabilities into society proved to be training in self-care housekeeping, the use of assistive devices, spatial orientation and independent movement they underwent as part of social rehabilitation. They also received training in communication skills, financial literacy, and legal issues. The respondents had the opportunity to participate in a variety of activities that increased their self-efficacy which significantly helped improve their independence.

An interesting finding reported by clients was the connection between the benefits of social rehabilitation and difficult periods in their lives. This also included relationships established during the first year of social rehabilitation. The thwarting of the most important periods in life, not managing to get better in life due to pointless investments in open-ended relationships, and the associated increasing problems are also highlighted in the 2021 study by Maryam Sobhani Nia, Simin Hosseinian, Ruhollah Zaboli (6). The motivation clients received from the rehabilitation and social workers in the selected rehabilitation facilities helped the clients significantly during these challenging periods as well as in their integration into society. It is important to ensure that judgements of all kinds are removed during this process. As in many other cases, education plays an important role in this regard (4).

In the case of the second group of respondents, as part of the evaluation of the worker-client collaboration by the rehabilitation and social workers, the rehabilitation and social workers of the selected rehabilitation facilities reported that it is necessary to have a motivational approach towards the clients. In this case, statements of this group of respondents coincided with those of the first group of respondents. According to the rehabilitation and social workers, a motivational approach can be obtained through education, communication, and individual client care. They consider it very important to have active cooperation from the client during rehabilitation. This group of respondents believe that only such cooperation between the client and the rehabilitation or social worker can contribute to the improvement of the client's health.

In this context, the respondents also stated that it is necessary to follow the educational process that the worker sets up with the client, and that cooperation with the client's family plays an important role in this process. It is also important, in their opinion, to eliminate the deterioration of the client's health and psychological condition. Rehabilitation and social workers also agreed that clients have shown interest in canister therapy, occupational therapy, art therapy, and aromatherapy combined with music during complex rehabilitation. Rehabilitation and social workers would like rehabilitation facilities to organize social events for clients, such as social or trivia quizzes. The research has shown the importance of elaborating comprehensive theoretical and empirical bases concerning social rehabilitation and its role in the integration of disabled persons into society. The research findings showed the need to increase professional awareness of the importance of complex rehabilitation and its modern trends and, last but not least, the need to improve the level of professional education in the field of complex rehabilitation and social rehabilitation.

Conclusion

Social rehabilitation helps people conduct themselves in everyday situations to ensure conditions for independent life. However, each person has certain limits which result from his or her abilities and what he or she wishes to achieve. Persons with disabilities must therefore be seen as individual human beings and the degree or type of their disability must be taken into account. They must not be denied the comprehensive specialist medical and psychosocial support they need, as this is the only way to achieve their inclusion. It is necessary to make it possible for them to lead an independent life, i.e. to provide them with services that give them access to the same social, political, economic, and cultural opportunities presented to the rest of the population. Social rehabilitation is instrumental in ensuring a life of dignity and quality for people with disabilities. It helps them meet their goals and achieve the fullest possible integration into soci-

ety. Social rehabilitation programs are also essential for people who are in a close relationship with a disabled person.

It is important to recognize that social rehabilitation is multidisciplinary. It is, therefore, necessary to implement social rehabilitation in facilities that are able to use multiple sources of funding to provide effective services. Social services are one of the key factors in social rehabilitation. In this context, it is also important to be aware of the possibilities of financial and organizational support for high-quality social services within municipalities, departments, and institutions.

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Caregiver Strain in Community Care

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Original Article

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Abstract:

The paper focuses on the identification of areas of strain in caregivers who, on a non-professional basis, provide care to a person with a neurological disease in a community care-based setting. The aim of the survey was to validate the nursing diagnosis Caregiver Role Strain. Through a group of experts, we found out which determining features and related factors of the aforementioned nursing diagnosis occur most often in clinical practice while caring for patients with a neurological disease. Furthermore, for assessing caregivers we used the Modified Caregiver Strain Index to find out which neurological diseases cause the greatest strain for them, and which gender and age group of caregivers are most predisposed to strain. The survey took the form of online questionnaires from April 2021 to Sep-

tember 2021. Caregiver strain occurs most often in caregivers who care for neurological patients. By analyzing the data, we came to the conclusion that the experts in our survey identified fatigue as the most important determinant. The group of experts identified the most important related factor - inexperience in providing care. Due to the demanding position of the caregiver, it is important for care providers to correctly and quickly identify potential stressors, and thus relieve the caregivers from their difficult mission.

Introduction

The basis of providing care in the community is to maintain family well-being and, at the same time, support the ability of family members to take care of the care receiver. We can understand providing home care by non-professional caregivers as a long-term, permanent and stressful commitment (Bruhn, 2016). However, providing care in the home environment not only affects the person to whom the care is provided, but also greatly affects family members. The longer the patient is dependent on the help of others, the more difficult the situation is for the family. Probably the most burdensome aspect of being a caregiver is the feeling of responsibility towards the cared-for person which represents a strain in the spiritual, social, mental and physical realms. The caregiver is often unaware of their overload which can lead to them becoming exhausted and eventually falling ill (Kolegarova *et al*., 2011, Kozuchova, *et al*. 2014, Pathak, 2020).

Survey: Caregiver strain in community care is an issue that receives little attention. Caregivers undergo major changes in their lives and they often give up their work, activities, interests in exchange for helping their loved ones. Therefore, it is very necessary to address this issue.

Aim: The aim of the survey was to identify the defining characteristics and related factors in the nursing diagnosis Caregiver Role Strain in caregivers who provide care at home on an unprofessional basis to a cared-for person with a neurological disease.

Work methodology and research methods

In order to obtain more reliable survey results, we decided to assess the caregiver through the Caregiver Strain Index. The assessment was carried out by expert nurses in the conditions of community care. To validate the nursing diagnosis we used quantitative methods to obtain the necessary data. For data collection, we created a questionnaire-type evaluation tool which we distributed to nurses via online social networks. The questionnaire consisted of six parts.

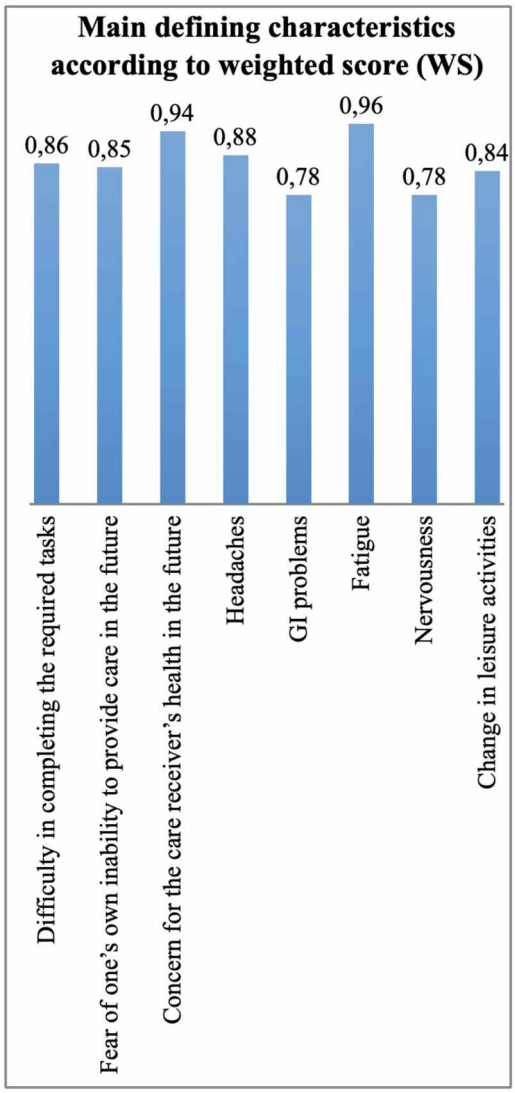
We selected the survey sample deliberately. The sample consisted of 85 nurses working in Slovakia in home nursing agencies, day hospitals, social service facilities or other facilities where they encounter caregivers who provide home care for a person with a neurological disease. Data collection took place from April 2021 to September 2021. Questionnaires were distributed online through social networks to nurses working in home nursing agencies, day hospitals, social service facilities or other facilities where they meet with caregivers who provide care in the home environment to a person with a primarily neurological disease.

Interpretation of results and discussion

The aim of the survey was to use expert nurses to determine the level of caregivers' strain by identifying the most common defining characteristics and related factors of the nursing diagnosis Caregiver Role Strain. We set 5 sub-objectives.

Sub-objective #1: To find out which defining characteristics of the nursing diagnosis Caregiver Role Strain are the most common in clinical practice in the care of patients with neurological diseases.

Graph 1 Main defining characteristics of nursing diagnosis Caregiver Role Strain

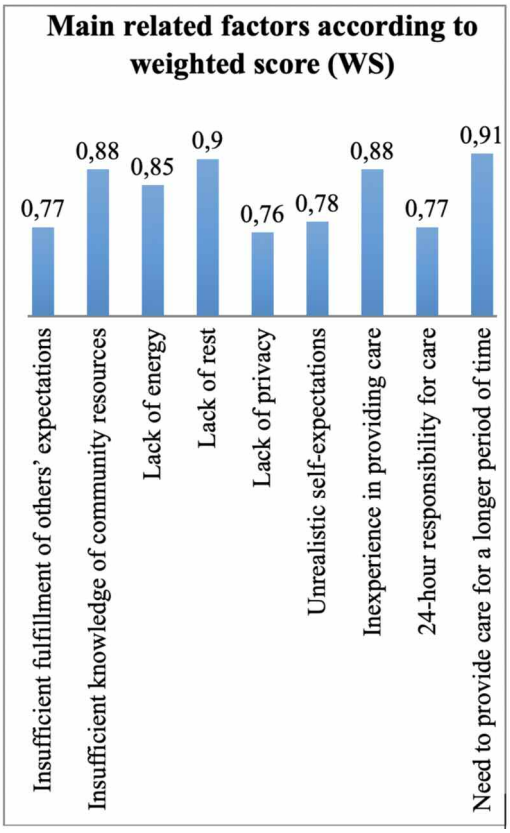


In care providers with an identified diagnosis Caregiver Role Strain in the care of a patient with a neurological disease, there is a significant difference in the occurrence of individual defining characteristics. Fatigue is the most common defining characteristic which was reported by the highest number of respondents at 88.24% and the group of experts assigned it the highest frequency of occurrence (WS = 0.96). The group of experts assigned WS = 0.78 to the two main defining characteristics - the GI problems and nervousness which is the lowest value among all the main defining characteristics.

We recorded the same results for the first sub-objective as the results of the authors Slamkova, Polednikova & Pavelova (2020) in which Slovak and Czech experts identified fatigue as one of the main defining characteristics. We also observed the same results as in the research of the authors Tabakova, Zelenikova & Kolegarova (2011). In their research, authors present the results in which Slovak experts identified fatigue as one of the defining characteristics. We also find some agreement with the research of the Brazilian authors Monteiro *et al*. (2004), who state that the concern for the care receiver's health is one of the most common defining characteristics. Experts in our survey assigned to the defining characteristic mentioned above the second highest significance WS = 0.94.

Sub-objective #2: To find out which related factors of the nursing diagnosis Caregiver Role Strain are the most common in clinical practice in the care of patient with neurological diseases. The group of community nursing experts identified 9 out of 53 main factors. Using the Likert Scale, they assigned the highest frequency to the following main related factors: insufficient fulfillment of others' expectations; insufficient knowledge of community resources; lack of energy; lack of rest; lack of privacy; unrealistic self-expectations; inexperience in providing care; 24-hour responsibility for care; need to provide care for a longer period of time.

Graph 2 Main related factors of the nursing diagnosis Caregiver Role Strain

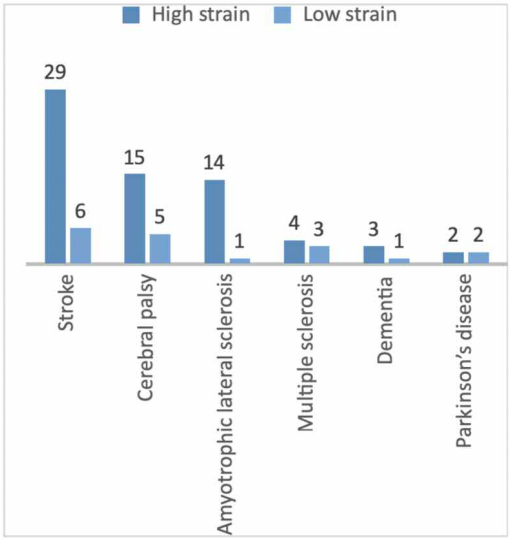


We found through statistical analysis of the data that care providers with an identified nursing diagnosis Caregiver Role Strain while caring for patients with neurological diseases show a significant difference in the occurrence of individual related factors. Inexperience in providing care is the most common of all the related factors, which was confirmed by the highest significance of 83.53% of respondents. At the same time, a group of experts assigned the second highest frequency of WS = 0.88 to this related factor. The group of experts assigned the highest frequency of occurrence to the factor - providing care is needed for a longer period of time WS = 0.91. The lowest significance by a group of experts (WS = 0.76) was assigned to one of the main related factors - lack of privacy.

We can compare the results of the presented studies with the results of our most frequently related factors in the nursing diagnosis Caregiver Role Strain. With the findings of Reed *et al*. (2014) it is possible to compare the main related factors - lack of rest, lack of privacy and the need for care over a longer period of time. With the results of the study by Garlo *et al*. (2010) we can see agreement with related factors - inexperience in providing care and providing care is needed for a longer period of time. With the study by Bremault-Philips *et al*. (2016) it is possible to compare the related factor of inexperience in providing care. In the data resulting from the research of the authors Serfelova & Hladekova (2010) we can see the agreement with the related factor – providing care is needed for a longer period of time. We can therefore state that the results of our survey are partially or in some respects the same as the results of other authors.

Sub-objective 3: To find which neurological illness represents the biggest caregiver strain based on the caregiver's assessment through the Caregiver Strain Index. The group of experts assessed the caregivers according to the Modified Caregiver Strain Index. Through the assessment, they identified the neurological disease that represents the greatest caregiver strain in providing care.

Graph 3 Neurological diseases according to the Caregiver Strain Index



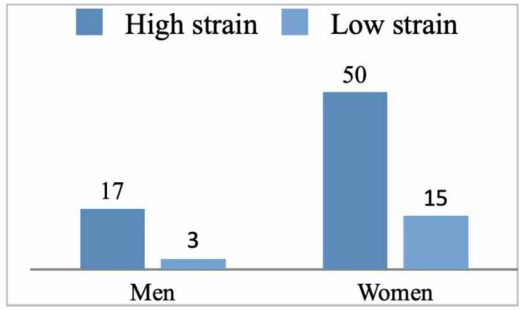
From the results of the experts, we identified the specific neurological disease that strains the care provider the most. It shows that 29 (43%) caregivers of the 67 highly strained caregivers provided care to a cared-for person who suffered a stroke. The remaining 15 highly strained caregivers cared for a person with cerebral palsy; 14 caregivers for a person with Amyotrophic Lateral Sclerosis; 4 caregivers for a person with Multiple Sclerosis; 3 caregivers cared for a person with dementia; 2 for a person with Parkinson's disease.

However, we concluded from the statistical analysis that neurological disease is not a predisposition to greater strain. Differences in strain with respect to neurological disease expressed in number or percentage are not significant.

The results of the presented research and study partially agree with our results. A consensus can be seen in the study by Garlo *et al*. (2010), who claim that the caregiver strain should be assessed regardless of the care receiver's diagnosis. Bremault-Philips *et al*. (2016) recommend educating caregivers providing care for people with dementia so that they can be better prepared for care in the future. Papastavrou *et al*. (2007) also state that caring for a person with Alzheimer's dementia put a heavy strain on more than half of the caregivers. However, our statistical survey showed that there is no significant dependence between the neurological disease and the level of strain. According to our survey the specific disease is not a predisposition to greater strain. We can only assume that the type of handicap, the degree of disability or dependency of the care receiver, or their age or polymorbidity, may be among the potential factors in the caregiver strain.

Sub-objective 4: To find out which gender has a greater predisposition to strain based on the caregiver assessment through the Caregiver Strain Index

Graph 4 Gender of care providers according to the Caregiver Strain Index



The results of the assessment of care providers by a group of experts through the Caregiver Strain Index showed that out of 67 highly strained caregivers, 50 of them are female (75%). Of the total number of caregivers, 59% are highly strained women providing care. By analyzing the data, we found that the caregiver's gender is not a predisposition to their greater strain.

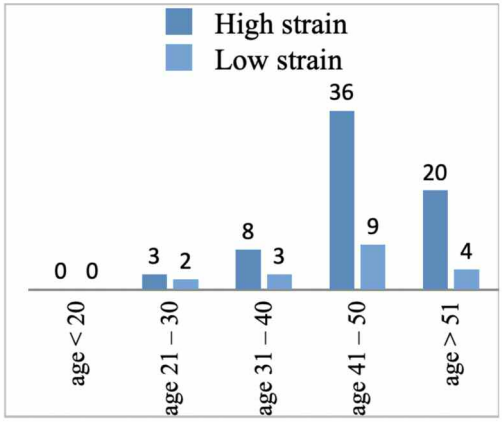
Based on the results of the assessment of care providers by a group of experts using the Caregiver Strain Index, we identified which gender of the care provider might be predisposed to strain. The obtained data showed that out of 67 highly strained caregivers, 50 of them are female (75%). Of the total number of caregivers, 59% are highly

strained female care providers. However, we found from a statistical analysis that there was no significant relationship between the Caregiver Strain Index and the gender of the caregiver. According to our survey, the gender of the caregiver is not a predisposition to a greater strain.

The results of the survey do not match the results of other authors who claim that the vast majority of caregivers are women. Some authors are of the opinion that the female gender is more strained in caring for the cared-for person. Our statistical analysis did not confirm this fact. We can state the agreement in the results of the study only with the author Hladekova (2010), whose survey results did not show significant differences in the degree of caregivers' strain with regard to their gender. At the same time, we agree with her view that the level of strain on women can be influenced by the division of tasks in the household.

Sub-objective 5: To find out which age group has a greater predisposition to strain based on the caregiver's assessment through the Caregiver Strain Index.

Graph 5 Age group of care providers according to the Caregiver Strain Index



The analysis showed that caregiver age is not a predisposition to their greater strain. According to the results of the experts, we have identified the age group which, based on the care provider's assessment through the Caregiver Strain Index may be a predisposition to the care provider's strain. Of the 67 highly strained caregivers 36 were care providers aged 41 - 50. This represents 54% of the total number of highly strained caregivers and 42% of the total number of caregivers. We found from a statistical analysis that there is no significant relationship between the Caregiver Strain Index and the age group. Therefore, based on the information obtained, we can assume that age is not a predisposition to greater strain. We noticed the agreement with the results of the authors' study of Tabakova & Vaclavikova (2008), but also with the author Glodzakova (2019), who are of the opinion that there is no statistical significance between the age of the care provider and their strain.

Conclusion

At present, we can consider family members' help, or having care providers for a chronically ill person, practically as a necessity. Help for caregivers is therefore a high priority, and it is important for professional care providers to correctly and timely identify the potential strain, and thus relieve family caregivers from their difficult mission at least partially.

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Marginalized Groups and their Health in Society

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Abstract:

Introduction: Health has its own social determinants (www.schulich.uwo.ca, 2022) which considerably affect the quality of provided healthcare (Baah, 2019). Chronic diseases place a significant burden on people in vulnerable social classes, races, and lower socio-economical positions and also on other groups of minorities (Havranek *et al.,* 2015).

Methods: The essence of our research was the comparison of the results of preventive medical examinations between marginalized and non-marginalized groups of patients. The chi-squared test, T-test and the Chi-squared Independence Test for the contingency table were used in the processing of the data obtained.

Results: In the overall evaluation of particular groups, we confirmed the significantly worse results of preventive medical examinations among marginalized patients compared to the majority population.

Conclusion: The results of our research clearly confirmed a significantly higher incidence of cardiovascular risk factors among patients living in a marginalized group. Simultaneously, the results predict a higher prevalence of colon cancer in this group. Social justice is a challenge for public health and social work.

Introduction

Marginalized groups have been characterized as the outermost groups in society (Alexander *et al.,* 2003). Health has its own social determinants (www.schulich.uwo.ca, 2022), which considerably affect the quality of provided healthcare (Baah, 2019). Chronic diseases place a significant burden on people in vulnerable social classes, races, and lower socio-economical positions and also on other groups of minorities (Havranek *et al.,* 2015). People are born, live, work and deal with illnesses under certain conditions. These conditions define the social determinants of health (WHO, 2010). Social determinants such as deprivation, inequitable availability, illiterateness, stigma, and racism significantly influence health equity (CDC, 2019). Systematic differences among people lead to health inequities (Braveman, 2006). Social justice is the most crucial part of social work (Payne, 2005). In nursing research, marginalization was first suggested as a theory by Hall *et al*. (1994). 7 essential factors were defined in this theory, namely "*intermediacy, differentiation, power, secrecy, reflectiveness, voice, and liminality*" (Hall *et al.,* 1994). Intermediacy relates to human borders and works as walls and links.

Differentiation or diversity means "*physical and social distance from the center*". Power is associated with the influence of those in the center (Hall et al., 1994 In Havrilla, 2017). Secrecy is another property of marginalized because the information is encompassed to create interpersonal bonds, hold trust, and bypass disloyalty. Reflectiveness is also the critical element of marginalized because marginalized persons have experiences that contrast them with better centrally encountered society members. If we talk about the voice as a condition of marginalized, we want to reflect on ways of communicating that distinguish marginalized groups from those at the center. Marginalized persons have altered perceptions of the time and self-image because of the consequences of the marginalizing experiences; it is the reason why liminality was classified as one of the 7 mentioned factors (Hall *et al*., 1994 In Havrilla, 2017) Many ethnical minorities have walls to valuable access to healthcare. The multicultural society is one of the examples where marginalized groups feel boundaries and injustice in the way to gain appropriate healthcare. "For example, In the UK, the expansion of myriad ethnic residents and linguistic groups, each with its cultural characteristics and health shapes, shows a problematic challenge to healthcare providers and policymakers to achieve fair access (Szczepura, 2005)."

Chauhan *et al*. (2020) analyzed 45 studies from 5 databases, namely MEDLINE, PUBMED, PsycINFO, EMBASE and CINAHL. The conclusion of this meta-analysis pointed to a "higher rate of hospital-acquired infections, complications, adverse drug events and dosing errors compared to the broader population (Chauhan et al. 2020)"; language proficiency was also the essential key factor (Chauhan *et al*. 2020)."017).

International Labor Office (2011) focused on the social determinants of health equity such as income, employment, social and health protection, the level of education, gender, age, and ethnicity in the West, Central and East Europe. Moreover, the authors highlighted that Roma women are the most vulnerable because of the lack of social protection. The frequently mentioned problem among the Roma population was drug addiction and high-risk sexual behavior. Also, according to the authors, unemployment was the most severe matter impacting the Roma population, namely in countries such as the Czech Republic, Greece, Portugal, Spain, and Slovakia, unemployment among the Roma population varied from 60 to 80%, and reached 100% in certain isolated areas (International Labor Organization, 2011).

The Roma population are notable ethnicity in the EU territory, with roughly 6 million (Dicka, 2021). The number of the Roma ethnicity in-

creased tenfold during the last 120 years in the Slovakia territory (Dicka, 2021). It was approximately 20,000 Roma communities in 1770, and the estimated forecast is 508,000 Roma citizens in 2020 in the Slovak Republic (Dicka, 2021). According to data in the Atlas of Roma Communities (2019), just 81.7% of the Roma population in the Slovak republic are non-integrated, and slightly more than half of them live on the edge and outside of settlements, namely 36.3% and 14%, respectively (Dicka, 2021).

WHO highlighted that the poor living conditions of Roma citizens in the EU have fatal consequences on their health (2022). The European Economic and Social Committee noticed the effects of the dire conditions in which Roma citizens live; the Committee showed that Roma´s life expectancy is tenfold lower compared to non-Roma citizens (/www.eesc.europa.eu, 2014). Moreover, a higher incidence of long term illnesses is observable among Roma (European Commission, 2014).

Prejudice is often experienced by Roma patients, and this is the reason why their distrust of healthcare services is so high (de Graaf P, 2016). The level of education has huge impact on the level of their health status (de Graaf P, 2016).

The major policy impact should be focused on the integration and economic inclusion of the Roma population in Europe (Fesus, 2012). These initiatives have to lead to better quality healthcare for Roma citizens and their social equity (Fesus, 2012). Barriers for the Roma in many countries to healthcare insurance have to be exceeded to gain better social benefits for this minority (Kuhlbrandt, 2014). The literature also described difficulties in finding a GP for the registration by Roma people (Delescluse, 2020).

Methods

Comparison of the results of preventive medical examinations between marginalized and non-marginalized groups of patients was the essence of our research. The Chi-squared test, T-test and the Chi-squared Independence Test for the contingency table were used in processing of data obtained.

Results

In the overall evaluation of particular groups, we confirmed the significant prevalence of dyslipidemia, hyperuricemia, hepatopathy of higher SCORE rate, and higher incidence of a positive iFOB test result ($p < 0.005$) in the marginalized population group. In the case of pre-diabetes ($p = 0.455$) and diabetes ($p = 0.391$) prevalence, we did not find a significant difference among the compared groups. While analyzing the male part of compared groups, we did not observe a considerable difference in the incidence of dyslipidemia ($p = 0.056$), hyperuricemia ($p = 0.705$) and arrhythmia ($p = 0.113$), whereas, in other monitored parameters the distinction was a detriment to the marginalized group ($p < 0.05$).

When we compared the female results in both of the monitored groups, we found a higher prevalence of pathological effects in the marginalized group ($p < 0.05$) except for the occurrence of glucose metabolism disorder where no significant difference was found ($p = 0.243$). While we compared the incidence of pathological outcomes in the monitored groups based on the age parameter, we did not observe any significant difference in the age population under 40 years in both of the monitored groups ($p > 0.05$), with the exception of the positive iFOB test with a higher prevalence of positive results in the marginalized group ($p=0.029$). In the 40 to 50 age group, we confirmed a higher incidence of pre-diabetes in the marginalized group ($p=0.034$). In addition, the same result was reached in the over 50 age group ($p=0.021$). Overall, a higher cardiovascular risk was affirmed among patients who were included in the marginalized group compared to patients who did not belong to the marginalized group ($p < 0.0001$).

Discussion

A higher prediction of a 10-year risk of fatal CVD (higher SCORE) was confirmed among patients from the marginalized group. Similar results are described in scientific literature. Schultz *et al*. (2018) mention that socio-economic level has a measurable and vital impact on cardiovascular health. The authors also defined socio-economic aspects that can lead to a higher prevalence of cardiovascular disease: earnings level, academic achievement, environmental factors, and employment status (Schultz, 2018). Dyslipidemia was more prevalent among marginalized groups of patients. Bartos & Badila (2011) measured cardiovascular risk factors among the Gypsy

population from Romania, and the authors surveyed 511 Gypsies. The research showed that studied patients had several cardiovascular risk factors, namely obesity (50.8%), diabetes mellitus (10.3%) and smoking (25,8 %). Elevated activity of the hepatic enzymes was noticeably more prevalent among the marginalized group of patients by several causalities such as viral hepatitis infections (Macejova *et al.,* 2020) or alcohol consumption (Babinská *et al*., 2014). Prevalence of positive stool test for occult bleeding was higher among the marginalized group of patients than in the majority population. The results may be due to a decreased diet quality because of socioeconomic status.

Conclusion

The results of our research confirmed a significantly higher incidence of cardiovascular risk factors among patients living in a marginalized group. Simultaneously, the results predict a higher prevalence of colon cancer in this group. Social justice is a challenge for public health and social work.

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Volunteering of Students of Helping Professions in Pandemic Times at the Faculty of Social Sciences and Health Care, CPU in Nitra, Slovakia

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Abstract:

Volunteering is an essential part of any modern society. In times of crisis, the need for assistance is greater than ever. Solidarity between people during the coronavirus pandemic increases when we come to realise that the consequences of the crisis are directly influenced by our responsibility, togetherness, and willingness to help each other. Students of the Faculty of Social Sciences and Health Care, Constantine the Philosopher University in Nitra also participated in volunteering activities. Students of health departments performed their activities in faculty hospitals; students of Social Work and Psychol-

ogy performed their activities in social services facilities, centers for families with children, community centers, hospices, civic associations, and wherever assistance was needed. Students learned how, where, when, and to whom to lend a helping hand in the subject Service Learning. Service Learning is a way of teaching and learning in which theoretical training is linked to the acquisition of practical experience. The added value of service learning is that in addition to one's own development, it allows helping others in their natural environment through a created activity. Service Learning activities respond to the needs of education (schools), practice (organizations) and self-development (students).

Introduction

The word *volunteering* originates in the Latin word *voluntarius,* which means voluntary; also, Italian *volonteroso* means willing, aspiring, enthusiastic. In the past, *charity* dominated; it referred to various activities motivated by love for a neighbor and an effort to help a human, humanity, the world, etc.; it was simply an act of good for the benefit of others who had no close family ties with a person. In this context, we can also mention the word close to volunteering, and it is *altruism*. **Altruism** is a system of a person's value orientations such as thinking, feeling, dealing, desire to help others without expecting financial or other compensation. It is about dedication as a characteristic feature, an attitude that puts the benefit of others above their own interests manifested by practical action. In altruism, it is the selfless nature of interpersonal relationships, love for the well-being of others, manifested in thinking, feeling, and acting that consider other people. The concept of altruism was introduced by A. Comte.

One of the more modern forms of assistance is *philanthropy*, which seeks to solve society's problems by promoting education and innovation and developing people's abilities to be able to help themselves and not be reliant on alms. It seeks to support people's abilities to help them start a process that will help them have a better quality of life. Ideally, it seeks to selectively solve society's problems so that they are fairer and better.

At present, we encounter concepts such as *prosocial behavior*, which is characterized by acts and deeds performed in favor of another person without expecting any reward (material or financial) or social consent. Such acts of conduct have the character of providing selfless assistance where no reward or reciprocation of assistance is expected in the future.

Furthermore, we draw attention to a significant and indispensable activity in *charity*, a more traditional combination of selfless assistance and charity, emphasizing helping a neighbor and helping people in need. In common perception, it seeks to alleviate immediate suffering, misery, and distress of people. It is charitable assistance to people, especially the old, the sick, the poor, the abandoned, and all those who cannot help themselves in their situation.

Volunteering is an activity performed for the benefit of others by free choice in free time and without any right to reward. In Slovakia, everyone can volunteer in various fields, such as: social fields; humanitarian and human rights organizations; cultural areas; environmental protection; sports; education activities. In Slovakia, the legislation and status of a volunteer, and legal relations in the exercise of volunteering activities are regulated by the Act No. 406/2011 Coll. on volunteering and on amendments to certain laws.

We draw attention to the European Parliament's report on the contribution of volunteering to economic and social cohesion, stating that volunteering:

- *represents an economic benefit* (according to the UN estimates, the economic benefit of nonprofit institutions represents 5% of GDP on average, while even a slight estimate of the time devoted to volunteering represents more than a quarter of this value),
- *is an important driver of the development of civil society and strengthening of solidarity*,
- *has a high level of added value*: for each Euro invested by organizations in support of volun-

teers, an average of 3 to 8 Euros have returned to them,
- is extremely *important for the development of social capital*,
- *can lead to significant savings in public services*,
- *is beneficial for the personal and social development of volunteers* and has a positive impact in a community, for example on interpersonal relationships,
- *leads to the direct involvement of citizens in local development* and, thus, can play an important role in promoting civil society and democracy, and
- can have a positive impact on human health and all age groups can benefit from this positive impact and can help prevent physical and mental illnesses.

The Office of the Plenipotentiary of the Government of the Slovak Republic for the Development of Civil Society, together with the representatives of relevant Departments of the Ministry of Education, Science, Research and Sport of the Slovak Republic and its contributory and budgetary organizations; non-governmental non-profit organizations; primary and secondary schools and academia is part of the working group for the purpose of creating the *Concept Paper on Children and Youth Volunteering Training and Education*. The main objective of the concept is *to integrate volunteering education and training in both formal and* ***informal education at all levels of education.***

Volunteers are people with big hearts who do not hesitate to help wherever they are needed. They are one of the main pillars of selfless assistance and participate in all the necessary activities. They are specially trained for individual activities. Volunteers are those who make us manage to do great things. We are grateful that there are still many people, young people among students, who opt for this selfless and amazing way of life volunteering is.

Basic information on the course of volunteering at the Faculty of Social Sciences and Health Care, CPU in Nitra

Students as volunteers in practice

Volunteers are an integral part in our country, especially in crisis situations such as the pandemic caused by Covid 19 lasting since 2020. Students – young people in helping professions provide their free time, energy, experience, skills, and empathy. Our volunteers are also crucial in building trust with communities. Through their work and engagement, they improve the quality of life of others while growing personally and gaining life experience.

When the Earth stopped in March 2020, there was silence – traffic was suspended, movement of people was restricted, working from home was initiated, and distance learning was established.

The pandemic has affected every person in our society.

It is time we ask ourselves about the negative and positive effects of Covid 19.

Negative effects of Covid 19:
- it has limited our freedom in social contacts,
- it has caused a lack of movement,
- it has weakened mental health,
- it has caused fear, fear of proximity, suspiciousness, denunciation, distrust, criticism, dissatisfaction, etc.,
- some people have lost their jobs, entrepreneurs have had to close their businesses, family crises (breakups), and
- in many cases, it has caused the loss of loved ones, friends, acquaintances, etc.

Positive effects of Covid 19:

People started to have more time for themselves and for their loved ones. There have been major changes in attitudes towards LIFE itself.
- strengthening family ties,
- becoming aware of the importance of each of us (isolated neighbors, homeless people, socially disadvantaged families, and all living on this planet...),
- we have learned to face changes in all areas of life,
- we have learned responsibility towards ourselves and others, more acts of kindness,
- more space for self-education, various hobbies, etc., and
- we have showed and learned more compassion, empathy, love, unconditional help – which resulted in more action in volunteering activities.

Objective and methods

The main objective was to map volunteering activities at the Faculty of Social Sciences and Health Care, CPU in Nitra, to determine the sequence of steps in incorporating volunteering into the curriculum of Social Work and Psychology – to create a plan, and to indicate possible risks in the implementation of volunteering activities and their elimination.

In social science, 2 basic approaches to research are defined: quantitative and qualitative. We have chosen the qualitative approach which requires: a very good orientation in the problem; more time and patience in data collection, and especially in its analysis, and evaluation and interpretation. To carry out the qualitative survey, we used: mapping; education; exploration of various possibilities and selection of the most suitable one; comparison; observation; interviews and counseling in the creation and implementation of service-learning projects in focus groups; evaluation; description.

We decided to use the qualitative approach for the following reasons: its exploration and inductive nature; it seeks a more thorough view of the studied issues; understanding and orientation; it reveals new facts; creates space for new possibilities of action; takes into account an holistic approach; works above all with words; requires empathy; and also an individual approach; prefers understanding in uniqueness; the information is subjective; and investigation of the problem is in-depth.

The sampling was purposeful; the sample consisted of students of Social Work and Psychology of the Faculty of Social Sciences and Health Care, CPU in Nitra, all years of Bachelor's and Master's Studies (NB: because it is an optional specific subject; it is chosen only by students who have an eminent interest).

Implementation of the objective: ***The first step was to map volunteering activities:***

Beginnings of volunteering at the Institute of Romology Studies, Faculty of Social Sciences and Health Care, Constantine the Philosopher University in Nitra

In 2013, the Institute of Romology Studies started to organize collections with the help of students of Social Work and Social Services.

The following were collected: clothing, footwear, school supplies, hygiene supplies, non-perishable foods, blankets and duvets.

For whom they were intended: community centers, crisis centers, maternity centers, social services facilities, and centers for families with children.

Wherever assistance was needed as part of an agreement between facilities and students: for example, students produced their own products on their own initiative: organized a Christmas punch and cabbage soup fair; baked cookies; used voluntary donations they received to buy thick socks for homeless people in the streets and shelters, etc.; school supplies for children from centers for families with children, community centers, socially disadvantaged families, etc.

Current state of volunteering at the Faculty of Social Sciences and Health Care

We wanted students who participated in volunteering activities to receive certain benefit in their own studies too. We decided to offer students an optional three-credit subject.

The second step of the survey plan was to get more information in learning – how to be a good volunteer, and management in this area:

To do this, it was necessary to train an educator who would pass on the acquired knowledge on the issue. PhDr. Katarina Vankova, PhD. acquired the necessary knowledge to create an optional subject (completion of the educator's course: Service Learning Teacher Training, UMB Banska Bystrica by doc. PhDr. Alzbeta Brozmanova Gregorova, PhD., in 2019), and with support of the management of the Faculty of Social Sciences and Health Care, the Dean Doc. PhDr. Rastislav Rosinsky, PhD., and approved by the Scientific Board, Service Learning 1 and Service Learning 2, as optional three-credit subjects, were included in the curriculum. Thus, we all who are selflessly keen to help joined together.

The third step of the survey plan was the development of the optional subjects Service Learning 1 and 2, which includes: how teaching will be carried out; who and where will provide consultations on the subject; recommended literature; specific subject syllabi; finally, assessment requirements:

How to be a good volunteer – we teach in Service Learning 1

Students' interest in the optional subject Service Learning is great which can be seen in the number of students enrolled at the time of the pandemic:

- Winter semester: 2020/2021 – 36 students,
- Summer semester: 2020/2021 – 65 students,
- Winter semester: 2021/2022 – 93 students.

Composition of students by departments, institutes, of all years:

- Department of Social Work,
- Institute of Romology Studies,
- Department of Psychology.

We believe that the number of students interested in the optional subject will increase every year. It should be remembered that at the Faculty of Social Sciences and Health Care, CPU in Nitra, we have students who study nursing, and clinical disciplines and emergency medicine – they perform their activities in hospitals and wherever medical assistance is needed; they are part of teams that perform important tasks in the first line of health care provision.

The fourth step was creation of the optional subjects and their inclusion in the curriculum:

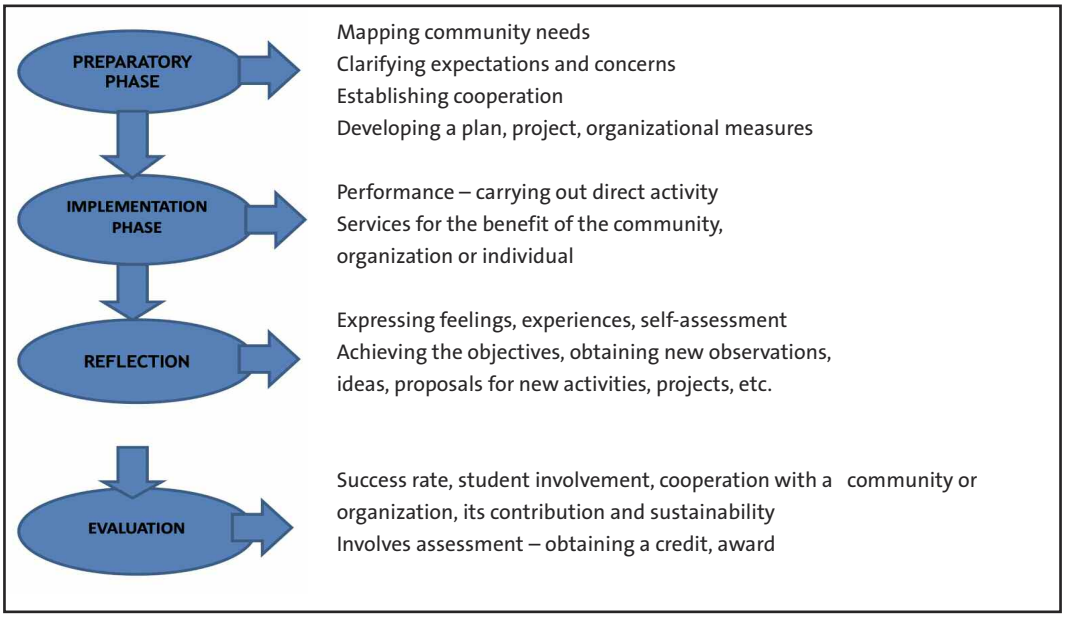
SERVICE LEARNING
is learning to professionally provide an adequately necessary and beneficial service in the form of various activities processed into a project for a particular community.

In Service Learning 1, we provide students with knowledge (13-week semester) on:

basic information about service learning; target groups; team formation and team cooperation important data about partner organizations and characteristics of their clients; and we draw attention to the *Volunteer Code of Ethics*, the importance of mapping and evaluating the needs of communities and their analysis. We emphasize the relationship between service-learning needs and strategies, and we teach their planning, budgeting, fundraising, promotion, and evaluation of a service-learning activity. Teaching also includes effective communication focused on resolving possible conflicts. Students are informed about possible risks and their elimination in the implementation of service-learning activities in the field, as well as the examples of good practice in the implementation of volunteering activities. The outcome is the development and presentation of their own volunteering activity project for which students receive 3 credits. But more importantly, they acquire deep theoretical knowledge through teaching which they can verify in practice in the next semester when implementing their project in a selected facility.

In Service learning 2, the service-learning project implementation is performed in the following semester (13-week semester). The outcome is the project implementation in the field, the provision of documentation, promotion, and treated photo gallery; students get three credits for the outcome, but basically, they gain more – they gain precious experience that moves them on their life path further.

A more detailed description of each service-learning step:



The fifth step in the plan was to indicate possible various risks that may arise in the field so that students can avoid them in time:

It is also appropriate to state possible risks posed by people from a community where students/volunteers tend to perform their own service-learning project:

- *people may not want to talk*: in this case, it is necessary to use the icebreaking method, for example to talk about one's own experiences, etc.,
- *some people may talk a lot and not give space to others*: in this case, it is appropriate to agree on the rules of discussion in advance, for example to define the time limit of seven minutes for a monologue, and
- *some people may not want to talk at all*: in this case, it is important to accept their attitude at that point – they may just want to be involved; however, it is especially necessary to pay attention to the reasons for their silence and create space for them because they may not want to interrupt someone else's speech, etc.

In the field, we may also encounter possible risks posed by a volunteer that need to be avoided, such as:

- *an unprofessional approach* that stems from a breach of the ethical rules by a volunteer,
- *creating chaos* in a community, team, or organization,
- *uselessness* caused by poorly chosen activity and insufficient mapping of the needs of a community or organization,
- *dissatisfaction* that stems from the lack of planning, organization of individual steps of an activity, not obtaining financial sources – a donor for the budget in the project necessary for the performance of the action,
- *an unnoticed change in the community* that is related to the ongoing dynamics of a community or organization,
- *lack of communication* between a provider and a recipient of the service, resulting in a rejection by a community or organization,
- *belated discovery that a selected activity does not match a volunteer's expertise,* and
- *omitting one of the community groups, a community or organization leader.*

Nature of elimination of possible risks in the field:

- building on what we already know, what we have learned,
- choosing the right community for one's own activity,

- mapping community or organization needs,
- establishing contacts, remembering a leader, manager or director of a community, organization,
- planning an activity – developing a service-learning project, following the teachers' instructions,
- an agreement on the implementation of the activity – with community leaders (appropriate date, creation of space, etc.),
- complying with all acquired theoretical knowledge throughout the whole 13-week semester of the optional subject Service Learning 1,
- Service Learning 2 in the next 13-week semester – implementing the steps that a student – volunteer has planned,
- implementing the project planned and approved in SL1, for which students – volunteers received a credit, and
- students/volunteers have the possibility to choose a Supervisor in the project implementation in the field (teachers who participated in teaching the optional subject Service Learning: doc. PhDr. Rastislav Rosinsky, PhD.; PhDr. Katarina Vankova, PhD.; PhDr. Jana Uhlarikova, PhD.; and PhDr. Katarina Minarovicova, PhD.).

Evaluation

We have achieved the objective. We have created the new optional subject which is currently attractive and attractive for students. The subject consists of two parts: in the first part, students learn theory and develop their own project; the second part includes the implementation of their own project in the field. We are proud of all the students who have been involved in volunteering activities under the optional subject in crisis situations such as the Covid-19 pandemic, and thus, they work and assist in different places in society wherever the situation is the most acute, and students are most needed. Students acquire multiple experiences by which they shape their established attitudes; can realize their potential in the form of their own projects; gain a desire for further knowledge; and thus acquire important responsibility, compassion, empathy, and dignity that are so necessary for the performance of social work in social services in our society.

Discussion

The whole course of mapping and creation, and the implementation were difficult, but the result was ultimately worth it, which is also evidenced by the number of volunteering activities carried out according to the defined rules. The uplifting thing is that there is a great deal of interest from the students in this optional subject, and there have been many activities carried out in the development of their own projects, even though the optional subject has only been taught since 2020, in distance education due to the pandemic measures. The students had difficult conditions to find a facility in their own area as part of the implementation of their own project, but in the end, everything was managed with the assistance of the subject supervisors.

Implementation of service-learning projects in the field during the pandemic.

Based on the volunteer agreements during the pandemic, our students implemented their learning projects:

Where learning projects were implemented most often: centers for families with children, community centers, social services facilities, primary schools, civic associations — assistance to animals, asylum centers, and hospices.

The most common activities in learning projects: the environmental field related to education, ergotherapeutic activities, tutoring in English and other subjects of primary school, various types of social assistance for the sick, the disabled, etc.

The students who completed the optional subject Service Learning 1 and 2 acquired:

- SELF-CONFIDENCE
- RESPONSIBILITY
- SELF-REALISATION
- SELF-REFLECTION
- EXPERIENCE
- SHAPING OF ESTABLISHED ATTITUDES
- DESIRE FOR KNOWLEDGE
- POSSIBILITY OF FUTURE EMPLOYMENT

Recommendations for practice

Based on our own experience, we can recommend to educational facilities, such as primary, secondary, and higher education institutions, to introduce a subject that will focus on teaching volunteering in theory and then implement it in

practice in a certain pre-selected target group. We offer supervision in the application of this issue in both theory and practice.

Conclusions

Volunteering is beneficial if it is beneficial for everyone involved – volunteers, clients, and society. Our students/volunteers are aware of the Universal Declaration on Volunteering adopted by the International Association for Volunteer Effort (2001, the Netherlands). Furthermore, students/volunteers also follow the very principles of the Declaration.

We sincerely wish all students/volunteers the wisdom, desire for further knowledge, and light and love in their hearts, so that their selfless assistance to clients is an example to others.

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The War in Ukraine and the Participation of St. Elizabeth University of Health and Social Work in Helping at Border Crossing Points

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Abstract:

War always means sacrifice, death, forced departure, pain, sorrow and suffering. All wars leave scars on the soul. The current situation in Ukraine is very serious. The war has affected millions of innocent people. St. Elizabeth's College of Healthcare and Social Work supports calls for solidarity, an end to the war and peace. Everyone from the university contributes not only by hand but also by heart to the joint work. Suffering must end!

The day war broke out in Ukraine, the lives of the whole world changed. We do not understand. We do not believe that such thing can happen in the 21st century. After all, we took peace for granted! But the reality is cruel! We watch people seeking safety and running from the war. Fortunately, we see the solidarity of people around the world engaging in humanitarian aid to people affected by the war. St. Elizabeth's University of Health and Social Work, Presov and Michalovce workplaces, are no exception.

Our university has been involved in this help since the first day the need arose. Our founder, Professor Krcmery, was the first to mobilize teachers and students from Michalovce and Presov workplaces, who are closest to the border crossing points with Ukraine. Our task was to map the need for assistance on all crossing points from Ukraine to Slovakia and to provide the necessary help. The first day we were at the Ubla border crossing point where we consulted the need for assistance and together with the management of the border crossing we addressed strategies to help. It was not so much about professional help as it was about human companionship, human warmth. We helped people escaping from Ukraine with their luggage and their children to safety of our country, to Slovakia. At first, it was the nearest villages whose inhabitants offered refuges to stay in their own homes. It was amazing! They helped people they didn't even know with an open heart and arms. The mayors of the villages vacated the premises of the school, the cultural house, which they adapted for sleeping and resting. At the border crossing point itself, students of our university, who live relatively close, helped with luggage, children, provided transportation by car, helped with delivery to safety. Since it was very cold, they bought blankets to warm up, which they handed out right on the territory of our state, along with hot drinks, tea, coffee.

Since the Red Cross had its stand there, our nursing students immediately reported as paramedics and helped as they knew. Students of our university, from the Department of Nursing, are also employed at the hospital in Snina, which has taken over the responsibility of providing health care to people from the Ubla border crossing point. In this way, our students also participated in providing care. A similar situation was at the border crossing in Vysne Slemencia. Here, our university students also helped as they knew. Since they had a situation mapped in the center of events, they knew what people fleeing war in Ukraine missed the most. They started to organize collections of clothes, food, hygiene supplies, etc. The commanders of the mentioned border crossings themselves evaluated that the Vysne Nemecke border crossing point which is the largest crossing, needs help to a greater extent. There was an enormous influx of people coming to our territory. Here, in cooperation with the Order of the Knights of Malta, we began to provide assistance services in continuous operation. Teachers and students in day and night shifts, who help with luggage, registration, equipping sim cards for phones, arranging transportation to other places by cars, buses, vans, but also by providing rest in heated tents and providing refreshments, food and improvised dining.

Thank God for the solidarity of all the volunteer organizations that were the first to get involved in the border crossings. We support each other, organize help and are always looking for ways to improve the care provided. The Salesian Sisters of Michalovce also work closely with us, who are also fluent in languages and interpret when and to whom it is necessary.

At the borders, it is also necessary to take care of small children who have their own specific requirements. For this purpose, our university has set up a container for mothers with children, where mothers can relax, take care of their baby, whether breastfeeding, preparing food for the baby, repacking, changing, or providing them with the necessary nursing care. The container is heated; there is a microwave, kettle, changing tables, diapers, toiletries and hygiene packages which mothers will also receive when leaving. There are also clothes and toys for children, which they enjoy very much. This baby container is available 24 hours a day. Students of the Department of Nursing ensure continuous day and night shifts.

Our St. Elizabeths's University of Health and Social Work, as it also has a branch workplace in Michalovce, also provides volunteer work in the hotspot in Michalovce where it provides services with doctors from all over the country in providing medical assistance in the tent of health professionals, also in day and night shifts. At first, it

was an inflatable tent that was heated. There were drugs, injections, intravenous infusions, bandages, disinfectants, beds, blankets, ECG device, blood pressure monitors, thermometer, oximeter, etc. Currently, it is a heated container that is stable. Doctors, in collaboration with our nursing students, provide health and nursing care to people who need it. Most commonly, people come with headaches, abdominal pain, problems with blood pressure, breathing, diabetes, but also injuries and wounds. Here they will be provided with care and, if necessary, transport will also be provided to the hospital in Michalovce. We are pleased that the doctors are satisfied with the cooperation with our university. They say that students have both knowledge and skills, as well as good communication with patients. It is also a great benefit that several students and teachers are English, German, Russian and Ukrainian speakers, so in many cases they are also interpreters.

As storage needs are also needed for humanitarian aid, the St. Elizabeth's University of Health and Social Work in Michalovce, at the initiative of the founder, Professor Krcmery, provided premises for the storage of medicines, food, hygiene supplies and clothing. Due to the very demanding and complex situation with the provision of temporary accommodation for people from the border who continued their journey to other places in Slovakia or abroad, accommodation facilities were set up in school premises, mainly for sleeping. The couches were bought; classrooms became dormitories. Also at the Presov workplace, collections of food, clothing and hygiene items were organized which were then transported to the border crossing points and to hostels where people from the border were accommodated in cooperation with the Greek Catholic Charity. We also prepared accommodations for people providing assistance at the borders who participate with our university in humanitarian aid.

Students are heavily involved in providing everything that is needed. The heads of the workplaces, the teachers, the assistants and even the cleaning lady mobilized all the forces to ensure that everything needed was secured. They were hospitable, welcoming, arranged for students to be transported to their border shifts and they keep providing all that for as long as necessary. The psychologist provides psychological help in such a difficult, psychologically demanding situation. Everyone contributes not only by hand but also by heart to the common work.

War always means sacrifice, death, forced departure, pain, sorrow and suffering. All wars leave scars on the soul. We perceive that the current situation in Ukraine is very serious. The war has affected millions of innocent people, but we believe there is hope. After all, people who offer help to those they do not know are praying for peace in the world, for leaders and for ending the war. World leaders have long called for peace, and the Holy Father, Pope Francis, calls on both sides to reconcile. Suffering must end! St. Elizabeth's College of Health and Social Work also supports calls for solidarity, an end to the war and peace. May GOD bless good works!

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The Benefit of Professional Parenthood for the Child

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Abstract:

The author points out the mission of professional families in childcare in substitute care. It approximates the benefits of professional families for children living outside their own families, especially in the area of filling their mental needs. It emphasizes the importance of a relationship that is important to the life of every person and especially to children in the process of their development. In the contribution, the author describes the legislative definition of professional parenthood in the Slovak Republic; approaches the roles of a professional parent in the care of a child, and emphasizes the importance of motivation for the performance of this profession; as well as the preparation for professional parenthood; the personality characteristic of professional parents.

The author also points to the merit of cooperation between professional parents and members of a multidisciplinary team in

addressing childcare issues. The contribution focuses on the benefits of professional parenting for the child, comparing this kind of childcare care provision in children's educational groups in children's homes.

Role of professional families

A professional family is a specific institute for childcare which, for serious reasons, have been excluded from the family environment. It is a form of constitutional care in which childcare is not provided in children's home areas, but in the home environment of professional families. Act No 305/2005 Coll defines the conditions for the performance of professional parenting in relation to the scope of preparation for replacement parenting, the requirements of professional parent's personality as well as the organizational provision of professional parenting.

Preparing for professional parenting under the current legislative conditions runs for 60 hours for those who have completed a full secondary education completed by a school-leaving examination. For those who meet the special condition of higher education, 40 hours of training is sufficient. In the care of one physical person who becomes a professional parent, up to three children may be placed in care. In the case of a married couple, a maximum of 6 children may be placed.

According to the Concept of Enforcement of Court Decisions in Children's Homes for the Years 2012-2015 with a View to 2020 - The Transformation Plan and the Deinstitutionality of Replacement Care, from January 1, 2016, every child under 8 years of age is placed in a professional family and from 1 January 2021 in a professional family, all children up to the age of 10 are placed. Only children who require special care in a specialized group of children's homes for their health condition will be exempt.

Childcare in a professional family is a great professional challenge for the quality of ensuring a child-friendly environment in which the child will be saturated with his/her psychological and social needs in the degree and quality that will be as close as possible to the life of the child in the normal family (Hudecova, Belkova, 2008).

1.1 Meaning of relationship

A great challenge for professional parents is to build a relationship with a child. This is necessary to fulfill all the intentions that professional parenting carries. Creating a relationship can be complicated for the initial mistrust of children towards professional parents as children can survive serious emotional injuries in the biological family and have no positive parental behavior.

Also, children can be severely traumatized by leaving a biological family and may have an inherent loss of separation from their parents. Unless a child in such a difficult situation is provided with professional assistance and isn´t fit to enter a professional family, his/her placement can bring a lot of pain and mutual misunderstanding to the child with professional parents.

Therefore, it is especially important for professional parents to be well-prepared to manage the adaptation phase after the child's arrival in their family and to be able to understand the needs for childcare loss treatment. As stated by Hasto (2005, p.90), "A safe childhood" is a "safe bond" in which the child knows that in stressful and anxiety-inducing situations he can rely on parental emotional and active support." It is very important for children who have not had such a relationship many times with parents to have the opportunity to create someone (Noskova, 2011).

2 Cooperation of the expert team

However, professional parents in the care of children in their families do not remain alone. They use the help of professional staff who are made up of children's home staff - directors, social workers, psychologists, educators as well as external staff - staff of primary and secondary schools attended by children or healthcare facilities that provide healthcare for children. An important supportive environment for professional families may be their wider family, friends and acquaintances. In difficult situations, they can get help and support from them, and also give children a family cohesive experience. However, situations where the social environment of professional parents doesn´t respond positively to their job role and don´t understand the sense of professional care can occur. It is important, there-

fore, that in preparing the candidates for professional parenthood, it is also important for those interested to communicate openly about their intention to become a professional parent with their close surroundings and to prepare their close relatives for the arrival of the child.

An area where the help of a team can be needed is also a help for biological children when a new child arrives in the family. There may be situations where biological children will perceive in the incoming children of their opponents and will fight for their parenting and attention.

2.1 Cooperation with the biological family of the child

A specific area is also to help children adjust to their relationship to biological parents. A professional family should be a temporary form of care until the child can return to the biological family or until a suitable replacement family finds it.

Professional parents, like people who have not been more closely involved in this field, can feel a certain threat in contact with children with a biological family. They often do not trust biological families to be able to change themselves and are therefore not very open to contact with them. However, professional parents must be aware of the fact that the regulation of their relationship to their parents plays a key role in their lives. Miklosko & Zarnay (2008, p.54) are of the opinion that "the shorter the separation of the child from the family, the greater the willingness of the parents to work together and the greater the likelihood of the child returning to the family".

Due to the demanding nature of this profession, we would like to argue that there is a need to improve the preparation for professional parenting as well as the professional-advisory service provided to professional families. It is important to take into account past experience of professional parenting and to take on new changes that will make the provision of this specific care more effective. In particular, it should be a matter of assessing the real capacity of the professional parent to pursue that profession. It is also very important to accompany the child and professional parents in the adaptive phase of mutual coexistence which should be preceded by contact with the child before the placement in a professional family (Bohunsky, 2011).

Professional parents should feel the co-responsibility and interest of employees of the children's homes as well as their wider social environment. A professional family is a place where children's needs can be saturated even at a more intense level than in groups of children right in their children's home. This is mainly because the child grows up in a narrow circle of people who payattention to the child. The child also has the opportunity to experience the role of family members which is veryimportant for his current as well as future life.

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Implementing Nursing Standards in Care Maps for Breast Cancer Patients

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Abstract:

Nursing care that adheres to nursing standards is more comprehensive, detailed, and patient-centered. Care maps are an important multidisciplinary tool for managing and improving the quality of nursing care provided to patients.

Aim: We verified the usability of nursing standards in care maps while treating patients with breast cancer, and we compared the activities of nurses while providing nursing care in selected workplaces.

Methods: The research group included 205 patients from surgical and the obstetrics - gynecology (OB/GYN) clinics and 24 nurses working at these clinics. To carry out the research, we applied a modified care map in the experimental subgroups

to record nursing activities, and in the control subgroups the nurses used the standard nursing documentation of the selected workplace. Within the investigated quantitative variables, we presented their numerical characteristics, used a linear descriptive statistic (n) and relative position – the arithmetic mean (). Using multivariate fuzzy C-means cluster analysis, we compared the specific procedures performed within individual subgroups of patients. We used an interview to find out the views of nurses on the implementation of care maps in the nursing practice of patients with breast cancer.

Results: In the experimental groups, nursing activities were recorded in a modified care map where we observed their higher number and differences in the documentation of nursing activities in comparison with the control groups. The opinions of nurses on the implementation of care maps in the treatment of patients with breast cancer in selected workplaces were mostly positive.

Conclusion: Based on the research results, there is a need to deepen the theoretical knowledge of nurses about managed nursing care and care maps and to use nursing standards as tools to ensure that quality nursing care is provided.

Introduction

Breast cancer is the most common cancer in the female population. Every year, 1,700 new cases occur in Slovakia. It is a disease with repercussions that not only affect the lives of every patient, but also create a significant societal problem due to the disease's high incidence in the population and high mortality rate (Konečný *et al*., 2005). Early and correct diagnosis is important for successful treatment.

At present, quality nursing care is gaining more and more prominence (Farkašová *et al*., 2005). The nursing standard is one means of protecting the patient from mishandling (Dobiášová, 2003). Care maps are also one of the tools of managed care (Koňošová, 2005, Tomková *et al*., 2008, Škrla, Škrlová, 2003, Mesárošová *et al*., 2007). They are developed for a specific diagnosis, procedure or treatment (Škrla, Škrlová, 2003). They are used in cases where the diagnosis is clear, the process of care provided is routine, but the variability of the care provided is a problem. Based on these principles, we focused on the use of nursing standards in care maps for patients with breast cancer.

Aim

The aim of the study was to verify the usability of nursing standards in care maps in treating patients with breast cancer and to compare the activities of nurses in selected workplaces in providing nursing care. We assumed that there would be a higher number of documented independent nursing activities at selected workplaces in the care maps than in the documentation of patients without the use of care maps. We focused on identifying possible differences in the recorded activities of nurses in selected workplaces and examined the attitude of nurses to the introduction of care maps into nursing practice, with the assumption that there would be a more positive attitude if the documentation is less time consuming.

Sets and methods

We carried out the research at the University Hospital in Nitra at the Department of Surgery and the Obstetrics - Gynecology (OB/GYN) clinics for 8 months. The research samples consisted of patients with a medical diagnosis of malignant breast tumor hospitalized at the surgical and OB/GYN clinics by deliberate selection, divided into experimental and control groups, and nurses working at the – surgical and OB/GYN clinics. A total of N = 205 patients participated in the research, of which n1 = 106 patients were from the surgical clinic and n2 = 99 patients from the – OB/GYN clinic.

The research sample was divided into four subgroups:

1st subgroup - patients from the surgical clinic included in the control group (hereafter SC) in the number of n = 48 patients. **2nd subgroup** - patients from the surgical clinic included in the experimental group (hereafter SE) in the number of n = 58 patients. **3rd subgroup** - patients from the OB/GYN clinic included in the control group (hereafter GC) in the number of n = 48 patients. **4th subgroup** - patients from the OB/GYN clinic included in the experimental group (hereafter GE) in the number of n = 51 patients.

The second research set consisted of N = 24 nurses (100%), of which n = 12 (50%) at the surgical clinic nurses, at the OB/GYN clinic n = 12 (50%) nurses. In this study we present a statistical evaluation of the first 5 days of hospitalization (day before the surgery, day of surgery and the first 3 days after surgery). To collect empirical data, we used an experimental method to compare two groups of patients - experimental and control, content analysis - medical documentation to obtain data in the control and experimental group and a standardized individual interview - an interview to find out the views of nurses on the implementation of care maps in nursing practice in patients with breast carcinoma. Subsequently, in experimental subgroups, we applied a modified care map for recording nursing activities using nursing standards - created according to Mesárošová, 2007 (In: Vörösová et al., 2007). In the control subgroups, the nurses implemented routine nursing practice and used the nursing documentation of the selected workplace.

Results and discussion

We present a statistical description of the investigated quantitative variables. We present their numerical characteristics; we use linear descriptive statistics (n) and relative positions - arithmetic mean ($\bar{x}$). For comparison, we present the mean values ($\bar{x}$) per n = 1 patient in each subgroup during the first 5 days of hospitalization. The order of individual items is reported as higher > and lower < value from the number $\bar{x}$ per 1 patient of documented activities in the relevant subgroups (we state the order by days of hospitalization, subgroup, $\bar{x}$, comparison, subgroup, $\bar{x}$).

As another statistical method, we will use multivariate fuzzy C-means cluster analysis to compare individual performances within all patient subgroups. We add all types of procedures within one patient and also within the monitored group. Using multivariate fuzzy C-means cluster analysis, we compare groups of procedures within groups of patients. We work with 80% similarity. If patients are at least 80% alike, the analysis declares them to be similar and puts them in one group. If the similarity is less than 20%, they are included in another cluster. The field in the range of 21% - 79% similarity is the so - called "fuzzy", where patients tend to resemble one of the clusters, but do not belong exactly anywhere. Clusters are formed on the basis of similar activities within individual items over a period of 5 days of hospitalization. In accordance with the Decree of the Ministry of Health of the Slovak Republic #364/2005 and No. 470/2006, we identified independent nursing activities that are used in the treatment of patients with breast cancer and we implemented them in a modified care map. Within the individual items of the modified care map, we focused on the description of consultations, examinations/laboratory tests, medications, monitoring, nursing diagnoses, assessment scales, physical activity, education training, nursing standards: structure and maintenance of nursing documentation (hereafter #2), preoperative nursing care (#3), blood pressure measurement (#5), body temperature measurement (hereafter #6), pulse measurement (#7), patient admission (#21), venous blood collection for examination (#24), oral administration of drugs (#35), subcutaneous injection (hereafter #37), morning and evening hygiene (#15), lower limb bandaging (#19), aseptic wound dressing (#29), introduction of a permanent urinary catheter in a woman (#32), application of intramuscular injection (#36), infusion administration (#43), peripheral cannula care (# 50), postoperative nursing care (#4), application of drugs for external use (#38), patient discharge (#23), cleansing enema (#30).

Table 1 Comparison of average number of used nursing standards in subgroups n = 205

The average number of used nursing standards in the subgroups				
subgroups /	SC	SE	GC	GE
days of hospitalization	$\bar{x}$	$\bar{x}$	$\bar{x}$	$\bar{x}$
1st day	5.15	8.16	7.17	8.00
2nd day	10.04	13.02	11.10	14.00
3rd day	7.73	11.20	6.06	11.76
4th day	3.82	6.71	3.73	6.69
5th day	4.65	7.74	3.71	5.76

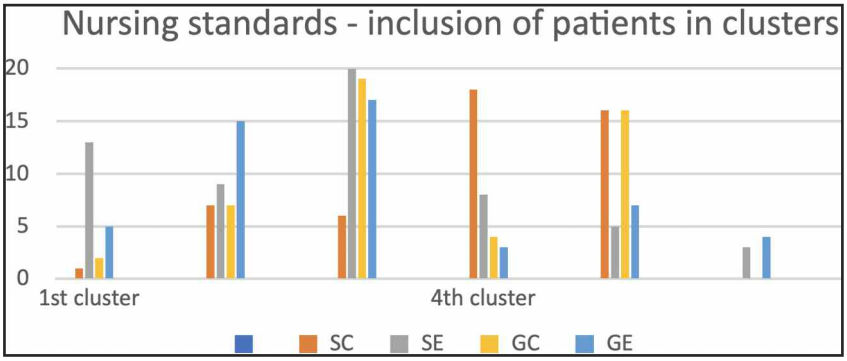
Statistical indicators from multivariate fuzzy C-means cluster analysis:

A patient belongs to 1st, 2nd, 3rd, 4th or 5th cluster if their affiliation function of C1, C2 & C3 is in the range of 0.800–1.000. A patient is rather 2 fuzzy, unclear, if the affiliation function of C2 is more than 0.5000 and at the same time less than 0.8000 and other affiliation functions are less than 0.5000. Clusters are formed based on similar activities within five days of hospitalization.

Table 1 Nursing standards - inclusion of patients in clusters n = 205

Sub-group	1st clusterC =0.9876		2nd clusterC =0.8979		3rd clusterC =0.9999		4th clusterC =0.8845		5th clusterC =0.9915		rather 2nd cluster C2 =0.7674		n	%
	n	%	n	%	n	%	n	%	n	%	n	%		
SC	1	0.49	7	3.41	6	2.93	18	8.78	16	7.80	0	0.00	48	23.41
SE	13	6.34	9	4.39	20	9.76	8	3.90	5	2.44	3	1.46	58	28.29
GC	2	0.98	7	3.41	19	9.27	4	1.95	16	7.80	0	0.00	48	23.41
GE	5	2.44	15	7.32	17	8.29	3	1.46	7	3.41	4	1.95	51	24.87
total	21	10.25	38	18.53	62	30.25	33	16.09	44	21.45	7	3.41	205	100

Graph 1 Nursing standards - inclusion of patients in clusters

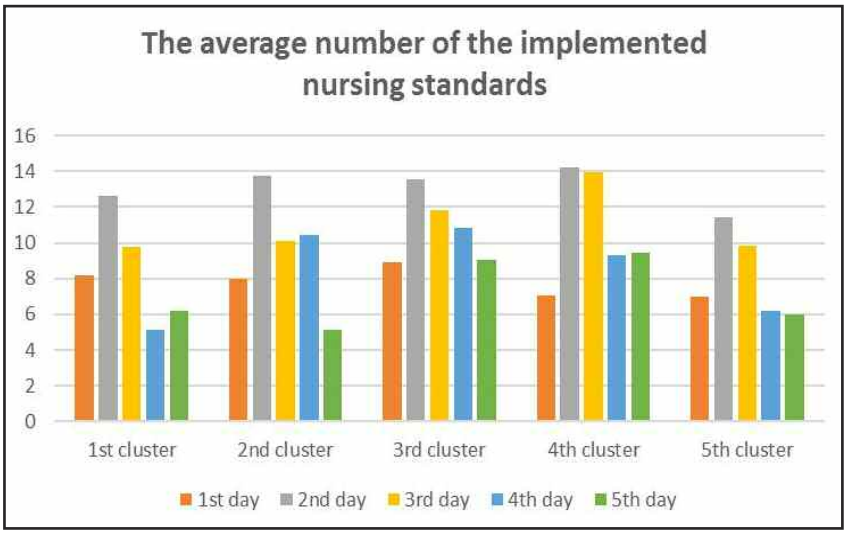


Significant findings in the percentage of patients in the clusters: SC – 8.78% patients in the 4th cluster > vs. 0.00% patients rather in the 2nd cluster. SE – 9.76% patients in the 3rd cluster > vs. 1.46% patients rather in the 2nd cluster. GC – 9.27% patients in the 3rd cluster > vs. 0.00% patients rather in the 2nd cluster. GE – 8.29% patients in the 3rd cluster > vs. 1.46% patients rather in the 4th cluster.

Table 2 Average number of nursing standards implemented on each day of hospitalization

cluster	1st cluster n = 21	2nd cluster n = 38	3rd cluster n = 62	4th cluster n = 33	5th cluster n = 44
day	$\bar{x}$	$\bar{x}$	$\bar{x}$	$\bar{x}$	$\bar{x}$
1st day	8.16	8.00	8.89	7.05	7.00
2nd day	12.63	13.76	13.57	14.21	11.46
3rd day	9.74	10.12	11.80	13.98	9.87
4th day	5.13	10.42	10.82	9.32	6.17
5th day	6.22	5.14	9.04	9.44	6.00
total	41.88	47.44	54.12	54.00	40.50

Graph 2 The average number of the implemented nursing standards



Significant differences in clusters: 1st cluster – 1st day $\bar{x}$ 8 nursing standards (2,3,5,6,7,21,35, 15), 2nd day $\bar{x}$ 13 nursing standards (2,3,5,6,7,35, 37,15,19,36,43,50,4), 3rd day $\bar{x}$ 10 nursing standards (2,5,6,7,37,15,19,43,50,4), 4th day $\bar{x}$ 5 nursing standards (2,6,37,15,4), 5th day $\bar{x}$ 6 nursing standards (2,6,37,15,29,4). 2nd cluster - 1st day $\bar{x}$ 8 nursing standards (2,3,5,6,7,21,35,30), 2nd day $\bar{x}$ 13 nursing standards (2,3,5,6,7,35,37,15,19, 36,43,50,4), 3rd day $\bar{x}$ 10 nursing standards (2,6,7, 37,15,19,43,32,50,4), 4th day $\bar{x}$ 10 nursing standards (2,6,37,15,19,29,32,43,50,4), 5th day $\bar{x}$ 5 nursing standards (2,6,37,15,4). 3rd cluster – 1st day $\bar{x}$ 9 nursing standards (2,3,5,6,7,21,24,35,15), 2nd day $\bar{x}$ 14 nursing standards (2,3,5,6,7,35, 37,15,19,29,36,43,50,4), 3rd day $\bar{x}$ 12 nursing standards (2,5,6,7,35,15,19,29,36,43, 50,4), 4th day $\bar{x}$ 11 nursing standards (2,5,6,7,35,37,15,29, 36,4,38), 5th day $\bar{x}$ 9 nursing standards (2,5,6,7, 35,37,15,29,4). 4th cluster - 1st day $\bar{x}$ 7 nursing standards (2,3,5,6,7,35,30), 2nd day $\bar{x}$ 14 nursing standards (2,3,5,6,7,51,37,15,19,32,36,43,50,4), 3rd day $\bar{x}$ 14 nursing standards (2,5,6,7,35, 37,15,19,29,32,36,43,50,4), 4th day $\bar{x}$ 9 nursing standards (2,5,6,7,35,37,15,29,4), 5th day $\bar{x}$ 9 nursing standards (2,5,6,7,35,37,15,29,4). 5th cluster - 1st day $\bar{x}$ 7 nursing standards (5,6,7, 21,24,35,37), 2nd day $\bar{x}$ 11 nursing standards (5,6,7,24,35,37,19,29,36,43,50), 3rd day $\bar{x}$ 10 nursing standards (5,6,7,35,37,29,36,43,50,4), 4th day $\bar{x}$ 6 nursing standards (5,6,7,35,37,29), 5th day $\bar{x}$ 6 nursing standards (5,6,7,35,29,37).

Comparison of the average number of nursing standards by clusters:

We state the data in this order: day of hospitalization, cluster, number of patients in the cluster, higher > and lower < value from the number $\bar{x}$ per 1 patient. 1st day of hospitalization – 3rd cluster n = 62 ($\bar{x}$ = 8.89) > 5th cluster n = 44 ($\bar{x}$ = 7.00); 2nd day of hospitalization – 4th cluster n = 33 ($\bar{x}$ = 14.21) > 5th cluster n = 44 ($\bar{x}$ = 11.46); 3rd day of hospitalization – 4th cluster n = 33 ($\bar{x}$ = 13.98) > 1st cluster n = 21 ($\bar{x}$ = 9.74); 4th day of hospitalization – 3rd cluster n = 62 ($\bar{x}$ = 10.82) > 1st cluster n = 21 ($\bar{x}$ = 5.13); 5th day of hospitalization – 4th cluster n = 33 ($\bar{x}$ = 9.44) > 2nd cluster n = 38 ($\bar{x}$ = 5.14).

Table 3 Comparison of average number of independent nursing activities in subgroups n = 205

Average number of independent nursing activitiesin subgroups				
subgroups	SC	SE	GC	GE
Days of hospitalization	$\bar{x}$	$\bar{x}$	$\bar{x}$	$\bar{x}$
1st day	14.50	25.77	18.77	24.59
2nd day	23.05	46.09	29.77	43.23
3rd day	20.78	40.02	23.73	38.55
4th day	14.68	25.36	17.18	29.82
5th day	15.27	29.36	15.00	26.82

It follows from the above that the number of independent nursing activities in the experimental groups is higher compared to the number of independent nursing activities in the control groups. Subsequently, we assumed that in the treatment of patients with breast cancer, there would be differences in the recorded activities of nurses at selected workplaces. Based on our experience from the implementation of the experiment, we can state that the modified care map presented by us unified the activities of nurses at the workplaces.

Table 4 Average number of recorded nursing activities

subgroups	SC	SE	GC	GE
	$\bar{x}$	$\bar{x}$	$\bar{x}$	$\bar{x}$
consultation	7.00	8.79	7.00	9.01
monitoring	22.50	22.86	20.00	21.94
nursing diagnosis	12.25	25.95	5.00	27.22
assessment scales	0.00	9.44	0.00	10.47
nursing standards	31.38	46.83	31.77	46.22
independent nursing activities	40.46	63.50	47.88	70.31
total	113.59	177.37	111.65	185.17

It is clear from the statistical analysis that nurses do not document all their activities in their routine practice. In the experimental groups, there were minimal differences in the method of documenting nursing activities due to the doctor's prescription, or due to a change in the health status of patients.

The last area of our research was the assumption that the attitude of nurses to the implementation of care maps into nursing practice will be more positive if the documentation is less time consuming. We conducted individual standardized interviews with the nurses. First, we asked them what their personal experience of how to keep nursing records through care maps was. We asked whether nurses feel more confident in their performance when working with nursing standards. Finally, we asked if it is currently possible in the conditions of their department, to keep nursing documentation through care maps. According to 87% of nurses, even at the present time and in the current conditions of individual clinics, it would be possible to keep nursing documentation through care maps. Based on this fact, we can confirm that the attitude of nurses to the implementation of care maps is positive.

Conclusion

The topic of the work was created in an effort to focus on improving the work of nurses at both surgical and OB/GYN Clinics using nursing standards in care maps which represent a rational approach to the problem. The experimental groups recorded independent nursing activities compared to the control groups. The care map modified by us met all the attributes of quality nursing care. 83% of nurses expressed a positive attitude towards maintaining nursing documentation in the form of care maps. We are convinced that there are differences in the nursing care provided for breast cancer patients between clinics. The first significant difference is the length of hospital stay - at the surgical clinic on average 6.6 days, at the OB/GYN clinic 11.5 days. Other important findings include the application of a cleansing enema before breast surgery at the OB/GYN clinic, the introduction of a permanent urinary catheter perioperative at the OB/GYN clinic and the frequency of the surgical wound dressing (at the surgical clinic, the first dressing was performed on the third postoperative day, at the OB/GYN clinic on the first day after the operation). In our opinion, these identified differences show a need for clinic managements to work in unison. One suitable option would be to develop care maps for specific diagnoses and to ensure consistency and quality through them.

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