

CLINICAL SOCIAL WORK

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CONTACT

Michal Oláh
Peter G. Fedor-Freybergh
Editor-in-Chief
e-mail: michalolah@gmail.com

Eva Grey
Commissioning editor
e-mail: eva.grey@gmail.com

Andrej Fukas
Proofreader
e-mail: andrejfukas@gmail.com

CLINICAL SOCIAL WORK

by **International Scientific Group of Applied Preventive Medicine I - GAP Vienna, Austria**

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

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NEW SOCIAL REFORM IN MARGINALIZED ROMA COMMUNITIES IN SLOVAKIA (I.E. THE ROMA REFORM)

Michal Oláh¹, Peter Pollák²

1. St. Elizabeth University of Health and Social Work in Bratislava

2. Ministry of internal affairs of Slovak Republic, SR Government attorney for roma communities

Key words:

social reform; marginalized Roma communities; Slovakia

Abstract

New social reform in marginalized Roma communities in Slovakia has been developed to be a strategy to solve the extreme marginalization of slovak Roma, mostly for their poverty. Main thesis of „The Roma reform – right path“ deal with the solution of social exclusion of this community from the majority. However, the essential problem is structural, related to the poverty of Romani, caused primarily by the lack of work opportunities. Reform aims to impact the economic policies of the state in order to create new jobs for romani on standard labor market in line with biblical „nothing for free“ for those able to work:

- to initiate positive social-economic changes in life of citizens living in complicated life situation who are threatened by extreme poverty, initiate the improvement of citizen coexistence;
- good education and ability of children and youth from not stimulating social background to assert themselves on the labor market;
- implementation of more reasonable system of social benefits payment;
- implementation of arrangements to assure no delinquency immunity for social dependent individua.

INTRODUCTION

Roma social reform represents a complex system reform including more than 90 arrangements in fields of education, law enforcement, accomodation, social system, employment and supporting politics. System arrangements are focused on solutions of the extended problem of populace groups, citizens in danger of extreme poverty, including the socially inadaptible. Proposed arrangements are referred mainly to risk families, identified by combination of following factors: parents education level, income level, parent longterm unemployment level, material background, indebtedness, truancy and assumption that a child doesn't understand the tuition language at the beginning of elementary school attendance.

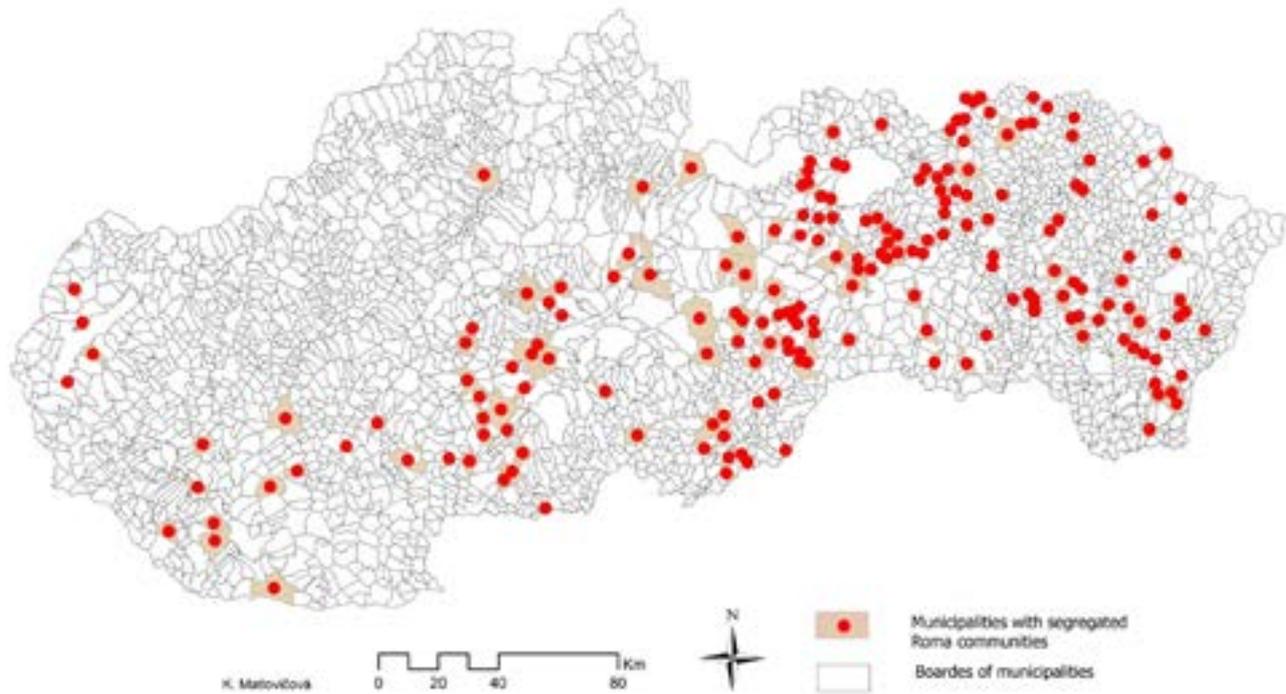
METHODS

Reform relates to all inadaptible inhabitants of SR. In democratic countries it is impossible to legislate based on ethnical or national reference. Aim of the reform is to enable the improvement of life situation to those citizens, who behave responsibly and actively towards their family, society and state.

In case a family is identified as risk, competent authorities will deal with it. If a positive change in behavior of individual or family is not achieved, following repressive actions will be established:

- change in form and level of social benefit payments will be applied on entire families;
- implementation of parent responsibility for delinquency and criminal acting of their children;
- accomodation benefit and a right to be inegrated to activation work system will be addition-

Map 1. Municipalities with segregated Roma communities in Slovakia



ally conditioned whether a person commits a delinquency or criminal act, and whether a person obeys legal duties.

RESULTS

New social reform in marginalized roma communities in Slovakia primarily focuses on a reform of social system, covered in 10 points:

1. Social system does not make any difference between those individuals who try to live honestly, are interested in work, take care of their children, obey the law, and those who do the complete opposite. All the depending people are put together and treated as things who only need to be paid out their monthly benefit.
 - 1.1. Problem: anonymous social system is ineffective, unjust, not motivating, and therefore it doesn't help in integration and in elimination of dependence on state social aid.
 - 1.2. Solution: form and level of state social aid as well as the approach of state towards the citizens will consider the approach of citizens towards society and state.
2. System allowing a benefit for a newborn baby, not binded to a certain purpose, to be paid in cash to risk parents, is questionable. In case of these parents, benefit is not used to saturate child's needs but their own.
 - 2.1. Problem: cash payment of a benefit and an extra bonus on the occasion of child birth to parents from risk families is not an effective tool in behalf of a child.
 - 2.2. Solution: to use the resources meant as benefit and extra bonus on the occasion of child birth to cover the costs related to integration of a child from risk family into compulsory pre-school attendance.
3. Socially dependent parent receives 17 EUR per month for child's school attendance. This benefit is not purposefully bound, it can be arbitrarily spent, and so usually is.
 - 3.1. Problem: Cash payment of a school attendance benefit to parents is not an effective tool in behalf of a child and it unnecessarily raises other parents' feelings of injustice.
 - 3.2. Solution: to use the resources meant as school attendance benefit for children from socially dependent family to cover the costs related to establishment of all-day education system for this child.
4. One-time monthly payment of social benefits which can be arbitrarily spent by risk parents, causes that many children from these families starve for major part of a month.
 - 4.1. Problem: one-time monthly payment of social benefits causes unnecessary financial shock in risk families which usually are not able to handle it responsibly. This results in ineffective distribution

of costs, lower resistance towards usury, bigger temptation to give in hazard, etc...

4.2.Solution: to pay the financial part of social benefits to risk parents weekly on their bank account. Parents would use bank credit card with no debit possibility. Bank account would ideally be administered by State treasury, with maximum cost of bank service controlled by state.

4.3.Problem: social benefits payment that occurs in a period of few days in entire community or everywhere in Slovakia causes time-centered shock in entire local community with massive elements of crowd behavior. The community experiences days of plentitude, as well as next days or weeks of lack of resources together. This fact enhances negative behavior in times of plentitude and doesn't enable mutual aid in times of lack of resources.

4.4.Solution: to arrange social benefit payment schedule of community members into various days in month.

5. System which rewards children for giving birth to children doesn't lead towards education to responsible parenthood.

5.1.Problem: with parent rights given to parents of an underaged mother, these parents also acquire the rights to benefits and an extra bonus on the occasion of child birth.

5.2.Solution: no legal possibility to receive benefit and an extra bonus on the occasion of child birth in case of a child born to an underaged mother.

5.3.Problem: to obtain a parental benefit can be, in some cases, an attractive way for an underaged mother how to increase her incomes.

5.4.Solution: to reduce parental benefit to underaged mothers in half.

6. System of examination of family members together financially motivates socially dependent parents not to contract marriage so that they have ensured higher social benefit.

6.1.Problem: System of examination of family members together allocates more resources to parents who stay formally out of marriage, or more precisely to parents who divorce for that purpose.

6.2.Solution: To examine material need of a grown-up person separately from family status.

7. System arrangement of activating works and small public services, which leaves their organization on local government causes that these works are mainly performed only formally and local government leaders use them to establish their power

and de facto to buy votes for state money.

7.1.Problem: Organization and control of activating works and small public services is lead by local government representatives, who usually are in family or other relationship to their administrators

7.2.Solution: transfer the organization and especially control of activating works and small public services to Labor Offices

7.3.Solution: to oblige municipalities to partly cover the costs for activation benefit

7.4.Problem: Capacity of activation works and small public services per municipality is defined by an officer, what unnecessarily creates bribery environment.

7.5.Solution: Maximum number of jobs for activation works and small public services offered in municipality by local government or other state authority is set by Government Order as percentage rate related to all socially dependent in municipality.

7.6.Problem: real numbers of jobs for activation works and small public services is insufficient, resulting in insufficient activation of socially dependent.

7.7.Solution: to allow private sector, church, non-profit organizations, etc. to create low qualification jobs for activation works, with responsibility to pay the activation benefit being transferred from state to the new provider of activation.

7.8.Problem: Many beneficiaries provide various ancillary operations to other citizens.

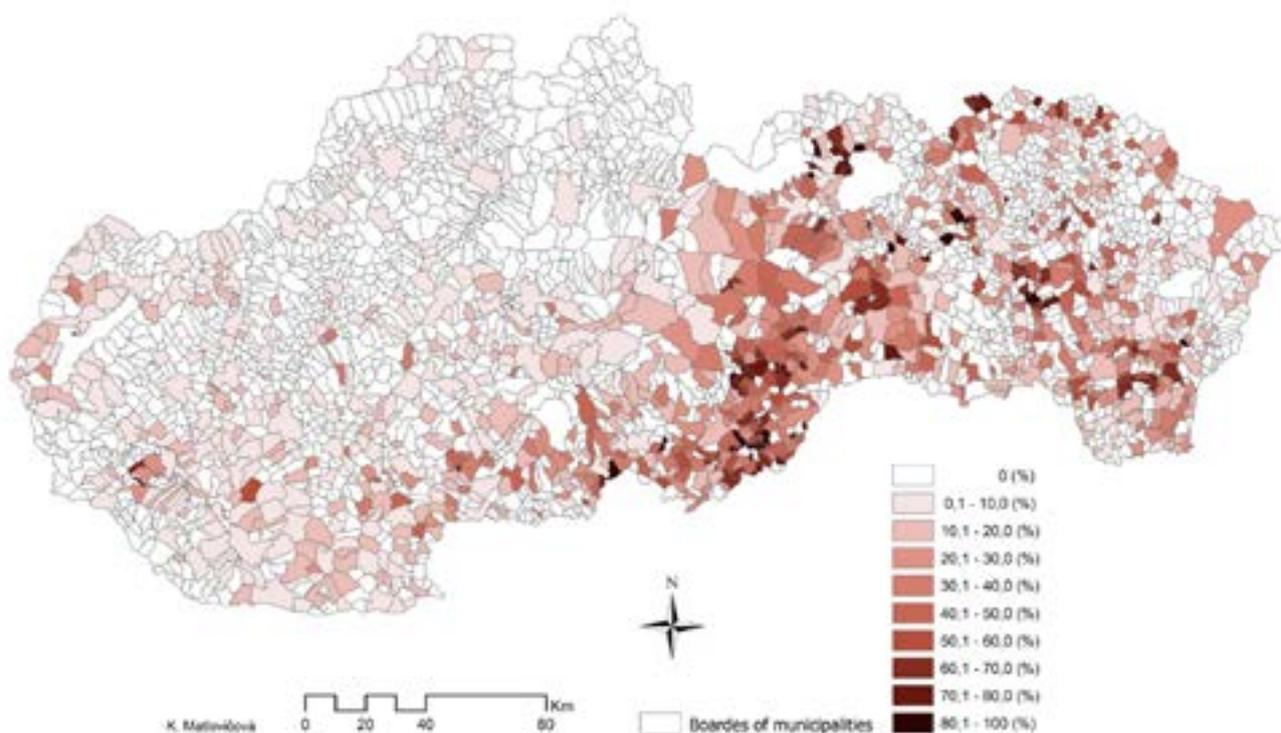
7.9.Solution: to allow to do activation works for other citizens, what would lead de facto to legalization of status quo and improvement of neighbour relationships, with responsibility to pay the activation benefit being transferred from state to the new provider of activation.

7.10. Decision of who will get the opportunity of activation via activation works and small public services, is on coordinator, named by mayor. Usually it concerns members of local government or employees of municipal office and therefore activation is allowed also to people who don't perform their legal duties or even commit delinquency or criminal acts.

7.11. Solution: Opportunity to get the activation job and enhance the family budget will be given only to those socially dependent, who perform all their legal duties, with special emphasis to regular attendance and behavior of their children in school, and who don't commit delinquency or criminal acts.

8. System of accommodation benefit is easy to misuse and not motivating.
 - 8.1.Problem: the right for benefit is acquired also by individual or family with asocial behavior
 - 8.2.Solution: the right for accommodation benefit paid in cash is acquired only by individual or family in the lower risk category. Benefit in other than cash form (cashing allowed to energy providers) will be acquired by individual or family in middle risk category, while individual or family in the highest risk category will have no right to this benefit.
 - 8.3.Problem: Childs return from compulsory pre-school education, or all-day education system, to a shack with 1 meter squared of floorage per person, highly increases the likelihood that the expensive socialization of the child will fail.
 - 8.4.Solution: enable families with low and middle risk rate, without accommodation of their own, to receive advance payments of accommodation benefits, which will be purposefully bound to purchase of building materials in order to self-helply build, reconstructre or buy a housing.
 - 8.5.Problem: System of accommodation benefit calculation allows easy misusage, e.g. by several contracts of lease made on one real estate.
 - 8.6.Solution: Accommodation benefit to be bound to number of family members with consistent decrease of benefit by each underaged family member.
- 8.7.Problem: Accommodation benefit is acquired to those in material need, who are the owners or tenants of the real estate, while those without their own estate or without the opportunity to contract of lease have no right to obtain the benefit.
- 8.8.Solution: every citizen in material need has the right for accommodation benefit, depending on performing their legal duties and committing delinquency or criminal acts.
9. Among people in material need there is markedly higher rate of people registered as disability pensioners or as unable to work.
 - 9.1.Problem: there is reasonable disbelief in objectivity of some doctors and their examination of health state of people in material need
 - 9.2.Solution: to identify doctors who show abnormal numbers of disabled people or people unable to work, and to re-examine those previously examined by him
10. Set-up of the institute of exclusive recipient allows its misuse.
 - 10.1. Problem: Many families enrolled in program of using the institute of exclusive recipient, use workers in charge of its supply to do their

Map 2. Percentage of Roma population in Slovak municipalities



shopping.

10.2. Solution: to arrange automatic quarter reduction of benefits realized by institute of exclusive recipient in order to cover the costs related to this service and stop misuse of the institute of exclusive recipient

10.3. Problem: payments of benefits stopped by using the institute of exclusive recipient and their subsequent retroactive payments demoralizes the recipients and doesn't help their resocialization

10.4. Solution: No retroactive payment of payments once stopped.

10.5. Problem: some kinds of social benefits of family members in material need are not included in the institute of exclusive recipient.

10.6. Solution: to allow the inclusion of all incomes from social benefits into the institute of exclusive recipient.

DISCUSSION - CONCLUSION

Roma social reform represents a vision for improvement of life of all Slovaks. Its aim is not to create roma and non-roma legislation, or to quick-and-easy solve several decades lasting problems. Casual people and professionals as well, often deal with legitimacy of some public administration actions, e.g. building wall between majority and roma minority, security system, misuse of substitute personal custody, missing legislation regarding community centers, terrain social workers with no competencies, unsettled inheritance procedures of socially dependent, false longtime inability to work, unjust calculation of pensions, development of protected workshops also for socially disabled individuals, cash payment of travel expenses to parents of school age children in advance, and many

other... Currently in Slovakia a new legislative act regarding material need is being prepared. This act is considered as base pylon of social system, which is guaranteed by the Constitution of Slovak Republic. Constitution of Slovak Republic guarantees covering of basic life needs of all the citizens of Slovak Republic, who asks for help. Act regarding material need rises from social reform or marginalized roma communities. New legislation brings connection between state social help and socially dependent person's responsibility towards his family, society and state.

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Correspondence to:

doc. PhDr. Michal Oláh, PhD., mim. prof.
St. Elizabeth University of Health & Social Sciences
Palackého 1, P. O. BOX 104
810 00 Bratislava, Slovenská republika
email: michalolah@gmail.com

Mgr. Peter Pollák, PhD.
Úrad splnomocnenca vlády Slovenskej republiky pre rómske komunity
Cukrová 14,
813 39 Bratislava, Slovenská republika
email: ppollak73@gmail.com

A SURVEY OF GENERAL, PROFESSIONAL AND PUBLIC AWARENESS ABOUT THE ISSUE OF KIDNEY DONATION AND TRANSPLANTATION

Ivica Gulášová¹, Lenka Görnerová², Ján Breza jr.³, Ján Breza^{3,4}

1. St. Elizabeth University of Health & Social Sciences, Bratislava, Slovakia
2. College of Polytechnics, Jihlava, Czech Republic
3. Faculty of Medicine, Comenius University, Bratislava, Slovakia
4. Urology Clinic with the Kidneys Transplantation Centre, Faculty Hospital Limbova, BratislavaSlovak Medical University, Bratislava

Key words: **employment; homeless people; labour market; measures for employment**

Abstract

Kidney transplantation provides hope for a better quality of life to patients with renal failure who are on dialysis. Authors conducted a survey to determine the level of awareness about kidney donation and transplantation.

DEFINITION OF THE RESEARCHED PROBLEM

The level of general, professional and public awareness about renal transplantation. 'Is our society well informed about the issue of kidney transplantation?'

OBJECTIVES OF THE SURVEY

- Determine the level of awareness of the population of the Slovak Republic regarding issues related to donation of kidney transplants.
- Examine the position of the general public on the issue of kidney transplantation.
- Determine the level of awareness from a group of health professionals regarding issues related to donation of kidney transplants.
- Examine the attitude of healthcare workers on the issue of kidney transplantation.
- Compare the findings between health care professionals and the general public.

EXPLORATORY METHODS

The survey was conducted using methods of observation and interview used in the pilot study during the preparatory phase of the survey. The main method was a survey questionnaire of our own design.

CHARACTERISTICS OF RESPONDENT SAMPLES

The survey involved 600 respondents. Respondents were divided into two basic groups: Group I consisted of 300 respondents - health-care professionals working in selected health facilities and Group II, which also consisted of 300 respondents - residents, representing a broad spectrum of the general public. The age range in both groups was between 18-80 years.

ORGANIZATION AND IMPLEMENTATION OF THE SURVEY

Time period of the survey: from 13.9.2007 to 19.7.2009.

Location of survey: The survey was conducted in Bratislava and Trenčín Region (Bratislava, Pezinok, Senec, Považská Bystrica, Trenčín, Púchov) .

ANALYSIS AND INTERPRETATION

The results of our findings were processed by content analysis of the questionnaire items and expressed in absolute numbers and percentages.

DEMOGRAPHIC DATA

Table 1. Gender of respondents

Gender	Healthcare staff		Public	
	n	%	n	%
Men	135	45.00	156	52.00
Women	165	55.00	144	48.00
<i>N</i>	300	100.00	300	100.00

Table 2. Age of respondents

Age	Healthcare staff		Public	
	n	%	n	%
Less than 20 years	6	2.00	9	3.00
20 - 30 years	12	4.00	34	11.33
31 - 40 years	156	52.00	131	43.66
41 - 50 years	87	29.00	92	30.66
More than 50 years	39	13.00	34	11.33
<i>N</i>	300	100.00	300	100.00

Table 3. Education of respondents

Education	Healthcare staff		Public	
	n	%	n	%
Basic	0	0.00	19	6.33
Secondary	182	60.66	168	56.00
Higher	118	39.33	113	37.66
<i>N</i>	300	100.00	300	100.00

TERM KIDNEY TRANSPLANTATION

Table 4. Have you ever heard the term kidney transplantation?

Answer	Healthcare staff		Public	
	n	%	n	%
Yes	300	100.00	281	93.66
No	0	0.00	19	6.33
<i>N</i>	300	100.00	300	100.00

Table 5. Would you be willing to donate your own kidney during your life?

Answer	Healthcare staff		Public	
	n	%	n	%
No	3	1.00	38	12.66
Yes - only to relative recipient	133	44.33	23	7.66
Yes - to relative or to stranger	121	40.33	11	3.66
I did not think about it	43	14.33	228	76.00
<i>N</i>	300	100.00	300	100.00

Table 6. Would you accept, if necessary, a kidney from another person?

Answer	Healthcare staff		Public	
	n	%	n	%
No	11	3.66	31	10.33
Yes – only from relative donor	53	17.66	18	6.00
Yes – from relative or from stranger	32	10.66	24	8.00
I did not think about it	204	68.00	217	72.33
<i>N</i>	300	100.00	300	100.00

Table 7. Have you ever heard about the concept of presumed consent?

Answer	Healthcare staff		Public	
	n	%	n	%
Yes	189	63.00	18	6.00
No	42	14.00	174	58.00
I do not know	69	23.00	108	36.00
<i>N</i>	300	100.00	300	100.00

Table 8. Awareness of respondents about: Transplantation Act of the Slovak Republic.

Answer	Healthcare staff		Public	
	n	%	n	%
Yes	202	67.33	21	7.00
No	98	32.66	279	93.00
<i>N</i>	300	100.00	300	100.00

Table 9. Do you think the system of presumed consent applies to all countries of the world?

Answer	Healthcare staff		Public	
	n	%	n	%
Yes	37	12.33	8	2.66
No	114	38.00	96	32.00
I do not know	149	49.66	196	65.33
<i>N</i>	300	100.00	300	100.00

Table 10. Would you sign disapproval of donation of your child's kidneys in the case of their early death?

Answer	Healthcare staff		Public	
	n	%	n	%
Yes	0	0.00	39	13.00
No	108	36.00	94	31.33
I do not know	192	64.00	167	55.66
<i>N</i>	300	100.00	300	100.00

Table 11. Would you sign the approval donation of your child's kidneys in the case of their early death?

Answer	Healthcare staff		Public	
	n	%	n	%
Yes	188	62.66	43	14.33
No	11	3.66	31	10.33
I do not know	101	33.66	226	75.33
<i>N</i>	300	100.00	300	100.00

Table 12. Do you think that the number of kidneys donors is sufficient to cover the number of waiting recipients for kidneys?

Answer	Healthcare staff		Public	
	n	%	n	%
Yes – there is are enough donors	0	0.00	138	46.00
No – there is a shortage of donors	300	100.00	462	54.00
<i>N</i>	300	100.00	300	100.00

Table 13. Do you agree with the free kidney donation?

Answer	Healthcare staff		Public	
	n	%	n	%
Yes	229	76.33	173	57.66
No	71	23.66	127	42.33
<i>N</i>	300	100.00	300	100.00

Table 14. Have you about worldwide trafficking (business) in kidneys ?

Answer	Healthcare staff		Public	
	n	%	n	%
Yes	252	84.00	196	65.33
No	48	16.00	104	34.66
<i>N</i>	300	100.00	300	100.00

Table 15. Could you imagine selling your kidney during your life / would you donate your kidney for financial gain?

Answer	Healthcare staff		Public	
	n	%	n	%
Yes	1	0.33	18	6.00
No	113	37.66	43	14.33
It depends on the circumstances – I cannot answer this question	186	62.00	239	79.66
<i>N</i>	300	100.00	300	100.00

Table 16. Who pays for kidney transplantation?

Answer	Healthcare staff		Public	
	n	%	n	%
Patient by him/herself	0	0.00	41	13.66
Insurance agency	157	52.33	78	26.00
Partly recipient and partly insurance	71	23.66	43	14.33
I cannot say	72	24.00	138	46.00
<i>N</i>	300	100.00	300	100.00

Table 17. Would you agree with the introduction of xenotransplantation into practice (transplantation in which the graft comes from a different species than the man)?

Answer	Healthcare staff		Public	
	n	%	n	%
Yes	33	11.00	12	4.00
No	102	34.00	42	14.00
I do not know	165	55.00	246	82.00
<i>N</i>	300	100.00	300	100.00

Table 18. In case that your religion prohibits you to undergo kidney transplantation, would you reject a kidney in a situation threatening your life?

Answer	Healthcare staff		Public	
	n	%	n	%
Yes	12	40.00	45	15.00
No	167	55.66	177	59.00
I do not know	21	7.00	78	26.00
<i>N</i>	300	100.00	300	100.00

DISCUSSION

We found that 133 respondents (44.33%) from the health workers and 23 respondents (7.66%) of the general public would be willing to donate their own kidney, but only to a relative. Each group, did not exceed the 50% response rate - that is half of the respondents - except 'I did not think about it' responses of the general public which 228 respondents (76%) chose. In case of kidney donation to a stranger, the answers were significantly different. The basic respondents, formed by the medical staff, were 121 respondents (40.33%) about 11 times more than the general public, where only 11 respondents (3.66%) answered. From those survey results, we conclude that the general public has significant reservations concerning kidney donation. Comparing responses of the healthcare staff with the general public we found considerable differences.

We were surprised that only 204 (68%) respondents of health workers did not think about the possibility of receiving a kidney for their own health, while from the general public 217 (72.33%) respondents did not think about it.

Next, 53 (17.66%) of healthcare workers agreed with the option but only from a relative donor, while the general public response rate was 18 (6%) - three times lower.

Regarding health workers receiving a kidney from a relative of unknown (foreign) donor, 32 (10.66%) said 'Yes'. This was 24 (8%) from general public respondents.

The fact that the demand for kidneys (trans-

plantation) constantly exceeds the number of kidney donors is known by all the respondents of the 300 (100%) healthcare staff, while in the general public, almost half the respondents - 162 (54%) know. To our surprise only 138 (46%) general public respondents thought the number of kidney donors to be sufficient. We found significant differences in the general public awareness of donor numbers which is striking.

The most significant differences between the two groups were found in awareness of Transplantation Law.

Donation and transplantation must be strictly legislated and controlled by the state. In the Slovak Republic applicable legislation is based on the presumed consent system. Again strikingly, we expected the healthcare staff would approach a 100% awareness. Our survey shows that awareness of presumed consent is better known by the healthcare staff compared by the general public group, but not satisfactory. We have to judge it insufficient.

Those results of our survey showing that 93% of the interviewed general public are unaware and do not even know of this law which applies in their own country (the Slovak Republic) is striking. Further, awareness of our two groups about application for transplantation systems in other countries was similarly insufficient.

The fact is that the worldwide kidney trade was known by the majority of respondents in both groups 252 (84%) by the healthcare staff and 196 (65.33%) by the general public.

The survey, showed great differences in attitudes and views between health professionals and the general public on organ donation and kidney transplantation.

The greatest differences between health professionals and the general lay public were mainly in the knowledge of Transplantation Laws and in understanding the terminology of kidney donation and transplantation. We conclude that both groups of respondents have a generally positive attitude towards kidney donation and kidney transplantation, but we found some of the information was not sufficient.

Based on our findings, we do propose several recommendations for Clinical Practices, Educational Institutions and for regulatory authorities for health: The primary role of all health professionals is to maintain the health of all citizens. This is one of the reasons why every healthcare professional should know the basic information about kidney transplantation. They should also have sufficient knowledge of the legal norms of the Slovak Republic regarding kidney transplantation and donation. It is important that health professionals are actively involved in health education about obtaining kidneys for transplantation and in a just manner professionally and ethically explain to patients the possibility of kidney donation and transplantation. We note, finding suitable donors should be understood and that public awareness should be raised through media coverage of donation and transplantation of kidneys and as an approach to donation of kidneys for transplantation in its entire complex and comprehensive way. Because ignorance is a prerequisite for failure in terms of improvement of numbers of suitable donors and thus saving lives of patients waiting for renal transplant.

Improving of awareness among health professionals about the above addressed issues should be conducted in several steps: education for all categories of health workers (including professionals from other medical disciplines) through workshops about kidney donation and transplantation; available and regularly delivered medical professional information materials; explaining organ donation and kidney transplantation to all students of medical specializations, of nursing faculties, public health schools, students of healthcare high schools; in particular, during lessons on medical ethics and bioethics, nursing ethics, preventive and clinical nursing, biology and genetics, urology, transplantation, surgery, communication, etc. ...

Improving of awareness among the general public about the above addressed issues should be done in several steps: acquisition of citizens as potential organ donors should be an essential requirement for health professionals; in cooperation with the media to inform students in secondary and higher schools on legal standards related to organ transplantation in the Slovak Republic in the form of lectures and discus-

sions that should take place on Organ Donation and Kidneys Day; produce promotional materials - leaflets and posters in collaboration with the Regional Public Health on the issue of kidney transplantation accepted by citizens to let them know the legislative changes; the topic of donation and transplant of kidneys should be more frequent; deploy leaflets in Doctor's offices, waiting rooms, corridors and Polyclinic Hospitals, schools, shopping centers or concerts for youths; streamline and expand the media campaign "Kidney of gold" to promote interest in this issue through the media; engaging and establishing programs for the general population; to publicize interviews with personalities who dedicated their lives to helping suffering patients; talking with doctors, nurses; publicize interviews with patients and their loved ones who had a kidney transplant and whose lives have changed dramatically with full and immeasurably better quality of life; publicize interviews with kidney donors as to why they so decided, what was their motive, and so on; to establish, much like the already existing club, The Society of Transplant Patients, a new society of supporters with patients waiting for renal transplant, whose members would be citizens of the Slovak Republic touched by this issue; approach them and wish they would also engage in it, such as organizing cultural events with presentation of products from various companies and businesses supplying transplant clinics and departments (pharmaceutical companies producing immunosuppressive agents, companies producing equipment for operating rooms; presenting products for patients both before and after transplantation. Trustingly, members of the club could be potential sponsors indirectly as mentioned above, or in direct financial ways.

CONCLUSION

This issue has a legitimate place in modern medicine. Therefore, awareness to all the adult population is an ethical duty of all competent, medical personnel. Proposals that we have indicated above could improve the level of awareness for the general public and the professional and medical community regarding this issue, which is still - at present - a very sensitive. It is necessary to provide not only information, but also encouragement to donate a kidney to a dear/close patient as well as to a stranger in need.

Correspondence to:

Prof. Dr.. Ivica Gulášová, PhD.
St. Elizabeth University of Health & Social Sciences, Bratislava, Department of Nursing, Faculty of Public Health,

Slovakia

Mgr. Lenka Gornerová
College of Polytechnics, Jihlava, Department of Health
Studies
Czech Republic

MUDr. Ján Breza, PhD. jr.
Department of Urology and Radiology and Centre for kid-
ney transplantations, Kramáre University Hospital, Brati-
slava, Slovakia

Prof. MUDr. Ján Breza, DrSc.
Department of Urology and Radiology and Centre for kid-
ney transplantations, Kramáre University Hospital, Medi-
cal Faculty of University of Komensky, Bratislava, Slovakia

CROSS CULTURAL MARRIAGES: A CASE STUDY OF THE KENYAN COMMUNITIES.

Victor Wanjala Namulanda¹

1. St. Elizabeth University of Health and Social Work in Bratislava

Key words:

Cross cultural marriages, communities, case study, Kenyan

Abstract

Cultural diversity exists in many communities of the world. Cross cultural marriage becomes more painful when everyone who is important to you in your family or your partner's family rejects you or your partner. The purpose of this study was to explore and compare marriage relationship in terms of the racial origin of respondents, parental acceptance of matrimony, religion, HIV status and other factors that are likely to increase marriage instability. For the purpose of the research, 131 married respondents (male and female) out of 1,084 were sampled. The sampled population was specifically selected from clients who had sought HIV testing services at the Mary Immaculate Center, Nairobi. A case study method with semi-structural questionnaire: Open and closed ended questions was used to gather the data. The collated data was analyzed and presented in graphs and tables.

The findings from the study showed that majority of marriages within the same ethnic community tend to live up to their expectation due to shared cultural value and beliefs though there could be a few case of misunderstanding among the couples unlike the marriages from different ethnic communities or race which in most cases easily end up in separation or divorce. The findings further indicate that many people hide in religion as ceremonial believers but do not subscribe to religious values to uphold the institution of marriage.

Therefore, I believe that retrospective cultural beliefs and individual values should not be dragged into marriage thereby destroying it, later leading to moral decline of the institution of marriage. It is upon courting couples to share their cultural values in advance in order to make marital adjustments before committing into marriage.

INTRODUCTION

Marriage is the fundamental institution of any society in the world. It is a universal social institution through which an adult male and female are permitted by social custom or religion to engage in an intimate relationship. Marriage usually involves relationship and may perpetuate it to meet mutual, reciprocal sexual, emotional and material need across the marital life cycle (Uddin. 2009).

There is no marriage without culture. Marriage and culture go hand-in-hand which can be positive or negative to the couples involved. It either strengthens marriage or breaks it from those who hold on to strict communal beliefs, norms or behaviors. The beliefs can be based on the community of origin, geographical area, religion and individual values. Each community has its traditional practices that guide it: especially, who to marry (tribes), where to marry (geographical), family status (socio-economic) and how it should be done (church or customary marriage).

Globalization has brought a lot of changes through socialization and education. But cultural values are still enshrined in people and it has been hard for people to do away with them. 'It is part of human genetics'. Therefore, these values are dragged into marriages and married couples who don't subscribe to the practices of the community end up separating or divorcing. It is no longer governed by elements of commitment and trust by the couples. Meaning that marriage has been reduced to just a nice social custom of celebration through church weddings or legal arrangements in the Attorney General's Office which in the end don't stand the heat of the test. In most cases, cross-cultural conflict revolves around the authority of our parents, financial decisions, and social interaction (Arnold, 2008)

A stable marriage, according to Van Pelt (2008), is that marriage in which there is an exclusive union between one man and one woman, publically acknowledged, permanently sealed, and physically consummated.

A marriage begins with the selection of the perfect partner of his/her choice and their delight in being together, doing things together, and sharing together. Along the same line, Chris Hart (2010, p.7) writes that true love entails commitment between partners. The partners place each other above all else and your partner's security and comfort is as important as your own. He goes further to say that partners must have deep emotional intimacy, meaning that they have to share their thoughts together without fear of embarrassment and that both of them are caring about each other's feelings and happiness.

The above unioning cannot just happen in a vacuum. There must be standards/rules, and these will be beliefs, norms, behaviors and community values that will spell out do's and don'ts. These then are passed on to the next generations through the language, customs, beliefs, attitudes, values goals, laws, traditions and moral codes (Bauwens and Anderson, 1992, p.19-92).

Culture is created by man and is not static. The community offers communal standards which can have a negative impact on family members and these limit the choice of partner to marry. If one defies these communal values, most likely some members of the family will reject the partner married. In most situations, neither our parents nor our respective churches

nor our college education ever prepare us for what we ultimately find most challenging concerning marriage choices (Arnold, 2008).

Couples would like to direct their difficulties to God for a solution, and these force one or both members to join a certain religion. This is because religious laws or ethics emphasize the importance of marriage as a God given institution that should be respected by those who decide have a family. Religious teachings direct people to respect marriage institution as a God given institution. But religion in itself has limitations, and has failed to offer a solution to marriage problems. Even religious marriages that are expected to stand the commitment trial of marriage because their foundation is based on religious morals do break. Religious marriage has become a social event where relatives and friends converge to celebrate when two are wedded. But after the event, (after consummation of the marriage) the long journey after walking down the aisles begins. Van Pelt (2008) says that at some point in life, relationships do have droughts or dry spells. And growth, at some points stops; boredom sets in; it becomes stale; romantic feelings fail during these tough times; and sex is no longer important either. Not even material possessions may mean anything. In summary, Culture can be a recipe for marriage stability or for breakage to those who cannot adjust to the changing circumstances which will therefore challenge the purpose of marriage.

METHODS

Mary Immaculate VCT center, a St. Elizabeth University project provides HIV/AIDS counseling and testing services to city residents of Nairobi. A total of 1,084 married people attended the Mary Immaculate VCT in 2012, and out of this number, 131 respondents (male and female) were selected. A case study with a semi-structural questionnaire both open and closed ended questions were used to gather information which was analyzed by use of Excel and the summation was presented in form of graphs and table.

RESULTS

The study focused on ethnic background, parental rejection of matrimony, religious beliefs, and HIV status of the sampled population. 131 respond-

ents, either in marriage, separated or divorced were interviewed. That is to say 79 (60%) females and 52 (40%) males participated in giving information as follows:

Figure 1. A comparison of marriage stability and ethnic background of the respondents.

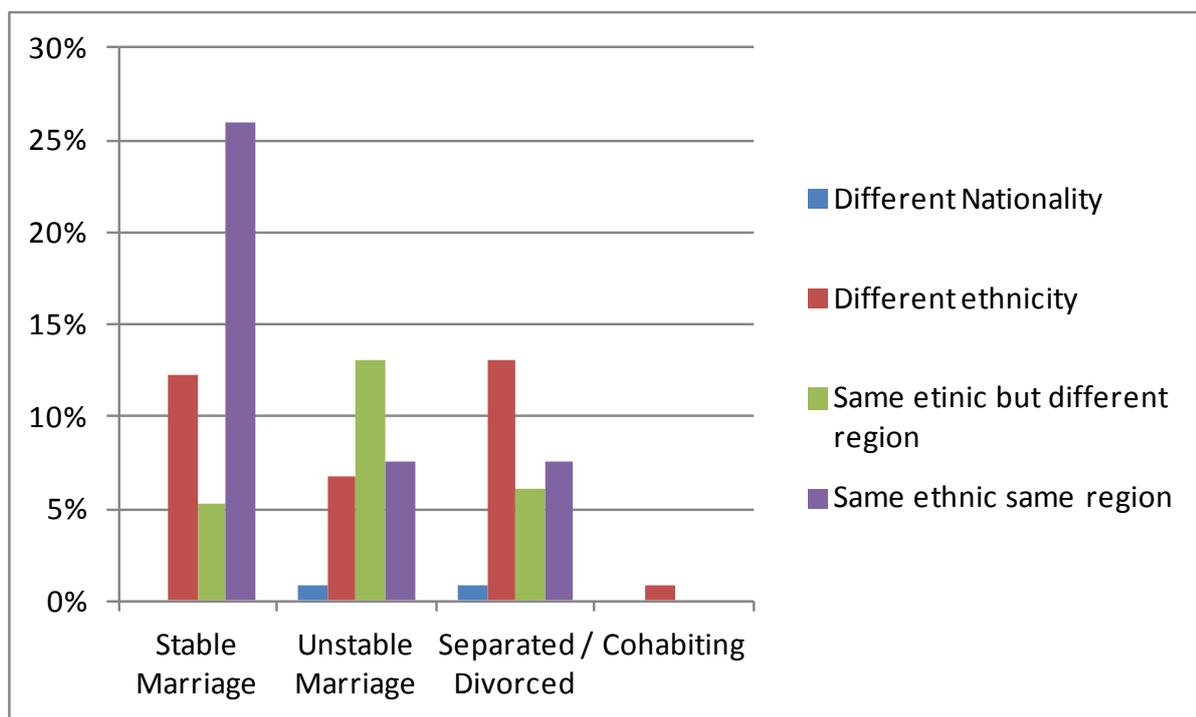


Fig. 1 shows a comparison of respondents according to stability of their marriage, ethnicity and region. Most of the respondents were in a stable marriage 43.5%; followed by 28.2% from unstable marriage; while 27.5% were separated/ divorced; 0.8% were cohabiting. According to Figure 1, 26% of those in stable marriage were from the same ethnic community; of the 43.5% in stable marriage, 26% were from the same ethnic community in the same region.; 12.2% were from different ethnic communities; 5.3% were from the same ethnic community but different county/region.

Of the 28.2% from an unstable marriage, 13% were from the same ethnic community but different county/region; 7.6% were from the same ethnic community from same county/ region; 6.8% were from a different ethnic community; 0.8% was from different nationality; 27.5% of those had separated or divorced, 13% were from different ethnic communities; 7.6% were from the same ethnic community in the same county/region; 6.1% were from the same ethnic community but different county/region; 0.8% were from different nationalities; lastly, 0.8% of the respondents were cohabiting.

Fig. 2 shows the comparison of marriage with couple's parents objecting or supporting Marriage. From the figure, the couples who's both sides of parents accepted their matrimony, 36.2% of the couples were in stable marriages; 11.5% of couples were in unstable marriages; 10.8% of the couples opted to separate or divorce due to individual, incompatible differences.

But in circumstances where the parents of couples objected their matrimony, for example, from parents of the men, 8% had separated/divorced, while the remaining 8% were in unstable relationship, with only 3% being in stable marriage. While on the side of the women's parent objection, 6.9% were in unstable relationships, 6.2% had separated/divorced; 3.8% were in stable marriage. And lastly, with both sides of the parents objecting to the marriage of their children, 2.3% were separated/divorced; 1.5% were in unstable relationship; 0.8% of the respondents were in stable marriage.

Figure 3 shows the comparison between religious affiliation and marital status. It was found that many of the married respondents 46.5% were Ceremonial Christians; 34.4% were professing different religions; 11.5% were devout Christians; 4.5% were

Figure 2. A comparison of marriage stability with parent's objecting to their matrimony.

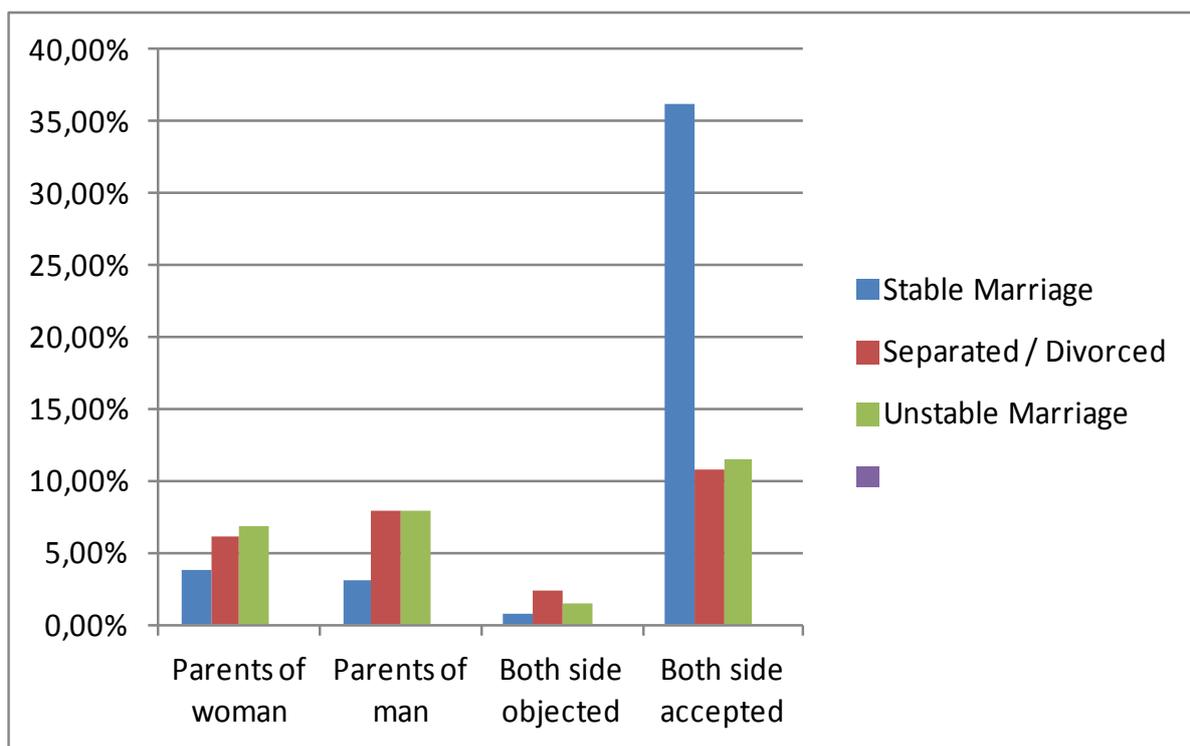
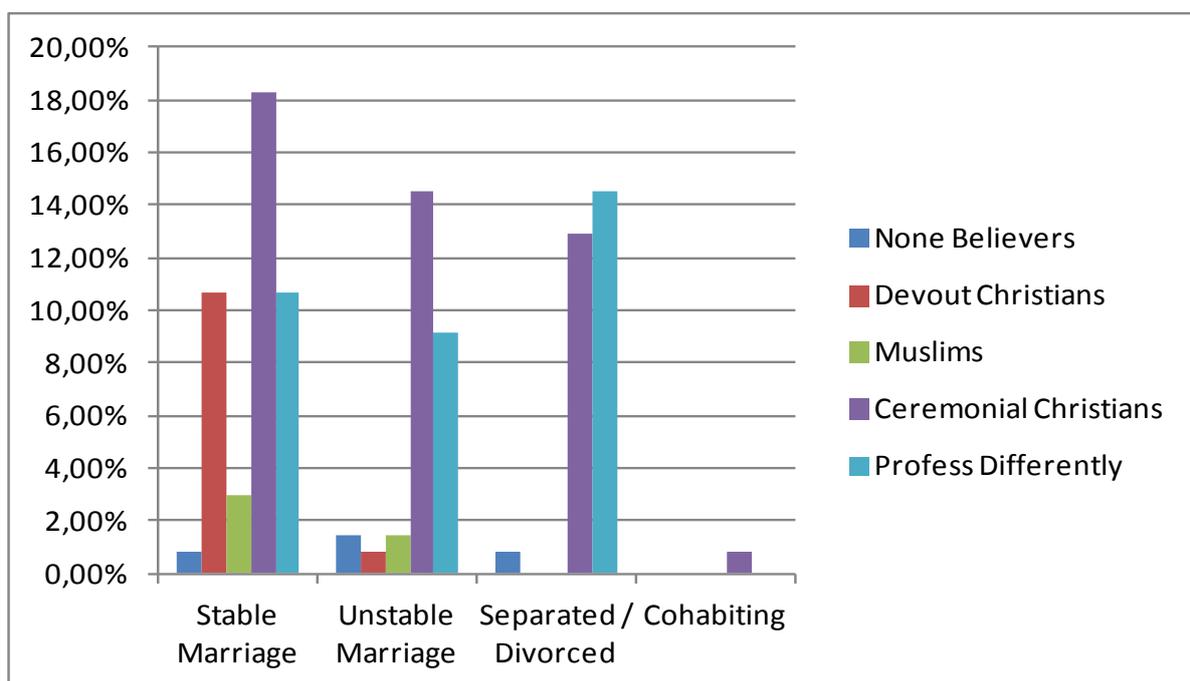
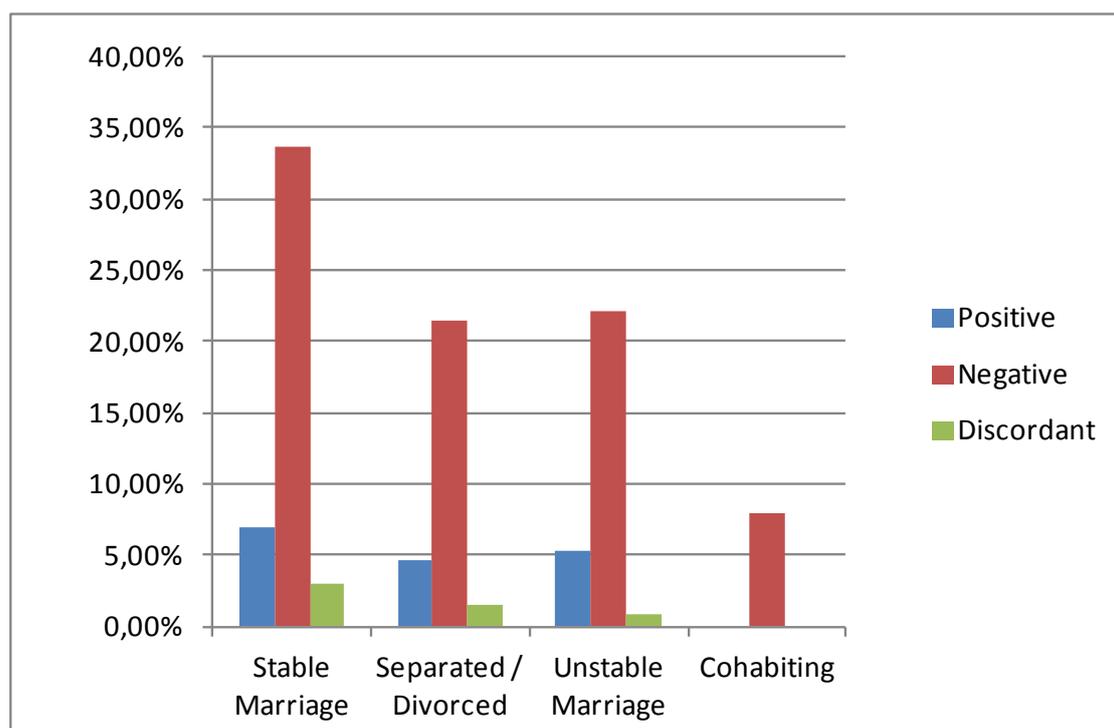


Figure 3. The frequency of religious beliefs of respondents in marriage.



devout Muslims. The total percentage of those in stable marriage was 43.5%. And of these, 18.3% were ceremonial Christians, as devout Christians; those professing different religions were 10.7% each; were devout Muslims; 08% were non-believers. 27.5% who had separated/divorced, 14.5% were ceremonial Christians; 9.2% professing differently, as non-believers; 1.5% each devout Muslims; 0.8% were the only

devout Christians. But in unstable marriage 28.2% of the respondents, 14.5% were professing different religions; 12.9% were ceremonial Christians; 0.8% of the respondents were non-believers.

Figure 4. A comparison of HIV status with marital status of respondents.

The figure shows that 33.6% of the respondents were negative in the stable marriage; 22.1% were negative in unstable marriage; while those that had separated/divorced were 21.4% negatives; cohabitation was 0.8% of the respondents were negative in that order. But those who had contracted HIV virus 6.9% were from Stable marriage; 5.3% from unstable marriage; while 4.6% of the respondents were from those who had separated or divorced. But the discordance was as follows: 3% were from the stable marriage; 1.5% from those that had separated /divorced; 0.8% from unstable marriage.

Table 1. Frequency of factors contributing to marriage problems.

Factors	Frequency	%
Unfaithfulness	57	54.30
Alcohol	8	7.60
Sickness	8	7.60
Infertility	6	5.70
Relative Manipulation	26	24.80
Total	105	100.00

The majority of the respondents 54.3% cited unfaithfulness is the major challenge of marriage stability; 24.8% pointed out the issue of control of marriage by relatives; 7.6% cited sickness and alcoholism as some of the factors also affecting the stability of

marriages; 5.7% mentioned infertility as one of the greatest problems in marriage.

DISCUSSION

The determinant of the stability of marriage in any given society/community is based on the ethnic diversity of the couple, educational background of the couple, occupations, political systems of the country and the financial status of the family. At the time of courting, the above factors tend to be ignored, as it said that before marriage the opposite always attracts and after marriage the opposite detract.

The result of the study showed that couples who marry from the same ethnicity tend to be stable. Even though they may experience individual problems, the couples could persevere as compared to marriages from different ethnic groups or nationalities which are most likely to end up in separation or divorce. Additionally, couples will not be satisfied with one another if separation or divorce won't happen. Supporting the point, (Koteskey 2010. P.28.) writes that Cross-cultural marriage adjustments often are more difficult than those in which both husband and wife are from the same culture. He recommends that all husbands and wives work through differences between them as individuals, then between their families of origin in that one marries a whole set of fam-

ily traditions and expectations, not just an individual. And lastly, the couple has to work through not only individual and family differences but also the much deeper cultural differences.

The findings of this study indicate that marriage among a couple that is accepted or blessed by the parents is most likely to remain stable despite the few challenges the couple could face. In addition to this, in case of problems among the couple, the parents are ready to settle the differences to save the marriage, unlike where the couples entered in matrimony without the parent's acceptance or blessing, there is little parental intervention and most likely the marriage will end up in separation or divorce. Reasons could be parents wanting to preserve their communal cultural diversities and not be influenced by imported cultural values of other communities or nationalities. Secondly, they are concerned about the educational backgrounds, occupation and financial stability of the other partner their son/daughter is to marry. Some parents say that a good woman/man with good education from a good family to marry with a poor man/woman is so disappointing. Couples who defy parent's advice are excluded from the family/community. This could lead to either one or both made uncomfortable or discriminated in the community. When couples experience marital challenges, the past always plays back, e.g.

'I wish I would have listened to my parents.

Home is always best. My parents had good reason as to why I shouldn't have married this man or woman. My marriage was cursed.'

Sometimes when one desires to marry, the worry is big questions: Will my parents, relatives, brothers or sisters support my choice? How do I feel about their apprehension? Will it have a negative outcome in future? Have I compromised my values because I hope things will be better?

Kenyan politics is tribal based and very polarizing. And this has strained many marriages from living up to expectations during elections. Kenya has more than 42 tribes and these tribes are confined regional/geographically being ethnically identified by political systems and cultures. Community relation is strained due to ethnically charged competition which is coupled with culture. For instance, when the aspir-

ing presidential candidates come from the two competing communities, the couples from the opposing communities are always in conflict. The politics is extended even in the household. For instance, there is always frosty relationship between Luos and Kikuyus couples, Kikuyus and Kalenjini couples. When a Luhya is married to a Kikuyu or vice versa, their marriage is always in shambles. The same applies to other tribes like Kalenjini from the Rift Valley, Mijikenda from the coastal region marrying other tribes from other regions. Those who have gone against the odds, end up separating or divorcing because of acrimony during times of elections. This has been one of the reasons many Kenyans fear marrying outside their tribe. When domestic violence sets in marriage, it becomes unacceptable, uncomfortable not accommodating to either of the couples leading to emptiness which could result in unfaithfulness in marriage where by one partner is excluded in terms of socializing with the rest of family members. In addition, there is no collective decision on matters touching family life. The outcome could be one partner wanting to get into another relationship for emotional support to deal with the emptiness or loneliness. It is true therefore, as Harold L. Arnold, (2008) says clearly that, 'Culture influences nearly every important aspect of marriage.' This study further indicates that most couples were not true believers. The results showed that most were ceremonial believers (church goers) 46.5%, and a good number of them 34.4% were professing differently as a couple; few of devout believers - 11.5% among the Christian; 4.5% among Muslim couples. Religion plays a pivotal role in holding marriage together. But again this depends on values system about marriage in denominations. Religion is about behavior, how one should conduct himself/herself. It is about how one should relate with the rest of the people within and outside community practice.

Religion brings sanity between its members that makes the family, community/society good and extending them to be good citizens of that country. One has the freedom to choose whoever to associate with, which begs the question: Under what circumstance should this freedom of worship be applied in marriage? Is it worthy for the couples to worship differently? How about the children - which side should they join? The world has many denominations with varying doctrines or teachings, rituals and beliefs.

Some religions uphold or believe in family values, some not. And, religious enculturation by couples could break or sustain marriage when individual values are unmet. But the question is, is it worthy for a sincere and devout Christian to marry someone who does not share or even rejects the same faith?

Religious differences/doctrines could break marriage completely to couples experiencing tough, trying moments due to individual value or beliefs. Even marital counseling will be impossible where couples seek support to salvage their marriage because:

1. The marriage bond between the couple is weak as they have different beliefs or values that do not strengthen their relationship. This can lead to easy separation or divorce.
2. Decision making becomes difficult and this could affect the children, because children cannot decide which side to join. Therefore, future repercussions for children could be poor development in terms of questionable personal morals, passive members or non-believers by not identifying themselves with any religion.
3. The religious differences among couples could also lead to either one or both becoming ceremonial believers or completely stop from associating with any denominations. And, this affects the morality of the family in totality.

The finding from the study further showed that there were more HIV positive status in stable marriage indicating that even if one is in a stable marriage that doesn't mean that partners are faithful to one another. Another factor is that discordant cases (one partner is HIV positive and the other one negative) were in all types of relationships. But, the challenge is how will the positive partner protect the negative partner from contracting the virus in the situation where religion, especially Muslim, and some Christian, advocates against condoms by followers?

Marital problems could also arise with infertility in couples who desire to have children. African people value children born to two parents in marriage for the continuation of the community and not by adopting. But in cases of infertility, the couple will start to blame one another and this could result in separation/divorce. Especially in the Luhya, Kisii or Luo people, infertile women will be subjected to

abuse, insults and rejection making it hard for them to survive the harsh environment.

In conclusion, the study found that there is high probability of the married couples to separate or divorce due to origin, ethnic diversity, race, religion and economic status.

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Correspondence to:

Victor Wanjala Namulanda, Mgr. PhD.
Mary Immaculate VCT Centre. Nairobi, Kenya
P.O. Box 17837 -00500. Nairobi.
Email: vinamu2001@yahoo.com

COMPLEXITY OF THE WORK OF NURSES IN HOSPITAL AND HOSPICE

Vlasta Dvořáková¹, Lada Nováková², Radim Křivák³

1. College of Polytechnics Jihlava
2. Havlíčkův Brod Hospital
3. Faculty of Natural Sciences, Comenius University Bratislava

Key words:

Burnout syndrome, Hospice, Patient, Hospital, Nurse

Abstract

The occupation of Nurse is demanding and requires working with an empathic approach. A false belief often arises that anyone who wants to be a good medic and help other people, must be able to suppress his/her own needs at the expense of the needs of patients and must be able to quickly adapt to stress and to conceal her/his own feelings. But the truth is that for a Nurse to give a good performance, she actually, first, must be in good mental, emotional and physical condition; must be refreshed; full of strength and energy. Nurses working in Internal Medicine Wards and Hospices are constantly confronted with suffering of the sick and dying so Nurses themselves may often feel mental fatigue and burnout.

INTRODUCTION

Suffering has always been, is, and will be present in humanity and therefore, it is extremely important to treat suffering as part of the human condition - life. Everyday, Nurses are confronted with suffering of various kinds and degrees and do their best to alleviate its symptoms. Czech Medical Healthcare is rather focused on the physical side of a patient and does not address, at all, other Holistic aspects – the mental, emotional and spiritual as is often done by nursing care professionals. The opposite is actually true. These other aspects affect Nurses, as much as they relate to a patient about whom we care.

Sick people usually reside in a Department of Internal Medicine or a Hospice for quite a long time. They are mainly elderly patients, but such Internal Medicine diseases as multiple sclerosis and cancer affect an increasingly younger generation of our population. At a Department of Internal Medicine and a Hospice, patients suffering can occur to a relatively large extent if not prevented. We may also notice that in Hospices there is a space for the appearance of all areas that relate to suffering: physical, psychological, social and spiritual (Šafránková, Nejedlá, 2006, Kle-

ner, 2011).

SUFFERING OF PATIENTS

"Suffering is the specific situation of great difficulty, due to the loss of integrity of the person or the threat, which leads to the cancellation of the holistic concept of man. Suffering lasts as long as the integrity is not recovered." (Munzarová, 2005, p 75). Suffering, illness, pain, dying and death can be inevitable progressions in life. No disease can progress without some suffering. Suffering is not only the undesirable accompaniment of disease, it is an integral part of every human existence, therefore there is no hiding from it. Human life has always been and will be linked to all sorts of misery. Therefore, the question arises of how suffering at different times and people was accepted and the role that people attributed to it (Hrozenska, Kasanová, 2011, Rokyta, Kršiak, Kozák, 2006).

DYING AND DEATH

Suffering, dying and death are highly

complex and challenging topics that are taboo for most of contemporary society, and therefore, discussions on these topics are preferably avoided. But, we must remember that questions of life and death are closely related (Hrozenská, Kasanová, 2011, Kelnarová, Matějková, 2010).

A terminal condition and dying are personal processes of gradually failing vital organ function. According to the authors Kelnarová and Matějková (2010), **dying begins at the moment of our birth**. It is an irreversible condition that is variously long; experienced in many forms; leading eventually to death. Death is a part of our lives as well as its beginning - birth. Death, determined by brain death, means cessation of human form and therefore recovery of vital signs is futile. The inevitability of death is a certain reality (Hrozenská, Kasanová, 2011, Kelnarová, Matějková, 2010).

The period of dying is often characterized by isolation, disappointment, pain, but also by confidence, faith, hope and fear for loved ones pain of loss, and searching for some spiritual point of view. Dying is the suffering of separation from one's own deepest self which is experienced as fear of the unknown and the loss of meaning. It induces human feelings of anxiety and fear that are intertwined. People tend to fear death because they are afraid that it will hurt; that at in the moment of death they will remain entirely alone; of their own failure to die (that they will not make it); that they will lose their dignity; that they will not complete the work they started; fear for their family. In fact, all this fear is of the unknown, of the power of death and that everything will end forever (Hrozenská, Kasanová, 2011, Munzarová, 2005).

According Kübler-Ross (1995), a dying person and those closest go through five stages, where they mentally reconcile with the progression of an incurable disease that leads to death; gradually come to terms with the knowledge that as strength wanes life is over. A dying person alone can no longer affect the actuality of his/her death; loses strength and motivation to fight for another day of life because of a awareness of his/her physical, psychological, social and spiritual problems; hopeless situation; loss of all prospects (Janáčková, 2007, Kelnarová, Matějková, 2010). Suffering in the final stage of a disease is incorrectly considered as useless and without sense, but it is useful and valuable for human dignity. *"A human has*

his dignity, because it is human. He can not lose it due to his illness." (Munzarová, 2005, p 12)

The aim for Nurses should be to ensure that a patient dies in dignity, i.e. to reduce suffering and eliminate pain and loneliness; of bringing hope by all possible means; allowing the dying person to live fully filled with moments of consciousness despite the approaching end of life (Munzarová, 2005).

It is of utmost importance to put dying and death into natural human perspective where understanding and love reduces pain and eases a way out of this world. A dying person needs the presence of loved ones; to maintain his dignity as was the case in the past when people died at home in familiar surroundings witnessed by loved ones who honored them. Today, the opposite is true. People in their dying stages are often abandoned, cast out, "deferred". Mostly this happens in hospitals when the family does not want or is not able to be at their bedside for unlimited time as is encouraged in Hospices. In hospitals there is reduced contact between a dying person and relatives; one dies in solitude or in the circle of medical professionals – strangers; relatives are not allowed to properly say goodbye to the dying; have no time for grieving (Hrozenská, Kasanová, 2011, Munzarová, 2005).

As medics, we see the face of death quite often; every day we learn it to reinforce a professional rationale. The reason is uncertainty as to how to accompany and how best to ethically treat a seriously ill or dying person (Kelnarová, Matějková, 2010). Meeting the bio-psycho-social and spiritual needs of a dying person helps to facilitate the departure from this world. A Nurse should be able to "accompany" the patient in his death, i.e. to accompany him/her on the road to reconciliation with loved ones; his own mortality; help with questions about the meaning of suffering and the meaning of life, in general; avoid emotional indifference to dying. If a patient feels the need to resolve inner affairs, but is not able to do so alone, our job is to help him in that; just to listen; to hold hands; to stroke his face; to talk; to try to understand; respect; stay in the presence of his closest; help to create proper conditions (privacy, silence, the chapel, presence of a divine service); or, preferably, to allow to be in a familiar environment; summon a Priest or a Psychologist, if he wishes; to try to ensure overall patient satisfaction. It is necessary for all Healthcare professionals to welcome

conversations about a rewarding life as well as about impending death; to bring hope to dying; to encourage the importance of good deeds done for loved ones and strangers during life; to assure that all conflict and misunderstanding can be remedied by understanding. It is expected that the family will support him; show love and gratitude for all received; resolve arguments and misunderstanding; help to organize unfinished business (Munzarová, 2005, Svatošová, 2012).

"The process of dying brings with it a range of challenges - long lasting pain and suffering for some dying, but also problems for witnesses, for relatives and caregivers and Healthcare professionals" (Kelnarová, Matějková, 2010, p 121). At the same time, dying gives hope for peacefulness until the last moment; quality departure from this world with minimal pain; and, especially, close sharing of remaining time between loved ones. With death, life is not meaningless. It allows us to take best advantage of as much "given time" as possible. The dying person who goes forward calmly toward death, may finally find the answer to the question: What is the meaning of life? (Kelnarová, Matějková, 2010).

BURNOUT SYNDROME

The term "burnout syndrome" was first used by Herbert J. Freudenberger in 1974 in USA. In general, burnout is described as a state of physical, mental and emotional exhaustion of a person, resulting in a prolonged and excessive exposure and persistence of individuals in stressful conditions which are for the person emotionally, physically and mentally extremely challenging. "Helping professions" suffer most from burnout syndrome characterized by high levels of intense labor; constant contact with people; dependence on evaluations from other people, medical staff - Nurses and Physicians (Bartošiková, 2006, Opavský 2011).

NURSES' WORK LOAD

Stress, high levels of intense labor and excessive duties on Nurses result in the occurrence of burnout. Nurses in their work encounter numerous diverse work loads.

PHASES OF BURNOUT

Actual burnout is the result of a long slow process:

Zero phase (pre-phase) - enthusiasm: the joy of work; our work has a certain sense; a medic has great expectations; ideals; what works best; has an abundance of ideas; sees a clear goal of their work; trying with all strength leads to overloading.

First phase - stagnation: loss of enthusiasm; individual reduction of his ideals; trying to meet all the requirements; efforts tend to be undervalued

Second phase - frustration: Healthcare imposes too many requirements that cannot be met; vanishes meaning of work; lack of energy; an individual feels that he/she does not manage anything; work begins to lose the system

Third phase - apathy: works just to get money for necessities of life; sees job as a source of livelihood; does just what "must" done; avoids communication with patients; has feelings of helplessness and hopelessness

Fourth phase - burnout: irritated by mere contact with a patient; loss of respect for other people and self; indifference; apathy; loss of sense of life; loss of professional interest; all enthusiasm fails from overall fatigue, frustration, fatigue. (Venglářová, 2007, 2011)

MANIFESTATIONS OF BURNOUT SYNDROME

Burnout is a state of exhaustion in three different areas based on chronic stress which incorporate various symptoms of this syndrome:

a. Physical exhaustion: Symptoms include chronic fatigue; loss of energy; pain in muscles, joints and spine which are manifested as pain throughout the body; breaking, a sense of physical weakness; changes in eating habits related to change in body weight; often ill; tires easily; appears excessively sleepy but in case of burnout does not rest; sense of guilt and failure.

b. Mental exhaustion: Shows a negative attitude to self and others; changes in lifestyle. For a person who is mentally drained there is pessimism; depres-

sion; anxiety; even thoughts of suicide may occur; a negative attitude - everything is wrong; does not want any changes or "novelty"; hard to concentrate; forgets; a dampening of all activity; sees no meaning in work, and later in life, the more stereotyped the job; routinely observes human nature and creativity.

c. Emotional exhaustion: Emptiness; emotionally exhausted; emotionless; experiencing a feeling of not knowing how to help others so will not solve any of their problems, worries and misery; losses empathy, sensitivity, friendliness; tries to avoid people; isolated from them and closes in on self; changes in social contacts at work and in personal life; pleasure of the company of others fades; family and friends perceived as an add burden (Bartošíková, 2006).

Manifestations of burnout are reflected in the private life of a medic, but also have an impact on the quality of services provided to sick patients. Early recognition of the first symptoms of burnout is the responsibility of management and managers (Opavský, 2011).

PREVENTING OF BURNOUT SYNDROME

Burnout can be prevented: feel a commitment to work, but it should not be our only goal; vary procedures; be ready for risks of a nursing profession; have awareness of the possibility of burnout syndrome, keep in good physical condition; know the self (self-knowing), love each other; meet personal needs (care of self, rest); take time for self; have hobbies; not carry work home; maintain good relationships with the people (especially the closest ones); be willing to ask (eg colleague) for assistance when help is needed; not seen as failure, our life will have meaning; live by ethical values; see live has meaning; set out specific, and mainly realistic and attainable goals wanting to be achieved in life (Bartošíková, 2006, Venglářová, 2011).

Question: How is it that Nurses in Hospices for the dying work lasts for years without burnout? It's a fact that Nurses are not only devoted to nursing procedures for patients, but also to supportive services as company. To "Accompany" a patient means to assist him in his search for the meaning of life; to help solve interpersonal conflicts; help by understanding mistakes and injustices of others or his/her own

(Svatošová, 2012).

HOSPICES AND RESPONSIBILITIES OF A NURSE IN A HOSPICE

In the Middle Ages Hospice was defined as a shelter or refuge for travelers, elderly and poor (rest houses). Hospital for the Dying, later called Hospice, originated in the mid-18th century in Dublin and Cork, Ireland, but significant development came in the 1960s in Great Britain and the USA. Thanks for the Hospice movement is owed to Dr. Cicely Saunders, who founded the UK Hospice of St. Christopher becoming the Founder and representative of comprehensive Hospice and palliative care promising help for the dying and their families. According to the World Health Organization (WHO) palliative care is the treatment and care of patients whose disease cannot be healed by curative treatment. It focuses on relieving of pain and other suffering, treating the symptoms of an incurable disease and broadening to addressing psychological, social and spiritual problems of patients (Haškovcová, 2007).

"Hospices are standard and specialized providers of palliative care." (Haškovcová, 2007, p 44). Hospice is a medical facilities, which emphasizes an holistic approach, providing assistance in the social field, not only for hospitalized patients and their loved ones, but also for survivors in the context of the dying and death of their loved ones. The main mission of Hospice is to help and to serve. It is based on respect for human life and respect for a person as a truly unique being. Hospice facilities ensure patients they will not suffer excruciating pain; they will respect their dignity in every situation; they will not be alone in the last moments of life. Hospice care for dying patients is the concentration of all resources to ensure the best quality of life and a good death (Marková, 2010 Svatošová, 2003).

A HOSPICE CANNOT REPLACE A HOSPITAL AND A HOSPITAL CANNOT REPLACE A HOSPICE

At a certain stage of a disease staying in hospital loses its meaning for care which is only offered in Hospice. We distinguish three forms of Hospice care - Home Hospice Care, Stationary Hospice Care and

Inpatient Hospice Care, where patients who cannot due to their condition be at home or in a care center are hospitalized. Effort is made to make patients feel more like home than in a hospital environment. Hospice visits are very welcome for their involvement in care for a seriously ill or dying person. Therefore there is unlimited opportunity to visit patients 24 hours a day. Involvement of family members in a treatment process is of great value not only for the patient but also for family. A family gets a good feeling that they did not fail and did their best for a peaceful and quiet departure of their loved one. A Doctor usually decides about admission to Hospice based on medical indications of patients. Admission to Hospice is also possible by written informed consent of patients who independently decide for Hospice because they need palliative care, but do not require hospitalization, and home care it is not enough. Preference is given to patients whose disease will die soon. Hospice was designed especially for those patients, for example, people with cancer for whom curative treatment is no longer effective (Marková, 2010 Svatošová, 2003).

A great emphasis is given in Hospice on the quality of life of a patient - quality until the end. The unique quality of nursing care lies primarily in the art of staff to "accompany" a patient, his family and later survivors to understand the meaning of suffering. It mainly consists in choosing suitably motivated staff and the possibility of their further education (Marková, 2010 Svatošová, 2003).

DEPARTMENT OF INTERNAL MEDICINE AND JOB DESCRIPTION OF NURSES

Department of Internal Medicine is an integral and essential part of hospital Departments, including Surgical, Pediatric and Gynecological and Obstetric Departments. IM deals with issues of prevention, clinical picture, diagnosis and treatment of diseases of internal organs. Internal Medicine is a basic medical discipline dealing with issues relating to internal diseases from which over time gradually developed other similar disciplines. This specialization has brought with it many disadvantages: loss of ability to interact; bilateral links between different disciplines; lack of an holistic view of a patient. However, to analyze the causes of a disease it is necessary to reverse synthe-

size for the most appropriate treatment. At the same time, despite this fundamental division, multiple access policies to a patient remain the same. Long term, chronically ill, elderly patients and the elderly are hospitalized at a Department of Internal Medicine. This implies considerable importance of the competence of medical personnel, including strong demands for nursing procedures for which general Nurses are primarily responsible. Comprehensive nursing care is exercised through nursing procedures. Actual care must be exercised in accordance with ethical codes. A Nurse must also follow the charter of patient's rights and adhere to standards of work that are different at each hospital. From physical and psychological points of view, care for patients at a Department of Medicine is very burdensome for Nurses (Šafránková, Nejedlá, 2006, Klener, 2011). It is necessary to respect the needs of patients: "*The needs are also in the focus of interest of other specializations because their satisfaction is very closely related to human actions and endeavors*" (Kopáčiková, Cetlová, Stančíak, 2012, p 77).

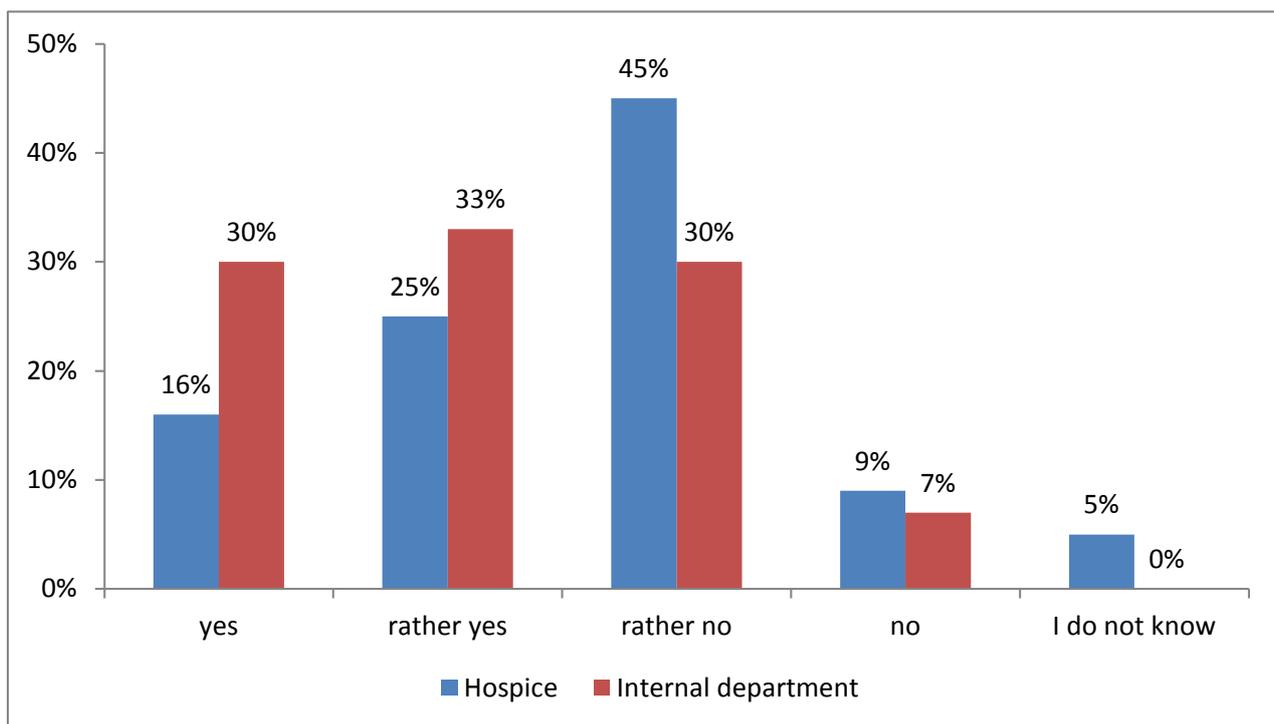
THE METHODOLOGY AND RESULTS OF RESEARCH

The research focused on the detection of performance of Nurses at two Internal Medicine Departments in two hospitals and two Hospices. 120 surveys were sent, out of which 101 respondents returned the questionnaires.

Out of the 44 interviewed respondents from Hospices, 7 (16%) think they are mentally exhausted, 11 (25%) marked "rather yes", 20 (45%) answer "rather not" and 4 (9%) indicate they do not feel mental exhaustion. 2 (5%) do not know if they feel mental exhaustion.

MENTAL EXHAUSTION OF NURSES

Figure 1. Mental exhaustion of Nurses

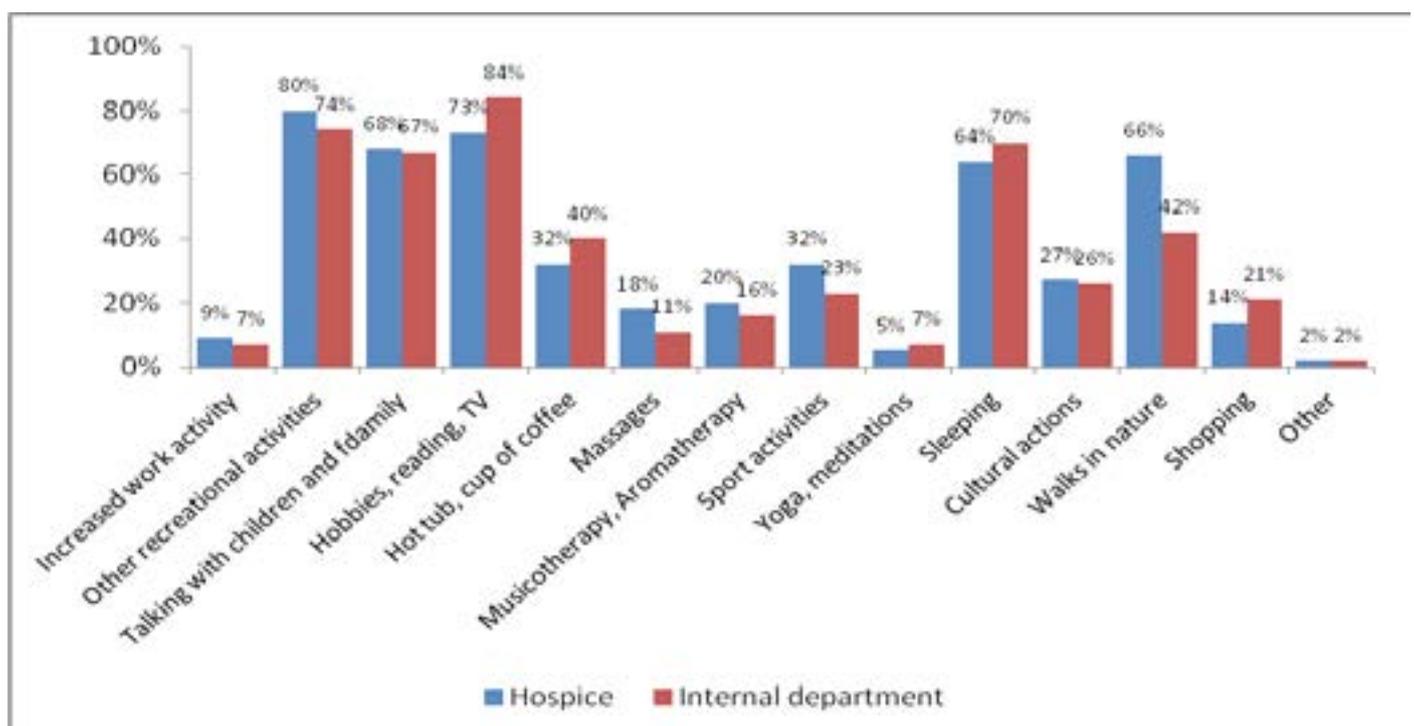


ACTIVITIES TO ESCAPE FROM MENTAL STRESS AND SUFFERING

(33%) answer “rather yes”, 17 (30%) response “rather not” and 4 (7%) did not think they were mentally exhausted. In the Internal Medicine Department none answered “I do not know”.

Of 57 respondents from Internal Medicine Departments, 17 (30%) think they are mentally exhausted, 19

Figure 2. Activities to escape from mental stress and suffering

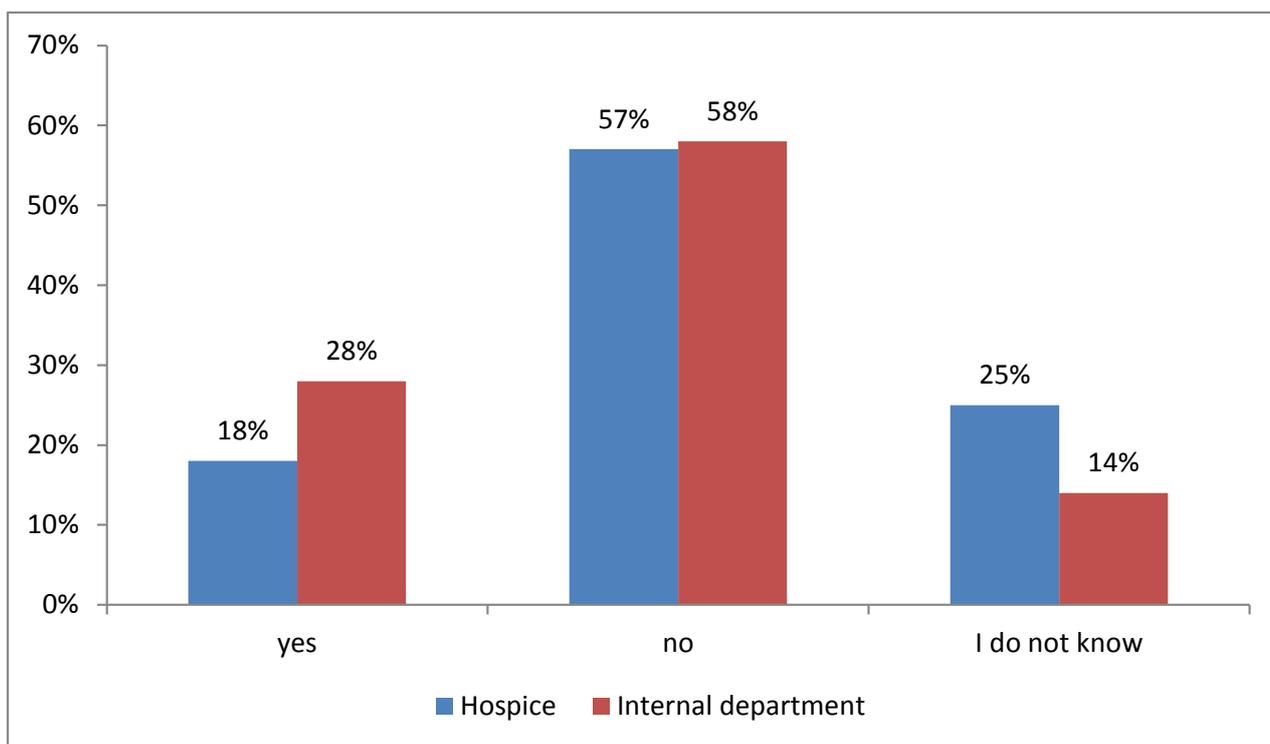


In Hospices out of 44 respondents 35 (80%), a majority, indicated activities unrelated to employment exercised reported increased activity in the workplace (yard work, housework), 32 (73%) stated their interests, hobbies, 30 (68%) lets off steam by spending time with loved ones - communicate with spouse, children, friends, 29 (66%) stay (walking) in nature, 28 (64%) to relax with sleep, 14 (32%) sport and sipping coffee or relaxing in a bath, 12 (27%) cultural events and activities, 9 (20%) listening to music and aromatherapy, 8 (18%) massage, 6 (14%) shopping, 4 (9%) more activity job, 2 (5%) running, yoga, meditation and acupuncture, 1 (2%) baking and making decorations.

On Internal Medicine Departments out of the 57 respondents, the majority, 48 (84%) stated that they are dedicated to their interests, hobbies, 42 (74%) engaged in work that is not related to their profession, a work at home or in the garden, 40 (70%) sleep, 38 (67%) with children, partners and friends, 24 (42%) walks in the countryside, 23 (40%) warm bath and a cup of coffee, 15 (26%) visiting cultural events such as concerts, theaters, cinemas, 13 (23%) sport, 12 (21%) shopping, 9 (16%) music therapy and aromatherapy, 6 (11%) massage, 4 (7%) yoga, meditation or acupuncture and increased activity manifested in patients in their care, 1 (2%) sit with friends and spend a nice time with them.

SUCCESS OF THE REMOVAL OF BURNOUT SYNDROME

Figure 3. Success of the removal of burnout syndrome



At Hospice facilities from 44 respondents 8(18%) answered "Yes", 25 (57%) answered "No", and 11 (25%) ticked the answer "do not know".

At Internal Medicine Departments from 57 respondents 16 (28%) answered "Yes" 33 (58%) answered "No" and 8 (14%) answered "do not know".

DISCUSSION AND RECOMMENDATIONS FOR PRACTICE

Being a Nurse means to serve others. This service includes two components: a Nurse literally gives her/himself to others, which can be very challenging. But the results of her/his work should also enrich her/him; promote her/his health; reinforce emotional strength to continue to help. Those aspects must be in balance. A Nurse should be able to distin-

guish when it is still going well and when it is beyond her/his capabilities. We should therefore strive for and consciously promote what is important to us, what we care about, and everything that brings us joy of life, health, strength and satisfaction.

Working in Healthcare involves daily contact with various stressful situations. It is very important that nursing staff be in good mental and emotional, as well as physical condition; to feel well and in balance; that all personal problems which could or might affect relationships with patients and other people are solved. When a Nurse is a balanced person, it can be expected that it is easy to neatly and creatively pursue her/his professional role. But, when a Nurse does not have the satisfaction of her own needs being met, she will not be able to satisfy well the needs of patients. For a Nurse to competently take good care of patients, she/he must first manage her/his own personal affairs. Help is available from a Psychologist, Hospital Chaplain or Priest in a facility not only for patients but also for staff; or a Supervisor, who should be from outside and not a person who works in the same Healthcare team.

CONCLUSION

Nurses are confronted with suffering of various kinds every day and seek to alleviate its symptoms. Work of Nurses in Internal Medicine and Hospice facilities demand deeply human and at the same time, a highly professional approach. A Nurse must be balanced within her own reality and her own mortality. Palliative care does not depend only on a Nurse but also on a whole multidisciplinary team, which offers effective teamwork between staff, volunteers and relatives of patients. But most importantly, when Nurses give all their energy to others they need to know how to recharge their own energy, strength and love.

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Correspondence to:

PhDr. Vlasta Dvořáková
College of Polytechnics Jihlava
Tolstého 16, Czech Republic
e-mail: vlastadvorakova@seznam.cz

Bc. Lada Nováková
Havlíčkův Brod Hospital
Husova 2426, Havlíčkův Brod, Czech Republic
e-mail: lada.novakova@onhb.cz

Mgr. Radim Křivák
Comenius University Bratislava
Natural Sciences faculty
Mlynska dolina, Slovak Republic
email: rescue.info@email.cz

SUFFERING OF PATIENTS IN THE DEPARTMENT OF INTERNAL MEDICINE AND IN HOSPICE

Vlasta Dvořáková¹, Lada Nováková², Radim Křivák³

1. College of Polytechnics Jihlava

2. Havlíčkův Brod Hospital

3. Faculty of Natural Sciences, Comenius University Bratislava

Key words:

Pain, Hospice, Patient, Nurse, Suffering

Abstract

Suffering that accompanies a disease can be mitigated, but not completely removed. Health professionals' attitudes toward suffering should be full of efforts to understand human suffering and to mitigate the suffering on both professional and human levels. Medical personnel should be able to control the depressed feelings of a suffering patient; on the other hand, they should avoid an other extreme, namely emotional indifference. Thus the main object and purpose is to reduce, and if it is possible to completely eliminate suffering associated with disease. If, despite of all efforts, we cannot eliminate suffering, the main role of healthcare professionals is therefore to preserve the dignity of a sufferer; his interpersonal relationships; approach him with humility; respect and maintain his quality of life at the required level.

INTRODUCTION

The issue of suffering is very broad and extensive. Most authors are primarily concerned in its physical form, i.e. pain. But the issue of psychological and social suffering has been less often described. In our work, we point out that at all aspects (bio-psycho-social and spiritual) of a patient can be influenced by suffering.

THE CONCEPT OF SUFFERING

"Pain is considered the most common source of suffering, and to the extent that two terms - pain and suffering - are usually associated, they are different forms of hardship." (Munzarová, 2005, page 74). The term 'pain' includes many other forms of human sufferings. Our native language does not distinguish whether it is physical or psychological pain, but the English language recognizes the concepts of 'pain and 'suffering, which are used as synonyms. Pain

leads to suffering, and suffering leads to a painful behavior (Janáčková, 2007, Raudenská, Javůrková, 2011).

"Since the beginning, humanity has been pursued by a wide range of diseases and people have tried to fight against suffering, pain and death" (Kopáčková, Cetlová, Stančiak, 2012, p 171).

Disease can be defined as a disorder of health. Like the concept of health, disease again can be based on a holistic concept - the concept of wholeness of a person in all its physical, psychological, social and spiritual areas (Zacharová, 2007). As stated by Křivohlavý (2002) disease is a state when there is something wrong, something that is beyond normal boundaries. Other authors characterize disease as a state of discomfort when a person does not feel well, and therefore is unable to fulfill her/his duties and assume her/his social role (Bártlová, 2005). The word disease is thus understood under two different concepts 'disease' and 'medical discomfort' (illness). The term 'disease' means deviation from certain specified standards, manifesting specific symptoms that can be

diagnosed. Disease is a biological phenomenon. The term 'medical discomfort', which can be seen by human emotional expressions, tells us that a given person is not well. Health discomfort is a psycho-social phenomenon (Zacharová, 2007).

SOMATIC-PSYCHICS AND PSYCHOSOMATIC PAIN

Efforts to reduce pain had been of great importance in ancient times and this has persisted into the present (Trachtová, 2010). Among fundamental human rights belongs the right not to suffer pain (Janáčková, 2007).

Different physical or mental factors are involved in every pain state (not in the same manner and not to same extent). Body condition (health) affects the human psyche and the psyche affects the somatic human condition. Like any disease and pain, at the moment it becomes disease there are somatic and psychological components. Therefore, in any manifestation of disease, medical staff must take notice of these two components. In somatic disease it is necessary to know a patient's mental state - mental strength, his efforts to heal and cooperation with the medical staff. We are talking about diseases as somatic-psychical, manifest deficiencies in the body, which in turn induce response in the human psyche. But disease affects more than the physical level. In psychosomatic illnesses it is also necessary to discover not just the physical condition because the cause is probably in the psyche, (Rokyta, 2009, Zacharová, 2007).

Adaptation to pain is small, but some chronically ill and people with cancer eventually learn the limits of pain, can control it and grow familiar with their pain. Pain takes a great toll on people - it changes their mind (frustration, depression, hopelessness, anxiety), mood and behavior (aggression, isolation) and their way of life. Prolonged exposure to unpleasant stimuli of chronic pain causes heavy sufferings; exhaust patients; make them feel exhausted and depressed. People suffering from chronic pain respond inadequately to common factors. This is pain that falls into somatic-psychical diseases (Trachtová 2010, Zacharová, 2007).

Psychological reaction to pain is suffering. Pain intensity consists of sensory and affective components. From these come the need not only of con-

servative treatment with drugs, but also psychological therapy which is often more effective with chronic pain than analgesics or opioids. Suffering does not always arise from pain due to physical disability, but may also result from long-lasting negative psychological processes (stress, fear, anxiety), which are reflected by a painful experience. This suffering descends into psychosomatic diseases (Trachtová, 2010).

Response to pain is different for each person and it is even different for the same person at different times depending on the inner experiencing of pain. People experience pain harder and more sensitively in a case of fatigue and exhaustion of the body, or if it is accompanied by fear (from examination or from intervention) and previous negative experience. Conversely, patients with severe depression experience pain less intensely and are less sensitive to it. Experiencing pain is influenced by learning; possible rewards; previous experience with pain; understanding the meaning of pain; personality traits of a person; and by educational and cultural influences from society (Various authors, 2006, Šamánková, 2011, Zacharová, 2007).

REDUCING OF PAIN CAUSED BY DIFFERENT KINDS OF SUFFERING

The main objective is to reduce the suffering that comes with pain. A patient has the right not to suffer pain, and from it comes the right to timely and professional treatment of pain (Janáčková, 2007). If a patient is given appropriate treatment, which helps to relieve him/her, then a patient does not ask for pain medicaments; the pain becomes bearable; and people tolerate it more. Not very strong pain leads to suffering if the sufferers fear that it is the cause of serious disease. On the contrary, suffering of tremendous pain may not be perceived as suffering if there is a hope that it will end soon and if he/she knows its cause (Munzarová, 2005). Today, most people tolerate pain much less than previous generations. It is a fact that life has become more comfortable than it was before. Even at low intensity pain doctors often prescribe analgesics and opioids, because for them it is the simplest technique to reduce or eliminate pain. Opioids should be used only when needed to reduce large, unbearable pain. They have many side effects and incorrect dosage (right drug, dose, route and fre-

quency of administration) may become addictive but they do not destroy the psyche of a patient. On the contrary, a patient will not be completely exhausted by terrible pain and will be able to communicate with loved ones. Finding, uncovering and sharing the difficulties of a different kind (bereavement, lack of hope, missed objectives, feelings of guilt, loneliness, fear, remorse), which is not related to a disease itself, leads to tolerating more significant pain. According to this rule, especially in a hospice, staff provides full healthcare. Through this kind of suffering most aware experts are focusing on mental and spiritual diseases. It is important to bear in mind that access to healthcare treatment of pain means a personal approach to suffering of patients, because it entails everything from his/her past and sustains their bio-psycho-social and spiritual needs. Doctors should learn and try to implement psychological means necessary to relieve pain or other means to improve the psyche such as walking in nature; talking; relaxing; sympathy; understanding and empathy; education and the provision of sufficient information; relaxation exercises; etc. (Bírešová, 2011, Munzarová, 2005, Zacharová, 2007).

MENTAL SUFFERING

Psychological needs are based on personal perception and experience of the world and on the need to develop personality (Šamánková, 2011). Among these needs primarily belong the need to respect human dignity, which is one of the most important aspects in the care of the sick. Human dignity is understood as respect for human existence regardless of age, social status and health. Dignity is a human to human tribute. It is also related to the ability of a person to create a meaningful picture of his/her life and him/herself. The need for dignity is not only important in terms of care itself, but also for good relations between patients and health professionals. Respect for human dignity concerns all medical staff including cleaning workers in a hospital, family members and friends of patients, especially in cases of severely ill and dying patients. All of the above are responsible for ensuring that a patient does not suffer from worry, fear and anxiety, therefore he will not have psychological suffering caused by ignorance, humiliation, by saying untruths etc. Doctors must respect the dignity of a patient when communicating serious diagnosis.

In practice, importance of respect for a hospitalized patient in healthcare becomes somewhat reduced and suppressed. Healthcare professionals often fail to respect human dignity; don't accurately write all interventions which they performed on a patient; a patient is almost treated as a 'things'; emphasis is on doing everything right according nursing practice; but somewhere along this is diminished interest in a person as such. An ordinary human approach toward a hospitalized patient is reduced and he/she then experiences a loss of personal identity (depersonalization); a patient becomes the subject of 'business' for a medical facility; and human - a living being - in nursing care is overlooked. A patient may lose dignity simply by addressing ('Grandma', 'Grandpa, without addressing a name); how answering of questions (austerity, arrogance, irreverence, aloofness, abruptness, simplification, diminutives). Self-dignity of a senior, the sick and elderly people is usually impaired by shame (embarrassment) during intimate performances such as personal intimate care, examinations from head to toe, dressing, defecation or exercises. This disruption of intimacy is changing the identity of a person - the loss of self-esteem; undervalued feelings of inferiority; powerlessness; feeling of her/himself as a burden for the institution. The loss of dignity may happen with the decreasing of value of an elderly patient, who at least in experience, wisdom, life and destiny that was reached in active life in her/his former social position in society.

A patient is terrified and worried about the symptoms and the disease itself, which he/she later experienced upon entering a hospital or other medical facility, at which time mental tension escalates. Everybody needs a sense of psychological and physical safety and security in life. When a person is in a medical facility he/she does not know, he/she encounters unfamiliar people and things, so feels especially threatened and frightened. It is for him/her a new environment where his/her need for privacy is disrupted, which is changing his/her social role from a healthy to a patient; from an independent being to subordinate of doctors and medical staff. For humans it is very difficult to obey and accept the fact that an active individual becomes a patient - someone who is dependent on the help of others because he/she cannot help him/herself. Here the ability of medical personnel, such as humility, respect, gentleness and sensitivity in

dealing with patients, or when communicating with them plays a critical role. The most important principle of healthcare should be truthfulness. According to Svatošová it is also important to tell a patient only as much as he wants to hear; when he or she wants to hear it; and is able to perceive us and listen to us. It is essential to gain the confidence of a patient in order to create a positive relationship with a patient for his/her support and for hope (Svatošová, 2012, Venglářová, 2007).

A disease goes hand in hand with stress. This intensifies a simultaneous action of fear and anxiety. People controlled by stress, respond too sensitively and are tense; impatient; irritable; have negative thinking; focus less; have extreme tiredness; apathy; depression; or vice versa aggression and malice; and all these are reflected in their relationships with others.

Once medical staff understands the stress behavior of a patient, it helps a patient to prepare for an upcoming stressful situation; try to minimize what causes stress for the patient; participates in his suffering; helps him/her to maintain a positive mental balance and thoughts; and finally, helps him/her maintain good relations with those closest (Opavský, 2011).

SOCIAL SUFFERING

One of the most stressing factors in human life is a fear of being alone. This means that a human is naturally given to be in community with others; be in contact with them; talk with them; share their opinions, knowledge and ideas. Man needs society; can never exist as an individual; and cannot be alone for a long time (Křivohlavý, Pečenková, 2004). These assertions imply the need for interpersonal relationships. This need is disrupted by illness, hospitalization itself and becomes social suffering to a human. Admitted to a medical facility, a person is torn from a network of social relations he/she had with others; limits their contact with loved ones (family members, friends); and interferes with relationships between them. A patient, therefore, who has lost some of his/her social role will suffer from feelings of social isolation. And, if is not attended by family, a patient is forced to actively seek new ties - he must find someone to be 'linked to who will be a friend, mentor, whom he could trust;

to whom he could rely on; who would have listened; tried to understand him; and protect him (Zacharová, 2007). ‘

The only people with whom a hospitalized patient is in contact with are other patients, doctors, nurses and other medical staff; most often, however, it is nurse because she is, on a human level, a person closest to a patient. In some cases, particularly in the elderly, there may appear a generation gap from nurses or a negative attitude towards old age; the interest and care of young patients is preferable to focusing on elderly patients. Thanks to resulting social isolation, especially in older people, it is very difficult to maintain their self-esteem (increasing sense of loneliness; creating of a feeling of separation); will seek company; will want to talk; to draw attention to him/herself, and therefore a nurse should spend as much time as possible with patients and not with administration or working at a computer. Here are qualities nurses should have and apply when dealing with a patient: be patient; attentive; friendly; optimistic; communicative; be able to listen and show interest; get along well with others; be resolute; willing; honest; fearless; etc. In disease a human loses his ability to work; is taken out of active work which he held in his job. When hospitalized, a patient directs his resources at combating a disease. A patient does not want to be a nuisance; passive; but would like to be actively involved; apply; collaborate and participate in his/her treatment. For example, an ordinary morning exercise; performing manual work help patients to gain back confidence; instill positive results to help overcome negative thoughts, anxiety, pain. The need for a positive review - it is a social need which is important for a patient featuring the art of praise, encouragement, appreciation for the effort.

Another social need is for respect of social identity. This is need for a person to be recognized, respected and integrated into a team that treated him fairly, with respect, tolerate his mood swings and respect his/her scale of values. Among social needs also belong needs for kindness and love. They are externally satisfied by a nurse being kind, empathetic, attentive, sensitive and understanding of a patient (Bártlová, 2005, Křivohlavý, 2010 Venglářová, 2007).

Social needs are also connected with cultural needs. Cultural environment and aesthetics allow a sick person to distract attention from himself, from his

illness, pain and suffering. Long-term disease affects all social and cultural activities. It is very important to know what a patient used to do (whether he watched information of what was happening in our country or in the world; that he regularly went to theater, cinema or concerts, exhibitions, or preferred watching television) before coming to the hospital or other facility. Depending on his/her lifestyle, on hospital equipment and on medical condition of a patient, we can provide small degrees of cultural activities to take place within a hospital; allowing TV watching; listening to radio; to inform about is happening outside a hospital from a website; provide literature. Some facilities even have a separate parlor dedicated for meetings with families or other capable patients themselves; where coffee is provided at a certain hour; games played; manual labor performed; and where there even should be piano. Making contact with other patients is a source of support for a patient; they can share their own experience which leads to mutual understanding of their situations (Křivohlavý, 2010 Šamánková, 2011).

SPIRITUAL SUFFERING

In addition to biological, psychological and social needs in humans we must take into account their spiritual needs, which also have impact on the experience of suffering in humans (Janáčková, 2007, p 17). This includes spiritual focus on human aspects such as religious, philosophical and psychological feelings. Spirituality deals with problems; with the overall mood of a person's thoughts; with questions that go beyond the human; questions about the meaning of life, of its origin. It positively affects the human capacity to cope with difficulties that are associated with the disease (Raudenská, Javůrková, 2011, Šamánková, 2011).

Spiritual needs are not widely discussed, but from a holistic point of view we should not underestimate them (Svatošová, 2012). A deeper understanding and integration of spiritual care in treatment increases the effectiveness of treatments selected by physician and health-care team. But how do we know that a patient has spiritual needs? To find out what patients have spiritual needs, we must first find out what environment and life situations patients come from to the hospital. A patient may trust himself to have such and such suffering. We can learn a lot of information

from the patient's family or the objects that a patient has with him – a cross, Bible or other religious book (Raudenská, Javůrková, 2011, Svatošová, 2012).

Medicine in this modern world focuses on the biological aspects of humans. Medicine is still progressing. This so called over-engineered; inventing newer and newer drugs; diagnostic tools and treatments. Man as a human being is gradually becoming an object too. And we must not forget that in addition to biological orientation, he/she also has psychosocial-spiritual dimensions. This factor shows at some stage of a disease, that in some people, a spiritual need may acquire greater importance than biological needs. Thus, failure to satisfy spiritual needs may become a more significant issue than physical pain. Under the term 'pain' are meant also many other human sufferings. People have hidden pain in their souls which they may not even be fully aware. Concerning spiritual suffering, people are generally thinking deeper about a process of dying (Janáčková, 2007, Svatošová, 2012).

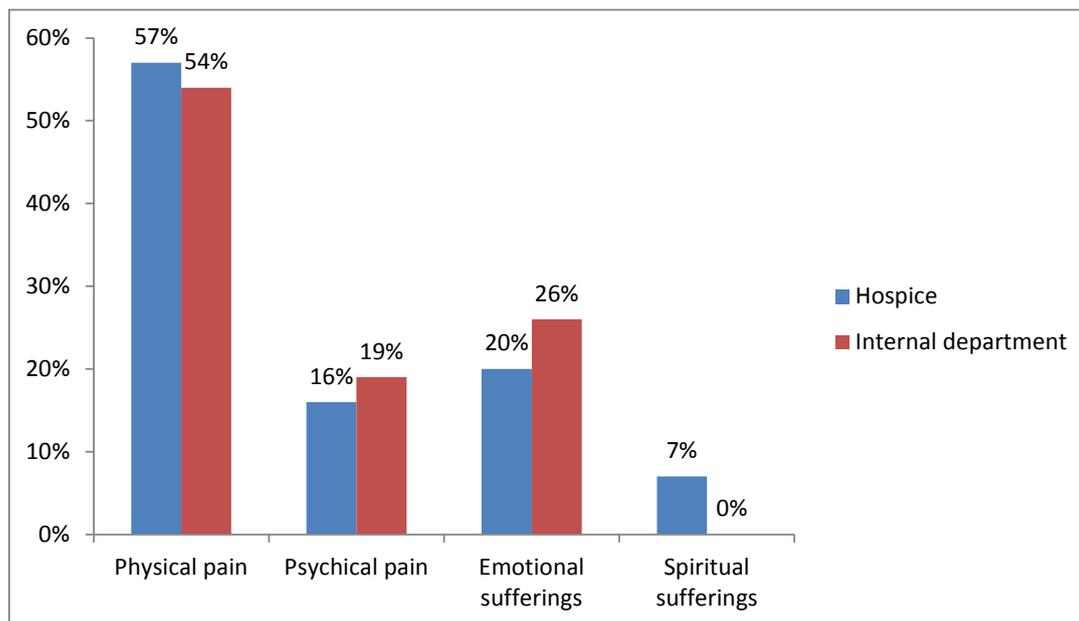
Meeting spiritual needs is important for peace of mind. It can bring great relief and strength to a patient. Surprisingly, 'non-believers' have spiritual needs rather than "religious" people. This is because in a state of dying 'infidels' think about their lives; whether bountiful or unsuccessful; think about their failures that are not reconciled with the world, with loved ones, and thereby with God. A magnificent step forward is to die with a feeling that everyone close forgives us and that we forgive all those who have hurt us (Svatošová, 2012). On the contrary, 'religious' people have a perception of God, and therefore, take such a stressful or difficult situation, as an opportunity, a challenge that opens them and significantly expands horizons and makes 'believers' ask key questions. 'Something is wrong and it happened therefore, that 'something has to be changed, while still changeable' (Svatošová, 2012).

THE METHODOLOGY AND RESULTS OF RESEARCH

In our work, we focused on finding symptoms in suffering patients from the perspective of nurses. The research was conducted at two internal compartments in two hospitals and in two hospices. 120 questionnaires were sent out, of which 101 were returned.

THE STRONGEST FORM OF SUFFERING FOR A PATIENT

Figure 1. The strongest form of suffering for a patient



Of 44 respondents working in hospice facilities, 25 (57%) stated that the strongest suffering is from a patient's physical pain; in second place was emotional pain which was reported by 9 (21%); 7 (16%) psychosocial suffering perceived as the least suffering for a patient; and 3 (7%) respondents spiritual pain. Of 57 respondents working in Internal Wards of hospitals, 31 (54%) say the strongest suffering for patients is physical pain; followed by 15 (26%) suffering emotional; 11 (19%) psychosocial pain. No respondent

answered that the strongest suffering for a patient in an Internal Department was spiritual pain.

The above Figure 1 shows that in both hospices (57%) and in Department of Internal Medicine more than half of the respondents (54%) identified physical pain as the greatest suffering which hospitalized patients can suffer from.

WAYS OF MITIGATING THE SUFFERING OF A PATIENT

Table 1. Ways of mitigating the suffering of a patient

	Hospice		Internal department		Total	
	n	%	n	%	n	%
Physical presence	35	79.50	31	54.40	66	65.30
Nursing care – satisfaction of needs	42	95.50	56	98.20	98	97.00
Cooperation on patient's care with family members	34	77.30	30	52.60	64	63.40
Providing contact with other patients (activation of patient)	26	59.10	25	43.90	51	50.50
Communication – discussion, small talks	44	100.00	50	87.70	94	93.10
Providing of spiritual service, discussion with priest, holy mass	36	81.80	29	50.90	65	64.40
Medications as prescribed by Doctor (analgetics, opioids)	36	81.80	52	91.20	88	87.10
Other	3	6.80	0	0.00	3	3.00
Total	257		273		530	

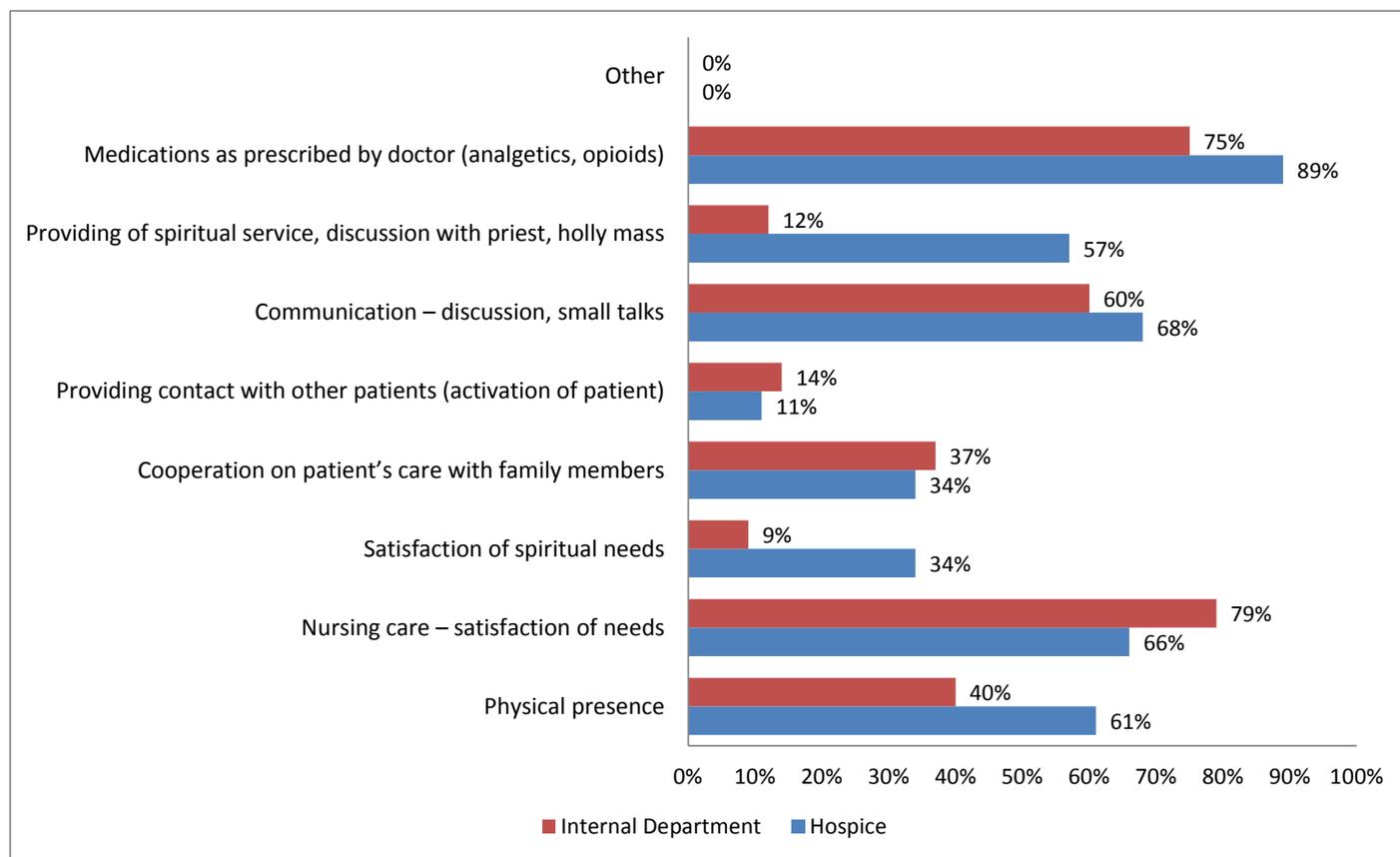
Of 44 respondents working in hospices, the highest possible number, 44 (100%) said reduction of suffering by communication with a patient; 42 (96%) satisfaction of needs through implementation of nursing care; 36 (82%) spiritual mediation services; 36 (82%) through medications administration prescribed by a doctor; 35 (80%) alleviate patient suffering by physical presence; 34 (77%) alleviate suffering with the help of family members; 26 (59%) liaising with other patients; 3 (7%) hospice's other ways of relieving á patient's suffering including art therapy; music therapy; private prayer for a patient; accompanying a patient with a secure assurance of a physical presence by another person.

Of 57 respondents working at an Internal

Department 56 (98%) implementing quality nursing care that meets a patient's needs inhibits suffering; 52 (91%) administration of medication prescribed by doctor; 50 (88%) communications and interviews with sufferers; 31 (54%) alleviate patient suffering by physical presence; 56 (98%), 30 (53%) cooperation with family of a sick person; 29 (51%) by spiritual mediation services; 25 (44%) facilitate contacts with other patients; 0 (0%) other ways of alleviating suffering of a patient.

MOST FREQUENT WAYS OF MITIGATING PATIENT'S SUFFERING

Figure 2. Most frequent ways of mitigating patient's suffering



Of 44 respondents from a hospice facility 39 (89%) reported that most patients had pain relief from medication prescribed by a doctor pain relieving; 30 (68%) communication; 29 (66%) help performed by nurses; 27 (61%) physical presence; 25 (57%) spiritual mediation services; 15 (34%) meeting the spiritual needs; collaboration by family members when performing care for a patient; 5 (11%) mediation contact

with others. The answer 'other' was not utilized in any of the surveyed hospice facilities. ‘

Of 57 respondents from Internal Departments 45 (79%) nursing care provided to a patient alleviates suffering of most patients; 43 (75%) pain relief medication filed under doctor's prescription; 34 (60%) communication techniques; 23 (40%) physical presence; 21 (37%) collaboration with a patient's family;

8 (14%) patient contact with other patients; 7 (12%) spiritual services; 5 (9%) meet the spiritual needs of a patient. One person answered that 'other' put a stop to suffering from an Internal Departments but does not say what.

DISCUSSION AND RECOMMENDATIONS FOR PRACTICE

Less than half of respondents who work at a Department of Internal Medicine, reported the presence of spiritual suffering of patients hospitalized in the department. Interestingly, we noted that in hospice facilities 57% of respondents, more than half, stated that spiritual suffering occurs in their patients. We believe that this is due to the fact that respondents from Internal Departments are dealing specifically with nursing care and with the satisfaction of basic biological needs of clients; the need for movement, nutrition, bowel habits, sleep, hygiene, breathing and need to be pain free. On the other hand, hospices focus on the needs of a patient in a spiritual area. Staff in hospices expend greater attention to these needs. Respondents from Internal Departments should take example from respondents from hospices and should consciously focus more on identifying and mitigating spiritual suffering. More than a half of respondents identified physical pain as the greatest suffering of hospitalized patients. The results also show that 73% of respondents from hospices are aware of ways to alleviate a patient's suffering. The Internal Department respondents have less information on how to mitigate suffering of a patient than in hospice facilities; only 60% of respondents are aware of these methods of mitigation suffering. Respondents from all facilities agreed that the relieving from most patient's suffering is drug application by pain medication. In second place is the alleviation of suffering by nursing care, third by communication.

We should, therefore, respect the uniqueness and complexity of humans and recognize all those inseparable areas. Nurses are often closer to suffering patients than doctors. Especially the burden of helping a suffering patient with whom they are in closer, more frequent and more opened contact lies on their shoulders. However, not all mitigation should be done only by a nurse. With cooperation of doctors, psychol-

ogists or priests (multidisciplinary team), individuals will complement each other, and thereby healthcare for a suffering patient will become integral and more complex and high-quality and the level and scope of provided care will improve.

A human is a unique, unrepeatable and original being. And as such, a human must be respected and we should try to understand the positive and negative aspects of his/her personality. It is therefore necessary that a medical staff to approach each patient individually and, especially, professionally, with dignity, respect, courtesy, friendliness and open hearts.

CONCLUSION

In an holistic context, a human is a bio-psycho-social-spiritual being, therefore we should respect him/her. A human is not merely the sum of biological, psychological, social and spiritual aspects, processes, and systems, but is an holistic entity; a complex whole being also experiencing a particular environment. Suffering is an integral part of every disease. Healthy people see their health as part of their life, as something granted and natural. But when they get ill, they discover a new dimension of perspective. From this point of view, suffering may have its positive side as well. Suffering reminds a human of his/her vulnerability and encourages responsible handling of each life. The adoption of human suffering, and concern for a suffering person, deepens and improves interpersonal relationships; consolidates friendship; human solidarity; leads to a greater humanity; and a humanity of sufferers, but also of their families and of all who try to help. Sufferers often can not help themselves, but other people can help them, primarily because shared suffering is better tolerated.

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Correspondence to:

PhDr. Vlasta Dvořáková
 College of Polytechnics Jihlava
 Tolstého 16
 Czech Republic
 e-mail: vlastadvorakova@seznam.cz

Bc. Lada Nováková
 Havlíčkův Brod Hospital
 Husova 2426, Havlíčkův Brod Czech Republic
 e-mail: lada.novakova@onhb.cz

Mgr. Radim Křivák
 Comenius University Bratislava
 Natural Sciences faculty
 Mlynska dolina
 Slovak Republic
 email: rescue.info@email.cz

SELECTED ASPECTS OF EMPLOYMENT OF UNIVERSITY GRADUATES IN THE LABOR MARKET

Monika Bačová¹, Zuzana Bričová²

1. Podnikovohospodárska fakulta so sídlom v Košiciach,
2. Ekonomická univerzita v Bratislave

Key words:

university graduates; unemployment, labor market, Slovakia

Abstract

The paper defines the position of Universities in Slovakia; points to the development of the number of Universities in Slovakia; to the development of the number of registered Graduates of the ten largest Universities according to the registered number of Graduates at the Office of Employment, Social Affairs and Family as registered unemployed; characterizes the development of the number of unemployed Graduates from different perspectives; points to the Catholic Church teaching about the sense and meaning of work and how to perceive the problem of unemployment, which is applied to Graduates in Slovakia.

INTRODUCTION

Theoretically, higher education offers University Graduates a number of advantages. It is often stated that University Graduates in developed countries are able to find a job more easily than Graduates with lesser education. This means that they are less endangered by unemployment. Their work is more qualified and they generally earn a higher salary. In spite of this, because of economic conditions in the Slovak Republic not all Graduates find a job immediately after graduation. They have the option to apply to the Office of Employment, Social Affairs and Family with the expectation that this Office will help them to find a job.

The aim of this paper is to highlight the development of Universities in Slovakia as well as the situation of employment opportunities of their Graduates in the labor market. It points out the importance and significance of work for people, as well as some other facts to which the Catholic Church draws attention, in connection with the problem of unemployment. It defines the mission of Universities in Slovakia; it characterizes the development of the number of Universities in Slovakia; and the registration of Graduates at the Office of Employment, Social Affairs and Family. It points out the development of the number of reg-

istered Graduates at the Office of Employment, Social Affairs and Family according to diverse factors, for example according to the degree of education; completed study specialization; the time of registration; and it indicates the way the Catholic Church, which *"in each time and all occasions has to fulfill the mission of truth in favor of society which would meet the requirements of man, his dignity and his mission"* (CIV 9), perceives the importance and significance of work. In the conclusion of the paper, attention is drawn to some aspects of the problem of unemployment from the point of view of the social doctrine of the Church and how it applies to University Graduates who have a problem with employment in the labor market.

UNIVERSITIES IN SLOVAKIA

The mission of Universities which are part of the European University Education and Common European Research according to § 1 paragraph 2 of Act No. 131/2002 of the Laws of Higher Education is to develop *"a harmonious personality, knowledge, wisdom, goodness and creativity in man and to contribute to the development of education, science, culture and health*

for the welfare of the whole society and this way to contribute to the development of an educated society”.

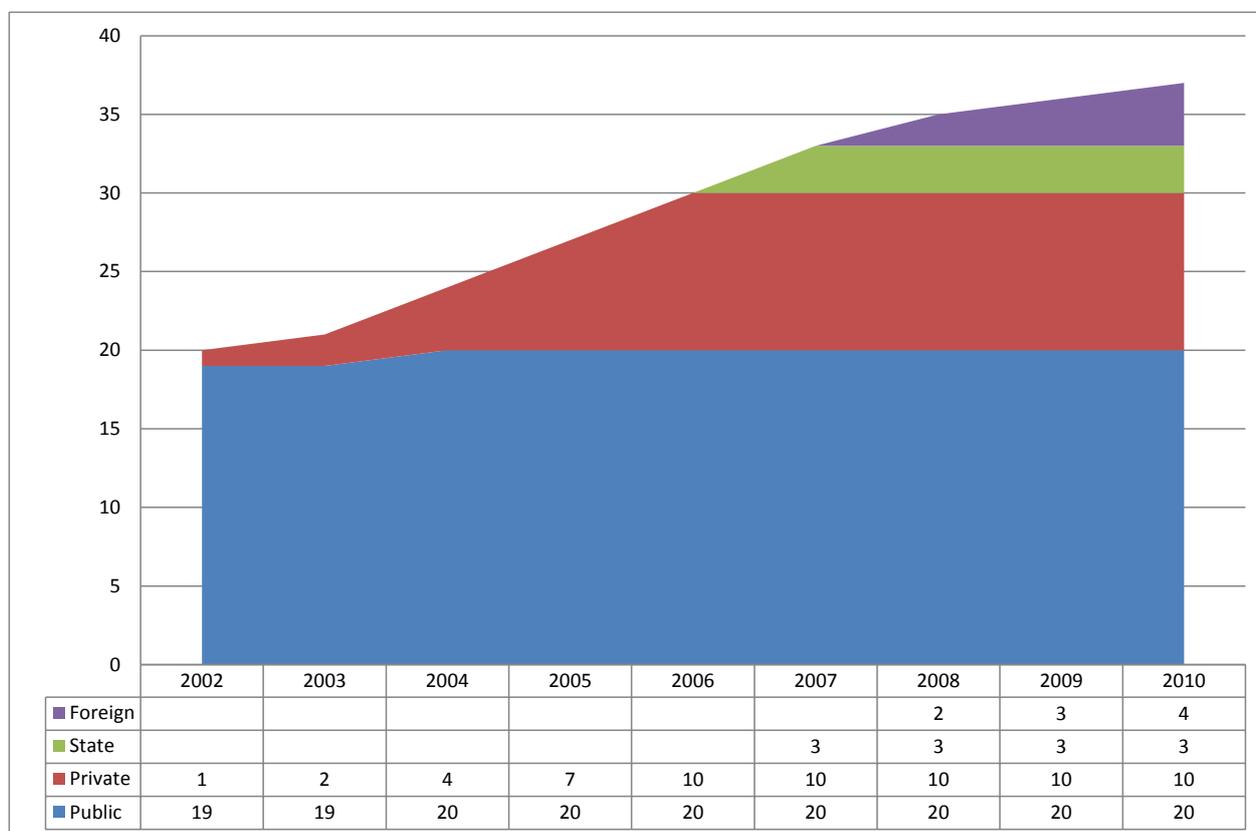
In relation to the above mentioned basic mission of Universities in Slovakia, the long term plan in educational, research, developmental, artistic and other creative activity fall within the purview of these Universities until 2014. Universities are considered as important and exclusive venues for qualified experts in all stages of University education; experts prepared to solve critical problems in contemporary Slovak Society; in the field of increasing the social and cultural level of Society; of economic growth; of improving the environment; and in other disciplines on regional, national as well as international levels. Therefore, from

the point of view of social practice, this long-term plan specifies also the requirement to create compliance between the structure of jobs in the economy and the preparation of a qualified labor force for the knowledge society sectional priorities

DEVELOPMENT OF THE NUMBER OF UNIVERSITIES IN SLOVAKIA

In Slovakia, at present, there are Public Universities, State Universities, Private Universities and Foreign Universities. The development of the number of Universities in Slovakia in the years 2003 – 2009 is given in Figure 1.

Figure 1. Development of the number of Universities in Slovakia 2003 – 2010



Source: Authors on the basis of Reports on the state of University education in 2003 and Annual Report on the state of University education in 2004 – 2010

In 2003, there were 19 Public Universities in Slovakia. In 2004 the University of J.Selye in Komárno started as the twentieth Public University. Since 2004, there have been twenty Public Universities in Slovakia. In 2003 there were two Private Universities – The University of Management in Trenčín and the University of Healthcare and Social Work of Saint Elisabeth

in Bratislava. In 2004, there were two more: The University of Economics and Management of Public Administration in Bratislava and Bratislava University of Law in Bratislava. In 2005, the number grew by three new Universities: The University in Sládkovičovo, The University of International Entrepreneurship ISM Slovakia in Prešov and Middle-European University

in Skalica. The first two of the above mentioned newly established Universities started offering University education as early as in the academic year 2005/2006. As for the legal form, four of the existing Private Universities were limited companies and three Non-profit Organizations. In 2006 three more Universities were established: Dubnica Technological Institute in Dubnica nad Váhom, Bratislava International School of Liberal Studies and University of Security Management in Košice.

Between 2007 - 2009, University education in Slovakia was offered by twenty Public Universities, ten Private Universities and three State Universities. The Ministry of Education did not monitor the activities of the Universities legally established in the EU and functioning in our territory until 2007. Since January 1st 2008, Foreign Universities from member states can gain the right to offer degrees from the Ministry of Education of the Slovak Republic to provide University education according to the legislation of the state of their headquarters. In 2007, three legislative procedures started gaining such rights. In 2008, two Foreign Universities: Bankovní Institut Vysoká škola, a.s. (headquarters in Czech Republic) and Vysoká škola Mezinárodních a veřejných vztahů Praha o.p.s. (established in Czech Republic) had the right to operate in the territory of the Slovak Republic. In 2009, the third University gained this right, too. All three Universities have their headquarters in the Czech Republic.

REGISTRATION OF GRADUATES AT THE OFFICE OF EMPLOYMENT, SOCIAL AFFAIRS AND FAMILY

The Office of Employment, Social Affairs and Family registers and statistically processes and provides information about the total number of job applicants – University Graduates and young people. A University Graduate job applicant younger than 25 years of age who has completed his required preparation for a job in full-time study less than two years earlier and has not gained his first regularly paid employment is considered to be an unemployed citizen. A job applicant is defined as a citizen looking for a job who is registered as unemployed at the Office of Employment, Social Affairs and Family after submitting a written application for employment mediation.

In the category of University Graduates, three stages of education are identified:

1. Higher vocational education (higher education completed by a bachelor degree),
2. University education,
3. Scientific education (qualification).

Registration at the Office of Employment, Social Affairs and Family is voluntary. The Graduate has no legal obligation to be registered as a job applicant at the Office of Employment, Social Affairs and Family. The Graduate who has no job and is not registered at the Office of Employment, Social Affairs and Family is considered to be a voluntarily unemployed person and is obliged to pay for his health insurance.

The parent of a High School leaver can claim family allowances until the end of the school holidays i.e. until 31st August in the given year but only provided that the school leaver did not apply for a job at the Office of Employment, Social Affairs and Family.

A Graduate is a person who completed his study at a State University by passing final examination loses the status of being a dependent child the day after completion of his/her study at the University and successfully passing a final examination. After completing University studies, health insurance for the Graduate is paid by the state only until the day of the state exam.

A Graduate who decides to be registered as a job applicant, after studies, has to personally submit a written application to be included in the registry of job applicants at the Office of Employment, Social Affairs and Family. Being registered within seven days after completing the study applicants will be listed in the registry of the job applicants the following day. If he/she applies for registration after seven days from completing his/her studies he/she will be listed in the registry of the job applicants from the day application is personally submitted.

A Graduate has no right to get unemployment benefits.

A Graduate listed in the registry of the job applicants at the Office of Employment,

Social Affairs and Family has the following rights but also duties.

The Office of Employment, Social Affairs and Family provides an applicant free of charge:

- information about job vacancies and possibilities of looking for job vacancies,
- information and counseling services,
- specialist counseling services,
- tools of active measures on the labor market.

The basic obligation of a job applicant in compliance with Law no. 5/2004 Collection of Act on Employment Services as amended is to appear at the Office of Employment, Social Affairs and Family once a month and submit evidence about active search for employment. The way of active search for employment is to be proved by the applicant him/herself from the following possible forms of documents:

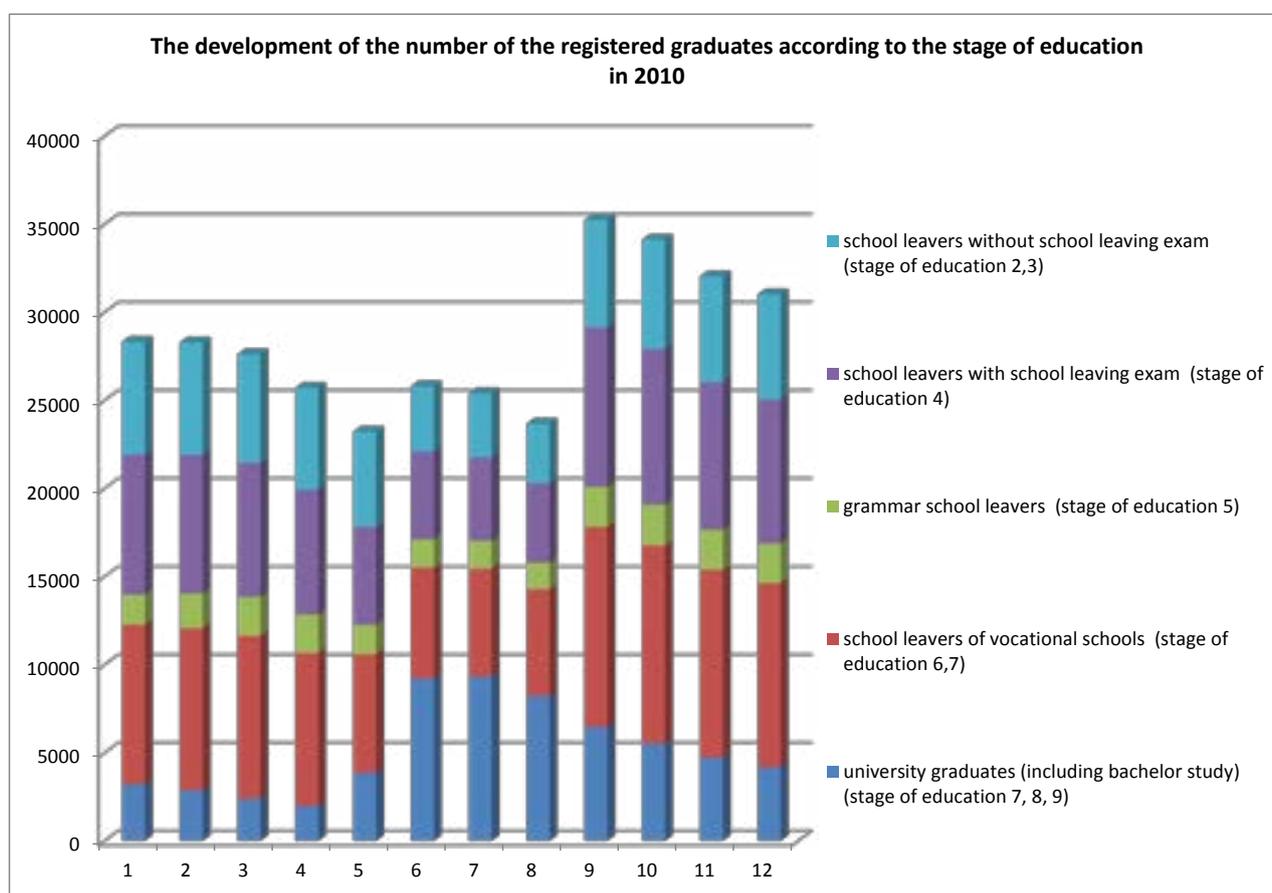
- job applications on the basis of real job vacancy in information, counseling or mediation systems about job opportunities,
- a document about personal search for job with an employer. A document from the same employer is possible to be submitted again only after three month,

- a certificate of the respective office offering permission to the applicant to carry out and perform a job as self-employed with the date of permission stamped on it,
- evidence of the initiation of the provision of personal assistance,
- evidence of the initiation of the provision of work assistance,
- an application for job mediation to a legal or physical entity which performs paid job mediation.

DEVELOPMENT OF THE NUMBER OF THE REGISTERED GRADUATES AT THE OFFICE OF EMPLOYMENT, SOCIAL AFFAIRS AND FAMILY

The Office of Employment, Social Affairs and Family keeps a registry and regularly publishes the numbers of Graduates according to the degree of education. Figure 2. shows the development of the number of the registered Graduates according to their educational degree in 2010.

Figure 2. The development of the number of the registered Graduates according to the stage of education in 2010



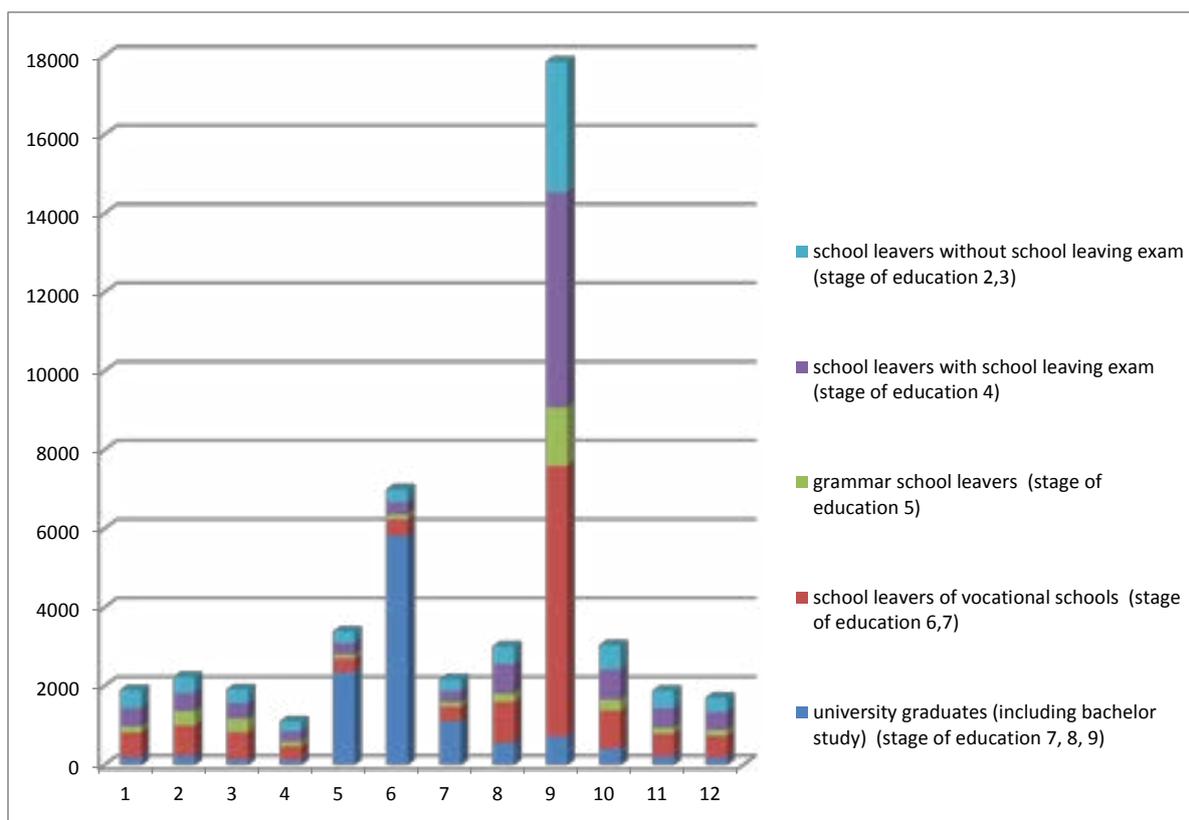
Source: Authors on the basis of data published on www.upsvar.sk

It follows from Figure 2 that in the first two month of the year 2010, the number of registered Graduates did not change. In March, April and May it slightly decreased. There was a growth in June followed by a new decrease in August. In September, there was sharp growth and in the following three months the number of registered Graduates is decreasing. The changes during the year are caused by natural factors. In May and June, University students finish their study. With the day of the state exam they stop being students and they register at the Office of Employment, Social Af-

fairs and Family. The parents of the High School leavers have the right to receive family allowances until August 31. Consequently, Graduates who have not found a job yet, apply for a job in September.

This phenomenon is explained in detail in the Figure 3. From the beginning of 2010, the inflow of job applicants – University Graduates was decreasing. In May and June when students are completing their studies, there are state exams and the inflow of these job applicants is growing sharply and in the following months it is decreasing and reaching lower numbers.

Figure 3. Development of the inflow of job applicants in 2010

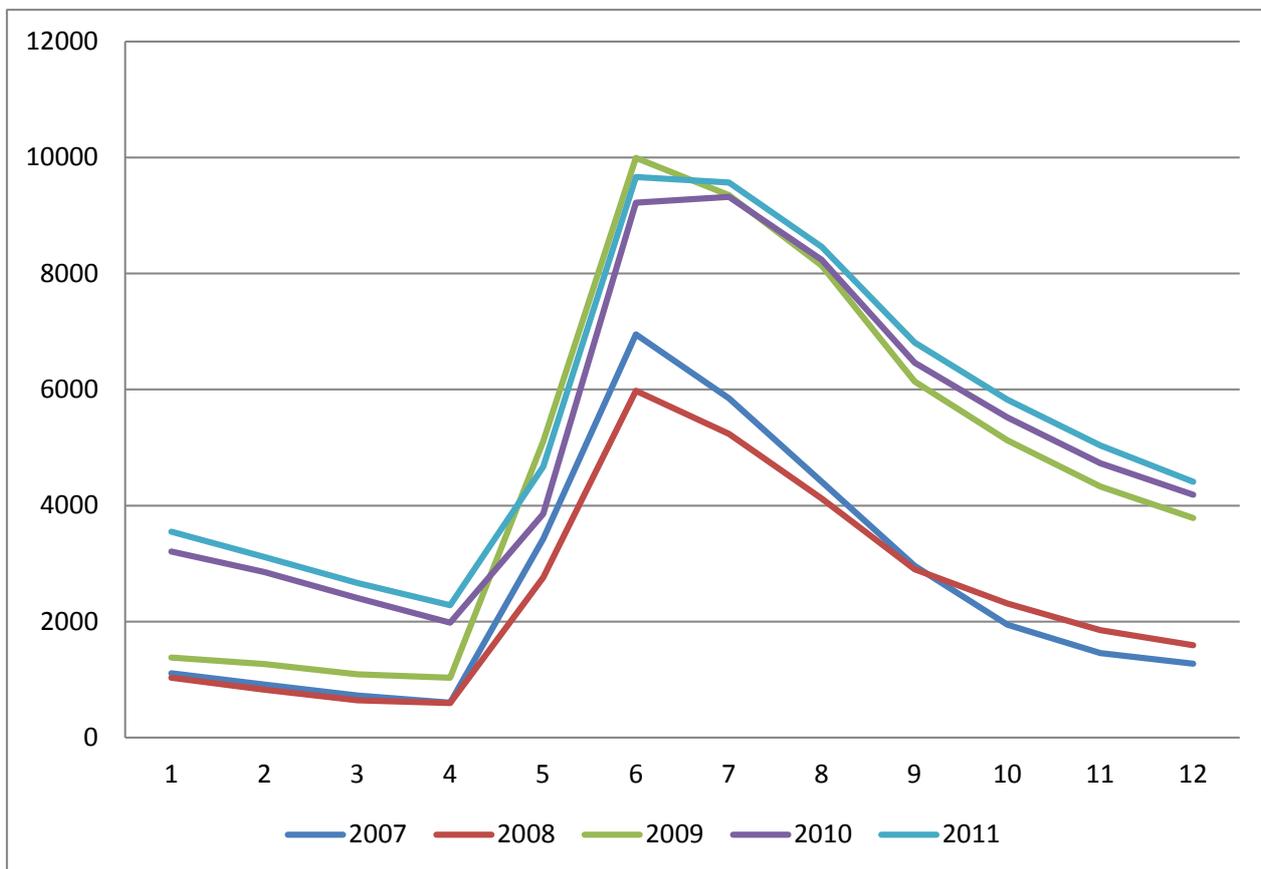


Source: Authors on the basis of data published on www.upsvar.sk

The situation in 2011 duplicates the development in the previous years. It means that in May and June, the number of registered job applicants - Graduates of Universities rises sharply, and from July to De-

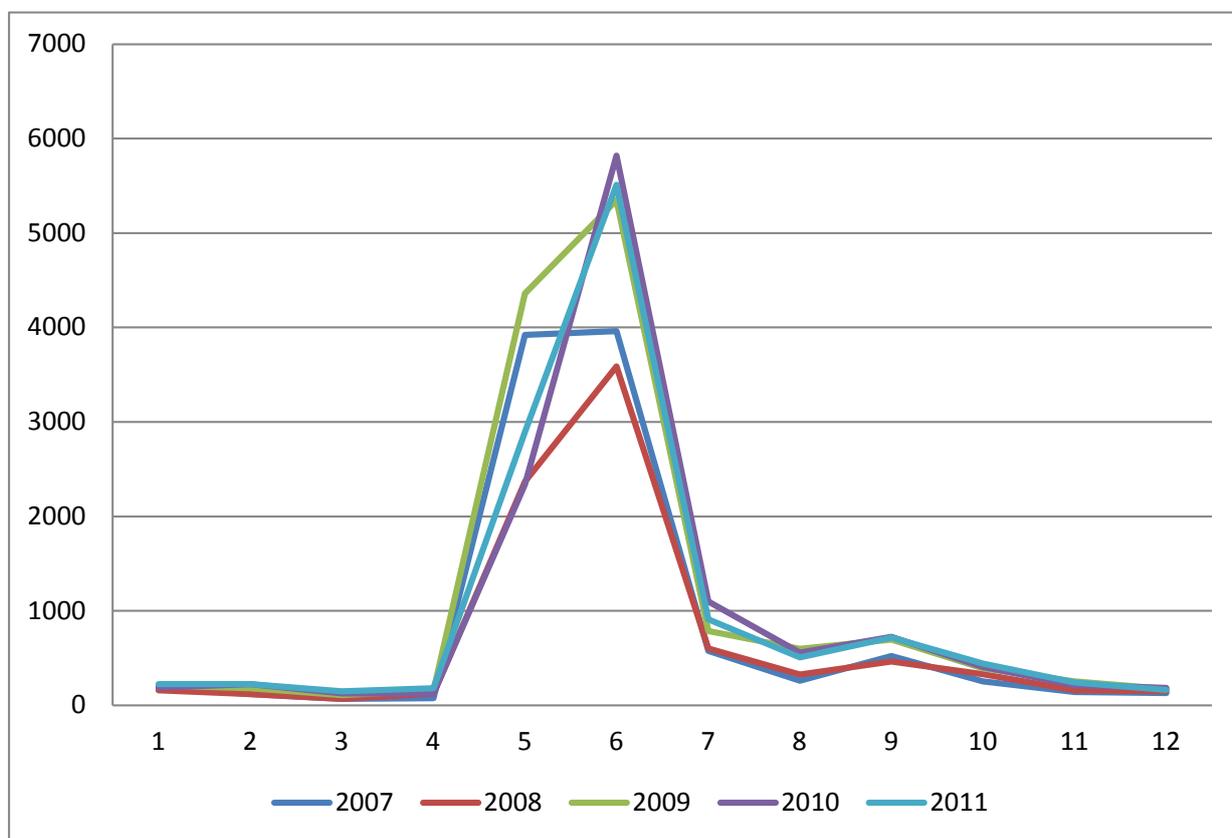
ember of the given year and from January to April of the following year their numbers fall. (Figure 4 and Figure 5).

Figure 4. The development of the number of the registered Graduates according to the stage of education in 2007- 2011



Source: Authors on the basis of data published on www.upsvar.sk

Figure 5. Development of the inflow of the job applicants in 2007- 2011



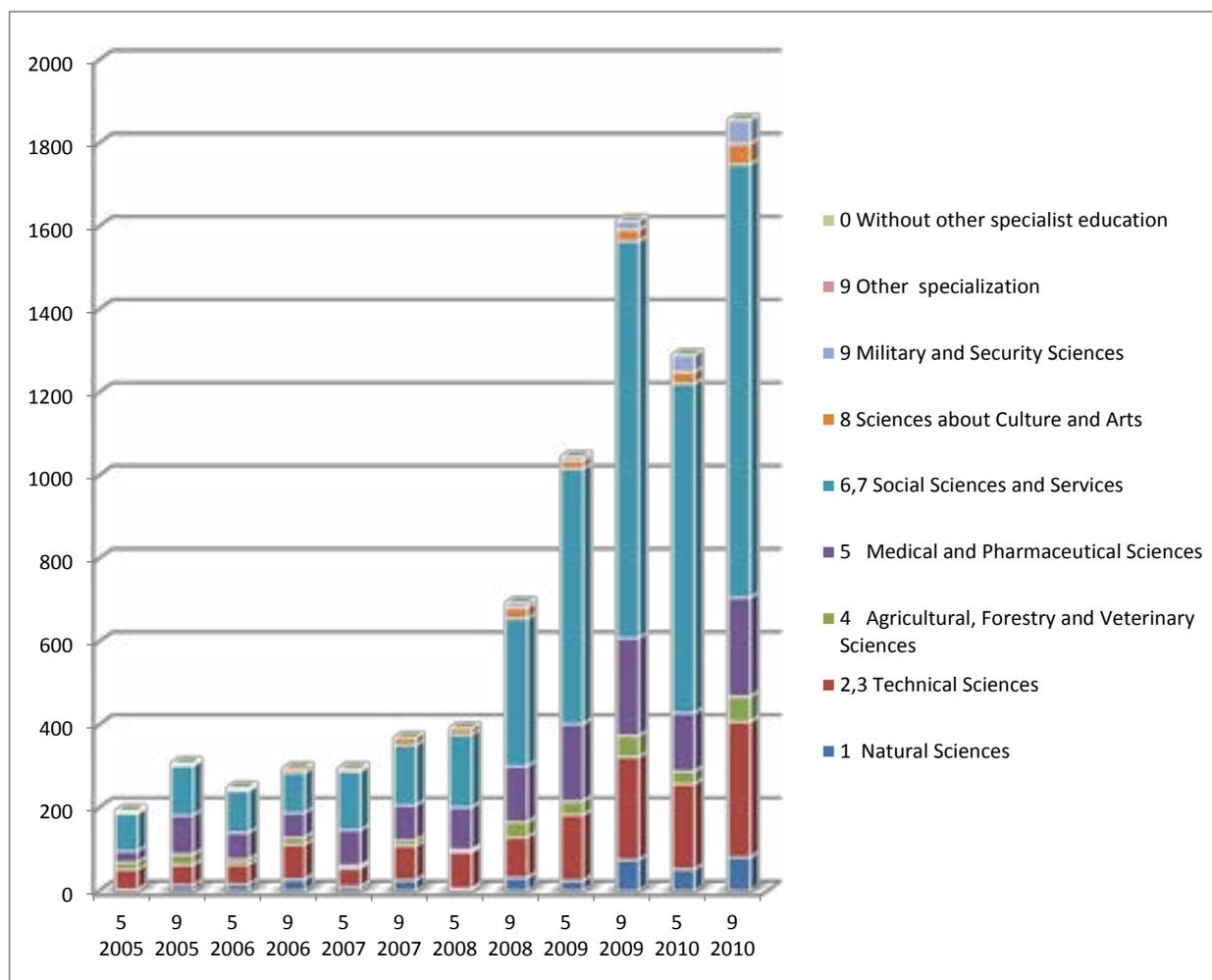
Source: Authors on the basis of data published on www.upsvar.sk

The Office of Employment, Social Affairs and Family monitors job applicants of University Graduates (as mentioned above) in three categories: Graduates with a higher specialist education, Graduates with a University education, and Graduates with a scientific education. The category of Graduates with higher specialist education is for those who reached higher education complete with a Bachelor Degree. It clearly follows from Figure 6 that the biggest proportion in this category consists of Graduates in the group of study specialization Social Sciences and Services which includes Philosophical Sciences, Economic Sciences, Economy and Organization, Trade and Services, Political Sciences, Legal Sciences, Historical Sciences, Journalism, Library Sciences and Scientific Information, Philological Sciences, Sciences about

Physical Culture, Pedagogical Sciences, Psychological Sciences, Complete Grammar School Education. In this group of study specialization there was a sharp growth in the number of registered job applicants in 2008 and 2009 (at the time of the first impact of the global crisis in Slovakia).

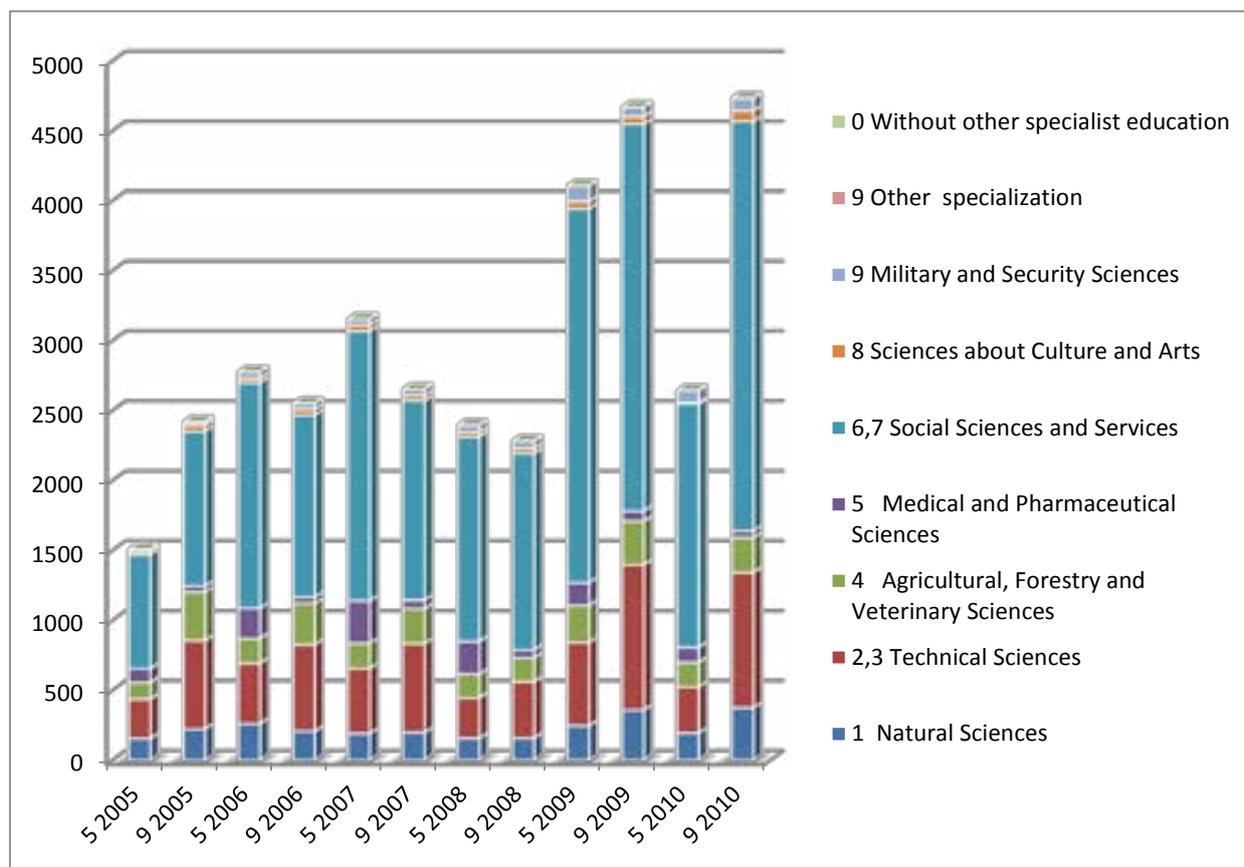
The growth of the number of the registered Graduates with University education of second stage (Figure 7) is influenced by the development of the whole economy. The Graduates apply for a job after passing state examination. Around the time of state exams, there is a growth which is followed by a Graduate decrease. Similar to the previously mentioned group the biggest number of registered job applicants is in the study specialization Social Sciences and Services.

Figure 6. The development of the number of Graduates with higher specialist education according to the study specialization.



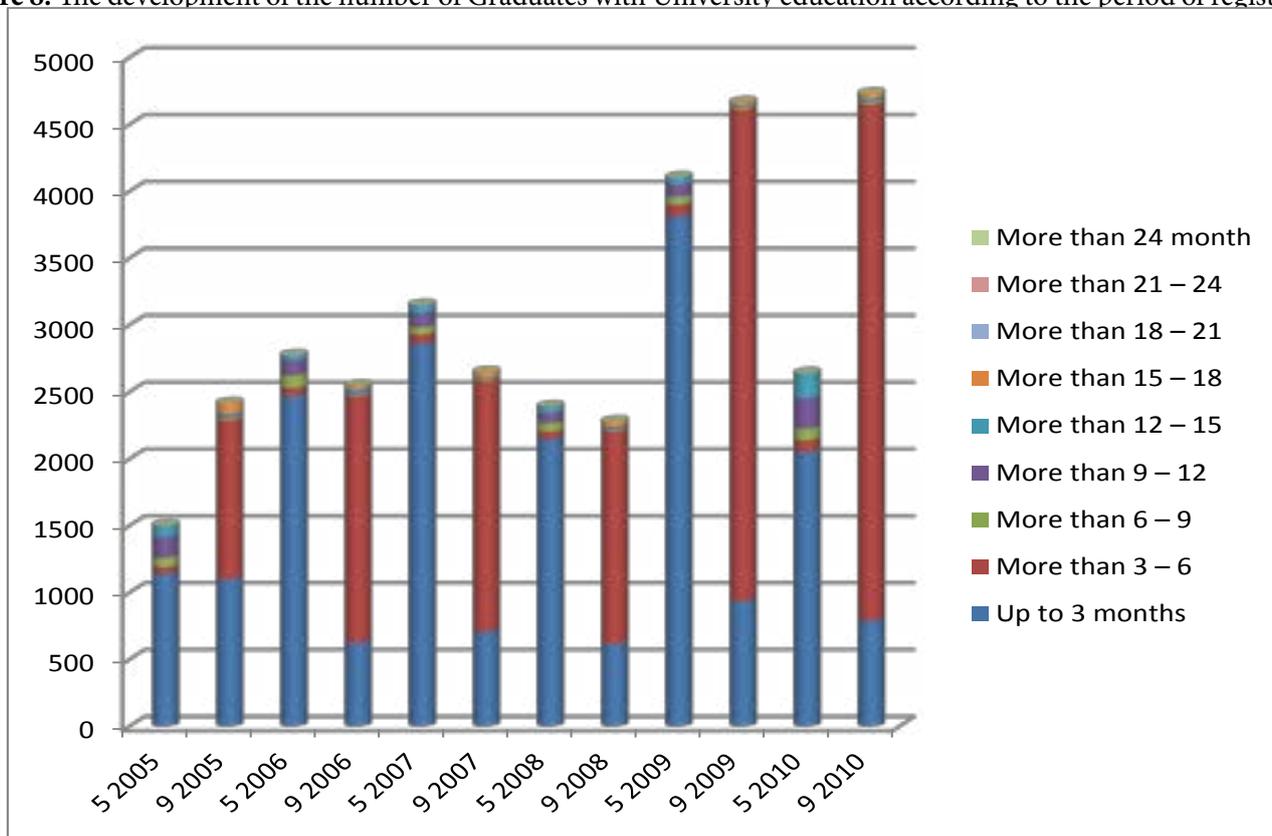
Source: Authors on the basis of data published on www.upsvar.sk

Figure 7. The development of the number of Graduates with University education according to the study specialization.



Source: Authors on the basis of data published on www.upsvar.sk

Figure 8. The development of the number of Graduates with University education according to the period of registration



Source: Authors on the basis of data published on www.upsvar.sk

Table 1. The development of the number of job applicants - Graduates of ten Universities with the highest number of registered Graduates in May

University/Year	2003	2004	2005	2006	2007	2008	2009	2010
Ekonomická univerzita v Bratislave	413	306	128	305	269	275	583	263
Katolícka univerzita Ružomberok					122	208	231	
Prešovská univerzita v Prešove	461	489	188	291	472			122
Slovenská poľnohospod. univerzita v Nitre	539	287	174	305	327	261	447	407
STU v Bratislave	300	283	111	174				
Trenčianska univerzita A. Dubčeka Trenčín						112	248	215
Trnavská univerzita v Trnave						86	166	115
TU v Košiciach	415	369	155	251	355	255	515	308
TU vo Zvolene	170		57					
UK v Bratislave	681	418	156	300	325	256	320	324
Univerzita Konštantína Filozofa v Nitre	195	241	148	349	292	298	565	
Univerzita M. Bela v Banskej Bystrici	138	188	92	154	264	182	211	214
Univerzita sv. Cyrila a Metoda v Trnave					105			102
UPJŠ v Košiciach		245	90	170	195	160		
Žilinská univerzita v Žiline	463	273		88			233	149
Ostatné vysoké školy	450	444	211	398	432	308	598	435
Total	4 225	3 543	1 510	2 785	3 158	2 401	4 117	2 654

Source: Authors on the basis of data published on www.upsvar.sk

Table 2. The development of the number of job applicants – Graduates of ten Universities with the highest number of registered Graduates in September

University/Year	2003	2004	2005	2006	2007	2008	2009	2010
Ekonomická univerzita v Bratislave	457	256	159	168	152	169	419	386
Prešovská univerzita v Prešove	333	283	153	240	305	233	355	362
Slovenská poľnohospod. univerzita v Nitre	614	571	372	346	267	189	416	411
STU v Bratislave	467	357	157	177	171	110	278	257
Trenčianska univerzita A. Dubčeka Trenčín							215	
TU v Košiciach	816	550	278	237	300	193	544	444
TU vo Zvolene	301	245						
UK v Bratislave	381	334	196	166	231	208	440	417
Univerzita Konštantína Filozofa v Nitre	241	255	165	194	170	206	335	370
Univerzita M. Bela v Banskej Bystrici	265	268	197	232	213	191	297	381
UPJŠ v Košiciach			141	139	147	144		218
Žilinská univerzita v Žiline	411	306	190	191	206	114	311	333
Ostatné vysoké školy	787	709	419	468	497	529	1 064	1 166
Total	5 073	4 134	2 427	2 558	2 659	2 286	4 674	4 745

Source: Authors on the basis of data published on www.upsvar.sk

It follows from the structure of the development of the number of registered job applicants - University Graduates - second stage, according to the period of registration that the Graduates in this category of applicants are registered up to three or six months.

Data about the numbers of job applicants of Graduates of ten Universities with the highest number of registered Graduates in 2003 - 2010 in May and September is given in the Table #1 and Table #2. In the tables we see the numbers of job applicants – Graduates with University education (second stage) and with scientific education (third stage).

MEANING AND SIGNIFICANCE OF WORK

Saint Thomas Aquinas distinguishes four aims of work: Ensures daily subsistence; prevents laziness which is the source of evil; restrains the lust of the flesh; and enables a man to give alms from surplus (Peschke K. H., 1999). These four purposes of work can be applied to contemporary professions for University Graduates.

According to Höffner (2002) the meaning of human work as well as the profession of man (or woman) can be summarized in seven points:

- Work as necessity - work is necessary because of the need for self-preservation of a man; the need to preserve the family; the need of its overall development.
- Work as a way of self-realization of man - God created man in His own image; man according to the example of God is obliged to imitate his Creator also at work; God calls man to be his partner in carrying out His plan. That is the reason why He does not carry out everything himself, but He allows space for man whom he equipped with the ability to get to know, to want and to create.
- Work as a means of forming the world and governing over the world - God created the world and finally created man, whom He gave power over the world and ordered him to rule the whole creation, and subdue the world. *“Be fruitful and multiply, and fill the earth and subdue it; and have dominion over the fish of the sea and over the birds of the air and over every*

living thing that moves upon the earth.” (Genesis 1, 28) *“These words refer to all the resources contained in the visible world and placed at man's disposal. However, these resources can serve man only through work. ... At the beginning of man's work is the mystery of creation.”* (LE 12)

- Work and profession as service - Höffner mentions a story by Johannes Tauler (+1361), who talks about a man, the friend of God, who has been cultivating the land for more than forty years. Once he asked God if He wanted him to stop this work and enter the services of the church. God answered “No!” He told him not to leave it. To remain with the sweat on the face to ensure his everyday bread. Consequently, continues Tauler, everybody must have his own profession.
Society requires four different kinds of human services:
 - » The work of a man who is intellectual
 - » The work of a workman who strives for the physical and mental health of a manager and
 - » The work of an economically active man
 - » The work of a man in the primary (agricultural) sector, secondary (industrial) sector, tertiary sector (sector of services)
- Work as punishment – Lev III. in his *Encyclical Rerum Novarum* points out that as for work, man, even in the initial state of innocence, would not remain idle. It's just what would be performed free of distractions of the soul; it is necessarily ordered to expiate sin; and it is not effortless and hassle ... pain is always present on earth ... so suffer and bear the legacy of man. There is no force or capabilities that could be removed completely from the world of suffering. He who promises a miserable life free from pain and toil, very calm and pleasant, introduces people and pulls himself onto a path that will lead to even greater pain than the current ones. (RN 14).
- Work as an effort - Christian teaching does not curse work, but work is mentioned as a strain, because after Adam's sin it has become a strain. A man who carries out his work responsibly

can say, together with the Apostle Paul: "Now, I rejoice in my sufferings for your sake, and in my flesh I am filling up what is lacking in the afflictions of Christ on behalf of his body, which is the church. (Kol 1, 24) John Paul II. In his *Encyclical Laborem Exercens* he says: "All work, whether manual or intellectual, is inevitably linked with toil. ... "Sweat and toil, which work necessarily involves the present condition of the human race, as a Christian - everyone who is called to follow Christ with the possibility of sharing lovingly in the work that Christ came to do. This work of salvation came about through suffering and death on a Cross. (LE 27

- Work as a celebration of God - man conscientiously carrying out his work (regardless of its type, form, or difficulty) glorifies God.

At present, we are often confronted with the fact that not everybody, not each University Graduate finds his profession, a profession which matches his inclinations, talents and abilities. Many people must be satisfied with a forced occupation. But for a Christian each occupation is a gift of God, because God calls man not only through the things he gives him (talents, abilities), but also things He sends him (disease and events which we usually call God's will). Therefore, Apostle Paul appeals to every man: "And whatever you do, whether in word or deed, do it all in the name of the Lord Jesus, giving thanks to God, the Father, through him." (Kol 3, 17)

"Profession is always the past but also a challenge to freedom and responsibility of man." (Höffner, J., 1990, p. 6-7). The above defined significance and sense of work applies to a University Graduate and requires him/her to prepare for a job with responsibility. Negligence in the framework of preparation is evidence of an irresponsible approach and is especially irresponsible when - as a result - a big damage to other people can arise.

John Paul II. In his *Encyclical Laborem Exercens* says that in present times: "Man's work ... has today in many cases ceased to be mainly manual, for the toil of human hands and muscles is aided by more and more highly perfected machinery and rapid development of science and technology has caused great changes in civilization." He continues, "Even in the age of ever more mechanized work, the proper subject of work continues

to be man". He considers technology to be an ally of work that human thought has produced. He understands it "not as a capacity or aptitude for work, but rather as a whole set of instruments which man uses in his work". It is an ally which facilitates work, perfects, accelerates and augments it. It leads to an increase in the quantity and quality of production. The rapid development of electronics technology, especially miniaturization, computer science etc. is associated with many dangers. Technology can "cease to be man's ally and become almost his enemy, as when the mechanization of work "supplants" him, taking away all personal satisfaction and the incentive to creativity and responsibility, when it deprives many workers of their previous employment, or when, through exalting the machine, it reduces man to the status of its slave. The biblical words "subdue the earth" undoubtedly include also technology, the world ... which is the fruit of the work of the human intellect and a historical confirmation of man's dominion over nature." (LE 5)

EMPLOYMENT OF UNIVERSITY GRADUATES IN THE LABOR MARKET VERSUS THE SIGNIFICANCE AND SENSE OF WORK

The above mentioned significance and sense of work also can be applied to the work of University Graduates. From those Graphs and Tables we see that the condition of Slovak Republic at the beginning of the 21st century. In an era of knowledge economy, we see a problem of unemployment of young people - University Graduates. Social Science in the Church points out that "The new discoveries and technologies, thanks to their enormous potential, can make a decisive contribution to the promotion of social progress, but if they remain concentrated in wealthier countries or in the hands of a small number of powerful groups, they risk becoming sources of unemployment and increase the gap between developed and underdeveloped areas." (KSNC 283)

Pope Benedict XVI in his *Encyclical Caritas in Veritate* also shows that "Unemployment today provokes new forms of economic marginalization, ... Being out of work or dependent on public or private assistance for a prolonged period undermines the freedom and creativity of a person and his/her family and social relationships, causing great psychological and

spiritual suffering.” (CV 25). This fact influences the life of the young person who has just completed studies at a University, even more. Full of enthusiasm, he/she finds that his/her ambitions are unrealizable. The Pope reminds us that *“The primary capital to be safeguarded and valued is man, the human person in his or her integrity: Man is the source, the focus and the aim of all economic and social life”* (CV 25)

John Paul II. in his *Encyclical Laborem Exercens* points out the problem that many different categories of people can become unemployed, *“Categories or groups of working intelligence, especially when together with an ever increasing approach to education and with an ever increasing number of people who reached degrees matching their cultural preparation, the need for their work is decreasing. Such unemployment of intelligence arises and increases when the available study does not focus on such kinds of jobs or services which are required by Society or when there is a lower demand for work for which a vocational education is required and when it is paid less than physical work.”* In Slovakia, we can also ask the questions: Do Universities educate Graduates of study specializations which are required by the needs of the society? How is the University Graduate rewarded?

DISCUSSION

The Office of Employment, Social Affairs and Family registers University Graduates and regularly twice a year, in May and September which list is published on their website. These published data are difficult to evaluate because University students complete their University studies at in different periods. Moreover, after completing their studies they have the option to decide whether to apply for job mediation immediately or look for a job themselves and only if they do not find any, can ask for mediation through the Office of Employment, Social Affairs and Family.

In spite of this fact, we can say that if University Graduates cannot become employed in the labor market, they look for a job through the Office of Employment, Social Affairs and Family. The consequences of non-employment of University Graduates in the labor market can be examined from different perspectives, for example economic, psychological and social.

The problem of unemployment is perceived by

the Church as distressing and especially painful when for young people who after completing their University studies enthusiastically stand at the beginning of their life; starting their families; becoming aware of a need to ensure their living by work. Cardinal Höffner summarized the teachings of the Catholic Church about the sense and significance of human work in six points. They can be applied fully also to the University students in Slovakia because:

- Work is a necessity for ensuring a means for satisfying one’s own needs and the needs of a family
- Graduates try to realize their potential in practice
- They are able to contribute to the forming of a society by their highly qualified work
- They are looking for or have already found their profession by which they are able to fulfill their mission of life
- Each work requires effort and sacrifice
- By his conscientious work a young man/woman also celebrates God.

CONCLUSION

Universities in Slovakia are considered to be significant and exclusive places of education of specialists at all degrees of University education. In spite of this, many University Graduates after completing their studies cannot find an appropriate job in the labor market, and therefore, on the basis of a written application, they ask the Office of Employment, Social Affairs and Family for job mediation. University Graduates up to 25 years of age are a specific group of job applicants. The problem of unemployment is getting especially frustrating concerning young people who, after appropriate cultural, technical and professional training, cannot find a job; find that although they try their best they are stopped from being able to take responsibility for their part in the economic and social development of Slovak Society.

LIST OF ABBREVIATIONS

CV	Caritas in veritate
Gn	Genesis
Kol	List Apoštola Pavla Kolosanom
KSNC	Kompendium Sociálnej náuky Cirkvi
LE	Laborem exercens
RN	Rerum novarum

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Correspondence to:

Mgr. Ing. Monika Bačová, PhD.
Katedra ekonómie
Podnikovohospodárska fakulta so sídlom v Košiciach
Ekonomická univerzita v Bratislave
Tajovského 13, 041 30 Košice
Slovensko
Tel.: +0421(0)55 / 7223111
Fax.: + 0421(0)55 / 623 06 20
E-mail: monika.bacova@euke.sk

Mgr. Zuzana Bričová
Katedra jazykov
Podnikovohospodárska fakulta so sídlom v Košiciach
Ekonomická univerzita v Bratislave
Tajovského 13, 041 30 Košice
Slovensko
Tel.: +0421(0)55 / 7223111
Fax.: + 0421(0)55 / 623 06 20
E-mail: zuzana.bricova@euke.sk

SOCIAL THESIS IN ALCOHOL ADDICTION

Nataša Bujdová¹, Bohuš Čepiga¹, Stanislav Bujda¹, Eva Razzouková¹

1. University of Health and Social Work, St. Elisabeth Bratislava

Key words:

alcohol; intervention; client; family; therapy

Abstract

The problem of alcoholism is still relevant and alive. We meet with it almost every day. Not only vicariously through the mass media, but this phenomenon was also observed in their neighborhood, some even in their own family. Alcoholic family members go through the same stages as a person who is addicted. Like an alcoholic, the family is making tremendous effort to not have to admit the problem.

INTRODUCTION

Alcoholism is a phenomenon that is known as pathological. A separate branch of science that examines the phenomena unhealthy, abnormal and generally socially undesirable, hence the obsessive addiction to alcohol is a social pathology. It can be seen as a branch of sociology. Social Pathology deals with the regularities of such behaviors, the company evaluated as undesirable because they violate the social, moral and legal norms. It is natural that we witness daily violations of various standards. In any social setting, there is a certain tolerance limit which is variable in time and in terms of the current level of socio-cultural knowledge of a particular company. Individuals differ in their behavioral patterns, which in the limit of tolerance fit. (Fischer, Skoda, 2009). Social Pathology alcoholism is very varied. It can be characterized as a failure to meet the requirements of normal social roles. A way to develop alcohol dependence, which is the procedural treatment. Recovery program usually begins outpatient phase, but in those where it is not sufficient, it is necessary institutional treatment, which aims to achieve a complete and permanent abstinence of the patient.

ADDICTION THERAPY

Treatment program, which aims to mitigate or eliminate undesired status of an individual or family is therapy. The original meaning of the word is support. The Greek word *therapeia* means to support. (Matousek, 2008, p. 227).

Therapist who provides therapy takes on the responsibility of caring for the client. It is those to whom you can rely, and who will support the client. The helping profession has three characteristics: 1. therapeutic significance between the client and helping, 2. use of psychological and social therapeutic techniques to influence client, 3. special license, which must be the one who performs therapy. (Matousek, 2008, s.165).

The psychotherapy is practiced by specially trained psychotherapist. The therapeutic relationship between client and therapist sets the stage on which the therapist works. The methods of making psychotherapy therapy include individual, group, community, family or art therapy. By Levicka (2007, p. 110) may be "therapeutic relationship to the client benefit or harm." Therefore, social workers must constantly aware of their own values, and objectively evaluate the therapeutic relationship. Therapists have to define precisely the task - they do what they want with the client to achieve, and how they plan their work.

Therapeutic community is by Kratochvil: "a special form of intensive group sychotherapy, where cli-

ents, mostly different ages, gender, and education, living together for some time, and in addition to group sessions share another common program with employment and other diverse activities, which enables to this small model of screened problems of his own life, particularly his relationship to the people. The community is therapeutic because apart from that projection also allows feedback of maladaptive behavior, encouraging gain insight into their own problems and its own share of creating this problem is to enable corrective experience, and supports the training of more appropriate behaviors.“ (In: Kalina, 2008 , p.17).

The treatment of clients with primary alcohol dependence in therapeutic communities are relatively few reports. Dutch authors (Van de Valde, Schaap, Land) on a sample of 900 patients showed that the therapeutic community “originally created for users of drugs works equally also good in alcoholics”, and their success as well as for drug clients - perseverance in the treatment and continuation of treatment following (Kalina, 2008, p. 280). Therapeutic communities provide medium-term or long-term residential treatment 6-18 months. Intensive, structured treatment in therapeutic communities is divided into 4 phases. Emphasis is placed on intensive therapeutic process and community life.

Individuals who are in a difficult situation or suffer long-term psychological and somatic problems are addressed psychosocial intervention. Its aim is to attempt to enter the human habitat and other human efforts to establish internal psychological balance. Psychosocial intervention is the professional activity carried out by a specific person or organization in order to improve the quality of life of individuals or groups. It is a work that responds to the request individual or social. (Hoskovcová, 2009).

Psychosocial intervention is often focused on social aspects. In this case it is done in natural social situations. In some cases, using a therapeutic community and halfway houses. The techniques used for such intervention have a collective character. Under this intervention will apply various theories of human behavior and social environment.

The basic strategy of psychosocial interventions by Hoskovcová (2009) are:

1. providing psychological or medical services (counseling, crisis intervention, using the

therapeutic procedures such as music therapy, physical therapy),

2. education (providing information about the problem and methods of coping),
3. enjoyment of social activities that allow to express feelings and thoughts (debriefing, defusing),
4. encourage and create conditions for natural personal development (through physical activity),
5. development of interpersonal skills (mediation services, relaxation techniques, support client self-sufficiency),
6. strengthening existing social network in the community (self-help groups)
7. improving professional skills (teaching professionals for early detection of adverse events among clients)
8. provision of material assistance (create a sense of safety for the client).

The process of treatment is usually very long and complicated. It is very important that all who participate in treatment / client, parents, social workers, doctors, therapists / act so as to attempt any of them been destroyed. It may happen that a client with a therapist is against the parents. These situations are nothing special. Families share the success of treatment is considerable and adolescents, it is doubly true. The first major task of the family is that all its members accepted the fact that they are living with alcoholics. Most treatment programs include systematic collaboration with the family. Dependent family member needs from their loved ones above all openness. (Vodáčková et al., 2002).

Crisis intervention is limited to the minimum therapeutic intervention is always there and then, where the state of emergency so that other psychotherapeutic choice at the moment does not allow. This is easily achievable by current aid - to give a stable personality, but also perspective. The term crisis intervention services covers a wide range of volunteers, professionals from help lines to standard psychiatric services. Crisis intervention is usually shorter, except psychologist, psychiatrist, working on her social worker, doctor, family member or friend.

Consideration of crises person is most important for the effectiveness of crisis intervention. Considering starters emergencies. These include in particular time, space, inadequate response, especially suicide.

Other triggers are past traumatic experiences and further present countervailing strategy and its pre-crisis level of functioning. Crisis intervention carries crisis interventionist. Since the crisis intervention list in the system of professional assistance during crisis intervention require personal qualities and principles that have characterized his behavior. (Hoskovcová, 2009).

Crisis intervention worker has to have concern for people and desire to help them. This is reflected in a peaceful understanding of human weakness, the impartiality, the compassion, the participation and willingness to stand up. Must not treat people with hate, irony, indifference, internal resistance, aggression. Crisis interventionist is to have the ability to communicate verbally and nonverbally as well as the skill to easily make contact with people averse and aggressive. Communication style to be effortless, natural, that there was no cooperation from the client. Congruency is important from a social worker.

Communication activities to include empathy. Empathic understanding arises in communications and communications. Who knows well is able to communicate and collaborate. It is a quality of personality analogous to communication. Initiative and dynamism - a strong internal target orientation, deployment of personal energy for this process. Stability is the result of autonomy, decision-making power and resilience.

Crisis intervention worker with high social intelligence is knowledgeable people, it makes sense to understand the social structure and logic of social behavior. Includes personal moral integrity and ethical values of certainty. Crisis worker enters the persons who participate in the issue. This feature occupies an intermediary, it confronts each other, negotiate and act as a mediator. In this position proximity effect allows a personal relationship. Social worker tends to the withdrawal of negative feelings. In the explanation of feelings must be the worker and the client clear that deal with feelings will only to the extent as is necessary to solve the problem. It is important to recognize the boundaries that divide the actual assistance from psychotherapy.

Collateral effect of each crisis is the loss of mental balance, which touches each other and to different extents. However, the crisis can be seen as an opportunity to try yourself, your limits. Because it is the crisis we often pushes further by preventing indi-

viduals remain at an advanced level.

Helpline is a tool that helps a person in sudden mental disorders in personal conflict in emotional loneliness in strained interpersonal relationships. Helpline telephone as the first aid station exists since 1953 and was in London. It was founded by an Anglican priest Chad Varah. A similar view emerged and helplines worldwide.

In Slovakia, was founded in 1977 as the first line of trust department of the hospital in Humenné. Later arose others that had a special focus. The most frequent problems with which the caller turning to helplines is a problem psychic partner. To call the helpline abstinent alcoholics relapsed.

GROUP THERAPY

When working with clients of social work is necessary to work with the social environment, especially with the family. We consider therefore work with family socio-educational group therapy for. The purpose of social work with a group of the psychosocial effect on a group of people with some common features, and in order to become integral personality or re-discovered it and be able to seamlessly develop socially globally. (Mühlpachr, 2008, p. 41).

Group therapy is suitable for all clients, except people feisty, aggressive, and people who have great social inhibitions. The basic remedies that are used in group therapy is group dynamics. Represents the relationships and interactions between group members. This applies when the client problems persist and can not handle it alone. Although man is a social creature in some cases does not attempt to present their problems before the group, considering his problem for intimate wishing to be tackled individually. He feels that narrate their problems before the group could endanger his life and that of his family that someone from the group this information tell-surroundings. Other times, the client feels that it is important to help him expert and not lay people who make up the group. Practices that will benefit the client psychotherapist can be very well considered and the procedure must be agreed with the client.

Working with the group has its rules. Rieger in Matoušek et. al (2008) identifies the following key points:

1. confidentiality and trust - information obtained during the group sessions are confidential and can not be without the author's permission to present surroundings,
 2. openness and honesty - if the client feels supported and safe in the group can tell about yourself and intimate things, it is important to express your true feelings,
 3. the right to say "stop" - if the client feel that approaching a subject which it is not pleasant to the retelling group has every right not to talk about it, other people must be respected,
 4. responsibility for self and others - working with others requires respect the fundamental rule of social coexistence, and it is right to respect for privacy, intimacy and autonomy of each member of the group,
 5. compliance with organizational rules - rules for group work are given at the outset, all members are required to follow such basic rules such as: regular attendance, punctuality, an excuse for not meeting beforehand.
4. We made a courageous moral inventory of herself
 5. We admitted to God, ourselves and others, what we did wrong.
 6. We are ready for it, that God remove our defects of character.
 7. Humbly we asked God to remove our defects.
 8. We wrote a list of all the people who hurt us, and we are willing to correct their mistakes.
 9. We have tried, wherever possible; eliminate the damage we have caused, except if it could hurt someone.
 10. We continue to take personal inventory and admit what we did wrong.
 11. Through prayer and meditation we try to improve our conscious contact with God.
 12. We ask only for the fact that we know his will and the strength to fulfill it.
 13. When using this program will achieve spiritual enlightenment, by passing this message to others and ourselves, we will follow these principles in all situations of life. "

From choosing the model work, it depends on the objectives and tasks of group work. Papelová and Rohmanová (In: Oláh, Schavel, 2006) sets forth three models of social work with groups:

- Model common objectives,
- Model remedial objectives
- Model aims to build on reciprocity, solidarity.

Since the seventies of the twentieth century has been developing self-help and support groups. Their aim is to link the natural and artificial groups, because they create the clients themselves. So far, the largest self-help group in the world - a movement Alcoholics Anonymous was founded in 1935. In Alcoholics Anonymous was published the following twelve step program of Alcoholics Anonymous (Beattieová, 2006, s.233):

1. "We confessed that we are defenseless against alcohol, that our lives became unmanageable.
2. We believe that it will help us more power than we are, and heal us.
3. We decided to entrust your will and your life to God.

In 1970, a movement founded Al-Anon with the group of people closely associated with alcoholics. Self-help groups are still the most important form of aid in the world. Membership in a self-help group is not prescriptive, but is based on democratic principles. It is true that man here to help not only accepts but also it provides. If someone is able to help the other, and can even help each other. People like clusters share the same or very similar problem, so it may not explain each other. Despite the failure remains a part of the group member is encouraged to stand. Self-help groups are using to get rid of helplessness and can change the unfavorable living situation.

Most self-help groups help their members cope with physical and mental illness, or substance abuse. Members can provide information, sometimes even providing direct practical assistance, have common interests. In relation to professional workers in health care facilities and social services may be members of self-help groups critical. In many cases, aid self-help groups is not enough, then the additional service to professional services (Matousek, 2008).

Between 1957 - 1960 operated in Poland Kruciáta of restraint. This Kruciáta was a "marian" movement that struggle with alcoholism and misbehavior directed to the restoration of person. Kruciáta

liberation person is not the an organization or association but program activities arising from the Christian understanding of responsibility and involvement.

It is also a testimony by Christian way of life, charity work and apostolate. Patron Kruciáty liberation person is immaculate Mother of the Church. The basic commitment is to maintain complete abstinence from alcohol at the time of membership heck. Member undertakes not to offer not to buy alcohol and alcoholic beverages. For the drunkard is the only way to salvation maintaining total abstinence until death. Kruciáta person liberation movement should be aimed at a wide range, which seeks to mobilize around monolithic program and work all people of good will who desire to save the nation.

Although the social work group aims to remedy the management of group and the achievement of the goals together, not to forget the individual symptoms and needs of all its members. Lessons learned in the group to be beneficial to the development of individual personality in the group.

RESOCIALIZATION

Resocialization by Matousek (2008, p. 174) is “a return to socially accepted behaviors in people who have strayed from it.” Unless the client is given due care and social reintegration program after completing the change achieved in the reintegration probably permanent issue. Enter into the process of of resocialization clients mostly involuntarily. The main objective of aftercare for the client is to stabilize his lifestyle, fitness abstinence, gradual release binding’s client and social worker. Social work is at this stage supporting character. Client support often consists of clarifications client commitments and issues that must be addressed and its priorities. At this stage assesses the client’s current situation, social stability and its ability to operate without support.

Resocialising program is designed to recover, rebuild and reclassify the value system of the individual and the cause newly learned behaviors. In practice, we meet with the involvement of significant others in the social reintegration process dependent person. Family involvement is directly indicated in the placement of juveniles in resocialization centers. In family therapy is primarily an effort to uncover maladaptive functioning of its individual members, facilitate com-

munication within the family, expressing feelings and survival. It is counterproductive to indicate the family as the main culprit of compassion and survival.

Resocialization is the process of removing already acquired, but inadequate, inappropriate or socially undesirable behavior patterns, norms, social roles, knowledge and skills of individuals and their replacement by others - with new, more appropriate, socially desirable, and the like. A complex of measures, procedures and activities (economic, social, health, employment, educational, psychological, cultural - educational) aimed at socializing treated subjects from any pathological dependence upon completion of the therapy.

The aim is continuous and rigorous abstinence. Resocialization of addiction is a long process of removing already acquired, but inadequate, inappropriate or socially undesirable behavior patterns, norms, social roles, knowledge and skills of individuals and their replacement by others - with new, more appropriate purposeful and directed influence, guidance pretreatment addicts. Success is determined by of resocialization effect of activating the intrinsic ability person to overcome personal and social consequences of addiction and to engage in life in a natural environment. The process is thus programmatically focused on lifestyle change through changes in thinking, in order to achieve full integration, a full return to normal life. (Lindenmeyerhas, 2009).

Passing recovery program is the first step and the basis for of resocialization alcoholic, but not a sufficient intervention. The patient enters the treatment process, which adjusts to the new situation. Begins the process of active social learning, which depends integrated into the work and family environments. They learn a new perceive, experience and respond to rapidly changing conditions of social life. Resettlement, reintegration and re-education as part of aftercare target a particular composition to restore abilities lost due to excessive alcohol consumption, that is to harmonize personality abstinent alcoholic.

CONCLUSION

Alcoholism of a family member is in sharp contrast to the interests, needs, objectives and targets families. It is one of the biggest social problems of our society. Benefiting all sections of our society, draining

power and resources that could be used more effectively elsewhere. An extreme approach to alcoholism is a statement of prohibition - prohibition of manufacture, sale, distribution, importation and use of alcohol. The companies who chose this approach has prevailed smuggling, the fine form of sale and distribution of alcohol, created secret places where alcohol is served, which was usually associated with a rise in crime.

This suggests that alcoholism is not a social problem only by subjective criteria, but also recognizes this problem and objective measures shall be taken against him. The growth of alcohol consumption and its adverse consequences of its use, we see that the measures would be more effective if applied to all elements that we can use to combat alcoholism. What is important is the question of individual attitudes conditional education and knowledge of the enemy. Much depends on transferring scientific knowledge into practice and popularization. But most importantly - do not underestimate the dangers of alcoholism represents for the individual and for society as a whole.

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Correspondence to:

PhDr. Nataša Bujdová, PhD.
natasabujdova@gmail.com

Mgr. Bohuš Čepiga
bohuscepiga@gmail.com

PhDr. Stanislav Bujda
stanislav.bujda@gmail.com

PhDr. Eva Razzouková
razzoukova@gmail.com

A CRITICAL VIEW OF THE EUROPEAN MODELS OF FAMILY POLICY

Milan Fula¹

1. University of Health and Social Work, St. Elisabeth Bratislava

Key words: family policy; relational capital; family mainstreaming; social subjectivity of a family

Abstract

The article is based on noting of multiplicity of forms of a welfare state and corresponding family policies. It identifies three conceptual models (the liberal, socialist and the corporative) which are inspiring the family policies in Europe and summarily analyses their achievements and failures.

Based on this evaluation and ongoing revolution in the family structure and behaviour it notes a crisis of family policies and a need of a new orientation of a family policy. Within the national family policies, there is a need for a new subsidiary model, which would support the relation goods of the family. For achieving this goal, it is necessary to adopt the family mainstreaming. In the context of a family policy crisis, the article outlines a new relational model of a family policy whose reference point is to be a complex subsidiarity and a social subjectivity of a family, defined as a relation of a complete reciprocity between the genders and generations.

INTRODUCTION

Recently, there has been a new interest in the family and its future in the European countries. In almost all of the countries, there is an effort to redefine and revive social policies for supporting the family. In 1989, the European Union introduced the family as a topic of primary political interest in the Community. This positive interest in families continued in creating The European Alliance for Families, in request for an active family policy (family friendly) and inter-generational solidarity (KOM, 2007; EÚ, 2012). Considering the revolutionary changes in the family behaviour, it is an extremely difficult theoretical and practical challenge for each of the countries and the European Union as well.

THE CRITIQUE OF THE MODELS OF FAMILY POLICY

A family policy must operate with the

criterion of the well-being of the family. (Zimmermann, 1992). A family policy is made up of a series of measures by public authorities, aimed at facilitating resources (in a general sense) to ensure that all families may function in the best possible conditions. These measures are shaped by the country's value system, traditions and inspiring principles. We can speak about five different geopolitical family policy areas within Europe (Donati, 2003; Zimmerman, 2003):

- The Francophone area (France, Belgium, and Luxembourg) characterized by generous and diversified family policies (high financial support, wide services);
- The middle European area (Germany, Austria, Poland, Czech Republic, Slovakia) where family institution policies are typical (high financial support, lower support of services);
- The Scandinavian area (Sweden, Norway and Denmark, Finland) is characterized by the development of social state based on gender parity, childcare and the professional and family life balance (lower financial support, high support

of services);

- The Anglophone area (United Kingdom) where predominant interventions in poverty and social exclusion are typical (low financial support, low support of services);
- The Mediterranean area (Italy, Spain, Portugal, Greece) characterized by fragmentary interventions in favour of families (lower support of families because of continuing family solidarity).

There exists a plurality of highly varied welfare regimes and models of family policy (Zimmerman, 2003; Gauthier, 1996). The most widespread classification of author Esping-Andersen (1990) which distinguishes regimes of liberal welfare typical of the Anglo-Saxon countries, the regimes of socialist welfare typical of the Scandinavian countries, the regimes of conservative or corporate welfare typical of the countries of central Europe, and regimes of the so-called “familistic welfare” in the Mediterranean countries.

Stated classification was subjected to legitimate critique: it is an ethnocentric classification (Scandinavian model, which is considered the best); it contains a negative ideological vision of the family (adopts an individualistic philosophy); it does not grasp the far more complex empirical variety of the models (Arts, Gelissen, 2002). P. Donati (2003, 2012) suggests the classification of the ideal-type models of family policy, based on their main characteristics (the fundamental characteristic principle, the definition of family, and the fundamental regulatory criterion) and practical (both positive and negative) results. He differentiates the three ideal-type models of family policies in the 1900's:

- Liberal model: the principle inspiring is one of individual liberty and the protection of privacy; the family is essentially defined as a contractual institution between individuals; the laws of the market (private ownership and contracts) regulate the family. The positive is the free choice of the family and its management; the negatives are the assistance to individualism and the fragmentation of the social network; overall, it co-produces a culture in which the family becomes useful/useless for an individual;
- Corporate (categorical) model: the fundamen-

tal principle is a collective solidarity (according to work categories); the family is defined as a social institution based on complementarity between genders and on subsidiarity between generations; social security systems (designed to sustain the worker's family in respect to his/her status in the labour market). The positive of this model is the public support of family solidarity. The negative is the lack of equality between genders and generations (deficit of equal opportunities); overall the family becomes a support of the state (the opposite of subsidiarity);

- Socialist model: the principle inspiring is social equality; the family corresponds to the household or the anagraphical family; political command of resources in order to support the family responsibilities of individuals (politics over/against markets). The positives are equality and redistributions of sources for the weak. The negatives are threat of poverty and loss of social links; overall, the family becomes an affective aggregation of individuals.
- In all three ideal-type models of family policies their subject and object – the family – is problematized – concerning either minority family type (corporate model) or a family understood as an unspecified aggregate of individuals with their needs (liberal and socialist model) – to the point where the sense of family policy itself is doubted. If the real content of the term ‘family’ is emptied, it is then questionable whether we can still speak about family policy. Family policies of a traditional welfare state actually become policies to improve lives of individuals (they support simple relationships in care and equal opportunities implementation) apart from their gender and generational relationships. In summary, current national family policies, which combine liberal and socialist model, individualise people, weaken and consume social family capital and thus conduce to family disintegration. (Fula, 2011).

Considering the ongoing revolution in family structure and behaviour (decrease of nativity, population aging, increasing number of independently living persons, divorces, single-parent and reconstructed

families, homosexual couples and families, problem families, fatherless children, etc.) it is not enough to deal with family indirectly (like with a demographical problem, poverty, equal opportunities, employment, social inclusion).

We can say summarily, that the crisis of family policies is caused by multiple reasons (Donati, 2012b; Donati, 2003):

- Family policies have prevailingly assisting character: the help is provided to individuals, so that they can release themselves from family tasks, which leads to collectivisation – the state takes over functions of the family (e.g. through the system of collective care institutions in hands of the state) and consequently to overload of the social system;
- the family policy often identifies with matrifocal policies, centred on the woman and on the mother-child dyad (in Scandinavian countries and the European Union in general) and with weakening of the role of father;
- Many policies privatise values and family behaviour by the fact that they encourage individuals to understand family relationships as a private matter and as a result of private preferences and decisions;
- It concerns only implicit policies for family, because they are concentrated on individuals in their life cycle and on the help to individual generation categories (children seniors);
- It is about indirect policies for family, because they concern general subsistence of individuals (health, education, basic income, accommodation, job, etc.); mostly they use the family as an instrument to fight poverty and social exclusion.

This approach circumvents the basic question of family policy: what 'being a family' or creating a family means and what are its social functions. In other words, an authentic family policy should respect the fact that "the family based on full reciprocity between genders (marriage) and generations (civilisational heritage transmission) is the greatest social resource of the society." The reason is that the family generates primary social capital, namely "the quality of relationships (imbued with trust, cooperation, reciprocity) which makes the human capital grow (personal tal-

ents, creativity), associative capital (relationship networks creating common good), civic capital (public behaviour)". (Fula, 2011, p.121-122). The 'standard-constituted family' which is understood as the union between a man and a woman united in marriage with two or more children, is what ensures most satisfaction to its components because it creates greater human and social capital (Donati, 2012b).

Passive acceptance of pluralisation family forms and failure to differentiate between family and parafamily forms of cohabitations (without stable covenant and complete gender and generational reciprocity) leads to reduction of the family (substantial social institution) to primary affective relationships. This means to agree implicitly with increasing number of potentially unhappy persons because of connection between dynamics of pluralised family relationships and individual and social difficulties, diseases and pathologies. Unfortunately, in political and economic systems there is lack of sufficient knowledge of the modern poverty in families consisting of relationship deficit, which also influences social cohesion. (Donati, 2001).

If we realise that the family is not only a private but also a public matter because of its social value and functions (the family is a mediator between individuals; the family itself represents social capital which the society cannot do without) we detect the need to regulate actual transformation process of the family in the collective interest (and not to let it take its natural course, because it leads to pathological consequences either) (Donati, Solci, 2011). We need to completely rethink family policies, which must be geared above all to the creation of the family.

THE RELATIONAL MODEL OF FAMILY POLICY

Considering the crisis of current family policies and the revolutionary changes in family structure and behaviour a renewal of family policy is required. In other words new situation demands transition from social policies based on family revisualization to social policies focused on "social subjectivity" of the family.

The new orientations for family policies requires (Donati, 2012):

- Subsidiary policies: assistance has to be granted so that people could realise their tasks in family and in social networks; the subsidiarity between state and family means that the former has to operate towards the autonomy and the empowerment of the family and family associations;
- Policy for the family nucleus: centred on the reciprocity between genders and between generations;
- Policies valorising family relationships as relational good (social capital). The family is a primary relational good which is supra-individual. (Donati, Solci, 2011);
- Explicit policies: centred on the relationships between genders and between generations, for the valorisation of social intermediations implemented by the family.

The search for new social policies is particularly evident in the so-called “third ways” that look for progressive models, able to combine liberal and communitarian elements (Giddens, 2001). Pérez Adán (2001, p.137) believes that a progressive democratic policy would consist in recognizing the family as an intermediary social group on which a specific “sovereignty” should be conferred. He proposes elaborating a new definition of the family as a communitarian entity. David M. Anderson (2001) considers it is necessary to move on to policies that are strongly subsidiary in the sense of creating a social environment capable of supporting the initiatives of local communities and families. Considers that „the best model of the functioning family“ is „the intact two-parent family” (Anderson, 2001, p.110). He proposes a law that develops family unity (Family Unit Act).

Theoretical and practical answers for dilemmas of family policy depend on the acceptance of “relational logic”, within which the family rights and interventions of family policies need to be drafted. Relational perspective valorises the ability of families to produce their own good autonomously and admits that “the more the social policies work with family relationships, on family relationships and for family relationships, the more they become family policies”. (Donati, 2003, s. 24).

We need policies that support the family as a social subject. It means to understand the family as an investment and a multiplier of the social, cultural and economic development. The family is not only a social

safety net, but principally it is a subject of cohesion and development of the society.

We need to stand the family and its interests into the centre of public policy. The term “family mainstreaming” refers to a complex strategy (open to innovations and examples of good praxis) which positively takes the family into consideration in all policies (the assessment of laws, projects, government programs, tax systems, etc.). Policies of women employment and equal opportunities (so called gender mainstreaming) have to be integrated with the family policy (family mainstreaming). In other words, policies applying family perspective emphasise intra-family and extra-family relationships so that they rectify negative consequences of policies focused on individuals without taking their family relationships into consideration. The family policy has to be understood as an assistance of relations of reciprocity between genders and generations in all areas of life. As an example of this, there is the idea of harmonization between work in occupations and family, which demands applying a new philosophy inspired by mutual subsidiarity. (Donati 2012).

In the 21st century we need constructing a “family-friendly” human society and adequate material and normative conditions which instigate “social subjectivity” of the family in all its forms (educational, caring, tax, civil-participatory). In this meaning, an internationally reputable Italian sociologist Donati (2003, 2012) proposes new relational model for family policies, which contains four key elements:

- Criteria that distinguish family policy: We speak about family policy if it respects the distinction between the family well-being and the non-family well-being. In order to remove the indefiniteness of this distinction the reference to the family must be expressed in its social subjectivity: family policies are those, which recognise this subjectivity;
- Definition of family: in social policy the family should be defined as a relationship of full reciprocity between the sexes and generations;
- Complex citizenship of the family: The family has its own set of rights-duties inasmuch as it is a relationship of conjugal and inter-generational solidarity. The citizenship is termed complex because it is both societal (civil) and political;
- The complex subsidiarity principle in social poli-

cies: the relationships between the family and other societal sub-systems (state, market, and third sector institutions) must be regulated by the principle of mutual development of each person's specific tasks. Subsidiarity is complex because it not only defends (from the interference of higher orders), but also promotes, the family (actively sustains it in its autonomy, empowers the family).

CONCLUSION

We state that family remains to be an extremely delicate and highly controversial topic given by its existential and social importance and diversity of contemporary concepts of a family. There is no doubt that the dispute about the family is one of the crucial political topics and that the significance of family politics is growing on the national and the European level as well. Despite of the social and cultural changes „the family as a relationship of full reciprocity between the genders and generations does not have an ethical equivalent nor a functional alternative, because the added social value created by the family does not arise anywhere else. That is why a globalized society has a civilizational future only as long as it will be able to support the family, which is the source of primary human, spiritual and social capital of society, and the culture of family which develops the vital connection between the private and public happiness of its citizens.“ (Fula, 2011, p.123).

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Correspondence to:

Milan Fula, Doc. ThDr. Ing. PhD.
St. Elizabeth University of medicine and social work
Detached workplace Saleziánium
Rajecká 17, 01 001, Žilina

SPORT AND DOING SPORTS BY THE DISABLED POSTTRAUMATIC RETURN TO LIFE

Zlata Ondrušová¹, Romana Píteková², Miloslav Bardiovský³, Zuzana Gáliková⁴

1. University of Health and Social Work, St. Elisabeth Bratislava
2. personal assistant
3. wheelchair sportsman, competitor and participant of the Paralympic Games
4. translator and contact person

Key words:

trauma, health disability, movement, social support, relationships, connected persons, coping, hardness, Paralympic Games London 2012

Abstract

The immediate physical health and social status of an individual who is post-traumatically challenged is personally, as well as emotionally, a very difficult, intense and dramatic life situation not only for the family, but also for the people in close relationship.

Due to injury or other significant reasons, a person with a serious disability becomes as a helpless child, a bad old boy, a hostile patient. As disabled persons with a "new" social status, we naturally are drawn into new relationships. Inevitably, of course, we become integrated into a community of people with disabilities.

INTRODUCTION

Sport is a specific type of physical activity for a person. According to Čierniková and Lednický (2009) it is an important social phenomenon in which people from all social groups find their self-fulfillment, satisfaction and a sense of victory. It is a way of self-realization and self-affirmation for each person to express his/her abilities. Through sport we have an opportunity for the application and development of social and personal values.

Sport is influenced by and interwoven in society through mutual bonds; it is directly dependent on society – on its economic, social, cultural and value system. The concept of sport includes subcategories such as school sport, sport for all, performance and professional sport for the healthy population as well as for people with disabilities (Labudová, Zrubák, 1998). All people should have access to sport and sport activities, which is the reason why their specific needs should be accepted and, if necessary, appropriate special parameters for people with disabilities need to be created. The European Commission urges member states and sport organizations to address the needs of

athletes with disabilities, to make sport centers available for them, to have qualified trainers for skill appropriate competitions for them based on scientific knowledge. Therefore, the strategic action plan of the European Union in matters of disability "shall take into account the importance of sport for people with disabilities and support member states in this area" (European Commission White Paper on Sport, 2007).

The topic for this work is focused on the possibility of involvement of people with physical disabilities into sport activities on performance level up to top level. Our sport activities frequently began as a form of post-traumatic adaptation and continue to professional and top sport. It is also a part of lifelong learning and is associated with purposeful and meaningful living, living of life. It is a form of interaction and communication with our reference group of athletes with disabilities as well as with the wider environment, i.e. with the intact people.

The possibility to do sports, study and learn is not a privilege for the disabled, for wheelchair users, and other people with disabilities. It

is a chance for us and our responsibility to be a part of society. Thanks to this purposeful activity, individual effort and acting, inner human values that facilitate self-realization are formed and strengthened. Over the years, after the accident that happened to me 24 years ago, I have been active in facilitating sports for the disabled. Suffering from multiple disabilities, I am bound to my wheelchair. I belong to a group of athletes – Paralympic Representatives of the Slovak Republic. Sport has become an important means of my post-traumatic rehabilitation, adaptation, integration and social inclusion. Good, acceptable and meaningful interpersonal relationships in sport make it easier to overcome social, opinionated, religious and racial prejudice. Due to mutual interaction with intact athletes, I can create new friendships, develop satisfaction and compensate for the effects of physical disability. I am pleased and satisfied with exceeding my limits. Sport and long-term sport training has become a vital source of my self-realization. It has fulfilled my life and existence.

POST-TRAUMATIC EXPERIENCE: With the increase in post-traumatic effects, I consider my injury – a trauma event which deeply and significantly influenced my life. The out of the blue injury happened unexpectedly. My achieved social status as a top sportsman and student changed immediately.

While the fact that what had happened was not my fault, I joined the accredited status of the disabled. The following feelings appear in small or larger scale after injury: frustration, frustrating situations, mental trauma, anxiety, fear, deprivation, agoraphobia and sociophobia. Living through it, suffering it, overcoming it, I have gained a strong foundation for next steps – I go by wheelchair anywhere possible; and anywhere impossible!!

MOVEMENT: we – the disabled use hands and wheelchair for moving and locomotion. We live by moving – we move, ergo we are. Cogito, ergo moveo, ergo sum.

In times of rapid developments in medicine and technology, there is an unsuspected hope. Charm, sense, options, purpose of movement is wonderful. Living with a wheelchair in an ordinary life is manageable! We are able to “get used” to disability to a certain extent. We try and finally learn to live de-

cently. Riapoš (2012) “Man with a disability needs to be taught to live”. We add: “Acquired disability is only difficulty and restriction of locomotion.”

HOPE: Křivohlavý (2006) writes: “Adopting an aim as your own, is a process of reaching and achieving the aim itself through the teleological action is characterized by hope. Hope is an expression of the entire special-purpose action”.

Purposeful acting leads, aids and directs the disabled sportsman as the bee on the way to the hive. Acceptance of aids, understanding and dealing, learning and managing of “the new way” is individual. It can be very demanding. To acknowledge the status of disabled with acceptance of a wheelchair as an integral part of oneself is a victory. Simply – we have already got legs! If we open our minds, people and life become open for us. I am paraphrasing the words by Jurovský: “...from realizing oneself, consciousness of the disabled is developing again in a favorable positive social context.”

SOCIAL SUPPORT: FAMILY, PERSONAL ASSISTANCE = INFLUENCE FOR A DISABLED SPORTSMAN: I realize – based on my personal experience – cognitive (mental) processes are determined by mind power (cognition) and motivation. Needs and motives create an activity and activities of organism are to a large extent influenced by social environment. Numerous ordinary, minor facts and factors that a mobile (walking) man does not realize can influence the way of thinking and form judgment, decision making, behavior and acting of the disabled in kairos (crossroads) of their limited normal life situations. In a situation and position after trauma, the disabled is supported by their family, personal assistant, close persons, in other words, their close social environment. Attitudes, reactions, behavior, actions of these connected people create the complex functioning of the family, the disabled and people around them.

Applying research by Sommersová (1944, in Požár, 2007) from her studies on attitudes of families toward disabled children and concerning attitudes of close relatives towards “their” disabled: “Acceptance of the disabled person with his disability!!!” People - family and close friends – accept the disabled in a reasonable, objective and equal way. Positive, clear, effec-

tive motto and goal for these individuals is: “We will do and achieve together as much as we can!! Trust in connected friends and in one’s strength and abilities strengthen strong mental support for the disabled.”

As disabled people we need help to live. In our family there is natural cooperation. A personal assistant is an inevitable part of our training and sport process when we want to carry out specific sports activities. Personal assistance (hereinafter referred to as “PA”) is an institutional form of assistance for the disabled (Act No. 447/2008 on social assistance). A good PA helps and supports personal growth and independence of the disabled. It is a relationship between two people based on trust and respect. We reach goals mutually. We respect each other. With a good connected person (PA) we have more variable and wider personal space. We certainly live an enhanced quality life.

We – disabled sportsmen – consider their PA as a necessary, important and irreplaceable person. People – sportspersons – the disabled persons need races and competitions among “one’s mates”, i.e. among disabled sportsmen. In the atmosphere of sports and disabled sportsmen we learn to recognize emotions which each of us goes through. We “live” in the sport arena. We are all equal here. To a large extent we understand who we – the disabled sportsmen – can become. We get cheered up, respect, we have joy from sport competing, we can be rewarded and essentially we are the winners. Loss can and should

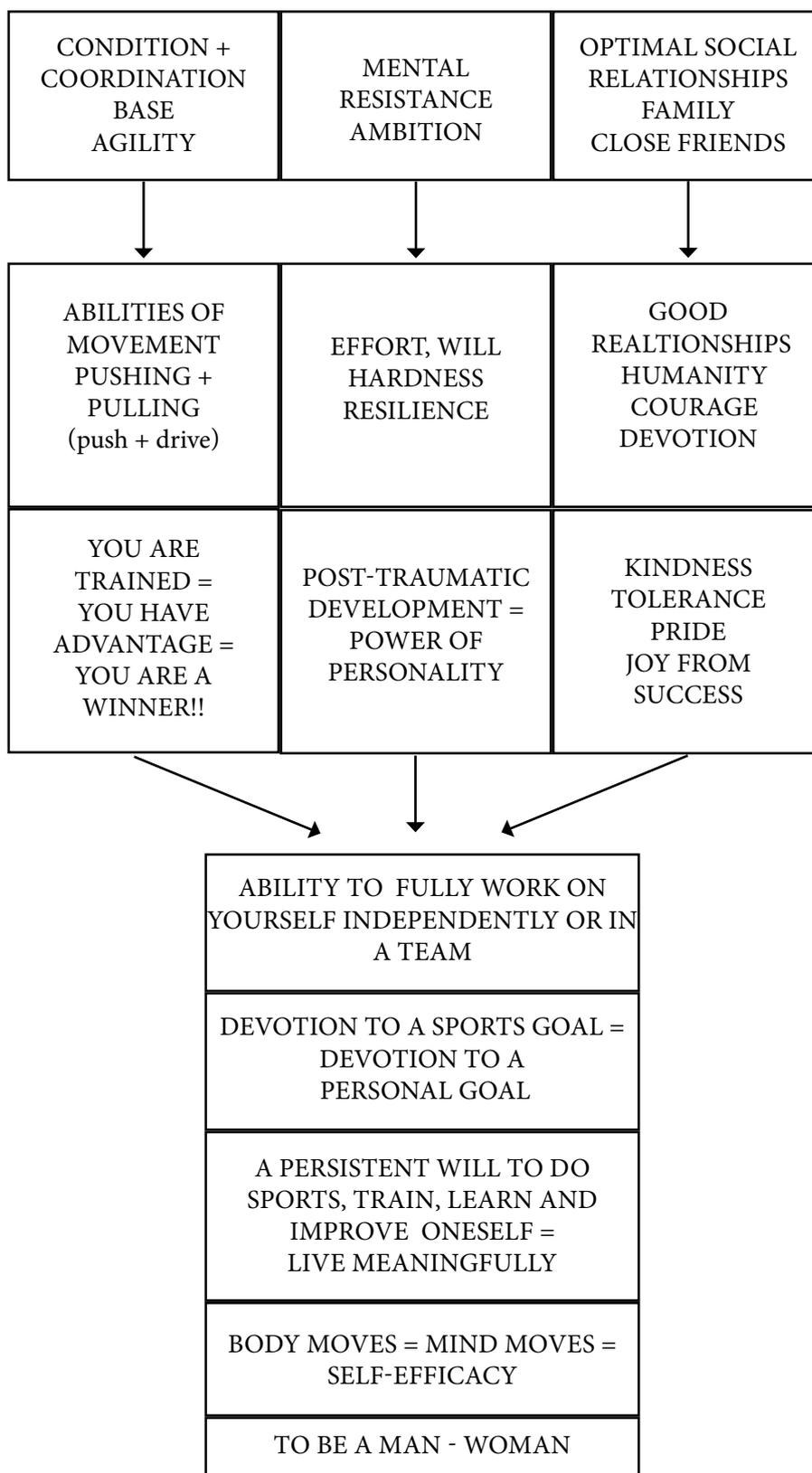
move us forward, as well. We should realize, “digest” and maybe suffer and learn from the loss, from the failure. Then we become stronger, more positive and we can motivate others. We acquire a feeling of self-efficacy. Intact people change their attitudes towards us. We acquire a new, healthy view of the world. We build and strengthen our positive self-feelings, self-respect and self-confidence.

Examples of 3 essential personal victories:

1. Accepting a wheelchair as an integral part of ourselves = we have got legs!
2. Open our minds = people and living are open for us!
3. Keep reasonable self-respect, self-confidence, self-importance and trust also in the Universe = we are in a positive social context!”

RELATIONSHIP: according to Hašto (Werner, 1993, Dornes, 2000, in Hašto, 2006): “The stable relationship with at least one individual, who loves the person and is a stable support for him/her, proves to be a significant protective factor and the source of resilience and saluto-genesis.” The social environment of the family with a wheelchair disabled member is influenced also by these factors: relationships, finance, barrier-free housing etc. House (1988) writes: “...social relations and relationships have positive motivational and emotional impacts on human body’s resilience.”

Figure 1: Mosaic of personal and relationship factors of posttraumatic development.



Source (Bardiovský, M., Píteková, R. 2012).

Realizing of self-efficacy can and should be a motivating factor of changes for the disabled sportsperson. Positive changes in realization of self-efficacy can “push, pull, drive and move” the individual. Inner conviction and personal will are significant factors for long-term success with regards to (re)socialization,

(re)habilitation, integration/inclusion and success for individuals = a goal seeking life of the disabled person (modified by Bardiovský according to Hergenrather, Rhodes, TURNER § Barlow, 2008).

Appreciation is an important, needed and motivating factor for the disabled – see Maslow: Pyramid!

SPORT AND DOING SPORTS BY A DISABLED PERSON

Doing sports is a specific form of human activity. Doing any sport with any intensity is a kind of workout! I consider using my arms when moving on my manual wheelchair to be a strenuous physical activity, sport. "Only" the weight of wheelchair is about 10 – 15 kg, plus the body. Plus, for example, immobile legs plus backpack and personal paraphernalia. Thus, I advocate that:

"A lot of what we can achieve, reach or accomplish is in our minds. It all depends on our wishes, strength of our will and resilience."

Then our body follows the mind to a certain extent.

Doing some sport actively is for a disabled person a good way of self-realization and it can be a kind of affirmation of his/her abilities. Sport is an important part of rehabilitation after an injury - re-adaptation, re-socialization, making-up, integration and inclusion. Doing some sport is for a person using a wheelchair the best way to influence and motivate close friends, other disabled people and intact people, as well. All the dimensions of doing some sport create and strengthen character, and good and meaningful interpersonal relationships. These relationships help us find new friendships, compensate the consequences of our handicap, and we enjoy improving our skills and abilities. As a sportsperson, we have much emotional experience. We cooperate (a person is naturally a very social creature) and we compete (a person is also very competitive). Sport is our vital source of self-realization. It is a meaning and a way of life. Thanks to sports we can develop and strengthen our personal and social values.

COPING is handling a stressful situation by deliberate choice of a certain strategy. This strategy is usually aimed at a specific activity. The purpose is to improve the total balance. In doing sports, we prefer coping - an approach directed at an activity. When a wheelchair disabled sportsperson learns and masters active coping strategy, he/she gains and strengthens their personal resilience or even firmness in stressful situations.

We define **HARDINESS** as a complex of per-

sonal attitudes that involve 3 components:

1. Commitment - As a man in a wheelchair and sportsman I am keenly engaged in all the matters connected with it. I appreciate myself and I am aware of the purpose of my role in the world. I am responsible for the task and its final effect.
2. Control: A personal feeling connected with experiencing something and acting somehow; it is faith in one's own knowledge, skills and choice; it is faith in personal ability to step in, take action and manage the whole situation.
3. Challenge and Change: I interpret it as an opportunity. Life is naturally dynamic, changeable and malleable. I am open to new inspiring experience, I am responsible and I control a flexible handling of the situation. I can quit the task or I can distinguish when I can be successful.

ASPIRATION: according to Baroš (1997) is a special-purpose action. It is a desire for something; it is an amount of present or future personal requirements and commitment regarding our performance, self-realization and self-determining, our employment in personal life and society.

SPORT done by disabled people in wheelchairs has some specific features. Sporting events for disabled people have a more than 115-year history. The first championship for amputees, where 67 competitors took part, was held in 1895 in Nogen sur Marne (Kreutz, 1976). In 1944, the British government founded the curative rehabilitation center for retired wheelchair disabled people in Stoke Mandeville. Neurosurgeon, Sir Ludwig Guttmann included sports as a part of disabled people's therapy. Sir Guttmann then also conceived the idea of Paralympics which was carried out as the "Olympics for people using wheelchairs" which were held as a part of Summer Olympics in 1960 in Rome. The Summer Paralympics have taken place since 1960 and Winter Paralympics have been held since 1976. In 1989, the International Paralympic Committee (IPC) was founded. Labudová (2004) writes: "The aim and limelight of IPC is to organize the top sporting events (Summer Paralympics, Winter Paralympics, World Championship, European Championship) for disabled sportsmen from all over the world." The will power, resolution and persistence of disabled sportspersons give strength and are set as an example and inspiration for others. Therefore, the Paralympic competitors represent the role models,

challenge and hope as well. A person using a wheelchair has to face a lot of problems, but he/she should accept, grasp and handle all the situations, opportunities and enjoyments that the life brings.

“ELITE OF THE DISABLED PEOPLE”

We called all the disabled people who have reached a high social status, some above-average results in their jobs or who were especially successful in sports as the Elite of disabled people (Požár, 2007, in Bardiovský, 2007). “What does not destroy me makes me stronger ... strength arises from weakness, ability from deficiencies” (Stern, 1921). Vygotsky (1983) says that the idea of overcompensation has the predominant role in all the psychological systems bringing the concept of integrated personality to the fore. “Super-compensation” changes illness to superhealth, weakness to strength! Adler (1927) concluded from that his “basic psychological law on transformation of organ inferiority to mental aspiration, compensation and overcompensation.” Unique individuals - “the elite of disabled people” – motivate others. They play a positive motivation role in sports, in the field of education and work... even without any intention. However, “Elites” do not emerge from nothing. They can achieve extraordinary results thanks to the help of other people. My personal assistant brings support and assistance to my life, sport activities and my social life.

PARALYMPIC GAMES LONDON 2012: After several years of hard training, competing, managing of “a million small things in a life of the disabled” and also by top performances we – I, with my PA – have nominated, participated and I actively competed at the Paralympic Games in London 2012. At the age of 53, I made my best discus throw of the year 2012: in the Paralympics competition in London I threw 19.83 meters and won 7th place out of the best 20 competitors!!

Talent and effort are precious phenomena – they need to be protected and developed. In the case of disabled people – it is even rarer, more important and more urgent. We are sure that we will do a lot of useful things for development of active, diligent talents among disabled people (Bardiovský, Požár, Píteková).

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Correspondence to:

doc. PhDr. Zlata Ondrušová, PhD.
St. Elizabeth University of Health & Social Sciences
Palackého 1, P. O. BOX 104
810 00 Bratislava, Slovenská republika
email: zlatica.ondrusova@vssvalzbety.sk

APPROACHES OF A MUNICIPALITY TO INHABITANTS OF SOCIALLY EXCLUDED LOCALITIES

Pavel Kliment¹

1. Palacky University, Olomouc

Key words:

social exclusion, levels of social exclusion, municipality's strategies regarding socially excluded persons

Abstract

The objective of the article is to identify roles of agents of the process of social exclusion. It is focused on two major agents of this process; the first one is inhabitants of blocks of flats situated in the given locality. The second agent is the municipality, namely the Statutory City of Olomouc, owning some blocks of flats occupied by excluded individuals. The contribution may become a "good practice example" put into practice in the area of a municipality's social policy.

INTRODUCTION

Social exclusion (social marginalization) in its wider sense can be defined as a situation when an individual or a group of individuals do not participate fully in the economic, political and social life of society, when their access to incomes and other resources does not allow them to achieve such life standard that is regarded acceptable in society they live in. (Sirovátka, 2004, p. 19).

Hradecký and Hradecká state that social exclusion is a process where individuals or entire groups of individuals are marginalized in society and their access to resources available to other members of society is limited or prevented. These resources include especially employment, housing, social protection, health care and education. (Hradecký, Hradecká, 1996, p. 25).

It is clear that social exclusion can be understood as an attained state as well as a process heading towards this state; significant is the impossibility or restraint of participation in the life of society and its advantages.

Social exclusion can be examined on several levels. Then it is possible to talk about economic, social (in the narrower sense), cultural, symbolical, political and spatial exclusion. (Mareš, 2000, pp. 287-288).

Economic exclusion is characterized by exclusion from the labour market followed by the state of

poverty. Bearers of economic exclusion adapt themselves to the given situation, use the black labour market and become dependent on social security benefits.

Social exclusion in the narrower sense manifests itself in the decline of civic and other social activities as well as the reduction of contacts with one's environments and impossibility to participate in wider social networks – such formations stand off, produce and reproduce themselves in the given place. They move away from social control as well behaviour patterns typical of the majority what significantly influences the socialization process – known is the absence of positive models. (Topinka, Kliment, 2010, p. 25).

Cultural exclusion is manifested in the processes of achieving (but rather not achieving) and developing of the necessary level of education which is the key means of employment in the performance-oriented society. Symbolical exclusion is characterized by stigmatization from the majority society; it ascribes extremely negative stereotypes to such excluded individuals. In the case of political exclusion such individuals are excluded from the political life on the level of both subject and object. Spatial exclusion is the most visible manifestation of social exclusion; it is life characterized by a poor quality of

housing. It is about settlement (territorial, residential) segregation at or even beyond the limits of the usual social differentiation.

It is possible to discuss socially excluded individuals, groups as well as entire localities. A socially excluded locality can be situated in a municipality from which it is separated with physical or symbolic barriers. Still such a locality is often found on the periphery of a municipality.

Socially excluded localities come into existence primarily on the social principle, only secondarily on the ethnic principle. Despite the fact that a significant part of the public in the Czech Republic perceives social exclusion “mainly as a problem of the occurrence of the ethnically different population in the majority environment, not only as a problem of the occurrence of extremely poor classes” (Gabal, Čada, Snopek, 2008, p. 5). The cause of the birth of such localities is material and social poverty of their inhabitants, only then it is their ethnicity.

The total extent of social exclusion will be observed in the extent of exclusion on each partial level.

CHARACTERISTICS OF THE EXAMINED PLACES AND CHOSEN METHODOLOGY

A 2006 report titled “Analysis of Socially Excluded Roma Localities and Absorption Capacities of Subjects Functioning in This Field” identified four socially excluded localities in the territory of the city of Olomouc. There were approximately 550 persons, representing 0.55 % inhabitants of the city of Olomouc, living in the examined localities of the city in the time of elaboration of the report.

The following localities were regarded socially excluded: two blocks of flats, one in 51 Holická Street and the second one in 70 Přichystalova Street, then the Hotel House (Hotelový dům) in Velkomoravská Street and several family houses in Mrštíkovo Square. All the blocks of flats were property of the municipality. These were places where the Roma inhabitants were the majority but the common denominator of the local residents was the fact that they all were in the situation of material and social poverty. The number of socially excluded localities has decreased to three now. The Hotel House is not reckoned a socially excluded locality anymore; it has undergone a recon-

struction as well as a change of the system of provision of accommodation what excluded mainly large Roma families from this locality.

The inhabitants of Holická and Přichystalova streets were interviewed in 2011 in order to define roles of the inhabitants of the excluded localities in the process of social exclusion; the presumption was that the municipality as the owner of the houses could influence conditions and character of the local housing.

The house in Holická Street consists of 30 flats; it was not fully occupied at the time of the survey because the future of the house was not sure. The house is located in the very periphery of the city and functions as a flat substitute. It is a flat substitute for tenants of the city-owned flats who have not fulfilled their duties resulting from contractual relations in their original dwellings. The inhabitants of the house can use only cold water, sanitary facilities are common here. If a tenant had fulfilled her/his duties in this place for two years, she/he got an opportunity to obtain a rental contract for Přichystalova Street.

The house in Přichystalova Street comprises 72 flats. The house is not spatially segregated, is located in the neighbourhood of houses occupied by individuals who cannot be described as socially excluded. A rental contract for these flats is supplemented by an agreement of commitment and a deposit (a new tenant pays a deposit of 10,000 CZK and, besides it, settles the debt left by the previous tenant of the flat coming up to tens of thousands of crowns). The rental contract is concluded for a fixed period of time and prolonged for another period in case of fulfilment of the contractual duties. If the contractual relations are broken by them, the tenants are moved out. The block of flats was fully occupied at the time of the survey. A future reconstruction of the house was being discussed. The interviewed did not report any case of the local inhabitants fulfilling their duties thoroughly and obtaining a rental contract for another location that would not bear attributes of social exclusion.

The basic fundamental unit of the survey was a household. A household was defined as a group of persons living in a flat, who are related by blood or marriage or partnership. The most numerous household consisted of 13 persons. In one case the household consisted of an individual living in a flat independently. The final number of interviewed households was 53; representatives of thirteen households were not

reached; nine households rejected their participation in interviewing. Thus information was obtained from 70 % households. It was followed by the technique of focus group, attended by 30 persons. The first focus group consisted of men living here; the second one of women living here; the third one of employees of supporting organizations who provably fulfilled some of the forms of social work. Reports by the men and women living here served for completing the image of the role of the inhabitants in the process of social exclusion; the reports of the support employees helped mainly identify the role of the municipality in the examined process.

CHARACTERISTICS AND STRATEGIES OF CONDUCT OF EACH AGENT

Four fifths of the inhabitants of the mentioned localities presented themselves as Roma (they live in a fully Romani or mixed relationship) what implies a strongly ethnic characteristic of the place. The survey further showed that most local inhabitants regarded their stay here emergency and temporary. Thus most inhabitants regarded the place rather a ghetto (involuntary stay) than an ethnic enclave (the stay here was chosen voluntarily). Still, a great desire for a change of housing did not correspond with the actual possibilities of the local inhabitants; signs of significant social exclusion could be observed on all the above-mentioned levels – absolute superiority of jobless persons, dependent on welfare benefits, with only primary education, a half of the households having debt both in the form of execution or owed rent. Besides, the municipality as the owner of the flats supported only the local inhabitants' mobility among the excluded areas. Lacking was support for those who fulfilled their contractual duties in order to move outside these localities. The longer the inhabitants had lived in the localities the more they realized that it was impossible to break free from it.

Dependence on the place was also supported by the institute of payment of refundable deposits and mainly the acceptance of the obligation of the previous tenant. The implemented measure is controversial also because this debt was demanded also from the previous tenant as well. The initial costs needed for obtaining a rental contract casted many households

in material and social needs into the spiral of over-indebtedness. They obtained rental contracts but they had to take out loans due to which they were not able to instalments in the long-term horizon; subsequently they had had debts of rent and thus loose the rental contracts as well as housing. What is left for them then is the debt demanded from them by the municipality.

Furthermore, the approach of the municipality to the inhabitants of the examined localities quite significantly changed during year 2012. The municipality cancels contracts with those inhabitants who owe rents without filling the empty flats. Only approximately 30 flats are occupied in Přichystalova Street today, about 5 flats in Holická Street. The Holická block of flats is planned to be expanded and reconstructed, and it is still designed for housing for inhabitants in material and social needs. The future of the Přichystalova house is to be decided by the municipality during this year; with regard to the fact that it is not a spatially excluded locality there are concerns that it could follow the fate of the Hotel House. Tenants from Přichystalova Street who fulfilled their duties related to payments for their housing expenses are offered rental flats in a different locality; nevertheless these are often large or of higher rent, and the amount of rent does not correspond with the financial capacities of these persons. Thus their desire for getting a flat outside an excluded locality is confronted with the reality.

It is obvious that the decision of the municipality bodies can cause the termination of another excluded locality. Still, if the locality ceases to exist due to the aggravation of living conditions of the local inhabitants from the outside then it will be forcing them out rather than a solution of the existing problem. There will be a question left whether the excluded persons stay in the territory of the city despite the unarticulated expectations and they only disperse themselves around the city in the first stage of adaptation to the new situation. Subsequently the processes of social exclusion will cause the formation of new segregated localities, owned by new subjects where conditions and functioning cannot be regulated directly by the municipality.

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Correspondence to:

Pavel Kliment, PhDr. Ph.D.
Department of Sociology and Andragogy,
Philosophical Faculty, Palacký University, Olomouc,
tř. Svobody 26, 771 80 Olomouc
pavel.kliment@upol.cz

PERCEPTION OF FAMILY AND FAMILY POLICY FROM SELECTED ASPECTS

Mária Hardy¹, Zuzana Takáčová²

1. St. Elizabeth University of Health and Social Work
2. The Institute of Social Work of Divine Mercy, Zilina

Key words:

family; policy; community; marriage

Abstract

This article should give an answer to the issue of the meaning of family in our society. Society does not always acknowledge the fact that it lives and thrives through family. This applies also in the field of social policy of the state. There are new trends, including in Slovakia, which relativise the importance of marriage and family. Therefore, it is essential for every member of society to understand the value of the family and to give it comprehensive support through state family policy.

INTRODUCTION

“The family is a small social group whose members are connected by blood and kinship.” (Drozdíková, Ďurajková, 2009, p. 9). For development and self-realization of the human being the best ground is situated in the family. Through the creative power of marriage and family society also obtains the necessary fundamentals for social cohesion and order. Today, there are parents who, due to the demands of not having enough time to devote to children, cannot achieve effective parenthood, and therefore, the necessary emotional attachment is disrupted. The role of family policy should be to ensure that families are motivated to care for their members as much as possible. Many countries, including Slovakia, have their own institutionalized state social policy. Its focus should not be only every citizen in particular, but also the family as a community.

PERCEPTION OF FAMILY FROM THE POINT OF VIEW OF THE CHURCH

The family is the first social formation in which a child is involved. The influence of the mother is discernible before childbirth. In the next period the impact of the father is also noticeable and later that of the grandparents. The mother is the main source of

knowledge, habits, behavior and social relations for the child. Among the most important factors that shape the life of the child is the economic situation of the family. „In the transition to the market mechanism family suffers of the threats of poverty, unemployment, uncertainty leading to the disorientation of interanl relationships of the family members.“ (Zelina In Šatánek, 2005, p. 93). Pope John Paul II. states that “the social dimension is innated to every man, finds its first place in marriage and family.” Family is namely the community in which could be built the sense of personal human dignity, a life of virtue, and development of great humanity.

The role of the family is even indicated in the book of Genesis, where God created man and female in his own image. God did not creat them for living in the community alone and separately. The first people received the task to multiply and to prosper. In this message we can sense to some extent the parental role of the man and woman.

The importance of the family institution is written very clearly in the previously cited dokument, Familiaris Consortio. Pope John Paul II. says that “the family is and can be a place where its members have to get to know and to live the core values of social life such as justice, dialogue, mutual love.“ Thus, there is a real relationship between the family and society, which should

follow the same principles:

- First of all, the family should participate in the implementation of various services to the community; the state institutions should not interfere with the rights and the obligations of family, but rather to assist and defend it.
- For its irreplaceable functions the family has a right to be supported from the state - society would receive irreparable harm if the family did not get appropriate help. Family should be able to fulfill its special educational mission. The state should have a support function in relation to the family on the principle of subsidiarity.
- Finally, it is important to remark that the state should not deprive the family of such tasks which the family can perform by itself. At the same time the state institutions should do everything possible to keep the family functioning normally.

IMPLEMENTATION OF FAMILY POLICY WITHIN THE STATE - THE IMPACT OF NEW CIRCUMSTANCES

The state should be implementing family policy mainly based on the principles of subsidiarity. The state has no right to restrict family relationships and should rely on the family to deal with the problems which it is capable of dealing with. On the other hand, it is necessary to take into account new issues and circumstances that the state has to face in the implementation of family policy:

- reduction in the number of marriages and births. There is an issue for the state: old-age insurance system and pension system;
- increase in divorces. Begin to increase the socio-educational problems: divorce "orphans", single-parent families;
- unmarried life partnership and unmarried parenthood - this new situation raises the question for the state of constitutional understanding of marriage and family;
- the structural disadvantage of families in economic and social life: the indifferent market to the family. Specifically: the pay rate does not

take account of whether the recipient must only take care of themselves, or even the family. Also aspect of the market price of the goods is the same, whether we buy a product for one or more persons. Family policy should also remember the situation when one of the husbands gives up his job because of the children, and then actually he gives up income, but also his right to pension insurance. Finally, the time devoted to children and interruption of employment of either parent reduces chances in a competitive environment and career in the employment.

Despite these problems the government has enabled first the family to cope with the requirements of the present time. The role of state family policy is to consider the important fact that in today's society the number of children is a significant cause of social inequality. In a family with several children, where one parent gives up work due to upbringing, the income often decreases to less than half its possible total. In society, to have and to raise children is often something which is punished rather than rewarded. In this context, there is, especially for young families, also the problem of housing - a small apartment for a family with several children.

FAMILY FUNCTIONS IN SOCIETY

The answer to this subject contains a wide range of issues and it is difficult to respond exhaustively to all. For Hanobik (In Hardy et. al., 2011, p. 127) is „family the most important part of the society and responsible for the upbringing and education of future generations.“

First, we assume that the family is organically connected with society, because it maintains and develops by continuous service. The people are born and obtain their first social skills in the family. It should also be noted that community experience and sharing should characterize the daily life of the family, and this is the first and fundamental contribution to society.

The basic functions of the family to society might include the following:

- Ensuring future generations and the development of "human wealth". This humanity is ac-

quired often in the family. Therefore, this function of the family is crucial for society.

- Ensuring solidarity between generations. In essence, this leads to a settlement between the generation of workers and the elderly. This system implies a certain solidarity between generations. However, this can only be maintained if the future number of people capable of work is not too small in relation to the recipient. Families provide this solidarity by bringing up the next generation, while they deserve solidarity as well.

FAMILY POLICY OBJECTIVES

The general objective of family policy is to create a friendly social environment for the family in society. Mungová (2005) recommends using legislative and non-legislative tools to achieve the following:

- to work towards removing the obstacles to which families are exposed and which threaten their stability,
- to create the conditions for the functioning of families, and to mutually support them,
- to enhance awareness of family values in a whole society,
- to strengthen the responsibility which parents and family members have to each other.

The concept of family policy is certainly not confined to one area of social policy, such as redistribution and financial assistance to families by the state. Family policy must permeate the entire social policy, and at all levels of government. In addition, the family policy of the state contains in itself the legal aspects that affect the functioning and life of the marriage and the family.

objective of family policy – the legal protection of marriage and family

This should be one of the fundamental tasks of the state for family policy. The state should protect marriage and the family, as inter-related institutions, such as the constitution. Those are specific laws that should protect the family.

Individual areas of assistance resulting from the very concept of social protection of the family. Therefore we consider the key definition of the term social and legal protection, which is understood in

two dimensions (Repková, 2005):

- a) Legal protection of the rights and interests of each person must be the interest of the whole of society and its legal system. There appears to be substantial legal protection for people who do not have full or partial capacity to effectively promote and protect their interests and needs: children, elderly people, mentally ill, etc.
- b) Social protection refers to the social rights of people. According to the European Social Charter we are talking about areas of the law relating to labor conditions and remuneration, protection of families, children, adolescents, employed women, housing support, social security, health care and social assistance.

Objective of family policy – the balancing family expenses. This balancing should significantly mitigate three structural economic disadvantage borne by families though cannot fully compensate them. These are a direct cost of children, loss of income and unfavorable consequences for old-age insurance. In general, under the law, there are two classic ways of balancing family expenses: non-taxable amounts and children's benefits.

Objective of family policy – social policy support. The system of social assistance for families in the state social policy is implemented also at the hand of social work using following tools: social prevention, social counseling, socio-legal protection, social services, social benefits and compensation.

The concept of state family policy in Slovakia is based on the EU's Lisbon Strategy and on long-term objectives inherent in the change of the socio-economic circumstances and ongoing reforms. In this update of family policy are given the following tasks. In the field of education to ensure quality education for every child, regardless of family and socio-economic environment and to strive for lifelong education. In the field of housing through housing policy to put in place the measures to promote the mobility and the access to housing of low-income groups. In the field of social policy to ensure better coordination of employment policy and social protection of the family. In the field of legal protection of the family to seek out if the family fails in its essential functions, to do everything possible to adjust and improve relationships of family

members and to try to rehabilitate family problems in order for the family to achieve stability and fulfill its tasks.

CONCLUSION

In the context of understanding the importance of the family in relation to society we should eventually agree with John Paul II. who supports the family as follows: „When egoism, anti-natalist propaganda, totalitarian practices, moral poverty, natural and cultural poverty, hedonistic consumption mentality want to strangle the source of life, and ideological systems associated with various lack of interest and love, to deprive family the educational role, this community must be provided with special care.“

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Correspondence to:

Hardy Mária, PhD., PhD.
St. Elizabeth University of Health and Social Work
The Institute of Social Work of Divine Mercy
Legionárska 2
010 01 Žilina

hardy@sopza.sk

Takáčová Zuzana, PhD.
St. Elizabeth University of Health and Social Work
The Institute of Social Work of Divine Mercy
Legionárska 2
010 01 Žilina
z.takacova@gmail.com

ETHICAL PROBLEMS IN THE TRANSPLANTATION OF KIDNEYS FROM THE LIVING DONOR

Ivica Gulášová¹, Lenka Görnerová², Ján Breza jr.³, Ján Breza^{3,4}

1. St. Elizabeth University of Health & Social Sciences, Bratislava, Slovakia

2. College of Polytechnics, Jihlava, Czech Republic

3. Faculty of Medicine, Comenius University, Bratislava, Slovakia

4. Urology Clinic with the Kidneys Transplantation Centre, Faculty Hospital Limbova, BratislavaSlovak Medical University, Bratislava

Key words:

living kidney donor; receiver of kidney; voluntariness; informed consent; ethical principles

Abstract

Removal of a kidney from a living donor, unlike from dead donors, brings even more ethical and legal problems which impact two individuals - to the donor as well as to the receiver. The authors analyze ethical rules for removal of a kidney for transplantation from living donors which must be based on clear ethical rules in the framework of the legal structure of the Slovak legislature regarding donating of a kidney. And, it is very rigorous in the domain of the donating organs from living donors. Further, they present the importance of consultation with the Transplantation Center which evaluates the effects of a kidney removal from a living donor. It offers the potential impact on living kidney donors and the related ethical principles as well as the circumstances surrounding the donation: the voluntariness, free decision, intimacy of information, rewarded and unpaid donation, competence of the paramedical staff who participate in this transfer and protective measures employed. Special attention is paid to the providing of information to the living donor and to the receiver of a kidney, inclusive of an informed consent by the living donor. Finally, the authors analyze the ethical aspects in the soliciting of the voluntary consent of the living donor.

INTRODUCTION

Organ transplants are a matter relating to each person. They “represent an act of social and individual solidarity” (Glasa, 1994). “Currently, the Slovak Republic can remove organs or tissues from deceased or from living donors. There are not and will never be enough living donors. In recent years the number of donated kidneys from living donors increased significantly. This increase “can be attributed to a number of factors including the shortage of dead kidneys donor, advances in surgery, sufficient evidence of favorable transplant outcome and low risk to the kidney donor (CEU, Brussels, 2007). Only organs without which a healthy individual can live without problems can be

removed from voluntary living donors. Thus either paired organs - kidneys or tissue that has the ability of comprehensive regeneration - bone marrow and skin can come under consideration. First of all, we should take into account the health of donor because it effects the healthy organism (Valenta, Třeška, Hasman, 1999).

Medically-technical interventions into the physical component of a personal significantly affects not only the psychological but also the moral nature of people. Kidney donations from living donors, unlike kidney donations from dead donors, bring even more ethical and legal issues affecting two individuals - donor and recipient. “During the removal and transfer of

organs and tissues from a living donor to a recipient, there occurs damage to the material components of individual rights of one person in order to preserve or maintain physical and personal rights of another person” (Cifra, 2005).

In kidney transplantations from living donors it is assessed whether the benefit of transplantation to the recipient in terms of universal social values outweighs the harm caused by taking a transplant from a donor (Cifra, 2005).

Transplantation of organs and tissues transfers from living donors must be based on clear ethical rules under the appropriate legal structure (Glasa, 1994). Slovak legislation concerning organ donation is very strict in the case of a living donor organ donation. “Terms of the removal of organs, tissues and cells from living donors are defined in section 36 of the Act No. 576/2004. To remove organs, tissues and cells from the body of a living donor for their transfer to the body of another person can be conducted only if it is assumed that their removal will not seriously jeopardize the health of the donor; if there is expected the direct therapeutic benefit to the recipient; if the benefit to the recipient outweighs the harm the donor; if a suitable organ, tissue or cells cannot be provided from a dead donor and if there is not available an alternative therapy with better or comparable results” (Ministry of Health). Furthermore, in paragraph 36 it is stated that the removal will not take place when there is a serious threat to the health of the donor - even when he provided informed consent.

Prerequisites for the successful removal of a kidney and its transfer to a recipient are approved by Consilium of Transplant Center. Consilium also considers if all the conditions for removal of kidneys are met. In Slovakia, living donors can be genetically related - parents, siblings or unrelated, but close as husband, wife, as well as an emotionally close unrelated person. Donation of a kidney for the purpose of transfer to the body of another person (transplantation), who is directly genetically related to the donor, may be carried out only after the approval by the Consilium of Transplant Center. Collection and transmission of kidneys from the body of living donor to recipient who is remotely genetically related to the donor or to a recipient genetically unrelated to a donor may be exercised only in exceptional cases and only after the approval of Ethical Commission which is named by the

Ministry of Health (Kováč, 2005). An immunological match big role here plays.

Legislation in Slovakia excludes from an organ donation any persons who are in arrest custody or in prison.

When a kidney is donated by a living donor there arises, in addition to the legal issues, a number of ethical issues and related problems. Among these problems are the admissibility of voluntary and freely undergoing of intervention into the physical integrity of the person in the interest of society. So the question of an informed and free consent by a living donor is followed by the issue of providing information to the donor and the recipient of a scheduled procedure or of possible complications during the kidney collection.

An important ethical issue is the respect for confidentiality (anonymity between living donors and recipients); payments and charges - a non-profitable character of facility performing a kidney transplant; the competence of the participating medical personnel and the use of protective measures.

INFORMED CONSENT OF LIVING DONOR

Informing the patient is controlled by “ethical discourse and ethical requirements”. One of the most important ethical principles applied in doctor - patient relationship and, consequently, in codes of conduct as is, for example, the Declaration of Patients’ Rights, is the rule of informed consent. Informed consent means for a living donor to voluntarily accept to undergo therapeutic procedures necessary for the collection of a kidney as his doctor provides him with adequate information about his condition. There applies a rule that informed consent can include a revocation at any time by the person who expressed it.

The Principle of Informed Consent consists of two basic elements:

1. provision of information;
2. obtaining of consent (Nouza, 1991).

PROVIDING INFORMATION TO LIVING DONOR AND TO RECIPIENT

Relevant and important information regarding the receiving of a kidney from the body of a living donor should be properly explained and disclosed to the patient. An element of disclosure must include voluntariness and competence. From the point of view of ethics, it is important that when a doctor informs a patient, the principle of human autonomy is respected. The concept of autonomy in ethics is one of the basic concepts and means to respect the person (patient) as a human being in their physical, mental, emotional and spiritual unity. An autonomous person is characterized by the ability to act freely. Any person can universally balance their physical integrity and values associated with it. Respect for the autonomy of an individual is one of the most important values of a civilized way of life. Each person should be involved in any and all decisions that affect and influence his life.

A doctor is obliged to inform and educate a living donor in a manner which is as extensive and inclusive as possible given the nature of the kidney removal procedure, potential risks that may arise due to removal of a kidney, the pain and potential limitations for a living donor after kidney donation. Evidence that this information was provided to a living donor and to a kidney recipient from a living donor are inscribed in medical records and confirmed by the signature of a patient - it is called informed consent of the patient.

Great emphasis is given to the fact that a doctor, when providing information, does not use technical terms. Using science speak is a very common mistake of medical staff when providing information to patients - to living donor and to kidney recipient. A living donor often does not understand the technical terms and that is what is causing a lack of information - for example about the potential risks of the procedure.

Briefing of a live kidney donor and a recipient should be implemented under existing policies regarding informing a patient (Vítko, Nouza, 2001). We should not forget that the patient is the one who has the right to actively decide about his physical integrity and therefore we should provide him enough truthful and accurate information regarding his health status and any possible risks that may arise after removal or reception of kidney. Based on the provided information either a living donor or a recipient should be able to make an informed decision whether he/she really

wants to undergo planned surgery (Priestley, 2004).

OBTAINING OF VOLUNTARY CONSENT

Removing a kidney from a body of a living donor may be made only after written statement of voluntary consent by a living donor and a kidney recipient. Voluntary consent is an essential moment of decision in the donation and reception of a kidney. Voluntariness of informed consent means that the physician should not use any coercion, deceit or threat toward a the potential donor or recipient. Before obtaining voluntary consent from a potential living donor it is important to determine whether the potential living donor is fully informed of his mental stability, his ability to effectively, responsibly and freely decide after he was fully informed of all possible risks and complications associated with the collection or receiving of a kidney.

A philosophical question arises as to whether it can really be a decision "without coercion". The decision to donate a kidney during life is in most cases done under the pressure of vitally important needs of an emotionally close recipient. However, it is to a certain extent a "coercion" of one's own conscience and not pressure from the outside. In addition to mental stability of a potential living donor it is important to consider the family and interpersonal situation of a living donor and of a recipient. In the case of genetically or emotionally related, donation a doctor must very carefully determine family relationships. Before planned surgery the whole family should meet with a Psychologist who examines them and pays close attention to whether there are present any pathological relationships among members of family.

Psychologist should be experienced in family therapy and should be able to detect if there are any hidden pressures or manipulations in the clan to push a family member - a potential living donor - to a kidney donation. In this case it is so called emotional blackmail. A family can be, as a matter of fact, a source of support, as well as a source of conflict. A Psychologist is the one who should assess whether, in fact, this is a voluntary donation or hidden emotional blackmail. The basis for an examination of voluntary informed consent is open and honest two-way communication (Honzák, 2005).

Removal of a kidney from a living donor is not only an ethical but also a significant legal issue because it is a serious interference with the life of donor. Therefore, legal rules define the way of agreement or disagreement with a kidney donation, the way of instructing of recipient and a living donor and the conditions under which transplantation can be performed (Smith, 2005). Slovak legislation concerning organ donation is very strict in the case of a living donor organ donation. Terms of donation of organs or tissue from living donors in the Slovak Republic is regulated by the above-mentioned Act No. 576/2004 on healthcare services related to health care and on amendments to certain laws, paragraph 36. "The donor may only be only a person with full legal capacity who submitted the written informed consent after previous examination. In exceptional cases, a donor can be the person incapable of providing informed consent based on the informed consent of his/her legal representative" (Ministry of Health). It is possible only when it concerns the donation of regenerative tissues and if there is not another suitable donor who is capable of giving informed consent as when a potential donor and recipient are brother or sister of the donor, and, when the donation has life-saving potential for the recipient. When the kidney is removed from a living donor dual active consent is required the. One is consent of a donor with the removal of a kidney and with its transplantation to a recipient, and the second is the consent of a recipient with transplantation of a kidney from a living donor.

CONCLUSION

Everybody has universal ethical principles and moral values and everyone has freedom of choice but it seems that some people's lives depend just on our decisions. In the case of a living donor, he/her shows his/her love and help even at the cost of a risk to his/her own health and life (Munzarová, 2005). It is a gesture of maximal and sometimes heroic selflessness whose value cannot be expressed in figures.

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Correspondence to:

Prof. Dr.. Ivica Gulášová, PhD.
St. Elizabeth University of Health & Social Sciences, Bratislava,
Department of Nursing, Faculty of Public Health, Slovakia

Mgr. Lenka Gornerová
College of Polytechnics, Jihlava,
Department of Health Studies
Czech Republic

MUDr. Ján Breza, PhD. jr.
Department of Urology and Radiology and Centre for kidney transplantations,
Kramáre University Hospital, Bratislava, Slovakia

Prof. MUDr. Ján Breza, DrSc.
Department of Urology and Radiology and Centre for kidney transplantations,
Kramáre University Hospital, Medical Faculty of University of Komensky, Bratislava, Slovakia

ETHICAL APPROACH TO THE DYING AND TERMINALLY ILL PATIENTS

Ivica Gulášová¹, Lenka Görnerová², Ján Breza jr.³, Ján Breza^{3,4}

1. St. Elizabeth University of Health & Social Sciences, Bratislava, Slovakia

2. College of Polytechnics, Jihlava, Czech Republic

3. Faculty of Medicine, Comenius University, Bratislava, Slovakia

4. Urology Clinic with the Kidneys Transplantation Centre, Faculty Hospital Limbova, Bratislava, Slovak Medical University, Bratislava

Key words:

terminally ill; dying patient; suffering; dying stage; Elisabeth Kübler-Ross

Abstract

In our time, thoughts of mortality are culturally, consciously or unconsciously suppressed. Nursing care for the terminally ill and dying patients is not only focused on the individual but also includes family members. In addition to professional medical care including an holistic approach, empathy, respect for the rights of the dying and his bio-psycho-social needs, the goal is improvement in the quality of life. The end-stage of disease presents us a number of questions: how to tell a patient that he is dying, the meaning of suffering, the meaning of life, prolonging of the suffering and the like. Each terminally ill and dying patient has the right to respect, humane care and deserves a dignified death. The idea of hospice is based on respect for life and respect for a human being as a unique, unrepeatable being. The aim of palliative care is to achieve the best possible quality of life for patients and their families. In the nursing literature we often see described and quoted stages of dying as visioned by Elisabeth Kübler Ross. Nursing is currently in need of further research on the effectiveness of the various models and standards of nursing care for terminally ill and dying patients.

INTRODUCTION

We all know that we will die, but we do not think about it during the course of our daily lives. Mortality is often consciously or unconsciously “suppressed”. In history, there have been times when it was impolite or even rude to talk about death and funeral cars were not allowed to travel during the day. Death, dying and all related phenomena are dealt with through an interdisciplinary scientific branch called Thanatology whose content is ‘dispersed’ into more traditional disciplines - philosophy, ethics, medicine, theology, nursing, sociology, psychology, etc. Each of these sees the same problem from different point of view (Bošmanský, Rusnak, 1996).

FEAR OF DEATH

Is it important or even necessary to think about death? Death as a natural process is not tragic. Already in ancient times, Aristotle divided his work *Man and Nature* into three basic parts - *About Birth*, *About Death*, and *About Soul*. He held small scientific debates in which he dealt with the issue of death (Dufferová, 2002). Nature seems indifferent to Life and Death. Only human reflection attaches tragic meaning to death. That we will not exist anymore is judged cruel and tragic. I know the fact that death is destroying life; but I do not know how or when. The question of the meaning of human life is linked to the finality of every human’s existence and cannot be solved outside of it (Green, 1998). Death may vary. It can be tragic, quiet, sad or dramatic, sudden or long

time proclaimed. In whatever specific form death comes, it should be respected as a social act, an event that always involves more people than just the dying person. Dying and death are classified; they take place discreetly, mostly without our presence. Regarding death, humans are often hypersensitive; reacting hysterically, most immaturely and irresponsibly. In the 20th and 21st Centuries, we tabooed death and dying, and we pushed death out of our minds, but we could not remove it from our lives. Because truthfully, we never actually think about our finality and we are not interested in this phenomenon of human life, we never reconcile with it. In Anthropology, we focus on essential elements which are discovered at the foundations of every culture: these are the values that reveal the orientation of its primary elements and behaviors (personal and community) (Csontos, 1996). Up to our first encounter with death, we think that there is enough time and that it does not concern us.

What can we do right now to transform our perception of death? How can a person come to terms with the death of a relative or friend if he/she does not reconcile his or her own finality? Fear of dying is natural because dying means a journey into the unknown, and, to some extent, it is normal to fear entry into the unknown. To balance gentleness and strength in relation to dying is one of the most difficult spiritual tasks (Stinissen, 2004).

Here are some factors which can cause anxiety in terminally ill and dying patients:

- Fear of abandonment and solitude
- Progression of the disease
- Fear of physical complications through the course of the disease with overall regression and loss of human dignity
- Fear that there will not be anybody to listen
- Fear that they will die alone
- Fear that their needs will not be met

THE DYING PATIENT

A dying patient goes through various stages in his/her struggle before reconciling with his/her illness and inevitable death. Elisabeth Kübler-Ross, in interviews with dying people, demonstrated that sensitively and professionally guided conversation helps turn dying persons away from apathy and surrender

to fate; that those conversations are more effective than psychotropic drugs, because they lead the dying to find strength within someone who listens to them with compassion and empathy. In the case of terminally ill person, we can validate that new, true ideas can cause immediate change in the physical body. Actually, muscles, blood and bones are just the solid expression and physical consequence of predominant thoughts. Changed thoughts immediately reflect in the nature and in the properties, revealing change in the visible shape of the body. If the invisible force of the body changes then the visible has to change (Mulford, 1995).

The author divided the stages of dying: shock → denial → depression → negotiating → adoption (or acceptance)

Death and dying are affected by psychological approaches, by experiences expressed by older as well as younger patients, by the mentality of ending, by fear, by trauma of losing loved ones and by our personal attitude toward our own death (Senčík, 1998).

The patient may desperately visit one doctor after another hoping that the disease diagnosis was not correct. Sooner or later, he will have to acknowledge the harsh reality face to face and he could often react angrily. "Why me?" In the first stage of depression he laments on his lost life and then he begins to lose interest in his surroundings.

How to tell a patient that he/she is dying?

Once the diagnosis is confirmed, the patient should be well informed about the seriousness of his/her illness. At the same time, however, some hope should be given and we should tell him/her about all possible treatment options. No patient should, however, be immediately told that he is dying (Moos, 2001). It should be well thought through how to tell this fact to a patient.

A patient has the right to know how serious his/her illness is. While the family should be informed of the seriousness of the illness, when the patient does not wish it, we should accept his/her decision. The family should not inform without consent – but only if written permission is in the medical records allowing a doctor or nurse to inform a specific family member.

The rights of dying patients:

A patient in an incurable stage of a disease has the

right to relief and sedation as corresponds to current knowledge and capabilities of health and nursing care for the dying.

A terminally ill and dying patient has the right to humane treatment.

A patient has the right in the last moments of his life to be accompanied by a person of his choice.

A patient has the right to die with dignity.

A patient has the right to strict compliance with his/her written request not to be resuscitated and to reject the application of resuscitation procedures and/or therapeutic interventions. When a patient, being fully informed, refuses necessary medical care, a doctor requires the statement of refusal in writing or an otherwise demonstrable form.

MISERY

If requested the meaning of suffering could be found in this difficult situation when it is possible to 'learn' something new. A terminally ill person is forced to think of his own humanity, feeling that his/her body is not a simple possession which may be treated in any way (Green, 1999). In this dying experience with so much discomfort and pain, various thoughts can come to mind of the dying person allowing a new light of understanding about the meaning of a life which is coming to an end.

SOCIAL ASPECTS OF SUFFERING

At first glance, it would appear that the problem of disease and suffering is a matter of medicine and/or philosophical-theological theodicy. Society is focused on the performance, success and profit in medical care. A life without pain is an ideal for many people so many dying patients hide their disease from family, work colleagues and even their private doctors.

Many people are ashamed about their suffering: paralyzed, old and dying are often hidden away in institutions, retirement homes or hospitals. Although there are many reasons, the number one factor is fear (Green, 1999).

The fear is confrontation with their inescapable future, suffering and dying. Humans often have ideas and expectations generating serious difficulties to acknowledge something that reminds them of what inevitably will happen to them. In general, suffering

brings serious changes, particularly dealing with loneliness, isolation and feelings of uselessness.

These feelings are influenced by three factors:

- The circumstances of suffering (gender, type of disease)
- Internal personal resources (psychological, cultural, interpersonal, spiritual)
- External support (family, friends, work environment)

LONGEVITY

Patients, in the course of the end-stage of their disease, i.e. those who have reached their final stage of illness, confront us with many challenges (Heer, 1969). For survivors, the most serious confrontation comes when we are compelled to be witnesses at the very end of loved ones suffering transitioning into death and an end of suffering.

Ethical aspects of the aging process and prolonging of life:

- Human dignity, quality and meaning of life, the value of life (Hamžik, 2002)
- The right to self-determination, space for individual choices, individual and society relationship
- The rationale behind our and foreign laws relating to the treatment of persons at the end of their lives
- Anticipatory decisions, living wills.

Where is the best care for our dying?

Most patients prefer dying at home, but some prefer a health facility. These are mainly people who have lived very lonely and those living in difficult relationships with their relatives. In the terminal stages of disease, there is also another option where people can go through the last moments of life with dignity (Green, 1998): it is called palliative care in a hospice. The idea of hospice is based on respect for life and respect for the human being as an unique, unrepeatable being. It is intended to care for patients in the final stage of their lives when their disease has stopped responding to medical treatment. Experience has shown that the most common hospice patients are those with cancer - up to 90%.

The aim of palliative care is to achieve the best possible quality of life for patients and their families. WHO, the World Health Organization, declares that palliative care:

- Affirms life and regards dying as a normal process
- Does not speed up nor postpone death
- Provides relief from pain and other annoying symptoms
- Incorporates mental and spiritual aspects into patient's care
- Creates a support system that allows patients to live as actively as possible until death
- Creates a support system which helps the family to cope with the patient's disease and with grief after the death.

CONCLUSION

“Nobody is born alone and no one should die alone!” - this sentence includes the very element that defines dignified dying - the presence of another person. This presence of another person makes the processes of both birth and death social acts. With the possibility of a basic ritual of loving accompaniment to the last journey of life we can create a real base for a compassionate framework for dying and death. The physiological face of death is not widely known, and therefore it is sometimes considered “inappropriate” or “ugly”. It is generally preferred to look at death only from the “esthetic” point of view. Certainly it is healing to witness the end of suffering through a merciful death, when the very act of dying is calm, balanced and reconciled, and is mirroring the compassionate, respectful state of everybody around him/her.

The dignity of death can be recognized by way of the careful and dedicated treatment offered to a departing human being who needs and receives our professional care. We should consciously move beyond the aesthetic criteria that prevent us from accepting the inevitable natural physiological symptoms as the body releases its last breath. The work of the nursing team that cares for ill and dying patients is very demanding and requires appropriate social evaluation. In addition to professional assistance, Nurses also provide their patients with consolation, encouragement and hope, and stand by them until the last

moment with the understanding that the ethics of terminal care are revealed in their ability to take responsibility for a patient to themselves (Štefko, 2003).

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Correspondence to:

Prof. Dr.. Ivica Gulášová, PhD.

St. Elizabeth University of Health & Social Sciences, Bratislava, Department of Nursing, Faculty of Public Health, Slovakia

Mgr. Lenka Gornerová

College of Polytechnics, Jihlava, Department of Health Studies

Czech Republic

MUDr. Ján Breza, PhD. jr.

Department of Urology and Radiology and Centre for kidney transplantations, Kramáre University Hospital, Bratislava, Slovakia

Prof. MUDr. Ján Breza, DrSc.

Department of Urology and Radiology and Centre for kidney transplantations, Kramáre University Hospital, Medical Faculty of University of Komensky, Bratislava, Slovakia

ETHICAL AND LEGAL PROBLEMS IN THE ALLOCATION OF KIDNEYS

Ivica Gulášová¹, Ján Breza jr.², Lenka Görnerová³, Ján Breza²

1. St. Elizabeth University of Health & Social Sciences, Bratislava, Slovakia

2. University Hospital Kramáre, Department of Urology, Center for Renal Transplantation, Slovak Medical University in Bratislava and Faculty of Medicine, Comenius University, Bratislava, Slovakia

3. College of Polytechnics, Jihlava, Czech Republic

Key words:

kidney donor; kidney recipient; list for transplant candidates; ethical aspects; center for transplantation of organs

Abstract

The concept of prevention of social pathology - as the optimization of the bio-psycho-socio-cultural-spiritual regulation of behavior - is based upon other studies of Prof. Damian Kováč, who understands human being not only as a bio-psycho-social creature, but rather as a bio-psycho-socio-cultural-spiritual being, while the integration of personality is not simply a pure predisposition, but it is the result of self-formation by cultivation. This is most effectively realized through mental regulation by means of system regulators such as wisdom, prosocialness, tolerance, moderation, responsibility, humbleness, conscientiousness, and meaningfulness of life. If this multisector intervention (and prevention) is to be reasonably effective toward social-pathological factors, it cannot ignore this five-factor conditionality.

SUMMARY

In order to fulfill its beneficial potential, transplantation of kidneys demands well structured organizational access from administrative, medical and nursing disciplines. The authors explain the necessity for individual country's information systems - such as the Coordination Center for Organic Transplantation in Slovakia - The Slovak Center for Organic Transplantation (SCOT) - to maintain up-to-date lists of candidates for transplantation. They see the task and mission for SCOT running both lists of candidates waiting for kidney transplantation and for potential kidney donors. They also want SCOT to cooperate with other European and World Transplantation Centers. Very urgent ethical questions arise because there is great disparity between the numbers of donors and recipients. First is the priority for the allocation of kidneys for registered recipient candidates. Selection of a recipient of a kidney presents several contradictory ethical questions which the authors analyze. For example, what are the criteria procedures for choosing a potential recipient - medical criteria,

social criteria. And, what about the financial and social position of the recipient candidate? How do those aspects relate to the basic ethical principles - legal, autonomic, beneficent (benefit a patient) and non-maleficent (least possible harm)? They pay special attention to the remuneration of the donor, especially their voluntariness. Here, they refer to contemporary laws on the rights of patients and the risks arising from problems of donor's kidneys, such as poverty, social situation or sympathy with people. Finally, they refer to facts, that given problems not only impact donors and recipient candidates of kidney transplantation, but they have much wider social, political, economic, cultural and religious aspects to which our society does not pay urgent & necessary attention.

INTRODUCTION

Despite support for the decision to donate a kidney, in many countries available resources do not meet medical demands. Renal

transplantations require a well-structured, organized approach from administrative and medical resources to ensure appropriate response for public health to implement the growing gap in donors. It is therefore very important and necessary for individual countries to create a well-functioning, robust, information system containing lists of donors and candidates for renal transplantation. Such waiting lists should be based on fundamental and clearly defined selection criteria applicable to both the donors and the recipients (Glasa, 1994).

In the Slovak Republic, transplantation of organs is coordinated by the Slovak Center for Organ Transplantations (SCOT). One of the tasks of this Slovak Center for Organ Transplantation is the maintenance of the National Transplantation Register of SR - the transplant waiting list. The National Transplant Registry keeps the list of recipients waiting for a kidney transplant and the list of kidney donors. SCOT cooperates with European and International Transplant Centers.

“Information on appropriate donors facilitate the Normative Act No. 576/2004 by which the provider of institutional care is required to report details of potential donors to the donor registry kept by the Ministry of Health” (2., p. 293).

Ethically, important and challenging are allocation priorities according to the waiting lists for donated organs. Worldwide there is a great disparity between donors and those waiting for a kidney. The demand for kidney transplantation is increasing faster than the number of potential donors resulting in constantly growing waiting lists in all EU countries. Numbers of suitable donors are low compared to the many hopeful candidates of organizations around the world communicating with each other. *“In 2006, there were approximately 40,000 patients in need of a transplant organ on EU waiting lists”* (TA, SR, EU, 2006). In the USA, 90,946 candidates were registered for organ transplantation (TA, SR, EU, 2006). Obviously, these numbers have increased substantially by 2013. It is very difficult to reduce the number of registered patients and to shorten their waiting times. Regarding kidney donation, time is of great importance. For a registered person it may take several months or even years to find a suitable kidney donor. It's almost like winning the Lottery. We often see the expectant patient die before a suitable donor is found. *“In the EU, in 2006, every day nearly ten people waiting for a transplant of vital organs died”* (TA, SR, EU, 2006). Again, this must be significantly higher in 2013. We face many moral allocation problems selecting a candidate for kidney transplant. Evaluation and selection of the

kidney recipient raises significant controversial ethical issues. If a suitable kidney is found which patient is chosen to receive it? Optionally, should the kidney be transplanted to an elderly person whose life depends on it; to a young person who has a greater chance that his/her body accepts the new kidney; to a rich individual who is willing to pay a large sum of money for funding which could help to save thousands of other people; or, simply give this kidney to the first one who is listed on the waiting list meeting the compatibility criteria? Which criteria should we use choosing a potential kidney recipient? (Melišová, 2000). Should the decision be made solely on medical, or additionally on social criteria? What role do we allow money and social position to play? From a moral point of view it is obvious that the criteria for the allocating kidneys should be justified and not in any way discriminative and/or utilitarian. This means that the choice of the kidney recipient should not be influenced by race, age, gender, religion, social status or by social benefit.

The decision about who has priority in obtaining a kidney relies primarily on immunological and clinical factors. Most important are the specified allocation criteria, including their many ethical issues. Registered patients should accept that kidneys are distributed in an effort to achieve the maximum antigenic match. Therefore, the waiting time for each hopeful kidney recipient varies. When a kidney becomes available, or if someone dies, the most compatible recipient should be clear in the shortest possible time. Sometimes, we cannot use removed kidneys because there is a low degree of compatibility. A kidney with a low degree of antigenic conformity cannot guarantee that the recipient's body accepts it. Currently, Medicine seeks to solve such a problem by immuno-suppression by suppressing the autoimmune reactions of the body against the new kidney. Despite this, there can arise medical and ethical questions. Will a potential recipient's body be able to integrate a low-compatible kidney. A potential recipient has the right to refuse such an offered kidney. So, such a kidney may be transplanted to another less suitable recipient. The right of the potential recipient to refuse an offered kidney and wait for the most appropriate kidney with maximum antigenic compliance is, in terms of other potential beneficiaries, ethically questionable. This problem arises even more in relation with so-called marginal donors because there is still the question of whether long-term use of these organs is not worse. In such situations, it is necessary to address the issue of consent to the fully informed patient and his approval for the procedure (Valenta, Třeška, Hasman, 1999).

Allocation criteria are those which primarily

determine the allocation of a kidney to a potential recipient. All other options prove to be completely ridiculous (arbitrary) and subjective, not recognizing the intrinsic value of every human being independent of any external circumstances (Křchová, Radkovský, 2001).

REMUNERATION AND GRATUITOUSNESS

Remuneration and gratuitousness in kidney donation are topics that present many ethical issues and questions. Renal transplantation donation without charge becomes a global problem leading to an even greater problem - the trafficking in kidneys. Current opportunities, the rise of anonymous kidney donors brings the question whether excluding reimbursement of costs associated with kidney donation (lost profit, travel fees, etc.) should these non-voluntary donors receive any incentive to increase donor numbers. All payments present the risk of breaching all ethical principles (Honzák, 2005).

The increasing dominance of economy over humanity creates a very dangerous trend and requires conscious, professional response against kidney donation as an organ auction. What role does influence and finances play here? Is it possible to sell a kidney before death? Affirmative answers can only be given by utilitarians who would argue that all would be used for the good of mankind, and that those decisions of individuals to sell would certainly be autonomous. Sale of the human body, or its parts, is in direct conflict with human dignity and the body would fall to the level of 'material goods'. This would lead to degradation and de-personalization of medicine and of the whole of society. Such procedures would become a risk to living donors and would undoubtedly result in discrimination against the poor and economically vulnerable individuals in society who would easily become objects of exploitation (Munzarová, 2005).

The question of kidney donation reward is becoming increasingly important mainly due to extreme distribution of wealth and power in our world.

In the EU, and in the SR trafficking in organs, tissues and cells is explicitly prohibited. In our country kidney donation is free even when the kidneys are taken from living donors. Such attitude towards donation is exactly defined by legislation and expressed in Act No. 576/2004 of healthcare services related to healthcare and amendments to certain laws. *"Withdrawal and transfer of organs, tissues and cells in order to gain financial or other material profit is prohibited"* (2., p. 293).

In 2002, the Council of Europe adopted the so called Convention on Human Rights and Biomedicine, which stated that the human body, and hence its parts, must not be abused for financial gain. Donating of kidneys must be done without profit to the donor and if the donor is no longer alive to the patient's family (Rozsival, Tomiuc, 2003). Selling of my own kidney is illegal and it is a serious violation of human rights and dignity.

The lack of kidneys for transplantation and imperfect legislation in some countries represents a growing threat from illegal trade in kidneys. Only humans are human, and therefore there are cases where some individuals grossly misuse this rare and unique opportunity to lifesaving and deal not only with their own, but also with other human's kidneys.

Obtaining the 'material' often leads to a targeted death (Valenta, Třeška, Hasman, 1999). 'Renal transplantations become illegal at the moment professional traders threaten or force their victims to give up their kidneys, taking advantage of their financial hardship' (Priestley, 2004). Kidneys are taken from corpses without their consent for donation of their kidneys sometimes even before their death. Traders offer attractive amounts of money, while some people are blackmailed. Extensive exploitation of vulnerable individuals occurs in our society (Priestley, 2004).

In our contemporary world, this issue of 'trafficking' is not only connected with kidneys, respectively whole organs, as well as various parts of the human body - bones, cartilage, tissues, including blood derivatives. Such business is growing dynamically dependent on how modern science pushes the boundaries of biomedical use of human body parts & systems. 'Trafficking of human tissues and organs is a form of human trafficking' (Priestley, 2004). This illegal trade in kidneys is conducted by organized criminal groups who track down and remove kidneys from poor and/or powerless victims in developing countries and deliver them to wealthy recipients in the European Union.

Kidney trafficking is now a new worldwide problem. In the 1980s, experts observed the phenomenon later known as 'transplant tourism' as prosperous Asians began traveling to India and other parts of Southeast Asia to receive kidneys from poor donors. From then on new portals were opened.

For criminal organizations without boundaries this trafficking offers unlimited profits. It is a lucrative opportunity to get rich (TA, SR, EU, 2006). Through their trade in kidneys international criminal groups earn more and more money - their profits rise proportionally with the increasing demand for kid-

neys (Pravda, 2007).

The black market in kidneys typically extends beyond frontiers and has become global because its gains arise from the existing differences in the living standards in rich and poor countries. Despair and poverty are forcing living people to sell their healthy kidneys. Recipient patients from rich countries visit backward countries to buy kidneys from living donors. Organized groups are buying kidneys and other body parts for their businesses especially in poorer parts of Eastern Europe. Specialized, illegal dealers in kidneys are often linked to private clinics in countries where the oversight of healthcare is minimal, if any. Kidneys are bought from living human donors with cheap money from poor countries such as India, Pakistan, Iran, Brazil, Peru, Bolivia, South Africa, but also from European countries such as Romania or Moldova and are sold to candidates for transplant in rich countries such as the USA, Canada, Israel and Europe. The whole process has a 'mafia' character (Sýkora, 2006).

The largest market for kidneys in the world is in China and Pakistan. National People's Congress of China on 21 March 2006 passed a Law that prohibits the commercial sale of human kidneys and also prohibits anyone younger than 18 years of age from donating organs. China and Pakistan have undergone steps to ban the sale of human organs. These measures should reduce 'transplant tourism'. It is, however, assumed that the black market for kidneys in both countries is continuing even after the ban. Human rights activists argue that Chinese sale of kidneys are motivated by profit, regardless of medical ethics (Pravda, 2007).

There is a rapidly increasing global evolution of kidney trade mediated through the internet. Internet, the greatest symbol of globalization, is a resource that brings candidates for a kidney transplant new opportunities and enables them to take the initiative for their own destiny. Many of those who are waiting for several years now create their own websites in order to find someone who can 'donate' a needed kidney. Of course, they offer compensation for expenses associated with travel and lost wages. We can discover organizations which are called 'non-profit organizations' on those websites. In fact, they are profitable organizations which manage dedicated web portals where potential kidney donors can log in at institutions from all around the world. Candidates are required to pay a commitment fee to access this database of donors. The relatively low fee gives a large number of candidates an interesting source of revenue for administrators of such portals.

In general, legislation in several countries in the world, while prohibiting the sale and purchase of kidneys for transplantation, does allow compensation for financial costs associated with the donation. Most doctors believe that the sale of kidneys is unethical, but some believe that the controlled system of sales would be beneficial in the current climate of need. The above mentioned trade in kidneys is somewhere in the gray zone between laws that clearly reject the commodification of the human body and legislatively tolerated so called associated financial costs of collection, transmission, storage, testing and kidney transplantation. Among the organizations that openly and legally purchase kidneys where it is permitted by law and organizations that are declared as non-profit and charitable, there is almost no difference in the turnover of money - differences are only in tax returns (Sýkora, 2006).

Black market in organs and so called 'Transplant Tourism' are expanding incredibly. When we go deeper into those issues and when we open our eyes, instead of selfless doctors working hard with super-human efforts, and instead of donors - selfless heroes and instead of the grateful recipients, we find that in our society it is not a valuable service of human to human, but violation of law and especially violation of human dignity.

Estimates suggest that illegal trade in kidneys in Europe does not occur so often, but politically and ethically it is a very serious situation about which we should inform society. And, we should try to bring the situation to the awareness of all people. Worldwide kidney donation remains as a kind social taboo resulting in a shortage of donors and excessively long waiting lists. This is an urgent issue, which we do not like to think or talk about or want to see (Jurašková, 2003). The human being is a creature who often does not allow himself to see those situations which endanger his/her health.

CONCLUSION

The progress of medicine is steeply advancing. Organ transplantation is a constantly evolving branch. We already know, as we mentioned above that the demand for kidney transplants outweighs the number of kidney donors. It is this fact that motivates scientists to discover possibilities of kidney transplantation with other than human tissue. Scientists worldwide are searching for solutions on how and with what to replace human tissue such as kidneys. The discovery of replacement kidneys with so-called 'artificial kidneys' would solve the problem of the shortage of kidneys for society. This would resolve the overall ethical,

legal and medical issues of kidney donation and kidney transplantation. Scientists admit that the kidney could be replaced either by bio-materials or tissue derived from animal tissue. But also the facts mentioned above and the invention of new biomaterials will become a new ethical problem which will have to be addressed in the near future.

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Correspondence to:

Prof. Dr. Ivica Gulášová, PhD.
Narcisová 40
821 01 Bratislava, Slovak Republic

MUDr. Ján Breza, PhD. jr.
Prof. MUDr. Ján Breza, DrSc.
University Hospital Kramáre,
Department of Urology,
Center for Renal Transplantation,
Slovak Medical University in Bratislava
Slovak Republic

Mgr. Lenka Görnerová
College of Polytechnics
Jihlava, Czech Republic

THE IMPORTANCE OF THE SOCIAL SERVICES IN THE SOCIAL FAMILY POLICY IN CZECH REPUBLIC

Jiří Tůma¹, Lucie Maliňáková²

1. St. Elizabeth University of Medicine and Social Work Bratislava, Institute of St. Johann Nepomuk Neumann Příbram
2. Faculty of Theology, University of South Bohemia, České Budějovice

Key words:

family; social policy; social services

Abstract

The changes in the structure of family and family behaviour are one of the most considerable and the most important changes that we can see in the social area. The aim of this work is an analysis, if state develops and provides the conditions for support of the family with children with the using of the social services. During the 1990s, the Czech Republic, as well as some other European countries, underwent considerable changes in family behaviour. Besides fundamental changes, such as decrease number of marriages, increase the number of single-parent families e.c. There have also been some cultural and structural changes contributing to a new interpretation of the concept of family and family life. Abandoning the traditional models of the family and the liberalization of family life have presented us with new challenges to provide the conception of family policy. This contribution refers to the basic tendencies and features that have characterised family behaviour in the past as well as nowadays, with reference to other European countries. Subsequently We analyse conditions for the development of the family social services and review the role of the family policy in this development.

INTRODUCTION

The family of interest to laymen and scientists. Despite of this interest and maybe because of its there is no universal consensus on the concept of family. So how do changing family and family behavior, such changing as the interpretation of this term. We can see a change interpretive frameworks through the theories, the concept of Durkheim, the family was seen as a kindred connected by blood relationship to the nuclear family as seen by Parsons. The nuclear family is the same household, which consists of parents and children. . Lack of uniformity in the definition of family is found in the European area today. It can be observed that in the old continent to meet two definition of families. On the one hand, the family is seen as the coexistence of people assigned to each partner, marital or parental relationship. On the other hand, is seen

as a family unit household. The family of the count and those who live together in one household. Interpretive choice is entirely up to the individual national governments. In general, however, that the definition of family, national governments often favors the second option. One of the most significant and visible changes that we observe in society, changes in family structure and family meetings. The aim of this study is to explore whether the state creates conditions for supporting families with children through the social services. The theoretical part shows the evolution of the family over one and a half centuries. Describes the most important milestones and value changes in the lives of families here in our country, and with reference to other European countries. Subsequently, analyzes the possibilities of social services for families with children.

THE FAMILY AND THE CHANGES

From the mid-19th century, we can see very significant changes in the family behavior. These changes are the part of the transformation society, which is called the demographic transition and demographic transition. In this process, there is a significant variation in the level of mortality and fertility rates. Traditional family dealing was characterized by the fact that most couples began to give birth to their children after marriage. Demographic transition brings change this behavior. Couples still begin and continue to childbirth after the marriage, but the children are not born throughout the whole period fertility women. This demographic transition gradually affected all industrialized nations. Factors that caused the disruption of the status quo in large numbers. It can be said that it is the interaction of both cultural and structural factors that were associated with the collapse of traditional society and the emergence of modern society. (Navrátilová, 2007, p. 2). Other significant changes in family dealing occur in the first half of the 70th the last century. The processes associated with them are some authors, denoted as the second demographic transition. The marital act is still to much large reduction in childbirth rates than in the previous demographic transition. Due to changes in family behavior decreased childbirth rate, which significantly violated existing demographic structure of the population. In addition to reducing the childbirth rate, increased the numbers of divorces and the number of single-parent families. There was also a rise in cohabitation and increased the number of children out of marriage. Some people put these changes in the context of profound cultural and value changes that are characterized by individualization and pluralization of values, identities and life styles. As part of these changes are beginning to strongly promote the values and views towards greater emancipation and empowerment of women. It also increases the importance of emotional parenting functions, which may be fully

saturated even with just one child in the family. Prior to these families as a result of these processes opens up the possibility of many options. On the other hand, families are exposed to major risks and uncertainties that are related to these elections. Other factors that limit the freedom of choice to decide for childbirth are the difficulties faced by women in particular, in reconciling work and parental roles. (Navrátilová, 2007, p. 5). Another of the period, which is characterized by a significant change in family behavior in the Czech Republic is 90 years, is the isolation in which it was concluded by the end of the Second World War because of the Soviet subjugation. Before this time the families were one of the features of Western European type. If we followed the norms of family behavior, in this development have been among the Eastern European family type. Family dealings are characterized by high rates of marriage, abortion and childbirth rates and divorce. Marriages and births were mostly implemented at the beginning of reproductive age women. The Socialist government has supported the work of women and fertility as well. The enforcement of this model of family policy returning our country back to the traditional family type. Restoration company has stopped violently destroyed some elements of industrial society and development returned back to the traditional structures that have an important impact on the family behavior.

The nineties marked the end to the extensive population development. Changes in family behavior are some of the most striking changes in our newly emerging companies. Among the most important changes in family behavior are falling marriage and childbirth rates. At the same time marginalizing marriage to a later period and reduce abortions. Couples concluding marriage are already more economically independent and have own housing. It reduces the dependence of adult children on their parents. The main features of family behavior Czech family returned to families meeting of the West European type. (Navrátilová, 2007, p. 6)

Table 1. Indicators of family behavior in selected countries in Europe (1999)

Country	The total fertility rate	The average age of the woman at first childbirth	The children born out of marriage (%)	The total marriage rate of single women
Sweden	1.50	27.9	55.3	0.46
Netherlands	1.65	28.7	22.9	0.61
France	1.77	28.7	40.7	0.57
UK	1.68	28.9	38.8	0.53
Denmark	1.73	27.4	44.9	0.67
Austria	1.32	26.3	30.5	0.53
Germany	1.36	28.0	21.6	0.60
Italy	1.22	28.0	8.7	0.62
Slovenia	1.21	26.1	35.4	0.48
Czech republic	1.13	24.6	20.6	0.48
Hungary	1.29	24.8	28.0	0.46
Poland	1.37	24.4	11.7	0.63

Source: NAVRÁTILOVÁ, J. 2007. Role sociálních služeb v rodinné politice. [online]. Leden 2007. [citované 2013-01-22]. Dostupné na internetu: <http://data.rodina.quonia.cz/soubory_ke_stazeni/ROLE_SOCIALNICH_SLUZEB_V_RODINE_POLITICE.doc> s. 3.

Previous Table 1. shows at the most important changes in family behavior. The number of children that would be born per one woman declined to a level lower than that of other nations, as well as and the marriage rate has remained at a lower level than that of most other EU countries. Although the age of the first childbirth increase, remains compared to other countries even lower.

THE VALUES OF THE FAMILY BEHAVIOR

Contemporary modern family is shaped by the values that prevailed at the beginning of the nineties and beyond. This is especially the increase of

individualism and pluralism. It also reinterprets the position of women in society and family. Women far more striving for a better position in the labour market and social position in the society. (Navrátilová, 2007, p. 8). The scientific research which found that “while in 1991, 67% of Czech respondents considered that a woman needs to have children to saturation her life, and in 1999 it was only 44%. Similarly, when in 1991, 70% of respondents agreed with the claim that the child in pre-school suffers (when his mother is at the job), in 1999 it was only 47%.” This research gives the Czech respondents together with Slovenians from the area post-socialist. This view is significantly lower than in some Western European countries like France, Germany or Italy.

Table 2. The answers to the question “Do you think that a woman needs children that her life had been filled or it is not necessary“

Country	Children need	Do not children need	Quantity
Sweden	24.8	75.2	960
Netherlands	7.1	92.9	996
France	67.1	32.9	1 525
UK	20.6	79.2	863
Denmark	24.8	75.2	877
Austria	33.9	66.1	1 227
Germany	54.0	46.0	1 864
Italy	56.4	43.7	1 881
Slovenia	38.0	65.0	966
Czech republic	44.1	55.9	1 803
Hungary	94.1	5.9	959
Poland	69.6	30.4	1 021

Source: NAVRÁTILOVÁ, J. 2007. Role sociálních služeb v rodinné politice. [online]. Leden 2007. [citované 2013-01-22]. Dostupné na internetu: <http://data.rodina.quonia.cz/soubory_ke_stazeni/ROLE_SOCIALNICH_SLUZEB_V_RODINE_POLITICE.doc> s. 4.

This value shift in Czech society can not be interpreted as an impairment of the child, lack of motivation or desire to have a child. In the Czech society is still a desire to have children. Based on data from 2000, that “there is strong evidence that the desire to have children people still drop it. European men and women in the age group 25-34 show a surprising consensus as to the optimal number of children they would like to have. Average number in the EU countries is 2.4 children with almost no variation of this number...” These data also confirm the results of research conducted Public Opinion Research Center. During an-

swering the value attributed Czech men and women of child was found that in their lives the value of the child takes the second most important place. Before the desire to have a child placed need a steady partner. The desire to have a partner may be on the same level with the value of the child, because life with the partner sets the stage for having children. The time perspective did not record the change of the value of the child, as indicated in Table 3. This means that the desire to have a child persists regardless of the time evolution in the society. (Navrátilová, 2007, p. 9).

Table 3. The average value of the life goals in 2003 a 2005

Goals	2003	2005
Have a steady partner	3.03	3.01
Have a children	3.24	3.23
Succesfull career	3.40	3.38
Get married	4.02	3.93
Achieve the highest possible education	4.18	4.24
Have an interests	4.80	4.75
Social life	5.32	5.47

Source: Navrátilová, 2007

The vast majority of respondents held the view that an individual should have the children throughout life, does not matter for private reasons or in the interest of the whole society. The negative reactions arouse the possibility of life without the children. Almost half of respondents (48%) considers that the children should be born into a functioning relationship. We can not overlook the difference between the desire to have children and the real accomplishment of this desire. The difference between the number of children that would like to have a family and the number how many children they actually have is talking about the so-called "missing children" (child gap). These are factors that act as barriers to the birth of missing children. It seems that it play a significant role in the structural indicators, which include mainly social risks such as the direct costs associated with children, difficulties especially for women under the coordination of the their careers and their responsibilities associated with caring for children. These barriers limit the options for potential parents to have a child. The parents' decision to have a baby is the result of many cultural and structural indicators. The identified data create space for family interaction acting through government intervention. Research has focused on the monitoring of family behavior shows that the value of children in society still has high dimension, which maintains a nearly constant rate. Children are still important factors not only in the lives Czech respondents. Find-

ing answers to the question why we have such a low childbirth rate, if you so wish kids will probably be directed to look for reasons both external and internal environment in families. Family behavior is largely influenced by environmental factors in which families live. It is certainly not irrelevant whether family policy creates opportunities for families with children or whether the conditions set out barrier against families with children. It is important to consider that in spite of the possibility to have a child, today parents could choose among many other offers. The decision to have a child is only one of the "options" that compete with the other values and intentions in the lives of parents. It can not be practical available for the parents to compare the other desires, values e.c. It is a challenge for the design of pro-family social services created by the state establishment. These social services could be based on factual needs of families and could be create the right conditions for families. (Navrátilová, 2007, p. 7).

**THE VIEW OF THE ACT
NO. 108/2006, COLL.
FOCUS ON SOCIAL SERVICES**

The “Social Services Act” was conceived many years. After a couple of unsuccessful submissions, the new Social Services Act originated in the March 2006. Its effectiveness is dated 1.1.2007. As part of the

Social Services to govern the provision of assistance and support to individuals in difficult social situations through social services and benefits (care allowance). By law, social service means those activities that provide assistance and support to persons for the purpose of social inclusion and the prevention of social exclusion. The law regards the family as the natural social environment (point 3 of the law). The law in point 32 divides social services into three basic types, which are (a) social counseling, (b) social welfare services, and (c) social prevention services. Each of these can be provided in the context of the difficult situation of families with children. (Act No. 108/2006 Coll.)

Ad a) The social counseling support is provided to families especially in vocational guidance through the provision of social services, marital and family counseling.

Ad b) Social welfare services seemingly the most immediate problems affecting families with children. They are designed especially to individuals who are less able to care for themselves due to age, and whose situation requires regular assistance of another person. Social care services are then defined in point 38 of the law as services to assist people to ensure their physical and emotional self-sufficiency, in order to allow them the highest possible level of integration into normal society. Also in this category are services that can in a difficult situation of families with children (especially long-term sick or handicapped people) to be helpful in the solution.

Ad c) The social prevention services is to help individuals overcome their difficult social situation and to protect society from the emergence and spread of undesirable social phenomena. According to point 53 of the law social prevention services help prevent the social exclusion of people who are threatened by a social crisis, habits and way of life leading to conflict with society, a socially disadvantaged environment and danger to the rights and legitimate interests of the criminal activities of other individuals. We can find social prevention services for families in the services of social prevention area. In the point 65 of the law we can find special service for families with children called social activation service. (Act No. 108/2006 Coll.). If we analyze the aforementioned law in terms of family support, we can see that the support is for especially families with a child which is already compromised due to long-term development critical life social situations that parents can not overcome without help, and that there are other risks to its development. The law prefer secondary and tertiary prevention than primary prevention. Primary prevention is not explicitly mentioned by the law. (Navrátilová,

2007, p. 10).

CONCLUSION

The aim of this study was to explore whether the state establishment creates suitable conditions for supporting families with children through the social services. In the present work, we considered it useful to summarize the basic data on families and we briefly describe a formal aspect, which defines the scope of the services for families with children in the Czech Republic. A closer insight into these documents can be seen starting to correspond to the contemporary conception of family policy, but also deficits. It is quite visible that the Action Plan Support to Families based on the National Family Policy Concept. It develops its goals and gives them a particular form. What is new here is particularly emphasize the need to give the family a really important position in our society and generally improve conditions for families, especially at a time when they must provide education and care for their children. The Action Plan Support to Families admits emphasis on promoting a healthy functioning families unlike the Act No. 108/2006 Coll. on Social Services. With its basic premises is based on current trends in family support, as we know from other western European countries. There is an emphasis on creating favorable conditions for families than instrumental proposals that would result in reduced levels of free choice families. (Navrátilová, 2007, p. 11). If you research the Act No. 108/2006 Coll. on Social Services in context of its previous two documents, there is quite a noticeable difference in perceptions of what services should be provided to families. If the Action Plan Support to Families and the National Family Policy Concept support interventions in primary prevention, then the mentioned law is to promote activities that have an emphasis on secondary and tertiary prevention. This difference is largely due to motives for which the documents were created. The Act No. 108/2006 Coll. is a reaction to developments and trends in the provision of social services. Point 3 of Act No. 108/2006 Coll. define the term of social service. This term means the activity as providing assistance and support to individuals in difficult social situations in order to prevent social inclusion or social exclusion (Act No. 108/2006 Coll.). It is therefore particularly to support the integration process, which is seen as a basic idea of current social policy. This law does not explicitly expressed support functioning families with children. They are not in it anchored conditions that would give space for family activities, which would be based on the civil society. There is a space created for

families with children, which is threatened by the development of long-term critical social situation which parents are unable to solve them, and that there are the risks of further threats to development. Analysis of formal documents, among which are made for families with children shows that among them there is no clear continuity and consensus in support of families with children. These services are hardly reflected in the basic law (Act No. 108/2006 Coll.), which regulates their provision. It can therefore be seen that the spread of support the services to families with children through the offerings of services will be very problematic, because it has no legislative support in the Act No. 108/2006 Coll. and there is no context and connection to other laws, their purpose is to support families with children. (Navrátilová, 2007, p. 12).

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Correspondence to:

Tůma Jiří, PhDr., PhD.
St. Elizabeth University of Medicine and Social Work Bratislava,
Institute of St. Johann Nepomuk Neumann Příbram
Jiráskovy sady 240
26101 Příbram, , Czech Republic
jirkatuma@centrum.cz

Maliňáková Lucie, Mgr.
Faculty of Theology, University of South Bohemia
Kněžská 8
370 01 České Budějovice, Czech Republic
malina@tf.jcu.cz

THE ISSUE OF VICTIMS OF HUMAN TRAFFICKING IN THE SLOVAK REPUBLIC

Martin Valentíny¹, Magdaléna Halássová¹

1. Constantine the Philosopher University in Nitra, Faculty of Social Sciences and Health

Key words:

victim; human trafficking; family; Assistance and support program for victims of human trafficking

Abstract

Human trafficking is one of the most substantial phenomena of this period. Following the international commitments, the Slovak Republic is obliged to build a complex system of protection and assistance for victims of human trafficking. The strategy of solving these problems currently bases upon the National Program on the Fight against Human Trafficking for the years 2011-2014. It regulates the operation of the Support and protection program for victims of human trafficking (IOM, 2010). In most cases, a victim as a part of a family system returns back to the family after traumatizing experience connected with trafficking. We believe that the focus of assistance and support provided within the framework of the Assistance and support program for victims of human trafficking aimed exclusively at victims is insufficient from a point of view of a family as a system. Therefore, we deem it appropriate to consider broadening the scope of the program aimed at assistance and support for victims through services which will focus on reinstating the whole family system. We think that it would support not only a successful reintegration, but also the prevention of re-trafficking.

DEFINITION OF HUMAN TRAFFICKING

„Human trafficking is recruitment, transportation, transfer, harbouring or receipt of persons by means of the threat or use of force, abduction, deception, fraud, coercion, abuse of power, within which the person has no other real and acceptable possibility but to accept the threat by giving or receiving of payments or benefits to achieve the consent of a person having control over another person for the purpose of exploitation, regardless of the fact whether victims of human trafficking agreed with the purpose of exploitation. Exploitation includes, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or removal of organs for illegal purposes.“ (IOM, 2008, p. 2) For better understanding of what the victim of human trafficking has gone through, we deem it

necessary to present a mechanism of human trafficking. Not every victim goes through the entire mechanism. Many victims don't make it to the rescue phase and subsequent reintegration. With regard to the fact that the paper focuses on reintegration, we consider victims who were successfully rescued and the reintegration phase could subsequently take place.

HUMAN TRAFFICKING MECHANISM

Recruitment - Methods of receipt of victims vary. In Slovak conditions, the most frequent is an offer of attractive job abroad. It can be an offer from a stranger, but also from a trusted acquaintance or a job offer advertisement. Just as there is no way to describe a typical victim of human trafficking, there is no way to describe a typical perpetrator. Very often, victims are persuaded to work abroad by women acting friendly, creating an impression that they truly want to help. The most frequently offered jobs are a model, barmaid, dancer, waitress, au-pair or baby-sitter. An-

other way of alluring the victim is “faking love”. After a short relationship with a victim, the perpetrator finds a way to transport them abroad and sell them or forces them to work as a stripper or a prostitute. There is a similar danger in dating advertisements or advertisements offering a marriage with a foreigner. The most drastic method which is used the least is abduction of the victim right from the street. The purpose is usually a forced prostitution or an illegal adoption in case of children.

Transportation - Transport is one of the most characteristic features of human trafficking. In Slovak conditions, an automobile or air transport is used most frequently. According to police estimates, victims of human trafficking presumably cross the official border checkpoints agreeing to go abroad at first, realizing only in their destination country that the purpose of a journey is other than agreed. Coordination of transport is presumably arranged outside our area; however, it is important to warn that trafficking may also take place within the country and the victim doesn't have to cross borders. In that case, we speak about intrastate trafficking.

Harbouring and receipt - During transportation and after their arrival, victims are kept hidden at various places. These places are guarded, so the victims don't have a chance to escape. They live in poor conditions, many times they are held in prisons, blackmailed, tormented, working for free or for a minimum wage.

Coercion - Victims' documents are abroad often taken away, which makes them more vulnerable. They are forced to perform the work for the purpose of which they were sold by means of threats, force or drugs. As their status often is not legal (they don't have a work permit, visas, etc.), victims are an easy target of blackmailing or intimidation. They aren't paid for their work or get only minimum amount of money, as they have to pay their “debt” to traffickers for mediation of work, accommodation and so forth. Not all trafficked persons are exposed to all of the listed methods of coercion. Physical violence doesn't have to occur. Examples of this are cases when persons trafficked for the purpose of provision of sexual services are denied medical examination and they can't choose or refuse customers or some sexual practices.

Abuse - If a person is forced to work and originally agreed conditions are abused, it is highly probable that it is a case of human trafficking.

Rescue and reintegration - If a rescue is successful, there is no typical scenario. The escape might be successful in an unguarded moment, thanks to police raid or with the help of a third person. However, res-

cue is only the beginning of what victims have to cope with. Many victims who managed to return home are reluctant to confide their experience in anyone from fear for themselves, for their relatives or of feeling ashamed for what happened to them. Reintegration into life and coping with trauma is a complicated process that victims in most of the cases are unable to handle on their own. Therefore, it is necessary that they themselves or their family members seek professional help which will at least partly mitigate consequences that human trafficking brings along (IOM, 2008).

The purpose of human trafficking may vary. Victims may be exploited for the purpose of forced prostitution, forced labour, forced marriage, forced begging, economic exploitation, removal of organs and other. The purpose of trafficking, but also the whole process, is different with every victim and it needs to be looked at as such. Just as every victim is unique, the way of coping with this difficult life situation differs from one to another. Besides individual characteristics of victims, an important role can be played by the purpose of trafficking, length of time spent in the trafficking cycle, way and process of rescuing, victim identification process, victim's status, participation in criminal prosecution of perpetrators, reintegration into life, etc.

Following the international commitments, the Slovak Republic is obliged to build a complex system of protection and assistance for victims of human trafficking. The Slovak Republic is mostly the country of origin of victims. The strategy of solving these problems currently bases upon the National Program on the Fight against Human Trafficking for the years 2011-2014. It regulates the operation of the Program of Support and Protection for Victims of Human Trafficking.

Within its framework, a complex care is provided to victims of human trafficking – both Slovak citizens and foreigners – in time of crisis care, or, more precisely, during recovery period in the duration of 90 days. After this period, if victims decide to cooperate with law enforcement authorities, a complex care is provided to them during the whole criminal procedure. After the criminal procedure, care is provided to victims if needed during reintegration period in the duration of 90 days (IOM, 2010).

The extent and quality of services provided to Slovak citizens as well as foreigners or persons without any nationality as victims of human trafficking are stated in the Regulation of the Minister of the Interior of the Slovak Republic No. 47/2008 on securing the Program of Support and Protection for Victims of

Human Trafficking as amended by the Regulation of the Minister of the Interior of the Slovak Republic No. 170/2010. Victims of human trafficking – both Slovak citizens and foreigners – are provided with complex care based on a principle of equality and non-discrimination according to individual needs of victims.

Complex care for a victim of human trafficking provided within the Program of Support and Protection for Victims of Human Trafficking, a Slovak citizen, involves:

- separation from criminal environment,
- assistance in voluntary return to the Slovak Republic,
- possibility of anonymous accommodation, if the victim requests it,
- 90-day period of crisis care and if victims decide to cooperate with law enforcement authorities, complex care during the whole criminal procedure as well,
- financial support, social support, psychosocial counseling, psychotherapeutic services, legal counseling, health care,
- requalification courses,
- 90-day reintegration period,
- possibility to be included in the witness protection program according to legislation,
- possibility of financial compensation (IOM, 2010).
-

Based on contracts with the Ministry of Interior of the Slovak Republic, assistance and protection within the Program of Support and Protection for Victims of Human Trafficking was provided in 2012 by one international and three non-governmental organizations:

IOM – International Organization for Migration - The subject of a contract is the provision of complex and return assistance to victims of human trafficking during their return into the country of origin and provision of reintegration service in the territory of the Slovak Republic, with maximum number of victims included in the program at once according to the contract being 20 and the total number throughout the whole contract being 50. In 2012, IOM identified 31 victims of human trafficking, 19 of which were included in the program. One victim was transferred into care of Slovak Catholic Charity and one into care of Slovak Crisis Centre DOTYK.

As of 31.12.2012, the total number of victims of human trafficking provided with assistance is 19. 'Open Arms' Citizens' Association – Help for Chil-

dren in Crisis (Náruč – pomoc deťom v kríze). The subject of a contract is the provision of complex care for child victims of human trafficking. In 2012, no care was provided to a child victim of human trafficking at this level.

Slovak Catholic Charity - The subject of a contract is the provision of reintegration to victims of human trafficking and their identification, primarily among foreigners in reception and accommodation centres and detention camps, education of the young and other potential victims of human trafficking, with maximum number of victims included in the program at once according to the contract being 10 and the total number throughout the whole contract being 20. Slovak Catholic Charity identified 6 victims of human trafficking in 2012 who did not express an interest to enter the program. In 2012, 2 victims of human trafficking were integrated in the program. As of 31.12.2012, 5 victims of human trafficking are provided with assistance.

Slovak crisis centre DOTYK - The subject of a contract is identification and the provision of social services and crisis intervention to victims of human trafficking, with maximum number of victims included in the program at once according to the contract being 10 and the total number throughout the whole contract being 40. Slovak crisis centre DOTYK identified 3 victims of human trafficking in 2012, one of whom has not yet entered the program. In 2012, 3 victims were integrated in the program and as of 31.12.2012, 13 victims of human trafficking are provided with assistance.

During 2012, 22 victims were integrated in the program and provided with complex assistance from listed non-governmental organizations and international organization.

As of 31.12.2012, support and protection is provided to 37 victims of human trafficking (Prehľad o obetiach..., 2013).

Table 1. Data on victims of human trafficking integrated in the Program of Support and Protection for Victims of Human trafficking in 2012

No.	Sex	Age	Region of origin	Demograph. environment	Marital status	Education (*)	Target country	Exploitation purpose
1.	M	33	KE	regional capital	single	Z	not specified	forced begging
2.	M	50	BB	district town	divorced	Z	Italy	forced labour, forced begging
3.	Z	17	BA	regional capital	single	Z	Austria	sexual exploitation
4.	Z	37	PO	town	divorced	SSM	United Kingdom	forced labour
5.	Z	19	KE	regional capital	married	Z	UK	sexual exploitation
6.	Z	24	Bulgaria	district town	married	none	Germany	sexual exploitation
7.	Z	17	PO	municipality	single	Z	Italy	sexual exploitation
8.	Z	23	KE	town	single	Z	United Kingdom	sexual exploitation
9.	Z	18	PO	district town	single	Z	Belgium	sexual exploitation
10.	Z	27	Cameroon	regional capital	single	VS	Ukraine	sexual exploitation
11.	Z	15	BA	regional capital	single	SZS	Hungary	sexual exploitation
12.	Z	20	KE	municipality	single	Z	United Kingdom	sexual exploitation
13.	M	33	BB	district town	single	Z	Belgium	forced begging
14.	Z	19	BB	settlement	single	SS	Slovak Republic	sexual exploitation
15.	M	53	PO	district town	widower	Z	United Kingdom	
16.	Z	22	BB	district town	married	SSM	Austria	sexual exploitation
17.	Z	31	PO	municipality	divorced	unknown	United Kingdom	sexual exploitation
18.	M	26	BB	municipality	unmarried partner	none	Italy	forced begging
19.	Z	37	KE	regional capital	unmarried partner	SS	United Kingdom	sexual exploitation, attempt of forced marriage
20.	M	42	KE	regional capital	unmarried partner	SS	United Kingdom	attempt of forced marriage
21.	Z	19	KE	district town	single	Z	not specified	sexual exploitation
22.	Z	31	KE	district town	single	Z	United Kingdom	attempt of sexual exploitation

Source: The Ministry of Interior of the Slovak Republic

*Z = primary education, SZŠ = special primary education, SŠ = secondary education, SŠM = secondary education with leaving exam, VŠ = higher education.

The table above shows data on victims of human trafficking who were integrated in the Program of Support and Protection for Victims of Human Trafficking in 2012.

16 out of 22 victims were women representing 72.7% and 6 were men, i.e. 27.3%. Young victims were represented by 4 females.

Most victims came from the Košice Region. From a point of view of demographic environment, most victims – 68.2% – came from district towns and regional capitals of the Slovak Republic.

As far as the average age of male victims is concerned, the lowest age (35.3 years) was reported in the Košice Region and the highest (53 years) in the

Prešov Region. In females, the lowest average age was reported in the Bratislava Region (16 years) and the highest (25.7 years) in the Prešov Region.

From a point of view of education, 59.1 % of victims had completed an elementary school before they were trafficked. The percentage represents 13 victims of a total number. 5 victims, i.e. 22.7% had a secondary education. One victim reported a higher education and one didn't specify their education.

Classification of victims according to their marital status shows that most victims (54%) were single without any commitments.

The purpose of trafficking in 2012 in 15 female victims was sexual exploitation, in two cases com-

bined with forced marriage attempt. The number of victims increased by 5 compared to 2011. In comparison to 2011, the trafficking of men for the purpose of forced labour decreased from 9 to 2 victims. On the contrary, the number of male victims of trafficking for the purpose of forced begging increased from 1 to 3 victims.

Most victims of human trafficking who were integrated in the program were exploited in the United Kingdom (Prehľad o obetiach..., 2013).

A VICTIM OF HUMAN TRAFFICKING AS A PART OF A FAMILY SYSTEM

The practice of social work with family shows that a family can't be considered a collection of people which could be described using a language to describe individuals. Effective social work with family means a system work with the whole family. It is a tradition of social work in our area that social worker works only with an individual who is problematic or referred to as such by the their family (Gabura, 2006).

Not all victims of human trafficking necessarily use the possibility of integration in the Program of Support and Protection for Victims of Human Trafficking; they cope with the situation in every way on their own. Family has a significant supportive function.

If we look at a family as a whole, the member of which became a victim of human trafficking, their reintegration into family and society can be problematic for a number of reasons.

In victims of human trafficking, following manifestations are typical:

- Fear- of being alone, of being found and punished by traffickers, of revealing their history by people surrounding them, of legal proceedings, of their own anger, of sexually transmitted diseases and AIDS, of sleep (nightmares), etc.
- Feelings of guilt- for making a mistake, for being stupid, for breaking cultural and religious customs, for not being able to care for their family, etc.
- Anger- about themselves for allowing it to happen, about others for not protecting them, about the society, about the intervention in their life, etc.
- Feeling of shame- feeling of dirt, defamation, humiliation, feeling that everyone knows and will look at them differently, etc.
- Feeling of betrayal- from those who introduced

them to traffickers, feeling of being betrayed by everything and everyone.

- Depression and feelings of helplessness- a loss of control, a feeling that it never gets better again, being haunted by their experience, feelings of discrimination, etc.
- Shock- a feeling of losing all emotions, inability to cry, "Why me?" questions, etc.
- Disorientation- inability to calm down, every day is a struggle, memory failures, etc. (Identifikácia obchodovaných osôb, 2008 In Žáková, 2011).

From a point of view of receipt of victims, reasons for leaving home country may vary. They are often defined by a combination of "push" and "pull" factors, "push" factors being related to the situation in a given country perceived as unfavourable and "pull" factors being related to the expectations of target countries (IOM, 2008). It may often be the case that if the reintegration of the victim is not effective, they repeatedly accept risk-bearing job offers in order to financially secure their families, etc.

The above described facts support thoughts on whether the scope of the Assistance and support program for victims of human trafficking should be broadened in individual cases by services for the victim's family. The reintegration plan should include work with the whole family and should not be aimed only at victims. We perceive a successful reintegration also as prevention of re-trafficking.

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Correspondence to:

Magdaléna Halášová, Mgr.
Constantine the Philosopher University in Nitra,
Faculty of Social Sciences and Health
Kraskova 1
949 01 Nitra
magdalena.halasova@ukf.sk

Martin Valentíny, Mgr.
Constantine the Philosopher University in Nitra,
Faculty of Social Sciences and Health
Kraskova 1
949 01 Nitra
martin.valentiny@ukf.sk

ETHICAL PROBLEMS OF THE TRANSPLANTATION OF KIDNEYS FROM THE DEAD DONOR

Ivica Gulášová¹, Ján Breza jr.², Lenka Görnerová³, Ján Breza²

1. St. Elizabeth University of Health & Social Sciences, Bratislava, Slovakia
2. University Hospital Kramáre, Department of Urology, Center for Renal Transplantation, Slovak Medical University in Bratislava and Faculty of Medicine, Comenius University, Bratislava, Slovakia
3. College of Polytechnics, Jihlava, Czech Republic

Key words:

kidney transplantation; kidney donor; recipient of kidney; cadaverous kidney; ethical dilemma; brain death; legislative

Abstract

Human trafficking is one of the most substantial phenomena of this period. Following the international commitments, the Slovak Republic is obliged to build a complex system of protection and assistance for victims of human trafficking. The strategy of solving these problems currently bases upon the National Program on the Fight against Human Trafficking for the years 2011-2014. It regulates the operation of the Support and protection program for victims of human trafficking (IOM, 2010). In most cases, a victim as a part of a family system returns back to the family after traumatizing experience connected with trafficking. We believe that the focus of assistance and support provided within the framework of the Assistance and support program for victims of human trafficking aimed exclusively at victims is insufficient from a point of view of a family as a system. Therefore, we deem it appropriate to consider broadening the scope of the program aimed at assistance and support for victims through services which will focus on reinstating the whole family system. We think that it would support not only a successful reintegration, but also the prevention of re-trafficking.

INTRODUCTION

Medical Ethics is the part of the ethical sub-discipline called Bioethics which follows basic ethical principles in Biology. Ethics in healthcare can be called as normative ethics which are based on clear principles and policies of the related internal morality of medicine. The fundamentals of medical ethics are based on the Hippocratic tradition and on the traditions of the major religions. Hippocratic ideas and principles of the relationships between healthcare professionals and patients are based on the respect for life and love for human beings; healthcare is understood as an art and mission. The healthcare profession has many specific guidelines and no doubt imposes very high standards on the person who performs it (Cifra, 2005).

Medical ethics is as professional ethics concerned not only with moral standards and ethical values and their implementation, but also, to moral requirements that determine behavior, relationships and patterns characteristic of professionals working in the field of healthcare (Munzarová, 2005). It is a set of principles of behavior and plays a very important role in healthcare.

The basis of any ethics, regardless of what philosophical direction it deals with, is the free will of man and two rules. The first rule is conscience (so-called internal rule) and the other is ethical standards (understood as external rule). In addressing ethical issues between individuals it is very difficult to achieve a consensus of opinion. That is why, in the past, four basic ethical principles were introduced that should guide us in taking care of an ill person. These principles include the Principle of Non-maleficence. This

principle requires that medical personnel limit and prevent possible risks in the prevention, diagnosis and treatment process. Then follows the Principle of Beneficence which requires the request that the conduct of healthcare professionals always has to be in the interests of life and health of the patient thus always in the interest of his own good. It contains the basic rules of the medical profession - to preserve life, restore health, improve the quality of life and relief from suffering and pain. The third principle is the Principle of the Autonomy of the Individual which presumes that healthcare professionals are interested in the existence of the individual and are trying to explain in a clear manner the issues of his/her health and seek to obtain his informed consent. It directs us to the awareness that the patient is not only a recipient of medical information but that the patient's opinion should be taken into account in the diagnostic and therapeutic practice. The last is the Principle of Justice in the provision of indicated healthcare. It creates a kind of ideal that is constrained not only by economic but also by human and geographic capabilities that reduce fair access to healthcare. These four basic principles underline the general concept of morality (Vlček, 2007). Ethics in healthcare should not be taken lightly just because it deals with problems related not only to individuals but also to entire communities. It also implies the recognition that the human being is more than just a physical box. This can be stated regardless of whether we believe in the existence of a soul or not. Man is, in fact, more than just an individual. Man is a being who is characterized by several relationships. It is the relationship to oneself, relationship to other people, to the world around us and also to things that are beyond us – such as to God (Krchová, Radkovský, 2001). The relationship between two individuals plays an important role. It is the relationship between helping and suffering persons, the relationship between a person who not only heals, but also cares about human suffering in situations without any hope of saving life, and individual who entrusts him in his distress and suffering and who trusts him (Munzarová, 2005). Ethical responsibility is implied in Violation of Ethics Rules, which is respectively a violation of social ideas of humanity, dignity, honorable behavior of the medical staff, in a spirit of respect for every human life from its beginning to end. In the History of Medicine, there have been many examples when ethical responsibility has played a positive as well as a negative role. An ethical obligation of the health professional is professional healthcare for an individual as well as society in accordance with the Principles of Humanity, in terms of respect for human life and with respect

for the dignity of every human being. Evaluation of ethical attitudes is difficult and therefore in our society were created Ethics Committees that assess ethical issues and violations of ethical principles in the provision of healthcare (Parnly, 2001). The ethics Committee is composed of health workers, workers of other professions whose expertise is required for the operation of the Ethics Committee and of persons without professional skills for the performance of the medical profession or research. It consists of at least five members. Various penalties may be given for violation of some principles. The Ethics Committee is obliged to keep records of its activities and to document cases in which the principles of ethics were not followed (Vlček, 2007). Ethical values have their basis in the meeting of the needs of individuals and society. Every person has the right to decide on matters of their health but also a personal obligation to care for their health. Each also has the right to help from the society to enable the maintenance of health, to recover it again or to adequately cope with an adverse health status (Zeman, 1993).

The issue of kidney donation and transplantation has in recent years become the scourge of medical ethics. Organ transplants in their ethical, social and economic consequences affect the whole society. They represent the act of social and individual solidarity. *“Replacement of damaged vital organs by healthy ones opened a new chapter and perspective of modern Medicine and ethics”* (Caban, 2000). *“Organ transplants and tissue transfers should be based on clear ethical rules within the appropriate legal structure.”* The introduction of organ transplantation into clinical practice has produced a number of issues of technical, immunological, legal, religious and moral character. The most serious ethical problems are associated with the issue of donors. The moral side of the issue of donations and transplants of organs varies greatly depending on whether the transfer is from a living donor or from a dead one. From this distinction derive many ethical issues, such as: the issue of determining an individual's death, the shortage of donors, trafficking in organs, remunerated or voluntary donation, organ allocation criteria and informed consent of the donor.

ETHICAL PROBLEMS OF THE REMOVAL OF ORGANS FROM DECEASED DONORS

Deceased donors are the most common ones and in some cases (e.g., heart or liver transplantation) sole source of organs for transplantation purposes. The body of a donor, who died under certain condi-

tions, is a source of valuable assets that can save life or help more patients. Organ donation in the event of death is considered the right thing. Transplantation of tissues and organs from a dead individual brings many ethical issues relating to both the donor and to the recipient of organ. In the following chapters we will deal with two major problems that arise from the removal of organs or tissues from deceased donors. These are questions that deal with 1) the definition of death and 2) those that focus on the consent of donor to the taking of organs and tissues after death.

THE QUESTION OF THE DEFINITION OF DEATH OF AN INDIVIDUAL

The basic problem is the definition of death of an individual. In earlier times, the validation of death was based on experience. In the past, respiratory arrest and cardiac activity or the presence of signs leading to the decay of the body meant, the death of a person. With the gradual development of knowledge and possibilities, especially in the field of resuscitation, in cases of artificial maintenance of respiratory function or blood circulation, new questions related to death are raising. When do we declare a person dead? How to properly define death? When we can disconnect the apparatus from the ill if they are dependent on them? Is it possible to stop treatment in patients with long-term unconsciousness when their brain is damaged when there is no hope to improve their state? Can we keep, 'dead' person 'alive' in the order for removal of his/her organs and tissues for transplantation? How long? What can guarantee us that those changes are irreversible? We have outlined just a few problematic issues which are discussed and polemic in our society. Since the 1960s, new criteria for the definition of death constantly appear (Munzarová, 2005). In most countries brain death is defined as the death of an individual although his breathing can be secured by connection to artificial ventilation. By means of modern resuscitation, current intensive therapy allows us to maintain blood circulation and respiration even after the termination of all brain function. If this condition is permanent than it is referred to as brain death and is considered as the death of an individual. In relation to this, from the moral aspect, two ethical issues may arise. The first issue is the danger that in order to save the life of the recipient, the resuscitation care for a possible donor is prematurely terminated (Jurašeková, 2003). But in this case, it should not be forgotten that a potential organ donor has the right to life which he would not be denied. On one hand, there

is the respect for one's life and to his rescue and, on the other hand is the moral side of the removal of a vital organ from a donor, impaired from life, shall not be in any way hurt him or restrict his right to life (Valenta, Třeška, Hasman, 1999). Such procedure as removal of a body organ from a donor before his death would be clearly rejected, even if intended to save the life of another person, because it is not only unethical and inhumane, but also illegal (Cifra, 2005). The second problem is the possibility of the prolonging of clinical death to gain the time to prepare for transplantation. A controversial issue is the recognition of brain death as the death of an individual due to the fact that for centuries the criterion for death was a permanent cessation of breathing and heartbeat. There is agreement with the definition of brain death as the death of an individual among most world religions including Catholic, Protestant, Jewish and also some Islamic religions. Japan, for example, belongs among the countries that do not recognize brain death as the death of an individual (Jurašeková, 2003).

Legal recognition of brain death is a necessary condition for removal and use of functionally capable organs from deceased donors for transplantation purposes. The basic technical and medico-legal problem is the definition of diagnostic criteria for the determining and verifying of brain death. "*Regulation of transplants is contained in Act No. 576/2004 about healthcare services related to healthcare and on amendments to certain law provisions.*" This Act defines brain death as the death of the whole brain and specifies criteria for the diagnosis of brain death (Ministry of Health).

The basic criteria for establishing brain death include:

- Deep irreversible coma
- Complete loss of all brain reflexes
- The absence of spontaneous breathing
- Loss of reactivity to external and internal stimuli (Caban, 2000)

CONFIRMATION TEST

A confirmation test is performed to confirm the clear statement of the clinical diagnosis of brain death. It is the evidence of cessation of cerebral circulation by medical devices for the measuring of activity of brain functions (brain panangiography, electroencephalography, auditory screening of stem evoked potentials). These confirmatory tests are alternatives but just one of them needs be conducted. Selection of the test depends on the cause, on nature of brain dam-

age and on available hospital equipment. The test is chosen by the Consilium that determines the respective brain death (Ministry of Health). Physicians who diagnose brain death cannot be involved in any subsequent kidney transplant (Caban, 2000).

When brain death of an individual is reliably and unambiguously diagnosed, it is approved to proceed with the removal of a kidney from a deceased donor and transplantation of that kidney into a new organism. These criteria have to exclude approaches that are contrary to Christian morality when obtaining organs from donors (Jurašková, 2003).

An important issue occurs in the unification of the concept of death as it is defined by various disciplines - such as Philosophy, Theology, Law, Biology and Medicine. It is clear that every definition concerning the time of death is only a question of consensus, for the death is, in the biological sense, a process and not just the exact time (Munzarová, 2005).

THE ISSUE OF CONSENT TO THE VIOLATION OF INTEGRITY OF A DECEASED PERSON

Not all countries in the world have implemented the same transplant system.

Among the difficult but solvable problems belongs the issue of consent to the violation of integrity when organs are removed from a dead body. To violate the integrity of the dead body brain death must first be determined in accordance with the legislation. Organ donation and transplantation are medical treatments that require full participation of all a society. The ethical question of how and whether it is necessary to obtain informed consent to the violation of body integrity of a dead individual is approached differently in different countries depending on their cultural values, economic and social factors and especially on the established transplant system in the respective country (CEC, Brussels 2007).

There exist in the world three major approaches to the donation of organs after death:

- Informed consent (opting in)
- Presumed consent (opting out)
- Required approval (required request)

INFORMED CONSENT

Informed consent (opting in) is a system that requires the consent of the donor (or a relative) with tissue collection before his/her death. It requires the active approach of potential donors. Potential donors

should at all times carry an Organ Donation Card which indicates their consent to the disruption of body integrity after death (Parmly, 2001). This system is applied, for example, in Germany, the USA, Canada, Japan and in the Netherlands (Klimajová, 2004). This approach to informed consent supports the autonomous decision of each individual in serious matters as well as the solidarity with other people - especially with those who suffer.

It is appropriate to actually think about the declaration of the donor. In everyday language, we use the word 'donor' for those who voluntarily and from love give something to somebody. It manifests the warm and positive relationship with the recipient. A person also can be called a 'Donor' who declares his/her consent to donate organs after his/her death. Such a person presents something to somebody whom he does not know and it manifests his/her own solidarity and humanity towards other people living in their society. Perhaps, most of us agree that the organs of somebody who is already dead cannot help him anymore and may actually save the lives of people suffering and waiting for this gift. The decision to donate his/her organs is quite a heavy burden for everyone and especially for the youth. It forces a person to think about his/her own mortality and death. Very often, the fear of organ abuse is present (Munzarová, 2005).

This type of agreement is not very convenient because it cannot provide a sufficient source of organs. Most people are not in any way interested in the problem of transplantation and do not, therefore, have sufficient motivation for such an act. This issue requires widespread awareness and education especially about the importance of donating organs and tissues (Munzarová, 2005). In some countries, the lack of donor consent can be replaced by the consent of the next of kin. There can be considerable difficulty in such an approach which in the short term still allows a collection of tissues and organs but requires contact with relatives who must be notified about the death of a close relative to obtain consent for organ removal.

IMPLIED CONSENT

Most European countries have adopted a system of the recognition of the so-called presumed consent (opting out) (Valenta, Třeška, Hasman, 1999). It is a system where the Law presumes the consent of the donor with the collection and transfer of organs after his death. If during his life a person has not issued a statement that he disagree with the collection and transfer of organs to violate the personal integrity af-

ter death, defined for purposes of the Law, the consent is automatically assumed and in the event of death, a competent doctor can remove the organs or respectively the tissues (Cifra, 2005).

If the deceased has not left any written document, his relatives do not have the right to refuse the removal of his/her organs. In the case of adolescents under 18 years or of persons deprived of legal capacity their legal representative shall during their lives oppose the procurement of organs after death (Klimajová, 2004). The purpose of this legislation is obviously to increase the number of potential suitable donors who are still in shortage in favor of those waiting for transplantation. Anyone can during his lifetime exclude the interference with his physical integrity after death (except as provided by law) when he expresses in the prescribed manner during his life, his opposition to the removal and use of his organs, regardless of whether it is motivated by religion, belief or any other reason. The right to preserve their physical integrity belongs to every civilized society and culture (Cifra, 2005). Presumed consent is applied in countries such as Austria, France, Greece, Spain, Finland, Norway, Sweden, Slovakia, Belgium, Slovenia, Luxembourg, Hungary, Czech Republic or Slovak Republic (Klimajová, 2004).

“Body integrity, as the right of personal physical nature, is protected under the Constitution and under the Civil Code” (Cifra, 2005). Any person may freely dispose of their body integrity as long as he meets the conditions laid down by the Law. During his life, if a Slovak citizen disagrees with the procurement of organs after death, he has the opportunity to write a statement of rejection of organ and tissue after death with an authorized signature and register it in the SCOT (Slovak Centre of organ transplants) (Klimajová, 2004).

SCOT coordinates transplantation of organs and tissues throughout the Slovak Republic and it falls under the Ministry of Health.

Its tasks consist of:

- In the leadership of the National Transplant Registry – so called waiting lists, register of donors and recipients of organs,
- Lab activity: immunological and immunogenetic testing (HLA-typing, cross-match ...) patient waiting lists, organ donors and other patients
- In keeping of a register of persons who were opposed in writing to donate organs after death (the register of not-donors) (SCOT).

Currently, the registry of not-donors registers

in the Slovak Republic about two hundred persons (Webster, 2006). Disagreement can be revoked at any time - the procedure is analogical as in the statement of disagreement. Before any procurement of organs and tissues of the body of a deceased donor is done, the provider must verify that this potential donor is not kept in the register of not-donors (Kováč, 2005). The advantage of this method is that virtually everyone who dies in a hospital meets these medical criteria and thus, after death becomes an organ donor. During their life, very few people actively express a disagreement with donating of their organs or tissues. The system of presumed consent facilitates the work of doctors who, in the case of death, do not need to deal with sensitive issues such as how to ask relatives for organ donation.

In the application of presumed consent arises the ethical issue whether the donor is truly aware that he will become the donor. Consent is one thing and the other is non-opposition. Consent is a manifestation of the autonomy of the individual only if it is conscious and free. The absence of objections does not mean free volition (Munzarová, 2005). The donor should be consulted if he really wants to be a donor. Only a small portion of the population is aware of the issues related to organ donation. Most of Slovakia's population, however, knows that without their written opposition, in the case of their deaths, interference with their bodily integrity for the purpose of removal of organs and tissues may be performed, (Cifra, 2005). Here apply the principle that the ignorance of the Law is no excuse. Because of our ignorance there can be no objection (Klimajová, 2004). The presumed consent legislation is one of the provisions indicating the continuing paternalistic approach in healthcare (Cifra, 2005). If people are to have the confidence in this system then it is necessary to inform society and to raise them to be in solidarity with others about this issue. It is necessary to disseminate information on issues of transplantation and organ donation. Similarly, it is also important that we encourage people to talk openly about organ donation and about their feelings on the topic and to familiarize ourselves with the wishes of relatives.

REQUIRED CONSENT (REQUIRED REQUEST)

It is a system in which the principle is that every potential donor should be addressed in advance if he really wants to be a donor. Everyone has the right to express his opinion on his/her own personal choice. By this method, their view could be properly

taken into account as it would certainly be complying with respect to the wishes of the deceased and his family. Implication of this system is questionable - when should we address the potential donor if he agrees with organ donation? At the entrance to the hospital? At that time people tend to be intimidated and their families are afraid for the lives of their loved ones. There is very little hope that such an approach leads to success or to the right decision on the appropriateness of such action. This raises other problematic situations. For example, there is the situation when a potential donor would not meet the criteria for the donation of organs and tissues. In that case, a donor would not be asked about the donation and he might feel humiliated, despised and worthless. Other problematic situations are cases of sudden deaths of people, such as in car accidents. The death of young and healthy people frequently occurs during automobile accidents. These people can no longer be asked about their decision to donate organs and it is equally doubtful about the appropriateness of the reaching of their relatives whom must also be inform about the death of their loved ones (Munzarová, 2005). The required consent system puts the greatest demands on medical staff and often places them in psychologically disadvantaged and fragile situations (Klimajová, 2004).

CONCLUSION

It emerged from our surveys, that few people know closely the problems of patients with renal failure and their 'hardships' of life and in most cases consider the issue of donation of kidneys from deceased donors as distant and unattractive. Society is still very much needing to support patients with renal failure for whom the kidney transplant means the 'redemption' of their problems and an incomparably different and better quality of life for these patients. Media coverage and increased levels of awareness among the general public and also among the professional public is the task whose implementation presumes a growing interest in this issue.

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&SectionID=58&SubSectionID=60

Correspondence to:

Prof. Dr. Ivica Gulášová, PhD.
Narcisová 40
821 01 Bratislava
Slovak Republic

MUDr. Ján Breza, PhD. jr.
Prof. MUDr. Ján Breza, DrSc.
University Hospital Kramáre,
Department of Urology,
Center for Renal Transplantation,
Slovak Medical University in Bratislava
Slovak Republic

Mgr. Lenka Görnerová
College of Polytechnics
Jihlava
Czech Republic

PATIENT'S RESPONSE TO ADVERSE NEWS

Ivica Gulášová¹, Lenka Görnerová², Ján Breza, jr.³, Ján Breza^{3,4,5}

1. St. Elizabeth University of Health & Social Sciences, Bratislava, Slovakia

2. College of Polytechnics, Jihlava, Czech Republic

3. Urology Clinic and Centre for kidney transplantations, L. Derér Faculty Hospital, Kramáre, Bratislava, Slovakia

4. Faculty of Medicine of Comenius University, Bratislava, Slovakia

5. Slovak Medical University, Bratislava, Slovakia

Key words:

adverse report; patient's response; adaptation; awareness; psychosocial support

Abstract

In this article, the authors analyze responses of patients after notification of an adverse report concerning the state of their health. They describe that, because of a disease, hidden features - characteristic of the patient's personality - can surface. In their analysis, the authors find that patients can respond to the news in a number of different ways. They may express anger, rebellion, aggression, apathy, a tendency to escape; resignation; question the specific diagnosis; settle for a physician's professional qualities; show distrust; touchiness; selfishness; etc. In the conclusion, they make a point that it is very important to take into account how every patient should be psychologically approached in the best possible way so that his/her needs are respected, and the rights of both him and his family are safeguarded.

INTRODUCTION

Notification of diagnosis ... The first reaction of a patient ... Is each and every patient like every other human individual? Can we assume and count on it? Certainly, we should! It is very important for further collaboration with a patient, but especially for a humane understanding of his/her situation. The way we behave to a patient in a notification of adverse health report will be what a patient will remember for a long time – the remainder of her/his life.. We have to note that, in this area, there are certain things we can do and there, a good clinical psychologists can help, but only if they have a gift of empathy, of being able to find the right words, and the kindness as well as be familiar with basic clinical knowledge concerning the specific diagnosed disease the patient has been hospitalized for in their department. Therefore, we make an appeal to improve the training of future clinical psychologists so that they can play this role in assisting in troubled times of patients. The role of the physician remains the same, because he/she is the only one to inform the

patient about the state of his health.

In the course of a disease, the psyche of a patient may exhibit special personality traits that affect the further course of a disease: **Suggestibility**, increased susceptibility of a patient's perception to accept critical information; **Touchiness** related to suspicion as a personal characteristic. A patient experiences his illness as a priority problem; **Egocentrism**, a patient focuses on himself and his problems; **Hypersensitivity** arises from weakening of the nervous system of a patient as a result of disease. It can be caused by prolonged pain, fear of diagnostic and therapeutic interventions, insomnia, etc. In the course of a disease, there may occur other patient responses to specific and unknown situations among which may be **adaptation problems**; **Regression**, a decrease of patient's personality level which can affect not only children but also adults (Křivohlavý, 2002).

A patient's response to serious diagnosis is affected by many factors: age of a patient;

course and duration of a disease; examination methods; the quality of relationship to family members.

We can usually distinguish several phases.

Discussing serious or imminent death diagnosis, people react in different ways. Bouchal (1993) lists a number of different reactions:

- Reconciliation and Settlement (acceptance of the inevitable)
- Passive resignation (apathy and lack of interest)
- Escape into memories of past
- Escape into fantasy and thoughts about immortality
- Positive compensation - the effort to complete started work
- Negative compensation - alcohol, drugs, over-eating, sexual excesses, etc.

STAGES OF ACCEPTANCE OF A CHANGED HEALTH STATUS OF PATIENTS WITH CANCER

Rebellion, denial

A patient refusing to believe the truth of diagnosis asks: "Why me?" The role of a nurse in this stage is mainly to establish contact with a patient, to gain his confidence, to listen to him.

Aggressiveness

A patient, in powerlessness may resort to anger and unconsciously punish his surroundings for his fate. A nurse has to be able to objectively assess a patient; to leave space to discharge emotions; to understand that behavior is a manifestation of deep despair and helplessness (Svatošová, 1999).

Questioning, negotiating

At this stage, a patient's hope of recovery is commonly re-awakened; question the accuracy of diagnosis; turns to alternative medicine or healers (Svatošová, 1999).

Resignation

Different patients experience this period in different ways depending on specific life attitudes. Patients with a sense of fulfillment in life perceive this incurable disease in a different way from those without such a sense of fulfillment in life. The sense of life does not refer to the length of time, but is associated with the fulfillment of one's mission on earth.

Acceptance, reconciliation

This stage represents the ideal state which we aspire to achieve in the sphere of a sensitive approach in all incurable patients. It involves the acceptance of death as the integral part of life (Grumanová, 2008).

An oncological disease is usually a huge and unexpected intervention into the life of not only the patient, but also that of his family.

The responsibility of health professionals is to enable the patient to experience the best possible contact with those closest.

Here are a few principles of behavior and communication with relatives and loved ones of a cancer patient:

- A nurse has to allow personal or telephone contact with the patient's relatives or other persons who positively affect his mental state.
- When a nurse feels that visits of some persons negatively affect the condition of a patient or a patient's wishes she should, after consultation with the doctor, tactfully warn relatives to reconsider their position.
- A nurse has to ensure that visits do not disturb other patients.
- A nurse is to show, in a sensitive and tactful way, her common feelings to patient's relatives.
- To attain a state of well-being, a patient benefits immensely when she/he manages to balance any disturbed relationships with close ones and relatives.

CONCLUSION

Patients often ask nurses whether his present life filled with pain and suffering has had any meaning. Here, emotionally intelligent nurses with their ability of not hurting a patient with inappropriate responses is of vital importance. It is essential to prepare a patient for the challenges he/she will meet in the course of treatment and to give him/her enough time to cope with the reality. The most important part of the care, which health and social workers provide to their patients, is that they do not abandon them.

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Correspondence to:

Prof. Dr. Ivica Gulášová, PhD.
St. Elizabeth University of Health & Social Sciences, Bratislava, Slovakia

Mgr. Lenka Görnerová
College of Polytechnics, Jihlava, Czech Republic

MUDr. Ján Breza, jr., PhD.
Urology Clinic and Centre for kidney transplantations, L. Denér Faculty Hospital, Kramáre, Bratislava, Slovakia

Prof. MUDr. Ján Breza, DrSc.
Urology Clinic and Centre for kidney transplantations, L. Denér Faculty Hospital, Kramáre, Bratislava, Slovakia
Faculty of Medicine of Comenius University, Bratislava, Slovakia
Slovak Medical University, Bratislava, Slovakia

STRENGTHENING PARENTING COMPETENCIES - THE ROLE OF SOCIAL WORKERS IN THE PROCESS OF REMEDIATION OF FAMILIES

Katarína Minarovičová¹

1. Constantine the Philosopher University in Nitra

Key words:

social work; family remediation; support; development; parenting skills; competencies

Abstract

Family remediation is a process in which parents develop, respectively acquire skills necessary to ensure adequate care for their children. It is also a process, during which disturbed interpersonal relationships within the family community come to healing. When working with clients, a Humanistic approach emphasizes acceptance of the client's personality, including his/her incorrect decisions and mistakes. A major challenge for Social Workers is to find a baseline attitude toward a client in which we accept his/her weaknesses; accept him/her; at the same time, focus on correcting his/her inappropriate habits and behaviors which cause a client (emotional) pain and makes his/her social functioning difficult. It is especially challenging for Social Workers to help parents who have temporarily lost relationship with their children to acquire necessary awareness in order to better understand the needs of their children and be able to respond to them in more fulfilling ways. In my article, I point to five key areas of Social Work with families of children who have been removed from the family environment and entrusted to Institutional Care.

Restoring the functionality of families is a challenge of every society which cares about the wellbeing, health and growth of its people. In periods of significant societal changes which impact nearly every area of people's lives, family functionality plays an irreplaceable role. Understanding, fulfillment and love can be found in families in which parents approach the education of their children responsibly and understand it is their task to address the needs of their children. That is, they try to understand and try to fulfill the developmental needs of their children. Often, parents who themselves have not experienced unconditional acceptance and good care in their families or have not experienced a positive model of being a father and mother, cannot adequately meet the needs of their children.

In terms of Social Work with dysfunctional families, when children have been removed from their original families and been entrusted to Institutional Care, our team of Social

Workers focuses on areas of childcare, in which parents lack necessary skills. Counseling discussions are dedicated to finding the reasons for the crisis which forced removal of children from their families. We work to strengthen and encourage parents to such a correction of their behavior that, after all and any deficiencies have been removed, they would get their children back. To achieve this correction, we use Social Work Methods which include training desirable behavior in nursing; providing childcare; modeling and role playing in order to recognize their own behavior; recognizing the needs of others; practicing conflict resolution between parents and children; problem clarification; confrontation; abreaction; expression; encouragement. A detailed description of some of these methods can be found in the research of authors Gabura and Mydlíková (2004).

When working with dysfunctional families we try to initiate a support network of close and extended family members who often were not aware of the problems of their nuclear family and therefore had been unable to help. We also provide clients with psy-

chological and special pedagogical care offered by our external collaborators; the process of our work with clients is supervised. A philosophical approach of our Social Work with these clients is based on the principles of the training program PRIDE (from the English word pride) which highlights five key areas in which parents have to be skilled if they want to provide necessary, appropriate care for their children:

1. child protection and nutrition,
2. recognizing and meeting developmental needs of the child and determining his/her developmental delays,
3. supporting relationships, respectively emotional bonds in the biological family,
4. creating secure lifetime relationships ability to work as a member of a professional team.

Here are specific skills parents should develop and acquire in these areas:

1. Child protection and nutrition

Parents learn to understand that a child needs to be provided with full meals, clothes, good hygienic conditions and healthcare. Many parents fail to provide children with adequate food, often due to lack of funds. We teach them to manage money in a way to be able to prepare adequate daily meals for their children within their budgets. Parents learn to keep a cash book in which they control the income and expenses of their family. If a family has a right to receive selected benefits or grants, we provide social counseling and accompany parents in dealing with relevant authorities. In case of healthcare, we closely monitor its provision; often, improve care of children by training especially less mature mothers.

2. Recognizing and meeting developmental needs of the child and determining his/her developmental delays

Understanding the developmental needs of the child is a field of education which is discussed when working with parents. We educate parents in knowing what behavior and needs of the child are pertinent to the age of a child (age appropriate) and how parents should proceed in order to meet those needs. Emphasis is placed on understanding of the individuality of a child; some parents want to repeat their educational approaches to the child depending on how they took care of their previous child or children without taking into account the specifics of a particular child's devel-

opment and his/her individual needs. After determining a child's possible retardation in one developmental stage, we, and the parents contact selected specialists in order to design and implement therapeutic aid.

3. Supporting relationships, respectively emotional bonds in the biological family

Separation from family causes a child severe emotional pain. In my dissertation work, I focused on finding a measure of emotional frustration concerning deprivation among children in foster homes. I hypothesized that children who had contact with their family of origin during placement in a foster home were less emotionally frustrated; less deprived than for children who had no contact with their family. Collection of information was difficult but because of the method used - Sabbatsberg Self-evaluation Scale of Deprivation - which was developed by Professor Peter G. Fedor-Freybergh in 1972-1974 at Sabbatsberg Hospital at the Karolinska Institute in Stockholm – the hypothesis proved obtained confirmational results. Confirmed was that children who had no contact with their biological family during the placement in a foster home, that is, there was no contact, were more emotionally frustrated, more deprived than children who had contact with their family. These results emphasize the almost existential need of children to continue in maintaining a relationship with their parents; understand the reasons why they were separated; and gain a chance to reconnect with their family (Mínarovičová, 2009).

4. Creating secure lifetime relationships

By structured counseling interviews we lead parents to understand what significant impact a family has on a healthy mental life of their child. We try to make parents sufficiently understand the significance of their parental responsibilities; what a child expects from them; how they should improve their deficiencies; and ensure the unconditional acceptance of their child. Through a program of planned meetings within the family circle, we invite members of the close and extended family who are willing to assist parents with childcare. In addition to solving specific problems of a dysfunctional family, we also regulate the relationships within the extended family and try to strengthen them. Parents learn to trust their abilities and in the whole process of working with them, we focus on the need for a safe family environment for their child.

5. Ability to work as a member of a professional

team

During the whole remediation process we strengthen parent's confidence in the Institutions and Organizations involved in solving their problems. We mediate information on the powers of individual offices and facilities and highlight the importance of mutual cooperation. Since the Office of Labor, Social Affairs and Family, Municipal Offices, facilities for social protection and social guardianship and accredited organizations create a common plan for helping families from which children were taken away. Cooperation in solving the situational dynamics within these families entities is essential. As an example of good practice, we show parents improvements of the social situation of many families which, in cooperation with our team on selected subjects, achieved positive changes and their children returned to their care.

Since 2005, through Social Work, we have been helping traumatized children and parents to find a way how to come back together. We try to modify the family environment of dysfunctional families to such an extent that it will be possible for the children to return from foster homes back to the family. Approximately 120 families were involved in the projects that we have conducted up to this time. By following the above approaches when working with families, in cooperation with our partners, the Office of Labor, Social Affairs and Family in Nitra and the Office of Labor, Social Affairs and Family in Nové Zámky, we were able to help 18 children return back to their biological families; 15 children were put to substitute care with their close relatives; and 32 children were not taken away from their family environment.

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Correspondence to:

Constantine the Philosopher University in Nitra
Faculty of Social Sciences and Health Care
Dr.Katarína Minarovičová
Kraskova 1
949 01 Nitra
mail : kminarovicova@ukf.sk

About the author:

The author works at the Constantine the Philosopher University in Nitra as a Professional Assistant at the Department of Social Work and Social Sciences;. a professional worker for dysfunctional and foster families in the non-governmental organization aiming to help children in foster homes - Úsmev ako dar; Co-ordinator of Social Projects that focus on direct exercise of terrain Social Work in dysfunctional families; Supervisor and participant in an extensive national project aiming to increasing the employability of professional parents.

CURRENT PROBLEMS IN HIV//AIDS IN 2012-2013

M. Bartkovjak, J. Benca, Babalova M., Bezekova M., Bukovinova P., E. Horvathova, D. Horvathova, E. Ceploova, M. Chabadova, N. Hvizdakova, L. Vojtasova, A. Kalavska, M. Mojtová, G. Mikolasova, N. Kulkova, J. Sokolova, E. Mihalikova, J. Suvada, A. Krsakova, L. T. Alumbasi, A. Ondrusova, I. Kmit and Tropicteam Members

St. Elizabeth PhD programe Bratislava, Slovakia EU

Key words:

HIV; TBC; children; sexual risk factor

Abstract

Current problems on HIV/AIDS including Social , nursing and public health aspects are reviewed by the SEUC Tropicteam. Epidemiology and prevention remains together with unknown HIV status major problems in current management of this disease worldwide.

DRUG-RESISTANT TUBERCULOSIS TREATMENT COMPLICATED BY ANTIRETROVIRAL RESISTANCE IN HIV COINFECTED PATIENTS: A REPORT OF SIX CASES IN LESOTHO

Hind Satti

Am. J. Trop. Med. Hyg., 89(1), 2013, pp.174-177

Treating drug-resistant tuberculosis (DR-TB) is particularly challenging in high human immunodeficiency virus (HIV) prevalence settings. Neither antiretroviral resistance testing nor viral load monitoring is widely available in sub-Saharan Africa, and antiretroviral resistance can complicate the clinical management for DR-TB/HIV coinfecting patients. We describe six cases of antiretroviral resistance in DR-TB patients with HIV coinfection in Lesotho. Two patients died before or immediately after antiretroviral resistance was detected by genotyping; the remaining four patients were switched to effective antiretroviral therapy (ART) regimens. Favorable DR-TB treatment outcomes in coinfecting patients require successful management of their HIV infection, including treatment with an effective ART regimen. Coinfecting patients undergoing DR-TB treatment may require closer monitoring of their response to ART, including routine viral load testing, to ensure that they receive an effective ART regimen concurrent with DR-TB treatment.

PREVALENCE OF HIV INFECTION AMONG SURVIVORS OF SEXUAL ASSAULT AT PRESENTATION IN HOSPITAL

Adegoke O. Adefolalu

Victims of sexual assaults are routinely tested for HIV in order to discover if they require prophylaxis. This study aimed to determine the prevalence of HIV infection among survivors of sexual assault attending a large peri-urban health facility in KwaZulu-Natal, a province of South Africa. Data from the medical records of the available 534 sexual assault cases that attended the facility between 2005 and 2009 were extracted and reviewed: 19.7% tested HIV positive and HIV prevalence among the survivors over the 5 years increased from 15% in 2005 to 19% in 2009. Screening sexual assault survivors for HIV provides a good opportunity to identify those who will benefit from HIV prophylaxis and HIV-infected persons who need HIV care and treatment.

PROVISION OF BEDNETS AND WATER FILTERS TO DELAY HIV-1 PROGRESSION: COST-EFFECTIVENESS ANALYSIS OF A KENYAN MULTISITE STUDY

Eli Kern

Tropical Medicine and International Health, August 2013, Vol. 18, No. 8, pp. 916-924

To estimate the effectiveness, costs and cost-effectiveness of providing long-lasting insecticide-treated nets (LLINs) and point-of-use water filters to antiretroviral therapy (ART)-naïve HIV-infected adults and their family members, in the context of a multisite study in Kenya of 589 HIV-positive adults followed on average for 1.7 years.

The effectiveness, costs and cost-effectiveness of the intervention were estimated using an epidemiologic-cost model. Model epidemiologic inputs were derived from the Kenya multisite study data, local epidemiological data and from the published literature. Model cost inputs were derived from published literature specific to Kenya. Uncertainty in the model estimates was assessed through univariate and multivariate sensitivity analyses.

We estimated net cost savings of about US\$ 26 000 for the intervention, over 1.7 years. Even when ignoring net cost savings, the intervention was found to be very cost-effective at a cost of US\$ 3100 per death averted or US\$ 99 per disability-adjusted life year (DALY) averted. The findings were robust to the sensitivity analysis and remained most sensitive to both the duration of ART use and the cost of ART per person-year.

The provision of LLINs and water filters to ART-naïve HIV-infected adults in the Kenyan study resulted in substantial net cost savings, due to the delay in the initiation of ART. The addition of an LLIN and a point-of-use water filter to the existing package of care provided to ART-naïve HIV-infected adults could bring substantial cost savings to resource-constrained health systems in low- and middle-income countries.

PREVALENCE OF PTSD AND DEPRESSION AND ASSOCIATED SEXUAL RISK FACTORS, AMONG MALE RWANDA DEFENSE FORCES MILITARY

Judith Harbertson

Tropical Medicine and International Health, August 2013, Vol. 18, No. 8, pp. 925-933

To assess depression and PTSD prevalence among the Rwanda Defense Forces (RDF) and evaluate whether sexual risk behaviour, STIs, HIV and alcohol use were significantly higher among those who screened positive.

Consenting active-duty male RDF personnel, aged ≥ 21 years, completed an anonymous sexual risk survey linked to HIV rapid testing that included standardised assessments for PTSD (PCL-M), depression (CES-D) and alcohol use (AUDIT). PTSD and depression prevalence were calculated (data available for 1238 and 1120 participants, respectively), and multivariable regression analyses were conducted.

22.5% screened positive for depression, 4.2% for PTSD and 3.4% for both. In adjusted analyses, odds of either depression or PTSD were significantly higher in participants reporting STI symptoms (OR = 2.27, 2.78, respectively) and harmful alcohol use (OR = 3.13, 3.21, respectively). Sex with a high-risk sex partner, lower rank and never deploying were also significantly associated with depression in adjusted analyses.

Nearly one-fourth of RDF participants screened positive for PTSD or depression, which impacts sexual risk behaviour, HIV acquisition risk and military readiness. Findings may extend to other deploying militaries and provide additional evidence of an association between mental health status and sexual risk behaviour. Effective mental health treatment interventions that also include alcohol use assessments, STI identification/treatment and sexual risk behaviour reduction are needed.

COBICISTAT VERSUS RITONAVIR AS A PHARMACOENHANCER OF ATAZANAVIR PLUS EMTRICITABINE/TENOFOVIR DISOPROXIL FUMARATE IN TREATMENT-NAIVE HIV TYPE 1-INFECTED PATIENTS: WEEK 48 RESULTS

Joel E. Gallant

The Journal of Infectious Diseases 2013, 208: 32-9

Cobicistat (COBI) is a pharmacoenhancer with no antiretroviral activity in vitro.

An international, randomized, double-blind, double-dummy, active-controlled trial was conducted to evaluate the efficacy and safety of COBI versus ritonavir (RTV) as a pharmacoenhancer of atazanavir (ATV) in combination with emtricitabine (FTC)/tenofovir disoproxil fumarate (TDF) in treatment-naive patients. The primary end point was a human immunodeficiency virus type 1 (HIV-1) RNA load of <50 copies/mL at week 48 by the Food and Drug Administration snapshot algorithm; the noninferiority margin was 12%.

A total of 692 patients were randomly assigned to a treatment arm and received study drug (344 in the COBI group vs 348 in the RTV group). At week 48, virologic success was achieved in 85% of COBI recipients and 87% of RTV recipients (difference, -2.2% [95% confidence interval, -7.4% to 3.0%]); among patients with a baseline HIV-1 RNA load of >100 000 copies/mL, rates were similar (86% vs 86%). Similar percentages of patients in both groups had serious adverse events (10% of COBI recipients vs 7% of RTV recipients) and adverse events leading to discontinuation of treatment with the study drug (7% vs 7%). Median increases in the serum creatinine level were 0.13 and 0.09 mg/dL, respectively, for COBI and RTV recipients.

COBI was noninferior to RTV in combination with ATV plus FTC/TDF at week 48. Both regimens achieved high rates of virologic success. Safety and tolerability profiles of the 2 regimens were comparable. Once-daily COBI is a safe and effective pharmacoenhancer of the protease inhibitor ATV.

FACTORS ASSOCIATED WITH ADHERENCE AMONGST 5295 PEOPLE RECEIVING ANTIRETROVIRAL THERAPY AS PART OF AN INTERNATIONAL TRIAL

Jemma L. O'Connor

The Journal of Infectious Diseases 2013, 208: 40-9

We assessed factors associated with antiretroviral therapy (ART) adherence, including specific ART medications.

The Strategies for Management of Antiretroviral Therapy study was an international antiretroviral therapy (ART) strategy trial that compared intermittent ART, using CD4(+) T-cell count as a guide, to continuous ART. Adherence during the 7 days before each visit was measured using self-report. We defined high adherence as self-report of taking "all" pills for each prescribed ART medication; all other reports were defined as suboptimal adherence. Factors associated with adherence were assessed using logistic regression with generalized estimating equations.

Participants reported suboptimal adherence at 6016 of 35 695 study visits (17%). Factors independently associated with suboptimal adherence were black race, protease inhibitor-containing regimens, greater pill burden, higher maximum number of doses per day, and smoking. Factors independently associated with higher adherence were older age, higher education, region of residence, episodic treatment, higher latest (at the time of adherence) CD4(+) T-cell count, and being prescribed concomitant drugs (ie, medications for comorbidities). Of specific drugs investigated, atazanavir, atazanavir/ritonavir, fosamprenavir, indinavir, indinavir/ritonavir, and lopinavir/ritonavir were associated with suboptimal adherence, and tenofovir disoproxil fumarate/emtricitabine was associated with higher adherence.

In this, the largest analysis of ART adherence to date, some protease inhibitor-containing regimens and regimens with >1 dose per day were associated with suboptimal adherence.

HIV TREATMENTS HAVE MALARIA GAMETOCYTE KILLING AND TRANSMISSION BLOCKING ACTIVITY

Charlotte V. Hobbs

The Journal of Infectious Diseases 2013, 208: 139-48

Millions of individuals being treated for human immunodeficiency virus (HIV) live in malaria-endemic areas, but the effects of these treatments on malaria transmission are unknown. While drugs like HIV protease inhibitors (PIs) and trimethoprim-sulfamethoxazole (TMP-SMX) have known activity against parasites during liver or asexual blood stages, their effects on transmission stages require further study.

The HIV PIs lopinavir and saquinavir, the nonnucleoside reverse-transcriptase inhibitor nevirapine, and the antibiotic TMP-SMX were assessed for activity against *Plasmodium falciparum* transmission stages. The alamarBlue assay was used to determine the effects of drugs on gametocyte viability, and exflagellation was assessed to determine the effects of drugs on gametocyte maturation. The effects of drug on transmission were assessed by calculating the mosquito oocyst count as a marker for infectivity, using standard membrane feeding assays.

Lopinavir and saquinavir have gametocytocidal and transmission blocking activities at or approaching clinically relevant treatment levels, while nevirapine does not. TMP-SMX is not gametocytocidal, but at prophylactic levels it blocks transmission. Specific HIV treatments have gametocyte killing and transmission-blocking effects. Clinical studies are warranted to evaluate these findings and their potential impact on eradication efforts.

ANTIRETROVIRAL THERAPY AND PRE-EXPOSURE PROPHYLAXIS: COMBINED IMPACT ON HIV TRANSMISSION AND DRUG RESISTANCE IN SOUTH AFRICA

Ume L. Abbas

The Journal of Infectious Diseases 2013, 208: 224-34

The potential impact of antiretroviral therapy (ART) and pre-exposure prophylaxis (PrEP) with overlapping and nonoverlapping antiretrovirals (ARVs) on human immunodeficiency virus (HIV) transmission and drug resistance is unknown.

A detailed mathematical model was used to simulate the epidemiological impact of ART alone, PrEP alone, and combined ART + PrEP in South Africa.

ART alone initiated at a CD4 lymphocyte cell count <200 cells/ μ L (80% coverage and 96% effectiveness) prevents 20% of HIV infections over 10 years but increases drug resistance prevalence to 6.6%. PrEP alone (30% coverage and 75% effectiveness) also prevents 21% of infections but with lower resistance prevalence of 0.5%. The ratio of cumulative infections prevented to prevalent drug-resistant cases after 10 years is 7-fold higher for PrEP than for ART. Combined ART + PrEP with overlapping ARVs prevents 35% of infections but increases resistance prevalence to 8.2%, whereas ART + PrEP with nonoverlapping ARVs prevents slightly more infections (37%) and reduces resistance prevalence to 7.2%.

Combined ART + PrEP is likely to prevent more HIV infections than either strategy alone, but with higher prevalence of drug resistance. ART is predicted to contribute more to resistance than is PrEP. Optimizing both ART and PrEP effectiveness and delivery are the keys to preventing HIV transmission and drug resistance.

PROPHYLACTIC EFFECT OF ANTIRETROVIRAL THERAPY ON HEPATITIS B VIRUS INFECTION

Hiroyuki Gatanaga

Clinical Infectious Diseases 2013, 56(12):1812-9

Hepatitis B virus (HBV) infection is common in HIV-infected individuals, especially in men who have sex with men (MSM). Almost all currently used regimens of antiretroviral therapy (ART) contain lamivudine (LAM) or tenofovir disoproxil fumarate (TDF), both of which have significant anti-HBV activity. However, the prophylactic effect of ART on HBV infection has not been assessed previously.

HBV-non-vaccinated HIV-infected MSM were serologically evaluated for HBV infection using stocked serum samples. Cases negative for HBV surface antigen (HBsAg), antibody to HBsAg (anti-HBs), and antibody to HBV core antigen (anti-HBc) in first serum samples were serologically followed until last available stocked samples. HBV genotype and LAM-resistant mutation (rtM204V/I) were analyzed in cases that became HBsAg-positive.

The first stocked samples were negative for all analyzed HBV serological markers in 354 of 1,434

evaluated patients. The analysis of their last samples indicated HBV incident infection in 43 of them during the follow-up period. The rate of incident infections was lower during LAM- or TDF-containing ART (0.669 incident infections in 100 person-years) than during no ART period (6.726 incident infections in 100 person-years) and other ART (5.263 incident infections in 100 person-years) ($P < 0.001$). Genotype A was most prevalent in them (76.5%) and LAM-resistant HBV was more frequent in incident infections during LAM-containing ART (50.0%) than in those during no ART and other ART (7.1%) ($P = 0.029$).

LAM- and TDF-containing ART seem to provide prophylaxis against HBV infection, though drug-resistant strains seem to evade these effects.

RESPONSE TO THE AIDS PANDEMIC - A GLOBAL HEALTH MODEL

Peter Piot

N Engl J Med 2013, 368: 2210-8

Just over three decades ago, a new outbreak of opportunistic infections and Kaposi's sarcoma was reported in a small number of homosexual men in California and New York.^{1,2} This universally fatal disease, which was eventually called the acquired immunodeficiency syndrome (AIDS), was associated with a complete loss of CD4+ T cells. Within the first year of its description, the disease was also identified in patients with hemophilia, users of injection drugs, blood-transfusion recipients, and infants born to affected mothers. Soon thereafter, a heterosexual epidemic of AIDS was reported in Central Africa, preferentially affecting women.^{3,4} Little did we know at the time that this small number of cases would eventually mushroom into tens of millions of cases, becoming one of the greatest pandemics of modern times.

Within 2 years after the initial reports of AIDS, a retrovirus, later called the human immunodeficiency virus (HIV), was identified as the cause of AIDS.⁵ Diagnostic tests were developed to protect the blood supply and to identify those infected. Additional prevention measures were implemented, including risk-reduction programs, counseling and testing, condom distribution, and needle-exchange programs. However, HIV continued to spread, infecting 10 million persons within the first decade after its identification.

The second decade of AIDS was marked by further intensification of the epidemic in other areas of the world, including the southern cone of Africa, which saw an explosive HIV epidemic. Asia and the

countries of the former Soviet Union also reported a marked increase in the spread of HIV. However, by the mid-1990s, with the discovery of highly active antiretroviral therapy, rates of death in developed countries started to decline. The use of antiretroviral drugs during pregnancy also resulted in a substantial decline in mother-to-child transmission of HIV in high-income countries. However, without access to antiretroviral drugs in low and middle-income countries, rates of death and mother-to-child transmission continued to increase, with 2.4 million deaths and more than 3 million new infections reported in 2001. Of these new infections, two thirds occurred in sub-Saharan Africa.

PAEDIATRIC HIV CARE IN SUB-SAHARAN AFRICA: CLINICAL PRESENTATION AND 2-YEAR OUTCOMES STRATIFIED BY AGE GROUP

Jihane Ben-Farhat

Tropical Medicine and International Health, Vol. 18, No. 9, pp: 1065-1074, Sept 2013

To examine age differences in mortality and programme attrition amongst paediatric patients treated in four African HIV programmes.

Longitudinal analysis of data from patients enrolled in HIV care. Two-year mortality and programme attrition rates per 1000 person-years stratified by age group (<2, 2-4 and 5-15 years) were calculated. Associations between outcomes and age and other individual-level factors were studied using multiple Cox proportional hazards (mortality) and Poisson (attrition) regression models.

Six thousand two hundred and sixty-one patients contributed 9500 person-years; 27.1% were aged <2 years, 30.1% were 2-4, and 42.8% were 5-14 years old. At programme entry, 45.3% were underweight and 12.6% were in clinical stage 4. The highest mortality and attrition rates (98.85 and 244.00 per 1000 person-years), and relative ratios (adjusted hazard ratio [aHR] = 1.92, 95% CI 1.56-2.37; incidence ratio [aIR] = 2.10, 95% CI 1.86-2.37, respectively, compared with the 5- to 14-year group) were observed amongst the youngest children. Increased mortality and attrition were also associated with advanced clinical stage, underweight and diagnosis of tuberculosis at programme entry.

These results highlight the need to increase access, diagnose and provide early HIV care and to accelerate antiretroviral treatment initiation for those eligible. Adapted education and support for children and their families would also be important.

BLOOD GLUCOSE AS A PREDICTOR OF MORTALITY IN CHILDREN ADMITTED TO THE HOSPITAL WITH FEBRILE ILLNESS IN TANZANIA

Behzad Nadjm

Am J Trop Med Hyg, 89(2),2013, pp: 232-237

Data from a prospective study of 3,319 children ages 2 months to 5 years admitted with febrile illness to a Tanzanian district hospital were analyzed to determine the relationship of blood glucose and mortality. Hypoglycemia (blood sugar < 2.5 mmol/L and < 45 mg/dL) was found in 105 of 3,319 (3.2%) children at admission, and low-normal blood glucose (2.5-5 mmol/L and 45-90 mg/dL) was found in 773 of 3,319 (23.3%) children. Mortality was inversely related to admission blood sugar; compared with children with an admission blood glucose of > 5 mmol/L, the adjusted odds of dying were 3.3 (95% confidence interval = 2.1-5.2) and 9.8 (95% confidence interval = 5.1-19.0) among children with admission blood glucose 2.5-5 and < 2.5 mmol/L, respectively. Receiver operating characteristic (ROC) analysis suggested an optimal cutoff for admission blood sugar of < 5 mmol/L in predicting mortality (sensitivity = 57.7%, specificity = 75.2%). A cutoff for admission blood glucose of < 5 mmol/L represents a simple and clinically useful predictor of mortality in children admitted with severe febrile illness to hospital in resource-poor settings.

UNDERVACCINATION OF PERINATALLY HIV-INFECTED AND HIV-EXPOSED UNINFECTED CHILDREN IN LATIN AMERICA AND THE CARIBBEAN

Regina C. M. Succi

The Pediatric Infectious Disease Journal, Vol. 32, No. 8, Aug 2013

Perinatally HIV-infected (PHIV) children may be at risk of undervaccination. Vaccination coverage rates among PHIV and HIV-exposed uninfected (HEU) children in Latin America and the Caribbean were compared.

All PHIV and HEU children born from 2002 to 2007 who were enrolled in a multisite observational study conducted in Latin America and the Caribbean were included in this analysis. Children were classified as up to date if they had received the recommended number of doses of each vaccine at the appropriate in-

tervals by 12 and 24 months of age. Fisher's exact test was used to analyze the data. Covariates potentially associated with a child's HIV status were considered in multivariable logistic regression modeling.

Of 1156 eligible children, 768 (66.4%) were HEU and 388 (33.6%) were PHIV. HEU children were significantly ($P < 0.01$) more likely to be up to date by 12 and 24 months of age for all vaccines examined. Statistically significant differences persisted when the analyses were limited to children enrolled before 12 months of age. Controlling for birth weight, sex, primary caregiver education and any use of tobacco, alcohol or illegal drugs during pregnancy did not contribute significantly to the logistic regression models. PHIV children were significantly less likely than HEU children to be up to date for their childhood vaccinations at 12 and 24 months of age, even when limited to children enrolled before 12 months of age. Strategies to increase vaccination rates in PHIV are needed.

POOR EARLY VIROLOGIC PERFORMANCE AND DURABILITY OF ABACAVIR-BASED FIRST-LINE REGIMENS FOR HIV-INFECTED CHILDREN

Karl-Günter Technau

The Pediatric Infectious Disease Journal, Vol. 32, No. 8, Aug 2013

Concerns about stavudine (d4T) toxicity have led to increased use of abacavir (ABC) in first-line pediatric antiretroviral treatment (ART) regimens. Field experience with ABC in ART-naïve children is limited.

Deidentified demographic, clinical and laboratory data on HIV-infected children initiating ART between 2004 and 2011 in a large pediatric HIV treatment program in Johannesburg, South Africa, were used to compare viral suppression at 6 and 12 months by initial treatment regimen, time to suppression (<400 copies/mL) and rebound (>1000 copies/mL after initial suppression). Adjusted logistic regression was used to investigate confounders and calendar effects.

Two thousand thirty-six children initiated either d4T/3TC- or ABC/3TC-based first-line regimens in combination with either boosted lopinavir (LPV/r) or efavirenz (EFV). 1634 received d4T regimens (LPV/r $n = 672$; EFV $n = 962$) and 402 ABC regimens (LPV/r $n = 192$; EFV $n = 210$). At 6 and 12 months on ART, viral suppression rate was poorer in ABC versus d4T groups within both the LPV/r and EFV groups

($P < 0.0001$ for all points). In ABC groups, time to suppression was significantly slower (log-rank $P < 0.0001$ and $P = 0.0092$ for LPV/r- and EFV-based, respectively) and time to rebound after suppression significantly faster (log-rank $P = 0.014$ and $P = 0.0001$ for LPV/r- and EFV-based, respectively). Logistic regression confirmed the worse outcomes in the ABC groups even after adjustment for confounders.

BACTEREMIA, CAUSATIVE AGENTS AND ANTIMICROBIAL SUSCEPTIBILITY AMONG HIV-1-INFECTED CHILDREN ON ANTIRETROVIRAL THERAPY IN UGANDA AND ZIMBABWE

Victor Musiime

The Pediatric Infectious Disease Journal, Vol. 32, No. 8, Aug 2013

Bacteremia is common in HIV-infected children in Africa, including after start of antiretroviral therapy (ART), but there are limited data on causative pathogens and their antimicrobial sensitivity patterns in this population.

We analyzed data on blood cultures taken from HIV-infected children developing acute febrile illness after enrollment to the Antiretroviral Research for Watoto (ARROW) clinical trial in Uganda and Zimbabwe. Patterns of bacterial pathogens and their antimicrobial susceptibilities were determined and bacteremia rates calculated over time from ART initiation.

A total of 848 blood cultures were obtained from 461 children, of which 123 (14.5%) from 105 children (median age 3.5 years, 51% girls) were culture positive, including 75 (8.8%) with clearly pathogenic organisms. The event rates for positive cultures with clearly pathogenic organisms after 0-1, 2-3, 4-11 and ≥ 12 months on ART were 13.3, 11.4, 2.1 and 0.3 per 1000 person-months of follow-up, respectively. The pathogens isolated (n; %) were *Streptococcus pneumoniae* (36; 28.3%), *Staphylococcus aureus* (11; 8.7%), *Klebsiella pneumoniae* (6; 4.7%), *Pseudomonas aeruginosa* (6; 4.7%), *Salmonella* spp (6; 4.7%), *Escherichia coli* (5; 3.9%), *Haemophilus influenzae* (1; 0.8%) and fungal spp (4; 3.1%). Other bacteria of doubtful pathogenicity (n = 52; 42%) were also isolated. Most isolates tested were highly (80-100%) susceptible to ceftriaxone, cefotaxime and ciprofloxacin; very few (~5%) were susceptible to cotrimoxazole; *S. pneumoniae* had high susceptibility to amoxicillin/ampicillin (80%).

Rates of proven bacteremia were >20-fold

higher immediately after starting ART compared with 12 months later in African HIV-infected children. *S. pneumoniae* was most commonly isolated, suggesting need for pneumococcal vaccination and effective prophylactic antibiotics.

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EMERGING ISSUES IN GLOBAL HEALTH

T. Oelnick, M. Bartkovjak, M. Bezekova, M. Babalova, J. Benca, A. Kalavska, J. Suvada, B. Silharova, E. Ceploova, N. Hvizdakova, E. Horvathova, M. Mojtoová, J. Sokolova, I. Beldjebel, N. Kulkova, G. Mikolasova, J. M. Muli, M. Chabadova, M. Franekova, D. Horvathova, L. Vojtasova, I. Kmit and Tropicteam Members
St. Elizabeth University Bratislava, Slovakia

Key words:

global; health

Abstract

Current problems of Global Health Issues are critically reviewed and referenced by the members of the tropicteam including middle East Coronavirus, Asian Influenza.

GOOD HEALTH AT LOW COST 25 YEARS ON: LESSONS FOR THE FUTURE OF HEALTH SYSTEMS STRENGTHENING

Dina Balabanova

Lancet 2013, 381: 2118-33

In 1985, the Rockefeller Foundation published *Good health at low cost* to discuss why some countries or regions achieve better health and social outcomes than do others at a similar level of income and to show the role of political will and socially progressive policies. 25 years on, the *Good Health at Low Cost* project revisited these places but looked anew at Bangladesh, Ethiopia, Kyrgyzstan, Thailand, and the Indian state of Tamil Nadu, which have all either achieved substantial improvements in health or access to services or implemented innovative health policies relative to their neighbours. A series of comparative case studies (2009–11) looked at how and why each region accomplished these changes. Attributes of success included good governance and political commitment, effective bureaucracies that preserve institutional memory and can learn from experience, and the ability to innovate and adapt to resource limitations. Furthermore, the capacity to respond to population needs and build resilience into health systems in the face of political unrest, economic crises, and natural disasters was important. Transport

infrastructure, female empowerment, and education also played a part. Health systems are complex and no simple recipe exists for success. Yet in the countries and regions studied, progress has been assisted by institutional stability, with continuity of reforms despite political and economic turmoil, learning lessons from experience, seizing windows of opportunity, and ensuring sensitivity to context. These experiences show that improvements in health can still be achieved in countries with relatively few resources, though strategic investment is necessary to address new challenges such as complex chronic diseases and growing population expectations.

RAPID RE-INFECTION WITH SOIL-TRANSMITTED HELMINTHS AFTER TRIPLE-DOSE ALBENDAZOLE TREATMENT OF SCHOOL-AGED CHILDREN IN YUNNAN, PEOPLE'S REPUBLIC OF CHINA

Peiling Yap

Am. J. Trop. Med. Hyg., 89(1), 2013, pp. 23-31

Post-treatment soil-transmitted helminth re-infection patterns were studied as part of a randomized controlled trial among school-aged children from an ethnic minority group in Yunnan province, People's Republic of China. Children with a soil-transmitted helminth infection (N = 194) were randomly assigned to triple-dose albendazole or placebo and their infection status monitored over a 6-month

period using the Kato-Katz and Baermann techniques. Baseline prevalence of *Trichuris trichiura*, *Ascaris lumbricoides*, hookworm, and *Strongyloides stercoralis* were 94.5%, 93.3%, 61.3%, and 3.1%, respectively, with more than half of the participants harboring triple-species infections. For the intervention group (N = 99), the 1-month post-treatment cure rates were 96.7%, 91.5%, and 19.6% for hookworm, *A. lumbricoides*, and *T. trichiura*, respectively. Egg reduction rates were above 88% for all three species. Rapid re-infection with *A. lumbricoides* was observed: the prevalence 4 and 6 months post-treatment was 75.8% and 83.8%, respectively. Re-infection with hookworm and *T. trichiura* was considerably slower.

EFFECTIVENESS OF RAPID TRANSPORT OF VICTIMS AND COMMUNITY HEALTH EDUCATION ON SNAKE BITE FATALITIES IN RURAL NEPAL

Sanjib K. Sharma

Am. J. Trop. Med. Hyg., 89(1), 2013, pp. 145-150

Snake bite is a major public problem in the rural tropics. In southern Nepal, most deaths caused by neurotoxic envenomation occur in the village or during transport to health centers. The effectiveness of victims' transport by motorcycle volunteers to a specialized treatment center, combined with community health education, was assessed in a non-randomized, single-arm, before-after study conducted in four villages (population = 62,127). The case-fatality rate of snake bite decreased from 10.5% in the pre-intervention period to 0.5% during the intervention (relative risk reduction = 0.949, 95% confidence interval = 0.695-0.999). The snake bite incidence decreased from 502 bites/100,000 population to 315 bites/100,000 population in the four villages (relative risk reduction = 0.373, 95% confidence interval = 0.245-0.48), but it remained constant in other villages. Simple educational messages and promotion of immediate and rapid transport of victims to a treatment center decreased the mortality rate and incidence of snake bite in southeastern Nepal. The impact of similar interventions should be assessed elsewhere.

PUBLIC HEALTH SIGNIFICANCE OF INVASIVE MOSQUITOS IN EUROPE

Schaffner F.

Clin Microbiol Infect 2013, 19, 685-692

There are currently five invasive *Aedes* mosquito species known to be established in Europe, namely *Aedes albopictus*, *Aedes aegypti*, *Aedes japonicus*, *Aedes atropalpus* and *Aedes koreicus*. *Aedes albopictus* and *Aedes aegypti* are the incriminated vectors in the recent outbreaks of chikungunya and dengue fever in Europe. However, both laboratory experiments and field observations indicate that these invasive mosquitoes have a potential to also transmit other pathogens of public health importance. Increasing travel and pathogen introduction, expansion of vector distribution, and both environmental and climatic changes are likely to raise the risk of pathogen transmission by these invasive *Aedes* mosquitoes. Their vector status and their involvement in pathogen transmission are dynamic processes that shape the future of mosquito-borne disease epidemiology in Europe. Beside vector surveillance, enhanced disease surveillance will enable the early detection of cases and the prompt implementation of control measures.

MOSQUITO-BORNE DISEASE SURVEILLANCE BY THE EUROPEAN CENTRE FOR DISEASE PREVENTION AND CONTROL

Zeller H.

Clin Microbiol Infect 2013, 19, 693-698

For a few years, a series of traditionally tropical mosquito-borne diseases, such as chikungunya fever and dengue, have posed challenges to national public health authorities in the European region. Other diseases have re-emerged, e.g. malaria in Greece, or spread to other countries, e.g. West Nile fever. These diseases are reportable within the European Union (EU), and the European Centre for Disease Prevention and Control collects information in various ways to provide EU member states with topical assessments of disease threats, risks and trends for prompt and appropriate public health action. Using disease-specific expert networks, the European Surveillance System (TESSy) collects standardized comparable information on all statutory communicable diseases in a database. In addition, the event-based surveillance aims to detect potential public health threats early, and to

allow timely response and support to blood deferral decisions for pathogens that can be transmitted through blood donation. Laboratory capacity for early detection is implemented through external quality assessments. Other activities include the development of guidelines for the surveillance of mosquito vectors, and the production of regularly updated maps on the currently known occurrence of mosquito vector species.

AN INTENSIVE LONGITUDINAL COHORT STUDY OF MALIAN CHILDREN AND ADULTS REVEALS NO EVIDENCE OF ACQUIRED IMMUNITY TO PLASMODIUM FALCIPARUM INFECTION

Tuan M. Tram

Clinical Infectious Diseases 2013, 57(1): 40-7

In experimental models of human and mouse malaria, sterilizing liver stage immunity that blocks progression of Plasmodium infection to the symptomatic blood stage can be readily demonstrated. However, it remains unclear whether individuals in malaria-endemic areas acquire such immunity.

In Mali, 251 healthy children and adults aged 4 to 25 years who were free of blood-stage Plasmodium infection by PCR were enrolled in a longitudinal study just prior to an intense six-month malaria season. Subsequent clinical malaria episodes were detected by weekly active surveillance and self-referral. Asymptomatic *P. falciparum* infections were detected by blood-smear microscopy and PCR analysis of dried blood spots which had been collected every two weeks for seven months.

As expected, the risk of clinical malaria decreased with increasing age (log-rank test, $P=.0038$). However, analysis of PCR data showed no age-related differences in *P. falciparum* infection risk (log-rank test, $P=.37$).

Despite years of exposure to intense *P. falciparum* transmission, there is no evidence of acquired, sterile immunity to *P. falciparum* infection in this population, even as clinical immunity to blood-stage malaria is clearly acquired. Understanding why repeated *P. falciparum* infections do not induce sterile protection may lead to insights for developing vaccines that target the liver stage in malaria-endemic populations.

IMMUNOTHERAPY FOR INVASIVE MOLD DISEASE IN SEVERELY IMMUNOSUPPRESSED PATIENTS

Amar Safdar

Clinical Infectious Diseases 2013, 57(1): 94-100

Response to systemic antifungal therapy alone remains disproportionately less satisfactory in immunosuppressed transplant and oncology patients. As insight in fungal immunopathogenesis forges ahead, interventions for boosting immune functions along with antimicrobial drugs has shown promise in pre-clinical experiments. The clinical experience with immunotherapy for invasive mold disease is limited. Most studies have involved small numbers of patients at a single institution or data collected retrospectively. An overview of various facts of immune modulatory drug intervention is presented, including major considerations in antifungal immunotherapy in immunosuppressed patients. Patients in whom immunotherapy is being considered must be critically evaluated to identify the underlying immune defects, including treatment-induced immunosuppression. Antifungal immunotherapy is appealing; however, before routine clinical use is recommended, well-designed prospective comparative clinical trials are urgently needed.

INCREASING ECHINOCANDIN RESISTANCE IN CANDIDA GLABRATA: CLINICAL FAILURE CORRELATES WITH PRESENCE OF FKS MUTATIONS AND ELEVATED MINIMUM INHIBITORY CONCENTRATIONS

Barbara D. Alexander

Clinical Infectious Diseases 2013, 56(12): 1724-32

Fluconazole (FLC) resistance is common in *C. glabrata* and echinocandins are often used as first-line therapy. Resistance to echinocandin therapy has been associated with FKS1 and FKS2 gene alterations.

We reviewed records of all patients with *C. glabrata* bloodstream infection at Duke Hospital over the past decade (2001-2010) and correlated treatment outcome with minimum inhibitory concentration (MIC) results and the presence of FKS gene mutations. For each isolate, MICs to FLC and echinocandins (anidulafungin, caspofungin, and micafungin) and FKS1 and FKS2 gene sequences were determined. Two hundred ninety-three episodes (313 isolates)

of *C. glabrata* bloodstream infection were analyzed. Resistance to echinocandins increased from 4.9% to 12.3% and to FLC from 18% to 30% between 2001 and 2010, respectively. Among the 78 FLC resistant isolates, 14.1% were resistant to 1 or more echinocandin. Twenty-five (7.9%) isolates harbored a FKS mutation. The predictor of a FKS mutant strain was prior echinocandin therapy (stepwise multivariable analysis, odds ratio, 19.647 [95% confidence interval, 7.19-58.1]). Eighty percent (8/10) of patients infected with FKS mutants demonstrating intermediate or resistant MICs to an echinocandin and treated with an echinocandin failed to respond or responded initially but experienced a recurrence.

Echinocandin resistance is increasing, including among FLC-resistant isolates. The new Clinical and Laboratory Standards Institute clinical breakpoints differentiate wild-type from *C. glabrata* strains bearing clinically significant FKS1/FKS2 mutations. These observations underscore the importance of knowing the local epidemiology and resistance patterns for *Candida* within institutions and susceptibility testing of echinocandins for *C. glabrata* to guide therapeutic decision making.

INFLUENCE OF GEOGRAPHICAL ORIGIN AND ETHNICITY ON MORTALITY IN PATIENTS ON ANTIRETROVIRAL THERAPY IN CANADA, EUROPE AND THE UNITED STATES

Clinical Infectious Diseases 2013, 56(12): 1800-9

Our objective was to assess differences in all-cause mortality, as well as AIDS and non-AIDS death rates, among patients started on antiretroviral therapy (ART) according to their geographical origin and ethnicity/race in Europe, Canada, and the United States. This was a collaboration of 19 cohort studies of human immunodeficiency virus-positive subjects who have initiated ART (ART Cohort Collaboration) between 1998 and 2009. Adjusted mortality hazard ratios (AHRs) were estimated using Cox regression. A competing risk framework was used to estimate adjusted subdistribution hazard ratios for AIDS and non-AIDS mortality.

Of 46 648 European patients, 16.3% were from sub-Saharan Africa (SSA), 5.1% Caribbean and Latin America, 1.6% North Africa and Middle East, and 1.7% Asia/West; of 1371 patients from Canada, 14.9% were First Nations and 22.4% migrants, and of 7742 patients from North America, 55.5% were African American and 6.6% Hispanic. Migrants from SSA (AHR, 0.79; 95% confidence interval [CI], .68-

.92) and Asia/West (AHR, 0.62; 95% CI, .41-.92) had lower mortality than Europeans; these differences appeared mainly attributable to lower non-AIDS mortality. Compared with white Canadians, mortality in Canadian First Nations people (AHR, 1.48; 95% CI, .96-2.29) was higher, both for AIDS and non-AIDS mortality rates. Among US patients, when compared with whites, African Americans had higher AIDS and non-AIDS mortality, and hazard ratios for all-cause mortality increased with time on ART.

The lower mortality observed in migrants suggests "healthy migrant" effects, whereas the higher mortality in First Nations people and African Americans in North America suggests social inequality gaps.

10 X '20 PROGRESS-DEVELOPMENT OF NEW DRUGS ACTIVE AGAINST GRAM-NEGATIVE BACILLI: AN UPDATE FROM THE INFECTIOUS DISEASES SOCIETY OF AMERICA

Helen W. Boucher

Clinical Infectious Diseases 2013, 56(12): 1685-94

Infections caused by antibiotic-resistant bacteria, especially the "ESKAPE" pathogens, continue to increase in frequency and cause significant morbidity and mortality. New antimicrobial agents are greatly needed to treat infections caused by gram-negative bacilli (GNB) resistant to currently available agents. The Infectious Diseases Society of America (IDSA) continues to propose legislative, regulatory, and funding solutions to this continuing crisis. The current report updates the status of development and approval of systemic antibiotics in the United States as of early 2013. Only 2 new antibiotics have been approved since IDSA's 2009 pipeline status report, and the number of new antibiotics annually approved for marketing in the United States continues to decline. We identified 7 drugs in clinical development for treatment of infections caused by resistant GNB. None of these agents was included in our 2009 list of antibacterial compounds in phase 2 or later development, but unfortunately none addresses the entire spectrum of clinically relevant GNB resistance. Our survey demonstrates some progress in development of new antibacterial drugs that target infections caused by resistant GNB, but progress remains alarmingly elusive. IDSA stresses our conviction that the antibiotic pipeline problem can be solved by the collaboration of global leaders to develop creative incentives that will stimulate new antibacterial research and development. Our aim is the

Table 1. Systemic Antibacterial Drug Approvals Since 1998^a

Antibacterial	Year Approved	Novel Mechanism?
Ritapensine ^b	1998	No
Quinupristin/dalfopristin ^c	1999	No
Moxifloxacin	1999	No
Gatifloxacin ^d	1999	No
Linezolid	2000	Yes
Ceftoren pivoxil	2001	No
Ertapenem	2001	No
Gemifloxacin ^d	2003	No
Daptomycin	2003	Yes
Telithromycin ^e	2004	No
Tigecycline ^f	2005	Yes
Doripenem	2007	No
Televancin	2009	Yes
Ceftaroline fosamil	2010	No

^a Rifaximin (FDA approved in 2004) and tedizolid (FDA approved in 2011) are not systemically absorbed, and so are not included on this list.
^b Antituberculous agent.
^c Infrequently used due to adverse event profile.
^d Withdrawn from market due to adverse event profile.
^e Label warning regarding possible excess mortality.

Table 2. Antibacterial Pipeline (Anti-Gram Positive and Anti-Gram Negative), Big Pharma

Company	Since 1998	Phase 2/3
Abbott Laboratories	0	0
AstraZeneca	0	2
Bayer	0	0
GlaxoSmithKline	0	1
Lilly	0	0
Merck/Schering-Plough	1	1
Novartis	0	0
Ortho McNeil/Johnson & Johnson	1	0
Pfizer/Wyeth	2	0
Roche	0	0
Sanofi	0	0

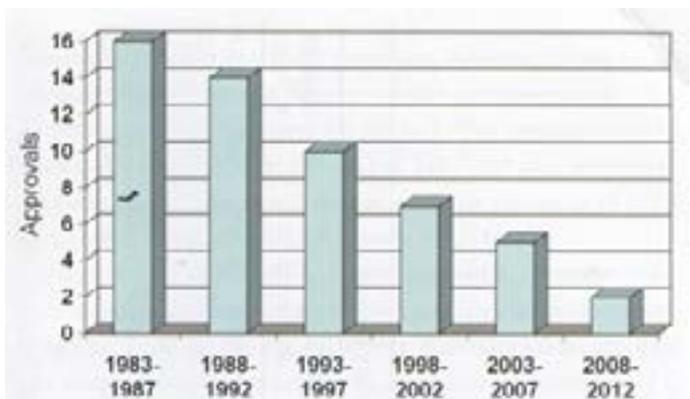


Figure 1. New systemic antibacterial agents approved by the US Food and Drug Administration per 5-year period, through 2012. Modified from Spellberg 2004 [23].

Product	Class (Mechanism of Action)	Novel Mechanism of Action?	Status	Activity Targets							
				Enterobacteriaceae			Pseudomonas aeruginosa			Acinetobacter spp	
				ESBL	sCBP	mCBP	WT	MDR	mCBP	WT	MDR
1. Ceftazidime/avibactam (CXA-201, CXA-101/azobactam)	Antipseudomonal cephalosporin/BLI combination (cell wall synthesis inhibitor)	No	Phase 3 (cUTI, cIAI)	Yes	No	No	Yes	IE	No	No	No
2. Ceftazidime/avibactam (ceftazidime/AVI 100)	Antipseudomonal cephalosporin/BLI combination (cell wall synthesis inhibitor)	No	Phase 3 (cIAI)	Yes	Yes	No	Yes	IE	No	No	No
3. Ceftaroline-avibactam (CPT-avibactam; ceftaroline/AVI 104)	Anti-MRSA cephalosporin/BLI combination (cell wall synthesis inhibitor)	No	Phase 2 (cUTI, cIAI)	Yes	Yes	No	No	No	No	No	No
4. Impenem/AVI 2005	Carbapenem/BLI combination (cell wall synthesis inhibitor)	No	Phase 2 (cUTI, cIAI)	Yes	Yes	No	Yes	IE	No	IE	No
5. Placemium (ACH-490)	Aminoglycoside (protein synthesis inhibitor)	No	Phase 2 (cUTI)	Yes ^g	Yes ^g	IE	No	No	IE	No	No
6. Eravacycline (TP-434)	Fluorocycline (protein synthesis inhibitor targeting the ribosomal)	No	Phase 2 (cIAI)	Yes ^g	Yes	IE	No	No	No	IE	IE
7. Brilacidin (PMX-00603)	Peptide defense protein mimetic (cell membrane disruption)	Yes ^g	Phase 2 (ABSSSI)	Yes	IE	IE	IE	IE	IE	No	No

Activity based on available information.
 Abbreviations: ABSSSI, acute bacterial skin and skin structure infection; BLI, beta-lactamase inhibitor; cIAI, complicated intra-abdominal infection; cUTI, complicated urinary tract infection; ESBL, extended-spectrum beta-lactamase producers; IE, insufficient evidence available; mCBP, metallo-carbapenemase producers (eg, NDM, VIM, IMP); MDR, multidrug-resistant pattern including co-resistance to aminoglycosides, gentamicin, tobramycin, fluoroquinolones, tetracyclines, and broad-spectrum penicillins by various mechanisms (armed on common genetic elements); MRSA, methicillin-resistant *Staphylococcus aureus*; sCBP, serine carbapenemase producers such as KPC; WT, wild-type pattern for species.
^g Intravenous antimicrobials not listed in IDSA's 2009 drug status report [2].

creation of a sustainable global antibacterial drug research and development enterprise with the power in the short term to develop 10 new, safe, and efficacious systemically administered antibiotics by 2020 as called for in IDSA's "10 x'20 Initiative."

HOSPITAL OUTBREAK OF MIDDLE EAST RESPIRATORY SYNDROME CORONAVIRUS

Abdullah Assiri

N Engl J Med 369, 5, Aug 2013

In September 2012, the World Health Organization reported the first cases of pneumonia caused by the novel Middle East respiratory syndrome coronavirus (MERS-CoV). We describe a cluster of health care-acquired MERS-CoV infections.

Medical records were reviewed for clinical and demographic information and determination of potential contacts and exposures. Case patients and contacts were interviewed. The incubation period and serial interval (the time between the successive onset of symptoms in a chain of transmission) were estimated. Viral RNA was sequenced.

Between April 1 and May 23, 2013, a total of 23 cases of MERS-CoV infection were reported in the eastern province of Saudi Arabia. Symptoms included fever in 20 patients (87%), cough in 20 (87%), shortness of breath in 11 (48%), and gastrointestinal symptoms in 8 (35%); 20 patients (87%) presented with abnormal chest radiographs. As of June 12, a total of 15 patients (65%) had died, 6 (26%) had recovered, and 2 (9%) remained hospitalized. The median incubation period was 5.2 days (95% confidence interval [CI], 1.9 to 14.7), and the serial interval was 7.6 days (95% CI, 2.5 to 23.1). A total of 21 of the 23 cases were acquired by person-to-person transmission in hemodialysis units, intensive care units, or in-patient units in three different health care facilities. Sequencing data from four isolates revealed a single monophyletic clade. Among 217 household contacts and more than 200 health care worker contacts whom we identified, MERS-CoV infection developed in 5 family members (3 with laboratory-confirmed cases) and in 2 health care workers (both with laboratory-confirmed cases). Person-to-person transmission of MERS-CoV can occur in health care settings and may be associated with considerable morbidity. Surveillance and infection-control measures are critical to a global public health response.

REDUCED LUNG-CANCER MORTALITY WITH LOW-DOSE COMPUTED TOMOGRAPHIC SCREENING

N Engl J Med 2013, 365, pp395-409

The aggressive and heterogeneous nature of lung cancer has thwarted efforts to reduce mortality from this cancer through the use of screening. The advent of low-dose helical computed tomography (CT) altered the landscape of lung-cancer screening, with studies indicating that low-dose CT detects many tumors at early stages. The National Lung Screening Trial (NLST) was conducted to determine whether screening with low-dose CT could reduce mortality from lung cancer.

From August 2002 through April 2004, we enrolled 53,454 persons at high risk for lung cancer at 33 U.S. medical centers. Participants were randomly assigned to undergo three annual screenings with either low-dose CT (26,722 participants) or single-view posteroanterior chest radiography (26,732). Data were collected on cases of lung cancer and deaths from lung cancer that occurred through December 31, 2009.

The rate of adherence to screening was more than 90%. The rate of positive screening tests was 24.2% with low-dose CT and 6.9% with radiography over all three rounds. A total of 96.4% of the positive screening results in the low-dose CT group and 94.5% in the radiography group were false positive results. The incidence of lung cancer was 645 cases per 100,000 person-years (1060 cancers) in the low-dose CT group, as compared with 572 cases per 100,000 person-years (941 cancers) in the radiography group (rate ratio, 1.13; 95% confidence interval [CI], 1.03 to 1.23). There were 247 deaths from lung cancer per 100,000 person-years in the low-dose CT group and 309 deaths per 100,000 person-years in the radiography group, representing a relative reduction in mortality from lung cancer with low-dose CT screening of 20.0% (95% CI, 6.8 to 26.7; $P=0.004$). The rate of death from any cause was reduced in the low-dose CT group, as compared with the radiography group, by 6.7% (95% CI, 1.2 to 13.6; $P=0.02$).

Screening with the use of low-dose CT reduces mortality from lung cancer.

TARGETED VERSUS UNIVERSAL DECOLONIZATION TO PREVENT ICU INFECTION

Susan S. Huang

N Engl J Med 2013, 368, pp225-65

Both targeted decolonization and universal decolonization of patients in intensive care units (ICUs) are candidate strategies to prevent health care-associated infections, particularly those caused by methicillin-resistant *Staphylococcus aureus* (MRSA). We conducted a pragmatic, cluster-randomized trial. Hospitals were randomly assigned to one of three strategies, with all adult ICUs in a given hospital assigned to the same strategy. Group 1 implemented MRSA screening and isolation; group 2, targeted decolonization (i.e., screening, isolation, and decolonization of MRSA carriers); and group 3, universal decolonization (i.e., no screening, and decolonization of all patients). Proportional-hazards models were used to assess differences in infection reductions across the study groups, with clustering according to hospital.

A total of 43 hospitals (including 74 ICUs and 74,256 patients during the intervention period) underwent randomization. In the intervention period versus the baseline period, modeled hazard ratios for MRSA clinical isolates were 0.92 for screening and isolation (crude rate, 3.2 vs. 3.4 isolates per 1000 days), 0.75 for targeted decolonization (3.2 vs. 4.3 isolates per 1000 days), and 0.63 for universal decolonization (2.1 vs. 3.4 isolates per 1000 days) ($P=0.01$ for test of all groups being equal). In the intervention versus baseline periods, hazard ratios for bloodstream infection with any pathogen in the three groups were 0.99 (crude rate, 4.1 vs. 4.2 infections per 1000 days), 0.78 (3.7 vs. 4.8 infections per 1000 days), and 0.56 (3.6 vs. 6.1 infections per 1000 days), respectively ($P<0.001$ for test of all groups being equal). Universal decolonization resulted in a significantly greater reduction in the rate of all bloodstream infections than either targeted decolonization or screening and isolation. One bloodstream infection was prevented per 54 patients who underwent decolonization. The reductions in rates of MRSA bloodstream infection were similar to those of all bloodstream infections, but the difference was not significant. Adverse events, which occurred in 7 patients, were mild and related to chlorhexidine.

In routine ICU practice, universal decolonization was more effective than targeted decolonization or screening and isolation in reducing rates of MRSA clinical isolates and bloodstream infection from any pathogen.

CLINICAL FINDINGS IN 111 CASES OF INFLUENZA A (H7N9) VIRUS INFECTION

Hai-Nv Gao

N Engl J Med 2013, 368, pp2277-85

During the spring of 2013, a novel avian-origin influenza A (H7N9) virus emerged and spread among humans in China. Data were lacking on the clinical characteristics of the infections caused by this virus.

Using medical charts, we collected data on 111 patients with laboratory-confirmed avian-origin influenza A (H7N9) infection through May 10, 2013.

Of the 111 patients we studied, 76.6% were admitted to an intensive care unit (ICU), and 27.0% died. The median age was 61 years, and 42.3% were 65 years of age or older; 31.5% were female. A total of 61.3% of the patients had at least one underlying medical condition. Fever and cough were the most common presenting symptoms. On admission, 108 patients (97.3%) had findings consistent with pneumonia. Bilateral ground-glass opacities and consolidation were the typical radiologic findings. Lymphocytopenia was observed in 88.3% of patients, and thrombocytopenia in 73.0%. Treatment with antiviral drugs was initiated in 108 patients (97.3%) at a median of 7 days after the onset of illness. The median times from the onset of illness and from the initiation of antiviral therapy to a negative viral test result on real-time reverse-transcriptase-polymerase-chain-reaction assay were 11 days (interquartile range, 9 to 16) and 6 days (interquartile range, 4 to 7), respectively. Multivariate analysis revealed that the presence of a coexisting medical condition was the only independent risk factor for the acute respiratory distress syndrome (ARDS) (odds ratio, 3.42; 95% confidence interval, 1.21 to 9.70; $P=0.02$).

During the evaluation period, the novel H7N9 virus caused severe illness, including pneumonia and ARDS, with high rates of ICU admission and death.

SCREENING INPATIENTS FOR MRSA – CASE CLOSED

Michael B. Edmond

N Engl J Med 2013, 368, pp2314-2315

One of the most controversial concepts in health care epidemiology during the past decade has

been the active detection and isolation of patients with methicillin-resistant *Staphylococcus aureus* (MRSA) colonization. The basic strategy is to screen inpatients for MRSA, typically with a polymerase-chain-reaction-based technology, in order to rapidly identify patients colonized with the organism and then initiate contact precautions (place them in a private room and require gowns and gloves on room entry).

Active detection and isolation without decolonization was not effective in reducing rates of MRSA-positive clinical cultures, MRSA bloodstream infections, or bloodstream infections from any pathogen.

The implications of this study are highly important. The lack of effectiveness of active detection and isolation should prompt hospitals to discontinue the practice for control of endemic MRSA. A benefit will be a reduced proportion of patients requiring contact precautions, which is a patient-unfriendly practice that interferes with care.¹⁰ In addition, the folly of pursuing legislative mandates when evidence is lacking has been shown, and laws mandating MRSA screening should be repealed.

CARDIOVASCULAR RISKS WITH AZITHROMYCIN AND OTHER ANTIBACTERIAL DRUGS

Andrew D. Mosholder

N Engl J Med 2013, 368, 18, pp1665-1668

In 2011, approximately 40.3 million people in the United States (roughly one eighth of the population) received an outpatient prescription for the macrolide azithromycin, according to IMS Health. The study showed that the risks of death, both from any cause and from cardiovascular causes, associated with azithromycin were greater than those associated with amoxicillin. For every 21,000 outpatient prescriptions written for azithromycin, one cardiovascular death occurred in excess of those observed with the same number of amoxicillin prescriptions. Despite such caveats, the results presented by Ray et al. warrant serious attention. A chief strength of the results is the time-limited pattern of the risk: the azithromycin-associated increase in the rates of death from any cause and from cardiovascular causes spanned days 1 through 5, reflecting the typical 5-day duration of azithromycin administration (e.g., Zithromax Z-Pak).

PENICILLIN TO PREVENT RECURRENT LEG CELLULITIS

Kim S. Thomas

N Engl J Med 2013, 368, pp1695-703

Cellulitis of the leg is a common bacterial infection of the skin and underlying tissue. We compared prophylactic low-dose penicillin with placebo for the prevention of recurrent cellulitis.

We conducted a double-blind, randomized, controlled trial involving patients with two or more episodes of cellulitis of the leg who were recruited in 28 hospitals in the United Kingdom and Ireland. Randomization was performed according to a computer-generated code, and study medications (penicillin [250 mg twice a day] or placebo for 12 months) were dispensed by a central pharmacy. The primary outcome was the time to a first recurrence. Participants were followed for up to 3 years. Because the risk of recurrence was not constant over the 3-year period, the primary hypothesis was tested during prophylaxis only.

A total of 274 patients were recruited. Baseline characteristics were similar in the two groups. The median time to a first recurrence of cellulitis was 626 days in the penicillin group and 532 days in the placebo group. During the prophylaxis phase, 30 of 136 participants in the penicillin group (22%) had a recurrence, as compared with 51 of 138 participants in the placebo group (37%) (hazard ratio, 0.55; 95% confidence interval [CI], 0.35 to 0.86; $P=0.01$), yielding a number needed to treat to prevent one recurrent cellulitis episode of 5 (95% CI, 4 to 9). During the no-intervention follow-up period, there was no difference between groups in the rate of a first recurrence (27% in both groups). Overall, participants in the penicillin group had fewer repeat episodes than those in the placebo group (119 vs. 164, $P=0.02$ for trend). There was no significant between-group difference in the number of participants with adverse events (37 in the penicillin group and 48 in the placebo group, $P=0.50$). In patients with recurrent cellulitis of the leg, penicillin was effective in preventing subsequent attacks during prophylaxis, but the protective effect diminished progressively once drug therapy was stopped.

USE OF AZITHROMYCIN AND DEATH FROM CARDIOVASCULAR CAUSES

Henrik Svanström

N Engl J Med 2013, 368, pp1704-12

Azithromycin use is associated with an increased risk of death from cardiovascular causes among patients at high baseline risk. Whether azithromycin confers a similar risk in the unselected general population is unknown.

We conducted a nationwide historical cohort study involving Danish adults (18 to 64 years of age), linking registry data on filled prescriptions, causes of death, and patient characteristics for the period from 1997 through 2010. We estimated rate ratios for death from cardiovascular causes, comparing 1,102,050 episodes of azithromycin use with no use of antibiotic agents (matched in a 1:1 ratio according to propensity score, for a total of 2,204,100 episodes) and comparing 1,102,419 episodes of azithromycin use with 7,364,292 episodes of penicillin V use (an antibiotic with similar indications; analysis was conducted with adjustment for propensity score).

The risk of death from cardiovascular causes was significantly increased with current use of azithromycin (defined as a 5-day treatment episode), as compared with no use of antibiotics (rate ratio, 2.85; 95% confidence interval [CI], 1.13 to 7.24). The analysis relative to an antibiotic comparator included 17 deaths from cardiovascular causes during current azithromycin use (crude rate, 1.1 per 1000 person-years) and 146 during current penicillin V use (crude rate, 1.5 per 1000 person-years). With adjustment for propensity scores, current azithromycin use was not associated with an increased risk of cardiovascular death, as compared with penicillin V (rate ratio, 0.93; 95% CI, 0.56 to 1.55). The adjusted absolute risk difference for current use of azithromycin, as compared with penicillin V, was -1 cardiovascular death (95% CI, -9 to 11) per 1 million treatment episodes.

Azithromycin use was not associated with an increased risk of death from cardiovascular causes in a general population of young and middle-aged adults.

INTESTINAL MICROBIAL METABOLISM OF PHOSPHATIDYLCHOLINE AND CARDIOVASCULAR RISK

Wilson W.H. Tang

N Engl J Med 2013, 368, pp1575-84

Recent studies in animals have shown a mechanistic link between intestinal microbial metabolism of the choline moiety in dietary phosphatidylcholine (lecithin) and coronary artery disease through the production of a proatherosclerotic metabolite, trimethylamine-N-oxide (TMAO). We investigated the relationship among intestinal microbiota-dependent metabolism of dietary phosphatidylcholine, TMAO levels, and adverse cardiovascular events in humans.

We quantified plasma and urinary levels of TMAO and plasma choline and betaine levels by means of liquid chromatography and online tandem mass spectrometry after a phosphatidylcholine challenge (ingestion of two hard-boiled eggs and deuterium [d9]-labeled phosphatidylcholine) in healthy participants before and after the suppression of intestinal microbiota with oral broad-spectrum antibiotics. We further examined the relationship between fasting plasma levels of TMAO and incident major adverse cardiovascular events (death, myocardial infarction, or stroke) during 3 years of follow-up in 4007 patients undergoing elective coronary angiography.

Time-dependent increases in levels of both TMAO and its d9 isotopologue, as well as other choline metabolites, were detected after the phosphatidylcholine challenge. Plasma levels of TMAO were markedly suppressed after the administration of antibiotics and then reappeared after withdrawal of antibiotics. Increased plasma levels of TMAO were associated with an increased risk of a major adverse cardiovascular event (hazard ratio for highest vs. lowest TMAO quartile, 2.54; 95% confidence interval, 1.96 to 3.28; $P < 0.001$). An elevated TMAO level predicted an increased risk of major adverse cardiovascular events after adjustment for traditional risk factors ($P < 0.001$), as well as in lower-risk subgroups.

The production of TMAO from dietary phosphatidylcholine is dependent on metabolism by the intestinal microbiota. Increased TMAO levels are associated with an increased risk of incident major adverse cardiovascular events.

HEALTH-EDUCATION PACKAGE TO PREVENT WORM INFECTIONS IN CHINESE SCHOOL-CHILDREN

Franziska A. Bieri

N Engl J Med 2013, 368, pp1603-12

Soil-transmitted helminths are among the most prevalent sources of human infections globally. We determined the effect of an educational package at rural schools in Linxiang City District, Hunan province, China, where these worms are prevalent. The intervention aimed to increase knowledge about soil-transmitted helminths, induce behavioral change, and reduce the rate of infection.

We conducted a single-blind, unmatched, cluster-randomized intervention trial involving 1718 children, 9 to 10 years of age, in 38 schools over the course of 1 school year. Schools were randomly assigned to the health-education package, which included a cartoon video, or to a control package, which involved only the display of a health-education poster. Infection rates, knowledge about soil-transmitted helminths (as assessed with the use of a questionnaire), and hand-washing behavior were assessed before and after the intervention. Albendazole was administered in all the participants at baseline and in all the children who were found to be positive for infection with soil-transmitted helminths at the follow-up assessment at the end of the school year.

At the follow-up assessment, the mean score for the knowledge of helminths, calculated as a percentage of a total of 43 points on a questionnaire, was 90% higher in the intervention group than in the control group (63.3 vs. 33.4, $P < 0.001$), the percentage of children who washed their hands after using the toilet was nearly twice as high in the intervention group (98.9%, vs. 54.2% in the control group; $P < 0.001$), and the incidence of infection with soil-transmitted helminths was 50% lower in the intervention group than in the control group (4.1% vs. 8.4%, $P < 0.001$). No adverse events were observed immediately (within 15 minutes) after albendazole treatment.

The health-education package increased students' knowledge about soil-transmitted helminths and led to a change in behavior and a reduced incidence of infection within 1 school year.

FAMILY CLUSTER OF MIDDLE EAST RESPIRATORY SYNDROME CORONAVIRUS INFECTIONS

Ziad A. Memish

N Engl J Med 2013, 368, pp2487-94

A human coronavirus, called the Middle East respiratory syndrome coronavirus (MERS-CoV), was first identified in September 2012 in samples obtained from a Saudi Arabian businessman who died from acute respiratory failure. Since then, 49 cases of infections caused by MERS-CoV (previously called a novel coronavirus) with 26 deaths have been reported to date. In this report, we describe a family case cluster of MERS-CoV infection, including the clinical presentation, treatment outcomes, and household relationships of three young men who became ill with MERS-CoV infection after the hospitalization of an elderly male relative, who died of the disease. Twenty-four other family members living in the same household and 124 attending staff members at the hospitals did not become ill. MERS-CoV infection may cause a spectrum of clinical illness. Although an animal reservoir is suspected, none has been discovered. Meanwhile, global concern rests on the ability of MERS-CoV to cause major illness in close contacts of patients.

FUNGAL INFECTIONS ASSOCIATED WITH CONTAMINATED METHYLPREDNISOLONE INJECTIONS

Carol A. Kauffman

N Engl J Med 2013, 368, pp2495-500

An unprecedented outbreak of fungal infections has been associated with injection of methylprednisolone that was contaminated with environmental molds. The index case, which prompted clinicians at Vanderbilt University to call the Tennessee Department of Health and which brought this event to national attention, was reported by Pettit et al. on October 19, 2012, at NEJM.org and in the November 29, 2012, issue of the Journal.¹ We now summarize our understanding of this outbreak as of June 7, 2013.

CONTROLLED TRIAL OF PSYCHOTHERAPY FOR CONGOLESE SURVIVORS OF SEXUAL VIOLENCE

Judith K. Bass

N Engl J Med 2013, 368, pp2182-91

Survivors of sexual violence have high rates of depression, anxiety, and post-traumatic stress disorder (PTSD). Although treatment for symptoms related to sexual violence has been shown to be effective in high-income countries, evidence is lacking in low-income, conflict-affected countries.

In this trial in the Democratic Republic of Congo, we randomly assigned 16 villages to provide cognitive processing therapy (1 individual session and 11 group sessions) or individual support to female sexual-violence survivors with high levels of PTSD symptoms and combined depression and anxiety symptoms. One village was excluded owing to concern about the competency of the psychosocial assistant, resulting in 7 villages that provided therapy (157 women) and 8 villages that provided individual support (248 women). Assessments of combined depression and anxiety symptoms (average score on the Hopkins Symptom Checklist [range, 0 to 3, with higher scores indicating worse symptoms]), PTSD symptoms (average score on the PTSD Checklist [range, 0 to 3, with higher scores indicating worse symptoms]), and functional impairment (average score across 20 tasks [range, 0 to 4, with higher scores indicating greater impairment]) were performed at baseline, at the end of treatment, and 6 months after treatment ended.

A total of 65% of participants in the therapy group and 52% of participants in the individual-support group completed all three assessments. Mean scores for combined depression and anxiety improved in the individual-support group (2.2 at baseline, 1.7 at the end of treatment, and 1.5 at 6 months after treatment), but improvements were significantly greater in the therapy group (2.0 at baseline, 0.8 at the end of treatment, and 0.7 at 6 months after treatment) ($P < 0.001$ for all comparisons). Similar patterns were observed for PTSD and functional impairment. At 6 months after treatment, 9% of participants in the therapy group and 42% of participants in the individual-support group met criteria for probable depression or anxiety ($P < 0.001$), with similar results for PTSD.

In this study of sexual-violence survivors in a low-income, conflict-affected country, group psychotherapy reduced PTSD symptoms and combined de-

pression and anxiety symptoms and improved functioning.

CARDIOVASCULAR EFFECTS OF INTENSIVE LIFESTYLE INTERVENTION IN TYPE 2 DIABETES

N Engl J Med 2013, 369, pp145-54

Weight loss is recommended for overweight or obese patients with type 2 diabetes on the basis of short-term studies, but long-term effects on cardiovascular disease remain unknown. We examined whether an intensive lifestyle intervention for weight loss would decrease cardiovascular morbidity and mortality among such patients.

In 16 study centers in the United States, we randomly assigned 5145 overweight or obese patients with type 2 diabetes to participate in an intensive lifestyle intervention that promoted weight loss through decreased caloric intake and increased physical activity (intervention group) or to receive diabetes support and education (control group). The primary outcome was a composite of death from cardiovascular causes, nonfatal myocardial infarction, nonfatal stroke, or hospitalization for angina during a maximum follow-up of 13.5 years.

The trial was stopped early on the basis of a futility analysis when the median follow-up was 9.6 years. Weight loss was greater in the intervention group than in the control group throughout the study (8.6% vs. 0.7% at 1 year; 6.0% vs. 3.5% at study end). The intensive lifestyle intervention also produced greater reductions in glycated hemoglobin and greater initial improvements in fitness and all cardiovascular risk factors, except for low-density-lipoprotein cholesterol levels. The primary outcome occurred in 403 patients in the intervention group and in 418 in the control group (1.83 and 1.92 events per 100 person-years, respectively; hazard ratio in the intervention group, 0.95; 95% confidence interval, 0.83 to 1.09; $P = 0.51$).

An intensive lifestyle intervention focusing on weight loss did not reduce the rate of cardiovascular events in overweight or obese adults with type 2 diabetes.

USE OF ORAL FLUCONAZOLE DURING PREGNANCY AND THE RISK OF BIRTH DEFECTS

Ditte Molgaard-Nielsen

N Engl J med 2013, 369: 830-9

Oral fluconazole was not associated with a significantly increased risk of birth defects overall or of 14 of the 15 specific birth defects of previous concern.

COLISTIN AND RIFAMPICIN COMPARED WITH COLISTIN ALONE FOR THE TREATMENT OF SERIOUS INFECTIONS DUE TO EXTENSIVELY DRUG-RESISTANT ACINETOBACTER BAUMANNII: A MULTICENTER, RANDOMIZED CLINICAL TRIAL

Emanuele Durante-Mangoni

Clinical Infectious Diseases 2013, 57(3): 349-58

Extensively drug-resistant (XDR) *Acinetobacter baumannii* may cause serious infections in critically ill patients. Colistin often remains the only therapeutic option. Addition of rifampicin to colistin may be synergistic in vitro. In this study, we assessed whether the combination of colistin and rifampicin reduced the mortality of XDR *A. baumannii* infections compared to colistin alone.

This multicenter, parallel, randomized, open-label clinical trial enrolled 210 patients with life-threatening infections due to XDR *A. baumannii* from intensive care units of 5 tertiary care hospitals. Patients were randomly allocated (1:1) to either colistin alone, 2 MU every 8 hours intravenously, or colistin (as above), plus rifampicin 600 mg every 12 hours intravenously. The primary end point was overall 30-day mortality. Secondary end points were infection-related death, microbiologic eradication, and hospitalization length.

Death within 30 days from randomization occurred in 90 (43%) subjects, without difference between treatment arms ($P = .95$). This was confirmed by multivariable analysis (odds ratio, 0.88 [95% confidence interval, .46-1.69], $P = .71$). A significant increase of microbiologic eradication rate was observed in the colistin plus rifampicin arm ($P = .034$). No difference was observed for infection-related death and length of hospitalization.

In serious XDR *A. baumannii* infections, 30-day mortality is not reduced by addition of rifampic-

in to colistin. These results indicate that, at present, rifampicin should not be routinely combined with colistin in clinical practice. The increased rate of *A. baumannii* eradication with combination treatment could still imply a clinical benefit.

TRAVELERS WITH CUTANEOUS LEISHMANIASIS CURED WITHOUT SYSTEMIC THERAPY

Morizot G.

Clinical Infectious Diseases 2013, 57(3): 349-58

Cutaneous leishmaniasis (CL) is a disfiguring but not life-threatening disease. Because antileishmanial drugs are potentially toxic, the World Health Organization (WHO) recommends simple wound care or local therapy as first-line treatment, followed or replaced by systemic therapy if local therapy fails or cannot be performed.

To determine the feasibility and impact of the recommended approach, we analyzed the results of a centralized referral treatment program in 135 patients with parasitologically proven CL.

Infections involved 10 *Leishmania* species and were contracted in 29 different countries. Eighty-four of 135 patients (62%) were initially treated without systemic therapy. Of 109 patients with evaluable charts, 23 of 25 (92%) treated with simple wound care and 37 of 47 (79%) treated with local antileishmanial therapy were cured by days 42-60. In 37 patients with large or complex lesions, or preexisting morbidities, or who had not been cured with local therapy, the cure rate with systemic antileishmanial agents was 60%. Systemic adverse events were observed in 15 patients, all receiving systemic therapy.

In this population of CL patients displaying variable degrees of complexity and severity, almost two-thirds of patients could be initially managed without systemic therapy. Of these, 60 were cured before day 60. The WHO-recommended stepwise approach favoring initial local therapy therefore resulted in at least 44% of all patients being cured without exposure to the risk of systemic adverse events. Efforts are needed to further simplify local therapy of CL and to improve the management of patients with complex lesions and/or preexisting comorbidities.

BLOOD-PRESSURE TARGETS IN PATIENTS WITH RECENT LACUNAR STROKE: THE SPS3 RANDOMISED TRIAL

Lancet 2013, 382: 507-15

Lowering of blood pressure prevents stroke but optimum target levels to prevent recurrent stroke are unknown. We investigated the effects of different blood-pressure targets on the rate of recurrent stroke in patients with recent lacunar stroke.

In this randomised open-label trial, eligible patients lived in North America, Latin America, and Spain and had recent, MRI-defined symptomatic lacunar infarctions. Patients were recruited between March, 2003, and April, 2011, and randomly assigned, according to a two-by-two multifactorial design, to a systolic-blood-pressure target of 130–149 mm Hg or less than 130 mm Hg. The primary endpoint was reduction in all stroke (including ischaemic strokes and intracranial haemorrhages). Analysis was done by intention to treat. This study is registered with ClinicalTrials.gov, number NCT 00059306.

3020 enrolled patients, 1519 in the higher-target group and 1501 in the lower-target group, were followed up for a mean of 3.7 (SD 2.0) years. Mean age was 63 (SD 11) years. After 1 year, mean systolic blood pressure was 138 mm Hg (95% CI 137–139) in the higher-target group and 127 mm Hg (95% CI 126–128) in the lower-target group. Non-significant rate reductions were seen for all stroke (hazard ratio 0.81, 95% CI 0.64–1.03, $p=0.08$), disabling or fatal stroke (0.81, 0.53–1.23, $p=0.32$), and the composite outcome of myocardial infarction or vascular death (0.84, 0.68–1.04, $p=0.32$) with the lower target. The rate of intracerebral haemorrhage was reduced significantly (0.37, 0.15–0.95, $p=0.03$). Treatment-related serious adverse events were infrequent.

Although the reduction in stroke was not significant, our results support that in patients with recent lacunar stroke, the use of a systolic-blood-pressure target of less than 130 mm Hg is likely to be beneficial.

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EMERGING SOCIAL AND HEALTH ISSUES IN TUBERCULOSIS AND MALARIA IN DEVELOPING WORLD

N. Kulkova, I. Beldjebel, D. Komanicky, I. Kmit, M. Bartkovjak, J. Sokolova, G. Mikolasova, E. Ceploova, J. Benca, D. Horvathova, A. Kalavska, S. Dobrodenkova, T.L. Alumbasi, N. Hvizdakova, L. Vojtasova, M. Mojtová, M. Babalova, M. Bezekova, A. Krsakova, A. Ondrusova, J. M. Muli, J. Suvada, B. Silharova, E. Horvathova, P. Bukovinova, M. Chabadova, I. Szabo and Tropicteam Members

SEUC, University of Trnava, Slovakia

St. Charles Foucoud Clinic Beirut, Lebanon

Key words:

tuberculosis; leprosy; malaria

Abstract

Emerging problems in tuberculosis, malaria and other tropical disorders, including their Social impact is referenced from major Infectious diseases and global Health Journals by the members of the St. Elizabeth University College Tropicteam

OBESITY AND OUTCOMES IN PATIENTS HOSPITALIZED WITH PNEUMONIA

Kahlon S.

Clin Microbiol Infect 2013, 19: 709-716

Studies suggest obesity is paradoxically associated with better outcomes for patients with pneumonia. Therefore, we examined the impact of obesity on short-term mortality in patients hospitalized with pneumonia. For 2 years clinical and radiographic data were prospectively collected on all consecutive adults admitted with pneumonia to six hospitals in Edmonton, Alberta, Canada. We identified 907 patients who also had body mass index (BMI, kg/m²) collected and categorized them as underweight (BMI < 18.5), normal (18.5 to <25), overweight (25 to <30) and obese (>30). Overall, 65% were >65 years, 52% were female, and 15% reported recent weight loss. Eighty-four (9%) were underweight, 358 (39%) normal, 228 (25%) overweight, and 237 (26%) obese. Two-thirds had severe pneumonia (63% PSI Class IV/V) and 79 (9%) patients died. In-hospital mortality was greatest among those that were underweight (12 [14%]) compared with normal (36 [10%]), overweight (21 [9%]) or obese (10 [4%], $p < 0.001$ for trend). Compared with those of normal weight, obese patients had significantly lower rates of in-hospital mortality in multivariable logistic regression analyses: adjusted odds

ratio (OR), 0.46; 95% CI, 0.22-0.97; $p = 0.04$. However, compared with patients with normal weight, neither underweight (adjusted OR, 1.13; 95% CI, 0.54-2.4; $p = 0.7$) nor overweight (adjusted OR, 0.94; 95% CI, 0.52-1.69; $p = 0.8$) were associated with in-hospital mortality. In conclusion, in patients hospitalized with pneumonia, obesity was independently associated with lower short-term mortality, while neither being underweight nor overweight were. This suggests a protective influence of BMIs > 30 kg/m² that requires better mechanistic understanding.

A META-ANALYSIS OF SELF-ADMINISTERED VS DIRECTLY OBSERVED THERAPY EFFECT ON MICROBIOLOGIC FAILURE, RELAPSE AND ACQUIRED DRUG RESISTANCE IN TUBERCULOSIS PATIENTS

Jotam G. Pasipanodya

Clinical Infectious Diseases 2013, 57(1): 21-31

Preclinical studies and Monte Carlo simulations have suggested that there is a relatively limited role of adherence in acquired drug resistance (ADR) and that very high levels of nonadherence are needed for therapy failure. We

evaluated the superiority of directly observed therapy (DOT) for tuberculosis patients vs self-administered therapy (SAT) in decreasing ADR, microbiologic failure, and relapse in meta-analyses.

Prospective studies performed between 1965 and 2012 in which adult patients with microbiologically proven pulmonary *Mycobacterium tuberculosis* were separately assigned to either DOT or SAT as part of short-course chemotherapy were chosen. Endpoints were microbiologic failure, relapse, and ADR in patients on either DOT or SAT.

Ten studies, 5 randomized and 5 observational, met selection criteria: 8774 patients were allocated to DOT and 3708 were allocated to SAT. For DOT vs SAT, the pooled risk difference for microbiologic failure was .0 (95% confidence interval [CI], -.01 to .01), for relapse .01 (95% CI, -.03 to .06), and for ADR 0.0 (95% CI, -0.01 to 0.01). The incidence rates for DOT vs SAT were 1.5% (95% CI, 1.3%-1.8%) vs 1.7% (95% CI, 1.2%-2.2%) for microbiologic failure, 3.7% (95% CI, 0.7%-17.6%) vs 2.3% (95% CI, 0.7%-7.2%) for relapse, and 1.5% (95% CI, 0.2%-9.90%) vs 0.9% (95% CI, 0.4%-2.3%) for ADR, respectively. There was no evidence of publication bias.

DOT was not significantly better than SAT in preventing microbiologic failure, relapse, or ADR, in evidence-based medicine. Resources should be shifted to identify other causes of poor microbiologic outcomes.

U. S. HOSPITALIZATIONS FOR PNEUMONIA AFTER A DECADE OF PNEUMOCOCCAL VACCINATION

Marie R. Griffin

N Engl J Med 2013, 369: 155-63

The introduction of 7-valent pneumococcal conjugate vaccine (PCV7) into the U.S. childhood immunization schedule in 2000 has substantially reduced the incidence of vaccine-serotype invasive pneumococcal disease in young children and in unvaccinated older children and adults. By 2004, hospitalizations associated with pneumonia from any cause had also declined markedly among young children. Because of concerns about increases in disease caused by non-vaccine serotypes, we wanted to determine whether the reduction in pneumonia-related hospitalizations among young children had been sustained through 2009 and whether such hospitalizations in older age groups had also declined.

We estimated annual rates of hospitalization

for pneumonia from any cause using the Nationwide Inpatient Sample database. The reason for hospitalization was classified as pneumonia if pneumonia was the first listed diagnosis or if it was listed after a first diagnosis of sepsis, meningitis, or empyema. Average annual rates of pneumonia-related hospitalizations from 1997 through 1999 (before the introduction of PCV7) and from 2007 through 2009 (well after its introduction) were used to estimate annual declines in hospitalizations due to pneumonia.

The annual rate of hospitalization for pneumonia among children younger than 2 years of age declined by 551.1 per 100,000 children (95% confidence interval [CI], 445.1 to 657.1), which translates to 47,000 fewer hospitalizations annually than expected on the basis of the rates before PCV7 was introduced. The rate for adults 85 years of age or older declined by 1300.8 per 100,000 (95% CI, 984.0 to 1617.6), which translates to 73,000 fewer hospitalizations annually. For the three age groups of 18 to 39 years, 65 to 74 years, and 75 to 84 years, the annual rate of hospitalization for pneumonia declined by 8.4 per 100,000 (95% CI, 0.6 to 16.2), 85.3 per 100,000 (95% CI, 7.0 to 163.6), and 359.8 per 100,000 (95% CI, 199.6 to 520.0), respectively. Overall, we estimated an age-adjusted annual reduction of 54.8 per 100,000 (95% CI, 41.0 to 68.5), or 168,000 fewer hospitalizations for pneumonia annually.

Declines in hospitalizations for childhood pneumonia were sustained during the decade after the introduction of PCV7. Substantial reductions in hospitalizations for pneumonia among adults were also observed.

USE OF THE XPERT MTB/RIF ASSAY FOR DIAGNOSING PULMONARY TUBERCULOSIS COMORBIDITY AND MULTIDRUG-RESISTANT TB IN OBSTETRICS AND GYNAECOLOGY INPATIENT WARDS AT THE UNIVERSITY TEACHING HOSPITAL, LUSAKA, ZAMBIA

Matthew Bates

Tropical Medicine and International Health, Vol. 18, No. 9, pp: 1134-1140, Sept 2013

In high-tuberculosis (TB)-endemic countries, comorbidity of pulmonary TB in hospitalised patients with non-communicable diseases is well documented. In this study, we evaluated the use of the Xpert(®) MTB/RIF assay for the detection of concomitant pulmonary TB in patients admitted to the University Teaching Hospital, Lusaka, Zambia, with a primary

obstetric or gynaecological condition.

The Study population were inpatients admitted with a primary obstetric or gynaecological problem who had a concomitant cough and were able to expectorate a sputum sample. Sputum samples from 94 patients were analysed for the presence of *Mycobacterium tuberculosis* (M.tb) by standard smear microscopy, MGIT culture, MGIT drug-susceptibility testing (DST) and the Xpert(®) MTB/RIF assay. The sensitivity and specificity of the Xpert(®) MTB/RIF assay were evaluated against the culture gold standard.

Twenty-six of 94 (27.7%) patients had culture-confirmed pulmonary TB. The Xpert(®) MTB/RIF assay had a sensitivity of 80.8% [95% CI: 60.0-92.7%] compared against MGIT culture. The Xpert(®) MTB/RIF assay was more sensitive than sputum smear microscopy (21/26 (80.8%) vs. 13/26 (50.0%), $P = 0.02$) and detected an additional eight culture-confirmed cases. Culture DST analysis identified two monoresistant M.tb strains: one resistant to rifampicin (rifampicin sensitive by the Xpert(®) MTB/RIF assay) and one to ethambutol. HIV infection was linked with a 3-fold increase in risk of TB, accounting for 87.5% (21/24) of TB cases. 50% of cases presented as comorbidities with other communicable diseases (CDs) and non-communicable diseases (NCDs).

As an alternative to sputum microscopy, the Xpert(®) MTB/RIF assay provides a sensitive, specific and rapid method for the diagnosis of pulmonary TB in obstetric or gynaecological inpatients. Pulmonary TB is an important cause of concomitant comorbidity to the obstetric or gynaecological condition necessitating admission. TB and HIV comorbidities with other communicable and non-communicable diseases were also common. More proactive screening for TB comorbidity is required in obstetric and gynaecological wards.

A SYSTEMATIC REVIEW OF THE EFFECTIVENESS OF HOSPITAL AND AMBULATORY-BASED MANAGEMENT OF MULTIDRUG-RESISTANT TUBERCULOSIS

Amal Bassili

Am J Trop Med Hyg, 89(2), 2013, pp: 271-280

A systematic review of the literature was conducted on the effectiveness of MDR-TB management. A meta-analysis of treatment outcomes of patients treated in hospitals versus ambulatory-based models was performed in accordance with PRISMA guidelines. The pooled treatment success rate was 66.4%

(95% confidence interval [CI] 61.4-71.1%), with no statistical difference between ambulatory (65.5%; 55.1-74.6%) and hospital-based models (66.7%; 61.0-72.0%). The pooled death rate was 10.4% (6.3-16.5%), the pooled treatment failure rate was 9.5% (7.3-12.4%), and the defaulter rate was 14.3% (10.5-19.1%). None of the differences between the two models were statistically significant for any of the outcomes considered. This work improves the quality of the evidence available supporting the World Health Organizations (WHO) recommendation that patients be treated using mainly ambulatory care, conditional on infection control measures in the home and clinic, clinical condition of the patient, availability of treatment support to facilitate adherence to treatment, and provisions for backup facility to manage patients who need inpatient treatment care.

ATTRIBUTABLE MORTALITY OF VENTILATOR-ASSOCIATED PNEUMONIA: A META-ANALYSIS OF INDIVIDUAL PATIENT DATA FROM RANDOMISED PREVENTION STUDIES

Wilhemina G. Melsen

Lancet Infect Dis 2013, 13: 665-71

Estimating attributable mortality of ventilator-associated pneumonia has been hampered by confounding factors, small sample sizes, and the difficulty of doing relevant subgroup analyses. We estimated the attributable mortality using the individual original patient data of published randomised trials of ventilator-associated pneumonia prevention.

We identified relevant studies through systematic review. We analysed individual patient data in a one-stage meta-analytical approach (in which we defined attributable mortality as the ratio between the relative risk reductions [RRR] of mortality and ventilator-associated pneumonia) and in competing risk analyses. Predefined subgroups included surgical, trauma, and medical patients, and patients with different categories of severity of illness scores.

Individual patient data were available for 6284 patients from 24 trials. The overall attributable mortality was 13%, with higher mortality rates in surgical patients and patients with mid-range severity scores at admission (ie, acute physiology and chronic health evaluation score [APACHE] 20-29 and simplified acute physiology score [SAPS 2] 35-58). Attributable mortality was close to zero in trauma, medical patients, and patients with low or high severity of illness scores. Competing risk analyses could be done

for 5162 patients from 19 studies, and the overall daily hazard for intensive care unit (ICU) mortality after ventilator-associated pneumonia was 1.13 (95% CI 0.98-1.31). The overall daily risk of discharge after ventilator-associated pneumonia was 0.74 (0.68-0.80), leading to an overall cumulative risk for dying in the ICU of 2.20 (1.91-2.54). Highest cumulative risks for dying from ventilator-associated pneumonia were noted for surgical patients (2.97, 95% CI 2.24-3.94) and patients with mid-range severity scores at admission (ie, cumulative risks of 2.49 [1.81-3.44] for patients with APACHE scores of 20-29 and 2.72 [1.95-3.78] for those with SAPS 2 scores of 35-58).

The overall attributable mortality of ventilator-associated pneumonia is 13%, with higher rates for surgical patients and patients with a mid-range severity score at admission. Attributable mortality is mainly caused by prolonged exposure to the risk of dying due to increased length of ICU stay.

UNIVERSAL ACCESS TO CARE FOR MULTIDRUG-RESISTANT TUBERCULOSIS AN ANALYSIS OF SURVEILLANCE DATA

Dennis Falzon

Lancet Infect Dis 2013, 13: 690-97

The prospects for global tuberculosis control in the near future will be determined by the effectiveness of the response of countries to their burden of multidrug-resistant (MDR; resistance to, at least, isoniazid and rifampicin) tuberculosis. During the 2009 World Health Assembly, countries committed to achieve universal access to MDR-tuberculosis care by 2015. We assessed the progress towards the 2015 targets achieved by countries accounting for 90% of the estimated MDR-tuberculosis cases in the world in 2011.

We analysed data reported to WHO by 30 countries expected to have more than 1000 MDR-tuberculosis cases among notified patients with pulmonary tuberculosis in 2011.

In the 30 countries, 18% of the estimated MDR-tuberculosis cases were enrolled on treatment in 2011. Belarus, Brazil, Kazakhstan, Peru, South Africa, and Ukraine each detected and enrolled on treatment more than 50% of their estimated cases of MDR-tuberculosis. In Ethiopia, India, Indonesia, the Philippines, and Russia, enrolments increased steadily between 2009 and 2011 with a mean yearly change greater than 50%; however, in these countries enrolment in 2011 was low, ranging from 4% to

43% of the estimated cases. In the remaining countries (Afghanistan, Angola, Azerbaijan, Bangladesh, China, Democratic Republic of the Congo, Kenya, Kyrgyzstan, Moldova, Mozambique, Burma, Nepal, Nigeria, North Korea, Pakistan, South Korea, Thailand, Uzbekistan, and Vietnam) progress in detection and enrolment was slower. In 23 countries, a median of 53% (IQR 41—71) patients with MDR-tuberculosis successfully completed their treatment after starting it in 2008—09.

PLASMODIUM VIVAX MALARIA PRESENTING AS ACUTE RESPIRATORY DISTRESS SYNDROME: A CASE REPORT

Ahmad Kashfi Ab Rahman

Tropical Doctor 2013, 43, (2), 83-85

Severe pulmonary involvement in malaria has been frequently reported in cases of *Plasmodium falciparum* infection but rarely in vivax malaria. We look at a case of a 38-year-old man living in a malaria endemic area who presented with acute respiratory distress syndrome (ARDS) caused by *P. vivax*. DNA polymerase chain reaction (PCR) confirmed that it was not a mixed infection. After specific antimalarial therapy and intensive supportive care, the patient was discharged from the hospital. This case illustrates that *P. vivax*-induced ARDS is not uncommon and should be readily recognized by the treating physicians. A confirmatory test with PCR is required in order to exclude *P. falciparum* co-infection.

POST-MALARIA NEUROLOGICAL SYNDROME: A RARE MANIFESTATION OF COMMON DISEASE

Rajeev Nayak

Tropical Doctor 2013, 43, (2), 86-87

Several systemic and neurological complications can occur with *Plasmodium falciparum* malaria, of which cerebral malaria is well known and is the most serious. Rarely, patients may suffer a neurological disorder that occurs after complete recovery from *P. falciparum* infection, an entity known as post-malaria neurological syndrome (PMNS). It is a rare and transient clinical syndrome in which patients with symptomatic malaria infection, after parasitic clearance from the peripheral blood, develop neurological

symptoms within 2 months of recovery. We report a case of PMNS manifesting as bilateral common peroneal nerve palsy leading to foot drop.

ADULT MALARIA CHEMOPROPHYLAXIS PRESCRIBING PATTERNS IN THE MILITARY HEALTH SYSTEM FROM 2007-2011

Coleen M. Kersgard

Am J Trop Med Hyg, 89(2), 2013, pp: 317-325

The Military Health System (MHS), with 9.7 million beneficiaries, represents an enormous pool of potential travelers requiring malaria prevention measures. A systematic search of the MHS electronic pharmacy record was performed for prescriptions of atovaquone-proguanil (AP), chloroquine (CQ), doxycycline (DC), mefloquine (MQ), primaquine (PQ) to adult patients from 2007 through 2011. Over 1,000,000 were identified, including 161,341 primary prophylaxis prescriptions originating from civilian facilities. Military facility prescription volume rose from 50,128 (PQ < 1%, AP 4%, CQ 6%, DC 53%, MQ 36%) in 2007 to 166,649 (PQ < 1%, AP 3%, CQ < 1%, DC 94%, MQ 2%) in 2011. Mefloquine use diminished in all clinics over time. The majority of military facility prescriptions originated from primary care clinics (83%); primary care clinics predominantly and increasingly prescribed DC, whereas specialty travel clinics predominantly and increasingly prescribed AP. Prescribing patterns in the MHS varied by time, practice setting, beneficiary status, and provider specialty. These changes, including among non-active duty military patients, are temporally associated with policy changes intended for the active duty force.

FURTHER SHRINKING THE MALARIA MAP: HOW CAN GEOSPATIAL SCIENCE HELP TO ACHIEVE MALARIA ELIMINATION?

Archie C. A. Clements

Lancet Infect Dis 2013, 13: 709-18

Malaria is one of the biggest contributors to deaths caused by infectious disease. More than 30 countries have planned or started programmes to target malaria elimination, often with explicit support from international donors. The spatial distribution of malaria, at all levels of endemicity, is heterogeneous. Moreover, populations living in low-endemic set-

tings where elimination efforts might be targeted are often spatially heterogeneous. Geospatial methods, therefore, can help design, target, monitor, and assess malaria elimination programmes. Rapid advances in technology and analytical methods have allowed the spatial prediction of malaria risk and the development of spatial decision support systems, which can enhance elimination programmes by enabling accurate and timely resource allocation. However, no framework exists for assessment of geospatial instruments. Research is needed to identify measurable indicators of elimination progress and to quantify the effect of geospatial methods in achievement of elimination outcomes.

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MALNUTRITION AND MATERNAL / GLOBAL SOCIAL / HEALTH DEVELOPMENT

Benca J., Bartkovjak M., Bukovinova P., Kalavska A., Kafkova J., Ceploova E., Hvizdakova N., Kolibab M., Dobrodenkova S., Marada J., Franekova M., Kuranova Z., Vojtasova L., M. Mojtoová, Silharova S., Horvathova D., Muli J.M., Ondrusova A., Krsakova A., Discantini V., Babalova M., Bezekova M., Vojtikevicova E., Horvathova E., Kmit I.

St. Elizabeth University Bratislava, Slovakia

Key words:

malnutrition; child; healths; psychosocial; sequent

Abstract

Maternal undernutrition contributes to 800 000 neonatal deaths annually through small for gestational age births; stunting, wasting, and micronutrient deficiencies are estimated to underlie nearly 3•1 million child deaths annually. Progress has been made with many interventions implemented at scale and the evidence for effectiveness of nutrition interventions.

ASSOCIATIONS OF LINEAR GROWTH AND RELATIVE WEIGHT GAIN DURING EARLY LIFE WITH ADULT HEALTH AND HUMAN CAPITAL IN COUNTRIES OF LOW AND MIDDLE INCOME: FINDINGS FROM FIVE BIRTH COHORT STUDIES

Linda S Adair

Lancet 2013, 382: 525-34

Fast weight gain and linear growth in children in low-income and middle-income countries are associated with enhanced survival and improved cognitive development, but might increase risk of obesity and related adult cardio-metabolic diseases. We investigated how linear growth and relative weight gain during infancy and childhood are related to health and human capital outcomes in young adults.

We used data from five prospective birth cohort studies from Brazil, Guatemala, India, the Philippines, and South Africa. We investigated body-mass index, systolic and diastolic blood pressure, plasma glucose concentration, height, years of attained schooling, and related categorical indicators of adverse outcomes in young adults. With linear and logistic regression models, we assessed how these outcomes relate

to birthweight and to statistically independent measures representing linear growth and weight gain independent of linear growth (relative weight gain) in three age periods: 0-2 years, 2 years to mid-childhood, and mid-childhood to adulthood.

We obtained data for 8362 participants who had at least one adult outcome of interest. A higher birthweight was consistently associated with an adult body-mass index of greater than 25 kg/m² (odds ratio 1.28, 95% CI 1.21-1.35) and a reduced likelihood of short adult stature (0.49, 0.44-0.54) and of not completing secondary school (0.82, 0.78-0.87). Faster linear growth was strongly associated with a reduced risk of short adult stature (age 2 years: 0.23, 0.20-0.52; mid-childhood: 0.39, 0.36-0.43) and of not completing secondary school (age 2 years: 0.74, 0.67-0.78; mid-childhood: 0.87, 0.83-0.92), but did raise the likelihood of overweight (age 2 years: 1.24, 1.17-1.31; mid-childhood: 1.12, 1.06-1.18) and elevated blood pressure (age 2 years: 1.12, 1.06-1.19; mid-childhood: 1.07, 1.01-1.13). Faster relative weight gain was associated with an increased risk of adult overweight (age 2 years: 1.51, 1.43-1.60; mid-childhood: 1.76, 1.69-1.91) and elevated blood pressure (age 2 years: 1.07, 1.01-1.13; mid-childhood: 1.22, 1.15-1.30). Linear growth and relative weight gain were not associated with dysglycaemia, but a higher birthweight was associated with decreased risk of the disorder (0.89, 0.81-0.98).

Interventions in countries of low and middle income to increase birthweight and linear growth

during the first 2 years of life are likely to result in substantial gains in height and schooling and give some protection from adult chronic disease risk factors, with few adverse trade-offs.

NUTRITION-SENSITIVE INTERVENTIONS AND PROGRAMMES: HOW CAN THEY HELP TO ACCELERATE PROGRESS IN IMPROVING MATERNAL AND CHILD NUTRITION?

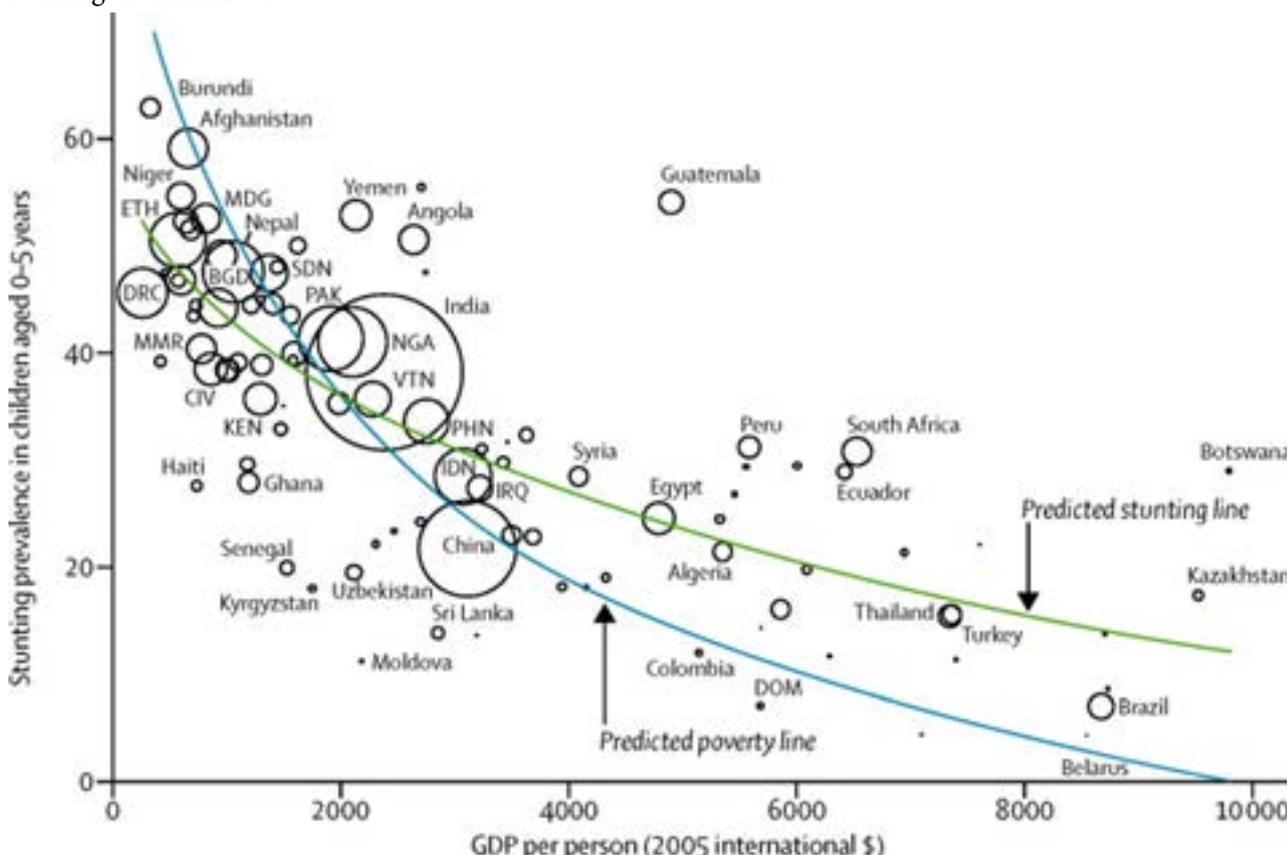
Marie T Ruel

Lancet 2013, 382: 536-51

Acceleration of progress in nutrition will require effective, large-scale nutrition-sensitive programmes that address key underlying determinants of nutrition and enhance the coverage and effectiveness of nutrition-specific interventions. We reviewed evidence of nutritional effects of programmes in four sectors—agriculture, social safety nets, early child development, and schooling. The need for investments to boost agricultural production, keep prices low, and increase incomes is undisputable; targeted agricultural programmes can complement these investments by supporting livelihoods, enhancing access to diverse diets in poor populations, and fostering women's empowerment. However, evidence of the nutritional

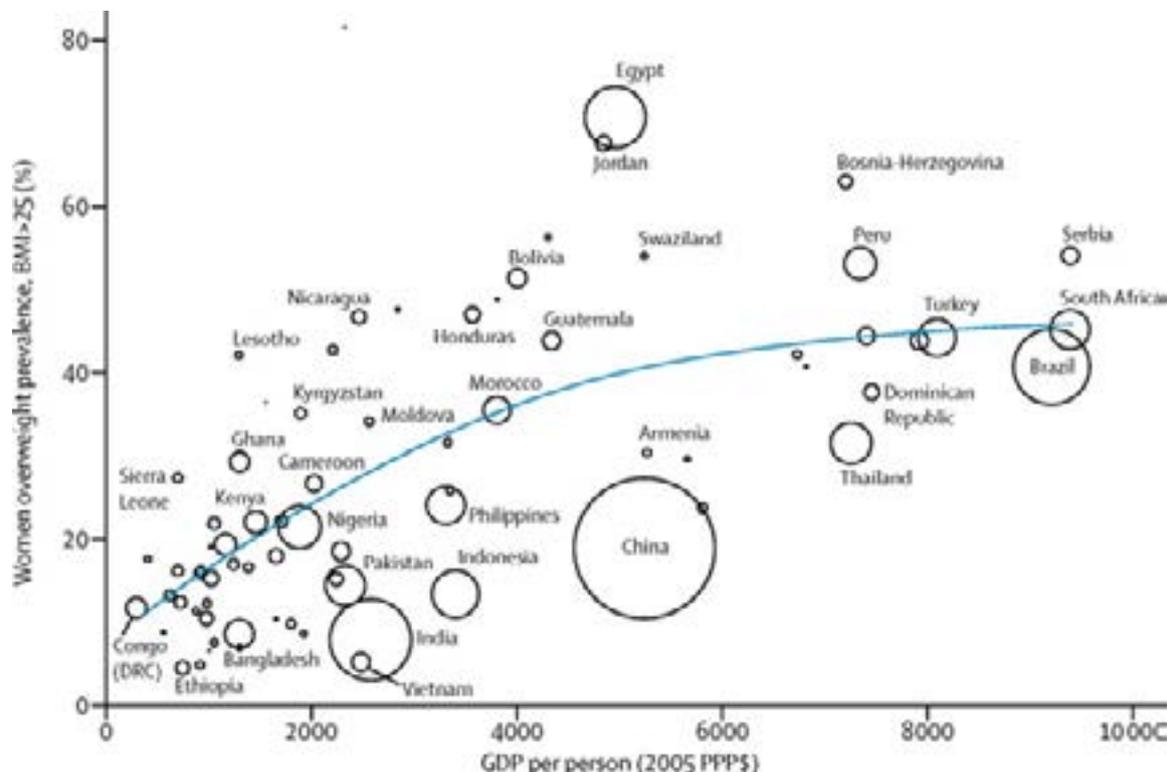
effect of agricultural programmes is inconclusive—except for vitamin A from biofortification of orange sweet potatoes—largely because of poor quality evaluations. Social safety nets currently provide cash or food transfers to a billion poor people and victims of shocks (eg, natural disasters). Individual studies show some effects on younger children exposed for longer durations, but weaknesses in nutrition goals and actions, and poor service quality probably explain the scarcity of overall nutritional benefits. Combined early child development and nutrition interventions show promising additive or synergistic effects on child development—and in some cases nutrition—and could lead to substantial gains in cost, efficiency, and effectiveness, but these programmes have yet to be tested at scale. Parental schooling is strongly associated with child nutrition, and the effectiveness of emerging school nutrition education programmes needs to be tested. Many of the programmes reviewed were not originally designed to improve nutrition yet have great potential to do so. Ways to enhance programme nutrition-sensitivity include: improve targeting; use conditions to stimulate participation; strengthen nutrition goals and actions; and optimise women's nutrition, time, physical and mental health, and empowerment. Nutrition-sensitive programmes can help scale up nutrition-specific interventions and create a stimulating environment in which young children can grow and develop to their full potential.

Figure 1. Prevalence of stunting in children aged 0–5 years and GDP per person. Most observations for prevalence of stunting are from 2000–08.



The fitted curves are locally weighted regressions of prevalence of stunting in children aged 0–5 years and poverty (<\$1.25 per person, per day), against GDP per person. The adjustment to international dollar units converts income expressed in nominal dollars to one that is expressed in terms of international dollars, which have the same estimated purchasing power as a dollar in the USA, accounting for local prices. The size of the circles represents the estimated population of stunted children aged 0–5 years, in about 2005, on the basis of multiplication of stunting prevalence by UN estimates of the population of children aged 0–5 years. Data are sourced principally from the Demographic and Health Surveys,¹⁸ with observations for some countries sourced from WHO.¹⁹ GDP=gross domestic product. BGD=Bangladesh. CIV=Côte d’Ivoire. DOM=Dominican Republic. DRC=Democratic Republic of the Congo. ETH=Ethiopia. IDN=Indonesia. IRQ=Iraq. MDG=Madagascar. MMR=Myanmar (Burma). KEN=Kenya. NGA=Nigeria. PAK=Pakistan. PHN=Philippines. SDN=Sudan. VTN=Vietnam.

Figure 2. Prevalence of women overweight (BMI>25) and GDP per person, for low-income and middle-income countries. Most observations for prevalence of women overweight are from 2000–10.



The fitted curve is a locally weighted regression of prevalence of women overweight against GDP per person. The correlation between prevalence of women overweight and the log of GDP per person is 0.71 and is significant at the 1% level. The size of the circles represents the estimated population of overweight women aged 15–49 years, in about 2005, on the basis of multiplication of prevalence of women overweight by the UN population estimates of the female population aged 15–49 years. Data are sourced principally from the Demographic and Health Surveys¹⁸ and WHO.¹⁹ DRC=Democratic Republic of the Congo. GDP=gross domestic product. PPP=purchasing power parity.

THE POLITICS OF REDUCING MALNUTRITION: BUILDING COMMITMENT AND ACCELERATING PROGRESS

Stuart Gillespie

Lancet 2013, 382: 552-69

In the past 5 years, political discourse about the challenge of undernutrition has increased substantially at national and international levels and has led to stated commitments from many national governments, international organisations, and donors. The Scaling Up Nutrition movement has both driven,

and been driven by, this developing momentum. Harmonisation has increased among stakeholders, with regard to their understanding of the main causes of malnutrition and to the various options for addressing it. The main challenges are to enhance and expand the quality and coverage of nutrition-specific interventions, and to maximise the nutrition sensitivity of more distal interventions, such as agriculture, social protection, and water and sanitation. But a crucial third level of action exists, which relates to the environments and processes that underpin and shape political and policy processes. We focus on this neglected level. We address several fundamental questions: how can enabling environments and processes be cultivated, sustained, and ultimately translated into

results on the ground? How has high-level political momentum been generated? What needs to happen to turn this momentum into results? How can we ensure that high-quality, well-resourced interventions for nutrition are available to those who need them, and that agriculture, social protection, and water and sanitation systems and programmes are proactively reoriented to support nutrition goals? We use a six-cell framework to discuss the ways in which three domains (knowledge and evidence, politics and governance, and capacity and resources) are pivotal to create and sustain political momentum, and to translate momentum into results in high-burden countries.

MATERNAL AND CHILD UNDERNUTRITION AND OVERWEIGHT IN LOW-INCOME AND MIDDLE-INCOME COUNTRIES

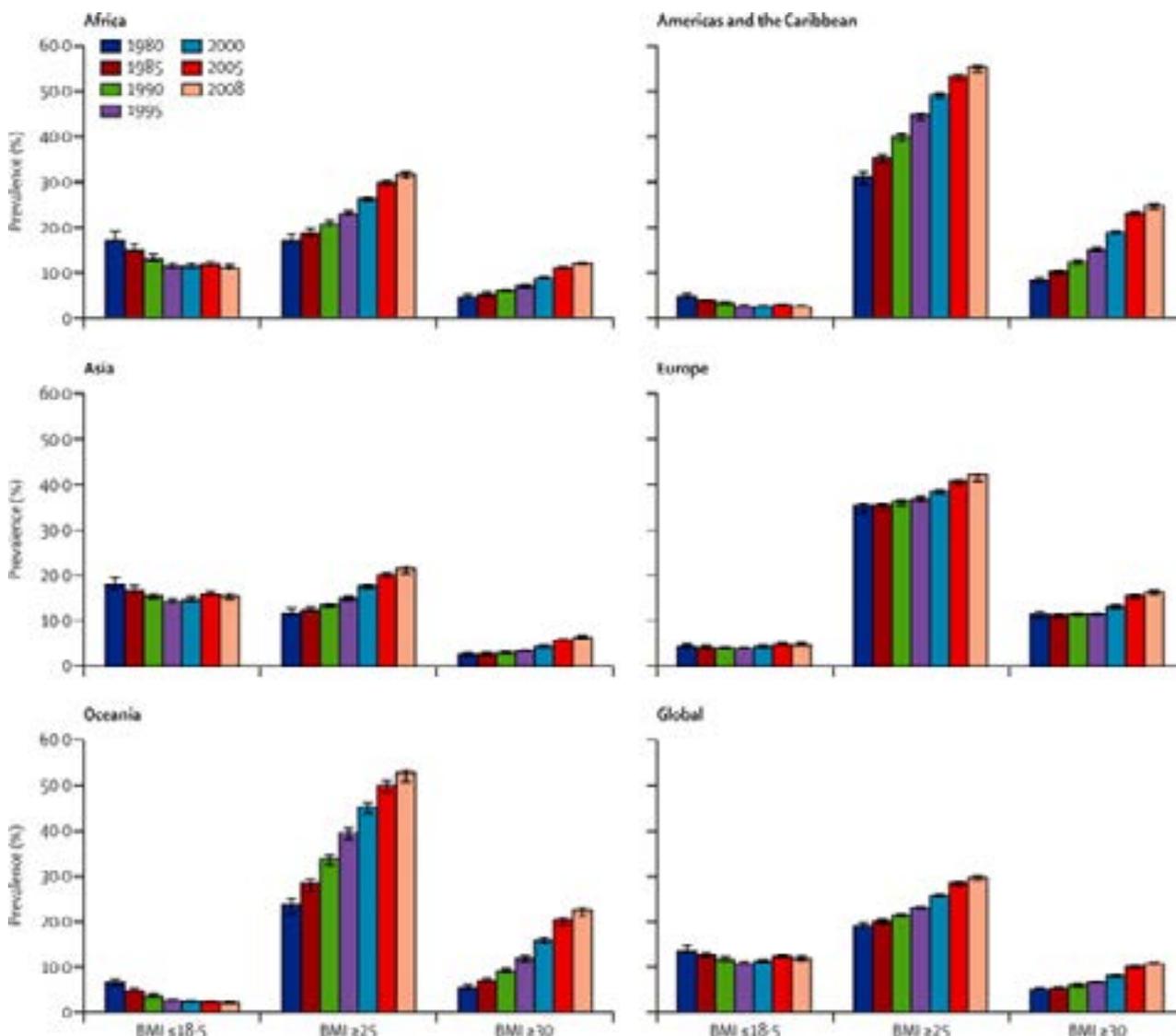
Robert E. Black

Lancet 2013, 382: 427-51

Maternal and child malnutrition in low-income and middle-income countries encompasses both undernutrition and a growing problem with overweight and obesity. Low body-mass index, indicative of maternal undernutrition, has declined somewhat in the past two decades but continues to be prevalent in Asia and Africa. Prevalence of maternal overweight has had a steady increase since 1980 and exceeds that of underweight in all regions. Prevalence of stunting of linear growth of children younger than 5 years has decreased during the past two decades, but is higher in south Asia and sub-Saharan Africa than elsewhere and globally affected at least 165 million children in 2011; wasting affected at least 52 million children. Deficiencies of vitamin A and zinc result in deaths; deficiencies of iodine and iron, together with stunting, can contribute to children not reaching their developmental potential. Maternal undernutrition contributes to fetal growth restriction, which increases the risk of neonatal deaths and, for survivors, of stunting by 2 years of age. Suboptimum breastfeeding results in an increased risk for mortality in the first 2 years of life. We estimate that undernutrition in the aggregate—including fetal growth restriction, stunting, wasting, and deficiencies of vitamin A and zinc along with suboptimum breastfeeding—is a cause of 3.1 million child deaths annually or 45% of all child deaths in 2011. Maternal overweight and obesity result in increased maternal morbidity and infant mortality. Childhood overweight is becoming an increasingly important contributor to adult obesity, diabetes,

and non-communicable diseases. The high present and future disease burden caused by malnutrition in women of reproductive age, pregnancy, and children in the first 2 years of life should lead to interventions focused on these groups.

Figure 3. Trends in thinness (BMI <18.5 kg/m²), overweight (BMI ≥25 kg/m²), and obesity (BMI ≥30 kg/m²), using population weighted average prevalences for women aged 20–49 years UN regions and globally, 1980–2008. Error bars are 95% CIs.



BMI=body-mass index.

Table 1. Prevalence of vitamin A deficiency (1995–2005), iodine deficiency (2013), inadequate zinc intake (2005), and iron deficiency anaemia (2011)

	Vitamin A deficiency				Iodine deficiency (UIC <100 µg/L)	Zinc deficiency (weighted average of country means)	Iron deficiency anaemia (haemoglobin <110 g/L)	
	Children <5 years		Pregnant women				Children <5 years	Pregnant women
	Night blindness	Serum retinol <0.70 µmol/L	Night blindness	Serum retinol <0.70 µmol/L				
Global	0.9% (0.1–1.8)	33.3% (29.4–37.1)	7.8% (6.5–9.1)	15.3% (6.0–24.6)	28.5% (28.2–28.9)	17.3% (15.9–18.8)	18.1% (15.6–20.8)	19.2% (17.1–21.5)

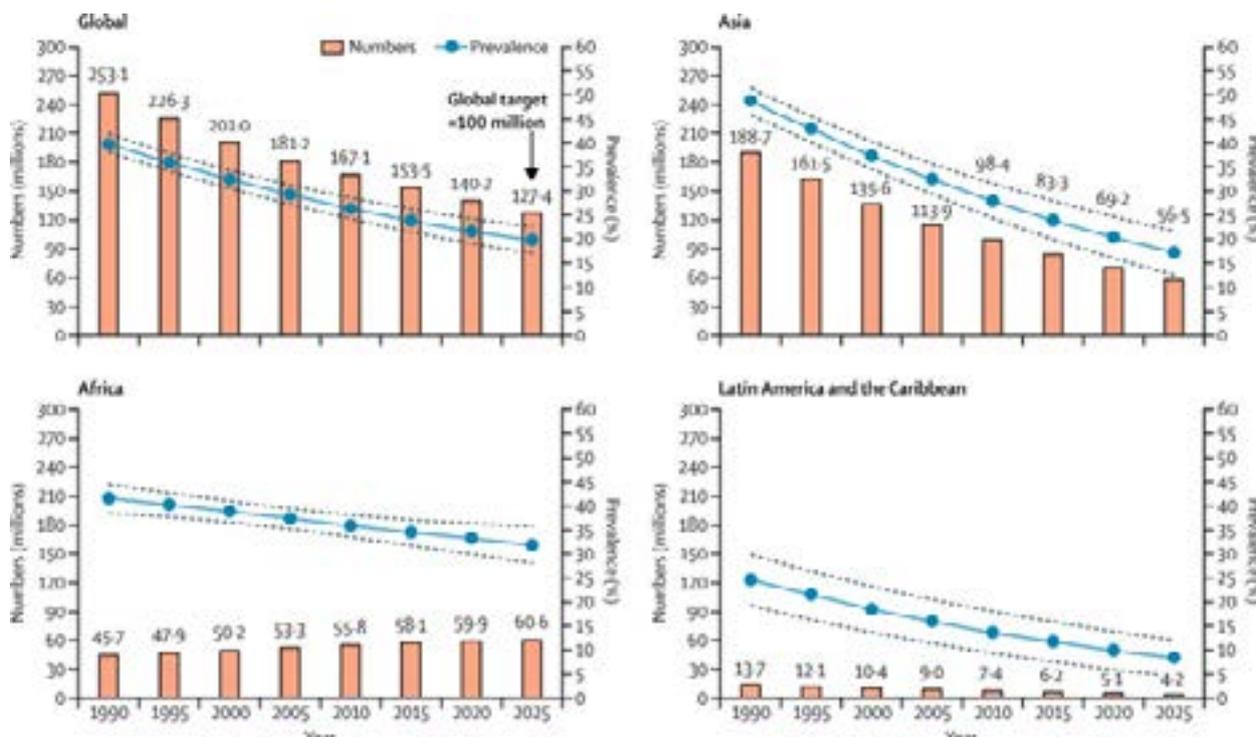
Africa	2.1% (1.0–3.1)	41.6% (34.4–44.9)	9.4% (8.1–10.7)	14.3% (9.7–19.0)	40.0% (39.4–40.6)	23.9% (21.1–26.8)	20.2% (18.6–21.7)	20.3% (18.3–22.4)
Americas and the Caribbean	0.6% (0.0–1.3)	15.6% (6.6–24.5)	4.4% (2.7–6.2)	2.0% (0.4–3.6)	13.7% (12.5–14.8)	9.6% (6.8–12.4)	12.7% (9.8–16.0)	15.2% (11.7–18.6)
Asia	0.5% (0.0–1.3)	33.5% (30.7–36.3)	7.8% (6.6–9.0)	18.4% (5.4–31.4)	31.6% (30.7–32.5)	19.4% (16.9–22.0)	19.0% (14.5–23.4)	19.8% (15.8–23.5)
Europe	0.7% (0.0–1.5)	14.9% (0.1–29.7)	2.9% (1.1–4.6)	2.2% (0.0–4.3)	44.2% (43.5–45.0)	7.6% (6.2–9.1)	12.1% (7.8–16.2)	16.2% (12.6–19.7)
Oceania	0.5% (0.1–1.0)	12.6% (6.0–19.2)	9.2% (0.3–18.2)	1.4% (0.0–4.0)	17.3% (16.6–18.1)	5.7% (1.0–10.3)	15.4% (7.0–25.2)	17.2% (9.7–25)

Table 2. Global deaths in children younger than 5 years attributed to nutritional disorders

	Attributable deaths with UN prevalences*	Proportion of total deaths of children younger than 5 years	Attributable deaths with NIMS prevalences†	Proportion of total deaths of children younger than 5 years
Fetal growth restriction (<1 month)	817 000	11.8%	817 000	11.8%
Stunting (1–59 months)	1 017 000	14.7%	1 179 000	17.0%
Underweight (1–59 months)	999 000	14.4%	1 180 000	17.0%
Wasting (1–59 months)	875 000	12.6%	800 000	11.5%
Severe wasting (1–59 months)	516 000	7.4%	540 000	7.8%
Zinc deficiency (12–59 months)	116 000	1.7%	116 000	1.7%
Vitamin A deficiency (6–59 months)	157 000	2.3%	157 000	2.3%
Suboptimum breastfeeding (0–23 months)	804 000	11.6%	804 000	11.6%
Joint effects of fetal growth restriction and suboptimum breastfeeding in neonates	1 348 000	19.4%	1 348 000	19.4%
Joint effects of fetal growth restriction, suboptimum breastfeeding, stunting, wasting, and vitamin A and zinc deficiencies (<5 years)	3 097 000	44.7%	3 149 000	45.4%

Data are to the nearest thousand.*Prevalence estimates from the UN.†Prevalence estimates from Nutrition Impact Model Study (NIMS).

Figure 4. Trends in prevalence and numbers of children with stunted growth (HAZ <-2), by selected UN regions and globally, 1990–2010, and projected to 2025 on the basis of UN prevalence estimates HAZ=height-for-age Z score.



Data from UNICEF, WHO, World Bank.154

Figure 5. Trends in prevalence and numbers of overweight (WHZ >2) children, by selected UN regions and globally, 1990–2010, and projected to 2025, on the basis of UN prevalence estimates WHZ=weight-for-height Z score.

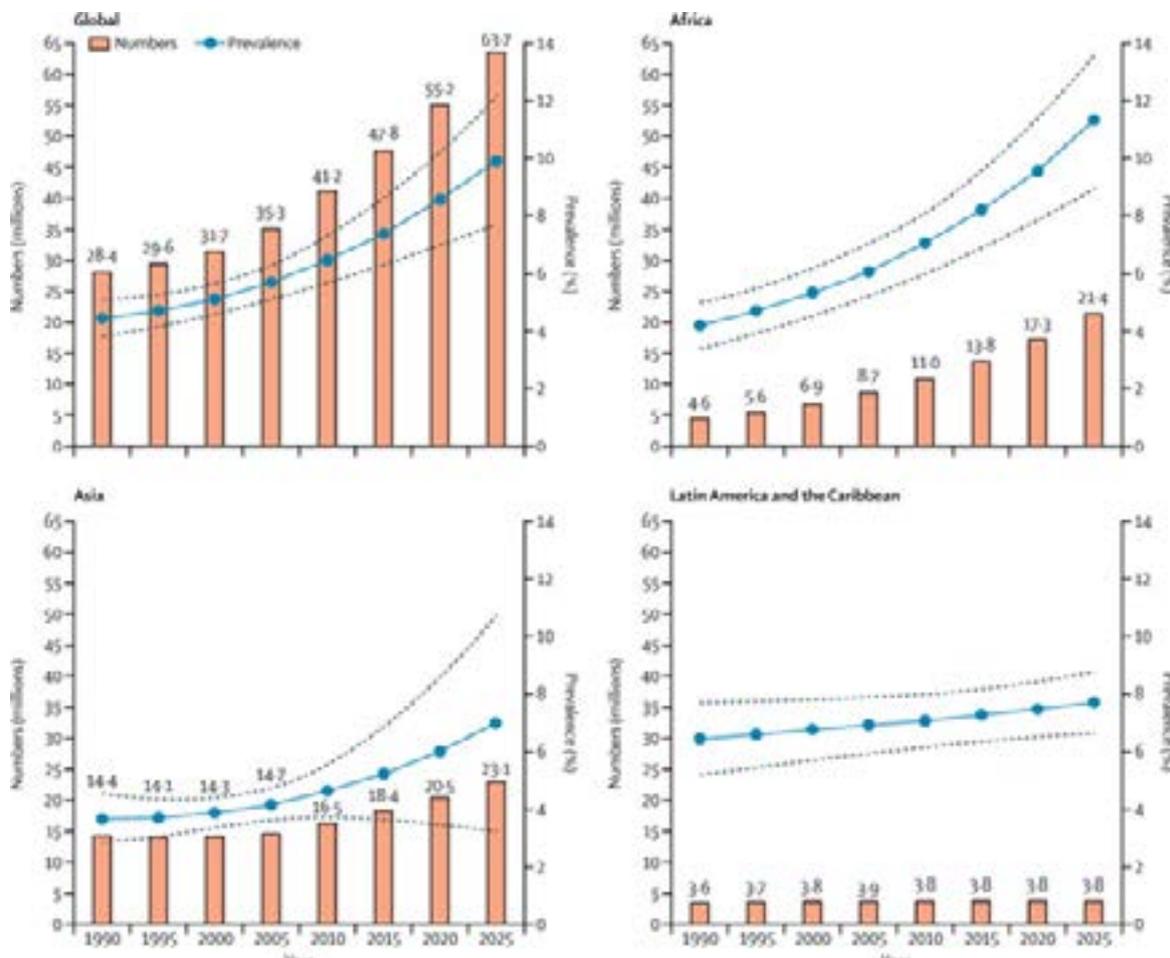
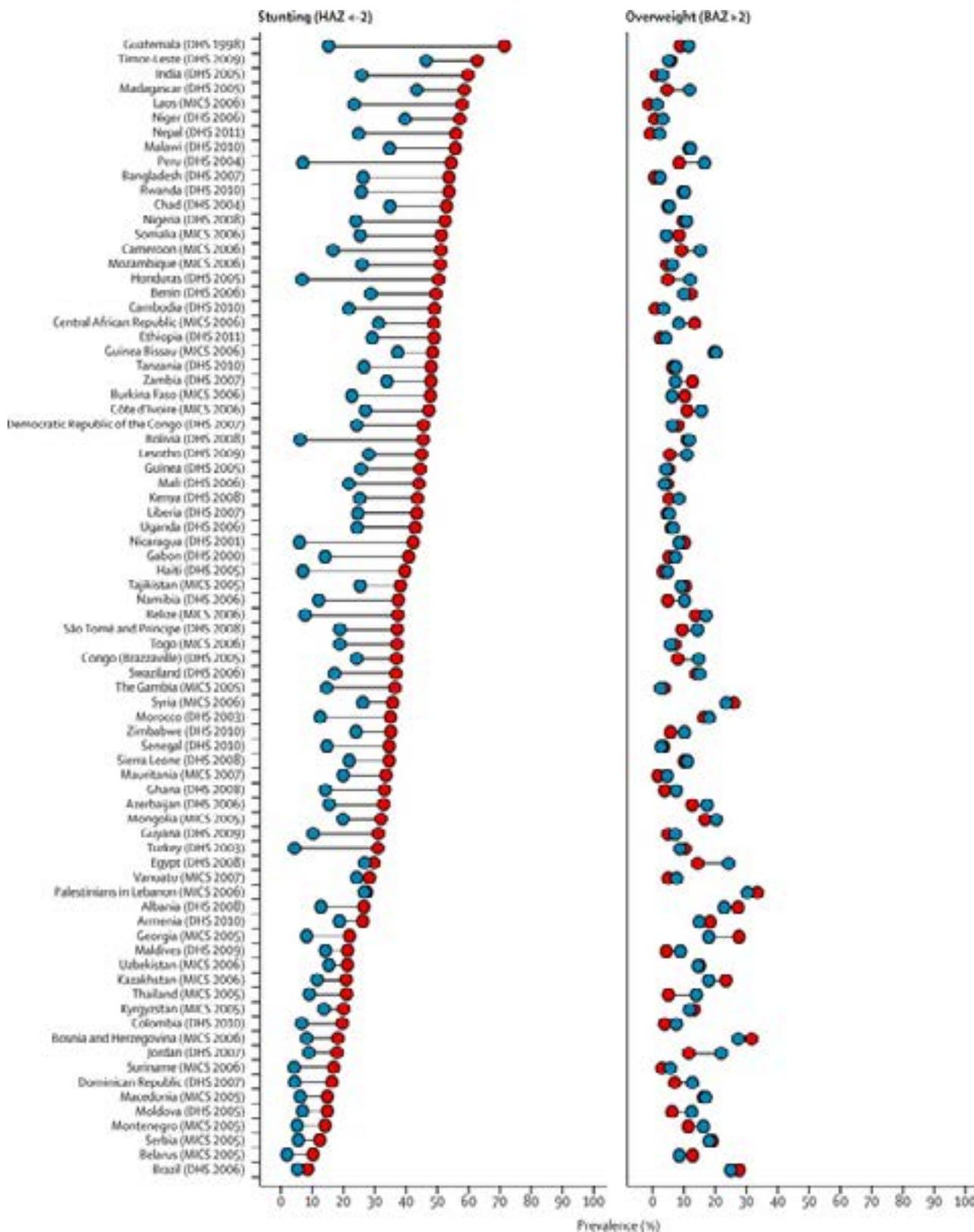


Figure 6. Prevalence of stunting (HAZ <-2 Z scores below median) and overweight (BAZ >2 Z scores above median) for highest and lowest wealth quintiles in selected countries. Red circles are lowest wealth quintiles, blue circles are highest wealth quintiles.



HAZ=height-for-age Z score. DHS=Demographic and Health Survey. MICS=Multiple Indicator Cluster Survey. BAZ=body-mass index for age Z score.

Globally, 165 million children are stunted, undernutrition underlies 3.1 million

Promising interventions exist to improve maternal nutrition and reduce fetal growth restriction and small-for-gestational-age (SGA) births in appropriate settings in developing countries, if scaled up before and during pregnancy. These interventions include balanced energy protein, calcium and multiple micronutrient supplementation and preventive strategies for malaria in pregnancy.

Reduction of SGA in at-risk populations, although further evidence from effectiveness assessments might be needed to guide a universal policy change.

Data for the effect of various.

Conditional cash transfers and related.

Innovative delivery strategies.

Nearly 15% of deaths of children younger than 5 years can be reduced.

The maximum effect on lives saved is noted with management of acute malnutrition.

The additional cost of achieving 90% coverage of these proposed interventions would be Int\$9.6 billion per year.

A

Folic acid supplementation

Neural tube defects can be a 72% reduction in risk of development of neural tube defects and a 68% reduction in risk. Review of folic acid supplementation during pregnancy showed that folic acid supplementation improved mean birthweight, with a 79% reduction in the incidence of megaloblastic anaemia. Fortification of cereals and other foods might be a feasible way to reach the population in need.

Iron or iron and folic acid supplementation

Maternal multiple micronutrient supplementation.

Maternal calcium supplementation

Maternal iodine supplementation or fortification.

Balanced energy and protein supplementation.

B

Neonates delayed cord clamping

Neonatal vitamin K administration

Neonatal vitamin A supplementation

Kangaroo mother care

C

Nutrition interventions in infants and children.

Promotion of breastfeeding and supportive strategies.

EVIDENCE-BASED INTERVENTIONS FOR IMPROVEMENT OF MATERNAL AND CHILD NUTRITION: WHAT CAN BE DONE AND AT WHAT COST?

Zulfiqar A. Bhutta

Lancet 2013, 382: 452-77

Maternal undernutrition contributes to 800 000 neonatal deaths annually through small for gestational age births; stunting, wasting, and micronutrient deficiencies are estimated to underlie nearly 3.1 million child deaths annually. Progress has been made with many interventions implemented at scale and the evidence for effectiveness of nutrition interventions and delivery strategies has grown since The Lancet Series on Maternal and Child Undernutrition in 2008. We did a comprehensive update of interventions to address undernutrition and micronutrient deficiencies in women and children and used standard methods to assess emerging new evidence for delivery platforms. We modelled the effect on lives saved and cost of these interventions in the 34 countries that have 90% of the world's children with stunted growth. We also examined the effect of various delivery platforms and delivery options using community health workers to engage poor populations and promote behaviour change, access and uptake of interventions. Our analysis suggests the current total of deaths in children younger than 5 years can be reduced by 15% if populations can access ten evidence-based nutrition interventions at 90% coverage. Additionally, access to and uptake of iodised salt can alleviate iodine deficiency and improve health outcomes. Accelerated gains are possible and about a fifth of the existing burden of stunting can be averted using these approaches, if access is improved in this way. The estimated total additional annual cost involved for scaling up access to these ten direct nutrition interventions in the 34 focus countries is Int\$9.6 billion per year. Continued investments in nutrition-specific interventions to avert maternal and child undernutrition and micronutrient deficiencies through community engagement and delivery strategies that can reach poor segments of the population at greatest risk can make a great difference. If this improved access is linked to nutrition-sensitive approaches—ie, women's empowerment, agriculture, food systems, education, employment, social protection, and safety nets—they can greatly accelerate progress in countries with the highest burden of maternal and child undernutrition and mortality.

- WHO recommends initiation of breastfeeding .
- Vitamin A supplementation in children.
- Iron supplementation in infants and children.
- Multiple micronutrient supplementation in children.
- Preventive zinc supplementation in children.
- Treatment of severe acute malnutrition.
- Facility-based management of SAM according to the WHO protocol.

Case fatality rates were typically 20–30% in children with SAM treated in hospitals or rehabilitation units, and rates were higher (50–60%) for oedematous malnutrition. A previous review⁴ of existing studies had estimated that following the WHO protocol, as opposed to standard care, would lead to a 55% reduction in deaths.

Community-based management of SAM ready-to-use therapeutic foods (RUTF) with standard care, RUTF had faster rates of weight gain.

Notably, a new randomised controlled trial⁹⁸ compared standard RUTF with RUTF and additional 7 day, either amoxicillin or cefdinir, in children with uncomplicated SAM. This trial showed that the children receiving an antibiotic had a lower mortality rate, faster recovery rate, SAM. RUTF for communi-

ty-based treatment, which has substantially. Available evidence shows use of RUTF compared. SAM as research to fill.

D

- Delivery platforms and strategies for implementation of nutrition-specific interventions.
- Fortification of staple foods and specific foods.
- Cash transfer programmes.
- Community-based platforms for nutrition education and promotion.
- Delivery of nutrition interventions in humanitarian emergency settings.
- Evidence for emerging interventions.
- Household air pollution.
- Maternal vitamin D supplementation.
- Maternal zinc supplementation.
- Omega-3 fatty acid supplementation.
- Vitamin D supplementation in children.
- Zinc supplementation for treatment of newborn infections and childhood pneumonia.
- Lipid-based nutrient supplementation.

Table 4. Review of nutrition interventions for women of reproductive age and during pregnancy

	Evidence reviewed	Setting	Estimates
Folic acid supplementation			
Women of reproductive age	Systematic review of five trials ¹⁹ of periconceptual folic acid supplementation	Developing and developed countries	Significant effects: NTDs (RR 0.28, 95% CI 0.15–0.52), recurrence of NTDs (RR 0.32, 95% CI 0.17–0.60) Non-significant effects: other congenital abnormalities, miscarriages, still births
Pregnant women	Systematic review of 31 trials	Mostly developed countries	Significant effects: mean birthweight (MD 135.75, 95% CI 47.85–223.68), incidence of megaloblastic anaemia (RR 0.21, 95% CI 0.11–0.38) Non-significant effects: preterm birth, still births, mean predelivery haemoglobin, serum folate, red cell folate
Iron and Iron-folate supplementation			
Women of reproductive age	Systematic review of 21 RCTs and quasi-experimental studies	Developing and developed countries. Intervention mostly given in school settings. Mostly effectiveness studies	Intermittent iron supplementation Significant effects: anaemia (RR 0.73, 95% CI 0.56–0.95), serum haemoglobin concentration (MD 4.58 g/L, 95% CI 2.56–6.59), serum ferritin concentration (MD 8.32, 95% CI 4.97–11.66) Non-significant effects: iron deficiency, adverse events, depression

Pregnant women	Systematic review of 43 RCTs and quasi-experimental studies (34 iron alone, eight iron-folate)	Developed and developing countries. Intervention delivered in community or at facility antenatal clinic. Mostly effectiveness studies	<p>Daily iron-alone supplementation</p> <p>Significant effects: low birthweight (RR 0.81, 95% CI 0.68–0.97), birthweight (MD 30.81 g, 95% CI 5.94–55.68), serum haemoglobin concentration at term (MD 8.88 g/L, 95% CI 6.96–10.80), anaemia at term (RR 0.30, 95% CI 0.19–0.46), iron deficiency (RR 0.43, 95% CI 0.27–0.66), iron deficiency anaemia (RR 0.33, 95% CI 0.16–0.69), side-effects (RR 2.36, 95% CI 0.96–5.82)</p> <p>Non-significant effects: premature delivery, neonatal death, congenital anomalies</p> <p>Iron-folate supplementation</p> <p>Significant effects: birthweight (MD 57.7 g, 95% CI 7.66–107.79), anaemia at term (RR 0.34, 95% CI 0.21–0.54), serum haemoglobin concentration at term (MD 16.13 g/L, 95% CI 12.74–19.52)</p> <p>Non-significant effects: low birthweight, premature birth, neonatal death, congenital anomalies</p>
MMN supplementation			
Pregnant women	Systematic review of 21 RCTs	Developed and developing countries. Studies compared MMN with two or fewer micronutrients	<p>Significant effects: low birthweight (RR 0.88, 95% CI 0.85–0.91), SGA (RR 0.89, 95% CI 0.83–0.96), preterm birth (RR 0.97, 95% CI 0.94–0.99)</p> <p>Non-significant effects: miscarriage, maternal mortality, perinatal mortality, stillbirths, and neonatal mortality</p> <p>Insufficient data for neurodevelopmental outcomes</p>
Calcium supplementation			
Pregnant women	Systematic review of 15 RCTs	Developed and developing countries. Mostly effectiveness trials	<p>Preterm birth (RR 0.76, 95% CI 0.60–0.97)</p> <p>Non-significant effects: perinatal mortality, low birthweight, neonatal mortality</p>
Iodine through iodisation of salt			
Pregnant women	Systematic review of five RCTs	Mostly developing countries. Mostly effectiveness trials	<p>Significant effects: cretinism at 4 years of age (RR 0.27, 95% CI 0.12–0.60), developmental scores 10–20% higher in young children, birthweight 3.82–6.30% higher</p>
Maternal supplementation with balanced energy protein			
Pregnant women	Systematic review of 16 RCTs and quasi-experimental studies	Developing and developed countries	<p>Significant effects: SGA (RR 0.66, 95% CI 0.49–0.89), stillbirths (RR 0.62, 95% CI 0.40–0.98), birthweight (MD 73g, 95% CI 30–117)</p> <p>Non-significant effects: Bayley mental scores at 1 year</p>

NTD=neural tube defects. RR=relative risk. MD=mean difference. RCT=randomised controlled trial. MMN=multiple micronutrient. SGA=small-for-gestational age.

Table 5. Review of nutrition interventions in neonates

	Evidence reviewed	Setting	Estimates
Delayed cord clamping			
Term neonates	Systematic review of 11 RCTs	Developing and developed countries. 24 and 36 weeks' gestation at birth	Significant effects: increased newborn haemoglobin concentration (MD 2.17 g/dL, 95% CI 0.28–4.06) Non-significant effects: postpartum haemorrhage, severe postpartum haemorrhage Delayed cord clamping was associated with an increased requirement for phototherapy for jaundice
Preterm neonates	Systematic review of 15 RCTs	Developing and developed countries	Significant effects: reduced need for blood transfusion (RR 0.61, 95% CI 0.46–0.81), decrease in intraventricular haemorrhage (RR 0.59, 95% CI 0.41–0.85), reduced risk of necrotising enterocolitis (RR 0.62, 95% CI 0.43–0.90) Peak bilirubin concentration was higher for delayed cord clamping group (MD 15.01 mmol/L, 95% CI 5.62–24.40)
Neonatal vitamin K administration			
Neonates	Systematic review of two RCTs for intramuscular vitamin K and 11 RCTs for oral vitamin K	Developing and developed countries	Significant effects: One dose of intramuscular vitamin K reduced clinical bleeding at 1–7 days and improved biochemical indices of coagulation status. Oral vitamin K also improved coagulation status
Vitamin A supplementation			
Very low birthweight infants	Systematic review of nine RCTs	Developed countries	Significant effects: reduced number of deaths and oxygen requirement at 1 month of age. Non-significant effects: one large trial showed no significant effect on neurodevelopment assessment at 18–22 months of age
Term neonates	Systematic review of five RCTs and quasi-experimental studies	Developing countries	Significant effects: reduction in infant mortality at 6 months (RR 0.86, 95% CI 0.77–0.97) Non-significant effects: infant mortality at 12 months (RR 1.03, 95% CI 0.87–1.23) Little data available for cause specific mortality, morbidity, vitamin A deficiency, anaemia, and adverse events
Kangaroo mother care for promotion of breastfeeding and care of preterm and SGA infants			
Healthy neonates	Systematic review of 34 RCTs	Developing and developed countries	Significant effects: increase in breastfeeding at 1–4 months after birth (RR 1.27, 95% CI 1.06–1.53), increased breastfeeding duration (MD 42.55 days, 95% CI 1.69–86.79)
Preterm neonates	Systematic review of 16 RCTs	Developing and developed countries	Significant effects: reduction in the risk of mortality (RR 0.60, 95% CI 0.39–0.93), reduction in nosocomial infection and sepsis (RR 0.42, 95% CI 0.24–0.73), reduction in hypothermia (RR 0.23, 95% CI 0.10–0.55), reduced length of hospital stay (MD 2.4 days, 95% CI 0.7–4.1)

RCT=randomised controlled trial. MD=mean difference. RR=relative risk. SGA=small-for-gestational age.

Table 6. Review of nutrition interventions for women of reproductive age and during pregnancy

	Setting	Estimates
Breast feeding promotion in infants		
Systematic review of 110 RCTs and quasi-experimental studies	Developing and developed countries	Significant effects: educational or counselling interventions increased EBF by 43% (95% CI 9–87) at day 1, by 30% (19–42) till 1 month, and by 90% (54–134) from 1–6 months. Significant reductions in rates of no breastfeeding also noted; 32% (13–46) at day 1, 30% (20–38) 0–1 month, and 18% (11–23) for 1–6 months. Non-significant effects: predominant and partial breastfeeding
Complementary feeding promotion in children 6–24 months of age		
16 RCTs and quasi-experimental studies	Mostly from food secure populations. Various foods used	Nutrition education in food secure populations Significant effects: increased height gain (SMD 0.35; 95% CI 0.08–0.62), HAZ (SMD 0.22; 95% CI 0.01–0.43), weight gain (SMD 0.40, 95% CI 0.02–0.78) Non-significant effects: stunting, WAZ Nutrition education in food insecure populations Significant effects: HAZ (SMD 0.25, 95% CI 0.09–0.42), stunting (RR 0.68, 95% CI 0.60–0.76), WAZ (SMD 0.26, 95% CI 0.12–0.41) Complementary food provision with or without education in food insecure populations Significant effects: HAZ (SMD 0.39, 95% CI 0.05–0.73), WAZ (SMD 0.26, 95% CI 0.04–0.48) Non-significant effects: stunting (RR 0.33, 95% CI 0.11–1.00)
Preventive vitamin A supplementation in children 6 months to 5 years of age		
Systematic review of 43 RCTs	Developing and developed countries	Significant effects: reduced all-cause mortality (RR 0.76, 95% CI 0.69–0.83), reduced diarrhoea-related mortality (RR 0.72, 95% CI 0.57–0.91), reduced incidence of diarrhoea (RR 0.85, 95% CI 0.82–0.87), reduced incidence of measles (RR 0.50, 95% CI 0.37–0.67) Non-significant effects: measles-related and ARI-related mortality
Iron supplementation in children		
Systematic review of 33 RCTs and quasi-experimental studies	LMICs. Participant's ages ranged from neonates to 19 years	Intermittent iron supplementation Significant effects: decreased anaemia (RR 0.51, 95% CI 0.37–0.72), decreased iron deficiency (RR 0.24, 95% CI 0.06–0.91), increased haemoglobin concentration (MD 5.20 g/L, 95% CI 2.51–7.88), increased ferritin concentration (MD 14.17 mcg/L, 95% CI 3.53–24.81) Non-significant effects: HAZ, WAZ Evidence for mental development, motor skill development, school performance, and physical capacity was assessed by very few studies and showed no clear effect
Systematic review of 17 RCTs	Developing and developed countries. In children aged 6 months to 15 years	95% CI 0.15–0.46), increased intelligence quotient scores (≥ 8 years age; SMD 0.41, 95% CI 0.20–0.62) Non-significant effects: Bayley mental development index in younger children (≤ 27 months old), motor development
MMN supplementation including iron in children		
Systematic review of 18 trials	Mostly developing countries. In children aged 6 months to 16 years	MMN supplementation Significant effects: increased length (MD 0.13, 95% CI 0.06–0.21), increased weight (MD 0.14, 95% CI 0.03–0.25) MMN might be associated with marginal increase in fluid intelligence and academic performance in healthy school children

Systematic review of 17 RCTs	Developing countries. Mostly effectiveness studies. In children aged 6 months to 11 years	<p>Micronutrient powders</p> <p>Significant effects: Reduced anaemia (RR 0.66, 95% CI 0.57–0.77), reduced iron deficiency anaemia (RR 0.43, 95% CI 0.35–0.52), reduced retinol deficiency (RR 0.79, 95% CI 0.64–0.98). Improved haemoglobin concentrations (SMD 0.98, 95% CI 0.55–1.40). MNP was associated with a significant increase in diarrhoea (RR 1.04, 95% CI 1.01–1.06)</p> <p>Non-significant effects: serum ferritin, zinc deficiency, stunting, wasting, underweight, HAZ, WAZ, WHZ, fever, URI</p>
Zinc supplementation in children		
Systematic review of 18 RCTs	Mostly developing countries. In children younger than 5 years	<p>Preventive zinc supplementation</p> <p>Significant effects: mean height improved by 0.37 cm (SD 0.25) in children supplemented for 24 weeks, diarrhoea reduced by 13% (95% CI 6–19), pneumonia reduced by 19% (95% CI 10–27)</p> <p>Non-significant effects: mortality (cause specific and all-cause)</p>
Systematic review of 13 trials	Developing and developed countries. In children younger than 5 years	Non-significant effects: Mental developmental index, psychomotor development index

RCT=randomised controlled trial. EBF=exclusive breastfeeding. HAZ=height-for-age Z score. WAZ=weight-for-age Zscore. WHZ=weight-for-height Z score. MMN=multiple micronutrient. ARI=acute respiratory infection. URI=upper-respiratory infection. SMD=standard mean difference. MD=mean difference. RR=relative risk.

Table 7. Review of evidence for disease prevention and management

	Setting	Estimates
WASH interventions		
Overview of three systematic reviews	Developing countries	Significant effects: reduced risk of diarrhoea with hand washing with soap (RR 0.52, 95% CI 0.34–0.65), with improved water quality, and with excreta disposal
DHS data from 65 countries	Developing countries	Significant effects: a recent World Bank report ⁷⁸ based on analysis of trends in DHS data suggests that open defecation explained 54% of international variation in child height by contrast with GDP, which only explained 29%. A 20 percentage point reduction in open defecation was associated with a 0.1 SD increase in child height A Cochrane review of the effect of WASH interventions on nutrition outcomes is underway
Maternal deworming		
Systematic review of five RCTs	Developing countries	Non-significant effects: one dose of anthelmintic in second trimester of pregnancy had a non-significant effect on maternal anaemia, low birthweight, preterm births, and perinatal mortality
Deworming in children (for soil-transmitted intestinal worms)		
Systematic review of 34 RCTs	Developing countries	<p>Non-significant effects: one-dose deworming had a non-significant effect on haemoglobin and weight gain.</p> <p>For multiple doses at 1 year follow up, there was a non-significant effect on weight, haemoglobin, cognition, and school attendance</p> <p>Treatment after confirmed infection</p> <p>Significant effects: one-dose of deworming drugs increased weight (0.58 kg, 95% CI 0.40–0.76) and haemoglobin (0.37 g/dL, 95% CI 0.1–0.64). Evidence on cognition was inconclusive</p> <p>These analyses are corroborated by the large-scale DEVTA trial⁸⁸ of regular deworming and VAS over 5 years, which also did not show any benefits on weight gain or mortality</p>
Feeding practices in diarrhoea		

Review of 29 RCTs	Developing countries	Significant effects: in acute diarrhoea, lactose-free diets, when compared with lactose-containing diets, significantly reduced incidence of diarrhoea (SMD -0.36, 95% CI -0.62 to -0.10) and treatment failure (RR 0.53, 95% CI 0.40-0.70) Non-significant effects: weight gain
Zinc therapy for diarrhoea		
Systematic review of 13 studies	Mostly Asia	Significant effects: reduced all-cause mortality reduced by 46% (95% CI 12-68), diarrhoea-related admissions to hospital by 23% (95% CI 15-31) Non-significant effects: diarrhoea-specific mortality, diarrhoea-prevalence Zinc reduced duration of acute diarrhoea by 0.50 days and persistent diarrhoea by 0.68 days
IPTp/ITN for malaria in pregnancy		
Systematic review of 16 RCTs	Mostly Africa	Significant effects: Anti-malarials to prevent malaria in all pregnant women reduced antenatal parasitemia (RR 0.53, 95% CI 0.33-0.86), increased birthweight (MD 126.7 g, 95% CI 88.64-164.75), reduced low birthweight by 43% (RR 0.57, 95% CI 0.46-0.72) and severe antenatal anaemia 38% (RR 0.62, 95% CI 0.50-.) Non-significant effects: perinatal deaths
Systematic review of six RCTs	Developing countries	Significant effects: ITNs in pregnancy reduced low birthweight (RR 0.77, 95% CI 0.61-0.98) and reduced fetal loss (first to fourth pregnancy; RR 0.67, 95% CI 0.47-0.97) Non-significant effects: anaemia and clinical malaria
Malaria prophylaxis in children		
Systematic review of seven RCTs	Developing countries of West Africa	Significant effects: Reduced clinical malaria episodes (RR 0.26; 95% CI 0.17-0.38), reduced severe malaria episodes (RR 0.27, 95% CI 0.10-0.76). IPTc also reduced risk of moderately severe anaemia (RR 0.71, 95% CI 0.52-0.98) Non-significant effects: all-cause mortality
Systematic review of 22 RCTs	Developing countries in Africa	Significant effects: ITNs improved packed cell volume of children by 1.7 absolute packed cell volume percent. When the control group used untreated nets, the difference was 0.4 absolute packed cell volume percent. ITNs and IRS reduced malaria-attributable mortality in children (1-59 months) by 55% (95% CI 49-61) in Plasmodium falciparum settings

WASH=water, sanitation, and hygiene. RCT=randomised controlled trial. DHS=Demographic and Health Survey. GDP=gross domestic product. RR=relative risk. MD=mean difference. SMD=standard mean difference. WAZ=weight-for-age Z score. HAZ=height-for-age Z score. DEVTA=de-worming and enhanced vitamin A. IPTp=intermittent preventive treatment of malaria in pregnancy. IPTc=IPT in children. ITN=insecticide-treated bednets. IRS=indoor residual spraying.

Figure 7. Countries with the highest burden of malnutrition. These 34 countries account for 90% of the global burden of malnutrition.

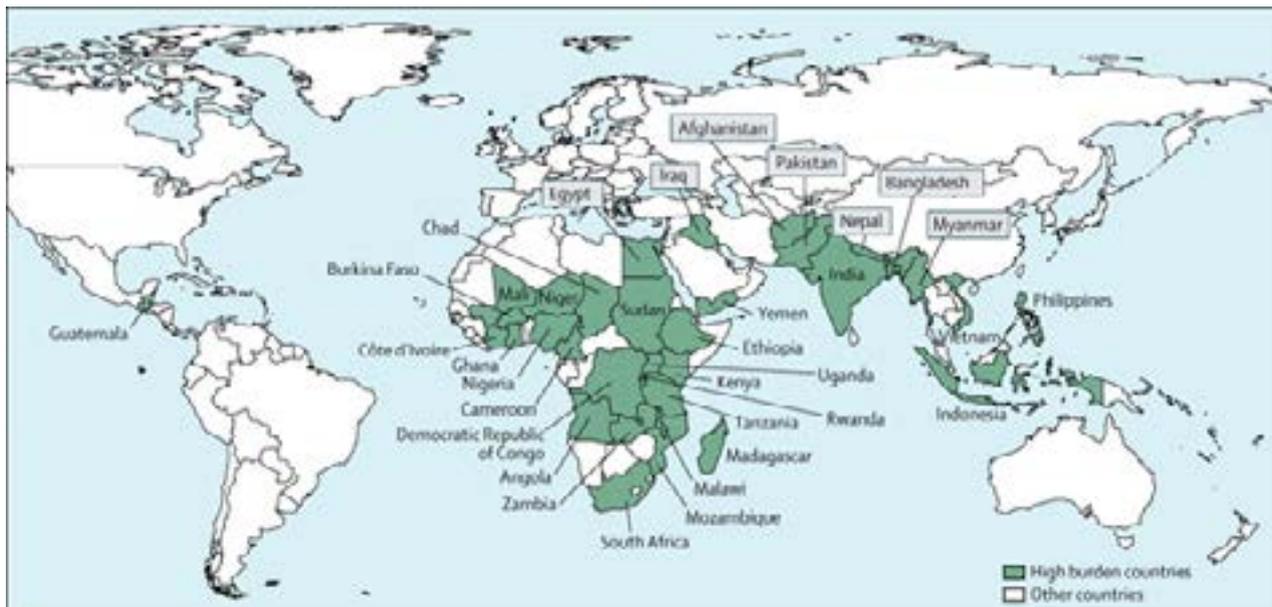


Figure 8. Effect of scale up of interventions on cause-specific deaths. Error bars are ranges.

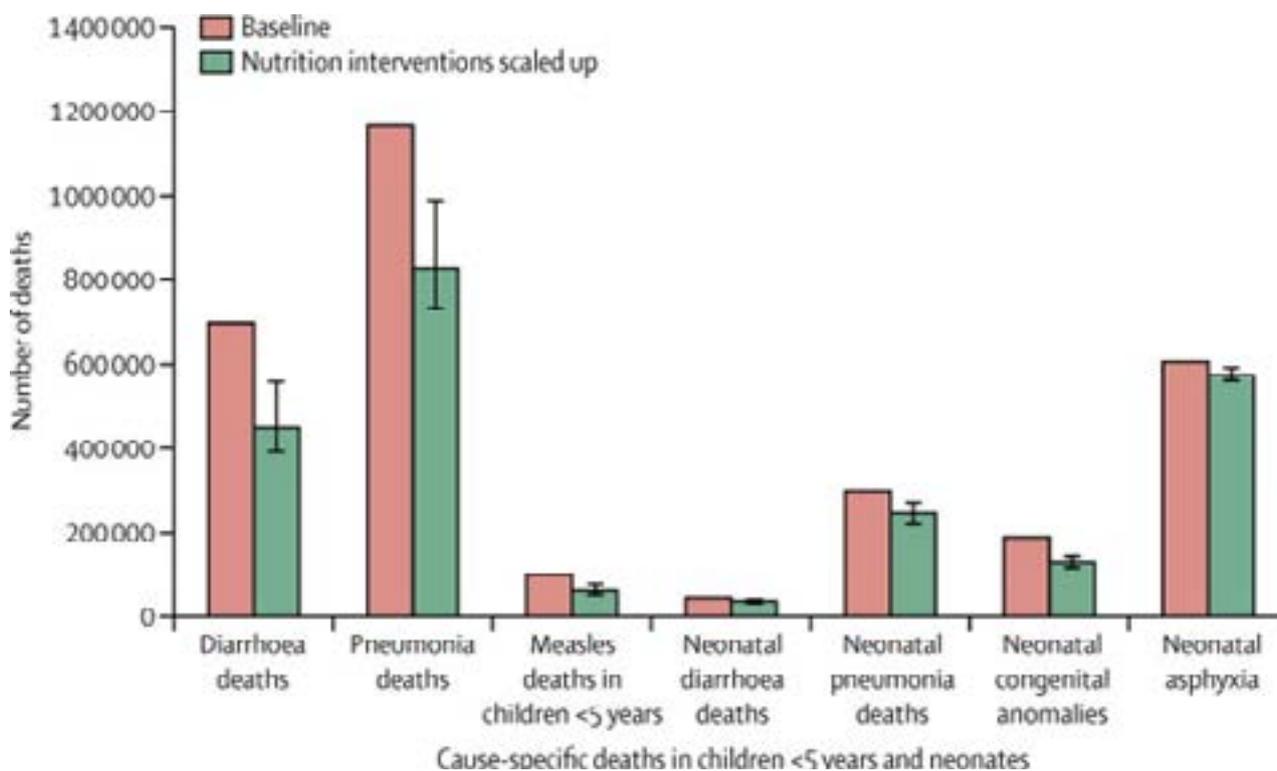
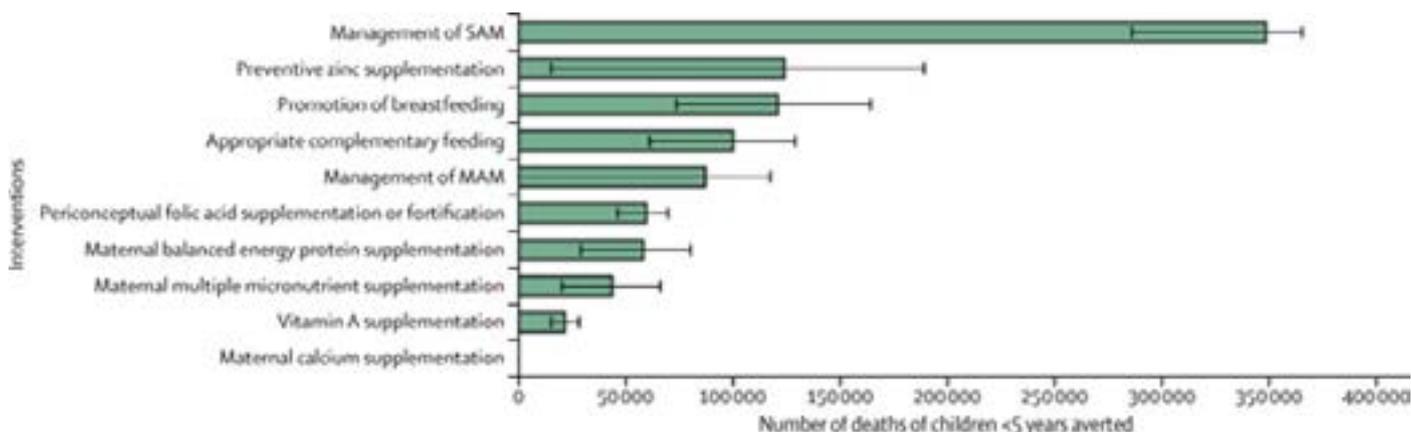


Figure 9. Effect of scale up of interventions on deaths in children younger than 5 years. Error bars are ranges. Promotion and use of iodised salt not modelled for mortality effect.



SAM=severe acute malnutrition. MAM=moderate AM.

Table 8. Total additional annual cost of achieving 90% coverage with nutrition interventions, excluding management of moderate acute malnutrition, in 34 countries with more than 90% of the burden

Salt iodisation	\$68
Multiple micronutrient supplementation in pregnancy (includes iron-folate)	\$472
Calcium supplementation in pregnancy	\$1914
Energy-protein supplementation in pregnancy	\$972
Vitamin A supplementation in childhood	\$106
Zinc supplementation in childhood	\$1182
Breastfeeding promotion	\$653
Complementary feeding education	\$269
Complementary food supplementation	\$1359
SAM management	\$2563

PRACTICAL DOSING OF PRAZIQUANTEL FOR SCHISTOSOMIASIS IN PRESCHOOL-AGED CHILDREN

Piero L. Olliaro

Tropical Medicine and International Health, Vol. 18, No. 9, pp: 1085-1089, Sept 2013

Schistosomiasis is known to occur in preschool-aged children, but achieving accurate dosing of praziquantel in its current form is challenging. While waiting for a paediatric formulation, there is a need to develop a means for using the available products to treat this age group. Current 600-mg tablets are differently scored to give units of 150 mg (a quarter of a tablet) or 300 mg (half a tablet).

We examined several dosing schemes to dose accurately (40-60 mg/kg) children aged 3-72 months (weight range 4-25 kg, based on available weight-for-

age growth references from sub-Saharan Africa and Brazil, n = 106,230).

Adequate dosing can be achieved with formulations that can be split into four 150 mg quarters for children weighing 5 kg or more, and with tablets that can be split into two 300 mg halves for children weighing 10 kg or more. Giving ½ tablet for 5-7 kg; ¾ tablet for 8-10 kg; 1 tablet for 11-15 kg; 1 ½ tablet for 16-21 kg; and two tablets for 22-25 kg will have 100% of subjects correctly dosed within the target 40-60 mg/kg range.

Formulations that can be divided into four parts (to give 150 mg increments) are preferred for children weighing less than 11 kg; the same dosing can be applied with 600 mg praziquantel formulations that can be divided into four quarters or two halves from 11 kg body weight.

UNNECESSARY INJECTING OF MEDICINES IS STILL A MAJOR PUBLIC HEALTH CHALLENGE

GLOBALLY

Gore C.

Tropical Medicine and International Health, Vol. 18, No. 9, pp: 1157-1159, Sept 2013

It is dismaying to learn that such a large number of countries do not appear to have these data available in light of what has been documented regarding injection overuse in developing countries. Much of the evidence is from the 1980s and 1990s, but more recent studies in China and Egypt found unnecessary health facility injection rates of 57% and 95%, respectively (Yan et al. 2006; Bodenschatz et al. 2009). A 2006 Pakistani study estimated that 94% of therapeutic injections nationally are unnecessary (Altaf et al. 2006). A 1999 review article summarising earlier evidence noted levels of unnecessary injections ranging from 70% to 99% in various patient populations in India, Indonesia, the Russian Federation and Tanzania.

It is dismaying to learn that such a large number of countries do not appear to have these data available in light of what has been documented regarding injection overuse in developing countries. Much of the evidence is from the 1980s and 1990s, but more recent studies in China and Egypt found unnecessary health facility injection rates of 57% and 95%, respectively (Yan et al. 2006; Bodenschatz et al. 2009). A 2006 Pakistani study estimated that 94% of therapeutic injections nationally are unnecessary (Altaf et al. 2006). A 1999 review article summarising earlier evidence noted levels of unnecessary injections ranging from 70% to 99% in various patient populations in India, Indonesia, the Russian Federation and Tanzania.

THE FUKUSHIMA ACCIDENT AND TRAVEL MEDICINE – ANALYSIS AND RECOMMENDATIONS

School C.

Travel Medicine and Infectious Disease 2013, 11, 139-145

The accident at the nuclear site in Fukushima has fostered a fear of the consequences of radioactive contamination among many, especially regarding travel to Japan and the import of Japanese goods. We give a general overview of the assessment of the effects of ionizing radiation and a summary of the

consequences of the Japanese accident. We report the results of the measurement of radionuclide intake among travelers returning from Japan, carried out at the whole-body counter of the Institute for Work Design of North Rhine-Westphalia (LIA.NRW) in Düsseldorf.

In summary, there are no indications against travel to Japan from a radiological point of view. The external exposure as well as the internal exposure from ingestion of radionuclides will, on average, not be higher than the world average. The total radiation exposure for people living in Japan will remain within the range of natural exposure in Japan. The total radiation exposure in Japan will be lower than the natural radiation exposure for a large part of the European population. Only the restricted areas and evacuation zones around the Fukushima nuclear site should be avoided, but they are not freely accessible anyway. Higher than average exposure is possible when staying in Fukushima prefecture. The consumption of purchased Japanese food is possible without restrictions as the food is subject to monitoring in line with international standards, and the current data strongly indicates that the ingestion pathway is of minor importance.

EYE PROBLEMS ON EXPEDITIONS

Daniel S. Morris

Travel Medicine and Infectious Disease 2013, 11, 152-158

Visual loss in the wilderness setting is at best disabling and at worst potentially fatal. However many physicians have a poor knowledge of ophthalmology and the basic skills that could be applied in situations away from definitive care.

This paper is intended for physicians, interested non-medical people and expedition operators as a practical guide to the treatment and prevention of eye problems on expeditions.

Some of the eye conditions described in this paper are unique to the high altitude setting, such as high altitude retinopathy and some could happen in any environment, such as trauma, dry eyes and contact lens problems. As with any aspect of an expedition, preparation is vital to prevent and avoid eye problems. It is therefore important that pre-existing ocular conditions are known about and appropriate drugs and equipment are available in expedition first aid kits.

In the event of a visual problem, it is always

better to be cautious and evacuate a patient rather than a risk a sight-threatening complication. However this paper should provide a non-ophthalmologist with the skills to treat the eye conditions described.

TRAVEL-ASSOCIATED FAECAL COLONIZATION WITH ESBL-PRODUCING ENTEROBACTERIACEAE: INCIDENCE AND RISK FACTORS

Åse Östholm-Balkhed

J Antimicrob Chemother 2013, 68: 2144-2153, May 2013

To study the acquisition of extended-spectrum β -lactamase-producing Enterobacteriaceae (ESBL-PE) among the faecal flora during travel, with a focus on risk factors, antibiotic susceptibility and ESBL-encoding genes.

An observational prospective multicentre cohort study of individuals attending vaccination clinics in south-east Sweden was performed, in which the submission of faecal samples and questionnaires before and after travelling outside Scandinavia was requested. Faecal samples were screened for ESBL-PE by culturing on ChromID ESBL and an in-house method. ESBL-PE was confirmed by phenotypic and genotypic methods. Susceptibility testing was performed with the Etest. Individuals who acquired ESBL-PE during travel (travel-associated carriers) were compared with non-carriers regarding risk factors, and unadjusted and adjusted ORs after manual stepwise elimination were calculated using logistic regression.

Of 262 enrolled individuals, 2.4% were colonized before travel. Among 226 evaluable participants, ESBL-PE was detected in the post-travel samples from 68 (30%) travellers. The most important risk factor in the final model was the geographic area visited: Indian subcontinent (OR 24.8, $P < 0.001$), Asia (OR 8.63, $P < 0.001$) and Africa north of the equator (OR 4.94, $P = 0.002$). Age and gastrointestinal symptoms also affected the risk significantly. Multiresistance was seen in 77 (66%) of the ESBL-PE isolates, predominantly a combination of reduced susceptibility to third-generation cephalosporins, trimethoprim/sulfamethoxazole and aminoglycosides. The most common species and ESBL-encoding gene were *Escherichia coli* (90%) and CTX-M (73%), respectively.

Acquisition of multiresistant ESBL-PE among the faecal flora during international travel is common. The geographical area visited has the highest impact on ESBL-PE acquisition.

RISK OF GUILLAIN-BARRÉ SYNDROME AFTER SEASONAL INFLUENZA VACCINATION AND INFLUENZA HEALTH-CARE ENCOUNTERS: A SELF-CONTROLLED STUDY

Jeffrey C. Kwong

Lancet Infect Dis 2013, 13: 769-76

The possible risk of Guillain-Barré syndrome from influenza vaccines remains a potential obstacle to achieving high vaccination coverage. However, influenza infection might also be associated with Guillain-Barré syndrome. We aimed to assess the risk of Guillain-Barré syndrome after seasonal influenza vaccination and after influenza-coded health-care encounters.

We used the self-controlled risk interval design and linked universal health-care system databases from Ontario, Canada, with data obtained between 1993 and 2011. We used physician billing claims for influenza vaccination and influenza-coded health-care encounters to ascertain exposures. Using fixed-effects conditional Poisson regression, we estimated the relative incidence of hospitalisation for primary-coded Guillain-Barré syndrome during the risk interval compared with the control interval.

We identified 2831 incident admissions for Guillain-Barré syndrome; 330 received an influenza vaccine and 109 had an influenza-coded health-care encounter within 42 weeks before hospitalisation. The risk of Guillain-Barré syndrome within 6 weeks of vaccination was 52% higher than in the control interval of 9-42 weeks (relative incidence 1.52; 95% CI 1.17-1.99), with the greatest risk during weeks 2-4 after vaccination. The risk of Guillain-Barré syndrome within 6 weeks of an influenza-coded health-care encounter was greater than for vaccination (15.81; 10.28-24.32). The attributable risks were 1.03 Guillain-Barré syndrome admissions per million vaccinations, compared with 17.2 Guillain-Barré syndrome admissions per million influenza-coded health-care encounters. The relative and attributable risks of Guillain-Barré syndrome after seasonal influenza vaccination are lower than those after influenza illness. Patients considering immunisation should be fully informed of the risks of Guillain-Barré syndrome from both influenza vaccines and influenza illness.

CLINICAL EPIDEMIOLOGY OF THE GLOBAL EXPANSION OF KLEBSIELLA PNEUMONIAE CARBAPENEMASES

Silvia Munoz-Price L.

Lancet Infect Dis 2013, 13: 785-96

Klebsiella pneumoniae carbapenemases (KPCs) were originally identified in the USA in 1996. Since then, these versatile β -lactamases have spread internationally among Gram-negative bacteria, especially *K pneumoniae*, although their precise epidemiology is diverse across countries and regions. The mortality described among patients infected with

organisms positive for KPC is high, perhaps as a result of the limited antibiotic options remaining (often colistin, tigecycline, or aminoglycosides). Triple drug combinations using colistin, tigecycline, and imipenem have recently been associated with improved survival among patients with bacteraemia. In this Review, we summarise the epidemiology of KPCs across continents, and discuss issues around detection, present antibiotic options and those in development, treatment outcome and mortality, and infection control. In view of the limitations of present treatments and the paucity of new drugs in the pipeline, infection control must be our primary defence for now.

	Class	Status	Advantages	Caution
Ceftazidime-avibactam (AstraZeneca/Forest, Wilmington, DE, USA)	Cephalosporin-BLI	Phase 3	Furthest advanced BLI combination; uses well-established cephalosporin at high doses (up to 2 g plus 0.5 g avibactam every 8 h)	Occasional resistance if other enzymes are also present ¹⁹ . Strains with metallo-carbapenemases, rather than KPC enzymes, are resistant
Ceftaroline-avibactam (AstraZeneca/Forest, Wilmington, DE, USA)	Cephalosporin-BLI	Entering phase 3	Also covers methicillin-resistant <i>Staphylococcus aureus</i> but (unlike ceftazidime-avibactam) not <i>Pseudomonas aeruginosa</i>	Higher doses might be needed than used for ceftaroline alone. Strains with metallo-carbapenemases, rather than KPC enzymes, are resistant
Plazomicin ACHN-490 (Achaogen, San Francisco, CA, USA)	Aminoglycoside	Completed phase 2	Active versus most isolates with KPC enzymes, ²⁰ evades aminoglycoside-modifying enzymes	Compromised by rRNA methylases, which sometimes accompany KPC enzymes in China, ²¹ although these are not present in typical ST258-KPC strains elsewhere
Eravacycline TP-434 (Tetraphase, Watertown, MA, USA)	Tetracycline	Completed phase 2	Active vs Enterobacteriaceae with KPC or other carbapenemases ²²	Efficacy of tetracyclines in severe infections is debated
Imipenem-MK7655 (Merck, Summit, NJ, USA)	Carbapenem-BLI	Phase 2	Uses a well-established carbapenem ²³	Strains with metallo-carbapenemases, rather than KPC enzymes, are resistant
Aztreonam-avibactam (AstraZeneca/Forest, Wilmington, DE, USA)	Monobactam-BLI	Phase 1	Also covers Enterobacteriaceae with metallo-carbapenemases ²⁴	Spectrum mostly confined to Enterobacteriaceae
Biapenem RPX7009 (Rempex, San Diego, CA, USA)	Carbapenem-BLI	Phase 1	Novel boronate inhibitor; biapenem is less compromised than other carbapenems vs Enterobacteriaceae with metallo-carbapenemases	Resistance can arise in isolates with high biapenem minimum inhibitory concentrations, probably owing to hyperproduction of KPC enzymes
BLI 30072 (Basilea, Basel, Switzerland)	Monosulfactam	Phase 1	Stable to metallo-carbapenemases and OXA-48 carbapenemases as well as KPC enzymes ²⁵	Vulnerable to the SHV extended-spectrum β -lactamases, which often accompany KPC enzymes (eg. in ST258 <i>K pneumoniae</i>) ²⁶

BLI- β -lactamase inhibitor; KPC-*Klebsiella pneumoniae* carbapenemase.

Table 2: Drugs in clinical development that are active against Enterobacteriaceae with *Klebsiella pneumoniae* carbapenemases

THE EMERGENCE OF INFLUENZA A H7N9 IN HUMAN BEINGS 16 YEARS AFTER INFLUENZA A H5N1: A TALE OF TWO CITIES

Kelvin K. W. To

Lancet Infect Dis 2013, 13: 809-21

Infection with either influenza A H5N1 virus in 1997 or avian influenza A H7N9 virus in 2013 caused severe pneumonia that did not respond to typical or atypical antimicrobial treatment, and resulted in high mortality. Both viruses are reassortants with internal genes derived from avian influenza A H9N2 viruses that circulate in Asian poultry. Both viruses have genetic markers of mammalian adaptation in their haemagglutinin and polymerase PB2 subunits, which enhanced binding to human-type receptors and improved replication in mammals, respectively.

Hong Kong (affected by H5N1 in 1997) and Shanghai (affected by H7N9 in 2013) are two rapidly flourishing cosmopolitan megacities that were increasing in human population and poultry consumption before the outbreaks. Both cities are located along the avian migratory route at the Pearl River delta and Yangtze River delta. Whether the widespread use of the H5N1 vaccine in east Asia—with suboptimum biosecurity measures in live poultry markets and farms—predisposed to the emergence of H7N9 or other virus subtypes needs further investigation. Why H7N9 seems to be more readily transmitted from poultry to people than H5N1 is still unclear.

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INSTRUCTIONS FOR AUTHORS

We would like to offer you an opportunity to contribute to CSW Journal content as we would like to aspire to create a collection of real experiences of social workers, doctors, missionaries, teachers, etc. CWS Journal is published by the International Scientific Group of Applied Preventive Medicine I-GAP in Vienna, Austria.

The journal is to be published quarterly and only in English language as it will be distributed in various foreign countries.

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

Your contribution should fit into **the following structure**:

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Yours sincerely,

Michal Oláh, Ph.D.

Edition of journal

no.2, vol.4, 2013

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Editor-in-Chief: Peter G. Fedor-Freybergh, Michal Oláh

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