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Social and Health Problems of the Marginalized and the Handicapped Original Articles

- ✓EDITORIAL: SOCIAL AND HEALTH PROBLEMS OF THE MARGINALIZED AND THE HANDICAPPED
- ✓SOCIAL PROTECTION PRIORITIES FOR INTERNAL MIGRANTS IN KHARKIV REGION, UKRAINE
- ✓MIGRATION AND INTEGRATION: A DILEMMA IN THE INTEGRATION OF AFGHAN REFUGEES IN RELATION TO CRIMES IN KHYBER PAKHTUNKHWA
- ✓INTEGRATED COMMUNICATION AS A MARKETING INSTRUMENT IN THE ECONOMY AND PHARMACEUTICAL INDUSTRY
- ✓DISPARITIES IN SOCIAL DEVELOPMENT & STATUS OF WOMEN IN BIMARU / EAG STATES OF INDIA
- ✓EFFECT OF EDUCATIONAL PROGRAM ON PRESSURE ULCER PREVENTION INTERVENTION AMONG NURSES OF INTENSIVE CARE UNITS AT A PUBLIC HOSPITAL, PAKISTAN
- ✓KNOWLEDGE, ATTITUDE AND PRACTICE OF KANGAROO MOTHER CARE AMONG NEONATAL NURSES
- ✓RELIGIOSITY AND SOCIAL CAPITAL AS PREVENTION OF SOCIO-PATHOLOGICAL PHENOMENA
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Photo:

Michael Olah, A broken hand: This Iraqi migrant has
been beaten by the Croatian police and repatriated
to Bosnia and Herzegovina's illegal migrant camp in
Velika Kladuša.

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Editorial

Social and Health Problems of the Marginalized and the Handicapped

This Current Issue of the Clinical Social Work Journal presents two important issues: that health problems of the marginalized and the handicapped are not issues only of developing but also high income (developed) countries.

We present submissions from India, Pakistan, Iran and Saudi Arabia dealing with similar issues as in the Central and Eastern European regions as reported by authors from Austria, Slovakia, Poland, Czech Republic and Ukraine.

We see such similarities despite improving economies, including the Southern Asian region which report increasing annual economic growth in India, Pakistan, Iran, and Saudi Arabia which has one of highest incomes in the Middle East. Probably the position of social workers is not as strong as we see in the UK or Scandinavia. In Central Europe, and mainly in Ukraine, the competencies of social workers are apparently not strong enough to protect the vulnerable populations and groups such as we see in this issue, chronically ill, migrants, homeless, elderly, etc.

Economic growth as we see in Central Europe is not the only issue in social policy. In this Christmas Issue in the EU, or New Year Issue in other countries, more humanistic and empathic approaches will attract our attention to those vulnerable and socially disadvantaged, living, or even starving, so closely near us.

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Social Protection Priorities for Internal Migrants in Kharkiv Region, Ukraine

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Original Article

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Abstract:

Background. In 2014, an armed conflict began in the eastern territories of Ukraine. In Kharkiv region, there are one of the highest numbers of internal migrants in need of social assistance in Ukraine.

Objective is to define effective strategies of social service provision to internal migrants (or internally displaced persons in Kharkiv region.

Methods. General scientific methods and special scientific

methods (content analysis method and others) are applied. The analysis of the secondary sociological information array concerning the problems of social protection of internally displaced persons in Ukraine and Kharkiv region.

Results. It is argued that the social assistance project „Helping Hand“ has become the most successful in the social field for IDPs.

Conclusions. The most successful projects on providing social assistance to internal migrants in Kharkiv are highlighted: in employment and housing spheres. The focus on organizational issues in obtaining social services for internal migrants is made.

Introduction

In 2014, an armed conflict began in eastern Ukraine, as a result leaving part of Donetsk and Luhansk regions beyond the control of the Ukrainian state. The fighting in eastern Ukraine has threatened the lives of thousands of people so they have been forced to flee their homes. The official website of the Ministry of Social Policy of Ukraine states: „Since 2014, Ukraine has been in a state of undeclared war. Some of its territories are illegally annexed by the neighboring state, some are temporarily occupied by the same aggressor, hostilities are taking place on part of the territory. Almost one and a half million citizens of Ukraine were forced to leave their homes and move to the territory under the control of the Ukrainian authorities in search of protection, and often of a mere rescue“ (1).

These events determined the unprecedented internal and external displacement of a large number of the Ukrainian population. „In the Ukrainian scientific literature, in media these people are referred to as „internal migrants“, „forced migrants“, in official documents – „internal migrants“, which most closely corresponds to the English term „internally displaced persons (IDPs)“ (2, p. 264). Thus, in the legislation of Ukraine, these internal migrants who left „their place of residence as a result or in order to avoid the negative effects of armed conflict (3) are referred to as „internally displaced persons“ (IDPs).

According to the United Nations, as of June 2015, there were 1.4 million internal migrants (internally displaced persons) registered in Ukraine. Moreover, Ukraine ranks ninth in the world in this indicator (4, p. 275).

Currently, the situation has not changed ut-

terly. Currently, the situation has changed very little. As of April 13, 2020, the number of internally displaced persons in Ukraine is 1,446,881 (5). These are IDPs from the temporarily occupied territories of Donetsk and Luhansk regions and the Autonomous Republic of Crimea. Of these: 367,849 persons are working age; 197,672 children; 51,355 persons with disabilities; 724,427 – pensioners; 1,173,283 families.

Today Kharkiv region is a border territory with Russia and a frontline region bordering both Donetsk and Lugansk regions where hostilities continue. In Kharkiv region there is one of the highest indicators of the number of internally displaced persons (IDPs) due to the armed conflict in the Donbas (Donetsk and Lugansk regions). The calculation of real data on the number of internal migrants arriving to Kharkiv region from the area of armed conflict is quite complicated. In Kharkiv region in August 2015, the total number of internally displaced persons was 185,600 (6, p. 40). In February 2016, 212,600 IDPs were officially registered. However, at the same time, the administration of Kharkiv region has repeatedly stated that, along with undocumented internal migrants, there are more than 300,000 internally displaced persons in the region (7, p. 124).

As of 02.04.2020 (8), 134,111 internally displaced persons (108,361 families) have been registered by the social protection authorities in Kharkiv region. The forced internal migration of the population from some regions of Donetsk and Lugansk regions and the Autonomous Republic of Crimea to other regions of Ukraine has caused many different problems. One of the most important problems for IDPs has been that of social protection.

Situation with social protection of internal migrants in Kharkiv region, Ukraine

For the optimal consideration of the level of social protection of internally displaced persons (internal migrants) in Kharkiv region, let us turn to the analysis of sociological research. Let us analyze those sociological surveys whose respondents, on the one hand, were representatives of social services and, on the other, forced migrants.

A social survey was conducted in Kharkiv in October 2015 to identify problems in the activities of the municipal social services in dealing with internally displaced persons (6, p. 41). In general, Kharkiv was ready to welcome inland migrants. Also the city's population attitude toward the IDPs was also quite positive. It was noted that a significant part of social service workers actively involve volunteers in working with internally displaced persons.

However, internally displaced persons faced a variety of problems. They needed additional social services'; the creation of additional organizational structures to provide these services for example, counseling points where they could get legal assistance; social and rehabilitation centers; groups where advice from people with similar experience could be obtained and so on. The fact is that there were no new social protection services for migrants from the conflict zone in Kharkiv (as in Ukraine as a whole). Already existing social services urgently reoriented their activities to help IDPs arriving in Kharkiv since the spring 2014.

It should be noted that later (in 2017), three new large social service centers „Prozory Ofis“ (Transparent Office) were established in Kharkiv, where internally displaced persons from the area of armed conflict are provided with a wide range of necessary social services.

Housing, registration and employment services for internally displaced persons have become the most complex services for Kharkiv social service workers. In particular, finding a job for many IDPs has been a big problem.

On the whole, the workload of social workers in Kharkiv region has increased and its context has changed due to the need to provide new social services to a new social group – internal migrants. Yet, the overwhelming majority of social workers at that time did not receive additional funding (6, p. 45).

A sociological survey, conducted among internal migrants in Kharkiv region in 2016, stated that the most common problems faced by IDPs were „housing, access to health care, and underemployment“ (7, p. 126).

A previous sociological survey conducted in the city of Kharkiv in January-February 2015 among internally displaced persons who sought help from the charitable organization „Caritas“ also saw the most acute problems of lack of housing and underemployment. The IDPs were found to be in a very difficult financial situation. For 84% of respondents, lack of their own housing is a major problem. Next in importance were the following problems: „lack of funds for the most necessary things (38%); lack of work in general (30%); lack of necessary clothing (29%)“ (4, p. 278). According to the study, internally displaced persons mostly relied on themselves (47%) and support of their relatives (29%) in solving material problems. Equal were the proportions of persons who relied on financial support from the state and volunteers.

The socio-demographic portrait of internally displaced persons in Kharkiv region can be described in general terms. A 2016 study found that „among newcomers, 25.4% are people aged 35 to 44, the least represented demographic is young people (7.2%) and older people (8.1%)“ (7, p. 125). By gender, in Kharkiv region there were more women (70%) than men (30%).

It is interesting to look at the distribution by occupational groups: the most represented was the group of managers, specialists and employees were 61.6% of those displaced to Kharkiv region (7, p. 125). These data correlate with the level of education of internal migrants: 72% have higher education; 17% – vocational education; 11% – secondary education.

The high educational level of internal migrants who moved to Kharkiv region is also highlighted in another previous sociological survey conducted in 2015. It revealed that more than half of the respondents have higher education. Also, the results of the survey showed that every tenth respondent held a management position at the level of an institution or subdivision of an enterprise» (4, p. 278). That is, it can be assumed that forced migrants with a high level of education also had a corresponding high professional status before leaving their place of permanent residence.

Overall, large-scale internal migration in Ukraine has caused both objective and subjective consequences for internal migrants (7, p. 33). First and foremost, is about increasing competition in the labor market affecting locals who had become hosts for IDPs. Demand for rental housing also increased significantly. Overload of health care and educational institutions was observed.

Thus, the most pressing problems, which internal migrants in Kharkiv region have faced, are lack of housing and underemployment for internally displaced persons from armed conflict.

The results of basic directions of social assistance to internal migrants in Kharkiv region

One of the successful projects to assist internally displaced persons from the area of armed conflict in the Kharkiv region is the project „Ruka Dopomohy“ (Helping Hand), which has been operating in the region since 2017. This project was implemented by the Ministry of Social Policy of Ukraine with the support of the World Bank which is being implemented as part of a broader strategy of modernizing the system of social support for the population. The goal of the „Helping Hand“ project is to help „IDPs and needy families' dependents get rid of welfare payments reliance; to get a decent job or start their own business“ (9). Therefore, the key objective of the project is to bring back IDPs to the labor market. The „Helping Hand project involves engaging participants in economic activity, taking into account the particularities and aspirations of each. For Ukraine, this is an entirely new mechanism of social protection. At the same time, such projects have proved their effectiveness and efficiency in the countries of the European Union.

In Kharkiv region, one of the mechanisms of the „Helping Hand project has become provision of zero-interest reimbursable financial assistance (microcredits) to those participants who dream of setting up their own business.

During 2017-2018, 1,000 internally displaced persons participated in the project in Kharkiv region. About 500 internal migrants were employed or engaged in community service. It should be noted that the „Helping Hand“ project offers employment assistance to people who are

looking for a stable income. However, if there is no desired vacancy at the time of application, the project offers various options for temporary paid work for the benefit of the community.

48 internally displaced persons received financial assistance and became entrepreneurs in the Kharkiv region. It is interesting to note that with the help the project already existing businesses have created 44 jobs for migrant workers. The support of the „Helping Hand“ project participants and consultancy assistance have continued today: in particular of those entrepreneurs, the vast majority of whom are effectively developing their businesses and paying taxes.

A characteristic of the „Helping Hand“ project is to encourage local businesses to create new jobs. If representatives of a particular local business employ two project participants, the enterprise itself can receive interest-free loans from the state for the purchase of new equipment.

The „Helping Hand“ project has been the most successful one in the social field for those people who have moved from the conflict zone to Kharkiv. Illustrative in this context is the example of Alina Starchenko, who used to live in Luhansk region. With the start of hostilities in Luhansk region, Alina left her home and moved to Kharkiv. With a college degree in economics she was looking for a new job. Before the war she had worked as an accountant. Alina Starchenko decided to start her own business and applied for employment assistance to Kharkiv City Employment Center (10). Because she had the status of an internally displaced person, she was invited to take part in the pilot project „Helping Hand“ at the Employment Center. Alina successfully wrote and defended a business plan on furniture production. Shortly, she received a lump sum unemployment payment. With this money she purchased furniture manufacturing equipment. Today, Alina Starchenko together with her husband and employees are making baby beds and planning to expand production capacity.

Since 2016, important projects have been implemented in Kharkiv region to help solve the urgent problems of internally displaced persons. In particular, these are the following projects: a pilot project on involvement of low-income families and internally displaced persons in accordance with the Resolution of the Cabinet of Ministers

of Ukraine No. 1154 dated December 2, 2015 (as amended); a project „Entrepreneurial Initiatives Development Center in Kharkiv“ (implemented with the support of the International Renaissance Foundation); projects of the Caritas-Kharkiv Charitable Foundation (11).

The „Livelihoods“ project under the auspices of the Caritas-Kharkiv Charitable Foundation (11) has become interesting in terms of solving the internal migrants' employment problems. This project started in September 2015 for the employment of internally displaced persons – „Career for New Life“. The purpose of the project was to provide comprehensive assistance to displaced persons addressing employment and integration issues in the new community. The „Livelihoods“ project has several areas of assistance for internally displaced persons: providing initial consultation to identify customer requests; employment assistance; creation of a beneficiary base; assisting with resume writing; assistance in matching job vacancies in accordance with the experience and wishes of clients and in accordance with the current labor market. The careerfornewlife.com employment site provides online counseling to internally displaced persons within the project. Internal migrants are also provided with individual grants for vocational training to enhance their employment opportunities.

In 2016, out of the total number of internally displaced persons employed in Kharkiv region, employees (51.5%) were more successful, and the percentage of employment of workers was 35.1% (7, p. 125). This was due to the fact that the workers in the Donbass (Donetsk and Luhansk regions) had mostly worked in the mines. As there are no mines in Kharkiv region, workers who had been displaced had to acquire new skills and look for new jobs. In Kharkiv region, agriculture, processing and trade account for the largest number of employed internal migrants.

Quite the most difficult problem for majority of internally displaced persons is housing. In Kharkiv region, compact settlements were organized for the displaced persons from the armed conflict zone: modular settlements; temporary settlements; etc. „Affordable Housing“ and „Homeownership“ programs were also funded to provide housing for internally displaced persons in urban and rural areas (2, p. 266).

Kharkiv City Council approved „Socio-Economic Municipal Target Program for Construction (Acquisition) of Affordable Housing for 2010-2025“. Under this program, internally displaced persons are eligible for preferential loans for the construction or purchase of affordable housing.

On the issue of housing for internally displaced persons, Kharkiv Regional State Administration cooperates with international organizations. Within the framework of the project „Promotion of Social Infrastructure Development (USIF V)“ with the support of Ministry of Economic Development and Cooperation of Germany (BMZ) and Credit Institute for Reconstruction (KfW) 6 micro-projects for reconstruction of residential buildings for internally displaced persons are underway in Kharkiv region in the towns of Bohodukhiv, Krasnograd, Lozova, Dergachi, Izyum, village of Zolochiv (12).

At the same time, in Ukraine the implementation of the state policy on ensuring the rights of internal migrants is characterized by the lack of a strategic vision on the issue of housing for them.

Conclusions

Today Kharkiv region is a border area with Russia and a frontline with both Donetsk and Lugansk regions, where hostilities have been taking place since 2014. The fighting in eastern Ukraine has threatened the lives of thousands who were forced to flee their homes. In Kharkiv region, there is one of the highest numbers of internal migrants in need of social assistance in Ukraine.

Priorities in social protection of internal migrants in Kharkiv region were identified: housing; employment; access to health care. The most successful projects for providing social assistance to internal migrants in Kharkiv are highlighted in the area of employment and housing. It is argued that the social assistance project „Ruka dopomohy“ (Helping Hand) for helping people who have moved from the conflict zone to Kharkiv has become the most successful in the social sphere. The key objective of the project is to return those unemployed internally displaced persons to the labor market. The „Helping Hand“ project involves engaging participants in economic activity, taking into account the particularities and aspirations of each.

The focus is on organizational issues in obtaining social services for internal migrants.

Thus, they needed additional social services, the creation of additional organizational structures to provide these services: for example, counseling points where they would obtain legal assistance; social and rehabilitation centers; groups where advice from people with similar experience could be shared. The fact is that there were no new social protection services for migrants from the conflict zone created in Kharkiv (as in Ukraine as a whole). Already existing social services have urgently reoriented their activities to help IDPs.

The basic characteristics of the socio-demographic portrait of internal migrants in Kharkiv region are revealed, in particular, a high level of education which requires flexibility in formulating employment strategies. It was internal migrants with higher education who were more successfully employed in Kharkiv. Whereas among the internally displaced persons of the working professions, the percentage of employed persons was much lower. This was due to the fact that the workers in the Donbass (Donetsk and Luhansk regions) mostly had worked in mines. As there are no mines in Kharkiv region, workers who have been displaced have to acquire new skills and look for new jobs that put new tasks before social protection authorities. In Kharkiv, agriculture, processing and trade account for the largest number of employed internal migrants.

Overall, large-scale internal migration in Ukraine has had both objective and subjective consequences for internal migrants. First and foremost, it is about increasing competition in the labor market, affecting locals who have become hosts for displaced people. The demand for rental housing has also increased significantly. Overload of health care and educational institutions began to be observed.

At the same time, in Ukraine the implementation of the state policy on social protection of internal migrants is characterized by fragmentary and lack of strategic vision in solving many issues.

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12. ANALYTICAL REVIEW OF REGIONAL HOUSING PROGRAMS FOR INTERNALLY DISPLACED PERSONS (2018) United Nations Refugee Agency (UNHCR) Kyiv, 2018, 58 pp.

Migration and Integration: A Dilemma in the Integration of Afghan Refugees in Relation to Crimes in Khyber Pakhtunkhwa

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Abstract:

Migration is a universal phenomenon that has presence since human existed on earth. People move from one place to another having a variety of purposes, where the most common and dominant reasons are compulsions and inadequacy of resources to fulfill life needs at the country of origin. The current study is an attempt to understand the phenomenon of migration especially Afghan refugees residing for more than three decades in the KP province of Pakistan. The research work is part of a PhD study on migration and criminality which asserts on the associated parameters with migration that lead to unhealthy activities in the host society. The study is framed under qualitative

research design utilizing the qualitative tools for data collection and thematic analysis in three major Divisions i.e. Peshawar, Mardan and Malakand of the province. The central and district jails were selected for identification of respondents and conduction of interviews to dig out the actual facts. The study concludes that unstable socio-political structure of the society diminishes the provision of basic rights to the Afghan refugees where the local masses consider them a threat to their socio-economic, cultural and political existence. On the contrary, the Afghan refugees become expressive and reactionary and develop feelings of inferiority and deprivation when not given with the expected demands that lead to their mal-integration and mal-social-practices for their survival, integration and settlement.

Background of the Study

People move from one place to another to fulfill their basic needs of life. In order to transgress borders, these movements are defined as international migration and treated with great concerns in receiving societies. The persons living for a period of one year outside their countries of origin are considered as international migrants, which are estimated as 214 million (in 2008) including labor force, refugees, asylum seekers, students and professionals in various fields constituting 3% of the total world population (Koser 2010).

Migration being an international phenomenon has given rise to a debate on multiculturalism and ethnic diversification where the people at the receiving end consider such movement a threat to their respective identities (Synder 2011). Research studies and official records emphasize that migration might be both 'voluntary' and 'involuntary' (Ministry of Foreign Affairs 2001), which is most often caused by political unrest, socio-economic problems and insecurity in the under-developed countries. In addition, the emergence of globalization has strengthened such movement in terms of proactive as well as reactive migration (Richmond 1994).

Being a controversial and highly debated phenomenon, migration entails (both) productive and destructive repercussion on countries of (both) the origin and receiving of the mover. At their initial entry to the receiving country, the international migrants are faced with a number of issues ranging from their food and shelter to getting citizenship. It is generally understood that people moving from one place (especially their

origin) to another (mostly destination and non-native) face hardships in their (re)settlement and adjustment.

In such a flow of hardship, the most common and foremost constrained object of their lives is their integration in the host society. Upon arrival into the host society, they come in conflict with a new culture and challenge the parental attitudes, behaviors, authorities and perceptions (Choudhry, Jandu, Mahal, Singh, Sohi-Pabla, Mutta 2002; Michel, 2004). As a result, the migrants get traumatized and caught in "bicultural expectations" (Segalm, Mayadas 2005). Most often, they are either less-integrated or disintegrated because of no family support and stability"; socio-economic networks; language proficiency; interpersonal skills; personal resilience (Carter, Polevnychok, Friesen, & Osborne 2008; Enns, 2008; MacKay, Tavares, 2005; Murdie 2008). Among these, the significant issue that the migrants are faced with is the receiving of education. They face difficulties in getting formal education as most of them do not inherit literary skills and a good academic background from their countries of origin (Rossiter; Rossiter 2009). Apart from education, migrants also face health problems during and on their arrival into the host societies. During their travel they are faced with poor health services including malnutrition, lack of access to proper health care services, and overcrowded camps (situated at both the sending and receiving societies) (Pavli, Maltezou 2017).

These parameters (along with dozens more) shake their social life with miseries. The diversity

in their settlement, the vulnerability of domestic workers and emerging trends of xenophobia add to already unfavorable scenarios and make them worse. The situation even becomes more exacerbated when these challenges lead them to indulge in illegal activities for their survival and existence. They lose the social capital and become involved in crimes, violence and gang activities (Gordon, 2000; Wortley, 2003; Wortley, Tanner 2007).

The Argument

Migrants face problems almost everywhere on their arrival that mainly correspond to the issues of their reception and socio-economic adjustment/resettlement in host societies (Menvis 2010). Initially, they make their demands for water, food, housing, education, health services, sanitation and transportation, and in some cases for natural resources such as grazing and firewood (World Bank Report, 2011).

Migrants also bring with them some expectations into the host communities. They aspire for a job or a source for earning which is most often not favorable. They usually fail to properly assess the situation in labor market because most of them do not permit migrants due the overwhelming labor market, youth bulge, limited vacancies and government restrictions (Ocho, Williams 2005). With the migrant-status, in many countries they are usually not allowed to work, which diverts them towards illegal mechanisms and thus indulge in criminality (Menjívar, Lakhani 2016).

Relationally, the problems in accommodation usually force them to settle in slums. The infrastructure that exists such as sewage, water supply, medical services and sanitation services are badly affected so when they are settled in such areas that do not meet the required standard of life (Mberu, Ezech, Chepngeno–Langat, Kimani, Oti 2013), which creates a sense of deprivation, inferiority and frustration among them to think negatively and engage illegality.

The slum-based-settlement paves the way for a new culture of miseries and vulnerabilities which compels the migrants to adopt a short way out that is more likely to be illegal. These illegalities (crimes) to which migrants are most frequently related are non-violent. In this context, the crimes data indicates that in migrants the most widely spread crimes are counterfeiting,

crimes against property (shoplifting or snatching, petty thefts) along-with in some instances the committing of violent crimes. Data concerning homicides show that the committing of the one third killings in the host communities is related to migrants (Savona, 1996). Migrants are also involved in crimes like drug abuse and trafficking, and violation of immigration laws in host communities. In response, the legal system instills punishments on migrants that are most often stricter than given to the natives for same misconducts. Resultantly, the migrants create a feeling of hatred and revolt for natives that further lead to the commission of expressive (violent) crimes in the host community (Savona, 1996).

The facts mentioned above might be elaborated in relative perspective in terms of the status of the receiving country. It is factually understood that the facilitation of migrants in stable and unstable countries must be different. A migrant entering to a developed country (first world) will be entertained appropriately while will be treated differently in the states that are suffering from instability (Third World). Similarly, Pakistan as a Third World country (suffering from economic, political, sectarian, educational etc. challenges) has received an alarming number of Afghan refugees since the Soviet occupation of Afghanistan in 1979.

Based on these facts, the integration of Afghan refugees in Pakistan is at the verge of deprivation and destitution. The country has witnessed almost 3 million refugees in 2017, which shows a significant number of Afghans in Pakistan (Khan 2017). The situation has been worsened when dire needs of the arriving population are not properly met and managed. They have struggled (and are still struggling) a long way for their existence, integration and survival in many aspects. Among these, the illegal way has been predominantly adopted when added by the diversity in their settlement, the vulnerability of domestic workers and proliferation of xenophobia among the arriving masses.

Objectives of the Study

The current study is based on a broad objective i.e. 'investigation of the socio-economic problems in integration of Afghan refugees in relation to their involvement in crimes in Khyber Pakhtunkhwa'. In this context, two major indica-

tors have been identified, which play a dominant role in worsening the issue of their integration, which in-turn, lead them to adopt criminal and illegal ways for their settlement, integration and/or survival or existence. These objectives are:

To highlight the role of diversity in refugees' settlement in their mal-integration and criminal conducts

To investigate the vulnerability of domestic workers with a tendency to defective integration and criminality of Afghan refugees in the area

Plan of Work/Methodology: Nature and Locale of the Study

The study is framed under qualitative research design to assess and investigate subjects' (Afghan refugees') behaviors in terms of their integration and diversion/adoption to illegal means for survival and existence. The study is conducted in Khyber Pakhtunkhwa Province where the three major Divisions i.e. Peshawar (Central Jail Peshawar); Mardan (High Security Prison); Malakand (District Jail Malakand) are selected for study.

Samples, Sampling Technique, Data Collection and Analysis

The samples were conveniently selected from the mentioned jails qualifying the 4-point criterion i.e. (1) Afghan refugee, (2) a male, (3) above 18 years of age and (4) convicted for crime(s). Based on this, a total of 80 samples were selected and interviewed through an interview guide while the responses were recorded both on paper and audio recorder. In addition, three (03) Focus Group Discussions were also conducted with the subject respondents, where case studies and observation methods were also applied when deemed necessary. The collected data is thematically analyzed in terms of translation, transcription and narration to unfold the facts as below:

Diversity of Refugees' Settlement

The resettlement process varies from group to group and context to context. It is neither a particular group nor a segment in society that faces difficulties in resettlement but also becomes difficult to resettle with in one's own ethnic group. Different researchers have reflected with different typologies of refugees' resettlement.

Colic-Peisker and Tilbury (2003) while working with Bosnian refugees in Australia argue that the refugees inheriting resources are likely to be easily settled. On the contrary, refugees characterized as 'endurers' and 'victims', who face multiple challenges of being forced to leave for resettlement in countries and communities in a vastly different social environment. Consequently, they suffer from mental health issues during their refuge and are likely to adopt a 'passive' approach to resettlement and will relatively live in social isolation and distance not only from the mainstream society, but also their „ethnic community“ (Colic-Peisker, Tilbury 2003).

The ability to successfully resettle in receiving societies also depends on cultural distance, the displacement experience, and resilience of individuals in overcoming difficulties. However, it is argued that refugees should have access to a labor market. Keeping them out of labor markets will create a sense of deprivation, distress and tension and hinder their social integration and increase poverty (McColl et al. 2008). In this context, the empirical data asserts as

„We are peacefully living in our neighborhood and want to live with our community. They (the locals) call upon us and taunt us as 'kala ba zey (when will you leave)', 'mahajara ao da khrey jajara, dera khurey ao dera obasey (Oh migrant, you are the magazine (to be read as a weapon's magazine) of donkey, you eat more and then pee more', 'kabaliya khpal watan ta za kana halalom dy' (Oh man of Kabul, move back or I'll slaughter you) (An Afghan child expressed his feeling) we live away from them so we have not learnt anything from them.“

„We cannot live with the locals because we are large in size (the family size), and unable to rent a house because they are expensive. We are also different from each other in terms of solemnizing our marriages as well as festivals. Your (locals) marriages are too expensive, and we are unable to do so, for example you give two- or three-times meal in a marriage and we provide only once. We are compelled to adopt the illegal means and earn illegally, because we don't have any support other than we offer labor. I was working with another Afghani (a cloth seller) and I stole some cloth to sell and earn. He caught me battered me so ferociously to make me insane

and senseless. I'll do it again, because I have eight sisters and I am the only earner in the family. How can a person keep such a large family on daily wages, which is less than five hundred rupees a day?

Presently, I am not in a position to do any harm to others, but if I come into power, I'll behead and slaughter all Pakistanis, because I abhor them extremely. They are so cruel to us that they hadn't yet accepted us as humans. We are dealt inhumanly in Police stations, courts and by general public. I am powerless, because the law deals us differently here. We have to provide three Pakistani guarantors if arrested by police. Pakistanis are not accepting us as humans, so from where shall I find three men to offer my bail and become a guarantor. This discriminatory attitude is making me furious and hateful toward these people, which compels me to adopt the criminal and violent methods for survival."

Analysis and Discussion

Settlement of strangers has always been an issue in the entire world. Migrants almost in all parts of the world are supposed to be strangers and outsiders. With the passage of time, they become so resembled with the host community that they consider themselves as insiders. Same is the case with Afghan refugees in Pakistan, where initially they intended to find only a shelter to live, while after spending decades, they are engulfed in local community to such an extent where their disapproval leads to disruption.

The empirical information also points to such fact that they have developed a long range of expectation in the local community. In addition, they are more associated in Khyber Pakhtunkhwa province because of lingual and cultural similarities in both the segments. In this context, the problem arises when the local community denies their equality and deals them absurdly which in most instances is not tolerated by the Afghans. The locals expect that they should be grateful, submissive and passionate towards few of the discriminatory practices in return of the benefits they are given with in such limited resources. Here the locals are confronting issues of poverty, unemployment, health services and education, etc. but still they have accommodated the huge burden of Afghans who (according to locals) are

occupying the market and scarce availability of jobs. Such a conflict of interests and expectations lead both the communities into conflicting situations and force the strangers to adopt the rebellious way for meeting their needs and integration. The primary data thus explicitly depicts that the intolerance of the locals makes the non-locals intolerant and compel them to integrate by force and settle in an unplanned manner which most often ends in violence and resumes in hatred.

Vulnerability of Domestic Workers

Refugees work both in formal and informal economies. However, the most available work is the household cleaning and childcare. Women are serving in homes and most of men are likely to find employment in the service sector working as chauffeurs, deliverymen or gardeners. Refugee workers are also discriminated in terms of wages as compared to the local workers. It is also believed that refugees working as domestic workers are not protected by labor laws. Jureideni's (2009) study indicates that 10% of the respondents complained that they have been victims to sexual assaults, including rape, inappropriate touching and sexual demand and are fired when refusing such demands. As a result, many refugees are jobless in the local markets. Under such circumstances, refugees get insecure, deprived, frustrated and reported to resort to alternative means to fulfill their needs. Response from the local Afghan migrants reported in the following manner:

"I had to work for 5 rupees of wages. The wage level was higher in the market for the locals i.e. Rs.12. We did not fight for our wage with the local, the reason was we were poor and Afghans. I also managed for my home with the help of locals with whom I had come in contact. There was a hell of a difference. You (indicates himself, to be read as 'I') cannot tell your relatives that you were working as a laborer in Pakistan once you go back. The jobs we are offered in Pakistan are so cheap and menial that we feel ashamed of doing them, but we have to do them for our survival, otherwise we'll die of hunger. Such contemptuous treatment makes us frustrated and feeling to revolt arises from inside."

We (means I – original extracts reflect the word 'we') are working with Pakistani. We have

no such problems with Pakistanis besides wages. Pakistanis are preferred on Afghanis; it is because of the threats and no jan pehchan (understanding and identity). We are paid less and late; Pakistanis are paid more and in-time; this is the only difference we are faced with. Now can you tell me, what is the extent of this discrimination – either minor or major?

In this context, market liberalization also causes deprivation, social unrest and disruptive behavior (Haruna 2015). The unequal status of the labor market is not only responsible for the poor economic performance but also affects social behavior which creates a sense of distrust and frustration among individuals leading them to crimes. In addition, Becker (1968) has argued on the link of income inequality with committing of crimes. He says that crimes would be committed if the potential benefits of illegal acts are greater than the costs of apprehensions. Thus, people resort to commit criminal behavior when it pays more than a job in labor market.

However, without the right to work, research works reveal that refugees seek a wide range of means to generate alternative income. These strategies are revealed to be used by both the natives and refugees (Lewis 2007). Crawley et al., (2011) have also recorded that few women and men have been resorted to engage in some irregular working as sex workers.

„I am taking ice (the methamphetamine drug). I enjoy sex when I am in habit of taking ice. Those who are rich will enjoy it most (with high laughter). I cannot say exactly but 20% of the whole society is involved in sexual relations. I am doing sex for taking satisfaction. You cannot imagine that how much money I can earn from such acts. I will not stop from doing such acts because we require a lot of money to fulfill our needs.“

However, the studies independently note the involvement in crimes being the only strategy for survival. A survey conducted by Querton (2012) revealed that several women were found involved in sex works as means of their survival. While Phillimore and Goodson (2010) depict that since the women are susceptible to sexual abuse, their involvement in sex work is not attributed to the income resources but to other exchanges as well, such as accommodation. While on the other hand, men are more able to seek and resort to in-

formal employment. The involvement in the informal economy is likely to be more prominent in refugees who are refused being asylum seekers (Taylor, 2009).

„I was working with a Pakistani for the last 20 years. He did not know that I was an Afghani but came to know when I took his money. I used to bring cars from other parts of the country. He had developed trust in me and even he never hesitated to transfer/transact money. One day he asked me to go to the bank and bring money. It was about one million rupees and I had not seen such a huge amount in my life. I took the money and absconded from the scene. I was arrested by police in Lahore brought to court. I confessed my crime and was imprisoned for seven years. I had thought that is better to take a huge money which I had in hand than I could earn in half a century.“

Analysis and Discussion

The third world has long been confronted with dozens of malpractices: the social structure is distorted; the economic structure is unable to hold the standard of life; the political institution is not capable of bringing order in society which brings adversity in social life. In such scenarios, the advent of strangers to such a community and in such a large proportion in no time worsens the situation. The literary and empirical discussion asserts that Pakistan and Afghanistan are no way structurally and administratively dissimilar. Although there might be a difference in their progress, Pakistan with such a huge population is still struggling to provide medium level life standards to its masses. In the meanwhile, the arrival of vast Afghan refugees was an unbearable responsibility for Pakistani society. In such conditions, both the parties (Paki and Afghani) are in the right. Being similar in terms of culture, language and religion, the Afghan migrants consider themselves rightful of being treated with respect, honor and equality, while contrary to this, the Pakistanis are complaining of this wrong decision to encompass more than 3 million extra population. The KP province particularly has been most vulnerable in this context, where domestic workers are deprived of the already scarce opportunities for jobs. On the other hand, the complaint of Afghanis might be acceptable that they are

treated beyond discrimination. Even human rights are also not available to them which compel them to indulge in unhealthy and criminal conducts. Thus, saturation of the job market results in scarcity of employment. Afghans offer jobs at low wages, where the self-esteem of locals has been threatened. They either remain jobless or come into confrontation with Afghans to snatch their rights back.

Conclusion

Transgression of borders through people's migrations from one place to another is a certified fact. It is either a need of people to move; a compulsion to meet some needs; to avoid some unpleasant threat. Such movements take place in dynamic situations which yield diverse results depending on the purpose of movement; the socio-cultural and economic and political conditions of both the countries (origin and destination); the socio-economic status of the mover.

The fact is evident that the movement that takes place in compulsion because of the socio-political and structural unrest in the countries of origin yields unpleasant results in the host countries. The immigrants are usually not welcomed, rather they enter the country either by force, or solicitation or illegally. All these parameters for movement of people are unwelcoming, which in turn put the immigrants into another challenging scenario to face. Both the local masses and governments do not let them live freely and rarely accept them being ordinary citizens having all rights and privileges.

Similarly, the current study has intended to identify the factors that restrict the integration and settlement of Afghan refugees in KP province. These migrants, although residing for more than 3 decades, are still faced with discriminatory practices and are yet to be accepted as general masses. These refugees are considered special masses who in the name special care, are dealt in special circumstances. The study found multiple reasons that these people confront in their of settlement and integration. The most deeply engraved parameter is the instability of Pakistani socio-political structure. The exponentially higher population of the country is living below standardized minimums of life combating with issues of destitution, joblessness, insufficient health services, security problems and ex-

tremism. In such scenarios, the advent of more than 3 million extra population in extremely pathetic conditions, was never easy for such a country which has been and is struggling hard to fulfill basic needs of its masses.

Consequently, issues emerged in settlement of these refugees as they were kept in isolation in the form of camps. This isolation created a distance between the locals and the migrants because there was a clash of expectation between both the parties. The migrants were expecting a welcoming and respectful approach, while the locals considered them as a burden and invaders on the already devastated economy and a threat to the scarcely available income resources. After spending several decades, they are still considered outsiders and kept at distance, which is no more acceptable to the migrants these days. This conflict of thoughts based on economic resources and settlement issues, led the outsiders to think differently and adopt some other ways to find solution. In this context, the rational choice approach of criminal studies was justified, that the Afghan refugees adopted the illegal ways to integrate themselves, which gave birth to a new kind of conflict between the arrivers and the receivers in terms of adjustment, integration, settlement and job market. The study reveals that the continuation of such struggle between both segments might result into actual conflict (which in many instances has taken place) and might lead to a new argument of forceful settlement of these refugees.

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Integrated Communication as a Marketing Instrument in the Economy and Pharmaceutical Industry

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Abstract:

Communication between people always takes place on a cognitive level. The processes of information processing, internal and external situations and social interaction are among the essential characteristics of communication. How does a pharmacy affect the customer? How is the pharmacy perceived externally? The question here is: If communication is less effective on a verbal level than on a presentation level.

Introduction

Globalization, digitalization and demographic change are leading to increasing competitive pressure for pharmacies. This is also intensified not least by competition in communication between them. It is therefore not surprising that more and more companies are using unusual communication concepts in order to bind customers whose attention, processing and perception capacities are limited. Corporate communication is thus becoming increasingly important in order to survive in saturated markets¹. Communication between people always takes place on a cognitive level. The processes of information processing, internal and external situations and social interaction are among the essential characteristics of communication². Nevertheless, there is no generally valid definition for the term, because communication is understood to be primarily actions that are interpreted differently depending on the situation, the means of communication and the person. If the term communication is derived from the French and English „communiquer“ and „to communicate“, its meaning can be translated as „to communicate“ or „Communication“. The two terms „converse“ and „conversation“ form the opposite. These always indicate an exchange of information between people. According to this view, communication would therefore be one-sided, because in this case the sender would communicate and the receiver would merely listen, which in turn would not indicate a pure information exchange. However, communication means more: the purpose of communication is to encourage people to enter into a mutual exchange of realities and images and, in addition, to inform the respective recipient³. This is done through different communication channels. The media landscape, for example, has undergone major changes in recent years. Classical communication channels and media such as newspapers, radio or television have been supplemented or even replaced by various social

media channels such as blogs, Facebook or newsletters. It can therefore be assumed that, in addition to classic communication instruments, social media communication also has a considerable influence on corporate success. (Trusov et al. 2009). In addition, there is a constantly increasing use of social media channels, which has led to a change in the type of communication. The previous transmitter-receiver model has been replaced by the transmitter-multi-receiver model. A message is now not only transmitted from sender to receiver, but - depending on the distribution of the message - from one sender to many receivers. (Bruhn et al., 2011, p.40).

Communication policies

The communication policy (promotion), the fourth P in the marketing mix, deals with the exchange between customers and companies. Accordingly, external communication is directed directly to the previously defined target groups. In particular, external communication is defined as the impression made by the company from the outside: How does a pharmacy affect the customer? How is the pharmacy perceived externally? Here, communication is less effective on a verbal level than on a presentation level. On the basis of different sales channels (e.g. advertising via blog) it can then be decided which content is ultimately communicated to the outside world⁴. In addition to PR (public relations) and product placement, communication policy also includes sales promotion, personal sales and advertising⁵.

However, these pose challenges for integrated communication. These challenges are described by the five dimensions according to Kirchner (2006). These dimensions include⁶:

- Integrated self-portrayal: Consistent self-portrayal only works if there is a clear market positioning that reflects both the values and the personality of the brand.
- Interdepartmental planning and cooperation:

¹ Vgl. Esch et al. (2009), Brand identity as a basis for the design of internal and external communication

² Vgl. Strohner (2006), Communication, p. 28

³ Vgl. Ternes (2008), Communication – A- Key Qualification, p. 20

⁴ See. Manweiler (2014), Impacts on the implementation of a management scheme p. 13

⁵ See. Freter (1983), Market and customer segmentation: customer – oriented market design and processing. Pp. 292

⁶ See. Integrated Business Communication, pp. 86-100

Companies are complex, so integrated communication can only work if departments work together on an interdisciplinary basis.

- Customer orientation: Customer loyalty must be strengthened through holistic relationship management.
- Stakeholder-oriented integration: An integrated communication concept takes into account all relevant stakeholders, e.g. shareholders, suppliers or employees.
- Anchoring communication in pharmacies: Derivation of a communication strategy from the corporate strategy. In addition, the integrated communication also serves as an interface between the public and pharmacies as well as for obtaining feedback for the company. This dimension is particularly important so that communication can be integrated into corporate management.

Basically, therefore, „integrated“ means nothing more than „united“, meaning a union between personal communication and various marketing measures - from traditional radio advertising to viral marketing and social media marketing.

Online marketing is becoming increasingly important here. Since extremely short response times are required on the Internet, companies must react very quickly to inquiries. Otherwise, potential customers may quickly switch to another company with shorter response times. This is why more and more companies are now acquiring their customers via social media channels such as Facebook, Xing or Twitter. This means that brand presence on the Internet is becoming increasingly important. A good sales channel or a good advertisement for your own pharmacies is also the use of a homepage. It is not for nothing that the German management consultant Prof. Hermann Simon (2000) said:

„In marketing, the Internet is not everything, but without the Internet, everything is nothing“⁷.

This sentence clearly shows how important online marketing now is in the overall picture of marketing. Communication must therefore also be targeted in online marketing. This goal is achieved by integrated communication, in partic-

ular by using different social media strategies. The most important strategies include the Influencer strategy, which enables an active customer dialogue between the company and the customer, for example on a Facebook page or with the help of a celebrity on television. The customer dialogue creates proximity, which leads to a perceived enthusiasm among consumers or customers and is reflected in word-of-mouth propaganda. This knowledge can be implemented by the management in campaigns and leads in the long run to a better perception of the respective company⁸. A good example of this is the advertising of the „Ratiopharm twins“ for products of the drug manufacturer Ratiopharm due to its „product diversity“. Accordingly, every campaign includes a communication concept and the more digital the world becomes, the easier communication becomes for companies. New viral campaigns enable companies to get in touch with their customers in a more targeted way and thus change not only the way they communicate, but also their own business models and corporate culture. The campaigns of the new digital world must be faster, more targeted and above all more complex in order to keep customers happy.

Conclusions

1. communication via social media can have a positive effect on a company, as in this case, but also a negative effect if it is done in an imprudent manner
2. Greenpeace skilfully focused its social media communications by using the channels specifically for campaigns against Nestlé

These actions ultimately led Nestlé to fundamentally rethink its public image and, in the meantime, to completely change its social media communication.

Another example of successful integrated communication is the „Pfizer“ company with its marketing campaign on „Viagra“. The drug belongs to the group of phosphodiesterase type 5 (PDE5) inhibitors and contains the active ingredient sildenafil. Viagra is used to increase potency in men⁹. The uniqueness of Pfizer and Vi-

⁷ Simon (2000), The Great Handbook of Strategic Concepts, p. 158

⁸ See. Esch (2014), Brand identity as a basis for the design of internal and external communication, p. 493

⁹ See. NetDoktor (2020), Viagra (28.02.2020), <https://www.netdoktor.de/medikamente/viagra/> [28.02.2020]

agra was particularly evident in 2002 with a successful integrated campaign. In this campaign, Pfizer relied on a celebrity and used an influencer strategy that did not even exist in this form at the time. Football star Pelé talked about erectile dysfunction in a TV spot, thus breaking a taboo subject. He also encouraged other men to consult a doctor if they had problems. The campaign became very popular in combination with advertisements in the public print media, response possibilities via telephone hotline as well as reply postcards and information tour with a specially designed truck¹⁰.

Integrated communication is establishing itself - as seen in the two examples - more and more as a cross-cutting function between pharmacies and customers. The new form of communication makes it easier to reach a wide range of customers and to operate on several platforms simultaneously, as well as offline. Marketing is no longer carried out via one channel only, but reaches a much larger target group through targeted placement in the respective networks than would be possible via the classic channels, such as television or radio. Integrated communication has thus become a communication factor between customer and company that should not be underestimated. The influence of social networks on people and their everyday life is constantly growing. Due to the networking of people worldwide and the ongoing globalization, social networks in particular will continue to play an important role within Internet communication. Pharmacies have to be aware of these developments and must react to them promptly.

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¹⁰ See. Pogoda (2003), You would also like to know that you need to sell, p. 54f.

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Disparities In Social Development & Status of Women In Bimaru / Eag States Of India

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Abstract:

The problem of Regional disparities in the level of economic development is almost universal. Its extent may differ in different economies. But its existence can hardly be challenged seriously in any country of respectable size. The achievement of Empowered Action Group (EAG) states (Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Rajasthan, Orissa, Uttar Pradesh and Uttarakhand) in the area of social sector indicators have not come up to the desired level. Since Mid 1980's Ashish Bose 'BIMARU' still prevailed. The study revealed that overall female literacy has shown strong correlation with indicators of development, means low income persist but amidst all the shortcomings, the female literacy can drag these states on the path of development with a healthy labor force. More emphasis

should be laid on female literacy programs so that these states can also be pulled out of abject poverty. Although Government has stated „Beti Padyoo Beti Bachoo“ and Sarv Shiksha Abhiyan/Right To Education, But ground realities are too far from the slogan given by the Government.

Introduction:

India's misfortune during the British rule was not only confined to the backwardness of the masses and increasing unemployment, under-employment and disguised unemployment but also accentuation of uneven spatial development caused by the colonial policy. Consequently, after independence, India emerged as a federation of a few relatively rich and industrialized states along with many poor states which subsisted mainly on agriculture with primitive techniques and semi-feudal agrarian relations¹.

There is growing concern over the developing regional disparity in the country. The lagging regions complain of neglect and demand special care to attend to their specific problems². It is interesting to note that while planning models in India have become fairly sophisticated in relation to inter-temporal phasing and perspective planning, there has been no comparable extension of analysis to question spatial planning³. No single country would be regarded as having a well-integrated economy as long as glaring disparities exist between the levels of development and standards of living among its different regions.

Indian economy witnessed good growth in the post liberalization era but these high growth rates instead of decreasing inter-personal dispar-

ities has more or less widened them leading to social unrest among masses in many states of the country. These glaring disparities often threaten the political and economic stability of the country. The problems of regional and inter-personal disparities are vulnerable to generate discontent and disbelief and may endanger the very integrity of the country. No development is possible in the midst of social tension and civil disturbance.

In the mid 80s, economist analyst Ashish Bose⁴ coined an acronym BIMARU, in a paper submitted to then Prime Minister Rajiv Gandhi. BIMARU has a resemblance to a Hindi word „Bimar“ which means sick. This was used to describe the bad state of economy in the backward states of Bihar, Madhya Pradesh, Rajasthan, and Uttar Pradesh. BIMARU is an acronym formed from the first letters of the names of the states. Later Odisha was included in the list resulting in the name BIMAROU. Several studies, including those by the UN, showed that the performance of the BIMARU states affected the GDP growth rate of India. Some of these states are also red corridor.

The difference in economic and population growth rates between the BIMARU states and other Indian states sharpened over the 1990s. The economy of four BIMARU states grew at an av-

erage of 4.6% per year in the 1990s, compared to 6.5% per year for India as a whole. Since population growth in the BIMARU states was much higher than the Indian average in this period, the income disparity between the BIMARU states and India as a whole also increased⁵. The government had constituted an Empowered Action Group (EAG) under the Ministry of Health and Family Welfare following 2001 census to stabilize population in eight states (called EAG states) that were lagging in containing population. As per the latest census, EAG states Bihar, Jharkhand, Uttar Pradesh, Uttarakhand, Rajasthan, Madhya Pradesh, Chhattisgarh and Odisha have shown little improvement. They cover over 45% of India's population.

This research paper focuses on disparities in BIMARU states.

Inter-state comparison with respect to certain indicators has been used to shed light on the subject. Apart from highlighting the position of different states with respect to certain indicators, an attempt has been made to examine the correlation between different indicators of development (23 indicators: 12 related to the overall social sector development; 11 indicators related to status of women). These include social as well as economic indicators. The study focuses on trends of growth in different social indicators in under-developed states (BIMARU OR EAG) which include development indicators in: literacy; life expectancy; infant mortality; death rate; growth rate of population; birth rate; sex ratio (0-6 years); safe drinking water households; number of PHC, CHC (Primary Health Centers and Child Health Care Centers) and sub-districts under NRHM (National Rural Health Mission); anemia in women; ; economic indicators include per capita net state domestic product at current prices; vocational training, poverty & headcount ratios; Financial inclusion. To explain the study in a meaningful way, we have included several indicators related to women empowerment. These are: desire to limit child bearing; prevalence of severe anemia in women; percentage of women age 15-49 below 145 cm (nutritional status of women); percentage of women who want more sons than daughters; percentage of experience of physical or emotional or sexual spousal violence; percentage of women with Marriage age before 18 years;

total fertility rate; share of women in employment under MGNREGA (Mahatma Gandhi National Rural Employment Guarantee Act).

Study Area:

The most conspicuous features of the demographic characteristics of the EAG states (former BIMARU states) are its: high fertility; high Infant Mortality Rate (IMR); high Maternal Mortality Rate (MMR); high population growth rate; low literacy rate; high „Gender Literacy Differential“. The plains of Ganga, Yamuna, Narmada, Mahanadi presently supports near about two thirds of the population of the region which is also a high density region. The population of the region in 1951 was only 13.43 million. In 2011 the region had a population of 555.175 million indicating a decadal growth rate of near 25% on the face of national decadal growth rate of 17.7 %. The population growth rate varies from state to state. The highest decadal growth rate was seen in the state of Bihar of 25.4% than the National Average. The uneven distribution of population is mainly due to diverse physiographic conditions and disparity in the socio-economic development that the region has experienced in recent decades. The high population growth rates are attributed to the high fertility rate in this region. This phenomenal increase in population has great impact, not only on the demographic composition of the region but also has serious socio-economic consequences which get reflected in political turmoil and consequent conflicts witnessed in the entire region. An attempt has been made in this study to examine: the determinants for this unusually high population growth rate; the present distribution pattern; some demographic, socio-economic and environmental implications arising out of these.

Objectives:

1. To analyse the present condition of Empowered Action Group states with respect to socio economic indicators.
2. To find the relation of literacy with respect to social sector indicators.
3. To analyse the status of women in Empowered Action Group states.
4. To study relative aspects of the women's literacy rate among Empowered Action Group states.

Data Base and Methodology:

This paper is based on secondary data. To analyse the objectives, data regarding literacy, sex ratio and other demographic variables of EAG states are gleaned from The Census of India (2011), planning commission report of March 2012-13, 2014-15, 2016-17; Sample Registrar Statistics 2010, 11, 12, 13, 14 National Family Health Survey-3; Family welfare statistics 2011-12; and Economic Survey 2012-13, 14-15, 16-17.

The condition of inequality in different social sector development indicators in the BIMARU states is sought to be explained with the help of a coefficient of variation. The trends in coefficient of variation are ascertained to study the direction in regional disparities with respect to particular indicators over the period of time. Sampath6 (1977) used this technique to measure regional disparities. The co-efficient of variation is ascertained as follow:

$$CV = \frac{S}{X} \times 100\%$$

Where, C.V= coefficient of variation, S= Standard Deviation, X= Mean

To find the relation between overall literacy vis-à-vis female literacy with respect to social sector indicators, the coefficient of correlation is used. The coefficient of correlation is denoted by the symbol 'r', it is one of the very few symbols that are used universally for describing the degree of correlation between two series. The formula for computing Correlation 'r' is;

$$r_{(x,y)} = \frac{COV_{(x,y)}}{S_x S_y}$$

$r_{(x,y)}$ = correlation of the variables x and y

$COV_{(x,y)}$ = covariance of the variables x and y

s_x = sample standard deviation of the random variable x

s_y = sample standard deviation of the random variable y

Further to check the relationship between variables are significant or not, we are applying t-test statistics

Formula for the t test the Correlation Coefficient

$$t = r \sqrt{\frac{n-2}{1-r^2}}$$

with degrees of freedom equal to n - 2.

So there are large numbers of the techniques and methods through which the extent of disparities can be measured and degree of correlation between two series can be found out.

Results

In this paper a comparison has been made in the level of social-sector development among EAG states (Bihar, Madhya Pradesh, Orissa, Rajasthan, Uttarakhand, Jharkhand, Chhatisgarh and Uttar Pradesh). The study discerns whether the level of literacy in EAG states has any correlation with social indicators like: life expectancy; infant mortality; total death rate; growth rate in population; sex ratio (0-6 years); safe drinking water; number of PHC and CHC and sub districts under NRHM; anemia in women. Apart from these social indicators, the economic indicators such as: per capita net state domestic product at current prices; vocational training; poverty head-count ratio; financial inclusion has any relation with literacy rate; whether level of literacy affects any of these indicators positively or not. A general contention is that literacy plays a major role in economic development of any society or region. Since independence, these underdeveloped states have been more or less in same plight despite efforts by government to reduce disparities through 5-year plans. The present incumbent government's motto of inclusive growth also gives more or less a shady picture. It is found (Table 1) in the study that Bihar which is having a low level of literacy of 63.82% as compared to national average (74.04%); or average of EAG states (70.37) had a negative correlation with life expectancy (-.255); birth rate (-.242); sex ratio (-.245); growth rate of population (-.646); number of PHC, CHC and other sub-districts under NRHM (-.258). It means that, there is low degree of negative correlation. Same is the case with all other backward states which have also shown a low degree of negative correlation with above mentioned indicators related to overall social sector development. It is important to mention that among all the above mentioned indicators,

growth rate of population has a moderate negative correlation with overall literacy. It means, with the increase in education level, this indicator shows declining trend and this is a positive trend for the economy. On the other hand, infant mortality; death rate; vocational training institutes; financial inclusion; per capita NSDP; poverty head count ratio; safe drinking water revealed a positive correlation. The only single indicator i.e., per capita NSDP which shows high degree of positive correlation with overall literacy (0.859), may be the reason that these underdeveloped states are also the pockets from where migration of labor, or work force is to other states like Bihar Uttar Pradesh are major labor migrating hubs in the country. So their contribution to their own state is high.

Further, the other important indicator, which has shown a positive result when related to literacy, was infant mortality rate. The study reveals that the states which have a low literacy rate have a high infant mortality rate. So, literacy plays a positive role in decreasing the infant mortality rate. While in other indicators its role remains dubious. So we can say that apart from literacy there are certain social factors which play a dominant role in case of other indicators which are showing a low degree of negative correlation with literacy. Overall sex ratio (0-6 years) turned

out to be very disappointing in Rajasthan (888) and Uttarakhand (890). These figure even turned out to be even less than both combined average of EAG states (924) and at the national level (918). In fact, the poor sex ratio is a reflection of maladies in the society.

Discrimination of gender at the family level and at the social level is the root cause of such an unfavorable sex-ratio. Higher female mortality in different age group is also responsible for the low sex ratio. Female infanticide and neglect lead to high female mortality and thus a decline in the sex ratio. Further, under counting of females in different census; neglect of the girl child; frequent child bearing; discrimination against females are some other causes of the low sex ratio⁷.

It was observed that, those states having more vocational training programs, have more financial inclusion. For example, in U.P, M.P vocational institutes are higher (294 and 99 respectively) and second highest among EAG states and also these states have higher financial inclusion.

Though, overall literacy shows positive correlation with some social sector indicators and negative correlation with other social sector indicators, a close analysis and bifurcation of literacy rate between male and female has given glaring results.

Table 1 Social Sector Development in BIMARU States Year 2016-17

States	Literacy	Life Expectancy at Birth	Infant Mortality Rate (IMR)	Growth rate of population (% decadal)	Birth Rate	Sex Ratio (0-6 years)	Death Rate	Vocational Training Institute	Financial Inclusion (Household Availing Banking Services)	Per capita NSDP at current prices	Poverty Headcount Ratio	Safe Drinking Water Household (%)	# of PHC, CHC & other Subdistricts under NRHM
Bihar	63.82	67.7	42	25.4	27.6	935	6.6	20	44.4	31229	33.7	94.0	612
Chhattisgarh	71.04	65.4	40	22.6	22	969	7.2	NA	42	58297	30.4	86.3	589
Jharkhand	67.63	63.4	48	22.3	24.8	948	6.9	25	53.0	46131	31.2	60.1	456
Uttarakhand	79.63	65.8	50	19.2	26.7	890	6.7	69	63.8	103349	29.23	92.2	654
Madhya Pradesh	70.63	63.8	54	20.4	26.3	918	8.0	99	46.6	54030	31.7	78.0	651
Orissa	73.45	64.8	51	14.2	19.6	941	8.4	NA	45.0	54241	32.6	75.3	394
Rajasthan	67.06	67.5	47	21.3	25.6	888	6.5	17	68.0	65098	14.7	78.1	1500
Uttar Pradesh	69.72	63.8	50	20.2	27.2	902	7.7	294	72.0	37630	29.4	95.1	903
Combined Average of BIMARU states	70.37	65.27	47.75	20.70	24.97	924	7.25	65.50	54.35	56251	29.16	82.38	719
Degree of Correlation w.r.t Literacy		-.255	.420	-.646	-.242	-.245	.256	.066	.154	.829	.126	.155	-.258
t-test		.645	1.135	2.08	1.54	1.56	.645	.162	.381	3.60**	.311	.384	.656
India	74.04	67.5	40	17.7	21.4	918	7.0	3450	58.7	74380	21.9	85.5	13835

Source: Census of India 2011, latest NFHS-3, Economic Survey 2012-13, 14-15, 16-17

Table 2 Status of Women With Respect to Social Sector Development Year 2016-17

States	Female Literacy Rate	Life Expectancy at Birth	Infant Mortality Rate	Desire to limit child bearing (#of living children 2)	Prevalence of Severe Anemia in women (15-49)	% women age 15-49 below 145cm (Nutritional Status)	% women who want more sons than daughters	% experience of physical emotional or sexual spousal violence	Marriage age before 18 years	Total Fertility Rate	Share of Women in Employment Under MGNREGA	Coefficient of Variation
Bihar	53.33	68.0	43	60.2	1.0	15.9	39.2	60.8	63.7	3.4	28.82	64%
Chhatisgarh	60.59	64	59	75.3	1.9	11.9	32.8	32.3	50.5	2.8	30	72%
Jharkhand	56.21	62	55	64.3	1.3	18	28.1	40.9	60.2	3	29.4	63%
Uttarakhand	70.70	69	40	86.3	1.5	7.5	20.7	29.8	26.0	2.5	32	88%
Madhya Pradesh	60.02	65.5	55	81.9	1.0	8.4	30.8	49.1	52.6	2.9	42.48	72%
Orissa	64.36	65.9	52	82.3	1.5	13.1	24.2	41.2	37.5	2.1	38.60	73%
Rajasthan	52.66	70.0	49	72.8	2.5	5.0	34.3	50.2	58.4	2.8	69.20	68%
Uttar Pradesh	59.06	65.2	52	64.2	1.6	14.4	33.5	45.0	52.2	3.1	16.98	71%
Combined average BIMARU states	59.61	66.20	50.62	73.41	1.54	11.77	30.45	43.66	50.14	2.82	35.93	70%
Degree Correlation w.r.t Literacy		.039	-.218	.776	-.147	-.236	-.856	-.766	-.966	-.690	-0.294	
t-test		.095	.547	2.89**	.364	.594	4.09**	3.24**	9.2**	2.34	.756	
India	65.46	69.3	42	83.2	1.8	11.4	22.4	39.7	45.6	2.3	47.98	72%

Source : Census of India 2011, Latest NFHS-3 , Economic Survey 2012-13,14-15,16-17. Note: significance at 5%.

Table 3 Literacy Differential

Serial No.	STATE NAME	MALE LITERACY	FEMALE LITERACY	OVERALL LITERACY RATE	LITERACY DIFFERENTIAL INDEX
1	BIHAR	73.39	53.33	63.82	0.31
2	JHARKHAND	78.45	56.21	67.63	0.33
3	UTTARPRADESH	79.24	59.06	69.72	0.29
4	RAJSTHAN	80.51	52.66	67.06	0.42
5	CHHATTISGRAH	81.45	60.59	71.04	0.29
6	MADHYA PRADESH	80.53	60.02	70.63	0.29
7	UTTARAKHAND	88.33	70.70	79.63	0.22
8	ORRISSA	82.40	64.36	73.45	0.25
	India	82.10	65.46	74.04	0.22

Source: As per Table 1 & 2

Status of women with respect to social sector development reveals that female literacy as compared to overall literacy plays a vital role for the development of the society. It is found that (Table 2) Rajasthan and Bihar are: lowest with respect to female literacy as compared to a combined average of EAG states; had a negative correlation with infant mortality; prevalence of severe anemia in women; percentage of women age 15-49 below 145 cm; percentage of women who want more sons than daughters; percentage of experience of physical, emotional or sexual violence; marriage age before 18 years and total fertility rate. It means with the increase in female literacy all the above mentioned indicators shows declining trends. Hence, we can say that in this scenario, women's education is the major factor behind women empowerment. It is seen that marriage before 18 years shows highest negative (-.966) correlation with female literacy. It means girls want to continue their education rather than preferred marriage. Not even in this indicator, percentage of women who want more sons than daughters also shows negative correlation (-.856). The reason behind is that, in rural areas people believe that more sons mean more division in property. However, girls are studying more and earning well and bringing prosperity home. On the other hand, low level of literacy-the economically poor look to children as helping hands to their family. Hence, it is seen that there is no bar on number of children in uneducated

poor families as they think children are assets not liabilities.

Though overall literacy shows a positive correlation with the infant mortality rate, close analysis of the female literacy rate reveals a negative correlation with infant mortality revealing a negative correlation. The fact of the matter is that the states where their women are more literate and aware, they are having a low infant mortality rate. So the policy maker should emphasize increased girl education because if a girl is educated then the coming generation also get educated.

The female work participation rate is considered an important indicator of gender development. Basically, it is the level of prosperity; socio-economic set-up; literacy; etc. which leads to a higher female work participation rate (FWPR). However, a high work participation rate need not imply higher gender status in all circumstances. In this study, we observed that there is a weak negative correlation share of women in employment under MGNREGP with literacy. It means there is no space for educated women in such a project and is only associated with the uneducated women. So, we can say that to promote female literacy Government should start some programs for educated women under MGNREGP.

Further, the only one indicator which showed positive result when related to female literacy was desire to limit child bearing (.776). We can say that along with literacy some other factor like

medical aids over the years has increased and hence the death rate has decreased, which has change the mentality of rural population that having more children will result in surviving children. In old days medical facilities were not good compared to modern times. On the other hand, due to expenses on the higher side, urban couples are also restricting having children.

It can be concluded that in order to reduce gender disparity the government should set up more educational institutions. To increase enrollment of girls in schools in rural areas measures should be adopted by the government to provide safety for the school going girls. The Maharashtra government has started special buses so girls from other states may also attend such type of facility; focus on girl's safety to increase the education level. Secondly, female literacy can be improved by increasing the country's infrastructure like school to be accessible to village and community. In many villages there is not even a middle school; no girls toilet; due to all these problems and social taboos people don't want to send girls in or out of the village for study. Thus we can say that the real development of an area in fact depends upon education, because education leads to human capital formation and helps in awakening of the masses. Further, government initiatives; availability of educational infrastructure; social awareness; prosperity; exposure and the location of the area from the state headquarter appear to determine the level of literacy in an area.

Problems of Regional disparities on the level of economic development are almost universal. Their extent may differ in different economy. But their existence can hardly be challenged seriously in any nation of respectable size. To keep this thing in mind, we have tried to analyse the relative aspect of female literacy rate in EAG states. It was observed that Jharkhand and Bihar having fewer disparities (63% and 64%) as compared to rest of the BIMARU states. On the other hand, Uttarakhand, Orissa and M.P. (88%, 73% and 72 % respectively) had higher disparity.

Discussion

The HDI (Human Development Index) reported in the Human Development Report (HDR) published by United Nations Development Program (UNDP) is relatively a better

method of measuring growth than using just gross domestic product (GDP). HRI captures progress in terms of basic capabilities to live a long and healthy life'; to be educated and knowledgeable; to enjoy a decent economic standard of life / Quality of Life. According to the latest HDR 2018, the HDI for India was 0.638, with an overall global ranking of 130 (out of the 189 countries). However, there should be no room for complacency as India is still in the medium human development category with countries like Sri Lanka, Thailand, the Philippines, Egypt and Indonesia and our results which are showing a low degree of correlation of literacy and other indicators of development is more or less prove this. The social system, structure and social taboos also play a major role for all these indicators mentioned above. All EAG states even show a low level of life expectancy at birth than the national average of 67.5 years in 2011. While developed states like Punjab, Haryana, Gujarat, Kerala, Maharashtra continued to have life expectancy above the national average. These glaring disparities between different states of India are widening as inter-personal disparities are also on the rise.

Conclusion

So far the Government has tried to reduce disparities in these states by following inclusive development. But inclusive development means social as well as financial inclusion. Because the present study reveals that though some backward states have a little bit better literacy level, this level even shows negative or low degree of correlation with other indicators of development. Despite more than six decades of planned economic development a large part of the population, particularly landless agricultural laborers of backward states, marginal farmers, SCs, STs, and OBCs, suffer social and financial exclusion. Though government's policies are directed to uplift backward states so as to enable everyone to reap benefits of growth the goal remains a mirage. The present study established a close connection between social inclusion and financial inclusion. Inclusive development also includes the objective of reduction of inter-state disparities. The study reveals that socio-economic performance of the states has been varied. While EAG states have performed well in terms of female lit-

eracy when it is correlated with other women's empowerment indicators Vis-à-vis overall literacy. These backward states have their own socio-economic problems for which there is no uniform solution, making the implementation of policy measures difficult. Adding to this are inherent problems of lower growth rate and lack of infrastructure and development. Social inclusion is closely linked to financial inclusion and corrective steps are needed in this direction.

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Effect of Educational Program on Pressure Ulcer Prevention Intervention among Nurses of Intensive Care Units at a Public Hospital, Pakistan

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Abstract:

Objective: The purpose of this study is to evaluate the effect of an educational program on pressure ulcer prevention intervention among nurses in intensive care units at a public hospital in Pakistan.

Design: It is a Quasi experimental study.

Participants: 144 staff nurses with different educational backgrounds working more than 6 month in an intensive care units were participants.

Methods: They were evaluated pre-test. Workshops, lectures and hands on practice related to pressure ulcer prevention intervention were conducted. After these interventions post-tests were taken.

Results: There was a major difference between the mean knowledge score about the pressure ulcer preventive measures among nurses before (5.73 ± 1.488) and after ($12.01 \pm .908$) education sessions. P value is 0.000 which was less than .001 shows a significant difference in mean knowledge score before and after the education.

Conclusion: Knowledge base practices improved the quality of life and care. In the current study, post-test knowledge of nurses after a seminar, lecture and literature which given by the researcher, show improvement and most of the nurses get high marks in post-test session.

INTRODUCTION

Localized damage to skin tissue due to prolonged and extensive weight on bony eminences is called a pressure ulcer (Zeb et al., 2015). Pressure ulcer is a communal and excruciating health condition of immobilized patients (Uba, Alih, Kever, Lola, 2015). Pressure ulcers effect people all over the world (Hsu, Tsao, Sung 2013).

In health care organization's education is considered as a first step in prevention from pressure ulcer. Knowledge amongst nurses show a vital role in the prevalence of pressure ulcer reduction, management and prevention in hospitals (Levine, Ayello, Zulkowski, Fogel 2012). In hospital setting where the nurses are skillful at risk assessment and planning of PU management, and implementation of prevention, the level of incidence of pressure ulcer is lower (Andrade et al., 2014). Educational intervention is a significant tool to enhance nurses' knowledge and to prevent PUs (Cox, Roche, Van Wynen 2011).

The pervasiveness of PU indicates that the most focused need of nursing care is prevention of pressure ulcers. The occurrence of PUs was 18.1% in different health care settings across 5 countries (Vanderwee, Clark, Dealey, Gunningberg, Defloor, 2007). PUs play an imperative role in spread of infection especially in hospital settings; increase patient morbidity; mortality rate; hospitalization. The important component of patient safety goals are to minimize the number of pressure ulcers (Mohamed, Weheida 2015).

In the USA, predictable cost of pressure ulcer treatment exceeds \$11 billion per annum (Gray-Siracusa, Schrier 2011). Nurses play an important role in prevention of PUs. A nurse is the person in clinical settings who early recognizes the signs and symptoms of PUs. They should plan a teach-

ing program for patients to prevent PUs (De Meester, Van Bogaert, Clarke, Bossaert, 2013).

Educational intervention is an appropriate mechanism for transferring knowledge and awareness for nurses and patients (Brunner, Sudarth, Bare, Boyer, Smeltzer 1988; Masoumi, Masoumi, Shoujaei, Sharafi 2015). Moreover, nurses' knowledge enhancements reduce the cost of treatment; reduce pain; reduce human suffering (Smith, Waugh 2009).

Furthermore risk assessment, documentation, training, prevention and treatment guidelines are inadequate in nursing care relative to pressure ulcers (Saleh, Qaddumi, Anthony 2012). A survey was conducted in 16 Belgian hospitals to gain knowledge of nurses relative to PU. It was a cross sectional multicenter study using a valid and reliable questionnaire used to measure the results during February 2016 to December 2017. The result of this study revealed a low level of information of nurses regarding pressure ulcer prevention (De Meyer, Verhaeghe, Van Hecke, Beeckman 2019).

METHODS

Research design

A quasi experimental study design was used to explore the effect of an educational session of pressure ulcer prevention intervention among nurses of intensive care units. The study area was intensive care units at Lahore General Hospital Lahore.

Participants

The participants in this study was recruited through convenient sampling of 144 nurses were working in ICUs at Lahore General Hospital La-

hore with different educational backgrounds who agreed to participate in this study.

Research instrument

The research instrument consisted of the following sections:

Section 1: socio-demographic data

Data characteristics of the nurses were age, sex, education, marital status and experience.

Section 2: Structured knowledge questionnaire

It was used to evaluate the nurse's knowledge about prevention of pressure ulcers of immobilized patients. A 13-item knowledge assessment instrument was offered to measure the knowledge of nurses regarding PU prevention.

Section 3: Teaching program

The teaching program was planning used to cover the knowledge and practice for prevention and management of pressure ulcers.

DATA COLLECTION PROCEDURE

After taking official written permission to conduct this study from head of department. The purpose and nature of the study was described before consent.

Nurse's educational program

The preparatory phase

After taking informed consent from nurses, socio-demographic data was collected. After that pre-knowledge assessment of nurses regarding pressure ulcer prevention was done with the help of a pre-test questionnaire. Time for filling of assessment questionnaire was about 20 minutes.

Interventional Phase

The second phase of this study was give education to nurses regarding pressure ulcer prevention through lectures. The educational program consisted of 8 sessions over 1 month. Each teaching session time was 2 hours. Each lecture was focused on the general knowledge of pressure ulcers. Participants were taught through lecture, group discussion and questions. Printed material related to pressure ulcer prevention with guidelines was given to participants after each teaching session.

Evaluation phase

An evaluation phase was started after teaching sessions to all groups of participants. The 13-item knowledge questionnaire post-test was filled immediately after each lecture.

RESULTS

Table 1: Demographic Data of Participants Nurses pre and post Education

Variables	Number (n)	Per cent
Gender:		
Females	144	100%
Age:		
20-25 years	68	47.2
26-30 years	62	43.1
31-35 years	12	8.3
36-40 years	2	1.4
Experience:		
1-5 years	124	86.1
6-10 years	15	10.4
11-15 years	1	0.7
16-20 years	4	2.8
Qualification:		
General Nursing	139	96.5
Generic 4 Year BSN	3	2.1
Post RN 2 year BSN	2	1.4

Table 1 Reveals that all 100% (n=144) nurses were female. Age of Nurses were: 47.2% (n=68) age 20-25 years; 43.1% (n=62) age 26-30 years; 8.3% (n=12) 31-35 years of age; only 1.4% (n=2) nurses 36-40 years of age. Experience wise majority were: having less experience 86.1% (n=124) had experience 1-5 years; 10.4% (n=15); 6-10 years and only 3.5% (n=5); had more than 10 years of clinical experience. Majority 96.5% (n=139) were: General Nursing Diploma holders; 2.1% (n=3) were Generic BSN; 1.4% (n=2) were Post Rn BSN nurses.

Table 2: which statement is correct? **a.** Malnutrition causes pressure ulcer. **b.** A lack of oxygen causes pressure ulcers. **c.** Moisture causes pressure ulcers.

Response	Knowledge Before education		Knowledge After education	
	Frequency	%	Frequency	%
Wrong	117	81.3	26	18
Correct	27	18.8	118	82

Above Table 2 reveals that on a question of the cause of pressure ulcer development pre-education only 18.8% gave correct responses that lack of oxygen causes pressure ulcers which increased to 82% correct responses after the education for preventive pressure ulcer measurements.

Table 3: Extremely thin patients are more at risk of developing a pressure ulcer than obese patients. **a.** The contact area involved is small and thus the amount of pressure ulcer is higher. **b.** The pressure is less extensive because the body weight of patients is lower than the body weight of obese patients. **c.** the risk of developing the vascular disorder is higher for obese patients, this increases the risk of developing pressure ulcers.

Response	Knowledge Before education		Knowledge After education	
	Frequency	%	Frequency	%
Wrong	89	61.8	1	0.7
Correct	55	38.2	143	99.3

Above Table 3 suggests that why very thin patients are at greater risk of developing pressure ulcer which was correctly replied by 38.2% before education, who knew that the contact area involved is small and thus the amount of pressure is higher while 99.3% participants replied correctly after the education session.

Table 4: What happens when a patient, sitting in bed in a semi-upright position (60°), slides down? **a.** Pressure increases when the skin sticks to the surface. **b.** Friction increases when the skin sticks to the surface. **c.** Shearing increases when the skin sticks to the surface.

Response	Knowledge Before education		Knowledge After education	
	Frequency	%	Frequency	%
Wrong	71	49.3	1	0.7
Correct	73	50.7	143	99.3

Above Table 4 reveals that on the question, what happens when a patient, sitting in bed in a semi-upright position (60°), slides down? About 50.7% gave correct responses which increased to 99.3% correct responses after the ed-

ucation of preventive pressure ulcer measurements.

Table 5: Which statement is correct? **a.** Soap can dehydrate skin and thus the risk of pressure ulcers is increased. **b.** Moisture from urine, faces, or wound drainage causes pressure ulcers. **c.** Shear is the force which occurs when the body slides and the skin sticks.

Response	Knowledge Before education		Knowledge After education	
	Frequency	%	Frequency	%
Wrong	33	22.9	2	1.5
Correct	111	77.1	142	98.5

Above Table 5 suggests that on the question, moisture from urine, faces, or wound drainage causes pressure ulcers, which was correctly replied by 77.1% in before education while 98.5% participants replied correctly after the education session.

Table 6: Which statement is correct? **a.** Recent weight loss which has brought a patient below his or her ideal weight increases the risk of pressure ulcers. **b.** Very obese patients using medication that decreases the peripheral blood circulation are not at risk of developing pressure ulcer. **c.** poor nutrition and age have no impact on tissue tolerance when the patient has normal weight.

Response	Knowledge Before education		Knowledge After education	
	Frequency	%	Frequency	%
Wrong	81	56.3	3	2.4
Correct	63	43.8	141	97.6

Above Table 6 reveals that on the question, recent weight loss which has brought a patient below his or her ideal weight increases the risk of pressure ulcers, where 43.8% gave correct responses which increased to 97.6% correct responses after the education of preventive pressure ulcer measurements.

Table 7: There is NO relationship between pressure ulcer risk and **a.** Age **b.** Dehydration **c.** Hypertension.

Response	Knowledge Before education		Knowledge After education	
	Frequency	%	Frequency	%
Wrong	76	52.8	2	1.5
Correct	68	47.2	142	98.5

Above Table 7 suggests that on the question no relationship of hypertension with developing pressure ulcer which was correctly replied by 47.2% in before education while 98.5% participants replied correctly after the education session.

Table 8: Which statement is correct? **a.** A pressure ulcer extending down to the fascia is a grade 3 pressure ulcer. **b.** A pressure ulcer extending through the under/lying fascia is a grade 3 pressure ulcer. **c.** A grade 3 pressure ulcer is always preceded by a grade 2 pressure ulcer.

Response	Knowledge Before education		Knowledge After education	
	Frequency	%	Frequency	%
Wrong	108	75	3	2.4
Correct	36	25	141	97.6

Above Table 8 reveals that on the question, that pressure ulcer extending through the under/lying fascia is a grade 3 pressure ulcer, in pre education only 25% gave correct responses which increased to 97.6% correct responses after the education of preventive pressure ulcer measurements.

Table 9: Which statement is correct? **a.** A blister on a patient's heel is a/ways a pressure ulcer of grade **b.** All grades (1,2, 3, and 4) of pressure ulcers involve loss of skin layers. **c.** When necrosis occurs, it is a grade 3 or a grade 4 pressure ulcer.

Response	Knowledge Before education		Knowledge After education	
	Frequency	%	Frequency	%
Wrong	78	54.2	25	17.2
Correct	66	45.8	119	82.8

Above Table 9 suggests that on a question when necrosis occurs, it is a grade 3 or a grade 4 pressure ulcer which was correctly replied by 45.8% in before education while 82.8% participants replied correctly after the education session.

Table 10: Which statement is correct? **a.** Friction or shear may occur when moving a patient in bed. **b.** Superficial lesion, proceeded by non-blanch able erythema is probably a friction lesion. **c.** A kissing ulcer (copy lesion) is caused by pressure and shear.

Response	Knowledge Before education		Knowledge After education	
	Frequency	%	Frequency	%
Wrong	65	45.1	26	18
Correct	79	54.9	118	82

Above Table 10 reveals that on question, friction and shear causes' pressure ulcer, in pre educational session 54.9% gave correct responses which increased to 82% correct responses after the education of preventive pressure ulcer measurements.

Table 11: Which statement is correct? In a sitting position, pressure ulcers are most likely to develop on: **a.** Pelvic area, elbow and heel. **b.** Knee, ankle and hip. **c.** Hip, shoulder and heel.

Response	Knowledge Before education		Knowledge After education	
	Frequency	%	Frequency	%
Wrong	57	39.6	1	0.7
Correct	87	60.4	143	99.3

Above Table 11 suggests that on statement in a sitting position, pressure ulcers are most likely to develop on Hip, shoulder and heel, which was correctly replied by 60.4% in before education while 99.3% participants replied correctly after the education session.

Table 12: Which statement is correct? **a.** All patients at risk of pressure ulcers should have a systematic skin inspection once a week. **b.** The skin of patients seated in a chair, who cannot

move themselves, should be inspected every two to three hours. **c.** The heels of patients who lie on a pressure redistributing surface should be observed minimum a day.

Response	Knowledge Before education		Knowledge After education	
	Frequency	%	Frequency	%
Wrong	111	77.1	0	0
Correct	33	22.9	144	100

Above Table 12 reveals that a question on frequent assessment of skin to prevent pressure ulcer in pre-education only 22.9% gave correct responses which increased to 100% correct responses after the education of preventive pressure ulcer measurements.

Table 13: Which statement is correct? **a.** Risk assessment tools identify all high risk patients in need of prevention. **b.** The use of risk assessment scales reduces the cost of prevention. **c.** A risk assessment scale may not accurately predict the risk of developing a pressure ulcer and should be combined with clinical judgment.

Response	Knowledge Before education		Knowledge After education	
	Frequency	%	Frequency	%
Wrong	101	70.1	4	3
Correct	43	29.9	140	97

Above Table 13 suggests that risk assessment tools identify all high risk patients in need of prevention which was correctly replied by 29.9% in before education while 97% participants replied correctly after the education session.

Table 14: Which statement is correct? **a.** The risk of pressure ulcer development should be assessed daily in all nursing home patients. **b.** Absorbing pads should be placed under the patient to minimize the risk of pressure ulcer development. **c.** A patient with a history of pressure ulcer runs a higher risk of developing new pressure ulcers.

Response	Knowledge Before education		Knowledge After education	
	Frequency	%	Frequency	%
Wrong	61	42.4	48	33.5
Correct	83	57.6	96	66.5

Above Table 14 reveals that on a question of above statement, pre education 57.6% gave correct responses which increased to 66.5% correct responses after the education of preventive pressure ulcer measurements.

Table 15 Paired sample t test for knowledge score among Nurses before and after Education

Variables	Mean± S.D	P value
Nurses knowledge before education	5.73±1.488	.000
Nurses knowledge after education	12.01±.908	

Table 15 findings represent the overall knowledge score on the knowledge base questionnaire regarding the preventive measures of pressure ulcer. All Nurses were asked 13 knowledge based questions before an education session and then after providing education about the pressure ulcer prevention among the prolong bed ridden patients. The findings suggest that average pre education score was 5.73±1.488 out of total 13, whereas the average post education score was found to be 12.01±.908 out of 13 total which represents a clear prominent difference after providing the education to nurses. There was a significant difference between the mean knowledge score about the pressure ulcer preventive measures among nurses before and after education sessions. P value was 0.000 which was less than .001 shows a significant difference in mean knowledge score before and after the education.

Discussion

The current study tested nurses' knowledge on the subject of preventive methods of pressure ulcers among nurses. A low average score 5.75 out of 13 was found which shows a very low level of knowledge among nurses. A similar study was conducted in Nigeria to weigh the at-

titude, practice and knowledge of PU preclusion in University of Maiduguri Teaching Hospital. The study was a cross sectional descriptive survey of 99 nurses; data was collected through a self-developed and authenticated questionnaire tool. The results showed low level of knowledge of PU prevention, attitudes and practices among nurses (Uba et al., 2015).

The findings of this current study reveal that there was a significant difference between the mean knowledge score about the pressure ulcer preventive measures among nurses before and after education sessions. P value is 0.000 which is less than .001 shows a significant difference in mean knowledge score before and after the education. Another similar study finding revealed that nurses' knowledge regarding the pressure ulcer preventive measures was increased with the help of education programs among nurses working in hospital (Saleh et al., 2012). The result of a previous study revealed same kind of results where a positive association of education regarding pressure ulcer prevention protocol was found with nurses' knowledge to ward pressure ulcer prevention. The pretest result indicated that nurses' knowledge was a moderate level (74.05% SD $\pm$ 13.499), nurses attitude was positive (42% SD $\pm$ 4.767) and nurses practice was (67% SD $\pm$ 2.983). However, the mean percentage of all posttest showed a significant (Gunningberg, Hommel, Bååth, & Idvall, 2013). According to another study Adherence to the preventive measures showed a significant increase (11.7%) between the first month of the program and the final month (58.5%) of the assessment. Initial PU rate was 20.9, with a decrease in the rate to 14.0 per 1000 bed occupancy days ($P < .05$) after the risk management program (Araya & Febré, 2017).

Limitations: The sample proportion is small and from a precise circumscribed group therefore the results cannot be comprehensive to the larger population.

Conflict of interest: There was no conflict of interest in this study.

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Discussion

Pressure ulcers remain a significant problem in the health care system. Pressure ulcers prevention educational program was effective in increasing the knowledge of nurses; improving the practices related to PUs care; decreasing the incidence of pressure ulcers (PUs) occurrence among patients. In this current study, an apparent barrier for using pressure ulcer prevention intervention (PUPI) is lack of knowledge in clinical practice. Nurses are not fully aware the importance of using up-to-date information. In this study, pre-knowledge tests of nurses was poor scored. Most nurses have low competency level to demonstrate pressure ulcer prevention intervention (PUPI). Knowledge base practices have improved the quality of life and care. In the current study, post-test knowledge of nurses after seminar, lecture and literature which was given by the researcher, was improved and most nurses get high marks in post-test session.

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Knowledge, Attitude and Practice of Kangaroo Mother Care among Neonatal Nurses

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Abstract:

Introduction: Kangaroo mother care has been established as having an important role in the care of infants, particularly in preterm and low birth weight infants. Kangaroo mother care implementation depends on knowledge, attitude, and practice by neonatal nurses.

Objectives: To assess the knowledge, attitude and practice of kangaroo mother care among the nurses of neonatology in a tertiary care hospital.

Methods: This study was a descriptive cross sectional study in which data were collected from 38 nurses of neonatology departments. The study respondents were nurses and head nurses. They were assessed through a questionnaire in three domains, knowledge (10 items), attitude (8 items), and practice (4 items).

Results: In knowledge domain only 32% nurses knew that kangaroo mother care is a method of care in neonates; 12% nurses were sure about the components of kangaroo mother care and verbalized these components; 38% nurses answered that kangaroo mother care is beneficial for low birth weight infants; only 56% nurses knew about infant position in kangaroo mother care. In attitude domain: 82% nurses agreed that kangaroo mother care technique is beneficial for infants; 76% nurses agreed that mothers also were satisfied for adoption of this method. In practice it was observed that 12(32%) nurses guided and counseled mothers how to practice it.

Conclusions: According to the above results, it is clear that knowledge, practice and attitude, among nurses about kangaroo mother care are at an optimum level after lecture and training intervention. However, there is scope for fulfilling the gaps to get better practices, and training workshops are necessary to bring in behavior change among nurses.

INTRODUCTION

Kangaroo Mother Care (KMC) is defined by World Health Organization as early, continuous and prolonged Skin to Skin Contact (SSC) between the infant and the mother (Guenther et al., 2017). It is a substantiation based technique that is minimizing the morbidity and mortality rate in newly born infants (Chan, Bergelson, Smith, Skotnes, Wall, 2017). KMC has been used as the natural means of body temperature regulation for low birth weight (LBW) infants that is increasingly implemented in the world (Uwaezuoke, 2017). The WHO states that KMC “should be started after clinically stabilizing of a neonate (Morgan et al., 2018). KMC is a non-conventional low income process of infant care (Bera et al., 2014).

Moreover, KMC technique is biologically sound and universally accessible for all infants, particularly for the premature (Heidarzadeh, Hoseini, Ershadmanesh, Gholamitabar Tabari, Khazaei, 2013). The position of a mother in KMC is vertical or upright. The infant is placed between the breasts of a mother for direct skin to skin contact (Bear & Mellor, 2017). According to WHO KMC is comprised of 4 basic components that offer: prolonged SSC; exclusive breastfeeding; early discharge from hospital; follow-up (Health, 2003). KMC involves placing the neonate into prolonged and continuous SSC with the mother after birth; breastfeeding; early discharge from hospital; compassionate follow-up

at home. Claimed benefits of KMC as support to the clinical alleviation of several detrimental features of prematurity need to be evidence based (Bear & Mellor, 2017).

Implementation of any intervention is strongly influenced by attitude (Singh, Mishra, & Gupta, 2018). It has been pragmatic that despite a number of available evidences about the benefits of kangaroo mother care, the implementation of KMC is often influenced by the personal knowledge and beliefs of health care providers (Flynn & Leahy-Warren, 2010). Consequently, the study objective was to assess the knowledge, attitude, and practices (KAP) of kangaroo mother care amongst nurses in a tertiary care hospital.

MATERIALS AND METHODS

Setting: This was a cross-sectional study conducted in the Neonatal Intensive Care Unit-I & Unit-II of a tertiary care setup in Lahore, Punjab (Pakistan). The healthcare setup offered facilities such as: outpatient; inpatient; newborn care services.

Population: The nurses from neonatology are directly involved in the care of newborns, they were taken as study respondents to assess the knowledge, attitude, and practice about kangaroo mother care.

Instrument: A questionnaire which comprised on demographic characteristics of the nurses were collected by: age; years of experience in dealing with newborns; education; formal

training in kangaroo mother care; familiarity with kangaroo mother care. The questionnaire comprised in 3 domains: knowledge (11 items); attitude (8 items); practice (4 items). Closed ended questions were used to evaluate their knowledge and attitudes.

Procedure: Before the study the questionnaire applied on 6 nurses for assessing the gaps and re-structuring it. The pretested questionnaire was applied on 38 nurses of both units (Neonatology unit I & II).

RESULTS

The questionnaire was given to 38 nurses including head nurses from the department of neonatology and maternal and reproductive health. All the nurses responded to the questionnaire. The demographic characteristics of the respondents are stated in Table 1.

Table 1: Demographic Characteristics of neonatal nurses

Characteristics of neonatal nurses	n=38
Department (%)	
NNU-I	50%
NNU-II	50%
Age (Mean $\pm$ SD)	31.03 $\pm$ 1.8
Experience of NNU in year (Mean $\pm$ SD)	12.12 $\pm$ 1.71
Designation (%)	
Head Nurses	12%
Charge Nurses	88%
Training in KMC	
Yes	16%
No	84%

50% nurses from NNU-I and 50% from NNU-II responded. The mean age of participants was 31.03 $\pm$ 1.8. Work experience (year) in a neonatal nursery unit was 12.12y $\pm$ 1.71. Out of the 38 nurses 6 (12%) were head nurses and 32 (88%) were charge nurses. 16% of nurses had received formal training in KMC, while 84% of nurses had no training. All the respondents were female.

Table 2: KAP of nurses about KMC

Sr. #	Questions	Responses of Nurses	
		Yes	No
Knowledge-I			
1.	Do you know about KMC?	32%	68%
2.	Do you know about the components of KMC?	12%	88%
3.	Is KMC beneficial for low birth weight infants?	38%	62%
4.	Does infant in prone position naked with mother's bare chest?	56%	44%
5.	Does mother sit in an upright position during KMC?	40%	60%
6.	Is the minimum time of KMC 1hour?	22%	78%
7.	Is the infant dressed only a diaper during KMC?	36%	64%
8.	Is KMC stopped after first complete breastfeeding?	38%	62%
9.	Is temperature maintained in the KMC room?	48%	52%
10.	Does Nurse help mother to adopt KMC position?	72%	28%
Attitude-II			
11.	Do you agree KMC is beneficial to preterm infants?	82%	18%
12.	Do you agree KMC is beneficial to mothers?	76%	24%
13.	Do you agree KMC is given by anyone?	66%	44%
14.	Do you agree KMC is started as soon as possible after birth?	72%	28%
15.	Do you agree infant can breastfeed in KMC position?	86%	14%
16.	Do you agree KMC can given to infants with oxygen inhalation?	48%	52%

17. Do you agree KMC is given to ventilator infants?	12%	88%
18. Do you agree KMC has no associated risks?	64%	36%
Practice-III		
19. Do you guide the mother about KMC?	36%	64%
20. Do you guide the father about KMC?	28%	72%
21. Do you re-examine the implementation of KMC?	38%	62%
22. Do you use placard, posters, and videos for KMC implementation?	42%	58%

Knowledge regarding KMC in Nurses

In knowledge domain: only 32% of nurses knows about the KMC method of care for neonates; 12% of nurses are sure about the components and verbalized correctly about skin to skin contact of an infant and the mother, early discharge, and supportive follow-up; 38% of nurses answered that KMC is beneficial for low birth weight infants. Infant is prone naked with mother’s bare chest in KMC; 56% of nurses knew about it; 40% nurses know about mother’s position in KMC; 22% of nurses know the time duration of KMC; 36% know about the infant dress up in KMC; 62% of nurses know that KMC does not stop after first complete breastfeeding; 48% of nurses know that KMC room temperature is maintained; 72% of nurses know that there is need to help mother for adoption of the KMC position (Table 2).

Attitude of Nurses regarding KMC

The KMC technique is beneficial for the neonate: 82% of nurses agreed. Mothers also are satisfied for adoption of this method: 76% of nurses agreed; 66% of nurses said that KMC can be given by anyone rather than mothers; 72% of nurses agreed KMC started as soon as possible after birth; 86% agreed that infant can breastfeed in KMC position; only 48% of nurses agreed KMC can be given to infants with oxygen inhalation; only 12% agreed that KMC can be given with ventilator; 64% said that KMC has no associated risks (Table 2).

Practice of Nurses regarding KMC

It was observed that 12 (32%) nurses guided and counseled mothers about practicing KMC and its benefits and how to do KMC at home; only 28% guided the father about this technique; 38% re-examined the infants and their mothers; 42% explained the method through play cards, posters and videos.

DISCUSSION

KMC is a low cost, safe and effective method for the care of LBW infants (Charpak et al., 2005). For the thriving implementation KMC needs supervision, motivation, and care from the healthcare team. Therefore, it is important to assess the KAP of health care professionals for the same. In the current study only 12 (32%) of nurses can define KMC; 12% correctly knew about components of KMC; 38% knew the benefits of KMC in LBW infants. A study conducted by Dalal et al. and discovered that 33.1% of doctors had clear knowledge about KMC; 29.7% had knowledge about eligible infants (Dalal, Bala, & Chauhan, 2014). Another study conducted in Kenya elaborated that 87.5% of health care professionals knew the need of KMC for the LBW infants; 94.3% knew that KMC practice is through skin to skin contact (Bogonko, 2013). A study conducted in Africa on a staff of nurses affirmed that a majority of nurses had the knowledge of KMC (Solomons & Rosant, 2012).

Moreover, studies from under-developing countries provided more evidence about KMC adoption. Low birth weight infants can’t maintain their body thermo-regulation and remain in hypothermia. According to research, during skin to skin contact LBW infants maintained their body temperature (Charpak et al., 2005). In the present research study, nurses mostly had no formal training; but 82% agreed that KMC beneficial for the LBW infants; many agreed that skin to skin contact increases the breastfeeding rate, and help mother to bonding with their newly born infants. Dalal et al., stated that 73.8% of health care professionals had well known about KMC preventing LBW infants from hypothermia; 27.6% believed that KMC helps to maximize the breastfeeding rate (Dalal et al., 2014). In another study 38.6% of health care professionals knew that KMC leads toward effective breastfeeding. Therefore, this present study closely related to

the other studies in regards to basic knowledge and benefits of KMC.

In the present study 36% of nurses counseled the mothers, while a study conducted by Solomons & Rosant elaborated that healthcare professionals mostly did not believe there was need of guidance to mothers for adoption KMC method (Solomons & Rosant, 2012). It is important that mothers are encouraged and facilitated by healthcare professionals for practicing KMC which is missed during routine practice. Limitations in the reserch are due to cross sectional patterns: KAP of nurses regarding KMC; an interventional study in which training and lectures given to staff would be a design to find better results and generalize the findings.

CONCLUSION

KAP by nurses of neonatology had no optimum level. Nurses know that KMC has several benefits. The proportion of actual practice for the eligible infants is low. Therefore, it is important to held workshops and train nurses on a regular basis for the same reason to increase their knowledge that bring change in attitude and practice.

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Religiosity and Social Capital as Prevention of Socio-Pathological Phenomena

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Abstract:

According to M. Fforde, the era of postmodernity is characterized by a form of cultural collapse as it reveals many phenomena indicating that human in contemporary society is directed towards “desocialization.” This process represents an overall cultural shift as well as a change in the models of human. These are the main factors of the cultural crisis (Kuna, 2006). This paper is dedicated to an analysis of the issue of religion as social capital in conditions of increasing societal risks. We work with an hypothesis that socio-pathological phenomena are rather determined by cultural and secularization factors.

Theoretical view:

Context of a postmodern world

The Authors in the paper: *Suicide and Society: The Sociological Approach* (2019) presented social context of the second demographic transition which has brought profound changes in value orientations and moral attitudes of today's society. In the microspace of an individual it has become increasingly difficult to create one's own identity; answer fundamental existential questions; or create a meaningful horizontal and vertical world of relationships and a coherent support system. Instead of an individual's identity being formed in the process of primary and secondary socialization, it is often deformed, having been influenced by de-socialization of family, school or peer environments. Mesospace of community life has also suffered consequences caused by the lost community (*Gemeinschaft*) and modernization processes of the industrial and post-industrial society. Fforde describes the concrete manifestations of desocialization in his book *Desocialisation: The crisis of Post Modernity* using the example of the British society. However, it is important to emphasize that British society is already subject to globalization and universalization in the European socio-cultural space. In concrete terms, desocialization involves a conflict between anthropologies. The facts that man is anchored in transcendence, and that a negation of transcendence in his life has condemned him to a life of emptiness and absolute vanity, are not taken into consideration. Fforde speaks about the false anthropologies that do not recognize the soul within man but accept a model of „material matrix“ to describe man. It means that the model of man as created by God, who infuses a soul to him, or what corresponds to a so-called „spiritual“ model, is constantly denied. The material matrix acts against the community by supporting a lifestyle of selfish individualism and thus weakens the relations between people. The breakdown of ties between people is clearly demonstrated by cultural breakdown: the decay of good manners in politic life; the increase in people living alone; the low electoral turnouts; the high levels of crime and violence; and family crisis (Fforde, 2010)¹.

As some authors comment, „(...) the negative evolutionary influences of the Western European culture will now be exported, among other countries, to Slovakia as well. There follows his (M. Fforde's) argument. The contemporary Western culture is characterized by the expansion of phenomena such as secularization and dechristianization as well as by the dominance of the materialistic view of man. These views have not only replaced Christian understanding of man but they also represent the natural matrix and have a tendency to create convincing but deformed opinions about who we are by choosing one aspect of our self and enhancing it to the level of the superior truth concerning who we are and what we do. The introduced material matrix stimulates selfish individualism; the breakdown of community; consequently, people find themselves in the state of loneliness and isolation. Therefore the material matrix is the main cause of this state – desocialization. This evolution is very negative since desocialization is closely connected with lack of happiness and with mental unease on a large scale. One of its practical consequences will be an increase in the number of people suffering from various psychological problems. These contribute to lower quality of life. However, paradoxically, this problem is not solved by elimination of its roots but by prescribing some anti-depressants. This is only one of the examples of how people try to escape their suffering by recourse to varied therapies which make their illness even worse.“

M. Fforde believes that Western materialism will lead to an export of desocialization to Central Europe. He sees this as a serious threat. He also claims that Slovakia is now in the process of rising exposure to the dynamics of Western culture. The process of globalization and European Union membership contribute significantly to this situation. He also speaks about the risks in the admiration and the uncritical approach adopted by the post-communist countries to the penetration of western culture as demonstrated by an almost automatic adoption of Western lifestyle and values. He adds that after the devastating effects of Communism, Slovakia has to

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¹ Matthew Fforde, *Western Materialism and the Exportation of Desocialization*, 23-25.

face further challenges concerning Christianity and society². Slovakia was involved with materialistic and anti-Christian ideologies until 1989, and in the same year, it was brought face to face with the Western form of consumer materialism and laicism. However, both forms have a common basis – the reproductive interpretation of man – a rejection of transcendence that is antihuman. According to M. Fula, from the ideological point of view, Slovakia does not face a completely new challenge because it already experienced a fight for man's soul during the Communist regime. It can profit from this fight when dealing with the penetration of Western materialism³. It must be emphasized, however, that while Slovakia is involved in the cultural crisis of Western countries, its dynamics are qualitatively and quantitatively different. Consequently, the origins of the crisis under scrutiny are identical in the whole Europe.

The issue of desocialization is a general problem extending over all social, ethic, political and religious domains. The spread of desocialization cannot be stopped, but our aim is to outline some characteristics of the phenomenon to help people become immune to it. Desocialization of society must be primarily dealt with within the scope of religion and Christianization – the spreading of Christianity⁴.

In the context of the above facts, it is clear that the egoistic emphasizing of the individual's importance has become a prevailing lifestyle. Too much importance is attached to economic wealth, powerful positions, social prestige and delights. These determinants are closely connected with a searching for individual benefits which logically contradict the existence of the authentic collectiveness. We live in a modern, rushed and over-technological era where the decisive factors of man's success are to be the best, the first and the only, all at the same time. We want success at any price. However we do not bother about the consequences of this „track.“ We proceed in the community with no regard for

other people; without respect for generally accepted rules, social conventions and especially fundamental ethic and moral rules. Thus we exclude ourselves from society as such and do not want to perceive its seriousness. We put ourselves on its periphery, its boundary and so we contribute to desocialization of the present time.

One of today's major issues is the question of whether post-modern Europe is undergoing a serious social crisis. This issue is illustrated by undesirable facts such as overconsumption; decay of family; individualistic materialism; relativism of values; loss of interest in public matters. There is another connected question: Are these facts the consequence or the cause of the universal decline of Christian religiosity in Europe, as well as in Slovakia? This thesis is dealt with in detail by M. Babic who adopted a critical approach focusing on the essay written by above mentioned M. Fforde. On the one hand, his article is an analysis of all the phenomena concerning the decline of postmodern society. On the other, as a cultural historian, he tries to point out multiple similarities between the civilizations of the past and the present.

Desocialization is therefore closely connected with secularization processes, as well as with the progression of secularization and a materialistic view of man according to the models and theories of postmodern anthropologies. These trends are demonstrated by the retreat of the individual, with his misguided and often materialistic goals, from the real community to his own egoistic and over-individualistic world. In concrete terms, this corresponds to the relativistic understanding of truth; the consumerist approach to love; the instability of alternative forms of collective life; the escape from social responsibility in political parties and other organizations; the decay of family; the increase in the number of *singles*; the spreading of mistrust among citizens; the state of depression; the prevalent violence; the high levels of crime (Tomko, 2006).

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² Matthew Fforde, *Western Materialism and the Exportation of Desocialization*, 257, 264.

³ Milan Fula, *The anthropological stimuli to solve the crisis of the West*, In *Slovakia, materialism and desocialization*, 196-197.

⁴ Jan Duda, *What will stop the desacralization in Slovakia* In *Slovakia, materialism, and desacralization*, 227-228.

Religiosity as an anthropological constant in the context of post-modern culture crisis.

According to Marian Mraz's (Mraz, 2014) concept, religiosity represents a basic cognitive and axiological component of social reality (Voegelin, Berger, Luckmann). It is the discovery of the meaning of life and universe that goes beyond the secularly specified borders. Religiosity is a particularly significant habitual attribute of man as an individual; it is a principal element contributing to culture. It serves as a foundation for thinking about the meaning of life of an individual and the society. It draws from the sapientiality of man – i.e. from his reason. Wisdom – *sapientia* – is an adaptation ability which is responsible for spiritual and cultural dimensions in biosphere – anthroposphere and noosphere. Wisdom – *sapientia* is closely related to another anthropological constant, religiosity. Drawing on Durkheim's postulate of religiosity as anthropological constant, Voegelin defines it as something inherent in man, something he cannot „get rid of“. Boyer regards religiosity as „natural human ability“ and a new attribute of our standard cognitive abilities. Therefore, it is possible to perceive religiosity as an anthropological constant and any science or social and political project ought to take it into consideration and address it. Man has ambitions of the Absolute and thus his essential desire for happiness and a vision of pan-human unity cannot be boxed up in the world of secular limitations.

It is beyond doubt that religion is a universal phenomenon. Efforts to replace it with positive science or to destroy it using political means have failed. Postmodern era has discovered *horror vacui* – fear of empty spaces, nothingness and absurdity that cannot be driven away either by the entertainment industry or the cult of hedonism (Mraz, 2014). Rejected religiosity has suddenly become a subject of interest for the ideologists of postmodernism. For Luckmann and Berger, *religiositas* means a symbolic universe as a basic cognitive and value framework of social reality. They assume that the religious elements in today's society are present in our way of thinking, especially when assigning a more profound meaning to our actions and life in general. (Berger, Luckmann 2010).

Scientific research into a phenomenon of religion was initiated by a leading French sociolo-

gist Émile Durkheim. Religion is an objective social fact, a universal phenomenon resulting from the very essence of social reality. In his book, *The Elementary Forms of Religious Life*, Durkheim defines religion as a unified system of beliefs and practices relative to sacred things, that is to say, things set apart and forbidden; a system of beliefs and practices which unite all those who adhere to them into a single moral community called Church.

Durkheim stresses an integrative function of religion. Religion is, therefore, an expression of our collective consciousness and images of society. It is an important determinant that ensures integrity of the society by strengthening collective consciousness and thus preventing anomie.

In his work, Max Weber, a creator of *interpretative sociology*, analyses impact of religious ideas on economic structures of the society. Religion as a means of human rationality determines life practice and it is a force behind social transformations.

Thomas O'Dea, supporter of a functionalist theory of religion, advocates a basic proposition stating that the social system tries to maintain a balance of those social institutions whose purpose is to regulate human actions. Religion is one of the elementary forms of institutionalized social action whose main goal is to partake in maintaining the stability of the whole system.

O'Dea was concerned with a question encompassing three dimensions – social system, culture and personality. He wanted to determine what functions religious institutions have in maintaining the stability of social system, personality and culture as a whole. O'Dea listed six basic functions of religion in the society with the focus on two goals. Religion provides an orientation for something outside the world of empirical experience and ordinary everyday life. It allows an individual to experience and overcome the feeling of deprivation and frustration that today's world bring with respect to this transcendent reality beyond the empirical. The second goal is to provide some sense of safety and security through participation in rituals that connect man with the supernatural world. The six functions are:

- religion provides support, consolidation and comfort in an insecure world;
- through cult and ceremonies it provides tran-

scendent relationship and by doing so it is instrumental in finding a sense of security. It helps an individual to find his place in the world. Religion contributes to stability and helps maintain the necessary order, not only social but also ontological;

- religion sacralises norms and values of society, it prefers group goals to individual desires;
- religion can provide values that challenge the established norms and hereby support the change of an existing social order;
- religion helps to form and maintain identity;
- religion facilitates transition from one age group into another.

Milton Yinger, supporter of a functionalist concept of religion, attempted to set forth a definition of religion in a broader sense of this phenomenon. He proposes that any social phenomenon can be identified as „religious“ if it helps an individual to deal with and explain death, suffering, evil and injustice. Yinger claims that religion is a system of beliefs and practices by means of which a group of people deals with existential problems of human life. Yinger sees religion as a dynamic phenomenon changing over time, a phenomenon which satisfies specific needs within a social system.

Thomas Luckmann maintains a similar stance on religion and its status in modern society. He sees religion as an ability of human beings to transcend their biological nature. Man is the only creature able to construct a world of objective and ontological meanings that present morally binding and all-encompassing reality. For Luckmann, therefore, religion is not only a sociocultural but also an anthropological phenomenon. Everything that is *tout court* human is *ipso facto* religious. On the other hand, unreligious phenomena are those that originate in animal nature of a man, in his biological constitution common with animals. (Luckmann 1967: 25; Berger 1971a: 268-271).

Today, even materialistic socio-biology begins to perceive religiosity as „a genetically preconditioned attribute of human psyche“ (Remes, 2003). Translated into the language of today's anthropology, religiosity is an extraordinary anthropological constant, a habitual trait of an individual and an essential element contributing to the formation of culture.

Pascal Boyer teaches classes in psychology and anthropology at Washington University in St.

Louis. Although he draws from a materialist conviction that the entire human thinking results from the structure and processes of our brain, his view on spirituality and religiosity is more or less undermined by his claims that brain „naturally guides our morality and social relationships“. He backs his statement with the theory of evolutionary origin of religious thinking. In the course of human development, religiosity has enabled man to cultivate and maintain large coalitions of not related individuals and build a mutual trust based on criteria of reliability. Boyer (2011) regards religiosity as a „natural human ability“ and a new attribute of our standard cognitive abilities. Unbelief in the supernatural is, to a certain extent, a result of our development against our innate cognitive predispositions. Religiosity is closely linked to a development of one's sociability, it forces man to stay vigilant for any dangers and prevent risks, and inculcate an intuitive adherence to social norms found within particular ethos. Contemporary social science, too, highlights the role of religion in cultural reinforcement of solidarity and cooperation within a particular group. In contemporary religious systems, sacred books and traditions can be seen as inspirational sources for social support (Szot, 2010a).

According to the concepts of *religious prosociality*, religions support action that is intended to benefit other people, although it might cause harm to the doer. Sacred texts of all big religions explicitly command people to be prosocial. Another common trait is a therapeutic dimension of religiosity.

The rediscovery of religiosity might have come as a shock to some reductionist postmodern sciences. Yet it has long been an established fact for therapists that authentic religious faith conceals mysterious and surprising possibilities: it transcends; allows man go beyond limitations of space and time; even beyond the limits of biological life; brings essential anthropological optimism; releases in man powers and energies one could have only assumed. There have been cases of many evident and yet mysterious occurrences, be it spontaneous or medically inexplicable cures, surely linked to spiritual powers in *condition humana* – in the structure of human being we do not know yet. In this new light, religiosity is again introduced to man as a specific power which is not only a key value in his value system,

but it can also serve as a source of meaning of one's life, his physical and mental wellbeing. And here we arrive at the very essence of our existential desire for immortality. In this context, current sociology of religion shows religion, as a central cultural and social phenomenon having an important role mainly in relation to borderline situations or turning points in the lives of individuals and the whole society. On one hand, man lives in conditions of insecurity, coincidence and being aware of one's own weakness, he experiences situations outside his anticipation and control. On the other hand, man lives in society with prevailing individualism, differentiation, consumerism, value relativism, and axiological chaos and that all can result in alienation, frustration and loss of identity. Finding ourselves in these situations can lead to existential problems we all desire to find answers to. It is religion that offers that answer because it transcends everyday empirical experience and transfers problems to the realm of sacrum, offering a sense of security, safety and support (Adamski, 2011, p.5).

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Evaluation of Changes in Selected Life Areas from the Perspective of Shelter Users in the Czech Republic

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Abstract:

OBJECTIVE: The objective of the paper is to evaluate the ongoing changes in specific life areas from the perspective of shelter users.

DESIGN: In order to fulfil this objective, we have chosen a quantitative research strategy.

PARTICIPANTS: The data was collected from 135 participants, people living in shelters for homeless people.

METHODS: We used tailor made questionnaire based on metha-analysis.

RESULTS: The research results show that the changes in individual life areas are interconnected and the users go through

positive changes in shelters as well as negative changes. An important finding was the perceived relationship between the acquisition and keeping of stable housing and self-development, self-confidence, and self-efficacy. Respondent's sex and length of stay in the shelter house were found to be important factors affecting the changes in life situations.

CONCLUSION: Based on the research results, implications for social work in shelters have been determined.

Introduction

The paper conceptually stems from two sets of contemporary trends in social work with homeless people. The first is the dynamics of the characteristics of the target group, and the second set is the characteristics of social work (with the given target group) in contemporary social work in the Czech Republic. In relation to the target group of homeless people, there are four tendencies both at the national (Czech Republic) and the international levels:

a) increase in homeless people and people in danger of becoming homeless (Feantsa, 2019; Kucharova & Janurova, 2016); **b)** constant or increasing number of homeless people who fail to be integrated into permanent housing due to the permeable system of social housing (Glumbikova, 2017; Towers, 2000); **c)** increase in the complexity of problems of homeless people (Gardner, 2006); **d)** persistent oppressive approach to homeless people (Anooshian, 2005; Glumbikova *et al.*, 2018a).

The Czech Republic currently does not have a law on social housing, only a Concept of Preventing and Tackling Homelessness Issues in the Czech Republic until 2020 (MoLSA, 2013) and the Social Housing Concept of Czech Republic 2015-2025 (MoLSA, 2015), which define the basic principles of solving the issue of homelessness. However, these documents do not hold the validity of a law and their principles are not enforceable. The above-mentioned reveals that the help to homeless people in the Czech Republic is currently primarily in the agenda of social services.

Concerning the above-mentioned, it is more important than at any other time to evaluate changes in users' life situations which occur in social work in social services and shelters. The objective of this paper is to evaluate the perceived changes in specific areas of a life situation through shelter user's perspective and based on

that, to determine the implications of social work in shelters.

Areas of evaluating the life situation of people living in shelters

There is currently no standardized tool for assessing the changes in the life situation of homeless people in the Czech Republic, so we made meta-analysis of this topic to find all relevant areas of assessment the changes in the life situation of homeless people. It included expert studies in the Czech, English, and German language (not older than 2000). The meta-analysis also included texts from the following databases: PROQUEST, WISO, SAGE, EBSCO, and Springer-Link. Within the meta-analysis, we looked for the key words: future, hope in homeless people, recovery, factors of changes, individual planning; and their equivalents in the Czech and German languages. The data was processed using thematic analysis. Based on a meta-analysis of expert publications related to this issue, the evaluation of a life situation and desired future of homeless people may include the following topics: acquisition and retention the housing (f. e. Groundswell, 2015; Lux & Mikeszova, 2013; Patterson & Tweed, 2009), financial literacy (f. e. Glumbikova, 2017; Shobe & Page-Adams, 2001, health (f. e. Fitzpatrick-Lewis *et al.*, 2011; Laporte *et al.*, 2010; Luo & McGrant, 2006; social sources of support (f. e. Glumbikova, 2017; Groundswell, 2015; Mayock *et al.*, 2011; Neale & Stevenson, 2015; Shier *et al.*, 2010; Webber & Joubert, 2015; relying on oneself and self-evaluation (f. e. Gerull & Merckens, 2012; Groundswell, 2015; Lux & Mikeszova, 2013; Shier *et al.*, 2010; Weber & Joubert, 2015); meaningful spending of leisure time: work, meaningful spending of leisure time: self-development (f. e. Gerull & Merckens, 2012; Groundswell, 2015; Lens *et al.*, 2009 worries about the future, and life stability (f. e. Foster &

Spencer, 2011; Henwood *et al.*, 2015; Patterson & Tweed, 2009.

Methodology

The objective of the research was to evaluate the shift in relevant areas of life in the perspective of shelter male and female users. The selection of the participants was carried out in the form of the intentional sampling with following criteria: **a)** affiliation to a region (selection from all 14 regions of the Czech Republic); **b)** the target group of the shelter (men and women); **c)** voluntary participation in the research. Altogether, 135 persons participated in the research, 95 men and 40 women. The median of the length of stay in the shelter was 6 months. The maximum stated length was 61 months. Within the research, there were 61 persons who stayed in the shelter longer than the stated median (median included) (out of whom 38 men and 23 women) and 57 persons who lived in the shelter shorter than the stated median (out of whom 41 men and 16 women).

The data collection technique was a tailor made questionnaire which was constructed based on the search of expert publications processed by the meta-analysis of the expert publications mentioned above. The questionnaire was piloted with the target group (N=8) with respect to the intelligibility of the questions by the target group. The questionnaire held the nature of 10 evaluated scales: (acquisition and retention of housing; financial literacy; health; social sources of support; relying on oneself; self-evaluation; meaningful spending of leisure time; work, meaningful spending of leisure time; self-development; worries about the future, and life stability), which the users filled in with numerical data (perceived level of target acquisition in the given area in the range 1-10) at the time of entering the shelter (past) and at the moment (present). The questionnaire was administered using assisted administration, when the shelter user always filled in the questionnaire in cooperation with the researcher.

Within the research, we determined the following research objectives (RO) based on the literature review (Glumbikova *et al.*, 2018a; Lux & Mikeszova, 2013):

RO1: Find out if the scale acquisition and retention of housing is mutually (interconnected) in other scales (evaluated areas of life situations of homeless people in shelters).

RO2: Find out if the sex of the respondent (man/woman) affects the closeness of the scale relationships in the questionnaire (evaluated areas of life situations of homeless people in shelters).

RO3: Find out if the length of the stay in the shelter (over/under the median) affects the closeness of the scale relationships in the questionnaire (evaluated areas of life situations of homeless people in shelters).

RO4: Find out if the sex of the respondent (man/woman) affects the percentage of the total level of positive changes (in all scales) from the past to the present.

RO5: Find out if the length of the stay in the shelter (over/under the median) affects the percentage of the total level of positive changes (in all scales) from the past to the present.

RO6: Find out if the sex of the respondent (man/woman) affects the percentage of the total level of negative changes (in all scales) from the past to the present.

RO7: Find out if the length of the stay in the shelter (over/under the median) affects the percentage of the total level of negative changes (in all scales) from the past to the present.

The data was analysed using the statistical software R, R Core Team (2018). For the purposes of comparing the ratios between various target groups, we used the score test (Miettinen & Nurminen, 1985) and its implementation in the R language library (Laud, 2018). For the purposes of correlations estimation, we used the Spearman correlation coefficient and p-values were calculated by non-parametric methods.

The research implementation was grounded in the Ethical Principles of Psychologists and Code of Conduct (American Psychological Association, 2010) and observed the valid legislation of the Czech Republic.

Possible limitations of the research are reflected in the form of a non-random sampling of the research group; therefore, the achieved results cannot be generalised.

Data analysis and interpretation

The following part of the paper will present evaluation of research objectives RO1 to RO7:

Evaluation of RO1: The data analysis results reveal that the scale acquisition and retention of housing is mutually (intercon-

nected) in other scales (evaluated areas of life situations of homeless people in shelters).

Acquisition and retention of housing correlates with the following scales: financial literacy (correlation coefficient: 0.34); meaningful spending of leisure time; self-development (0.38); self-evaluation (0.43); worries about the future (0.30). Acquisition and retention of housing is related by the homeless people in shelters with finances and worries about the future. The above-mentioned implies that self-evaluation and self-development of homeless people is a very important area affecting the acquisition and retention of housing.

Evaluation of RO2: The correlations between scales (evaluated life areas) showed differences based on the respondents' sex. For women, acquisition and retention of housing correlates only with the scale of self-evaluation (0.64). For men, acquisition and retention of housing correlates with scales: financial literacy (0.39); self-development (0.36); self-evaluation (0.34). Acquisition and retention of housing and self-evaluation are thus connected irrespective of the respondent's sex.

Evaluation of RO3: The correlations between scales (evaluated life areas) showed differences based on the respondents' length of stay in the shelter. People whose length of stay in the shelter was over the median showed the correlation of the scale of acquisition and retention of housing with: financial literacy (0.45); meaningful spending of leisure time; self-development (0.45); self-evaluation (0.51). People whose length of stay in the shelter was under the median showed the correlation only with the scales of self-development and life stability (0.43). Connection of financial literacy and acquisition and retention of housing develops in homeless people in shelters over time. Connection of acquisition and retention of housing and self-development seems to be constantly present in the life situation of homeless people living in shelters.

Evaluation of RO4: Positive changes from the past to the present in 3 or fewer areas were experienced by 20.7% of respondents. Positive changes in 3 or fewer areas from the past to the present was experienced by 26% of men and 75% of women. Sex of homeless people living in shelters significantly affects the perception of positive changes. Only a quarter of women

perceived their life situation changed at least in more than 4 measured areas.

Percentage of positive changes in scales with the highest overall positive percentage changes from the past to the present when **dividing respondents according to the sex** were:

financial literacy (67% of men and **82% of women**); acquisition and retention of housing (77% of men and **89% women**); worries about the future (58% of men and **82% women**);

a life stability (67% of men and **96% women**). **A stay in a shelter is thus perceived by the majority of men and women as a positive change in their housing and financial situation leading to the increase of life stability and a drop in worries about the future.**

Evaluation of RO5: Concerning the length of stay in a shelter, positive changes from the past to the present were experienced by 21% of respondents over the median of the length of stay in the shelter and 24% of respondents under the median. The length of stay in a shelter does not have a significant impact on the perceived percentage of changes in the areas of the life situation of homeless people.

Evaluation of RO6: At least one negative change from the past to the present was experienced by 47.4% of the respondents of which 48.4% men and 45% women. Therefore, the difference in sex is not significant concerning the experiencing negative changes from the past to the present.

Evaluation of RO7: The difference between the people with the length of stay in shelters over the median and under the median is significant. People living in a shelter over the median of the length of stay in a shelter experienced a negative change in 36% of cases and people living in a shelter under the median of the length of stay in a shelter experienced a negative change in 56% of cases. A long-term stay in a shelter is thus a factor with a certain predictive ability to experience negative changes in some of the life areas. Negative changes in scales with the highest overall **negative** changes from the past to the present when **dividing the respondents according to the median of the length of stay in a shelter** were: finances (8.2% of the respondents over the median and 8.8% of respondents under the median); meaningful spending of leisure time; work (5.4% of respondents over the

median and 5.8% of respondents under the median); social sources of support (10.7% of respondents over the median and 8.9% of respondents under the median); self-evaluation (8.8% of respondents over the median and 7.6% of respondents under the median).

Discussion, implications, and conclusion

The result analysis shows that individual life areas of homeless people are mutually interconnected (Groundswell, 2015; Lux & Mikeszova, 2013). An interesting finding is the fact that acquisition and retention of housing is directly connected with meaningful spending of leisure time similarly as in Gerull & Merckens (2012) or Groundswell (2015), i.e. with self-development, and self-evaluation of homeless people (similarly, Shier *et al.*, 2010; Weber & Joubert, 2015). Connection of the acquisition and retention of housing with self-evaluation is not affected by the respondent's sex, however it appeared similarly in Glumbikova *et al.* (2018a). In context of the above-mentioned, the shelters can be advised to focus more on: a) use of the recovery concept; b) use of the strength-based approach (see f. e. Epstein *et al.*, 2000).

Another interesting factor in relation to shelters operation is that 20.7% of respondents experienced positive changes in 3 or fewer evaluated areas. There is a significant difference in users living in a shelter under the median (6 months) of length of stay (36% of respondents) and over the median of the length of stay (56% of the respondents); the length of stay in a shelter has the potential to increase the percentage of people experiencing a negative change at least in one of the evaluated area; similarly in Lux & Mikeszova (2013). Most negative changes were experienced in: worries about the future (15.6%); meaningful spending of leisure time; self-development (14.4%); social sources of support (10 %); health (9.0%). The above-mentioned implies that shelters should be perceived as only a temporary housing in a crisis situation, not as a tool of social or housing policy leading to full-fledged reintegration (in all observed areas) of permanent housing; similarly in Lux & Mikeszova (2013).

The research results also show that sex is an important factor to achieve positive changes in individual areas of the lives of homeless people

in shelters similarly as in Glumbikova *et al.* (2018a). Positive changes from the past to the present in 3 or fewer areas were experienced by 75% women and only 26% of men. Only a quarter of women perceived that their life situation has changed in at least 4 measured areas. Apart from the above-mentioned, it seems to be necessary to apply a gender-sensitive approach in social work with people living in shelters, which will enable to consider diverse and complex situations of homeless women and men (see f. e. Mayock *et al.*, 2015; Savage, 2016). Recognition of gender in specific life areas of homeless people would help clarify how gender in shelters is reproduced and connected with gender discourses.

This paper has met its objective to evaluate perceived changes in specific life areas from the shelter users' perspective and based on this evaluation to determine the implications for social work in shelters.

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Brief Survey of History of Roma people in the Great Rye Island

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Original Article

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Abstract:

The main aim of this work is to represent the history of Roma people on Great Rye Island. The work deals with the historical review of these Roma minorities. It shows their historical and social background down the centuries. It scopes some important regions and analyses of family names in the designated area. The biggest part of the work is a conclusion about Roma people in the period after and before the war and how they lived during these years. This work also has some analytical information about Roma families and uses some life-related materials. The end of the work sums up the most significant steps of these people.

Introduction

In my article I would like to write about Roma people and their connection regarding present day Slovakia. I would like to present the main historical events that had a big impact on this minority group and not least emphasize their historical background. Gypsy people did not have literacy in the early period, but we have historical sources that depict that this minority group also had history.

The main aim of this article to analyze the main characteristic features of Gypsy people and their community along with a need to deal with their contemporary social background and relations.

Historical review

The first appearance of Roma people originated in the 11th century. During the centuries, especially the 14th century was a critical period for them because some groups of Gypsies wandered traveling to various parts of Europe. According to Ravasz (2005) this can be seen as a major pathway for that minority group. He claims that some families originated in the 16th century, but this group did not connect to Great Rye Island. A main reason why they did not travel can be seen in their development as a farming population. It included household behaviors as collecting potatoes, building works, etc.

In the 17th century the problem of this civilization was the same. Some Gypsy groups travelled to Europe, but they have been prosecuted and killed. Unfortunately other groups did not like them because of their behavior. Two places where Roma people lived were Nitra and Bratislava.

The first author who wrote about Roma people was Samuel Augustini (ab Hortis). In his monography he presented some important data: *„From those Gypsies who are married the children must be taken away to be far from their parents and relatives even by force to prevent them from being in any relationship with other Gypsies. At the same time, a better education should be provided for them. In some places they have already started it and where they were unwilling to support this aim voluntarily, it was enforced by violence“* (Augustini, 1995, p. 62).

According to the author, it can also be seen that they had other possibilities. The other thing that Augustini dealt with was the issue of Roma children. He stated: *„They have reported from Fallendorf Village on Great Rye Island that on the 24th of last month, between 5 and 6 o'clock in the morning, they took again from Pruk (in Hungarian: Dunahidas, in Slovak currently Most pri Bratislave), the older children, who as with the former ones will get an education by which they will be able to gradually doff their inborn disobedience. Among the children destined for re-education there was also a 14 years old girl who was to be taken away as a bride. In her despair or anger she was tearing her hair and her behavior was always erratic“* (Augustini, 1995, p. 62).

Most of the children were raised at home in family, only few of them were taken to farmer foster parents. Only two boys from Dolne Devicany (today a part of Devicany and Dunajska Streda) and Horné Saliby attended school.

Adult Roma people worked in an agricultural area during winter and they were also making some music during summertime. Many of them were smiths, harvestmen, pickers and thrashers. Most of the families lived in Velke Uľany and 13 families in Samorin. The most common family names were: Sarkozi, Mezei, Sipos, Rigo, Ujvari, Danis, Buga and Mundi (Horvathova, 1964).

The first data of Gypsies living in Nove Zamky came from the 18th century. During this period gypsies were divided into two groups: first were the new urban serfs and the other was the upper class. It included names such as Munka, Cirok, Anyalay, Balogh, Sultsek and Dome.

Roma people are connected to the Roman Catholic religion. Gypsies had a national local language, but they also spoke Hungarian. In the region of Nitra and Bratislava they also spoke the Slovak language. In Nitra 17.7%, in Bratislava 22.6%, in Ostrihom 59.3% and in Komarno 70.9% spoke the Romani language. These data refer to the major language assimilation of Roma people living in southern Slovakia during the 19th century.

Another important event in Roma history was the census by the Minister of Interior on March 15, 1924. According to the Slovak National

Archive we can find censuses in Dunajska Streda, in Galanta, in Samorin and in Komarno.

Among the 121 Gypsy family names common ones in these geographical territories were: Danis, Farkas, Koavacs/Kovac, Kurucz/Kuruc, Olah, Rigo, Sarkozi and Stojka. (Mann, 1998).

The biggest territory where they lived was the area of Dunajska Streda. According to the four biggest territories we can find some family names that were particular in these areas.

Dunajska Streda district: *Abraham, Banyak, Bertok, Bottlo, Burdy, Danis, Dani, Horvath, Kardos, Katona, Kurucz, Lakatos, Levai, Meszaros, Mezzei, Piroška, Rigo, Sarkozi, Sipos, Stojka, Vezpremi, Vontzemü.*

Galanta district: *Banyak, Bartos, Bihari, Bitto, Bottlo, Farkas, Herak, Horvath, Janoska, Kardos, Karvay, Kmeto, Kok, Kovacs, Kuki, Kurucz, Lakatos, Meszaros, Mezzei, Olah, Patkolo, Rigo, Salay, Sarkozi, Sipos, Vizvary, Voros*

Komarno district: *Bertok, Dome, Farkas, Katona, Kovacs, Kurucz, Lakatos, Levai, Meszaros, Mezzei, Piroška, Sarkozi, Stojka, Vezpremi*

Other districts: *Bitto, Bujko, Burdy, Dome, Farkas, Horvath, Karvay, Kovacs, Kulina, Kuruc, Kurthy, Lakatos, Mezzei, Olah, Patkolo, Sarkozy, Stojka, Vezpremi*

There were also some family names that were typical in other regions. Mezei, Rigo and Sarkozi the most widespread ones and the family name Buga was particular in Dunajska Streda, Bundi was found in Tomasov and Stvrtok na Ostrove, and the name Ujvari in Malinovo and Maly Mager (Mann, 1998).

Gypsies in the Great Rye Island during the Slovak State (1939–1945)

One of the most tragic events in the history of Roma people was their prosecution during World War II. The situation in Slovakia was not very good for them because they had to deal with the same problems as other minorities like the Hungarians. During that period C. Necas was the only person who wrote one monography about that time and the social and economic background of Gypsy people. He described the situation that during the war there were anti-Roma rules and Nazi Germany had also some cruel activities against these minorities.

They were taken to relocation camps situated in Komarno. After that, the German nation took

them into concentration camps, mainly to Dachau. Many of Roma people that were originated from Great Rye Island were transported from Hurbanovo. On March 30, 1945 the German army stopped there and during the evening 53 Gypsy adults and 7 children were killed. It was a taboo topic for many years. From that period we have just a very short description because many of the survivors and local people did not want to reveal the situation therefore we did not have many sources (Necas, 1994).

The Gypsies and Southern Slovakia after 1989

The population of Gypsy origin were censused by the state administration authorities without their knowledge. The last such census reflects the state as of December 31, 1989, according to which in the four districts of Great Rye Island 21,988 Roma people lived in total, making up 4.6% of the total population. In the individual districts the number and rate of Roma population developed as follows: Dunajska Streda 5,558 (5.1%), Galanta 7,365 (5.1%), Komarno 3,880 (3.5%), Nove Zamky 5,185 (3.4%). The Gypsies of Great Rye Island usually belong to the group of Roma settled down a long time ago. With the subgroup of Hungarian Roma (Rumungro), in the northern part of the region we can also find Slovak Gypsies. The border between the two groups has been undefined so far, and probably developed according to the number of ethnically dominant population.

In the census held in March 1991, after a period of 60 years, Roma people for the first time had the chance to freely ethnically identify themselves. In Slovakia 80,627 persons identified themselves as being of Roma ethnicity. This data was less than one-third the data according to the official census held in 1989. In general, it can be stated that Gypsies follow the ethnicity of the majority population of their direct environment. The comparison of data of the population census on 1991 and the data of last population conscription by the so called national councils in the Communist era (1989) shows that in the districts of southern Slovakia with major ethnic Hungarian population fewer probably Roma people identified themselves as being actually of Roma ethnicity than in the regions with major Slovak majority population. Thus for example in the Dunajska Streda district 686 persons identi-

fied themselves as of Roma ethnicity, which is 12.3% of the assumed Roma population; in the other districts these data were as follows: Galanta 782 (10.6%), Komarno 925 (23.8%), Nove Zamky 764 (14.7%).

The above mentioned census of Gypsy population in 1893 also showed that Roma people living in southern Slovakia have assimilated in their language to the local Hungarian population. It can be assumed that the Roma population considered Hungarian culture as a role model, which they had tried to adopt. In this process another important fact played a role, that since the 19th century the performers of popular Hungarian melodies have been mainly Gypsy musicians, which contributed to the decrease of ethnical-cultural differences (Mann, 1998). Roma people may consider the forcing of belonging to Roma ethnicity as a manifestation of segregation. What has been also revealed is an incident in Zlate Klasy in 1995. In September, teachers distributed primers in Roma language to the pupils in order to diminish the language handicap of the children. The next day the outraged parents came to the school and returned the textbooks saying that their children are the same as the others. This incident reinforces our assumption that for Roma people the language of the majority is more important than their own mother tongue.

Gypsies living on Great Rye Island have been known as excellent musicians. As an example of this we can mention that in 1854 in Nove Zamky there lived 43 families having 218 members out of which 22 were musicians. In the late 19 century, here lived the famous Lajos Kolompar Komlosi who with his band also performed in Budapest, Vienna, London, Berlin and Dresden. In the interwar period the talented Roma musicians performed not only in Bratislava but also in other bands playing in cafés and spas in other cities (among these the most famous musician families were: Balogh, Banyak, Bertok, Bihari, Bitto, Buga, Danis, Farkas, Levay, Mozsi, Olah, Piroska, Rigo, Szendrey, Sarkozi). *Smithery music* was widespread among the Gypsies even after World War II mainly in Podunajske Biskupice. The 10 smitheries performing artistic blackwork mainly for foreign clients operating in Dunajska Luzna represents an especially outstanding level of these smithery workshops.

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Sleep Disturbances in Seniors with Parkinson's Disease

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Abstract:

Introduction: The prevalence of sleep disturbances in patients with Parkinson's disease is very high. It is one of the factors that significantly affects the health care, nursing care and also quality of life of patients and their family members.

Design: For the purpose of the research, design of a prospective quantitative study was chosen based on an assessment scale.

Aim: The research aim was to map out the prevalence of sleep disturbances in patients with Parkinson's disease and to find out the influence of sex (gender) and stage of the disease on the sleep disturbances prevalence.

Methods: We used the Parkinson's Disease Sleep Scale PDSS-2 to assess the symptoms of sleep disturbances. We statistically

computed the results using the chi-square test and Mann-Whitney U test. The research sample consisted of 220 respondents diagnosed with Parkinson's disease, who were included in the sample on the basis of deliberate selection.

Results: Out of the total respondents, 115 (52.3%) show mildly severe sleep disorder according to the score of the sleep scale from 0 to 20; 67 (30.5%) respondents show moderate sleep disorder; 38 (17.3%) show severe sleep disorder according to the score of the sleep scale from 21 to 40. The median score was higher in women (20.5) compared to men (19) with no statistical significance ($p=0.646$). When comparing sleep disturbances by the stage of the disease, the median score was 10.5 at an early stage while 10.0 at advance stage, this difference was not significant (p value= 0.477).

Conclusion: The issue of the sleep disorders prevalence in patients with Parkinson's disease is highly urgent. In conclusion, we can state that neither sex (gender) nor the stage of the disease has a clear effect on the manifestations of sleep disturbances in patients with Parkinson's disease.

INTRODUCTION

Sleep plays an important role in a person's good health and well-being throughout life. Sufficiency of quality sleeping protects our mental and physical health, quality of life and safety (Doktorova 2018). More than 40% of seniors have problems with falling asleep and sleep as such. Spira *et al.* (2012) states that sleep issues in seniors are usually associated with health problems as well as changes in daily activities and reduced mobility. Research shows that the main cause of deteriorating sleep quality is not age, but diseases that affect the elderly. Limited social contacts also contribute to the state of worsened sleep, which results in a decrease in physical activity in outdoor areas (Plhakova 2013).

Parkinson's disease is a progressive degenerative neurological disease occurring in older adults that requires long-term health care and nursing care also (Shin & Hendrix 2013). The disease is characterized by a set of basic motor symptoms that include: rigidity; bradykinesia; tremors; postural instability (Kalia & Lang 2015). Bares *et al.* (2015) include other motor symptoms including: poor upright posture; slow walking; micrographia; masked face; decreased blinking frequency; blepharospasm; dysphagia; dysarthric speech; foot and thumb dystonia; rigidity in gentle upper limb movements. Parkinson's disease is often considered to be a movement disorder manifested by motor symptoms. In addition to the motor symptoms that define

the diagnosis of the disease, there is a wide range of non-motor symptoms that patients may suffer from and which reduce their quality of life. Non-motor symptoms are not only common, but also insufficiently reported by patients and their caregivers or healthcare professionals (Maass & Reichmann 2013). Non-motor symptoms are receiving more and more attention and can often affect the patient much more than motor symptoms.

We divide non-motor symptoms into 4 categories: 1) autonomic dysfunctions (gastrointestinal discomfort, increased salivation, eye accommodation disorders), 2) mental disorders (mood changes, cognitive deficits, psychoses, depression), 3) pain, 4) sleep disorders (Havrankova *et al.* 2016). Sleep disorders include: sleep fragmentation, daytime somnolence, breath disorder during sleeping, restless legs syndrome and nightmares. They occur in 60 to 98% of patients with Parkinson's disease (Swick, 2012). Non-motor symptoms have received little attention for several years, but now these symptoms are known to be significant predictors of morbidity in determining quality of life, disease costs and degree of institutionalization (Havrankova *et al.*, 2016). Although Parkinson's disease primarily affects mobility, it is clear that it is not the only manifestation of this disease and there are a number of other symptoms, including sleep disorders and vigilance maintaining. Figuratively speaking, a patient with Parkinson's disease

never sleeps (Dusek 2010). Bargiotas *et al.* (2016) state that although James Parkinson described sleep disorders as part of the clinical picture in his observations in 1817, interest in sleep disorders did not increase until the 20th century. In the disease, sleep disorders and excessive daytime sleepiness are multifactorial complex issues and are secondarily caused by motor and non-motor symptoms, as well as primary sleep disorders. Sleep disorders include restless legs syndrome and REM sleep behavior.

In order to successfully address sleep disorders in patients with Parkinson's disease, a detailed assessment is required. Depression results in the most common sleep disorders associated with frequent nocturnal arousals and anxiety and their solution lies in the treatment of this disease (Benetin *et al.* 2014). Sleep disorders are a common non-motor complication that have a major impact on the quality of life of patients and relatives. They can manifest at any stage of the disease and usually become more severe as the disease progresses. Because sleep is a basic and essential physiological need for humans, most patients with Parkinson's disease complain of sleep disorders. The burden caused either directly or indirectly by these symptoms is enormous. Symptoms of sleep disorders that have been documented include: insomnia of several types; including difficulty falling asleep or staying asleep; excessive daytime sleepiness; sleep disturbance with eye accommodation; restless legs syndrome; periodic limb movements in sleep as well as during vigilance (Sobreira-Neto *et al.* 2017). Sleep disorders are not only associated with a significant deterioration in patients' quality of life, but are also associated with a greater need for health care and nursing care (Bartolomei *et al.* 2018).

The aim of the research was to map out the prevalence of sleep disturbances in patients with Parkinson's disease and to determine the influence of sex (gender) and stage of the disease on the prevalence of sleep disturbances.

METHODS AND STUDY GROUP

The design of a cross-sectional quantitative study performed on the basis of a questionnaire survey was chosen for this research. The method of the respondents choosing was intentional. The criteria for including the respondent into the research sample was: the diagnosis of Parkinson's disease and age over 60 years. The study group consisted of 220 respondents, of which 128 (58%) were men

and 92 (42%) women. The youngest respondent of both sexes was 50 years old and the oldest man was 88 years old and the woman 85 years old. The average age of the respondents was 76.8 years. The early disease group consisted of 128 (58%) patients and advanced disease stage group consisted of 92 (42%) patients. Although the set of respondents was not evenly distributed, the individual groups were statistically comparable.

We used the Parkinson's Disease Sleep Scale, PDSS-2 to assess sleep disorders in patients with Parkinson's disease. PDSS-2 is a specific 15-point self-assessment scale that preferentially assesses sleep disorders. It consists of 15 questions related to various sleep and nocturnal disorders, focusing on the frequency of nocturnal symptoms in patients in the last 7 days. The sleep scale is divided into three domains 1) nocturnal motor symptoms, 2) nocturnal symptoms of Parkinson's disease, 3) disturbed sleep. The patient evaluates each question in one of five categories from 4 - very often (6 - 7 times a week), 3 - often (4 - 5 times a week), 2 - sometimes (2 - 3 times a week), 1 - occasionally (once a week) to 0 (never) except for item 1, which is the reverse of the rating. After the sum of points for all 3 domains, the total score ranges from 0 (no failure) to 60 (maximum nocturnal failures). Each domain individually scores from 0 to 20. The assessment scale was edited by additional demographic data of sex (gender) and stage of the disease.

The research took place in the period from January 2019 to October 2019 in four neurological outpatient clinics in the Trnava region. We used descriptive statistics, then chi-square test to test significant differences in proportions and the Mann-Whitney U test to test significant differences in medians of score. For testing of followed influences, a significance level of p value less 0.05 was set. Individual items from the assessment scale were used. The obtained data were processed using Microsoft Office Excel and analyzed in SPSS 16.0.

RESULTS

The prevalence of sleep disorders in patients with Parkinson's disease is high and diverse. Our research found that according to the overall Parkinson's Disease Sleep Scale score, each respondent had some sleep disorder. Out of total, 115 (52.3%) respondents show mild severe sleep disorders according to the score scale from 0 to 20, of which 74 (57.8%) are men and 41 (44.5%) are women.

Moderate sleep disorder was present in 67 (30.5%) respondents according to the score scale from 21 to 40, of which 33 (25.8%) are men and 34 (37.0%) are women. Severe sleep disorder was showed by 38 (17.3%) respondents according to the score scale from 41 to 60, of which 21 (16.4%) are men and 17 (18.5%) women. There was no significant difference in men and women proportion by chi-

square test ($p=0.127$).

The highest recorded score in our research sample was 47. We did not record a score of more than 50 points in our research sample. Median value reached 19.5 in total assessment score, while for men 19.0 and for women 20.5. This difference was not significant by using Mann-Whitney U test ($p=0.127$) (Figure 1).

Figure 1: The total score of the assessment scale, $n=220$.

Score	Total, $n=220$			Male, $n=128$			Female, $n=92$			p value
	n	%	median	n	%	median	n	%	median	
0-20	115	52.3	19.5	74	57.8	19.0	41	44.5	20.5	0.127 $\chi^2=4.131$
21-40	67	30.5		33	25.8		34	37.0		0.646 $Z=-0.051$
41-60	38	17.3		21	16.4		17	18.5		

% percentage; χ^2 value of chi-square test; Z value of Mann-Whitney U test

We performed the analysis of the achieved scores for its individual domains: *nocturnal motor symptoms*, *nocturnal symptoms of Parkinson's disease* and *disturbed sleep*. We divided the achieved score into three categories: from 0 to 10, from 11 to 16 and from 17 to 20. We performed the analysis for the whole group, then according to the sex (gender) and according to the current stage of the patients' disease. The results are presented in Figure 2 and Figure 3. The maximum achievable score for each domain is 20.

Figure 2: Total sleep scale score by sex of respondents.

Nocturnal motor symptoms										
Score	Total, $n=220$			Male, $n=128$			Female, $n=92$			p value
	n	%	median	n	%	median	n	%	median	
0-10	140	63.6	9.0	82	64.1	8.5	58	63.0	8.0	0.410 $\chi^2=1.803$
11-16	75	34.1		41	32.0		34	37.0		0.819 $Z=-0.228$
17-20	5	2.3		5	3.9		0	0		
Nocturnal symptoms of Parkinson's disease										
Score	Total, $n=220$			Male, $n=128$			Female, $n=92$			p value
	n	%	median	n	%	median	n	%	median	
0-10	140	63.6	10.5	82	64.1	8.0	58	63.0	7.5	0.055 $\chi^2=5.821$
11-16	39	17.7		23	18.0		26	28.3		0.595 $Z=-0.532$
17-20	41	18.6		23	18.0		8	8.7		
Disturbed sleep										
Score	Total, $n=220$			Male, $n=128$			Female, $n=92$			p value
	n	%	median	n	%	median	n	%	median	
0-10	104	47.3	10.0	60	46.9	10.5	44	47.8	9.5	0.099 $\chi^2=4.619$
11-16	79	35.9		41	32.0		38	41.3		0.672 $Z=-0.423$
17-20	37	16.8		27	21.1		10	10.9		

% percentage; χ^2 value of chi-square test; Z value of Mann-Whitney U test

Overall evaluation of the sleep scale by individual domains

In the domain *Nocturnal motor symptoms* in the whole group, 140 (63.6%) respondents reported score in the range from 0-10; 75 (34.1%) respondents reported score from 11-16; 5 (2.3%) respondents reported score 17 and more, with the median of score 9.0. In the domain of *Nocturnal symptoms of Parkinson's disease* in the range from 0-10 reported score 140 (63.6%) respondents; in the medium range from 11-16 scored 39 (17.7%) respondents; 41 (18.6%) respondents reported score 17 and more. The median score reached value 10.5. In the *Disturbed Sleep* domain, median of score 10.0, 104 (47.3%) respondents reported score in the range from 0-10; 79 (35.9%) respondents reported score from 11-16; 37 (16.8%) respondents scored 17 and more points (Figure 2).

Overall evaluation of the sleep scale in individual domains and by sex

Men and women achieved similar results in all domains. In the domain *Nocturnal motor symptoms*, men reported scores in the range of 0-10 in the number of 82 (64.1%) and women in the number of 58 (63.0%). In the range from 11-16 points, 41 (32.0%) men and 34 (37.0%) women reported the given score. Scores higher than 17 points were reported by 5 (3.9%) men and 0 (0%) women. These differences in men and women proportions were not statistically significant ($p=0.410$) by chi-square test. The median score reached value 8.5 in men while 8.0 in women. This difference was not significant by Mann-Whitney U test with p value 0.819.

In the domain *Nocturnal symptoms of Parkinson's disease* in the range from 0-10 was reported

Figure 3: Total sleep scale scores by stage of disease.

Nocturnal motor symptoms										
Score	Total, n=220			Early stage of the disease, n=123			Advanced stage of the disease, n=97			p value
	n	%	median	n	%	median	n	%	median	
0-10	132	60.0	9	54	43.9	11	78	80.4	10	0.001 $\chi^2=34.969$ 0.709 $Z=0.025$
11-16	85	38.6		69	56.1		16	16.5		
17-20	3	1.4		0	0		3	3.1		
Nocturnal symptoms of Parkinson's disease										
Score	Total, n=220			Early stage of the disease, n=123			Advanced stage of the disease, n=97			p value
	n	%	median	n	%	median	n	%	median	
0-10	125	56.8	9.5	54	43.9	9.5	71	73.2	9	0.004 $\chi^2=20.167$ 0.980 $Z=-0.532$
11-16	64	29.1		44	35.8		20	20.6		
17-20	31	14.1		25	20.3		6	6.2		
Disturbed sleep										
Score	Total, n=220			Early stage of the disease, n=123			Advanced stage of the disease, n=97			p value
	n	%	median	n	%	median	n	%	median	
0-10	102	46.4	9	52	42.3	8.5	50	51.5	8.0	0.026 $\chi^2=7.273$ 0.905 $Z=-0.119$
11-16	78	35.5		41	33.3		37	38.1		
17-20	40	18.1		30	24.4		10	10.3		

% percentage; χ^2 value of chi-square test; Z value of Mann-Whitney U test

by 82 (64.1%) men and 58 (63%) women, in the range from 11-16 by 23 (18.0%) men and 26 (28.3%) women. Scores above 17 points were reported by 23 (18.0%) men and 8 (8.7%) women. Differences in men and women proportions in this domain was not significant using chi-square test ($p=0.055$). Men felt higher impact of the disease (median 8.0) compared to women (7.5), with no statistical significance ($p=0.595$).

In the domain *Disturbed sleep*, we found score 0-10 in men in the number of 60 (46.9%) and in women in the number of 44 (47.8%). Scores between 11 and 16 were reported by 41 (32.0%) men and 38 (41.3%) women. We found scores above 17 in 27 (21.1%) men and 10 (10.9%) women. Using chi-square test, we did not significant difference in followed proportion ($p=0.099$) (Figure 2).

Overall evaluation of the sleep scale in the individual domains and by stage of the disease

We performed the analysis for individual stages of Parkinson's disease - early and advanced stage. Median total score was 9.5 in the early stage patients and 9.0 at the advanced disease patients with no statistical significance ($p=0.477$).

In the domain *Nocturnal motor symptoms*, respondents reported scores in the early stage of the disease in the range from 0-10 in the number of 54 (43.9%) and in the advanced stage in the number of 78 (80.4%) respondents. In the range of 11-16 points, 69 (56.1%) respondents in the early stage of the disease and 16 (16.5%) respondents in the advanced stage of the disease reported the given score. Scores higher than 17 were reported by 3 (3.1%) respondents in the advanced stage of the disease. We found by the chi-square test significant difference ($p=0.001$) in the domain by the stage of disease, with the majority of patients at advanced stage in level of score 0-10 points. Median score reached value 11 at early stage of disease while 10.0 at advanced stage. This difference was not significant by Mann-Whitney U test with p value 0.709.

In the domain *Nocturnal symptoms of Parkinson's disease* in the range of 0- 10 reported score 54 (43.9%) respondents in the early stage of the disease and 71 (73.2%) in the advanced stage of the disease. In the range from 11 - 16, 44 (35.8%) respondents in the early stage of the disease and

20 (20.6%) respondents in the advanced stage of the disease reported the given score. Scores above 17 were reported by 25 (20.3%) respondents in the early stage of the disease and 6 (6.2%) respondents in the advanced stage of the disease. We found out by the chi-square test significant difference ($p=0.004$) in the domain by the stage of disease, with the majority of patients at advanced stage in level of score 0-10 points. Median score reached value 9.5 at early stage of disease while 9.0 at advanced stage. This difference was not significant by Mann-Whitney U test with p value 0.980.

In the *Disturbed Sleep* domain, we recorded score from 0-10 in 52 (42.3%) respondents in the early stage of the disease and in 50 (51.5%) respondents in the advanced stage of the disease. Scores in the range of 11-16 were reported by 41 (33.3%) respondents in the early stage of the disease and 37 (38.1%) respondents in the advanced stage of the disease. We recorded score above 17 in 30 (24.4%) respondents in the early stage of the disease and in 10 (10.3%) respondents in the advanced stage of the disease. We found by chi-square test significant difference ($p=0.026$) in the domain by the stage of disease, with majority of patients at advanced stage in level of score 0-10 points. The median score reached value 8.5 at early stage of disease while 8.0 at advanced stage. This difference was not significant by Mann-Whitney U test with p value 0.905 (Figure 3).

DISCUSSION

Sleep disorders in patients with Parkinson's disease are very common but remain underestimated because they are not commonly assessed in clinical practice (Jongwanasiri *et al.* 2014). The disease is mainly associated with impairment of motor function. However, it is less known, but in some cases more significant, that the disease may manifest itself in a wider range of non-motor symptoms, with several adverse consequences.

Non-motor symptoms occur in approximately 88% of patients. Non-motor symptoms are usually present in the early stage of the disease. Some symptoms, such as sleep disorders, precede several motor symptoms of the disease (Bostantjopoulou *et al.* 2016). For answering our assumptions about sleep disorders in respondents with Parkinson's disease, we chose the Parkin-

son's Disease Sleep Scale 2nd Revised Version (PDSS2). According to expert sources, PDSS-2 is a reliable, valid, accurate and potentially therapeutic tool for measuring sleep disorders in given disease. Unlike the first version, PDSS-2 has been expanded to include a spectrum of nocturnal sleep disturbances (Trenkwalder et al., 2011).

Najafi *et al.* (2013) reported a total PDSS-2 score in the group of patients - 55, indicating severe sleep disorders, while the mean total score in the control group was 20. This study evaluated 34 patients with Parkinson's disease and 34 healthy in the control group (Najafi *et al.* 2013). In our research, the highest total score was 47. We did not find values higher than 50 in the whole study group. Menza *et al.* (2010) showed in his study that sleep problems were very common and affect approximately three quarters of patients. The most common disorder was difficulty falling asleep at night. It is the difficulty of sleeping at night that can really affect any aspect of sleep. Other common sleep disorders were sleep apnea, behavioral disorders in REM sleep and restless legs syndrome (Menza *et al.*, 2010). Piao *et al.* (2017) in his study reported a research sample of 218 respondents, which is almost identical to our sample. In his study, he reported the incidence of restless legs syndrome in 40.37%, while in our research, the incidence of restless legs syndrome occurred in almost 33% of respondents. Suzuki *et al.* (2012) in a study on sleep disorders in patients with the disease observed that the incidence of restless legs syndrome ranged from 0.98 to 16%. He also compared his results with the author Piao. He concluded that the higher frequency of restless legs syndrome in the Piao study may be due to differences in patients' age and duration of disease (Suzuki *et al.* 2012). The prevalence of restless legs syndrome in Chinese patients with Parkinson's disease is approximately 8-35%, which is also close to our research. These symptoms often begin or worsen during a rest or evening (Hogl & Stefani, 2017).

Najafi *et al.* (2013) pointed to an association between sleep disorders and disease duration. We did not deal with duration of the disease in our research. We dealt with the stage of the disease, where we were interested in the difference between the stage of the disease and the achieved score in the sleep scale. Respondents in the early stage achieved approximately the same score as

in the advanced stage. Junho *et al.* (2018) found in his study that excessive daytime sleeping affects 40% of patients in the study and is associated with older age, restless legs syndrome, depressive and anxiety symptoms, and poorer sleep quality. Thorough assessment and management of sleep problems in patients with Parkinson's disease may contribute to improving the quality of life.

Lynet *et al.* (2017) observed 225 respondents with Parkinson's disease. The average age of the respondents was 65.7 years and the average duration of the disease was 8.18 years. Among the respondents, 53.8% reported difficulty falling asleep, 23.6% had excessive daytime sleeping, and 71% of patients were taking sleeping pills. In our research, we had an average age of 76.8 years. The lowest age for both sexes (genders) in the research sample was 60 years. Lyn *et al.* (2017) report 53.8% of respondents with difficulty falling asleep. Difficulty falling asleep in our survey, 16.36% of respondents rated the frequency of difficulty falling asleep as very often, i.e. 6 to 7 days a week. 10.91% of respondents rated the frequency of difficulty often, i.e. 4 to 5 days a week. The highest percentage (43.64%) of respondents rated the frequency occasionally - 1 day a week. Smith *et al.* (1997) report that sleep disorders were significantly higher in women than in men. Sleep disorders occurred in 25% of men and 41% of women. In our research, we assumed that there is a difference in the sleep scale score between men and women with Parkinson's disease. Although the research showed differences between the sexes, this difference was not statistically significant.

Norlinah *et al.* (2009) conducted a national survey of 220 respondents with Parkinson's disease. The number of respondents is identical to our research. Sleep disorders at night were reported by 215 respondents. The most common problems were: difficulty staying asleep; sleep without waking up; frequent need to urinate at night. Despite these difficulties, 2/3 of respondents rated the quality of sleep as acceptable or good. The average length of sleep was 6.5 to 7 hours, but approximately 8% of respondents reported less than 5 hours of sleep per night. Hypnotic or sedative drugs were used by 29% of patients to help with sleep. Only half of the patients told their physician about nocturnal problems (Norli-

nah *et al.* 2009). Problems of staying asleep without waking up and the frequent need to urinate at night is part of the domain of disturbed sleep in the PDSS-2 sleep scale. The overall score for disturbed sleep was 20. A score of 10 was assessed by 47.3% of patients. In the range from 11 to 20 points, 52.7% of respondents scored, when we can already talk about more serious sleep disorders in the domain of disturbed sleep. The frequency of difficulties in staying asleep and sleep without waking up was assessed by 52.73% of patients more than 4 days a week. The frequency of needing to urinate at night was assessed by 60% of patients more than 4 days a week. In this case, we agree with the result of Norlinah *et al.* (2009), who rated the overall quality of sleep as acceptable or good. In our research, 47.3% of respondents report good sleep more than 4 days a week and 52.3% of patients less than 3 days a week.

The aim of the study by Porter *et al.* (2008) were to describe in detail the frequency and nature of sleep disorders in a population of 122 respondents diagnosed with Parkinson's disease. Of the total number of 122 respondents, 27 (22%) had PDSS-2 scores above 40 points, which they rated as significant sleep disorders, with sleep fragmentation and nocturia being the most commonly reported problems. In our research, we recorded a scale score ranging from 21 to 40 in 67 (31%) respondents and we recorded the highest score up to 50 in 38 (17%) respondents. We evaluate this result as severe sleep disorders. We did not find any score higher than 50 in the entire research set. Chung *et al.* (2013) report that up to 60-76% of respondents with Parkinson's disease have a sleep disorder called insomnia. Nocturnal hypokinesia, nocturnal and early morning dystonia, and impaired mobility are considered as common causes. In practice, attention is focused on the motor symptoms of the disease and are probably considered to be the primary causes of sleep disorders. The frequency of muscle cramps that woke respondents from sleep in our survey was not high. 80 (36.36%) respondents never experienced muscle cramps at night and 68 (30.91%) respondents occasionally. We can see similar results in the morning painful position of the hands or feet. In 72 (32.73%) respondents this problem never occurred and in 76 (34.55%) respondents it occurred occasionally.

Almost all the authors of the research studies agree that sleep disorders in patients with Parkinson's disease are very common and occur in relatively high percentages, which was confirmed in our research sample. Disturbed sleep needs to be addressed from several aspects. It is a problem that cannot be underestimated, because it negatively affects the course of the disease, mental state and cognitive functions, thereby affecting the quality of life.

In nursing practice, nurses assess the physical aspects of the disease, such as tremor, rigidity, and postural instability in patients with Parkinson's disease. Motor symptoms of the disease are traditionally considered to be the most important features of the disease and, of course, are given the most attention both in research and in clinical practice. Nevertheless, the disease affects patients' lives in a broader sense than just physical harm. Many of the non-motorized aspects of the disease, such as the sleep disorders we investigate, are very common and significantly affect the daily lives of these patients. Disturbed sleep affects the patient's self-sufficiency and cognitive functions, which in turn significantly affect the patient's mental state and can cause depression.

CONCLUSION

Sleep plays an important role in a person's good health and well-being throughout life. Sufficiency of quality sleep protects our mental and physical health, quality of life and safety. Persistent lack of sleep can increase the risk of some chronic health problems. Disturbed sleep is very common and affects quite a high percentage in patients with Parkinson's disease. It can manifest itself as sleep fragmentation, insomnia, excessive daytime sleepiness and other sleep disorders. The role of nursing is to be interested in the problems of sleep disturbance in patients; to discuss healthy and quality sleep; to offer information on appropriate behavior in the field of sleep hygiene with an emphasis placed on improving sleep satisfaction. All patients should be informed of good sleep hygiene and should try to maintain a regular sleep plan. A better assessment of these aspects of the disease could significantly reduce these problems, thereby improving patients' quality of life. Nurses are key to providing effective clinical management to patients with Parkinson's disease. Patients need basic nursing care because

they face common problems such as sleep disturbance. Nurses are ideal for assessing personal problems and difficulties, for providing educational and emotional support. They can help neurologists in assessing the physical and mental condition of the patient. Disturbed sleep affects the quality of life not only for the patient but also for the family. Therefore, there is a need for patients, relatives, nurses and caregivers to gain a better knowledge and understanding of the disease and to mitigate the impact of the disease on the patient's daily life. An important step is the involvement of health care institutions providing care for patients with Parkinson's disease in research studies that address various issues, not just sleep disorders. The results of research can then be applied in practice, which in turn can reduce the prevalence of disturbed sleep in patients.

LIMITS

We see the limits of our research in a relatively not common diagnosis, which makes it impossible for a higher number of respondents, therefore the results cannot be generalized to the entire population of patients with Parkinson's disease.

ETHICAL ASPECTS AND CONFLICT OF INTEREST

Authors declare that the study has no conflict of interest and the ethical aspects of the research were respected.

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