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Including: Social Work, Humanitary Health Intervention, Nursing, Missionary Work

# CLINICAL SOCIAL WORK *AND HEALTH INTERVENTION*

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Source: Adriana Sidikova

*Issue: Health and Social Care in Imprisoned, Orphans and Homeless*

## Original Articles

✓ INFECTIOUS DISEASES AMONG IMPRISONED - RISK FACTORS AND OUTCOMES (REVIEW)

✓ ANTIMICROBIAL SUSCEPTIBILITY OF RESPIRATORY ISOLATES FROM HOMELESS POPULATION IN AN URBAN ENVIRONMENT

✓ MIGRANTS ARE COLONIZED BY RESISTANT BACTERIA DURING THEIR PROLONGED STAYS IN REFUGEE CAMPS

✓ A DAILY LOW-THRESHOLD INTEGRATION CENTER FOR THE HOMELESS. MODEL OF SOCIAL AND HEALTHCARE FOR EXCLUDED POPULATIONS

✓ INCREASING INFECTIONS WITH CANDIDA SPP. AND MARINE SPECIES OF PSEUDOMONAS AMONG MIGRANTS FROM SYRIA CROSSING MEDITERRANEAN SEA BETWEEN GREECE AND TURKEY

✓ INTERNALLY DISPLACED POPULATIONS, NEW CHALLENGES AND OPPORTUNITIES

✓ FAMILY GROUP CONFERENCE AND ITS ROLE IN ADDRESSING HOMELESSNESS WORLDWIDE

✓ SPECTRUM OF COMMUNICABLE DISEASES AT THE MEA CULPA SHELTER FOR THE HOMELESS IN BRATISLAVA – 15 YEAR FOLLOW UP

✓ REVERSIBILITY OF ANTIBIOTIC RESISTANCE IN AN ORPHANAGE OF CHILDREN WITH AIDS IN CAMBODIA

✓ ST. LOUISE HOSPITAL FOR MARGINALIZED HOMELESS POPULATION: TB AND OTHER INFECTIOUS DISEASES ARE RARE

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## Editorial

This issue on topic Health and Social Care for Imprisoned, Orphans and Homeless consists of ten articles I believe will be beneficial for researchers, practitioners and the general public, too.

Focusing on when we think about the individual fate of homeless, people may feel remorse and perhaps even disgust and repulsion. Societal prejudices associated with the problem of homelessness sometimes induce atmospheres of fear; the “expert opinion” that it is their own fault; if they wanted, they would work; after all, “Nobody gave me anything for free either!”.

Sadly, in my opinion, some Social Services or their providers, set the homeless in the social system as professional consumers of Social Services. In recent decades, we see many so-called social tourists who migrate from one social center to another, from city to city, from one Social Worker to another and manage to live without any effort to snip the umbilical cord from (within their circumstances) generous Social Services. In some cases, we even met some extremes, when they refused an apartment with minimal rent which would terminate their social tourism. While such cases are a minority, I believe they are products of a non-systematic social policy of the state which persuades its citizens about a generous welfare state which will resolve all their problems. We must not incline to any of these extremes. Neither sorrow associated with maternity, nor leaving a person alone is a correct approach to homeless people. It is necessary to understand that none of the homeless have planned their future this way. Many of them had, for a certain period of life, a functioning marriage and family, employment, career - some had been University Teachers, Priests, Engineers, Medical Doctors, Doctors of various Sciences; but, of course, mostly, people without completed basic education, or graduates of special schools. Currently, there is a new specific group forming, consisting of migrants and refugees, who are often qualified but the language barrier condemns them to low levels of the society ladder.

Social Service Professionals do not like to use the term “homeless” because it is stigmatizing and humiliating during contact with clients. A lesser and more appropriate phrase is “people without a home”. The general public uses and understands the word “homeless” mostly as something pejorative: “Only filthy beggars from the street and wanderers (vaga-bonds) are often considered as homeless. People usually try to avoid them, because meeting them raises feelings of repulsiveness” (Tvrdoň, Kasanova, 2004). Homeless people perceive us through the lens of their reality experiences, and they often do not believe we can understand their suffering when we have not had such experiences.

The three main functions of social assistance to homeless people is providing housing, problem solving (including counseling) and catering. In Slovakia, these are carried out mainly through construction of refuges and food distribution. However, besides accommodations and social counseling to the homeless, these refuges (the simplest form of housing by Social Services for homeless people) seldom offer a real opportunity to change their lives through any instructive rehabilitation programs. The aims are mainly keeping clients alive; essentially providing necessary housing, food, and clothing. If there should be real integration of homeless people into society, Social Work should not just stay at that level. The homeless are among the most at risk groups for Social Workers. They are multiply marginalized; discriminated in housing, financial assistance, in the labor market, and in supporting relationships. Thanks to seemingly insurmountable problems endangering their

health, welfare and life, the homeless require capable and competent supportive crisis intervention.

The mechanism of their employment and success in finding and maintaining work habits on a purely commercial principle leads to serious doubts about any more permanent sense of social measures in the form of social enterprises; activation works; various packages of Social Services. In addition to the enormous financial costs and the need for resulting efficiency, the risk of abuse of finances by intermediaries linked with the problem of fading EU funds, they ultimately deprive homeless people of their dignity and paradoxically create so called “hungry valleys”. In the medium and long term perspective, they may even lock them in the poverty trap; dependence on the welfare state (there is a reason why it is said, that that large-scale social network is more like rocking a “tranquilizing” network and not the engine of social change and sustainable prosperity).

I feel that the key solution to the poverty issue of homeless people affected by poverty (especially generational) is more in the hands of good and successful entrepreneurs, than in the legalities of the Social Services Act and the Employment Services Act.

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## Few words from the Editors-In-Chief

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

Students want to grasp both: theoretical knowledge and also the practical models used in social work. And it is our obligation to present and help students understand the theory of social work as well as showing them how to use these theoretical findings in evaluating the current social situation, setting the right goals and planning their projects.

This is a multidimensional process including integration on many levels. Students must respect client's individuality, value the social work and ethics. They must be attentive to their client's problems and do their best in applying their theoretical knowledge into practice.

It is a challenge to deliver all this to our students. That is also why we have decided to start publishing our journal. We prefer to use the term 'clinical social work' rather than social work even though the second term mentioned is more common. There is some tension in the profession of a social worker coming from the incongruity about the aim of the actual social work practice. The question is whether its mission is a global change of society or an individual change within families. What we can agree on, is that our commitment is to help people reducing and solving the problems which result from their unfortunate social conditions. We believe that it is not only our professional but also ethical responsibility to provide therapeutic help to individual and families whose lives have been marked with serious social difficulties.

Finding answers and solutions to these problems should be a part of a free and independent discussion forum within this journal. We would like to encourage you – social workers, students, teachers and all who are interested, to express your opinions and ideas by publishing in our journal. Also, there is an individual category for students' projects.

In the past few years there have been a lot of talks about the language suitable for use in the field of the social work. According to Freud, a client may be understood as a patient and a therapist is to be seen as a doctor. Terminology used to describe the relationship between the two also depends on theoretical approach. Different theories use different vocabulary as you can see also on the pages of our journal.

Specialization of clinical social work programmes provides a wide range of education. We are determined to pass our knowledge to the students and train their skills so they can one day become professionals in the field of social work. Lately, we have been witnessing some crisis in the development of theories and methods used in clinical social work. All the contributions in this journal are expressing efforts to improve the current state. This issue of CWS Journal brings articles about social work, psychology and other social sciences.

Michael Olah  
Peter G. Fedor-Freybergh  
*Edition of the journal*





# Infectious Diseases Among Imprisoned - Risk Factors and Outcomes (Review)

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**Abstract:**

Of the estimated 10.2 million people incarcerated worldwide on any given day in 2014, it is estimated that 3.8% have HIV (389,000 living with HIV), 15.1% have HCV (1,546,500), 4.8% have chronic HBV (491,500), and 2.8% have active tuberculosis (286,000). The prevalence of HIV, hepatitis B virus, hepatitis C virus, and tuberculosis are higher in prisons than in the general population in most countries worldwide, mainly because of the criminalization of drug use and the detention of people who use drugs. Another important risk factor is sexual behavior, where MSM represent major risk for transmission of infectious diseases. Overcrowding and poor infrastructure are responsible for parasitic infections. Improving conditions in prisons, finding alternatives to detention and mostly available HAART and preventive programs for HIV, HCV and tuberculosis, could be the options how to lower the numbers of infected people.

**Conflict of interest:**

The authors whose names are listed in the title of the article certify that they have NO affiliations with or involvement in any organization or entity with any financial interest (such as honoraria; educational grants; participation in speakers' bureaus; membership, employment, consultancies, or other equity interest), or non-financial interest (such as personal or professional relationships, affiliations, knowledge or beliefs) in the subject matter or materials discussed in this manuscript.

**Introduction**

The negative and mutually reinforcing nature of incarceration, substance use disorders, and blood-borne viruses such as HIV, hepatitis C virus, and tuberculosis is problematic and results in a concentration and interaction between these health and social conditions. Of the estimated 10.2 million people incarcerated worldwide on any given day in 2014, it is estimated that 3.8% have HIV (389,000 living with HIV), 15.1% have HCV (1,546,500), 4.8% have chronic HBV (491,500), and 2.8% have active tuberculosis (286,000). The few studies on incidence suggest that intra-prison transmission is generally low, except for large-scale outbreaks. However, there are several factors increasing risk of transmission of these diseases either during detaining, but after discharge as well. (1-4)

**Risk factors for infectious diseases among imprisoned:**

Commonest risk factor for many infectious diseases is sexual and addictive behavior. MSM are leaders in risky sexual behavior especially in long-term imprisonment; sexual behavior is linked to HIV, HBV and HCV as well. Another major risk factor is intravenous drug use. Despite strict conditions in prisons, it's more common than expected. Common drugs such as cocaine, heroin, marijuana, are rarely imported due to screening, but prisoners can produce their own "substances" similar to classic drugs. Contaminated syringes play the major role in the transmission of hepatitis B, C and HIV.

Another risk factor for infectious diseases is overcrowding. However, the spectrum of IDs linked to overcrowded prisons is different from those transmitted sexually or by blood. Typical IDs related to overcrowding are respiratory tracts infections; among them also tuberculosis and influenza. Despite of possibility of TB vaccination for neonates in some countries, in prisons, this vaccination is still not implemented; neither is flu vaccination. Unfortunately, prevention of TB is closely linked to the “deadly synergy” of both, TB and HIV, but other sexually transmitted diseases as well. Another risk factor for TB transmission is the fact that only 10% of imprisoned are receiving antiretroviral therapy. Absence of ARV therapy is a major risk factor for progressing to AIDS and developing opportunistic infections, such as TB, HBV, herpes zoster and others. Apart from TB, other infectious diseases linked to conditions in prison are leptospirosis, scabies and pediculosis. Ecto-parasites are sometimes directly linked to sexual behavior, too, but mostly to poor hygiene and infrastructure in some regions. (5-10)

## Preventive Programs

The prevalence of HIV, hepatitis B virus, hepatitis C virus, and tuberculosis are higher in prisons than in the general population in most countries worldwide, mainly because of the criminalization of drug use and the detention of people who use drugs. Prisons are risk environments for these infections to be further concentrated, amplified, and then transmitted to the general community after prisoners are released. In the absence of alternatives to incarceration, prisons and detention facilities, there is the possibility to reduce these risks by promoting primary and secondary prevention strategies for these infections to improve prisoners' health and also to reduce risk throughout incarceration and on release. (1)

However, large gaps exist in the implementation of these strategies across all regions. Several studies showed that anti-HIV and anti-TB preventive programs are only successful, when combined together. Collaboration between the criminal justice and public health systems will be required for successful implementation of these strategies. (2)

The prison setting therefore presents not only challenges, but also opportunities, for the prevention and treatment of HIV, viral hepatitis, and tuberculosis. At the same time, even when WHO guidelines recommend treatment for all patients, irrespective of CD4 count, coverage with antiretroviral therapy in some regions is less than 10% and is compounded both by suboptimal screening for diseases and low coverage of evidence based HIV prevention strategies (e.g., opioid agonist therapies with methadone or buprenorphine, or needle and syringe programs. (3) Effective treatment of opioid use disorders with opioid agonist therapies prevents blood-borne infections via reductions in injection in prison and after release. (4) But the most effective way of controlling these infections in prisoners and the broader community is to reduce the incarceration of people who inject drugs.

**Table 1** Commonest infections in prisoners

### Commonest Infectious Diseases in Imprisoned:

1. Related to substance/drug use and misuse  
Blood born – hepatitis B, C, HIV, MRSA, Candida spp.
2. Related to sexual behavior  
HIV, HCV – MSM, syphilis, gonorrhea, other STDs
3. Related to overcrowding and poor infrastructure

RTI: TB and, influenza, Pneumococcus  
SSTI: Ecto-parasitosis, Scabies, Pedic-  
ulosis, etc.

4. Related to poor food and water supply  
Hepatitis A, leptospirosis

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# Antimicrobial Susceptibility of Respiratory Isolates from Homeless Population in an Urban Environment

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**Abstract:**

Resistance to ATB from respiratory isolates of homeless residents with symptoms of URTI in 2012 – 2017 were analyzed. Resistance was tested in years 2008, 2012 and 2016 with no major resistance patterns found. MRSA resistance was less than 5% and PR less than 3% of all isolates. Despite majority of increasing population is not vaccinated against H. influenza and St. pneumonia, influenza, no major ID outbreaks were present and no case of TB was noted.

**Conflict of interests:**

The authors whose names are listed in the title of the article certify that they have NO affiliations with or involvement in any organization or entity with any financial interest (such as honoraria; educational grants; participation in speakers' bureaus; membership, employment, consultancies, or other equity interest), or non-financial interest (such as personal or professional relationships, affiliations, knowledge or beliefs) in the subject matter or materials discussed in this manuscript.

**Introduction**

The number of homeless population in the EU is increasing. The homeless population may be at risk of certain communicable diseases such as tuberculosis, hepatitis B, C, HIV, pediculosis, scabies and other skin and soft tissue infections. Some areas with high appearance of homeless people experienced epidemics of MRSA and other outbreaks. (1-5) The aim of this communication was to describe common ID in two outpatient health care facilities for homeless in 2012-2017 in Bratislava; screening for about half a million permanent citizens of capitol and 100,000 migrating population on a daily basis from surrounding cities.

**Patients and Methods**

From December 2012 to January 2017, we have recorded more than 6,000 visits of homeless between the ages 19 to 86. Ambulatory treatment was offered for the majority of cases after assessment of their health status, either in the St. Elisabeth University shelter, or Mea Culpa Dormitory shelters in Bratislava.

**Results**

3,131 homeless patients (50.1%) presented with infectious diseases; commonest were upper respiratory tract infections (70.5%) followed by skin and soft tissue infections (20.5%) and ecto-parasites (5.1%, scabies as commonest). Only about 4.7%

of all cases with severe ID were diagnosed; commonest diagnoses being pneumonia, infected necrosis of lower limbs after frost-bites or leg ulcers. Only four suspected but not confirmed cases of TB have been described (0.1%) which is in correlation with the average Slovak population with 0.01-0.1% prevalence (Tab.1). Concerning antimicrobials used amoxicillin, azitromycine, doxycycline and cotrimoxazole for SSTI and scabicides for ectoparasites with or without ivermectin has been commonly used. In 103 symptomatic homeless patients with lower RTI, swabs from nose and tonsils were obtained but no emergence of resistance in respiratory pathogens has been observed. Only one isolate of Penicillin resistant Pneumococcus (PRP) (1%) and three MRSA (3.95%) have been observed.

## Conclusion

According to our 15 years epidemiological observation, homeless population does not represent major threat for other urban population in Bratislava. To decrease the incidence of upper RTI in homeless patients, vaccination against influenza a pneumococci mainly in patients over 65 years old should be considered and also for those staying in stationary shelters. Regular swabs from respiratory and gastrointestinal tract are advisable too.

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# Migrants are Colonized by Resistant Bacteria during their Prolonged Stays in Refugee Camps

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**Abstract:**

Despite 1.5 million migrants (MM) and refugees using the Balkan Route from Syria/Iraq via Turkey, Greece, Serbia, Croatia, Slovenia or Hungary to Austria and Germany and smoldering exodus of 250,000 MM via Mediterranean Route, who entered Italy, Spain and Malta from the African continent, every year for 10 years at least, no major epidemics were noted. Reasons for this may vary, but there is public concern of transmitting resistant micro-organisms to Europe. The aim of the study was to estimate whether there is such a risk; where are migrants colonized by bacteria; what type of bacteria are they carrying. Migrants are colonized by bacteria during prolonged stay in refugee camps in inappropriate conditions; migrating migrants are not hosts for resistant bacteria. Conditions in camps should be addressed to prevent spreading resistant micro-organisms.

**Conflict of interest:**

The authors whose names are listed in the title of the article certify that they have NO affiliations with or involvement in any organization or entity with any financial interest (such as honoraria; educational grants; participation in speakers' bureaus; membership, employment, consultancies, or other equity interest), or non-financial interest (such as personal or professional relationships, affiliations, knowledge or beliefs) in the subject matter or materials discussed in this manuscript.

**Introduction**

Fortunately, the refugee crisis in the EU has not yet had major any health consequences. Despite 1.5 million migrants (MM) and refugees using the Balkan Route from Syria/Iraq via Turkey, Greece, Serbia, Croatia, Slovenia or Hungary to Austria and Germany and smoldering (slow flow) of 250,000 MM via the Mediterranean route entered from the African continent via Malta, Italy and Spain every year for last 10 years at least, no major epidemics were noted. Only sporadic cases of Hepatitis A, Scabies and non-specific diarrhea were noted. Even epidemic diseases like influenza,

decimating every early Spring in Central Europe, or cholera so typical for mass gathering and migrating weren't noted.

There are several reasons why it may be possible:

- Good health infrastructure in (partially) EU transiting countries (Italy, Malta, Greece, Croatia, Serbia, Hungary, Austria),
- Healthy population migrating (young adolescents, children with families),
- Acceptable vaccination status apart of very small infants from Syria (Tulio Prestilio 2015),

- Good health and overall education of MM on prevention and early therapy of infectious diseases,
- Screening for some infectious diseases during transit.

However, Points 3 and 4 are present only among those migrating via Balkan and not via Mediterranean Route.

On the negative side of the coin are the substantial ship tragedies off Malta, Lampedusa and Sicily, resulting to 6,000 to 10,000 non-infectious deaths.

## Patients and methods

Samples from oropharynx of 40 migrating migrants between Hegyeshalom (HU) and Nickelsdorf (AT) were obtained between Sept. – Nov. 2016. Stationary migrants/asylum seekers were located in Veria/Alexandria

from refugee camps (1,016 samples). Swabs were taken from symptomatic patients and transported to the National Reference Laboratory. Resistance to antimicrobial patterns in both groups were compared and assessed.

## Results and discussion

Comparing the etiology in respiratory isolates of both groups, there was a significant difference in *S. aureus* and *Candida* spp. among both groups. *S. aureus* was significantly more frequent among migrants residing for 3-6 months in a refugee camp (12.2% vs 2%  $p < 0.01$ ) and *Candida* spp. (*C. albicans* 7, and non-*Albicans Candida* spp. 3) as well. Also, the overall member of pathogens colonizing the respiratory systems of migrants was significantly higher among migrants in camp in comparison to migrating migrants in the Nickelsdorf or Hegyeshalom

**Table 1** Stationary migrants in Greek migrant camp Alexandria versus migrating migrants in the Balkan Route: discrepancies in colonization of the RTI with respiratory infections diseases pathogens.

	Stationary Migrants SM	Migrating Migrants MM	P
	48	101	
<b>A) Grampositive Bacteria</b>			
<i>S. aureus</i>	5*	2	P<0,01
MSSA	4	2	
MRSA	1	0	
<i>St. pyogenes</i> (ERY-R)	1	1	
<i>St. pneumoniae</i> (PEN-)	0	2	
<b>Total</b>	6	7	
<b>B) Gramnegative</b>			
HOCA	1		
HAIN	1		
Enterobacteriaceae	2	6	
Pseudomonaceae	1	1	
<b>Total</b>	5	7	
<i>Candida</i> spp. (total)	10	2	P<0,01
<i>C. albicans</i>	7	2	
NAC	3	0	

Health Posts (22 of 45, 48.5% vs. 15 of 101, 15%,  $P < 0.05$ ). Some rare (marine) organism such as *Ps. stutzeri*, *Neisseria fermentans* and others were isolated from the migrating migrants subgroups, indicating having crossed the sea during traveling. (1-5) Surprising findings were of a significantly higher population of bacterial and fungal pathogens when comparing the respiratory isolates in stationary migrants compared to migrating migrants which indicates that SM are much more frequently colonized with bacteria pathogens and pathogens transferred during long-term stays in the facility. (6-10)

## Conclusions

Migrants in camps and closed communities might be at significantly higher risk of infection with resistant strains of bacteria, than those who are on the move. However, more studies are needed to confirm this hypothesis. Prolonged stays in camps without proper nutrition and living conditions should be matters of concern as well.

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# A daily Low-threshold Integration Center for the Homeless. Model of Social and Healthcare for Excluded Populations

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**Abstract:**

Vulnerable populations, such as homeless people often have limited access to healthcare and use emergency departments of hospitals for the majority of their medical problems. This leads to increased costs for hospitals and longer waiting times for acute cases. Low-threshold centers for the homeless are good examples of how to integrate this population, at least partially, into society. Having the possibility of complex medical care in these facilities is a good model of care. Most of the patients have various infectious diseases including seasonal flu and SSTI; various wounds and injuries. Psychological disorders and alcoholism are another serious issue which needs addressing. Besides, this kind of approach can attract more clients, even those who are not in need for shelter.

**Conflict of interest:**

The authors whose names are listed in the title of the article certify that they have NO affiliations with or involvement in any organization or entity with any financial interest (such as honoraria; educational grants; participation in speakers' bureaus; membership, employment, consultancies, or other equity interest), or non-financial interest (such as personal or professional relationships, affiliations, knowledge or beliefs) in the subject matter or materials discussed in this manuscript.

**Introduction**

The number of homeless population in EU is increasing. The homeless population is in substantial risk of medical, psychiatric, and social problems including tuberculosis, HIV infection, hepatitis, alcoholism and substance abuse, skin and foot disease, schizophrenia and related psychoses, malnutrition, and trauma. The homeless are also less likely to be integrated into the primary care system and routinely utilize emergency departments for a majority of their healthcare needs. This is associated with significant healthcare costs which could be prevented by using primary care centers for the homeless which are usually run by NGO's. Furthermore, neither the exact number of such people nor the spectrum of diseases in this population in post-communists countries has not been properly identified. In the

capitol Bratislava and in the second largest city Kosice, the same estimated number of homeless is around 3,000 people. The aim of this paper was to describe the commonest infectious diseases present in a low-threshold center for the homeless and to and to evaluate the contribution of a doctor in such a project.

**Patients and Methods**

This study was conducted between 2012-2017 in Bratislava where this center serves for about 3-4,000 homeless population. The shelter is integrating outdoor homeless clients from the capitol and surrounding cities and cooperates with street workers who are actively seeking clients. Treatment also is provided right on the street for clients who don't want or are not able to come to center.

Since 2014, there is a doctor available in center once a week for more difficult cases with possibility of referring patients for further treatment to a Specialist in hospital. In total, 1,349 patients were treated, some of them more than once, and more than 2,300 diagnoses have been made. There were approximately 30 patients per doctor per day.

## Results and Discussion

The most frequent health problems varied according to the season; in winter, most common were various injuries, ulcers, infected wounds, abscesses and frostbites. On the other side, in summer, different types of skin infections, such as impetigo, rose, microbial eczema, fungal infections and abscesses were most common.

**Table 1** Percentage of infectious diseases according to the season:

### Autumn - Winter

- Bronchitis acute 20%
- Leg ulcer 19%
- Injuries, infected wounds 15%
- Tonsillitis 12%
- Infected eczema 10%
- Chronic complications of alcohol dependence 7%
- Scabies, lice 5%

### Spring – Summer

- Impetigo 21%
- Asthma bronchial 17%
- Atopic dermatitis 11%
- Injuries, infected wounds 10%
- Lice, scabies 9%
- Acute conjunctivitis 7%
- Psychiatric disorders, depression 5%

The other significant group of diseases were psychological, mainly depressions, suicidal behavior, alcoholism and alcoholism related conditions, such as epilepsy. Infectious diseases also had a seasonal character;

influenza, tonsillitis, bronchitis, sinusitis and pneumonia were most common, typically arising in November and lasting up to March.

## Conclusion

The homeless population remains excluded from society. Healthcare is often unaffordable due to debts to health insurance companies and patients are non-compliant. Low-threshold centers with availability of a doctor seem to be a good model to ensure healthcare for the homeless population. However, this option is still not widely used nor supported. We recommend this model for every institution working with homeless population. Psychiatrist and Psychotherapist would be an important benefit for this community as well. Wider cooperation with Specialists is also recommended.

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# Increasing Infections with *Candida* spp. and Marine Species of *Pseudomonas* among Migrants from Syria crossing Mediterranean Sea between Greece and Turkey

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Original Article

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**Abstract:**

The data about the epidemiological situation and public health risk of migrants crossing the sea is still lacking, their colonisation with bacteria with potential resistance is questionable. The aim of this study was to describe the most frequent bacteria species colonising migrants who crossed the sea during their journey to Europe in comparison to those who used Balkan route via Turkey and Greece. Commonest pathogens in samples tested in patients with pneumonia were *S. aureus* (18%), Enterobacteriaceae (17%) and *M. catharralis* (15%). *Candida* species and marine microorganisms replaced the pathogenic flora in patients with respiratory tract infections, who previously stayed long time in the nature or had to cross the sea during their journey.

**Conflict of interest:**

The authors whose names are listed in the title of the article certify that they have NO affiliations with or involvement in any organization or entity with any financial interest (such as honoraria; educational grants; participation in speakers' bureaus; membership, employment, consultancies, or other equity interest), or non-financial interest (such as personal or professional relationships, affiliations, knowledge or beliefs) in the subject matter or materials discussed in this manuscript.

**Introduction**

Over the past 4 years, Europe has experienced an increasing influx of migrants crossing the Mediterranean Sea seeking humanitarian protection and/or improved living conditions. Most are fleeing war, persecution or extreme poverty. The number of sea migrants has escalated substantially since 2011 (62,500 in 2011, 43,000 in 2013, 170,000 in 2014) following the Syrian war, the rise of the *Islamic State*, as well as the political crisis in Libya. In 2015 about a million of them have reached Europe.(1,2) There have been several studies of their health status; most of them suffer respiratory tract infections, acute diarrhoea and other conditions caused by poor hygiene

and infrastructure on the move. (2-5) The health status and spectrum of diseases can vary according to origin and previous social status. (6-7) However we are still lacking data about the epidemiological situation and public health risk of migrants crossing the sea, their colonisation with bacteria with potential resistance is questionable.

The aim of this study was to describe the most frequent bacteria species colonising migrants who crossed the sea during their journey to Germany in comparison to those who used Balkan route via Turkey, Greece, Slovenia, Hungary and Austria.

## Patients and methods

Only symptomatic patients presenting with signs of lower respiratory tract infection – fever, tachycardia, respiratory distress and cough were included. Previous travelling history was obtained, together with informed consent. Patients were divided into three groups: of those, who crossed the Mediterranean Sea, those who used land for whole journey and stationary migrants. Samples of nasopharyngeal swabs and sputum were collected and send to the National reference microbiological laboratory in Nitra, for susceptibility test. Patients were given empiric treatment due to the unavailability of further monitoring. In total, 101 patients were included.

## Results and discussion

Commonest pathogens in samples tested in patients with pneumonia were *S. aureus* (18%), Enterobacteriaceae (17%) and *M. catharralis* (15%). All pathogens were susceptible for tested antimicrobials, in both groups – stationary migrants and migrating migrants. The most probable explanation for this may be the fact, that patients were coming from rural (less exposed) environment.

As far as Enterobacteriaceae were concerned (17%), 95% were ESBL negative and susceptible for tested antimicrobials. *S. pneumoniae* was rare and *H. influenzae* we found only in few cases (2-3%), probably due to the vaccination of the coming population. Two things were statistically significantly different in both groups (see table 1). First was colonisation of the patients with *Candida* spp., mainly with *Candida albicans*, which was significantly more common in group of SM. The other was finding of marine microorganisms in patients who had to cross the sea during their journey (5%), such as *A. hydrophila*, *S. maltophilia* and others.

## Conclusions

*Candida* species and marine microorganisms replaced the pathogenic flora in patients with respiratory tract infections, who previously stayed long time in the nature or had to cross the sea during their journey. Despite the *Candida* was the leading species among both groups of migrants, we assume, it was rather colonising, not causing pathogen, in contrast to marine microorganisms. This fact should be considered when prescribing empirical therapy for migrants.

**Table 1** Comparison of microbial etiology in respiratory tract isolates among migrants with LRTI

Venue of clinic/health post	Total	Austria	Slovenia	Greece	p	p	p
Number of LRTI	101	35	29	37	At vs. SL	AT vs. GR	SL vs. GR
Type of migrants	NA	MM	MM	SM (camp)			
<i>S. aureus</i>	18 (17,9%)	10 (29%)	5 (17%)	3 (9%)		0.01	
MRSA	0	0	0	0			
<i>S. pneumoniae</i>	3 (3%)	1 (3%)	2 (6,5%)	0			
PRP	0	0	0	0			
<i>H. influenzae</i>	2 (2%)	2 (6%)	0	0			
BLPAR	0	0	0	0			
<i>M. catharralis</i>	17 (14,9%)	9 (27%)	4 (17%)	4 (11%)			
Enterobacteriaceae	17 (17%)	7 (20%)	6 (21%)	4 (12%)			
ESBL+	1	1	0	0			
<i>Ps. aeruginosa</i>	3	1 (2,5%)	1 (3,3%)	1 (2,8%)			
Non-aeruginosa ps. species	6	0	1 (3,3%)	5 (14%)		0.01	0.04
<i>Candida</i> spp.	42	10 (29%)	9 (32%)	23 (60%)		0.04	0.04
<i>Candida albicans</i>	30	5 (14,2%)	4 (17%)	21			
Non-albicans <i>Candida</i>	12	5 (14,2%)	5 (17%)	2 (5,4%)			

\* MM- migrating migrants on the move

\*\* SM – stationary migrants in camps

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# Internally Displaced Populations, New Challenges and Opportunities

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Original Article

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## Abstract:

Prestilio *et al.* (1) in his recent research from Sicily, Italy, recently stated that there are now twice as many internally displaced people (IDPs) as refugees worldwide. Internal displacement associated with conflict and violence has been rising since 2003. There were 8.6 million new cases during 2015. Some 4.8 million people were newly displaced in the Middle East alone, significantly more than in the rest of the world. Combined Yemen, Syria and Iraq accounted for over half

of the total. Elsewhere, Ukraine, Nigeria, Democratic Republic of the Congo (DRC), Afghanistan, Colombia, Central African Republic and South Sudan had the highest numbers. In terms of total headcount, there were 40.8 million IDPs worldwide as a result of conflict and violence at the end of 2015 – an increase from 2.8 million in 2014, the highest figure ever. Just ten countries accounted for over two-thirds of the total, around 30 million people: Colombia, DRC, Iraq, Sudan and South Sudan have featured in the list of the ten largest internally displaced populations every year since 2003.

### **Conflict of interest:**

The authors whose names are listed in the title of the article certify that they have NO affiliations with or involvement in any organization or entity with any financial interest (such as honoraria; educational grants; participation in speakers' bureaus; membership, employment, consultancies, or other equity interest), or non-financial interest (such as personal or professional relationships, affiliations, knowledge or beliefs) in the subject matter or materials discussed in this manuscript.

Disasters displaced around 19.2 million people across 113 countries in 2015, more than twice the number who fled conflict and violence. Over the past eight years, a total of 203.4 million, or an average of 25.4 million displacements have been recorded every year. As in previous years, South and East Asia dominated in terms of absolute figures, but no region of the world was unaffected. India, China and Nepal had the highest numbers, with 3.7 million, 3.6 million and 2.6 million respectively. The vast majority of displacement took place in developing countries, and the worst effects of catastrophes were experienced by populations of small island countries.

Continuing of large crises (such as the one in Syria) should lead to a new and more complex approach to displacement. Moreover, less mentioned but significant forms of displacement also deserve our attention. Three of most frequent of these causes are criminal violence, drought and development projects. Estimation of their effects is difficult due to the uncertain counts and monitoring.

A comprehensive approach should address either political factors (so people do not have to flee from homes) and when displacement becomes inevitable, addressing immediate needs is required, but in cooperation with the development sector if sustainable solutions are to be achieved, as there is a clear trend of displacement becoming more protracted. Actually, we can say that the distinction between internal and cross-border displacement is unhelpful in a globalized world. Displacement is a multi-dimensional challenge that must involve humanitarian aid, sustainable development, peace-building, disaster risk reduction and climate change adaptation work. More comprehensive monitoring of displacement is needed to ensure that all IDPs, and people vulnerable to displacement, are included in efforts to respond to their needs and address long-term development objectives.

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# Family Group Conference and its Role in addressing Homelessness Worldwide

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Original Article

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## Abstract:

All over the world is proved the effectiveness of the conferencing model of the work with the social and family network. A proven effective way for enhancing and strengthening the family system is conducting meetings and family circles. Family Group Conferences (FGC) as the old, but newly uncovered way of the social work, definitely has important



role also in the homelessness issue. Content analysis conducted interviews with 42 members of 14 families and 16 professionals who participated in FGC, we have identified supporting factors strengthening the family system through implementation FGC in homelessness issue.

**Objective:**

*In 40 countries of the world there is the Family Group Conference model used in the solving homeless issue. The aim of our research was to discover the impact of the using Family Group Conference model in the social work with the family at the solving family homelessness.*

**Design:**

Pilot study.

**Participants:**

*The 42 clients suffering by the homelessness problem participated in the study and 16 professionals involved in Family Group Conference interviewed during one year period (2015-2016). Original Articles 8 Clinical social Work and Health Intervention Clinical Social Work and Health Intervention Vol. 8 No. 1 2017*

**Methods:**

*Qualitative research (semi-structured interviews) were evaluated by Atlas program by the methodology based on the grounded theory.*

**Results:**

*Participants defined supporting factors which influenced more effective solving their homeless problem by the using Family Group Conference model.*

**Conclusion:**

*The pilot study shows that Family Group Conferences improves the quality of life and contribute to the more effective solutions of the homelessness issue. However, there is a need for prolonged study with more clients in order to demonstrate the effectiveness of this model.*

Professor Jozef Mikloško, PhD. since his undergraduate study devoted to multi-disciplinary attitude to the family issue. His long-term interest in the prenatal psychology and medicine is used at the Institute of prenatal and perinatal medicine, psychology and social sciences of the St. Elizabeth University.

As a co-founder of Smile as a gift (1991) and since 1992 as a chairman of this professional NGO he is involved in systematical and conceptual changes in the field of child protection system and family policy. As a member of the Committee of Experts on deinstitutionalization calls for positing new pro-family starting points in substitutional

care as a member of the Committee for Children and Youth of the Government Council for Human Rights, national minorities and Gender equality promotes the principles of strengthening the rights of children and their families in our society. Emília Bezáková, PhD and Ján Herák are colleagues cooperating with professor Mikloško on the conceptual and research work.

## Introduction

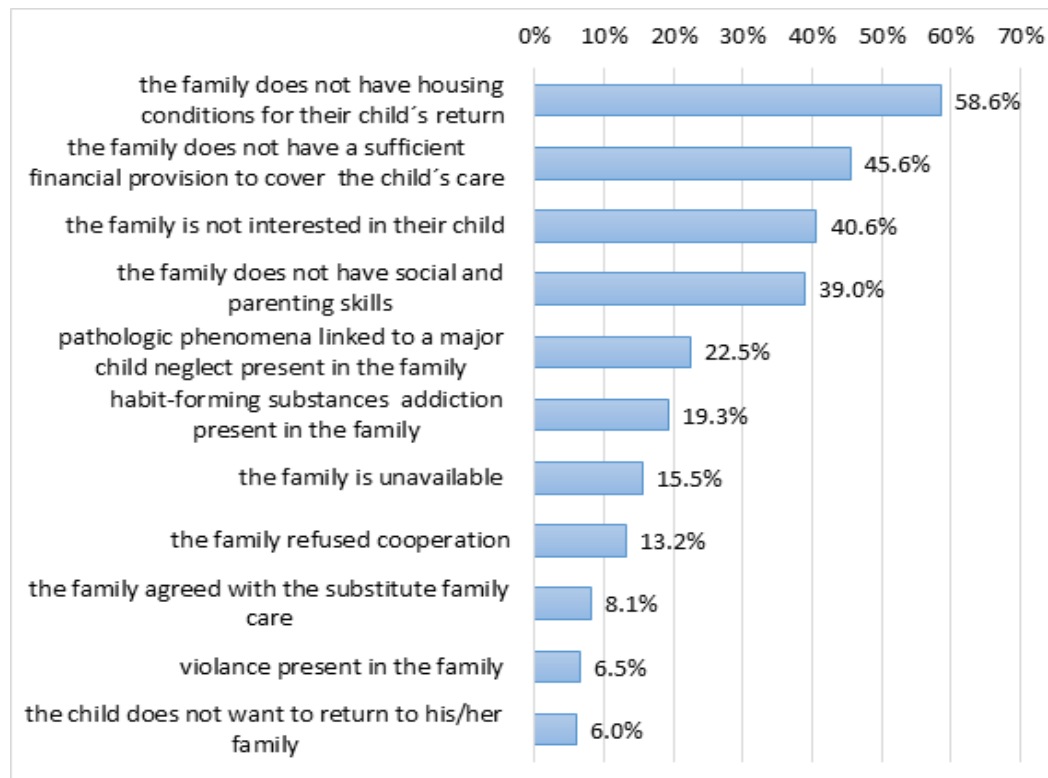
More recently, some local authorities have developed services using the Family Group Conferencing (FGC) model to address the needs of adult service users and their families including elder abuse, children learning disabilities, adults with mental health difficulties, internationally they are also used to plan for release of prisoners

from jail, for discharge of adults from hospital and in addressing homeless and debt.

In Slovakia is nowadays critical situation in the issue of homelessness of the families. Many children cannot live with their parents because of lack of housing possibilities. The reason of the separation the children from their families is not lack of the interest of the parents to take care about their children, but lack of their social skills and lack of the economic and social securities for the families.

An alarming outcomes brought the research of the reasons out of home placement of the children (Mikloško, 2014), interesting comparison of these results is available through the current data of the reasons preventing the child's return from the children's homes to the family which we have been taken by Úsmev ako dar 2014, and presente in the attached Chart No. 1.

**Chart No. 1** What prevents the child from his/her return to the family (multiple response)



**Source** Data collection on children in residential children homes, UaD, 2014

The research outcomes of the out of home placement of the children from the families (Mikloško, 2014) and the research of the factors influencing reunification of the children with families (Miklošková, Fero, Bytčáneková, 2016) confirms that not character of reasons as a single factor determines the chance of the child to return home, but the support provided and the possibility to solve the reasons leading to the exclusion.

The exclusion of children from the families being identified by research results, therefore, despite the complexity and severity, have been proved as not impassable causes of separation of children from their families, yet, they are a significant signal for system changes in the social legal protection system. The prevailing economic character of the reasons that have been repeatedly cited by the competent authorities' social workers in the research Vulnerable families 2006-2013 (Mikloško, 2014) is fundamentally contrary to the Family Act No.36 / 2005 Coll, which excludes economic reasons for taking out a child from his/her family.

A Family Group Conference can modestly contribute to the solution of the actual situation and shake with the stagnation and sense of insulation of the weak family member. FGC opens new doors and initiate new energy of the family system. FGC brings together the family (and extended family members, friends and neighbours) to plan and make decisions to safeguard and promote a child's welfare.

### History of FGC

Family group conferences draw upon Maori culture and their development was a response to the large number of Maori children being removed into state institutions. Family group conferences are now recognised in law (The Children, Young Persons and their Families Act 1989) in New Zealand as being the key process by

which families make informed and responsible decisions, recommendations and plans for their children and young people. In fact it is a requirement that before any child can be taken into state care, a referral for a family group conference must be made. They also form part of decision making in New Zealand's youth justice system.

### What is Family Group Conferencing?

The Family Group Conference is the meeting of the extended family and the social network of the family prepared by an independent coordinator (outsider), who has absolutely no other connection with the family. The family and their group of close people to the child, who are brought together, want to create a plan that includes decisions intended to decrease or eliminate certain problems or risks for a child within the family, or within institutional care.

Together with professionals, the family and members of their social network share their concerns, knowledge and experience. Afterwards, the family meets alone, without other people, to draw up a plan that includes the precisely described agreements. The legally appointed guardian/family supervisor then endorses the plan on the condition that it is safe for the child and meets the child's needs and also legal requirements.

FGCs are generally structured to incorporate four distinct stages:

- **Referral:**  
Family members and agency agree that FGC is required and co-ordinator is appointed.
- **Preparation:**  
Co-ordinator identifies family network, meets with people attending to discuss the reason for the meeting and invite them to participate.
- **Meeting:**  
Agency staff and/or other parties provide information to enable the family

to develop a plan for the child, everyone attending discusses situation, family meets in private to discuss plan, plan is deliberated upon, amended if necessary and agreed by all attendees. In some situations the plan may then need to be agreed by another forum e.g. child protection case conference.

- **Review:**

Operation of plan is reviewed, FGC may be convened to amend/replace plan.

In the Family Group Conference all resources around a family system are brought together by a trained and precisely prepared coordinator. Those present discuss in seclusion, without referrer, social care worker and coordinator, what the issue is and what plan is fitting, using their own resources. The benefit of this is that it does not depend on the capabilities of the system, case manager and social care worker to formulate the care need, but allows the family to retain responsibility for their child and make solutions using their own resources and the resources of their social network. Based on the plan as formulated by the family, the social care worker offers the services required.

### Results of the FGC model

Research of the FGC model reports very interesting results regarding the success of the model. The plans of the families show the potential and possibilities of attending family network members, it can be interpreted that they are interested in contributing to the improvement of the life of the child with whom they have a relationship, mutual history and specific ties.

Along with research of 10.000 FGCs (Pagée, 2016), in around 75% of the referrals an independent coordinator was able to establish the cohesion needed to result in a conference. Half of the families in the remaining

25% of the cases arrived at a solution without the need for an official conference, and the other half was unable to organize a conference due either to the lack of safety this would involve or for other reasons. On average, thirteen people take part in a conference and they arrive at eighteen agreements.

A distinctive feature of these conferences is that they often ignore the tunnel vision approach typical of professional care providers and seek coherence in solutions involving an average of at least four general areas of their lives (such as housing, finances, health and education). Many agreements (around 80%) have the family group itself accept responsibility for what needs to be done. The other 20% involve having the family ask for assistance from subsidised professional services. Within three months, the majority of the agreements have been met by the family members. And satisfaction concerning the conference is great among children, parents, other family members and the professionals. FGC professionals and tradition say that 67% of family plans are better and 33% are as good as their own plans for the family. No plan is less evaluated. Re-abuse after FGC is declared at 6% after a FGC (normally 16 – 25% in traditional social work). With social workers 78% of plans are successful even after 1.5 years. (Pagée, 2016).

### Objective

This review of research and practice in Family Group Conferencing was undertaken during 2015 -2016 in the Smile as a Gift (NGO) –FGC Centre in Slovakia. It comprised two distinct, but complementary parts: FGC agenda reviews and interviews with the family members and professionals who have participated in Family group Conferences. The aims of the research were to review evidence of the impact of FGC for families with socio-economic problems

and homeless problem and to gather views about the influence and experience of FGC on their family life.

## Results

Factors strengthening the family system through implementation Family Group Conferencing model (communicated by professionals)

- a. Positive experiences and concrete outcomes coming out of the FGC of the research are consistently proclaimed by all participants (stakeholders, family members, members of the wide social networks)
- b. Among family members interviewed, FGC was widely valued as a means of healing, empowering, linking and initiating families and translating the rhetoric of best interest of a child into practice. It was recognised that best interest of a child can be difficult issue in the present climate of professionally led, risk averse practice. FGC was also viewed as a way of according children the rights to participate in decisions affecting them and, if possible, to be cared for within their own family.
- c. In terms of its practical benefits, FGC was viewed as an effective means of producing comprehensive and realistic plans for family which were created by the wider family. It was regarded as a task-centred decision-making and widening circle process which, although not designed to achieve this, may strongly contribute to improvement and change of family atmosphere and relationships.

Factors strengthening the family system through implementation Family Group Conferencing model (communicated by family members)

1. A better understanding of the problem and its context within the family *"I did not understand before, what exactly they want from me. Nothing it was not good. Still, I was under a lot of pressure."*
2. Breaking the social isolation of families, supporting the establishment of new relations for the family *"I did not believe it, what's there and promised to comply with that can we really take time for yourself."*
3. Reconnective the previous promotion of relations *"They did not know what to make of us have to think when our children married, dodging us now understand what happened and how it before, I mean, I think even better ..."*
4. Finding and engaging a broader support network of family
5. Improved relations in the family system
6. Increase understanding towards the needs of the child *"I finally understand why we are still arguing, I understand what my team is still sulking about to say"*
7. Increase confidence in the professionals *„Now I believe she really want us to help, not to judge us“.*
8. Confirmation of self-worth family members *"After a long time anyone has actually listened and tried to understand me"*
9. The demonstration of the mutual respect and the respect of involved professionals *"They talked with me, as between themselves, no one did not point the finger at me"*

10. Confirmation of the parental role in their children's lives, acknowledgment of responsibility for child *"They talked to me like I was still mom did not talk about me like some of what failed, they said:" Your children need you."*
11. A sense of acceptance by the wide family and wider social network

The unique aspects of implementing family group conferencing with homeless people.

- the timing of conferences,
- the specific needs of the homeless people,
- the use of modifications/alternatives to casual FGC,
- help with access to informations,
- the clear role of the professionals

Factors on the family side affecting the reunification of a child with the homeless parents are:

- ethnicity of families (less favorable to reunificate are children with perceived Roma ethnicity)
- the nature of community of the child's family
- the region where the family lives,
- cooperating behavior of professionals with parents after the separation,
- the living situation of the parents
- parents' attitude to the solution of problems that were behind the exclusion of the child from the family

## Conclusion

In the most of the interviews FGC was viewed as a practically effective way of working with families whose strengths and resources often remain untapped by mainstream practice. In terms of the research evidence, it is well established that most participants are positive about the FGC process

and that, with appropriate information and support, extended families can develop plans which are acceptable to social work services. The enthusiasm of family members and professionals who have experience of FGC is impressive. They give many examples of professionals who change their minds and families who have been helped to make practical plans and sometimes significant changes through their involvement in this process.

## Families who are homeless or at risk of being homeless

It is perhaps with families who are homeless or at risk of being homeless that the use of FGC is most straightforward. Avoiding a family being homeless is a very clear and pressing reason for involving the wider family and wider social network. FGC was used widely for children away from home or being considered for a care placement because of homelessness of the family. In some instances family members were able to offer children a home. In others, FGC resulted in very close contact arrangements which allowed children to have a continuing sense of belonging to a family, even if out of home placement is necessary. Both outcomes were acknowledged as potentially extremely beneficial for children.

Correspondingly, developing contact plans or support which will enable a child to return home from the crisis centre or children's home brings family responsibilities clearly into focus. A number of respondents gave examples of family or social network members agreeing to care for children until parents find the housing and sustaining the arrangement over several months. FGC enable children stay with close people during the crisis situation in the family, so that the child would have a continuing sense of belonging and people to support family connection during time of separation.

Problematic issue is social worker resistance to refer the need of FGC, so introducing procedural mandate promoted this development. Different views were expressed about the stage at which it was best to involve the extended family, with some respondents favouring early intervention and others suggesting that the wider family was more likely to engage in response to a specific risk e.g. when out of home placement was being considered.

We learned much from our practice about conducting Family Group Conferences. Over time, we started to be able to answer significant questions, most of which came from care professionals who saw an approaching change in their roles.

The aim of the paper was to find out the supportive factors of the family empowerment to solve their socio-economic situation and homelessness by Family Group Conferences.

The research results show the potential and importance of the Family Group Conference model in facing homelessness issue. We believe that our work will contribute to understanding the importance of more intensive support of the natural family relationships and to supporting the process of planned system changes aimed at pro-family wide networking social work.

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## Conflicts of interest

None declared.

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# Spectrum of Communicable Diseases at the Mea Culpa Shelter for the Homeless in Bratislava – 15 year follow up

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**Abstract:**

This study covering 2002 – 2017, presents an overview of communicable and non-communicable diseases in a model of a high threshold shelter for the homeless; providing screening for about 50,000 homeless population. Clients were seeking humanitarian assistance, from 1 to 64 nights, with a Doctor available twice weekly. No infectious disease outbreak of diarrhea, hepatitis, HIV, TB was recorded, except the seasonal flu-like diseases January to March every year.

**Conflict of interest:**

The authors whose names are listed in the title of the article certify that they have NO affiliations with or involvement in any organization or entity with any financial interest (such as honoraria; educational grants; participation in speakers' bureaus; membership, employment, consultancies, or other equity interest), or non-financial interest (such as personal or professional relationships, affiliations, knowledge or beliefs) in the subject matter or materials discussed in this manuscript.

**Introduction**

Healthcare for a marginalized population in the former Post-socialistic CEE (V4) countries is delayed compared to other EU countries. Shelter for the homeless provides healthcare and screening for important communicable diseases common to the homeless such as hepatitis, HIV, TB and ecto-parasites (1-5). Celebrating its 15th Anniversary, the University Mea Culpa Shelter provides basic healthcare and screening for TB and other major respiratory diseases. (6-8) A doctor is present twice weekly to do basic public health surveillance. The aim of this study is to compare the spectrum of ID and inform about potentially possible outbreaks within the 15 years of existence of this second oldest shelter in Bratislava.

**Patients and Methods**

Located about 15 minutes from the city center, the capacity of the Mea Culpa Shelter

is 42 beds. It is the second oldest and currently largest shelter. The oldest shelter, Resoty, has 21 beds since 1991. Within the last 15 years, Mea Culpa has offered 73,630 (4) days of 12 month 24 hour accommodation and food for 6,226 clients. A part of Mea Culpa, is the St. Luise de Marillac Hospital for Homeless. For last 12 years, St. Vincent, a low-level shelter, has been provided by the Lazarist Vincentine Order.

**Results and Discussion**

In 2010-2011 a physician was available on request, but this was insufficient to cover every need for medical attention. Currently, a GP is present twice weekly for clinic and is also available by telephone for acute cases. The spectrum of IP diagnoses shows in about 50% of all consultations within last 15 years included mainly upper respiratory tract infections (upper RTI) 72.5%; lower RTI 12.4%; skin and soft tissues infections (SSTI) 15%.

Similar etiology has been described for shelters in the EU (9-12). No outbreak of any ID within 15 years was noted, neither diarrhea nor ecto-parasites or SSTI. However, periodic outbreaks of upper RTI (influenza-like diseases) are present every year despite pressure to vaccinate clients against the flu.

## Conclusions

Most common communicable and non-communicable diseases are in correlation with most EU countries. The Mea Culpa Shelter model providing medical care is a good option for socially excluded populations, especially the homeless.

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# Reversibility of Antibiotic Resistance in an Orphanage of Children with AIDS in Cambodia

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**Abstract:**

Orphans and street children together with crime and poverty represent significant causes for social pathology in developing countries. The aim of this paper is to compare resistance patterns of ATB resistant bacteraemia on admission, and after a 10-15 years stay in closed social facilities – Houses for Orphans, in Cambodia. Reversibility of ATB resistance has been noted after a 10-15 years stay due to significant improvement of their immune system due to 90 – 100% adherence to antimicrobial therapy (ARV) against their HIV infection.

**Conflict of interest:**

The authors whose names are listed in the title of the article certify that they have NO affiliations with or involvement in any organization or entity with any financial interest (such as honoraria; educational grants; participation in speakers' bureaus; membership, employment, consultancies, or other equity interest), or non-financial interest (such as personal or professional relationships, affiliations, knowledge or beliefs) in the subject matter or materials discussed in this manuscript.

**Introduction**

According to UNICEF statistics, around 100 million children are living on the streets around the world. The majority of them, condemned in extreme poverty, are living in Sub-Saharan Africa and Southeast Asia. Just in Cambodia, there are an estimated 20,000 children living and begging on Phnom Penh's streets. Street children are at significantly higher risk of abuse, neglect, exploitation and criminal activities. Their poor nutritional status and vitamin deficiency are background for many infectious diseases, including RTI, diarrhea and parasites. Poor management of infectious diseases can contribute to antimicrobial resistance, especially in countries where antibiotics are widely accessible without prescription. The highest burden of malnutrition, infectious diseases and mortality is for HIV positive children from socially disadvantaged environments. (1-5)

The aim of this paper is to compare resistance patterns of ATB resistant bacteraemia on admission to the facility and 10 to 15 years after the admission. The study has been conducted at two houses for HIV positive children, one in Phnom Penh and the other in Sihanoukville.

**Patient and Methods**

In total, 149 HIV positive children aged 6 to 18 years living in orphan houses were included in the study. 120 children (80%) are on first line treatment with either Nevirapine or Efavirenz. 29 children were receiving second line treatment of ARV. When there was an occurrence of respiratory tract infection, samples of sputum and oropharynx swabs were analyzed for pathogen identification and resistance to antimicrobials. With occurrence of resistant bacteria, the colonizing of infected respiratory tracts was analyzed and compared with chi-squared test for statistical analysis in univariate model.

## Results and Discussion

Initially, all pathogens found, had very high resistance to antimicrobial agents. On admission 90% of all *S. aureus* were MRSA; 75% pneumococci were penicillin-resistant; 66% of *S. pyogenes* were erythromycin-resistant. After 10-14 years of HAART, resistance decreased to about 25-33% in previously mentioned pathogens. The change of

## Conclusion

Antibiotic resistance in street children with HIV in Cambodia is high and decrease with proper ARV administration; improved nutrition; safe environments. Therefore environment, nutrition and compliance to ARV remain the biggest challenges for reaching sustainable development targets.

**Table 1** Comparison of ATB resistance to respiratory tract isolates in orphans with AIDS before and after ART treatment.

	On admission	2016
<i>S. aureus</i> / MRSA	90%	25%
<i>S. pneumoniae</i> ./ PRP	75%	25%
<i>S. pyogenes</i> ./ERY-SP	66%	33%
Enterobacteriaceae/ ESBC	70%	55%
<i>Candida</i> Spp	70%	45%
<i>PS.aeruginosa</i> spp/CTAZ-R	90%	55%
<i>Acinetobacter</i> spp / CTA-R	90%	45%

resistance was most significant in *S. aureus* and *S. pyogenes*, where resistance to the majority of antimicrobials decreased by 50 - 70%. The rate of resistance with gram-negative bacteria was similar: for example, 70-90% of all enterobacteria were producing betalactamase with extended spectrum (ESBL) and were resistant to third generations of cephalosporines; 75% of all candida species were initially resistant to fluconazole (Table 1.) The decrease in resistance was 20-40%. The reversibility of ATB resistance has been noted 10-14 years after admission, probably due to significant improvement of their immune systems and to 90-100% adherence to antimicrobial therapy. Conditions of environment and nutrition are probably also significant factors (3-5); these hypotheses, however, need more research.

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## St. Louise Hospital for Marginalized Homeless Population: TB and Other Infectious Diseases are Rare

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**Abstract:**

The aim of this retrospective study was to provide an overview of reasons for hospitalization in a homeless devoted hospital of St. Louise de Marillac with 25 beds serving an urban homeless population. The majority of 25 beds are filled by patients with civilization and psychosocial diseases related to permanent stress and marginalization such as hypertension, diabetes, motion pathology after trauma and chronic alcohol intoxication. Communicable diseases such as severe RTI, scabies, skin/soft tissue infections and leg ulcers were the only ID observed. However, no case of Hepatitis A, HBV, HIV, TB or infections diarrhea have been observed within the last year.

**Conflict of interest:**

The authors whose names are listed in the title of the article certify that they have NO affiliations with or involvement in any organization or entity with any financial interest (such as honoraria; educational grants; participation in speakers' bureaus; membership, employment, consultancies, or other equity interest), or non-financial interest (such as personal or professional relationships, affiliations, knowledge or beliefs) in the subject matter or materials discussed in this manuscript.

**Introduction**

Homelessness in Central Europe V4 countries with former socialist social security system is a common phenomenon. Also the homeless population in the whole EU is increasing.(1-2) The homeless population is in substantial risk of medical, psychiatric, and social problems such as tuberculosis, HIV infection, hepatitis, alcoholism and substance abuse, skin and foot disease, schizophrenia and related psychoses, malnutrition, and trauma. About 5-10,000 homeless are registered within 10 major Slovak urban cities with population of about 1.2 mil citizens. (3-5) The aim of this short communication is to describe the spectrum

of diagnoses for hospitalization within a 25 bed hospital for the homeless in St. Louise de Marillac in 2016.

**Patients and Methods**

St. Louise de Marillac Hospital was funded solely for homeless people to cover their health care needs due to the experience of systematical exclusion of the homeless population from chronic health care. The majority of these patients are therefore forced to misuse emergency departments for their problems which causes delay of care for urgent patients and significant costs. Some charities, such as St. Elizabeth University and St. Vincent de Paul Order (Lazarists)

of the Slovak Province are providing shelters and social care for patients. Hospital for homeless had about 256 patients hospitalized for 1-182 days in 2016. One nurse is present during the day and a doctor plus pharmacist is visiting twice weekly.

## Results and Discussion

The commonest diagnoses for in-patients in the St. Louise de Marillac Hospital were infectious, but were related to homelessness in correlation with our expectations (skin and soft tissue diseases, parasites, leg ulcers, freezing - less necrosis related in winter, RTI, etc.). Other major groups of diseases were psychosocial disorders and stress-related diseases such as depression, hypertension, diabetes, asthma which were present in 80-85% of all admissions apart of February (influenza month), where upper respiratory system infections (RTI) were prevalent as similarly described from shelters worldwide (6-8) or from refugee camps (4).

## Conclusions

The majority of beds in hospitals for homeless patients are covered by patients with civilization and psychosocial diseases related to the permanent stress and marginalization such as hypertension, diabetes, motion pathology after trauma and chronic alcohol intoxication. Infectious diseases such as severe RTI or scabies or skin/soft tissue infected ulcers were the only IDs which were observed. No case of Hepatitis A, HBV, HIV, TB or infectious diarrhea have been observed within the last year.

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## Contributor's guidelines

Allow me to introduce a new expert journal – Clinical Social Work and Health Care. We would like to offer you an opportunity to contribute to its content as we would like to aspire to create a collection of real experiences of social workers, doctors, missionaries, teachers, etc. CWS Journal is published by the International Scientific Group of Applied Preventive Medicine I-GAP in Vienna, Austria.

The journal is to be published semi-annually and only in English language as it will be distributed in various foreign countries.

We prefer to use the term 'clinical social work' rather than social work even though it is less common. In the profession of clinical social work, there clearly is some tension coming from unclear definitions of competence of social workers and their role in the lives of the clients; the position of social work in the structures of scientific disciplines especially in cases where people declare themselves to be professionals even though they have no professional educational background. These are only few of the topics we would like to discuss in the CWS Journal.

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All articles must be in accordance with the current language standards in English, current ISO and the law on copyrights and rights related to copyrights.

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