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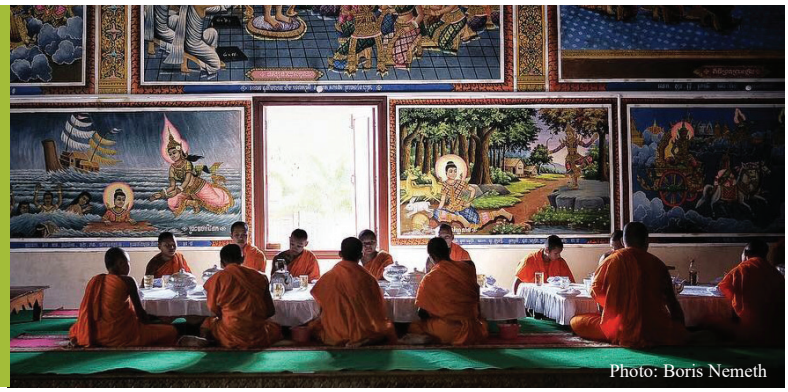
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Issue: Social Pathology as a Consequence of Psycho-social Disorders

Original Articles

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Issue 1/2019: Social Pathology as a Consequence of Psycho-social Disorders
Issue 2/2019: Health Intervetions for the Health for all initiative from SPA to Slums Issue
Issue 3/2019: Perception of Health Sciences by Consumers Issue
Issue 4/2019: Social and Health Palliative Care

Contact
International Gesellschaft für angewandte Präventionsmedizin i-gap e.V. (International Society of Applied Preventive Midicine i-gap)
Währinger Str. 63
A-1090 Vienna, Austria
Tel. : +49 - 176 - 24215020
Fax : +43 / 1 4083 13 129
Mail : office@i-gap.org
Web : www.i-gap.org

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Daniel J. West, Jr.

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Affiliated Institutions:
Panuska College of Professional Studies, Scranton, USA
St. Elizabeth University of Health and Social Work, SVK
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Editorial

There are no great things, only small things with great love. Happy are those –
Commonly attributed to Mother Teresa

The world is healthier. Global efforts of collaboration are having an impact, and enormous progress has been made in improving health status. These changes in population health can be attributed to new health technologies (vaccines, new antibiotics, Social media, etc.), improved nutrition, increased education and economic growth. There have been significant reductions in death from tuberculosis, AIDS, malaria and meningitis. Additionally, child mortality has been reduced. Improvements have been noted with maternal health. However, this is only part of the story on global health. Today we stand at an important crossroad in confronting global forces that truly impact health. We need multidisciplinary endeavors with well-trained global health leaders, partnerships, policy makers and researchers. Public-private partnerships are needed to support multicultural collaboration and cooperation in designing better health systems. Addressing social determinants of health will have a pronounced impact on non-communicable diseases and the reduction of poverty. As a global society, we recognize the relationship between health and human development. Health is an entitlement due every person because of being human. Human rights are considered universal and something that cannot be taken away. The preamble to the Constitution of the World Health Organization (WHO) claims under health principles that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being." Health is linked with education, employment, infectious diseases, governments, community health, basic health care, health policy, vulnerable populations, poverty and peace. The global challenge is quite clear – global security and freedom requires leadership in working with the poor, sick and marginalized persons. Complex emergencies and natural disaster have a significant impact on global health, as well as wars, civil conflict and health disparities. Every country in the world is confronted with cost, quality and access issues that can only be addressed if leaders are properly trained and willing to commit the necessary resources to improve health. This special issue examines mental health, obesity, smoking, homelessness and the HIV epidemic. In the CEE region, there is a need to understand health issues related to IDPs, refugees, immigration and marginalized persons. These more complex global health issues require new knowledge, increased financing, use of interdisciplinary teams, and global partnerships. The World Health Organization (WHO) defined health as "a state of complete physical, mental and social well being and not merely the absence of disease or infirmity." Future developments in population health necessitate that healthcare leaders recognize and address the social determinants of health, non-communicable diseases, and the social-behavior risk factors associated with health. Environmental health, nutrition and the importance of culture to health requires working together to improve global health through sustainable strategies and innovation.

Daniel J. West, Jr., Ph.D., FACHE
Professor and Chairman
Department of Health Administration & Human Resources
The University of Scranton

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

The Smoking Problem in Slovakia: Cessation Strategies & Recommendations

A. Adamo (Amanda Adamo), S. Szydlowski (Steven Szydlowski)

Original Article

University of Scranton, PA, U.S., Master of Health Administration Graduate Program, USA

E-mail address:

amanda.adamo@scranton.edu

Reprint address:

Amanda Adamo
University of Scranton, PA
Scranton Hall
Scranton, PA 18510
USA

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Reviewers:

Gabriela Lezcano
University of California, San Francisco, USA
Gunther Dorfmeister
Vienna General Hospital, Vienna, Austria

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Abstract:

Objective: The aim of this research is to analyze the smoking problem in Slovakia and offer strategies and recommendations for cessation.
Methods: This paper is a secondary source research study augmented by person to person conversation.

Results: Efforts are being made to control the smoking problem in Slovakia; however, opportunities exist to increase public knowledge and awareness of the negative effects of smoking.
Conclusion: The study indicated that the Slovak Republic is experiencing a smoking problem. Steps are being taken in the right direction to increase public awareness of this issue and reduce smoking. Increasing public knowledge and public health legislations are needed to control this problem. There is opportunity to conduct future research on smoking trends.

Introduction

Smoking is bad for health. Smoking harms nearly every organ in the body and is directly responsible for a significant number of diseases and deaths. Alcohol use, firearm-related incidents, HIV/AIDS, illegal drug use, and motor vehicle incidents combined would still not compare to the number of deaths caused by smoking. This public health issue is responsible for more than 7 million deaths annually (CDC, 2018). Although the rate of smoking is declining people are still smoking. Efforts are needed to further impact the percentage of people using tobacco.

Risk Factors

Deaths caused by this problem are not just a result from direct smokers. Secondhand smoke can be just as detrimental to people. Non-smokers who breathe in secondhand smoke take in nicotine and other toxic chemicals just like smokers do. The more second- hand smoke you breathe, the higher the levels of these chemicals in your body (American Cancer Society, 2018). Smokers are more likely to develop a number of diseases that affect the heart and blood vessels. For instance, smoking causes stroke and coronary heart disease as well as a leading risk factor for chronic diseases such as cancer, lung diseases and cardiovascular diseases (CDC Europe, 2018).

Prevalence

Tobacco use is the single most preventable cause of disease and death. Europe has the highest prevalence of daily tobacco smoking among adults (country range 10-38%) and some of the highest prevalence rates of tobacco use by adolescents (CDC Europe, 2018). Smoking causes a number of diseases as previously mentioned. Adding to this fact, oral diseases are most frequently found in Europe and share risk factors that are associated with other non-communi-cable diseases. Studies document a synergistic effect of tobacco and excessive alcohol use on the manifestation of oral cancer (CDC Europe, 2018). Oral cancer is a significant component of the burden of non-communicable diseases in Europe. Tobacco use is a major cause of perio-dontal diseases and premature tooth loss; children born to women who use tobacco during pregnancy may have congenital defects such as cleft lip and palate. Efforts are needed to prevent such cancers and diseases and obtain better health outcomes.

Demographics

In Slovakia, smoking is very widespread. Over a third of the population smoke. However, stricter anti-smoking legislation efforts have been made in order to control this issue and protect the health of its citizens. The air has been cleared in most restaurants, cafes, bars and pubs and a few places offer separate

rooms to reduce the effects of secondhand smoke. To avoid complications and reconstruction, many restaurants or pub owners have opted to go entirely smoke free. Other non-smoking areas include health care facilities, universities, and indoor offices. The stricter the anti-smoking legislation for Slovakia the stronger the impact will be on reducing smoking habits of the population at large and lessen the outcomes of, diseases, disability and death.

Adolescent Smoking

Although efforts have been made, reducing the numbers of smokers has been difficult. Smoking among young girls is on the rise and since smoking is popular among younger women, it has been increasing with potentially negative consequences for their future health. Smoking in adolescence increases the risk of developing cardiovascular diseases, respiratory illnesses, and cancers. The trend of younger girls smoking can be a result of peer pressure and shying away from the "good girl" image proving to others that they are grown up. Media influences and advertising cater to younger women and inadvertently show that smoking makes them thin by curbing their appetite. Interventions are needed to prevent younger people from starting to smoke in the first place and reduce their chances for premature diseases and death.

Current Policy

Slovakia's efforts to control smoking have made improvements to the number of individuals who smoke. Smoke-free policies have been shown to reduce tobacco consumption and encourage individuals to quite. Slovakia signed the WHO Framework Convention on Tobacco Control (FCTC) Treaty in 2004 to help fight the tobacco epidemic. This treaty made great improvements for countries controlling the tobacco issue. However, more efforts can be made to strengthen the controls. The WHO FCTC and its guidelines are still not being used to their fullest potential and more work is needed to control the tobacco epidemic. Improvements are in demand to reduce the number of smokers and increase the overall health of Slovakia.

Strategies & Recommendations

There are a few strategies and recommendations that can be made in order to help control this public health issue and have shown to be effective in doing so. Health promotion is pivotal in the drive to reduce smoking and the growing number of diseases worldwide. Public education is an integral part of the efforts to both prevent the initiation of smoking as well as encourage cessation (Larzelere, Williams 2012). By increasing the public's knowledge about smoking cessation methods, health professionals can support and encourage a larger number of smokers to quit. This can be done by encouraging health professionals to use cessation interventions in their practice and educate patients as to the harmful effects of smoking. Health practitioners can inform patients about the benefits of tobacco cessation; and distribute nicotine replacement pharmacologies to patients that may have trouble quitting on their own. Another smoking cessation strategy that can be used is encouraging public role models like educators, nurses, medical students, community members, and doctors to spread the awareness of the negative effects smoking has and motivate cessation.

As previously mentioned, more youth are beginning to smoke. This can be due to peer pressure from their friends or the media. More often than not, younger people are unaware of the effects smoking truly has on their lives. In order to control this, school-based prevention programs are beneficial

to prevent adolescent smoking and increase their knowledge at a young age. The goal of such initiatives is to keep young people tobacco free.

Smoking in the workplace can result in the loss of productivity and increase absenteeism. By offering smoking cessation programs in the workplace, organizations can improve employee health, and over the long term, can bolster the bottom line by reducing health costs and improving productivity. Some organizations will not hire smokers due to the effects smoking has on other employees and the organization. Organizations can implement a policy restricting smoking in the workplace and offer cessation programs among employed smokers. This strategy can be effective in making for happier and healthier employees.

Public health actions must be taken to control this issue to make for a healthier population. Slovakia must strengthen national monitoring and surveillance in order to create evidence-based legislative measures and programs for tobacco control. This can be done with the help of the WHO Framework Convention on Tobacco Control (FCTC). Such measures of this treaty include: monitoring tobacco use and prevention policies; protecting people from second-hand tobacco smoke; offering help to quit; warning about the dangers of tobacco; raising taxes; enforcing bans; etc. (WHO Europe, 2018).

Conclusion

Slovakia has made great strides to control smoking by enforcing bans on tobacco use, raising taxes, health warnings, etc.; however, there are still opportunities for increased reduction in smoking. Smoking is the most preventable cause for disease and death. Control efforts are needed to reduce this problem. With the help of legislative measures and public health education this problem can be controlled and positive results achieved. More public knowledge and education is needed to spread the awareness of the detrimental effects this risk factor. Tighter surveillance and monitoring is called for in order to create evidence based legislation and cessation interventions to get this problem under control.

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School Curriculum and HIV/AIDS: A Study of District Swat

I. Ullah (Ihsan-U-Ullah)[1], A. Naz (Arab Naz)[2], T. Khan (Tariq Khan)[3], S. Khan (Sarfraz Khan)[4], A. Gul (Ayesha Gul)[5], W. Khan (Wassem Khan)[6], N. Khan (Nasar Khan)[7]

Original Article

[1] PHD Scholar, Department of Sociology University of Malakand, Khyber Pakhtunkhwa, Pakistan
[2] Professor Department of Sociology, University of Malakand, Khyber Pakhtunkhwa Pakistan
[3] Assistant Professor Department of English University of Malakand Khyber Pakhtunkhwa, Pakistan
[4] Assistant Professor Sociology, QAU Islamabad, Pakistan
[5] Department of Social Work, SBKWU University Baluchistan, Pakistan
[6] Lecturer Sociology University of Malakand, Khyber Pakhtunkhwa Pakistan
[7] Lecturer Sociology University of Chitral Pakistan

E-mail address:

arab_naz@yahoo.com

Reprint address:

Ihsan-U-Ullah
Department of Sociology
University of Malakand
Khyber Pakhtunkhwa
Pakistan

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Reviewers:

Steve Szydlowski
University of Scranton School of Education, USA
Victor Namulanda Wanjala
Catholic university of Eastern Africa, Nairobi, Kenya

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Abstract:

This study was performed in District Swat Khyber Pakhtunkhwa Pakistan. It aimed to underline the problem of school level health education and specifically the insufficiency of contents related to HIV (Human Immune Virus)/AIDS (Acquired Immune Deficiency Syndrome) in the curriculum taught at school resulting in unawareness of students concerning basic information on HIV/AIDS. This study is both qualitative and quantitative in nature whereas simple random sampling (SRS) and proportional allocation method were used for selection of samples. Textual analysis of school books was carried out to note down the relevant general information (sufficiency and deficiency) with reference to HIV/AIDS. A textual analysis of selected 8 books of grades 9 and 10 was conducted to interpret the presence of textbook matter discussing HIV/AIDS in current school books. Results of the data analysis proved that school syllabus and books are incomplete in respect to the contents for awareness on HIV/AIDS. In addition, a total of 150 respondents were selected from grades 9 and 10, students of male government schools of the area and data regarding HIV awareness was collected through questionnaire. Most of the respondents were found to be unfamiliar with prevention and mode of transmission of HIV/ AID.

Introduction

All over the world, young people are at the center of the HIV epidemic; almost half of all HIV-infected public are aged 15-24 years (Monasch & Mahy, 2006). In 2007, Southeast Asia and the Pacific region have the succeeding highest prevalence of HIV with an estimated 1.27 million young people living with HIV (United Nations Population Fund, HIV/AIDS Branch, 2008.). Many reasons increase the vulnerability of young people to HIV but lack of awareness has been identified as one of the leading factors (Anderson, Kann, Holtzman, Arday, Truman & Kolbe, 1990). Whereas many channels are present through which information can be offered to young people (Kirby, Laris, & Rolleri, 2005), interventions through the education sector have been implemented throughout the world to contact a large number of young people easily (Thomson, Currie, Todd & Elton, 1990).

HIV/AIDS, reproductive health and sexuality are multifaceted and controversial subjects that teachers and schools may be reluctant to tackle (Oshi, Nakalema, and Oshi, 2005). Curriculum designers need to prepare adequate syllabuses and distribute those to schools so as to guide teachers on what to teach and how. The syllabuses need to be graded according to grades (Paul, 2012). Over the last decade, there has been increased support for the teaching of life skills to young people, partly due to the perceived limitations of information-based HIV/AIDS education (Boler & Aggleton, 2004).

Dealing with young people is a long-term investment. Young people are a force for change, and it is vital to implement protected behavior patterns before they become sexually active. The school system is the single social structure with the potential to

reach all of these young people (UNESCO, 2002). Young people are at the center of the HIV/AIDS epidemic. Their behavior; the degree to which their rights are protected; the services and information they receive can help to determine the quality of life of millions of people. Young people are particularly vulnerable to HIV infection and they may also carry the burden of caring for family members living with HIV/AIDS. Around the world, AIDS is shattering young people's opportunities for healthy adult lives. Nevertheless, it is young people who offer the greatest hope for changing the course of the epidemic (UNAIDS, 2001).

Schools are key locations for health promotion and shaping children's minds from an early age. The input of health promotion to the health and well-being of students has been increasingly and widely acknowledged. On the other hand, the progress of suitable approaches for evaluating health promotion in schools is still a major topic of conversation (Pommier, Guevel & Jourdan, 2010). Children spend most of their day in school and it is one of the most noteworthy communities they belong to apart from their family. It is now acknowledged that school plays an important role by providing protection and support for children affected by HIV and AIDS (Ishikawaa, Pridmoreb, Carr- Hillb & Chaimuangdee, 2011).

Curriculum-based education can add to providing what young people need in a structured format, with flexible approaches that can be executed in a variety of situations. With these features, curriculum-based approaches comprise an important strategy in addressing HIV/AIDS and unintended pregnancy. Program evaluations and overview studies have found that curriculum-based HIV education can be effective in widely differing geographic areas; various cultural settings; among youth of different income levels; and both sexes (Kirby, Laris & Rolleri, 2005).

Considering Pakistani society, it is researcher's observation that a matriculate school boy/girl is not capable even to define HIV/AIDS. After school life this deficiency leads the individual to carry out various preventable mistakes. Comparing this scenario of our country with the external world it is evident that every person in the community must know some of the very vital health related concepts theoretically as well as practically concerning this disease. Some of the key areas are preventive health measures like safe use of needles; careful blood receiving and donating; protective sexual behavior; etc.

Although literacy rate of District Swat is higher as compared to other districts, the school syllabus is limited concerning health contents leading to deficient health education and hence health problems in the area. The major increase in the communicable and non-communicable diseases in this area witnesses the low level of health awareness among the literate as well as illiterate populations. This study helps to analyze the fundamental gaps in school syllabus and the degree of importance given to the issue of infectious diseases like HIV/AIDS. This study highlights the deficiency in school curriculum regarding contents on HIV/AIDS as well as the unawareness of students about this disease.

Objective of the Study

This study has been designed to analyze the contents in school syllabi regarding the information and text for HIV/AIDS and other related diseases. The intention is to also analyze the efficacy of the syllabi in promoting awareness among students regarding such diseases or their causes.

Hypothesis

Insufficient HIV/AIDS related contents in school curriculum leads to unawareness in students.

Materials and Methods

Content Analysis of School Textbooks

During the process of inquiry four of the vital subjects of grades 9 and 10 i.e. Biology, General Science, Health and Physical Education and Islamic Education were selected purposively for content analysis regarding HIV/AIDS. The contents of these books have thoroughly analyzed and the list of the contents has been given at the end of the paper.

(table-1). The female primary, middle, high and higher secondary schools are 429, 48, 20 and 04 respectively (Elementary & Secondary Education Department, Govt. of NWFP, 2008). As the researcher could not cover the whole area therefore it was limited to the government high and secondary schools situated inside Mingora city. Due to the problem of accessibility the study was further limited to boy's schools only and the girls' schools were excluded.

Table 1: Number of Functional Govt. Schools, Enrollment and Working Teachers in Swat 2007-08

There are 8 High Schools (male) in Mingora city, 50 % (04 Schools) were selected through Simple Random Sampling (SRS). These schools were G.H.S.S. Amankot, G.H.S No. 3 Shah Dara, G.H.S No. 4 Mulla Baba and G.H.S Nawaykaly represented by S1, S2, S3 and S4 respectively.

Gender	Primary			Middle			High			Higher/Secondary		
	School	Enrol.	Working Teacher	School	Enrol.	Working Teacher	Schools	Enrol.	Working Teacher	Schools	Enrol.	Working Teacher
BOYS	841	133598	3033	84	8325	618	67	21242	1080	13	8704	397
GIRLS	429	67606	1580	48	3675	273	20	9288	255	4	3679	74
TOTAL	**1270**	**201204**	**4613**	**132**	**12000**	**891**	**87**	**30530**	**1335**	**17**	**12383**	**471**

Source: **Annual Statistical Report 2007-08, District Swat: EMIS Elementary & Secondary Education Department, Govt. of NWFP**

Total number of students in grades 9 and 10 in the selected 4 schools gave the target population of 547. As each school has different numbers of students, samples were selected through William Lawrence Neuman Formula of Proportional Allocation Method (Neuman, 2000) which is given as

$$\text{Stratum Sample Size} = n = \frac{\text{Population of the Stratum}}{\text{Total Population of the Strata}} \times \text{Sample Size}$$

Sampling Technique

In district Swat the number of male primary, middle, high and higher secondary schools are 841, 84, 67 and 13 respectively

Sample Frame

Now representing target population i.e. 547 by "N", the selected sample size i.e. 150 by "n" and the selected schools with S1, S2, S3 and S4 and their population is 169, 239, 73, and 66 respectively then using Proportional Allocation Method the sample size of stratum n1 will be calculated as under:

$$\text{G.H.S.S. Amankot} = n_1 = \frac{S_1}{S} \times 150, \text{ by putting values } 169/547 \times 150 = 46$$

Similarly by calculating all the strata the following sample frame is obtained.

School Name	Denoted by	Strata	Population	Sample Size
G.H.S.S Amankot	S1	n1	169	46
G.H.S No. 3 Shah Dara	S2	n2	239	66
G.H.S No. 4 Mulla Baba	S3	n3	73	20
G.H.S Nawaykaly	S4	n4	66	18
TOTAL	S	N	547	150

Tool of Data Collection

In this study a structured questionnaire was used for data collection.

Data Analysis

The collected data is analyzed through SPSS (Statistical Package for Social Science) software (16th version).

Results & Discussion

Part-I: Content Analysis of School Text Books with respect to HIV/AIDS Contents

Keeping in view the main theme of HIV/AIDS, the researchers of the current study selected school level textbooks for analysis. As the field data is collected from the students of grades 9 and 10 therefore the selection of books for analysis was also delimited to a total of 4 books from both these classes. The books included Biology, General Science, Islamic Study (compulsory) and Health & Physical Education (grades 9 and 10).

Biology for Grades 9 & 10:

It is the main subject taught to the students of science in grades 9 and 10 containing some information regarding human anatomy and physiology. This book has a total of 18 chapters in which nine chapters are taught in grade 9 while the other half are taught in grade 10. The contents included in this course are majorly concerned with basic biological terms, solving a biological problem, composition of cells and tissues and various sections like circulation, enzymes and biodiversity. The study of various systems like gaseous exchange, homeostasis, coordination, support and movement and reproduction is also part of the course. The only chapter which can be considered as interrelated with health education is Chapter 8 entitled "Nutrition". This chapter contains basic composition of nutrients; balanced diet and various important aspects of human physical needs (see annex I). It is concluded that out of 18 chapters no information regarding HIV/AIDS is included.

General Science for Grades 9 & 10:

General Science is the core subject taught to the students of Arts and Humanities in grades 9 and 10. A single book is used for both the classes half of the chapters are covered in grade 9 while the remaining half is taught in grade 10. Among the total 11

chapters, two of the chapters are concerned with human health and diseases. Chapter 4 is titled "Human Health" while chapter 5 is named "Diseases: Causes and Prevention" (see annex II). Both of these chapters can be considered as supportive material regarding improving students' health although specific knowledge regarding HIV/AIDS is missing in these sections as well. The rest of the 9 chapters contain technical matter regarding science and technology.

Health & Physical Education (HPE) for Grades 9 & 10:

There are 19 chapters in this subject, 9 for grade 9 and 19 for grade 10. A close analysis of the contents proves that there are 6 chapters (1, 10, 12, 13, 16 & 17) related to health education (Annex III). The rest of the contents are mainly concerned with technical points regarding athletics and sports. Although 30-40% of the contents of this subject are closely related to health education, no specific titles are included regarding HIV/AIDS.

Islamic Education (Compulsory) for Grades 9 & 10:

This subject is divided into three parts, a total of 17 lessons. Part-I has 7 lessons and all of the chapters contain *Quranic Verses* and their Urdu translation. Part-II contains a single chapter having *Ahadith* and its Urdu translation and explanation. In Part-III various religious concepts has been described and interpreted. This part has 9 chapters among which only chapter 5 "Ablution & Physical Cleanliness" can be considered connected to health education but not to HIV/AIDS (Annex IV). Textual analysis of textbooks shows that the contents are insufficient regarding information on HIV/AIDS and contains much specified knowledge according to the subject under study.

Part-II

To review the impact of insufficient contents regarding HIV/AIDS in school curriculum, the general concept of school students about HIV/AIDS, its mode of transmission and preventive measures was assessed. The data collected in this aspect is analyzed in tables and charts and explained respectively.

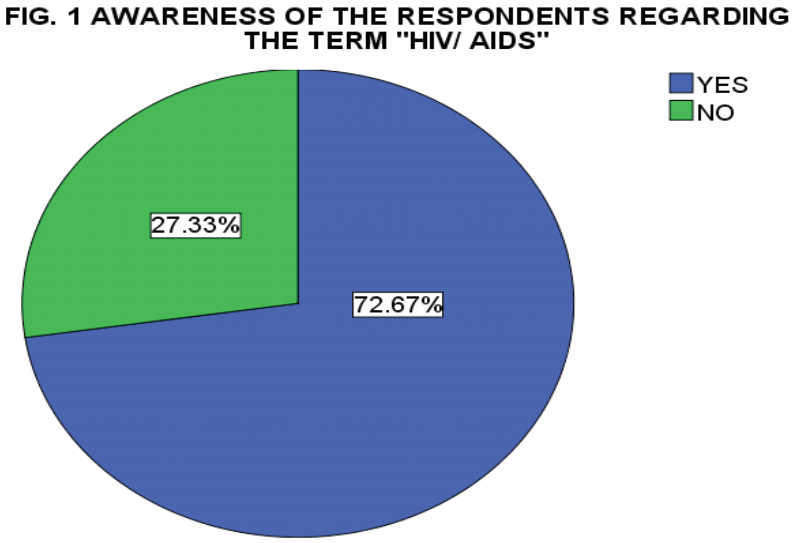
The most basic inquiry made in this study was about the students' awareness concerning the term "HIV/ AIDS". The data is summarized in Table 2 below.

Table 2: AWARENESS OF RESPONDENTS REGARDING THE TERM "HIV/ AIDS"

Have you ever heard the term HIV/AIDS in your school life?	Freq.	Percent	Cumul. Percent
YES	109	72.7	72.7
NO	41	27.3	100.0
Total	150	100.0	

Source: Field Data

Explanation: The analyzed data shows that majority of the respondents i.e. 109 out of 150 (72.7%) were of the opinion that this term is known to them. The data is presented below as pie chart (fig.1).



The next inquiry made in this research study was to assess the knowledge of respondents about the mode of transmission of HIV/ AIDS (Table- 03).

Explanation: The collected data reveals that majority of the school students i.e. 87.3% (131 out of 150) are unaware about the rout of transmission of HIV/ AIDS (Fig. 02).

Table 3: AWARENESS OF STUDENTS REGARDING MODE OF TRANSMISSION OF HIV/AIDS

What is the mode of transmission of HIV/ AIDS?	Freq.	Percent	Cumul. Percent
Through infected blood, sharps	4	2.7	2.7
Through food and water	10	6.7	9.3
Unprotected sex	5	3.3	12.7
Don' t Know	131	87.3	100.0
Total	150	100.0	

Source: Field Data

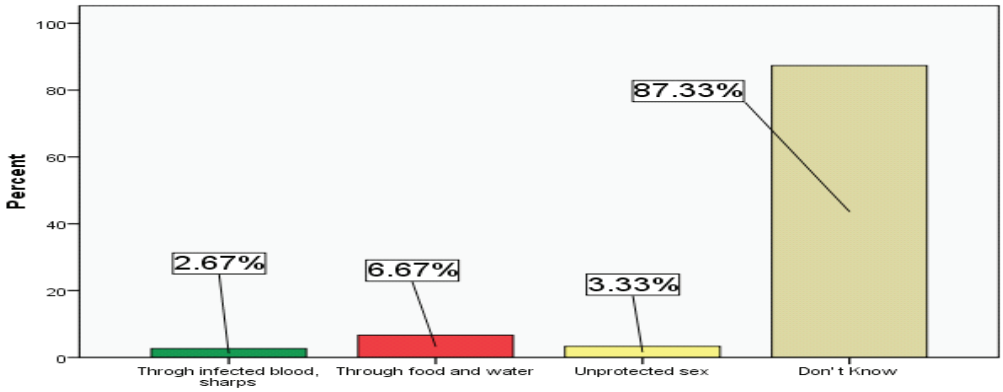


FIG. 2 AWARENESS OF STUDENTS REGARDING MODE OF TRANSMISSION OF HIV/ AIDS

During the course of research all the respondents were asked about the preventive measures against HIV/AIDS (Table 4).

All the respondents were asked that whether contents on HIV be included in school syllabus (Table 5).

Table 4: AWARENESS OF RESPONDENTS ABOUT PREVENTION OF HIV/ AIDS

How HIV/AIDS can be prevented from transmission?	Freq.	Percent	Cumul. Percent
Protected Sexual Behavior	3	2.0	2.0
Avoiding infected blood, sharps	6	4.0	6.0
Avoiding food used by HIV Patient	5	3.3	9.3
Don' t Know	136	90.7	100.0
Total	150	100.0	

Source: Field Data

Explanation: The collected data is analyzed and tabulated which proves that majority of the respondents i.e.136 out of 150 (90.7%) are unable to recognize the basic prevention against HIV/ AIDS (Fig. 3).

Explanation: Majority of the respondents agreed that contents on HIV should be introduced in the school curriculum (129 out of 150 i.e. 86 %). Fig. 4 illustrates the data.

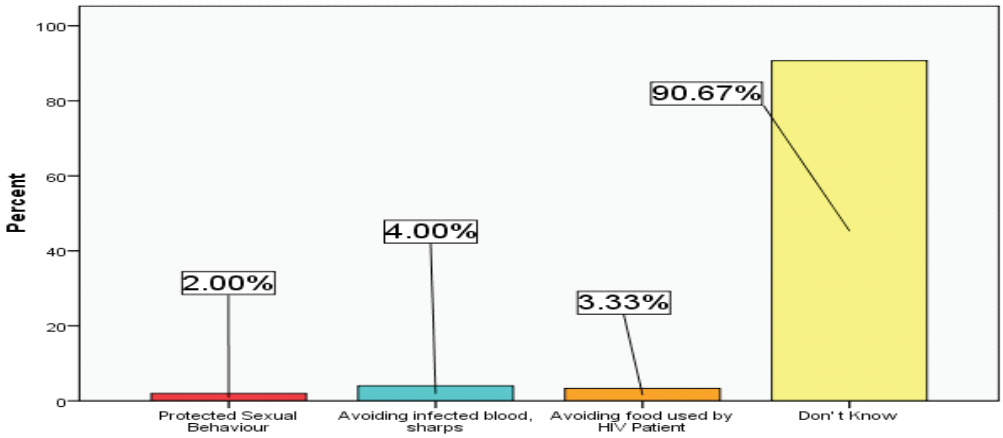
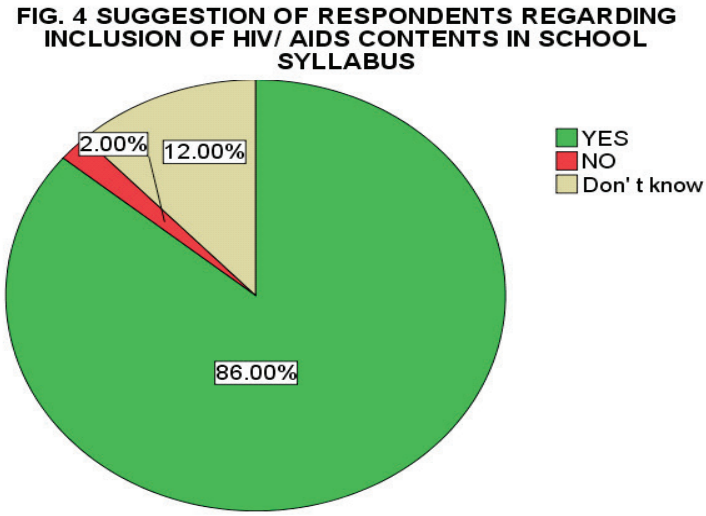


FIG. 3 AWARENESS OF RESPONDENTS ABOUT PREVENTION OF HIV/ AIDS

Table 5: SUGGESTION OF RESPONDENTS REGARDING INCLUSION OF HIV/AIDS CONTENTS IN SCHOOL SYLLABUS

Should contents on HIV/AIDS be included in school syllabus?	Freq.	Percent	Cumul. Percent
YES	129	86.0	86.0
NO	3	2.0	88.0
Don' t know	18	12.0	100.0
Total	150	100.0	

Source: Field Data



Beside the inquiry on inclusion of HIV contents, the students were also asked about the addition of contents regarding other infectious diseases in the curriculum. The collected facts are analyzed in Table 6 below.

Explanation: The data shows that majority of the respondents i.e. 124 out of 150 (82.7%) wishes to include contents regarding infectious diseases in school syllabus (Fig. 5).

Table 6: SUGGESTION OF STUDENTS ABOUT INCLUSION OF CONTENTS ON INFECTIOUS DISEASES IN CURRICULUM

Should the contents on other infectious diseases be included in the current school curriculum?	Frequency	Percent	Cumul.Percent
YES	124	82.7	82.7
NO	13	8.7	91.3
DON'T KNOW	13	8.7	100.0
Total	150	100.0	

Source: Field Data

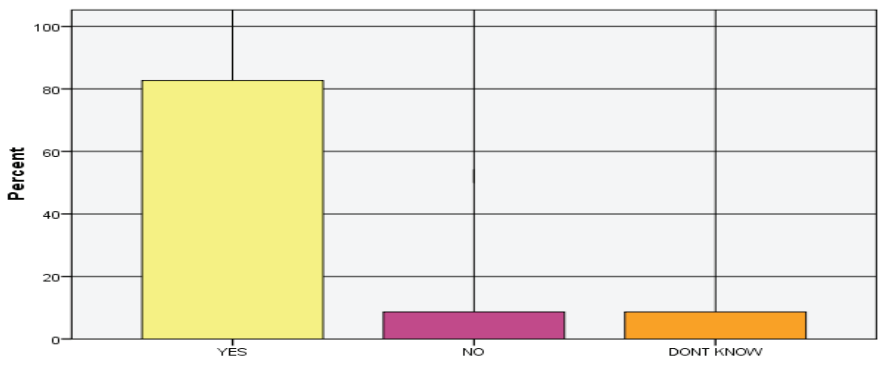


FIG. 5 SUGGESTION OF STUDENTS ABOUT INCLUSION OF CONTENTS ON OTHER INFECTIOUS DISEASES IN CURRICULUM

Conclusion

Closing the discussion, it is evident that school syllabus and books are incomplete in respect to the contents on HIV/AIDS. Due to this, students of the government schools are unaware about the basic transmission and prevention of HIV. The major focus of the books is on issues mostly related to economy, sciences as well as issues related to the outcome of the education system. However, the major focus i.e. health and particularly HIV/AIDS is missing in the discussion of the text of the selected books.

Recommendations

- Health Education on HIV/AIDS must be offered to all the students in government schools equally via a comprehensive course outline.
- Public Health Department ought to be involved in designing a uniform health education curriculum for school. This syllabus must contains stuff on infectious diseases especially HIV/AIDS.

Annex I

Biology for Class 09 & 10- Book Content Titles

Book Name and Class	Chapter Titles
Biology for Grade 9	• Introduction to Biology • Solving a biological Problem • Biodiversity • Cells and Tissues • Cell Cycle • Enzymes • Bio- energetic • Nutrition • Transport
Biology for Grade 10	• Gaseous Exchange • Homeostasis • Coordination • Support and Movement • Reproduction • Inheritance • Man and His Environment • Biotechnology • Pharmacology

Annex II

General Science for Grade 9 & 10 - Book Content Titles

Book Name and Class	Chapter Titles
General Science for Grade **9 & 10**	• Introduction (The Role of Science) • Our Life and Chemistry • Biochemistry and Biotechnology • Man and his Health • Diseases- Causes and Prevention • Environment and Natural Resources • Energy • Electricity • Electronics • Science and Technology • Space Research and Pakistan Atomic Energy Plan

Annex III

Health & Physical Education for Grade 9 & 10- Book Content Titles

Book Name and Class	Chapter Titles
Health & Physical Education for Grade 9	• Introduction to Physical Education • Physical Movements • Gymnastics and Physical Activity • Posture and Posture Imbalance • Massage • Physical Fitness- Characteristics of a Good Athlete • Tournament System • Sports Rules • Athletics Rules

Health & Physical Education for Grade 10	• Importance of Physical Education • Recreation and Small Area Games • Definition of Health, Community Health and its Importance • Health Prevention • Training: Physical Exercises for correcting Posture • Joints and Muscles • Healthy School Environment & Infectious diseases • Our Food • Sports Rules • Athletics Rules

Annex IV

Islamic Education (Compulsory) for Grade 9 & 10- Book Content Titles

Book Name and Class	Chapter Titles
Islamic Education (Compulsory) for Class 9 & 10	**Part-I** Initial 07 chapters contain Quranic Verses & Translation **Part-II** Chapter 08- Ahadith & Translation **Part-III** • Introduction to Quran • Following Allah & His Prophet (PBUH) • Knowledge and its Importance • Zakat • Physical Cleanliness • Patience and Our individual & Collective Life • Importance of Daily Life • Migration and Jihad • Human Rights

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Impact of Syrian Refugees in Slovakia: Psychological Implications

S. Macurak (Shelby Macurak), D.J. West, Jr. (Daniel J. West, Jr.)

Original Article

University of Scranton, PA., Master of Health Administration Graduate Program, USA

E-mail address:

shelby.macurak@scranton.edu

Reprint address:

Shelby Macurak
University of Scranton
Scranton Hall
Scranton, PA. 18510
USA

Source: Clinical Social Work and Health Intervention *Volume: 10* *Issue: 1*
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Reviewers:

Victor Namulanda Wanjala
Catholic University of Eastern Africa, Nairobi, Kenya
Gabriela Lezcano
University of California, San Francisco, USA

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Abstract:

Syrian refugees have become a topic of international discussion. The Syrian Civil War has led 13.1 million Syrians in need of human assistance from neighboring countries. While being in need of physical resources like food and shelter, refugees also experiences psychological implications in this difficult time. These psychological difficulties include depression and anxiety from losing loved ones and constantly being surrounded by a warzone. As a response, funding and other

solutions have taken place through organizations like the Office of the United Nations High Commissioners for Refugees (UNHCR) and the European Union (EU). An example of a current solution would be the use of Emergency Transit Centers. While there are solutions in place, they lack in focus on mental health. The recommendations are to request more funding, request outside help with counselors or mental health advocates, and develop a realistic assessment of capacity.

Introduction

The Syrian Civil War officially began on March 15, 2011. The war broke out due to protestors demanding an end to authoritarian practices and the government's response was violent and extensive use of police, military, and paramilitary forces. Militias were formed by the citizens which expanded the conflict to a fully engulfed civil war (Britannica, 2018). Per the World Vision, 13.1 million Syrians need humanitarian assistance today (2018). The seven-year war has broken down the social and business ties that connected neighbors to their community. Buildings and homes have been destroyed including healthcare centers, hospitals, schools, utilities, and water and sanitation systems (World Vision, 2018). According to Skolnik, the situation in Syria is categorized as a complex humanitarian emergency which is a complex, multi-party, intra-state conflict resulting in a humanitarian disaster which can establish regional and international security threats (2016).

Today, 5.6 million Syrians have fled the country as refugees with 1.3 million who have requested asylum in Europe. According to Merriam-Webster (2018), asylum can be defined as protection given to political refugees by a nation. In Slovakia, there are a total of 923 refugees and 26 asylum seekers which accounts for less than 1% of the total population (Irish Examiner, 2018). This is a small percentage; however, it is important to keep in mind that it has the potential to grow and may result in undocumented refugees within the country. In 2017, Syrians have accounted for one-third of successful asylum cases (Globsec, 2017). Refugees come from Syria to Slovakia to be in a safer environment and seek employment for their future.

Politically, Slovakia acts as a transit country for the Syrians. This means that refugees are in Slovakia for a short period of time in between leaving Syria and going to their permanent country (Irish Examiner, 2018). In fall 2016, ten percent of Slovak citizens responded in a Eurobarometer survey. The results showed that Slovak citizens opposed the new refugees due to reasons including security risks, lack of cultural compatibility, and economic burden of the country (Globsec, 2017). They felt that resources were being taken away from Slovak citizens to be given to the refugees. This does not seem to be the case.

Mental Implications

Children

More than half of the refugees are displaced children. UNICEF defined a child displacement as the separation of children from their parents due to several varied reasons including civil war (2018). For a majority of them, war is all the children have ever known which has led to extreme effects. These extreme effects include diseases and malnutrition, child labor and child soldiers, child marriage and abuse, and lack of education opportunities. More than two million of Syrian children are out of school

due to over one-third of the schools not being in use (World Vision, 2018).

Adolescent and Adult

A significant source of stress for refugees is the ongoing concern about the safety of their family members. The environment of a civil war can lead to the separation of family members. According to Hassan (2016), the mental implications include the feelings of estrangement, loss of identity, and struggling to adapt to life as refugees within a foreign country. Refugees are forced to leave their homeland and find shelter in foreign countries. Normally, the refugees are not welcomed by the other countries citizens. While it is not a good situation on either end, the discrimination against refugees contributes to stress and the feeling of isolation (Hassan et. al., 2016). The most common clinical disorders that arise from the mental implications include depression, prolonged grief disorder, post-traumatic stress disorder, and various forms of anxiety disorders (The Borgen Project, 2017). These implications derive from the emotional repercussions of living in a warzone and fleeing to surrounding countries for safety.

In the Borgen Project (2017), the issue is that the International Medical Corps found that Syrian refugees and internally displaced persons have extremely limited access to mental health facilities. Of these people, fifty-four percent suffer from severe emotional disorders like depression and anxiety. Internally displace persons (IDPs) can be defined as someone who is forced to flee their home during a complex humanitarian emergency but stay in the country in which they were living. This is a major issue because the mental difficulties of refugees are not being cared of due to a number of reasons. A key factor is that countries are dealing with a shortage of mental health providers due to the lack of mental health centers and professional. If countries do not have the ability to provide services or resources to their own citizens, how are they expected to provide them to others?

Current Solutions

The current Slovakia policy demonstrates a commitment to offering five-hundred and fifty university scholarships to refugees by 2021 (Globsec, 2017). This shows an educational assurance for refugees to have a brighter future and have the opportunity to provide for themselves and others through higher education. Other solutions within the policy include notable participation in Frontex and European Asylum Support Organization (EASO), funding to a number of organizations around this topic, and the operation of the Gabčíkovo center. This center hosts up to five hundred Syrian asylum seekers that are registered in Austria and are waiting for their application to be processed (Globsec, 2017). Lastly, there is the operation of the Emergency Transit Centers. Operated and financed by UNHCR and International Organization for Migration (IOM), these centers were built to provide temporary housing and facilitate their resettlement in safety. Currently, the capacity in a center is up to two-hundred and fifty refugees. During their six month stay, refugees prepare for resettlement through completing IOM health assessments, pre-departure orientation courses, and arrange international transport to their resettlement destinations. UNHCR provides the travel documents, health care and social services while the Slovak Republic grants visa upon their arrival and offers accommodation, meals, and basic hygiene items (WHO/Europe, 2018).

Further Issues and Recommendations

Further issues within Syrian refugees include insufficient housing, draining of Slovak Resources, and overall lack of mental

health access for Slovak Citizens. Emergency transit centers only host up to two-hundred and fifty refugees when current data shows that there are nine-hundred and twenty-three refugees in the country. The center is unable to hold even half of the refugees that are in the Slovakia. Another issue listed is the perception that citizens have on the refugees. Many citizens feel that their resources are being drained due to providing for the refugees when that is not the case. As mention previously, majority of these movements for the refugees are funded by government or not-for-profit organizations. Lastly, the number of psychiatrists for the country is low. The country is experiencing a gap in mental health workers. If the country is unable to accurately treat their citizens when it comes to mental, they can not be expected to treat people outside of it (WHO 2018).

Ultimately, the focus should be shared between Slovak's citizens and the refugees. This could become more feasible through requesting more funding from the European Union and UNHCR. These two organizations are key players when it comes to the safety and future of refugees. If more wages are needed, more funds can be requested to cover the costs. The shelter situation can be solved through developing a realistic assessment of capacity. While the number of refugees is relatively low, it is important for the country to be able to do their part as a transit country. Through a development for realistic capacity, the country will be able to see if they need a second emergency transit center or other resources. Lastly, there should be a request for outside help with obtaining counselors or mental health advocates to assist with resolving the issue of access to mental health for refugees. Mental implications can have lifelong effects on a person when left untreated. It is important to have the ability to treat to better prepare this individuals for a bright future.

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Self-Help Groups and Social Support of Patients with Multiple Sclerosis

L. Majernikova (Ludmila Majernikova), D. Magurova (Dagmar Magurova), H. Galdunova (Helena Galdunova)

Original Article

University of Presov in Presov, Faculty of Health Care,
Department of Nursing, Slovakia

E-mail address:

majernikova@unipo.sk

Reprint address:

Ludmila Majernikova
University of Presov in Presov
Faculty of Health Care
Department of Nursing
Partizanska 1
08001 Presov
Slovakia

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Reviewers:

Michael Costello
University of Scranton School of Education, USA
Roberto Cauda
University Catholica Clinica, Gemeli, Rome, Italia

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Abstract:

Objective: The goal of the study was to compare the quality of life of patients with multiple sclerosis (MS) in Eastern Slovakia Region from the point of view of support MS organizations.
Design: comparative study, cross-sectional study.

Methods and participants: The sample of research consisted of 121 patients with multiple sclerosis (53 respondents who attended the self-help organization and 68 who did not attend the organization). We used to evaluate the standardized questionnaire WHOQOL-BREF.
The results indicate that social intervention have a positive impact on the quality of life of physical, mental and social health.
Conclusion: Clinical observation of the results of studies present that social support provided to clients with chronical disease can be very useful.

Introduction

Social support is a set of various support activities that come from supporting resources from the client environment. These include family, relatives, and friends, but also professionals at different jobs (such as a doctor, nurse, therapist, social worker and psychologist). The essence of social support lies in the awareness that other people are available to us and are willing to provide assistance if needed. Achievable social support means a form of assistance that is readily available in the immediate vicinity of a particular person, both on an official and unofficial level. In relation to this plane, we can talk about social support as a personal resource; in this sense the social support includes all the resources available for the individual within his / her individual social network. In general, we can say that perceived social support, that is, the kind of social intervention that the individual really contemplates is a reflection of social relations in the environment to which the individual belongs (Dimunova, 2017).

The high incidence of chronic illnesses in the Slovak Republic stimulates a comprehensive solution of the situation of these patients. As part of the overall approach, it is indispensable to address the issue of social support and support for these clients as well. Social support and good social relationships make a significant contribution to health, and their undeniable protective significance has also been demonstrated in the context of chronic diseases such as MS to which we pay attention in our study (Rakova, Bednarek, 2015).

Characteristics of the population and methodology

The sample consisted of 121 patients with multiple sclerosis (MS) comprised of 71 women and 50 men. The first comparative sample of respondents, who did not do social group self–help support interventions (NS) consisted of patients from Hospital Sv. Jakub n.o., Bardejov, Hospital Vranov nad Toplou consisted of 68 respondents. The second comparative research sample visited a self-help group (SS), and consisted of 53 patients diagnosed with MS who are registered members of the MS organizations in Presov, Vranov nad Toplou and Kosice.

Table 1: Characteristic of respondents

	NS n (68)	%	SS n (53)	%
Gender				
Male	34	50	16	30
Female	34	50	37	70
Eduaction				
Highschool without graduation	13	19	9	17
High school with graduation	45	66	36	68
University	10	15	8	15
Age (M ± SD)	45.1 ± 12.73		47,0 ± 13.2	
Duration off disease (M± SD)	13.4 ± 8.11		14.2 ± 7.96	

n – number, M – mean, SD – standard deviation

Both compared groups of respondents mostly had prevalently a high school education with graduation. The average duration of disease in patients SH was 14.2 ± 7.96 and NSH 13.4 ± 8.11 (Table 1). We used the standardized questionnaire from the World Health Organization WHO-QOL-BREF (short version) (Dragomirecka, Bartonova, 2006). The statistical analysis was performed using the statistical software package STATISTICA 14. Proportion comparisons were carried out with the Student's t-distribution. A value of $p<0.05$ was set to indicate statistical significance for all comparisons. Correlation analysis was used in order to explore the statistical significance of relationships between each domain of the quality of life and the social support. Parametric statistics Pearson correlation coefficients were used in study.

Results

In general physical health, we noted significant differences in energy for life ($p <.001$) and satisfaction with sleep ($p <.001$). In other domains, we did not notice significant differences in the compared groups. In psychological health, we found significant differences better scores for patients visiting the club. Significant differences were seen in feeling of life meaningful ($p <.001$), enjoyment of life ($p <.001$), negative emotions and able to concentrate ($p <.05$). Significant differences were found in the social and environmental aspects of the quality of life according to membership of MS organizations. The results showed better rating in respondents with social support in the spheres of satisfaction with sexual life ($p <.001$), satisfaction with self ($p <.01$), satisfaction with friends support ($p <.001$) and financial satisfaction ($p <.001$) (see Table 2). Statistically significant differences between respondents were discovered in the quality of life (QoL) in three domains of the WHOQOL BREF questionnaire. The social supported patients had statistically significance higher QoL in physical ($p = 0.0310$), psychological ($p = 0.0077$) and social ($p = 0.0000$) domains of QoL than not supported patients (see Table 2, Figure 1).

Figure 1 Results of WHOQOL-BREF - domains of QoL

Parametric statistics, Pearson correlation coefficients were used, where we found positive correlation between social support and domains of QoL. Our research showed significant differences in three domains of quality of life between the patients according to their membership in supporting organizations ($p \leq 0.05$ for physical, $p \leq 0.01$ for psychical and social domain of QoL). The dependence in physical, psychical and social domains was founded too (see Table 3). The results showed that the duration of SM was negatively.

Table 2: Analysis of the WHOQOL-Bref

Domain		**SS n (53)** M (SD)	**NS n (68)** M (SD)	p level
General physical Health	Ability to get around	3.33 (0.94)	2.98 (1.08)	0.514
	Energy for life	3.19 (0.62)	2.39 (1.11)	0.000***
	General health Satisfaction	3.25 (0.85)	3.49 (0.90)	0.200
	Discomfort, pain	3.32 (1.21)	3.33 (0.78)	0.390
	Accept bodily appearance	3.38 (0.98)	3.18 (1.11)	0.382
	Satisfaction with sleep	3.28 (0.88)	2.49 (0.79)	0.000***
Psycholo-gical Health	Feel life meaningful	2.69 (0.54)	2.09 (0.73)	0.000***
	Enjoyment of life	2.69 (0.54)	2.09 (0.73)	0.000***
	Negative emotions	3.24 (0.88)	2.72 (0.97)	0.016*
	Feel safe in daily life	2.63 (0.94)	2.09 (0.88)	0.053
	Able to concentrate	3.19 (0.48)	2.31(0.98)	0.000***
Social relations	Personal relations satisfaction	2.55 (0.61)	2.68 (0.73)	0.249
	Satisfaction with sex	3.93 1.12)	2.95 (0.93)	0.000***
	Satisfaction with self	3.12 (0.73)	2.83 (0.76)	0.007**
	Satisfaction with friends support	2.68 (0.42)	1.98 (0.54)	0.000***
Environ-ment Health	Satisfaction with health service	3.48 (0.45)	2.98 (0.64)	0.044*
	Financial satisfaction	3.33 (1.02)	2.98 (0.79)	0.040**
	Satisfaction with condition of place of living	3.22 (1.01)	3.30 (0.98)	0.290
	Opportunity for leisure activities	3.22 (0.98)	3.63 (0.89)	0.562
	Information satisfaction	2.12 (0.69)	2.27 (0.58)	0.235
WHO QOL BREF Domain Health	Physical	12.48 1.98)	11.49 2.05)	0.0310*
	Psychological	11.39 (2.75)	10.38 2.55)	0.0077**
	Social	11.40 (2.98)	9.57 (2.99)	0.0000***
	Environmental	12.48 (1.98)	11.49 (2.05)	0.0310*

*** significant at the 0.001 level, ** significant at the 0.01 level, * significant at the 0.05 level

Table 3: Pearson correlation coefficients for each domain of the quality of life and social support

Domains	Physical domain	Psychical domain	Social domain	Environ. domain	Social support	During MS
Physical		**0.583****	**0.277***	0.011	**0.276***	0.004
Psychical	**0.583****		**0.794****	0.258	**0.561****	0.189
Social	**0.277***	**0.794****		0.215	**0.741****	0.124
Environment	0.011	0.258	0.215		0.251	0.208
Social support	**0.276***	**0.561****	**0.741****	0.251		0.238
During SM	0.004	.189	0.124	0.208	0.238	

** Correlation is significant at the 0.01 level,* Correlation is significant at the 0.05 level

Discussion

Social support is recognized as a determinant of health, which acts upstream of traditional risk factors to affect the health and well-being of individuals. Social support is based on the perception that interpersonal relationships are able to fulfill the following functions: emotional support (caring, love, and empathy); instrumental support (concrete ways people assist each other such as providing financial assistance); social companionship (spending time with others); guidance (finding solutions to a problem); appraisal (Majernikova, Obrocnikova, 2019). Although there have been studies on the relationship between social support and QoL in patients with chronic progressive degenerative neurological diseases (Schwartz and Frohner, 2005; Nishida *et al.,* 2012), research investigating this association in patients with neuropathy is scarce. The relationship between social support and severity of disease has also not been well established.

In our study respondents' results positively correlated with social support - the psychological domain ($p < .01$), the social domain ($p < .001$) and the physical domain ($p < .05$). From the point of view of duration of the disease, we did not find any significant correlation of relationships. Respondents with a better perception of physical health showed a positive correlation in other domains in quality of life other than environmental.

Numerous epidemiological studies have reported that poor social support is associated with negative treatment response to dysthymia (Oxman *et al*., 2001); seasonality of mood disorder (Michalak et al., 2003); the presence of depression comorbid in several medical illnesses, such as multiple sclerosis (Mohr *et al*., 2004); cancer (Manel *et al*., 1999, Wong *et al*., 2013, Salonen *et al*., 2010); rheumatoid arthritis (Revenson *et al*., 2015). In contrast to low social support, high levels appear to buffer or protect against the full impact of mental and physical illness. The relationship between good social support and superior mental and physical health has been observed in diverse populations including college students, unemployed workers, new mothers, widows, and parents of children with serious medical illnesses (Johnson *et al.,* 1997, Christianson *et al*., 2013, Kang *et al*., 2010).

Conclusion

Based on the theoretical analysis of available literature, studies and our results, we suggest the following intervention recommendations needed for practice, especially for health staff.

1. As regards health care, attention should be paid to the quality of life through modern and recommended measuring instruments whose results need to be analyzed and on that basis to apply changes in nursing practice.
2. Health staff should engage in self-help groups and clubs because they often miss high-quality feedback to monitor the area of knowledge and skill management of the patient and her/his family as well as the quality of life in the social sphere.
3. Further reason for greater involvement of health staff into self-help groups is to improve continuous health care for chronically ill.
4. It is essential that other professionals from different fields of medicine are also involved in the self-help movement who by their knowledge and experience improve their club activity.
5. Availability of specialist services, from different areas according to character of the organization which can change

the attitudes of the sick and their family members (psychologist, social worker, etc.) is important.
6. Provide assistance in setting up self-help groups in locations where it is needed & desirable.
7. Helping to increase the cooperation of self-help groups and organizations in Slovakia, in this way it is possible to achieve mainly the exploitation of different experiences in the area of club activity, to increase their mutual support and co-responsibility.
8. In larger measure establish international contacts with other clubs and self-help groups aimed at helping the sick.
9. Support professional guidance online counseling, online membership through expert guidance of such counselors; contributions to discussions on websites by nurses who have sufficient professional and practical experience.
10. Part of the conferences should be "patient seminars" which would solve the problems of the sick and their families at a professional level.

Ethical requirements - participation in the study was voluntary and anonymous. Each person was informed about the objective of the survey and the way of completing the questionnaires. Then, informed consent for participation in the study was signed by each [erspn. The survey procedure was in accordance with the Declaration of Helsinki.

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Innovations of Food Security in Central, Eastern and Western Europe (Review)

L. Nardelli (Lauren Nardelli), D.J. West, Jr. (Daniel J. West, Jr.)

Original Article

University of Scranton, PA, U.S., Master of Health Administration Graduate Program, USA

E-mail address:

lauren.nardelli@scranton.edu

Reprint address:

Lauren Nardelli
University of Scranton, PA
Scranton Hall
Scranton, PA 18510
USA

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Vlastimil Kozon
Allgemeines Krankenhaus – Medizinischer Universitätscampus, Vienna, Austria
Roberto Cauda
University Catholica Clinica, Gemeli, Rome, Italia

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Abstract:

Objective: This research will attempt to identify the causes for the increase in the inefficiencies of nutrition. Additionally, there is an effort to identify what is missing nutritionally by means of conducting a comparative analysis against surrounding European countries to help determine these insufficiencies.

Methods: This paper is a secondary resource on the access, availability, affordability, and education on Food Security.

Results: Surrounding countries of Central, Eastern and Western Europe should change their current policies and implement certain laws for food wasting. These countries should increase efforts to further investigate diseases that are attributed to severe food insecurity.
Conclusion: This research noted that surrounding countries in Central, Eastern and Western Europe are implementing food programs and agriculture policy changes.

Introduction

Food insecurity is a limited access to nutritious food necessary to live a healthy lifestyle. Food insecurity does not affect all individuals. Individuals who are food insecure have social patterns of vulnerability in the household and environment. It is a significant public health problem affecting mostly the middle to low income class in various countries. Individuals who are food insecure are more susceptible to chronic diseases due to the inability to access adequate health resources.

Food security was first defined by experts in the 20th century as the ability of a country to provide its residents enough nutritious food necessary for individual's health and to lead productive lives (Dzurickova, 2). However, in 1996, at the World Summit on Food Security, the Food and Agriculture Organization (FAO) stated food security exists when at all times, people have physical, social, and economic access to sufficient, safe, and nutritious food to meet needs and preferences for an active healthy lifestyle (Dzurickova, 2). This term has expanded vastly since continuing research in the subject matter.

Concerns

Malnutrition continues to be a single threat to public health globally. It contributes to 2.2 million child deaths per year and in Europe, it is estimated 33 million people are at risk for malnutrition (eufic, 2011). When a child faces nutritional deficiencies she or he is not getting the proper nutrients needed for child growth and development which can lead to stunted growth in children.

Food wasting is another major factor in food security. According to ec.europa.edu, (2017), in Europe it is estimated that 20% of the total food produced is lost or wasted. Food waste does not only happen in supermarkets but is lost along the whole supply chain from farms to processing and manufacturing. Climate change can also contributed to food waste.

Obesity rates are currently on the rise worldwide. Even though people suffer from lack of calories and nutrients, the number of individuals who are overweight and obese is often associated with low income. Lower income individuals turn to processed or fast food because it is affordable and accessible. Behaviors and excess consumption of food can increase personal health burdens and chronic diseases such as diabetes, heart disease and cancer (easac.eu, 2017). When individuals are not intaking the proper nutrients needed to help the body fight chronic diseases, it makes them more susceptible to chronic diseases that can be detrimental to their health.

Prevalence and Impact

According to the European Pediatric Association (2017), the prevalence of food insecurity has increased during recent years in several European countries. The United

Nations Children's fund conducted a study that found within 28 European countries 18% of households were moderate to severe food insecure; 14% had the inability to access food; 20% of households reported having lack of funds to purchase food (European Pediatric Association, 2017).

Impact

Access is one of the many contributing factors that impacts food insecurity. When individuals do not have a car to get to the grocery store or the closest grocery store is over 100 kilometers away, this reduced access to food in the household.

The demographic transformation is making it hard to keep up with food demand due to population growth. People are constantly migrating from place to place with growing families. This can be seen in the rural aging population because elderly people are migrating more towards warmer climates. This can also affect their access to food because not many elderly people drive, or family members are not around to help them access proper food resources.

Behavioral change has a big impact on food insecurity because of the choices individuals make when it comes to nutritional choices. For example, food consumption plays a role in behavioral choices because one can chose how much to eat in one setting.

When individuals are hungry late at night or just want something quick and cheap, they are more likely to access a fast food place rather than selecting fresh fruits and vegetables. Controlling food intake is important through education. If people are more aware and understand fats, oils, sugars and carbohydrates they are more likely to make healthier nutritional choices. Another important educational practice could be learning how to read the back of a nutritional label while grocery shopping to decide which food belongs in the cart. Although, this can be hard to do when there is a transformation of food systems. This shift can be seen in both grocery stores and in the environment where fast food chains are rapidly growing. More processed foods are being sold in grocery stores because they are affordable and easy to make. However, people are not aware of the amount of sodium, antibiotics, and other nutritional resources that are in processed foods.

Food Security in Slovakia

According to the foodsecurityindex.eiu, (2017), Slovakia is ranked 34th out of 70 countries in Europe for food security. Throughout numerous research articles, Slovakia is a country that has improved food security compared to neighboring countries. Three strengths Slovakia has to approach this issue is presence of food safety net programs, nutritional standards, and food safety. Slovakia also ranks 32 in the category of affordability. This indicator considers the food safety net programs which include in-kind food transfers; conditional cash transfers (food vouchers); the existence of school feeding programs funded by the government (foodsecurityindex.eiu, 2017). The data also indicated the presence of food safety net programs is 1.4% above the world average in this category.

One of the challenges that was found while conducting this research was protein quality. According to foodindexsecurity.eiu, (2017), Slovakia is -13.8% below the world average in protein quality. Protein is an essential part of a diet because it is an important building block of bones, muscles, skin, and blood. It also helps in building and repairing tissue.

Conclusion

Research and innovation are two drivers that will help increase food security in Europe and globally. Focusing on nutrition and diet are key. Food insecurity does not only

present an issue in Europe, but worldwide. It is a social problem, which leads to a public health problem because without the proper nutrients, chronic diseases and other significant health problems can arise. Education, implementation, and change are key drivers to help turn people from food insecure to secure and living an active healthy life.

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Obesity Prevention Strategies for Teenage Adults in Central and Eastern Europe

J. Robinson (Justin Robinson), S. Szydlowski (Steven Szydlowski)

Original Article

University of Scranton, PA., Master of Health Administration Graduate Program, USA

E-mail address:

justin.robinson@scranton.edu

Reprint address:

Justin Robinson
University of Scranton
Scranton Hall
Scranton, PA. 18510
USA

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Reviewers:

Gunther Dorfmeister
Vienna General Hospital, Vienna, Austria
Jirina Kafkova
Nairobi, St. Bakitha Clinic, Kenya

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Abstract:

Objective: This research paper discusses the obesity problem affecting the younger population in Central and Eastern Europe. Through analyzing information from the World Health Organization (WHO) and other realizable sources, current and future prevention strategies are examples alone with the potential health risk factors presented by being obese.

Methods: This paper is a secondary resource of obesity in the younger adult population in Central and Eastern Europe, with strategies to decrease the effects on these individuals.
Results: The Central and Eastern European countries of Slovakia, Czech Republic, Hungary, and Poland should expand the knowledge of assisting younger adults on the importance of understanding healthy eating habits as well as incorporating physical activity into their daily lifestyle.
Conclusion: This research shows the need to increase the demand for educating and providing support services for the younger population. The importance of healthy eating and the risk associated with lack of exercise caused by unhealthy habits in Slovakia, Czech Republic, Hungary and Poland.

Introduction

Almost every country around the world has experienced some form of obesity in their population. The key to overcoming these issues and preventing a widespread epidemic is knowing how to prevent these measures before it increases. Obesity is having a body mass index (BMI) greater than 25, which is determined by the body mass of an individual divided by the square of their body height, known as the greater weight to height ratio. Obesity is becoming one of the greatest challenges in public health in Europe. Currently is responsible for 2-8% of health cost and 10-13% of deaths throughout the European region (World Health Organization, n.d.).

Demographics

The obesity rate in the European countries of Slovakia, Czech, Hungary and Poland continues to rise. A 2016 study showed obesity notes for the population of young 18 year olds and older male and females as follows: Slovakia 21.0% males and 19.9% females; Czech Republic 26.4% in males and 25.4% in females; Hungary 28.2% males and 24.6%females; Poland 23.7% males and 22.2% females (Knoema, 2016).

The 2016 statistics showed the Czech Republic and Hungary as having the most individuals of male and female falling into the obesity category. The numbers in the Czech Republic, Hungary and Poland are showing a decrease in their percentage of obese individuals, but Slovakia is still showing an increase at an annual rate of 2.4% each year in their male community if proper prevention measures are not performed.

Some important factors contributing to the increase in weight for individuals has socially, personally, and environmental determinants. The key concerns are mostly being led by: lack of physical activity being conducted by the younger population; being introduced to bad eating habits early in life; lack of educational knowledge to distinguish unhealthy and healthy food options; lack of resources available locally to choose healthy foods.

Obesity has many potential risk factors associated with being overweight. The leading concern in Central and Eastern Europe as a result of being obese is Diabetes. According to the WHO, 80% of all type 2 diabetes cases were associated with obesity; 55% were related to hypertension;

35% contributing to cardiovascular disease. Obesity is also considered as the 5th leading death risk. Personal risk also plays an important role in the younger population. Being obese can produce low self-esteem, depression and reduce confidence.

The projected obesity rate for 2030 has the Czech Republic nearly doubling its obesity rates in the years to come. Slovakia and Poland are expected to increase quite similar to one another. It is estimated by the European commission that obesity contributes to 7% of the total health care expenditure (around 81 billion euros per year). Obesity contribute to an increase in the diabetes costing health care around 10% of their expenditure and is expected to increase to 17% by 2030 if preventative measures are not conducted. The total cost of diabetes being treated is around 300 million euros per year with an expected increase of approximately 1% every 3 years. If this current trend continues, it is expected that obesity will impact 15 million people or 10% of European younger adults being considered overweight. Only Hungary is expected by the World Health Organization to slowly decrease obesity numbers in the younger population by 2030.

Slovakia vs Czech Republic Intervention Comparison

The comparison of Slovakia and the Czech Republic in terms of intervention policies and action plans currently in place to reduce the obesity rate are quite similar to one another, but still have improvements and differences presented by both countries in how they are handling their obesity prevention methods. Slovakia is incorporating different polices and plans to cut the intake of the types of unhealthy food choices their younger generation is consuming. In doing so, they are partnering with professional networks in providing health-enhancing physical activity guidance, and the proper education to be aware of their healthy choices. Also, developing marketing policies on being able to cut the high fats, salt and sugar (HFSS) consumption in their teen population. The Czech Republic is producing similar interventions, but with limited consumer awareness and their inability to develop a policy to assist in the high fats, salt and sugar consumption in regards to their teen community. Additional interventions both countries could incorporate to aid in these strategies, would be to further educate and discuss the potential health risks associated with lack of exercise and unhealthy eating. Informing the younger community prior to their full adulthood could reduce future risk and even encourage young people to change their habits and gain a healthier livelihood.

Obesity Prevention Strategies

Prevention is key to aiding in the health of our younger population. Slovakia, the Czech Republic, Hungary and Poland have all provided their own strategies to prevent and aid in the decrease of preventing further obese individuals. Slovakia's strategies are: conducting regulations on the advertising of unhealthy food options through social networks such as TV, internet, or radio broadcast. Partnering with local or professional networks to increase physical activity produce proper learning techniques or technology advancements for younger adults to learn the importance of how to read food labels and distinguish the difference in appropriate foods. Teaching younger adults about the certain types of foods they consume can have an impact on their future livelihood.

The Czech Republic strategies are: incorporating pricing policies for regulating the consumption of healthy foods, which would tax unhealthy options and allow tax breaks for healthy choices; placing restrictions highly on processed foods and beverages

with high sweetener content. Strategies include reducing the current inactive status of the population; increasing physical activity; increasing consumer awareness through seminars and the mass media advertising on the importance of healthy lifestyles.

Hungary have incorporated the Public Health Product Tax to reduce the consumption of unhealthy choices, having higher cost prices on sweetened or unhealthy products would lead to an individual to cut these and encourage healthy options. The path Hungary has taken in this product tax has reduced consumption of unhealthy foods by 16-28%.

Poland is expanding the regulations on meals; controlling portion sizes with clear document- ation of food labelling key to impacting obesity rates in the young population. Incorporating the expansion of health care coverage for obesity treatment; through weight management meetings; educational classes; medications to assist in preventing any further future increase in the obese population.

Conclusions and Recommendations

The projection for overcoming obesity risk includes changing eating habits and increasing exercise. Incorporating the public health product tax which tax's unhealthy foods forcing teens to choose more healthy options. Increasing the amount of daily physical activity and monitoring nutritional intake is key to dieting and overall weight control. Lastly, having the knowledge and education to teach younger adults proper health choices and understanding how the choices of foods impact future health and lifestyles.

This research emphasizes the effects of obesity while focusing on teenage adults in Central and Eastern Europe, especially in Slovakia, Czech Republic, Hungary and Poland. The key takeaway from this research is the increase in demand for educating and providing support services for the younger population to know the importance of healthy eating and the risk associated with lack of exercise caused by unhealthy habits. The interventions currently in place require further research. Other action plans include reducing salty, sugary and fatty foods which encourages individuals on a financial budget to choose healthy options because of incorporating the new tax policy on unhealthy foods. The action plans of enhancing physical activity will drastically drop the obesity percentage by incorporating some physical involvement in their everyday lifestyles.

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Improving Mental Health Access in Central and Eastern Europe: A Review of current systems

E. Steele (Elizabeth Steele), S. Szydlowski (Steven Szydlowski)

Original Article

University of Scranton, PA., Master of Health Administration Graduate Program, USA

E-mail address:

Elizabeth.Steele@scranton.edu

Reprint address:

Elizabeth Steele
University of Scranton
Scranton Hall
Scranton, PA. 18510
USA

Source: Clinical Social Work and Health Intervention *Volume: 10* *Issue: 1*
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Reviewers:

Arab Naz
University of Malakand Chakdara Khyber Pakhtunkhwa, Pakistan
Selvaraj Subramanian
SAAaRMM, Kuala Lumpur, Malaysia

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Abstract:

Objective: This paper outlines the current access of Mental Health services in Slovakia. Examining information from the World Health Organization and other peer-reviewed articles, the author outlines the current Mental Health system and identifies areas of improvement.

Methods: This paper is a secondary resource on the access of Mental Health and the implications of stagnate change within Central Eastern Europe.
Results: The various ministries Slovakia should change their current Mental Health policy. The country should also increase efforts to integrate Mental Health into the primary care setting, as well as increase documentation of available statistics for Mental Health professionals and future research opportunities.
Conclusion: This research indicated that Slovakia struggles with up-to-date documentation of Mental Health statistics, as well as financial viability of services. Demonstrating that access to care remains an issue.

Introduction

Mental Health access is a topic that is often put aside when "more pressing" topics hit the media. Mental Health can be defined as any neuropsychiatric disease that impairs a person's mental state and affects their daily living (World Health Organization 2014). This can be anything from major or minor depression, major or minor anxiety, to schizophrenia, etc. Mental Health is not only an issue in central and Eastern Europe but has also been a topic of discussion all over the world. Globally, 120 million people suffer from depression and 24 million from schizophrenia (Chelala, Cesar 2013). The World health organization states that about 1 in 4 people have been affected by one type of Mental Health disorder. This accounts for about 450 million people being affected, with depression being the 4th leading cause of burden of disease. The World Health Organization states that by 2020 depression will increase to the 2nd leading cause of burden of disease (World Health Organization 2001). Addressing Mental Health issues in a growing global concern. Since about 90% of documented suicides are due to a Mental Health issues and suicides account of 17.6% of all deaths; if left unattended these rates will only rise (World population review 2018).

Demographics

The Slovakia Republic, similar to other countries around the world, is struggling to adapt to the needed increase in access for Mental Health. As of 2016, there were 9.7 suicides per 100,000 people in the Slovakia Republic (Organizations for Economic Co-operation and Development 2016). Mental Health is ranked the second leading cause of death in Europe among the age group of 15-29-year-old individuals; second only to road traffic accidents. In 2017, the World Health Organization stated that although many Europeans suffer from Mental Health, three out of four people suffering from major depression are not receiving adequate treatment.

Mental-Health Services

Mental Health is 26% burden of disease for the country of Slovakia. There is a Mental Health policy and plan, however, due to unknown restraints, plans are not updated yearly. This inability to stay updated with current policies can cause delays in implantation and delivery of care. During the 2008 revision of Slovakia's Mental Health Plan, Slovakia hoped to increase the timeliness for implementation and strove to integrate Mental Health into the primary care setting (World Health Organization 2011). The

impact of these initiatives will be discussed further in the article.

Barriers to Mental Health

There are three main barriers identified by the State Members themselves that highlight a global struggle for better access to care. These barriers include: insufficient funding;, insufficient availability of Mental Health professionals; and as stated before, the stigma that still surrounds Mental Health today (Stefan Lassan 2017).

Solutions and opportunities

The first area of opportunity is to conduct more research on Mental Health trends within Slovakia, as well as observe how other organizations and countries are assessing their need and moving forward with action.

The Czech Republic is a great example of a country who is also struggling with Mental Health but trying to mitigate the barriers to access. With 20 pilot organizations being placed around the country, they are trying to find the solutions that best fit their society and are the most financially viable. Since their main target is to increase the quality of life for patients, they are breaking these pilot organizations into an 8-step plan. A few of these steps include developing standards and methodology for quicker care and access for patients; increasing research and education; a closer look at sustainable funding; interdepartmental cooperation. Two main targets of these organizations will be to focus on sustainable funding and an improved financial model. Since one of the barriers that State members have identified was lack of funding, Czech Republic is looking into an outpatient setting for Mental Health disorders. Stefan Lassan stated that it costs about 5 million koruna to house 10 patients in hospital beds, but the same amount of money the system can house 100 outpatients (Stefan Lassan 2017). This is an example of taking the money that the country is already using and thinking of new and innovative ways of using that money.

Primary Care Action

Using a general practitioner, in a primary care setting will improve Mental Health access. Developing comprehensive based programs to work with community networks, will help engage the population on the importance of Mental Health and reduce the stigma associated with it. Focusing on the physical health such as nutrition and exercise will also help the patients increase their chance of recovery. The Mental Health Foundation found that people who were obese had a 55% increased risk of developing depression and people who were depressed had a 58% increase in the risk of becoming obese. (Mental Health Foundation 2018) Having general practitioners focus on the importance of nutrition and exercise with all patients will help to decrease the prevalence of Mental Health disorders. Furthermore, general practitioners can treat patients who are unable to seek psychiatric trained physicians due to the lack of qualified personnel. Since one in three general practitioners' encounters with patients involved Mental Health, this should be something that physicians are discussing throughout their education and professional career. (Mind Charity 2016).

Conclusion

With the increased prevalence in Mental Health as well as the suicide rates associated with Mental Health, it is imperative that action be taken to give patients adequate access to care. Annually or bi-annually updating Mental Health policy, reducing the stigma throughout health care facilities and the general population, would improve the delivery of care. Addressing both physical and Mental Health will help patients better

understand their diagnosis and provide them with better outcomes. If left untreated, depression will rise to the 2nd leading cause of burden of disease and therefore those affected will be 58% more likely to become obese. Obesity, leading into another issue we struggle with globally, also causes issues for individual health and longevity. Using the general practitioners and increasing financial resources will be the pillars of success for tackling these issues in the future.

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Analysis on The Role of Rehabilitation Centers and its Effects on The Reducation of Drug Addiction in Quetta City

Z. Unnisa (Zaib Unnisa)[1], A. Gul (Ayesha Gul)[2], A. Naz (Arab Naz)[3]

Original Article

[1] M. Phil Scholar Dept. of Sociology, SBK Women's U. Quetta. Balochistan, Pakistan
[2] Assistant Professor Social Work Department, SBK Women's University Quetta. Balochistan, Pakistan
[3] Prof, Sociology Department, University of Malakand. Khyber Pakhtunkhwa, Pakistan

E-mail address:

gul_aisha@hotmail.com

Reprint address:

Ayesha Gul
Social Work Dept. SBKWU University Balochistan
Bawrery Road, Quetta
Balochistan
Pakistan

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Abstract:

Narcotics have become a global problem and have assumed to be progressively serious issue internationally. World Health Organization (WHO) defined drugs as "any substance when consumed by the living

organism may alter one or more functions. The treatment and rehabil-itation of drug addicts is long and painful journey from drug dependency to a healthy and drug-free lifestyle. Rehabilitation programmers are extremely costly and demand highly motivated people to take care of drug addicts in any given circumstances. In Pakistan, the majority of existing treatment and rehabilitation facilities provide detoxification services. The Detoxification and Rehabilitation Complex Quetta was established in 26 March 2009. The current study is qualitative in nature that seeks to find out the effects in reduction for drug addicts in Quetta City. The data was gathered by conducting interviews and Focus Group Discussion (FGD) among administrative staff, nurses and the family members of the rehabilitation center and the family members of addicts. Using statistical tools of Microsoft Office (Excel) the data derived from the interviews was analyzed. The result of the study indicated that problems like: lack of community support; easily available psychoactive drugs in the society; partial number of drug rehabilitation centers; lack of medicines in the rehabs; lack of doctors; etc. are the key factors that hinder the treatment process. A variety of supportive services for enhancing the rehabilitation process were found to be in practice These trainings include life skills training; job counseling; skills like shoe making, tailoring, electrical work; etc. Being an Islamic state, counseling through religious scholars is a common practice as to make the addicts realize and get ready to give up the drugs. The present study established that the medicinal drugs used in the treatment did affect the treat-ment. Most of the enrolled clients get fully well after completion of the treatment. The Detox and Rehab has been in action since 2009 and located in the outskirts of Quetta (Eastern-by-pass) and getting popularity among the masses for its treating and rehabilitation purposes.

Background of the Study

Narcotics have become a global problem and have assumed to be a progressively concerning issue internationally. Drug abuse is becoming a serious threat to developed and developing countries (Collins, 2012). Extensive efforts are being made by governments to reduce the illegal production, marketing and supply of all type of drugs. The United Nations has taken in account a manuscript demanding reduction where a complete policy to suppress the requirement of substances of drug abuse was started. Core principles were planned which would be combined to sponsor co-operation among all relevant bodies, and would include an extensive range of suitable interventions and encourage healthy and social developed members, their families and countries. It must decrease the unpleasant outcomes of drug use for the members of the society (White W. L, 1998).

A Brief History of Drug Use in Pakistan

Pakistan has faced the crisis of drug use since it came into existence. The country faces the largest heroin use market in the Southeast Asian area. While the whole area

is suffering from drug trafficking in South Asia, Pakistan has become its most horrible victim. Opium and poppy have often been in cultivation in most parts of Pakistan. Opium was sold in stores authorized for the first part of the decade. After independence in 1947, the government followed the same laws as in the late 19th century, when the "Hadoop" law was officially announced. The law prohibited the cultivation, manufacture, trade and exercise of drugs in Pakistan, which caused the closure of the legal drug shops. However, illegal and ease of availability of drugs continued. By the start of 1980, heroine drugs use spread outside the country. Pakistan emerged as an important exporter of drugs like heroin in the 1980s, after an immense arrival of Afghan refugees. The main outcome of this flood was a major rise in use of domestic heroin in the country. In comparison to other drug addicts, heroin addicts rose from 7.5% in 1983 to a shocking 51% by the end of 1993. Since then, the use of heroin has reached epidemic proportions. Its size in Pakistan affected almost all socio-economic groups. Like all other human development evils, the crisis of drug abuse affects the most helpless; most of the drug addicts in Pakistan are from the poorest sections of society (Altaf A Shah *et al*., 2007).

The Purpose of Study

The current study was designed to identify role of rehabilitation center in terms reducing the number of drug addicts. The aim was to get opinions of the staff offering management in the Rehab (Quetta) regarding their viewpoints on the factors that hinder the treatment process, reducing the number of drug abusers.

Objectives

The core objectives of the study are:

Analyses of the role of a rehabilitation center for drug addicts.

Find out the effects of rehabilitation center in the reduction of drug addiction in the society.

Recommend how the role of a rehabilitation center can be improved to reduce the addiction problem.

Research Questions

The current study specially attempts to answer the following phrases.

Background Information of the Respondents and their qualifications and experience.

Major factors hampering treatment processes in rehabilitation.

Supportive services for clients to enhance the process of drug abuse rehabilitation.

Perception of employees on the nature of drugs and treatments offered.

The Research Design

This study is based on the qualitative in nature that seeks to find out the effects in reduction for drug addicts in Quetta City. Data were gathered by conducting interviews and Focus Group Discussion among administrative staff, nurses and family members of the rehabilitation center and family members of addicts.

Participants

In this study the family members and the administrative staff and nurses from the rehabilitation center in Quetta City were selected. The participants were from different areas; administrative staff was 5; 3 nurses; 4 family members for Focus Group Discussion.

Data Collection Tool

This study was conducted to measure the effects in reduction of drug addicts in Quetta City. The first step in the data collection process was to obtain permission from the administer of detoxification and rehabilitation

center located in eastern by pass. A research visit was made to the Detoxification and Rehabilitation Center in Eastern Bypass Quetta. For getting information, a qualitative research technique was conducted with the administrative staff, nurses and family numbers of the addicts. In-depth interviews and focus group discussion (FGD) were used as data collection tools in this study. After receiving permission from the Administer, interviews were taken with the administrative staff and the nurses. FGD (focus Group Discussion) was also conducted among the family members of government rehabilitation and a private rehabilitation center. The core themes of the interview and discussion are as follow:

The proposed study is a qualitative research.

The proposed study is a case study as it is an analysis on a Rehabilitation Center situated in Quetta City.

Since the proposed study is a qualitative research, detailed interviews with the management of the rehabilitation center were conducted. An interview protocol will be developed to guide the interview process.

The sample of the proposed study is the higher and middle management employees of the rehabilitation center.

The total number of interviewees will be five.

Two employees are from senior management and three are middle management of the rehabilitation center.

The data is collected from the interviews and from publications, reports and analysis of rehabilitation center to analyses the role of the rehabilitation center and its effects on reduction of drug addiction in Quetta City.

Significance of the Study

This current study was designed to highlight the role of the rehabilitation center and pinpoint the factors that might hinder treatment processes in the drug rehabilitation center in Quetta, Pakistan. The findings of the study may help the treatment personnel and the Government to identify problems associated with treatment of drug abusers thus alerting them about possible consequences. Since drug abuse affects the entire society, from the findings, the government may drive policies based on the results of the study which would be supportive to identify how to direct their possible partial resources to uplift the effectiveness of centers.

Literature Review

The foundation of the detoxification and restoration complex at Eastern By-pass Quetta is \n upshot of the activity by the Honorable High Court of Baluchistan, by passing a request in the Constitution Petition (CP) No.181 of 2000. The development work of the complex was finished in February 2009 and it was handed over to the Social Welfare Department, Government of Baluchistan at the start of March being functionalized on 26th March 2009. Without doubt, the foundation of such an establishment is a superb accomplishment and it would be extraordinary not put on record the endeavors made by personnel and gatherings. There has been exceptionally efficient help to higher-ups of the Government of Baluchistan including the commendable Baluchistan Chief Justice, commendable Chief Secretary Baluchistan, the Additional Chief Secretary, and The Finance Secretary, The Social Welfare Secretary, Deputy Social Welfare Secretary and the E.D.O. Community Development.

Treatment for drug addicts varies depending on the activities and strategies used to alleviate symptoms and inducing changes (Jilek, WG, 1994). The types of treatment offered are distinct from their underlying

philosophies, expected goals, target groups and the context in which they are provided, that is, surgeries or residential.

Many agencies that provide treatment for drug addicts offers two or more treatment modalities. They include detoxification, pharmacological, psychological / counseling and therapeutic interventions. The community also provides rehabilitation services, relapse prevention, and 12 Step post-treatment services (Ashley, M. J*et al.,*1995). However, studies have shown that treatment is influenced by the type of drug abuse; the type of program performed; the time period between the start of drug use and treatment.

A study on national treatment in the United Kingdom conducted in the late 1990s on 1,075 patients (UN 2000) showed that people in residential treatment have shown better results to curb heroin abuse than those in outpatient programs.

Amodeo *et al.,* (2006) noted that drug addiction is generally a chronic disease. The disease characterized by relapses and occasional treatments are often not sufficient and no single treatment approach is appropriate for all individuals. Therefore, it is necessary to apply a variety of interventions, since the type of treatment needed is based on the severity of the addiction. A study developed by the Drug Abuse Reporting Program (DARP, 1989) researching 44,000 customers has included 139 programs in the United States in the 1990s. Results indicate improvements in particular regarding heroin. The study also revealed that the longer customers remained the better the results of treatment. Customers who remain in treatment for less than three months, in general, did worse than those who stayed in therapy longer. The dropouts are worse compared to people who have been treated. The commitment at the beginning of the treatment was associated with high stages of abstinence abuse. Therefore, long-term residential treatment programs seemed to get the best results.

A survey conducted by Drug Strategies (2001) revealed that early interventions provide assistance and substantial reduction of drug use. It is also less expensive to do treatments available only after individuals develop addiction. It was also noted that the types of drug abuse tends to vary with age. Bhang and alcohol abuse are the most frequent among customers less than 18 years, while cocaine is associated with older addicts. Although treatment is required as an essential component of the overall drug demand reduction strategy, in the majority of developing countries the number of drug addicts who have access to nursing services is very small, which indicates the need to strengthen and expand treatment infrastructure. It was also stressed that not all drug users seek treatment and those who do tend to do so late in their drug abuse. And, most countries do not have adequate treatment infrastructure which reduces the chances of success (UN 2000).

No previous study has been done to investigate the role of the Detoxification and Rehabilitation Center in Quetta in particular and in Balochistan in general. So the current initial study is conducted to analyse the role of the rehabilitation center and its effects on the reduction of drug addiction in Quetta.

Data Analysis/Results

The data analysis was carried out on the basis of research questions. Results were discussed on the basis of the main areas of the current study including drug abusers treatment procedures and factors hampering overall treatment. The results of the current study were done on computer by using data analyzing tools. Tables and figures were presented where necessary.

Professional Qualifications

The respondents were asked to specify their professional qualifications. 60% of them had 16 years of education (Masters) in various fields of education; 20% had 14 years of education (Graduate) and 20% had 12 years of education (Intermediate). Besides their professional qualification, they had undergone various professional enhancing trainings so that they get well integrated in the Center for better results.

Investigation made by Miller *et al*. (1976) and Ashery *et al*. (1985) concluded that treatment for drug addicts depended on skilled professionals. Treatment would follow standard procedures of therapy including confrontation, clarification and eradication of behavior. The best results could only be achieved by professional treatment staffs.

Major Factors Hampering Treatment Process

The respondents of the study were asked to indicate problems that could hinder treatment of drug addicts in the Centers. They indicated problems like: lack of community support; easily available psychoactive drugs in the society; partial number of drug rehabilitation centers; lack of medicines in the rehabs; lack of doctors; etc. are the key factors that hinder the process of treatment. Therefore, no measurable changes in terms of reduction in the number of drug abuses are seen in the society. Miller *et al*. (1976) studies showed that anti-abuse, tranquillizers, sedatives, anti-depressants were used in order to withdraw, help and maintain addicts who were willing to stop drug abuse. An addict has various problems so the treatment must focus the individual's, psychological, physical, emotional and social-economic conditions. Mwenesi *et al.,* (1995) studied that readily available psychoactive drugs pose problems as the drug addicts once treated might go back to practice abusing drugs.

Supportive Services for Clients to Enhance the Process of Drug Abuse Rehabilitation

The respondents were asked to indicate if they offered supportive services and what kind of supportive services to the admitted clients. A variety of supportive services were found to be in practice for enhancing rehabilitation process. These trainings include life skills training; job counseling; skills like shoe making, tailoring, electrical work etc. Being an Islamic state, counseling through religious scholars is a common practice to make the addicts realize and get ready to give up drugs. Amedeo *et al*. (2006) suggested that supportive services like vocational trainings are very important for successful treatment. Emphasizing strongly on vocational services during residential treatment could prove helpful for clients to overcome barriers to employment.

Perception of Employees on the Nature of Drugs and Treatments Offered:

The current study establishes the perception of the employees on drugs and treatments given to addicts. The respondents were asked if the drugs and treatment given have any influence. Most of the respondents overwhelmingly supported that medicinal drugs used did affect the treatment. Most of the enrolled clients get fully well after the completion of the treatment.

Focus Group Discussions

An interview was conducted among various family members of drug addicts. The relationship of the participating members with addicts was of brother, uncle and cousin. The aim and purpose of the interview was made clear before to the participants. The participants disclosed that their loved ones are in

addiction from 1 to 2 years. They consider friend's environment the root cause of drug addiction. They had taken their loved ones for treatment in government and private hospitals but found government hospitals better, more caring and economically favorable as compared to private treatment centers. They added that private hospitals are expensive and lack most basic facilities,. It was further added that the government hospitals had a good system of feedback while the private hospitals had no feedback system. They found the environment of government hospitals supportive and conducive where the behaviors of the staff members were appreciated. Opinion whether the addicts get fully back to their normal life was divided. Some addicts got well and stopped drugs while some went back and started taking/ using narcotics again since they joined their addicted friends again. They suggested that the hospitals must increase their capacity of enrollment and allow the family members to meet their loved once a week. They showed the sign of satisfaction on the performance of the rehabilitation center to which a majority of parents of addicts agreed with outcomes of the rehab center.

The Performance of Rehab

The data provided by the Administrator of Detox and Rehab as how many patients got enrolled yearly from 2009-2016. The data shows a significant increase in the enrollment of patients in rehab. The data further indicates that the number of drug addicts is increasing in the society which is an alarming situation to both family members and the country. Therefore, a significant enrollment is seen in the data given below. The data provides strong basis of confidence development on the performance of Detox and Rehab among the performance and drug addicts both, confirming the dedication and commitment of Rehab to bring patients back to normal life.

Calendar Year	No. Of Patient in the Center
2009	91
2010	108
2011	135
2012	150
2013	198
2014	218
2015	251
2016	322

Figure: Performance of Social Welfare Detox and Rehabilitation Center

Figure: Yearly treated patents in social welfare rehabilitation center

Comparison of Detox and Rehab Vs Private Rehab (Milo Shaheed Trust)

The data (given below) obtained by making a comparison between Detox and Rehab and Milo Shaheed Trust show that both the organizations are treating the drug addicts to a great extent. Milo Shaheed Trust (A non-government, non-profitable organization) has been in action since 1989 and is located in the heart of Quetta City and is playing a key role in treating of drug addicts and rehabilitating their lives. Whereas, The Detox and Rehab has been in action since 2009 and located in the outskirts of Quetta (Eastern-by -pass) and getting popularity among the masses for its treating and rehabilitation purposes.

Year	2010	2011	2012	2013	2014	2015	2016
Detox and Rehab	108	135	150	198	218	251	301
Milo Shaheed Trust	313	329	311	303	337	350	402

Figure: yearly Treated Patients and Detox and Rehab Center with Milo Shaheed Trust

Figure: Compression Chart of Detox and Rehab Center with Milo Shaheed Trust

Discussion

Does the use of drugs such as methadone simply replace one drug addiction with another?

No. As used in maintenance, Methadone and LAAM do not replace heroin. They are safe and efficient drugs for opioid dependence that are administered orally in regular and fixed doses. Its pharmacological effects are markedly different from those of heroin. As used in maintenance treatment, Methadone and LAAM are not heroin supplements. "I injected, I smoked, I smoked heroin, I caused an almost instantaneous takeover or a brief period of euphoria that we do not know in a short time, and we signed a 'crash'." The individual then feels an intense desire to consume more heroin to stop the shock and restore euphoria. The cycle of euphoria, shock and desire, which is repeated several times a day, is a cycle of addiction and alteration of behavior. These characteristics of the use of the skin result from the rapid beginning of the drug action and its short duration of action in the support. An individual who uses heroin several times a day subjects his brain and body to be marked, rapid reactions to the flu while the optical effects come and go. These flu shots can alter a significant number of important bodily functions. Because heroin is illegal, people who participate in treatment often become part of a group of people living in the air due to haste and crimes for fitness. Methadone and LAAM have much more gradual action injections than heroin and, as a result, patients stabilized with these drugs do not undergo any alteration. Furthermore, both drugs disappear much more slowly than heroin, so there is no sudden shock and the brain and body are not exposed to the marked fluctuations observed with heroin use. Maintenance treatment with methadone or LAAM significantly reduces the desire for heroin. If a person is held in adequate doses, regular doses of methadone (once a day) or LAAM (several times a week) try to take heroin, the euphoric effects of heroin will be significantly higher. Patients undergoing maintenance therapy do not suffer from medical abnormalities or behavioral destabilization caused by rapid fluctuations in drug stages in heroin addicts.

Role of criminal justice system in the treatment of drug addiction

Increasingly, research is showing that treatment for drug-addicted offenses during and after hospitalization can have a significant beneficial effect on the future of drug use, criminal behavior and social functioning. The case of integrating therapeutic approaches for drug addiction with the criminal justice system is convincing. Combination treatment based in prison and in the community for treatment reduces the risk of both cancer and criminal behavior and the relapse of drug use. For example, a recent study established that inmates who participated in a treatment program in Delawa State Prison and continued to receive this program on a post-prison work release program, there are 70% less than anyone else. The participants return to drug use and support rest. Most invoices with the criminal justice system are not in jail, but they are supervised by the community. For people with known drug problems, an additional carpet may be recommended for treatment as a test condition. Research has shown that people who enter treatment under legal pressure have as favorable results as those entering voluntarily (Charles 1999). The criminal justice system makes drug agents who enter therapy through a variety of mechanisms, such as deviating non-violent criminals to treatment; stipulating treatment as a condition of promotion or prevention letting; setting up specialized courts. Who manages cases for drug-related crimes? The drug courts, another model, are dedicated to cases of drug offenses. They mandate and or-

ganize treatment as an alternative to prison, and monitor progress in treatment and other services for organized criminals involved in the drug. The most efficient models integrate criminal justice and systems for the treatment of risks and services. Treatment personnel and criminal justice work together in implementation of plans and monitoring and supervision, as well as on the systematic use of penalties and rewards for drug addicts in the criminal justice system.

How does pharmacological treatment work to reduce the spread of HIV/AIDS and other infectious diseases?

Many addicts, such as heroin or cocaine addicts and in particular people who inject drugs are at greater risk for HIV/AIDS and other infectious diseases such as hepatitis C, diseases and sexual infection. For these individuals and the community at large, the treatment of drug addiction is disease prevention. Drug injectors who do not enter treatment are up to six times more likely to be infected with HIV than injectors who enter and remain in treatment. Addicts who enter and continue treatment reduce the activities that can spread diseases, such as sharing syringes and engaging in unprotected sexual activity. Participation in treatments also offer opportunities for evaluation, advice and advice for additional services. The best drug abuse treatment programs provide HIV counseling and offer HIV testing to their patients.

Here are the 12 steps or self-help programs in the treatment of drug addiction

Self-help groups can integrate and extend the effects of professional treatment. Leading self-help groups are those that are affiliated with Alcoholics, Narcotics Anonymous (NA) and Anonymous Cocaine (CA), who are all based on the 12-step 20 21 model for smart recovery. Most drug addiction programs encourage patients to participate in a self-help group during and after formal treatment.

How can families and friends make a difference in the life of someone in need of care?

Families and friends can play a fundamental role in motivating people with drug problems to enter and stay in care. Family therapy is important, especially for adolescents. The participation of a family member in a person's treatment program can strengthen and extend the benefits of the program.

Is the treatment of drug addiction worth its cost?

The treatment of drug dependency is profitable in relation to drug use and related social and health costs. Treatment is less expensive than alternatives, not to mention drug addict's relief. For example, the average cost of a full year of methadone maintenance treatment is about $4,700 per patient, while a full year of incarceration costs about $18,400 per person. The treatment of drug addiction is a reduction in drug use and related social and health costs. According to various conservative estimates, every $1 invested in drug addiction treatment programs yields between $4 and $7 in reducing drug-related crime, criminal justice costs and theft alone. When health care savings are included, total savings can outweigh the costs at a 12 to 1 ratio. Major savings for the individual and society also result from significant declines in interpersonal conflicts, productivity improvements in the workplace and reductions in drug-related accidents.

Drugs are substances (solid, liquid or gas), that when consumed, breathed in, injected, smoked, absorbed through and reinforced may bring physiological alterations to normal body functions. "Drug abuse" is

defined to be self-administration of a drug in frequently significant quantities that may hamper an individual's ability to perform life activities efficiently and which may prove to be socially, physically, or emotionally harmful.

Addiction of any drug is referred to be a serious problem that badly affects the brain and behavior of an individual. The drugs change normal brain physiology creating so called better feelings of happiness, short-lived, and tend to have long-standing side effects on brain physiology and its performance (Donaghy, ME, 1997). Drug addiction is considered a serious, long-lasting, health worsening issue irrespective of sex, background or age of drug addicts. Nevertheless, it can be treated. Drug addiction goes on in some expected stages. Addicts feel the urge of craving and use drugs often, failing to quit by self-efforts. It is therefore, necessary to provide timely support and reasonable treatment to eradicate this fast-growing problem. Drug Rehabilitation Complexes therefore, become so important in the formation of drug addict free society (Broome, 1998).

Drug dependency (addiction) is generally a habit of daily consumption of drugs without which an individual can no longer stay comfortable and cannot do life activities. If drug intakes stop that may likely produce unwanted symptoms like vomiting, shaking of body, itching in bones, joint pain, diarrhea etc.

As in other parts of the country, Quetta is also facing the narcotics problem. Therefore, in Quetta three rehabilitation centers are functioning. Especially, the Government of Balochistan Social Welfare Rehabilitation Center is playing a vital role in this regard, the Rehabilitation Center is giving free treatment; teaching them different skills (i.e. making shoes, using computer, tailoring, educating; developing religious values; taking them towards sports; etc.

Conclusion

Results of the present study revealed that easily available psychoactive drugs in society; partial number of drug rehabilitation centers; lack of medicines in the rehabsl lack of doctors; etc. are key factors that hinder the process of treatment. Therefore, no measurable changes in terms of reduction in the number of drug abuses are seen in the society. A variety of supportive services were found to be in practice for enhancing rehabilitation processes. These trainings include life skills training; job counseling; skills like shoe making, tailoring, electrical work; etc. Being an Islamic State, counseling through religious scholars is a common practice to make the addicts realize and get ready to give up the drugs. Most of the respondents overwhelmingly supported that drugs used did affect the treatment. Most of the enrolled clients get fully well after the completion of the treatment. It was established that the Government Hospitals had good systems of feedback while the environment of Government Hospitals was supportive and conducive where the behaviors of the staff members were appreciated. The present study showed a signifi-cant increase in the enrollment of patients in rehab confirming the dedication, commitment and remarkable performance of Rehab to bring back the patients to the normal life.

The Detoxification and Rehabilitation Complex has been functioning since 2009 and located in the outskirts of Quetta (Eastern-by-pass) gaining popularity among the masses for its treatment and rehabilitation support playing a central role in the reduction of drug addicts in society.

Narcotics have become a global problem and have assumed to be a progressively serious issue internationally. So based on the

current study the following recommendations are suggested.

Recommendations

From the research findings the following recommendations were made:

There must be a clear policy to standardize the treatment measurements to certify that they are comprehensive and result bearing.

The Ministry of Health through the Government must give subsidy in the cost of treatment to the drug abusers.

The Ministry of health must make sure of the timely supply of medicines to drug rehabilitation centers.

Treatment Centers must ensure training of treatment personnel so that they become fully aware of the environment and nature of addicts.

The Government must increase the number of drug rehabilitation centers.

The Government must add some chapters regarding various forms of narcotics and their side effects and conduct seminars in the educational institutions to alert the young generation.

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Homelessness in Central and Eastern Europe

E. Sadowski (Erica Sadowski), S. Szydlowski (Steven Szydlowski)

Original Article

University of Scranton, P.A, U.S Master of Health Administration Graduate Program, USA

E-mail address:

Erica.sadowski@scranton.edu

Reprint address:

Erica Sadowski
University of Scranton, PA
Scranton, PA 18510
USA

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Pawel Czarnecki
Rector of the Warsaw Management University, Poland
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Abstract:

Objective: Homelessness is an increasing public health issue which has been observed on a global wide scale for decades. Within Europe, the current status accounts for a vast number of homeless individuals. Due to the nature of this growing problem, the rate of homelessness within Central and Eastern Europe requires strategizing as well as an in-depth analysis of existing literature. Several plausible causes of homelessness are highlighted such as migration, mental illness, and various other origins. This research explores national strategies and community-based

interventions in efforts to reduce homelessness and improve health status in surrounding European countries.

Methods and Materials: Research concerning homelessness is considered to be a secondary source research study. The information describes several factors which contribute to such prevalence in Central and Eastern Europe.

Conclusion: The research displayed an upward trend concerning homelessness rates within Central and Eastern Europe. There is an opportunity to create additional community-based interventions regarding the homelessness population as well as those who face social exclusion. Decreasing the rates of homelessness will assist the health system at large in addition to increasing the employment rate.

Introduction

According to the European Commission, homelessness is defined as "beyond sleeping rough, homelessness may include situations of living in temporary, insecure or poor-quality housing" (European Commission, 2018).

Prevalence

Currently there are approximately three million homeless individuals in Europe. An estimated 410,000 of these individuals are found sleeping in the country's streets. From the year of 2008 to 2014, the number of people at risk of poverty or social exclusion has increased from 116 million to 121 million. Overall, in fifteen of the European countries homelessness has increased in the last five years (Home EU, 2016). The status of homelessness may be associated with various contributing factors. These contributing factors include poverty; uncertain physical/mental health; family breakdown; societal barriers as well as many other issues. The poverty rate may be attributed to the unemployment rate and lack of affordable housing. Physical and mental health factors could be correlated to addictions which will lead to a decreased rate of access to care. Factors such as community and family breakdown may incorporate divorce and/or separation of parents or guardians which could potentially lead to increased homelessness rates. More often than not, citizens may not ponder societal barriers. Those who are homeless typically do not have a form of identification and even in some cases they are unable to obtain any citizenship. Upon Czechoslovakia splitting into separate entitles, a number of nationality problems arose. Not all individuals living on Czech territory were able to obtain citizenship. Other factors, could be migration, ageing, and inadequate support for people leaving care facilities, hospitals, prisons, or other institutions.

Statistics Tell a Story

In Slovakia, the poverty rate is 13%, the number of homeless individuals is about 23,500, and the health expenditure is 8.1% of the gross domestic product (Central Intelligence Agency, 2018).

In Czech Republic, the poverty rate is 9.7% and the total health expenditure of the gross domestic product is 7.4%. In the country of Czech Republic, the homeless population is significantly higher. The estimated number of homelessness individuals is about 65,500 (Central Intelligence Agency., 2018).

The country of Austria has a total poverty rate of 3% and the total health expenditure is 11.2% of the gross domestic product. In the city of Vienna, about 70% of the country's homeless population is found within the city. In total, there is about 15,000 homeless individuals. A prevention plan has been formulated for all three countries, however not all tasks of anticipation have been fulfilled such as social services.

Homelessness is a Health Threat

Homeless individuals may be predisposed to worse health outcomes due to a whole host of reasons. These factors may correlate to: poor living conditions; food insecurity; limited resources for self-care; little to no transportation just to state a few factors (Schrag.J. 2014). Homeless people may face: reduced life expectancy; health problems; discrimination; isolation; barriers to access to basic public services and benefits.

Among those who are classified as homeless several common health problems were observed. The most common health problems seen among homeless people are: mental disorders; alcohol and drug use; injuries; skin infections and infestations; poor foot and mouth care; poor compliance with medications; blood-borne viruses such as hepatitis B, hepatitis C and HIV (Homeless Healthcare, 2018). Homeless people are; six times more likely to die from suicide; 2.5 times more likely to die from natural causes; 15 times more likely to die from intentional harm than the general population (Homeless Healthcare, 2018).

Slovakia Health Profile Explored

According to the Slovakia Health Profile, Cardiovascular disease also known as CVD causes more than half of all deaths across the European Region. CVD causes 46 times the number of deaths and 11 times the disease burden caused by AIDS, tuberculosis and malaria combined in Europe. One must recognize, 80% of premature heart disease and stroke is preventable (World Health Organization, 2016). Also, non-communicable diseases account for 89% of all deaths. In the year 2016, the total population of Slovakia was 5,444,000. However, the total number of deaths in 2016 was 51,000 according to the World Health Organization.

Shortage of Resources

Globally, there is a shortage of health care professionals such as nurses, physicians, support staff, etc. The lack of physicians is concerning for the general population but the homeless population as well. There is a reduced access for primary care. In order to receive care, one would most likely be forced to visit the emergency department in which care coordination is an issue. In 2016, Bratislava had 6.8 physicians per 1000 population. Other regions of Slovakia, had 2.6 - 3.3 physicians per 1,000 (World Health Organization, 2016). The shortage of resources impacts the number of patients who visited the emergency department because primary care was not available. The shortage of resources correlates to medical education as well. As a health care system, efforts are needed to make the primary care realm more attractive. Currently, only 9% of medical graduates choose general practice due to compensation considerations.

Community Based Initiatives

A coffee shop in Slovakia known as *Dobre Dobre* strives to cope with the increased homeless population rate. They participate and follow the philosophy, "buy a homeless man a coffee, and he'll drink for ten minutes. Give him a job in a coffee shop and he may be able to stay off the street forever." *Dobre Dobre* provides income to homeless

individuals, attempts to adjust public policy and perception, the program provides counseling and job caching as well (Otte, E, 2017).

In other countries, such as Austria and Czech Republic homeless individuals are gaining employment as tour guides. In Austria, *Shades Tour Vienna* allows those who are homeless to gain employment. Every tour incorporates visits to an emergency night shelter, soup kitchen, and training social worker session (Independent (2016).

The tour's provided in the Czech Republic are a mimic of the layout in Austria. In the Czech Republic the company who provides the tour is known as *Pragulic. Pragulic* was launched in 2012 to provide employment to homeless individual's while raising awareness to such hardship. The tour guides receive a flat fee plus tips as well as free haircuts, assistance finding additional employment and access to a psychologist (Poverty Tourism, 2016). Also, the tour guides are offered various team building exercises. If you participate in such a tour in the Czech Republic, you are able to experience a 24-hour homeless experience.

Housing First Guide Europe, is a practical material bringing knowledge and experience together to create context which aims to support practitioners and policy makers. *Housing First* initiated five pilot programs in various major cities including Amsterdam, Budapest, Copenhagen, Lisbon and Aberdeen (Housing Future, 2018). All of the pilot programs, had succession rates over 50% after three years completion of the pilots.

Stopa Slovensko, is another community-based intervention which provides integrated services for at risk and extreme exclusion and/or poverty. *Stopa Slovensko's* philosophy is "one will never endure a second night out on the streets". The organization focuses heavily on prevention for individuals (Stopa Slovensko, 2016). It provides therapeutic activities and support communities by treating individuals. Also, *Stopa Slovensko* trains homeless individuals in: work skills; technology education; basic information technology skills; social work support; etc. (World Habitat, 2018).

Conclusion

Globally, a health care system must strive to provide adequate health services and strive for high quality of care at a low threshold cost. Clinicians should focus on the whole personality by tailoring health treatment to an individual's needs. There must be better care coordination from hospital to mental health services throughout not only the homeless population but other populations as well. The homeless population desperately needs additional shelters as well as integrated health services concerning primary care physicians.

Conclusion

In the year of 2020, one of Europe's overarching goals is to reduce the poverty level by 20 million. The Ministry of Health wishes to increase the effectiveness of existing polices which would include the right to housing. Currently, The Slovak Constitution does not contain provisions guaranteeing the right to housing, only provisions guaranteeing protection of privacy and protection of home (FEANTSA, 2018). Globally, the public support for the homeless is needed. Additional pilot programs are necessary such as *Housing First* and broadcast *Stopa Slovensko*. Efforts are needed to remove barriers concerning rental properties, discover options concerning additional shelters, as well as many other community-based initiatives to reduce homelessness.

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A Sociological Analysis of Road Accidents among Teenagers Motor Bike Riders in District Dir Lower, Khyber Pakhtunkhwa

S. Ullah (Sana Ullah)[1], A. Naz (Arab Naz)[2], B. Ali (Basit Ali)[3]

Original Article

[1] PhD Scholar (Sociology) University of Malakand, Khyber Pakhtunkhwa, Pakistan
[2] Professor in Sociology, Dean Social Sciences, University of Malakand, KPK, Pakistan
[3] PhD Scholar, Department of Sociology, AWKUM, Khyber Pakhtunkhwa, Pakistan

E-mail address:

sana_871@yahoo.com

Reprint address:

Sana Ullah
University of Malakand
Khyber Pakhtunkhwa
Pakistan

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Tadeusz Bak
Warsaw Management University, Poland
Daniel J. West, Jr.
University of Scranton, Department of Health Administration and Human Resources, USA

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Abstract:

Road accidents in general and among motor bike riders in particular are one of the growing health issues these days in Pakistan. Road accidents are a global concern, but the situation has become worsened particularly in Pakistan. It is an unfortunate fact that the issue is not given as

much importance as the issue persists. In road crash accidents, Pakistan stands 1st in Asia and 48th in the world, while the metropolitan city of Pakistan, Karachi is ranked as fourth in the list. Continuous fatal crashes among teenagers motor bike riders results in numerable deaths and injuries in Pakistan. Regular movement of military freight, rapid urbanization, excessive motorization, and congestion, increased the risks to road traffic users. The current study was carried out in District Dir Lower, province of Khyber Pakhtunkhwa, Pakistan. Primary data was collected from 30 respondents conveniently selected, including casualty staff of DHQ Timergara, THQ Chakdara, THQ Shamshi Khan Talash, parents, teenage motor bike riders, and traffic police inspectors. The collected data was qualitatively and thematically analyzed in order to clarify the issue under study. The study concluded that multiple social, economic and cultural factors contribute to road accidents among teenagers motor bike riders. The study also forwarded some suggestions.

Introduction

The use of motorcycles has increasingly become a popular means of transport in low and middle income countries around the world (World Health Organization, 2006). Every day, thousands of people lose their lives in roads accidents, while millions other are left with disabilities or emotional scars that they will carry for the rest of their lives (MacLeod *et al*., 2010). Around the world, children, teenagers and young adults are among the most vulnerable. Every hour of the day, forty youngsters die as a result of road traffic crashes, which means that every day another one thousand families have to cope with the unexpected loss of a loved one (Toroyan, 2015). The death of a teenager from preventable incidents further adds to the pain and suffering, and leave their families with emotional wounds that take decades to heal. The future of any country is its young people, and a nation cannot afford losing their youth on road traffic crashes. Males are more involved in road accidents, and similar results are found in various research studies, that young age males are more likely to be the victim in road traffic crashes (Waylen & McKenna, 2008). Similarly, among drivers, young males under the age of 25 years are almost three times as likely to be killed as their female counterparts. This may reflect the fact that because of the prevalent socio-cultural reasons males are more likely to be on the roads, and have a greater propensity to take risks as compared to females (Flamme, 1998). Besides, the socio-economic condition of a family also affects the likelihood of a teenage or youth being killed or injured in a road traffic crash, while those from economically poor backgrounds are at the greatest risk. This relationship is found not only between higher-income and lower-income countries, but within countries as well (Nantulya & Reich, 2002).

Road accidents among teenage motorbike riders are a global concern causing thousands of deaths and injuries each day, and traffic fatalities have increased by 46% from 1990 to 2010, and are expected to jump from the eighth to the fifth leading cause of death by 2030 (WHO, 2008). Motorbike accidents in general and among teenagers are particularly increasing and an estimated 92% of the annual road-traffic fatalities throughout the world occur in developing countries like Pakistan (WHO,

2013). While looking to this as a global concern, the United Nations has also declared the current decade 2011-2020 as the decade of Action for Road Safety (UNO, 2010). So, there is only one year left. Motorcycle riding among teenagers is rapidly increasing in Pakistan, attracting a much wider number of young adults than in the past decades. The overall number of road related accidents and deaths in Pakistan have been greatly increased in recent years. Many socio-cultural factors such as lack of driving experience, inappropriate safety awareness, training and education among teenage motorbike riders has increased the risks of road crashes among teenager riders (Savolainen & Mannering, 2008 and Lin & Kraus, 2009). Unfortunately, in District Dir Lower motorbike-related collisions among teenagers has been on the rise in recent years, and the amount of motorbike-related crashes in Dir Lower is much higher compared to crashes of other vehicles. The increased accident rates are due to a number of factors, including the amount of driving experience, family control, peer factors, lack of awareness regarding traffic rules, license status, and education level of the drivers. The issue calls for immediate attention of the research scholar to explore its socio-cultural causes to minimize the intensity of the issue in global as well as local context.

Study Rationale

Road accidents among teenage motorbike riders is a global concern and has emerged as a serious health issue. It costs millions of lives and left many million people either disabled or injured every year across the globe (Toroyan, 2015). The current figure of road related deaths shows that by 2020 it would be the world's third leading cause of deaths, while the introduction of two and three-wheeled vehicles has further worsened the situation (Astrom, Moshiro, Hemed, & Heuch, 2006 & Peden, 2004). It is predicated from the present rapid increase in motorbikes that by 2035 the two and three wheelers will increase by 175% reaching 550 million (The Clean Air Initiative for Asian Cities, 2011). The rapid rise is increasingly linked to the socio-economic situation of a country, as more citizens mainly purchase two and three wheeled vehicles, which results in the rise of road-traffic injuries and deaths (Kopits & Cropper, 2005; Paulozzi, Ryan, Espita & Hardeman, 2007). In this influx motorcycles are of particular concern because motorcycles are more dangerous than any other type of motorized vehicle, and motorcyclists were about 30 times more likely to die in a traffic crash than a passenger in a car (National Highway Traffic Safety Administration, 2012).

Approximately, 1,000 young people under the age of 25 years are killed in road traffic crashes on daily basis, while another 1.2 million people die of road crashes each year particularly in low-income and middle-income countries (WHO, 2013). Similarly, road traffic injuries are the leading cause of death among 15–19-year-olds teenagers; the second leading cause of death for those in the 10–14-years; 20–24-years age (Beeck, Borsboom, & Mackenbach, 2000). Further, the vast majority i.e. 90% of all road traffic deaths and injuries occur in low-income and middle-income countries including Pakistan (Peden *et al*., 2004); while children and young people under the age of 25 years account for over 30% of those who are killed or injured in road traffic crashes (WHO, 2002). Besides, many children and young people who have been involved in road traffic collisions are left with long-term or permanent injuries or disabilities (Jacob, Aeron & Astrop, 2000). Road accidents among teenage motorbike riders is a social issue having multiple socio-economic and cultural factors. But, the issue is always dealt with in relation to engineering perspectives

looking into road designs. However, the present study was conducted in District Dir Lower, Khyber Pakhtunkhwa, Pakistan in order to analyze the socio-cultural factors behind the issue which is of great sociological significance but very little has been done so far in exploring the social causes/factors of the issue, on which the present research will specifically focus.

Methodology

The study was conducted in District Dir Lower. Primary data was collected from a total of 30 respondents using convenient sampling techniques. In this regard, out of the total sample 10 respondents were teenage motorbike riders who have been in motorbike road accidents but were survived after sustaining minor or severe injuries. Further, 6 casualty staff members were selected, 2 each from District Headquarter Hospital Timergara, Tehsil Headquarter Hospital Chakdara and Tehsil Headquarter Hospital Shamshi Khan Talash Dir Lower. Furthermore, data was also collected from 8 parents whose son either died or sustained injuries because of motorbike accidents. Similarly, data was also collected from 6 Traffic Police Inspectors two each in Timergara, Talash and Chakdara in order to know their opinions regarding the issue. The study was qualitative in nature and data was collected through interview using an interview guide. The respondents were divided into three categories and codes were developed for each category of respondents such as for teenage motorbike riders' code was (1TMR) and for casualty staff members' code was (2CSM) for the parents of the teenagers, the code was (3PTMR) and for Traffic Police Inspectors the code was (4TPI). Also separate points, topics or questions were prepared and asked from all categories of the respondents. In the current study, a sample of 30 respondents is justified, because in similar qualitative nature studies conducted by Delawala & Ahmad in 1995 also utilized 18 and 30 sample size respectively.

Results and Discussion

Part-A

Demographic Characteristics of the Teenage Motorbike Riders

Age Group	Frequency	Percentage	Total
13-14	2	20	2
14-15	3	30	3
15-17	3	30	3
16- 18	2	20	2
Total	**10**	**100**	**10**
Family Types	**Frequency**	**Percentage**	**Total**
Joint Family	4	40	4
Nuclear Family	4	40	4
Extended Family	2	20	2
Total	**10**	**100**	**10**
Education	**Frequency**	**Percentage**	**Total**
Illiterate	3	30	3
Primary	2	30	2
Middle	3	30	3
Matric & above	2	20	2
Total	**10**	**100**	**10**
Marital Status			
Married	2	20	2
Unmarried	8	80	8
Total	**10**	**100**	**10**

The above table is about the demographic characteristics of the first category of respondents. Out of the total 10 respondents 2 (20%) were between the age of 13-14; 3 (30%) between 14-15; 3 (30%) between 15-17; the remaining 2 (20%) between 16-18 years. Further, 4 (40%) respondents each

were living in joint and nuclear families; 2 (20%) were living in extended families. Further, out of the total respondents 3 (30%) were illiterate, 2 (20%) were having primary education: 3 (30%) were educated up to middle level while the remaining 2 (20%) were educated up to matric and above. Out of the total respondents a very small number i.e. 2 (20%) were married; the remaining 8 (80%) were unmarried.

Demographic Characteristics of the Casualty Staff Members

Designation	**Frequency**	**Percentage**	**Total**
Senior Medical officer	2	33.3	2
Medical officer	2	33.3	2
Dispenser	1	16.6	1
Nurse	1	16.6	1
Total	6	**100**	6
Duty Hours	**Frequency**	**Percentage**	**Total**
8 00 am - 2 00 Pm	3	50	3
2 00 pm - 8 00 Pm	2	33.3	2
8 00 pm - 8 00 am	1	16.6	1
Total	**6**	**100**	**6**
Cases/Accidents related emergency/s Attended during duty per week	**Frequency**	**Percentage**	**Total**
1-2	2	33.3	2
2-3	3	50	3
3-4	1	16.6	1
Total	6	100	6

The above table portrays information about the second category of respondents i.e. casualty staff members. In this regard, out of the total 2 (33.3%) respondents were senior medical officers; 3 (33.3%) were medical officers; 1 (16.6%) were the category of dispensers; 1 (16.6%) were nurses. The table further indicates the duty hours of respondents and out of the total 3 (50%) respondents' duty hours were from 8:00 am to 2: 00 pm; 2 (33.3%) from 2:00 pm to 8:00 pm; only 1 (16.6%) from 8:00 pm to 8:00 am. Also, the table shows that the number of motorbike accident cases attended by respondents in their duty hours; 2 (33.3%) attended from 1-2, motorbike accidents cases; 3 (50%) attended 2-3 motorbike accidents in duty hours; 1 (16.6%) attended 3-4 motorbike accident cases during their duty hours.

Demographic Information of the Parents of Teenage Motorbike Riders

Age Group	**Frequency**	**Percentage**	**Total**
35-40	3	37.5	3
41-45	2	25	2
45-50	2	25	2
51-55	1	12.5	1
Total	**8**	**100**	**8**
Family Types	**Frequency**	**Percentage**	**Total**
Joint Family	3	37.5	3
Nuclear Family	3	37.5	3
Extended Family	2	25	2
Total	**8**	**100**	**8**
Education	**Frequency**	**Percentage**	**Total**
Illiterate	3	37.5	3
Primary	2	25	2
Middle	2	25	2
Matric & above	1	12.5	1
Total	**8**	**100**	**8**

The table above is about the demographic characteristics of third category (the parents of teenage motorbike riders). The analysis shows that out of the total respondents 3 (37.5%) were between the age of 35-40; 2 (25%) between 41-45; 2 (25%) between 45-50; 1 (12.5%) between 51-55 years. Similarly, the table indicate that out of the total respondents 03(37.5%) were belonging to joint family system, 03(37.5%) were living in nuclear families, and rest of respondents i.e. 02(25%) were living in extended family system. Further, the education status of the respondents shows that majority of them i.e. 03(37.5%) were illiterate, 02 (25%) each were educated up to primary and middle level, while only a small number i.e. 01(12.5%) education level was matric and above.

Part-2
Thematic Discussion

Teenager Developmental Factors and their Motorbike Accidents

Teenagers do not understand reaction to complex traffic situations in the same way as adults and because of their developmental immaturity they lack certain abilities that adults possess in handling difficult traffic environments. Their immaturity increases their risk to road traffic crashes. In addition, in their teens they want to exert physical energy; explore many things; want to play complicated and risky games which expose them to greater risks of being hit by another vehicle. Besides, teenagers may unconsciously take risks because they lack appropriate skills; seek sensation; seek new experiences irrespective of the risks associated to the experiences. This sensation seeking has been on the rise between the ages of 9 to 14 years, peaking in late adolescence or the early 20s, and then declining steadily with age (Arnett, 2002 & Zuckerman, 1994). Similar views were also by respondents during field interviews:

"……. It is true that children in their teenage are unable to handle difficult situation like adult. They are physically as well as mentally immature, seeking fun in everything including driving on the road …."(2CSM & 3PTMR)

Another respondent said that:

"……. Children in their teenage are immature and they are playing on the road with their motorbikes, which expose them to road crashes……" (2CSM).

Risk taking is a normal occurrence during adolescence, a distinguished period of an individual's development (Courtois, 2011). Barbalat et al. (2010) imply that adolescents tend to choose riskiest options because they like risk taking more than adults and ignore the future consequences of their choices. Regarding risk seeking among teenager motorbike riders and their road crashes a respondent was of the opinion that:

"….. *Teenagers are unaware of the consequences of risk taking on the roads because of their immaturity. They are absorbed in their own without having any consideration for the surroundings….." (2CSM & 3PTMR).*

Most of the risky behaviors are taken at adolescence which is both very harmful for a teenager himself as well as for others. These behaviors are commonly found in those individuals who are self-absorbed with egotistic impulse, having invalid experience and passing through an identity crisis, particularly increase his sensations seeking in speed and taking risks on the road (Coslin, 2003).

Parental Guidance, Support & Road Accidents

Parents play an important role in formation of the behavior of their young children,

and also make important decisions regarding the exposure of their children to risks. They also influence how often or how long children may be in traffic or on the road, and whether or not their children use child restraints or helmets. Similarly, parents serve as important role models for their children who in turn learn and imitate adults' actions and risks (OECD, 2004). There are also various learned behavioral factors among adults in relation to road traffic accidents including motorbike accidents. It was argued by a respondent during field interview that:

"..... I will feel no hesitation in saying that we the parents are responsible for the situation. Being a father I have to socialize my children in a decent way. Also providing motorbike to our teenage children is our fault....." (2CSM & 3PTMR).

In this regard, a study conducted by Bingham and Shope (2004) about risky driving among adolescents and young adults found that certain risky driving behavior among young drivers were the result of low level of parental monitoring, an increased parental permissiveness, and a weaker social bond. In fact, these individuals are likely to endanger themselves and others through risky driving (Bingham & Shope, 2004). In this regard, a respondent shared that:

"…….Parents has no check on their children, and do not monitor their activities. While purchase of a motorbike for a teenage child is a great mistake on the part of most parents....."(3PTMR).

Family environment and children socialization influence adolescent driving behavior and in a study by Taubman and Katz, (1997) found a close relation between risky driving, road accidents and family environment. Those parents of the young motorbike riders who see their parents as good role models, who are commitment to road safety and follow the define speed limits on the roads, tended to take lesser risks and they drove more carefully and less aggressively. However, teenagers whose parents are not following road safety measure and speed limits are taking more risks while driving (Jonah, Thiessen and Yeung, 2001). For validation an extract from an interview is mention below:

"……I will say that those parents do don't follow traffic rules and speed limits while driving set bad example for their, and they imitate our irresponsible road safety behavior...." (2CSM & 3PTMR).

Another respondent said that:

"..... In solving the issue the role of parents is very important. They should have some control over their children in order to bring reduction in the intensity of the issue ....." (4TPI).

Similarly, family factor is the most important in the creation of a high-risk profile in young drivers, and consequently high-risk drivers maintained the risky driving behavior of their parents, whereas low-risk drivers had attitudes to road safety similar their parents (Sabate, Arnau & Sala, 2014). Improvements in parental supervisory role at driving learning stage also promote teen drivers skills acquisition and reduction of their risky driving behaviors (Curry, Peek, Haman & Mirman, 2015). Conclusively, parents' socialization and family environment play significant role in behavior formation of the individual in general as well as related to driving.

Motorbike Accidents and Personality Dimensions

Two factors seems to be greatly associated with road accidents i.e. factors related to traffic environment and the human determinant i.e. the driver himself (Chliaoutakis, Demakakos, Tzamalouka, 2002) while the majority of the accidents are associated with human factor. Social factors are greatly contributing to road accidents, and accident of young motorbike drivers was associated with lack of tolerance, getting

easily irritated, expressing aggression and developing hostility towards other drivers, and not being able to control his/her emotions (Chliaoutakis et al., 2012). Similarly, it was found in a study conducted by Norris, Matthews & Riad (2000), that road accidents among motorbike riders is strongly influenced by high hostility among drivers on road and their poor self-esteem. Field information in this context reflects similar findings and a respondent explained that:

"……. Teenage motorbike drivers are indeed emotional, and lack tolerance. In order bypass one another they get involved in excessive speed……" (2CSM & 3PTMR).

In this context similar studies indicate that personality factors such as mental health, depression, aggression contribute to road accidents among young motorbike riders aged between 18 and 24 years (Javadi, Azad, Tahmasebi, Rafiei & Tajlili, 2015) and put the motorbike riders in high risk driving and life threatening consequences. Another respondent added that:

"….. In my opinion risky driving, over speeding and driving without caring for traffic rules are the major causes of road accidents among teenagers' motorbike riders….."(4TPI).

Another respondent admitted that:

"….. I have to admit that the risky attitude, over speeding and aggression during driving is putting our children at risk…." (2CSM).

There also exist strongest correlations between risky driving patterns and antisocial behavior, excessive alcohol consumption, social status, civic engagement, peer relationships and gender (Vassallo, Lahausse & Edwards, 2016). However, the risk taking characteristics mostly exist in teenagers and they have poor hazard anticipation skills which put the young motorbike drivers to the risks of road accidents (Waylen, McKenna, 2008 & McDonald, Goodwin, Pradhan & William, 2015).

Teenager Motorbike Accidents and its Relation to Speed

High speed increases the chance of death or severe injury among all road users particularly among youth. In addition, in higher speed it becomes difficult for a driver to stop and avoid an accident. Over speeding is much more likely to be a factor in a fatal crash when the driver is under 25 years old (Paris, Transport Research Centre, 2006), and it is amongst the most common traffic violation committed by young drivers in the initial years of driving (Australian Transport Safety Bureau, 2002). Among the young two-wheeler riders' speeding inclination is linked to other factors including general attitude to riding, riding behaviors i.e., engaging in competition and stunts, motives associated with riding fast, sensation seeking and traffic violations (Michael, Sharma, Mehrotra , Banu , Kumar & Sudhir, 2015). Having inclination towards high speed is one amongst many factors that increase the risks of accident among teenager motorbike riders. In this regard a respondent also shared that:

"…….I will argue that most of the motorbike accidents are because of over speeding. In order to bypass others on the roads these young drivers cross speed limits and violate traffic rules and safety measures ...." (4TPI).

Similarly, research studies indicate that in over speeding men have significantly greater inclination than women and the inclination towards over speeding is increasing when these drivers are getting more experience in driving (Styles *et al*., 2005). While among young motorcyclists (aged 10 - 16 years) the more the rider had experience the higher was the risk of accident (Rathinama, Nairb, Guptaa, Joshia & Bansala, 2007). During field interviews similar views were shared by respondents, an extract from an interview mentioned:

"……In my opinion both the experienced and inexperienced drivers are involved in risky speed. But an accident does not care for experience and inexperience but it is a sudden occurrence……" (2CSM & 4TPI).

Another respondent argued that:

"…. Teenagers are unaware of road safety measures and their over speed on the road is for competition, enjoyment and showing the superiority of himself and his bike….."(4TPI).

Research studies found that 35% of young motorbike riders did not respect safety distances from other vehicles; 20% of them were already involved in an accident (Michael, Sharma, Mehrotra, 2014). Over speeding was influenced by many factors such as lack of awareness about road safety; motives for speeding; speed competition; seeking enjoyment; desire to reduce travel time (Michael, Kumar & Sudhir, 2014). Conclusively, high speed, violating traffic rules, involving in speed competition on roads and seeking enjoyment in high speed were the main factors of road accidents among teenage motorbike riders.

Lack of Protection, Driving Without a License and Over Loading

Road safety is the biggest problem among teenage motorcyclist which makes them more vulnerable to accident (Ahmad & Nguyen, 2003). Furthermore, motorcyclists despite having high speeds do not wear helmets or provide helmets. An extract of interview:

"….. In my opinion most of motorcycle riders ignore road safety i.e. not wearing helmet, which is most dangerous…." (4TPI).

Similarly, the majority of the young motorbike riders do not possess a driving license. They are also not aware of the existence of the traffic rules and road signs; violate traffic rules; overestimate their driving skills (Chiu, Kuo, Hung & Chen, 2000). Similar findings were also found during field interviews and a respondent was of the view that:

"….. Majority of the motorcycle drivers do not have a license, and violate traffic rules regularly…." (4TPI).

In this regard, excessive carriage of passengers and goods also cause road accidents among motorbike riders. In rural as well as in urban areas there are tendencies among young motorcyclists to carry excessive passengers on one motorcycle, including heavy and hazardous goods like heavy petrol. A respondent argued that:

"….. Motorcycle is used for carrying more than one person. Also various goods of daily use are also transported through motorcycles….."(2CSM & 3PTMR, 4TPI).

Conclusion

The current research focused on the socio-cultural factors of road accidents among teenage motorbike riders in District Dir Lower, of Khyber Pakhtunkhwa. The issue was assessed with a sociological lens in order to highlight the socio-cultural aspects of the issue. The research concluded that road traffic accidents among teenage motorbike riders are increasing and result in many deaths, injuries and material loss around the world, including Pakistan. The young generation is more involved in accidents of motorbike due to several socio-cultural factors including their immaturity; lack of skills and experience; lack of parental control; inappropriate riding skills; desire for high speed; sensation seeking; lack of awareness regarding traffic rules and road safety measures. During the study, iIt was also found that road speed competition and stunt behavior were considered as fun; performed for show off and self-satisfaction; most motorcyclists had an accident performing

stunts or competitions. The study also found that road accidents among teenage motorbike riders is a social issue and the research has provided a better insight into the social factors influencing rider intentions, behavior and serious crashes.

Recommendations

Although there is no clear cut outline for avoiding road accidents, the research outlines certain suggestions to reduce road traffic crashes among youth particularly among teenage motorbike riders. In light of the findings of the research there is a dire need to look into the issue socially, focusing on creation of awareness; knowledge regarding traffic rules; recognition of various signals; use of road safety measures. The issue also requires financial investments in prevention efforts, and during designing of road safety initiatives policy-makers and leaders need to recognize young motorbike riders' vulnerabilities as well as their inexperience, developmental needs and allocate separate routes for them. In addition, the traffic department should improve license issuing system, i.e. issue license after skill and written test; ensure the implementation of traffic laws; make 18 years as a minimum age for motorbike riding. There is also need to challenge the notion that road traffic crashes are unavoidable; make room for a pro-active, preventive approaches in order to reduce motorbike accidents among teenagers preventing numerous deaths and injuries on the roads.

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