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REVIJA ZBORNICE ZDRAVSTVENE IN BABIŠKE NEGE SLOVENIJE -
ZVEZE STROKOVNIH DRUŠTEV MEDICINSKIH SESTER, BABIC IN ZDRAVSTVENIH TEHNIKOV SLOVENIJE

REVIEW OF THE NURSES AND MIDWIVES ASSOCIATION OF SLOVENIA



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OBZORNIK ZDRAVSTVENE NEGE

NAMEN IN CILJI

Obzornik zdravstvene nege (Obzor Zdrav Neg) objavlja izvirne in pregledne znanstvene članke na področjih zdravstvene in babiške nege ter interdisciplinarnih tem v zdravstvenih vedah. Cilj revije je, da članki v svojih znanstvenih, teoretičnih in filozofskih izhodiščih kot eksperimentalne, neeksperimentalne in kvalitativne raziskave ter pregledi literature prispevajo k razvoju znanstvene discipline, ustvarjanju novega znanja ter redefiniciji obstoječega znanja. Revija sprejema članke, ki so znotraj omenjenih strokovnih področij usmerjeni v ključne dimenzije razvoja, kot so teoretični koncepti in modeli, etika, filozofija, klinično delo, krepitev zdravja, razvoj prakse in zahtevnejših oblik dela, izobraževanje, raziskovanje, na dokazih podprto delo, medpoklicno sodelovanje, menedžment, kakovost in varnost v zdravstvu, zdravstvena politika idr.

Revija pomembno prispeva k profesionalizaciji zdravstvene nege in babištva ter drugih zdravstvenih ved v Sloveniji in mednarodnem okviru, zlasti v državah Balkana ter širše centralne in vzhodnoevropske regije, ki jih povezujejo skupne značilnosti razvoja zdravstvene in babiške nege v postsocialističnih državah.

Revija ima vzpostavljene mednarodne standarde na področju publiciranja, mednarodni uredniški odbor, širok nabor recenzentov in je prosto dostopna v e-obliki. Članki v Obzorniku zdravstvene nege so recenzirani s tremi zunanjimi anonimnimi recenzijami. Revija objavlja članke v slovenščini in angleščini in izhaja štirikrat letno.

Zgodovina revije kaže na njeno pomembnost za razvoj zdravstvene in babiške nege na področju Balkana, saj izhaja od leta 1967, ko je izšla prva številka Zdravstvenega obzornika (ISSN 0350-9516), strokovnega glasila medicinskih sester in zdravstvenih tehnikov, ki se je leta 1994 preimenovalo v Obzornik zdravstvene nege. Kot predhodnica Zdravstvenega obzornika je od leta 1954 do 1961 izhajalo strokovno-informacijsko glasilo Medicinska sestra na terenu (ISSN 2232-5654) v izdaji Centralnega higienskega zavoda v Ljubljani.

Obzornik zdravstvene nege indeksirajo: CINAHL (Cumulative Index to Nursing and Allied Health Literature), ProQuest (ProQuest Online Information Service), Crossref (Digital Object Identifier (DOI) Registration Agency), COBIB.SI (Vzajemna bibliografsko-kataložna baza podatkov), Biomedicina Slovenica, dLib.si (Digitalna knjižnica Slovenije), ERIH PLUS (European Reference Index for the Humanities and the Social Sciences), DOAJ (Directory of Open Access Journals), J-GATE, Index Copernicus International.

SLOVENIAN NURSING REVIEW

AIMS AND SCOPE

Published in the Slovenian Nursing Review (Slov Nurs Rev) are the original and review scientific and professional articles in the field of nursing, midwifery and other interdisciplinary health sciences. The articles published aim to explore the developmental paradigms of the relevant fields in accordance with their scientific, theoretical and philosophical bases, which are reflected in the experimental and non-experimental research, qualitative studies and reviews. These publications contribute to the development of the scientific discipline, create new knowledge and redefine the current knowledge bases. The review publishes the articles which focus on key developmental dimensions of the above disciplines, such as theoretical concepts, models, ethics and philosophy, clinical practice, health promotion, the development of practice and more demanding modes of health care delivery, education, research, evidence-based practice, interdisciplinary cooperation, management, quality and safety, health policy and others.

The Slovenian Nursing Review significantly contributes towards the professional development of nursing, midwifery and other health sciences in Slovenia and worldwide, especially in the Balkans and the countries of the Central and Eastern Europe, which share common characteristics of nursing and midwifery development of post-socialist countries.

The Slovenian Nursing Review follows the international standards in the field of publishing and is managed by the international editorial board and a critical selection of reviewers. All published articles are available also in the electronic form. Before publication, the articles in this quarterly periodical are triple-blind peer reviewed. Some original scientific articles are published in the English language.

The history of the magazine clearly demonstrates its impact on the development of nursing and midwifery in the Balkan area. In 1967 the first issue of the professional periodical of the nurses and nursing technicians Health Review (Slovenian title: Zdravstveni obzornik, ISSN 0350-9516) was published. From 1994 it bears the title The Slovenian Nursing Review. As a precursor to Zdravstveni obzornik, professional-informational periodical entitled a Community Nurse (Slovenian title: Medicinska sestra na terenu, ISSN 2232-5654) was published by the Central Institute of Hygiene in Ljubljana, in the years 1954 to 1961.

The Slovenian Nursing Review is indexed in CINAHL (Cumulative Index to Nursing and Allied Health Literature), ProQuest (ProQuest Online Information Service), Crossref (Digital Object Identifier (DOI) Registration Agency), COBIB.SI (Slovenian union bibliographic / catalogue database), Biomedicina Slovenica, dLib.si (The Digital Library of Slovenia), ERIH PLUS (European Reference Index for the Humanities and the Social Sciences), DOAJ (Directory of Open Access Journals), J-GATE, Index Copernicus International.

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Editorial / Uvodnik

Health literacy: the key to better health

Zdravstvena pismenost: ključ do boljšega zdravja

Tamara Štemberger Kolnik^{1, 2, *}

Over the past thirty years, health literacy has received considerable attention across the globe. The HLS-EU Consortium (Bauer, 2018) summarises the World Health Organization's (1998) definition of health literacy as a concept encompassing an individual's cognitive and social abilities in terms of recognising and applying useful health information. The situation the world is facing amidst the current pandemic has shown the importance of awareness-raising and the provision of information which is clearly comprehensible, accessible and useful in daily life. This is the only way to achieve a high level of awareness and responsibility which will enable individuals to take care of their own health, understand health instructions and orient themselves within the healthcare system when they need it. These are the key messages of health literacy at the level of an individual. An increasingly important health issue in Europe and beyond (Kickbusch, 2013; Kickbusch, et al., 2013), health literacy refers to the ability of people to meet the complex requirements of maintaining their health within modern society.

In the past, the conceptual understanding of health literacy was strongly focused on the challenges associated with health treatment and the traditional role of the patient within the healthcare system, but over time and through in-depth investigation, this notion has evolved. Today, the concept goes well beyond the techniques of the acquisition of knowledge related to health within the healthcare system. It now incorporates the skills and abilities to search for health-related information, critically assess the information obtained, and integrate it into one's own life in the direction of maintaining one's health related to the health of the community (Sorensen, et al., 2015). Along these lines, we interpret the development of the concept as one directed towards raising the health literacy of an individual or a population with the aim

of promoting a responsible attitude towards one's own health and the health of the community, and primarily towards strengthening the patient's active role in the treatment process (Sørensen, et al., 2015). While raising the health literacy of individuals and the population, the strategy of patient treatment by healthcare providers must be aimed towards improving the self-efficacy of patients. In this regard, Batterham and colleagues (2016) and Lee and colleagues (2016) associate health literacy with the work of healthcare professionals and their attitude towards the patient, an attitude which should evolve from an authoritative approach to a collaborative one. A high level of health literacy is the foundation not only for a healthy daily life, but also for the management of potential chronic diseases, and represents the basis for seeking appropriate help within the healthcare system when needed. Sørensen (2016) stresses that health literacy is influenced not only by the information the patient obtains from the healthcare system but also by personal, situational, social and environmental factors. Personal factors include, for example, age, gender, race, socio-economic status, level of educational attainment, occupation, employment, income and general literacy (Parnell, 2015). Situational factors, on the other hand, include social support, family and peer influences, media use and one's physical environment (Rowlands, et al., 2017), while social and environmental factors include one's demographic status, culture, language, as well as political forces, and social systems (Sørensen, 2016).

Health literacy at the societal level

Despite the fact that European health policy makers devote increasing attention to the "health for all" principle and support the individual and the community in maintaining health, researchers

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and experts note that the data on the state of health literacy in Europe are nevertheless scarce (Sorensen, et al., 2015; Paasche-Orlow, et al., 2018). Health literacy therefore poses an important challenge to health policies and practices across Europe. Sørensen, and colleagues (2015) believe that the approach to the development of a health-literate population at the national level requires the knowledge of population characteristics and a systematic, comprehensive national programme or strategy.

Lower levels of individual or community health literacy are associated with poor health-related knowledge, failure to manage chronic diseases and frequent entries into the healthcare system (Rowell, et al., 2015), resulting in higher costs (Hedelund Lausen, et al., 2018). The reasons for lower levels of health literacy cannot be attributed solely to individuals' lack of knowledge or motivation, nor to their incompetence. Instead, poor health literacy should be viewed as a social concept reflected in individuals' social conditions and the challenges they face in their current living and working environments (Bauer, 2018). The level of health literacy depends on communication within the healthcare system, the complexity of the healthcare system and a clear and simple navigation through the system. Clarity in health communication allows for a quick and easy reception of the provided health information, and its application in daily life, which is crucial for the self-efficient management of health problems and fast navigation through the healthcare system (Schaeffer, et al., 2018). In the context of treating patients with chronic diseases, the World Health Organization (2013) cautions against focusing on acute episodes and hospital treatment, as this creates a patient dependent on the healthcare system. If we wish to raise the health literacy of the population and promote self-efficacy in the management of chronic diseases, treatment must include various specialists and different levels of the healthcare system all working together to achieve an active participation of the patient in the treatment process. Schaeffer and colleagues (2018) point out that healthcare systems are not yet ready for such treatment and for the growing need for the provision of credible information and support to patients in maintaining health or managing chronic diseases. In developed countries, healthcare systems are often too complex for the user, while the information patients receive within the system is often too complicated and provided in language that is difficult to understand (Kanj & Mitic, 2009). These problems may also be accompanied with the high expectations of healthcare professionals who demand an active engagement of the patient in the process of treatment and rehabilitation. Health literacy is thus, on the one hand, a concept that is becoming increasingly important in modern society, and on the other hand also one associated with often insurmountable challenges faced by the individual

(Schaeffer, et al., 2018). Therefore, the development of a health-literate society requires an integrated inter-ministerial approach which will allow for a vigorous action of the entire society in the direction of reinforcing the responsibility for one's own health. This process requires active engagement of the school system – through integration of health-related topics into school curricula –, of work organizations – through a responsible attitude towards the health of their employees –, as well as a responsible involvement of the healthcare system, and, not least, of policies and research institutions, as it is only through such joint action that a national strategy for enhancing the level of health literacy of the population can be developed (Brooks, et al., 2017).

Specific health literacy

Babnik and colleagues (2013) outline the development of the concept of health literacy in the following three key directions: (1) towards a predominantly medically-oriented concept, which focuses on individuals as the users of the healthcare system in which they obtain health-related information (World Health Organization, 1998; American Medical Association, 1999); (2) towards a broader approach focused on public health issues, which emphasises the dynamics of the relationship between the individual, the healthcare system and one's living and working environment (Mårtensson & Hensing, 2012; Sørensen, 2013), and (3) towards the development of interpretations of specific health literacy as interpretations of programmes intended for a specific population, whose aim is to promote functional health literacy in the field of the health needs of individuals related to chronic illnesses (Coffman, et al., 2012; Mullen, 2013; Wawrzyniak, et al., 2013; Tzeng, et al., 2018).

Specific health literacy is also associated with individual population groups, as each vulnerable group is characterised by certain specific features which need to be taken into account. In this context, the elderly represent a particularly vulnerable population group. What is especially important in facilitating the advancement of health literacy in this group is appropriate communication, taking into account the decline in cognitive abilities, and an appropriate response to the specific health needs of individuals (Brooks, et al., 2017). Another vulnerable group with equally distinct specific features is that of children and young people. Research shows that improving health literacy in early childhood is key to one's development and personal health (Guo, et al., 2018) in adulthood (Bröder, et al., 2017). Specific health literacy thus defines vulnerable groups as special groups of patients with specific health problems who often need healthcare services, which is often associated with lower levels of health literacy and a lower quality of life (Paasche-Orlow, et al., 2018).

Instruments for enhancing health literacy

Health literacy is a lifelong process which can be enhanced through learning and can thus be seen as a measurable outcome of health education and health promotion. As with all forms of learning, any major differences in the teaching methods, media and content used will lead to different outcomes. There are two elements to the process of enhancing health literacy, namely: the provision of health information through more personal forms of communication, and the provision of health information through information media such as television, radio and modern forms of online media outlets (Nutbeam, 2015). In such a flood of health-related information, an individual may find it extremely challenging to extract those bits of information which are credible, evidence-based and professionally supported. Modern sources of information often use health as a marketing strategy. In terms of personal health literacy, health literacy may be briefly defined as an individual's skills and abilities to obtain and apply health-related information (Nutbeam, 2000).

The fact that the information people obtain and trust affects the level of health literacy (Tzeng, et al., 2018), is reflected in various areas. People with lower levels of health literacy are not aware of the importance of preventive check-ups and a healthy lifestyle and are not familiar with their health status (Morris, et al., 2006). Low levels of health literacy are associated with more frequent emergency medical visits and more frequent and prolonged hospitalisations (Baker, et al., 2002). Horvat and colleagues (2018) associate low levels of health literacy with inappropriate use of medicines, while Zarcadoolas and colleagues (2006) also mention the non-use or inappropriate use of health services, inadequate management of chronic diseases, irresponsible behaviour in emergency situations, poor health, lack of self-esteem and confidence, social inequality and reduction in personal and social expenses.

Schiavo (2014) defines health communication as a tool which represents the path to the improved health literacy of the individual and the population. According to the author, health communication includes the use of human, multimedia and other communication skills and technologies for informing the public on health-related issues and presenting strategic plans within in the healthcare sector.

The purpose of health communication is to create unified linguistic, cultural and innovative communication, which is to be applied by the healthcare system and other media engaged in health promotion (Babnik & Štemberger Kolnik, 2013). Relying on various programmes, health communication is a planned process of influencing social changes which promote a change in the lifestyle habits of individuals and the community in the field of public health. As

such, it can be used to enhance the health literacy of the population at the national level. Tools such as health promotion and health education are closely associated with public health practice and education or training (Simons-Morton, 2013) with the aim of promoting health in the context of socio-environmental changes or changes in personal health. Through unified health communication at all levels of social life, we can provide the patient with support in the event of a change in their lifestyle habits, and, in the long run, prevent the spread of unhealthy lifestyle habits. Health literacy is related to an individual's knowledge, critical awareness, contemplation and personal development in terms of making qualified decisions both in the private sphere and in society, where the individual can influence political decisions aimed at creating a healthy and supportive environment so as to improve quality of life (Sørensen, 2013).

The concept of health literacy can thus be defined as lifelong learning which engages the individual as well as the community in developing the opportunities and abilities to maintain their health and the health of the community. Within the healthcare system, nurses monitor the population and have the opportunity to offer guidance to vulnerable groups and patients with chronic diseases, engage in acute health-related situations and carry out promotional activities aimed at supporting the individual and raising collective awareness for better health. At the level of primary, secondary and tertiary prevention, preventive programmes provide the platform for a wide range of activities directed towards raising the health literacy of individuals and the population. To create an orderly and sustainable healthcare system, it is essential to have healthcare professionals who are aware of the fact that a high level of health literacy is the key to having autonomous patients who know how to take care of their own health and are actively involved in treatment or rehabilitation. A highly health-literate population implies that everyone is able to make the best decisions when choosing health-related behaviour patterns and when entering the healthcare system. Given that the European Survey (Sørensen, 2013) found that the countries included in the survey show a low level of health literacy, which was also found in a smaller-scale survey conducted in Slovenia (Kozar, 2013), it should be noted that as healthcare professionals we need to be keenly aware of the fact that the patient in treatment may not understand the instructions received.

Slovenian translation / Prevod v slovenščino

V zadnjih tridesetih letih je bilo zdravstveni pismenosti v svetu namenjeno veliko pozornosti. Evropski konzorcij za zdravstveno pismenost (Bauer, 2018) povzema definicijo Svetovne zdravstvene organizacije (World Health Organization, 1998),

v kateri je zdravstvena pismenost definirana kot koncept, ki zajema kognitivne in socialne sposobnosti posameznika na področju prepoznavanja in uporabe koristnih zdravstvenih informacij. Situacija, s katero se sooča svet v času pandemije, je pokazala, kako pomembno je ozaveščanje ljudi ter posredovanje razumljivih in dostopnih informacij, uporabnih v vsakdanjem življenju. Le tako lahko pri posameznikih dosežemo visoko stopnjo ozaveščenosti in odgovornosti, ki jim omogoča, da znajo skrbeti za lastno zdravje, razumejo navodila s področja zdravja in se znajdejo v zdravstvenem sistemu, ko to potrebujejo. To so ključna sporočila zdravstvene pismenosti na ravni posameznika. Gre za vse pomembnejše zdravstveno vprašanje tako v Evropi kot tudi širše (Kickbusch, 2013; Kickbusch, et al., 2013).

Zdravstvena pismenost se nanaša na zmožnosti ljudi, da izpolnjujejo kompleksne zahteve za ohranjanje zdravja v sodobni družbi (Rowell, et al., 2015). Konceptualno razumevanje zdravstvene pismenosti je bilo močno naravnano na izzive, povezane z zdravljenjem in tradicionalno vlogo pacienta v zdravstvenem sistemu, vendar se je s časom in poglobljenim proučevanjem tovrstno pojmovanje razširilo. Danes koncept presega tehnike pridobivanja znanj, povezanih z zdravjem znotraj zdravstvenega sistema. Razteza se na možnosti in znanja za iskanje informacij, pomembnih za zdravje, kritično presojo pridobljenih informacij ter njihovo povezavo z lastno življenjsko situacijo v smeri ohranjanja lastnega zdravja, povezanega z zdravjem skupnosti (Sørensen, et al., 2015). V skladu s tem razumemo razvoj koncepta v smeri učinkov dviga zdravstvene pismenosti posameznika ali populacije s ciljem spodbuditi odgovornost do lastnega zdravja in zdravja skupnosti, predvsem pa krepiti aktivne vloge pacienta v procesu zdravljenja (Sørensen, et al., 2015). Ob dvigu zdravstvene pismenosti posameznika in populacije je ključnega pomena usmeriti strategijo obravnave pacienta s strani izvajalcev zdravstvenih storitev v izboljšanje samoučinkovitosti pacientov. Ob tem Batterham in sodelavci (2016) ter Lee in sodelavci (2016) z zdravstveno pismenostjo povežejo tudi delovanje zdravstvenih delavcev in njihov odnos do pacienta, ki naj bi se spreminjal iz avtoritativnega pristopa v sodelovalnega. Visoka stopnja zdravstvene pismenosti je temelj zdravega vsakdanjega življenja, obvladovanja morebitnih kroničnih obolenj ter podlaga za iskanje ustrezne pomoči v zdravstvenem sistemu, ko je to potrebno. Sørensenova (2016) poudarja, da na zdravstveno pismenost poleg informacij, ki jih pacient pridobi v zdravstvenem sistemu, vplivajo tudi osebni, situacijski, družbeni in okolijski dejavniki. Med osebne dejavnike spadajo na primer starost, spol, rasa, socialno-ekonomski status, izobrazba, poklic, zaposlovanje, dohodek in splošna pismenost (Parnell, 2015). Situacijske determinante zajemajo socialno podporo, družinske in vrstniške

vplive, uporabo medijev in fizično okolje (Rowlands, et al., 2017), družbene in okolijske dejavnike pa opišemo kot demografski položaj, kulturo, jezik, politične sile in družbene sisteme (Sørensen, 2016).

Zdravstvena pismenost na ravni družbe

Kljub vse večji pozornosti evropskih oblikovalcev zdravstvene politike, usmerjeni v »zdravje za vse« ter podporo posamezniku in skupnosti pri ohranjanju zdravja, raziskovalci in strokovnjaki ugotavljajo, da je podatkov o stanju zdravstvene pismenosti v Evropi malo (Sorensen, et al., 2015; Paasche-Orlow, et al., 2018). Zato zdravstvena pismenost predstavlja pomemben izziv za zdravstvene politike in prakse po vsej Evropi. Sørensen in sodelavci (2015) menijo, da pristop k razvoju zdravstvene pismene populacije na državni ravni zahteva poznavanje populacijskih značilnosti z oblikovanjem sistematičnega, celovitega nacionalnega programa oziroma strategije.

Nizka stopnja zdravstvene pismenosti posameznika ali populacije je povezana s slabim zdravstvenim znanjem, neobvladovanjem kroničnih obolenj in pogostimi vstopi v zdravstveni sistem (Rowell, et al., 2015), pa tudi z višjimi stroški slednjega (Hedelund Lausen, et al., 2018). Razloge za nizko stopnjo zdravstvene pismenosti ne gre pripisati izključno pomanjkljivemu znanju ali motivaciji posameznika ter njegovi nekompetentnosti. Upoštevati jo je treba kot družbeni koncept, ki se odraža v družbenih razmerah, v katerih ljudje živijo, ter izzivih, s katerimi se soočajo v življenjski situaciji in v trenutnem okolju, v katerem živijo in delajo (Bauer, 2018). Pomembni dejavniki zdravstvene pismenosti so komunikacija v zdravstvenem sistemu, kompleksnost zdravstvenega sistema in razumljiva ter enostavna navigacija po njem. Razumljiva zdravstvena komunikacija omogoča hitro in enostavno sprejemanje podanih zdravstvenih informacij ter njihovo uporabo v vsakdanjem življenju, kar je ključnega pomena za samoučinkovito obvladovanje zdravstvenih težav in hitro navigacijo po zdravstvenem sistemu (Schaeffer, et al., 2018). Svetovna zdravstvena organizacija (2013) opozarja na obravnavo pacienta s kroničnimi obolenji, usmerjeno na akutne epizode in bolnišnično zdravljenje, kar ustvarja pacienta, odvisnega od zdravstvenega sistema. Za dvig zdravstvene pismenosti populacije in spodbujanje samoučinkovitosti na področju obvladovanja kroničnih bolezni je nujno v obravnavo vključiti različne strokovnjake in različne ravni zdravstvenega sistema, ki delujejo v smeri aktivne udeležbe pacienta v procesu zdravljenja. Schaefferjeva in sodelavci (2018) opozarjajo, da zdravstveni sistemi niso pripravljeni na tovrstno obravnavo ter naraščajoče potrebe po verodostojnih informacijah in podpori pacienta pri ohranjanju zdravja ali obvladovanju kroničnih obolenj. V razvitih državah so zdravstveni sistemi pogosto preveč kompleksni in za uporabnika zapleteni,

informacije, ki jih pacienti dobijo v zdravstvenem sistemu, pa prekompleksne in podane v uporabniku nerazumljivem jeziku (Kanj & Mitic, 2009). Na drugi strani so pogosto velika pričakovanja zdravstvenih delavcev, ki zahtevajo aktivno vključevanje pacienta v proces zdravljenja in rehabilitacije. Zdravstvena pismenost tako postaja po eni strani koncept, ki ima vse večji pomen v sodobni družbi, hkrati pa je povezan z izzivi posameznika, ki jim pogosto ni kos (Schaeffer, et al., 2018). Za razvoj zdravstveno pismene družbe je tako potreben integriran medresorni pristop, ki bi omogočil intenzivno delovanje celotne družbe v smeri krepitev odgovornosti do lastnega zdravja. V tem procesu odigrajo pomembno vlogo šolski sistem z vključevanjem zdravstvenih vsebin v učne programe, odgovornost delovnih organizacij do zdravja zaposlenih, odgovornost zdravstvenega sistema ter ne nazadnje odgovornost politike in raziskovalnih inštitucij, ki le skupaj lahko ustvarijo nacionalno strategijo za dvig zdravstvene pismenosti populacije (Brooks, et al., 2017).

Specifična zdravstvena pismenost

Babnik in sodelavci (2013) so razvoj koncepta zdravstvene pismenosti opredelili v treh ključnih smereh: (1) v smeri pretežno v medicino usmerjenega koncepta, ki se osredotoča na posameznika kot uporabnika zdravstvenega sistema, v katerem pridobiva informacije, povezane z zdravjem (World Health Organization, 1998; American Medical Association, 1999); (2) v smeri širšega pristopa, usmerjenega v javnozdravstvene probleme, ki poudarjajo dinamiko odnosa med posameznikom, zdravstvenim sistemom in okoljem, v katerem živi in dela (Mårtensson & Hensing, 2012; Sørensen, 2013), ter (3) v smeri razvoja razlag specifične zdravstvene pismenosti, ki predstavljajo razlage programov, namenjenih specifični populaciji za funkcionalno zdravstveno opismenjevanje na področju individualnih zdravstvenih potreb, povezanih s kroničnim obolenjem (Coffman, et al., 2012; Mullen, 2013; Wawrzyniak, et al., 2013; Tzeng, et al., 2018).

Specifična zdravstvena pismenost se veže tudi na posamezno populacijsko skupino, saj ima vsaka ranljiva skupina posebnosti, ki jih je treba upoštevati ob delu z njo. Posebej ranljiva skupina prebivalstva so starejši. Za podporo pri dvigu nivoja zdravstvene pismenosti so v tej skupini še posebej pomembni primerna komunikacija, upoštevanje upada kognitivnih sposobnosti ter odzivanje na specifične, individualne zdravstvene potrebe (Brooks, et al., 2017). Otroci in mladi imajo kot posebna ranljiva skupina svoje posebnosti. Raziskovalci ugotavljajo, da je izboljšanje zdravstvene pismenosti v zgodnjem otroštvu ključnega pomena za razvoj in osebno zdravje (Guo, et al., 2018) v starejšem obdobju (Bröder, et al., 2017). Specifična zdravstvena pismenost opredeljuje ranljive

skupine ali posebne skupine pacientov s specifičnimi zdravstvenimi problemi, ki večkrat potrebujejo storitve zdravstvenega sistema, kar je pogosto povezano z nižjo stopnjo zdravstvene pismenosti in nižjo kakovostjo življenja (Paasche-Orlow, et al., 2018).

Orodja za dvig zdravstvene pismenosti

Zdravstvena pismenost je vseživljenjski proces, ki se izboljšuje z učenjem in se lahko šteje kot izmerljiv izid zdravstvene vzgoje in promocije zdravja. Tako kot pri vseh oblikah učenja bodo pomembne razlike v učnih metodah, medijih in vsebini privedle do različnih rezultatov. Izboljšanje zdravstvene pismenosti vključuje dva elementa: posredovanje zdravstvenih informacij z bolj osebnimi oblikami komuniciranja ter posredovanje zdravstvenih informacij s pomočjo informacijskih medijev, kot so televizija, radio in sodobne oblike internetnih možnosti (Nutbeam, 2015). V poplavi informacij, povezanih z zdravjem, je za posameznika velik izziv izluščiti tiste, ki so verodostojne, znanstvene in strokovno podprte. Sodobni viri informiranja zdravje pogosto uporabijo kot marketinško potezo. Z vidika individualne zdravstvene pismenosti lahko na kratko opredelimo zdravstveno pismenost tudi kot posameznikovo sposobnost in veščine, ki jih uporablja za pridobivanje in uporabo z zdravjem povezanih informacij (Nutbeam, 2000).

Informacije, ki jih ljudje pridobivajo in jim zaupajo, vplivajo na stopnjo zdravstvene pismenosti (Tzeng, et al., 2018), kar se odraža na različnih nivojih. Ljudje z nižjo stopnjo zdravstvene pismenosti se ne zavedajo pomembnosti preventivnih pregledov in zdravega načina življenja ter ne poznajo svojega zdravstvenega stanja (Morris, et al., 2006). Nizka stopnja zdravstvene pismenosti je povezana s pogostejšimi obiski nujne medicinske pomoči ter s pogostejšo in daljšo hospitalizacijo (Baker, et al., 2002). Horvat in sodelavci (2018) nizko stopnjo zdravstvene pismenosti povezujejo z neprimerno uporabo zdravil, Zarcadoolas in sodelavci (2006) pa še z neuporabo ali neprimerno uporabo zdravstvenih storitev, neprimernim obvladovanjem kroničnih obolenj, neodgovornim ravnanjem v urgentnih situacijah, slabim zdravstvenim stanjem ljudi, pomanjkanjem lastnega ugleda in samozavesti, socialno neenakostjo ter racionalizacijo lastnih in družbenih stroškov.

Schiavo (2014) definira zdravstveno komunikacijo kot orodje, ki predstavlja pot do boljše zdravstvene pismenosti posameznika in populacije. Zdravstvena komunikacija po avtorjevem mnenju zajema uporabo človeških, multimedijskih in drugih komunikacijskih spretnosti in tehnologij za informiranje o zdravstvenih vprašanjih ter podajanje strateških načrtov javnega zdravstva.

Namen zdravstvene komunikacije je, da se ustvari enotno jezikovno, kulturno in inovativno sporazumevanje, uporabno v zdravstvenem sistemu in drugih medijih, usmerjenih v promocijo zdravja (Babnik & Štemberger Kolnik, 2013). Opirajoč se na različne programe, postane zdravstvena komunikacija načrtovani proces vplivanja na družbene spremembe, ki spodbujajo spremembo življenjskih navad posameznika in skupnosti na področju javnega zdravja. Kot taka se lahko uporabi za dvig zdravstvene pismenosti populacije na nacionalnem nivoju. Orodja, kot so promocija zdravja, zdravstvena vzgoja in vzgoja za zdravje, so tesno povezana z javno zdravstveno prakso in izobraževanjem ali usposabljanjem (Simons-Morton, 2013) s ciljem spodbujanja zdravja v okviru socialno-okolijskih sprememb ali spreminjanja osebnega zdravja. Z enotno zdravstveno komunikacijo na vseh nivojih socialnega življenja bomo podprli pacienta pri morebitnem spreminjanju življenjskih navad, dolgoročno pa preprečili širitev nezdravih življenjskih navad. Zdravstvena pismenost se opira na posameznikovo znanje, kritično zavest, kontemplacijo in človekov razvoj v smislu sprejema kvalificiranih odločitev tako na zasebnem področju kot v družbi, v kateri lahko posameznik vpliva na politične odločitve, usmerjene v ustvarjanje zdravega podpornega okolja za dvig kakovosti življenja (Sørensen, 2013).

Koncept zdravstvene pismenosti tako lahko opredelimo kot nenehno učenje, ki vključuje posameznika in skupnost v razvoju možnosti in sposobnosti za ohranjanje lastnega zdravja ter zdravja skupnosti. Medicinske sestre spremljajo populacijo in imajo v zdravstvenem sistemu možnost usmerjati tako posamezne ranljive skupine kot paciente s kroničnimi obolenji, se vključevati v akutne situacije, povezane z zdravjem, in izvajati promocijske aktivnosti za podporo posamezniku ter za dvig kolektivne zavesti za boljše zdravje populacije. Preventivni programi tako na ravni primarne kot sekundarne in terciarne preventive omogočajo široko paleto aktivnosti za dvig zdravstvene pismenosti posameznikov in populacije. Z zavedanjem zdravstvenih delavcev, da je visoka stopnja zdravstvene pismenosti ključ do samoučinkovitih pacientov, ki znajo poskrbeti za lastno zdravje in se aktivno vključiti v zdravljenje ali rehabilitacijo, se lahko ustvarja urejen in vzdržan zdravstveni sistem. Visoko zdravstveno pismena populacija pomeni, da je vsakdo sposoben sprejemati najboljše odločitve, ko izbira vzorce vedenja, povezanega z zdravjem, in ko vstopa v zdravstveni sistem. Glede na to, da so z evropsko raziskavo (Sørensen, 2013) ugotovili, da v vključenih državah prevladuje nizka stopnja zdravstvene pismenosti, kar je bilo ugotovljeno tudi z manjšo raziskavo, izvedeno v Sloveniji (Kozar, 2013), je smiselno opozoriti, da se moramo zdravstveni delavci močno zavedati, da imamo v procesu obravnave pogosto pacienta, ki ne razume prejetih navodil.

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Izvirni znanstveni članek / Original scientific article

Quality of life of alcohol-dependent adults: a mixed-methods study Kakovost življenja odraslih, odvisnih od alkohola: raziskava mešanih metod

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Key words: alcohol dependence; social support; focus groups; satisfaction

Ključne besede: odvisnost od alkohola; socialna podpora; fokusne skupine; zadovoljstvo

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ABSTRACT

Introduction: Alcohol dependence is the most prevalent addiction disorder that develops gradually as an interplay of individual and social factors. It impacts the quality of life of affected individuals. The purpose of this study was to examine the quality of life of alcohol-dependent people at different stages of treatment compared to individuals without alcohol dependence.

Methods: A mixed-methods study was conducted. First, a cross-sectional study ($n = 502$) was conducted using a validated Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q). Focus groups for subjective quality of life assessment were also conducted. Data were analysed using descriptive and inference methods (Mann Whitney U Test) with the SPSS, version 20 programme.

Results: Non-dependent participants are significantly more satisfied with each of the quality of life component than alcohol-dependent participants. Differences were demonstrated in a sense of well-being and leisure-time activities. Differences between alcohol-dependent and non-dependent participants were seen in the domains of physical health, work satisfaction and social relationships.

Discussion and conclusion: Alcohol-dependent participants reported a lower quality of life than non-alcohol dependent participants as alcohol dependents confront numerous problems associated with their dependence. There is a need for further research in the field of alcohol dependence in relation to the quality of life.

IZVLEČEK

Uvod: Odvisnost od alkohola je najbolj razširjena motnja odvisnosti, ki se razvija postopoma kot posledica medsebojno povezanih individualnih in družbenih dejavnikov. Vpliva na kakovost življenja prizadetih posameznikov. Namen raziskave je bil preučiti kakovost življenja oseb, odvisnih od alkohola, na različnih stopnjah zdravljenja v primerjavi s posamezniki brez odvisnosti od alkohola.

Metode: Izvedena je bila študija mešanih metod. Najprej je bila opravljena presečna raziskava ($n = 502$) s pomočjo validiranega vprašalnika o zadovoljstvu z življenjem (Q-LES-Q). Osnovane so bile tudi fokusne skupine za subjektivno oceno kakovosti življenja. Podatki so bili analizirani z opisno in inferenčno statistiko (Mann Whitney U Test) s pomočjo programa SPSS, verzija 20.

Rezultati: Udeleženci, ki niso odvisni od alkohola, so bistveno bolj zadovoljni z vsako izmed komponent kakovosti življenja kot tisti, ki so odvisni od alkohola. Razlike so se pokazale v počutju in v prostočasnih dejavnostih, pa tudi na področju fizičnega zdravja, zadovoljstva pri delu in družbenih odnosov.

Diskusija in zaključek: Udeleženci, odvisni od alkohola, poročajo o slabšem zadovoljstvu z življenjem kot udeleženci, ki niso odvisni od alkohola. Soočajo se namreč s številnimi težavami, povezanimi z odvisnostjo. Obstaja potreba po nadaljnjem raziskovanju odvisnosti od alkohola v povezavi s kakovostjo življenja.



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Introduction

Quality of life has recently received much attention as a dimension that influences individuals' well-being and their satisfaction with life (Srivastava & Bhatia, 2013; Daepfen, et al., 2014). World Health Organization (WHO) defines Quality of Life as an individual's perception of their position in life in the context of the culture and value systems in which they live, and in relation to their goals, expectations, standards and concerns. It is a broad-ranging concept affected in a complex way by the person's physical health, psychological state, personal beliefs, social relationships and their relationship to salient features of their environment (WHO, 2019).

Personal satisfaction is related to subjective feelings in several domains of the quality of life including physical health, social relationships, work and the ability to function in daily life. The current global economic, environmental, energy and demographic crises contribute to a reduced quality of life, particularly of vulnerable groups, which includes people with addiction disorders and mental health problems. Individuals with alcohol dependence have a higher risk of social exclusion (Sheeraz, et al., 2019). With no end yet in sight to the global economic and financial crisis, the situation of the above-mentioned vulnerable groups may be expected to worsen, resulting in a reduced quality of life. Alcohol dependence is a disorder, defined by the World Health Organization (WHO, 1951) in 1951 as a pattern of excessive drinking, reaching a level where the person shows significant psychological consequences that place them at an increased risk for physical and mental health problems, poor social relationships and social and economic difficulties.

Epidemiology of alcohol dependence

Alcohol use prevalence varies across countries. However, mean lifetime prevalence of alcohol use is 80 %, ranging from 3.8 % to 97.1 %. Moreover, the risk of alcohol use disorder onset begins in adolescence and is often developed by the age of 18 (Glantz, et al., 2020). Roberts and colleagues (2020) explored the feasibility of hospital discharge data across countries in Europe to estimate alcohol dependence prevalence. There is a weak correlation between hospital discharges due to any condition from the F10 diagnostic category and alcohol dependence prevalence. Prevalence of alcohol dependence in Slovenia is 6.2 %. Alcohol dependence is more common in adult men than women, although alcohol misuse has been increasing in women and young individuals (Wall & Quadara, 2014; Lee, et al., 2020). Statistical data provided by the World Health Organization (WHO, 2014b) show that in Slovenia there are more men (10.5 %) dependent on alcohol than women (2 %). Increasing alcohol consumption

in women is the result of economic development and changing gender roles (Wilsnack, et al., 2013; Bratberg, et al., 2016). In the European Union, the highest rates of excessive drinking are seen in the younger population (WHO, 2014a). Heavy episodic drinking (at least once a week is 60 g of pure alcohol or five or more drinks on one occasion) is reported by over one fifth of Europeans aged 15 years and over (WHO, 2014b). Although alcohol use declines with age (Grundstrom, et al., 2012), studies have shown that alcohol consumption is higher in older adult population (León-Munoz, et al., 2015; Emiliussen, et al., 2017). WHO (2014a) states that alcohol consumption is generally more frequent in older people than in other age groups. Furthermore, older people are less able to cope with a similar level of alcohol intake because of age-related changes in their body composition (Arndt & Schultz, 2016).

In some European countries, alcohol consumption has recently been decreasing (e.g. Spain, France) (Ministry of Health, 2016). Slovenia is among European countries with the highest per capita alcohol consumption at between 10 to 13 litres of pure recorded and unrecorded alcohol (Ministry of Health 2015; WHO, 2011, 2018). The research (WHO, 2014b) has shown an average of 11.6 litres of pure recorded alcohol per capita, which represents a decrease in alcohol consumption. Furthermore, unrecorded alcohol use is widespread and estimated by some experts to reach an additional 5 litres of pure alcohol per capita (Hovnik Keršmanc, et al., 2012), although the research published by the WHO (2014a) has shown an unrecorded alcohol consumption of 1 litre per capita and an increase in the following years to 1.8 litre per capita (WHO, 2018). In 2011-2017, 6072 deaths (per two million population) from alcohol-related causes were recorded in Slovenia (National Institute of Public Health, 2017, 2018). The economic cost of alcohol-related work absenteeism was 3.64 million euros (National Institute of Public Health, 2014), which represents a substantial burden for Slovenia. Alcohol misuse is a factor in more than one in three road traffic accidents (Stojiljković, 2012; Javna agencija RS za varnost prometa, 2018), and about half of all criminal offenses are committed under the influence of alcohol (Galbicsek, 2019).

Quality of life

The quality of life is defined as "the quality of the social and physical environment in which people pursue the gratification of their wants or needs" (Power, 2020, p. 3). According to Brodani and Kovacova (2019), the quality of life represents a positive interaction between various forms of social structure and personal satisfaction. Measuring the quality of life presents a considerable challenge because measuring objective factors is more straightforward than estimating

subjective indicators of personal satisfaction, which are inherently unreliable (Križman, 2012). Many studies (Kaplan, et al., 2012; Mathiesen, et al., 2012; Kim & Kim, 2015) have been conducted measuring the quality of life of alcohol dependent individuals, however, they were conducted among the general population, whilst other studies (Kaplan, et al., 2012; Martinez, et al., 2014; Ortolá, et al., 2016) were conducted among older adults. Studies have shown that the presence or severity of psychiatric comorbidities is associated with a lower quality of life in individuals with alcohol misuse disorders, and that the quality of life of these individuals is markedly lower compared to those without alcohol dependence (Connor, et al., 2006; Bobes-Bascaran, et al., 2015; Pasareanu, et al., 2015). It also seems that there may be differences in the quality of life that are gender influenced (Stein, et al., 2016). However, there are limited studies comparing treated alcohol-dependent individuals and non-dependent individuals, with only one such study conducted in the past (Connor, et al., 2006). It seems that there is no association between the duration of abstinence and the quality of life (Connor, et al., 2006). Although a study conducted in Spain (Ortolá, et al., 2016) showed that alcohol consumption is somehow correlated with the quality of life, there has not been enough research done to validate this statement, particularly regarding the issues from a qualitative perspective.

Aims and objectives

The aim of this study was to examine the dimensions of the quality of life in alcohol-dependent and non-alcohol dependent individuals at different stages of psychosocial treatment compared to individuals without alcohol dependence. The research question was as follows:

– What is the difference in the perception of the quality of life between alcohol-dependent and non-alcohol dependent individuals?

The following hypothesis was tested:

H1: The greatest reduction in the quality of life by participants will be reported before treatment.

Methods

A mixed methods study was performed to collect both quantitative and qualitative data on the quality of life of alcohol-dependent individuals in comparison to non-dependent individuals. The research used a cross-sectional design with four sample groups. A survey was used to establish the difference in the quality of life at three stages of treatment (Pre-During-Post) between those who were alcohol-dependent and those who were not, using the Q-LES-Q instrument. The focus groups were used to explore the views and perspectives of alcohol-dependent and non-dependent participants about the factors that had

influenced their quality of life. The study followed a two-phase design: 1) a cross-sectional study and 2) focus groups interviews.

Description of the research instrument

Participants' quality of life was assessed using the Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q) (Endicott, 2000). The questionnaire was developed to measure the degree of enjoyment and satisfaction in different areas of life (physical health, mood, work, leisure-time activities, and social relationships) in the early nineties in the USA. The long version of the Q-LES-Q questionnaire used in this study consists of 93 questions and takes about 20 minutes to complete. Responses to questions are recorded on a 5-point Likert scale, using the categories "never", "rarely", "sometimes", "often", and "always". Scores are expressed as percentages of the total score for each quality of life factor. Higher values correspond to a higher satisfaction with life and thus a better quality of life but do not represent normative values for the quality of life. The Q-LES-Q questionnaire is most commonly used for self-evaluation in patients with mental disorders (Demyttenaere, et al., 2008). The questionnaire had previously been reported to have an internal consistency coefficient (Cronbach's alpha) of 0.90 (Ritsner, et al., 2005). Internal consistency coefficients for specific domains in the present study were physical health (0.930); work (0.937); leisure-time activities (0.894); and overall well-being (0.880). In 2000, the Q-LES-Q questionnaire was translated into several languages, including Slovenian.

Description of the sample

The research sample consisted of 502 participants aged between 20 and 64 years, the average age was 42 ($s = 9.3$) years. The average years spent in education was 10.91 years. Participants were divided between a study group with alcohol dependence ($n = 359$) and a control group without alcohol dependence ($n = 143$). The study group participants were subdivided into three categories according to the stage of treatment for alcohol dependence: pre-treatment, within-treatment and post-treatment. Alcohol-dependent pre-treatment participants were recruited at first attendance at a psychiatric hospital, within-treatment participants were recruited from psychiatric hospitals where they were undergoing outpatient treatment for alcohol dependence and post-treatment participants were recruited from the out-patient groups that they attended following a completion of treatment for alcohol dependence, so an available sampling technique. A control group was recruited: these were adults who identified themselves as not having any problems with alcohol dependence, using a snowball sampling technique. The intervention and control groups were matched by gender, age and education.

Table 1: *Participants by gender*

Tabela 1: *Udeleženci po spolu*

<i>Gender / Spol</i>	<i>Group / Skupina</i>	<i>Quantitative sample / Kvantitativni vzorec</i>		<i>Qualitative sample / Kvalitativni vzorec</i>	
		<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>
Female	Pre-treatment	39	7.8	1	5.0
	Within-treatment	23	4.6	1	5.0
	Post-treatment	39	7.8	1	5.0
	Controls	38	7.6	2	10.0
Male	Pre-treatment	104	20.7	4	20.0
	Within-treatment	50	9.9	4	20.0
	Post-treatment	104	20.7	4	20.0
	Controls	105	20.9	3	15.0
Total		502	100.0	20	100.0

Legend / Legenda: n – number / število; % – percentage / odstotek

Overall, the sample consisted of 72.3 % men and 27.7 % women. The within-treatment group contained the largest proportion of women; almost one third of participants in this group were female (Table 1).

The qualitative sample consisted of four groups of five participants ($n = 20$), following the same inclusion criteria as the quantitative study (pre-treatment, within-treatment and post-treatment group and the control group without alcohol dependence). Three focus groups ($n = 15$) were held with the study sample, each group included one female and four male participants. The group without alcohol dependence ($n = 5$) included two females and three male participants.

Description of the research procedure and data analysis

The study was approved by the Slovenian National Medical Ethics Committee in 2014. The research permission was obtained from the management of each psychiatric institution. All respondents participated in the survey on a voluntary basis. Focus group participants received an information sheet on the study and provided informed consent prior to participating in the focus groups.

The authors obtained permission from the author to use the questionnaire for data collection in the Slovenian context. Quantitative analysis of the data was performed in the SPSS version 20.0 (SPSS Inc., Chicago, IL, USA). Data was presented as Mean (\bar{x}) and Standard deviation (s) for all variables. Furthermore, the non-parametric Mann-Whitney U test was used in order to compare the probability value (p) of less than 0.05 and was chosen as a statistically significant level.

Qualitative data were collected using focus group interviews. Four interviews were conducted (control group – healthy individuals, and alcohol-dependent participants before, during and post-treatment). Prior to forming focus groups, we obtained consent from the institution, the National Medical Ethics Committee

and the participants. Participation was anonymous and on a volunteer basis. The focus groups participated for approximately 90 minutes. The data were analysed using content analysis. A list of categories was derived that were based on the concepts studied in the quantitative part of the study. As part of the content analysis the number of individual occurrences for each domain in focus group interviews was recorded. Specific paraphrasing techniques were used, including discarding non-recurrent and uninformative information, generalising from specific terms to more abstract categories and grouping related occurrences into broader categories.

Results

Cross-sectional study

When comparing the quality of life factors between the alcohol and non-alcohol dependent samples it can be seen that the alcohol dependence group was the lowest for the physical health factor and the highest for work satisfaction, whereas participants without alcohol dependence were the lowest for work satisfaction and the highest for leisure-time activities (Table 2).

There was a statistically significant difference in subjective feelings ($p = 0.008$) with participants without alcohol dependence reporting significantly higher satisfaction than those with alcohol dependence as depicted in Table 2. Similarly, there was also a significant difference in leisure-time activities ($p = 0.001$) (Table 3). Differences were also observed for other quality of life items with participants without alcohol dependence reporting greater satisfaction.

There were no statistically significant differences in the quality of life items between the pre-treatment, within-treatment and post-treatment groups.

When examining differences in the quality of life in participants with and without alcohol dependence by gender, age and education, the differences in the quality of life were most apparent between

Table 2: Quality of life factors between dependent and non-dependent groups
Tabela 2: Dejavniki kakovosti življenja med odvisnimi in neodvisnimi skupinami

Quality of life Factors / Dejavniki kakovosti življenja	Group / Skupina	n	\bar{x} (s)	U / p
Physical Health	Alcohol dependent	357	63.1 (13.0)	23388.000 / 0.143
	Non-alcohol dependent	143	65.5 (12.6)	
Subjective Feelings	Alcohol dependent	356	72.9 (14.8)	21593.000 / 0.008
	Non-alcohol dependent	143	76.9 (13.1)	
Work	Alcohol dependent	231	80.5 (15.4)	11339.000 / 0.585
	Non-alcohol dependent	102	81.2 (11.2)	
Leisure Time Activities	Alcohol dependent	324	71.1 (15.3)	17786.000 / 0.001
	Non-alcohol dependent	136	76.0 (13.7)	
Social Relationships	Alcohol dependent	355	70.4 (13.7)	22594.000 / 0.071
	Non-alcohol dependent	142	72.9 (11.6)	

Legend / Legenda: n – number / število; \bar{x} – mean / povprečje; s – standard deviation / standardni odklon; U – Mann-Whitney test value / vrednost Mann-Whitney testa; p – statistical significance / statistična značilnost

participants of different gender (Table 3). Alcohol-dependent women had significantly lower scores for the quality of life items, including physical health ($p = 0.001$), overall sense of well-being ($p = 0.006$), and subjective feelings ($p < 0.001$) and leisure-time activities ($p = 0.046$). Among participants without alcohol dependence there were no significant differences according to gender. Younger participants generally reported higher satisfaction with the quality of life items than older participants, but only leisure-time activities in non-dependent participants reached statistical significance ($p = 0.029$). There were also differences in satisfaction with the quality of life items according to education. Higher education levels

of alcohol-dependent participants was associated with higher satisfaction with physical health ($p = 0.001$), overall sense of well-being ($p = 0.006$), and leisure-time activities ($p = 0.009$). In contrast, for non-dependent participants a significant difference according to education was seen only in the physical health category ($p = 0.010$) with higher education being associated with better physical health.

Focus Groups

Focus group participants were asked to rate their quality of life on the scale from 1 to 10, with 1 being the

Table 3: Statistically significant differences between dependent and non-dependent groups (gender, age and education)
Tabela 3: Statistično pomembne razlike med odvisnimi in neodvisnimi skupinami (spol, starost in izobrazba)

Variables / Spremenljivke	Test	Physical health / Fizično zdravje	Subjective feelings / Občutki	Work / Delo	Leisure time activities / Dejavnosti v prostem času	Social relationships / Socialni odnosi	
Gender	Dependent alcohol group	Z	-3.410	-3.825	-0.544	-1.998	-1.217
		p-value	0.001	0.000	0.587	0.046	0.223
Non-dependent alcohol group		Z	-0.821	-1.724	-0.243	-1.525	-1.182
		p-value	0.412	0.085	0.808	0.127	0.237
Age	Dependent alcohol group	Z	-0.074	0.042	0.008	0.038	-0.116
		p-value	0.164	0.431	0.898	0.494	0.029
Non-dependent alcohol group		Z	-0.234	-0.059	0.108	-0.047	0.014
		p-value	0.005	0.487	0.282	0.590	0.869
Education	Dependent alcohol group	Z	-2.620	-2.021	-1.459	-2.125	-0.701
		p-value	0.009	0.043	0.145	0.034	0.483
Non-dependent alcohol group		Z	-2.563	-1.739	-0.010	-1.465	-1.906
		p-value	0.010	0.082	0.992	0.143	0.057

Legend / Legenda: Z – Z-score / Z-vrednost; p – statistical significance / statistična značilnost

lowest quality of life and 10 the highest. The average score among alcohol-dependent participants was 7.

a) Quality of life factors identified by the alcohol-dependent participants before treatment

An analysis of focus group interviews comparing the frequency of usage of pre-defined categories by participants identified that alcohol-dependent participants before treatment assigned the greatest importance to the following quality of life factors: leisure-time activities (taking holidays, sports activities, relaxation), home and family relations (having an understanding family and partner, loving relationships, contact with children, caring for children), for example 'I can rely most on my partner and both my sisters, who always gave me the help I needed, but I have two good friends, if I need help even at any hour at night'. Financial well-being and material living standard (having enough to get by, absence of financial difficulties and not having to depend on social support, salary income), a peaceful and relaxed life (living a peaceful, relaxed life), satisfaction with life (feelings of satisfaction with life) and an adequate diet (a healthy and adequate diet) were also identified as important factors.

b) Quality of life factors identified by the alcohol-dependent participants within treatment

Regarding the quality of life alcohol-dependent participants within treatment rated leisure-time activities, home and good family relations, financial well-being and material living standard, a peaceful and relaxed life, satisfaction with life, an adequate diet and happiness as the most important factors. On average, they rated their quality of life with a score of 5.3, on the scale from 1 to 10.

c) Quality of life factors identified by the alcohol-dependent participants after treatment

Alcohol-dependent participants after treatment emphasised the importance of health and being free from alcohol dependence, home and good family relations, financial well-being and material living standard, a peaceful and relaxed life, suitable work environment and adequate diet. Quality of life factors were regarded as being unique to an individual ('That you're happy with your life, not that someone has some norms about the quality of life..., I think the quality of life depends on each individual). The participants emphasized the value of a stress-free life, being healthy and maintaining good nutrition. Work was also valued as providing satisfaction with the quality of life and recognising the need to be loved, with some seeking spiritual assistance to improve their quality of life. Similarly to the other focus groups, this

group discussed the importance of social support from family and friends. Those who lacked such support recognized the need for self-sufficiency in coping 'I'm used to solve things for myself' while acknowledging 'but I know it's easier if you can share a part of the load'. The need to access professional support was raised and how it could have been sought earlier.

On the scale from 1 to 10, they rated their quality of life with an average score of 9.4. In the group without alcohol dependence, health and independence, home and good family relations, financial well-being and material living standard, as well as suitable work environment were emphasised as the most important factors for the quality of life. On the scale from 1 to 10, non-dependent participants rated their quality of life with an average score of 8.6.

Discussion

Alcohol dependence is a chronic mental disorder that develops over a number of years, or even decades (WHO, 2014a). During this period various problems emerge in biopsychosocial, spheres of individuals' lives and their significant others. This study has shown that those with alcohol dependence have a reduced quality of life that affects both, the individuals concerned and their significant others, supporting the findings by Krizman (2012) and Ortolá and colleagues (2016). A study reported an association of dependence with the health-related quality of life; one study found that alcohol dependence affects the overall health-related quality of life and the specific domains of general health, physical and mental health, general and social functioning, activities of daily living, as well as pain and sleep (Levola, et al., 2014). This study concluded that for several of these domains, including general health, physical and mental health, and general and social functioning, as well as for overall health-related quality of life, alcohol dependence was the main underlying cause of impairment. In this study from both the qualitative and quantitative findings, health-related quality of life was significantly improved by treatment interventions, and in several, albeit not all instances, these improvements were facilitated by abstaining from or reducing alcohol intake. However, when comparing the alcohol and non-alcohol dependent groups, there was no difference in the overall quality of life. Instead, these differences only showed in some quality of life domains, including the domain of subjective feelings and satisfaction with leisure time activities. It was also clear in this study that alcohol dependent women had significantly lower scores in a range of domains compared to women without alcohol dependence.

Although recent research on the adequacy of various quality of life measures is inconclusive on whether alcohol dependence is associated with a clinically relevant decrease in the quality of life, it does suggest

that alcohol-dependent individuals have a lower quality of life in specific domains (Čuček Trifkovič, 2008; Laudet, 2011). This study supports this view as participants in the alcohol dependent group showed that alcohol-dependent individuals have a reduced quality of life in specific domains, but not the overall quality of life. No significant differences were found between alcohol-dependent participants before treatment, within-treatment and post-treatment. The hypothesis that the greatest reduction in the quality of life would be reported by participants before treatment, which would, in turn, motivate them to seek treatment for alcohol dependence, was not confirmed.

Qualitative results showed that there are differences between study groups in subjective evaluations of the quality of life. Alcohol-dependent participants were more likely to emphasize leisure-time activities, good family relations and material well-being before treatment. Health and being free from alcohol dependence were not seen as important factors for the quality of life. The latter was most frequently mentioned by participants in the post-treatment stage, who have already experienced the challenges of treatment for alcohol abuse and problems associated with it. For these participants, health was of the greatest importance. This determinant of the quality of life was also frequently mentioned by participants within-treatment. Generally, the highest satisfaction with the quality of life was reported by participants post-treatment, and the lowest by participants within-treatment.

A key limitation of this study is the cross-sectional design because it is not possible to infer any causal relationships, however this may be mitigated as one of the main strengths of this study is that it combined qualitative and quantitative data collection tools. The use of a psychometrically validated tool also adds cogency to the results of this study. Although some characteristics were controlled in both groups, significant associations between groups were difficult to interpret. Additionally, interviewer bias and social acceptability factors could be identified as other co-founders. The sampling and observation timings are another limitation, thus the generalisability or transferability of the findings cannot be guaranteed. Future studies could include a longitudinal design combined with focus groups and also assess comorbid conditions.

Conclusion

It has been argued that it is vitally important to assess the effect of alcohol misuse disorders on an individual's overall well-being, especially since alcohol abuse can be considered a chronic condition. The management of alcohol misuse disorders should have as its goal a broad definition of what constitutes a recovery model, which includes both abstinence and improved

quality of life and biopsychosocial functioning, as well as the capacity to function independently in society in their own treatment planning and outcome assessment. Views on the quality of life differ because of individuals' perceptions, values and wishes. There are also differences in the quality of life between adults who are dependent on alcohol and those who are not. This study examined the quality of life in alcohol-dependent adults compared to those who are not alcohol-dependent and found that there are statistically significant differences between the two groups in the quality of life. There are also differences in objective and subjective views of their quality of life. There were differences in the domains of physical health and well-being, work satisfaction, leisure-time activities and social relationships. This study contributes to the knowledge based on the quality of life of alcohol dependent individuals and the way this quality of life can be impacted on. Health professionals need to consider and include the quality of life as an assessment domain from a bio-psycho-social perspective and investigate how this can be maintained and improved.

Conflict of interest / Nasprotje interesov

The authors declare that no conflicts of interest exist. / Avtorji izjavljajo, da ni nasprotja interesov.

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Ethical approval / Etika raziskovanja

The study was approved by the Slovenian National Medical Ethics Committee (No. 26 / 06 / 09). / Pridobljeno je bilo etično dovoljenje za izvedbo raziskave pri Komisiji Republike Slovenije za medicinsko etiko (Št. 26 / 06 / 09).

Author contributions / Prispevek avtorjev

The first, second and third authors designed the study, interpreted the data and prepared the first draft. The fourth and fifth authors prepared the article in English. The last author helped with statistical data analysis, coordinated the writing of the article and contributed to the final version of the article. / Prva, druga in tretja avtorica so načrtovale raziskavo, interpretirale podatke in pripravile osnutek članka. Četrta in peta avtorica sta pomagali pri pripravi članka v angleškem jeziku. Zadnja avtorica je pomagala pri statistični analizi podatkov, koordinirala pisanje in končno ureditev članka.

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Izvirni znanstveni članek / Original scientific article

Kultura rojevanja na Goriškem v 20. stoletju: kvalitativna analiza porodnih zgodb

Childbearing culture in the Goriška region in the 20th century: a qualitative analysis of birth stories

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Ključne besede: rojstvo; izkušnje; porodne prakse; zadovoljstvo žensk; obporodna skrb

Key words: birth; experience; maternity practice; satisfaction of women; postnatal care

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IZVLEČEK

Uvod: Nosečnost in z njo povezan porod sta za žensko in njeno družino zelo pomembna in čustvena dogodka, ki s seboj prinašata veliko sprememb. Namen kvalitativne raziskave je bil skozi primere porodnih zgodb proučiti kulturo rojevanja na Goriškem v 20. stoletju.

Metode: V raziskavi je bila uporabljena deskriptivna interpretativna metoda. Uporabljen je bil namenski vzorec šestih žensk. Najmlajša izmed sodelujočih je bila stara 66 let, najstarejša pa 95 let. Raziskava je potekala aprila 2019. Podatki so bili zbrani z delno strukturiranim intervjujem in analizirani s pomočjo metode analize vsebine.

Rezultati: Identificirane so bile štiri teme: (1) spomini na porodno izkušnjo, (2) opis porodne izkušnje v resničnosti takratnega časa, (3) podporna vloga ožje in širše skupnosti v obporodni oskrbi in (4) determinacija zdravstvenega statusa skozi družbeni status. Pri porodnem dogodku doma so sodelovale babice in bližnje sorodnice, medtem ko so porodni dogodek v bolnišnici oblikovali zdravstveni delavci. Lajšanje porodne bolečine ni bilo v ospredju. Porod je potekal v hrbtnem položaju. Informacije o rojevanju so se prenašale od ene do druge ženske. Prva porodna izkušnja je prelomna za doživljanje poroda.

Diskusija in zaključek: Porod in obporodno dogajanje sta v tistem času in prostoru v večji meri izpolnila pričakovanja žensk kljub nekaterim socialnim dejavnikom in pomanjkanju materialnih dobrin, ki jih v današnjem času prepoznavamo kot neobhodne.

ABSTRACT

Introduction: Pregnancy and birth are very important and emotional events for a woman and her family that result in many changes. The purpose of the qualitative research was to examine the birth culture in the Goriška region in the 20th century through birth stories.

Methods: The study used a descriptive interpretative method. We used a dedicated sample of six women who were willing to talk about their birth experience. The youngest of the participants was 66 years old and the oldest was 95 years old. The data were collected through a partially structured interview and analysed using the content analysis method.

Results: Four themes were identified: (1) memories of the woman's birth experience, (2) description of the birth experience in terms of the reality of that time, (3) the supportive role of the narrow and wide community in post-natal care and (4) determining a health status through social status. Midwives and close relatives participated in the birth at home, while the maternity event at the hospital was designed by healthcare professionals. The relief of labour pain was not at the forefront. The birth took place in the back position. Birth information was transmitted from one woman to another. The first birth experience is a turning point in experiencing childbirth.

Discussion and conclusion: Childbirth and postpartum events have mostly met women's expectations at that particular time and space despite the influence of certain social factors and lack of material goods that are now recognized as essential.



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Uvod

Porod je opredeljen kot naravni zaključek nosečnosti; je fiziološki, socialni in psihoemocionalni dogodek, ki smo ga zaradi preprečevanja neželenih dogodkov medikalizirali in je zato postal medicinsko, edukativno in raziskovalno področje (Prosen & Tavčar Krajnc, 2016). Raven rodnosti se povsod po svetu znižuje. V Evropi je že tako nizka, da obnavljanje generacij ni več zagotovljeno. Od sredine 18. do sredine 20. stoletja se je raven rodnosti zmanjšala za polovico. Sredi 18. stoletja je bilo povprečno število 6 živorojenih otrok na eno poročeno žensko, ob vstopu v 21. stoletje pa je bila rodnost le še 1,2 otroka na žensko (Šircelj, 2006). Danes je rodnost po podatkih Statističnega urada Republike Slovenije (2018) 1,61 otroka na žensko v rodni dobi, kar še vedno ne zadošča za obnavljanje prebivalstva.

Porod se je nekoč odvijal na domovih žensk. Potekal je na tleh, pokritih s slamo, saj vzmetnic ni bilo, pomoč pa so nudile starejše ženske. Zaradi nestrokovne porodne pomoči in pomanjkanja znanja so se porodi velikokrat končali smrtno (Zupančič Slavec & Slavec, 2011). Sprva so pri porodu pomagale ženske, ki so same že rodile in imele nekaj izkušenj na tem področju, v 18. stoletju pa so bile postavljene norme, ki so jih babice morale izpolnjevati, če so želele opravljati to delo (Borisov, 1995; Prosen, 2016). Sprva so babice pomagale na domu, v sredini 20. stoletja pa se je njihovo delovanje preselilo v porodnišnice (Prosen & Tavčar, 2016).

V 20. stoletju so se okoliščine rojstva otroka bistveno spremenile. Prišlo je do premika porodov v porodnišnice, kar je povezano s spremembami v porodnih praksah, okolju in ljudeh, ki porodni dogodek obkrožajo. Porod je postal v zahodni družbi medikaliziran (Prosen, 2016). Porodništvo se je razvijalo in s tem so na trg prihajali različni tehnični pripomočki, odkritje anestetikov je pomenilo začetek protibolečinske terapije, vedno večji pomen je dobivala higiena rok in posledično je bilo tudi manj materlnih in fetalnih smrti (Zupančič Slavec & Slavec, 2011). V tem času se je razvilo prepričanje, da je priprava na porod nujna, kar je privedlo do izoblikovanja materinskih šol (Drglin, 2003). Do novih odkritij je prišlo na področju kontracepcije. Njen razvoj je v šestdesetih letih 20. stoletja povzročil velik premik od naravnih metod preprečevanja nosečnosti k hormonski kontracepciji, kar je ženskam omogočilo načrtovanje družine ter posledično vključevanje v javno življenje in delo (Zupančič Slavec, 2018). Do sprememb je prišlo tudi na področju prehrane novorojenčkov. V drugi polovici 20. stoletja so se na trgu pojavile otroške stekleničke in gumijaste dude, izum mlečnih nadomestkov v šestdesetih in sedemdesetih letih pa je nadomestil dojenje (Prosen & Tavčar Krajnc, 2016; Mičetić-Turk, et al., 2017). Velika sprememba je bila tudi vstop očetov v porodni blok. Nekdaj je veljalo, da je sodelovanje moških pri porodu nesprejemljivo, vendar se je mnenje počasi spreminjalo in posledično

so očetje konec šestdesetih let začeli prisostvovati porodu (Drglin, 2003).

Namen in cilji

Namen raziskave je bil skozi primere porodnih zgodb proučiti kulturo rojevanja na Goriškem v drugi polovici 20. stoletja, vključno z okoliščinami, ki so porod v tem času določale. Izbrali smo intervjuvanke, ki so rodile v času, ko se je porod iz domačih hiš selil v institucionalno organizirano zdravstveno oskrbo. Cilj v raziskavi je bil odgovoriti na dve raziskovalni vprašanji: Kakšna je bila porodna izkušnja žensk v tistem času in prostoru z vidika njihovega socialnega statusa (ali statusa njihove družine)? Kako so v tem kontekstu doživljale porod?

Metode

Uporabljena je bila kvalitativna raziskovalna paradigma, v okviru katere smo izbrali deskriptivno-interpretativni pristop. Ta pristop omogoča izčrpen povzetek vsakdanjih dogodkov in s tem tudi natančnost pri raziskavi (Polit & Beck, 2014), saj je bil namen preučiti predvsem izgrajeno resničnost rojevanja v tistem času in prostoru.

Opis instrumenta

Podatki so bili pridobljeni z delno strukturiranim intervjujem, v katerega smo vključili vprašanja odprtega tipa. Takšen intervju je fleksibilnejši, odgovori so bolj spontani, osebni, samoodkrivajoči in konkretni (Kordeš & Smrdu, 2015). Poleg intervjuja smo uporabili tudi pregled dokumentacijskega gradiva (slikovno gradivo, ki so ga hranile intervjuvanke).

Vnaprej so bila pripravljena vodilna vprašanja, razvita na podlagi pregleda literature (Borisov, 1995; Drglin, 2003) ter ciljev raziskave. Primeri vprašanj: Povejte mi, kako se je vaš porod pričel? Kje ste pridobili informacije o poteku poroda, skrbi za otroka itd.? Kako ste bili zadovoljni z obporodno podporo (prvič, drugič itd.)? Kako ste doživljali porod? Kako je bilo roditi doma (za tiste, ki so rodile na domu)? Kakšne so bile možnosti zdravstvene oskrbe med porodom?

Opis vzorca

Namenski vzorec je vključeval šest žensk, ki so bile pripravljene deliti svoje zgodbe. Pri vključevanju v vzorec smo poleg pripravljenosti sodelovanja upoštevali tudi njihovo starost, okolje poroda ter tudi kognitivno sposobnost sodelujočih. Identifikacija »ključnih primerov« je bila zaradi tematike težavna, zato je vključevanje v vzorec temeljilo na pragmatični oceni zadostnosti in refleksiji vsebine po vsakem opravljenem intervjuju (Vasileiou, et al., 2018). Najmlajša sodelujoča je imela 66 let, najstarejša pa 95 let. Štiri ženske so imele vaginalni porod, od tega

Tabela 1: Demografski in drugi podatki o sodelujočih
Table 1: Demographic and other data about the participants

Ime / Name	Starost / Age	Starost ob prvem porodu / Age at first birth	Stopnja izobrazbe / Level of education	Bivališče / Residence	Zakonski stan / Marital status	Kraj rojstva / Place of birth	Število otrok / Number of children	Porodna anamneza / Gynecological medical history
Ivica	95	25	Nedokončana osnovna šola	Podeželje	Poročena	Prvi porod doma, drugi v porodnišnici	2	Spontani splav
Stanka	66	20	Poklicna šola	Podeželje	Poročena	Porodnišnica	2	Urgentni carski rez
Marica	79	30	Osnovna šola	Podeželje	Poročena	Porodnišnica	2	Elektivni carski rez
Anka	68	20	Osnovna šola	Podeželje	Poročena	Porodnišnica	2	Ruptura presredka
Majda	73	23	Poklicna šola	Podeželje	Poročena	Porodnišnica	2	Spontani splav, ruptura presredka
Zorica	76	21	Osnovna šola	Podeželje	Poročena	Prvi in drugi porod doma, tretji in četrti v porodnišnici	4	Ruptura presredka

dve na domu in dve v porodnišnici, ena ženska je imela urgentni carski rez in ena elektivni carski rez. V porodnišnici so bile vse porodnice deležne britja spolovila in klistir (Tabela 1).

Opis poteka raziskave in obdelave podatkov

Potencialno sodelujoči so bili osebno povabljeni k sodelovanju v raziskavi. Pri tem smo jim razložili namen in cilj raziskave ter se glede na njihovo dosegljivost dogovorili za datum intervjuja. Dostop do sodelujočih je bil omogočen po osebnih poznanstvih, kasneje pa z metodo snežne kepe. Sodelujoče so bile ob vabilu tudi zaprosene, da prenesejo informacijo o raziskavi svojim prijateljicam in sorodnicam, ki bi želele sodelovati. Intervjuji so potekali spomladi 2019 na domovih sodelujočih. Zaradi upoštevanja etičnih vidikov raziskovanja so sodelujoče v raziskavi podpisale t. i. informirano soglasje, v katerem so se ponovno seznanile z namenom raziskave, potekom, tveganjih, koristmi, predvidenim trajanjem intervjuja, zaupnostjo podatkov in prostovoljnem sodelovanjem. Posebej je bilo poudarjeno, da lahko na kateri koli točki intervju prekinemo oziroma da glede na svojo željo ne podajo odgovora na vprašanje. Z informiranim soglasjem so intervjuvanke pisno privolile tudi, da dovoljujejo uporabo fotografij, saj so nekatere svoje zgodbe prikazovale tudi s pomočjo fotografij. Dovolile so, da jih preslikamo, pri čemer so bile opozorjene, da na ta način težko zagotovimo anonimnost. Po uporabi (preslikanju) so jim bile fotografije vrnjene.

Intervjuji so v povprečju trajali približno 15 minut in so bili zvočno snemani. Zvočni zapisi intervjuvank so bili večkrat poslušani, nato je bila opravljena dobredna transkripcija. Ker so intervjuji potekali v narečju, so bili transkripti popravljeni le toliko, da so

se približali splošnemu pogovornemu jeziku. Oznaka III v besedilu pomeni izpust iz besedila z namenom zagotavljanja varovanja podatkov. Prav tako smo zaradi varovanja osebnih podatkov imena žensk zamenjali z namišljenimi imeni. Slikovno gradivo arhivske narave, ki nam je bilo zaupano, prikazuje okolje in osebe preteklega časa, zaradi česar je morebitna prepoznavnost praktično nemogoča.

Pri kvalitativni analizi vsebine smo sledili priporočilom, ki jih je podala avtorica Sandelowski (2000), ter se pomaknili bolj v interpretativni vidik. Metoda analize vsebine je bila izvedena v osnovnem petstopenjskem zaporedju (Yin, 2010): (1) sestavljanje besedila, (2) razstavljanje besedila – kodiranje, (3) sestavljanje besedila – združevanje v večje pomenske enote, (4) interpretacija rezultatov in (5) zaključek.

Rezultati

Identificirane so bile štiri teme: (1) spomini na porodno izkušnjo, kjer so se ženske razgovorile o svojih porodnih zgodbah, (2) opis porodne izkušnje v resničnosti takratnega časa, (3) podporna vloga ožje in širše skupnosti v obporodni oskrbi in (4) determinacija zdravstvenega statusa skozi družbeni status (Tabela 2).

Spomini na porodno izkušnjo

Ženske so podajale opise svojih porodnih zgodb vse od poteka nosečnosti do okrevanja po porodu. Iz teh pripovedi lahko razberemo, da se živo spominjajo dogodka, čeprav se je zgodil že dolgo nazaj. Pripovedi prikazujejo, kako zelo čustven dogodek je bil porod zanje. V opisih so navajale različna čustvena stanja – od strahu, razočaranja in obžalovanja pa vse do velikega veselja ob rojstvu novorojenčka. Prav posebej

Tabela 2: Identificirane teme**Table 2: Identified themes**

<i>Tema / Theme</i>	<i>Podteme / Subthemes</i>
Spomini na porodne zgodbe	Porod kot čustveni dogodek Pojmovanje nosečnosti in poroda v preteklosti
Opis porodne izkušnje v resničnosti takratnega časa	Pripomočki, prostor in priprava na porod Porodna bolečina Poporodna oskrba in okrevanje
Podporna vloga ožje in širše skupnosti v obporodni oskrbi	Podpora in vloga lastne matere ob porodu Podpora moža pri porodu Podpora zdravstvenih delavcev in priučenih oseb, ki so pomagale pri porodu Podporna vloga skupnosti
Determinacija zdravstvenega statusa skozi družbeni status	Socialne razmere, ki so krojile rojevanje

je negativna čustva izrazila ženska, ki je rodila s carskim rezom, saj so se takrat posluževali le splošne anestezije, zaradi česar ji je bila odvzeta možnost spremljanja poroda in takojšnjega srečanja z otrokom.

Prvič te je malo strah, ne veš, kako bo. Kako, kaj in koga. Je več trema kot vse ostalo (Ivica, 95 let).

Niti me ni bilo strah roditi doma. Me je bilo bolj strah roditi potem v drugo, ker sem vedela, kako to gre. Prvo niti ni bilo. Strah te je samo, ker misliš na to, da bi šlo vse v redu. Vedela sem, da mora otrok priti na svet in da ni kaj [smeh]. [...] Sem pa tako jokala, ker sem mislila, da v tretje bo punčka. Ma je bila pa v četrto (Zorica, 76 let).

Potem sem dobila splošno anestezijo. Takrat ni bilo druge možnosti. To pa mi je bilo najbolj hudo. To sem si vedno želela, da ne bi bilo tako. Recimo zdaj, ko dajo lokalno, veš in čutiš, to je res drugo. Takrat pa si zaspal. [...] To mi je bilo edino žal, to pa res. Če že ne moreš roditi, je pa to ena taka stvar, če lahko vidiš in tako. Ker potem po splošni anesteziji si pa tako neveden in ne veš za sebe dejansko (Stanka, 66 let).

Ena izmed intervjuvank je posebej izpostavila negativen odnos do nosečnosti in starokopitno pravilo glede prehranjevanja nosečnice.

Jej za dva, glej, da boš jedla za dva, tisto starokopitno pravilo in potem sem se za drugi porod zavestno odločila, da ne bom jedla za dva, da bom jedla samo zase in je bilo res. Sem se zredila samo 8 kg in ne 23 kg, kot sem se prvič, in je šlo bolj na hitro. [...] In skrivati tisti trebuh, smo nosile taka široka krila, kot da skrivaš ne vem kaj. Tisti odnos ni bil pravi (Majda, 73 let).

Opis porodne izkušnje v resničnosti takratnega časa

Večina žensk (štiri od šestih) je rodila v porodnišnici, kjer je bila le ena porodna soba, tako da je lahko rojevalo več žensk istočasno v istem prostoru, praksa pa je bila, da je porod potekal leže na hrbtu. Doma sta ženski rodili v svoji sobi ob zares skromnih materialnih razmerah.

V porodni sobi je bilo pet postelj, tako da jih je lahko rodilo pet hkrati. Pri meni smo tri rojevale istočasno.

Posebej je bila postelja, ločena z zaveso. Samo z zaveso je bilo ločeno. To je bila stara konjušnica. Prav zadnja soba je bila porodna in eno okno je gledalo dol na cesto, tako da tista, ki je bolj močno kričala, jo je bilo kar slišati dol na cesto (smeh) (Majda, 73 let).

Prostor, kjer sem rojevala, je bil navadna soba. Blazina, ma ni bilo vzmeti. Je bila blazina in na vrh so dali tisto perje od koruze, ki je bilo vsako leto prečiščeno (Ivica, 95 let).

Rojevala sem v sobi, kjer še zdaj spim. December je bil. Soba je bila mrzla, ni bilo zakurjeno. Nismo imeli ne peči, ne nič v sobi. Rojevala sem leže na postelji (Zorica, 76 let).

Rojevala sem leže. To me je motilo. Ne vem, zakaj. Vsi smo morali ležati. Tega nisem mogla razumeti, ker jaz sem se hotela usesti, ker meni bi bilo lažje, če bi se usedla. Ampak so bila taka pravila. Sem še spraševala, če se lahko usedem, pa mi je rekla, da ne (Majda, 73 let).

Takrat raznih pregledov, z izjemo poslušanja srčnega utripa plodu, med porodom niso izvajali. Posluževali so se le Pinardove slušalke in Leopoldovih prijemov za ugotavljanje lege ploda.

Ne, nobenih pregledov niso delali, razen babice s tisto slušalko (smeh). In pogledale so, da je plod pravilno obrnjen. Drugega nič (Majda, 73 let).

Po navedbah dveh intervjuvank so se posluževali tudi metode grobega zunanega iztiskanja plodu. Poleg skromne opreme se je pomankanje kazalo tudi pri anestetikih, saj so vse intervjuvanke navajale, da porodnih bolečin niso lajšali. Pri drugem obisku porodnišnice so bile sicer že uvedene nekatere novosti, vključno s protibolečinsko terapijo.

Najprej so mi predrli mehur, ker mi drugače voda še ni odtekla. [...] Vem, da sem mislila, da me bodo umorili (smeh). Ena velika roka se je spustila na moj obraz in mi je pritiskala oči dol in glavo in s kolenom je zdravnik porival na trebuh. Z roko mi je tiščal, da mi ne bi popokale žilice od oči. Tisto se mi je zdelo najbolj grozno od vsega tistega, kar je bilo. Ja, bolelo je, ja, normalno, da je bolelo, porod sam je bolet. [...] Nič, z nobeno stvarjo niso lajšali bolečin (Majda, 73 let).

In ker je bila to sobota pred praznikom, pred 4. julijem, je bilo malo osebja. Nekaj časa je bila babica

sama, in potem ko se začeli hudi popadki, je dobila še eno čistilko, da je prišla noter [smeh]. In ker še ni šlo s tistimi popadki, jaz sem se trudila, mučila eno uro tam in ni šlo in ni šlo. In potem se spomnim, da mi je babica šla s kolenom na trebuh in z rokami in mi je pritiskala na vse strani. Potem tisto je trajalo še nekaj popadkov, mi je pritiskala na trebuh s tako silo, potem sem se raztrgala, ker me ni prej prerezala, in potem se je končno rodila punčka (Anka, 68 let).

Takrat niso nič dajali, niso imeli kaj dati za olajšati bolečino (Zorica, 76 let).

Ženske so povedale, da je bil prvi porod najdaljši, vsi naslednji pa so potekali hitreje in lažje. Ležalne dobe v porodnišnici so bile dolge, saj so navajale, da so bile v bolnišnici od pet do enajst dni, nekoliko dlje tiste, ki so imele carski rez. Ena intervjuvanka je omenila, da je imela zaradi poporodnega zapleta srečo, da je rodila v porodnišnici. Svojega otroka so po porodu videle šele naslednji dan ali celo čez več dni.

Pet dni sem bila v bolnišnici. Takrat sem šla potem domov, takšna grozna vročina je bila. Smo šli z nekim starim fičom (smeh) (Anka, 68 let).

Deset dni sem bila v bolnišnici. Mislím, da sem prišla deseti dan domov (Stanka, 66 let).

Po porodu so vzeli otroka, ga umili, oblekli in potem so mi jo dali za trenutek v naročje, da sem jo malo popestovala. Potem so jo vzeli in takrat ni bilo kot zdaj, tisti dan je bila nedelja in sem jo videla šele v torek ob osmi uri, ko so jo prinesli na prvo dojenje. Ti ne veš, kako je bilo hudo, sem bila tam v sobi, sem bila zadnja in drugim so nosili dojit in ti si tam čakal, kdaj bodo prinesli tvojega otroka, da ga boš videl, kakšna je. Dva dni je nisem videla (Anka, 68 let).

Ja, je bil drugi hitrejši, lažji, glede na to, da sem se pri prvem preveč zredila in je bilo ravno zato verjetno oteženo rojevanje. [...] Samo potem sem imela pa komplikacije – kapilarne krvavitve, ker so me stisnili za trebuh in pahnili kri ven. Potem sem imela cel popoldan gor kocko ledu, da mi je zmrznil trebuh. In je razlagal zdravnik, da so s takim porodom, če so ženske doma rojevale, umrle, navadno so izkrvavele (Majda, 73 let).

Podporna vloga ožje in širše skupnosti v obporodni oskrbi

Pri porodu doma so večinoma pomagale ženske. Obe intervjuvanki, ki sta rodili doma, navajata, da sta pri porodu pomagali babica in mama.

[...] In sem sedela na peči, in ko je prišla mama v hišo, sem ji rekla, da sem vsa mokra. Takrat mi je odtekla že voda. Mama mi je rekla, naj se kar odpravim, se malo umijem in grem gor v sobo (Ivica, 95 let).

Pri porodu so bile moja mama, ena teta in tašča. Tri ženske in babica (Zorica, 76 let).

Ja, pri porodu smo bile samo jaz in babica in mama, ki je prišla sem pa tja kaj pogledat (Ivica, 95 let).

Partnerji so bili takrat izvzeti iz porodnega prostora, nekoliko manj doma kot v porodnišnici, saj so doma

po svojih močeh pomagali babici. Njihova vloga je bila pretežno priskrbeti pomoč ženskam oziroma jih peljati v porodnišnico.

In potem se je začelo in sem šla v posteljo in čakala na čudež [smeh]. Potem je mož odšel iskat babico, sreča je bila blizu, je šel hodit na drug hrib. Takrat nismo imeli avta, nismo imeli nič. Je pomagal babici prinesiti torbo. [...] Ne, mož ni bil pri porodu. Je bil ves iz sebe in je kadil gor na oknu. Sicer je bil v pripravljenosti, če bi bilo kaj za pomagati. V glavnem so bile moja mama, teta in še tašča. Mož je pa otroka prišel pogledat takoj, ko sem rodila. [...] In potem sem bila očitno malo raztrgana, zato je šel mož po zdravnika, da me je prišel zaščit (Zorica, 76 let).

V porodnišnici so pomoč nudile medicinske sestre, babice in zdravniki. Intervjuvanke so bile večinoma zadovoljne z odnosom strokovnjakov, predvsem so poudarjale svoj odnos z bobicami.

Je bila pa zelo prijazna ta babica in je hitro vse uredila. [...] Babica je prišla takoj. Me je pregledala, je rekla, da ravno hitro ne bo, da prvi porod ne gre tako hitro. Je prišla zjutraj, je bila pa cel dan tukaj pri meni. [...] Ja, je bila res taka prijazna in dostopna ženska, zelo prijazna. Tako, da me je hodila potem tudi vsak dan obiskovat, pregledat otroka, in ko je bilo za kopati (Zorica, 76 let).

Zdravnik, babica in medicinske sestre. Več jih je bilo, ker so mislili, da bodo morali narediti carski rez (Majda, 73 let).

Nekoliko pomoči je družinam nudila tudi skupnost, tako da jim je podarila nekaj osnovnih pripomočkov za novorojenčka. Ker so živeli v pomankanju, je bila to takrat za družine pomembna gesta, ki so se je, kot pravijo tudi intervjuvanke, močno razveselili. Kot je povedala ena izmed intervjuvank, pa so tudi nekdanji poudarjali pomen dojenja, saj so ženski z namenom, da tega procesa ne bi ovirali, omogočili, da je bila dlje časa doma.

Ja, od socialnega smo tudi dobili nekakšne plenice, eno malenkost so dali že v nosečnosti, da smo imeli potem že pripravljeno. Nekaj za silo, ampak lepo. Pakete, plenice in osnovne potrebščine za dojenčka smo dobili pa od občine (Ivica, 95 let).

Ja, sem dojila otroka več kot eno leto. In potem je še zdravnik v III [op. a. omeni kraj dela] uredil, ker sem samo dojila, da sem bila še doma, namesto po štiri ure sem bila ves čas doma in sem potem začela kar po osem ur delati, ker je bilo predaleč (Zorica, 76 let).

Determinacija zdravstvenega statusa skozi družbeni status

Porodni dogodek je krojila tudi revščina. Ženske iz oddaljenih krajev niso imele avtomobilov, zato je bil dostop do že tako oddaljene porodnišnice še težji. Ker telefonov ni bilo, niso mogle domov sporočiti, da so rodile. Najstarejša izmed intervjuvank je doma rojevala na koruznih lupinah, saj niso imeli vzmetnice.

Saj veš, revščina je bila. Nismo imeli vzmetnice, ampak

tiste olupke od koruze. Smo imeli posteljo iz tistega, ki je bila vsako leto očiščena, oprana (Ivica, 95 let).

[...] In potem je prišel mož nevede, ali sem že rodila ali ne, ker ni bilo telefonov, nisem imela kam sporočiti, da sem rodila (Anka, 68 let).

Ja, ampak če pomisliš, koliko dela je bilo doma, vse tisto oprati, rjuhe, takrat ni bilo pralnega stroja, smo morali vse na roke oprati. Uboga moja mama. [...] Ja, ni bilo lahko. Če primerjaš zdaj, ko imajo vse. Plenice, vse je bilo treba prati na roke. Takrat so bile tiste navadne plenice. Vse je bilo treba prekuhavati, vse na roke. Šele pri tretjem otroku smo dobili pralni stroj. Pozimi nismo imeli kje sušiti, zvečer, ko so šli vsi spat, sem potegnila vrv čez kuhinjo, da sem dala sušiti. Saj ne moreš verjeti (Zorica, 76 let).

Za Goriško regijo sta imeli ključno vlogo porodnišnica v Postojni in nato še porodnišnica v Šempetru. Ena izmed intervjuvank je povedala, kako mučna je bila zanjo pot do Postojne, pri drugi intervjuvanki pa je bila oddaljenost porodnišnice razlog za porod na domu.

Tisti dan je bil močan dež, cesta ni bila asfaltirana do Postojne. Me je prišel iskat ameriški Rdeči križ, kombi, in je tako treslo tja po cesti. In so mi pravili tišči, tišči. In nisem mogla več. So rekli, da saj bomo kmalu tam, sta bila z mano babica in mož, sta me držala. Takšno trpljenje, ko čakaš, komaj, da sem pričakala (Ivica, 95 let).

Ker smo bili zmenjeni tako, da bom rodila doma, ker bi morala iti roditi v Postojno, pri prvih dveh otrocih še ni bilo šempetrške porodnišnice. Smo morali vsi v Postojno. In še avta nismo imeli. Bi morali dobiti še kakšen avto, da nas pelje. [...] Takrat je zdravnik dovolil roditi doma, ker je videl, da je bila cela nosečnost v redu. Če bi bilo slučajno kaj sumljivega, ne bi bilo tako, bi morala iti v Postojno. Samo takrat za nas so bili takšni časi, da nismo imeli avta, si moral koga prositi (Zorica, 76 let).

Primanjkljaj se je kazal tudi v izvajanju prenatalne zdravstvene vzgoje. Ženske so nekaj informacij o porodu in negi novorojenčka dobile od babic in ginekologov, največ pa od drugih žensk.

Ma ne, ni bilo materinske šole, nič. Takrat si šel v posvetovalnico na pregled in tik pred koncem so povedali, kaj in kako. Ostalo so pa povedale babice, kar so povedale mame, mama še ne tako, ker jo je bilo sram povedati, bolj drugi (Zorica, 76 let).

Ma jaz sem največ informacij dobila, ker sem bila en mesec pred porodom v porodnišnici osem dni, ker sem imela povišan krvni tlak. Sem bila pa v sobi prav pri tistih, ki so že rodile. In tam so veliko povedale, kaj in kako je bilo. Tudi kako je po porodu. Večino pa je potem povedala babica, ki je prišla iz III [op. a. omeni kraj] na dom. Kar petkrat je prišla in ona mi je največ povedala. Materinske šole nismo imeli oziroma jaz nisem vedela zanjo, lahko, da je bila, ma jaz nisem vedela (Anka, 68 let).

Ena izmed intervjuvank je podala primer, kako je babica svetovala glede prehranjevanja novorojenčka.

Oba otroka sem dojila pet tednov, z muko, ma ne dovolj. Potem smo dodajali mešanice Bebiron. To je bilo takrat najboljše. Potem pa smo začeli s kravjim mlekom, nam je to tudi babica svetovala. Krave so bile zdrave in je bilo v redu (Marica, 79 let).

Diskusija

Prehod v materinstvo je pomemben mejnik v življenju mnogih žensk. Ključni dogodek v tem procesu je porod. Ženske imajo zato glede te izkušnje velika pričakovanja (Preis, et al., 2019). Kako zelo pomemben je porod za ženske, se kaže v tem, kako natančno se ga spominjajo tudi mnoga leta pozneje – vse od ure začetka popadkov pa do minute natančno ure rojstva otroka (Prosen, 2016). Porod je vsekakor subjektivna izkušnja in vsaka ženska ga dojema po svoje, tudi intervjuvank v tej raziskavi. Razlike se začnejo že pri porodnem prostoru, kjer porod kot akt poteka. Intervjuvanki, ki sta rodili doma, sta rojevali v sobi, starejša izmed njiju niti ne na postelji, ampak na koruznih lupinah. V porodnišnici se je dogodek odvijal v porodni sobi, kjer je več žensk lahko rojevalo istočasno; intimnosti ni bilo veliko, saj so bile postelje ločene le z zaveso. Lahko povzamemo, da so bile porodne prakse v institucionalnem okolju v primerjavi s sodobnimi, ki so sicer tudi danes predmet kritičnega javnega diskurza, bistveno slabše tako z vidika varovanja osebnega dostojanstva kot tudi drugih značilnosti rojevanja v tem okolju. Tiste, ki so rodile v porodnišnici, so bile deležne rutinskega britja spolovila in klistirja. Zanimivo je, da tudi najstarejša intervjuvanka, ki je rodila doma, govori o tem, kako ji je mama naročila, naj se pred porodom pripravi in umije. To kaže na to, da so tudi doma poudarjali predpripravo, pa čeprav ta ni vključevala britja. Povprečna starost intervjuvank pri prvem porodu je bila 23 let, kar je precej nižje v primerjavi z današnjo, ki je 31 let (Statistični urad Republike Slovenije, 2018).

Izkušnje, ki so nam jih ženske zaupale v intervjujih, so prispevale k iskanju odgovorov na postavljeni raziskovalni vprašanji. Prvo raziskovalno vprašanje je izhajalo iz dejstva, da so bile ženske zaradi pomanjkanja informacij v petdesetih in šestdesetih letih 20. stoletja na porod še vedno največkrat nepripravljene, kot navaja Zupančič Slavec (2018). To lahko potrdimo tudi na podlagi porodnih zgodb. Ženske so bile strokovnih informacij deležne le v manjši meri s strani ginekologov in babic, druge informacije so bile v veliki meri nestrokovne, pridobljene iz pripovedi in izkušenj drugih žensk. Danes je za izobraževanje poskrbljeno s t. i. šolo za starše, ki jo starši v pričakovanju obiskujejo v sklopu številnih srečanj (NIJZ, 2019). Raziskovalno vprašanje je izhajalo tudi iz dejstva, o katerem piše Drglin (2003): porod na hrbtu, ki se je uveljavil v tridesetih letih 20. stoletja, je bil najpogostejši položaj rojevanja v 20. stoletju, kar nakazujejo tudi izjave intervjuvank,

saj so vse rojevale leže na hrbtu. V današnjem času, ko se postavlja žensko v središče zdravstvene oskrbe, je položaj za rojevanje seveda prepuščen njeni izbiri. To potrjuje tudi raziskava, v kateri je več žensk poročalo, da so se lahko med porodom gibale, da bi našle udoben položaj; lahko so izbrale porod na tleh ali v vodi, v pokončnem položaju in ne nujno na postelji, v stoječem, čepečem ali klečečem položaju (Henderson & Redshaw 2016). Izkušnje intervjuvank potrjujejo tudi, da je bilo sodelovanje moških pri porodnem procesu nesprijemljivo, saj partnerji niso bili prisotni niti pri porodu doma niti v porodnišnici. Spremembe so se kazale pri delnem prisostvovanju moških pri porodnem dogodku na domu, saj je po pripovedi ženske mož pomagal tako, da je šel po babico in ji pomagal prinesiti stvari, tudi po zdravnika in bil na voljo, če bi bilo treba kar koli pomagati. Danes so partnerji v večini primerov prisotni pri porodu (Henderson & Redshaw, 2016).

Da med porodom niso izvajali raznih pregledov, z izjemo poslušanja plodovih srčnih utripov s Pinardovo slušalko in izvajanja Leopoldovih prijemov za ugotavljanje lege plodu, se sklada s podatki, da so v regionalni porodnišnici začeli izvajati različne preiskave šele po letu 1970 (Borisov, 1995). Tudi porodnih bolečin niso lajšali, vsaj pri prvem porodu še ne. Kot je opisala ena izmed intervjuvank, je bilo takrat samoumevno, da morajo bolečino, ki jo hitro pozabiš, prestati. Danes se za lajšanje bolečine poslužujemo številnih farmakoloških sredstev, med katera sodijo področna analgezija, inhalacijski analgetiki, narkotiki in pomirjevala ter različne nefarmakološke tehnike, tako da je samoumevnost prenašanja bolečine pozabljena (Poličnik, 2015). V eni izmed raziskav (Poličnik, 2015) so ženske med najučinkovitejšo metodo lajšanja bolečine uvrščale epiduralno analgezijo, ki ji je sledila tehnika dihanja.

Raziskava, ki so jo izvedli Clesse in sodelavci (2018), je pokazala, da je najpomembnejši faktor zadovoljstva odnos s strokovnjaki ter stalna podpora. To smo ugotavljali tudi pri intervjuvankah, saj so te navajale prijaznost zdravstvenega osebja kljub dogodkom, ki bi jih danes prepoznali kot negativne (npr. pritisk na fundus), a jih same niso označile kot take. Iz pripovedi je razvidno tudi, kako zelo pomemben je bil za ženske odnos z babico, ki so ga zelo poudarjale. Na medicinski ravni pa na visoko zadovoljstvo vplivajo občutek varnosti, rojstvo zdravega otroka ter razumska raba zdravil in porodniških intervencij (Clesse, et al., 2018). Tudi na primeru porodnih zgodb lahko sklepamo, da sta na pozitivno porodno izkušnjo nedvomno vplivala izid poroda in rojstvo zdravega novorojenčka. To se je v intervjujih kazalo tudi s čustvenim načinom pripovedovanja. Raziskave so pokazale razlike v zadovoljstvu žensk, ki so imele spontani vaginalni porod, načrtovani ali urgentni carski rez in vaginalni porod z neko obliko izhodne operacije. Pri ženskah z urgentnim porodom obstaja večja verjetnost za

negativne izkušnje: instrumentalni vaginalni porod je v primerjavi s spontanim vaginalnim porodom predstavljal slabše izkušnje, urgentni carski rez pa je povezan z najslabšo porodno izkušnjo (Preis, et al., 2019). Do podobnih zaključkov smo prišli v naši raziskavi, kajti vse intervjuvanke, ki so imele vaginalni porod, so navajale pozitivna čustva, veselje, nekatere so s solzami v očeh pripovedovale o dogodku. Edina, ki je izrazila negativna čustva (obžalovanje), je bila intervjuvanka s carskim rezom, saj poroda ni doživela tako, kot si je želela – pri njem ni mogla aktivno sodelovati, niti ni svojega otroka videla takoj po rojstvu.

Izkušnjo poroda doma v primerjavi s porodom v porodnišnici je ena izmed intervjuvank opisala kot »prihod v nebesa«. Upoštevati moramo, da je bilo takrat doma prisotno veliko pomanjkanje materialnih dobrin in je bila bolnišnica že s tega vidika prepoznana kot »boljša izbira«. Pogoji so se z leti izboljševali, kar se kaže pri opisu nadaljnjih porodov žensk v porodnišnici, kjer so se že kazale novosti, kot je npr. protibolečinska terapija. Če primerjamo z današnjim časom, so bile ležalne dobe enkrat daljše kot danes, najbolj pomembna pa je možnost, da danes matere lahko sobivajo z novorojenčkom, kar takrat ni bilo mogoče. Ženske so po porodu videle svojega otroka šele naslednji dan ali celo čez več dni, kar je zanesljivo vplivalo na njihovo psihično počutje ter na navezanost oziroma prehod v materinstvo. Poleg tega imamo danes na razpolago avtomobile, številne medicinske naprave v bolnišnicah in pripomočke za novorojenčke, ki si jih nekoč niso znali niti predstavljati ali so si jih le želeli. Kljub temu jih po ugotovitvah Prosen (2016) v današnjem času v institucionalni oskrbi zaradi nepremišljene rabe pogosto kritično presojava. Čeprav bi tudi danes lahko razpravljali o avtonomiji žensk ob rojevanju, je iz zgodb razvidno, da imajo ženske danes kljub vsemu več možnosti izbire, boljše zdravstveno in socialno varnost.

V raziskavo je bil vključen manjši vzorec žensk iz različnih predelov Goriške, kar ne dovoljuje široke generalizacije. Kljub temu je bila zadostnost podatkov in ponavljanje zaznano že po petem intervjuju. Starejše ženske, ki bi bile pripravljene govoriti o svoji porodni izkušnji, je bilo tudi zelo težko najti, kar kaže tudi odnos družbe tistega časa do rojevanja. Omejitve so povezane tudi z raziskovalno metodo, saj obstaja možnost, da je natančen spomin na porodno zgodbo zaradi daljšega časovnega obdobja zbledel. Prosen (2016) navaja, da na spomine preteklih dogodkov in s tem na resničnost podatkov lahko vpliva tudi okolica, zato smo ta vpliv skušali zmanjšati s tem, da smo intervjuje izvedli na domovih žensk, kjer so se počutile udobno. Prihodnje raziskovanje je smiselno usmeriti v podrobno etnografsko raziskavo, osvetliti tudi razlike med mestnim in podeželskim okoljem ter proučiti vidik še živečih zdravstvenih delavcev, ki so v tistem času sodelovali pri rojevanju.

Zaključek

Porod je edinstven dogodek, naravni in družbeni mejnik človekovega življenja, ki prinaša številne spremembe. Gre za enega najbolj čustvenih dogodkov, ki se za vedno vtisne v spomin in ga ni moč izbrisati. Z raziskavo smo uspeli pridobiti neposredne izjave žensk, ki so imele drugačno izkušnjo od današnje, kar nam daje vpogled v raznolikost številnih področji in s tem omogoča primerjavo današnjih praks s preteklimi. Porod in obporodno dogajanje sta v preteklem času v večji meri izpolnila pričakovanja žensk kljub vplivu nekaterih socialnih dejavnikov in pomanjkanju materialnih dobrin, ki jih v današnjem času prepoznavamo kot neobhodne.

Nasprotje interesov / Conflict of interest

Avtorja izjavljata, da ni nasprotja interesov. / The authors declare that no conflicts of interest exist.

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Avtorja sta raziskavo konceptualno zastavila skupaj. Izvedla jo je prva avtorica. Soavtor je sodeloval pri analizi podatkov ter pregledu članka. Pri pisanju članka sta avtorja sodelovala enakovredno. / The authors jointly conceptualised the study design which was performed by the first author. The co-author was involved in data analysis and final approval of the article. In the writing of the article both authors participated equally.

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Izvirni znanstveni članek / Original scientific article

Spolna disfunkcija pri slovenskih pacientih z multiplo sklerozo: presečna raziskava Sexual dysfunction in Slovenian patients with multiple sclerosis: a cross sectional study

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Ključne besede:

demielinizacija; spolnost; motnja

Key words: demyelination; sexuality; disability

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IZVLEČEK

Uvod: Spolna disfunkcija je pri pacientih z multiplo sklerozo pogosta, ustreznih podatkov za slovensko populacijo pa ni na voljo. Namen raziskave je bil ugotoviti vrsto in delež spolne disfunkcije, razlike med moškimi in ženskami ter morebitno povezavo med spolno disfunkcijo in značilnostmi pacientov.

Metode: Presečna raziskava je bila izvedena pri pacientih z multiplo sklerozo, ki so imeli spolne odnose v zadnjih šestih mesecih in so izpolnili vprašalnik MSISQ-19 (Multiple Sclerosis Intimacy and Sexuality Questionnaire). V raziskavi je sodelovalo 368 pacientov povprečne starosti 40,9 leta in trajanjem bolezni 10,2 leta. Nevrološko prizadetost smo ocenili z EDDS (Expanded Disability Status Scale). Za primerjavo številčnih spremenljivk smo uporabili neparni t-test, za primerjavo kategoričnih spremenljivk hi-kvadrat, povezanost med značilnostmi pacientov ter posamezno obliko spolne disfunkcije pa smo ocenili s pomočjo korelacijskega koeficienta po Spearmanu.

Rezultati: Delež spolne disfunkcije, definiran kot odgovor 4 ali 5 na katero koli vprašanje v MSISQ-19, je znašal 37 %, deleži primarne, sekundarne in terciarne spolne disfunkcije pa 39,4 %, 39,9 % in 40,8 %. Med spoloma ni bilo statistično pomembnih razlik. Statistično značilno, a zelo šibko linearno korelacijo smo ugotovili med značilnostmi pacientov (starost, trajanje bolezni, EDSS, trajanje partnerske zveze) ter posamezno obliko spolne disfunkcije.

Diskusija in zaključek: Spolno disfunkcijo ima 37 % slovenskih pacientov z multiplo sklerozo. Med spoloma ni statistično pomembnih razlik, kar velja tudi za posamezne vrste spolne disfunkcije, kot so primarna, sekundarna in terciarna.

ABSTRACT

Introduction: Although sexual dysfunction in multiple sclerosis patients is frequent, there is no data for Slovenian population. The purpose of the present study was to examine the form and prevalence of sexual dysfunction, differences between males and females, and a potential link between patient characteristics and sexual dysfunction.

Methods: A cross-sectional study was conducted on patients with MS who have had sexual relation within the last 6 months and who completed the MSISQ-19 (Multiple Sclerosis Intimacy and Sexuality Questionnaire). 386 patients were included in the study with an average age of 40.9 years, and a duration of illness of 10.2 years. Neurological dysfunction was assessed with the EDDS (Expanded disability status scale). For a comparison of numerical variables and categorical variables, the unpaired t-test and a hi-square test were used, respectively. The correlation between patient characteristics and the type of sexual dysfunction was assessed by using the Spearman coefficient.

Results: The proportion of sexual dysfunction, defined as answer 4 or 5 to any question in the MSISQ-19, was 37 %. The proportions of primary, secondary and tertiary sexual dysfunction were 39.4 %, 39.9 % and 40.8 %, respectively. There were no statistically significant differences between males and females. A statistically significant but highly weak linear correlation was demonstrated between patient characteristics (age, MS duration, EDSS, duration of partnership) and different forms of sexual dysfunction.

Discussion and conclusion: Sexual dysfunction is present in 37 % of Slovenian MS patients. There are no statistically significant differences between men and women, which is also true for individual forms of sexual dysfunction including primary, secondary and tertiary sexual dysfunction.



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Uvod

Multipla skleroza (MS) je kronična vnetna demielinizacijska bolezen osrednjega živčevja, ki je domnevno avtoimunskega izvora (Putzki & Hartung, 2009). Ženske obolevajo dva- do štirikrat pogosteje kot moški (Kalb, 2007; Hirst, et al., 2008; Putzki & Hartung, 2009; Leray et al., 2016). Glede na to, da so demielinizacijski plaki lahko razsejani po vsem osrednjem živčevju, so znaki in simptomi praviloma različni in obsegajo motnje vida, motnje koordinacije, sfinkterske motnje, spastičnost, tremor, bolečine, motnje razpoloženja, povečano utrudljivost, kognitivne motnje in motnje mokrenja (Reitman & Kalb, 2008). Opisane spremembe lahko fizično in psihično vplivajo tudi na spolnost, ki je eden bolj kompleksnih vidikov človeškega življenja (Cassidy Pfohl, 2005). Odvisna je tako od delovanja anatomskega kot tudi psihološkega sistema, v katerega so vključeni emocionalni in kognitivni procesi (Calabro, 2018). V zvezi s spolnostjo je pomembno poudariti, da se MS najpogosteje pojavi v letih, ko so ljudje spolno najbolj aktivni in je njihova reprodukcijska sposobnost na višku.

Primarna spolna disfunkcija nastane kot posledica demielinizacijskih lezij v hrbtenjači in možganih ter ima neposreden vpliv na spolne občutke in odzive. Kaže se kot zmanjšan ali celo odsoten libido, spremenjeni občutki v genitalijah ali parastezije ter zmanjšano število ali intenziteta orgazmov. Pri moških se pojavi erektilna disfunkcija, pri ženskah pa zmanjšana vaginalna vlažnost in zmanjšan tonus vaginalnih mišic (Lording, 2005; Sharon van Rey, 2005; Delaney & Donovan, 2017). Sekundarna spolna disfunkcija nastane zaradi drugih simptomov MS, ki nimajo neposrednega vpliva na spolno funkcijo. Tako lahko utrudljivost zmanjša interes za spolnost in vpliva na spontanost, spastičnost vpliva na udobje in položaj pri spolnem odnosu, odsotnost občutkov v genitalijah zmanjšuje udobje in zadovoljstvo, šibkost moti spolni odnos, bolečina zmanjša željo po spolnih odnosih in zadovoljstvo, kognitivna prizadetost pa vpliva na pozornost in psihogeno spodbudo (Cassidy Pfohl, 2005; Foley & Werner, 2012). Terciarna spolna disfunkcija nastane zaradi psihičnih, socialnih in kulturnih razlogov, ki vplivajo na željo po spolnosti. Pomembno vlogo imata tudi slaba samopodoba in pomanjkanje samozavesti. Pacienti si dopovedujejo, da kot invalidi niso spolno privlačni. Značilne so misli: »Če sam sebe ne maram, kako naj pričakujem, da me bo nekdo drug videl kot spolno privlačnega«; »Spolnost je zadnja stvar, ki je zame trenutno pomembna« (Dewis & Thornton, 1989; McDonald, 2005; Christopherson, et al., 2006; Ghasemi, et al., 2020).

Medtem ko podatki iz literature kažejo, da je prevalenca spolne disfunkcije pri pacientih z MS zelo velika, a tudi variabilna, saj jo ima 40–80 % žensk in 50–90 % moških (Foley, et al., 2005; Azimi, et al.,

2019), ustreznih podatkov glede na slovenske paciente z MS nimamo. Menimo celo, da je ta problem pri nas pogosto podcenjen in spregledan. Namen raziskave je bil tako ugotoviti vrsto in delež spolne disfunkcije (primarna, sekundarna, terciarna), morebitne razlike med moškimi in ženskami ter morebitno povezavo med spolno disfunkcijo in starostjo, stopnjo izobrazbe, trajanjem partnerske zveze, trajanjem bolezni in stopnjo nevrološke prizadetosti.

Metode

Opravili smo presečno deskriptivno raziskavo pri pacientih s potrjeno diagnozo MS, ki so imeli spolne odnose v zadnjih šestih mesecih in so izpolnili vprašalnik MSISQ-19 (*Multiple Sclerosis Intimacy and Sexuality Questionnaire*).

Opis instrumenta

Vprašalnik *Multiple Sclerosis Intimacy and Sexuality Questionnaire* (MSISQ-19) meri spolno disfunkcijo, vsaka postavka pa je razvrščena v eno od treh kategorij: primarna spolna disfunkcija, sekundarna spolna disfunkcija in terciarna spolna disfunkcija. Sestavljen je iz 19 vprašanj in v praksi omogoča oceno vpliva simptomov bolezni na spolno življenje. Primeren je za oba spola. Pacient na petstopenjski Likertovi lestvici označi, v kakšni meri simptomi MS vplivajo na njegovo spolno aktivnost ali zadovoljstvo v zadnjih šestih mesecih. Številke od 1 do 5 pomenijo naslednje: 1 – nikoli (nikoli niso vplivali na mojo spolno aktivnost ali zadovoljstvo), 2 – redko, 3 – občasno, 4 – skoraj vedno, 5 – vedno (vedno so vplivali na mojo spolno aktivnost ali zadovoljstvo) (Sanders, et al., 2000). Vprašalnik ima zelo visoko notranjo zanesljivost, Cronbachov alfa koeficient za celoten vprašalnik je 0,91, za primarno spolno disfunkcijo 0,82, za sekundarno spolno disfunkcijo 0,85 ter za terciarno spolno disfunkcijo 0,87.

Stopnjo prizadetosti zaradi MS smo ocenili z lestvico EDSS (*Expanded Disability Status Scale*). Lestvica ima razpon od 0, kar pomeni, da je pacient brez nevrološke prizadetosti, do 10, kar pomeni smrt zaradi bolezni.

Opis vzorca

V raziskavo smo uvrstili paciente s potrjeno diagnozo MS, ki se zdravijo v specializiranih centrih MS (Ljubljana, Maribor) ali na nevroloških oddelkih drugih slovenskih bolnišnic (Celje, Novo mesto, Izola, Šempeter, Slovenj Gradec, Murska Sobota). Med marcem 2017 in junijem 2018 je vprašalnik o spolni disfunkciji izpolnilo 414 pacientov, ki so imeli v zadnjih šestih mesecih spolne odnose. Na vsa vprašanja je odgovorilo 368 (89 %) pacientov, ki smo jih uvrstili v nadaljnjo analizo. Ti pacienti so bili v povprečju stari 40,9 leta (Tabela 1). Žensk je bilo 270,

Tabela 1: Splošne značilnosti in socialno-ekonomski status anketiranih pacientov z multiplo sklerozo, ki so odgovorili na vsa vprašanja (MSISQ-19)**Table 1:** Patient characteristics and socio-economic status in multiple sclerosis patients who responded to all questions (MSISQ-19)

Značilnosti / Characteristics	Vsi / All (n=368)	Moški / Men (n=98)	Ženske / Women (n=270)	p
Starost (v letih), \bar{x} (s)	40,9 (9,7)	42,1 (10,1)	40,4 (9,6)	0,137
Trajanje bolezni (v letih), \bar{x} (s)	10,2 (7,2)	11,1 (7,7)	9,9 (7,0)	0,168
EDSS, \bar{x} (s)	2,6 (1,8)	2,8 (2,1)	2,5 (1,7)	0,138
Izobrazba, n (%)				
Osnovna šola	16 (4,3)	2 (2,0)	14 (5,2)	0,004
Poklicna/srednja	198 (53,8)	68 (69,4)	130 (48,1)	
Univerzitetna	139 (38,8)	23 (23,5)	116 (43,0)	
Magisterij/doktorat	15 (4,1)	5 (5,1 %)	10 (3,7)	
Status, n (%)				
Dijak / študent	10 (2,7)	2 (2,0)	8 (3,0)	0,146
Zaposlen	162 (44,0)	39 (40,0)	123 (45,6)	
Brezposeln	35 (9,5)	6 (6,1)	29 (10,7)	
Skrajšan delovni čas	83 (22,6)	22 (22,4)	61 (22,6)	
Zakonski status, n (%)				
Samski	41 (11,1)	13 (13,3)	28 (10,4)	0,383
Poročen	184 (50,0)	54 (55,1)	130 (48,1)	
Izvenzakonska zveza	139 (37,8)	30 (30,6)	109 (40,4)	
Ločen	4 (1,1)	1 (1,0)	3 (1,1)	
Trajanje partnerske zveze (v letih), \bar{x} (s)	17,0 (10,4)	17,0 (10,5)	17,0 (10,4)	0,948

Legenda / Legend: MSISQ-19 – vprašalnik Multiple Sclerosis Intimacy and Sexuality Questionnaire, ki meri stopnjo spolne disfunkcije / Multiple Sclerosis Intimacy and Sexuality Questionnaire, measuring the degree of sexual dysfunction; EDSS – Expanded Disability Status Scale, razpon od 0 (brez nevrološke prizadetosti) do 10 (smrt zaradi bolezni); p – statistična značilnost / statistical significance; n – number / število; % – odstotek / percentage; s – standardni odklon / standard deviation; \bar{x} – povprečje / average

moških pa 98. Povprečen čas trajanja bolezni je bil 10,2 leta, povprečna ocena po EDSS pa 2,6. Večina pacientov (53,8 %) je imela opravljeno srednjo ali poklicno šolo, zaposlenih pa je bilo 44 %. Prevladovali so poročeni (50 %), povprečno trajanje partnerske zveze je bilo 17 let. Statistično pomembna razlika med spoloma je obstajala le v izobrazbi ($p = 0,004$), in sicer je bil večji delež univerzitetne izobrazbe pri ženskah (43 % proti 23,5 %).

Opis poteka raziskave in obdelave podatkov

Udeležence smo predhodno seznanili z namenom raziskave in jim pojasnili, da v raziskavi sodelujejo prostovoljno ter da sodelovanje lahko brez kakršnih koli posledic odklonijo. Pacienti so izpolnili vprašalnik MSISQ-19 v papirnati obliki ali v spletnem orodju IKA. Pacienti, ki so izpolnili vprašalnik v papirnati obliki, so podpisali tudi informirana soglasja. Za raziskavo smo predhodno pridobili pisna soglasja predstojnikov posameznih nevroloških klinik in centrov MS.

Številčne spremenljivke smo prikazali kot srednje vrednosti in standardne deviacije, kategorične pa kot deleže v odstotkih. Spolno disfunkcijo, ki smo jo prikazali tudi kot kategorično spremenljivko, smo po priporočilu vprašalnika definirali kot

odgovor 4 ali 5 na petstopenjski Likertovi lestvici. Za primerjavo številčnih spremenljivk med spoloma smo uporabili neparni t-test, za primerjavo kategoričnih spremenljivk pa hi-kvadrat. Morebitno povezanost med značilnostmi pacientov (starost, trajanje bolezni, EDSS, trajanje partnerske zveze) ter posamezno obliko spolne disfunkcije glede na MSISQ-19 smo ocenili s pomočjo korelacijskega koeficienta po Spearmanu. Statistično značilna je vrednost $p < 0,05$. Za obdelavo podatkov smo uporabili statistični program SPSS, verzija 22 (SPSS Inc., Chicago, IL, ZDA).

Rezultati

Delež spolne disfunkcije glede na MSISQ-19 je znašal 37 % brez pomembne razlike med spoloma (Tabela 2). Tudi v deležu primarne spolne disfunkcije (39,4 %), sekundarne spolne disfunkcije (39,9 %) in terciarne spolne disfunkcije (40,8 %) ni bilo pomembnih razlik med spoloma. To velja tudi, če smo posamezno vrsto spolne disfunkcije ocenili številčno.

Pri iskanju povezave med značilnostmi pacientov (starost, trajanje bolezni, EDSS, trajanje partnerske zveze) ter posamezno obliko spolne disfunkcije smo ugotovili statistično značilno, a zelo šibko linearno korelacijo (Tabela 3).

Tabela 2: Stopnja in vrste spolne disfunkcije anketiranih pacientov, ki so odgovorili na vsa vprašanja (MSISQ-19)
Table 2: Sexual dysfunction in multiple sclerosis patients who responded to all questions (MSISQ-19)

Značilnosti / Characteristics	Vsi / All (n=368)	Moški / Men (n=98)	Ženske / Women (n=270)	p
Delež spolne disfunkcije, n (%)	136 (37)	39 (39,8)	97 (35,9)	0,934
Spolna disfunkcija po MSISQ-19 (19–95), \bar{x} (s)	34,0 (11,7)	33,8 (12,4)	34,0 (11,4)	0,850
Delež primarne spolne disfunkcije*, n (%)	145 (39,4)	41 (41,8)	104 (38,5)	0,689
Primarna spolna disfunkcija (5–25)***, \bar{x} (s)	10,0 (4,2)	9,5 (4,2)	10,2 (4,1)	0,166
Delež sekundarne spolne disfunkcije*, n (%)	147 (39,9)	43 (43,9)	104 (38,5)	0,351
Sekundarna spolna disfunkcija (9–45)***, \bar{x} (s)	15,8 (5,9)	15,7 (5,7)	15,8 (5,9)	0,880
Delež terciarne spolne disfunkcije*, n (%)	150 (40,8)	44 (44,9)	106 (39,3)	0,065
Terciarna spolna disfunkcija (5–25)***, \bar{x} (s)	8,2 (3,7)	8,6 (4,2)	8,1 (3,5)	0,236

Legenda / Legend: MSISQ-19 – vprašalnik Multiple Sclerosis Intimacy and Sexuality Questionnaire, ki meri stopnjo spolne disfunkcije / Multiple Sclerosis Intimacy and Sexuality Questionnaire, measuring the degree of sexual dysfunction; * – definirano kot odgovor > 4 na katero koli vprašanje / defined as value >4 to any question; ** – razpon vrednosti / span of values; p – statistična značilnost / statistical significance; n – number / število; % – odstotek / percentage; s – standardni odklon / standard deviation; \bar{x} – povprečje / average

Tabela 3: Korelacijski koeficienti (Spearman) med posameznimi značilnostmi pacientov in komponentami spolne disfunkcije

Table 3: Spearman correlation coefficients between different patient characteristics and sexual dysfunction

Značilnosti / Characteristics	MSISQ-19	Primarna / Primary	Sekundarna / Secondary	Terciarna / Tertiary
Starost, r_s (p)	0,316 (< 0,001)	0,316 (< 0,001)	0,308 (< 0,001)	0,139 (0,007)
Trajanje bolezni, r_s (p)	0,247 (< 0,001)	0,221 (< 0,001)	0,247 (< 0,001)	0,143 (0,006)
EDSS, r_s (p)	0,377 (< 0,001)	0,296 (< 0,001)	0,417 (< 0,001)	0,220 (< 0,001)
Trajanje partnerske zveze, r_s (p)	0,261 (< 0,001)	0,252 (< 0,001)	0,250 (< 0,001)	0,118 (0,031)

Legenda / Legend: MSISQ-19 – vprašalnik Multiple Sclerosis Intimacy and Sexuality Questionnaire, ki meri stopnjo spolne disfunkcije / Multiple Sclerosis Intimacy and Sexuality Questionnaire, measuring the degree of sexual dysfunction; EDSS – Expanded Disability Status Scale, razpon od 0 (brez nevrološke prizadetosti) do 10 (smrt zaradi bolezni); p – statistična značilnost / statistical significance; n – number / število; % – odstotek / percentage; s – standardni odklon / standard deviation; \bar{x} – povprečje / average

Diskusija

Spresečno raziskavo pri slovenskih pacientih z MS, ki so bili v povprečji stari 41 let in so imeli EDSS 2,6, smo ugotovili, da ima 37 % pacientov spolno disfunkcijo ter da ni statistično pomembnih razlik med spoloma, kar velja tudi za posamezne vrste spolne disfunkcije (primarna, sekundarna in terciarna). Med splošnimi značilnostmi pacientov ter posamezno obliko spolne disfunkcije smo sicer ugotovili statistično značilno, a zelo šibko linearno korelacijo, ki pa je praktično gledano nepomembna. Razmerje med ženskami in moškimi preiskovanci je bilo v naši raziskavi 2,6 : 1,0, kar je primerljivo z raziskavami v tujini in ustreza tudi splošno sprejetemu vzorcu zbolevanja za MS (Hirst, et al., 2008; Putzki & Hartung, 2009).

Če primerjamo naše izsledke s podobnimi raziskavami, lahko ugotovimo, da je delež spolne

disfunkcije pri naših pacientih med nižjimi tako pri moških kot pri ženskah. Podobno prevalenco so ugotovili le Tzortzisa in sodelavci (2008), ki so v raziskavo vključili 63 pacientk z novodiagnosticirano MS in z našo raziskavo primerljivim EDSS (2,3), v kontrolno skupino pa 61 zdravih prostovoljk z enakimi osnovnimi značilnostmi. Pri pacientkah z MS so spolno disfunkcijo ugotovili pri 34,9 %, v kontrolni skupini pa pri 21,3 %. Podobno raziskavo s kontrolno skupino zdravih prostovoljk so opravili tudi pri 64 iranskih bolnicah z MS.

Pomembna razlika med skupinama je bila le v doseganju orgazma in stopnji depresije, medtem ko o deležu spolne disfunkcije avtorji žal ne poročajo (Alehashemi, et al., 2019). Ostale raziskave poročajo o bistveno večjih deležih spolne disfunkcije, kar je verjetno tudi posledica višje starosti pacientov, daljšega trajanja bolezni, večje nevrološke prizadetosti in

ne nazadnje tudi različne metodologije ter uporabe različnih vprašalnikov. Tako sta Lew - Starowicz in Rola (2013) pri 137 ženskah z MS vsaj eno obliko spolne disfunkcije ugotovila pri 83 %, Čelik in sodelavci (2013) pa pri 60,7 %, in sicer pogosteje pri ženskah (59,3 %) kot pri moških (40,7 %). V novejši ameriški raziskavi, v kateri so prav tako uporabili vprašalnik MSISQ-19, so spolno disfunkcijo ugotovili pri 64,2 % pacientov, ki so bili v povprečju stari 46 let (Domingo, et al., 2019).

Kilic in sodelavci (2012) so pri 45 turških pacientih z MS (23 žensk in 22 moških) ugotovili, da je spolna disfunkcija v večji meri prisotna pri ženskah (60,9 %) kot pri moških (13,6 %). Na zelo nizek delež spolne disfunkcije pri moških je verjetno vplivalo tudi to, da je turška družba zelo konzervativna ter religiozna, zato je spolnost še vedno tabu. Ker ljudje s področja spolnosti ne prejmejo nobene formalne izobrazbe, so moški še vedno tisti, ki jim spolnost pripada in se lahko predajajo užitek, za ženske pa pomeni le zakonsko dolžnost. Nalogi slednjih sta rojevanje ter skrb za družino, kar lahko ob preobilici dela vodi v hormonske spremembe. Po drugi strani pa nekateri moški verjetno niso bili pripravljeni govoriti o težavah s spolnostjo, saj v turški kulturi prevladuje miselnost, da so moški vedno pripravljeni na spolne odnose. Poleg tega so intervjuje z moškimi opravljale le ženske, zato je možno, da so moški težje spregovorili o intimnih problemih. K veliki razliki med deležem moške in ženske spolne disfunkcije je verjetno pripomoglo tudi daljše trajanje bolezni pri ženskah (Kilic, et al., 2012).

Kisić-Tepavčević in sodelavci (2015) so šestletno raziskavo opravili pri 93 srbskih pacientih z MS, pri katerih so ocenili prisotnost in stopnjo spolne disfunkcije na začetku bolezni, po treh letih in po šestih letih. Ugotovili so, da so se simptomi spolne disfunkcije bistveno poslabšali v času trajanja raziskave tako pri moških kot pri ženskah (Kisić - Tepavčević, et al., 2015). Problemi s spolnostjo so prisotni tudi pri homoseksualnih pari, kar je raziskal Esmail (2010), ki je v raziskavo vključil štiri moške homoseksualne pare. MS je zmanjšala spolno aktivnost in število spolnih odnosov, vzroki pa so bili pomanjkanje energije, utrudljivost, zmanjšanje libida ter težja vzpostavitev erekcije in ejakulacije. Poglobljene intervjuje pri pacientkah z MS so opravili Yilmaz in sodelavci (2017), ki so izpostavili tri glavne teme: negotovost, spremembe v spolnem življenju ter občutek manjvrednosti. Pacientke so bile zaskrbljene zaradi napredovanja bolezni in vpliva MS na njihovo telesno zdravje. V spolnosti so občutile predvsem pomanjkanje spolne sle, zmanjšane občutke, nezmožnost doseči orgazem ter zmanjšanje spolnega zadovoljstva. Dve pacientki sta poročali tudi o urinski inkontinenci med spolnim odnosom. Pacientke so izpostavile dejstvo, da se v zakonskem življenju počutijo nesposobne kot ženske (Yilmaz, et al., 2017).

Relativno nizka prevalenca spolne disfunkcije pri slovenskih pacientih z MS nas ne sme zavesti, saj je možno, da je naša raziskava problem deloma

podcenila. Ne glede na to pa vprašalnik MSISQ-19, ki smo ga uporabili v raziskavi, nedvomno predstavlja dobro izhodišče za začetek pogovora med pacienti in zdravstvenim osebjem o težavah v spolnosti. Še vedno je namreč spolnost prepogosto tabu tema, o kateri pacienti in tudi zdravstveni delavci težko spregovorijo. Velikokrat tudi težko opišejo svoje težave, saj naš jezik nima primernih izrazov za določena doživljanja in občutke. Ker se spolna disfunkcija lahko pojavi že v zgodnji fazi bolezni, je zelo pomembno, da s pacienti o njej spregovorimo čim prej. Pacientu je treba povedati, da so te težave lahko posledica bolezni in da jih lahko s skupnimi močmi tudi uspešno zmanjšamo ali celo odpravimo. Pacient mora dobiti občutek, da nam o temi ni neprijetno govoriti. Najbolj primeren trenutek, da spregovorimo o njej, je, ko pacienta povprašamo o motnjah mokrenja in defekacije, vse skupaj pa lahko nadgradimo še s tem, da reši enega od vprašalnikov o spolni disfunkciji.

Pri obravnavi spolne disfunkcije je potreben holističen pristop ter vključitev različnih strokovnjakov: zdravnikov (urologov, ginekologov, psihiatrov, nevrologov, zdravnikov družinske medicine), medicinskih sester, psihologov, socialnih delavcev, fizioterapevtov, delovnih terapevtov ter zakonskih in družinskih psihoterapevtov. Ob sodelovanju različnih strok in ob multidisciplinarni timski obravnavi lahko najdemo priložnost za pomoč pacientom s tovrstnimi težavami. Glede na to, da je depresija pogost spremljevalec MS, ki vpliva tudi na spolno disfunkcijo, bi bilo treba pri obravnavi teh pacientov narediti rutinski pregled razpoloženja tako na primarni ravni kot tudi pri specialistični obravnavi. Poleg usposobljenega zdravstvenega osebja pa je ključ do boljše spolnosti nedvomno odkrit pogovor s partnerjem (Kalb, 2012). Ker MS spremeni tudi pravila in vloge med partnerjema, se moški velikokrat ne počutijo več dovolj močnejši, saj morajo žene prevzeti nekatere njihove aktivnosti. Zato pogosto težko spregovorijo o svojih problemih. Moški se lahko počutijo tudi manj samozavestni in nesposobni, da bi spolno vzburlili svoje partnerke, zaradi česar se njihova vloga močnega in samozavestnega partnerja spremeni v odvisno in podrejeno.

Glavna pomanjkljivost naše raziskave je, da nimamo ustrezne kontrolne skupine zdravih prostovoljcev, ki bi se z našimi preiskovanci ujemale v spolu, starosti in drugih relevantnih značilnostih. Poleg tega je naša raziskava presečna, zato se spolna disfunkcija lahko spreminja, kar bi lahko ugotovili z longitudinalno raziskavo. Kljub temu da je bilo v raziskavo uvrščenih okoli 10 % slovenskih pacientov z MS, bi z večjim številom preiskovancev še povečali zanesljivost naših izsledkov.

Zaključek

V primerjavi z nekaterimi raziskavami v tujini je pogostost spolne disfunkcije pri slovenskih pacientih

z MS med najnižjimi. Ker pa je naša raziskava prva te vrste, bo v prihodnosti treba pridobiti še dodatne podatke na večjem vzorcu pacientov in po možnosti ob sočasni uporabi kontrolne skupine zdravih prostovoljcev. Na tem področju je potreben premik, tako da bi obravnavo teh simptomov vključili v redne nevrološke preglede in po zgledu iz tujine organizirali tudi učne delavnice za paciente in njihove partnerje.

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Prispevek avtorjev / Author contributions

Prva avtorica je načrtovala raziskavo, opravila pregled obstoječe literature, izvedla raziskavo ter sodelovala v uvodu, metodah, rezultatih, diskusiji in zaključku. Druga avtorica je sodelovala pri izboru literature, uvodu in metodah. Tretji avtor je sodeloval pri rezultatih, diskusiji in zaključku. / The first author was responsible for planning of the study, the review of the literature, conducting of the study, and contributed to Introduction, Methods, Results, Discussion and Conclusion of the paper. The second author contributed to the review of the literature, and contributed to Introduction and Methods. The third author contributed to Results, Discussion and Conclusions.

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Izvirni znanstveni članek / Original scientific article

Pregled publiciranja izbranih bibliografskih enot visokošolskih učiteljev strokovnih predmetov zdravstvene nege: retrospektivna raziskava

A review of publishing selected bibliographic units by lecturers of professional subjects in the study programme of nursing: a retrospective study

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Ključne besede: zdravstvo; visoko šolstvo; fakultete; kakovost; medicinska sestra.

Key words: health care; higher education; faculties; quality; nurse.

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IZVLEČEK

Uvod: Kakovost študijskih programov je povezana s strokovno in znanstveno usposobljenostjo visokošolskih učiteljev. Namen raziskave je bil pregledati publicistično aktivnost visokošolskih učiteljev izbranih strokovnih predmetov v visokošolskih institucijah za zdravstveno nego v Sloveniji.

Metoda: Retrospektivno so bili pregledani javno dostopni podatki o publiciranju 76 visokošolskih učiteljev, nosilcev dvanajstih strokovnih predmetov v sedmih visokošolskih institucijah na področju zdravstvene nege, za obdobje 2010–2015. Podatki so prikazani z opisno statistiko.

Rezultati: V prikazanem obdobju je bilo evidentiranih 4.337 enot publiciranja, na enega visokošolskega učitelja povprečno 57,32 ($s = 59,05$). Od tega je bilo največ mentorstev diplom ($n = 2928$, 67,30 %), najmanj izvirnih znanstvenih člankov ($n = 268$, 6,21 %), še manj preglednih znanstvenih člankov ($n = 46$, 1,10 %). Obstajajo razlike v publiciranju na splošno med fakultetami ($\chi^{(2)} = 14,272$, $p = 0,027$), pri mentorstvih ($\chi^{(2)} = 16,767$, $p = 0,010$), preglednih znanstvenih člankih ($\chi^{(2)} = 28,442$, $p < 0,001$) uredništvih ($\chi^{(2)} = 17,870$, $p = 0,007$).

Diskusija in zaključek: Nosilci strokovnih predmetov zdravstvene nege kažejo različne aktivnosti na področju publiciranja bibliografskih enot. Visokošolske institucije naj spodbujajo visokošolske učitelje k publiciranju ter s tem pospešujejo njihov strokovni in znanstveni razvoj. Publiciranje znanstvenih bibliografskih enot bi bilo smiselno dodati tudi merilom za habilitacijo v naziv predavatelja.

ABSTRACT

Introduction: The quality of study programmes is related to the academic skills of higher education lecturers. The aim of the research was to examine the publications of lecturers of professional subjects at higher education institutions offering nursing study programmes in Slovenia.

Method: Publicly available data of publications by 76 lectures of 12 professional subjects at higher education institutions offering nursing study programmes were retrospectively reviewed for the period from 2010 to 2015. Data are presented with descriptive statistics.

Results: 4337 units of publication were published in the period, per one lecturer 57.32 ($s = 59.05$). The most units were mentoring diploma theses ($n = 2928$, 67.30%), the lowest number of units comprised the publication of original scientific articles ($n = 268$, 6.21%), and there were even fewer review articles published ($n = 46$, 1.10 %). There are significant differences in all published units between faculties ($\chi^{(2)} = 14.272$, $p = 0.027$), in mentoring ($\chi^{(2)} = 16.767$, $p = 0.010$), review articles ($\chi^{(2)} = 28.442$, $p < 0.001$) and editorial units ($\chi^{(2)} = 17.870$, $p = 0.007$).

Discussion and conclusion: The holders of professional nursing subjects engage in various activities in the field of publishing bibliographic units. Higher education institutions should encourage higher education lecturers to publish and thus promote their professional and scientific development. Publication of scientific bibliographic units could be added as one of the criteria for appointment to the titles of higher education teachers including the title of lecturer.



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Uvod

Poklic medicinske sestre je eden izmed sedmih poklicev, ki so v Evropski uniji (EU) regulirani. Z regulacijo poklica je omogočena mobilnost delovne sile, v tem primeru diplomirane medicinske sestre oziroma diplomiranega zdravstvenika znotraj držav EU (Galbany-Estragués & Nelson, 2016). Vsi prebivalci EU imajo tako dostop do enako kakovostnih in varnih zdravstvenih storitev. Z direktivama so postavljeni minimalni standardi za izobraževanje medicinskih sester in kompetence poklica v EU (Directive 2005/36/EC, 2013/55/EU; Dalle Rose & Haug, 2014). Obe direktivi omogočata tudi razvoj kakovostnega študija zdravstvene nege (Skela-Savič, 2015a, 2015b). Najnovejša direktiva iz leta 2013 opredeli pogoje za vstop v študij in poklicne kompetence (Directive 2013/55/EU): (1) študij zdravstvene nege zahteva 12 let predhodnega splošnega izobraževanja; (2) izobraževanje je ovrednoteno s kreditnimi točkami (European Credit Transfer System, v nadaljevanju ECTS) in traja najmanj tri leta oziroma 4.600 ur, od tega 2.300 ur v kliničnem okolju; (3) študent pridobi znanja in veščine za ugotavljanje potreb pacienta po zdravstveni negi.

Če pogledamo nekoliko v preteklost, vsaj do prve direktive (Directive 2005/36/EC), je bil razvoj izobraževanja v zdravstveni negi omejen na dve fazi: prva predstavlja dodiplomsko izobraževanje na prvi bolonjski stopnji, druga pa izobraževanje na drugi in tretji stopnji. Slednja v nekaterih članicah EU še ni končana, program študija zdravstvene nege pa še ni poenoten (Råholm, et al., 2010; Lahtinen, et al., 2014), čeprav sta države k temu pred 13 leti pozivala že Spitzer in Perrenoud (2006). Pogosto citirana avtorja sodita med prve, ki so ocenjevali tudi razlike v izobraževanju medicinskih sester v EU na podlagi direktive (Directive 2005/36/EC; Kajander-Unkuri, et al., 2013; Lahtinen, et al., 2014). Avtorji (Spitzer & Perrenoud, 2006; Råholm, et al., 2010; Lahtinen, et al., 2014; Skela-Savič, 2015a, 2015b) navajajo precej težav, s katerimi se srečujemo pri razvoju univerzitetnega izobraževanja: pomanjkanje doktorjev znanosti med medicinskimi sestrami oziroma nizko število akademsko izobraženih posameznikov v zdravstveni negi, ki bi lahko vodili razvojne procese, različne pristope pri razvoju druge in tretje stopnje študija med državami EU. Tudi v slovenskem prostoru med visokošolskimi institucijami obstajajo razlike v organizaciji študija zdravstvene nege (Directive 2005/36/EC, 2013/55/EU; Skela-Savič, 2015a, 2015b).

Nekateri avtorji (Warne, et al., 2010; Collins & Hever, 2014) ugotavljajo, da je reguliran poklic prinesel tudi prednosti, kot je ureditev enotnega izobraževanja. Študijski programi so primerljivi glede na pridobljene kompetence medicinskih sester po študiju (Kajander-Unkuri, et al., 2013). V obdobju vsesplošnega pomanjkanja medicinskih sester je pomembno, da se oblikuje skupni kompetenčni model izobraževanja,

ki bo hkrati omogočal tudi mobilnost delovne sile, pacientom pa zagotavljal najvišjo mero kakovosti in varnosti v zdravstveni obravnavi (Kajander-Unkuri, et al., 2013). Razlike v izobraževanju medicinskih sester lahko pripišemo pomanjkanju informacij o študijskih programih v posameznih državah, neenotni strokovni terminologiji in nedostopnosti informacij o programu posameznih fakultet v uradnih jezikih EU. Vsebinska izobraževalnih programov na dodiplomski ravni naj izobrazijo strokovnjake zdravstvene nege, ki razumejo znanje, podprto z dokazi, in ga znajo uporabljati (Melnyk, et al., 2014). Ker je spreminjanje izobraževalnih programov za nove države drago, je pomembna podpora že razvitih držav na tem področju, kar se kaže predvsem v dostopnosti vsebin njihovih programov (Lahtinen, et al., 2014). Koristno bi bilo, da bi bilo izobraževanje za medicinsko sestro primerljivo tako na ravni evropskih držav kot tudi z državami izven evropskega prostora (Avstralijo in Ameriko) (Baumann & Blythe, 2008; Nilsson, et al., 2014).

Visokošolsko izobraževanje v Republiki Sloveniji za zdravstveno nego je regulirano z omenjenima evropskima direktivama (Directive 2005/36/EC, 2013/55/EU) in Zakonom o visokem šolstvu (ZViS, 2012). Zakon med drugim predpisuje statusna vprašanja visokošolskih institucij, pogoje za opravljanje visokošolske dejavnosti, opredeljuje javno službo v visokem šolstvu in ureja način njenega financiranja. Opredeljuje tako funkcijo fakultet, ki skrbijo za znanstveno-strokovni razvoj, kot funkcijo visokih strokovnih šol, ki so namenjene izobraževalni dejavnosti na področju ene ali več sorodnih oziroma med seboj povezanih strok. V Sloveniji imamo na področju zdravstvene nege osem visokošolskih institucij (Ministrstvo za izobraževanje, znanost in šport [MIZS], 2016). Zaradi poenotenja programov in dviga kakovostne ravni so bili v letu 2015 izdelani predlogi smernic za akreditacijo študijskega programa prve stopnje zdravstvene nege. Smernice poudarjajo, da je pomembna opredelitev usposobljenosti visokošolskih učiteljev za delo, ki se izkazuje z objavami in drugimi dokazanimi aktivnostmi (Skela-Savič, 2015a, 2015b). Kar štiri priporočila so namenjena visokošolskim učiteljem in njihovem profesionalnemu razvoju, kar se odraža v njihovem publiciranju in posredno tudi v odličnosti fakultet v lokalnem in mednarodnem okolju. Razvoj fakultet naj bi torej temeljil na profesionalnem razvoju članov fakultete, kar se odraža v njihovih raziskovalnih dosežkih v domačem in mednarodnem prostoru (O'Sullivan & Irby, 2011). Kakovost visokošolskih učiteljev je že bila predmet mnogih prispevkov tako v tujini (Williamson, 2004; Cave, 2005; Elliott & Wall, 2008) kot tudi v Sloveniji (Skela-Savič, 2015a). Nekateri celo predlagajo, naj se glede na publiciranje visokošolskih učiteljev oblikuje kazalnik kakovosti, ki bo služil samooceni in primerjavi kakovosti fakultet (Broome, et al., 2019). Predlog zadnjih smernic za akreditacijo visokošolskih institucij na področju zdravstvene nege narekuje tudi predloge za habilitacijo visokošolskih

učiteljev (Skela-Savič, 2015a): (1) ustreznost bibliografije na področju, ki ga visokošolski učitelj pokriva; (2) dokazila o uspešnem mednarodnem sodelovanju; (3) dokazljivi navedki v znanstveni literaturi; (4) pozitivne ocene poročevalcev. Ker menimo, da je kakovost študija zdravstvene nege povezana tudi s publiciranjem izvjalcev strokovnih predmetov, smo se odločili, da z raziskavo preverimo njihovo bibliografsko aktivnost.

Namen in cilji

Namen raziskave je bil pregledati bibliografske enote visokošolskih učiteljev strokovnih predmetov v visokošolskih institucijah na študijskem programu prve stopnje zdravstvene nege v slovenskem prostoru. Raziskovalna vprašanja, ki smo si jih zastavili, so bila:

- Kakšen je bil povprečen obseg objav izbranih bibliografskih enot za raziskavo visokošolskih učiteljev strokovnih predmetov v obdobju med letoma 2010 in 2015?
- Kakšne vrste tipologij objav v bibliografskem zapisu so imeli visokošolski učitelji strokovnih predmetov v obdobju med letoma 2010 in 2015?
- Kakšne so razlike v tipologiji izbranih bibliografskih enot v raziskavi visokošolskih učiteljev med vsemi visokošolskimi institucijami visokošolskih programov za zdravstveno nego?

Metode

V raziskavi smo uporabili opisni retrospektivni kvantitativni raziskovalni dizajn.

Opis instrumenta

Za namen raziskave smo naredili zbirno tabelo. Izbrali smo 12 strokovnih predmetov. Za vsak predmet smo poiskali nosilce posameznih področij (strokovne predmete): (1) etika, (2) raziskovanje, (3) geriatrija, (4) internistka, (5) onkologija, (6) supervizija, (7) zdravstvena vzgoja in promocija zdravja, (8) ginekologija, (9) obravnava mladostnika, (10) mentalno zdravje, (11) patronažna dejavnost, (12) organizacija in management. V tabelo smo zapisovali podatke o bibliografskih zapisih oziroma enotah posameznega visokošolskega učitelja, ki so objavljeni v sistemu COBISS: (1) število objavljenih izvirnih znanstvenih člankov (tipologija v sistemu COBISS 1.01), (2) število objavljenih preglednih znanstvenih člankov (tipologija v sistemu COBISS 1.02), (3) število objavljenih strokovnih člankov (tipologija v sistemu COBISS 1.00), (4) število monografij (gre za samostojno poglavje v sistemu COBISS, kamor spada več tipov objav), (5) število mentorstev (gre za samostojno poglavje v sistemu COBISS, vključili smo vsa izvedena mentorstva in somentorstva znotraj visokošolskega študija), (6) število recenzij (samostojno poglavje v sistemu COBISS) in (7) število sodelovanj v

uredniških odborih (v nadaljevanju število uredništev) (samostojno poglavje v sistemu COBISS).

Na podlagi spletnih strani vključenih visokošolskih institucij smo zbrali tudi nekatere sociodemografske in druge podatke visokošolskih učiteljev: (1) strokovni predmet, ki ga visokošolski učitelj predava, (2) najvišja dosežena visokošolska izobrazba, (3) osnovna visokošolska izobrazba iz zdravstvene nege, (4) habilitacijski naziv in (5) visokošolska institucija na področju zdravstvene nege, kjer je visokošolski učitelj zaposlen.

Opis vzorca

Vzorec so sestavljali nosilci, visokošolski učitelji izbranih strokovnih predmetov za raziskavo iz petih fakultet in dveh visokih šol za zdravstveno nego. Izbranih je bilo 12 strokovnih predmetov, ki smo jih lahko po vsebini primerjali med seboj, kar je skupaj 84 strokovnih predmetov. Med njimi ($n = 84$) je bilo kar 8 visokošolskih učiteljev večkratnih nosilcev strokovnih predmetov. Tako je končni vzorec vključeval 76 visokošolskih učiteljev strokovnih predmetov, od tega jih 9 (11,84 %) ni imelo osnovne visokošolske izobrazbe iz zdravstvene nege, 66 (86,84 %) visokošolskih učiteljev je izkazovalo osnovno visokošolsko izobrazbo iz zdravstvene nege, za enega visokošolskega učitelja (1,34 %) pa ni bilo mogoče pridobiti podatka iz javno dostopnih informacij. Največ visokošolskih učiteljev je bilo doktorjev znanosti ($n = 22$, 28,95 %). Po habilitacijskih nazivih je bilo največ visokošolskih učiteljev predavateljev ($n = 38$, 50,00 %), najmanj pa rednih profesorjev ($n = 3$, 3,94 %) (Tabela 1).

Opis poteka raziskave in obdelave podatkov

Podatke smo za namen raziskave pridobili na javno dostopnih spletnih straneh visokošolskih institucij s področja zdravstvene nege, ki naj bi uradne podatke redno posodobljale v skladu z akreditacijskimi merili (ZViS, 2012). V nadaljevanju smo na teh spletnih straneh za vsakega nosilca strokovnega predmeta poiskali njegovo prosto dostopno osebno bibliografijo v vzajemni bibliografsko-kataložni bazi podatkov virtualne knjižnice (COBIB.si). Predpostavljali smo, da imajo vsi habilitirani visokošolski učitelji bibliografsko bazo ustrezno urejeno. V Sloveniji je osem visokih šol in fakultet s področja zdravstvene nege. V vzorec smo najprej želeli vključiti visokošolske učitelje vseh osmih visokošolskih institucij za zdravstveno nego. Na koncu smo izbrali sedem visokošolskih institucij / fakultet, ki omogočajo študij zdravstvene nege. Ene nismo vključili, ker za leto 2016 nima javno dostopnih podatkov oziroma jih nismo našli.

V nadaljevanju smo prikazovanje rezultatov posameznih izobraževalnih institucij anonimizirali, tako da smo izobraževalne institucije označili F1–F7 (dodelili smo jim naključno kodo). Anonimizirali smo tudi vse visokošolske učitelje (nosilce izbranih strokovnih

Tabela 1: Opis vzorca**Table 1: Description of the sample**

Vzorec / Sample	n	%
Osnovna izobrazba visokošolskega učitelja iz zdravstvene nege		
Da	66	86,84
Ne	9	11,84
Ni mogoče pridobiti podatka	1	1,32
Izobrazba visokošolskih učiteljev		
Dodiplomski študij, prva stopnja bolonjskega programa	4	5,26
Univerzitetni študij	15	19,73
Druga stopnja bolonjskega programa	16	21,05
Znanstveni magisterij	18	23,68
Doktorat	22	28,95
Ni mogoče pridobiti podatka	1	1,33
Habilitacijski naziv visokošolskega učitelja		
Predavatelj	38	50,00
Višji predavatelj	21	27,63
Docent	8	10,52
Izredni profesor	5	6,57
Redni profesor	3	3,94
Ni mogoče pridobiti podatka	1	1,34

Legenda / Legend: n – število / number; % – odstotek / percentage

predmetov) in vsakemu dodelili ustrezno število 1–12 glede na nosilstvo strokovnega predmeta (tako ima npr. »etika« kodo 1 pri vseh izobraževalnih ustanovah). Pri vsakem nosilcu smo pod njegovo fakulteto zbrali podatke o njegovem delovanju na strokovnem in znanstvenem področju glede na zapis v osebni bibliografiji prosto dostopne virtualne knjižnice (COBIB.si).

Zbiranje podatkov smo avtorji opravili v februarju in marcu 2016 za obdobje 2010–2015. Analizo podatkov smo opravili s programom IBM SPSS, verzija 22 (SPSS Inc., Chicago, IL, ZDA). Za zbrane številске podatke smo najprej ocenili normalnost porazdelitve podatkov. S pomočjo Kolmogorov–Smirnovskega testa smo ugotovili,

da podatki niso normalno porazdeljeni, zato smo v nadaljevanju uporabili neparametrične bivariate statistične teste. Glede na osnovno opisno statistiko smo uporabili povprečje, standardni odklon, delež, od bivariate statističnih testov pa Mann-Whitneyev U in Kruskal Wallisov test (Pallant, 2002). Pri tem smo upoštevali mejo statistične značilnosti $p < 0,05$.

Rezultati

Največ visokošolskih učiteljev strokovnih predmetov, ki niso imeli osnovne izobrazbe iz zdravstvene nege, je bilo na F 2 ($n = 3$, 4,00 %), sledita F 3 in F 6 (vsaka

Tabela 2: Visokošolski učitelji po habilitacijskih nazivih – predstavljeno po izobraževalnih institucijah glede na skupno število ($n = 76$)**Table 2: Lecturers and their appointed titles – according to their education institution in comparison to the whole sample ($n = 76$)**

Habilitacijski naziv / Appointed title	F 1 n (%)	F 2 n (%)	F 3 n (%)	F 4 n (%)	F 5 n (%)	F 6 n (%)	F 7 n (%)	Skupaj / Total n (%)
Predavatelj	5 (6,66)	5 (6,66)	4 (5,33)	5 (6,66)	8 (10,66)	6 (8,00)	5 (6,66)	38 (50,66)
Višji Predavatelj	2 (2,66)	4 (5,33)	4 (5,33)	5 (6,66)	1 (1,33)	1 (1,33)	4 (5,33)	21 (28,00)
Docent	3 (4,00)	0 (0,00)	4 (5,33)	1 (1,33)	0 (0,00)	0 (0,00)	0 (0,00)	8 (10,67)
Izredni profesor	1 (1,33)	1 (1,33)	0 (0,00)	1 (1,33)	1 (1,33)	1 (1,33)	0 (0,00)	5 (6,67)
Redni Profesor	1 (1,33)	2 (2,66)	0 (0,00)	0 (0,00)	0 (0,00)	0 (0,00)	0 (0,00)	3 (4,00)

Legenda / Legend: n – vzorec / sample; % – odstotek / percentage; F1–F7 – vse udeležene fakultete v raziskavi / all participating faculties in research.

Tabela 3: Število posameznih objav po fakultetah glede na vse objave skupaj ($n = 4.356$)
Table 3: The number of published units according to faculties with regard to all publications ($n = 4.356$)

Pred./ Lecturer	Vse objave / All publications n (%) / \bar{x} (s)	I.04 n (%) / \bar{x} (s)	I.02 n (%) / \bar{x} (s)	I.01 n (%) / \bar{x} (s)	Mon n (%) / \bar{x} (s)	Men n (%) / \bar{x} (s)	Rec n (%) / \bar{x} (s)	Ured n (%) / \bar{x} (s)
F 1	713 (16,35) / 59,42 (23,04)	3 (0,07) / 0,25 (0,62)	2 (0,05) / 0,16 (0,39)	32 (0,75) / 2,66 (4,43)	17 (0,40) / 1,42 (2,35)	604 (13,87) / 50,33 (25,48)	39 (0,90) / 3,25 (3,93)	16 (0,38) / 1,33 (2,23)
F 2	1059 (24,32) / 96,27 (57,30)	10 (0,24) / 0,83 (1,27)	5 (0,12) / 0,42 (1,16)	59 (1,37) / 4,92 (5,16)	34 (0,79) / 2,83 (2,72)	848 (19,48) / 70,66 (45,22)	65 (1,50) / 5,42 (5,97)	38 (0,88) / 3,17 (4,57)
F 3	580 (13,29) / 52,63 (30,68)	7 (0,19) / 0,63 (0,90)	13 (0,30) / 1,18 (1,21)	42 (0,97) / 3,82 (4,10)	19 (0,45) / 1,72 (1,77)	423 (9,73) / 38,45 (22,66)	52 (1,20) / 4,72 (2,77)	24 (0,56) / 2,19 (4,58)
F 4	798 (18,32) / 66,50 (71,67)	100 (2,30) / 8,33 (23,63)	15 (0,35) / 1,25 (1,91)	80 (1,84) / 6,66 (11,47)	102 (2,35) / 8,50 (13,57)	289 (6,66) / 24,08 (32,01)	96 (2,21) / 8,00 (6,31)	116 (2,68) / 9,66 (15,17)
F 5	413 (9,95) / 39,36 (71,92)	15 (0,37) / 1,36 (2,42)	0 (0,00) / 0,00 (0,00)	21 (0,48) / 1,90 (3,73)	24 (0,55) / 2,18 (8,18)	263 (6,05) / 23,91 (45,28)	44 (1,01) / 4,00 (6,15)	46 (1,07) / 4,19 (8,35)
F 6	476 (10,93) / 59,50 (81,40)	1 (0,05) / 0,13 (0,29)	10 (0,23) / 1,251 (1,44)	25 (0,58) / 3,13 (6,07)	53 (1,22) / 6,63 (8,25)	350 (8,04) / 43,75 (57,33)	15 (0,35) / 1,88 (3,49)	22 (0,51) / 2,75 (6,04)
F 7	298 (6,84) / 33,11 (43,85)	14 (0,32) / 1,55 (2,28)	1 (0,05) / 0,11 (0,30)	9 (0,22) / 1,00 (2,09)	34 (0,79) / 3,78 (5,94)	151 (3,47) / 16,78 (24,09)	43 (0,99) / 4,78 (4,85)	46 (1,06) / 5,11 (8,05)
Skupaj	4.337 (100) / 57,32 (59,05)	150 (3,54) / 1,97 (9,23)	46 (1,10) / 0,61 (1,19)	268 (6,21) / 3,52 (6,09)	283 (6,55) / 3,72 (7,38)	2928 (67,30) / 38,53 (40,86)	354 (8,16) / 4,66 (5,14)	308 (7,14) / 4,05 (8,14)

Legenda / Legend: F 1 – F 7 – vse udeležene fakultete v raziskavi / all participating faculties in research; Pred. – visokošolski učitelj / higher education lecturer; I.04 – strokovni članek / professional article; I.02 – pregledni znanstveni članek / review scientific article; I.01 – izvirni znanstveni članek / original scientific article; Mon – monografija / monograph; Men – mentorstvo / mentorship; Rec – recenzija / review; Ured – uredništvo / editorialship; n – število posameznih enot bibliografskih zapisov po nosilcih predmetov / number of single publishing units by the holder of a subject; % – odstotek / percentage; \bar{x} – povprečje / average; s – standardni odklon / standard deviation

fakulteta $n = 2, 2,67 \%$). Gre za predmete raziskovanje, etika, mentalno zdravje, organizacija in management, supervizija ter promocija zdravja. Največ nosilcev predmetov je bilo habilitiranih v naziv predavatelj ($n = 38, 50,66 \%$) (Tabela 2).

V raziskovanem obdobju je bilo v bibliografiji vključenih visokošolskih učiteljev zapisanih 4.356 bibliografskih enot. Od tega je bilo največ mentorstev ($n = 2.928, 67,30 \%$). Če smo primerjali bibliografske enote posameznih visokošolskih institucij, je bilo največ izvirnih znanstvenih člankov publiciranih na F 4 ($n = 80, 29,86 \%$), kjer so imeli dva akademsko izobrazbena visokošolska učitelja strokovnih predmetov (enega docenta in enega izrednega profesorja), sledila je F 2 ($n = 59, 22,02 \%$), kjer so imeli tri akademsko izobrazbene posameznike (enega izrednega profesorja in dva redna profesorja). F 7 ($n = 9, 3,36 \%$) ni imela akademsko izobrazbenih visokošolskih učiteljev izbranih strokovnih predmetov (Tabela 2, Tabela 3).

Na F 5 so bili štirje predavatelji, ki v pregledanem obdobju niso izkazovali aktivnosti na nobenem drugem področju razen na področju mentorstev, na F 1 sta bila dva taka visokošolskega učitelja, na F 6 pa en. Na F 1 in F 5 je bilo šest visokošolskih učiteljev, ki v pregledanem obdobju niso publicirali niti izvirnega niti preglednega znanstvenega članka. Izmed sedmih izbranih visokošolskih institucij so se pri štirih nosilci strokovnih predmetov podvajali (gre za različne nesorodne strokovne predmete): F 3, F 5, F 6 in F 7. Največ podvajanj je bilo na F 6, kjer so se štirje predavatelji pojavljali pri sedmih strokovnih predmetih.

Če gledamo tipologijo bibliografskih enot glede na visokošolske institucije, je prihajalo do statično pomembnih razlik pri vseh objavah ($\chi^{2(2)} = 14,272, p =$

$0,027$), preglednih znanstvenih člankih ($\chi^{2(2)} = 28,442, p < 0,001$), mentorstvih ($\chi^{2(2)} = 16,767, p = 0,010$) ter uredništvih ($\chi^{2(2)} = 17,870, p = 0,007$).

Primerjava visokošolskih učiteljev z osnovno izobrazbo iz zdravstvene nege in ostalih kaže statistično pomembne razlike le pri izvirnih znanstvenih člankih ($U = 134,000, p = 0,005$) in monografijah ($U = 158,000, p = 0,018$) (Tabela 4). V obeh primerih so imeli več objav visokošolski učitelji z osnovno izobrazbo iz zdravstvene nege.

Glede na končno izobrazbo smo ločili visokošolske učitelje v dve skupini: v prvo skupino smo uvrstili tiste z dodiplomsko izobrazbo prve bolonjske stopnje, univerzitetno izobrazbo in drugo bolonjsko stopnjo; v drugo pa tiste z znanstvenim magisterijem in doktoratom. Statistično pomembne razlike so se glede na doseženo izobrazbo pokazale med obema skupinama pri vseh tipologijah bibliografskih enot, razen pri preglednih znanstvenih člankih in monografijah (Tabela 4). V vseh primerih so imeli več objav višje izobrazbeni.

Glede na habilitacijo smo visokošolske učitelje prav tako razdelili v dve skupini: v prvo skupino smo uvrstili predavatelje in višje predavatelje, druga pa je zajela docente, izredne in redne profesorje. Statistično pomembne razlike so se pokazale pri izvirnih znanstvenih člankih ($U = 215,000, p < 0,001$) in monografijah ($U = 316,000, p = 0,016$). Docenti, izredni in redni profesorji so imeli več objav (Tabela 4).

Izbrani nosilci strokovnih predmetov so imeli 4.337 vseh objav. Po visokošolskih institucijah je bilo največ objav na F 2 ($n = 1.059, 24,32 \%$). Povprečje so dosegale F 1 ($\bar{x} = 59,42, s = 23,04$), F 2 ($\bar{x} = 96,27, s = 57,30$), F 4 ($\bar{x} = 66,50, s = 71,67$) in F 6 ($\bar{x} = 59,50, s = 81,40$) (Tabela 3).

Tabela 4: Razlike med publiciranjem glede na fakulteto, osnovno izobrazbo (zdravstvena nege ali ne), dokončano izobrazbo in habilitacijski naziv

Table 4: Differences in publication activity between faculties, basic education level (nursing or not), completed education qualifications and appointed title

Kazalnik / Indicator	\bar{x}	s	Fakulteta / Faculty $\chi^{2(2)} / p$	Osnovna izobrazba / Basic education U / p	Končna izobrazba / Completed education U / p	Habilitacijski naziv / Appointed title U / p
Vse objave	57,37	59,49	14,272 / 0,027	210,500 / 0,158	350,500 / < 0,001	391,500 / 0,170
Strokovni članki	1,97	9,57	12,399 / 0,054	263,500 / 0,528	478,500 / 0,004	430,500 / 0,305
Pregledni članki	0,59	1,22	28,442 / < 0,001	239,500 / 0,260	641,000 / 0,336	424,000 / 0,244
Izvirni članki	3,51	6,26	9,244 / 0,160	134,000 / 0,005	335,000 / < 0,001	215,000 / < 0,001
Monografije	3,95	7,60	9,767 / 0,135	158,000 / 0,018	565,500 / 0,098	316,000 / 0,016
Mentorstvo	38,64	41,14	16,767 / 0,010	260,500 / 0,552	395,500 / 0,001	432,000 / 0,386
Recenzije	4,66	5,19	11,947 / 0,063	291,000 / 0,921	366,500 / < 0,001	388,000 / 0,152
Uredništva	4,04	8,44	17,870 / 0,007	299,500 / 0,896	465,500 / 0,005	422,500 / 0,292

Legenda / Legend: n – število enot publiciranja / publication unit; \bar{x} – povprečje / mean; $\chi^{2(2)}$ – Kruskal-Wallisov test / Kruskal-Wallis test; U – Mann-Whitneyev test / Mann-Whitney test; p – statistična značilnost / statistical significance

Med 150 enotami imajo največ strokovnih člankov objavljenih nosilci predmetov na F 4 ($n = 100$, 66,66 %), sledi F 2 ($n = 10$, 6,66 %) (Tabela 3). Povprečje preglednih znanstvenih člankov glede na 76 visokošolskih učiteljev je bilo 0,61 ($s = 1,19$), najvišje povprečje so imeli visokošolski učitelji na F 4 ($\bar{x} = 1,25$, $s = 1,91$) in F 6 ($\bar{x} = 1,25$, $s = 1,44$) (Tabela 3). Povprečje izvirnih znanstvenih člankov je bilo 3,52 ($s = 6,09$). Povprečje sta presejali F 4 ($\bar{x} = 6,66$, $s = 11,47$) in F 2 ($\bar{x} = 4,92$, $s = 5,16$) (Tabela 3).

Diskusija

Izmed vseh pregledanih bibliografskih enot v raziskavi je bil delež kakovostnih, ki jih predstavljajo izvirni znanstveni in pregledni članki, nizek. Menimo, da visokošolski učitelji strokovnih predmetov v svojih okoljih potrebujejo več spodbud za raziskovalne priložnosti in kompetence s strani visokošolskih institucij. Polit in Beck (2018) pojmujeta raziskovanje in publiciranje kot pomemben del profesionalizma v zdravstveni negi. V Sloveniji se moramo vprašati, kakšni izvajalci zdravstvene nege želimo biti: zgolj dobri strokovnjaki ali tudi dobri profesionalci – to vprašanje so si že zastavili nekateri drugi avtorji (Skela-Savič, 2009; Bregar, 2013). S pomočjo razvoja z dokazi podprtega znanja na visokošolskih institucijah bo lahko tudi klinična praksa razvijala nova znanja, iskala rešitve, podprte z dokazi, in se oddaljila od dokazov, ki temeljijo na tradiciji, intuiciji, logičnem razmišljanju, izkušnjah dela, ter drugih virov dokazov, ki niso znanstveno osnovani (Pollit & Beck, 2018).

Pomanjkanje raziskovalnega znanja medicinskih sester pri nas predstavlja ključno oviro pri implementaciji z dokazi podprtega znanja v zdravstveno nego v kliničnih okoljih (Bole & Skela-Savič, 2018). Poe in White (2010) pravita, da je izvajalce zdravstvene nege treba usposobiti do te mere, da z dokazi podprto znanje »zacveti« (ang. *flourishes*). Zato je še toliko pomembneje, da se vprašamo o pomenu profesionalizma ne le na ravni kliničnega okolja, ampak tudi na ravni fakultete. Fakultete morajo prevzeti svoj del odgovornosti in spodbujati visokošolske učitelje k večji dejavnosti na področju raziskovanja, kljub temu da kontekst visokostrokovnih programov za habilitacijo od njih tega ne zahteva (ZViS, 2012). S tem bodo razširili svoja znanja tudi na področju znanstvenega dela, ki ga bodo lahko kot predavatelji strokovnih predmetov in mentorji predali študentom.

Tuji avtorji (Tschannen, et al., 2014; Blush, et al., 2017) prav tako zaznavajo problem pomanjkanja raziskovalnih kompetenc visokošolskih učiteljev. Glede na naše ugotovitve obstajajo velike razlike med posameznimi visokošolskimi institucijami, kar lahko kaže, da imajo te še velike priložnosti za razvoj svojih visokošolskih učiteljev. Sredstva je treba vlagati v razvoj visokošolskih učiteljev na nivoju magistrskih ali doktoratov, tako strokovnih kot znanstvenih (Daw, et

al., 2018), kljub temu da so vstopni pogoji za formalne kompetence visokošolskih učiteljev za dodiplomski nivo nižje (Tschannen, et al., 2014; Blush, et al., 2017; Daw, et al., 2018). Vsekakor je profesionalizem v zdravstveni negi tesno povezan z raziskovalnimi kompetencami zaposlenih v zdravstveni negi (Skela-Savič, et al., 2017). Glede diskurza profesionalizma v zdravstveni negi v slovenskem prostoru lahko izpostavimo le nekaj avtorjev, ki se bolj ali manj pojavljajo od leta 2004 naprej (Kvas & Seljak 2004; Seljak & Kvas, 2004; Pahor, 2006; Starc & Ilič, 2007; Starc, 2009; Starc, et al., 2012; Skela-Savič, 2013; Starc, 2014; Starc, 2016; Skela-Savič, et al., 2017). Vsem je skupno, da poudarjajo izobraženo medicinsko sestro.

Največ visokošolskih učiteljev je bilo habilitiranih v naziv predavatelj. Kljub temu da so vstopni kriteriji za visokošolske učitelje na dodiplomskem izobraževanju zdravstvene nege nižji, se poudarja razvoj kompetenc visokošolskih učiteljev v zdravstveni negi v smeri raziskovalne usposobljenosti (Blush, et al., 2017; Daw, et al., 2018). Bullin (2018) kot vstopni pogoj za visokošolskega učitelja priporoča celo doktorat. Nekateri visokošolski učitelji v naši raziskavi producirajo izjemno veliko kakovostnih bibliografskih enot, spet drugi manj oziroma nič. Skela-Savič (2013) izpostavlja pomanjkanje publiciranja medicinskih sester ter ugotavlja, da te v večini niso dovolj raziskovalno usposobljene (Skela-Savič, 2013; Skela-Savič, et al., 2017).

Poudarja se, naj imajo diplomanti razvite različne veščine za reševanje problemov v praksi, kakršna je na primer tudi uporaba znanja, osnovanega na dokazih (Dowding, et al., 2012; Sommers, 2018). Ta znanja morajo pridobiti že v času študija, kar pomeni, da so visokošolski učitelji usposobljeni za njihovo podajanje in predstavljajo gonilo razvoja stroke zdravstvene nege na posameznih področjih. Rezultati kažejo, da nekateri v pregledanem obdobju niso publicirali nobenega znanstvenega ali preglednega dela. Področje njihovega dela predstavljajo mentorstva in druga dela, ki sicer zahtevajo strokovno znanje, ne kažejo pa veččin publiciranja znanstvenih bibliografskih enot. Cilj znanja, podprtega z dokazi, je navsezadnje boljša oskrba pacientov (Poe & White, 2010). Potreba po teh znanjih v klinični praksi ni bila še nikoli tako velika, kot je sedaj (Daw, et al., 2018).

Med izbranimi visokošolskimi institucijami v raziskavi je – če gledamo samo izvorne znanstvene in pregledne znanstvene članke, ki so jih v ocenjevalnem obdobju publicirali visokošolski učitelji strokovnih predmetov – število objav nizko. Ker med visokošolskimi učitelji strokovnih predmetov prevladujejo predavatelji in višji predavatelji, ki za habilitacijo potrebujejo manj objav, je lahko znanje, podprto z dokazi, manj zastopano, saj je razumevanje tega bolj značilno za visokošolske učitelje s habilitacijskimi nazivi od docenta naprej (Seyyedrasooli, et al., 2012). Pri tem je treba poudariti,

da pri nas verjetno še nismo presegli faze, o kateri je avtorica Skela-Savič (2009) že leta 2009 napisala: » [V Sloveniji [smo] še v fazi, ko so v ospredju aktivnosti za predstavljanje pomena raziskovanja za zdravstveno nego in za odkrivanje ovir razvoja raziskovanja.«

V nadaljevanju je treba izpostaviti tudi, da se kot nosilci predmetov v treh visokošolskih institucijah pojavljajo isti visokošolski učitelji. Verjetno gre za visokošolske učitelje, ki so usposobljeni za poučevanje več predmetov, ali pa gre bolj za problem, da v Sloveniji ni dovolj usposobljenih visokošolskih učiteljev za osem visokošolskih institucij s področja zdravstvene nege. S tem se srečujejo tudi v tujini, kjer pravijo, da je pridobivanje in razvoj visokošolskih učiteljev zahtevna naloga (Reid, et al., 2013; Blush, et al., 2017; Daw, et al., 2018). Za umeščanje v visokošolski prostor potrebujejo medicinske sestre veliko podpore (Blush, et al., 2017; Daw, et al., 2018). Po drugi strani se je izkazalo tudi, da izbranih strokovnih predmetov v raziskavi ne poučujejo le medicinske sestre, ampak tudi strokovnjaki drugih področij.

V strokovni javnosti se pojavljajo razprave o kakovosti visokošolskega študija zdravstvene nege v Sloveniji in usposobljenosti visokošolskih učiteljev strokovnih predmetov. Na tak zaključek napeljujejo ugotovitve raziskave (Skela-Savič, 2015), ki zelo poudarjajo predvsem usposobljenost visokošolskih učiteljev in zavezo visokošolskih institucij, da povečajo svoje zahteve do njih. Tudi v tujem prostoru so se že pred 15 leti začeli ukvarjali s kakovostjo oziroma oblikovanjem standardov za visokošolske učitelje zdravstvene nege (Hardicre, 2003). Strokovni ali znanstveni doktorat je za poučevanje v visokošolskem prostoru na tako zahtevnem področju, kot je zdravstvo, nujen (Blush, et al., 2017). Delo visokošolskih učiteljev strokovnih predmetov zdravstvene nege je zahtevno (Blush, et al., 2017), saj imajo visokošolski učitelji običajno dva delodajalca: klinično okolje in visokošolsko institucijo, ki ima pogosto večje zahteve, kot so učiteljeve visokošolske formalne delovne obveznosti. Tako klinično okolje kot visokošolska institucija pričakujeta od visokošolskih učiteljev dobro klinično delo s pacienti, študenti, prav tako pa tudi raziskovanje (Holopainen, et al., 2009). Vsekakor gre za zahtevno vlogo, pri čemer naj bi bil visokošolski učitelj strokovnega predmeta tako dober klinični strokovnjak kot akademik (Ousey & Gallagher, 2010).

Pri primerjavi visokošolskih institucij med seboj smo ugotovili velike razlike v kakovosti bibliografskih enot – če jo ocenjujemo tudi glede na publiciranje. Naše delo ni prvo na tem področju in ga lahko vzporejamo s tujo raziskavo (Broome, et al., 2019), ki je fakultete primerjala med seboj glede na njihovo dejavnost na področju publiciranja. Pri našem pregledu bibliografskih enot je pomembno, da ne gledamo samo njihovo skupno število, ampak predvsem njihovo kakovost, na kar opozarjajo tudi Broome in sodelavci (2019).

Od kakovostnega visokošolskega učitelja strokovnega predmeta se pričakuje, da je dober klinik, ima komunikacijske sposobnosti, je več v pedagoškem procesu, hkrati pa mora biti tudi raziskovalec (Salminen, 2009; Tschannen, et al., 2014; Morales, et al., 2017; Blush, et al., 2017; Daw, et al., 2018). Vprašanje je, kakšna je vloga in sposobnost managementa visokošolskih institucij na področju zdravstvene nege pri razvoju visokošolskih učiteljev strokovnih predmetov, ki bi razumeli in tudi izvajali znanstveno delo. Tu imajo konkurenčno prednost mlajše fakultete, saj so mlajši visokošolski učitelji, ki se še razvijajo, dokazano bolj večji akademskega dela kot starejši (Smith & Boyd, 2012). Strinjamo se z avtorico Skela-Savič (2015), da so predvsem fakultete odgovorne, da določijo notranje spodbude za razvoj visokošolskih učiteljev strokovnih predmetov s področja zdravstvene nege.

V vse večjem povpraševanju po kompleksnih zdravstvenih storitvah prebivalcev razvitega in nerazvitega sveta je pomembno, da na trg dela prihaja vse bolj usposobljen kader zdravstvene nege, ki zna zbirati dokaze in jih uporabiti pri svojem kliničnem delu (Daw, et al., 2018). Znanstvena pismenost visokošolskih učiteljev ni le naš diskurz, saj njihovo kompetentnost v raziskovanju poudarjajo tudi tuji avtorji (Salminen, 2009; Broome, et al., 2019). Tudi v Sloveniji je treba glede na naše rezultate povečati dejavnosti visokošolskih učiteljev za spodbujanje znanstvenoraziskovalnega dela.

Avtorji smo izvedli prvo primerjavo o publiciranju visokošolskih učiteljev strokovnih predmetov na področju zdravstvene nege v Sloveniji. Za primerjavo smo izbrali število posameznih izbranih bibliografskih enot. Lahko bi vključili tudi druge enote bibliografije, vendar smo se skušali omejiti le na tiste enote, za katere smo ocenili, da bodo za naš namen raziskave najbolj primerni. Morebitna vključitev ostalih enot bibliografije, kot so objavljeni znanstveni in strokovni prispevki, vabljeni predavanja, predavanja v tujini itd., predstavlja priložnost za nadaljnje raziskovanje. Omenjeno področje naše raziskave je le majhen del dejavnosti visokošolskih učiteljev, ki pa je pomemben za razvoj stroke zdravstvene nege. Naša raziskava ima še vrsto drugih metodoloških pomanjkljivosti. Nismo upoštevali konkretnih obremenitev posameznih visokošolskih učiteljev, kar bi lahko pomembno vplivalo na njihovo raziskovalno dejavnost. Podatki, ki smo jih zajeli iz javnih evidenc, so lahko pomanjkljivi, mogoče je, da avtorji nimajo posodobljenih podatkov. Zajem podatkov za raziskavo je bil narejen za obdobje 2010–2015. Novejše ločnice letnic zajema podatkov bi lahko pokazale drugačne izsledke.

Zaključek

Kakovost visokošolskih institucij se odraža tudi v projektih, raziskovalnih dejavnostih in publiciranju, v prispevku k razvoju, zaradi česar je fakulteta vsekakor ustanovljena. Nosilci omenjenega so visokošolski

učitelji. Visokošolske institucije pridobivajo ugled v domačem in mednarodnem prostoru glede na prepoznavnost svojih učiteljev, ki se odraža tudi v njihovem raziskovalnem delu. Prav bi bilo, da visokošolske institucije s tem postanejo bolj privlačne za študente, ki se odločajo, kam se bodo vpisali, kot tudi za klinična okolja, ki se odločajo, kakšno medicinsko sestro – zdravstvenika želijo imeti. Priložnost in naloga visokošolskih institucij je, da spodbudijo akademski razvoj svojih zaposlenih. V Sloveniji je potreben tudi razmislek, ali imamo dovolj usposobljenih visokošolskih učiteljev strokovnih predmetov, ki dosegajo današnje zahteve izobraževalnih institucij.

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Prvi avtor je izvedel zasnovo raziskave in napisal zasnovo članka. Drugi avtor je nadziral celoten potek raziskave, skrbel za verodostojnost podatkov ter sodeloval pri pisanju članka. / The first author conducted the research and designed the outline of the article. The other author supervised the research, ensured the credibility of data and participated in writing the article.

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Review article / Pregledni znanstveni članek

Experiences of individuals with various sexual orientations with healthcare professionals: integrative literature review

Izkušnje posameznikov različne spolne usmerjenosti z zdravstvenimi delavci: integrativni pregled literature

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Key words: heteronormativity; gender identity; homosexuality; homophobia; discrimination; bisexuality; transgender persons

Ključne besede:

heteronormativnost; spolna identiteta; homoseksualnost; homofobija; diskriminacija; biseksualnost; transspolne osebe

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ABSTRACT

Introduction: Individuals may belong to different sexual minorities. Such a personal circumstance should not influence the quality of healthcare. Yet, many face discrimination due to their sexual orientation, while the healthcare system is typically heteronormative. The objective of this integrative review was to provide a synthesis of research evidence on the experiences of lesbian, gay, bisexual and transgender (LGBT) individuals with healthcare professionals.

Methods: An integrative literature review was employed, and codes and categories were identified. A literature search was performed in the databases Springer Link, SAGE, CINAHL, Academic Search Elite and MEDLINE. The key words used were: "experiences", "healthcare", "gay patient experiences", "gay", "lesbian", "homosexual", "bisexual" and "transgender". Primary sources were selected according to inclusion and exclusion criteria. Thematic analysis was conducted with an open coding of the results of selected sources.

Results: A total of 6,839 studies were screened from June to August 2018 and 14 (published between 2009 and 2017) were selected for the final analysis. The results yielded 41 codes, combined into two categories termed: 'Positive experiences of LGBT individuals with healthcare professionals' and 'Negative experiences of LGBT individuals with healthcare professionals'.

Discussion and conclusion: The experiences of LGBT individuals with healthcare professionals are ambivalent. Although positive experiences prevail, negative ones should not be overlooked as they are derived from heteronormativity and sometimes even prejudice and homophobia. Healthcare professionals need cultural competences which reflect the developments in a society and the needs of its individuals.

IZVLEČEK

Uvod: Posamezniki lahko pripadajo različnim spolnim manjšinam. Ta osebna okoliščina ne sme vplivati na kakovost zdravstvene obravnave. Kljub temu številni doživljajo diskriminacijo zaradi svoje spolne usmerjenosti, zdravstveni sistem pa je prežet z normo heteronormativnosti. Namen integrativnega pregleda je bil sinteza dokazov glede izkušenj lezbijk, gejev, biseksualnih in transspolnih (LGBT) oseb z zdravstvenimi strokovnjaki.

Metode: Uporabljena je bila metoda integrativnega pregleda literature s tematsko analizo rezultatov izbranih virov na način oblikovanja kod in kategorij. Literaturo smo iskali po elektronskih podatkovnih bazah Springer Link, SAGE, CINAHL, Academic Search Elite in MEDLINE. Iskali smo s pomočjo angleških ključnih besed: »experiences«, »healthcare«, »gay«, »lesbian«, »homosexual«, »bisexual« in »transgender«. Izbor primarnih virov smo opravili glede na vključitvene in izključitvene kriterije. Tematska analiza je potekala na način odprtega kodiranja rezultatov izbranih virov.

Rezultati: Skupno smo v obdobju od junija do avgusta 2018 presejali 6.839 virov; v končno analizo smo jih uvrstili 14 (objavljenih med letoma 2009 in 2017). Oblikovali smo 41 kod, ki smo jih združili v 2 kategoriji: »Pozitivne izkušnje LGBT-posameznikov z zdravstvenimi delavci« ter »Negativne izkušnje LGBT-posameznikov z zdravstvenimi delavci«.

Diskusija in zaključek: Izkušnje LGBT-posameznikov z zdravstvenimi delavci so ambivalentne. Čeprav prevladujejo pozitivne izkušnje, negativnih ne smemo zanemariti, saj izvirajo iz heteronormativnosti, včasih pa celo predsodkov in homofobije. Zdravstveni delavci potrebujejo kulturne kompetence, ki so odraz razvoja družbe in potreb posameznikov v njej.



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Introduction

Sexual orientation denotes who a person is attracted to physically and sexually, as well as romantically and emotionally (Kersey-Matusiak, 2013). Sexual orientation can be heterosexual: attraction towards a different biological sex; homosexual: attraction towards the same biological sex; or bisexual: attraction towards both biological sexes (Giddens & Sutton, 2013). The revised International Council of Nurses (ICN) Code of Ethics for Nurses explicitly states in its preamble that "nursing care is respectful of and unrestricted by considerations of" gender and sexual orientation (ICN, 2012). This means that gender identity and sexual orientation is a personal circumstance which cannot influence the quality of provided nursing care in any way. However, the fact that discriminatory practices are not allowed does not mean that they do not exist (Edwards, 2012). Up to now, more attention has been given to individuals with various sexual orientations compared to those with various gender identities. Gender identity refers to how an individual identifies themselves: as a man, a woman or other (Kersey-Matusiak, 2013). After the year 2000, research evidence on attitudes towards individuals with various sexual orientations in healthcare has revealed less standard homophobia, an increase in tolerance and acceptance, and less judging, but still a certain degree of distance (Rondahl, et al., 2004).

Sociologists have termed this phenomenon 'new homophobia' and claim that it is much more furtive and subtle (Kuhar, et al., 2011): the term homophobia denotes "different forms of general, political, social, moral and personal disagreement with homosexuality per se; it includes judging, aversion, disagreement and violence, as well as depreciation, criticism and discrimination of individuals with same-sex sexual orientation". 'New homophobia' can be characterised as stigmatisation, a concept which is also commonly experienced by other marginalised social groups. However, stigmatisation should not be examined only from the perspective of those stigmatising, but also (or primarily) from the perspective of those being stigmatised. Research evidence thus shows that individuals with various sexual orientation or gender identities are bothered mainly by the high degree of heteronormativity in today's society (Rondahl, 2009). The term heteronormativity is defined as "the sum of social norms that developed around heterosexuality throughout history and are based on the binary opposition male-female" (Bibič, et al., 2011). Individuals with a different sexual orientation are a specific group, a minority with certain characteristics and needs; healthcare professionals are often not aware of these characteristics and needs and therefore cannot provide the most appropriate care (Dunjić-Kostić, 2012).

Aims and objectives

The aim of this integrative literature review is to present a synthesis of evidence on the experiences of individuals with various sexual orientations with healthcare professionals. The goal of the review is to contribute to a better understanding of patients with various sexual orientations to facilitate the provision of ethical and culturally competent healthcare.

The following research questions were posed:

- What are the experiences of individuals with various sexual orientations and / or gender identities with healthcare professionals?
- Do individuals with various sexual orientations and / or gender identities feel stigmatized or face discrimination in the healthcare system?

Methods

Review methods

An integrative literature review was conducted according to the guidelines set by Whitemore and Knafl (2005). The search for literature was conducted in electronic databases between June 2018 and August 2018. The databases Springer Link, SAGE, CINAHL, Academic Search Elite and MEDLINE were searched. The following key words together with Boolean operators were used: *experiences* AND *healthcare* AND *gay* OR *lesbian* OR *homosexual* OR *bisexual* OR *transgender*. Sources were selected according to the inclusion and exclusion criteria which are presented in Table 1 below.

Results of the review

We obtained 11,347 hits in the Springer Link database; after applying inclusion and exclusion criteria, 13 articles were selected for further analysis (Figure 1). The search in SAGE database yielded 3,391 hits, six of which were selected for further analysis after inclusion and exclusion criteria were applied. The search in other databases (CINAHL, Academic Search Elite and MEDLINE) at first yielded 4,749 hits; after applying the criterion of qualitative research, 97 articles remained. Of these, five were selected for further analysis. In total, 24 articles were thus selected for further analysis. Based on a full-text screen, we further eliminated 10 articles: two systematic literature reviews, two sources with the oldest date of publication and six articles that failed to provide the answers the research questions. Thus, 14 primary sources were retrieved for final analysis (mostly qualitative and mixed methods research designs and one quantitative research study). They were published from 2010 onwards, with the exception of one article published in 2009 (Figure 1).

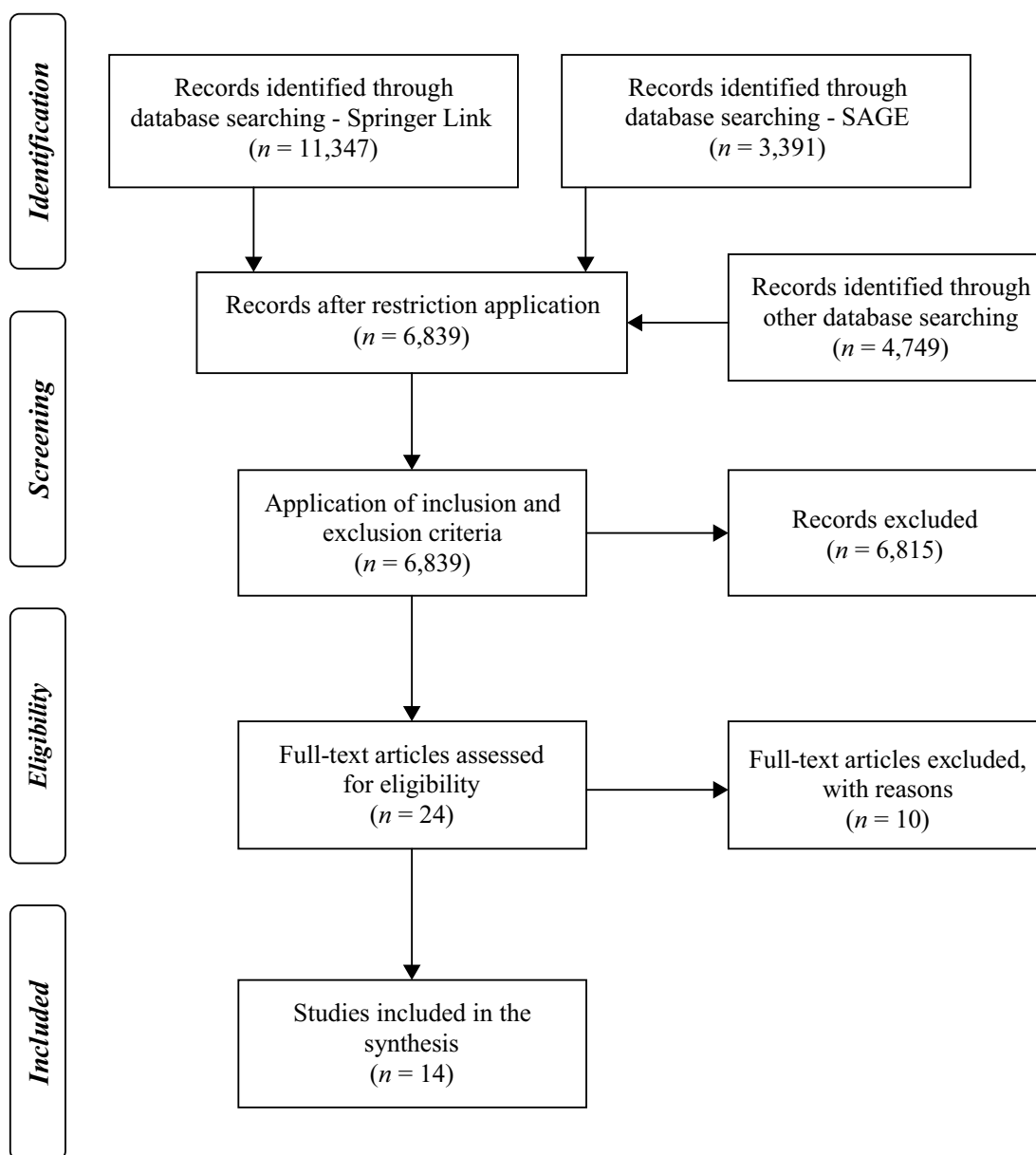


Figure 1: Review process flowchart

Slika 1: Shema procesa pregleda

The quality assessment of the review and the description of data processing

All sources are reviewed research papers from international scientific journals with an impact factor, available either in printed or electronic form online. The quality of selected articles were assessed separately based on utilised research designs. Qualitative papers were assessed based on the guidelines described by Streubert and Carpenter (2011), quantitative papers were assessed based on the guidelines set by Long (2002), and mix-methods papers were assessed based on the guidelines described by Pluye and colleagues (2009). The assessed quality of articles varies: we evaluated most of them

to be good or very good, while one article was rated as sufficient. All the selected articles were considered as appropriate, especially in terms of diversity of the described experiences with healthcare professionals.

Sources included in the final analysis were processed using the method of thematic text analysis, in which codes and categories were identified according to the guidelines described by Vogrinc (2008). The so-called open / inductive coding was employed. Coding units included key findings that were categorised into codes. Thus, a thematic text analysis was conducted for the Results section of each source included in the final analysis. Codes with similar content were merged to form broader categories, presented in Results.

Table 1: Inclusion and exclusion criteria**Tabela 1: Vključitveni in izključitveni kriteriji**

<i>Inclusion criteria / Vključitveni kriteriji</i>	<i>Exclusion criteria / Izključitveni kriteriji</i>
Publications in scientific journals	Sources related to sexually transmitted diseases, HIV-infection, AIDS, STD testing
Published between 2009 and 2018	Sources related to health or illness in general
Scientific articles in English	Epidemiological data, prevention, screening
Full-text articles	Sources related to patient knowledge
Qualitative, quantitative or mix-methods research designs	Sources related to pathology, treatment of diseases, dependence illnesses
Examination of the experiences of LGBT individuals with healthcare professionals	Sexual practices or sexual violence
/	Sources related to quality of life, social issues or violence in general
/	Attitudes of different social groups to individuals with various sexual orientations
/	Parenting and LGBT families
/	Research methodology

Table 2: Analysed sources**Tabela 2: Analizirani viri**

<i>Author (country) / Avtor (država)</i>	<i>Research method / Raziskovalna metoda</i>	<i>Research purpose / Namen raziskave</i>	<i>Sample / Vzorec</i>	<i>Key findings / Ključne ugotovitve</i>
Katz, 2009 (Canada)	semi-structured in-depth interview	to describe the experiences of gay and lesbian cancer patients in Canadian healthcare system	7 gays and lesbians	experiences with disclosure of sexual orientation to healthcare professionals were positive, neutral or the disclosure was ignored; oncology care is governed by heteronormativity
Duffy, 2011 (Ireland)	unstructured interview	to examine the experiences of lesbians as users of the Irish healthcare system	12 lesbians	lesbians' experiences included prejudice, heteronormativity, discrimination and a lack of genuine communication
Eady, et al., 2011 (Canada)	focus groups; semi-structured questionnaire	to understand the experiences of bisexual individuals with the mental healthcare system and to determine their perception of healthcare professionals' attitude towards bisexuality	55 bisexual men and women	most experiences could be categorized as negative, including judgment, heteronormativity and pathologisation; some had a positive experience, characterised by openness, non-judgment, acceptance, support and self-education
Vanden-Langenberg, et al., 2012 (USA)	semi-structured interview	to investigate the experiences of lesbian, gay and bisexual individuals with genetic counselling	12 gays, lesbians, and bisexual men and women	positive experiences included well-being, equality, consideration, enabling a choice, and security
Riggs, et al., 2014 (Australia)	mixed methods design: survey and open questions	to investigate the experiences of transgender individuals with the Australian healthcare system	188 transgender men and women	positive experiences were connected to professionalism, willingness to help, knowledge, respect, caring and compassion; negative experiences were connected to hurtful questions

Continues / Se nadaljuje

<i>Author (country) / Avtor (država)</i>	<i>Research method / Raziskovalna metoda</i>	<i>Research purpose / Namen raziskave</i>	<i>Sample / Vzorec</i>	<i>Key findings / Ključne ugotovitve</i>
Lyons, et al., 2015 (Canada)	semi-structured in- depth interview	to investigate the experiences of transgender individuals with drug addiction treatment	34 transgender men and women	negative experiences included discrimination, social exclusion, violence, abuse, and stigmatization; positive experiences were connected to acceptance and respect
Marques, et al., 2015 (Portugal)	semi-structured interview	to describe the positive and negative experiences lesbians have when seeing physicians, especially about their sexual and reproductive health	30 lesbians	negative experiences included fear, shame, discrimination and heteronormativity; positive experiences were connected to being accepted, the absence of direct disapproval and protection of confidentiality
Rasberry, et al., 2015 (USA)	mixed methods research—cross- sectional study and interview	to help inform the development of school strategies aimed at connecting teenage men having sexual intercourse with men with preventive services	415 + 32 teenage men having sexual intercourse with men	in the school setting, teenage men would prefer to discuss sexual health with a school counsellor or a school nurse; teenagers appreciate openness, the desire to help, non-judgment, stating facts and providing details
Hirsch, et al., 2016 (Germany)	questionnaire	to investigate lesbians' access to healthcare services and explain the role of general physicians in the process	766 lesbians	experiences of lesbians included fear, discrimination, concealing of one's identity, heteronormativity
Victor & Nel, 2016 (South Africa)	semi-structured in- depth interview	to examine the experiences of LGB individuals with psychotherapy and counselling	15 gays, lesbians, and bisexual men and women	positive experiences included acceptance, non-judgment, honesty, warmth, professionalism, calmness, kindness, listening, caring, sensitivity, compassion; negative experiences included non-acceptance, prejudice, dichotomy, non-understanding, sexualisation
Hoffkling, et al., 2017 (USA)	semi-structured interview	to identify the needs of transgender men in regard to family planning and around pregnancy	10 trans-gender males	transgender individuals faced a high level of heteronormativity, a lack of evidence-based information, discrimination, fear, a lack of cultural competences, transphobia, and avoidance; positive experiences included protection of privacy, absence of irritating questions, acceptance and self-education
Hoyt, et al., 2017 (USA)	focus groups	to describe the experiences of gay men with prostate cancer	11 gay men	experiences of gay men included stigmatisation, prejudice, discrimination, fear, lack of caring, non- understanding, and heteronormativity
Müller, 2017 (South Africa)	interview; focus groups	to examine the experiences of LGBT individuals with healthcare in South Africa	44 gays, lesbians, bisexual and transgender males and females	experiences were connected to heteronormativity, geographic conditioning, lack of public funding, discrimination, homophobia, violation of rights, abuse, prejudice, lack of knowledge, fear, avoidance, and hiding
Westerbotn, et al., 2017 (Sweden)	semi-structured interview	to describe the experiences of transgender individuals with healthcare professionals	14 trans-gender males and females	most respondents reported neutral experiences; however, they did notice a lack of knowledge and they all reported having had a negative experience at some stage; experiences included heteronormativity, fear and, consequently, avoidance of healthcare services

Table 3: *Codes combined in categories***Tabela 3:** *Kode, oblikovane v kategorije*

<i>Category</i>	<i>Codes</i>	<i>Authors</i>
Positive experiences of LGBT individuals with healthcare professionals	openness, non-judgment, acceptance, awareness of lack of knowledge, appropriate provision of healthcare services, LGBT-friendly physician, protection of privacy / confidentiality, respect, inclusion of partner, support, consideration, absence of direct disapproval, honesty, warmth, caring, professionalism, compassion, equality, confirmation of identity, absence of irritating questions, calmness, kindness, listening, sensitivity, empathy	Katz, 2009; Duffy, 2011; Eady, et al., 2011; Vanden-Langenberg, et al., 2012; Riggs, et al., 2014; Lyons, et al., 2015; Marques, et al., 2015; Rasberry, et al., 2015; Hirsch, et al., 2016; Victor & Nel, 2016; Hoffkling, et al., 2017; Westerbotn, et al., 2017;
Negative experiences of LGBT individuals with healthcare professionals	disrespectful healthcare, provision, non-acceptance, impatience, disrespect, offensive questions, non-understanding, lack of empathy, sexualisation, fear of negative experiences, violation of rights, lack of knowledge, ridiculing, insolence, lack of time, failure to care, judging, heteronormativity	Katz, 2009; Duffy, 2011; Eady, et al., 2011; Riggs, et al., 2014; Lyons, et al., 2015; Rasberry, et al., 2015; Victor & Nel, 2016; Hoffkling, et al., 2017; Hoyt, et al., 2017; Müller, 2017; Westerbotn, et al., 2017

Results

Analysed scientific sources are presented in Table 2 and discussed below.

A thematic analysis of the Results section of the selected sources ($n = 14$) yielded results that were translated into 41 codes. In the next step of the analysis, codes with a similar theme were combined to form two categories; these were termed: 'Positive experiences of LGBT individuals with healthcare professionals' and 'Negative experiences of LGBT individuals with healthcare professionals', and are shown in Table 3.

Positive experiences of LGBT individuals with healthcare professionals

In general, LGBT individuals have positive experiences with healthcare professionals (Katz, 2009; Riggs, et al., 2014; Marques, et al., 2015; Westerbotn, et al., 2017), but this could also be because some do not come out with their sexual orientation or gender identity, or even purposefully conceal it. In one study 60.6 % of respondents had not informed their primary care provider about their sexual orientation (Hirsch, et al., 2016). Nevertheless, most respondents reported receiving the same healthcare provision as others and said their gender identity was not unnecessarily emphasised (Westerbotn, et al., 2017), they also mainly had positive experiences with general practitioners (Riggs, et al., 2014) and characterised school nurses as being open and caring (Rasberry, et al., 2015). Moreover, respondents reported having mainly positive experiences with gender reassignment surgery and postoperative support received (Riggs, et al., 2014). Positive experiences are connected to openness, non-judgment, acceptance and support (Eady, et al., 2011); to acceptance, consideration and respect of sexual orientation or gender identity (Lyons, et al., 2015); to privacy protection, confirmation of sexual orientation or gender identity, and absence of irritating questions

(Hoffkling, et al., 2017); they also included acceptance, non-judgment, honesty, warmth, care, professionalism, calmness, kindness, listening, sensitivity, and empathy (Victor & Nel, 2016); and they refer to professionalism, a willingness to help, knowledge, care, respect, and compassion (Riggs, et al., 2014). Acceptance, absence of direct disapproval, and protection of confidentiality contribute to a positive attitude (Marques, et al., 2015). Respondents highly regard staff members who are aware of their own lack of knowledge and express a desire to self-educate (Hoffkling, et al., 2017), and feel that school staff should be open, express a desire to help, and should not be judgmental (Rasberry, et al., 2015). An important element of best practice examples is including the partner in healthcare provision (VandenLangenberg, et al., 2012), as partners play a crucial supportive role for (cancer) patients (Katz, 2009). In a private hospital, the experience was exemplary (Duffy, 2011).

Negative experiences of LGBT individuals with healthcare professionals

Despite a prevalence of positive or appropriate experiences, negative experiences were nevertheless present, significant and, most of all, persistent. All respondents reported having had a negative experience at some point (Westerbotn, et al., 2017). Many met with negative judgment (Eady, et al., 2011) or disrespectful healthcare provision due to their sexual orientation or gender identity (Müller, 2017), while in one study most of the experiences described could be categorised as negative (Eady, et al., 2011). Participants experienced stigma, prejudice, and discrimination (Lyons, et al., 2015; Hoyt, et al., 2017). Other examples of negative experiences include non-acceptance, prejudice, dichotomy, non-understanding, sexualisation (Duffy, 2011; Victor & Nel, 2016), and sometimes they were connected to offensive questions (Riggs, et al., 2014), respondents also described a lack of caring and understanding (Hoyt, et al., 2017). There was evidence of transphobia experienced by some

respondents which ranged from mocking to rudeness and dismissal (Hoffkling, et al., 2017). Some reported that school nurses were unkind, overworked and impatient (Rasberry, et al., 2015), a lack of empathy coming from nurses was common (Duffy, 2011). Disrespect was conveyed both through verbal abuse and non-verbally (Müller, 2017). Sometimes therapists wanted to discuss sexuality, although respondents wanted to discuss other issues (Eady, et al., 2011). The majority of respondents experienced that healthcare professionals lacked knowledge (Westerbotn, et al., 2017); there is, for example, a lack of biomedical research addressing the specific issues of (transgender) individuals (Hoffkling, et al., 2017), and healthcare professionals' lack of knowledge was worryingly high (Müller, 2017). Fear of negative experiences may prevail over the possibility of positive acceptance (Duffy, 2011), and many fail to disclose their sexual orientation due to past negative experiences (Eady, et al., 2011). There were also reports of sexual violence (Lyons, et al., 2015). LGBT individuals do not file complaints about violations of their rights—either because they do not know how to or because they believe that this would not help solve anything (Müller, 2017).

Discussion

We have found that experiences of individuals with various sexual orientations with healthcare professionals are ambivalent. Most experiences are positive or at least neutral. Negative responses, including disrespect, neglect or judgment, reveal a lack of empathy and a lack of cultural competences. To neglect the information that a patient is, for example, a homosexual, as we explain, can be positive in the sense that they receive the same treatment as everybody else – the ethic principle of equity – and that healthcare professionals do not allow stereotypes or prejudice to influence the provision of healthcare. However, neglecting such information can in some cases also result in overlooking an important dimension of the patient's life, which may in turn affect the health / illness status.

Sexual orientation has many characteristics of a social health determinant. Sexual minority group members more often report a poorer overall health status: they report experiencing long-term psychological or emotional states 2-3 times more often compared to heterosexuals; they are also more likely to live in underprivileged areas (Elliott, et al., 2014). In addition to a higher incidence of psychological distress, sexual minority group members are more likely to have a mental disorder (substance abuse, depression, anxiety, eating disorders) or somatic disease (cancer, cardiovascular disorders) and are more likely to commit suicide (Stewart & O'Reilly, 2017). Considering the above, the neglect of sexual orientation can result in a lower quality of healthcare provision which is not completely patient-oriented, or, as explained by Klančar and colleagues (2013),

healthcare professionals may disregard the specific factors of a health risk. Although in general, negative experiences of LGBT individuals with healthcare professionals are rare, the fact that they are 1.5 times more common compared to the general population is disconcerting (Elliott, et al., 2014), while positive experiences could also be influenced by the geographic area or privileged identity (Jowett & Peel, 2009).

The noted deliberate absence of the LGBT population from the healthcare system is problematic from the perspectives of public health, politics, and from the biopsychosocial perspective. Some research evidence shows that fear of discrimination can lead individuals to avoid the healthcare system (Hoffkling, et al., 2017); similarly, other research results reveal that some respondents failed to seek needed healthcare provision due to fear (Westerbotn, et al., 2017), or that many even decided to stop their treatment early due to stigmatisation or a sense of endangerment (Lyons, et al., 2015). Homophobia represents an obstacle to accessing healthcare services (Dente, 2013). Many LGBT individuals report avoiding healthcare services due to fear of discrimination and homophobia (Müller, 2017), which is not the case with the majority population. Just under one in ten respondents say that they decided not to receive the necessary check-ups or treatment due to fear of discrimination (Hirsch, et al., 2016).

The two most problematic issues related to the LGBT community and healthcare are heteronormativity and discrimination. Heteronormativity is a phenomenon generally pervasive in the society, representing a norm and stigmatising all those who deviate from it. Healthcare professionals usually assume that their patients are heterosexuals (Marques, et al., 2015; Hoyt, et al., 2017). Discrimination represents a violation of basic human rights and is prohibited by law. Homophobia, however, is the issue that continues to exist and persist in all its forms, both in the society in general, and in the healthcare system. The phenomenon is nowadays known as 'new homophobia' a much more veiled version, appearing in different, more subtle forms than before (Kuhar, et al., 2011). In healthcare, it can be explained as the general ethical stance of healthcare professionals (physicians and nurses alike must adhere to the Code of Ethics), but without the comprehensive understanding and empathy towards individuals with various sexual orientations (Krnel, et al., 2015). Because being influenced by stereotypes and prejudice, as well as religion, healthcare professionals sometimes do not approve of the behaviour of LGBT individuals and do not want to be in contact with them (Krnel, et al., 2015). Healthcare professionals may also wrongly interpret their behaviour as a choice, a transitional period, immaturity, or even a danger or pathology, instead of embracing it as an individual's legitimate identity. Of course, heteronormativity greatly contributes to this. In Slovenian healthcare system for example, heteronormativity is reflected

in the correction of statements made by LGBT individuals by some healthcare professionals or in the form of stereotypical questions and / or statements made by healthcare professionals (Krnel & Skela-Savič, 2017). It is definitely crucial that LGBT individuals are treated as people and not as patients (Victor & Nel, 2016).

Young people prefer to talk to staff members who state facts and provide details (Rasberry, et al., 2015). In general, the LGBT community values knowledge and has noted that healthcare professionals lack knowledge on specific needs and issues connected to the LGBT identity (Victor & Nel, 2016; Hoffkling, et al., 2017; Müller, 2017; Westerbotn, et al., 2017). This is also a result of heteronormativity, stigmatisation, and marginalisation. A lack of knowledge can lead to a failure to address specific needs, something that has already been noted (Marques, et al., 2015), but even more importantly, it hinders healthcare professionals from obtaining the information which could be crucial for diagnostics and treatment. Thus, healthcare professionals should have enough cultural competencies to address specific issues related to the LGBT health. Just over one in five respondents assessed their physician's knowledge of specific topics positively (Hirsch, et al., 2016). Lack of information hinders educated decision-making (Hoffkling, et al., 2017), which in turn may compromise the quality of healthcare provision. Furthermore, lack of knowledge may lead to excessive questions being asked, making some individuals uncomfortable, to the execution of unnecessary diagnostic procedures, or, conversely, to phasing out or denying the necessary diagnostic procedures or treatment. Lack of knowledge also leads to sexualisation, and perhaps takes the most problematic form when expressed as pathologisation. Respondents have experienced the pathologisation of their transgender identity (Hoffkling, et al., 2017), but we should also mention the pathologisation of bisexuality. The former is still defined as a mental disorder, compared to homosexuality which has officially not been classified as a mental disorder since 1973 (Erić, 2011), while the latter has faced a lack of understanding and non-acceptance even within the LGBT community, known as biphobia. Lack of knowledge was emphasised as an important issue also in a recent review by Nhamo-Murire and Macleod (2017).

Even though homosexuality was removed from the International Classification of Diseases in 1989, there are still some known cases of treating homosexual orientation (Erić, 2011). Such is the example of a high-profile case in Croatia, where a teenage woman was involuntarily hospitalised and treated for being a lesbian in a psychiatric hospital for many years on the initiative of her parents (Tratnik, 2009). This has launched much ethical dilemmas and debates. There are no such cases known in Slovenia. In terms of experiences

of individuals with various sexual orientations with healthcare professionals in Slovenia one pilot study is available (Krnel & Skela-Savič, 2017) that has found that most respondents have good experiences with healthcare professionals; none of them mentioned experiences of homophobia, discrimination or violence.

Conclusion

The experiences of LGBT individuals with healthcare professionals are ambivalent and conditioned by heteronormativity. Although positive experiences prevail, negative experiences cannot be overlooked because they draw from stereotypes, prejudice, and homophobia. Lack of knowledge significantly contributes to them. Despite stigmatisation and discrimination being ethically unacceptable and legally prohibited, LGBT individuals still experience them in their many forms, while remaining marginalised and quite invisible themselves. Sexual minority group members have more negative experiences with the healthcare system compared to the general population. Nowadays, the so-called "new homophobia" is present in the healthcare system. In order to provide the LGBT population with high-quality healthcare services, healthcare professionals need to have the necessary cultural competences and an ethical attitude towards patients.

Conflict of interest / Nasprotje interesov

The authors declare that no conflicts of interest exists. / Avtorja izjavljata, da ni nasprotja interesov.

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Ethical approval / Etika raziskovanja

The study need no ethical approval, and was conducted in accordance with the Code of Ethics for Nurses and Nurse Assistants of Slovenia (Kodeks etike v zdravstveni negi in oskrbi Slovenije in Kodeks etike za babice Slovenije, 2014). / Raziskava ni potrebovala odobritve etične komisije. Članek je pripravljen v skladu s Kodeksom etike v zdravstveni negi in oskrbi Slovenije (2014).

Authors contribution / Prispevek avtorjev

The first author carried out all the phases of research and writing the article. The second author mentored the first author and directed the research and writing of the article. / Prvi avtor je izvedel vse faze raziskave in pisanja članka. Druga avtorica je mentorica prvemu avtorju in je usmerjala raziskavo in pisanje članka.

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NAVODILA AVTORJEM

Splošna navodila

Članek naj bo napisan v slovenskem ali angleškem knjižnem jeziku, razumljivo in jedrnato, dolg naj bo največ 5000 besed za kvantitativno in do 6000 besed za kvalitativno zasnovane raziskave. Število besed se nanaša na besedilo članka in ne vključuje naslova, izvlečka, tabel, slik in seznama literature. Avtorji naj uporabijo Microsoft Wordovo predlogo, ki je dostopna na spletni strani uredništva. Vsi članki, ki so uvrščeni v uredniški postopek, so recenzirani s tremi anonimnimi recenzijami. Revija objavlja le izvirna, še neobjavljena znanstvena dela. Za trditve v članku odgovarja avtor oziroma avtorji, če jih je več (v nadaljevanju avtor), zato mora le-ta biti podpisan s celotnim imenom in priimkom, treba je navesti strokovne naslove, akademske nazive avtorja in izvolitev v pedagoški ali raziskovalni naziv, v kolikor ga avtor ima. Če je članek napisan v angleškem jeziku, morajo biti v angleškem jeziku zapisani tudi strokovni naslovi, akademski nazivi in izvolitev v pedagoški ali raziskovalni naziv. Avtor mora pri oddaji članka dosledno upoštevati navodila glede standardizirane znanstvene opreme, videza in tipologije dokumentov ter navodila v zvezi z oddajo članka. Članek bo uvrščen v nadaljnjo obravnavo, ko bo pripravljen v skladu z navodili uredništva.

Če članek objavlja raziskavo na ljudeh, naj bo v podpoglavju metod *Opis poteka raziskave in obdelave podatkov* razvidno, da je bila raziskava opravljena skladno z načeli Helsinško-Tokijske deklaracije, opisan naj bo postopek pridobivanja dovoljenj za izvedbo raziskave. Eksperimentalne raziskave, opravljene na ljudeh, morajo imeti soglasje komisije za etiko bodisi na ravni ustanove ali več ustanov, kjer se raziskava izvaja, bodisi na nacionalni ravni.

Naslov članka, izvleček, ključne besede, tabele (opisni naslov in legenda) ter slike (opisni naslov oz. podpis in legenda) morajo biti v slovenščini in angleščini, le-to velja tudi za angleško pisane članke, le da so v tem primeru našete enote navedene najprej v angleščini in nato v slovenščini. Skupno število slik in tabel naj bo največ pet. Tabele in slike naj bodo v besedilu članka na ustreznem mestu. Za prikaz rezultatov v tabelah, slikah in besedilu je treba uporabljati statistične simbole, ki jih avtor najde na spletni strani revije, poglavje Navodila. Na vsako tabelo in sliko se mora avtor v besedilu sklicevati. Uporaba sprotnih opomb pod črto ni dovoljena.

Opredelitev tipologije

Uredništvo razvrsti posamezni članek po veljavni tipologiji za vodenje bibliografij v sistemu COBISS (Kooperativni online bibliografski sistem in servisi) (dostopno na: http://home.izum.si/COBISS/bibliografije/Tipologija_slv.pdf). Tipologijo lahko predlagata avtor in recenzent, končno odločitev sprejme glavni in odgovorni urednik.

Metodološka struktura članka

Naslov, izvleček in ključne besede naj bodo v slovenščini in angleščini. Naslov naj bo skladen z vsebino članka in dolg največ 120 znakov. Oblikovan naj bo tako, da je iz njega razviden uporabljeni raziskovalni dizajn. Če naslovu sledi podnaslov, naj bosta ločena s podpičjem. Navedenih naj bo od tri do šest ključnih besed, ki natančneje opredeljujejo vsebino članka in ne nastopajo v naslovu. Izvleček naj bo strukturiran, vsebuje naj 150–220 besed. Napisan naj bo v tretji osebi. V izvlečku se ne citira.

Strukturirani izvleček naj vsebuje naslednje strukturne dele:

Uvod (Introduction): Navesti je treba ključna spoznanja dosedanjih raziskav, opis raziskovalnega problema, namen raziskave, v katerem so opredeljene ključne spremenljivke raziskave.

Metode (Methods): Navesti je treba uporabljeni raziskovalni dizajn, opisati glavne značilnosti vzorca, instrument raziskave, zanesljivost instrumenta, kje, kako in kdaj so se zbirali podatki in s katerimi metodami so bili obdelani in analizirani.

Rezultati (Results): Opisati je treba najpomembnejše rezultate raziskave, ki odgovarjajo na raziskovalni problem in namen raziskave. Pri kvantitativnih raziskavah je treba navesti vrednost rezultata in raven statistične značilnosti.

Diskusija in zaključek (Discussion and conclusion): Razpravljati je treba o ugotovitvah raziskave, navesti se smejo le zaključki, ki izhajajo iz podatkov, pridobljenih pri raziskavi. Navesti je treba tudi uporabnost ugotovitev in izpostaviti pomen nadaljnjih raziskav za boljše razumevanje raziskovalnega problema. Enakovredno je treba navesti tako pozitivne kot tudi negativne ugotovitve.

Struktura izvirnega znanstvenega članka (1.01)

Izvirni znanstveni članek je samo prva objava originalnih raziskovalnih rezultatov v takšni obliki, da se raziskava lahko ponovi ter ugotovitve preverijo. Revija objavlja znanstvene raziskave, za katere zbrani podatki niso starejši od pet let ob objavi članka v reviji.

Uvod: V uvodu opredelimo raziskovalni problem, in sicer v kontekstu znanja in znanstvenih dokazov, v katerem smo ga razvili. Pregled obstoječe znanstvene literature mora utemeljiti potrebo po naši raziskavi in je osnova za oblikovanje namena in ciljev raziskave, raziskovalnih vprašanj oz. hipotez in izbranega dizajna raziskave. Uporabimo znanstvena spoznanja in koncepte aktualnih mednarodnih in domačih raziskav, ki so objavljena kot primarni vir in niso starejša od deset oziroma pet let. Obvezno je citiranje in povzemanje spoznanj raziskav in ne mnenj avtorjev. Na koncu opredelimo namen in cilje raziskave. Priporočamo zapis raziskovalnih vprašanj (kvalitativna raziskava)

oz. hipotez (kvantitativna raziskava).

Metode: V uvodu metod navedemo izbrano raziskovalno paradigmo (kvantitativna, kvalitativna) in uporabljeni dizajn izbrane paradigme. Podpoglavja metod so: *opis instrumenta, opis vzorca, opis poteka raziskave in obdelave podatkov*.

Pri *opisu instrumenta* navedemo: opis sestave instrumenta, kako smo oblikovali instrument, spremenljivke v instrumentu, merske značilnosti (veljavnost, zanesljivost, objektivnost, občutljivost). Navedemo avtorje, po katerih smo instrument povzeli, ali navedemo literaturo, po kateri smo ga razvili. Pri kvalitativni raziskavi opišemo tehniko zbiranja podatkov, izhodiščna vprašanja, morebitno strukturo poteka zbiranja podatkov, kriterije veljavnosti in zanesljivosti tehnike zbiranja podatkov.

Pri *opisu vzorca* navedemo: opis populacije, iz katere smo oblikovali vzorec, vrsto vzorca, kolikšen je bil odziv vključenih v raziskavo, opis vzorca po demografskih podatkih (spol, izobrazba, delovna doba, delovno mesto ipd.). Pri kvalitativni raziskavi opredelimo še možnosti vključitve in izbrani način vključitve v raziskavo, vrsto vzorca, velikost vzorca in pojasnimo zasičenost vzorca.

Pri *opisu poteka raziskave in obdelave podatkov* navedemo etična dovoljenja za izvedbo raziskave, dovoljenja za izvedbo raziskave v organizaciji, predstavimo potek izvedbe raziskave, zagotovila za anonimnost vključenih ter prostovoljnost pri vključitvi v raziskavo, navedeno obdobje, kraj in način zbiranja podatkov, uporabljene metode analize podatkov, pri slednjem natančno navedemo statistične metode, program in verzijo programa statistične obdelave, meje statistične značilnosti. Pri kvalitativni raziskavi natančno opišemo celoten potek raziskave, način zapisovanja, zbiranja podatkov, število izvedb (opazovanj, intervjujev ipd.), trajanje izvedb, sekvence, transkripcijo podatkov, korake analize obdelave, tehnike obdelave in interpretacije podatkov ter receptivnost raziskovalca.

Rezultati: Rezultate prikažemo besedno oz. v tabelah in slikah ter pazimo, da izberemo le en prikaz za posamezen rezultat in da se vsebina ne podvaja. V razlagi rezultatov se osredotočamo na statistično značilne rezultate in tiste, ki so nas presenetili. Rezultate prikazujemo glede na stopnjo zahtevnosti statistične obdelave. Pri prikazu rezultatov v tabelah in slikah je za vse uporabljene kratice potrebna pojasnitev v legendi pod tabelo ali sliko. Rezultate prikažemo po postavljenih spremenljivkah, odgovorimo na raziskovalna vprašanja oz. hipoteze. Pri kvalitativnih raziskavah prikažemo potek oblikovanja kod in kategorij, za vsako kodo predstavimo eno do dve reprezentativni izjavi vključenih v raziskavo, ki najbolje predstavita oblikovano kodo. Naredimo shematični prikaz dobljenih kod in iz njih razvitih kategorij ter sodbo.

Diskusija: V diskusiji ugotovitve raziskave navajamo na besedni način (številčnih rezultatov ne navajamo).

Nizamo jih po posameznih spremenljivkah in z vidika postavljenih raziskovalnih vprašanj oz. hipotez, ki jih ne ponavljamo, temveč nanje besedno odgovarjamo. Rezultate v razpravi pojasnimo z vidika razumevanja, kaj lahko iz njih razberemo, razumemo in kako je to primerljivo z rezultati drugih raziskav in kaj to pomeni za uporabnost naše raziskave. Pri tem smo odgovorni in etični ter rezultate pojasnjujemo z vidika spoznanj naše raziskave in z vidika spoznanj, ki so preverljiva, splošno znana in primerljiva z vidika drugih raziskav. Pazimo na posploševanje rezultatov in se pri tem zavedamo omejitev raziskave z vidika instrumenta, vzorca in poteka raziskave. Upoštevamo načelo preverljivosti in primerljivosti. Oblikujemo rdečo nit razprave kot smiselne celote, komentiramo pričakovana in nepričakovana spoznanja raziskave. Na koncu razprave navedemo priporočila, ki so plod naše raziskave, in področja, ki jih nismo raziskali, pa bi jih bilo treba, ali pa smo jih, vendar naši rezultati ne dajejo ustreznih pojasnil. Navedemo omejitve raziskave.

Zaključek: Na kratko povzamemo ključne ugotovitve izvedene raziskave, povzamemo predloge za prakso, predlagamo možnosti nadaljnjega raziskovanja obravnavanega problema. V zaključku ne citiramo ali povzemamo.

Članek naj se zaključi s seznamom literature, ki je bila citirana ali povzeta v članku.

Struktura preglednega znanstvenega članka (1.02)

V kategorijo preglednih znanstvenih raziskav sodijo: sistematični pregled literature, pregled literature, analiza koncepta, razpravni članek (v nadaljevanju pregledni znanstveni članek). Revija objavlja pregledne znanstvene raziskave, za katere je bilo zbiranje podatkov končano največ tri leta pred objavo članka v reviji.

Pregledni znanstveni članek je pregled najnovejših raziskav o določenem predmetnem področju z namenom povzemanja, analiziranja, evalviranja ali sintetiziranja informacije, ki so že bile publicirane. V preglednem znanstvenem članku znanstvena spoznanja niso le navedena, ampak tudi razložena, interpretirana, analizirana, kritično ovrednotena in predstavljena na znanstvenoraziskovalen način. Na osnovi kvantitativne obdelave podatkov predhodnih raziskav (metaanaliza) ali kvalitativne sinteze (metasinteza) rezultatov predhodnih raziskav prinaša nova spoznanja in koncepte za nadaljnje raziskovalno delo. Struktura preglednega znanstvenega članka je enaka kot pri izvornem znanstvenem članku.

V **uvodu** predstavimo znanstveno, konceptualno ali teoretično izhodišče kot vodilo pregleda literature. Končamo z utemeljitvijo, zakaj je pregled potreben, zapišemo namen, cilje in raziskovalno vprašanje.

V **metodah** natančno opišemo uporabljeni raziskovalni dizajn pregleda literature. Podpoglavja metod so: *metode*

pregleda, rezultati pregleda, ocena kakovosti pregleda in opis obdelave podatkov. Metode pregleda vključujejo razvoj, testiranje in izbor iskalne strategije, vključitvene in izključitvene kriterije za uvrstitev v pregled, raziskane podatkovne baze, časovno obdobje iskanja objav, vrste objav z vidika hierarhije dokazov, ključne besede, jezik pregledanih objav. Rezultati pregleda vključujejo število dobljenih zadetkov, število pregledanih raziskav, število vključenih raziskav in število izključenih raziskav. Uporabimo diagram poteka raziskave skozi faze pregleda, pri izdelavi si pomagamo z mednarodnimi standardi za prikaz rezultatov pregleda literature (npr. PRISMA-Preferred Reporting Items for Systematic Review and Meta-Analysis). Ocena kakovosti pregleda in opis obdelave podatkov vključuje oceno uporabljene iskalne strategije in kriterijev za dokončni nabor uporabljenih zadetkov, kakovost vključenih raziskav z vidika hierarhije dokazov ter način obdelave podatkov.

Rezultate prikažemo tabelarično kot analizo kakovosti vključenih raziskav. Tabela naj vključuje avtorje raziskave, leto objave raziskave, državo, kjer je bila raziskava izvedena, namen raziskave, raziskovalni dizajn, proučevane spremenljivke, instrument, velikost vzorca, ključne ugotovitve idr. Jasno naj bo razvidno, katere vrste raziskav glede na hierarhijo dokazov so vključene v pregled literature. Rezultate prikažemo besedno, v tabelah in slikah, navedemo ključna spoznanja glede na raziskovalni dizajn. Pri kvalitativni sintezi uporabimo kode in kategorije kot rezultat pregleda kvalitativne sinteze. Pri kvantitativni analizi opišemo uporabljene statistične metode obdelave podatkov iz vključenih znanstvenih del.

V **diskusiji** v prvem delu odgovorimo na raziskovalno vprašanje, nato komentiramo ugotovitve pregleda literature, kakovost vključenih raziskav, svoje ugotovitve primerjamo z rezultati drugih primerljivih raziskav, razvijemo nova spoznanja, ki jih je doprinesel pregled literature, njihovo teoretično, znanstveno in praktično uporabnost, navedemo omejitve raziskave, uporabnost v praksi in priložnosti za nadaljnje raziskovanje.

V **zaključku** poudarimo doprinos izvedenega pregleda, opozorimo na morebitne pomanjkljivosti v splošno uveljavljenem znanju in razumevanju, izpostavimo pomen bodočih raziskav, uporabnost pridobljenih spoznanj in priporočila za prakso, raziskovanje, izobraževanje, menedžment, pri čemer upoštevamo omejitve raziskave. Izpostavimo teoretični koncept, ki bi lahko usmerjal raziskovalce v prihodnosti. V zaključku ne citiramo ali povzemamo.

Navajanje literature

Vsako trditev, teorijo, uporabljeno metodologijo, koncept je treba potrditi s citiranjem. Avtorji naj uporabljajo *harvardski sistem* (npr. Anglia 2008) za navajanje avtorjev v besedilu in seznamu literature na koncu članka. Za navajanje avtorjev v **besedilu**

uporabljamo npr.: (Pahor, 2006) ali Pahor (2006), kadar priimek vključimo v poved. Če gre za dva soavtorja, priimeka ločimo z »&«: (Stare & Pahor, 2010). V besedilu navajamo *do dva avtorja*, če je avtorjev več navedemo le prvega in dopišemo »et al.«: (Chen, et al., 2007). Če navajamo več citiranih del, jih ločimo s podpičji in jih navedemo po kronološkem zaporedju, od najstarejšega do najnovejšega, če je med njimi v istem letu več citiranih del, jih razvrstimo po abecednem vrstnem redu: (Bratuž, 2012; Pajntar, 2013; Wong, et al., 2014). Kadar citiramo več del istega avtorja, izdanih v istem letu, je treba za letnico dodati malo črko po abecednem redu: (Baker, 2002a, 2002b).

Kadar navajamo sekundarne vire, uporabimo »cited in«: (Lukič, 2000 cited in Korošec, 2014). Če pisec članka ni bil imenovan oz. je delo anonimno, v besedilu navedemo *naslov*, v oklepaju pa zapišemo »Anon.« ter letnico objave: *The past is the past* (Anon., 2008). Kadar je avtor organizacija oz. gre za korporativnega avtorja, zapišemo ime korporacije (Royal College of Nursing, 2010). Če ni leta objave, to označimo z »n. d.« (ang. no date): (Smith, n. d.). Pri objavi fotografij navedemo avtorja (Foto: Marn, 2009; vir: Cramer, 2012). Za objavo fotografij, kjer je prepoznavna identiteta posameznika, moramo pridobiti dovoljenje te osebe ali staršev, če gre za otroka.

V **seznamu literature** na koncu članka navedemo bibliografske podatke / reference za *vsa v besedilu citirana ali povzeta dela* (in samo ta!), in sicer po abecednem redu avtorjev. Sklicujemo se le na objavljena dela. Kadar je avtorjev več in smo v besedilu navedli le prvega ter pripisali »et al.«, v seznamu navedemo prvih šest avtorjev in pripišemo »et al.«, če je avtorjev več kot šest. Za oblikovanje seznama literature velja velikost črk 12 točk, enojni razmik, leva poravnava ter 12 točk prostora za referencami (razmik med odstavki, ang. paragraph spacing).

Pri citiranju, tj. dobesednem navajanju, citirane strani zapišemo tako v navedbi citirane publikacije v besedilu: (Ploč, 2013, p. 56); kot tudi pri ustrezni referenci v seznamu (glej primere v nadaljevanju). Če citiramo več strani iz istega dela, strani navajamo ločene z vejico (npr.: pp. 15–23, 29, 33, 84–86). Če je citirani prispevek dostopen na spletu, na koncu bibliografskega zapisa navedemo »Available at:« ter zapišemo URL- ali URN-naslov ter v oglatem oklepaju dodamo datum dostopa (glej primere).

Primeri navajanja literature v seznamu

Citiranje knjige:

Hoffmann Wold, G., 2012. *Basic geriatric nursing*. 5th ed. St. Louis: Elsevier/Mosby, pp. 350–356.

Pahor, M., 2006. *Medicinske sestre in univerza*. Domžale: Izolit, pp. 73–80.

Ricci Scott, S., 2007. *Essentials of maternity, newborn and women's health nursing*. 2nd ed. Philadelphia: Lippincott Williams & Wilkins, pp. 32–36.

Citiranje poglavja oz. prispevka iz knjige, ki jo je uredilo več avtorjev:

Berryman, J., 2010. Statewide nursing simulation program. In: W.M. Nehring & F.R. Lashley, eds. *High-fidelity patient simulation in nursing education*. Sudbury (Massachusetts): Jones and Bartlett, pp. 115–131.

Girard, N.J., 2004. Preoperative care. In: S.M. Lewis, et al., eds. *Medical-surgical nursing: assessment and management of clinical problems*. 6th ed. St. Louis: Mosby, pp. 360–375.

Kanič, V., 2007. Možganski dogodki in srčno-žilne bolezni. In: E. Tetičkovič & B. Žvan, eds. *Možganska kap – do kdaj?* Maribor: Kapital, pp. 33–42.

Citiranje knjige, ki jo je uredil en ali več avtorjev:

Borko, E., Takač, I., But, I., Gorišek, B. & Kralj, B. eds., 2006. *Ginekologija*. 2. dopolnjena izd. Maribor: Visoka zdravstvena šola, pp. 269–276.

Robida, A. ed., 2006. *Nacionalne usmeritve za razvoj kakovosti v zdravstvu*. Ljubljana: Ministrstvo za zdravje, pp. 10–72.

Citiranje članka iz revij (v drugem primeru dostopnega tudi na spletu):

Cronenwett, L., Sherwood, G., Barnsteiner, J., Disch, J., Johnson, J., Mitchell, P., et al., 2007. Quality and safety education for nurses. *Nursing Outlook*, 55(3), pp. 122–131.

Papke, K. & Plock, P., 2004. The role of fundal pressure. *Perinatal Newsletters*, 20(1), pp. 1–2. Available at: http://www.idph.state.ia.us/hpcdp/common/pdf/perinatal_newsletters/progeny_may2004.pdf [5. 12. 2012].

Pillay, R., 2010. Towards a competency-based framework for nursing management education. *International Journal of Nursing Practice*, 16(6), pp. 545–554.

Snow, T., 2008. Is nursing research catching up with other disciplines? *Nursing Standard*, 22(19), pp. 12–13.

Citiranje anonimnega dela (avtor ni naveden):

Anon., 2008. The past is the past: wasting competent, experienced nurses based on fear. *Journal of Emergency Nursing*, 34(1), pp. 6–7.

Citiranje dela korporativnega avtorja:

United Nations, 2011. *Competencies for the future*. New York: United Nations, p. 6.

Citiranje članka iz suplementa revije oz. suplementa številke revije:

Hu, A., Shewokis, P.A., Ting, K. & Fung, K., 2016. Motivation in computer-assisted instruction. *Laryngoscope*, 126(Suppl 6), pp. S5–S13.

Regehr, G. & Mylopoulos, M., 2008. Maintaining competence in the field: learning about practice, through practice, in practice. *The Journal of Continuing Education in the Health Professions*, 28(Suppl 1), pp. S19–S23.

Rudel, D., 2007. Informacijsko-komunikacijske tehnologije za oskrbo bolnika na daljavo. *Rehabilitacija*, 6(Suppl 1), pp. 94–100.

Citiranje prispevka iz zbornika referatov:

Skela-Savič B., 2008. Teorija, raziskovanje in praksa v zdravstveni negi – vidik odgovornosti menedžmenta v zdravstvu in menedžmenta v visokem šolstvu. In: B. Skela-Savič, et al., eds. *Teorija, raziskovanje in praksa – trije stebri, na katerih temelji sodobna zdravstvena nega: zbornik predavanj z recenzijo. 1. mednarodna znanstvena konferenca, Bled 25. in 26. september 2008*. Jesenice: Visoka šola za zdravstveno nego, pp. 38–46.

Štemberger Kolnik, T. & Babnik, K., 2012. Oblikovanje instrumenta zdravstvene pismenosti za slovensko populacijo: rezultati pilotske raziskave. In: D. Železnik, et al., eds. *Inovativnost v koraku s časom in primeri dobrih praks: zbornik predavanj z recenzijo. 2. znanstvena konferenca z mednarodno udeležbo s področja zdravstvenih ved, 18. september 2012*. Slovenj Gradec: Visoka šola za zdravstvene vede, pp. 248–255.

Wagner, M., 2007. Evolucija k žensko osredinjeni obporodni skrbi. In: Z. Drglin, ed. *Rojstna mašinerija: sodobne obporodne vednosti in prakse na Slovenskem*. Koper: Univerza na Primorskem, Znanstveno-raziskovalno središče, Založba Annales, Zgodovinsko društvo za južno Primorsko, pp. 17–30.

Citiranje diplomskega, magistrskega dela, doktorske disertacije:

Ajlec, A., 2010. *Komunikacija in zadovoljstvo na delovnem mestu kot del kakovostne zdravstvene nege: diplomsko delo univerzitetnega študija*. Kranj: Univerza v Mariboru, Fakulteta za organizacijske vede, pp. 15–20.

Rebec, D., 2011. *Samoocenjevanje študentov zdravstvene nege s pomočjo video posnetkov pri poučevanju negovalnih intervencij v specialni učilnici: magistrsko delo*. Maribor: Univerza v Mariboru, Fakulteta za zdravstvene vede, pp. 77–79.

Kolenc, L., 2010. *Vpliv sodobne tehnologije na profesionalizacijo poklica medicinske sestre: doktorska disertacija*. Ljubljana: Univerza v Ljubljani, Fakulteta za družbene vede, pp. 250–258.

Citiranje zakonov, kodeksov, pravilnikov:

Zakon o pacientovih pravicah (ZPacP), 2008. Uradni list Republike Slovenije št. 15.

Zakon o preprečevanju nasilja v družini (ZPND), 2008a. Uradni list Republike Slovenije št. 16.

Zakon o varstvu osebnih podatkov (uradno prečiščeno besedilo) (ZVOP-1-UPB1), 2007. Uradni list Republike Slovenije št. 94.

Kodeks etike medicinskih sester in zdravstvenih tehnikov Slovenije, 2010. Uradni list Republike Slovenije št. 40.

Pravilnik o licencah izvajalcev v dejavnosti zdravstvene in babiške nege Slovenije, 2007. Uradni list Republike Slovenije št. 24.

Citiranje zgoščenk (CD-ROM):

International Council of Nurses, 2005. *ICNP version 1.0: International classification for nursing practice*. [CD-ROM]. Geneva: International Council of Nurses.

Sima, Đ. & Požun, P., 2013. *Zakonodaja s področja zdravstva*. [CD-ROM]. Ljubljana: Društvo medicinskih sester, babic in zdravstvenih tehnikov.

NAVODILA ZA PREDLOŽITEV ČLANKA

Članek je treba oddati v e-obliki preko spletne strani revije. Revija uporablja Open Journal System (OJS), dostopno na: <http://obzornik.zbornica-zveza.si>. Avtor mora natančno slediti navodilom za oddajo članka in izpolniti vse zahtevane rubrike. Pred oddajo članka naj avtor članek pripravi v naslednjih dveh ločenih dokumentih.

1. Naslovna stran, ki vključuje:

- naslov članka;
- avtorje v vrstnem redu, kot morajo biti navedeni v članku;
- popolne podatke o vseh avtorjih (ime, priimek, dosežena stopnja izobrazbe, habilitacijski naziv, zaposlitev, e-naslov) in podatek o tem, kdo je korespondenčni avtor; če je članek napisan v angleščini, morajo biti tako zapisani tudi vsi podatki o avtorjih; v sistem je vključena e-izjava o avtorstvu;
- informacijo, ali članek vključuje del rezultatov večje raziskave oz. ali je nastal v okviru diplomskega, magistrskega ali doktorskega dela (v tem primeru je prvi avtor vedno študent);
- izjave (statements): avtorji morajo ob oddaji rokopisa podati sledeče izjave (pri slovensko pisanem članku so vse izjave tako v slovenščini kot tudi v angleščini), ki bodo po zaključenem recenzentskem postopku in odločitvi za sprejem članka v objavo prikazane na koncu članka pred poglavjem *Literatura*.

Zahvala / Acknowledgements

Avtorji se lahko zahvalijo posameznikom, skupinam ali sodelujočim v raziskavi za sodelovanje v raziskavi (izbirno).

Nasprotje interesov / Conflict of interest

Avtorji so dolžni predstaviti kakršnokoli nasprotje interesov pri oddaji članka. V kolikor avtorji nimajo nobenih nasprotujočih interesov naj zapišejo naslednjo izjavo: »Avtorji izjavljajo, da ni nasprotja interesov.«

Financiranje / Funding

Avtorji so dolžni opredeliti kakršnokoli finančno pomoč pri nastajanju članka. Ta informacija je lahko podana z imenom organizacije, ki je financirala ali sofinancirala raziskavo, ter v primeru projekta z imenom in številko projekta. V kolikor ni bilo nobenega financiranja, naj avtorji zapišejo naslednjo izjavo: »Raziskava ni bila finančno podprta.«

Etika raziskovanja / Ethical approval

Avtorji so dolžni podati informacije o etičnih vidikih raziskave. V primeru odobritve raziskave s strani komisije za etiko zapišejo ime komisije za etiko in številko odločbe. V kolikor raziskava ni potrebovala posebnega dovoljenja komisije za etiko, so avtorji to dolžni pojasniti. Glede na posamezen tip raziskave lahko avtorji na primer zapišejo tudi naslednjo izjavo: »Raziskava je pripravljena v skladu z načeli Helsinško-Tokijske deklaracije (World Medical Association, 2013) in v skladu s Kodeksom etike v zdravstveni negi in oskrbi Slovenije (ali) Kodeksom etike za babice Slovenije (2014),« v skladu s katero je treba v seznamu literature navajati oba vira.

Prispevek avtorjev / Author contributions

V primeru članka dveh ali več avtorjev so avtorji dolžni opredeliti prispevek posameznega avtorja pri nastanku članka, kot to določajo priporočila International Committee of Medical Journal Editors (ICMJE), dostopno na: <http://www.icmje.org/recommendations>. Vsak soavtor članka mora sodelovati v najmanj dveh strukturalnih delih članka (Uvod / Introduction, Metode / Methods, Rezultati / Results, Diskusija in zaključek / Discussion and conclusion). Za vsakega avtorja je treba napisati, v katerih delih priprave članka je sodeloval in kaj je bil njegov prispevek v posameznem delu.

2. Glavni dokument, ki je anonimiziran in vključuje naslov članka (obvezno brez avtorjev in kontaktnih podatkov), izvleček, ključne besede, besedilo članka v predpisani strukturi, tabele, slike in literaturo. Avtorji lahko v članku uporabijo največ 5 tabel / slik.

Obseg članka: članek naj vsebuje največ 5000 besed za kvantitativno in do 6000 besed za kvalitativno

zasnovane raziskave. V ta obseg se ne štejejo izvleček, tabele, slike in seznam literature. Število besed članka je treba navesti v dokumentu »Naslovna stran«.

Za **oblikovanje besedila članka** naj velja naslednje: velikost strani A4, dvojni razmik med vrsticami, pisava Times New Roman, velikost črk 12 točk in širina robov 25 mm. Obvezna je uporaba oblikovne predloge za članek (Word), dostopne na spletni strani Obzornika zdravstvene nege.

Tabele naj bodo označene z arabskimi zaporednimi številkami. Imeti morajo vsaj dva stolpca ter opisni naslov (nad tabelo), naslovno vrstico, morebitni zbirni stolpec in zbirno vrstico ter legendo uporabljenih znakov. V tabeli morajo biti izpolnjena vsa polja, obsegajo lahko največ 57 vrstic. Za njihovo oblikovanje naj velja naslednje: velikost črk 11 točk, pisava Times New Roman, enojni razmik, pred in za vrstico 0,5 točke prostora, v prvem stolpcu in vseh stolpcih z besedilom leva poravnava, v stolpcih s statističnimi podatki leva poravnava, vmesne pokončne črte pri prikazu neizpisane. Uredništvo si pridružuje pravico, da preobsežne tabele, v sodelovanju z avtorjem, preoblikuje.

Slike naj bodo oštevilčene z arabskimi zaporednimi številkami. Podpisi k slikam (pod sliko) in legende naj bodo v slovenščini in angleščini, pisava Times New Roman, velikost 11 točk. Izraz slika uporabimo za grafe, sheme in fotografije. Uporabimo le dvodimenzionalne grafične črno-bele prikaze (lahko tudi šrafure) ter resolucijo vsaj 300 dpi (dot per inch). Če so slike v dvorazsežnem koordinatnem sistemu, morata obe osi (x in y) vsebovati označbe, katere enote / mere vsebujeta.

Članki niso honorirani. Besedil in slikovnega gradiva ne vračamo, kontaktni avtor prejme objavljeni članek v formatu PDF (Portable Document Format).

Sodelovanje avtorjev z uredništvom

Članek mora biti pripravljen v skladu z navodili in oddan prek spletne strani revije na <http://obzornik.zbornica-zveza.si>, to je pogoj, da se članek uvrsti v uredniški postopek. Če uredništvo presodi, da članek izpolnjuje kriterije za objavo v Obzorniku zdravstvene nege, bo poslan v zunanjo strokovno (anonimno) recenzijo. Recenzenti prejmejo besedilo članka brez avtorjevih osebnih podatkov, članek pregledajo glede na postavljene kazalnike in predlagajo izboljšave. Avtor je dolžan izboljšave pregledati in jih v največji meri upoštevati ter članek dopolniti v roku, ki ga določi uredništvo. V kolikor avtor članka ne vrne v roku, se članek zavrne. V kolikor avtor katere od predlaganih izboljšav ne upošteva, mora to pisno pojasniti. Po zaključenem recenzijem postopku uredništvo članek vrne avtorju, da popravke odobri, jih upošteva in pripravi čistopis. Čistopis uredništvo pošlje v jezikovni pregled.

Avtor prejme prvi natis v korekturo s prošnjo, da na njem označi vse morebitne tiskovne napake, ki jih

označi v PDF-ju prvega natisa. Spreminjanje besedila v tej fazi ni sprejemljivo. Korekture je treba vrniti v treh delovnih dneh, sicer uredništvo meni, da se avtor s prvim natisom strinja.

NAVODILA ZA DELO RECENZENTOV

Recenzentovo delo je odgovorno in zahtevno. S svojimi predlogi in ocenami recenzenti prispevajo k večji kakovosti člankov, objavljenih v Obzorniku zdravstvene nege. Od recenzenta, ki ga uredništvo neodvisno izbere, se pričakuje, da bo odgovoril na vprašanja, ki so postavljena v obrazcu OJS, in ugotovil, ali so trditve in mnenja, zapisani v članku, verodostojni in ali je avtor upošteval navodila za objavljanje. Recenzent mora poleg znanstvenosti, strokovnosti in primernosti vsebine za objavo v Obzorniku zdravstvene nege članek oceniti metodološko ter uredništvo opozoriti na pomanjkljivosti. Ni treba, da se recenzent ukvarja z lektoriranjem, vendar lahko opozori tudi na jezikovne pomanjkljivosti. Pozoren naj bo na pravilno rabo strokovne terminologije. Posebej mora biti recenzent pozoren, ali je naslov članka jasen, ali ustreza vsebini; ali izvleček povzema bistvo članka; ali avtor citira (naj)novejšo literaturo in ali citira znanstvene raziskave avtorjev, ki so pisali o isti temi v domačih revijah; ali se avtor izogiba avtorjem, ki zagovarjajo drugačna mnenja, kot so njegova; ali navaja tuje misli brez citiranja; ali je citiranje literature ustrezno, ali se v besedilu navedena literatura ujema s seznamom literature na koncu članka. Dostopno literaturo je treba preveriti. Oceniti je treba ustreznost slik ter tabel, preveriti, če se v njih ne ponavlja tisto, kar je v besedilu že navedeno. Recenzentova dolžnost je opozoriti na morebitne nerazvezane kratice. Recenzent mora biti še posebej pozoren na morebitno plagiatstvo in krajo intelektualne lastnine.

S sprejetjem recenzije se recenzent zaveže, da jo bo oddal v predpisanem roku. Če to ni mogoče, mora takoj obvestiti uredništvo. Recenzent se obveže, da vsebine članka ne bo nedovoljeno razmnoževal ali drugače zlorabil. Recenzije so anonimne: recenzent je avtorju neznan in obratno. Recenzent bo v pregled prek sistema OJS prejel le vsebino članka brez imena avtorja. V sistemu OJS recenzent poda svoje strokovno mnenje v recenzijem obrazcu. Če ima recenzent večje pripombe, jih kot utemeljitev za sprejem ali morebitno zavrnitev članka na kratko opiše oz. avtorju predlaga nadaljnje delo, pri čemer upošteva njegovo integriteto. Zaradi večje preglednosti in lažjih dopolnitev s strani avtorja lahko recenzent svoje pripombe in morebitne predloge vnese v besedilo članka, pri tem uporabi možnost, ki jo ponuja Microsoft Word – sledi spremembam (Track changes). Recenzent mora biti pozoren, da pred uporabo omenjene možnosti prikrije svojo identiteto (slediti spremembam, spremeni ime/Track changes, change user name). Recenzentsko verzijo besedila članka z vključenimi anonimiziranimi predlogi nato recenzent naloži v sistem OJS in omogoči avtorju, da predloge dopolnitev vidi. Končno odločitev o objavi članka sprejme uredniški odbor.

Literatura

World Medical Association, 2013. World Medical Association Declaration of Helsinki: ethical principles for medical research involving human subjects. *Journal of the American Medical Association*, 310(20), pp. 2191–2194. Available at: <http://www.wma.net/en/20activities/10ethics/10helsinki/DoH-Oct2013-JAMA.pdf> [1. 9. 2016].

Kodeks etike v zdravstveni negi in oskrbi Slovenije in Kodeks etike za babice Slovenije, 2014. Ljubljana: Zbornica zdravstvene in babiške nege Slovenije – Zveza strokovnih društev medicinskih sester, babic in zdravstvenih tehnikov Slovenije.

Posodobljeno: 21. 11. 2016

Citirajte kot:

Obzornik zdravstvene nege: navodila avtorjem in recenzentom, 2016. *Obzornik zdravstvene nege*. Available at: <http://www.obzornikzdravstvenenege.si/Navodila.aspx> [23.12.2016].

MANUSCRIPT SUBMISSION GUIDELINES

General policies

The manuscript should be written clearly and succinctly in a standard Slovene or English language and conform to acceptable language usage. Its length must not exceed 5000 words for quantitative and 6000 for qualitative research articles, excluding the title, abstract, tables, pictures and literature. The authors should use the Microsoft Word template, accessible at the editorial website. All articles considered for publication in the Slovenian Nursing Review will have been subjected to an external, triple-blind peer review. Manuscripts are accepted for consideration by the journal with the understanding that they represent original material, have not been published previously and are not being considered for publication elsewhere. Individual authors bear full responsibility for the content and accuracy of their submissions. The statement of responsibility and publication approval must be signed by the authors' full name. The author's (or authors') professional, academic titles and possible appointments to pedagogical or research title must be included. If the article is written in English, all the titles must be translated into the English language. In submitting a manuscript, the authors must observe the standard scientific research paper components, the format and typology of documents, and submission guidelines. The manuscript must be accompanied by the authorship statement, a copy of which is available on the journal website. The statement must be undersigned by the author and all co-authors in the order in which each is listed in the authorship of the article. The manuscript will not be submitted to editing process before the statement has been received by the editorial office. The latter should also be notified of the designated corresponding author (with their complete home and e-mailing address, telephone number), who is responsible for communicating with the editorial office and other authors about revisions and final approval of the proofs. The title page should include the manuscript title and the full names of the authors, their highest earned academic degrees, and their institutional affiliations and status. The manuscript is eligible for editorial and reviewing process if it is prepared according to the uniform requirements set forth by the editorial committee of the Slovenian Nursing Review.

If the article publishes human subject research, it should be evident from the methodology chapter that the study was conducted in accordance with the Declaration of Helsinki and Tokyo. All human subject research including patients or vulnerable groups, health professionals and students requires review and approval by the ethical committee on institutional or national level prior to subject recruitment and data collection.

The title of the article, abstract and key words, tables (descriptive subtitle and legend), illustrations (descriptive subtitle or signature and legend) must be submitted in Slovene and English. The same applies to the articles written in English, where the above units must be given first in the English language, followed by the Slovene translation. The total of five data supplements per manuscript is allowed.

Tables and other data supplements should adequately accompany the text. The results presented in tables and other data supplements should be presented in symbols as required by the journal, available at the journal website, chapter Guidelines. The authors should refer to each of these supplements in the text. The use of footnotes and endnotes is not allowed.

Typology of articles

The editors reserve the right to re-classify the article in a topic category that may be more suitable than originally submitted. The classification follows the adopted typology of documents/works for bibliography management in COBISS (Cooperative Online Bibliographic System and Services) accessible at: http://home.izum.si/COBISS/bibliografije/Tipologija_slv.pdf. Reclassification can be suggested by the author or reviewer, the final decision rests with the editor-in-chief and the executive editor.

Methodological structure of an article

The title, the abstract and the key words should be written in the Slovene and English language. A concise but informative title should convey the nature, content and research design of the paper. It must not exceed 120 characters. If the title is followed by a subtitle, a semicolon should be placed in between. Up to six key words separated by a semicolon and not included in the title, define the article content and reflect the article's core topic or message. Articles must be accompanied by an abstract of no more than 150-220 words written in the third person. Abstracts accompanying articles must be structured and should not include references.

A structured abstract is an abstract with distinct, labelled sections for rapid comprehension. It is structured under the following headings:

Introduction: This section states the main question to be answered, and indicates the exact objective of the paper and the major variables of the study.

Methods: This section provides an overview of the research or experimental design, the research instrument, the reliability of the instrument, methods of data collection, and analysis indicating where, how and when the data were collected.

Results: This section briefly summarizes and discusses the major findings. The information indicated in this section should be directly connected to the research question and purpose of the study. In

quantitative studies it is necessary to state the statistical validity and statistical significance of the results.

Discussion and conclusion: This section states the conclusions and discusses the research findings drawn from the results obtained. Presented in this section are also limitations of the study and the implications of the results for practice and relevant further research. Both, the positive and the negative research findings should be adequately presented.

Structure of an Original Scientific Article (1.01)

An original scientific article is only the first-time publication of original research results in a way that allows the research to be repeated, and the findings checked. The research should be based on the primary sources which are not older than five years at the time of the publication of the article.

Introduction: In the introductory part the research problem is defined within the context of knowledge and scientific evidence it was developed. The review of scientific literature on the topic provides a rationale behind the work and identifies a problem highlighted by the gap in the literature. It frames a purpose and aims for a study, research questions or hypotheses as well as the method of investigation (a research design, sample size and characteristics of the proposed sample, data collection and data analysis procedures). The research should be based on the primary sources of the recent national and international research which are not older than ten or five years respectively, if the topic has been widely researched. Citation of sources and references to previous research findings is obligatory, while the authors' personal views are not given. Finally, the research intentions and purposes are stated. Recommended is also the framing of research questions (qualitative research) and hypotheses (qualitative research) to investigate or guide the study.

Method: This section states the chosen paradigm (qualitative, quantitative) and outlines the research design. It usually includes sections on research design; sample size and characteristics of the proposed sample; description of research process; and data collection and data analysis procedures.

The *description of the research instrument* includes information about the construction of the instrument, the mode of instrument development, instrument variables and measurement properties (validity, reliability, objectivity, sensitivity). Appropriate citations of the literature used in research development should be included. In qualitative research, a technique of data collection should be given along with the preliminary research questions, a possible format or structure of data collection and process, the criteria of validity and reliability of data collection.

The *description of a sample* defines the population from which the sample has been drawn, the type of

the sample, the response rate of the participants, the respondents' demographics (gender, educational level, length of work experience, post currently held, and the like). In qualitative research, the category of sampling technique and the inclusion criteria are also defined and the sample size saturation is explained.

The *description of the research procedure and data analysis* includes ethical approvals to conduct a research, permission to conduct a research in an institution, description of the research process, guarantee of anonymity and voluntariness of the research participants, period and place of data collection, method of data collection and analysis, including statistical methods, statistical analysis software and programme version, limits of statistical significance. A qualitative research should include a detailed description of modes of data collection and recording, number and duration of observations, interviews and surveys, sequences, transcription of data, steps in the data analysis and interpretation, and receptiveness of a researcher.

Results: This section presents the research results descriptively or in numbers and figures. A table is included only if it presents new information. Each finding is presented only once so as to avoid repetition and duplication of the content. Explanation of the results is focused on statistically significant or unexpected findings. The results are presented according to the level of statistical complexity. All abbreviations used in figures and tables should be provided with explanatory captions in the legend below the table or figure. The results are presented according to the variables, answering all the research questions or hypotheses. In qualitative research, the development of codes and categories should also be presented, including one or two representative statements of participants. A schematic presentation of the codes and ensuing categories are given.

Discussion: The discussion section analyses the data descriptively (numerical data should be avoided) in relation to specific variables from the study. The results are analysed and evaluated in relation to the original research questions or hypotheses. The discussion part integrates and explains the results obtained and relates them with those of previous studies in order to determine their significance and applicative value. Ethical interpretation and communication of research results is essential to ensure the validity, comparability and accessibility of new knowledge. The validity of generalisations from results is often questioned due to the limitations of qualitative research (sample representativeness, research instrument, research proceedings). The principles of reliability and comparability should be observed. The discussion includes comments on the expected and unexpected findings and the areas requiring further or in-depth research as indicated by the study results. The limitations of the research should be clearly stated.

Conclusion: Summarised in this section are the author's principal points and transfer of new findings into practice. The section may conclude with specific further research proposals grounded on the substantive content, conclusions and contributions of the study, albeit limitations cited. Citations of quotes, paraphrases or abridgements should not be included in the conclusion.

The article concludes with a list of all the published works cited or referred to in the text of the paper.

Structure of a Review Article (1.02)

Included in the category of review scientific research are: literature review, concept analyses, discussion based articles (also referred to as a review article). The Slovenian Nursing Review publishes review scientific research, the data collection of which has been concluded maximum three years before the publication of an article.

A review article is an overview of the latest works in a specific subject area, the works of an individual researcher or a group of researchers with the purpose of summarising, analysing, evaluating or synthesising the information that has already been published. Research findings are not only described but explained, interpreted, analysed, critically evaluated and presented in a scientific research manner. A review article brings either qualitative data processing of the previous research findings (meta-analyses) or qualitative syntheses of the previous research findings (meta-syntheses) and thus provides new knowledge and concepts for further research. The organizational pattern of a review article is similar to that of the original scientific article.

The **introduction** section defines the scientific, conceptual or theoretical basis for the literature review. It also states the necessity for the review along with the aims, objectives and the research question.

The **method** section accurately defines the research methods by which the literature search was conducted. It is further subdivided into: review methods, the results of the review, the quality assessment of the review and the description of data processing.

Review methods include the development, testing and search strategy, predetermined criteria for the inclusion in the review, the researched data bases, limited time period of published literature, types of publications according to hierarchy of evidence, key words and the language of reviewed publications.

The *results of the review* include the number of hits, the number of reviewed research works, the number of included and excluded sources consulted. The **results** are presented in the form of a diagram of all the research stages of the review. The international standards for the presentation of the literature review results may be used for this purpose (e.g. PRISMA - Preferred Reporting Items for Systematic Review and Meta-Analysis.

The quality assessment of the review and the description of data processing include the assessment of the research approach and the data obtained as well as the quality of included research works according to the hierarchy of evidence, and the data processing method.

The results should be presented in the form of a table and include a quality analysis of the sources consulted. The table should include the author's research, the year of publication, the country where the research was conducted, the research purpose and design, the variables studied, the research instrument, sample size, the key findings, etc.

It should be evident which studies are included in the review according to hierarchy of evidence. The results are presented verbally and visually (tables and pictures), the main findings concerning the research design should also be included. In qualitative synthesis the codes and categories are used as a result of the qualitative synthesis review. In quantitative analysis, the statistical methods of data processing of the used scientific works are described.

The first section of the **discussion** answers the research question which is followed by the author's observations on literature review findings, the quality of the research works included. The author evaluates the review findings in relation to the results from other comparable studies. The discussion chapter identifies new perspectives and contributions of the literature review, their theoretical, scientific and practical applicability. It also defines research limitations and points the way forward for applicability of the review findings and further research.

The **conclusion** section emphasises the contribution of the literature review conducted, it sheds light on any gaps in previous research, it identifies the significance of further research, the translation of new knowledge and recommendations into practice, research, education, management by taking into consideration the research limitations. It also pinpoints theoretical concept which may guide or direct further research. Citations of quotes, paraphrases or abridgements should not be included in the conclusion.

Literature Citation

In academic writing the authors are required to acknowledge the sources from which they draw their information, including all statements, theories or methodologies applied. The authors should follow the *Harvard referencing system* (Anglia 2008) for in-text citations and in the reference list at the end of the paper. **In-text citations** or parenthetical citations are identified by the authors' surname and the publication year positioned within parenthesis immediately after the relevant word and before the punctuation mark: (Pahor, 2006). If a citation functions as a sentence element, the author's surname is followed by the year

of publication within parenthesis: Pahor (2006). In case of two authors, their surnames are separated by a "&": (Stare & Pahor, 2010). If there are *more than two authors*, only the first author's last name is noted followed by "et al.": (Chen, et al., 2007). Several references are listed in the chronological sequence of publication, from the most recent to the oldest. If several references were published in the same year, they are listed in alphabetical order: (Bratuž, 2012; Pajntar, 2013; Wong, et al., 2014).

In citing works by the same author published in the same year, a lower case letter after the date must be used to differentiate between the works: (Baker, 2002a, 2002b).

In citing secondary sources they are introduced by "cited in" (Lukič, 2000 cited in Korošec, 2014). In citing a piece of work which does not have an obvious author or the author is unknown, the in-text citation includes the title followed by "Anon." in parenthesis, and the year of publication: *The past is the past* (Anon., 2008). In citing a piece of work whose authorship is an organization or corporate author, the name of the organization is given, followed by the year of publication (Royal College of Nursing, 2010). If no date of publication is given, it is notified by a "n. d." (no date): (Smith, n. d.). An in-text citation and a full reference must be provided for any images, illustrations, photographs, diagrams, tables or figures reproduced in the paper as with any other type of work: (Photo: Marn, 2009; source: Cramer, 2012). If a subject on a photo is recognisable, a prior informed consent for publication should be gained from the subject or from a portrayed child's parent or guardian.

All in-text citations should be listed in the **reference list** at the end of the document. Only the citations used are listed in the reference list, which is arranged in the alphabetical order according to authors' last name. In-text citations should not refer to unpublished sources. If there are several authors, the in-text citation includes only the last name of the first author followed by the phrase et al. and the publication date. When authors number more than six, the reference list includes the first six authors' names followed by et al. The list of references should be in alphabetical order according to the first author's last name, character size 12pt with single spaced lines, aligned left and with 12pt spacing after references (paragraph spacing).

Cited pages are included in the in-text citation if the original segment of the text is cited (Ploč, 2013, p. 56) and in the reference list (see examples). If several pages are cited from the same source, the pages are separated by a comma (e.g. pp. 15–23, 29, 33, 84–86). If a source cited is accessible also on the World Wide Web, the bibliographic information concludes with "Available at", followed by URL- or URN-address and a date of access in square brackets (See examples).

Citation Examples by Type of Reference

Citing books:

Hoffmann Wold, G., 2012. *Basic geriatric nursing*. 5th ed. St. Louis: Elsevier/Mosby, pp. 350–356.

Pahor, M., 2006. *Medicinske sestre in univerza*. Domžale: Izolit, pp. 73–80.

Ricci Scott, S., 2007. *Essentials of maternity, newborn and women's health nursing*. 2nd ed. Philadelphia: Lippincott Williams & Wilkins, pp. 32–36.

Citing a chapter/essay in a book edited by multiple authors:

Berryman, J., 2010. Statewide nursing simulation program. In: W.M. Nehring & F.R. Lashley, eds. *High-fidelity patient simulation in nursing education*. Sudbury (Massachusetts): Jones and Bartlett, pp. 115–131.

Girard, N.J., 2004. Preoperative care. In: S.M. Lewis, et al., eds. *Medical – surgical nursing: assessment and management of clinical problems*. 6th ed. St. Louis: Mosby, pp. 360–375.

Kanič, V., 2007. Možganski dogodki in srčno-žilne bolezni. In: E. Tetičkovič & B. Žvan, eds. *Možganska kap – do kdaj?* Maribor: Kapital, pp. 33–42.

Citing a book edited by one or multiple authors:

Borko, E., Takač, I., But, I., Gorišek, B. & Kralj, B. eds., 2006. *Ginekologija*. 2. dopolnjena izd. Maribor: Visoka zdravstvena šola, pp. 269–276.

Robida, A. ed., 2006. *Nacionalne usmeritve za razvoj kakovosti v zdravstvu*. Ljubljana: Ministrstvo za zdravje, pp. 10–72.

Citing a journal article (the second example refers to citing from the source available online):

Cronenwett, L., Sherwood, G., Barnsteiner, J., Disch, J., Johnson, J., Mitchell, P., et al., 2007. Quality and safety education for nurses. *Nursing Outlook*, 55(3), pp. 122–131.

Papke, K. & Plock, P., 2004. The role of fundal pressure. *Perinatal Newsletters*, 20(1), pp. 1–2. Available at: http://www.idph.state.ia.us/hpcdp/common/pdf/perinatal_newsletters/progeny_may2004.pdf [5. 12. 2012].

Pillay, R., 2010. Towards a competency-based framework for nursing management education. *International Journal of Nursing Practice*, 16(6), pp. 545–554.

Snow, T., 2008. Is nursing research catching up with other disciplines? *Nursing Standard*, 22(19), pp. 12–13.

Citing anonymous works (author is not given):

Anon., 2008. The past is the past: wasting competent, experienced nurses based on fear. *Journal of Emergency Nursing*, 34(1), pp. 6–7.

Citing works with society, association, or institution as author and publisher:

United Nations, 2011. *Competencies for the future*. New York: United Nations, p. 6.

Citing an article from a journal supplement or issue supplement:

Hu, A., Shewokis, P.A., Ting, K. & Fung, K., 2016. Motivation in computer-assisted instruction. *Laryngoscope*, 126(Suppl 6), pp. S5-S13.

Regehr, G. & Mylopoulos, M., 2008. Maintaining competence in the field: learning about practice, through practice, in practice. *The Journal of Continuing Education in the Health Professions*, 28(Suppl 1), pp. S19–S23.

Rudel, D., 2007. Informacijsko-komunikacijske tehnologije za oskrbo bolnika na daljavo. *Rehabilitacija*, 6(Suppl 1), pp. 94–100.

Citing from published conference proceedings:

Skela-Savič B., 2008. Teorija, raziskovanje in praksa v zdravstveni negi – vidik odgovornosti menedžmenta v zdravstvu in menedžmenta v visokem šolstvu. In: B. Skela-Savič, et al., eds. *Teorija, raziskovanje in praksa – trije stebri, na katerih temelji sodobna zdravstvena nega: zbornik predavanj z recenzijo. 1. mednarodna znanstvena konferenca, Bled 25. in 26. september 2008*. Jesenice: Visoka šola za zdravstveno nego, pp. 38–46.

Štemberger Kolnik, T. & Babnik, K., 2012. Oblikovanje instrumenta zdravstvene pismenosti za slovensko populacijo: rezultati pilotske raziskave. In: D. Železnik, et al., eds. *Inovativnost v koraku s časom in primeri dobrih praks: zbornik predavanj z recenzijo. 2. znanstvena konferenca z mednarodno udeležbo s področja zdravstvenih ved, 18. september 2012*. Slovenj Gradec: Visoka šola za zdravstvene vede, pp. 248–255.

Wagner, M., 2007. Evolucija k žensko osredičeni obporodni skrbi. In: Z. Drglin, ed. *Rojstna mašinerija: sodobne obporodne vednosti in prakse na Slovenskem*. Koper: Univerza na Primorskem, Znanstveno-raziskovalno središče, Založba Annales, Zgodovinsko društvo za južno Primorsko, pp. 17–30.

Citing diploma theses or master's theses and doctoral dissertations:

Ajlec, A., 2010. *Komunikacija in zadovoljstvo na delovnem mestu kot del kakovostne zdravstvene nege: diplomsko delo univerzitetnega študija*. Kranj: Univerza v Mariboru, Fakulteta za organizacijske vede, pp. 15–20.

Rebec, D., 2011. *Samoocenjevanje študentov zdravstvene nege s pomočjo video posnetkov pri poučevanju negovalnih intervencij v specialni učilnici: magistrsko delo*. Maribor: Univerza v Mariboru, Fakulteta za zdravstvene vede, pp. 77–79.

Kolenc, L., 2010. *Vpliv sodobne tehnologije na profesionalizacijo poklica medicinske sestre: doktorska disertacija*. Ljubljana: Univerza v Ljubljani, Fakulteta za družbene vede, pp. 250–258.

Citing laws, codes and regulations:

Zakon o pacientovih pravicah (ZPacP), 2008. Uradni list Republike Slovenije št. 15.

Zakon o preprečevanju nasilja v družini (ZPND), 2008a. Uradni list Republike Slovenije št. 16.

Zakon o varstvu osebnih podatkov (uradno prečiščeno besedilo) (ZVOP-1-UPB1), 2007. Uradni list Republike Slovenije št. 94.

Kodeks etike medicinskih sester in zdravstvenih tehnikov Slovenije, 2010. Uradni list Republike Slovenije št. 40.

Pravilnik o licencah izvajalcev v dejavnosti zdravstvene in babiške nege Slovenije, 2007. Uradni list Republike Slovenije št. 24.

Citing compact disk material (CD-ROM):

International Council of Nurses, 2005. *ICNP version 1.0: International classification for nursing practice*. [CD-ROM]. Geneva: International Council of Nurses.

Sima, Đ. & Požun, P., 2013. *Zakonodaja s področja zdravstva*. [CD-ROM]. Ljubljana: Društvo medicinskih sester, babic in zdravstvenih tehnikov.

ARTICLE SUBMISSION GUIDELINES

The corresponding author must submit the manuscript electronically using the Open Journal System (OJS) available at: <http://obzornik.zbornica-zveza.si/>. The authors should adhere to the accepted guidelines and fill in all the sections given. Prior to submission the authors should prepare the manuscript in the following separate documents.

1. The title page includes:

- the title of the article;
- the full names of the author/s in the sequence as that in the article;
- the data about the authors (name, surname, their highest academic degree, habilitation qualifications and their institutional affiliations and status, their mailing address), and the name of the corresponding author. If the article is written in the English language, the data about the authors should also be given in English. The authorship statement is included in the system;

- the information whether the article includes the results of some other larger research or whether the article is based on a diploma, master or doctoral thesis (in which case the first author is always the student) and the acknowledgements;
- authors' statements: Along with the manuscript, the authors have the obligation to submit the following statements (in the articles written in the Slovene language, the English version of the statements must be included. The statements will be included before the "Reference list" section after the manuscript has been reviewed and accepted for publication.

Acknowledgements

All contributors who do not meet the criteria for authorship and provided purely technical help or general support in the research (non-author contributors) can be listed in the acknowledgments.

Conflict of interest

When submitting a manuscript, the authors are responsible for recognizing and disclosing any conflicts of interest that might bias their work. If there are no such conflicts to acknowledge, the authors should declare this by the following statement: "The authors declare that no conflicts of interest exist."

Funding

The authors are responsible for recognizing and disclosing in the manuscript all sources of funding received for the research submitted to the journal. This information includes the name of granting agencies funding the research, or the project number. If there are no such conflicts or financial support to acknowledge, the authors should declare this by the following statement: "The study received no funding."

Ethical approval

The manuscript should include a statement that the study obtained ethical approval (or a statement that it was not required), the name of the ethics committee(s) and the number/ID of the approval. If the research required no ethics approval, the ethical and moral basis of the work should be justified. Depending on the nature of the research, the authors can write the following statement: "The study was conducted in accordance with the Helsinki-Tokyo Declaration (World Medical Association, 2013) and the Code of Ethics for Nurses and Nurse Assistants of Slovenia, (or) the Code of Ethics for Midwives of Slovenia (2014)." Both sources should be included in the reference list.

Author contributions

In case of more than one author, the contribution of each author should be clearly defined according to the International Committee of Medical Journal Editors (ICMJE) recommendations (<http://www.icmje.org/recommendations/>). Each co-author must participate in at least two structural parts of the article (Introduction, Methods, Results, Discussion and Conclusion). In addition, it should be identified to which stage of manuscript development each author has substantially participated (conception, design, execution, interpretation of the reported study or to the writing of an article).

2. **The main document** should be anonymized and includes the title (obligatorily without the authors and contact data), the abstract, the keywords, the text in the agreed format, the tables, the figures, pictures and literature. Authors may use up to 5 tables/pictures in the article.

Length of the manuscript: Its length must not exceed 5000 words for quantitative and 6000 for qualitative research articles, excluding the title, abstract, tables, pictures and literature. The number of words should be given in the document "The title page".

The following **manuscript format** for submissions should be used: the text of the manuscript should be formatted for A4 size paper, double spacing, written in Times New Roman font, font size 12pt with 25 mm wide margins. Obligatory is the use of Microsoft Word template available at the Slovenian Nursing Review website.

The tables contain information organised into discrete rows and columns. They are sequentially numbered with Arabic numerals throughout the document according to the order in which they appear in the text. They should include at least two columns, a descriptive, but succinct title (*above the table*), the title row, optional row totals and column totals summarizing the data in respective rows and columns, and, if necessary, the notes and legends. There are no empty cells left in a table and the table size should not exceed 57 lines. Tables must conform to the following type: All tabular material should be 11pt font, Times New Roman font, single spacing, 0.5 pt spacing, left alignment in the first column and in all columns with the text, left alignment in the columns with statistical data, with no intersecting vertical lines. The editors, in agreement with the author/s, reserve the right to reduce the size of tables.

Figures are numbered consecutively in the order first cited in the text, using Arabic numerals. Captions and legends are given below each figure in Slovene and English, Times New Roman font, size 11. Figures are all illustrative material, including graphs, charts, drawings, photographs, diagrams. Only 2-dimensional, black-and-white pictures (also with

hatching) with a resolution of at least 300 dpi (dot per inch) are accepted. If the figures are in 2-dimensional coordinate system, both axis (x and y) should include the units or measures used.

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The editorial board – author/s relationship

The manuscript is sent via web page to: <http://obzornik.zbornica-zveza.si/>. The Slovenian Nursing Review will consider only the manuscripts prepared according to the guidelines adopted. Initially all papers are assessed by an editorial committee which determines whether they meet basic standards and editorial criteria for publication. All articles considered for publication will have been subjected to a formal blind peer review by three external reviewers in order to satisfy the criteria of objectivity and of knowledge. Occasionally a paper will be returned to the author with the invitation to revise their manuscript in view of specific concerns and suggestions of reviewers and to return it within the agreed time period set by the editorial board. If the manuscript is not received by the given deadline, it will not be published. If authors disagree with the reviewers' claims and/or suggestions, they should provide written reasoned arguments, supported by existing evidence. Upon acceptance, the edited manuscript is sent back to the corresponding author for approval and resubmission of the manuscript final version. All manuscripts are proofread to improve the grammar and language presentation. The authors are also requested to read the first printed version of their work for printing mistakes and correct them in the PDF. Any other changes to the manuscript are not possible at this stage of publication process. If authors do not reply in three days, the first printed version is accepted.

GUIDE TO REVIEWERS

Reviewers play an essential part in science and in scholarly publishing. They uphold and safeguard the scientific quality and validity of individual articles and also the overall integrity of the Slovenian Nursing Review. Reviewers are selected independently by the editorial board on account of their content or methodological expertise. For each article, reviewers must complete a review form on a OJS format including criteria for evaluation. The manuscripts under review are assessed in light of the journal's guidelines for authors, the scientific and professional validity and relevance of the topic, and methodology applied. Reviewers may add language suggestions, but they are

not responsible for grammar or language mistakes. The title should be succinct and clear and should accurately reflect the topic of the article. The abstract should be concise and self-contained, providing information on the objectives of the study, the applied methodology, the summary and significance of principal findings, and major conclusions. Reviewers are obliged to inform the editorial board of any inconsistencies. The review focuses also on proper use of the conventional citation style and accuracy and consistency of references (concordance of in-text and and-of-text reference), evaluation of sources (recency of publication, reference to domestic sources on the same or similar subjects, acknowledgement of other publications, possible avoidance of the works which contradict or disaccord with the author's claims and conclusions, failure to include quotations or give the appropriate citation). All available sources need to be verified. The figures and tables must not duplicate the material in the text. They are assessed in view of their relevance, presentation and reference to the text. Special attention is to be paid to the use of abbreviations and acronyms. One of the functions of reviewers is to prevent any form of plagiarism and theft of another's intellectual property.

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Literature

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Nasveti za umivanje rok

— Novi koronavirus SARS-CoV-2 —

0



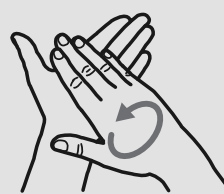
Pred umivanjem vedno odstranimo ves nakit. Roke najprej zmočimo pod tekočo vodo.

1



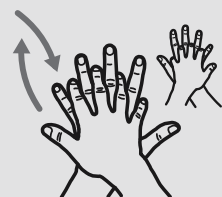
Roki namilimo.

2



Milimo dlan ob dlan.

3



Z desno dlanjo milimo hrbtišče leve roke in obratno.

4



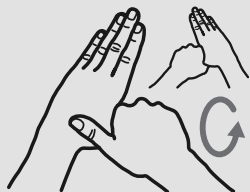
S prsti ene roke milimo med prsti druge roke.

5



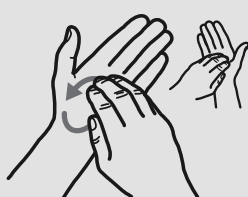
S sklenjenimi rokami milimo z dlanjo proti dlani. Roki zamenjamo in ponovimo.

6



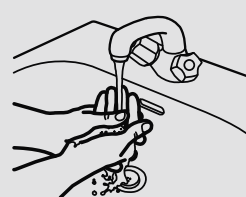
Z dlanjo krožno milimo stegnen palec druge roke, roki zamenjamo in ponovimo.

7



Konice prstov ene roke namilimo s krožnimi gibi v obe smeri po dlani druge roke. Roki zamenjamo in ponovimo.

8



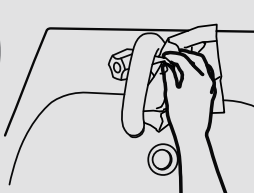
Roke temeljito speremo pod tekočo vodo.

9



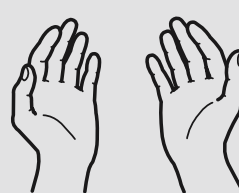
Roke dobro osušimo s papirnato brisačo.

10



Pipo zapremo s komolcem ali papirnato brisačo.

11



Roki milimo vsaj **1 minuto**.

MEDICINSKE SESTRE IN BABICE SO TEMELJ
VSAKEGA ZDRAVSTVENEGA SISTEMA



2020
MEDNARODNO LETO
MEDICINSKIH SESTER
IN BABIC



Obzornik zdravstvene nege

Slovenian Nursing Review

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