

GERONTOLOŠKO DRUŠTVO SRBIJE

11. MEĐUNARODNI GERONTOLOŠKI KONGRES

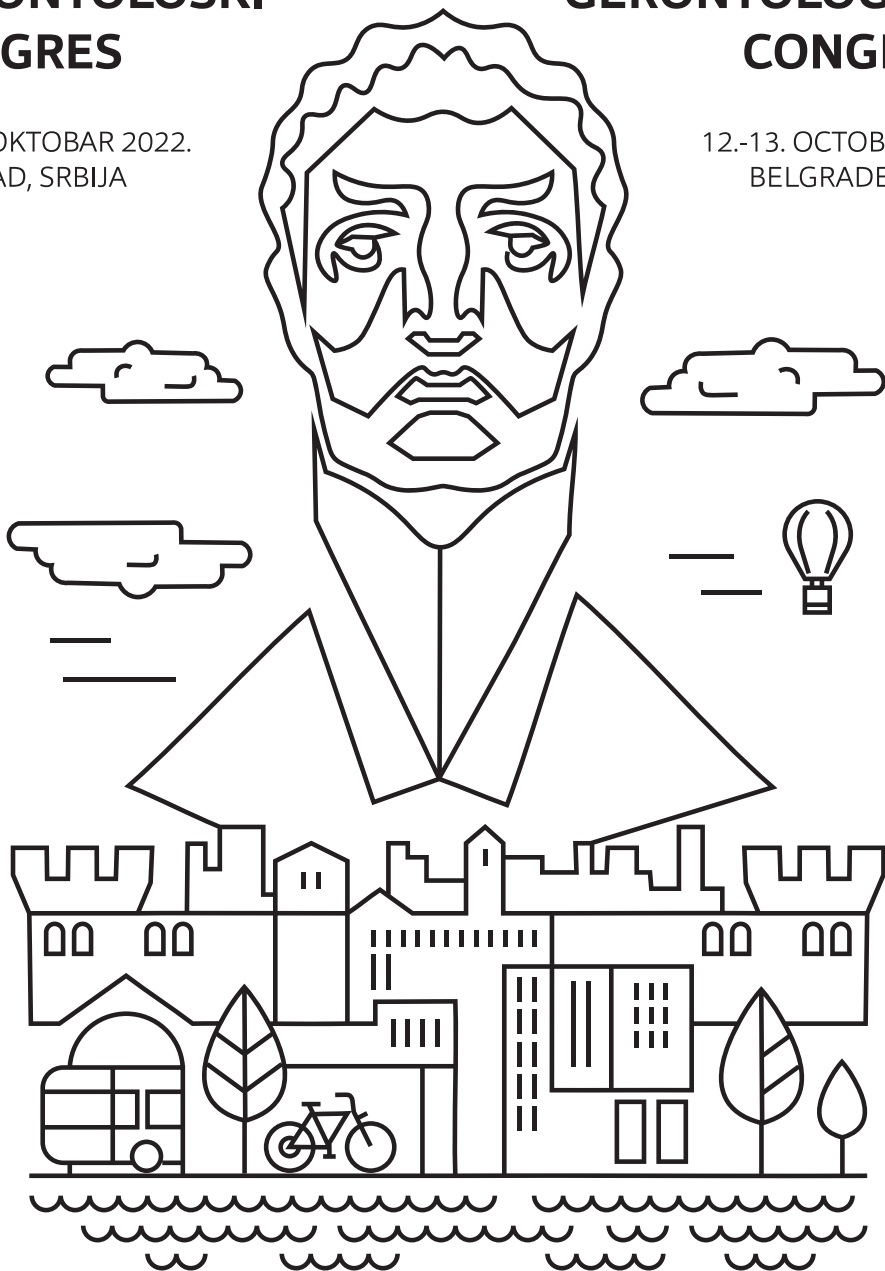
12.-13. OKTOBAR 2022.
BEOGRAD, SRBIJA



GERONTOLOGICAL SOCIETY OF SERBIA

11th INTERNATIONAL GERONTOLOGICAL CONGRESS

12.-13. OCTOBER, 2022
BELGRADE, SERBIA



„GERONTOLOGIJA: MOGUĆNOSTI I PERSPEKTIVE U POST KOVID-19 SVETU“

„GERONTOLOGY: OPPORTUNITIES AND PERSPECTIVES IN THE POST COVID-19 WORLD“



POVERENIK ZA
ZASTITU
RAVNOPRAVNOSTI



Влада Републике Србије
МИНИСТАРСТВО ЗА РАД,
ЗАПОШЉАВАЊЕ, БОРАЧКА
И СОЦИЈАЛНА ПИТАЊА



giz
Gesellschaft für
Internationale
Zusammenarbeit
GmbH



carnex

**GERONTOLOŠKO DRUŠTVO SRBIJE
GERONTOLOGICAL SOCIETY OF SERBIA**



**11th International Gerontological Congress
11. Međunarodni gerontološki kongres**

**GERONTOLOGY: OPPORTUNITIES AND
PERSPECTIVES IN THE POST COVID-19 WORLD**

**GERONTOLOGIJA: MOGUĆNOSTI I PERSPEKTIVE U
POST KOVID-19 SVETU**

12-13 October 2022, Palace Serbia – Belgrade, Serbia
12-13. oktobar 2022. Palata Srbija – Beograd, Srbija

**GERONTOLOGIJA: MOGUĆNOSTI I PERSPEKTIVE
U POST KOVID-19 SVETU /**

**GERONTOLOGY: OPPORTUNITIES AND PERSPECTIVES
IN THE POST COVID-19 WORLD**

Zbornik radova/International Congress Proceedings

11. Međunarodni gerontološki kongres / 11th International Gerontological Congress

12-13. oktobar 2022. Palata Srbija – Beograd, Srbija / 12-13 October 2022, Palace Serbia – Belgrade, Serbia

Izdavač: Gerontološko društvo Srbije, Simina 19, 11000 Beograd / **Published by:** Gerontological Society of Serbia, Simina 19, 11000 Belgrade

Za izdavača / For the publisher: Nataša Todorović

Glavna i odgovorna urednica / Editor in chief: Nataša Todorović

Prevod / Translation: Uroš Smiljanić

Tehnička obrada / Technical processing: Teodora Hrnjaković

Design: Marija Živković Beograd, 2022.

Circulation: 150 copies / Tiraž 150 kopija

ISBN-978-86-915731-8-8

CIP - Каталогизacija у публикацији
Народна библиотека Србије, Београд

316.66-053.88(082)

342.7-053.9(082)

159.922.63(082)

МЕЂУНАРОДНИ геронтолошки конгрес (11 ; 2022 ; Београд)

Gerontologija : mogućnosti i perspektive u post kovid-19 svetu : [zbornik radova] / 11. međunarodni gerontološki kongres, 12-13. oktobar 2022. Palata Srbija – Beograd, Srbija ; [glavna i odgovorna urednica Nataša Todorović] ; [prevod Uroš Smiljanić] = Gerontology :

opportunities and Perspectives in the Post COVID-19 World : [international Congress Proceedings] / 11th International Congress of Gerontology, 12-13 October 2022, Palace Serbia – Belgrade, Serbia ; [editor in chief Nataša Todorović] ; [translation Uroš Smiljanić]. -

Beograd : Gerontološko društvo Srbije ; Belgrade = Gerontological Society of Serbia, 2024 (Požarevac : GrafoIN). - 420 str. : table i graf. prikazi ; 24 cm

Tiraž 150. - Str. 7-11: Opening speech of the President of the Gerontological Society of Serbia : a wake-up call / Nataša Todorović. - Napomene uz tekst. - Bibliografija uz svaki rad. - Rezime. ISBN 978-86-915731-8-8

а) Старење -- Социолошки аспект -- Зборници б) Људска права -- Стари људи -- Зборници в) Ковид 19 -- Пандемија -- Социолошка истраживања -- Зборници

COBISS.SR-ID 150490377

TABLE OF CONTENTS

OPENING SPEECH OF THE PRESIDENT OF THE GERONTOLOGICAL SOCIETY OF SERBIA: A WAKE-UP CALL

Natasa Todorovic 7

1. MAPPING OF EXISTING HIGH-QUALITY TOOLS, RESOURCES, AND GUIDELINES RELEVANT TO THE MENTAL HEALTH AND WELLBEING OF OLDER ADULTS - WHO EUROPEAN REGION

Frederique Djurdjevic, Cassie Redlich, Yongjie Yon, Manfred Huber, Ledia Lazeri..... 12

2. TRAUMA THEORY AND VIOLENCE ACROSS THE LIFE COURSE FROM AN AGEING PERSPECTIVE

Patricia Brownell 63

3. RECENT AND CURRENT ELDER ABUSE RESEARCH IN NORWEGIAN CONTEXT

Wenche Karin Malmedal..... 78

4. NEED FOR HEALTH AWARENESS OF OLDER PERSONS IN STARA ZAGORA, BULGARIA WITH REGARD TO THE COVID-19 VACCINE PROPHYLAXIS

Hristina Milcheva, Rozalina Yordanova..... 94

5. INTERGENERATIONAL SOLIDARITY IN THE CRISIS TIMES: ON THE BORDER BETWEEN PERSONAL CHOICE AND SOCIAL RESPONSIBILITY

Natasa Todorovic, Teodora Hrnjakovic, Milutin Vracevic, Milos Todorovic 109

6. POSITIVE CORRELATION OF THE PANDEMIC AND CRISIS PERIODS WITH THE INTENSIFICATION OF UNIVERSAL ALL-GENERATIONAL PROBLEMS AND THE NEEDS FOR ALL-GENERATIONAL SOLIDARITY

Radmila Urosevic 128

7. IN THE DOLDRUMS OF COVID-19: OLDER PEOPLE'S OPINIONS ABOUT THE PROTECTION MEASURES APPLIED IN SERBIA AGAINST COVID-19 AND SUGGESTIONS FOR FUTURE MEASURES

Sladjana Dragisic Labas, Milana Ljubcic 139

8. THE INFLUENCE OF THE AGE STRUCTURE ON INCREASED MORTALITY DURING THE COVID PANDEMIC - THE EXAMPLE OF SERBIA

Jelena Stojilkovic Gnjatovic 160

9. EDUCATIONAL OFFER OF THE UNIVERSITY FOR THE THIRD AGE

Jovan Miljkovic, Bojan Ljubic 182

10. PSYCHOSOCIAL SUPPORT IN THE RETIREMENT PROCESS WITH SPECIAL EMPHASIS ON (POST) COVID-19 WORLD

Teodora Hrnjakovic, Milena Blagojevic..... 203

11. ADULT EDUCATION: THE PATH TO ACTIVE AGING

Aleksandra Krstic 227

12. PROMOTIONAL ACTIVITIES OF THE "INTERNATIONAL DAY OF OLDER PERSONS - OCTOBER 1" CAMPAIGN BEFORE AND DURING THE COVID-19 PANDEMIC

Katarina Boricic 250

13. CHALLENGES IN FRONT OF FAMILIES CARING FOR THEIR MEMBERS LIVING WITH DEMENTIA – EXPERIENCES IN PILOTING SUPPORT SERVICES

Nadezda Sataric, Maja Gajic Kvascev, Natalija Perisic..... 262

14. THE PROTECTION OF PEOPLE WITH ALZHEIMER'S DISEASE AND OTHER TYPES OF DEMENTIA - CAN WE DO IT BETTER?

Marina Milic Babic 287

15. CARING FOR PERSONS WITH A DIAGNOSIS OF DEMENTIA IN A SOCIAL CARE INSTITUTION DURING AND AFTER THE COVID-19 VIRUS PANDEMIC

Milica Petkovic, Aleksandra Nikitovic, Stefan Topalovic, Zuhra Hodzic, Aleksandra Romic 312

16. CHALLENGES OF AGING OF PERSONS LIVING WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) – PLHIV

Milena Radakovic, Aleksandra Bozinovic-Knezevic..... 328

17. MONITORING IN INSTITUTIONS FOR THE ACCOMMODATION OF ADULTS AND OLDER PERSONS USING IoT (INTERNET OF INTELLIGENT DEVICES)

Danijela Vasic Djukanovic, Dragica Novicic, Biljana Vujic, Ivana Lukic.. 353

18. NORMATIVE COURSES OF ACTION IN POST-COVID-19 CIRCUMSTANCES

Mirjana Vlatkovic, Nada Jovanovic, Milica Djordjevic, Milos Minic..... 373

19. THE IMPACT OF EPIDEMIOLOGICAL MEASURES DURING THE COVID-19 VIRUS ON THE PSYCHO-SOCIAL LIVE OF USERS IN SOCIAL CARE INSTITUTIONS

Milena Stojiljkovic, Dusanka Cepic, Anita Djukovic, Marina Arsic..... 390

20. THE IMPACT OF THE CORONA VIRUS PANDEMIC ON WORK-OCCUPATIONAL THERAPY ACTIVITIES WITHIN AN INSTITUTION FOR THE ACCOMMODATION OF ADULTS AND OLDER PERSONS

Katarina Krajcinovic, Jasmina Obradovic, Predrag Mijic, Srdjan Atanackovic, Vlado Radulj..... 403

Redakcijski odbor / Editorial board:

Foreign members

Prof. dr Patricia Bronwell, profesor emeritus, Fordham University, New York, United States of America, Prof. dr Wenche Marmedal, Faculty of Medicine and Health Sciences, Department of Public Health and Nursing, NTNU, Norway, Prof. dr Krasimir St. Vizev, Vice Dean of the Faculty of Public Health, Head of Department of Preventive Medicine, Faculty of Public Health, Medical University-Sofia, Bulgaria, Prof. dr Silvia Rusac, Pravni fakultet Sveučilište u Zagrebu, Hrvatska, Dr Sonja Podgorelec, Institut za migracije i narodnosti, Hrvatska, Prof. dr Gentiana Qirjako, Faculty of Medicine, Tirana, Albania, Prof. dr Jolanta Mackowicz, Institute of Educational Sciences, Pedagogical University of Krakow, Poland

Resident members

Nataša Todorović, MA predsednica GDS, Crveni krst Srbije, INPEA, Prof. dr Natalija Perišić, Univerzitet u Beogradu – Fakultet političkih nauka, Odeljenje za socijalnu politiku i socijalni rad, Brankica Janković, MA poverenica za zaštitu ravnopravnosti, Prof. dr Ljiljana Manić, Visoka škola socijalnog rada, Beograd, Prof. dr Nebojša Despotović, Kliničko-bolnički centar “Zvezdara” i Medicinski fakultet, Univerzitet u Beogradu, Prof. dr Aleksandra Milićević Kalašić, Gradski zavod za gerontologiju i palijativno zbrinjavanje, Beograd i Departman za socijalni rad, FMK, Univerzitet Singidunum, Prof. dr Dragana Stjepanović Zaharijevski, Filozofski fakultet Univerziteta u Nišu, Prof. dr Mirjana Rašević, Institut društvenih nauka, Prof. dr Mirjana Devedžić, Geografski fakultet Univerziteta u Beogradu, Prof. dr Dragana Dinić, Gerontološko društvo Srbije, Prof. dr Slađana Dragišić Labaš, Filozofski fakultet, Univerzitet u Beogradu, Milutin Vračević, MA, Crveni krst Srbije, INPEA, Prof. dr Dejan Nešić, Institut za Medicinsku fiziologiju, Medicinski fakultet Univerziteta u Beogradu, Prof. dr Sanja Mazić, Institut za medicinsku fiziologiju, Medicinski fakultet Univerziteta u Beogradu, Dr sci. Maša Vukčević Marković, Filozofski fakultet Univerziteta u Beogradu, Odeljenje za psihologiju, Dr sci. med. Katarina Boričić, Institut za javno zdravlje Srbije “Dr Milan Jovanović Batut”, Doc dr Jelena Stojilković Gnjatović, Geografski fakultet Univerziteta u Beogradu, dr Suzana Pavlović, Član Nadzornog odbora Gerontološkog društva Srbije, VISAN, Visoka zdravstveno sanitarna škola strukovnih studija

Recenzenti / Reviewers:

Prof. dr Patricia Bronwell, profesor emeritus, Fordham University, New York, United States of America, Prof. dr Wenche Marmedal, Faculty of Medicine and Health Sciences, Department of Public Health and Nursing, NTNU, Norway, Prof. dr Krasimir St. Vizev, Vice Dean of the Faculty of Public Health, Head of Department of Preventive Medicine, Faculty of Public Health, Medical University-Sofia, Bulgaria, Prof. dr Silvia Rusac, Pravni fakultet Sveučilište u Zagrebu, Hrvatska, Dr Sonja Podgorelec, Institut za migracije i narodnosti, Hrvatska, Prof. dr Gentiana Qirjako, Faculty of Medicine, Tirana, Albania, Prof. dr Jolanta Mackowicz, Institute of Educational Sciences, Pedagogical University of Krakow, Poland

Nataša Todorović, MA predsednica GDS, Crveni krst Srbije, INPEA, Prof. dr Natalija Perišić, Univerzitet u Beogradu – Fakultet političkih nauka, Odeljenje za socijalnu politiku i socijalni rad, Brankica Janković, MA poverenica za zaštitu ravnopravnosti, Prof. dr Ljiljana Manić, Visoka škola socijalnog rada, Beograd, Prof. dr Nebojša Despotović, Kliničko-bolnički centar “Zvezdara” i Medicinski fakultet, Univerzitet u Beogradu, Prof. dr Aleksandra Milićević Kalašić, Gradski zavod za gerontologiju i palijativno zbrinjavanje, Beograd i Departman za socijalni rad, FMK, Univerzitet Singidunum, Prof. dr Dragana Stjepanović Zaharijevski, Filozofski fakultet Univerziteta u Nišu, Prof. dr Mirjana Rašević, Institut društvenih nauka, Prof. dr Mirjana Devedžić, Geografski fakultet Univerziteta u Beogradu, Prof. dr Dragana Dinić, Gerontološko društvo Srbije, Prof. dr Slađana Dragišić Labaš, Filozofski fakultet, Univerzitet u Beogradu, Milutin Vračević, MA, Crveni krst Srbije, INPEA, Prof. dr Dejan Nešić, Institut za Medicinsku fiziologiju, Medicinski fakultet Univerziteta u Beogradu, Prof. dr Sanja Mazić, Institut za medicinsku fiziologiju, Medicinski fakultet Univerziteta u Beogradu, Dr sci. Maša Vukčević Marković, Filozofski fakultet Univerziteta u Beogradu, odeljenje za psihologiju, Dr sci. med. Katarina Boričić, Institut za javno zdravlje Srbije “Dr Milan Jovanović Batut”, Doc. dr Jelena Stojilković Gnjatović, Geografski fakultet Univerziteta u Beogradu, dr Suzana Pavlović, Član Nadzornog odbora Gerontološkog društva Srbije, VISAN, Visoka zdravstveno sanitarna škola strukovnih studija

OPENING SPEECH OF THE PRESIDENT OF THE GERONTOLOGICAL SOCIETY OF SERBIA: A WAKE-UP CALL

Demographic aging of the population marked the last years of the 20th century and the beginning of the 21st century. Estimates show that by 2050, one billion people will be over the age of 60. Governments around the world will have to adapt their policies of social and health care, education, employment, development, it will be necessary to include ageing in all policies in order for societies to adapt to accelerated ageing.

And it is precisely the last three years in which we live with Covid that have been a wake-up call at all levels, individual, family, local, national and global. What we learned in this period:

First, we learned that it is imprecise to talk about older population as a group with the same or similar needs. We need to think about older persons as a heterogeneous group, and public policies must reflect this heterogeneity. Precisely in the approach to understanding demographic aging and creating an adequate response, it is crucial to recognize the heterogeneity of the population over 65 and that ageing must not be viewed as a process that occurs after the age of 65, but as a process that refers to the entire life cycle. Older age is a social construct which, given the large differences within the population over 65 and the increasing differences as the number of years increases, is not sufficiently clear or usable as a socio-demographic

category and, on the contrary, contributes to prejudices about older persons. During the pandemic not everyone needed the same help; some only needed help with procurement because they couldn't go out, others needed much more. It was necessary to have data on these people and coordinate it all, and again, with ever limited resources. Even rich countries like Norway have limited resources, so it is essential to know how to best use these limited resources and how to target the support as best as possible.

Another important conclusion is that we must be aware that precisely during crises, age-sensitive and high-quality data on the needs of different categories of older persons can enable us to create effective public policies and support services. You do not have the same need for support if you are 65+ or if you are 85+. You have the same rights, but your access to rights is different if you live in Belgrade and are a retired university professor, or if you are a woman living in the countryside in Eastern Serbia and have no transport, no health centre, no local shop for groceries, and no mobile phone service either. Access to rights is asymmetric, the more educated and financially situated have better access to rights, because they are better informed. And that is why access to information is important, and we are all responsible for that access, and we need to work in partnership between the public and civil sectors.

Further in this period, we concluded that it is important to develop a greater number of services in the community that should be in accordance with the needs of older population and their families. We need long-term care services that must involve multi-sector and coordinated action; without such action the already existing inequalities in society can deepen even more. Long-term care services will enable dignified ageing, but will also help the family take better care of their older member, but also to spend more quality time with their functionally dependent family member.

Mental health is another important issue that we have started to talk about more openly. This issue is important both for older persons during

the pandemic and for the entire population, and we have encountered numerous factors that affect mental health. The pandemic has brought with it uncertainty and fear to older persons: fear of whether they will have enough money or food, fear and uncertainty related to the risk of infection and how it will affect their health, and fear that the infection will lead to a potentially fatal outcome, uncertainty of how long the pandemic may last, but also the uncertainty regarding the financial security of the older person as well as their family. Despite this, not enough attention is paid to the mental health of older persons, because many things are normalized. Ageing is associated with various losses, with the loss of a partner, friends, so if an older person is depressed and sad or has become forgetful, we immediately say that this is a normal part of old age and ageing. Through normalizing such phenomena, we overlook risks and tend to become aware of them only when they become a problem. It is necessary to enable regular screenings for depression, in order to design interventions. It is necessary to provide older persons more opportunities to be involved because social contacts are necessary to maintain people's health and well-being.

Even before Covid, we knew that documented violence against older persons was the tip of the iceberg and that it was massively under-reported. The World Health Organization estimates that one in six people over the age of 60 experience abuse, but only one in 24 report it. Such violence usually occurs in the home of an older person, and the perpetrators are usually family members or caregivers, and reporting is associated with a sense of shame and humiliation. Hence there is a large difference between the number of reported cases and the estimated actual number. In addition, data collection on abuse is often not age-sensitive, and in this case all persons over 65 fall into the same statistical category, which hinders the design of better targeted prevention and response. During the COVID-19 epidemic, data shows that the risk of elder abuse has increased. For example, two organizations in Great Britain report an increase in the number of cases of 37 percent and 17

percent of older people being the target of abuse. COVID-19 has increased the risk of violence, especially neglect, financial violence and psychological violence. The neglect was both intentional and unintentional, the state of emergency was an excuse for some not to visit their older parents, but on the other hand, some did not have time, especially those who worked and had children.

The first step in protection is to change the image of older persons as passive recipients of assistance to active members of society. This is necessary to fight against ageism. Ageism is many things, starting with not recognising the contribution of older persons to the communities, families and society. It is also a paternalistic attitude towards older persons that undermines their autonomy and dignity.

Another risk is that digitalization may increase the exclusion and loneliness of older persons. Some older persons are digitally included, but for many, digitalization poses the risk of deepening inequality. We do need to think how to increase digital inclusion of older persons and the possibility that robots can help us in some cases, because soon we will not have a sufficient number of caregivers, but it is also necessary to take care of those who are not able to use modern technologies. They must not be forgotten.

It was the Covid pandemic that showed that there is solidarity in our society, that in the most difficult situations there is that “natural” solidarity, the need to help someone, someone who is in trouble and feeling directly endangered. That solidarity was reflected not only through the activities of volunteer organizations, but through the activities of ordinary people, relatives and neighbours. We must be aware that solidarity begins precisely in the street and the building where we live, in the school we attend, in the organization where we work. But it must be promoted much more as a building block of our society and our communities.

Insufficient promotion of the importance of solidarity in society and communities is not often a topic we discuss. Also, solidarity should be part of our system of education, so that people learn and have the feeling that it is necessary to “give back to the community” for what it has invested in us. Society and local communities must value solidarity much more as a desirable and important virtue. People show solidarity for altruistic reasons, because they want to help and because they feel better for having done something useful and helped someone. It is also important that as a society we have a social recognition for those who help. This is important because there are people whose daily life is a continuous struggle for survival and who, compared to other people, live in difficult economic, health or social circumstances, and it is these people who need help and support on a daily basis. They need continuous solidarity.

We can say that we have begun to recognize the multiple roles that older persons play in the family, but also in the society, whether they are caregivers, volunteers or where they work, and we must not forget that now.

This wake-up call is not a criticism, this is a way of learning how to improve what we did, how to improve future responses, how to highlight examples of good practices, how to do better. Certainly, the new United Nations Convention would improve access to the human rights of older persons in all situations, including action in accidents and crises.

Natasa Todorovic
President
Gerontological Society of Serbia

Original scientific paper UDK: 364:616.89-008.454-053.9
616.892.3-053.9

Handed over: 14.09.2023.

Accepted: 30.09.2023.

MAPPING OF EXISTING HIGH-QUALITY TOOLS, RESOURCES, AND GUIDELINES RELEVANT TO THE MENTAL HEALTH AND WELLBEING OF OLDER ADULTS - WHO EUROPEAN REGION¹

***Frederique Djurdjevic, Cassie Redlich, Yongjie Yon,
Manfred Huber, Ledia Lazeri²***

Abstract

Mental health conditions are highly prevalent and represent one of the leading causes of suffering and disability in the European Region. In 2021, more than 150 million people in the WHO European Region were living with a mental health condition, and only one in three people living with depression received the care they need. To address these gaps in mental health services and support, many of which have been made worse by the COVID-19 pandemic, the WHO European Region launched in September 2021 a Pan-European Mental Health Coalition (thereafter Coalition). The Coalition aims to target gaps in mental health services by gathering national leaders, professionals, members of civil society, representatives of international organizations and

¹ Funding source: a modified version of this paper was commissioned and funded by the Pan-European Mental Health Coalition.

² WHO Europe, djurdjevic@who.int (Consultant WHO Europe)

experts to collaborate on bringing mental health out of the shadows and into the mainstream. Key priorities for the Coalition include transforming mental health services and integrating mental health into emergency response and recovery efforts, as well as promoting mental health and preventing mental ill health across the life course.

The WHO European Region organized the first meeting of the Coalition in May 2022 to begin the development of six working packages, including Work Package III: Mental Health and wellbeing of older adults. A mapping exercise of existing high-quality tools, resources, and guidelines relevant to the mental health and wellbeing of older adults for the WHO European Region was commissioned in Summer 2022 by the Coalition. This paper is a modified version of the mapping exercise.

This research highlights the overarching challenge facing older adult mental health services, beyond chronic and systemic constraints of underfunding and staff shortages. A contrast exists between the specific and often complex mental health needs of this diverse group, and the systemic and individual barriers which currently prevent their mainstream access to high quality care. Barriers include, amongst others:

- *fragmented care pathways with other sectors of the health system, such as acute care;*
- *professional and institutional biases including ageist and discriminatory attitudes from health and social care workers;*
- *difficulties with access and/or acceptability of online/digital psychological interventions;*
- *generic adult mental health services which do not target their specific needs, partly due to the lack of involvement of older people in shaping their services in line with their individual preferences;*
- *Quality standards and indicators still tend to equate mental health services with dementia care, though slow improvements are ostensible.*

Individual barriers requiring behaviour change, such as the internalised stigma common among older people that mental health support provides little benefit, even though evidence points to the contrary, will be more difficult to shift. Policies to encourage social participation, both to enhance wellbeing and reduce a risk factor for mental illness in old age, could be prioritised. Some promising case studies are worthy of note; these are highlighted throughout the paper. ³

Keywords: *dementia, depression, mental health, older adults, loneliness.*

³ **General disclaimer:** *The views expressed by authors, editors, or expert groups do not necessarily represent the decisions or the stated policy of the World Health Organization.*

LIST OF ABBREVIATIONS

BABCP	British Association for Behavioural and Cognitive Psychotherapies
COVID-19	Coronavirus disease 2019
EPW	European Programme of Work
ICOPE	Integrated Care for Older People
ICROMS	Integrated quality Criteria for the Review Of Multiple Study designs
InterRAI	International Resident Assessment Instrument
MEDLINE	Medical Literature Analysis and Retrieval System Online
EFAMH	European Framework for Action on Mental Health (2021-5)
Embase	Excerpta Medica Database
CINAHL	Cumulative Index to Nursing and Allied Health Literature
PsycINFO	Psychological Information Database
MeSH	Medical Subject Headings
NHS	National Health Service (UK)
NICE	National Institute for Health and Care Excellence (UK)
NSW	New South Wales (Australia)
OECD	Organization for Economic Cooperation and Development
WHO	World Health Organization
WHO mhGAP	WHO Mental Health Gap Action Programme

MAPPING OF EXISTING HIGH-QUALITY TOOLS, RESOURCES, AND GUIDELINES RELEVANT TO THE MENTAL HEALTH AND WELLBEING OF OLDER ADULTS

Background

The challenges posed by mental health conditions touch all ages and social groups. They include a surge of diseases of despair, the persistent prevalence of depressive and anxiety disorders among young people, the growth of self-harm and suicide, and the unmet needs of people with dementia or autism spectrum disorder. Specific challenges are the rise of burnout among health workers; the need to confront the mental health fallout of the COVID-19 crisis; and the need to support the resilience of communities affected by conflict.

The membership of the *Coalition* aims to reflect the diversity of action needed to implement a whole-of-society approach to mental health system reform. Besides Member State representatives, health care professionals and organizations, the *Coalition* taps non-government organizations and international non-governmental organizations, business organizations, charities, people with lived experience and more. With WHO Regional Office for Europe as facilitator and central node, the *Coalition* aims to create a network of actors to implement comprehensive and sustainable change throughout the Region.

Members and supporters of the Coalition, including representatives from Member States, WHO Collaborating Centres and civil society, first came together in early May 2022. A discussion began on the priorities and objectives of six Work Packages⁴ and key outputs over the next six to twelve months. While holding parallel sessions has resulted in some fragmentation of the working package topics, participants all saw these packages as interrelated and impossible to successfully implement in isolation. Fragmentation was considered a practical necessity in the context of this meeting. Integration of the packages to achieve the objectives of WHO's European Framework for Action on Mental Health (EFAMH) will be approached concurrently with the development of the content. This Framework (EFAMH) covers the period 2021–2025, setting out a response to current mental health challenges arising from the negative impact that the COVID-19 pandemic has had on population mental health and well-being. For each *Coalition* Work Package, a mapping exercise of existing key resources in the relevant field (focusing on frameworks and guidelines rather than individual research) was commissioned. For Work Package III, resources were gathered in relation to older adult mental health and wellbeing. From these, some of the key challenges in this field have been highlighted in this paper, as well as promising case studies. The synthesis is provided below.

⁴ The parallel session on Work Package V, Mental Health in Emergencies, was not held in order to devote time to the mental health and psychosocial support (MHPSS) response to the war in Ukraine, which was still developing at the time of the meeting. Instead, an hour-long briefing panel session was held, featuring WHO and Ukrainian experts delivering MHPSS in Ukraine and neighbouring countries.

Outline and aims of the mapping

This mapping exercise, commissioned by the *Coalition*, was conducted in July and August 2022, with the aim of identifying existing high-quality tools, resources, and guidelines relevant to the mental health and wellbeing of older adults. The aims of this research were to underpin the design and development of mental health policy and programmes, aligned with the WHO European Framework for Action on Mental Health (EFAMH) 2022-25. While occasionally resources had a global perspective, the focus remained on the WHO European Region.

The mapping exercise was conducted by a co-author (FD), using the following research questions developed by several co-authors (CR, MH and YY) as a guiding thread: 1) To identify relevant policies and policy frameworks with regards the treatment of mental health or neurological conditions for older adults, or the enhancement of their mental wellbeing; 2) To identify relevant quality standards and frameworks related to the above; 3) To describe models of treatment and care related to the above; and 4) To identify potential case studies of promising practice related to the above.

The objectives of this mapping exercise were the following: 1) To identify relevant policies and policy frameworks with regards the treatment of mental health or neurological conditions for older adults, or the enhancement of their mental wellbeing; 2) To identify relevant quality standards and frameworks related to the above; 3) To describe models of treatment and care related to the above; and 4) To identify potential case studies of promising practice related to the above.

Methods

Search strategy

A search of Web of Science, Academic Search Elite, MEDLINE, Embase, CINAHL and PsycINFO was conducted for relevant studies published between January 2012 and August 2022. All authors contributed to the development of the search strategy; the primary search was conducted by FD in July and August 2022.

A systematic search of the WHO Publications list was conducted. A search of the grey literature including conference abstracts through OpenGrey, Google Scholar and the Grey Literature Report was also completed, including a review of the reference list of included studies and relevant review articles. No geographical limits were imposed on the search, to avoid excluding studies which may have included countries from the WHO European Region. The literature search was restricted to English language publications. A quick scan of Russian and French studies was made.

To identify relevant studies, our search strategies used a combination of subject headings, and free text search terms including the following terms:

(‘older adult*’ OR ‘older people’ OR elderly OR ‘aged population’ OR ‘older population’ OR ‘senior citizen*’ OR ‘geriatr* population’) AND (‘Mental health’ OR ‘Mental illness’ OR psychiatr* OR depression OR dementia OR suicide OR wellbeing OR stigma) AND (tool* OR resource* OR guideline* OR guidance OR framework OR ‘quality of care’ OR standard* OR indicator*) AND (policy OR policies OR program*) OR (Implementation OR design OR develop*).

The final strategies included relevant synonyms and incorporated appropriate search tools to ensure maximum sensitivity.

The following types of study were included:

Policies, Policy frameworks, Quality standards/frameworks

- a. Policies/frameworks/standards focused on the treatment of mental health or neurological conditions and/or the enhancement of mental wellbeing
- b. Policies/frameworks/standards related to the treatment of individuals aged 60 years and over
- c. Policies/frameworks/standards related to the provision of treatment in healthcare, long-term care, and community settings
- d. Global or European Region policies/frameworks/standards
- e. Published in English

Umbrella reviews/review of reviews

- f. Models of treatment/care for mental health, neurological conditions, or the enhancement of mental wellbeing
- g. Models of treatment /care related to the treatment of individuals aged 60 years and over
- h. Models of treatment /care related to the provision of treatment in healthcare, long-term care, and community settings
- i. Includes evidence from literature in the European Region
- j. Published in peer-reviewed journals
- k. Published in English

Condition or domain being studied

Mental health is a priority of the WHO's European Programme of Work (EPW), 2020–2025. The EPW's Mental Health Flagship Initiative focuses on transforming attitudes around mental health, expediting mental health reforms and accelerating progress towards universal health coverage for people with mental health conditions.

Following the:

- (1) recommendations of the WHO Technical Advisory Group on the Mental Health Impacts of COVID-19 in the WHO European Region issued in June 2021;
- (2) Athens Summit Statement on the Actions required to address the impact of the COVID-19 pandemic on mental health and service delivery systems in the WHO European Region, held in Athens on 22-23 July 2021; and
- (3) endorsement, at the WHO Regional Committee for Europe in September 2021, of the European Framework for Action on Mental Health 2021-2025 (EFAMH), the WHO Regional Director launched the Pan-European Mental Health Coalition on 30th September 2021, in the presence of Her Majesty, Queen Mathilde of the Belgians, and the EU Commissioner for Health and Food Safety, Ms Stella Kyriakides.

The *Coalition* will be the implementation vehicle of the EFAMH and will work on six working packages. Of relevance to this review is *Work Package III⁵: Supporting the mental health and wellbeing of older adults*.

Participants/population Inclusion criteria

Study participants are older adults (aged 60 years and over) of any gender. They may have any mental health or neurological condition (such as dementia, depression, or anxiety disorder), which may or may not have been diagnosed and is being treated in any setting. Studies were included where participants are defined as having a mental health condition, even

⁵ Other work packages are the following: Supporting leadership capacity building for mental health (WP1), Supporting the mental health and wellbeing of children, adolescents and youth (WP2), Supporting the promotion of mental health in the workplace (WP4), Supporting integration of mental health into the preparedness for, response to, and recovery from crises and emergencies (WP5) and Supporting countries to transform mental health systems (WP6).

if specific diagnoses are not provided. For instance, participants were recruited into the study because they are receiving care from a secondary care community mental health team or international equivalent.

Context

Published studies and reports were conducted in any setting (e.g., participants living in the community, residential care, long-stay inpatient hospital). Studies were not ranked or excluded based on the quality of their methodology.

Data extraction (selection and coding)

Titles of studies identified using the electronic search strategy and other methods (e.g., reference chaining and scrutiny of reference lists) were screened independently by one review author (FD) to identify studies that potentially meet the eligibility criteria. The full text of potentially eligible studies was independently assessed for eligibility by a second reviewer (CR). If needed, disagreements would be resolved through discussion with a third reviewer (YY). For any missing data, up to two attempts will be made to contact the study authors. If needed, disagreements will be resolved by discussion between two authors and by referral to a third author.

One review author (FD) independently extracted relevant data from included studies. The data extraction forms were developed (FD) and then piloted and reviewed by a second co-author (CR). Extracted information was conducted for each type of evidence: document title, author(s), date of publication, country/region of origin, age range of focus, study setting; study population and participant demographics and baseline characteristics; details of any diagnosis/condition(s) of focus; disclosure/conflict of interest notes.

In addition, for each type of evidence, the following data was extracted:

Type of evidence	Output
Policies	Relevant clauses
Policy frameworks	Domains
Quality standards/frameworks	Domains, principles and/or indicators
Umbrella reviews/review of reviews	Description of intervention, delivery strategies, variables assessed, evaluation results
Case studies	Evidence type and summary

These were refined and finalised following extraction of the first five documents for each type of evidence.

Strategy for data analysis

A thematic analysis was structured around the types of care settings and target population characteristics. Thematic analysis is used in qualitative research and focuses on examining themes or patterns of meaning within data; it is one of the most common forms of analysis within qualitative research (Braun & Clarke, 2006; Guest et al., 2012). It emphasizes identifying, analysing, and interpreting patterns of meaning (or “themes”) within qualitative data.

Results

The primary search was conducted by one co-author (FD) between 20.07 and 20.08.2022. A search of Web of Science, Academic Search Elite, MEDLINE, Embase, CINAHL, PsycINFO and Central and Eastern European Online library was conducted for relevant studies published between 01.01.2012 and 01.08.2022. A search strategy was applied involving the United States Library of Medicine's MeSH terms where appropriate.

In addition, FD conducted a search of the WHO Publications list, the grey literature, including conference abstracts through OpenGrey, Google Scholar and the Grey Literature Report and reviewed the reference list of included studies and relevant review articles. No geographical limits were imposed on the search to avoid excluding studies which may have included countries from the WHO European Region. The literature search was restricted to English language publications, though a quick scan of relevant Russian and French publications was conducted. A data extraction template was piloted by FD and revised following feedback from a co-author (CR).

The initial search strategy recorded [$\pm$ 620] resources; the titles were then screened for relevance by FD. Following a discussion with a co-author (CR), the search strategy was refined, which uncovered further resources ($n = 162$). This new list was screened for relevance by FD. The reference lists of key full-text publications were checked to identify any relevant resources that had not been identified in the searches. In addition, we solicited several researchers to identify additional unpublished or grey literature; new resources ($n = 4$) were included as a result. The following Tables categorise the resources by author, type, date and country/region. Some of the headings overlap so resources may appear in more than one category. Occasionally, resources were included even though they were outside the geographical remit or timeframe.

Appendix 1 lists the resources, these are classified by category of resource, country, date and author, and link to the webpage of the resource.

Table 1. Categories of resource identified in the mapping exercise

Resource category	n =
Framework	14
Action plan	14
Implementation resource	5
Guidance/guidelines	12
Tool	11
Quality indicator/standard	15
Promising case study	9

Table 2. Aim(s) of the resources identified in the mapping exercise (as of 08.2022)

Aim	n = 69
Quality improvement	14
Service design	20
Policy design/development	14
Policy implementation	19
Other	2

Table 3. Mental health conditions identified in the mapping exercise (as of 08.2022)

Mental health condition	n =64
Depression	6
Suicidal thoughts	6
Anxiety	0
Dementia/cognitive decline	18
All mental health conditions addressed	34
Not specified	7

Table 4. Categorisation of the authors of the resources

	<i>n</i> =
International/umbrella organisations	
WHO	27
OECD	3
Alzheimer Europe	1
European Commission ⁶	2
interRAI	1
National health bodies	
Australia	
Mental Health Commission of New South Wales	1
Australasian Health Infrastructure Alliance	1
New South Wales Department of Health	1
Belgium	
Centre de Référence en Santé Mentale [<i>Mental Health Reference centre</i>]	1
Canada	
Canadian Coalition for Seniors' Mental Health	2
Mental Health Commission of Canada	1
Canadian Institute for Health Information	1
Institut National de Sante Publique du Québec [<i>National Institute of Public Health for the Province of Québec</i>]	1
France	
Comité Stratégique de la Santé Mentale et de la Psychiatrie [<i>Strategic Comity on Mental Health and Psychiatry</i>]	1
French Ministry of Solidarity and Health	1

⁶ One of these papers, the Mental Health in Older People Consensus paper is from 2008

Republic of Ireland	
Health Information and Quality Authority	1
Scotland	
Public Health Scotland	3
NHS Health Scotland	1
Age Scotland	1
UK	
NHS/NHS Health England	5
National Collaborating Centre for Mental Health	1
Quality Network for Older Adult Mental Health Services	1
BABCP	1
Age UK	2
Royal College of Psychiatrists/Joint Commissioning Panel for Mental Health	3
National Institute for Clinical Excellence (NICE)	3
Healthcare Commission	1
Academic papers	
Russian Federation	1
France	1
Australia	2
UK	1
Slovakia	1
US	1
Multi-country	8

Analysis

Challenges across older adult mental health services, and ensuing policy recommendations, have been clustered into seven preliminary themes, based on the available evidence. These recommendations may support the design of future policy in this area.

Though conducted in a robust way, this mapping exercise was not a systematic review, so any definitive conclusions should be avoided from these initial findings. Furthermore, only English-speaking resources were included - with a few exceptions in French and Russian - so undoubtedly some advances in the field will have been overlooked. Lastly, this research was conducted by a single researcher, so the risk of bias should be acknowledged. Nonetheless, the results provide an overview of the current frameworks and tools relating to the field. Challenges across the older adult mental health services landscape persist, which have been clustered into preliminary themes. Based on the available evidence, some initial policy recommendations are put forward.

The seven suggested policy recommendations are listed below:

- (1) Eliminate ageism and related stigma and discrimination
- (2) Reduce service fragmentation and access barriers through improved governance
- (3) Increase participation of older adults in the health decisions which affect them
- (4) Increase workforce knowledge and skills
- (5) Create specialist mental health services for older adults
- (6) Ensure services for older adults are culturally sensitive to their (non-medical) needs
- (7) Encourage social participation to reduce social isolation and risk factors (as a preventive measure)

Each theme is outlined below. Examples of encouraging developments and promising case studies are illustrated for every theme.

1. Eliminate ageism and related stigma and discrimination

Mental health is key to our well-being – including in later life, and everyone has the right to a good life as we grow older. Older persons face many barriers including ageism, sexism, and ableism in accessing mental health care and services, such as treatment for depression or anxiety. In addition, there is a need to ensure that people with lived experience of dementia and their caregivers (who may be ‘stigmatized by association’) are not discriminated against. An older person may not seek mental health support for several reasons:

- (1) because of the prevailing narratives that they would not benefit from these services, or
- (2) that older adults themselves simply internalized ageism that they are a burden to the health system, or
- (3) that health and care professionals may not recommend mental health support because they believe that depression and dementia are a normal part of ageing.

Ageism affects assessment, decision-making and actions to address self-harm and suicide for older people and exercises a baleful influence on mental health strategy, funding, and delivery. Conscious and unconscious bias, at professional and institutional level, is often preventing older adults from accessing mental health support. The solutions are numerous, but the first step is to recognise the issue. To start with, investment in older people’s mental health services needs to be rebalanced towards specialised services. We need a strategy for services that clearly recognises older people’s specialised needs, better data monitoring to ensure these needs are met, and a commitment to address the current inequality at all levels of the care system. Linked to this previous point, clinicians need to be trained to avoid diagnostic overshadowing; evidence shows that response rates of psychological therapy amongst older adults are higher than their younger cohorts (Saunders et al., 2021).

Relevant promising case studies

- 1) The *Global Report on Ageism* (WHO, 2021) outlines a framework for action to reduce ageism including specific recommendations for different stakeholders. It brings together the best available evidence on the nature and magnitude of ageism, its determinants, and its impact. It outlines what strategies work to prevent and counter ageism, identifies gaps, and proposes future lines of research to improve our understanding of ageism.
- 2) The *WHO toolkit for dementia-friendly initiatives* (WHO, 2021) supports individuals, communities, and countries in raising awareness of, and empowering people living with dementia, to remain in, and be a significant part of, their community. The toolkit provides practical guidance and tools that can support efforts, including planning and implementation activities, to create dementia-inclusive societies.

2. Reduce service fragmentation and access barriers through improved governance

Care for older people is fragmented and navigating access to appropriate services is challenging due to current funding arrangements and models of care. Service access pathways need to be easier to travel, with support provided to facilitate access where needed. Collaboration between governments needs to continue to identify and trial alternative models for funding care and services for older people, with a view to enhancing integration and responsiveness to local needs. Resource allocation should be informed by local clinical and support needs, with bureaucratic hurdles minimised. The processes and outcomes of localised decision making should be benchmarked against evidence-based and expert consensus targets and principles. Taking a “whole systems approach”, seems to be a cornerstone of many of the frameworks, notably concerning the importance of integrated services with primary, community and long-term care and social services.

Related Promising case studies

- 1) The *Guidance on Collaborative approaches to treatment - depression among older people living in care homes* (Royal College of Psychiatrists & British Geriatric Society, 2018), addresses symptoms of depression in long-term care settings in a more systematic way. It provides several useful case studies.
- 2) Promising examples of collaborative care models for older adults living with mental illness include mental health-residential aged care partnerships implemented through the New South Wales⁷ Ministry of Health's Pathways to Community Living Initiative. Collaboration across the mental health, aged care, primary health care, community managed and disability service systems is critically important.

⁷

In Australia

3. Increase participation of older adults in the decisions which affect them

Bernard Isaacs (1924-1995), eminent Professor of Geriatric Medicine, said: *'Design for the young and you exclude the old; design for the old and you include the young'* (Giles-Corti et al, 2008). Whatever the response(s) to support people with lived experience and their caregivers, we must ensure as a society that voices are included and to ensure that younger people understand this is also about our future selves.

The desire and ability of older people to exert choice and control over their own care should be encouraged. Robust models for consumer and carer participation should include older adults. Service user and carer involvement should occur systematically not only in terms of mental health policy design and implementation, but also in the delivery and evaluation of services. Co-production should be encouraged to ensure the usability and acceptability of older adult mental health services, such as clear signposting on where to obtain (online) mental health support, particularly for those who may be less digitally literate. Currently, user involvement can appear tokenistic or diluted.

Related promising case studies

- 1) The WHO's Global Dementia Observatory Knowledge Exchange Platform [<https://globaldementia.org/en>] consults with a panel of people with lived experience of dementia to review any resource that is submitted to their Platform for inclusion.
- 2) The *National Standards for residential care settings of older people* in Ireland (2016) were developed using findings from focus groups with residents, relatives or friends and staff in eight residential care services.
- 3) Consultation with experts by experience: <https://www.alliance-scotland.org.uk/blog/news/older-people-and-mental-health-informing-national-policy-implementation/>

4. Increase workforce knowledge and skills

The issue of age-friendly competency as part of the training for the health and care workforce (which is also ageing) needs to be raised, to recognize the needs of older persons and ensure health professionals have the necessary education to ask questions which can be difficult or uncomfortable (e.g., on suicidal ideation).

As people live longer with mental illness and comorbid (co-existing) chronic physical illness, the need for skilled, highly trained professionals and for growth in the care support workforce, becomes predominant. Workforce training for staff working in hospital, community, residential settings, and primary health care is needed, underpinned by professional standards and competencies, to enhance their understanding, knowledge, and skills about older adults in general and older people's mental health and suicide risk. Older adults' mental wellbeing may be impacted by several factors including financial worries, social isolation, and abuse. The resources to secure a stable and competent workforce that is fit for purpose in the coming years will require government commitment, along with regulation on skill mix and staff ratios in residential care settings.

The ageing of the healthcare workforce poses a challenge throughout the WHO European Region to the sustainability of the workforce due to the difficulty of replacing workers when they enter retirement. This is particularly the case for medical doctors: in 13 of the 44 countries that reported data on this issue, 40% of medical doctors are over 55 years of age (WHO, 2022).

Related promising case studies

- 1) One of the recommendations of the Walloon Region⁸ report entitled *Benchmarks for a Mental Health Policy* (2018), is to address the training needs in mental health and psychiatry for certain professionals such as family doctors working in services for older adults.
- 2) Three case studies for positive practice in mental health services are suggested in NHS/England's *Older People's Mental Health Competency Framework* (HEE/NHS, 2020). This Framework provides essential competencies, such as the skills, knowledge and behaviours required for the delivery of effective support, care, and services for older people living with mental illness. It also supports the integration of health services and their respective workforces, with respect to shared goals, improved communication and the opportunity for joint education and training.

⁸ Region in Belgium

5. Create specialist mental health services for older adults

Generic adult mental health services, with few exceptions, often incorporate services for older adults, with dementia care being the one exception. Frameworks which were identified in this mapping exercise ($n = 14$) mostly do not present a specific segment on older adult mental health services, in contrast to child, perinatal and adult services. For example, though the title includes *Self-harm and Suicide Prevention Competence Framework – Adults and Older Adults* (NHS, 2018), the latter is applicable to adults aged 18 and over; the Framework has no specific section describing our target population. The needs of older people are complex and different to those of working-age adults. Better and more innovative specialist services are needed locally to meet these needs.

Related promising case studies

- 1) Several countries are currently adapting their national suicide prevention strategies (to the specific needs of older adults):
 - The VigilantS model in France (Plancke et al, 2021)
 - The Zero Suicide Framework in Australia (Wand & McKay, 2021)
- 2) A case study in the US of a comprehensive framework is presented as a community-based suicide prevention strategy that employs health (including mental health) clinicians, professionals working in the ageing sector, caregivers, and older adults themselves to recognize and respond to those who may be in distress. The framework for preventing older adult suicide should include knowledge about risk factors, a theoretical basis that explains the high prevalence of older adult suicide, and a transdisciplinary prevention strategy that shares responsibility for suicide prevention among professional and lay members of the community (Fullen, 2015). This group presents distinct patterns of help seeking and service needs, accompanied by differences in risk factors, presentations, and outcomes of suicidal behaviours. Urgent and longer-term actions are essential to effectively implement the models in this population.

6. Ensure services for older adults are culturally sensitive to their (non-medical) needs

Older adults, just like any population, is not a homogenous entity; it masks different groups according to their (sometimes intersecting) cultural, sexual orientation, ethnic and religious preferences. In some communities, labels such as mental illness, abuse, or suicide, may be taboo subjects, increasing the barriers for them to access mental health support. Older adults are at an elevated risk of suicide; support services need to be developed in collaboration with this group to ensure acceptability from these communities.

Communities need to think creatively on how to connect with older people's mental health (or indeed at any age) outside traditional clinical settings. Professions which interact with members of the public can be provided with basic training on how to work in a dementia-friendly way; examples include hairdressers, receptionists, or bus drivers.

Related promising case study

- 1) This systematic review of culturally sensitive interventions for ethnic minority older people living with mental illness (Littlefield & Villareal, 2021) includes a series of case studies, which are relevant to culturally sensitive mental health services for older persons.

7. Encourage social participation to reduce social isolation and loneliness risk factors (as a preventive measure)

Aristotle the Greek philosopher said, “Man is by nature a social animal”. In recent times, rates of social isolation and loneliness in older adults have become a distressing and pervasive global trend (Chawla et al, 2021), which itself carries risk factors for poor mental health (Meltzer et al, 2013) and different forms of abuse across community and residential settings (Burnes et al, 2015). Social isolation and loneliness of older adults is both a risk factor and consequence of poor health. Indeed, the health risks of prolonged isolation are equivalent to smoking 15 cigarettes a day (Holt-Lunstad et al, 2015). Social isolation and loneliness are distinct but related concepts (WHO, 2021). Social isolation refers to the objective state of having a small network of kin and non-kin relationships and thus few or infrequent interactions with others, while loneliness is defined as the painful subjective feeling – or “social pain” – which results from a discrepancy between desired and actual social connections (Cacioppo et al, 2014; Perlman & Peplau, 1981; Prohaska et al, 2020; WHO, 2021).

Creating Age Friendly environments that support later lives – including mental health, needs to be reiterated. Actions needs to be implemented and taken locally to support older adults and their families. For example, loneliness damages older people’s mental health. But better infrastructure and supportive communities can help foster social connections. Hence, cities and communities can be powerful shapers of our physical and mental well-being (WHO, 2017).

This social phenomenon should be tackled not least because of the harmful impact it has on an individual’s wellbeing, but also to enable and protect safe, supportive, and healthy social environments that can foster relationship-building for an ageing population. Loneliness and social isolation can be experienced at any stage of an individual’s life course, de-

terminated by a complex set of antecedents, namely individual-level characteristics (gender, income, poor health) (Boehlen et al, 2022), accelerated rates of urbanization, shifting household living arrangements, forced and economic migration, poor health behaviours, cognitive decline, and a digital divide between generations, amongst others (Fakoya et al, 2020). These above-mentioned risk factors have all contributed to a rise in the prevalence of social isolation and loneliness amongst our aged populations.

Tackling the matter in an ageing society calls for strong intersectoral and gender approaches, with sufficient awareness of the intersectional nature of disadvantage and vulnerability. For instance, family caregivers, older women and individuals facing financial strain are at increased risk of social isolation. Moreover, the COVID-19 pandemic has undoubtedly transformed the landscape of social connectedness and exacerbated the risk factors for social isolation and loneliness, in part through measures of social distancing and shielding. This public health crisis has nonetheless drawn attention to the scope of this societal issue, increasing the urgency for the development and evaluation of digital interventions that can address social isolation and loneliness in older age groups.

There is a need to increase knowledge exchange on effective and innovative models to prevent, identify and combat social isolation and loneliness among older people and their caregivers, including through promoting digital literacy and the use of digital technology. Digital interventions can play a key role in this arena. Such interventions, addressing different sub-themes of this issue, such as socially assistive robots and connections to various digital communities, have been advanced in recent years, both at the individual and community level.

Both social isolation and loneliness and digital literacy have been identified by stakeholders as key action areas; the deliverables of this review will underpin further work on these issues.

Related promising case studies

- 1) A global evidence gap map of (published) digital interventions for reducing social isolation and loneliness in older adults was recently conducted by the Campbell Collaboration (Welch et al, 2022).
- 2) Advocacy Brief on social isolation and loneliness among older people (WHO, 2021), which summarizes the scale, impact, and harms of social isolation and loneliness among older people, and outlines what can be achieved to decrease them. This brief describes proposes a three-point global strategy for tackling these issues.
- 3) The WHO Global database of Age-Friendly Practises: <https://extranet.who.int/agefriendlyworld/afp/>

Conclusion

This mapping exercise provides an overview of some of the latest resources available across the WHO European region. The authors have tried to synthesise some of the key challenges currently facing older adults in relation to their mental health and wellbeing. Any individual, regardless of their circumstances, can develop a mental health disorder across the life course, including at advanced ages. Older adults need to know that it is acceptable and that it is their right to request mental health support. They should also expect mental health services to be delivered in an age-friendly environment.

Mental health services are now offering more opportunities for individuals to express their opinion on the care they receive. In addition, service users can provide valuable feedback on how they would like mental health services to communicate with them (for example by letter, text, app etc). Giving older adults the opportunity to shape their care can improve mental health services by making them more accessible and acceptable to their

needs and preferences. Caregivers, who may themselves be older adults, are also being provided with more opportunity to voice their opinions.

There is a trend across health care in general towards the provision of support online. Older persons – like any age cohort - are not a homogenous group. Some may be digitally literate, while others struggle to communicate or show resistance to using the technology. How this group is going to be affected by this transition, and how to ensure that quality of care is upheld in online settings, deserves further exploration.

The recent COVID-19 pandemic has amplified some of the risk factors for mental illness at every age group, including for older persons who may already have been socially isolated and experiencing loneliness. Further research is needed on the effect of this pandemic on ageist and other stigmatising behaviours against this group. While not replacing clinical care, communities play a critical role in relieving some of the pressure on mental health services, by providing age-friendly environments, which are conducive to mental wellbeing.

Demographic change is impacting on the demand for older adult health services, including mental health. As individuals age, long-term conditions may become more prevalent, which can add to the complexity of care if the person develops or has pre-existing mental health needs. The health and social care workforce should be fit for purpose in handling the specialized care needs of older adults.

In recent years, there has been a visible transition across health systems to manage the growing prevalence of co-morbid long-term conditions, and in turn the management of these chronic diseases. Mental health services need to adapt to the growing prevalence and complexity of chronic diseases in older age groups; a trend towards person-centred integrated care with other parts of the health system can help to ensure an optimal continuum of care.

References

Boehlen, F., Maatouk, I., Friederich, H., Schoettker, B., Brenner, H., & Wild, B. (2021). Loneliness as a gender-specific predictor of physical and mental health-related quality of life in older adults. *Quality of Life Research*, 31(7), 2023–2033. <https://doi.org/10.1007/s11136-021-03055-1>.

Burnes, D., Pillemer, K., Caccamise, P. L., Mason, A., Henderson, C. R., Jr, Berman, J., Cook, A. M., Shukoff, D., Brownell, P., Powell, M., Salamone, A., & Lachs, M. S. (2015). Prevalence of and Risk Factors for Elder Abuse and Neglect in the Community: A Population-Based Study. *Journal of the American Geriatrics Society*, 63(9), 1906–1912. <https://doi.org/10.1111/jgs.13601>.

Cacioppo, J. T., Cacioppo, S., & Boomsma, D. I. (2013). Evolutionary mechanisms for loneliness. *Cognition & Emotion*, 28(1), 3–21. <https://doi.org/10.1080/02699931.2013.837379>

Chawla, K., Kunonga, P., Stow, D., Barker, R., Craig, D., & Hanratty, B. (2021). Prevalence of loneliness amongst older people in high-income countries: A systematic review and meta-analysis. *PLOS ONE*, 16(7), e0255088. <https://doi.org/10.1371/journal.pone.0255088>.

Fakoya, O., McCorry, N., & Donnelly, M. (2020). Loneliness and social isolation interventions for older adults: a scoping review of reviews. *BMC Public Health*, 20(1). <https://doi.org/10.1186/s12889-020-8251-6>.

Fullen, M. C. (2015). Mobilizing the community to prevent older adult suicide. *Illness, Crisis, & Loss*. <https://doi.org/10.1177/1054137315589699>

Giles-Corti, B., Knuiman, M., Timperio, A., Van Niel, K., Pikora, T., Bull, F., Shilton, T., & Bulsara, M. (2008). Evaluation of the implementation of a state government community design policy aimed at increasing local walking: Design issues and baseline results from RESIDE, Perth West-

ern Australia. *Preventive Medicine*, 46(1), 46–54. <https://doi.org/10.1016/j.ypmed.2007.08.002>

Guest, G., MacQueen, K., & Namey, E. (2012). *Applied thematic analysis*. Thousand Oaks, California: SAGE Publications. p. 11. <http://www.sagepub.com/books/Book233379>. Holt-Lunstad, J., Smith, T. B., Baker, M. D., Harris, T., & Stephenson, D. (2015).

Loneliness and social isolation as risk factors for mortality. *Perspectives on Psychological Science*, 10(2), 227–237. <https://doi.org/10.1177/1745691614568352>. Littlefield, S., & Villareal, R. (2021).

A Systematic Review of Culturally Sensitive Interventions for Ethnic Minority Elders with Mental Illness. Williams Honors College, Honors Research Projects. 1411. https://ideaexchange.uakron.edu/honors_research_projects/1411.

Meltzer, H., Bebbington, P., Dennis, M. S., Jenkins, R., McManus, S., & Brugha, T. S. (2013). Feelings of loneliness among adults with mental disorder. *Social psychiatry and psychiatric epidemiology*, 48(1), 5–13. <https://doi.org/10.1007/s00127-012-0515-8>.

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017).

Thematic Analysis: Striving to Meet the Trustworthiness Criteria. *International Journal of Qualitative Methods*, 16(1), 1-13.

Perlman, D., & Peplau, L.A. (1981). Toward a social psychology of loneliness. In: Gilmour R, Duck S (Eds.). *Personal relationships*. London: Academic Press. 3:31–56. <https://peplau.psych.ucla.edu/wp-content/uploads/sites/141/2017/07/Perlman-Peplau-81.pdf>.

Plancke, L., Amariei, A., Danel, T., Debien, C., Duhem, S., Notredame, C., Wathélet, M., & Vaiva, G. (2020). Effectiveness of a French Program to Prevent Suicide Reattempt (VIGILANS). *Archives of Suicide Research*, 25(3), 570–581. <https://doi.org/10.1080/13811118.2020.1735596>.

Prohaska, T. R., Burholt, V., Burns, A., Golden, J., Hawkey, L. C., Lawlor, B. A., Leavey, G., Lubben, J. E., O'Sullivan, R., Perissinotto, C., Van Tilburg, T., Tully, M. A., Chapot, V., & Fried, L. P. (2020). Consensus statement: loneliness in older adults, the 21st century social determinant of health? *BMJ Open*, 10(8), e034967. <https://doi.org/10.1136/bmjopen-2019-034967>.

Royal College of Psychiatrists & British Geriatric Society. (2018). Depression among older people living in care homes — collaborative approaches totreatment. <https://bjgp.org/content/69/685/e578/tab-e-letters>.

Welch, V., Ghogomu, E. T., Barbeau, V. I., Boulton, E., Boutin, S., Haitas, N., Kneale, D.,Salzwedel, D. M., Simard, R., Herbert, P., & Mikton, C. (2022). PROTOCOL: Digital interventions to reduce social isolation and loneliness in older adults: An evidence and gap map. *Campbell systematic reviews*, 18(3), e1260.<https://doi.org/10.1002/cl2.1260>.

Saunders, R., Buckman, J. E. J., Stott, J., Leibowitz, J., Aguirre, E., John, A., Lewis, G., Cape, J., & Pilling, S. (2021). Older adults respond better to psychological therapy than working-age adults: evidence from a large sample of mental health service attendees. *Journal of Affective Disorders*, 294, 85–93. <https://doi.org/10.1016/j.jad.2021.06.084>.

Wand, A., & McKay, R. (2021). The Zero Suicide Framework requires adaptation to include older adults. *Australian and New Zealand Journal of Psychiatry*, 55(4), 427–428. <https://doi.org/10.1177/0004867421998758>.

World Health Organization. (2017). *Age-friendly environments in Europe: a handbook of domains for policy action*. World Health Organization.17p. ISBN: 9789289056076.

<https://www.who.int/europe/publications/i/item/9789289056076>

World Health Organization. (2021). *Social isolation and loneliness among older people:advocacy brief*. World Health Organization.17p. <https://apps.who.int/iris/handle/10665/343206>. License: CC BY-NC-SA 3.0 IGO.

World Health Organization. (2021b). *Global report on ageism*. Geneva: World Health Organization. Licence: CC BY-NC-SA 3.0 IGO. <https://www.who.int/teams/social-determinants-of-health/demographic-change-and-healthy-ageing/combating-ageism/global-report-on-ageism>.

World Health Organization. (2022). *Health and care workforce in Europe: time to act*. Copenhagen: WHO Regional Office for Europe. Licence: CC BY-NC-SA 3.0 IGO. <https://www.who.int/europe/publications/item/9789289058339>

Appendix 1. List of resources clustered by category, country, date and author.

Resource (n =)	Country (-ies)	Date	Author(s)	Link
Framework (n = 14)				
Optimising Older People's Quality of Life: An Outcomes Framework. Strategic outcomes model	Scotland	2014	Cohen et al. (NHS Scotland)	http://www.healthscotland.scot/media/1159/optimising-older-people-quality-of-life-strategic-outcomes-model-08-14.pdf
Older People's Mental Health Competency Framework	England	2020	NHS and Health Education England	https://www.e-lfh.org.uk/wp-content/uploads/2020/04/OlderPeoplesMentalHealthCompetencyFramework-V1.8.pdf
The Zero Suicide Framework requires adaptation to include older adults	Australia	2021	Wand et al.	https://journals.sagepub.com/doi/10.1177/0004867421998758
WHO European Framework for Action on Mental Health 2021–2025	Multi	2022	WHO/Europe	https://www.who.int/europe/publications/i/item/9789289057813
WHO European Framework on Healthy Ageing (forthcoming)	Multi	tbc	WHO/Europe	Unpublished

The Senses Framework: improving care for older people through a relationship-centred approach. Getting Research into Practice (GRiP) Report No 2	UK	2006 ⁹	Nolan et al.	https://shura.shu.ac.uk/280/1/PDF/%20Senses%20Framework_Report.pdf
Defining a Population Mental Health Framework for Public Health	Quebec (Canada)	2014	Institut National de Sante Publique du Quebec	https://cenpps-nchpp.ca/defining-a-population-mental-health-framework-for-public-health/
Self-harm and suicide prevention competence framework (adults and older adults)	England	2018	NHS and Health Education England	https://www.ucl.ac.uk/pals/sites/pals/files/self-harm_and_suicide_prevention_competence_framework_-_adults_and_older_adults_8th_oct_18.pdf
Community mental health framework for adults and older adults	UK	2019	NHS and National Collaborating Centre for Mental Health	https://www.england.nhs.uk/publication/the-community-mental-health-framework-for-adults-and-older-adults/
Quality Mental Health Framework	Canada	2021	Mental Health Commission of Canada	https://www.mentalhealthcommission.ca/wp-content/uploads/2021/09/QMHC_Framework_infographic_eng.pdf

⁹ This Framework was included even though it falls outside the scope of the search strategy as it is still widely being used: <https://journals.sagepub.com/doi/pdf/10.1177/1471301216682880>

European Quality Framework for long-term care services	Multi	2012	WeDo project team (EU)	https://www.age-platform.eu/sites/default/files/EU_Quality_Framework_for_LTC-EN.pdf
National Mental Health Policy Framework and Strategic Plan 2013-2020	South Africa	2013	Department of Health, Republic of South Africa	http://www.safmnh.org/wp-content/uploads/2020/09/National-Mental-Health-Policy-Framework-2013-2020.pdf
Dignity of older persons: multi-dimensional framework	All	2021	Banerjee et al.	https://www.frontiersin.org/articles/10.3389/fpsy.2021.774533/full
Competency framework: Mobilizing the Community to Prevent Older Adult Suicide, Illness, Crisis & Loss	US	2015	Fullen, M.C.	https://doi.org/10.1177/1054137315589699
Action plans (n = 14)				
Comprehensive mental health action plan 2013-2020	Multi	2013	WHO	https://apps.who.int/ebwha/pdf_files/WHA66/A66_R8-en.pdf?ua=1
WHO Global action plan on the public health response to dementia 2017 - 2025	Multi	2017	WHO	https://www.who.int/publications/i/item/global-action-plan-on-the-public-health-response-to-dementia-2017---2025

Coronavirus (COVID-19): mental health - transition and recovery plan	Scotland	2020	Scottish Government	https://www.gov.scot/publications/mental-health-scotlands-transition-recovery/
Global strategy and action plan on ageing and health (2016-2020)	Multi	2017	WHO	https://www.who.int/publications/i/item/9789241513500
Policy Position Paper: Mental Health (Older people)	England	2019	Healthcare England/Age UK	https://www.ageuk.org.uk/globalassets/age-uk/documents/policy-positions/health-and-wellbeing/ppp_mental_health_england.pdf
Mental health in older people: A Consensus Paper	Multi	2008	Jané-Llopis & Gabilondo (EU)	https://ec.europa.eu/health/ph_determinants/life_style/mental/docs/consensus_older_en.pdf
First Meeting of the pan-European Mental Health Coalition: from Debate to Action	Multi	2022	WHO/Europe	https://www.who.int/europe/publications/item/WHO-EURO-2022-5769-4534-65202#:~:text=Download%20(582.2%20kB),Overview,content%20of%20each%20working%20package.
Five Year Forward View for Mental health (England)	England	2016	NHS	https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

Five Year Forward View for Mental health (England) and One Year on	England	2017	NHS	https://www.england.nhs.uk/wp-content/uploads/2017/03/fyfv-mh-one-year-on.pdf
Tackling abuse of older people: five priorities for the United Nations	Multi	2022	WHO	https://www.who.int/publications/item/9789240052550
Decade of Healthy Ageing platform: Social Isolation and Loneliness	Multi	2022	WHO	https://www.decadeofhealthyageing.org/topics-initiatives/other-topics/social-isolation-loneliness#:~:text=UN%20Decade%20of%20Healthy%20Ageing,and%20loneliness%20among%20older%20people&text=This%20advocacy%20brief%20on%20social,by%20the%20COVID%2019%20pandemic.
Specialist Mental Health Services for Older People – New South Wales Service Plan - 2005-2015	NSW (Australia)	2006	NSW Department of Health	https://www.health.nsw.gov.au/mentalhealth/resources/Publications/nswsmhsop-serviceplan-2005-2015.pdf
Repères pour une politique wallonne de santé mentale [Benchmarks for a Walloon Policy in Mental Health]	Walloon region (Belgium)	2018	Centre de Référence en santé mentale	http://www.cresam.be/wp-content/uploads/2018/06/Rep%C3%A8res_CR%C3%A9SaM_2018.pdf

Feuille de route: santé mentale et psychiatrie [Roadmap for French mental health and psychiatry]	France	2021	Ministère des solidarités et de la santé	https://www.sante.fr/feuille-de-route-de-la-sante-mentale-et-de-la-psychiatrie
Implementation resource (n = 5)				
Mise en oeuvre de la Feuille de route: Santé mentale et psychiatrie en France [French implementation of the Roadmap for French mental health and psychiatry]	France	2022	Ministère des solidarités, de l'autonomie et des personnes handicapées [Ministry of Solidarity, Autonomy and People with Disabilities]	https://handicap.gouv.fr/mise-en-oeuvre-de-la-feuille-de-route-sante-mentale-et-psychiatrie
The ICOPE implementation guide	Multi	2019	WHO	https://www.who.int/publications/item/9789241515993
Older people and mental health – informing national policy implementation	Scotland	2021	ALLIANCE, Age Scotland, See Me and Voices Of eXperience	https://www.alliance-scotland.org.uk/blog/news/older-people-and-mental-health-informing-national-policy-implementation/

NHS Mental Health Implementation Plan 2019/20 – 2023/24	England	2019	NHS	https://www.longtermplan.nhs.uk/publication/nhs-mental-health-implementation-plan-2019-20-2023-24/
Reducing stigma and discrimination against older people with mental disorders: A Technical Consensus Statement	Multi	2002 ¹⁰	WHO	https://www.who.int/publications/i/item/WHO-MSD-MBD-02.3
Guidelines/Guidance (n = 12)				
Integrated care for older people: WHO guidelines on community-level interventions to manage declines in intrinsic capacity	Multi	2017	WHO	https://apps.who.int/iris/handle/10665/258981
Guidance for commissioners of older people's mental health services	UK	2013	Joint Commissioning Panel for Mental health	https://mentalhealthpartnerships.com/resource/guidance-for-commissioners-of-older-peoples-mental-health-services/

¹⁰ This Consensus Statement was included because even though it falls outside the period of research as it was the only relevant resource from WHO on stigma of mental health in older people

National Guidelines for Seniors' Mental Health: The Assessment of Suicide Risk and Prevention of Suicide	Canada	2006	Canadian Coalition for Seniors' Mental Health	https://ccsmh.ca/wp-content/uploads/2016/03/NatlGuideline_Suicide.pdf
Guidelines for Psychological Practice for Older Adults	US	2014	American Psychological Association	https://www.apa.org/practice/guidelines/older-adults
NICE [National Institute for Clinical Excellence] Guidance on wellbeing of older people	England	2015	NICE	https://www.nice.org.uk/guidance/ng32
Towards a dementia plan: a WHO guide	Multi	2018	WHO	https://www.who.int/publications/i/item/9789241514132
WHO mhGAP Guideline Update	Multi	2015	WHO	https://www.who.int/publications/i/item/9789241549417
Guidance on community mental health services: Promoting person-centred and rights-based approaches	Multi	2021	WHO	https://apps.who.int/iris/handle/10665/341648

Risk reduction of cognitive decline and dementia: WHO guidelines	Multi	2019	WHO	https://www.who.int/publications/item/9789241550543
Improving Access to Psychological Therapy Positive Practice Guide Older People	UK	2021	BABCP, Age UK, the Mental Health Foundation, IAPT services	https://babcp.com/Therapists/Older-Adults-Positive-Practice-Guide
A Practice Primer on Mental Health in Older People (Guidance)	England	2017	NHS England	https://www.england.nhs.uk/publication/a-practice-primer-on-mental-health-in-older-people/
Australasian Health Facility Guidelines Part B - Health Facility Briefing and Planning 0135 – Older Persons Acute Mental Health Unit	Australia	2012	Australasian Health Infrastructure Alliance	https://www.healthfacilityguidelines.com.au/files/b-0135-older-persons-acute-mental-health-unitpdf
Tools (n = 11)				
WHO and Campbell evidence and gap map on digital interventions for reducing social isolation and loneliness in older adults	Multi	2022	WHO	https://www.who.int/initiatives/decade-of-healthy-ageing/evidence-gap-map/sil-digital

WHO mhGAP dementia module	Multi	2017	WHO	https://www.who.int/publications/i/item/dem-training-module
Social isolation and loneliness among older people: Advocacy Brief	Multi	2021	WHO	https://www.who.int/publications/i/item/9789240030749
WHO iSupport tool	Multi	2019	WHO	https://www.who.int/publications/i/item/9789241515863
Be he@lthy, be mobile: a handbook on how to implement mDementia	Multi	2021	WHO	https://www.who.int/publications/i/item/9789240019966
Mental wellbeing in oldest old age: The EMMY Assessment tool	Multi	2011	National MWIA Collaborative (Cooke et al. (2011))	http://www.emmydecisionsupport.com/
WHO QualityRights Toolkit	Multi	2012	WHO	https://www.who.int/publications/i/item/9789241548410
Living with the Times: a mental health and psychosocial support toolkit for older people	Multi	2021	IASC	https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergency-settings/living-times-mental-health-and-psychosocial-support-toolkit-older-adults-during-covid-19-pandemic

Towards a dementia inclusive society. WHO toolkit for dementia-friendly initiatives (DFIs)	Multi	2021	WHO	https://www.who.int/publications/item/9789240031531
EQUIP - Ensuring Quality in Psychological Support	Multi	2022	WHO	https://www.who.int/teams/mental-health-and-substance-use/treatment-care/equip-ensuring-quality-in-psychological-support
WHO MiNDbank: More Inclusiveness Needed in Disability and Development	Multi		WHO	https://extranet.who.int/mindbank/
Quality Indicator(s)/Standard(s) (n = 15)				
National Minimum Standards Care Homes for Older People	Malta	2014	WHO MiNDbank	https://www.mindbank.info/item/5489
Dementia Quality Standard	UK	2019	NICE	https://www.nice.org.uk/guidance/qs184
National Standards for Residential Care Settings for Older People in Ireland	Ireland	2016	Health Information and Quality Authority	https://www.hiqa.ie/sites/default/files/2017-01/National-Standards-for-Older-People.pdf

Worsened Mood in Long-Term Care [Indicator from Canadian Institute for Health Information]	Canada	2022 (updated)	Canadian Institute for Health Information	https://www.cihi.ca/en/indicators/worsened-depressive-mood-in-long-term-care
Health at a Glance 2021: OECD Indicators	Multi	2021	OECD	https://www.oecd.org/health/health-at-a-glance/
Measuring progress: indicators for care homes	Multi	2010	European Centre for Social Welfare Policy and Research	https://myhomelife.org.uk/wp-content/uploads/2021/09/EU-Report-on-Quality-Indicators-in-Care-Homes.pdf
Optimising Older People's Quality of Life: An Outcomes Framework Strategic outcomes model	Scotland	2014	Cohen et al (NHS Scotland)	https://www.healthscotland.scot/media/1159/optimising-older-people-quality-of-life-strategic-outcomes-model-08-14.pdf
Dementia in Europe Yearbook 2017: Standards for residential care facilities in Europe	Europe	2017	Alzheimer Europe	https://www.alzheimer-europe.org/resources/publications/dementia-europe-yearbook-2017-standards-residential-care-facilities-europe
Mental Health Quality Indicators: Background and Secondary Definitions	Scotland	2018	Scottish Government	https://www.gov.scot/publications/mental-health-quality-indicators-background-secondary-definitions/

Selected indicators of mental health in the elderly - The participants the University of the Third Age	Slovakia	2016	Tomagova et al.	http://cejnm.osu.cz/artkey/cjn-201602-0005_vybrane-ukazovatele-psychiekeho-zdravia-seniorov-posluchacov-univerzity-tretieho-veku.php
Standards for Older Adult Mental Health Services (5 th edition)	UK	2019	Quality Network for Older Adult Mental Health Services/ Royal College of Psychiatrists' Centre for Quality Improvement	https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/older-adult-wards-qn/qnoamhs-5th-edition-standards.pdf?sfvrsn=ac2002d4_2
European Quality Framework for long-term care services	EU	2012	WeDO project (European Partnership for the Wellbeing and Dignity of Older people)	https://ec.europa.eu/social/main.jsp?langId=en&catId=89&newsId=1724&furtherNews=yes
interRAI Quality Indicators	Multi		interRAI	https://interrai.org/applications/quality-indicators/
Mental health quality indicator profile	Scotland	2021	Public Health Scotland	https://publichealthscotland.scot/publications/mental-health-quality-indicator-profile/mental-health-quality-indicator-profile-28-september-2021/

The patient experience in community mental health services for older people: a concept mapping approach to support the development of a new quality measure	Multi	2018	Wilberforce et al.	https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-018-3231-6
Promising case study(-ies) (n = 9)				
Decade of Healthy Ageing platform: Social Isolation and Loneliness	Multi	2021	WHO	https://www.decadeofhealthyageing.org/topics-initiatives/other-topics/social-isolation-loneliness#:~:text=UN%20Decade%20of%20Healthy%20Ageing,and%20loneliness%20among%20older%20people&text=This%20advocacy%20brief%20on%20social,by%20the%20COVID%2019%20pandemic
Global Dementia Observatory Knowledge Exchange Platform	Multi		WHO	https://globaldementia.org/en
Depression among older people living in care homes	GB	2018	British Geriatrics Society	https://www.bgs.org.uk/resources/depression-among-older-people-living-in-care-homes-report
World Mental Health Report	Multi	2022	WHO	https://www.who.int/teams/mental-health-and-substance-use/world-mental-health-report

Understanding effective approaches to promoting mental health and preventing mental illness across the life course: examples of practice	Multi	2017	OECD	https://www.oecd.org/els/health-systems/Understanding-Effective-Approaches-to-Promoting-Mental-Health-and-Preventing-Mental-Illness_HealthWP97.pdf
Ageism in Mental Health Assessment and Treatment of Older Adults (Chapter 15)	Multi	2018	Bodner et al.	https://link.springer.com/chapter/10.1007/978-3-319-73820-8_15
Commissioning Cost-Effective Services for Promotion of Mental Health and Wellbeing and Prevention of Mental Ill-Health	England	2017	McDaid et al	https://www.lse.ac.uk/business/consulting/reports/commissioning-cost-effective-services-for-promotion-of-mental-health-and-wellbeing-and-prevention-of-mental-ill-health
Adults and later life (case studies for older adult mental wellbeing)	UK	2022	Mental Health Foundation	https://www.mentalhealth.org.uk/our-work/programmes/adults-and-later-life
A Systematic Review of Culturally Sensitive Interventions for Ethnic Minority Elders with Mental Illness	Systematic review (multi= China, Myanmar, the Netherlands, Portugal, the United States, and Sweden)	2021	Littlefield, Sarah and Villareal, Rosalind	https://ideaexchange.uakron.edu/honors_research_projects/1411

MAPIRANJE POSTOJEĆIH VISOKOKVALITETNIH ALATA, RESURSA I SMERNICA RELEVANTNIH ZA MENTALNO ZDRAVLJE I BLAGOSTANJE STARIJIH ODRASLIH - SZO EVROPSKI REGION

**Frederique Djurdjevic, Cassie Redlich, Yongjie Yon,
Manfred Huber, Ledia Lazeri**

Rezime

Problemi sa mentalnim zdravljem su veoma rasprostranjeni i predstavljaju jedan od vodećih uzroka patnje i invaliditeta u Evropskom regionu. U 2021. godini, više od 150 miliona ljudi u Evropskom regionu SZO živelo je sa problemima sa mentalnim zdravljem, a samo jedna od tri osobe sa depresijom dobila je potrebnu negu. Da bi se adresirali ovi nedostaci u mentalnim zdravstvenim uslugama i podršci, od kojih su mnogi pogoršani pandemijom KOVID-19, Evropski region SZO pokrenuo je u septembru 2021. Panevropsku koaliciju za mentalno zdravlje (u daljem tekstu Koalicija). Cilj Koalicije je da se usmeri na nedostatke u mentalnim zdravstvenim uslugama okupljanjem nacionalnih lidera, profesionalaca, članova civilnog društva, predstavnika međunarodnih organizacija i stručnjaka kako bi se zajednički radilo na izvlačenju mentalnog zdravlja iz senke i njegovom stavljanju u mainstream. Ključni prioriteti Koalicije uključuju transformaciju mentalnih zdravstvenih usluga i integraciju mentalnog zdravlja u hitne reakcije i napore za oporavak, kao i promociju mentalnog zdravlja i prevenciju mentalnih bolesti tokom celog života.

Evropski region SZO organizovao je prvi sastanak Koalicije u maju 2022. godine kako bi započeo razvoj šest radnih paketa, uključujući Radni paket III: Mentalno zdravlje i blagostanje starijih odraslih. Mapiranje postojećih visokokvalitetnih alata, resursa i smernica relevantnih za mentalno zdravlje i blagostanje starijih odraslih za Evropski region SZO naručeno je u leto 2022. godine od strane Koalicije. Ovaj rad je modifikovana verzija vežbe mapiranja.

Ovo istraživanje ističe sveobuhvatni izazov sa kojim se suočavaju usluge mentalnog zdravlja starijih odraslih, pored hroničnih i sistemskih ograničenja nedovoljnog finansiranja i nedostatka osoblja. Postoji kontrast između specifičnih i često složenih potreba za mentalnim zdravljem ove raznolike grupe i sistemskih i pojedinačnih barijera koje trenutno sprečavaju njihov pristup visokokvalitetnoj nezi. Barijere uključuju, između ostalog: fragmentirane puteve nege sa drugim sektorima zdravstvenog sistema, kao što je akutna nega; profesionalne i institucionalne predrasude uključujući starosne i diskriminatorne stavove zdravstvenih i socijalnih radnika; teškoće sa pristupom i/ili prihvatljivošću online/digitalnih psiholoških intervencija; generičke usluge mentalnog zdravlja odraslih koje ne ciljaju njihove specifične potrebe, delimično zbog nedostatka uključivanja starijih ljudi u oblikovanje njihovih usluga u skladu sa njihovim individualnim preferencijama; standardi kvaliteta i indikatori još uvek teže da izjednače usluge mentalnog zdravlja sa negom demencije, iako su spora poboljšanja vidljiva.

Pojedinačne barijere koje zahtevaju promenu ponašanja, kao što je internalizovana stigma koja je uobičajena među starijim ljudima da mentalna podrška pruža malo koristi, iako dokazi ukazuju na suprotno, biće teže promeniti. Politike za podsticanje društvene participacije, kako bi se poboljšalo blagostanje i smanjio faktor rizika za mentalne bolesti u starijem dobu, mogle bi biti prioritetne. Neke obećavajuće studije slučaja su vredne pažnje; one su istaknute kroz ceo rad.

Ključne reči: demencija, depresija, mentalno zdravlje, stariji odrasli, usamljenost.

ACKNOWLEDGMENTS

The authors of this report would like to take this opportunity to thank the *Coalition* members for identifying the mental health and well-being of older adults as a priority topic for one of the work packages. Several colleagues provided feedback and comments on earlier versions of this Report, for which we are indebted. Dr Stefania Ilinca (WHO/Europe) provided useful suggestions on an early version of the research Protocol of the mapping exercise in August 2022, while Dr Chris Mikton (WHO/HQ) identified possible avenues for identifying resources.

The dissemination of results of this report was conducted on two occasions already. We are very grateful to Nataša Todorovic, President of the Gerontological Society of Serbia, for having invited us to present our preliminary results at the 11th International Gerontological Society Congress in Belgrade, Serbia (12 and 13 October 2022). We also presented a draft version of this paper at the second *Coalition* Meeting in Ankara, Turkey (23 and 24 November 2022). Authors FD, MH, and YY would like to extend their gratitude to WHO Consultant Gianluca di Giacomo for his support in the preparation of the presentations, and to Olga Tchachtchina Pettersson (WHO/Europe) for her administrative assistance in preparing for the trip.

Original scientific paper UDK: 364-787.22-053.9
159.922.63
343.988-053.9

Handed over: 13.04.2023.

Accepted: 25.05.2023.

TRAUMA THEORY AND VIOLENCE ACROSS THE LIFE COURSE FROM AN AGEING PERSPECTIVE

Patricia Brownell¹¹

Abstract

Trauma in child abuse and domestic violence has been discussed in the literature for a number of years, but only recently has elder abuse been part of this discourse. Siloes based on stage-specific perspectives of abuse, neglect, and violence continue to limit understanding of trauma as it affects individuals across the life course. However, a recent prevalence studies on violence against women in the Balkans has included older women in community samples as well as questions about child abuse, and recent elder abuse prevalence studies have included these questions as well (Babovic et al., 2022).

Findings from this and other studies consistently identify child abuse as a risk factor for abuse in later life. The international human rights movement for a binding instrument to promote human rights of older people also advocates a holistic understanding of older people and their lived experience. Finally, intersectionality and life course analyses have been applied to better understanding of unequal aging and health disparities in older age and

¹¹ **Patricia Brownell**, Associate Professor Emerita of Social Service, Fordham University & United States Representative, International Network for the Prevention of Elder Abuse (INPEA) brownell@fordham.edu

could help to provide insight into violence across the life course, culminating in old age. Translational research to practice is also critical, and some examples are presented of how an understanding of trauma enhances work with older adults who are victims of violence. It is important that gender-based implications are also explored.

The presentation will focus on a summary of published English language scholarship to date that builds toward a deeper understanding of violence across the life course culminating in older age. It will critically summarize recent prevalence data that identify a correlation between child abuse and older adult abuse. It will also provide an overview of different theoretical frameworks that have been offered in the literature to explain this correlation, as well as challenges of each. There will be a particular focus on trauma theory as an explanatory framework, with suggestions for application of this theoretical framework to a better understanding of how early adverse experiences can lead to late life abuse.

Resilience as well as risk is a theme that surfaces in the literature on violence and abuse across the life course culminating in old age. Translational research objectives in social work and the applied social sciences require that findings from research data lead to real life solutions. Intervention research on violence across the life course is at a preliminary stage but some interventions have been developed and tested. Implications for the field of gerontology and recommendations for future research will conclude the presentation.

Keywords: Trauma, Elder abuse, Resilience, Risk, Life course

Older Adult Abuse and Trauma Theory from a Life Course Perspective: A Paradigm Shift

Recent prevalence and prospective studies on interpersonal violence (IPV) show a link between child abuse, intimate partner violence and older adult mistreatment that did not emerge from stage-specific studies. In line with emerging developmental understanding of interpersonal violence from a life course perspective, early life trauma is emerging as an explanatory theory of IPV across the lifespan. In the field of elder abuse, the life course perspective challenges more traditional explanations for IPV in later life, such as ageism. This creates new opportunities for prevention and intervention strategies to end violence against older women.

Definition of Trauma (from the US Substance Abuse and Mental Health Administration (SAMHSA))

Trauma is defined as circumstances or events that are perceived as physically or emotionally life threatening or harmful by individuals and have a lasting negative effect on their functioning as well as their spiritual, emotional, social and mental being. Interpersonal trauma can include neglect, abuse and violence that is carried out against an older adult at different times in their life by someone in a position of trust, or through lack of expected protection by a significant other. This definition links trauma theory and interpersonal violence experienced by an older person. Is it a definition of trauma that can be experienced by someone of any age. Until recently, neglect, abuse and violence were conceptualized differentially based on the life stage of the victim. An understanding of violence across the life course is changing how we think about this from an aging perspective, according to National Academy of Medicine discussion paper authors Ivengar and Gray (2019).

A Life Course Perspective on Trauma

Kaiser Permanente of California, USA, and The US Centers for Disease Control (CDC) initiated a study in the 1990s called The Adverse Childhood Experiences Study (ACES). This used a prospective study design to follow health care patients from childhood into old age and found a significant relationship between early experiences of neglect, abuse and violence, and adult health and behavioral outcomes. These included intimate partner violence and suicidal behaviors, according to the US Adult Protective Services Technical Assistance Resource Center. Judith Herman (2015), a prominent American psychiatrist, originated the term 'complex trauma' to describe the long term consequences of family and intimate partner violence, trafficking and other life threatening situations on women if not treated. Research with Holocaust survivors and their families embraces a trauma-focused understanding of the aftereffects of horrific world events like war and genocide, according to Lola Straussner and her research team at New York University. Marsha Linehan (2019), psychologist, helped to expand the understanding of how lack of attunement by caregivers of vulnerable children in developmentally formative years can lead to long lasting personality distortions and difficulties in mastering adult life tasks like intimate partner relationships, family, childrearing and work.

Trauma and Elder Abuse in Research, Practice and Policy: Framing the Issue

Scholars seeking to understand elder abuse within a trauma-focused lens include Joy Ernst and Tina Maschi (2018). According to them, elder abuse definitions do not take into account a lifespan perspective, meaning consideration of trauma experienced earlier in life. This may include family violence, exposure to war and terrorism, and unexpected loss of loved ones. These experiences may cause vulnerability in people of all ages, including older adults, and if undetected and untreated, increase risk of elder abuse. Elder abuse and domestic violence prevalence researchers, including Ron Aceirno and colleagues (2010) and Lynn McDonald and Cynthia Thomas (2013) identified child abuse as a risk factor for elder abuse in their studies. Elizabeth Podnieks (1992) recounted a subject in her doctoral dissertation study on elder abuse as saying she was grateful for being a child abuse victim because it helped her endure abuse as an old woman, suggesting she had not resolved and worked through the earlier trauma.

Theory Development in Elder Abuse and Traumatic Stress

A special issue of the *Journal of Trauma & Dissociation*, edited by Shelly Jackson (DePrince & Jackson, 2020), psychologist and elder abuse researcher, focused on exploring the connection between elder abuse and trauma. She states that the experience of elder abuse has only recently been understood as a traumatic stressor and research on earlier life traumas experienced by older adults. As a result, new theories are emerging on the integration of life course development and stress processes linking life events and cognitive processes. While elder abuse could be a potential life stressor, previous trauma exposure especially if interpersonal earlier in life, affects risk for and subsequent coping with elder abuse.

Trauma Theory and Abuse Across the Life Course

Trauma emerged as a way of talking about/treating mental health issues of domestic violence victims that was not stigmatizing and did not blame the victim. Beginning in the 1970s, social work and psychology were among the professional discipline that took the lead in developing feminist practice models for battered women. Trauma was an acceptable way of talking about mental health and battered women. Trauma is caused by abusive situations and not the other way around. According to psychiatrist Natalie Shainess (1985), domestic violence is not caused by masochism of the victim. Longitudinal studies show a correlation among experiences of child abuse, adult domestic violence and abuse in older age. Trauma theory can begin to explain links between abuse experienced at different points in the life course and initiate an intergenerational dialogue between younger and older women. It can also be used to advocate for trauma-informed interventions for child abuse, dating violence and spouse/partner violence as a preventive strategy against older adult abuse.

Prevalence Studies: Why are They Important?

Prevalence studies on interpersonal violence against older adults are important for advocacy with policymakers. Demonstrating that this is a widespread social problem can assist in obtaining resources to address this. It can also help to frame the issue of interpersonal violence across the life course. Historically, this has been studied from a life stage-specific perspective. A life course perspective is new to an understanding of older adult abuse. They can also help to educate the public and shape public opinion toward an understanding that older people are victims of abuse as well as children and younger adults. Hopefully it can draw the generations together and stop competition for finite resources among life stage violence adherents.

Recent Prevalence Studies that Include a Life Course Perspective

As noted, a secondary analysis of data from a prevalence study on violence against women in the West Balkans and selected contiguous countries found that experiencing violence as a child was a strong predictor of abuse among older women in the study sample. A research group in Malaysia found a link between child abuse and elder abuse among community-dwelling Malaysian older adults (Asyraf et al., 2021). A study on revictimization of older Mexican women found not only a high rate of revictimization but also high rates of child abuse and intimate partner violence among study subjects who reported experiencing abuse as older adults, according to researchers Dr. Giraldo-Rodriguez et al. (2022). A large scale study conducted in Beijing, China, that examined associations between adverse childhood experiences and victimization in later life found that poor economic status of family of origin and physical punishment by parents when young were both significantly associated with older adults' reported experience with abuse in later life, demonstrating intersectionality of violence and poverty (Chen et al., 2022).

Prospective Studies: The Gold Standard

Prevalence studies on elder abuse have been criticized for relying on retrospective memories of subjects on the grounds their cognitive abilities may be impaired, and they have old-fashioned ideas about sharing unpleasant experiences. While ageist, these concerns have provided grounds for questioning findings. Prospective studies, in contrast, capture data on life course events in real time. The Adverse Children's Experiences Study (ACES) is an example of a studies that captures data on individuals from childhood and more recently, older adulthood. ACES, undertaken by Kaiser Permanente in the 1990s identifies a correlation between childhood adverse conditions and health problems, including abuse, in adulthood and for older adults (Felitti, 2002).

Wisconsin Longitudinal Study as a Prospective Study

A longitudinal study of men and women who graduated from Wisconsin high schools in 1957, designed to identify individual and family characteristics and relationships to educational attainment and employment experiences. A recent analysis of these data found a correlation between reported child abuse and risk for elder abuse, according to researchers Drs. Easton and Kong (2020). They proposed a theory of cumulative advantage to explain this link. Some dimensions of intersectionality were not captured in this study because of lack of race and ethnic diversity among the largely German, English and Scandinavian ancestry of the original study cohort.

Trauma Informed Approach to Clients Living with Violence

A trauma informed approach to service delivery for older people with interpersonal violence in their lives challenges professionals to reframe how they think about service delivery, according to Risa Breckman, social worker and elder abuse expert, and colleagues (2020). An individual's response to interpersonal violence can be influenced by unresolved traumatic experiences in the past, including in their family of origin, beliefs about their own self-efficacy or worthiness to live their lives free of violence, or realistic assessments of alternatives to their present situation. According to Breckman, traumatized people are not remembering traumatic experiences from the past, they are living them. A professional's responsibility is to assist those living with violence develop alternatives and support victims and families to live violence-free lives.

Translational Research: Promoting a Trauma Informed Perspective on Service Delivery

A trauma informed approach is based on a set of principles from the organizational culture to the individual level. These include realizing the widespread impact of trauma and potential paths to recovery; recognizing the signs and symptoms of trauma in clients, family, procedures and practice; integrating knowledge into policies, procedures and practice; and resisting retraumatizing clients as well as professional staff. Reconceptualizing violence across the life course as trauma-driven requires a change in the way services are designed and professionals interact with victims in older age. Interventions and programs designed to be trauma informed are new. While intervention research in elder abuse is lagging, according to Dr. David Burnes and others (2019), it is lacking in trauma work with older victims of interpersonal violence. This gap presents exciting new challenges for researchers, particularly those now entering the field.

Future Direction to End Partner and Non-Partner Violence, Neglect and Abuse Across the Life Course

Violence against older women needs to be brought into the Violence Against Women (VAW) research framework (United Nations, 2013). Significant work has been done by the Serbian Red Cross using data from the OSCE violence against women study. Historically, abuse of older adults research has linked elder abuse with child abuse, ignoring adult abuse and in particular domestic violence and its impact on older women. To date, violence across the life course has been presented in siloes, with the older adult silo represented as one dominated by vulnerability, decrepitude and end of life suffering. This is no longer considered an accurate picture of aging, much less old age. Most older people are resilient, creative and capable of learning and change, according to researcher Dr. Tina Maschi and colleagues (2012).

Human Rights Perspective on Abuse, Neglect and Violence Against Older Persons

As in research on interpersonal violence in general, existing human rights instruments pertaining to partner and non-partner violence to date have followed a state-specific model, according to social work professor Marciana Popescu and colleagues (2022). UN Conventions (international treaties) and other binding international instruments have been ratified to address the rights of children and women of reproductive age, including the right to live lives free of violence, but none exist to date for protection of rights of older persons. This further fragments protections across the life course. A binding global instrument that protects human rights of older adults is still pending. Research on normative gaps in law across nations is critical to the eventual success of advocates for an international instrument protecting older people from abuse, neglect and violence.

Conclusion

The human rights perspective on abuse, neglect and violence against people in later life challenges older perspectives on elder abuse by refocusing attention on the life course and holistic, intersectional, risk and resilience and rights-based factors. A final challenge for those seeking a paradigm shift from stage-specific conceptualizations of elder abuse to interpersonal violence across the life course is how to integrate gerontology and geriatrics within existing life course violence and trauma-informed frameworks and, simultaneously, maintain a focus on older adults. In the meantime, a life course perspective continues to be validated by prevalence and prospective study data. Research that integrates the life course and an understanding of violence and trauma is more important than ever.

References

Acierno, R., Hernandez, M. A., Amstadler, A. B., Resnick, H. S., Steve, K., Muzzy, W. and Kilpatrick, D. G. (2010). Prevalence and correlates of emotional, physical, sexual, and financial abuse and potential neglect in the United States: the national elder mistreatment study. *American Journal of Public Health*, 100, 2, 292-297.

Adult Protective Services technical Assistance Center (n.d.). Trauma-informed approach to adult protective services. Retrieved on July 20, 2022, from: <https://apstarc.acl.gov>.

Asyraf, M., Dunne, M. P., Hairi, N.N., Hairi, F. M., Radzali. N., and Yuen, C. W. (2021). The association between elder abuse and childhood adversity: a study of older adults in Malaysia. *Plos One*, <https://doi.org/10.1371/journal.pone.0254717>,

Babovic, M., Brownell, P., Vracevic, M., and Todorovic, N. (2022). Exploring violence against older women in the Western Balkans, Moldova and Ukraine. Red Cross of Serbia: Belgrade, Serbia. Retrieved on July 15, 2022, from www.redcross.org.rs/media/8062.

Breckman, R., Levin, M., Mantrone, L. and Solomon, J. (2020). The things they carry: advancing trauma-informed responses to elder abuse. New York: NYC Center on Elder Abuse & The Harry and Jeanette Weinberg Center for Elder Justice.

Burnes, D., Ernst, J., Brownell, P. (2019). Stop Family Violence. In: Sanders, S., Kolomer, S., Waites Spellman, C., Rizzo, V. (eds) *Gerontological Social Work and the Grand Challenges*. Springer, Cham. https://doi.org/10.1007/978-3-030-26334-8_3

Chen, M. and Chan, K. L. (2022). Elder abuse and neglect in China: prevalence, co-occurrence, and intergenerational risk factors. *Journal of Interpersonal Violence*, 37, 11-12, NP9839-NP9862.

Choi, M., Brownell, P. & Moldovan, S. I. (2017). International movement to promote humanrights of older women with a focus on violence and abuse against older women. *InternationalSocial Work*, 60 (1), 170-18

DePrince, A. P. and Jackson, S. L. (2020). Moving the field forward: elucidating the nexus between elder abuse and trauma. *Trauma & Dissociation*, 21, 2, 151-157.

Easton, S. D. and Kong, J. (2020). Childhood adversities, midlife health, and elder abuse victimization: a longitudinal analysis based on cumulative disadvantage theory. *Journal of Gerontology B.*, XX, 1-12.

Ernst, J. S. and Maschi, T. (2018). Trauma-informed care and elder abuse: a synergistic alliance. *Journal of Elder Abuse & Neglect*, 30, 5, 354-367.

Felitti, V. J. (2002). The relation between adverse childhood experiences and adult health: turning gold into lead. *The Permanente Journal/Winter 2002/6*, 1, 44-47.

Giraldo-Rodriguez, L., Mino-León, D., Aragón-Girjalva, S. O., and Agudelo-Botero, M. (2022).

The revictimization of older Mexican women: understanding the accumulation of multiple victimizations throughout a lifetime. *BMC Geriatrics*, 22, 41, <https://doi.org/10.1186/s12877021-02734-5>.

Herman, J. L. (2015). *Trauma and recovery: The aftermath of violence--from domestic abuse to political terror*. Hachette: UK.

Iyengar, V. and Gray, J. (2019). *Trauma caused by injury or abuse in later life: experiences, impacts, and the federal response: discussion paper*. Washington, DC: National Academy of Medicine.

Linehan, M. (2019). *Building a life worth living*. New York: Random House.

Maschi, T., Baer, J. C., Morrissey, M. B., and Moreno, C. (2012). The aftermath of childhood trauma on late life mental and physical health: a review of the literature. *Traumatology*, 19, 1, 1-16.

McDonald, L. and Thomas, C. (2013). Elder abuse through a life course lens. *International Geriatrics*, August 25, 8, 1235-43. Doi:10.1017/5104161021300015x.

Podnieks, E. (1992). National survey on abuse of the elderly in Canada. *Journal of Elder Abuse & Neglect*, 4, 1-2, 5-58.

Popescu, M. L., Brownell, P., & Pyatetskaya, T. (2022). Violence against women and girls across the lifespan. In Congress, E. P., Meister, D., Osborn, S. C., and Takooshian, H. (Eds.), *Behavioral science in the global arena: global mental, spiritual, and social health*. Charlotte, N.C., Information Age Publishing, Ind.

Shainess, N. (1985). *Sweet suffering: woman as victim*. Pocket Books.

Straussner, S. L. A. and Calnan, A. J. (2014). Trauma through the life cycle: a review of current literature. *Clinical Social Work*, 42, 323-335.

United Nations (2013). *Neglect, abuse and violence against older women*. New York: Department of Social and Economic Affairs, Division for Social Policy and Development. Retrieved from <https://www.un.org, ST/EAS/351>.

TEORIJA TRAUME I NASILJE KROZ CEO ŽIVOTNI TOK IZ PERSPEKTIVE STARENJA

Patricia Brownell

Rezime

O traumi u zlostavljanju dece i nasilju u porodici se u literaturi govori već dugi niz godina, ali tek nedavno je zlostavljanje starijih postalo deo ovog diskursa. Silosi zasnovani na specifičnim perspektivama zlostavljanja, zanemarivanja i nasilja nastavljaju da ograničavaju razumevanje traume i njenog uticaja na osobe tokom njihovog životnog toka. Međutim, nedavne studije rasprostranjenosti nasilja nad ženama na Balkanu uključile su starije žene u uzorke zajednice, kao i pitanja o zlostavljanju u detinjstvu, a nedavne studije o rasprostranjenosti zlostavljanja starijih su takođe uključile ova pitanja.

Nalazi ove i drugih studija dosledno identifikuju zlostavljanje u detinjstvu kao faktor rizika za zlostavljanje u kasnijem životnom dobu. Međunarodni pokret za ljudska prava koji se zalaže za obavezujući instrument za promovisanje ljudskih prava starijih osoba se takođe zalaže za holističko razumevanje starijih osoba i njihovog životnog iskustva. Konačno, analize interseksionalnosti i životnog toka primenjuju se kako bi se bolje razumele nejednakosti starenja i zdravstvenih dispariteta u starijoj dobi i mogu pomoći da se pruži uvid u nasilje tokom životnog toka, koje kulminira u starosti. Prevođenje istraživanja u praksu je takođe od kritične važnosti, a u ovom radu su predstavljeni neki primeri kako razumevanje traume poboljšava rad

sa starijim osobama koje su žrtve nasilja. Važno je istražiti i rodno zasnovane implikacije.

Prezentacija će se fokusirati na rezime objavljenih izveštaja na engleskom jeziku do danas koje doprinose dubljem razumevanju nasilja tokom životnog toka a koje kulminira u starijoj dobi. Kritički će sažeti nedavne podatke o rasprostranjenosti koji identifikuju korelaciju između zlostavljanja u detinjstvu i zlostavljanja ustarijem životnom dobu. Takođe će dati pregled različitih teorijskih okvira koji su ponuđeni u literaturi da bi se objasnila ova korelacija, kao i izazovi svakog od njih. Poseban fokus će biti na teoriji traume kao okviru za objašnjenje, sa predlozima za primenu ovog teorijskog okvira za bolje razumevanje toga kako rana negativna iskustva mogu dovesti do zlostavljanja u kasnom životu.

Otpornost i rizik su tema koja se pojavljuje u literaturi o nasilju i zlostavljanju kroz životni tok a koja kulminira u starosti. Translacioni ciljevi istraživanja u socijalnom radu i primenjenim društvenim naukama zahtevaju da nalazi iz istraživačkih podataka dovedu do rešenja u stvarnom životu. Interventno istraživanje o nasilju tokom životnog toka je u preliminarnoj fazi, ali su neke intervencije razvijene i testirane. Zaključićemo izlaganje implikacijama za oblast gerontologije i preporukama za buduća istraživanja.

Ključne reči: *trauma, nasilje nad starijima, otpornost, rizik, celoživotni tok*

Review work UDK:343.988-053.9(481)

343.85:343.62-053.9

Handed over: 30.10.2023.

Accepted: 22.01.2024.

RECENT AND CURRENT ELDER ABUSE RESEARCH IN NORWEGIAN CONTEXT

Wenche Karin Malmedal¹²

Abstract

Research on elder abuse in Norway is still in its infancy, but during the last decade several studies have been conducted based on the active elder abuse research group at Norwegian University of Science and Technology in Trondheim. The last years, this research has resulted in three completed PhD's and two ongoing PhD projects, as well as other research projects. The vast majority of the studies have been conducted in nursing homes, with nursing home staff as informants/respondents, but there are also studies using relatives as informants and studies among home-dwelling persons with dementia.

So far, quantitative studies have aimed to reveal and describe different aspects on elder abuse, both with regards to types and prevalence, and it's associations. Staff's and relatives' perceptions on abuse and neglect have been investigated in qualitative studies. This short presentation will give an overview of the most recent and current studies on elder abuse from Norwegian contexts, both from institutional- and community settings.

¹² **Wenche Karin Malmedal**, Department of Public Health and Nursing, Norwegian University of Science and Technology (NTNU), Wenche.k.malmedal@ntnu.no

After the presentation the participants will have gained insight in research activities on elder abuse in Norway, as well as an overview of main results and where to find more information on the different studies.

Keywords: *Elder abuse, Research, Institutional settings, Community settings, Studies*

Elder abuse at NTNU

This paper will give a brief overview of five different studies on elder abuse that have had offspring from Norwegian University of Science and Technology (NTNU). The paper will also introduce Norwegian health care system to older persons and in particular the long-term care system. I acknowledge the contribution from all my colleagues who have contributed to these studies, in particular the PhD-students involved. All have made great effort in bringing forward new knowledge in this understudied research area. Their names are to be found in the reference list.

Long-Termcare in Norway

Norway, and thus Norwegian health care system is governed at two levels, the national (state) and local level (counties and municipalities). The local government (the municipalities) are responsible for: home care (home assistance and home nursing), respite care, service housing and group living-arrangements, nursing homes (NHs), rehabilitation (physiotherapy, occupational therapy, mental health care etc.), family medicine/ general practitioners etc. The national level (the state) is responsible for: hospitals, specialized rehabilitation, and ambulant specialists. In Norway, most health provided is from public providers, like state or municipalities. Less the 2% of hospital beds are provided by for-profit private providers.

Long-term care is provided both in the patients' own homes and in institutions, for older persons typically nursing homes. Around 14% of those 80+ lives in a nursing home (approx. 44 000). The nursing homes can shortly be described this way:

- 24 hours skilled care services
- a statutory obligation for the municipalities
- provide medical and nursing care, rehabilitation and respite care

- mostly owned and run by the municipalities
- staff: 31% RNs, 45% LPN (high school), 24% aides/assistants
- nursing home departments are required to be managed by registered nurses (RNs)
- single rooms (< 95%)

The nursing home patients are sicker and more helpless than earlier years and about 50% of all yearly deaths in Norway happen in NHs. The characteristics of the nursing home patient are:

- more than 80 % suffer from dementia
- more than 80% have extensive care needs
- 2/3 show clinically significant psychiatric or behavioural symptoms
- submission causes: cognitive impairment (42%), stroke (15%), mental illness (9%), heart and lung diseases (8%)
- mean age: 85 years, 71 % female
- mean number of drugs: 6.7

Ageing in place is an expressed goal for the Norwegian health authorities and long-term care is also provided in the persons' own homes. Like the rest of the world, Norway is expecting a tremendous growth in the number of persons with dementia the next decades. Most of them will stay in their own homes, at least for a long period. Support and services for persons with dementia and their informal caregivers in Norway include home nursing services, practical homecare services, adult daycare services, and dementia education or training for persons with dementia or their informal caregivers (Norwegian Directorate of Health, 2019). We know that nine out of ten persons with dementia receive care from friends and relatives. This can be stressful to the caregiver, and one must be aware of possible negative outcomes.

Elder abuse

Elder abuse can be defined as “a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person” (WHO, 2002). It can take many forms, but five subtypes are often mentioned: psychological, physical, sexual, and financial abuse and neglect. Elder abuse is recognized as a public health and human right problem and has many negative outcomes for those exposed as well as for the society in general. A systematic review on the prevalence of elder abuse in community settings found the prevalence for overall elder abuse to be 15.7% (Yon et al., 2017). Older persons may be abused by relatives, friends, or caregivers (paid or unpaid). From nursing home settings, we do not have “true” prevalence numbers, studies mostly use self-reports from staff. A meta-analysis by Yon et al. (2019) calculated that 64.2% of the staff admitted perpetrating at least one incident of elder abuse the last year. Nursing home residents may be exposed to abuse and neglect from staff, relatives/other visitors, and co-residents.

Five studies on elder abuse

With basis in the research group Aging and Older Persons’ Health at NTNU, we have conducted five different projects related to elder abuse from 2017 and till now:

- Elder abuse in Norwegian nursing homes: a cross-sectional exploratory study
- The role of leadership in promoting patient safety in nursing homes
- Relatives’ perceptions of abuse and neglect of nursing home patients
- A qualitative study of neglect in nursing homes - staff’s perspective
- Stretched to the limit? - The role caregiver burden has on the extent of elder abuse among home-dwelling persons with dementia

<https://www.ntnu.edu/ism/research/aging#/view/publications>

In the following, short descriptions of each of the studies will be given, with full references to all published articles for further reading.

Study 1 Elder abuse in Norwegian nursing homes: Prevalence and risk factors

In this study, PhD-student Anja Botngård was the main researcher and we cooperated with University of Southern California, Keck School of Medicine.

The overall aim was to generate new knowledge on the extent, nature, and risk factors of elder abuse in Norwegian nursing homes. The three sub studies had specific aims: (I) estimate the prevalence of observed and perpetrated staff-to-resident abuse in Norwegian nursing homes, and examine demographic differences between staff who reported perpetrating and not-perpetrating acts of abuse, (II) estimate the prevalence of resident-to-resident aggression (RRA) in Norwegian nursing homes, and examine differences in facility characteristics between nursing homes with a high and low occurrence of RRA, (III) examine risk factors on different levels of the ecological model (individual, relational, institutional) associated with staff-to-resident psychological abuse, physical abuse, and neglect in Norwegian nursing homes.

The method was a national, cross-sectional survey of 3.693 nursing staff recruited from 100 nursing homes all over Norway. The response rate was 60.1%. The different tools and the statistical methods used are described in detail in the three published papers from these sub-studies. There are three published articles from this study: Botngard et al. (2020a); Botngard et al. (2020b); Botngard et al. (2021).

All in all, 76% of the staff had observed, and about 60% admitted perpetrating, at least one incident of staff-to resident abuse during the previous year. The most common types of abuse were psychological abuse and neglect. There are different risk factors associated with the different types of abuse. Factors like care-related conflicts and resident aggression were associated with all three types of abuse. Regarding resident- to- resident

aggression, almost 90% of the staff had observed one or more incidents during the last year. Verbal and physical aggression was most reported. The staff also observed relative-to-resident abuse and about 46% had observed one or more incidents the previous year. Acts of physical and psychological character were most reported.

The conclusion is that nursing home residents are exposed to many types of abuse from staff, relatives, and aggressive behaviour from co-residents. The findings indicate a need for strategies to improve the quality of life and safety of residents in nursing homes.

Study 2 The role of leadership in promoting safety for nursing home residents and preventing elder abuse and neglect

In this study, PhD-student Janne Myhre was the main researcher. We co-operated with Deakon University School of Nursing and Midwifery, Australia.

The aim of the study was to explore the role of leadership in patient safety concern related to elder abuse and neglect. The three sub studies had specific aims: (I) explore how nursing home leaders perceive elder abuse and neglect, (II) explore what nursing home leaders experience as barriers and enablers to reporting elder abuse and neglect, and (III) explore how nursing home leaders follow up on information and reports of elder abuse and neglect. There are three published articles from this study: Myhre et al. (2020a); Myhre et al. (2020b); Myhre et al. (2020c).

The research design was qualitative and explorative, using both focus group discussions and individual interviews as data collection method. A total of 21 nursing homes from six municipalities were included and 43 ward managers (n=28) and nursing home directors (n= 15) participated.

A main finding was that the nursing home leaders lacked awareness about elder abuse and neglect. During the discussions they came up with examples of incidents that could be harmful to the resident. There was an ambiguity in the leaders, on the one hand they described situations as harmful, but still they tried to find excuses for why they happened. The ward managers experienced that it was difficult to gain information about abuse from the formal reporting system, and they tried to obtain information from other sources. The nursing home directors on the other hand, were more positive to the existing reporting system. Findings from this study also revealed that nursing home directors and care managers do not have the same opinion about what causes elder abuse.

One conclusion of this study was that in its present form, the Norwegian adverse events reporting system is not designed to detect elder abuse and neglect. There is a need for clarification what to report and how to follow up the reported incidents.

Study 3 Relatives' perceptions of abuse and neglect of nursing home patients

In this study we did not have PhD-students, but experienced researchers. This study was a co-operation between NTNU and Norwegian Centre for Violence and Stress Studies.

The rationale for this study was that most studies on elder abuse and neglect in nursing homes are based on reports from staff and there is a need for giving voice to the residents by investigating their relatives' experience with elder abuse. The specific research questions were:

- What do relatives perceive as abuse?
- How are incidents of suspected abuse experienced?
- How are incidents of suspected abuse communicated with the staff?
- What role do relatives have as contributors to promoting a care-culture free from abuse and neglect?The research design was qualitative with individual interviews with 18 relatives from all regions of Norway. There is one published article in English from this study: Saga et al. (2021).

A main finding was that relatives in this study had observed all types of abuse and neglect, and that these are not single acts, but a part of daily life in nursing homes. Relatives perceived neglect as most pervasive and staff-to-resident psychological abuse as a key problem. The relatives experienced low competence among nursing staff, and they felt that the patients' needs were not met. When the relatives notified the staff or leaders, they felt that they were not heard, and even sometimes they felt maltreated by the staff.

The study concludes that including relatives in a committed partnership with the nursing home will reduce the risk of abuse.

Study 4 A qualitative study of neglect in Norwegian nursing homes - staffs' perspective

In this study, PhD-student Stine Borgen Lund is the main researcher. In this study we cooperate with University of Southern California, Keck School of Medicine.

The purpose of this study was to generate new knowledge on the processes leading to- and upholding neglect in Norwegian nursing homes. The aim was to provide important knowledge that can contribute to the development and implementation of preventive measures.

The research design was qualitative explorative, with a constructivist grounded theory approach. Data was collected through 5 focus-group discussions with total 20 participants and 10 individual interviews with nursing home staff. There are two published articles (the third is submitted): Lund et.al. (2023a); Lund et al. (2023b).

The findings show that the staff use different strategies to make neglect an acceptable practice. These strategies were identified as when the staff legitimize neglect by neglecting neglect, when the staff are not recognizing their own behaviour as neglectful, as expressed in their actions and language, and normalizing missed care when resources are lacking and nursing staff are rationing care. Neglect in nursing homes is sometimes invisible due to a combination of personal and organizational factors. Staff may minimize "missed care" and not consider it neglect, so it is not reported. In addition, they may be reluctant to acknowledge or reveal their own or colleagues' neglectful practices.

One conclusion is that nursing staff's legitimization of neglect and a reporting culture making neglect invisible are some of the processes leading to and maintaining neglect in Norwegian nursing homes. Knowledge and awareness of these practices can prevent neglect of resident in nursing homes.

Study 5 Stretched to the limit? - The role caregiver burden has on the extent of elder abuse among home-dwelling persons with dementia

In this study, PhD-student Gunn Steinsheim is the main researcher, and we cooperate with University of Southern California, Keck School of Medicine.

The overall purpose of the study is to enable the municipal health services to prevent elder abuse of home-dwelling persons with dementia. The specific aim is to investigate how the informal caregiver's experience of caregiver burden affects the ability to master the caregiving task, as well as what factors can lead to elder abuse.

The design was a cross-sectional study of relatives of persons with dementia (n=549) with an anonymous self-reported questionnaire in the mail. The three sub studies investigated different aspects of the problem. There are two published articles (the third is submitted): Steinsheim et al. (2022); Steinsheim et al. (2023).

The three sub studies had specific aims: (I) describe the proportion of abusive episodes among home-dwelling persons with dementia and their informal care-givers (ICG) and explore differences between IGSs who report or do not report abusive episodes, (II) to find individual, relational, and community factors associated with psychological and physical abuse of home-dwelling person with dementia, (III) explore which factors are associated with informal caregivers' subjective burden when caring for persons living at home with dementia.

The results show that two-thirds of informal caregivers had committed at least one abusive episode toward the person with dementia the past years, most frequent reported was psychological abuse. One-third of the informal caregivers had experienced aggression from the person with dementia, also

here the most reported type was psychological abuse. The most prominent risk factor for both subtypes of abuse (physical and psychological) was the caregiver being a spouse. In addition, risk factors for psychological abuse were having a higher caregiver burden, experiencing psychological aggression from the person with dementia, and the person with dementia being followed up by their general practitioner. For physical abuse, the protective factors were the ICG being female and having an assigned personal municipal health service contact, while the risk factors were the ICG attending a caregiver training program and experiencing physical aggression from the person with dementia and the person with dementia having a higher degree of disability. Informal caregivers' mental distress and care recipients' BPSD were the factors with the strongest association with subjective burden.

This study expands knowledge about elder abuse among home-dwelling persons with dementia and this is essential to be able to reduce the risk and prevent abuse.

Final remarks

Even though some of the studies are smaller and from a limited geographical area, we truly believe that our findings have contributed to a greater knowledge on the complexity of the prevalent and multifaceted problem of elder abuse. In many countries there is still a lack of awareness regarding elder abuse and neglect, both in community settings and in nursing homes. Recognition of the phenomena is the first step toward change, but it needs to be followed up by actions. I share the same hope as stated by Karl Pillemer (1991), one of the early researchers in this field: that we can develop "...a society in which all of the elderly live free from fear of maltreatment".

Funding

Study 1-3 was funded by the Norwegian Research Council. Study 4 was funded by NTNU, and study 5 was funded by Dam Foundation, Norway.

References

Botngård, A. Eide, AH. Mosqueda, L. & Malmedal, WK. (2020a) Elder abuse in Norwegian nursing homes: a cross-sectional exploratory study. *BMC Health Services Research*. vol. 20 (9).

<https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-019-4861-z>

Botngård, A. Eide, AH. Mosqueda, L. & Malmedal, WK. (2020b) Resident-to-resident aggression in Norwegian nursing homes: a cross-sectional exploratory study. *BMC Geriatrics*. vol. 20. <https://doi.org/10.1186/s12877-020-01623-7>

Botngård, A. Eide, AH. Mosqueda, L. Blekken, LE. & Malmedal, WK. (2021) Factors associated with staff-to-resident abuse in Norwegian nursing homes: a cross-sectional exploratory study. *BMC Health Services Research*. vol. 21 (1). <https://doi.org/10.1186/s12913-021-06227-4>

Lund, SB. Skolbekken, J-A. Mosqueda, L. & Malmedal, WK. (2023a) Legitimizing neglect - a qualitative study among nursing home staff in Norway. *BMC Health Services Research*. volum 23 (1). <https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-023-09185-1>

Lund, SB. Skolbekken, J-A. Mosqueda, L. & Malmedal, WK. (2023b) Making Neglect Invisible: A Qualitative Study among Nursing Home Staff in Norway. *Healthcare*. volum 11 (10). <https://www.mdpi.com/2227-9032/11/10/1415>

Myhre, J. Malmedal, WK. Saga, S. Ostaszkievicz J & Nakrem S. (2020a) Nursing home leaders' perceptions of factors influencing the reporting of elder abuse and neglect: a qualitative study. *Journal of Health Organisation and Management*. vol. 34 (6). <https://ntnuopen.ntnu.no/ntnu-xmlui/handle/11250/2680194>

Myhre, J. Saga, S. Malmedal, WK. Ostaszkievicz, J. & Nakrem, S. (2020b) Elder abuse and neglect: an overlooked patient safety issue. A focus group study of nursing home leaders' perceptions of elder abuse and neglect. *BMC Health Services Research*. vol. 20 (199). <https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-020-5047-4>

Myhre, J. Saga, S. Malmedal, WK. Ostaszkievicz, J. & Nakrem, S. (2020c) React and act: a qualitative study of how nursing home leaders follow up on staff-to-resident abuse. *BMC Health Services Research*. vol. 20 (1). <https://doi.org/10.1186/s12913-020-05969-x>

Norwegian Directorate of Health. (2019). Nasjonal kartlegging av kommunenes tilrettelagte tjenestetilbud til personer med demens 2018 [National survey of the municipalities' services for people with dementia 2018]. <https://www.helsedirektoratet.no/rapporter/nasjonal-kartlegging-av-tilbudet-til-personer-med-demens>.

Saga, S. Blekken, LE. Nakrem, S. & Sandmoe, A. (2021) Relatives' experiences with abuse and neglect in Norwegian nursing homes. A qualitative study. *BMC Health Services Research*. vol. 21 (684). <https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-021-06713-9>

Steinsheim, G. Saga, S. Olsen, B. Broen, HK. & Malmedal, W. (2022). Abusive episodes among home-dwelling persons with dementia and their informal caregivers: a cross-sectional Norwegian study. *BMC Geriatrics*, 22(852). <https://doi.org/10.1186/s12877-022-03569-4>

Steinsheim, G. Malmedal, W. Follestad, T. Olsen, B. & Saga, S. (2023). Contextual factors associated with abuse of home-dwelling persons with dementia: A cross-sectional exploratory study of informal caregivers. *International Journal of Environmental Research and Public Health*, 20(4), 2823. <https://doi.org/10.3390/ijerph20042823>

WHO. The Toronto Declaration on the Global Prevention of Elder Abuse; World Health Organization: Geneve, Switzerland, 2002.

Yon, Y. Mikton, CR. Gassoumis, ZD. & Wilber, KH. Elder abuse prevalence in community settings: a systematic review and meta-analysis. *Lancet GlobHealth*. 2017;5(2): e147–e56. <https://www.sciencedirect.com/science/article/pii/S2214109X17300062>

Yon, Y. Ramiro-Gonzalez, M. Mikton, CR. Huber, M. & Sethi, D. The prevalence of elder abuse in institutional settings: a systematic review and meta-analysis. *Eur J Pub Health*. 2019;29(1):58–67. <https://academic.oup.com/eurpub/article/29/1/58/5033581>

NEDAVNA I AKTUELNA ISTRAŽIVANJA ZLOSTAVLJANJA STARIJIH U NORVEŠKOJ

Wenche Malmedal

Rezime

Istraživanje zlostavljanja starijih u Norveškoj je još uvek u povoju, ali je tokom poslednje decenije sprovedeno nekoliko studija zahvaljujući aktivnoj grupi za istraživanje zlostavljanja starijih na Norveškom univerzitetu nauke i tehnologije u Trondhajmu. Poslednjih godina ovo istraživanje je rezultiralo sa tri završena doktorska i dva tekuća doktorska projekta, kao i drugim istraživačkim projektima. Ogromna većina studija sprovedena je u staračkim domovima, sa osobljem staračkih domova kao izvorom informacija/ispitanicima, ali postoje i studije koje koriste rođake kao izvor informacija i studije među osobama koje žive u domu sa demencijom.

Do sada su kvantitativne studije imale za cilj da otkriju i opišu različite aspekte zlostavljanja starijih, u smislu tipova i prevalencije, kao i njegovih asocijacija. Percepcije osoblja i rođaka o zlostavljanju i zanemarivanju su istražene u kvalitativnim studijama.

Ova kratka prezentacija će dati pregled najnovijih i aktuelnih studija o zlostavljanju starijih iz norveškog konteksta, kako iz institucionalnog tako i iz okruženja zajednice.

Nakon prezentacije, učesnici će dobiti uvid u istraživačke aktivnosti o zlostavljanju starijih u Norveškoj, pregled glavnih rezultata kao i uputstvo gde pronaći više informacija o različitim studijama.

Ključne reči: *zlostavljanje starijih, istraživanja, u institucijama, u zajednici, studije*

Original scientific paper UDK: 364-783-053.9(497.2)
616.98:578.834

Handed over: 19.01.2024.

Accepted: 26.01.2024.

NEED FOR HEALTH AWARENESS OF OLDER PERSONS IN STARA ZAGORA, BULGARIA WITH REGARD TO THE COVID-19 VACCINE PROPHYLAXIS

Hristina Milcheva¹³, Rozalina Yordanova¹⁴

Abstract

Older persons are a population that is vulnerable to various diseases as well as negative effects of environmental risk factors. Changes in their immune system contribute to increased frequency and severity of infections. Every year, more adults worldwide suffer from serious health problems for which vaccines are available. One of the factors in increasing life expectancy is the reduction of infectious diseases as a cause of morbidity and mortality.

The aim of our research: was to study perspectives of older persons on the necessity for health awareness on COVID-19 vaccine prevention, their willingness to be vaccinated and the reasons for hesitancy or refusal to vaccinate. Survey, interview, observation, analysis of scientific literature, statistics from regional databases were the materials and methods that we used to conduct our

¹³ **Hristina Milcheva**, Trakia University, Faculty of Medicine, Department of Healthcare, Stara Zagora, Bulgaria, email: hristina.milcheva@trakia-uni.bg

¹⁴ **Rozalina Yordanova**, Trakia University, Medical College, Stara Zagora, Bulgaria

study. In the period July-August 2022, we conducted a survey among 63 older persons from Stara Zagora, consisting of questions, aimed at the demographic data of the respondents, their awareness of the recommended COVID-19 vaccines, the reasons for refusing a vaccine, and the personal contribution of each of them to the protection of public health.

The results that we obtained were as follows: According to statistics, 23.9% of the sample in the Stara Zagora region received two doses of the COVID-19 vaccination between March 2020 and March 2021.

Our survey shows an approximate coverage of those vaccinated against the disease. The analyzed sample reveals that nearly half (29, 46%) of older persons have received a COVID-19 vaccine. The main reason why the surveyed older persons would not undertake vaccination was the lack of health awareness in (15, 33%), uncertainty in vaccine effectiveness (9, 20%), concern about the presence of side effects (23, 51%). Those who would not recommend vaccination to relatives and friends were not a small percentage (23, 51%). Nearly half of the respondents (29, 46%) would like to be informed about vaccine prevention against COVID-19, preferring to receive the information in the form of a health talk from a specialist in the field.

Conclusion: The health awareness of older persons about vaccine prevention would help to increase their motivation to vaccinate. Vaccination is the most effective strategy for preventing a number of infectious diseases, facilitating healthy aging and guaranteeing the maintenance of collective immunity at a high level.

Keywords: *Vaccine prophylaxis, COVID- 19, Health awareness, Older persons*

„It is not important to know everything, it is important to know where to find it.“

Albert Einstein

Introduction

Older persons are a population that is vulnerable to various diseases as well as negative effects of environmental risk factors. Vankova D. et al., 2014 conclude that people over 65 years of age have a lower health-related quality of life. According to Yordanova R. and Milcheva H., 2022 changes in older persons' immune system contribute to increased frequency and severity of infections. Every year, more adults worldwide suffer from serious health problems for which vaccines are available. This becomes a major social burden, as infectious diseases are often associated with long-term consequences such as disruption in daily activities, the onset of disabilities or loss of independence. Older persons often require continuous care at great financial and psychological cost to the public health system and to families. These diseases often lead to hospitalization, and sometimes to the death of patients. According to the National program for the improvement of vaccine prevention, 2023 the analysis of Bulgarians' health status reveals that the COVID-19 pandemic significantly affects general life expectancy and increases mortality, particularly among older persons. A key factor in increasing life expectancy is the reduction of infectious diseases as a cause of morbidity and mortality. According to Yordanova R. and Milcheva H., 2022, the vaccination is the most effective strategy for preventing a number of infectious diseases, facilitating healthy aging and guaranteeing the maintenance of collective immunity at a high level.

In recent years, vaccination plans have been individualized, paying particular attention to older persons at higher risk of infectious diseases,

distinguishing these individuals from older persons without co-existing chronic diseases. For this purpose, National program for the improvement of vaccine prevention is introduced. It seems that very little is known regarding vaccine prophylaxis in older persons who are at higher risk. This also applies to the COVID-19 vaccine, a concern for which a National Information Portal in Bulgaria was established – <http://coronavirus.bg>. Therefore, there is an urgent need to better understand the complex interactions between age, comorbidities, and the immune system in order to develop more immunogenic vaccines and to improve recommendation and awareness of older persons with comorbidities.

Vaccination hesitancy has been a concern worldwide for several decades, and the picture is even more controversial with recommended vaccines for adults and older persons. The conspiracy theories around the quick development and production of vaccines, especially those for COVID-19, as well as their composition, safety, and potential adverse effects, have a significant impact. This leads to hesitancy and reluctance to vaccinate among a significant part of the population, including educated people and those in the medical field. Based on trustworthy, scientific evidence on the advantages of vaccination, it is appropriate to increase health awareness among all groups in this direction, minimizing the risk of severe illness and mortality.

In their scientific research Porter E. et al., 2023 studied vaccination attitudes among older population in ten countries on two continents and found that misinformation did not play a decisive role in vaccination attitudes and behavior and based on the misinformation widely circulating around the world, there is no apparent effect on willingness to receive a vaccine. The results of another study by Bulgarian scientists Pancheva R. et al. 2023, highlight the significant relationship between attitudes towards vaccinations against COVID-19 and attitudes towards mandatory vaccinations for children, emphasizing the need for wide education in the context of low vaccination coverage against COVID-19 and the need of increasing con-

fidence in vaccines to strengthen the immunization program in Bulgaria. Research of Baev M. et al., 2021, registers attitudes towards vaccines against COVID-19 among Bulgarians over the age of 16 and shows a clear division in society on the issue. The proportion of those who trust vaccines is equal to the proportion of those who would not accept a vaccine against the coronavirus infection. Anti-vaccination attitudes in Bulgaria and abroad were taken into account, as they traditionally have an impact on immunization coverage in our societies. In their study, the research team directly observed some anti-vaccination opinions and the ongoing efforts to restrict public efforts to limit the pandemic. In his research, Petkov T., 2022 found that the lack of complete information about the vaccines themselves, as well as the poor awareness of the population, not only in the Burgas region in Bulgaria, but also in the whole country, is the main reason that the respondents, who would never get vaccinated are the majority.

The increased susceptibility to infectious diseases in older persons makes them an important target group for vaccination. Most vaccines are less immunogenic and effective in this population due to age-related changes in the immune system.

Immune prophylaxis is constantly improving along with the progress of medical sciences by developing more advanced technologies for safe and more effective vaccines, which increases the population health status. Centers for Disease Control and Prevention, 2023 and Ivanova V. et al., 2017 demonstrated the significance of vaccinations and immunomodulators in preventing a number of harmful viral and bacterial illnesses. As health and travel opportunities increase in old age, the importance of travel vaccines for those over 60 years of age is increasing. However, according to Weinberger B. and Grubeck-Loebenstein, 2012, little is known about the immunogenicity and efficacy of travel vaccines in this age group. According to the World Health Organization, in addition to the development of new vaccines, (including against COVID-19) it is crucial to raise awareness

of the importance of vaccination beyond the pediatric area, as vaccination coverage is still far from optimal for the older population. It is necessary to emphasize the key role of health professionals in increasing the health awareness of the population, including the benefits and risks of vaccination.

Aim

The aim of our research was to study perspectives of older persons on the necessity for health awareness on COVID-19 vaccine prevention, their willingness to be vaccinated and the reasons for hesitancy or refusal to vaccinate.

Metodology of Research

In the period July-August 2022, we conducted a survey among 63 older persons from Stara Zagora, Bulgaria, consisting of questions, aimed at the demographic data of the respondents, their awareness of the recommended COVID-19 vaccines, the reasons for refusing a vaccine, and the personal contribution of each of them to the protection of public health. We did an observation and analysis of all the surveys, scientific literature and regional databases related to the subject.

Results and Discussion

Demographic data: The gender and age distribution of the respondents is presented in Figures 1 and 2. In the sample, there were 42 women (67%), and the largest number of representatives is in the 51-60 and 61-65 age groups (18 for each group).

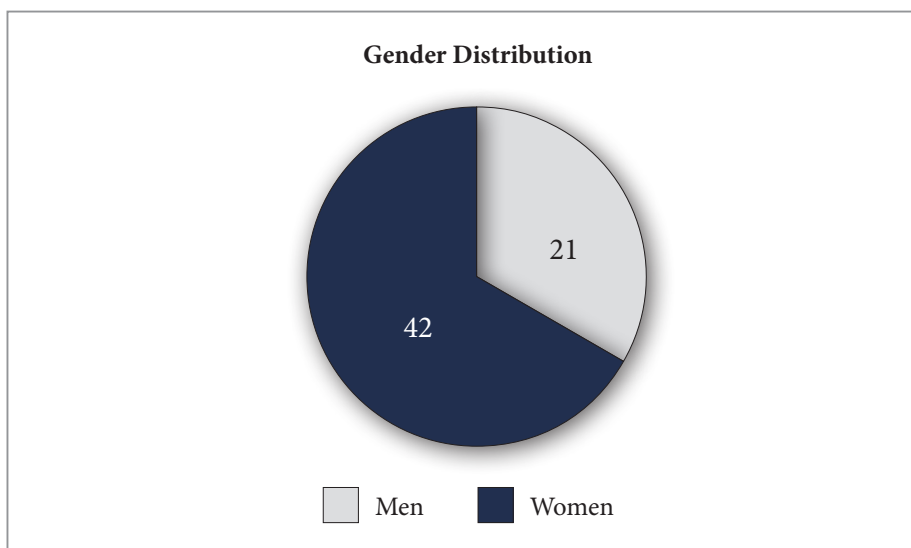


Figure 1. Gender distribution of the respondents surveyed

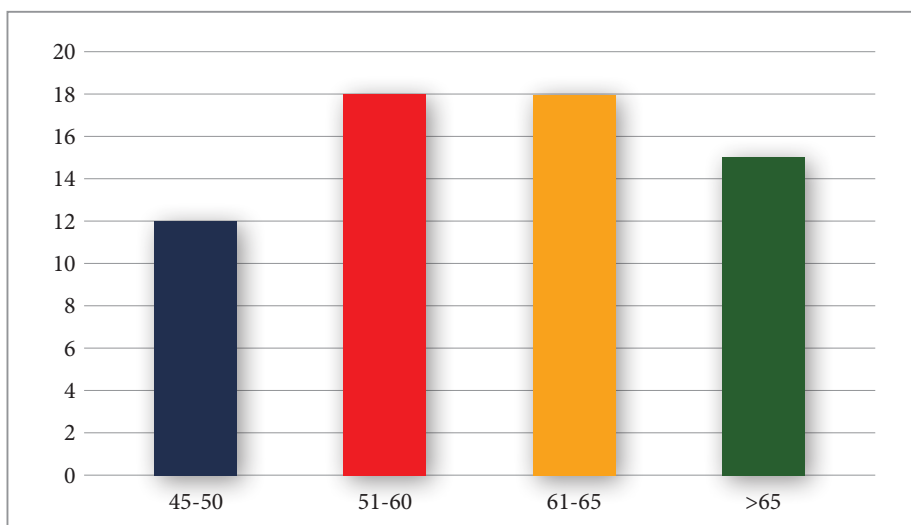


Figure 2. Age distribution of the respondents surveyed

According to statistics provide by Yordanova R. and Milcheva H., 2022, 23.9% those who were surveyed in Stara Zagora region received two doses of the COVID-19 vaccination between March 2020 and March 2022. Our survey shows an approximate coverage of those vaccinated against the disease.

In our study we found that the main reason why the surveyed older persons undertook vaccination was to protect themselves and their relatives from infection (60%). Other reasons given in a significantly smaller percentage (7% each) of those surveyed are: stopping the flow of patients to hospitals, family recommendation, peace of mind, personal responsibility (Figure 3).

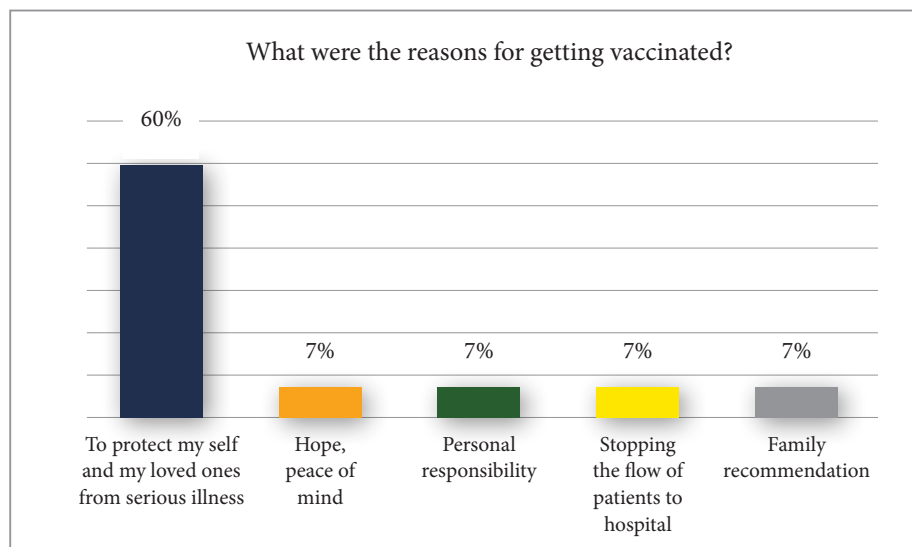


Figure 3. Reasons for being vaccinated

Many of the respondents are unsure (45%) or would not at all recommend vaccination to their relatives and friends (31%), which, at almost half of the study population is a significant proportion, (Figure 4).

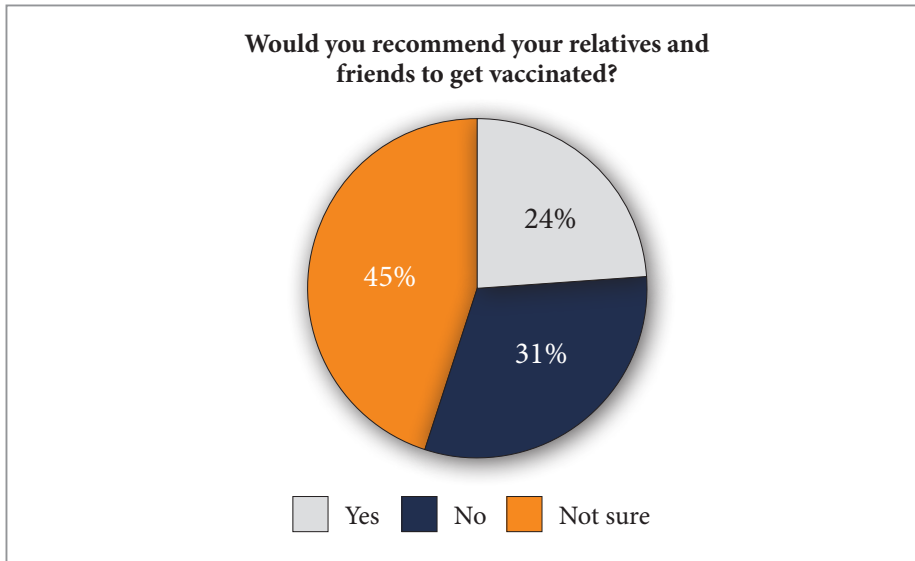


Figure 4. Recommend or not the COVID-19 vaccination

The main reason why the respondents would not take vaccination was the lack of health awareness (15, 33%), uncertainty in vaccine effectiveness (9, 20%), and concern about the presence of side effects (23, 51%) (Figure 4). As we indicated above, the scientific studies in the recent years looked into people's attitude towards vaccines and society's attitude towards them. A wider information campaign is needed regarding the benefits and risks of vaccines for older persons, especially those for COVID-19.

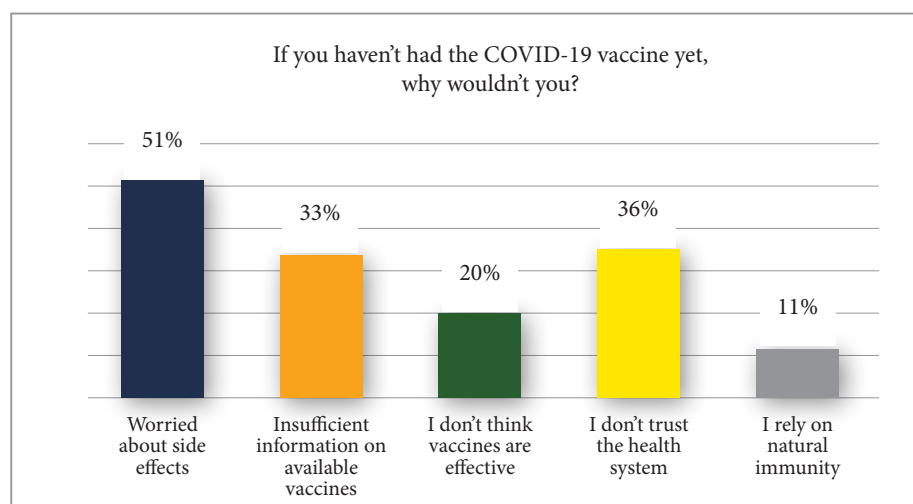


Figure 5. Reason why the respondents would not take vaccination

Almost half (29, 46%) of the surveyed would like to be informed about the vaccine prevention against COVID-19, preferring to receive the information in the form of a health talk from a specialist in the field (Figure 5). We believe that although our sample of covered respondents is not very large, the results are nevertheless indicative and confirm the need for health awareness that could be provided by competent people through various ways, including media, social networks and the Internet.

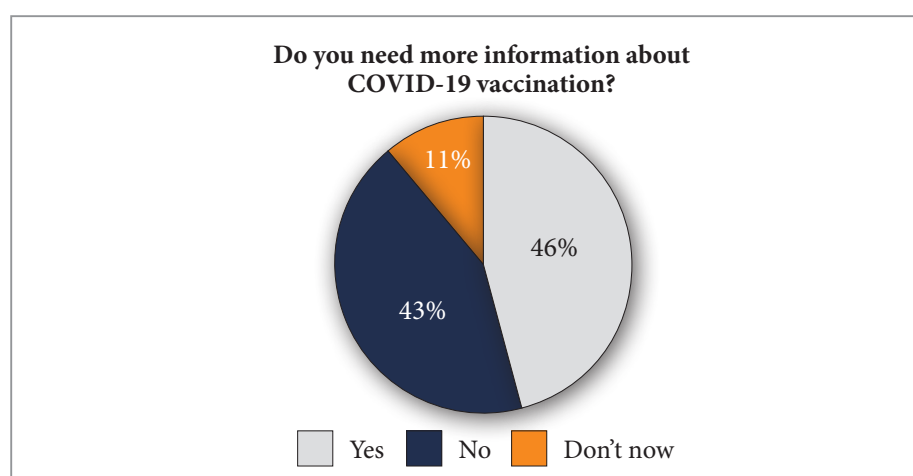


Figure 6. Need of awareness about COVID-19 vaccination

Discussion and Conclusion

Although the percentage of older persons who have received vaccination is low at the population level, the Stara Zagora region has seen an increase, 2023 in the proportion of studied sample of older persons who are vaccinated.

The main reason why the adults surveyed would not take vaccination was lack of health awareness, uncertainty in the effectiveness of vaccines, concern about the presence of side effects and therefore would not recommend vaccination to relatives and friends.

Almost half of the respondents would like to be informed about vaccine prevention against COVID-19, preferring to receive the information in the form of a health talk from a specialist in the field.

Conclusion: Vaccination is the most effective strategy for preventing a number of infectious diseases at the population level. It is essential to develop vaccination strategies specifically tailored to older population, in terms of both vaccine composition and vaccination protocols, taking into account the aging immune system and inflammation, the two main features of aging. According to the World Health Organization, 2023, increasing the effectiveness of vaccine implementation worldwide requires a planned and coordinated effort by health institutions in all countries. The health awareness of older persons about vaccine prevention would help to increase their motivation to vaccinate. Using human resources (healthcare professionals) rationally to increase the health awareness of the population, regarding the benefits and possible risks of vaccination, is an important condition for expanding the number of the vaccinated.

References

Baev M., Naseva E., Stoilchev G. (2021), Attitudes towards vaccines against COVID-19 in Bulgaria, *General medicine*, 23(4): 10-18.

Centers for Disease Control and Prevention, Vaccines, available at: <https://www.cdc.gov/vaccines/index.html>

https://health.ec.europa.eu/system/files/2022-01/2021_chp_bulgaria_bulgarian.pdf

Ivanova V., Dimitrova D., Ivanova E., Gergova R., (2017), Prevention of infections by vaccines and immune modulators, *Varna Medical Forum*, 6(2):310-321.

National Information Portal in Bulgaria regards Covid-19, available at: <http://coronavirus.bg>

National program for the improvement of vaccine prevention, available at: https://www.mh.government.bg/media/filer_public/2023/01/30/natsionalna_programa_za_podobriavane_na_vaksinoprofilaktikata_na_sezonniia_grip_i_pnevmonokokovite_infektsii_2023-2026

Pancheva R., Chamova R., Ivanova E., Kolarova M., Rohova M., Hadzhieva S., Mihailov N., Radeva N., Paunov C. (2023), Attitudes towards vaccination against COVID-19 and the mandatory immunization calendar in Bulgaria, *Pediatrics*, 63(3): 23.

Petkov T. (2022), Public attitudes of the population related to “Covid-19”, *Management & Education*, 18(6): 70.

Porter E., Velez Y., Wood T.J. (2023), Correcting COVID-19 vaccine misinformation in 10 countries, *Royal Society open science*, 10(3), 221097.

State of Health in the EU , The health profile of the country , 2021

Weinberger B., Grubeck-Loebenstien B. (2012), Vaccines for the elderly, *Clinical microbiology and infection: the official publication of the European Society of Clinical Microbiology and Infectious Diseases*, 18 (5): 100-108.

World Health Organization, Vaccine safety, available at: <https://www.who.int/vaccinesafety/initiative/tools/>

Yordanova R., Milcheva H., (2022), Vaccine prophylaxis in elderly - advantages and risks, *Management & Education*, 18(5): 100-102.

POTREBA ZA ZDRAVSTVENOM SVEŠĆU STARIJIH OSOBA U STAROJ ZAGORI U VEZI SA PROFILAKTIČKOM VAKCINOM PROTIV KOVID-19

Hristina Milcheva, Rozalina Yordanova

Rezime

Starije osobe su populacija koja je podložna raznim bolestima kao i negativnim uticajima faktora rizika životne sredine. Promene u njihovom imunološkom sistemu doprinose povećanju učestalosti i ozbiljnosti infekcija. Svake godine sve više odraslih ljudi širom sveta pati od ozbiljnih zdravstvenih problema za koje su dostupne vakcine. Ključni faktor u povećanju očekivanog životnog veka je smanjenje zaraznih bolesti kao uzroka morbiditeta i mortaliteta.

Cilj: Proučiti stavove starijih o neophodnosti zdravstvene svesti o prevenciji vakcinacije protiv KOVID-19, njihovoj spremnosti da se vakcinišu i razlozima oklevanja ili odbijanja vakcinacije.

Materijali i metode: anketa, intervju, posmatranje, analiza naučne literature, statistika iz regionalnih baza podataka. U periodu jul-avgust 2022. godine sprovedi smo anketu sa 63 starije osobe iz Stare Zagore, koja se sastojala od pitanja, usmerenih na demografske podatke ispitanika, njihovu svest o preporučenim vakcinama protiv KOVID-19, razloge odbijanja vakcine, i lični doprinos svakog od njih zaštititi javnog zdravlja.

Rezultati i diskusija: Prema statističkim podacima, 23,9% uzorka u starozagorskom regionu primilo je dve doze vakcine protiv KOVID-19 u periodu od marta 2020. do marta 2021. Naša anketa pokazuje približan obuhvat onih koji su vakcinisani protiv ove bolesti. Analizirani uzorak otkriva da je skoro polovina (29, 46%) starijih osoba primila vakcinu protiv KOVID-19. Glavni razlog zašto ispitane starije osobe ne bi da primime vakcinu bio je nedostatak zdravstvene svesti kod (15, 33%), nesigurnost u efikasnost vakcine (n = 9, 20%), zabrinutost zbog prisustva neželjenih efekata (23, 51%). Nije mali procenat onih koji ne bi preporučili vakcinaciju rođacima i prijateljima (23, 51%). Skoro polovina ispitanika (29, 46%) bi želela da se informiše o vakcinaciji protiv KOVID-19, najradije da informacije dobije u vidu zdravstvenog razgovora sa specijalistom iz te oblasti.

Zaključak: Zdravstvena svest starijih o vakcinaciji pomogla bi da se poveća njihova motivacija za vakcinaciju. Vakcinacija je najefikasnija strategija za prevenciju niza zaraznih bolesti, omogućava zdravo starenje i garantuje održavanje kolektivnog imuniteta na visokom nivou.

Ključne reči: *profilaktičke vakcine, KOVID-19, zdravstvena prevencija, starije osobe*

Original scientific paper UDK: 316.621-053.6/.9
616.98:578.834

Handed over: 20.12.2023.

Accepted: 12.01.2024.

INTERGENERATIONAL SOLIDARITY IN THE CRISIS TIMES: ON THE BORDER BETWEEN PERSONAL CHOICE AND SOCIAL RESPONSIBILITY

**Natasa Todorovic¹⁵, Teodora Hrnjakovic¹⁶,
Milutin Vracevic¹⁷, Milos Todorovic¹⁸**

Abstract

Intergenerational solidarity represents a social construct and an unbreakable bond between the youth and the old age, knowledge and experience, vision and wisdom. Exchange between generations encourages humanity, empathy, love and tolerance, and this way of accepting differences and rejecting stereotypes when it comes to the older population ennobles the society especially.

Nurturing intergenerational solidarity is a prerequisite for social well-being and a sensible community which recognizes networking, validation and support instead of labelling, rejection and misunderstanding. During transition, this kind of solidarity stands out, knowing that social sensitivity in

¹⁵ **Natasa Todorovic**, Red Cross of Serbia, natasa@redcross.org.rs, Gerontological Society of Serbia

¹⁶ **Teodora Hrnjakovic**, University of Belgrade – Faculty of Political Science, teodorahrnjakovicfpn@yahoo.com

¹⁷ **Milutin Vracevic**, Red Cross of Serbia, milutin@redcross.org.rs, Gerontological Society of Serbia

¹⁸ **Milos Todorovic**, Growit Agile, m.dj.96.fb@gmail.com

crisis times demands integrated community aiming towards social progress. COVID-19 pandemic especially emphasized solidarity as a value and reminded us how important intergenerational exchange is in times of social stagnation.

Within the SHAI project and regarding the World Elder Abuse Awareness Day, 15th June, Red Cross of Serbia organized intergenerational workshops in Boljevac, Zaječar, Kragujevac, Užice, Sombor and Subotica. 248 persons (176 women and 72 men) attended. Structured questionnaire named “Intergenerational solidarity: quantitative research” was used to interview the participants and they were divided into three age groups: below 30, between 31 and 65 years of age and over 65. Interview results show that consent between all age groups exists when it comes to intergenerational solidarity in contemporary society.

According to the opinion of the participants, the key actors in development of intergenerational solidarity are the family, media and education system, and more than two third of respondents think that COVID-19 has brought generations together. One thing that all interviewees agree on is that the activities of healthy ageing and campaign on the Decade of Healthy Ageing may contribute to promotion of intergenerational solidarity, which is essential for further social development.

Keywords: *intergenerational solidarity, virus COVID-19, responsibility, older people, society*

Intergenerational solidarity

Intergenerational solidarity is a phenomenon of special value for social and economical development. Although this phenomenon has different interpretations and definitions, perhaps most important of them all is that it represents social cohesion within society, and that it encourages closeness, understanding and mutual support (Bengston, Olander and Haddad, 1976). Intergenerational solidarity can be manifested in various situations, between different social groups - family members, employees in organisations, young and older and others, but the result of such interactions is development of positive relationships between the interacting individuals. In times of crisis, such as wars, epidemics, economic crisis, migrations and natural disasters, this kind of understanding and mutual help between generations is of great importance for survival and further prosperity of society. Crisis times mostly bring fear for the population, uncertainty about the future, struggle for personal survival and make people question their very existence, and interpersonal relationships especially may become shaky. During such periods, society and individuals are particularly vulnerable, and all the perceived pros and cons of a certain age group come to the surface. Empowering the entire community is in resources which would enable vulnerable groups to overcome challenges that they are facing, with the help of another group which has the resources for such situations. When it comes to the older community, resources which they possess are wisdom, previously acquired experience, years of service, stable relationships and steady financial income (pension). Speaking of youth, pros of this age group are youthful optimism, preparedness, creativity and physical fitness, which would successfully respond to the needs of older generations whose cognitive and physical abilities are no longer sufficient for their needs. Because of listed reasons, the need for this kind of work comes from the tendency to point out the meaning of intergenerational solidarity and its role during times of crisis.

Intergenerational solidarity is a complex concept and a social contract which enables socio-economical development, building bridges within families and communities, especially when common characteristics and interests are present. Additionally, it connects people through values, emotions, exchange and consensus and it offers the possibility of imparting knowledge and culture between different age groups – children, youth, adults and the older persons (Cruz - Saco, 2010). This phenomenon represents the challenge as a subject of research, since it is composed of multiple elements. Six main dimensions which help in measuring of intergenerational solidarity in research practices are:

- Solidarity through association – frequency and patterns of interactions between family members in different activities;
- Emotional solidarity – degree of positive attitudes towards family members and the degree of reciprocity of these relationships;
- Consensual solidarity – degree of investment in values, positions and beliefs between family members;
- Functional solidarity – degrees of help and resource exchange;
- Normative solidarity – level of commitment to your role in family and fulfilment of family obligations;
- Structural solidarity – geographic distance between family members (Bengtson and Roberts, 1991).

Intergenerational solidarity represents exchange, but support as well; it can be represented in three ways:

- Practical support – it reaches between different generations within the family, and it represents help to parents about the chores, parental care, nurture in case of illness or disablement, care about children and else;
- Financial support – financial exchange between different generations;
- Social support – value of this support can be seen through children visiting older parents, giving advice or care (Kalmijn, 2005).

Every means of support is care giving as well, so it is important to pay attention to these informal caregivers as one of the main resources of intergenerational solidarity. According to the Canadian Coalition of Informal Caregivers, an informal caregiver is a person who provides constant care and nurturing without reimbursement for their family members and friends who need help because of physical, cognitive or mental health problems (Canadian Caregiver Coalition, 2001). The definition of informal caregivers provides values which this invisible social group promotes and it reflects in solidarity, mutual care and support. Position of informal caregivers in modern society is insufficiently recognized by formal decision makers dealing with family protection, although there are positive moves to development of a system of long term care in our society. Unlike the formal type of care which implies professional relationship, financial compensation, defined working hours and the right to vacation and sick leave, informal caregiving is provided in relationships which are characterised by mutual closeness, trust and love, and this kind of caregiving is specified and economically invisible (Todorović and Vračević, 2023). In that regard, informal caregiving promotes intergenerational solidarity, and in times of crisis this kind of care represents priority in family systems and between different generations. The fact is that around the world informal care is given by 249 million women and 132 million men (United Nations, 2023), which shows its value and presence, but also the lack of sufficient recognition by formal systems of care.

Opposed to intergenerational solidarity as a concept which is necessary for sustainability of mankind, intergenerational ambivalence and family disputes are especially pronounced in transition times and socially sensitive situations. The theory of intergenerational ambivalence is based on the idea that a high level of closeness, care and support can exist alongside displays of conflict and tension (Luescher and Pillemer, 1998). Ambivalence can exist on multiple levels – looking at the entire relationship we can explain in what way it functions and how this relationship is structured. On the other hand,

only specific aspects of a relationship and interactions within can be seen as ambivalent (Sones, 2016). Researchers believe that ambivalence is a normal aspect of family functioning and that these conflicts help family members to see one another and improve family relations (Lowenstein, 2007).

The importance of intergenerational solidarity in modern society can be seen by UN's advocacy for this kind of relationship as well as actions which are meant to create the world for all ages as a prerequisite for fulfilling the needs of a sustainable development, without leaving anyone behind (UN, 2022). However, rising changes in modern society, first and foremost demographic ageing, pose a question of mutual cooperation, exchange and solidarity between different generations, all of it with the aim of reaching general social wellbeing. World's Health Organization data show that the population ages much faster than it was in the past, and that in 2030 one out of six persons on the planet will be over 60 years of age. It means that the share of the older population will rise from one billion, which was the case in 2020 up to 1.4 billion by 2030 (WHO, 2022). On the other hand, the intensifying migration of young and working active population reduces the capacity for networking, deeper connections and understanding of the needs of older members of the society. Challenges that the older population faces include diversity in the ways of ageing. Ageing is an individual process which requires the recognition of the spectre of needs of older persons, and understanding of the degree of dependency of this group in the society (due to a loss of certain cognitive and physical functions) and readiness to provide help when older persons face challenges (Ibid). One of commitments for improving the quality of life of older persons is global cooperation through The United Nations Decade of Healthy Aging (2021 – 2030) which is coordinated with Sustainable Development Goals. The goal of Decade of Healthy Aging is dignified life in an environment favourable for growth, life, play and ageing (WHO, n.d.). However, the disappearance of the traditional family model (due to many people who become parents at a later age

or the people who choose not to have children at all) jeopardises establishment of intergenerational solidarity, alongside the reduced birth rates and disbalance in older-younger relationship (Todorović and Vračević, 2023). According to the last Census in 2022, average age in Republic of Serbia is 43.8, and women are approximately three years older than men. Share of the older population compared to the entire population equals 22.1 percent, while in 2011 it amounted to 17.4 percent. Trend of decreasing share when it comes to persons between 15 and 64 is present - from 68.3 percent to 63.5 percent, while the population younger than 15 has not shown any significant changes (Republic Institute for Statistics, 2023). This kind of data shows that the Republic of Serbia follows the same statistical trends of the world population when it comes to increasing share of older population, which poses a challenge and a question for consideration on future establishment of intergenerational solidarity.

Research conducted by the Red Cross of Serbia in 2019 on the topic of intergenerational exchange in Serbia shows that 37.6 percent of older persons have difficulties performing activities of daily life, and it is estimated that up to 90 percent of the older persons in Serbia relies on the help within a family. When it comes to intergenerational exchange, the most frequent way of exchange is providing financial aid and gifts, and then the support in activities of daily life. When it comes to services, 13.1 percent provide help with activities of daily life on regular basis. Research also shows that the young and the middle aged people get financial aid from the older persons, while older persons get help in services from younger generations (Vračević et al, 2019). One of the most transparent examples that represent solidarity in Serbian society is the pension system. In Serbia, so called PAYG (pay as you go) system is established on the concept of intergenerational solidarity, and it implies financing of pensions from contributions which are being paid by the current generation of the employed, who are gaining the right to financing of their own pensions by the means of future generations (Stanić

et al, 2009). Research conducted in Serbia during 2019 by the Red Cross of Serbia has shown that the state has the largest responsibility (47.4%) in giving financial aid to older persons (while families provide 26.5% of financial aid), and that the dominant responsibility of families is to provide help to older persons in doing activities of daily life. In separate interviews the opinions were divided: 44.9% of interviewed population think that financial aid is a family responsibility while 40.6% states that it is a responsibility of the government (Todorović et al, 2019).

Crisis situations represent the periods when intergenerational solidarity is especially emphasised, or when it lacks. In emergencies risks that occur are enhanced and they primarily depend on the very characteristics of the situation, but also on the individuals. Children and adolescents, older persons, people with health problems, people living in poverty, women and minority populations represent particularly sensitive groups (Todorović and Vračević, 2023). COVID-19 pandemic presented uncertainty and danger to all generations. Its prevalence affected intergenerational solidarity, on a macro and micro level. In that regard, WHO posted an appeal for international cooperation and solidarity as key values for restoring global health security, in present time and in the future as well (WHO, 2020). The Age Platform Europe pointed out that COVID-19 is a serious global challenge which requires strong action, at the European Union level, and through national actions. "It is our responsibility to be present for people around us during the pandemic - to help our families, friends, neighbours and everybody else in our community, and the key component of action is the support to vulnerable groups and solidarity as an answer as collective response to pandemic. Further on, Age Platform Europe points out that during the pandemic the existence of social cohesion and solidarity between generations was needed more than ever" (Age Platform Europe, n.d.).

In the Republic of Serbia, COVID-19 pandemic affected all generations, and especially socially sensitive groups. Research that was conducted by the Social Inclusion and Poverty Reduction Unit (SIPRU) of the Government of Serbia in cooperation with the organisation Help Net on the impact of the pandemic shows that older population during the pandemic has been especially affected by the governmental measures of isolation, mandatory wearing of masks and social distance. These measures were introduced to ensure preservation of health of older population through minimising contact and risky exposure. For this paper it is of special importance that most of the older population during the pandemic received help from their relatives, friends, neighbours, i.e. their informal social network (Jovanović, Đukić and Ajvazović, 2021). Further on, the research done by Labaš on challenges of active ageing and mental health during pandemic COVID-19 in Serbia shows that older persons mostly think that the pandemic is a stressful life event which has an impact to their mental health, triggering negative emotions such as the feeling of uncertainty, fear, sadness. Thanks to their environment, lifestyle that includes active ageing and personal strategies in battling stress, most of the interviewed older persons have managed to successfully overcome the challenges that the pandemic has brought (Labaš, 2021).

SHAI Project

The European Union Support to Social Housing and Active Inclusion (SHAI) project was implemented between 2 August 2021 and 31 July 2022 with support provided by European Union and the United Nations Population Fund (UNFPA). It had several components and objectives with the second one, “Support to older persons health and inclusion during and in the aftermath of COVID-19 crisis” being relevant for the activities described herewith. In the framework of the project, the implementing Red Cross of Serbia branches in Boljevac, Kragujevac, Sombor, Subotica, Užice and Zaječar have organised intergenerational discussions/workshops on 15 June, on the occasion of the World Elder Abuse Awareness Day. These workshops were attended by 248 people (72 men and 176 women). These occasions were used to poll the participants on the topics related to intergenerational solidarity using a structured questionnaire entitled “Intergenerational Solidarity: Qualitative Research”. The respondents were divided into three age groups: 1. Those below 30, 2. Those between 31 and 65 3. Those over 65.

In general, all groups agree that intergenerational solidarity exists in the contemporary society in Serbia. Further on, the degree of agreement with individual questions will be analysed in more detail. The participants are also in agreement on the key influences on the development of intergenerational solidarity in individuals, with the overwhelming majority of all age groups recognising family, the education system and the media as the key factors in this development. More than two thirds of all respondents think that the COVID-19 pandemic brought the generations closer together and almost 100% agree that Healthy Ageing activities and the Decade of Healthy Ageing campaigns will contribute to improving intergenerational solidarity, as well as that intergenerational society is essential for the development of the society. The responses show that younger respondents have more favourable opinions on contributions of both generations to the national economy.

In the age group below 30, there were 67 respondents in total, 78.8% of them female and 21.2% male. Most of them have high school level education (65.2%) with 13.6% having completed only primary school and 21.2% having completed college or university studies. Majority of respondents in this group agree that intergenerational solidarity is present in the contemporary society (68.2%) but as high as one fifth (21.2%) denies its existence while 10.6% think it is only partially present. Out of those who believe it is present, 15.6% claim that they see it in all segments of daily living. It is encouraging to see that 76.2% of the respondents in this age group recognise pension system as an example of intergenerational solidarity (Kasagi, 2021), while 97% agree that family influence is key in developing the sense of intergenerational solidarity in a person. 76.9% also agree that the system of education plays a key role as well, but even more (81.8%) see the media as essential in this regard. An interesting split can be observed regarding whether modern technologies contribute to increased intergenerational solidarity. Only 51.5% of the respondents agree, while 48.5% disagree. Regarding whether the COVID-19 pandemic managed to bring the generations together, 74.2% agree with this statement. The respondents also overwhelmingly disagree with the supposition that older persons present a burden to the national economy (84.4%), but not an insignificant proportion (15.6%) agrees with this statement. On the flipside, 70.8% disagree with the statement that persons in their twenties provide insignificant contribution to the national economy. 94.9% of the respondents agree that Healthy Ageing activities and the Decade of Healthy Ageing campaigns will contribute to improving intergenerational solidarity, while all the respondents agree that intergenerational society is essential for the development of the society.

In the age group between 31 and 65 there were 113 respondents, 67.3% of them female and 32.7% male. Almost a clean half – 51.3% – of a high school education level, whereas 48.7% are college and university graduates. Majority of the respondents in this age group – 73.5% – consider intergen-

erational solidarity to be present in the contemporary society, but a fifth (20.4%) deny its existence and 6.2% think it is only partially present. In this age group, the majority (56.9%) do not consider pension system as an example of intergenerational solidarity. Family influence is overwhelmingly recognised as essential for developing intergenerational solidarity in an individual (92.9%), while 78.4% agree that the education system is also a key influence. 78.6% agree that the media play an essential role in this regard as well. Regarding the contribution of modern technologies to development of intergenerational solidarity, this age group has a more optimistic outlook: 65.4% agree with this statement. 64.9% also agree that the COVID-19 pandemic contributed to bringing people of different generations closer together in a positive way. In regards to the burden to the national economy, a clean third (33%) think that older persons are in fact a burden while two-thirds (68.1%) think that persons in their twenties do not contribute significantly to the national economy. Majority agrees that Healthy Ageing activities and the Decade of Healthy Ageing campaigns will contribute to improving intergenerational solidarity (96.4%) and 99.1% consider intergenerational solidarity essential to the development of the society.

There were 72 respondents in the over 65 age group, 76.4% female and 23.6% male, 55.6% of them with high school education, 31.9% with college or university degrees and 12.5% with just primary school. More than half of the respondents (58.6%) agree that intergenerational solidarity exists in the contemporary society – which is lower than among younger respondents. 31.4% deny that it exists and 10% recognise it only partially. This group considers the pension system as an example of intergenerational solidarity: with 63.9% agreeing that it is a good an example of this concept. 95.7% the respondents are of the opinion that the family is essential for developing a sense of intergenerational solidarity in individuals, while 73.9%% consider education system to be very important in this sense and 83.1% agree that the media plays the key role. This group, however, is overwhelmingly of the

opinion that modern technologies contribute to increased intergenerational solidarity (75.4%) and more than two thirds (71.8%) are of the opinion that COVID-19 brought the generations closer together. In regards to burdening the economy 39.7% agree that older persons are a burden for the national economy. As for the persons in their twenties and their contribution to the national economy, 66.7 % think that the contribution is insignificant. 92.3% of the respondents agree that Healthy Ageing activities and the Decade of Healthy Ageing campaigns will contribute to improving intergenerational solidarity and 98.6% of them agree that intergenerational solidarity is significant for the development of the society. Considering the differences in opinion and attitudes between generations, in some cases very significant, it is clear that further research will be needed to explore the causes of these differences and provide suggestions on how to address them in the future.

Concluding consideration

Networking and respect between different generations present a prerequisite for quality life and dignified old age. In times of crisis, as it was with the COVID-19, sharing of experiences, skills and acceptance of different identities and nurturing of universal values through joint work and socializing is of crucial importance for the survival of the entire community. Talking about intergenerational solidarity during COVID-19 crisis, research performed within the framework of SHAI project has shown that the majority of interviewed people think that intergenerational solidarity exists in a modern society in Serbia, and that the development of this phenomenon is mostly influenced by family, followed by education system and the media. Results of the same research show that the pandemic has brought something good, meaning that two thirds of participants think that COVID-19 virus has brought generations closer together. Prejudices about different generations are not as prevalent as it may seem as shown through younger participants supporting the opinion that both younger and older generations contribute to national economy. Finally, almost all participants agreed that the activities of healthy aging and campaign within the Decade of Healthy Ageing will contribute to development of intergenerational solidarity which also represents the key factor for further development of society. COVID-19 pandemic has left long term consequences to all age groups. Losses in one's family and social circle, fear for their own safety and health of the nearest and dearest have influenced mental health and social wellbeing on a global level. The answer for overcoming such hardships that come along with emergencies and of transition periods should be predominantly looked for in intergenerational cooperation, on micro level (smaller groups such as family and friends), and on macro level (in relationships between younger and older persons through larger social groups). Behind every collective responsibility there is an individual who should serve as an example with their personal choices to all past, present and future generations. In the times of crisis when solidarity calls for action, we are all reminded that humanity thrives on togetherness, not on alienation.

References

Age Platform Europe (n.d.). *Covid – 19: with great challenge must come great solidarity*, available at [COVID-19: with great challenge must come great solidarity - AGE Platform Europe \(age-platform.eu\)](https://age-platform.eu/covid-19-with-great-challenge-must-come-great-solidarity) accessed on 23.11.2023.

Bengston, V.L. & Roberts, E.L. (1991). Intergenerational Solidarity in Ageing Families: An Example of Formal Theory Construction. *Journal of Marriage and the Family*, pp. 856 – 870.

Bengston, V.L., Olander, E.B. & Haddad, A.A. (1976). *The “generation gap” and ageing family members: Toward a conceptual model*. U.J.F. Gubrium (Ed). *Times, roles and self in old age*. Human Sciences Press; New York, pp. 237 – 263.

Bengston, V.L., Scharder, S.S. (1982). Parent – Child Relations. Research Instruments in *Social Gerontology*, vol. 2, University of Minnesota Press, Minneapolis, pp. 115 – 128.

Cruz – Saco, M. (2010). *Intergenerational solidarity. Intergenerational solidarity: strengthening economic and social ties*. New York. Palgrave Macmillan, pp. 9 – 34.

Jovanović, V., Đukić, D., Ajvazović, M. (2021). *Istraživanje o uticaju epidemije virusa kovid 19 na položaj osetljivih grupa u Republici Srbiji (stariji, osobe sa invaliditetom, LGBT)*. Tim za socijalno uključivanje i smanjenje siromaštva Vlade Republike Srbije.

Kalmijn, M. (2005). *International solidarity: A review of three theories and their evidence*, available at [Intergenerational solidarity : A review of three theories and their evidence | Semantic Scholar](https://www.semanticscholar.org/entry/International-solidarity-A-review-of-three-theories-and-their-evidence).

Kasagi, E. (ed.) (2021). *Solidarity Across Generations, Comparative Law Perspectives*, Springer Cham.

Labaš, S. (2021). *Društveni aspekti starenja u vreme pandemije kovida 19: izazovi aktivnog starenja i mentalno zdravlje u vreme pandemije kovida 19 u Srbiji*. Univerzitet u Beogradu: Filozofski fakultet.

Lowenstein, A. (2007). Solidarity – conflict and ambivalence: Testing two conceptual framework and their impact on quality of life for older family members. *The Journal of Gerontology, Series B: Psychological Sciences and Social Sciences*, 62:S100-S107.

Luesscher, K. & Pillemer, K. (1998). Intergenerational Ambivalence: A New Approach to the Study of Parent – Child Relations in Later Life. *Journal of Marriage and the Family*, 60 (2): 413 – 425.

Lum, J. (2011). Informal Caregiving, available at <https://www.toronto.ca/content/dam/crncc/knowledge/infocus/informalcaregiving/InFocus-InformalCaregiving.pdf> accessed on 22.05.2023.

Luscher, K. (2002). Intergenerational Ammbivalence: Further Steps in Theory and Research. *National Council on Family Relations: Journal of Marriage and Family*, Vol. 64, No. 3. pp. 585 – 593.

Mekić, D. & Antonijević, I. (2020). *Smernice za postizanje međugeneracijske saradnje i solidarnosti u zajednici*. Beograd: Beogradski centar za ljudska prava.

Republički zavod za statistiku (2023). *Starost i pol*, available at [STA-ROST I POL | O POPISU STANOVNIŠTVA \(stat.gov.rs\)](https://stat.gov.rs/) accessed on 15.11.2023.

Sones, R.J. (2016). *Exploration of Intergenerational Ammbivalence, Parenting Practices, and the Impact on Grandparenthood Dimensions*. University of Northern Colorado: College of Education and Behavioral Sciences – Department of Applied Psychology and Counselor Education.

Stanić, K., Matković, G., Bajec, J., Chiappe, R. & Rakić, N. (2009). *Penzijski sistem u Srbiji*. Beograd: BearingPoint.

Todorović, N., Vračević, M. (2019). *Međugeneracijska saradnja za početnike*, Beograd: Centar za odgovornu akciju.

Todorović, N., Vračević, M. (2023). *Ja, neformalni negovatelj: vodič za neformalne negovatelje*. Beograd: Crveni krst Srbije.

Todorović, N., Vračević, M., Stanisavljević, D. & Milić, N. (2019). *Međugeneracijska solidarnost između porodice i države*. Beograd: Crveni Krst Srbije.

United Nations (2022). *International solidarity: creating a world for all ages*, available at [International Youth Day 2022: Intergenerational Solidarity: Creating a World for All Ages | United Nations For Youth](#), accessed on 10.06.2023.

United Nations (2023). *International Day of Care and Support*, available at [International Day of Care and Support | United Nations](#) accessed on 03.11.2023.

Vlajić, M. (2021). Dominantni teorijski pristupi u proučavanju intergeneracijskih odnosa u porodici. *Sociologija*, Vol. LXIII, No. 4,

Vračević, M., Todorović, N., Zajić, G. & Kuzmanov, L. (2019). *Međugeneracijska razmena u Republici Srbiji*. Beograd: Crveni krst Srbije.

World Health Organization (2020). *Solidarity Call to Action*, available at [Solidarity Call to Action \(who.int\)](#) accessed on 17.07.2023.

World Health Organization (2022). *Ageing and Health*, available at [Ageing and health \(who.int\)](#), accessed on 10.06.2023.

World Health Organization, *WHO's work on the UN Decade of Healthy Ageing (2021 – 2030)*, available at [WHO's work on the UN Decade of Healthy Ageing \(2021-2030\)](#) accessed on 23.10.2023.

MEĐUGENERACIJSKA SOLIDARNOST U KRIZNIM VREMENIMA:

NA GRANICI IZMEĐU LIČNOG IZBORA I DRUŠTVENE ODGOVORNOSTI

**Nataša Todorović, Teodora Hrnjaković, Milutin Vračević
Miloš Todorović**

Rezime

Međugeneracijska solidarnost predstavlja društveni konstrukt i neraskidivu vezu između mladosti i starosti, znanja i iskustva, vizije i mudrosti. Razmena između generacija podstiče čovekoljublje, empatiju, ljubav i toleranciju, a ovakav vid prihvatanja različitosti i odbacivanja stereotipa kada su u pitanju starije osobe dodatno oplemenjuje društvo.

Negovanje međugeneracijske solidarnosti preduslov je za društveno blagostanje i senzibilisanu zajednicu koja prepoznaje umrežavanje, uvažavanje i podržavanje umesto etiketiranja, odbacivanja i nerazumevanja. U vreme tranzicije ovakav oblik solidarnosti posebno se ističe, imajući u vidu da socijalna osetljivost u kriznim situacijama zahteva integrisanu zajednicu usmerenu ka društvenom boljitku. KOVID – 19 virus posebno je naglasio solidarnost kao vrednost i podsetio nas koliko je međugeneracijska razmena važna u periodima društvene stagnacije.

U okviru SHAI projekta povodom Svetskog dana nasilja nad starijima, 15. juna, Crveni krst Srbije je organizovao međugeneracijske radionice u Boljevcu, Zaječaru, Kragujevcu, Užicu, Somboru i Subotici, a radionicama je prisustvovalo 248 ljudi (176 žena i 72 muškarca). Prilikom realizacije projekta korišćen je strukturirani upitnik pod nazivom „Međugeneracijska solidarnost: kvalitativno istraživanje“, a ispitanici su bili podeljeni u tri starosne grupe: do 30 godina, između 31 i 65 godina i stariji od 65 godina. Rezultati istraživanja pokazali su da postoji saglasnost svih starosnih grupa oko postojanja međugeneracijske solidarnosti u savremenom društvu. Kao ključne aktere u razvoju međugeneracijske solidarnosti većina ispitanika prepoznaje porodicu, medije i obrazovni sistem, a više od dve trećine ispitanika smatra da je KOVID – 19 virus zbližio generacije. Ono u čemu su ispitanici saglasni jeste da će aktivnosti zdravog starenja i kampanje povodom Dekade zdravog starenja doprineti unapređenju međugeneracijske solidarnosti što je od suštinskog značaja za dalji razvoj društva.

Ključne reči: *međugeneracijska solidarnost, KOVID–19 virus, odgovornost, stariji, društvo*

Professional paper UDK: 316.62:[616.98:578.834

Handed over: 20.04.2023.

Accepted: 11.01.2024.

POSITIVE CORRELATION OF THE PANDEMIC AND CRISIS PERIODS WITH THE INTENSIFICATION OF UNIVERSAL ALL-GENERATIONAL PROBLEMS AND THE NEEDS FOR ALL-GENERATIONAL SOLIDARITY

Radmila Urosevic¹⁹

Abstract

The process of globalization as well as digitalization, which intensified social radiation by sending an incessant avalanche of information, news and warnings, and especially the COVID-19 pandemic, made the personal problems of the individual, their fears, anxiety and existential problems become universal, regardless of generational affiliation, gender, education, work status. The COVID-19 virus proved to be a catalyst for all the above-mentioned problems and confirmed that crisis periods in a society also have their good sides. What are these good sides? The two-year work via Zoom, in cooperation with the Božidarac Cultural Institution, provided valuable materials that can determine the content of psycho-social support for individuals from the entire region aged 7 to 77. About 5,000 individuals from Serbia and the region (North Macedonia, Montenegro, Bosnia and Herzegovina, Croatia) went through 42 workshops, 42 surveys and 42 evaluations. The modern times we live in confuse older persons and do not provide them with sufficient room to find their way. Younger generations report symmetrical problems in inter-

¹⁹ **Radmila Urošević**, Volonterski servis Zvezdara, pecija59@gmail.com

personal communication, insufficient knowledge of social skills, absence of adopted life goals, stable values and norms, principles of applicable self-help and empowerment, as well as seeking help in the family and even less in the community. Perhaps in such a context, where the problem of the modern person is relating to humanizing their everyday life, older persons have a significant advantage because they have experience of life in the community, as well as interactions. It definitely is not easy for any generation, and the problems that gerontologists, sociologists, psychologists and social workers highlighted in previous decades as “problems of the third age” are now not the “exclusive right” of gray-haired people, whom social marginalization makes excluded, lonely, thwarted. The development of technology has missed the original goal of serving humanity and consumers of digital content, not respecting measure and balance, become consumers with a real risk of digital radiation. The loneliness and social distancing that COVID-19 has brought with it has further directed individuals of all generations to consume virtual content.

One of the realistic and sustainable solutions should be the development of a program of intergenerational exchange and solidarity as an objective and spontaneous intergenerational inclusion, which everyday life should verify and remind us that every age has advantages and disadvantages. More than ever, we lack programs of activation, empowerment, help and support for individuals, programs that will be practical, socially healing and help establish the lost trust of the individual, family and community that healthy and continuous interaction, understanding, help and self-help can contribute to reaching a healthy society, for young, middle-aged and older generation.

Keywords: COVID-19 as a catalyst, Social radiation, Universality of problems, Intergenerational exchange, Universal empathy and solidarity, Inclusive support programs, COVID distance and digital radiation, Social viruses.

Introduction

The process of globalization as well as digitalization, which increased social radiation by sending an instant avalanche of information, news and warnings, and especially the COVID-19 pandemic, made the personal problems of the individual, their fears, anxiety and existential problems become universal, regardless of generational affiliation, gender, education, employment status. In the years of the pandemic, which are our reality, the COVID-19 virus proved to be a catalyst for all the above-mentioned problems and confirmed that crisis periods in society also have their good sides. Loneliness, alienation, depression, a variety of mental problems, lack of face-to-face communication for various reasons make the reality of ordinary people dreary, uninspiring, scared, no matter how old they are.

The “combined” action and pressure of globalization, digitization and the pandemic are processes that have unequivocally determined the problem, opportunities, life situations and psycho-social-economic position of modern man. Under the microscope of these processes, we see that the context of the everyday life of an ordinary person has changed drastically, and the helplessness affects all generations to the extent that they feel it as something that frustrates them and makes them less independent in their daily functioning. The most important indicators, i.e. the list of problems and/or social damage, was detected through continuous work with the participants of Radmila Urošević’s online creative workshops organized by the “Božidarac” Cultural Institution, as well as surveys and evaluations as a source of verification and the obtained material that is the subject of this analysis and research.

Participation of participants in the list of priority problems of individuals in COVID-19 conditions of everyday life

The needs detected during two and a half years of work (which continues at the request of the participants) were analyzed, in the continuity of 2 workshops per month (42 workshops, surveys and evaluations) in Zoom format, in cooperation with the Božidarac Cultural Institution. The material obtained was used as a direct participation of the expressed priority problems of individuals of all generations. It is important to point out that, according to the received proposals, the content of psycho-social support for individuals from the region of the former Yugoslavia, but also from a wider area (individuals who emigrated from these countries and live in diaspora) between the ages of 7 and 77 was planned. About 5,000 individuals from Serbia and the region (North Macedonia, Montenegro, Bosnia and Herzegovina, Croatia) went through 42 workshops, 42 surveys and 42 evaluations. So, the last years, the period from 2020 to 2022, have made the problems of ordinary people universal, regardless of how old they are. In material times, the immaterial becomes more visible and much needed, and this is primarily about communication, empathy, and solidarity.

According to the representation of reported personal problems, we can make a ranking list of topics that have been especially intensified in the COVID years. Those are:

1. Loneliness and depression;
2. Health, especially mental;
3. Fears (for personal and health of the closest ones, existence, life perspective);
4. Undefined frustrations and anxiety;
5. Decline in self-confidence;
6. Partner relations;

7. Intergenerational conflicts;
8. The need for intergenerational exchange;
9. Insufficient and/or poor communication with family members;
10. Decrease in vital energy, motivation and/or libido;
11. Need for support and help from professionals.

The modern times we live in confuse seniors and do not give them much space to find their way. Younger generations report symmetrical problems of awkwardness in interpersonal communication, insufficient knowledge of social skills, absence of adopted life goals, stable values and norms, principles of applicable self-help and empowerment, as well as seeking help in the family and even less in the community. Perhaps in such a context of the modern man's problem of humanizing his everyday life, seniors are at an important advantage because they have experience of life in the community, interactions. It definitely is not easy for any generation, and the problems that gerontologists, sociologists, psychologists and social workers highlighted in previous decades as "problems of the third age" are now not the "exclusive right" of grey heads, which social laziness makes excluded, lonely, thwarted. The development of technique and technology has eluded the original goal of serving humanity. They crossed the dangerous line and started serving themselves and their owners, and consumers of digital content, not respecting moderation and balance, become consumers with a real risk of digital radiation and their own "robotization". The loneliness and distance that COVID 19 has recommended has further led individuals of all generations to consume virtual content. It becomes noticeable that life in COVID conditions induced a loss of balance and equilibrium in the daily functioning of the individual in such a way that the mandatory and controlled distances isolated them and deprived them of closeness, interaction, reciprocity, direct communication and seeing. That "pressure from above" inevitably affected the loss of balance as a "domino effect" on the "pressure from below" that remained in individuals through the feeling of

fear, insecurity and risk even when the measures were “relaxed”. Evaluations and conducting a survey after the mentioned workshops served as useful instruments in selecting topics as well as looking at each topic individually when it comes to the intensity of specific problems and needs of workshop participants, their perception of optimal solutions and willingness to be active and involved in solving them.

Cramped life in isolation conditions intensified intergenerational and partner conflicts, misunderstanding and poor communication, but also the need for it to be better. COVID-19 has intensified the need of individuals for empathy and solidarity, the need for a strong, inspiring family.

In particular, it should be borne in mind that the participants of the workshops are individuals who are not ignorant, socially excluded and digitally illiterate citizens, and who in turn represent a whole contingent of particularly vulnerable and thwarted people who do not have the same opportunities. Their problem is not the subject of this study, but it is socially responsible for them to be mentioned.

Optimal responses of the system to the problem of individuals induced by the pandemic

First of all, it should be underlined once again that the intensification of psychosocial problems of individuals in pandemic living conditions did not start due to the COVID isolation regime. They were only the catalyst of already started processes of alienation, isolation and self-isolation of individuals in modern living conditions determined by the development of technique and technology, the dominance of the values of the consumer society, the struggle for the existence of the impoverished middle class, the older population, people with disabilities and developmental problems, as well as young people in search for the first job and loneliness and alienation that spread like a “social epidemic”. The good thing about this “COVID evil”

is that the focus on the mentioned problems is greater for professionals because they are more visible and an additional indicator of social damage as a consequence of the overall global processes for individuals and humanity.

Asked to say for themselves what would help them the most in solving personal problems, the workshop participants stated:

1. Available and free help from professionals, counselling centres;
2. Intergenerational exchange and better communication;
3. Education and workshops in online format and, when the conditions are met, “in the third dimension”;
4. Developing social skills;
5. Involvement in activities and programmes in the community;
6. Support for families with children (parenting skills, educational models, how to help children learn)
7. Media articles that talk in an affirmative way about mental problems, how to deal with them, a more meaningful life during the pandemic;
8. Available literature that is not overly professional;
9. Existence of support and self-help groups.

One of the realistic and sustainable solutions should be the development of a programme of intergenerational exchange and solidarity as an objective and spontaneous intergenerational inclusion, which everyday life should verify and remind us that every age has advantages and disadvantages. COVID-19 is a lesson that directs us to each other in a cruel way. More than ever, we lack programs of activation, empowerment, help and support for individuals. Programmes that will be practical in life, socially healing and that will restore the lost trust of the individual, family and community that healthy and continuous interaction, understanding, help and self-help can “throw” the strongest and farthest on the way to a healthy society, young, middle-aged and older generation. Infection with the virus in a short time took many lives and left even more individuals with numerous

consequences and complications. If we accept the statement of academician Vladeta Jerotić that modern man is “infected” by the struggle for material things, loneliness and the absence of joy in small things, and we know that there is no vaccine for social infection, what will we do with such an infection that does not have the drama of COVID, but is it no less disastrous?

At the beginning of every improvement, if not to a healthy, then to a healthier society, is a change staring within. In this case of the entire society and community, a change in awareness is necessary that solidarity, humanity, mutual informal help and interaction are valuable and, in the long term, one of the most sustainable solutions to live more humanely regardless of age, gender, education and future crises that befall us. As far as professionals, systems and individuals are concerned, we should be as prepared as possible.

The state’s optimal response should be a package of help and support for individuals of all generations in various formats through various online but also interactive workshops and education, SOS telephone support, help and self-help groups, counselling centres for individuals and families. Bearing in mind the pressure induced by the pandemic on the mental health of individuals, it is necessary to create psychosocial and health programs that will be active both interventionally and preventively throughout the year.

It seems to me that the change within individuals has slowly but surely already occurred in the past COVID years. Since in our environment it is more acceptable to keep silent about problems and it is a shame to admit that we have a problem and even more to ask for and receive help, one of the positive “assets” of the pandemic is the willingness of individuals to admit first to themselves and then to others that they are difficult, that they are not well, that they have a problem and – to ask for help. That kind of openness to change values and norms and create new, more desirable and useful ones is in the best interest of individuals, families, and communities.

References

Berner, C. (1996), *Communication Mastery*, Dijada, Zaječar.

Braden, G. (2009), *The Spontaneous Healing of Belief: Shattering the Paradigm of False Limits*, Hay House Inc., Carlsbad.

Ivanović, D. (2011), *Od usamljenosti do odnosa*, Metaphysica, Belgrade.

Pecija Urošević, R. (2020), *Starenje bez autocenzure*, Plavi krug, Belgrade.

Todorović, N., Vračević, M. (ed), (2020), *Time Without Time*, Red Cross of Serbia, Belgrade.

POZITIVNA KORELACIJA PANDEMIJE I KRIZNIH PERIODA SA INTENZIVIRANJEM UNIVERZALNIH SVEGENERACIJSKIH PROBLEMA I POTREBA ZA SVEGENERACIJSKOM SOLIDARNOŠĆU

Radmila Urošević

Rezime

Proces globalizacije, kao i digitalizacija, koji je pojačao socijalnu radijaciju slanjem iz trena u tren lavine informacija, vesti i upozorenja i posebno pandemija KOVID-19, učinili su da lični problemi pojedinca, njegovi strahovi, anksioznost i egzistencijalni problemi postanu univerzalni, bez obzira na generacijsko pripadanje, pol, obrazovanje, radni status. Virus KOVID-19 pokazao se kao katalizator svih navedenih problema i potvrdio da krizni periodi u društvu imaju i svoje dobre strane. Koje su to dobre strane? Dvogodišnji rad u Zoom formatu, u saradnji sa Ustanovom kulture Božidarac, dragocena su građa koja može da odredi sadržaj psiho-socijalne podrške pojedinaca iz celog regiona uzrasta od 7 do 77 godina. Kroz 42 radionice, 42 ankete i 42 evaluacije prošlo je oko 5.000 pojedinaca iz Srbije i regiona (Severne Makedonije, Crne Gore, Bosne i Hercegovine, Hrvatske). Savremeno doba u kojem živimo zbunjuje starije osobe i ne pruža im dovoljno prostora da se snađu. Mlađe generacije navode simetrične probleme u međuljudskoj komunikaciji, nedovoljno poznavanje socijalnih veština, odsustvo usvojenih životnih ciljeva, stabilnih vrednosti i normi, principa primenljive samopomoći

i osnaživanja, kao i traženje pomoći u porodici, a još manje u zajednici. Možda u takvom kontekstu, gde se problem savremenog čoveka odnosi na humanizovanje svakodnevnog života, starije osobe imaju značajnu prednost jer imaju iskustvo života u zajednici i interakcijama. Definitivno nije lako nijednoj generaciji, a problemi koje su gerontolozi, sociolozi, psiholozi i socijalni radnici prethodnih decenija isticali kao „probleme trećeg doba” sada nisu „ekskluzivno pravo” sedih glava, koje socijalni lapot čini isključenim, usamljenim, osujećenim. Razvoj tehnologije izmakao je prvobitnom cilju da služi čovečanstvu i konzumenti digitalnih sadržaja, ne poštujući meru i balans, postaju konzumenti sa realnim rizikom od digitalne radijacije. Usamljenost i socijalno distanciranje koje je KOVID-19 doneo sa sobom dodatno su usmerili pojedince svih generacija na trošenje virtuelnih sadržaja.

Jedno od realnih i održivih rešenja trebalo bi da bude razvoj programa međugeneracijske razmene i solidarnosti kao objektivne i spontane međugeneracijske inkluzije, koju svakodnevni život treba da verifikuje i podsećti nas da svako doba ima prednosti i mane. Više nego ikad nedostaju nam programi aktivacije, osnaživanja, pomoći i podrške pojedincima, programi koji će biti praktični, socijalno lekoviti i pomoći uspostavljanju izgubljenog poverenja pojedinca, porodice i zajednice da zdravu i kontinuiranu interakcija, razumevanje, pomoć i samopomoć mogu doprineti dostizanju zdravog društva mladih, srednjih i starijih generacija.

Ključne reči: *KOVID-19 kao katalizator, socijalna radijacija, univerzalnost problema, međugeneracijska razmena, univerzalna empatija i solidarnost, programi inkluzivne podrške, covid distanca i digitalna radijacija, socijalni virusi.*

Original scientific paper UDK: 316.644-053.88(497.11)

616.98:578.834

Handed over: 20.03.2023.

Accepted: 25.04.2023.

IN THE DOLDRUMS OF COVID-19: OLDER PEOPLE'S OPINIONS ABOUT THE PROTECTION MEASURES APPLIED IN SERBIA AGAINST COVID-19 AND SUGGESTIONS FOR FUTURE MEASURES²⁰

Sladjana Dragisic Labas²¹, Milana Ljubicic²²

Abstract

In this paper, we examine the opinions of older people from Belgrade about the measures implemented during the pandemic caused by the SARS-COV-2 virus in a two-year period (2020-2022). The sample, which consisted of 30 respondents aged 65 to 93, also included doctors specializing in different fields, so it was possible to obtain information from medical experts as well. The analysis of the respondents' narratives was complemented by several interviews conducted by other doctors who had more contact with older people during the pandemic. In this manner, we collected important information shedding light on the experiential and emotional perspectives, as well as the

²⁰ The implementation of this research was financially supported by the Ministry of Education, Science and Technological Development of the Republic of Serbia within financing scientific-research work at the University of Belgrade, the Faculty of Philosophy (Agreement No. 451-03-68/2022-14/ 200163).

²¹ **Sladjana Dragisic**, University of Belgrade, Faculty of Philosophy, Full Professor, sladjadl@yahoo.com

²² **Milana Ljubicic**, University of Belgrade, Faculty of Philosophy, Full Professor, milanaljubicic@yahoo.com

professional one. According to our findings, the majority of the respondents, including the medical experts, rated the total lockdown measures as too strict, ineffective, bad, inconsiderate, but also discriminatory, while they rated the current measures as ineffective, i.e., too liberal. They suggest finding a middle ground or “the right measures adapted to the pandemic situation”. The research findings are valuable for planning current and future protective measures in crisis situations.

Keywords: COVID-19 protection measures, Older people’s opinions, Complete lockdown, Current measures

Introduction

From the moment when the World Health Organization declared the global health crisis a public health threat of international importance on 30 January 2020, and then the pandemic on 11 March 2020 (<https://covid19.rs/o-covid-19-virusu/>), different countries introduced various measures intended to protect population from the “new” virus, ranging from complete lockdown to a liberal approach. At the beginning of the pandemic, the former form of protection was applied, for example, in China, Italy and Serbia, while the latter was applied in Sweden, Great Britain and the Netherlands, and later in Serbia as well (Pešić, 2021: 103), although it was estimated that the greatest risk of high mortality from COVID-19 was run by the countries with a large share of the elderly in the total population (Denmark, Sweden, the Netherlands and Finland), particularly if they lived in multigenerational families and in underdeveloped countries with the poorer health protection systems (Arsalan et al., 2020).

The findings obtained from a number of countries (Germany, Hong Kong, several US federal states) point that the observation of the prescribed protection measures from COVID-19, such as physical distance and washing hands, varies depending on: subjective perceptions of the disease, trust in health institutions and governments, political attitudes, personal characteristics and earlier experience with some measures (mask wearing)²³. The acceptance of the measures in all these countries was affected by: the as-

²³ The factors affecting the observation of the protection measures against COVID-19 may also be found in other studies. In Oakland, New Zealand (Kaine, Greenhalgh, Wright, 2022), most respondents who observed the prescribed protection measures showed a high level of support to the community and the way of pandemic “management” by the government. This was an important factor for motivating individuals and adjusting their behaviour towards the protection measures (mask wearing, physical distance, testing in the event of not feeling well). Personal factors – personal beliefs about the efficiency of the measures and positive experiences in the application of the measures – proved to be more important than the fear of formal sanctions in Slovenia (Mihelič, Jelovčanin, Prislán, 2021). In Belgium, the protection measures were less accepted by younger men who spoke French and who *had already had* the virus (van Loenhout et al., 2022).

assessment of measure efficiency, previous experience, and the intention of protecting oneself and others. If the measures were understood only as the protection of others, individuals in some countries tended to accept them less frequently. Among the persons (countries) with more dominant collectivism, the acceptance of the measures was larger. Therefore, if the measures were assessed as efficient, with personal experience and collectivism, their acceptance was larger (Santana et al., 2022). The connection between political ideology and the acceptance of recommendations in fighting the COVID-19 pandemic proposed by the Serbian government is indicated in one study (Pavlović, Todosijević & Stanojević, 2021), and also that the risk perception, physical distance and political support are present to a larger extent among the right-oriented ones. The citizens' trust in the healthcare system was a significant predictor of the observation of the protection measures against COVID-19 (physical distance and mask wearing) in a number of countries²⁴, unlike the trust in the political leaders, where this connection was not identified. Stronger trust in health institutions included transparency of information – giving justifications, providing feedback and open expression of insecurity. Therefore, according to these findings, during the public health crisis the citizens relied more on the professional institutional guidelines than on the political leaders (Badman et al., 2022).

Sociological research shows that the ruling structures during the pandemic attempted to find such an organizational form that would ensure the balance between health goals and economic interests and social needs, but in many countries, behind these general goals, there was the promotion of personal and particular interests (Cvejić, 2021: 48), and “collective solidarity was replaced by egoistic attempts of individuals to act solely in their own interest” (Pešić, 2021: 116). The health crisis requested larger involvement

²⁴ This refers to the following countries. Australia, Canada, Germany, Israel, Spain, Great Britain, the USA, Japan, South Korea, China and New Zealand.

of the government in the protection of the population health, as well as of economy, but, according to the findings, a strong neoliberal ideological matrix (individualization of the citizens' responsibility became a pandemic management strategy, also called "epidemiological neoliberalism"), although inefficient, persisted during the pandemic (Pešić, 2021: 108). The same occurred in Serbia, and after the first wave of the pandemic and the introduction of the state of emergency²⁵ (from 15 March to 7 May 2020) and complete lockdown for those older than 65 (during the period of 35 days, with periodically permitted going out early in the morning, from 4 to 7 a.m.), "the imperative of life was soon replaced by the imperative of economy" (Poletić, 2021:81), the withdrawal of almost all measures, despite the disapproval of the majority of medical experts.

At the time of the global health crisis, inequalities (social, economic and racial) generated by neoliberalism became even more visible because the most affected were those with the minimum resources (material, social and cultural). That was the situation of the elderly in Serbia who lived alone, particularly those who needed the care and help from the others, the majority of whom were women. Most social protection services were either suspended or provided with substantial restrictions, while the provision of healthcare services was reduced and restricted to urgent condition (<http://socijalnoukljucivanje.gov.rs/rs/objavljeni-rezultati-istrazivanja-starije-zene-udoba-korone-iskustva-i-izazovi/>), although the COVID measures of physical distance and self-isolation demanded stronger, both formal and informal, social support (material and emotional).

The difficulties related to mental and physical health and the reduction or loss of material resources of the population during the pandemic as compared to the pre-pandemic period are indicated by the research from

²⁵ The state of emergency may be seen as a turning point – "before and after the corona", while the period after the abolition of the state of emergency is also called "new normality" and perceived as a transition period until the establishment of "normality" (Žikić, Stajić & Pišev, 2020).

different countries. According to the findings of a Polish study, one out of five respondents had the symptoms of anxiety and depression, while among them there were more women, people living alone, the unemployed, those of a poorer material status, with worse health and chronic diseases (Dziedzić et al., 2021). A similar response to the pandemic can be found in the research conducted in the Netherlands (Dekker et al., 2022). In the USA, among the respondents from the states applying the measures of complete lockdown there were more frequent cases of anxiety and loneliness, and the presence of the concern for finance than among the respondents from the states where these measures were not applied (Tull et al., 2020, according to Cugmas et al., 2021). Similar findings, although predominantly for the elderly living alone (complete lockdown lasting more than 50 days) were also obtained in India (Regy et al., 2021). According to some research studies, the elderly coped successfully with the pandemic conditions at lower levels of anxiety and depression than the younger population in a number of countries (Barzilay et al., 2020; Gonzales Sanguino et al., 2020; Rossi et al., 2021, according to Radoman, 2021), including Serbia (Džamonja Ignjatović et al., 2020; Radoman, 2021; Dragišić Labaš, 2021, 2022). Namely, the elderly, old-age pensioners, and some still employed, who had material resources and accommodation, with a higher level of education and with a wider informal social network (providing them with emotional and instrumental support) and those aging actively, “underwent” better all the stages of the pandemic (Dragišić Labaš, 2021, 2022). However, they belong to a group of the privileged ones in comparison to the poor with a weak social network, who need institutional support.

In this paper we deal with the so-called privileged elderly, who expressed their opinions about the protection measures for the older population and the society’s (lack of) care for their health. Whether this assigned position will enable them to act in the community and to encourage the government and politicians to introduce different protection measures for

the elderly in the future will be shown in practice by the new waves of the coronavirus. It is quite disputable whether the voices of the elderly will be heard or whether they will remain in the same position – discriminated and marginalized, in fact, on a “thin line” between emphatic ageism and open discrimination, where the elderly are denied the right to be social actors and independent of others (Whitton, 1997, according to Ljubičić, 2021), which is particularly pronounced during crises, including the ongoing global health crisis.

Methodological framework

Research sample and aim

The paper uses a number of data from the research into social aspects of ageing during the COVID-19 pandemic, which was conducted in the course of 2021.²⁶ The sample included 25 respondents (14 female and 11 male) aged from 65 to 93, while for the purposes of this paper 5 more respondents were involved (the total of 30). All the respondents were interviewed again and they also spoke to three doctors. This is an adequate, snowball sample, while a semi-structured questionnaire was used for interviewing. The interviews were organized by telephone or Skype, as well as in the respondents' homes. The respondents' names were changed. The research was aimed at reaching the knowledge about the respondents' attitudes towards protection measures against COVID-19 applied for the elderly, as well as the population in Serbia during the two-year period (2020-2022), as well as their suggestions for future protection measures.

²⁶ This is the research conducted within the scientific-research project *Man and Society during a Crisis*, financed by the Faculty of Philosophy, the University of Belgrade.

Result analysis

Demographic characteristics of the respondents

The greatest number of our respondents belongs to the age category 65-74 (17 of them), while in the following two age categories (75-84 and 84+) there were 13 respondents *together*. As for gender, there were 16 women and 14 men. Higher and high education is the characteristic of a larger number of the elderly (17) as compared to those with the secondary school degree (13). All the respondents are old-age pensioners with, in their opinion, “solid” and “smaller” pensions. All of them have their own residential space. About half of our respondents are married (12), while there are ten widowers and widows, and four of them are divorced. As it could be anticipated, a larger number of widowers/widows belong to the category 85+, namely seven women and two men. All the respondents have children, most of them two children. Two-member families are dominant (16), being composed of the respondent and the spouse, or the respondent and the child, while nine respondents live alone (Dragišić Labaš, 2021).

The respondents’ opinion about the protection measures undertaken against COVID-19 at the beginning of the pandemic and today

At the time of the first interview (January-March 2021), as well as now (August 2022), most respondents believed that the complete lockdown measure for the elderly was “inadequate, inconsiderate, excessive and rather bad”, and it led to an increased feeling of fear and to worse mood. The measures varied from the strict ones (complete lockdown for the elderly) to the liberal ones. Strict measures were even understood as a “punishment for old age and a burden to the society”, as well as “disrespect and false concern”. A smaller number of the respondents thought that “the measure was perhaps good, but they were not sure”, while the smallest number of them

believed that it was necessary at that moment. A female respondent states the following:

“It was insane to lock down only the elderly. They should have been able to go out during normal hours. In fact, it was not concern at all. The government did not find its way from the beginning until the end. Instead of rushing, they should have been cautious when introducing measures, when something is unknown... No one controlled the measure of compulsory mask wearing. All the time, from the very beginning of the pandemic, the measures were contradicting (Milena, 67, university degree, proof-reader, married, two-member family, one child). Another female respondent thinks in a similar way: “The lockdown for the elderly had no effect. It was inhuman and rigorous. People suffered, they were dissatisfied and it produced a countereffect. All contacts were lost, which created panic among many of them and made them depressed. It was not easy to find your way in this situation; here I’m referring to the Crisis Headquarters. It was difficult to introduce the proper measures, but they went from one extreme to another” (Jelena, 68, university degree, literature teacher, widow, living alone, one child).

Harsh criticism against the protection measures at the beginning of the pandemic refer to the prescribed shopping hours (from 4 to 7 a.m.) as being completely unadjusted to the daily routine of the elderly and their needs.

“I remember it was terrible for pensioners to go grocery shopping at 4 o’clock a.m., while my brother, who is older than me, had to go because he lives alone... Our sleeping cycle was completely disturbed, and the elderly sleep badly anyway... The elderly were completely deflected” (Sanja, 89, university degree, paediatrician, widow, living alone, two children). “Complete lockdown was excessive; people could not do shopping during normal hours. Everything could have been done differently, for example like Slovenians, where the elderly went grocery shopping between 9 and 10 a.m.” (Ivana, 75, university degree, neuropsychiatrist, married, two-member family, one child).

At the beginning of the pandemic, due to different and even contradicting information about the coronavirus obtained on TV and via other media, the elderly were confused and indecisive, not knowing how to behave and “who to listen to”. The research also shows a rather relaxed attitude of the population in Serbia towards COVID-19 at the outset of the pandemic, which was influenced by the media presenting the disease as the one “affecting respiratory organs among the elderly, or possibly persons with grave chronic health problems; younger people, or those with sound health, should not be afraid of it”. This opinion persisted before the substantial increase in the number of the infected and deceased (Žikić, Stajić & Pišev, 2020: 955). That is why some respondents find the media responsible for the “confusion in the minds of the elderly”.

“I didn’t believe in everything they said on TV; they really exaggerated. We were frightened every day, and the people have lost trust in the politicians” (Milorad, 70, secondary school degree, 71, carpenter, married, two-member family, two children). *“The media confused people with its alternating optimism and pessimism”* (Danijela, 73, university degree, psychologist, widow, living alone, two children). *“On TV they never get round to saying what the solution is. That is why I didn’t know whether it was necessary to lock down the elderly completely”* (Božidar, 82, university degree, economist, widower, two-member family, two children). *“In the beginning, the media talked about the most ridiculous virus. People were completely confused. Anti-vaxxers were constantly in the media sphere, and the people watched it and believed in it because they saw it on TV”* (Milena).

Because of various information placed in the media, many respondents stayed at home longer than it was prescribed by the protection measures. Therefore, one female respondent says: *“Even when it was allowed to go out, I didn’t do it because I didn’t know what to think. I’ve never experienced it before. There were epidemics beforehand, but we were never forbidden to go out”* (Mileva, 74, completed elementary school, worker, married, two-member

family, two children). Another respondent says: *“I didn’t leave the apartment for four months... I would just open the window and watch the people”* (Mirjana, 77, university degree, artist, divorced, living alone, three children).

Current measures, two years after the beginning of the COVID-19 pandemic, are also criticized by many respondents who find them too liberal and yet unadjusted to the situation. The number of the infected is on the rise; certain measures are recommended, but not prescribed. A female respondent says: *“Now that the number of the infected is going up, there is no referential body that would determine the measures. The working hours of the COVID hospitals are made longer, but it isn’t enough. Prevention measures and their control are necessary. Drastic lockdown measures were implemented earlier, but other measures that are necessary today have not been implemented”* (Milena). *“In the previous interview, I said that there were different stories, but I believe that it is a natural virus. Contagion will last at least 2-3 years more. Now, when the number of the infected is going up, it is necessary to prescribe and control the measure of mask wearing in closed space. In that way, the young would take care of the elderly who are supposed, for example, to get on a bus or enter a shop”* (Aleksandar, 85, university degree, surgeon, married, two-member family, three children).

The respondents who, in the previous interview (2021), had justified the complete lockdown measures or were not sure whether they were good, now find them unadjusted and harsh.

“At the time when it was happening and when there were many death cases, I justified the lockdown, but then I started doubting whether it was smart. The elderly retired, became alienated... the lockdown also disturbed some family relations; due to the inability to move, many were dissatisfied. We were directed towards each other. My husband was terrified; my friend did not go out for months and therefore felt lonely and helpless, starting to forget. Because she didn’t walk too much, now walks with difficulty. With the passage of

time, I realized that the measures were too harsh, and then they were relaxed abruptly, with the Exit festival, with holidays, all for the sake of money. Now the number of death cases and of the patients on the ventilators is increasing. Now I find it necessary to wear a mask, and I do” (Svetlana, 71, secondary school degree, agricultural technician, married, three-member family, two children). Dragoslava states a similar thing: *“I was really afraid at the beginning of the pandemic, which was largely contributed to by my daughter. She believed that I had to take great care because of my age and illness. At that time, I found it useful for the elderly not to go out, but now I can see that the consequences of those measures are much worse than getting infected. I had the virus, but because of not moving enough I was physically and mentally worse off. Still, I am recovering slowly”* (Dragoslava, 88, university degree, geography and mathematics teacher, widow, living alone, two children).

The respondents found themselves more responsible than the younger ones and pointed out that from the very beginning of the pandemic to the moment of the survey they had mainly observed all the prescribed measures. *“We aren’t responsible only for ourselves, but for the others as well. I am still wearing a mask and I take great care because of other people. I will act responsibly before this is finished”* (Nikola, 87, secondary school degree, welder, widower, living alone, one child). *“We observed all the measures. I didn’t go out even longer than it was prescribed because I obey everything our doctors tell us”* (Sofija, 88, no school degree, agricultural worker, widow, living alone, two children). *“I was quite responsible at the beginning of the pandemic and I still am. I wear a mask in the street whenever the number of the infected is increasing, as well as when I take a bus, although I rarely go by bus. No one wears a mask any more, which is not alright while we claim to be concerned about each other”* (Rade, 78, secondary school degree, hair stylist, married, two-member family, one child).

Perception of complete lockdown from *emotional and professional perspectives*, at the beginning of the pandemic and two years later

Our respondents think that the pandemic affected their mental health and at the beginning of the pandemic they most frequently listed the presence of fear, anxiety, concern for others, sadness, bad mood, poor concentration and problems with memorizing, uncertainty, but not “more serious psychological problems” that would require professional help. They tried to cope with stress, particularly pronounced during complete lockdown, in all available ways (Dragišić Labaš, 2021). Stopping any contact with children, grandchildren and friends was the most difficult thing. Online contact was helpful, but it could not replace live contact. We find similar opinions in the research conducted in more than 20 countries (van Breen et al., 2022), which also confirms that online contact did not manage to replace face-to-face contact or to alleviate the feeling of loneliness caused by the reduction in social contacts. That is why it is recommended to apply other strategies apart from complete lockdown and social isolation. For this topic, the opinions of all our respondents were significant, but we will select the experience of the female respondent who is a neuropsychiatrist.

“I saw people who were afraid when they started going out for a few hours in the afternoon. The information from the media created greater fear – extreme and irrational. Fear reduces immunity and, along with the existing somatic diseases of the elderly, this is a serious problem. Healthcare is one thing, but causing fear is something completely different. People are afraid of the fatal disease and when they constantly think about it, they are tense. This is the psychological factor leading to lower immunity” (Ivana).

As it has already been said, the elderly missed most social contact with their children and other close people. The period of complete lockdown was the hardest and then, as they say, they managed to “get out of such state

relatively quickly”. They pointed out huge differences in the group of the elderly, i.e., bad assessment that everyone belonged to the *vulnerable group*, as well as that their vulnerability in stressful life circumstances is prejudice. They also believe that they are more experienced and better prepared for life problems than the younger ones (Dragišić Labaš, 2022). This perception is similar to the opinion one of our doctor respondents: *“A number of the elderly are really exposed to risk because of comorbidities, but not seeing close people was a huge problem. It caused a crisis and raised the question – how can I cope on my own. There was fear of getting ill, of not being able to reach hospital and get adequate help... At the beginning of the pandemic anxiety and concern increased, while some people developed sub-depressive condition, but it was transient after all. A small number of them kept on being afraid”* (Biljana, 56, psychiatrist, 29 years of employment). Teodora, our respondent from the sample, also a doctor, i.e., neuropsychiatrist, has expressed her opinion and suggestions. *“Psychiatric and psychotherapeutic support should have been available at the beginning of the pandemic and later on... There should have been more telephone assistance apart from hospital Doctor Laza Lazarević. Psychiatrists could have worked within outpatient hospitals, and retired psychiatrists and psychotherapists could have worked as volunteers”* (Teodora, 74, university degree, neuropsychiatrist, widow, two-member family, one child).

A doctor specializing in internal medicine describes the first protection measures undertaken for those older than 65 as too harsh and as a *“sign of fear and disorientation when it comes to unknown things potentially highly harmful for health”*. Due to such measures, the already existing, i.e., chronic diseases further worsened among the elderly. Two years later, *“after months-long wandering in the protocols”*, this doctor thinks that the obtained knowledge and conclusions were not used by the doctors, and also that we are the *“society with a short memory”*. In her opinion, not it is necessary to wear a mask in certain situations, in closed space, but without constantly taking it off and putting it on, which is done by many people (Tamara, 55, 30 years of employment).

The opinion of a general practitioner (with the total of 2,300 patients in her files) gives us a “broader picture” that contains events related to the beginning of the pandemic, personal experience and description of the consequences of complete lockdown for the elderly. *“The measures of complete lockdown were rather bad. However, it is easy to say something smart now. In the beginning no one knew what to do, but here it was really exaggerated. Those measures didn’t protect people after all. The elderly were believed to be the most threatened ones, but in fact it wasn’t like that. It couldn’t be predicted either. No one knew how the pandemic would proceed. Other countries had huge variations”* (Nina, 58, 33 years of employment). In our country, according to this respondent, insight into the protection measures prescribed for those older than 65 was formed with the passage of time, because the consequences on the health of the elderly could be clearly seen after the first wave and complete lockdown. *“Moderate measures should have been implemented continuously, without closing everything down at one moment, and then opening everything immediately afterwards... It was wrong to open and allow everything at the same time, and that is why there is a large number of the infected. The measures for the elderly were drastic and led to total discrimination of this population. People moved less, communicated less, which led to degenerative diseases becoming acute and to the development of other diseases. People who used to be active now stayed immobile in bed for months. After complete lockdown, serious problems arose... They include a large number of thrombosis cases, strokes, hip fractures, and people could not get medical help. The consequences of the first wave were the elderly getting down with other diseases, and not infected with the coronavirus... Complete lockdown did more harm to them than the coronavirus itself. Only now we are aware of how bad complete lockdown was”*. This is what the doctor says about the current measures: *“Now I would make mask wearing compulsory in public transport and in shops. Our goal can’t be to get infected”* (Nina, 58, 33 years of employment).

Conclusion

The data obtained from the analysis of narratives of the respondents older than 65, the doctors from the sample itself, as well as the employed doctors, confirm the considerations of the sociologists and other experts that the government had “generally taken mixed and confusing positions regarding the pandemic, reducing its importance in the beginning, while introducing rather strict measures later” (Pavlović, Todosijević & Stanojević, 2021), while once again it took a liberal attitude “without any measures”. The responsibility was transferred to the citizens, while the care for the elderly dwindled and finally disappeared.

Ageism and discrimination present before the pandemic only became stronger during the COVID-19 pandemic through emphasizing high vulnerability of the elderly (Momtaz, 2020; Monahan et al., 2020, according to Ljubičić, 2021) and prescribing special measures that eventually proved harmful. Complete lockdown for those older than 65, as the strictest protection measure against COVID-19, was assessed as inconsiderate and inefficient because it undermined the physical and mental health of the elderly. Thus, the senior citizens in Serbia were most affected by the strict measures, and today they are most threatened by the failure to introduce measures, particularly in some places such as public transport and shops.

The respondents emphasized that the media were responsible for the “confusion in the minds of the elderly” and the “extended state of fear”. The majority of the respondents, the medical experts from the sample and the employed doctors pointed to the irresponsibility of the government in such a serious health crisis and its false care for the elderly. For who know what time, the elderly found themselves “between empathic ageism and open discrimination” (Ljubičić, 2021). In the end, the belief remains that the special measures for the elderly will not be introduced again, and that the results of this and similar research will affect the designing of future protection measures in crisis situations.

References

Arsalan, M., Mubin, O., Alnajjar, F., & Alsinglawi, B. (2020). COVID-19 Global Risk: Expectation vs. Reality, *International Journal of Environmental Research and Public Health*, (17),1-10. <https://www.mdpi.com> › 17

Badman, Ryan, Wang, Ace, Skrodzki, Martin, Cho, Heng-Chin, Aguilar-Lleyda, David, Shiono, Naoko, Yoo, Seng Bum Michael, Chiang, Yen-Sheng, Akaishi, Rei (2022). Trust in Institutions, not in Political Leaders, Determines Compliance in COVID-19 Prevention Measures within Societies across the Globe, *Behavioral Sciences*, 12, 170: 1-20.

Cugmas, Marjan, Ferligoj, Anuška, Kogovšek, Tina & Batagelj, Zenel “The social support networks of elderly people in Slovenia during the COVID-19 pandemic”, *PLoS ONE*, 2021, vol.16,no.3,pp.1-16. https://www.researchgate.net/publication/349768973_The_social_support_networks_of_elderly_people_in_Slovenia_during_the_Covid-19_pandemic

Cvejić, Slobodan (2021). “Medical profession” in the jaws of political power: manipulation of the medical members of the Crisis Headquarters during the COVID-19 pandemic”. In: Ivana Spasić (ed.), *Pandemic, society and symbolic order: public discourse in/about the crisis caused by COVID-19*, Univerzitet u Beogradu – Filozofski fakultet, Službeni glasnik, Beograd, 2021, pp. 47-69.

Dekker, Maria, Frielink, Noud, Hendriks, Alexander & Embregts Petri “The General Public’s Perceptions of How the COVID-19 Pandemic Has Impacted the Elderly and Individuals with Intellectual Disabilities”, *International Journal of Environmental Research and Public Health*, 2022, vol.19, no.5, pp. 2855. <https://www.mdpi.com/1660-4601/19/5/2855>

Dragišić Labaš, Slađana (2021). “Challenges of active ageing and mental health during the COVID-19 pandemic in Serbia”. In: Slađana Dragišić Labaš (ed.), *Social aspects of ageing during the COVID-19 pandemic*, Uni-

verzitet u Beogradu – Filozofski fakultet, Službeni glasnik, Beograd, 2021, pp. 117-134.

Dragišić Labaš Slađana (2022). Active ageing during the COVID-19 pandemic: creating new activities, *Gerontologija* (in the process of printing).

Dziedzic, Beata, Idzik, Anna, Kobos, Ewa, Sienkiewicz, Zofia, Kryczka, Tomasz, Fidecki, Wieslaw & Wysokiński, Mariusz. "Loneliness and mental health among the elderly in Poland during the COVID-19 pandemic", *BMC Public Health*, 2021, vol. 21, pp. 1976.

Džamonja Ignjatović, Tamara, Stanković, Biljana & Klikovac, Tamara (2020). Experiences and the quality of life of the elderly during the COVID-19 pandemic and imposed restrictive measures in Serbia, *Psihološka istraživanja*, vol. 23, no. 2, pp. 201-231.

<https://search.bvsalud.org/global-literature-on-novel-coronavirus-2019-ncov/resource/en/covidwho-1501996>

Kaine, Geoff, Greenhalgh, Suzie & Wright, Vic (2022). Compliance with COVID-19 measures: Evidence from New Zealand, *PLOS ONE*, 17, 2: 1-20. <https://doi.org/10.1371/journal.pone.0263376>

Ljubičić, Milana, "The elderly's everyday life and official discourse about coronavirus: between social care and ageism. In: Slađana Dragišić Labaš (ed.), *Social aspects of ageing during the COVID-19 pandemic*, Univerzitet u Beogradu – Filozofski fakultet, Službeni glasnik, Beograd, 2021, pp. 67-84.

Mihelič, Anže, Jelovčan, Luka & Prislán, Kaja (2021). Internal and external drivers for compliance with the COVID-19 preventive measures in Slovenia: The view from general deterrence and protection motivation, *PLOS ONE*, 16, 11: 1-18. <https://doi.org/10.1371/journal.pone.0259675>

Pavlović, Zoran, Todosijević, Bojan & Stanojević, Dragan (2021). Support for the Measures in Fighting the COVID-19 Pandemic: The Role of Political Ideology, *Psihologija*, 54, 2: 207-222.

Pešić, Jelena (2021). "Pandemic and neoliberal discourses". In: Ivana Spasić (ed.), *Pandemic, society and symbolic order: public discourse in/about the crisis caused by COVID-19*, Univerzitet u Beogradu – Filozofski fakultet, Službeni glasnik, Beograd, 2021, pp.103-125.

Poleti Ćosić, Dunja (2021). "From saving life to saving economy; strategies of legitimization of measures for suppressing the contagion in Serbia". In: Ivana Spasić (ed.), *Pandemic, society and symbolic order: public discourse in/about the crisis caused by COVID-19*, Univerzitet u Beogradu – Filozofski fakultet, Službeni glasnik, Beograd, 2021, pp. 69-87.

Radoman, Marija. "Mental health of the elderly in Serbia – research into support systems during the COVID-19 pandemic". In: Slađana Dragišić Labaš (ed.), *Social aspects of ageing during the COVID-19 pandemic*, Univerzitet u Beogradu – Filozofski fakultet, Službeni glasnik, Beograd, pp. 135-150.

Regy, Minitta, Kiran, Pretesh & Gnanaselvam, Nancy (2021). Anxiety and Resilience among the Elderly During the COVID-19 Related Lockdown in Anekal, Karnataka, *Indian Journal of Gerontology*, вол.35, бр.2, pp. 143-150. <https://pesquisa.bvsalud.org/global-literature-on-novel-coronavirus-2019-ncov/resource/pt/covidwho-1200559>

Santana, Paula Ana, Korn, Lars, Betsch, Cornelia & Bohm, Robert (2022). Lessons learned about willingness to adopt various protective measures during the early COVID-19 pandemic in three countries, 17, 3: 1-16. *PLOS ONE*. <https://doi.org/10.1371/journal.pone.0265892>

van Breen, Jolien, Kutlaca Maja, Koç, Yasin, Jeronimus, Bertus, Reitsema, Anne, Jovanović Veljko, et al. "Lockdown Lives: A longitudinal study of inter-relationships amongst feelings of loneliness, social contacts and solidarity during the COVID-19 lockdown in early 2020", Durham University Library, Stockton Road, Durham DH1 3LY, United Kingdom, 2022.

van Loenhout, Joris, Adriaan, Frank, Vanderplanken, Kirsten, Van den Broucke, Stephan & Aujoulat, Isabelle (2022). COVID-19 measures in Belgium: how perception and adherence of the general population differ between time periods, *BMC Public Health* 22,245: 1-12. <https://doi.org/10.1186/s12889-022-12654-7>

Žikić, Bojan, Stajić, Mladen & Pišev, Marko (2020). New social and cultural normality and COVID-19 in Serbia from February to May 2020. *Etnoantropološki problem*, vol. 15, no. 4: 949-978.

U ZATIŠJU KORONE: MIŠLJENJE STARIJIH O MERAMA ZAŠTITE OD KOVIDA-19 PRIMENJENIM U SRBIJI I PREDLOZIMA ZA BUDUĆE MERE

Slađana Dragišić Labaš, Milana Ljubičić

Rezime

U radu se bavimo ispitivanjem mišljenja starijih osoba iz Beograda o merama koje su primenjene u toku pandemije izazvane virusom SARS-COV-2 u dvogodišnjem periodu (2020-2022). U uzorku, koji je činilo 30 ispitanika, starosti od 65 do 93 godine, našli su se i lekari različitih specijalnosti, te je bilo moguće dobiti informacije i od medicinskih stručnjaka. Analiza narativa ispitanika dopunjena je sa nekoliko intervjuova dobijenih od strane zaposlenih lekara koji su u toku pandemije imali više kontakata sa starijima. Tako smo prikupili značajne informacije iz ugla doživljenog i emocionalnog i iz stručnog ugla. Prema dobijenim nalazima većina ispitanika kao i stručnjaci - lekari su mere potpunog zatvaranja procenili kao previše stroge, neefikasne, loše, nepromišljene, ali i diskriminišuće, dok su sadašnje procenili takođe kao neefikasne, tj. previše liberalne. Predlažu nalaženje sredine ili „prave mere prilagođene pandemijskoj situaciji“. Rezultati istraživanja dragoceni su za planiranje sadašnjih kao i budućih zaštitnih mera u kriznim situacijama.

Ključne reči: mere zaštite od KOVID-19, mišljenja starijih, potpuno zatvaranje, sadašnje mere

Original scientific paper UDK: 616.98:578.834-036.88

Handed over: 26.05.2023.

Accepted: 12.06.2023.

THE INFLUENCE OF THE AGE STRUCTURE ON INCREASED MORTALITY DURING THE COVID PANDEMIC - THE EXAMPLE OF SERBIA²⁷

Jelena Stojilkovic Gnjatovic²⁸

Abstract

Population development under regular circumstances is relatively easy to predict if the components of population dynamics are stable. Current and extreme changes such as pandemics have also left a significant “demographic” mark in the past, so the COVID-19 pandemic also led to changes in fertility, mortality and migration. The aim of this paper is to examine the importance of the age structure for the mortality of the population in Serbia (without data for Kosovo and Metohija), in order to reveal the fundamental reasons for the extremely large increase in the mortality of the population in 2020 and 2021. This increase can certainly be linked to the COVID-19 epidemic as the main cause of mortality, but also to the fact that mortality has increased due to the overburdening of the healthcare system, as indicated by the general mortality of the population.

²⁷ Radjena stao kao rezultat istraživanja koje je podržalo Ministarstvo nauke, tehnološkog razvoja i inovacija, projekat br. 451-03-47/2023-01/200091.

²⁸ **Jelena Stojilkovic Gnjatovic**, Geografski fakultet, Univerzitet u Beogradu, jelena.gnjatovic@gef.bg.ac.rs

The paper uses the both direct and indirect standardization methodology in order to eliminate the influence of the age structure on the mortality of the population. In this way, it is possible to answer the question of how much the mortality of the population would have been if the COVID-19 pandemic had not happened, i.e. how much mortality would have differed if it had happened, for example in some moment in the past. Standardization of the age-specific mortality rates of the population of Serbia in the years of the pandemic revealed a great influence of the age structure on the increase in mortality, and the main reason can be the influence of cohort inertia, i.e. the influx of numerous baby boomer generations into the old population. The shape of the mortality curve of those who died from the coronavirus shows a rather low mortality of the young and middle-aged persons, while with age, especially after the age of 65, the specific death rates rise sharply.

The coincidence of the ageing of the baby boom generation and the epidemiological crisis caused by COVID-19 has led to unfavorable demographic changes that are most obviously reflected in the increase in the absolute number of deaths with the highest values ever since mortality rates have been monitored by modern vital statistics. The general conclusion points to the fact that the number of deaths in Serbia would have been significantly lower if the corona virus pandemic had occurred when the population was younger.

Keywords: Age structure, Mortality, Standardization, Population aging, Serbia

Introduction

The modern demographic reality is the world where fewer and fewer children are born and people live longer and longer (as they did on average until pandemic outbreak in 2020). Demographic history can be framed in different perspectives that point to the particular reason why this is becoming general norm. Some theories emphasize the importance of fertility decline and technological improvements for the escape from Malthusian trap, while other highlight the public health advances for major shifts in the demographic transition (Cunning, 2011). Still, no argument can be made against the fact that past epidemics had overwhelming impact on course of population trajectories, since disappearance of plague was the first and pivotal moment for mortality patterns to be transformed, followed by vaccination uptake (Preston, 1975). For general population, the shape of mortality curve was dictated with age of population dying, and during long demographic transition, its form has been changed substantially from J to U-shape. Available data show that various pandemic had different age profile of mortality, which means its affect on overall mortality differed. Only in XX century, there had been three pandemics that were not predicted nor in periodicity or patterns, designated by presumed sited of origins - Spanish in 1918, Asian in 1957, and Hong Kong influenza in 1968 (Kilbourne, 2006). Each burdened population with different age specific death rates, Spanish influenza had “W” shaped mortality curve with very high mortality rates in younger than 5, healthy young adults aged 20-40 years and older then 65 years. The mortality rates of Asian flu resembled the “J” shape since only older population had greater chance of dying, and Hong Kong flu was the most distinct since death rates were similar for all age groups with only slight excess for students and adults ages 35-39 (Glezen, 1996).

Under the assumption of regular circumstances, demographic projection methods are equipped well enough to predict the population

developments, meaning that using theoretical knowledge on the components of population dynamics, we could get a glimpse into the future. But, as Frejka (1981, 24) stated, “population is a component of the complex societal dynamic system in which we are never likely to understand all the existing and developing interrelations, and even if we did, it is unlikely that we could predict all the future economic, political, environmental, and other developments that interact to shape future population growth”. Pandemic of COVID-19 confirmed that complexity dimension, given the not just pandemic itself could not be predicted just as previous pandemics wasn't, but also question of scope of influences it had on mortality, fertility and migration even after pandemic started were unanswerable.

The feature of most pandemics is instant and extreme changes, foremost in mortality patterns, but also on the other components of population dynamics, leaving a significant “demographic” mark in fertility, mortality and migration. The COVID-19 outbreak is no exception in this regard, given profound influence it had on every demographic aspect of population development. The systemic nature of interconnections between mortality, fertility and migration can be further linked to the age structure, meaning that change in one system component can affect other aspects. Most visible impact of COVID-19 was on mortality, since noticeable increase in morbidity rates from new virus transpose to the higher mortality indicators. Fertility is known as driver force in age structure changes and COVID-19 pandemics had influence on birth rates, additionally postponing or altering the fertility decisions. With the purpose of health protection, the movement restrictions in the early pandemic waves, coupled with banned border crossing, led to less migration activities, influencing migration stocks as well (Figure 1).

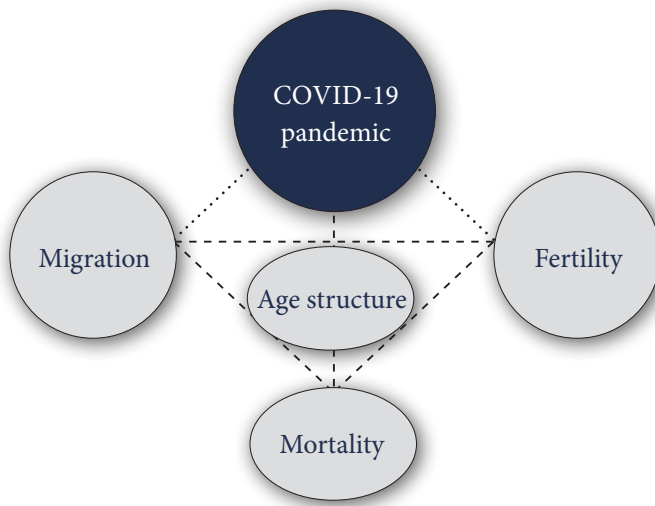


Figure 1. Interrelation of COVID-19 pandemic and population dynamic components.

The aim of this paper is to examine the importance of 2020 and 2021 “COVID-19 years” for mortality and age structure changes in Serbia and provide proper methodological framework for understanding unprecedented rise in mortality counts and rates. After method of standardization and data sources are introduced, the paper explores two research questions: would mortality be different if pandemic outbreak happened in some other point in the past and what would be the mortality of the population if the COVID-19 pandemic had not happened. The discussion of results and concluding remarks give the wider commentary on the importance of age composition in aging Serbia, possible reasons for substantial death toll caused by pandemic and advocate for the better preparation and mitigation strategies for (even still unforeseen) health challenges of ageing population.

Data and Method

In order to encompass the implication of the sudden rise in the mortality in Serbia after March 2020 due to COVID-19 pandemic spread, the paper uses the standardization methodology to eliminate the influence of the age structure on the mortality. The crude mortality rate is heavily influenced by age structure, so this measure can be challenging for comparison purposes. The highest crude mortality rates are not always found in the counties with most severe mortality, but if standard population is appropriate, the highest age standardized death rates will pinpoint the countries with most unfavorable mortality (Watcher, 2006). Fundamental reason where crude mortality rates are favorable but age standardized mortality are higher rates can be age structure of population. The biological basis of mortality depicted on mortality curve reveals that young population will have less deaths, so age-standardization is the approach that clears these relations so that they are differently perceived when put into accurate perspective. There are two types of standardization, and the available data and research purpose dictates which particular standardization can be used. This paper uses both forms – direct and indirect standardization since its aim is to make temporal comparison for one country.

It is important to stress that age standardized mortality rates can not be stand alone measure since they need to be compared to the particular country or point in time in order to have meaning. In the case of assessment of the age structure importance for Serbia's high mortality during first year of pandemic, two research questions are aimed to be answered with according methodology and data:

- 1) If pandemic onset was in some moment in the past, would mortality be different?

The direct standardization is used: the age-specific mortality rate for 2020 and 2021 was calculated using estimated data on age structure and available vital statistics on mortality. These age-specific rates were multiplied with the number of estimated population in appropriate age brackets in the

period 1991-2019 and then summarized. This number shows the expected number of deaths if given population would have same age specific mortality as Serbia did in 2020 and 2021. When divided with total number of standard population, the age-standardized mortality rate is obtained. For the calculation of age standardized mortality rates - m^{ds} the following notation and formulae is used:

$$m^{ds} = \frac{\sum n m_x * n \bar{P}_x^s}{\bar{P}^s} * 1000$$

$n m_x$ - age-specific mortality rate

$n \bar{P}_x^s$ - standard age structure

$\bar{P}^s$ - standard population

2) If pandemic did not occur, would mortality differ compared to actual 2020 and 2021 mortality?

In order to answer this question, the indirect standardization is used: the age-specific mortality rates in period 2009-2019 are calculated for Serbia and then those values are multiplied with age structure in 2020 and 2021. The premise is that the age structure in 2020 and 2021 exposed to the mortality levels from previous period can show the difference between the scenario where population is subjected to pre-pandemic mortality and actual mortality in pandemic years. For the calculation of age standardized mortality rates – m^{is} the notation and formulae used is:

$$m^{is} = \frac{M}{\sum n m_x^s * n \bar{P}_x} * m^s$$

$n m_x$ - age-specific mortality rate

$n \bar{P}_x$ - standard age structure

M - absolute mortality – number of deaths

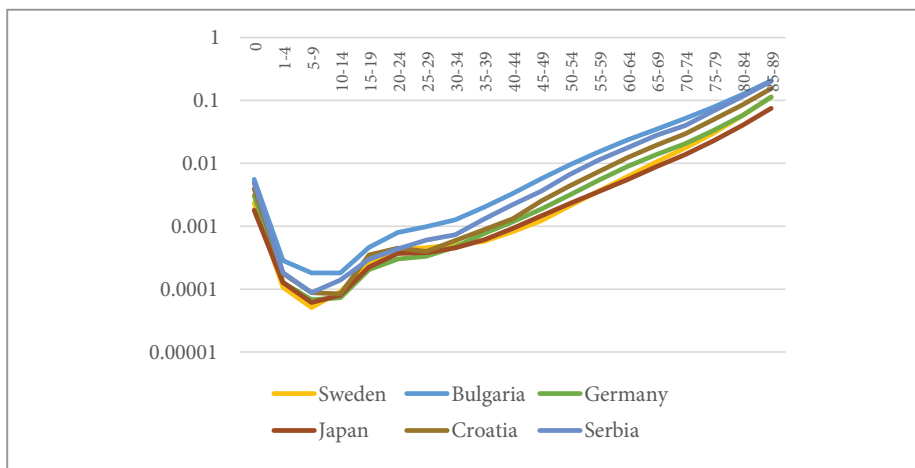
m^s - mortality rate in standard population

The data on age structure and mortality counts are obtained from Statistical Office of Republic of Serbia (SORS 2022a, 2022b). The age structure is taken for period 1991-2020 and mortality counts are available for 2009-2020, thus limiting longer time period analysis. Additionally, data on causes of mortality are used, particularly those classified in newly formed code for special purposes which in 2020 and 2021 were deaths from corona virus. It should be noted that data for Kosovo and Metohija were not available and all calculation and results are only applicable for corresponding population.

Results

The outbreak of COVID-19 in 2020 posed the crucial question for mortality level and it related very closely to the shape of the mortality curve not only for those who passed from the coronavirus, but overall population dying. As already mention, previous pandemic in the last century had various shapes of the mortality curve, directly affecting excess mortality. In the case of corona virus, the age-mortality profile shows a quite low mortality of the young and middle-aged persons, while in older age groups, especially after the age of 65, the specific death rates increase substantially (Dowd et al., 2020). The demographer has been depicting mortality curve on log scale for greater visibility, and different countries had to endure more or less mortality hit after COVID-19 outbreak. For example, Japan and Sweden, even though very old countries, had smallest mortality rates compared to bit higher indicators in Germany. On the other side are high values recorded in Croatia, then Serbia and lastly Bulgaria, where it is quite clear that Bulgaria had the worst age specific death rates in chosen group (Graph 1).

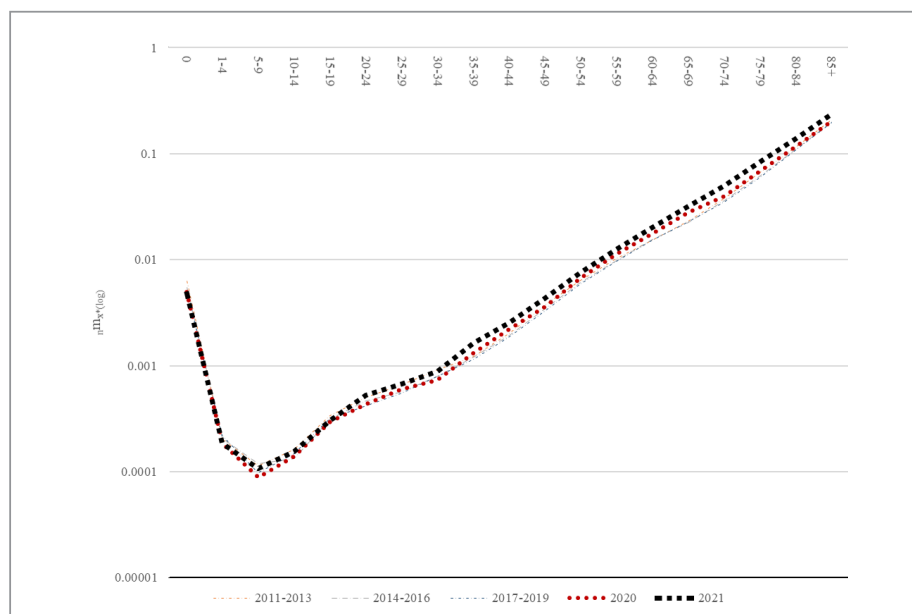
Graph 1. Age specific death rates, chosen countries, 2020



Data Source: HMD, SORS (2022a, 2022b). Author's calculations

In order to analyze the change in mortality patterns in Serbia in pre- and post-COVID-19 period, the comparison between the death rates for 5-year age groups should be starting point. The Graph 2 shows that three year averages (2011-2013, 2014-2016 and 2017-2019) had lower mortality in all age groups after 40s, compared to 2020. There is almost no difference in this pre-pandemic years in terms of age-specific mortality rates, but when compared to first pandemic year, there are small differences in death rates in younger population that are due to restrictions in 2020 when various accidents were avoided, thus decreasing the chances for fatal outcomes. This is important in context of comparison with previous period because lower mortality in younger population during this year is significant for further standardization and results elaboration. The mortality in 2021, when such restrictions were lifted is almost the same in young, but noticeably differs for older population.

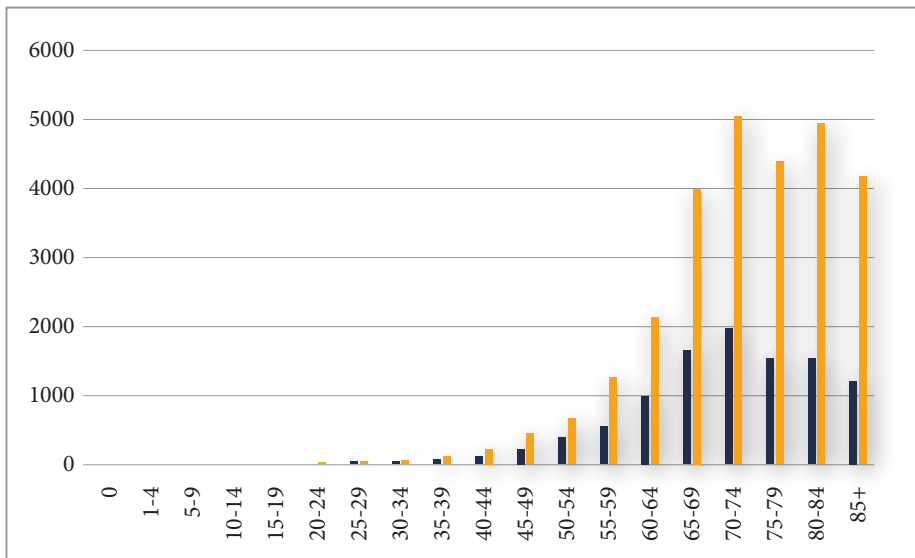
Graph 2. Age specific death rates, Serbia, chosen years



Data Source: SORS (2022a, 2022b). Author's calculations

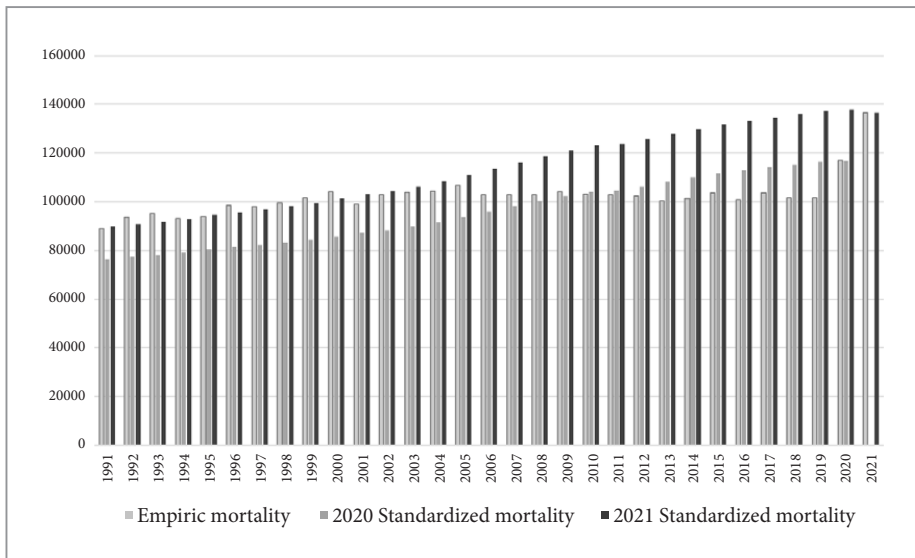
One of important question is what is the extent of mortality burden posed by COVID-19, and given the time distance from the pandemic onset, it can be partially answered. While in the first months (and year), the disease detection and determination of cause of death was challenging, in April 2020 World Health Organization gave instructions (2020, WHO) for handling the coding in case of COVID related death. New codes assigned in range of U00 and U089 were given for various forms of COVID deaths, making it possible to distinguish pandemic and non-pandemic mortality. New ICD-10 codes for COVID-19 were U07.1 COVID-19 if virus were identified and U07.2 COVID-19 virus was not identified (clinically-epidemiologically diagnosed, probable and suspected COVID-19). In 2020 there was registered 10 353 deaths that had code for special purposes, and 27737 in 2021. Still, another important dimension is age structure, as Graph 3 shows that older population was disproportionally burdened with novel cause of death.

Graph 3. Causes of death Codes for special purposes (U00-U89), 2020 and 2021



Data Source: SORS (2022b).

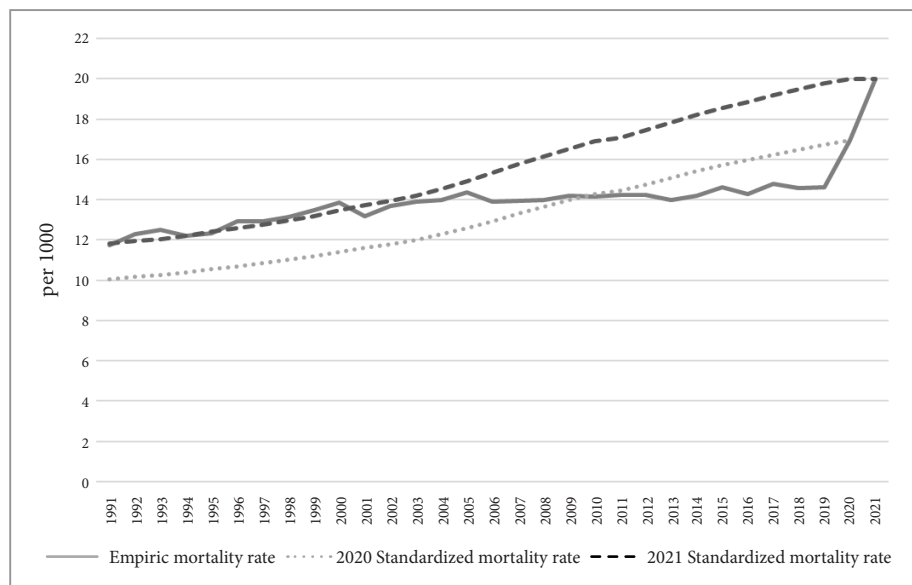
The last year when number of deaths was less than 100 000 was 2001 (99 008) after which this count fluctuated in the range of minimum of 100 300 (2013) to maximum of 106 771 (2006), until 2020 when sky-rocketed to 116 850 and 136 622 in 2021. This data undoubtedly point to the huge impact of COVID-19 on overall mortality, but without standardization, the deeper analysis would be limited. As the logical result of mortality standardization, in the years where death rates are taken for comparison (2020 and 2021), the empiric and standardized deaths counts are equal. If we had scenario where mortality rates in 2020 were happening to the population in some previous years, the number of deaths would differ to some extent from the recorded mortality counts (Graph 4). The main results analysis can be linked to two periods, the first is the 2010-2019 and other 1991-2009. In the case of more recent period, number of deaths in population that would be subjected to the mortality rates as in 2020 would be higher than real documented values. If mortality rates from 2020 were applied to population age structure in 1991-2010, the summed number of deaths would be less than recorded counts, which at first glance seems contrainditive. The explanation for this unexpected conclusion is in the relations of the age structure and mortality curve characteristics. As stated above, the younger population experienced more favourable mortality in 2020 as movement was restricted, and on the other hand, the population before 2010 had more favourable age structure, ie. less numbers of older population. With this two conditions, the standardized expected number of deaths diverge more as the 2020 mortality rates are multiplied with younger age structure (more distant time horizon in 1990 manifests greater discrepancy compared to the 2000s).

Graph 4. Empiric and standardized mortality counts as in 2020 and 2021, Serbia

Data Source: SORS (2022a, 2022b). Author's calculations

The first year of pandemic was peculiar for many reasons, and for subject of this investigation the facts that COVID-19 onset was in March (not entire year of demographic events were included) and that population during first months expressed more diligence toward measures for reduced contamination is explaining why the following rise in the number of deaths in 2021 is not unexpected. If there was a population that was subjected to the mortality rates from 2021 and age structure in years 1991-2020, such population would have higher mortality counts than empiric values in all XXI century. There is noticeable convergence between real and standardized values in the 1990s, but as in previous case, the only reason is difference in age structure. It should be emphasized that even much younger population in 1990s (in 1991 average age was 37,7, in 2002 40,2 and in 2011 42,2) would not be able to “offset” the huge death toll from 2021.

Graph 5. Age-standardized mortality rates as in 2020 and 2021. (direct)



Data Source: SORS (2022a, 2022b). Author's calculations

Graph 5 quite clear depicts the extend of mortality crisis due to COVID-9 since its values rose from the stagnant average of 12‰ in 1990s to 13‰ in 2000s and 14‰ to sharp 16.9‰ in 2020 and 20‰ in 2021. If mortality in 2020 is used for comparation purposes, the calculated age-standardized death rates would be higher than actual after 2010, revealing the importance of cohort inertia. The ageing of the numerous baby boom generation and their gradual transition to older that 65 was main reason for this temporal division. Namely, as oldest baby boomers (born in 1947) passed „old-age trashold“ of 65 in 2012, created major shift in age structure led to rejunevation of older population (Stojilković Gnjatović & Devedžić, 2020). If higher mortality rates from 2020 were assumed for older population, the age standardized rate would be higher than recorded one. On the other hand, younger population in 1990s and 2000s would been have less impacted. If we take 2021 for comparison, this indicator reveals the severity of COVID-19 pandemic, since age strandardized death rates would be high-

er than actual one in period after 2000, and only in the 1990s the empiric and standardized rates would be similar. This again confirms already mentioned importance of age structure, so that on average younger population in the 1990s would have endured the same mortality impact from pandemic as real population did from hardships from this unfortunate period.

Table 1. Age-standardized mortality and mortality rates (indirect)

	Number of deaths (M)	Mortality rate (m)	Standardized m 2020	Standardized m 2021
2009	104000	14.21	12.66	12.79
2010	103211	14.16	12.81	12.94
2011	102935	14.22	12.71	12.83
2012	102400	14.22	12.90	13.03
2013	100300	14.00	12.94	13.07
2014	101247	14.20	13.36	13.49
2015	103678	14.61	13.90	14.04
2016	100834	14.29	13.76	13.89
2017	103722	14.77	14.41	14.55
2018	101655	14.56	14.35	14.50
2019	101458	14.61	14.56	14.71
2020	116850	16.94	16.94	17.12
2021	136622	19.99		19.99

Data Source: SORS (2022a, 2022b). Author's calculations

The second part of conducted research highlights the abstract situation where COVID-19 did not happen so that age specific mortality rates in 2009-2019 are applied on the age population structure as it was estimated in 2020 and 2021. One of methodological constraint is the related to the punctuality of estimates because their base is 2011 census and international migration is not included in this appraisal. Nevertheless, the calculated data (Table 1) shows that if age structure from 2020 and 2021 has held constant and

mortality intensity is changed, the age standardized mortality rates would be different (lower) than actual ones. The reason is changed age structure in pandemic years with decreased number of older population leading to different ratios between recorded and estimated mortality. For example, if population in 2020 were dying as the population in 2019 did, the age standardized mortality rate would be 14,56‰, lower than recorded value. If COVID-19 did not burdened population, the population would have lower mortality in all analyzed years compared to highest 16,94‰ in 2020 and 19,99‰ in 2021, with greater distinction as we go further in the past.

Discussion and Concluding Remarks

This paper is intentionally using the standardization and age standardized mortality ratios for assessment of importance of age structure for unprecedented rise in mortality counts, and not the other indicators such as absolute number of excess deaths, per capita rate of excess deaths or z-score as such measures are perceived as not suitable for comparison of attributable mortality (Cube et al., 2021). While issues may rise in case of international comparison when defining the standard population (Bignami Van Assche, Ghio, 2022), the thorough analysis for one county does not suffer for such difficulties. Also, the motivation behind this approach is closely related to difference between cohort and period approach, and as suggested by Goldstein and Lee (2020: 22038), the period life expectancy is not appropriate measure of pandemic shock as it assumes that "the epidemic is experienced each year over and over again as person gets older". Since we do not have available cohort measures of life expectancy, period life expectancy change in pandemic years has to be discussed with caution.

There is no doubt that COVID-19 had deep and overreaching impact on all societal spheres in Serbia, with demographic system being particularly affected through components of population change. Previous research on impact assessment on fertility (Vasić, 2021) rose important questions of

how negative and long would be the “lifespan” of corona outbreak and its influence on number of births, estimating that there would be between 2,2 and 5,5 thousand babies less than is would otherwise be. This aspect is immensely important, given the relevance of fertility for age structure. The estimated average age of population in pandemic year resemble the indicator from previous years, even though the massive change in older population happened due to increased mortality. Theoretically, this indicator should be lower pointing to population rejuvenation, and it would be if the number of births did not fell. This further poses huge challenges for determination of future behavior of population relevant for population projection since it limits the prediction capacity. On the other hand, Galjak (2021) estimated that since women younger than 50 were disproportionally less affected with COVID-19 related mortality, the future direct cost of premature mortality on birth rates will not be extensive. Penev (2021) rightfully concluded that it is not probable that natural movement and age structure issues would be easily overcome and that pandemic will leave the demographic consequences for future period. The importance of interconnectivity between age structure and mortality patterns examined in this paper additionally frame development paths of population in present and shape the outline of further expectations.

Given that population in Serbia is among the oldest in the world and that measures that incorporate the life expectancy into population ageing research also indicate unfavorable trends (Stojilković Gnjatović, Devedžić, 2016), the high cost in mortality counts during pandemic was inevitable. The changes in internal age distribution in older population after 2012, when post-WWII baby boom generation started transition to widely marked “old age of 65+”, are another dimension that amplified the base condition for very steep rise in mortality counts. As demonstrated in the paper, if COVID-19 crises from 2020 occurred to the population of Serbia in some point in the past, the death toll and intensity of dying would be less pronounced. This is particularly true for the period when popula-

tion was younger (1990s and 2000s). The gravity of mortality burden in 2021 is confirmed with standardization method, as even 5 year younger population on the average in the 1990s would not be less ill-affected compared to actual mortality. The opposite direction of standardization reveals that imaginary situation where COVID-19 did not happen and where population in Serbia had mortality rates as in previous years, the age standardized mortality rate would be noticeably lower ranging from 12‰ to 14‰ than those experienced in 2020 (16,94‰) and 2021 (19,99‰).

Finally, not all excess mortality can be attributed to the corona virus as cause of death, since the difference from the 3-year average of absolute number of deaths before the pandemic and cause of death related to corona virus is not negligible, i.e. around 4200 in 2020 and 6600 in 2021. This is pointing to the great difficulties that population endured as health system was overcrowded with those in need. The postponement of non-life treating procedures led to further deterioration of health of population, calling for careful re-examination of past experiences and adequate measures in case of future health treats. Additionally, even though the gender perspective was not included in the analysis, the recognition of this important dimension for any evidence based policy toward older population and desired health improvements should not be omitted.

References

Bignami Van Assche S., Ghio D. (2022), Comparing COVID-19 fatality across countries: a syntheticdemographic indicator, *Journal of Population Research*, Vol. 39, pp. 513–525.

Canning, D. (2011), The causes and consequences of demographic transition. *Population Studies*, Vol. 65, no. 3. pp. 353–361. doi:10.1080/00324728.2011.611372.

Dowd J.B., Andrianola L., Brazela D. M., Botondia V., Blocka P., Dinga X, Liua Y, Millsa M.C. (2020), Demographic science aids in understanding the spread and fatality rates of COVID-19, *PNAS*, Vol. 117, pp. 9696–9698.

Frejka T. (1981). World Population Projections: A Concise History, *The Population Council*, No 66. pp. 30.

Galjak M. (2021), The effects of covid-19 pandemic on the premature mortality in Serbia in 2020, *Demografija*, Vol. 18, pp. 57-70.

Glezen W. P. (1996), Emerging Infections: Pandemic Influenza, *Epidemiologic Reviews*, Vol. 18, No. 1, pp. 64-76.

Goldstein, J, Lee R. (2020), Demographic perspectives on the mortality ofCOVID-19 and other epidemics, *PNAS*, Vol. 117, No. 36, pp. 22035–22041.

Marinković I. (2021), Regionalna analiza smrtnosti od covid-19 u Srbiji 2020, *Demografija*, Vol. 18, pp. 39-56.

KilbourneE. D. (2006), Influenza Pandemics of the 20th Century, *Emerging Infectious Diseases*, Vol. 12, No. 1, pp. 9-14.

Penev G. (2021), Demografski bilans srbije u prvoj godini pandemije covid-19,*Demografija*, Vol. 18, pp. 1-18.

Preston S. H. (1975), The Changing Relation between Mortality and Level of Economic Development, *Population Studies*, Vol. 29, No. 2, pp. 231-248. <https://www.jstor.org/stable/2173509>

Wachter K. W. (2006), *Essential Demographic Methods*, Berkeley, University of California.

World Health Organization. (2020). International guidelines for certification and classification (coding) of covid-19 as cause of death. Geneva: World Health Organization.

SORS (2022a), Population estimates by age and sex, comparative overview on the municipality level, <https://data.stat.gov.rs/Home/Result/18010602?languageCode=en-US&displayMode=table&guid=06a22cdd-f4d1-4cae-a692-24769653e0f0>

SORS (2022b), Deaths, by the causes of death, sex and age, <https://data.stat.gov.rs/Home/Result/18030302?languageCode=sr-Cyrl&displayMode=table&guid=91eb02a9-312d-4867-8fcb-d45babbcf927>

Stojilkovic Gnjatovic J, Devedzic M. (2016), Certain characteristics of population ageing using a prospective approach: Serbia as a case study, *Vienna Yearbook of Population Research*, Vol. 14, pp. 89–106

Stojilković-Gnjatović, J., & Devedžić, M. (2020). Kohortno “talasanje” kompenzacionih i krnjih generacija kroz pokazatelje oštine i dubine starenja stanovništva u Srbiji. *Demografija*, Vol. 17, 9-28.

von Cube M., Timsit J.F., Kammerlander A., Schumacher M (2021), Quantifying and communicating the burden of COVID-19, *BMC Medical Research Methodology*, 21:164, pp. 1-11.

Vasić P. (2021), Covid-19 and fertility in Serbia - rough pandemic impact assessment, *Demografija*, Vol. 18, pp. 19-38.

UTICAJ STAROSNE STRUKTURE NA POVEĆANU SMRTNOST U VREME KOVID-19 PANDEMIJE – PRIMER SRBIJE

Jelena Stojilković Gnjatović

Rezime

Razvitak stanovništva u redovnim okolnosti je relativno lako predvidiv ukoliko su komponente populacione dinamike stabilne. Trenutne i ekstremne promene poput pandemija su i u prošlosti ostavljale značajan “demografski” trag, tako da je i pandemija virusa KOVID-19 dovela do promena u fertilitetu, mortalitetu i migracijama.

Cilj rada je ispitivanje značaja starosne strukture za mortalitet stanovništva u Srbiji (bez podataka za Kosovo i Metohiju), kako bi se otkrili temeljni razlozi za izuzetno veliko povećanje smrtnosti stanovništva u 2020. i 2021. godini. Ovo povećanje se svakako može dovesti u vezu sa virusom KOVID-19 kao osnovnim uzrokom smrtnosti, ali i činjenicom da je mortalitet porastao i zbog opeterćenosti zdravstvenog sistema, na šta ukazuje opšta smrtnost stanovništva. Rad koristi metodologiju direktne i indirektne standardizacije kako bi se eliminisao uticaj starosne stukture na mortalitet stanovništva. Na taj način se može odgovoriti na pitanje koliki bi mortalitet stanovništva bio da se pandemija KOVID-a nije desila, odnosno koliko bi se smrtnost razlikovala da desila npr. u nekom trenutku u prošlosti. Standardizacija starosno-specifičnih stopa mortaliteta stanovništva Srbije u

godinama pandemije otkrila je veliki uticaj starosne stukture na povećanje smrtnosti, a kao glavni razlog može se izvojiti uticaj kohortne inercije, odnosno priliv populaciono brojnih generacija baby boomera u staro stanovništvo. Oblik krive mortaliteta umrlih od korona virusa pokazuje prilično nisku smrtnost mladih i sredovečnih, dok sa starošću, naročito nakon 65 godina, specifične stope umrlih naglo rastu.

Koincidencija starenja baby boom generacija i epidemiološke krize izazvane KOVID-om dovela je do nepovoljnih demografskih promena koje se najočitije ogledaju u povećanju apsolutnog broja umrlih sa najvišim vrednostima od kad slučajeve smrti prati moderna vitalna statistika. Opšti zaključak ukazuje na činjenicu da bi broj umrlih u Srbiji bio osetno manji da se pandemija korona virusa desila kada je populacija bila mlađa.

Ključne reči: *starosna stuktura, mortalitet, standardizacija, starenje stanovništva, Srbija*

Original scientific paper UDK: 378.147.091.31-053.9

Handed over: 21.02.2023.

Accepted: 07.03.2023.

EDUCATIONAL OFFER OF THE UNIVERSITY FOR THE THIRD AGE²⁹

Jovan Miljkovic³⁰, Bojan Ljubic³¹

Abstract

Universities for the third age, although they are not the only providers of education intended for older population, represent an important pillar of education for this special target group. After more than three decades of the establishment of the first university for the third age in Serbia, the dynamics regularities of the adult education system development also operate in this part of its subsystem. In accordance with social changes, the number of institutions classified as universities for the third age, the offer of their programs, as well as the geographical distribution of these institutions, and thus the availability of their educational offer to the older population, are changing. The purpose of this work is to determine the characteristics of the educational offer of universities for the third age: distribution on the territory of the Republic of Serbia, program orientation, organizational forms of realization of educational activities and ways in which they are adapted to the target population. In terms of methodology, the research relies on a qualitative research paradigm, within which a

²⁹ The implementation of this research was financially supported by the Ministry of Science and Technological Development and Innovation of the Republic of Serbia as part of the financing of scientific research work at the University of Belgrade - Faculty of Philosophy (contract number 451-03-47/2023-01/ 200163).

³⁰ Jovan Miljkovic, The University of Belgrade – Faculty of Philosophy, jovan.miljkovic@ff.bg.ac.rs

³¹ Bojan Ljubic, The University of Belgrade – Faculty of Philosophy, bojangleljubic@gmail.com

multiple case study was applied as a research model, and content analysis was used as a method, more precisely, content analysis of the websites of the university's educational offer for the third age, along with their narrative analysis.

The research results indicate insufficient and unequal distribution of universities for older persons, limited range of educational content within the traditional, general education (liberal) oriented educational offer (mainly artistic and recreational programs, as well as programs for learning a foreign language and overcoming ICT challenges) offered to older persons in different parts of Serbia, and traditional forms of teaching (mainly courses and less frequently individual teaching). For now, older participants are not offered the possibility of online classes, which would compensate geographically uneven institutional offer. The educational offer is mainly adapted to the needs of the older population through smaller financial resources required for participation in the program, in some cases the possibility of paying in instalments, as well as the realization of some programs in the morning hours. The results of the research open up issues of elitist character of the universities for the third age, how to stimulate the increase in the number of universities for the third age, their further program and organizational diversification, as well as ways in which potential barriers to the participation of older persons could be removed, that is, greater adjustment of the characteristics of the educational offer to the needs of the older population.

Keywords: *Universities for the third age, Educational offer, Educational program, Education of older persons.*

Introduction

“We are the first people in history who live with the reasonable expectation of growing old” (The Sunday Times, 1990: as cited in: Živanić, 2005: 4). Civilizational shifts in several fields have caused the phenomenon of the elderly to become global, and Serbia is not only involved in these trends, but also a leader in them. Statistical office of the Republic of Serbia (Republički zavod za statistiku, 2021) presents data according to which 21.1% of people over 65 years of age live in Serbia.”With an average population age of 43.4 and a life expectancy of 74.2 years, Serbia is one of the oldest European countries” (Develdžić, Stoilković Gnjatović, as cited in: Manić, Miljković, 2022: 121).

With the changing demographic image of the elderly, as well as the scientific and technical component of modern civilization, the relation of society towards this particular stratum also changed.”The goal of modern social care for the elderly should not only be to ensure a peaceful, but also an active ageing” (Milošević, 2009: 207). Active ageing enables the preservation of physical and mental health, and the prerequisite is the prevention of social isolation and marginalization of the elderly population. Learning and education as part of active ageing play a key role. Therefore, the question is not whether to learn in old age, but what and how to learn. According to Laslett (1989), an advocate of the university for the third age, old age is a period of life disengaged from work and care for young children and elderly parents, and it represents the ideal period for self-actualization and for making up for all that we could not achieve in the previous period.

It is hard not to notice that this is still a somewhat elitist concept of an elderly person, a person in pensioner status whose retirement incomes allows him/her not to have to work, and whose descendants do not expect him/her to provide financial assistance or to look after his/her grandchildren and prepare meals for a large family, because the complete independence of

the younger family members and the “empty nest” phase never occurred. In this sense, “education for the third age aims to offer the possibility for creative and free activities, which creates the conditions for new ambitions and new perspectives in society” (Milošević, 2009: 211). Also, there are researchers (Kujundžić, Milić, as cited in: Milošević, 2009) who add to the stated aims the right to activity and profession, to perform work activities, if there are desires and abilities for that. Regardless of the fact that Laslett’s concept of the third age is only an unattainable ideal for many in Serbia, it is also “an example of positive practice in our country, which should certainly be supported and developed in the field of education of the elderly through the University for the Third Age” (Milošević, 2009: 212). In the following lines we will refer to some of the characteristics of this type of institution for the education of the elderly.

The origin and genesis of the universities for the third age

According to Laslett (1989), the concept of the third age is of French origin, and it was in this country that the first educational institutions intended for the elderly population were established in the 1970s. More precisely, “the first such university was founded in Toulouse in 1973” (Savićević, 2004: 97). The idea and practice become international, so for example the first university for the third age in Britain was founded in the summer of 1981 (Laslett, 1989), and in the same year, according to the data reported by Savićević (2004: 98 - 99), “there were 170 universities for the third age in the world in which 125.000 old people were educated”. In 1995 Jarvis (as cited in: Kulić, Despotović, 2005: 16) states “that universities for the third age exist in almost every European country today”. We can proudly state that the former Socialist Federal Republic of Yugoslavia (SFRY), and also Serbia as its constituent, in terms of universities for the third age, are not far behind European trends.

The first university for the third age on the territory of Serbia, and the second in the SFRY, was founded on November 10, 1989 in Belgrade. The founders were the Institute for Pedagogy and Andragogy of the Faculty of Philosophy in Belgrade, the Editorial Board of the educational program of TV Belgrade and Peoples' University Braća Stamenković, and the project within which the university was founded was managed by prof. Snežana Medić, Ph.D.

It is worth noting that the first university for the third age in Yugoslavia was founded in Slovenia in 1984 by the Andragogical Society of Slovenia and the Faculty of Philosophy in Ljubljana. "From then until today, the Slovenian Third Age University has grown into a national network of 53 universities in 51 locations across Slovenia" (<https://www.utzo.si/o-nas>).

Unfortunately, the development of universities for the third age in Serbia did not follow the growth pace of universities for the third age in Slovenia. For thirteen whole years, PU Braća Stamenković was the only university for the third age in Serbia."At the beginning of 2002, the Institute for Pedagogy and Andragogy of the Faculty of Philosophy, in cooperation with the Adult Education Society, launched a new project called 'Expanding the Network of the Universities for the Third Age.'"The bearer of this project is PU 'Braća Stamenković', which, as one of the founders of the University for the Third Age, has rich experience and valuable results in this field. The following institutions were selected as partners: PU 'Božidar Adžija', 'Đuro Salaj' AD, Culture and Education Center 'Čukarica', 'Novi Sad' Open University, PU 'Pavle Stojković' from Niš and Gerontology Center from Vršac" (Živanić, 2005: 36). Given that the adult education system is a dynamic system, which must be constantly in dialectic movement and adapt to the needs of the specific community, its general, political and educational goals and concepts (Miljković, 2019: 47-48), it is not surprising that, soon after the initiative to expand the network of universities for the third age, there is also a change in the institutional framework of the education subsystem

referring the elderly. "Since there was an significant dropout from PU 'Pavle Stojković' and all the necessary prerequisites for the further realization of this Project were not created, this partner is no longer in the Network of Universities for the Third Age. From the 2004/2005 school year, the new partner became the Workers' University in Smederevo" (Živanić, 2005: 38). By this act, Smederevo becomes the southernmost university for the third age point in Serbia, and all other southern territories of the Republic of Serbia are left without this type of educational offer that elderly can use. There are several reasons for this, and Medić (2005: 21) believes that "since its establishment, the University for the Third Age has been a unique, exclusive and avant-garde institution. Unfortunately, it has retained its status until today, although the idea was that the University for the Third Age in Belgrade would be a tested model that would serve to popularize this idea throughout Serbia". This exclusive, in brief, rests on the economic opportunities of older citizens and their educational level, which is more common among older population in developed countries comparing to Serbia. Authors from the most economically developed parts of the world emphasize important changes related to the elderly population in their countries, pointing out, "the importance of changes of a qualitative nature, such as better health care, education and income of adults and the elderly." (...) In such circumstances, it is quite natural that adults and the elderly have a 'better economic position' and feel much younger than their parents, when they were their age" (Kulić, Despotović, 2005: 16). Almost two decades ago, Medić (2005: 20) presented data that to a large extent still applies to Serbia today: "the elderly are a group with a special risk of poverty, and a quarter of the total number of poor people are elderly". Regarding the educational level of the participants, we can refer to the data presented by Nikolić (2005: 34), according to which in the 2003/2004 school year, 0.43% of participants (1 participant) attended educational programs at the PU "Braća Stamenković" with a basic education and 46.96% (108 participants) with a higher vocational education. This once again confirms the countless times proven andragogical theo-

ry, according to which “length of schooling and higher education are significant variables of participation in adult education” (Kulić, Despotović, 2005: 161), i.e., that people with higher formal education participate more often in adult education. Given that Serbia cannot boast of a large share of highly educated people in the total population, and that percentage is even lower among older citizens, it is clear that the target group of universities for the third age is quite narrow compared to the total population of older citizens, and that is located in developed parts of Serbia.

In the research carried out by Milošević in 2009, the existence of a university for the third age in Smederevo is no longer mentioned, which reduces the network of these institutions to 4 institutions in Belgrade (PU “Braća Stamenković”, PU “Božidar Adžija”, KEC Čukarica and “Đuro Salaj” AD), one in Novi Sad (Open University) and one in Vršac (Gerontology Center).

By researching the educational offer of universities for the third age, which we realized in 2022, and which is presented in this paper, we came to the facts that the institutional network of these universities has changed again and that it currently consists of five universities for the third age, of which all based in Belgrade: Cultural Center “Čukarica”, Education Center “Đuro Salaj”, Academia “Educativa”, “Božidarac”, “Božidar Adžija”. It is noticeable that in the network of universities for the third age, there is no founder of this network, PU “Braća Stamenković”, which was renamed to Educational Center “Braća Stamenković”, and directed its educational offer in the direction of professional training and vocational education. What is also new is that part of the institutional network of universities for the third age, in addition to the educational offer at the headquarters of the organization (Belgrade), has its branches all over Serbia. Thus, Academia Educativa offers its programs in: Loznica and Šabac, “Božidar Adžija” realizes programs in: Niš, Novi Sad, Odžaci, Šabac, Senta, Smederevo, Srbobran and Valjevo, while the implementation of educational programs of “Božidarac” can be found in: Novi Pazar, Novi Sad, Požarevac, Senta and Vranje.

The Cultural Center “Čukarica” and the Education Center “Đuro Salaj” still stick to their original concept, to implement the programs as before - exclusively in Belgrade.

As for the educational programs of the first universities for the third age, when they were conceived, they marked “a return to the earlier traditions of education from the pre-industrial period, which had a general educational (liberal) character and included mostly the leisure class. The education provided by universities for the third age is focused mainly on the personality, not on production, on ‘being’, not on ‘doing’” (Savićević, 2004: 97-98). In the same spirit and philosophy, programs were created in the first Serbian university for the third age, which were very broadly and ambitiously conceived, and content-wise grouped under the Green, Red, Blue, Pink, White and Spectrum programs. The Green Program, i.e. the program for the preservation and improvement of the human environment, envisaged program units such as: healthy food, alternative sources of energy, horticulture, etc. The Red Program is the program for preserving and improving human health was conceived from the following program units: medicine, psychology, nutrition, world programs in the field of health prevention, etc. The Blue Program, i.e. the program for the preservation and improvement of cultural and historical values, included sub-programs: history, philosophy, ethnology, history of art, archeology, etc. The Pink Program is the program for the preservation of artistic values and artistic abilities, included special units: fine arts, applied arts, musical arts, literature, theater and stage arts, etc. The White Program, i.e. the program of preservation and improvement of language and communication culture, included: foreign languages, languages of peoples and nationalities (this was the era of the SFRY), classical languages, computer literacy, and journalism, etc. The Spectrum Program is the program of preserving and improving skills, manual dexterity and physical abilities included the following special units: pedagogical skills, handicrafts, cooking, crafts, sports and recreation, social

games, hobby activities, etc. In the first year of operation, the University offered and realized three of the listed programs: painting, English language and a health program with recreation. In the following 15 years of operation, the University for the Third Age “Braća Stamenković” implemented a large number of organizational forms of adult education with a variable composition of participants (lectures, forums, art evenings), and among one-year courses we can, according to the data presented to us by Živanić (2005: 29) identify the following programs (listed according to the number of participants from the most attended to the least attended): fine arts (drawing and painting, watercolor, portrait, icon painting); foreign languages (English, German, French, Spanish); computer literacy (Windows, Word, Internet); physical culture (recreation, yoga, tai chi); history (history of art, history of Christianity); applied art (patchwork, weaving, macramé, ceramics, wood-carving, artistic photography); health program; dance school; craft skills (tailoring and sewing, decorative furniture); musical art; herbs; psychology; massage and self-massage; arranging flowers; literature.

Research methodology framework

The research was carried out during July and August 2022, with the aim of trying to get an answer to the research question: what are the characteristics of the educational offer of universities for the third age in Serbia? In order to answer our basic research question, we used a qualitative research paradigm, the philosophical-theoretical basis of which is the theory of understanding (Matović, 2013: 20). This means that we try to get to the meaning in the context, to the interpretation of the construction of reality related to the subject of research. Within the aforementioned approach, we decided on a method of content analysis, in this case the websites of universities for the third age where their educational offer is advertised, as well as narrative analysis. The analysis of the websites of institutions that are advertised as universities for the third age is aimed at determining the program orienta-

tion of the provider of educational services, and the analysis of the narrative at the communicativeness of the website with the target group, as well as at emphasizing the special adaptations of the offer to the target group (teaching staff, price and organizational aspects).

Research results analysis and interpretation

By analyzing the content of websites, we have obtained data on the current educational offer of the network of universities for the third age. Having in mind the original structure of the program for the third age, we regret to state that there is not a single program in the current program that could be classified within the Green, Blue and Red programs. Table 1 shows that 4 out of 5 universities for the third age offer Pink educational programs, and the drawing and painting program is the only one that is represented in the offer of all institutions that have this type of program in their offer.

Table 1: Pink programs offered by the network of universities for the third age

The Pink Program of the University Network for the Third Age	
Institution	Programs
Education Center „Đuro Salaj“	Drawing and painting
	Dance
	University for the Third Age Choir
Academia Educativa	Drawing and painting
	Painting on silk
	Artistic ceramics
	Sculpting
	Musical arts: Piano, guitar, synthesizer, accordion, violin, flute, drums...
	Solo singing
	Solfeggio
	Traditional songs singing school
Culture Center “Čukarica”	Drawing and painting
„Božidarac“	/
„Božidar Adžija“	Drawing and painting
	Solo singing
	A therapeutic dose of music
	Adžija Choir

We can state that these are the so-called programs “for your soul” with which an elderly person begins or continues to develop his artistic potential, which in the previous age, due to professional or family obligations, were thrown into the background. However, neither the social nor the health aspect that occurs in the implementation of the mentioned programs should be ignored. Elderly people, through participation in these programs, socialize with people of similar age and similar interests, while remaining physically and mentally active.

As for the White programs, these are the only ones offered by all the institutions that are in the network of institutions for the third age. Table 2 shows that there is no greater variability in the program offer and that White programs are variations of two programs: foreign language learning programs and training programs referring work on computer and/or mobile phone use. The computer training program is the only program offered by all institutions in the network of universities for the third age.

Table 2: White programs offered by the network of universities for the third age

The White Program of the University Network for the Third Age	
Institution	Programs
Education Center „Đuro Salaj“	Foreign languages (English, Italian, Spanish, German, French, Russian)
	Computer literacy training
	Computer + mobile phone
Academia Educativa	Foreign languages (English, German, Spanish, French, Italian, Greek, Russian, etc.)
	Informatics, basic course
	Informatics, social networks
Culture Center “Čukarica”	Informatics
	English for the third age
„Božidarac“	Computer literacy for the retired elderly
	Additional education referring Viber, Whatsapp, Facebook and YouTube services
	General English language course for retired elderly
„Božidar Adžija“	WINDOWS + WORD + EXCEL + INTERNET

We can fully characterize the offer of White programs as contemporary “literacy” programs, because both foreign languages and digital competences belong to the domains of key competences in the modern world, without which not a single person can actively participate in it. In the field of digital literacy, there is a large potential target group for educational intervention -

current data say that “even 59% of the population aged 65 to 74 do not use a computer” (as cited in: Manić, Miljković, 2022: 123). It is interesting that computer training was an integral part of the offer of the first university for the third age since its foundation, but until 1998 there was no greater interest in it. It seems that the emigration of young people from Serbia was the trigger for the elderly, who remain in Serbia, to develop an interest in these areas. Jakovljević (as cited in: Manić, Miljković, 2022: 125) “emphasizes that after finding the meaning and function of digital literacy (wanting to communicate in a faster, simpler and cheaper way) retired elderly fully accepted the Internet as a new form of communication, and that somehow there was no difficulties in mastering the necessary skills and knowledge”. The digitization trend continues, and the current time offers more opportunities (e-banking, e-citizen, etc.) that are especially tempting since the corona virus pandemic. Without disputing the self-actualizing role of learning foreign languages, it is worth noting that the English language is actually the language of ICT, and that a large number of software applications are actually in this language, so it can also be partially related to the program described above.

Spectrum programs are the smallest group of programs offered by universities for the third age. One institution does not offer them at all, and among the offered programs, recreational yoga and tai chi programs appear more often than others.

Table 3: Spectrum programs offered by the network of universities for the third age

The Spectrum Program of the University Network for the Third Age	
Institution	Programs
Education Center „Đuro Salaj“	Yoga for the Third Age (55+)
	Tai Chi / Chi Gong
Academia Educativa	Tailoring and sewing
	Recreational Yoga Program
Culture Center „Čukarica“	Tai Chi Chuan
	Knitting workshop
„Božidarac“	/
„Božidar Adžija“	Decoupage

Alike the Pink programs, the Spectrum programs have the function of leisure, relaxation, companionship and preservation of physical and mental health. Unlike Pink programs, these programs do not require artistic talent, but require relatively good physical health and mobility.

By analyzing the narratives of the educational offer expressed on the websites of the institutions that make up the institutional network of universities for the third age, we identified some aspects of the agreement of all institutions and aspects in which certain discrepancies occur.

What all the institutions agree on is the introductory part of the offer, which describes the emergence of the university for the third age and the goals it tries to achieve, with a belief in the mission of educating the elderly. All programs offered are in the form of courses or individual lessons that are implemented exclusively in a traditional way, that is, no university for the third age offers the possibility of attending any online form of education. This surprises us, because about 30% of people aged 65 to 74 still use a computer, and due to the still current corona virus, this form of teaching could be attractive to them. Also, in this way, the uneven geographical distribu-

tion of universities for the third age would be partially compensated, and thus the accessibility of educational programs would increase. It is possible, however, that live socializing is the dominant motive for the participation of the elderly in university programs for the third age, and that the field of study itself is a secondary motivational force. Of course, this hypothesis should be tested empirically by some future research. It is interesting that as far as the teaching staff is concerned, not a single institution emphasizes their didactic-methodical competence for working with adults, that is, with the elderly population, and if their qualities are emphasized, only their professional knowledge is emphasized. This does not mean that these institutions do not have andragogists or andragogically trained teaching staff, but it simply means that they did not recognize this aspect as important in presenting their own educational offer.

What narratively distinguishes the websites of the organizations that make up the network of universities for the third age is the use of expressions and terms that emphasize that these are programs intended for the elderly population. For example, the website of Božidarac emphasizes at every step that it is an offer intended for the elderly: in the very name of the courses (“Computer literacy for the retired elderly” or “General English language course for retired elderly”) or in the description of the courses themselves: “Spurred by the idea of the need for full integration and participation of the elderly in the social community through lifelong education and active ageing, Božidarac designed and implements a computer course for our elderly fellow citizens” (<https://www.bozidarac.rs/lat/kurs-racunar-za-penzionere-windows-word-internet/>). The opposite is the “Božidar Adžija” website, where, apart from the link “University for the Third Age” under which the educational offer is located, nothing highlights the particularity of the population to which the offer is intended. The offer of other institutions is somewhere between these two extremes - somewhere there is no way to guess which population is in focus and how the offer is adapted

to it, and somewhere we have very clear wording: “this is an opportunity to promote self-confidence in the elderly” - course painting of the Culture Center Čukarica, or a yoga course for the elderly (55+) realized by “Đuro Salaj” in which it is emphasized that it is intended for “elderly people, those who are not able to do intense and too demanding exercises”.

There is also a discrepancy regarding the prices and terms of payment for educational services. When passing judgment on this segment of the educational offer, it should be borne in mind that the average amount of pension in Serbia during the first six months of 2022 did not exceed 31.000 RSD (<https://www.pio.rs/sites/default/files/Statistike/Prosecna%20penzija/2022/Prosecan%20iznos%20penzije%2026092022.pdf>). The highest price of an educational service was for individual solo singing lessons (8.000 RSD per month or 1.000 RSD per class), and the cheapest was singing in the Adžija Choir for 1.500 RSD per month. For some educational services institutions offer the possibility of paying in installments, and only in one case was a comparative moment highlighted in which it is clearly seen that the same service is financially more favorable for the elderly than for other adults (the English language course at the CultureCenter “Čukarica” for adults costs 24.000 RSD, and 16.000 RSD for elderly, with the option of paying in 4 installments).

Some of the institutions emphasizes, in addition to the financial adjustments of the educational offer to the possibilities of the elderly, the convenient time for the realization of educational activities, i.e. in the morning hours.

Concluding remarks

After almost three and a half decades since the establishment of the first university for the third age in Serbia, we can state that the concept has withstood the test of time and that it has established itself as an educational institution in the Serbian system of adult education. At the same time, it can be stated that, in accordance with its dynamic character, the concept of

the university for the third age experienced certain institutional transformations - the closure of some and the opening of other institutional units. Despite the institutional transformations, this educational concept was and remains elitist on two grounds: based on the economic possibilities of potential participants and based on their level of education.

Analyzing the current situation in Serbia on both grounds, we regret to state that the elitist character of the institution will continue in the coming period, and that, accordingly, the offer will probably be limited to the more developed parts of Serbia. What gives potential hope that the possibility of attending this institution will be offered in less developed parts of Serbia is the decentralization of the universities for the third age themselves, that is, the opening of their branches throughout our country. The offer of the universities for the third age is relatively uniform - mainly artistic and recreational programs are represented, as well as programs for learning foreign languages and overcoming the challenges of ICT.

Distance learning opportunities do not yet exist, but this is likely to change over time, with more computer users among the aging population. In advertising and communication with potential users of educational services, the emphasis on the financial moment dominates, which is understandable, given the economic situation in the country, but also the position of the target group. Although modest in number, the educational and program aspect of the universities seems stable, having withstood the test of time. We hope that future universities for the third age will find ways to preserve existing educational programs and to develop the interest of participants in new ones, enriching the range of their offer, and thus the possibility of a better quality of life for the elderly. Despite its elitist character, universities for the third age represent one of the pillars of education for the elderly, and we hope that social circumstances will favor this, so that in the future an increasing number of our elderly fellow citizens will be able to afford such an educational experience.

References

Kulić, R. i Despotović, M. (2005). *Uvod u andragogiju*. Beograd: Svet knjige.

Laslett, P. (1989) *A Fresh Map of Life: the Emergence of the Third Age*. London: George Weidenfeld and Nicolson Limited.

Manić, Lj. i Miljković, J. (2022). Bezbednost starijih na internet, *Bezbednost*, 64, (3), 120 – 139.

Matović, N. (2013). *Kombinovanje kvanitativnog i kvalitativnog pristupa u pedagoškom istraživanju*. Beograd: IPA.

Medić, S. (2005). Univerzitet za treće doba – agent promena u obrazovanju starih. U S. Živanić, (Ur.) (2005). *Univerzitet za treće doba* (str. 19 – 24). Beograd: Univerzitet za treće doba, Narodni univerzitet “Braća Stamenković” i Društvo za obrazovanje odraslih.

Milošević, L. (2009). Obrazovanje za treće životno doba u funkciji očuvanja i unapređivanja života u starosti, *Godišnjak za sociologiju*, 5, (5), 207 – 217.

Miljković, J. (2019). *Sistem obrazovanja odraslih: pogled iz konteksta*. Beograd: IPA.

Nikolić, T. (2005). Ko su polaznici univerziteta za treće doba. U S. Živanić, (Ur.) (2005). *Univerzitet za treće doba* (str. 31 – 35). Beograd: Univerzitet za treće doba, Narodni univerzitet “Braća Stamenković” i Društvo za obrazovanje odraslih.

Republički zavod za statistiku (2021). *Upotreba informaciono-komunikacionih tehnologija u Republici Srbiji*. Beograd: Republički zavod za statistiku.

Savićević, D. (2005). *Učenje i starenje*. Beograd: IPA.

Živanić, S. (2005). Mreža univerziteta za treće doba. U S. Živanić, (Ur.) (2005). *Univerzitet za treće doba* (str. 36 – 38). Beograd: Univerzitet za treće doba, Narodni univerzitet “Braća Stamenković” i Društvo za obrazovanje odraslih.

Web pages

Slovenian Univerity for the Third Age: <https://www.utzo.si/o-nas/>, visited on 07.10.2022.

Education Center “Đuro Salaj”: <https://www.salajobrazovanje.co.rs/univerzitet-za-trece-doba/>, visited on 7.10.2022.

Academia Educativa: <http://www.academiaeducativa.org/>, visited on 03.10.2022.

Culture Center “Čukarica”: <https://www.kccukarica.rs/srp/programi-za-odrasle-i-trece-doba>, visited on 03.10.2022.

“Božidarac”: <https://www.bozidarac.rs/lat/o-nama/>, visited on 06.10.2022.

“Božidar Adžija” AD: <https://adzija.com/trece-doba/>, visited on 06.10.2022.

Educational Center “Braća Stamenković”: <http://www.bracastamenkovic.edu.rs/>, visited on 06.10.2022.

The Pension and Disability Insurance Fund of the Republic of Serbia: <https://www.pio.rs/sites/default/files/Statistike/Prosecna%20penzija/2022/Prosecan%20iznos%20penzije%2026092022.pdf>, visited on 03.10.2022.

OBRAZOVNA PONUDA UNIVERZITETA ZA TREĆE DOBA

Jovan Miljković, Bojan Ljujić

Rezime

Univerziteti za treće doba, iako nisu jedini provajderi obrazovanja namenjenog starijoj populaciji, predstavljaju značajni stub obrazovanja ove osobene ciljne grupe. Posle više od tri decenije osnivanja prvog univerziteta za treće doba u Srbiji, zakonomernosti dinamike razvoja sistema obrazovanja odraslih deluju i u ovom delu njegovog podsistema. Shodno društvenim promenama, menja se broj institucija koje se svrstavaju u kategoriju univerziteta za treće doba, ponuda njihovih programa, kao i geografska rasprostranjenost ovih institucija, a time i dostupnost njihove obrazovne ponude starijoj populaciji.

Namera ovoga rada je da utvrdi karakteristike obrazovne ponude univerziteta za treće doba: njihovu distribuciju na teritoriji Republike Srbije, programsku orijentaciju, organizacione oblike realizacije obrazovne aktivnosti i načine na koje su prilagođeni ciljanoj populaciji. U metodološkom pogledu, istraživanje se oslanja na kvalitativnu istraživačku paradigmu, u okviru koje je primenjena multipla studija slučaja kao model istraživanja, a kao metoda korišćena je analiza sadržaja, tačnije, analiza sadržaja veb sajtova obrazovne ponude univerziteta za treće doba, kao i analizu njihovog narativa.

Rezultati istraživanja ukazuju na nedovoljnu i nejednaku distribuciju univerziteta za treće doba, ograničeni raspon obrazovnog sadržaja u okviru tradicionalne, opšteobrazovno (liberalno) orijentisane obrazovne ponude (uglavnom umetnički i rekreativni programi, kao i programi učenja stranog jezika i savlađivanja IKT izazova) koji se nudi starima u različitim delovima Srbije, kao i na tradicionalne oblike realizacije nastave (uglavnom kursevi i ređe individualna nastava). Za sada se starijim participantima ne nude mogućnosti onlajn nastave, čime bi se kompenzovala geografski nejednaka institucionalna ponuda. Obrazovna ponuda je uglavnom prilagođena potrebama starije populacije kroz manja finansijska sredstva potrebna za participaciju u programu, u nekim slučajevima i mogućnost plaćanja na rate, kao i realizaciju nekih programa u prepodnevnim časovima. Rezultati istraživanja otvaraju pitanja elitističkog karaktera univerziteta za treće doba, načina stimulisanja povećanja broja univerziteta za treće doba, njihove dalje programske i organizacione diverzifikacije, kao i načina na koje bi se mogle otkloniti potencijalne barijere za participaciju starih, odnosno, većeg prilagođavanja karakteristika obrazovne ponude potrebama starije populacije.

Ključne reči: *univerziteti za treće doba, obrazovna ponuda, obrazovni programi, obrazovanje starijih.*

Review paper UDK: 364-787.3:[616.98:578.834(497.11)
368.914(497.11)

Handed over: 25.12.2023.

Accepted: 12.01.2024.

PSYCHOSOCIAL SUPPORT IN THE RETIREMENT PROCESS WITH SPECIAL EMPHASIS ON (POST) COVID-19 WORLD

Teodora Hrnjakovic³², Milena Blagojevic³³

Abstract

Retirement represents a transitional life event and a developmental phase that consists of new tasks, challenges and opportunities in an individual's life. The integration of previous experiences, acceptance and adaptation to the new role affect the further life course of not only the retired person but also support networks such as family, friends, the work team and the wider social environment. Retirement enables a type of new identification that requires a certain adaptability, coping with new everyday life, the benefits that the retired status provides, but also risk factors that can affect mental health such as depression, identity crisis, insufficient self-esteem and damaged relationships within the immediate family and wider social community. The global COVID-19 pandemic further increased the vulnerability of older persons and negatively affected their adaptive abilities. An uncertain future, social isolation, additional health risks and questionable financial stability are just some of the challenges that population of older persons faced during the global crisis, and the conse-

³² **Teodora Hrnjakovic**, Faculty of Political Science – University of Belgrade, PhD candidate in Social Work, teodorahrnjakovicfpn@yahoo.com

³³ **Milena Blagojevic**, NGO ADRA, Master of Social Work, milena.blagojevic@adra.org.rs

quences of which are still being felt today. Unfortunately, one gets the impression that older persons are left to their own devices when it comes to preparing for retirement, bearing in mind that in our country there are no preventive programs whose attention would be diverted to the prevention of risk factors for the mental and physical health of this target group.

Therefore, in this paper authoresses with the assistance of content analysis and theoretical approaches explore the effectiveness and presence of psychosocial support oriented towards retirement process. Based on the identified challenges, authoresses offer potential recommendations for creating and further developing support programs for retired persons, as well as improving their position in the transition period.

Keywords: *older persons, retirement, COVID-19, psychosocial support, active ageing*

Concept of Pension and Retirement Process in the Republic of Serbia

The concept of pensions has evolved over time, both globally and nationally. What assuredly remains the same is that retirement represents a new stage of life for the older people and that society is in a (moral) obligation to provide its member with a dignified retirement. Most countries have a regulated retirement system, while their levels of coverage and certain characteristics may vary. The first official pension system in the world as we know it today is found in Germany, designed by the famous chancellor Otto von Bismarck more than a century ago (Börsch-Supan and Wilke, 2004). Our country has come a long way when it comes to structuring the retirement process – from October 10, 1833 when Serbian Prince Miloš Obrenović signed the first pension decision, through 1850 when the first pension law was enacted in Serbia – until the introduction of the Law on Pension and Disability Insurance, which has been in force since 2003 (Tešanović and Folić, 2018). Pension in its fundamental sense constitutes monthly payment and other benefits to which the insured person is entitled in the event of old age, disability, death and related risks (Grupa autora, 1976). Defined in this manner, pension is a key factor for material well-being and a protective factor against poverty (Babović et al., 2018).

Regarding national legislation, aforementioned law regulates that pension and disability insurance rights shall entail in cases of: old age – a right to receive old age pension and early old-age pension; disability – a right to receive disability pension; death – a right to receive family pension; in case of bodily damage caused by a workplace injury or an occupational disease – a right to receive cash compensation for bodily damage and in case of caregiver's assistance – caregiver's benefit (Law on Pension and Disability Insurance, 2003). The focus of this work will be on beneficiaries of old age pension, where the insured is entitled to the same at the age of 65 and at

least 15 years of insurance or after 45 years of insurance, except for women whose age requirement is 63 years and 6 months in 2023, with an increasing trend of two months added every subsequent year. When it comes to early old-age pension, in 2023, the insured person is entitled to the pension after completing 40 years of pensionable service and aged at least 60 years (for men) and after completing 40 years of pensionable service and aged at least 59 years and six months (for women). Early retirement pensions are permanently reduced by 0.34% for each missing month to the age of 65, with a reduction not exceeding 20,4% (Ibid).

Our country has adopted a pay-as-you-go pension plan, as a form of intergenerational solidarity in which pensions are financed from the contributions of current employees who will also receive payment from future generations when they retire (Tešanović and Folić, 2018). In addition to this mandatory public pension and disability insurance, there is voluntary pension insurance which, through the individual contributions, serves as a supplement to pensions that will be received from the state fund (Damnjanović, 2017). According to the data of the Statistical Office of the Republic of Serbia, pensioners constitute nearly 1.6 million of the total population of which 694,653 are men and 897,914 are women (Statistical Office of the Republic of Serbia, 2023).

Advantages and Challenges of Retirement

We live in an era of rapid ageing of the global population. Projections indicate that by the year 2050, the demographic cohort aged 60 and above is anticipated to reach 2.1 billion (United Nations, 2015). Likewise, our country will go through an intensive demographic ageing process, where according to the projected movement of population, in 2041 more than every fourth person in Serbia will be over 65 (Statistical Office of the Republic of Serbia, 2023). Therefore, decades ago, experts from various humanistic disciplines emphasized that retirement and the transition into the third age should not be automatically associated with terms such as old age, poor health or inactive members of society. Retirement is a transition to another stage of life characterized by numerous changes in previous roles, daily routines, income and physical and mental well-being (Krstić-Joksimović, Zotović-Kostić and Petrović 2014). While for one, this new life developmental can be an opportunity to get to know oneself again and enjoy different activities due to increased free time, on the other hand, it can be associated with hopelessness, loneliness and loss of identity. Accordingly, “retirement in the modern world is perceived as a shock and so-called “social death” or as a “realm of freedom and leisure”” (Knežić, 2011: 38).

As previously emphasized, retirement usually means having more free time. Therefore, we cannot discuss this topic without mentioning the concepts of active ageing and lifelong learning. Active ageing refers to community participation that contributes to improving the quality of life and relies on three pillars: health, social participation (participation in various activities) and security (economic factors such as pension) (Egeljić-Mihailović, 2023). The results of the research of 105 participants of the Network of universities for the Third Age showed that participation in educational, recreational and cultural activities significantly improves the quality of life through „socializing and acquiring new friends, maintaining psycho-phys-

ical health, acquiring new knowledge, making up for lost ones, filling the void, feeling of uselessness, enriching personality, satisfaction, creativity, time dedicated to myself – doing what I love and communicating“ (Knežić, 2011 according to Pejatović and Živanić, 2006). The well-known folk proverb „One learns as long as one lives“ is especially significant in the process of retirement and ageing. This has been globally recognized through adoption of The Madrid International Plan of Action on Ageing and the Political Declaration in 2002. This plan promotes principles such as recognition of the social, cultural, economic and political contribution of older persons, equality of opportunity throughout life with respect to continuing education, training and retraining as well as vocational guidance and placement services, reduction of the cumulative effects of factors that increase the risk of disease and consequently potential dependence in older age (United Nations, 2002). This is shown by a study that included almost 3,000 older Canadians and found that formal and informal forms (library, internet use, volunteering, etc.) of education and lifelong learning were positively correlated with health literacy (Merriam and Kee, 2014). An experimental study in Ljubljana showed that volunteering, where the respondents were in the role of tourist guides, led to a transformation of life views and stereotypes not only of the participants, but also of their families and friends (Furlan, 2020). Based on all of the above, we can conclude that retirement is a chance for a person to get to know himself/herself in other ways and to devote himself/herself to things that because of work he/she could not do before.

On the other hand, there are many negative aspects related to retirement and ageing. Several studies have indicated that effective adjustment to retirement is significantly influenced by adequate preparation and retirement planning (Mutran, Reitzes and Fernandez, 1997; Sharpley and Layton, 1998; Noone, Stephens and Alpass, 2009; Wong and Earl, 2009). However, one gets the impression that the retirement of an employed person is still seen as a vacant position and material security, while the focus is not shift-

ed to preparing for life after working life (Knežić, 2011). A study conducted in 2014 on a sample of 191 retirees showed that 56.4% of respondents believe that potential retirement preparation programs are necessary and useful, where, as the most crucial aspects, they assess measures for improving health and structuring time organization (Krstić-Joksimović, Zotović-Kostić and Petrović 2014). Common negative aspects of retirement include a decrease in income, an identity crisis caused by the loss of a professional role, weakened contact with former colleagues, potentially poor health, and a reorganization of family relationships (Ibid). Consequently, one of the challenges can be dealing with depression and anxiety, which are the most common mental health conditions among older people (World Health Organization, 2017). Research on a sample of 225 older people shows that one in three respondents needs some form of additional psychological support (Dimoski et al., 2023). Therefore, meaning in life is a special probability reduction factor of developing or intensifying depression, as life purpose is associated with better mental health, especially in periods such as retirement (Hallford et. al, 2016). Another major obstacle to well-being after working life is ageism. It is the phenomenon of stereotyping and discrimination of a person based only on his age (Vesić, 2021). A meta-analysis that studied the influence of stereotypes about ageing suggests that negative attitudes contribute to the experience of loneliness, poorer mental health, illness and disability in older age, while positive ones lead to improved health and faster recovery from stressful and traumatic events (Krstić-Joksimović, 2019). That is why it is necessary to work on raising the awareness of society members about the consequences of ageism, as well as all the truly positive aspects of retirement and ageing for all of us.

Additionally, in the Republic of Serbia about three quarters of new male pensioners and about a half of female pensioners will retire before they reach the statutory retirement age (women at around 58 year for women and men 61) (International Monetary Fund, 2013). Furthermore, if we con-

sider the increase in life expectancy and the fact that our country is in the rank of countries where both women and men over the age of 65 can expect to spend most of their lives in good health (healthy life years indicator – it is predicted that in our country those who have entered their sixth decade of life will live for another twenty years without major health problems) (Stojilković-Gnjatović, Paunović-Radulović and Mirić, 2016), it is clear that persons have more free time and potential to remain active members of society after the retirement process. Both individuals and society would benefit from it, and to a certain extent, the negative consequences of retirement would be prevented. That is why it is important to implement and promote programs aimed at life preparation for after working life. Finally, the outlined challenges are becoming more difficult in the world of COVID-19 virus, which will be delved into more detail in the following chapter.

Retirement Process in the Time of COVID-19

In previous chapters we have defined the basic ideas, reviewed the retirement process in Serbia and pointed out both the positive and the negative aspects of this life event. COVID-19 epidemic created an atmosphere in which emotions such as fear, uncertainty and worry dominated the people. The period of emergency has significantly influenced socially vulnerable groups, including older persons. Crisis situations, especially the ones in which health safety is jeopardised, significantly influence mental health of the older population. Uncertainty regarding the future, social isolation during quarantine and strict epidemiological measures are just some of the aspects which had a negative impact on mental health of older people. Loneliness does not affect only increased anxiety and depression; it amounts to higher stress levels, inflammations and hypertension, while the social isolation is linked to increased mortality, diminishing of life quality and dementia in older persons (Webb and Chen, 2022). Only some of the research shows that older people reported symptoms of depression during

2020 and duration the pandemic with higher frequency than before (Adamović et al, 2021 according to Koma et al., 2020). Research that Armitage and Nellums conducted in 2020 has also pointed out that the older persons faced greater social withdrawal and loneliness during quarantine, which left far-reaching consequences on their mental health and everyday functioning (Armitage and Nellums, 2020). Santini and associates pointed out that older people who were facing greater social isolation had higher probability to feel anxious and sad, especially if they did not have appropriate care, family or developed social network (Santini et al., 2020). Older people who were in the retirement process during the pandemic have gone through a doubled process of transition – looking from one point of view, life events such as retirement represents a transitional period in which the individual ceases working relationship and gains the right on pension payment, entering the new role in a society. On the other hand, COVID-19 pandemic represented a transition period and it demanded adjustment to newly created circumstances concerning everyone, including older people. Potential factors which influenced persons in the retirement process during the pandemic included loss of job, increased stress, health hazards and age discrimination (Dahl and Knepper, 2020). Certain researches show that the third of people in the retirement process consider that process as stressful and transitional (Calvo and Sarisian, 2011) and that this kind of life event leads to diminished personal well-being (Donaldson et al., 2010). Economic uncertainty linked to the COVID-19 pandemic potentially influenced some older persons to prolong their retirement due to financial needs, or the loss of job forced some people to retire sooner than they had planned (Carr et al, 2021; Feher and de Bidegain, 2020). Additionally, COVID-19 has limited the possibilities of the individuals who were already retired and have been deprived of volunteering, group activities or education, which influenced their mental health and their well-being. Result of limited possibilities in everyday life represented the loss of purpose for older people who are retired, although this extraordinary situation has provided the motivation to older persons

to improve their technological knowledge and develop their digital literacy (Hill et al., 2020; Morrow-Howell et al., 2020).

In the Republic of Serbia, restrictive isolation in institutional accommodation facilities, low material income and undeveloped social services were just some of the problems that the older population faced during the pandemic (Kalašić et al., 2021). Negative emotions that this social group had during the pandemic were mostly in relation to movement restriction epidemiological measures for the population over 65, which caused them tension and anxiety. This restrictive measure made older persons feel that they had no control over their life, which made them feel helpless and humiliated (Ignjatović et al., 2020). During the period of emergency epidemiological measures, retired persons worldwide and in Serbia as well have had additional financial support – their pension checks were delivered safely (the government made sure that their pensions were delivered to their home addresses or they had the possibility to authorize the individual who would collect their pensions for them); they had the right to collect one-time pension bonus that amounted to 4000 dinars which was delivered with one of the pension checks (Todorović, n.d.). However, during the COVID-19 crisis, the value of pension checks lagged behind the average salary - in the beginning of 2021, the average pension has fallen to 50% of the average salary (Republic Institute of Statistics and Republic Fund for Pension and Disability Insurance, n.d.). People responded to financial aid of 100 Euro which was provided by the government as something significant, and priority was given to retired people. Opposite to that example, according to research conducted by Jovanović and associates (2021), older people state that they were in need of more significant financial aid during the pandemic. Considering research conducted by Joksimović and associates (2014), results that were gathered show that the degree of adjustment to retirement was the degree of satisfaction during this life event and the state of health, we can surmise that COVID-19 epidemic had additional impact on adaptation to change among the retired population.

Psychosocial Support in the Retirement Process and During COVID-19 Crisis

It was already pointed out that retirement represents transitional life period that influences both mental and health. It can be characterized as a period of identity crisis in which an older person enters a completely new social role and recreates his/her everyday life. Resources for prevailing the crisis should be first and foremost sought in social support provided for those individuals during the crises period (Drča, 2012). Social support represents “interpersonal exchange which includes emotions (affection, admiration, love), validation (expression of respect) and help (time, money, leadership)” (Vlajković, 1992: 104). Generally speaking, it represents readiness of the environment to show help and support in times of crises, and in situations of hard or transitional life events (Ibid). Further on, restructuring of older persons life provides opportunities for new activities and further participation in society in different ways. Volunteering in a community, group activities and intergenerational solidarity are just some of the answers to potential challenges which the retirement process can bring. Research shows that volunteering in the older age can improve mental and physical health. Worldwide, there are projects which have mandatory programmes for support of older people to learn and acquire new information and skills that can be used in volunteering (Wolf and Brady, 2010). Certainly one of the most important resources in giving psychosocial support to older persons is intergenerational solidarity and intergenerational activities – spending time with their grandchildren, mentorship programmes which the older population can provide for school children and students in relation to professional orientation and their further development (Meriam and Kee, 2013). The fact that older people can seek professional help through consulting psychologists should not be forgotten. When professionals and volunteer work with older persons going through a crisis period as they retire, it is important to provide their beneficiaries with opportunity and encouragement to show their feelings and estimate their actions and behavior (Drča, 2012).

Abrupt and disruptive changes brought on by the COVID-19 epidemic created an unexpected crisis for the older persons (including retired people) which demanded swift response and additional psychosocial support. HelpAge International (2020) pointed out that the key principles in planning, development and growth of psychosocial support to older persons are the following:

- recognition that certain older individuals have strong coping mechanisms and that they can help others;
- recognition of different roles which older women and men have in the household and their community;
- recognition of significant roles of informal caretakers and their psychosocial needs;
- recognition of potential risk for older women can be exposed to greater violence or abuse, especially during the periods in which the families were in quarantine;
- recognition of needs that older people have the need for timely information on COVID – 19 and safeguarding mechanisms;
- nurturing of principles as hope, certainty, calmness and social networking;
- recognition and building of community understanding of COVID-19 and its influence on older persons.

There are several ways and levels of psychosocial support which are being given in crisis situations such as COVID-19 epidemic:

- through basic services and safety, when the wealth and well-being of the people can be protected through provision of food, water, health care and accommodation;
- through the help for the community and family because this kind of crisis can affect family relationships and social networking within the community;

- through focused support and
- specialized services with special psychological and psychiatric support for the individuals with impaired mental health (Todorović et al., 2018).

Only some of the activities provided for emotional and social support, with the purpose of improving psychosocial welfare are: psychological education, psychological first aid, peer support, self-help groups, referral to specialized services and other support groups (Ibid).

World Health Organization (2020) has pointed out that the psychosocial considerations important for mental health of the older people during extraordinary situation:

- older persons especially the ones who were in isolation and older persons with dementia can be anxious and stressed. That is why it is important to provide adequate practical and emotional support through family and health workers;
- it is important to inform older persons, providing the information in simple, clear, respectful and patient manner;
- it is important to ensure that an older person has access to all medical drugs that she or he uses;
- providing information in practical matters is also important - how to call a taxi, how have their food delivered or get medical help provided at home;
- everyday physical exercises maintain mobility and it help reduce boredom;
- regular routines and contacts with loved ones are of crucial for maintaining mental health of older people.

During the COVID-19 pandemic, psychosocial support for older people (including pensioners) was mostly reflected in the care and support pro-

vided by close family members. One of the examples of intergenerational solidarity is the visits to older people by volunteers during the quarantine when they were delivered basic foodstuffs necessary for everyday life. On the other hand, the negative aspects of the pandemic are reflected in the overabundance of information served to the older people, leading to an infodemic. The negative consequences of the COVID-19 were also felt by support providers, and according to the conducted research, more than 70 percent of informal caregivers felt the burden of care and symptoms of depression (Rajović, 2022). The mentioned forms of support refer to the older people, but not specifically to those who were currently in the process of retirement.

Mental health neglect with the older people in transition processes leaves far reaching consequences on quality of life in older age. It reflects not only on older persons, but their close surroundings, and above all, their informal networks. Researching the topic of this work, the authors have not recognized sufficient research about mechanisms of psychosocial support in the process and after retirement of the older people. On the other hand, research has shown that this form of support is very much needed. Persons that are more involved in the retirement process show lower levels of anxiety and depression, but also a higher level of self-respect (Taylor-Carter et al., 1997). A topic with this kind of significance opens possibilities for international and national decision makers to pay more attention to support programmes for older persons in transition periods. Additionally, this kind of programmes have special significance in emergency periodssuch as epidemiological emergencies when mental and physical health of older people is additionally affected.

Conclusion

Retirement as new stage in life on one hand can lead to well-spent leisure time, a multitude of activities, and rediscovering oneself, while on the other it can be associated with loss of identity, poor mental health, loneliness, and meaninglessness. COVID-19 pandemic has further complicated the situation for those who find themselves in this process. The effects of ageism, the lack of psychosocial support when preparing for life after retirement, as well as the post COVID-19 world make things even more difficult. Additionally, with the increase in life expectancy, effective years spent in good health, as well as the trend of early-age retirement, we can conclude that support for those who are approaching the end of their working life is indispensable so that the negative consequences do not prevail. In the Republic of Serbia, the main law related to the retirement process does not sufficiently recognize psychosocial support as an important factor in this life event, but exclusively deals with the procedure and criteria for acquiring the status of pensioner. Although international organizations have emphasized the impact of COVID-19 on mental health of older people and the importance of psychosocial support during crisis periods, one gets the impression that there are not enough psychosocial support mechanisms for those facing a double transition – retirement and COVID-19.

Therefore, this paper represents an attempt to turn attention towards the retirement process not only focusing on the procedural aspect, but to point out the significance of psychosocial aspects which retirement process brings along. It is also to be had in mind that retirement of an employee means one working place more but also a material concern, so the commitment to retirement preparation should include different kinds of support, including support in training as to avoid depression and having a retired older persons spend the next years of their life awaiting death (Knežić, 2011). What is certain is that eradicating ageism and encouraging active age-

ing and lifelong learning is the path we should choose. This implies working on sensitization of employers regarding the provision of psychosocial support to persons who will acquire status of pensioners; implementation of preventive and retirement preparation programs (counselling centres for pensioners, workshops on structuring free time, platforms for exchanging experience, individual psychological counselling); additional information for future retirees about the activities and benefits to which they are entitled; promoting intergenerational solidarity.

It is crucial for the current generations of the working population to prepare the ground for upcoming life events such as retirement, bearing in mind that older people were not always older and recognizing that they, too, will one day be in that position.

References

Adamović, M., Todorović, V., Stošljević, M. (2021). *Depresija kod starijih osoba koje su doživele pad*. Beograd: Univerzitet u Beogradu, Fakultet za specijalnu edukaciju i rehabilitaciju.

Armitage, R., Nellums, LB. (2020). COVID – 19 and the consequences of isolating the elderly. *Lancet Public Health*, vol. 5, pp. 235.

Babović, M., Veličković, K., Stefanović, S., Todorović, N., Vračević, M. (2018). *Socijalna uključenost starijih osoba (65+) u Srbiji*. Beograd: Crveni krst Srbije.

Börsch-Supan, A., Wilke, C. (2004). *The German Public Pension System: How It Was, How It Will Be*. Cambridge: National Bureau of Economic Research.

Calvo, E., Sarkisian, N. (2011). *Retirement and well – being: Examining the characteristics of the life course transitions*. IPP Documento de Trabajo 2, Universidad Diego Portales: Public Policy Institute.

Carr, D., Matz, C., Taylor, M., Gonzales, E. (2021). Retirement transitions in the United States: Patterns and pathways from full – time work. *Public policy & Ageing Report*, 31(3), 71-77.

Dahl, G., Knepper, M. (2020). *Age Discrimination across the Business Cycle*, Working Paper 27581, National Bureau of Economic Research.

Damnjanović, R. (2017). Dobrovoljno penzijsko osiguranje kao mogućnost dodatne finansijske sigurnosti. *Vojno delo*, 69(2), 322-332.

Dimoski, J., Todorović, N., Vračević, M., Vukčević-Marković, M. (2023). *Depresija kod starijih osoba – zaštitni i faktori rizika*. Beograd: Psychosocial Innovation Network. Available at: <https://psychosocialinnovation.net/wp-content/uploads/2023/02/Depresija-kod-starijih-osoba-zastitni-i-faktori-rizika.pdf>

Donaldson, T., Earl, J., Muratore, A. (2010). Extending the integrated model of retirement adjustment: Incorporating mastery and retirement planning. *Journal of Vocational Behavior*, 77, 279-289.

Drča, J. (2012). *Društvo i stari*. Novi Sad: Prometej.

Egeljić-Mihailović, N. (2023). *Aktivno starenje i socijalna participacija korisnika domova za smeštaj i negu starih lica*, Doktorska disertacija, Novi Sad: Univerzitet u Novom Sadu, Medicinski fakultet.

Feher, C., de Bidegain, I. (2020). Pension Schemes in the COVID – 19 crisis: Impacts and policy considerations. *International Monetary Fund: Fiscal Affairs*.

Furlan, M. (2020). Older People's Transformative Learning in a Project Group. *Andragoške studije*, 11, 111-126.

Grupa autora. (1976). *Popularna enciklopedija*. Beograd: BIGZ.

Hallford D., Mellor, D., Cummins, R., McCabe, M. (2016). Meaning in Life in Earlier and Later Older Adulthood Confirmatory Factor Analysis and Correlates of the Meaning in Life Questionnaire. *Journal Of Applied Gerontology*, 37(10), 1270-1294.

HelpAge International, *Psychosocial support for older people in the context Of COVID-19*. Available at: [covid19-psychosocial-guidelines-for-older-people.pdf \(helpage.org\)](https://www.helpage.org/covid19-psychosocial-guidelines-for-older-people.pdf) accessed on 11/24/2023.

Hill, P., Lewis, N., Burrow, A. (2020). Purpose after retirement during COVID-19: Trying to find direction in retirement communities. *American Journal of Geriatric Psychiatry*, 28(7), 788-789.

Ignjatović, T., Stanković, B., Klikovac, T. (2020). Iskustva i kvalitet života starijih osoba tokom pandemije Kovid-19 i uvedenih restriktivnih mera u Srbiji. *Psihološka istraživanja*, 23(2), 201-231.

International Monetary Fund, European Department. (2013). *Republic of Serbia: Selected Issues Paper*. Washington, D.C.: International Monetary Fund. Available at: <https://www.elibrary.imf.org/view/journals/002/2013/207/002.2013.issue-207-en.xml?rskey=9xKqcZ&result=1>

Jovanović, V., Đukić, D., Ajvazović, M. (2021). *Istraživanje o uticaju epidemije virusa kovid 19 na položaj osetljivih grupa u Republici Srbiji (stariji, osobe sa invaliditetom, LGBT)*. Tim za socijalno uključivanje i smanjenje siromaštva Vlade Republike Srbije.

Knežić, V. (2011). *Ne samo koliko živeti – o starenju i starosti*. Beograd: Institut za kriminološka i sociološka istraživanja.

Koma, W., True, S., Fuglesten-Binie, J., Cubanski, J., Orgera, K., Garfield, R. (2020). *One in four older adults report anxiety or depression amid the COVID -19 pandemic*. Kaiser Family Foundation.

Krstić-Joksimović, K. (2019). *Putanja prevladavanja smrti bračnog partnera u starosti – prospektivna dnevnička studija*, Doktorska disertacija, Novi Sad: Univerzitet u Novom Sadu, Filozofski fakultet.

Krstić-Joksimović, K., Zotović-Kostić, M., Petrović, J. (2014). Subjektivni i objektivni faktori prilagođenosti na penzionisanost. *Primenjena psihologija*, 7(2), 157-172.

Law on Pension and Disability Insurance, Official Gazette of the Republic of Serbia no. 34/2003, 64/2004 – CC, 84/2004 – other law, 85/2005, 101/2005 – other law, 63/2006 – CC, 5/2009, 107/2009, 101/2010, 93/2012, 62/2013, 108/2013, 75/2014, 142/2014, 73/2018, 46/2019 – CC, 86/2019, 62/2021, 125/2022, 138/2022 and 76/2023.

Merriam, S., Kee, Y. (2014). Promoting Community Wellbeing: The Case for Lifelong Learning for Older Adults. *Adult Education Quarterly*, 64(2), 128-144.

Morrow-Howell, N., Galucia, N., Swinford, E. (2020). Recovering from the COVID-19 Pandemic: A focus on older adults. *Journal of Ageing & Social Policy*, 32(4-5), 526-535.

Mutran, E., Reitzes, D., Fernandez, M. (1997). Factors that influence attitudes toward retirement. *Research on Aging*, 19, 251-273.

Noone, J., Stephens, C., Alpass, F. (2009). Preretirement planning and wellbeing in later life: A prospective study. *Research on Aging*, 31, 295-317.

Pejatović, A., Živanić, S. (2006). *Obrazovanje i kvalitet života u starosti*, Sedmi nacionalni gerontološki kongres, Vrnjačka Banja.

Rajović, T. (2022). *Mentalno zdravlje neformalnih negovatelja tokom pandemije Kovid – 19 u Srbiji: modelovanje strukturalnim jednačinama*. Beograd: Univerzitet u Beogradu, Medicinski fakultet.

[Republic Fund for Pension and Disability Insurance. Average pensions in Serbia, available at Просечан износ пензије | Републички фонд за пензијско и инвалидско осигурање \(pio.rs\)](#), accessed on 16.01.2024.

Santini, Z., Jose, P., York Cornwell, E., Koyangi, A., Nielsen, L., Hinrichsen, C., Meilstrup, C., Madsen, K., Koushede, V. (2020). Social disconnectedness, perceived isolation, and symptoms of depression and anxiety among older Americans (NSHAP): a longitudinal mediation analysis. *Lancet Public Health*, 5(1), 62-70.

Sharpley, C., Layton, R. (1998). Effects of age of retirement, reason for retirement and pre-retirement training on psychological and physical health during retirement. *Australian Psychologist*, 33, 119-124.

Statistical Office of the Republic of Serbia (2023). *Statistical yearbook*. Belgrade: Statistical Office of the Republic of Serbia. Available at: <https://publikacije.stat.gov.rs/G2023/Pdf/G20232056.pdf>

Statistical Office of the Republic of Serbia. (2023). *Population by economic activity, age and sex*. Belgrade: Statistical Office of the Republic of Serbia. Available at: <https://data.stat.gov.rs/Home/Result/3104020801?languageCode=en-US&displayMode=table>

Statistical Office of the Republic of Serbia. [Average salaries in Serbia, available at https://www.bing.com/search?pglt=41&q=prosecne+zarade+u+srbiji&cvid=860bacc3e5a245c290a7c93613724529&gs_lcrp=EgZjaHJvbWUqBggAEAAAYQDIGCAAQABhAMgYIARBFQD-kyBggCEAAAYQDIGCAMQABhAMgYIBBAAGEAyBggFEAAAYQDIG-CAYQABhAMgYIBxAAGEAyBggIEAAAYQNIBCDc2OThqMGoxqA-IAsAIA&FORM=ANNTA1&PC=ASTS](https://www.bing.com/search?pglt=41&q=prosecne+zarade+u+srbiji&cvid=860bacc3e5a245c290a7c93613724529&gs_lcrp=EgZjaHJvbWUqBggAEAAAYQDIGCAAQABhAMgYIARBFQD-kyBggCEAAAYQDIGCAMQABhAMgYIBBAAGEAyBggFEAAAYQDIG-CAYQABhAMgYIBxAAGEAyBggIEAAAYQNIBCDc2OThqMGoxqA-IAsAIA&FORM=ANNTA1&PC=ASTS) accessed on 16.01.2024.

Stojilković-Gnjatović, J., Paunović-Radulović, D., Mirić, N. (2016). Upotreba podataka iz SILC ankete za izračunavanje zdravih godina života, in *Sekundarne analize podataka dobijenih kroz istraživanje anketa o prihodima i uslovima života (SILC)*, Mladenović, B. (ed.). Belgrade: Tim za socijalno uključivanje i smanjenje siromaštva Vlade Republike Srbije i Program Ujedinjenih nacija za razvoj.

Taylor-Carter, M., Cook, K., Weinberg, C. (1997). Planning and expectations. *Gerontology*, 23, 273-288.

Tešanović, B., Folić, M. (2018). Penziono osiguranje sa posebnim osvrtom na Republiku Srbiju. *Vojno delo*, 70(3), 395-413.

Todorović, N. (n.d.). *Older Persons in the Republic of Serbia and COVID-19 Pandemic* available at: [UNFPA Serbia | Older Persons in the Republic of Serbia and COVID19 pandemic](#), accessed on 11/23/2023.

Todorović, N., Vračević, M., Rihter, L., Bogdanović, N., Kašlić-Milićević, A., Miloradović, S., Janković, B. (2018). *Psihosocijalna podrška u nesrećama: priručnik za profesionalce i volontere Crvenog krsta Srbije*. Beograd: Crveni krst Srbije.

United Nations, Department of Economic and Social Affairs, Population Division. (2015). *World Population Ageing*. New York: United Nations. Available at: https://www.un.org/en/development/desa/population/publications/pdf/ageing/WPA2015_Report.pdf

United Nations. (2002). *Political Declaration and Madrid International Plan of Action on Ageing*. New York: United Nations. Available at: <https://www.un.org/esa/socdev/documents/ageing/MIPAA/political-declaration-en.pdf>

Vesić, Z. (2021). *Gerontologija*. Beograd: Fakultet političkih nauka.

Vlajković, J. (1992). *Životne krize i njihovo prevazilaženje*. Beograd: Nolit.

Webb, M., Chen, C. (2022). The COVID-19 pandemic's impact on older adults' mental health: Contributing factors, coping strategies, and opportunities for improvement. *International Journal of Geriatric Psychiatry*, 37(1), 1-7.

Wolf, M., Brady, E. (2010). Adult and continuing education for an ageing society. In C.E.Kasworm, A.D.Rose, and J.M.Ross – Gordon (Eds.). *The handbook of adult end continuing education*, Los Angeles, CA: Sage.

Wong, J., Earl, J. (2009). Towards an integrated model of individual, psychosocial, and organizational predictors of retirement adjustment. *Journal of Vocational Behaviour*, 75, 1-13.

World Health Organization (2017). *Mental health of older adults*. Switzerland: World Health Organization. Available at: <https://www.who.int/news-room/fact-sheets/detail/mental-health-of-older-adults>

World Health Organization (2020). *Mental health and psychosocial considerations during the COVID – 19 outbreak*, available at [Mental health and psychosocial considerations during the COVID - 19 outbreak \(who.int\)](https://www.who.int/publications-detail/mental-health-and-psychosocial-considerations-during-the-covid-19-outbreak) accessed on 11/25/2023.

IZAZOVI PENZIONISANJA STARIJIH OSOBA U POST-KOVID-19 SVETU

Teodora Hrnjaković, Milena Blagojević

Rezime

Penzionisanje predstavlja prelazni životni događaj i razvojnu fazu koju čine novi zadaci, izazovi i mogućnosti u životu pojedinca. Integracija prethodnih iskustava, prihvatanje i prilagođavanje novoj ulozi utiču na dalji životni tok ne samo penzionisane osobe već i mreže podrške kao što su porodica, prijatelji, radni kolektiv i šire društveno okruženje. Odlazak u penziju omogućava jedan vid nove identifikacije koja zahteva određenu adaptibilnost, suočavanje sa novom svakodnevnicom, beneficije koje penzionisani status pruža, ali i faktore rizika koji se mogu odraziti na mentalno zdravlje poput depresije, krize identiteta, nedovoljnog samovrednovanja i narušenih odnosa unutar uže porodične i šire društvene zajednice. Globalna pandemija izazvana KOVID – 19 virusom dodatno je pojačala ranjivost starijih osoba i negativno uticala na njihove adaptivne sposobnosti. Neizvesna budućnost, socijalna izolacija, dodatna zdravstvena ugroženost i upitna finansijska stabilnost samo su neki od izazova sa kojima se starija populacija suočavala tokom trajanja svetske krize, a čije posledice se i danas osećaju. Nažalost, stiče se utisak da su starije osobe prepuštene same sebi kada je u pitanju priprema za odlazak u penziju, imajući u vidu da u

našoj državi ne postoje preventivni programi čija bi se pažnja preusmerila na predupređivanje faktora rizika po mentalno i fizičko zdravlje ove ciljne grupe.

Stoga, u ovom radu autorke kroz primenu analize sadržaja i teorijskih pristupa istražuju svrsishodnost i prisustvo psihosocijalne podrške orijentisane na proces penzionisanja. Na osnovu identifikovanih izazova, autorke nude potencijalne preporuke za kreiranje i dalje razvijanje programa podrške penzionisanim osobama, kao i unapređenje njihovog položaja u periodu tranzicije.

Ključne reči: *stariji, penzionisanje, KOVID-19, psihosocijalna podrška, aktivno starenje*

Professional paper UDK: 37.018-053.9

Handed over: 02.10.2023.

Accepted: 10.10.2023.

ADULT EDUCATION: THE PATH TO ACTIVE AGING

Aleksandra Krstic ³⁴

Abstract

The pandemic caused by the COVID-19 virus has left a visible mark on the individual, as well as on the global level, affecting on different spheres of an individual's life and therefore on a society as a whole. Such an influence contributes even more unfavorably to the position of vulnerable groups which certainly includes the population of older persons. The question is asked set whether and in which way we can promote active aging, as opposed to discriminatory politics aimed at this group. The paper presents some of the possibilities and perspectives that can greatly contribute to improve the status of older people. Analyzing the professional and scientific literature, it can be seen that adult education is exactly one of the possibilities. Permanent education of adults, on the one hand, is reflected in the development of professional competences for working with the older persons, as well as participation in the professional staff in the process of adult education, for the shake of greater efficiency in the provision of services. On the other hand, this trend should also promote the education of the older persons, which reflects in their own contribution, development on their own leisure time, and to the uprising of their own self-confidence and feelings of usefulness and belonging to society. Such a

³⁴ Aleksandra Krstic, Home for the Care and Accommodation of older persons "Epicur", Belgrade (M.A. in Andragogy, aleksandra.domepikur@gmail.com)

multifaceted action of adult education and professional staff, and population of the older persons can greatly contribute to a more favorable perception of age in society. The effectiveness of learning can be maintained throughout entire life, only if it is directed in the right way and if the effects of its action are visible. Because, satisfying educational needs, an adult realizes his own potential.

The need does not exist only within the individual, but also in the environment in which the educated person takes action. The concept of life-long learning should be an important segment in adult life. Therefore, before the creators of educational, social and health policies a serious challenge is set-measures and the undertaking of specific activities of society, but also in order to legally, they were informed about the attainability and availability of the services directed to them precisely.

Keywords: *needs, aging process, adult education, possibilities and perspectives*

Introduction

Diverse perspectives and approaches to the aging process have contributed to making entering this process a challenge. The question arises whether this is our own perception of the process through which we will all inevitably pass, or is it actually the perception of older people as the sole carriers of the same?

Once, seniors were respected as bearers of diverse and instructive experiences with far-reaching implications, especially for upcoming generations. Today, we cannot help but wonder whether and to what extent older individuals are aware of their own potentials and have open opportunities to express them. Unfortunately, today they are deprived of invoking their own experiences and sharing them with others.

Considering that Serbia has not sufficiently provided conditions for the quality of life of older persons but instead confronted them with numerous challenges - economic, health-related, social - it should not surprise us that the current trend regards aging as a period of decline, illness, and dependence on others (Babović, Veličković et al., 2018; Green, 2010).

Various social upheavals are fertile ground for strengthening discriminatory attitudes towards vulnerable groups. Starting from wars, through some entrenched mythical customs like senicide, when their maintenance becomes a burden for the family, older people are treated disrespectfully without any justified basis.

The pandemic caused by COVID-19 is just another contribution to viewing older persons as “irresponsible, breaking measures,” or they are “privileged” compared to the rest of the population (Milojević, 2021).

On the other hand, the idea of active aging, an optimal, dignified process that will become indispensable at some point in life, has existed for too long. It is continually supplemented over time, changing its contours, striving to break free from numerous pressures and barriers.

“Societal care for adults should not only ensure peaceful but also actively organized old age,” aiming for certain principles: that older individuals should be treated as independent personalities, entirely equal to other members of society (Andrić, Dobrić, 2019:91).

Therefore, this paper represents just one attempt to approach the phenomenon of aging, as well as the population of older persons as carriers of that process, from an optimistic perspective, by adding another component - education. Because “many older people learn, although they are not aware of learning” (Medić, 2012:78, according to: Milanović Dobrota B., 2017).

Do older individuals educate themselves, and in what way? What are their predominant (educational) needs? Are the personnel responsible for ensuring their rights competent enough to provide services to older persons?

The intention was to point out in what ways and to what extent adult education can influence a more favorable perception of old age, both individually and from the perspective of the entire social environment. The attempt to understand how significant the role of adult education is in promoting active aging might still be considered successful after all.

Population of Older Persons and Its Characteristics

When discussing members of the older population, it's difficult to start without addressing society's negative attitudes towards them. Many authors rely on the standpoint that older individuals are actually a “budget burden,” particularly viewed from the perspective of social protection. Author Milosavljević (Milosavljević, 2012) states that “the darkest forecasts start from the assumption that even the most developed Western economies will collapse in the 21st century under the burden of expenses for older persons” (Gudović, 2006, p. 88, according to: Milosavljević, 2012, p. 11).

Authors advocating this viewpoint aim to indicate that the increased need for support among older people from institutional protection will slow down economic development, affect the reduction of the state budget, and so on. Such a trend, aside from being discriminatory, will undoubtedly devalue the opportunities for older individuals to engage in work after retirement, instead of being an encouraging factor, both for them and for society as a whole. Hence, the question arises whether and to what extent it is feasible to replace these negative trends by raising awareness and emphasizing the possibilities and contributions that seniors can make to a society. Very often, they themselves are not aware of these possibilities, being stifled in all aspects of life without opportunities to express themselves and their needs.

On the other hand, there are authors who advocate diametrically opposing views. One of them is Thornstam, who in the 1980s presented his own developmental theory of positive aging, based on empirical research, emphasizing that “aging is a natural developmental process towards maturity and wisdom” (Rajani, 2015, p. 1467, according to: Milojević, Manić, 2019, p. 101).

To understand different authors’ approaches regarding members of the older population, let’s delve into some presentations of research available in scientific literature.

Research on Various Perceptions and Characteristics of the Population of Older Persons

One research presentation with this theme indicates that out of 1,430 surveyed individuals aged over 65, 25% reported experiencing discrimination in employment as they find it very challenging to cover their expenses after retirement (Milankov, Opačić, 2014, according to: Milanović-Dobrota, 2017).

Regarding the relationship between the young and older persons, the results of one study indicate that 67% of youths aged 13 to 17 consider the needs of older people less important but are reasonably satisfied with soci-

ety's treatment towards them. To influence intergenerational cooperation through fostering volunteer activities among the youth, authors note that "nurturing a proper attitude towards older persons and encouraging mutual respect and esteem is crucial, not only for the proper psychosocial development of children and youth and their education in the desired direction but also for the quality of life and mental well-being of the older population" (Marić, Sakač, 2017:59).

In terms of the rights of older persons to some form of financial support, author Matković points out the gap between their needs and the state's capacity to address them. About ninety thousand individuals over 65 (7% of population of older persons) receive some form of financial compensation, meeting the needs only of those most vulnerable. Evaluated from the perspective of state expenditure for long-term care (0.55% of GDP), the author points out the state's unsystematic response to the needs of older citizens (Matković, 2012).

The results of these studies, besides reflecting a realistic image of society concerning its older citizens, can also serve as an impetus for action and providing guidelines for a more favorable image and respect for older persons, contributing to their integration into society.

Needs of Older Persons

"Old age is a period where one painfully feels the tension between the need to maintain control and the necessity to learn to let go and yield to certain inevitabilities." (Milivojević, Manić, 2019:100). This is just one of numerous definitions of old age, indicating that older people have their needs that should be acknowledged, just like any other category within society. With the development of society but also of an individual's personality, these needs become more complex and their scope changes.

When discussing individuals in the third age, it is not uncommon that their health needs are primary, given their susceptibility to frequent illness-

es, chronic conditions, declining physical and cognitive functions, where feelings of abandonment dominate. In line with this, they require support from their environment. Some of the prevailing needs of older persons mentioned in the literature are the need for purpose, belonging, social security, and housing security (Tasić, Davidović et al., 2007).

It is crucial to respond to their need to seek their own place in society, desiring an active role and contributing to it. When they cease to be economically active, it is certain that they can still contribute through their activities and engagement, securing their place in society. The act of retiring will not diminish the needs that enabled them to be economically active, namely educational needs. In this regard, Milosavljević notes that “those who earned respect through work during their active phase of life deserve respect even after that phase.” (Milosavljević, 2013:486).

Some authors note a correlation between learning and improvement in adult and older age, quality of life, psychophysical health, and well-being (Marić, 2012). The impact of education on social adjustment and life expectancy should not be overlooked either (Shuller, Watson, 2009).

When observing needs from this aspect, one cannot help but question whether the societal community satisfies the needs of older persons or whether older persons themselves can largely contribute to meeting some of the numerous needs of society necessary for its survival.

Adult Education in Improving the Societal Status of Older Persons

The fundamental basis of this chapter is the realization of the possibility for education to serve as a means of reducing prejudices against older persons, thereby achieving multiple benefits.

On one hand, this will contribute to a new perception of old age in society, and on the other hand, to their motivation for involvement in society (Marić, 2012). In this regard, authors propose educating older persons about their rights, as well as educating members of the social community on the most effective ways to respond to what, based on these rights, belongs to them.

This will be achieved by examining the educational offer, as well as the opportunities for participation in educational activities for older persons, and on the other hand, through the professional development of personnel, primarily professionals in the field of social and healthcare who provide services to older persons.

The concepts of “lifelong learning,” “lifelong education,” “permanent education” represent the foundation of andragogy, an independent scientific discipline that deals precisely with adult education. Lindeman, one of the creators of adult education theories, notes that adult education should serve not only to improve personal skills and work abilities, but “happiness should also be sought outside of work,” suggesting that every individual should strive to work on oneself, self-improvement. Adults have the need to influence the process of creating learning, relying on their own experience as the richest source of learning (Knowles, Holton III, Swanson, 2005, p.40).

Authors Kulic and Despotović (Kulic, Despotović, 2005) emphasize that lifelong education provides a higher quality of life and individual development, as well as active participation in the social life of the community to which they belong (Kulic, Despotović, 2005; Schuller&Watson, 2009).

Speaking of educational activities for members of the third age, author Milošević highlights the importance of lifelong adult education to provide a higher quality and more meaningful life for older individuals, influencing increased self-confidence and meaningful use of leisure time. Gerontology centers, as well as universities for the third age, represent one model of working with older persons, where they have the opportunity to fulfill their time through productive activities: painting, writing, computer work. This will contribute not only to acquiring new content but also to increasing personal satisfaction (Milošević, 2009; Marić, 2012).

We've observed different perspectives of authors regarding the contributions of adult education to various aspects of an adult individual's life. Additionally, education contributes to more meaningful use of leisure time, which older persons have more of compared to other categories. The question of leisure time has proven to be delicate. Too much unorganized and unfulfilling free time can lead individuals to listlessness and apathy. Precisely for this reason, education takes on a leading role in organizing and giving meaning to it, as a productively fulfilled leisure time with rich content and diverse activities affects the quality of an adult's, and even an older person's, life.

Participation of Older Adults in Educational Activities - Practical Examples

1. **The DASUN Project** from 2011 resulted from the collaboration between the Faculty of Philosophy and the Center for General Scientific Continuing Education in Ulm, Germany. The project aimed to promote the idea of active aging through educational programs. 85 participants aged over 65 took part, and the research results revealed the following: 84.5% of seniors showed readiness to participate in lifelong learning programs, particularly in the following areas: foreign languages, health preservation, modern technologies (Medic, Milosevic, 2015, p. 162).

2. **The Academic Week Project** in 2012 directly built upon the previous project. Out of 139 participants over 65 years old, 95% expressed the most interest in the content offered by the Faculty of Medicine (Ibid). It is not surprising that older adults are willing to engage lifelong with content that contributes to improving their physical and mental health.
3. **Program for the Future - 10 years of the 65 Plus project** in Croatia (2008-2018) supports the education of older adults within institutional care through various opportunities:
 1. "Books to the Door," where magazines and books are delivered to homes of older persons.
 2. Art workshops.
 3. Computer literacy classes.
 4. Generational meetings where seniors have the opportunity to pass on their rich knowledge and experiences to children.
 5. Classroom Without Borders - presenting educational workshops in health and social care.
 6. 65 Plus Exhibition - showcasing the artistic achievements of older adults.
 7. Gymnasium for physical exercise (Ercegovac, Sholz, and Tuzlancic, 2018).

The above examples indicate that lifelong education is not only applicable but also implementable in practice. It demonstrates that individuals of any age category can acquire new knowledge if sufficiently motivated and shown the visible effects of their actions.

Education of Professionals for More Effective Services for Older Persons

Considering that the life of citizens within a state unfolds within the societal community to which they belong, it is of great importance for society to take necessary steps to modernize the work of professional services. These services should be tailored to respond promptly to the needs of different population categories. In this regard, for the older population, it is crucial for the healthcare system to be adapted precisely to their needs, which, in practice, is not always the case. There is an impression that the healthcare needs of older persons are out of sync with the healthcare system.

“A senior patient exhibits signs of illness because they are ill, not because they are old” (Davidović, Milović, 2013:40). Since a significant number of healthcare facilities lack home care services, there is a need to improve home care, making it easier for older persons to receive treatment at home. In this context, it is important to point out the perspective of some authors who emphasize prevention, public health, and the education of healthcare workers.

Furthermore, when it comes to the healthcare of older persons, authors Ignjatović and Žegarac highlight the necessity of improving social work practices within the healthcare system, as the existing number of social workers within that sector is not satisfactory, leading to the deprivation of certain social support services (Džamanja Ignjatović, Žegarac, 2015).

Authors Suzman and Harper stress that the economic status of the older population is one of the primary indicators contributing to the attainment of healthcare services. Due to a lack of financial resources, many services will be denied to them, especially in situations requiring constant medical supervision (Suzman & Harper, 2013).

In the user-service provider relationship, the most important aspects are the preparation skills of professionals working with older persons and

specific skills in effective communication. Service providers need to be highly motivated to empower older persons, ensuring that their individuality, desires, and needs are respected (Lynch, 2016:80).

Author Maslach (Maslach, 2015) speaks about burnout syndrome in social workers, describing it as “emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur in individuals engaged in any type of work involving people” (Dražić-Ljubotina et al., 2014, p.13, cited in: Borjanić-Bolić, 2019, p.119).

In the previous chapters, we have seen the skills that professionals need to possess to meet the demands of this delicate target group, as the key lies in establishing a relationship in the user-service provider context. In the following, we will become acquainted with some specific proposals to enhance that relationship.

Researchers who have studied the activities of the Open University in Great Britain list four categories of needs for professional development:

1. Personal needs, relating to expanding formal education to achieve personal goals.
2. Economic needs, as an incentive for redirection within the current profession.
3. Professional needs, emphasizing the importance of continuous knowledge updating to prevent obsolescence.
4. Social needs, requiring knowledge necessary to respond to the demands of the societal community (Jarvis, 1985, p.57-58, cited in: Savićević, 1989:106).

Within the TEMPUS project “Strengthening Higher Education for Social Policy Development” from 2013, the aim was to create new curricula to develop competencies for future professionals in various segments of social

protection. It also aimed to encourage professionals to actively participate in creating measures and strategies. The authors observe a shortage of employed social workers in comparison to norms and an imbalance between increased workload complexity, and standards that are not adjusted to it (Džamanja Ignjatović, Žegarac, 2015).

In practice, there are various educational programs intended for holders of different professions who need to constantly undergo skill training and development programs to retain their work licenses or engage in other fields. As emphasized by the author Marić, it is primarily reliant on “non-automated work, with a tendency for continuous employee improvement” (Marić, 2012:90).

We have seen the importance of continuous commitment and engagement of direct service providers in the domains of social and health care. This reaffirms that education has taken a leading role in achieving a more effective service provider-client relationship. Only through this way can services reach their ultimate users and can be effectively implemented.

Opportunities and Perspectives of Adult Education for Active Aging

Starting with an attempt to indicate the specific application of adult education and the benefits it can bring in practice, it primarily relies on the Integrated Model of Social Protection (Medić, Brkić et al., 2010; Medić, Milošević, 2015, p. 158). These authors base the concept of the mentioned model on the assertion that users, their needs, and rights are the cornerstone of the social protection model. It emphasizes the close connection between adult education and social protection, where education is directed towards seniors, the informal system (family, friends), and the formal system (professionals dealing with providing services to seniors) (ibid).

Going forward, we will have the opportunity to examine how the model functions, how it is realized, and what its feasibility is in practice.

The model itself indicates the realization of three sets of rights:

1. The right to live in a natural environment - where education for life in the family is highlighted as a separate thematic area, crucial for facing challenges and providing support to families with older members.
2. The right to develop and preserve personal potentials - refers to health education programs, primarily for seniors.
3. The right to integrated social life within the community - which is achieved through various forms of support for seniors to actively participate in the community (Ibid, p. 162).

We have had the opportunity to see how older adults, through education, can integrate into the social community, becoming equal members regardless of age. What is of utmost importance is enabling them to realize their corresponding rights, for which they are uninformed or face barriers on the path to achieving them.

More than 160,000 seniors in Serbia lack any form of financial support. An example from 2020 points out that in Serbia at that time, there were 65% old-age pensioners, 20% family pensioners, and 15% disability pensioners.

Taking into account that a large number of senior citizens are uninformed about their rights to receive additional support for care and assistance, increased allowances, one-time financial aid, or lack valid documentation, nor support when applying for any of the mentioned rights, it is not surprising that the existential question of seniors is significantly disrupted.

Outreach Program - Work Method or a New Social Welfare Service

Outreach, literally translated, means “reaching out to someone outside,” which perfectly applies to vulnerable categories outside institutional frameworks, where it is necessary to provide them with support when referring them to relevant institutions (Vasilijic, 2021). In essence, this is an innovative method representing the inception of the first preventive method in social work. It involves taking relevant steps and activities to include vulnerable groups (those living in inaccessible areas, older persons, the homeless, single-person households) in the social welfare system. The aim is to initially “reach out” to such categories, in their homes or places of frequent gathering, to inform them about their rights and guide them to relevant institutions (same source). The practice of outreach dates back to post-World War II when the first forms of support for children and the most vulnerable families emerged. These were the seeds of this program, which further developed over time, becoming the first preventive working method through the realization of the “Services for Sensitive Groups” project since 2018.

A vivid example dates back to 2021 in Valjevo, where 90 socially and healthily vulnerable individuals were cared for. Author Cucic outlines the following activities within the outreach program: 1. Sharing information (the target group is informed about their rights in a suitable manner, either in their homes or at places of frequent gatherings); 2. Gathering information about a specific target group (to realize a specific individual's right); 3. Referral to other services and institutions; 4. Mediation between institutions and the target group; 5. Monitoring and support during the realization of a specific service (Cucic, 2019). This service can be provided by an outreach worker or field collaborator who has completed basic training enabling them to provide such services. The experience of attending one of these training sessions, organized by the “Duga” Association from Sabac,

is exceptional. It is certain that without sufficient empathy, one cannot approach this profession.

Also noteworthy is that the outreach service does not cease once a person is referred to an institution to realize a particular right but continues to provide support as long as there is a need for it. It is important to mention that relevant steps were taken in 2021 when representatives of the Ministry of Labor, Employment, Veterans, and Social Affairs were introduced to outreach. There is consensus that outreach should be considered a social welfare service, for which certain steps toward standardization need to be taken. This is a vivid example of the interconnectedness and interdependence of social, educational, and health policies. We have seen how adult education can enable the realization of certain rights in the fields of health and social protection.

This is a significant shift that can greatly contribute to improving the status of older persons by informing them of their rights in a suitable manner, guiding them, and providing support during their realization. The intention of this chapter is to raise awareness of how an outreach worker or field collaborator “reaches out” to an individual or group in their home or a place of frequent gathering (during holidays, in front of churches, cemeteries, on the streets, etc.), provides relevant information, and involves themselves in the entire process of providing support for the realization of a right. This can include a one-time financial aid, where, aside from the individual’s lack of knowledge about how to realize that right, they might lack a valid document required for the procedure. This underscores the level of commitment and expertise of the fieldworker in understanding the problems of each specific user. And perhaps most importantly, the support of the field collaborator does not cease once the individual is referred to an institution but remains present as long as there is a need for it.

Conclusion

With the conclusion of one's working life, a completely new phase of life begins, which every senior experiences in their own unique way. Some of them are, so to speak, obliged to work to improve their standard of living. However, it remains questionable whether such needs will always be recognized by society in an acceptable manner. Others surrender without the will to face the challenges of the social system, experiencing the retirement process as a form of deprivation, of extinguished possibilities, thus sinking into apathy. Certainly, there are those who perceive this process as an opportunity for self-improvement, to productively fill their well-deserved available time. They engage in active living rather than surrender, nurturing an optimistic attitude over depression. One mode of quality living is precisely lifelong learning.

"If the onset of illness and disability can be delayed until the latest stages of life, efforts should be made to improve the quality of life until the end of life" (Erdber, 2013, cited in: Medić, Milošević, 2015, p. 157). Author Jarvis, one of the creators of various adult education theories advocating for lifelong learning, emphasizes that learning is one of the most basic human activities. Thanks to the development of information technology, it has expanded from limited space learning to distance learning (Jarvis, P. Holford, J. Griffin, C. 2003, p. 12).

The role of lifelong learning is precisely to facilitate living in the societal community to which an individual belongs, regardless of age. Education for the third age, as well as education for those who should enable members of the third age to be recognized, respected, and able to realize their rights. According to some authors, lifelong education contributes to a positive self-image and a sense of self-respect (Costa & McCrae, 1993).

The intention of this work was precisely to understand the extent and nature of the contribution of adult education to the quality of life in old age.

Also, to seek an answer to whether lifelong education genuinely enables active aging. The presentation of the outreach program is just one illustrative example in practice, where through educational, social, and health policies, members of the older population can integrate into the societal community. The ultimate goal is for seniors to feel like integral members of that system, rather than passive observers.

References

Andrić, A., Dobrić, T. (2019): Education as a factor of the quality of adults' free time, Department of Pedagogy, University of Priština, temporarily based in Kosovska Mitrovica: Proceedings of the Faculty of Philosophy in Priština, 2019, Vol. 49, No. 4, pp. 89-105.

Babović, M., Veličković, K. et al. (2018): *Social inclusion of older persons (65+) in Serbia*, Belgrade: Red Cross of Serbia.

Borjanić Bolić, E. (2019): Organizational conditions and burnout syndrome among social workers. In V. Ilić, M. Ćurić (Eds.) (2019). *Paradigm, a journal for theory and practice in social work, special education, and rehabilitation*, No. 2, (pp. 117-134), Belgrade: Higher School of Social Work.

Vasilijić, M. (2021): *Handbook on outreach work - organization, implementation, and development of outreach programs*, Belgrade: Team for Social Inclusion and Poverty Reduction of the Government of the Republic of Serbia.

Davidović, M. (2013): Active aging - concepts, principles, and advantages. In M.

Davidović, L. Milović, T. Simović, J. Urošević (2013): *Abstracts and selected works in total*, Higher Medical School of Professional Studies in Čuprija.

Ercegovac, S., Sholz, V., Tuzlančić, I. (2018): Program for the future - ten years of the "65 plus" project in the libraries of the city of Zagreb, *Librarian's Messenger of Croatia*, Vol. 61, No. 2, pp. 199-220.

Jarvis, P., Holford, J. & Griffin, C. (2003): *The theory and practice of learning*, London: Kogan Page.

Knowles, M. S., Holton, E. F. & Swanson, R. (2005): *The Adult Learner: The Definitive Classic in Adult Education and Human Resource Development*, Boston: Taylor & Francis Ltd.

Kulić, R., Despotović, M. (2005): *Introduction to andragogy*, Belgrade: Svet knjige.

Lynch, R. (2016): *Practice of social work with older persons, a positive person-centered approach*, Belgrade: Faculty of Political Sciences, University of Belgrade.

Marić, M. (2012): Lifelong learning, general life satisfaction, and psychological well-being, *Andragogical studies, journal for the study of adult education*, University of Novi Sad, Faculty of Education in Sombor.

Marić, M., Sakac, M. (2017): Nature and quality of the relationship between children and young people towards older persons in our environment, *Proceedings*, Faculty of Education in Užice (No.19), pp. 59-74.

Matković, G. (2012): *Long-term care for older persons in Serbia - situation, policies, and dilemmas*, Belgrade: Faculty of Economics, Finance and Administration.

Milanović Dobrota, B. (2017): Understanding biological, psychological, and sociological aspects of old age in the adult population, *Andragogical Studies*, Institute for Pedagogy and Andragogy, No.1, pp. 125-144.

Milivojević, T., Manić, Lj. (2019): Journey to meaning - Aging and spirituality, *Paradigm, a journal for theory and practice in social work, special education, and rehabilitation*, No.2, (pp. 99-115), Belgrade: Higher School of Social Work.

Milojević, E. (2021): Ageism in the discourse about older persons during the COVID-19 pandemic in Serbia, *Communication and Culture Online*, Vol. 12, No. 12, pp. 119-143.

Milosavljević, Lj. (2013): *Construction of old age as a social problem*, Belgrade: Department of Ethnology and Anthropology, Faculty of Philosophy.

Medić, S., Milosević, Z. (2015): Integrated educational support for older persons: towards a new quality of education for older persons. In E. Hebiba, B. Bodroški

Spariosu, A. Ilić Rajković (Eds.) (2015): *Research and development of the quality of education in Serbia - state, challenges, and perspectives*, Belgrade: Faculty of Philosophy, University of Belgrade, Institute for Pedagogy and Andragogy.

Robert R. Mc Crae & Paul T. Costa Jr. (1993): A Five- Factor Theory of Personality. in L.A. Pervin & O.P. John (Eds.), *Handbook of Personality: Theory and research* (2nd ed.) New York: Guilford, 1999.

Savićević, D. (1989): *Concepts of educational needs in andragogy*, Belgrade: Institute for Textbooks and Teaching Aids, Institute for Pedagogical Research, and Department for Andragogy, Faculty of Philosophy, University of Belgrade.

Shuller T. & Watson D. (2009): *Learning Through Life: Inquiry into the future for Lifelong Learning*, National Institute of Adult Continuing Education.

Suzman R, Harper, S. (2013): *Dawning of a New Age for Longitudinal Cohort Data*, *Journal of Population Ageing*, Springer Science and Business Media Dordrecht.

Tasić, M., Davidović, M., Milićević Kalashić, A., Shevo, G. (2007), *Geriatric Practicum*, Institute of Gerontology.

Cucic, V. (2019): *Manual on outreach work - organization, implementation, and development of outreach programs*, Team for Social Inclusion and Poverty Reduction.

Džamanja Ignjatović, T., Žegarac, N. (2015): Needs for professionals in social protection in the field of social activities in local self-governments in Serbia, from: *Education in the field of social work and social policy for the 21st century*, University of Niš.

<https://www.masina.rs> (visited on January 5, 2023)

<http://www.asocijacijaduga.org.rs> (visited on January 5, 2023)

OBRAZOVANJE ODRASLIH: PUT KA AKTIVNOM STARENJU

Aleksandra Krstić

Rezime

Pandemija izazvana virusom KOVID-19, ostavila je vidljive tragove, kako na idividualnom, tako i na globalnom planu, utičući na različite sfere života pojedinca, a samim tim i na društvo u celini. Takav uticaj još nepovoljnije doprinosi položaju već ranjivih grupa, u koju zasigurno spada i populacija starih. Postavlja se pitanje da li i na koji način možemo promovisati aktivno starenje, nasuprot diskriminatorskoj politici usmerenoj na ovu grupaciju. U radu su iznete neke od mogućnosti i perspektiva koje umnogome mogu doprineti poboljšanju statusa starijih ljudi. Analiziranjem stručne i naučne literature, može se uvideti da je obrazovanje odraslih, upravo jedna od mogućnosti. Permanentno obrazovanje odraslih, sa jedne strane, ogleda se u razvoju stručnih kompetencija za rad sa starijima, kao i participaciji stručnih kadrova u procesu obrazovanja odraslih, zarad što veće efikasnosti u pružanju usluga. Sa druge strane, ovakav trend treba da promoviše i obrazovanje starijih osoba, koje se ogleda u njihovom vlastitom doprinosu, kako prilikom osmišljavanja sopstvenog slobodnog vremena, tako i podizanju vlastitog samopouzdanja i osećanja korisnosti i pripadnosti društvu. Takvo višestruko delovanje obrazovanja odraslih, i stručnih kadrova, i populacije starih, može umnogome da doprinese povoljnijoj percepciji starosti u društvu.

Efikasnost učenja se može održati tokom čitavog života, samo ukoliko je učenje usmeravano na pravi način i ukoliko su vidljivi efekti njegovog delovanja. Jer, zadovoljavanjem obrazovnih potreba, odrastao čovek ostvaruje sopstvene potencijale.

Potreba ne postoji samo unutar pojedinca, već i u sredini u kojoj pojedinac deluje. Koncept celoživotnog učenja trebalo bi da postane bitan segment u životu odrasle osobe. Stoga se pred kreatore obrazovnih, socijalnih i zdravstvenih politika postavlja ozbiljan izazov- donošenje mera i preduzimanje konkretnih aktivnosti kako bi se stariji uključili u aktivnosti društva, ali i kako bi pravovremeno bili informisani o dostupnosti i raspoloživosti usluga namenjenih upravo njima.

Ključne reči: *potrebe, proces starenja, obrazovanje odraslih, mogućnosti i perspektive*

Review paper UDK: 316.6:[616.98:578.834
394.268

Handed over: 21.02.2023.

Accepted: 11.03.2023.

Promotional activities of the “International Day of Older Persons - October 1” campaign before and during the COVID-19 pandemic

Katarina Boricic³⁵

Abstract

Introduction: The International Day of Older Persons is celebrated in the world and in our country on October 1, in accordance with Resolution 45/106 proclaimed by the United Nations General Assembly on December 14, 1990, with the aim of emphasizing the importance of adapting the living environment to needs and abilities inhabitants of the third age.

Objective: This study aims to assess the impact of the COVID-19 pandemic on the implementation of promotional activities of the “International Day of Older Persons - October 1” campaign.

Method: Data on the frequency of implemented promotional activities were obtained from reports submitted by district public health institutes/institutes that participated in the implementation of the campaign. In the statistical analysis of the data, descriptive statistics were used and the data were presented in tabular form.

³⁵ Institute of Public Health of Serbia “Dr. Milan Jovanovic Batut”

Results: If we look at the implemented activities within the “International Day of Older Persons - October 1” campaign in the period October 2019 - October 2021, we can see a decrease in the number of public health institutes/institutions that mark the campaign by 15%, as well as a decrease in the number of all health - educational activities with the exception of activities that were realized online. Among the realized promotional activities, the largest percentage of decline in the realization of press conferences (by 80%) and individual and group health-educational work (by 75%) is noticeable. The most common channel of communication was communication via television as a mass media before the COVID-19 pandemic, whose frequency decreased by 58% during the pandemic, while during the pandemic, the most common channel of communication became online communication, whose frequency increased by 12% during the pandemic.

Conclusion: This paper showed that the pandemic that started in March 2020 affected the scope and content of the implementation of health promotion activities, which is a consequence of the changes in the way and organization of the work of health promotion employees in institutes and institutes for public health.

Keywords: *health promotion, COVID-19 pandemic, elderly*

Introduction

Health promotion is a concept based on the aspiration to improve the connection between people and their social environment, putting in the foreground the responsibility of the individual for his own health and the influence of social and natural environment factors on the health of the entire social community. Through the concept of new public health care, health promotion, and primary health prevention are imposed as priority areas for promotional action in the local community. Health promotion includes the cooperation of several government sectors and several scientific disciplines and a developed partnership between the community and the health sector, which has special importance for health in this area (First International Conference on Health Promotion, Ottawa, 21 November 1986).

Health education (today closely related to health promotion) has a role in empowering individual choice, appropriate use of health care/services, raising awareness, and empowering the community (Tones, 2002).

Today, health education represents consciously created learning opportunities that include some form of communication designed to improve health literacy, while also addressing the knowledge and development of life skills that are desirable for individual and community health (Nutbeam, 1998).

There are several divisions of health-educational methods in the literature, and one of the most commonly used is the one given by Green, which divides health-educational strategies into three large groups: communication methods, skill acquisition strategies, and organizational methods.

Communication methods include individual methods (interview, counseling), lectures, discussions, and media techniques (mass media, audiovisual means, program learning, educational television). Skill acquisition strategies include group work, skill acquisition, demonstration practice, simulations, dramatizations, sociodrama, role-playing, case studies,

computerized models, creative workshops. Organizational methods include social actions, campaigns, working with associations and self-help groups, social planning, and organizational development (Živković, 2000).

The Institute for Public Health of Serbia “Dr. Milan Jovanović Batut” coordinates the planning, implementation, monitoring, and evaluation of health promotion activities at the national level through the network of district institutes and institutes for public health up to the coordinator of health and educational work in the health center. All health-educational activities take place in cooperation with partners in the health and non-health sectors (Public health strategy in the Republic of Serbia 2018–2026, 2018).

The International Day of Older Persons is celebrated in the world and in our country on October 1, in accordance with Resolution 45/106 proclaimed by the General Assembly of the United Nations on December 14, 1990, with the aim of emphasizing the importance of adapting the living environment to the needs and abilities of the third-generation population era. Following this initiative, in 1991, the General Assembly of the United Nations, in accordance with Resolution 46/91, adopted the principles of the United Nations relating to the elderly. At the World Assembly on Aging in 2002, the Madrid International Action Plan on Aging was adopted to respond to the opportunities and challenges of population aging in the 21st century and to promote the development of society for all generations (International Day of older persons – homepage | division for inclusive social development (DISD))

Also, the period between 2020 and 2022 was marked by the COVID-19 pandemic. Taking into account that the risk of disease is higher among the elderly, public health campaigns in this period included promotional activities with the aim of raising awareness of the special needs of the elderly, as well as emphasizing the responsibility of the elderly towards their own health and their role in the stages of readiness and responding to the current and future pandemic.

In 2020, the International Day of Older Persons was aimed at increasing the understanding of the impact of the pandemic on the elderly, health policy and the health care system, [7] while the same campaign in 2021 was aimed at respecting the rights and needs of users of digital technologies in order to ensure digital equality for all generations including appropriate public health policies, accessibility, digital literacy and internet safety, as the pandemic has brought innovative mostly online methods of communication such as the use of mobile apps and websites(2021 UNIDOP: “Digital Equity for all ages” | division for inclusive social development (DISD))

Objective

The aim of this study is to review the impact of the COVID-19 pandemic on the implementation of health promotion activities of the “International Day of Older Persons - October 1” campaign.

Method

Data on the frequency of implemented health promotion activities were obtained from reports submitted by district public health institutes/ institutes that participated in the implementation of the campaign in 2019, 2020 and 2022. In the statistical analysis of the data, descriptive statistics were used and the data were presented in tabular form.

Results

If we look at the implemented activities within the “International Day of Older Persons - October 1” campaign in the period October 2019 - October 2021, we can see a decrease in the number of public health institutes/ institutions that mark the campaign by 15%, as well as a decrease in the number of all health-educational activities except activities that were realized online. Among the realized health-educational activities, the largest percent-

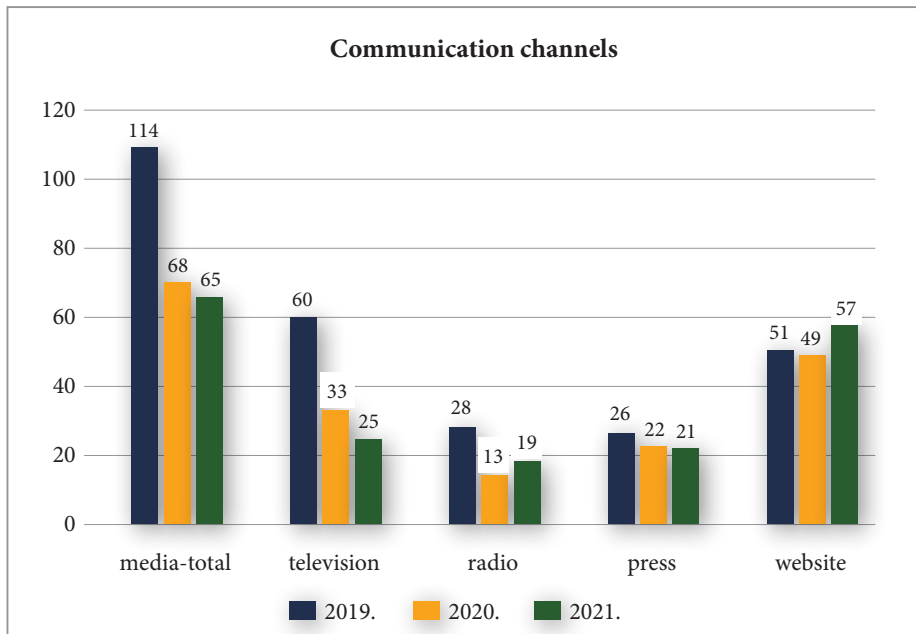
age of decrease in the realization of press conferences (by 80%) as well as individual and group health-education work (by 75%) is noticeable. (Table 1)

Table 1. Implementation of health and educational activities within the campaign “International Day of the Elderly - October 1” in the period October 2019. - October 2021.

Activities (Number)	2019.	2020.	2021.	Trend (%) (2021./2019.)
IPHs	13	11	11	-15%
Organizational meeting	156	69	76	-51%
Lecture - number	102	28	36	-65%
Lecture - number of participants	2540	531	623	-75%
Website	51	49	57	+12%
Individual health and educational work	2669	689	659	-75%
Group health and education work	529	255	132	-75%
Public manifestations	19	9	12	-37%
Public manifestations - assessment of participants	2868	791	616	-79%
Health and educational exhibitions	74	62	45	-39%
Tribunes	0	0	0	
Press conferences	5	14	1	-80%
Number of partners	128	51	59	-54%

The most represented channel of communication during the implementation of health education activities during the “International Day of Older Persons - October 1” campaign was communication through television as mass media during the celebration of this campaign before the COVID-19 pandemic, the frequency of which decreased by 58% during the pandemic, while during pandemic, the most common channel of communication became online communication, the frequency of which increased by 12% during the marking of this campaign during the pandemic. (Chart 1)

Chart 1. Implementation of media activities during the campaign, in the period from 2019 to 2022



When we talk about distributed health-promotional material, it can be seen that the most common health-promotional material distributed during the campaign was a leaflet, and that there was a decrease in both the total number of distributed material and the number of distributed posters, leaflets and brochures in the observed period. (Table 2.)

Table 2. Realization of the number of distributed health promotional materials during the campaign in the period from 2019 to 2022

Activities (Number)	2019	2020	2021	Trend (%) (2021/2019)
Poster	121	141	109	-10 %
Leaflet	4687	4747	1655	-65%
Brochure	2480	2322	677	-73%
Other	116	450	190	+64%
Number of distributed health promotion	7404	7660	2631	-64%

Discussion

The results of this study showed that during the COVID-19 pandemic, there was a decrease in the number of all health-educational activities during the campaign marking, with the exception of activities conducted online through digital content. Similar results were obtained in studies published by the same author (Boričić, 2021, Boričić, 2022).

The new changes can be explained primarily by the measures introduced to ban gatherings during the pandemic in order to prevent the spread of the virus, which on the other hand led to the introduction of innovations in the implementation of health-educational activities that were carried out predominantly online. Given that the target group of this campaign was aimed at the elderly who are at the highest risk of digital exclusion precisely because of the existence of numerous barriers due to disabled or difficult access to the Internet, lack of skills (for example, according to the data of the Republic Institute of Statistics, 13.2% of the elderly used internet to get information from the website of public institutions), lack of self-confidence, fear of safety on the internet and lack of motivation, the question arises to what extent health-promotional messages reached the elderly and met their needs during the pandemic (Kovačević et al, 2020).

Conclusion

This paper showed that the pandemic that began in March 2020 affected the scope and content of the implementation of health promotion activities, which is a consequence of the changes in the way and organization of the work of health promotion employees at the national, district and at the local level.

References

Boričić K. Promotional activities of the “European Cervical Cancer Prevention Week” campaign before and during the 4th Congress of Social Medicine of Serbia with international participation, COVID-19. Public health: protection and improvement of population health/book of abstracts / 2-3 December 2021, Belgrade.

Boričić K. Providing Health Education Services in Primary Health Care Institutions Before and After the COVID-19 Pandemic. The First World Conference Fighting COVID-19 Pandemic - Health Challenges, 26-28 March 2022, Belgrade, Serbia

International Day of Older Person. United Nations: Department of Economic and Social Affairs Ageing (<https://www.un.org/development/desa/ageing/international-day-of-older-persons-homepage.html>, access March 2023).

Kovačević M., Šutić V., Rajčević U., Milaković A. Use of information and communication technologies in the Republic of Serbia, 2020. Belgrade: Republic Institute of Statistics. in 2020.

Nutbeam D. Health Promotion Glossary, WHO/HPR/HEP/98.1. Geneva: World Health Organization; 1998.

Ottawa Charter for Health promotion, WHO, Geneva, 1986.

Public health strategy in the Republic of Serbia 2018–2026. “Official Gazette of RS”, number 61 of August 8, 2018.

Tones K. Health promotion, health education and public health. In: Detels R, McEwen J, Beaglehole R, Tanaka H. Oxford Textbook of Public Health, 4th edition. Volume 2. Oxford University Press; 2002.

Živković M. Content and methods of health-educational work. In: Cucić et al. Social medicine. Belgrade: Contemporary Administration; 2000.

(<https://www.un.org/development/desa/ageing/international-day-of-older-persons-homepage/2020unidop.html>, access March 2023).

2020 UNIDOP: “Pandemics: Do They Change How We Address Age and Ageing?”

2021 UNIDOP: “Digital Equity for All Ages” (<https://www.un.org/development/desa/ageing/2021-unidop-digital-equity-for-all-ages.html>, access March 2023).

PROMOTIVNE AKTIVNOSTI KAMPANJE „MEĐUNARODNI DAN STARIJIH OSOBA – 1. OKTOBAR“ PRE I TOKOM KOVID-19

Katarina Boričić, Ljiljana Pavlović

Rezime

Uvod: Međunarodni dan starijih osoba se u svetu i kod nas obeležava 1. oktobra, uskladu sa Rezolucijom 45/106 koju je proglasila Generalna skupština Ujedinjenih nacija 14. decembra 1990. godine, sa ciljem da se naglasi važnost prilagođavanja životnog okruženja potrebama i sposobnostima stanovnika trećeg doba. Nakon ove inicijative, Generalna skupština Ujedinjenih nacija je 1991. godine, u skladu sa rezolucijom 46/91, usvojila principe Ujedinjenih nacija koji se odnose na starije osobe. Na Svetskoj skupštini o starenju 2002. godine usvojen je Madridski međunarodni akcioni plan za starenje kako bi se odgovorilo na mogućnosti i izazove starenja stanovništva u 21. veku i promovisao razvoj društva za sve generacije.

Cilj: Cilj ovog rada je da se sagleda uticaj pandemije KOVID-19 na realizaciju promotivnih aktivnosti kampanje „Međunarodni dan starijih osoba – 1. oktobar“.

Metod: Podaci o učestalosti realizovanih promotivnih aktivnosti dobijeni su iz izveštaja dostavljenih od strane okružnih instituta/zavoda za javno zdravlje koji su učestvovali u realizaciji kampanje. U statističkoj analizi podataka korišćena je deskriptivna statistika a podaci su predstavljeni tabelarno.

Rezultati: Ako posmatramo realizovane aktivnosti u okviru kampanje „Međunarodni dan starijih osoba – 1. oktobar“ u periodu oktobar 2019. - oktobar 2021. godina, zapaža se opadanja broja instituta/zavoda za javno zdravlje koji obeležavaju kampanju za 15%, kao i opadanje realizovanog broja svih zdravstveno – vaspitnih aktivnosti izuzev aktivnosti koje su se realizovale onlajn. Među realizovanim promotivnim aktivnostima, zapaža se najveći procent opadanja realizacije konferencija za novinare (za 80%) kao i individualnog i grupnog zdravstveno-vaspitnog rada (za 75%). Najzastupljeniji kanal komunikacije je bila komunikacija putem televizije kao mas medija pre pandemije KOVID-19, čija je učestalost opala za 58% tokom pandemije, dok je tokom pandemije najčešći kanal komunikacije postala onlajn komunikacija, čija je učestalost porasla za 12% tokom pandemije.

Zaključak: Ovaj rad je pokazao da je pandemija koja je započela u martu 2020. godine uticala na obim i sadržaj realizacije zdravstveno-promotivnih aktivnosti, što je posledica nastalih promena u načinu i organizaciji rada zaposlenih na poslovima promocije zdravlja u institutima i zavodima za javno zdravlje.

Ključne reči: *promocija zdravlja, pandemija KOVID-19, starije osobe*

Original scientific paper UDK: 364.4-053.9:616.892.3

Handed over: 01.08.2023.

Accepted: 29.08.2023.

CHALLENGES IN FRONT OF FAMILIES CARING FOR THEIR MEMBERS LIVING WITH DEMENTIA – EXPERIENCES IN PILOTING SUPPORT SERVICES

Nadezda Sataric³⁶, Maja Gajic Kvascev³⁷, Natalija Perisic³⁸

Abstract

This paper focuses on the challenges faced by families caring for members living with dementia in Serbia and the presentation of the results of a pilot project for provision of services by the Counseling Centers in three cities in Serbia (Kragujevac, Čačak and Belgrade) and the Day Care Center, targeting families and their members living with dementia in Belgrade. The Counseling Center services have been provided to families since 2020, while the piloting of the Day Care Center service was carried out in 2021-2022.

Caring for a family member living with dementia has a significant effect on the personal lives of carers. There is a major disruption of preexisting familial dynamics. Carers frequently encounter misunderstandings within their societal sphere as to the challenges and difficulties they face. They themselves often fall ill due to the emotional and physical strain and pressure to which they are exposed. They are faced with numerous dilemmas and doubts regarding the care of the family member living with dementia. At the same time,

³⁶ MSc, Association of Citizens "Strength of Friendship – Amity", Belgrade

³⁷ Serbian Association for Alzheimer's Disease, Belgrade

³⁸ University of Belgrade – Faculty of Political Science

they point to the benefits of caring for someone living with dementia: care represents a source of their personal growth and development, gives a certain meaning to their life, and more besides.

Structured activities carried out in the scope of the Counseling Center services and the Day Care Center have proven to be well accepted by both carers – i.e. families – and their members living with dementia. Their most important benefits for carers are described as stemming from the counseling, information, peer support and respite provided. Evaluations of these services also point to the most pressing challenges confronted by carers; those of fear and frustration in connection with the condition of the family member living with dementia and the lack of opportunities for their more substantive care in a systematic manner within society.

Keywords: *dementia, care, people living with dementia, families – informal carers, services for people living with dementia, Counseling Center services, Day Care Center services*

Introduction

The provision of support and care for a family member living with some form of dementia is increasingly attracting the attention of not only families, but also experts in the field of health and social care and policy makers, both globally and nationally, with an emphasis being placed on local community levels. The final decade of the last century saw progress on a global scale in terms of the human rights of people living with dementia, resulting in demands for a changed paradigm, confronting statements such as “a person with dementia is in some ways an empty shell, which lacks feelings or understanding, [...] decisions must be made in their name by those who take care of them” (Spiker, 2013: 316). People living with dementia began to be understood as people with their own personalities and life histories, who were (still) able to communicate with their environments (Sabat, 2018). Tom Kitwood’s chapter in a book titled “The New Culture of Dementia Care” of 1995 was very influential to offer new coherent theory based on anecdotal evidence in favor of this new culture (Marshall, Tibbs, 2006). It was a key moment in terms of the prevention and overcoming of ‘the old ways’, which were largely focused on segregation, incarceration and stigmatization of people living with dementia and their carers, and aimed to empower them and provide them with voices. It starts from the notion that “a person becomes a person through other people” (Marshall, Tibbs, 2006: 12) and takes into account emotional needs common to all people, ones that are commonly in danger of being undermined in people living with dementia: identity, inclusion, occupation and attachment. An emphasis on person-centered care for persons living with dementia has meant that “[the] focus should be on the person who is the recipient of care, rather than simply [on] providing care in accordance with routines organized for staff convenience, efficiency, or some other criteria” (Fazio, Pace, Flinner, Kallmyer, 2018: 11). “Person-centered care also means that the user is supported and cared of in such way that he/she feels enabled, valued, and socially confi-

dent” (Sabat, 2018: 177). Alongside this, the so-called ‘citizenship approach’ to dementia has emerged, suggesting that people living with dementia are able to both receive and give, and that they themselves are experts in dementia. These encouraging developments made Marshall and Tibbs claim at the start of the 21st century that “there are now enough enthusiasts and experts, many of them social workers, to have reached a critical mass and the momentum for change has started” (Marshall, Tibbs, 2006: 201).

In Serbia, a register of people living with dementia has been recently established, but this is (at the time of writing) far from comprehensive.³⁹ When considering the estimates of the World Health Organization that between 6% and 10% of people aged 65 and over are at risk of dementia, as well as 1% to 2% of those younger than 65, it can be assumed that there are more than 130,000 persons living with (a risk of) dementia in Serbia today. Alongside uncertainties regarding their number, there are many other uncertainties which are far more important, relating to the availability of care provided to them, its quality and cost, etc. Two main shortcomings in terms of the care of people living with dementia in Serbia are a predominantly medical approach (due to the overwhelming importance attributed to the medical aspect of dementia in the absence of integrated medical and social care) and a systemic absence of support to carers, a large proportion of which lies in the sphere of informal support. Namely, the biggest care burden is placed upon the family, and especially on its female member(s).

This paper proceeds in the following way. After the introductory part, the roles of families in caregiving in general – and more specifically in regard to their members living with dementia – is presented. In relation to this, complementary theoretical findings are elaborated in order to reflect

³⁹ The World Health Organization initiated and has been supporting worldwide national activities of establishing registers of people living with dementia, central national associations for the condition, under the name Alzheimer’s or dementia, as well as national action plans and strategies for dementia in line with its “Global action plan on the public health response to dementia (2017-2025)” (Haapala, Carr, Biggs, 2019).

the known shortcomings and advantages of taking care of a family member living with dementia, as well as key lessons learned on a global level about the requirements that care of people living with dementia should be in compliance with. This part is followed by the discussion of the care of people living with dementia in Serbia, with a focus on the presentation and evaluation of two services in the national context: counseling for carers, and daycare services for people living with dementia. The number of service users is rather modest, as is detailed in the text, but their uptake of such services provides us with important insights as to their needs. Further research, both qualitative and quantitative, is needed to enable an incorporation of the perspectives and voices of families and their members living with dementia to allow an understanding of the best means for the provision of sustainable care.

Family, care and dementia

The production, organization and provision of care are divided between four sectors of social welfare: the state, the market, the civil sector and the family (Razavi, 2007; Spiker, 2013). Historically, the family (or the informal sector) provided the lion's share of care to its members. Despite the addition of the other three sectors, informality even today remains the most distinctive characteristic of care provided to the elderly. However, certain aspects of the development of family support services for the care of elderly members, including care for a family member living with dementia, still remain neglected. Differences exist in terms of support societies (i.e. the remaining sectors) provide to families providing care to their members. Also, as a rule, comparatively more family support services are provided in the segment of childcare in comparison to those for elderly family members (including those living with dementia).

The commonly cited reason for family involvement in the care of its members is reciprocity in relationships between family members, based on affective attachment and love, duties and obligations, shared past, etc.:

“Strictly speaking, we have an obligation to take care of each other. One cannot survive without the other” (Johnstone, 2003: 23). Moreover, as a result of caregiving, relationships between family members, as a rule, become increasingly better (Razavi, 2007). Research show that there are numerous benefits for carers, across at least three dimensions: “in relationship with one’s self (the carer), for example, personal growth; in relationship with the care recipient, for example, a deepened dyadic relationship; and in relationship with others, for example, new care-related relationships” (Pysklywec, Plante, Auger, Mortenson, Eales, Routhier, Demers, 2020: 349). Finally, the closure of institutions and promotion of a community care concept are also arguments in favor of providing care within the family. The community is not an abstract locality, and entering into the community usually means living in (some form of) a family unit. The role of the family in this regard cannot be emphasized enough: “the role of the state is complementary to the care provided by others. The function of planning is not to leave it out” (Spiker, 2013: 237).

However, arguments against family involvement in care also exist, and numerous dilemmas can be pointed out. First of all, the identification of the family as a social welfare sector flourished with the rise of feminist literature. Feminists highlighted the fact that ‘support provided by the family’ is not synonymous with ‘community care’, but rather that ‘the family’ actually means ‘the woman’. Thus, when it is said that family members provide care, it is actually a female family member who provides care. Society’s expectations of women in this respect are high and unquestionable, and “women are essentially exploited by the care we call ‘informal’” (Ungerson, 1999: 70). These expectations can be especially unfair towards older women, who may be forced to provide care to others in spite of also needing care themselves (Linč, 2016). Various studies prove that there is a close connection between the feeling of empathy, the feeling of guilt, and the distribution of gender roles. Women, due to the gender roles imposed upon them, are additionally burdened with the constant feeling of guilt associated with taking

on the burden of caring for others. The majority of carers are women, and they mostly rely on other women: daughters, sisters, friends. Care is seen as well-suited to women “because they are ‘natural’ carers” (Keating, McGregor, Yeandle, 2021: 619). This is affirmed by the impact of “connection[s] between cultural beliefs and the caring role” (Kaewwilai, Duggleby, Santos Salas, O’Rourke, 2023: 132). This type of care is considered ‘free’, although it is not. The costs for families are multiple, and not only material. The costs of caregiving are both emotional and psychological, and are often associated with the loss of social interactions with other members of society. Material costs, on the other hand, can be both direct and indirect. Direct are those costs related to the purchase of various necessities for the care of a family member, while indirect are those related to missed earnings or even a complete absence of such, due to the impossibility of employment arising from taking care of a family member. In this way, the state is the biggest beneficiary of informal care, because it eliminates the numerous costs it would incur from its gross national income by including the family, instead transferring those costs to the informal sector. The quality of services provided by the family is rarely taken into consideration; despite the family’s intentions to provide the best possible care, such care may not be of a high quality, due to a variety of factors. Oftentimes, families lack the competences to provide adequate care, and it may also be the case that the familial environment is one in which neglect and/or abuse exists (Perišić, 2016). Objective reasons that call into question the capacity of the family to remain “the main place for meeting the needs of the elderly” (Linč, 2016: 15) indicate the need for a more detailed consideration of the role of the family in providing care in the future. Furthermore, the concept of wellbeing of carers, which includes material, relational and subjective wellbeing (Keating, McGregor, Yeandle, 2021: 617), needs to be scrutinized in detail in the future.

Research focused on additional specificities of caring for a family member living with dementia shows that carers “report poorer life satisfaction

and well-being in comparison to carers supporting people with other long-term conditions and the wider adult population” (Victor, Rippon, Quinn, Martyr, Clare, 2021: 448). Some carers of family members living with dementia described their feelings in terms of being frightened and isolated (Hole, Harrison Denning, 2019), under very high stress, burden and strain. They were significantly more likely to experience depression and anxiety, and also indicated more depressive symptoms than non-dementia carers. For some carers, the demands of caregiving may cause declines in their own health (Alzheimer’s Association, 2023), which is reflected in the specifics of the cycle of care. Namely, in the beginning of the caring process, a family member living with dementia “suffers more, and in the later stages, when mental control weakens and the disease takes over the person, it is considered that the family, that is, the carer, suffers more” (Laklija, Milić Babić, Rusac, 2009: 72). The cycle of care for a person suffering from Alzheimer’s disease, as the most common form of dementia, has been identified as going through three phases, which are usually arranged in time in the following way:

- In months 1 to 18, the carer is confident, faces challenges well, and receives help from other family members and the wider environment;
- In months 19 to 36, family members withdraw, the primary carer remains the sole carer, and he/she has regular contact only with the health services. He/she begins to use various pharmaceutical products, in order to be able to perform his/her caring duties;
- In months 37 to 50, the carer uses tranquilizers, and his/her physical health declines. He/she faces increasing difficulties in caring for a family member, and it is difficult for him/her to find support. Most often, in this phase, the family comes to the rescue, and if this does not happen, the carer himself/herself becomes ill, and it may happen that he/she also requires a carer (Laklija, Milić Babić, Rusac, 2009).

One of the biggest challenges in a caring relationship of this kind is the lack of reciprocity, i.e. the carer has the feeling that he/she has put in a lot of effort into care, which the family member living with dementia is unable to recognize at all. The time spent requiring care is up to three-quarters of the day, and increases with the progression of dementia (Laklija, Milić Babić, Rusac, 2009).

Authors have coined the term ‘care crisis’ to denote “chronic system failures and bad outcomes for the people involved” (Keating, McGregor, Yeandle, 2021: 611). Therefore, partnerships between society (with its different stakeholders) and informal carers are of utmost importance: “formal organizations have better technical knowledge and greater social resources, and developed general work principles, while informal care providers are better at providing help in everyday unpredictable tasks, e.g. understanding the daily needs of the patient” (Rusac, 2016: 443). Developing more inclusive services for people living with dementia refers also to work and communication with their informal carers (Linč, 2016). In particular, social work skills are deemed important for work in the field of dementia, especially those guided by person-centered approach (as already mentioned in the introduction) that includes empathy and an understanding of each person as unique, as well as an appropriate cultural and ethical awareness.

Dawn Brooker adapted the general principles of a person-centered approach to support work with people living with dementia, outlining its four key components:

1. valuing and respecting people living with dementia and their carers;
2. treating people living with dementia as individuals with unique needs;
3. seeing the world from the perspective of the person living with dementia;
- and 4. creating a positive social environment in which the person living with dementia can experience relative well-being through care that promotes the building of relationships (Fazio, Pace, Flinner, Kallmyer, 2018). In her book

“Person-centred dementia care: Making services better” of 2006 Brooker also outlined key indicators for each of these four components (Table 1).

Table 1 – Key components of a person-centered approach in work with carers and their family members living with dementia and indicators thereof

Key component	Indicator
Valuing carers	Having a clear vision, developing practices that value employees, creating systems to support staff development, designing supportive and inclusive physical and social environments, and ensuring quality improvement mechanisms.
Individualized care	Developing and regularly reviewing care plans that reflect strengths and needs, allowing use of personal possessions, accommodating individual preferences and daily routines, learning about individual life stories, and offering a variety of activities.
Taking the perspective of the person living with dementia	Communicating effectively, experiencing empathy, monitoring the physical environment, assessing physical health, uncovering reasons for behaviors, and being an advocate.
Creating a positive social environment	Treating individuals with respect, creating an atmosphere of warmth, validating feelings, providing appropriate support and assistance, and fostering a sense of community.

Source: Fazio, Pace, Flinner, Kallmyer, 2018: 12.

Types of interventions vary, and are usually combined. A 2023 survey undertaken in the United States of America summarized them in seven groups: case management, psycho-educational approaches, counseling, psycho-therapeutic approaches, respite, support groups, and multi-component approaches (Alzheimer’s Association, 2023).

Case management provides assessment, information, planning, referral, care coordination and/or advocacy for those caring for family members living with dementia. Psycho-educational approaches include information about dementia, resources and services available to those living with dementia and their carers, ways to improve skills necessary for an effective response to dementia, etc. (Alzheimer’s Association, 2023). Namely, teaching

carers the skills required to care for a family member living with dementia also belongs to the domain of social work (Linč, 2016).

Counseling is also considered one of the most important services for informal carers of persons living with dementia:

“Carers constantly say that they need someone to listen to them. They know that there are often no answers and that little can be done, but they want to take the opportunity to talk to someone who can help them develop their plans and approaches. We all know the benefits of this, but sometimes we forget that some things cannot be shared with the family and that talking to an empathetic outsider can be extremely helpful” (Marshall, Tibbs, 2006: 190).

Such counseling is believed to help carers to see more clearly the situation and implications of their caregiving. Psycho-therapeutic approaches involve the establishment of a therapeutic relationship between the carer and a therapist, among other things, in order to promote the carer’s well-being (Alzheimer’s Association, 2023). Family therapy can also have great potential, since it treats dementia as a family ‘problem,’ as opposed to a “problem” of the person living with dementia or their carer(s) (Marshall, Tibbs, 2006). Carers of family members living with dementia also point to the importance of respite care:

“[W]hen the person with dementia spends time either away from home in a care setting or supported at home by a paid care worker in order to relieve the carer [...] It [gives] them some ‘breathing space,’ connecting with professionals, asking questions or learning through observing how staff interacted with the person with dementia and/or offered support” (Hole, Harrison Denning, 2019: 599).

Group work with carers is also highly valued in social work, and it is often emphasized that the group is extremely important for the exchange of information. It is believed that a group thus formed has the potential

to grow into a self-help group. Therefore, peer relations are considered of extreme importance in work with carers and people living with dementia:

“[H]elping them to feel that ‘I’m not the only one’ and to see that there ‘is life after diagnosis’. The emotional support that carers gained by attending support groups was emphasized: ‘you don’t feel embarrassed to talk about these things ... it was such a relief that somebody was going through all the things’. Some carers also noted benefits for people with dementia: ‘he could share his condition, he could talk to people who were at different stages.... he felt at ease and not threatened and not worried and not in denial’. These groups helped carers develop their ‘understanding’ about the illness and were a useful source of information” (Hole, Harrison Denning, 2019: 599).

Finally, multi-component approaches are those bearing intensive support strategies based on the combination of multiple forms of interventions – such as those that have been mentioned: education, support and respite – into a single service (Alzheimer’s Association, 2023).

Supporting families and their members living with dementia – piloting care services in Serbia

A 2014 survey conducted in Belgrade, Serbia, showed that more than 80% of 120 respondents whose family members live with dementia had considered that the existence of day care centers would be extremely important both for themselves and their family members. The respondents considered that the provision of additional necessary care to those living with dementia through structured, adapted activities, which would be carried out with the support of specially trained experts and volunteers, would be useful and that such day care centers could serve as a meeting place for carers who share challenges, so that their loneliness and alienation due to caring could be alleviated. It was also expected that the time that the family member liv-

ing with dementia spent in the day care center would temporarily relieve the carer and give him/her the opportunity to have some time for themselves and their needs, to rest from mental and physical stress, which reduces the possibility of burnout, i.e. to strengthen themselves for the new challenges of care. The same research showed the necessity of the existence of a counseling service for informal carers, for the purpose of training to provide the highest quality care possible, as well as psychological support in the course of dealing with a diagnosis of dementia, and overcoming fear and frustration in the process of caring, support in solving legal issues associated with the onset of dementia in a family member, and all other related challenges. The role of counseling centers in connecting carers to one another is particularly important, because through the exchange of experiences invaluable knowledge and friendly relationships are gained, which empower carers to feel that they are neither alone nor lonely in the best and most effective way. Family members expressed their willingness to participate in partial – even full – financing of such a day care service, just so that they would not have to place their family members in an institution and to enable themselves to be as efficient as possible in providing care (Satarić, Milićević Kalašić, 2014).

Taking into account both theoretical considerations and evidence from the field, hearing the voices of users and considering their perspectives, in 2014 an informal coalition of 14 civil society organizations from Belgrade was formed to jointly advocate with the local government of Belgrade to include the right to day care services for people living with dementia in the catalogue of rights relating to social protection, and to start development of such a service. The advocacy coalition was not a success, but was advised by the city government to pilot the service beforehand, in order to allow an evaluation of its outcomes.

In the meantime, in 2020, the Serbian Association for Alzheimer's Disease was formed. Among other things, the association works on the development of services absent at the local community level for people liv-

ing with Alzheimer's and all other forms of dementia. In the same year, the Counseling Center services for informal carers of people living with dementia were piloted by Amity (a Serbian civil society organization) in three cities in Serbia: Belgrade, Kragujevac and Čačak, with 80 carers in total being able to use their services. The evaluation of the Counseling Center services for informal carers confirmed earlier knowledge about challenges faced by informal carers. A majority of participants described a combination of mental and physical stress and overload over an extended period of time, which is also marked by uncertainty and fear for the family member for whom they are caring, as well as for the consequences of the condition on overall familial relationships and health. In addition to exhaustion, lack of time for personal interests and even paid jobs, there was also a strong fear of whether caregiving tasks are performed well enough, as well as an awareness that caregiving was a burden for the whole family and that there was a lack of understanding in their environment regarding the difficulties that they faced as carers. Respondents also made suggestions regarding the branching-out of support, introducing new services (professional carers, a day care center that would combine all the needs of the people living with dementia and their carers, support and self-help groups, exchange of experiences and professional education) (Nikolin, Satarić, Perišić, 2021).

A year later, in June 2021, the Day Care service for people living with dementia was piloted in Belgrade in cooperation between the Serbian Association for Alzheimer's Disease and Amity, with the intention of providing services once a week for 3 hours for up to 10 users in initial, middle and advanced stages of dementia. The services were provided by one professional, a social worker experienced in work with people living with dementia, as well as volunteers from the Association for Alzheimer's Disease, and others. All volunteers were informal carers with experience of caring for a family member living with dementia, students of psychology and other supporting professions, and pensioners with an affinity for working with people. The

volunteers received training on communicating with people living with dementia. The funding of the Day Care service is project-based, and the advocacy group continues to be active in making arguments for an introduction of the right to day care services into the catalogue of social welfare services.

Counseling Center services

The Counseling Centers for Informal Carers of Dependent Elderly Persons were designed with a view to contributing to the improvement of the quality of life of informal carers of family members living with dementia, as well as more equal participation of women and men in the economy of caregiving, while also promoting the redistribution of unpaid work. Targeted users of the Counseling Center services were, first and foremost, informal carers who care for people living with dementia. The aim of the services was to empower users to care for their family members more efficiently, with less effort and be more involved in their professional and social lives. Their activities consisted of workshops, a telephone counseling center, presentations of caregiving activities, preparation and distribution of printed materials, public appearances of experts on local television and the strengthening public awareness of caregiving work performed by carers, conversations with medical doctors about the roles of informal carers, and education on dementia. An emphasis was placed on the topics of dementia and familial relationships, care of people living with dementia and self-care, ways to effectuate social rights, communication with people living with dementia, etc. (Nikolin, 2020).

Of the 29 informal carers who used the services, over 80% of respondents indicated the high degree of relevance of the Counseling Center services to themselves. A minority (almost 18%) stated that while the Counseling Center services were useful, they were not necessary, and none of the respondents answered that the services meant relatively little or nothing to them. Of primary importance to the respondents were the counseling with

a social worker, obtaining information, and peer support. These were also evaluated as the most important aspects by service providers and coordinators. On top of this, professionals experienced the lack of understanding of the burden of care carers, both from wider society and within their own family, their frequent feelings of powerlessness and exhaustion, and caregivers' consequent health deterioration. Therefore, professionals also valued the respite function of the Counseling Center services for the carers. This respite was also valued by the carers, according to their statements: namely, more than half of them (55%) stated that they felt "as if someone understood them" and "as if there was someone to complain to". Nine respondents (31%) pointed to the importance of acquiring new knowledge about dementia, while one quarter of the respondents stated that they felt as if they had a little rest when they came to the Counseling Centers. In a quarter of the answers, it was pointed out that, thanks to the Counseling Centers, informal carers had the feeling that they would be able to continue in their role. Four informal carers stated that they felt they were "doing something important", two that they "have more will", and one that they "feel like a fighter". None of the carers experienced the uptake of the service as a waste of time, nor did it evoke negative or destructive associations (Nikolin, 2020; Perišić, 2020).

Day Care Center

The day care service was primarily intended to provide occupational therapy to persons living with dementia, in order to preserve their cognitive abilities as long as possible and to enable them to stay with their families, but also to meet the needs of the families. More precisely, it was designed to act as a form of respite for carers during the period of continuous care for the family member, and to provide advice and empowerment for their caregiving roles. Therefore, the targeted users are both carers and persons living with dementia. The services are aimed at preserving and maintaining users'

cognitive, social and physical abilities/functions. The purpose is to improve the quality of their lives through the upkeep and development of social, psychological and physical functions and skills, in order to slow down the loss of functional ability (in regard to physical mobility, independent nutrition, dressing, and similar) to as great an extent as possible, and to slow down the progression of the disease through appropriate medicative therapy. At the same time, the services provide informal carers with time to engage in their professional activities and their other chores at home, and to make better use of their free time. Carers can also engage in exchanges of experience and information with other carers. The Counseling Center services became incorporated within the Day Care Center in Belgrade with a view to it becoming a place where carers could share their feelings: sadness, fear, worry, guilt, anger, and, with the help of a professional, learn how to deal with difficult situations, talk openly, feel that someone understands them, that they have support, to learn how to best help the patient. The purpose of these counseling services is to empower informal carers to be able to care for their family members living with dementia more efficiently when they are not in the Day Care Center, and to have greater participation in their professional, social and family lives.

The activities of the day care service consist of:

- 1) Occupational activities, which encourage directing the attention of people living with dementia and encourage their sensory-motor, cognitive, integrative and psychosocial abilities;
- 2) Cultural and entertainment activities for persons living with dementia;
- 3) Rehabilitation and therapeutic activities, which support the preservation of the physical condition and mobility of persons living with dementia on the one hand, and their communication/speech on the other; and
- 4) Informative counseling activities with informal carers (Satarić, Gajić Kvašček, 2022).

The first evaluation of the day care service, which was conducted shortly after its establishment, i.e. only two months after the beginning of operations, included only five carers. The purpose of the survey was to obtain feedback in terms of future activities that would improve the service. The answer of one of the carers combines all the received suggestions:

“The service is needed every day. Also, organized pick-up and drop-off of persons with dementia would make organization easier for us. It would be great if the stay was organized within the municipalities in which the persons with dementia live.”

The second evaluation was conducted around one year after the operations began. Ten informal carers participated, eight of whom did not participate in the previous evaluation. Their answers to the question “What do you find most difficult in caring for your family member living with dementia?” revealed numerous challenges with which they have been living:

“That the mother/father is alone for most of the day (without supervision).”

“I am fearful that I will make a mistake.”

“Society does not have any understanding of us, and does not offer any help.”

“I cannot go anywhere, I cannot socialize. I live like I’m under house arrest.”

“I am uncertain how I will cope when the disease progresses. I feel tensions and uncertainties every day.”

The service was evaluated as very relevant and relevant by 8 and 2 respondents respectively. The satisfaction with the daycare service, i.e. its benefits for the carers and their family members living with dementia, is reflected in the following answers:

“My mother got those three hours to feel valuable and important again, to enjoy herself, and I got support and understanding.”

“I am not alone; I have the support of people who are going through the same thing. The changes in my father are visible and for the better. His concentration is better, he is happier, he laughs, enjoys himself, remembers, learns songs, wants to come again.”

“My mother is supported by volunteers. If we don’t come for two weeks, I notice a decline in her daily functioning.”

“It gives the feeling that not everyone has forgotten about those suffering from this type of disease.”

“I get ideas about activities that we can organize at home with my father when he does not come to day care.”

“I dressed nicely, I went out of the house to meet people, I socialized with people who have a similar problem, and I have nice memories after every visit. All this gives me new energy to last until the next Thursday.”

On top of this, 6 carers felt empowered after they started going to the Day Care Center, especially after using counseling services, stating that they learned something, that they felt comfort, etc.; 7 felt that somebody understood them; 5 stated that they rested a bit; whereas 4 stated that they began to feel that they could persevere and that they have more willpower.

Conclusion

In Serbia, care for people living with dementia and support to their informal carers primarily fall under the auspices of healthcare and, consequently, the medical model. An approach that would fully take into account the human rights of people living with dementia and their families could be implemented under the framework of a model that would acknowledge their citizenship, rights and needs. The split between the health and social care sectors is not beneficial for people living with dementia nor their car-

ers, and the integration of health and social sectors would actually increase the wellbeing of both. Having said this, two concerns should be borne in mind: fragmentation of sectors would not be overcome in the event that their integration is not seamless and if the so-called 'silo mentality' perseveres. Namely, values and principles in favor of human rights of the carers and their family members living with dementia should be shared by the health and social sectors, and guide them in their work in the field of dementia.

Listening to the voices of carers and their family members living with dementia is the key to an effective organization of services, and current approaches need substantive adaptations to reflect this. The limited experiences in the organization of services in support of carers presented in this paper enable important insights about those aspects that are valued by carers, with many of them being echoed by professionals. And while there is an agreement as to the significance of counseling, peer support and the provision of a respite to carers, obstacles in regard to their organization so that they are fully in compliance with the needs of carers and their family members living with dementia exist. The availability of support services is scarce, and their organization is not flexible enough: they fail to offer services 24 hours a day, 7 days a week. In the face of austerity measures and constant financial constraints, there seems to be no sign that social services for carers and their family members living with dementia will be organized in such a way, even in the future. Therefore, significant efforts should be made in order to be able to say that a momentum for change in the field of dementia has truly begun in Serbia.

References

- Alzheimer's Association (2023). Alzheimer's Disease Facts and Figures. *Alzheimers Dement*, 19(4). DOI 10.1002/alz.13016.
- Fazio, S., Pace, D., Flinner, J., Kallmyer, B. (2018). The fundamentals of person-centered care for individuals with dementia. *Gerontologist*, 58(1): 10–19.
- Haapala, I., Carr, A., Biggs, S. (2019). What would I want? Dementia perspectives and priorities among people with dementia, family carers and service professionals. *International Journal of Care and Caring*, 3(1): 39–57.
- Hole, C., Harrison Denning, K. (2019). Dementia service provision and the role and benefits of an Admiral Nurse service: the findings of a needs analysis in one area of rural England. *International Journal of Care and Caring*, 5(4): 597–602.
- Johnstone, D. (2003). *Comparative social policies in Europe*. Frankfurt am Main: Europaischer Verlag der Wissenschaften.
- Keating, N., McGregor, J., Yeandle, S. (2021). Sustainable care: theorising the wellbeing of caregivers to older persons. *International Journal of Care and Caring*, 5(4): 611–630.
- Kaewwilai, L., Duggleby, W., Santos Salas, A., O'Rourke, H. (2023). Asian family carers of persons living with dementia: a stress and coping model. *International Journal of Care and Caring*, 7(1): 131–148
- Laklija, M., Milić Babić, M., Rusac, S. (2009). Neki aspekti skrbi o članu obitelji oboljelom od Alzheimerove bolesti. *Ljetopis socijalnog rada*, 16(1): 69–89.
- Linč, R. (2016). *Praksa socijalnog rada sa starima – pozitivan pristup orijentisan prema osobi*. London: Sage.

Marshall, M., Tibbs, M-A. (2006). *Social work with people with dementia – Partnerships, practice and persistence*. Bristol: BASW and Policy Press.

Nikolin, S. (2020). *Analiza korisnosti i procena održivosti usluge Savetovališta za neformalne negovatelje zavisnih starijih osoba*. Beograd: Crveni krst Srbije, Amity, Laris.

Nikolin, S., Satarić, N., Perišić, N. (2021). Podrška neformalnim negovateljima osoba koje žive sa demencijom. *Gerontologija*, XLIX(2): 95–113.

Perišić, N. (2020). *Razvoj savetovališta za neformalne negovatelje zavisnih osoba i promocija preraspodele neplaćenog rada – izveštaj o evaluaciji*. Beograd: Crveni krst Srbije, Amity, Laris.

Perišić, N. (2016). *Socijalna sigurnost – pojmovi i programi*. Beograd: Univerzitet u Beogradu – Fakultet političkih nauka.

Pysklywec, A., Plante, M., Auger, C., Mortenson, W., Eales, J., Routhier, F., Demers, L. (2020). The positive effects of caring for family carers of older adults: a scoping review. *International Journal of Care and Caring*, 4(3): 349–375.

Razavi, S. (2007). *The political and social economy of care in a development context – Conceptual issues, research questions and policy options*. Geneva: United Nations Research Institute for Social Development.

Sabat, S. (2018). *Alzheimer's Disease & Dementia*. Oxford: Oxford University Press.

Satarić, N., Gajić Kvašćev, M. (2022). Iskustva pilotiranja usluge dnevnog boravka za obolele od demencije u Beogradu. *Gerontologija*, L(1): 103–122.

Satarić, N., Milićević Kalašić, A. (2014). *Život bez sećanja – istraživanje o potrebama za Dnevnim centrom za dementne u Beogradu*. Beograd: US-AID, Amity i Trag fondacija.

Spiker, P. (2013). *Socijalna politika – teorija i praksa*. Beograd: Univerzitet u Beogradu – Fakultet političkih nauka.

Ungerson, C. (1999). The informal sector. In: P. Alcock, A. Erskine, M. May (Eds.), *The student's companion to social policy* (pp. 169–174). Oxford: Blackwell Publishers.

Victor, C., Rippon, I., Quinn, C., Martyr, A., Clare, L. (2021). The role of subjective social status in living well for carers of people with dementia: findings from the Improving the experience of Dementia and Enhancing Active Life programme. *International Journal of Care and Caring*, 5(3): 447–267.

IZAZOVI ZA PORODICE ČLANOVA KOJI ŽIVE SA DEMENCIJOM– ISKUSTVA PILOTIRANJA USLUGA PODRŠKE

Nadežda Satarić, Maja Gajić Kvašček, Natalija Perišić

Rezime

Predmet ovog rada je sagledavanje izazova sa kojima se susreću članovi porodica u nezi članova koji živi sa demencijom u Srbiji i predstavljanje rezultata pilotiranja usluga Savetovaništva u tri grada u Srbiji (Kragujevcu, Čačku i Beogradu) i Dnevnog boravka za negovatelje i članove njihovih porodica koji žive sa demencijom u Beogradu. Usluge Savetovaništva za negovatelje članova porodice koji žive sa demencijom pružaju se od 2020. godine, dok je pilotiranje usluge Dnevnog boravka sprovedeno u intervalu 2021-2022. godine.

Negovanje bolesnog člana porodice veoma mnogo utiče na lični život negovatelja. Uglavnom se poremeti dinamika ranijeg uobičajenog funkcionisanja porodice. Negovatelji nailaze na nerazumevanje i od strane okoline za izazove i teškoće sa kojima se susreću. Često i sami obolevaju zbog emotivnih i fizičkih napora kojima su izloženi. Negovatelji se susreću sa brojnim dilemama i nedoumicama oko nege člana porodice koji živi sa demencijom. Istovremeno, negovatelji ukazuju na određene koristi od nege člana porodice koji živi sa demencijom: nega predstavlja izvor njihovog ličnog rasta i razvoja, daje određeni smisao njihovom životu itd.

Strukturirane aktivnosti koje se sprovode u Savetodavnom centru i u Dnevnom boravku pokazale su se kao dobro osmišljene i još bolje prihvaćene i od strane osoba koje žive sa demencijom i od strane njihovih srodnika, neformalnih negovatelja. Kao najvažnije koristi od usluga opisane su one koje proističu iz savetovanja, dobijanja informacija od drugih koji se nalaze u istoj negovateljskoj situaciji i pružanje “predaha”. Evaluacija usluga ukazuje i na najvažnije izazove sa kojima se suočavaju negovatelji, a to su strah i frustracija u vezi sa situacijom člana porodice koji živi sa demencijom i odsustvo prilika za kompleksniju negu, koju bi društvo pružalo na sistematski način.

Ključne reči: demencija, nega, osobe žive sa demencijom, porodice – neformalni negovatelji, usluge za osobe žive sa demencijom, usluge Savetodavnog centra, usluge Dnevnog centra.

Review paper UDK: 364-787:616.89-008.434.37
364-787:616.892.3-056.24

Handed over: 15.02.2023.

Accepted: 10.06.2023.

THE PROTECTION OF PEOPLE WITH ALZHEIMER'S DISEASE AND OTHER TYPES OF DEMENTIA - CAN WE DO IT BETTER?

Marina Milic Babic⁴⁰

Abstract

Alzheimer's disease involves a chronic, progressive degeneration of brain cells, entailing a decline of physical, psychological and mental functions. The progression of the disease precipitates the deterioration of the patients' condition, profoundly affecting persons with the disease and their closest family members. The disease is incurable; it decreases the quality of life for patients and involves various symptoms, depending on the patient and the stage of the disease. Consequently, persons with the disease are not expected to retain the ability to protect their rights and interests. The violation of the rights and interests commonly occurs in the everyday life of the elderly, who thus represent a highly vulnerable social group. Accordingly, the state has different mechanisms that protect the human rights and dignity of people with the disease. The protection mechanisms involve legal capacity, palliative care and the principle of informed consent. This paper examined the effects of the current coronavirus pandemic on the lives of people with Alzheimer's disease and other types of dementia, highlighting the need to protect this highly vulnerable group within the elderly population.

⁴⁰ Marina Milić Babić, PhD. Associate professor, University of Zagreb - Faculty of Law, Social Work Study Centre, e-mail: mmilic@pravo.hr

The paper discussed theoretical findings and identified several avenues for improving the lives of persons with the disease and their families. Furthermore, the author described the available benefits and services in the social welfare system for advancing the quality of life of people with Alzheimer's disease and other types of dementia. Finally, a review of research findings, rights, services and protection mechanisms indicated opportunities for enhancing formal support networks, which could facilitate the considerable challenges of providing care for family members. Moreover, designing effective support networks for patients and their family members could benefit the entire society, improve the quality of life for patients, minimize placement in institutions, prevent caregiver burnout for family members caring for persons with the disease, and ultimately, reduce the costs of care.

Keywords: *Alzheimer's disease, human rights, COVID-19, formal support*

1. Introduction

Population aging is a prominent (if not prevailing) global demographic trend. The advanced age entails numerous health afflictions, including severe conditions such as dementia, having different causes, commonly Alzheimer's disease (Dološić, 2016, Abate, Memo and Uberti, 2020). Alzheimer's disease involves a chronic, progressive degeneration of brain cells, entailing a decline of physical, psychological and mental functions for patients (Puljak et al., 2005). The disease affects approximately every 12th person over the age of 65. After the age of 85, over 50% of the elderly population has Alzheimer's disease. With the rapidly growing elderly population, dementia is expected to soar in the future (Puljak et al., 2005). Alongside age as a major demographic predictor of dementia, women appear more susceptible than men (in Europe, 6,650,228 women have dementia against 3,130,449 men) (Alzheimer Europe, 2020). Alarmingly, the number of people with dementia is expected to double by 2050, reaching 14,298,671 in the EU and 18,846,286 in the wider European region. That increase would notably affect the social welfare and health care systems (Alzheimer Europe, 2020). A similar trend is projected at the global level, with 152 million people expected to suffer from dementia by 2050. Accordingly, the World Health Organization has recently proclaimed dementia as a public health priority (Abate, Memo and Uberti, 2020).

Given the nature of Alzheimer's disease and the ensuing functional decline, persons with the disease depend on the assistance and care of others in many aspects, notably concerning the protection of human rights. Under the circumstances, the protection falls within the state domain, which has the duty to promote the rights and dignity of persons with the disease (Dološić, 2016). The state sets up mechanisms, mainly addressing legal capacity, palliative care and the principle of informed consent (Dološić, Milić Babić and Rusac, 2019).

This paper closely examined Alzheimer's disease and the mechanisms for protecting the human rights of patients based on current research in the field. Finally, it surveyed the effects of the coronavirus pandemic on persons with the disease and their care and offered a critical review of the issue with suggestions for improving the existing practice.

2. Alzheimer's disease

Alzheimer's disease is a brain condition that entails cognitive decline and, ultimately, death. Although its progression is different for every person, it is nevertheless irreversible. Alzheimer's disease is the prevailing cause of dementia, with symptoms and signs similar to other types of dementia (MSD Croatia, 2020). It is therefore difficult to distinguish dementia caused by Alzheimer's disease from other types of dementia. For this reason, the disease is frequently misdiagnosed as another type of dementia. The onset of the disease is generally mild, involving impaired memory, cognition or performance of daily activities. However, in some cases, the disease may have a sudden onset, triggered by severe illness, emotional distress, change of environment, surgical procedures, etc. As mentioned above, the disease is progressive and entails brain cell degeneration (Puljak et al., 2005).

Depending on the affected part of the brain and the related brain structures, the functional decline and its symptoms (physical, psychological or mental) may differ. Nevertheless, the functional decline is irreversible, with varying progression (eight to twelve years on average, yet also shorter (three years) or longer (twenty years)). The progression of the disease follows three stages: early, middle and late. Determining the exact stage of the disease for individual patients presents a specific challenge due to the soft and blurring distinction between the stages and varying individual symptoms. Common symptoms involve memory loss, spatial and temporal disorientation, feelings of helplessness, inability to perform the activities of daily living, mood and behavior disorders, etc. (Puljak et al., 2005).

The disease severely disrupts not only the lives of the patients but also the lives of their loved ones. The care needs of patients entail a radical transformation of family life, with utmost dedication to care provision. As the disease is incurable, the only remedy is to slow its progression, maintaining the person in the initial stages of the disease for as long as possible. Educating and supporting family caregivers is paramount, as well as preventing early placement in institutions (Puljak et al., 2005).

3. Mechanisms for the protection Human Rights of People with Alzheimer's diseases

As people with Alzheimer's disease often lose the ability to take care of themselves and make decisions independently, the state has the duty to protect their human rights and dignity (Dološić, 2016). In that regard, the principal mechanisms involve legal capacity, palliative care and the principle of informed consent (Dološić, Milić Babić and Rusac, 2019).

3.1. Legal capacity

Legal capacity is the ability to acquire rights and responsibilities through declarations of will, i.e. through personal declarations, granted upon the age of majority (Legal Clinic of the School of Law in Zagreb, 2013). In simple terms, it denotes the right to make independent decisions about life. Consequently, removing legal capacity infringes on the basic human right to make independent decisions (Štrkalj Ivezić, 2012). Therefore, decisions on removing legal capacity should be made with caution. Firstly, it should be assessed whether guardianship would address any specific issues or if the person would rather benefit from other mechanisms that do not infringe on basic human rights, such as supported decision-making (Dološić, Milić Babić and Rusac, 2019). In Croatian legislation, the Family Act from 2015 stipulated that legal capacity could no longer be fully removed. For a partial removal of legal capacity, it is necessary to determine in which aspects the person has the capacity to protect his/her interests, and in which not. It is also important to encourage persons under guardianship to make independent decisions (as much as possible), to act according to their attitudes, personality and personal wishes, and to provide support (Dološić, Milić Babić and Rusac, 2019). Article 12 of the Convention on the Rights of Persons with Disabilities urged the countries to replace the mechanisms of substitute decision-making (such as guardianship) with support mecha-

nisms for exercising legal capacity (for example, supported decision-making) (Gurbai, 2012).

In supported decision-making, individuals are assisted in making independent decisions and choices based on appropriate information. The process implies respecting individual interests, preferences and wishes, and fostering trust between the persons who provide and those who receive support. Supported decision-making promotes two human rights - the right to independent decision-making, and the right to take risks and make “wrong” decisions (Gurbai, 2012).

3.2. Palliative care

The right to palliative care represents a basic human right of people with Alzheimer’s disease (Dološić, 2016, Dološić, Milić Babić and Rusac, 2019). It involves care aimed at raising and enhancing the quality of life for patients and their families by relieving pain, discomfort and difficulties, as well as determining the priorities for treatment. For Alzheimer’s disease patients, palliative care begins (or should begin) as soon as the disease is diagnosed, and it is generally long-term (Mimica, 2011). In the final, so-called terminal stage of Alzheimer’s disease, family members are usually no longer able to take care of the patient adequately, requiring placement in specialized institutions. The prices of accommodation are often high and, unfortunately, unaffordable for many. With growing life expectancy, the need for accommodation of people with Alzheimer’s disease increases against a shortage or insufficient capacities of institutions providing such services (Mimica, 2011). The advantages and the need for institutional placement at the terminal stage are substantial, while professionals and caregivers (i.e. palliative care providers) face various critical and demanding circumstances daily, such as immobility, infections, pain, cardiopulmonary resuscitation, hospitalization and other terminal care procedures. Therefore, palliative care professionals require new and need to further the existing professional

competencies. In this respect, improving communication skills is imperative. Namely, with the progression of the disease, communication becomes increasingly challenging for people with dementia. They experience difficulties with expression and understanding, which causes frustration for patients and care providers. Adequate education and training of professionals and caregivers could prevent and mitigate frustration that further complicates patient care, notably assistance with daily activities, learning and other aspects of life (Mimica, 2011).

3.3. Principle of informed consent

Historically, the concept of informed consent first appeared in 1947 at the Nuremberg trial as part of the Nuremberg Code. It addresses the patient's right to access information while deciding about medical treatment and the patient's right to accept or refuse medical recommendations or treatment proposals (Brkljačić, 2013, Dološić, 2016, Dološić, Milić Babić and Rusac, 2019). It derives from the principle of patient autonomy, acknowledging that one is entitled to make life decisions in line with personal goals and values. Nowadays, informed consent pertains to the basic human rights of patients (Turković, 2008, Dološić, 2016, Dološić, Milić Babić and Rusac, 2019). Once given, consent can also be withdrawn at any point. For people with Alzheimer's disease, the capacity to give informed consent represents a contentious issue. In the case of incapacity, legal representatives or guardians may also give consent on behalf of the patient alongside the option of advance directive. The latter does not substitute informed consent; the consent is rather a constituent of the advance directive. There are different types of advance directives, well preceding informed consent (Milas Klar-ić, 2010, in Dološić, 2016, Dološić, 2016, Dološić, Milić Babić and Rusac, 2019). For example, the living will safeguards the autonomy of a person's will, involving a statement with specific wishes and giving the authority to another person to decide about the termination of life support on behalf of

the patient (Hlača, 2008, in Dološić, 2016). Some advance directives also entitle trusted persons to make decisions on behalf of individuals who lost their decision-making ability (so-called proxy directives, powers of attorney, etc.) (Milas Klarić, 2010, in Dološić, 2016). Advance directives are generally in written form. The legislation of each country governs their content, form, possibilities for revocation or modification and other details. In terms of content, advance directives include personal data, the areas they address and the proxies. Several advance directives may coexist with different “mandates”. However, an advance directive does not constitute a will. Generally, it covers matters such as medical procedures (i.e. treatment of the body), but it can also extend to property matters. Moreover, it has a lifetime effect, whereas a will serves to manage the testator’s property after death, having a legal effect only upon death (Milas Klarić, 2010, in Dološić, 2016).

4. Review of previous research

Despite a significant body of research on Alzheimer's disease, most studies primarily focus on medical implications, including its causes, the effectiveness of medication, treatment methods, etc. On the contrary, this section of the paper will review relevant research on the mechanisms for protecting the human rights of people with Alzheimer's disease.

In 2017, the organization Alzheimer Europe conducted an extensive survey of European countries, presenting and comparing national policy responses to the challenges of dementia in different areas. The first area examined the aspects of care (accessibility and affordability), while the second area analyzed the medical and research aspects (cost of Alzheimer's drug treatment, availability of clinical trials, and the involvement of European countries in research initiatives on dementia). The third area discussed policy issues, such as prioritizing policies on dementia and dementia-friendly communities (i.e. the level of inclusion). The final, fourth area considered human rights and legal aspects, such as the level of respecting legal rights, the ratification of international and European human rights charters, and support for caregivers and employment. 36 European countries participated in the research initiative, both EU member states and non-member countries (Alzheimer Europe, 2017).

Countries received points for each area, forming a ranking list, with a higher number of points indicating a better result. Finally, individual results for each area produced an overall score, combining the results from ten different categories so that each category contributed 10% to the overall score. The indicated score represented a percentage of the total maximum score that the countries could achieve. As a result, Finland achieved the highest overall score (75.2), followed by the United Kingdom - England (72.4, in the survey, England and Scotland are presented individually, due to different legislation), the Netherlands (71.2), Germany (69.4), the United Kingdom

– Scotland (68.8) and Denmark (64.2). Conversely, Albania (11.4), Latvia (20.6), Bosnia and Herzegovina (24.4) and Romania (24.5) were at the lower end of the list, as well as Croatia with 32.8 points (Alzheimer Europe, 2017).

In the area of human rights and legal aspects relevant to our study, the results are as follows. In terms of respecting legal rights, the Czech Republic, France, Israel, the Netherlands, Slovenia and the United Kingdom (England and Scotland) achieved the highest score (100 points). Croatia scored 75 points, placing the country in the upper half of the ranking. Finland and Norway scored best in the ratification of international and European human rights charters (83 points), while Croatia, scoring 50 points, was placed in the lower half of the ranking. In the area of support for caregivers and employment, Ireland was first, scoring 100 points, followed by Belgium, Germany, Greece and Slovakia with 80 points. In this area, Croatia however, was at the lower end of the ranking, in the group of countries with 0 points (Alzheimer Europe, 2017).

Based on the results, Finland, the United Kingdom - England and the Netherlands had the most advanced policy framework on dementia, whereas Albania, Latvia and Bosnia and Herzegovina needed to make significant progress and reforms to improve the lives of people with dementia (Alzheimer Europe, 2017).

Another research study, conducted in the United States from 2003 to 2017, aimed to determine the trends and factors concerning the place of death of people with Alzheimer's dementia. Namely, in that period, the percentage of people who died at home or in a hospice increased from 13.6% (at home) and 0.2% (hospice) in 2003 to 21.9% (at home) and 6.2% (hospice) in 2017. On the other hand, the percentage of people who died in hospitals or retirement homes in that period fell from 65.7% (retirement home) and 12.7% (hospital) in 2003 to 55% (retirement home) and 8% (hospital) in 2017. Men were notably more likely to die in a hospice or hospital than

at home or in a retirement home. Furthermore, non-white, Hispanic and married persons were more likely to die at home or in a hospital and less likely to die in a retirement home. A higher level of education indicated greater chances of dying at home or in a hospice and lower chances of dying in hospitals or retirement homes. Also, the urban or rural residence strongly predicted the place of death. Given the increasing number of people with Alzheimer's dementia who died at home, research results indicated a growing need for support for caregivers and palliative care at home (Cross et al., 2020).

Suver et al. (2020) researched the principle of informed consent and the process of giving consent by interviewing research coordinators at two Alzheimer's Disease Research Centers in the United States. Data was collected through semi-structured face-to-face interviews with 15 coordinators from the Alzheimer's Disease Research Centers at the University of Wisconsin and Emory. Most coordinators were female (10), under 40 years old (11) and had one year of experience as research coordinators of Alzheimer's disease (10). The interviews lasted from 25 to 45 minutes (30 minutes on average). The coordinators suggested that before engaging in a conversation about informed consent, they tried to establish empathetic communication and put their correspondents at ease. The process of giving consent lasted between 15 minutes and 1 hour at Emory University and 30 minutes to 1 hour at the University of Wisconsin, due to different lengths of the informed consent questionnaire, according to the interviewed researchers (12 pages at Emory and 22 pages at the University of Wisconsin). The respondents experienced three main difficulties. Lack of attention represented the first challenge (due to the duration of the consent process, participants often lost their attention halfway through the questionnaire). Other issues involved the complexity of the research procedures, the structure of the questionnaire and research materials, and the timeline of the research procedures (often several months after giving consent). The final challenge concerned prior knowledge, including confusion about the scien-

tific elements of research, misinformation about the medical procedures and non-distinction between participation in research and medical procedures (for example, participants perceived participation in the research study as another diagnostic procedure, they expected to receive medical results, such as blood tests, etc.) (Suver et al., 2020).

The coordinators mentioned being frequently asked about the pain of participating in research and the related medical procedures. Also, they suggested adapting the questionnaire and the research instrument to participants, adjusting the vocabulary and the way of speaking, and prioritizing information depending on the participants' attitudes to facilitate the understanding of the consent procedures. They equally observed that participants with severe cognitive impairment deferred more to the opinion of others, which made them more susceptible to outside pressure and influences. Among the challenges of giving consent, coordinators suggested that both centres expected people to remember and verbalize the risks/advantages of participating in the research study (as presented by the coordinator) before signing, which was particularly difficult for people with memory impairment. The research coordinators recommended monitoring the participants' attitudes and the expressed preferences during the conversation, without expecting them to remember the key points of the discussion. Based on the research results, the authors concluded the informed consent process presented considerable difficulties for people with Alzheimer's disease, which called for more flexible approaches. For example, participants could receive the questionnaire in advance so that they could become somewhat familiar with it and discuss possible questions/doubts during the conversation. Also, eConsent could be used, with integrated multimedia instructions for completing the questionnaire and further clarification of the details on the research for which consent is given (Suver et al., 2020).

Carabellese et al. also researched informed consent (2018), examining the capacity to consent for people with Alzheimer's disease in Italy. The par-

ticipants formed two groups: the experimental (70 people with Alzheimer's disease admitted to the Department of Neurodegenerative Diseases at the University of Bari, 43 women and 27 men) and the control group (83 people without neurodegenerative diseases hospitalized at the Department of Geriatrics at the same university, 38 women and 45 men).

Research instruments involved the MacArthur Competence Assessment Tool for Treatment (MacCAT-T), neurological evaluations, the Neuropsychiatric Inventory, etc. The results indicated that a significant proportion of participants from the experimental group lacked the capacity to consent, due to complex general cognitive and executive dysfunctions, notably participants with moderate cognitive impairment who experienced greater difficulties than persons with mild impairment. The study signaled two significant findings. It confirmed the benefits of instruments indicating the level of neurocognitive functioning, notably the required level that determined the capacity to consent to medical treatment. Moreover, the results revealed instances when people with Alzheimer's dementia and the accompanying neurocognitive disorders were subjected to medical procedures without their consent (in Italy it was required to document and monitor the capacity to consent) (Caraballese et al., 2018).

In 2020, Pettigrew et al. (2020) published a research study on the attitudes of people with Alzheimer's disease and their caregivers about advance care planning (ACP) and end-of-life care, including possible differences based on ethnicity. The research was conducted in 13 geographically dispersed Alzheimer's Disease Centers in the United States, involving 431 caregivers of people with Alzheimer's disease of different ethnicity. According to research results, most respondents were informed about dementia and palliative care. Furthermore, the patients generally wished to reach the end of life comfortably (involving the so-called comfort-care approach). Also, a high proportion of patients (87%) had legal advance care planning (legal ACP), including living will, as well as informal advance care planning (79%

of patients). African-Americans with Alzheimer's disease expressed a lower preference for the comfort-care approach (58%, compared to 81% of caucasian participants), as well as a lower interest in legal advance care planning (legal ACP) (73% compared to 89% of caucasian participants). Moreover, African-American participants seemed less informed about dementia and more influenced by religious/spiritual beliefs concerning the preferred types of medical treatment. Ultimately, all respondents needed more information about the different stages of dementia and palliative care options. Based on the results, the researchers suggested that greater awareness-raising efforts could reduce the discrepancies in attitudes toward advance care planning (ACP) between patients of different ethnicities. Notably, raising awareness should focus on the clinical picture and the progression of dementia, as well as the challenges of end-of-life care, further promoting advance care planning (ACP) (Pettigrew et al., 2020).

5. COVID-19

The COVID-19 pandemic caused a tremendous global disruption in many areas. Rare people had not been affected by the pandemic and its implications. Specific social groups were particularly vulnerable, notably the elderly with medical conditions, having the largest share in the total number of deaths from the coronavirus disease (Sm-Rahman et al., 2020). People with Alzheimer's disease and other types of dementia were equally highly vulnerable, for various reasons. Firstly, due to their cognitive impairment, they were less able or entirely unable to understand and assess the risk or adhere to health and safety recommendations. Namely, to control the spread of the virus, most countries prescribed health and safety measures, such as wearing protective masks, maintaining physical distance, frequent hand washing and many others, which persons with dementia struggled to follow, mainly due to memory impairment, inherent to the disease (Sm – Rahman et al., 2020). Also, they often suffered from accompanying mental disorders, such as anxiety and depression, which risked aggravating during the pandemic. That was particularly alarming as depression, anxiety and intense emotional distress generally accelerated cognitive decline (El Haj et al., 2020). Besides psychological difficulties, patients often had other medical conditions, such as high blood pressure, issues with the blood circulatory system, etc., further increasing the risk of death from the coronavirus (Sm – Rahman et al., 2020).

The pandemic profoundly affected many patients living in retirement homes. Alzheimer's disease is associated with an increased risk of death from the coronavirus, notably paired with accommodation in large residential institutions (Matias - Guiu, Pytel and Matias - Guiu, 2020). Moreover, most homes in Europe and North America significantly restricted the daily activities of residents, including movement, interaction, group activities, joint dining, etc. (El Haj et al., 2020). Although the health and safety restrictions aimed to protect the at-risk population, at the same time, they

considerably affected the quality of life. El Haj et al. (2020) researched anxiety and depression based on a sample of 58 participants with Alzheimer's disease living in retirement homes in France. The research results indicated higher levels of depression and anxiety (depression $M=14.21$, $SD=3.17$, anxiety $M=13.24$, $SD=3.39$) compared to the pre-pandemic period (depression $M=12.34$, $SD=4.10$, anxiety $M=11.38$, $SD=4.36$).

Even patients who lived with their families or alone could not escape the negative effects of the pandemic. Namely, many social services they depended on (food delivery, group exercise, music and animal therapy, socializing, etc.) were no longer available, paired with a disrupted contact with family members (when caregivers got sick, communication became difficult as most persons with the disease could not use technology, etc.) (Sm – Rahman et al., 2020).

Against this backdrop, Sm – Rahman et al. (2020) explored several avenues for addressing the aforementioned challenges effectively. For example, people could be reminded of the health and safety recommendations regarding the coronavirus (wearing a mask, washing hands, etc.). Also, families could engage in different activities through technology (online socializing, phone calls, playing games, etc.). Families might also connect in informal networks to exchange experiences and support each other in caring for family members with the disease. Moreover, the pandemic period could even serve to improve family relationships. Namely, before the pandemic, family members might have had less time to socialize and connect with the person with Alzheimer's disease (due to other obligations). However, now they might use more of their free time to deepen and strengthen family relationships due to remote work and more time spent at home (Sm – Rahman et al., 2020). In the institutional environment, psychological help is essential, such as cognitive behavioral therapy, meditation, etc. Staff and caregivers should also receive training to enhance their capacities for tackling the challenges of living and working in institutions during the pandemic (El Haj et al., 2020).

6. Critical review and suggestion for improving the practice

Alzheimer's disease affects individuals and their families in various ways, notably concerning human rights. Given the nature of the disease and the resulting inability of people with the disease to affirm their rights, their family members, the community and, ultimately, the state should step up in this respect. This paper reviewed the main mechanisms of the state for protecting the human rights and dignity of people with Alzheimer's disease. Formally, all mechanisms served to protect the rights of individuals; nonetheless, their practical application appeared inconsistent, resulting in inadequate protection of rights. Notably, the risk of removing legal capacity as defined by law appeared quite high. In practice, it was arguable whether the user perspective and the opinion of persons under guardianship were properly considered when making relevant decisions on their behalf. In our view, the legal capacity of people with Alzheimer's disease should not be removed by default; they should rather get adequate support to make decisions independently for as long as possible. Supported decision-making was pivotal as it protected the right to make personal decisions and risks (Gurbai, 2012), supporting independent living for as long as possible. Another protection mechanism, palliative care, in many cases, seemed to be offered too late (if at all). Namely, palliative care should be introduced as soon as the disease is diagnosed (Mimica, 2011); rather than at the terminal stage of the disease. At that stage, home care could become too demanding due to numerous secondary symptoms (infections, pain, etc.) (Mimica, 2011). Consequently, placement in specialized institutions appeared inevitable. The cost of palliative care represented a considerable barrier, notably its availability in terms of locations and institutional capacities. In Croatia, Dološić (2016) identified palliative care institutions for people with Alzheimer's disease only in the counties of Zagreb, Istria and Koprivnica-Križevci. Under the circumstances, the right to palliative care might be denied, which

the authors considered unacceptable. Therefore, ensuring the availability of palliative care should become the state priority, including an even geographical distribution of institutions throughout the country.

Informed consent also presented its challenges. Although it was the right of every patient (Turković, 2008, Dološić, 2016, Dološić, Milić Babić and Rusac, 2019), the capacity to consent was a matter of dispute. A research study from Italy confirmed this assumption based on the significant proportion of patients who lacked the mental and cognitive capacity to consent (Caraballese et al., 2018). Therefore, further promotion and mainstreaming of the advance directives are needed, allowing people to decide in advance (while their capacity is still preserved) about medical procedures and/or authorize a trusted person/s to make decisions on their behalf once they are no longer able to do so.

7. Conclusion

The most common cause of dementia, Alzheimer's disease, is becoming a growing concern for many countries, with the number of patients expected to increase in the future. That outlook is notably distressing, considering that Alzheimer's disease affects the individual and the family. Although the disease usually has a mild onset (except for the triggers that may accelerate the course of the disease), its progression and the ensuing cognitive decline are continuous. The disease is incurable and patients face a decreased quality of life for the remainder of their lives. The symptoms vary, depending on the person and the stage of the disease. Therefore, there is a well-founded apprehension that people would not be able to protect their rights and interests. For this reason, the state has several mechanisms for protecting the patient, their rights and dignity, namely legal capacity, palliative care and the principle of informed consent.

Alzheimer's disease is also the focal point of many research studies, generally considering the medical aspects of the disease, its causes, treatment methods, etc. Despite the importance of medical responses, researching non-medical approaches for coping with the disease and providing care is critical. Therefore, this paper reviewed relevant research studies on mechanisms for protecting the human rights of patients. The review contributed to a better understanding of the protection of patient rights in practice, signaling the need and the avenues for improvement.

In 2020, the coronavirus pandemic presented a tremendous new challenge for humanity, including Alzheimer's patients and their caregivers. The pandemic has transformed everyday life, notably for persons with medical conditions. Whether the patients lived in institutions (retirement homes) or at home, the combat against the virus presented significant challenges considering their condition. Supporting people with the disease in their daily activities has thus become quintessential, relying on the positive aspects of the pandemic. For example, many might use the opportunity to reconnect with their family members, receive psychological support through therapy, learn to use technology, etc. At the end of the pandemic, both people and the world will certainly have changed, and we can only hope it is for the better.

References

Abate, G., Memo M., & Uberti D. (2020). Impact of COVID-19 on Alzheimer's Disease Risk: Viewpoint for Research Action. *Healthcare* 2020, 8(3), 286.

Alzheimer Europe (2017). *European Dementia Monitor 2017 – Comparing and benchmarking national dementia strategies and policies*. Accessed on 30.12.2020. at website Alzheimer Europe: <https://www.alzheimer-europe.org/content/download/189956/1420091/file/2017%20European%20Dementia%20Monitor.pdf>.

Alzheimer Europe (2020). *Dementia as a European Priority: A policy overview*. Accessed on 31.12.2020. at website Alzheimer Europe: [https://isu.com/alzheimer-europe/docs/dementia as a european priority](https://isu.com/alzheimer-europe/docs/dementia%20as%20a%20european%20priority).

Brkljačić, M. (2013). Etički aspekti komunikacije u zdravstvu [Ethical aspects of communication in health care]. *Medicina Fluminensis*, 49(2), 136-143.

Caraballese, F., Felthous, A. R., La Tegola, D., Piazzolla, G., Distaso, S., Logroscino, G., Leo, A., Ventriglio, A., & Catanesi, R. (2018). Qualitative analysis of the capacity to consent to treatment in patients with a chronic neurodegenerative disease: Alzheimer's disease. *International Journal of Social Psychiatry*, 64(1), 26-36.

Cross, S. H., Kaufman, B. G., Taylor Jr., D. H., Kamal, A. H., & Warraich, H. J. i (2020). Trends and Factors Associated with Place of Death for Individuals with Dementia in the United States. *Journal of the American Geriatrics Society*, 68(2), 250-255.

Dološić, S. (2016). *Ljudska prava oboljelih od Alzheimerove bolesti [Human rights of persons with Alzheimer's disease]*. Final specialist thesis. Osijek: University of Josip Juraj Strossmayer in Osijek, School of Law Osijek.

Dološić, S., Milić Babić, M., & Rusac, S. (2019). Alzheimerova bolest kroz prizmu ljudskih prava [Alzheimer's disease from the human rights perspective]. *Socijalna psihijatrija*, 47(4), 470-496.

El Haj, M., Altintas, E., Chapelet, G., Kapogiannis, D., & Gallouj, K. (2020). High depression and anxiety in people with Alzheimer's disease living in retirement homes during the Covid-19 crisis. *Psychiatry Research*, 291, 2020.

Gurbai, S. (2012). Alternative skrbništvu u praksi: odlučivanje uz podršku, mreža podrške i zaštitni mehanizmi [Alternatives to guardianship in practice: supported decision-making, support network and protection mechanisms]. In Meić, B. (ed.), *Poslovna sposobnost i skrbništvo – raskorak između Konvencije o pravima osoba s invaliditetom i prakse [Legal capacity and guardianship - discrepancies between the Convention on the Rights of Persons with Disabilities and the practice]*. (pgs. 83-89). Zagreb: Ombuds-woman for Persons with Disabilities.

Matias – Guiu, J. A., Pytel, V., & Matias – Guiu, J. (2020). Death Rate Due to COVID – 19 in Alzheimer's Disease and Frontotemporal Dementia. *Journal of Alzheimer's Disease* 78(2), 537-541.

Mimica, N. (2011). Demencija i palijativna skrb [Dementia and palliative care]. *Neurologia Croatica*, 60(3-4), 119-123.

MSD Hrvatska (2020). *Alzheimerova bolest [Alzheimer's disease]*. Accessed on 1.1.2021. at website MSD Hrvatska: <http://www.msd-prirucnici.placebo.hr/msd-prirucnik/neurologija/delirij-i-demencija/alzheimerova-bolest>.

Pettigrew, C., Brichko, R., Black, B., O'Connor, M. K., Guerriero Austrom, M., Robinson, M. T., Lindauer, A., Shah, R. C., Peavy, G. M., Meyer, K., Schmitt, F. A., Lingler, J. H., Domoto – Reilly, K., Farrar – Edwards, D., & Albert, M. (2020). Attitudes toward advance care planning among persons with dementia and their caregivers. *International Psychogeriatrics*, 32(5), 585-599.

Legal Clinic of the School of Law in Zagreb (2013). *Lišenje poslovne sposobnosti [Removing legal capacity]*. Accessed on 1.1.2021. at the website of the Legal Clinic of the School of Law in Zagreb: <http://klinika.pravo.unizg.hr/content/lisenje-poslovne-sposobnosti>.

Puljak, A., Perko, G., Mihok, D., Radašević, H., & Tomek – Roksandić, A. (2005). Alzheimerova bolest kao gerontološki javnozdravstveni problem [Alzheimer's disease as a gerontological health care issue]. *Medicus*, 14(2), 229-235.

Sm – Rahman, A., Hung Lo, C., Ramic, A., & Jahan, Y. (2020). Home-Based Care for People with Alzheimer's Disease and Related Dementias (ADRD) during COVID-19 Pandemic: From Challenges to Solutions. *International Journal of Environmental Research and Public Health*, 17(24), 9303.

Suver, C. M., Hamann, J. K., Chin, E. M., Goldstein, F. C., Blazel, H. M., Manzanares, C. M., Doerr, M. J., Astahan, S. J., Mangravite, L. M., Levey, A. I., Lah, J. J., & Edwards, D. D. (2020). Informed Consent in Two Alzheimer's Disease Research Centers: Insights From Research Coordinators. *AJOB Empirical Bioethics*, 11(2), 114-124.

Štrkalj Ivezić, S. (2012). Procjena kapaciteta za odlučivanje kao ključan faktor u donošenju odluke za lišavanje poslovne sposobnosti [Assessing decision-making capacity as key factor in deciding on removing legal capacity]. In Meić, B. (ed.), *Poslovna sposobnost i skrbništvo – raskorak između Konvencije o pravima osoba s invaliditetom i prakse [Legal capacity and guardianship - discrepancies between the Convention on the Rights of Persons with Disabilities and the practice]*. (pgs. 66-75). Zagreb: Ombudswoman for Persons with Disabilities.

Turković, K. (2008). Pravo na odbijanje medicinskog tretmana u Republici Hrvatskoj [The right to refuse medical treatment in the Republic of Croatia]. *Medicina Fluminensis*, 44(2), 158-170.

ZAŠTITA LJUDI KOJI BOLUJU OD ALCHAJMEROVE BOLESTI I DRUGIH DEMENCIJA – MOŽEMO LI BOLJE?

Marina Milić Babić

Rezime

Alchajmerova bolest je neizlečivo, progresivno propadanje moždanih ćelija, zbog čega oboleli doživljavaju gubitak fizičkih, psihičkih i mentalnih funkcija. Napredovanje bolesti kod oboljele osobe donosi pogoršanje stanja, pa je to bolest koja ne pogađa samo pojedinca, već duboko pogađa i članove porodice, posebno članove obitelji koji su najbliže oboljelom. S obzirom na to da ne postoji lek za bolest, očekuje se da će osoba imati značajno narušen kvalitet života, a simptomi koji ga pogađaju su različiti, u zavisnosti od osobe i stadijuma bolesti. Stoga postoji opravdana bojazan da ljudi neće moći da zaštite svoja prava i interese. Povrede prava i interesa osoba sarije životne dobi česta su pojava u praksi, jer osobe starije životne dobi spadaju u ranjive skupine društva. Iz tog razloga postoje određeni mehanizmi kojima država štiti oboljele osobe i njihova ljudska prava i dostojanstvo. Mehanizmi zaštite mogu se opisati kroz: poslovnu sposobnost, palijativno zbrinjavanje i institut informisanog pristanka. Kako je aktuelna pandemija KOVID-19 uticala na živote osoba obolelih od Alchajmerove bolesti i drugih demencija biće prikazano u radu sa ciljem da se aktuelizuje potreba za zaštitom ove posebno osjetljive grupe u okviru starije populacije. U radu će biti predstavljena

teorijska saznanja, ali i određena rešenja koja mogu poboljšati život obolele osobe i članova porodice. Pored toga, autor predstavlja prava i usluge u sistemu socijalne zaštite, koje su namenjene poboljšanju kvaliteta života osoba koje boluju od Alchajmerove bolesti i drugih demencija.

Zaključno, pregledom istraživanja, prava i usluga i mehanizama zaštite, moguće je izgraditi adekvatniju mrežu formalne podrške koja će članovima porodice olakšati ovaj izuzetno izazovan proces zbrinjavanja bolesne osobe. U interesu je cijelokupnog društva izgraditi sustavnu mrežu podrške oboljenom i članovima obitelji, kako bi se unaprijedila kvaliteta života oboljelog, smanjila insitucionalizacija ali i sagrijevanje skrbnika, tj. člana obitelji koji je preuzeo njegovateljsku ulogu i u konačnici troškovi skrbi za oboljelu osobu.

Ključne reči: *Alchajmerova bolest, ljudska prava, KOVID-19, formalna podrška*

Professional paper UDK: 616.98:578.834]:616.892.3-056.24
364-787:616.892.3-056.24

Handed over: 20.03.2023.

Accepted: 17.05.2023.

CARING FOR PERSONS WITH A DIAGNOSIS OF DEMENTIA IN A SOCIAL CARE INSTITUTION DURING AND AFTER THE COVID-19 VIRUS PANDEMIC

**Milica Petkovic⁴¹, Aleksandra Nikitovic⁴²,
Stefan Topalovic⁴³, Zuhra Hodzic⁴⁴,
Aleksandra Romić⁴⁵**

Abstract

The life of persons diagnosed with dementia during the pandemic has been the subject of numerous studies around the world. Scientific research has dealt with this topic from different angles. Some of the studies focused on the impact of the infection on the health status of people diagnosed with dementia, investigating the specifics related to the clinical picture, the course of the disease as well as the course of recovery.

⁴¹ **Milica Petković**, Social Worker in the Gerontological Center Belgrade, WU Home "Bežanijska kosa", petkovicm@ugcb.rs

⁴² **Aleksandra Nikitović**, Medical Doctor in the Gerontological Center Belgrade, WU Home "Bežanijska kosa", nikitovica@ugcb.rs

⁴³ **Stefan Topalović**, Psychologist in the Gerontological Center Belgrade, WU Home "Bežanijska kosa", topalovics@ugcb.rs

⁴⁴ **Zuhra Hodžić**, Social Worker in the Gerontological Center Belgrade, WU Home "Bežanijska kosa", hodzicz@ugcb.rs

⁴⁵ **Aleksandra Romić**, Social Worker, Head of a separate unit of home accommodation in the Gerontological Center Belgrade, WU Home "Bežanijska kosa", romica@ugcb.rs

On the other hand, studies in the field of social protection investigated psychological reactions to extraordinary circumstances caused by the pandemic and various coping mechanisms in persons with a diagnosis of dementia, their relatives and staff who provide care in social protection institutions. In addition, the studies investigated the impact on the cognitive functioning of these persons as well as the increased risk of deterioration of cognitive-mnemonic functions in persons who were previously diagnosed with mild changes in the cognitive sphere. The results of the studies show that the COVID-19 pandemic had a significant-negative impact on the quality of life of persons diagnosed with dementia.

In the Gerontological Center Belgrade Institution within the “Bežanijska Kosa” WU, there are departments specialized in providing social and health care services to persons diagnosed with dementia. This paper shows the beneficiaries’ reactions to the extraordinary circumstances caused by the pandemic, the changes in the organization of the institution’s work and the specifics related to the care and provision of services to the beneficiaries during the pandemic. The paper presents statistical data related to the rate of infection, the clinical picture and the health status of beneficiaries who have been confirmed to have an infection, changes in behaviour and mental state, as well as the way in which the institution adapted care and service provision during the pandemic.

Qualitative methods were used in the work, which involved interviewing employees in the department for persons diagnosed with dementia, as well as analyzing the institution’s documentation.

The obtained results confirm the findings of previous research on the negative impact of the pandemic on the quality of life of persons diagnosed with dementia. The key factors that contributed to this was social isolation, which was reflected in the reduced interaction of the beneficiaries with relatives and other persons close to them, which was conditioned by measures of prevention and protection against the spread of infection.

Keywords: dementia, COVID-19, social protection, social isolation

Introduction

With the aging of the population and the increase in life expectancy, the number of people suffering from dementia is increasing. According to 2015. estimates by the Alzheimer's International Organization, about 50 million people are living with a diagnosis of dementia, with a tendency to grow to 82 million by 2030, and 152 million by 2050. (Alzheimer's disease international, World Alzheimer Report 2020). There are no precise data on the number of people diagnosed with dementia in Serbia. According to the 2011 index, more than one million people in Serbia are 65 and older, and it is estimated that dementia is present in 6% to 10% of them (Satarić, Kalašić, p. 4) According to data from 2019 in Serbia, there were 129,000 people suffering from some form of dementia (Satarić, Kvašček Gajić, 2022).

Dementia is defined as a syndrome, that is, a set of symptoms and signs, rather than a single disease (Pavlović, 2008, p. 35). Dementia is an gein mental deterioration in at least two of the following five areas that are not due to delirium: memory, speech, visual spatial skills, executive (spatial) functions, personality, and mood (Pavlovic according to Cummings, Benson, p. 35). They are most often divided into the three most prevalent forms: Alzheimer's disease, dementia with Lewy bodies and Vascular dementia. The most common type of dementia is Alzheimer's disease and it represents 60% of all dementias (Pavlović, 2008, p. 37). The first symptoms of dementia are problems remembering recent events and problems performing daily, routine activities. Symptoms will primarily manifest in activities where there are the greatest demands, such as performing work duties and tasks, while only later it will manifest itself in everyday life and performing household duties. Early diagnosis of dementia is very important in order to start taking appropriate therapy at the earliest possible stage. The environment often does not notice the first symptoms or attributes them to the "normal" process of

forgetting in an elderly person, which is why it is necessary to increase the awareness of public opinion about the initial signs of dementia and the possibilities for testing and diagnosing it, in order to slow down the degenerative process as much as possible. dementia. Early establishment of a diagnosis is the first step in further planning the future of a person diagnosed with dementia, as well as his family and people from his environment who should provide him with support. What experience shows is that in Serbia most people show up late for examination, when there has already been a significant decline in intellectual and other functions (Pavlović, p. 64).

Symptoms that indicate dementia can be categorized into cognitive disorders such as forgetfulness, difficulties in finding appropriate words and understanding speech, disorientation in time and space; psychiatric symptoms such as depression, apathy, insomnia, delusional mood changes, suspiciousness, hallucinations; personality change such as withdrawal from society, inappropriate sexual behavior, loss of interest; wandering, agitation, anxiety, as well as changes in daily functioning, such as the inability to find the way home, neglect of personal hygiene, difficulty managing money, etc. (Pavlović, p. 64). These symptoms lead to cognitive problems and behavioral disorders, which can lead to deterioration of the social relations of the person with dementia as well as their role in the community.

After the emergence of the pandemic caused by the COVID-19 virus, numerous studies were devoted to determining the connection between the infection and changes in the health and psychophysical state of people. As one of the vulnerable groups, people diagnosed with dementia were particularly vulnerable during the pandemic.

Studies investigating the impact of the pandemic on people diagnosed with dementia have focused on several different areas. Part of the papers dealt with the impact of changes in the functioning of institutions caused

by the pandemic, as well as the impact that preventive measures had on the lives of people diagnosed with dementia in the community (Cipriani, G., & Di Fiorino, M. 2020). Other studies looked at the challenges faced by carers and family members of people diagnosed with dementia and the effects of the emergency on their mental health (Tousi, B., 2020; Savla, J., et al, 2021; Cohen, G., et al. 2020). The third group of studies focused on changes in cognitive-mnemonic functions in persons with a diagnosis of dementia in whom infection with the COVID-19 virus was confirmed (Simonetti, A., et al, 2020). These studies tried to determine whether there was additional damage in people who had the virus compared to those who had no confirmed infection, as well as in relation to the expected course of the disease. The last group of studies focused on the health consequences and specifics related to the risk of disease as well as specifics related to the clinical picture in persons diagnosed with dementia compared to the general population (Liu, N., et al, 2020).

The results of the research showed that people with a diagnosis of dementia were at an increased risk of developing a severe clinical picture after contracting the COVID-19 virus, as well as that there was an increased risk of worsening neuropsychiatric symptoms, as a result of prevention measures that restricted people's movement, as well as measures related to social distancing that led to additional social isolation of these persons (Numbers, K., & Brodaty, H. (2021). Other studies that included large samples showed that the mortality rate and the development of a severe clinical picture to a greater extent present in persons diagnosed with dementia compared to the general population (Hariyanto, et al, 2021). Some studies indicated that the clinical picture was atypical, which made early recognition of symptoms and timely hospitalization difficult. The most common symptoms at the beginning of the disease were delirium and changes in functional status (Bianchetti, A., et al. 2020). There are also studies that indicate that a diagnosis of Parkinson's disease and a diagnosis of dementia were predictors

of a severe clinical picture and an increased risk of death regardless of the severity of the subject (Tahira, AC, et al 2021).

Regarding the behavioral and psychological symptoms of dementia, studies have shown that during the pandemic, apathy, anxiety and agitation were the most pronounced, the appearance and intensity of which was determined by the long duration of isolation from other people. According to these studies, the treatment was mostly reflected through changes in psychopharmacological therapy. Studies have also highlighted the importance of staff caring for people diagnosed with dementia, as well as the role of technology in enabling these people to stay in touch with friends and family members during periods of isolation (Simonetti, A., et al, 2020). Some studies state that deterioration of cognitive-mnemonic functions is most observed in people with dementia of the Alzheimer's type (Rainero, I., et al, 2021).

The biggest challenge in providing care involved compliance with preventive measures - wearing protective masks, social distancing and occasional prohibition of movement. Studies have shown that people with a diagnosis of frontotemporal dementia had the most difficulties, due to the significantly reduced capacity of these people in understanding and accepting social norms and rules (Suzuki, M., et al. 2020). A large number of studies agree that the pandemic has had a significant impact on increasing the stress of caregivers of people diagnosed with dementia. An increased presence of symptoms such as anxiety and depressive symptoms was observed (Rainero, I., et al, 2021).

Method

A qualitative method was used in the research, which included a structured interview with employees who work in departments where users with a diagnosis of dementia are accommodated. In addition, an analysis of the Institution's medical records was used.

Changes in work at Dementia wards during Pandemic

WU Dom "Bežanijska kosa" is one of the four working units of nursing home within the Gerontological Center Belgrade and takes care of 580 users of the nursing home service - adults and elderly people aged 26 and over. The nursing home has four buildings intended for the accommodation of users - three studio buildings A1, A2, A3, which have a capacity of 220 places and stationary building B, which has 360 places. Housing, hygiene, nutrition, health care and nursing, occupational and physical therapy, social work, psychological assistance and others are provided in the nursing home. Services are provided depending on the user's needs.

In the WU Dom "Bežanijska kosa", in the inpatient facility, there are two departments for the accommodation of persons diagnosed with dementia, where users are accommodated depending on their mobility and functional abilities. The total capacity of both departments is 157 places.

The first case of a user falling ill with COVID-19 in the Dom "Bežanijska kosa" was recorded on November 9, 2020.

In the first wave of the epidemic, a total of 173 users fell ill, of which 37 were diagnosed with dementia.

In the second wave of the epidemic, a total of 74 users fell ill, of which 9 were diagnosed with dementia.

In the third wave of the epidemic, a total of 184 users fell ill, of which 63 were diagnosed with dementia.

The impact of the application of measures against COVID-19 at work on the daily life of users with Dementia

In the period from the beginning of the COVID-19 epidemic in Serbia and the declaration of a state of emergency, after receiving instructions on the actions of employees in order to prevent the spread of the COVID-19 virus in the Institution, they are in accordance with the instructions from March 28, 2020. visits and going out of beneficiary outside the Institution were suspended and the contact of professional workers with users was limited⁴⁶. Bearing in mind that the adopted instructions are general, that is, they refer to all users of the services of institutions for the accommodation of adults and the elderly, regardless of their diagnoses and specific needs, the same had to be applied to beneficiary diagnosed with dementia. Also, by instruction⁴⁷ from 18.05.2020. it was foreseen that the person coming to the accommodation must be in preventive isolation for 14 days, alone in the room, which required additional spatial reorganization and the separation of a part of the department for the reception of new beneficiary, which will have a space for walking and a space for the living room. According to the instructions of the Ministry of Labour, Employment, Veterans and Social Affairs from April 20, 2020⁴⁸ upon the return of the beneficiary from the hospital treatment of COVID-19, the beneficiary must be in isolation for 14 days if the family/guardian is not able to take over the beneficiary so that the beneficiary will be in self-isolation in the family environment for the next 14 days. During the epidemic in the nursing home, none of the relatives had the possibility to take over the beneficiary for isolation in home conditions.

⁴⁶ <https://www.minrzs.gov.rs/sites/default/files/vanredno-stanje/2020.03.28.%20Nalog%200001.pdf>

⁴⁷ <https://www.minrzs.gov.rs/sites/default/files/2020-05/2020.05.18.%20Instrukcija%200022.PDF>

⁴⁸ <https://www.minrzs.gov.rs/sites/default/files/vanredno-stanje/2020.04.20.%20Instrukcija%20016.pdf>

Isolation of beneficiary with a diagnosis of dementia for 14 days was a very big challenge, both for the beneficiary themselves and for the employees in direct contact with them. It is known that a change in the living environment is stressful for a person with dementia, while staying in an unfamiliar environment isolated from other users also caused confusion and anxiety for the users who came to the accommodation.

In order to mitigate the negative effects of the application of measures of preventive protection against the COVID-19 virus, a reorganization of the department where beneficiary with a diagnosis of dementia reside was implemented. Part of the department is set aside for the reception of new beneficiary who, upon admission, stayed alone in the room, a part of the department where they can walk, a living room with all the accompanying equipment necessary for the beneficiary is provided.

In the period when positive cases of COVID-19 were registered in the department, it was ensured that, if there are no indications for hospital treatment, the sick beneficiary remain in their familiar environment and in contact with the employed staff who are familiar to them.

Considering the prohibition of visits in the home, it is recorded that the sudden termination of contact with close persons who visited them daily has a negative effect on the daily functioning of the beneficiary. As an alternative to beneficiary visits, video calls have been introduced to enable beneficiary to continue contact with their family. It has been shown that a video call is not an adequate substitute for “face-to-face” contact for beneficiary who are in the late stages of dementia, it additionally causes confusion for the person. Beneficiary who are in the middle and early stages of dementia have positively accepted video calls as an alternative to visits.

Impact of COVID-19 on the brain and cognition (Clinical picture)

The older people are at greater risk of developing severe forms of COVID-19 infection due to age-related factors and a higher prevalence of comorbidities, and are therefore more exposed to the possibility of having permanent cognitive and neuropsychiatric impairments. (Alonso-Lana S. et al, 2020). People diagnosed with dementia are at an additional risk of developing severe symptoms of COVID-19 infection due to difficulties in understanding and implementing preventive epidemiological measures and the inability to clearly indicate the initial symptoms of infection and timely response in treatment. In addition to the appearance of common symptoms of COVID-19 infection such as fever, cough, muscle pain, after receiving a positive test for COVID-19, additional stress for users was the necessity of going to a COVID clinic for screening, as well as eventual hospitalization. The very fact that a person with dementia is in a new environment, with unknown people with masks and protective equipment can cause anxiety, agitation and further lead to the need for sedation, which can further worsen the symptoms of infection and complicate the treatment process (Korczyń AD, 2020). The most frequently registered cognitive deficits were in the speed of sensory information processing, impairment of executive functions, phonemic fluency, so-called memory encoding and difficulties in repeating previously preserved orders and habits. After hospitalization, patients had a long time window or process of adaptation to the isolation space in the nursing home and the functioning space after isolation in which they stayed before the covid infection. Also, the persistence of certain new cognitive dysfunctions, in relation to COVID-19 patients treated in outpatient conditions, is deeper and longer.

Great health and social support is provided to our beneficiary by the entire team of employees, with whose stimulation, general and medical care, as well as the provision of psychological security, greatly facilitates the daily life and recovery of beneficiary suffering from dementia.

Conclusion

The pandemic caused by the COVID-19 virus had a significant impact on changes in the psychophysical and health status of users diagnosed with dementia. The experience of the staff confirms the findings of other research that the key challenges in the care of the beneficiaries were reflected in ensuring compliance with preventive measures to protect against the spread of infection. In addition, the findings of other studies were confirmed that the pandemic significantly affected the increased intensity of neuropsychiatric symptoms such as anxiety and agitation, but also depressive symptoms such as lethargy, reduced activity and occasional problems with sleep and appetite.

The key factor that contributed to the changes in the health status is the social isolation of the beneficiary during the pandemic. The reduction of some negative symptoms after the abolition of certain measures and the re-introduction of regular visits by family and close people is proof of the above.

The experiences of employees at the Institution in providing care beneficiary with a diagnosis of dementia show the importance of regular contact with close people of beneficiary with a diagnosis of dementia. The implications for the care of these persons through the social protection system during the duration of extraordinary circumstances such as those caused by the pandemic, are reflected in the additional need to take into account the specific needs of beneficiary with a diagnosis of dementia during the planning of the organization of the work of institutions and the decision on protection measures in order to reduce negative consequences on the beneficiaries health and functionality.

References

Alonso-Lana S., Marquie, Ruiz A., Boada M. (2020). Cognitive and Neuropsychiatric Manifestations of Covid-19 and Effects on Elderly with Dementia. *Frontiers in Aging Neuroscience*, 12, 588872.

Bianchetti, A., Rozzini, R., Guerini, F., Boffelli, S., Ranieri, P., Minelli, G., ... & Trabucchi, M. (2020). Clinical presentation of COVID19 in dementia patients. *The journal of nutrition, health & aging*, 24(6), 560-562.

Cipriani, G., & Di Fiorino, M. (2020). Access to care for dementia patients suffering from COVID-19. *The American Journal of Geriatric Psychiatry*, 28(7), 796-797.

Cohen, G., Russo, MJ, Campos, JA, & Allegri, RF (2020). Living with dementia: increased level of caregiver stress in times of COVID-19. *International Psychogeriatrics*, 32(11), 1377-1381.

FLEMING, R., ZEISEL, J. & BENNETT, K. 2020. *World Alzheimer Report 2020: Design Dignity Dementia: dementia-related design and the built environment Volume 1*, London, England: Alzheimer's Disease International.

Hariyanto, TI, Putri, C., Arisa, J., Situmeang, RFV, & Kurniawan, A. (2021). Dementia and outcomes from coronavirus disease 2019 (COVID-19) pneumonia: a systematic review and meta-analysis. *Archives of Gerontology and Geriatrics*, 93, 104299.

Korczyn AD. Dementia in the COVID-19 Period. *J Alzheimers Dis*. 2020;75(4):1071-1072. doi: 10.3233/JAD-200609. PMID: 32538858; PMCID: PMC7369036

Liu, N., Sun, J., Wang, X., Zhao, M., Huang, Q., & Li, H. (2020). The impact of dementia on the clinical outcome of COVID-19: a systematic review and meta-analysis. *Journal of Alzheimer's Disease*, 78(4), 1775-1782.

Numbers, K., & Brodaty, H. (2021). The effects of the COVID-19 pandemic on people with dementia. *Nature Reviews Neurology*, 17(2), 69-70.

Pavlović D. (2008) *Dementia: a neurological and psychological guide*. Belgrade: Calligraf.

Rainero, I., Bruni, AC, Marra, C., Cagnin, A., Bonanni, L., Cupidi, C., ... & SINDem COVID-19 Study Group. (2021). The impact of COVID-19 quarantine on patients with dementia and family caregivers: A nation-wide survey. *Frontiers in aging neuroscience*, 12, 625781.

Satarić N., Kvašček Gajić M. (2022) Experiences of piloting a day care service for dementia sufferers in Belgrade, Serbian Association for Alzheimer's Disease

Satarić N., Milićević Kalašić A. (2014) *Life without memories: Research on the needs of the Day Care Center for the Demented in Belgrade*. Belgrade: Amity, Trag Foundation, USAID.

Savla, J., Roberto, KA, Blieszner, R., McCann, BR, Hoyt, E., & Knight, AL (2021). Dementia caregiving during the "stay-at-home" phase of the COVID-19 pandemic. *The Journals of Gerontology: Series B*, 76(4), e241-e245.

Simonetti, A., Pais, C., Jones, M., Cipriani, MC, Janiri, D., Monti, L., ... & Sani, G. (2020). Neuropsychiatric symptoms in the elderly with dementia during the COVID-19 pandemic: definition, treatment, and future directions. *Frontiers in psychiatry*, 11, 579842.

Republic of Serbia, Ministry of Labour, Employment, Veterans and Social Affairs (2020)

Account; Instruction on the way of work of social protection institutions for accommodation of users and social protection organizations for providing home accommodation services for adults and the elderly in the

procedure of reception of users of accommodation services; Website visited: October 8. 2022

<https://www.minrzs.gov.rs/sites/default/files/202005/2020.05.18.%20Instrukcija%20022.PDF>

Republic of Serbia, Ministry of Labour, Employment, Veterans and Social Affairs (2020); Instruction on the procedure for the re-admission of accommodation service users after returning from Covid-19 treatment to a social protection institution for the accommodation of users/social protection organization for the provision of home accommodation services for adults and the elderly; site visited: October 8, 2022<https://www.minrzs.gov.rs/sites/default/files/vanredno-stanje/2020.04.20.%20Instrukcija%20016.pdf>

Republic of Serbia, Ministry of Labour, Employment, Veterans and Social Affairs (2020) Order; website visited: October 8, 2020

<https://www.minrzs.gov.rs/sites/default/files/vanrednostanje/2020.03.28.%20Nalo%20001.pdf>

Suzuki, M., Hotta, M., Nagase, A., Yamamoto, Y., Hirakawa, N., Satake, Y., ... & Ikeda, M. (2020). The behavioral pattern of patients with frontotemporal dementia during the COVID-19 pandemic. *International psychogeriatrics*, 32(10), 1231-1234.

Tahira, AC, Verjovski-Almeida, S., & Ferreira, ST (2021). Dementia is an age-independent risk factor for severity and death in COVID-19 inpatients. *Alzheimer's & Dementia*, 17(11), 1818-1831.

Tousi, B. (2020). Dementia care in the time of the COVID-19 pandemic. *Journal of Alzheimer's Disease*, 76(2), 475-479.

ZBRINJAVANJE LICA SA DIJAGNOZOM DEMENCIJE U USTANOVI SOCIJALNE ZAŠTITE TOKOM I NAKON PANDEMIJE VIRUSA KOVID-19

**Milica Petković, Aleksandra Nikitović, Stefan Topalović,
Zuhra Hodžić, Aleksandra Romić**

Rezime

Život osoba sa dijagnozom demencije tokom pandemije bio je predmet brojnih studija u svetu. Naučna istraživanja su se bavila ovom temom iz različitih uglova. Neke od studija su se fokusirale na uticaj infekcije virusom KOVID-19 na zdravstveno stanje osoba sa dijagnozom demencije istražujući specifičnosti vezane za kliničku sliku, tok bolesti kao i tok oporavka. Sa druge strane studije iz oblasti socijalne zaštite istraživale su psihološke reakcije na vanredne okolnosti izazvane pandemijom i različite mehanizme prevladavanja kod osoba sa dijagnozom demencije, njihovih srodnika i osoblja koje pruža negu u ustanovama socijalne zaštite. Osim toga, studije su istraživale i uticaj na kognitivno funkcionisanje ovih osoba kao i na povećan rizik od pogoršanja kognitivno-mnestičkih funkcija kod osoba kod kojih je ranije dijagnostifikovane blage promene u kognitivnoj sferi. Rezultati studija pokazuju da je pandemija izazvana virusom KOVID-19 imala značajan negativan uticaj na kvalitet života osoba sa dijagnozom demencije.

U Ustanovi Gerontološki centar Beograd u okviru RJ „ Bežanijska Kosa“ postoje odeljenja specijalizovana za pružanje usluga socijalne i zdravstvene zaštite osobama sa dijagnozom demencije. U ovom radu prikazane su reakcije korisnika na vanredne okolnosti izazvane pandemijom, promenama u organizaciji rada ustanove i specifičnostima vezanim za negu i pružanje usluga korisnicima za vreme trajanja pandemije. U radu su prikazani statistički podaci vezani za stopu infekcije, kliničku sliku i zdravstveno stanje korisnika kod kojih je potvrđena infekcija, promene u ponašanju i psihičkom stanju kao i način na koji je ustanova prilagodila negu i pružanje usluga tokom trajanja pandemije.

U radu su korišćene kvalitativne metode koje su podrazumevale intervjuisanje zaposlenih na odeljenju namenjenom osobama sa dijagnozom demencije kao i analiza dokumentacije ustanove.

Dobijeni rezultati potvrđuju nalaze prethodnih istraživanja o negativnom uticaju pandemije na kvalitet života osoba sa dijagnozom demencije. Ključni faktor koji je tome doprineo je socijalna izolacija koja se ogledala u smanjenoj interakciji korisnika sa srodnicima i bliskim osobama koja je bila uslovljena merama prevencije i zaštite od širenja infekcije.

Ključne reči: demencija, KOVID-19, socijalna zaštita, socijalna izolacija

Professional paper UDK: 613-056.24:[616.98:578.828

Handed over: 20.02.2023.

Accepted: 11.03.2023.

CHALLENGES OF AGING OF PERSONS LIVING WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) – PLHIV

Milena Radaković⁴⁹, Aleksandra Božinović-Knežević⁵⁰

Abstract

Persons living with HIV (PLHIV) are one of the most stigmatized and discriminated groups. Philanthropy's 2-decade long experience confirms that PLHIV are still exposed to stigma and discrimination, regardless of the legislation on the prohibition of discrimination.

Philanthropy aims to shed light on aspects of aging with HIV in the context of social welfare and health care. According to the Institute for Public Health of Serbia "Dr Milan Jovanović Batut" data, 4.317 infected persons have been registered in the Republic of Serbia from the beginning of the epidemic in 1985 until November 20, 2021. 2.104 persons fell ill with AIDS (acquired immunodeficiency syndrome). The vast majority of persons who found out about their HIV-positive status in the first two decades of the epidemic are now people in the 65+ age category. Since 1997, ARV (antiretroviral therapy) has been available and free of charge. The therapy extends PLHIV life span and significantly reduces the rate of contracting illness and dying from AIDS.

⁴⁹ **Milena Radaković**, licensed professional in Social Care and Project Coordinator, Philanthropy, The Charitable Foundation of the Serbian Orthodox Church

⁵⁰ **Aleksandra Božinović-Knežević**, Project Coordinator, Philanthropy, The Charitable Foundation of the Serbian Orthodox Church

However, aging with HIV brings certain challenges when it comes to overall health status, access to health care, and access to social welfare services.

Reducing stigma and discrimination in practice would lead to better quality services for PLHIV. Greater awareness of health care and social welfare personnel would contribute to PLHIV' improved quality of life and equal exercise of rights.

Exposure to stigma and discrimination, along with inability to exercise human rights lead to impairment of mental health. In this context, PLHIV are further weakened in representing and practicing their rights, which prevents them from utilizing existing protection mechanisms in case of violation of their rights.

COVID-19 pandemic has highlighted the challenges persons living with infectious diseases face. Additional information and education of PLHIV is needed, as well as continuous systemic action in order to reduce stigma and discrimination.

Keywords: *HIV, aging, social welfare and health care, access to services, human rights, stigma and discrimination*

Introduction

HIV is an abbreviation for the Human Immunodeficiency Virus, which is the causative agent of HIV infection. AIDS, or Acquired Immunodeficiency Syndrome, represents the final and most severe stage of HIV infection, characterized by various clinical manifestations. The virus attacks the human immune system by directly and indirectly leading to a decrease in the production of CD4+ T cells, which are the primary drivers of the human defense system. (1) What is characteristic of this virus is that it is exclusively transmitted among humans.

According to the World Health Organization, there are 38.4 million people living with HIV worldwide, of whom 4.2 million are aged 50 or older. In America, 50% of those infected with the virus are older than 50 years. According to data from the Institute of Public Health of Serbia “Dr. Milan Jovanović Batut”, from the appearance of the first infection case in 1985 to November 20, 2021, there have been 4,317 people registered with HIV in the Republic of Serbia, of whom 2,104 have developed AIDS. From infection to the onset of the first symptoms, an average of 7 years can pass, but this period can be longer, up to 15 years, and is referred to as the latent period.

Antiretroviral Therapy (ART)

In the treatment of HIV infection, antiretroviral therapy (ART) is widely applied today, leading to stable suppression of viral replication. Regular use of this therapy improves the quality of life for people living with HIV and reduces the risk of transmission of the infection. Additionally, the lifespan of those affected is extended, and the success of the therapy depends on the consistent intake of medications and adherence to recommendations by infectious disease specialist.

According to the World Health Organization, 28.7 million people living with HIV received antiretroviral therapy, resulting in a global therapy coverage rate of 75% in 2021.

Since 1997, highly active antiretroviral therapy has been available and provided free of charge in the Republic of Serbia, with all treatment costs covered by the Republic Health Insurance Fund. Since 2008, the treatment of HIV infection has been decentralized and is carried out at the Clinic for Infectious and Tropical Diseases at the Clinical Center of Serbia in Belgrade, the Clinical Center of Vojvodina in Novi Sad, the Clinical Center in Niš, and since 2009, also at the Clinical Center in Kragujevac.

Challenges of Living with HIV

Family, as the basic unit of human society, can be a source of social support for individuals living with HIV, but it can also be a source of stress when it comes to disclosing and safeguarding information about one's HIV-positive status. It is common for close family members to struggle with accepting this information and sometimes even reject their affected family member. In intimate relationships, difficult life situations that come with chronic illness can also be a source of problems and ongoing stress, especially for older individuals.

In later life, new life roles such as becoming grandparents, psychological changes, fears, anxiety, depression, consequences of poor and unhealthy nutrition, unhealthy habits like smoking and alcohol or drug use, chronic illnesses, disability, insufficient physical activity, or changes in sexual life can all impact the quality of life.

Carrie Maxwell (2018) categorizes the problems that can affect the quality of life of people living with HIV into four groups: depression, isolation, stigma, and aging-related issues. Under depression, there is a mention of reduced HIV advocacy and general health-related concerns. The com-

bination of depression and HIV-related conditions can affect adherence, which is the patient's ability to follow the treatment regimen agreed upon between the patient and the doctor, particularly in terms of taking medications. Diseases and conditions related to aging can occur much earlier in people living with HIV compared to the general population, including cardiovascular diseases, renal insufficiency, and memory-related issues.

Stigmatization and Discrimination of People Living with HIV

Stigmatization is the labeling or discrediting of a person in society based on some personal characteristic. Stigmatization often leads to discrimination.

Discrimination involves treating equals unequally and unequals equally. To constitute discrimination, there must be some personal characteristic of the victim (real or perceived). In the case of discrimination against people living with HIV, it relates to their health status. Individuals with HIV are frequently denied access to healthcare services, medical interventions, admission to healthcare facilities, rehabilitation, spa accommodation, and may experience insults and belittlement. Discrimination can also occur outside the healthcare sector, such as the inability to access senior care facilities, exclusion from public events, cultural or sports activities, or even being denied service at a store. Older individuals living with HIV can face discrimination based on their health status, age (ageism), and possibly other attributes, such as disability, sexual orientation (older gay men), nationality, mental health issues. When individuals are discriminated against based on multiple personal characteristics, it's referred to as intersectional discrimination.

Stigmatization and discrimination of HIV-positive individuals have existed since the 1980s, when HIV first appeared. In the early days, HIV was referred to as the "plague of the 20th century," and individuals living with

HIV were often labeled as deviant, immoral, and sinful. Little was known about the virus and its modes of transmission, and it was associated with death and certain societal groups: the gay population, drug users, and sex workers. Even today, after so many years of understanding how the virus is transmitted and the associated risk behaviors, people living with HIV are still sometimes spoken about with disdain and a desire for punishment.

Exposure to stigmatization and discrimination has significant consequences, particularly on the mental health of individuals living with HIV. Many of them fear encountering prejudices when trying to access care and support. Therefore, it's crucial to educate all personnel in care institutions on how to treat these individuals confidentially and with respect.

From 2014 to 2016, Philanthropy conducted a project monitoring the human rights of people living with HIV, supported by the European Union delegation. The project used a methodology of participatory holistic human rights monitoring, which consisted of three elements: monitoring of individual experiences of people living with HIV/AIDS, systemic monitoring, and analysis of relevant laws, public policies, and programs, as well as monitoring of societal attitudes through media reporting on this population. This methodology takes into account the analysis of key human rights principles contained in the Universal Declaration of Human Rights and other international legal documents in the field of human rights. During the monitoring of individual experiences, 100 in-depth interviews were conducted to gain insight into the life experiences of people living with HIV/AIDS and the types of human rights violations they face. As part of the project, a systemic monitoring of discrimination was also conducted in 2015 in collaboration with the Commissioner for the Protection of Equality in the Republic of Serbia, which showed that the healthcare system continues to be the area where people living with HIV are most discriminated against. Additionally, there is reluctance to report cases of discrimination, with civil society organizations often reporting cases on behalf of individuals.

Furthermore, in various social interactions with family, friends, and in partner and neighbor relationships, various forms of discrimination can often occur. Strong social relations have a positive impact on the quality of life. Therefore, it is essential to have a supportive environment that can provide social support and practical assistance if needed for older individuals living with HIV.

Aging and HIV

In some countries, individuals over the age of 50 are excluded from routine data collection on HIV/AIDS prevalence. Many doctors do not test older individuals for HIV, which can lead to some cases being missed because the symptoms of HIV/AIDS can be interpreted as symptoms associated with normal aging. However, it is noticeable that the number of documented HIV/AIDS cases among the older population is increasing. Here, the importance of raising awareness among older individuals about HIV should be emphasized because many of them may be caregivers for an infected family member. From our experience, family members often do not initially know how the infection is transmitted, so additional education is needed for all those who care for the affected individual, especially when the symptoms of the disease are further complicated or due to comorbidities with other associated illnesses.

Challenges of Aging with HIV in Serbia

According to data from the Institute of Public Health “Dr. Milan Jovanović Batut” from 2022, out of the total number of people diagnosed with HIV infection between 2002 and 2021, there are currently 157 individuals in Serbia aged 65 and above, born between 1927 and 1956, including 130 men and 27 women.

The challenges of aging for HIV-positive individuals in Serbia are not different significantly from the challenges faced by their peers. Some of their concerns are similar: low pensions, financial insecurity, chronic illnesses, loss of loved ones, and loneliness. However, there is one significant difference in the lives of older HIV-positive individuals. The vast majority of them live in fear of who will find out about their HIV-positive status, whether this information will spread further, and how the person living with HIV will cope with it. From our experience, we know that about 80% of individuals have not disclosed their HIV-positive status. They are primarily afraid of rejection by family and friends and other unpleasant consequences. Only those who must know are aware of their status: infectious disease specialists and general practitioners. In practice, infectious disease specialists prescribe antiretroviral therapy (ARV) and refer patients for further specialist examinations and diagnostic procedures. Potential problems arise when hospitalization and fatal outcomes occur. In such cases, most people with HIV turn to their designated infectious disease specialist. They then assess the person's health condition and its potential connection to HIV infection and, based on the assessment, either refer the patient for further treatment or treat them within the HIV department of the Clinic for Infectious and Tropical Diseases. During further referrals, it is sometimes indicated in the referrals that the person is HIV+. Sometimes, reactions to receiving HIV+ patients are inappropriate and completely contrary to professional ethics and norms of behavior. There are still instances of written labeling of medical documentation for HIV+ patients, despite the decision of the Commissioner for the Protection of Equality in 2015 that only disease codes or refusals of medical interventions can be recorded. Likewise, there are shining examples of dedicated and educated doctors who treat HIV-positive patients without any issues. The importance of education and the application of ethical norms of the Medical Chamber of Serbia should be emphasized here.

In case of a fatal outcome, the deceased person is buried in a hermetically sealed metal coffin, which is then placed in a wooden coffin. If the family did not know the cause of death of the deceased, this additional procedure causes stress and discrimination. The change in the Regulations on the Burial of Deceased Persons who died from infectious diseases occurred in 2020. Prior to that, the body of the deceased was placed in a black bag, so the family could not provide clothing for the deceased. Such a situation, especially in small communities, leads to post-discrimination of the deceased person's family.

HIV and Other Diseases and Conditions

HIV is often associated with other diseases, and in such cases, we refer to comorbidity. The most common associated diseases include specific types of tumors, such as Kaposi's sarcoma. In addition, other diseases, especially cardiovascular diseases and liver diseases, can occur. Due to a weakened immune system, people living with HIV are susceptible to various viral infections. The risk of bone fractures and decreased bone mass is also higher. For example, diabetes is 4 times more common in this population. Because of all these factors, care should focus on preventing disease complications.

What is characteristic of the older population is that there is better adherence among older people living with HIV - the patient's ability to adhere to the therapeutic regimen agreed upon between the patient and the doctor, including taking medication regularly.

Pension System

Until the early 2000s, individuals diagnosed with HIV/AIDS could apply for disability pensions. An additional requirement was having 5 years of work experience. After that, HIV infection was declared a chronic disease, and it was no longer a condition for early retirement. Today, individuals

living with HIV/AIDS can only qualify for a disability pension if their condition progresses to the point of causing permanent disability (opportunistic infections and other illnesses). Depending on their level of work ability, a person may be entitled to a disability pension or reassignment to a less demanding job.

As for those who retired when HIV infection was a requirement for a pension, some were pressured by employers, while others did it to prevent the spread of information about their HIV-positive status. Consequently, most of these pensioners receive low pensions and engage in additional work, often in the informal or “black” market, without reporting it for mandatory social insurance. Some are financially supported by their children and families.

Out of the total number of beneficiaries in Philanthropy’s support program, 81 are pensioners. Among them, 51 individuals took early retirement, 15 received old-age pensions, and the remaining 15 inherited pensions (family’s pensions). Regarding older beneficiaries, 6 are elderly individuals who have not yet qualified for a pension.

Social and Healthcare System

Social protection for individuals with HIV/AIDS in Serbia is guaranteed, as for the other citizens, in accordance with the Law on Social Protection. Problems in accessing social protection rights for people living with HIV/AIDS often arise due to the jurisdiction of the Center for Social Work based on place of residence. In many cases, the place of residence and the place of actual residence differ. The fear of disclosing their HIV+ status in smaller communities and the availability of better healthcare in larger cities are the main reasons why some individuals change their registered address to one where they do not actually reside. This results in them not accessing the rights they are entitled to by law.

In the past, individuals living with HIV/AIDS have faced issues such as denial of certain social protection rights, including home care, refusal of admittance to care facilities, direct work with beneficiaries, counseling, denial of pension rights, child allowances, health insurance rights, unemployment benefits, and exclusion from active employment measures.

The Law on Health Insurance, in Article 22, stipulates that insured persons include those who belong to population groups at increased risk of disease, among whom are individuals in connection with the treatment of HIV infection or other infectious diseases. Interviews conducted during systematic monitoring reveal that many people living with HIV/AIDS in Serbia, despite legal provisions, cannot access healthcare services beyond the services provided by Infectious Disease Clinics.

Within the healthcare system, there are frequent cases of denial of the right to see specialist doctors, dentists, refusal to provide emergency medical assistance, refusal to perform surgical procedures, and other services. During interviews within the Human Rights Monitoring conducted by Philanthropy, users most often reported visible notation of their HIV positive status on their medical files (often with a red marker) instead of using the disease code B20-B24. This was particularly problematic in small towns and cities where news of an HIV positive status spread quickly among the residents, leading to further discrimination against the person. However, with the new regulations that began to apply in April 2021, aligned with the Law on Patients' Rights, the disease code is no longer entered on sick leave certificates, so employers no longer have information about the employee's illness during sick leave.

It's essential to emphasize that the risk of HIV transmission in everyday activities within a person's home or a care facility for the elderly is almost non-existent. Moving a person, bathing, changing bed linens, taking temperature and blood pressure readings, cleaning a room or toilet do not

pose a risk of HIV transmission. Caregivers sometimes give the last bath to a person with HIV due to the possibility of infection, but there's no need for this precaution. When a user with HIV leaves the facility or passes away, there is no need for additional disinfection measures.

Voluntary Confidential Counseling and Testing (VCCT)

Voluntary Confidential Counseling and Testing (VCCT) refers to confidential discussions between a client and a trained counselor aimed at helping the client cope with their concerns, stress, or fears related to HIV infection. Serbia is a country with a low rate of testing, which is available to everyone, and it's the only way to find out one's HIV positive status. VCCT can be conducted in civil society organizations specializing in this field, as well as at the Institute for Public Health. In practice, it's not uncommon for doctors not to immediately suspect HIV in older patients, and some time may pass before a patient undergoes testing for sexually transmitted diseases and HIV.

According to data from the United States, in 2019, 10% of individuals who tested HIV-positive were aged 55 and older. Furthermore, older individuals diagnosed with HIV are more likely to have late-stage disease, indicating that they have been living with the virus for several years. In 2019, there were 388,322 people aged 55 and older living with HIV, constituting 37% of the U.S. population living with HIV.

Respondents, who discovered their HIV+ status within the last 5 years generally did not have unpleasant experiences related to receiving their test results. However, participants who found out about their status earlier had numerous negative experiences, including disclosing their results to family members, results being sent directly to the Infectious Diseases Clinic without direct communication, insufficient information about HIV, testing

without the patient's knowledge, results given in an envelope or via email, and even receiving someone else's results.

Modern studies highlight that pre- and post-HIV testing counseling is the most effective and cost-efficient intervention compared to other methods. It plays a role in prevention but also allows for early access to treatment and serves as a gateway for emotional and social support, as well as medical care. A significant advancement has been made in organizing counseling and testing outside of healthcare institutions, in the field, to reach a broader population.

Support Program for People Living with HIV

Philanthropy, The Charitable Foundation of the Serbian Orthodox Church, has been continuously implementing a Support Program for people living with HIV since 2003. The primary activities of the project include volunteer team visits to hospitalized patients at the Clinic for Infectious and Tropical Diseases at the Clinical Center in Belgrade, home visits to the most vulnerable health users, organized social gatherings for beneficiaries, assistance with packages of basic groceries and hygiene products, support in accessing guaranteed rights, application of anti-discrimination mechanisms, psychological support (individual and group) provided by psychotherapists, education, training of professionals in the social welfare system (accredited training program by the Chamber of Social Welfare), training of teachers and school staff (accredited program by the Institute for the Improvement of Education), and collaboration with government and non-government sectors on numerous projects and activities aimed at preventing sexually transmitted diseases and supporting people living with HIV.

Of the total number of our users, 87 users are over 65 years old, and 82 users are over 55 years old, so we will have a significantly larger number of users over 65 in the coming years. The oldest beneficiaries in Philanthropy's

support program was born in 1926. Regarding HIV status, 56 users have been living with HIV for more than 20 years, and the remaining 31 users for more than 10 years.

The importance of support

The majority of our older beneficiaries (80%) lived alone even before learning about their HIV-positive status, while the remaining individuals lost their partners or family support. Because of the possibility of rejection by their closest family and loved ones, individuals rarely disclose their status or do so only to a very small circle of trusted people. The general recommendation of psychotherapists is for people living with HIV to consult with professionals before deciding to disclose their status to prepare for different scenarios in case of rejection.

Among older beneficiaries, it's noticeable that they have been forming small groups of people living with HIV for many years. These groups are of utmost importance to them as they feel safe and protected within them, all connected by one common factor - their chronic illness. Unfortunately, as members pass away, these groups become smaller and finding new empathetic members who share the same values becomes difficult. If they have a trusted person who has been with them since the moment they learned of their positive status, it's usually a close family member: children, siblings, or a long-time friend. Individuals who discover their status in later years very rarely confide in their parents or minor children. According to them, they do this to protect their loved ones from problems and discrimination. Losing a reliable life partner is extremely difficult for people living with HIV, not only because someone with whom they shared their life is gone, but also because they have no one with whom to share their secret. Often, individuals from civil society organizations providing support to people living with HIV are the only ones who know the beneficiaries' status, and they play a crucial role in their lives.

Individuals who decide not to share their status with anyone continue to socialize with old friends. However, according to their admissions, living life with such a secret is challenging, especially as they grow older. What also weighs heavily on them is the regular, secretive taking of medication, hospitalizations, and disability. There's always a lingering suspicion that some people know about their status but respect their decision not to talk about it. A particular concern is how their children will treat them in their old age. In this field, there are very different examples: children who fully accept their HIV-positive parents (especially mothers), children who completely reject their parents (especially fathers when they learn about their homosexual orientation), and children who emotionally or economically blackmail their parents to see them or their grandchildren. If these experiences are negative, they leave emotional and psychological consequences on people living with HIV.

In all the examples and processes mentioned above, continuous psychotherapeutic support is of the most importance. Older beneficiaries are less likely for individual sessions but have highly successful self-help groups where they mainly focus on overcoming negative family experiences. For our beneficiaries, it's essential to have access to free and continuous psychotherapeutic support.

Intergenerational Collaboration

Guided by the Sustainable Development Goals, particularly Goal 3, which aims to ensure healthy lives and promote well-being for all at all ages, we have developed specific activities related to intergenerational solidarity.

Considering that older beneficiaries are just one part of the group of HIV-positive beneficiaries we support, it's essential for us to connect them with younger ones. These two seemingly very different groups complement each other since they are all linked by the same chronic illness. The times when older beneficiaries became infected with the HIV virus are entirely different; decades separate them, and they deal with different issues. During

the gatherings we organize, older beneficiaries share their experiences of living with HIV with younger ones. It serves as a demonstration that it's possible to live with this chronic disease, but more importantly, to age with quality. The motto used to be "You can live with HIV," but today it's "You can age with HIV." Younger beneficiaries, especially those with more knowledge in information technology and modern technology, conduct workshops on computer usage and web applications for older users.

Residential Care Facilities for the Older persons

Placement in residential care facilities for the older persons can be a significant source of stress for individuals living with HIV. While there are no legal barriers to placing HIV-positive individuals in such facilities, the practical reality can be quite different. There is often some reason given for refusing admission, but it is never explicitly stated, and it is never directly mentioned that the person is being denied due to their HIV-positive status. Our past experience shows that when placing individuals with HIV-positive status in social welfare institutions, such as Residential Care Facilities for older persons, it takes effort to secure permanent or temporary accommodation.

Specifically, a positive result in laboratory tests as part of mandatory and recommended health examinations of biological material for the presence of anti-HIV antibodies, anti-HCV antibodies, antitreponemal antibodies, and HBsAg should not be a limitation for receiving medical or other services, including accommodation in social welfare institutions (Residential Care Homes for older persons, Institutions for children without parental care, shelters for victims of violence, student dormitories, and other facilities) (Article 36 of the Regulation on Mandatory Health Examinations of Certain Categories of Employees in Sanitary Supervision Facilities, Mandatory and Recommended Health Examinations for Certain Population Categories, Official Gazette of the Republic of Serbia, No. 3/2017.)

Palliative Care

Although the Republic of Serbia has a Palliative Care Strategy, this type of service is not organized adequately. According to the Regulation on the Content and Scope of Rights to Health Care from Mandatory Health Insurance and Participation for the year 2019, diseases such as HIV/AIDS in the terminal phase require comprehensive and continuous care (Article 11, paragraph 7, Regulation on the Content and Scope of Rights to Health Care from Mandatory Health Insurance and Participation for 2019). In practice, individuals with HIV/AIDS in the terminal phase of the disease are often placed in the HIV/AIDS department of the Clinic for Infectious Diseases, where unfortunately, many of them pass away.

Protection of Personal Data and Privacy

The Constitution of the Republic of Serbia, in Article 2, guarantees the protection of personal data. In the Law on Personal Data Protection (Official Gazette of RS, No. 87/2018), Article 4, paragraph 1, point 16, specifies that data on health is a special category of personal data, i.e., data related to an individual's physical or mental health, including data on the provision of healthcare services, which reveal information about their health status. The processing of health data is not possible without the explicit consent of the individuals whose data is being processed.

The Law on Patients' Rights regulates the right to privacy and the confidentiality of information, as well as the right to the confidentiality of patients' health data.

The Code of Medical Ethics of the Medical Chamber of Serbia (Official Gazette of RS, No. 104/2016) establishes an obligation to protect patients' privacy and maintain professional confidentiality.

In practice, in various sectors, at different locations and levels, information about a person's HIV-positive status is often disclosed, which can lead to unforeseeable consequences. In such cases, the affected person can initiate proceedings to protect their rights before various independent government bodies (Patient Rights Protector, Commissioner for the Protection of Equality, Commissioner for Information of Public Importance and Personal Data Protection, Ombudsman). However, this happens very rarely in practice. When it does occur, it is more common for affected individuals to reach out to a civil society organization, which can initiate proceedings on their behalf. Older individuals very rarely report such incidents, and when they do, it is often because their status was disclosed to their children or close relatives by healthcare professionals.

Mental Health

Numerous studies show that individuals with chronic illnesses tend to have limited social networks. Illnesses that cause less visible physical impairments tend to elicit less empathy and social support, which can exacerbate feelings of loneliness. This includes many autoimmune diseases, including HIV/AIDS. Mental health is an extremely important topic as it directly affects adherence in HIV-positive individuals.

The most common mental health issues that can arise after learning about an HIV-positive status are depression and anxiety. Cases of suicide, directly or indirectly related to an HIV diagnosis, are also possible. Psychosis is not uncommon among people living with HIV, either as a primary or secondary diagnosis. In a large-scale study conducted in 2014, which involved 832 women living with HIV from 94 countries, the extent and impact of mental health on their sexual and reproductive health, as well as human rights, were examined. The diagnosis of HIV was identified as a critical point for mental health problems, with about 70% of respondents reporting experiences of depression (74.0%), shame (70.8%), self-blame (70.0%),

feelings of rejection (69.9%), and insomnia (68.4%), among others. Compared to rates before an HIV diagnosis, problems that occurred “due to” or “because of” an HIV diagnosis showed a significant increase in all mental health issues, ranging from 1.2 times (substance use) to 6.7 times (paranoia). Analyses showed that the average number of mental health problems occurring after an HIV diagnosis is significantly higher than before the diagnosis.

Dementia is also a common diagnosis that occurs in later stages of the disease and includes severe attention deficit, memory loss, and character changes. One of the positive effects of antiretroviral therapy (ART) is that it improves existing deficits and slows the progression of dementia. Since ART has extended the lives of people living with HIV, they are more susceptible to psychological problems related to living with a chronic illness, making continuous psychosocial support of paramount importance.

Various negative aspects of aging with HIV can be overcome through health promotion, mental health care, support groups, and various activities aimed at active aging.

COVID-19 and HIV

The COVID-19 pandemic has somewhat overshadowed the ongoing HIV/AIDS pandemic, especially in African countries. Initially, both pandemics were somewhat similar and often compared, but a vaccine for COVID-19 was quickly developed, in large part due to research related to HIV vaccine development. This has partially brought the COVID-19 pandemic under control. Unfortunately, HIV/AIDS medications are not accessible to everyone, and prevention measures are very limited. Both pandemics have been accompanied by various conspiracy theories and discrimination against those affected.

Regarding people living with HIV who are on antiretroviral therapy (ART) and have controlled HIV (meaning they don't have detectable vi-

rus levels), they are, if vaccinated against COVID-19, protected from severe forms of COVID-19 to a similar extent as the general population, although other underlying chronic conditions should be considered.

One of the main consequences during the COVID-19 pandemic that negatively impacted people living with HIV/AIDS was the fact that doctors, infectious disease specialists, and epidemiologists were engaged in COVID-19 “red zones.” HIV/AIDS centers in all four Infectious Disease Clinics (Belgrade, Novi Sad, Niš, and Kragujevac) operated at reduced capacity due to the new situation. This led to disruptions in disease monitoring, with patients regularly receiving therapy but experiencing delays in follow-up blood tests.

Regarding COVID-19 vaccination, the medical recommendation was for HIV-positive individuals to get vaccinated. Precise data on the number of vaccinated HIV-positive individuals are still lacking, but our experience indicates that the majority of them have been vaccinated, especially those aged 65 and older.

Recommendations for Improving the Position of People Living with HIV in the Republic of Serbia

At the first place, we need to work on implementing the measures outlined in the Strategy for the Prevention and Control of HIV Infection and AIDS in the Republic of Serbia 2018-2025 (Official Gazette RS, No. 6/2018). These measures include increasing the availability of social welfare services and care for people living with HIV (accommodation in residential facilities, palliative care). To achieve this, we must ensure adequate social protection for people living with HIV, build capacities, and provide care in line with their needs. Continuous education of healthcare and social workers and other service providers on caring for these individuals is essential.

Furthermore, efforts should be directed towards protecting human rights, reducing and eliminating stigma and discrimination in the environment towards people living with HIV and key populations at risk, all while fully respecting their human rights.

Instead of a conclusion

“Before you judge me and my life, put on my shoes and walk my path! Traverse the streets, hills, and valleys! Feel the pains and the joys! Go through the years that I’m going through, stumble over every stone that comes my way, rise again and follow the same path, just as I do! Only then can you judge me!” Patriarch Pavle

References

Alajbeg, I., et al. (2018). Aging with HIV - A comprehensive care approach. Zagreb: Croatian Association for Combating HIV and Viral Hepatitis.

Božinović-Knežević, A., et al. (2016). Monitoring the Human Rights of People Living with HIV/AIDS in the Republic of Serbia - Holistic Report. Belgrade: Charity Foundation of the Serbian Orthodox Church, Philanthropy.

Code of Medical Ethics of the Medical Chamber of Serbia, Official Gazette of RS, No. 104/2016

Institute of Public Health of Serbia "Dr. Milan Jovanović Batut". (2022). World AIDS Day, December 1st: Let's Equalize. Accessed on December 19, 2023, at www.batut.org.rs.

Law on Personal Data Protection, Official Gazette of RS, No. 87/2018), Article 4, paragraph 1, point 16

Law on Social Protection, Official Gazette of RS, No. 24/2011 i 117/2022

Orza, L., et al. (2015). How does living with HIV impact on women's mental health? Voices from a global survey. Journal of the International AIDS Society. Accessed on January 9, 2023, at <https://onlinelibrary.wiley.com/doi/abs/10.7448/IAS.18.6.20289>.

Regulation on Mandatory Health Examinations of Certain Categories of Employees in Sanitary Supervision Facilities, Mandatory and Recommended Health Examinations for Certain Population Categories, Official Gazette of the Republic of Serbia, No. 3/2017, Article 36

Regulation on the Content and Scope of Rights to Health Care from Mandatory Health Insurance and Participation for 2019, Article 11, paragraph 7

Simić, D., et al. (2019). *Positive Life*. Belgrade: Charity Foundation of the Serbian Orthodox Church, Philanthropy.

Simić, D., et al. (2020). Epidemiological Determinants of HIV Infection and AIDS in the Republic of Serbia at the End of November 2020. Accessed on January 9, 2023, at www.pozitivanzivot.rs.

World Health Organization. (2022). HIV. Accessed on January 19, 2023, at www.who.int.

IZAZOVI STARENJA OSOBA KOJE ŽIVE SA VIRUSOM HUMANE IMUNODEFICIJENCIJE (HIV)

Milena Radaković, Aleksandra Božinović-Knežević

Rezime

Osobe koje žive sa HIV-om su jedna od grupacija koje su najizloženije stigmati i diskriminaciji. Naše dvodecenijsko iskustvo u radu potvrđuje da su osobe koje žive sa HIV-om i dalje, bez obzira na zakonsku regulativu o zabrani diskriminacije, izložena stigmati i diskriminaciji. Naš rad ima za cilj da rasvetli aspekte starenja sa HIV-om u kontekstu socijalne i zdravstvene zaštite. Prema podacima Instituta za javno zdravlje Srbije "Dr Milan Jovanović Batut" od početka epidemije 1985.godine do 20. novembra 2021. u Republici Srbiji je registrovano 4.317 inficiranih od kojih su 2.104 osobe obbolele od AIDS-a (sindroma stečenog gubitka imuniteta). Velika većina korisnika koji su za svoj HIV pozitivan status saznali u prve dve decenije epidemije, sada su osobe u starosnoj kategoriji 65+. Od 1997. godine ARV (antiretroviralna terapija) je dostupna i besplatna. Terapija produžava životni vek osoba koje žive sa HIV-om i značajno smanjuje stopu oboljevanja i umiranja od AIDS-a (sindroma stečenog gubitka imuniteta). Međutim, starenje sa HIV-om nosi određene izazove kada je u pitanju zdravstveno stanje, pristup zdravstvenoj zaštiti kao i pristup uslugama socijalne zaštite.

Smanjenje stigme i diskriminacije u praksi dovelo bi do kvalitetnijih usluga za osobe koje žive sa HIV-om, a veća informisanost osoblja u zdravstvenom i socijalnom sistemu doprinela bi unapređenju kvaliteta života i jednakom ostvarivanju prava. Svest o izloženosti stigmi i diskriminaciji i nemogućnost ostvarivanja ljudskih prava, dovode do narušavanja mentalnog zdravlja. U tom kontekstu, osobe koje žive sa HIV-om su dodatno oslabljene za zastupanje i ostvarivanje svojih prava, što ih sprečava da koriste postojeće mehanizme zaštite u slučaju kršenja njihovih prava.

Pandemija COVID-19 virusa istakla je u prvi plan probleme i poteškoće osoba obolelih od zaraznih bolesti. Potrebno je dodatno informisanje i edukacija osoba koje žive sa HIV-om, ali i kontinuirano delovanje na strukturnom nivou u cilju smanjenja stigme i diskriminacije.

Ključne reči: HIV, starenje, socijalna i zdravstvena zaštita, pristup uslugama, ljudska prava, stigma i diskriminacija

Review paper UDK: 364-783.2:005.8

Handed over: 20.03.2023.

Accepted: 28.08.2023.

MONITORING IN INSTITUTIONS FOR THE ACCOMMODATION OF ADULTS AND OLDER PERSONS USING IoT (INTERNET OF INTELLIGENT DEVICES)

**Danijela Vasic Djukanovic⁵¹, Dragica Novicic⁵²,
Biljana Vujic⁵³, Ivana Lukic⁵⁴**

Abstract

The recent pandemic that swept the world clearly shows that the readiness (functionality) of nursing homes for accommodation of older persons (especially the inpatient type, dementia wards) is reflected in their flexibility and adaptability in difficult (unpredictable) circumstances. Potentially unwanted events that can affect the work of these institutions can be prevented in real time by automating the infrastructure for monitoring, absorption and quick recovery from a crisis, using IoT (Internet of Things - Intelligent Devices). The systems best positioned for future extreme demands will be those whose operational specifications are adapted to respond quickly and efficiently to any natural or man-made threats. This means planning and working to optimize the information management environment and infrastructure for timely response.

⁵¹ **Danijela Vasić Đukanović**, Occupational therapist at the Gerontology Center Belgrade, WU Dom "Stacionar", e-mail: radterapija04@ugcb.rs,

⁵² **Dragica Novičić**, Social worker at the Gerontology Center Belgrade, WU Dom "Stacionar", e-mail: novicicd@ugcb.rs

⁵³ **Biljana Vujić**, Social worker, manager of a separate facility at the Gerontology Center Belgrade, WU Dom "Stacionar", e-mail: vujicb@ugcb.rs

⁵⁴ **Ivana Ilić**, Trainee social worker at the Gerontology Center Belgrade, RJ Dom "Stacionar", e-mail: Ilicivana258@gmail.com

Automation gains importance when it is known that in the conditions of the recent pandemic, a fair number of employees were unable to work, which led to problems in the implementation of all services. In various scientific papers and discussions on the topic of optimizing the work of institutions, it is emphasized that readiness means the ability to predict and study the full scope of potential unwanted events that may affect the state of the institution's system. With today's ever smarter facilities (information) management systems, it is possible to achieve a high level of facility optimization.

Internet of Things (IoT) - Internet of things or Internet of intelligent devices, is a term that refers to physical devices equipped with sensors and software, which are currently connected to the Internet (or a local computer network) to collect and share data. The Internet of intelligent devices is a technology that ensures the efficient connection of the digital and physical worlds, i.e. connecting real-world sensors to the Internet. In other words, it is a set of interconnected devices, that is, a system of mechanical and digital devices and objects, which allows data to be transmitted over the Internet, processed, and customized information becomes available to the target group (employees, professionals).

Keywords:*inpatient facility organization, social work, employee education, internet, intelligent devices, internet of things*

Introduction

During the COVID-19 pandemic, primary health care (PHC) systems in the WHO European Region faced an unprecedented increase in the needs, procedures and methods of patient care in relatively unknown (unexplored) circumstances. Member countries responded by accelerating the development of procedures, methods and tools whose research was ongoing, showing different degrees of adaptation and transformation. The WHO European Center for Primary Health Care has launched a new series of information guides to meet health expectations(WHO/europe | NEW WHO/europe information series highlights the transformation of primary health care during COVID-19).

Recognizing the situation related to the epidemic of the disease COVID-19 and the need for special care of the sensitive population, the Ministry of Labour, Employment, Veteran and Social Affairs(Regulations Related to Preventing the Spread of the Corona Virus) from the very beginning of the onset of the disease was in constant cooperation with service providers within the framework of social protection to whom it delivered instructions, regulations and recommendations.

Bearing in mind the fact that older persons are at a higher risk of developing a more severe form of the disease COVID-19 and possible complications than the general population, as well as the fact that the risk of infection in any form of organized accommodation and residence is extremely high, the Ministry has undertaken a series of information and guidance activities for employees in the primary care sector, on how to act in the current conditions of the epidemiological situation.

Nursing homes are organizations with complex activities that include different profiles of employees from different professions, who cooperate with each other in order to provide care, prevention and treatment services. The very nature of the inpatient care home creates an environment where the possibility of infection is extremely high.

On the basis of various researches, it is necessary to undertake measures that will contribute to the understanding of the importance of rapid response of institutions in unknown situations and their analysis, in order to predict the occurrence of similar pandemics in the near or distant future in a timely manner, in order to undertake measures of prevention, care and treatment in the conditions of institutions that accept high-risk users.

The paper provides an overview of possible innovations, which have already taken root in the developed world and which are increasingly available both to providers of health care and care and to users. Examples of application in health institutions in the conditions of unforeseen situations are given: illness of service provider workers, their absence (lack of workers)... as well as methods and processes that will become common in such institutions in the future.

Given the diverse composition of professional teams (medical workers, caregivers, social workers, legal service, support service...) in such a complex organization, we use the name medical or health workers for all of them.

1. Examples of the application of the Internet of things (IOT) in Healthcare system

Healthcare devices represent one of the fastest growing sectors in the IoT market. In fact, the value of this sector - sometimes called the Internet of Medical Things (IoMT) - is predicted to reach \$176 billion by 2026.

In order to understand what IoT means for IoT as a whole and how healthcare IoT devices should be monitored and managed, one must understand the multiple ways in which IoT devices can be used for healthcare. While the most popular example of IoT in healthcare is remote patient monitoring - meaning IoT devices that collect patient data such as heart rate and body temperature - there are many other examples of IoT in the healthcare industry. Statistics show that over 20,000 of these devices are currently in use globally.

Below are some of the ways IoT is changing healthcare, as well as how the use of IoT devices for medical purposes impacts IoT security(10 internet of things (IOT) healthcare examples 2024).

1.1 Healthcare monitoring devices

IoT devices offer numerous new opportunities for healthcare professionals to monitor patients, as well as for patients to monitor themselves. In addition, the diversity of wearable IoT devices presents a number of benefits and challenges, both for healthcare providers and their patients.

1.1.1. Remote monitoring of patients

Remote patient monitoring is the most common application of IoT devices for healthcare. IoT devices can automatically collect health parameters such as heart rate, blood pressure, temperature and more from patients who are not physically present in a healthcare facility, eliminating the need for patients to travel to a provider or for patients to collect data themselves.

When an IoT device collects patient data, it forwards it to a software application where healthcare professionals and/or patients can view it. Algorithms can be used to analyze data to recommend treatments or generate alerts. For example, an IoT sensor that detects an unusually low heart rate of a patient can generate an alert so that healthcare professionals can intervene. A major challenge with remote patient monitoring devices is ensuring that the highly personal data these IoT devices collect is secure and private.

1.1.2. Glucose monitoring

For the vast majority of patients with diabetes, glucose monitoring has traditionally been difficult. Not only is it inconvenient to check glucose levels and record the results manually, but it only reports the patient's glucose level at the time the test was performed. If levels vary significantly, periodic testing may not be enough to detect the problem. IoT devices can help address these challenges by providing continuous, automated monitoring of patients' glucose levels. Glucose monitors eliminate the need for manual record keeping and can alert patients when glucose levels are problematic. Challenges include designing IoT glucose monitoring devices that:

- a. It is small enough for continuous monitoring without disturbing patients
- b. It does not consume so much electricity that it is necessary to top it up often.

However, these are not insurmountable challenges, and devices that address them promise to revolutionize the way patients manage glucose monitoring.

1.1.3. Heart rate monitoring

Like glucose, heart rate monitoring can be challenging, even for patients presenting in healthcare settings. Periodic heart rate checks do not protect against rapid fluctuations in heart rate, and conventional continuous heart monitoring devices used in hospitals require patients to be permanently strapped to monitors, which hinders their mobility. Today, a variety of small IoT heart rate monitoring devices are available, allowing patients to move as they please while ensuring that the heart's activity is continuously monitored. Guaranteeing ultra-accurate results remains somewhat of a challenge, but most modern devices can provide an accuracy rate of around 90 percent or more.

1.1.4. Monitoring hand hygiene

Traditionally, there has not been a good way to ensure that providers and patients in a healthcare facility wash their hands properly to reduce the risk of spreading infection. Today, many hospitals and other healthcare facilities are using IoT devices to remind people to sanitize their hands when they enter hospital rooms. The devices can even provide instructions on how to properly sanitize your hands. The big disadvantage is that these devices can only remind but not do it for them. However, research suggests that these devices can reduce infection rates by more than 60 percent in hospitals.

1.1.5. Depression and mood monitoring

Information about patients' depressive symptoms and general mood is another type of data that has traditionally been difficult to collect on a continuous basis. Healthcare workers could occasionally ask patients how they were feeling, but they could not predict sudden mood swings. Often patients do not report their true feelings.

"Mood-sensitive" IoT devices can address these challenges. By collecting and analyzing data such as heart rate and blood pressure, the devices

can provide information about a patient's mental state. Advanced IoT mood monitoring devices can even track data such as a patient's eye movements. The key challenge here is that such indicators cannot accurately predict symptoms of depression or other causes of concern, as traditional personal mental health assessments often cannot.

1.1.6. Monitoring of Parkinson's disease

In order to most effectively treat patients with Parkinson's disease, healthcare providers must be able to assess how the severity of their symptoms varies throughout the day. IoT sensors promise to make this task much easier by continuously collecting data on Parkinson's symptoms. At the same time, the devices give patients the freedom to live in their own homes, rather than spending long periods in the hospital for observation.

1.2. Other examples of IoT/IoMT

While wearable devices such as those described above remain the most commonly used type of IoT device in healthcare, there are devices that go beyond tracking to actually providing treatment, or even "live" in or on the patient. Examples include the following:

1.2.1. Connected inhalers

Conditions such as asthma or COPD (chronic obstructive pulmonary disease) often involve attacks that occur suddenly and with little warning. Inhalers connected to the Internet of Things can help patients by monitoring the frequency of attacks as well as collecting data from the environment so that healthcare professionals understand what triggered an attack. In addition, connected inhalers can alert patients when they forget their inhalers at home or when they use them incorrectly.

1.2.2. Ingestion sensors

Collecting data from the human body is usually done by invasive methods. With ingestible sensors, it is possible to collect information from the digestive and other systems in a much less invasive way. They provide insight into stomach PH levels or help determine the source of internal bleeding. They must be small enough to be easily swallowed. They must also have the ability to dissolve and pass easily through the human body. Several companies are working hard on ingestible sensors that meet these criteria.

1.2.3. Connected contact lense

Smart contact lenses provide another opportunity to collect health data in a passive, unobtrusive way. At the same time, they could include micro-cameras that allow users to effectively take pictures with their eyes, which is probably why companies like Google have patented connected contact lenses. Whether used to improve health outcomes or for other purposes, smart lenses promise to turn the human eye into a powerful tool for digital interactions (Badshah, 2021).

1.3. Why Security Matters for Healthcare IoT

To make the most of IoT for healthcare, critical security challenges must be addressed. Above all, IoT device developers, managers, and healthcare professionals must ensure that they adequately secure the data collected by IoT devices. Much of the data collected by medical devices qualifies as protected health information under HIPAA and similar regulations. As a result, IoT devices could be fertile ground for the theft of sensitive data if not properly secured. Eighty-two percent of healthcare organizations report experiencing attacks on their IoT devices. Developing secure IoT hardware and software is one step in addressing this challenge. It is equally important to ensure that healthcare IoT devices are properly managed to protect against data from unmonitored devices falling into the wrong hands. For

example, a patient monitoring device that has an older version of software or firmware, or a device that is not properly decommissioned after it is no longer needed, could offer attackers an opportunity to infiltrate a network or steal protected health information. Proper detection and classification of all IoT devices on a healthcare provider's network helps protect against this risk. Once networks of IoT devices are properly identified, classified, regulated, and secured, service providers can monitor device behavior to identify anomalies, perform risk assessments, and segment vulnerable devices from critical devices. In a hyper-connected healthcare system, the volume and heterogeneity of IoT devices creates a complex and increasingly unsustainable reality for healthcare technology, IT and security organizations. It is necessary to understand exactly what is connected to the network, what it does and how to perfect the protection.

2. Examples of smart technology in Healthcare

Smart healthcare technology is changing the way patients are treated with telehealth, remote care and health monitoring technology that connects patients and doctors like never before.

Examples of some of the ways smart technology is being used in healthcare to improve the patient experience, improve proactive care procedures and create a healthier world(5 examples of smart technology in Healthcare).

2.1. Remote monitoring and automated health systems

Remote patient healthcare monitoring is a growing trend that is moving beyond traditional healthcare and into mainstream culture. Smart watches and fitness trackers have become standard for many people by tracking health factors like heart rate, blood oxygen, heart rate irregularity and more. In healthcare, providers are turning to devices to help patients by continuously monitoring their conditions and making proactive care choices based on data trends and predictions. For example, connected inhalers are a smart healthcare technology that saves lives by helping patients track their use and reminding them when to take their dose to keep their condition stable for as long as possible. Sixty-six percent of asthma deaths could have been prevented with smart monitoring technology like connected inhalers. There are a number of different wearable devices that patients can wear to help improve overall health care. One of the key innovations in healthcare devices is wearable biosensors used by providers around the world to monitor patients and administer proactive care. These sensors are worn on the body and monitor vital parameters such as temperature and heart rate to provide their healthcare providers with more information and insight into disease progression and overall health. Recently, these biosensors have helped the world monitor the spread of COVID-19 by monitoring patients to detect symptoms and other signs of the virus that would help us better understand and treat it.

2.2. Connected emergency solutions

Connectivity can significantly improve the efficiency and response time of emergency services, something that can be the difference between life and death. With modern smart healthcare technology, it is possible to share data between ambulances, doctors, emergency services and accident and emergency departments within a reasonable time frame enabling a real-time response. Now it is completely possible due to newer technology that provides faster communication, video calls with doctors from ambulances, easier admission to the hospital with an already open medical history. Upon arrival, doctors may already have the patient's data on hand - including vital signs, blood pressure, heart rate, temperature, etc.

2.3. Smart hospital management

Smart hospital management can help improve efficiency and effectiveness, positive patient experience, and assist physicians by connecting digital systems to facilitate access to information such as bed occupancy, device usage, equipment status, materials and supplies, and other operational data. Monitoring this information and using it in decision-making can improve resource management, reduce wastage and avoid shortages due to poor monitoring or inaccurate data collection.

2.4. AI (Artificial intelligence) in healthcare

Using AI in healthcare can help providers make informed decisions and significantly improve patient care with proactive care predictions, faster data analysis and even faster diagnosis. Using trained artificial intelligence to recognize and diagnose specific diseases within test results can significantly increase the number of patients processed and diagnosed (in some cases, 4x faster), significantly reducing wait times.

3. Digitalization of Health care Institutions and Health Care

3.1. Scanning (collection), storage and sharing of data

Today, with the classic way of doing business, medical workers spend 21% of their time on paperwork, which is not directly related to their field of work(America's - physicians foundation). Time savings can be achieved by healthcare professionals using smart devices. Smart devices with built-in scanning capabilities can deliver automated, more cost-effective and safer patient interactions. For example, scanning a barcode on a patient's wristband can provide instant access to key information such as the patient's identity, treatment card, and the name of the selected physician. The simplicity, flexibility and low cost of using smart scanning devices and process automation make healthcare more patient-centered and can enable the shift of treatment from hospitals to home care. As the healthcare sector moves from a high-cost to a more cost-effective model focused on reducing unnecessary costs, mobile scanning will be vital for gathering situational data to create a shared report from the beginning to the end of a patient's movement through the system. Mobile, smart scanning is transforming patient care in other ways. By achieving compliance, supply chains become more modern and secure. Drug Administrations like the FDA(Commissioner, Regulatory information)create drug databases and medical equipment that can be searched. Health workers need the so-called lifelong learning to remain successful in their work and promote patient safety. They need to track data on modern products, using tools that are cheaper and more efficient than classic ones, without compromising tracking performance. Mobile, smart devices successfully perform these tasks.

Technology is reshaping the relationship between the patient, supply chains and the healthcare system. Mobile smart devices play a key role, as they have become available to patients and are already in widespread use (A journey towards Smart Health the impact of digitalization...).

3.1. Modern access using smart devices

Powerful enterprise-level data collection performance is now possible on mainstream consumer smart devices, such as smartphones and tablets. Mobile digital workflows are already helping healthcare organizations increase operational efficiency and improve patient safety in the following ways:

3.2.1. Reduced error rate

Electronic prescription reduces the number of errors in medication administration. Paper-based recipes pose a greater risk of human error, but are still widely used. Access to digital databases using smart devices allows medical professionals immediate access to patient records.

3.2.2. Less paperwork

Administrative tasks are performed more efficiently and at lower costs. Automating workflows allows tasks to be completed faster and more accurately.

3.2.3. Affordable mobile automation

When automation is available in hospitals, it often comes in the form of expensive computers on wheels (COVs). By using mobile hospital apps on smartphones that are easy to use and affordable, staff can more easily work at the patient's bedside in teams and in shifts.

3.2.4. Fast and accurate inventory management

An inventory manager outside the operating room must quickly find available equipment and drugs. By using a smartphone to scan a barcode on a patient's wristband, medical device or data on a pharmaceutical product, it obtains the necessary drug/equipment data, checks and confirms that it is in stock - all in real time.

3.2.5. Improved patient outcomes

Increasing accuracy and safety in performing routine tasks, such as medication administration and observation, increases preventive health measures and accelerates positive treatment outcomes. A secure and smart mobile scanning app connects healthcare staff with medical records and displays real-time information at the bedside.

Patient care becomes truly patient-centered. Paperwork and administrative overload are a burden everywhere, taking up valuable time that could otherwise be spent with patients. Caring for older population is more effective and manageable. Older populations, more prone to chronic diseases, are a huge burden on an already overburdened health care system. Coordinating ancillary, primary and hospital care by sharing real-time patient information with mobile technology such as wearables and smartphones brings efficiency and cost-effectiveness to care.

Supply chains meet rigorous standards for safety and efficiency by improving visibility of shared inventory to manufacturers, service providers, distributors, pharmacies...

3. Conclusion

Smart healthcare technology is changing the game in more ways than one. With more treatment monitoring options available to more people, doctors can use data, artificial intelligence and other innovations to take a more proactive, data-driven approach to healthcare.

Healthcare organizations are under enormous pressure for a number of reasons. People are living longer, and in the last two decades the number of older residents in most developed countries has exceeded the number of children. The digital revolution is rapidly reshaping patient lifestyles as well as healthcare delivery models. Constant reforms in the provision of medical services, i.e. patient protection, while controlling health care costs is a constant challenge that is becoming more and more difficult. In medical organizations that work under these conditions, problems such as: heavy administrative workload, staff working in teams, usually of diverse expertise, too many errors. All this reduces patient safety.

Recording and connecting data through digital systems are in rapid development, but there is a long way to go in achieving the set goals. When organizations collect and share accurate, situational and verifiable data, they are able to build digital workflows that help generate accurate and timely information, improve business efficiencies, meet regulatory requirements and ultimately, improve patient safety. Digitized health systems are typically highly centralized organizations that are becoming larger and more complex. The good side of digitalization: everyone who works together in one “seamless” system for disease prevention, hospitalization, protection of adults and older persons will generally treat and protect people who need a certain type of care with better quality. Healthcare professionals across the healthcare system and supply chains are now better connected and can share information in real time. This helps to develop a quality system for monitoring patients, their laboratory samples, medical records and necessary medical supplies.

Hospitals are becoming smart machines. Hospitals will transform into real-time healthcare systems that use operational intelligence to improve patient care. Advances in mobile scanning technology are changing the way healthcare organizations operate. By applying smart technology, the way healthcare is managed will be more efficient, and patients will be provided with better quality and safer treatment.

References

5 examples of smart technology in Healthcare. Impact. (n.d.). <https://www.impactmybiz.com/blog/smart-technology-in-healthcare/>

10 internet of things (IOT) healthcare examples. Ordr. (2024, June 13). <https://ordr.net/article/iot-healthcare-examples>

A journey towards Smart Health the impact of digitalization ... (n.d.-a). https://www2.deloitte.com/content/dam/Deloitte/lu/Documents/life-sciences-health-care/lu_journey-smart-health-digitalisation.pdf

America's - physicians foundation. (n.d.-a). [https://physiciansfoundation.org/wp-content/uploads/2017/12/Biennial Physician Survey 2016.pdf](https://physiciansfoundation.org/wp-content/uploads/2017/12/Biennial_Physician_Survey_2016.pdf)

Badshah, N. (2021, February 7). The smart contact lens that monitors for diabetes and strokes. The Times & The Sunday Times: breaking news & today's latest headlines. <https://www.thetimes.co.uk/article/the-smart-contact-lens-that-monitors-for-diabetes-and-strokes-frsvqstnj>

Commissioner, O. of the. (n.d.). Regulatory information. U.S. Food and Drug Administration. <https://www.fda.gov/regulatory-information>

Regulations related to the prevention of the spread of the corona virus. The latest EXPERT DOCUMENTS related to the state of emergency and the disease COVID-19. (n.d.). <https://www.paragraf.rs/pravni-strucni-komentari-propisi-vanredno-stanje.html>

WHO/europe | NEW WHO/europe information series highlights the transformation of primary health care during COVID-19. (n.d.). <https://www.euro.who.int/en/health-topics/Health-systems/primary-health-care/news/news/2021/6/new-whoeurope-information-series-highlights-the-transformation-of-primary-health-care-during-covid-19>

MONITORING U USTANOVAMA ZA SMEŠTAJ ODRASLIH I STARIH LICA PRIMENOM IOT (INTERNET INTELIGENTNIH UREĐAJA)

**Danijela Vasić Djukanović, Dragica Novčić,
Biljana Vujić, Ivana Ilić**

Rezime

Nedavna pandemija koja je zahvatila svet jasno pokazuje da se spremnost (funkcionalnost) domova za smeštaj starih osoba (naročito stacionarnog tipa, odeljenja demencije, ...) ogleda u njihovoj fleksibilnosti i prilagodljivosti u teškim (unapred nepredvidljivim) okolnostima. Potencijalno neželjeni događaji koji mogu uticati na rad ovih ustanova, mogu se predupređiti u realnom vremenu automatizacijom infrastrukture za monitoring, apsorpciju i brz oporavak od krize, primenom IoT (Internet stvari - Inteligentni uređaji). Sistemi koji su najbolje pozicionirani za buduće ekstremne zahteve biće oni čije su radne operacije prilagođene da brzo i efikasno reaguju na sve prirodne pretnje ili pretnje koje je stvorio čovek. Ovo znači planiranje i rad na optimizaciji okruženja i infrastrukture za upravljanje informacijama za blagovremeno reagovanje.

Automatizacija dobija na značaju kada se zna da je u uslovima skorašnje pandemije, dobar broj zaposlenih bio radno onemogućen, što je dovelo do problema u radu svih službi. U raznim naučnim radovima i diskusijama,

na temu optimizacije rada ustanova, ističe se da spremnost znači sposobnost predviđanja i proučavanja punog obima potencijalnih neželjenih događaja koji mogu uticati na stanje sistema ustanove. Sa današnjim, sve pametnijim, sistemima za upravljanje objektima (informacijama), moguće je postići visok nivo optimizacije ustanove.

Internet of Things (IoT) - Internet stvari ili Internet inteligentnih uređaja, je pojam koji se odnosi na fizičke uređaje opremljene senzorima i softverima, koji su trenutno povezani na internet (ili lokalnu računarsku mrežu) da bi prikupljali i delili podatke. Internet inteligentnih uređaja je tehnologija koja obezbeđuje efikasno povezivanje digitalnog i fizičkog sveta, tj. povezivanje senzora iz stvarnog sveta sa internetom. Drugim rečima, to je skup međusobno povezanih uređaja, odnosno sistem mehaničkih i digitalnih uređaja i predmeta, koji omogućava da se podaci prenose preko interneta, obrade a prilagođene informacije postaju dostupne ciljnoj grupi (zaposlenima, stručnim radnicima...).

Ključne reči: *organizacija stacionara, socijalni rad, obrazovanje zaposlenih, internet, inteligentni uređaji, internet stvari*

Review paper UDK: 342.77:[616.98:578.334(497.11)

Handed over: 20.03.2023.

Accepted: 28.08.2023.

NORMATIVE COURSES OF ACTION IN POST- COVID-19 CIRCUMSTANCES

**Mirjana Vlatkovic⁵⁵, Nada Jovanovic⁵⁶,
Milica Djordjevic⁵⁷, Milos Minic⁵⁸**

Abstract

The pandemic of the infectious disease COVID-19 has in a short period of time caused major social changes throughout the world and brought uncertainty to people's lives.

In the Republic of Serbia, since the outbreak of the infectious disease, various anti-epidemic measures have been applied, which were aimed at preventing the emergence of the infection and its spread. Obligations to comply with them are established by various legal acts; the adoption, application, consequences and relationship with other regulations in the legal system of our country will be discussed in this paper, along with observations on possible future legal action.

⁵⁵ **Mirjana Vlatković**, msr pravnik, pravnik-sekretar u Ustanovi Gerontološki centar Beograd, pravnici@ugcb.rs

⁵⁶ **Nada Jovanović**, msr pravnik, pravnik-sekretar u Ustanovi Gerontološki centar Beograd, jovanovicn@ugcb.rs - kontakt,

⁵⁷ **Milica Đorđević**, msr pravnik, pomoćnik direktora u Ustanovi Gerontološki centar Beograd, djordjevicm@ugcb.rs

⁵⁸ **Miloš Minić**, dipl. pravnik, rukovodilac pružaoca usluge u zajednici u Ustanovi Gerontološki centar Beograd, RJ Dnevni centri klubovi, minicm@ugcb.rs PREVESTI – ne znam kako preveste pravnik 😊 Iurist?

The adopted measures had uneven impact on the population, in this particular case discriminating between citizens based on age by applying movement restrictions to older persons and persons placed in residential care institutions for adults and older persons. The goal of this procedure was to preserve the life and health of older population through the prevention of infection, all based on, at the given moment, available scientific research and experiences of other countries in the fight against this disease. Legally, the question of the constitutionality of the acts that introduced the movement restriction, as well as the very basis for declaring a state of emergency, can be raised. The very basis for making such a decision, referring to the Constitution of the RS, is controversial as disputed by the legal profession. The decision to declare a state of emergency was made five days before the COVID-19 pandemic was declared. It is also disputable why the National Assembly was exempted from deciding on the declaration of a state of emergency and the measures taken during a state of emergency, why the National Assembly did not meet even though there were no obstacles to it, and the Constitution expressly mandates that in the event of a state of emergency being declared, it must meet without invitation. The proposal for declaring a state of emergency was not submitted by the authorized proposer. The Decision on declaring a state of emergency as well as the Decision on lifting the state of emergency do not contain any explanation. The decision on declaring a state of emergency, as well as the Government's decree on measures during a state of emergency, were not submitted for ratification to the National Assembly within 48 hours as prescribed by the Constitution.

In the provision of social protection services, the consistent application of anti-epidemic measures contrasted the rights to life and health of beneficiaries already placed in a social protection institution and the right of persons who need accommodation to exercise the same right and timely provided social protection services, in a social protection institution where beneficiaries are provided needed medical help and care. Older persons, as a vulnerable popu-

lation category, enjoy special protection in accordance with the international conventions ratified by our country, therefore, in order to protect older persons, both during the pandemic, which particularly emphasized their vulnerability, and in regular circumstances, it is necessary to especially respect their rights during the adoption of regulations the needs and risks that age carries.

The pandemic has shown to what extent the objective circumstance of the fight against an invisible enemy through positive regulations can affect the quality of life of certain categories of the population, and that it is always relevant to consider the improvement of human rights and freedoms in order to prevent the violation of factual equality in society. In order to achieve the above, it is necessary to look at all the facts and circumstances during the pandemic and adopt strategic documents for handling such situations while respecting the rights and freedoms of sensitive social groups.

Keywords: COVID-19, social protection, institutional accommodation, health care, adults and older persons, movement restriction, preservation of human rights, equality.

Introduction

The pandemic of the infectious disease COVID-19 in a short period of time has caused major social changes throughout the world and brought uncertainty to people's lives.

Since the outbreak of the infectious disease in the Republic of Serbia, various anti-epidemic measures have been applied, which were aimed at preventing the emergence of the infection and its spread. Obligations to comply with anti-epidemic measures are established by various legal acts, the adoption, application, consequences and relationship with other regulations in the legal system of our country will be discussed in this paper, along with observations on possible future legal action.

1. Responsibility of the State for preventing the spread of Infectious disease

The pandemic of the infectious disease COVID-19 has actualized the issue of responsibility for the safety and protection of the lives of citizens, where the answer is primarily found in the responsibility of the home state to protect its residents through normative and other actions. Through the process of globalization, that responsibility has been transferred to supra-national entities, as universal mechanisms for the protection of the population at the global level, which exceed the capabilities of the home states. However, in the pandemic situation, it was noticed that the World Health Organization or the European Union did not sufficiently provide an adequate response to this health disaster, and that it turned out that the response of individual countries was the most effective, taking into account the degree of obligation of the applied measures. The state is the bearer of sovereign power and is the only one that can apply coercive measures in case of non-compliance with regulation (Lobanov & Selin, 2021).

“The concept of human security implies that the center of security policy analysis is no longer a state or a nation, but an individual”. “If we take into account the elements of human security, which include aspects of the economy, health, food, environment, politics, individual and community security, it can be said that the pandemic we are experiencing has threatened not only the health of individuals, but also it leaves consequences for groups of individuals, as well as that it is not only a matter of health consequences, but also of economic and social ones”(Ejdus, 2012), (Mudrinić, 2021).

By comparing the national security strategies of the USA, Great Britain, France, Russia and the Republic of Serbia, it can be seen that the mentioned foreign countries have recognized epidemics of a wide range of infectious diseases as the biggest security risks, while in our Strategy the aforementioned is not given too much importance, but risks and threats are classified based on the consequences that may occur (Mudrinić, 2021).

2. Anti-Epidemic measure of movement restriction

Measures adopted in the Republic of Serbia, which concerned the prevention of the occurrence and spread of the infectious disease COVID-19 during the so-called of the first wave of the disease included, first of all, restriction of movement in order to maintain social distance and reduce the possibility of infection. The adopted measures had an uneven impact on the population, in this particular case making a difference between citizens based on age by applying movement restrictions to older persons and persons placed in social care institutions that provide home accommodation services for adults and older persons. The goal of this procedure was to preserve the life and health of older persons through the prevention of infection, all based on, at the given moment, available scientific research and experiences of other countries in the fight against this disease.

The Constitution of the Republic of Serbia in Art. 39. st. 1. stipulates that everyone has the right to freely move and reside in the Republic of Serbia, to leave it and to return to it. In paragraph 2 of the same article, the Constitution provides that freedom of movement and residence and the right to leave the Republic of Serbia may be limited by law, if this is necessary for the purpose of conducting criminal proceedings, protecting public order and peace, preventing the spread of infectious diseases or defending the Republic of Serbia. The Constitution provides that human and minority rights guaranteed by the Constitution may be limited by law if the limitation is allowed by the Constitution, for the purposes for which the Constitution allows it, to the extent necessary to satisfy the constitutional purpose of the limitation in a democratic society and without encroaching on the essence of the guaranteed right (Constitution of the Republic of Serbia).

The restriction of movement for persons over 65 years of age was particularly restrictive, considering that a complete ban on movement was foreseen, with relaxations in certain periods of the night, i.e. early morning

hours, in order to enable older persons to go shopping and only in certain retail establishments. The aim of the adopted measures was to preserve the life and health of older persons living both in private households and in collective housing. Nevertheless, it is inevitable to raise the question of the necessity of introducing measures with such a restrictive degree. The responsibility of the state to protect each of its inhabitants, bearing in mind its special sensitivity in case of “attack” by an invisible enemy, was a logical justification for acting with a special degree of caution.

In the restrictions of human rights, it is always necessary to act in accordance with the principle of proportionality. In the fight against COVID-19, an important factor was the impossibility of assessing the harmful consequences and their extent. Therefore, measures were taken that were the only ones that could prevent the occurrence of the disease itself - preventive measures. Given that the route of transmission of the COVID-19 disease is droplet, physical distance is the safest form of prevention. This is especially considering that in the so-called during the first wave of this infectious disease, there was a shortage of protective masks at the global level. Later, with the stabilization of the supply of protective masks, and then with the invention of the vaccine, there could be talk of a “relaxation” of the measures.

In the context of movement restrictions, it is particularly important to emphasize that in the period from March 14, 2020. until 12.03.2022. in 2008, the Order on banning visits and restricting the movement of persons in institutions for the accommodation of older persons was in force (Law on Protection of the Population from Infectious Diseases). In the context of the provisions of the Law on the Protection of the Population from Infectious Diseases, the basis for the adoption of the Order on the prohibition of visits and the restriction of movement in the facilities of institutions for the accommodation of older persons (“Official Gazette of the RS “ no. 28/2020, 66/2020 and 87 /2020), given that the same in Art. 52. st. 1. t. b and art. 53. st. 1. t. 2 stipulates that the minister can order the restriction of movement in

the area affected by the emergency situation. That the stated legal wording was not an adequate basis for passing the Order is evidenced by the amendments to the Law, which introduced Art. 31 b, paragraph 1 of which reads: “The preventive measure of restricting the freedom of movement of persons in collective housing in order to prevent the introduction of infection into the collective is ordered by the minister in case of an epidemic of infectious diseases of greater epidemiological significance, if there are indications”. Therefore, the freedom of movement was completely abolished for citizens over the age of sixty-five in a state of emergency, by a Government Decree, not by law, and it was only later “legalized”. (Milić, 2021), (Law on Protection of the Population from Infectious Diseases),(Rakić Vodinelić, 2021).

Point 2 of the Order on the prohibition of visits and restriction of movement in the facilities of institutions for the accommodation of older persons is disputed, which reads: “Users of the institutions from point 1 of this order are prohibited from leaving the institutions”. Institutions for residential accommodation of adults and older persons are open-type institutions, where users come for accommodation based on their own declaration of will. The order was in effect for almost two full years. It is debatable whether this restriction of movement was proportionate to the goal it was intended to achieve. No amendment to the Order has eased this measure, even when visits were made possible to users who were fully vaccinated in periods when no epidemic was declared in the institution from 02/03/2021. year, so it is questionable whether its actuality was even reviewed during the period of validity and whether scientific achievements and the prevalence of diseases in the local community were monitored. It should be borne in mind that older persons, although designated as the most vulnerable category of the population that can be most affected by the COVID-19 disease, are also a category of the population that is made vulnerable and isolated by other social phenomena (ceasing work engagement, lack of social contact, family separation, chronic diseases and reduced strength and functionality). The necessity of a complete ban on leaving institutions for almost two

years, during which there were sufficiently long periods of time in which public gatherings were allowed without restrictions, is questionable. Could protection against the disease COVID-19 in collective accommodation be achieved by prescribing the obligation to wear protective masks, or was it necessary to limit the movement of persons who, due to difficulties in life, stay in domestic accommodation for a period of several years?

The Law on the Protection of the Population from Infectious Diseases ("Official Gazette of the RS" 15/2016), which was in force at the time of the outbreak of the infectious disease COVID-19, provided in art. 3. st. 5. that the implementation of measures to protect the population from infectious diseases and the provision of funds for their implementation have priority over the implementation of other measures in the field of health care. The law further establishes the criteria for infectious diseases - that they can lead to significant illness and/or death, that their prevention requires wider coordination of activities, that the exchange of information can provide early warning about threats to public health, that the grouping of data can indicate factors responsible for the occurrence of infectious diseases, that there are effective preventive measures for them, and that comparing the frequency in other environments can contribute to the assessment and improvement of the population protection program against infectious diseases. The law also foresees the possibility of declaring a disease that is not specified in Article 5 of this law and which can threaten the population of the Republic of Serbia to a greater extent with an infectious disease, the prevention and suppression of which is in the interest of the Republic of Serbia, as well as to determine the appropriate measures, conditions, method of implementation, the perpetrators and means of enforcement. On the basis of this provision, a Decision was made on the declaration of the disease COVID-19 caused by the SARS-CoV-2 virus as an infectious disease on March 10, 2020. The law obliges all persons who constantly or occasionally excrete the causative agents of infectious diseases to comply with the prescribed measures and instructions determined by the competent medical doctor, i.e. medical doctor specializing in epidemiology (Rakić Vodinelić, 2021).

Isolation is one of the special measures to protect the population from infectious diseases(Rakić Vodinelić, 2021).

Quarantine, in accordance with the Law, is a measure that restricts freedom of movement and establishes mandatory health examinations for healthy persons who have been or are suspected of having been in contact with persons suffering from infectious diseases or with a person who is suspected of being sick from the infectious disease specified in art. 27. of the Act, during the period of contagiousness, that is, in the event of the appearance of another infectious disease that the Minister, in cooperation with the Commission, determines poses a threat to the health of the population of the Republic of Serbia. The doctor of medicine, specialist in epidemiology of the competent institution, that is, the public health institute, determines which persons are subject to the obligation to be placed in quarantine(Rakić Vodinelić, 2021).

The Constitutional Court in Decision no. IUo -45 /2020 from 25.10.2020. year, on the occasion of contesting the measures prohibiting movement during the state of emergency, pointed out the existence of a legal regime of deviation from human rights in extraordinary circumstances, which is of a temporary nature, assuming the declaration of a state of emergency. The reason for the declaration of a state of emergency was the danger of the spread of the infectious disease COVID-19, which was considered a danger that threatens the survival of citizens and the state, after which the Government, with the co-signature of the President of the Republic, adopted the Decree on measures during the state of emergency. One of the measures was a ban on the movement of persons over 65 years of age. The Constitutional Court found that the said measure was introduced in accordance with the degree of vulnerability of that category of population from the infectious disease COVID-19, that discrimination was not carried out, nor did the said measure represent deprivation of freedom, but only effective protection against the possibility of contracting the disease (Constitutional Court of the Republic of Serbia, 2020).

Regarding this issue, judge Dr. Tamas Korhec gave a dissenting opinion, asking the basic question whether the Government of the RS prescribed measures deviating from the human rights and freedoms guaranteed by the Constitution or whether it authorized the state administration authorities to prescribe these measures themselves. Judge Korhec stated that the norms of the Regulation were formulated in an extremely general way, and by analyzing the relevant provisions of the Constitution and the law, he concluded that “state administration bodies are part of the executive branch of government”, that the principle of separation of powers, as well as the principle of constitutionality, represent an obstacle even for the The National Assembly to voluntarily transfer the right to create original binding rules of conduct”. Judge Korhec stated that “the material legal limitation prescribed in Article 16, paragraph 2. The Law on State Administration has not been complied with, which states that state administration bodies cannot by regulation determine their own or others’ competences, nor establish rights and obligations for natural and legal persons that are not established by law”. Judge Korhec stated that “the provisions of Art. 2 and 3. Regulations would have been constitutionally indisputable if (Constitutional Court of the Republic of Serbia, 2020)the Government by Decree itself prescribed the measure of ban and restriction of movement in public places, while at the same time authorizing the minister (not the ministry) to specify the ban with his act in terms of the time period of the ban, specific space and categories that are exempt from the ban, at the same time specifying certain boundaries and frameworks for concretization in the implementation of measures”. Regarding the legal inconsistency between the provisions of points 1 and 2 of the Order on the restriction and prohibition of the movement of persons on the territory of the Republic of Serbia and the provisions of Article 2 of the Regulation, Judge Korhec expressed the opinion that, with the Order, the Ministry went beyond the scope of the Regulation’s norm, considering that that it was authorized to limit or even prohibit the movement of persons in public places, and never their movement outside public places, which was done considering that it is forbidden to move and go out of apartments and gardens” (Constitutional Court of the Republic of Serbia, 2020).

3. The question of the basis of possible mandatory Vaccination

As the issue of mandatory vaccination against the infectious disease COVID-19 has been mentioned several times in the public, and the constitutionality of such a provision if it were to be adopted, it should be noted that the Constitutional Court decides on the same in the case of an initiative to determine the constitutionality. In the following text, the most important reflections of M. Jovanović on this topic will be presented, which are related to the analysis of the decision of the European Court of Human Rights in the case of *Vavříčka and Others v. the Czech Republic*. In this case, the ECtHR embarked on an analysis of proportionality - whether the measure of compulsory vaccination of children against certain diseases protects a legitimate objective ("protection against diseases that could pose a serious risk to health"), the existence of a general consensus among member states on the effectiveness and the effectiveness of vaccines, recognized "the authority of the scientific community that considers the measure effective and safe". Also, it was determined that it cannot be considered disproportionate that the state asks those for whom vaccination poses a distant health risk to accept this universally practiced measure as a form of legal obligation, all in the name of social solidarity and at the expense of a small number of vulnerable children who cannot benefit from vaccination" (Jovanović, 2021). Also, the Court stated that, "in the protection of personal beliefs, Article 9 of the Convention did not always guarantee the right to behave in the public sphere in the manner determined by such a belief", and "the Court found that there was no violation of Article 9, considering that mandatory vaccination applies to everyone". The position of the Constitutional Court on the issue of mandatory vaccination of children against the diseases listed in the Law on the Protection of the Population from Infectious Diseases was that "the interference of the legislator in the realization of the right to physical and mental integrity is based on the need to protect the health of the entire

population and the persons in question, that as such it is justified and proportionate to the goal to be achieved". Considering the stated position that "non-vaccinated children are discriminated against vaccinated", the Constitutional Court (keeping in mind that "discrimination represents different treatment of persons in the same or similar situations without reasonable justification") concluded that "the who does not submit to the legal obligation of vaccination cannot be considered discriminated against the one who has submitted to that obligation, because they are not in the same or similar situation" (Jovanović, 2021).

4. Conclusion

The pandemic has shown to what extent the objective circumstance of the fight against an invisible enemy through positive regulations can affect the quality of life of certain categories of the population, and that it is always relevant to consider the improvement of human rights and freedoms in order to prevent the violation of factual equality in society. In order to achieve the above, it is necessary to look at all the facts and circumstances during the pandemic and adopt strategic documents for handling such situations while respecting the rights and freedoms of sensitive social groups. It is especially important when prescribing measures to take into account their impact on the quality of life of a person, and when applying restrictive measures that limit certain rights prescribed by the Constitution, limit them in accordance with the principle of proportionality, and also so that the restrictions last only for the time period in for whom they are necessary and represent the only way to protect assets protected by the Constitution.

References

Constitution of the Republic of Serbia. (n.d.). <https://www.paragraf.rs/propisi/constitution-of-the-republic-of-serbia.html>

Constitutional Court of the Republic of Serbia (2020, October 30). Decision No. IUO-45/2020: Propisi.net: Svi propisi republike Srbije Online. PROPISI.NET | Svi propisi Republike Srbije online. <https://www.propisi.net/odluka-ustavnog-suda-rs-broj-iuo-45-2020/>

Ejdus, F. (2012). MEĐUNARODNA BEZBEDNOST – Teorije, sektori i nivoi. Official gazette.

Jovanović, M. (2021, August 23). Constitution and COVID-19. Peščanik. <https://pescanik.net/ustav-i-covid-19/>

Law on Protection of the Population from Infectious Diseases. (n.d.). https://www.paragraf.rs/propisi/zakon_o_zastiti_stanovnistva_od_zaraznih_bolesti.html

Lobanov, K., & Selin, B. (2021). Human security and state functioning in the context of pandemic and post-pandemic COVID-19. Godišnjak Fakulteta bezbednosti, 1, 145-155. https://doi.org/10.5937/fb_godisnjak0-35440

Milić I. (2021), On the occasion of amendments to the Law on the Protection of the Population from Infectious Diseases (What's New in the so-called Corona Law), Proceedings of the Faculty of Law in Novi Sad 2021, 259.

Mudrinić, L. (2021). International challenges, risks and threats in human security and health. In Megatrend revija (2021st ed., Vol. 18, pp. 401–422). Megatrend University.

Rakić Vodinelić, V. R. (2021, October 1). Smrt I mi. Peščanik. <https://pescanik.net/smrt-i-mi/>

NORMATIVNI PRAVCI DELOVANJA U POST KOVID-19 OKOLNOSTIMA

**Mirjana Vlatković, Nada Jovanović,
Milica Đorđević, Miloš Minić**

Rezime

Pandemija zarazne bolesti KOVID-19 u kratkom roku je izazvala velike društvene promene u čitavom svetu i donela neizvesnost u ljudske živote. U Republici Srbiji su od pojave zarazne bolesti primenjivane različite protivepidemijske mere, koje su imale za cilj sprečavanje pojave zaraze i širenja iste. Obaveze poštovanja istih ustanovljene su različitim pravnim aktima, o čijem donošenju, primeni, posledicama i odnosu sa drugim propisima u pravnom sistemu naše zemlje će biti reči u ovom radu, uz izlaganje zapažanja o mogućem budućem pravnom delovanju.

Donete mere nejednako su uticale na stanovništvo, u konkretnom slučaju praveći razliku između građana na osnovu životne dobi primenom ograničenja kretanja na starija lica i lica smeštena u ustanove socijalne zaštite koje pružaju uslugu domskog smeštaja za odrasla i starija lica. Cilj ovakvog postupanja bilo je očuvanje života i zdravlja starijih lica kroz prevenciju zaražavanja, a sve na osnovu, u datom trenutku, raspoloživih naučnih istraživanja i iskustava drugih država u borbi protiv ove bolesti. Pravno se može postaviti pitanje ustavnosti akata kojima je ograničenje kretanja uvedeno, kao i samog osnova za proglašenje vanrednog stanja. Sam osnov donošenja ovakve odluke pozivajući se na Ustav RS, polemisan je kao sporan od strane pravne pravne struke. Odluka o proglašenju vanrednog stanja doneta je pet dana pre nego što

je proglašena pandemija bolesti KOVID-19. Sporno je zašto je Narodna skupština izuzeta iz odlučivanja o proglašenju vanrednog stanja i merama koje se preduzimaju u vreme vanrednog stanja, zašto se Narodna skupština nije sastala iako nisu postojale bilo kakve prepreke za to, a Ustav izričito nalaže da se u slučaju proglašenja vanrednog stanja ona obavezno sastaje bez poziva. Predlog za proglašenje vanrednog stanja nije podneo ovlašćeni predlagač. Odluka o proglašenju vanrednog stanja kao i Odluka o ukidanju vanrednog stanja ne sadrže nikakvo obrazloženje. Odluka o proglašenju vanrednog stanja kao ni uredbe Vlade o merama za vreme vanrednog stanja nisu podnete na ratifikaciju Narodnoj skupštini u roku od 48 časova kako je propisano Ustavom.

U pružanju usluga socijalne zaštite je dosledna primena protivepidemijskih mera suprotstavila prava korisnika već smeštenih u ustanovu socijalne zaštite na život i zdravlje i pravo lica kojima je smeštaj neophodan na ostvarivanje istog prava i blagovremeno pruženu uslugu socijalne zaštite, u ustanovi socijalne zaštite u kojoj se korisnicima pruža potrebna medicinska pomoć i nega. Stariji kao ranjiva kategorija stanovništva uživaju posebnu zaštitu u skladu sa međunarodnim konvencijama koje je naša država ratifikovala, stoga je u cilju zaštite starijih, kako u toku pandemije, koja je naročito naglasila njihovu ugroženost, tako i u redovnim okolnostima, potrebno tokom donošenja propisa naročito uvažiti njihove potrebe i rizike koju ta životna dob nosi.

Pandemija je pokazala u kojoj meri objektivna okolnost borbe protiv nevidljivog neprijatelja kroz pozitivne propise može uticati na kvalitet života određenih kategorija stanovništva, te da je uvek aktuelno promišljanje u pogledu unapređenja ljudskih prava i sloboda radi sprečavanja narušavanja faktičke ravnopravnosti u društvu. Radi ostvarivanja navedenog, potrebno je sagledati sve činjenice i okolnosti u doba pandemije i doneti strateške dokumente za postupanje u ovakvim situacijama uz uvažavanje prava i sloboda osetljivih društvenih grupa.

Ključne reči: *KOVID-19, socijalna zaštita, domski smeštaj, zdravstvena zaštita, odrasli i stariji, ograničenje kretanja, očuvanje ljudskih prava, ravnopravnost*

Scientific critique / discussion UDK: 613-056.24-053.9

364-54-053.9

616.98-084:578.834

Handed over: 20.03.2023.

Accepted: 28.08.2023.

THE IMPACT OF EPIDEMIOLOGICAL MEASURES DURING THE COVID-19 VIRUS ON THE PSYCHO-SOCIAL LIVE OF USERS IN SOCIAL CARE INSTITUTIONS

**Milena Stojiljkovic⁵⁹, Dusanka Cepic⁶⁰,
Anita Djukovic⁶¹, Marina Arsic⁶²**

Abstract

At the end of 2019 and throughout the following years, the world faced a wide-scale COVID-19 pandemic. The World Health Organization on 11/03/2020 declared the coronavirus pandemic in the world. The state of emergency in our country was introduced on March 15, 2020, in order to prevent the spread of the virus. The introduction of the state of emergency was accompanied by a number of different measures, which included the wearing of protective masks and gloves, restriction of movement, and the prohibition of visits in social protection institutions, quarantine measures for the sick, isolation

⁵⁹ Milena Stojiljković, social worker at the Gerontological Center Belgrade, WU Dom "Voždovac", milena.stojiljkovic5@gmail.com

⁶⁰ Dušanka Čepić, social worker at the Gerontological Center Belgrade, WU Dom "Voždovac", dusica.cepic.11@gmail.com

⁶¹ Anita Đuković, psychologist at the Gerontological Center Belgrade, WU Dom "Voždovac", djukovica@ugcb.rs

⁶² Marina Arsić, occupational therapist at the Gerontological Center Belgrade, WU Dom "Voždovac", arsicm@ugcb.rs

blocks, etc. The aforementioned led to general beneficiary dissatisfaction, fear for their lives and those of their loved ones, loneliness, depression and anxiety. The introduced epidemiological measures affected the general quality of life of the beneficiaries. Beneficiaries of the nursing home believe that the restriction of movement has led to reduced mobility, weight gain and lack of fitness, and they also believe that the daily spread of panic and fear has caused passivity and a sense of dependence on others. In order to alleviate the stress caused by the pandemic, professional workers and associates provided the necessary support and assistance to beneficiaries in accordance with epidemiological measures, which was reflected in frequent contacts through individual conversations, providing psycho-social support to both beneficiaries and relatives, and also immediate caregivers, then mediation in the exercise of certain social and health care rights, cooperation with banks for the payment of accommodation costs, procurement of medicines, desired foodstuffs and other necessities.

As part of the work-occupational therapy activities, which were organized in accordance with the current epidemiological situation in the nursing home in smaller groups, an effort was made to reduce beneficiary dissatisfaction with the imposed restrictions, with the aim of preserving the quality of life. Beneficiaries were encouraged to show mutual solidarity and responsibility for each other.

The measures, recommendations and instructions of the relevant ministry that were in force in nursing homes during the coronavirus pandemic were precisely aimed at protecting the health of the beneficiaries, and the beneficiaries were forced to change the daily activities they had been engaged in for years and adapt to the measures dictated by the pandemic. The coronavirus “required” reduced physical contact with family and friends, which was the hardest thing for them to accept. In order to respond to the challenges of the coronavirus and reduced physical contact with family and friends, the Institution has enabled a certain number of beneficiaries to have virtual contacts through video calls.

The global pandemic has undoubtedly led to many changes in society and, as they say, “it will never be the same again.” The changes were particularly pronounced in the sphere of social relations and the general quality of life of beneficiaries.

Keywords: *coronavirus, epidemiological measures, beneficiaries, social protection institutions, quality of life, restrictions, support measures*

Introduction

In late 2019 and early 2020, we faced the global pandemic of the coronavirus, COVID-19. The first cases of the virus were recorded in China (Wuhan). In a short time, the virus spread to Europe in early 2020, and then to North and South America, Australia and Africa. In the Republic of Serbia, the presence of the coronavirus was recorded in March 2020.

The Constitution of the Republic of Serbia defines that a state of emergency is declared when “public danger threatens the survival of the state or citizens” (Constitution of the Republic of Serbia). The citizens of the Republic of Serbia faced just such a danger when, due to the coronavirus pandemic, a state of emergency was declared on March 15, 2020 by the Decision on Proclamation of a State of Emergency (Official Gazette of the Republic of Serbia, 2020a). Namely, two bodies were formed in the Republic of Serbia with the aim of taking adequate measures in the fight against the coronavirus. It is about the Crisis Staff for the suppression of the epidemic of COVID-19 and the Coordinating Body for the implementation of the Program of Economic Measures to reduce the negative effects caused by the pandemic of the infectious disease COVID-19 and support the economy of the Republic of Serbia.

The state of emergency was introduced in order to prevent the spread of the virus, which meant wearing protective masks, gloves, restricting movement, limiting physical distance, banning the operation of schools, introducing a curfew, banning the movement of people aged 65 and over, which was especially difficult this population group. The state of emergency implied a change in the work model of many establishments and institutions, the performance of service and private activities under special conditions. This was reflected in the reorganization of the work of health institutions, the formation of covid clinics at health centers, and also, for the purpose of monitoring the health status of infected people, temporary fa-

cilities were created for the treatment of those suffering from the infectious disease COVID-19 (Belgrade Fair, Stark Arena, Chair Hall in They are not). The state of emergency was abolished by the Decision on the abolition of the state of emergency on May 6, 2020 (Official Gazette of the Republic of Serbia, 2020c). The coronavirus pandemic has completely changed people's daily lives, and especially the lives of users in facilities for older persons, who have been particularly affected by the measures since the beginning of the pandemic. The users of the homes were "forced" to change the daily activities they had been engaged in for years and adapt to the measures "dictated" by the pandemic. Daily routines and recreational activities were interrupted, and concern for their own health and that of their loved ones caused many to feel depressed, anxious, scared, and even disinterested in anything.

Influence of Epidemiology measures on the quality of life of users in the Home

The coronavirus has significantly affected people's quality of life on three levels: physical, psychological and social. It is known that physical activity reduces anxiety and depression, improves cognitive functions, improves response to stress, improves sleep quality, and affects the overall quality of life. According to the Constitution of the World Health Organization from 1948, the quality of life of older persons is defined as "a state of physical, mental and social well-being, and not merely the absence of disease and infirmity" (World Health Organization). Therefore, a prerequisite for mental health is physical activity, as stated by the director of UNICEF, Henrietta Faure: "Mental health is part of physical health and we cannot allow ourselves to continue to look at it differently." "No matter how old we are, the corona time undermines our mental health in the same way. Social isolation is an additional pressure on the fear of illness and death, as well as worries about existence. "Covid has further increased the fears of modern man by not providing him with a perspective, which was assumed to always exist" (Urošević, 2020).

The coronavirus “required” to limit physical contact while staying connected with family and friends. In order to respond to the challenges of the coronavirus, a small number of users of the “Voždovac” Home used modern technology in order to maintain contact with relatives and friends, thereby reducing mutual fear and mutual concern for each other. A large number of users did not have technical capabilities or skills for this type of communication, and support and help was provided by professional workers and other personnel in direct work with them, in order to prevent difficult moments and crisis situations that they, as isolated, faced. In this way, he tried to maintain regular contact with relatives and friends. Also, in this way, support is provided to users for making purchases, monitoring information and monitoring other internet content.

Professional workers and staff of the Home were a continuous link between users, relatives, friends and all relevant institutions of importance for users. In moments of crisis, some users did not understand all the efforts made by the employees to alleviate or prevent the moments of crisis they were facing (restricted movement, separation from family, unavailability of all services as before). They often demanded that the Institution “abolish” certain epidemiological measures.

The users of RJ Dom “Voždovac” are provided daily psycho-social support through individual conversations with professional workers and associates. They were encouraged to share their current feelings and ask for help, if they needed it, and they were also instructed on mutual solidarity and respect for each other’s needs. Through individual conversations, most users pointed out that they feel worried about the life and health of their family members, and also that they have feelings of fear, loneliness, depression and anxiety. Also, the users of the Home believe that the measures they were included in gave them the impression that they are “invisible in society” and that the daily “spread” of panic and fear causes them a sense of guilt, isolation, passivity and a sense of dependence on others.

In order to preserve existing capacities and improve new skills, and use their full potential, in accordance with epidemiological measures, group work was organized, as well as work-occupational therapy activities in smaller groups of up to five users with physical distancing (making New Year's cards, decorative subjects, growing flowers, reading poetry...).

Adaptation of Older Persons to changes caused by coronavirus

The global pandemic, an insufficiently clearly defined cause and prognosis of the disease, additionally influenced the problems of fear, uncertainty, anxiety, and depression to intensify and leave consequences in the sphere of the user's psycho-social functioning.

As much as the life of old people is determined by the same denominator, years, each individual is affected by a multitude of different biological, psychological and social factors that determine the content of his existence. Some users have managed to preserve their meaning and orientation to "today" and "tomorrow" and to adapt to their age and the changes brought about by the pandemic, despite their years. Some others, with less capacity, who had more emotional stress during their life, were not able to make sense of their existence, face sudden changes and accept them.

The support of professional workers, in addition to health care, was a crucial segment of support for older persons in homes. Daily conversations, mediation with relatives, services in the Home, as well as institutions outside the Home, were of great importance for the users. During the period of adaptation to the new life circumstances caused by the coronavirus, due to the fear and uncertainty of the duration of this "plague", a number of users left the accommodation. It was evident that the unrealistic expectations of individual users in meeting their personal needs, which were not included in the norms of services, were increased, expecting them to be "normally"

satisfied in the new circumstances. Professional workers also understood such user behavior. Users' fear and uncertainty about the outcome of the pandemic made it impossible for users to adapt to new situations, which comprehensively affected their inappropriate and unacceptable manifest behavior. This additionally influenced the increased engagement of professional workers, in order to alleviate crisis situations and help users to overcome them.

Working persons in the Home during the duration of the State of Emergency

During the duration of the coronavirus pandemic, the Decree on organizing the work of employers during a state of emergency was adopted, which recommends working from home for those activities that could be performed at home. However, there are employers who could not implement that recommendation (Official Gazette of the Republic of Serbia, 2020b). Employees in social welfare institutions that provide institutional accommodation were at constant risk of infection, primarily due to the type of work they perform, and also due to the fact that they came into contact with a large number of service users and other employees.

Namely, the Government of the RS adopted the Regulation on the organization of the work of social protection institutions for the provision of home accommodation during the state of emergency (Official Gazette of the Republic of Serbia, 2020b). The regulation referred to public and private institutions of the institutional type, and it defined a special model of their work in case of the emergence of the coronavirus. It meant that, if a user or an employee becomes infected with the current virus, they will be referred to a health facility for treatment, and other users and employees will remain in isolation at the facility for 14 days. Also, in the event that a new case of coronavirus is confirmed during the isolation period, the isolation of users and employees is extended for 14 days. This was also stressful for the em-

ployed staff, fearing, first of all, for their personal life, the life of their family, and on the other hand, the necessity of performing work tasks and providing assistance to this sensitive population group.

Conclusion

In the circumstances caused by the COVID-19 virus, it was very difficult for older persons to accept the situation and the measures that were being implemented: fears for their personal lives and the lives of their loved ones, concerns about financial security. The security of pension payments was one of the important moments for the users of the Home due to paying for accommodation and meeting basic and other personal needs. Restrictions on movement, prohibition of visiting relatives is also one of the important factors that affected the quality of life of older persons in homes. They often pointed out that it was one of the basic human rights that they were denied and that the majority did not understand and had a hard time accepting.

They evaluated the information in the media as inadequate measures, emphasizing that it was insufficient and contradictory, that they were denied the opportunity to exercise their right to check-up health services, go to the bank and personally withdraw money, go shopping. They especially emphasized that they lacked the help and support of family and friends due to many restrictions, which also applied to them.

They rated enhanced hygiene measures, the introduction of a curfew, because it was valid for all citizens, not just older persons, and the help of volunteers as good epidemiological measures. The state's financial assistance was evaluated as positive, since older persons had priority in realizing the right to financial assistance from the state, which was also reflected in the payment of one-time assistance and assistance in kind.

During the pandemic, the need for psycho-social support and the "constant" presence of professional workers and other personnel who pro-

vided them with a sense of security was expressed. This need was much more pronounced compared to the period before the coronavirus.

There is no doubt that the coronavirus pandemic has affected health, production, social and economic flows at the global level. The measures, recommendations and instructions of the Ministry of Labour, Employment, Veterans and Social Affairs and the Ministry of Health, which were in effect in nursing homes during the coronavirus pandemic, were precisely aimed at the best welfare for everyone.

Recommendations

- it is necessary to work on supporting and empowering users to accept the changed living conditions caused by the coronavirus;
- provide psycho-social support services;
- enable timely and accurate information about protection measures, treatment, changes in the provision of services, application of new measures, etc.
- to reorganize the work of all services in the House (health, social, psychological, work-occupational services, service services in the House);
- formation of isolation departments for the purpose of monitoring the health status of infected users.

Professional workers will continue to strive to, through individual conversations, providing psycho-social support, through advisory work, develop, strengthen and preserve the capacities of users and develop the necessary skills for easier adaptation to changed circumstances in crisis situations.

References

Constitution of the Republic of Serbia. (n.d.). <https://www.paragraf.rs/propisi/constitution-of-the-republic-of-serbia.html>

Official Gazette of the Republic of Serbia, no. 29, 15 March 2020, Decision on declaring a state of emergency <https://www.paragraf.rs/glasila/rs/sluzbeni-glasnik-republike-srbije-29-2020.html>

Official Gazette of the Republic of Serbia, no. 31, 16 March 2020, Decision on declaring a state of emergency <https://www.paragraf.rs/glasila/rs/sluzbeni-glasnik-republike-srbije-31-2020.html>

Official Gazette of the Republic of Serbia, no. 65, 6 May 2020, Decision on lifting a state of emergency <https://www.paragraf.rs/glasila/rs/sluzbeni-glasnik-republike-srbije-65-2020.html>

Urošević, R. (2020). Self-help in the time of corona. In Journal of Gerontology (2020, Vol. 2, pp. 28), Gerontological Society of Serbia

World Health Organization. (n.d.). Constitution of the World Health Organization. World Health Organization. <https://www.who.int/about/accountability/governance/constitution>

UTICAJ EPIDEMIOLOŠKIH MERA TOKOM TRAJANJA VIRUSA KOVID-19 NA PSIHO-SOCIJALNI ŽIVOT KORISNIKA U USTANOVAMA SOCIJALNE ZAŠTITE

**Milena Stojiljković⁶³, Dušanka Čepić⁶⁴,
Anita Đuković⁶⁵, Marina Arsić⁶⁶**

Rezime

Krajem 2019. godine i tokom narednih godina, svet se suočio sa pandemijom širokih razmera izazvanim virusom KOVID-19. Svetska zdravstvena organizacijajedana 11.03.2020. godine proglasila pandemiju koronavirusa u svetu. Vanredno stanje u našoj zemlji uvedeno je 15. marta 2020. godine u cilju sprečavanja širenja virusa. Uvođenje vanrednog stanja pratilo je i niz različitih mera što je podrazumevalo nošenje zaštitne maske i rukavica, ograničavanje kretanja, a u ustanovama socijalne zaštite i zabranu poseta, mere karantina za obolele, izolacione blokove... Napred navedeno, dovelo je do opšteg nezadovoljstva korisnika, straha za svoj i život najbližih, usamljenosti, depresije i anksioznosti.

⁶³ **Milena Stojiljković**, Social Worker at the Gerontological Center Belgrade, WU Dom "Voždovac", milena.stojiljkovic5@gmail.com

⁶⁴ **Dušanka Čepić**, Social Worker at the Gerontological Center Belgrade, WU Dom "Voždovac", dusica.cepic.11@gmail.com

⁶⁵ **Anita Đuković**, Psychologist at the Gerontological Center Belgrade, WU Dom "Voždovac", djukovica@ugcb.rs

⁶⁶ **Marina Arsić**, Occupational therapist at the Gerontological Center Belgrade, WU Dom "Voždovac", arsicm@ugcb.rs

Uvedene epidemiološke mere su uticale na opšti kvalitet života korisnika. Korisnici Doma smatraju daje ograničavanje kretanja dovelo do smanjene pokretljivosti, povećanja telesne težine i nedostatka kondicije, a takođe smatraju da je svakodnevno širenje panike i straha izazvalo pasivnost i osećaj zavisnosti od drugih. U cilju ublažavanja stresa izazvanog pandemijom, stručni radnici i saradnici pružali su neophodnu podršku i pomoć korisnicima u skladu sa epidemiološkim merama, a što se ogledalo u čestim kontaktima putem individualnih razgovora, pružanje psiho-socijalne podrške kako korisnicima, tako i srodnicima, pa i neposrednim negovateljima, zatim posredovanja u ostvarivanju određenih prava iz socijalne i zdravstvene zaštite, saradnji sa bankama radi plaćanja troškova smeštaja, nabavci lekova, željenih namirnica i drugih potrepština. U okviru aktivnosti radno-okupacione terapije, koje su organizovane u skladu sa aktuelnom epidemiološkom situacijom u Domu u manjim grupama, nastojalo se redukovati nezadovoljstvo korisnika nametnutim ograničenostima, a u cilju očuvanja kvaliteta života. Korisnici su podsticani na međusobnu solidarnost i odgovornost jednih za druge.

Mere, preporuke i instrukcije resornog ministarstva koje su tokom trajanja pandemije koronavirusa bile na snazi u domovima za stare, upravo su imale za cilj zaštitu zdravlja korisnika, te su korisnici bili „prinudeni“ da promene svakodnevne aktivnosti kojima su se godinama bavili i prilagode se merama koje diktira pandemija. Koronavirus je „zahtevao“ smanjene fizičke međusobne kontakte sa porodicom i prijateljima, a što su korisnici domskih usluga najteže prihvatili. Kako bi odgovorili na izazove koronavirusa i smanjene fizičke kontakte sa porodicom i prijateljima, Ustanova je korisnicima omogućavala virtuelne kontakte putem videopoziva.

Pandemija globalnih razmera nesporno je dovela do mnogih promena u društvu. Promene su posebno bile izražene u sferi socijalnih odnosa i opšteg kvaliteta života korisnika.

Ključne reči: KOVID-19, epidemiološke mere, korisnici, ustanove socijalne zaštite, kvalitet života, ograničenja, merepodrške.

Professional paper UDK: 613-056.24-053.9:615.851.3
364-54-053.9
616.98-084:578.834

Handed over: 20.03.2023.

Accepted: 25.04.2023.

THE IMPACT OF THE CORONA VIRUS PANDEMIC ON WORK-OCCUPATIONAL THERAPY ACTIVITIES WITHIN AN INSTITUTION FOR THE ACCOMMODATION OF ADULTS AND OLDER PERSONS

**Katarina Krajinovic⁶⁷, Jasmina Obradovic⁶⁸,
Predrag Mijic⁶⁹, Srdjan Atanackovic⁷⁰, Vlado Radulj⁷¹**

Abstract

The current pandemic caused by the corona virus has a significant impact on the functioning of accommodation facilities around the world, and the Republic of Serbia is no exception. In March 2020, the World Health Organization declared the new corona virus a global pandemic and called on governments to take urgent and vigorous measures to reduce the consequences of the spread of this highly contagious virus. Therefore, the aim of this paper is to examine the impact of the corona virus pandemic on occupational therapy activities within the Gerontological Centre Belgrade, WU Dom "Bežanijska kosa". The impact of the pandemic was analyzed through a non-standardized

⁶⁷ Katarina Krajinović, Gerontological Center Belgrade, "Bežanijska kosa" krajinovick@ugcb.rs

⁶⁸ Jasmina Obradović, Gerontological Center Belgrade, "Bežanijska kosa"

⁶⁹ Predrag Mijić, Gerontological Center Belgrade, "Bežanijska kosa"

⁷⁰ Srdan Atanacković, Gerontological Center Belgrade, "Bežanijska kosa"

⁷¹ Vlado Radulj, Gerontological Center Belgrade, "Bežanijska kosa"

questionnaire, a direct conversation with the beneficiaries of nursing home accommodation services, lived experiences, as well as through a comparative presentation of the activities of occupational therapists before and during the corona virus pandemic. The analysis of the questionnaire was carried out by grouping the questions into three parts that include biographical data and length of stay in the home, occupational therapy activities before the corona virus pandemic, as well as questions aimed at further improvement of occupational therapy activities. The activities of occupational therapists before and during the pandemic are shown through the analysis of implemented activities based on data obtained from annual reports in the period from 2019 to 2021.

The results of the aforementioned analyzes showed that the corona virus pandemic had a significant impact on the activities of occupational therapy, which was reflected in the dynamic engagement of occupational therapists including on tasks jobs that they were not engaged in before the pandemic, as well as the need for innovative approaches in meeting the needs of the beneficiaries of nursing home accommodation services. This work has shown that occupational therapy represents an important segment of the daily activities of beneficiaries of the nursing home and that the activities of occupational therapy have risen to a higher level due to a flexible approach to meeting the needs of the beneficiaries during the corona virus pandemic.

Keywords: *pandemic, corona virus, work-occupational therapy, beneficiaries, gerontology*

Introduction

At the end of 2019, an epidemic of the SARS-CoV-2 virus, better known as the corona virus, broke out in China, which soon turned into a global crisis, and in January 2020, the World Health Organization declared the epidemic a public health threat of international importance (Cruz et al., 2021; Mahase et al., 2020). Soon after, in March 2020, the World Health Organization declared the new corona virus a global pandemic and called on governments to take urgent and vigorous measures to reduce the consequences of the spread of this highly contagious virus. The first cases of corona virus patients were recorded in the Republic of Serbia at the beginning of March, and not long after, on March 15, 2020, a state of emergency was declared due to the corona virus pandemic by the Decision on Proclamation of a State of Emergency (Government of the Republic of Serbia, 2020).

The current pandemic caused by the corona virus has a significant impact on the functioning of accommodation facilities around the world, and the Republic of Serbia is no exception. Increased mortality rates in adult careelderly care and facilities internationally (Thompson et al., 2020) led to the introduction of control measures and restrictions that applied to both service users and staff. The Ministry of Labor, Employment, Veterans and Social Affairs of the Republic of Serbia, starting from March 10, 2020, passed a series of acts related to the epidemiological situation caused by the corona virus. The acts were aimed at implementing hygienic and protective measures, rules of conduct in social welfare institutions, organizing work schedules and working hours of employees, limiting visits, gatherings and movements, which directly affected the quality of life of users of home accommodation services.

The impact of the corona virus pandemic was particularly reflected in the social life of the users and the implementation of the content of work-occupational therapy within the institution for the accommodation

of adults and older persons, the aim of which is to motivate the users to participate in individual and group activities that are in line with their interests, physical and cognitive abilities (Chimento-Díaz et al., 2022; Radulj et al., 2018; Richardson et al., 2022). Therefore, the aim of this work is to examine the impact of the corona virus pandemic on occupational therapy activities within the Gerontology Center Belgrade, RJ Home “Bežanijska kosa” through a questionnaire, direct conversation with users of home accommodation services, lived experiences, as well as through comparative presentation of the activities of occupational therapists before and during the corona virus pandemic.

1. Materials and Methods

1.1. Respondent population

The population of respondents that was included in the research, in the time period from August to September 2022, consisted of users of home accommodation services within the Gerontological Center Belgrade, RJ Dom “Bežanijska kosa”. The research involved 80 beneficiaries who are in accommodation ranging from 2 months to 324 months, while the median period of accommodation was 48 months. Out of a total of 80 users, 53 users (66%) were accommodated in an apartment facility (accommodation facility A) which is intended for housing mobile and mentally preserved persons, while 27 users (34%) were accommodated in a stationary facility (accommodation facility B) which is intended for accommodation of semi-dependent and dependent persons.

1.2. Data collection

Data for the research were collected on the basis of anonymous questionnaires, as well as annual reports of work-occupational therapy. The goal of this double acquisition of data was to see to what extent the corona virus pandemic had an impact on the activities of occupational therapists through annual reports, while the questionnaires aimed to show the impact of the pandemic on the activities of users within occupational therapy.

1.2.1. Questionnaires

The questionnaire was grouped into three units that included biographical data and length of stay in the home, occupational therapy activities before the corona virus pandemic, as well as questions aimed at further improvement of occupational therapy activities. The questions used in the questionnaire are shown in Table 1. Questions numbered 4, 5, 8, 13 and 17 were open-ended, while the other questions were rounded. Questionnaire

data were collected by occupational therapists from the “Bežanijska Kosa” Home, who have many years of experience in working with adults and older persons in the framework of social protection.

Table 1. Questions used in the questionnaire

no. question

1. At which facility are you staying?
2. What gender are you?
3. List the years of life?
4. Years of residential care?
5. How did you become familiar with the contents of work-occupational therapy?
6. If you do not attend the contents of work-occupational therapy, state the reasons:
7. Do you think that the contents of work-occupational therapy were significant for your stay in the Home before the corona virus pandemic?
8. How did you complete your free time in the Home before the corona virus pandemic?
9. Which facilities in the Home gave you the greatest pleasure before the corona virus pandemic?
10. Do you think that the corona virus pandemic has affected your involvement in work-occupational therapy activities?
11. Are there any contents of work-occupational therapy that you missed during the corona virus pandemic?

12. Do you think that the contents of occupational therapy were significant for your stay in the Home during the corona virus pandemic?
13. How did you complete your free time at the Home during the corona virus pandemic?
14. Did modern technologies (mobile phone, computer, internet, social networks, etc.) enable you to maintain contact with family members and friends in an easier way during the corona virus pandemic?
15. Do you consider it necessary to improve your knowledge when using modern technology (mobile phone, computer, Internet, social networks, etc.)?
16. Should new activities be designed in addition to the existing work-occupational activities?
17. If you have a proposal, suggestion, remark, etc., please state:

1.2.2. Annual reports of work-occupational therapy

The annual occupational therapy reports of the Gerontological Center Belgrade, RJ Dom “Bežanijska kosa”, whose purpose is to show the set of annual activities of occupational therapists, were analyzed for the period from 2019 to 2021. The reports contain information on group and individual work with users, the way sections are conducted, thematic gatherings as well as cultural and entertainment events, while there is also information on work assignments in accordance with epidemiological measures. Reports are drawn up at the end of the year by occupational therapists and submitted to the housing services specialist.

2. Results

2.1. Questionnaires

The population of respondents that was included in the research consisted of 29 persons (36%) of male gender and 51 persons (64%) of female gender. The age group of users from 76 to 85 years old, which had 41 respondents (51%), represented the most represented group, while the other groups under 65 years old, from 66 to 75 years old and over 86 years old had 8 (10%), 17 (21%) and 14 (18%) respondents, respectively. When asked about the method of familiarization with the content of occupational therapy, the users most often stated that they were introduced to it by an occupational therapist, while there were also answers such as conversations with other users, bulletin boards and information from a social worker. Out of a total of 80 respondents, 41 respondents (51%) declared that they visit the contents of work-occupational therapy, while 8 (10%), 3 (4%) and 11 (14%) users declared that they do not visit them due to their health condition, lack of information and lack of interest, respectively. In addition to the aforementioned reasons, users in 21% of cases stated that the fear of infection and independent organization of daily activities were the reasons why they did not regularly visit occupational therapy facilities. Figure 1 shows the distribution of users' answers to questions number 7, 10, 12, 14 and 15. A total of 47 users (59%) answered that the contents of occupational therapy were significant for their stay in the Home before the corona virus pandemic, while 11 users (14%) did not respond because their accommodation was not realized in the period preceding the pandemic. The corona virus pandemic had a significant impact on engagement in occupational therapy activities in 64% of cases (51 users), although in 59% of cases (47 users) respondents declared that the contents of occupational therapy were significant for their stay in the Home during pandemic. Modern technologies contributed to 84% of respondents (67 users) maintaining contact with

family members and friends in an easier way during the pandemic, however, only 44% of respondents (35 users) consider it necessary to improve their knowledge in this area. Figure 2 shows the answers to questions number 11 and 16. It can be noted that 55 users (69%) declared that they lacked the contents of work-occupational therapy during the pandemic, while 23 users (29%) believe that it is necessary in addition to introduce existing and new activities. From Table 2, it can be seen that before the corona virus pandemic, users most often completed their free time through cultural and entertainment activities, trips to the library, thematic gatherings, creative workshops, excursions and walks, and that, in accordance with the restrictions introduced, more numerous and more frequent beneficiaries' gatherings are most often proposed.

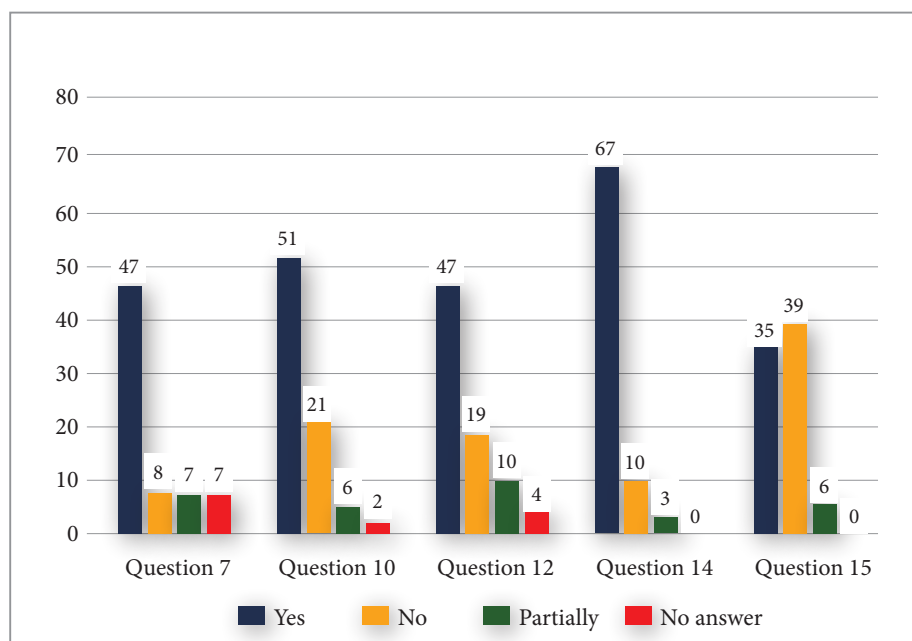


Figure 1. Distribution of user responses to questions number 7, 10, 12, 14 and 15

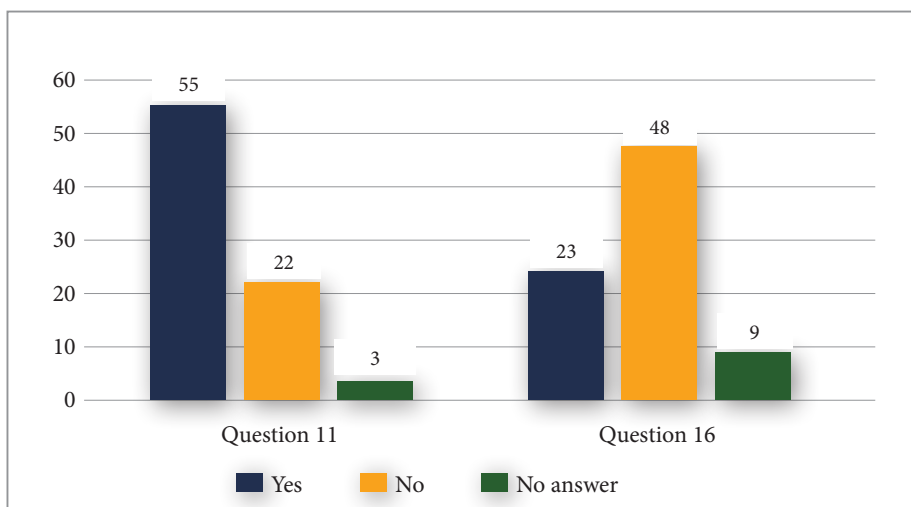


Figure 2. Distribution of user responses to questions number 11 and 16

Table 2. Questions used in the questionnaire

no.	number of answers [%]	The most frequent answers to the question
question 8	71%	Cultural and entertainment activities, trips to the library, creative workshop, excursions and walks
question 9	69%	Cultural and entertainment facilities, sports and recreational facilities, workshops, group work through thematic gatherings
question 17	80%	Satisfaction with the current contents with the proposal to implement more numerous and frequent gatherings of users

2.2. Annual reports of work-occupational therapy

Based on the annual report from 2019, that is, before the corona virus pandemic, the daily activities of occupational therapists were focused on individual and group work with users of inpatient and apartment facilities. An individual approach aimed to assess interest and affinity towards certain areas, based on which future activities for users were planned for the purpose of structuring free time as successfully as possible. Newspa-

pers were delivered daily and users were accompanied when they went to the store, pharmacy or post office, which are available in the Home. Group work, in addition to the creative, hobby and decoupage workshop, was held in the form of therapeutic gatherings, through the reading of passages from literary works, the processing of cultural topics and conversations about everyday topics, as well as through the choral, literary and flower section. Organized sports and recreational activities included the accompanying of users by occupational therapists on trips and events outside the Institution. Various cultural and entertainment programs were reflected in concerts, performances, presentations, film screenings, theater performances and literary meetings in the cinema hall of the House, as well as visits to cultural institutions. Intergenerational cooperation was maintained with children from kindergartens, primary and secondary schools. Traditional cultural and entertainment manifestations and religious holidays were celebrated with thematic exhibitions of the users' handicrafts inside the Home, as well as in other institutions. In accordance with the epidemiological situation, according to reports from 2020 and 2021, individual and group occupational therapy had the majority of activities in certain parts of the year, as before the state of emergency, while preventive protection measures were mandatory for participation in activities. The number of users in the premises of the Home was strictly taken into account, with the mandatory wearing of protective masks by occupational therapists and users. In accordance with the epidemiological situation, cultural and entertainment events were held periodically and on a reduced scale. For the purpose of support and success in overcoming the newly created situation, users were provided with the necessary information every day, while in cooperation with a psychologist, a billboard with messages of psychological support was created. During the period of the user's isolation, psychological support was provided through telephone conversations and the delivery of handicraft materials, books and daily newspapers. Online shopping and trips to stores outside the Home were organized by occupational therapists for users who were not able to

do the same with the involvement of relatives or other important persons. Reception, disinfection and delivery of packages to users, which included medicines, diapers, food and other essentials, were part of the daily activities of occupational therapists. In the period when work duties were organized in the form of 15-day shift work, i.e. isolation within the Home, cooperation was achieved through viber groups with parents of elementary school children, which contributed to the creation of greeting cards for all users on the occasion of the Easter holidays. When conducting visits to users, which are organized outdoors or in specially designated rooms, an integral part of the work duties included activities in the form of keeping records of the visits, measuring the body temperature of visitors, monitoring the number of persons present and observing preventive protection measures. Users are provided daily support when establishing contact with family members and other persons, through telephone or video calls. In this period, a new workshop, ie a tailoring salon, was formed. In accordance with the epidemiological situation, film screenings were broadcast in the cinema hall, the designated seating areas were specially marked with the aim of maintaining the necessary distance in a closed room. Traditional cultural and entertainment manifestations and religious holidays were celebrated in accordance with the epidemiological situation, with the presence of a small number of people and with strict adherence to preventive protection measures.

3. Discussion

This paper presents and analyzes the impact of the corona virus pandemic on occupational therapy activities within an institution for the accommodation of adults and older persons. From the previously presented results, it can be noted that the corona virus pandemic had a significant impact on occupational therapy activities. According to the annual report prepared before the corona virus pandemic, the activities carried out at the “Bežanijska kosa” Home included frequent and diverse contents that were in line with the interests of a large number of users. With the new epidemiological situation, according to the reports from 2020 and 2021, activities of cultural and entertainment content and work-occupational therapy were realized in certain periods of the year, but with a special emphasis on preventive protection measures that were mandatory for participation. In periods when visits to users could not be realized, a significant part of the activities of occupational therapists included helping users to establish phone conversations and video calls with close family members and other important persons. In addition, 1) purchase and delivery of medicines, diapers and other foodstuffs, 2) receiving, checking and disinfecting packages delivered by relatives and other persons, 3) carrying out control in the form of measuring the body temperature of visitors and observing preventive protection measures in periods when visits to users were carried out, they represented activities that were carried out during the largest period of working hours, which directly resulted in the reduction of activities in the field of work-occupational therapy. This statement is directly correlated with the responses of users from the questionnaire, who most often stated that the corona virus pandemic affected their engagement in occupational therapy activities due to the fact that the activities were carried out only in certain periods of the year, i.e. in accordance with the epidemiological situation in the Home. The majority of users declared that the contents of occupational therapy were significant for their stay in the Home before the

corona virus pandemic, which is related to the variety of contents that were available to users of various interests on a daily basis. The users most often answered that they completed their time in the Home before the pandemic through various cultural and entertainment activities, trips to the library, creative workshops, excursions and walks, however, during the pandemic, most of the mentioned activities could not be held or took place with certain restrictions, which significantly affected the social life of users. Based on these analyses, and oral conversations, both with users and with employees, it was noticed that there was a lack of cultural and entertainment content and group gatherings to the greatest extent. In the absence of continuous direct work with users by occupational therapists, a significant increase of users who independently completed their free time during the pandemic with various activities such as: independent trips to workshops, playing social games with other users, growing flowers independently, writing poetry, painting etc. The corona virus pandemic has clearly shown that, in addition to numerous occupational therapy activities, it is necessary to introduce training for the purpose of mastering modern technologies. Almost half of the respondents consider it necessary to improve their knowledge in order to use modern technologies more effectively, which is a clear guideline for further improvement of occupational therapy.

4. Conclusion

This paper presents an original research on the impact of the corona virus pandemic on work-occupational therapy activities within the Gerontology Center Belgrade, RJ Dom “Bežanijska kosa”. The corona virus pandemic had a significant impact on the activities of occupational therapy, which was reflected in the dynamic engagement of occupational therapists and in jobs that were not represented before the pandemic. Occupational therapy is a flexible discipline that is adaptable to the changes caused by the corona virus pandemic. There is a need for innovative approaches in meeting the needs of users of home accommodation services. Based on the obtained research results, the user’s need for improving knowledge in the field of managing modern technologies is observed, which represents a clear guideline for the future improvement of content and activities within occupational therapy. The goal of further research will be a deeper study of the effects of the pandemic on the social life of users, as well as on the organization and implementation of occupational therapy by occupational therapists in the post-covid era.

References

- Chimento-Díaz, S., Espino-Tato, I., Garcia-Alonso, J. M., & Cantero-Garlito, P. A. (2022). Lessons learned: Occupational therapy in nursing homes during the first wave of COVID-19 in Spain. *Healthcare (Basel)*, 10(1), 117. <https://doi.org/10.3390/healthcare10010117>
- Richardson, G., Cleary, R., & Usher, R. (2022). The impact of the COVID-19 restrictions on nursing home residents: An occupational perspective. *Journal of Occupational Science*, 29(3), 386-401. <https://doi.org/10.1080/14427591.2022.2066158>
- Mahase, E. (2020). China coronavirus: WHO declares international emergency as death toll exceeds 200. *BMJ*, 368, 408.
- Palacios Cruz, M., Santos, E., Velázquez Cervantes, M., & León Juárez, M. (2021). COVID-19, a worldwide public health emergency. *Revista Clínica Española*, 221, 55-61.
- Thompson, D. C., Barbu, M. G., Beiu, C., Popa, L. G., Mihai, M. M., Berteanu, M., & Popescu, M. N. (2020). The impact of COVID-19 pandemic on long-term care facilities worldwide: An overview on international issues. *BioMedical Research International*, 2020, Article 8870249. <https://doi.org/10.1155/2020/8870249>
- Vlada Republike Srbije. (2020). Proglašeno vanredno stanje na teritoriji čitave Srbije. Retrieved from <https://www.srbija.gov.rs/vest/451323/proglaseno-vanredno-stanje-na-teritoriji-citave-srbije.php>
- Radulj, V., Obradović, J., Džaković, M., & Mijić, P. (2018). Potrebe starijih za struktuiranjem slobodnog vremena. In *Tematski zbornik sa X međunarodnog gerontološkog kongresa Starenje i ljudska prava 2018* (pp. 187-194).

UTICAJ PANDEMIJE KORONA VIRUSA NA AKTIVNOSTI RADNO-OKUPACIONE TERAPIJE U OKVIRU USTANOVE ZA SMEŠTAJ ODRASLIH I STARIH LICA

**Katarina Krajinović, Jasmina Obradović, Predrag Mijić,
Srđan Atanacković, Vlado Radulj**

Rezime

Trenutna pandemija uzrokovana korona virusom ima značajan uticaj na funkcionisanje ustanova za smeštaj širom sveta, a Republika Srbija nije izuzetak. Svetska zdravstvena organizacija je u martu 2020. godine, proglasila novi KOVID -19 s globalnom pandemijom i pozvala vlade da preduzmu hitne i energične mere, kako bi se umanjile posledice širenja ovog vrlo zaraznog virusa. Stoga, cilj ovog rada je da se ispita uticaj pandemije korona virusa na aktivnosti radno-okupacione terapije u okviru Ustanove Gerontološki centar Beograd, RJ Dom „Bežanijska kosa“. Uticaj pandemije je analiziran kroz nestandardizovan upitnik, neposredan razgovor sa korisnicima usluga domskog smeštaja, proživljena iskustva, kao i kroz komparativni prikaz aktivnosti radnih terapeuta pre i tokom pandemije korona virusa. Analiza upitnika se sproveda grupisanjem pitanja u tri celine koje obuhvataju biografske podatke i dužinu boravka u domu, aktivnosti radno-okupacione terapije pre pandemije korona virusa, kao i pitanja koja su usmerena na dalje unapređenje aktivnosti radno-okupacione terapije.

Aktivnosti radnih terapeuta pre i tokom pandemije prikazane su kroz analizu realizovanih aktivnosti na osnovu podataka dobijenih iz godišnjih izveštaja u periodu od 2019. do 2021. godine.

Rezultati napred navedenih analiza su pokazali da je pandemija korona virusa značajno uticala na aktivnosti radno-okupacione terapije, što se ogledalo u dinamičnom angažovanju radnih terapeuta i na poslovima koji nisu bili zastupljeni pre pandemije, kao i da se pojavila potreba za inovativnim pristupima u zadovoljavanju potreba korisnika usluga domskog smeštaja. Ovim radom je pokazano da radno-okupaciona terapija predstavlja bitan segment svakodnevnih aktivnosti korisnika domskog smeštaja i da su se aktivnosti radno-okupacione terapije podigle na viši nivo usled fleksibilnog prilaza zadovoljavanju potreba korisnika domskog smeštaja za vreme pandemije korona virusa.

Ključne reči: *pandemija, koronavirus, radno-okupaciona terapija, korisnici, gerontologija*