ANDRAGOŠKA SPOZNANJA

Studies in Adult Education and Learning

Vsebina/Contents

Poročila, odmevi, ocene/Reports, Replies, Reviews

Andragoška spoznanja/Studies in Adult Education and Learning, 2021, 27(2), 3-13
DOI: https://doi.org/10.4312/as/10406

UVODNIK

IZOBRAŽEVANJE ODRASLIH NA PODROČJU ZDRAVJA: POMEN DRUŽBENOKULTURNIH DIMENZIJ IN INTERDISCIPLINARNOSTI

Izobraževanje odraslih na področju zdravja postaja vedno bolj obsežno polje v andragogiki ter drugih družboslovnih, humanističnih in medicinskih vedah (English, 2012; Nutbeam, 2019; Wang, 2014), kar se med drugim odraža v samostojnih revijah (npr. *Health Education Journal*), interdisciplinarno zasnovanih razpravah o raziskovanju, kot npr. v *Social Theory and Health Education* (Leahy idr., 2020), v mednarodnih projektih (npr. *Last Aid*), mnogovrstnosti praks in tudi v pestrosti poimenovanj: zdravstvena vzgoja, izobraževanje za zdravje, zdravstveno izobraževanje, vzgoja in izobraževanje za zdravje, razvoj zdravstvene pismenosti ali zdravstveno opismenjevanje, ozaveščanje o zdravju.

Temeljni namen vseh teh dejavnosti je razvoj zmožnosti, da ljudje ohranjajo zdravje in se ob težavah z zdravjem informirano odločajo. S tem mislimo na razvoj zmožnosti pri različnih skupinah (mlajši odrasli, starejši odrasli, splošna javnost), da pridobivajo, razumejo in uporabijo informacije, pomembne za odločanje in ravnanje, povezano z zdravjem (Nutbeam idr., 2019, str. 1). Z besedno zvezo *vzgoja in izobraževanje za zdravje* poimenujemo vse procese oblikovanja/vzgajanja in spodbujanja človeka-v-okolju z namenom, da razvija zmožnosti emocionalnega, kognitivnega in somatskega učenja ter ravnanja z zdravjem ali boleznijo. Vzgoja in izobraževanje za zdravje je holističen proces, vključuje celotno osebo in njeno okolje. To torej ni proces, ki bi bil ločen od okolja. Sodobne teoretske paradigme in praktične aktivnosti so osredotočene na to, da vzgoja in izobraževanje kot proces in kot dejavnost, ki naj prispevata k zdravju ljudi ali uravnavanju bolezni, izhajata iz družbenokulturnih okoliščin. To pomeni, da morajo izobraževalci poznati širši družbenokulturni kontekst, politične in ekonomske značilnosti posameznega okolja in tudi njegove biološke ter okoljske razsežnosti. Poleg makroelementov morajo tako poznati tudi tradicijo, znanje, navade tiste skupine, za katero pripravljajo izobraževalne programe, ter značilnosti posameznika (Gilbert idr., 2015; Leahy idr., 2020; Willis idr., 2014). Ker so vsi ti makro- in mikroelementi, odnosi in procesi del družbenokulturnega sistema, je treba o njih tudi kritično misliti. To implicira, da se zavedamo različnega razumevanja pojmov zdravje, bolezen in zdravljenje, na kar opozarjajo medicinski antropologi.

Doživljanje in razumevanje zdravja je torej odvisno od družbenokulturnega okolja. Prav tako pa je odvisno od teoretskih interpretativnih vzorcev. Za interpretativno ogrodje se

vedno pogosteje uporabljajo integrativni bio-psiho-socialni modeli, med katere uvrščamo model salutogeneze, ki v ospredje postavlja procese spodbujanja zdravja. To velja tudi za takšne situacije, ki so povezane s kroničnimi boleznimi, travmami, primanjkljaji, ovirami. V razpravah srečamo tudi koncepte, kot sta trdoživost (*resilience*) in blagostanje (*well-being*).

Vzgoja in izobraževanje za zdravje sta namenjena različnim ciljnim skupinam: tako tistim, ki imajo težave z zdravjem, kot tistim, ki naj bi se izognile težavam na tem področju. Poseben izziv so programi za izobraževanje posebnih ciljnih skupin, kot so manjšine, migranti, starejši, ter posebne tematike, npr. izobraževanje za higieno ustne votline, promocija zgodnjega odkrivanja in zdravljenja raka dojk, detabuizacija težav v duševnem zdravju, ozaveščanje o rabi kontracepcije, izobraževanje pri pripravi na porod in druge vrste izobraževanja staršev (gl. Lauzon in Farabakhsh, 2014; Silberberg, 2020). S sodobnimi demografskimi spremembami, kot so migracije, se odpirajo še dodatne tematike, npr. vprašanja o izobraževanju za sporazumevanje, vprašanja o večkulturnih stikih s tujejezičnimi bolniki v zdravstvenih ustanovah (gl. Pokorn in Lipovec Čebron, 2019).

Izobraževanje za zdravje je v svojem razvoju prešlo različne faze. Najprej je bilo namenjeno predvsem preventivnim programom, s katerimi so se ljudje opolnomočili za odločanje in ravnanje pri ohranjanju zdravja (npr. spoštovanje pravil higiene, skrb za doječe matere in novorojenčke), pozneje pa se je razvilo v izobraževanje za zdravje, ki je zasnovano z namenom formiranja ali transformiranja navad in praks v vsakdanjem življenju (npr. zdrava prehrana in gibanje). Poleg preventivnih programov se razvijajo tudi programi, ki so namenjeni spoprijemanju z boleznijo ter razvoju novih veščin in navad (npr. razvoj prehranskih navad pri diabetesu). Naslednja značilnost v razvoju izobraževanja za zdravje je povezovanje različnih akterjev pri pripravi programov. Povezujejo se izobraževalni in zdravstveni sistem, sistemi politike in upravljanja, sistem dela. Nosilci izobraževanja, učenja in promoviranja so različni. Prav tako so zelo raznolike strategije izobraževanja, ki se približujejo skupnostnemu izobraževanju in načelom skupnostne psihologije (Francescato idr., 2020; Seedat idr., 2017).

Ob vsem tem se zastavlja tudi vprašanje raziskovalnih strategij. Raziskave so v preteklosti slonele predvsem na pozitivistični paradigmi, v sodobnosti pa se porajajo novi kvalitativni in postkvalitativni pristopi (Cardano idr., 2020). Sprašujemo se, kako v raziskovanju in razvoju izobraževanja odraslih na področju zdravja odsevajo t. i. obrati: narativni obrat, afektivni obrat. Kakšna je uporaba avtoetnografije, biografske metode, narativnih metod? Kakšna je vloga akcijskega raziskovanja in participatornega akcijskega raziskovanja glede na poststrukturalistično teorijo prakse? Kako na raziskovanje in razvoj vzgojno-izobraževalnih programov za zdravje vplivajo »neoliberalni časi« in težnje po komodifikaciji zdravja, izobraževanja? Kako na izobraževanje za zdravje vplivajo pritiski, da bi »šibkosti« nekaterih ljudi in skupin razumeli kot nekaj samoumevnega in odvisnega zgolj od njih samih? Če sprejmemo ugotovitve, da je znanje družbenokulturno umeščeno, kakšne so epistemološke, didaktične, etične posledice in implikacije za načrtovanje raziskav in izobraževalnih programov? Ali raziskovalne strategije dajejo glas vsem vključenim v

vzgojo in izobraževanje za zdravje? Kako na izobraževalne programe vplivajo intersekcijske neenakosti in ali jih v raziskavah zaznamo?

Družbenokulturni, politični in ekonomski vidiki so zelo pomembni za razumevanje odzivanja prebivalcev na bolezni, okužbe, epidemije ter za analiziranje ukrepov, na katere se skupine ljudi različno odzivajo. Nekatere skupine v času epidemije covida-19, ki povzroča velike kognitivne disonance in negotovosti, iščejo referenčne točke, ki bi pomagale pri urejanju kaotičnosti, tudi tako, da se zatečejo v popačeno interpretacijo znanstvenih spoznanj. Vsi ti izzivi implicirajo razmislek o razmerjih med zdravjem in znanjem, spretnostmi, navadami, učenjem, epistemološkimi sistemi ipd. Razmisliti je treba o temah, kot so: družbenokulturni vidiki zdravja, bolezni in zdravljenja, vloga skupnosti v izobraževanju odraslih za zdravje ter vloga skupnostnega učenja in izobraževanja pri spoprijemanju z zdravstvenimi težavami.

V tej tematski številki je odnos med izobraževanjem in zdravjem/boleznijo osvetljen *z dveh zornih kotov*. Prvi obravnava vpliv izobraževanja, vključenosti v izobraževalne programe na zdravje in dobro počutje. Vključenost mlajših odraslih in starejših odraslih v izobraževanje vpliva na dobro počutje in zdravje. Izobraževanje, ki ga izvajajo na švedskih ljudskih univerzah in je namenjeno ljudem z avtizmom, prispeva k rehabilitaciji in predstavlja podporno okolje. Hedegaard, Hugo in Bjursell v članku *Ljudska univerza kot spodbudno okolje za udeležence z visoko funkcionalnim avtizmom* ugotavljajo, da je izobraževanje za udeležence z avtizmom pozitivno z vidika udeležencev, zaposlenih in ravnateljev. Meulenberg v prispevku *Dvojezičnost in jezikovno izobraževanje za izboljšanje kognitivnega zdravja starejših ljudi* analizira vpliv dvojezičnosti in implikacije za jezikovno izobraževanje starejših, saj lahko k zdravemu staranju pripomore tudi aktivna raba več jezikov. Formosa v svojem članku *Zbiranje dokazov o vplivu učenja starejših odraslih na aktivno staranje: kvantitativna študija* pa predstavlja rezultate študije o tem, da ima učenje starejših močan pozitiven vpliv na dejavno staranje, saj učenje blaži socialno izolacijo in kognitivno slabitev. Izobraževanje v starosti prispeva k boljšemu zdravju, telesnemu in duševnemu blagostanju.

Drugi zorni kot razmerja med zdravjem in izobraževanjem odpira pogled na izobraževanje, ki je ciljno pripravljeno z namenom izboljševanja znanja o zdravju/bolezni. Prosen in Ličen v članku *Izboljševanje zdravstvene pismenosti nosečnic z uporabo sodobnih pristopov v zdravstveni vzgoji: integrativni pregled literature* razčlenita koncept zdravstvene pismenosti kot ključne socialne determinante zdravja ter razmišljata o sodobnih pristopih zdravstvene vzgoje za nosečnice v t. i. razvitem svetu. Ugotavljata, da je proces posodabljanja zdravstvene vzgoje prepočasen in premalo progresiven. Podobno ugotavlja tudi Švab o vlogi splošnih knjižnic, ki bi lahko bile zelo pomembni akterji pri ozaveščanju javnosti o zdravju in tudi o lažnih novicah, ki so z njim povezane. Avtorica članka *Zdravstveni kotički in izobraževanje za zdravje v splošnih knjižnicah* je v svoji raziskavi analizirala prednosti in pomanjkljivosti delovanja zdravstvenih kotičkov v slovenskih splošnih knjižnicah. Zapiše, da so poseben izziv pri načrtovanju in izvajanju izobraževanja za zdravje informacijsko slabše pismeni prebivalci, zato bi morali zdravstveni kotički razviti

nove strategije delovanja, ki bi se približale različnim ciljnim skupinam. Posebno področje za načrtovanje izobraževalnih programov so teme, ki so v našem kulturnem okolju še vedno tabuizirane. Taka tema je umiranje. Zelko, Jakšič in Krčevski Škvarč v svojem članku *Ozaveščanje javnosti o paliativni oskrbi: evalvacija tečaja Zadnja pomoč (Last Aid) v Sloveniji* opisujejo izkušnje iz mednarodnega projekta skupnostnega izobraževanja o paliativni oskrbi, ki ga izvajajo v 18 državah, in sicer podajajo predvsem evalvacijo programov Zadnja pomoč v Sloveniji. Pomembno vlogo v vzgoji in izobraževanju za zdravje imajo tudi zdravstveni delavci. Lipovec Čebron in Huber sta v članku *Evalvacija kulturnih kompetenc na področju zdravstva: Zakaj je potrebno vpeljati kvalitativne pristope?* predstavili različne poskuse merjenja kulturnih kompetenc v zdravstvu. Na podlagi primerov iz tujine in Slovenije sta dokazovali, kako pomembno je na tem področju dopolnjevanje kvantitativnih metod s kvalitativnimi ter kako potrebno je premakniti pozornost od merjenja kulturnih kompetenc posameznih zdravstvenih delavcev k evalvaciji celotnega izobraževanja in njegovih izvajalcev.

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LITERATURA IN VIRI

Cardano, M., Giarelli, G. in Vicarelli, G. (ur.). (2020). *Sociologia della salute e della medicina*. Il Mulino.

English, L. (ur.). (2012). *Adult education and health*. University of Toronto. https://doi.org/10.3138/9781442685208

Francescato, D., Tomai, M. in Ghirelli, G. (2020). *Fondamenti di psicologia di comunità*. Carocci.

Gilbert, G., Sawyer, R. in McNeill, E. (2015). *Health education: Creating strategies for school and community health*. Jones & Bartlett Learning.

Lauzon, A. in Farabakhsh, R. (2014). The power of collaborative inquiry and metaphor in meeting the health literacy needs of rural immigrant women: A case of parent education. V V. Wang (ur.), *Handbook of research on adult and community health education: Tools, trends, and methodologies* (str. 51–67). IGI Global. https://doi.org/10.4018/978-1-4666-6260-5.ch004

Leahy, D., Fitzpatrick, K. in Wright, J. (ur.). (2020). *Social theory and health education: Forging new insights in research*. Routledge. https://doi.org/10.4324/9781351048163

Nutbeam, D. (2019). Health education and health promotion revisited. *Health Education Journal*, *78*(6), 705–709. https://doi.org/10.1177/0017896918770215

Nutbeam, D., Levin-Zamir, D. in Rowlands, G. (ur.). (2019). *Health literacy in context: Settings, media, and populations*. MDPI. https://doi.org/10.3390/books978-3-03897-472-7

Pokorn, N. in Lipovec Čebron, U. (ur.). (2019). *Večjezično zdravje: Komunikacijske strategije in večkulturni stiki s tujejezičnimi bolniki v slovenskem zdravstvenem sistemu*. Znanstvena založba Filozofske fakultete Univerze v Ljubljani. https://doi.org/10.4312/9789610601364

Seedat, M., Suffla, S. in Christie, D. (ur.). (2017). *Emancipatory and participatory methodologies in peace, critical, and community psychology*. Springer. https://doi.org/10.1007/978-3-319-63489-0

Silberberg, M., Muhlbaier, L., Hart-Brothers, E., Weaver, S. in James, S. (2020). The role of socioeconomic status in a community-based study of diabetes secondary prevention among African

Americans. *International Journal of Health Promotion and Education.* https://doi.org/10.1080/14635240.2020.1866999

Wang, V. (ur.). (2014). *Handbook of research on adult and community health education: Tools, trends, and methodologies.* IGI Global. https://doi.org/10.4018/978-1-4666-6260-5

Willis, C. D., Saul, J. E., Bitz, J., Pompu, K. in Jackson, B. (2014). Improving organizational capacity to adress health literacy in public health: A rapid realist review. *Public Health*, *128*(6), 515–524. https://doi.org/10.1016/j.puhe.2014.01.014

Andragoška spoznanja/Studies in Adult Education and Learning, 2021, 27(2), 3-13
DOI: https://doi.org/10.4312/as/10406 Editorial

EDITORIAL

ADULT EDUCATION IN THE FIELD OF HEALTH: THE IMPORTANCE OF SOCIO-CULTURAL DIMENSIONS AND INTERDISCIPLINARITY

Adult education in the field of health is becoming increasingly relevant in andragogy as well as in other social sciences, humanities, and medical sciences (Nutbeam, 2019; Wang, 2014; English, 2012). This is also reflected in publications such as the *Health Education Journal*, interdisciplinary approaches to research such as *Social Theory and Health Education* (Leahy et al., 2020), international projects such as Last Aid, many diverse practices as well as a variety of terms including health education, education for health, developing health literacy, and health awareness.

The central purpose of all these activities is to develop people's abilities to take care of their health or to be able to make informed choices when it comes to health problems. This refers to developing the abilities of diverse groups (younger adults, older adults, the general public) to acquire, understand and use information that affects their choices and their actions when it comes to health (Nutbeam et al., 2019, p. 1). The term *education for health* refers to all the processes of forming/educating and encouraging a person within an environment to develop emotional, cognitive and somatic learning abilities as well as health or illness management. Education for health and well-being is a holistic process that includes the entire person and their environment. It is not a process that is separate from one's environment. Contemporary theoretical paradigms and practical activities are focused on the fact that education as a process and as an activity that benefits people's health or illness management stems from their socio-cultural circumstances. This means that educators must be knowledgeable about the wider socio-cultural context, the political and economic circumstances of a particular environment, its biological and environmental dimensions. Besides the macro elements, educators must also be familiar with the traditions, the knowledge and the habits of the group they are preparing educational programmes for, as well as the characteristics of individuals (Leahy et al., 2020; Gilbert et al., 2015; Willis et al., 2014). Because all of these macro and micro elements, relationships and processes are part of the socio-cultural system, they also need to be considered and given critical thought. As medical anthropologists have pointed out, this

implies that we are aware of the different ways terms like health, illness and treatment are understood.

How we experience and understand health depends on our socio-cultural environment as well as on theoretical interpretative patterns. An increasingly used interpretative framework is the integrative biopsychosocial model, which includes the salutogenic model, highlighting the processes that support health. This also applies to situations linked to chronic illness, trauma, deficit, and impairment. Studies in this field also feature concepts such as resilience and well-being.

Education for health is meant to serve various target groups: those facing health problems as well as those trying to prevent them. Specific challenges need to be addressed in health education programmes with target groups such as minorities, migrants, the elderly, as well as programmes on specific topics, for example, oral hygiene, promoting early detection and treatment for breast cancer, breaking the stigma attached to mental health problems, raising awareness about contraception, education about childbirth and other forms of education for parents (cf. Lauzon & Farabakhsh, 2014; Silverberg, 2020). Modern demographic changes such as migration open up questions, for example, about communication education, multicultural contact with foreign language speaking patients in health institutions (cf. Pokorn & Lipovec Čebron, 2019).

Education for health has gone through different phases of development. At first it was centred on prevention programmes, empowering people to make decisions and take action to stay healthy (e.g., following the rules of good hygiene, care for nursing mothers and new-borns), and later developed into education for health focused on forming or transforming habits and practices in everyday life (e.g., a healthy diet, exercise). Additionally, programmes for managing illness and developing new skills and habits (e.g., dietary habits for diabetes) were also developed. A significant element of education for health is also connecting the different actors involved in setting up these programmes: education systems and healthcare systems, the systems of politics and government, the systems of work. There are many educators and promoters in this field, as well as a variety of educational strategies that often come close to community education and the principles of community psychology (Francescato et al., 2020; Seedat et al., 2017).

All this also raises the question of research strategies. Past research was predominantly based on the positivist paradigm, while contemporary research has also utilised new qualitative and post-qualitative approaches (Cardano et al., 2020). Another question concerning adult education in the field of health is also how its research and development reflect the narrative and the affective turn. How does it use autoethnography, the biographical method, narrative methods? What is the role played by action research and participatory action research in the frame of poststructuralist theory? How are research and development of health literacy programmes affected by neoliberalism and the tendency to commodify health and education? How is education for health affected by the pressures to understand the ‘weaknesses’ of certain people and groups as something that is taken as a

given and as dependent solely on themselves? If we accept the idea that knowledge is embedded in society and culture, what epistemological, didactic and ethical consequences and implications does this have for planning research and educational programmes? Do research strategies give a voice to everyone involved in education for health? How does the intersectional nature of inequality affect educational programmes and is it detected in research?

Socio-cultural, political and economic aspects are all very important when it comes to understanding how people respond to illness, infection, pandemic, and in order to analyse the measures which different groups of people react to in different ways. In the time of the pandemic, which has caused a great deal of cognitive dissonance and uncertainty, some groups of people seek out reference points in order to make sense of the chaos – also by finding refuge in inadequate or inappropriate interpretations of scientific findings. All of these challenges urge us to contemplate the relationship between health and knowledge, skills, habits, learning, epistemological systems, etc. We need to consider issues such as the socio-cultural aspects of health, illness and treatment, the role of community in adult education for health, and the role of community learning and education when facing health problems.

The thematic issue before you explores the relationships between education and health/illness *from two perspectives.* The first perspective deals with the effect that participating in educational programmes on health and well-being has on younger and older adults. Swedish folk high schools provide education for people with autism that contributes to their rehabilitation and provides students with a supportive environment. Hedegaard, Hugo, and Bjursell's article *Folk High School as a Supportive Environment for Participants with High-Functioning Autism* finds that students with autism respond well to this type of education and that the students, the staff as well as the head teachers view this form of education as positive. Meulenberg's article concerns *Bilingualism and Language Education to Improve the Cognitive Health of Older People* and analyses the effect of bilingualism and the implications it has for adult language education. The active use of more than one language beneficially contributes to healthy ageing. Formosa's *Building Evidence for the Impact of Older Adult Learning on Active Ageing: A Quantitative Study* presents the results of a study on how learning positively affects active ageing in older people. Learning helps avert social isolation and cognitive impairment; as one gets older, learning contributes to better health, physical and emotional well-being.

The second perspective on the relationship between health and education centres around education that aims to improve knowledge about health/illness. In *Improving the Health Literacy of Pregnant Women Using Contemporary Approaches in Health Education: An Integrative Literature Review* Prosen and Ličen identify the concept of health literacy as a vital social determinant of health and examine the contemporary approaches to health education for pregnant women in the so-called developed world. They find that the process of modernising health education has been too slow and insufficiently progressive. In a similar vein, Švab discusses the role of public libraries as important actors

in raising awareness among the general population on issues of health and specific issues such as health-related "fake news". Her article *Health Zones and Health Education in Public Libraries* is based on research that analyses the advantages and disadvantages of health zones in Slovenian public libraries. She writes that planning and delivering health education to less information literate users is a particular challenge, and that health zones should develop new strategies to attract different target groups. *Raising Public Awareness of Palliative Care: Evaluating a Last Aid Course in Slovenia* addresses the evaluation of educational programmes on a topic that still remains taboo – dying. In this article Zelko, Jakšič and Krčevski Škvarč focus on evaluating a Last Aid course that was run in Slovenia and is part of an international project of community education on palliative care conducted in 18 countries. An important role in education for health is also played by healthcare workers, and this is the topic of Lipovec Čebron and Huber's *The Evaluation of Cultural Competence in Healthcare: Why Is the Introduction of Qualitative Approaches So Needed?* The authors present different attempts at measuring cultural competences in healthcare. Based on examples from abroad and from Slovenia they show how important it is to supplement quantitative methods with qualitative ones. They also highlight the need to shift attention from measuring the cultural competences of individual healthcare workers onto the evaluation of educational courses and education providers.

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REFERENCES

Cardano, M., Giarelli, G., & Vicarelli, G. (Eds.). (2020). *Sociologia della salute e della medicina*. Il Mulino.

English, L. (Ed.). (2012). *Adult education and health*. University of Toronto. https://doi.org/10.3138/9781442685208

Francescato, D., Tomai, M., & Ghirelli, G. (2020). *Fondamenti di psicologia di comunità*. Carocci.

Gilbert, G., Sawyer, R., & McNeill, E. (2015). *Health education: Creating strategies for school and community health*. Jones & Bartlett Learning.

Lauzon, A., & Farabakhsh, R. (2014). The power of collaborative inquiry and metaphor in meeting the health literacy needs of rural immigrant women: A case of parent education. In V. Wang (Ed.), *Handbook of research on adult and community health education: Tools, trends, and methodologies* (str. 51–67). IGI Global. https://doi.org/10.4018/978-1-4666-6260-5.ch004

Leahy, D., Fitzpatrick, K., & Wright, J. (Eds.). (2020). *Social theory and health education: Forging new insights in research*. Routledge. https://doi.org/10.4324/9781351048163

Nutbeam, D. (2019). Health education and health promotion revisited. *Health Education Journal*, *78*(6), 705–709. https://doi.org/10.1177/0017896918770215

Nutbeam, D., Levin-Zamir, D., & Rowlands, G. (Eds.). (2019). *Health literacy in context: Settings, media, and populations*. MDPI. https://doi.org/10.3390/books978-3-03897-472-7

Pokorn, N., & Lipovec Čebron, U. (Eds.). (2019). *Večjezično zdravje: Komunikacijske strategije in večkulturni stiki s tujejezičnimi bolniki v slovenskem zdravstvenem sistemu*. Znanstvena založba Filozofske fakultete Univerze v Ljubljani. https://doi.org/10.4312/9789610601364

Seedat, M., Suffla, S., & Christie, D. (Eds.). (2017). *Emancipatory and participatory methodologies in peace, critical, and community psychology*. Springer. https://doi.org/10.1007/978-3-319-63489-0

Silberberg, M., Muhlbaier, L., Hart-Brothers, E., Weaver, S., & James, S. (2020). The role of socioeconomic status in a community-based study of diabetes secondary prevention among African Americans. *International Journal of Health Promotion and Education.* https://doi.org/10.1080/14635240.2020.1866999

Wang, V. (Ed.). (2014). *Handbook of research on adult and community health education: Tools, trends, and methodologies.* IGI Global. https://doi.org/10.4018/978-1-4666-6260-5

Willis, C. D., Saul, J. E., Bitz, J., Pompu, K., & Jackson, B. (2014). Improving organizational capacity to adress health literacy in public health: A rapid realist review. *Public Health*, *128*(6), 515–524. https://doi.org/10.1016/j.puhe.2014.01.014

Andragoška spoznanja/Studies in Adult Education and Learning, 2021, 27(2), 15-32 UDK: 374.7:376
DOI: https://doi.org/10.4312/as/9817 Scientific article

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FOLK HIGH SCHOOL AS A SUPPORTIVE ENVIRONMENT FOR PARTICIPANTS WITH HIGH-FUNCTIONING AUTISM

ABSTRACT

The aim of this article is to explore the Folk High School as a supportive environment for participants with neuropsychiatric functional impairments, primarily high-functioning autism, from the perspectives of the participants, the staff, and the principals. The participants' perspective consisted of 21 interviews, the teachers' perspective was observed in three focus-group interviews, and the principal's perspective through 19 telephone interviews. Folk High School is shown to be supportive because it: (i) creates a safe and caring environment, (ii) places the individual participant at the centre of its operations, and (iii) is based on the provision and articulation of clear structures. A limited focus on the classroom and the course content is too narrow for a group of individuals with high-functioning autism. It is important to examine the relationships between different categories of workers and how they, in an interwoven symbiotic system, can provide the participants with the best possible conditions for learning.

Keywords: *education, folk high school, high-functioning autism, learning experiences, subjective inclusive environment*

LJUDSKA UNIVERZA KOT SPODBUDNO OKOLJE ZA UDELEŽENCE Z VISOKO FUNKCIONALNIM AVTIZMOM – POVZETEK

Članek se osredotoča na ljudsko izobraževanje na srednješolski ravni, ki ponuja spodbudno okolje za udeležence z nevropsihiatrično motnjo, predvsem visoko funkcionalnim avtizmom, z vidika udeležencev, zaposlenih in ravnateljev. V okviru študije je bilo izvedenih 21 intervjujev z udeleženci izobraževanja, trije intervjuji s ciljnimi skupinami učiteljev in 19 telefonskih intervjujev z ravnatelji. Ljudsko izobraževanje se je izkazalo za spodbudno, saj (i) ustvari varno in prijazno okolje, (ii) je osredinjeno na posameznika ter (iii) vzpostavi jasne strukture in oblike dela. Usmerjenost, ki je omejena zgolj na učilnico in učno

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vsebino, je za skupino posameznikov z visoko funkcionalnim avtizmom preveč ozka. Prav tako pa je pomembno raziskati odnos med različnimi vrstami zaposlenih in kako lahko ti kot medsebojno povezan simbiotični sistem udeležencem ponudijo najboljše možne pogoje za učenje.

Ključne besede: *izobraževanje, ljudska univerza, srednja šola, visoko funkcionalni avtizem, učne izkušnje, subjektivno vključujoče okolje*

INTRODUCTION

The situation for people who have different functional impairments in the West has worsened in several aspects. In 2003 the EU (European Commission, 2003) noted that access to both work and study opportunities was worse for people who had some form of functional impairment. Since then, it has further worsened because of increasing demands (OECD, 2010). Research has shown that people with high-functioning autism (HFA) generally find it more difficult to complete their education (Howlin & Moss, 2012; Levy & Perry, 2011) due to a lack of adaptations, bullying, and social exclusion (Dymond et al., 2017; Giarelli & Fisher, 2013; Nuske et al., 2019). The situation for people with HFA in Sweden follows the same pattern (Adolfsson & Simmeborn Fleischer, 2013; Larsson Abbad, 2007; Simmeborn Fleischer, 2012).

One can with some justification claim that people who have different functional impairments, for instance, HFA, are excluded from school, and in the long run, working life. This happens despite the fact that Sweden, like many other countries, has for a long time been inspired by UNESCO‘s ambition of “education for all” and the idea of integration where all students should, as far as possible, learn together in shared learning environments (UNESCO, 1994). The inclusion and integration available are often concentrated on geographical or objective aspects such as sharing classrooms with others, while less attention is paid to individuals’ feelings of being included (Porter, 2000). Licsandru and Cui (2018) suggest “subjective social inclusion” as a concept to draw attention not only to the practical arrangements of inclusion but also to the interpersonal aspects. Furthermore, in an effort to increase our knowledge of this area, the National Agency for Special Needs Education and Schools in Sweden (2017) has called for qualitative research and participant-centred perspectives with regards to students who have functional impairment and their own experiences of different forms of education. The ambition of this article is therefore to pay special attention to students with HFA and their experiences of their education, which offers different types of adaptations and support, and supplement these by also paying attention to how the staff and the principals perceive their education.

In Sweden, there are Folk High Schools (FHSs), which are institutions for “liberal” or “popular” education. In contradistinction to other educational institutions, FHSs have been able to meet the educational and social needs of people with functional impairments. These circumstances have aroused the interest of researchers who are interested in examining what it is that lies behind FHSs’ success in offering a supportive environment

for participants with neuropsychiatric functional impairments, primarily those who have been diagnosed with HFA. This is of relevance because other educational institutions have not succeeded in doing what FHSs have done in this regard.

The aim of this article is to explore the Folk High School as a supportive environment for participants with neuropsychiatric functional impairments, primarily high-functioning autism, from the perspectives of the participants, the staff, and the principals.

Education as rehabilitation and habilitation

Even though one's education may not suffice to secure gainful employment (Andersson, 2008), the educational process itself can constitute a valuable environment in which an individual can grow and develop. Education thus has value in itself and should not merely be seen as a measure to be deployed on the job market. During one's education, in addition to the formal learning that takes place and is linked to specific subject content, *informal learning* takes place, learning which touches on one's social interaction and understanding of the world around us. In previous research, informal learning has been described as important to people with HFA since it contains valuable experiences for the individual alongside the subject content being taught (Adolfsson & Simmeborn Fleischer, 2013; Giarelli & Fisher, 2013; Simmeborn Fleischer, 2012). Such informal learning also includes becoming acquainted with certain social skills, i.e., *social learning*. Social learning is of particular relevance to people with HFA because they often suffer from a lack of social competence (Barnhill, 2007; Fiske & Taylor, 2013; Gillberg & Ehlers, 2006; Happé & Frith, 2006; Striano & Reid, 2008); note that this lack of social competence is a potential obstacle to obtaining gainful employment (Attwood, 2008) and becoming more socially included. Previous studies (Hedegaard & Hugo, 2017; Hugo & Hedegaard, 2017, 2020) have demonstrated the importance of social learning, especially since it provides opportunities for people with HFA to develop the ability to create social relationships and social networks, to have the courage to ask for help, and to engage in public speaking. Social learning can also be associated with formal learning and, as such, constitutes its own subject content. For example, there are three general FHS programs which are aimed at people with HFA. The aim of these programs is to offer the participants course content which helps them to understand themselves better, deal with everyday situations, and develop socially, which together can increase their subjective societal inclusion. In addition, there is an FHS program which is more career- and independent living-oriented, and is aimed at allowing participants to develop suitable skills so that they will fit in on the labour market and manage to live on their own (Folk High School, 2019), which increases the opportunities for more objective inclusion.

Folk High School as an Educational Approach

The FHS system is a unique school form in the Swedish education system because of its social dimensions and the way it creates meaningfulness for the participants who are enrolled there. In this context, every person's equal value is also emphasised (Andersén, 2011;

Bjursell & Nordvall, 2016; Paldanius, 2007). This entails that the FHS is based on fundamental principles of taking a holistic view of the individual and to knowledge that is related to a person's whole life-situation. Personal development and the individual's experience of meaningfulness are central to this approach. The people who study at the FHS are called *participants* in contrast to the rest of the Swedish education system. This follows from the FHS's principles with respect to personal freedom and voluntary action wherein participants are viewed as co-creators in the educational process (Andersén, 2011). The FHS also enjoys a long tradition of organising courses which have the expressed purpose of including people who have different needs, for example, people with functional impairments, senior citizens, people who have previously not succeeded in their educational endeavours, and newly-arrived immigrants/refugees (Kindblom, 2016; Nylander et al., 2015; Skogman, 2015; The Swedish National Council of Adult Education, 2018a).

According to Skogman (2015) and Nylander et al. (2015), the FHS is characterised by a certain "openness" and "accessibility" which facilitates the academic endeavours of participants with functional impairments. In 2017 the FHS received additional funding from the State (re-enforcement fund) which was to be spent on specific pedagogic support for participants with functional impairments (The Swedish National Council of Adult Education, 2018b). The proportion of participants with functional impairments at FHSs increased during the 2000s and the particular group which benefits from this re-enforcement funding today are participants with neuropsychiatric functional impairments (The Swedish National Council of Adult Education, 2018b), including people with HFA. Today, there are 156 FHSs in Sweden with approximately 57,000 participants enrolled in long-term courses (equivalent to programs at university) each year and approximately 54,000 participants who are enrolled in short courses (equivalent to independent courses at universities) (The Swedish National Council of Adult Education, 2019). One third of all participants enrolled in the general courses have a functional impairment. For specialised courses, this proportion is 13% (The Swedish National Council of Adult Education, 2017). In addition, 34 FHSs offer complete courses and programs which are solely adapted for participants with functional impairments. 8 of these 34 schools offer the same for young adults with HFA (Folk High School, 2019).

High-Functioning Autism

HFA falls under the diagnostic category of "neuropsychiatric functional impairment". People who are assigned this diagnosis are often attributed limitations such as a lack of social cognition (Barnhill, 2007; Cotter et al., 2018; Erol et al., 2018; Fiske & Taylor, 2013; Gillberg & Ehlers, 2006; Hinterbuchinger et al., 2018; Striano & Reid, 2008; Tulaci et al., 2018) and the ability to feel empathy (Bal et al., 2010; Golan et al., 2006; Wallace et al., 2011). Research has also shown that people with HFA have a lack of enterprise and are unable to take initiative (Adams & Jarrold, 2012; Low et al., 2009). Furthermore, they possess a reduced ability to make plans and to be flexible (Happé & Frith, 2006). This research has, however, been challenged by other studies which show that poor results on all types of tests may be attributed to the respondent's difficulties in understanding

what is expected of him/her from the testing psychiatrist and researcher, and may not be indicative of any specific cognitive impairment (White, 2013). The medical paradigm has a great deal of influence, however, and as a result of this influence, the *impaired* abilities are what is taken into account with respect to people who are diagnosed with HFA (Linton, 2014).

An understanding of these impaired abilities can provide information on how one might go about securing adequate support for people with HFA. A close examination of the individual's impairments during the diagnostic phase should be complemented with a "relational examination" with respect to the support to be provided in an educational context. This has been mandated by the Swedish National Council of Adult Education (2018b) with respect to the disbursement of the above-mentioned re-enforcement funding. We also note that in the *Discrimination Act* (Swedish Statute Book, 2008) and throughout the Swedish National Board of Health and Welfare (2017) it is highlighted that the *context* is a strong factor which influences whether a functional impairment is an impediment or not. A functional impairment should thus be understood as something dynamic, in the sense that it emerges in the interaction between the person and the person's environment. This entails that the person's environment can potentially instantiate a functional impairment. Such a view on functional impairment has direct consequences on support arrangements. It is the social environment, in the form of norms and attitudes, in conjunction with the physical environment which needs to be adapted first, with the aim of being inclusive, supportive, and not posing a functional hindrance (Nirje, 1994).

In practical terms, the approach described above can entail, in a school context, for example, that inter-personal support and adapted school assignments be offered to the individual. In previous studies, the following adaptations have been shown to work for HFA students: (i) the possibility of working on one's own, (ii) focusing on one task at a time, and (iii) being given the freedom to decide how one will spend one's time (Hedegaard & Hugo, 2017; Hugo & Hedegaard, 2017).

METHODOLOGY

Selection and Research Methods

We initially identified which FHSs offer educational courses or programs for people with neuropsychiatric functional impairments. It was noted that 34 FHSs offer such courses or programs, of which 8 offered specific programs for participants with HFA.

Data collection took place at three of the eight above-mentioned FHSs during the autumn of 2017. These three FHSs offered several programs for participants with HFA. These included general courses which were adapted for participants with HFA (corresponds to upper secondary school), participants with HFA who attended "regular" integrated general courses without any specific adaptations together with participants without any impairments (also corresponds to upper secondary school), and participants who attended special preparatory courses which provided education in independent living, work-life,

and social competence. In total, five different courses were included in the study. Each of the 34 FHSs was contacted with the request that we interview the school principal. 19 principals obliged us with an interview.

The participant perspective is based on 21 research interviews with participants from five different study programs. All of the 21 participants were young adults, between the ages of 18 to 28 years of age, with HFA. 16 of the participants are men and 5 are women. 12 of the participants lived at the FHS. The participant interviews lasted between 21 and 80 minutes. The interviews were conducted separately. The interviews with the participants consisted of semi-structured life-world interviews (Kvale & Brinkmann, 2009) and covered the overarching theme of their experiences of the FHS, such as relationships with teachers and other participants, as well as teaching and learning and coping with living by themselves at the school.

The perspective of the staff was studied through three focus-group interviews with teachers and social pedagogues (from now on called staff) from the same FHSs as the participants. The three focus-group interviews included five, four, and two respondents respectively, eight of whom are women and three are men. The duration of the focus-group interviews was between 67 and 72 minutes in length. The focus-group interview method (Halkier, 2010; Wibeck, 2010) is used in research and evaluation exercises with smaller groups, especially when the aim is to capture and understand both a group's shared experiences and individual experiences of a specific context which they are part of.

The perspective of the principals was recorded through telephone interviews with school principals and superintendents (from now on called principals) at 19 of the 34 FHSs which offer courses and programs for people with neuropsychiatric functional impairments. 8 female and 11 male principals chose to participate. These interviews were conducted by a research assistant who employed a structured interview approach. The reasons why the other principals declined to be interviewed were, primarily, because they were newly-appointed, did not have the time to be interviewed, or were tired of answering questionnaires. 7 of the 19 principals reported that their schools have offered, offer, or plan to offer courses that are specifically aimed at participants who have been diagnosed with HFA. The other principals reported that their schools offered courses for people with different functional impairments and that, in their general courses, they had participants with functional impairments.

All of the interviews mentioned above were transcribed and a qualitative content analysis (Krippendorff, 2004) was performed in three steps. The interviews focused on the latent abstraction level (Graneheim & Lundman, 2004) in order to capture a condensed but broad description of the participants' experiences. The first step consisted of a careful reading in order to gain overall insight into the material. Based on this reading, the material was later encoded by keywords and phrases. In the final step, the material was read through again to create content categories based on the previous keywords and phrases. This procedure was similar for all three interview groups, but the participants' perspective

focused on the description of how young adults with HFA experience the FHS and the specially-adapted teaching that is offered there. The focus in the interviews with the staff was how teachers and social pedagogues describe their experiences of teaching and other support function arrangements. The focus in the interviews with the principals was more general and dealt with how the institution's operations are adapted for people with neuropsychiatric functional impairments, including those with HFA.

Ethical Considerations

The participants were informed of the aim of the study and they gave their consent to participate in the study. The respondents' right to integrity entails that they were treated and described in the study confidentially. In summary, we followed the ethical code which the humanities and social studies are governed by (Swedish Research Council, 2002; 2005).

RESULTS

The results are presented thematically in terms of the common features in the three perspectives which emerged in the interview material with regards to the factors which influence a FHS's ability to provide a supportive environment to the group of participants under discussion. These include: (i) a safe and caring atmosphere, (ii) placing the individual at the centre of the school's operations, and (iii) the provision and articulation of clear structures.

A Safe and Caring Atmosphere

All of the participants described the FHS as a safe and caring environment, where none of them had experienced any form of insult or felt socially excluded:

> It feels nice… like I knew everyone after the first week. It feels like a community in some way. And I have understanding for other people's difficulties and they have an understanding for my own difficulties. So I dare to be more open. For me, this is a very positive thing. (D8)

A safe and caring environment should be ensured not just during class but also outside the classroom. This was possible because many of the participants often stay at the FHS's boarding facilities. This involves taking a holistic view of the participants' total life-situation and an awareness that the conditions for teaching and learning may very well be created outside the classroom. This is demonstrated by the support functions that are provided by the school, of which the participants report the social pedagogue, independent-living support staff, and personal assistants as being the most important part. The most important forms of support that is provided address getting up in the morning, maintaining a daily schedule, and being punctual. Several participants report that classroom teaching and learning has never been a problem for them. Instead, having consistent attendance is considered to be an issue. One participant states the following in this regard:

> The biggest support I need in my studies is making sure I go off to class. This is the biggest problem that I've had throughout my whole school career. […] Before, I never felt good at school, before I came here. When I finally came in here I started to work… I have no problem with that. […] Before, if I woke up too late, then I didn't dare go to class, because I didn't want everyone to look at me. I felt so very bad because of that. […] Now, I have someone who sends a message to me… if it's past nine then I get a message about that. (D17)

The support functions that the staff highlighted as relevant were the conversational support activities they offer and the help they provide regarding practical issues for the participants. A number of participants used professional conversational support provided by a psychologist or school curator, whilst a greater number of the participants spoke directly with their teacher, mentor, and/or social pedagogue. Above all, the need for an adult who is present and who has the ability to create a trusting relationship with the participant was highlighted as important. The following report about conversational support was made during a focus-group interview:

> It's really important that they're supported in their communication with us teachers… or the assistants. That someone… it can be a mentor or someone else… helps to create a good relationship with the teachers. And to find forms of communication… because it might not be the case that you can talk… we have tried loads of different [forms]… you can write a diary every week… or you can send an email… or talk… if communication becomes difficult then that's a very important support function. (FHS2)

Irrespective of whether conversational support is provided by a psychologist, curator, teacher, mentor and/or a social pedagogue, it is key to whether a participant is able to have their individual needs met and thereby feel safer. Regarding the more tangible, practical support that is provided – this may include a wake-up call in the morning, making sure that participants retire at a reasonable time at night, and acting as an informal escort for a participant who is about to enter a new and unknown social environment. This practical support function is primarily performed by the social pedagogues. However, whatever role an individual holds within the organisation, the staff were in agreement that it was this type of support that the participants are most in need of.

The principals also emphasised the importance of a safe and caring environment. The mere provision of an education was not enough; the principals try to ensure that each participant's whole-life was functioning properly; including the participant's school attendance, independent living, and use of leisure time, as a way to a safe and supportive learning environment:

> In fact there's not much difference between this group and regular students. What are needed are adaptations to accessibility. There's no lack of ability to

> learn, there's no lack of intelligence, but rather, it's a question of accessibility and is a democratic question. So, we work hard so that everyone can have the same opportunities. (R14)

The principals noted that, given that each individual is different, it is important that the education system offers different pathways, so that everyone can enjoy the same opportunities and benefit from the education that society offers. The principals are well-aware of the fact that participants with functional impairments can experience difficult times as they progress through the education system, before they come to the FHS:

> There are many sad school stories. When they come to us, they've often gone through the compulsory school system and failed. They've tried high school studies and failed. It's a long journey to take even if you possess the intellectual capacity. […] They're broken, you might say. (R17)

Taken together, it seems that the priorities which the staff and principals make with respect to creating a safe and supportive environment are appreciated by the participants.

Placing the Individual Participant at the Centre of School Operations

According to the participants, it was clear that they are given attention to as individuals and their individual needs are satisfied at the FHS, as shown in the first theme. When it comes to more classroom-related support, many of the participants report that it was the first time in their educational careers that they were provided with classroom instruction that worked for them and that they felt that they could succeed in their studies. The participants state that they feel less stressed by their studies than previously thanks to the FHS's ability to deal with each person individually. The study pace was also experienced as being more manageable than their previous school experience:

> The teachers are very knowledgeable… the studies are adapted after the diagnosis […]. Very nice teachers and they're understanding of me, if, for example, I don't understand something, so they can explain it to me so I do understand. (D2)

A frequent way that teachers individualised their teaching was to give the participants extra time, including extra time to become used to studying, being punctual, and making demands of oneself. The teachers also gave them time to build up their self-confidence and self-worth. The initial journey for these participants is often long and arduous because of their previous life-situation, which included isolation and social exclusion, as well as painful experiences from their previous school attendance. They need time to "re-set" – a time where discretion and compliance are paramount. The educational context then becomes an environment where participants are provided with the opportunity to build-up themselves and their abilities, step-by-step. During one focus-group interview with the staff, the following was reported concerning the function of the educational experience with respect to creating a safe and individually-adapted environment for the participants:

> I would say that what's special about it is that you need… perhaps what you have planned doesn't work, in fact you need a certain degree of, to individually find out what works for the participants. Perhaps not all the time, but during the courses, you know, or the educational time, so I usually speak individually to them. And that I feel that sometimes there'll be a situation where they come to a halt, and there's some kind of issue… something that I, as a teacher, need to solve. (FHS1)

The majority of these participants had adapted study timetables which allowed them to study only a few subjects simultaneously and they had the opportunity to complete one task/assignment before they started a new one. The placement of the individual participant at the centre of the school's operations was also made apparent during the interviews with the principals. One principal highlighted the fact that the whole of the FHS's pedagogic approach was directed at taking the individual into account:

> The whole teaching team is well-acquainted with adapting their teaching to the group that we have. This is because of the foundations of the Folk High School pedagogic approach, that we're not controlled by syllabi from the State, like every other school environment, but instead we construct our own syllabi and course plans together with the participants whilst they are studying, which results in us adapting the manner in which our operations are conducted, not daily, but quite often. (R2)

The way of working which exists at the FHS establishes a good foundation which can be used to (i) identify the needs of those individuals who attend the FHS, (ii) take note of what abilities they have, and (iii) determine how these abilities can be used to support the participants' educational endeavours. During the interviews, a number of questions were asked about educational courses and programs that are aimed at people with neuropsychiatric functional impairments, especially people with HFA. However, most of the principals chose not to differentiate one diagnosis from another: "The course participants say that they're here because we treat them like any other person who, however, needs some support, somewhat like a person who has poor sight might need spectacles" (R5). Several principals think that it was problematic to categorise people into different categories and shied away from using the term *functional impairment*. The preferred term at FHSs is *functional variation*: "My school board wants me to say *functional variation*" (R2). Some principals claim that terminology is a complex question, and it is complex because people with the same diagnosis can be quite different.

> Whatever functional variation or functional impairment the individual may have, we usually say: 'Ok, you have this type of diagnosis but how are things working out for you?' This is because variation within a diagnosis and across-diagnosed individuals is so great that the diagnosis itself says too little. Then we talk to the individual and often engage in nice conversations with the

> individual who might say: 'I find it difficult in these types of situations.' And then we reply: 'OK, then we'll support you in how you deal with or avoid these situations'. (R2)

There exists a longstanding tradition within the FHS movement to place the individual at the centre of things while simultaneously viewing the individual as part of a larger cultural and social context. This approach was apparent in the interviews with the participants, the staff, and the principals.

The Provision and Articulation of Clear Structures

Participants with HFA can have a diminished ability to plan things and to be flexible. In the interviews, the need for a clear structure was spoken about, a structure which includes clearly delimited and clearly formulated study assignments:

> When it works best for me… that's when… 'This is what we're going to do'… that's when there's a clear assignment and it's clearly set out what the assignment is and how much. I don't like to be set a deadline… because I get stressed about it. I want a clear ending […]. It feels like a very clear arrangement and that's a very positive thing for me. (D5)

During classroom discussions, a clear structure is also important. Everyone should be allowed to speak in turn, and the participants should know when their turn to speak is, so that they can prepare themselves for that:

> I feel more comfortable that our turns are set out… the teacher is quite good at that… so everyone can say what they think, you know. I've always found it difficult to be the one who expresses opinions. (D7)

One reason why clear structures and instructions are provided is because this creates predictability, something which the participants appreciate. Knowing exactly what is going to happen during a lesson, throughout the school day, and even throughout the school week (both inside and outside the classroom), subjects the participants to less stress and anxiety caused by unforeseen events:

> On Mondays, during the first class hour, they explain what'll happen during the week and what you should think about… sometimes they tell [us] about some after-school activities […]. It's nice to know what's happening during the week… nice to know what'll happen. If we didn't have weekly planning then we'd be quite stressed. It's nice to have weekly planning instead of being shocked every time… oh dear now something new is happening today… oh dear now again and once more. Then you get stressed […] every class which we have here they set it out, what'll happen during the lesson […] [and] I think that's really good. Later, after two hours, it's time for food. You also get to see

> the menu… what food is on offer. Then you know, oh yes, I can eat this food today. Then you can focus on what'll be for supper. (D16)

During the focus group interviews, a picture of what it means to teach these participants with HFA emerged. The staff members with previous experience of teaching at a "regular" school remarked that there was not a great difference between teaching at an FHS with participants with HFA and what they did before. However, one difference was their opinion that participants with HFA were in greater need of understanding the purpose of a lesson and of social activities. Consequently, more time was required to provide motivation for why different educational activities were to be performed. Furthermore, it was noted that the introduction of spontaneous elements in a lesson did not work:

> everything must follow a clear theme… it doesn't work if you do an activity which does not fulfil a function and which I cannot motivate… 'what should I do, and why, and for how long, and with whom'… if it's not clear… then it's better not to do anything… and we've noticed… that we're going to add subjects to other courses… and 'now we'll do something fun'… it always goes wrong. (FHS1)

This need to always understand the purpose of each teaching element is linked to the participants' often genuine and specialist interests. In parts of a subject, the participants might be so knowledgeable that the challenge for the teacher is to find sufficiently stimulating assignments for them to maintain their motivation. In other parts of a subject, their lack of knowledge might be evident. Taken together, this situation often required the teachers to seesaw between levels within one and the same subject. In such cases, it is important to continually link new knowledge to existing knowledge, to areas where the participants already have high levels of motivation. The principals also identified "structure" as a fundamental aspect which had to be present if the teaching was to work for the participants:

> There are clear routines, Monday to Friday. We go through the week and all the practical aspects. Each day is pretty well mapped out. Then we have individual relaxation rooms and we also have the possibility that they can eat in peace in the dining room. Many of them are particularly sensitive to noise; they have problems with loud noises and such. (R10)

Some of the principals remark that this is a way of working that makes extreme demands on the available resources. However, this was necessary if things are to work for these participants. One way of dealing with this logistically is to make a great deal of resources available to the participants at the beginning of a course to create understanding and to establish a common ground from which to move on from.

DISCUSSION

The aim of this article was to explore the Folk High School as a supportive environment for participants with neuropsychiatric functional impairments, primarily high-functioning autism, from the perspectives of the participants, the staff, and the principals.

We found that the FHS functions as a supportive environment for participants with neuropsychiatric functional impairments by (i) creating a safe and caring environment, (ii) placing the individual participant at the centre of its operations, and (iii) including the provision and articulation of clear structures.

A safe and caring environment is based on a holistic view of the social context. A narrow focus on the classroom and course content is too restrictive for people with HFA. Given that it is quite common for students at an FHS to board there, it is possible to adopt a holistic stance towards the individuals' everyday activities and their development. According to Skogman (2015) and Nylander et al. (2015), the FHS is characterised by "openness" and "accessibility" which facilitates the academic endeavours of participants with HFA. This observation is in agreement with the results of our study, where the FHS is described as accessible and suitably adapted to the participants. These adaptations include those made in and outside the classroom, both of which facilitate teaching.

Placing the individual participant at the centre of its operations entails basing the teaching on the individuals' needs more than on the course content. Key to such teaching is a form of participation which focuses on the *learning individual*, not on the subject *per se*. This approach can be linked to the FHS's institutional values and principles and the social and meaningful dimensions which stem from the holistic view that knowledge is related to a person's whole life situation (Andersén, 2011; Bjursell & Nordvall, 2016; Paldanius, 2007). As previous research (Hugo & Hedegaard, 2020) has also noted, the fact that teaching at FHSs is centred on the participant also means that participants are provided with the opportunity to work at their own pace and they are not stressed by demands of achieving certain goals within a set time limit, as is the case in other schools. The result of this is that it often takes somewhat longer to complete various courses. Teaching at FHSs is presented in a manner which is congruent with the principle that "the learning that takes place at FHS is based on inter-personal interaction where the participants are viewed as co-creators in processes which are informed by every person's equal value" (Andersén, 2011; Bjursell & Nordvall, 2016; Paldanius, 2007). This is demonstrated by the fact that the participants are listened to and may participate in the planning of the delivery of course content.

The provision and articulation of clear structures was mentioned with respect to the participants' situation as a whole; dining schedules as well as the structure of the teaching were important. The importance of clear and controlling (but also individually adapted) structures was present in all three perspectives. Previous studies have highlighted a lack of enterprise and an inability to take initiative among people who have been diagnosed with HFA (Adams & Jarrold, 2012; Low et al., 2009), as well as a diminished ability to

engage in planning, and to be flexible (Happé & Frith, 2006). Providing clear structure is thus one way in which participants with HFA are supported. There exists, however, a risk that clear structures and control might clash with the staff's and principal's ideas concerning self-responsibility, as espoused by FHSs foundational principle that people's participation must be "free and voluntary". In this context, "free and voluntary" means that participation is voluntary and the individuals are expected to behave in an independent manner and take responsibility for their own learning. With respect to the specific group under discussion here, these principles are put to the test. Questions may be raised concerning how much social responsibility a teacher (or other members of staff) should take on.

CONCLUSION

The FHS appears, primarily through the participants' experiences but also through the stories of the staff and principals, as a supportive and inclusive environment for participants with HFA. The forms of education we have studied within the framework of this study are all non-integrated and can, based on UNESCO's definition of inclusion (1994), be considered as excluded. However, by (above all) taking part in the 21 participants' experiences of the FHS and also their previous experiences of objectively inclusive education (Porter, 2000) where the participants were often met with intolerance, a lack of understanding and social exclusion, the present study has contributed to the knowledge on how subjective social inclusion (Licsandru & Cui, 2018) can be expressed in practice. Instead of being constantly integrated and practically included in "regular" classes at FHS, participants with neuropsychiatric functional impairments, primarily high-functioning autism, regularly engage in activities with participants from other classes at the FHS outside the classroom (this can be anything from lunch to various cultural events) as part of the training included in the education. There seems to be an awareness at FHSs that subjective social inclusion can be created and/or experienced despite practical classroom-related exclusion, which, based on many of the participants' previous school experiences, should be shown by more education providers.

Limitations and Recommendations for Future Research

The FHS is often presented as an educational institution which can meet the needs of certain groups of individuals who have not achieved success in other educational contexts. The positive experiences which were reported in the interviews may partially depend on the fact that there was an initial selection process regarding who participated in the study, for example, that those participants who like the FHS also remain there. If there were participants who did not have such a positive experience, they had probably left by the time we conducted our interviews, and thus they were not represented in the study. The fact that the participants were older than they were when they attended compulsory school and/or high school may also be of further relevance. However, the potential influence of the participants' age remains to be investigated further in future studies.

Implications

Notwithstanding the limitations of this study, it has contributed to the field with valuable knowledge. Using the three perspectives on the FHS, we conclude that the existence of an inclusive environment for people with HFA is a function of understanding the individual's complete context and life circumstances. This is the case if one wishes to provide a learning experience which contributes to a person's personal and social growth that allows the individual to benefit from the educational content that is offered. A limited, narrow focus on the classroom and subject content is thus too restrictive for people with HFA. The participants were satisfied with their studies at the FHS, and the principals emphasised that focus should not be placed on the diagnosis but rather on the individual – devoting attention to every individual to come to an understanding of what works for each person. The participants, staff, and principals were all in agreement about the importance of clear and controlling structures which are individually adapted to suit the participants' needs. We note a certain difference in how the participants view the social pedagogue as being key to enjoying a functional everyday life, whilst the staff and the principals emphasised the need for special pedagogues. Regarding the holistic approach which the FHS endorses, it is important not to emphasise hierarchies and the distribution of different responsibilities; instead, it is important to appreciate the relationships existing between different professional categories and note how they are woven together into a symbiotic relationship as they strive to provide the best possible conditions conducive to learning.

Acknowledgements

We would like to thank all the participants, educators, and principals/superintendents at the various Folk High Schools who took part in this study. This work was supported by the Swedish Agency for Youth and Civil Society, under grant number: DNR 1942/17.

REFERENCES

Adams, N. C., & Jarrold, C. (2012). Inhibition in autism: Children with autism have difficulty inhibiting irrelevant distractors but not prepotent responses. *Journal of Autism and Developmental Disorders, 42*(6), 1052–1063. https://doi.org/10.1007/s10803-011-1345-3

Adolfsson, M., & Simmeborn Fleischer, A. (2013). Applying the ICF to identify requirements for students with Asperger syndrome in higher education. *Developmental Neurorehabilitation, 18*(3), 190–202. https://doi.org/10.3109/17518423.2013.819947

Andersén, A. (2011). *Ett särskilt perspektiv på högre studie? Folkhögskoledeltagares sociala representationer om högskola och universitet*. Jönköping University.

Andersson, T. (2008). *Asperger, ADHD och arbete*. Andet utbildning och förlag.

Attwood, T. (2008). *Den kompletta guiden till Aspergers syndrom*. Studentlitteratur.

Bal, E., Harden, E., Lamb, D., Van Hecke, A. V., Denver, J. W., & Porges, S. W. (2010). Emotion recognition in children with autism spectrum disorders: Relations to eye gaze and autonomic state. *Journal of Autism and Developmental Disorders, 40*(3), 358–370. https://doi.org/10.1007/s10803-009-0884-3

Barnhill, G. P. (2007). Outcomes in Adults with Asperger Syndrome. *Focus on Autism and Other Developmental Disabilities, 22*(2), 116–126. https://doi.org/10.1177/10883576070220020301

Bjursell, C., & Nordvall, H. (2016). Inledning. In *Folkbildningens frihet och värde: metaperspektiv på folkhögskolor och studieförbund* (pp. 7–23). The Swedish National Council of Adult Education.

Cotter, J., Granger, K., Backx, R., Looi, C. Y., & Barnett, J. H. (2018). Social cognitive dysfunction as a clinical marker: A systematic review of meta-analyses across 30 clinical conditions. *Neuroscience & Biobehavioral Reviews, 84*, 92–99. https://doi.org/10.1016/j.neubiorev.2017.11.014

Dymond, S. E., Meadan, H., & Pickens, J. L. (2017). Postsecondary education and students with autism spectrum disorders: Experiences of parents and university personnel. *Journal of Developmental and Physical Disabilities, 29*(5), 809–825. https://doi.org/10.1007/s10882-017-9558-9

Erol, A., Akyalcin Kirdok, A., Zorlu, N., Polat, S., & Mete, L. (2018). Empathy, and its relationship with cognitive and emotional functions in alcohol dependency. *Nordic Journal of Psychiatry, 71*(3), 205–209. https://doi.org/10.1080/08039488.2016.1263683

European Commission. (2003). *Disability and Social Exclusion in the European Union: Time for change, tools for change: Final study report.* European Commission.

Fiske, S., & Taylor, S. (2013). *Social cognition: From brains to culture*. Sage.

Folk High School. (2019). *Sök kurser*. https://www.folkhogskola.nu/sok-kurser/?query=asperger

Giarelli, E., & Fisher, K. (2013). Transition to community by adolescents with Asperger syndrome: Staying afloat in a sea change. *Disability and Health Journal, 6*(3), 227–235. https://doi.org/10.1016/j.dhjo.2013.01.010

Gillberg, C., & Ehlers, S. (2006). *Asperger Syndrome: An Overview*. National Autistic Society.

Golan, O., Baron-Cohen, S., & Hill, J. (2006). The Cambridge mindreading (CAM) face-voice battery: Testing complex emotion recognition in adults with and without Asperger syndrome. *Journal of Autism and Developmental Disorders, 36*(2), 169–183. https://doi.org/10.1007/s10803-005-0057-y

Graneheim, U. H., & Lundman, B. (2004). Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today, 24*(2), 105–112. https://doi.org/10.1016/j.nedt.2003.10.001

Halkier, B. (2010). *Fokusgrupper*. Liber.

Happé, F., & Frith, U. (2006). The weak coherence account: Detail-focused cognitive style in autism spectrum disorders. *Journal of Autism and Developmental Disorders, 36*(1), 5–25. https://doi.org/10.1007/s10803-005-0039-0

Hedegaard, J., & Hugo, M. (2017). Social dimensions of learning - The experience of young adult students with Asperger syndrome at a supported IT education. *Scandinavian Journal of Disability Research, 19*(3), 256–268. http://doi.org/10.1080/150174192016.1273132

Hinterbuchinger, B., Kaltenboeck, A., Baumgartner, J. S., Mossaheb, N., & Friedrich, F. (2018). Do patients with different psychiatric disorders show altered social decision-making? A systematic review of ultimatum game experiments in clinical populations. *Cognitive Neuropsychiatry, 23*(3), 117–141. https://doi.org/10.1080/13546805.2018.1453791

Howlin, P., & Moss, P. (2012). Adults with autism spectrum disorders. *Canadian Journal of Psychiatry, 57*(5), 275–283. https://doi.org/10.1177/070674371205700502

Hugo, M., & Hedegaard, J. (2017). Education as habilitation: Empirical examples from an adjusted education in Sweden for students with high-functioning autism. *Andragoška spoznanja/Studies in Adult Education and Learning, 23*(3), 71–87. https://doi.org/10.4312/as.23.3.71-87

Hugo, M., & Hedegaard, J. (2020). Inclusion through folk high school in Sweden – the experience of young adult students with high-functioning autism. *Disability and Rehabilitation*, 1–10. https://doi.org/10.1080/09638288.2020.1717651

Kindblom, L. (2016). *Invandring och svenskundervisning - så började det*. Leif Kindblom förlag.

Krippendorff, K. (2004). *Content analysis: an introduction to its methodology*. Sage.

Kvale, S., & Brinkmann, S. (2009). *Den kvalitativa forskningsintervjun*. Studentlitteratur.

Larsson Abbad, G. (2007). *"Aspergern, det är jag" - En intervjustudie om att leva med Asperger Syndrom*. Linköpings Universitet, Institutionen för beteendevetenskap och lärande.

Levy, A., & Perry, A. (2011). Outcomes in adolescents and adults with autism: A review of the literature. *Research in Autism Spectrum Disorders, 5*(4), 1271–1282. https://doi.org/10.1016/j.rasd.2011.01.023

Licsandru, T. C., & Cui, C. C. (2018). Subjective social inclusion: A conceptual critique for socially inclusive marketing. *Journal of Business Research, 82*, 330–339. https://doi.org/10.1016/j.jbusres.2017.08.036

Linton, F. K. (2014). Clinical Diagnoses Exacerbate Stigma and Improve Self-Discovery According to People with Autism. *Social Work in Mental Health, 12*(4), 330–342. https://doi.org/10.1080/15332985.2013.861383

Low, J., Goddard, E., & Melser, J. (2009). Generativity and imagination in autism spectrum disorder: Evidence from individual differences in children's impossible entity drawings. *British Journal of Developmental Psychology, 27*(2), 425–444. https://doi.org/10.1348/026151008x334728

National Board of Health and Welfare. (2017). *Insatser och stöd till personer med funktionsnedsättning - Lägesrapport 2017.* National Board of Health and Welfare.

Nirje, B. (1994). The Normalization Principle and Its Human Management Implications. *The International Social Role Valorization Journal, 1*(2), 19–23.

Nuske, H. J., McGhee Hassrick, E., Bronstein, B., Hauptman, L., Aponte, C., Levato., L., Stahmer, A., Mandell, D. S., Mundy, P., Kasari, C., & Smith, T. (2019). Broken bridges—new school transitions for students with autism spectrum disorder: A systematic review on difficulties and strategies for success. *Autism, 23*(2), 306–325. https://doi.org/10.1177/1362361318754529

Nylander, E., Bernhard, D., Rahm, L., & Andersson, P. (2015). *oLika TillSAMmanS: En kartläggning av folkhögskolors lärmiljöer för deltagare med funktionsnedsättning*. Linköping University Press.

OECD. (2010). *Sickness, disability and work: Breaking the barriers: A synthesis of findings across OECD countries.* OECD Publishing.

Paldanius, S. (2007). *En folkhögskolemässig anda i förändring: En studie av folkhögskoleanda och mässighet i folkhögskolans praktik*. Linköping: Linköpings universitet.

Porter, F. (2000). Social exclusion: what's in a name? *Development in Practice, 10*(1), 76–81. https://doi.org/10.1080/09614520052529

Simmeborn Fleischer, A. (2012). Support to students with Asperger syndrome in higher education – the perspectives of three relatives and three coordinators. *International Journal of Rehabilitation Research, 35*(1), 54–61. https://doi.org/10.1097/MRR.0b013e32834f4d3b

Skogman, E. (2015). *Att studera som vuxen med funktionsnedsättning. En fördjupad studie av studerandes erfarenheter*. The National Agency for Special Needs Education and Schools.

Striano, T., & Reid, V. (Eds.). (2008). *Social cognition: Development, neuroscience and autism*. Wiley-Blackwell.

Swedish Research Council. (2002). *Forskningsetiska principer inom humanistisk-samhällsvetenskaplig forskning*. Swedish Research Council.

Swedish Research Council. (2005). *Särskilda anvisningar för utbildningsvetenskap*. Swedish Research Council.

Swedish Statute Book. (2008). *Diskrimineringslag (2008:567).* Ministry of Employment.

The National Agency for Special Needs Education and Schools. (2017). *Villkor för utbildning - Kartläggning av nuläge för barn, elever och vuxenstuderande med funktionsnedsättning.* The National Agency for Special Needs Education and Schools.

The Swedish National Council of Adult Education. (2017). *Folkbildningsrådets samlade bedömning – Folkbildningens betydelse för samhället 2017.* The Swedish National Council of Adult Education.

The Swedish National Council of Adult Education. (2018a). *Folkbildningsrådets samlade bedömning – Folkbildningens betydelse för samhället 2018*. The Swedish National Council of Adult Education.

The Swedish National Council of Adult Education. (2018b). *Folkhögskolans förstärkningsbidrag – En fördjupad analys 2017.* The Swedish National Council of Adult Education.

The Swedish National Council of Adult Education. (2019). *Fakta om folkbildningen.* The Swedish National Council of Adult Education.

Tulaci, R. G., Cankurtaran, E. S., Özdel, K., Öztürk, N., Kuru, E., & Özdemir, I. (2018). The relationship between theory of mind and insight in obsessive-compulsive disorder. *Nordic Journal of Psychiatry, 72*(4), 273–280. https://doi.org/10.1080/08039488.2018.1436724

UNESCO. (1994). *The Salamanca statement and framework for action on special needs education*. UNESCO.

Wallace, G. L., Case, L. K., Harms, M. B., Silvers, J. A., Kenworthy, L., & Martin, A. (2011). Diminished sensitivity to sad facial expressions in high functioning autism spectrum disorders is associated with symptomatology and adaptive functioning. *Journal of Autism and Developmental Disorders, 41*(11), 1475–1486. https://doi.org/10.1007/s10803-010-1170-0

White, S. J. (2013). The triple I hypothesis: Taking another's perspective on executive dysfunction in autism. *Journal of Autism and Developmental Disorders, 43*(1), 114–121. https://doi.org/10.1007/s10803-012-1550-8

Wibeck, V. (2010). *Om fokuserade gruppintervjuer som undersökningsmetod*. Studentlitteratur.

Andragoška spoznanja/Studies in Adult Education and Learning, 2021, 27(2), 33-52 UDK: 374.7
DOI: https://doi.org/10.4312/as/9577 Scientific article

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BILINGUALISM AND LANGUAGE EDUCATION TO IMPROVE THE COGNITIVE HEALTH OF OLDER PERSONS

ABSTRACT

This article explores whether lifelong bilingualism can be associated with delayed age-related cognitive decline, with cognitive (or brain) reserve as the mechanism that compensates by positively increasing the functional capacity of the brain for older persons. A structural review of recent psychoneurolinguistic studies shows that older bilinguals display several years of delay in dementia symptoms as compared to monolinguals, as well as that positive effects exist in bilingual brain networks, also related to other neurodegenerative disorders. The field is clearly missing an established methodology, nevertheless, lifelong bilingualism can be considered to induce cognitive reserve. Drawing from these implications, we hypothesize that successful ageing could be facilitated by the active use of multiple languages, and in this light, we discuss language education for older persons, the role of Third Age Universities, the implementation of crucial aspects in such courses, and the proper assessment of the effectiveness of language proficiency and cognition.

Keywords: *executive function, bilingualism, language education, stroke, older persons*

DVOJEZIČNOST IN JEZIKOVNO IZOBRAŽEVANJE ZA IZBOLJŠANJE KOGNITIVNEGA ZDRAVJA STAREJŠIH LJUDI – POVZETEK

V članku raziskujemo, ali lahko vseživljenjsko dvojezičnost povezujemo z zamikom starostnega pešanja kognitivnih sposobnosti in kognitivno rezervo kot mehanizmom, ki pozitivno vpliva na možganske zmogljivosti pri starejših ljudeh. Pregled novejših psiho- in nevrolingvističnih študij kaže, da pri starejših dvojezičnih osebah prihaja do večletnega zamika pojava simptomov demence v primerjavi z enojezičnimi osebami ter da obstajajo pozitivni učinki dvojezičnih možganskih mrež, prav tako povezani z drugimi nevrodegenerativnimi boleznimi. Na tem področju manjka metodologija, vendar pa lahko vseživljenjsko dvojezičnost povezujemo tudi s kognitivno rezervo. Na tej podlagi lahko postavimo hipotezo, da k zdravemu staranju lahko pripomore tudi aktivna raba več jezikov, na podlagi tega pa razpravljamo o jezikovni izobrazbi za starejše ljudi, vlogi univerz za tretje življenjsko obdobje, izvajanju kritičnih vidikov tovrstnih tečajev ter ustrezni oceni učinkovitosti znanja jezikov in kognicije.

Ključne besede: *izvršilne funkcije, dvojezičnost, jezikovno izobraževanje, možganska kap, starejši ljudje*

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INTRODUCTION

In Slovenia the older subpopulation worries about current and future personal health (Kavčič et al., 2012) and is dissatisfied or has unmet needs regarding health care services (Hlebec, 2018; Hlebec et al., 2016; Pevec & Pisnik, 2018), which altogether might contribute to personal identity crises (Zaletel et al., 2011) and possibly perpetuate cognitive decline later in life. However, educated older persons have shown less expression of narrow social identity (through limited social interactions from a smaller living environment), but more broad social identities formed by a general interest in society (Zaletel et al., 2011). Furthermore, older Slovenian persons that learn languages have mentioned maintenance of cognitive function and social inclusion (Miklič, 2018), love for language and travelling (Zavrl & Radovan, 2016) as reasons to learn new language skills, which might contribute to broad social identities. This might help explain why adults and older persons participate in foreign language courses at Slovenian Third Age Universities (Bizjak, 2010; Miklič, 2018; Sešek, 2012; Zavrl & Radovan, 2016) at what amounts to 49% of all annually offered courses (Sešek, 2012). There has not been much data collected on the cognition of the participants, but this does illustrate that older Slovenians are motivated to learn foreign languages.

This paper explores whether the use of multiple languages through life can improve cognitive health. An initial milestone paper by Bialystok et al. (2007) posed that lifelong bilingualism delays the onset of dementia, and several studies have been arguing in favour or against this ever since.

Thus, we will explore the population studies addressing the association between bilingualism and a delay in dementia, investigate the changes in brain physiology as corresponding neurobiological evidence, and describe the effects bilingualism has on other neurological disorders. Finally, we will also discuss empirical studies evaluating language education in older persons. With the goal of inducing beneficial health effects for the older population, recommendations are provided for implementing psycholinguistic research and language education for older persons at Third Age Universities.

THEORETICAL BACKGROUND

The active control of using multiple languages is a unique feature of humans. Language proficiency (speaking, listening, reading and writing) has been correlated to enhanced cognition (e.g. Diamond, 2013) as well as to a beneficial influence on children's cognitive development (e.g. Kovács & Mehler, 2009). The reason is that language contributes to behaviour, and in turn, behaviour is controlled by cognitive processes, often called executive functions. Examples of executive functions include attention, inhibition, working memory, planning, fluid intelligence, etc. (Diamond, 2013), and they are also involved in obtaining language proficiency.

Proficiencies in multiple languages acquired over a person's lifetime lead to bi- and multilingualism. These have been noted to enhance cognition, and although their effects are

somewhat muted in adulthood (Bialystok et al., 2012), a discussion has recently emerged on the benefits of life-long bilingualism and its effectiveness in older adulthood. A study by Bialystok et al. (2007) is the basis of this discussion. The authors suggest that lifelong bilingualism protects against age-related cognitive decline and may even postpone the onset of dementia symptoms. The lifelong exposure to, and the use of multiple languages, is supposed to be building up cognitive reserve.

Cognitive or brain reserve is a hypothetical definition which poses that through cognitive training the brain becomes more efficient, various parts will be more strongly connected, alternative pathways are used to execute brain functions, and eventually because of this, the brain is able to cope better with damage, infection, and disease (Stern, 2002). Over the last few decades, it has been proposed that cognitive reserve can be induced by several factors, like continual engagement in stimulating physical, intellectual, and social activities (Stern, 2012). Nowadays these factors are known to maintain cognitive functioning important for successfull ageing, and well-known co-factors that play crucial roles include level of education, occupational status, and socio-economic class.

RESEARCH METHODOLOGY

The search strategy and literature selection process followed the protocol of *preferred reporting items for systematic reviews and meta-analysis* (Moher et al., 2009). The following databases were searched: PubMed Medical Information System, Web of Science, and ScienceDirect, using a combination of keywords: bilingualism, language, older person, elderly, dementia, cognitive reserve. Studies needed to be published within the last 15 years and have reported the average age and number of older persons with distinction between monolinguals and bilinguals, and basic language proficiency.

DOES LIFELONG BILINGUALISM DELAY DEMENTIA?

The initial epidemiological study by Bialystok et al. (2007) affiliated with universities and health networks in Toronto, Canada, noticed that among immigrants who had been diagnosed with dementia but showed equal levels of cognition, monolinguals were clinically diagnosed with dementia at the average age of 75.4 years, versus 78.6 years for bilinguals, with no differences between the genders. In other words, the bilinguals experienced the onset symptoms later, and were diagnosed for dementia approximately 4.1 years later than the monolinguals.

In another independent Canadian immigrant study by Chertkow et al. (2010), the diagnosis of Alzheimer's disease-related dementia (ADRD) was delayed by almost 5 years in immigrants and in non-immigrants whose first language was French, but not for non-immigrants whose first language was English. In general, a small but significant protective effect was found in people who spoke more than two languages (Chertkow et al., 2010), where no gender differences were found. Bialystok et al. (2007) followed up their research with another set of English immigrants, but now only diagnosed with

probable ADRD (Craik et al., 2010), and again the bilingual patients were diagnosed 4.3 years later and reported the onset of symptoms 5.1 years later than the monolingual patients.

The studies that followed focused on non-immigrant populations. In California, the United States of America, a study among Spanish-English bilinguals who had been diagnosed with probable ADRD showed that a higher degree of bilingualism was associated with later ages of onset and diagnosis, although only in the less-educated patients (Gollan et al., 2011). In India, bilinguals speaking either Telugu, Hindi, Dakkhini, English, or a combination, developed ADRD on average 4.5 years later than monolinguals (Alladi et al., 2013), even in illiterate individuals, indicating that the difference in onset of dementia likely was not the effect of education, but better developed cognitive skills.

However, three large prospective cohorts from North America (Lawton et al., 2015; Yeung et al., 2014; Zahodne et al., 2014) did not find associations between bilingualism and the risk for dementia, irrespective of whether bilingualism was measured by self-reporting or an objective test. An explanation for the findings of these three large prospective cohorts perhaps lies in the previously mentioned study by Gollan et al. (2011), where it was reported that the relation of increasing levels of bilingualism were associated with increasingly later ages of diagnosis and onset of symptoms among Spanish-English bilinguals only in low-educated bilinguals, while no such effect was observed in higher educated subjects (although no monolingual control group was included and the sample size was small). For the large cohorts, education was not reported to influence the association of bilingualism and the onset of dementia symptoms, however, the levels of education were not reported in detail.

These studies were predominantly of a retrospective nature, that is, where the researchers grouped the subjects based on their exposure data and in retrospect compared the incidences of dementia. Recently, two prospective cohort studies were published where the baseline exposure data were collected before any of the subjects had developed any form of dementia. Thus, during a year of clinical monitoring, Bialystok et al. (2014) in Canada and Woumans et al. (2015) in Belgium confirmed that compared to monolingual subjects, bilingual ones were several years older in both age of dementia symptoms manifestation and the date of their first clinical diagnosis. Both studies observed a delay for bilinguals in manifestation and in diagnosis (about 5 years) for French-English and French-Dutch respectively, independent of gender and other lifestyle factors. Additionally, various executive functions were tested, of which the evaluated performances were comparable on the first occasion, while over the year of observation, similar declines in both mono and bilinguals were observed (Bialystok et al., 2014; Woumans et al., 2015).

However, some groups found conflicting results, challenging the relation and making the topic controversial. For example, a study from the U.K. among a Welsh-English

population (Clare et al., 2016) did not find a significant delay in the onset of dementia in bilinguals and monolinguals. At the age of diagnosis, the bilinguals had 3 years of difference (but not statistically significant), at which point they were already cognitively impaired, but did not differ significantly in executive functions (besides, over time some bilingual executive functions remained at a higher strength level).

In addition, another retrospective study with a New York ageing cohort (with self-reported language proficiency) was investigated by Sanders et al. (2012) and concluded that bilingualism does not have an independent protective effect against dementia, but rather induced a small non-significant increase of the risk to develop dementia, and higher education further enhances this risk. An Australian study with a large cohort spanning 20 years also concluded that quantity and quality of education, and not bilingualism, are a predictor of cognitive decline (Mukadam et al., 2018). Gollan et al. (2011) suggested that the power of cognitive reserve for delaying ADRD, particularly for higher educated bilinguals, did not have a further effect, and they posed that there had to be an upper limit on the amount of cognitive reserve. A recent meta-analysis on the pooled data of several of the above-described prospective cohorts by Mukadam et al. (2017) gave a combined odds ratio of dementia of 0.96 in bilinguals compared to monolinguals. However, Mukadam et al.'s statistical and methodological approach was heavily debated (e.g. Woumans et al., 2017).

Due to incomplete information gathered by these prospective and retrospective studies, the psycholinguistic field initialised an on-going public discussion that has addressed some inconsistencies regarding the methodological issues for this kind of psycholinguistic research. To eliminate controversy in future studies, the following methodological aspects need to be aligned: 1) the level of bilingualism or multilingualism and its lifetime span need to be determined properly, based on objective language proficiency tests; 2) standard cognitive test batteries addressing various executive functions need to be implemented that generate comparable datasets; 3) detailed information on the education of the participants (both in time and degrees) are needed; 4) new longitudinal studies fulfilling these basic methodologies need to be performed.

Nevertheless, from the studies on about 2000 patients with reasonable assessment of both language proficiency and dementia incidences (summarised in Table 1), it is possible to draw a preliminary conclusion that bilingualism (or multilingualism) might be an effective cognitive lifestyle to significantly delay the onset of ADRD symptoms (4 to 5 years), irrespective of gender, various lifestyle factors, or the combination of language proficiencies.

Table 1
Overview of the research papers' study characteristics regarding lifelong bilingualism and dementia

Study	Study type, number of participants, (N), description of persons, bilinguals (B), monolinguals (M), average age (y), percentage female (%)	Name of study and organisation, country, time period, first and other languages	Impact of lifelong bilingualism on dementia
Alladi et al. (2013)	Retrospective; N=650, dementia registered older patients, 66.2y, 35%; M=257, 61.1y, 49%; B=391, 65.6y, 35%	Memory Clinic of a university hospital in Hyderabad, India, between 2006–2012; Telugu, Dakkhini, Hindi, English	B developed dementia 4.5y later than M; significant difference in age at onset ADRD as well as frontotemporal and vascular dementias, also observed in illiterate patients; no additional benefit to speaking more than 2 languages.
Bialystok et al. (2007)	Retrospective records analysis of cohort; N=184, 90% older immigrants; M=91, 75.4y, 53%; B=93, 78.6y; 59%	Memory Clinic at Baycrest, Toronto, Canada, between 2000–2005; French, English, Polish, Yiddish, German, Romanian, Hungarian	B significant difference of 4.1y later age of onset of dementia symptoms; B were 3.2y older than M at the time of initial clinic appointment; delayed onset of symptoms for B significant in probable ADRD patients (delay of 4.3y), for other dementias, with 3.5y delay; no difference in the rate of cognitive decline between B and M.
Bialystok et al. (2014)	Longitudinal; N=149, older MCI or ADRD diagnosed patients; M=73, 52%; B=76, 55%	Sam and Ida Ross Memory Clinic at Baycrest, Toronto, Canada, with 3 sessions over one y; French, English	B several years older than M at age of symptom onset (4.7y for MCI, 7.3y for ADRD) and date of first clinic visit (3.5y for MCI, 7.2y for ADRD), independent of lifestyle variables; first testing, performance on the EF tasks comparable between M and B; EF performance declined over 3 sessions, but no differences in the rate of decline between M and B.
Cherthow et al (2010)	Retrospective records analysis of cohort; N=632, older immigrants and non-immigrants; M=379, 76.7y, 63%; B=253, 77.6y; 52%	Memory Clinic of the Jewish General Hospital, Montreal, Canada, between 1997–2006; French, English, Canadian aboriginal languages	Non-significant 1.0y difference, with B having symptom onset slightly later; immigrant B were diagnosed 5.1 y later than M; non-immigrant B, the difference was significant, with M having dementia diagnosis 2.6 years later than B; no difference in rate of cognitive decline between B and M.

Study	Study type, number of participants, (N), description of persons, bilinguals (B), monolinguals (M), average age (y), percentage female (%)	Name of study and organisation, country, time period, first and other languages	Impact of lifelong bilingualism on dementia
Claire et al. (2016)	Cross-sectional cohort; N=86, older diagnosed ADRD patients; M=49, 78.8y, 45%; B=37, 80.8y, 57%	Memory Clinics in North Wales, United Kingdom; Welsh, English	Non-significant difference in age at time of diagnosis; B 3y older than M, but B were significantly more cognitively impaired at time of diagnosis; no significant differences between M and B in EF tests; B appeared to show relative strengths in the domain of inhibition and response conflict.
Craik et al. (2010)	Longitudinal; N=211; diagnosed with probable ADRD; M=109, 72.6y, 55%; B=102, 77.7y, 58%	Sam and Ida Ross Memory Clinic at Baycrest, Toronto, Canada, between 2007–2009; English, Yiddish, Polish, Italian, Hungarian, French, other languages	B diagnosed 4.3y later; B onset symptoms reported 5.1y later; equivalent cognitive level; no immigration effect; M received more formal education.
Gollan et al. (2011)	Retrospective longitudinal; N=44, Hispanic older persons; B prefer English=22, 75.1y; B prefer Spanish=22, 77.1y	University of California, San Diego Alzheimer's Disease Research Center, San Diego, California, United States, between 2002–2007; Spanish, English	Higher degrees of bilingualism associated with increasingly later age-of-diagnosis and age of onset of symptoms; significant interaction between years of education and bilingualism.
Lawton et al. (2015)	Retrospective cross-sectional; N=1777, 80.5y, immigrant and U.S.-born, Hispanic Americans; M=1152; B=625	Latino Study on Aging, Sacramento, Sacramento Area, California, United States, between 1988–2008; Spanish, English	Mean age of dementia diagnosis was not significantly different for B, M; B dementia cases were significantly better educated than M; US-born B and M did not differ significantly in education.
Mukadam et al. (2018)	Retrospective longitudinal; N=2087, older participants, 65y; M=1901; B=186	Australian Longitudinal Study of Ageing, Adelaide, South-Australia between 1992–2014; English, other languages	B lower baseline MMSE scores than M, explained by education that partly explained baseline EF test scores differences; B and M did not differ in MMSE decline over time nor on baseline EF tests.

Study	Study type, number of participants, (N), description of persons, bilinguals (B), monolinguals (M), average age (y), percentage female (%)	Name of study and organisation, country, time period, first and other languages	Impact of lifelong bilingualism on dementia
Sanders et al. (2012)	Retrospective longitudinal, N = 1779, older citizens, 78.6y, 61%; M=1389, 78.3y, 61%; B=390, 79.4y, 61%	Einstein Aging Study at Bronx, New York, United States, between 1993–2010; English, non-native English speakers	No statistically-significant association between non-native English speaking and incident dementia or ADRD; increased risk of dementia for non-native English speakers with ≥16 years of education.
Woumans et al. (2015)	Longitudinal; N=134, new probable ADRD patients; M=69, 76.4y, 70%; B=65, 77.9y, 70%	Ghent University Hospital and Brussels University Hospital, Ghent and Brussels, Belgium, between 2013–2014; French, Dutch, English, German, other languages	Significant delay for B of 4.6y in manifestation and 4.8y in diagnosis.
Yeung et al. (2014)	Retrospective cross-sectional; N=1616; community-dwelling older persons; M=913; 77.4y, 60%; B=703; 77.1y, 58%	Canadian Study of Health and Aging, Manitoba, Canada, between 1991–1997; English, French and other bilingual	B had lower education, lower 3MS scores, more subjective memory loss, and more likely to be diagnosed with cognitive impairment; B no dementia at both two timepoints compared with M; no association between B and dementia at first timepoint; no association between B and dementia at second timepoint.
Zahodne et al. (2014)	Retrospective cross-sectional; N=1067, Spanish emigrants; M=637, 75.7y, 72%; B=430, 74.9y, 64%	Washington/Hamilton Heights Inwood Columbia Aging Project, Northern Manhattan, Washington, United States between 1992–1999; Spanish, English	B associated better memory and executive function at baseline; B not independently associated with rates of cognitive decline or dementia conversion.

Note. ADRD = Alzheimer's Disease-Related Dementia; 3MS = modified MMSE; EF = Executive Function; MCI = Mild Cognitive Impairment; MMSE = Mini-Mental State Examination; y = year

BRAIN STRUCTURES AND THEIR RELEVANCE TO LANGUAGE AND BILINGUALISM

It is especially important to discuss cognitive brain reserve in connection with the human trait of highly evolved language proficiency. In the last few decades, our understanding of the brain's functionality has dramatically improved, and we know about the brain's

plasticity, meaning it adapts its functionality to repeated stimuli and/or activities. Learning and memory processes are a good example of research with repeated natural stimuli that has yielded profound understanding of changes in the brain at the neuronal level and their networks, identifying essential adapted biochemical pathways (e.g. Ramakers et al., 1997).

Although the brain circuits, structures, and the corresponding executive functions activated with language usage are not fully understood or identified and might in fact vary for the different ages (Mohades et al., 2015), the brain areas presumed to be potentially involved will be discussed, and if possible, the observed neuroanatomical changes therein coinciding with the use of multiple languages.

Two networks are presumed to play important but distinct roles during language processes. The *executive control network (ECN)* is generally associated with focused cognitive tasks, working memory, control processes and other executive functions, and links dorsolateral frontal and parietal neocortices. During many cognitive tasks when the *ECN* is activated, the *default mode network (DMN)* shows reduced activity (Crittenden et al., 2015). The *DMN* is a widely distributed connected network of brain areas influencing behaviour and non-focused tasks, with presumed modulating roles in language processing: in dementia patients with ADRD, the *DMN* is often being negatively affected, but for bilinguals the *DMN* has been shown to be increasingly connected (Grady et al., 2015; Perani et al., 2017).

Within the *executive control network*, language control is determined by the activation of the following areas: the *temporal-parietal cortex*, with the classic *Broca* and *Wernicke* areas (important in speech production and speech comprehension as well as various non-language cognitive tasks), is responsible for maintaining the target of conversation; the *left prefrontal cortex* updates the language, inhibits the language that is not being used, and corrects errors (Luk et al., 2010, 2011). From studying young bilingual subjects, it is believed that the *anterior cingulate cortex* monitors the selection of the correct language and verifies whether language and requirement are matching, i.e., conflict monitoring (Abutalebi et al., 2012). The activity of the *anterior cingulate cortex* increases while switching languages, and it communicates with other areas of the brain, among others the subcortical areas, the *nucleus caudatus*, and the *basal ganglia*, including the left *putamen*, which supervise language selection. Their activities vary with language proficiency, while the switch from most to least proficiently spoken language triggers the highest activity (Abutalebi et al., 2013a; 2013b). These subcortical areas can in turn modulate the activity of the *prefrontal cortex* (Luk et al., 2011). The hippocampus (one in each hemisphere) is part of the subcortical limbic system and crucial for language learning since both short- and long-term memory depend on its activity.

Brain areas are generally composed of white and grey matter. While grey matter contains the neuronal cell bodies, dendrites, and the axon terminals with the synapses, white matter contains the axons connecting the different areas of grey matter to each other. In

bilinguals with probable ADRD atrophy was substantially greater in the temporal areas as compared to monolinguals with ADRD (Schweizer et al., 2012). However, Gasquoine (2016) correctly points out that the bilingual research has yielded inconsistencies in white and grey matter changes (and/or their relation to executive functioning). A reason would be that straightforward interpretation was hindered because the research conducted until then comprised predominantly young bilinguals, while only recently older subjects have been investigated in more detail. Recent studies with older subjects have noticed that bilinguals and monolinguals overall did not differ in grey matter volume (Borsa et al., 2018; Gold et al., 2013a; Olsen et al., 2015). It has been noted that more grey matter is present in the *dorsolateral prefrontal cortex* of bilinguals (Abutalebi et al., 2015), with greater frontal lobe white matter volume (Olsen et al., 2015), despite bilinguals showing lower white matter integrity (Gold et al., 2013a). An explanation for the latter findings is that changes in brain integrity and volume could represent different processes of atrophy, occurring at different times. Nevertheless, recent reviews, taking more relevant studies into account, have concluded that bilinguals show overall better-preserved grey and white matters (Pliatsikas, 2019), with structural changes in language-relevant brain areas (Hayakawa & Marian, 2019), among others larger hippocampal volumes (Voits et al., 2020).

For monolinguals, the thickness of temporal pole cortices was smaller with advancing age (Olsen et al., 2015), which was not observed for bilinguals. In addition, it was shown that older bilinguals with ADRD had higher tissue densities and thicker cortices in medial-temporal areas than age-matched monolinguals (Anderson et al., 2018; Duncan et al., 2018).

On the matter of executive functioning, age-related performance reductions were observed while comparing older and younger bilinguals (Gold et al., 2013b). Older bilinguals outperformed their age-matched monolinguals. Furthermore, older bilinguals displayed decreased activation in the *left frontal cortex* and *cingulate cortex* as compared to age- and cognitively matched older monolinguals, and this was directly correlated to better task-switching performance (Gold et al., 2013b). In line with this are the functional magnetic resonance imaging scans during the performance of the Simon task, a switching and response task depending on the ability to suppress irrelevant information. Older bilinguals as compared to older monolingual persons typically did not recruit frontal brain areas, instead predominantly activating the left inferior parietal area (Ansaldo et al., 2015), a typical opposite of the posterior-anterior shift observed in normal ageing. The review by Pliatsikas (2019) concludes that bilinguals with ADRD who perform equally well in cognitive tests as monolinguals do show less severe neurodegeneration. This is also reflected in that bilinguals who do have larger hippocampi do not perform better when it comes to episodic memory (Voits et al., 2020).

A posterior-anterior shift, combined with increased connectivity in both the *DMN* and *ECN*, is a classic brain feature believed to be a compensation mechanism in ageing persons (Ansaldo et al., 2015; Gold, 2015; Perani et al., 2017). While monolingual seniors have an extended and bilateral pattern of neuronal decline with age, bilingual seniors show a less-extended and only leftward pattern of age related effects (Borsa et al., 2018).

Besides, in bilingual patients with probable ADRD (Perani et al., 2017), metabolic hypoconnectivity patterns were observed that significantly correlated with the degree of lifelong bilingualism (Perani et al., 2017), corresponding to the brain areas mentioned for the leftward age decline by Borsa et al. (2018). For bilinguals, the connectivity was increased bilaterally in frontoparietal areas, as well as for specific language areas in the right-hemisphere (Gold, 2015; Perani et al., 2017).

In conclusion, there are structural changes of critical right hemispheres of the *ECN* for older bilinguals, and the absence of the posterior-anterior shift, but enhanced connectivities and thicker neocortices in both the *DMN* and *ECN* in ageing bilinguals. In combination with the delay in onset/manifestation of dementia and the positive assessments of the executive functions for bilinguals, these would indeed suggest that bilinguals wait longer before attending a clinic, as they rely longer on their more connected brain structures formed by active multiple language use during their life, possibly inducing cognitive reserve.

BILINGUALISM-INDUCED NEUROPROTECTIVE EFFECTS IN OTHER NEUROLOGICAL DISORDERS

As pointed out in the previous paragraphs, lifelong bilingualism seems to be associated with a later onset of dementia, and with a structurally changed and more connected, perhaps more resilient brain. This raises the question whether life-long bilingualism affects the incidence or severity of neurological disorders other than dementia later in life.

Besides bilingualism delaying ADRD for 3.2 years (Alladi et al., 2013), the same study from India also reports delays in other dementias, for example, vascular dementia for 3.7 years, where different cellular structures are targeted and which is often associated with a high incidence of stroke. A sudden limitation of blood supply to certain parts of the brain deprives the neurons of oxygen and nutrients causing cellular damage, and if it is too long or too severe, irreversible neuronal cell death. The vascular risk factor might be different for higher lifelong language proficiency. Thus, Ischemic stroke patients were retrospectively evaluated by a clinical research centre (Alladi et al., 2016) and showed a twice as high percentage of patients with intact cognitive functions after stroke for bilinguals as compared to monolinguals. This suggests that bilingualism has a protective role in post-stroke cognitive impairment.

Frontotemporal dementia was also delayed for 6.0 years (Alladi et al., 2013). Here the frontal and the lateral parts of the brain, the areas coinciding with the maintenance and control of language, are affected by neuronal death. Alladi and colleagues diagnosed 193 patients with frontotemporal dementia syndromes over a decade (Alladi et al., 2017). Especially the age of onset of the behavioural type of frontotemporal dementia was significantly delayed for as long as 5.7 years, independently of other factors like education and gender (Alladi et al., 2017). However, this was not the case for other types of frontotemporal dementia, including motor neuron disease with a delay of (merely) 3 years, and only 0.7 years for the aphasia type, where the language comprehension and production

are affected due to brain damage in the left hemisphere (indirectly due to the trauma of the disease which is often a stroke).

Parkinson's disease is a motor-neurodegenerative disorder in which the dopaminergic producing neurons of the *substantia nigra* face early neuronal death during a person's life. This usually affects the person's movement, gait, and balance, as well as causes rigidity and tremors; the consequences of these manifestations are often fatal. Since the *substantia nigra*, one of the basal ganglia, is affected and plays a crucial role in the supervision of language selection and modulation of the activity of the prefrontal cortex (see previous section), language might be impaired beside additional executive functions. A cross-sectional cohort among a Welsh-English population of Parkinson's disease patients (Hindle et al., 2015) showed that the monolinguals performed better in the language tests. Moreover, despite the finding that the bilingual Parkinson's disease patients did not perform better in overall executive control tasks than the monolingual Parkinson's patients, the degree of bilingualism correlated with better nonverbal reasoning and better working memory (Hindle et al., 2015). In contrast, among a population of Catalan-Spanish bilinguals, Parkinson's patients showed decreased processing speed, less accuracy and more errors in language switching tasks as compared to healthy non-Parkinson's bilinguals (Cattaneo et al., 2015). It was noted that these abilities of language control became impaired only when the non-linguistic abilities were affected by the disease. This suggests that some mechanisms of bilingual language control are not necessarily dependent on the *ECN* (Cattaneo et al., 2015). Because these performances were not compared to healthy executive functions and the properties of monolingual control networks, the effects of life-long bilingualism on Parkinson's disease remain largely unexplored.

Another neurodegenerative disorder, Huntington's, is heritable, and causes neuronal cell death in the basal ganglia, *nucleus caudatus*, and *putamen*, and eventually in the *cerebral cortex* as well. Changes in mood and mental abilities are often the earliest symptoms, while later failure of both coordination and gait occur. Martínez-Horta et al. (2019) thoroughly investigated the brain structures and executive functions of Spanish-Catalan bilinguals and concluded that the higher use of bilingualism moderates the degree of neural integrity, giving rise to higher grey matter volumes in multiple frontotemporal regions. These life-induced changes had a significantly better impact on task performances like inhibition, attention and anticipation, monitoring and task-switching; they also contributed to better preserved motor and functional capacity among the Huntington's patients (Martínez-Horta et al., 2019). These results hint at some cognitive advantage induced through life-long bilingualism for Huntington's disorder patients.

Looking at these various neurological disorders, it seems that life-long bilingualism does make the ageing brain more connected, strengthened through essential trajectories, and thus, in general creates a brain capable of coping with the damage of neurological disorders for longer. In other words, bilingualism does induce some form of cognitive reserve. Unfortunately, descriptions of the effects of lifelong bilingualism on most clinical neurodegenerative disorders (other than dementia) have been limited.

PLANNING LANGUAGE EDUCATION AS A NEUROPROTECTIVE MEASURE FOR OLDER PERSONS

Despite positive associations of language proficiency and early life cognition (Diamond, 2013; Kovács & Mehler, 2009), associations between language learning and cognitive advantages for later in life are under investigation (Poisnel et al., 2018), but are mostly embedded in earlier literature.

Bak et al. (2014) tested the influence of bilingualism in 853 participants over 63 years and showed a positive effect of bilingualism on old age cognition, including for those who acquired their second language in adulthood (Bak et al., 2014). In addition, a retrospective cohort in the U.S.A. investigated whether language education before the age of 18 was associated with the risk of developing mild cognitive decline (Wilson et al., 2015). The results showed that higher levels of foreign language instruction during childhood were associated with lower risk of developing cognitive decline in old age but not with the rate of decline.

An English-French technology-based language learning programme in which 14 older French persons participated, attending 16 2-hour sessions over a period of 4 months (Ware et al., 2017), showed that the scores for both cognition and subjective feelings of loneliness and social isolation at post-intervention did not change. Yet the intervention was perceived as difficult, enjoyable, and stimulating. Bak et al. (2016) showed that attending a Scottish-Gaelic language course once per week for 5 hours for 3 weeks improved the attention in the older persons compared to non-attendants. Meanwhile, 4 hours or less per week showed an inconsistent pattern: some improved but others stayed the same or deteriorated. However, a recent study with monolingual older persons attending a Spanish-Basque language course for 5.5 hours for over 8 months (Ramos et al., 2017), and older Telugu-English bilinguals (Mishra et al., 2019) did not show any difference between cognition or performances in switching paradigms. On the other hand, a study with older Dutch-Frisian bilinguals reported to switching often between the two languages as active bilinguals, did show significant differences in switching paradigms in favour of the bilinguals (Houtzager et al., 2017). This discrepancy in switching results is explained in that bilinguals may not often use skills like shifting, switching, inhibition, or monitoring and that only the on-going practice of these skills through active usage of bilingualism may modulate executive control (Houtzager et al., 2017). In other words, the active use of two languages, and not just passive exposure to them, requires the activation of essential cognitive mechanisms (Borsa et al., 2018). It is important to note that only such cognitive challenges then translate into better performance on tasks measuring individual cognitive components, including switching paradigms, once proficiency is levelled up (that is, later in life). This is important to consider in designing a study, since to investigate bilingual advantages through language education, the study needs to include a protocol to properly assess certain functions.

Thus, to have older persons learn a new language up to proficiency, continue to practice active bilingualism, and subsequently contribute to building up cognitive reserve, one

needs to carefully plan the learning paradigm. The following recommendations build on previous notions (Miklič, 2018; Zavrl & Radovan, 2016) and further research is needed to propose proper and effective methodologies that fulfil these recommendations: 1) establish personal difficulties and make sure the older person's auditory and visual perceptions are not hindered during classes; 2) incorporate abundant time within the period of learning (preferably long, not flash courses); 3) add multiple contact hours with repetitions during the educational period (preferably hours scattered over several days a week for effective memorisation); and 4) challenge the participants by using multiple languages during the assignments to demand shifting, switching, and inhibition activities. Moreover, language education for older persons needs to be approached differently from other age groups. Hence, 5) courses need to fullfil a personal service to each participant and therefore course materials and interactions depend on the participants' personal experiences and acquired knowledge, and 6) the content for a class will be challenging to prepare and compile, and should be much more varied in nature. Besides, 7) depending on the objectives of both the teacher and the participant, the improvement of language proficiency and cognitive abilities, and/or life satisfaction requires a clear and detailed assessment plan of the effectiveness of both language learning and cognition. The present review clearly indicates that the field of psychoneurolinguistics has only recently started to develop such criteria.

CONCLUSIONS

The current paper presents evidence that life-long bilingualism will provide the older brain with stronger neural pathways to cope better with neurological damage. Consequently, it is suggested that learning an additional foreign language at later ages might follow that relation, provided the second language will be maintained and actively used.

The small Republic of Slovenia, situated in the heart of Europe and surrounded by larger countries, is a multilingual nation and the use of multiple languages is very common. Two of its border regions are officially bilingual: Hungarian and Italian are publicly used and protected, while many more languages are spoken and many dialects can be found over several generations. Like in other parts of Europe, in the future these might be recognized as separate languages, more or less distinct from the official language. This multilingual aspect of Slovenia is reflected in that older Slovenian adults are very motivated to learn foreign languages (Miklič, 2018; Sešek, 2012) and the number of potential students of language courses conducted by the Third Age University could number a few thousand annually (Sešek, 2012). There is an opportunity for Third Age Universities to act as social gathering points and places to learn new or maintain and upgrade foreign language skills beneficial for one's personal brain health. The motivation for participating ranges from love of languages to the maintenance of cognitive abilities (Bizjak, 2010; Miklič, 2018; Sešek, 2012; Zavrl & Radovan, 2016), but the effectiveness in the long-term has not been evaluated in terms of cognition or life satisfaction (Bizjak, 2010; Miklič, 2018; Sešek, 2012; Zavrl & Radovan, 2016). Third Age Universities should link their adult education

process to a more scientific evaluation through standardised language proficiency and cognitive test batteries, and establish collaborations with psycholinguistic and social fields. After all, the positive long-term effects on cognition and life satisfaction language courses have for older persons in terms of contributing to brain health and the public health perspective would be widely applicable, socially, and economically relevant, and cost effective as well.

Slovenian Third Age Universities can contribute to increasing general public health. An unconscious will to maintain one's cognitive abilities might be contagious as less socially active older persons might be persuaded more easily to join their friends and participate. The Universities can adapt their courses to be socially and cognitively challenging for various social backgrounds, and in this way, the older subpopulations might undergo reductions in social isolation and an increase in self-confidence, leading to better cognitive health. Foreign language instruction and its effectiveness, in collaboration with academia, provides an opportunity to emphasize the benefits of such courses and present them as a neuroprotective advantage contributing to better brain health. Besides, the older population might gain more appreciation within society for providing evidence of the potential benefits of bilingualism and/or its neuroprotective advantages, while the adult education process will become more widely appreciated as socially relevant.

Acknowledgements

Special thanks to Dr. Janja Plazar and Dr. Irina Moira Cavaion for useful suggestions regarding previous versions of the manuscript.

Funding

This work was prepared as part of the research programme Kinesiology for Quality of Life (P5-0381), funded by the Slovenian Research Agency.

REFERENCES

Abutalebi, J., Della Rosa, P. A., Castro Gonzaga, A. K., Keim, R., Costa, A., & Perani, D. (2013b). The role of the left putamen in multilingual language production. *Brain & Language*, *125*(3), 307–135. https://doi.org/10.1016/j.bandl.2012.03.009

Abutalebi, J., Della Rosa, P. A., Ding, G., Weekes, B., Costa, A., Green, D. W. (2013a). Language proficiency modulates the engagement of cognitive control areas in multilinguals. *Cortex, 49*(3), 905–911. https://doi.org/10.1016/j.cortex.2012.08.018

Abutalebi, J., Della Rosa, P. A., Green, D. W., Hernandez, M., Scifo, P., Keim, R., Cappa, S. F., & Costa, A. (2012). Bilingualism tunes the anterior cingulate cortex for conflict monitoring. *Cerebral Cortex*, *22*(9), 2076–2086. https://doi.org/10.1093/cercor/bhr287

Abutalebi, J., Guidi, L., Borsa, V., Canini, M., Della Rosa, P. A., Parris, B. A., & Weekes, B. S. (2015). Bilingualism provides a neural reserve for aging populations. *Neuropsychologia*, *69*, 201–210. https://doi.org/10.1016/j.neuropsychologia.2015.01.040

Alladi, S., Bak, T. H., Duggirala, V., Surampudi, B., Shailaja, M., Shukla, A. K., Chaudhuri, J. R., & Kaul, S. (2013). Bilingualism delays age at onset of dementia, independent of education and immigration status. *Neurology*, *81*(22), 1938–1944. https://doi.org/10.1212/01.wnl.0000436620.33155.a4

Alladi, S., Bak, T. H., Mekala, S., Rajan, A., Chaudhuri, J. R., Mioshi, E., Krovvidi, R., Surampudi, B., Duggirala, V., & Kaul, S. (2016). Impact of bilingualism on cognitive outcome after stroke. *Stroke*, *47*(1), 258–261. https://doi.org/10.1161/STROKEAHA.115.010418

Alladi, S., Bak, T. H., Shailaja, M., Gollahalli, D., Rajan, A., Surampudi, B., Hornberger, M., Duggirala, V., Chaudhuri, J. R., Kaul, S. (2017). Bilingualism delays the onset of behavioral but not aphasic forms of frontotemporal dementia. *Neuropsychologia*, *99*, 207–212. https://doi.org/10.1016/j.neuropsychologia.2017.03.021

Anderson, J. A. E., Grundy, J. G., de Frutos, J., Barker, R. M., Grady, C., & Bialystok, E. (2018). Effects of bilingualism on white matter integrity in older adults. *Neuroimage*, *167*,143–150. https://doi.org/10.1016/j.neuroimage.2017.11.038

Ansaldo, A. I., Ghazi-Saidi, L., & Adrover-Roig, D. (2015). Interference control in elderly bilinguals: Appearances can be misleading. *Journal of Clinical and Experimental Neuropsychology*, *37*(5), 455–470. https://doi.org/10.1080/13803395.2014.990359

Bak. T. H., Long, M. R., Vega-Mendoza, M., & Sorace, A.. (2016). Novelty, challenge and practice: The impact of intensive language learning on attentional functions. *PloS One*, *11*(4), https://doi.org/10.1371/journal.pone.0153485

Bak, T. H., Nissan, J. J., Allerhand, M. M., & Deary, I. J. (2014). Does bilingualism influence cognitive aging? *Annals of Neurolology*, *75*(6), 959–963. https://doi.org/10.1002/ana.24158

Bialystok, E., Craik, F. I. M., Binns, M. A., Ossher, L., & Freedman, M. (2014). Effects of bilingualism on the age of onset and progression of MCI and AD: Evidence from executive function tests. *Neuropsychology*, *28*(2), 290–304. https://doi.org/10.1037/neu0000023

Bialystok, E., Craik, F. I., & Freedman, M. (2007). Bilingualism as a protection against the onset of symptoms of dementia. *Neuropsychologia*, *45*(2), 459–464. https://doi.org/10.1016/j.neuropsychologia.2006.10.009

Bialystok, E., Craik, F. I. M., & Luk, G. (2012). Bilingualism: consequences for mind and brain. *Trends in Cognitive Sciences*, *16*(4), 240–250. https://doi.org/10.1016/j.tics.2012.03.001

Bizjak, K. (2010). Neformalno pridobivanje znanja tujega jezika. *Studies in Adult Education and Learning*, *16*(2), 77–87. https://doi.org/10.4312/as.16.2.77-87

Borsa, V. M., Perani, D., Della Rosa, P. A., Videsott, G., Guidi, L., Weekes, B. S., Franceschini, R., & Abutalebi, J. (2018). Bilingualism and healthy aging: Aging effects and neural maintenance. *Neuropsychologia*, *111*, 51–61. https://doi.org/10.1016/j.neuropsychologia.2018.01.012

Cattaneo, G., Calabria, M., Marne, P., Gironell, A., Abutalebi, J., & Costa, A. (2015). The role of executive control in bilingual language production: A study with Parkinson's disease individuals. *Neuropsychologia*, *66*, 99–110. https://doi.org/10.1016/j.neuropsychologia.2014.11.006

Chertkow, H., Whitehead, V., Phillips, N., Wolfson, C., Atherton, J., & Bergman, H. (2010). Multilingualism (but not always bilingualism) delays the onset of Alzheimer's disease: evidence from a bilingual community. *Alzheimer Disease and Associated Disorders*, *24*(2), 118–125. https://doi.org/10.1097/WAD.0b013e3181ca1221

Clare, L., Whitaker, C. J., Craik, F. I., Bialystok, E., Martyr, A., Martin-Forbes, P. A., Bastable, A. J. M., Pye, K. L., Quinn, C., Thomas, E. M., Mueller Gathercole, V. C., & Hindle, J. V. (2016). Bilingualism, executive control, and age at diagnosis among people with early-stage Alzheimer's disease in Wales. *Journal of Neuropsychology*, *10*(2), 163–185. https://doi.org/10.1111/jnp.12061

Craik, F. I., Bialystok, E., & Freedman, M. (2010). Delaying the onset of Alzheimer disease: Bilingualism as a form of cognitive reserve. *Neurology*, *75*(19), 1726–1729. https://doi.org/10.1212/WNL.0b013e3181fc2a1c

Crittenden, B. M., Mitchell, D. J., & Duncan, J. (2015). Recruitment of the default mode network during a demanding act of executive control. *eLife*, *4*. https://doi.org/10.7554/eLife.06481

Diamond, A. (2013). Executive functions. *Annual Reviews of Psychology*, *64*, 135–168. https://doi.org/10.1146/annurev-psych-113011-143750

Duncan, H. D., Nikelski, J., Pilon, R., Steffener, J., Cherthow, H., & Phillips, N. A. (2018). Structural brain differences between monolingual and multilingual patients with mild cognitive impairment and Alzheimer disease: Evidence for cognitive reserve. *Neuropsychologia*, *109*, 270–282. https://doi.org/10.1016/j.neuropsychologia.2017.12.036

Gasquoine, P. G. (2016). Effects of bilingualism on vocabulary, executive functions, age of dementia onset, and regional brain structure. *Neuropsychology*, *30*(8), 988–997. https://doi.org/10.1037/neu0000294

Gold, B. T. (2015). Lifelong bilingualism and neural reserve against Alzheimer's disease: A review of findings and potential mechanisms. *Behavioral Brain Research, 281*, 9–15. https://doi.org/10.1016/j.bbr.2014.12.006

Gold, B. T., Johnson, N. F., Powell, D. K. (2013b). Lifelong bilingualism contributes to cognitive reserve against white matter integrity declines in aging. *Neuropsychologia, 51*(13), 2841–2846. https://doi.org/10.1016/j.neuropsychologia.2013.09.037

Gold, B. T., Kim, C., Johnson, N. F., Kryscio, R. J., & Smith, C. D. (2013a). Lifelong bilingualism maintains neural efficiency for cognitive control in aging. *Journal of Neuroscience*, *33*(2), 387–396. https://doi.org/10.1523/JNEUROSCI.3837-12.2013

Gollan, T. H., Salmon, D. P., Montoya, R. I., & Galasko, D. R. (2011). Degree of bilingualism predicts age of diagnosis of Alzheimer's disease in low-education but not in highly educated Hispanics. *Neuropsychologia*, *49*(14), 3826–3830. https://doi.org/10.1016/j.neuropsychologia.2011.09.041

Grady, C. L., Luk, G., Craik, F. I., & Bialystok, E. (2015). Brain network activity in monolingual and bilingual older adults. *Neuropsychologia*, 66, 170–181. https://doi.org/10.1016/j.neuropsychologia.2014.10.042

Hayakawa, S., & Marian, V. (2019). Consequences of multilingualism for neural architecture. *Behavioral and Brain Functions*, *15*(1), 6. https://doi.org/10.1186/s12993-019-0157-z

Hindle, J. V., Martin-Forbes, P. A., Bastable, A. J., Pye, K. L., Martyr, A., Whitaker, C. J., Craik F. I. M., Bialystok, E., Thomas, E. M., Mueller Gathercole V. C., & Clare, L. (2015). Cognitive reserve in Parkinson's disease: The effects of Welsh-English bilingualism on executive function. *Parkinson's Disease*, *2015*, 943572. https://doi.org/10.1155/2015/943572

Hlebec, V. (2018). Evaluation of access to long-term care services for old people ageing in place in Slovenia. *Zdravstveno Varstvo*, 57(3), 116–123. https://doi.org/10.2478/sjph-2018-0015

Hlebec, V., Srakar, A, & Majcen, B. (2016). Determinants of unmet needs among Slovenian old population. *Zdravstveno Varstvo*, *55*(1), 78–85. https://doi.org/10.1515/sjph-2016-0011

Houtzager, N., Lowie, W., Sprenger, S., & De Bot, K. (2017). A bilingual advantage in task switching? Age-related differences between German monolinguals and Dutch-Frisian bilinguals. *Bilingualism: Language & Cognition, 20*(1), 69–79. https://doi.org/10.1017/S1366728915000498

Kavčič, M., Hrast, M. F., & Hlebec, V. (2012). Starejši ljudje in njihove strategije shajanja s tveganji za zdravje . *Zdravstveno Varstvo*, *51*, 163–172. https://doi.org/10.2478/v10152-012-0019-7

Kovács, A. M., & Mehler, J. (2009). Cognitive gains in 7-month-old bilingual infants. *Proceedings of the National Academy of Sciences of the United States of America*, *106*(16), 6556–6560. https://doi.org/10.1073/pnas.0811323106

Lawton, D. M., Gasquoine, P. G., & Weimer, A. A. (2015). Age of dementia diagnosis in community dwelling bilingual and monolingual Hispanic Americans. *Cortex*, *66*, 141–145. https://doi.org/10.1016/j.cortex.2014.11.017

Luk, G., Anderson, J. A., Craik, F. I., Grady, C., & Bialystok, E. (2010). Distinct neural correlates for two types of inhibition in bilinguals: Response inhibition versus interference suppression. *Brain & Cognition*, *74*(3), 347–357. https://doi.org/10.1016/j.bandc.2010.09.004

Luk, G., Green, D. W., Abutalebi, J., & Grady, C. (2011). Cognitive control for language switching in bilinguals: A quantitative meta-analysis of functional neuroimaging studies. *Language & Cognitive Processes*, *27*(10), 1479–1488. https://doi.org/10.1080/01690965.2011.613209

Martínez-Horta, S., Moreu, A., Perez-Perez, J., Sampedro, F., Horta-Barba, A., Pagonabarraga, J., Gomez-Anson, B., Lozano-Martinez, G. A., Lopez-Mora, D. A., Gamacho, V., Fernández-León, A., Carrió, I., & Kulisevsky, J. (2019). The impact of bilingualism on brain structure and function in Huntington's disease. *Parkinsonism & Related Disorders*, *60*, 92–97. https://doi.org/10.1016/j.parkreldis.2018.09.017

Miklič, T. (2018). Vidiki učenja tujih jezikov na univerzi za tretje življenjsko obdobje. *Studies in Adult Education and Learning*, *24*(2), 57–75. https://doi.org/10.4312/as.24.2.57-75

Mishra, R. K., Padmanabhuni, M., Bhandari, P., Viswambharan, S., & Prasad, S. G. (2019). Language proficiency does not modulate executive control in older bilinguals. *Aging, Neuropsychology and Cognition*, *26*(6), 920–951. https://doi.org/10.1080/13825585.2018.1562029

Mohades, S. G., Van Schuerbeek, P., Rosseel, Y., Van de Craen, P., Luypaert, R., & Baeken, C. (2015). White matter development is different in bilingual and monolingual children: A longitudinal DTI study. *PloS One*, *10*(2). https://doi.org/10.1371/journal.pone.0117968

Moher, D., Liberati, A., Tetzlaff, J., Altman, D. G., & PRISMA group. (2009). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. *Annals of Internal Medicine*, *151*(4), 264–269. https://doi.org/10.1371/journal.pmed.1000097

Mukadam, N., Jichi, F., Green, D., & Livingston, G. (2018). The relationship of bilingualism to cognitive decline: The Australian longitudinal study of ageing. *International Journal of Geriatric Psychiatry*, *33*(2), 249–256. https://doi.org/10.1002/gps.4778

Mukadam, N., Sommerlad, A., & Livingston, G. (2017). The relationship of bilingualism compared to monolingualism to the risk of cognitive decline or dementia: A systematic review and meta-analysis. *Journal of Alzheimer's Disease*, *58*(1), 45–54. https://doi.org/10.3233/JAD-170131

Olsen, R. K., Pangelinan, M. M., Bogulski, C., Chakravarty, M. M., Luk, G., Grady, C. L., & Bialystok, E. (2015). The effect of lifelong bilingualism on regional grey and white matter volumes. *Brain Research*, *1612*, 128–139. https://doi.org/10.1016/j.brainres.2015.02.034

Perani, D., Farsad, M., Ballarini, T., Lubian, F., Malpetti, M., Fracchetti, A., Magnani, G., March, A., & Abutalebi, J. (2017). The impact of bilingualism on brain reserve and metabolic connectivity in Alzheimer's dementia. *Proceedings of the National Academy of Sciences of the United States of America*, *114*(7), 1690–1695. https://doi.org/10.1073/pnas.1610909114

Pevec, T., & Pisnik, A. (2018). Empirical evaluation of a conceptual model for the perceived value of health services. *Zdravstveno Varstvo*, *57*(4), 175–182. https://doi.org/10.2478/sjph-2018-0022

Pliatsikas, C. (2019). Multilingualism and brain plasticity. In J. W. Schwieter (Ed.), *Handbook of the Neuroscience of Multilingualism* (pp. 230–251). John Wiley & Sons.

Poisnel, G., Arenaza-Urquijo, E., Collette, F., Klimecki, O. M., Marchant, N. L., Wirth, M, de La Sayette, V., Rauchs, G., Salmon, E., Vuilleumier, P., Frison, E., Maillard, A., Vivien, D., Lutz, A., Chételat, G., & Medit-Aging research group. (2018). The Age-Well randomized controlled trial of the Medit-Ageing

European project: Effect of meditation or foreign language training on brain and mental health in older adults. *Alzheimer's & Dementia*, *4*, 714–723. https://doi.org/10.1016/j.trci.2018.10.011

Ramakers, G. M., Pasinelli, P., Hens, J. J., Gispen, W. H., & De Graan, P. N. (1997). Protein kinase C in synaptic plasticity: Changes in the in situ phosphorylation state of identified pre- and postsynaptic substrates. *Progress in Neuro-psychopharmacology & Biological Psychiatry*, *21*(3), 455–486. https://doi.org/10.1016/s0278-5846(97)00013-4

Ramos, S., Fernández-García, Y., Antón, E., Casaponsa, A., & Duñabeitia, J. A. (2017). Does learning a language in the elderly enhance switching ability? *Journal of Neurolinguistics*, *43*(A), 39–48. https://doi.org/10.1016/j.jneuroling.2016.09.001

Sanders, A. E., Hall, C. B., Katz, M. J., & Lipton, R. B. (2012). Non-native language use and risk of incident dementia in the elderly. *Journal of Alzheimer's Disease, 29*(1), 99–108. https://doi.org/10.3233/JAD-2011-111631

Schweizer, T. A., Ware, J., Fisher, C. E., Craik, F. I., & Bialystok, E. (2012). Bilingualism as a contributor to cognitive reserve: Evidence from brain atrophy in Alzheimer's disease. *Cortex*, *48*(8), 991–996. https://doi.org/10.1016/j.cortex.2011.04.009

Sešek, U. (2012). Neformalno učenje tujih jezikov v Sloveniji – posnetek iz zraka. *Vestnik za Tuje Jezike, 4*(1–2), 149–157. https://doi.org/10.4312/vestnik.4.149-157

Stern, Y. (2002). What is cognitive reserve? Theory and research application of the reserve concept. *Journal of the International Neuropsychological Society*, *8*(3), 448–460. https://doi.org/10.1017/S1355617702813248

Stern Y. (2012). Cognitive reserve in ageing and Alzheimer's disease. *Lancet Neurology*, *11*(11), 1006–1012. https://doi.org/10.1016/S1474-4422(12)70191-6

Voits, T., Robson, H., Rothman, J., & Pliatsikas, C. (2020, July 17). *The effects of bilingualism on the structure of the hippocampus and on memory performance in ageing bilinguals.* PsyArXiv. https://doi.org/10.31234/osf.io/8hcxz

Ware, C., Damnee, S., Djabelkhir, L., Cristancho, V., Wu, Y. H., Benovici, J., Pino, M., & Rigaud, A. S. (2017). Maintaining cognitive functioning in healthy seniors with a technology-based foreign language program: A pilot feasibility study. *Frontiers in Aging Neuroscience*, *9*, 42. https://doi.org/10.3389/fnagi.2017.00042

Wilson, R. S., Boyle, P. A., Yang, J., James, B. D., & Bennett, D. A. (2015). Early life instruction in foreign language and music and incidence of mild cognitive impairment. *Neuropsychology*, *29*(2), 292–302. https://doi.org/10.1037/neu0000129

Woumans, E., Santens, P., Sieben, A., Versijpt, J., Stevens, M., & Duyck, W. (2015). Bilingualism delays clinical manifestation of Alzheimer's disease. *Bilingualism: Language & Cognition, 18*(3), 568–574. https://doi.org/10.1017/S136672891400087X

Woumans, E., Versijpt, J., Sieben, A., Santens, P., & Duyck, W. (2017). Bilingualism and cognitive decline: A story of pride and prejudice. *Journal of Alzheimer's Disease*, *60*(4), 1237–1239. https://doi.org/10.3233/JAD-170759

Yeung, C. M., St. John, P. D., Menec, V., & Tyas, S. L. (2014). Is bilingualism associated with a lower risk of dementia in community-living older adults? Cross sectional and prospective analyses. *Alzheimer Disease and Associated Disorders*, *28*(4), 326–332. https://doi.org/10.1097/WAD.0000000000000019

Zahodne, L. B., Schofield, P. W., Farrell, M. T., Stern, Y., & Manly, J. J. (2014). Bilingualism does not alter cognitive decline or dementia risk among Spanish-speking immigrants. *Neuropsychology*, *28*(2), 238–246. https://doi.org/10.1037/neu0000014

Zaletel, M., Levec, T., Zajec Mihelič, A., & Zaletel Kragelj, L. (2011). Individual and social identity of residents of old people's homes in Slovenia. *Zdravstveno Varstvo*, *50,* 272–285. https://doi.org/10.2478/v10152-011-0006-4

Zavrl, K., & Radovan, M. (2016). Tečaji španščine za starejše odrasle na univerzi za tretje življenjsko obdobje in v dnevnih centrih aktivnosti za starejše. *Studies in Adult Education and Learning*, *22*(1), 7–20. https://doi.org/10.4312/as.22.1.7-20

Andragoška spoznanja/Studies in Adult Education and Learning, 2021, 27(2), 53-74 UDK: 374.7
DOI: https://doi.org/10.4312/as/9934 Scientific article

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BUILDING EVIDENCE FOR THE IMPACT OF OLDER ADULT LEARNING ON ACTIVE AGEING: A QUANTITATIVE STUDY

ABSTRACT

Lifelong learning constitutes one of the pillars of active ageing on the basis that learning reinforces wellbeing and enables older people to stay healthy and engaged in society. This paper reports on a pretest-posttest study carried out at the University of the Third Age in Malta that measured the impact of late-life learning on levels of active ageing. The findings demonstrated that participation in older adult learning has a strong positive impact on the participants' levels of active ageing and constitutes a resilient source of social capital in later life, and that people who presumably have had positive early experiences of education are more motivated to engage in late-life learning. The paper concludes that lifelong learning in later life acts as a possible mitigation to the social isolation, cognitive impairment, and age discrimination that people tend to experience in later life.

Keywords: *University of the Third Age, social capital, successful ageing, Malta*

ZBIRANJE DOKAZOV O VPLIVU UČENJA STAREJŠIH ODRASLIH NA AKTIVNO STARANJE: KVANTITATIVNA ŠTUDIJA – POVZETEK

Vseživljenjsko učenje je eden od temeljev aktivnega staranja, saj učenje krepi dobro počutje in tako omogoča starejšim ljudem, da ostajajo zdravi in vključeni v družbo. Članek poroča o študiji tipa prej-potem (pretest-posttest), izvedeni na Univerzi za tretje življenjsko obdobje na Malti, ki je merila učinek, ki ga ima učenje kasneje v življenju na aktivno staranje. Ugotovitve so pokazale, da ima učenje starejših odraslih močan pozitiven vpliv na stopnjo aktivnega staranja udeležencev in zanje pomeni vir socialnega kapitala, hkrati pa so ljudje, ki so imeli v zgodnjem življenju pozitivne izkušnje z učenjem, bolj motivirani, da sodelujejo pri učenju tudi kasneje. Članek ugotavlja, da vseživljenjsko učenje pri starejših odraslih lahko blaži socialno izolacijo, kognitivno oslabitev in starostno diskriminacijo, ki se običajno pojavijo pri starejših.

Ključne besede: *univerza za tretje življenjsko obdobje, socialni kapital, uspešno staranje, Malta*

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INTRODUCTION

The terms "active ageing" and "lifelong learning" have become catchphrases of our era, slogans bandied about in conferences, symposia, and seminars by academics, policy-makers, trade unionists, non-governmental organisations, and employers alike (Formosa, 2019b, 2019c). This is both welcoming and promising since one does not have to go back many years to when the adage "you cannot teach an old dog new tricks" was an unfailing assumption across all facets of the social fabric (Findsen & Formosa, 2011). However, while one finds many research articles highlighting how learning in later life constitutes a key determinant of active ageing (e.g. Boulton-Lewis & Buys, 2015; Tam, 2013), generally such studies followed a qualitative methodological framework. Indeed, quantitative enquiries that assess the impact of older adult learning on active ageing and which provide confirmatory statistical evidence remain elusive. It is certainly not enough to merely associate participation in older adult learning with the ideals of active ageing, especially since the assumption that any type of education improves the quality of life and wellbeing of older people is nothing other than conventional wisdom (Formosa, 2011).

This article responds to such a lacuna by reporting upon a pretest-posttest study carried out at the University of the Third Age (U3A) in Malta which sought to measure the impact of participation in older adult learning on the levels of active ageing of new members. The subsequent section of the article delineates the key boundaries of active ageing, older adult learning, and how they interface with each other. It is followed by a brief note on the research design of the study which is warranted for reliability and validity purposes. The fourth and fifth sections present the results of the study and its analytical implications, before a concluding part notes the salient implications of this research study and recommendations for further research.

ACTIVE AGEING AND OLDER ADULT LEARNING

The notion of "active ageing" can be traced to the 1960s when the consensus amongst gerontologists was that ageing successfully in later life hinged on the maintenance of activity patterns and values typical of middle age. An oft-cited definition of active ageing is

> the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age. Active ageing applies to both individuals and population groups […]. The word 'active' refers to continuing participation in social, economic, cultural, spiritual and civic affairs, not just the ability to be physically active or to participate in the labour force. (World Health Organization, 2002, p. 12)

Whilst initially the World Health Organization's (WHO) (2002) policy framework hinged active ageing upon three pillars – namely, health, participation and security – subsequent years witnessed the addition of "lifelong learning" as a fourth pillar (International Longevity Centre Brazil, 2015). The rationale was that "lifelong learning is important

not only to employability but also to the reinforcement of well-being […][;] it equips us to stay healthy, and remain relevant and engaged in society" (International Longevity Centre Brazil, 2015, p. 48). This integration of "lifelong learning" into the active ageing discourse also resulted from the rising number of studies uncovering positive correlations between (i) longer periods of compulsory education and better health/income levels, (ii) participation in adult education and self-esteem, confidence, social participation, and physical activity levels, and (iii) enrolment in older adult learning and higher self-reported cognitive performance, health, and levels of activity (Narushima et al., 2018).

The WHO's discourse is far from ideal and has been criticised from various fronts, most notably for its western geographical and gender biases, neglecting certain sectors of the older population such as people with disabilities and non-heterosexual people, and for expecting older adults to maintain the same levels of activity as they did in middle age since this is tantamount to denying the onset of old age (Formosa, 2020). Indeed, contemporary times witnessed the emergence of an active ageing discourse where "being active" implied the continued engagement in any social, economic, cultural or civic activity at the level of one's capacity in later life. Yet the WHO's framework remains extremely beneficial to the ongoing advocacy work in favour of the human rights of older people. It also served to transcend the traditional conceptualisations of later life away from the constricted realms of health-oriented policy and towards the "mainstream of economic, social and cultural debate" (Salter & Salter, 2018, p. 1069). In Walker's words,

> the WHO policy added further weight to the case for a refocusing of active aging away from employment and toward a consideration of all of the different factors that contribute to well-being […]. [I]t emphasized the critical importance of a life-course perspective […][;] to prevent some of the negative consequences associated with later life, it is essential to influence individual behavior and its policy context at earlier stages of the life course. (Walker, 2009, p. 84)

Turning our attention to older adult learning, this occurs when older adults, "individually and in association with others, engage in direct encounter and then purposefully reflect upon, validate, transform, give personal meaning to and seek to integrate their ways of knowing" (Mercken, 2010, p. 9). Statistical research on the participation rates of older people in learning activities remains elusive. However, a review of the available literature elicited three key findings: a lower percentage of older learners compared to younger peers, a sharp decline of participation as people reached their seventh decade, and that typical learners are middle-class women (Formosa & Findsen, 2016b). A key debate in older adult learning is concerned not with "whether we can or cannot teach or retrain an older adult" but "to what end?" and "why?" Primarily, late-life learning was commended for assisting adults to adjust to the negative transformations that accompany "old age", such as decreasing health, the retirement transition, reduced income, death of a spouse, and changing social and civic obligations (Formosa, 2019a). Glendenning and Battersby (1990), and later Formosa (2010, 2012), posited a more radical agenda and bestowed

late-life learning with the responsibility of empowering older people with the necessary advocacy skills that are needed to mitigate against the exclusionary forces brought on by neo-liberalism and capitalism. In reaction, Percy (1990, p. 237) posited a humanistic rationale whereby learning was perceived as a "personal quest" that prioritises "process" over "content", and where the role of an educator "is to facilitate the process of learning for the learner" rather than "persuade him [sic] to social action or to be dissatisfied if a certain political awareness is not achieved". Others advocated the possibility of "transcendental" learning for older adults to reflect on their lives and repair relationships, and hence, understand their role in the world and attitudes towards death (Russell, 2008).

One finds a range of literature focusing on that interface between older adult learning and active ageing. Two of the most prominent researchers in this field, Gillian Boulton-Lewis and Maureen Tam, have long decreed how continued learning benefits active ageing (e.g. Boulton-Lewis et al., 2006; Boulton-Lewis & Tam, 2012; Tam, 2013, 2014). Their studies refer to a myriad of primary and secondary research to highlight the existing positive relationship between physical, emotional, and social wellbeing on the one hand, and late-life learning on the other. In separate studies, they concluded:

> Active ageing, in its simplest terms, is a strategy to maximize the quality of life and well-being of elders […]. Elder Academies wield the greatest potential for realizing the goal of achieving active ageing through elder learning. (Tam, 2013, p. 257)

> [E]ngagement in learning […] keeps older people involved in enjoying and living life fully through building self-confidence and coping strategies, maintaining cognitive functioning and knowledge, managing their health, keeping up with technological developments, maintaining social relationships, and encouraging wisdom. (Boulton-Lewis & Buys, 2015, p. 764)

Other research trails take us to the specific long-ranging impact of participation in non-formal learning on the levels of active ageing of older men (Formosa et al., 2014; Fragoso et al., 2014; Tambaum et al., 2019) and older women (Formosa, 2005; Wilińska, 2016). Whilst one cannot dispute the capacity of learning initiatives to lead towards improved levels of physical, emotional and social capital – all of which are key catalysts and determinants for active ageing in later life –, it is problematic that research studies that use an operationalised tool to measure and quantify the impact of learning on active ageing remain lacking. One reason underlying this misfortune is that the WHO provided little practical guidance regarding the definition or measurement of each active ageing pillar and instead encouraged nations to utilise the framework to identify and address the needs of their ageing population within the context of their own unique cultures and values. Truly, the quasi-experimental investigations conducted by Fernández-Ballesteros and colleagues (2012), which found that late-life learning improved learners' cognitive performance, health and levels of social activity, and emotional balance on one hand, and reduced negative self-perceptions on ageing and group stereotypes on the other, were

promising developments. However, these studies utilised generic assessment tools measuring a range of welfare and cultural stereotype indicators (e.g. Watson et al., 1988) rather than applying an operationalised tool that measures "active ageing" as such. Elsewhere, Arpino and Solé Auró (2019) used, highly arbitrarily, three variables from the *Survey of Health, Ageing and Retirement in Europe* (Börsch-Supan et al., 2015) – social participation, paid work, and grandchild care – to measure active ageing when several studies have warned against the usage of composite indicators since such an approach disguises poor performance in parts of the system due to the aggregations involved (Ravallion, 2010). Therefore, a key lacuna of many research designs included the confounding of the meanings of active ageing and wellbeing. This lapse emerged clearly in Boulton-Lewis and Buys's (2015, p. 764) research conclusions when they stated that "the purpose of the research described in this paper was to explore, from the perspectives of older people, *active learning that might enhance* wellbeing" (italics added). Such confounding of active ageing and wellbeing is not unique in the field of gerontology. Indeed, confounding successful and productive ageing with quality of life, or reducing it to either one of its components of wellbeing or life satisfaction, is also common. This study's efforts to resolve such a confounding challenge is presented in the forthcoming section.

METHODS

The aim of the study was to investigate the impact of participation in third age learning on levels of active ageing. Objectives were threefold: (i) to assess the change on levels of active ageing following participation in an older adult learning programme; (ii) to identify differences in changes to levels of active ageing according to age, gender, educational attainment, and attendance turnout; and (iii) to locate those domains of active ageing that benefit most following participation in a late-life learning programme. This study had its genesis in the Centre for Third Age Education (2013–2017) project founded by the Tempus Programme of the European Union in which the U3A in Malta was one of 17 partners. Permission to participate in this project, thereby carrying out this study, was obtained from the University of Malta and its University Research Ethics Board, under whose auspices lies the Maltese U3A. The study opted for a quasi-experimental research enterprise that included a one-group pretest-posttest design to compare groups or/and to measure the change that took place following an intervention, and included four key stages. The *first* stage consisted of locating an appropriate late-life learning programme in which the pretest-posttest study could be carried out. It was decided to embed the study in the University of the Third Age (U3A) in Malta. The U3A was founded in Toulouse in 1973 and can be defined as

> socio-cultural centres where senior citizens [sic] may acquire new knowledge of significant issues, or validate the knowledge which they already possess, in an agreeable milieu and in accordance with easy and acceptable methods, with the objective of preserving their vitality and participating in the life of the community. (Midwinter, 1984, p. 18)

Instrumentation

The *second* stage concerned locating a suitable instrument to measure active ageing. There exist four assessment scales of active ageing: the Active Ageing Index (AAI) (Zaidi, 2015), the University of Jyvaskyla Active Ageing Scale (UJACAS) (Rantanen et al., 2019), the Active Aging Scale for Thai Adults (AAS-T) (Thanakwang et al., 2014), the WHO (2002) model of active ageing, and the Australian Active Ageing (Triple A) study (Buys & Miller, 2012). While the AAI was precluded due to its fallacious assumption that "an increase in the indicator results from an improvement in the elders' conditions, rather than a deterioration of the conditions in the rest of the population" (Amado et al., 2016, p. 209), the AAS-T was also dropped as some of its factors are exceedingly specific to the Thai cultural fabric. The WHO definition was also rejected on the basis that the research found that the emergent data was not found to fit the resulting statistical model (Bélanger et al., 2017; Fernández-Ballesteros et al., 2013). At the same time, the attempt to quantify active ageing in the Australian Active Ageing (Triple A) study, despite being

Table 1
The UJACAS 17-item scale on active ageing

Scale abbreviation	Full scale item
Crafting	I have done crafting, DIY or other pastimes requiring manual skills.
Artistic pursuits	I have drawn, sung or played a musical instrument, written or practiced some other artistic pursuit.
Social events	I have taken part in various events or activities to do with studying or with clubs or associations.
Nature	I have gone outside and enjoyed the nature.
Physical exercise	I have practiced keeping physically fit.
Cognitive training	I have made an effort to exercise my mind or memory.
Using technology	I have used a computer or a pad.
Helping others	I have helped or supported people close to me or other people.
Maintain social relations	I have done things to maintain my social relationships.
Meet new people	I have taken actions to make new acquaintances.
Promote own matters	I have taken responsibility for furthering matters relating to my own life.
Societal activity	I have taken responsibility for promoting societal or public matters.
Make days interesting	I have done things to make my days more interesting or delightful.
Make home cosy	I have improved or maintained the cosiness of my home.
Appearance	I have taken care of my external appearance.
Economic balance	I have ensured that my financial affairs are in order.
Spirituality	I have acted to further matters according to my faith or worldview.

From *University of Jyvaskyla Active Ageing Scale UJACAS*, by Gerontology Research Center, n.d. (https://www.gerec.fi/en/research/activeageing/active-ageing-agnes-study/active-ageing-scale-ujacas/).

both comprehensive and rigorous, still needs to be validated for different national contexts. Ultimately, this study opted for the UJACAS, which consists of a 17-item scale, whereby each item consists of a standard 5-pont Likert dis(agreement) scale. A key factor underlying this decision was that the UJACAS expounded active ageing as a quantifiable entry, by validating its scores against other indicators of activity and wellbeing by an occupational therapist, and also by checking for any possible problems regarding reliability issues (Rantanen et al., 2019) (Table 1).

In comparison to other empirical scales for active ageing, the strengths of the UJACAS are the definition of active aging at the level of the individual that was used as the foundation for its development, the novelty of developing a scale for assessing active aging as a quantifiable construct, the item response analyses, and the participant involvement (Rantanen et al., 2019).

Sample

The *third* stage involved the sampling procedure and the collection of data. Since Malta is a bilingual nation and U3A members are literate in both the English and Maltese languages (Formosa, 2016), the plan was for the UJACAS English version to be distributed to all *new members* of the University of the Third Age at the start and end of the first academic semester, in October 2018 (T1) and June 2019 (T2) respectively. During the piloting phase, which took place at the end of September 2018, it turned out that whilst respondents were confused by the linguistic nuances discerning the first three columns of the original UJACAS – namely, "will to act", "ability to act", and "possibility to act" – they had no problems with understanding and completing the final column titled "frequency of doing". A decision was thus taken to collect data only on the latter item, thus inquiring about the respondents' levels of engagement in the 17-scale events during the past four weeks. As in the original UJACAS, respondents had an option of five answers: "very much", "quite a lot", "to some extent", "only a little", and "not at all" (Ratanen et al., 2019). Table 2 compares the respondents across their demographic characteristics and attendance at the U3A.

Whilst 73% of new U3A members were women, the remaining 27% were men. The respondents' age was also not evenly distributed, with a relatively high percentage of people aged in the 60–64 age bracket (56.9%). The mean and median age stood at 67.1 and 65 years respectively. The majority of new members (70.8%) had attained a secondary level of education, although a significant percentage of 26.3% reported that they attended educational classes at the post-secondary level. As regards attendance during the October 2018–June 2019 period, the majority of respondents (59.1%) attended more than 75% of the learning sessions. While rank-biserial correlation coefficient tests found no significant association between either gender and age (0.048, $p = 0.221$) or between gender and educational attainment (0.103, $p = 131$), Kendall's rank correlation coefficient uncovered a significant and negative "moderate" association between age and educational attainment (- 0.673, $p = 0.0321$).

Table 2
Demographic data of participating U3A members at T1 and T2 (N=137)

Demographic data	Category	Number	Per cent
Gender	Male	37	27
	Female	100	73
Age (years)	60-64	78	56.9
	65-69	39	28.5
	70-74	18	13.2
	75-79	1	0.7
	80-84	1	0.7
Highest educational attainment	Primary education	4	2.9
	Secondary education	97	70.8
	Tertiary education	36	26.3
Attendance (percentage)	1 - 25	7	5.1
	26 - 50	10	7.3
	51 - 75	39	28.5
	76 - 100	81	59.1

Procedure

The *final* stage consisted of the procedural analysis of data. The data was analysed using the Statistical Package for Social Scientists (Version 27). Reflecting the study's aim and objectives, the null and research (alternative) hypothesis were as follows:

Null Hypothesis 1:
There is no statistically significant difference between pre-test and post-test score results.
Alternative Hypothesis 1:
There is a statistically significant difference between pre-test and post-test score results.

Null Hypothesis 2:
There is no relationship between gender and changes in the scores of active ageing.
Alternative Hypothesis 2:
There is a relationship between gender and changes in the scores of active ageing.

Null Hypothesis 3:
There is no relationship between age and changes in the scores of active ageing.
Alternative Hypothesis 3:
There is a relationship between age and changes in the scores of active ageing.

Null Hypothesis 4:
There is no relationship between educational attainment and changes in the scores of active ageing.

Alternative Hypothesis 4:
There is a relationship between educational attainment and changes in the scores of active ageing.

Null Hypothesis 5:
There is no relationship between turnout in attendance and changes in the scores of active ageing.
Alternative Hypothesis 5:
There is a relationship between turnout in attendance and changes in the scores of active ageing.

Null Hypothesis 6:
Turnout in attendance impacted each specific form of active ageing in an equal measure.
Alternative Hypothesis 6:
Turnout in attendance impacted each specific form of active ageing in different measures.

The data analysis procedure included 5 independent and 17 dependent variables. The former consisted of age, gender, educational level, and the number of lectures attended over a nine-month period, and the latter entailed each of the 17 items on the UJACAS scale. As there is no official record of attendance, as per the U3A's ethos of "learning as an end-in-itself", this variable was conditional upon self-reported statements. Prior to the comparing of variables, tests were conducted to determine whether the distribution of data was normal. While descriptive statistics were used to define the independent demographic data, the rank-biserial correlation coefficient test was used to examine whether there was any significant association between gender, age, and educational attainment. Subsequently, the Kendall's rank correlation coefficient examined any significant association between age and educational attainment. While the Wilcoxon signed-rank test was utilised to compare the mean UJACAS scores between T1 and T2, the effect size (Cohen's d) was calculated to indicate the standardised difference in active ageing between time points (Cohen, 1992). The study also conducted analyses to compare mean UJACAS scores against gender (rank-biserial test), age (Kendall test), educational attainment (Kendall test), and attendance (Kendall test).

RESULTS

The targeted population consisted of 167 first-time members at the U3A. Each member was forwarded two copies of the questionnaire that included an identical index number on each copy, and asked to complete one copy during October 2018 (pre-test stage) and another copy in June 2019 (post-test stage). 150 questionnaires were collected at the pre-test stage, of which two were excluded due to incomplete data, leaving a total of 148 completed surveys. One hundred and thirty-seven questionnaires were collected at the post-test stage, with none exhibiting incomplete data. The shortfall in completed forms required that the 11 missing questionnaires, located from the matching index numbers, were to be discarded. This left a total of 137 matched questionnaires for data analysis (82% response rate, margin of error: 3.56%). Prior to the comparison of variables, tests were conducted to determine

whether the data sets were normally distributed. In this respect, both the Kolmogorov-Smirnov and Shapiro-Wilk tests concluded that the data test was not normally distributed ($p = 0.004 / < 0.001$), and thus required that the data analysis makes use of non-parametric tests. This result was an expected result since Likert scale data are never normally distributed in that values are bound either on the left- and or right-hand side (Khamis, 2008).

Pre-test analysis

The internal consistency (Cronbach's alpha) of the UJACAS scale at T1 and T2 was found to be "good" (0.879) and "excellent" (0.922) respectively. Table 3 compares the mean scores obtained by comparing the respondents' scores in the UJACAS scale at T1 and T2 through the Wilcoxon signed rank test.

Table 3
Mean, median, and standard deviations of UJACAS scores at T1 and T2

Scales	T1 (*N* = 137)			T2 (*N* = 137)			t-test scores (p-value) T1 vs. T2
	Mean	Median	SD	Mean	Median	SD	
Crafting	2.48	3	± 0.79	3.08	4	± 1.15	3.482
Artistic pursuits	2.48	2	± 0.68	3.12	3	± 1.11	3.290
Social events	2.71	3	± 0.86	3.79	4	± 1.01	7.484
Nature	2.77	3	± 0.96	3.73	4	± 0.96	4.380
Physical exercise	2.78	3	± 0.99	3.76	4	± 0.99	6.888
Cognitive training	2.78	3	± 1.01	3.88	4	± 1.01	7.720
Technology	2.59	2	± 0.95	3.60	4	± 1.01	7.001
Helping others	2.58	2	± 1.08	3.63	4	± 1.05	7.142
Maintain soc. relations	2.48	2	± 1.08	3.57	3	± 1.21	7.588
Meet new people	2.81	3	± 0.97	3.73	4	± 0.96	7.199
Promote own matters	2.93	3	± 0.87	3.35	4	± 1.06	7.512
Societal activity	2.79	3	± 0.87	4.05	4	± 1.25	7.825
Make days interesting	2.66	3	± 0.87	3.37	4	± 0.88	4.310
Make home cosy	2.67	3	± 0.97	3.54	4	± 1.31	4.381
Appearance	2.48	2	± 1.00	3.61	4	± 1.04	4.565
Economic balance	2.54	2	± 1.02	3.43	4	± 1.02	4.394
Spirituality	2.62	2	± 1.07	3.43	4	± 1.08	4.294

The effect size for the difference in the UJACAS post-test scores was 0.748, hence close to the Cohen (1988) convention for a strong effect ($d = 0.8$). Data analysis also found a significant and positive improvement in the *overall* scores between the two timeframes ($t = 7.700$, $p < 0.001$). As a result, Null Hypothesis 1 was rejected in favour of the alternative hypothesis that there is a systematic significant difference between pre-test and post-test score results.

Analysing each item on the scale, one finds that while the strongest relationships were recorded for "societal activity", "maintain social relationships", "attending social events", "helping others", "meet new people", "cognitive training" and "using technology" – in that order.

As regards the second hypothesis, the rank-biserial correlation coefficient test found a weak, albeit significant, association between gender and score improvements in the levels of active ageing (0.112, p = 0.029) (Table 4). Hence, Null Hypothesis 2 was rejected and Alternative Hypothesis 2 was affirmed. A scatter diagram of both variables found that women tend to hold higher score improvements than men (Figure 1).

Table 4

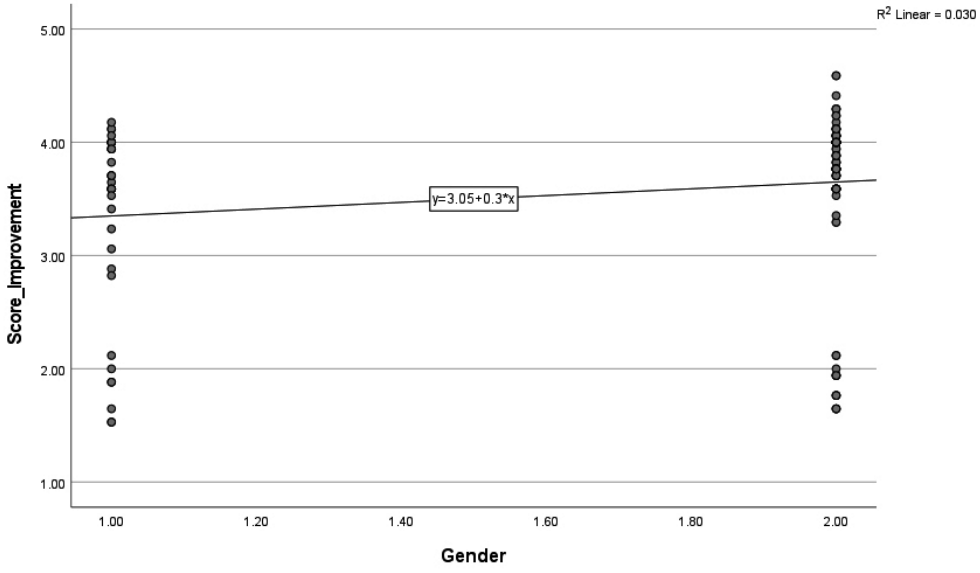
Bivariate correlation between gender and changes in the scores of active ageing (Rank-Biserial)

		Score improvement	Gender
Score improvement	Pearson Correlation	1.000	.112*
	Sig. (2-tailed)	.	.029
	N	137	137
Gender	Pearson Correlation	.112*	1.000
	Sig. (2-tailed)	.029	.
	N	137	137

*. Correlation is significant at the 0.05 level (2-tailed).

Figure 1

Scatter diagram for gender (1=Men, 2=Women) and changes in the scores of active ageing



As regards the third hypothesis, the Kendall's coefficient of rank correlation found a weak, albeit significant, relationship (0.177, p = 0.014) between age and score improvements in the indicators of active ageing (Table 5). Hence, Null Hypothesis 3 was rejected in favour of Alternative Hypothesis 3. A scatter diagram of both variables found that younger members tend to hold higher score improvements than older ones (Figure 2).

Table 5

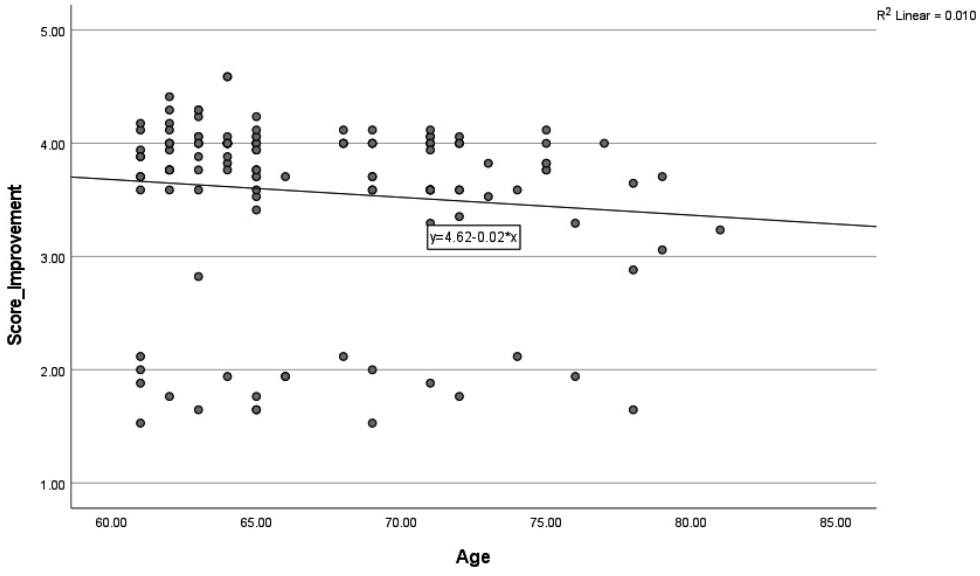
Bivariate correlation between age and changes in the scores of active ageing (Kendall's tau b)

		Score improvement	Age
Score improvement	Correlation Coefficient	1.000	.177*
	Sig. (2-tailed)	.	.014
	N	137	137
Age	Correlation Coefficient	.177*	1.000
	Sig. (2-tailed)	.014	.
	N	137	137

*. Correlation is significant at the 0.05 level (2-tailed).

Figure 2

Scatter diagram for age (years) and changes in the scores of active ageing



As regards the fourth hypothesis, the Kendall's coefficient of rank correlation found a statistically significant and strong relationship (0.801, p = 021) between educational

attainment and score improvements in the levels of active ageing (Table 6). Hence, Null Hypothesis 4 was rejected in favour of Alternative Hypothesis 4, in that a relationship was found between educational attainment and changes in the scores of active ageing.

Table 6
Bivariate correlation between educational attainment and changes in the scores of active ageing (Kendall's tau b)

		Score improvement	Educational attainment
Score improvement	Correlation Coefficient	1.000	.801*
	Sig. (2-tailed)	.	.021
	N	137	137
Educational attainment	Correlation Coefficient	.801*	1.000
	Sig. (2-tailed)	.021	.
	N	137	137

*. Correlation is significant at the 0.05 level (2-tailed).

As regards the fifth hypothesis, the Kendall's coefficient of rank correlation found a statistically strong and significant relationship (0.825, $p < 0.001$) between turnout in attendance and score improvements in the levels of active ageing (Table 7). Null Hypothesis 5 was rejected in favour of Alternative Hypothesis 5, which anticipated a statistically significant relationship between turnout in attendance and changes in the scores of active ageing.

Table 7
Bivariate correlation between attendance turnout and changes in the scores of active ageing (Kendall's tau b)

		Score improvement	Turn out in attendance
Score improvement	Correlation Coefficient	1.000	.825*
	Sig. (2-tailed)	.	.000
	N	137	137
Attendance turnout	Correlation Coefficient	.825*	1.000
	Sig. (2-tailed)	.000	.
	N	137	137

*. Correlation is significant at the 0.05 level (2-tailed).

The final null hypothesis anticipated that there is no statistically significant relationship between turnout in attendance and changes in the different scores of active ageing. However, Kendall's coefficient of rank correlation found strong, moderate and weak

statistically significant relationships between turnout in attendance and scores of active ageing (Table 8). Null Hypothesis 6 was rejected in favour of Alternative Hypothesis 6, as attendance at the U3A had a different impact on the various indicators of active ageing.

Table 8

Multivariate correlations between attendance turnout and scores of active ageing (Kendall's tau b)

	Active Ageing variables						
		Crafting	Artistic pursuits	Social events	Nature	Exercise	Cognitive training
Attendance	Correlation Coefficient	0.627**	0.011	0.509**	0.197**	0.204**	0.550**
	Sig. (2-tailed)	< 0.001	0.886	0.005	0.009	0.006	0.008
		Technology	Helping others	Maintain relations	Meet new people	Promote own matters	Societal activity
	Correlation Coefficient	.182*	.754**	.781**	.718**	.384**	.819**
	Sig. (2-tailed)	.015	< 0.001	< 0.001	< 0.001	< 0.001	< 0.001
		Make days interesting	Make home cosy	Appearance	Economic balance	Spirituality	
	Correlation Coefficient	.710**	.309**	.275**	.271**	.397**	
	Sig. (2-tailed)	< 0.001	< 0.001	< 0.001	< 0.001	< 0.001	

*. Correlation is significant at the 0.05 level (2-tailed).
**. Correlation is significant at the 0.01 level (2-tailed).

As Table 8 attests, "strong" relationships were uncovered between turnout in attendance and "societal activity" (0.819, $p < 0.001$), "maintain social relations" (0.781, $p < 0.001$), "helping others" (0.754, $p < 0.001$), "meet new people" (0.718, $p < 0.001$), and "make days interesting" (0.710, $p < 0.001$) in the respective order.

DISCUSSION

Despite the inclusionary methods professed by the Maltese U3A when targeting potential members, the majority of members were aged in the 60–64 age bracket, women, and holding a secondary education certificate. Such statistics were anticipated since participation surveys have long found U3A members to be young-old middle-class women (Formosa, 2019f). Since the only admission requirement for U3A membership in Malta is the passing of one's 60th birthday, it is to be expected that many new members will be in

their early years of retirement which at the time of research stood at 63 in Malta. At the same time, given that in Malta only about 10% of women aged 55 or over are in formal employment (National Statistics Office, 2020), many women are able to join the U3A once they reach their 60th birthday. Moreover, it has been noted that the increased presence of women learners at U3As is due to the feminisation of ageing and the increased motivation of older women, especially wives who have never been in paid employment, to enrol in learning programmes and leisure organisations to make up for the time spent as domestic workers (Midwinter, 1996). However, Formosa (2019e) questioned this rationale and argued that one must look at other possible explanations, such as gendered trends in association affiliation in later life and older men's negative perceptions of community education. In his view, the reason underlying such low participation for older men was succinctly pinned down by Gorard's (2010) critique of discourses about barriers to learning, when noting that adult men "are not put off by barriers, but by the lack of interest in something that seems alien and imposed by others" (p. 357). Indeed, it has long been recorded that past experience in education is a key determinant of continued interest and participation in late-life learning (Findsen & Formosa, 2016a). As Formosa argued, this should not come as a surprise

> considering the term 'university' in its title. Working class elders are generally apprehensive to join an organization with such a 'heavy' class baggage. Moreover, the liberal-arts curriculum of U3As is perceived as alien by working-class elders who tend to experience 'at-risk-of-poverty' lifestyles. (Formosa, 2007, p. 203)

The fact that data analysis recorded no association either between gender and age or between gender and educational attainment demonstrated a statistically acceptable mix of data. Moreover, the negative "moderate" association between age and educational attainment reflected the fact that young-old people are always found to be better educated than older people due to consistent rises in the compulsory schooling age and improvements in national educational systems during the past half a century (Formosa & Galea, 2020).

A holistic analysis of the results leads to four key inferences. First, one can presume that the weak, albeit significant, associations between age and gender on the one hand, and score improvements in the levels of active ageing on the other, were due to two key factors. On the one hand, younger older people have higher levels of cultural, financial, and physical capital than older people (Gilleard & Higgs, 2020). Consequently, they have better opportunities and resources to be able to follow-up on the recommendations proposed by the U3A facilitators which can range from improving one's nutritional intake, joining organisations, taking up new hobbies such as photography or visiting museums, reading more books, to travelling. On the other hand, older women tend to have stronger ties both inside and outside the family as they generally hold durable relationships with sisters and cousins but also with sisters-in-law and are acquainted with many women in the community through their membership in voluntary associations. This goes some

way in explaining the higher scores of older women since friends correlate positively to participation in leisure activities. Orsega-Smith and colleagues (2007) found that having active friends or being encouraged by at least one person were the most influential stimuli to participate in activities, so that "if an older adult is exposed to a leisure activity and participates with supportive friends, he/she will be more committed participating in that activity than someone who has no friends with whom to do those activities" (Toepoel, 2013, p. 359).

Secondly, and most central to the study, the significant difference between pre-test and post-test score results confirmed that participation in late-life learning opportunities does lead to improved levels of active ageing. There are unmistakable health benefits from participating and attending late-life learning programmes, benefits that can be split into physical and mental wellbeing. The U3As' unique blend of learning and social activities places an unorthodox emphasis on autonomy and participation, thus countering the "decline and loss paradigm" commonly associated with increasing chronological age. Participation in U3As provides older learners with a renewed focus in their personal lives, which strengthens their mental wellbeing by bolstering their sense of purpose, self-confidence, and self-worth. This is especially valuable to older people who have not yet come to terms with retirement, are still experiencing a sense of bereavement and social alienation following the loss of a working day's structure and lifelong colleagues. Indeed, a study on the relationship between emotional wellbeing and participation in the São Paulo U3A in Brazil concluded that "the students [sic] who had been longer on the program run by the institute studied, exhibited higher levels of subjective and psychological well-being [...] where the satisfaction and benefits gained [from learning] extend into other areas of life" (Ordonez et al., 2011, p. 224).

Third, the fact that the strongest relationships were recorded between attendance turnout on the one hand, and "societal activity", "maintain social relationships", "attending social events", "helping others", and "meet new people" on the other, demonstrated that late-life learning is a resilient source of social capital in later life. In line with the argument above that highlighted the general positive relationship between networking and active ageing, U3As have much potential in permeating members with improved levels of social capital and may arise as an arena of social cohesion by providing mutual support in times of life crisis or difficult life transitions such as in the case of bereavement, sickness or moving house (Kimberley et al., 2016). Older adult learning leads participants to maintain social relationships, attend social events, assist others and receive support, whilst making new friends. As was reported in the United Kingdom, because

> most U3A activities take place during the day and on weekdays, participants reflected that it provided a good replacement for the previous work time […] [and] joining the U3A was a planned positive step in retirement offering the opportunity to meet new people who were different from those in the workplace (Third Age Trust, 2018, p. 13).

Indeed, U3As hold a strategic role in mitigating against loneliness and isolation, as many members offer continuous support and presence to each other on a daily basis (Maćkowicz & Wnęk-Gozdek, 2019). The arising sense of social cohesion is particularly evident when one realises that the U3A movement is an important part of the lifelong education system, a key segment of building a learning and intergenerational society, one of the basic public services enjoyed by civil society, and a channel towards active citizenship in later life (Percy, 2019). One learner at the Maltese U3A expressed it thus:

> Before I joined the U3A I used to spend whole days indoors. The weekends were the worst. Having no one to spend one's free time with was very depressing. Here I met many old acquaintances of mine, some of whom were with me at school, whilst also making new friends. I enjoy meeting them because we all have similar backgrounds, and comparable interests and opinions. Sometimes we plan Sunday morning visits to Valletta or afternoon walks. I still spend some days alone but never the whole weekend now. (Older man U3A learner, as cited in Formosa, 2019e, p. 89)

It is thus not surprising that most research in educational gerontology reports that the majority of older people claimed that their motivation to enroll in U3As stemmed from their quest to "make up for lost opportunities" and to "meet people of similar interests" (Formosa, 2019d).

Finally, the strong positive relationship between educational attainment and scores of active ageing contributes further evidence to what Lamb and Brady (2005) called the "education begets education phenomenon", which "suggests that people who presumably have had positive early experiences with education are motivated to seek more of the same" (p. 209). This result corresponds to the findings of Keaney and Oskala's (2007) survey which concluded that engagement with the arts declines noticeably after the age of 65 not due to increasing age but due to limiting disabilities or illnesses, a low income, living alone, having low levels of educational attainment, and being of lower socioeconomic status. They thus argued that "education appears to be one of the strongest predictors of arts engagement, with increasingly high rates of attendance and participation amongst older adults with higher educational qualifications" (Keaney and Oskala, 2007, p. 345). Similarly, Newman and colleagues' (2013) qualitative study on the responses of older people to contemporary visual art also concluded that participation is influenced by the participants' levels of cultural capital which, in turn, is affected by their life course experiences – especially levels of educational attainment.

CONCLUSION

This study clearly revealed that participation in older adult learning has a positive impact on the participants' levels of active ageing. While the results found no association between either age or gender and active ageing, a relationship was found between active

ageing and educational attainment and attendance turnout. This implies that older people with higher-than-average levels of educational attainment and those who attend classes more frequently will experience higher levels of active ageing than others. At the same time, when seeking to locate those domains of active ageing that benefit most following participation in a late-life learning programme, this study found that the highest improvements were registered with respect to "societal activity" and "maintain social relations", thus demonstrating the unmistakable role of older adult learning in improving and strengthening social capital in later life. This study therefore joins other qualitative research (Boulton-Lewis & Buys, 2015; Tam, 2013) in attributing higher levels of active ageing following participation in late-life learning and pressuring policy makers and institutions to widen the provision of lifelong learning programmes for older people. This is also important since older adult learning has proved itself to be a possible mitigation to the social isolation, cognitive impairment, and age discrimination that people tend to experience in later life as such programmes provide older adults with the possibility of strengthening their life and vocational skills, maintaining and extending social networking, and enhancing their feelings of being a vital part of society.

Finally, some words of caution due to the study's limitations. The study is a quantitative study conducted at a specific time in a Southern European context so that the results may not be wholly generalisable to other countries with diverse cultural conditions. Further comparative research is required to ascertain the global value of the results and to determine whether the positive impact of older adult learning on active ageing is stronger or weaker in other cultural and geographical contexts. At the same time, it should be noted that members at the U3A in Malta reflect international participation trends in U3As and do not generally have any significant physical or mobility limitations, and tend to be women, heterosexual and living in urban localities (Formosa, 2021). Hence, the results in this paper attest only to a specific typology of older people, the middle-class heterosexual able-bodied and cognitively healthy types. Yet, the circumstances surrounding later life are more complex and one needs to question why many older adults – such as older men, those living in rural areas, older people with disabilities, ethnic minorities – still do not participate in late-life learning. One thus wonders whether a truly stratified sample of older people would beget different results than the ones reported herein. One hopes that future quantitative studies on that interface between older adult learning and active ageing will be carried out to iron out these possible nuances.

REFERENCES

Amado, C. A. F., São José, J. M., & Santos, S. P. (2016). Measuring active ageing: A Data Envelopment Analysis approach. *European Journal of Operational Research*, *255*(1), 1–17. https://doi.org/10.1016/j.ejor.2016.04.048

Arpino, B., & Solé Auró, A. (2019). Education inequalities in health among older European men and women: The role of active aging. *Journal of Aging and Health*, *31*(1), 185–208. https://doi.org/10.1177/0898264317726390

Bélanger, E., Ahmed, T., Filiatrault, J., Yu, H. T., & Zunzunegui, M. V. (2017). An empirical comparison of different models of active aging in Canada: The international mobility in aging study. *The Gerontologist*, *57*(2), 197–205. https://doi.org/10.1093/geront/gnv126

Börsch-Supan, A., Kneipo, T., Litwin, H., Myck, M., & Weber, G. (Eds.). (2015). *Ageing in Europe - Supporting Policies for an inclusive society*. De Gruyter. https://doi.org/10.1515/9783110444414

Boulton-Lewis, G. M., & Buys, L. (2015). Learning choices, older Australians and active ageing. *Educational Gerontology*, *41*(11), 757–766. https://doi.org/10.1080/03601277.2015.1039455

Boulton-Lewis, G. M., Buys, L., & Lovie-Kitchin, J. (2006). Learning and active aging. *Educational Gerontology*, *32*(4), 271–282. https://doi.org/10.1080/03601270500494030

Boulton-Lewis, G. M., & Tam, M. (Eds.). (2012). *Active ageing, active learning: Issues and challenges*. Springer. https://doi.org/10.1007/978-94-007-2111-1

Buys, L., & Miller, E. (2012). Active ageing: Developing a quantitative multidimensional measure. In G. Boulton-Lewis & M. Tam (Eds.), *Active ageing, active learning: Issues and challenges* (pp. 103–118). Springer. https://doi.org/10.1007/978-94-007-2111-1

Cohen, J. (1992). A power primer. *Psychological Bulletin*, *112*(1), 155–159. https://doi.org/10.1037/0033-2909.112.1.155

Fernández-Ballesteros, R., Caprara, M., Schettini, R., Bustillos, A., Mendoza-Nunez, V., Orosa, T., Kornfeld, R., Rojas, M., López, M. D., Santacreu, L. M., Molina, M. Á., & Zamarrón, M. D. (2013). Effects of university programs for older adults: Changes in cultural and group stereotype, self-perception of aging, and emotional balance. *Educational Gerontology, 39*(2), 119–131. https://doi.org/10.1080/03601277.2012.699817

Fernández-Ballesteros, R., Molina, M. Á., Schettini, R., & del Rey, Á. L. (2012). Promoting active aging through university programs for older adults: An evaluation study. *GeroPsych: The Journal of Gerontopsychology and Geriatric Psychiatry*, *25*(3), 145–154. https://doi.org/10.1024/1662-9647/a000064

Findsen, B., & Formosa, M. (2011). *Lifelong learning in later life: A handbook on older adult learning*. Sense Publishers.

Findsen, B. & Formosa, M. (2016a). Concluding remarks. In B. Findsen & M. Formosa (Eds.), *International perspectives on older adult education: Research, policies, practices* (pp. 507–519). Springer. https://doi.org/10.1007/978-3-319-24939-1_44

Findsen, B., & Formosa, M. (2016b). Introduction. In B. Findsen & M. Formosa (Eds.), *International perspectives on older adult education: Research, policies, practices* (pp. 1–9). Springer. https://doi.org/10.1007/978-3-319-24939-1_1

Formosa, M. (2005). Feminism and critical educational gerontology: An agenda for good practice. *Ageing International*, *30*(4), 396–411. https://doi.org/10.1007/s12126-005-1023-x

Formosa, M. (2007). A Bourdieusian interpretation of the University of the Third Age in Malta. *Journal of Maltese Education Research*, *4*(2), 1–16.

Formosa, M. (2010). Universities of the Third Age: A rationale for transformative education in later life. *Journal of Transformative Education*, *8*(3), 197–219. https://doi.org/10.1177/1541344611419857

Formosa, M. (2011). Critical educational gerontology: A third statement of principles. *International Journal of Education and Ageing*, *2*(1), 317–332.

Formosa, M. (2012). European Union policy on older adult learning: A critical commentary. *Journal of Aging and Social Policy*, *24*(4), 384–399. https://doi.org/10.1080/08959420.2012.735162

Formosa, M. (2016). Malta. In B. Findsen & M. Formosa (Eds.), *International perspectives on older adult education: Research, policies, practices* (pp. 161–272). Springer. https://doi.org/10.1007/978-3-319-24939-1_23

Formosa, M. (2019a). Active ageing in the fourth age: The experiences and perspectives of older persons in long-term care. *Geopolitical Social Security and Freedom Journal*, *2*(1), 78–92. https://doi.org/10.2478/gssfj-2019-0008

Formosa, M. (2019b). Active ageing through lifelong learning: The University of the Third Age. In M. Formosa (Ed.), *The University of the Third Age and active ageing: European and Asian-Pacific perspectives* (pp. 3–18). Springer. https://doi.org/10.1007/978-3-030-21515-6_1

Formosa, M. (2019c). Concluding remarks and reflections. In M. Formosa (Ed.), *The University of the Third Age and active ageing: European and Asian-Pacific perspectives* (pp. 259–272). Springer. https://doi.org/10.1007/978-3-030-21515-6_21

Formosa, M. (2019d). Educational gerontology. In D. Gu & M.E. Dupre (Eds.), *Encyclopedia of gerontology and population ageing*. Springer. https://doi.org/10.1007/978-3-319-69892-2_411-1

Formosa, M. (2019e). Third age learning for active ageing in Malta: Successes and limitations. In M. Formosa (Ed.), *The University of the Third Age and active ageing: European and Asian-Pacific perspectives* (pp. 81–93). Springer. https://doi.org/10.1007/978-3-030-21515-6_7

Formosa, M. (2019f). Universities of the Third Age. In D. Gu & M. E. Dupre (Eds.), *Encyclopedia of gerontology and population ageing*. Springer. https://doi.org/10.1007/978-3-319-69892-2_412-1

Formosa, M. (2020). Activity theory as a foundation for active ageing policy: The Maltese experience. *Social Gerontology Journal*, *18*(1), 13–24. https://doi.org/10.24917/10.24917/24500232.181.1

Formosa, M. (2021). From invisibility to inclusion: Opening the doors for older men at the University of the Third Age in Malta. *Gerontology and Geriatrics Education*. https://doi.org/10.1080/02701960.2021.1913413

Formosa, M., Chetcuti Galea, R., & Farrugia Bonello, M. (2014). Older men learning through religious and political affiliations: Case studies from Malta. *Andragoška spoznanja/Andragogic Perspectives*, *20*(3), 57–69. https://doi.org/10.4312/as.20.3.57-69

Formosa, M., & Galea, R. (2020). Critical educational gerontology at a senior centre in Malta: Possibilities and limitations for critical consciousness. *Educational Gerontology*, *46*(2), 59–71. https://doi.org/10.1080/03601277.2020.1711587

Fragoso, A., Ricardo, R., Tavares, N. & Coelho, A. (2014). Shoulder to shoulder? Masculinities and informal learning in later life. *Andragoška spoznanja/Andragogic Perspectives*, *20*(3), 27–39. https://doi.org/10.4312/as.20.3.27-29

Gerontology Research Center. (n.d.). *University of Jyvaskyla Active Ageing Scale UJACAS*. https://www.gerec.fi/en/research/activeageing/active-ageing-agnes-study/active-ageing-scale-ujacas/

Gilleard, C., & Higgs, P. (2020). *Social divisions and later life: Difference, diversity and inequality*. Polity Press.

Glendenning, F., & Battersby, D. (1990). Why we need educational gerontology and education for older adults: A statement of first principles. In F. Glendenning & K. Percy (Eds.), *Ageing, education and society: Readings in educational gerontology* (pp. 219–231). Association for Educational Gerontology.

Gorard, S. (2010). Participation in learning: Barriers to learning. In G. Cooper, J. Field, U. Goswani, R. Jenkins, & B. Sahakian (Eds.), *Mental capital and wellbeing: Inquiry into the future of lifelong learning* (pp. 351–360). Wiley-Blackwell.

International Longevity Centre Brazil. (2015). *Active ageing: A policy framework in response to the longevity revolution*. International Longevity Centre Brazil.

Keaney, E., & Oskala, A. (2007). The golden age of the arts? Taking part survey findings on older people and the arts. *Cultural Trends*, *16*(4), 323–355. https://doi.org/10.1080/09548960701692696

Khamis, H. (2008). Measures of association. How to choose? *Journal of Diagnostic Medical Sonography*, *24*(3), 155–162. https://doi.org/10.1177/8756479308317006

Kimberley, H., Golding, B., & Simons, B. (2016). The company of others: Generating knowhow in later life. *International Journal of Lifelong Education*, *35*(5), 509–521. https://doi.org/10.1080/02601370.2016.1224038

Lamb, R., & Brady, R. M. (2005). Participation in lifelong learning institutes: What turns members on? *Educational Gerontology, 31*(3), 207–224. https://doi.org/10.1080/03601270590900936

Maćkowicz, J., & Wnęk-Gozdek, J. (2019). Late-life learning for social inclusion: Universities of the Third Age in Poland. In M. Formosa (Ed.), *The University of the Third Age and active ageing: European and Asian-Pacific perspectives* (pp. 95–105). Springer. https://doi.org/10.1007/978-3-030-21515-6_8

Mercken, C. (2010). *Education in an ageing society*. Drukkerij.

Midwinter, E. (1984). Universities of the Third Age: English version. In E. Midwinter (Ed.), *Mutual Aid Universities* (pp. 3–19). Croom Helm Ltd.

Midwinter, E. (1996). *Thriving people: The growth and prospects of the U3A in the UK*. Third Age Trust.

Narushima, M, Liu, J., & Diestelkamp, N. (2018). Lifelong learning in active ageing discourse: Its conserving effect on wellbeing, health and vulnerability. *Ageing & Society*, *38*(4), 651–675. https://doi.org/10.1017/S0144686X16001136

National Statistics Office. (2020, July 10). *World population day: 11 July 2020* [News release]. https://nso.gov.mt/en/News_Releases/Documents/2020/07/News2020_114.pdf

Newman, A., Goulding, A., & Whitehead, C. (2013). How cultural capital, habitus and class influence the responses of older adults to the field of contemporary visual art. *Poetics (Amst)*, *41*(5), 456–480. https://doi.org/10.1016/j.poetic.2013.07.001

Ordonez, T. N., Lima-Silva, T. B., & Cachioni, M. (2011). Subjective and psychological well-being of students of a University of the Third Age. *Dementia e Neuropsychologia*, *5*(3), 216–225. https://doi.org/10.1590/S1980-57642011DN05030010

Orsega-Smith, E. M., Payne, L. L., Mowen, A. J., Ho, C.-H., & Godbey, G. C. (2007). The role of social support and self-efficacy in shaping the leisure time physical activity of older adults. *Journal of Leisure Research*, *39*(4), 705–727. https://doi.org/10.1080/00222216.2007.11950129

Percy, K. (1990) The future of Educational Gerontology: A second statement of first principles. In F. Glendenning & K. Percy (Eds.), *Ageing, education and society: Readings in educational gerontology*. Association for Educational Gerontology.

Percy, K. (2019). 'An alternative ageing experience': An account and assessment of the University of the Third Age in Britain. In M. Formosa (Ed.), *The University of the Third Age and active ageing: European and Asian-Pacific perspectives* (pp. 33–43). Springer. https://doi.org/10.1007/978-3-030-21515-6_3

Rantanen, T., Portegijs, E., Kokko, K., Rantakokko, M., Törmäkangas, T., & Saajanaho, M. (2019). Developing an assessment method of active aging: University of Jyväskylä Active Aging Scale. *Journal of Aging and Health*, *31*(6), 1002–1024. https://doi.org/10.1177/0898264317750449

Ravallion, M. (2010). *Mashup indices of development* [policy research working paper 5432]. The World Bank.

Russell, H. (2008). Later life: A time to learn. *Educational Gerontology*, *34*(3), 206–224. https://doi.org/10.1080/03601270701835981

Salter, B., & Salter, C. (2018). The politics of ageing: Health consumers, markets and hegemonic challenge. *Sociology of Health & Illness*, *40*(6), 1069–1086. https://doi.org/10.1111/1467-9566.12743

Tam, M. (2013). A model of active ageing through elder learning: The Elder Academy Network in Hong Kong. *Educational Gerontology*, *39*(4), 250–258. http://dx.doi.org/10.1080/03601277.2013.750931

Tam, M. (2014). Understanding and theorizing the role of culture in the conceptualizations of successful aging and lifelong learning. *Educational Gerontology*, *40*(12), 881–893. https://doi.org/10.1080/03601277.2014.907072

Tambaum, T., Tuul, F., & Sirotkina, R. (2019). What is missing - Older male learners or a community strategy? *Andragoška spoznanja/Studies in Adult Education and Learning*, *25*(2), 67–79. https://doi.org/10.4312/as.25.2.67-79

Thanakwang, K., Isaramalai, S. A., & Hatthakit, U. (2014). Development and psychometric testing of the active aging scale for Thai adults. *Clinical Interventions in Aging*, *9*, 1211–1221. https://doi.org/10.2147/CIA.S66069

Third Age Trust. (2018). *Learning not lonely. Living life. Expanding horizons. Challenging conventions*. The Third Age Trust. https://indd.adobe.com/view/c99ad603-0622-4636-b12c-9f8ad363dae8

Toepoel, V. (2013). Ageing, leisure, and social connectedness: How could leisure help reduce social isolation of older people? *Social Indicators Research*, *113*(1), 355–372. https://doi.org/10.1007/s11205-012-0097-6

Walker, A. (2009). Commentary: The emergence and application of active aging in Europe. *Journal of Ageing & Social Policy*, *21*(1), 75–93. https://doi.org/10.1080/08959420802529986

Watson, D., Clark, L. A., & Tellegen, A. (1988). Development and validation of brief measures of positive and negative affect: The PANAS scales. *Journal of Personality and Social Psychology, 54*(6), 1063–1070. https://doi.org/10.1037/0022-3514.54.6.1063

Wilińska, M. (2016). Proud to be a woman: Womanhood, old age, and emotions. *Journal of Women & Aging*, *28*(4), 334–345. https://doi.org/10.1080/08952841.2015.1017431

World Health Organization. (2002). *Active ageing: A policy framework*. World Health Organization.

Zaidi, A. (2015). Creating and using the evidence base: The case of the Active Ageing Index. *Contemporary Social Science*, *10*(2), 148–159. https://doi.org/10.1080/21582041.2015.1056750

Andragoška spoznanja/Studies in Adult Education and Learning, 2021, 27(2), 75-91 UDK: 374.7:618
DOI: https://doi.org/10.4312/as/10187 Znanstveni prispevek

Mirko Prosen, Sabina Ličen

IZBOLJŠEVANJE ZDRAVSTVENE PISMENOSTI NOSEČNIC Z UPORABO SODOBNIH PRISTOPOV V ZDRAVSTVENI VZGOJI: INTEGRATIVNI PREGLED LITERATURE

POVZETEK

Optimalne zdravstvene izide v nosečnosti povezujemo s stopnjo zdravstvene pismenosti, ki je danes prepoznana kot ključna socialna determinanta zdravja. Namen integrativnega pregleda literature je bil preučiti, kateri sodobni pristopi (intervencije) zdravstvene vzgoje za dvig zdravstvene pismenosti nosečnic so razviti v svetu ter kakšna je vključenost strokovnjakov drugih disciplin v intervencije zdravstvene vzgoje. Pregledani so bili članki, objavljeni med letoma 2010 in 2021, iz naslednjih elektronskih podatkovnih zbirk: Cinahl in Medline (prek baze EBSCOhost), PubMed in ScienceDirect. V končno vsebinsko integrativno analizo je bilo umeščenih pet kvantitativnih raziskav. Zbrani podatki so bili analizirani z metodo tematske analize. Raziskave poročajo o vplivu zdravstvene pismenosti na prepričanja/stališča, znanje in življenjski slog med nosečnostjo, obenem pa tudi kažejo na to, da je vključevanje drugih, nezdravstvenih strokovnjakov v zdravstvenovzgojne intervencije zelo omejeno. Vidne so spremembe v pristopu sodobne zdravstvene vzgoje, a hkrati tudi to, da je ta proces prepočasen in nezadostno progresiven.

Ključne besede: *nosečnost, prenatalna zdravstvena vzgoja, intervencija, socialna determinanta, zdravje*

IMPROVING THE HEALTH LITERACY OF PREGNANT WOMEN USING CONTEMPORARY APPROACHES IN HEALTH EDUCATION: AN INTEGRATIVE LITERATURE REVIEW – ABSTRACT

Optimal health outcomes in pregnant women are related to their level of health literacy, which is now recognised as an important social determinant of health. Therefore, the aim of this integrative literature review was to investigate what contemporary approaches (interventions) to health education are being developed to increase health literacy among pregnant women worldwide and the involvement of experts

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from other disciplines in health education interventions. The articles reviewed were published between 2010 and 2021 in the following electronic databases: Cinahl and Medline (via the EBSCOhost database), PubMed, and ScienceDirect. We identified five quantitative studies and analysed the collected data using thematic analysis. The results of these studies show the influence health literacy has on beliefs/attitudes, knowledge, and a healthy lifestyle during pregnancy, but also reveal that the involvement of other non-health professionals in health education interventions is very limited. Visible changes have been made in the approaches of contemporary health education, but this process has also been too slow and not progressive enough.

Keywords: *pregnancy, prenatal education, intervention, social determinant, health*

UVOD

Nosečnost je prelomno življenjsko obdobje vsake ženske, povezano s prehodom v materinsko vlogo, a je obenem tudi pomembno družbeno dejanje, zaradi česar je vpliv družbe nanj velik. Skrb in želja vseh je, da se zdravi nosečnici rodi zdrav otrok, pri čemer optimalne zdravstvene izide povezujemo na strani nosečnice s stopnjo zdravstvene pismenosti. Ta je prepoznana kot ključna socialna determinanta zdravja in pogosto opisana kot stopnja, do katere imajo posamezniki zmožnost pridobivanja, obdelave in razumevanja osnovnih zdravstvenih informacij in storitev, potrebnih za sprejemanje ustreznih z zdravjem povezanih odločitev. Zmanjšana zdravstvena pismenost je povezana s slabšimi izidi, povezanimi z zdravjem, vključno z omejeno možnostjo samooskrbe ali vključevanja v preventivo (Lupattelli idr., 2014; Vila-Candel idr., 2020; Zibellini idr., 2021). V dosedanjih raziskavah je bila namreč dokazana močna heterogena povezava pri opredeljevanju in merjenju zdravstvene pismenosti med ženskami in moškimi. Številni dokazi kažejo na povezanost med nizko zdravstveno pismenostjo žensk in slabimi izidi, povezanimi z zdravjem. Pri tem je nedvomno dokazano, da stopnja zdravstvene pismenosti žensk vpliva na izide, povezane z zdravjem vse njene družine (Vila-Candel idr., 2020).

Raziskave, ki povezujejo nosečnost z zdravstveno pismenostjo, pogosto spregledajo kulturni kontekst, saj gre pri zdravstveni pismenosti za preplet kognitivnih in socialnih veščin, ki so določujoče v smislu pridobivanja in razumevanja znanja. Dejstvo je, da je »tradicionalna« zdravstvena vzgoja pogosto informacije le posredovala, in sicer kot obliko krizne intervencije obravnavanega problema, in tako prevečkrat ostajala le na svojem ožjem zdravstvenem področju, zanemarjala pa pedagoške, psihološke, izobraževalne in komunikološke prvine. S tem je tudi povezano vprašanje, ali klasične oblike izobraževanja nosečnice oziroma para danes dosegajo želene premike v smeri doseganja višje stopnje zdravstvene pismenosti in ali sodobni pristopi vključujejo sodelovanje drugih znanstvenih disciplin. Namen integrativnega pregleda literature je zato preučiti, kateri sodobni pristopi (intervencije) zdravstvene vzgoje za dvig zdravstvene pismenosti nosečnic so razviti v svetu ter kakšna je vključenost strokovnjakov drugih disciplin v okviru primarnega zdravstvenega varstva in zunaj zdravstva. Ugotovitve zadnjih dveh desetletij namreč jasno kažejo, da je vključevanje pacientov, njihovih družin, laične javnosti, drugih

»nezdravstvenih« strok izjemno močno orodje, ki prispeva k dvigu zdravstvene pismenosti (Turner, 2017).

Koncept zdravstvene pismenosti

Têrmin »zdravstvena pismenost« je bil vpeljan v 70. letih prejšnjega stoletja in je danes prepoznan kot pomemben in določujoč element zdravja. Zdravstvena pismenost pomeni postaviti lastno zdravje kot tudi zdravje svoje družine in skupnosti v kontekst razumevanja dejavnikov, ki vplivajo na zdravje, ter v kontekst poznavanja ukrepov za ohranjanje zdravja. Posameznik z zadostno stopnjo zdravstvene pismenosti je sposoben prevzeti odgovornost za lastno zdravje kot tudi zdravje svoje družine ali skupnosti (Sørensen idr., 2012).

Zdravstvena pismenost je danes prepoznana kot eden najpomembnejših dejavnikov in determinanta posameznikovega zdravja ter tudi možnosti dostopanja do zdravstvenih storitev (Nutbeam in Lloyd, 2021; Vila-Candel idr., 2020). Sørensen idr. (2012) so v skladu z znano opredelitvijo koncepta zdravstvene pismenosti predstavili matrico štirih kompetenc zdravstvene pismenosti, ki so jo aplicirali na tri domene zdravja oziroma zdravstvene dejavnosti (Tabela 1). Z vidika sodobnega razumevanja zdravja so v opredelitev zdravstvene pismenosti isti avtorji jasno vpeljali koncept družbenega okolja in njegovega vpliva na posameznikovo stopnjo zdravstvene pismenosti. Podobno sta pred njimi začrtala Parker in Ratzan (2010), ki sta dejala, da je treba zdravstveno pismenost razumeti kot aplikacijo osebnih veščin, ki jih usmerja okolje, v katerem bodo te veščine uporabljene. Če je zdravstvena pismenost razumljena kot opazovan skupek veščin, potem ta pristop nujno usmerja intervencije za izboljševanje posameznikovih veščin in zmožnosti skozi izobraževanje. Prepoznavanje vpliva situacijskih zahtev in kompleksnosti usmerja pozornost tudi na poenostavljanje komunikacije in premagovanje kompleksnosti zdravstvenega sistema, da bi osebe lažje vstopale vanj.

Zdravstveno pismenost lahko na podoben način kot splošni koncept pismenosti klasificiramo v tri skupine – funkcionalno, interaktivno in kritično zdravstveno pismenost, pri čemer se zlasti zadnji dve pojavljata v ospredju sodobnih modelov promocije zdravja (Nutbeam in Lloyd, 2021; Rowlands idr., 2017). Funkcionalna se nanaša na osnovne veščine, ki so prepoznane kot zadostne za to, da posameznik pridobi ključne zdravstvene informacije in uporabi znanje v krogu predpisanih aktivnosti. Interaktivna zdravstvena pismenost se nanaša na bolj napredno obliko veščin, ki omogočajo posamezniku, da izlušči zdravstvene informacije in pomen iz različnih oblik komunikacije, uporabi nove informacije v spreminjajočih se okoliščinah ter v interakciji z drugimi pridobi dodatne informacije in sprejme odločitev. Kritična zdravstvena pismenost pa je opredeljena kot najbolj napredna oblika, s katero je mogoče kritično analizirati zdravstvene informacije, pridobljene iz različnih virov. Posamezniki z razvitimi tovrstnimi veščinami imajo veliko večji nadzor nad razmerami, ki lahko vplivajo na njihovo zdravje, zlasti pa jim omogočajo prepoznavanje socialnih, ekonomskih in drugih okoljskih determinant zdravja, ki vplivajo na zdravje (Nutbeam in Lloyd, 2021).

Tabela 1
Matrica štirih kompetenc zdravstvene pismenosti

	Dostop/pridobitev informacij, pomembnih za zdravje	Razumeti informacije, pomembne za zdravje	Procesirati/ presoditi informacije, pomembne za zdravje	Implementirati/ uporabiti informacije, pomembne za zdravje
Zdravstveno varstvo	Sposobnost dostopanja do informacij o zdravstvenih ali kliničnih vprašanjih	Sposobnost razumeti zdravstvene informacije in njihov pomen	Sposobnost interpretirati in oceniti zdravstvene informacije	Sposobnost sprejeti informirane odločitve o zdravstvenih vprašanjih
Preprečevanje bolezni	Sposobnost dostopanja do informacij o dejavnikih tveganja za zdravje	Sposobnost razumeti informacije o dejavnikih tveganja in njihov pomen	Sposobnost interpretirati in oceniti informacije o dejavnikih tveganja za zdravje	Sposobnost sprejeti informirane odločitve o dejavnikih tveganja za zdravje
Promocija zdravja	Sposobnost pridobivanja novih spoznanj o determinantah zdravja v kontekstu socialnega in fizičnega okolja	Sposobnost razumeti informacije o determinantah zdravja v kontekstu socialnega in fizičnega okolja in njihov pomen	Sposobnost interpretirati in oceniti informacije o determinantah zdravja v kontekstu socialnega in fizičnega okolja	Sposobnost sprejeti informirane odločitve o determinantah zdravja v kontekstu socialnega in fizičnega okolja

Prirejeno po Sørensen, K., Van den Broucke, S., Fullam, J., Doyle, G., Pelikan, J., Slonska, Z. in Brand, H. (2012). Health literacy and public health: A systematic review and integration of definitions and models, BMC Public Health, 12(1), 80.

V zgoraj naštetih primerih gre za vprašanje konteksta in konceptualne umeščenosti zdravstvene pismenosti. En pogled znatno poudarja klinični vidik zdravstvene pismenosti in komplianco s predlagano zdravstveno oskrbo, medtem ko drugi postavlja v ospredje zdravstveno pismenost kot izid osebnih, socialnih in okoljskih vplivov. V obeh primerih je kontekst ključen (Rowlands idr., 2017), a dejstvo je, da je tudi pogosto spregledan.

Problem zdravstvene pismenosti v kontekstu sodobne družbe

Povezava med zdravstveno pismenostjo in izidi za zdravje posameznika je dodobra raziskana in potrjena. Manj pa je preučevana povezava med zdravstveno pismenostjo v povezavi s socialnimi determinantami zdravja (Nutbeam in Lloyd, 2021), zaradi česar se postavlja vse več vprašanj o vplivu kontekstualnih okoliščin na zdravstveno pismenost. Stopnja izobrazbe, revščina, zaposlitev, znanje tujega jezika, kraj bivanja so samo nekatere značilnosti, ki so jih povezali z zdravstveno pismenostjo (Nutbeam in Lloyd, 2021; Rowlands idr., 2017; Schillinger, 2020) in zaradi katerih lahko govorimo o zdravstveni

pismenosti kot o socialni determinanti zdravja. Vendar pa je ta povezanost zelo kompleksna, saj vključuje vpliv zelo širokega socialnega gradienta, zaradi česar je to velik metodološki izziv pri merjenju delovanja teh vplivov na zdravstveno pismenost (Nutbeam in Lloyd, 2021).

Zaradi delovanja osebnih, družbenih in okoljskih vplivov je zdravstvena pismenost tudi vzrok mnogih neenakostih v zdravju oziroma dostopanju do zdravja. Dvig zdravstvene pismenosti v populaciji in izboljševanje dostopanja do zdravstvenih storitev osebam z nižjo zdravstveno pismenostjo je pomembna strategija za premagovanje neenakosti (Nutbeam in Lloyd, 2021; Rowlands idr., 2017; Schillinger, 2020), ki se je je treba zavedati tudi, ko govorimo o izboljševanju zdravstvene pismenosti nosečnic. S tem so namreč povezani izidi za zdravje nosečnice in otroka, še bolj v primerih, ko je zdravstvena pismenost nizka in tveganje za razvoj neenakosti povečano. Poznavanje delovanja zdravstvene pismenosti in razumevanje vplivov nanjo kažeta na potrebo po spremembi pristopa v zdravstveni vzgoji, tako da bi ta vključila specifični družbeni kontekst zdravstvene pismenosti nosečnic, in to ne samo s spremembo metod učenja/poučevanja, ampak tudi z interdisciplinarno (če ne multidisciplinarno) obravnavo. Zaradi izidov, povezanih z nosečnostjo, in prepoznanega tveganja za zdravje v tem obdobju je ključno razvijati interaktivno in kritično zdravstveno pismenost, kar pa s klasičnimi metodami učenja/poučevanja težko dosežemo.

Namen

Namen integrativnega pregleda literature je kritična analiza empiričnih ali preglednih znanstvenih člankov o sodobnih pristopih (intervencijah) zdravstvene vzgoje za dvig zdravstvene pismenosti nosečnic ter o vključenosti strokovnjakov drugih disciplin v aktivnosti zdravstvene vzgoje v okviru primarnega zdravstvenega varstva in zunaj zdravstva.

METODE

V raziskavi je bil uporabljen pregled znanstvene literature s področja sodobnih pristopov zdravstvene vzgoje, ki vnašajo multidisciplinarno obravnavo z namenom dviga zdravstvene pismenosti nosečnic.

Metode pregleda

Raziskava temelji na integrativnem pregledu literature, ki je bil opravljen aprila 2021. V ta namen so bile uporabljene smernice pregleda po Whittemore in Knafl (2005), ki vključuje petstopenjski okvir, in sicer identifikacijo problema, iskanje literature, vrednotenje kakovosti virov, analizo podatkov in predstavitev rezultatov. Smernice omogočajo sintezo kvalitativnih ter kvantitativnih raziskav in raziskav na podlagi mešanih metod dela, povezanih s preučevano tematiko. Na ta način sta zagotovljeni večja kompleksnost pregleda in zmanjšana možnost za napačno interpretacijo virov. Dodatno smo uporabili ocenjevanje kakovosti raziskav po pristopu GRADE (ang. *Grading of Recommendations, Assessment, Development and Evaluation*). Pri pregledu so bili upoštevani naslednji vključitveni kriteriji: (i) izvirni znanstveni članki, objavljeni v slovenskih in angleških znanstvenih revijah;

(ii) članki, objavljeni med letoma 2010 in 2021; (iii) članki, ki vključujejo polnoletne nosečnice. Iz pregleda so bili izključeni: (i) uvodniki revij, protokoli, strokovni članki, pisma uredniku, poročila; (ii) nepopolna besedila, povzetki in (iii) članki neustrezne tematike. Do literature smo dostopali prek elektronskih podatkovnih zbirk oziroma mednarodnih baz podatkov, in sicer Cinahl in Medline (prek baze EBSCOhost), PubMed in ScienceDirect. Za iskalne izraze smo določili kombinacijo naslovov, uporabljenih fraz in prostega besedila ali ključnih besed v iskalniku Medical Subject Headings (MeSH), in sicer *Health Literacy, Health Education, Educational Strategies, Educational Methodologies, Patient Education, Pregnancy, Pregnant Women, Prenatal Care, Antenatal Care, Health Professionals, Multidisciplinary Approach*, ter si pri iskanju virov pomagali z Boolovimi operaterji (AND, OR).

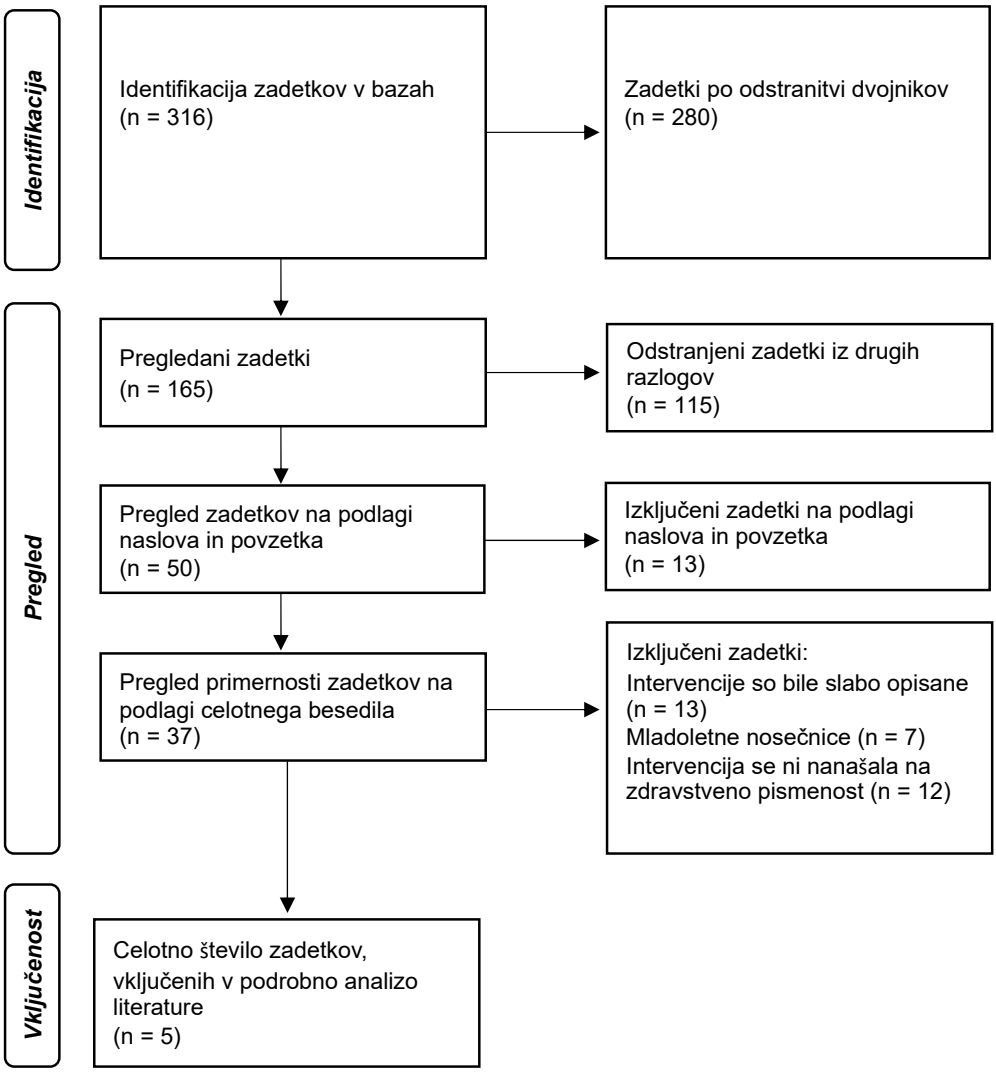
Rezultati pregleda

Na podlagi vključitvenih in izključitvenih kriterijev je bilo skupaj identificiranih 316 zadetkov. Zadetke smo nadalje uvozili v program Zotero, brezplačno in odprtokodno programsko opremo, ki omogoča hkrati organiziranje in shranjevanje virov, upravljanje in citiranje ter identifikacijo dvojnikov. Tako smo identificirali 36 dvojnikov. Po odstranitvi dvojnikov je bilo v nadaljnji pregled vključenih 280 člankov. Pred pregledom naslovov in povzetkov je bilo dokončno vključenih 165 člankov. Pregled, identifikacija in odločanje o uporabnosti pregledanih virov so prikazani s pomočjo diagrama PRISMA 2020 (Page idr., 2021) (Slika 1).

Ocena kakovosti virov in potek analize

V tej fazi smo neodvisno ocenili kakovost raziskav z orodjem za kritično ocenjevanje mešanih metod dela (ang. *MMA Tool*) (Hong idr., 2018), ki omogoča oceno metodološke kakovosti raziskav v petih kategorijah (Whittemore in Knafl, 2005). V nadaljevanju so bila neskladja odpravljena na podlagi razprave med avtorjema, dokler ni bil dosežen dokončni konsenz. Poleg tega je bil za nadaljnje ocenjevanje kakovosti raziskav v smeri njihove uporabe v klinični praksi uporabljen pristop GRADE, ki vključuje razvrščanje raziskav v smislu priporočil. Na ta način so bile raziskave ocenjene z visoko, zmerno ali nizko oceno, zaradi česa je mogoče sklepati o zanesljivosti priporočil na podlagi pregledanih raziskav.

Slika 1
Potek, prikazan z diagramom PRISMA



REZULTATI

V končno vsebinsko integrativno analizo smo umestili pet kvantitativnih raziskav. Zbrani podatki so bili analizirani z metodo tematske analize. Tabela 2 prikazuje ključne informacije identificiranih raziskav.

Tabela 2
Osnovne značilnosti vključenih raziskav

Avtor(ji)	Leto	Metode	Vzorec	Namen	Ocena kakovosti
Kupratakul idr.	2010	Randomizirana kontrolirana raziskava	Ženske > 32 tednov nosečnosti	Raziskati, ali izobraževanje na podlagi programa strategij opolnomočenja izboljšuje izključno dojenje v prvih šestih mesecih po porodu	Visoka
Raynes-Greenow idr.	2010	Randomizirana kontrolirana raziskava	Ženske (primipara) > 37 tednov nosečnosti	Zmanjšati negotovost med nosečnicami glede rabe sredstev za lajšanje porodnih bolečin ter zmanjšati anksioznost in povečati zadovoljstvo	Zmerna
Yee idr.	2014	Randomizirana kontrolirana raziskava	Ženske 6–26 tednov nosečnosti	Ugotoviti, ali lahko interaktivni računalniški program izboljša pacientovo znanje o genetskem presejanju in možnih diagnozah	Nizka
Roter idr.	2015	Randomizirana kontrolirana raziskava	Ženske 12–30 tednov nosečnosti	Razviti in evalvirati intervencije za izboljšanje komunikacijskih veščin med nosečnicami z omejeno zdravstveno pismenostjo	Nizka
Adams idr.	2017	Ne-randomizirana raziskava	Nosečnice	Izboljšati znanje o zdravju ustne votline nosečnic	Zmerna

V Tabeli 3 so predstavljeni rezultati na podlagi vsebinskih kategorij, in sicer »Intervencija/strategija«; »Odgovorna oseba za aktivnost« in »Pogostost/Frekvenca ponujenih aktivnosti« v sklopu zdravstvene vzgoje oziroma zdravstvenega izobraževanja.

Tabela 3
Značilnosti novih pristopov zdravstvene vzgoje nosečnic

Avtor(ji)	Leto	Intervencija/strategije	Odgovorna oseba za aktivnosti	Pogostost/frekvenca aktivnosti
Kupratakul idr.	2010	Frontalno poučevanje – znanje o dojenju + tehnike + praksa + strategije opolnomočenja + kritična refleksija + izmenjava znanja (ang. *storytelling*) antenatalno izobraževanje + postnatalna podpora	Medicinska sestra Svetovalec za dojenje (ang. *lactation consultant*)	Vse ženske so izključno dojile in bile spremljane po telefonu *7.* in 14. dan v 1., 2., 3., 4., 5. in 6. mesecu po porodu oz. prek obiskov na domu v primerih, ki so se pri dojenju pojavile težave.

Avtor(ji)	Leto	Intervencija/strategije	Odgovorna oseba za aktivnosti	Pogostost/frekvenca aktivnosti
Raynes-Greenow idr.	2010	Sposobnost odločanja – delovni zvezek (55 strani) + delovni list + 40 minut vodnik (avdio CD) o lajšanju porodne bolečine	Babice	Prvo spremljanje – > 37 tednov nosečnosti Drugo spremljanje – 12–16 tednov po porodu
Yee idr.	2014	Pisne intervencije – standardna zdravstvena vzgoja + interaktivno izobraževalno orodje za razjasnitev zdravstvenih/ medicinskih izrazov in informacij o prenatalnem presejanju + genetika	/	Udeleženke so pri delu z izobraževalnim orodjem lahko porabile različno količino časa (asinhrono izobraževanje).
Roter idr.	2015	Pisne intervencije – »Zdravi otroci zdrave mame«, računalniško podprto izboljšanje komunikacijskih veščin	Zdravnik porodničar	/
Adams idr.	2017	Pisne intervencije + učni pripomočki (zobna ščetka, zobna pasta, zobna nitka ...)	Medicinske sestre Babice Zobozdravnik Ustni higienik Psiholog	Enkratna izvedba – dva izobraževalna modula, ki temeljita na znanju

Tematiko intervencij in zdravstvene izide oziroma izboljšanje zdravstvene pismenosti prikazuje Tabela 4.

Tabela 4
Vpliv novih pristopov na zdravstveno pismenost nosečnic

Avtor(ji)	Leto	Tematika	Zdravstveni izidi/Zdravstvena pismenost
Kupratakul idr.	2010	Dojenje	Strategije poučevanja in učenja znatno izboljšajo stopnje izključno dojenja pri 14 dneh 1., 2., 4., 5. in 6. meseca po porodu.
Raynes-Greenow idr.	2010	Lajšanje porodnih bolečin	Strategije poučevanja in učenja znatno izboljšajo znanje in posledično odločanje nosečnic o možnostih lajšanja porodnih bolečin.
Yee idr.	2014	Prenatalno genetsko presejanje in možne diagnoze	Ženske, vključene v zdravstveno izobraževanje in učenje na podlagi prenatalnega diagnostičnega izobraževalnega orodja na podlagi najsodobnejše interaktivne tehnologijo, so izboljšale sposobnost pridobivanja, interpretacije in razumevanja informacij o prenatalnem genetskem presejanju in diagnozah.

Avtor(ji)	Leto	Tematika	Zdravstveni izidi/Zdravstvena pismenost
Roter idr.	2015	Komunikacijske veščine	Intervencija »Zdravi otroci zdrave mame« je pri nosečnicah izboljšala verbalno izražanje in s tem sposobnost podajanja informacij o njihovem zdravstvenem in psihosocialnem stanju.
Adams idr.	2017	Zdravje ustne votline	Na podlagi intervencije se izboljša zdravje ustne votline nosečnice: zmanjšanje zobnih oblog, krvavitev dlesni in globine žepa za 4 mm ali več.

V pregled vključene raziskave so bile opravljene v Združenih državah Amerike, Tajski in Avstraliji. Velikost vzorca se je gibala med 80 in 395. Trajanje nosečnosti je bilo ob vključitvi v raziskavo različno. Ena izmed raziskav je vključevala nosečnice ne glede na trajanje nosečnosti (Adams idr., 2017), preostale pa so vključevale nosečnice od 6. do 26. tedna nosečnosti (Yee idr., 2014), nosečnice med 12. in 30. tednom nosečnosti (Roter idr., 2015) oziroma nosečnice po 30. tednu nosečnosti (Kupratakul idr., 2010; Raynes-Greenow idr., 2010). Raziskave niso vključevale ali izključevale žensk glede na njihovo kulturno pripadnost ali izobrazbo. Tudi primarni izidi intervencij zdravstvene vzgoje so se razlikovali, vendar pa vse raziskave, vključene v ta pregled, kažejo na to, da sodobni pristopi v zdravstveni vzgoji pozitivno vplivajo na zdravstveno pismenost nosečnic.

Kupratakul idr. (2010) so raziskovali, ali izobraževanje na podlagi programa strategij opolnomočenja izboljšuje izključno dojenje v prvih šestih mesecih po porodu. V svoji raziskavi navajajo, da obstaja veliko raziskav o intervencijah, na podlagi katerih naj bi matere postale dovolj opolnomočene, da bi svoje otroke v prvih šestih mesecih izključno dojile, vendar pa je bila stopnja uspešnosti intervencij še vedno nižja od mednarodnega priporočila Svetovne zdravstvene organizacije. Zato so v svoji raziskavi po pregledu literature intervencijo načrtovali na podlagi prakse izmenjave znanja s procesom opolnomočenja (ang. *Knowledge Sharing Practices with Empowerment Strategies*). Intervencijski model so sestavljali komunikacijske spretnosti, demonstracija, dobre prakse in pripovedovanje zgodb. Poleg tega je model vključeval proces opolnomočenja po Gibsonu (1991), ki pravi, da navezanost matere na otroka – vez med njima in ljubezen do njega – pozitivno vpliva na motivacijo in vzdržuje proces opolnomočenja. Ta je sestavljen iz štirih korakov, to so odkrivanje resničnosti, kritična refleksija, prevzem odgovornosti in vztrajanje. Rezultati raziskave so pokazali, da bi lahko predlagani model intervencije znatno izboljšal izključno dojenje v primerjavi z znanjem, ki so ga nosečnice pridobile s tradicionalno zdravstveno vzgojo.

Raynes-Greenow idr. (2010) so z raziskavo med nosečnicami želeli vplivati na zmanjšanje neznanja in posledično negotovosti glede rabe sredstev za lajšanje porodnih bolečin, sočasno s tem pa doseči zmanjšanje anksioznosti in povečanje zadovoljstva nosečnic. V ta namen so razvili pripomoček za odločanje o možnostih in načinu lajšanja porodnih bolečin, ki informacije predstavi v dveh oblikah: v obliki pisnega materiala – knjižice in zvočnega materiala – avdiovodnika (CD). Gradivo je bilo razvito in pilotno preizkušeno, postopki pregleda so bili opravljeni v multidisciplinarni skupini strokovnjakov (vendar

pa vir ne navaja, kdo so bili ti strokovnjaki – poleg babic). Vsebina pomoči pri odločanju (knjižica in avdiovodnik) je bila presojana po Flesch-Kincaidovi lestvici razumljivosti učnega materiala in ocenjena z oceno 9,9, kar dokazuje, da je bila vsebina na stopnji razumljivosti učencu devetega razreda. Končna knjižica je imela približno 55 strani A5, priložen pa je bil tudi štiristranski delovni list formata A3. Informacije so bile predstavljene v zelo razumljivem slogu, tako da so bile uporabnicam prijazne. Rezultati so pokazali, da pomoč pri odločanju izboljša znanje o lajšanju porodnih bolečin med nosečnicami, ne da bi povečala njihovo anksioznost. Pomembno je, da so bile nosečnice po takšni obliki zdravstvene vzgoje bolj ozaveščene in so menile, da imajo dovolj informacij za sprejemanje odločitev v tej smeri.

Leta 2014 so Yee idr. (2014) raziskali, ali lahko interaktivni računalniški program izboljša pacientovo znanje o genetskem presejanju in možnih diagnozah. V ta namen so razvili interaktivno orodje, ki je nosečnicam omogočalo ogled notranjosti telesa v 3D-obliki. Program je vključeval virtualni vodnik, ki je bil uporabnicam v pomoč pri razlagi zapletenih medicinskih izrazov ter jim omogočal zastavljanje vprašanj v zvezi s tem. Različni moduli programa so zajemali informacije o osnovnih konceptih prenatalnega testiranja, anatomiji, pogostih genetskih nepravilnostih ter druge specifične informacije o možnostih invazivnih in neinvazivnih testov, vključno z biopsijo horiontskih resic in amniocentezo, ter možnih tveganjih. Rezultati so pokazali, da nosečnice, vključene v zdravstveno vzgojo na podlagi prenatalnega diagnostičnega izobraževalnega orodja, ki sledi najsodobnejši interaktivni tehnologiji, izboljša sposobnost pridobivanja, interpretacije in razumevanja informacij o prenatalnem genetskem presejanju in diagnozah.

Roter idr. (2015) so razvili intervencije za izboljšanje komunikacijskih veščin med nosečnicami z omejeno zdravstveno pismenostjo. Oblikovali so 20-minutni računalniški program *Zdravi otroci in zdrave mame* (ang. *Healthy Babies and Healthy Moms*), ki temelji na komunikacijskih veščinah in ključnih didaktičnih načelih. Namen programa je, da se nosečnice aktivneje in učinkoviteje vključijo v dialog s porodničarjem in preostalim zdravstvenim osebjem ob prenatalnih obiskih ter so sposobne zastavljati usmerjena vprašanja, izražati zaskrbljenost in skrbi ter tako reševati težave med nosečnostjo. Program vodi uporabnice skozi tri tematska področja, povezana z določenimi veščinami, za katere se domneva, da vplivajo na komunikacijske spretnosti. Ključna didaktična načela so vodila zasnovano intervencijo skozi modeliranje, vizualizacijo, miselno vajo in opolnomočenje. Rezultati podpirajo učinkovitost intervencije *Zdravi otroci in zdrave mame* pri izboljšanju komunikacije med porodničarjem in nosečnico, ne da bi se posledično podaljšala dolžina obiska na domu. Nosečnice so bile ob koncu izobraževanja bolj verbalno aktivne in so pokazale večjo rabo ciljnih komunikacijskih veščin, vključno z izražanjem pomislekov, ter s tem demonstrirale sposobnost podajanja informacij o svojem zdravstvenem in psihosocialnem stanju.

Adams idr. (2017) so na podlagi sodobnih pristopov v zdravstveni vzgoji izboljšali znanje o zdravju ustne votline nosečnic. Raziskovalni tim je vključeval zobozdravnika, parodontologa, ustnega higienika, psihologa, babico in medicinsko sestro. Razvili so izobraževalno

intervencijo, ki temelji na strokovnih smernicah na področju ustnega zdravja. Moderatorji so intervencijo izvedli skozi triurno usposabljanje, ki je vključevalo delo z didaktičnimi pripomočki in demonstracije. V dveh modulih so najprej ponudili predavanja o temah: i) pomen materinega zdravja ustne votline, ii) pogoste težave v ustni votlini, iii) varnost in pomen zobne oskrbe med nosečnostjo in nato učenje praktičnih veščin: i) pravilno ščetkanje zob in ii) samotestiranje zdravja dlesni. Krvavitev kaže na vnetje, ki bi se moralo zmanjšati s pravilnim ščetkanjem in uporabo zobne nitke. Udeleženke so prejele pripomočke – vključno z zobnimi ščetkami, fluoridno zobno pasto, zobno nitko, dvominutnim časovnikom za ščetkanje – in ilustrirana navodila za uporabo zobne nitke. Slednja so izhajala iz na dokazih utemeljenih informacij s področja promocije zdravja ustne votline v času nosečnosti. Prav tako sta pred začetkom modula in ob zaključku vse udeleženke intervencije pregledala zobozdravnik in zobni higienik, nosečnice so rešile tudi vedenjske teste. Rezultati so pokazali, da predlagana intervencija izboljša zdravje ustne votline nosečnice: dosegli so zmanjšanje zobnih oblog, krvavitev dlesni in globine žepa za štiri milimetre ali več.

RAZPRAVA

Po našem vedenju je pričujoča raziskava prvi integrativni pregled literature, ki preučuje vpliv sodobnih pristopov zdravstvene vzgoje na splošno zdravstveno pismenost nosečnic, opravljena pri nas. V končni pregled smo vključili pet raziskav o zdravstveni pismenosti nosečnic, v katerih so raziskovalci kvantitativno izmerili učinke intervencij z vsaj enim potrjenim orodjem in drugimi strokovnjaki. Raziskave poročajo o vplivu zdravstvene pismenosti na prepričanja/stališča, znanje in življenjski slog med nosečnostjo, vendar pa tudi kažejo na to, da je vključevanje drugih, nezdravstvenih strokovnjakov v zdravstvenovzgojne intervencije zelo omejeno, kar kliče po spremembah na področju zdravstvenega opismenjevanja odraslih. Razlog za to je zlasti v hitro spreminjajočih se družbenih okoliščinah, ki so določujoče, ko govorimo o vplivu na zdravstveno pismenost oziroma na stopnjo zdravstvene pismenosti. Slednja je z vidika izidov za zdravje še posebej določujoča za zdravje nosečnice in še nerojenega otroka, med epidemijo COVID-19 pa se to zdi še toliko bolj pomembno, saj je tveganje za zdravje nosečnice in še nerojenega otroka še povečano.

Zadnjih nekaj let se raziskovanje, praksa in odnos do zdravstvene vzgoje odraslih odmikajo stran od tradicionalnih pristopov, ki se skladno z biomedicinskim modelom usmerjajo v zdravstveno-medicinsko obravnavo, v bolj širši, inter- oziroma multidisciplinarni pristop. V tem širšem kontekstu je mogoče zdravstveno opismenjevati populacijo tudi v drugih okoljih, in ne samo in zgolj v okolju zdravstvenih institucij (šola, dom, delovno mesto, lokalna skupnost ipd.) ali pod okriljem zdravstvenih strokovnjakov. Nedavno dopolnjena opredelitev zdravstvene pismenosti govori o zdravstveni pismenosti kot o skupku veščin, ki jih je mogoče razviti skozi učinkovito komunikacijo in izobraževanje (Nutbeam, 2019). Funkcionalna, interaktivna in kritična zdravstvena pismenost zagotavljajo ogrodje za presojo intervencij oziroma pristopov zdravstvene vzgoje za dvig zdravstvene pismenosti,

vendar pa danes vemo, da dolgotrajne spremembe vzorcev vedenja, povezanih z zdravjem, zagotavljata zlasti interaktivna in kritična zdravstvena pismenost (Sentell idr., 2020), ki veljata za aktivni obliki razvijanja zdravstvene pismenosti. Te dragocene veščine, ki jih odlikuje prenosljivost, se nenehno razvijajo, oblikujejo in dograjujejo skozi življenjski cikel ter s tem prilagajajo raznolikemu in spreminjajočemu se okolju, družbenemu kontekstu in sodobnemu načinu življenja. To je obenem razlog, zakaj danes vse bolj potrebujemo posameznikom ali skupini prilagojene zdravstvenovzgojne pristope (in storitve), ki spodbujajo k razvijanju veščin zdravstvene pismenosti (Vamos idr., 2020) in posledično k preprečevanju oziroma zmanjševanju neenakosti, povezanih z zdravjem (Nutbeam, 2019; Schillinger, 2020).

Oskrba in spremljanje ženske skozi nosečnost je sklop kliničnih in izobraževalnih pristopov v smeri spodbujanja zdravja nosečnice in otroka. Za to obdobje so značilne določene fizične in čustvene spremembe, ki jih vsaka ženska doživlja različno, in bi zato morala biti zdravstvena oskrba celostna, tim, ki nosečnico spremlja, pa sestavljen iz različnih strokovnjakov. Predvsem pa se kakovost antenatalne obravnave nosečnice ne sme osredotočati le na njene kvantitativne vidike, kot na primer število posvetovanj in ginekoloških pregledov, temveč je na tem mestu nujna vključitev strategij za zagotavljanje celostne oskrbe, med katerimi želimo v ospredje postaviti sodobne izobraževalne pristope v sklopu zdravstvene vzgoje (Herval idr., 2019). Nekatere raziskave kažejo na to, da še posebej tiste nosečnice, ki sodijo v nizko tvegane v povezavi z nosečnostjo, kažejo na pomanjkanje znanja o spremembah, ki izvirajo iz nosečnosti, in o pripravah na porod (Silva idr., 2016).

Danes znotraj strukturiranih in namenskih zdravstvenovzgojnih obravnav obstaja veliko različnih strategij za promocijo zdravstvene pismenosti nosečnic (Kamali idr., 2018; Solhi idr., 2019; World Health Organisation, 2021), ima pa vsaka strategija svoje prednosti in slabosti. V tem pregledu je bilo predstavljenih in obravnavanih pet raziskav, ki opisujejo različne strategije za dvig zdravstvene pismenosti nosečnic, vendar za vsako od teh strategij obstajajo izzivi. Nekateri pristopi zdravstvene vzgoje, ki smo jih vključili v pregled, opisujejo med drugim še vedno tradicionalno obliko podajanja informacij nosečnicam oziroma se osredotočajo na tiskane zdravstvene informacije v obliki knjig, člankov in brošur, ki pomagajo zvišati stopnjo zdravstvene pismenosti nosečnic. Izvajalci zdravstvenih storitev lahko ponudijo pisne (tiskane) informacije za zvišanje ravni zdravstvene pismenosti, vendar pa lahko tudi pri tem pristopu naletimo na določene omejitve. Ženske morda nimajo dostopa do teh zdravstvenih vsebin, tiste, ki dostop imajo, pa morda teh vsebin ne bodo cenile, če so preveč znanstvene ali zapletene (Karamolahi idr., 2019). V pregledu so omenjeni tudi avdio in drugi sodobni informacijsko-komunikacijski tehnološki pristopi za opolnomočenje nosečnic. Na žalost so ti poskusi promocije zdravstvenih informacij zelo odvisni od geografske lege in ravni javnega financiranja, nosečnice s slabšim socioekonomskim statusom pa so v takih primerih še vedno v slabšem oziroma neenakem položaju (Karamolahi idr., 2019). Obenem pa pričujoči izzivi prinašajo tudi priložnosti za kombinacijo strategij in pristopov za učinkovito spodbujanje zdravstvene pismenosti (Nawabi idr., 2021). Glede vključevanja različnih strokovnjakov denimo Nacionalni inštitut

za javno zdravje (NIJZ, 2016) predlaga, da se v zdravstveno vzgojo nosečnice poleg diplomirane medicinske sestre in pediatra po možnosti vključujejo še diplomirani psiholog ter drugi strokovni sodelavci in sodelavke.

Ena najpogostejših strategij za spodbujanje zdravstvene pismenosti nosečnic pri nas so šole za bodoče starše (šole za starše). Vendar pa šole za starše ne morejo zajeti vseh informacij v zvezi z nosečnostjo, porodom in starševstvom. To so pokazale tudi analize in pregled stanja njihovega izvajanja v Sloveniji, in sicer, da se vzgoja za zdravje za bodoče starše izvaja zelo raznoliko, da obstajajo velike razlike med posameznimi šolami za starše tako glede vsebine kot uporabljene metodologije (NIJZ, 2018). Koncept zdravstvene pismenosti za nosečnice zato prinaša priložnost, da razmišljanje o izvedenih aktivnostih znotraj šol za starše s klasičnega podajanja informacij prenesemo v rabo sodobnih pristopov v zdravstveni vzgoji, ki bo temeljila na opolnomočenju nosečnic za materinstvo (Nawabi idr., 2021).

V Sloveniji so otrokom, mladostnikom in odraslim danes na voljo številni programi vzgoje za zdravje in zdravstvene vzgoje, ki so usmerjeni v ohranjanje in krepitev zdravja ter pridobivanje zdravih življenjskih navad. Izvajajo jih strokovnjaki iz centrov za krepitev zdravja, to so diplomirane medicinske sestre, dietetiki, fizioterapevti, kineziologi in psihologi. Centri za krepitev zdravja izvajajo številne programe in aktivnosti, med njimi tudi prenovljen in posodobljen program *Priprava na porod in starševstvo*. S posodobljenimi vsebinami in načinom izvajanja programa je bodočim staršem zagotovljen dostop do kakovostnih in preverjenih informacij ter veščin, kar vodi do boljše zdravstvene pismenosti nosečnic (Krepitev zdravja za vse, 2019). Vendar pa poleg vsebine, ki jo program vključuje, ni izrecno prikazano ali zapisano, kateri drugi strokovnjaki poleg strokovnjakov zdravstvene nege se vključujejo v izvedbo programa, če se sploh vključujejo. Predvsem pa so potrebne dodatne raziskave o vplivu izvajanja programa na dvig zdravstvene pismenosti nosečnic, o kakovosti rabe sodobnih pristopov v izobraževanju nosečnic in dodani vrednosti sodelovanja multidisciplinarnega tima v tem pristopu.

ZAKLJUČEK

Zdravstvena pismenost danes presega okvire zgolj funkcionalne zdravstvene pismenosti, saj so družbene okoliščine in s tem zdravstvene informacije vse bolj kompleksne. Razumevanje slednjih zahtevamo danes že od naših najmlajših, saj je sposobnost, da se pravočasno in pravilno odzovemo na zdravstvena tveganja, povezana z optimalnimi izidi za zdravje, kar sodobna družba danes prepoznava kot nujo in celo civilizacijsko normo. Tudi nosečnost je obdobje, kjer v »družbi tveganj« prepoznavamo povezana zdravstvena tveganja in pričakujemo, da bodo nosečnice ravnale na način, da bodo ohranile svoje zdravje in tudi zdravje svojih potomcev. V teh prizadevanjih je bila zdravstvena vzgoja nosečnic tradicionalno najboljše orodje za dvig zdravstvene ozaveščenosti nosečnic, vendar pa je v svoji tradicionalni obliki danes postala neodzivna na spremenjene družbene okoliščine, družbeno ustvarjene neenakosti v zdravju in/ali dostopanju do njega in ne nazadnje na

potrebe novodobnih žensk. Uvajanje novih pristopov, metod učenja/poučevanja, uvajanje interdisciplinarnosti in celo multidisciplinarnosti vsebin in izvajalcev, odmik iz kliničnih okolij v okolja, kjer ženske živijo in delajo, so samo nekatere spremembe, ki jim moramo na tem področju v bodoče pričakovati. Rezultati pregleda literature kažejo na spremembe v pristopu sodobne zdravstvene vzgoje, a hkrati tudi na to, da je ta proces prepočasen in premalo progresiven.

LITERATURA IN VIRI

Adams, S. H., Gregorich, S. E., Rising, S. S., Hutchison, M. in Chung, L. H. (2017). Integrating a nurse-midwife-led oral health intervention into CenteringPregnancy prenatal care: Results of a pilot study. *Journal of midwifery & women's health*, *62*(4), 463–469. https://doi.org/10.1111/jmwh.12613

Gibson, C. H. (1991). A concept analysis of empowerment. *Journal of Advanced Nursing*, *16*(3), 354–361. https://doi.org/10.1111/j.1365-2648.1991.tb01660.x

Herval, Á. M., Oliveira, D. P. D., Gomes, V. E. in Vargas, A. M. D. (2019). Health education strategies targeting maternal and child health: A scoping review of educational methodologies. *Medicine*, *98*(26), e16174. https://doi.org/10.1097/md.0000000000016174

Hong, Q. N., Fàbregues, S., Bartlett, G., Boardman, F., Cargo, M., Dagenais, P., Gagnon, M. P., Griffiths, F., Nicolau, B., O'Cathain, A., Rousseau, M. C., Vedel, I. in Pluye, P. (2018). The Mixed Methods Appraisal Tool (MMAT) version 2018 for information professionals and researchers. *Education for Information*, *34*(4), 285–291. https://doi.org/10.3233/EFI-180221

Kamali, Z., Abedian, Z., SaberMohammad, A. in Dehnavi, Z. M. (2018). The effect of small group teaching on quality of life in pregnant women with nausea and vomiting: A clinical trial. *Journal of education and health promotion*, *7*, 112. https://doi.org/10.4103/jehp.jehp_162_17

Karamolahi, P. F., Khalesi, Z. B. in Niknami, M. (2019). Pregnant women's health literacy promotion strategies: A review. *Journal of Pharmaceutical Research International*, *28*(2), 1–8. https://doi.org/ https://doi.org/10.9734/jpri/2019/v28i230198

Krepitev zdravja za vse. (2019). *S podporo Centra za krepitev zdravja do zdravih življenjskih navad*. https://www.krepitev-zdravja.si/izvajalci-programa/center-za-krepitev-zdravja/

Kupratakul, J., Taneepanichskul, S., Voramongkol, N. in Phupong, V. (2010). A randomized controlled trial of knowledge sharing practice with empowerment strategies in pregnant women to improve exclusive breastfeeding during the first six months postpartum. *Journal of the Medical Association of Thailand*, *93*(9), 1009–1018.

Lupattelli, A., Picinardi, M., Einarson, A. in Nordeng, H. (2014). Health literacy and its association with perception of teratogenic risks and health behavior during pregnancy. *Patient Education and Counseling*, *96*(2), 171–178. https://doi.org/https://doi.org/10.1016/j.pec.2014.04.014

Nacionalni inštitut za javno zdravje. (2016). *Strokovne podlage za nadgradnjo skupinske vzgoje za zdravje za bodoče starše in predlog skupinske vzgoje za zdravje za starše otrok do enega leta*. NIJZ.

Nacionalni inštitut za javno zdravje. (2018). *Vzgoja za zdravje za bodoče starše*. https://www.nijz.si/sl/vzgoja-za-zdravje-za-bodoce-starse

Nawabi, F., Krebs, F., Vennedey, V., Shukri, A., Lorenz, L. in Stock, S. (2021). Health literacy in pregnant women: A systematic review. *International Journal of Environmental Research and Public Health*, *18*(7), 3847. https://doi.org/10.3390/ijerph18073847

Nutbeam, D. (2019). Health education and health promotion revisited. *Health Education Journal*, *78*(6), 705–709. https://doi.org/10.1177/0017896918770215

Nutbeam, D. in Lloyd, J. E. (2021). Understanding and responding to health literacy as a social determinant of health. *Annual Review of Public Health*, *42*(1), 159–173. https://doi.org/10.1146/annurev-publhealth-090419-102529

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., Shamseer, L., Tetzlaff, J. M., Akl, E. A., Brennan, S. E., Chou, R., Glanville, J., Grimshaw, J. M., Hróbjartsson, A., Lalu, M. M., Li, T., Loder, E. W., Mayo-Wilson, E., McDonald, S., … Moher, D. (2021). The PRISMA 2020 statement: An updated guideline for reporting systematic reviews. *BMJ*, *372*, n71. https://doi.org/10.1136/bmj.n71

Parker, R. in Ratzan, S. C. (2010). Health literacy: A second decade of distinction for Americans. *Journal of Health Communication*, *15*(sup2), 20–33. https://doi.org/10.1080/10810730.2010.501094

Raynes-Greenow, C. H., Nassar, N., Torvaldsen, S., Trevena, L. in Roberts, C. L. (2010). Assisting informed decision making for labour analgesia: A randomised controlled trial of a decision aid for labour analgesia versus a pamphlet. *BMC Pregnancy Childbirth*, *10*, 15. https://doi.org/10.1186/1471-2393-10-15

Roter, D. L., Erby, L. H., Rimal, R. N., Smith, K. C., Larson, S., Bennett, I. M., Cole, K. W., Guan, Y., Molloy, M. in Bienstock, J. (2015). Empowering women's prenatal communication: Does literacy matter? *Journal of Health Communication*, *20(*sup2), 60–68. https://doi.org/10.1080/10810730.2015.1080330

Rowlands, G., Shaw, A., Jaswal, S., Smith, S. in Harpham, T. (2017). Health literacy and the social determinants of health: A qualitative model from adult learners. *Health Promotion International*, *32*(1), 130–138. https://doi.org/10.1093/heapro/dav093

Schillinger, D. (2020). The intersections between social determinants of health, health literacy, and health disparities. *Studies in health technology and informatics*, *269*, 22–41. https://doi.org/10.3233/SHTI200020

Sentell, T., Vamos, S. in Okan, O. (2020). Interdisciplinary perspectives on health literacy research around the world: More important than ever in a time of COVID-19. *International Journal of Environmental Research and Public Health*, *17*(9), 3010. https://doi.org/10.3390/ijerph17093010

Silva, E. P., Lima, R. T. in Osório, M. M. (2016). Impact of educational strategies in low-risk prenatal care: Systematic review of randomized clinical trials. *Cien Saude Colet*, *21*(9), 2935–2948. https://doi.org/10.1590/1413-81232015219.01602015

Solhi, M., Abbasi, K., Ebadi Fard Azar, F. in Hosseini, A. (2019). Effect of health literacy education on self-care in pregnant women: A randomized controlled clinical trial. *International journal of community based nursing and midwifery*, *7*(1), 2–12. https://doi.org/10.30476/ijcbnm.2019.40841

Sørensen, K., Van den Broucke, S., Fullam, J., Doyle, G., Pelikan, J., Slonska, Z. in Brand, H. (2012). Health literacy and public health: A systematic review and integration of definitions and models. *BMC Public Health*, *12*(1), 80. https://doi.org/10.1186/1471-2458-12-80

Turner, T. (2017). Health literacy and medical education. V R. A. Connelly in T. Turner (ur.), *Health Literacy and Child Health Outcomes Promoting Effective Health Communication Strategies to Improve Quality of Care* (str. 57–72). Springer. https://doi.org/10.1007/978-3-319-50799-6

Vamos, S., Okan, O., Sentell, T. in Rootman, I. (2020). Making a case for "education for health literacy": An international perspective. *International Journal of Environmental Research and Public Health*, *17*(4), 1436. https://doi.org/10.3390/ijerph17041436

Vila-Candel, R., Martínez-Arnau, F. M., de la Cámara-de las Heras, J. M., Castro-Sánchez, E. in Pérez-Ros, P. (2020). Interventions to improve health among reproductive-age women of low health literacy: A systematic review. *International Journal of Environmental Research and Public Health*, *17*(20), 7405. https://doi.org/10.3390/ijerph17207405

Whittemore, R. in Knafl, K. (2005). The integrative review: Updated methodology. *Journal of Advanced Nursing*, *52*(5), 546–553. https://doi.org/10.1111/j.1365-2648.2005.03621.x

World Health Organisation. (2021). *Promoting healthy pregnancy*. https://www.who.int/activities/promoting-healthy-pregnancy

Yee, L. M., Wolf, M., Mullen, R., Bergeron, A. R., Cooper Bailey, S., Levine, R. in Grobman, W. A. (2014). A randomized trial of a prenatal genetic testing interactive computerized information aid. *Prenatal Diagnosis*, *34*(6), 552–557. https://doi.org/10.1002/pd.4347

Zibellini, J., Muscat, D. M., Kizirian, N. in Gordon, A. (2021). Effect of health literacy interventions on pregnancy outcomes: A systematic review. *Women and Birth*, *34*(2), 180–186. https://doi.org/10.1016/j.wombi.2020.01.010

Andragoška spoznanja/Studies in Adult Education and Learning, 2021, 27(2), 93-107 UDK: 374.7:027
DOI: https://doi.org/10.4312/as/10188 Znanstveni prispevek

Katarina Švab

ZDRAVSTVENI KOTIČKI IN IZOBRAŽEVANJE ZA ZDRAVJE V SPLOŠNIH KNJIŽNICAH

POVZETEK

V članku je prikazana raziskava o zdravstvenih kotičkih v slovenskih splošnih knjižnicah. Namen je bil analizirati dejavnosti zdravstvenih kotičkov in predstaviti prednosti ter pomanjkljivosti oz. izzive. Uporabljene so bile različne metode zbiranja podatkov: intervjuji s knjižničarji, analiza spletnih strani in družbenih omrežij ter opazovanje. Rezultati so pokazali, da se knjižnice zavedajo pomena izobraževanja za zdravje in organizirajo veliko število izobraževanj za zdravje, vendar pa se ta le v manjši meri izvedejo v zdravstvenih kotičkih. Zdravstveni kotički so urejeni in smiselno umeščeni v knjižnični prostor, potrebovali pa bi nove strategije za izobraževanje za zdravje. Poseben izziv pri načrtovanju in izvajanju izobraževanja za zdravje so informacijsko slabše pismeni uporabniki, saj mnogo priložnosti pridobivanja informacij ponujajo prav splet in družbena omrežja. S spremenjeno strategijo izobraževanja bodo lahko v prihodnosti zdravstveni kotički imeli močnejšo vlogo pri ozaveščanju uporabnikov na področju zdravja.

Ključne besede: *splošne knjižnice, zdravstveni kotički, zdravje, izobraževanje*

HEALTH ZONES AND HEALTH EDUCATION IN PUBLIC LIBRARIES – ABSTRACT

The article presents research on health zones in Slovenian public libraries. The aim of the research was to analyse their activity and to identify their advantages and disadvantages or challenges. The data collection methods used were interviews with librarians, analysis of websites and social networks, and observation. The results of the research show that libraries are aware of the importance of health education and organise a large number of health education events. However, these are offered only to a limited extent in the health zones themselves. While health zones are well organised and suitably embedded in library spaces, new strategies for health education are needed. One challenge in planning and delivering health education, particularly when it comes to less information literate users, are the many opportunities to acquire information online and on social networking sites. With the change in education strategy, health zones can play a bigger role in raising awareness among health users in the future.

Keywords: *public libraries, health zones, health, education*

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UVOD

Splošna knjižnica je javna služba, ki ima izobraževalno, informacijsko, kulturno in razvedrilno vlogo v lokalni skupnosti in družbi nasploh. V današnji družbi so knjižnice vedno bolj pomembne tudi na področju ozaveščanja in izobraževanja o zdravju, zdravem načinu življenja, dobrem počutju itd. Knjižnice podpirajo prebivalce in organizacije v lokalni skupnosti pri pridobivanju, vrednotenju in uporabi zdravstvenih informacij.

Mreža 58 slovenskih splošnih knjižnic je zelo dobro organizirana, saj na 273 lokacijah vsem prebivalcem omogoča uporabo knjižničnih storitev (Narodna in univerzitetna knjižnica, 2021). Storitve in dejavnosti na področju izobraževanja za zdravje so stalna ponudba vseh slovenskih splošnih knjižnic z namenom uresničevanja pravic državljanov do dostopa do informacij s področja zdravstva in pravice do obveščenosti in samostojnega odločanja o zdravju (Nacionalni svet za knjižnično dejavnost, 2018; Zakon o pacientovih pravicah, 2008, čl. 5). Četudi je informacijska in izobraževalna vloga splošnih knjižnic namenjena vsem prebivalcem, pa knjižnice niso vključene v projekt Dvig zdravstvene pismenosti v Sloveniji (Nacionalni inštitut za javno zdravje [NIJZ], 2021).

Namen prispevka je na podlagi rezultatov analize virov in intervjujev podati odgovore na izzive knjižnic in lokalnih skupnosti pri zagotavljanju kakovostnih informacij s področja varovanja zdravja in izobraževanja za zdravje. Kot posebno prakso za ozaveščanje in izobraževanje o zdravju smo izbrali zdravstvene kotičke, ki bodo predstavljeni v drugem delu članka.

ISKANJE ZDRAVSTVENIH INFORMACIJ

V okviru raznolikih vrst pismenosti se je razvila tudi zdravstvena pismenost, ki je pomemben koncept za izobraževanje o zdravju v knjižnicah. Eden izmed vidikov zdravstvene pismenosti je izbor zdravstvenih informacij iz najbolj relevantnih virov. Raziskave kažejo, da posamezniki, ki imajo nizko razvito zdravstveno pismenost, opravijo manj pregledov, se pozneje odločijo za obisk zdravnika, imajo težave z razumevanjem informacij pri zdravniku in slabše skrbijo za svoje zdravje (Coulter idr., 2006; Estacio in Comings, 2013; Kickbusch, 2008; Rubenstein, 2016; Sørensen idr., 2012). Ljudje, ki iščejo zdravstvene informacije, se med seboj razlikujejo glede na spol, starost, izobrazbo, zdravstveno stanje, socialno-ekonomski status ter glede načinov in razlogov pridobivanja informacij. Po nekaterih raziskavah najpogosteje iščejo zdravstvene informacije ženske z višjo izobrazbo in višjim dohodkom ter starejše osebe (Anker idr., 2011; Komel, 2016; Zickuhr, 2010). Šinko (2012) je ugotovila, da starejši kot so uporabniki, več zanimanja kažejo za izobraževanje na področju zdravja (o boleznih, alternativnih metodah zdravljenja itd.). Ob tem velja poudariti, da je bila izobrazbena sestava vzorca višja od povprečne izobrazbe v Sloveniji.

Najpogosteje se zdravstvene informacije iščejo na spletu, ki je najbolj priljubljen zaradi enostavnosti iskanja, hitrosti in spoznavanja izkušenj drugih (Pletneva idr., 2011; Ramšak, 2011). Velik delež uporabnikov uporablja splet za iskanje informacij o boleznih, prehrani, gibanju in dietah (Andreassen idr., 2007; Fox in Duggan, 2013). Večina začne iskanje s

splošnim iskanjem v iskalnikih in ne na zdravstvenih spletnih straneh ter v povprečju med rezultati iskanja pregleda dve do pet spletnih strani (Fox in Rainie, 2002). Uporabniki menijo, da je iskanje po spletu težko, kot zahtevno pa ocenjujejo tudi presojanje verodostojnosti pridobljenih informacij (Huotari idr., 2015). Dandanes je mnogo zdravstvenih informacij tudi na družbenih omrežjih, a večina starejših uporabnikov (nad 60 let) nikoli ni bila prijavljena na Facebookove strani o zdravju in zdravem načinu življenja (Pálsdóttir, 2014). Razlogi za iskanje zdravstvenih informacij se razlikujejo glede na zdravstveno stanje osebe pred zdravstveno obravnavo, med njo in po njej (Delić idr., 2006; Kozel, 2010).

PREGLED VRST IZOBRAŽEVANJA ZA ZDRAVJE V KNJIŽNICAH

Izobraževanje za zdravje se v splošnih knjižnicah že dolgo izvaja. Najstarejša elementa pri razvoju ozaveščanja in izobraževanja za zdravje sta knjižnična zbirka in referenčni pogovor. Knjižnice posebno skrb posvečajo izgradnji in razvoju knjižnične zbirke s področja zdravja in zagotavljajo svojim uporabnikom individualne informacije. Poleg tega organizirajo neformalna izobraževanja za uporabnike, ozaveščajo lokalno skupnost o skrbi za zdravje in sodelujejo z zdravstvenimi institucijami. Kot četrti element omenimo tudi profesionalno izpopolnjevanje knjižničarjev na področju iskanja in vrednotenja zdravstvenih informacij (Bennett-Kapusniak, 2018; Rubenstein, 2016). Vse štiri ravni se v praksah knjižnic medsebojno prepletajo.

Knjižnice so javni prostor, tudi za osebe, ki se soočajo s telesnimi in duševnimi boleznimi, ter zatočišče mnogim marginaliziranim skupinam (Morgan idr., 2016), zato so različne dejavnosti izobraževanja za zdravje namenjene različnim skupinam. Omogočanje dostopa vsem do informacij in gradiva na različnih nosilcih in v različnih formatih je ena glavnih nalog knjižnic, ki je tudi zakonsko določena v *Zakonu o knjižničarstvu* (2001).

Viri za razvoj znanja o zdravju so razvrščeni v knjižnične zbirke in organizirani po univerzalni decimalni klasifikaciji (UDK), razen v Mestni knjižnici Kranj. Večina tovrstnega tiskanega gradiva je razporejena v skupini 61 (UDK 61 – medicina) in podskupinah. Ker izobraževanje za zdravje vključuje telesno in duševno zdravje, naj omenimo, da so dela o duševnem zdravju razvrščena v skupino 159.9, nekatera gradiva pa so tudi pri družbenih vedah (UDK 331, 355, 364).

Uporabniki knjižnice bolj zaupajo tiskanim kot spletnim virom in zelo malo uporabljajo vire, ki so navedeni na spletni strani knjižnice (Ingham, 2014). Pri iskanju virov pogosto prosijo za pomoč knjižničarja. Če uporabnik za pomoč o zdravstvenih informacijah prosi knjižničarja, traja referenčni pogovor od 10 do 30 minut (Linnan idr., 2004). Knjižničarji, ki v referenčnem pogovoru razrešujejo informacijske potrebe uporabnika, ne dajejo razlag o zdravju, temveč predvsem o pridobivanju relevantnih, zanesljivih informacij. Ker so uporabniki knjižničnih virov različni, lahko nastane težava, če imajo knjižnice relevantne vire, a so informacije v teh virih preveč zahtevne ali vsebujejo strokovno terminologijo in so zato splošnemu uporabniku nerazumljive (Powell idr., 2011). Večina knjižničarjev zdravstvenih informacij ne obravnava kakorkoli drugače kot informacije z

drugih področij, a se zavedajo, da morajo uporabniku postavljati podvprašanja previdno, saj nekateri težko spregovorijo o svoji bolezni (Resman, 2018; Rubenstein, 2016). Zato v *Zdravstvenih in medicinskih smernicah* Sveta referenčnih in uporabniških storitev Ameriškega knjižničarskega združenja (2015) navajajo načine za posredovanje informacij s strani knjižničnega osebja, ki pri tem potrebuje posebne kompetence in občutek za sočloveka. Mnoge knjižnice so pozorne na osebe, ki v knjižnico ne morejo priti, in jim omogočajo referenčni pogovor prek različnih komunikacijskih kanalov ter jim zagotavljajo dostavo gradiva na dom (po pošti, dostava s kolesom …). Kot obliko svetovanja lahko štejemo tudi telefonski pogovor.

Uporabniki se lahko srečujejo še z drugimi ovirami, kot je pomanjkanje bralne ali informacijske pismenosti (Resman, 2018). Do teh uporabnikov lahko knjižničarji pristopijo posredno, npr. z organizacijo različnih prireditev, ki imajo namen razvijati ozaveščenost o zdravju in so sicer namenjene vsem uporabnikom. Dogodki so oblikovani kot predstavitve knjig (npr. v okviru literarnih prireditev) in kot predavanja (v okviru ciklov ali kot priložnostna predavanja na specifično tematiko). Predavanja in delavnice vodijo zdravstveni delavci, prostovoljci, večinoma upokojeni strokovnjaki ali študenti zdravstvenih strok.

Dandanes knjižnice razvijajo izobraževalne strategije ozaveščanja tudi s sodobnimi komunikacijskimi mediji: vse slovenske splošne knjižnice imajo stran na Facebooku, manj pa so dejavne na Instagramu in Twitterju (Švab, 2020). Od začetka pandemije covida-19 se je na družbenih omrežjih pojavilo veliko informacij, a hkrati tudi dezinformacij o zdravju, t. i. fake news. Vendar pa so le nekatere knjižnice obveščale in ozaveščale o trenutni zdravstveni situaciji oz. zdravju nasploh.

V tujini imajo pri zagotavljanju in posredovanju zdravstvenih informacij in izobraževanju za zdravje najpomembnejšo vlogo medicinske knjižnice.[1] Njihov namen je razširiti vlogo knjižnic pri posredovanju zdravstvenih informacij na laično javnost. Splošne knjižnice se povezujejo z medicinskimi knjižnicami in drugimi zdravstvenimi organizacijami, predvsem v lokalnem okolju (Collins, 2015). Sodelovanje splošnih knjižnic v aktivnostih izobraževanja za zdravje v razvitih državah podpirajo tudi ministrstva za zdravje, saj želijo spodbuditi uporabnike k uporabi zanesljivih virov informacij. V ta namen izvajajo predstavitve virov zdravstvenih informacij v knjižnici in na drugih dogodkih v lokalni skupnosti, pripravljajo razstave na temo zdravja, zdravstvenopromocijske aktivnosti v lokalni knjižnici (npr. meritve krvnega tlaka), delavnice s specifično zdravstveno tematiko itd., ponekod pa so vzpostavili zdravstvene kotičke (ang. *Health zones*), kjer so na razpolago razne brošure, tudi društev, revije, prospekti, plakati, zloženke s seznami priporočene literature s področja zdravja (Kodela, 2015; Radick, 2015).

1 Ameriška Nacionalna knjižnica za medicino z bazo MedlinePlus (https://medlineplus.gov/), Združenje medicinskih knjižnic s sekcijo Customer and Patient Health Information Caucus (CAPHIC; https://www.mlanet.org/caphis) in evropsko združenje EAHIL s sekcijo Public Health Information Group (PHIG; http://eahil.eu/sig-2/public-health-information-group/).

Slovenske splošne knjižnice so razvile kar nekaj projektov izobraževanja za zdravje. Prvi projekt »Javne knjižnice za zdravje občanov« se je začel leta 2007 pod okriljem Rdečega križa v Celju. Leta 2011 je bil izpeljan projekt »Zdravstveni kotiček«, v katerem so sodelovale Centralna medicinska knjižnica, Mestna knjižnica Ljubljana, enota Knjižnica Otona Župančiča, Knjižnica Mirana Jarca Novo mesto in Mariborska knjižnica. Knjižničarji so se udeležili izobraževanja Centralne medicinske knjižnice, ki je tudi oblikovala zbirko spletnih virov (Rožić idr., 2010).

Knjižnice imajo zelo dobro in široko razvejeno prireditveno dejavnost tudi s področja zdravja, manj pa sta poznana vloga in delovanje zdravstvenih kotičkov pri izobraževanju za zdravje. Namen raziskave je predstaviti, kakšne zdravstvene informacije in storitve ponujajo knjižnice svojim uporabnikom s pomočjo zdravstvenih kotičkov in s kakšnimi izzivi se srečujejo pri izobraževanju za zdravje med uporabniki.

METODOLOGIJA

Za namen raziskave smo si zastavili naslednja raziskovalna vprašanja:
- Kako delujejo zdravstveni kotički v slovenskih splošnih knjižnicah?
- Katere so prednosti delovanja zdravstvenih kotičkov in s kakšnimi izzivi se soočajo?
- Kako uporabniki splošnih knjižnic iščejo zdravstvene informacije in kako uporabljajo zdravstvene kotičke?

Raziskava je bila zasnovana kot kvalitativna (Flick, 2018). Da bi odgovorili na zastavljena raziskovalna vprašanja, smo podatke zbirali na več načinov, s kombinacijo več metod pa smo upoštevali načelo triangulacije na ravni zbiranja podatkov.

Podatke smo zbirali (a) z analizo virov, spletnih strani in družbenih omrežij knjižnic, (b) z obiskom knjižnic, opazovanjem, fotografiranjem zdravstvenih kotičkov in (c) z intervjuji knjižničarjev. V raziskavi je bil uporabljen polstrukturiran intervju z vnaprej pripravljenimi odprtimi vprašanji. Podatke smo zbirali od marca 2020 do avgusta 2021. Intervjuje smo opravili junija in avgusta 2021, izvedli smo tri osebne in en telefonski pogovor s knjižničarji,[2] ki so pristojni za zdravstvene kotičke. Sodelujočim smo zagotovili anonimnost njihovih odgovorov in zaupnost podatkov. Zbrani podatki so bili analizirani z metodo analize besedila. Po analizi besedil smo ugotovitve združili v teme, ki so sledile raziskovalnim vprašanjem. Rezultate v nadaljevanju prikazujemo najprej po posameznih lokacijah zdravstvenih kotičkov in nato glede na izzive, s katerimi se srečujejo.

PRIKAZ REZULTATOV

Samo nekatere osrednje območne knjižnice informirajo uporabnike glede zdravja in izobraževanja za zdravje s pomočjo zdravstvenih kotičkov. To so: Mestna knjižnica Kranj, Mestna knjižnica Ljubljana, Mariborska knjižnica in Knjižnica Mirana Jarca Novo mesto.

2 Uporabljena je moška oblika kot enotna oblika, tudi zato, da bi s tem popolnoma zakrili identiteto vprašanih knjižničark in knjižničarjev.

V nadaljevanju predstavljeni zdravstveni kotički v slovenskih splošnih knjižnicah so razvrščeni po letu nastanka.

Zdravstveni kotiček v Mestni knjižnici Ljubljana

V letu 2011 je začel delovati prvi zdravstveni kotiček, to je bilo v Knjižnici Otona Župančiča v Mestni knjižnici Ljubljana, z namenom, da bi izobraževali in pomagali pri iskanju relevantnih informacij. Kasneje so zasnovali tudi Demenci prijazno točko. Zdravstveni kotiček in Demenci prijazna točka delujeta v prvem nadstropju. Na voljo so računalnik za iskanje informacijskih virov o zdravju, zloženke, revije in zgibanke ter zbirka knjig. Uporabniki segajo po razstavljeni literaturi in brošurah v kotičku. Ugotovitve iz pogovorov in opazovanja kažejo, da mlajši iščejo e-vire sami doma. Starejši in manj izobraženi niso tako motivirani in se slabše znajdejo pri iskanju e-virov, tudi zaradi težav pri uporabi računalnika. Iskanje se jim zdi zahtevno zaradi velike količine informacij in si želijo predvsem informacije iz tiskanega gradiva, kot so knjige, enciklopedije, leksikoni itd. V začetku delovanja zdravstvenega kotička so v knjižnici glede nakupa gradiva dobili kakšno priporočilo ali opozorilo Centralne medicinske knjižnice, v splošnem pa se odzivajo na povpraševanje uporabnikov, zato imajo literaturo (tudi v tujem jeziku) o alternativnih in komplementarnih načinih zdravljenja in skrbi za dobro počutje. Veliko imajo na voljo tudi študijskega gradiva, ki si ga izposojajo predvsem študenti in dijaki. Pri iskanju primernega tiskanega gradiva med policami starejši uporabniki pogosto izrazijo svoje težave z zdravjem in si želijo pogovora s knjižničarjem.

Najbolj so obiskane brezplačne dejavnosti: predavanja, delavnice, tečaji, meritve tlaka in sladkorja v krvi. Ob tem so se, predvsem starejši uporabniki, radi pogovarjali o svojih zdravstvenih težavah z izvajalci teh meritev. Preventivnih akcij se je v obdobju 2014–2017 v 33 terminih udeležilo 545 uporabnikov in zaposlenih v knjižnici. V okviru zdravstvenega kotička so bili načrtovani tedenski obiski in prisotnost strokovnjaka prostovoljca, ki naj bi v knjižnici dajal strokovne informacije. Zaradi majhnega obiska so tovrstno svetovanje po dveh mesecih opustili. Po drugi strani pa se je število prireditev na tematiko zdravja iz leta v leto povečevalo. Te se ne odvijajo v zdravstvenem kotičku, temveč v dvorani. Med letoma 2011 in 2017 so organizirali 205 prireditev, ki se jih je udeležilo 10.201 obiskovalcev, poleg tega so pripravili še 95 razstav (gl. Resman, 2018).

Leta 2016 je bila na spletni strani Mestne knjižnice Ljubljana postavljena Infotočka e-gradiv javnih oblasti,[3] ki vključuje eZdravje s sklopi. Na spletni strani zdravstvenega kotička[4] pa so navedene storitve, ki jih ponujajo svojim uporabnikom: pomoč knjižničarja, knjižnična zbirka, predavanja, brezplačne meritve krvnega tlaka in sladkorja, razstave in zloženke ter publikacije z informacijami o zdravju in delovanju društev. Vendar pa navedene storitve nimajo hiperpovezav, ki bi vodile na Infotočko e-gradiv javnih oblasti. Na družbenih omrežjih je Mestna knjižnica zelo dejavna, redno promovira dogodke in

3 Infotočka je dostopna na https://www.mklj.si/infotocka-e-gradiv-javnih-oblasti/ezdravje/.

4 Spletna stran zdravstvenega kotička je dostopna na https://www.mklj.si/zdravstveni-koticek/.

predavanja na temo zdravja, bralne sezname, nekaj objav pa je bilo tudi v povezavi z zdravstvenim kotičkom.

Kot smo omenili v uvodu, je pri razvoju zdravstvene pismenosti pomembno tudi profesionalno izobraževanje knjižničarjev, ki dejavnosti razvijajo in organizirajo. Tako smo pri raziskovanju prakse izobraževanja za zdravje ugotovili, da se je knjižničar izobraževal z obiski v tujini. Poleg izobraževanja v Centralni medicinski knjižnici je zaposleni v okviru Erasmusu+ obiskal splošno knjižnico v Veliki Britaniji in se seznanil z njihovimi storitvami pri izobraževanju za zdravje. Za širšo skupnost knjižničarjev pa je Mestna knjižnica Ljubljana pripravila različne predstavitve in izobraževanja ter zasnovala predavanje za knjižnične delavce Zdravstveno opismenjevanje v splošni knjižnici.

Oblikovali so tudi koncept Borza zdravja, ki celostno obravnava posredovanje zdravstvenih informacij in zdravstveno opismenjevanje v Mestni knjižnici Ljubljana.

ZDRAVstveni KOTiček v Knjižnici Mirana Jarca Novo mesto

V Knjižnici Mirana Jarca Novo mesto so leta 2011 uredili zdravstveni kotiček, v katerem so različne zloženke, predvsem pa plakati s področja zdravja. Zloženke so oblikovali z namenom, da bo iskanje želene literature enostavno in hitro. Opremili so jih tudi z dodatnimi informacijami in povezavami na spletne strani iskane tematike. Ob zdravstvenem kotičku je prostor za iskanje informacij na računalniku. Razstave s področja zdravja pripravljajo tudi na razstavnem panoju na hodniku ob vhodu v knjižnico, v knjižnici ali na oddelku, ki je povezan s posamezno ciljno skupino (npr. razstava o dojenju je bila na otroškem oddelku knjižnice). Ob tem priložnostno razstavijo tudi izbrano gradivo. Na panojih je izpostavljen logotip zdravstvenega kotička, na panoju ob vhodu pa tudi logotip NIJZ, saj knjižnica redno sodeluje z Nacionalnim inštitutom za javno zdravje. Sodelujejo tudi z zdravstvenim domom in različnimi organizacijami in društvi, ki delujejo na področju zdravja in preventive. Zelo dobre izkušnje in odzive imajo na celodneven dogodek s predavanji, delavnicami in razstavo, ki ni nujno lokacijsko vezana samo na zdravstveni kotiček. Trenutne obiskovalce knjižnice nagovorijo k udeležbi na delavnici ali predstavitvi, in ko se oblikuje dovolj velika skupina, jo izvedejo. V njihovi praksi lahko v ospredje postavimo element animacije uporabnikov. Tovrsten način izvedbe se je izkazal kot učinkovit, saj je udeležba večja kot pri vnaprej razpisanih, fiksnih terminih.

Gradivo, predvsem knjige s področja zdravja, ni postavljeno v zdravstvenem kotičku ali njegovi neposredni bližini. Odgovorni za zdravstveni kotiček deluje proaktivno in samoiniciativno: daje predloge za dogodke, jih organizira in izvede, daje pobude za objave na družbenih omrežjih, kontaktira NIJZ in sodelujoče pri pripravi razstav itd.

Na spletni strani so oblikovali virtualni zdravstveni kotiček ZDRAVstveni KOTiček,[5] ki ima podstrani Zdravstveni viri in Aktualno. Na predstavitveni strani so ponujene spletne povezave na informacije o koronavirusu (predvsem na NIJZ in aktualne podatke v

5 Virtualni ZDRAVstveni KOTiček je dostopen na https://www.nm.sik.si/si/studijski/zdravstveni-koticek/.

Mestni občini Novo mesto). Ponujeni so e-viri tujih založnikov v angleščini. Na podstrani Zdravstveni viri so kratki opisi spletnih virov in povezave na slovenske spletne strani, na podstrani Aktualno pa program Svit. Knjižnica Mirana Jarca Novo mesto je dejavna na Facebooku. Tam skrbi za splošne objave s področja zdravja, spodbuja k zdravemu načinu življenja in vabi k solidarnosti ter krvodajalstvu. Objave sicer prejmejo majhen odziv, kar pa ni nujno najboljši kazalnik pomembnosti in branosti med uporabniki.

Bralna lekarna v Mariborski knjižnici

V enoti Nova vas pri Mariborski knjižnici od leta 2013 deluje zdravstveni kotiček, ki so ga poimenovali Bralna lekarna. Poleg strokovne literature, predvsem revij, knjižničarji ponujajo zlasti poljudna dela, ki se dotikajo različnih bolezenskih stanj. Gradivo izbira ambasador knjižnice mag. Aco Prosnik, ki dvakrat letno vodi tudi pogovor z avtorji poljudnih del, ki opisujejo določene zdravstvene težave (npr. pogovor o knjigi Hipokrat je bil kuhar: poti iz medicinskih in prehranskih zablod z avtorjem Ivanom Sočejem).

Na spletni strani Mariborske knjižnice nimajo podstrani, ki bi ponujala informacije o Bralni lekarni. Na spletni strani »Kako smo se imeli« je navedeno le poročilo s treh dogodkov iz leta 2013 (Zdravstveni bralni kotiček v Knjižnici Nova vas), 2015 (Zdravstveni kotiček: Glava dela čudeže) in 2016 (Bralna lekarna: Predstavitev knjige Hipokrat je bil kuhar). Na družbenih omrežjih (Facebook in Instagram) je knjižnica zelo dejavna, vendar posebnega poudarka na izobraževanju za zdravje nismo zasledili.

Idejna zasnova zdravstvenega kotička se je preoblikovala, saj ne deluje v prvotno zastavljenih okvirih projekta zdravstvenih kotičkov.

Zdravstveni kotiček v Mestni knjižnici Kranj

Najnovejši slovenski zdravstveni kotiček je bil v Mestni knjižnici Kranj odprt leta 2017, leta 2021 pa so postali tudi Demenci prijazna točka. Kotiček je v drugem nadstropju, oblikovan je prostorno, ima nekaj sedežev, mizo in stole, izpostavljene so revije, zgibanke in tematsko obarvane monografije, ki jih priložnostno menjujejo. V neposredni bližini je knjižnično gradivo s področja zdravja.

V zdravstvenem kotičku ali dvorani izvajajo delavnice za različne specifične skupine (npr. za nosečnice in mlade mamice) ali uporabnike s specifičnimi težavami (npr. težavami s prekomerno težo). Vse dogodke objavijo v Mesečniku – napovedniku dogodkov v Mestni knjižnici Kranj. Večje število obiskovalcev ob dogodku v zdravstvenem kotičku je lahko moteče za preostale obiskovalce knjižnice, ki iščejo gradivo ali želijo več tišine zaradi študija ali branja. Zato so dogodke izvedli v času zaprtosti knjižnice, vendar je treba v tem primeru poskrbeti za večjo varnost celotne knjižnice in zagotoviti ob koncu prireditve skupen odhod obiskovalcev iz knjižnice. Zdravstveni kotiček je namenjen bolj pogovorom in predstavitvam, manj pa predavanjem, saj ni opremljen z avdio-vizualno opremo, ki bi omogočala projekcije in ozvočenje. Tako se večina izobraževanj za zdravje izvede v knjižnični dvorani, ki ima najboljše pogoje za obiskovalce in predavatelje.

Opazno je sodelovanje med knjižnico in zdravstveno ustanovo, saj na spletni strani Zdravstvenega doma Kranj oglašujejo dogodke, ki se odvijajo v zdravstvenem kotičku (Zdravstveni dom Kranj, 2021).

Mestna knjižnica Kranj ima na spletni strani podstran Zdravstveni kotiček,[6] kjer so predstavljeni razlogi za obstoj, lokacija in aktivnosti zdravstvenega kotička: pomoč pri iskanju zdravstvenih informacij, predavanja, tečaji in zaznamovanje svetovnega dneva zdravja. V letu 2021 so v sodelovanju s Centrom za krepitev zdravja posneli kratke, 15-minutne oddaje *Na zdravje* na temo prehrane, o krepitvi imunskega sistema, čiščenju zob in aerobni vadbi. Med družbenimi omrežji so dejavni na Facebooku, Instagramu in Twitterju. Na Facebooku objavljajo sporočila o zdravju, ki jih posredujejo od drugih institucij (npr. Preventivni program za odrasle, 21. 12. 2017), zaznamujejo svetovni dan zdravja (npr. svetovni dan zdravja, 7. 4. 2021) in napovedujejo dogodke v zdravstvenem kotičku, predavanja (npr. o ledvicah in ledvičnih boleznih, 19. 3. 2018) ali pa poročajo o povezovanju z zdravstvenimi ustanovami (obisk kranjske porodnišnice in izročitev pisma iz knjižnice novorojenčkom, 15. 6. 2021). Na Instagramu so objavili dva videa Na zdravje: okrepimo imunski sistem (93 ogledov, 3. 2. 2021) in o povišanem krvnem tlaku (97 ogledov, 8. 12. 2020). V okviru cikla Znanost na cesti je bilo izvedeno tudi predavanje Bliskovit razvoj cepiv proti novemu koronavirusu SARS-COV-2 (16. 10. 2020), poleg tega promovirajo knjižnično gradivo, npr. promocija prek treh naslovnic knjig o epidemiji skozi čas (12. 10. 2020).

Izzivi zdravstvenih kotičkov v slovenskih splošnih knjižnicah

Ob snovanju projekta zdravstvenih kotičkov je opazno veliko pričakovanje in navdušenje, vendar se je skozi čas izkazalo, da se ti soočajo z mnogimi izzivi in problemi pri ureditvi ustreznega prostora, zagotavljanju prisotnosti zaposlenih, posredovanju informacij, organizaciji dogodkov ter pri izobraževanju in povezovanju knjižničarjev.

Ustrezen prostor in zagotavljanje prisotnosti zaposlenih oz. zdravstvenih strokovnjakov

Splošne knjižnice so zdravstvene kotičke umestile v zatišni del knjižnice, kajti vsak prostor ni primeren za ta namen. V kotičku naj bi se odvijali referenčni pogovori s področja zdravja, pogovori z zdravnikom, farmacevtom ali zdravstvenim delavcem, ki bi redno prihajal v knjižnico. Za tovrstne pogovore bi prostor moral omogočati večjo zaupnost in zasebnost. Za druge dogodke so zdravstveni kotički premajhni, sploh če pritegnejo večje število obiskovalcev. Če je okrog kotička postavljeno gradivo, takšne pogovore motijo uporabniki, ki iščejo gradivo. Zaradi odmaknjenosti kotičkov od knjižničarjev pa ti nimajo večjega pregleda, nadzora ali možnosti spremljanja dejanske uporabe zdravstvenega kotička. Pogostejša prisotnost knjižničarjev v zdravstvenem kotičku bi ponudila priložnosti za pogovore z uporabniki, ki bi enostavneje izrazili potrebe po zdravstvenih informacijah, po drugi strani pa bi zahtevala reorganizacijo dela zaposlenih.

6 Podstran je dostopna na https://www.mkk.si/asset/p5m6ZrKGRXXWiWhTA.

Posredovanje informacij

Izkušnje glede povpraševanja po zdravstvenih informacijah so različne. Knjižnice ne vodijo posebne statistike, koliko je kotiček dejansko obiskan in uporabljan. Od posameznika in njegovih osebnostnih značilnosti je odvisno, ali bo za pomoč pri iskanju zdravstvenih informacij vprašal knjižničarja. Mnogi, predvsem starejši, vprašajo knjižničarja v knjižnici, nekateri pa vprašajo tudi prek drugih komunikacijskih kanalov. V referenčnem pogovoru uporabnik izrazi, kakšna je njegova informacijska potreba, v tem pogovoru pa se mora s knjižničarjem vzpostaviti tudi zaupanje. Pri tem je od uporabnika, knjižničarja in preostalih navzočih v prostoru odvisno, koliko jasno jo bo uporabnik definiral. Nekateri govorijo zelo naglas, po drugi strani pa nekatere uporabnike lahko moti že navzočnost drugih knjižničarjev ali uporabnikov, ki so v bližini.

Glede na veliko količino relevantnega gradiva, ki je v knjižnici na voljo, je ta proces usmerjanja in svetovanja o informacijah ali virih zahteven.

Organizacija dogodkov

Mnogi uporabniki knjižnice ne pričakujejo, da bodo določene storitve, povezane z zdravjem, dobili v knjižnici, zato je potreben čas, da se ljudje navadijo na neke dejavnosti in da se udomačijo v prostoru knjižnice. V nekaterih knjižnicah izvajajo razne zdravstvene meritve, v drugih ne. Razlogi, da teh meritev (npr. krvnega tlaka) ne izvajajo, so lahko slabša obiskanost ali stroški, povezani z nabavo ustreznega materiala in plačilom honorarja izvajalcem.

Predavanja in delavnice za zdravje so dobro obiskani. Odgovorni za zdravstvene kotičke samo ponekod sodelujejo pri izbiri tematike predavanj in predavateljev. Število obiskovalcev prireditev je v splošnem težko predvidljivo, razen pri znanih predavateljih, ko je že vnaprej zagotovljena dobra obiskanost. Izbira predavateljev je zahtevna in običajno previdnost ni odveč, kot so poudarili moji sogovorniki v intervjujih. Veliko prednost in hkrati izziv pomeni navezovanje in vzpostavitev stikov z zdravstvenimi ustanovami in društvi v lokalnem okolju. Kot pri vseh knjižničnih prireditvah je pomemben čas izvajanja nekega dogodka. Če so dogodki v času odprtosti knjižnice, je lahko moteče za preostale uporabnike, če pa se izvajajo v času zaprtosti, je treba poskrbeti za varnost prostorov. Vsebina izobraževanj pritegne različno starostno strukturo obiskovalcev, npr. mladi pridejo na delavnice prve pomoči, starejši na meritve tlaka. Celodnevni dogodki so zahtevni z vidika organizacije, vendar se opaža veliko prednosti, kot je npr. učinkovitejša promocija, večja prepoznavnost in vidnost, boljša obiskanost in lažja organizacija delavnic. Zdravstveni kotički so postali na neki način razstavni prostori za gradivo, revije, letake itd., dogodki pa se odvijajo v dvoranah, kjer je na voljo tudi vsa oprema za izvedbo predavanj.

Med epidemijo covida-19 so dejavnosti v zdravstvenem kotičku opustili, nekatera predavanja in izobraževanja za zdravje so izvedli na internetu.

Izobraževanje zaposlenih in medsebojna povezanost knjižnic z zdravstvenimi kotički

Velika prednost knjižnic, ki imajo zdravstvene kotičke, so dodatno izobraženi knjižničarji. Ti so se izobraževali glede uporabe zdravstvenih virov, kar je organizirala Centralna medicinska knjižnica. V okviru Erasmusa+ je knjižničar spoznal tudi dobre prakse tujih knjižnic. Kasneje pa se knjižničarji niso več organizirano izobraževali, temveč so samostojno iskali primere dobrih praks v različnih virih, se povezovali z nacionalnimi in lokalnimi institucijami. Manjka večja povezanost med knjižničarji knjižnic, ki imajo vzpostavljene zdravstvene kotičke. Nekateri dogodki ali razstave bi lahko postali potujoči oz. bi se izvedli v več knjižnicah, ki nimajo prostorskih ali zaposlitvenih zmogljivosti za zdravstveni kotiček.

DISKUSIJA

Z raziskavo smo želeli osvetliti delovanje splošnih knjižnic pri izobraževanju za zdravje, ugotovitve kažejo, da obstaja veliko inovativnih praks, ki pa se morajo stalno prilagajati.

Zamisel zdravstvenih kotičkov je dobra, pričakovanja velika, vendar zdravstveni kotički ne delujejo tako, kot so bili v začetku zasnovani. Da bi bilo delovanje optimalno in bi uporabniki knjižnice in lokalna skupnost imeli več koristi, bi bilo treba poiskati nove možnosti, priložnosti in rešitve ter vzpostaviti predvsem stike z ministrstvi in zdravstvenimi institucijami ter nenehno spremljati potrebe ljudi v lokalnem okolju. Treba bi bilo najti nove oblike izobraževanja, ki bi jih lahko vključili neposredno v zdravstvene kotičke, kar vse prinaša finančne in profesionalne izzive.

Trenutno so zdravstveni kotički namenjeni predvsem razstavam, brskanju po brošurah, revijah in izpostavljenem gradivu, lahko pa tudi študiju ali delu na računalniku, ki ni (nujno) povezano z izobraževanjem za zdravje. Največ informacij s področja zdravja posredujejo uporabnikom v tiskani obliki, zato računalnik v zdravstvenem kotičku ne opravlja funkcije, zaradi katere je bil tja nameščen. Po drugi strani pa je opazno digitalno razhajanje pri starejših, ki so manj vešči iskanja po spletu ali različnih podatkovnih bazah. Glede na hiter proces staranja prebivalstva tako v Evropi kot tudi v Sloveniji je potrebna večja angažiranost knjižnic pri delu s starejšimi, ki imajo drugačne potrebe kot mlajši ter kažejo primanjkljaj na področju informacijske pismenosti. Razvite IKT-spretnosti so eden izmed pogojev za izobraževanje za zdravje, saj je vedno več zdravstvenih informacij v digitalni obliki. Zato starejši, ki so manj vešči iskanja po spletu ali različnih podatkovnih bazah, iščejo predvsem tiskano gradivo, kar je ugotovil tudi Ingham (2014). Prav starejši radi poklepetajo s knjižničarji o zdravju, o čemer so pisali tudi Linnan idr. (2004), kar kaže na potrebo, da knjižničarji temu namenijo dodaten čas in tudi razvijejo profesionalne spretnosti usmerjanja in svetovanja.

Glede na to, da se v knjižnicah zaznava potreba po zdravstvenih informacijah in izobraževanju za zdravje, bi morali razmisliti tudi o prostorski umestitvi zdravstvenega kotička v knjižnici, saj se večina predavanj izvede v knjižnični dvorani oz. prireditvenem prostoru,

kjer je na voljo tudi vsa oprema (ozvočenje, projektor, stoli itd.). Kot pomanjkljivost je zaznati, da knjižničarji, ki so pristojni za zdravstvene kotičke, nimajo vedno vpliva na izbiro predavateljev in tematik predavanj s področja zdravja. Velik potencial imajo knjižnice tudi zaradi vzpostavljenih stikov z organizacijami, ki se ukvarjajo s področjem zdravja. Na ta način bi lahko nastalo še več kakovostnih izobraževanj in spletnih vsebin. Ena od priložnosti je tudi izboljšanje medsebojnega sodelovanja in povezovanja med knjižnicami z zdravstvenimi kotički, ki bi imelo za knjižničarje in lokalno skupnost veliko prednosti.

Čeprav so se razmere po pandemiji covida-19 bistveno spremenile, pa večjih sprememb ali prilagoditev glede izobraževanj za zdravje ni zaznati (razen nekaj videoposnetkov). Zdi se, da so vsi v pripravljenosti in čakajo, da bodo ob sproščanju zdravstvenih ukrepov ponovno začeli izvajati dejavnosti, ki so jih imeli pred pandemijo.

Izobraževanje za zdravje naj bi bilo namenjeno vsem družbenim skupinam, a naše ugotovitve kažejo, da mladi kljub kompleksnosti podatkovnih baz ne izražajo potrebe po pomoči knjižničarjev pri iskanju relevantnih zdravstvenih informacij, zelo malo pa je dogodkov, ki bi namensko nagovarjali to starostno skupino. Objav z zdravstveno tematiko je na družbenih omrežjih knjižnic relativno malo, čeprav je v trenutnem obdobju verjetno to najbolj smotrna pot, saj bi z objavami (morda tudi plačanimi) lažje dosegli mlajše uporabnike in neuporabnike knjižnic.

Izvedba raziskave ima svoje prednosti in slabosti. Največja prednost je v tem, da smo analizirali vse knjižnice, ki imajo zdravstveni kotiček, in izvedli intervjuje s knjižničarji, ki skrbijo in vodijo zdravstvene kotičke ter so prepričani o pomembnosti izobraževanja za zdravje lokalnega prebivalstva. Naše ugotovitve tako izhajajo predvsem z zornega kota organizatorjev izobraževanja, zato bi morali raziskavo nadaljevati s proučevanjem, kakšna je uporabniška izkušnja zdravstvenih kotičkov, kako uporabniki pridobivajo in uporabljajo informacije v zdravstvenih kotičkih ter kakšen je vpliv pridobljenih informacij na večjo kakovost njihovega življenja. Rezultati večje raziskave, v katero bi bile vključene vse slovenske splošne knjižnice, bi morda pokazali, kakšno je splošno mnenje glede izobraževanja za zdravje, katere aktivnosti knjižnice še izvajajo in ali imajo izoblikovane drugačne strategije in načrte glede izobraževanja za zdravje. Raziskava se je izvajala v izredno negotovem času epidemije covida-19, ko so knjižnice zaradi zdravstvenih ukrepov omejene pri izvajanju svojih dejavnosti. Večina aktivnosti se seli na splet, kjer pa je tudi večina iskalcev zdravstvenih informacij (Andreassen idr., 2007; Ramšak, 2011; Traver idr., 2016).

ZAKLJUČEK

Z raziskavo smo naredili prvo in celotno analizo delovanja zdravstvenih kotičkov ter postavili v ospredje izzive, s katerimi se soočajo.

Izobraževanje za zdravje je v splošnih knjižnicah zelo fluidna praksa in se premika med različnimi strategijami: včasih je bolj intenzivno delo v zdravstvenih kotičkih, včasih pa v obliki večjih prireditev v prireditvenih prostorih oz. dvoranah. Glede na to, da se število prireditev z zdravstveno tematiko povečuje, prireditve pa so dobro obiskane, so

zdravstveni kotički kot del celovite strategije animacije, ozaveščanja in izobraževanja o zdravju dosegli cilj. Žal pa knjižnice ne vodijo evidence o uporabi ali obiskanosti zdravstvenega kotička ali koliko je ta pripomogel k večji informiranosti o zdravju in boljši kakovosti življenja. Za tovrstne ugotovitve bi morali raziskavo nadaljevati z vključitvijo uporabnikov.

Knjižnice so pomemben center za izobraževanje odraslih, in da bi zdravstveni kotički v polnosti izpolnjevali svojo vlogo in namen, bi se morali preoblikovati in razviti nove strategije izobraževanja za zdravje. Ker je knjižnica stičišče lokalne skupnosti vseh družbenih slojev, lahko nagovarja tudi marginalizirane skupine, zato so ti kotički priložnost za srečevanje manjših skupin. Mnogi prihajajo v knjižnico tudi z namenom, da se lahko s kom pogovarjajo, zato knjižničarjem pripovedujejo o svojih zdravstvenih težavah. Z vključenostjo v majhne medgeneracijske skupine ali pare, ki bi jih vodili prostovoljci, bi ponudili nove oblike druženja in pogovora o zdravju.

Potrebna bi bila večja promocija zdravstvenih kotičkov, knjižnice bi lahko bolj izkoristile moč interneta, predvsem družbenih omrežij. Z različnimi pristopi, vsebinami v različnih oblikah (besedilo, zvok, slika, video) bi za zdravje izobraževali vse prebivalce lokalne skupnosti (tudi nečlane). Te dejavnosti bi bile zelo pomembne tudi zaradi vedno večje invazije lažnih novic na področju zdravja.

Ugotovili smo, da knjižnice, ki imajo zdravstvene kotičke, že sodelujejo z zdravstvenimi ustanovami, društvi in organizacijami v lokalnem okolju, a so po drugi strani premalo prepoznane s strani društev kot prostor za srečevanje ljudi s podobnimi zdravstvenimi težavami. Opazna je odsotnost medsebojnega povezovanja med knjižnicami pri izobraževanju za zdravje, kar bi prineslo večje koristi tudi za tiste knjižnice, ki zdravstvenih kotičkov še nimajo. Pri načrtovanju in izvedbi novih pristopov bi bilo vsekakor dobrodošlo sodelovanje različnih strokovnjakov.

LITERATURA IN VIRI

Andreassen, H. K., Bujnowska-Fedak, M. M., Chronaki, C. E., Dumitru, R. C., Pudule, I., Santana, S., Voss, H. in Wynn, R. (2007). European citizens' use of E-health services: A study of seven countries. *BMC public health*, *7*(1), 1–7. https://doi.org/10.1186/1471-2458-7-53

Anker, A. E., Reinhart, A. M. in Feeley, T. H. (2011). Health information seeking: A review of measures and methods. *Patient education and counseling*, *82*(3), 346–354. https://doi.org/10.1016/j.pec.2010.12.008

Bennett-Kapusniak, R. K. (2018). *Public library programs and services for midlife and beyond: Expanding opportunities for a growing population.* ABC-CLIO.

Collins, L. N. (2015). Healthy libraries develop healthy communities: Public libraries and their tremendous efforts to support the Affordable Care Act. *Journal of consumer health on the Internet*, *19*(1), 68–76. https://doi.org/10.1080/15398285.2014.988467

Coulter, A., Ellins, J., Swain, D., Clarke, A., Heron, P., Rasul, F. in Sheldon, H. (2006). *Assessing the quality of information to support people in making decisions about their health and healthcare.* Picker Institute Europe. http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.108.4236&rep=rep1&type=pdf

Delić, D., Polašek, O. in Kern, J. (2006). Internet health-information seekers in Croatia-who, what, and why? *Medical informatics and the Internet in medicine*, *31*(4), 267–273. https://doi.org/10.1080/14639230600991726

Estacio, E. V. in Comings, J. (2013). Health literacy: Exploring future directions and potential contributions from health psychology. *Journal of Health Psychology, 18*(8), 997–1003. https://doi.org/10.1177/1359105313476978

Flick, U. (2018). *An Introduction to Qualitative Research.* Sage.

Fox, S. in Duggan, M. (2013). *Health online 2013.* Pew Internet & American Life Project. https://www.ordinedeimedici.com/documenti/Docs7-cybercondria-PIP-HealthOnline.pdf

Fox, S. in Rainie, L. (2002). *How Internet users decide what information to trust when they or their loved ones are sick.* Pew Internet & American Life Project.

Huotari, M. L., Enwald, H., Hirvonen, N., Keränen, A.-M., Jokelainen, T., Salonurmi T. in Niemelä, R. (2015). Everday health information literacy in counselling on healthy eating: The case of PrevMetSyn. V S. Kurbanoglu, S. Špiranec, E. Grassian, D. Mizrachi in L. Roy (ur.), *Information literacy: Moving toward sustainability: Third European Conference, ECIL 2015, Tallinn, Estonia, October 19–22, 2015, Revised Selected Papers* (zbirka Communications in Computer and Information Science, št. 552, str. 223–232). Springer. https://doi.org/10.1007/978-3-319-28197-1_23

Ingham, A. (2014). Can your public library improve your health and well-being? An investigation of East Sussex Library and Information Service. *Health Information & Libraries Journal, 31*(2), 156–160. https://doi.org/10.1111/hir.12065

Kickbusch, I. (2008). Health literacy: An essential skill for the twenty-first century. *Health Education, 108*(2), 101–104. https://doi.org/10.1108/09654280810855559

Kodela, T. (2015). Po nova znanja za knjižnico, 2. del – v Stoke-on-Trent v Veliko Britanijo. *Knjižničarske novice, 25*(8/9), 22–25.

Komel, A. (2016). *Študija uporabnikov medicinske literature v Goriški knjižnici Franceta Bevka* [Diplomsko delo]. Univerza v Ljubljani, Filozofska fakulteta.

Kozel, J. (2010). *Uporaba interneta v zdravstvene namene* [Diplomsko delo]. Univerza v Mariboru, Fakulteta za elektrotehniko, računalništvo in informatiko.

Linnan, L. A., Wildemuth, B. M., Gollop, C., Hull, P., Silbajoris, C. in Monnig, R. (2004). Public librarians as a resource for promoting health: Results from the Health for Everyone in Libraries Project (HELP) librarian survey. *Health Promotion Practice, 5*(2), 182–190. https://doi.org/10.1177/1524839903258018

Morgan, A. U., Dupuis, R., D'Alonzo, B., Johnson, A., Graves, A., Brooks, K. L., McClintock, A., Klusaritz, H., Bogner, H., Long, J. A., Grande, D. in Cannuscio, C. C. (2016). Beyond books: Public libraries as partners for population health. *Health Affairs*, *35*(11), 2030–2036. https://doi.org/10.1377/hlthaff.2016.0724

Nacionalni inštitut za javno zdravje. (2021). *Projekt Dvig zdravstvene pismenosti v Sloveniji (ZaPiS).* https://www.nijz.si/sl/projekt-zapis-dvig-zdravstvene-pismenosti-v-sloveniji

Nacionalni svet za knjižnično dejavnost. (2018). *Strokovna priporočila in standardi za splošne knjižnice (za obdobje 2018-2028).* https://www.gov.si/assets/ministrstva/MK/Zakonodaja-ki-ni-na-PISRS/Kulturna-dediscina/2ffbd52377/Strokovna-priporocila-in-standardi-za-splosne-knjiznice.pdf

Narodna in univerzitetna knjižnica. (2021). *BibSiSt Online: Statistični podatki o knjižnicah*. http://bibsist.nuk.uni-lj.si/

Pálsdóttir, Á. (2014). Preferences in the use of social media for seeking and communicating health and lifestyle information. *Information Research: An International Electronic Journal*, *19*(4).

Pletneva, N., Vargas, A. in Boyer, C. (2011). *How do general public search online health information.* Health On the Net Foundation. https://www.hon.ch/Global/pdf/Khresmoi/KRESMOI_internet_health_search_information_HON.pdf

Powell, J., Inglis, N., Ronnie, J., in Large, S. (2011). The characteristics and motivations of online health information seekers: Cross-sectional survey and qualitative interview study. *Journal of medical Internet research*, *13*(1), e20. https://doi.org/10.2196/jmir.1600

Radick, L. (2015). Improving health literacy, one public library at a time. *American Libraries*, *46*(11/12), 48–53.

Ramšak, M. (2011). V pričakovanju e-zdravja: Medicina, tehnologija, družba in etika. *Etnolog: glasnik Slovenskega etnografskega muzeja, 21*(72), 35–55.

Resman, S. (2018). *Borza zdravja v MKL: Smernice za delovanje.* Mestna knjižnica Ljubljana. https://www.mklj.si/wp-content/uploads/2021/04/Borza_zdravja.pdf

Rožić, A., Tržan-Herman, N. in Jakac-Bizjak, V. (2010). Zdravstveni kotiček – delo na projektu "Splošne knjižnice za zdravje občanov". *Knjižničarske novice, 20*(10), 11–15.

Rubenstein, E. L. (2016). Health information and health literacy: Public library practices, challenges, and opportunities. *Public Library Quarterly, 35*(1), 49–71. https://doi.org/10.1080/01616846.2016.1163974

Sørensen, K., Van den Broucke, S., Fullam, J., Doyle, G., Pelikan, J., Slonska, Z. in Brand, H. (2012). Health literacy and public health: A systematic review and integration of definitions and models. *BMC public health*, *12*(1), 1–13. https://doi.org/10.1186/1471-2458-12-80

Svet referenčnih in uporabniških storitev Ameriškega knjižničarskega združenja. (2015). *Health and medical reference guidelines.* https://www.ala.org/rusa/resources/guidelines/guidelinesmedical

Šinko, S. (2012). Splošne knjižnice in izobraževanje odraslih. *Andragoška Spoznanja, 18*(3), 53–61. https://doi.org/10.4312/as.18.3.53-61

Švab, K. (2020). Facebook, Instagram in Twitter osrednjih območnih knjižnic med karanteno zaradi COVID-19. *Knjižničarske novice, 30*(5), 7–9.

Traver, M., Basagoiti, I., Martinez-Millana, A., Fernández-Llatas, C. in Traver, V. (2016, August). Experiences of a general practitioner in the daily practice about Digital Health Literacy: The real needs. V *38th Annual International Conference of the IEEE Engineering in Medicine and Biology Society* (str. 5644–5647). IEEE. https://doi.org/10.1109/EMBC.2016.7592007

Zakon o knjižničarstvu (ZKnj-1). (2001). *Uradni list RS*, št. 87/1, 96/02. http://www.pisrs.si/Pis.web/pregledPredpisa?id=ZAKO2442

Zakon o pacientovih pravicah (ZPacP). (2008). *Uradni list RS*, št. 15/08, 55/17 in 177/20. http://pisrs.si/Pis.web/pregledPredpisa?id=ZAKO4281

Zdravstveni dom Kranj. (2021). *Vabilo na večerne klepete o zdravju v Mestno knjižnico Kranj.* https://www.zd-kranj.si/?subpageid=13&page=4&contid=259

Zickuhr, K. (2010). *Generations 2010: Online activities.* Pew research and Internet Project. https://www.pewresearch.org/internet/2010/12/16/online-activities/

Andragoška spoznanja/Studies in Adult Education and Learning, 2021, 27(2), 109-122
DOI: https://doi.org/10.4312/as/10171 UDK: 374.7: 616-039.75; Znanstveni prispevek

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OZAVEŠČANJE JAVNOSTI O PALIATIVNI OSKRBI: EVALVACIJA TEČAJA ZADNJA POMOČ (*LAST AID*) V SLOVENIJI

POVZETEK

Ozaveščanje in izobraževanje splošne javnosti o paliativni oskrbi lahko izboljša tako paliativno oskrbo kot zadnje dneve življenja bolnikov z neozdravljivo boleznijo. To je tudi namen mednarodnega programa Zadnja pomoč (Last Aid), v okviru katerega poteka skupnostno izobraževanje o paliativni oskrbi, ki ga izvajajo v 18 državah. V Sloveniji smo ga začeli izvajati v drugi polovici 2019 in doslej izvedli 25 tečajev. Do zdaj se je tečaja udeležilo 350 ljudi, 255 jih je izpolnilo in vrnilo ocenjevalne vprašalnike. Namen prispevka je predstaviti analizo evalvacije tečaja Zadnja pomoč v Sloveniji. Na podlagi analize podatkov, pridobljenih s kvalitativno in kvantitativno metodo, lahko ugotovimo, da je bil izobraževalni program dobro sprejet tudi v slovenskem okolju, saj so bili udeleženci zelo zadovoljni tako z vsebino kot z izvedbo tečaja. Z najvišjo oceno (5) je tečaj v celoti ocenilo 87,7 % udeležencev, posamezne module pa je z najvišjo oceno ocenilo več kot 75 % udeležencev. Medtem ko so udeleženci večinoma pozitivno ovrednotili interaktivnost tečaja in priložnost izmenjave izkušenj na njem, pa analiza evalvacije kaže tudi, da je treba program nadgraditi z dodatnimi temami.

Ključne besede: *paliativna oskrba, izobraževanje, splošna javnost, tečaj Last Aid, Slovenija*

RAISING PUBLIC AWARENESS OF PALLIATIVE CARE: EVALUATING A LAST AID COURSE IN SLOVENIA – ABSTRACT

Raising awareness and educating the general public about palliative care can improve both palliative care itself and the last days of patients with incurable illnesses. This is also the purpose of the international programme Last Aid, which provides community training on palliative care and is carried out in 18 countries. It was first implemented in Slovenia in the second half of 2019 and 25 courses have been conducted thus far. 350 people have attended the course and 255 have completed and handed in the evaluation questionnaires. The aim of the article is to present our analysis of the Last Aid course evaluation

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in Slovenia. Based on the analysis of the data obtained by the qualitative and quantitative method, we can conclude that the educational programme was well received by the Slovenian population as the participants were very satisfied with both the content and implementation of the course. The course received the highest grade (5) from 87.7% of the participants and individual modules were assessed with the highest grade by more than 75% of the participants. Overall, the participants mostly evaluated the interactivity of the course and the opportunity to share experiences as positive, however, the analysis also shows that the programme needs to be upgraded to include additional topics.

Keywords: *palliative care, education, general public, Last Aid course, Slovenia*

UVOD

Življenjska doba ljudi se podaljšuje. Pred nekaj desetletji so bile razlog za smrt predvsem nalezljive bolezni, danes pa se v zahodnem svetu ukvarjamo večinoma s kroničnimi nenalezljivimi boleznimi, čeprav smo trenutno v obdobju pandemije koronavirusne bolezni. Kot kaže statistika smrti med prebivalci v državah članicah Evropske unije, so med nenalezljivimi kroničnimi boleznimi najpogostejši vzrok za smrt ishemične bolezni srca, cerebrovaskularne bolezni ter maligna neoplazma traheje, bronhija in pljuč (Eurostat, 2016). Uspešno zdravljenje kroničnih obolenj prispeva k temu, da ljudje s temi obolenji kljub krhkosti in povečani ranljivosti živijo dlje časa, obenem pa vse pogosteje potrebujejo paliativno oskrbo.

Gellie idr. (2015) so umiranje opredelili kot pomembno temo v sodobni družbi. Odnos do te teme odseva, koliko je družba sočutna (ali nesočutna) do najranljivejših članov skupnosti. Vendar pa sta temi smrti in umiranja v zahodni potrošniški družbi potisnjeni na obrobje in izključeni iz vsakdanjega življenja (Walter, 1991), zaradi česar je tudi pogovor o teh temah za večino ljudi še vedno boleč in mučen (Payne idr., 2008). Podobno se dogaja s paliativno oskrbo, katere vloga je izboljšanje kakovosti življenja v zadnjem življenjskem obdobju. Zaradi tabuizacije smrti in umiranja prebivalci slabo poznajo načela paliativne oskrbe ter se redkeje odločajo zanjo (Dionne-Odom idr., 2019; Haruta idr., 2021; Lane idr., 2019). Pri tem pa raziskovalci ugotavljajo, da izobraževanje o paliativni oskrbi in umiranju lahko prispeva k boljšemu poznavanju tega področja ter, posledično, pripomore k sprejemanju smrti kot dela življenja in k boljši oskrbi neozdravljivo bolnih v zadnjih dneh življenja (Bollig in Heller, 2016).

V paliativni oskrbi gre za holističen pristop, saj zajema obravnavo različnih človekovih potreb: telesnih, družbenih, duševnih in duhovnih. Zaradi obravnave tako različnih ravni potreb mora temeljiti na dobrem sodelovanju med izvajalci znotraj tima (World Health Organization, 2002, str. 105). Pomemben člen v paliativni oskrbi so tudi svojci in neformalni negovalci bolnika, ki lahko neozdravljivo bolnemu prihranijo marsikatero nepotrebno intervencijo, če imajo več znanja o paliativni oskrbi. Svojci paliativnemu timu namreč pogosto pomagajo pri razumevanju bolnika, saj tim z njihovo pomočjo lažje ovrednoti njegove težave in dopolni zgodbo, ki jo pove bolnik (Lopuh, 2018). Vendar pa se,

kot ugotavlja Šket (2020), pogosto dogaja, da imajo svojci napačne predstave o paliativni oskrbi in se z njo ne morejo sprijazniti. Enako ugotavljajo tudi Hudson idr. (2012), ki menijo, da svojci z dovolj znanja vedo, kaj lahko pričakujejo v času umiranja bolnika, za katerega skrbijo, kakšne komplikacije se lahko ob tem pojavijo in kako naj jih rešujejo. Pogosto pa se zgodi, da paliativne oskrbe ne poznajo dovolj, se izogibajo temi smrti in na umiranje bližnjega niso pripravljeni.

Sprejemanje umiranja je del družbenih značilnosti, značilnosti posameznika in znanja, ki se je razvilo v različnih vedah. Umiranje je del filozofskih in antropoloških (Milčinski in Bajželj Bevelaqua, 2011), sociooloških in psiholoških študij, ki se zelo pogosto ukvarjajo predvsem z žalovanjem (Parkes in Prigerson, 2010) ter razvijajo svetovalne in izobraževalne programe za soočanje z izgubo in žalovanjem (Hooyman idr., 2021; Worden, 2018). Programi so torej namenjeni ljudem, ki žalujejo. Manj pa je izobraževalnih programov, ki bi bili namenjeni splošni javnosti in bi prebudili pozornost do problema minljivosti.[1]

Ravno ozaveščanje javnosti o paliativni oskrbi je bilo vodilo Georga Bolliga pri pripravi štiriurnega tečaja Zadnja pomoč *(Last Aid*),[2] ki je bil prvič izveden v Nemčiji, nato so sledili tečaji na Norveškem in Danskem (Bollig idr., 2019). Gre za standardiziran mednarodni tečaj, z izvedbo katerega je Bollig želel spodbuditi javno razpravo o smrti in umiranju ter udeležencem posredovati osnovne informacije o tem, kaj lahko sami storijo za lajšanje trpljenja. Ta tečaj izvajamo tudi v Sloveniji in smo ga z dovoljenjem avtorja v nekaterih pogledih prilagodili slovenskemu okolju.[3] Izvajati smo ga začeli v drugi polovici 2019 in doslej imeli 25 izvedb tečaja, ki se jih je udeležilo 350 oseb. Namen prispevka je predstaviti evalvacijo tečaja v Sloveniji, pri čemer smo izhajali iz analize evalvacijskih vprašalnikov.

TEČAJ ZADNJA POMOČ

Georg Bollig idr. (2021a) pišejo, da je znanje o zadnji pomoči enako pomembno kot znanje o prvi pomoči, zato je tečaj pripravljen po vzoru tečajev prve pomoči. Po avtorjevem prepričanju se prve pomoči učimo vsi, čeprav jo redko izvajamo, o umiranju in smrti pa je znanje v splošni javnosti skromno, čeprav se vsak izmed nas v življenju zagotovo sreča tako z umiranjem drugih kot z lastno minljivostjo.

Z oblikovanjem tečaja Zadnja pomoč je Bollig želel vpeljati nov način ozaveščanja javnosti o paliativni oskrbi, ki se je izkazal kot smiseln in potreben. Od leta 2015 do zdaj se je tega tečaja udeležilo več kot 26.000 ljudi, pri čemer se je za izvajanje aktivnosti v lokalnih skupnostih izobrazilo več kot 2000 inštruktorjev (Bollig idr., 2019). V mednarodni delovni

1 Razvija se novo področje, študije smrti in življenja (*Death and Life Studies*), ki je na presečišču medicine, družboslovja in humanistike. V psihologiji se pojavlja izraz tanatologija, v vzgoji in izobraževanju tanatogogika ali izobraževanje o smrti.

2 Čeprav traja le štiri ure, ohranjamo izraz tečaj, ker želimo biti zvesti originalnemu avtorjevemu poimenovanju.

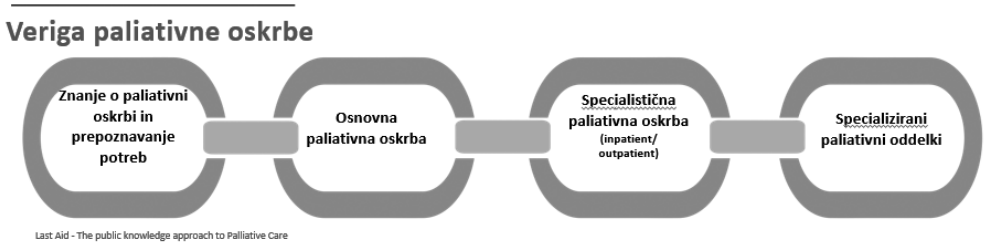
3 Gre predvsem za prilagoditve zakonskih podlag in organizacijskih struktur, ki se vključujejo v oskrbo paliativnih bolnikov in njihovih svojcev, saj so te v vsaki državi nekoliko drugačne in tako izziv za mednarodno skupino, ki bedi nad vsebino in kakovostjo tečaja.

skupini Zadnja pomoč trenutno sodeluje 16 držav (Bollig in Zelko, 2020; Zelko in Bollig, 2021), tečaj pa je bil dobro sprejet v mnogih državah. Pilotna študija v Nemčiji je pokazala, da so tudi posebni tečaji za otroke in najstnike imeli zelo dober odziv pri udeležencih ter da večina otrok in najstnikov želi govoriti o smrti in umiranju (Bollig idr., 2020).

Metoda, ki ji sledi tečaj Zadnja pomoč, je kombinacija »situacijskega učenja« (*situated learning*), ki je pogojeno z interakcijo med udeleženci in nadgrajuje predhodno znanje in izkušnje (Stein, 1998), ter »učenja v sodelovanju« (*cooperative learning*). Uporablja načela skupnosti prakse (*community of practice*), kjer so zbrani udeleženci, ki imajo podobne interese in se srečajo v želji, da izboljšajo svoje znanje za prakso in ukrepanje v prihodnosti (Wenger-Trayner in Wenger-Trayner, 2015). Koncept tečaja Zadnja pomoč temelji na predpostavki, da mora postati znanje o paliativni oskrbi del javnega izobraževanja že od osnovne šole naprej.

Veriga paliativne oskrbe (Bollig idr., 2021a) je namreč tako močna, kolikor je močan njen najšibkejši člen (Slika 1). Prvi člen verige opredeljujeta znanje o paliativni oskrbi ter prepoznavanje potreb bolnikov in svojcev v splošni javnosti. Vsi naslednji členi so lahko učinkoviti in močnejši ravno zaradi sodelovanja skupnosti, ki razume potrebo po paliativni oskrbi in je zmožna o njej razpravljati, ko jo potrebuje. S tem spodbujamo razmišljanje o zadnjem življenjskem obdobju in prispevamo k detabuizaciji smrti.

Slika 1
Veriga paliativne oskrbe



Prilagojeno po Bollig, G., Brandt Kristensen, F. in Lykke Wolff, D. (2021a). Citizens appreciate talking about death and learning end-of-life care – a mixed-methods study on views and experiences of 5469 Last Aid Course participants. *Progress in Palliative Care, 29*(3), 140–148.

Sodelovanje splošne javnosti in zdravstvenih delavcev v paliativni oskrbi je pomembno zaradi številnih dejavnikov, med katere prištevamo: demografske spremembe, naraščanje števila starejših s kroničnimi boleznimi, pomanjkanje negovalnega kadra, spremenjeno strukturo družine in ohranjanje človeškega dostojanstva obolelega. Podobno kot veriga preživetja v urgentni medicini je tudi »veriga paliativne oskrbe« ponazoritev poti paliativne oskrbe v skupnosti.

Bollig idr. (2021b) tudi poudarjajo, da znanje na tem področju lahko prispeva k izboljšanju oskrbe najšibkejših članov skupnosti in se kaže v sočutnosti družbe; družbe, kjer

ne prevladuje individualizem, temveč zavedanje, da skupnost tvorimo in ustvarjamo vsi ljudje. V tem smislu gre za udejanjanje ideje sočutne skupnosti, v kateri člani sodelujejo pri zagotavljanju paliativne oskrbe v mejah svojih spretnosti in možnosti. Začetnik prakse sočutnih skupnosti (*Compassionate community*)[4] je Allan Kellehear (2013), ki ugotavlja, da je »oskrba ob koncu življenja odgovornost vsakega od nas« (str. 1071).

Tečaj Zadnja pomoč vključuje koncept sočutnih skupnosti, saj spodbuja javni diskurz o umiranju, smrti ter preizprašuje odnos posameznika in družbe do teh tem. Tečaj, na katerem udeleženci pridobijo osnovne informacije o umiranju, paliativni oskrbi in smrti, sestavljajo štirje moduli: *Smrt je del življenja, Načrtovanje oskrbe in odločanje, Lajšanje trpljenja in težav, Slovo*. Priporočljivo je, da skupina udeležencev ne presega števila 15, saj je tako omogočena dobra interakcija med sodelujočimi na tečaju. Tečaja se lahko udeleži vsak, ki ga tema zanima, saj predhodno poznavanje tematike ni potrebno.

Tečaj smo v Sloveniji začeli izvajati v drugi polovici leta 2019 in smo do leta 2021 izvedli 25 ponovitev, ki se jih je udeležilo 360 oseb. Med udeleženci so bili študentje, zdravniki, medicinske sestre, fizioterapevti, inženirji, ekonomisti, pedagoški delavci, socialni delavci, duhovniki, redovnice, prostovoljci, zdravilci in predstavniki drugih zainteresiranih javnosti. Nekateri so se udeležili tečaja za nove inštruktorje in bodo pridobljeno znanje v strukturirani obliki posredovali svojim lokalnim skupnostim. Izobraževanje v Sloveniji organiziramo na Inštitutu za paliativno medicino in oskrbo Medicinske fakultete v Mariboru. Tečaje za inštruktorje v Sloveniji lahko vodijo inštruktorji s pridobljeno mednarodno licenco. V Sloveniji imamo tri takšne posameznike, ki so izvedli osem tečajev za nove izvajalce tečaja v lokalnem okolju. Pri izvedbi tečajev se uporabljajo različne strategije. Poleg tečaja v živo smo med pandemijo izvajali tečaj tudi na daljavo (prek spleta smo imeli pet izvedb). Pripravili smo tudi spletni tečaj (webinar) za gluhe in naglušne z znakovnim jezikom. Udeležence smo aktivno vključili v potek tečaja tako, da so nekaj dni pred izvedbo dobili po elektronski pošti drsnico z vsebino, ki so jo potem na svoj način predstavili preostalim udeležencem. Moderatorja tečaja, ki sta bila vedno vsaj dva, pa sta poskrbela za dopolnitve informacij, če je bilo to potrebno.[5]

METODA

Podatke o evalvaciji tečaja smo zbrali z vprašalnikom, ki so ga udeleženci izpolnili ob koncu tečaja. Vprašalnik sestavljajo vprašanja odprtega in zaprtega tipa in je razdeljen na tri dele. Prvi del vsebuje štiri vprašanja, ki omogočajo oceno celotnega tečaja in modulov s petstopenjsko lestvico. Drugi del sestavlja šest podvprašanj, v katerih smo udeležence

4 Ta koncept je promovirala Svetovna zdravstvena organizacija (SZZ) v navezavi na »zdrava mesta« ali »zdrave skupnosti«, ki izhajajo iz osemdesetih let prejšnjega stoletja.

5 Poleg omenjenega tečaja velja omeniti še dva pomembna programa na tem področju, in sicer *Metulj* in *Levjesrčni*. Slovenski projekt Metulj je program, ki uspešno skrbi za ozaveščanje bolnikov in svojcev o možnostih pomoči v paliativni oskrbi bolnikov (Zavratnik idr., 2015). Programe ozaveščanja in pomoči svojcem izvajajo tudi v slovenskem društvu HOSPIC, kot primer naj omenimo program za otroke Levjesrčni (Duraković, 2020).

spraševali o vtisih o tečaju, razumevanju posameznih tem in predlogih za delo v prihodnje. V tretjem delu vprašalnika smo zbirali sociodemografske podatke (spol, starost in poklic).[6]

V analizo so bili vključeni vsi pravilno izpolnjeni vprašalniki, ki so bili oddani od junija 2019 do marca 2020. Analiza zbranih podatkov je bila opravljena s programom IBM SPSS (Statistical Package for the Social Science) 26.0. Rezultati analize so predstavljeni v tabelarični obliki. Statistično značilnost smo določali na podlagi kriterija vrednosti $p \leq 0{,}05$. S postopki opisne statistike smo izračunali osnovne statistične parametre (frekvenca, delež, povprečje, standardni odklon). Za preverjanje razlik v oceni tečaja in posameznih modulov glede na spol in starostno skupino udeleženca smo uporabili neparametrične teste, saj je predhodni test normalnosti porazdelitve pokazal, da podatki ne sledijo normalni porazdelitvi. Normalnost porazdelitve podatkov smo preverjali s testom Kolmogorov-Smirnova, za preverjanje razlik pa smo uporabili Kruskal-Wallisov (K-W) in Mann-Whitneyjev (M-W) test.

Odprta vprašanja v anketnem vprašalniku, ki se nanašajo na temo prispevka in najbolje odražajo zadovoljstvo ali nezadovoljstvo udeležencev s tečajem ter vsebujejo predloge za prihodnost, smo analizirali s pomočjo kvalitativne raziskovalne metodologije (analiza besedila).

REZULTATI

V Tabeli 1 so prikazane osnovne značilnosti udeležencev tečaja, ki so v celoti izpolnili ocenjevalne liste in smo jih vključili v našo raziskavo.

Tabela 1
Sociodemografske značilnosti udeležencev tečaja LAST AID

		Število	Delež (v %)
Spol	Moški	37	15,2
	Ženski	206	84,8
Povprečna starost (st. odklon) (v letih)		50,44 (16,122)	
Starostni razred	Mladi (manj kot 35 let)	48	19,9
	Udeleženci srednjih let (35–64 let)	139	57,7
	Starejši (65 let in več)	54	22,4
Izobrazba	Osnovnošolska	3	1,8
	Srednješolska	62	37,6
	Visokošolska	100	60,6

Ocene celotnega tečaja in posameznih modulov so prikazane v Tabeli 2. Relativno gledano je največ udeležencev tako tečaju v celoti (87,7 %) kot tudi posameznim modulom (več kot 75 % pri vseh) dodelilo najvišjo oceno, tj. 5 oziroma odlično.

6 Pri obdelavi podatkov se je izkazalo, da je večina udeležencev pod poklic zapisala doseženo izobrazbo, zato je bilo opravljeno naknadno kodiranje odgovorov v ustrezno raven izobrazbe.

Tabela 2
Ocene celotnega tečaja in posameznih modulov

Ocena	Celotna delavnica (n = 243)	Modul 1: Smrt je del življenja (n = 250)	Modul 2: Načrtovanje oskrbe in odločanje (n = 249)	Modul 3: Lajšanje simptomov in težav (n = 248)	Modul 4: Slovo (n = 248)
1 nezadovoljivo	1 (0,4 %)	1 (0,4 %)	1 (0,4 %)	1 (0,4 %)	1 (0,4 %)
2 zadovoljivo	0 (0,0 %)	1 (0,4 %)	0 (0,0 %)	0 (0,0 %)	0 (0,0 %)
3 dobro	2 (0,8 %)	4 (1,6 %)	4 (1,6 %)	5 (2,0 %)	3 (1,2 %)
4 zelo dobro	27 (11,1 %)	38 (15,2 %)	50 (20,1 %)	33 (13,3 %)	33 (13,3 %)
5 odlično	213 (87,7 %)	206 (82,4 %)	194 (77,9 %)	209 (84,3 %)	211 (85,1 %)
Povprečje (sd)	4,86 (0,436)	4,79 (0,522)	4,75 (0,518)	4,81 (0,493)	4,83 (0,466)

Opomba: sd = standardni odklon

Na podlagi starosti udeležencev smo definirali tri starostne skupine: mladi (manj kot 35 let), udeleženci srednjih let (35–64 let) in starejši (65 let in več) ter preverili, kako se ti razlikujejo v oceni celotnega tečaja in posameznih modulov. Povprečne ocene tečaja in posameznih modulov glede na starostno skupino udeleženca so prikazane v Tabeli 3. Te nam kažejo, da so bili tako s tečajem kot celoto kot s posameznimi moduli najbolj zadovoljni udeleženci srednjih let, saj so ti izkazali v povprečju višje ocene kot pa mlajši in starejši udeleženci.

Tabela 3
Povprečna ocena tečaja in posameznih modulov glede na starostno skupino udeleženca in Kruskal-Wallisov H-test razlik

	Mladi	Srednjih let	Starejši	Kruskal-Wallisov H-test
Celotna delavnica	4,78 (0,471)	4,93 (0,264)	4,76 (0,687)	H = 6,360; df = 2; p = 0,042*
Modul 1: Smrt je del življenja	4,65 (0,565)	4,87 (0,398)	4,70 (0,735)	H = 9,993; df= 2; p = 0,007*
Modul 2: Načrtovanje oskrbe in odločanje	4,58 (0,613)	4,85 (0,354)	4,66 (0,717)	H = 10,836; df = 2; p = 0,004*
Modul 3: Lajšanje simptomov in težav	4,79 (0,504)	4,86 (0,387)	4,67 (0,718)	H = 4,071; df = 2; p = 0,131
Modul 4: Slovo	4,73 (0,536)	4,89 (0,314)	4,76 (0,687)	H = 4,437; df = 2; p = 0,109

Opomba: Poleg povprečja je (v oklepaju) prikazan tudi standardni odklon. Oznaka * kaže statistično značilno stopnjo $p < 0,05$.

Ženske so (v povprečju) dodelile višjo oceno celotnemu tečaju kot pa moški (4,89 vs. 4,69). Tudi povprečne ocene za posamezne module so različno ocenjene glede na spol.

Tabela 4
Povprečna ocena tečaja in posameznih modulov glede na spol udeleženca in Mann-Whitneyjev U-test razlik

	Moški	Ženske	Mann-Whitneyjev U- test
Celotna delavnica	4,69 (0,796)	4,89 (0,332)	U = 3.093,5; p = 0,102
Modul 1: Smrt je del življenja	4,59 (0,798)	4,82 (0,456)	U = 3.176,0; p = 0,033*
Modul 2: Načrtovanje oskrbe in odločanje	4,51(0,804)	4,80 (0,437)	U = 2.967,0; p = 0,007*
Modul 3: Lajšanje simptomov in težav	4,69 (0,749)	4,82 (0,442)	U = 3.342,5; p = 0,284
Modul 4: Slovo	4,69 (0,749)	4,85 (0,398)	U = 3.283,0; p = 0,173

Opomba: Poleg povprečja je (v oklepaju) prikazan tudi standardni odklon. Oznaka * kaže statistično značilno stopnjo p < 0,05.

Zaradi majhnega števila udeležencev z osnovnošolsko izobrazbo (le trije) smo za analizo razlik v zadovoljstvu oziroma oceni tečaja glede na izobrazbo oblikovali dve kategoriji dosežene izobrazbe: srednješolska ali nižja (sni) in visokošolska (vs). Povprečne ocene nam kažejo, da so udeleženci z visokošolsko izobrazbo celotni tečaj ocenili v povprečju z višjo oceno kot preostali udeleženci s srednješolsko ali nižjo izobrazbo (4,86 vs/4,83 sni), vendar gre za majhne razlike v oceni, ki niso statistično značilne. Podobno velja tudi za posamezne module – udeleženci z visokošolsko izobrazbo so modulom dodelili v povprečju višjo oceno kot udeleženci s srednješolsko ali nižjo izobrazbo. Največje razlike v povprečni oceni udeležencev glede na doseženo izobrazbo obstajajo pri Modulu 2 (*Načrtovanje oskrbe in odločanje*) (4,79 vs/4,67 sni), najmanjše pa pri Modulu 3 (*Lajšanje simptomov in težav*) (4,84 vs/ 4,81 sni); pri Modulu 1 (*Smrt je del življenja*) ta razlika znaša 4,81 vs/4,75 sni, pri Modulu 4 (*Slovo*) pa 4,84 vs/4,77 sni.

V nadaljevanju predstavljamo glavne ugotovitve, ki izhajajo iz odgovorov na odprta vprašanja. Osredotočili smo se na dve vprašanji,[7] ki najbolje prikazujeta oceno uporabljenih didaktičnih metod in priporočila za delo v prihodnosti. V odgovorih na vprašanje *Kaj vam je bilo še posebej všeč, kaj bi posebej pohvalili*? in na poziv *Veseli bomo vaših komentarjev in predlogov* smo prepoznali 40 kod, ki smo jih združili v osem kategorij in dve temi. Prva tema so metode, uporabljene pri izvedbi tečaja.

7 Analiza odgovorov na preostala tri vprašanja (*Katera tema vas je posebej nagovorila?; Pridobil sem nekaj več samozavesti pri soočanju z naslednjimi temami ...; Kakšen je vaš osebni vtis glede tečaja?*) in iz nje izhajajoče ugotovitve presegajo obseg tega prispevka.

Tema 1: Ocena uporabljenih didaktičnih metod

Kategorije: interaktivnost, primeri iz prakse, izobraževanje odraslih in metodološki pristop

Večina udeležencev je bila zelo zadovoljna[8] z interaktivnostjo in vključevanjem udeležencev v interakcijo z moderatorji tečaja. Praktične izkušnje in zgodbe so bile zelo dobro sprejete. Z aktivnim vključevanjem nam je uspelo spodbuditi tudi samorefleksijo glede predstavljene teme.

V nadaljevanju navajamo nekaj izjav udeležencev:
- »Zanimivo je bilo, da je vsak udeleženec predstavil delček predavanja in dobil različne asociacije ob drsnici.«
- »Interaktivnost, sodelovanje udeležencev, zelo dobro pripravljen in izveden tečaj o težki temi.«
- »Primeri iz prakse, razumljivo predstavljena težka tema. Spodbuja razmišljanja o smrti.«
- »Zelo zanimivo predavanje, metodološko in andragoško zelo dobro pripravljeno in izvedeno.«

Tema 2: Predlogi za delo v prihodnje

Kategorije: izobraževanje otrok in mladih, tečaji v skupnosti, medicinske šole in dodatne vsebine

Pri analizi odgovorov drugega izbranega vprašanja smo pridobili informacije o željah in predlogih udeležencev za prihodnje delo.

Pri pregledu druge teme je bilo zanimivo, da so udeleženci prepoznali potrebe po ozaveščanju laične javnosti, vključitvi navedenega izobraževanja v šolski sistem in celo predlagali nadgraditev tečaja s temami, ki so bile le omenjene, ne pa podrobneje predstavljene v tem osnovnem tečaju.

Navajamo nekatere izjave udeležencev:
- »[…] da bi se to predavalo na srednjih šolah, kot so zdravstvena, gimnazija.«
- »Premalo se govori o tej temi; ko je v bolnici umiral svojec, nisem vedela, kam se obrniti po informacije, vse je le o zdravstvenem stanju. Razširiti tečaj v skupnosti.«
- »Nadgraditi in razširiti modul, kako komunicirati z agresivnimi svojci in več o duhovni oskrbi.«
- »Predavanje, ki te strezni, saj se premalokrat zavedamo, da je smrt del življenja. O tem nas na fakulteti premalo naučijo.«

8 V tej fazi evalvacije tečaja smo povpraševali po zadovoljstvu, nismo testirali znanja in uporabe znanja v praksi. To bo predmet naslednje faze evalvacije, ki bo izvedena šest mesecev po opravljenem tečaju.

RAZPRAVA

Glede na ocene so bili udeleženci zelo zadovoljni tako z vsebino kot izvedbo tečaja. Udeleženci so tečaju v celoti (87,7 %) kot tudi posameznim modulom (več kot 75 % pri vseh) dodelili najvišjo oceno, tj. 5 oziroma odlično (Tabela 2). Statistično značilno se je tečaja udeležilo več žensk (Tabela 1) in z njim so bili bolj zadovoljni višje izobraženi ter udeleženci starostne skupine med 35 in 64 leti (Tabela 3 in Tabela 4). Predvsem modula *Smrt je del življenja* ter *Načrtovanje in odločanje* nekoliko odstopata pri oceni zadovoljstva s posameznimi vsebinami. Struktura udeležencev ni presenetljiva, še posebej, če poznamo rezultate raziskav, ki ugotavljajo, da delo neformalnih negovalcev najpogosteje opravljajo ženske srednjih let (Miyawaki idr., 2017; AARP Public Policy Institute in National Alliance for Caregiving, 2015; Yee in Schulz, 2000).

Druženje in izmenjavo osebnih izkušenj na tečaju so naši udeleženci ocenili kot veliko prednost tečaja. Dali so tudi zanimive predloge in usmeritve za nadaljnje delo. Podobne izkušnje opisujejo tudi drugi raziskovalci (Bollig idr., 2021a), ki ugotavljajo, da je ozaveščanje o temi, ki je še vedno v veliko okoljih tabuizirana, uspešno takrat, ko izberemo načine, s katerimi se približamo splošni populaciji in jo vključimo v proces izmenjave mnenj in informacij. Znanje, ki ga udeleženci tečaja pridobivajo, namreč ni ločeno od življenja in se na simbolni ravni povezuje s smrtjo. Poleg tega se v odzivih udeležencev prepoznava potreba po »normalizaciji« smrti in zagotavljanju priložnosti, da prepoznajo smrt in umiranje kot družbeni proces in ne le kot medicinski izid (Abel in Kellehear, 2016). V tem smislu so pomembne številne pobude, programi in projekti, ki so v zadnjih letih vse bolj razširjeni: od »death cafes«, promocije paliativne oskrbe v zdravstvu, izobraževanja o smrti in umiranju do sočutne skupnosti. Vse to so pristopi, s katerimi želijo posameznike in skupnosti spodbuditi, da razmišljajo o smrti in se odzivajo na vprašanja ob koncu življenja (Kellehear, 2016).

Iz analize odgovorov udeležencev tečaja je očitno, da so bili z uporabljenimi izobraževalnimi metodami zadovoljni (Tema 1). Pohvalili so interaktivnost, izmenjavo osebnih zgodb in izkušenj ter vključevanje udeležencev v izvedbo tečaja. Za nadaljnje delo na tem področju so povedne izkušnje izobraževalnih programov iz drugih držav. Med različnimi izobraževalnimi iniciativami velja posebej omeniti izkušnjo iz Japonske, kjer so pripravili izobraževalni program, v katerem so kot vodilno učno strategijo uporabili zgodbe. Nato so opravili raziskavo o učinkovitosti posredovanja znanja o oskrbi ob koncu življenja s pomočjo zgodb oziroma pripovedi. Ugotovili so, da je izobraževalni program z uporabo narativnih metod poglobil laično razumevanje koncepta oskrbe ob koncu življenja. Izkušnje, ki so bile del pripovedi, so udeležencem omogočile, da so premagali eksistencialno grozo pred smrtjo in na simbolni ravni vzpostavili odnos z drugimi (Haruta idr., 2021).

Udeleženci tečaja so v svojih izjavah poudarili, da bi potrebovali več znanja o umiranju in paliativni oskrbi. V tem smislu so ugotovitve naše raziskave skladne z drugimi, ki poudarjajo potrebe po izobraževanju javnosti o paliativni oskrbi in oskrbi v bolnišnicah (Patel in Lyons, 2020; Ramasamy Venkatasalu idr., 2018; Shalev idr., 2018;). Podobno tudi Lane

idr. (2019) v svoji raziskavi ugotavljajo, da bi se v ZDA morali osredotočiti na ozaveščanje in odpravljanje napačnih predstav javnosti o paliativni oskrbi. S tem bi lahko izboljšali kakovost oskrbe pacientov v vseh življenjskih obdobjih.

Podatki, ki nam jih je doslej uspelo analizirati, so zanimivi ne samo zaradi dobrih ocen tečaja, temveč tudi zaradi predlogov za organizacijo prihodnjih izobraževanj o tej temi. Tako kot udeleženci iz drugih držav so tudi udeleženci v Sloveniji svetovali nadgradnjo tečaja z nekaterimi temami in izvedbo tečajev v šolah (Bollig idr., 2021a). O dobrih izkušnjah poročajo tudi s spletnih izobraževanj, ki bodo za del populacije zanimivi tudi po končani pandemiji (Bollig idr., 2021b).

ZAKLJUČEK

Izkušnje s tečajem Zadnja pomoč v Sloveniji so podobne tistim v drugih državah. Tečaj je bil dobro sprejet in ocenjen kot uspešen, pri čemer so udeleženci pohvalili tako vsebino kot izvedbo. Vendar pa je pandemija okrnila izvedbo skupnostnega izobraževanja »v živo« in spodbudila nove oblike dela, kot je izvedba tečaja po spletu. Ugotavljamo, da bo treba v prihodnosti oblikovati standarde spletnega izobraževanja in poskrbeti za promocijo tečaja v različnih skupnostih ob upoštevanju družbenokulturnih značilnosti lokalnega okolja.

Za konec naj se na kratko ustavimo pri slednjem. Zagotovo je eden izmed prihodnjih izzivov izvedbe tečaja v Sloveniji večje upoštevanje družbenokulturne raznolikosti. Glede na to, da je tečaj nastal v mednarodnem okolju, ne upošteva lokalnih specifik, zaradi česar se je v prihodnjih izvedbah tečaja v Sloveniji pomembno bolj posvetiti potrebam posameznih lokalnih skupnosti. Pomen odzivanja na lokalne potrebe poudarjajo tako raziskave v tujini (Isaacson, 2018; Shen idr., 2020) kot v Sloveniji (Zelko in Švab, 2016). Hayes idr. (2020) so v kvalitativni analizi, ki je bila izvedena v Avstraliji, v ospredje postavili naslednje pomembne teme, ki jih moramo upoštevati, ko se pogovarjamo o načrtovanju zadnjega življenjskega obdobja: razlike v morali, zdravstvena pismenost, pismenost o smrti (*death literacy*) in kulturna raznolikost. McGrath in Holewa (2006) sta v svoji raziskavi, ki se je ukvarjala s paliativno oskrbo staroselcev v Avstraliji, to še dodatno podkrepila, ko sta med pomembnimi dejavniki pri organizaciji paliativne oskrbe navedla spoštovanje kulturne identitete, s katero sta mislila spoštovanje kulturnih praks in prepričanj ter življenjskega sloga. Družbenokulturna raznolikost je del slovenske realnosti in prav je, da jo pri načrtovanju programov skupnostnega izobraževanja upoštevamo (Lipovec Čebron, 2020; Marković, 2009). Zapostavljanje družbenokulturne raznolikosti pri izvedbi tečaja Zadnja pomoč v Sloveniji se kaže tudi v tem, da nam nanj še ni uspelo pritegniti udeležencev z nižjo izobrazbo niti predstavnikov drugih etničnih skupin, ki živijo v Sloveniji. Deloma je to posledica epidemije, ki je pogojevala drugačne oblike in pogoje izvedbe tečaja, deloma pa zadržanega obveščanja javnosti o možnosti brezplačnih tečajev na temo umiranja in smrti v lokalni skupnosti.

LITERATURA IN VIRI

AARP Public Policy Institute in National Alliance for Caregiving. (2015). *Caregiving in the U.S.: 2015 report*. NAC; AARP.

Abel, J. in Kellehear, A. (2016). Palliative care reimagined: A needed shift. *BMJ Supportive & Palliative Care*, *6*(1), 21–6. https://doi.org/10.1136/bmjspcare-2015-001009

Bollig, G., Brandt, F., Ciurlionis, M. in Knopf, M. (2019). Last aid course: An education for all citizens and an ingredient of compassionate communities. *Healthcare, 7*(1), 19. https://doi.org/10.3390/healthcare7010019

Bollig, G., Brandt Kristensen, F. in Lykke Wolff, D. (2021a). Citizens appreciate talking about death and learning end-of-life care – a mixed-methods study on views and experiences of 5469 Last Aid Course participants. *Progress in Palliative Care, 29*(3), 140–148. https://doi.org/10.1080/09699260.2021.1887590

Bollig, G. in Heller, A. (2016). The last aid course – A simple and effective concept to teach the public about palliative care and enhance the public discussion about death and dying. *Austin Palliative Care, 1*(2), 1010.

Bollig, G., Mainzer, K., Fiedler, H. in Pothmann, R. (2020). The last aid course for kids and teens from 8–14 years – preliminary results from the first pilot test. *Hospice & Palliative Medicine International Journal, 4*(1), 1–3. https://doi.org/10.15406/hpmij.2020.04.00176

Bollig, G., Meyer, S., Knopf, B., Schmidt, M. in Hayes Bauer, E. (2021b). First experiences with online Last Aid courses for public palliative care education during the COVID-19 pandemic. *Healthcare, 9*(2), 172. https://doi.org/10.3390/healthcare9020172

Bollig, G. in Zelko, E. (2020). Why should everybody learn Last Aid to provide end-of-life care? *Community Medicine and Public Health, 6*(2), 198–199. https://doi.org/10.17352/2455-5479.000105

Dionne-Odom, J. N., Ornstein, K. A. in Kent, E. E. (2019). What do family caregivers know about palliative care? Results from a national survey. *Palliative and Supportive Care, 17*(6), 1–7. https://doi.org/10.1017/S1478951519000154

Duraković, E. (2020). Tabor levjesrčnih – terapevtsko-edukativna metoda dela z žalujočimi otroki. *Utrip, XXXVIII*(2), 33–35.

Eurostat. (2016). *Statistika vzrokov smrti.* https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Archive:Statistika_vzrokov_smrti&oldid=540327

Gellie, A., Mills, A., Levinson, M., Stephenson, G. in Flynn, E. (2015). Death: A foe to be conquered? Questioning the paradigm. *Age and Ageing, 44*(1), 7–10. https://doi.org/10.1093/ageing/afu116

Haruta, J., Oishi, A. in Den, N. (2021). How and what do laypeople learn about end-of-life care using narrative? A case study in educational research. *The Asia Pacific Scholar, 5*(1), 16–24. https://doi.org/10.29060/TAPS.2020-5-1/OA2126

Hayes, B., Fabri, A. M., Coperchini, M., Parkar, R. in Austin-Crowe, Z. (2020). Health and death literacy and cultural diversity: Insights from hospital-employed interpreters. *BMJ Supportive & Palliative Care*, *10*(1), e8. https://doi.org/10.1136/bmjspcare-2016-001225

Hooyman, N. R., Kramer, B. in Sanders, S. (2021). *Living Through Loss: Interventions Across the Life Span*. Columbia University Press.

Hudson, P., Remedios, C., Zordan, R., Thomas, K., Clifton, D., Crewdson, M., Hall, C., Trauer T., Bolleter, A., Clarke, D. M. in Bauld, C. (2012). Guidelines for the psychosocial and bereavement support of family caregivers of palliative care patients. *Journal of palliative medicine, 15*(6), 696–702. https://doi.org/10.1089/jpm.2011.0466

Isaacson, M. J. (2018). *Addressing palliative and end-of-life care needs with Native American elders. International Journal of Palliative Nursing, 24*(4), 160–168. https://doi.org/10.12968/ijpn.2018.24.4.160

Kellehear, A. (2013). Compassionate communities: End-of-life care as everyone's responsibility. *QJM: An International Journal of Medicine, 106*(12), 1071–1075. https://doi.org/10.1093/qjmed/hct200

Kellehear, A. (2016). Commentary: Public health approaches to palliative care – the progress so far. *Progress in Palliative Care, 24*(1), 36–8. https://doi.org/10.1080/09699260.2015.1103499

Lane, T., Ramadurai, D. in Simonetti, J. (2018). Public awareness and perceptions of palliative and comfort care. *The American Journal of Medicine, 132*(2), 129–131. https://doi.org/10.1016/j.amjmed.2018.07.032

Lipovec Čebron, U. (2020). Jezikovne in kulturne ovire v zdravstvenih ustanovah. V I. Huber, U. Lipovec Čebron in S. Pistotnik (ur.), *Neenakosti in ranljivosti v zdravju v Sloveniji: Kvalitativna raziskava* v 25 okoljih (str. 120–140). NIJZ.

Lopuh, M. (2018). Na razpotju med paliativno oskrbo, etiko in pravom. V S. Kraljić, J. Reberšek Gorišek in V. Rijavec (ur.), *27. posvetovanje Medicina, pravo in družba: Sodobni izzivi in dileme* (str. 41–46). Univerzitetna založba Univerze v Mariboru. https://doi.org/10.18690/978-961-286-147-6.6

Marković, R. (2009). *Spoštovanje kulturne, verske in jezikovne raznolikosti v Sloveniji.* [Magistrsko delo]. Nova univerza, Fakulteta za državne in evropske študije.

McGrath, P. D. in Holewa, H. (2006). Seven principles for Indigenous palliative care service delivery: Research findings from Australia. *Austral-Asian Journal of Cancer, 5*(3), 179–186.

Milčinski, M. in Bajželj Bevelacqua, A. (ur.). (2011). *Življenje, smrt in umiranje v medkulturni perspektivi.* Znanstvena založba Filozofske fakultete Univerze v Ljubljani.

Miyawaki, A., Tomio, J., Kobayashi, Y., Takahashi, H., Noguchi, H. in Tamiya, N. (2017). Impact of long-hours family caregiving on non-fatal coronary heart disease risk in middle-aged people: Results from a longitudinal nationwide survey in Japan. *Geriatrics Gerontology International*, *17*(11), 2109–2115. https://doi.org/10.1111/ggi.13061

Parkes, C. M. in Prigerson, H. G. (2010). *Bereavement: Studies of grief in adult life* (4. izd.). Routledge. https://doi.org/10.4324/9781315829753

Patel, P. in Lyons, L. (2020). Examining the knowledge, awareness, and perceptions of palliative care in the general public over time: A scoping literature review. *American Journal of Hospice and Palliative Medicine, 37*(6), 481–487. https://doi.org/10.1177/1049909119885899

Payne, S., Seymour, J. in Ingleton, C. (2008). *Palliative care nursing: Principles and evidence for practice: principles and evidence for practice* (2. izd.). McGraw-Hill; Open University Press.

Ramasamy Venkatasalu, M., Sirala Jagadeesh, N., Elavally, S., Pappas, Y., Mhlanga, F. in Pallipalayam Varatharajan, R. (2018). Public, patient and carers' views on palliative and end-of-life care in India. *International Nursing Review, 65*(2), 292–301. https://doi.org/10.1111/inr.12403

Shalev, A., Phongtankuel, V., Kozlov, E., Shen, M. J., Adelman, R. D. in Reid, M. C. (2018). Awareness and misperceptions of hospice and palliative care: A population-based survey study. *American Journal of Hospice and Palliative Medicine, 35*(3), 431–439. https://doi.org/10.1177/1049909117715215

Shen, J. J., Dingley, C., Yoo, J. W., Rathi, S., Kim, S. K., Kang, H. T. in Frost, K. (2020). Sociocultural Factors Associated with Awareness of Palliative Care and Advanced Care Planning among Asian Populations. *Ethnicity & Disease, 30*(3), 459–468. https://doi.org/10.18865/ed.30.3.459

Stein, D. (1998). *Situated learning in adult education.* ERIC Digest, 195, ed418250. https://www.ericdigests.org/1998-3/adult-education.html

Šket, A. (2020). I*zkušnje negovalnega osebja z zagotavljanjem paliativne oskrbe v domovih za starostnike* [Diplomsko delo, Univerza v Mariboru, Fakulteta za zdravstvene vede]. DKUM. https://dk.um.si/IzpisGradiva.php?id=78105&lang=slv

Walter, T. (1991). Modern death: Taboo or not taboo? *Sociology, 25*(2), 293–310. https://doi.org/10.1177/0038038591025002009

Wenger-Trayner, E. in Wenger-Trayner, B. (2015). *Introduction to communities of practice.* https://wenger-trayner.com/introduction-to-communities-of-practice/

Worden, J. W. (2018). *Grief counseling and grief therapy: A handbook for the mental health practitioner* (5. izd.). Springer. https://doi.org/10.1891/9780826134752

World Health Organization. (2002). *National cancer control programmes: Policies and managerial guidelines* (2. izd.). WHO.

Yee, J. L. in Schulz, R. (2000*).* Gender differences in psychiatric morbidity among family caregivers: A review and analysis. *The Gerontologist, 40*(2), 147–164. https://doi.org/10.1093/geront/40.2.147

Zavratnik, B., Ebert Moltara, M. in Mehle, M. G. (2015). 1734 The nurses' role in a joint multi-professional collaboration for preparing written material about palliative care in Slovenia - Project "Butterfly" [Povzetek predstavitve plakata]. *European Journal of Cancer*, *51,* S259. https://doi.org/10.1016/S0959-8049(15)30030-7

Zelko, E. in Bollig, G. (2021). *Report from the 2. International LAST AID Conference Online — The social impact of palliative care* [Poročilo konference]. *AIMS Medical Science, 8*(1), 42–45. https://doi.org/10.3934/medsci.2021005

Zelko, E. in Švab, I. (2016). Overcoming cultural cleavages: Results from a health promotion intervention among Roma. *Acta medico-biotehnica,*(1), 33–41.

Andragoška spoznanja/Studies in Adult Education and Learning, 2021, 27(2), 123-140 UDK: 37.012
DOI: https://doi.org/10.4312/as/10185 Scientific article

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THE EVALUATION OF CULTURAL COMPETENCE IN HEALTHCARE: WHY IS THE INTRODUCTION OF QUALITATIVE APPROACHES SO NEEDED?

ABSTRACT

The article seeks to stimulate dialogue about the evaluation of cultural competence in healthcare. The first part of the paper presents the different attempts to measure cultural competence in the field of healthcare and critically analyses the problems that arise concerning the use of instruments that measure the cultural competence of health providers. The second part of the article focuses on the evaluation process of the first cultural competence educational programme for healthcare workers in Slovenia, serving as an example to demonstrate the importance of complementing quantitative methods with qualitative ones and to emphasize the need to shift the focus from measuring the cultural competence of individual healthcare workers to the evaluation of educator performances, patient perspectives, and the cultural competence of healthcare institutions as a whole.

Keywords: *cultural competence, healthcare, education, evaluation, qualitative and quantitative methods*

EVALVACIJA KULTURNIH KOMPETENC NA PODROČJU ZDRAVSTVA: ZAKAJ JE TREBA VPELJATI KVALITATIVNE PRISTOPE? – POVZETEK

Namen prispevka je spodbuditi dialog o evalvaciji kulturnih kompetenc v zdravstvu. V prvem delu članka bosta avtorici predstavili različne poskuse merjenja kulturnih kompetenc v zdravstvu, pri čemer bosta kritično analizirali probleme, ki se pojavljajo ob uporabi instrumentov, namenjenih merjenju kulturnih kompetenc zdravstvenih delavcev. V drugem delu članka pa se bosta osredotočili na evalvacijski postopek prvega izobraževalnega programa s področja kulturnih kompetenc zdravstvenih delavcev v Sloveniji. Evalvacijski postopek v Sloveniji bo služil kot primer, na podlagi katerega bosta avtorici pokazali na pomen dopolnjevanja kvantitativnih metod s kvalitativnimi ter potrebe po tem, da premaknemo pozornost

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od merjenja kulturnih kompetenc posameznih zdravstvenih delavcev k evalvaciji izvajalcev izobraževanja, k perspektivi pacientov ter k evalvaciji kulturnih kompetenc celotnih zdravstvenih ustanov.

Ključne besede: *kulturne kompetence, zdravstvo, izobraževanje, evalvacija, kvalitativne in kvantitativne metode*

INTRODUCTION

In recent decades, cultural competence has been one of the most popular concepts when it comes to the education of healthcare workers. Cultural competence efforts arose as a response to calls for new medical models that address the shifting demographics of ethnic migrants (Napier et al., 2014). Namely, many health care providers across Europe reported being in daily contact with heterogeneous groups of migrants who may speak only foreign languages, exhibit different health-seeking behaviours, and have different expectations of care, for which healthcare workers were not prepared. This resulted in many language-related and intercultural miscommunications and produced unfavourable health outcomes (Lipovec Čebron, 2017; Martínez, 2010). The growing health disparities that minority communities face (Barker & Beagan, 2014) clearly indicate that the "one-size-fits-all" healthcare model is incapable of adequately meeting the needs of an increasingly heterogeneous population (Barker & Beagan, 2014; Carpenter-Song et al., 2007).

The first steps in the field of cultural competence were taken in the USA as far back as the early 1970s (Muaygil, 2018, p. 15). At the time employees in the public sector began to feel increasingly unprepared to serve diverse and continuously changing populations (Muaygil, 2018, p. 15). Noticing these transformations, the healthcare sector also recognised that providing equitable medical care for different groups was a very challenging goal (Muaygil, 2018). Healthcare professionals initially "utilized an individualized model: clinicians were urged to recognize and understand the unique needs, preferences, and values of each patient individually in order to ensure effective delivery of a service" (Muaygil, 2018, p. 16). Over time, however, many different methods, approaches and models of cultural competence evolved in different countries and a variety of terms have been used in relation to cultural competence or similar concepts[1] (Cai, 2016; Diallo & McGrath, 2013; Jenks, 2011). These various efforts had a similar foundation: the acknowledgement that culture matters in healthcare and the commitment to respect cultural differences. Moreover, different cultural competence efforts had the common goal of ensuring equal healthcare access for and quality health care delivery to persons with diverse cultural and socio-economic backgrounds, i.e. people with a variety of values, norms, social practices,

1 For example, culturally appropriate care, intercultural health, multicultural healthcare, cross-cultural healthcare, cultural sensitivity, cultural intelligence, cultural responsiveness, cultural safety or cultural humility (Cai, 2016, p. 268; Diallo & McGrath, 2013, p. 122; Jenks, 2011, p. 210). These concepts are sometimes used interchangeably with the term cultural competence, and sometimes as its hyponym or hypernym, indicating a significant terminological confusion in this field (Lipovec Čebron & Huber, 2020).

health beliefs, and health practices (Barker & Beagan, 2014; Cai, 2016; Carpenter-Song et al., 2007; Halbwachs, 2019; Muaygil, 2018). Thus, these efforts were not focused only on minority, marginalised or deprivileged groups of patients, but were instead trying to ensure access to healthcare institutions and quality health care delivery for all patients (Schouler-Ocak et al., 2015, p. 436).

Over the following decades, courses in cultural competence have increasingly become part of many health education programmes in North America and Europe. Not only targeting medical students, these courses are common in educational programmes for other health professionals and are a part of continuous medical education (Schouler-Ocak et al., 2015). Moreover, the last thirty years have seen a remarkable increase in theories, models, and approaches to teaching and conducting research in cultural competence, which is evident from the impressive quantity of scientific articles on this subject (Halbwachs, 2019; Perng & Watson, 2012; Purnell, 2016; Razlag Kolar et al., 2019). Many recent cultural competence efforts want to not only influence the clinical level in terms of patient-provider interaction, but also in terms of institutionalised healthcare policies and services (Barker & Beagan, 2014; Carpenter-Song et al., 2007; Schouler-Ocak et al., 2015). In this context, they were incorporated into the nationally as well as internationally recognised standards for healthcare quality assessment (Jenks, 2011)[2] and a range of instruments to measure the cultural competence of health care providers and institutions were created (Diallo & McGrath, 2013; Pulido-Fuentes et al., 2017).

The following pages critically reflect on the dilemmas and problems that arise in connection to the instruments intended to measure the cultural competence of health providers. In the first part of the article, the different attempts to measure cultural competence in the field of healthcare will be presented and the problems that arise concerning the use of instruments that measure the cultural competence of health providers will be critically analysed. The second part of the article will focus on the evaluation process of the first cultural competence educational programme for healthcare workers in Slovenia. The 20-hour course took place in different locations across the country and 485 healthcare workers and other professionals working in primary-level health care attended the 13 cycles in 2018 and 2019. The evaluation process will demonstrate the importance of complementing quantitative methods with qualitative ones and establish the need to shift the focus from measuring the cultural competence of the individual healthcare worker to the evaluation of educator performances, patient perspectives, and the cultural competence of healthcare institutions as a whole.

2 In 2001, the Culturally and Linguistically Appropriate Service (CLAS) standards were established in the USA – a series of 14 requirements and recommendations for the development of CLAS (Office of Minority Health, 2001). On the basis of these standards, cultural competence efforts include a range of activities (from using interpreters to recruiting providers from underrepresented ethnic groups, creating ethnically specialised clinics as well as educating and training health providers) (Jenks, 2011, p. 210).

MEASURING CULTURAL COMPETENCE

As previously mentioned, courses in cultural competence have experienced a remarkable upswing in recent decades and have become an integral part of graduate and postgraduate study curricula at medical and health sciences faculties (e.g., Beach et al., 2005; Jenks, 2011; Napier et al., 2014) as well as continuing educational programmes for health care providers (Battle, 2010; Eche & Aronowitz, 2017; Razlag Kolar et al., 2019). However, it should be emphasized that these efforts to address the "softer" side of healthcare in education are neither new nor unique (Jenks, 2011, pp. 210–211). What is new and singular is the fact that legislative and regulatory efforts – particularly in North America and in some parts of Europe – have accelerated the introduction of cultural competence in the field of healthcare education. The consequences of this development are impressive: for example, a survey of medical schools in California found that between 1991 and 1992 only 13 of 98 schools offered a cultural sensitivity course, which was optional (Lum & Korenman, 1994, as cited in Jenks, 2011), while 10 years later 100% of the schools included issues of cultural diversity as a requirement (Wilson & Houghraling, 2001, as cited in Jenks, 2011, p. 211). These and other courses across different countries vary in length (from a one-day course to a continual year-long course), method (from lectures to different workshops), the number of participants (from a few participants to large groups), form (from online courses to immersion programmes designed to expose providers to various groups of patients) (Jenks, 2011, p. 211), approach (from the categorical approach, where information about specific groups is provided, to the cross-cultural approach, where methods for communicating with and caring for patients from diverse backgrounds are taught) (Jenks, 2011, pp. 216–217), and the professional background of the lecturers (varying from interdisciplinary groups that include renowned experts in the field of social sciences, humanities as well as healthcare, to a single novice lecturer). Therefore, two courses with an identical title featuring "cultural competence" could, on the one hand, indicate a short training session that lasts a few hours and only addresses a few basic concepts, and on the other hand, refer to a programme that spans several months and provides an in-depth understanding of this field through interactive lectures, role play, participant observation, and cultural consultation (Schouler-Ocak et al., 2015, p. 437; see also Kirmayer et al., 2008).

As the variety of courses in cultural competence increased it also became necessary to assess their impact. In general, many authors estimated that cultural competence is one of the key strategies with which healthcare institutions seek to overcome the problem of unequal care for increasingly heterogeneous populations and point to the need for educating health care providers in this field (Babnik & Šavle, 2014; Betancourt, 2006; Napier et al., 2014; Purnell, 2016). Numerous studies have also proved that cultural competence can significantly contribute to safer and more efficient care (Betancourt, 2006; Campinha-Bacote, 2002) as well as improve the accuracy of diagnosis and clinical outcomes (Cai, 2016; Napier et al., 2014) by addressing the needs of different groups – not only marginalised and deprivileged ones, but others as well. As a result, both healthcare

professionals and patients are more satisfied with the treatment process and quality of care. Furthermore, overall satisfaction with the work and employee relationships in healthcare facilities also increases (Barker & Beagan, 2014; Cai, 2016) and the frequency of medical errors declines.

While recognising the many achievements cultural competence efforts have made, there exist certain conceptual and methodological pitfalls connected to many such projects, especially those in the field of education (Lipovec Čebron & Huber, 2020). As we will see in the following pages, there is a terminological and conceptual confusion that arises in defining cultural competence in educational programmes. Besides problematic attempts to define cultural competence, anthropologists (e.g., Cai, 2016; Carpenter-Song et al., 2007; Kleinman & Benson, 2006; Pulido-Fuentes et al., 2017) have sharply criticised the conceptual background and implementation of various educational programmes on cultural competence that are based on an oversimplified and erroneous understanding of culture – one that is in stark opposition to the anthropological understanding of this concept. Multiple authors (Carpenter-Song et al., 2007; Kleinman & Benson, 2006; Kumaş-Tan et al., 2007; Pulido-Fuentes et al., 2017) have pointed out that the most troubling aspect of these educational programmes is the misguided equation of culture with race, nationality and ethnicity, and the use of the concept of culture to conceal social and economic inequalities, which in practice leads to negative or even harmful consequences (Lipovec Čebron & Huber, 2020).

Besides various studies and reviews that assessed cultural competence in healthcare on a general level, there has been an increasing emphasis on examining cultural competence on an individual level and therefore to measure the cultural competence of individual health care providers. This shift emerged as a response to criticism suggesting that satisfactory evidence has not yet been presented to support the commonly-held belief that cultural competence is sufficient to produce the desired patient and family outcomes (Bhui et al., 2007; Schim & Doorenbos, 2010). As a result, many proponents of cultural competence started pushing for more tangible, measurable, "objective" proof of the positive effects of culturally competent healthcare. Some of the authors even perceive the introduction of measuring cultural competences as a fundamental step towards assessing cultural competence learning strategies and towards achieving cultural competence among health care providers (Cai, 2016; Ličen et al., 2017; Smedley et al., 2003). Or, as Larry Purnell (2016) puts it: "While cultural competency is widely promoted, the lack of tools to measure cultural competency limits the ability to evaluate when culturally congruent care is truly delivered" (p. 126). This resulted in the creation of a range of instruments to measure the cultural competence of health care providers and healthcare institutions (Diallo & McGrath, 2013; Pulido-Fuentes et al., 2017).

An overview of these instruments gives the impression that the field of cultural competence measuring is experiencing rapid growth. More than a decade ago, Zofia Kumaş-Tan et al. (2007) defined 54 different instruments used to measure cultural competence in training courses, acknowledging that "there is indeed little uniformity in the methods

used to evaluate cultural competence in the training of health professionals" (p. 548). Nowadays the variety of different instruments and tools used for measuring cultural competence in healthcare seems to be endless, so this section will focus only on those which seem to be referenced most frequently. The majority of the instruments were developed on the basis of models and theories of well-known authors in this field such as Madeleine Leininger, Josepha Campinha-Bacote, Larry D. Purnell, Marianne Jeffreys, etc. In some cases, theories or models have an accompanying tool to measure cultural competence (Purnell, 2016, p. 125),[3] while in others researchers create only individual instruments. When designing these instruments, researchers usually draw on the work of Josepha Campinha-Bacote (1996, 1998, 2002) and identify three[4] main components of cultural competence that are to be measured: *cultural sensitivity*, which refers to a health care provider's appreciation of, respect for, and comfort with patients' cultural diversity (Cai, 2016, p. 270); *cultural knowledge*, which deals with a knowledge and understanding of different cultural worldviews and practices (Gunaratnam, 2007, p. 471); and *cultural skill*, which refers to the ability to collect relevant cultural data concerning a patient's health problem, and also incorporates relevant data into care planning and provision in a culturally sensitive manner (Cai, 2016, p. 270; Gunaratnam, 2007, p. 471; Campinha-Bacote, 2002; see also Halbwachs, 2019).

Building on these three (or more) components, researchers usually develop a self-reported assessment tool to measure health care providers' knowledge, attitude and/or behaviours regarding the culture and health of a specific as well as general population. There have been many attempts to develop such a tool, for example, one by Shoa-Jen Perng and Roger Watson (2012) includes 4 domains (cultural awareness, cultural knowledge, cultural sensitivity, cultural skill) that are measured by 9–10 items each.[5] In order to measure their level of cultural competence, the participants need to respond to 41 items using a five-point Likert-type scale (with the response categories strongly agree, agree, no comment, disagree, strongly disagree) (Perng & Watson, 2012, p. 1680). In this context, the participants show the level of their cultural skills by agreeing or disagreeing with statements such as: "I can teach and guide other nursing colleagues about the differences and similarities of diverse cultures" or "To me collecting information on each clients' belief/behavior about health/illness is very easy." Correspondingly, their level of cultural knowledge is measured by responding to items such as "I can explain the possible relationships

3 Probably the most well-established model in this context is *The Process of Cultural Competence in the Delivery of Healthcare Services* (Campinha-Bacote, 2015), which includes four self-reported tools for measuring cultural competence, each addressing a particular profile of healthcare workers. For example, *Inventory For Assessing The Process Of Cultural Competence Among Healthcare Professionals In Mentoring* (IAPCC-M), *Inventory For Assessing The Process Of Cultural Competence Among Healthcare Professionals – Student Version* (IAPCC-SV), and others (Campinha-Bacote, 2015).

4 In her works Campinha-Bacote (2002, p. 181) defined five (not three) main constructs of the cultural competence model: cultural awareness, cultural knowledge, cultural skill, cultural encounter, and cultural desire.

5 The specificity of this tool is that the researchers used Mokken scaling to establish whether items on a scale conform to a cumulative, hierarchical structure (Perng & Watson, 2012, p. 1680).

between the health/illness beliefs and culture of the clients", while the level of cultural sensitivity is established with items such as "I usually actively strive to understand the beliefs of different cultural groups" (Perng & Watson, 2012, p. 1682).

Similar self-report questionnaires with several items addressing cultural knowledge, cultural sensitivity and/or cultural skills can be found using many different scales (e.g., Baghadi & Ismaile, 2018; Chae & Lee, 2014). These may vary in the number of items that range from 25 (Schim et al., 2003) to 83 (Jeffreys, 2000) and in the Likert-type scales that vary from 4 points (Campinha-Bacote, 1999) to 10 (Jeffreys, 2000; see also Chae & Lee, 2014). Moreover, the scales differ according to the profile of healthcare workers they are intended for: some are aimed at all profiles of healthcare workers (Schim et al., 2003), others only at healthcare professionals (Campinha-Bacote, 1999) or students (Jeffreys, 2000). Certain instruments are developed not only for a specific group of healthcare workers but also for their specialised fields of expertise:

> For example, one instrument developed for evaluating this construct was targeted toward assessing one aspect of cultural competence such as cultural awareness in students (Rew, Becker, Cookston, Khosropour, & Martinez, 2003), whereas another focused on a specialty group of mixed professionals in hospice care (Schim, Doorenbos, Miller, & Benkert, 2003). (Tulman & Watts, 2008, p. 162)

Why Are the Instruments that Measure Health Care Providers' Cultural Competence Inappropriate?

As in some other fields of cultural competence where authors seldom engage in critical examinations of the theoretical concepts underlying cultural competence and in the different aspects of the training process (Willen et al., 2010, p. 247), critical analyses of existing instruments for measuring cultural competence are few and far between. In this section, we will present a short overview of the main conceptual and methodological problems connected to the instruments that measure cultural competence in healthcare. Namely, we will address problems that concern the validity and reliability of these instruments, the problematic theoretical concepts and assumptions behind them, and the questionable need to measure and quantify cultural competence in healthcare.

a) Problems Related to the Validity of the Instruments

One of the most common criticisms concerning the instruments that measure cultural competence in healthcare is related to questions of their validity. Some researchers in this field acknowledge the need to examine the validity of the instruments (Perng & Watson, 2012; Razlag Kolar et al., 2019) and others openly pronounce the existing instruments to be inaccurate: "However, to date, a valid and reliable means to measure the extent to which content on cultural competence is taught and retained by our students does not exist" (Tulman & Watts, 2008, p. 161). Some authors attribute this shortcoming to the fact that the majority of these instruments relies on self-report measures (Betancourt et al.,

2003; Kumaş-Tan et al., 2007; Perng & Watson, 2012; Purnell, 2016) that cannot be rigorously examined and is susceptible to social desirability effects. The authors of one of the self-reported assessment tools for clinical nurses admit:

> Given the nature of cultural competence, there is the possibility of a social desirability response set. Although anonymity was maintained during the data collection procedure, respondents may have chosen answers that they perceived to meet social norms as professional nurses. (Chae & Lee, 2014, p. 311)

b) Problematic Theoretical Concepts and Assumptions Behind the Instruments

Another, though less common criticism, concerns the theoretical concepts on which the instruments that measure the cultural competence of health care providers are based. Some authors see the main problem in the absence of a clear definition of cultural competence as well as in the lack of clarity about what it encompasses: "whereas many measures are based on the awareness–knowledge–skill model of cultural competence, there is ongoing dispute about the very meaning of and components of cultural competence" (Kumaş-Tan et al., 2007, p. 548). This lack of a unanimous definition of the concept of cultural competence is, according to some, one of the main obstacles preventing the creation of valid and reliable quantitative instruments (Chae & Lee, 2014; Perng & Watson, 2012; Suh, 2004).

Although such criticism is usually made only *en passant* in works that focus specifically on measuring cultural competence, it brings up the same conceptual problems that anthropologists have emphasized for a long time. Namely, they (e.g., Kleinman & Benson, 2006; Pulido-Fuentes et al., 2017) recognise cultural competence as an abstract and theoretical concept that seems difficult to define and is therefore difficult to teach and understand well (Diallo & McGrath, 2013, p. 122). Moreover, the anthropological criticism that addressed the conceptual background and the implementation of various cultural competence courses (Lipovec Čebron & Huber, 2020) could certainly be expanded to include the instruments measuring cultural competence in healthcare.

In examining the most widely used measuring instruments, Kumaş-Tan et al. (2007, p. 548) identified some underlying assumptions that clearly show how they oversimplify both culture and cultural competence. Based on their findings, the first assumption behind the majority of the instruments is that culture is more or less equivalent to race and ethnicity (Kumaş-Tan et al., 2007, p. 549). Correspondingly, the most common anthropological criticism of cultural competence educational programmes emphasizes that although cultural competence has been expanded beyond its initial definition to include gender, social class, and sexual orientation, in practice, it tends to still be equated with ethnicity and race (Barker & Beagan, 2014; Carpenter-Song et al., 2007; Kleinman & Benson, 2006). Anthropologists warned against such an understanding of culture as it is misleading and fails to effectively address diversity within cultural groups and only reinforces harmful ethnic stereotypes and biases (Lipovec Čebron & Huber, 2020). The second common assumption shaping the instruments that measure cultural competence, pointed out by

Kumaş-Tan et al. (2007, p. 551), is that they tend to equate the cultural with the ethnic and racialised Other while the dominant groups are seen as culture-free. The idea that culture is an attribute possessed only by the "other" race or an ethnic group different from "ours" has also frequently been criticised by anthropologists that evaluated the cultural competence courses. One of the main problems with this focus on the "exotic" cultures of "others" in cultural competence is that it gives health professionals an incentive not to face their own socio-cultural conditionality and reinforces the false assumption that biomedicine is culture-free (Carpenter-Song et al., 2007, p. 1364). Moreover, Kumaş-Tan et al. (2007) found other hidden assumptions in cultural competence instruments that are highly problematic, such as the idea that the main problem of cultural incompetence lies in the practitioners' lack of familiarity with the Other or that the respondents to the questionnaires of these instruments are "white and that the recipients of care are patients from ethnic and racialized minority groups" (p. 554).

c) The Questionable Need to Measure and Quantify Cultural Competence

The last and also less frequent criticism found in the relevant literature is connected to a simple question: why should the cultural competence of health care providers even be measured and/or quantified?

It is clear that behind this enormous quantity of different instruments, tools and scales lies the need to assess the cultural competence of health care providers as well as the urge to evaluate the "effectiveness" of the cultural competence courses and related endeavours. Nevertheless, it seems interesting that researchers in the field focus only on quantitative methods and rarely consider more qualitative approaches – and even when they do, the qualitative approaches are utilised only to supplement quantitative methods (Purnell, 2016, p. 126). It should be noted that cultural competence was introduced into healthcare to address the "softer" side of medicine, specifically to sensibilize health care providers to cultural dimensions of clinical encounters that are difficult to quantify. Despite this being the initial purpose, it seems that different fields of cultural competence underwent drastic transformations once they became part of the healthcare system. As a result, the highly complex, multidimensional and elusive concept of culture was, in a clinical setting, often reduced to a technical skill (Kleinman & Benson, 2006, p. 1673) in order to be concrete and measurable, while at the same time "cultural competence tools became so categorized and rigid that they can be likened to diagnostic criteria one may use to diagnose and manage a disease condition such as pneumonia" (Muaygil, 2018, p. 17). These observations are in line with Tervalon and Murray-Garcia's (1998) statement that:

> in the laudable urgency to implement and evaluate programs that aim to produce cultural competence, one dimension to be avoided is the pitfall of narrowly defining cultural competence in medical training and practice in its traditional sense: an easily demonstrable mastery of a finite body of knowledge, an end point evidenced largely by comparative quantitative assessments (Tervalon & Murray-Garcia, 1998, p. 118).

These authors and a few others suggest exploring different methods for evaluating cultural competence – qualitative and mixed methods such as participant observation, student essays, student or practitioner journals, qualitative interviews or/and open-ended questionnaires (Kumaş-Tan et al., 2007, pp. 549–555). Similar appeals to introduce alternative approaches that will include observations during clinical practice are also present:

> Can evidence of culturally competent practice be seen in the patient's medical record, including assessment data? What about direct observations of professionals while practicing? A literature search for this dialogue did not reveal any articles that addressed all three elements. (Purnell, 2016, p. 126)

The above quote indicates that these kinds of approaches are quite uncommon, since few researchers advocate for a non-quantitative approach in evaluating cultural competence. However, as we shall see in the next section, when evaluating a cultural competence course in Slovenia, we tended to follow this line of reasoning.

EVALUATION OF A CULTURAL COMPETENCE COURSE IN SLOVENIA

In the previous section we have seen that the most common focus of different instruments and tools in the field of cultural competence is to measure health care providers' cultural competence and that these instruments rely predominantly on quantitative methods. As we have tried to show, these evaluating instruments are connected with many methodological weaknesses as well as significant conceptual and epistemological problems. In this section we will briefly present our experiences with the evaluation of the first[6] cultural competence course for healthcare workers in Slovenia, entitled *Developing the Cultural Competences of Healthcare Professionals*. The evaluation process of the course tried to avoid the limitations of previously adopted approaches abroad: instead of measuring the individual providers' cultural competence, the evaluation focused on the educator performances as well as the impact of the cultural competence course on the participants as a group and not as individuals. Moreover, instead of exclusively relying on quantitative methods, the evaluation process was based on a mixed methods approach and therefore combined quantitative and qualitative methods.

The cultural competence course in Slovenia was a 20-hour course carried out during 2018 and 2019[7] by an interdisciplinary team of experts[8] in 13 cycles that were held in different

6 Several other training courses were organised later, but they were shorter and non-continual. One such example was a training course entitled *A Patient Doesn't Speak Slovenian! A Challenge for Healthcare Professionals in Slovenia*, held in 2017, which also included themes from the field of cultural competence (more at: http://multilingualhealth.ff.uni-lj.si/). Another related educational training course was *Cultural Competence, Doctor–Patient Communication, and Minority Health*, which took place in 2018 as a summer school.

7 The course was piloted in 2016 for 41 healthcare professionals in three healthcare centres as part of the project *Towards Better Health* and *Reducing Inequalities in Health – Together for Health*, coordinated by the National Institute of Public Health.

8 The course was organised by the National Institute of Public Health within the framework of the project *Model Community Approach to Promote Health and Reduce Health Inequalities in Local Communities*

Slovenian cities and attended by 485 healthcare workers and other professionals working in primary-level health care. The course consisted of a three-day educational programme organised in the form of interactive lectures that alternated with workshops on a variety of topics[9]. The planning and implementation of this course was a six-year process[10] that was accompanied by many dilemmas, difficulties and attempts to avoid the main pitfalls of previous educational programmes abroad. As these aspects of the cultural competence course have already been analysed elsewhere (Lipovec Čebron et al., 2019; Lipovec Čebron & Huber, 2020), we will here focus only on its evaluation process.

The evaluation of the course comprised of four different approaches: quantitative evaluation questionnaires for the participants, lecturer self-evaluation, participant observation, and open-ended questionnaires at the beginning and at the end of each course. Of the four chosen approaches, only one was quantitative. The decision to combine these approaches was based on experiences with mixed methods research that showed how the strengths of quantitative and qualitative approaches offset the different weaknesses of the two when used together (Brewer & Hunter, 1989). Moreover, we chose the mixed methods approach since we wanted to achieve a more in-depth understanding (Plano Clark et al., 2008, p. 365) of the course by capturing the perspectives of both lecturers and participants. In the following pages we will briefly present each evaluation approach (see Figure 1) without analysing the gathered evaluation results as they are not the focus of this article and have already been partially published elsewhere (Lipovec Čebron et al., 2019; Lipovec Čebron & Huber, 2020).

As already emphasized, the only part of the evaluation that was based on quantitative methods was the evaluation questionnaire for the participants filled in at the end of each day; they were asked to assess each lecture on a five-point Likert-type scale (1 – very poor; 2 – poor; 3 – good; 4 – very good; 5 – excellent) and also used the scale to express their satisfaction with the content, evaluate the perceived usefulness of the topics presented and the organisational aspect of each particular day of the course (for more, see Lipovec Čebron & Huber, 2020).

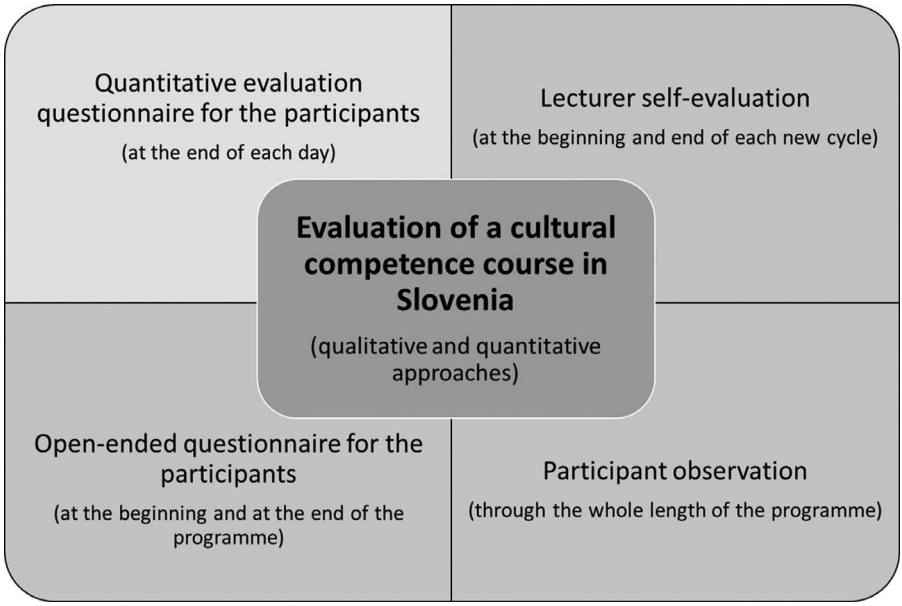
The other three approaches were qualitative. Lecturer self-evaluation took place at the beginning and end of each new cycle in the form of self-reflective notes, which were forwarded to the coordinators of the educational programme. These notes were of various lengths and quality, and they focused on several different issues: some considered the

(MoST). More about the MoST project is available at https://www.nijz.si/sl/most-model-skupnostnega-pristopa-za-krepitev-zdravja-in-zmanjsevanje-neenakosti-v-zdravju-v-lokalnih.

9 The title of the first day of the programme was *Why are cultural competences important?* The second day held the title *Different culture and health dimensions in the context of the preventive and promotion in healthcare*, and the third day was entitled *Socio-economic impact on health and culture, with a special focus on vulnerabilities and violence*.

10 The authors of this article were members of the interdisciplinary work group that was responsible for the planning, content design and implementation of this educational programme, *Developing the Cultural Competences of Healthcare Professionals.*

Figure 1
Evaluation of the Educational Programme in Slovenia



advantages and disadvantages at the organisational level, others discussed the reactions of the participants to particular topics or provided positive and negative criticism of various parts of the course. Similar information was provided at the self-evaluation meeting of all the lecturers held at the end of the last educational cycle.

The third method used was participant observation, which was conducted throughout the entire duration of the programme. An individual who was not a participant or lecturer[11] was present every day, participated in all of the educational activities and made notes about the educational process.[12] At the end of the course, he or she summarised the notes into a report and forwarded it to the coordinators. These reports were longer and more systematic than the lecturers' self-evaluations, and were of various depths: some of them illustrate mostly external facts, while the majority of the reports provided in-depth descriptions of many aspects of the educational process.

The last form of evaluation was the anonymous open-ended questionnaire presented to the participants at the beginning and at the end of the programme. The participants had 15 minutes to answer three questions: *What do you understand under the term cultural competence? How do you imagine intercultural mediation in your work? How do you at your work adapt to the needs of vulnerable individuals in your environment?* The same

11 This was usually a master's student of ethnology and cultural anthropology or a National Institute of Public Health employee.

12 All the participants' names and personal information were anonymised on the spot.

questions were asked at the end of the programme in order to understand to what extent the group comprehended and internalised the three key topics of the educational programme.

Based on the experiences with combining these four different approaches, we can deduce that their complementarity was essential for the evaluation process. Similarly to other researchers in this field (Košmerl, 2021; Plano Clark et al., 2008), we can assume that the value of the mixed methods approach arises from the different perspectives that can be included by combining quantitative and qualitative methods, while "researchers may obtain stronger, more corroborated conclusions when the results are derived from two different types of data instead of only a single type" (Plano Clark et al., 2008, p. 366). Namely, the results derived from the quantitative questionnaire offered the coordinators and lecturers immediate and clear information which was convenient as a start, but acquired meaning and usefulness only when compared and interpreted together with the results of other evaluation methods. For example, when a lecturer would receive a low rating for a particular workshop, the quantitative questionnaire could not provide the reason for the rating and, therefore, the workshop could not be successfully improved in the future. Only reading the participant observation report usually enabled the lecturers to fully understand the ratings of their performance. Similar advantages were observed in other aspects of the educational process measured using the quantitative questionnaire: from general satisfaction with the contents of the educational programme to the evaluation of the perceived usefulness of the presented curricula and the organisational aspect of each particular day of the course. The results of the quantitative questionnaire provided useful but one-dimensional and superficial information that needed to be further contextualised to understand the outcome. This necessary information was provided with the help of the three qualitative methods used. Furthermore, they offered new insights and brought up questions that were not covered or even considered in the quantitative questionnaire.

However, it is important to emphasize that we do not want to claim that the evaluation process was without its flaws. Like other mixed methods research (Plano Clark et al., 2008) our evaluation process also required considerable time, since the analysis of the qualitative approaches results was lengthy and therefore available only several weeks after the end of the course. Nonetheless, the key weakness of the evaluation process was that it excluded the evaluation of the impact of the educational programme on health care in practice. Like most evaluation instruments used abroad (see Purnell, 2016, p. 126), it never stepped outside the lecture room into the field of everyday practice in healthcare facilities, where the concrete influence of the programme could be observed. Therefore, it excluded the very subject that cultural competence in healthcare was meant for – the user.

CONCLUSION

Despite decades of remarkable growth in the importance of cultural competence in healthcare and an immense number of various quantitative instruments, tools or scales that measure the cultural competence of health care providers, it is surprising that few

researchers engage in the critical examination of these instruments. As Kumaş-Tan et al. (2007) concluded:

> As we educators in the health professions develop and implement cultural competence training, we face the question of how to evaluate these initiatives. This is largely because of present difficulties in measuring cultural competence. Unfortunately, the literature provides little guidance. (p. 548)

Precisely because of the obvious lack of critical reflection into evaluating cultural competence in healthcare, we found it crucial to present the most commonly used evaluation approaches – all of which are almost exclusively based on quantitative methods and associated measuring instruments. As we tried to show in the previous sections, these measuring instruments are connected with methodological weaknesses as well as significant conceptual and epistemological problems, including ones that concern the validity and reliability of these instruments, problematic theoretical concepts and assumptions behind these instruments, as well as the questionable need to measure and quantify cultural competence in healthcare.

Considering these shortcomings of the majority of measuring instruments, we tried to forgo them in evaluating the first cultural competence educational programme for healthcare workers in Slovenia. Instead of exclusively relying on quantitative methods, the evaluation process was based on the mixed methods approach, using quantitative as well as qualitative methods. The evaluation comprised of four different approaches: quantitative evaluation questionnaires for the participants, lecturer self-evaluation, participant observation, and open-ended questionnaires for the participants at the beginning and at the end of each course. Of the four chosen approaches, only one was quantitative. Based on the weaknesses of the evaluations of such educational programmes abroad and instead of measuring the individual providers' cultural competence, as is the usual approach in the majority of the currently existing quantitative measuring instruments, we chose to focus on the evaluation of the lecturers' performances as well as the "effect" the cultural competence course had on the participants as a group and not as a single individual.

Although we successfully avoided some previously detected weaknesses, we instead faced other issues, among them the lengthiness of the evaluation process and the fact that the process did not include the evaluation of the impact the educational programme had on health care in practice or the perspective of healthcare users.

Finally, considering that some propositions to create quantitative instruments to measure the cultural competence of healthcare workers have recently emerged in Slovenia (Ličen et al., 2017; Razlag Kolar et al., 2019; Sotler, 2016), we want to emphasize that – taking into account our multi-year process of planning, organising, and evaluating a cultural competence programme – we strongly advise against it. Instead, we propose the use of qualitative or mixed methods. We also suggest avoiding the evaluation of the cultural competence of an individual health care provider and instead focusing on the evaluation

of educator performances, patient and client perspectives, service outcomes and organisational competence (Kumaş-Tan et al., 2007, p. 549); in fact, focusing on healthcare institutions as a whole seems to be the most promising direction of all.

REFERENCES

Babnik, K., & Šavle, M. (2014). Kulturna raznolikost: Komunikacija s pacienti iz različnih etničnih, kulturnih in jezikovnih okolij. In T. Štemberger Kolnik, D. Ravnik, K. Babnik, & M. Bulič (Eds.), *Zdravstvena nega v javnem zdravju: Druga znanstvena konferenca z mednarodno udeležbo: Zbornik prispevkov* (str. 153–159). Založba Univerze na Primorskem.

Baghadi, A. N., & Ismaile, S. (2018). Cultural competency of nursing faculty teaching in baccalaureate nursing programs in the United States. *Australasian Medical Journal, 11*(2), 126–134. https://doi.org/10.21767/AMJ.2018.3335

Barker, K., & Beagan, B. (2014). Making assumptions, making space: An anthropological critique of cultural competency and its relevance for queer patients. *Medical Anthropology Quarterly, 28*(4), 578–598. https://doi.org/10.1111/maq.12129

Battle, A. (2012). Can cultural competence have an impact on health disparities? In S. R. Notaro (Ed.), *Advances in Education in Diverse Communities: Research policy and Praxis: Vol. 9. Health Disparities Among Under-Served Populations: Implications for Research, policy and praxis* (pp. 263–276). https://doi.org/10.1108/S1479-358X(2012)0000009016

Beach, M. C., Price, E. G., Gary, T. L., Robinson, K. A., Gozu, A., Palacio, A., Smarth, C., Jenckes, M. W., Feuerstein, C., Bass, E. B., Powe, N. R., & Cooper, L. A. (2005). Cultural competence: A systematic review of health care provider educational interventions. *Medical Care, 43*(4), 356–373. https://doi.org/10.1097/01.mlr.0000156861.58905.96

Betancourt, J. R. (2006). *Improving quality and achieving equity: The role of cultural competence in reducing racial and ethnic disparities in health care*. Commonwealth Fund.

Betancourt, J. R., Green, A. R., Carrillo, J. E., & Ananeh-Firempong II, O. (2003). Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Reports 118*(4), 293–302. https://doi.org/10.1093/phr/118.4.293

Bhui, K., Warfa, N., Edonya, P., McKenzie, K., & Bhugra, D. (2007). Cultural competence in mental health care: A review of model evaluations. *BMC Health Services Research, 7,* 15. https://doi.org/10.1186/1472-6963-7-15

Brewer, J., & Hunter, A. (1989). *Multimethod research: A synthesis of styles.* Sage.

Cai, D. Y. (2016). A concept analysis of cultural competence. *International Journal of Nursing Sciences, 3*(3), 268–273. https://doi.org/10.1016/j.ijnss.2016.08.002

Campinha-Bacote, J. (1996). A culturally competent model of nursing management. *Surgical Service Management, 2*(5), 22–25.

Campinha-Bacote, J. (1998). *The process of cultural competence in the delivery of healthcare services*. Transcultural C.A.R.E. Associates.

Campinha-Bacote, J. (1999). A model and instrument for addressing cultural competence in health care. *The Journal of Nursing Education*, 38(5), 203–207.

Campinha-Bacote, J. (2002). The process of cultural competence in the delivery of healthcare services: A model of care. *Journal of Transcultural Nursing,* 13(3), 181–184. https://doi.org/10.1177/10459602013003003

Carpenter-Song, E. A., Nordquest Schwallie, M., & Longhofer, J. (2007). Cultural competence reexamined: Critique and directions for the future. *Psychiatric Services, 58*(10), 1362–1365. https://doi.org/10.1176/ps.2007.58.10.1362

Chae, D. H., & Lee, C. Y. (2014). Development and psychometric evaluation of the Korean version of the cultural competence scale for clinical nurses. *Asian Nursing Research, 8*(4), 305–312. https://doi.org/10.1016/j.anr.2014.06.004

Diallo, A. F., & McGrath, J. M. (2013). A glance at the future of cultural competency in healthcare. *Newborn & Infant Nursing Reviews, 13*(3), 121–123. https://doi.org/10.1053/j.nainr.2013.07.003

Eche, I. J., & Aronowitz, T. (2017). Evaluating cultural competence of pediatric oncology nurses at a teaching hospital: A pilot study. *Journal of Pediatric Oncology Nursing*, *34*(6), 1–5. https://doi.org/10.1177/1043454217713452

Gunaratnam, Y. (2007). Intercultural palliative care: Do we need cultural competence? *International Journal of Palliative Nursing, 13*(10), 470–477. https://doi.org/10.12968/ijpn.2007.13.10.27477

Halbwachs, K. (2019). Samozavedanje in kritična refleksija v modelih kulturne kompetentnosti v zdravstvu. In B. Filej & B. M. Kaučič (Eds.), *Medkulturna oskrba v zdravstvu* (pp. 51–64). Visoka zdravstvena šola v Celju.

Jeffreys, M. R. (2000). Development and psychometric evaluation of the trans-cultural self-efficicacy tool: A synthesis of findings. *Journal of Transcultural nursing, 11*(2), 127–136. https://doi.org/10.1177/104365960001100207

Jenks, A. C. (2011). From 'lists of traits' to 'open-mindedness': Emerging issues in cultural competence education. *Culture, Medicine, and Psychiatry, 35*(2), 209–235. https://doi.org/10.1007/s11013-011-9212-4

Kirmayer, J. L., Rousseau, C., Jarvis, G. C., & Guzder, J. (2008). The cultural context of clinical assessment. In A. Tasman, J. Kay, J. A. Lieberman, M. B. First, & M. Majeds (Eds.), *Psychiatry* (3rd ed., Vol. 1, pp. 55–65). Wiley. https://doi.org/10.1002/9780470515167.ch4

Kleinman, A., & Benson, P. (2006). Anthropology in the clinic: The problem of cultural competency and how to fix it. *PLOS Medicine, 3*(10), 1673–1676. https://doi.org/10.1371/journal.pmed.0030294

Košmerl, T. (2021). Kombinirani raziskovalni pristopi kot način združevanja kvalitativnih in kvantitativnih metod. *Sodobna pedagogika*, *72*(1), 88–107.

Kumaş-Tan, Z, Beagan, B., Loppie, C., MacLeod, A., & Frank, B. (2007). Measures of cultural competence: Examining hidden assumptions. *Academic Medicine,* 82(6), 548–557. https://doi.org/10.1097/ACM.0b013e3180555a2d

Ličen, S., Karnjuš, I., & Prosen, M. (2017). Ensuring equality through the acquisition of cultural competence in nursing education: A systematic literature review. In A. Petelin, N. Šarabon, & B. Žvanut (Eds.), *Health of the working-age population* (pp. 113–121). University of Primorska Press.

Lipovec Čebron, U. (2017). Ko nujno postane nenujno: Raziskovanje zdravstvenih vidikov migracij v Sloveniji. *Glasnik Slovenskega etnološkega društva,* 57(1–2), 54–64.

Lipovec Čebron, U. (2020). Jezikovne in kulturne ovire v zdravstvenih ustanovah. In I. Huber, U. Lipovec Čebron, & S. Pistotnik (Eds.), *Neenakosti in ranljivosti v zdravju v Sloveniji: Kvalitativna raziskava v 25 okoljih* (pp. 120–140). Nacionalni inštitut za javno zdravje.

Lipovec Čebron, U., & Huber, I. (2020). Cultural competence and healthcare: Experiences from Slovenia. *Etnološka tribina*, *50*(43), 68–88. https://doi.org/10.15378/1848-9540.2020.43.02

Lipovec Čebron, U., Pistotnik, S., Farkaš-Lainščak, J., & Huber, I. (2019). Medkulturne kompetence in zdravstvena oskrba v Sloveniji. In B. Filej & B. M. Kaučič (Eds.), *Medkulturna oskrba v zdravstvu* (pp. 35–49). Visoka zdravstvena šola v Celju.

Martínez, G. (2010). Language and power in healthcare: Towards a theory of language barriers among linguistic minorities in the United States. In J. L. Watzke, P. C. Miller, & M. Mantero (Eds.), *Readings in Language Studies: Language and Power 2* (pp. 59–74). International Society for Language Studies.

Muaygil, R. A. (2018). From paternalistic to patronizing: How cultural competence can be ethically problematic. *HEC Forum, 30*(1), 13–29. https://doi.org/10.1007/s10730-017-9336-1

Napier, D., Anca, C., Butler, B., Calabrese, J., Chater, A., Chatterjee, H., Guesnet, F., Horne, R., Jacyna, S., Jadhav, S., Macdonald, A., Neuendorf, U., Parkhurst, A., Reynolds, R., Scambler, G., Shamdasani, S., Zafer Smith, S., Stougaard-Nielsen, J., Thomson, L., … Woolf, K. (2014). Culture and Health. *The Lancet, 384*(9954), 1607–1639. https://doi.org/10.1016/S0140-6736(14)61603-2

Office of Minority Health. (2001). *National standards for culturally and linguistically appropriate services in health care: Final report*. US Department of Health and Human Services.

Perng, S. J., & Watson, R. (2012). Construct validation of the nurse cultural competence scale: A hierarchy of abilities. *Journal of clinical nursing*, *21*(11–12), 1678–1684. https://doi.org/10.1111/j.1365-2702.2011.03933.x

Plano Clark, V. L., Creswell, J. W., O´Neil Green, D., & Shope, R. J. (2008). Mixing quantitative and qualitative approaches: An introduction to emergent mixed methods research. In S. N. Hesse-Biber & P. Leavy (Eds.), *Handbook of Emergent Methods* (pp. 363–387). The Guilford Press.

Pulido-Fuentes, M., González, L. A., Vieira Martins, M. F., & Flores Martos, J. A. (2017). Health competence from a transcultural perspective: Knowing how to approach transcultural care. *Procedia – Social and Behavioral Sciences, 237*(21), 365–372. https://doi.org/10.1016/j.sbspro.2017.02.022

Purnell, L. (2016). Are we really measuring cultural competence? *Nursing Science Quarterly, 29*(2), 124–127. https://doi.org/10.1177/0894318416630100

Razlag Kolar, T., Filej, B., & Kaučič, B. M. (2019). Pomen kulturne kompetentnosti medicinskih sester za kakovostno in k pacientu usmerjeno zdravstveno nego in oskrbo. In B. Filej & B. M. Kaučič (Eds.), *Medkulturna oskrba v zdravstvu* (pp. 75–95). Visoka zdravstvena šola v Celju.

Schim, S. M., & Doorenbos, A. Z. (2010). A three-dimensional model of cultural congruence: Framework for intervention. *Journal of Social Work in End-of-Life & Palliative Care*, *6*(3–4), 256–270. https://doi.org/10.1080/15524256.2010.529023

Schim, S. M., Doorenbos, A., Miller, J., & Benkert, R. (2003). Development of a cultural competence assessment instruments. *Journal of Nursing Measurment, 11*(1), 29–40. https://doi.org/10.1891/jnum.11.1.29.52062

Schouler-Ocak, M., Graef-Calliess, I., Tarricone, I., Qureshi, A., Kastrup, M. C., & Bhugra, D. (2015). EPA guidance on cultural competence training. *European Psychiatry, 30*(3), 431–440. https://doi.org/10.1016/j.eurpsy.2015.01.012

Shoa-Jen, P., & Watson, R. (2012). Construct validation of the Nurse cultural competence scale: A hierarchy of abilities. *Journal of Clinical Nursing, 21*(11–12), 1678–1684. https://doi.org/10.1111/j.1365-2702.2011.03933.x

Smedley, A., Stith, J, & Nelson, A. R. (Eds.). (2003). *Unequal treatment confronting racial and ethnic disparities in health care.* The National Academies Press. https://doi.org/10.17226/12875

Sotler, R. (2016). Merjenje kulturnih kompetenc v zdravstvu - uporabnost in zanesljivost. In D. Velikonja Kregar (Ed.), *Celostna obravnava pacienta: Zbornik prispevkov: Mednarodna znanstvena konferenca* (pp. 74–75). Fakulteta za zdravstvene vede Novo mesto.

Suh, E. E. (2004). The model of cultural competence through an evolutionary concept analysis. *Journal of Transcultural Nursing, 15*(2), 93–102. https://doi.org/10.1177/1043659603262488

Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved, 9*(2),117–125. https://doi.org/10.1353/hpu.2010.0233

Tulman, L., & Watts, R. J. (2008). Development and testing of the blueprint for integration of cultural competence in the curriculum questionnaire. *Journal of Professional Nursing, 24*(3), 161–166. https://doi.org/10.1016/j.profnurs.2008.01.006

Willen, S. S., Bullon, A., & Good, M.-J. D. (2010). Opening up a huge can of worms: Reflections on a "cultural sensitivity" course for psychiatry residents. *Harvard Review of Psychiatry, 18*(4), 247–253. https://doi.org/10.3109/10673229.2010.493748

Wilson, L., & Houghtaling, S. (2001). *Report on a study of cultural competence teaching in California medical and dental schools.* University of California San Francisco.

Andragoška spoznanja/Studies in Adult Education and Learning, 2021, 27(2), 141-146
DOI: https://doi.org/10.4312/as/10422 Poročila, odmevi, ocene

PEDAGOŠKO-ANDRAGOŠKI DNEVI 2021

Pedagoško-andragoške dneve (PAD) smo v letu 2021 na Oddelku za pedagogiko in andragogiko Filozofske fakultete Univerze v Ljubljani organizirali nekoliko kasneje, ne v januarju, temveč v septembru. Vzrok za zamik je bila pandemija covida-19, saj dogodka v januarju nismo mogli izpeljali v živo, medtem ko nam je septembra to vendarle uspelo. Organizacijski odbor PAD 2021 smo sestavljali: dr. Monika Govekar-Okoliš – predsednica ter člani Nina Breznikar, dr. Matej Urbančič in dr. Marko Radovan. Programski odbor pa so poleg dr. Monike Govekar-Okoliš sestavljali dr. Jana Kalin, dr. Nives Ličen in dr. Marjeta Šarić. PAD 2021 je vključeval pet plenarnih predavanj, tri vzporedne diskusijske skupine, v katerih so potekale predstavitve primerov dobrih praks, in fotografsko razstavo na Filozofski fakulteti. Letošnja novost PAD 2021 je bil tudi predkonferenčni dogodek, Študentski PAD (šPAD). Študentje Oddelka za pedagogiko in andragogiko so v sredo, 15. septembra 2021, prvič izvedli *Študentski pedagoško-andragoški dan.* Predstavili so šest raziskovalnih in seminarskih nalog o raznolikih temah (šolskem svetovalnem delu, učenju odraslih z motnjo v duševnem razvoju, transformativnem učenju ob žalovanju, izobraževanju zaporniških delavcev, izobraževanju odraslih o zborovskem petju ter predkarierenem razvoju). Temu je sledila skupinska diskusijska delavnica. Za zaključek pa je bila v popoldanskem času na daljavo organizirana tudi kavarna doktorskih študentov oddelka z gostjo Katjo Lihtenvalner, ki jo je vodila dr. Nives Ličen.

Osrednji del *Pedagoško-andragoških dnevov* pa se je odvil v četrtek, 16. septembra 2021, na Filozofski fakulteti Univerze v Ljubljani (39. izvedba). Naslovna tema srečanja je bila *Inovativna učna okolja in izkušnje iz karantene*. Posebna pozornost se je tokrat namenila razmislekom, kako je pandemija covida-19 vplivala na pedagoge in andragoge ter na njihovo vzgojno-izobraževalno delo. Poskušali smo odgovoriti na vprašanja, ali se je spremenila njihova praksa poklicnega oz. strokovnega delovanja ter kako in koliko so se učili ob izkušnji dela na daljavo. Zanimalo nas je tudi, kako so pedagogi in andragogi doživljali ta čas in kako so se soočali z ovirami (npr. z nezmožnostmi soočanja z nepredvidljivimi težavami, strahom, nizkimi pričakovanji in motivacijo). Eno izmed ključnih vprašanj pa je bilo tudi, ali so spremenjene razmere dela pomembno spodbujale oz. ovirale poklicni razvoj pedagoga in andragoga.

Na začetku PAD sta dekan Filozofske fakultete Univerze v Ljubljani dr. Roman Kuhar in predstojnica Oddelka za pedagogiko in andragogiko dr. Klara Skubic Ermenc v uvodnem nagovoru poudarila pomen PAD in njegovo aktualno tematiko. O formalnostih poteka PAD je spregovorila dr. Monika Govekar-Okoliš, ki je bila moderatorka plenarnega dela predavanj.

Prvo plenarno predavanje sta imeli dr. Jana Kalin in gostujoča predavateljica z Andragoškega centra Slovenije dr. Petra Javrh. Naslov njunega predavanja je bil *Možnosti učenja drug od drugega na delovnem mestu v času pandemije*. Povedali sta, kako se je v času pandemije poklicno življenje učiteljev močno spremenilo, saj so se morali čez noč prilagoditi na poučevanje na daljavo. Ob tem sta poudarili, da je drugačen način dela terjal tudi spremembe v poklicnem usposabljanju učiteljev. Izzivi, ki jih je prinesla epidemija na področju poklicnega razvoja učiteljev, so bili predvsem pomanjkanje znanja o informacijsko-komunikacijski tehnologiji na strani učiteljev, fizična izolacija od kolegov, osebne težave pri spopadanju z epidemijo ter pomanjkanje motivacije za učenje. Ugotovitve raziskave, ki sta jo predstavili, so pokazale, da so ovire pri poklicnem razvoju v času epidemije postavljali tudi nizke predstave o sebi in lastnih zmožnostih za učenje, nizka pričakovanja, nezmožnost soočanja z nepredvidljivimi težavami, strah in izogibanje tveganju. Izpostavili sta tudi, da sta še zlasti med epidemijo covida-19 pomemben dejavnik spodbujanja ali oviranja poklicnega razvoja bili tudi klima in podpora institucije, v kateri je posameznik deloval. Naj ob tem poudarimo spodbudne rezultate raziskave Kalin idr. (2021), v kateri so ravnatelji potrdili, da je kriza strokovne delavce in ravnatelje tesno povezala. V času dela od doma so mnoge strokovne delovne skupine okrepile sodelovanje in učenje drug z drugim ter preizkušanje drugačnih pristopov. S tem so zelo različne praktične probleme dela na daljavo idr. reševale s kolegialnim prenašanjem znanja med seboj. Ključna ugotovitev plenarnega predavanja je bila, da je učenje na delovnem mestu odvisno od treh pogojev: medsebojnega zaupanja, podpore zunaj in znotraj institucije ter izzivov. Prepletanje vseh treh vidikov pa predstavlja način in priložnost učiteljev za poklicno rast z močnim potencialom.

Drugo plenarno predavanje z naslovom *Soočanje učiteljev s čustvenimi izzivi pri delu na daljavo* je imela dr. Marjeta Šarić. S predstavitvijo rezultatov aktualnih študij je postavila v ospredje, kako pomembno je razumevanje in uravnavanje čustvenih odzivov učiteljev med pandemijo. Spremembe v načinu dela so namreč pri učiteljih sprožile različne čustvene odzive, pri čemer pa je soočanje s čustvi odvisno od treh dejavnikov: individualne psihološke perspektive, čustvene fleksibilnosti in socialnokonstruktivistične perspektive. Iz predstavljenih podatkov raziskav je izpeljala načela za uspešno soočanje s čustvi pri delu, pri čemer je poudarila dva ključna vidika: 1) možne vire moči in oblike podpore za ohranjanje temeljnega duševnega ravnotežja ter 2) vlogo skupnosti, znotraj katere se čustva porajajo, prenašajo, uravnavajo in tudi razpustijo. Pri tem je opozorila, da sta pri konstruktivnem soočanju s čustvenimi stresorji ključna elementa soodvisnost in prepletenost obeh vidikov.

Na naslovno vprašanje *Covid-19: zgolj izkušnja ali točka preloma v profesionalnem razvoju učitelja?* je v naslednjem plenarnem predavanju odgovarjala dr. Danijela Makovec Radovan. Predstavila je pomen učiteljevega profesionalnega razvoja in poudarila, kako se učitelj izpopolnjuje na strokovnem področju, kako dopolnjuje svoje pedagoške kompetence in ravnanja ter se pri tem tudi osebnostno spreminja. Povedala je tudi, da je ta proces močno vpet v kulturno in družbeno dogajanje ter da učiteljevega profesionalnega razvoja

ne moremo obravnavati posplošeno, ampak vedno terja individualen pristop. Na profesionalni razvoj pa pomembno vplivajo učiteljeva prepričanja, pričakovanja o svojem poklicu in vlogi, kot tudi pričakovanja, ki jih imajo neposredno do učitelja njegovi učenci, vodstvo šole, sodelavci in starši. To se je še posebej izrazilo med epidemijo covida-19, ko se je bilo treba hitro prilagoditi novim načinom dela, spremembam, doživljanju stisk, nemoči idr. Vse to je vplivalo na delo učiteljev in njihov profesionalni razvoj. Učitelji so ob tem doživeli karierni šok, ki je v njih sprožal vprašanje: Kaj zdaj to pomeni zame kot učitelja? Predavateljica je izpeljala tri nauke, ki se jih lahko naučimo iz obdobja pandemije: 1) odziv posameznika na spremembe v profesionalnem razvoju učitelja je odvisen od prepletanja kontekstualnih in individualnih dejavnikov, pri čemer je ključno tudi širše ozaveščanje o kariernem šoku in kako se z njim spopadati; 2) treba je analizirati kratkoročne in dolgoročne učinke kariernega šoka in 3) negativni karierni šok lahko spodbudi tudi pozitivne izide, saj je omogočil, da so se učitelji hitro odzvali, se učili novih pristopov učenja na daljavo, po šolah pa se je povečalo tudi kolegialno učenje. Glavna ugotovitev plenarnega predavanja je bila, da je bil čas epidemije covida-19 priložnost za razvoj številnih novih znanj. Ob tem je predavateljica poudarila, da bi morala vodstva šol analizirati vse nevralgične točke iz časa epidemije, hkrati pa bi morala tudi država nameniti več sredstev za razvijanje in spodbujanje profesionalnega razvoja učiteljev in za razvoj možnosti kombiniranih oblik dela v šolah, kjer je to seveda možno in smiselno.

Četrto plenarno predavanje z naslovom *Tri pandemične lekcije o vzgoji in izobraževanju* je imel gostujoči predavatelj dr. Tomaž Grušovnik s Pedagoške fakultete Univerze na Primorskem. Kot prvo lekcijo je navedel, da se je z ustavitvijo javnega življenja in vzpostavitvijo šolanja na daljavo pomembnost vzgojno-izobraževalnih institucij v družbi povečala. Širša javnost je namreč šele ob izkušnji šolanja lastnih otrok doma odkrito priznala, kako nepogrešljiv je lik učitelja. Da so vzgojno-izobraževalne institucije pomemben del družbene infrastrukture, se je pokazalo tudi pri zagotavljanju enakih možnosti izobraževanja, saj je bila kakovost šolanja na daljavo zelo odvisna od izobraženosti staršev. Druga lekcija, ki jo je predstavil predavatelj, je bila, da se vloga vzgojno-izobraževalnih institucij ne prepoznava le v prenašanju informacij, temveč predvsem v izgrajevanju ustreznega spoznavnega značaja in krepitvi spoznavnih vrlin pri posamezniku. Slednje je namreč bistveno, da se je posameznik sposoben soočati s svetom lažnih novic, postresničnostjo in teorijami zarot, ki so se v času pandemije še okrepile. Tretja lekcija o vzgoji in izobraževanju v času pandemije pa je povezana s samim izobraževanjem na daljavo. Izkušnje so pokazale, da izobraževanje na daljavo ponuja tudi prednosti, zlasti razvoj novih didaktičnih gradiv, izboljšanje znanja na področju uporabe informacijsko-komunikacijske tehnologije ter povečanje dostopnosti izobraževanja in sodelovanja večjega števila izvajalcev in udeležencev. Opozoril je tudi na poglede določenega segmenta populacije, ki bi se rada vrnila zgolj k t. i. tradicionalnim oblikam učenja in poučevanja. S tem se odpira konflikt na področju vzgoje in izobraževanja, ki bi lahko zaviral uvajanje novih oblik izobraževanja na daljavo, zlasti zaradi pravnoformalnih vidikov, ki urejajo to področje in so nastali pred epidemijo covida-19. Predavatelj je zato še posebej poudaril pomen pedagogike kot znanstvene discipline ter vzgoje in izobraževanja nasploh, ki mora prispevati k formaciji

aktivnega državljana, k razvijanju njegovih osebnih potencialov ter poskrbeti, da bo postal radoveden, pogumen in kritičen posameznik.

Zadnje plenarno predavanje pa je imelo naslov *Vzgoja v času pandemije zahteva izgradnjo inovativnih učnih okolij – primer vzgoje z umetnostjo.* Dr. Robi Kroflič, dr. Petra Štirn Janota in Darja Štirn, obe predavateljici prihajata z Zavoda Petida, so uvodoma izpostavili, kako se je šolanje v času izobraževanja na daljavo spremenilo v obliko usmerjenega učenja na domu, hkrati pa so poudarili, da se je s potezami prosvetne politike krepila tudi negativna podoba mladostnikov v javnem prostoru. Mlade so naslavljali kot skupino neodgovornih ljudi, ki ne upoštevajo zaščitnih ukrepov in prispevajo k širitvi virusa. Opozorili so, da se je premalo pozornosti posvečalo pastem digitaliziranega sveta, zlasti (dez) informacijam. Vse to pa je povzročilo, da je zaznati povečanje socialnih in psihičnih stisk, osamljenosti, (samo)destruktivnega vedenja in celo samomorilnih misli med mladimi. V nadaljevanju predavanja so predstavili projekt SKUM (*Razvijanje sporazumevalnih zmožnosti s kulturno-umetnostno vzgojo*). Prikazali so, kako lahko vzgoja z umetnostjo vzpostavi tesen stik med pedagoškimi delavci, umetniki oz. kulturnimi institucijami in otroki/mladostniki. Opisali so, kako so v vzgojno-izobraževalnih institucijah sodelujoče učitelje in umetnike pozvali, da najdejo načine za nadaljevanje projektov vzgoje z umetnostjo, tematiko projektov pa povežejo s problemi, ki jih otroci/mladostniki med pandemijo doživljajo kot zase najbolj pomembne. Kot izhodišče umetniške komunikacije so izbrali različne načine pripovedovanja in poslušanja zgodb. Izbrane tematike umetniških projektov so poglabljali z refleksijo otrok/mladostnikov o okoliščinah, v katerih so se znašli v času epidemije. Glavni namen je bil, da so poskušali otroke/mladostnike premakniti iz pasivnega položaja v aktivno držo okoljskega aktivizma in upora.

Po končanih plenarnih predavanjih so se udeleženci PAD razdelili v *tri diskusijske skupine*. Prvo skupino z naslovom *Delovno mesto: prostor zaupanja, podpore, izzivov* sta moderirali dr. Jana Kalin in dr. Petra Javrh. Udeleženci so si izmenjali izkušnje iz karantene o podpori in predvsem o izzivih, ki so se v času izobraževanja na daljavo pojavili na delovnem mestu. V skupini so sodelovali tako učitelji in svetovalni delavci iz osnovnih in srednjih šol kot tudi andragogi, izobraževalci odraslih in visokošolski učitelji. V diskusiji se je izkazalo, da je v času dela na daljavo strokovne delavce pestilo več problemov: pomanjkanje motivacije pri delu z učenci, ki imajo učne in vedenjske težave, soočanje z neznanjem pri uporabi različnih spletnih aplikacij in orodij, občutek sramu ob poskusih vzpostavitve zasilne komunikacije z učenci, starši, spoznanje o novem učenju ter uporabi različnih spletnih aplikacij in orodij ter problem pri spretnostih ločevanja delovnega od zasebnega okolja. Pri delu s študenti je bila zelo zahtevna hibridna oblika dela (pol študentov je bilo v predavalnici, pol na daljavo). Skozi čas se je motivacija študentov zmanjšala, saj študenti niso bili več tako aktivni, učitelji pa so se spraševali, kako naj predavajo, da bodo spodbudili študente k sodelovanju. Na drugi strani pa je bilo zaznati tudi podporo med učitelji, kolegi v aktivih, kjer je sodelovalo tudi vodstvo posamezne institucije. V veliko pomoč so bili medsebojno sodelovanje, svetovanje, podpora ter neformalni pogovori v spletnem okolju. Pokazalo se je, kako pomembno je bilo v času dela

od doma znati uravnavati poklicne obveznosti z zasebnim življenjem, kar je bil za mnoge zelo stresen izziv.

Drugo diskusijsko skupino z naslovom *Soočanje s čustvenimi izzivi na delovnem mestu v času pandemije* je moderirala dr. Marjeta Šarić. Namen diskusije je bil povezati obravnavano temo z osebnimi izkušnjami in jih izmenjati v skupini. V nadaljevanju so udeleženci na kratko povzeli osrednje teme diskusije. V ospredju je bilo, kako sta za soočanje s čustvi ob vračanju v »običajne razmere« po obdobju dela od doma potrebna čas in tudi sočutje do sebe, kako je pomembno zavedanje, da morda nismo enako produktivni ali hitri pri delu, kot smo bili vajeni od doma. To spoznanje nam lahko pomaga razumeti učence, dijake in študente ter se bolj senzitivno odzvati v odnosu do njih. Tudi oni potrebujejo čas, potrpežljivost in podporo, ko se vračajo v učilnice in predavalnice. Ugotovitev skupine je bila, da je s tem, ko je učitelj dovzeten za lastno ranljivost, lahko bolj odprt in dovzeten tudi za potrebe drugih. Poudarjena je bila Gogalova misel o učitelju kot človeku in da je njegovo ključno orodje prav njegova osebnost. To seveda vključuje vse razsežnosti, vključno z zavedanjem lastnega čustvenega dogajanja. Ob koncu razprave so se udeleženci dotaknili tudi vprašanja proaktivnosti pedagoga in andragoga v raziskovanju čustvenega doživljanja v kontekstu lastnega pedagoškega/andragoškega dela.

Tretjo skupino z naslovom *Vzgoja v času pandemije zahteva izgradnjo inovativnih učnih okolij – primer vzgoje z umetnostjo* je moderiral dr. Robi Kroflič. V okviru diskusijske delavnice so besedo dobile pedagoginje in pedagogi z različnih vzgojno-izobraževalnih institucij, ki so z otroki in mladostniki tudi v času šolanja na daljavo izvajali dejavnosti vzgoje z umetnostjo. Primere dobre prakse so predstavili predstavniki iz Dijaškega doma Ivana Cankarja, Srednje zdravstvene šole Slovenj Gradec in Gimnazije Ljutomer. Vse te vzgojno-izobraževalne institucije so tudi del projekta SKUM. Udeleženci diskusijske skupine so se strinjali, da so tovrstni projekti v šolski praksi vsekakor dobrodošli, a hkrati poudarili, da se lahko učitelj avtonomno odloča in v okviru svojega predmeta vsebine poveže z aktualnimi dogajanji v družbi ter s tem spodbuja aktivno in kritično državljansko držo posameznika.

PAD 2021 se je sklenil s fotografsko razstavo Mateja Peljhana z naslovom *Covid-19: misliti z umetnostjo* v galeriji Peti štuk v petem nadstropju Filozofske fakultete. Razstava je na ogled od 14. septembra do 14. oktobra 2021. Fotograf Matej Peljhan je po poklicu klinični psiholog in je v okviru razstave prikazal različne probleme, vprašanja, dileme in strahove, s katerimi smo se srečevali v času pandemije covida-19. S pomočjo svojih družinskih članov in različnimi domačimi pripomočki je ustvaril zanimive fotografije, ki opisujejo doživljanje pandemije covida-19.

Sklenemo lahko, da je imel čas pandemije covida-19 močan vpliv na vse pedagoge in andragoge. Izmenjava teoretičnih pogledov in ugotovitev iz raziskav, ki smo jih v okviru diskusijskih skupin dopolnili še s primeri iz prakse, je pokazala, da prav nihče ni ostal ravnodušen. V ospredje so bili postavljeni različni problemi na štirih ravneh:

- *osebni problemi* (način doživljanja sebe znotraj osebne psihološke perspektive, soočanje z različnimi ovirami: nizke predstave o sebi in zmožnostih za učenje, nizka pričakovanja, nezmožnost soočanja z nepredvidljivimi težavami, strah in izogibanje tveganju idr.),
- *situacijski problemi* (način dela oz. vzgoje in izobraževanja na daljavo, težave pri spretnosti ločevanja delovnega od zasebnega okolja idr.),
- *širši institucionalni problemi* (s perspektive socialne konstrukcije, povezovanja s kolegi, vodstvom institucije),
- *družbeni problemi* (pod vplivom ustavljenega javnega življenja in soočanja s postresničnostjo, lažnimi novicami in teorijami zarot).

Izkazalo se je, kako aktualna in pomembna je bila tematika letošnjih PAD, saj smo lahko tako kritično osvetlili in razmislili, kako smo v formalnem in neformalnem izobraževanju z otroki, mladimi in odraslimi učenci doživljali to obdobje, kaj smo se iz tega obdobja lahko naučili in kaj je smiselno ohraniti tudi, ko se bosta življenje in delo dokončno vrnili v ustaljene tirnice. Gotovo pa je bil spremenjen način dela priložnost za razvoj spretnosti poučevanja na daljavo in za pridobitev širših informacijsko-komunikacijskih spretnosti.

Hkrati smo ugotovili, da je nujen tudi nadaljnji razmislek o okrepitvi izobraževalnega in emancipatornega potenciala informacijsko-komunikacijske tehnologije v izobraževanju. Smiselno je, da bi vodstva šol in izobraževalnih institucij čimprej analizirala nevralgične točke iz časa epidemije covida-19 in si postavila nove cilje ter tako prispevala k dvigu kakovosti vzgoje in izobraževanja. Pri tem bi tudi država morala nameniti več sredstev za usposabljanje učiteljev in za razvoj možnosti kombiniranih oblik dela v šolah in drugih izobraževalnih institucijah (tudi za odrasle), kjer je to seveda možno in smiselno.

Izkušnja covida-19 nas je pretresla, hkrati pa opogumila in obogatila v zavedanju, da je pomembna motivacija vseh za vseživljenjsko učenje in izobraževanje zlasti na področju informacijsko- komunikacijske tehnologije. Zavedamo se, da so za razvoj kariere pedagogov in andragogov pomembni prav medsebojno zaupanje, kolegialna podpora drug drugemu ter prava mera strokovnih izzivov, ki vodijo v kakovostnejši osebni in profesionalni razvoj, s tem pa v kakovostnejšo vzgojo in izobraževanje.

Monika Govekar-Okoliš in Nina Breznikar