Exploring Effects of Institutional Care on the Life of Elderly: The Case of Mekedonia Humanitarian Association

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This is to certify that the thesis prepared by Eskedar Sibuh, entitled *" Effects of institutional care on the life of elderly: The case of Mekedonia Humanitarian Association*" submitted in partial fulfillment of the requirements for the degree of Masters of Social Work compiles with the regulations of the University and meets the accepted standards with respect to originality and quality.

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Acronyms

AAU- Addis Ababa University

AU – Africa Union

E.C – Ethiopian Calendar

G.C – Gregorian Calendar

HIV/AIDS – Human Immuno Virus/Acquired Immuno Deficiency Syndrome

IFSW – International Federation of Social Work

KICCE – Kaliti Institutional Care Center for the Elderly

MHA – Mekedonia Humanitarian Association

MOLSA – Ministry of Labor and Social Affairs

NASSW – National Association of School of Social Work

NPOAOP – National Plan of Action on Older Persons

QoL – Quality of Life

UN – United Nations

WGEA – Working Group on Elder Abuse

WHO – World Health Organization

Abstract

This study assesses the effects of institutional care on the life of older persons in Mekedonia Humanitarian Association (MHA). Effects of institutional care on economic, social, spiritual, psychological and health conditions of care recipients are examined. Older persons and staffs of Mekedonia Humanitarian Association (MHA) were participated in the study. The total number of participants in the in-depth interview was 10 from those who receive care and 5 from staffs of MHA. Qualitative method with case study design was employed. The researcher used in-depth interview, observation and document analysis as tools to collect data. In analyzing data, the researcher used three procedures that are organizing, summarizing and interpreting the data. The collected data were organized and analyzed through qualitative research approach. Out of the ten care recipients, eight of them are satisfied by the services given in MHA whereas two of them are not .They feel as if they are dependent on others to satisfy their needs and wants and this leads them to a feeling of depression. The study has a great implication for social work practice in the area of policy formulation, advocacy, community mobilization, empowerment, service provision, assessment and research in the areas of institutional care for older persons.

Key words: Institutional Care, Elderly or older persons, Ageing, Social life, Economic status, Psychological well being, Spiritual life and Health status

CHAPTER ONE

1.1 Introduction

Most developed countries have accepted the chronological age of 65 as a definition of 'elderly' or older person. The term 'elderly' or older person has different meaning in different countries; it is mainly explained and is related to chronological age, functional age as well as retirement age. According to the UN definition, older persons are those people whose age are 60 years and over. The definition has gained acceptance in Ethiopian context as it coincides with the countries official retirement age.

Population aging is now a worldwide phenomenon. United Nations projections indicate that both developed and developing regions will face notable increases in the proportions that will be above age 60 in the next 45 years and that, within this older segment, the proportions above age 80 will increase rapidly (United Nations, 2003). For example, in the more developed regions, the proportion of the population 60 years or older is estimated to advance from 19 percent to 32 percent between 2000 and 2050, with those 80 years and older constituting better than one out of four of the elderly at the future date. For the developing regions, the comparable growth in the percentage of those 60 and older is from 8 percent to 20 percent, with those 80 and older growing to one-out-of six elderly. This unprecedented demographic shift has potentially adverse affects on socioeconomic development and the well-being of the older population, and these consequences of population aging have received increasing scrutiny in recent years (The World Bank, 1994; United Nations, 2004; Organization for Economic Co-operation and Development, 1998).

Among many older industrialized countries these trends have been in evidence for some years, but for many developing regions this is a relatively new phenomenon and gives rise to a somewhat different set of concerns. Among these is the fact that many of these countries are experiencing rapid population aging at lower levels of socioeconomic development than the currently industrialized nations. As a result, they may face a more limited range of societal responses to a situation where the future

elderly have smaller size networks while ongoing social trends such as increased education and migration have disrupted their traditional sources of support. The population aged 60 or over is growing at a faster rate than the total population in almost all world regions. Globally, the population aged 80 years or over is growing faster than any younger age group within the older population. The population of centenarians, those aged 100 years or over is growing fastest (United Nations, 2003).

Due to urbanization, industrial developments, the advance in science and technology, and modern way of life people are nowadays able to live longer. Various studies and reports verify that the number of older persons in the world is growing at unprecedented rate. In Ethiopia, due to serious shortage of data, it is difficult to provide detailed analysis of older persons. Nowadays, older persons are encountered with various problems which eventually expose them to begging due to absence of the necessary family and community support. Hence, it is common to see that older persons who have the knowledge and the skill to help not only themselves but others are facing serious problems and resort to begging (United Nations, 2003).

Mekedonia Humanitarian Association (MHA) is an indigenous non-governmental, non-profit and independent organization founded on 07 January 2010. The humanitarian service was started with 40 care recipients and 10 volunteers. By now, the institution holds around 750 care recipients and over 170 volunteers. The number of both older persons and volunteers are growing exponentially. The organization is an Ethiopian Resident Charity under the legal supervision of the Ethiopian Federal Government Charities and Societies Agency and headquartered in Addis Ababa, Ethiopia.

MHA is dedicated to providing housing, clothing, food, counseling, information and other necessities to elderly and people with disabilities. In pursuit of its mission, MHA focuses on the most vulnerable and disadvantaged elder people and those with disabilities to meet their priority social agendas and supports them by using varied approaches and strategies.

MHA envisions Ethiopia where all the elderly people and those with disabilities have access and equal opportunities to basics in life. The ultimate goal of MHA is to enable the elderly people and those with disabilities to lead overall better life by tackling exclusion problems and providing services they need in association with Governmental and non-governmental organizations.

Fundraising and other activities are organized and carried out with the help of volunteers. Members and non-members can be engaged at different stages by contacting the lead staff of the organization. Membership is open to all Ethiopians and non-Ethiopians who share the vision of MHA. In addition to the regular financial contribution (fees) that members make, they are expected to attend the meetings/assemblies of MHA and to promote the achievement of the objectives through active participation and engagement.

As I had observed, MHA is located around Kotebe at a special place called 'bireta bire't and it has five campuses. Of these five campuses one is used as a store. The other four are used as a dormitory for older persons and mentally disabled people and other supporting purposes. There is medium clinic inside the center in which medical services are rendered. As it is explained in the interview, the health services are carried by professional volunteers. If there are critical cases, patients are referred to some governmental hospitals in line with established agreement with the care centre. Care recipients are gathered from streets of Addis Ababa and other parts of the country who are elderly and mentally disabled people. The elderly and mentally disabled people reside on separate rooms. Most services are provided by professional volunteers. The Motto of the institution is' it is enough to be human to help human being''. The main financial sources for the institution are donors, income from ceremony of wedding, birthdays, money collected from boxes displayed in public and so on. Some elderly are engaged in income generating activities like handicrafts. Recently, Addis Ababa city administration gave 30,000m^2 land and the institution plans to accommodate 3000 care recipients. Assessing the effects of institutional care is important to design intervention plan for the life of elderly.

1.2 Statement of the problem

Older persons in Ethiopia are traditionally supported by the extended family system (MOLSA, 2006). However, due to rapid growth of cities and the emergence of complexities associated with social, economic and cultural changes, the family in Ethiopia is changing. Although family ties are still vital in rural Ethiopia, industrialization, migration, education and modernization are playing a big role in transforming the structure of extended family system into nuclear families in the cities. The traditional extended family, which is gradually changing to the nuclear one, is losing its strength to support the vulnerable sector of the society including older persons (MOLSA, 2006).

The government of Ethiopia provides institutional care for older persons in three homes for the aged. These are Beteselehome home for aged, Abrha Bahata home for the aged and Kaliti Institutional Care Center for Elderly (KICCE). Beteselehome is located at Debre Libanos which is about 110km north of Addis Ababa. It provides shelter, food, clothing, medical service and recreational facilities for older persons (MOLSA, 2007). Abrha Bahata is located in the city of Harar and is rendering services for older persons. KICCE is the third governmental institution care center which is found in Addis Ababa at a special place called kaliti.

All the above mentioned institutional care centers are governmental. My study will be conducted in Mekedonia Humanitarian Association which is privately owned. Older persons are getting variety of services from the institution especially those that are necessities to human being. This paper focused on older persons who are institutional care recipients and the impact of institutional care on the life of older persons. The paper tried to investigate the impact of institutional care on the economic, health, psychological, spiritual and social conditions of the older persons. I am interested to undertake this study because I strongly believe that older persons are sources of accumulated knowledge and that in turn will help to bring development in a country. In addition to this, from my personal experience I lost three of my

grandparents without knowing them and I only know my grandmother. For this reason, I have great passion and love to older persons. Even if there are some prior researches on older persons, I cannot get enough researches done on institutional care of older persons. The following research questions are paused in order to assess the effects.

1.3 Research questions

General research question:

- What are the impacts of the services provided in the MHA?

Specific research questions:

- How does institutional care influence economic status of older persons?
- What is the impact of institutional care on social life of older persons?
- How does institutional care influence the psychological wellbeing of older persons?
- How does institutional care influence the spiritual life of older persons?
- How do services given by the institution impact the health status of older persons?

1.4 Objectives of the study

1.4.1 General objective

- To explore effects of institutional care on the life of older persons.

1.4.2 Specific objectives:

- To assess health status of residents of institutional care.
- To investigate the psychological influence of institutional care on older persons.
- To explore the economic support given by the institution.

- To explore social interaction within recipients of institutional care and the outside environment that comprises family members, relatives and surrounding communities.
- To explore spiritual life of older persons who are institutional care recipients.

1.5 Significance of the study

This study is expected to be helpful for different segments of the society. Governmental and non-governmental institutions can use it for designing strategies to support elderly for those who are engaged in institutional care. Institutions that are engaged in giving institutional care for elderly can share experience and learn constructive lesson from it when necessary. It can also be used as a reference material for those who have interest to do researches on institutional care.

1.6 Scope of the study

The study focused on Mekedonia Humanitarian Association. Due to time and financial constraints, other institutions are not included. Even in the selected institution, purposive sampling is used to choose participants in the collection of data.

1.7 Limitations of the study

This is a case study conducted on Mekedonia Humanitarian Association that leads its generalizability in question. Even if, it is tried to exhaustively assess conditions of the association, generalizing the findings in other contexts is difficult. Time constraint on the side of the staffs of MHA due to fund raising programs was also a challenge.

1.8 Operational definitions

- **Elderly/ older persons**: there is no United Nations standard numerical criterion, most countries have accepted the chronological age of 60+ years as a definition of 'elderly' or older person (Unite Nations, 2003).

- **Aging**: according to WHO it is the process of becoming older, a process that is genetically determined and environmentally modulated.

- **Institutional care**: It is a type of long term care that comprises providing food, shelter, medical support, clothing and counseling services in a permanent institutional set up.

- **Psychological Well-being**: refers to the simple notion of a person's welfare, happiness, advantages, interests, utility, and quality of life (Burris, Brechting, Salsman, & Carlson, 2009)

- **Health:** As defined by World Health Organization (WHO), it is a "State of complete physical, mental, and social well being, and not merely the absence of disease or infirmity" (WHO, 1994).

- **Social life**: defined as the ability to adapt to social situations and to have and maintain satisfying interpersonal relationships (Donatelle et al., 2001).

- **Spirituality**: can be defined as “the quest for understanding life’s ultimate questions and the meaning and purpose of living, which often leads to the development of rituals and a shared religious community, but not necessarily” (Koenig et al., 2004)

1.9 Organization of the paper

This paper is organized in to five chapters. The first chapter comprises introduction, statement of the problem, research questions, objectives of the study, significance of the study, scope of the study, limitations of the study and operational definitions. The second chapter is all about related literatures. Chapter three discusses about methodology. Under this research design, research field and population, sampling technique , selection criteria, data collection procedures and methods, data analysis methods and

ethical considerations are presented. The fourth chapter is about findings and discussions. The final chapter discusses social work implications and conclusions that can be drawn from the study. Finally, reference lists and appendixes are attached at the end of the paper.

CHAPTER TWO

2. LITERATURE REVIEW

2.1. Global trend of old age

In 1950, there were 205 million persons aged 60 or over in the world. By 2012, the number of older persons had increased to almost 810 million. It is projected to more than double by 2050, reaching 2 billion. Currently there are 15 countries with more than 10 million older persons, seven of these being developing countries. By 2050, 33 countries are expected to have 10 million people aged 60 or over, including five countries with more than 50 million older people. Out of these 33 countries, 22 are currently classified as developing countries. The population aged 60 or over is growing at a faster rate than the total population in almost all world regions. Globally, the population aged 80 years or over is growing faster than any younger age group within the older population. The population of centenarians, those aged 100 years or over is growing fastest (United Nations, 2003).

As cited in Vincent, Philipson & Downs (2006, p.10), retirement is a modern phenomenon and in the twentieth century it has come to dominate our thinking about and understanding of old age. The ageing of the world population is progressive and rapid. It is an unprecedented phenomenon that is affecting nearly all countries of the world. As long as fertility continues to fall or remains low and old-age mortality keeps on declining, the proportion of older people will continue to increase. In the past ten years alone, the number of people aged 60 or over has risen by 178 million – equivalent to nearly the entire population of Pakistan, the sixth most populous country in the world. And in China alone, the estimated number of older people in 2012 is 180 million. Older persons are projected to exceed the number of children for the first time in 2047. Presently, about two thirds of the world's older persons live in developing countries. Because the older population in less developed regions is growing faster than in the more developed regions, the projections show that older persons will be increasingly concentrated in the

less developed regions of the world. By 2050, nearly 8 in 10 of the world's older population will live in the less developed regions (United Nations, 2003).

Ageing results from the demographic transition, a process whereby reductions in mortality are followed by reductions in fertility. Together, these reductions eventually lead to smaller proportions of children and larger proportionate shares of older people in the population. Ageing is taking place almost everywhere, but its extent and speed vary. In most developed countries, the population has been ageing for many decades, while in developing countries, population ageing has taken place relatively recently, as their mortality and fertility levels have fallen. Currently, the most aged populations are in the developed countries, but the majority of older persons reside in developing countries. Given that the rate of growth of the older population in developing countries is significantly higher than in developed countries, the older population of the world will increasingly be concentrated in the less developed regions (United Nations, 2003).

As indicated in the report in the Ethiopian annual statistical abstract published in July, 2006, the total population of Ethiopia was 75 million out of which 3.3 were aged 60 and above. Likewise, out of the total of 12.2 million of urban dwellers 538,800 and out of 62.9 million rural dwellers 2.8 million people were older persons. So, it is clear from the report that the bulk of the aged population lives in the rural areas (MOLSA, 2006).

2.2 Developmental Aspects of Ageing

Older persons are not only owners of extensive knowledge and rich experience accumulated during their long life, but they are also capable to participate in the social and economic development of their countries if they are given the chance. To enable older persons take part in development efforts has double advantage. On one hand they will get the opportunity for employment and feel productive and on another, they can be self -supportive and improve the quality of their own lives. Since they have the capacity to teach history, culture and work, the community should be able to make use of this.

2.3 Humanitarian aspect of Ageing

Older persons have the same intrinsic rights as everyone else, but there are specific realities – from limited access to services, education and job opportunities to elder abuse, neglect and abandonment – that render violation of their rights more frequent and cause them to be one of the most vulnerable population groups in any society. There is a worldwide toleration of age discrimination and ageism. Age discrimination occurs whenever an individual or individuals are treated differently simply as a consequence of their age. Age discrimination can be directly experienced, as in a refusal of training or education because an individual is deemed "too old", or indirectly, such as in the non collection or non-presentation of data on morbidity and/or mortality for people over 65 years – as if illness and death after a certain age is of no interest to society. This translates into a failure to develop policies and interventions that could improve health in older age (United Nations, 2004).

Laws mitigating age discrimination do exist in some countries, but they are most commonly limited to employment, and even so, the right to work, with its social criticality, is far from assured. Legislative attention seldom extends to such vital areas as social and health care, long-term support, or provision of other goods and services. The UN General Assembly, in its various resolutions stated that all the necessary efforts should be made to protect fundamental human rights without discrimination and partiality. Based on these resolutions, there are now many decisions, principles, directives and conventions adopted with a view to enable different section of the society to proper attention according to their problems and interests (United Nations, 2003).

As stated in United Nations (2003), the UN principles for older persons independence, participation, care, self-fulfillment and dignity are being exercised in Ethiopia and many other countries. In this connection, it is important to create environments conducive for older persons to lead a dignified life with their rights protected and their basic needs fulfilled. These will eventually enable them participate in the economic, social, cultural, civil and political affairs of their country. However, these

opportunities cannot be realized equally everywhere in the society due to a number of reasons. While in developed countries there exists the capacity and opportunity to protect rights and fulfill basic necessities of older persons, the situation in developing countries is quite difficult in the sense that services are not provided adequately due to backwardness and poverty.

2.4 Challenges of population ageing

Population ageing has significant social and economic implications at the individual, family, and societal levels. It also has important consequences and opportunities for a country's development. Although the percentage of older persons is currently much higher in developed countries, the pace of population ageing is much more rapid in developing countries and their transition from a young to an old age structure will occur over a shorter period. Not only do developing countries have less time to adjust to a growing population of older persons, they are at much lower levels of economic development and will experience greater challenges in meeting the needs of the increasing numbers of older people (United Nations, 2004).

According to UN (2004), financial security is one of the major concerns as people age. It is an issue for both older persons and a growing challenge for families and societies. Population ageing is raising concerns about the ability of countries to provide adequate social protection and social security for the growing numbers of older persons. In many countries, expectation is that the family will take care of its economically dependent older members. While some families support their older relatives, others are not in a financial position to do so in a way that does not affect their own economic situation.

Older persons who do not have family to support them are especially vulnerable. Informal support systems for older persons are increasingly coming under stress, as a consequence, among others, of lower fertility, out-migration of the young, and women working outside the home. There is an increasing consensus that countries must develop social protection systems that cover at least the basic needs of all older persons. Ensuring a secure income in old age is seen as a major challenge for governments facing

fiscal problems and competing priorities. Some countries are increasingly worried whether they will be able to pay for pensions and whether they will ultimately be able to prevent a rise of poverty in old age, particularly in countries where the majority of older persons are employed in the informal sector (United Nations, 2004).

Health is another major concern for older persons. The demographic transition to an ageing population, accompanied by an epidemiological transition from the predominance of infectious diseases to non-communicable diseases, is associated with an increasing demand for health care and long-term care. Although not an inevitable outcome of growing old, the numbers of older people affected by mental health problems are increasing due to population ageing. Their management has become an increasing concern for both developing and developed countries. Maintaining good health and access to health care is a core concern of older people everywhere. In many developed countries quality of care and rising healthcare costs are major issues related to population ageing (United Nations, 2004). Age-related discrimination is one of the most frequent challenges faced by older persons in the exercise of their human rights, in developed and developing countries alike. Even though certain cases of reasonable and proportionate differences in treatment on the grounds of age are permitted, there are circumstances in which old age is the basis for denial of services, limitation on accessing benefits, performing activities or exercising rights. Many older people are acutely aware of discrimination due to age, while others are unaware of their rights and wrongly accept this treatment as part of being old. Poor conditions earlier in life place older people at risk of serious health problems and adversely affect their health and vitality. The understanding that the living environment, working conditions, nutrition and lifestyle choices in younger years influence our health in older age should be a key ingredient for policies and programs with an intergenerational focus (United Nations, 2004).

2.5 Rights of the elderly

Rights of the elderly are those declared in the UN principles of older persons adopted in 1991 and they are independence, participation, care, self-fulfillment and dignity. These principles are based and

articulated in the context of international convention of human rights adopted in 1948 by the UN. Basic needs of the elderly are met when their rights to obtain food, shelter, health services, employment, income generation, social insurance, credit, education and training on equal basis, live in areas of their choice, participate actively on issues of their concern, legal protection that enables to live in freedom, support from community and institutional services, free to practice their faith and receive special services and lead a dignified life.

Since the lives of the elderly are closely intertwined with that of the society, they have the right to develop and execute policies on issues concerning their life and well being, to transmit knowledge and experience to the younger generation. They have also the right to serve their society as volunteers in creating and developing conditions conducive to development.

The elderly have the right to be engaged in activities that protect their rights, and that they have the right for social protection in accordance with the cultural laws and norms of the society. These provisions however should be considered as a right, not as a privilege. It is right and proper to provide the elderly with timely preventive and curative services so as to protect their physical & mental well being and enable them to have healthy life, and with legal protection needed to live in freedom as well as the appropriate institutional and rehabilitative services. It is necessary to protect their rights to have shelter, medical institutions and care centers for the elderly and protect their human dignity. The right to their faith and liberty.

One of the things older persons require to lead a healthy and happy life peacefully is to get proper respect. They need to be evaluated and treated fairly without being discriminated on economic capacity, physical disabilities, age, gender, race and ethnic background. Provision of support to the elderly should by no means imply imposition or a feeling of dependency, inferiority, or passive recipient of support. More importantly their right should be respected not from external support only, but from their own active participation

2.6 Elderly life in Ethiopia

As stated in National Plan of Action on Older Persons (NPOAOP) (1998- 2007), Ethiopia is one among the poorest countries in the world with 44.2 percent of its population living below poverty line. It is understood that disease, protracted war, recurrent drought, absence of good governance are some among the many problems facing the country. These problems together with the modern way of life caused by growing urbanization and modernization are now eroding the culture of intergenerational solidarity and mutual support that has been existing for a very long time and this increased the vulnerability of the society in general and older persons in particular. The achievement and contribution of older persons in our society in areas of family, community, religion, Idir and Iqub is an evidence, that they owe a lot to their country, history and culture. Taking into account the enormous contributions of older persons, the society has a longstanding culture to give due consideration to our senior citizens and protect their rights.

Poverty become more acute among older persons because once they are exposed to it, it is much more difficult for them to come out of it. Health problems, lack of balanced diet, shelter, unsuitable residential areas, absence of family and community support, absence of social welfare coverage, limited social security services, absence of education and training opportunities, limited employment and income generating opportunities are some of the factors contributing to the poverty of older persons (NPOAOP, 1998- 2007).

On the other hand HIV/AIDS is further complicating the problems of older persons. Older persons are being left helpless and without support as result of the death of their off springs caused by HIV/AIDS. They are exposed to poverty as they expend their limited asset and income to take care and pay the bills of their children infected by the virus. In spite of their being old, they are also shouldering the responsibility of bringing up their grand children in the country who lost their parents due to HIV/AIDS. However, due to the absence of networking and inability to streamline the activities of the concerned bodies in conducting in depth study and designing and implementing programs and projects

and due to the absence monitoring and evaluation systems and lack of implementation capacity, it has been difficult to improve the lives of the elderly to a significantly better level (NPOAOP, 1998- 2007).

In order to bring concrete results with visible impact in the life of the elderly by expanding services and supports, Ethiopia has developed National Plan of Action on older persons /1998 – 2007 E.C/ in line with the Madrid International Plan of Action of the elderly, UN Principles on Ageing and AU's policy. Key Issues addressed under National plan of action on older persons /1998-2007/ were: health and well being, family and community care, rights of the elderly, housing and living environment, social security education and training, employment and income generation ,poverty reduction, HIV/AIDS, gender and older persons, food and nutrition, emergencies and protection of life and property.

2.7 Institutional care for older persons

In many parts of the world, governments have introduced various community based services and programs to support the elderly and their families bearing in mind the peculiarity of their environment. Long term care can be provided through in-home services or day care centers. The forms of care provided can range from assistance in dressing, bathing and ambulating to sophisticated medical life support systems (Gelfand, 1984). The uniqueness of long term care facilities lies in their constraint on individual choice in everyday situations since the person living in these settings must adjust to being removed from normal individual or family living patterns. Existing long term residences include chronic care hospitals, private and public nursing homes, homes for the aged, psychiatric hospitals, and veterans administration facilities. All of these facilities provide varied levels of care ranging from extended, skilled and intermediate care to personal and boarding care. Long term care facilities are run under a variety of auspices including public, private/non-profit, or proprietary organizations.

The history of long term care institutions began with the almshouses and the public poor houses of colonial America (Gelfand, 1984). When a family or individual could no longer care for person, that person became the responsibility of the government. The disabled, aged, widowed, orphaned, feeble minded and deranged and victims of disasters were mixed together in almshouses, hospitals, workhouses,

orphanages and prisons. Officials made poverty generated by physical disability and economic distress. Through time, almshouses became increasingly popular and in 1834, the poor law of England reaffirmed this approach. This philosophy of isolating older persons from the society continued to be the predominant social policy throughout the nineteenth century.

It is generally accepted that most old people prefer to live independently in their own homes (Vaarama et al. 2008). However, institutional care in nursing or residential home is often the only option available for frail and dependent people, who require higher levels of support. Moreover, social and demographic changes throughout Europe show a weakening of family and community networks, resulting in a reduction in informal support from family and friends to allow frail old people to remain at home.

The government of Ethiopia and experts in the field of aging has realized that institutional care is a primitive and absolute type of service and it should not be encouraged (MOLSA, 2007). The reasons for this are; running institutional care is expensive and overhead costs are very high. It displaces older persons from the locality they lived for a long time. Disintegration and isolation from the community is the main feature of institutionalization and it hinders the feeling of responsibility from the part of the community to care for older persons. It also creates loss of identity and respect. Older persons in institutions are often given derogatory names that imply uselessness, helplessness and dependency. It denies the right of older persons to contribute to the development of their country.

As cited in MOLSA (2007, P.88), there is argument in the field of Gerontology that institutional care can be used as a last resort when highly vulnerable older persons need strict surveillance with the help of day attendants. Institutions can also be considered when we have older persons who cannot get care from immediate or extended body who do not have other option other than institution.

Care institutions provide adapted and safe environments and provide a range of care, such as support in everyday activities and medical procedures. In addition to these instrumental issues, increasing attention has also been paid to the general quality of life and clients through facilitating social participation, leisure activities and supporting clients' lifestyles, while trying to preserve individuals'

autonomy and control. At the same time however, the individual has to conform to the social roles and rules prevalent in the institution. Among older people, this process can lead to " induced dependency" whereby the person undergoes psychological changes, loss of personal competence and even physical deterioration (Vaarama et al. 2008).

Residents of care institutions community have serious limitations in their abilities to take care of themselves because of the illnesses or frailties of advanced age. These conditions and associated functional decline inevitably have an impact on quality of life. As well as physical functioning, other factors such as psychological, social and emotional changes can have an impact on wellbeing and satisfaction with life (Vaarama et al. 2008)

The World Health Organization's (WHO) general definition of Quality of Life (QoL) in 1995 (cited in Vaarama et al. 2008, p.196) emphasizes the individual's own perception of their position in life and their goals, expectations, standards and concerns. This definition also includes the culture and value systems in which an individual lives. QoL in the context of institutional care differs from general QoL and from health – related QoL.

2.8 Effects of institutional care on lives of elderly

2.8.1 Effects on health

Health trends among elderly people are complex. In some countries there is less severe disability than in the past, but generally an increase in mild disability and functional impairment can be observed. There is limited ability to treat effectively one of the most disabling common disorders, cognitive decline, and the accumulating burden of disease due to the obesity epidemic. The ability of older people to remain healthy and independent requires the provision of a supportive environment, including well-designed living conditions, access to economic resources, and appropriate health care (Jang and Kim, 2009).

In developed countries, where acute care and institutional long-term care services are widely available, the use of medical care services by adults rises with age, and per capital expenditures on health care is relatively high among older age groups. Accordingly, the rising proportion of older people is

placing upward pressure on overall health care spending in the developed world, although other factors such as income growth and advances in the technological capabilities of medicine generally play a much larger role. Health systems for older adults that optimize health in ageing must include more than care to respond to the presence of illness. Prevention matters, both for the individual and for communities. Prevention for older adults includes primary, secondary and tertiary prevention of disease or geriatric conditions of falls and frailty – such as through physical activity, nutrition, smoking cessation and injury, pain, depression; control of disease, such as diabetes, heart disease and blood pressure to prevent worsening; and prevention of loss of independence from these conditions. Health and social policies will thus need to deliver appropriate systems to respond to the needs of ageing populations. Given the important long-term implications, this remains relevant even in the current period of financial and economic turbulence. Furthermore, although population ageing will bring some additional costs, these can be reduced by the application of appropriate and well coordinated health and social policies that slow the rate of health decline associated with ageing and thus the amount of health care services required With an increasing number of chronic conditions and co-morbidities, elderly patients are often seeing a number of different providers of both social and health care services. Effective health interventions, particularly health promotion and disease prevention programs that target the main causes of morbidity and mortality, can help to minimize the cost pressures associated with ageing by ensuring that people stay healthy in old age. These include interventions to tackle obesity and hypertension, immunizations, and fall prevention programs (Choi, 2003).

2.8.2. Effects on social interaction

There are a variety of views on the significance of social connectedness in elderly populations. Even in senior living communities, social isolation is apparent. Isolation is less common in men, but when they do suffer from loneliness, is reportedly more stressful (Manthorp, 2010). Circles of friends tend to become smaller though for both men and women in their old age. While the increasing number of deaths

of elderly friends does play a role in downsizing social circles, there is also evidence indicating that social behaviors and interactions change with the increase in age.

Maintaining good social relationships, whether with peers, workers, family, friends or the wider community, is key to quality of life for older people (Percival, 2010). Yet isolation and loneliness are problems shared by many older people with high support needs (Cattan, 2010). Being in a communal setting does not, in itself, protect older people from social isolation. Those with mobility, cognitive and/or sensory impairments are at particular risk of being excluded from the social life of housing with care schemes (Callaghan, 2009).

The development of positive social relationships in eldercare settings is not entirely dependent on the residents as individuals. Social environments are influenced by factors such as socio-economic status of the residents, staff to resident ratios, policies and programs related to each specific facility, architecture and available space for recreation, and cultural or religious homogeny. Socio-economic status though is often a determinant of each of these other environmental factors. The more affluent elderly tend to opt for smaller facilities with larger staff to resident ratios and more personal and recreational space (Moos and Igra 1980).

At the same time, it is reasonable to assume that the staffs in more expensive assisted living communities are better trained to establish more socially cohesive environments for their residents. Moos and Igra (1980) research indicates that often times the larger social structure of a nursing home invites residents' involvement in democratic decision making for the facility simply because of the outnumbering of residents to staff. In large facilities housing mostly cognitively intact persons, it has been argued that the most efficient means of accommodating residents' needs is by leaving the decision making up to the larger group of residents themselves. This does not confirm that residents of larger nursing home facilities have greater influence over their environment as a whole. Another possible benefit to the larger nursing homes is the larger population of residents with which the individual can make contacts with and develop friendships. There have been found to be significant associations between the perceived well-being of

individuals and their active engagement in social interaction. A larger population of residents as a whole implies a larger population of cognitively intact persons than might be found in a smaller assisted living facility (McKee, Houston, and Barnes 2002).

2.8.3 Effects on psychological aspect

Older adults enjoy good mental health. However, it is anticipated that the number of older adults with mental and behavioral health problems will almost quadruple, from 4 million in 1970 to 15 million in 2030. Mental health disorders including anxiety and depression, adversely affect physical health and ability to function, especially in older adults. Some late-life problems that can result in depression and anxiety include coping with physical health problems, caring for a spouse with dementia or a physical disability, grieving the death of loved ones, and managing conflict with family members. In particular, a growing number of studies reveal associations between social activities and elders' physical and mental well-being (Kang, 2010). Addressing these problems and treating often overlooked mental health conditions results in decreased emotional suffering, improved physical health, lessened disability, and a better quality of life for older adults and their families. Increasing access to mental health services for older adults will reduce health care expenditures by lowering the frequency of primary care visits, medical procedures, and medication use. According to the study of Kang and Park (2008), the level of well-being in life among residents who have conversations and share feelings with their roommate(s) is higher than those who do not. Close friendships with roommates in residential care is regarded as having a meaningful effect on satisfaction, including the individual's well-being with his or her residential facilities, positive affection, and perceived level of social support.

Psychologists play a significant role in addressing the mental health needs and supporting the strengths of our growing population of older adults. Psychologists provide services to older adults in a variety of settings, including health care facilities, community-based private or group practices, and places where older adults reside in their homes, long term- care and assisted-living facilities, and hospices. Psychologists work both independently and as members of interdisciplinary teams. As team

members, psychologists collaborate with a variety of professionals, including medical and other mental health care services providers, to ensure comprehensive care. There are large numbers of older people with mood and anxiety disorders, both in the community and in aged care facilities, who would benefit from psychological interventions that have been proven to be effective with older people (Gatz, et al., 1998).

2.8.4 Effects on spiritual life

Spirituality can be defined as the quest for understanding life's ultimate questions and the meaning and purpose of living, which often leads to the development of rituals and a shared religious community, but not necessarily (Koenig et al., 2004). Spiritual care is not necessarily religious. Religious care should always be spiritual. Spiritual care might be said to be the umbrella term of which religious care is a part. It is the intention of religious care to meet spiritual need (Spiritual Care Matters, 2009). Spirituality encompasses wide ranging attitudes and practices which focus on the search for meaning in human lives, particularly in terms of relationships, values and the arts. It is concerned with quality of life, especially in areas that have not been closed off by technology and science. Spirituality may, or may not, be open to ideas of transcendence and to the possibility of the divine' (Ferguson, 2011). In addition, a growing awareness exists that greater involvement in religion and a cultivation of spirituality is associated with better physical and mental health well-being across the age spectrum (Bae, 2002; Yoon, 2006). A number of recent studies have suggested that religion and spirituality play an important role in maintaining health among the elderly, in coping with stress (Nelson-Becker, 2005) and negative affection (Cho, 2002), as well as in recovery from relationship problems (Kang, 2009) and illness (Centore and Clinton, 2008). In addition, the factors of religiosity and spirituality have been found to have salutary effects on well-being in life among older adults despite the existence of stressors from the aging process. A large number of studies have also demonstrated that people who are more involved in and committed to religion tend to enjoy better physical and mental health than do individuals who are not as religious (Yoon and Lee, 2007).

Spirituality in all of its diverse forms and meanings names particular inadequacies that have been perceived or sensed within health care and it is these inadequacies that people wish to resist. By raising the importance of meaning, purpose, hope, love, God or relatedness issues that often come to prominence during the experience of being ill, the language of spirituality points towards the gap between experience and current practices and becomes a point of resistance and protest against the absence of some kinds of care (Swinton and Pattison, 2010).The domain of spiritual care has received less attention than other aspects of palliative care within quality improvement efforts in part because there are many challenges to application of quality improvement efforts in spiritual care (Kapp and Nelson-Becker, 2007). Failure to assess spiritual needs may potentially neglect an important patient need; it also fails to consider patients as whole persons. Communication with patients and families about spiritual issues ranges from preliminary screening in order to identify potential spiritual issues to a spiritual history taken by trained health care providers to a spiritual assessment by a board-certified chaplain. The evidence base suggests that genuine and intentional accompaniment of people on their ageing journey; giving time, presence and listening are the core of good spiritual practice (Puchalski and Romer,2000).

2.8.5 Effects on economy

Older persons have gathered substantive experience throughout their lives. They should be enabled to capitalize on this experience, for example by pursuing entrepreneurial activities and joining the labor market. The workplace provides income as well as social networks and a sense of being needed and contributing productively to a society to people of all ages. Many employees who reach retirement age still feel healthy and fi t enough to continue working. Others depend on the income and may choose to continue working for that reason. If the formal employment sector does not accommodate them, they may be driven to the informal sector and suffer from worse conditions, becoming more vulnerable. Older persons should be given the opportunity to continue working for as long as they are able and willing. Actively increasing integration of older persons into the workplace is vital for achieving a balanced

diversity of age groups in the workplace. Reduced capacity to earn a personal income and contribute to the household income – even indirectly – has clear implications for dignity and empowerment, of the person and within the family. Even when older persons are supported by their families in terms of food and shelter, the fact that they do not have their own resources may affect their autonomy and capacity to exercise choice, and lead to them being seen potentially as a burden. (Neal and Toni, 2005).

Numerous studies have shown that social pensions – which are delivered regularly and by right, even where relatively small – have the potential to shift that balance and ensure that older people take their role as family members who can actually participate in taking decisions. Social protection in the form of income and access to services makes a crucial contribution to address the symptoms and structural causes of poverty and inequalities. Regular income and support for basic services facilitates access to service providers, supports families' access to education, employment, health and food, and confers dignity and status on the recipient. A minimum pension can help compensate for a lifetime of poverty and exclusion. Family benefits, such as child grants which target the next generation, are a direct intervention aimed at reducing the inequalities faced by a family. Children in families which include an older person in receipt of a social pension have been shown to benefit, in terms of nutrition and education, from the contribution which these relatively small payments make to family income (Soares et.al, 2006). Social protection systems also contribute to building and strengthening of a state-citizen contract. Such programs – particularly when based on claimable entitlements – have the potential to strengthen the potential for people to hold governments to account. They can provide a catalyst for practical benefits such as improved identity registration that have a direct impact on representation – for example – through the electoral system and the capacity to claim entitlements. Pensions have also been shown to improve ID registration and electoral registration, ensuring that older people have the capacity and the autonomy to vote, a right which is highly prized. Regular income enables marginalized people to think beyond their immediate daily survival and gain greater control over their resources and life choices. Thus the impetus

to extend social protection floors, which are both rights-based and life course-focused, provides a powerful guiding framework for the empowerment of older people. (Esther Duflo, 2000)

2.9 Public opinion of older people

As people live longer and the ageing population grows worldwide, it becomes increasingly important to identify prevailing attitudes towards older people in society. Ageist attitudes may lead to discrimination and mistreatment of older people. Furthermore, it is essential to understand factors that influence how we understand and perceive ageing and older people (McConatha et al. 2004; Narayan 2008; Raman et al. 2008). These factors can then be targeted when educational and social interventions are being developed to protect and improve the treatment of older people.

The ageing of the world's population brings with it many new social, political, and economic challenges (WHO 2002). Within this context,public receptions of ageing and older people impact on the formulation and implementation of social policies affecting the elderly (Arnold-Cathalifaud et al. 2008; Musaiger & D'Souza 2009). For example, as people age, their need for day-to-day support and healthcare is likely to increase. According to Zhou (2007), good quality care service and healthy relationships with older adults are necessary, but are unlikely if people's views of older adults are negative.

A report by the Working Group on Elder Abuse (WGEA), a group set up to advise and to make recommendations to the Irish government in relation to issues regarding elder abuse, identified a need for academic knowledge on public perceptions of ageing and older people (WGEA 2002). This call for research into attitudes related to older people was also identified by Rupp et al. (2005) who stated that research in to the perceptions of ageing and older people is warranted given the potential negative impact of ageism on both individuals and organiztions alike.

Overall it is evident from the literature on the public's perceptions of ageing that older people are predominantly associated with poor health and are generally perceived as weak and frail. Older people are

also characterized as having physical impairments, needing physical support aids as well as having declining eyesight and hearing. Although some evidence exists which indicates that older people are viewed as having the capacity to live long independent lives, the majority are stereotyped as becoming progressively frail and needing support as they get older. It is acknowledged that although the stereotypes of older people as weak, frail and disabled result from the ageing process and therefore have a basis in reality, some researchers have argued that it is not the experience of all older people and is often based more on myth than reality (Barrett & Pai, 2008).

2.10 Aging as a social construct

Studies of household size during the 20th century show that older persons of developed countries are increasingly likely to live alone. This is presumably due to the increasing shift in cultural values that lend toward privacy and independnce (Hayes 2002). Through the course of the 20th century the generations among families began to move away from each other in search of work or a change in lifestyle (Hareven 1994). And while kin assistance to elderly family members is still common, the moving of elders into the younger generation's home is increasingly less prevalent (Hayes 2002). There are several different theories used to explain the various changes in self perceptions and social interactions associated with aging. The learned dependency theory describes how dependent behaviors of the aged person are utilized to secure social contact (Maddox 2001). The degree and type of dependency depends on environmental factors (Baltes *et al.* 1987). In the case of an elderly individual living in their own home in the community, not being able to walk or drive to the grocery store might influence more frequent visits from family and friends to bring over meals.

Depending upon the circumstances and actual need for assistance, this type of forced social interaction may or may not be severely imposing to the person's own well-being. In the case of individuals living in a long-term care facility or at home with a live in caregiver, any unnecessary dependency on the caregiver to help with minor daily activities such as getting dressed or reaching for far

away objects might lead to the acceleration of the aging process via disuse of muscles and motor skills. Gerontologists Margaret Baltes and Laura Cartensen (1999) explain that dependency of this nature is socially learned as a means of maintaining social contact in the effort to avoid loneliness. One social construction of old age is that of dependency. It is normalized and accepted by society and invites social support. Independence on the other hand is ignored just as it is in one's youth or mid-life. If one's social world is gradually declining, as happens to many individuals as they age, independence might negatively affect their mental well-being by inviting loneliness. But becoming overly dependent on the help of others becomes detrimental to the individual's physical functioning when the end result is having a caregiver do everything for them. This type of care giving is prevalent in many long-term care facilities and serves to foster the negative effects of learned dependence.

2.11 Standard of living and quality of life in old age

A common experience of growing old is loss of income (Vincent, 2003). The changing material circumstances of older people are a further experience of old age example of the impact of social institutions on old age. The possibilities of living a satisfactory old age are severely constrained by how much money they have. Many older people even in the developed world continue to live in relative poverty. For Europe as cited in Vincent, (2003, p.15), the main trends of the twelve members of European Union in material standards as:

- Rising living standards for older people, particularly those aged 50 to 74;
- Wide variation between countries;
- Poverty and low incomes among a significant minority of older people in most countries;
- Older women, particularly widows, having a higher incidence of poverty;
- Growing income inequalities among pensioners (John Vincent, 2003).

CHAPTER THREE

3. METHODOLOGY

3.1 Research design

Qualitative research approach is used to undertake this study. Knowledge is located in the meaning; people make of it and can be acquired through communication about their meaning. A close relationship with research participant will bring achievement for qualitative research (Creswell, 2003:173). Qualitative methodological approach involves that do not attempt to quantify their results through statistical summary or analysis. Qualitative research seeks to describe various aspects about behavior and other factors. In qualitative research, data are often in the form of descriptions, not numbers. The goal of qualitative research is to look for meaning and stress is laid on socially constructed nature of reality. (Abiy et al., 2009). I preferred to use qualitative research approach than quantitative research approach because my intention is to describe the effects of institutional care than quantifying using numbers.

This study used case study method to explore factors affecting the life of older persons under institutional care. Case study is used in many situations to contribute to our knowledge of individual, group, organizational, social, political and related phenomena (Yen, 2003). Case studies involve an in-depth examination of a single person or a few people. The goal of the case study is to provide an accurate and complete description of the case. The principal benefit of case studies is that they expand our knowledge about the variations in human behavior. Although experimental researchers are typically interested in overall trends in behavior, drawing sample-to-population inferences, and generalizing to other samples, the focus of the case-study approach is on individuality and describing the individual as comprehensively as possible. The case study requires a considerable amount of information, and therefore conclusions are based on a much more detailed and comprehensive set of information than is typically collected by experimental and quasi experimental studies. (Marczyk et. al 2005:148) .

3.2 Selection criteria

In order to conduct an in-depth interview, I used age and health status as selection criteria. When we come to age, I included those whose age is 60 years or above since my title is about older persons. Since the institution is helping those suffering with mental illness, health condition was also considered while selecting for an interview. From the older persons, language proficiency, those who can communicate properly and willing to participate are taken for an in-depth interview. With regard to staffs of MHA, my selection criteria were experience, responsibilities in the institution and willingness to participate.

3.3 Sample size

The sample size in a qualitative case study research will be about four to five cases Creswell (2014: 180). You stop collecting data when the categories (or themes) are saturated. When gathering fresh data no longer sparks new insights or reveals new properties Charmaz (2006) as cited in Creswell (2014). The total number of care recipients in MHA is about 750 people of these 405 are older persons and the others are mentally ill. The total number of participants in the in-depth interview is 10 from those who receive care and 5 from staffs of MHA.

3.4 Sampling technique

The researcher used purposive sampling for the selection of participants in the study. The reason why the researcher chooses purposive sampling was that, for the sake of meeting directly older persons who are institutional care recipients. The idea behind qualitative research is to purposefully select participants or sites that will best help the researcher understand the problem and the research question, Creswell (2014,180). Purposive sampling is one of the sampling techniques in qualitative research that is deliberately made to select respondents based on their natural ability to give the required information, Padgett (2008, 53).

3.5 Data collection tools or instruments

Data was collected from care recipients, staffs of MHA and secondary sources. Data collection instruments or tools were an in-depth interview, observation and analysis of secondary data sources.

3.5.1 In-depth interview

In-depth interview is a qualitative research technique that involves conducting intensive individual interviews with a small number of respondents to explore their perspectives on a particular idea, program, or situation. It involves six stages (Ritchie & Lewis, 2003). These stages of interview include: arrival of the researcher, introducing the research, beginning the interview, during the interview, ending the interview and after the interview. In the entire interview, I followed each stages of an in-depth interview. It is best to conduct interview in a setting where the respondent feels most comfortable (WHO, 19994). I conducted some of the interviews in their dormitories and others in compound's hall as per their preferences.

The researcher conducted face to face interviews with participants. The study used unstructured and generally open ended questions. The interview guide was prepared by the researcher based on the research questions and the specific objectives. In-depth interview was undertaken with care recipients and staffs of MHA. The interview guide was prepared in English and then translated to Amharic. The interview was carried out in Amharic language. The interview took from 30 to 45 minutes per individuals. The recorded responses were transcribed to written notes in Amharic and then translated in to English for further analysis.

3.5.2 Observation

Kreuger & Neuman (2003, p.4) noted, 'if something happens to you, if you personally see it or experience it, you accept it as true. Personal experience or seeing is believing has a strong impact and is a forceful source of knowledge'. In combination with the process of an in-depth interview, observation was

used as an additional instrument of data gathering technique. The main advantage of this observation was to understand the expression, feeling and perception of participant's reaction. According to Creswell (2009; 181) through qualitative observations it is possible that researchers can take field notes on the behavior and activities of individuals at the research site.

3.5.3 Document analysis

The researcher used different written documents especially those studies done on MHA to supplement the study. Reports of the institution, broachers and documentary prepared by the institution were used as sources of data. As Morgan and Kunnel (1996, p.53) stated, 'secondary analysis is the study of existing data initially collected for another purpose and many of the most valuable contributions to our knowledge based on this method'.

3.6 Method of data analysis

Kreuger and Newman (2003) explained that concept formation is an integral part of data analysis and begins during data collection. Thus, conceptualization is one way that a qualitative researcher organizes and makes sense of data and analyzes the data by organizing it into categories on the basis of themes, concepts or similar features. In analyzing data, the researcher used three procedures that are organizing, summarizing and interpreting the data. After collecting the data in the above different data collection instruments, they were categorized into major ideas for their specific cases to shape the basic research question. As a result, this will help the researcher to summarize the data successfully to the case. Then, the organized and summarized data were discussed or interpreted carefully. Interpretations were concerned in reflecting the words and acts of the data source and the researcher's personal judgment will be used to strengthen the findings.

3.7 Ethical Consideration

The analyses as well as the disclosure of material facts were conducted in an ethical and strictly supervised procedure. Strong ethical considerations were attended in the study. Participants were requested their permission on the interview and the use of information confirmed as to the study purpose only.

Formal letter received from AAU School of Social Work was submitted to the institution and granted ethical clearance. Concerns about issues of power and control over information in research have led to important debates about how researchers should approach the process of researching something about which they have no personal experience (Fawcell and Hearn 2004; Jones 2004) and how they then incorporate the knowledge they gain in to their research (Beresford and Croft 2001).

Researchers need to ensure that they are not exploiting experiences of others for their own professional advancement. Where repeated engagements do not lead to any experience of change/ or where the engagement comes into a conflict with the primary aims and interests of the group taking part in reports of 'research fatigue' (Butt and O'Neil 2004; Clark 2008) (see Beresford and Croft 2011). Researchers should try to create a sense of mutual trust between themselves and participants Jo Moriarty (2011: 24).

3.8 Data collection procedures

On the first date of my visit, I met the receptionist who was really cooperative and I explained the reason for my visit. She told me that I have to get permission from the institution before starting my study. But the manager was out of the compound and I left the compound taking an appointment. On the second day visit, I met the deputy manager and explained the objectives of my study and submitted the support letter from my school. She was willing and told me to visit the compounds and see the documentary film prepared by MHA. On the same date, I saw the documentary film and visited the

compounds with the receptionist. Brief explanations were given to me by the receptionist and I got the chance to observe the services provided by MHA. I was also able to build rapport with the older persons. On the third day, I met with documentation and information officer and he showed me the profiles of residents. In addition to this, he filled the interview guideline that is prepared for the administration staff. And then, I took an appointment to undertake an in-depth interview with the selected ten care recipients for next day. On the date of my appointment, I collected data using in-depth interview and observation. The interview guideline that was prepared for the staffs was filled by them. I also collected secondary data sources on the same date.

Before conducting the interviews, I explained to the participants about the research objectives and got oral consent to participate. Of those who were selected for interview, two of them were not willing and I replaced them by other care recipients. I used tape recorder by their consent and recorded the interview. The interviews took time ranging from 25 minutes to 1 and half hours. I confirmed to them that the recorded data will be destroyed after the completion of the study. I separated from the participants by giving hug and great thanks for their cooperation.

CHAPTER FOUR

4. DATA PRESENTATION, ANALYSIS AND DISCUSSION

4.1 Data presentation

The purpose of this study is to assess the effects of institutional care on the life of older persons in Mekedonia Humanitarian Association (MHA). In this chapter, the researcher presented the results obtained from selected older persons and staffs of MHA. The presentation had different themes and the following data are about the background information of older persons. The names used to represent older persons are pseudonyms.

Table 1: Background information about older persons

S.no.	Name of older person	Sex	Age	Educational status	Year of enrollment
1	Abera	M	66	Diploma	2005
2	Tadesse	M	75	-	2007
3	Kebede	M	70	-	2007
4	Almaz	F	81	-	2006
5	Seifu	M	70	Up to grade 10	2005
6	Mandefro	M	95	Religious teachings	2004
7	Alganesh	F	65	-	2005
8	Kibnesh	F	73	-	2007
9	Yared	M	69	-	2005
10	Zuriyash	F	60	-	2005

The following is the detailed explanation of the older persons life situation before and after joining MHA. The data is presented sequentially as indicated in the above table.

Case one

Abera was born in north Shoa zone at a place called Debre Birhan. He graduated from Harrar college in diploma major Public Administration and minor accounting during the reign of Haile Selessie. He was living in Addis Ababa at a special place called 'Janmeda' was being married. They were having no children. His wife was a graduate in diploma in accounting. They were living in good condition inside her families' compound. Abera was serving as a soldier from 1971G.C. to 1990G.C. for 20 years and reached to 'Kolonel Maereg'. Hulet teyet egirachew wist ena sosit fintirtari jerbachew wist ale. Due to this reason, he was released from military institution being pensioner. After retirement from the military service, he started work in Defense Planning and Program office as a planner and program officer from 1991G.C. to 1994 G.C. for four years. And then, he was one of the founders of Ethiopian Free Press Agency and worked there from 1994 G.C. to 2004 G.C. for eleven years. He was engaged in interpreting life history of actresses and astrology works for private newspapers and magazines. In 2004 G.C., he left Ethiopian Free Press Agency and started to translate books by getting Birr 14 per page. He had worked this until 2011 G.C. and translated about 20 books. In 2011G.C. he lost his wife. It was tough time to Abera. Following her death, he escaped from his home and started to live in street around bus station. He was having a sister living a better life but he didn't want to live with her. After the death of his wife, he faced mental illness and became half paralyzed. The reason for Abera to join MHA was a student who saw him on a street while she went to school and home. She tried to explain to him about MHA but Abera was having no trust on the institution that work with children and older persons. He believes as if they are lying. So, convincing him to join MHA was a big challenge. But, workers of MHA came to his place by the student's telephone call and explained about the services given and then finally Abera was convinced to go with them. There were around 100 older persons when Abera joined MHA. Surprisingly, without

using medicines he recovered from his mental illness and paralysis by continuous psychological advice and practice respectively. After relieved from his sufferings, Abera started to work as a cashier in MHA. He is attending spiritual activities in a nearby church named 'Kidane Mihiret' and in programs that are prepared in MHA compound. He is free from work once in a week (Monday) and go to his friends and spend time with them. His friends from Ethiopia and abroad usually came to visit him. Abera is so happy by the services that are delivered in MHA. According to his view, the food, clothing and living condition in MHA is satisfactory. Currently, he interpreted one book by the sponsorship of an Ethiopian Woman who is living in London and the book is in its edition stage. Abera wants to continue in the work of interpretation and has a plan to publish his biography in the form of a book. Finally, he was grateful to Ethiopians for the donations they give to MHA and asked to collaborate in building the new building that is going to be constructed in Addis Ababa on a land given to MHA freely from Addis Ababa City Administration.

Case two

Tadesse was born in Betcho city. He was living with his relatives doing agricultural activities. But he couldn't work in peace with his relatives and then he came to Addis Ababa. As he said, he couldn't live in harmony with his relatives due to his aggressive characteristics. He was begging in Keranyo Medhanealem Church during the day time and spent the night in his sister's compound. He joined MHA by a woman who was working in MHA. Tadesse was suffering from gastritis and got treatment in MHA clinic. He was also facing diseases on his eyes and ears and got treatment from Zenebework Hospital before joining MHA. He also got additional treatment for his eyes and ears in clinic of MHA but still has seeing and hearing problems. Due to his seeing problem, he spends all of his time in MHA compound even he couldn't go to church. According to his explanation, food is prepared based on his interest that is favorable to his gastritis. When it is fasting time, fasting foods are prepared. Tadesse has no relationship with his relatives but the wife of his sister's son visited him repeatedly coming to

MHA before she moved out of Ethiopia. He has good relationship with the staffs of MHA. As Tadesse explained, he is happy by the services given in MHA. He is highly satisfied by the food he eat, the home he lives and the clothes he wear. He said that 'He will never leave MHA even if they asked him to go'.

Case three

Kebede was born in Wukro in tigray region. He left his hometown and went to wolega during the drought that brought high crisis during the dergue regime. After spending sometime in wolega, he went to bishoftu to work as a shepherd t but people saw him that he is aged, they gave him explanation about admission to MHA and started to live there. Kebede has no contact with any of his relatives. He has good relation with the staffs of MHA and the older persons. He didn't get married and had no children. He got medication in clinic of MHA and recovered from being blind. Kebede is facing severe gastritis problem and special foods that are favorable to his health are prepared by the institution. He complains about some older persons who were going out of the compound and got drunk. Due to these people, all older persons were forbidden to go out of the compound for any reason. Kebede was having follow up in a nearby church to get holy water baptism to recover from his illness. But, due to the ban, this spiritual activity was suspended. He was so angry about this. He believes that punishment has to be passed to those who act against the law. General punishment is not right. Except going to church he spent the rest of his time in the compound. According to him, the services provided by MHA are more than satisfactory. Finally, kebede said that 'I feel as if I am living in heaven'.

Case four

Almaz is the first woman to be interviewed. She was born in Addis Ababa at a special place called 'Dejach Wondyirad'. She was living in a kebele house being married to her husband. Almaz was having two children. . She lost her husband and two of her children during the dergue regime in war. A fter the death of her husband and children, she was living alone for about thirty years. As explained by her, this time was very challenging.

Due to the need to reconstruct the village, Almaz and her neighbors were forced to resettle to 'Jemo condominium site'. But Almaz was old and facing complicated health problems. Due to this, the kebele officials communicated with the management of MHA and Almaz was admitted to the institution. MHA usually take older persons from streets but Almaz was taken from her home. She is visited by her neighbors and some of her relatives. Almaz has good relationship with the staffs of MHA and the older persons. As she said, the medical services given in the clinic and referral mechanisms are very nice. She said that I am getting better health care services. As Almaz said, it is not only the medical service but also the food provision, clothing and dormitory situations are nice. Her smile when she explained about the services is amazing.

Case five

Seifu was born in western gojam in a city called Dangilla. He was a soldier in dergue regime. He didn't want to talk about his families. He has totally quit the relationship that he was having with his families and relatives. Seifu came to Addis Ababa and started to live on a street after he retired from the military due to health problems. He lost his two eyes during war. He got admission to MHA by his own request to the institution before two years. After joining MHA, he got medical treatment to his eyes and one of his eyes started to see. He is so grateful to MHA in this regard. He usually go to church to attend spiritual activities in the nearby churches. He sometimes walks around the compound and has some relationships with the surrounding community. Seifu has good relationship with the staffs of MHA as well as the older persons with whom he is living. Comparing his life condition before joining MHA with the current one, he said that the life condition in MHA is much more than his expectation. He is very happy by the services given in MHA.

Case six

Mandefro was born in Ambala. Agriculture was his source of income. In addition to the agriculture, he served in a church as a priest. He was married and has one child. He can't live in

agreement with his wife and then divorced. His child preferred to live with his mom so that Mandefro is separated from his child too. Gradually he was facing pains on his eyes and didn't get proper medication. As a result of this, he lost his eyes. He then lived in his hometown by the help of his relatives for some time and came to Addis Ababa expecting better life condition. But, life in Addis Ababa was not as such simple as he expected. So, he was forced to be beggar and lead his life on a street. After spending considerable time on a street, he got admission to MHA by workers of MHA by a telephone call they received from unknown person. After joining MHA, he got medical treatment to his eyes but he can't get cured from being blind. Although he is unable to see, he is happy by the life that he leads in MHA. He has no relationship with his families (former wife and child) but he is sometimes visited by his relatives. He is so grateful to Mekedonia workers and has good relations with them. He sometimes go to church with his colleagues. He explained that the room mates have time to discuss about their life and take corrective measures when necessary. Even if he is grateful to MHA, he regrets about being receiver of care. He said that, *'Yezaren ayaderegewena enem yerase geta neberku. Zare keleb teseferolegne yemenore turetegna honku enji'*.

Case seven

Alganesh was born in a place called belesa. She was earning her income by doing as a daily laborer in a private organization. She was not married and has no children. Alganesh has no contact with any of her relatives. But, later on she faced health complications and couldn't continue her work. She suffered from eye problem and mental illness. As a result of these challenges, she started to live on a street. Mekedonia Humanitarian Association workers took her from the street and started to live there. She got medical treatment in a clinic that is found in MHA and referral services so that she recovered from her illnesses. Currently, she is in good health status. Alganesh is involved in some activities in MHA like preparation of food items. She has good relations with the staffs of MHA and the residents. She is

attending church programs in the nearby churches. She is unhappy by her dependence on MHA to meet her needs. She said that it is other persons who decided what is important to me.

Case eight

Kibnesh was born in Addis Ababa at a place called arat kilo. She was married to her husband but having no children. She suddenly lost her husband by death. After the death of her husband, it was very difficult for her to cover living costs like house rental fee and purchase of food items that forced her to live on a street. Kibnesh was having an uncle here in Addis Ababa but they don't agree. She lived on a street for four years and then joined MHA by MHA workers. She was in good health condition. Kibnesh usually goes to church to attend spiritual programs. She usually has no agreement with the residents as well as the staffs of MHA. Regarding the services, she believes that the services are nice.

Case nine

Yared was born in a place called Lasta. He was a farmer. He was married and had two children. Gradually he became sick and couldn't engage himself in agriculture. He suffered from severe eye problem and high blood pressure. Due to this reason, his wife divorced him and got married to another person. She took the children with her. After this, he left his hometown and came to Addis Ababa. Since he was having no one in Addis Ababa, he started living on a street by being a beggar. Yared was taken from a street by MHA workers. After that, he got medical treatment for his illnesses and he is now in a better condition than before. He is so grateful to workers of MHA. He has good relation with the residents of MHA. He has no communication with his families and relatives. He is attending church programs in the nearby community. Yared is satisfied by the services given in MHA.

Case ten

Zuriyash was born in a place called merhabete. She was married to her husband but had no children. Her husband was a farmer. She was a housewife and depended on her husband for getting necessities of life. She was having peaceful marriage. But gradually her husband families started to interfere in their marriage and forced to divorce her. Their reason was their believe that she is barren. After divorcing her, he got married to another woman. And then life became hard to Zuriyash and came to Addis Ababa. Life was not as such easy in Addis Ababa so that she was forced to live on a street. She lived many years on a street and faced severe health problems specially tuberculosis. She was taken from the street by the workers of MHA. After the medical treatment in MHA, she just recovered from her illnesses. She never knows the condition of her relatives. She has good relations with the staffs and residents of MHA. Zuriyash believed that the services given in MHA are very satisfactory. She sometimes attends church programs in nearby churches.

4.2 Discussion

This section integrates the findings of the study with the relevant literatures. The results of my findings and profiles of older persons revealed that the numbers of care recipients who have children are by far less than those with no children. Studies conducted from 1991 to 2001 in England and Wales by Emily & Mark (2007) described that there is a strong association between morbidity and disability, especially cognitive impairment and institutional admission. Disability is the major cause of admission to institutional care accounting 75% (severely disabled) of home care residents in England. Emily & Mark (2007) further presented taking evidence from the longitudinal studies from North America, that lower socio-economic status, including not being a home owner, being unmarried, and living alone are associated with higher probability of entry to institutional care. They also showed the findings from recent Swedish evidence that suggests older people with children are less likely to enter institutional care than the childless.

4.2.1 Economic aspects of life in MHA

As Vincent (2003) stated, 'a common experience of growing old is loss of income'. All the respondents of my interview were losing their income. As studies revealed, many older people even in the developed world continue to live in relative poverty. But, the severity of the problem varies from country to country. In developing countries like Ethiopia, the probability of living under poverty in old age is high.

The number of ageing people is growing at a faster rate in developing countries like Ethiopia and these developing countries have less time to adjust to a growing population of older persons, they are at much lower levels of economic development and will experience greater challenges in meeting the needs of the increasing numbers of older people. As a result of this, older persons are facing financial insecurity.

As family ties are losing, the family members are denying supporting the older persons. Extended family system is changing to nuclear one that exposes the older persons to depend on other ways to help their life like institutional care. Results of respondents of this study revealed that the older persons are forced to be beggars to cover their basic necessities.

As it can be understood from the results of interview, the residents of MHA has no income source that is paid in cash. They are supported economically by providing food, shelter, blankets, shoe, clothes and pillow. Food is served four times a day.

Almost all respondents of the study were engaged in an informal sector like agriculture, serving in church or they were dependent on the income of their partners that led them not to benefit from the country's pension system. This aggravates economic problem of the older persons.

4.2.2 Health aspects of life in MHA

Maintaining good health and access to health care is a core concern of older people everywhere. As literatures indicate, the growing number of older persons is accompanied by mental illnesses and health problems that need even long term care and support system. Regarding the health aspect of life in MHA, there is a medium clinic inside one of the compounds and health services are given by volunteer professionals. If the patient needs extra medication, he/she will get referral to other government hospitals like Zewditu, Menelik II, Tekur Anbessa, ,Zenebework,and Yekatit 12. The institution has special agreement with these hospitals. In addition to this, medical doctors will come to the clinic on Tuesday, Thursday and Sunday and give services to those who need medication. Saturday morning psychiatrists came to the clinic and give psychological services to mentally ill care recipients.

Loss of vision is the common health problem. One respondent said that, *'Previously, I usually go to church but now stopped going to church due to sight problem'*

One respondent said that, *'he has severe blood pressure that led him to take medicines on a regular basis'*

Three care givers explained that most of the care recipients have poor health and usually visit the clinic. As these respondents replied, causes of frequent health problems are age related.

Results of this study showed that most of the older persons are facing sight problems, two of them gastritis and one of them mental illness. These illnesses were treated by the medium clinic in the institution and by referral services.

4.2.3 Social aspects of life in MHA

As it can be observed from the living condition of the older persons, they are living in group at least six individuals per a room. Some of the room mates have discussion time that helped them to

strengthen their social ties. Getting drunk is sometimes a reason for conflicts that arise within the residents.

Most of the respondents of this study said that they totally quit the relationship they have with their families, former friends and relatives. Some of them are still having communication with their neighbors and relatives. One respondent of this study said that *'I usually walk around this compound and have good social relationship with our neighbors and if I disappeared for more than a week these neighbors came and asked me about my situation. He explained this fact by saying 'meweled kunkua new'. People who have blood relationship with me didn't know where .I am living even whether I am alive or not.'*

Relationship with family members and relatives is relatively weak compared to that of the former friends. One respondent said that *'My friends are worthy compared to my families and relatives '*

The social relationship between the residents of MHA and the surrounding community is relatively good. When people have celebrations like arba, mut amet, serg and mirikat, they came to the institution and celebrate with the older persons. The older persons are also invited by different event organizers like balageru ayidel. They are so grateful to everyone who came to visit them. But sometimes due to some residents of MHA who get drunk and cannot control themselves, there is disrespectfulness and stereotyping. Sayings like 'kareju ayibeju' have a negative impact on the well being of the older persons.

4.2.4 Psychological aspects of life in MHA

Literatures revealed that older persons are exposed to discrimination due to the public fear that they need long time support. This in turn affects the psychological wellbeing of the older persons. Feelings of loss, hopelessness, loneliness, despair, sleeplessness, grievance and depression are the psychological problems that are faced by the older persons. As the staff respondents mentioned (3

respondents), getting psychological counseling from the professionals who come to the compound every Saturday is very helpful to cope from bad feelings. The causes of bad feelings for the older persons are separation from family ties, friends and neighbors, being dependent on the services, unsatisfied by the quality of service they get and loss of other possible options except accepting institutional care.

Older persons in MHA use several coping mechanisms when they feel depressed, lonely, grieve, hopeless or have other bad feelings. As all respondents from the staff agreed, the commonly used coping mechanism is prayer. The other coping mechanism is to watch television and play games like dama. Chatting with friends is also taken as a coping mechanism. As one respondent from the staff said, *' Some of the older persons go to the nearby places to drink local drinks (tej, tela, areke) in order to avoid bad feelings but this is strictly forbidden by MHA'*

4.2.5 Spiritual aspects of life in MHA

Respondents of this study said that they are engaged in different spiritual activities. Most of them are going to the nearby churches to attend spiritual programs. Spirituality in MHA is expressed by fasting, going to church, by putting the paintings of saints in the room, by baptizing with holy water, by praying and listening to spiritual songs.

4.2.6 Services provided by MHA

MHA provides holistic institutional services that include food, shelter, clothing, health and care giving. Daily meals are provided four times a day. Special meals are prepared during holidays. As observed, the condition of the dormitory is crowded. The dormitories accommodate from six to forty two beds. Of course, the dormitories size varies.

Older persons who are sick get immediate services from the medium clinic. Medical doctors are also working in the clinic on Tuesday, Thursday and Sunday. Those who have psychological problems get counseling services from the psychiatrists who came on Saturday morning on a regular basis. Older

persons who are facing mental illness are kept in isolated room until they recover from their illness. Uninterrupted supervision and care is given for them. Sometimes, religious persons are invited to the compouSnd and give spiritual teachings and counseling for those who are interested.

CHAPTER FIVE

5. CONCLUSIONS, RECOMMENDATIONS AND SOCIAL WORK IMPLICATIONS

5.1 Conclusions and recommendations

This study was conducted to explore the effects of institutional care on the life of older persons. I took MHA as a case and employed qualitative research design to assess the situations that older persons face by being institutional care recipient. Based on this premise, data is collected from ten older persons and five staffs. The results of this study show that institutional care has various effects on the life of older persons.

As I have seen in the video which is prepared by MHA, older persons became institutional care recipients due to economic, social and health problems (It could be physical or psychological). Being institutional care recipient has effects on the life of older persons that can be revealed in their economic, social, spiritual, psychological and health aspects.

In the economic aspect of institutional care, there is no means to get money from the institution. The services are provided in kind. Some of the care recipients got money from their former friends and relatives

In the social aspects of the institutional care, there are three categories. These are social interaction among residents of MHA, social interaction between care recipients and the surrounding community and social interaction between care recipients and their former social networks like families, children, relatives, neighbors and friends. There is good social interaction between residents of MHA except in cases where individuals came to their residence by drinking alcohols. Of course this happens rarely.

Regarding social interaction between care recipients and former social ties, this is almost interrupted. Older persons rely on non relatives and have relatively maintained relationship with their

former friends and neighbors than relatives. The extent of relationship with family ties like children and other relatives is not strong. The reason for this loss relationship is that fear of providing support for older persons. Social interaction between the older persons and the surrounding community is minimal. Since most of older persons spend their time in the compound, there is no room to create social interaction with the surrounding community.

These older persons attend spiritual activities in order to get relieve from their problems. Prayer is their major coping mechanism from their problems. Spirituality in MHA is expressed by fasting, going to church, by putting the paintings of saints in the room, by baptizing with holy water, by praying and listening to spiritual songs.

The psychological aspect presents the feelings and emotions of older persons and the coping mechanism that they employ to avoid bad feelings. Older persons have different feelings because of being institutional care recipients. Most of the older persons are happy but few of them are unhappy by being dependent even for their basic necessities. The feelings they encounter include hopelessness, depression, loneliness, sleeplessness, despair and grievance.

Health difficulty of older persons in MHA is more of seeing problem. This is due to the age of the care recipients. They got treatment in the clinic that is found in MHA compound and when necessary they are referred for better medication to hospitals. Mental illnesses are treated by psychiatrists. Gastritis and high blood pressure are also health problems of the older persons. For gastritis problem, they get medical treatment as well as food is prepared as per their conveniences.

Generally speaking, the living conditions of the elderly are much better than their previous life. The MHA is doing its best to improve the standards of living in the institution. Significant progress is expected when the institution is transferred to new site with more facility and services.

Here are some recommendations which help to improve the quality of existing care setting of MHA:

- The location, design and layout of the residential care setting should be suitable for its stated purpose. It should be accessible, safe, hygienic, spacious and well maintained and meets residents' individual and collective needs in a comfortable and homely way.

  (ventilation, fire safety regulations, lighting, storage space, accommodation fitted with locks suited to his/her capacities, outdoor space communal space, treatment rooms, kitchens, laundry, offices, bedrooms, toilet and washing facilities

- The individual accommodation and communal space provided should be improved and certain arrangements should be in place to ensure that the elderly privacy, dignity and modesty are respected at all times, and with particular regard to: maintaining social contacts to the extent to which he/she wishes to do so spending time alone, in accordance with his/her wishes, wearing his/her own clothing dressing and undressing being assisted to eat and drink.

- The care setting should provide an environment that is conducive to residents, staff, family, advocates or representatives, and visitors being able to raise issues and make suggestions and complaints (verbally or in writing) in a spirit of openness and partnership and without fear of adverse consequences.

- All staff should have up-to-date knowledge and skills, appropriate to their role, to enable them to manage and respond to behavior that is challenging. There should be arrangements in place to obtain advice, training and support from key professionals with the required expertise. Staffs should receive training in safe food handling as appropriate to their role and are compliant with safe food handling.

- The elderly should be given opportunities for participation in meaningful and purposeful activity, occupation or leisure activities, both inside and outside the residential care setting, that suit his/her needs, preferences and capacities. Particular consideration is given to residents with dementia and other cognitive impairments, residents with visual, hearing or dual sensory impairments, residents with communication difficulties and residents with physical or learning disabilities.
- Care setting should have a clear policy and procedures on the management of elderly accounts in accordance with standard guidelines. The center must develop written policies and procedures to ensure security and development of the residents. These policies and procedures may include but are not limited to administration, personnel, environment and security ,social environment and resident care

Government should establish a mandatory insurance program for long term care especially for the most vulnerable elders. Government and private industry should do enough to promote high quality long term care including home and community based care.

5.2 Social work implications

The social work profession promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance well-being. Utilizing theories of human behavior and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work (IFSW, 2004).

As cited in Compton, Galaway and Cournoyer (2005), one function of social work is to locate, coordinate and obtain formal social support through the provision of case management services. This involves assisting clients to identify their social support wants and needs, determine where and how these needs may be secured within the community and secure appropriate formal services. Therefore, social

work practice has to start from identifying the residents' bio psychosocial and spiritual needs and has to respect the clients' right, in this case older persons to participate in the process when they receive care.

Social work is an empowering profession that facilitates positive change for individuals, groups, family, and communities; it is true that social workers are devoted to the underlying principles as social change, social justice, and equality of opportunity for the vulnerable, disadvantaged, and marginalized segments of the society NASSW (2005).

Advocacy is essential to ensure the rights of institutional care recipients and improve the quality of services. The advocacy work can range from policy advocacy to influence the existing policies and guidelines and case advocacy to describe the situation of long term recipients and improve the quality of services.

Social work is based on respect for the inherent worth and dignity of all people, and the rights that follow from this. Social workers should uphold and defend each person's physical, psychological, emotional and spiritual integrity and well-being (IFSW, 2004). As it can be seen from the staff profile of MHA, there are no social work professionals who are engaged in care giving services. Care givers are from other disciplines and most of them are educated up to secondary school completion. Hiring social work professionals is crucial who can apply their knowledge to improve the lives of care recipients. Skill trainings on the areas of social work and human services have to be given to the existing care givers.

Thus, presence of social workers in the institution will help to defend the care recipient's physical, psychological, emotional and spiritual integrity and well-being.

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Interview guideline for staffs of MHA

This interview guideline is prepared to gather information from staffs of MHA. It basically has two parts namely:

I. Questions related to opinions of the staffs of MHA.

II. Questions related to the services of MHA.

I. Questions related to opinions of the staffs of MHA.

- What is your educational background?
- What is your level of education?

☐ Completed grade 12 ☐ Bachelor degree

☐ Certificate ☐ Above Bachelor degree

☐ Diploma

- Sex

☐ Male ☐ Female

- Age

☐ Up to 20 years ☐ 20 to 30 years ☐ Above 30 years

- What is your responsibility in MHA? For how long have you been working here?
- What is your general view about older persons?
- What do you fell about your work? With whom do you work often?
- What kinds of trainings do you get to improve your services?
- What are the challenges you encountered by working with older persons?

II. Questions related to the services of MHA.

- What kinds of services are given to care recipients?
- What major psychological problems are there?

- To what extent do you think the services provided by the institution are changing the lives of care recipients? How?
- How do the care recipients interact socially? Within? With the outside environment?
- What can be said about the spiritual life of the care recipients?
- How do the older persons get medical services?
- What needs to be done in order to improve the service provision?
- Anything to add?

Thank you for your cooperation.

Interview guideline for administration staff of MHA

This interview guideline is prepared to gather information from administration staff of MHA to get general information about the institution.

- When was MHA founded? Why? How? Where?
- For how long will the support continue?
- What is the structure of MHA?
- How many older persons enrolled at the start? Current number of care recipients?
- What is the age range of care recipients?
- What is the health status of the older persons?
- How do you enroll older persons to your institution?
- Can you explain conditions of the offices?
- What about the staff profile? How many staffs? Sex combination? Educational status? Work experience?
- What is the capacity of MHA?
- In what conditions are the dormitories?
- Who supports this institution?
- Anything to add?

Thank you for your cooperation.

Interview guideline for care recipients

This interview guideline is prepared to gather information from care recipients of MHA. It basically has five parts namely:

I. Background information.

II. Questions related to care recipients life condition before joining MHA.

III. How do the care recipients get admission to MHA?

IV. Questions related to care recipients life condition after joining MHA.

V. Anything to add.

I. Background information.

- Sex:
- Place of birth:
- Age:
- Educational status:
- Religion:
- Year of enrollment:
- Cause for being institutional care recipient

II. Questions related to care recipients life condition before joining MHA.

- What was your source of income?
- What was your family situation?
- How about your spiritual belief? Were you attending religious institutions?
- How was your health status?
- How was your relationship with your families? Relatives? The surrounding community?
- What was your marital status? Were you having children?

III. How do the care recipients get admission to MHA?

- How did you get admission to MHA? By who were you referred?

IV. Questions related to care recipients life condition after joining MHA.

- What do you feel about services being provided by the institution?
- How do you spend your time?
- What kind of spiritual activities are you doing?
- What do you feel about your economic status? How do you evaluate services given in terms of health related issues?
- How is your social relationship with residents of MHA? With the staffs? With parents and former friends? The surrounding community?
- What can be said about the private issues like safety of keeping your private things? Bathroom? Toilet usage? …
- Are there ways to express your opinions?
- What do you feel about being institutional care recipient?
- What do you like to be if you have another option than being institutional care recipient?
- How much are you happy? Unhappy? Why?
- In your opinion, what additional services should be included?

V. Anything to add.

Thank you for your cooperation.

Consent form

Hello dear participant (s)

My name is Eskedar Sibuh. I am a post graduate student of School of Social Work in Addis Ababa University. I am undertaking a research on the effects of institutional care on the life of older persons at Mekedonia Humanitarian Association for the partial fulfillment of the requirement for the Degree of Master of Social Work.

You are selected to participate in this research because you are directly related to the research topic that I am dealing with. The participation with this research is purely voluntary. Your participation in the research process is really crucial to attain the research objectives. I ask you to be genuine when you are replying my questions. I will use tape recorder to record our conversation and it will be used only for the research purpose. In order to assure confidentiality, I will delete our conversation upon the completion of the study.

Thus, if you are willing to participate in this interview, I kindly request you to put your signature on the part provided under. Whenever you have anything to ask , you are most welcomed. I really appreciate your cooperation.

Eskedar Sibuh Participant

Signature ---------- ----------

Date ---------- ----------

Declaration

I, the undersigned, declare that this thesis is my original work and has not been presented for a degree in any other university, and that all the sources of materials used for the research project have been dully acknowledged.

Student's Name	Signature	Date
Eskedar Sibuh	----------	June 2015
Advisor's Name		
Mengistu Legesse (PhD)	----------	June 2015

ለመቄዶንያ አረጋውያንና የአዕምሮ ህሙማን መርጃ ተቋም ሠራተኞች የተዘጋጀ ቃለ መጠይቅ

የዚህ መጠይቅ አላማ ለትምህርታዊ ዕሑፍ ስለሆነ የሚያውቁትን ትክክለኛ መረጃ በመሙላት ስለሚተባበሩ ከወዲሁ አመሰግናለሁ፤ ይህ መጠይቅ የተዘጋጀው ከመቄዶንያ ሰራተኞች መረጃን ለማሰባሳብ ነው፡ መጠይቁ ሁለት ዋና ዋና ክፍሎች አሉት፡፡ እነሱም፡-

I. በአጠቃላይ ሰራተኞቹን በተመለከተ
II. ከመቄዶንያ አገልግሎት አሰጣጥ ጋር በተገናኘ

I. አጠቃላይ ሰራተኞቹን በተመለከተ

- የተማሩት የትምህርት አይነት ምንድን ነው ?
- የትምህርት ደረጃ

☐ እስከ 12ኛ ክፍል ☐ የመጀመሪያ ዲግሪ

☐ ሰርተፍኬት ☐ ከመጀመሪያ ዲግሪ በላይ

☐ ዲፕሎማ

- ፆታ

☐ ወንድ ☐ ሴት

- ዕድሜ

☐ እስከ 20 ዓመት ☐ ከ30 ዓመት በላይ

☐ ከ20 – 30 ዓመት

- በማዕከሉ ያለዎት የሥራ ሐላፊነትዎ ምንድን ነው ?
- በማዕከሉ ውስጥ ለምን ያህል ጊዜ አገልግለዋል ?
- ወደማዕከሉ ለመግባት የቻሉት እንዴት ነው ?
- ስለአረጋውያን ያለዎት አመለካከት ምንድን ነው ?
- ስለስራዎ የሚሰማዎት ስሜት ምንድን ነው ?
- ስራዎት በአብዛኛው ከማን ጋር ያገናኝዎታል ?
- ስራዎትን የበለጠ ለማቀላጠፍ የሚረዱ ስልጠናዎችን አግኝተዋል ?
- ከአረጋውያን ጋር በመስራትዎ ያገጠመዎት ተግዳሮቶች አሉ ?ካሉ ምንድን ናቸው?

II. <u>ከመቄዴንያ አገልግሎት አሰጣጥ ጋር በተገናኘ</u>

- የሚሰጡትን አገልግሎቶች በዝርዝር ግለፁ ?
- ዋና ዋና የሚያጋጥሙ የሥነ - አእምሮ ችግሮች ምንድን ናቸው ?
- የሚሰጡት አገልግሎቶች የአረጋውያኑን ሕይወት ከመለወጥ አንፃር ምን ያህል ውጤታማ ናቸው ? ለውጥ አምጥተዋል ካሉ እንዴት ?
- አረጋውያኑ እርስ በርስ ያላቸው ግንኙነት ምን ይመስላል ? ከሰራተኞችስ ጋር? ከአካባቢው ማህበረሰብስ ጋር ?
- አረጋውያኑ እንደየእምነታቸው መንፈሣዊ አገልግሎት የሚያገኙበት መንገድ አለ ? ካለ እንዴት ?

- በተቋሙ የሚሰጠውን የጤና አገልግሎት አብራሩ፡፡
- በተቋሙ የሚሰጡትን አገልግሎቶች የበለጠ ለማሻሻል ምን ቢደረግ ይላሉ?
- የሚጨምሩት ሐሳብ ካለ

ስለትብብርዎ ከልብ አመሰግናለሁ!

<u>ለመቄዶንያ አረጋውያንና የአእምሮ ሕሙማን መርጃ ተቋም</u>

<u>መረጃ ባለሙያ የተዘጋጀ ቃለ መጠይቅ</u>

የዚህ መጠይቅ አላማ ለትምህርታዊ ዕሑፍ ስለሆነ የሚያውቁትን ትክክለኛ መረጃ በመሙላት ስለሚተባበሩ ከወዲሁ አመሰግናለሁ፡፡

ጥያቄዎቹ ስለተቋሙ አጠቃላይ መረጃ ለማግኘት የተዘጋጁ ናቸው፡

- ተቋሙ መቼ ተመሰረተ ? ለምን ? እንዴት ? የት ?
- የሚደረገው ድጋፍ ቀጣይነት ምን ይመስላል ?
- የተቋሙ መዋቅር እንዴት ነው ?
- ተቋሙ ሥራውን ሲጀምር ምን ያህል ሰዎችን ተቀበለ ? አሁን ያለውስ ቁጥር ምን ይመስላል ?
- በተቋሙ ድጋፍ የሚደረግላቸው ሰዎች እድሜ ከስንት እስከ ስንት ይሆናል?
- የአረጋውያኑ የጤና ሁኔታ ምን ይመስላል ?
- አረጋውያንን ወደማዕከሉ የምትቀበሉት እንዴት ነው ?
- የቢሮዎቹ ሁኔታ ምን ይመስላል ?
- ምን ያህል ሰራተኞች አሉ ? የሰራተኞቹ የፆታ ስብጥር ምን ይመስላል ? የትምህርት ደረጃቸውስ ? የሥራ ልምዳቸውስ ?
- ተቋሙ ምን ያህል ሰዎችን የመቀበል አቅም አለው ?
- የአረጋውያኑ የመኖሪያ ክፍሎች ሁኔታ እንዴት ይገለፃል ?
- ተቋሙ በማን ይደገፋል ?
- የምትጨምሩት ነገር ካለ ?

ስለትብብርዎ ከልብ አመሰግናለሁ!

<u>ለመቄዶንያ አረጋውያንና የአእምሮ ሕሙማን መርጃ ተቋም</u>

<u>አገልግሎት ተጠቃሚዎች የተዘጋጀ ቃለ መጠይቅ</u>

የዚህ መጠይቃ አላማ ለትምህርታዊ ጽሑፍ ስለሆነ የሚያውቁትን ትክክለኛ መረጃ በመስጠት ስለሚተባበሩ ከወዲሁ አመሰግናለሁ፡፡ ይህ መጠይቅ አምስት ዋና ዋና ክፍሎች አሉት፡፡ እነሱም፡-

I. አጠቃላይ መረጃ
II. ወደ ማዕከሉ ከመግባታቸው በፊት ስለነበሩበት የኑሮ ሁኔታ
III. ወደ ማዕከሉ እንዴት እንደገቡ
IV. ወደ ማዕከሉ ከገቡ በኋላ ስላለበት የኑሮ ሁኔታ
V. የሚጨምሩት ነገር ካለ

I. አጠቃላይ መረጃ

- ዕድሜ
- የትውልድ ቦታ
- እድሜ
- የትምህርት ደረጃ
- ሃይማኖት
- ወደተቋሙ መቼ ገቡ ?
- ወደ ተቋሙ እንዲገቡ መንስኤ የሆነው ነገር ምንድን ነው ?

II. ወደማዕከሉ ከመግባታቸው በፊት ስለነበሩበት የኑሮ ሁኔታ

- የገቢ ምንጭዎ ምን ነበር ?
- የቤተሰብዎ ሁኔታ ምን ይመስላል ?
- መንፈሣዊ ሕይወትዎ እንዴት ነበር ? የእምነት ተቋማት በመሔድ ይካፈሉ ነበር ?
- የጤና ሁኔታዎ ምን ይመስል ነበር ?
- ከቤተሰብዎ ጋር የነበረዎት ግንኙነት ምን ይመስላል ? ከዘመድ ጋርስ ? ከአካባቢው ማህበረሰብ ጋርስ ?

- የጋብቻዎ ሁኔታ ምን ይመስላል ? ልጆች አለዎት ?

III. ወደ ማዕከሉ እንዴት እንደገቡ

- ወደ ማዕከሉ እንዴት ገቡ ? ለመግባትዎ ምክንያት የሆነው ማን ነበር ?

IV. ወደ ማዕከሉ ከገቡ በኋላ ስላሉበት የኑሮ ሁኔታ

- በማዕከሉ የሚሰጡትን የተለያዩ አገልግሎቶች እንዴት ይገመግሙታል ?
- ጊዜዎትን እንዴት ያሣልፋሉ ?
- ምን አይነት መንፈሣዊ እንቅስቃሴ ላይ ይሣተፋሉ ?
- ስላሉበት ኢኮኖሚያዊ ሁኔታ ምን ይላሉ ? ከጤና ጋር በተገናኘ የሚሰጠውን አገልግሎት እንዴት ያዩታል ?
- የግል የሚባሉ ጉዳዬች እንዴት ይስተናገዳሉ ?ለምሣሌ ፡- መታጠቢያ ቤት አጠቃቀም ? ሽንት ቤት አጠቃቀምና የመሳሰሉት
- ሐሳባችሁን የምትገልፁበት መንገድ አለ ?
- በተቋሙ ውስጥ በመሆንዎት ምን ይሰማዎታል ?
- በተቋሙ ውስጥ ከመሆን ይልቅ ሌላ አማራጭ ቢኖርዎት ምን መሆን ይፈልጋሉ ?
- ምን ያህል ደስተኛ ነዎት ? ካልሆኑስ ለምን ?
- ካሉት አገልግሎቶች በተጨማሪ ምን ቢኖር ይላሉ ?

V. የሚጨምሩት ነገር ካለ ?

ስለትብብርዎ ከልብ አመሰግናለሁ!

<u>የስምምነት ቅፅ</u>

ሰላም ውድ የዚህ መጠይቅ ተሣታፊዎች

እኔ እስከዳር ስቡህ እባላለሁ፡፡ በአዲስ አበባ ዩኒቨርስቲ የሶሻል ወርክ ትምህርት ክፍል የድህረ ምረቃ ፕሮግራም ተማሪ ስሆን ለሁለተኛ ዲግሪ መመረቂያ የሚሆን የማሟያ ጥናት በማድረግ ላይ እገኛለሁ፡፡ የዚህ ጥናት አላማ በመቄዶንያ የአረጋውያንና የአእምሮ ሕሙማን መርጃ ማዕከል የሚገኙ አረጋውያን በተቋሙ ውስጥ መሆናቸው ያለውን ተፅዕኖ ለመገንዘብ ትኩረት ያደረገ ነው፡፡

በዚህ ጥናት እንዲሳተፉ የተመረጡበት ምክንያት ከማደርገው ጥናት ጋር ቀጥተኛ ግንኙነት ስላለዎት ነው፡፡ በዚህ ጥናት ላይ መሣተፍ ሙሉ በሙሉ በፈቃደኝነት ላይ የተመሰረተ ነው፡፡ በዚህ ጥናት ላይ የጥናቱ አላማ እንዲሳካ የርስዎ ተሳትፎ በጣም ወሳኝ ነው፡፡ ይህንን መጠይቅ ሲመልሱ በተቻለ መጠን ትክክለኛና እውነተኛ መረጃ እንደሰጡኝ አደራ እላለሁ፡፡ በቃለ መጠይቁ ወቅት የድምፅ መቅረጫ እጠቀማለሁ፡፡ ይህም መረጃ ለጥናቱ አላማ ብቻ የሚውልና ጥናቱ እንዳለቀ የሚጠፋ ይሆናል፡፡

ስለዚህ በዚህ መጠይቅ ለመሣተፍ ፈቃደኛ ከሆኑ ከታች በተዘጋጀው ቦታ ላይ ፊርማዎትን እንዲያስቀምጡ እጠይቃለሁ፡፡ ምንም አይነት ጥያቄ ካለዎት እባክዎ ይጠይቁ፣ ስለትብብርዎ ከልብ አመሰግናለሁ፡፡

እስከዳር ስቡህ

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ቀን _____

የጥናቱ ተሣታፊ

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