ADDIS ABABA UNIVERSITY

SCHOOL OF GRADUATE STUDIES

DEPARTMENT OF SOCIOLOGY

Institutional Care Provided for the Elderly and Residents Perception of the Quality of Care Provided by Mekedonia Home for the Elderly and Mentally Disabled

By

TEWODROS HABTEGIORGIS ZIKARGE

October, 2016

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A Thesis Submitted to the School of Graduate Studies of Addis Ababa University in Partial Fulfillment of the Requirements for the Degree of Master of Arts in Sociology

Research Advisor: - Dr. Yeraswork Admassie

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This is to certify that the thesis prepared by Tewodros Habtegiorgis Zikarge entitled: Institutional Care Provided for the Elderly and Residents Perception of the Quality of Care Provided by Mekedonia Home for the Elderly and Mentally Disabled; submitted in partial fulfilment of the requirement for the Degree of Master of Arts in Sociology complies with regulation of the University and meets the accepted standards with respect to the originality and quality.

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Acronyms

ADL:	Activities of Daily Living
ANOVA:	Analysis of Variance
CSA:	Central Statistical Agency
HAI:	Help Age International
IADL:	Instrumental Activities of Daily Living
IGA:	Income Generating Activity
MHEMD:	Mekedonia Home for the Elderly and Mentally Disabled
MOLSA:	Ministry of Labor and Social Affairs
NGO:	Non-Governmental Organization
PSNP:	Productive Safety Net Program
RCFE:	Residential home Care Facilities for the Elderly
SD:	Standard Deviation
SPSS:	Statistical Package for Social Sciences
UN:	United Nations
WHO:	World Health Organization

Abstract

This study was conducted with the aim of assessing institutional care provided for the elderly and residents perception of the quality of care provided by Mekedonia Home for the Elderly and Mentally Disabled. From 530 residents of the institution this study used 175 randomly selected sample residents. The study used mixed-method approach (a concurrent nested strategy). The survey which was employed in this study focused on gathering information on the types of care, levels of care and the residents' perception of the quality of care provided. In addition, in-depth interviews and focus group discussions were conducted with purposively selected residents and key informant interview with key administrative staffs who are in charge of providing care and support, focusing on the available resources and problems associated with care and support. The study revealed that there are food, clothing, shelter, recreational and health care services provided by the institution and most sample residents believe each service provision as good and excellent. The study also disclosed that there are significant variations in the perceptions' of residents with regard to the quality of care, in accordance with their disability status and sex. As a result, there is a statistically significant difference between physically abled and disabled respondents in terms of their rating of the quality of care or perception. Physically disabled residents are found to be positive to quality of care than physically abled residents. Sex also resulted in differential perceptions. Males are found to be positive to quality of care than females. There is also a statistically significant relationship between respondent's age and duration of stay in the institution and their rating of the quality of care provided. The qualitative data revealed that, even though residents thought they are having a better life than their past circumstances, they had also mentioned some care related problems within the institution. Inadequate bath and bed rooms and communal recreational facilities, decreased care givers attention on the process of care giving activity, insufficient physical space for residents to care with and living together with mentally disabled residents are the major problems mentioned. One of the possible interventions to curb the problems of vulnerable population is an institutional care system. This intervention is of paramount importance in time of crises like family lose, health complication and poverty driven street-life.

Keywords: Institutional care, Quality of care and Residents

CHAPTER ONE
INTRODUCTION

1.1. Background of the study

Most elderly prefer to remain in their homes where they are able to maintain the integrity of their social network, preserve environmental landmarks and enjoy a higher quality of life. However, due to complex socio-economic and political circumstances elderly people lose their independent livings (Luppa & Tobias, 2009).

Nowadays, elderly people are encountered with various problems this is due to limited government social welfare schemes and weakening of traditional family and community support. Thus it is common to see elderly who have the knowledge and skill to help not only themselves but others facing serious problems and resorting to begging and sleeping in streets (Ministry of Labor and Social Affairs, 2006, p4).

In Ethiopia, elderly people make up a relatively small portion (2.8%) of the total population, and traditionally their main source of support has been the household and family, supplemented in many cases by other informal mechanisms, such as kinship networks and mutual aid societies (Ministry of Labor and Social Affairs, 2006, p4).

Currently, at the national level, government and non-government organizations as well as association of retired persons have started to make greater efforts in tackling problems of the elderly. One of the solution, as the elderly became in such a condition, is the development of institutions to care for them (Adamek & Alemnesh, 2014). These elderly care institutions which are private or humanitarian, voluntary and charity associations such as Mekedonia Home for the Elderly and Mentally Disabled, are assumed to be significant to increase the quality of life of the elderly with good quality of care.

Quality of care has become an increasingly popular term and is now spoken of in diverse contexts. Its usage has become widespread covering almost all facets of daily living. Quality of care is especially relevant for residents in home care facilities (such as Mekedonia) who may be considered as one of the most vulnerable groups in society given their increasing age and levels of dependency (Hibjamic, 2009, pp3-10).

Mekedonia Home for the Elderly and Mentally Disabled (MHEMD) is an indigenous non-governmental, non-profit and charity organization, founded on 7th January 2010. The purpose of the institution is to support elderly people and people with disabilities who otherwise have no means of survival by providing them with shelter, clothing, food, and other basic services.

Mekedonia is a residential home care unit that is more than just a provider of support; it is also the permanent dwelling place of residents. It has the potential, therefore, to influence and affect many aspects of the residents' daily lives beyond health and functional ability. It is important, therefore, that researchers, policy-makers and other interested parties recognize and understand the important elements that constitute a good quality of care in elderly home care in order to put in place mechanisms that will ensure that this objective is achieved.

It is in this regard that this thesis attempts to assess actual care provided and the residents' perceptions of Quality of care by taking of Mekedonia Home for the Elderly and Mentally Disabled (MHEMD) and the elderly care recipients as a frame of study.

1.2. Statement of the Problem

There are a number of studies that address issues of the elderly in Ethiopia both at macro and micro level analysis. (Such as, an assessment made by Help Age International Ethiopia and Cordaid, 2013) focusing on older people's livelihoods & the state of health and ageing, an inquiry made by (MOLSA, 2012) on ways and means of providing assistance to older persons and persons with disabilities and an investigation made by (United Nations Department of Economic and Social Affairs, 2011) focusing on the Social Situation, Well-Being, Participation in Development and Rights of Older Persons etc. This and other studies were designed to explore and describe the situation of the elderly in the context of local sociocultural and economic frameworks.

Though much has been studied to explore and describe the situations of the elderly in the above outlined contexts, the field of institutional elderly care and quality institutional elderly care has not been amply researched in the past. Only few academic researches has been conducted in assessing the situation of elderly people under the institutional care settings, (such as Eskedar ,2015) conducted a research on exploring the effects of institutional care on the elderly's life And (Segniwork, 2014) had studied the experiences and practices of old age home care and support to the elderly living in the institutions.

However, the main motivation for this research is based on the awareness that issues of institutional care provision for the elderly and the quality of the care provided are particularly relevant in the study of the condition of elderly people in institutional care settings. Because, in institutional care elderly need, not only home care but also concrete help in daily life, emotional and social support to maintain the lifestyles they like. Elderly institutional care are not just a matter of extending life, but of enhancing life situations of the elderly with a good quality care, and this

should be a major consideration in how studies assess the actual care provisions and impact of the services provided and consumed (Marja Vaarama, 2008).

Therefore, this creates a gap in the academic literature. To fill the gap in the academic literature thus, this study was directed at searching for actual care provided by the selected institution and the perception of residents' with regard to quality of care provided.

1.3. Objectives of the study

1.3.1. General Objective

The main purpose of this study is to assess the actual care provided to the residents by Mekedonia and the perception of residents with regard to the quality of the care provided.

1.3.2. Specific Objectives

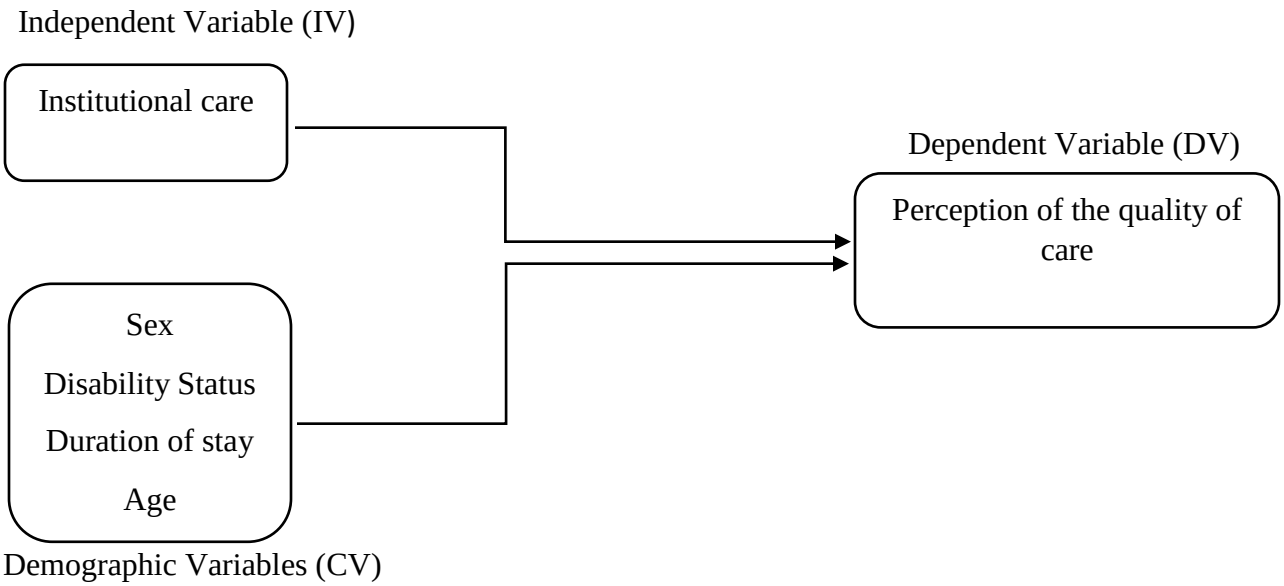
Specifically, this study aims:

1. To assess the type and level of care being provided by Mekedonia
2. To assess the perceptions of residents' with regard to the quality of care being provided
3. To examine the relationship between age, duration of stay and perceptions of the quality of care
4. To identify available resources and challenges associated with the care and support provided by Mekedonia

1.4. Conceptual Framework and Operational definition

The following conceptual framework is set up to analyze and understand the relationship between the various factors which determine the variation in the perception of residents with regard to the quality of care provided.

Figure 1: Conceptual framework of the study



It is hypothesized that multiple factors are responsible to influence the perception of residents with regard to the quality of care provided. The socio-demographic characteristics of residents such as resident's sex, disability status (physically disabled and abled), duration of stay (the amount of time residents stayed in the institution and age are supposed to bring variations in the perception of residents towards the quality of care provided by the institution. It is based on the above assumptions that the data gathered from survey respondents and interviewees are analyzed and inferences are made.

1.4.1. Operational definition of the research variables and measurement of key variables

The following table shows the identification of variables from concepts, and those of indicators to the variables. It also shows the level at which the indicators are measured.

Table-1: Operational definition and measurement of key variables

Concept	Variable	Indicators	Level and Unit of Measurement
Socio- demographic characteristics	Sex	Indicates male or female	(1)Male, (2) Female • **Nominal**
	Age	Length of time (year) that one has been alive	Age in completed years • **Ratio**
	Marital status	Indicate never married, married, widowed, and divorced	(1)Never married, (2)Married, (3)Divorced, (4)Widowed • **Nominal**
	Disability Status	Residents physical health conditions	(1)Physically disable, (2)physically able • **Nominal**
	Duration of stay	Length of time stayed at the institution	Time completed in months • **Ratio**
	Educational qualification	Level of Education attained	(1)Cannot read and write, (2)Read only, (3)Can Read and write, (4)Attended grade 1-4, (5)Attended grade 5-8, (6)Attended grade 9-12, (7)Attended vocational training, and (8)Attended higher education • **Ordinal**
	Income	Total monthly income	Amount in ETB • **Ratio**
Institutional care	Types & level of care	The types of care & support	(1)Yes, (2)No • **Nominal scale**
		Residents rating of level of care and support provided by Mekedonia	(4)Excellent, (3)Good, (2)Fair, (1)Poor • **Ordinal scale**
Quality of care	Residents Perception of the Quality of care provided by Mekedonia	Likert scale measures of residents own appraisal of quality of care	Single item score • **Ordinal/Interval**

1.4.2. Conceptual definition of terms

Aging: refers to the process of physiological, psychological and social change that are progressive, detrimental and irreversible, of structural and functional body organ (WHO, 2004, p35).

Disability status: refers to difficulty in carrying out tasks of daily life. The person can't take care of him or herself. It is any loss of normal physical abilities due to illness, or injury or accident.

Duration of stay: refers to the amount of time that residents had stayed in the institution from the day of arrival to the time of data collection.

Elderly: refers to a category of adults who have attained advanced ages, 60 or 65 years. Ethiopia uses 60 years and above to refer to the elderly (United Nation, 2010, p1).

Elderly institutional care: refers to residential care facilities for the elderly which serve persons 60 years and older. They provide room, board, house-keeping, supervision, and personal care assistance with basic activities like personal hygiene, dressing, eating and walking. It could be private, public or voluntary care facility. In this research, it refers to MHEMD which is charitable or voluntary, none profit care organization (Quadagno, 1999).

Residents: refers to elderly care recipients who are dwelling on the residential home care i.e. Mekedonia.

Quality of care: although it is a multi-dimensional concept, in this study it is measured through the various elements such as, prevalence of meaningful activities, residents spiritual wellbeing, physical comfort, availability of private space for the residents, dignity of the residents, meaningful relationships with one another and with staff, which are all related to the care provided by MHEMD (Kane, 2003.

1.5. Significance of the study

This study is important in terms of serving as input to improve the standard and quality of social welfare service of Ethiopian elderlies, to bring about concrete results with visible impact in the life of the elderly by expanding services and supports through concerted efforts of organizations working the elderly and securing the participation of the elderly themselves. It is also very important in terms of serving to expand and strengthen services for the older persons based on institutional and community participations.

With all efforts by non-governmental organization, voluntary association and community action-groups desiring to establish services to assist and support the elderly has been encouraged and supported, it is then, very important to capture the circumstances of care delivered by the elderly institutional care and issues of the elderly under the institution. This study is also of utmost importance for planning, designing and implementation of programmes and strategies to ensure improvements in the quality of the life of elderly.

It is also hoped that the findings of the study will be very helpful for further studies in the area of institutional care of the elderly in general and quality of care in particular.

1.6. Limitations

This study is limited in terms of coverage and depth owing to financial and time constraint. It has a limited scope of focusing on the institutional care provided for the elderly and their perceptions of the quality of care provide particularly focusing on a single selected elderly care center in Addis Ababa (i.e. Mekedonia). Therefore the service provision of this institution and the perception of the elderly may not represent the case of other elderly care centers. As it has focused in the assessment of the service provided by the studied institution and the perception of

the institutionalized elders, this study also didn't entertain the perspectives of other elderly who are non-institutionalized.

1.7. Organization of the paper

This research paper is organized into five chapters. The first chapter introduces the background, statement of the problem, objectives, scope, significance and limitation of the study. Chapter two reviews the relevant literature that is related to the subject under study. Chapter three deals with research method which consists of sampling techniques and sample size determination, data collection instruments, data types and data sources, methods of data analysis and interpretation and description of the study institution. Quantitative and qualitative data were analyzed and discussed under chapter four. Finally, chapter five presents summary of the major findings, conclusion and recommendation of the study.

CHAPTER TWO

REVIEW OF RELATED LITERATURES

Chapter Overview

In studying aging and the life course, all social science researchers are confronted with challenges of defining the population to be studied (i.e. elderly population segments). Therefore, it is very vital to begin through defining old age and concept of ageing. And then this chapter would discuss, the global and regional trends in aging and the growing importance of aging, trends of elderly population in Ethiopia, the situation of elderly people in Ethiopia, structural schemes for elderly in Sub-Saharan Africa and Ethiopia, institutional care and types of elderly care, understanding and measuring Quality of care and Theoretical orientations. Finally, it discusses the quality of care for elderly institutional care.

2.1. Defining old Age

When is someone old? Although the question sounds simple, definitions of aging and old age vary widely. In studying older people and the aging process, researchers need some marker of age. The choice they make often depends on the nature of the issue under investigation rather than some abstract conception of old age (United Nations, 2010, p1).

The concept elderly refers to a category of adults who have attained advanced ages, 60 or 65 years. The Ethiopia uses 60 years and above to refer to the elderly. In the developed countries where life expectancy is high and the age of retirement from active public economic activity is 65 years, the elderly are defined as persons aged 65 years and above. In developing countries on the other hand, since life expectancy is lower and the age of retirement is 60 years, the elderly are considered as persons aged 60 years and above. (United Nation, 2010, p1)

The elderly are also known as the aged, with an associated concept of ageing that can be applied to an individual person or a total national population. An individual person is ageing when he/she attains ages that are classified as old ages. Population ageing on the other hand refers to a process whereby the proportion of the aged or the elderly in a total national population increases. This process which until recently was characteristic of the populations of developed countries is now being experienced by the developing countries as well. (United Nation 2010:2)

2.2. The concept of ageing: what is aging?

According to the World Health Organization (2004, p35), ageing refers to "a normal biological process defined as those time-dependent, irreversible changes that lead to progressive loss of functional capacity after the point of maturity." The changes, that the World Health Organization listed include "…physiological, psychological and social that are progressive, detrimental and irreversible, of structural and functional body organs." The organization (2004, pp35-36) affirms that normal ageing is not a disease, but eventually leads to structural and functional decline and involves increased susceptibility to diseases due to intrinsic and extrinsic factors (WHO, 2004).

The chronological definition of old age differs from country to country, depending on the cultural, economic, and overall developmental stage of the society in question. For example, in many developed countries, a person is considered older at the age of 65, which is an age at which a person is entitled to pension or retirement benefits (Help Age International Ethiopia, 2013).

For the purpose of this study, the researcher take the definition of the United Nations (2007), which puts age 60 as "the dividing line between older and younger cohorts of the population." This definition, would not only save us from debating on a relativist concept, but is also in line with the definition of older people in our country as used by the Ministry of Labor and Social Affairs (MOLSA) and other relevant governmental offices.

2.3. Global and regional trends in aging and the growing importance of aging

Aging and the situation of elderly is one of the emerging concerns in demography both globally and regionally. This concern is also being progressively pushed to the top of the developmental policy agenda due to the changed and changing characteristics of the global and regional demographic distribution in terms of age. Not only has the world witnessed a dramatic increase in its total population having grown from 2.5 billion in 1950 to 6.9 billion in 2010, and projected to balloon to 9.1 billion in 2050(UN World Population Prospects: The 2008 Revision), but it has also experienced dramatic increase in the proportion of its aging population. The latter is particularly true of the developed region of the world, and the developing and least developed regions are to follow suit in the coming decades with falling fertility and mortality (CSA 2011, pp1-3).

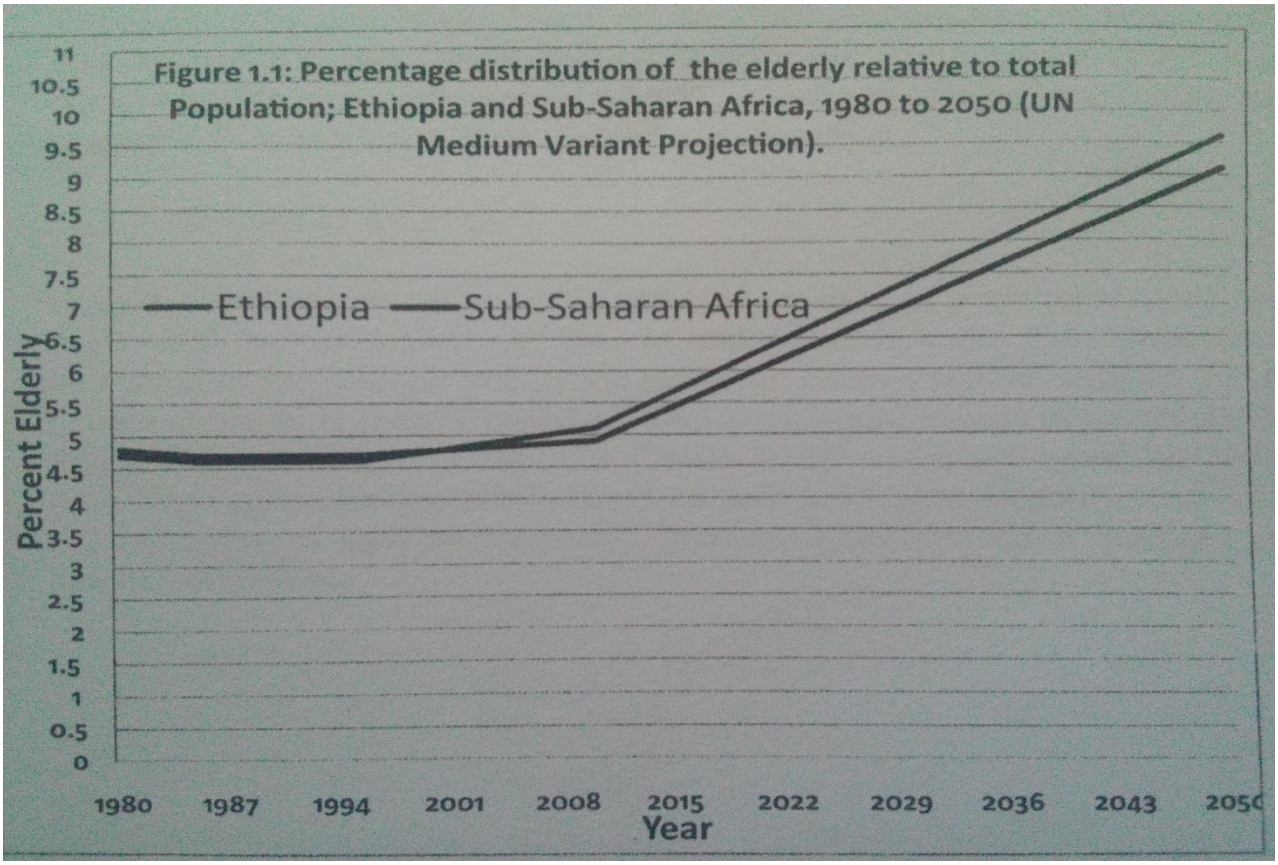
In 1980, the over 60 year's old population of the world was 378.2 million and accounted for 8.5 percent of the total population of nearly 4.4 billion. In 1985, it climbed to 425.2 million making up 8.8 percent of the 4.8 billion total world population. Then, by 1995 the global elderly population grew to 538.6 million accounting for 9.4 percent of the 5.7 billion total world population. In 2010, the figures were 759.1 million for the elderly and 6.9 billion for the total world population, with the elderly making up 11.0 percent of the latter. Forty years in to the future, in 2050, the world population that is projected to balloon to a total of nearly 9.2 billion will include a large elderly population of about 759.1 million with a share of 21.9 percentage of the total population (CSA 2011, pp1-3).

Thus, pictures emerging from the analysis of the trends the total and elderly regional populations are quite different from the above described global ones and also from that of one another. There is, for instance, a marked difference between those of the developed and least developed regions

including sub-Saharan African regions. For the sake of brevity, only the region closest to Ethiopia, namely sub-Saharan Africa is considered here, below.

While the trends of the total and the elderly populations are stable and quite similar to that of the global trends in absolute terms, the percentage change of the elderly populations is characterized by being more or less stable over the first 30 years and by a rather dynamic growth during the second 40 years from 2010 to 2050, according to the UN projection. Thus, in 1980, the total p[population of Sub-Saharan Africa that was 389.8 million contained 18.6 million persons of over 60 years old accounting for 4.8 percent. By 1985, the total populations of the region and that of the elderly had grown to 449.7 million and 21.3 million respectively, but the percentage shares of the elderly did not change significantly having decreased by a fraction of a percentage point. Similarly, by 1995, the total population and that of the percentage share of latter again remained the same. By 2010, the two populations had increased to 863.3 and 27.9 million respectively, indicating only a slight increase of the percentage share of the elderly (from 4.7 to 4.9 percent). UN projections show that this is going to be dramatically altered in the course of the coming 40 years with falling fertility and mortality. By 2050 the total and the elderly populations of sub-Saharan Africa will reach nearly 1.8 billion and 160 million respectively, and the percentage share of the elderly population will also dramatically rise to 9.1 percent (from 4.9 to 9.1). put in differently, while only one out of every twenty persons living in sub-Saharan Africa throughout the period 1980-2010 was aged 60 and above, one in eleven persons in the region will be of this age by 2050 (CSA 2011, pp1-3).

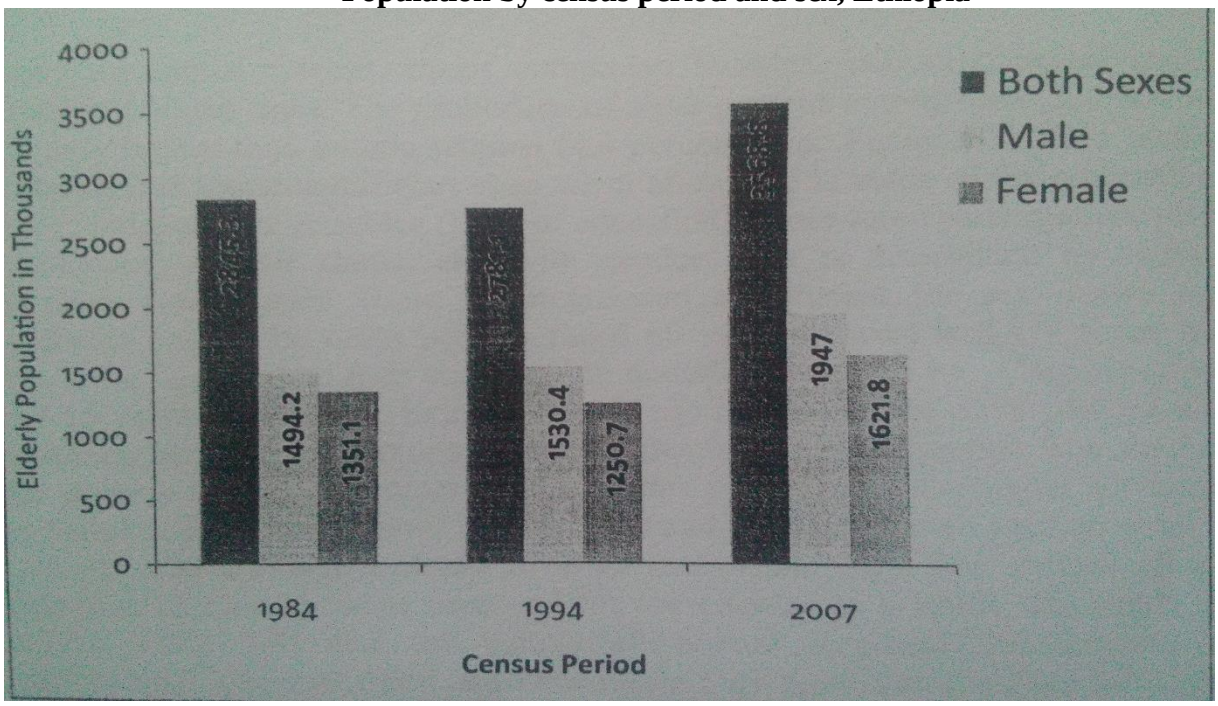
Figure 2: Percentage distribution the elderly relative to total population; Ethiopia and sub-Saharan Africa, 1980 to 2050(UN Medium variant projection).



2.4. Trends of elderly population in Ethiopia

The trend in the proportion of elderly persons out of the total population is not showing an increase as expected in the globe, the reason for this might be the existing higher rate of fertility in almost all parts of the country. Though the proportion of the elderly is not increasing their absolute number has increased over the past 30 years (See Figure 2 below), (CSA 2011, p7).

Figure-3: Distribution of elderly (aged 60 years and over) Population by census period and sex, Ethiopia



2.5. The situation of elderly in Sub-Saharan-Africa and Ethiopia

Economic security, health and disability, and living conditions in old age are policy concerns throughout the world, but the nature of the problem differs considerably from continent to continent and between and within countries. In sub-Saharan Africa older people make up a relatively small fraction of the total population, and traditionally their main source of support has been the household and family, supplemented in many cases by other informal mechanisms, such as kinship networks and mutual aid societies (Cohen & Menken 2006, pp9-19).

Although careful empirical research has been undertaken on long-term trends in the welfare of older people, there are a number of reasons to believe that traditional caring and social support mechanisms in sub-Saharan Africa are under increasing strain. Located on the least developed and poorest continent, African economies are still heavily dependent on subsistence agriculture,

and average income per capita is now lower than it was at the end of the 1960s. Consequently, the region contains a growing share of the world's poor. In addition, reductions in fertility and child mortality have meant that, despite the huge impact of the HIV/AIDS epidemic across much of the region, both the absolute size and the proportion of the population age 60 and over have grown and will continue to grow over the next 30 years (Cohen & Menken, 2006).

In Ethiopia, older people have traditionally been viewed in a positive light, as repositories of information and wisdom. And while Ethiopian families are generally still unbroken, but development and modernization are closely connected with social and economic changes that can weaken traditional social values and networks that provide care and support in later life. Formal education, for example, leads to greater independence and autonomy and weakening traditional social ties and obligations, factors that tend to undermine traditional extended family systems (Cohen & Menken 2006, p19).

The aging of individuals and populations and the changing position and well-being of older people in sub-Saharan Africa and Ethiopia present a set of key challenges to begin to address. Yet evidence and a strong knowledge base of information on the nature and dynamics of poverty, health, social support networks, and the changing roles and responsibilities of older people and their implications are lacking (Cohen & Menken 2006, p20).

2.6. Overview of social protection interventions in Sub-Saharan Africa and Ethiopia

2.6.1. Formal Social Protection schemes

While policy makers in sub-Saharan Africa such as Ethiopia are becoming increasingly aware of the needs of older people, there is general agreement that the types of social welfare programs in place in other parts of the world are too expensive to replicate in sub-Saharan Africa given the size of their economies (Kalasa 2001as cited in Cohen & Menken 2006, pp29-32). Thus there is a need to search for alternative approaches that might achieve a similar function but at lower cost. The concept of social protection is one that is gaining increasing attention in development circles as a useful policy framework for addressing issues of poverty and vulnerability (Garcia & Gruat, 2003 as cited in Cohen & Menken 2006, pp29-32).

Ethiopia has drafted a national social protection policy. According to MOLSA, the policy defines social protection as being a set of 'formal and informal interventions that aim to reduce social and economic risks, vulnerabilities and deprivations for all people and facilitates equitable growth'. It provides the framework for the coordination and provision of social protection services in Ethiopia defining the roles and responsibilities of the government of Ethiopia at the federal, regional and local level to manage a social protection system to fulfill the constitutional rights of citizens.

Traditionally, social protection for older people in sub-Saharan Africa and Ethiopia, is provided by both formal and informal programs and practices that have been developed to reduce poverty and vulnerability in old age. But with per capita income below a few hundred dollars in most sub-Saharan African countries, it is no surprise to find that formal social security systems across the region cover only a small fraction of the population. Except for Mauritius and the Seychelles

and a few countries in Southern Africa, including South Africa, Botswana, Lesotho, and Namibia, all of which operate social pension schemes aimed at comprehensive coverage, most countries' formal social security programs never reach the urban or rural poor. Except for these few countries, the extended family unit remains the main source of support for the vast majority of older people in sub-Saharan Africa when they can no longer work (Cohen & Menken 2006, pp29-32).

2.6.1.1. Social Insurance Programme (Pension)

In Ethiopia Social Security Agency has managed a social insurance scheme since 1963. Coverage was limited to civil servants, the police and military. The Social Insurance Scheme, which is a contributory pension scheme, provides benefits in old age, invalidity, survivors and employment injury or 1 per cent of Ethiopians. The CSA estimated (2007) a total of 1.8 million persons engaged in gainful employment in government, parasitical and the private sector. This constitutes 7.2 per cent of the total workforce engaged in urban and rural areas. Thus, even the 7.2 per cent of workers who have social security coverage is limited to the employees of government and parasitical institutions (MOLSA, 2012).

The private and charitable organizations, which employ less than one per cent of people of working age, provide some employment benefits including a contributory provident fund that employees are paid, usually at termination of employment. They may cover part or all of health fees that employees may incur. Other than the above schemes, almost all self-employed and unemployed people have no access to any kind of formal social insurance (MOLSA, 2012).

2.6.1.2. Social Security Programs

In many Western countries, formal social security is an important policy instrument for governments to redistribute wealth, combat poverty, and reduce inequalities between various segments of society. But in sub-Saharan Africa, current social security schemes are extremely marginal both in terms of percentage of the labor force that is covered and the size of pensions that are received. In most sub-Saharan African settings, national social insurance schemes cover less than 5 percent of the labor force and expend less than 1.5 percent of their gross domestic product on pensions (Fox & Palmer 2001 as cited in Cohen & Menken 2006, pp32-34). Consequently, in the majority of countries in sub-Saharan Africa, social protection programs have a very modest effect on poverty alleviation. The largest social protection programs for older people in sub- Saharan Africa are occupational pension schemes, but these typically cover only people who have worked in the public sector, in state enterprises, or in large private firms in the modern sector. The self-employed, workers in the informal sector, domestic workers, and the vast majority of the population living in rural areas and engaged in subsistence agriculture or other forms of subsistence living, such as nomadic pastoralist, are still excluded from formal social security schemes and must rely on their families for support and protection when they can no longer work (Cohen & Menken 2006, pp32-34).

Bailey (2004) identifies several distinct patterns of social protection schemes that have developed in sub-Saharan Africa. Even though most countries did not introduce programs until after their independence, most schemes have been strongly influenced by their countries' colonial heritage, with the types of programs in Anglophone Africa differing from those in Francophone Africa. At one end of the spectrum are countries, for example South Africa, that have introduced schemes aimed at near universal cover- age. Other countries currently provide no form of social security, either because nothing has been set up yet or because previously

established schemes have been dismantled or disrupted for various reasons, including, not infrequently, armed conflict. Apart from government schemes, voluntary private pensions can also be found in many countries, although, again, their coverage tends to be restricted to formal sector workers.

Most sub- Saharan African pension schemes are financed by contributions made by both employers and employees, with the contribution rate in most cases being higher for the employer. In the case of South Africa's social pension, the scheme is financed through general tax revenue. Given the structure of the schemes and the nature of the labor force in most sub-Saharan African countries, the vast majority of those actually covered by formal social security schemes are neither the poorest of the poor nor women (Cohen & Menken 2006, pp32-34).

Impact of Social Security programs on Elderly

An important policy question with respect to any social welfare program has to do with the extent to which the program creates dependency and has a negative effect on labor supply. Betrand et al. (2003) as cite in Cohen & Menken 2006, pp36-37) found that pensions can have a negative effect on the labor supply of working-age adults residing in pension-receiving households. However, Betrand et al. (2003) investigated only the labor supply of adults resident in the house- hold. Posel et al. (2004) as cited in Cohen & Menken (2006: 36-37) argued that the social pension also affects the propensity of household members to migrate to find work, which acts as a positive supply response to the receipt of a social pension. In their chapter in this volume, Lam et al. contribute to this debate by examining how the social pension affects the decision to withdraw from the labor force by older people. By analyzing census and survey data, the authors found that, although the pension is associated with high rates of withdrawal from the

labor force, the rates are somewhat less sharp than those observed for similar programs in Europe.

Another crucial policy question in the region is whether economic growth is needed in order to broaden the social safety net. Kakwani & Subbarao (2005) as cited in Cohen and Menken 2006,pp 36-37) investigate the likely fiscal implications of providing some sort of social pension to older people in various sub-Saharan African countries and study the impacts on poverty rates. The authors have found that the fiscal cost of providing a universal noncontributory social pension to all of older people in sub-Saharan Africa would be quite high, around 2 to 3 percent of gross domestic product, a level comparable to or even higher than the current levels of public spending on health care in some sub- Saharan African nations. The authors argue that the case for universal social pensions also appears to be weak on welfare grounds, inasmuch as there are other groups competing for scarce safety net resources (such as families with many children) whose incidence and prevalence of poverty is much higher than that of older people.

Given that a universal social pension program appears out of reach in most countries and is difficult to defend on purely social welfare grounds, the authors then explore various options for targeted social pensions using a fixed budget constraint of 0.5 percent of gross domestic product and a fixed benefit level of 70 percent or 35 percent of the poverty threshold for older people defined as age 60 or 65 and older. Two household types were considered: households with older people living with children and house- holds with older people only. The authors found that the introduction of social pensions targeted to these groups would yield considerable reductions in the prevalence of household-level poverty, both for the targeted groups and for the national average.

Nevertheless, as the authors point out, the operational feasibility of such a program is very weak. The administrative burden of operating such a scheme is enormous and would be likely to lead to dissolution and reformation of certain types of households in order to make them eligible to claim a pension. Bearing this is mind, the authors also investigate the fiscal implications of providing a social pension to only poor older people, regardless of the type of household in which they reside. The authors conclude that the best option is to target the pension only to the poor, keep the benefit level low, and the age of eligibility at 65 and older (Kakwani & Subbarao 2005 as cited in Cohen and Menken 2006, pp36-37).

2.6.2. Informal Schemes

Given the problems and formidable financial and administrative hurdles to expanding formal social security schemes in sub-Saharan Africa, policy makers also need to know whether there are ways to expand and support any of the various forms of informal social protection schemes that exist around the continent as a means to provide a vital safety net for certain vulnerable populations. A wide variety of informal community-based arrangements have been developed in rural areas aimed at spreading risk among friends and extended family members, with neighbors, or with other participants. These can often involve self-help or community based- initiatives that draw on sub-Saharan African traditions of shared support and kinship networks. In parts of Zimbabwe, for example, the government has successfully reintroduced the concept of the Zundera Mambo (literally “the Chief’s Granary”), which refers to the harvest from a common field that is stored in a common granary and used at the discretion of the chief in order to ensure that the community has sufficient food in the event of a drought or a poor harvest (Dhemba et al. 2002 as cited in Cohen and Menken 2006, pp37-38).

There are many other examples of groups that have come together as spontaneous responses to poverty. Rotating savings and credit associations and mutual aid societies, for example, are commonly used throughout sub- Saharan Africa to compensate for failures in existing formal financial markets. In rotating credit and savings associations, participants periodically contribute fixed amounts of money and allocate the fund on a lottery or rotational basis to its members. The scheme encourages small-scale capital accumulation and savings and allows members to meet various welfare objectives, such as to pay school fees, meet medical expenses, or buy food. Funds can also be used to start or promote small businesses and acquire assets, including livestock (Kimuyu 1999 as cited in Cohen & Menken 2006, pp37-38).

Burial societies (for instance *Idir* in Ethiopian terms) are another form of rotating savings scheme. In burial societies, members pay periodically to the society, and, when the member dies, the family receives money to help offset the funeral expenses. These types of scheme are very popular in sub- Saharan Africa, particularly in urban areas. Much more is known about in-formal social security systems in sub-Saharan Africa than about formal social security systems, but it is generally believed that informal schemes also suffer from a number of chronic problems and in their current form fail to provide much in the way of long-term protection against various forms of risk (Mchomvu et al. 2002 as cited in Cohen & Menken 2006, pp37-38).

By the early 2000s, there was a growing consensus between the Ethiopian Government and donors on the need to reform the emergency food aid system in favor of a more productive approach to providing a safety net to vulnerable populations. In response, in 2005 the Government launched an alternative system, the Productive Safety Net Program (PSNP), to help address the needs of chronically food insecure households. Ethiopia's PSNP is an international flagship program both in its scope and in its partnership approach, having reoriented a rural

safety net to better respond to the needs of food insecure households and create productive investments to underpin rural economic growth and environmental rehabilitation. This is achieved through: (i) the predictable provision of adequate food and cash transfers to targeted beneficiary households, thus allowing effective consumption smoothing and avoiding asset depletion; and (ii) the creation of productive and sustainable community assets that contribute to the rehabilitation of severely degraded areas and increase household productivity. The goal of the PSNP is to invest in productive assets in rural communities as well as provide asset protection against shocks as part of a rural growth and poverty reduction strategy. Thus, bringing a vital effect on well-being of older people and other household members.

2.7.

Institutional care for the elderly

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 as cited in Eskedar, 2015, pp16-18). 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 cited in Eskedar, 2015, pp16-18). 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 (Eskedar, 2015, pp16-18).

It is generally accepted that most old people prefer to live independently in their own homes (Vaarama et al. 2008, as cited in Eskedar, 2015, pp16-18). 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.

Social and demographic changes throughout Africa show a weakening of family and community networks, resulting in a reduction in informal support from family and friends to allow elderly people to remain at home. The government of Ethiopia and experts in the field of aging has realized that institutional care is a primary type of service and it should be encouraged (MOLSA, 2007). According to MOLSA, 2006, p88), there is an 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, cited in Eskedar, 2015, pp16-18).

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, as cited in Eskedar, 2015, pp16-18).

The World Health Organization's (WHO's) general definition of Quality of Life (QOL) in 1995 Vaarama et al. 2008, p196 as cited in Eskedar, 2015, pp16-18) 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. Quality of life in the context of institutional care differs from general QOL and from health – related quality of life.

With so many elderly care options available in many countries of Europe and USA, it's easy to feel confused and overwhelmed by the vast number of care types and styles of elderly living communities. Thus, it's important to differentiate the terminology and the differences between various elderly care institutions.

Types of Elderly Institutional Care

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. In Ethiopia institutional care for the elderly are minimum however, there are certain institutions that are working at supporting and taking care of elderly. There are various types of elderly institutional care options in different countries. The following are some of the types of care for the elderly:

A. **Independent living communities:** refers to senior independent living communities provide to seniors who are very independent with few medical problems. Residents live in fully equipped private apartments (Quadagno, 1999). A variety of apartment sizes are available from studios to large two bedrooms. Fine dining services are offered with custom-designed meal packages. Often, residents can choose to pay for a specified number of meals per day. Frequently, there are numerous social outings and events to choose from for entertainment (Quadagno, 1999).

B. Nursing Home Care: provide around-the-clock skilled nursing care for the frail elderly who require a high level of medical care and assistance. Twenty-four hour skilled nursing services are available from licensed nurses. Many nursing homes now provide short-term rehabilitative stays for those recovering from an injury, illness or surgery. Long-term care residents generally have high care needs and complex medical conditions that require routine skilled nursing services.

Residents typically share a room and are served meals in a central dining area unless they are too ill to participate. Activities are also available. Some facilities have a separate unit for Alzheimer's residents (Quadagno, 1999).

C. Residential Home Care Facilities: Residential home Care Facilities for the Elderly (RCFE) serve persons 60 and older. They provide room, board, housekeeping, supervision, and personal care assistance with basic activities like personal hygiene, dressing, eating, and walking. Facilities usually centrally store and distribute medications for residents to self-administer (Quadagno, 1999).

This level of care and supervision is for people who are unable to live by themselves but who do not need 24 hour nursing care. They are considered non-medical facilities and are not required to have nurses, certified nursing assistants or doctors on staff. Other terms used to refer to this level of care are assisted living facilities, board and care homes, rest homes and that component of Continuing Care Retirement Communities (CCRCs) that provide personal care and supervision (Quadagno, 1999). Residential Care Facilities for the Elderly or Assisted Living Facilities must meet care and safety standards set by the State and are licensed and inspected by the Department of Social Services, Community Care Licensing (CCL). (Quadagno, 1999).

D. Home Care: home care allows older people to remain in their own homes while receiving the assistance they need to help them remain independent. Typically, home care involves providing assistance with Activities of Daily Living (ADLs) such as bathing, dressing and meal preparation or Instrumental Activities of Daily Living (IADLs) such as transportation, paying bills, making appointments and simply being there to provide companionship and emotional support. Home

care services range from once a week to 24 hours a day depending on the needs of the client (Quadagno, 1999).

E. Respite Care: provides a temporary break for caregivers by allowing a resident to have a short-term stay in a community that can meet their needs. Many assisted living communities and nursing homes have a respite care program. Residents typically stay from a week to a month, depending on their situation. They receive all of the services of the community. Respite stays may also serve as a 'get acquainted' period for the senior. Many residents find that they enjoy their stay and decide to move in soon after the short-term visit. Respite programs are available for assisted living and Alzheimer's residents (Quadagno, 1999).

2.8. Sociological Theories of Aging and Elderly Institutional Care

2.8.1. Goffman’s total Institution Theory

Ervin Goffman’s theory of total institution has been universally recognized as key to understanding the impact of institutions on inmates. Goffman characterized the ‘‘total institution’’ as an environment where residents live in a congregated setting, with the same group of people, and do the same activities. Institutional constraints on residents in care for the elderly with one another, and live under the same set of rules. Typically, people living under these conditions lose their individualism and live with very little autonomy. Often actual or symbolic barriers prevent beneficiaries from entering or leaving the facilities. This causes greater difficulty in contacting and interacting with people who live outside of the facilities. (Marson, 2013, pp143-153)

While Goffman's research was conducted on mental institutions, his ''total institution'' theory has been applied to other institutional settings, including the elderly institutional (Gubrium 1993, Savishinsky, 1991 & Vladeck, 1980 as cited in Marson, 2013, pp143-153).

Goffman's theories have been accepted as classic explanations of institutional life. It served as a prototype for anthropologists, sociologists and gerontologists (Gubrium, 1993 & Vladeck, 1980 as cited in Marson, 2013, pp143-153). These works describe the humiliation, loss of dignity, loss of freedom, and lack of choice experienced by elders placed in an institutional setting, as well as the efforts of residents to adapt to this new environment. In studies focusing on the early impact of institutionalized living, physical and psychological decline was found primarily in the first year of institutionalization (Lieberman & Tobin, 1983 as cited in Marson, 2013, pp143-153).

In one qualitative study, Clark and Bowling (1990) tested whether the total institution theory held in a long stay hospital ward and in smaller nursing homes for the elderly. They found that the theory only applied to the hospital ward. The research reported here focuses on larger facilities, thus distinguishing it from Clark and Bowling's work. Overall, while many researchers have utilized Goffman's theories in shaping their research, very few have empirically tested them in long-term care facilities for the aged. This thesis has used this theory as a frame work to test residents' perception for the quality of care in Mekedonia.

2.8.2. Disengagement theory

Disengagement theory, is a sociological theory which originated in the United States in the 1960s. This theory proposes that ageing entails a gradual withdrawal or disengagement from personal relationships or society in general. This results in the marginalization of older people in society. However, this theory has been strongly criticized by researchers who found little

evidence that older people disengage themselves from their surroundings. They found that while older people's social relationships change, and they have fewer social relationships, these are often deeper relationships. Where disengagement does occur it may be due to other factors such as disability, poverty, retirement or widowhood (National council for the elderly, 1994, pp10-15)

2.8.3. Exchange theory

Exchange theory proposes that interaction is only sustained as long as it is profitable to the participants. This theory argues that as older people have less to give in an economic sense, they become powerless, passive and compliant. However this fails to acknowledge that older people have currencies other than money to barter in their exchange with other people. These include knowledge and experience (National council for the elderly, 1994, pp10-15).

2.8.4. Political economy theory

The political economy theory argues that ageing is shaped by social and economic factors and that the way many people experience ageing depends on the way society values older people. For example, if older people are seen as an economic burden in society this will cause intergenerational tensions and negative attitudes to ageing. Although these theories are negative they help us to understand how negative attitudes to ageing arise (National council for the elderly, 1994, pp10-15)

2.8.5. Continuity theory

The last of the sociological theories we will consider in this chapter is the continuity theory of ageing. This theoretical perspective contends (Atchley, 1989 as cited in Segniwork, 2014, p18) that our values, preferences and patterns of behavior remain consistent over our life span

regardless of the life changes we experience. Continuity theory argues that the latter part of life is simply a continuation of the earlier part of life: how we are as younger people will determine, how we are as older people, and the patterns we have developed over a lifetime will determine our behaviors and beliefs and values in older age. This does not deny the capacity for change over a lifetime but values the developments made and their impact on us as older people.

Andrews (1999), as cited in Segniwork, 2015, p18) challenges the ageist culture that pervades and argues that old age should not be wished or theorized away, and that doing so is in itself an ageist activity. She suggests that the challenge is not to conquer old age but to challenge the ageist culture to which we belong. Without a lifetime behind us she argues that we have no history, no story and no self.

2.9. Understanding and measuring the concept of quality of care

While quality of care is a useful and widely used expression, its apparent simplicity masks the complexity and ambiguity surrounding the concept. There is much debate and confusion over what elements should be included in quality of care, how these various elements should be measured and who should do the measuring (Murphy *et al.* 2006, pp39-61).

There is no single definition describing this concept, which makes it more difficult to think about domains of quality of care. It is important, however, to provide a framework for the exploration and measurement of quality of care for beneficiaries in elderly residential home care settings. While an objective assessment of quality of care is important, the subjective experiences of residents also matter; these must be communicated if we are to move towards an understanding

of the ‘good care’ within residential care. It is only then that policy-makers will be able to develop quality of care indicators and implement meaningful regulatory structures to improve quality of care in residential home care centers (Murphy *et al.* 2006, pp39-61)

Despite the complex and subjective nature of quality of care and the various measurement difficulties it poses, quality of care is being increasingly recognized as a key outcome of the care of older people. Sander and Walden (1985) as cited in Murphy *et al.* 2006, p41) describes the ideal residential home as a place where people live their lives with as little physical or psychosocial discomfort as possible, ‘with dignity and a good quality of life’. The life of the residential home resident, they suggest, should be better than or as similar as possible to the life he or she would choose to live at the street or at home respectively.

There is an evolving literature on quality of care for people in residential home care, which has identified a number of important key domains including: identity, autonomy, physical environment, social environment, connectedness, and meaningful activity (Kane *et al*. 2003)

Quality of care could be understood differently from different perspectives such as the care and support provider (Mekedonia), and the care recipients. This leads to a question about who is in position to determine the acceptable level of quality. However, this study focuses on the perception of care recipients with regard to the quality of care provided by Mekedonia.

2.10. Separating Quality of Care and Quality of Life

The move to institutional care is a huge transition and period of upheaval for older dependent people. Residents have altered the conditions of their lives for long periods of time, often forever (Kane, 2003, pp28-36). Therefore, institutional care has the potential to influence residents’ lives

either positively or negatively on outcomes that include more than just health status. The long-stay care facility shapes where people live, how they live, whom they see, what they do, and the relationships transpiring within families and communities (Kane, 2001). Outcomes of institutional care include elements of living as well as care. Kane, 2003, pp28-36), notes that quality of life is often treated as a luxury in relation to care outcomes. While health-related quality of life has been the most common measure of quality of life in nursing homes, it is also important to take account of a wider concept of quality of life. Concepts such as self-esteem, sense of self and identity, sense of control and spiritual well-being have been largely ignored in the measurement of quality of life of older people in healthcare settings, which have tended to focus on narrow, medically orientated definitions of health (Bond & Corner 2004 as cited in Murphy et al 2006, pp39-61).

The emphasis in discourse and policy developments relating to quality in institutional elderly care internationally and in developing country like Ethiopia has been far from ensuring adequate standards of care for residents in institutional care. It's to mean standards cannot be set on air with the existing nonprofit voluntary care organizations for older people. However, the concentration on care standards is necessary but not sufficient to ensure a good quality of life for residents in residential care. Many researchers have emphasized the distinction between quality of care and quality of life and the need to separate the two in policy discussions (Kane *et al.* 2003b, Kane 2003c, Birren & Dieckmann, 1991 as cited in Murphy 2006, pp39-61).

While the quality of care provided in residential care facilities is an important contributor to a resident's quality of life, there must be recognition of other important factors that play a role in quality of life in residential care (Murphy, 2006). Gentile (1991) makes this distinction explicit: Whereas quality of care is measured by the cleanliness of the environment, compliance with

regulations, and the type of nursing and care provided, quality of life focuses on the attitudinal and affective atmosphere of the facility in addition to quality of care as one component.

The unique nature of institutional care settings poses a challenge to the measurement and analysis of quality in these institutions. Institutional care facilities are both a healthcare setting and a person residence (Phillips, 2001, Katz & Gurland 1991 as cited in Murphy, 2006, pp39-61).

CHAPTER THREE

RESEARCH METHOD

Chapter Overview

In this chapter, the researcher begins with discussing the background information of the study institution and organizational structure and management of the institution and types of people admitted in to the institution then goes on to the detail research approaches and methods such as research design, sampling techniques, data collection tools and methods of data analysis employed in this study.

3.1. Background of the institution: Mekedonia Home for the Elderly and Mentally Disabled

This study was conducted among the residents of Mekedonia Home for the Elderly and Mentally Disabled (here after referred as (MHEMD). The name Mekedonia is derived from a bible word; as it is mentioned on the verse of 2 Corinthians 8:1-15, it asserts that instead of starting with a request for money, Macedonians begins with an example of sacrificial giving. Macedonian people built churches with great commitment and generosity. The Macedonians gave not just as much as they were able (literally "according to their ability") but beyond (v. 3). Macedonians were not pressured into giving. They gave willingly. In fact, they urgently pleaded to be involved (v. 4). Therefore, it is in this biblical exemplary Macedonian peoples that the institution came to be named. According to Edwin A. Judge (1982), describes Macedonia as a splendid tract of land, centered on the plains of the gulf of Thessalonica. It was a prosperous area. Running up the great river valleys into the Balkan Mountains, it was famous for its timber and precious metals.

Mekedonia is an indigenous non-governmental, non-profit and charity organization, founded on 07 January 2010. The purpose of Mekedonia is to support elderly people and people with disabilities who otherwise have no means of survival by providing them with shelter, clothing,

food, and other basic services. 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.

Currently, it is providing the above services to eight hundred and fifty (850) destitute and disabled elderly people. Its residents were homeless people picked up from different parts of the country such as Hawassa, Debre Zeit, Debre Libanos, Addis Ababa and Guder.

The institution is planning to build an all rounded complex to give more services to the ones who have not been reached. In addition, it is working on sustainable ways of supporting the residents. Its ultimate goal 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.

It is well known that as a population increases the demand for basic needs also increases. Whereas the young and the middle aged struggle for survival in one or another way the elderly and mentally disabled who have no one to care of are left alone and exposed to vulnerable life. It is with this fact and seeing them on the streets lacking basic needs the organization came into existence in order to give them the proper care including medication. From the ones who were very sick during their existence after getting proper medication and treatment some are cured and have now reached to the stage of serving the organization in their capacity. The following table (Table 3) illustrates the number of residents with their respective health status and sex. The figures were received from the institutions information center and health department and the medical checkups were also made by the institution itself.

Table- 2: Distribution of residents by sex and health status at Mekedonia Home for the Elderly and Mentally Disabled (MHEMD)

Residents Health Status	Sex		
	Male	**Female**	**Both sexes**
Mentally disabled	215	105	320
Physically disabled	198	47	245
Physically & Mentally abled	213	72	285
Total	**626**	**224**	**850(N)**

Source: (Mekedonia Home for the Elderly and Mentally Disabled, information center, 2015)

The number of the needy was initially few and now has reached to 850 as it increases from day to day. According to the institutions data which is illustrated in the table (Table 3) 38% (320) of the residents are mentally disabled) and 29% (245) are physically disabled while 34% (285) are physically abled from both sexes.

3.1.1. Organizational structure and Management of Mekedonia

Mekedonia is founded by devoted and dedicated individual with few committed supporters of different professions. It is organized under flat departmentalization for the sake of the major tasks of ensuring availability of resources for the needy, planning, implementation, evaluation and ensuring optimum use of resources at all levels. The organization has a management team that consists of director/coordinator, professionals and accountant/cashier. There are also 40(forty) volunteer facilitators who distribute donation boxes and pledge form letters. Regarding their positions: there is 1 health officer (B.Sc.), 6 nurses with diplomas, 1 laboratory technician with diploma, 40 facilitators with different qualifications including social workers and 37 caregivers with different statuses (MHEMD, 2016).

Mekedonia is led by a general assembly, followed by board members chosen by the general assembly. Under the board of directors there is Executive director who is responsible for the day to day leadership. Following there is a vice director and a manager who are coordinating the

volunteers and other staffs of the institution. Mekedonia is all in all volunteers driven agency. Almost all of the staffs of the institutions are unpaid volunteers. Excluding visiting volunteers, currently there are 40 volunteers who are engaged in various activities in the institution. Activities performed by these volunteers are ranging from providing professional service to helping in logistics activities and labor work. The institution is currently gaining the most resource for the care and service from the local donors and the wider public. (MHEMD, 2016).

3.1.2. Types of people admitted in to the institution

Mekedonia Home for the Elderly and Mentally Disabled, is receiving elderly people and other needy individuals from around the country. It is not only a home for elderly people but also a residence for persons with other kind of health problems including mentally disabled persons. According to the words of the coordinating staff, the admission criteria to the center include the following main points:

- Living in the streets due to absence of helping family or relatives
- Who have complicated health problems in relation to using toilet
- Those who can't pay for any kind of caring service
- Who are above the age of 18 and who can't pay for their living
- Mentally or physically disabled peoples found in the streets without help
- Those who are referred to our institution by the Addis Ababa bureau of Labor and social affairs.

Generally, the admission reasons mentioned by the interviewed elders in Mekedonia as pushing factors for their institutionalization also supports the above list of criteria used by the institutions. Interviewed elders were living either in the church yards or streets by making their living through begging. In Mekedonia there is formal pre-admission assessment about the elders. They

wash their body, undergo assessment on the previous life history of the elderly (what makes him/her exposed for his/her present life situation?), photographing them to document their previous appearance, admitted elders are even filmed to document a CD copied file. There are also formal health checkups and general assessments. Finally after they are proved to have no communicable disease, and are free from mental illness, elders are assigned bed rooms and provided clothing. Those who are mentally disabled undergo further medical checkups. The institution is currently gaining the most resource for the care and service from the local donors and the wider public.

3.2. Research Approach

There are two basic approaches to research, quantitative approach and qualitative approach. Quantitative approach involves the generation of data in quantitative form which can be subjected to rigorous quantitative analysis in a formal and rigid fashion. This usually means survey research where a sample of population is studied (questioned or observed) to determine its characteristics, and it is then inferred that the population has the same characteristics (Kothari, 2004, p5).

Qualitative approach to research is concerned with subjective assessment of attitudes, opinions and behavior. Research in such a situation is a function of researcher's insights and impressions. Such an approach to research generates results either in non-quantitative form or in the form which are not subjected to rigorous quantitative analysis. Generally, the techniques of focus group interviews and depth interviews are used (Kothari, 2004, p5).

Many major authors and researchers felt that quantitative and qualitative research methodologies are compatible. Triangulating both qualitative and quantitative approach (Mixed-method

approach) is the most appropriate to reach at a level of truth and enables the researcher to come up with complementary and convergence of facts (Redinour & Newman, 2008). Many social scientists now believe there is no major problem area that should be studied exclusively with one research method. Thus, this study used a concurrent nested strategy, for the purpose of achieving the targeted research objectives. In such use of a strategy the primary purpose is given for gaining a broader perspective that could be gained from using only the predominant data collection method. Secondary purpose is use of embedded method to address different research questions or garner information from different groups or levels within an organization (Terrell, 2012). In this study the predominant data collection method is survey instrument.

3.3. Data Sources

3.3.1. Secondary sources of data

Secondary data were acquired through reviewing various studies related to the topic in order to find out the various issues to be considered with regard to institutional based support at older ages. Several written documents including journals, articles, books and other archival documents which focus on the situation of elderly people in Ethiopia, schemes of assistance for the elderly, the concept of quality of care, quality of care in elderly homes, measures, Indicators, and Improvement of Quality of care in elderly homes. The review of these documents has been useful in identifying the gaps in previous researches on the subject under study and in the selection of appropriate research framework and tools for the study.

Besides, the study has made use of different written documents especially those studies done on MHEMD to supplement the study. Reports of the institution, broachers and documentaries prepared by the institution were also used as sources of data.

3.3.2. Primary source of Data

The information gathered from the secondary sources were substantiated by the information that was obtained from primary sources. In this regard, a combination of both quantitative (survey) and qualitative (in-depth interviews, focus group discussion) were employed to acquire firsthand information from selected respondents in the residential home care center. These data are collected via structured questionnaire, in-depth interview and focus group discussions focusing, among others, on socio-economic and demographic characteristics of residents, types and level of care and support by the institution, residents' perception towards the quality of care across the various domains of quality of care such as dignity, physical comfort, privacy, purposeful or meaningful activity, social relationships, and spiritual wellbeing.

3.4. Quantitative data collection

For the purpose of collecting quantitative data, survey research method was employed as a major type of data collection method for collecting valid and reliable data from sample famer respondents.

3.4.1.Survey research

As one of the most popular and advantageous methods of social research, survey research method was employed in order to obtain the necessary (both quantitative and qualitative data) information from sample respondents of the study population.

3.4.1.1. Survey design

A cross-sectional survey design was employed so as to obtain information about the present situation which is related to the issue under study. Data's were collected at one point in time from a randomly selected samples from the population at that time. However, the cross sectional survey

design was made to approximate longitudinal survey design, as questionnaire elements that refer to the past were included. (Yeraswork, 2010, p171).

3.4.1.2. Survey sampling

For the purpose of achieving the objectives of the study, stratified random sampling techniques were used to select sample residents. Stratified sampling is a sampling design in which separate samples are drawn from different segments of a population in order to ensure the proportionate representation of each of the segments in the overall sample (Yeraswork, 2010, p135).

For instance, this study was undertaken on the elderly & disabled population of institutional care. Thus, disability status and sex are very important variables and along these two variables thereby it was possible to employ stratified sampling technique which can nearly reduce the sampling error to zero (Yeraswork, 2010, p135).

Sampling was conducted as follows: Firstly, the population was partitioned into homogenous subsets i.e. the sampling frame (the roster) was divided between that which contains the names of (males and females), (residents with physical disability and the physical ability), and then appropriate random samples were drawn from each of the subsets.

Likewise, according to the statistical figures of the institution, from the total residents of 850, 320 of them were mentally disabled (see table 3) hence they were thought as they provide less information for the study; they are removed from the sampling frame. Out of the remaining 530 residents, with 95 % confidence interval and by 5% sample size proportionate, a total of 175 sample residents (using the online sample size calculator) were estimated. The selection process was conducted through random numbers generator in SPSS Version 20) from each of the sampling

categories (i.e. sex and disability status). To do so, a list of residents' (sample frame) was obtained from the institutions administrative office.

In summary, from each of stratifying categories of physically-abled male residents (213), physically-disabled male residents (198), and physically abled female residents (72) and 47 physically disable female residents, 53, 54, 37, & 29 sample residents were randomly selected from respective populations by using SPSS.

3.4.1.3. Survey Instrument

A structured questionnaire was used to gather data related to the issue under study from the sample respondents. The questionnaire includes both close and open-ended questions for obtaining detailed information. The questions are drafted for the purpose achieving the drawn research objectives. Thus to gain information about the types and level of care provided, structured questions were employed whereas, for measuring the perception of residents about quality of care provided, Likert scale was employed.

3.5. Qualitative data collection

For the purpose of collecting qualitative data, among a number of qualitative methods, key-informant interview, in-depth interview and Focus group discussion have been employed for this study.

3.5.1. Key Informant Interview and In-depth Interviews

Key informant in-depth-interviews and In-depth interviews were conducted mainly with both purposively selected six residents (two female and four male) and three key administrative staffs (Executive director, Health department head and Human resource and logistics head) of the institution. All the in-depth interviews and key informant interviews were conducted using Amharic language as a medium of instruction. The kind of care provided, the available resources

and problems associated with care and support, and other important background information on care and support issues in the institution were the main focus of the interview.

3.5.2. Focus Group Discussions (FGDs)

Two focus group discussions each containing eight elderly residents (two female and six male at the first group & four female four male at the second group) were conducted with purposively selected residents. The inclusion criteria for the focus group discussion were: aged 60 and over, those who are free of mental illness (they were identified by the intuitions medical checkups and with the help of nurses of the institution), and residing in the institution for a period of 12 months or more. Elders with mental illness were excluded since such health disorder may forbid them from giving valid consent. The FGD checklist was made to include topics particularly related to the actual care provision by the home and the psychosocial need of the residents. Finally, the outcome from the FGD was separately analyzed with an in-depth interview.

3.6. Methodological Triangulation

As can be already anticipated from a look at the various methods of data collection which were employed in the research, the data collected for the study were analyzed quantitatively and qualitatively in combination so as to enhance the require and trustworthiness of the research. The study employed a methodological triangulation which can be briefly summarized in the form of the following table:

Table-3: Methodological Triangulation

Specific Objectives	Units of Analysis	Data Sources	Methods of Data Collection
To assess the type and levels of care being provided by the home	Residents' of Mekedonia	Sample residents	Survey
To assess perception of residents' with regard to quality of care provided	Residents' of Mekedonia	Sample residents	Survey
To examine the relationship between age, duration of stay and perception of the quality of care provided	Residents' of Mekedonia	Sample residents	Survey
To identify available resources and challenges associated with the care and support	The institution (i.e. Mekedonia)	a) Members of the in-depth interview b) Key administrative staffs c) Group members in FGD	a) In-depth interview b) Key informant interview c) Focus-group Discussion

3.7. Primary Data Analysis and Interpretation

In the due process of data analysis, a strategy of a concurrent nested strategy was employed. That is; there are two data collection methods (survey instrument & in-depth interviews and key informant in-depth interviews); then the qualitative data is embedded (i.e. nested) within the quantitative data. Priority is given to the primary data collection method. Data are mixed during the analysis phase. The study used to elaborate or expand the findings of quantitative data (survey) with the qualitative data. The sub-sections bellow describes the details of the quantitative and qualitative data analysis.

3.7.1. Quantitative data analysis

The quantitative data that was collected using the survey instrument (questionnaire) is analyzed using descriptive statistics (frequency, percentages and mean distribution). In addition, the statistical analysis tool SPSS (Version 20) was utilized for analysis in terms of searching for difference among categories (Independent sample t-test). Correlations and linear regression had also been employed to examine associations between age, duration of stay and residents rating of quality of care.

3.7.2. Qualitative data analysis

The qualitative analysis of qualitative data was employed in this study for it is best suited to achieve the objectives of the study by analyzing oral accounts of residents based on their lived experiences. The qualitative data was obtained through KII, in-depth interviews and focus group discussion.

3.8. Ethical Considerations

Ethical clearance was sought prior to data collection from the researcher. Informed consent was obtained from all residents and staff prior to data collection.

Given that the resident sample group was defined as a vulnerable group (Polit and Beck 2004 as cited in Murphy *et al*. 2006), special consideration were given to ways of consider if they wished to participate.

They were assured that they had a right to withdraw at any point without consequences. Once consent was obtained, participants were allocated a study number obtaining informed consent. The research assistant described the study in detail a minimum of 24 hours before the data

collection was scheduled. This gave residents and administrative staffs an opportunity and all interview data collected were identifiable by this study number only.

Questionnaires were also been given a study number and all identifying data were removed. Data was entered into the statistical programme by study number only. Anonymity, privacy and confidentiality were maintained at all times. In sum,

- All information were collected from respondents and key informants with their consent and willingness
- All information obtained from the sources was kept confidentially
- The data was analyzed and interpreted without naming any of the respondents and informants
- Limitations and failures that the study faces are honestly explained
- The different assumptions and theories that are utilized from other books, journals and researches are properly cited and acknowledged

CHAPTER FOUR

DATA PRESENTATION AND ANALYSIS

Chapter overview

This chapter presents background characteristics of the respondents and analyzes information related to institutional care provided and the perception of residents with regard to the quality of care provided. The section presenting background characteristics of respondents and information pertaining institutional care provided and related issues are based on primary data collected through survey and interviews.

4.1. Descriptive findings

The sections that follow describe sample respondents' sex, age, educational qualification, marital status, place of residence and disability status.

A total of 175 respondents were participated in this research. Among the 175 sample respondents, 109(62.3%) were male respondents, and the remaining 66 (37.7%) of them were female respondents. It was found to be very important to observe whether there is variation in terms of rating of respondents with regard to the quality of care provided by sex of residents.

As indicated in the following table, the distribution of respondents' by their disability status were among a total of 175 respondents, 92(52.6 %) samples were physically able whereas, the remaining 83 (47.4%) were physically disabled.

Among, 175 sample respondents, most of the respondents 64 % (112) are born in rural areas and the remaining 36% (63) are born in urban areas. Therefore, from this data we can conclude that most of the elderly left their original place of birth and end up on urban areas, such mobility of

elderly has made life strong to cope in addition to their low educational status and absence of source of support.

In the examination of marital status and religious denominations of the distribution of respondents, as it is presented in the above table, those respondents who has got divorced are 35.4%, 28.6% of the respondents' has never married whereas 20.6% had lost one of their spouses, the least proportion i.e.15.4% of the respondents has got married. Looking at the religious denominations of the respondents, most of the respondents belong to the orthodox religion 48.6%, 24.6% of the respondents' are Muslim and 24.6 % are Catholics and finally the least proportion, 10.3 % of the respondents belong to the protestant religion.

The educational qualification of respondents was measured in ordinal level. Thus, out of the total 175 respondents, 23.4% (41) of the respondents' can only read and write, 21.1% (37) had attended grade 5-8. 20%(35) of the respondents' can only read,17.1%(30) had attended grade 1-4, 14.3%(25) can't read and write, 2.3%(4) had attended grade 9-12 and 1.1%(2) of the respondents' had attended vocational training. Finally the least proportion that is only 0.6% (1) of the respondents' had attended higher education. Moreover, from the above data we can conclude that lower educational attainment of elderly may leads to lower class jobs with minimum wages, and hampers their ability to win life and end up on the street.

As it is also illustrated in the table below, all of the sample respondents' use to have income, and most of the sample respondents, 93.1% (163) use to have their income through begging, 3.4%(6) use to have income through children and relatives support, 2.9%(5) use to have income through salary whereas, the least proportion, 0.6%(1) of sample respondents use to have income from pension.

Table:-4 Categorical descriptive statistics of the study sample (N=175)

Variable		Frequency	Percentage
Sex	Male	109	62.3
	Female	66	37.7
	Total	175	100
Disability status	Physically disabled	83	47.4
	Physically abled	92	52.6
	Total	175	100
Place of birth	Urban	63	36
	Rural	112	64
	Total	175	100
Marital status	Never married	27	15.4
	Married	36	20.6
	Divorced	62	35.4
	Widowed	50	28.6
	Total	175	100
Religious Affiliation	Orthodox	85	48.6
	Protestant	18	10.3
	Catholic	29	16.6
	Muslim	43	24.6
	Total	175	100
Educational status	Can't read & write	25	14.3
	Read only	35	20.0
	Can only read & write	41	23.4
	Attended grade1-4	30	17.1
	Attended grade 5-8	37	21.1
	Attended grade 9-12	4	2.3
	Attended vocational training	2	1.1
	Attended higher education	1	0.6
	Total	175	100
Source of income before admission to Mekedonia	Salary	5	2.9
	Pension	1	0.6
	Children or relatives support	6	3.4
	Begging	163	93.1
	Total	175	100

Source: Researchers' survey data (2016)

As indicated in the following table the mean age of research participants was 65.1486 (SD=11.86). The minimum age was 41 and the maximum was 96 years of age**.** Since care

provision is a combination of various attributes of the respondents, it was hypothesized that age difference among the respondents may result in difference in the resident's perception with regard to quality of care provided. Moreover as it is indicated in the operational definition of this study, duration of stay was defined as the amount of months that the particular respondent stayed in the institution beginning from the day of entrance to the time of data collection. Accordingly, the mean month was 20.93 (SD=9.50). The lowest month was 5 and the highest was 40 month.

Rating of quality of care has a mean of 31.45 and a standard deviation of 3.67. The possible highest and lowest scores are 40 and 10 respectively, and 40 and 22 are the highest and the lowest scores observed. On the one hand, the range between the highest and the lowest scores observed implies that residents have a differential perception regarding the quality of care provided by Mekedonia. On the other hand, the mean score indicates that most of the respondents have positive perception for the quality of care provided.

The table also illustrates about respondents' total monthly income in Ethiopian birr (ETB). Likewise, from the given data in table – the mean monthly income of research participants was 322.9(SD=110.69). The minimum monthly income was 60 and the maximum was 600 ETB. Moreover, it is possible to conclude that, most of the elderly were engaging in street begging and are earning money that is not on a regular bases. Consequently, such uneven income might facilitated this elderly people not to think beyond their immediate daily survival and gain greater control over their resources and life choices.

Table-5: Descriptive statistics of age, duration of stay, total monthly income of respondents and rating of the quality of care provided

Variable	N	Minimum	Maximum	Mean	Std. Deviation
Age	175	41	96	65.15	11.861
Duration of stay	175	1	40	20.94	9.507
Rating of the quality of care	175	22	40	31.45	3.670
Total monthly income	175	60	600	322.94	110.691

Source: Researcher's survey data (2016)

4.2. Actual care and support provided by Mekedonia

There are services provided to residents in Mekedonia. The main services provided for the admitted elders, includes; Shelter/bed rooms/, food, health care service, hygiene facilities, assisted caring, clothing and funeral service when they died. The other supporting services though it is not well enough as it was indicated by the coordinator includes, recreational facilities such as, TV room facility (four in four meeting halls), and indoor games.

This section of the chapter presents the actual care provisions of Mekedonia and it explains the types and levels of service provisions as it is stated and leveled by the residents themselves. The table below summarizes the types and levels of care provided:

Table-6: Residents rating of the available services provided at Mekedonia (N=175)

Actual care provision at Mekedonia	Level of care	Frequency	Percentage
Provision of food service	Poor	12	6.9
	Fair	4	2.3
	Good	95	54.3
	Excellent	64	36.6
	Total	175	100
Provision of clothes	Poor	1	0.6
	Fair	31	17.7
	Good	85	48.6
	Excellent	58	33.1
	Total	175	100
Provision of health care service	Poor	4	2.3
	Fair	8	4.6
	Good	71	40.6
	Excellent	79	45.1
	Total	162	92.6
Availability of adequate bed rooms	Poor	52	29.1
	Fair	55	31.4
	Good	47	26.9
	Excellent	21	12
	Total	175	100
Availability of adequate bath rooms	Poor	53	30.3
	Fair	61	34.9
	Good	39	22.3
	Excellent	22	12.6
	Total	175	100

Source: Researcher's survey data (2016)

All sample residents were asked if they believe that there is adequate food service at Mekedonia. And out of the total 175 sample residents, 163(93.1%) of the samples believe that there is adequate food service, whereas, the remaining 12(6.9%) believe that there is no adequate food service at Mekedonia. Furthermore, respondents were asked to rate the available food service at Mekedonia.

As shown in the table above, all respondents were asked to rate the level of food service despite their differential outlook about the presence of adequate food service at Mekedonia. Likewise, 54.3% of sample respondents' had rated the food service as good, 36.6% has rated the food service as excellent, whereas, 6.9 and 2.3 percent has rated the food service as poor and fair respectively. Therefore, from the above data it is possible to conclude that respondents' had a positive outlook for the food service at Mekedonia.

Respondents' were asked whether the institution provide them clothes. Likewise, all the respondents' 175(100%) has replied as they are provided with clothes. In addition, respondents were asked whether the provided clothes fulfill their interests (i.e. residents were asked if the provided clothes are distributed based on their needs).

As such, all sample respondents were asked to rate the clothing service at the institution. Most of the sample respondents', 48.6% has rated the clothing service as good, 33.1% of the samples has rated as excellent, whereas, 17.7% has rated as fair and only one or 0.6% of the sample respondents' has rated the clothing service as poor. Moreover from the above data it is possible to conclude that, even though residents are not interested with the clothes they are receiving but, they have a positive outlook for the clothing service.

The researcher was also interested to know whether the provided clothes fulfill the interest of residents (i.e. residents were asked if the provided clothes were distributed based on their needs). Thus, it is 41.7% of the total sample respondents' that are interested in the provided clothes, whereas, 58.3% of the sample respondents' replied as they are not interested in the given clothes. Accordingly, from the above data we can understand that though all of the residents are benefited from the provided clothes but there is disparity in terms of their specific needs for the provided clothes. Hence the clothes are acquired from volunteer personalities it might not fulfill their specific needs. As such, most of them are not interested with the provided clothes.

Mekedonia is serving residents in four compounds, one owned and three rented compounds. The bed rooms inhibit between eight and forty (in temporary shelters) residents. There are bed rooms constructed with metal sheets used as temporary residences to receive the needy elders whose admission couldn't be delayed until the construction of regular residence. Beds in Mekedonia are double stairs. Elders are assigned to the ground bed and younger elders are assigned to sleep on the upstairs beds. As it is indicated in the table above, all sample residents were asked if they believe that there is adequate bed rooms at Mekedonia. And out of the total 175 sample respondents 118 samples (67.4%) believe that there is no adequate bed room at Mekedonia whereas, the remaining 57(32.6%) of the samples believe that there is adequate bed rooms. Furthermore, respondents were also asked to rate the available bed rooms. Despite respondents' differential response about the adequacy of bed rooms, all sample respondents were asked to rate the available bed rooms. Likewise, 31.4% of sample respondents' had rated the available bed rooms as fair, 29.7% has rated as poor, whereas, 26.9 and 12 percent has rated the available bed rooms as good and excellent respectively. Therefore, from this data, it is possible to conclude

that residents had unfavorable outlook for the existing bed rooms this is because most of them believed that there is no adequate bed rooms and the existing bed rooms lack quality.

This study had also tried to find out residents past sleeping circumstances, in order to have a clear understanding of their present outlooks of the service they are receiving. In doing so all sample respondents were asked, how they use to sleep before they were admitted in to Mekedonia. Most of the respondents i.e. 66.3% replied that they were sleeping alone and the remaining 33.7% had replied as they use to sleep together with others and most of the respondents' that is 68% use to sleep anywhere in the street whereas, few of them i.e. 2 (1.1%) of the respondents use to sleep with grandchild or children.

It's important to combine and discuss about the respondents' past and present sleeping situation in order to come up with a clear understanding of the resident's rating of the available bed rooms at Mekedonia. As it is indicated in table, 31.9 and 29.7 percent of the respondents has leveled the situation of bed rooms at Mekedonia as fair and poor respectively which is more or less unfavorable outlook. Whereas, majority of i.e. 68 and 12 percent of the respondents has replied as they were living on the streets and in church yards respectively which is nearly 80 percent. Therefore, from this data, in particular and from the two data's in general, it is possible to conclude that even though, residents had come up from the worse sleeping situation still the existing sleeping rooms are not adequate and the situation of the bed rooms are uncomfortable for residents as it is expected to be.

The other service provided by Mekedonia was bath room and all sample residents were asked if they believe that there is adequate bath rooms at Mekedonia. Out of the total 175 sample respondents 100 samples (57.1%) has believed that there is no adequate bath room at Mekedonia.

Whereas, the remaining 75(42.9%) of the samples has believed that there is adequate bath rooms. Furthermore, respondents were also asked to rate the available bath rooms.

As it is visible in the above given data, all sample respondents were asked to rate the available bath room facility regardless of their differential outlook about the adequacy of the bath rooms. Likewise, 34.9% of sample respondents' had rated the available bath rooms as fair, 30.3% has rated as poor. It is, 22.3 and 12.6 percent of the sample respondents who has rated the available bathe rooms as good and excellent respectively. Therefore, from this data, it is possible to conclude that residents had unfavorable outlook for the existing bathe rooms, this is because most of them (57.1%) believe that there is no adequate bathe rooms and the existing bathe rooms lack quality which is nearly 65.2%.

Maintaining a good health and access to health care is a core concern of elderly people everywhere. As literatures indicate, the growing number of elderly persons is accompanied by mental illnesses and health problems that need even long term care and support system. Regarding the health care service at Mekedonia, all sample respondents' were asked if Mekedonia is having a health care service or if it has a health post or a clinic and if they have been benefited from it. Accordingly, all of the sample respondents' know that Mekedonia has a clinic. And it is 162(92.6%) of the sample respondents' who has replied as they have been benefited from the available clinic. Whereas, it is only 13(7.4%) of the sample respondents' has replied as they have never used the available clinic at Mekedonia.

Furthermore, those 162 (92.6%) of the sample respondents' who had been benefited from the available clinic, were asked to rate the available health care service. As it can be seen from the data, 92.6% of the respondents' have been treated or benefited from the available health care service. Whereas, 7.4% of the respondents' has never been benefited. Consequently, out of

92.6% of sample respondents, who has been benefited from it, 48.8% of the sample respondents' has rated the available health care service as, it is excellent, 43.8% of the sample respondents' has rated as it is good. Whereas, 4.9% rated as it is good and only four or 2.5% of the sample respondents' has mentioned as it is poor. Moreover, from the data provided we can conclude that, most of the residents are more satisfied by the health care service provided by Mekedonia.

Also as the information gained from in depth interview, there is referral system for the patients in need of extra medications, the patient will get referred to other government hospitals like Zewditu, Menelik II, Tekur Anbessa, Zenebework, Yekatit 12, and St. Paulos. The institution has special agreement with these hospitals. Volunteer medical doctors will also 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.

One of the health care givers has explained that most of the care recipients have poor health and usually visit the clinic. Some other nurses has also added, as causes of frequent health problems are age related.

It was also revealed that most of the older persons are facing sight, mobility and hearing problems, some of them gastritis and others suffered mental illness. These illnesses were treated by the medium clinic in the institution and by the referral hospitals.

Provisions and use of aid equipment by physically disabled residents

The table below indicates the number of physically disabled respondents who have been provided with aid equipment and are using the provided aid equipment. Likewise, all sample respondents were asked to mention the type of aid equipment's they use in the institution. Accordingly, ramps comes first with 48 frequencies, followed by walking aid equipment with

frequencies of 45 and handrails with a frequencies of 17 respectively**.** The smallest use of aid equipment was ramps and electric wheelchairs with a frequencies of 2 and 3 respectively.

Table:-7: Frequency and percentage distribution of physically impaired respondents who commonly use aid equipment at Mekedonia

Use of aid equipment	Yes	No	Total
Walking aid equipment	45 (25.7)	130 (74.3)	175(100)
Manual wheelchair	48 (27.4)	127 (72.6)	175(100)
Electric wheelchair	3 (1.7)	172 (98.3)	175(100)
Handrails along corridors	17 (9.7)	158 (90.3)	175(100)
Ramps	2 (1.1)	173 (98.9)	175(100)
Special eating utensils	11 (6.3)	164 (93.7)	175(100)
Special writing utensils	7 (4)	168 (96)	175(100**)**

Source: Researchers' survey data (2016)

Availability of communal recreational facilities

Institutional care has the potential to influence residents' lives either positively or negatively on outcomes that include more than just health. It shapes where elderly live, how they live, whom they see, what they do, and the relationships transpiring within families and communities (Kane, 2001). Therefore it is very important to study the availability of entertainment facilities at Mekedonia, so that it is possible to understand how residents are engaged in meaningful and

Table-8: Frequency and percentage distribution of respondents' by any entertaining program provided by Mekedonia

Variable		No.	%
Was there any entertaining program provided by Mekedonia?	Yes	132	75.4
	No	43	24.6
Total		**175**	**100.0**

Source: Researchers' survey data (2016)

Respondents were asked about, whether there has been any entertaining programs which were produced and provided by Mekedonia and if they are entertained, as it is seen in the above table (table 8), most of the sample respondents' i.e. 75.4% has mentioned as there was entertaining programs produced by Mekedonia. Whereas, 24.6% of the samples has replied as there was no entertaining programs provided by Mekedonia.

Sample respondents were also asked about the availability of entertainment facilities at Mekedonia. Accordingly, television comes first with 175 frequencies, followed by Video or DVD with frequencies of 140 and Newspapers and magazine with a frequencies if 136 respectively**.**

It is summarized in the following table below:

Table-9: Frequency and percentage distribution of Communal recreational facilities at Mekedonia

Recreational Facilities	Yes	No	Total
Television	175(100)	0	175 (100)
Newspapers or magazine	136 (77.7)	39 (22.3)	175 (100)
Library or book lending service	15 (8.6)	160 (91.4)	175 (100)
Video or DVD	140 (80)	35 (20)	175 (100)
Indoor games	121 (69.1)	54 (30.9)	175 (100)
Musical instruments	11 (6.3)	164 (93.7)	175 (100)
Coffee or tea making facilities	1 (0.6)	174 (99.4)	175 (100)

Source: Researchers' survey data (2016)

4.3. Respondents' rating of the quality of care provided by Mekedonia

In order to come up with a clear picture of residents perception towards the quality of care provided, a Likert scale was employed in which the sample residents were asked to indicate their level of agreement to 10 critical statements (Strongly agree, Agree, Disagree, and Strongly

Disagree). The issues raised by the statements to measure residents' perception were: physical comfort (beds, sitting chair discomforts etc.), prevalence of meaningful activities, and availability of private space for the residents, dignity of the residents, meaningful relationships with one another and with staff, and spiritual wellbeing, which are all related to the care provided by Mekedonia.

The residents rating of the quality of care provided by Mekedonia is normally distributed. The normal distribution of the data on this variable is important not only to make descriptive statement about empirical distribution, but more importantly to apply inferential statistics in this study and link the sample to the population.

One of the objectives of this study is to assess the variations in the perception with regard to the quality of care among categories of the home residents. As can be seen from the conceptual framework (See Figure 1), perception of the quality of care is supposed to be influenced by disability status and sex and it is associated to duration of stay and with the ages of the residents. Hence, it is essential to see the difference in perception among respondents so as to answer the question – why do perceptional differences exist among residents? The analyses help to lay a foundation for achieving the above mentioned objective. The sections below discuss this difference with regard to respondents' disability status, duration of stay and sex and association with age.

4.3.1. Sex and rating of the quality of care provided

According to the survey data collected from the sample respondents, female respondents have a higher mean score (Mean=32.84) than male respondents (Mean= 30.59) regarding their rating of the quality of care provided by Mekedonia (See table 17 below). The average mean difference is 2.25. Using the appropriate statistical test (Independent Sample t-test), however, the mean difference between male and female respondents' rating of the quality of care is statistically significant (sig. (2-tailed) = 0.000). Therefore, there is statistically significant difference between male and female respondents' rating of the quality of care provided by Mekedonia. That is Males (Mean=32.84) have more positive perception to quality of care than females (Mean= 30.59).

Table -10: Independent sample t-test between sexes in terms rating of the quality of care provided

Variable	Sex	N	Mean	Std. Deviation	df	t	P
Respondents' rating of the quality of care provided by Mekedonia	Male	109	**30.5963**	3.77644	173	-4.111**	.000
	Female	66	**32.8485**	3.02422			

Source: Researchers' survey data (2016)
*P**<0.001*

4.3.2. Disability status and rating of the quality of care provided

The incidence of disability is known to increase with old age. The first most likely causality of disability is mobility. Impaired mobility increases dependence on caregivers. In a number of cases the disability may be permanent which makes the elderly person dependent until death. As such, the intensity of care an older person requires increases with disability. It was also hypothesized that disability status difference among respondents would result in variation of rating of the quality of care provided. According to the survey data collected from the sample respondents, physically disabled respondents have greater mean score (Mean=32.38) than physically abled respondents (Mean= 30.59) regarding their rating of the quality of care provided

by Mekedonia (see table 18 below). The average mean difference is 1.78. Using the appropriate statistical test (Independent Sample t-test), however, the mean difference between physically disabled and physically abled respondents' rating is statistically significant (t= 3.309, df = 173, sig. (2-tailed) = 0.001).

Therefore, there is statistically significant difference between physically disable and able respondents' rating of the quality of care provided. Thus, signifying a differing perception between the disability status groups. Physically disabled residents (Mean=32.38) have more positive perception to quality of care than physically abled residents (Mean=30.59).

Table -11: Independent sample t-test between disability status groups in terms of rating of the quality of care provided by Mekedonia

Variable	Disability status	N	Mean	Std. Deviation	df	t	P
Respondents' rating of the quality of care provided by Mekedonia	Physically disable	83	**32.3855**	3.33068	173	3.309**	.001
	Physically able	92	**30.5978**	3.77109			

Source: Researcher's survey data (2016)
*P**<0.01*

4.3.3. Rating of quality of care by age and duration of stay

A. Bivariate correlation

A bivariate correlation analysis was made to examine if there is a relationship between rating of quality of care, age and duration of stay. As indicated in the table 12 below, age has a weak negative ($r_=$ -.258, P< .001) correlation with rating of the quality of care provided. The relationship is statistically significant at 99% confidence interval. The negative relationship depicts that as respondents' age increase, they think of the quality of care provided is poor. In contrast, respondents with younger age generally think of the quality of care provided as good. Whereas, rating of the quality of care has a weak positive correlation with duration of stay(r

=.159, P< 0.05) the relationship is statistically significant at 95% confidence interval. Moreover, Age and duration of stay had no significant relationship.

Table- 12: Correlation matrix rating of the quality of care provided, age and duration of stay

	Rating of quality of care	Age	Duration of stay
Rating of quality of care	1	1	1
Age	-.258**	-.117	
Duration of stay	.159*		

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

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

B. Linear Regression

A simple regression analysis was conducted to test the effect of age and duration of stay on the rating of the quality of care provided. As the data above depicted, age is weak but negatively associated (β = -.258, P<0.01) with the rating of quality of care provided. Besides the R^2 value for the two variables is 0.066 indicating that the rating of quality of care provided is explained 6.6% of the variance in in respondent's age. Moreover, a significant regression equation was found (F= 12.304, p<0.001) with an R^2 of 0.066. Respondents rating of the quality of care provided was as a mean score of in Likert scale is equal to 36.639 +-0.080 when age is measured by age completed in years. Rating of the quality of care decreased by -0.080 for each one year increase in age. Therefore, age is not a predictor of rating of quality of care. Hence, from the Pearson bivariate correlation and the linear regression, it is possible to conclude that respondents with a relatively higher age will have a negative perception for the quality of care provided by Mekedonia.

Table- 13: Simple regression analysis for age of respondents predicting the rating of the quality of care provided

Variable	Unstandardized Coefficients		Standardized Coefficients
	B	Standard Error	β
Constant	36.639	1.505	-.258
Age of respondents	-.080**	.023	
R^2		.066	
F		12.304***	

a. Dependent Variable: Respondents' rating of the quality of care provided by Mekedonia

***P< 0.001**P< 0.01, *P<0.05

Regarding respondent's duration of stay and their rating of the quality of care provided, a simple regression analysis was also employed. As the data above depicted, duration of stay is weak but positively associated (β = .061, P<0.01) with the rating of quality of care provided. Besides the R^2 value for the two variables is 0.025 indicating that the rating of quality of care provided is explained 2.5% of the variance in in respondent's age. Moreover, a significant regression equation was found (F= 4.494, p<0.001) with R^2 of 0.025. Respondents rating of the quality of care provided was as a mean score of in Likert scale is equal to 30.160 +-0.061 when duration of stay is measured by length of time stayed in month. Rating of the quality of care increased by only 0.061 for each one month stay in the institution. Therefore, from the linear regression, it is possible to conclude that respondent's duration of stay is not predictor of rating of the quality of care provided.

Table- 14: Simple regression analysis for duration of stay of respondents predicting the rating of the quality of care provided

Variable	Unstandardized Coefficients		Standardized Coefficients
	β	Standard Error	β
Constant	30.160	.666	-.159
Duration of stay	.061**	.029	
R^2		.0.025	
F		4.494***	

Dependent Variable: Respondents' rating of the quality of care provided by Mekedonia

***P< 0.001, **P< 0.01, *P<0.05

4.4. Available resources for care and support

In addition to the above discussed survey data. This study also used key informant in-depth interview, in- depth interview and focus group discussions with selected residents and key administrative staffs; in order to deeply probe the situation of care and support by the institution and care received by the residents

The institution is currently gaining the most resource for the care and service from the local donors and the wider public. The administrator explains about the help they receive from the society and local donors in the following manner,

> *We are gaining too much support from the public, they bring us soap and other sanitary materials and clothes; interested individuals come and celebrate their marriage; couples visit elders and celebrate their anniversary and birth dates; individuals celebrate "Tezkar" / a commemorative prayer for the dead ones, celebrated by feeding and pleasing the needy peoples/ etc. we have six vehicles currently one belongs to the founder with which we started to work, another donated by the government charity agency, one a donation of Abyssinia flour factory owner, and the other three bought from the institution capital and all are in use currently for various activities of the institution. . .*

There are also continuous donations delivered regularly, Abyssinia Flour factory is providing 1000 kilogram flour monthly, DH Geda flour factory is providing 400 kilograms of flour monthly, Derba Cement factory transfers 100,000 birr monthly, and other contributors support the institution by the time they visit the center. The coordinator explains it further;

> *we are assured of a 3000 karee meter construction land for our permanent care center, following it we are planning to engage in multiples of Income Generating Activities, like bakery, metal work, wood work, to build our own hospital . . . we have now sufficient human resource most of them are volunteer individuals who want to live here by dedicating their life helping the activities of the center.*

As a result of its advocacy endeavors, Mekedonia is gaining greater public attention. Every day there are visitors in the compound who visit the elders and contribute their share both in-kind and in cash. There are enterprises assisting the institution by assigning monthly contributions. Professionals deliver their service in a way important to change the life situation of resident elders.

As it was indicated by the administrator of the institution, all these activities made the institution local resource dependent which is a guarantee for sustainable service provision. Volunteer activity can be assumed as backbone of the institution's service delivery. Except the two nurses hired by donor individuals, all the staffs of the institution are volunteers serving without payment.

4.5. Problems associated with care and support

Residents raised problems associated with care and support from the institution. In an effort to understand the residents' experience of the care and support services provided to them, selected elders were asked to discuss on the issue and reflect on the points. The care and support services provided at Mekedonia are not an entirely complaint free. Most of the discussants prefer the institution only as compared to their previous life before admission. The following is a direct quotation of the 72 years old residents which narrates about his feeling on the care related problems of the institution,

> *Life is very comfortable here, we have everything. We have clean clothes, we have beds to sleep, and our dish is full. It is impossible to get such a place but, through times it might be due to getting bored or getting tired or it might be due to behavioral problems, care givers are decreasing there attention. That's why I think now a days care givers have decreased their attention of care than in the previous times.*

Residents of the institution had also raised points with regard to the availability and sufficiency of the existing resources. According to the participants, though they are satisfied with the present care and support which is far better from their past circumstances, still there are also certain problems on the process of care giving activity and resources.

Grounding on the study participants emphasis of responses, there are certain problems related with both caring service and living facilities. The administrative staff of the Institution also accepts the existence of these problems. According to his words,

> *Some of the problems of elderly residents in the institution are: The first one is medication; most of the medicines prescribed by the physicians are nonexistent in our clinic and expensive to buy. As much as the budget for the institution is concerned, we are spending too much money for medical treatments. Some of the health care diagnostic services are too expensive for us but now a days thanks for government and non-governmental hospitals they are sharing our costs for medication. The other problem is related with facilities of the institution, most of the bed rooms are constructed by metal sheets and need renovation service. There is also insufficient bathe room and recreational facilities in which we want to improve.*

In most days of the researchers' visit to the institution, it was witnessed that, elderly and mentally disabled residents were living together in the institution. The research participants had also raised problems with regard to this issue. As a 62 year's old elder states:

> *I have seen and received some care and support during the previous regimes. But this is very special. We had everything, nothing is less. However, to mention some; we are now living with mentally disabled beneficiaries... Sometimes they disturb us, sometimes they shout loudly and throw things toward elders. Perhaps I know that they didn't brought it by themselves but it makes us sad to see them…so it would be better if we are separated from them and I hope this comes better when the new building plan becomes accessible and starts working.*

Most of the residents prefer to express their feeling by praising the hard works of the founder for comforting them. They hardly mentioned any bad feelings created as a result of lacking services or dissatisfying care and support. Rather participant elders express their comfort to stay longer in the center and their satisfaction at the service provision positively.

An elder who is 95 years old residing in the center puts his feeling about his life, "It is very fine, I don't worry about what to eat and drink, and there is no problem. I am living as if I am in my own home.

Another 78 years elder who stayed at the center for more than two years states,

After joining this center, am living very well in clothing, food, and shelter. It is very good place and I am comfortable and very thankful to the founder.

After all, it can be summed up that residents are happier by the care and support they are receiving from the institution. However, they had also mentioned as there are certain problems that they want to be solved and improved.

4.6. Care related Problem solving mechanisms

In assessing the problems associated with care and support, this study had also came across issues of mechanisms of solving problems, discharges and withdrawals from the institution.

As it was mentioned by beneficiary participants and administrative staff interviewees'; there are organized committees at each level of the institutional structure (such as food committee, hygiene committee, discipline committee etc.) and there would be a meeting which could be conducted twice a month as necessary. Therefore, residents are motivated to point out problems associated with the care and support they receive through the organized committees and on the general meetings.

In addition, one of the points of interest mentioned in the focus group discussion was elderly discharge cases of the center. The discussants explains that there were discharges of residents as it was necessary but the discharges are not due to discipline case or by the initiation of the institution.

Discussants mentioned that, there are discharges when residents find their family members who were lost each other for various reasons, there are also elders here who went for street life after disagreements with family or relatives and these kinds even reject their families, when their family members found them and try to take for reunion, they even don't like to be taken. Sometimes residents cry out to stay in the institution than reunion.

As per the word of one of the administrative staff;

> *We have around five such cases who rejected reunion, we would like if they were taken by family members to get additional space for new needy entrants, but they preferred death than reunion with their family. There are also discharges because of addictions to drugs which are forbidden with the regulation of the institution*

In sum, Mekedonia had an organized structure of problem solving mechanisms, discharge and withdrawals. Yet, there are few elders who leave the institution but, the discharges and withdrawals are mainly initiated by the elderlies themselves. They are leaving the institution when they succeed in finding someone to help them, and those who have had something before admission and found it difficult to live in the institution than the life they had out of the institution.

CHAPTER FIVE
SUMMARY AND CONCLUSION

5.1. Summary of Major Findings

The main objectives of this study is to undertake critical assessment of the institutional care provided for the elderly and residents perception towards the quality of care provided. Data were gathered using survey questionnaire, in-depth interviews, focus group discussions with residents and key informant interviews from the study institution or administrative staffs who work in the institution.

The study was specifically directed at identifying the kind and levels of care provided to the residents as it was rated by care receivers' themselves, examining the perception of residents towards the quality of care provided, and investigating problems associated with care and support

5.1.1. Actual care and support provided by Mekedonia

The main services provided for the residents, includes, Shelter/bed rooms/, food, health care service, hygiene/bath room/ facilities, assisted caring, and clothing services. The other supporting services though it is not well enough as it was indicated by the coordinator includes, recreational facilities such as, TV room facility (four in four meeting halls), and indoor games. The findings of actual care and support provided are summarized as follows:

- Data gathered from survey respondents revealed that, most respondents 93.1 percent believe that there is adequate food service at Mekedonia whereas only 6.9 percent of the

respondents believe that there is no adequate food service. And most of them rated the food service as good and excellent (54.3 & 36.6 percent respectively).

- Similar data gathering techniques had also been employed in order to assess the existence and adequacy of clothing and health care services, bed, bath room and communal recreational facilities. Sample respondents' were also made to rate the delivered services. Accordingly, most of the frequency data distribution of all service deliveries revealed that respondents' believe as, the existing services are adequate and rated as fair, good and excellent. It is only small proportion of respondents who has believed that the services/facilities are inadequate and rated as it is poor.
- Most common inadequate kind of service deliveries/facilities include; bath & bed room and recreational facilities. Out of the total sample respondents' it was 67.4 and 54.9 percent who has replied as there is inadequate bed and bathe room facilities respectively. In addition, 29.7 percent rated the bed rooms as it is poor and 31.4 percent rated as fair. Whereas, 30.3 percent of the sample respondents' rated bathe room facility as poor, and 34.9 percent rated as fair. Thus, these data signifies inadequacy and poor bed & bathe room and recreational facilities.
- Most favored or highly rated type of service delivery is health care service. Out of 92.6 percent who has been benefited from the health care service of the institution, 48.8 and 43.8 percent rated as it is excellent and good respectively. Thus, signifying provision of enhanced health care service.
- Most respondents i.e. 75.4 percent has replied as there was an entertaining activity which was made by the institution. However, the survey data indicates that though there are different recreational facilities (such as television, video or DVD, indoor games, musical

newspapers and magazines), it was not good enough for residents to engage in a flexible behavior that results in self-affirming ability or to gain active pleasure in doing of or watching an activity.

5.1.2. Variations in the rating of the quality of care provided

- The residents rating of the quality of care was supposed to differ based on sex. And sex was found to be statistically significant, ($x^2(1)$ = 19.351, sig. (2-tailed) = 0.000), in influencing the perception towards quality of care between male and female residents. Thus, male are found to have positive perception than females towards the quality of care provided.
- The residents' rating of the quality of care was also supposed to differ based on disability status. And there is statistically significant difference (t=3.309, df =173, sig. (2-tailed) = 0.001), between physically disabled and physically abled residents, in terms of their rating quality of care provided by Mekedonia. Thus, signifying a differing perception towards the quality of care. Physically disabled residents (Mean=32.38) have a positive perception to quality of care than physically abled residents (Mean=30.59).
- Data gathered from the survey respondents disclosed that age and duration of stay are significantly associated to residents' rating of the quality of care provided. There was an indirect relationship between age and rating of the quality of care (r = -.258, sig. (2-tailed) = 0.001).Thus, indicating as age of respondents' increase, they think of the quality of care provided is poor. In contrast, respondents' with younger age generally think of the quality of care provided as good. Whereas, duration of stay is found to have a weak positive correlation with rating of the quality of care(r= .159, p< 0.001)

- A simple regression analysis was conducted to test the effect of age and duration of stay on the rating of the quality of care provided. Age was weak but negatively associated (β = -.258, P<0.01) with the rating of quality of care provided. Besides the R^2 value for the two variables is 0.066 indicating that the rating of quality of care provided is explained 6.6% of the variance in in respondent's age. Moreover, a significant regression equation was found (F= 12.304, p<0.001) with R^2 of 0.066. Respondents rating of the quality of care provided was as a mean score of in Likert scale is equal to 36.639 +-0.080 when age is measured by age completed in years. Rating of the quality of care decreased by -0.080 for each one year increase in age. Therefore, from the Pearson bivariate correlation and the linear regression, it is possible to conclude that respondents with a relatively higher age will have a negative perception for the quality of care provided by Mekedonia.
- Regarding respondent's duration of stay and their rating of the quality of care provided, a simple regression analysis was also employed. As the data above depicted, duration of stay is weak but positively associated (β = .061, P<0.01) with the rating of quality of care provided. Besides the R^2 value for the two variables is 0.025 indicating that the rating of quality of care provided is explained 2.5% of the variance in in respondent's age. Moreover, a significant regression equation was found (F= 4.494, p<0.001) with R^2 of 0.025. Respondents rating of the quality of care provided was as a mean score of in Likert scale is equal to 30.160 +-0.061 when duration of stay is measured by length of time stayed in month. Rating of the quality of care increased by only 0.061 for each one month stay in the institution. Therefore, from the linear regression, it is possible to conclude that respondent's duration of stay is not predictor of rating of the quality of care provided.

5.1.3. Available resources for care and support at Mekedonia

- It was mentioned by executive director that, the institution is currently gaining the most resources for service delivery; from the local donors and the wider public. There are also continuous donations delivered regularly from various organization, enterprises, volunteer individuals and other contributors who support the institution by the time they visit the center.
- It was also mentioned that, all the available human and financial resources made the institution local resource dependent which is a guarantee for sustainable service provision.

5.1.4. Problems associated with care and support at Mekedonia

- Data's gained through key informant in-depth-interviews, in-depth interviews and focus group discussions indicate that though residents are satisfied with the present care and support which is far better from their past circumstances, still there are certain problems on the care giving activities and resources.
- Majorly stated problems include; inadequate bathe and bed rooms and communal recreational facilities, decreased care givers attention on the process of care giving activity, insufficient physical space for residents to care with and living together with mentally disabled residents.

5.1.5. Care related problem solving mechanisms at Mekedonia

- It was mentioned by resident participants and administrative staff interviewees' that; there are organized committees at each level of the institutional structure (such as food committee, hygiene committee, discipline committee etc.) and there would be a meeting which could be conducted twice a month as necessary. Therefore, residents are motivated

to point out problems associated with the care and support they receive through the organized committees and on the general meetings.

- The other main point of interest mentioned in the focus group discussion was elderly's discharge cases of the center. The discussants explains that there were discharges of residents as it was necessary but the discharges are not due to discipline case or by the initiation of the institution.
- As mentioned by one of the key administrative staff, there are few elders who leave the institution and the discharges & withdrawals are mainly initiated by the elderlies themselves. They are leaving the institution when they succeed in finding someone to help them, reunion with lost family members due to various reasons, and those who have had something before admission and found it difficult to live in the institution than the life they had out of the institution. And sometimes, because of addiction to drugs that are forbidden with the regulation of the institution.

5.2. Conclusion

With a growing pressure from destitute aging population on social & health care use and expenditure, it is very important to systematically assess the nature and quality of institutional based care for the elderly, and discover the effects of institutional living upon elder people themselves in order to find out whether institutions for the elders were necessary in our society, and if so what form they should take.

From the study findings, it is possible to draw a definite conclusion that institution based care and support service which focuses on the needy elders have rescued the late life situations of the elders. While the most detailed study is required to understand the quality of care and living condition, it is possible to conclude that the service of the institution has changed the life situation of the elders.

The residents, despite having been forgotten by the society to live in the streets for long period of time, driven out of their families, and living helplessly were found enjoying their institutional life. The findings of the survey, in-depth interviews and focus group discussions have indicated that, residents are made to receive services such as shelter, food, clothes and health care services. They spent their spare time by playing card games, chatting with friends, watching T.V and having discussions among themselves. Except with some problems associated to care such as; inadequate bathe and bed rooms and communal recreational facilities, decreased care givers attention on the process of care giving activity, insufficient physical space for residents to care for and living together with mentally disabled patients, most beneficiaries expressed their opinion that they are living a better life than their living arrangement before admission.

In developed countries it is considered that old age homes as the last resort and staying there as equivalent to being thrown in a dustbin. But, that was not true in the case with the residents of these old age home. They were not discomforted with their stay rather; they were enjoying their communal living. As a result, of institutional living they are able to enjoy and connect to the community regardless of gender, class, and religious differences.

Moreover, in the assessment of residents' rating of the quality of care provided, there was variations in terms of sex, disability status and duration of stay in the institution. The study found out that, disability status and sex difference among the residents were found to be significant resulting in a differing rating of the quality of care provided. The study also found out that residents duration of stay at the institution resulted in a differing rating of the quality of care provided. Whereas age and rating of the quality of care were found to have a weak negative correlation; as residents' age increase, they think of the quality of care provided is poor. In contrast, respondents with younger age generally think of the quality of care provided as good.

In foreseeing the future; the government, voluntary agencies and NGOs in the country should better make arrangements for institutional support and care for the elderly. The public participation and volunteer activities were shown playing a decisive role in the care giving activity and showing respect to the resident elders. Residents in the institutions expressed their feeling about societal visit and support as important societal belongingness which they were not experiencing in their previous life.

5.3. Recommendations

Institutional care recipients, especially those who are suffering from frailty want to be addressed in a polite, friendly and appropriate manner and treated with respect for their personal privacy, hygiene and appearance, choice of clothes and furnishings and access to appropriate care and assistance with eating, drinking, washing, toilet and other daily activities are required.

As institutional elders are the most segregated and forgotten segment of the society, it is an ideal practice area where professional values and practice principles are applied in real life.

Multiples of practice tasks are vacant waiting for the attention of professionals, practitioners and advocates. Caring, counseling, training, advocating and institutional management are all needs the involvement of gerontologists, sociologists, social work practitioners and other professionals.

Social scientists should be better to engage themselves in elderly care institutions and involve in trainings of care givers, in the areas relevant to the service such as, emotional support and assistance in coping with transition of move to the institution, orientation to the home, its staff, policies, and procedures, including rights, responsibilities, and grievances, ongoing relatedness and intimacy with family and loved ones, issues of choice and control over decisions affecting care, recognition and opportunity for expression of religious/ethnic/cultural identity, contributing to the life and functioning of the institutional community, structured social and group interaction opportunities inside and outside the home, help with feelings of loss that occur throughout the stay in the home, help with fears and anxieties that may occur throughout the stay in the home etc.

One of the prior importance of social scientists in this area is in relation with advocating for the wide spread involvement of the community in institutional care giving. With the engagement of

social scientists, it is possible to improve the living condition of elders and to ease the service provision of the institutions through implementing planned service provision strategies.

The role of social scientists in the admission process is also important in providing information to residents regarding the institution, institutional policies, schedules, and services. Registering the social history of the resident is another task to be performed by social workers. On arrival at the center the social history of residents should be recorded including medical records and other significant information about the residents.

Participating volunteers in the caring service is of paramount importance both to the institution and the beneficiary elders of the institution. Volunteers can bring additional personal contact to the beneficiaries; they can provide new services to the elderlies as well as serve as a link between the institution and the community.

Volunteers may be recruited and assigned to specific purposes such as serving, as walking helpers, reading books to the elders, social grouping coordinators within the beneficiaries, to collect feedback and recommendation for service quality improvement, to assist the professional care giving and more.

Advanced policies, programs, and professional behavior that can promote older adults' self-advocacy, lifelong learning, civic engagement, and necessary caring service in times of crises are a must to happen progressively. Though the national social protection policy had included the cases of elders as an important focus area of intervention in the policy framework, it is nonexistence in reality. There still are policy gap in improving and leading institutional care center in away appropriate to the needs of elderly people. Policy frameworks and action plans

targeting to intervene in life changing activities of the elderly needs to work hard in creating harmonious environment for the elderly including well managed institutions of aging.

In addition to recognizing elders as one important part of the society, expanding policies and programs that can address better institutional care and community support, the social care of elders, housing, and service access needs of older people is required.

Policies aimed to preserve the integrity of Social Security and expanding public, private, and commercial systems involvement in providing institutional and economic support for older adults is needed. Policy frameworks aimed at establishment of public funded institutional care services needed to be developed.

Advocating towards policy formulation targeting the health care of elderly and frail elders treatment and availing high-quality medical equipment and medication services are required in the sphere of policy.

There is an evident lack of research on elders and elderly care institutions. Further detailed research can be undertaken in the area of service provision and living arrangement of institutional services.

Researchers may include the service qualities of institutions, the spirituality of residents, and age friendly living arrangements. Future studies may also come up with more detailed life experience of elders in the institutions. Involvement of the elders into development activities and knowledge transfer can also be studied with upcoming researchers who interested in the area of old age.

As far as educational importance of this study is concerned, academicians who would like to know the situation of elders in institutions; this paper is an important source of first insight. Students who are learning on human service related courses will be benefited much from this

paper. They can grasp an important glimpse of understanding about the organizational set-ups of elderly care institutions, they can find what institutional elders are saying about their life in the institutions, and more over this study can alert them to further study institutional care and care center management in a broader and integrated manner.

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7. Annexes

Annex A: Questionnaire prepared for residents at Mekedonia

Preamble

Dear respondents! My name is Tewodros H/giorgis. I am carrying out this study in titled *Institutional care provided to the elderly and residents perception of quality of care provided by Mekedonia Home for the Elderly and Mentally Disabled (MHEMD.*. The study is part of the requirements for completion of the degree of Masters of Arts in Sociology at Addis Ababa University. This study would inform interventions and contributes to the improvement of the quality of life of the elderly in institutional settings. This questionnaire includes questions related to your socio-demographic background, kind and levels of service delivery, and indicators of quality of care. To achieve the objectives of this research, your genuine responses are highly important. I would like to assure you that the information you provide will be kept confidential. I thank you so much in advance for sacrificing your precious time to complete this questionnaire.

Segment 1: Certification

Enumerator name: _____Signature: _____ Date (D-M-Y):_____

Questionnaire ID Number: _____

Segment 2: Socio-demographic background

1. Sex (Male= (1), Female= (2)]----------
2. Age ----------
3. Place of birth:- [Rural=(1), Urban=(2)] ----------
   [Town---------- Zone---------- Wereda---------- Kebele----------
4. Mother tongue language :- ----------
5. Religion: [Orthodox Christian=(1), Catholic Christian=(2), Protestant Christian=(3), Muslim=(4), Others specify=(5)] ----------
6. Educational qualification [Cannot read and write =(1), Read only=(2), Can only read and write=(3), Attended grade 1-4 =(4), Attended grade 5-8, = (5) Attended grade 9-12,= (6),= Attended vocational training=(7), Attended higher education =(8)]----------
7. Marital status [Never married= (1), Married=(2) , Divorced=(3),Widowed=(4)]----------
8. Duration of stay: how long have you been living at Mekedonia? ----------

9. How do you evaluate your current physical-functional health [Physically impaired=(1), Mental state=(2), behavioral state=(3), Combination of the above =(4), free of the above states=(5), others(specify) =(6)---------- ☐
10. How do you rate your level of dependency on others?
    [Not dependent= (1), Low = (2), Medium = (3), High= (4)]---------- ☐
11. How do you rate your level of dependency on use of aid equipment?
    [Not dependent= (1), Low = (2), Medium = (3), High= (4)]---------- ☐
12. Before you admitted to Mekedonia, with whom did you use to live? ---------- ☐
    [In my own home= (1), with my grandchild/children= (2), with other relatives= (3), in church yards, Anywhere on the street= (5), others (specify) ----------
13. Before you admitted to Mekedonia how do you use to sleep? ---------- ☐
    Alone= (1), Together with others= (2), others (specify) ----------
14. Before you admitted to Mekedonia, how many times you use to eat per day? ---------- ☐
    [Ones per day= (1), Twice per day= (2) Three times per day= (3)]
15. Do you use to have income? Yes=(1), No=(2) ---------- ☐
16. If yes, was it permanent or randomly earned? Permanent=(1), Random=(2) ---------- ☐
17. From where do you use to get the income? ---------- ☐
    [Salary= (1) pension= (2) from children or relatives support= (3) Begging= (4)
    Others (specify) ----------
18. Whether it was permanently or randomly gained income, how much you use to gain per month? ☐☐☐

Segment 3: kind and level of service provisions

1. Do you believe, that there is adequate food service at Mekedonia? Yes= (1), No= (2) -- ☐
2. If yes, how would you rate the level of food service? Poor = (1) Fair= (2), Good= (3), Excellent = (4), ---------- ☐
3. Do you believe, that there are adequate bed rooms for residents?
   Yes= (1), No= (2) ---------- ☐
4. If yes, how would you rate the adequacy of bed rooms? Poor = (1) Fair= (2), Good= (3), Excellent = (4) ---------- ☐
5. Do Mekedonia provide you with clothes? Yes=(1), No=(2)---------- ☐
6. If yes, how would you rate the adequacy of clothing service? [Poor = (1) Fair= (2), Good= (3), Excellent = (4)] ---------- ☐
7. Does it fulfills your interest? Yes=(1), No=(2)---------- ☐

8. If Yes, how would you rate the worthiness of clothing service?[Poor = (1) Fair= (2), Good= (3), Excellent = (4)]----------
9. Do Mekedonia have a health post/center/clinic? Yes=(1), No=(2)----------
10. Have you ever been treated (or benefited from) a health post/center/clinic at Mekedonia? Yes=(1), No= (2) ----------
11. Have you ever been referred to a hospital due to serious health issues? Yes = (1), No= (2) ----------
12. If yes where? Please specify_____
13. Are there any health care services for beneficiaries in need of special medical follow-ups (such as HIV infected elders, elderlies with mental and emotional problems, elderlies with neurological and dementia etc.) Yes=(1) No=(2) ----------
14. In your opinion, how would you rate the level of health care service at Mekedonia? [Poor = (1) Fair= (2), Good= (3), Excellent = (4)]----------
15. Was there any entertaining program produced by Mekedonia? Yes=(1), No=(2)----
16. Are any of the following communal recreational facilities available for residents at Mekedonia (**please tick more than one alternative if appropriate**)?

(1) Television
(2) Newspapers
(3) Video/DVD
(4) Library/book lending
(5) In door games
(6) Musical instruments
(7) Bar
(8) Tea/ coffee making facilities

If others please specify _____

17. Is there adequate bathing facility for residents at Mekedonia? Yes=(1), No= (2) ---
18. If yes, how would you rate the level of the bathroom facility? [Poor = (1) Fair= (2), Good= (3), Excellent = (4)] ----------
19. Have you habituated or used any of the following at Mekedonia **(please tick more than one alternative if appropriate)**?

(1)Walking aids
(2) Manual wheelchairs
(3) Electric wheelchairs
(4) Handrails along corridors

(5) Ramps

(7) Special eating utensils

(8) Special writing utensils

(9) Handrails along dining room/sitting room walls

If others please specify_____

20. Is there any advice available regarding the provision of the above equipment? Yes= (1), No= (2) ----------

21. Is there any arrangement made by Mekedonia in order to resolve conflicts between residents? Yes= (1), No=(2)----------

Thank you for your cooperation!

Segment 4: Residents' rating of the Quality of care provided

The following question could be used as a lead in to the quality of care scales: "I am going to ask you some questions about the quality of care here at MHEMD. I am asking these questions so that it can tell how well MHEMD are providing service to the beneficiary elderlies. There are no right or wrong answers to my questions and the whole discussion concerns what life is like for you here at MHEMD."

(INSTRUCTION: Circle for each item the answer that most closely expresses your feelings.)

1. I'm by and large free of physical discomfort since I joined Mekedonia.

4	3	2	1
Strongly agree	Agree	Disagree	Strongly disagree

2. I feel that, within the limits of my capacity, I' am as independent as I wish to be at Mekedonia.

4	3	2	1
Strongly agree	Agree	Disagree	Strongly disagree

3. I feel as if, I'm belittled, and humiliated at Mekedonia.

1	2	3	4
Strongly agree	Agree	Disagree	Strongly disagree

4. There is no interesting things to watch or participate when I spend my Leisure time at Mekedonia.

1	2	3	4
Strongly agree	Agree	Disagree	Strongly disagree

5. I'm engaged in meaningful relationship with fellow residents and staffs.

4	3	2	1
Strongly agree	Agree	Disagree	Strongly disagree

6. I'm denied from meeting my spiritual and religious needs in terms of Prayer, fasting, etc. at Mekedonia.

1	2	3	4
Strongly agree	Agree	Disagree	Strongly disagree

7. The food that is provided by Mekedonia is excellent.

4	3	2	1
Strongly agree	Agree	Disagree	Strongly disagree

8. The cloth provided by Mekedonia is adequate.

4	3	2	1
Strongly agree	Agree	Disagree	Strongly disagree

9. The health care service provided by Mekedonia is adequate.

4	3	2	1
Strongly agree	Agree	Disagree	Strongly disagree

10. All in all, I am inclined to feel that the services provided by Mekedonia are wonderful.

4	3	2	1
Strongly agree	Agree	Disagree	Strongly disagree

Score: ☐☐

አዲስ አበባ ዩኒቨርስቲ

ማህበራዊ ሳይንስ ኮሌጅ

ሶስዮሎጂ ትምህርት ክፍል

Annex B: ለመቄዶንያ አረጋውያንና የአእምሮ ህሙማን መረጃ ተቋም አገልግሎት ተጠቃሚዎች የተዘጋጀ መጠይቅ

መግቢያ

ውድ የዚህ መጠይቅ ተሳታፊ እኔ ቴዎድሮስ ሀ/ጊዮርጊስ እባላለሁ፡፡ በአዲስ አበባ ዩኒቨርስቲ የሶስዮሎጂ ትምህርት ክፍል የድህረ ምረቃ ፕሮግራም ተማሪ ስሆን ለሁለተኛ ዲግሪ መመረቂያ የሚሚያ ጥናት በማድረግ ላይ እገኛለሁ፡፡ የዚህ ጥናት አላማ በመቄዶንያ የአረጋውያንና የአእምሮ ሕሙማን መረጃ ማእከል የሚገኙ አረጋውያን በተቋሙ የሚያገኙዋቸው አገልግሎቶችና የአገልግሎቶቹን ጥራት ለመገንዘብ ትኩረት ያደረገ ነው፡፡

በዚህ ጥናት እንዲሳተፉ የተመረጡበት ዋና ምክንያት ከሚደረገው ጥናት ጋር ቀጥተኛ ግንኙነት ስላለዎት ነው፡፡ በዚህ ጥናት ላይ መሳተፍ ሙሉ በሙሉ በፍቃደኝነት ላይ የተመሰረተ ነው፡፡ በዚህ ጥናት ላይ የጥናቱ አላማ እንዲሳካ የርስዎ ተሳትፎ በጣም ወሳኝ ነው፡፡ ይህ መጠይቅ ለትምህርታዊ ጽሁፍ አላማ ብቻ የሚውል ይሆናል፡፡

ለጥናቱ መሳካትም የእርስዎ እውነተኛ ስሜትዎን የሚገልጸውን ምላሽ ከፍተኛ ሚናን ይጫወታል፡፡ ስለዚህም በአክብሮትና በሙሉ ትህትና ይህን መጠይቅ ለመመለስ እንድትተባበሩኝ እጠይቃለሁ፡፡ ጊዜዎን ሰውተው ይህን መጠይቅ ለመመለስ ፍቃደኛ በመሆንዎ ከልብ አመሰግናለሁ፡፡

መጠይቅ

ክፍል 1

የመረጃ ሰብሳቢው/ዋ ስም---------- ፊርማ---------- ቀን ----------

የመጠይቅ መለያ ቁጥር ----------

ክፍል 2፡ <u>የመጠይቁ ተሳታፊዎች አጠቃላይ መረጃ</u>

1. **ፆታ፡-** [ወንድ =(1) ሴት=(2)]---------- ☐
2. **እድሜ፡-** [65 አመት እና ከዚያ በታች = (1) 65-74 = (2) 75-84=(3)
   85-94= (4) 95 አመት እና ከዚያ በላይ= (5)] ----------☐
3. **የአፍ መፍቻ ቋንቋ----------**
4. **የትውልድ ቦታ፡-** ----------☐
   [ገጠር = (1) ከተማ= (2)]
5. **የትውልድ ስፍራ፡- ከተማ---------- ዞን----------ወረዳ---------- ቀበሌ--------**
6. **ሀይማኖት፡-** [ኦርቶዶክስ ክርስቲያን= (1) ካቶሊክ ክርስቲያን= (2)
   ፕሮቴስታንት ክርስቲያን= (3) **መስሊም**=(4)]----------☐
   ሌላ ካለ ይጥቀሱ----------
7. **የትምህርት ደረጃ፡**----------☐
   [**ማንበብና መጻፍ የማይችል/የማትችል**=(1) ከ1-4ኛ **ክፍል**=(4)
   ማንበብ ብቻ የሚችል/የምትችል= (2) 5-8ኛ **ክፍል**=(5)
   ማንበብና መጻፍ ብቻ የሚችል/የምትችል=(3) 9-12ኛ **ክፍል** =(6)
   ተግባረድ= (7) **ከፍተኛ ትምህርት=** (8)]
8. **የጋብቻ ሁኔታ፡**----------☐
   [**ያላገባ/ች**=(1) **ያገባ/ች** =(2)
   አግብቶ የፈታ/ታች=(3) **ባለቤቱ/ቷ የሞተበት/ባት**=(4)]
9. **ወደ መቄዶንያ ከመግባትዎ በፊት ከማን ጋር ነበር የሚኖሩት?----------☐**
   በራሴ ቤት =(1) **ከልጅ/ጆች ጋር** =(2) **ከሌሎች ዘመዶች ጋር** =(3)

በቤተ ክርስቲያን መቃብር ቤት= (4) የትም የት በመንገድ ዳር =(5)

ሌላ ካለ ይጥቀሱ----------

10. ወደ መቄዶንያ ከመግባትዎ በፊት እንዴት ነበር የሚተኙት?----------

ለብቻ =(1) በጋራ=(2) ሌላ ካለ ይጥቀሱ----------

11. ወደ መቄዶንያ ከመግባትዎ በፊት በቀን ምን ያህል ጊዜ ይመገቡ ነበር?-----

በቀን 1 ጊዜ=(1) በቀን 2 ጊዜ= (2) በቀን 3 ጊዜ=(3)

12. ትንሽም ቢሆን ገቢ ነበረዎት ወይ? አዎ =(1) የለም=(2)----------

13. ለጥያቄ ቁጥር 12 ምላሽዎ "አዎ" ከሆነ ቋሚ ገቢ ወይስ አልፎ አልፎ የማ?-

ቋሚ=(1) አልፎ አልፎ =(2)

14. ከየት የሚገኝ ገቢ ነበር?----------

ከራሴ ስራ ክፍያ =(1) ጡረታ=(2) የልጅ ወይም የዘመድ እርዳታ =(3)

የአደባባይ ልመና=(5) ሌላ ካለ ይጥቀሱ----------

15. ቋሚ ሆነ አልፎ አልፎ ይገኝ የነበረ ክፍያ ከነበረዎት በአማካኝ በወር ስንት ብር ያህል ይሆን ነበር? | | | | |

ክፍል ሶስት : <u>የአገልግሎት አይነት እና መጠን</u>

1. በተቋሙ በቂ የምግብ አቅርቦት አለ ብለው ያስባሉ? [አዎ= (1) አይ=(2)]------
2. ለጥያቄ ቁ.1 ምላሽዎ "አዎ" ከሆነ የተቋሙን የምግብ አቅርቦት እንዴት ይመዝኑታል?--

ዝቅ ያለ/ ደካማ=(1) መጠነኛ=(2) ጥሩ= (3) በጣም ጥሩ=(4)

3. በተቋሙ በቂ የመኖሪያ ክፍሎች አሉ ብለው ያስባሉ?----------

አዎ= (1) አይ=(2)

4. በጥያቄ ቁ.3 ምላሽዎ "አዎ" ከሆነ የመኖሪያ ክፍሎቹን ሁኔታ እንዴት ይመዝኑታል?---

ዝቅ ያለ/ ደካማ=(1) መጠነኛ=(2) ጥሩ= (3) በጣም ጥሩ=(4)

5. ተቋሙ የተለያዩ አልባሳትን ያቀርብልዎታል?----------

አዎ= (1) አይ=(2)

6. በጥያቄ ቁ.5 ምላሽዎ "አዎ" ከሆነ የአልባሳት አቅርቦቱን እንዴት ይመዝኑታል?-

ዝቅ ያለ/ ደካማ= (1) መጠነኛ=(2) ጥሩ= (3) በጣም ጥሩ=(4)

7. አልባሳቱ የእርስዎን ፍላጎት የሚያሟሉ ናቸው? አዎ= (1) አይ=(2)-------

8. በጥያቄ ቁ.7 ምላሽዎ “አዎ” ከሆነ የአልባሳቱን ጥራት እንዴት ይመዘኑታል?----

ዝቅ ያለ/ ደካማ= (1) መጠነኛ= (2) ጥሩ= (3) በጣም ጥሩ= (4)

9. ተቋሙ የጤና እንክብካቤ አገልግሎት ወይም ክሊኒክ አለው?----------

አዎ= (1) አይ= (2)

10. በተቋሙ ክሊኒክ ወይም የጤና ተቋም ተገልግለው ያውቃሉ ወይ?----------

አዎ= (1) አይ= (2)

11. ከባድ በሆነ ህመም ምክንያት ወደ ሌላ የጤና ተቋም/ ሆስፒታል ሂደው እንዲታከሙ ተመርቶልዎት ያውቃል? አዎ= (1) አይ=(2)----------

12. ለጥያቄ ቁ.11 ምላሽዎ “አዎ” ከሆነ የት ነበር የተመራልዎት፤ እባክዎ የህክምና ተቋሙን ስም ይጥቀሱ----------

13. ተቋሙ ልዩ የጤና እንክብካቤ አገልግሎት ለሚሹ (ለምሳሌ ለኤች አይ ቪ ህመምተኛ፣ የአእምሮ ህመም እና የመርሳት ችግር ላለባቸው ወዘተ.) አረጋውያን የጤና ድጋፍ ያደርጋል? አዎ= (1) አይ=(2)----------

14. በእርስዎ አመለካከት የተቋሙን የጤና እንክብካቤ አገልግሎት እንዴት ይመዘኑታል?----

ዝቅ ያለ/ ደካማ=(1) መጠነኛ=(2) ጥሩ= (3) በጣም ጥሩ=(4)

15. ተቋሙ ያዘጋጀውና እርስዎ የተዝናኑበት የመዝናኛ ዝግጅት ኖሮ ያውቃል ወይ? አዎ= (1) አይ=(2)

16. በተቋሙ ውስጥ ከሚከተሉት የጋራ የመዝናኛ አገልግሎቶች የትኞቹ ይገኛሉ? (እባክዎ በተሰጠው ሳጥን ይህን ✓ ልክት ያስቀምጡ፤ምርጫዎ ከአንድ በላይ ከሆነም መምረጥ ይችላሉ)

1. ቴሌቪዥን
2. ጋዜጦች
3. ቪዲዮ/ዲቪዲ
4. መጠጥ ቤቶች
5. ቤተ መጽሀፍት
6. የቤት ውስጥ ጨዋታዎች
7. የሙዚቃ መሳሪያዎች
8. ሌላ ካለ እባክዎን ይጥቀሱ ----------

17. በተቋሙ በቂ የመታጠቢያ ቤት አለ? አዎ=(1) አይ=(2)----------☐

18. በጥያቄ ቀ. 17 ምላሽዎ "አዎ" ከሆነ የተቋሙን የመታጠቢያ ቤት ሁኔታ እንዴት ይመዘኑታል?---------- ☐

ዝቅ ያለ/ ደካማ=(1) መጠነኛ=(2) ጥሩ= (3) በጣም ጥሩ=(4)

19. ከዚህ በታች ከተዘረዘሩት መሳሪያዎች በዚህ ተቋም ውስጥ የትኞቹን መሳሪያዎች ይጠቀማሉ? (እባክዎ በተሰጠው ሳጥን ይህን ምልክት ያስቀምጡ ☑ ምርጫዎ ከአንድ በላይ ከሆነም መምረጥ ይችላሉ)

1. ምርኩዝ ☐
2. በእጅ የሚሰራ ተሽከርካሪ ወንበር ☐
3. በኤሌክትሪክ የሚሰራ ተሽከርካሪ ወንበር ☐
4. ደረጃ ሲወጣና ሲወረድ የሚያዝ ድጋፍ (ቅስት) ☐
5. መውጫ እና መውረጃ ተንቀሳቃሽ መሰላል ☐
6. ልዩ የመመገቢያ ቁሳቁስ ☐
7. ልዩ የመጻፊያ ቁሳቁስ ☐
8. ሌላ ካለ እባክዎን ይጥቀሱ----------

20. ከላይ በጥያቄ ቁ.19 ለተዘረዘሩት መሳሪያዎች ከተቋሙ ስለ አጠቃቀማቸው የግንዛቤ ማስጨበጫ ትምህርት አግኝተዋል? አዎ= (1) አይ= (2) ---------- ☐

21. በተቋሙ ለሚከሰቱ የእርስ በርስ ግጭቶችን ለመፍታት የተመቻቸ አሰራር አለ?

አዎ= (1) አይ= (2) ----------☐

ክፍል አራት፡ <u>የአገልግሎት ጥራት ማሳያዎች</u>

ከዚህ በታች የተዘረዘሩት ጥያቄዎች የአገልግሎት ጥራት መመዘኛ መሳሪያዎች ናቸው። እነዚህ የአገልግሎት ጥራት መመዘኛ መለኪያ ጥያቄዎች ምንም እንኳ ሙሉ ለሙሉ የአገልግሎት ጥራቱን ባያመላክቱም ከሌሎች መመዘኛዎች ጋር በመደመር የአገልግሎቱን ጥራት አመላካች እንደሚሆኑ ይታመንባቸዋል። ስለሆነም ለጥያቄዎቹ ትክክለኛ ምርጫውን በማክበብ እንዲመርጡ እጠይቃለሁ።

1. የተቋሙን ጥራት በተቋሙ ውስጥ ካለዎት አካላዊ ምቾት (የመኝታ አልጋ መጎርበጥ፣ የመቀመጫ ወንበር መቆርቆር ወ.ዘ.ተ.) አንጻር እንዴት ይመዝኑታል? ---------- ☐

   ዝቅ ያለ/ ደካማ=(1) መጠነኛ=(2) ጥሩ= (3) በጣም ጥሩ=(4)

2. የተቋሙን ጥራት በተቋሙ ውስጥ ካለዎት በነጻነት ከመስራት ወይም ከመተግበር አንጻር እንዴት ይመዝኑታል?---------- ☐

   ዝቅ ያለ/ ደካማ=(1) መጠነኛ=(2) ጥሩ= (3) በጣም ጥሩ=(4)

3. የተቋሙን ጥራት በተቋሙ ውስጥ ካለዎት ብቻ የመሆን ነጻነት አኳያ እንዴት ይመዝኑታል?---------- ☐

   ዝቅ ያለ/ ደካማ=(1) መጠነኛ=(2) ጥሩ= (3) በጣም ጥሩ=(4)

4. የተቋሙን ጥራት በተቋሙ ውስጥ ካለዎት ክብር አንጻር እንዴት ይመዝኑታል?---------- ☐

   ዝቅ ያለ/ ደካማ=(1) መጠነኛ=(2) ጥሩ= (3) በጣም ጥሩ=(4)

5. የተቋሙን ጥራት በተቋሙ ውስጥ ካለዎት አዝናኝ ተሳትፎዎች እንዲሁም የእረፍት ጊዜዎን ከሚያሳልፉባቸው ተግባራት አንጻር እንዴት ይመዝኑታል?---- ☐

   ዝቅ ያለ/ ደካማ=(1) መጠነኛ=(2) ጥሩ= (3) በጣም ጥሩ=(4)

6. የተቋሙን ጥራት ከተቋሙ ውጪ ካሉ ቤተሰቦችዎ (ዘመድ አዝማዶችዎ) ጋር ጥሩ ግንኙነት እንዲኖርዎ ከማመቻቸት አንጻር እንዴት ይመዝኑታል?---------- ☐

   ዝቅ ያለ/ ደካማ=(1) መጠነኛ=(2) ጥሩ= (3) በጣም ጥሩ=(4)

7. የተቋሙን ጥራት ከተቋሙ ውስጥ ካሉ አረጋውያን ጋር ጥሩ ግንኙነት እንዲኖርዎ ከማመቻቸት አንጻር እንዴት ይመዝኑታል?---------- ☐

   ዝቅ ያለ/ ደካማ=(1) መጠነኛ=(2) ጥሩ= (3) በጣም ጥሩ=(4)

8. የተቋሙን ጥራት ከተቋሙ ውስጥ ካሉ ሰራተኞች ጋር ጥሩ ግንኙነት እንዲኖርዎ ከማመቻቸት አኳያ እንዴት ይመዝኑታል? ---------- ☐

   ዝቅ ያለ/ ደካማ=(1) መጠነኛ=(2) ጥሩ= (3) በጣም ጥሩ=(4)

9. የተቋሙን ጥራት ከተቋሙ ውስጥ ያለዎት መንፈሳዊና ሀይማኖታዊ ፍላጎትዎን (ለምሳሌ ጸሎት የማድረግ፣ የመጾም ወዘተ) ከማሟላት አኳያ እንዴት ይመዝኑታል?---
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ዝቅ ያለ/ ደካማ=(1) መጠነኛ=(2) ጥሩ= (3) በጣም ጥሩ=(4)

ክፍል 5፡- <u>የተቋሙ ተጠቃሚ አረጋውያን ለተቋሙ አገልግሎት ጥራት ያላቸው አመለካከት።</u>

መመሪያ፡- እባክዎን የእርስዎን ትክክለኛ ስሜት የሚገልጸውን ምላሽ በማክበብ ይምረጡ።

1. አነሰም በዛም ይህን ተቋም ከተቀላቀልኩ በኋላ አካዊ ከሆኑ ሳንካዎች ወይም ጋሬጣዎች ነጻ ሆኛለሁ።

   4 3 2 1

   በጣም እስማማለሁ እስማማለሁ አልስማማም በጣም አልስማማም

2. ባለኝ የአቅም ውስንንነት ውስጥም ሆኜ ቢሆን በዚህ ተቋም በራሴ ሀሳብ የምሰራ ነጻ ሰው ነኝ።

   4 3 2 1

   በጣም እስማማለሁ እስማማለሁ አልስማማም በጣም አልስማማም

3. በዚህ ተቋም ምንም አይነት ክብር የሌለኝ መስሎ ይሰማኛል።

   1 2 3 4

   በጣም እስማማለሁ እስማማለሁ አልስማማም በጣም አልስማማም

4. በዚህ ተቋም ሁሉም ነገር አሰልቺና ተደጋጋሚ ናቸው።

   1 2 3 4

   በጣም እስማማለሁ እስማማለሁ አልስማማም በጣም አልስማማም

5. በዚህ ተቋም ከረጋውያንንና ሰራተኞች ጋር ጥሩ ግንኙነት አለኝ።

   4 3 2 1

   በጣም እስማማለሁ እስማማለሁ አልስማማም በጣም አልስማማም

6. በዚህ ተቋም መንፈሳዊና ሀይማኖታዊ ፍላጎቶቼን (ለምሳሌ የመጻም፣ የመጸለይ ወዘተ) ማሟላት አልችልም።

   1 2 3 4

   በጣም እስማማለሁ እስማማለሁ አልስማማም በጣም አልስማማም

7. የተቋሙ የምግብ አቅርቦት በጣም ጥሩ ነው።

4	3	2	1
በጣም እስማማለሁ	እስማማለሁ	አልስማማም	በጣም አልስማማም

8. የተቋሙ የአልባሳት አቅርቦት ግሩም ነው።

4	3	2	1
በጣም እስማማለሁ	እስማማለሁ	አልስማማም	በጣም አልስማማም

9. የተቋሙ የጤና እንክብካቤ አገልግሎት ግሩም ነው።

4	3	2	1
በጣም እስማማለሁ	እስማማለሁ	አልስማማም	በጣም አልስማማም

10. በአጠቃላይ ተቋሙ የሚሰጣቸው አገልግሎቶች በሙሉ ግሩም ናቸው።

4	3	2	1
በጣም እስማማለሁ	እስማማለሁ	አልስማማም	በጣም አልስማማም

ድምር | | |

ስለትብብርዎ ከልብ አመሰግናለው!!

አዲስ አበባ ዩኒቨርስቲ

ማህበራዊ ሳይንስ ኮሌጅ

ሶስዮሎጂ ትምህርት ክፍል

ለመቄዶንያ አረጋውያንና የአእምሮ ህሙማን መረጃ ተቋም አገልግሎት ተጠቃሚዎች የተዘጋጀ የጋራ የመወያያ ነጥብ

መግቢያ

ውድ የዚህ ውይይት ተሳታፊዎች እኔ ቴዎድሮስ ሀ/ጊዮርጊስ እባላለሁ፡፡ በአዲስ አበባ ዩኒቨርስቲ የሶስዮሎጂ ትምህርት ክፍል የድህረ ምረቃ ፕሮግራም ተማሪ ስሆን ለሁለተኛ ዲግሪ መመረቂያ የሚሆን የሚሚያ ጥናት በማድረግ ላይ እገኛለሁ፡፡ የዚህ ጥናት አላማ በመቄዶንያ የአረጋውያንና የአእምሮ ሕመማን መረጃ ማእከል የሚገኙ አረጋውያን በተቋሙ የሚያገኙዋቸው አገልግሎቶችና የአገልግሎቶቹን ጥራት ለመገንዘብ ትኩረት ያደረገ ነው፡፡

በዚህ ጥናት እንዲሳተፉ የተመረጡበት ምክንያት ከሚደረገው ጥናት ጋር ቀጥተኛ ግንኙነት ስላለዎት ነው፡፡ በዚህ ጥናት ላይ መሳተፍ ሙሉ በሙሉ በፍቃደኝነት ላይ የተመሰረተ ነው፡፡ በዚህ ጥናት ላይ የጥናቱ አላማ እንዲሳካ የርስዎ ተሳትፎ በጣም ወሳኝ ነው፡፡ ይህ መጠይቅ ለትምህርታዊ ጽሁፍ አላማ ብቻ የሚውል ይሆናል፡፡

ለጥናቱ መሳካትም የእርስዎ እውነተኛ ስሜትዎን የሚገልጸውን ምላሽ ከፍተኛ ሚናን ይጫወታል፡፡ ስለዚህም በአክብሮትና በሙሉ ትህትና ይህን መጠይቅ ለመመለስ እንድትተባበሩኝ እጠይቃለሁ፡፡ ጊዜዎን ሰውተው ይህን መጠይቅ ለመመለስ ፍቃደኛ በመሆንዎ ከልብ አመሰግናለሁ፡፡

<u>የጋራ መወያያ ነጥቦች</u>

- በተቋሙ የሚገኙ የመርጃ ግብአቶች ምንድን ናቸው? አሁን ላሉት ተጠቃሚ አረጋውያንና አዲስ ለሚመጡ አረጋውያን በቂ ነው?
- በአሁን ሰአት በተቋሙ ውስጥ እያጋጠሙ ያሉ ችግሮች ምንድን ናቸው?
- ቢቻል በተቋሙ ምን ምን አገልግሎቶች ቢጨመሩ ጥሩ ነው ትላላችሁ?
- በአሁኑ ጊዜ በተቋሙ የሚታዩ ጥሩ ጥሩ ገጽታዎች የትኞቹ ናቸው?
- ችግሮቹን ለይቶ ለማውጣትና መፍትሄ ለመሻት ማእከሉ እንዴት ያሉ መንገዶችን እና ዘዴዎችን ይከተላል?

በውይይቱ ላይ ስለተሳተፉ ከልብ አመሰግናለሁ!

Annex C: Interview guideline for key administration staff of Mekedonia Home for the Elderly and Mentally Disabled (MHEMD)

Name of the Institution: MHEMD

Position of the respondent: _____

Age: _____ Sex: _____ Educational background: _____

Profession: _____ Work experience: _____

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

- ✓ When was MHEMD founded? Why? How? Where?
- ✓ For how long will the support continue?
- ✓ What is the structure of MHEMD?
- ✓ 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?
- ✓ Are there any training given to care givers, what are the contents?
- ✓ What is the capacity of MHEMD?
- ✓ What are the regular services provided? List them out please
- ✓ In what conditions are the dormitories?
- ✓ Who supports this institution?
- ✓ What external interventions do you have to help the elders of the institution?
- ✓ Do you have anything to add?

Thank you for your cooperation!

Interview guideline for Residents of Mekedonia Home of the Elderly and Mentally Disabled (MHEMD)

Dear Participants! My name is Tewodros H/giorgis. I am carrying out this study in titled *Institutional care provided to the elderly and residents perception of quality of care provided by Mekedonia Home for the Elderly and Mentally Disabled (MHEMD).* The study is part of the requirements for completion of the degree of Masters of Arts in Sociology at Addis Ababa University. This study is thought to contribute for interventions and the improvement of the elderlies conditions at the institutional settings. In this session, questions related to care and support at Mekedonia will be asked. To achieve the objectives of this research, your active participation is essential. I thank you so much in advance for sacrificing your precious time to participate in this Interview.

Questions related to care and support provided by Mekedonia.

- ✓ What do you feel about services being provided by Mekedonia?
- ✓ How do you spend your time at Mekedonia?
- ✓ What kind of spiritual activities are you doing?
- ✓ How do you evaluate services given in terms of health related issues?
- ✓ How is your social relationship with fellow beneficiary residents of Mekedonia? 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?
- ✓ Are you happy at Mekedonia? Why?
- ✓ In your opinion, what additional services should be included?
- ✓ In your opinion how did you evaluate the quality of care in MHEMD?
- ✓ Do you have anything to add?

Thank you for your cooperation!

Annex D: FGD Guide

Dear Participants! My name is Tewodros H/giorgis. I am carrying out this study in titled *Institutional care provided to the elderly and residents perception of quality of care provided by Mekedonia Home for the Elderly and Mentally Disabled (MHEMD).* The study is part of the requirements for completion of the degree of Masters of Arts in Sociology at Addis Ababa University. This study is thought to contribute for interventions and the improvement of the elderlies conditions at the institutional settings. In this session, points related to the care environment and the quality of care will be raised and discussions would be followed. To achieve the objectives of this research, your active participation is essential. I thank you so much in advance for sacrificing your precious time to participate in this discussion.

Point of discussion

- What are the available resources for the care and support in this institution? Is it sufficient enough to care for the existing and coming elderly?
- What are the good things that you are witnessing in the institution?
- What are the problems you are facing currently?
- What type of activities does the institution had made in order to point out the problems and find for solutions?
- What services would you like to be provided if it was possible?