Experiences and practices of old age home care and support to the Elderly Living in the Institutions: Assessment at Three Selected Institutions in Addis Ababa

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Abstract

Experiences and practices of old age home care and support to the Elderly Living in the Institutions: Assessment at Three Selected Institutions in Addis Ababa.

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Given the economic advancements and well-being leading people to live longer, older people living in developing nations particularly in Africa are suffering from multi faceted problems. One of the possible interventions to curb the suffering of the elderly population is an institutional caring system. This intervention is of paramount importance in time of crises like family lose, health complication and poverty driven street life. Today in Ethiopia, it is becoming a day to day scene to see numerous elders begging in the streets for their living. Although it is in a limited effort and way, there are institutional care schemes in Ethiopia. This study tries to assess the experience of three selected old age care institutions about their care and support practice and Institutionalized elders views on their living conditions in institutions. The study is conducted using a qualitatively designed method in descriptive purpose. Employing a purposive sampling technique, a semi structured interview instrument was used to generate data from elders and key informants in the institutions. The findings of the study reveal that providing basic services to the neediest elders is the foundation goals of the institutions. And also understands that the service provision has changed the life situation of the resident elders. Participation of the community in the care and support is shown as an important resource for an effective caring process. The study also came across that, health care issue as a major concern in all the institutions.

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Abbreviations and Acronyms

AUPFPAA	African Union Policy framework and plan of action on Ageing
CSA	Central Statistics Agency
ECA	Economic Commission for Africa
FDRE	Federal Democratic Republic of Ethiopia
FGD	Focus Group Discussion
HAI	HelpAge International
KAMSD	Kibre Aregawuyan Migbare Senay Dirijit
KICCE	Kality Institutional Care Centre for the elderly
MEMDPCC	Mekedoniya Elderly and Mentally Disabled Peoples Care Centre
MoLSA	Ministry Of Labour and Social Affairs
NGO	Non Governmental Organizations
PLWHA	Peoples Living With HIV/AIDS
PVA	Participatory Vulnerability Assessment
SNNPRS	Southern Nations and National Peoples Regional State
UN	United Nations
UNDESA	United Nation Department Economic and Social Affairs
W H O	World Health Organization

CHAPTER 1- Introduction

1.1.Background of the problem

According to WHO (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." These irreversible changes that the World Health Organization listed include "…physiological, psychological and social that are progressive, decremental and irreversible, of structural and functional body organs." As cited by HAI (2011), the United Nations (2007) defined an older person as someone over 60 years of age and the "oldest old" refers to those over 80, who comprise the fastest-growing old age group, expanding at a rate of 3.8 percent a year, compared to the two percent a year for the 60-79 age group.

Based on HelpAge Internationals insight report of Global age watch index (2013) in just 10 years' time, the world's number of older people will exceed 1 billion. By 2050, there will be two billion older people, nearly 10 times as many as in 1950. Far from affecting only higher-income countries, population ageing is happening fastest in developing countries. Currently, more than two-thirds of older people live in developing countries. By 2050, this number will be four-fifths.

In Ethiopia People over the age of sixty make up around five percent, that is 3.6 million (CSA, 2008). From this number 1.5 million people are over the age of 70. Most of them have no reliable source of income. Currently only half a million older people have regular public sector pension (Assefa & Frehiwot 2003).

Basing the report of Ethiopian Statistical Agency censes and survey projection report (2012) depict that, older peoples who are 65 years of age and above comprises 3.3 % of the total population which is 2.5 million. This number is expected to grow by 2.5 times than now with in the coming 30 years which leads the country to have 6.4 million of elderly population. This remarkable increase in the country's old age population seeks the attention of all stakeholders in terms of considerations in policy making, social recognition and community participation for the needs and concerns of elderly people in their plan of action (CSA, 2012).

There is an underlying honor for older people in Ethiopia where family and community support systems are relatively strong. However, a substantial number of older people have no family and community support, mainly due to the death of relatives or separation caused by poverty, famine, war, disease and displacement and the weakening of family and community support structures (HAI, 2010). These multifaceted challenges of older peoples lead them to flow in large number to the streets of major cities. We may witness this vast number of old age peoples begging for their living on taxi and bus stations, on the gates of religious institution, on the main streets of the city and other public gatherings.

With an assessment study conducted in Addis Ababa to assess the vulnerability and living condition of older people in the city (HAI, 2010), the following main issues were identified as a priory concerns of older people; food insecurity, shelter, health care, clothing and psychosocial support among others. This same study calls for an integrated actions towards mitigating the problems of older people by designing and implementing food security and income generation programs, promoting the special health and wellbeing needs of older peoples, initiating programs to provide access for shelter and living environment and raising awareness on aging and the rights of older peoples.

Though the problems of older people are divers and complex there are few activities undertaken by stakeholders on the issues of aging and the problems of older people. Institutional care is one of these helping activities carried out by the government, various humanitarian organizations, local and International NGO's and individuals in a scattered and uncompromised manner.

The interest to work my thesis project on the experience of care and support to the elderly people came to my attention in Sep, 2013 when we were on field work for the course requirement of community development and planned change. During the time we have made a visit to Macedonia Elders and mentally disabled peoples care center. At the centre we witnessed street gathered elders were rescued from their complicated life situation they were experiencing before admission to the center. Then, with the belief that older persons should be able to live in dignity and benefit from family and community care and protection in accordance with society's cultural values, I wonder to know the practice of old age homes caring system and the client's views of their living condition at the care centres.

Finally with this initiation, this study made an effort to explore the experience of care giving institutions, the belief, attitude and experience of elders regarding the methods of treatment, resources available at the care centres for the care and support, and the needs of institutionalized elders living in the care centres.

1.2.Statement of the problem

The number indication for the amount of old persons in Ethiopia is clearly significant. Despite the limited resources offered to the nation, these people are often seen spared along streets. Lying on the roads if not begging around trying to win their daily meal is

common scenery throughout the country. The accumulated wealth of expertise and experience could have been used otherwise. However, old persons are usually pushed away from being the beneficiaries of the county's resource.

There are scattered attempts made to revitalize the forsaken old persons from both the government and the private sector seen in some places. The government up until June 2006 didn't have an action plan regarding old persons. This too late attained document tried to integrate and adopt different experiences ranging from the Madrid International Plan of Action (MIPAA) in 2002 to African Union Policy framework and plan of action on Ageing (AUPFAA) endorsed by heads of states in 2002 (FDRE, National Plan of Action on older persons, 2006). In general, the 10 year action plan aimed to improve the living condition old citizens of the nation. Nevertheless, it has been clearly absent from real actions on the ground to change the living conditions.

In Ethiopia, it is rare to find research studies conducted on the living conditions and general situations. Only few studies are available on older people. Although these studies are not national, they provide useful insights that could be applicable at the broader level.

One of such a study is an assessment on the living condition and vulnerability of poor urban older people in Addis Ababa, (HAI, 2010). Another is an assessment report on the care, support and treatment situations of older people in Southern Nations Nationalities and People's Regional State (SNNPRS), Nov 2009. In addition to the above two there is also a study on the state of health and aging in Ethiopia (HAI, 2013). Despite the obvious differences between the study areas in the above three assessment studies (Addis Ababa, which is metropolitan, the SNNPRS and five other regions), in terms of infrastructure,

availability of social services, life styles, and so on, the findings of the reports demonstrated the desperate situation of older people in a very similar way.

The firstly mentioned study had conducted Participatory Vulnerability Assessment (PVA) as a major study method in all the sub-cities of Addis Ababa and identified food insecurity (which is worsened by inflation) as the top priority concern of older people. The study also disclosed that among 1,070 older men and women respondents, 79 percent eat only once or twice a day, 78 percent have health problems, 51 percent receive no family support, and about 50 percent carry out household activities, such as housekeeping and caring for grandchildren (HAI, 2010).

Likewise, the second study which was conducted in the SNNPRS reported poverty (including food insecurity, poor health-care system, and lack of housing and decent living environment) and low/limited family support that resulted from the gradual erosion of the culture of extended family and mutual support, as the major problems older people are facing; Limited social welfare, lack of awareness of the special needs of older people [by duty bearers] and The State of Health and Ageing in Ethiopia: A Survey of Health Needs and Challenges of Service Provisions 2013 unavailability of institutional care providers also contributed their share to the problems" are shown as the main problems (Medhin Ethiopia, 2009).

The third study was conducted focusing on the state of health and aging. This study had employed a survey method of study and was happened in five regional states of the country, Namely Tigray, Afar, Amhara, Oromia, Southern Nations Nationalities and Peoples Regions as well as the Addis Ababa City Administration over the period of December 2011 to March 2012. Following a multistage sampling procedure, the study

comes across during the survey period; about 75 percent of the respondents were reported to be suffering from at least one chronic disease and of these 77.5 percent were undergoing medical treatment. The first three most common disease older people were receiving medical treatment for are eye problems (29 percent), followed by arthritis (20.17 percent) and hypertension (11.83 percent). Among the respondents, 23 per cent of them were reported not to be taking medical treatment for reasons that include; lack of money, physical incapacity to go to health facilities, and lack of trust in the healthcare service (HAI, 2013).

When it comes to the case of institutional care, the attention given to older peoples care center is meager, currently there are only three government managed institutions throughout the country caring for older peoples, these are, Bete-Selihome home for the aged, Abreha Bahata home for the aged and Kality Institutional care center for the Elderly. Bete-Selihome is located at Debre Libanos about 110 km north of Addis Ababa; currently administered by Oromia regional government and provides shelter, food, clothing, medical service and recreational facilities for more than 250 older persons. Abrha Bahta is located in the city of Harar and is rendering institutional service for 220 older peoples. Kality Institutional care center for the Elderly is the other institution caring for the elders in Addis Ababa at Kality sub city caring for 65 service recipients of older persons (Fasil, 2010).

Older persons play a key role in contributing to the social and economic fabric of the family and the community. However, their ability to provide consistent support is challenged through exclusion and discrimination. One area where older persons are forsaken is a well organized institution of elders care centers, which can help them lead a happy life in their sunset of this world.

An exploratory research conducted in one of the government managed institutions called Kality Institutional Care Center for the Elderly, described the social, psychological, spiritual, economic, heath and service aspects of life in an institutional care center. In the results, the researcher indicates through his findings that institutional care has its own disadvantages on the service recipients, like decreased social interaction. It creates bad feelings on the side of the resident like despair, guilty feeling, depression and other psychological problems. The dependency on service also causes a feeling of disappointment on older persons.

Exploring into available literatures cited above, I come across that there is a research gap in terms of old age people's treatment, care and support systems in the institutions where they have been treated. Though, it is an important issue to be focus on respecting, dignifying, helping and participating old age peoples, giving attention to an integrated care system in the community, the treatment themes for old age peoples at care centers are an equally important issue to be focused on. That is why this research is interested in assessing the trends of old age care institutions caring method, and client's views on their living condition at the institutions, their belief, attitude and experience on the methods of treatment, assessing resources available at the care institutions for the care and support, and exploring the needs of admitted elders living in the care centres is an important research area. Therefore, this research had assessed three elderly care institutions in Addis Ababa. Namely Kality Institutional Care Center for the Elderly, Kibre Aregawuyan Migbare Senay Dirijit and Mekedonian Elderly and Mentally Disabled Peoples Care Centre in light of social work care and support principles.

1.3.Research Questions

In line with the objective of assessing the elderly care and support methods in the institutions this research tried to answer the following research questions.

i. What are the major psychological, social, and emotional supports provided to elders who are admitted to the center?
ii. What are the belief, attitude and experience of the elderly on the method of care and support provided by the centers?
iii. What are the admission criteria to the care centers?
iv. What are the organizational structures and caring systems of the care centers?
v. What are the professional orientations of care givers in terms of elderly care?
vi. What are the resources available in the centers for the care and support? Requisite equipment & drugs, competence and responsiveness at all staff levels
vii. What are the needs of older peoples living in the care centers?

1.4.Objective of the study

1.4.1. General Objective

This study is generally aimed at assessing the care and support methods of Elderly Care Centers and clients' experience of the care and living arrangement in the three selected institutions; Kality Institutional Care Center for the Elderly, Kibre Aregawuyan Migbare Senay Dirijit and Mekedonian Elderly and Mentally Disabled Peoples Care Center.

1.4.2. Specific Objective

- To understand the living conditions of elders admitted to the studied Institutions
- To assess the belief, attitude and experiences of elders on the method of care and support.
- Explore care givers professional orientation in relation to working with older people.
- To assess resources available at the care centers for care and support to the elderly.

1.5.Significance of the study

This study is believed to contribute in sharing institutional care experiences of the care centers with interested organizations engaging and planning to engage in the area of elderly care. It is also believed to contribute a lot to practitioners intervening to support elders. It is also believed to reveal the care method experiences of elders residing in the care centers. It may provide insight on the care and support values of the centers. This study is also supposed to be an additional to the lacking literature in relation to the area of institutional care in Ethiopia.

1.6.Limitation of the Study

This study has a limited scope of focusing on the experience of elderly care institutions particularly focusing on three selected care centers in Addis Ababa. Therefore the experience of these institutions may not represent the case and experience of other elderly care centers. As it has focused in exploring the caring experience of the studied institutions and the belief and attitudes of the institutionalized elders, this research didn't entertain the perspectives of other elderly who are non institutionalized, community cared elderly, and non elder residents in the studied institutions.

CHAPTER 2- Literature Review

2.1.The concept of aging

Old age means reduced physical ability, declining mental ability, the gradual giving up of role playing in socio-economic activities, and a shift in economic status moving from economic independence to economic dependence upon other's for support. Old age is called "dark" not because the light fails to shine but because people refuse to see it (Gowri 2003). In the same way Old age is also manifested with changes in physical appearance, such as wrinkles appearing on the face; the greying of hair, slowing down of reactions, followed by restriction of movement and sense organs, and proneness to chronic illnesses (UN, 1975).

Old age has been divided into different groups: biological, physiological, emotional and functional. Biological aging is concerned with changes occurring in the structure and functions of the human body; physiological aging is concerned with individual and behavioural changes; emotional aging describes changes in one's attitude and lifestyle dependent on one's self-perception of being old; and finally functional aging is the comparison of individuals of the same age group in terms of those within the group being unable to maintain their functions in society (Ayranci & Ozdag, 2004).

Old age can be called as the near end of the life cycle of any human being. This is the time of (human) life at which corrosion and fall of physical abilities including sight, hearing, walking (stick required), etc. get started. This age is considered as the dependent age and also non economic age due to deterioration of physical abilities. This is the time at which a person gives up work as age does not allow him to do as much work as he was able to do

in his young life. In general, the age of 65 years and above is considered old age in present times (Azam., Ahmad., & Ahmad., 2012).

According to HelpAge International (2008), old person on the other hand is defined with the following three major perspectives; Chronological perspective: a person is said to be aged if he/she is 55 years and above (in developing countries) and 60-65 years and above (in developed countries). The older persons are further categorized into young old (55-69), old (70-79), and old old (80 years and above). Health perspective: a person is considered an older person if aged 60 and above. Those between 45 and 60 are considered pre-senile, while those who are 70 and above are older people at risk. Economic perspective: all older persons above 55 are grouped under (a) productive persons, namely those who are healthy physically and/or mentally and (b) non-productive older persons who are not healthy physically and/or mentally.

In the Ethiopian context, the UN definition of older persons, taking those people whose age is 60 years and over is acceptable as it coincides with the country's official retirement age (MoLSA, 2006).

The societal perception of aging in Ethiopia has both positive and negative reflection and presumptions attached towards aging and old age peoples. On the positive, older people are most commonly seen as wise, worthy of carrying responsibility, resolvers of conflicts (peace makers), community advisers, persons with great experience and authority (seasoned in specific expertise), and a lot more positive traits. What comes to mind when we hear the Amharic word shimagile (literally, old man) is often a person who would resolve conflicts and make peace. Accordingly, the process of resolving conflicts other than through arbitration has come to be called shimgilina. On the contrary, alike in other

parts of the world, ageing and older people are also perceived negatively. The Amharic word shimagile (old man) or Arogit (old woman) may imply physically fragile persons, easily susceptible to diseases, persons who could have little or no involvement in certain kinds of work, especially menial work, persons who need and deserve to be supported, etc. In extreme cases, there are also sayings that portray older people as no longer useful, as expressed in the Amharic saying "kareju aybeju" (HelpAge International 2013).

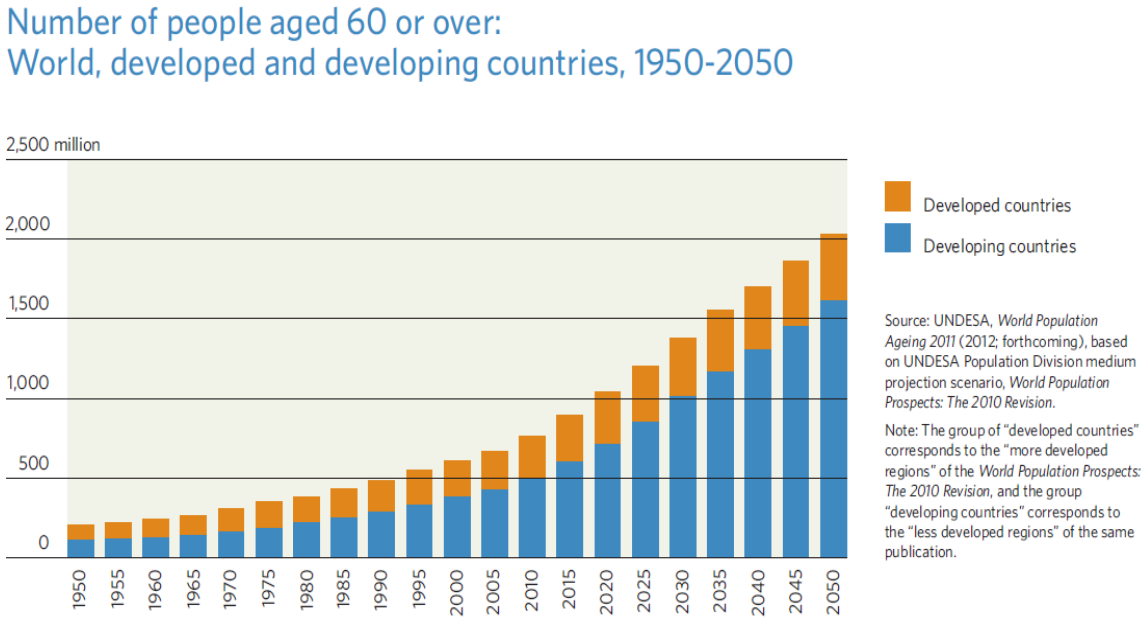
2.2.Population aging global trend

The human race is characterized by a long childhood and by a long old age. Throughout history this has enabled older persons to educate the younger and pass on values to them; this role has ensured man's survival and progress. The presence of the elderly in the family home, the neighborhood and in all forms of social life still teaches an irreplaceable lesson to humanity. (Extract from the Vienna International Plan of Action on Ageing, 1982)

Globally, the proportion of older persons is growing at a faster rate than the general population. This reflects tremendous and welcome advances in health and overall quality of life in societies across the world. But the social and economic implications of this phenomenon are profound, extending far beyond the individual older person and the immediate family, touching broader society and the global community in unprecedented ways (UNFPA & HAI, 2012).

In 1950, there were 205 million persons aged 60 years or over in the world. By 2012, the number of older persons increased to almost 810 million. It is projected to reach one billion in less than ten years and double by 2050, reaching 2 billion. There are marked differences between regions. For example, in 2012, around 6 % of the population in Africa was 60 years and over, compared with 10 % in Latin America and the Caribbean, 11 % in Asia, 15

% in Oceania, 19 % in Northern America, and 22 % in Europe. By 2050, it is expected that 10 % of the population in Africa will be 60 years and over, compared with 24 % in Asia, 24 % in Oceania, 25 % in Latin America and the Caribbean, 27 % in Northern America, and 34 % in Europe (UNFPA, 2012). Although developed countries have the oldest population profile, the vast majority of the older people—and the most rapidly aging populations—are in less developed countries (WHO, 2011). The following figure shows, the 60 or over aged population distribution between developed and developing countries.



Africa, the continent often referred to as the youngest in terms of age structure is experiencing the fastest growth rate of older people than any other continent in projections to 2050. There are alarming figures illustrating the rapid rate of change and the need to formulate comprehensive policy actions integrating the issues of the exponentially growing aging population. In 1950 the number of people aged 60 or over numbered approximately 12 million in Africa (ECA, 2007). By 2009 this number had increased to about 55 million people (UN, 2009). Projecting it further, according to the global age watch Index insight

report of HelpAge International, people aged 60 and over in Africa will reach 215 million by 2050.

Demographic research conducted in developed and developing countries indicates that current and past levels and trends of fertility, mortality and migration rates, determine the age structure of any population. These components of population dynamics are influenced, directly and indirectly, by a range of reproductive health and socio-economic factors, which are the domain of public policies, such as the level of nutrition, use of contraceptive methods, education and the level of income. Changes in population structure and ageing increase the pressure on public policy responses (ECA, 2008).

Ageing populations demand support to adequate health services, income security and sustainable gender sensitive social protection systems. The proportion of older people is increasing in all African sub-regions and this creates demand for public policy interventions to deliver adequate health services, income security and protection from poverty. The implications of the changing population age structure for public policy should be addressed from a multidisciplinary perspective to reflect the multidimensional impacts and repercussions (ECA, 2008).

Ethiopia being part of the developing nations is no exception to the growing concern of aging. Although it is one of the youngest populations, having 43 percent of its population under the age of 15, is also one of the exponentially aging countries (UNDESA, 2013). According to Central Statistical Authority's 2007 National census report, there are 3,565,161 (4.8 percent of the total Ethiopian population) peoples who are 60 years and above. Of these, about 532,093 (14.9 per cent) live in urban areas, whereas the rest 3,033,068(85.1 per cent) live in rural areas of the country (CSA, 2008). Within this old age

population, currently only 500,000 older people have regular public sector pension (MoLSA, 2012).

2.3.Theoretical Perspectives of Aging

By understanding and describing how we age and act in relation to our late ages, sociologists have developed several different theories of aging. Each perspective is underpinned by a set of values and implications for practice. The following are the most important three perspectives in relation to our practice with aging population.

Disengagement theory

Sociological literature presents a range of competing theories of ageing: disengagement theory at one end of the spectrum and successful ageing theory (sometimes described as activity theory) at the other. The genesis of the disengagement viewpoint is that older people themselves initiate the disengagement process. It does not take into consideration any societal processes and structures that curtail older people's opportunities for engagement.

Disengagement theory (Cumming and Henry 1961) though extremely controversial then and now and offering a bleak portrayal of old age, nonetheless has had a profound effect on views about ageing. Disengagement theory sees the older person's withdrawal from society as part of the natural ageing process, and as part of the normal pattern of life.

This theoretical perspective essentially sees old age as the time when people are preparing themselves for death. This includes the severing of relationships and ties. Ageing from this

theoretical perspective naturally brings with it a growing sense of powerlessness, loneliness, loss of role, loss of sense of purpose and with it increased dependency. From this theoretical perspective the position of older people as a non-productive and costly burden on society is easily assimilated as the cultural norm and becomes implicit in political and economic arguments.

Olsen (1982) criticizes the disengagement approach for ignoring the impact of social class on ageing experiences and how class structure and its social relationships prevent the majority of older people from enjoying a variety of opportunities or advantages. The disengagement perspective, it could be argued, feeds the negative stereotypes of ageing as the part of life to be feared, which in turn creates the circumstances driving disengagement and the negative stereotyping of older people, impacting their quality of care.

Activity theory

At the opposite end of the spectrum, activity theory is about successful ageing and contends that people develop ideas about themselves and their identity from two major sources: the things that they do, and the roles they fulfil in life. This theory identifies the many roles that people give up as they age, and the impact this has on people's identity. Hence this theoretical perspective argues that new and meaningful activities need to be substituted for those that have been lost. The view from this theoretical perspective is that activities in later life are essential to restore one's sense of well-being and value. To be worthwhile, activities need to have personal meaning; they can be solitary, with people, formal and informal – anything that gives meaning and value to the individual. Successful ageing begins then to equate with active ageing, denying the limitations of old age as long as possible.

This theoretical perspective needs to be tempered with the reality that some older people cannot maintain an active lifestyle, and some may not have the resources to maintain active roles. The danger of this theoretical perspective is that in an increasingly judgemental society, strapped for cash to support health and well-being, older people who do not remain active are perceived as responsible for their own decline and are therefore blameworthy. Activity theory has also been criticized for being overly idealistic and for forcing 'middle-class moral and family-oriented' activities on to older people (Katz 2000, p143).

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) that our values, preferences and patterns of behaviour 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 be how we are as older people, and the patterns we have developed over a lifetime will determine our behaviours 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) 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.

2.4.Stereotyping Older peoples

Stereotypes are a set of beliefs which shape the way we think and behave in everyday life. However, negative stereotypes, such as the ones denouncing older peoples as needy, unhappy, senile, and inactive have an adverse effect on older people. Not only do they interfere with older people's enjoyment and flourishing in the latter part of life but they also have a detrimental impact on people's health and well-being as they age.

In an important literature review, Richard & Michael (2009) studied stereotypes of older people in the work place by synthesizing findings from over 100 studies of age-related stereotyping at work. Based on their analysis, stereotypes of older workers have three strong themes. First, they are perceived as less motivated and competent at work. This meshes with the stereotype content model's conclusions—that older people are viewed as warm but not very competent—but in fact, there is little evidence that work performance declines with age (Richard & Michael, 2009). Second, numerous studies show that older employees are also viewed as harder to train or retrain and are thus inherently less valuable as employees. This stereotypic assumption may reflect the low-competence stereotype but also reveals assumptions of older employees' inability to change, their likely shorter tenure with the company, and less potential for development. Third, older workers are perceived as more expensive employees because they have higher salaries and, due to declining health, use more health care benefits.

Other researchers found that older people were particularly vulnerable to the threat imposed by negative age-related stereotypes if they were more educated (Hess, Hinson, & Hodges, 2009). In that work, older participants took a memory test that was described in one of two ways: as able to assess the impact of aging on memory (threat condition) or

having had the age bias removed from the test (no threat). Participants who felt threatened by the old-age stereotype and who were the most educated did the worst. Hess and his colleagues (2009) argue that better educated senior citizens identify with their group membership more and therefore are more vulnerable to internalizing stereotypes about their group. In addition to greater affiliation with their in-group—older people—seniors with more education are also more likely to participate in groups and organizations such as senior citizens' interest groups, defined for the older adult demographic.

According to Becca Levy's (2003) analysis, the more connections older adults have with these groups, the more they self-identify as old, become the target of old-age stereotypes, and internalize those stereotypes. Levy (2009) notes that unlike members of other negatively stereotyped groups who have the opportunity to gradually develop coping strategies throughout their lives, older adults don't become old until they reach a threshold defined by the broader culture (e.g., age 65, or retirement). As a result, they acquire their membership in a negatively stereotyped group rather abruptly and are not prepared to handle the negative stereotypes they suddenly face as members of that group. Moreover, the newly old bring with them the accumulation of negative attitudes and feelings toward the old they passively acquired throughout their lives. As new members of the group they stereotyped when they were younger, those stereotypes now apply to themselves, making self-stereotyping difficult to resist.

2.5.The Needs of aging population

Ageing is a victory of various development activities of our world. The UNFPA report of Aging in 21st century a celebration and challenge (2012), describes that people live longer because of improved nutrition, sanitation, medical advances, health care, education and

economic well-being. With the number and proportion of older persons growing faster than any other age group, and in an increasing range of countries, there are concerns about the capacities of societies to address the challenges associated with this demographic shift.

Given the economic advancements and well-being leading people to live longer, older people living in developing nations particularly in Africa are suffering from multi faceted problems. Processes of modernization, including individualism, urbanization and migration, and the impact of HIV/AIDS have eroded traditional systems of intergenerational family and community support where many people living with HIV/AIDS (PLWHA) become dependent on their parents for care rather than supporting them in older age (ECA, 2008).

World Health Organization's Social Development and Ageing panel report (2000) dictates that, in the same way longer life expectancy is celebrated as the success story of humanity, it is also paradoxically regarded as a challenge to health system. Longer lives are commonly associated with a prevalence of non-communicable and chronic diseases. This same report further describes the health issues of aging population, Poor adult populations in developing countries are increasingly at risk, while at the same time still suffering from the long term effects of infectious diseases. Further, injuries related to traffic accidents and occupational hazards are on a steep rise in developing countries causing long term disability and premature death.

The needs of old age population are not restricted to health complications but they are vulnerable to growing inadequacies in customary family support systems, prone to poverty and exclusion from health services (Aboderin, 2005).

Research conducted around the world focusing on Africa (Kakwani, & Subbarao, 2005., Barrientos, 2006, Shetty, 2012) indicates that three factors are placing an undue burden on the elderly. First, the burden on the elderly has enormously increased with the increase in mortality of prime age adults due to HIV AIDS pandemic and regional conflicts. Second, the traditional safety net of the extended family has become ineffective and unreliable for the elderly. Third, in a few countries, the elderly are called upon to shoulder the responsibility of the family as they became the principal breadwinners and caregivers for young children.

Looking the case for the Ethiopian elderly population, the absence of relevant literature in the area shadows the issue unobserved. Among the few studies one is an anthropological study conducted within the regional state of Amhara, this research found out the needs of the elderly living in that area are, food insecurity caused by shortage of land and unfair distribution of agricultural land, absence of appropriate shelter in association with poverty, unavailability of sanitary facilities like toilets, health complications and absence of health centers in the area, the burden of caring grand children, abuse and neglect are among others (Kifle, 2002).

The other study conducted in SNNPR identified the following to the needs of the elderly in the area, poverty in association with food insecurity, poor health-care system, lack of housing and decent living environment, nonexistent or limited family support driven by gradual erosion of the culture of extended family and mutual support are mentioned (Medhin Ethiopia, 2009).

A participatory research focusing on older people's livelihood in Ethiopia is another study which tries to identify the needs of the elderly and concluded that elders in Ethiopia are

challenged in achieving household security as a result of unreliable sources of income, instability in their livelihoods, lack of diversified livelihoods opportunities, and limited access to social and health services.

A more elaborated survey research was conducted by HelpAge International Ethiopia (2013), attempting to understand the state of health and aging in Ethiopia. This research covers the areas of Tigray, Afar, Amhara, Oromia, Southern Nations Nationalities and Peoples Regions as well as the Addis Ababa City Administration in its survey. This study identified elderly peoples in the study area are susceptible to age induced non-communicable diseases unlike other population group. About 75 per cent of the respondents of the survey were reported to be suffering from at least one chronic disease. Eye problems, arthritis and hypertension were the three diseases identified older peoples are suffering from ranking (29 per cent), (20.17 per cent) and (11.83 per cent) respectively. It is also mentioned that physical structures of health facilities are non age-friendly.

2.6. Institutional care for older peoples

As Cited in Gutsa (2011. P. 4), Townsend (1962) traced the development of institutional forms of care to the East where they were established by the Church in the Third and Fourth centuries.

Written documents about social care to elders reveal that, before the Second World War the only publicly funded social care for older and physically disabled people was through the Poor Law. From 1601, the Poor Law required each parish to levy rates to care for destitute people without family support. Those deemed unable to work due to old age or disabilities were regarded as deserving, but the level and type of care varied considerably locally and over time. At best, it funded a family member or a pauper woman to house and

care for an older or disabled person or provided a regular weekly payment, clothing and health care to enable them to stay in their own homes (Thane, 2009 : P.1).

From the 1950s the emphasis for social care was shifted to institutional care, according to Thane (2009), due to client preference and belief that this improved the quality of life of older and disabled people; improved medical knowledge and treatments; belief that community care was cheaper when demand for and costs of services were growing; continuous concern at inadequacy of community services and difficulty of defining and coordinating health and social care.

Older persons constitute one of the most vulnerable sections of the society. They are not only physically weak but, also lack economic resources, self esteem and social status. Under the changing socio-economic and demographic conditions family is unable to provide support and care to the older persons. Changes in the occupational structure and decline in the family size where adult children do not always live with their parents, as in the past leads to many emotional security problems of the older persons. In the light of these changes, living arrangements of the elderly has emerged as an important area of intervention (Sandhu & Arora, 1999).

Nelida and Peter (2009) discuss that long term care and support to the elderly is given only a minimal attention in developing countries. They mention some three reasons for this worrying neglect to the care of elderly; first, some policy-makers have been slow to recognize the rapid growth of very old populations, and greater priority is still given to younger age groups. Second, policy is dominated by concerns about formal pension programs, including contributory schemes and social pensions. Third, there is a tendency

to assume that informal support networks continue to function relatively well in most developing countries, reducing the need for specific policies and interventions.

Despite this complacency, there is considerable indirect evidence that most developing countries are facing a very rapid expansion in demand for long-term care. WHO (2002) case study report on ten developing countries describes these needs with two interrelated processes; one is the growth in factor that increase the prevalence of long-term disability in the population and the second is the change in the capacity of the informal support system to address these needs. According the WHO's developing countries case study report on long term care, the ageing of the populations in these countries has an impact on both of these processes. As the population ages, the percentage with chronic diseases and related disabilities rises significantly. Concomitant with these demographic and epidemiological changes, statistical evidence from the ten countries participated in the study indicate additional forces that impact on the ability of informal support systems to provide care. These factors include an increasing percentage of women in the labor force and increased migration. For example, the percentage of women participating in the labor force increased in Mexico from 9.1% in 1960 to 27.1% in 2000, in Costa Rica from 9.7% to 25.2%, and in the Republic of Korea from 17.3% to 42.7%.

2.7.Types of long term care

Long-term care may be either home-based or institutional. Home-based care may occur either in the home, or in the community setting. It is useful to distinguish between two types of home-based long term care services; first, Health-related care, which we refer to as home health. The Second one is, Care related to daily functioning, such as personal care (e.g. eating, bathing) and homemaking (e.g. cooking, cleaning).

Long-term care can be provided by formal caregiver, that is paid care, or informal care that is provided by persons who do not receive pay. Formal care services may be provided by governmental organizations; by local, national, or international nongovernmental organizations (NGOs); or by for-profit organizations. Formal care is usually provided by recognized professionals (e.g. nurses, doctors, and social workers) and/or by Para-professionals (e.g. personal care workers). Traditional healers may be an important additional source of care. Informal care includes care provided by nuclear and extended family members, neighbors, friends, and independent volunteers, as well as organized volunteer work through organizations such as religious groups (WHO, 2002).

CHAPTER 3- Research Methodology

3.1.Study Design

This research is designed to use a qualitative research method. Qualitative design is preferred, because it involves documenting real events, recording what people say (with words, gestures, and tone), observing specific behaviors, studying written documents, or examining visual images. These are all obviously the concrete aspects of the world Kruger & Neuman (2006, P. 158). Since the issue of care and support are subjective, as a result they are more easily expressed in words than in numerical terms. A case study design is chosen to show the detailed experiences and information of the selected care centers and their clients. According to Kotari (2004,P.115), through case study a researcher can obtain a real and enlightened record of personal experiences which would reveal man's inner strivings, tensions and motivations that drive him to action along with the forces that direct him to adopt a certain pattern of behavior. Alston & Bowles (2003, P. 198) also suggests that case study research is particularly important in social work settings because it allows a typical case, client, event, group or other phenomenon to be studied in order to reveal information which will aid the analysis of, and afford insights into, the wider target group. The information will assist in the development of an appropriate intervention strategy.

Applying Case studies of institutions the study conducted to provide thorough understanding about how the institutions operates, and how each activities of care and support fits together and serves the overall objectives of the organization.

3.2.Study area

The study areas for this paper are three selected elderly care centers in Addis Ababa. The first one, Macedonian elderly and mentally disabled peoples care center which is an indigenous non-governmental, non-profit and independent organization, established with the motto “to help peoples being a human is enough” was started its service in 2010 around Kotebe in the northeastern outskirt of Addis Ababa. This center is selected for its recent widespread advocacy works to reach the participation of the society in the care and support activity and the attention given to the institution by the society. The second one is Kibre Aregawuyan Migbare Senay Dirijit; a non-governmental humanitarian organization is the other care center providing institutional care. This institution is selected for its integrated care provision ranging from residence based care or community based care and support to institutional care. The third one is Kality Institutional Care Center for Elderly, it is the oldest Elderly care center managed by the government. It is selected for it has been providing care and support for more than 40 years. This institution is selected for it is the only government managed institution working towards elderly care located in Addis Ababa. And for it has a long stayed elderly care experience.

Kality Institutional care center for the Elderly /KICCE/ was established in 1970 during the reign of Emperor Haile Selassie. The objective for the establishment of this institution was to provide a holistic support for destitute elders and their family who were residing around Kolfe in Addis Ababa by the time. The institution is established over 3.4 hectare of land in the southern outskirt of Addis Ababa in Akaki Kality sub city.

KICCE has been providing institutional support for over forty years. There are 8 residential and 2 office blocks in addition to one larger hall which is serving as TV room, meeting hall

and dining room. The institution is sponsored by the Government and is administered under the direct supervision of Addis Ababa City Administration bureau of labor and social affairs.

Kibre Aregawuyan Migbare Senay Dirijit/KAMSD/ on the other hand was established in 2007 with a motto 'Dignity & better life for the elderly'. It is established by a self initiated philanthropist woman Ms. Workenesh Munie. Documented reports about the establishment history of the institution indicate that the founder had financed the welfare by her own for two years before the legal establishment of the institution as KAMSD.

KAMSD is located in the eastern outskirt of Addis Ababa in Bole Bulbula area in Bole sub city. It is residing with an over 8 hectare of land having two blocks, one serving both as residential and office and the other as Clinic, TV room and dining room.

Mekedonia Elderly and mentally disabled peoples care center is the third center under study. It was established in January 2010 with the aim 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 institution was initiated by Mr Biniam Belete, a young Diaspora from USA. This institution is providing service to beneficiaries with three rented compounds and one owned compound which belongs to parents of the founder. This institution is located around Kotebe Bireta-Biret, in the north eastern out skirt of Addis Ababa.

The target populations for the research were selected elders admitted to the above mentioned three institutions, care givers in each care centers who are working closely with the elders in a day to day basis, and administrators or coordinators of the institutions.

3.3.Participant Selection Criteria

Study participants for this study were selected with the help of registered documents about the elder's background and institutional history. Since the research is aimed at engaging the caring experience of the institution, to get the most relevant information the following criteria were employed to select individuals for the interview.

- Those who are over the age of 60 and are residents of the center
- Those individuals who stayed in the institution for a minimum of one year and above. So that they can give their lived experiences in the centers.
- Those individuals who were in a most desperate situation before joining the institution. This was determined with the guidance of recorded life history about the elders at the centers and lead by care givers in the center.

3.4.Method of data collection

Using purposive sampling techniques to select study participants, the data collection method engaged individual semi structured in-depth interview with selected clients of the centers and key informant interview with care givers and administrator or coordinators of the centers. According to Flick, the uses of semi-structured interviews have been highly increased recently and interviews allow the role of observations while interviewing (Flick, 2009, p.150). In addition, semi-structured interviews are characterized by creating an opportunity for the interviewer to decide the form and the order of the questions and May supports this by saying that, semi-structured interviews allow more latitude to probe beyond the answers facilitating a dialogue with the interviewee (May, 2001, p.111). Using purposive sampling, the selected clients of the institutions were informed about the objective and purpose of the study before the date of the interview. Confirming their

willingness to take part in the study, they were requested for an appointed date for the interview.

In addition, key informant interviews were held with care givers at the institution and administrative staffs. Care givers who were available during the time of the study data collection were contacted. Care centers observation and review of residents life history recorded documents of the centers were used as an additional source of information about both the clients and the institutions.

3.5.Sampling Procedure

A purposive sampling technique is employed for participant selection. This sampling procedure is selected for the sake of meeting and sharing the experiences of elderly people who are living in the institutions and to meet those peoples who are working directly with the elders in the institution. According to Padgett (2008) Purposive sampling techniques in qualitative research is made to deliberately select respondents based on their natural ability to give the required information. Based on the inclusion criteria listed earlier, the list of participants who were selected and became willing to be interviewed is depicted below in a table.

Table 1: Demographic representation of Study participants (n=16)

Name of Institution	Age	Gender	Length of stay at the Institution
Kality Institutional care centre for the Elderly (n=6)	60	M	2 years
	77	M	4 years
	81	M	5 years
	83	F	14 years
	88	M	2 years
	95	M	1 year and 2 months
Kibre Aregawuyan Migbare Senay Dirijit (n=4)	75	F	1 year and a month
	75	M	5 years
	77	F	2 years
	83	M	2 year
Mekedonia Elderly and Mentally Disabled Peoples Care Centre (n=6)	61	M	1 year and a month
	65	F	2 years
	77	M	2 year and 6 months
	78	M	2 year and 6 months
	81	F	3 years
	95	M	1 year and 8 months

Source: Investigator, May, 2014

3.6.Data analysis Technique

As a qualitatively designed research the data analysis process was an ongoing process throughout the data collection steps. In order to analyze the textual data, first the audio taped interviews were transcribed in to Amharic. Then I studied the data (interview transcription) repeatedly until I achieved an understanding of the main points. I highlighted "significant statements" that provide an understanding of the participants experience. Various colored pens were used to highlight these statements and a copy of the original interview transcript was used to highlight these statements in order to avoid confusion and keep the original material untouched. Then coding was held using a colored pen to extract all relevant statements and opinions of the respondents supporting the prior thematic areas of the study. The codes were collected to their corresponding thematic areas. This way the data collected through interview became ready for presentation. As far as the data

presentation is concerned, making the selected thematic areas to be the focus point of data presentation, the relevant data was presented in a way related to the thematic areas. Following the data presentation, a precise discussion is made guided by the research questions. In the discussion session a cross case synthesis was employed as a major analytical technique which was found important in analyzing multiple cases.

3.7.Ethical consideration

In order to ensure confidentiality of the information to be gathered from the study participants due attention was given. Participants were asked for their willingness to participate in the study, so that they can choose to continue or decline and not take part in the study. They were described the purpose of the study, the kind of participants required for the study, how the collected information is utilized and the potential benefits of the study. Based on their willingness the researcher collected a signed document of consent form the participants to confirm that they were willing to take part in the study.

In order to ensure confidentiality of the information the audio records are handled with utmost care. As a segment of the population requiring proper handling in the interview the investigator made the interview with only willing elders who are capable of giving consent. After completion of the study and the thesis defense, all the audio records were destroyed for the sack of keeping the privacy of the study participants. Furthermore, the issue of protecting participants from any opinion related harm was also considered.

CHAPTER 4- Data Presentation and Discussion

4.1.Data Presentation

4.1.1. Organizational Structure and staffing of the Institutions

KICCE is under the management of Addis Ababa city administration Bureau of Labor and Social Affairs. At the institution level there is a Coordinator who is the head of the institution, and under his leadership there are counselor, Clinical nurse, finance officer, record officer, care givers(8), cookers(6), laundry women(4) , guards(7), secretary, driver, store keeper, cleaning staffs(4). The institution totally has 38 staff who are currently on duty.

KAMSD on the other hand is managed by the founder as a managing director. Under the managing director, the structure is branched in to two; Institutional care and community based care. The institutional care branch is managed by the human resource manager at the top with the finance and administration manager. Under the human resource manger there are social workers who are taking care of the elders, secretary and cashier for the office management and kitchen staffs who engaged in cooking and preparing the meal service for the residents.

MEMDPCC is lead by a general assembly of more than 40 members, followed by board members chosen by the general assembly. Under the board 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. Exceptionally from other institutions, MEMDPCC is all in all volunteers driven agency. All the staffs of the institutions are unpaid volunteers. Excluding visiting volunteers, currently there are 70 volunteers who are engaged in various activities in the institution.

The activities performed by these volunteers are ranging from providing professional service to helping in logistics activities and labor work.

4.1.2. Resources available for help and Community participation

As a government managed institution, the income and other resources used for the help of elderly of KICCE are fulfilled from government budget. In addition to this yearly disbursed budget, the Institution is founded over a 3.4 hectare of land and there are bed rooms and office buildings. It has one vehicle used for all logistics activities in the institution. There are around forty staffs hired by the government with different tasks. In terms of community participation in the service delivery, the key informant for the interview who is the coordinator of the institution witnesses that there are no advocacy works held to attract the attention and the support of the community yet. But, if there are concerned individuals aiming to help by themselves, he says their door is open.

KAMSD on the other hand is initiated and managed by an Ethiopian woman philanthropist. It is a locally established NGO legally registered with the Ministry of Justice in July 2007 and re-registered with the Charities and Societies Agency of Ethiopia as an Ethiopian Residents Charity Organization. The founder of the institution has been supporting some elderly people for two years from her own family budgets through the provision of food, clothes and other supplies before the legal establishment and certification under the name of KAMSD.

Currently the income source of the institution is contributions from partner organizations of International organizations, Local NGOs, UN organizations and other sources. In addition to this, volunteers drawn from diverse professions and social backgrounds are the other source of support to the institution. Volunteerism is mentioned as one of the core

values that KAMSD promotes to serve the elderly. The social worker at the institution speaks about their resources,

> We engaged in community mobilization as one major source of support for the elderly, we have community based support, there are contributors who bring us *Teff*, clothing and many other items in-kind. We have organized committees to create awareness in the community; we develop project proposals to help elderly people through a community based support by engaging them into income generating activities. We present these projects to donors after the accomplishment of the programs we finance our office and other admin costs with the remaining budget. We got this 8000 square meter land from the government for our future multipurpose care and support center building. We have these two blocks of building constructed with a gift from a generous individual called Sr. Zenawit Ayele who gave us 1.1 million birr by selling her owned house. She even joined our center to live with the elderly peoples in our institution.

MEMDPCC 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 neediest elders whose admission couldn't be delayed until the construction of regular residence. Beds in MEMDPCC are double stairs. Elders are assigned to the ground bed and younger elders are assigned to sleep on the upstairs beds. 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 the like sanitary materials, clothes, interested individuals come and celebrate their marriage here, 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/.. . . 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 100000 birr monthly, and other contributors support the institution by the time they visit the center. The coordinator explains it further,

> we are waiting the issuance of a construction land for our permanent care center, following it we are planning to engage in multiples of IGA activities, like bakery, metal work, wood work, to build our own hospital . . . we have a huge human resource most of them are cured individuals through the center treatment and who want to live here by dedicating their life helping the activities of the center.

As a result of its advocacy endeavors, MEMDPCC is gaining greater public attention. Everyday 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 institutions service. Except the two nurses hired by donor individuals, all the staffs of the institution are volunteers serving without payment. This makes MEMDPCC exceptional from both institutions under study that it is entirely run by unpaid workers.

4.1.3. Types of people coming and admission process to the Institutions

Kality Institutional Care Center for the Elderly, as it is mentioned earlier, is a retirement place for elderly people. People coming to the center are all elders who are 60 years of age and above with some exceptions who are under the age of 60 and admitted temporarly as a result of the street dwellers clearing campaign by the government. The institution use some lists of admission criteria to be received as beneficiary of the institution. The following are some of criteria listed on the personal history registration document of the institution.

- Those who are 60 years of Age and above
- Those who are living with irresistible problems
- Those who are living in the streets.
- Who have no family or relative to help on retirement
- Who have no deposited money or any kind of property
- Who can testify their neediness from their neighborhood
- Who can approve their neediness from the Addis Ababa Bureau of Labor and social Affairs.

In application, they are required to bring testimonials about their situation. By presenting their case through process from their residential woreda to Kifleketem /Subcity/ and the Bureau of Labor and social affairs, they will be granted access to live in the institution. As per the statement of the admin coordinator, except some entrants who get in to the institution by government decision from street life, all other residents of the center came through this usual admission process of the bureau.

Kibre Aregawuyan Migbare Senay Dirijit on the other hand also specified its admission criteria to be followed. The following lists of criterias are mentioned by the administrator of the institution.

- Those elders who are 60 years of age and above
- Who have no family or any other relative to help
- Elderly people who lost their family supporter due to HIV/AIDS
- Elderly people who are willing to comply with the minimum requirements of the elderly home
- Elderly people who are sane
- Priority will be given for elderly women
- Who don't have home or any other shelter
- Those who are referred to KAMSD by Addis Ababa bureau of Labor and social affairs.
- Those who are found living on street begging and are willing to live in institution
- Those who are found sleeping on the streets with illness and other physical problems.

KAMSD use two way admission processes, one is receiving referrals from Addis Ababa Bureau of Labor and Social Affairs and the other is receiving needy elders living in the streets or elderly people coming from country side in search of assistance for their living. The social worker in KAMSD describes their admission process in the following way,

> "We receive elderly peoples who are referred to us by the social affairs bureau through their own process of neediness confirmation. But, this is not the only way we receive elders. We also use other sources; to collect needy elders from the streets and using the recommendation of other peoples, when they found needy elderly peoples, on the street and call us to take them."

Mekedonia Elderly and Mentally Disabled peoples care center is receiving elderly peoples and other needy individuals from around the country. MEMDPCC is not only a home for elderly peoples but also it is residence for persons with other kind of disability 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.

Unlike the other two Institutions under study, MEMDPCC is receiving all kinds of peoples with serious problems with no age limit for those who are more 18 years of age. The center is taking care of all sorts of inhabitants in its four compounds. MEMDPCC exceptionally uses its own effort to gather elderly peoples not only in Addis Ababa but also from around the country. One of the elderly who was interviewed was found admitted to the center from Debre-Birhan, some 130 kilo meters north east of Addis. As document reviews from the center reveal, there are admitted elders from Hawassa, Debre Zeit, Debre Libanos, and Guder.

In summary, the admission reasons mentioned by the interviewed elders in the institutions as pushing factors for their institutionalization also supports the above list of criteria used by the institutions. In all the centers, interviewed elders were living either in the church yards or streets by making their living through begging. In KAMSD and MEMDPCC there is formal pre-admission assessment about the elders. They undergo photographing them to document their previous appearance, in MEMDPCC admitted elders are even filmed to document a CD copied file. There are also formal health checkups and general assessments in both KAMSD and MEMDPCC. This situation is nonexistent at KICCE, where referred elders who come to the institution with referral letter from Bureau of labor and social affairs are just assigned bed rooms and provided clothing after registration process on their arrival.

4.1.4. Socio demographic characteristics of residents

KICCE provides service for some 108 elderly peoples currently. KAMSD holds 48 elderly peoples in its institutional service. MEMDPCC on the other hand has 500 peoples in the center including all kind of entrants. Because of discharge and new admissions, the number

of elders in the institutions varies from time to time. The following tabular presentation represents the number of elders during the time of data collection.

Table1. Demographic characteristic of residents

Institution	Total Number of Resident	Age above 60	Gender		Age of Residents	
			Male	Female	Minimum Age	Maximum Age
KICCE	105	85	40	45	61	101
KAMSD	48	48	30	18	65	95
MEMDPCC	500	350	280	70	60	116

Source: Investigator, May 2014

Note: Numbers are subject to change in all the three institutions, the above statistical data is recorded as of May 10, 2014.

4.1.5. Personal and Social History recording and documentation of the residents

Admitted elders at KICCE have their own individual profile of personal history registration. The personal and social history registration process starts on admission and is an ongoing process throughout the life of the elderly in the institution.

The list of personal identification and social history items registered includes, Full Name, Gender, Age, Educational Background, Marital status, Health Status, Identifying mark or any identification, Ethnic group, Religion, Place of birth, the time they come to Addis Ababa, Reason for their coming to Addis Ababa, Previous living address, Previous living arrangement or work, Reason for admission to the institution, Any additional comment.

A separate profile is prepared for each resident and it will be updated every time when a new phenomenon is happened to the elderly both physically and mentally. Their medical history is attached to their profile.

In KAMSD, the personal and social history recording includes the following main items, place of birth, birth date, religion, ethnic group, address, admission date, marital status, family address or contact person, health status, physical status, number of children (if any), previous job and living arrangement. In the same way to KICCE, the elders medical records are attached to the profile and they all have their own file of these profiles.

In MEMDPCC similar list of social and personal history identifiers are implemented to admitted residents. Name, Birth date, religion, ethnic group, recent address, marital status, place of birth, family address or contact person if any, health assessment report on admission, physical assessment on admission and photographs and film records of the appearance on admission are included to be recorded about the residents.

4.1.6. Care and support practices

Service provisions

There are some sorts of services provided to beneficiaries in all institutions. The main services provided for the admitted elders at KICCE includes, Shelter/bed rooms/, food, counseling service, 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, TV room facility (one in the meeting hall) and an acre of gardening land used by some elders who are physically able to work such stuffs.

Based on the interview result both from residents and the administrator, institutionalized elders at KAMSD receive the following services regularly. These include meal three times a day, residence or bed room, clothing, medical treatment, hygiene care, and entertainment services.

Similar lists of services are also provided in MEMDPCC. To look only the unique ones exceptionally provided there, the meal service is provided four times a day, there are volunteer physician visiting who check up the health status of the residents, there are two professional nurses following emergency cases and taking care in providing medication to treatment attending elders.

Care Giving Services

In terms of caring for the elderly people at KICCE, those elderly who are physically healthier are encouraged to take care of themselves and the frail elders who have difficulty in moving easily and bedridden are given the required care by the hired care givers. The caring activities include, cleaning their room, washing their body and clothes, helping them go to toilets. The care giver in KICCE speaks, “I help those elders who are bedridden, in taking them to toilets, I wash their body, moving them from wheelchair to bed and vise versa, feeding them and making their bed arrangements . . .,”

As per the word of the counselor at KICCE, these caring services are continually provided to elders who are suffering from some kind of disability to move by themselves. The administer states, “The care givers are always here, there are two working shifts for the care givers, so that the elders can access them when they want.”

Regarding caring service at KAMSD, they have two major areas of caring service. The first one is institutional care which includes, washing body, making bed, feeding, helping to go toilet and massaging the bedridden elders to the institutionalized elders. The second one is providing community care service, through which they integrate street begging elders who are able to work into the community by engaging them into income generating activities. This community based care service includes, renovating or repairing dilapidated houses of elders, providing skill based training, engaging them into IGA, providing financial support and medical treatment.

One of the care givers at the institution describes the daily tasks of care givers in the institution in this way, "We wash their clothes and change them their pajamas, we make their bed, we spoon feed those who can't eat by themselves, we help them go to toilet, massaging their body, and diapering. . ."

The caring service at MEMDPCC also includes, providing personal hygiene, health care service, washing their clothes, diapering, moving them out to the compound for refreshment. These caring services are provided to the bedridden elders and other healthier elders of the center are encouraged to care themselves by providing the necessary facilities, the likes of soap for bath service.

4.1.7. Discharges and Withdrawals

One of the points of interest focused in the key informant interviews was elderly discharge cases in the centers. The administrator at KICCE explains this process in the following way,

> Yes there are peoples who leave the institution. But they are leaving the institution only by themselves. Especially those who were gathered from the streets leave the institution by themselves . . . there are others incidence where they get family members or relatives after long time, there are cases where elders in the institution find their missed children . . . there are such cases . . .(Q, how about for disciplinary reasons?) In terms of disciplinary cases we don't push them to leave; we counsel them and keep in patience.... So, since the last two and half year of my coming to here, I don't remember any case of discharge for disciplinary reasons.

The counselor who have been working there for more than five years also have same idea about this discharge issue, only put in a different way;

> There are withdrawals from the elderly care center initiated by them, 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 here. I only remember one elderly discharged for disciplinary reason during the previous management period of the administrator.

Discharge cases are also applicable in the other care centers, KAMSD and MEMDPCC. A care giver at KAMSD stated;

> I remember only one individual who leave after spending a single night in the institution. He was living by begging in the street and was suffering from asthma, in admission he get his clothes changed and provided medication for his illness and left the other day . . . the other discharges are only due to death incidences.

In MEMDPCC the discharge case are slightly different, as per the statement made by the administrative coordinator,

> 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 don't like to be taken. Sometimes they even cry out to stay here than reunion, ... 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 is forbidden with the regulation of the institution.

4.1.8. Volunteerism and Community Participation

Except seasonal appearance of student practitioners who visit the center for academic purpose once in a while, there is no volunteers' activity to help the elderly at KICCE. All the caring activity of the center is performed by government hired workers of the Institution. The administrator of the institution explains that there are no efforts made to attract the public involvement in the care giving endeavor.

In KAMSD involving volunteerism to help the elderly is advocated as one of the core values of the institution. The institution uses the services of both visiting volunteers who come to the institution to serve in their profession and volunteers who help the institution by providing in-kind services such as food items, clothing, and financial support. One such activity of the volunteer explained by the social worker in the institution is, there is a

massage therapist who threats the elders voluntarily. And there shown one Nurse who occasionally comes to attend patient among the residents.

The care and support at MEMDPCC is conducted by volunteers. Excluding two professional nurses hired by individual donors, there are 70 volunteers working and living in the institution permanently and there are also many other peoples who are coming to help the elders either professionally or in any other task given by the center.

There are volunteers who came to the center to serve on meal hours, there are others who come to wash clothes of elders, and there are Nurses (Especially from Amanuel Specialized Hospital, who came regularly on Saturdays).

4.1.9. Care Givers Professional Orientation

Professional orientation of the care givers was one of the points of interest in the key informant interview.

The coordinator at KICCE referred the issue of not having professional care givers as one of the major problem in the institution. He emphasize that care giving should be performed by professionals.

> You know, such care and support activities should be given by professional care givers. But it is not adapted so in our country. Here we hire the care givers just like any other labor work job vacancies. And also they are not given any special trainings of elderly care giving. This is one of the problems. We sometime try to invite training institutions to provide trainings to our care givers, Other than that they are not hired professionally.

This same scenario is applicable to the other institutions; the Social worker at KAMSD describes the issue in this way, “Though not enough, we provide trainings to our care givers. Most of them are long stayed with the institution and are experienced in living with and caring for elderly people.”

The coordinating admin at MEMDPCC says, she was trained for six months about psychosocial treatment method by professionals from Mother Teresa center. She believes that they need trainings for other care givers, she stated that,

> We have requested many institutions in letter to help us train our care givers, but we haven’t yet received any response except one Health College who provide us training on health care management and service.” [She adds that], most of the care givers here are people who once were patients and get cured after treatment by the center. We just discuss and share experiences on our meeting days and whenever we face a challenge in service delivery. Everybody you see here is not a paid worker, it is all volunteer activity.

Two interviewed care givers at the center were both patients before. They both mention “being a person is enough to help peoples” they say they share experiences on individual characters of the elders in their meetings and try to treat the elders based on their information gathered from other care givers.

Beyond the absence of professionally oriented staff, shortage of care giving employees was mentioned by the admin respondents from KICCE and KAMSD. Thank to the numerous participation of volunteers, this shortage of care giving workers is not a problem to MEMDPCC.

4.1.10. Reasons for Institutionalization

As it may obviously be known, there are plenty of reasons for the elderly to be institutionalized. In all the three studied institutions, both beneficiaries, and key informants mentioned numerous reasons related to social institution break ups and absence of community informal help, as pushing factors for the elders to live in and cared in the institutions.

Respondents in KICCE list various reason as push factors to choose institutional life. The following are the main reasons mentioned by KICCE resident elders for their institutionalization; Illness, Termination from job without pension, Street life, To overcome loneliness, Worried about being a burden to children, As a result of street life clearance by government, inability to pay monthly payment to live in a monastery, institutional life preferred for them by relatives than living in a church yard.

As one of the respondent replied,

> "I was planning to live in a church yard at Yeka Michael, but my nephew disagrees with it. . . . And he brings me to his home. But after I arrive at his home, it became difficult for me to spend the day alone. Since, my nephew and his wife were working far from their home, they are coming to home only down in the night. as a result of this there was no one to help me in the house. So, I asked him to apply for *Kebele* and send me to institution where I can get care giver. He was not willing in the first place but through time looking my situation he applied for *Kebele* and they gave me admission at this center."

Elders in KAMSD identified the following points as their main reason for joining institutional life.

- Death of family, disagreement with relatives, insufficient pension fund.
- Poverty, Street life, begging life, inability to pay house rent, precarious life.
- Poverty, ignorance by care giver, loss of strength to work, loneliness, absence of relatives, confusion in living alone and thinking to commit suicide.
- Spiritual satisfaction

Joining institutional care center for spiritual satisfaction was mentioned by only one resident at KAMSD, she describes about her entrance to the center,

> "I was living in a well furnished villa house with my relatives and neighbors, but I was thinking to help the elderly peoples living in the streets and spent my remaining late life with them. Then I just sold my house and give the money for this Agency and admit myself to the center."

The push factors which let elders to live in institutions are almost the same. Mekedonian elders also have lists of reasons for their coming to be institutionally cared. To mention some list of reasons;

- Ignored by care giving daughter, illness and street life,
- Absence of caring family or relative and difficulty to move
- Illness cause by accident, living in church yard
- Conflict with families which let to live alone with old age and illness.

4.1.11. Belief, attitude and experience of residents about the institutions

Based on the interview data collected from the elders, most of the elderly in KICCE likes the institution for various reasons of their own as compared to their life situation before admission to the institution. As expressed by one of the respondents who is 60 years old and joined the institution from street life, “I like the place/the institution/, I don’t want to move anywhere until my death. You know, I was living in the streets; I faced many challenges there.”

This is true for other elders too particularly for those who came to the institution from street life and other sufferings. Those who came to the place from other life setups also have their own reasons that make them to like their stay at the institution.

The following elderly respondent came to this place accidentally. One early morning, He was going to his home from a night work, and unfortunately he was caught and forced by police men to join a gathering. By that time the Addis Ababa City Administration Bureau of Labor and Social Affairs was campaigning for street dwellers clearance in the city, the purpose of the campaign was to train street dwellers on Coble-Stone construction and other vocational trainings and engage them into work, so that they can supplement their life with the income. Of the gathered peoples on the campaign, some elderly and disabled peoples who were not fit to the training and labor work were sent to KICCE for retirement. Though this man has come to the institution in such an incident, he didn’t attempt to resign from the institution after admission. He explains his decision in this manner:

> After they bring me here, I liked the place, I prefer it than going back to one of my children home, because it is not that easy for my children to take care of me, I don’t

> want to be burden on them, they have their own life and children. So I choose to stay here. I choose this life than the other.

Elderly residents of KAMSD expressed their life experience in the institution positively. Some of the point's indicated by resident elders in KAMSD includes:

> "Life is very comfortable here, we have everything. We have clean clothes, we have bath for our body, and our dish is full. It is impossible to get such a place." An elderly man who is 83 years old and stayed in the institution for more than two years replied.

Another elder man who stayed for five years in the institution states: "It is a good place; we are eating and drinking well. They give us cloths, what else do we need then?"

The following 77 years old benevolent elderly woman was purposefully included in the study. She was living a decent life in her own. Finally she decided to join an elderly care institution by granting all her property and capital to the institution/KAMSD/ in order to get spiritual satisfaction.

She describes her experience about the caring service of the institution in the following way:

> Life here is very fine and comfortable the environment is very good. . . . After coming here I am enjoying a life better than I was living in my own house. I am being served everything, the founder is a very good person, and she is a woman of love. She wanders here and there to find fund for feeding us. You see we are all older and not working, we just wait here to bring us our daily food like a mother bird feeding her chicken.

Elderly residents in MEMDPCC also describe their living condition and life experience as a positive reflection.

A 78 years old elderly man speaks about his life condition in the center: “It is very fine, now I don’t worry about what to eat and drink, there is no problem. I am living as if am in my own home.”

Another elderly woman who is suffering from serious problem of mobility explains her experience of life in the centre in this way:

> After coming to here I am very fine, there are care givers here who help me go to toilet. They move me between my bed and wheelchair whenever I want to. Thanks to God, I am living much better now. If God cure me from this illness, I would like to help other patients in the center.

These voices of the elders indicate that, as compared to their previous living arrangement in the streets, elders are satisfied with the basic services provided at the institutions. We can see the responses of elders living in KICCE who are facing some sort of discomforts in the service provision and facility; they don’t disregard the basic service they are gaining there. Though it is poor to be called the suitable service for the elderly, they at least appreciate the institution for the shelter provided. The opinions of elders in the other two institutions by far indicate that they are living a better life beyond shelter in the other services too.

4.1.12. Belief, attitude and experience of beneficiaries about care and support of the Institutions

In an effort to understand the beneficiaries' experience of the care and support services provided to them by the institutions, selected elders were asked to share their experience.

The care and support services provided at KICCE are not an entirely complaint free. Most of the respondents prefer the institution only as compared to their previous life before admission. The following are direct quotations of the elders about their feeling on the care and support of the institution,

> The service is enough only for a poor, it is not for a rich... the living arrangement and care is preferable than other life. . . ", Replied an elderly who came to the institution through the street dwellers clearing campaign.

Another 81 years old elderly man who lived in the center for the last five years express his feeling about the service in the following way:

> The service was good before two years, it is now getting down from time to time . . it needs a good administration to care for the elderly . . . it is only for the shelter that I am here, . . . anyways, we are elders waiting for our death, it is not good to complain . . . the Previous nurse were visiting us all in our rooms, there are no such visit service after his resignation.

The following elderly nun, who responded that she don't want to say a word about complaining on the service provision also put her idea, "Who will listen to us if we say the service is not enough? . . . We better say whatever they give us is enough."

In all the interview responses from elders of KICCE, there is at least one kind of complain related with the service provision. Let's see the following list of ideas of three interviewed elders in the institution. They replied about their experience on the service provision,

> It is very good to live here in comparison to my previous street life . . . I am having shower everyday now, my clothing's are clean... but there are no enough health care, there are no medicines, . .. when we request them, they don't give us solutions, they replay us that they don't have budget, the budget is not disbursed from higher authority . . . the service is not enough but we have nowhere to complain at, they don't visit how our life is, we never seen the authorities. . . .As far as I am here I better say it is good I shouldn't say it is bad. There is a shortage of soap, it is enough and we get it very late, they don't give us on time. There were visiting donors and NGOs who were bringing us clothes before, and other items. It is declining now. It would have been very good if they have visited us, ask the frail elders about what they want, and take care of them properly.

Another elderly man who is 95 years of Age describes, "There are no regular checkups for our health status." And a 77 years Age elderly say, "This is not caring, a child and an elderly are the same, they both require attentive care."

The 95 years of Age elder also adds, ". . . . There is no hunger but the stew is not cooked well, most of us throw it. . . . You can see me, I have applied for the office to take me to hospital for my eye medication, but they say there is no car, it is 15 days from now, and they just keep silent."

Asked about their feeling on the caring service of the institutions to Elders in KAMSD elders have the following list of attitude and feelings about the institution.

> "I can't say that they should bring me this and that, they try much to their best to feed us, the founder is a brave woman she run here and there to bring our living. . . they give us clothing's, there is no problem in relation to health care, we have shower to clean our body, we have a nurse here in the center she give us medicines for minor illnesses, the service they are providing is enough for the time we are living in when life so hard and inflated." A 75 year old elder replied.

Most of the elder respondents in KAMSD prefer to express their feeling by praising the hard works of the founder for comforting them. They don't mention any bad feelings created as a result of lacking services or dissatisfying care and support.

Elders residing at MEMDPCC also 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."

It can be summed up that, elders in MEMDPCC and KAMSD are happier than the service provision of the institutions than the residents in KICCE.

4.1.13. Social Interaction of the elders

In most of the days of my visit to the institution at KICCE, I was looking residents sitting out of their rooms. Most of them discussing in pairs and groups, some were playing card games, others were making the land for harvest, and few others were weaving sweaters.

There are some efforts made by the administration to create socialization group, like grouping them in to committees and through which they can link to the society. The elders by themselves also have created social groups. The administrator of the institution replied about the socialization effort of the elders in the following manner,

> There are committees organized within them, where the elders can create social link with the society. But apart from that, they have social groups like *Iddirs* /association organized to help each other during funeral service/. These *Iddirs* are established by their own initiation; they lead them with their own elected representatives. Whenever a member of that *Iddir* passed away, they gather for three day at his/her room like in a way it is done in the normal social and cultural life. The institution helps them in such activities by providing the necessary materials.

Socialization efforts in the other two institutions /KAMSD and MEMDPCC/ are initiated by the elders themselves, an elder at MEMDPCC replied about his interaction with other residents, “We all know each other, particularly with the first round entrants, we play card game together, and we are all friends. . .”

Another elder from KAMDS responds, “We are living in a respectful tolerance to each other. We have nothing to deal for bad; we chat, joke and live together peacefully and in loving relation”

There are visiting’s by the public on weekends and holidays at MEMDPCC. This can help the elders develop a sense of importance and belongingness with the society and others. As one of the elder in the center explained,

> There is no one coming in search of me, but within the people coming to visit the center I find people whom I know before, they feel happy seeing me alive here, . . . they encourage me that I am strong,. . . I feel so happy with this. . . I feel as I have this much people loving and caring for me. . This is all happening because I am alive, before my admission I was even praying for God to kill me shortly.

Thus, the communal life in the institutions allowed the elders to develop social life styles as compared to their street life. It is possible therefore to say, institutional life is another opportunity to the residents to continue their societal belonging. In addition to this the advocacy activities of MEMDPCC towards community participation have brought the attention of the community to visit institutional elders. As the above respondent replied, institutional elders feel dignified and socially important when visited by the society.

4.1.14. Needs and problems of institutionalized Elders

Basing the interview responses of the study participant elders, residents of KICCE are not living comfortably, they have lists of problems related with both caring service and living facility. 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. The other problem is related with the age of the institution, most of the rooms are constructed more than forty years ago and need renovation service. The electric power and water pipe

> lines in the compound served for many years and caused repeated breakups. We have problems in providing recreational field and garden for the elderly; we have only one TV room with only one media channel . . . here we are working in our daily activity to curb temporary problems only. ”

Residents of the institution even mentioned much more problems they faced in the compound. One of the residents who lived five years there speaks,

> “The service of the institution was very good before, particularly with the first two years of my admission. There were aid agencies assistances periodically, the physicians were coming to our rooms and ask about our nights. . . It is deteriorating from time to time and reach zero now. There are delays in service provision; we are getting the yearly 2000 birr for clothing with 13 and 14 months. It is even not enough to buy clothing items; there are peoples who are dying due to absence of medication and without going to Hospital. ”

There are also some more implications of discomforts on the service delivery reflected by the interviewed residents. To list some of them, an elderly woman respond to the question, what would you like to be improved in the service provision? Her response was as follows.

> “No. . , I don’t want to say anything on this issue, you are trying to push me much, I don’t want to say a word on this issue, why should I complain, what will happen if we say the service is not enough, who will listen to us?”

Another respondent who is a 77 years old elderly also says “individuals in the management are weak, they don’t follow us, they don’t ask and see what we are eating, they don’t ask about our heath. They simply don’t care for us.”

There are also complains in religious practice place from those who can't move by themselves to religious institutions. As one of the visually impaired elderly explained,

> "There is no place for us very old and non moving patients to practice religious activities. I lost my both sights that I can't go to church or read Bible and other religious books. I feel as if I have lost my Christianity. Every one of us who couldn't move keeps silent on this issue that there is no one to listen to us. It is only this situation that always makes me feel that I am empty from inside"

Elders in the institution forwarded their opinions and feelings about the care and support of the institution wrapped with complains. They at least put one point of dissatisfaction. Their feeling ranged from "this service is enough only for a poor person" to "what care is this!? Caring for elderly is not like this. Elderly and child are the same that both need attentive care." They mention complains about service delays on monthly provision of soap and toilet paper, as we have seen above, there are cooking problems with the stew provided. They mentioned the absence of attention in controlling the service and visiting and correcting the care and support service. Recalling his experience about the service provision of the center before two years, one of the respondents Said, "It was very good before, particularly within the first two years of my admission, the service is deteriorating from time to time and reach zero by now."

One of the serious cases mentioned by KICCE residents is the service of the clinic in the institution. This case has also been supported by the opinion of the nurse, the clinic almost have no medicine including basic first aid care giving ones. The clinic is only served to write referrals to health centers. When elders are referred to health centers, they face serious problems of transportation which makes the situation even worse. Such shortage of

transportation is happening to elders who have hospital appointments for checkups and diagnostics.

The problem of elders in KICCE is not limited to this, as was expressed by the Nurse in the institution; the nutritional mix of their meal is unconsidered for long time that they eat dairy products only three times in a year. That is in public holidays of New Year, Christmas and Easter. The institution nurse expressed this situation as very much disgusting that the elders should have got best mixes of nutrition for their age. If not possible they shouldn't have been deprived of fair meal. But she states that the situation is far from this fact.

There are needs of elderly mentioned by key informants in the other two institutions; the social worker at KAMSD describes the needs of the elders in the institution,

> "The needs of elders are many, The first problems is their age by itself, as the science tells us, the more their age increases, the more they complain about the service they receive . . . there are problems related with old age behaviors, . . . but in most cases their problem is related with their background and the way they come through, there are elders who were living a very pleasant and well to do life but lost all their property all of a sudden, There are others who lost all their families in an accident, there are psychological breakups that need an intensive intervention of social workers in treating with their grief and loss. Sometimes they need more intimates to share with and friends to discuss than giving them food and cloths . . . And with this limited number of human resource it is difficult for us deliver them all their needs."

On the other hand needs of elderly in the MEMDPCC are related with health complications, as the word of the administrative coordinator at the center,

> "The first problem is HIV. The other thing is in relation with their age they can't control and wait to toilet for their excretions, they just let it out on their bed, their health complications are even difficult for operations especially for those who are over the age of 80, as it is impossible to undergo operations at this age. There are mental disabilities resulted from their life change from fine life to such misery, these are the main issues. . "

4.1.15. The growing demand for institutionalization

Given its current status, KICCE has a maximum capacity of inhabiting only 150 elderly people. But the demand for institutionalization is far higher than the capacity in reality. The administrator of the center explains this growing request for institutionalization as follows,

> As compared to the needy elderly found in the city, the number of elders admitted to our center is only a limited number. It is only to prioritize those who are in severe problems; we are planning to expand our service by extending the capacity of our institution to dwell up one thousand elders.

The counselor at the institution also agrees on this point and she explain that, ". . . I know there are many applications waiting for admission, but with the limited space and minimal budget allocated we have, it is impossible to receive as much elders as applied."

The case of the high demand for institutionalization also applies to the other two institutions under study. The social worker at KAMSD explains the case in the following way,

> We have the capacity to receive only 50 elders. We receive a minimum of 4 to 5 phone calls from the public addressing needy peoples fallen on the street, if you consider this all who fall on the streets without help, and the situation is even worse. You know, there are only few agencies engaged in institutional care and supporting elderly but the demand for help from needy elders is too far to reach.

In MEMDPCC, the case is observable to anyone who arrives at the institution. Although it is established far later than the other two institutions it is, it became a home for too much elders. There are around 300 elders in the care center; the coordinating administrator at the center describes the situation in the following manner;

> The demand is too high, you see we are receiving many elders every day, we are placing them in temporary rooms made only with metal sheets. We are doing this considering that this is even better for the elders to admitted than letting them to live a very difficult life in the streets.

A care giver at the same institution /MEMDPCC/ adds that, “the number is increasing exponentially; we receive at least three or four elderly per day.”

This fast-increasing demand for institutional care means that both the public and government must act decisively to increase participation, capacity, improve efficiency and fund services, or risk severe damage of health and wellbeing of the elderly.

The key informant interviewees in all the three institutions indicate that there is higher demand for institutionalization. This fact on the other hand reveals the increasing number of elders living in sufferings. Given their limited space and overall capacity to care for elders, the institutions are working hard to their capacity. They need the attention of both public and government efforts to strengthen them serve the more destitute.

4.2.Discussion

In this section of the study I tried to discuss briefly about the case studied institutions in a cross case analysis method. The discussion is presented focusing on the following main themes; the admission criteria and reason for institutionalization, service provision in the institution, community participation and volunteer's activity of caring for the elderly, institutionalized elders life experience in institutions, and the needs of elders in the institutions.

4.2.1. Admission Criteria and reason for institutionalization

As the study finding indicates, the admission criteria to the institutions mainly focus on prioritizing the neediest elders. The interview result of the institutionalized elders indicates that before their admission to the institutions they were either engaged in street begging or have been living in church yards waiting their means of living from the believers. This insecure and destitute living condition was the main issue behind their institutionalization. These push factors leading the elders to wander for help actually agrees with the pre specified admission criteria set by the institutions. Being a needy elder and living in the streets is mentioned in the entry criteria of all the institutions. Therefore it is possible to say that the admission criteria of the institutions are in congruent with the beneficiaries' response to reasons for their institutionalization.

The access for admission to KICCE needs to be supported by *Kebele* officials and witness from the neighbourhood. This looks difficult to be applicable for the street dwelling elders. It is a hard task for them to find witness for their street life. Although the coordinator at the centre expressed that assigned social workers of the *Kebeles* will study the life conditions of the applying elders, it is still inconsiderate that all applying elders will be reached by the social worker. Given its limited capacity, KICCE is not advocating and reaching other needy elders and it only considers admitting elders who apply to the institution with the help of information from other sources. This will shadow the effort of the institution to reach needy elders who fall in the streets without help and don't have information access about the institution.

The other two institutions under study on the other hand use their own effort to attract needy elders in addition to those who are referred to the institutions by Bureau of Labour and Social Affairs. Administrators in both institutions expressed that they receive phone calls from the public to collect chronically suffering elders found in the streets. In MEMDPCC the administrator further explains their effort that, they even go beyond Addis Ababa to admit elders suffering from street life and willing to be cared institutionally. These forwarding efforts of the two institutions will be a good opportunity for street elders who have no information about the institutions and are suffering from multi catastrophes without help.

4.2.2. Service provisions in the Institutions

It is evident from the findings that, there are slight differences in the services provided to elders in all three institutions. The basic services commonly provided to residents in all institutions include, bed rooms(shelter), meal, health care, personal hygiene, caring

services for the frail elders and funeral service when they die. These basic services provisions agree with the needs of elders in rural areas as described by Kifle Mengesha (2002). He mentioned that the basic socio economic problems old age population living in rural Ethiopia of Ensaro (Amhara region) includes food shortage, Shelter, health, toilet and being burden of caring dependents. The services provided in the institutions are also found to be coinciding with the priority concern of older people in Addis Ababa. According to the findings of HAI (2010) who conducted a study on vulnerability and living conditions of older people in Addis Ababa and reported that food, shelter, health, clothing and psychological support are among the priority concerns of older people in Addis Ababa. Therefore, these evidences from literature indicate that the basic services provisions of the institutions are matching with the needs of elderly peoples suffering from street life.

Although the above mentioned services are important for help, the way they are provided to the elders should also be a point of concern. Elders in KICCE have complains with the quality of meal provide. They expressed it as enough but not delivered with good cooking. They also complained about the caring service that they couldn't gain the required attention as an elderly. These expressed complaints are not existent in the other two non government institutions. Here it is possible to indicate the open research area, investigating the quality of life of the elderly in the institutions.

4.2.3. Community participation and volunteers' activity of caring for the elderly

It is to be recalled from the data presentation that the activities of community participation and volunteer engagement in elderly care have ease the burden of human resource shortage. The advocacy activity of MEMDPCC in attracting the helping hand of the

community is an exemplary one to be applied in the other institutions too. It is only KICCE that does not engage in participation of volunteers.

It is possible to understand from the finding that as a result of public volunteer participation, elders in the two non government institutions are gaining better service. There are Nurses and massage therapist volunteers at KAMSD. And on the other hand in MEMDPCC there are regular visits of Amanuel Hospital Psychiatric Nurses who diagnose the mentally disabled persons and elders. These professional supports are other than the in kind and in cash support the two institutions are gaining from the public.

The advocacy experiences of the two non government institutions, particularly MEMDPCC is an indicator that it is possible to create a helping public awareness and participate the community in the care giving service. This can change the cultural attitudes about elderly and integrate the degraded elders into societal participation and belongingness.

As Dandekar (1993), explained the elderly citizens are in need of urgent attention. They do not need our pity, but the understanding love and care of their fellow human beings. It is our duty to see that they do not spend the twilight years of their life in isolation, pain and misery. Older persons are, therefore, in need of vital support that will keep important aspects of their lifestyles intact while improving their over-all quality of life.

It is important to remember here the opinion of one the resident at MEMDPCC, who speaks about the community members visiting the institution. Where he expressed his feeling that, there are people happy looking him alive, he get the chance to meet peoples whom he know before in his earlier life, he get encouragement from the visiting public, he

feels he is still socially important and valued by the society. This man was even dreaming his early death before his institutionalization.

This eventually shows the positive result of community participation in the care and support delivery that has an adverse effect on the social belongingness of the elders beyond the economic benefit the institution can obtain.

4.2.4. Institutionalized Elders Life Experience In the Institutions

Interviewed elders in all the institutions at least have some reason to like their stay in the institutions. Even elders in KICCE who face serious difficulties both in the service delivery and caring facility have at least one reason to prefer their stay in the institution.

Their acceptance to the institutions with whatever service problems they face emanates from their previous life experiences. Most of the study participants were suffering from street life or some other helpless living arrangement before their admission to the institutions. Whenever they are asked for opinion about their life situation and experience in the institution, they immediately recall their preadmission life and start to compare between what they are gaining now and what they were suffering from.

One of the interviewed elderly who is 60 years old and stayed in KICCE for two years explained his experience about the centre that he like the place and don't want to move to any where untiol his death. He further compares his today life with that of hes earlier street life and the challenges he had faced in the street.

From such facts of the institutionalized elders' life experience, it is possible to understand that the multifaceted problems of elders living helplessly in streets can be solved with the provision of basic services like that of shelter, food, medical care, clothing, and personal

hygiene. But this concluding remark shouldn't cover the fact that elders need a dignified life with the most appropriate service and an age friendly environment.

4.2.5. Needs of Institutional Elders

The study found that most of the residents had a poor quality of health, which had not been improved by becoming institutionalised. To some extent, this could be blamed on the prevailing absence of health care service designed for old age. World Health Organization's Social Development and Ageing panel report (2000) dictates that, in the same way longer life expectancy is celebrated as the success story of humanity, it is also paradoxically regarded as a challenge to health system. Longer lives are commonly associated with a prevalence of non-communicable and chronic diseases.

Their needs are not limited to health care issues; they are also suffering from basic services provisions too. For example elders who are physically impaired and can't lead themselves to religious places are suffering from lacking spirituality. As an elderly in KICCE expressed his daily worry that there is no attention for the very old elders who can't access religious places by themselves. Especially for those who are disabled to move or visually impaired, they don't have a guide in there day to day life activities. They want religious leaders to visit them but there is no such situation in the centre.

There is a common belief that in old age people tend to become more and more inclined towards religion. To an extent, religion provides a sort of social support in the form of personal contact with other people at religious gatherings with whom they could share their thoughts. It is believed that, 'it is around this social and religious participation that the life of the old revolves' (Dubey, Bhasin, Gupta, & Sharma, 2011).

But these services are not provided because of absence of care givers who can guide those very old or physically disabled elders to religious places.

CHAPTER 5- Conclusion and Social Work Implication

5.1.Conclusion

From the institutions included in this study, it is possible to draw a tentative 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 life and living condition, it is possible to say the service of the institutions has changed the life situation of the elders.

The beneficiaries, 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. They spent their spare time by playing card games, chatting with friends, gossiping, watching T.V., and having discussions among themselves. Except residents at KICCE, who face certain problems associated with service delivery, attentive care and facility, residents in the other two institutions expressed their opinion that they are living a better life than their living arrangement before admission. Even they advocate for establishment of more old age homes to accommodate elders who are on the street waiting for help. Ara (1995), considered 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 beneficiaries of these old age homes. They were not discomforted with their stay rather; they were enjoying their communal living. As a result, of institutional living they are able to connect to the community regardless of gender, class, and religious differences have no significance. Foreseeing the future the government, voluntary agencies and NGOs in the country must make arrangements for institutional support and care for the elderly.

Community participation and volunteer activity were shown in the two non government institutions playing decisive role in the care giving activity and showing respect to the resident elders. Beneficiaries in the institutions expressed their feeling about societal visit and support as important societal belongingness which they were not experiencing in their previous life.

Guiding care givers in to professional orientation of elderly care is a forgotten aspect in all institutions. Care givers in all the three institutions are either volunteer who come to help the elders without any prior orientation or hired workers without any regular training towards elderly care. Only accumulated knowledge through experience, peer orientation and rarely happening informal trainings are the way outs used so far. Both the institutions and other stakeholders have to engage themselves in this matter either by training volunteer care givers or hiring professionally competent care givers.

5.2.Social Work Implication

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 social work 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 institutions management are all needs the involvement of social work practitioners and professionals.

Social work educational institutions should encourage and avail opportunities to develop and promote gerontological social work content and trainings to their students in their academic endeavor.

The study finding clearly showed the gap that, a social worker engaging in these elderly caring institutions should be aware of and encouraged to take advantage of the development and trainings of other care givers, in the areas relevant to the service such as, the psychology of older persons, mental health of the older adult and social gerontology.

Trainer social workers should provide care and support providing skills and trainings to institutional care givers, targeted at biopsychosocial spiritual treatments of elders and practice principles with elders.

One of the prior importances of social workers 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 workers, 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 workers in the admission process also is 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 resident elders of the institution. Volunteers can bring additional personal contact to the resident; they can provide new services to the residents as well as serve as a liaison 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 residents, 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 non existence 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 dearth 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 life 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 caring 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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Appendices

Annex 1. Interview guiding questions for institutionalized Elders

Background Information

Age_____ Sex_____ Place of Birth_____ Religion_____

Marital status_____ how long did you live in this institution_____

Elder's life in the institutions Vs service provision:

I. **How do you describe your life in the institution?**

Probing questions

Living in institution: - Do you like the institution you are live in now?

Did you like your shift to the institution: - how do you explain about the life change?

What makes it better off living in the institution than your previous living set up?

How do you feel about your life in this institution?

What do you feel about the peoples/residents/ of this residence?

Social interaction: How do you interact with other residents of the institution?

With how many of the residents do you know each other?

How do you spend the day at the center? What are your daily activities?

II. **Previous Life experience : Please describe to me your overall life experience**

Probing questions

Family setup: Whom you were living with before?

Have you got children? If yes, how many and where are they now?

Had you have an owned house before? What happened to it (if yes?)

Previous experience: what was your living arrangement before?

What was your source of income?

III. Admission and current living condition: tell me about your living condition in this center

Probing question

Reason for institutionalization: How did you become institutionalized?

What was the event which leads you to join this institution?

Admission to institution: how do you get to know about this institution?

Is there anyone who is shifted to the care center with you? Who are they if so? Do you have any relatives or visitors coming in search of you? Who is it if so?

IV. Living condition and Service provision

Probing question

Service provision: What services are you provided in this institution?

Meal service: what is your regular meal service in the center?

How many times do you eat per day, are you satisfied with it

What medical treatments are you attending currently?

Health care checkups: is there any chance to get diagnosed for health status checkups?

Do you like the care givers of the institution, what do u like about them and what you don't like?

Do you want to visit religious institution?

What are the religious practices you are engaged in?

How is the communication between you and the care givers? Do you have the freedom to ask whatever you would like to be done for you?

What makes this institution comfortable for elderly: Do you think there are enough services and facilities for care?

V. **Challenges faced due to institutionalization**: **- tell me about difficulties (if any) faced in the institution?**

What are the problems you are facing currently?

What do you think would happen to you if you didn't join this institution at all?

What services would you like to be provided if it was possible?

Would you prefer change: If you were given the power, what would you change about this institution?

Suppose that you were in charge of this organization, what changes would you make to change the center as a better place for elderly?

What are your ambitions, to be cured from illness, to get a better treatment and support, to leave this center or to die than living here, to live longer……

Annex 2. Guiding questions for Interview with key informants (care givers and administrator)

Name of the Institution_____

Position of the respondent_____

Age_____ Sex_____ Educational background_____

Profession_____ Work experience_____

A. What are the details of admission criteria to the institution?
B. What is the organizational structure?
C. What professions your staff composition is made up of?
D. How do you feel about working with older people and helping aged peoples
E. Do you think you will stay longer and help older peoples further? Why
F. What are the admission criteria of clients to the institution?
G. Is there any experience of recording the social histories of your clients, what list does it include
H. What are the available resources for the care and support in your institution?
I. How is the general health status of the residents?
J. Are there any referral systems for serious health issues? To what level you refer clients
K. The kind of persons admitted to the institution
L. Who are involved in the care and support?
M. What are the problems of peoples in the care center, what are the critical ones? List them cognates' out please.
N. What problems do you face in the service provision
O. What external interventions do you have to help the elders of the institution?
P. Are there any elders discharged from the care center for whatsoever reason
Q. Are there any nutritional arrangements in your food provision
R. What are the regular services provided? List them out please
S. What efforts are there to create socialization groups within the admitted elders
T. Are there any arrangements for the clients to visit religious places of their choice?
U. What is the income source of the institution
V. How do you think will the services of the center change the situation of elders?
W. In your views, what should the institution change to help elders in a better way?
X. Are there any training given to care givers, what are the contents?
Y. How is the trend of admission?
Z. Is there anything you would like to add?

Annex 3. Consent form

Good morning/ Good afternoon Sir, my name is Segniwork Lemma. I am a graduate student at Addis Ababa University, School of Social Work and doing a research on the care and support experience of old age care institutions to the elderly. You are selected as a study participant because you stayed for more than a year in this institution and you are eligible to be called an elder based on the criteria set for the study. I will be asking you some questions about your life and situation in this institution, your experience of the care and support and the needs you have unfulfilled. The whole of the interview will only last about 45 minutes and you are entirely free not to participate in the study. It is my intention to communicate you or the institution you are living in about the results of the study at the completion of the research.

We can make the interview here in your room or we can choose some other place you will be comfortable with. I can assure you that there are no foreseen dangers associated with you participating in this study. You also need to be aware that your cooperation is the most important and it is for free.

After I collected the data, I will be keeping it only for my personal use and will only be used for academic purposes. Until the data is processed I will keep it with me in my apartment and I will be the only person who will have access. After the completion of the study, only researchers will have access to the study document. Through it all, I will respect the confidentiality of the data including your name will be concealed and codified.

I really appreciate your cooperation. Moreover, signing this consent form indicates that you have read this consent form (or have had it read to you), that your questions have been answered to your satisfaction, and that you voluntarily agree to participate in this research study. You will receive a copy of this document.

Segniwork Lemma Research Participant

Signature ……. Signature……

Date …….. Date…….

Declaration

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

Student Name	**Signature**	**Date**
Segniwork Lemma	……..	…….

Advisor Name

Wassie Kebede (MSW, PhD)	……..	……