J Cross Cult Gerontol (2014) 29:389–404
DOI 10.1007/s10823-014-9244-7

ORIGINAL ARTICLE

"We Prefer Greeting Rather Than Eating:" Life in an Elder Care Center in Ethiopia

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Published online: 8 October 2014

Abstract In Ethiopia where family care is a centuries-long tradition, living in an elder care institution invariably brings social devaluation. Accordingly, this study explored the psychosocial needs of older adults in a residential elder care center in Ethiopia from the perspective of both staff and residents. Three focus group discussions of 24 residents and interviews with 5 staff persons revealed that elders were living a subsistence lifestyle, eating the same meal every day, mostly cutoff from the surrounding community, and lacking basic amenities. Despite the absence of basic amenities, residents yearned even more so for meaningful social interaction. Psychosocial support was both undervalued and underutilized by staff members, and thus, residents' psychosocial well-being appeared to be at risk. The addition of social workers in institutional care in Ethiopia may help to promote improved living standards. Advocacy is needed on behalf of residents to establish and implement guidelines on care and support of residents in old age homes. As elders in developing countries are living longer–a growing number with disabilities–at the same time that informal supports are waning, the need for developing long term care policies is becoming critical.

Keywords Older adult care center · Ethiopia · Psychosocial needs · Developing country

When there is a large or growing aging population, some type of long term care will certainly be required (Rash 2007). In developing nations, institutional care fills a need for the poorest elders who lack family support. While institutional care for elderly adults is relatively rare in Asia, Africa, and Latin America (Kennard 2006), the need for long term care in developing countries is increasing at a rate that far exceeds the rate in developed countries (Wu, Mao, and Xu 2008). Brodsky, Habib, and Hirschfeld (2003) point out that the increase in long-term disability in developing countries is occurring at a time when the capacity of informal support systems is compromised due to issues such as women's employment and migration. In light of

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these trends, the need for developing public long term care policies and services in developing countries "has become urgent" (Brodsky et al. 2003, p. 5).

In developing and developed countries alike, institutionalized elders face social loss and the accompanying negative impact on their psychosocial well-being. Loss of connection with a social network may have a harmful effect on one's mental and emotional well-being (Smith and Rosen 2009). The internal (psycho) and relational (social) aspects of well-being interact and influence each other and over time if these needs are not met, the person may develop psychosocial health problems. As a result, the overall well-being of the older adult may be negatively impacted (Help Age International [HAI] 2011). To counteract such loss, the provision of psychosocial support to older adults through showing concern and value through each communication has multiple advantages. Psychosocial support builds older adults' self-esteem, decreases worry, and brings hope and pleasure even in difficult situations (HAI 2011). Thus, psychosocial support is a key component to enhancing the quality of life of elders (Dubey et al. 2011). Components of psychosocial support include emotional support, affirmation, information, and assistance (Rash 2007). All are especially critical for residents of older adult care institutions.

Studies in institutional care settings in various countries underscore the importance of psychosocial support. In Palestine Ibrahim (2009) found that after entering an institution older adults faced multiple difficulties, including feelings of aloneness, missing their former lives, sadness with their present situation, continuous anxiety and worry about illness, feelings of insecurity, and lack of comfort. In India Dubey et al. (2011) found that older adults living in an institution were in poorer condition than their counterparts living in a family setting. Elders in institutional care were liable to loneliness and even despair. Vitorino et al. (2012) conducted an epidemiological study of 77 older adult residents in two long term care facilities in Brazil. Although the residents were socially adapted to their environment, they had a low level of physical health, most often expressed by the appearance of chronic pain. Older adults in institutional care lose their autonomy which can affect their functional ability, often leading to declines in their quality of life.

Rashid and colleagues (2012) examined the attitudes towards aging among residents of a 200 bed elderly care institution in Malaysia. The study concluded that social support is an important influence on elders' quality of life which in turn has a positive influence on attitudes towards aging. Timonen and O'Dwyer's (2009) study of elders living in institutional care in Ireland revealed challenges such as the provision of undesirable or cold food, lack of variety in the food served, elders' sense of independence being overwhelmed by the institutional system, and lack of consideration of residents' needs. Even if there were many people around, residents had few opportunities to form friendships and limited contact with family, contributing to a lack of confidence. Other challenges faced by residents were lack of consideration by staff, developing a dependency syndrome, and minimal capacity to change the environment (Timonen and O'Dwyer 2009). A dependency syndrome may develop when institutional staff orchestrates the daily lives of residents and thus residents begin to see themselves as dependent, coming to expect others to meet their needs. Bartle (2007) defines dependency syndrome as an attitude and belief that a group cannot solve its own problems without outside help.

Through interviews with residents, relatives, and staff members, Habjanic (2009) investigated the quality of institutional care in Slovenia. Data were collected in three public and one private nursing home located in two major cities of Ljubljana and Maribor. Most nursing staff were found to be capable of meeting physical rather than psychosocial needs of residents. Residents expressed a desire for more communication with the staff beyond customary greetings. Some residents reported that the poor attitude of nursing staff may lead to lower quality of care. Residents perceived staff as either mentally exhausted or dissatisfied with their

work environment. Other factors residents identified that diminished quality of life were limited opportunities for leisure activity and for relatives to participate in care provision.

Exploring the psychosocial needs of older people in extended care settings in Ireland, Cantwell (2008) concluded that the psychosocial well-being of elders was affected by the views of old age by both society and the staff. During caretaking, elders are predisposed to caretaker thinking and outlook rather than their own interests. According to Cantwell, the relationship between physiological, psychological, and social processes determines elders' quality of life. Indeed, the elder's social condition is the primary determinant that will lead to the improvement of physical and cognitive functioning and thus quality of life.

In Ethiopia, a government study on elderly care (BOLSA 2002) reported that though old age homes provide basic care, such facilities are generally perceived as an unhappy place to live and that residents consider that it was misfortune that brought them to an old age home. In one of the few such studies in Ethiopia, Fasil (2010) explored the effects of institutional care on the social, psychological, economic, spiritual, and health aspects of residents in a care center on the outskirts of the capital city of Addis Ababa. Residents generally had good relationships among each other; however, their relationship with the surrounding community was twofold. Those engaged in a community association or "Tsiwa" had a good relationship with community members; others experienced disrespect and stereotyping. In terms of psychological well-being, residents had feelings of sadness due to loneliness, despair, sleeplessness, and depression. Most had vision impairment and a variety of chronic health issues. Economically, older persons experienced disappointment due to dependency on the government (Fasil 2010). Likewise, the Bureau of Labor and Social Affairs (BOLSA 2002) in Ethiopia acknowledged that due to the loss of social ties, institutional care may have a deleterious effect on the psychological and social well-being of older adults. With these issues in mind, this study examined staff and resident perceptions of the psychosocial needs of elders in institutional care in Ethiopia and current efforts to provide psychosocial support.

Setting

Currently in Ethiopia, there are three governmental old age homes found in Addis Ababa, Oromiya, and Harare (MOLSA 2006). The study setting was the Bet Selihome Older Adults Care Center in Oromiya. The Center is one of the oldest indigenous institutions in Ethiopia, established more than a century ago to provide care and support for elderly nuns. The Center has two sites –Chagelle and Bet Selihome–both in Oromiya National Regional State, Debra Libanos District which is about 105 km north of Addis Ababa. The two sites are about a 30 minutes walk from each other. The Center was first established by Emperor Minilik II in 1909, in response to Empress Taitu Betul's request on behalf of elderly women who needed a retirement center just as their male counterparts. The center cared for elderly women until 1913 when it was converted to a shelter for monks and nuns of the Ethiopian Orthodox Christian faith. When the Derg Regime came to power in 1974, the Ethiopian Rehabilitation Organization, under the Ministry of Labour and Social Affairs (MOLSA), took over the administration of the center and remained so until 1997. Currently, the Labor and Social Affairs Agency of Oromiya Regional Government is authorized to monitor the center to ensure that older people can lead dignified, active, healthy and secure lives (Teshome Cheru et al.1998). Though the Center was initially established to give care and support to elders who were monks or nuns, the current government stance is that the services should be provided to impoverished older adults who lack family support. Thus, current eligibility criteria emphasize financial need, not religion. Nonetheless, many residents self-identify as nuns or monks given that is the tradition

for this particular older adult care center. At the time of the study, 264 residents lived in the two locations. Each resident had arrived with a support letter from the local government administration and had been chosen from the poorest of the poor. Most came from the Debre Libanos monastery and surrounding areas. The Debre Libanos monastery is one of the most well-known monasteries in Ethiopia, tracing its history back to the 13th century.

The sole access to the Bet Selihome compound is an 8 km hike over steep rocky terrain from the Tekle Haimanot Church. Chagelle is 5 km from the church. Because of the mountainous terrain, there is no road access to either site. The name Bet Selihome is derived from a biblical word referring to a house for bathing with holy water. The buildings in the compound are named after former emperors, e.g., Tayitu, Menilik, Zewditu, and Haile Selasie. There are two kinds of service providers– those who receive a monthly salary, and those whose work is voluntary and considered a sacred service. These caregivers receive only food in exchange for work. Fifteen "food for work" staff and 67 paid employees serve 264 residents at the two sites.

The community surrounding Bet Selihome and Chagelle is a mountainous farming community. Most residents live at a subsistence level. A number of older adults were observed begging outside of the church and along the path to Bet Selihome. Some long-term residents of the area harbor ill will towards the Center due to the perception that the institution captured land that they could have used for farming. On the other hand, most of the staff rent homes nearby and have good relationships with other community residents.

Bet Selihome has a large compound full of trees used for firewood for cooking. There are 2 milk cows, an ox, 2 calves, 9 donkeys, and several chickens roaming the compound. Donkeys carry different legumes and cereals to the grinding house where the injera (traditional Ethiopian bread) and shirowot (bean paste) are prepared daily. The grounds are very uneven and rocky; there are no paved walkways. The sole entrance to the compound is a set of steep, crumbling rocky stairs cut into the mountainside. Three concrete buildings house up to 12 female residents; a few rooms were single or double occupancy. Most residents slept in rooms with several beds. Male residents lived in small buildings constructed of mud and straw; up to seven men shared a room. With the help of an individual investor, a medical clinic was built in 2010. Due to the lack of medicines and medical supplies, however, it is not fully functional. One building with a single room serves as a "recovery" area for frail older adults who need complete care and support since they are incontinent and immobile. At the time of the study, nine frail older adults were living in this room cared for by two caretakers working on a shift basis. Separate buildings in the compound are used for cooking and storage. There is also a small church ("Sehele Mariam") where the older adults go for prayer and devotion. Residents used a toilet facility separate from the sleeping quarters; it had an outdoor spigot with running water. Though the toilet facility is well built, the seats are flat and low to the ground and not comfortable for older adults especially for those with joint pain. According to the office, 181 residents resided in Bet Selihome and 83 in Chagelle. Of this, 198 were females and 66 were males.

Methods

To learn about the psychosocial needs and support of older adult residents, the researchers used observation, document review, key informant interviews, and focus group discussions. To facilitate access to study participants, the first researcher contacted the Oromiya Labor and Social Affairs Office to request a support letter. Purposive sampling was used to select residents who were willing and able to share their perceptions of their needs. Similarly, staff members were purposely selected to reflect the variety of perspectives of staff from the cook to the facility manager.

Observation and Document Review Observation helped the researchers to document the socio-cultural context and to gain insight about daily life in the older adult care center. To ascertain the feasibility of the study approach and its suitability for older residents, the first researcher spent 3 days and nights at the institution in April 2013, allowing a firsthand look at the environment and the opportunity to observe how the residents go about their daily lives, how they interact with staff, and how they manage their affairs. Both researchers visited the care center on two other occasions in April and June of 2013. Written documents such as the roster of residents, financial ledgers, and a written history of Bet Selihome were reviewed to provide background information about the facility, its residents, and its expenses.

Key Informant Interviews Key informant interviews were conducted with five staff members who had worked at the institution for at least 6 months including the manager, the sole nurse, older adult nannies, and cooks. Four staff members worked at Bet Selihome and one at Chagelle. Interviews were arranged at a time convenient to participants, usually late morning. Prior to each interview, the informant's understanding of the process was assured and verbal informed consent was obtained. Study participants declined to be tape-recorded. Staff were asked to share their perceptions of residents' needs, focusing on psychosocial needs, and of efforts to meet those needs. Interviews were conducted in Amharic and then transcribed into English.

Focus Group Discussions Inclusion criteria for the resident focus groups were: aged 60 and over, good mental health, and residing in the institution for a period of 6 months or more. Elders with cognitive impairment were excluded since such impairment may forbid them from giving valid consent (Decker and Adamek 2003). All the discussants resided in this institution for a number of years; one participant lived there for more than 40 years. In total, 24 older adults (13 women, 11 men) participated in three FGD–8 in each focus group. One focus group was all men, one was all women, and the third group which was held in Chagelle was a mixed gender group. To ensure participants' privacy and comfort, FGD were held in a private room in both settings. To promote discussion, chairs were arranged in a circle. Participants were welcomed and made to feel comfortable. The researcher explained that her role was to act as a facilitator, not a participant. Verbal consent was obtained from all participants. However, residents were not open to having the sessions tape-recorded. Guiding questions in each focus group included: What does aging mean to you? What is the nature of care and support you receive? What is the nature of your relationship with staff? With family? With the neighborhood community? What challenges do you face? Are you happy? How is life in the institution compared to your former life? What are your recommendations?

Initially, some participants were reluctant to engage in the discussion, waiting for someone else to speak. However, the group members frequently signalled their agreement with what others shared. The researcher probed for further discussion and invited the quieter members of the group to express their opinions. Each focus group lasted 60–70 minutes. To check her perceptions of the views residents shared during each focus group, the researcher ended each session with a brief summary.

Data Analysis Prior to analysis, the data were transcribed into English. Field notes were checked for accuracy and completeness. The researchers also engaged in memoing as part of the data analysis process, taking note of personal or conceptual reflections (Given 2008). The first author coded the data by systematically reading through each transcript to identify the factors, based on previous literature, thought to influence the psychosocial well-being of older adults in institutional care including: health, social, and psychological conditions, relations with staff, family and community members, and views on aging. Code numbers were assigned to each of these topics as they were identified in each transcript. In addition, other topics

emerged from the data such as the actual practice of care and religious practices. As new topics were identified and coded, the researcher returned to the previous transcripts to see if the newly identified topics had been missed during the initial analysis. The codes based on the literature and those that emerged from the data were compared, contrasted, and refined leading to the identification of five overarching themes.

Study Limitations Financial and time constraints were a challenge for this study. With the 3 hour drive round trip from Addis Ababa and the arduous 45 minute hike to and from the study site, visits to the facility took an entire day. Incidentally, the geographic isolation and physically challenging hike to the care center was identified as the reason government officials rarely visit the site. In addition, participants' religious beliefs likely impacted the nature of information they shared with the researchers. Since the residents were mostly nuns and monks, they did not want to complain about their living conditions. Participants' disadvantaged backgrounds also likely shaped their perceptions as some acknowledged that if they were not in the care center, they would likely be begging on the streets. Furthermore, as the method of the study was mainly qualitative and the recruitment approach was purposive, findings cannot be generalized to other older adults living in institutional care but may inform or be transferable to similar contexts.

Results

The results are presented according to the five overarching themes that emerged from the data: gratitude for shelter despite inadequate provisions, lack of professional care, a strong desire for meaningful social interaction, the centrality of spiritual coping, and old age as a blessing. Before describing each theme, a brief summary of the institution's financial resources is provided.

Financial Resources Bet Selihome provides basic care for 264 older adults including food, clothing, shelter, and minimal health services. The total budget allocated by the Labour and Social Affairs Agency of Oromiya Regional Government for 2013 was 2,783,307 birr (146,954 USD). This budget was for all expenses including salaries, materials and services, maintenance and repairs, contractual service, construction material, electricity, water and telephone service. The annual expense for health supplies and consumable utilities was 35,000 birr (1,848 USD). The food budget was 1,433,375 birr per year (75,679 USD) which breaks down to 5429 birr (287 USD) per person annually, or 78 cents a day per person. The manager acknowledged that the severely restricted budget forbids the provision of holistic care to residents:

> We know these are older adults that need care. We serve them with what is available and what is there. This is budget -centered care. We cannot afford all they need, and that compromises their physical, emotional, social, and psychological well- being.

Gratitude for Shelter Despite Inadequate Provisions: "I Eat to Survive." Residents' daily menu consists of a small portion of "dabe" (a kind of bread) for breakfast, one "injera" with "shiro wot" at lunch time, and the same for dinner. Meat is served three times per year on New Year's, Christmas, and Easter. No fresh fruit or vegetables are provided on a regular basis. Residents occasionally use their own onion, oil, and spices to enhance their food. Residents can purchase 1 liter of cow's milk for 5 birr (about 18 cents). Since the residents have few resources, many cannot afford milk unless a visitor buys it for them.

Clothes and shoes are provided once a year. Residents who are able-bodied wash their own clothes and clean their own living space. Caregivers are mainly assigned only to the frailest elders. Caregivers generally do not receive any training. They assist frail elders with eating, showering once a week, washing their clothes, and managing incontinence.

Most of the residents are nuns or monks who have been staying in the center for a long time and do not want to complain about their living conditions. They are grateful because the organization saved them from being out on the street as beggars. Thus, they expressed appreciation for the support and care they received; however, a need for something to look forward to was evident. Despite the reluctance to complain, one resident stated with despair:

> I do not feel hungry or thirsty. I eat to survive. But, I don't think we are receiving a balanced diet that is needed for older adults. We always get ½ of dabe for breakfast, one injera with shirowot for lunch and the same for dinner. This seems to be proportional to the capacity of our country.

According to a staff member:

> In this institution most conditions should be improved. Especially, their meal menu must get emphasis. Older adults' physical power becomes weak due to age; they need body-building foods.

The facility manager acknowledged:

> They need more care than they are currently receiving. I never blame them when the residents shout at or insult me due to their injera being thin or different from before.

One caregiver shared that the difficulty of getting a balanced diet leads frail older adults to complete nervousness:

> Older adults with frailty are like children; they had loss of appetite and need food that suits them. I saw how much they become happy with changing their diet; they choose a variety of foods instead of the same items. But, we were informed from the office, there is shortage of budget for different food items. We might get such luck when some visitors brought some item of food for the sacred business; really they become happy.

Older adults explained that the primary benefit they receive is shelter; food is a lesser priority.

Even if residents express contentment with their living conditions, they note that the support they receive has been decreasing over time. The lack of sanitary material, tea and sugar, and the difficulty of getting clothes and shoes were noted by residents. An effort was made to provide more nutritious diets for two residents who were on ART for AIDS; however, the effort did not succeed due to budget constraints.

Lack of Professional Care for Physical And Mental Health: "No One Looks After You." The ten top health problems among the residents were arthritis, pneumonia, diarrhea, gastritis, urinary tract infection, conjunctivitis, anemia, upper respiratory tract infection, hypertension, and injuries from falls. Many of the residents had vision and hearing problems. Residents acknowledged their liability to hypertension and need for regular blood pressure checks. They struggled to get even basic medicines such as eye drops and pain reliever.

Residents who become ill were treated in the clinic which is staffed by one nurse. The nurse's limited experience and knowledge did not allow him to use all medicine properly. He wished to see greater use of physician and laboratory technicians in the clinic. Seriously ill residents may be referred to governmental hospitals, i.e., St. Paulos and Black Lion in Addis Ababa. However, the center does not provide a transport allowance; residents have to pay their

own way. According to the nurse, there were five psychiatry patients under treatment for almost twenty years including one who received a monthly injection. The older adults were dissatisfied with the medical treatment and nursing care available in the compound. There was a lack of medical instruments for diagnosing illness and a shortage of health professionals. Nevertheless, some residents expressed the value of holy water in treating their illnesses.

During the discussion with the residents about mental health, most confirmed having problems with forgetfulness. Some acknowledged problems with dementia. One female discussant expressed particular dissatisfaction with the living circumstances which affected her psychosocial well-being. The resident seemed depressed about the lack of medical intervention:

> You see, I know that old age had a consequence on our physical power but, it was not like this; I was diabetic before I came here, I could not get the investigation (medical diagnosis) and medicine here. This affects my ability to work and to interact with my friends and I feel tension in my head.

Depression is common, particularly when residents first arrive. The nurse explained that some residents sit for the whole day in one place without moving and he viewed this as depression. Others are restless, moving around the compound frequently and he labelled this anxiety. The absence of visits from government officials and the lack of meaningful interaction with the staff were also factors perceived to contribute to depression and anxiety. One resident explained sadly,

> You know you get up in the morning; no one from outside greets you, no one looks after you….oh!! I consider myself just like one of the household items. I do not feel like I am a human being. I also fear for my futurity.

One focus group discussant mentioned the negative consequences of conflict among residents:

> We cannot say that we always suit each other; sometimes we quarrel which we do not know the cause. For me this is a big challenge to live in this institution and to call myself a religious person. This condition disturbs our social relations and gives us trouble with our mental health.

There is no social worker or other staff person whose primary role is to enhance residents' social interactions and psychosocial well-being.

A Strong Desire for Meaningful Social Interaction: "We Prefer Greeting Rather Than Eating." Residents recognized the value of social interaction and repeatedly expressed a need for meaningful interaction with their caretakers. Though residents noted a mutual respect between residents and staff, they expressed a need for "deep relationships beyond greetings." Due to the lack of meaningful social interaction, nervousness, anxiety and depression were noted as common among residents. For their part, staff shared that they did not have the luxury of time to spend interacting with residents.

Though minimal, the meaningful interaction between staff and residents was perceived to be beneficial to residents' psychosocial well-being as such interactions facilitated the formation of relationships and promoted fulfillment of individual potential through the enhancement of residents' abilities. As one staff member shared:

> I think that it is good if we talk to them, good morning is a big thing for them, you know I can still do that…one day a frail older adult who became incontinent told me, she will get relief and can control her urine when she came to me for greeting. I think greeting is more of psychological reassurance that had value in their life.

The institution made various efforts to fulfill the residents' need for psychosocial support. In order to make residents feel part of a home-like environment, the staff prepares traditional ceremonies on major holy days according to Ethiopian culture. Offering local drinks and traditional holiday foods and congratulating the residents for welcoming the holy day are a source of pleasure for residents. A staff member shared that traditional morning greetings added considerably to residents' happiness. Residents acknowledged their desire to be greeted properly, i.e., in a respectful manner according to Ethiopian custom. One focus group participant shared, "we prefer greeting rather than eating."

Another way the institution provided psychosocial support was by arranging the residents in groups for discussion. They sit in groups of 3 and 4 to chat together. The manager noted that group discussion seems to be cognitively stimulating, socially rewarding, and psychologically beneficial:

> Oh, they get to chat and they got to talk, and to be honest with you I think it stimulates their brain as well.

One caretaker shared:

> They have their advantage because they are in a group; they feel that actually they are doing something together. I noticed a huge difference between when they are alone or in a group. Psychologically, it may give them a little lift; I noticed that they become more relaxed.

When some volunteers come to visit, the institution gives them permission to choose one older adult to take care of for 15 days for blessing purposes which is referred to as "BaleTesfa" (hope for blessing). Sometimes residents request a leave to visit their family. Their request is reviewed by the staff and if it is determined that they are healthy enough to make the trip and they have the resources to go, they are permitted to go visit their family.

The residents noted that the activities they performed in the compound such as helping the staff with preparing wood for cooking, preparing different food items, and gardening had a huge benefit for their physical, social and psychological health. The government official in the Oromia Labor and Social Affairs Office mentioned the importance of such daily activities in older people's lives. She noted if there is a garden and a compound to reproduce hens, this was valuable for elders' physical, psychological, and social health. Such activities are also helpful for income generation.

When recalling their former lives, residents consistently noted their sadness, especially the painful memories connected to the death of their children. As one female resident shared:

> I came to Bet Selihome in 1984. I had 2 children; one was military and the other one was a student which still I do not know where he is now. My eldest son came to Bet Selihome after the falling down of Derg regime and he was employed as a driver. It was a big blessing for me; I thought I am the most luckiest lady in this world. I cannot tell you how much I was happy. I discussed everything with him; he was nearby to me at any situation. He used to visit me frequently. Unfortunately, he died 7 years back; starting from those days for me life is meaningless; no happiness; I feel severe headache. When I am thinking about him I do not want to talk with anyone.

As she shared this story, she burst into tears. Likewise, a male resident shared,

> I decided to be a monk after the accidental death of my second child of three. Then I prefer to be far away from this world and I came here…."

One resident without children mentioned the benefits of the Care Center:

> I don't have children; nobody can take care of me. I seek care during the time of sickness and death. Consequently, I prefer to come to this retirement center; here, I am happy.

> Now I consider having someone beside me…you see this institution has tremendous advantage for those who are poor and childless. For me this institution is like a paradise.

Residents explained that they lived in the institution due to low socioeconomic status and lack of family support. They described themselves as a group of people who are far away from modern life who became nun and monks to live in a spiritual way. However, residents highlighted the need to be visited by their family. Most discussants felt sad about the lack of visits with their family, and some shared that they did not have any information about their family. One elder woman shared:

> What our family can do for us? We are here because we don't have family support. Regarding me, all 7 of my children have died. I had another 3 grandchildren… you know, they are working as a housemaid; I do not want to blame them, since they are also poor.

During an individual interview, a caretaker shared the view that if the older adults were not poor, they would not be interested in being institutionalized:

> To tell you the truth, they prefer to be in a home environment. I saw some of them become happy for long time after they have a visit from their family. I recognized most of them were depressed and sad due to the lack of family visits. Sometimes they talk to themselves–'Oh!! I had a child but I become like this.'

The residents seek family interaction not only for emotional support but also to get updates about their relatives, friends, and former comunities, and if possible, financial support as they have no other source of support. Hence, family interactions, though infrequent, were considered an important avenue for enhancing older adults' quality of life.

Comparing life in the retirement center with life in a home environment, most discussants expressed a preference for family life. However, some residents shared that with the institution responsible for providing food, shelter and clothing, they did not worry about their most basic needs being met. They stated that if they were in their own home it would be tiresome because of the continuous effort to fulfill their basic needs. Nevertheless, as one female focus group discussant stated:

> Who will not be happy if he has his own home and property, and gives order to his own belongings?

In an informal discussion one staff member stated:

> What else do they need? They are on retirement, they must be happy because they live without any effort. The organization is responsible for organizing everything for them. They have to pray for us since they are at the end of life.

Caregivers spoke of their inability to fulfill psychosocial support needs due to its low priority in their daily tasks:

> …physical care seems to be what's priority, and emotional, social and psychological part is neglected a little bit.

Workloads were continually mentioned by caregivers to be a significant impediment to the fulfillment of residents' psychosocial needs:

> ….we do not have the same amount of time as them. We cannot be forced to chat with older adults. We know that they want us to sit together and we could have a conversation with them. But, it is impossible.

In considering the broader aspects of the value of social interaction with the neighborhood community, the residents shared that they did not have a good connection with the neighborhood community. Some shared that they were treated with disrespect. Interactions were sometimes unpleasant and tension-filled. One focus group discussant described the poor attitudes of the neighboring community:

> …oh, I cannot tell you how much they consider us the poorest of poor lives without dignity. Before we started getting our pipe water in the compound, we used to fetch water together, but with priority for them; if we did not do so they insulted us, "Eh you poor, comes from another district for charity!" ('METHIE'). For me, this is the most painful word.

Though some residents desired more interaction with members of the surrounding community, they were afraid to approach them. One key informant shared that community members considered the land around the retirement center as their property and assumed that the institution captured their land. In contrast, during individual interviews a few residents shared about good communication with their neighbors, because most employees live in the surrounding community. The informant shared that they used to visit neighborhood homes during times of illness and births as is customary in Ethiopia. One older adult shared that he had good communication with the neighborhood community as he had done committee work with them in the past.

The centrality of spiritual coping."To pray and to live in the will of God is our main leisure activity." Throughout the focus group discussions, residents acknowledged that their satisfaction with life in the institution was primarily a reflection of their spiritual beliefs and practices. Several residents shared that they are living with the spirit of God–"our aim is to serve the Ethiopian people and our country through praying and to be blessed." Caregivers also articulated the value of religion as a means of meeting residents' need for psychological support. As one caregiver shared:

> We saw sometimes bizarre behavior in them; the best solution was to advise them in relation to a biblical story…aha this is it, they become calm; you should accept every life change because you got a reward from God.

When asked about their leisure time and what they enjoyed, almost all the older adults responded by laughing. As one respondent explained:

> Our purpose is not enjoyment. To pray and to live in the will of God is our main leisure activity that makes us happy. We forgot everything when we came into the church.

In general, residents' positive outlook was found to be associated with personal faith and spirituality. All discussants referred to their faith at some point during the discussion. One female resident explained the outlook she adopted in order to cope with significant loss in her life including the loss of her spouse, children, and her home:

> Most of us were wounded with our past life, I think when God has chosen you for a special purpose he did everything you do not like it. Finally I am here to pray and to be happy. God will not leave you idle.

A staff member shared a story of a resident who coped with loss using spiritual practice:

> There was a family living in high quality with comfortable life; they had one son who was a medical doctor. Unfortunately, he died in a car accident, and after 6 months their home was burned down by fire. Consequently, the older couple was obliged to be

> institutionalized in Bet Selihome. The aging mother could not cope with this situation and became sick and died. Then the old man was left alone. This situation made him mentally ill. He used to do specific work twisting rope for the whole day and night. He stopped talking with anyone. Finally, as a coping mechanism we advised him to become a monk. Then, he changed totally and became normal. You see, the religion and faith saved him.

Spiritual activities had special meaning in the elders' daily life. Praying, fasting, going to church and reading (if they can) or hearing someone preaching are some of the activities that helped them to accept their living conditions. Residents were eager to have someone read the Bible to them since most cannot read and write.

Since they devoted most of their free time to praying, residents had limited chance to use humor in their daily lives. The sense of being religious hindered them from indulging in humor and joking. However, on one visit to the compound a male resident invited the researchers into his mud hut with a sweeping arm gesture and an unexpected greeting, "Welcome to the Hilton!"

Male residents confirmed that listening to spiritual songs had a valuable impact and was considered a delightful leisure activity. A staff member shared that when older adults become depressed, religious instruction helps them to be calm. The manager who is also a monk offered such instruction on occasion. The use of holy water is acknowledged as a primary form of treatment for illness. As one resident stated:

> Why should we seek medical service rather than God's support? Holy water is our medicine.

Almost all of the residents pointed out that their spiritual activity helps not only themselves but all Ethiopian people. Furthermore, they explained "we are on the way for end of life; hopefully with our praying God will protect and save our people and our country." They expressed confidence in God's blessings.

Several residents explained that they no longer go to Tekle Haimanot church due to the high risk of falling and sight problems. Nevertheless, they have their own smaller church near the compound, where they practice their religious activity. Caregivers also acknowledged the significance of spirituality and faith in the life of the institutionalized elders.

Old Age as a Blessing: "Aging is a Gift of God." Participants' views of aging largely reflected their deep spirituality and were typified as, 'Age is a blessing someone receives as a gift from God.' Despite their living conditions, most residents replied that long life is best. In contrast, one resident shared:

> I am 70 years old. At this time, I do not feel like healthy person; I cannot walk as I want, I feel so tired; I consider that I am living in a hard situation; these days, life for me is not pleasant; I stayed the whole day in my bed. After all this circumstance, I do not deserve to live a long life. Age of 60 is enough for any individual.

Similarly, a key informant stated:

> I do not think that they are in comfortable situation. When I saw old adults with frailty become completely dependent; I never wish extended age.

One caregiver expressed the value of lessons passed on by residents:

> Aging is a gift of God; I got many valuable lessons from the older adults residing in Bet Selihome. They are full of knowledge; their experience teaches me a lot of things. Older adults' proverbs and tales had tremendous influence on my conception about the world.

Despite the daily challenges they faced, most of the residents who were interviewed maintained a positive view of aging.

Conclusion

This study explored the daily lives and psychosocial needs of older adults in residential care in Ethiopia from the perspective of both staff and residents. Despite the unique environment of this particular institution in Ethiopia, the findings of this study mirror results from other countries in relation to the desire for meaningful interaction with staff and the importance of family support. The centrality of spiritual coping was also evident. As in other countries (e.g., Habjanic 2009), long term care residents in Ethiopia reported social contacts as the most important factor promoting quality of life. As elsewhere in the world, the residents and staff in Ethiopia reported that residents' basic physical needs were given priority over psychosocial needs. Unlike in developed countries, however, staff received no training on meeting the psychosocial needs of elders. Consequently, social interaction was both undervalued and underutilized by staff members and thus, residents' psychosocial well-being appeared to be at risk. The Ethiopian elders faced many conditions that exacerbate depression in older adults as identified by Lucas (2009), including loss of status, loss of loved ones, poor health conditions, economic inactivity, limited community support, and poor medical care.

The older adult care center in Ethiopia was very resource poor and lacked even basic amenities such as soap and toilet tissue. The destitute circumstances impacted residents' social and psychological well-being both directly and indirectly. Several residents indicated dissatisfaction with the provision of the same items of food every day. Similarly, Timonen and O'Dwyer (2009) found that institutional care presented challenges in daily living for elders, such as the provision of undesirable or cold food or a lack of variety in the food being served. The Ethiopian elders appreciated having shelter, but had little to no resources to buy "extras" such as milk, spices, or oil or to pay for transportation to a medical facility. In terms of health care, residents were displeased with the unavailability of diagnostic instruments. Frail older adults who were immobile and incontinent did not receive any medical assessment.

Despite their bland and unchanging diet and lack of medical care, residents emphasized the need for more meaningful social interaction. This theme is consistent with results from another qualitative study that identified meaningful social interaction as a key component of institutionalized older adults' perceptions of "home" (Lewinson, Robinson-Dooley, and Grant 2012). The residents' acceptance of aging as a gift from God seemed to help them tolerate their living conditions. Taken as a whole, the present findings point to connection with family members, meaningful interaction with staff, engagement in different activities, a feeling of being respected, group interaction, and older adults' spirituality as sources of psychosocial support to long term care residents in Ethiopia.

Although the elder residents had diverse skills and experience, they were largely segregated from the surrounding community. To fulfill the national plan of action on aging (Government of the FDRE 2006), policy planners should consider ways of harnessing older adults' knowledge and skills to build connections with the community. Such connections may provide a way in which the older adults can continue to derive pride and psychosocial well-being from productive and meaningful roles. A starting point might be reaching out to the three local NGOs working on behalf of older adults that were observed on the hike to Bet Selihome. Programs that build on the skills of residents would also create opportunities for intergenerational learning. In most developing countries, older people were formerly farmers, small

traders, traditional healers, and domestic servants. The knowledge and skills of such older adults are largely unrecognized by policymakers and they are too often stereotyped as helpless or passive recipients. The realities of their day-to-day lives go largely unobserved. However, many older people are resourceful survivors, and are able to contribute to the well-being of their families and communities (MOLSA 2006). Social workers can lead the way in developing opportunities for long term care residents to become involved in civic engagement (Anderson and Dabelko-Schoeny 2010).

In many countries social workers have multiple and important duties in long term care centers (Perrin and Polowy 2008). The addition of social workers in institutional care in Ethiopia must be emphasized to promote improved living standards with the recognition of principles such as awareness of the worth and dignity of each individual, treating each individual with respect, creating an atmosphere of growth for residents, adopting a holistic perspective by recognizing the dynamic interplay of social, psychological, physical, and spiritual well-being, and advocating for a physical environment that is supportive rather than challenging to the individual. Such efforts will help to foster a positive self-image for residents through promoting continued social contact, decision-making opportunities, and independence (Perrin and Polowy 2008). Ideally, "the everyday life of the care setting is one in which residents play creative, active and meaningful roles" (Tester et al. 2003, p. 111). Importantly, social workers can train staff about the value of psychosocial support for improving residents' overall well-being. Several of Conradie's (1999) recommendations for improving institutional care for elders in South Africa could be applied in the Ethiopian context, including, developing and offering training to caregivers, an ombudsman office, public awareness campaigns, an institutional bill of rights for residents of old age homes, and community involvement in institutional care.

In addition to ensuring that residents' psychosocial needs are met, social workers and other helping professionals can empower residents to seek care and support not only from the onsite staff but also from government authorities. Advocacy is needed on behalf of residents to establish guidelines on care and support of residents in old age homes. The Ethiopian Developmental Social Welfare Policy of 1996 stated, "The state shall create conducive environment in order that the elderly are provided with special respect and care, and specially in order for elderly persons without support and pension to receive appropriate care and protection" (MOLSA 2004 as cited in CSA 2011). Social workers should strive to ensure that such policy is implemented, with due recognition of older adults residing in institutional care. Drower's (2002) challenge for social workers in South Africa seems pertinent:

> Faced with widespread poverty, enormous backlogs in service provision, increasing need and economic stagnation, South African social workers are challenged to fulfill new functions and develop more appropriate roles with respect to [the older adult] client group, and not to mimic functions and roles relevant in other parts of the world. (p. 13)

Based on an analysis of social protection programs for older adults in three developing countries including South Africa, Lloyd-Sherlock (2002) concluded that "obliging elders to live in sub-standard nursing homes represents [a] reprehensible form of social exclusion" (p. 708). Institutional mechanisms are needed to support residents' psychosocial well-being, including supporting family leaves, promoting care and support from volunteer visitors, and offering a variety of activities in the compound.

In Ethiopia, the main contributing factors to institutional living are poverty and lack of family support. Residents expressed a preference to live in a home environment with family. Thus, along with improving the support system within institutional settings, services are needed to enhance families' capacity to care for elders. Such services are largely non-

existent in Ethiopia. In developing countries, "bridging the gap between state provision and family support is particularly relevant in contexts of relative resource scarcity and rapid socio-cultural change" (Lloyd-Sherlock 2002, p. 711). Initiatives that promote income-generation among physically capable elders might also prevent premature institutionalization.

As in other parts of the world, the projected increase in the aging population in Ethiopia will fuel a growing need for long term care of frail older adults. The United Nations estimates that the number of adults 60 years and older worldwide will outnumber children under the age of 15 by 2045 (IFSW 2012). The rising number of older adults will generate new opportunities for both individual and societal growth. In order to improve the well-being of older adults, and to combat ageism that forbids older people from living with dignity, realizing their full potential, and accessing resources, aging-relevant social and economic policies, services, and research are needed. In this context, social workers can make a major contribution by advocating for "aging-friendly" policies and programs (IFSW 2012). A professional association of helping professionals committed to enhancing the lives of elders should be established in Ethiopia to strengthen and promote advocacy efforts on behalf of elders, especially those who lack family support.

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