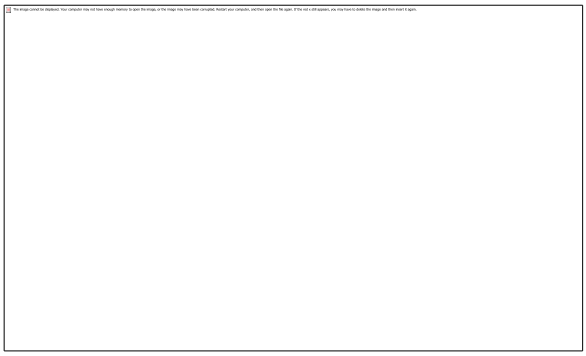
# LIVING PRACTICE OF PERSONS WITH DISABILITY IN OLD AGE IN HOD AMAL CARE CENTER AASHIKMA -5 MAALE ADOMIM, ISRAEL



**A Thesis Submitted to**

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**Submitted by:**

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## Letter of Recommendation

This is to certify that the thesis work entitled **"Living Practice of Persons with Disability in Old Age in HodAmal Care Center Aashikma-5 MaaleAdomim Israel"** has been prepared by Babu Ram Bayalkoti under my supervision. Therefore, I forward this thesis for its final evaluation and approval as per the rules of the department.

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## Approval Letter

This is to certify that the thesis work entitled **"Living Practice of Persons with Disability in Old Age in HodAmal Care Center Aashikma-5 MaaleAdomim, Israel"** prepared by Mr. Babu Ram Bayalkotihas been accepted for partial fulfillment of the requirements of the Master's Degree in Sociology by the evaluation committee.

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Date: February 2025

Babu Ram Bayalkoti

## Declaration

I hereby declare that the present thesis entitled, **"Living Practice of Persons with Disability in Old Age in HodAmal Care Center Aashikma-5 MaaleAdomim, Israel",** is my original work done for partial fulfillment for the requirement of the degree of M.A. Central Department of Sociology, T.U. under supervision of Prof. MadhusudanSubedi. All the ideas borrowed from the different authors are well acknowledged. The result of this thesis has not been presented or submitted anywhere else for the award of any degree for any other purposes. I assure that no part of the content of this thesis has been published in any forms before.

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Babu Ram Bayalkoti

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## Abbreviation

ADL: Activities of daily livings

ADA: Americans with Disabilities Act

UNCRPD: United Nations Convention on the Rights of Persons with Disabilities

NII: National Insurance Institute

UKL: United Kingdom

ICF: International classification of functioning

ICFCH: International classification of functioning, disabilities and handicaps

WHO: World Health Organization

CRDP: Convention on the rights of persons with disabilities

UNDP: United Nations Development Programme

IRP: Insolvency resolution process

GBD: Global burden of disease

SAARC: South Asian Association for Regional Cooperation

# CHAPTER I

# INTRODUCTION

## 1.1 Background of the Study

The thesis focuses on the experiences and daily practices of elderly individuals with disabilities residing in a care center. It examines the unique challenges they face, including physical, emotional, and social aspects of their lives. The study aims to highlight the impact of the care environment on their well-being, autonomy, and quality of life. By exploring the interactions between residents and caregivers, the research sheds light on the effectiveness of care practices and identifies areas for improvement. This thesis contributes to understanding how tailored care practices can enhance the living conditions of elderly individuals with disabilities, promoting dignity, independence, and social integration within the care center setting. Through qualitative analysis, the study provides valuable insights into the lived experiences of this vulnerable population, informing policy and practice in elder care services.

This research focuses on how these individuals manage their daily activities, interact with caregivers, and cope with challenges related to their disabilities. The study aims to highlight the impact of care practices on their autonomy, dignity, and overall quality of life. By understanding these living practices, the research seeks to improve care strategies and enhance the well-being of elderly persons with disabilities in institutional settings.

In old age in HodAmalcare center Aashikma-5 MaaleAdomim, Israel Within this nurturing environment, each resident with a disability is embraced as a unique individual with specific needs, preferences, and abilities. The care center operates on the principle that aging with a disability should not diminish one's quality of life but rather be met with compassionate support and innovative solutions to promote independence and well-being. At the heart of the care center's approach is the development of personalized care plans tailored to the distinct requirements of each resident. These plans are crafted through collaborative efforts between the resident, their family members, and a multidisciplinary team of healthcare professionals. By considering factors such as mobility limitations, sensory impairments, cognitive challenges, and psychosocial needs, these plans serve as comprehensive roadmaps for providing optimal care and support.

The perception of old age as a social problem rests upon the assumption that older persons are in some way separate from those who are not yet old that the aged and the non- aged are two different categories in human beings. Older persons are seen as segregated from society, producing a gap that must be bridged, while at the same time recognizing the particular needs and contribution of this group. This is manifest in the vocabulary on how older people can 'contribute to society' or alternatively whether they contribute 'a burden of old age'. Economically, older persons are often viewed as non-productive and therefore incapable of contributing to society. Thought impairment was seen as a prerequisite of disability ( Finkelstein, 2001a, p.8), at the heart of this social interpretation was a conceptual severing of any causal connection between impairment and disability: Disability is something imposed on top of our impairments by the way we are unnecessarily isolated and excluded from full participation in society. Disabled people are therefore an oppressed group in society. (UPIAS, 1976, cited in Finkelstein, 2001b, p. 1)

Care and support needs are intimately tied to the elderly with disabilities. As we all know that advancing age results in increasing problems and impairments in the psychosomatic and behavioral aspects. It also leads to the incidence of disabilities that affect the overall functioning of the person. So in the case of the elderly, sixty years and above they have issues related to physical movements, inability to do daily activities, and always shows dependency on others for satisfying their basic needs. A new estimation reported that half of the older people who are above sixty to sixty-five residing in the UK are having prolonged physical and psychological health problems [Office for National Statistic UK 2014], which shows they need continuous care and support throughout their life. Studies also highlighted that among them 20% of men and 30% of women are seeking help to do their Activities of Daily Living (ADL) [DandekarKumudini 1996]. It indicates that there will be a change of increasing the number of percentages in upcoming years.

Social production of disease/political economy of health refers to related (if not identical) theoretical frameworks that explicitly address economic and political determinants of health and distributions of disease within and across societies, including structural barriers to people living healthy lives. These theories accordingly focus on economic and political instructions and decisions that create, enforce and perpetuate economic and social privilege and inequality, which they conceptualize as root or "fundamental" causes of social inequalities in health. Although compatible with the eco-social theory of distribution, they differ in that they

do not systematically seek to integrate biological constructs into explanations of social patterning of health (Parker and Gagnon, 1995).

Materialist, or structuralism explanations of disease emphasize those social, political and economic factors beyond the control of individuals and which adversely affect their health. These factors range from the large-scale physical organization of the urban spaces that we live in, the way in which the hazards and pollutants of industrial and dockside areas are concentrated, to lead poisoning along industrial highways, and to the more local problems of isolation both socially and from health services because of a lack of access to transport. As individuals we are born into a society with a material structure that pre-exists us, shapes our aspirations, and limits or enable the pursuit of our goals. A review of materialist evidence for the causes of disease, that is an account based on social organization rather than the individual or biology, is presented. This is followed by an examination of socio-economic status and then of class analysis as explanatory framework for health inequalities (White, 2002).

The international classification of Functioning, Disability and Health (ICF) advanced the understanding and measurement of disability (WHO, 2001) which was developed through a long process involving academics, clinicians, and importantly, persons with disabilities (Bickenbach et, al., 1982). The ICF distinguishes between body functions (physiological or psychological, e.g. vision) and body structures (anatomical parts, e.g. the eye and related structures). The ICF also emphasis environmental factors in creating disability, which is the main difference between this new classification and the previous International Classification of Impairments, Disabilities and Handicaps (ICIDH). In the ICF, problems with human functioning are categorized in three interconnected areas namely impairments, activity limitations and participation limitations. Impairments are considered as problems in body function or alterations in body structure such as blindness or paralysis. Activity limitations refer to the difficulties encountered in executing activities such as walking, eating, etc. Participation restriction are problems while involve any area of life, such as facing discrimination in employment, transportation, etc. Hence, in this context, disability indicates the difficulties encountered in any or all three above mentioned functioning issues. The ICF can also be used to understand and measure the positive aspects of functioning such as body functions activities, participation and environmental facilitation. Disability generally arises due to the interaction of health conditions with contextual factors, such as environmental and personal factor.

A person have with a physical, mental, intellectual (including cognitive) impairment, either temporary or permanent which substantially limits a person's ability to function in one or more main areas of life. Disability in old age encompasses physical, sensory, cognitive, and mental health issues, often resulting from chronic diseases, injuries, and lifestyle factors. It impacts independence, social interactions, and quality of life. Effective management includes medical care, rehabilitation, assistive technologies, and social support, emphasizing prevention and comprehensive policy initiatives.

Disability is a significant global issue, affecting over one billion people, or approximately 15% of the world's population, according to the World Health Organization (WHO). Disabilities can be physical, intellectual, sensory, or psychosocial, and they impact individuals' quality of life, social participation, and access to resources. Governments and organizations worldwide have developed policies and support systems to ensure inclusion and accessibility for persons with disabilities.The global response to disability varies significantly based on economic, social, and political factors. Many developed nations have established robust healthcare systems, social welfare programs, and legal frameworks, such as the Americans with Disabilities Act (ADA) in the United States and the European Accessibility Act in the European Union. In contrast, low- and middle-income countries often face challenges in providing adequate services due to financial and infrastructural constraints (WHO, 2023)

International efforts, including the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), emphasize equal rights, accessibility, and the integration of people with disabilities into all aspects of society. Despite these efforts, many individuals with disabilities still experience discrimination, limited educational and employment opportunities, and inadequate healthcare support.Israel has made significant advancements in disability care, with a well-structured support system that includes government, non-governmental organizations (NGOs), and private initiatives. The country follows a holistic approach, emphasizing medical, social, and vocational rehabilitation.Israel has enacted several laws to support people with disabilities, including the Equal Rights for Persons with Disabilities Law (1998), which ensures accessibility, employment rights, and social inclusion. The National Insurance Institute (NII) provides disability benefits, rehabilitation services, and vocational training for individuals with disabilities.

Persons with disabilities in Israel face a mix of progress and challenges. While Israel has made significant advancements in policy and care systems, accessibility, inclusion, and equal opportunities remain key concerns. Many individuals with disabilities still struggle with social stigma, employment barriers, and insufficient accommodations in public spaces. Access to education and employment remains a critical issue, as persons with disabilities often encounter difficulties in securing jobs that match their skills. Although supported employment programs exist, they do not always cover all individuals' needs. Additionally, healthcare access and long waiting times for rehabilitation services pose challenges for persons with disabilities who require specialized care.Israel has shifted towards community-based models, emphasizing independent living and social participation. Programs such as supported employment, accessible housing, and inclusive education initiatives aim to integrate persons with disabilities into mainstream society. NGOs like Bizchut and the Israeli Association for the Advancement of Children with Disabilities work actively to promote rights and inclusion (Bizchut, 2021).

In Israel, approximately 20% of the elderly population, aged 65 and older, experience some form of disability. These disabilities often include mobility issues, chronic conditions, and cognitive impairments such as dementia. The National Insurance Institute provides financial support, and about 40% of elderly individuals receive home care services. Israel's healthcare system, alongside community services like day centers and support groups, aims to enhance the quality of life for older adults with disabilities. However, socio-economic disparities still pose challenges, necessitating ongoing efforts to improve access to care and support for this growing demographic. Here are some types of disability to involve old care centers in Israel.

Types of Disability

1. Physical disability: Physical disability indicates any physical limitations or disabilities that inhibit the physical function of one or more limbs of a certain person. In the Israel data report 2012 most of people physically disability in the working age population.

2. Mental health disability: A mental disability is a psychological condition that limits a major life activity in some way or requires special services. Mental disabilities can be caused by biological factors, environmental factors, substance abuse or brain trauma. Most individuals still felt uncomfortable seeking referral to mental health services through the public health system.

In the mental functions of the elderly with disabilities, it emphasizes the psychological issues they faced during the time of daily activities and also the stressful situations the elderly with disabilities faced when they have not received any care and support assistance. During the time of diagnosis, treatment, and medications elderly with disability are facing lots of psychological problems due to the inefficiency, unawareness, and also incapability to identify available needs and services in society [Tkatch, R. 2017]. Some of the studies explained that due to the disability and inability to move and also the low economic background resulted in ignorance on the part of health care professionals [Grundy E, Glaser, K. 2000]. Other psychological problems affected by elderly with disabilities are anxiety, fear, stress, headache, concern about the future, and severe fear. There are several studies systematically scope the negative feelings expressed by the respondents due to their inability to do their activities by themselves and always needing assistance and support for satisfying basic needs. The majority of the respondents have a severe fear of being a burden to others [Strout, K. 2018].

3. Cognitive disability: Problems with a person's ability to think, learn, remember, use judgment and make decisions. Cognitive disabilities can detrimentally impact the functional skills of a person in the realms of interpersonal communication, problem-solving and comprehension, as well as many other psychological and social processes.

4. Visual impairment: Vision impairment occurs when an eye condition affects the visual system and its vision functions. The age-standardized rate of legal-blindness in Israel per 100,000 residents decreased from 15.76 in 2009 to 11.83 in 2020.

5. Hearing impairment: a person who is not able to hear as well as someone with normal hearing-hearing thresholds of 20 dB or better in both ears, is said to have hearing loss. Hearing loss may be mild, moderate, severe or profound. In the Israel 8% population is a hearing disability.

6. Learning disabilities/Diagnosed ADHD: A learning disability is to do with the way someone's brain works. It makes it harder for someone to learn, understand or do things.

7. Chronic disease (exclusively): A disease or condition that usually lasts for 3 months or longer and may get worse over time. Chronic diseases tend to occur in older adults and can usually be controlled but not cured. The most common types of chronic disease are cancer, heart disease, stroke, diabetes, and arthritis.

The authors clearly identify about the disability and types of disability in Israel. It highlights the systemic barriers and societal attitudes that hinder full participation and equality for people with disabilities. The Lital, k., Yaraa, P., and Yael B. (2021) also discuss the legal and policy frameworks in place aimed at improving accessibility and support services. Through statistical data and case studies, the report underscores the need for enhanced public awareness and better implementation of inclusive practices. Additionally, it suggests policy recommendations to bridge the gaps in services and opportunities, promoting a more inclusive society.

Much research has been dedicated to identifying risk factors for the onset of disability by applying the disablement model originally developed by Nagi (1976). The main pathway of the model consists of four components: pathology, functional impairments, functional limitations, and disability. In old age, pathology causes impairments (e.g. decreased muscle strength, poor balance, low oxygen consumption). Impairments predispose people to functional limitations (e.g. slow walking speed, inability to grasp with hands) which lead to disabilities (e.g. difficulties in mobility and self-care). Research on disability in old age has identified several factors that contribute to shaping the dimensions and severity of disability. These factors include both non-modifiable risk factors, such as age, gender and genetics, and modifiable risk factors, which include both individual factors such as age-related diseases, impairments, functional imitations, poor coping strategies, sedentary lifestyles and other unhealthy behaviors, as well as the definition of the  situation by others, and their reactions and expectations, and characteristics of the environment and the degree to which it is free from, or encumbered with physical and socio-cultural barriers.

According to the disablement model, diseases are the main cause of impairments and functional decline which ultimately may lead to disability. People aged 70 years and over usually have 2-3 chronic conditions, which accounts for around two thirds of total national health care expenditure (Nilsson et al. 2002). About 90 % of all 75-year-olds have some clinical diagnosis. Interventions should, therefore, aim at the prevention and effective management of chronic illness (e.g. Grimley Evans 2000). Also, sensory disorders and particularly vision and hearing impairments are important causes of problems in carrying out daily activities (e.g. West et al. 2002).

- Social model of disability

The social model of disability sees disability as a result of societal barriers rather than individual impairments. It emphasizes that environmental, attitudinal, and institutional obstacles limit the full participation of people with disabilities in society. Unlike the medical model, which focuses on treatment, the social model advocates for removing these barriers to promote inclusion and equality. This approach aligns with a human rights perspective, emphasizing dignity and equal opportunities. By focusing on societal change, the social model has significantly influenced legislation, advocacy, and public awareness, fostering a more inclusive environment for all.

- Medical model of disability

The medical model of disability views disability primarily as a problem of the individual, caused by physical, mental, or sensory impairments. It focuses on diagnosing, treating, and managing these impairments through medical intervention. According to this model, the aim is to cure or alleviate the individual's condition to restore normal functioning. This approach often emphasizes the limitations and deficits of the person rather than considering external factors. The medical model has been criticized for neglecting the role of societal barriers and for promoting a narrow understanding of disability, which can lead to exclusion and stigmatization of individuals with disabilities.

### 1.2 Statement of the Problem

The study investigates the challenges these residents face in maintaining autonomy and dignity amidst physical and social barriers. It examines the adequacy of care practices, the quality of interactions with caregivers, and the overall impact on residents' well-being. By identifying gaps in current care practices, the thesis aims to provide insights for improving the quality of life for elderly individuals with disabilities in institutional settings.

Aging with a disability presents unique challenges that require specialized care and support. At HodAmal Care Centre, located in Aashikma,-5 MaaleAdomim, Israel, elderly individuals with disabilities face difficulties in managing daily activities, maintaining social interactions, and accessing adequate healthcare services. The extent to which they receive personalized care, adapt to their living environment, and cope with both aging and disability remains an essential area of study. Additionally, the role of caregivers, the effectiveness of support systems, and the overall quality of life of these individuals require thorough examination. This research seeks to explore how elderly persons with disabilities at HodAmal Old Care

Centre navigate their daily lives, interact with caregivers, and address challenges associated with their dual conditions.

Disability is a condition that affects everyone towards the end of the day life. The person become weak due to physical and mental problem health problem can come from various diseases. Normal walking may not to possible. Disability people in old age condition due to obstacles difficulties obstructions make their life full of pain. Family, social economic and political process can lead to stigma and depression of the right of life. Mental and physical weakness and health problem occur in old age condition people need a balance diet comfortable accommodation warm clothing, health care, walking equipment, recreation daily physical exercise to make daily life comfortable. If they don't communicate easily their daily life becomes difficult and their right to life is violated. In the context of the world, people with disabilities in old age live by the rules, lows religions, culture, values, economics, political, family social and cultural condition of their country, there are also document of the national and internal law and right for their benefit.

There is research gap on study of living practice of persons with disability in old age in Aasikma-5 MaaleAdomim, Israel. Living practice of persons with disability especially among care center, some of researcher and writer want to know about old age situation in a personal life and caring practice in disability in old age. The study fulfills the living practice of persons with disability in old age in care center two research gaps like gap of study time and gap of theme. In recent years such types of study could not conduct in my study area so there is gap of time of the study. Like that, there is gap in study because none of the research work has done in study area so that there is gap of research in study.

### 1.3 Research Questions

The study is based on the following research questions**;**

- What are the daily living practices and routines of elderly persons with disabilities in the care center and how do these practices contribute to their overall well-being?
- How the older people with disabilities condition benefits of living in the care center?
- What roles do family, society, relevant agencies, and political and economic policies play in shaping the lives of elderly persons with disabilities in the study area?

## 1.4 Objectives of the Study

The general objective of the study is to observing the conditions of the disabled old age persons. Examine the living practice of persons with disability in old age factors influencing the perception and treatment of disability among the elderly population and evaluate the existing support systems, including family, social and governmental assistance, available to elderly individuals with disabilities in the study area or Hodamal Aasikma-5 maaleadumim , Israel. However, the following are the specific objectives:

- To examine the daily living practices and routines of elderly persons with disabilities at the care center and assess their impact on the residents' overall well-being.
- To describe the older people with disabilities condition benefits of living in the care center.
- To analyze the role of family, society, related agency, political, economic policy rules in the life of person with old age disability in study area.

## 1.5 Significance of the Study

The study on "the living practice of disability in old age in HodAmal Aasikma-5 maaleAdomim Israel" holds profound significance in several dimensions. Firstly, it addresses a critical gap in research by focusing on the lived experiences of elderly individuals with disabilities within a specific geographic context. Understanding their daily realities, challenges, and coping mechanisms is essential for developing targeted interventions that cater to their unique needs. This research has practical implications for policymakers, healthcare professionals, and community organizations. By identifying gaps in existing support systems and services, the study can inform the development of more effective interventions and policies aimed at enhancing the quality of life for elderly individuals with disabilities in HodAmal Aashikma-5 MaaleAdomim. This could include improvements in infrastructure, accessibility, and social support networks, thereby promoting inclusivity and ensuring that this population can fully participate in community life.

The study contributes to the broader academic discourse on disability studies, gerontology, and community health. By offering empirical data and insights into the intersection of disability and aging within a specific cultural and contextual framework, the research enriches our understanding of the complex dynamics at play. This contributes to theory development and lays the groundwork for further research in this important area. The

localized approach of this study allows for a deeper exploration of the cultural, social, and environmental factors that influence the experiences of elderly individuals with disabilities in HodAmal old care center Aashikma-5. By considering these contextual nuances, the research provides a more comprehensive understanding of the lived realities of this population.

In the study on the living practice of disability in old age in HodAmal old care center Aashikma-5 MaaleAdomim Israel, holds significance in terms of addressing practical needs, advancing academic discourse, and promoting inclusive and understanding within the community. It has the potential to drive positive change and improve the lives of elderly individuals with disabilities in this specific geographic context and beyond.

### 1.6 Organization of the Study

The study has been organized into five different chapters including references and questionnaires. The first chapter is about introduction that deals with the background of the study, about the disability, statement of problem, objectives of the study, significance of the study, organization of the study. The second chapter covers the literature review including both theoretical and empirical aspects. The third chapter is about the research methodology which refers to research design, source of data, sampling procedure and data collection technique, data processing and analysis etc. Chapter four covers the data presentation and analysis of the study. Lastly, summary and conclusion are included in the fifth chapter.

# CHAPTER II

# REVIEW OF LITERATURE

Literature review is the most important parts of thesis writing. It enables us to get information about existing previous studies. Literature review surveys books, scholarly articles, and any other sources relevant to a particular issue, area of research, or theory, and by so doing, provides a description, summary, and critical evaluation of these works in relation to the research problem being investigated. The literature review of this thesis explores previous research and theories relevant to the study, identifying gaps and establishing the foundation for the current investigation. It synthesizes key findings, methodological approaches, and theoretical frameworks to contextualize the research within the broader academic discourse.

## 2.1 Theoretical Review

Parsons argued that contemporary society should not be understood as capitalist. Rather it was modern, and while it had a capitalist economy, it had a non-capitalist social structure. Medicine was a key example in his argument. Parsons also argued that strongly against any understanding of sickness purely biological. Cultural and social norms will determine what counts as disease and it is treated. For him, to be sick is to enter the 'sick role', which is controlled by the medical profession. Their task is to prevent individuals from trying to opt out of their social roles, which parsons acknowledge, may be detrimental to their health (White, 2002).

White (2002) explains medical knowledge is also shaped and produced out of economic and racial practices contradictor. White further adds Marxist approaches emphasize the causal role of economics in the production and distribution of disease, as well as the role that medical knowledge plays in sustaining the class structure (White 2002, p.6). He emphasizes the role of medicine in maintaining social harmony, pointing to the non- market basis of professional groups. At the same time its critical sociological edge is maintained by the way it highlights the social control function of medicine in enforcing compliance with social roles in modern society (White 2002).

Talcott Parsons (1951) introduced the "sick role" theory as part of his functionalist perspective on health, explaining how illness is a form of deviance that disrupts societal

stability. According to Parsons, when individuals become ill, they are temporarily exempt from normal social roles but are expected to seek medical help and strive to recover. He argued that healthcare professionals play a crucial role in restoring social order by guiding the sick back to health. His work emphasized the structured expectations society places on both patients and doctors, highlighting the social dimension of health and illness.

Over the last several decades, epidemiological studies have been enormously successful in identify risk factors for major diseases. However, most of this research has focused attention on risk factors that are relatively proximal causes of disease such as diet, cholesterol level, exercise and the like. We question the emphasis on such individually-based risk factors and argue that greater attention must be paid to basic social conditions if health reform is to have its maximum effect in the time ahead. There are two reasons for this claim. First we argue that individually-based risk factors must be contextualized, by examining what puts people at risk of risks, if we are to craft effective interventions and improve the nation's health. Second, we argue that social factors such as socioeconomic status and social support are likely "fundamental causes" of disease that, because they embody access to important resources, affect multiple disease outcomes through multiple mechanisms, and consequently maintain an association with disease even when intervening mechanisms change. Without careful attention to these possibilities, we run the risk of imposing individually-based intervention strategies that are ineffective and of missing opportunities to adopt broad-based societal interventions that could produce substantial health benefits for our citizens (Link, 1995).

Sociology has an important role in providing a counterpoint to the predominant biological and medical approaches to health and illness. As this chapter has illustrated, the social matters for virtually every aspect of health, illness, and healing. Our understandings of illness and response are embedded in the community and knowledge is created by individuals with specific background, orientation, and interest, highlighting that social factors play not simply a complementary, but a critical role. This role has perhaps never been more important, as the disease profile of societies has become more complex and it is clear that it is impossible to respond to health problems without a serious consideration of how they are embedded within specific cultural contexts. Consequently, the sociological imagination that allows us to connect the society to the individual has perhaps never been more important and holds a power to provide a crucial counterpoint to the biological approach, often assuming that there is a concrete reality to our illness and responses to it (Olafsdottir, 2013).

In mean time since sociologists do not accept the medical model of disease and illness as simply biological events, they then examine the social functions of medical knowledge. That is, they examine the way medical and biological explanations of disease function in our society. Medical knowledge is produced in and reflects structural features of society. It explains as 'natural' what, from a sociological perspective, are social phenomena. Why the working class is sicker and dies earlier? Why women are diagnosed sick more than men? Why ethnic groups do not receive the services they need? Requires a sociological explanation and not a biological one (White, 2002, p.13).

Livelihoods approach views the world from the point view the individuals, households, and social groups who are trying to make a living in volatile conditions and with limited asset. It provides a framework for understanding the opportunities and assets available to poor people and the source of their vulnerability, as well as the impact upon them of external organizations, processes and policies (Timilsina, 2007). The livelihood of elderly persons with disabilities is often compromised due to physical limitations, social isolation, and inadequate support systems. The livelihood condition in the care center with the disability old age and their residence condition caring maintain with the service.

Changes in pension policy are a good example of this process. During most of the 20$^{th}$ century in the 'development world' , pension systems were seen as a way of managing the cost of retirement, a means to compensate the workforce, and of encouraged fixed exit from the world of work on the basis of age (Phillipson 1998). The institutionalizing of age-related retirement led to a consensus on when individuals become 'old', regardless of their actual abilities. Despite good intentions, and increased the economic dependence of older persons. At the beginning of the 21$^{st}$ century, later life is perceived to be a time where continued working is both possible and desirable, resulting in policy changes that increase the age at which state pensions can be drawn, and create new questions for the purpose of late life in society (Walker 2006). Each suite of policies rests on a series of assumptions about what old age should be like. If one falls outside that 'moral economy', then one is seen to be a less valuable member of society and as less worthy of resources and recognition resulting in fewer options and, by implication, rights (Moulaert and Biggs 2012)

In the article Kane examine the multifaceted nature of evaluating nursing home care quality. They emphasize that traditional clinical metrics are insufficient, advocating for the inclusion of resident-centered measures such as satisfaction, social engagement, and environmental

quality. The Kanes highlight the crucial role of well-trained, adequately staffed personnel and stress the importance of family involvement and transparency. Their work calls for a comprehensive, resident-focused approach to ensure nursing homes provide dignified and satisfactory living conditions for elderly residents (Robert, Kane and Rosalie, 2005).

Ideas about the health and healing in Nepal, as MadhusudanSubedi argues, revolve around a wide range of medical belief and practices, and distinctive categories of functionaries including medical doctor (specialized in Allopathic medicine), health assistants, Nurses, dispensing chemists and pharmacists. Acupuncture therapists, Tibetan medical practitioners, Ayurvedic practitioners, Un medical practitioners folk healers, Dhamijhakries (shamans), herbal doctor, traditional birth attendants and other practitioners, non-formal or even illegal medical traditions are available as alternative therapists (Subedi, 2003).

Among the core human rights treaties, the Convention on the rights of Persons with Disabilities (CRDP) offers perhaps the most useful protection for older person. Although certainly not all older persons have disabilities and the Convention does not single out elderly people for special protection, many of its articles can be utilized by older persons seeking human rights protection. The Convention is special in that it does not define 'disability', and it marks a shift from a traditional 'medical model of disability to a rights-based approach (Kanter, 2009).

Fleck's contribution deserves to be more recognized, both historically and contemporarily. Historically, he deserves an important place in the antecedents of the sociology of medical knowledge and medical sociology generally. Without doubt Fleck's work is an outstanding application of Durkheim sociology to the study of medical knowledge. But his work also has a contemporary relevance for its foresight both methodologically and conceptually. Methodologically, the use of participant observation in the laboratory, which forms the core of his analysis of the Wasserman reaction, is an approach still under-utilized by sociologists of health. Conceptually, the argument and analysis of professional groups as carriers of thought styles provides a bridge between the level of individual action and macro concepts of social structure such as class and patriarchy. In fact, by adopting a Fleck perspective the sociologist is all patriarchy. In fact, look at the interaction of politics, knowledge and vested interests in producing knowledge of our bodies and our health (Fleck, 1935).

Disability is a form of social operation involving the social imposition of restrictions of activity on people with impairments and the socially engendered undermining of their

psycho-emotional wellbeing (Thomas, 1999,P. 60). In this social relational definition should be disability only corn into play when the restrictions of activity experienced by people with impairment are socially imposed, that is, when they are wholly social in origin. This means that it is entirely possible to acknowledge that impairments and chronic illness directly cause some restrictions of activity-but such non-socially imposed restrictions of activity do not constitute 'disability'. Such non-socially imposed restrictions might be better captured by the concept impairment effects (see Thomas, 1999) but space does not permit this point to be pursued here.

"A livelihood comprises the capabilities, assets (stores, resources, claims and access) and activities required for a means of living: a livelihood is sustainable which can cope with and recover from stress and shocks, maintain or enhance its capabilities and assets, provide sustainable livelihood opportunities for the next generation; and which contribute net benefits to other livelihoods at the local and global levels in the short and long terms" (Chamber & Conway, 1992). Elderly persons with disabilities in care centers often experience most of difficulties in the living practice. Dependence on caregivers and inadequate support impact their livelihood, underscoring the need for improved care practices to enhance their quality of life and independence.

Livelihood is the sum of ways and means by which individuals, households and/or communities make and sustain a living. It is a concept that encompasses practices and processes much beyond the regular income generating activities. By and large, livelihood encompasses not only the economic activities that people engage in, but also their social, institutional and organizational environment. Livelihood is a system that depends on the assets people draw upon, the strategies they develop to make a living, the context within which it is developed and finally all those factors that make a livelihood more or less vulnerable to shocks and stresses. The livelihood assets required may be tangible or intangible. These could also be categorized into groups such as human capital (skills, knowledge, health and ability to work), social capital (including informal networks, members of formalized groups and relationships of trust that facilitates co-operation and economic opportunities), natural capital (land, soil, water, forests and fisheries), physical capital (basic infrastructure, such as roads, water and sanitation, schools, ITC; and producer goods, including tools, livestock and equipment), financial capital (financial resources including savings, credit and income from employment, trade and remittance) and political capital (access to citizenship, right to vote, to participate in political affairs, legal rights) (UNDP,

2012). The livelihood conditions of elderly persons with disabilities in Hodamal old care center Aashikma-5 MaaleAdomim is often strained by limited mobility, dependency on caregivers, and insufficient tailored support. These factors can lead to reduced autonomy and financial challenges, highlighting the need for improved care practices to enhance their quality of life and independence.

Livelihoods are formed within social, economic and political contexts. Institutions, processes and policies, such as markets, social norms, and land ownership policies affect our ability to access and use assets for a favorable outcome. As these contexts change they create new livelihood obstacles or opportunities. Livelihoods are also shaped by the changing natural environment. The quality of soil, air and water; the climatic and geographic conditions; the availability of fauna and flora; and the frequency and intensity of natural hazards all influence livelihood decisions. How people access and use the assets, within the aforementioned social, economic, political and environmental contexts, form a livelihood strategy. The range and diversity of livelihood strategies are enormous. An individual may take on several activities to meet his/her needs. One or many individuals may engage in activities that contribute to a collective livelihood strategy. One important characteristic of livelihoods is their interdependence. Very few livelihoods exist in isolation. A given livelihood may rely on other livelihoods to access and exchange assets. Livelihoods also compete with each other for access to assets and markets. Thus positive and negative impacts on any given livelihood will, in turn, impact others (UNDP & IRP). In the study clearly define about the living practice or condition so that my research living practice of persons with disability in old age find out the how they achieve facilities and good service in the care center.

## 2.2 Empirical Review

Disability has often been defined as a physical, mental, or psychological condition that limits a person's activities. It has different meanings to different people, and in different contexts. The Global Burden of Disease (GBD) uses the term disability to refer to loss of health, where health is conceptualized in terms of functioning capacity in a set of health is conceptualized in terms of functioning capacity in a set of health domains such as mobility, cognition, hearing and vision (WHO, 2004).

Of the world's population of nearly 6.5 billion in 2004, 18.6 million (2.9%) were severely disabled and another 79.7 million (12.4%) had moderate long term disability, according to the definitions given by GBD. Disability prevalence rise strongly with age. The average global

prevalence of moderate and severe disability ranges from 5%in children aged 0-14 years, to 15% in adults aged 15-59 years, and 46% in adults aged 60 years and older. At all ages, both moderate and severe levels of disability are higher in low-and middle- income countries than in higher income countries; they are also higher in Africa than in other low-and middle-income countries. Older people make up a greater proportion of the population in high-income countries, but have lower levels of disability than their counterparts in low- and middle-income countries. Disability is also more common among children in the low-and middle-income countries. Moderate disability rates are also similar for males and females in high income countries, but females have somewhat higher rates of severe disability. In lowland middle-income countries, male and female disability rates are similar; although females aged 15-59 years tend to have higher levels of moderate disability in Africa, the Eastern Mediterranean and the Western Pacific (WHO, 2008).

The prevalence of disabling condition is almost the same for males and females, but the major contributing causes are different. While depression is the leading cause for both males and females, the burden of depression is 50% higher for females than males. Females also have a higher burden from anxiety disorders, migraine and Alzheimer and other dementias (WHO, 2008).

People with disabilities and people who are ageing with disabilities are on the rise all around the world. According to a report on disability published by the World Health Organization and the World Bank, roughly 15.3 per cent of people had disabilities in 2004 and about 15% of people had disabilities in 2010, with about 2-4 per cent of these persons with disabilities having severe functional difficulties. Age has a significant impact: the older you get, the more likely you are to become disabled. For these reasons, the relationship between ageing and disability has become extremely important, both in terms of its implications for ageing people's involvement, inclusion, and quality of life, as well as its implications for socio-sanitary organizations (Aging and disability 2021).

Holstein and Gubrium (2007) they see as two distinct social constructionist perspectives, one grounded in symbolic interaction-ism and the other more influenced by ethno methodology. They state that those using symbolic interaction-ism seek to understand the construction of the meaning of experiences. They see those pursuing the “more radical” ethno-methodological approach as bracketing the meaning of the experience to focus on the construction and use of the tacit understandings and structures that underlie that experience.

Thus, Holstein and Gubrium believe that a symbolic integrationist would be interested in the construction of meanings of experiences of health and illness, but leave out the symbolic integrationist emphasis on action, which addresses how actions reveal and construct tacit understandings and structures. These approaches how actions reveal both are relevant to symbolic integrationist work on aging, health and illness.

The criteria of ageing vary in SAARC regions too. Maldives has taken 65 years, Srilanka 55 years, Afghanistan, India and Pakistan 60 years, Bangladesh and Bhutan 58 years as criteria to define "elderly citizens". Cross-national comparison of the ageing process in the developing region is rather tricky. Part of the reason is that most of these countries started to address the issue of ageing very recently and therefore there is a dearth of data related to older population. Another problem is countries are using different cut off point to define old age, something depending on the official national ages of retirement (Acharya, 2001).

The prevalence of disability is higher for women compared to men for all adults, for the working age and the elderly. The gap in the prevalence of disability between women and men is the largest among the older population: 44.2% of older women have disability compared to 33.9% of older men. In addition, women more often than men have two or more severe or extreme difficulties: for instance, among working age individuals, the prevalence of having two or more severe or extreme difficulties stands at 4.8% for women compared to 2.4% for men. However, there is some variations depending on disability type and context. For example, blindness and visual impairment affects more women than men (Thompson, 2017).

A systematic review and meta-analysis to global vision impairment and blindness found that globally, prevalence of blindness is 36.0 million (0.48%) of which 56% were female. In addition, the prevalence of moderate and severe visual impairment was 216.6 million (2.95%) of whom 55% were female and 188.5 million (2.57%) had mild visual impairment of whom 54% were female (Bourne, Flaxman, Tasanee, &Cicinelli, 2017).

Nepalese society is still mostly rural, and religious beliefs have a strong influence: even those living in urban areas are likely to be affected by prevailing, traditional views. Views on disability are often inflected by religious teachings which regard it as a punishment for the prior misdeeds of the parents (Lamichhane, 2013). Prevailing illiteracy, ignorance, and negative perception on the disability in the society it is considered as the punishment of the god for some sin committed in the past life but it is not so. It occurs either congenital (by birth) or acquired due to accident or as a result of diseases or due to poverty prevailed in the

society. It is a human reality that occurs in all the ages from birth to old age (Timilsana, 2018).

Ellis (1998) has attempted to discuss about rural livelihood diversification, which is wide spread in all location, across farm size, and range of income and wealth. According to her studies, the significant proportion percent of rural households‟ income in sub-Saharan Africa comes from farm source. This figure is even more (80 to 90 percent) in southern Africa. In rural areas of low-income countries diverse portfolio play significant role in family wellbeing. Off farm wage work in agriculture and non-farm activities like trading, employment in urban area and abroad provide diverse livelihood option to the rural people. Diversification in their economic activities is necessary for them to increase and to sustain livelihood mitigating the effect of seasonality in income and reducing risk in their diverse activities. Preservation of natural resources and balance development in gender are other positive aspect of it. However, the chances of increasing differences between the rich and poor and gender imbalances are its possible shortcoming of rural livelihood diversification. In conclusion the removal of constraint and expansion for diversification are desirable polices which give individual and household more option to improve livelihood security and to raise their own living standard. The livelihood condition of persons with disabilities and the old age people struggle or take a good service in HodAmal old care centers directly impacts their quality of life. Adequate resources, accessible facilities, skilled caregivers, and inclusive programs are crucial for promoting independence and well-being. Addressing these needs ensures dignity and respect, fostering a supportive environment where individuals can thrive despite their challenges.

A helpful place to start might be with definitions of disability. One well-known set of definitions distinguishes between impairment, the absence or defect of a limb, organ or bodily mechanism, covering a range of physical, mental or sensory impairments, disablement or disability, the loss or reduction of function or ability as a consequence of impairment, and handicap, the disadvantage, constraint or restriction which results from disability. These definitions allow for the possibility that handicap may result from non-disabling impairments such as disfigurement. For sociological propose, it is disability and handicap which are of most interest, closely bound up as they are with social factors of one kind or another which intervene to influence the nature and scale of the problem(Jenkins, 1991).

## 2.3 Summary literature review

Many existing researches talks about different views of living practice of persons with disability in old age through there are still lack of finding concrete study and discussion about this topic. The aging process presents significant challenges for individuals with disabilities, particularly in institutional care settings. Research highlights that elderly persons with disabilities require specialized care that addresses both their physical and psychological needs. Studies on aging with disabilities emphasize the importance of personalized assistance, adaptive living environments, and social support to enhance their quality of life. Many scholars argue that access to healthcare, mobility assistance, and emotional well-being strategies are crucial factors in improving the daily experiences of elderly individuals with disabilities. Furthermore, the role of caregivers is pivotal, as their training and sensitivity directly impact the well-being of residents in long-term care facilities.

The care center provides a unique setting to examine these aspects in practice. Existing literature on elder care facilities in Israel suggests that integrating rehabilitation programs, fostering social inclusion, and ensuring adequate medical support contribute to better living conditions. However, gaps remain in understanding how residents with disabilities specifically adapt to aging in such institutions. Studies on similar care settings indicate that mental health support, community engagement, and caregiver relationships significantly affect their overall well-being. This research aims to build upon existing knowledge by exploring the lived experiences of elderly persons with disabilities at HodAmal old Care Centre, examining their coping mechanisms, social interactions, and the effectiveness of care strategies in meeting their evolving needs.

The living practices of elderly persons with disabilities at Care Centre, reflect both the challenges and the essential role of specialized care. Aging with a disability requires not only medical assistance but also emotional and social support to maintain dignity and independence. While existing literature highlights the importance of adaptive environments and caregiver involvement, I believe there is a need for more personalized approaches that prioritize individual autonomy and mental well-being. Care centre should focus on holistic care, integrating physical therapy, community interaction, and emotional support to enhance the quality of life. Observing how these individuals navigate daily activities and social relationships can provide valuable insights for improving elder care policies.

## 2.4 Gap of the Review

While existing research provides insights into aging with disabilities, there is limited literature specifically addressing the living practices of elderly persons with disabilities in institutional care settings such as HodAmal old care center in Israel. Until now, Nepal has a system of old age homes and rehabilitation centers, while abroad, good and well-organized care centers are operating under the special supervision of the government. Therefore, this research has done on HodAmal old care centers. In Nepal still hasn't make good old care center through government policy. Most studies focus on general elderly care or disability management separately, but few explore how these two factors intersect within long-term care facilities. The absence of research on how elderly individuals with disabilities adapt to institutional environments, maintain independence, and receive personalized care creates a significant knowledge gap.

Another gap in the literature is the lack of studies analyzing the effectiveness of care- giving strategies in such facilities. While research highlights the importance of trained caregivers, social inclusion, and medical support, there is insufficient data on how these factors specifically impact elderly individuals with disabilities in care center. Understanding whether the existing care models address both aging and disability-related needs is essential. Additionally, there is limited research on how these residents interact with their caregivers, cope with emotional challenges, and engage in social activities within the center. This gap makes it difficult to assess whether the current care practices effectively enhance their quality of life.

There is a need for more qualitative studies that explore the lived experiences of elderly individuals with disabilities in such care centers. Most available research relies on statistical data and medical assessments, overlooking the personal narratives and emotional aspects of aging with a disability in institutional care. A deeper understanding of their challenges, coping mechanisms, and support systems is crucial for improving care practices. Addressing these gaps will help develop better policies and care models to ensure a more inclusive, supportive, and fulfilling environment for elderly persons with disabilities at old care center.

# CHAPTER III

# RESEARCH METHODS

Research methodology is a process of arriving to the solution of problem through planned and systematic dealing with the collection analysis and interpretation of data. It refers to the various sequential steps while conducting research work. It tries to make clear view of method and process adopted in the entire aspect of the study.

## 3.1 Selection of the Study Area

HodAmal old care center was selected for this study. It is located in Aashikma-5 MaaleAdomim Israel. In Hod care center have been establish since 20 years more and long time, however, they were coming from Aasikma-5 MaaleAdomim area of Israel. Israel stands at the crossroads of Europe, Asia and Africa. Geographically, it belongs to the Asian continent and is part of the Middle East Region. In the west, Israel is bound by the Mediterranean Sea.

Living practice of disability they are physically and mental exercise in old age. For the old age people disable in area have been study the role of family society and government with them. The study area has been selected due to two reasons, it is accessible for researcher and such types of study has not been conducted in the study area which urgent need to analyzes the overall living practice situation of disable old age people and life struggle them and give a facility provide by government, organizations, family and other social factors in this study area.

## 3.2 Research Design

This area case of study observes HodAmal old care center Aashikma-5 MaaleAdomim Israel. It is based on micro level study. This is based on the descriptive and explanatory research design to fulfill the specific objects of the study. The research design is the plan and strategy to obtain the answers of the study. In the research living practice of persons with disability role of family, society, relevant agencies and political and economic policies is expressed through the descriptive research design with the simple table and impacts of remittance is presented through the explanatory research design. The data and information are analyzed with expression.

This study was carried out mostly on the basis of exploratory research design as because the study was done focusing living practice of disability in old age in care center. The study had also tried to explore the other aspects of old age or disability period in the care center living practice. It also followed the descriptive way to describe natural condition of study site and the living practice in care center. Thus, this study can be categorized as both exploratory and descriptive.

### 3.3 Universe and Sampling Procedure

There are in total 250 disable old age people in HodAmal old care center Aashikma -5 MaaleAdomim. Among them 95 male and 155 is female disability old age people live in there. Among the total disable person of old age; I have selected 50 respondents selected as a sample which is 20% of the total disable old age in a care center. There were 18 male and 32 and female respondents in this study. This study has concentrated on the disability in old age of the reproductive age (60 above). In this study most of disability person are female and half of total male residence in the care center I have been selected by purposive sampling method under non-probability sampling.

### 3.4 Nature and Sources of Data

The required data for this study were collected through primary and secondary sources. Both primary and secondary data sources are used to describe and analyze the study area. The collected data are both qualitative and quantitative. The primary data were collected through structured questionnaire, interview and observation whereas secondary data were collected from different published and non- published written document from individuals, experts, and organization related to the disability old age in care center. I have done a job in the care center from the 2 years ago for the care giver post. Similarly, I have carried and give a good deliver for my site and according to given duty schedule. I did regularly work to collect data and observation part in the field area.

#### 3.4.1 Primary Data

The sources of primary data are usually chosen and tailored specifically to meet the demands or requirements of particular research. In this study primary data were collected to identify the living practice in of disability in old age and collected from the field (study area) by using various data collection tools and techniques like survey questionnaires and observation.

### 3.4.2 Secondary Data

Book, articles, government reports, validate findings were the secondary data for this study they had been already published. It has been used in review section of the study. Secondary data help to explain the concept of disability and livelihood condition in care center of Israel. The secondary data section of a thesis involves analyzing existing research, statistics, and data sources relevant to the living practice of disability in old age.

## 3.5 Techniques of Data Collection

This research is conducted by disability person various methods for data collection. Both primary and secondary data are collected. The researcher himself collects the data from the respondents by conducting the questionnaire survey with living practice of persons with disability in care center by adopting various statistical data collection tools and techniques are adopted.

### 3.5.1 Questionnaire Survey

Structured and unstructured questionnaire was prepared to generate the realistic and accurate data from study area. The respondents were requested to fill up the questionnaire. In case of the respondents who could not fill up the questionnaire, the questions were asked to the respondents and answer was filled up to collect the required data. In the absence of care center senior person present at the condition of disabilities living practices was considered as the respondent. The data was collected through formal and informal interviews using structured, open and closed end questions. The prepared questionnaire includes both types i.e. open ended and close ended in order to acquire reliable information by making the respondent comfortable and ease to provide the information. Sometimes take the internal information about the older disabilities respondent of condition in old care center to use the unstructured questionnaire.

### 3.5.2 Interview Schedule

Structured questionnaire prepares to generate the realistic and actual data by conducting disability old age person from the study area. The respondents were asked a set of questions prepared according to the objectives of the study. I have conducted a structured interview in this study and I have conducted this interview with the every disability member of 50 sample size respondents who were living to their care center in study area in order to get more information use the unstructured questionnaire. Information obtained through these

interviews taken confidential to draw the overall scenario of the field and verification of the data collection from disability old age person living practice. And also the interview was focused on living practice, disabilities condition benefits of living in care center and role of family, society, relevant agencies, and political and economic policies lives of elderly persons with disabilities in the study area.

3.5.3 Focus Group Discussion

In the process of data collection the focus group discussion was carried out for the collection of data. The focus group discussion was held with the active participation of old age disabilities, member of care center's person were gathered for the purpose. Related unstructured questions were asked to get information for the study. These questions were related to changing aspects like change in health status, extent of disability, mental health, daily activity, social support, care center of behavior, health care access, environment factors, family and government support and quality of life.

### 3.6 Method of Data Analysis

These collected data were analyzed by using simple mathematical and statistical tools such as percentage and tables. It is categorized and tabulates according to the objectives of the study. Before analyzed the data, it had been categorized the information according to objectives and tabulate by plan way.

### 3.7 Limitation of the Study

Each and every study has its own limitation. This study is limited in living practice of disability in old age in HodAmal old care center Aashikma-5 MaaleAdomim Israel. For the purpose of the study in the Aasikma-5 MaaleAdomim Israel was selected as a study area and does not cover all the part of the country. So, it does not represent the entire country where the outcome of the might be different according to the time and space. The study was conducted with the small sample size of the population based on the availability of the respondents who fitted best for the study criteria. Therefore, the conclusion is generalized based on the information given by the respondents present for the study and the information is analyzed and interpreted as per their response. The study is also generalized to overall case of the people with physical disability in Israel which might not be similar in every case and every context. The experience might also differ which can produce different conclusion. Hence, the study is limited in its scope, study area and participants and not able to address all the issues related to people with physical disability.

# CHAPTER IV

## Living Practice of Disability Old Age in Care Center

This HodAmal old care center is located at Aashikma-5 MaaleAdomim, Israel, provides a critical support system for elderly residents living with disabilities. The center is dedicated to enhancing the quality of life for its residents through comprehensive care practices that cater to their unique needs. Residents at HodAmal old care center experience a tailored approach to care, which is crucial for addressing the diverse range of disabilities present. The center employs a team of skilled professionals, including nurses, caregivers, and rehabilitation specialists, who work collaboratively to ensure each resident receives personalized attention. This team focuses not only on medical care but also on the social and emotional well-being of the residents.

Accessibility is a cornerstone of the center's infrastructure, with facilities designed to accommodate mobility impairments, visual and hearing impairments, and other disabilities. This ensures that all residents can navigate the living spaces safely and independently. Moreover, the center places a strong emphasis on fostering a sense of community and inclusion among residents. Social activities and interactive programs are regularly organized to promote engagement and prevent isolation, which is particularly important for elderly individuals. Staff at HodAmal old care center is trained to maintain a respectful and compassionate approach, understanding the sensitivities and challenges faced by elderly residents with disabilities. The center also encourages resident participation in care decisions, fostering a sense of autonomy and respect.

In this study, HodAmal old care center strives to create an environment where elderly residents with disabilities can live with dignity, comfort, and a high quality of life. By prioritizing individualized care and community engagement, the center exemplifies best practices in elderly disability care in hasikma-5 MaaleAdumim, Israel.

### 4.1 Demographic Information

The demographic section of this thesis examines the characteristics of residents at the HodAmal care center in Aahikma-5 MaaleAdomim, Israel. It includes details on age, gender, duration of stay, and types of disabilities. By analyzing this data, we can better understand the composition of the resident population, which is crucial for tailoring care practices to meet their specific needs. This section provides a foundation for exploring how demographic

factors influence the lived experiences and care requirements of elderly residents with disabilities.

### 4.1.1 Age Composition of the Respondents

Age is one of the main social characteristics of the respondents that reflect the working or earning age of the respondent which effects on social structure. In this study only the people who are above 60 years old only participated. The following table indicates the age structure of the respondents.

**Table 4.1**

*Percent Distribution of Respondents by Age Group*

| S.N. | Age | Numbers | Percentage |
|---|---|---|---|
| 1 | 60-69 | 22 | 44 |
| 2 | 70-79 | 15 | 30 |
| 3 | 80-89 | 10 | 20 |
| 4 | Above 90 | 3 | 6 |
| | **Total** | 50 | 100 |

Source: Field Survey, 2024

In the table 1 portrays the age structure of the respondents. Data show that 44 percentage respondents are between 60 to 69 years old age group and 30 percentages are between 70 to 79 years age group. Like those 20 percentages are 80 to 89 years age group and 6 percent disability of old age in 90 above group of respondent. It indicates that majority of the respondents are young between 60 to 69 years old more than above 90 age of group disability respondents in care center. In this data understands most of residence or respondent lives between 60 -69 and 70-79 age group there in this care center. So that most of residences have been coming in old age disability condition live in the care center when they increase age or death zone period retire in life.

### 4.1.2 Sex Composition of the Respondents

In this study disability old age males, females and others are participated. Sex status is one of the main social characteristics of the respondents. It is possible to understand how society

looks at male and female. The sex composition of the respondents at the Hodamal old Care Center includes both male and female residents. Understanding this distribution is crucial for analyzing gender-specific needs and ensuring that care practices and policies are effectively tailored to address the unique requirements of both male and female elderly residents with disabilities. The following table shows the sex composition of the respondents.

**Table 4.2**

*Percentages distributions Sex status*

| S.N. | Sex | Numbers | Percentage |
|---|---|---|---|
| 1 | Male | 18 | 36 |
| 2 | Female | 32 | 64 |
| 3 | Others | - | - |
| | **Total** | 30 | 100 |

Source: Field Survey, 2024

Overhead table 2 indicates the sex structure of the respondent. It shows that 36 percentage are male and 64 percentage are female and haven't in others. Majority of the respondents are female in the care center. It's clear about this data most people leave in the care center of the female persons during the disability period. During the time of interview, it was tried to take unequal number from male and female, however, the numbers of females are double than the male in the HodAmal old care center.

4.1.3 Educational Status of Respondents

Education is on most important factors for the future caring and awareness. Therefore, it is a determining factor in how a person's disability condition in old age will be? In this study, it is found that the female and male respondents in the sample of this study. The educational status of respondents at the HodAmal care center varies widely, encompassing individuals with no formal education to those with advanced degrees. Analyzing educational backgrounds helps in understanding the residents' cognitive and social needs, and informs the development of tailored programs and activities that cater to different levels of cognitive engagement and learning abilities.

**Table 4.3**

*Percent Distribution of Respondents by Educational Status*

| Education Level | No. Respondents | Percentage |
|---|---|---|
| Primary | 3 | 6 |
| High School | 13 | 26 |
| Graduate | 19 | 38 |
| Post graduate | 15 | 30 |
| **Total** | **50** | **100** |

Source: Field Study, 2024

Table 4.3 shows that in this study of 50 respondents, the highest number of graduate educated person in literate is (38%) compare to other education level. It has been found that the least number of disabilities of old age male and female are at the primary level (6). The numbers of primary educated disability person are lower than the high school (26%), graduate (38%) and post graduate (30%) of the respondents. It is clear from the data that the primary educated respondent is lower than the high school, graduate and post graduate respondents. The disability of old age respondent education status is well in the quality of personal life. In the above data clear about the education status is higher than others in the Africa or Europe country.

4.1.4 Native Land of Respondents

In this study disability of old age respondents in care center come from Israel and native land another country. For the study has jobs and opportunity migrate people from Greece, France, Germany, U.K., USA and other countries of disability of old age people settle and lives in Israel old care center. The native land of respondents at the HodAmal old care center includes a diverse mix of individuals originating from various regions of Israel and abroad. Understanding their native land backgrounds is essential for providing culturally sensitive

care and fostering a sense of community among residents, ensuring that cultural traditions and languages are respected and incorporated into daily care practices.

**Table 4.4**

*Percent Distribution of Respondents by Native Land and Abroad country in Care Center*

| Native Land | No. Respondents | Percentage |
|---|---|---|
| Israel | 32 | 64 |
| Abroad | 18 | 36 |
| **Total** | **50** | **100** |

Source: Field Study, 2024

Table 4 shows the birth place of respondent in Israel and abroad. In this research work, there were 32 disabilities of old age respondents and the data of the question about the birth place or native land of respondents whose migrate settled to achieve in Israel. Disability old age peoples of family have busy in the business and job or settled personal life. In the care center 64% of disability old age respondent are Israel people and 36% of old age abroad respondent are migration from every country. In this research there are found 1/2 must of disability respondent in Israel and remaining migrate and come from abroad know live in Israel or they found Israel citizenship.

4.1.5 Living Care Center of Respondents

In this study, those disability people how long have their living in this old care center. About disability old age people have been living period in the care center of HodAmal. The experience of living in the care center for respondents at HodAmal old care center involves adapting to a supportive environment tailored to their unique needs. This encompasses daily routines, interactions with staff and fellow residents, access to medical and social services, and the overall atmosphere of the facility.

**Table 4.5**

*Percent Distribution of living period in care center of respondents*

| Living period in care center | No. Respondents | Percentage |
|---|---|---|
| Less than 6 months | 2 | 4 |
| 6 months to 1 year | 6 | 12 |
| 1-3 years | 26 | 52 |
| More than 3 year | 16 | 32 |
| **Total** | **50** | **100** |

Source: Field Study, 2024

In interpreting distribution percentage data, each percentage represents the proportion of the total sample falls within a specific category or range. 52% of respondents were living in the care center being highly rate; it indicates that nearly one-two of the sample expressed high levels of living residence in the care center. Conversely, 32% respondents were living more than 3 year in care center and 6% respondent's lives in less than 6 months. It suggests that a smaller portion of the sample falls into this category. Analyzing distribution percentages provides a clear understanding of how responses are distributed across different living period in care center insights into patterns, trends, and variations within the data set.

4.1.6 Types of Disability of Respondents

There is various kind of disabilities among them physical disabled group is selected for research. There are many physical disabled types or categories as well. In this study disabilities among respondents are categorized as physical (mobility impairments), sensory (vision or hearing loss), intellectual (cognitive limitations), mental health (psychological

conditions), and multiple disabilities (combining various impairments). Each type uniquely affects the respondents' experiences and their interactions with their environment.

**Table 4.6**

*Percent Distribution of Respondents by Types of Disability*

| Types of Disability | No. Respondents | Percentage |
|---|---|---|
| Physical impairment | 22 | 44 |
| Visual impairment | 8 | 16 |
| Hearing impairment | 6 | 12 |
| Cognitive impairment | 9 | 18 |
| Others | 5 | 10 |
| **Total** | **50** | **100** |

Source: Field Study, 2024

In interpreting distribution percentage data for types of disability, each percentage denotes the proportion of the total sample attributed to a specific disability category. There is 44% of respondents have mobility or physical impairments, it indicates that nearly half of the sample experiences challenges related to mobility. Similarly, 16% have visual impairments; it suggests that a smaller portion of the sample faces visual limitations. In this research data disability of old age residence respondents are 18% of cognitive impairment and others disabilities respondents are10%. Analyzing these percentages reveals the prevalence and distribution of different disability types within the population, facilitating targeted interventions, resource allocation, and tailored support services to address the diverse needs of individual's respondent with disabilities in the care center.

## 4.2 Living Practice in Care Center of the Respondents

In this HodAmal old care center, living practices are designed to promote the well-being and independence of residents with various disabilities. The daily routine for the disability old age residents includes structured activities that cater to physical, sensory, intellectual, and mental health needs. Residents follow personalized care plans developed in collaboration with healthcare professionals, ensuring individualized support. The environment is adapted to enhance accessibility, featuring ramps, handrails, and sensory-friendly spaces. Staff members are trained to provide specialized care, assisting with daily activities such as bathing, dressing, and medication management. Social interaction is encouraged through group activities like arts and crafts, music therapy, and recreational outings, fostering a sense of community and belonging.

This Hodamal old care center Aashikma- 5 MaaleAdomim provides regular health check-ups and therapy sessions are integral to the care regime, aimed at maintaining and improving the residents' physical and mental health. The disability old age relative and family involvement is also emphasized, with regular meetings to discuss progress and update care plans. Overall, the living practices in the care center prioritized dignity, autonomy, and quality of life for all residents.

### 4.2.1 Living Condition in Care Center of Respondents

In this HodAmal old care center Aashikma-5, respondents experience a structured routine with personalized care plans. The environment is fully accessible, featuring ramps and sensory-friendly spaces. Trained staff assist was with daily activities and medication management. Social and recreational activities, including group exercises and arts, play game and entertainment with music, foster community and engagement. Regular medical check-ups and therapy sessions ensure ongoing health and well-being, with family involvement encouraged.

**Table 4.7**

*Percent Distribution of Respondents by Living Condition in Care Center*

| Living Condition | No. Respondents | Percentage |
|---|---|---|
| Very Satisfied | 5 | 10 |

| | | |
|---|---|---|
| Satisfied | 18 | 36 |
| Neutral | 17 | 34 |
| Dissatisfied | 8 | 16 |
| Very dissatisfied | 2 | 4 |
| **Total** | **50** | **100** |

Source: Field Study, 2024

Interpreting distribution percentage data for living conditions in the care center involves analyzing residents' satisfaction levels across various categories. There are very satisfied 10% and satisfied are 35% with the living condition of residents report, it indicates a significant portion is highly content with their living arrangements. There are 34% of respondents neutral with the living condition in care center. Conversely, 16% express dissatisfaction and 4% is a very dissatisfied with the caring system, it suggests areas for improvement. Understanding these percentages or data most of residence are well living practice in the care center. Some of these disagree and very disagree with there are living practice so suggest to the care center have not enough good facility for the disability in old age residence.

4.2.2 Accessibility of Facilities of Respondents

The care center's facilities are designed for maximum accessibility to accommodate all respondents. Features include ramps; playground, entertainment with music, handrails, wide doorways, and sensory-friendly spaces. Common areas and living quarters are wheelchair-accessible. Adaptive equipment is available to support mobility and daily activities. These modifications ensure that all respondents can navigate the environment safely and comfortably, promoting independence and inclusive.

**Table 4.8**

*Percent Distribution of Respondents by Accessibility of Facilities*

| **Accessibility of Facilities** | **No. Respondents** | **Percentage** |
|---|---|---|
| Excellent | 5 | 10 |

| | | |
|---|---|---|
| Good | 10 | 20 |
| Fair | 17 | 34 |
| Poor | 13 | 26 |
| Very poor | 5 | 10 |
| **Total** | **50** | **100** |

Source: Field Study, 2024

Interpreting distribution percentage data for accessibility of facilities in the care center involves analyzing residents' satisfaction levels across various categories. The accessibility of facilities in fair of residents are 34%, it indicates a significant portion is high content with their access facilities. Respondents are saying excellent and very poor facilities are 10% in care center. It suggests areas find improvement. Understanding these percentages helps identify trends, prioritize enhancements, and tailor services to meet residents' preferences and needs effectively. This table of data informs targeted interventions and facility enhancements, ensuring all residents have adequate access to essential services and amenities, thus improving their quality of life.

4.2.3 Care Center Supports of Independence of Respondent

In this study disability old age in HodAmal old care center supports the independence of respondents by providing tailored assistance that promotes self-sufficiency and autonomy. Services include personalized care plans, skill development programs, and access to resources that enable individuals to manage daily activities and make informed decisions. This approach fosters a sense of empowerment and confidence, helping respondents maintain a higher quality of life while reducing dependency on external support.

**Table 4.9**

*Percent Distribution of Respondents by Care Center supports in Independence*

| **Supports of Independence** | **No. Respondents** | **Percentage** |
|---|---|---|
| Strongly agree | 20 | 40 |

| | | |
|---|---|---|
| Agree | 11 | 22 |
| Neutral | 9 | 18 |
| Disagree | 7 | 14 |
| Strongly disagree | 3 | **6** |
| **Total** | **50** | **100** |

Source: Field Study, 2024

Table 4.9 shows that, it has been found that the care center supports in independence of respondent. Its most of respondents strongly agree in the independence 40%. There care center disability old age residence respondents have 22% in agree with supported in independence. In this study strongly disagree in supports in independence respondents have 6%. Its indicate most of respondents or residence independence in care center. In the above data shows most of respondents or residence supports them for the every activities in the care center for the independence. But some of the data disagree respondents are the support for independence. It's suggest carefully give an all persons them of the independence with carefully.

4.2.4 Engage in Social Activities or Interact with other Residence

The disability of old age engaging in social activities or interacting with other residents is vital for enhancing emotional well-being and fostering community. The HodAmal Aashiukma-5 MaaleAdomim care center organizes events and group activities that encourage participation and relationship-building. These interactions help reduce isolation and promote mental health. By facilitating social engagement, the Care Center ensures residents can form supportive connections and enjoy a vibrant, connected living environment.

**Table 4.10**

*Percent Distribution of Respondents by Engage in Social Activities or Interact with other Residence*

| **Engage in Social Activities** | **No. Respondents** | **Percentage** |
|---|---|---|

| | | |
|---|---|---|
| Daily | 5 | 10 |
| Several time a week | 22 | 44 |
| Week | 10 | 20 |
| Rarely | 9 | 18 |
| Never | 4 | **8** |
| **Total** | **50** | **100** |

Source: Field Study, 2024

The distribution of disability of old age social activity engagement among residents is as follows: 10% interact daily, 44% engage several times a week, 20% participate weekly, 18% rarely engage, and 8% never interact. This data highlights were an engage in social activity with a significant portion participating infrequently, suggesting potential areas for improving disability of old age engagement in social activity. In this data have shown highest respondents engage in social activities or interact with other partners for the freedom, sharing each other culture, idea and others important event of life. Some of respondent have not engaged in activities or interact with other residence it's suggested for the care centers respondent equally rights all residence.

### 4.3 Care and Support

The HodAmal old care center Aashikma-5 provides comprehensive care and support tailored to the unique needs of its residents. Emphasizing a holistic approach, the center offers personalized care plans that address medical, emotional, and social well-being. It skilled healthcare professionals deliver round-the-clock medical care; ensuring residents receive prompt and effective treatment. The center also prioritizes mental and emotional health by providing counseling services, recreational activities, and social engagement opportunities.

Social activities and community interactions are integral parts of the center's support system. Regularly organized events and group activities encourage residents to build meaningful relationships and stay engaged, reducing feelings of isolation. Additionally, the care center offers skill development programs to promote residents' independence and self-sufficiency, enhancing their quality of life. There is supportive environment at HodAmal care center

Aashikma-5 fosters a sense of belonging and empowerment, ensuring residents feel valued and cared for in a community that prioritizes their overall well-being.

4.3.1 Quality of Care to Disability Old Age

The care center provides exceptional quality care for elderly individuals with disabilities, emphasizing personalized and comprehensive support. Skilled healthcare professionals deliver tailored medical treatments and physical therapy, addressing specific needs effectively. The center also offers mobility assistance and adaptive technologies to improve daily living. Emotional well-being is fostered through counseling and engaging activities, promoting a sense of community and inclusion.

In the study disability old age persons are in the care center achieve good service, systematic management service by government policy and care center managing team. This holistic approach ensures residents receive dignified, high-standard care, significantly enhancing their quality of life.

**Table 4.11**

*Percent Distribution of Respondents by Quality of Care to Disability Old Age*

| Quality of Care | No. Respondents | Percentage |
|---|---|---|
| Excellent | 8 | 16 |
| Good | 16 | 32 |
| Fair | 14 | 28 |
| Poor | 8 | 16 |
| Very poor | 4 | **8** |

| | | |
|---|---|---|
| **Total** | **50** | **100** |

Source: Field Study, 2024

The distribution of quality of care ratings for elderly with disabilities is as follows: 16% rate it as excellent, 32% as good, 28% as fair, 16% as poor, and 8% as very poor. To improve care quality, focus on enhancing training for caregivers, increasing staff-to-resident ratios, and implementing regular feedback mechanisms to address concerns promptly and ensure higher standards of care.

4.3.2 Attitude of the Staff towards Residence or Disability old age Persons

The staff's attitude towards residents with disabilities or old age is compassionate and respectful. They are trained to provide empathetic, patient-centered care, ensuring dignity and fostering a supportive environment. This positive attitude enhances residents' overall well-being, making them feel valued and understood in their daily interactions.

**Table 4.12**

*Percent Distribution of Respondents by Attitude of the Staff towards Disability Old Age Persons*

| **Attitude of the Staff Towards Residence** | **No. Respondents** | **Percentage** |
|---|---|---|
| Very respectful | 15 | 30 |

| | | |
|---|---|---|
| Respectful | 20 | 40 |
| Neutral | 11 | 22 |
| Disrespectful | 4 | 8 |
| Very disrespectful | - | - |
| **Total** | **50** | **100** |

Source: Field Study, 2024

In the above table distribution of staff attitudes towards elderly persons or disability old age with disabilities is as follows: 30% view the staff as very respectful, 40% as respectful, 22% as neutral, 8% as disrespectful, and non as very disrespectful. To improve staff attitudes, facilities should prioritize empathy training, establish clear behavioral expectations, and implement regular assessments of staff interactions. Encouraging a culture of respect and providing support for staff can significantly enhance the overall experience for elderly residents with disabilities.

4.3.3 Satisfied with Personal Care

In this research disability in old age with residence report satisfaction with personal care received at the center. It tailored to individual needs; the care includes medical support, assistance with daily activities, and emotional counseling. This personalized approach ensures comfort, dignity, and improved quality of life, fostering a positive living environment.

**Table 4.13**

*Percent Distribution of Respondents by Satisfied with Personal Care*

| Satisfied with Personal Care | No. Respondents | Percentage |
|---|---|---|

| | | |
|---|---|---|
| Very Satisfied | 8 | 16 |
| Satisfied | 21 | 42 |
| Neutral | 15 | 30 |
| Dissatisfied | 6 | 12 |
| Very dissatisfied | - | - |
| **Total** | **50** | **100** |

Source: Field Study, 2024

In the table 4.13 distribution of satisfaction with personal care among respondents is as follows: 16% are very satisfied, 42% are satisfied, 30% are neutral, 30% are dissatisfied, and 12% are very dissatisfied. To improve satisfaction levels, care providers should focus on personalized care plans, ongoing training for caregivers, and regular feedback loops to address and resolve issues promptly. Enhancing communication between caregivers and residents can also contribute to higher satisfaction by ensuring that individual needs and preferences are consistently met.

4.3.4 Medical Care Provided Rate to the Disability of Old Age

The medical care provided rate to elderly individuals with disabilities in care centers is a critical indicator of healthcare quality. These metric measures the frequency and adequacy of medical services delivered, reflecting the centers' ability to address the complex health needs of aging populations through timely interventions and continuous care.

**Table 4.14**

*Percent Distribution of Respondents by Medical Care Provided Rate*

| Medical Care Provided Rate | No. Respondents | Percentage |
|---|---|---|
| Excellent | 4 | 8 |
| Good | 18 | 36 |
| Fair | 16 | 32 |
| Poor | 8 | 16 |
| Very poor | 4 | **8** |
| **Total** | **50** | **100** |

Source: Field Study, 2024

In this table 4.14 shows distribution of ratings for medical care provided to elderly individuals with disabilities reveals a nuanced picture. While 8% respondents take a medical care is excellent and in very poor. 36% respondent is good indicating a substantial satisfaction rate. 32% respondent is deeming fair. It's suggesting areas to find improvement. However, concerning is the 16% rating it as poor, highlighting significant deficiencies. In this data show the most of respondent and residents achieve the medical care service is high. According to these concerns through targeted interventions can enhance the overall quality of medical care for this vulnerable demographic.

### 4.4 Policies and Practices

HodAmal old care center Aashikma-5 MaaleAdomim is committed to providing exceptional care for elderly individuals with disabilities through comprehensive policies and practices. In the care center disability old age peoples prioritizes individualized care plans living condition tailored to each resident's unique needs, encompassing medical, physical, and emotional support. Staff members undergo specialized training to effectively address diverse disabilities and ensure compassionate care delivery. Regular assessments and proactive interventions maintain residents' well-being and enhance their quality of life. Additionally, the center promotes social engagement and community involvement, fostering a supportive environment. Through these initiatives, HodAmal old care center strives to uphold dignity, independence, and holistic care for elderly individuals with disabilities.

4.4.1 Disability Old Age Feel Involved in Decision about Care and Daily Activity

Involving elderly individuals with disabilities in decisions about their care and daily activities is vital for promoting autonomy and well-being. By actively it's engaging them in the decision-making process, care providers empower these individuals to express their preferences, maintain a sense of control, and enhance their overall quality of life within care settings.

**Table 4.15**

*Percent Distribution of Respondents by Disability of Old Age Feel Involved in Decision about Care and Daily Activity*

| **Feel Decision about Care and Daily Activity** | **No. Respondents** | **Percentage** |
|---|---|---|
| Strongly agree | 6 | 12 |
| Agree | 12 | 24 |
| Neutral | 20 | 40 |
| Disagree | 8 | 16 |
| Strongly disagree | 4 | **8** |
| **Total** | **50** | **100** |

Source: Field Study, 2024

Interpreting distribution percentage data for the involvement of elderly individuals with disabilities in decisions about care and daily activities involves analyzing their agreement levels. For instance, 12% respondents are strongly agree or agree that they feel involved, it indicates a significant portion feel empowered in decision-making. Conversely, 24% respondents agree it suggests room for improvement. The feel decision about the care and daily activity in neutral respondent is higher than another 40%. In this data shows most of people medium feel with decision daily activity. Understanding these percentages offers insights into residents' autonomy and satisfaction levels, guiding care providers in enhancing

communication, promoting resident-centered care approaches, and ensuring that individuals with disabilities have a meaningful voice in shaping their care experiences within the facility.

### 4.4.2 Aware of the Care Center's Policies

In this research there in HodAmal old care centers disabilities are aware of the care center's policies is crucial for promoting their autonomy and informed decision-making. Providing accessible information and communication channels empowers these individuals to understand their rights, access available services, and actively participate in shaping their care experience, fostering a sense of agency and self-determination within the care setting.

**Table 4.16**

*Percent Distribution of Respondents by Aware of the Care Center's Policies*

| **Aware of the Care Center's Policies** | **No. Respondents** | **Percentage** |
|---|---|---|
| Yes, very aware | 29 | 58 |
| Somewhere aware | 15 | 30 |
| Not aware | 6 | 12 |
| **Total** | **50** | **100** |

Source: Field Study, 2024

Interpreting distribution percentage data for awareness of the care center's policies involves assessing respondents' levels of awareness. Similarly, 58% respondents are being indicated very aware or aware, it suggests a substantial portion is knowledgeable about the policies. 30% respondent is somewhere aware disability of old age in HodAmal old care center Aashikma-5 MaaleAdomim conversely, in the research 12% are not aware, it highlights a need for increased communication or education efforts. Understanding these percentages provides insights into the effectiveness of policy dissemination and resident engagement strategies. It guides care providers in improving communication channels, enhancing policy transparency, and ensuring that residents are well-informed participants in their care journey within the facility.

4.4.3 Satisfied with Overall Experience in the Care Center

Assessing the disability of old age satisfaction of individuals with disabilities regarding their overall experience in the HodAmal old care center is paramount for evaluating service quality and meeting residents' needs. By soliciting feedback through surveys, interviews, or focus groups, care providers can gain valuable insights into residents' perceptions, preferences, and areas for improvement. This information enables continuous refinement of care practices, ensuring a positive and fulfilling experience for all residents.

**Table 4.17**

*Percent Distribution of Respondents by Satisfied with Overall Experience in the Care Center*

| **Satisfied with Overall Care Center** | **No. Respondents** | **Percentage** |
|---|---|---|
| Very Satisfied | 9 | 18 |
| Satisfied | 21 | 42 |
| Neutral | 14 | 28 |
| Dissatisfied | 5 | 10 |
| Very dissatisfied | 1 | 2 |
| **Total** | **50** | **100** |

Source: Field Study, 2024

Interpreting distribution percentage data for overall satisfaction in the care center involves analyzing residents' perceptions across various satisfaction levels. In my research 18% are very satisfied and 42% are higher than others satisfied rate, it indicates a significant portion is content with their experience in the HodAmal old care center. In this research 28% of respondents are neutral. 2% are in dissatisfied overall care center and in this research of people or 1 person is very dissatisfied about the overall experience in the care center. Its understanding these percentages offers insights into the overall satisfaction levels within the care center, guiding facility management in addressing concerns, enhancing services, and

ensuring residents' well-being. It facilitates targeted interventions to optimize the quality of care and promote positive experiences for all residents within the facility.

### 4.5 Family Role and Support

Family plays a crucial role in supporting elderly individuals with disabilities in care centers. Regular visits and emotional support from family members can significantly enhance the residents' well-being, providing a sense of connection and belonging. Families are often contributing financially, helping to cover additional needs not met by the care center. Their involvement in care planning and decision-making ensures personalized care, aligning with the resident's preferences and history. Furthermore, family engagement can motivate care center staff to maintain high standards of care. Ultimately, active family participation fosters a supportive environment, promoting better mental and emotional health for elderly residents.

#### 4.5.1 Visits with Family Members in a Care Center

Family visits play a vital role in the lives of elderly residents in care centers, providing emotional and psychological benefits that enhance overall well-being. Regular visits can alleviate feelings of loneliness and depression, fostering a sense of continuity and connection to the outside world. These interactions also offer residents emotional support and validation, which are crucial for mental health. Family visits can improve residents' mood and engagement in social activities, leading to a more positive outlook.

**Table 4.18**

*Percent Distribution of Respondents by Visits with family members in the Care Center*

| Visits with Family Members | No. Respondents | Percentage |
|---|---|---|
| Daily | 7 | 14 |
| Weekly | 20 | 40 |
| Monthly | 16 | 32 |
| Rarely | 5 | 10 |
| Never | 2 | 4 |
| **Total** | **50** | **100** |

Source: Field Study, 2024

In the above data table visits with family members in the care center reveals that daily visit respondents family is (14%) in the care center and weekly (40%) in a total respondents relatives meet in a weekly it's a high rank of a table. The monthly visits (32%) in a related family member in the care center understanding about the disability persons living condition. Some of family members rarely visit and never come meet up with disability old age in a care center. Its shows highest family member caring and loving to the family member in the care center but some percentage of family members have not caring and visits in this care center. Its finding most of family worried about the living practice of persons disability in old age in the care center some of the ignore them.

4.5.2 Emotional Support Provided by Family in the Care Center

Emotional support from family members is a cornerstone of well-being for elderly residents in care centers. Regular communication and visits reassure residents that they are valued and loved, which is crucial for maintaining mental health. Emotional support from family members also encourages a positive outlook and resilience, helping residents cope with the challenges of aging and disability. In the care center residence family member give a support and daily emotional support by communication and mate in the care center physically for the daily understanding with living condition.

**Table 4.19**

*Percent Distribution of Respondents by emotional support provided by family in the Care Center*

| **Emotional Support provided by Family** | **No. Respondents** | **Percentage** |
|---|---|---|
| Very Satisfied | 6 | 12 |
| Satisfied | 15 | 30 |
| Neutral | 18 | 36 |
| Dissatisfied | 7 | 14 |
| Very dissatisfied | 4 | 8 |

| | | |
|---|---|---|
| **Total** | **50** | **100** |

Source: Field Study, 2024

The table on respondents by emotional support provided by family in the care center reveals varying levels of satisfaction among residents. In the above data are 12% respondents satisfied with emotional support provided in care center and 30% respondents are satisfied with the care center. Highest of them 36% respondents are neutral or nor satisfied nor dissatisfied with the emotional support provided by family in the care center. Similarly, some of the 14% respondents are dissatisfied with the family emotional support and 8% of respondents are very dissatisfied with the family support provided so that it's saying someone family member ignore the disability old age persons in care center.

4.5.3 Family Provided Financial Support

Family-provided financial support is vital for elderly residents in care centers, often covering expenses beyond basic care. This support can fund additional medical treatments, specialized therapies, and personal comfort items, enhancing the quality of life. In this study, family worried about the disability old age residence in this care center and provides the necessary things or financial support to the care center.

**Table 4.20**

*Percent Distribution of Respondents Family Provided Financial Support in the Care Center*

| **Family Provided Financial Support** | **No. Respondents** | **Percentage** |
|---|---|---|
| Yes | 31 | 62 |
| No | 8 | 16 |
| Occasionally | 11 | 22 |
| **Total** | **50** | **100** |

Source: Field Study, 2024

In the above table of data the respondent family caring in the center provided good service and takes a good response with the disability persons. In the research most of family three quartile of family give a financial support and loving them. But 16% of respondents have not given financial supports in the care center. In the totally data of respondents occasionally supports them or disability old age persons. Its shows most of family caring loving and worried about the living condition of persons with disability in old age but some family member are not interest with them living practice.

### 4.6 Society Role and Inclusion

Society plays a pivotal role in promoting inclusion for elderly care center residents through volunteer programs, community events, and inter-generational activities. In this study when society give a caring and loving to the elder or disability in old age persons in the care center they are emotionally or kindly happiness with the family addition they feel good inclusive with caring and support so that society can more role in the living practice of persons with disability in care center.

4.6.1 Included and Valued in Social Activity within the Care Center

Feeling included and valued in social activities within care centers is essential for elderly residents' well-being. Participation in group events, recreational activities, and communal gatherings fosters a sense of community and belonging. These interactions promote mental and emotional health, reduce loneliness, and enhance overall happiness. The disable residence persons want society love caring and meet all the time in communication or others. They want family love all social activity and family together party so that it’s an important valued of social activity in care center.

**4.21**

*Percent Distribution of Respondents by Included and Valued in Social activity within the Care Center*

| **Included and Valued in Social Activity** | **No. Respondents** | **Percentage** |
|---|---|---|
| Always | 7 | 14 |

| | | |
|---|---|---|
| Often | 20 | 40 |
| Sometimes | 16 | 32 |
| Rarely | 5 | 10 |
| Never | 2 | 4 |
| **Total** | **50** | **100** |

Source: Field Study, 2024

The distribution of disability of old age included and valued in social activity with the care center is as follows: 14% always included social activity, 40% included often, 32% sometimes included, 10% rarely included, and 4% never participate in the social activity. This data highlights an included and valued in social activity with a significant portion participating infrequently, suggesting potential areas for improving disability of old age included and valued in social activity. In the data has shown highest respondents included and valued in social activities or interact with other partners for the freedom, sharing each other culture, idea and others important event of life. Some of respondent have not included and valued in social activities or interact with other residence it's suggest for the care centers respondent equally right all residence.

### 4.7 Role of Related Agencies and Services

It related agencies and services play a crucial role in enhancing the quality of life for elderly residents in care centers. Healthcare providers, government, non-governmental organizations (NGOs), and social service agencies offer essential medical care, therapeutic services, and emotional support. These organizations also provide financial assistance, advocacy, and educational resources, ensuring comprehensive and individualized care. Collaboration with external agencies ensures that resident diverse needs are met, promoting their overall well-being and ensuring a higher standard of living within the care center.

#### 4.7.1 Related Agencies Quality of Healthcare Services Provided at the Care Center

The quality of healthcare services provided by related agencies in care centers is vital role for residents' well-being and happiness life. These agencies offer essential medical care, rehabilitation services, and mental health support, ensuring comprehensive health

management. High-quality healthcare services contribute to better physical and emotional health outcomes, enhancing residents' quality of life and promoting a supportive and nurturing care environment.

**Table 4.22**

*Percent Distribution of Respondents by Related Agencies Quality of Healthcare Service to Disability Old Age in Care Center*

| **Related Agencies Quality of Healthcare Service** | **No. Respondents** | **Percentage** |
|---|---|---|
| Excellent | 16 | 32 |
| Good | 16 | 32 |
| Fair | 11 | 22 |
| Poor | 7 | 14 |
| Very poor | - | - |
| **Total** | **50** | **100** |

Source: Field Study, 2024

The distribution of disability of old age shows related agencies give a quality of healthcare service in the care center. While 32% data shows excellent or provide good service in the care center for the disability person's good quality life and 32% respondent are saying give a good facilities in care center. However, concerning is the 22% of fair with the related agencies provided service. In poor respondents 14% have not enough a good service to the care center. In this data show the most of respondent and residents achieve the agencies provided quality healthcare service is highest. Addressing these concerns through targeted interventions can enhance the overall quality of healthcare service provided care center.

4.7.2 Support Services in Improving Living Condition

Support services significantly improve living conditions in care centers by addressing residents' diverse needs. These services include specialized medical care, therapeutic activities, mental health support, and social engagement programs. They enhance the overall

well-being of residents, promote independence, and ensure a higher quality of life. Effective support services foster a nurturing environment, enabling residents to live with dignity and comfort.

**Table 4.23**

*Percent Distribution of Respondents by Supported Services in Improving Living condition Disability of Old Age in Care Center*

| **Supported Service in Improving living Condition** | **No. Respondents** | **Percentage** |
|---|---|---|
| Very effective | 6 | 12 |
| Effective | 19 | 38 |
| Neutral | 15 | 30 |
| Ineffective | 6 | 12 |
| Very ineffective | 4 | 8 |
| **Total** | **50** | **100** |

Source: Field Study, 2024

In the above table distribution of supported services in improving living condition disability of old age in care center with disabilities is as follows; 12% as very effective, 38% as effective, 30% as neutral, 12% as ineffective, and 4% as very ineffective. In the above data supported service by agencies improving living condition in a highly rate in the care center. So that table improve most of respondent are saying effective improving in the living practice to do the supported government, NGO, INGO, other relative agencies provided best delivery to the disability residence in care center. Also, some of the respondent are saying supported services have not found as much as so that given a good service effect.

# CHAPTER V

# SUMMARY AND CONCLUSION

## 5.1 Summary

In this chapter, I have presented the summary of the research findings of this study project. This study is focus all disability of old age residence in HodAmal old care center, Aashikma-5 MaaleAdomim Israel and I have studied about their living practice of disability in old age. The center's environment is thoughtfully designed to care to diverse needs, offering both private and shared accommodations equipped with amenities that prioritize comfort and safety. At the heart of HodAmal old care center philosophy is a commitment to respecting residents' individuality and dignity, reflected in tailored care plans that address specific physical, medical, and emotional needs. Caregivers undergo specialized training to provide

compassionate support, fostering a nurturing atmosphere where residents feel valued and empowered.

Comprehensive policies and procedures uphold rigorous standards of care, encompassing medication management, nutrition, safety protocols, resident rights have used fully there. . Regular assessments ensure these policies are effectively implemented and adapted to meet evolving resident needs. Daily activities are caring to promote social interaction, cognitive stimulation, and physical well-being, ranging from recreational programs and cultural events to therapeutic sessions and educational workshops. Residents are actively encouraged to participate in decision-making regarding their daily routines and leisure activities, enhancing their sense of autonomy and engagement.

In this research disability old age respondents in care center who are involved in various service and engagement for best quality of life. They are daily activities in residence living condition in the care center. In the care center different types of disability are living there every day treatment and food diet deliver for the disability old age persons. In this research living condition of disability old age facilities and care rate system of the management policies and practice site of good or worst.

This research study has attempted to describe and analyze the experiences of individuals with physical disabilities in many aspects of living practice as a disabled person. The main purpose of the study is to identify the factors influencing the living practice of people with physical disability and get insight to their lived experiences. This research study has been carried out by using qualitative research methodology. The data and information for the study has been collected using both primary and secondary source of information. This research study has carried in depth interview and two focus group discussion using interview technique as the tools for data collection and the collected information has been analyzed in descriptive form. The analysis of the experiences of the participants' revealed that the livelihood condition of people with physical disability is determined by various factors. The interplay of those factors determines the quality of life and standard of living of people with physical disability. Factors like living practice in care center have care and support for good work like an entertainment, playing, physical exercise and others. The main factor of this research disability old age people's daily activities in care and support for the best environment and give most of facilities. The policies and practice indicate the care center of all facilities and daily activities for the disability peoples satisfied there.. All these factors

therefore influence the living practice of people with physical disability. It regulates the daily life activities play significant role to shape the condition of people with all types of disability.

In this field area situation, a total of 50 respondent take a sample for the research asked interview format question to the respondents. In the study that who is above 60 years old only participated. Female disabilities have (64%) residence higher majority then male. In my survey educational status is the disability of old age respondent well in the quality of personal life. In the field survey area, selected most of disability person belongs to Israel (64%) and another residence in abroad that migrate for best opportunity, business and other known in the care center. Analyzing distribution percentage were living time period in the care center access to medical and social services, and the overall facilities provide by the care center. In the care center disability of respondent's distribution data for types of disability, each percentage denotes the proportion of the total sample attributed to a specific disability category. In this data (44%) of respondents have mobility or physical impairments, it indicate that nearly half of the sample experiences challenges related to mobility. Categories as physical, visual, hearing, cognitive impairment and others disability persons are live in care center.

In this study found that, living practice in HodAmal old care center Aashikma-5 MaaleAdomim. The daily routine for disability old age residents includes structured activities that cater to physical, sensory, intellectual, and mental health needs. Residents follow personalized care plans developed in collaboration with healthcare professionals, ensuring individualized support. The environment is adapted to enhance accessibility, featuring ramps, handrails, and sensory-friendly spaces. Staff members are trained to provide specialized care, assisting with daily activities such as bathing, dressing, and medication management. The care centers environment is fully accessible, featuring ramps and sensory friendly space. Most of respondents satisfied person is (36%) and neutral (34%) in the living condition of care center. In the living condition in care center 16% of dissatisfied and 4% of very dissatisfied it suggest in the policies and caring practices improve somebody. Accessibility of respondents in the care center is medium its improve residence access in facility and overall service is nod bat and not very excellent. In the study disability old age has in HodAmal old care center Aashikma -5 MaaleAdomim Israel care center most of respondent support of independence in 40% of strongly agree and 22% in agree in the supported in independence. The disability of old age engaging in social activities or interacting with other residents is vital for enhancing emotional well - being and fostering community. 10% interact daily, 44%

engage several times a week, 20% participate weekly, 18% rarely engage, and 8% never interact. This data highlights a engage in social activity with a significant portion participating infrequently, suggesting potential areas for improving disability of old age engagement in social activity.

Social activities and community interactions are integral parts of the center's support system. Regularly organized events and group activities encourage residents to build meaningful relationships and stay engaged, reducing feelings of isolation. The supportive environment at HodAmal old care center Aashikma-5 MaaleAdomim fosters a sense of belonging and empowerment, ensuring residents feel valued and cared for in a community that prioritizes their overall well-being. In the study disability old age persons are in the care center achieve good service, systematic management service by government policy and care center managing team. This holistic approach ensures residents receive dignified, high-standard care, significantly enhancing their quality of life.32% as good, 28% as fair, 16% as poor, and 8% as very poor. To improve care quality, focus on enhancing training for caregivers, increasing staff-to-resident ratios, and implementing regular feedback mechanisms to address concerns promptly and ensure higher standards of care. This positive attitude enhances residents' overall well-being, making them feel valued and understood in their daily interactions. In my research respondents view of residence 30% view the staff as very respectful, 40% as respectful, 22% as neutral, 8% as disrespectful, and non as very disrespectful. To improve staff attitudes, facilities should prioritize empathy training, establish clear behavioral expectations, and implement regular assessments of staff interactions towards the respondents. This personalized approach ensures comfort, dignity, and improved quality of life, fostering a positive living environment. In this research respondents satisfied rate with the care center 16% are very satisfied, 42% are satisfied, 30% are neutral, 30% are dissatisfied, and 12% are very dissatisfied. To improve satisfaction levels, care providers should focus on personalized care plans, ongoing training for caregivers, and regular feedback loops to address and resolve issues promptly. The medical care provided rate to elderly individuals with disabilities in care centers is a critical indicator of healthcare quality. While 8% rate it as excellent or in very poor and 36% as good, indicating a substantial satisfaction rate, 32% deem it fair, suggesting areas for improvement. However, concerning is the 16% rating it as poor, highlighting significant deficiencies. In this data show the most of respondent and residents achieve the medical care service is high.

HodAmal old care center Aashikma-5 is committed to providing exceptional care for elderly individuals with disabilities through its comprehensive policies and practices. In the care center disability old age peoples prioritizes individualized care plans living condition tailored to each resident's unique needs, encompassing medical, physical, and emotional support. In the policies and practices living condition of disability old age residence involving elderly individuals with disabilities in decisions about their care and daily activities is vital for promoting autonomy and well-being. The feel decision about the care and daily activity in neutral respondent is higher than another 40%. In this data shows most of people medium feel with decision daily activity. In the care center disability old age residence aware to the living practice and policies 58% indicate being very aware or aware, it suggests a substantial portion is knowledgeable about the policies. 30% of somewhere aware disability of old age in HodAmal old care center Aasikma-5 MaaleAdomim Conversely, In the research 12% are not aware, it highlights a need for increased communication or education efforts. In this research 18% are very satisfied and 42% are higher than others satisfied rate, it indicates a significant portion is content with their experience in the HodAmal old care center. In the my research 28% of respondent neutral in satisfied overall care center and in my research 2% of people or 1 person is very dissatisfied about the overall experience in the care center. Understanding these percentages offers insights into the overall satisfaction levels within the care center, guiding facility management in addressing concerns, enhancing services, and ensuring residents' well-being.

Family plays a crucial role in supporting elderly individuals with disabilities in care centers. Regular visits and emotional support from family members can significantly enhance the residents' well-being, providing a sense of connection and belonging. Families often contribute financially, helping to cover additional needs not met by the care center. Their involvement in care planning and decision-making ensures personalized care, aligning with the resident’s preferences and history. Family visits play a vital role in the lives of elderly residents in care centers, providing emotional and psychological benefits that enhance overall well-being. the care center reveals that daily visit(14%) in the care center and weekly (40%) in a total respondents relatives meet in a weekly it’s a high rank of a table. The monthly visits (32%) in a related family member in the care center understanding about the disability persons living condition. Some of family members rarely and never come meet up with disability old age residence in a care center. Its shows highest family member caring and loving to the family member in the care center but some percentage of family members have

not caring and visits in the center. Emotional support from family members is a cornerstone of well-being for elderly residents in care centers. In the data are 12% respondents satisfied with emotional support provided in care center and 30% of respondents satisfied with the care center. Highest of them 36% respondents neutral or nor satisfied nor dissatisfied with the emotional support provided by family in the care center. Similarly, some of the 14% respondents dissatisfied with the family emotional support and 8% of respondents very dissatisfied with the family support provided so that it's saying someone family member after the living in care center ignore the disability old age persons in care center.

In the study society when give a caring and loving to the elder or disability in old age persons in the care center they are emotionally or kindly happiness with the family addition they feel good inclusive with caring and support so that society can more role in the living practice of persons with disability in care center. The disable residence persons want society love caring and meet all the time in communication or others. They want family love all social activity and family together party so that it's an important valued of social activity in care center. The distribution of disability of old age included and valued in social activity with the care center is as 14% always included social activity, 40% included often, 32% sometimes included, 10% rarely included, and 4% never participate in the social activity. This data highlights a included and valued in social activity with a significant portion participating infrequently, suggesting potential areas for improving disability of old age included and valued in social activity. In this data has shown highest respondents included and valued in social activities or interact with other partners for the freedom, sharing each other culture, idea and others important event of life.

Related agencies and services play a crucial role in enhancing the quality of life for elderly residents in care centers. Healthcare providers, government, non-governmental organizations (NGOs), and social service agencies offer essential medical care, therapeutic services, and emotional support. These organizations also provide financial assistance, advocacy, and educational resources, ensuring comprehensive and individualized care. The quality of healthcare services provided by related agencies in care centers are vital role for have not enough a good service to the care center. In this data show the most of respondent and residents achieve the agencies provided quality healthcare service is highest.

Finally in the  all the above mentioned factors, other factors like accessibility to facilities and services, social participation and personal perspective towards their disability are identified

that have significant role to influence the living practice of people with different types of disability. Accessibility to various kinds of facilities and services are found to be difficult for people with disability old age residence in HodAmal care center Aashikma-5 MaaleAdomim Israel. Most of the services and facilities meant for them are beyond their reach. They achieve good facilities; care to improve above different distribution data. In this care center all overall provide a good facilities and service to the old age disability residence.

### 5.2 Conclusion

According to the context of the current perspective, among the various types of care center establish in word like a child care center, old age care center, and reformatory. This content takes a care for the better life and achieves a quality of life in the all types of care center. In this research disability of old age living practice in care center and the daily life access, achieving service by the care center.

The living conditions at the HodAmal old care center, particularly for elderly residents with disabilities, exemplify the challenges and triumphs of providing compassionate care in a specialized facility. This center is dedicated to creating an environment that balances medical needs with emotional well-being, ensuring that residents experience both dignity and comfort in their later years. Despite the inherent difficulties associated with aging and disability, the care center emphasizes personalized attention, recognizing the unique needs of each individual. The staff trained both medical and empathetic care giving, play a crucial role in fostering a supportive community. They implement best practices are not only address physical health but also encourage social interaction and mental stimulation, which are vital for maintaining a high quality of life. Additionally, the facility's infrastructure is designed to be accessible and safe, reducing the risk of accidents and promoting independence as much as possible.

In this research the realities of providing care to this demographic include managing chronic conditions, navigating the emotional complexities of aging, and ensuring consistent, high-quality support. The HodAmal old care center's approach highlights the importance of a holistic strategy in elder care, one that integrates medical, psychological, and social aspects to create a nurturing environment. In conclusion, while the challenges are significant, the center's commitment to enhancing the lives of elderly residents with disabilities underscores the vital role such institutions play in our society. Their work serves as a model for other care centers, demonstrating that with the right resources and dedication, it is possible to offer a

fulfilling and dignified living experience for some of the most vulnerable members of our community.

Accessibility is a cornerstone of the physical environment at HodAmal care center Aashikma-5 MaaleAdomim. The facility is thoughtfully designed with wide corridors, spacious living areas, and strategically placed accessibility features such as ramps, handrails, and elevators. These accommodations ensure that residents with disabilities can navigate the premises safely and comfortably, fostering a sense of autonomy and freedom of movement. The care center is equipped with a wide array of assistive devices and technologies to enhance the daily lives of residents with disabilities. From mobility aids like wheelchairs and walkers to specialized devices for communication, hearing, and vision assistance, these tools are seamlessly integrated into the care environment to promote independence and facilitate engagement in meaningful activities.

Physical therapy and rehabilitation services play a pivotal role in supporting residents with disabilities in maintaining or improving their functional abilities. Under the guidance of skilled therapists, residents participate in tailored exercise programs aimed at enhancing strength, flexibility, balance, and mobility. Whether recovering from an injury, managing a chronic condition, or adapting to age-related changes, residents receive individualized care that empowers them to lead active and fulfilling lives. Residents with disabilities are encouraged to participate in a diverse range of social and recreational activities designed to be inclusive and enjoyable for all. Whether it's engaging in group outings, attending cultural events, or participating in art therapy sessions, these opportunities promote a sense of belonging, purpose, and fulfillment.

Central to the care center's philosophy is the recognition of each resident's inherent dignity, worth, and right to self-determination. Staff members are trained to approach their work with empathy, patience, and a deep respect for the autonomy and choices of residents with disabilities. Whether assisting with personal care tasks, facilitating leisure activities, or providing emotional support, staff members uphold the principles of person-centered care, ensuring that residents' voices are heard and their preferences honored at every turn.

The living practices for persons with disabilities in old age at HodAmal old care center embody a commitment to excellence, compassion, and empowerment. By embracing a holistic approach that addresses physical, emotional, social, and environmental dimensions of

care, the care center creates a nurturing home where residents with disabilities can flourish and thrive, regardless of age or ability.

To conclude it can be said that this study identified that for people with different types of disability of old age and they have living practice in care center, their living practice and condition of service, medical checkup, food management, entertainment and other facilities of the Care Center excels in providing compassionate, holistic care for elderly residents with disabilities. By combining medical expertise with emotional support, the center ensures as dignified and fulfilling living experience. The dedicated staff and thoughtfully designed infrastructure promote both safety and independence. Despite the challenges of aging and disability, the center's commitment to personalized care highlights its role as a model institution. Ultimately, it exemplifies how specialized facilities can significantly enhance the quality of life for the elderly, ensuring their golden years are comfortable and respectful. Overall, the living practice disability of old age in HodAmal old care center Aashikma 5 MaaleAdomim, Israel. Their living practices have satisfied to access in all facilities.

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**Appendix: 1**

**Survey Questionnaire**

- Demographic Information

1. What is your age?

a) 60-69 b) 70-79 c) 80-89 d) 90+

2. Gender:

a) Male b) Female c) Other

3. What is your education qualification?

a) Primary b) High school e) Graduate d) Post graduate

4. Which country is your native land?

a) Israel b) Another or Abroad

5. How long have you been living in this care center?

a) Less than 6 months b) 6 months to 1 year

c) 1-3 years d) More than 3 years

6. What type of disability do you have?

a) Physical impairment b) Visual impairment c) Hearing impairment

c) Cognitive impairment d) Other

- Living Practice in Care Center

7. How satisfied are you with your living conditions in the care center?

a) Very satisfied b) Satisfied c) Neutral

d) Dissatisfied e) Very dissatisfied

8. How would you rate the accessibility of facilities (e.g., bathrooms, playground, entertainment, dining areas) in the care center?

a) Excellent b) Good c) Fair

d) Poor e) Very poor

9. Do you feel that the care center supports your independence?

a) Strongly agree b) Agree c) Neutral

d) Disagree e) Strongly disagree

10. How often do you engage in social activities or interact with other residents?

a) Daily b) Several times a week c) Weekly

d) Rarely e) Never

- Care and Support

11. How would you rate the quality of care provided by the staff?

a) Excellent b) Good c) Fair

d) Poor e) Very poor

12. How would you describe the attitudes of the staff towards residents with disabilities?

a) Very respectful b) Respectful c) Neutral

c) Disrespectful e) Very disrespectful

13. How satisfied are you with the personal care (e.g., help with bathing, dressing) you receive?

a) Very satisfied b) Satisfied c) Neutral

d) Dissatisfied e) Very dissatisfied

14. How would you rate the medical care provided by the care center?

a) Excellent b) Good c) Fair

d) Poor e) Very poor

- Policies and Practices

15. Do you feel involved in decisions about your care and daily activities?

a) Strongly agree b) Agree c) Neutral

d) Disagree e) Strongly disagree

16. Are you aware of the care center's policies regarding disability support?

a) Yes, very aware b) Somewhat aware c) Not aware

17. How effective do you think the care center's policies are in addressing the needs of residents with disabilities?

a) Very effective b) Effective c) Neutral

d) Ineffective e) Very ineffective

18. How satisfied are you with your overall experience in the care center?

a) Very satisfied b) Satisfied c) Neutral

d) Dissatisfied e) Very dissatisfied

19. What improvements would you suggest for enhancing the quality of life for residents with disabilities in this care center?

_____

20. Do you have any suggestions to give very good quality service in the care center for the disability of old age residence?

- Family Role and Support

21. How often do you receive visits from family members?

a) Daily b) Weekly c) Monthly

d) Rarely e) Never

22. How satisfied are you with the emotional support provided by your family?

a) Very satisfied b) Satisfied c) Neutral

d) Dissatisfied e) Very dissatisfied

23. Does your family provide financial support?

a) Yes b) No c) Occasionally

- Societal Role and Inclusion

24. Do you feel included and valued in social activities within the care center?

a) Always b) Often c) Sometimes

d) Rarely e) Never

- Role of Related Agencies and Services

25. How would you rate the quality of healthcare services provided at the care center?

a) Excellent b) Good c) Fair

d) Poor e) Very poor

26. Are you aware of any support services provided by non-governmental organizations (NGOs) or other agencies?

a) Yes b) No

27. How effective are these support services in improving your living conditions?

a) Very effective b) Effective c) Neutral

d) Ineffective e) Very ineffective

28. How familiar are you with the government's policies on disability and elderly care?

a) Very good familiar b) Somewhat familiar c) Not familiar

d) Good familiar.

**Appendix: 2**

**Photos of field survey**