PERCEPTIONS AND DEMAND FOR CHILDCARE AND ELDERCARE SERVICES IN THE WESTERN BALKANS

A QUALITATIVE STUDY

1 DATA AND METHODOLOGY

During 2014 the World Bank conducted a mixed-method supply and demand side assessment of child and elderly care services in seven countries of the Eastern Europe and Central Asia (ECA) region, including four countries from the Western Balkans (WB): Bosnia and Herzegovina, Kosovo, FYR Macedonia, Serbia; Ukraine, Armenia and Kyrgyz Republic. The aim of the assessment was to better understand the context of childcare and eldercare provision in the region, and the distribution of formal and informal care. The supply assessment of available care services included surveys with service providers and focused on the quality, accessibility, and affordability of services. The demand assessment investigated the care needs and preferences of families with children and/or elders.

The demand assessment targeted households with children and/or elders and included an investigation of time use, care needs, perceptions, and preferences about care responsibilities, as well as barriers in access to formal child or elder care services. Whenever possible, it followed the dynamics of care demand and supply at the household level, with women and their labor force engagement at the center. This assessment included quantitative individual-level questionnaires, as well as qualitative focus group discussions (FGDs).

This brief presents a summary of the findings from the demand side focus group discussions at the Western Balkans regional level and compiles findings from Bosnia and Herzegovina, Kosovo, FYR Macedonia, Serbia FGDs.

Overall, a total of 39 FGDs were held across four countries in 13 locations. Both survey and the FGD participants were between the ages of 25 and 65; had child and/or elder care responsibilities; and had different levels of engagement in the labor market (employed, unemployed, and inactive). Two thirds of the participants were women, and one third were men (See Table 1).
Table 1 Number of FGDs held across the Western Balkans as part of the demand side assessment

<table>
<thead>
<tr>
<th>Country</th>
<th>By Gender/Employment Status</th>
<th>By Location</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Working Women</td>
<td>Non-Working women&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>Bosnia and Herzegovina</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Kosovo</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>FYR Macedonia</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Serbia</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>13</td>
<td>13</td>
</tr>
</tbody>
</table>

2 WOMEN’S CARE BURDEN IN THE WESTERN BALKANS

2.1 WOMEN’S CARE RESPONSIBILITIES

2.1.1 Descriptions of Women’s Care Responsibilities

The ultimate goal of care for both children and elderly, is described in broad terms of “ensuring physical and psychosocial well-being” of the “care receivers” who are perceived to be incapable of ensuring their own well-being without external support. Women’s descriptions of unpaid care for children and elderly involve: (a) tasks that involved direct physical service for the physical needs of the care receiver; (b) tasks that required spending quality time with the care receiver for their social, emotional care needs and ensuring cognitive well-being. In addition to these primary care tasks, participants also mentioned unpaid house chores and financial responsibilities to meet care needs as part of their broader care responsibilities (See Figure 2-1).

Figure 2-1 Row % of Women’s mentions in WB FGDs of different care tasks.

Generally the number of mentions of unpaid physical care tasks exceeded other care descriptions for both child and elderly and was followed closely by mentions of unpaid house care/chore responsibilities. The Petal Diagram activity on time use also shows that women relatively spend the most time on these two major activities.

Physical care tasks/needs are those that prioritize the physical well-being and health of the “care receivers.” It was this type of care that was mentioned most frequently for both children and elderly in all the discussions, suggesting that it makes up the better part of unpaid care responsibilities. For children, this group of care includes tasks such as: feeding, bathing, dressing, putting to sleep, caring when sick and ensuring the physical safety of the child. For elderly, the physical care work includes addressing both medical assistance needs and basic day-to-day needs which involves tasks such as: observing health, giving medication, taking to the doctors, feeding, helping with daily needs (including housework tasks such as cooking, cleaning, chopping wood), helping with basic needs (bathing, eating), etc. Among other paid care tasks mentioned, physical care tasks are also those that were the most mentioned by participants while ranking time allocation.

<sup>1</sup> Non-working women category includes unemployed and inactive women.
Social-emotional-cognitive care tasks/needs are those unpaid care tasks that are related to ensuring the psychosocial, emotional and cognitive wellbeing and happiness of the “care receivers” and involve spending quality time with them. For both children and elderly, these tasks include talking/chatting, showing love and affection and taking them for a walk. For children, playing with them, helping them in their homework and teaching them cognitive, physical and other skills also fall under this category; and for the elderly, much emphasis is placed on provision of a comforting environment. In comparison to unpaid physical care, these tasks seem to take less of women’s time.

The components and volume of unpaid house work responsibilities are also closely related to the physical care responsibilities of women, particularly because they involve tasks such as cooking and doing the laundry, as well as chopping firewood and shopping – tasks that are not solely related to child or elderly care, but are nevertheless about attending to the physical needs of the household members. Several women in different FGDs stated, for example, that house work would be more and take more time if the children were small or many.

Financial Care for elderly and children is also mentioned as a primary care responsibility by participants across WB. When asked about the meaning of care, many participants across different countries mentioned the financial aspects of care responsibilities that are needed to address physical and social-emotional care needs of care receivers in the family. Financial care for children covers being able to cover their basic needs required for their healthy development (like food, shelter, clothes etc.) and education. For elderly, it includes supporting them financially if they are not able to support themselves, or contributing to the costs of their care needs.

2.1.1 Factors That Affect Time Allocation on Care Tasks

Several factors affect care needs of children/elderly and the time allocation on care tasks by women, such as age of children, the level of care needed by the elderly, or living arrangements. Overall, participants reported that, most of the time, physical care tasks take more time than social-emotional care tasks for both children and elderly. For children, number and age of children are primary determinants: as children grow older and more independent, and as they start school, less time is spent on physical child care tasks (particularly those that are related to basic needs), and more time on tasks that require quality time: such as, helping in homework and conversing to provide guidance.

Time allocated on eldercare depends on the intensity of the care needs of the elderly on one hand, and on the living arrangements -or geographic proximity between the residences- of caregiver and care-receiver on the other. The most prominent factor that affects time allocated by women on eldercare is the degree to which the elderly is mobile and is able to take care of his/her own basic needs. Similarly, the health condition and medical needs of the elderly, as well as the distance between caregiver and care receiver homes also determine the amount of time spent on eldercare. Finally, in contrast to children, as elderly age, they are perceived to need both more physical care and socio-emotional care; however, as will be explained below, this overlap does not necessarily imply an increase in time allocation.

Overall, women in Western Balkans reported to allocate more time per day on childcare and less time on eldercare. Meanwhile, time allocation on responsibilities follows a different pattern for each type of care. Women’s descriptions of their care show that common childcare tasks undertaken in a day are more frequent, takes relatively longer time and are also spread more evenly over a week in comparison to elderly care tasks. Furthermore, caring for a child means constantly being attentive to her safety, even while undertaking other tasks. Elderly care tasks on the other hand are often either tasks that individually take little time but are spread over a day, or tasks that take a longer time but are not undertaken on a day-to-day basis.
For example, participants explain that two of the most mentioned of the elderly care tasks, measuring blood pressure and giving medications of elderly, take only a few minutes to accomplish and yet are crucial and, depending on the situation of the care receiver, sometimes should be done several times a day to ensure the health of the elderly. In other words, although the absolute time spent on care tasks are less, it nevertheless requires the commitment of the caregiver spread over a day. Conversely, taking the elderly to the doctors (including commuting and waiting) or providing care for parents who live afar a few times a week, take a longer time on an individual basis; however, these are not daily, but rather weekly tasks.

**Overall, gender roles seem to be relatively more defining for childcare division of labor within households regarding types of care responsibilities in comparison to those of eldercare.** Women’s and men’s own reports of their time use show a clear division of labor between men and women with regards to childcare. Both men and women mention undertaking care responsibilities that are related to education, development and quality time, however, it seems that even with these tasks, the burden of care is more on the women than men: “(Protesting) If I can do it, so can he! He can take the same responsibilities for everything: for children, school, all the activities... But he does not even know whom the class teacher is to go to the children’s parent-teacher meeting!” (Urban woman, Bosnia). Moreover, it is primarily women who mention bearing the physically more demanding responsibilities related to childcare as well as, again, the physically demanding housework.

**Figure 2-2 Number of Women’s mentions in WB FGDs of care support at home**

A significant proportion of the women reported having no paid or unpaid support in their care tasks.

<table>
<thead>
<tr>
<th>Women FGDs - number of mentions/women</th>
<th>Having no support</th>
<th>Having some unpaid support</th>
<th>Having some paid support (such as nurse or nanny)</th>
<th>Having financial support for care tasks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bosnia</td>
<td>25</td>
<td>52</td>
<td>7</td>
<td>12</td>
</tr>
<tr>
<td>Kosovo</td>
<td>26</td>
<td>25</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>Macedonia</td>
<td>17</td>
<td>38</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Serbia</td>
<td>20</td>
<td>25</td>
<td>1</td>
<td>5</td>
</tr>
</tbody>
</table>

Source Data: ECA Care Focus Group Discussions Qualitative Dataset

**Figure 2-3 Mentions of support for women in care and house responsibilities by family members**

It was observed that mothers (including mothers-in-law) and husbands had the highest number of mentions for provision of care support to women at home. Taken together with mentions of “parents,” number of mentions of mothers is higher than that of husbands. Other family members such as daughters, sons, sisters and brothers were also mentioned as providers of support for care.

Support for women in care also mainly comes from other women in the household and particularly mothers and mothers-in-law. Although husbands are also recounted as providing support in care tasks, discussions show that, regardless of whether the “care receivers” are children or elderly, support for the core
and more time-consuming physical care activities, are provided to women by their mothers or mothers-in-law (Figure 2-3). Conversely, husbands are more engaged in care tasks that require quality time; in this sense, their support is not the kind that would ease the burden of care on women is only “help”. Meanwhile a significant proportion of women across the FGDs also report having no paid or unpaid support available (Figure 2-2).

Women are not always content with their “de-facto” roles as care givers and many demand some changes in these roles. Many women think that redefining prevailing gender roles in their families, particularly with regards to house/care responsibilities and working for pay, would improve their lives and decisions. While not all women demand changes in gender roles, some have expressed agreement with the prevailing norms, among those who do, the changes desired primarily fall under two main categories: (a) demand for “more equal” division of labor at home, and to a lesser extent (b) more equal responsibilities regarding employment and financial independence.

2.2 THE IMPACT OF CARE RESPONSIBILITIES ON WOMEN’S LIVES

2.2.1 Impact on Education and Labor Force Participation of Women

Caregiving responsibilities negatively impact women’s participation in the labor market due to three main factors: norms around childcare, lack of affordable quality care services, and conditions at the workplaces that are unfitting for women with care responsibilities (See Figure 2-4).3

Social norms around family, childcare and gender, which define women in the family (mothers) as the primary bearers of child care responsibilities, result in prioritization of care responsibilities over employment prospects, and lead to interruptions in labor force participation for women. Some women view interruptions in their employment due to childcare as both a “mother's duty”, and as a “sacrifice” / “concession” in their careers – one, which women have to make for the sake of families and children, and yet one which curbs their long-term career potential. In this sense many women believe that having to quit jobs hinders them from a more successful career and from fulfilling their full potential.

Lack of formal or informal care service support, and particularly of childcare services that are suited to working women’s needs seems to be another cause for women’s career interruptions. Having no informal care support for their children, and no accessible formal services that could support them, was the reason why some women had to stop working.

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2 Discussions among women about the gender roles took place mostly in urban groups, and much less in rural groups with the exception of Serbia. In terms of intensity of discussions, Serbia was the country where these issues were discussed the most, and was followed by Bosnia and Macedonia. In terms of number of women who participated in the discussions, Bosnia was followed by Macedonia and Serbia.

3 Career interruption due to care work was primarily mentioned in Western Balkan FGDs around childcare responsibilities and services, although few women also voiced experiences of leaving employment due to their eldercare responsibilities.
and/or could not resume when they wanted to. Others mentioned that the availability of formal care services enabled their employment.

Finally, conditions at the workplaces that are unfitting for women with care responsibilities also result in career breaks. Several women in focus groups mentioned long working hours and high workloads that result in overtime work in weekend shifts or working home at nights as reasons why they quit working, explaining that they were not able to care for their children adequately.

Elderly care also poses a challenge for women’s participation in the labor force, particularly for the younger generation of women who are responsible for eldercare. In comparison to childcare, elderly care was mentioned less in the context of having to quit or being unable to work. Nevertheless, there were still a few women who were also affected by their eldercare work in their employment and education decisions. Even when the elders are not bedridden and do not have intense care needs, eldercare responsibilities can still keep women from working. This is because, although eldercare does not always take as much time per day as childcare, as explained above, the constant need to be alert about the elders’ health condition throughout one’s day prevents women from working.

2.2.2 Childcare & Challenges in the Workplace

Care responsibilities also impact women by making them subject to particular discriminatory practices or challenges at work and impact their productivity and/or promotion prospects. Two particular problems faced by women with children are (i) the lack of flexibility in working arrangements for women with care responsibilities, and (ii) negative discrimination towards women with children in recruitment practices.

A major challenge for working mothers seems to be lack of flexibility in working arrangements that ignore or disregard care responsibilities of women with young children. Many women, when asked how their bosses think of the way they balance work with care responsibilities, replied that their bosses only care about the work getting done; that they expect the same strict performance and attendance from them as they do from men and childless women: “You know what, they do not care. You just have to meet the norm. Nothing else matters” (Urban woman, Bosnia). This means that women who want to continue employment have to bear the burden of care on top of their already existing professional responsibilities, which at times might include frequent overtime or weekend shifts. Moreover, school meetings or children's illnesses generally require women’s commitment and might require them to take time off from work. Particularly children's illnesses are a major challenge as voiced across different groups: when children get sick, the responsibility of taking care of the child, or finding an appropriate solution generally falls on the shoulders of the women.

Participants explained that lack of flexibility in the working arrangements might often impact women’s productivity in the workplace negatively. Having too much care and professional work might have negative impacts on psychological and physical well-being of women, deteriorate their performance due to tiredness, cause them to work for longer hours for lost time, and might in the end create a cycle where unproductivity and poor-well being reinforce one another.

Conversely, as mentioned in the focus groups, understanding superiors can help women in balancing their care and professional responsibilities. Such a flexible approach eases the psychological

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4 Conversely sufficient division of labor within the family, and particularly availability of informal care providers at home, is voiced as the primary factor that enables women to continue their employment lives without (or with minimal) interruptions.
burdens that are brought by these competing demands and might allow women to stay in the work force, but it does not impact women's time use, as women have to compensate for the flexibility as overtime.

**In face of such challenges some women change their employment strategies and move on to less demanding jobs.** Several women in the FGDs, regardless of country, stated that changing the course of women's careers and taking up less demanding jobs or jobs with fewer working hours was a required way to balance demands of paid work with care responsibilities. Taking up less demanding jobs, women are able to attend to both care and paid work responsibilities while protecting their physical and psychological well being. On the other hand, this means women work in low-pay, low-qualification jobs and prevents women from getting higher positions in time.

2.2.3 Longer term implications of career interruptions

Some of the women who quit their jobs due to care responsibilities express willingness to go back to the labor force when the children are old enough. However, resuming work after interruption is not always easy. Intended or unintended career breaks due to care work and lack of formal/informal care services create a particular challenge for women in getting back to the labor force: “When you don’t find a solution for your children, you stop working. When they are grown, we are old. Now you can’t get a job. This is what our cost is; now 80% of the village is unemployed” (Rural woman, Kosovo).

**Interruptions in career with young children negatively affect women's competitiveness vis-à-vis younger or childless women, as well as men.** In the FGDs women, regardless of country, explained that women with children are very disadvantaged in the job market, as employees prefer childless and younger women due to concerns about productivity. In other words, once women are out of the labor force, it becomes difficult for many of them to find their way back in, in the current competitive circumstances. As a result, many women who cannot make it back to the job market have to accept unemployment.

**Interruptions in career might also make the opportunity costs of resuming work too high to bear and dissuade women from working.** As explained by some participants, those women who are decided on finding jobs might find out that their options are limited by lower quality jobs with lower pay and/or worse conditions in comparison to their previous work life, and see no added benefit in continuing to work. Family members, and particularly husbands, also might feel the same way and influence/encourage women to not work arguing the opportunity costs are too high. As a result women get even more deeply detached from the labor force.

Finally, it must be mentioned that resuming work after breaks for childcare does not always lead to an inability to find employment, neither are childcare and career breaks the only reasons for women’s unemployment in the region. Among focus groups there were participants who stated that they were able to find employment following their career breaks; however, the subject was not explored further in discussions, and it was not clear what differentiated their cases from those other women who were unable to do so. Moreover, many women explained, particularly in Kosovo (but also across other countries) that high unemployment in the country -rather than having children- was the cause that they were not able to find jobs. While discussions suggest that in the current competitive job market, caused by high unemployment rates, having children and aging are detrimental to women’s employment, the relationship between the two factors deserves further analysis.

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5 Part time jobs were the most mentioned in Serbia.
Finally, care responsibilities also impact women’s psychological and physical well-being. For working women, having to shoulder both childcare and professional responsibilities is challenging. The time use exercises, as well as women’s discussions, show that working women do not have much time for recreational activities. Often times, they have to balance competing demands at home and at work via concessions from their free times and sleep. These competing demands are not only tiring for their health but concerns about their own ability to achieve a balance is also hurtful for their psychologies, causing stress and anxiety. Eldercare responsibilities also affect women’s health. Especially caring for bedridden elderly or elders with mental conditions seems to be physically and mentally challenging for many women. Furthermore, the elderly caregivers very often involve middle-aged woman, themselves getting old. A participant also explained that unlike childcare, elderly care limits women’s mobility and “keeps you chained” in the house.

3 Demand For Childcare Services

3.1 Center-Based Childcare & Community Services

Perceptions on whether or not to use center-based childcare are shaped primarily by an interrelated assessment of potential benefits and harms of using these centers for the children (and their mothers) vis-à-vis the actual ability of the families to use these services. Qualitative analysis shows that positive perceptions to use childcare centers are primarily about those factors, observations and beliefs that motivate parents to send their children to care centers (such as the quality of ECD provision and consequent social, psychological, behavioral and cognitive benefits of using care centers for the child), as well as fulfillment of families’ key quality conditions by the care providers that ensure these motivational factors are met. Negative perceptions are about those factors and conditions in the absence of which the families would not or cannot send their children to care centers; such as factors related to quality, security and health. In the Western Balkan FGDs perceptions and views about using formal center-based childcare services across Western Balkan FGDs have been primarily positive (Figure 3-1).

3.1.1 Positive Perceptions on Use of Center-Based Childcare

Perceived Benefits for Children (Added-value of formal care)

Willingness of parents to use center-based formal care is closely related to the perceived benefits of enrollment for children’s development (ECD). Regardless of country or location, among those who were favorable to using kindergartens, the general view is that enrollment in kindergartens positively impacts development of children, in terms of (a) social & emotional development, (b) cognitive & linguistic development, and (c) school readiness and academic achievement.

Source Data: ECA Care FGDs Qualitative Dataset

- Kindergartens are viewed as spaces of socialization for children with their age peers; spaces where they play with friends, learn...
constructive behavior, such as cooperation and sharing, become more independent and spend a good time. As a motivation for enrollment, “socialization” was mentioned across all groups, and was particularly emphasized by urban women, regardless of employment status. Kindergartens are also seen as spaces where young children educated to attain good habits, get into the routine, and become more independent by learning basic self-care tasks. Along these lines, having had such pre-school education is also viewed as an investment on the child’s future by many, and furthermore by a few as a broader investment in the future generations.

(b) Cognitive and linguistic development of children. There is the general belief across groups that enrollment in kindergartens supports the cognitive development of children. Learning new words, improved self-expression and communication are some of the benefits voiced in this category. Cognitive and linguistic benefits of kindergarten enrollment are also viewed to be particularly beneficial for children with special needs, such as children with speech problems: “My younger child had a speech problem, so I wanted to enroll him in kindergarten as soon as I could. He fought with the problem on his own, then being with other children in the kindergarten, and I was very satisfied.” (Urban woman, Serbia)

(c) Future school readiness and higher academic achievement. In focus groups, participants explained how they view kindergarten as a preparation for school and explained their belief that attendance in kindergarten has long lasting impacts in terms of higher academic achievement. It was observed that mentions of the school readiness were visibly higher in number in rural groups, regardless of country.

Overall, happiness of the child and her smooth psychological and physical adaptation to the care environment acts as a barometer for parents to reevaluate their decisions to use kindergartens, as well as to measure their benefits for children. In many cases, participants’ positive mentions of the care centers also involved emphases on children's own happiness in the care environment: “We are happy if our children are happy. We love it when we take them to the daycare and they run to the lady who works there.” (Urban woman, Bosnia). Furthermore, across all groups, women explained that no matter how they feel about the added benefits of the care centers themselves and despite their willingness to use these services, the children's ability to get used to the new environment and his/her happiness was decisive in the final decision.

Meeting Adequate Standards

Parents’ perceptions of and willingness to use center-based formal care are also related to the fulfillment of families’ key quality conditions by the care providers, which center on physical and emotional safety and security of the child. It is observed that satisfaction with the teacher in particular plays a key role in participants’ perceptions of childcare services. Teachers’ relationship with and attitude toward the child is seen to be the major determinant of the benefits of kindergartens on children; conversely, an unqualified and inattentive teacher is perceived to be a risk towards child’s physical and emotional well-being. Similarly, quality of basic services, such as hygiene conditions in the facility, healthy meals or the level of basic care support provided to children by staff are seen to matter in terms of children’s healthy development.

Perceived Benefits to Mothers

Childcare services are thought to be also beneficial for the mothers, particularly with regards to labor force participation prospects. Center-based care, provided that it meets participants’ subjective minimum care requirements, is perceived to be beneficial for non-working women, by taking some of the burden of care from their shoulders and let them have some free time. But more important is kindergartens’ support role for working mothers. For many actual or potentially employed women with no access to informal care services
from their families, provision of formal care services are vital to continue or resume their employment. Similarly lack of formal care services also prevent some women from participating in the labor force, despite their willingness to do so. In such cases where supply is insufficient, mentions of positive perceptions to use care centers by women also involve demand for these services: “If we had a close-by daycare we would send them, but since we don’t have a daycare, we don’t go to work. If there is no one to take care of your children at home you don’t work.” (Rural woman, Kosovo)

3.1.2 Negative Perceptions on Use of Center-Based Childcare

**Perceived Inadequate Care Standards**

Poor quality of services in kindergartens was the primary theme that was mentioned as part of negative perceptions regarding center-based childcare. As will be examined in more detail below, regardless of country, many participants mentioned the overcrowding, frequent epidemics that make children sick, maltreatment of children by staff, inadequate basic care provision for children by staff and poor hygiene conditions as problems that would determine their decisions to not use kindergartens.

Diseases are a deficiency. If one gets the flu, then everyone else also gets it. My godmother withdrew her children from kindergarten. They were sickly, having high temperatures every once in a while. Now their grandparents babysit them. (Urban woman, Bosnia)

In Bosnia, participants also mentioned inadequate information provided to them by staff as a problem. In Kosovo, a man explained how he felt about using these services as follows: “You send your child in school and you never know what will happen or how they will come back” (Urban man, Kosovo). Overall, if the participants feel that the physical and emotional well-being of their children is at risk, then they chose not to use care services (More analysis on this is provided below in section on quality).

**Lack of smooth transition from home to childcare**

Lack of smooth transition from home to childcare for children was mentioned another barrier to using kindergartens, and affects many families’ decisions and willingness to use these services. A significant number of women, and particularly non-working ones, in the FGDs mentioned that they enrolled their children in kindergartens, however due to inability of the child to adapt (such as crying, not wanting to go, etc), they reversed their decisions after a few days / weeks. Participants were mostly worried about their children’s psychology and that being enrolled in a kindergarten could do more harm than good in the absence of child’s consent. Some women also explained that this period of transition, and seeing their children unhappy, was mentally very difficult also for them. As will be explained below, some thought that the problems of adaptation of children were to some extent to teachers’ qualifications and attentiveness.

**No perceived added-value of using care centers**

If informal childcare is available in the household, the decision to use childcare services depends on the perceived added-benefits of using care centers. Therefore, perceptions that kindergartens offer no added-benefits to children dissuaded parents from using these services. Seeing “no need” to use the childcare services solely due to availability of informal care at home, and hence considering it a waste of finances, seems to be more particular to men. In Serbia, a few men voiced this perspective and in Bosnia a woman shared her husband’s perspective. Provision of services below expected standards, particularly with regards to children’s development, also influence parent’s decisions; when parents think that the quality of the education and developmental care is low and/or child-staff ratios are high so as to prevent adequate attention paid to each child, they might be dissuaded from using these services.

**Norms on childcare and motherhood**
Strong norms on childcare and motherhood also shape negative perceptions on use of care centers. Although mentions of norms in shaping negative perceptions were very few across groups, it nevertheless came up in the discussions a few times. Several participants in the focus groups expressed that children should be cared for at home and/or by their mother, at least until a certain age. Lack of trust in the formal care givers can also influence such decisions. Sometimes the older generations (i.e. children’s grandparents) can also have an influence on such decisions; and at other times mothers might have to act in contradiction with these norms even though they support them and this might result in feelings of guilt.

To sum up, it is observed that perceptions on use of formal care services are primarily about positive and/or negative observations regarding attributes, and particularly (basic and value-added) quality of the current supply. Moreover, women’s views about their own roles within the family – whether they want to participate in the labor force or take care of their own children at home – also is influential with regards to these perceptions.

3.2 CURRENT ATTRIBUTES OF CHILDCARE CENTERS & EXPECTATIONS

3.2.1 Accessibility of Childcare

Accessibility of quality and affordable childcare is voiced as a general problem across Western Balkans, where supply of care services does not seem to meet (actual or potential) demand from households. In urban groups, regardless of country, lack of sufficient facilities and restricted capacity for children’s enrollment are the two inter-related main problems mentioned by women. In other words, although there is some recognition of supply of care services that are theoretically accessible to households by location, this is evened out by problems of insufficient supply and low capacity. In rural groups, the main problem is a total lack of childcare services; except for part-time compulsory pre-schooling that were mentioned by some participants, there seems to be no kindergartens or alternate services for childcare in villages where the FGDs were held.

Overall, in urban areas, insufficient number of affordable/public childcare centers and high demand from families creates a capacity problem and makes childcare inaccessible for many. Regardless of country, low capacities of the state-owned kindergartens seem to be the overarching problem that confronts urban families across Western Balkans. On one hand, there is the problem of inaccessibility: participants across Western Balkan focus groups explained that there are kindergartens, but enrollment is managed by long waiting lists, and often times families’ turn might never arrive. Nepotism for admission is perceived to be common and necessary as a way out of this problem – “you need to pull some strings to get in” – which is not an option for the majority of the citizens.

On the other hand, there is the problem of overcrowded classrooms and inaccessibility of childcare with adequate quality. In the absence of sufficient number of care centers with sufficient capacities, it is understood that many of the mostly-state-owned facilities are functioning far above their actual capacities. Therefore, high child-staff ratios seem to be a chronic urban problem shared by all of the seven Western Balkans, and one which trouble parents deeply: “The kindergartens should have more staff. One person for 30 children is crazy, how will they give them food?” (Urban woman Macedonia). Indeed, during the discussions

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6 Like with female labor force participation, the minimum age for children’s attendance to care centers was not always clear in discussions as the question was not among the key questions in the topic guide.

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on accessibility and quality, overcrowding classrooms was one of the most mentioned issue that dissuaded participants from using the childcare centers. As will be discussed below in more detail, not having sufficient capacity has serious implications in terms of deteriorated quality of care provision, which in return might have negative impacts on children’s social, emotional and physical development. Indeed, discussions show that access to high quality care is significantly limited either because lack of quality public services or because good quality services that are provided by private kindergartens are unaffordable for many families (Also see The Problem of Overcrowding below).8

**Provision of childcare services in rural areas either is scarce or non-existent.** For rural parents regardless of country, location seems to be the main problem in terms of accessibility. Either there are no kindergartens in the villages, or when they exist, they do so in the form of half-a-day pre-school education for 5-year-olds. Even then, there are problems of quality. In face of lack of supply, one solution for some families living in rural areas is using distant centers in neighboring towns or cities. However, ability to use care services afar also requires financial resources and, more often than not, rural families do not have the resources to bear the time and financial costs of using distant services (see also the Affordability section below).

**Regulations for public childcare services might also restrict accessibility to these services for households.** For example, in Kosovo urban FGDs, a non-working participant said that she was not able to enroll her child in a public kindergarten since public services accept children of working mothers only. In Kosovo rural FGDs, another participant explained that her from attempt to enroll her child in the public kindergarten in the nearby city where she also used to work was rejected since they were residents not in the city but in the village: “There is no way that they get accepted in a public daycare if they are from village and come here to Prishtina”.

**Hours of operation by care centers are closely related to accessibility of these services by families, as well as to whether these services meet care needs of communities.** Discussions in Bosnian, Macedonian and Serbian urban focus groups show that hours of operation is a concern for working women in particular, since working hours of kindergartens are not always in line with their own or their husbands’ professional working hours. In the Macedonia and Serbia urban FGDs for example, some participants welcomingly mentioned the recent extensions in the working hours of some kindergartens from 4.30 pm to 6 pm, and explained that longer hours of employment or working in shifts requires rearrangement of childcare service hours accordingly. Discussions in urban groups suggest that private care centers are perceived to have more flexible working hours than public ones, and so to be better at meeting demands of working women.

Importance of hours of operation was also mentioned in Serbian rural groups where both men and women voiced a need for kindergartens and explained how availability of childcare would not solve families’ labor force participation problems unless the services were full time.

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8 It must be added that views on availability of services voiced in FGDs are also affected by participants’ own perspectives of the current demand of these care centers. For example, in Bosnian FGDs two women mentioned that supply was sufficient (hence there was “positive accessibility”) with assumption that demand for formal care is low due to availability of informal care by mothers: “We have enough daycare facilities taking into account that our women do not work;” “Well, there is [sufficient number of kindergartens], because there are a lot of women who are at home so we take care of our children ourselves” (Urban women, Bosnia). In other words, participants’ statements of positive or negative accessibility does not reflect how the overall supply is across WB, but rather how they experience it within their own surroundings. Along these lines the qualitative analysis of participants’ statements on accessibility have primarily focused on negative mentions to understand the main problems regarding accessibility and the unfulfilled demand vis-à-vis supply. Without doubt, the analysis will be complemented by the supply side assessment for a more holistic picture.
### 3.2.2 Affordability of Childcare

Affordability of care was mentioned as a barrier to use childcare services across groups. The issue was discussed in more detail in Bosnia, Kosovo and Macedonia. It was not discussed much in Serbia.\(^9\) It was understood that costs of public care was less than private care centers. It was also understood that while public care is more affordable than private care, and although there were many participants who stated that public care was affordable, still there is an overall affordability problem that makes these services inaccessible for some segments of the population, such as these women.\(^10\) Moreover, for some more disadvantaged segments of the population that work for less pay (or minimum wage), their incomes are not enough to cover costs of care services they want to use. Kindergartens are very expensive. It costs an entire salary. “It costs 180 KM [and the minimum wage is 370 KM]. So for two children it costs an entire wage” (Urban woman, Bosnia).

The common view across Western Balkan groups is that generally there is a reverse relation between affordability and quality/accessibility of center-based childcare and that access to high quality care is limited. Analysis of discussions shows that a significant number of the participants view cost of public care services to be generally more or less affordable, yet believe that quality of service provision is not adequate.\(^11\) Conversely, private care services are often perceived to offer higher quality of care and benefits to children overall, however for many households these services are not affordable: “I think we have enough services, if you can afford them. But for us they’re financially unavailable. So the price is the problem. Not all families can afford them.” (Urban woman, Macedonia)

Affordability and accessibility also seems to have an overall reverse relationship; and affordable care is not accessible by all. As mentioned, insufficient supply of public services, as well as certain regulations, creates an accessibility problem for families. In such circumstances where they have no access to public care, use of private care centers remains as the only alternative for some families, however again these services are not affordable for the majority of households.

Inaccessibility by location also creates a different type of affordability problem related to costs of having to commute long distances to reach care, which was voiced particularly in the rural FGDs. In lack of childcare services nearby, families who are willing to use care services might need to send their children long distances to care centers available in the neighboring villages or districts. No matter how affordable the cost of care centers might be, the financial (as well as opportunity) costs of transportation might be too high for many families.

### 3.2.3 Quality of Childcare

Quality perceptions and expectations of participants in Western Balkan FGDs were discussed around three main themes: (i) quality of basic care services including infrastructure, (ii) quality of ECD activities, and (iii) quality of caregiving staff. Quality of basic services, by participants’ own accounts, includes sufficient care provision for children’s basic needs such as eating, cleaning, sleeping as well as measures that ensure children's health, safety and security. Quality of ECD activities relates to the content

\(^9\) During discussions, it was not always clear in transcripts whether participants were referring to public or private care services in their remarks.

\(^10\) There is need for further research in this, as it is not possible to tell from FGDs and qualitative analysis with segments of the population can afford the currently available services, or what the conditions are for affordability.

\(^11\) It must be noted that differentiating between whether the participants were mentioning public or private care was not always clear.
and/or variety of activities that benefit children’s social, behavioral and cognitive development, such as drawing, playing, singing, doing physical activities, as well as socio-behavioral education provided by caregivers. Quality of caregiving staff is described in FGDs with regards to capabilities of caregivers in adequately meeting both basic and ECD needs of children, and therefore is closely related to both the basic service quality and the quality of ECD.

**Quality of Basic Care Services:**

One of the most mentioned and commonly shared problem voiced in Western Balkan urban FGDs regarding basic services include frequent epidemics. Many participants reported constantly having their children getting sick in public kindergartens. Some also stated that despite their willingness to use kindergartens for its developmental benefits on children, these epidemics alone affected their decision to switch to home-based care (by themselves, grandmothers or nannies) instead of formal care centers.

Discussions show that frequent epidemics not only threaten the health of children, but also might place an additional burden on employed women using these services. Among working women who have to solely rely on kindergartens for care support, few reported that these epidemics were very troubling for them as their children getting sick would require them to take time off from work or to find some form of informal care solution in their place. As explained elaborately by this urban woman from Macedonia: “Kindergartens are ok, but children get ill frequently. So, who is going to look after the kid then? “

The quality of basic care services including infrastructure are perceived to be problematic particularly in public care centers. Other common (experienced or observed) problems regarding basic services, especially in public kindergartens, voiced in the FGDs include the following: infrastructure suffering from poor hygiene conditions, such as dirty toilets, kitchens and sleeping spaces, sheets, etc. mossy walls; unhealthy or day-old meals; lack of sufficient basic materials for children such as sleeping spaces/beds; lack of attention by staff that might endanger children’s safety; neglect of children’s basic needs by staff (such as not helping with toilet or hygiene needs, or neglecting making sure children are well fed); staff behavior that endangers children’s emotional well-being (such as yelling at children or inflicting physical harm). As might be seen, some of the problems identified with regards to basic service provisions in kindergartens were related to acts by staff / teachers.

**Quality & Attentiveness of Teachers**

Quality and qualifications of teachers are seen by parents to be the most significant factor in determining the overall quality of care. Having qualified teachers is seen to be directly related to ensuring children’s health and development and qualifications of teachers are seen to be directly related to the added benefits of using care centers. On one hand, quality of teachers, and their attentive, caring approach to children is viewed to have a key role in ensuring basic physical and psychological health of children, as outlined above. Treating children kindly, being attentive to all children’s needs without discrimination, and watching over them are the expectations of participants with regards to teacher quality. On the other hand, teachers also play an important role in children’s development: they are the ones who help children gain habits and enable a constructive learning environment for them. So the shared view among participants is that, keeping other issues constant, a well-trained and caring teacher makes a significant difference in terms of quality of care provided to children, even up to the point of compensating for other quality deficiencies.

There is general demand for improving the qualifications and performance of teachers in kindergartens, which will then (i) improve the quality of care provided to children and (ii) ensure healthy transition for children from home to childcare. Some of the main problems mentioned during focus groups regarding teachers concern mostly teacher behavior such as indifference of staff, inadequate
attention paid to children and maltreatment; all of which have potential long-term negative consequences for children's physical, emotional and cognitive well-being. Furthermore, several participants believe that teachers are not motivated or well equipped to guide children's transition from home to childcare – an important observation, especially because inability of children to adopt to kindergartens in the first few days is stated among one of the major reasons for early drop-outs from kindergarten (also see discussion above on adaptation of children).

There have also been numerous mentions of having qualified teachers across groups, however such cases seem to be arbitrary and depend on chance. During discussions, besides problems expressed regarding teacher quality, many urban women in various countries also explained how they were satisfied with their children's teachers and their provision of basic care and education. Some explained how despite some basic care service problems due to infrastructure, their children were very happy with the services because of the teacher, etc. Having such good experiences, however, does not seem to be due to systematic qualities of care provision in Western Balkans. Qualitative analysis shows that regardless of number of mentions, having teachers with adequate qualifications seem to be arbitrary and depend on chance, as also acknowledged by some participants themselves. As a solution some families pursue qualified teachers rather than institutions. Also generally, but not always, participants think that quality of teachers in private care centers are better than in public ones.

Overall, poor performance of teachers is attributed overcrowding in care centers, which is a common problem across all Western Balkans with many implications on quality, and will be examined in detail below.

The Problem of Overcrowding

The issue of overcrowding in kindergartens due to insufficient service supply, and consequent high child-staff ratios seems to be a common chronic problem across Western Balkans with various detrimental quality implications. Overcrowding seems to affect public kindergartens the most, and the number children that were mentioned across groups by class ranged from 30 to 60 children. The need for having more care staff to match the number of children (teachers) for adequate care was repeatedly voiced across groups. In some groups the number of children mentioned per staff was as high as 50. It was observed that even in cases where pre-schooling is mandatory by the state, and so high enrollment rates are to be expected, such as in Serbia, the capacities of facilities were still not perceived to meet the number of children.

Overcrowding is considered to be a serious problem by parents across Western Balkans, and is thought to negatively impact all other quality care attributes necessary for children’s wellbeing and development. Having “too many children” in facilities with insufficient physical capacity and few staff leads to deterioration in the quality of hygiene conditions, and causes unequal, insufficient and low quality direct care provision for each child by teachers. It is also viewed to be one of the reasons for frequent epidemics. Overcrowding is also perceived to negatively affect the developmental benefits of kindergartens for children due to limitations in the social, emotional and cognitive engagement of teachers with children. Furthermore, it is thought to be one of the reasons unequal attention is paid to each child as well as for maltreatment of children by teachers: “There are teachers who treat children inhumanely. It's theoretically impossible to manage a group of 30 kids!” (Urban woman, Serbia).

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12 Participants during discussions mentioned insufficient social engagement of staff with children, not treating all children equally, children with unchanged diapers, children who were not taken to the toilet, children who hurt themselves due to staff negligence, child bullying at school, children not eating well due to negligence, yelling at or severely punishing children, etc...
DEMAND FOR ELDERLY CARE SERVICES

Qualitative Analysis of discussions of elderly care and time use in Western Balkan FGDs shows that, regardless of the level of care that is needed, participants’ understandings of what constitutes adequate care for the elderly falls into three main categories: social-emotional needs (companionship), medical assistance needs (medication and examination) and basic day-to-day needs (house chores, self-care, security). Social-emotional needs are needs of elderly for socialization with others, like having conversations, playing games, etc. Medical assistance needs include medical attention paid to elderly, such as management of medications, monitoring of blood pressure, provision physical therapy and transportation to and from appointments with doctors. Basic day-to-day needs include help with meal preparation, cleaning, shopping and other house chores and assistance in daily living tasks like bathing and dressing. Based on this definition of care, perceptions and views about using formal center-based childcare services across Western Balkan FGDs have been primarily negative (Figure 4-1).

4.1 CENTER-BASED CARE AND OTHER FORMAL ELDERCARE FORMATS

Formats for elderly care that were mentioned in discussions include both center-based care and home-based care. During analysis, it was observed that, unlike childcare where the center-based child day-care format constituted the core of the discussions on formal provision of services, discussion of formal eldercare included mentions of different formats of care. Mentions of center-based care services for elderly included primarily residential eldercare (“elderly homes”) centers and, to a lesser extent, on centers for daily attendance such as retirement homes where elderly socialize during the day. In addition to center-based care, participants also mentioned forms of home-based formal care including full/part-time private care service provision by individuals or professionals, as well as regular home visits by social workers, or professional NGO staff, to provide support in medical and physical care for the elderly.

Perceptions on whether and which type of care format to use for the elderly are shaped by an assessment of potential benefits and harms of using these centers for the physical and emotional well-being of the elderly. This assessment is also guided by social norms and filial obligations that prioritize the well-being of elderly above all else and define family (and particularly children) as the main agent to realize this end. Qualitative analysis shows that negative comments on use of care centers focus primarily on residential care for elderly and mostly correspond to participants’ views about these facilities being harmful for the overall well-being of the elderly. The negative comments also suggest that the residential format of the elderly care centers is seen by a majority to be incompatible with the prevailing care norms and filial obligations. Positive comments correspond mostly to descriptions of exceptional cases when (i) enter-based formal care for elderly could be preferred over informal care by family, to (ii) the perceived benefits of center-
based care for the elderly and the (actual or potential) informal caregivers in the family, and (iii) to the alternate forms of formal care that would be preferred by participants (had they existed).

4.1.1 Negative Perceptions on Use of Center-Based Eldercare

The general view across Western Balkan FGDs is that the most appropriate form of care provision for elderly is care by family (informal care), and many believe that using residential care facilities would be socially unacceptable and also psychologically and physically harmful for the aging. First, using these facilities is thought to be at odds with the societal norms and filial obligations. Participants’ negative comments of using residential homes for the elderly often include a perceived sense of their loneliness, desolation and isolation from family members and a caring environment; “sending” aging members of the family to these centers is associated with “leaving” or “deserting” them by a majority of participants regardless of country, location or gender. Indeed participants’ statements about these facilities sometimes involved very strong and emotional language: 13”Even if there were elderly houses I would not send my parents there. I would feel like I have dumped them to the dogs if I would do that.” (Rural man, Macedonia)

The widespread belief mentioned across different groups is that elderly homes are for those old people who do not have families to take care of them or for the aging homeless: “I think that there are prejudices concerning the homes for the elderly. The view is that if a family sends someone to the home they renounced them; that they won’t take care of them.” (Urban woman, Bosnia)

Conversely, caring for elderly at home by family members is viewed by many, as an obligation as well as the most appropriate way of helping their aging loved ones to live out their remaining years in comfort, health, peace and dignity, in the companionship of their loved ones. A sense of mutual responsibility for the well-being of each other in the family is the overarching theme that permeates discussions on negative perceptions about formal elder care. On one hand, in belief that elderly will get the most adequate care at home, some feel that they owe this to their parents. In addition to filial obligations, societal norms also play a strong role in negative perceptions about and unwillingness to use formal elder care. Participants across different groups explained that they would be judged and criticized by their social circles if they used these services, and/or feel ashamed for doing so: [If you use elderly homes] you will definitely be the topic of the day. They’ll say: “She took care of him for so many years and now she gave up on him, took him to a retirement home.” (Rural woman, Macedonia)

The quality of these centers in all four countries are also perceived to be problematic in general and shape negative perceptions. Many participants, regardless of country, share the view that using these services would be harmful for the medical and psychosocial well-being of the old people. In the focus groups, not one of the participants had direct, personal experience of using residential care services. Nevertheless, some reported of their impressions of poor conditions such as lack of hygiene, overcrowding, insufficient number of staff, negligence, and physical and verbal abuse of the elderly by the personnel, as well as depression among the elderly.

Indeed not only quality but also the residential format of the elderly care centers seems to be a problem that is inconsistent with social norms and obligations that emphasize well-being of elderly. The discussions suggest that for some of the participants, negative perceptions are more about the residential format and the poor quality of formal care that is associated with “deserting” aging loved ones, than being

13 Participants used expressions such as “even the idea makes me nervous”, “the idea of sending is horrible”, “I would faint when I saw the conditions in the facility”, “it is inhuman to send them”, “those children who send their parents are tyrants”, etc…
against any form of formal care provision per se. For example, an urban woman from Macedonia explained how she thought residential eldercare was incompatible with norms in her community and with her own perceived obligations, and yet home-based formal care could be an option:

People will judge you; it would be uncomfortable for me to send my in-laws to a retirement home. They have lived with us so many years. It would be like chasing them out from the house. Engaging someone to look after them is different, however. I would do that if needed. (Urban woman, Macedonia)

4.1.2 Positive Perceptions on Use of Center-Based Eldercare

While participants in Western Balkan FGDs mentioned similar themes with regards to negative perceptions about center-based elderly care regardless of country, comments of positive perceptions of participants varied across individuals, countries. Some has underlined that, provided that they have adequate quality conditions, elderly homes are useful and necessary services for those aging members of the society who do not have (available) family members that can take care of them. Others however, sometimes openly disagreeing with the prevailing norms against use of formal elderly care services, participants suggested several ways in which the aging family members, as well as the caregivers, could benefit from provision of such quality services.

The benefits of formal center-based elderly care services (i.e. comments of positive perceptions) voiced primarily in Western Balkan FGDs include socialization of elderly, direct medical attention provision for the elderly, and lifting up the burden of care for the caregiver women.

First, benefits of elderly homes as (potential) spaces for socialization of elderly with their peers of their age were mentioned in all Western Balkan countries, regardless of location. Provided that they meet the necessary quality conditions, participants in Western Balkan FGDs described elderly homes as a place where the elderly, instead of being alone at home, would spend quality time with their friends, playing games and chatting. In this sense, spending the day in the elderly homes, but not the night, was perceived by some to be more beneficial for the socio-emotional care needs of the elderly. At the same time, participants also acknowledged that the prevailing societal norms around elderly care made such benefits invisible and difficult to talk about.

Second, direct and quality medical attention provision for the elderly in the residential facilities was viewed favorably. Particularly in Bosnia, Kosovo and Serbia, participants explained that these services could be better than care at home for those elderly who needed constant medical attention and/or physical care labor. Indeed, even among those participants who opposed use of elderly care services in general, there were those who made exceptions regarding cases that were difficult to manage at home, such as those elderly who were bedridden or who had severe Alzheimer’s: “People condemn that, but there are such ill people that one cannot take care of. You work, but he can't take care of himself, so you have to put him under control somewhere.” (Urban woman, Bosnia)

Center-based care services for the elderly were perceived to be beneficial not only for the care receivers but also for the (actual or potential) informal care providers in the family. Particularly in Serbia and Macedonia FGDs, some participants’ discussions of the positive perceptions of elderly care centers focused on the “emancipatory” functions of these services for the care-giving women. Based on their own experiences or on experiences of their mothers, participants explained the difficulties and the physical and psychological costs of elderly care on the caregiving women. Women’s care burden is particularly difficult to be borne if the care receivers are bedridden or suffer from mental disorders such as Alzheimer and the care givers themselves are middle aged women. Therefore, formal elder care was seen as a way to improve caregiver women’s quality of life; yet again provided that the quality of these facilities meet adequate care
expectations. In discussing benefits of formal elderly care, some emphasis on generational differences was observed, particularly in the Serbian groups. For example, many of the women who are providers of elderly care for aging loved ones explained that although they would welcome these services, they would not use them for their respective care receivers, many because of norms, and some because of lack of consent on the part of the elderly. On the other hand, the same women explained that they themselves would be willing to use elderly care services so as not to be a burden on their children, like their parents were on them. Some younger participants also confirmed the gradual changes in norms and perspectives regarding use of formal elderly care.

Finally, although it was mentioned only in a few groups by a few participants, provision of formal elderly care is also perceived to be a facilitator of women’s participation in the labor force. In several groups, women emphasized the day care, vis-à-vis the residential care function of formal care, as a facilitating service for family members, particularly women who want to continue their employment without interruption, again drawing attention to the need for supply of quality elderly care:

Yes, I would send my parents to elderly daycare. That would be very good while you work you know that somebody takes care of them at the daycare or otherwise you have to quit. (Urban woman, Kosovo)

What if your son and daughter-in-law are employed, and then you get sick? What will they do? Will they quit their jobs because of you? …to take care of you? If there would be an institution where he could send you during the day, you would not be a burden for your family. …People still think that if you send your aging ones to Elderly Home, you are deserting them. The mentality needs to change because the elderly home is not that harmful. (Rural woman, Kosovo)

In terms of the format of center-based care provision for the elderly, day-care services (part-time or full-time), just like in childcare, seems to be more compatible with the needs and norms of the participants, in comparison to residential homes. As seen above, it is observed that the benefits of care centers emphasized by participants are primarily related to day-care functions of these centers. Benefits such as socialization of the elderly, provision of day-time medical care, relieving the burden of care from other members of the family, facilitating women’s employment - all are seen to be served also by provision of day-care centers, where the elderly would be cared for during the day but leave for home in the evenings. This format is also seen to be more compatible with norms as it would allow old people to be also with their families.

“I would send my father-in-law if there were elderly daycare, just during the day, but to leave him there forever, no; I would feel bad. I don’t know it’s a pity to leave him there.” (Urban woman, Kosovo)

Meanwhile, contemporary patterns of employment, and particularly immigration of young people abroad for work, are also thought to create a need for residential care centers. Although it was not discussed in detail, some of the discussions in the groups, regardless of region suggest that the immigration of young people to other countries for work (such as Germany) created and will keep creating a problem of available informal care provision for the elderly. In such circumstances, residential care centers are seen to be important to address eldercare needs, despite prevailing norms that suggest otherwise.

Overall, qualitative analysis of positive and negative perceptions around formal elderly care suggests that while negative perceptions around norms and quality considerations dominate general views and decision-making processes, changing needs of women, (both due to employment and changing market conditions and due to the increasing burden of care on women), push for a change of norms and programs around elderly care. Hence, new formats of are necessary to suit these needs other than (or in addition to) residential care by family.

4.1.3 Other Care Formats: Views on Home-based Care in the Western Balkans
Home-based formal care emerges as an alternate to center-based care and is viewed favorably by many participants across different countries. Since caring for elderly at home by family members is viewed by many as the most appropriate way to provide care, both due to norms and practical concerns (such as quality of services and being in a comforting environment), home-based care emerges as the closest format to informal care and is overall viewed positively.

**Home-based formal care can be an alternate for informal care.** In Western Balkan FGDs participants mentioned at-home care provided by private care givers/nurses as an (actual or potential) alternate format that is currently in use. These include full-time home-based (or half-time, based on need) services given individuals or professionals, and include both medical and physical care tasks, depending on the need of the care receiver. These tasks range from administering medication and injections, to bathing and cleaning the care receiver and are thought to be particularly helpful for the informal care providers if the elderly is bedridden.

The advantage of this format, explained by participants, is that it is home-based so does not disrupt the comfort and way of life of the elderly, and the elderly is still close to her family. Furthermore, the low hygiene and capacity quality attributes associated with center-based care is mostly not associated with home-based private services. In other words, home-based care is closer than residential care to informal care in terms of meeting the norms and expectations of a significant number of participants. The disadvantage is that generally such services are expensive, and many participants explained cost as a barrier to use of such services. Nevertheless, willingness to use these services were observed in FGDs, and some women also explained that affordability of such services would enable them to work.

**Home-based formal care can also complement informal care.** Participants also mentioned regular home visits by social workers, or professional NGO staff to provide support in medical and physical care for the elderly. It is understood that such services, particularly for the bedridden elderly, is welcomed in households for it lightens the burden of care on the informal caregivers and improves the quality of care received by the elders; they also do not involve additional cost as inferred from the discussions. Moreover, public or NGO services provided to elderly with no family in undertaking house chores was also mentioned by participants, yet it was not mostly clear whether elderly with family (or potential informal care givers) could also use these services. Nevertheless, in circumstances where norms against residential care centers and belief that the elderly would not by consent go there are strong, one reason to demand house visits (home-based care) for those elderly without families, is that that they could also have other options.

### 4.2 CURRENT ATTRIBUTES OF ELDERLY CARE HOMES

#### 4.2.1 Accessibility of Elderly Care Services

FGDs suggest that there is an accessibility problem regarding residential eldercare centers, both in terms of location and capacity. Leaving aside the issue of whether they would use these services or not, when asked about accessibility, participants mentioned that residential care centers for elderly in urban centers are generally few, and the existing ones are far away and/or suffer from insufficient capacity.

Accessibility of residential care centers by location seems to be an important dimension that guides perceptions regarding use of these centers, and might have a negative impact on (actual and potential) demand for these services. It is understood that for those participants who are potentially more positive about using these services, location of the services carries great importance. As mentioned, use of residential care is often associated with “deserting,” “leaving them forever,” “abandoning” the elderly. Some of the discussions suggest that, among other reasons, location of these centers being far from homes of the elderly could also have a role in such perceptions; long distances might make it harder for families to visit, check on
and attend to physical or emotional needs of their aging loved ones and be with them as much as they would like and the elderly might need. Therefore, closeness of these facilities to the family homes seems to be important not only for practical purposes but also for compatibility with social norms and filial obligations: “Bigger retirement homes [with more capacity] are far away from us. I’ve heard it is difficult to get a place too; you need connections. If there were something in the town, we might have considered using it. Then you could visit the elders every day, help with stuff.” (Urban woman, Macedonia)

Furthermore, having no vacancy for newcomers, waiting lines, and insufficient infrastructure and staff capacity were mentioned as a shared social problem across urban FGDs - suggesting that the supply of residential care for elderly was below need and/or (potential) demand. In Bosnia participants also mentioned recent the shutdown of some of the existing elderly care centers, despite the already low supply. 14

Conditions for acceptance is another factor that was mentioned to hinder accessibility of eldercare centers.15 Participants’ statements suggest that for some countries, provision/availability of services are linked to retirement plans and pensions. This brings to mind the question of care service availability for those aging citizens who do not have social security, pensions or property: “If you are not a retired worker, you cannot stay there. There was this old, sick, woman, they pulled strings to get her in the retirement home, but instead they placed her in the shelter center for victims of domestic violence.” (Urban woman, Macedonia)

Insufficient or lack in supply of care services for elderly people was also viewed as a broader upcoming societal risk for elders, mainly due to labor migration abroad by youth. As mentioned, there is a strong general belief among some in the Western Balkans that residential care centers are for those elderly without families to care for them – either because they have no family, or because their children are abroad. However, supply of services even for these particular cases is not thought to be adequate in terms of location, capacity and format. Some participants thought that this constituted a social health risk as many young people (temporarily or permanently) have migrated and are migrating abroad, leaving their parents and older relatives behind. They pointed out that due to migration, informal family support that is upheld by norms may not be available for some now and even more so in the future.

Alternate formats to residential care exist, such as home-based service provision and recreational centers for elderly exist, however do not seem to be systematized. During discussions, home visits by NGOs or social workers, private caregivers and different forms of recreation centers were mentioned by participants as alternate formats of formal care supply. However, it was not often clear how accessible these services were, or how systematized they were. Also, it was not always clear what determined accessibility of these services. For example, it was unclear whether accessibility for home-based services depended on demand by citizens, or accessibility of recreational centers depended on membership or retirement, etc.

Home-based care provision from social actors is one format of alternate care that exists across Western Balkans. Non-state actors, and international and national NGOs in particular, seem to have a role in service provision to elderly in some localities, especially with regards to home-based service provision. For example, in Macedonian groups, participants explained that some NGOs offer free sugar and medical tests for elderly. In Bosnia, services of NGOs seem to have a particular role in provision of home care services for elderly, and various NGOs were mentioned to be providing physical and medical care for the bedridden NGO services that provide help to elderly in their daily tasks, such as shopping and house cleaning, was mentioned

14 This is another issue that was not explored detail in groups, as to their causes and effects.
15 Unfortunately, this issue was not discussed in detail during discussions, yet was briefly mentioned in Kosovo and Macedonia urban groups.
in Bosnia. Private nurses to provide care for elderly at home were also mentioned, yet mostly as an unaffordable alternate option.

**Formal care centers with daily services exist across Western Balkans, but are not widespread and do not always provide “care” for elderly; instead, they are more for recreational purposes.** Recreational facilities with day-based services exist to a certain extent. These facilities whose names and specific format varied from country to country (retirement homes, community centers, etc) had the common feature of providing services during the day. For example, in Bosnia, Serbia and Macedonia, participants mentioned community homes\(^\text{16}\) that provided a space for socialization and recreation of elderly during the day, but explained that these did not provide care services. A participant in Bosnia said that there are socialization venues / centers for elderly but most citizens did not know about it. In Kosovo, existence of day-care centers for elderly were mentioned. The discussions suggest that provision of more day-based care centers are demanded across groups, and not only those with recreational functions, but also with care functions: “I don’t understand something, we all send our children to daycare to work and do something, when it comes to elderly we all back off. What if there was elderly daycare from 8 am to 4 pm? Elderly are just like children; why they don’t accept that.” (Rural woman, Kosovo)

### 4.2.2 Affordability of Elderly Care Services

Negative affordability of both quality urban residential care and at-home private nurses for elderly was mentioned across all seven countries, but were discussed the most in Bosnia and Macedonia. Overall, the discussions suggest that the cost of center-based care is unaffordable for the majority of the FGD participants. Private center-based care services are always very expensive, yet discussions suggest that the public services are also not always affordable either. Particularly high costs of quality services make these services inaccessible for those families who would otherwise be willing to use them. Likewise hiring a nurse or a caregiver to offer private home-based services is not affordable for most families either: “The biggest problem are the finances. For me to hire someone to take care for my mother I need to pay her, but I am unemployed and maybe I will be unemployed 20 years more.” (Urban woman, Macedonia)

Affordability of care services, and particularly of home-based care, has an influence on the decisions to use which form of care as well as household division of labor. Where both center-based and home-based formal care is unaffordable, for many households provision of informal care and arranging an in-home division of labor remains as the only option, as explained by this urban woman from Macedonia: “In my case, with my mother being ill, there aren’t many options available, except to pay a person for a whole-day care. We can’t really afford that and my father and I want to be around my mother when she needs us. So the decision is to stay with her and switch shifts.” (Urban woman, Macedonia)

Retirement pensions of elderly and whether they are enough to cover the cost of services often times serve as a benchmark to measure the affordability of residential care or at-home private care options. Several participants across different countries stated that pensions of the elderly are insufficient to cover the financial costs of adequate care services; and voiced their demand for costs of elderly care centers to be aligned with the elderly retirement pensions. Pensions are seen to be the ideal potential source for formal care of elderly: “I was taking care of my mother, but when she started to receive pension money I hired woman to take care of her.” (Rural man, Macedonia) Insufficient pensions imply that families (i.e. children) would have to make additional financial contributions to cover the costs of care. For many families, such an arrangement

\(^{16}\) These were called “retirement homes” in Macedonia, “pensioners’ homes” in Serbia and “community homes” in Bosnia.
does not make sense, however particularly given the current economic circumstances of people living in these
countries, and frequent mentions of unemployment or low wages.

4.2.3 Quality of Elderly Care Services

Regardless of location or gender, there is agreement across the WB FGDs that affordable center-based institutional services that are available for elderly suffer from serious quality impediments, and that the quality of care provision is far below standards that could be considered adequate. Among all FGDs, the perceptions about quality seems to be relatively better in Bosnia and Serbia, however it is understood that some of the major problems associated with these services that are related to capacity, staff and basic service conditions are problematic in all countries.

Provision of basic quality services is a particular problem regarding elder-care centers. Particularly public elderly homes are thought to suffer from lack of hygiene, poor infrastructure (such as stuffy rooms), and low level of attendance by staff to the basic care needs of the elderly.

Low qualifications of staff and maltreatment of the elderly is another pressing problem. Some mentioned that in public centers, high elder-staff ratios also decreased the quality of service provision, and hindered delivery of adequate care for the residents. Others explained that the qualifications of staff were not sufficient enough to attend to care needs of the elderly.

When you get inside of the Elderly Home the atmosphere is very grim, very cold, on one side they were all handicaped, and I got the feelings that nurses were very cruel with them, maybe the daily routine makes them that way, yelling, the elderly need quite peace time, warmth. This one that we have I didn’t like at all, just if you don’t have a place where to go that would be the last place. They don’t have daily care, they could make improvements, it has small capacity and it is full. That is why I am surprised they didn’t build a new one (Urban woman, Kosovo)

In general, participants thought that private homes provided better services for the elderly than public homes. For example in Bosnia and Serbia, many participants explained that there were very good quality private residential centers: with clean rooms, places for socialization of the elderly, attentive staff and cozy environment. However, they added that these were not affordable for the majority of the population. In Kosovo and Macedonia too, participants explained that more quality private care centers were not affordable. In other words, like in childcare, a reverse relationship was observed between affordability and quality of care, but it was felt that in the case of the elderly supply of private quality care was relatively even less in supply.

It must also be noted that perceptions about the quality does not always depend on actual experiences, since most people do not use the elderly care centers. While there were some participants who referenced their own observations, expressions of learning about these centers from media or hearsay were also quite common: “The public homes are in horrible condition, it’s not right to just throw the elderly there to rot, I wouldn’t want that. I saw some on TV, they are falling apart, water drips from the roof. When I get older, I wouldn’t want to go. I would feel bad” (Urban woman, Macedonia).

Finally, perceptions about quality of eldercare services seem to be an influential factor in determining perceptions of participants with regards to whether or not to use eldercare centers, and sometimes can be confused with norms. As mentioned, perceptions of participants with regards to use of care centers were more negative than positive and also included an emphasis on norms about familial obligations. During discussions, a few times participants compared the care provision in their countries with those in the West where the care quality was perceived to be much better. Such statements suggest that norms about elderly care, even when they are strongly stated, do not always uphold family care and oppose formal care centers per se, but uphold the well being of the elderly above all else. In other words where the quality of care
is perceived to be low and harmful for elderly and the format incompatible with the needs of the elderly, then use of elderly homes would be inconsistent with the norms.