Quality of life in elderly people- A comparative study in different elderly homes of Kathmandu

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Santosh Dhungana
Principal Investigator

ABBREVIATIONS:

AD	After Death
ADL	Activities of Daily Living
ALF	Assisted Living Facility
ANM	Auxiliary Nurse Midwife
APD	Acid Peptic Disease
B/W	Black and White
BBS	Bir Bikram Shah
BP	Blood Pressure
BS	Bikram Sambat
CANE	Camberwell Assessment of Need for the Elderly
CAPE-BRS	Clifton Assessment Procedures for the Elderly – Behaviour Rating Scale
CDZ	Central Developmental Zone
CES-D	Center for Epidemiologic Studies Depression Questionnaire
CI	Confidence Interval
CoI	Co-Investigator
COPD	Chronic Obstructive Pulmonary Disease
CRC	Community Residential Care
DM	Diabetes Mellitus
DSM	Diagnostic and Statistical Manual for Mental Illness (published by the American Psychiatrists' Association)
EDZ	Eastern Developmental Zone
EPOC	(Cochrane) Effective Practice and Organisation Care Group
ERB	Ethical Review Board
EWF	Elderly Welfare Fund
F10	10 Friends, a group from Kathmandu
FGD	Focused Group Discussion
FWDZ	Far Western Development Zone
GIT	Gastro Intestinal Tract
HMG	His Majesty’s Government
HSBN	Health System Bibliography of Nepal

HTN	Hypertension
IADL	Instrumental Activities of Daily Living
IDS	Integrated Delivery System
KTM	Kathmandu
LSIA	Life Satisfaction Inventory A
LTC	Long Term Care
LTCI	Long Term Care Insurance
MeSH	Medical Subheading (in MEDLINE search)
MFAQ	Multidimensional Functional Assessment Questionnaire
MI	Myocardial Infarction
MIPAA	Madrid International Plan on Aging
MoC	Missionaries of Charity, followers of Mother Teresa
MOH	Ministry of Health
MWCSW	Ministry of Women, Child and Social Welfare
MWDZ	Mid Western Developmental Zone
NC	Nursing Care
NGO	Non-Governmental Organisation
NHRC	Nepal Health Research Council
NMC	Nepal Medical College
NOS	Not Otherwise Specified
PADL	Personal Activities of Daily Living
PADT	Pashupati Area Development Trust
PI	Principal Investigator
QoL	Quality of Life
RBB	Rastriya Badijya Bank
RC	Residential Care
SF36	Short Form with 36 questions, a tool to assess QoL in MHD patients, ie Maintenance Hemodialysis
SOS	as needed
THT	The Himalayan Times
TSCS	Tennessee Self Concept Scale

TUTH	Tribhuvan University Teaching Hospital
UNESCAP	United States Economic and Social Commission for Asia and Pacific
UNSC	University Nurses Senior Care
USAID	United States Agency for International Development
VDC	Village Development Committee
VP	Vice President
WDZ	Western Developmental Zone

Contents

Prologue

This is an independent research on the Quality of life in the elderly people living in different elderly homes of Kathmandu. The grant for this undergraduate research was approved by the NHRC on 13th of September, 2004 after recommendation of its ERB (Ethical Review Board). I completed an intensive training workshop on Research Methodology from NHRC itself following this approval on 3-7 of January, 2005. I completed this research in about 1 month. Elderly people being a largely neglected section of the society, I found this topic appealing to me and important at the same time. I purposefully selected the only government run housing for the elderly at Pashupati, another one run by the community and the third one a private NGO. The Co-Investigator and the volunteers have worked whole-heartedly and I hope we have pulled off a really good job out of this. There were hectic days of proposal formatting, literature review, data collection, analysis, report writing and formatting; and I think everything has paid off in the end. Of course we had our limitations- time, money and above all knowledge in the field of research, and I wouldn’t be surprised if experts fish out errors and biases in the work. But this has been a great learning experience all the same. Also, I would like to point out the discrepancy between our objective findings in the homes and the subjective perception of the inmates towards their quality of life. Utterly destitute, the inmates don’t know what to expect and don’t complain much, but that just doesn’t justify the dearth of problems they are facing- and there are ample rooms for improvement.

We hope our results and the problems we have identified will help the policymakers in their job in the future.

Thank you

Santosh Dhungana

Principal Investigator

Executive Summary

Many concepts of caring for the elderly have emerged through time. Basically they fall into 2 categories: "Homes for the aged" and "Housing for the Elderly". The former includes nursing homes and long term care(LTC) facilities where clinical care is provided to ill and aged people, usually for the rest of their life. Hospice or the end-of-life care is a similar concept. The latter includes community residential care(CRC), assisted living facilities(ALF), adult family home, family care home, planned care development, community aging-in-place, etc. In Nepal elderly population has always been considered passive recipients of support. Their choices, their satisfaction and their subjective perception towards their quality of life, their psychosocial problems, etc have always been undermined. There are over 30 NGOs in the name of elderly welfare in Kathmandu itself. Innumerable housings for the elderly are already sprouting in different parts of the country including Deughat, Matatirtha, Koteshwor, Godavari, Panauti, Shantinagar, Golfutar, Soaltee Mod, Balambu, Banepa, etc

Researches show that most adults prefer care in home/community settings by kin or non-kin, with few deeming nursing homes or other housing facilities acceptable[9] and that the elderly residing in the retirement center had significantly lower Personal Self and Family Self scores[10]. Results indicated that the women living independently had significantly ($P < .05$) higher physical activity levels compared to the women living in assisted-care facilities[11]. Six themes contribute to quality end-of-life care in LTC facilities: responding to resident's needs, creating a homelike environment, supports for families, providing quality care processes, recognizing death as a significant event, and having sufficient institutional resources[1]. There's a need to encourage the provision of informal assistance as well as the need to ensure the availability of sufficient staff and other formal helpers are available to provide formal care in these settings[13] and also substantial need for specialist services to address the unmet needs in these types of continuing-care settings, such as interventions for social disturbances in NC and suitable daytime activities in RC[14]. In one research in such residential care facility, twenty-four percent had a diagnosis of depression and 8% dementia, but few

had ever seen a mental health professional[16]. Over half (55%) had clinically significant levels of activity limitation and 37% had significant somatic symptoms. Despite provision of glasses or aids 31% could not see satisfactorily and 23% could not hear adequately. To address all these shortcomings in almost any kind of housing or homes for the elderly, new concepts of housing and care are emerging in recent days, including 'Retirement communities'[17], 'Close Care'[18], 'Aging in Place model'[19], 'Taking the community into home'[21], etc. The communities where the frail elderly lived are largely unaware of the valuable inputs they can make regarding the care of the aged[15] and hence harvesting the social capital should be a priority while planning housing schemes for the elderly. But in Nepal the only scheme existing is the simple concept of housing for the elderly that was conceived centuries ago. There has been no formal and thorough research into the different schemes for housing and caring for the elderly that can be feasible in Nepal nor is there any systematic inquiry into the quality of life in the existing housing facilities and the problems they are facing.

Keeping in view this grim situation, we started this research which is basically qualitative one. The design is of a Cross Sectional Comparative (Analytical) Study. We explored the socioeconomic, cultural and geographic characteristics of the inmates, including age/sex distribution and years of stay; modus operandi of the elderly homes including selection criteria, funding, facilities and problems; standard of fooding, lodging, environment, leisure and productive activities as well as activities of daily living (ADL); the health care delivery system; the level of satisfaction of the inmates towards their quality of life as well as the problems faced by the inmates and the management.

30% of the inmates from each housing were taken by stratified systematic sampling. Secondary data available from the offices of the elderly homes was also consulted. The tools of data collection included observation using a checklist and photography, interviewing the caretakers and the management staff with an interview guide/schedule and structured interview of the inmates with a preformed questionnaire. Pretesting was done to ensure the reliability of the tools besides consulting different international standard tools for assessing QoL. Yet some of the comparative conclusions are based partly on the data and partly on our subjective perceptions, as no statistical test of significance could be done due to the extremely small no. of sample frame in the other institutions except Pashupati.

Starting with Pashupati, this elderly home fully run by the government was established in 1938 BS (1882 AD) as Panchadev Paksala. The admission criteria which was similar in other facilities also included nepalese citizenship certificate showing the completion of 65 years and a clear-cut recommendation letter from the concerned authority (VDC or Municipality) stating inter alias that the person is orphan, helpless, poor and that he has nobody to take care of him.

Total 230 inmates are residing in Pashupati though the official number is 205 only, including 79 females and 126 males. The majority are from central developmental zone, specially Bagmati zone including Kathmandu, Bhaktapur, Patan and Kavrepalanchwok districts being the major. 49 % are in the 71-80 age group and 30 % in 60-70 age group though ages above 80 are also common. Newar castes predominate followed by Brahmin, Chettri and Mongolian castes including Bhote, Lama, etc. Only about a quarter of the inmates are living there for more than 10 years, which shows the replacement level and the mortality. A high number of disability was found, the majority being unable to walk, blind or mute. The services include 2 times meal per day, clothing distributed twice a year. They have fitted a B/W TV in almost each hall for entertainment, besides the regular *Bhajans* and occasional trips to religious places. All the religious festivals and rituals including for those who have passed away were duly observed. Regarding the medical services, one permanent clinic is present in the premises run by a staff nurse while a doctor visits thrice a week as well as missionaries of charity come and take care of the debilitated elderlys each day. For more complicated problems they were immediately taken to the hospital, though they felt a dire need of an ambulance of their own.

The home received a total of Rs. 50, 45,000/- this fiscal year from the government, which included all the expenses of the facility including the wages of the staffs and the bills. Many organisations, social service oriented or otherwise, help time to time by providing fund, food, clothes, medical services, washing and cleaning services, cultural programs, religious and educational discourses or taking the inmates out on a trip 20 staff is appointed

Regarding the general living conditions, the house is over a century old and dilapidated. Beds are arranged in 2 or 4 rows in each hall with very little private space. Sunlight can't enter the age-old latticed window, and they have to use electric lights even in the daytime. Ventilation is obviously poor. Rooms are very cold with no heating arrangement. Cleanliness is not apparent. Roofs are of tin and they leak in the winter. The overall hygiene of the mess and the cook though was satisfactory. Water source, waste disposal, toilets, bathrooms and the overall environment were satisfactory though the drainage into the Bagmati River got blocked now and then and the sewage would flood even the living quarters. Productive activities were minimal and interpersonal relation was alarmingly poor. No one knew when asked about the other. The behaviour of the staffs towards the inmates was very good.

Regarding medical problems, indigestion and diarrhea is common. Sister herself prescribes metronidazole, albendazole, H2 blockers and omeprazole as needed. Asthma is a very common respiratory problem followed by COPD and chronic cough. Almost 26-27 are using regular Salbutamol, Aminophylline or Asthalin. Chronic pain syndromes are common due to old age. Diclofenac, Ibuprofen (gel and tablets) are in common use. After they started permitting mental cases to stay, clonazepam, phenytoin, risperidone, lorazepam, sizodon, retilil, are found to be used regularly. Hypertension with BP above 150/90 are common but the sister thinks they are symptom less and hence need no medication The sister herself prescribes many antibiotics.

There are many problems faced by the management: due to lack of a proper housing facility, all types of inmates including very old, very ill, mentally ill, disabled and blind are being kept in the same place. The PADT now and then removes this part, tears down that part and promises to shift the whole housing are reluctant to leave the premises of Pashupati 'untouchable' castes. The budget for medical care, Rs 1, 80,000 or around Rs 800 per capita per year is still insufficient, given the chronic diseases that most inmates suffer from. Even the staffs working there lack in dedication and confidence.

Matatirtha senior citizens residence committee was started with the united effort by a group of local social activists from Mahadevsthan VDC in 1997 AD. 19 people are residing, mainly from Kathmandu and some from Sindhupalchwok, Lalitpur and Bhaktapur. Facilities including fooding, clothing, festivals as well as general living conditions including housing, mess, water, toilet, waste disposal, drainage, etc are satisfactory given the minimal number of inmates. But they are suffering a major crunch of resources and funding and hence aren't being able to organize outdoor trips or better facilities including medical services. They are also lacking in creative works though the interpersonal relation was much better than at Pashupati, probably due to the less number of inmates and the inmates were all quite satisfied with their quality of life. The committee operates from minimal fund from the government and the VDC as well as help from its members and well wishers- which seems to be much less as the general public usually doesn't even know that it exists. It has been a major challenge for the committee to construct its own private residential quarters and extend the capacity to 100.

Old age care center Koteshwor is an NGO registered in the year 2058 BS. Though the points listed in its manifesto sound very encouraging, we were disappointed to find a different reality Though they claim to be giving shelter to 35 and that the capacity is 100, we found only 12 people living there Nothing was transparent, including the executive committee, management staff, funding and affiliated international agencies. Only one staff was present and she dealt with everything and had clear instructions ‘not to say anything to any enquirers!’ Facilities including fooding, clothing, festivals as well as general living conditions including housing, mess, water, toilet, waste disposal, drainage, etc were good as they had a modern house but again interpersonal relations, creative work and source of entertainment were all virtually non-existent.

Perception and Attitude Survey showed that all the respondents felt very good or atleast better than at home in all the 3 housing facilities. This discrepancy is understandable, as the socioeconomic background of the inmates is usually so bleak and they have suffered so much that places that provide whatsoever standard of housing and facilities without them having to do anything is a sweet haven for them. They seemed to like the freedom, facilities, respect and care that they got in the housings, and many at Pashupati found it nice to live in such a religious place. One inmate in Koteshwor was particularly vocal about the utter lack of care from the managerial staffs in the home, even bordering on maltreatment. Almost all seemed to like the food though some complained that they are having problems observing dietary restrictions as they have to share the common mess and forced to have fatty and spicy food despite suffering from APD. 7 out of 24 responding males and 8 of 37 females at Pashupati and 2 of 8 inmates at Matatirtha found their room to be very congested and very cold in winter, and rightly so. Only 3 males and 6 females at Pashupati found the environment to be unhygienic, else most found it satisfactory though none found it excellent. When asked about outing, most inmates at Pashupati and Matatirtha used to go out once in more than 3 months while 4 of 24 males, 8 of 37 females and 3 of 5 inmates at Koteshwor said that they never do go out for outing. Almost none used to go out more than once in a month. At least in Pashupati most of them can be explained by their debility while it shows lack of fund in Matatirtha and lack of care in Koteshwor. Only 6 male (of 24 who responded) inmates at Pashupati replied that they are engaged in household activities. The females, including 8(of 37) at Pashupati and 6(of 8) at Matatirtha were involved in making wicks for traditional lights.

Many inmates in Pashupati used to have regular contact with the nurse for minor ailments. But there was no provision of regular periodic health checkup as such in place Only 2 males and 2 females in Pashupati and 2 at Matatirtha expressed dissatisfaction with the services. In Koteshwor, an inmate was complaining that they rarely get any checkup and only when the inmates got moribund were the managerial members called.

Most frequent illnesses were *fever, diarrhea, fainting, headache, asthma, disability and problems with vision.* Other included deafness, diabetes, hypertension, paraplegia, vague pain syndromes, hip dislocation, cough, itchy eyes, myalgia, kyphosis, cataract, jointpains, mental illness, acid peptic disease and even toothache among the males at Pashupati. The females responses were fever, asthma, facial swelling, limb joint back and other vague pain syndromes, APD, decreased vision and blindness, deafness, dizziness, bodyache, abdominal swelling, shortness of breath, nausea, seizures, hemiparesis, gangrene and amputation of one hand, disability, paraplegia, heart problems and burns.
At Matatirtha, the responses were refraction error, APD, joint pains, cataract, fracture femur, myalgia, cough, hypertension, etc. At Koteshwor, the responses were cataract, asthma, kyphosis, cough, etc.

On being asked," Has anyone left the place recently and why?" an alarming 22 males out of 24 and 29 of 37 responding at Pashupati said they didn’t know. At Koteshwor, many inmates had left as they either didn’t like the facilities or were maltreated, and the number of inmates was decreasing each day.

On being asked," Why did you come here?", 17 males and 25 females at Pashupati, 6 at Matatirtha and 3 at Koteshwor replied that they have no home left while the second most common answer was that they were mistreated at home. Almost none were left by the family there.

On being asked about any suggestions, at Pashupati**,** many pointed out the need for more cleaners and helpers for washing clothes. Many of them voiced concern of having to live with the mentally ill cases. Another majority found the rooms uncomfortable, dark, cold and congested. Many were reluctant to leave the religious place of ever they were shifted to other place. The so called 'lower castes' (Rai, Limbu, Magar, etc) pointed out the racial discrimination showed by the higher castes. A large number of inmates also pointed out that the alms handed out by the outsiders are not divided equally. At Matatirtha, most of them complained that they were not taken anywhere on any trips. Some thought that more consistent medical services were needed. Some also pointed out the need for toilets, garden and water tap. At Koteshwor, one inmate was particularly vocal about the total lack of care and attention.

At Pashupati there is a dire necessity of a well-equipped and spacious building with separate rooms for 2-4 persons and it should be one storied with attached toilets for the disabled, with lots of open space for gathering as well as good lighting, ventilation and heating system for the winter. It is necessary to create a homely environment and a sense of belongingness. Staffs should be provided with bonuses in recognition of the extra hours they serve to increase their morale. There should be more medical equipments provided. The inmates should be involved in more productive activities including physical exercises, religious discourses, trips and other means of entertainment. These suggestions hold true for any other housing facility also. With just one government run institution and money-centered NGOs, no matter how numerous they are, it won't solve the problem of the ever increasing population of helpless elderly. What we need is elderly-housing charity committees run by the community in as many VDCs as possible. This would avoid having to take the aged people away from the place they lived their whole life, utilizing the social capital at the same time.

Introduction

Many *Housings for the Elderly* are sprouting recently in different parts of the country. Many of them are NGOs while only a few are community operated and only one of them is fully run by the government. *HMG, MWCSW, Social Welfare Center, Elderly Home, Pashupati* was established in 1938 BS(1882 AD) as Panchadev Paksala and has been operating under this name since 2034 BS(1977 AD). The total sheltering capacity is 205, though the number of unregistered inmates is on the rise, and it intends to extend its capacity in the near future. It has been providing shelter to Nepalese citizen above 65 who is recommended by the concerned authority to be an orphan, helpless, poor or has nobody to take care of him.

Matatirtha Senior Citizens Residence Committee, Mahadevsthan VDC, Thankot was established by local social activists in 2054 BS and provides shelter to 19 elderly females fulfilling similar criteria. It is a non-profit community operated committee operating fully on the donations from its executive member and minimal help from the government.

Old Age Care Center, Koteshwor, Mahadevsthan-35 was established as an NGO in 2058 BS with the aim of providing shelter to 30 aged people.

Statement of the Problem

A regional survey by the UNESCAP on aging in Asia and Pacific done in June 2002 emphasizes that despite the fact that the older population in Nepal is still only 5-9%, it will experience considerable growth in the next few decades, almost *doubling of 60+ people in 50 years to come*. The continuing gender gap in life expectancy with female outliving the males will lead to many old women- widowed and without support, less educated, having poor health and worse financial situation as compared to men. With the materialistic life style taking over the developing society of Nepal, the cohesiveness of family has been rapidly unraveling. With economic pressure increasing, resulting in youth migration across the border, the elderly people are left at home and the in-laws consider them inactive, burdensome recipients of support. Economic hardship and terrorism striking hard in rural hills, most of them abandon home and come down to urban centers, where they eke out a living by begging or doing hazardous works. The government doles out a meager Rs 100 per month to widow over 60 and men over 75**.** *All this is bound to increase the need for housing for the elderly in years to come.*

Innumerable housings are already sprouting in different parts of the country including Deughat, Matatirtha, Koteshwor, Godavari, Panauti, Shantinagar, Golfutar, Soaltee Mod, Balambu, Banepa, etc. There are over 30 NGOs in the name of elderly welfare in Kathmandu itself. But in the lack of any quality control apparatus, many have just been a means of the so-called “Dollar Farming”. What will be the quality of life in these foster homes? Is it better to segregate all the dependent population of a country at one place without any quality control? Aren't negligence, unhygienic behavior, and lack of resources for proper facilities needed for an easy life going to make a severe impact on the quality of life? "Healthy old age" is not a contradiction of terms, but with the homeostenosis(decline in homeostatic reserve) of every organ system, it becomes mandatory to be very careful about ones health and try to keep it in optimum condition with regular checkup, exercise, proper hygiene, prophylaxis (like against influenza, pneumococcus), repairment of visual and auditory impairment including glaucoma, screening for morbid diseases (like breast cancer, cervical cancer, etc) and cautious behavior and regular medicine for people with diabetes, hypertension, etc. But all these are just daydream in our context. The situation is aggravated by unhygienic and risky practices that might be present in the foster homes, creating more diseases in the immunologically vulnerable elderly population.

The housing at Pashupati is more than a century old and is extremely congested. Funds are insufficient and individual care is lacking due to the high density. The one at Matatirtha doesn’t have its own building and has to literally depend on the alms handed over by well-wishers. In lack of proper research, no one can vouch for the NGOs like the one at Koteshwor that they are providing quality services and that they don’t have constraints and pitfalls.

Above all, *elderly population has always been considered passive recipients of support* in Nepal. Their choices, their satisfaction and their subjective perception towards their quality of life, their psychosocial problems, etc have always been undermined.

So a research was needed to identify the functioning of the care centers, the services provided including medical services and the standard of the same, the level of satisfaction of the inmates and their subjective perception towards their quality of life, different problems faced by the inmates and the management, to identify the aspects of the problems amenable to change and to suggest the solutions.

Rationale/Justification of the Research Topic:

The stated problem is a current and happening problem, with an ever-increasing proportion of homeless, destitute, incapacitated and poor elderly people. Since the housing for the elderly seems to be the only feasible answer to this for the time being, the problem if not properly handled, can have serious consequences in terms of mortality, morbidity and quality of life of the elderly. The problem has broad social, economic, political and health implications and is viewed as a concern by many different people- administrators, health professionals and general public. Care of the elderly is also one of the priority areas as published by MOH (HMG) in 1999. The Government of Nepal has also recently adopted *National Policy on Aging* since its 9th long-term plan. Above all, not much research work has gone into this topic, though it is a topic of much research in the western world. We believe the research will help administrators and policy makers to plan and implement necessary changes for addressing the problem.

Literature Review:

Quality of life in the elderly people especially in institutions has been a subject of major interest and research in the western world though the same cannot be said about the developing countries like ours. Probably the aging population in the west and the lack of resources in countries like ours partly explains this. During our Medline search on the topic, we found that the literature was replete with researches on the different aspects of life of the elderly in institutionalized places, including national and multinational studies, Cochrane database systematic reviews, meta-analysis and the like. Caring for the disabled and seriously ill or helpless, poor and discarded elderly has always been a subject of debate and research.

Many concepts of caring for the elderly have emerged through time. Basically they fall into 2 categories: **"Homes for the aged"** and **"Housing for the Elderly"***(*these are standard medical subheadings under which the Medline MeSH search was done). The former includes *nursing homes and long term care(LTC)* facilities where clinical care is provided to ill and aged people, usually for the rest of their life. *Hospice or the end-of-life care* is a similar concept. The latter includes *community residential care(CRC), assisted living facilities(ALF), adult family home, family care home, planned care development, community aging-in-place*, etc. Researches have been done on many of these concepts regarding their pros and cons and their impact on the quality of life and the level of satisfaction.

In one research on the quality of end-of-life care in long-term care facilities done in Canada, seventy-nine direct care providers from six LTC facilities participated in 12 focus groups[1]. The focus group discussions examined what made the difference between a "good" death and a "bad" death, and what changes in LTC would improve the care of dying residents. Analyses of the focus group data revealed six themes that contribute to quality end-of-life care in LTC facilities: *responding to resident's needs, creating a homelike environment, supports for families, providing quality care processes, recognizing death as a significant event, and having sufficient institutional resources.*

These findings challenge policy makers and providers to consider how to normalize life and death in LTC facilities.

Another research in Poland encompassed 80 inhabitants of an old people's home in Podkarpacie region[2]. The Nottingham Health Profile and the Self Evaluation Scale of professor J. Tylka were used to assess the QoL. Both questionnaires were complemented by questions about chronic diseases and rehabilitation procedure applied. Results of the analysis are preliminary. So far the research has shown a significant dependence of the QoL on *physical efficiency, pain and depression*. It has been also demonstrated that, in spite of a suitable rehabilitation base, too little importance is still attached too a comprehensive rehabilitation in the old people's homes.

In a controlled observational study in UK comparing quality of care for elderly residents in nursing homes and elderly people living at homes, the overall standard of care was inadequate when judged against the quality indicators, irrespective of where patients lived[3]. The overall prescribing of beneficial drugs for some conditions was deficient--for example, only 38% (11/29) (95% confidence interval 20% to 58%) of patients were prescribed β-blockers after myocardial infarction. The proportion of patients with heart disease or diabetes who had had their blood pressure measured in the past two years (heart disease) or past year (diabetes) was lower among those living in nursing homes: for heart disease, 74% (17/23) v 96% (122/127) (adjusted odds ratio 0.18, 0.04 to 0.75); for diabetes, 62% (8/13) v 96% (50/52) (adjusted odds ratio 0.05, 0.01 to 0.38). In terms of potentially harmful prescribing, significantly more patients in nursing homes were prescribed neuroleptic medication (28% (49/172) v 11% (56/526) (3.82, 2.37 to 6.17)) and laxatives (39% (67/172) v 16% (85/526) (2.79, 1.79 to 4.36)). Nursing home residents were less likely to have the appropriate diagnostic Read code linked to their prescribed neuroleptic drug (0.22, 0.07 to 0.71).

In another cross-sectional population survey in Tanzania to compare the nutritional status, functional ability and food habits of institutionalised and non-institutionalised elderly people, a total of 100 elderly people, fifty institutionalised and fifty non-institutionalised were included[4]. Gender distribution was of equal numbers. Anthropometric measurements of weights and heights were taken to enable calculation of Body Mass Index (BMI) of each subject. Questionnaires were used to collect information on types of foods, amount and frequency of consumption and functional abilities of the elderly. Amount of food consumed was expressed in grams per person per day. There were significant differences ($p=0.001$) in nutritional status between the institutionalised and the non- institutionalised males, but this relationship did not exist among the females. Similarly, 30% and 26% of the institutionalised males and females, respectively, and none of the non- institutionalised males was observed to be overweight. On the other hand, 39% and 23% of the non-institutionalised males and females, respectively, were underweight or malnourished. Consumption of sardines was higher ($p=0.05$) among the institutionalised subjects, but the situation was opposite for the case of fruits. Alcohol consumption was higher ($p<0.05$) among non- institutionalised subjects in both sexes. No difference was noted in consumption of beans, vegetables, cereals and meat. *The most common functional disability was urinary incontinence (36%)* while feeding (5%) was the least common. The most affected by urinary incontinence were institutionalised male subjects.

Japan is possibly the country with the most aged population and the highest life expectancy. In one recent article on the health and social system for the aged in Japan, the author states that Japan implemented a new social insurance scheme for the frail and elderly, *Long-Term-Care Insurance (LTCI)* on 1 April 2000[5]. This was an epoque-making event in the history of the Japanese public health policy, because it meant that in modifying its tradition of family care for the elderly, Japan had moved toward socialization of care. One of the main ideas behind the establishment of LTCI was to "de-medicalize" and rationalize the care of elderly persons with disabilities characteristic of the aging process. Because of the aging of the society, the Japanese social insurance system required a fundamental reform. The implementation of LTCI constitutes the first step in the future health reform in Japan. The LTCI scheme requires each citizen to take more responsibility for finance and decision-making in the social security system. The introduction of LTCI is also bringing in fundamental structural changes in the Japanese health system. With the development of the *Integrated Delivery System (IDS),* alternative care services such as assisted living are on-going. Another important social change is a community movement for the healthy longevity. For example, a variety of public health and social programs are organized in order to keep the elderly healthy and active as long as possible.

One pilot study randomly selected five nursing homes, five assisted living facilities, and 16 family care homes from a South-Central state in the US to identify correlates of resident psychosocial status[6]. In-person and telephone interviews were conducted with administrators and resident-family-staff triads (n = 79) to gather information on setting, resident functional status, family involvement, sociodemographic context, and resident psychosocial status. Results indicated that type of facility, resident health conditions, resident race, and facility family orientation were significantly correlated with dimensions of resident psychosocial status. The findings suggest that multiple informants are necessary to determine the processes that lead to residents' quality of life, and the consideration of diverse settings offers greater insight into how positive resident adaptation is achieved in long-term care.

Finally considering homes for the aged, one Cochrane database systematic review done in 2003 on Care home versus hospital and own home environments for rehabilitation of older people, randomised controlled trials (RCTs), controlled clinical trials (CCTs), controlled before and after studies (CBAs) and interrupted time series (ITS) that compared rehabilitation outcomes for persons 60 years or older who received rehabilitation whilst residing in a care home with those for persons 60 years or older who received rehabilitation in hospital or own home environments were selected from a wide range of databases[7]. Primary outcomes included functional outcomes using activities of daily living measurement (both personal and instrumental). Secondary outcomes included subjective health status; quality of life measures; return to place of usual residency; all cause mortality; adverse effects; readmission to an acute care facility; patient and carer satisfaction; number of days in facility and number of days receiving rehabilitation. Papers that fulfilled the comparison inclusion criteria were then independently scrutinised by all reviewers to assess whether they met EPOC methodological criteria for inclusion. This process resulted in 12 papers being assessed further for methodological validity. However, none of these studies met the inclusion criteria and they concluded that *there is insufficient evidence to compare the effects of care home environments, hospital environments and own home environments on older persons rehabilitation outcomes*. Although the authors acknowledge that absence of effect is not no effect. There are three main reasons; the first is that the description and specification of the environment is often not clear; secondly, the components of the rehabilitation system within the given environments are not adequately specified and; thirdly, when the components are clearly specified they demonstrate that the control and intervention sites are not comparable with respect to the methodological criteria specified by Cochrane EPOC group (Cochrane 1998). The combined effect of these factors resulted in the comparability between intervention and control groups being very weak. For example, there were differences in the services provided in the intervention and control arms, due possibly to differences in dominant remuneration systems, nature of the rehabilitation transformation, patient characteristics, skill mix and academic status of the care environment.

Now considering the **housing for the elderly**, the topic more akin to our research theme, one research in California on the satisfaction with care among community residential care residents, the authors conducted interviews with 176 CRC residents and their providers[8]. Logistic regression was used to identify resident and physical characteristics, policies and services, and aggregate resident characteristics associated with satisfaction. Residents had high levels of satisfaction, demonstrating most concern with the facility being able to meet their future needs and food quality. Resident demographics and health status were associated with satisfaction. Contrary to hypotheses, *facility type (adult family home and assisted living) was the only facility characteristic strongly associated with satisfaction*. Possible explanations include that the relationship between satisfaction and facility characteristics is more complex than expected, as well as significant challenges in measuring satisfaction and facility characteristics. The inconsistent results of previous satisfaction studies do not provide direction for imposition of uniform standards for facility characteristics, if the goal is improved satisfaction.

Regarding the Preferences for receipt of care among community-dwelling adults, *most adults preferred care in home/community settings by kin or non-kin, with few deeming nursing homes acceptable*[9]. Demographics and personal knowledge, experience, and expectations were marginally likely to influence preferences; males were more likely to prefer care in paid/professional settings. Women, who more often expressed preference for kin/home care, face demographic trends reducing available female kin who might be caregivers.

In yet another study that explored the self-concept of elderly adults residing in retirement centers as well as its relationship to other variables, including function of activities of daily living (ADL), subjective well being, etc, selected demographic attributes (sex, age, years of education etc.) were also examined for their relationship to self-concept[10]. The subjects were a convenience sample of people aged 65 or older who were recruited from a retirement center in the south of Taiwan (N = 42), and a control group of elderly living with their family (N = 33). The Tennessee Self-Concept Scale (TSCS) was used to measure self-concept. The Multidimensional Functional Assessment Questionnaire-Chinese Version (MFAQ) was applied to measure the function of activities of daily living. A total of 37 subjects from the retirement center group and 28 subjects from the home group completed these questionnaires. The data were analyzed using SPSS/PC software version 10.0. After multiple linear regression analysis, the results showed that *the elderly residing in the retirement center had significantly lower Personal Self and Family Self scores*. The variables of ADL, sex and subjective well-being had effects on the total self-concept. Female elderly individuals also revealed significant higher scores than males in the subscales of Moral- Ethical Self, Family Self, Social Self, Identity and Satisfaction Self. These results suggest we should design appropriate programs to increase elderly people's interaction with others and establish new social networks for them which may enhance a sense of positive self-concept.

A similar study conducted on women over the age of 60 years, living independently or in assisted-care facilities, answered a number of questions pertaining to their health status, physical activity levels, and quality of life[11]. Results indicated that the *women living independently had significantly (P <.05) higher physical activity levels compared to the women living in assisted-care facilities*. In addition, overall quality of life and the domains of physical health, social relationships, and environment were found to be significantly (P <.05) higher in the women living independently compared to the women living in assisted-care facilities. Correlational analyses revealed that physical activity levels correlated significantly (P <.05) with overall quality of life and the physical health domain. *It is concluded that there is an association between physical activity levels and quality of life in older women.*

Yet another research conducted on a similar vein showed that residents and family members had positive, but not strong, satisfaction with care[12]. Areas identified as often unsatisfactory were; *the mealtime experience, the nursing assistants, and recreational activities*. Preferred qualities of nursing assistants identified by both residents and family members were genuine concern, kindness, respect, and consistent attentiveness. Residents only identified a pleasant disposition as an essential quality of nursing assistants and only family members identified knowledge regarding aging, gentle assertiveness, and commitment to staying on the job as essential qualities of nursing assistants.

Another similar research purported to investigate the *patterns and predictors of formal and informal help* among a sample of older persons living in board and care homes (N = 617)[13]. Formal helpers such as facility staff, service agencies, and community organizations were the most common providers of assistance, particularly for activities of daily living (ADLs; e.g., bathing, dressing, toileting) that required close and continual proximity. Informal helpers such as family members, friends, and other residents were most likely to assist with *instrumental ADL (IADL)* tasks such as shopping and getting around outside. The need for assistance with ADLs predicted the amount of formal ADL help received by residents, whereas both ADL need and the presence of mental illness predicted the amount of IADL help received from formal sources. In contrast, demographic factors such as gender and race, as well as the frequency of family contact, predicted the amount of informal help with IADL tasks. White residents, women, and those with frequent family contact were among those most likely to receive assistance from informal helpers. *The results suggest the need to encourage the provision of informal assistance as well as the need to ensure the availability of sufficient staff and other formal helpers are available to provide formal care in these settings.*

One article describes the met and unmet needs of elderly residents of nursing care (NC) and residential care (RC) settings[14]. Thirty-four residents of an RC home and 40 residents of two NC settings were assessed. Each resident and a respective staff member were interviewed using the Camberwell Assessment of Need for the Elderly (CANE) to indicate the resident's current met and unmet needs. The Clifton Assessment Procedure for the Elderly-Behaviour Rating Scale (CAPE-BRS) was completed by the staff member to indicate the participant's current level of dependency. In addition, the Mini-Mental State Examination was administered to participants and DSM-IV diagnosis was recorded. A high number of needs were found in both RC and NC settings, the level of dependency being proportional to level of need. There was a core set of needs in both samples related to *difficulties with accommodation, food preparation, and self-care*. Both NC and RC homes were meeting these needs; however, *RC residents had a significantly greater level of unmet need for suitable day-time activities*. The greatest predictor of type of setting was gender and there were significantly more females in RC. *Controlling for gender, participants in NC had greater levels of dependency, particularly problems with apathy and social skills*, as measured on the CAPE-BRS. It is possible that-the greater level of social needs in NC residents had led to their placement in the more specialized NC settings. On the other hand, NC settings may be left caring for a group of residents that, because of their specific needs, have been difficult to place into RC. These findings have clinical implications for the future development of continuing care for the elderly. This study also highlighted that there is a substantial need for specialist services to address the unmet needs in these two types of continuing-care settings, such as interventions for social disturbances in NC and suitable daytime activities in RC . The CANE is a useful instrument to evaluate such needs in long-term-care settings.

The frail elderly in informal settlements find themselves in an extremely vulnerable position due to a number of factors, namely, their increasing dependency status, limited resources and adverse physical environment. A survey method was used to explore and to describe the world in which they live in informal areas[15]. The attitude, expectation and needs of the elderly in respect of their care was also determined. A random cluster sample was taken. Data was collected by means of interviews in terms of a semi-structured questionnaire. It appears that the frail elderly were happy in the environment in which they received care in spite of their unfavorable physical environment and limited resources. *The communities where the frail elderly lived were largely unaware of the valuable inputs they can make regarding the care of the aged*. This necessitates the development of programs in the heart of communities, owned by communities, where all role players in the care of the aged participate.

In one research in UK, eighty-seven residents from three sheltered accommodation schemes for people over 60 years, were interviewed about: their physical and mental health, social networks, social support, decision to move in, and how they found living in sheltered housing[16]. *Twenty-four percent had a diagnosis of depression and 8% dementia, but few had ever seen a mental health professional. Over half (55%) had clinically significant levels of activity limitation and 37% had significant somatic symptoms. Despite provision of glasses or aids 31% could not see satisfactorily and 23% could not hear adequately.* Locally integrated social networks were most common (41%). Residents with a private network (16%) were more likely than those with a locally integrated network to have significant activity limitation and to report often being lonely. There were no differences between network types in levels of depression or dementia. Poor health of a person or their spouse was the most commonly reported reason for moving to sheltered housing, followed by the possibly related reasons of problems with their old home no longer being suitable e.g. stairs, and because they wanted to have a warden or alarm system available should the need arise. Most residents were happy living in sheltered accommodation. Many made use of 'sheltered' features such as the common room, the communal laundry, the warden and the alarm. A minority of residents were lonely and a few were unhappy with sheltered accommodation.

Finally newer concepts are emerging on the subject of elderly housing. It has been claimed that **'retirement communities'**, defined in this instance as voluntary communities of older people living in shared, purpose-built housing, combine the best attributes of residential and community living[17]. Subjective health status may thereby be improved through a culture in which independence and autonomy are actively promoted. Concern has also been raised that age-segregated communities of this sort might produce 'ghettos' of increasing dependency and service demand. One study, conducted over a 12-month time period, found that when *compared to older people living in the local neighbourhood, the retirement community population maintained their physical and mental health* (utilising measures including the SF36, Life Satisfaction Index, and 18 semantic differentials). Investigation of these findings indicated that *peer support and safety/security, and 'autonomy with inclusion' were key factors in maintaining health status.*

The chronic ailments of old age such as stroke, coronary heart disease, severe arthritis and loss of sight have traditionally found care only in a nursing home. Taking care to the family house or sheltered home has drawbacks because of inappropriate accommodation. There is now an alternative that also reflects changing expectations on the part of the elderly. **'Close Care'** offers a solution to the crises of carer shortages and ever increasing nursing costs[18]. It also responds to the growing consumerist power of the elderly who seek more choice, more control and higher standards. (Michelle) Habell's involvement in the early growth of private purpose-designed nursing homes pointed to an emerging demand for accommodation which the residents identified as home and over which they exercised choice and control. *The elderly were moving from passive subjects of assessment and care to become a market with consumer tastes and power*. Coining the phrase Close Care, the team encouraged Habell's architectural solutions to evolve into hybrid schemes, which broke new ground by seeking to provide as normal a home as possible while flexibly accommodating all the disabilities of old age. In effect Close Care offers an invisible or *virtual nursing home where the elderly are motivated in self-help* by stimulating surroundings, control of their environment, choice of support and knowledge that they have their own home for life among friends and helpers. Close Care offers a solution to the rising costs of nursing care, overcomes the alienation of institutional environments and offers a way of integrating alert but frail and even confused persons back into a normal community and lead a normal day to day life .

The Aging in Place model of care for the elderly offers care coordination (case management) and health care services to older adults *so they will not have to move from one level of care delivery to another as their health care needs increase*[19]. University Nurses Senior Care (UNSC) of US is the service entity of this project and provides as its core service care coordination with a variety of service options. These options include care packages or services at an hourly rate to meet individual client needs. The Aging in Place project will be evaluated by comparing project clients to residents of similar acuity in nursing homes and to similar clients receiving standard community support services. Data from this project will be important to consumers, researchers, providers, insurers, and policy makers. The public has a negative view of nursing home placement that has, to some extent, been confirmed by *research finding that the health of a frail older person deteriorates each time he or she is moved.*

For example, one research in Japan examined direct and indirect effects, mediated by social contact, of *residential relocation* on well-being of the elderly and used longitudinal data of a national representative sample of individual aged 60 years and over (N = 1,474)[20]. The initial survey was conducted in 1987, and the follow-up survey was conducted three years later. Well-being was measured with the Center for Epidemiologic Studies-Depression Scale (CES-D) and the Life Satisfaction Index A (LSIA). Social contacts were measured in terms of frequency of contacts with relatives, friends and neighbors, as well as frequency of social participation. They found that *relocation had a positive direct effect on well-being, assessed by both CES-D and LSIA, but a negative indirect effect mediated by decline of social contacts.*

Yet another concept that has been reported is **'Taking the community into home'[21].** The changing demographics of the population are such that there is an increasing need for care for frail older people with both physical and mental health problems. At the same time, the increased migration of workers and their families means that care provision now has to embrace a range of cultures. The present paper explores how the concept of cultural safety has importance for those planning and providing care for older adults. The recognition that *removing individuals with mental health problems from their own environment causes increased disorientation and* confusion has led to some organisations trying to maintain the community aspects of life when independent living is no longer possible. The present paper focuses on two such organisations in the Netherlands, demonstrating how they have changed their practice to improve and enhance the quality of life of their clientele through 'taking the community into the home'.

Social capital is defined as the resources available to individuals and groups through social connections and social relations with others[22]. Access to social capital enables older citizens to maintain productive, independent, and fulfilling lives. As the U.S. population ages, accompanied by a rise in the prevalence of seniors living alone, the availability of social capital within communities will become an important ingredient of successful aging. Recent evidence suggests that many traditional forms of social capital in communities-as represented by *civic engagement in local associations and by the extent of voluntarism and social trust-are on the decline*. If this observation is correct, there is no simple solution to rebuilding this lost social capital. Novel forms of senior housing, such as *planned care developments and assisted-living facilities*, may offer promising modes of delivery of social capital to the aging population. However, assisted living remains financially inaccessible for a large segment of the U.S. population, so investment in *communities "aging in place" may be the key* to delivering the health dividends of social capital.

Talking of Nepal, investigators and journalists have pointed out the problems of senior housing, especially in Pashupati Elderly Home from time to time. In one article in Gorkhapatra daily, it points out the fact that due to the unmanageable number of inmates in the home, *many are compelled to spend their night in the verandah*[23]. Also since they started taking in the mentally ill persons, other inmates are getting disturbed night and day. Another article points out the fact that *dietary modifications are impossible even in elderly with chronic diseases due to the constraint of having to share the common mess*[24]. In yet another article, it points out the urgent need for an ambulance and that the traditional windows are causing much problem with lighting and ventilation[25].

One of the other major issues in Pashupati has been the constant attempt to shift the housing in some other area. In one article in The Himalayan Times daily, it points out the years long tussle with the Pashupati Area Development Trust (PADT), which is planning to shift the housing to Sankhamul and establish a museum there instead[26]. But this is completely against the inmates' sentiment, as they love living close to Pashupati due to religious reasons. *Since the housing falls within the area of Pashupati which has been included as one of the World Heritage Site, it can't be torn down and built anew*. One article in Gorkhapatra daily reported that after PADT brought down one of the wing used by the sisters from Missionaries of Charity(followers of Mother Teresa), they are having a hard time looking after the seriously ill and disabled persons[27].

The only accesible research on topic relating to elderly housing that we could find in the Health System Bibliography of Nepal (HSBN) was published in 1982. It was about indirect modernization and the status of the elderly in a rural third world setting[28]. This paper presents evidence that the *process of modernization can have a negative impact on the elderly in even the most remote rural third world settings*, even though those settings are not modernized or in the process of modernization in any of the normal uses of that concept. Fieldwork was conducted in Helambu, Nepal on a sample of 37 persons over the age of 50 that included 86 p.c. of population aged 60 over. Despite high levels of activity, health social and economic status, the elderly were greatly dissatisfied with their situation. The paper demonstrates the manner in which modernization in India has profoundly changed household/family organization in Helambu and produced this situation.

OBJECTIVES:

General: To identify the factors affecting the quality of life and the level of satisfaction in the inmates of one government run, one community operated and one private housing for the elderly in Kathmandu.

Specific:

1. To determine the modus operandi of the 3 elderly homes of Kathmandu, with respect to funding, care providers, selection criteria, facilities and problems.
2. To identify the socioeconomic, cultural and geographic background of the inmates
3. To determine the standard of housing, fooding, clothing, leisure activities, productive activities, health care delivery and other factors affecting the quality of life.
4. To establish the level of satisfaction of the inmates towards the facilities provided and their subjective perception towards their quality of life.
5. To identify different problems faced by the inmates, medical or otherwise.
6. To identify and recommend possible solutions to the problems faced by the management and the inmates.
7. To compare the above-mentioned variables in the 3 elderly homes of Kathmandu.

Research Questions:

Is the health status and quality of life satisfactory in the elderly home?

Is the environment of the home creating new illness, mental included, in the inmates?

Are the inmates getting necessary facilities and medical services?

Is the status of private run home better or worse than government run homes?

Are there any risky health practices among the inmates of the home?

METHODOLOGY:

Study Site Selection and its Justification:

HMG, MWCSW, Social Welfare Center, Elderly home, Pashupati is the only housing for the elderly run fully by the government and is also the largest in Nepal. The large number of inmates itself pose problems as much as the lack of international funding.

Matatirtha Senior Citizens Residence Committee is a community operated non-profit organisation. Being run by local social workers, it is obviously lacking in sufficient fund and facilities.

Old Age Care Center at Koteshwor is an NGO funded by the donations from its members and international agencies. It can be a model for studying all the NGOs sprouting in Nepal under the name of elderly welfare, as there is no any quality control or check and balance system for such institutions in Nepal.

Type of Study: Cross Sectional Comparative (Analytical) Study

Study Variables:

The following variables will be studied in all the 3 elderly homes to present a descriptive and comparative picture

1. Background/ Organismic/ Attribute Variables:

Socioeconomic, cultural and geographic characteristics of the inmates, including age distribution and years of stay.

2. Independent variables:

- Modus operandi of the elderly homes including selection criteria, funding, facilities and problems.
- Sex distribution of the inmates.
- Standard of fooding, lodging, environment, leisure and productive activities and health care delivery system.

3. Dependent Variables:

- Activities of daily living (ADL) - personal and instrumental.

- Level of satisfaction of the inmates towards the facilities and their quality of life.
- Problems faced by the inmates, medical or otherwise

4. Confounding/ Extraneous Variables:

Age and sex distribution and the previous social strata of the inmates may confound the relation between the dependent and the independent variables. *Matching* for sex and *stratification* for sex at the analysis stage is done to control this, though the other 2 factors might still confound the findings. Similarly *randomization* during sampling might also reduce the confounding.

Inclusion Criteria:

- Registered inmates of the 3 aforementioned elderly homes
- Should be able to communicate
- Should be able to communicate in Nepali or English dialect.

Exclusion Criteria:

- Those living at Pashupati without official registration. (25 excluded this way)
- Those who cannot communicate, including deaf, mute, deaf-mute and mentally ill. (A total of 47 at Pashupati and 3 at Matatirtha were excluded this way, but were replaced by others to keep the sample size unaffected.)
- Those who cannot communicate in Nepali or English. (1 at Matatirtha.)

SAMPLING:

Target population:

- All the registered inmates in the 3 elderly homes
- Management staff and care providers.

Sampling Units: inmates and staff

Sampling frame: all the registered inmates and all the staff and care providers.

Sample size:

- Available staffs and care providers
- 30% of the inmates from each housing: 62 at Pashupati, 4 at Koteshwor and 7 at Matatirtha
- Secondary data of *universal set* of inmates in all the 3 homes were taken for calculating the background information including the demographic, socio-economic, cultural and geographic distribution, years of stay and major illnesses.

Sampling Technique:

- Convenience sampling of the staffs that are available.
- *Stratified systematic sampling* of the inmates, the sample frame being divided into 2 strata: male and female and proportionate no. of sample drawn from each.

Research Strategy: The P.I., Co.I. and the Volunteers observed the functioning of the houses and their environmental conditions using an observation checklist and photography; interviewed the selected inmates using a pre-constructed questionnaire and also interviewed and discussed with the staffs and the care providers.
Medline search was done for the relevant literature.

Tools and Techniques for Data Collection:

- Secondary data available from the offices of the elderly homes, eg. the registration files of the inmates, register of the medical caretaker, etc
- Observation using a checklist and Photography
- Interviewing the caretakers, management staff including the head and the medical care provider: loosely structured interview with an *interview guide/schedule.*
- Structured interview of the inmates with a preformed questionnaire.
- Focused group discussion with the staffs and some of the inmates.

Pretesting of Tools: Pretesting was done before finalizing the questionnaire on 10 % of the sample of inmates at Pashupati.

Validity and Reliability:

- Different international standard tools for assessing QoL were consulted during preparation of the final questionnaire, including Nottingham Health Profile, TSCS, MFAQ, CAPE-BRS, CANE, CES-D, LSIA, etc which we hope increases the validity of our tool.
- Pretesting helped to make the questionnaire more practical and applicable
- Combining qualitative and quantitative tools, ie structured interview, loosely structured interview, FGD, observation and photography helped to increase the reliability of our research technique.

Process of Data Collection:

P.I., CoI and volunteers individually collected data from the inmates using the questionnaire, while all participated in the observations, FGD and interview with the staffs. CoI and volunteers were briefed by PI on the standard procedure of using the questionnaire to ensure uniformity in the collected data.

Ethical considerations:

This research was certified by the Ethical Review Board of NHRC as having no any ethical objections.

Human participants were required in this research to assess the level of satisfaction and the subjective perception of the inmates towards the facilities, their problems, and their overall QoL. Staffs and caretakers are also needed.

The total no. needed is as defined by the sample size.

Each of the participants was involved just once during the research.

They had to answer the structured and pretested questionnaires.

The participants were not vulnerable to any risk during the study, hence no health insurance was provided.

There was no direct benefit to the participants though they would be indirectly benefited by the identification of their problems and their solutions, if policy makers take them seriously.

The research tools are made as sensitive as possible to the social culture and values, Nepal being a predominantly Hindu nation.

Informed consent was taken verbally as it was almost impossible to make the elderly inmates sign a written consent, plus most of them were illiterate. Even then, all of the inmates were questioned in front of a witness, usually one of the staff. The CoI and the volunteers were authorized by the PI to take the informed consent. Noting was being withheld from the participants at the time of taking the informed consent.

Data Management and Analysis:

The results from the questionnaire were edited for making them amenable to analysis, and then fed into standard master tables. The results were analysed and presented in diagrammatic form using the Windows Excel 2003.

Work plan:

the contract was signed with NHRC on December 1st, 2004

Task	**Dates**	**Personnel**	**Days required**
1. Finalising the Research Proposal	Dec 30 to Jan 1	PI and CoI	3
2. Data collection at Pashupati including staff interview, observation and FGD	Jan 2 to Jan 7, 2005	PI, CoI and Volunteers	6
3. Data collection at Matatirtha	Jan 7 and 8	Same	2
4. Data collection at Koteshwor	Jan 9 and 10	Same	2
5. Data analysis	January and February	PI and CoI	7
6. Report writing and formatting	March and April	PI, CoI and computer technician	10

The work wasn't continuous during the months stated due to educational reasons of the investigators.

Biases in the study:

Utmost care was taken to prevent biases from the following sources and to increase the *accuracy* of the study:

1. To minimize bias in information collection:

- Questionnaires were prepared after consulting the aforementioned international standard tools used all over the world.
- All the data collectors were briefed by the PI on the guidelines to use the questionnaire.
- Open-ended questions were used where little was known to us.
- Leading questions, vaguely phrased questions and questions in illogical order were avoided.
- The tools were pretested.

2. To minimize observer bias:

- A protocol/checklist was used during observation. It was prepared after consulting standard observation checklists on similar topic.
- Interviews with the inmates were mostly of the structured type using preformed pretested questionnaire. Loosely structured or unstructured interviews were kept at a minimum.
- Data collectors worked in pairs during the observation and any loosely structured interview.
- Data was discussed and interpreted immediately after collecting it.
- Photography was used to store the things observed according to the checklist.

3. To minimize selection bias:

- Inclusion and exclusion criteria were rigidly defined.
- Stratified systematic sampling (type of probability sampling) was practiced
- Self-selection was not permitted to the inmates
- Judgment and convenience sampling were not practiced.
- There was a high response rate and substitution was rarely necessary. Yet some of the factors under study themselves made people unavailable for study, including

deafness and/or mutism and mental illness. This might have caused some selection bias that was unavoidable.

- Selection of the private housing at Koteshwor was among other similar housings by convenience, which might have introduced some bias in the study.

4. To minimize the effect of the interview on the informant:

- The purpose of the study was introduced to the informants adequately.
- Sufficient time was taken for each interview
- Informants were assured that their individual information and identity would be kept confidential.

5. To minimize information bias:

- Since secondary data from the inmates register was used for the background information, some information bias might have crept in. But we found the registers to be complete without any blank spaces.
- To minimize *memory or recall bias,* we limited the period of recall of information like illnesses and death to duration of 1 year only.

6. Interviewer's bias: Interviewer might have a preformed notion of what they are going to find. This couldn't be helped.

7. Measurement or classification bias: not applicable.

8. Confounding: see above.

Limitations of the study:

- The results cannot be extrapolated to the entire elderly population of Nepal due to the confounding variables like socioeconomic strata and others that might differ with those who don't live in such housings.
- The results from the private housing should only be cautiously extrapolated to other private housings in the country as their modus operandi might differ greatly.
- Some of the comparative conclusions (eg. that the interpersonal relations and the level of satisfaction in the community operated home is better than at Pashupati or private housings) are based partly on the data and partly on our subjective perceptions, as no statistical test of significance could be done due to the extremely small no. of sample frame in the other institutions.

Results

Note: some 40-colour photographs of the different aspects of the 3 elderly housings are included in the electronic version of this report. They collectively provide a good depiction of what the environment and the inmates are really like. We hope this helps reduce the observer bias in the study.

His Majesty's Government, Ministry of Women, Child and Social Welfare, Social Welfare Center, Elderly's home, Pashupati

Introduction:

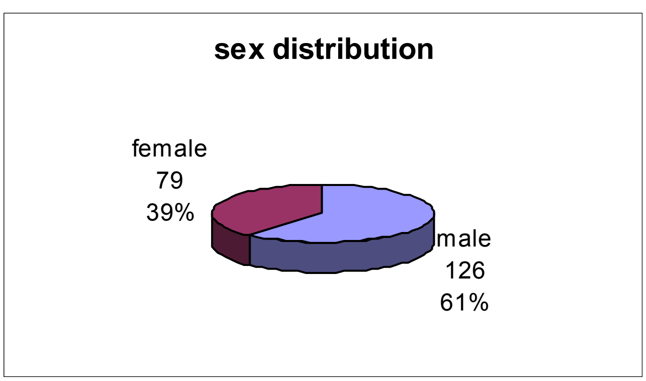
Fully run by the government, this housing was established in 1938 BS (1882 AD) as Panchadev Paksala during the regime of His Majesty Surendra BBS and has been operating under this name since 2034 BS (1977 AD). The total sheltering capacity is 205, though the number of unregistered inmates is on the rise (about 25 now), and it intends to extend its capacity in the near future.

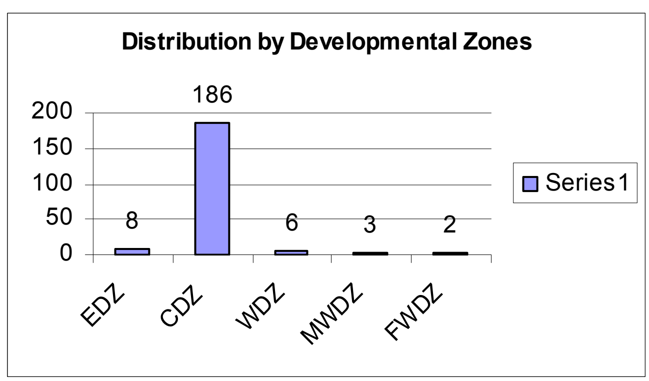
Criteria for admission of inmates:

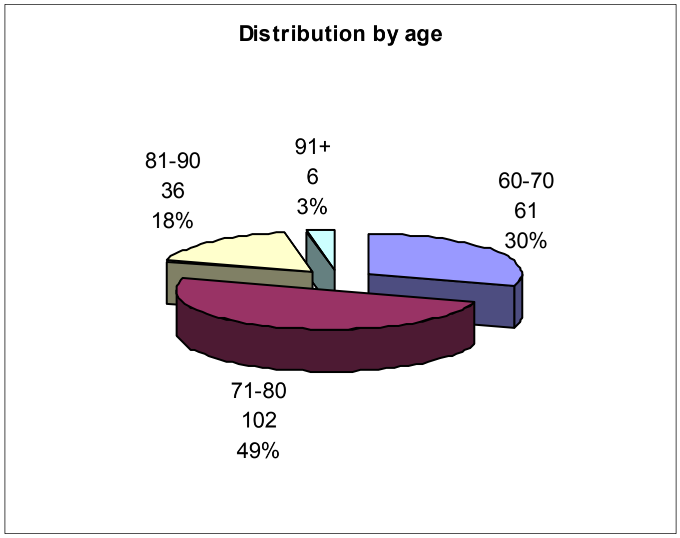
- Nepalese citizenship certificate showing the completion of 65 years.
- Clear-cut recommendation letter from the concerned authority (VDC or Municipality) stating inter alias that the person is orphan, helpless, poor and that he has nobody to take care of him.
- Application by the concerned person has to be approved by HMG, MWCSW.
- After approval, admission is made on vacancy.

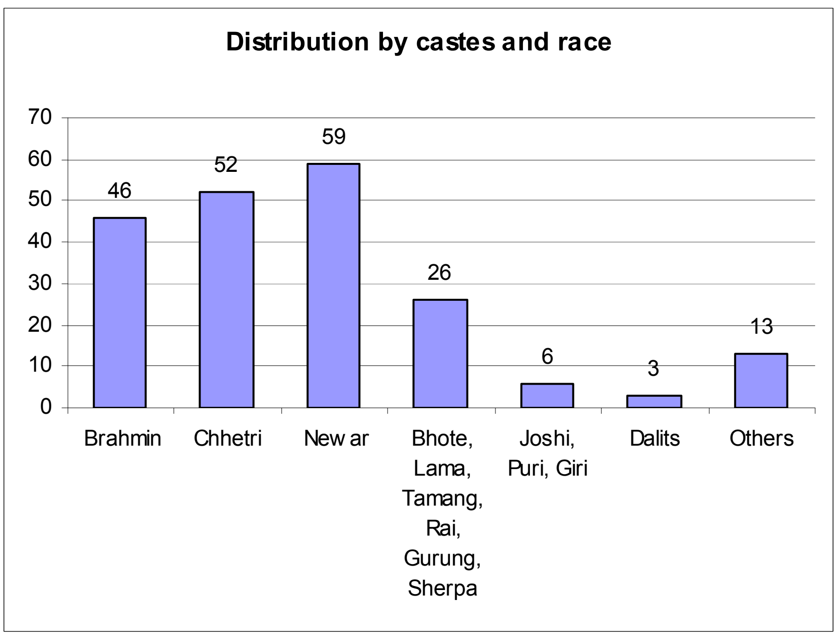
Inmates Profile:

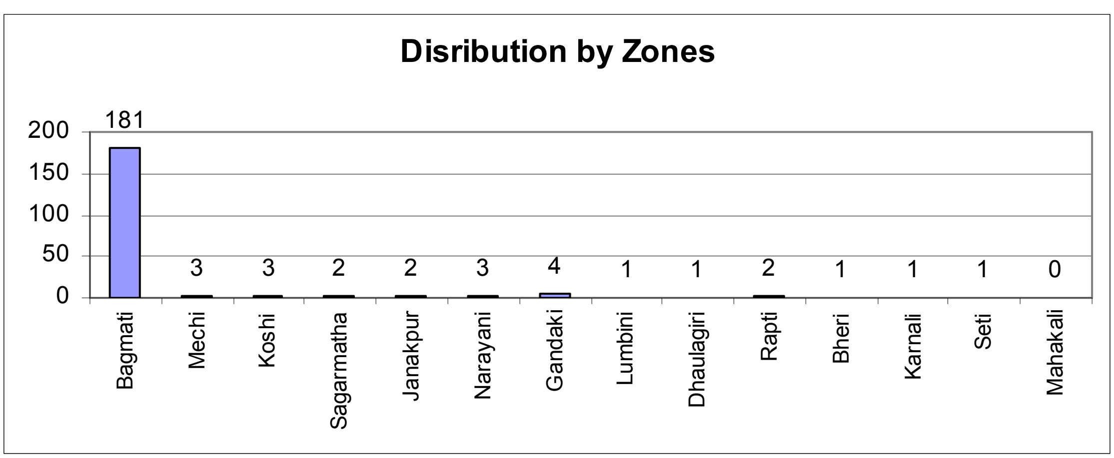
total persons residing about 230 though the official number is 205.

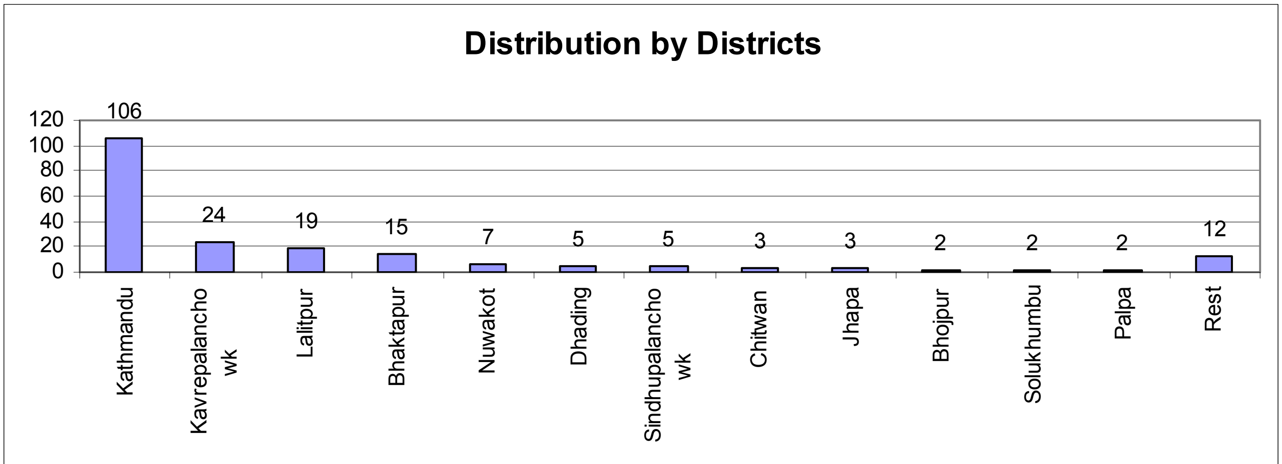




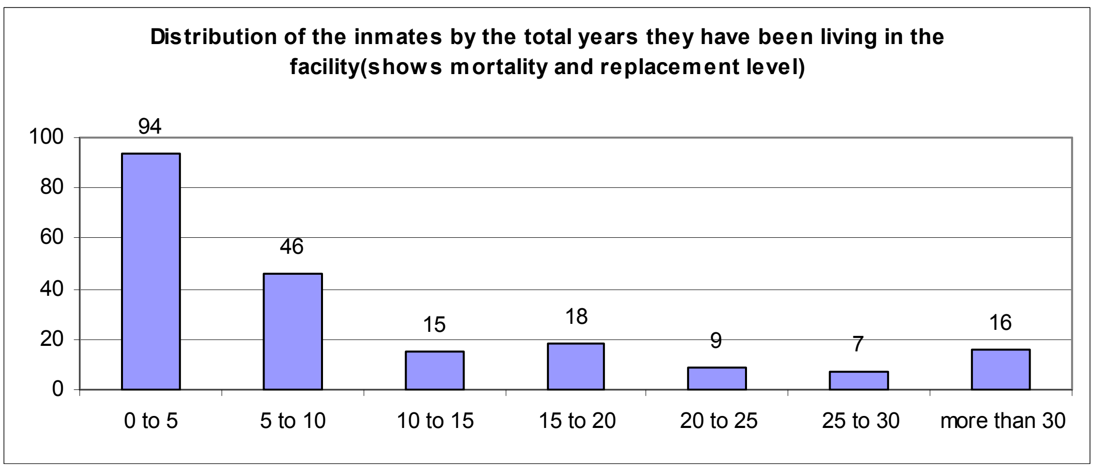

Distribution by age
91+
6
3%
60-70
61
30%
81-90
36
18%
71-80
102
49%


Distribution by castes and race
70
60
50
40
30
20
10
0
46
52
59
26
6
3
13
Brahmin
Chhetri
New ar
Bhote, Lama, Tamang, Rai, Gurung, Sherpa
Joshi, Puri, Giri
Dalits
Others


Disribution by Zones
200
150
100
50
0
181
3
3
2
2
3
4
1
1
2
1
1
1
0
Bagmati
Mechi
Koshi
Sagarmatha
Janakpur
Narayani
Gandaki
Lumbini
Dhaulagiri
Rapti
Bheri
Karnali
Seti
Mahakali



Note: The category 'rest' includes one inmate each from Bardia, Humla, Kaski, Gorkha, Doti, Janakpur, Morang, Argakhanchi, Rasuwa, Baglung, Pyuthan and Dolakha.



Disability profile:

Unable to walk:	leper	6
	Kyphosis	4
	Not otherwise specified	16
Blind:	one eye	4
	Both eye	12
Deaf:		9
Mute:		20
Deaf-mute:		6
Paralysed:		8

Mental cases:	6
Blind, deaf and mute	1
Deaf mute and unable to walk(NOS)	2
Mute and unable to walk(kyphosis)	1
Mute blind and mental case	1
Blind and mute	1
Blind and unable to walk(leper)	1
Total number of disabled persons	98

Services, Facilities and Objectives:

Fooding: morning 6-7 am: tea; 10 am: meal (dal*, bhat, tarkari*)
afternoon 2 pm: tea and biscuits; 5 pm: meal
twice a month: meat (milk products for vegetarians)

Clothing:

- twice a year (on *Bada Dashain* and *Chaite Dashain)*, a pair of shirt-pants (or *daura suruwal)*, cap, underwear and shoes for male and saree, blouse, petticoat and shoes for female. Bed sheet, mosquito net, sweater, mattress and blanket as needed.

Entertainment:

- Hymn chanting *(bhajan*) every morning and evening.
- 6-8 B/W TV, one in each hall and a color TV in the verandah.
- Cultural programmes conducted by various institutions from time to time.
- Trips to religious places from time to time including Manakamana, Bajrabarahi, Salinadi, Godavari, etc- either from the EWF (Elderly Welfare Fund) or with the help of various institutions.

Festivals and Rituals:

- *Dashain* is celebrated in a homely atmosphere with the inmates and staffs together performing the rituals for 3 days and sharing of *Tika* between themselves.
- *Tihar* celebrated with *Deusi, Bhailo* inside the premises of the housing and sharing *Bhaitika* among themselves.
- Other periodical festivals also celebrated including the International Elderly Day.
- Funeral rites performed in case anybody dies and an obituary gathering and rituals performed each year in *Jeshta* for the pacification of the deceased soul.

Medical Services:

- One permanent clinic is present within the premises of the home with an ANM providing services during office hours each day.
- A doctor from the Leprosy control center nearby visits 3 days a week
- Followers of Mother Teresa from the Missionaries of Charity serve some 50 seriously ill and disabled inmates everyday including washing and cleaning.
- Health checkup camps organized from time to time by different hospitals.
- Free eye treatment by Tilganga Eye Hospital, Sinamangal, KTM
- If serious, taken to Bir Hospital or to NMC, Attarkhel.
- For gynecological problems taken to Maternity Hospital, Thapathali

Funding and modus operandi:

The home received a total of Rs. 50, 45,000/- this fiscal year from the government, with the administrative, electricity and other expenses plus the wages of the staffs included. Just Rs. 1, 80,000 is separated for the medical treatment of the inmates, amounting to nearly Rs. 800 per head per annum. A EWF has been established with the saving account no. 5915 in Rastriya Banijya Bank, KTM. Well-wishers can also donate for this fund in the donation box kept within the premises of the home. Only 90% of the interest from the fund is spent on the services other than that provided by the government budget, like different religious tours, rituals, discourses and obituary.

Many organisations, social service oriented or otherwise, help time to time by providing fund, food, clothes, medical services, washing and cleaning services, cultural programs, religious and educational discourses or taking the inmates out on a trip. These well wishers include Missionaries of Charity, Marwadi Service Council, Tilganga Eye Hospital, Leprosy control center, students of humanities and social work from Padmakanya, St. Xaviers and other campuses, Campion college, Friends of Shanta Bhawan, World Hindu Youth Council, PADT, Rotary club, Lions club, Leo club, USAID, NMC, Hotel Annapurna, Satya Sai Center, etc. Individual well-wishers include actors like Santosh Pant, Madan Krishna Shrestha, Haribansha Acharya, etc and different foreigners. Media like Channel Nepal, The Gorkhapatra daily, The Samacharpatra daily, The Kantipur daily and others are also giving sufficient attention and covering their problems for the general public to know and help.

This way it seems that this center is enjoying a lot of limelight and attention from its well-wishers.

Management Staff: 20 staff is appointed including one office head, one administration and store in charge, one ANM, one accountant, 7 cooks, 5 attendants, 2 peons and 2 sweepers.

General living conditions (On observation)

Housing: The house is over a century old and dilapidated. It has 4 interconnected buildings surrounding a wide central space. It is made of mud and is 2 storied. In the ground floor, the north part has space for religious gathering and watching TV, a store and the main office room. The east part is occupied by the clinic and some inmates who sleep in the open verandah. The south side has mess, the dining place and an inner hall used by inmates too disabled to climb the stairs. West side has 3 rooms for the inmates. In the 2nd storey, halls on the east and the south side are occupied by female inmates and halls on the west and north by the males.

Beds are arranged in 2 or 4 rows in each hall with very little private space. The living condition is extremely congested and of a very poor quality. Sunlight can't enter the age-old latticed window, and they have to use electric lights even in the daytime. Ventilation is obviously poor. Rooms are very cold with no heating arrangement. Cleanliness is not apparent. Roofs are of tin and they leak in the winter. Fans are attached for the summer and there are electric bulbs, but that seems to be the only luxury they have. Some halls have TV and some don't, radio is not seen. Some inmates even cook their own meals on stove in such a congested environment.

Overall, our objective conclusion was of a very poor housing standard. Even many staffs and the inmates felt the same way.

Mess: Wood was used for fuel, but there was an exhaust fan. Tap water was used for cooking. There were tables and benches for dining. The overall hygiene of the mess and the cook was satisfactory, given the conditions.

Water: Sources were abundant, from tube well, hand pump, well to tap water. Some Euro guards and filters were fitted, else water treatment was not practiced, and many complained of lack of hot water in the winter.

Toilets: With the newly made 11 toilets, a total of 18 toilets were available. The inmate: toilet ratio is about 13. The conditions in only some of them were satisfactory. Bathrooms were hygienic and had solar heater attached for winter (courtesy of actor Santosh Pant.)

Waste Disposal: Dumping.

Drainage: Drainage of sewage and sullage was into the Bagmati river. The drainage system, though renovated, was unsatisfactory and according to the staffs, got blocked now and then. The sewage would then flood the living quarters in the south wing. In the rainy season, whole of the open spaces would flood with water.

Overall Environment: Environment was satisfactory.
A beautiful garden was built on the backyard by some of the inmates 2 yrs back. The central space has 5 shrines of *Mahadeva* (so called *Panchadeval)* and the inmates had recently built another one in the backyard.
The open space was used for gathering, working, sunbathing and for cultural and religious programmes.
Pollution was minimal though there was a lot of smoking among the inmates and the staffs alike.

Entertainment: 5-7 B/W TV were in the hall and one color TV with satellite channels in the verandah on the north side. One or the other well-wisher would come almost every day and chat with the inmates, feed them or help them with their things. Therefore, the inmates were getting constant attention and boredom was minimal.

Creative Work: Productive activities were minimal, except for some females busy spinning wicks for the traditional light, which they sell.

Interpersonal Relations: Interpersonal relation was alarmingly poor. No one knew when asked about the other. There was no any group as such and almost all were alone and on their own. Sense of friendship was poor. Some couldn't communicate due to deaf-mutism, serious disability or mental illness, but even the others were no good.

The behaviour of the staffs towards the inmates was very good, and the inmates loved the staff in turn- especially the head Mr Arjun Pd Gautam who has been working here for 6 years. The inmates, we were told, almost worship him, as he always provided ample time for their problems, worked even on holidays and even celebrated every festivals with them.

Medical Services- Demand and Supply

- Old age with its accompanying lethargy, weakness and other homeostenosis is the major illness, so to say.
- GIT problems: indigestion and diarrhea is common. Sister herself prescribes metronidazole, albendazole, H2 blockers and omeprazole as needed. Almost 50-60 inmates use aristozyme regularly. Polyvitamin complexes are also in daily use.
- Asthma is a very common respiratory problem followed by COPD and chronic cough. Almost 26-27 are using regular Salbutamol, Aminophylline or Asthalin. Oxygen cylinder and nebuliser are available in necessity.
- Myalgia, arthralgia, headache, backache and other chronic pain syndromes are common due to old age. Diclofenac, Ibuprofen(gel and tablets) are in common use. Some females are addicted to Voveran(diclofenac) and use them daily(analgesic abuse).
- Piles and uterine prolapse are also common.
- Eye discharges are common and many use regular eye drops. Poor vision is common and they are checked up at Tilganga eye hospital.
- Mental illnesses including epilepsy are also common after they started permitting mental cases to stay too. Clonazepam, phenytoin, risperidone, lorazepam, sizodon, retilil, are found to be used regularly on consulting the patient's records.
- Traumatic fracture is also seen sometimes in the females due to postmenopausal osteoporosis. The incidence is about 1 per year. One patient died due to hip fracture some 1 year back.
- Hypertension with BP above 150/90 are common but the sister thinks they are symptom less and hence need no medication. Only one male is taking Invas(Enalapril).
- One male had carcinoma lung and he expired. One female had undergone mastectomy and another one hysterectomy. But their records and exact diagnoses were not available.
- 3-4 diabetics use dianil (hypoglycemic oral drug) as per need.

- The sister herself prescribes many antibiotics including albendazole and metronidazole for GI problems, doxycycline for respiratory problems and uterine discharge, amoxicillin for respiratory problems and ciprofloxacin for respiratory problems, fever and wound infection.
- 10-15 persons die each year according to the sister though the exact causes couldn't be ascertained for lack of records.

Problems faced by the management:

1. Physical problems:

- due to lack of a proper housing facility, all types of inmates including very old, very ill, mentally ill, disabled and blind are being kept in the same place. This is a really pathetic situation. Corridors are small and the stairs are dark- making it very difficult for disabled persons to climb up.
- Since the present housing is within the premises of the Pashupati area listed under the world heritage site, the PADT now and then removes this part, tears down that part and promises to shift the whole housing to Sankhamul or to some other place, all in vain. Elderly are terrified, feel displaced and are reluctant to leave the premises of Pashupati for religious reasons.
- Since all of the inmates have to share the same rooms and the same mess, many religious minded people hold the grudge of having to live with the 'untouchable' castes.
- There's no attached toilet for the disabled and the seriously ill.
- The drainage system is very poor, inadequate and gets blocked every now and then.

2. Financial Problems:

- after accounting for all the administrative expenses, staff wages and bills for telephone, water and electricity, almost only half of the total budget goes to the facilities for the inmates. Sufficient funding is lacking for fooding, clothing and religious tours so that they have to depend on well-wishers which is not a constant source of fund.

- The budget for medical care, Rs 1, 80,000 or around Rs 800 per capita per year is still insufficient, given the chronic diseases that most inmates suffer from and the perennial use of medicines that is needed. The condition was even more pathetic 2 years back with an alarming sum of just Rs 4000/yr that was separated by the government for the medical services of all the inmates.
- There are very less productive activities going on, even though there are many inmates able and willing to work.

3. **Social problems:**

- Majority of the general public still don't have a positive attitude towards elderly and their housings. Most, including their own family, despise them as passive recipients of support. This, together with the ongoing Maoist Revolution that is leaving many aged helpless, homeless and terrified as their family either gets killed, leave the country or joins the Maoist. Most of these hapless persons come down to cities and eke out a living by begging or doing hazardous jobs. This has increased non-registered inmates in the Pashupati home each day, much more than they can handle. Even then, due to humanitarian reasons, they are forced to take in these people.
- The so-called untouchables (damai, sarki) are exasperated at the derogatory behavior shown by the so-called higher castes (Brahmin).

4. **Miscellaneous:**

- the 20 staff appointed is not enough for catering to some 230 inmates. Especially there is a big problem of washing clothes and cleaning, as many disabled inmates can't do it by themselves.
- Even the staffs working there lack in dedication and confidence, as many of the staffs and inmates pointed out. This might be because they have to

give excess time and have to work even on holiday, and still there's no arrangement for bonuses or any encouragement.

- The entry criteria is very cumbersome and unpractical or the disabled and helpless elderly.
- Lack of arrangement for free treatment in any hospital in case the inmates get seriously ill.
- Lack of medical equipments, space for treating serious patients, sterilizing and handwashing arrangements and proper dressing.

Matatirtha senior citizens residence committee

Mahadevsthan VDC, ward no. 3, KTM, Nepal

Introduction:

MSCRC was established as a result of the united effort by a group o local social activists from Mahadevsthan VDC in 1997 AD including Mr Basanta Guachan(Chairperson), Mrs Radhika Shrestha(Vice President) and Mr Durga Lal Shrestha(Secretary). It is a social non-profit NGO.

Criteria:

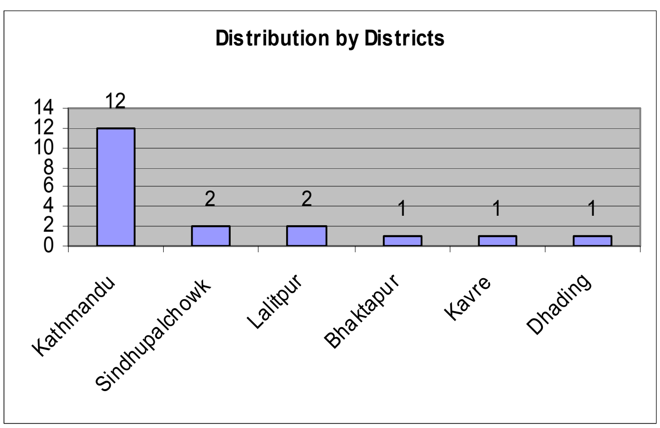
Any female citizen of Nepal over 65 years of age, of any ethnicity or religion, those who are needy, without shelter, without guardians and in need of care and attention; those who are recommended by the concerned authority and who commit to abide by the rules and regulations of the residence.

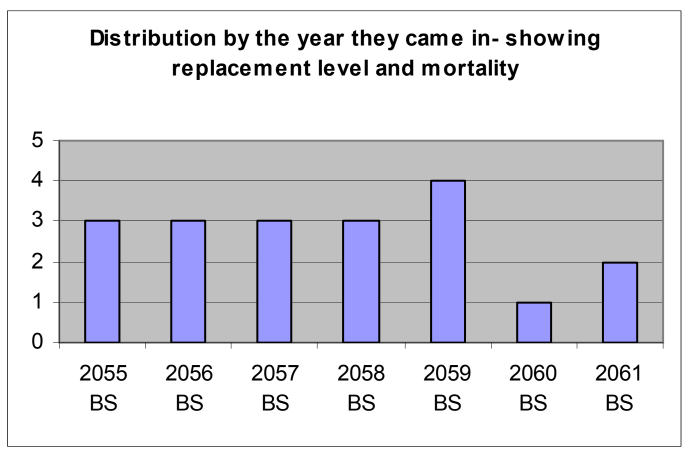
Background characteristics of the inmates:

Total capacity: 20, now residing: 19, total admitted till now: 46

Future plan to accommodate 100 people.

Deaf: 1, Mute: 1 and 1 couldn't speak Nepali dialect.





Facilities and objectives:

Fooding: major meal 2 times a day with tea and snacks in the morning and afternoon.

Many organizations and well wishers including Patan Maharjan family, Tahachal Sai Kendra, Galaxy Education Foundation, F10 group from Kathmandu, Students from Padmakanya Campus and Lazimpat club feed one meal per week or month on a regular basis.

Clothing: 2 sets of clothing per year unless some organization donates.

Entertainment: there's a TV in one room. Apart from this they used to take the inmates to trips to Manakamana, Dakshinkali, etc but these trips are getting very infrequent these days due to lack of fund.

Medical:

- nearby health post and medical shop
- if serious, taken to Jorpati(NMC) where the treatment is free
- health checkup once every year at NMC with free stay
- almost 10 to 12 people die each year

Festivals and Rituals:

- Dashain, Tihar, and other festivals celebrated as per the traditions
- Funeral rites performed if somebody dies

Funding and modus operandi:

- HMG hands over Rs 3 lakhs each year and the VDC office some 10,000
- Membership and the various fees collected from the members
- Donations in cash and kind by clubs, well wishers or by the resident on demise
- National and international agencies if any
- Regarding the expenses, the rent itself is Rs 5,000 per year, as they don't have their own building. Staffs get minimal wages (Rs 3,000 per month for 4 staffs)

- This committee is not recognized by the general public that well and hence is not benefiting from much attention and help from other clubs and well wishers.

Executive committee: consists of chairperson, vice president, secretary, treasurer, members and advisors. They visit from time to time and help financially in case of any emergency.

Management staff: consists of one office secretary, one assistant and two cooks

General living conditions (on observation):

Housing: old, rented two-storied building with 3 rooms, 1 office room, and 1 kitchen. The rooms are congested with 6-8 beds per room. The lighting and ventilation are good. Rooms are cold with no heating or cooling systems. There is lack of private space. Hygiene is satisfactory.

Mess: kerosene used as fuel. Water is brought from public tap. Water drainage is satisfactory. The cooks and the practices are hygienic. The inmates had to have their meal served in their own beds for lack of proper space.

Water: source is public tap. Water is treated by boiling.

Toilet: single toilet and the toilet: inmate ratio is unsatisfactory though the hygiene of the toilet is satisfactory.

Waste disposal: dumping in the nearby field.

Drainage: satisfactory, into a public drainage system.

Overall environment: there’s no open space, no garden, no shrine, and the overall hygiene is just satisfactory. Pollution is minimal though some of the inmates smoked regularly. They sunbathe in the roof in the winter, but due to a large building nearby, they don't get any sun after 1 pm in the afternoon.

Entertainment: one TV is all they have got, besides themselves!

Creative work: none, except some spinning wick.

Interpersonal relations: good, even with the staffs also.

Overall quality of life: good. Had it not been for the dearth of resources, such community run elderly homes are the best possible option than fully government or fully private owned housings, which have their own pitfalls. All the staffs are local and they understand the problems of the elderly are friendly and are eager to help.

Problems faced by the management:

Physical problems:

Due to the lack of financial resources, it has been a major challenge for the committee to construct its own private residential quarters and extend the capacity to 100 inmates with an inbuilt health clinic, agriculture, exercise, religious discourses and other facilities.

Financial problems: being run by community and being a non-profit organization, it is sustained literally in the alms provided by some handful of well- wishers. The staffs themselves feel bad that they are not able to provide necessary facilities including health checkup, entertainment and trips. Since this social service center is also neglected by far by the media, almost nobody knows about it and its problems.

Old age care center

Mahadevsthan-35, Koteshwor, Kathmandu

Introduction:

This NGO was registered in the year 2058 BS, in accordance with the Society Registration Act, 2034.

Criteria: it aims to look after the welfare of the aged people who are poor, incapacitated, helpless, suffering from chronic serious illness or have been discarded by the family or the society.

Objectives (as indicated in their manifesto):

- To rehabilitate, take care and provide treatment to the aged people.
- To utilize the experiences and abilities of the aged people for the benefit of the country and the people.
- To conduct studies and research relating to the problems concerning the aged people and publish books and bulletins on the same.
- To generate awareness through pamphlets, posters, audio, video, radio and television concerning the protection and promotion of the interests and welfare of the aged people.
- To organize national and international seminar and workshops to share and exchange experiences, ideas, knowledge concerning the means to protect and promote the welfare and interests of the aged people
- To seek necessary financial, social, educational and legal assistance for the rehabilitation of the incapacitated, helpless and poor aged people.
- To make the elderly people self-reliant by giving them different kinds of trainings.
- To enhance the capability of the aged people by conducting adult informal education, yoga, exercise, meditation and awareness programs.

- To emancipate the aged people from the prevailing social discriminatory ill practices and customs.

Code of conduct (in their manifesto):

- Residents of the center shall be required to wear logo and identity card given by the center.
- Alcoholic drinks and smoking are strictly prohibited in the precincts of the center.
- Food and drink from outside is not allowed.
- Relatives and friends are allowed to meet the residents only on Saturdays.
- Residents may leave the center only with prior permission. Relatives wishing to take the inmates outside have to apply in advance by filling the form available at the center.
- Except in emergency, the regular health checkup of the residents will be done on every Friday.

Criticism:

Though the points listed in its manifesto sound very encouraging and actually should be the ideal motto of every such social welfare institutions, we were disappointed to find a different reality. This center seems to be a perfect example of the so called 'dollar farming' NGO. Though they claim to be giving shelter to 35 and that the capacity is 100, we found only 12 people living there. Nothing was transparent, including the executive committee (headed by Mrs Sunam Nembang), management staff, funding and affiliated international agencies. Only one staff was present and she dealt with everything, from cooking to official works (which was none- there was no factual record whatsoever). We couldn't even interact with the executive members and both the staff and the inmates had clear instructions 'not to say anything to any enquirers!' though we had received written consent some months back. Yet we interviewed some of the inmates and surveyed the surrounding.

Facilities (on observation):

Housing: 3 houses were on rent, two of concrete and one of bricks with a tin roof, which the inmates said used to be used for keeping hens earlier! There were 2 rooms each in all houses for the inmates, one for the staff and one as kitchen. There were 2-4 beds per room. There was no congestion. The lighting and ventilation were good. There was no heating or cooling arrangement. The overall hygiene was good.

Mess: kitchen was in the shed. Kerosene was used as fuel. Source of water was tap water. Water treatment was not practiced. Wastes were dumped nearby. The cooking practices were hygienic.

Toilet: single toilet was in use. The other ones were locked up. The hygiene was just satisfactory.

Overall environment: there were plenty of open spaces. There were some flowers but no garden as such. There were no any shrines. Pollution, both internal and external, was minimal though some smoked. Overall, environmental hygiene was good.

Entertainment: a single TV was all that they had. They were never taken to any trips, though there were lots of promises.

Creative work was none

Interpersonal relation: extremely unsatisfactory relation with the staff. According to one of the inmates who was willing to speak, the executive members came once in a blue moon, while the staffs that live with them used to abuse them verbally and physically, threatened to throw them out, snatch their belongings and whatever somebody offers to them. There was extreme lack of attention and care, even when they were seriously ill. They felt extremely neglected. They are even discouraged from speaking to others and that was really preposterous.

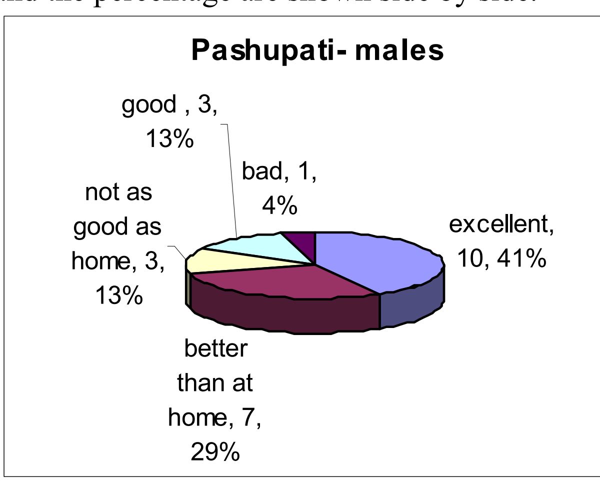
Health care: the inmates said one doctor used to come every 2 months though we couldn’t confirm that due to lack of co-operation.

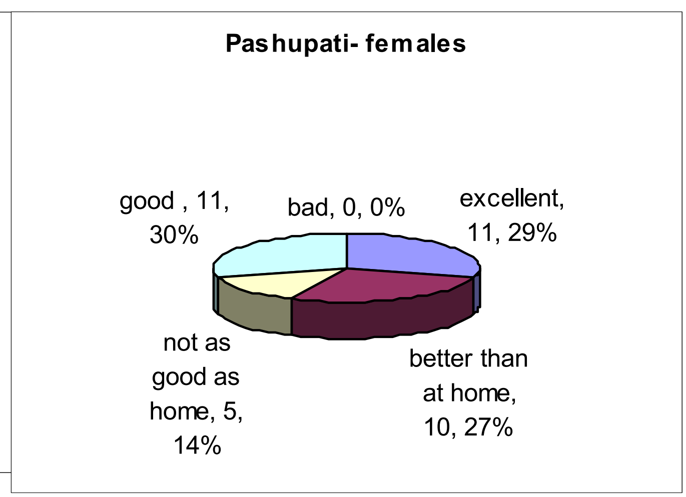
Overall quality of life: unsatisfactory though the physical infrastructure was good.

Perception and Attitude Survey:

Most part of the perception survey required a good level of co-operation from the inmates which we unfortunately couldn't get in the elderly home at Koteshwor. On top of that the total number of inmates at both Koteshwor and Matatirtha were so minimal that the results of the qualitative survey like perception survey would have a very low level of statistical significance, though whatever we learn about their life from a single person would be significant. So apart from Pashupati where the sample was large and the response was overwhelming and in some cases in Matatirtha too, we have ommitted the statistical presentation of the perception survey, especially of Koteshwor, though the overview of the situation and the subjective perception of the inmates is presented in the text along with our impression on observation. Yet we hope that in most part the way the inmates in Pashupati feel also reflect the way the inmates in the other housings also feel. Yet there is still a catch- many of the inmates were too old and/or disoriented to remember and answer properly, and many were just incooperative. This might have been a source of significant bias when it comes to such a very subjective survey. Yet the overall picture that we gained is worth mentioning.

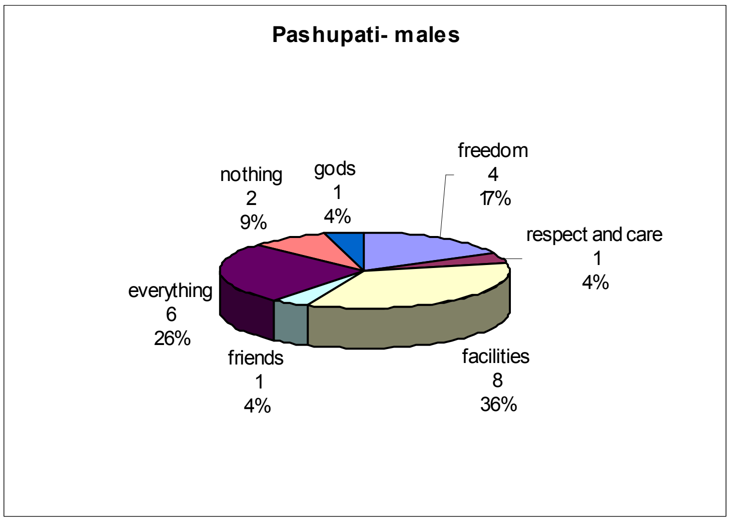
1. On being asked " How do you feel staying in this home?", the results in the 3 housing were as shown in the diagram. The total number of respondents to the particular question and the percentage are shown side by side.

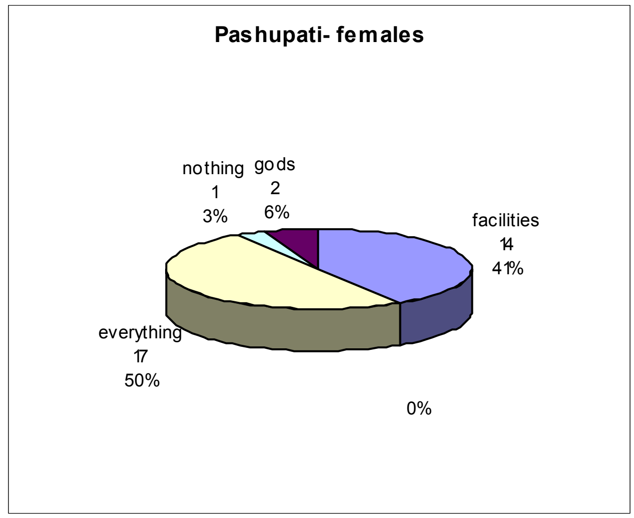


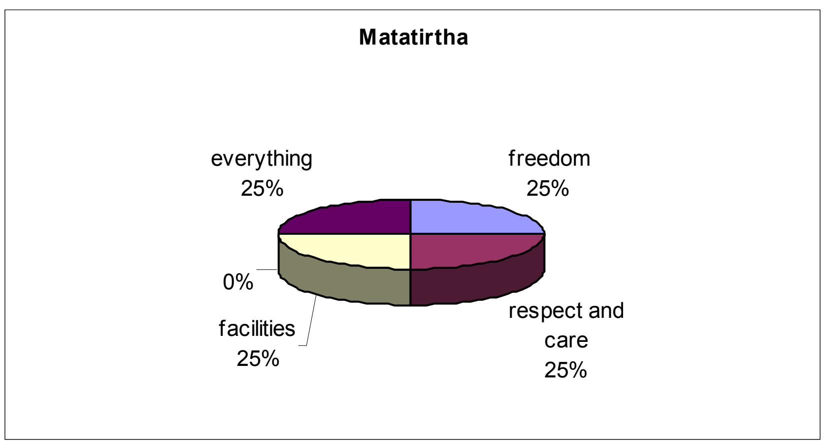


In Matatirtha, almost all the respondents felt very good or atleast better than at home. When asked specifically the inmates at Koteshwor also almost all responded to be satisifed with their life except for one of the more active and ready-to-speak inmate who was very vocal about the maltreatment and the lack of care and support in that home.

2. On being asked, " What do you like about staying over here?" the responses were:



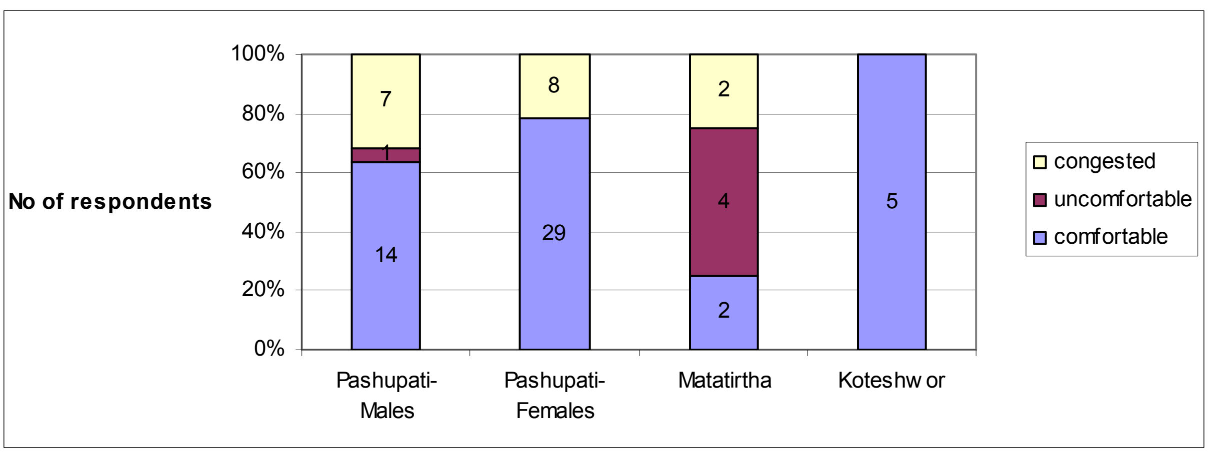




3. On being asked," How do you like the food over here?", the responses were: good except for 1 male at Pashupati finding it not good, and some 3 males and 5 females finding it just okay. Some complained that they are having problems observing dietary restrictions as they have to share the common mess and forced to have fatty and spicy food despite suffering from APD.

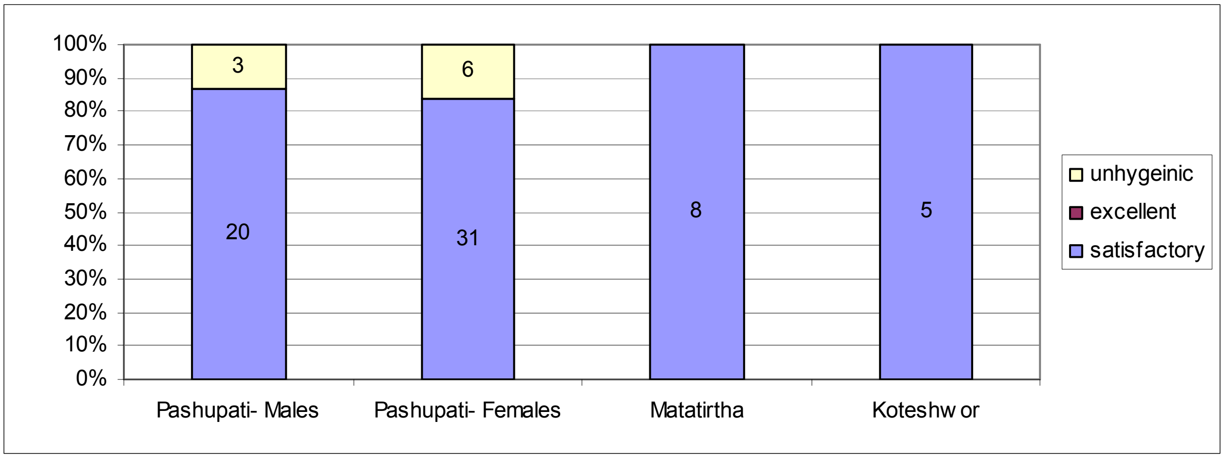
4. On being asked," What do you do in your free time?" and " Do you do any work now?", almost all replied that they do nothing productive, especially males. This might be due to their debility but even many males who were sound in health were not engaged in any productive activitites. Only 6 male(of 24 who responded) inmates at Pashupati replied that they are engaged in household activites like cleaning, gardening, making wood for cooking, etc. 1 replied he used to make cotton wicks for the traditional lights which he used to sell. This occupation as a source of some pocket money was more common among the females, including 8(of 37) at Pashupati and 6(of 8) at Matatirtha. The relative proportion seems to be much more at Matatirtha after accounting for the small sample over there. Many at Pashupati were engaged in Bhajans (religious chanting) in their free time. Actually there was regular Bhajans every morning before meal and every evening after meals. No any productive activities were found at Koteshwor. Only one person was literate over there, the actively speaking person we mentioned earlier and he used to spend his time reading books. Yet another inmate was involved in all the household activities.

5. On being asked," What do you feel about the room over here?" the responses were:

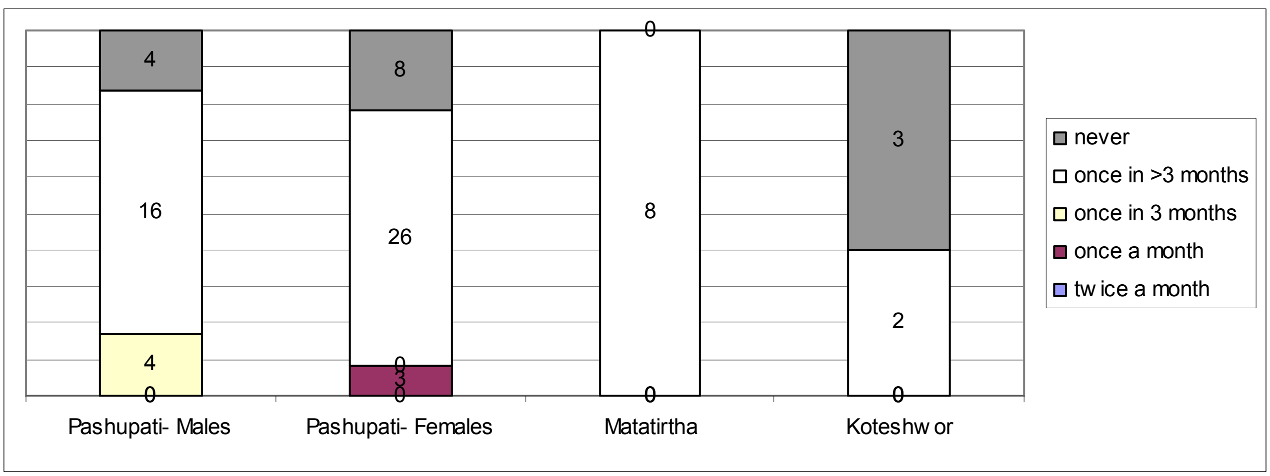


A large proportion of inmates at Pashupati found that the living quarter were very congested, and rightly so. Some felt it very uncomfortable to live with all others in a single corridor like room. While in Matatirtha a major proportion found the rooms to be very cold in winter because sunlight never entered the rooms. The inmates at Koteshwor understandably found the rooms good and comfortable.

6. On being asked," What do feel about the environment over here?", the responses were;



7. On being asked," How often do you go for an outing?" the responses were varied.



Many inmates were too debilitated or too sick or unable to walk or had motion sickness, and hence they never used to submit their names when asked for any outing. Still Pashupati was organising ample visits to outdoor places, many with the help of some organisation or educational institutions or some well wishers. On the other hand Matatirtha was recently suffering from a crunch of resources and since they were also lacking attention from the media and the general public, the staffs themselves were cognizant of the fact that they are not being able to take the inmates to any outing these days and also not being able to provide that much of facilities. This spirit in the staffs was encouraging. The scenario in Koteshwor was completely different. The managerial members rarely ever came to see if the inmates were having any problems, let alone provide them with any comfort like outing of any sort.

8. On being asked," When was the last time you had a health checkup?" the responses showed that many inmates in Pashupati used to have regular contact with the nurse for minor ailments. Some even had to be seen almost every day or so. They used to be seen by a doctor who comes there every week or in some hospital when they get sick. But there was no provision of regular periodic health checkup as such in place. Many even said they never had any health checkup, though we could not verify the significance of this response, keeping in mind that many inmates are either too old and/or disoriented to remember and answer properly or are disinterested or are simply venting their negative feelings. In Matatirtha, they said they used to have yearly health checkup with free stays at NMC but since some years NMC had stopped the service.

9. On being asked if they are satisfied with the medical services provided, almost all responded that they were satisfied. Only 2 males and 2 females in Pashupati and 2 at Matatirtha expressed dissatisfaction with the services, while in Koteshwor one more conscious inmate was complaining that they rarely get any checkup, and there was noone to look after them even when they were sick. One medical professional(we couldn’t make out if he was a certified practitioner or not) used to come in months though he was supposed to come every week, and even then it was a lot difficult to get any medicines.

10. On being asked how long one has to wait when he falls ill to get medical attention, in Pashupati the response was good as any sick person was immediately seen by the staff nurse while if they are serious and needed expert help they were either seen by the visiting doctor or were brought to some government hospital or to Tilganga if they have some eye problems. While in Koteshwor only when the inmates got moribund were the managerial members called and one of their inmates was hospitalised at that moment also in a moribund state.

11. On being asked what are the major illnesses that the inmates usually suffer from, the response was varied and depended on the knowledge of the respondent about the types of illnesses. The responses ranged from asthma, leprosy, disability, mental illnesses, diarrhoea, fever, epilepsy, diabetes, fainting, hematemesis, headache, TB, poor vision, bodyache, swelling of abdomen, cough, paralysis, blindness, etc in Pashupati. The inmates gave particular emphasis on the rising number of mental patients they have to live with since some years and complained that it was creating a lot of nuisance. Most frequent answers were fever, diarrhoea, fainting, headache, asthma, disability and problems with vision.

At Matatirtha, the responses were myalgia, cold, cough, headache, anorexia, fever, diarrhoea,etc with 2 cases of uterine prolapse and 3 cases of asthma on medication.

At Koteshwor, the responses were disability, asthma, gastroenteritis, diabetes and weakness.

12. To increase the reliability of our findings on the common illnesses in the homes, we again asked the inmates," Have you been suffering from any illness, chronic or otherwise, in this past one year?". The responses were blindness, deafness, diabetes, hypertension, paraplegia, walking difficulty, chest pain, head body and abdomen pain, decreased sight, hip dislocation, cough, itchy eyes, myalgia, kyphosis, cataract, jointpains, mental illness, asthma, gastritis and acid peptic disease and even toothache among the males at Pashupati. The females responses were fever, asthma, facial swelling, limb joint back and other vague pain syndromes, APD, decreased vision and blindness, deafness, dizziness, bodyache, abdominal swelling(subjective feeling or otherwise), shortness of breath, nausea, seizures, hemiparesis, gangrene and amputation of one hand, disability, paraplegia, heart problems and burns.

At Matatirtha, the responses were refraction error, APD, joint pains, cataract, fracture femur, myalgia, cough, hypertension, etc

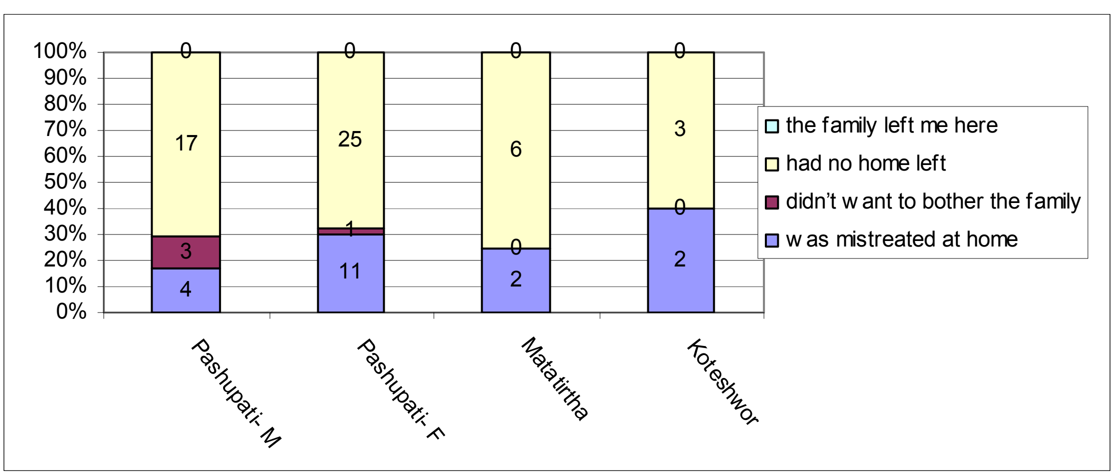
At Koteshwor, the responses were cataract, asthma, kyphosis, cough, etc

One interesting phenomenon that we observer in Pashupati was the complete oblivion about the condition of other inmates in their home. When asked about others as about their problems and if anyone has joined newly or died or left, many just said that they didn't knew and that they only have a limited circle of friends apart from which they knew nothing. There was an embarassing lack of interpersonal relations and communication though the same phenomenon was not observed in other hosing facilities.

13. On being asked," Has anyone left the place recently and why?", an alarming 22 males out of 24 and 29 of 37 responding at Pashupati said they didn't know, while some replied that one family took one of the inmate away while yet another couple left after just some days as they didn't like the facilities and that they had heard many good things about the place and had came with high expectations. At Matatirtha some replied that some inmates were taken away by the family. While at Kotehwor, many inmates had left as they either didn't like the facilities or were maltreated, and the number of inmates was decreasing each day.

14. On being asked," Why do you think most of the inmates come here?", again an alarming 10 males and 14 females at Pashupati said they didn't know. Else most other thought that the reason was a combination of all the options we gave, including that they were mistreated at home, they didn't want to bother their family, the family left them there or that they had no family and no home left. At Matatirtha, 2 of the 8 respondents said they didn't know and the others said it was either because they had no home left or were mistreated at home. The responses were similar at Koteshwor.

15. On being asked," Why did you come here?", the responses were as depicted.



One inmate at Koteshwor recited his sad story of having to come here after his sons and daughters all became Maoists. We were actually hoping to find a lot more of other inmates affected by the Maoist Revolution.

16. On being asked about any suggestions about the betterment of the housing facility, there were varied responses in each of the housing. These are related in their original form as far as possible below:

At Pashupati: Many pointed out the need for more cleaners and helpers for washing clothes. They pointed out the need for hot water supply during the winter and more clothing and bedding. Many of them voiced concern of having to live with the mentally ill cases who disturb them day and night and they cannot get enough sleep. Another majority found the rooms uncomfortable, dark, cold and congested and some thought that a new house with rooms in the ground floor would be nice. But still others said they were reluctant to leave the religious place they have been living in for so many years now. Still another major issue that some so called 'lower castes' (Rai, Limbu, Magar, etc) pointed out was the caste discrimination that many inmates of the so called 'upper castes' including Brahmins were responsible for. Many of them even didn’t drink water that the so called lower castes had touched, ie regard them as untouchables. Many pointed out the stark lack of interpersonal realtions and communication between the inmates. Yet another majority pointed out the need for more facilities, including radio, shoes as the ones provided don’t last the whole year, stove and better food. In fact some of the inmates complaining of having to eat the same type of meal each day and the lack of variety and change; not getting to eat what they like as well as having to eat in the common mess when they cannot tolerate fatty and spicy foods due to gastric problems. A large number of inmates also pointed out that the alms handed out by the outsiders are not divided equally. Some even blamed that the staffs themselves a large portion of it. A small number complained of lack of proper treatment and drugs, that the provided drugs don’t work and a few even complained of sister maltreating them. Many also pointed out the need for more caretakers. But overall they were all satisfied with their quality of life in the home and liked all the care and attention that they get from all types of people and organisation.

At Matatirtha, most of them complained that they were not taken anywhere on any trips. Some thought that more consistent medical services were needed. Some also pointed out the need for toilets, garden and watertap.

At Koteshwor, some felt very much alone and had nothing to do. Some of the inmates had stayed at Pashupati earlier and they said that the managerial committee of this housing facility brought them there giving hopes of better life, but that they now regret a lot coming there. One inmate was particularly vocal about the total lack of care and attention. He complained that a single girl managed the whole housing including cooking the meals. Other appointed staffs come once in a blue moon. The staffs mistreat the inmates and use abusive language and even extort money, food, clothes and other materials that some well wishers handed to the inmates. The meals are not good, sometimes even the lefeovers of the previous day. They don’t get treatment even when sick until they are serious and the treatment they do get is also not effective.

Discussion of findings:

Though our objective conclusion was of a poor housing standard in Pashupati and Matatirtha, inmates there were subjectively satisfied with their QoL. This discrepancy is understandable, as the socioeconomic background of the inmates is usually so bleak and they have suffered so much that places that provide whatsoever standard of housing and facilities without them having to do anything is a sweet haven for them. Lack of funding emerged as a major stumbling block in both the housings; the staff had many problems to relate, yet the inmates were satisfied. This was even more so in Matatirtha, with good relations among themselves and with the staff. This result is comparable with many researches in the west that have shown a high level of satisfaction among the inmates in community operated residential care settings[8,21,9,22].

The low level of interpersonal relations among the inmates in Pashupati is partly explained by their dependent status. Similar results have been found in the west too, showing problems with apathy and social skills[14] and limited participation in community life[29]. One research in Tokyo showed that relocation had a direct effect on the well-being but a negative effect indirectly mediated by the decline in social contacts[20].

The low level of productive activities including personal and instrumental ADL in all the elderly housings has also been reproduced in many researches in the west, and they have been positively correlated with the sense of well being and self-concept[13,29,10,11]. In one research in UK, 55% showed clinically significant activity limitation and 37% had significant somatic symptoms[16]. Yet another study in UK showed Residential care had a significantly greater level of unmet needs for suitable daytime activities[14].

Quality of clinical care was inadequate when judged against the quality indicators in all the houses. Similar results were found even in the developed countries of the west. One research showed only 38% were prescribed β blockers after MI, while prescription of neuroleptics and laxatives were higher[3]. Even we found increased and unnecessary use of aristozymes and analgesics. The researchers had suggested that better coordinated care for the patients would avoid the problems of overuse of unnecessary or harmful drugs, underuse of beneficial drugs and poor monitoring of chronic diseases. Even we found out very poor monitoring of HTN, DM and COPD.

The lack of attention to the inmates seen in Koteshwor was directly correlated with the low level of satisfaction and self-concept of the elderly. One research in Taiwan highlighted low personal self, social self and family self; as well as moral-ethical, identity and satisfaction scores when measured on the TSCS scale and was positively correlated with male sex, ADL(measured on MFAQ) and subjective well being[10].

Finally, one research in USA developed and validated a self-administered satisfaction survey instrument for the assisted living industry. The scale covers 6 key service dimensions: activities, personnel, dining, apartment, facility and management[30]. We also consulted this instrument while validating our own tools.

Conclusion and recommendations:

The problem of homeless, abandoned elderly people is looming large in the country. With just one government run institution and money-centered NGOs, no matter how numerous they are, wont solve the problem. What we need is community run elderly housing charity committees in as many VDCs as possible. Many have already started sprouting, including in Janakpur, Dharan, Rautahat, etc. This way, the elderly sections of the nation will neither become a burden on any government or non-government institutions, nor will they be a begging bowl for the mushrooming NGOs. They wont also be forced to live the locality they have been living in their whole life. The interpersonal relations and the level of satisfaction will also be as good as can be.

Finally, we have some specific recommendations for the 3 elderly housings we studied:

Pashupati:

Physical:

- There is a dire necessity of a well-equipped and spacious building with separate rooms for 2-4 persons and should be one storied with attached toilets for the disabled, lots of open space for gathering, good lighting, ventilation and heating system in the winter.
- There should be a system of separately placing the seriously ill, disabled and mentally ill persons.

Financial:

- Government should increase the annual budget handed to the housing, keeping in mind the necessity for better medical facilities, better entertainment facilities and keeping in view their plan to expand.
- Capable inmates should be taught productive activities.

Social: different programmes including educational lectures should be conducted to create a homely environment and a sense of belongingness and to control the negative feeling towards the so-called lower- castes.

Others:

- staff no. should be increased, especially medical staff and cleaners/ washers, including a system of permanent periodical visit by a doctor.
- Staffs should be provided with bonuses in recognition of the extra hours they serve to increase their morale.
- The criteria for inmate selection should be simplified.
- Steps should be taken towards providing free medical services indifferent government hospitals in Nepal.
- The helps provided by different social service institutions and well wishers should be coordinated and channeled in such a way that the inmates really benefit.
- The house should try to rehabilitate the inmates into their own homes if they still have their homes, and try to utilize the seat instead for a needy one.
- The house should try to increase its capacity in keeping with the ever-increasing demand.
- There should be more medical equipments provided, including apparatus for sterilization and other sterile procedures as dressing.

Matatirtha:

- It should try to build its own private residential quarters with the aforementioned facilities.
- The inmates should be involved in more productive activities including physical exercises, religious discourses, trips and other means of entertainment.
- Health checkup should be more regular in keeping with the high mortality rate.
- It should seek the free and selfless support of donor agencies and individuals and try to increase the membership.

Koteshwor: the first and foremost thing they need to do is make the activities more transparent, including the fund and the expenditure. The infrastructure is good but they need a lot of care and attention and a more dedicated staff.

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Annex 1. QUESTIONNAIRE FOR THE INMATES

Full Name……………………….. Age……….. Sex. (M/F)
Past Residence……………………………..
……………………………...
Past occupation(if any)……………………..

GENERALS

1) Since how many years have you been staying in this home?
a. <5 years b. >5 years
c. >10 years d. >15 years
2) How do you feel staying over here?
a. excellent b. better than at home
c. not as good as home d. others
3) What do you like about staying over here?
a. freedom b. respect and care
c. facilities d. others
4) Do you regret coming(or being sent) here?
a. Yes b.no
If Yes specify why? …………………………………..

OVERALL FACILITIES AND QUALITY OF LIFE

5) How do u like the food over here?
a. good b. not good
c. okay d. others
6)What do u do in your free time?
a. watch TV b. listen to radio
c. chat d. others(specify)
7) Do you do any work now? Y/N…………
If yes specify type and duration……………………………
8) What do you feel about your room here?
a. comfortable b. uncomfortable
c. congested d. others(specify)
9) What do you feel about the environment around here?
a. satisfactory b. excellent
c. unhygienic d. others
10) How often do you go for an outing?
a. twice a month b. once a month
c. once in 3 months d. once in >3 monthr

OVERALL HEALTH STATUS

11) Are you provided with regular health checkup? Y/N
If yes how often?…………
12) When is the last time you had a health checkup?

a. <1-month b. <3 month
b <6 months c. >6 months

13) Are you satisfied with the medical services provided? Y/N
If no, specify why?……………………………………..

14) If someone in this home falls ill, who provides the necessary checkup?
a. sister(nurse) b. visiting doctor
c. hospital OPD d. traditional healer
e. others

15) If someone is ill, how long he/she waits before seeking help?
a. 1 week b. 1 month
d. >1 month d. others

16) What are the major illness that the inmates commonly suffer from?
List. 1………………………….
2………………………….
3………………………….
4………………………….
5………………………….

17) Have you been suffering from any illness (chronic or otherwise) in this year?
Specify

Illness	Duration	Treatment if any

18) Have anyone left the place recently? Y/N
If yes why?
a. didn't like the facilities b. was mistreated
c. the family took them away d. others

19) Why do most of the inmates come here?
a. was mistreated at home b. didn't want to bother their family
c. had no home left (e.g. Widow) d. the family leave them here

20) Why did you come here ?
a. was mistreated at home b. didn't want to bother my family
c. had no home left (e.g. Widow) d. the family left me here

21) Can you make any suggestion as to how the quality of life of the inmates of this home can be improved?

Annex 2. Interview Guide for the (medical) caretaker

Name;…………………………………
Institution:……………………………………………………….
Designation:…………………………………

1) How long have you been working in this elderly home?
2) What do you like about working here?
3) What is the duty allocated to you in this home? Please explain.
4) What are the major (health) problems you attend to? Please explain in detail
5) What are the mostly prescribed medicines?
6) Has there recently been any major illness in the home? How was it treated?
7) Has there recently been any death in the home? Can you please explain the cause?
8) Who prescribes chemotherapeutic drugs like antibiotics?
9) Is any medical institution helping in the health care of the elderly in this home? Explain.
10) Who handles major cases in the home?
11) Do you think there should be any system of quality control among the emerging elderly homes in Nepal?
12) Do you have any recommendation whatsoever about improving this home in particular and all the elderly homes in general?

Thank you,

Annex 3. Interview Guide for the head of the elderly home

Name:…………………………………….
Name of the institution:………………………………………………..
Designation:…………………………………

1) How long have you been working in this position?
2) What do you like about working in this place?
3) (For the founder of the private institution):
   Can you please relate the inspiration behind opening this place?
4) Can you please enumerate the source of funding and the annual budget allocated?
5) Can you please explain the selection criteria for the inmates?
6) What is the health service delivery system like over here? Please explain.
7) What are the problems you are facing while managing this home? Please explain.
8) What are the major problems the inmates are facing?
9) What are the major health problems the inmates are facing, chronic, or otherwise? Please explain.
10) Are you facing any lack of resources, especially regarding the medical facilities?
11) Has there been any recent major illness in any of the inmates? How was it or is it being treated?
12) Has there been any recent death in this home? Can you please explain the cause?

13) Has anyone recently left the place? Can you please explain why?
14) What types of people are usually admitted here and for what type of reasons?
15) How much emphasis do you give towards rehabilitating the elderly into their own homes?
16) Do you think there should be any system of quality control among the emerging elderly homes in Nepal?
17) Do you think there should be transparency regarding the funding and selection of the elderly in the elderly homes?
18) Do you have any recommendation whatsoever about improving this home in particular and all the elderly homes in general?

Thank you,

Annex 4. Interview Guide for the General staffs

Name;……………………………………
Institution:………………………………………………………….
Designation:…………………………………

1. How long have you been working in this elderly home?
2. What do you like about working here?
3. What is the duty allocated to you in this home? Please explain.
4. What are the major problems the inmates face? Please explain in detail
5. What are the major problems the staff are facing?
6. What are the major problems the housing facility is facing?
7. Has there recently been any major illness in the home?
8. Has there recently been any death in the home?
9. Do you think there should be any system of quality control among the emerging elderly homes in Nepal?
10. Do you have any recommendation whatsoever about improving this home in particular and all the elderly homes in general?

Thank you,

Annex 5. OBSERVATION CHECKLIST

Name of the institution……………………………………………….
Established (B.S./A.D.)……….
Address…………………………………………………………………
Govt./NGO/INGO…………
Capacity………….
Occupancy number: Male… Female………..
Total no. of inmates admitted till now…………..
Affiliated organization (if any)…………………………………………...

GENERAL LIVING CONDITIONS

No. of rooms………. No of beds per room………… No of windows…….
Lighting system…………………

Walls: a. concrete b. mud
c. Wooden d. others

Roof: a. concrete b. wood
c. Tiles d. tin e. others
Other facilities(if any) ………………………………………………

Overall condition: a. satisfactory
b. Unsatisfactory

Toilet: toilet:Inmate ratio…………………
Condition: a. Hygienic
b. Unhygienic

Mess: Source of cooking water……………………..
Water drainage system………………………
Cooking fuel: a. LP gas b. Wood c. Kerosene
Cook: a. Hygienic b. Unhygienic
Practices: a. Hygienic b. Unhygienic

Water treatment: a. not practiced
b. Water filter
c. Boiling
d. Euro guard

Waste disposal: a: incineration
b. Dumping
c. Taken away by city waste disposal unit
d. No practiced

Overall environment:
Garden (if any) Y/N
Shrines (if any) Y/N
Open Space (if any) Y/N
Pollution Y/N

Hygiene: a. satisfactory b. unsatisfactory

Means of entertainment: TV……… Radio……….. Others…………….
(Specify Quantity)

No of caretakers: Male… Female…
Specify designations:………………………………………
………………………………………
……………………………………..
……………………………………. ..
………………………………………
Overall behavior of the caretakers:
a. Satisfactory b. Unsatisfactory

Medical care providers (if any)………………..
Specify Designations………………………………………….
…………………………………………….
…………………………………………….

Percentage of the budget allocated for health service……………….

Interpersonal relations between the inmates:
a. Satisfactory b. Unsatisfactory

Creative work being done if any…………………………………….

Overall quality of life: a. Satisfactory
b. Unsatisfactory

the end