

**SOCIO-ECONOMIC FACTORS INFLUENCING WELL-
BEING AMONG DALIT ELDERLY**

(A Study of Shivsatakshi Municipality of Jhapa District)

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DECLARATION

Except where otherwise acknowledged in the text, the analysis in this thesis represents my own original research.

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RECOMMENDATION

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**SOCIO-ECONOMIC FACTORS INFLUENCING WEL-BEING AMONG DALIT
ELDERLY**

(A Study of Shivsatakshi Municipality, Jhapa District)

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ABSTRACT

This thesis has been titled "Socio-Economic Factors Influencing Well-being Among Dalit Elderly : A Study Based on Dalits Elderly People of Shivastakshi Municipality, Jhapa District," aims to assess the various socio-economic and health-related issues faced by elderly Dalits. The specific objectives include examining their demographic and socio-economic status, living arrangements, utilization of elderly security allowances, and the impact of elderly pensions and free healthcare services on their well-being. Primary data was collected through direct interviews with 240(113 Males and 127 Females) Dalit elderly respondents aged 60 and above, using semi-structured questionnaires. This descriptive and quantitative study used SPSS for data management and logistic regression for analysis. The respondents 31 percent were aged 60-69, with 30 percent of females and 33 percent of males in the 60-64 age groups and (17.4% females, 18% males) were 75 and above. The gender distribution table shows that 51.2 percent of females and 49 percent of males were currently married. Nearly 95 percent of respondents were Hindu, while 5.42 percent were Christian. Altogether 68 percent of respondents were illiterate. Most respondents 82 percent were involved in agriculture. Arrangement of family was 49.6 percent lived in nuclear families, 48 percent in joint families, and 3 percent lived alone. The majority 77.1 percent have on elderly allowances as their income source, with 83 percent earning less than Rs.1,000 monthly. A high percentage 64.3 percent lived with their children or in-laws, and 73.3 percent were satisfied with their living conditions. Females reported higher satisfaction 77.2 percent compared to males 70 percent. Physical health issues were 41.2 percent reporting physical problems and 75 percent suffering from gastric issues. Total 89 percent experienced depression, and 89 percent felt loneliness or anxiety self-reported. A majority 82 percent received medical treatment from government hospitals, but over 97 percent were unaware of government-provided healthcare provisions. Logistic regression analysis showed that none of the socio-economic factors, including social security allowance, marital status, education, family type, sex, and age, had statistically significant effects on physical health problems. This study concludes that the socio-economic and health status of Dalits elderly, particularly females, requires more attention. Poor economic conditions were identified as a primary barrier to accessing social and healthcare services, highlighting the need for targeted interventions to improve their well-being.

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ACRONYMS AND ABBREVIATIONS

| | |
|---------|---|
| CBOs | Community Based Organizations |
| CBS | Central Bureau of Statistic |
| CDPS | Central Department of Population Studies |
| CDPS/TU | Central Department of Population Studies/Tribhuvan University |
| DSCA | District Senior Citizen Association |
| FGDs | Focus Group Discussions |
| GOs | Government Organizations |
| ICPD | International Conference on Population and Development |
| IEC | Information Education and Communication |
| KII | Information Education and Communication |
| KSE | Knowledge, Skills, and Experiences |
| LDCs | Less Developed Countries |
| MDCs | More Developed Countries |
| MoHP | Ministry of Health and Population |
| MOWCSW | Ministry of Women Children and Social Welfare |
| MPhil | Master of Philosophy |
| NEPAN | Nepal Participatory Action Network |
| NGOs | Non-Governmental Organizations |
| NPC | National Planning Commission |
| NRs. | Nepalese Rupees |
| PPS | Probability Proportional to Size |
| PSUs | Primary Sampling Units |
| SAARC | South Asian Association for Regional Co-operation |
| SSA | Social Security Allowance |
| SPSS | Statistical Package for Social Sciences |
| UN | United Nations |
| UNFPA | United Nations Population Fund |
| VHAI | Voluntary Health Association of India |
| WHO | World Health Organization |

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Dalits, previously known as "Untouchables," belong to the lowest stratum of the traditional Hindu caste system. The term "Dalit," which means "oppressed" or "broken" in Sanskrit and Marathi, reflects the severe social, economic, and political marginalization faced by this group. In the context of South Asia, primarily in India and Nepal, Dalits have historically been relegated to occupations considered impure or menial and have been subjected to various forms of exclusion and discrimination. Dalits, formerly known as "Untouchables," occupy the lowest stratum in the traditional Hindu caste system in Nepal. The term "Dalit" means "oppressed" or "broken," reflecting their historical and ongoing marginalization. Despite legal protections, Dalits face systemic exclusion and discrimination in Nepal. Socially, they are segregated, stigmatized, and subjected to untouchability practices that bar them from accessing communal resources like temples and water sources. Economically, Dalits are often confined to low-paying, menial jobs and face significant barriers to land ownership, which exacerbates their poverty. Educationally, Dalit children encounter discrimination, inadequate schooling facilities, and high dropout rates. Politically, Dalits are underrepresented in decision-making bodies and their issues are frequently neglected. Dalit women, in particular, face double discrimination based on caste and gender, resulting in severe socio-economic disadvantages and heightened vulnerability to violence and exploitation. This pervasive exclusion and discrimination against Dalits in Nepal underscores the need for robust legal enforcement and targeted social and economic interventions to ensure their equitable inclusion and upliftment.

Dalits in Nepal, particularly Dalit women, face severe social, economic, and political challenges. Their situation is characterized by systemic discrimination, economic deprivation, and social exclusion. Addressing these issues requires comprehensive and sustained efforts, including strict enforcement of anti-discrimination laws, economic empowerment initiatives, educational support, and targeted policies to protect and uplift Dalit communities. Special attention must be given to Dalit women, who endure multiple layers of marginalization, to ensure their inclusion and empowerment in all aspects of society.

In Nepal, Dalits are found social, economic, and political marginalization due to their position at the bottom of the traditional caste hierarchy. Socially, they face persistent untouchability practices, segregation, and stigmatization, which exclude them from communal activities and access to public services. Economically, Dalits are often relegated to low-paying, menial jobs and many remain landless, exacerbating their poverty and vulnerability. Educational barriers further limit their opportunities, as Dalit children face discrimination in schools and high dropout rates due to financial and social pressures. Politically, Dalits are underrepresented and their concerns are frequently overlooked. Dalit women experience compounded discrimination, suffering from both caste and gender biases. They are often confined to the most menial jobs, experience higher rates of unpaid labor, and face significant barriers to education and healthcare. Furthermore, Dalit women are disproportionately affected by gender-based violence and exploitation, with limited access to justice. Overall, Dalits and Dalit women in Nepal face systemic discrimination and exclusion, necessitating comprehensive and targeted interventions to ensure their inclusion and empowerment.

The caste system has created a social caste hierarchy, where Dalits are at the bottom or lowest of the social caste system rung. The term Dalit is used for those who faced caste-based discrimination and untouchability including social, cultural, and economically oppressed and backward (Khanal et al., 2012 & International Labour Office in Nepal., 2005). Dalits have a 0.434 Human Development Index (HDI), which is low in comparison to the other caste groups of Nepal (HDI Report 2014). Also, it has comprised 12.75 percent population in the total national population (Census 2021) which is a decrease from the Census report in 2011. However, Dalits are at the epicenter of identity politics in Nepal due to exclusion from the development mainstreaming (Lawoti, 2012). Because Dalits are dominated and excluded from the major influencing level they aren't able to smoothly implement their interest activities context of Nepal (Pariyar, 2022). Although Sustainable Development Goal 2015 has conceptualized No One Left Behind, which means equal participation and representation of any individual or group, & community in development without any barriers and restrictions. Context of Nepal, politically Dalits are representing in public administration sector through election.

Population aging has become a global phenomena as a result of decreasing fertility, mortality, and advancements in public health initiatives. Today's population is generally healthier and living longer. Population aging is a global issue that is causing challenges

for many nations, including Nepal, on the social, economic, and humanitarian fronts. The age threshold for the aging population varies over time and between nations.

In most developed countries 65 years and above is considered an aging population but in most of the developing countries, it is 60 years and above. The person after reaching 60 years and above comes to the stage of aging in Nepal. Thus, they are called elderly people or senior citizens. This age group is taken as an inactive and dependent population because they cannot perform their work properly due to physical weakness.

Dalit elderly persons in Nepal confront a range of formidable challenges deeply rooted in societal discrimination and economic marginalization. Socially, they often endure pervasive discrimination based on their caste, exacerbating feelings of exclusion from community life and denial of social respect. Economically marginalized due to historical disadvantages in education and employment, many struggle with inadequate income, limited savings, and dependency on others for financial support in their old age. Access to healthcare remains another significant hurdle, compounded by geographic remoteness, affordability issues, and discrimination within healthcare settings. Housing conditions are often substandard, lacking basic amenities, and barriers to accessing housing loans or government schemes further exacerbate their living conditions. Despite legal protections against caste discrimination, Dalit elderly may face challenges in accessing justice and legal rights due to systemic biases. These issues collectively impact their psychological well-being, contributing to isolation and mental health challenges. Addressing these complex issues requires comprehensive efforts to ensure equitable access to resources, protect their rights, and foster social inclusion for Dalit elderly persons across Nepal.

The relevance and significance of a study are fundamental to understanding its broader impact and importance. In research contexts, a study's relevance is often defined by its ability to address critical gaps in knowledge or to provide new insights into pressing societal issues. For instance, research focusing on the challenges faced by Dalit elderly persons in Nepal holds profound significance as it sheds light on the intersection of caste discrimination, aging, and socio-economic vulnerabilities. By exploring these issues, the study not only seeks to deepen our understanding of the unique challenges faced by this marginalized group but also aims to contribute to policy formulation and advocacy efforts aimed at improving their quality of life. Furthermore, such research plays a crucial role in promoting social justice by highlighting inequalities and advocating for the rights and well-being of marginalized communities. Ultimately, the relevance of this study lies in its

potential to inform interventions, influence policy decisions, and contribute to broader efforts towards creating a more inclusive and equitable society for all individuals, regardless of caste or age.

1.2 Statement of the Problem

In recent decades, Nepal has experienced gradual social changes, particularly the shift from joint families to nuclear families, changing lifestyles, and the emigration of Nepali people. Consequently, the health status of Nepalese older people has become significant, alongside globalization and population aging throughout the developing world. The separation or emigration of adult children results in difficulties for older people in managing daily work or household activities, health and medical care, and participating in social activities as they become physically weaker.

The demographic, socioeconomic, and health conditions of the elderly population in Shivasatakshi Municipality, Jhapa District, are the main subjects of this study. Along with analyzing their current health, it aims to comprehend the basic needs and support systems of the elderly Dalits residing in the study area. The nation's elderly citizens are its property and source of dignity. They are living archives of many resources—experiences—that they have amassed throughout the course of their lives. As such, the elderly population plays a significant role in society. In today's world, researching the elderly is crucial because it is a growing topic.

Many mental and psychological pressures are being experienced by the elderly as a result of growing nuclear families, generational divides, industrialization, urbanization, changes in the workforce, etc. Their voices are frequently controlled and disregarded, making them one of Nepal's most neglected social groups (Bisht, 2003). Elderly people in this condition are looking to their families, communities, and country for emotional and financial help. Various governmental and non-governmental groups that engage with aging populations will find this study useful in understanding the issues faced by senior Dalits. Policymakers and program developers may find it helpful in creating policies and initiatives that shield senior Dalits from discrimination and financial difficulties. Furthermore, this study might be used as a resource by academics and other interested organizations for future research on the problems facing senior Dalits

In recent decades, Nepal has undergone significant social transformations, including the shift from joint to nuclear families, changing lifestyles, and increased emigration of

Nepali citizens. In light of globalization and the aging of the population in developing countries, these changes have had a significant impact on the health and well-being of older persons.

The separation or emigration of adult children has created challenges for older individuals in managing daily activities, accessing healthcare, and participating in social interactions as they face physical decline. With an emphasis on senior Dalits in particular, this study intends to maintain the demographic, socioeconomic, and health status of older people in Shivasatakshi Municipality, Jhapa District. It seeks to understand their current health conditions, support systems, and basic needs within the community. Elderly respondents represent a vital repository of life experiences and knowledge, yet they often endure neglect and marginalization in Nepalese society. By exploring these issues, this research aims to inform governmental and non-governmental organizations working with aging populations, providing insights for policy-makers and program developers to mitigate social stigma, address economic hardships, and improve the overall well-being of elderly Dalits. Furthermore, it aims to serve as a foundational resource for future research and advocacy efforts concerning the challenges faced by elderly Dalits in Nepal

1.3 Research Questions

Based on the literature reviewed and conceptual framework, research questions furnished as follows;

- i. What is the well-being status of elderly Dalits in Shivasatakshi Municipality ?
- ii. How do socio-economic factors affect the well-being of elderly Dalits?
- iii. Which socio-economic factors most significantly impact the well-being among elderly Dalits?

1.4 Rational of the Study

In recent decades, Nepal has experienced gradual social changes, particularly the shift from joint families to nuclear families, changing lifestyles, and the emigration of Nepali people. Consequently, the health status of Nepalese older people has become significant, alongside globalization and population aging throughout the developing world. The separation or emigration of adult children results in difficulties for older people in managing daily work or household activities, health and medical care, and participating in social activities as they become physically weaker. It also examines the health state of the

elderly Dalits in the research area and aims to comprehend their basic requirements and support systems.

For the nation, elderly people are the property and human resources along with dignity of the nation. Elderly people are living reservoirs of innumerable resources (experiences) accumulated over their lives. Therefore, the aged population is an important part of society. Studying elderly people is of great importance in present society, as it is an emerging issue.

Many mental and psychological pressures are being experienced by the elderly as a result of growing nuclear families, generational divides, industrialization, urbanization, changes in the workforce, etc. Their voices are frequently controlled and disregarded, making them one of Nepal's most neglected social groups (Bisht, 2003). Seniors in this circumstance are looking to their families, communities, and country for financial and emotional support.

Various governmental and non-governmental groups that engage with aging populations will find this study useful in understanding the issues faced by senior Dalits. Policymakers and program developers may find it helpful in creating policies and initiatives that shield senior Dalits from discrimination and financial difficulties. Additionally, this study may serve as reference material for researchers and other concerned institutions for further studies on the issues of elderly Dalits.

1.5 Research objectives

The general research objective is to assess the well-being status among Dalit elderly living in Shivasatakshi Municipality. Similarly, the specific objectives are furnished as follows:

- i. To assess the well-being status of Dalits elderly.
- ii. To examine factors affecting well-being status of Dalits elderly.

1.6 Limitations of the Study

Every study has its limits because of time and budgetary constraints. This study's scope is restricted to the Shivasatakshi Municipality in the Jhapa district, as well as the following areas:

- i. The research only includes senior Dalits over 60; individuals from other castes and age groups are not included.

- ii. This study is limited only to the Shivasatakshi Municipality of Jhapa district due to financial and other constraints, so it may not represent all whole elderly people of Nepal.
- iii. The study mostly covers the socio-economic, demographic, psychological, and health status of elderly Dalits living the the area under study.

1.7 Organization of the Study

The arrangement of the chapters is covered in this section. This study is broken up into seven chapters overall. The background of the study, statement of problem, objectives, significance, limits, and study organization are all covered in the first chapter. The literature review is included in the second chapter. The third chapter contains a description of the research technique or research methodology. The demographic and socioeconomic features of elderly Dalits have been provided in Chapter 4. The factor affecting well-being status among Dalit elderly in the fifth chapter. An analysis of factors affecting well-being status among Dalit elderly in the sixth chapter of the report. The summary, results, discussion, conclusion, and recommendations are all included in the seven

CHAPTER TWO

LITERATURE REVIEW

2.1 Theoretical Review

A research study must include a literature review. Being conversant with the topic area is the primary goal of a literature review. It is far from it to examine the available materials or literature with an eye toward formulating an ageing theory. Throughout history, concerns about the elderly have been brought forth. While journals, studies, books, and magazines frequently discuss ageing-related topics, Nepal is likewise not immune to this issue.

The population's aging is currently a global phenomenon. People are becoming more aware of and vocal about the issues that older people experience in a number of different nations throughout the world. Each country uses a different definition for its aging or elderly population. While some people accept older people over 60, some welcome older people over 65. The standards used to determine an individual's advanced age are determined by the national context. Physical, mental, emotional, and social elements of age are defined by old age. Older adults experience a range of psychological issues as a result of these deteriorating characteristics.

In most societies, the decline in fertility is compounded by the ongoing decline in mortality rates, resulting in significant changes to the age composition of the population. Of particular note is the record rise in the proportion and total number of elderly people, including multiple elderly people (Chaulagain, 2004).

2.1.1 Biological Theories

Among the various theories underlying ageing, the following is perhaps the most salient.

2.1.1.1 Wear and Tear Theory

The literature says our bodies are like machines that get used up over time, just like anything else. The more we stress them, the faster they wear out (Donatelle et al., 1988). This theory suggests that aging is caused by this gradual damage to our cells and systems. Basically, our bodies wear out from being used and eventually stop working properly. Some people believe this means activities like jogging can damage joints in older adults, especially in the legs. Wear-and-tear theorists believe that this type of excessive stress on

the body causes key body parts to wear out earlier than necessary. Little scientific evidence exists to support this theory.

2.1.1.2 Cellular Theory

This theory explains aging as a cellular issue. As we age, more and more of our cells reach a state called senescence, where they stop dividing. This limits the body's ability to repair itself and respond to damage. Normal cell division slows down with each time a cell replicates, until it eventually reaches a point where it can't divide anymore. This "cellular clock" might be linked to a pre-programmed number of divisions a cell can go through. We're basically born with a set number of usable cells that can only divide a certain amount of times. Once they reach their limit, they die, leading to organ decline and the signs of aging (Donatella et al., 1988). The speed of this decline and its effects vary depending on the person and the specific organ system.

2.1.1.3. The autoimmune theory

This theory blames aging on a weakening immune system. Research shows our immune defenses get worse as we get older, making us more susceptible to illness. Eventually, stress and bad diet can overwhelm a compromised immune system, leading to disease and frailty (Donatella et al., 1988).. In some cases, the immune system seems to malfunction and attack the body itself, causing autoimmune diseases. While these can occur at any age, some scientists believe they become more common and severe with age.

2.1.1.4 Genetic Theory of Ageing

The genetic theory of aging says our genes hold the key to how long we live. They basically set a lifespan limit at conception, influenced by the genes we inherit from our parents. This theory revolves around telomeres, which are bits of DNA at the ends of chromosomes. These telomeres shorten each time a cell divides, and once they're gone, the cell dies. So, the more telomere repeats you have, the longer your cells can potentially live and the longer you might live overall.

2.1.1.5 Immunological Theory of Ageing

This theory suggests that aging is like a slow-motion autoimmune disease. Our immune system, which normally fights invaders, gets confused with age and starts attacking the body itself, but in a milder, more general way. This theory proposes that the immune

system plays a major role in how fast we age, although the exact mechanisms are still a mystery to scientists.

2.1.1.8 Theory of life satisfaction

For decades, scientists studying aging have been particularly interested in how happy people are as they get older. They call this happiness "subjective well-being" and have researched how to measure it and what factors make older adults feel more satisfied with their lives. Many studies have found that staying active is a key factor in feeling good as you age. But that's not all! Other important things for happiness in later life include being happy with your family, health, and home environment, having close friends, feeling connected to your community, having access to good healthcare, living in a neighborhood with similar people, and feeling good about the place you live (Bisht, 2006).

2.2 Empirical Review

- i. **Central Department of Population Studies (CDPS) et al. (2012):** Examined demographics, health, social care needs of elderly in Pharping. Found higher vulnerability among females, limited paid employment opportunities, and reliance on family support.
- ii. **Bisht (2006):** Analyzed elderly population in Kathmandu. Most were active, lived with family, but faced economic insecurity.
- iii. **Shoaib et al. (2011):** Explored impact of family support on health in Gujarat, Pakistan. Found a positive association between the two.
- iv. **Geriatric Center Nepal (GCN) (2010):** Reviewed socio-economic, health, and nutrition aspects of elderly. Highlighted inadequate access to healthcare and poverty.
- v. **Ashraf (2000) in Kerala:** Investigated perceptions of aging. Found feelings of burden and disrespect among some elderly.
- vi. **Participatory Research on Older People's Situation in Nepal (NEPAN) (2011):** Examined contributions and needs of elderly. Noted their active role in families and communities.

Key Findings:

- i. Elderly populations face challenges like limited income, poor access to healthcare, and social isolation.

- ii. Family support plays a crucial role in their well-being.
- iii. Self-reported health data might not fully capture the health issues of the elderly.
- iv. Marginalized groups like elderly Dalits require specific attention due to unique socio-economic and health disparities.
- v. More research is needed on regional variations and the use of advanced analytical techniques.

Gaps in Existing Research:

- i. Overreliance on self-reported health data, neglecting medical examinations.
- ii. Limited focus on marginalized groups like elderly Dalits.
- iii. Lack of comparative research across different regions of Nepal.
- iv. Underutilization of advanced data analysis methods.

Identified Gaps:

- i. **Need for Medical Examinations:** Studies relying solely on self-reported health data might miss crucial details about the physical and mental health of elderly people.
- ii. **Focus on Marginalized Groups:** More research is needed to understand the unique needs of elderly people from marginalized communities.
- iii. **Comparative Studies:** Research comparing the conditions of elderly people across different regions of Nepal is lacking.
- iv. **Advanced Analysis:** Utilizing advanced analytical techniques could provide deeper insights into factors affecting elderly well-being.

How this study differs:

- i. **Focus on Elderly Dalits:** This particular study aims to address the gap by focusing on elderly Dalits in Shivasatakshi Municipality.
- ii. **Medical Examinations:** Unlike prior studies, it incorporates medical examinations alongside surveys for a more comprehensive health assessment.
- iii. **Actionable Data:** This study aims to provide data that can be used to develop targeted policies and interventions to improve the lives of elderly Dalits.

This study goes beyond self-reported data by incorporating medical examinations for a more comprehensive health assessment of elderly Dalits. It focuses specifically on a marginalized group, aiming to understand their unique challenges. The research design aims to provide actionable data for targeted interventions to improve their well-

being. Overall, this passage highlights the need for more in-depth research on elderly people in Nepal, particularly those from marginalized groups and in rural areas. It emphasizes the importance of incorporating medical examinations alongside traditional survey methods for a more accurate understanding of their health needs. Researchers have conducted various studies to understand the lives of elderly people in Nepal. These studies shed light on different aspects like health, socio-economic conditions, and social roles. A key finding is that many studies rely on information people provide themselves, rather than medical examinations. This might not give a complete picture of their health. Additionally, most research has focused on general elderly populations or those in Kathmandu. There's a lack of studies on marginalized groups like elderly Dalits in specific regions. Future research should address these gaps. Including medical examinations would provide a more accurate understanding of health. Focusing on marginalized groups and comparing conditions across different areas of Nepal would give a clearer picture of the diverse needs of the elderly population. This would allow for better policies and programs to improve the well-being of elderly people in Nepal.

2.2.1 Global context

The phenomenon of global aging, where people are living longer and the elderly population is rapidly increasing. Here are the key points:

- i. **Success Story and Challenge:** Increased life expectancy due to healthcare advancements and lower mortality rates is considered a success, but it also presents challenges for societies.
- ii. **Growing Numbers:** The proportion of people aged 60 and above is rising worldwide, with projections indicating a doubling by 2050. This trend is faster in developed countries.
- iii. **Geographic Distribution:** Currently, most elderly people live in Asia, followed by Europe. Countries like China and India have significant elderly populations.
- iv. **Economic Impact:** Poverty is a major concern for many older adults, linked to factors like limited employment opportunities and social exclusion.
- v. **Future Implications:** Developing countries, which are experiencing a later fertility decline, might have less time to adapt to the consequences of an aging population.

Overall, the passage highlights global aging as a significant trend with both positive and negative aspects. It emphasizes the need for addressing the challenges faced by the growing elderly population, particularly in developing countries.

2.3 Policy Reviewed

2.3.1 Review of the Policy and International Declarations

The growing number of elderly people presents a challenge for healthcare systems. As stated by the World Health Organization (WHO), everyone has a right to be involved in their own healthcare (WHO, 1978). This is especially important for the elderly, who often face chronic health issues. Their needs go beyond just medical care; they also require psychosocial support. To address this growing need, particularly with the shift from extended families to nuclear families, healthcare systems must prioritize geriatric care (WHO, 1997).

However, there's a misconception that the elderly are a burden on society. The concept of "productive aging" challenges this view. It recognizes older adults as valuable resources who can contribute to society in various ways. A UN study conducted in 1990 across four countries (Chile, Sri Lanka, Thailand, and Dominican Republic) reinforces this idea. The study found that a significant portion of the elderly population (2,356 people aged 60+ were interviewed) actively participated in their families' social and economic well-being, with many even providing financial support. This suggests that the elderly are not only economically productive but also socially engaged and find satisfaction in these roles.

Any consideration of successful aging for these older people must address their economic needs while maintaining and expanding their options for productive contributions (Kaiser, 1993).

Holzer (1987) considered population policy goals for dealing with the economic consequences of aging in developed countries. The following recommendations are made:

- i. Long term population policy should assure the proper balance between basic age groups in keeping adequate relations between young, old, and the economically active population, Such a policy will guarantee a system of proper intergenerational transfers from labour to retirement
- ii. Social insurance planning for old-age income loss must begin 30-40 years ahead of expected imbalances in the age structure.

- iii. The most important constraints to withdrawing the elderly from the labour force after the combined effect of the greater coverage of pension schemes and increases in pension benefits, growing unemployment among both young and old, liberalization of retirement laws, re-structuring the labour force due to new technology, decreasing the official age limit of the retirement, and physical and mental health deterioration.
- iv. Instead of the obligatory retirement age limit, a functional rather than a chronological definition of ageing in labour and social legislation should be introduced. Moreover, voluntary rather than obligatory retirement should be supported as a fulfillment of the human rights of the elderly.
- v. The most important incentive to remain in the labour force by the elderly are labour shortages, people's desire to work to an old age due to social and psychological factors, opportunities to take part time jobs by retirees, creating jobs to match the elderly capabilities, pension deterioration due to the growing cost of living, and broken links with family:
- vi. Elderly family's labour force participation shows an upward trend in most developed countries and especially in those with centrally planned economies. This trend will affect labour markets and retirement systems in the future.

2.3.2 World Assemblies and International Conference on Ageing

There have been two major international conferences focused on aging issues. The first one took place in Vienna, Austria in 1982. The second conference was held in Madrid, Spain in April of 2002.

2.3.2.1 First World Assembly on Ageing

The first international conference on aging, held in 1982, resulted in the Vienna International Plan of Action. This plan, adopted by the United Nations, encouraged collaboration on research, training, and information sharing to create a global foundation for social policies concerning the elderly. Although Nepal wasn't involved in the initial assembly, they agreed to follow the plan to develop government policies promoting the well-being of their older population.

Nine years later, in 1991, the UN established the United Nations Principles for Older Persons. These 18 principles, categorized into five areas (independence, participation, care, self-fulfillment, and dignity), establish a broad framework for action related to

aging. The core idea is to empower older adults to be self-sufficient and contribute meaningfully to their families and communities.

- United Nations, (1982), Vienna World Assembly on Aging, International plan of action on ageing (26 July to 6 August 1982)
- United Nations, (2002), Second World Assembly on Ageing, Madrid, New York, 8-12 April 2002, A/CONF.197/9

The significant increase in the global elderly population (aged 60 and above). Here are the key points:

- i. **Historically Unprecedented:** Until recently, aging wasn't a major concern due to lower life expectancy and smaller elderly populations.
- ii. **Dramatic Increase:** The 20th century saw advancements in healthcare and sanitation, leading to a sharp rise in the number and proportion of elderly people.
- iii. **Shifting Demographics:** Developing countries are projected to experience the fastest growth in their elderly population, exceeding the proportion seen in developed countries today. This is due to declining birth rates and increasing life expectancy in those regions.
- iv. **Focus on the Future:** The population over 80 is expected to see a particularly significant increase. Many countries will face this surge in the coming decades.
- v. **Shared Responsibility:** Each nation has the right to design policies for its aging population, but international cooperation is crucial.
- vi. **Development with Dignity:** Policies should promote the well-being of the elderly and ensure equitable distribution of resources across generations. This includes recognizing cultural identities and fostering economic opportunities.
- vii. **Importance of Community Support:** Local authorities, NGOs, and volunteers can significantly contribute to caring for the elderly within family and community settings. Governments are encouraged to support such initiatives.
- viii. **Focus on the Vulnerable:** Particular attention should be given to the most disadvantaged elderly, including those living in poverty, women, and those in rural areas.

Until recently, aging wasn't a major concern. However, the 20th century saw advancements in healthcare leading to a significant rise in the number of people living to be 60 and older. This trend is expected to continue, with a particularly sharp increase in the population over 80.

This demographic shift presents a global challenge. Developing countries are projected to experience the fastest growth in their elderly population, surpassing even developed nations. To address this, international cooperation is crucial.

Effective policies are needed to ensure the well-being of this growing elderly population. These policies should promote fairness across generations in terms of resources and opportunities, while respecting cultural traditions. Local communities also play a vital role by providing support through volunteers, NGOs, and families. Finally, it's important to focus on the most vulnerable elderly, such as those living in poverty, women, and those in rural areas.

2.3.2.2 Second World Assembly on Ageing

The Madrid International Plan of Action

In response to the growing number of older adults worldwide, the Second World Assembly on Ageing adopted the Madrid International Plan of Action in 2002. This plan, adopted by Nepal and many other countries, outlines key strategies for nations to address the needs of their aging populations.

The plan focuses on three main areas:

- i. **Inclusion and Participation:** This includes promoting opportunities for older adults to be active contributors to society through employment, education, and civic engagement.
- ii. **Health and Well-being:** The plan emphasizes improving living conditions, access to healthcare, and overall well-being for older adults.
- iii. **Supportive Environments:** It calls for policies that prevent abuse and marginalization, and create enabling environments for older adults to live safely and with dignity.

Recognizing the rapid increase in the elderly population, particularly in developing countries, the plan acknowledges the challenges and opportunities this presents. It emphasizes the importance of empowering older adults and fostering intergenerational solidarity. Collaboration between governments, NGOs, and the private sector is seen as crucial for successful implementation. Overall, the Madrid International Plan of Action serves as a global roadmap for ensuring that older adults can live healthy, secure, and fulfilling lives to ensure the well-being and active participation of older adults. The

recommendations call for recognizing the contributions of older persons, promoting their rights and dignity, and facilitating their continued involvement in society

2.4 Nepal's National Policy

2.4.1 Senior Citizen Policy (2002)

This passage proposes a multi-pronged approach to improve the lives of senior citizens in Nepal. It emphasizes recognizing their skills and experience by creating programs that leverage their knowledge. Additionally, legal changes are proposed to guarantee their social security, rights, and interests. The plan goes beyond legalities and focuses on promoting respect for elders within families and society. Initiatives like awards for those who contribute positively to senior citizen well-being are envisaged. Educational institutions will also play a role by incorporating materials that foster respect for the elderly.

Financial security is another key concern. The plan proposes a national pension scheme, a social security fund, and improvements to existing programs like senior homes and old-age allowances. These programs will be streamlined for better effectiveness. Finally, to ensure successful implementation, a central committee will be established to oversee and coordinate all senior citizen programs across Nepal. Local bodies will collaborate to ensure regional coordination as well.

2.4.2 Strengthening the Lives of Senior Citizens: The Economic and Social Focus (Nepal, 2002)

This document outlines a "Senior Citizen Working Policy" focusing on improving the economic and social well-being of elderly people in Nepal. Here are the key points:

Economic Security:

- i. **Classification:** Senior citizens will be categorized based on their economic and physical needs, allowing for targeted support.
- ii. **Financial Assistance:** Allowances and other forms of aid will be prioritized for those with weak financial standing. Local income sources will be used to supplement national support.
- iii. **Local Projects:** Local governments will design annual projects to address the economic needs of vulnerable elders, including shelter and financial support.
- iv. **National Pension Scheme:** A national pension scheme will be implemented to provide broader social security.

- v. **Family Discounts:** Families with senior members will receive service discounts from government or financial institutions.
- vi. **Income-generating Opportunities:** Programs promoting income generation for capable elders based on their skills and interests will be prioritized, potentially partnering with social organizations.

Social Security:

- i. **Strengthening Family Support:** The policy emphasizes a family-based security system. For neglected elders, "Senior Citizen Consultation Service Centers" will be established to address grievances.
- ii. **Legal Protection:** Laws and regulations will be reviewed and amended to safeguard the rights and interests of senior citizens.
- iii. **Property Protection:** Measures will be taken to protect the property rights of elders, potentially including a system where children contribute financially to their parents' well-being.
- iv. **Senior Homes:** The government will encourage NGOs to establish and operate homes for helpless and neglected elderly individuals.

Overall, this policy aims to create a comprehensive system that provides economic and social support for senior citizens in Nepal, ensuring a more secure and dignified later life.

2.4.3 Tenth plan (2002-2007)

The Tenth Plan for Senior Citizens in Nepal: A Focus on Dignity and Security. This plan outlines Nepal's strategy for improving the lives of senior citizens. The key goals are to:

- i. **Utilize their Potential:** The plan aims to leverage the knowledge, skills, and experience of senior citizens in social development efforts.
- ii. **Enhanced Security:** Legal reforms and collaboration with local groups will ensure the rights and security of senior citizens.
- iii. **Community Support:** The plan encourages the formation of senior citizen clubs and community-based homes for a more comfortable and social life.
- iv. **Improved Healthcare:** Establishing geriatric wards in hospitals will provide specialized care for elderly patients.
- v. **Respect and Recognition:** Public awareness campaigns will promote respect for elders, and educational materials will highlight senior citizen issues.

- vi. **Financial Security:** Review and potential increases to existing allowances, along with exploring social security schemes, aim to improve financial well-being.

This comprehensive plan seeks to create a society that values its senior citizens and provides them with the support and opportunities they deserve.

2.4.4 Three-Year Interim Plan for Senior Citizens (Nepal, 2007-2010)

This plan focuses on improving the lives of elderly people in Nepal over a three-year period. Its main goal is to ensure senior citizens have:

- i. **Respectful Living:** The plan aims to create safe and comfortable living conditions for the elderly.
- ii. **Financial Security:** Protecting existing allowances and potentially exploring new avenues for financial support is a key aspect.
- iii. **Meaningful Roles:** The plan values the knowledge and experience of senior citizens and seeks ways to utilize them.
- iv. **Dignified Integration:** Efforts will be made to create an infrastructure that allows seniors to live with dignity within society.
- v. **Intergenerational Respect:** The plan aims to foster respect and a sense of responsibility towards the elderly in younger generations.
- vi. **Social and Economic Security:** The plan seeks to create a supportive environment that protects the rights, well-being, and economic security of senior citizens.

Overall, this plan focuses on short-term improvements to ensure a better quality of life for Nepal's elderly population.

2.4.5 Nepal's 15th Plan: Strengthening Protections for Senior Citizens (2019-2024)

Building on the foundation laid by previous plans, Nepal's 15th plan focuses on strengthening protections and improving the lives of senior citizens. Here are the key points:

- i. **Rights as a Foundation:** The plan recognizes the fundamental right of senior citizens to social security and special protection from the state, aligning with the UN's Sustainable Development Goals.
- ii. **Existing Programs:** The government's existing programs like old-age homes, daycare centers, and discounts on services will continue.

- iii. **Focus on Social Justice:** The plan emphasizes creating a society where senior citizens can live with ease, safety, and respect.

Specific initiatives include:

- i. **Enforcing Family Responsibility:** A system will be developed to ensure children take care of their parents.
- ii. **Senior Citizen Protection Policy:** A new policy will be formulated to safeguard the economic and social rights of senior citizens.
- iii. **Combating Abuse:** Mechanisms will be established to prevent and address violence and abuse against elders.
- iv. **Improved Healthcare:** Government hospitals with over 100 beds will have dedicated senior citizen wards. Additionally, private hospitals will be required to allocate at least 10% of beds for seniors with discounted rates.
- v. **Local Support Systems:** Senior citizen clubs, day-care centers, and health centers will be established at provincial and local levels.
- vi. **Focus on Vulnerable Elders:** Special provisions will be made for single, widowed, disabled, abandoned, and helpless senior citizens, ensuring they receive proper care, nursing, and medical treatment.
- vii. **Empowerment and Participation:** The plan aims to increase senior citizen participation in decision-making and access to resources, fostering a sense of ownership.
- viii. **Collaboration for Care:** Stakeholder agencies will collaborate to provide necessary services and facilities for the physically and mentally weak senior citizens.

Overall, the 15th plan demonstrates Nepal's commitment to creating a supportive environment where senior citizens can live with dignity and security.

2.5 International Day for Elderly People

The United Nations officially established October 1st as the International Day of Older Persons in 1990. This decision came after years of initiatives focused on aging populations, such as the Vienna International Plan of Action on Ageing. The International Day serves as a yearly celebration to recognize the valuable contributions of older adults. It's a day to appreciate their wisdom, dignity, and specific needs, while also recommitting ourselves to ensuring their well-being.

2.6 Ageing in Nepal

Nepal's elderly population is rapidly growing. From 1911 to 2011, the percentage of people over 60 doubled (CBS, 2014). The trend continued in the 2021 census (10.1%). In other words, the number and proportion of elderly people in Nepal is rising quickly. This trend is evident in the census data, which shows that the percentage of people over 60 has doubled in the past 100 years.

Table 2.1: Distribution of the elderly population in Nepal, 1981-2011

| Census Years | Population growth rate (%) | Older population growth rate (%) |
|--------------|----------------------------|----------------------------------|
| 2061 | 1.65 | 1.79 |
| 2071 | 2.07 | 2.42 |
| 2081 | 2.62 | 3.26 |
| 2091 | 2.1 | 2.26 |
| 2001 | 2.24 | 3.5 |
| 2011 | 1.35 | 3.15 |
| 2021 | 0.92 | 3.29 |

Source: CBS.2014, Population Monograph of Nepal, Vol. II page no.76, 2011, NSO. 2021

Nepal's elderly population is growing faster than the overall population. Census data shows this trend particularly between 1971 and 2021 (Table 1), where both the total population and the elderly population growth rates peaked. This indicates a rapid rise in the number of elderly people in Nepal.

2.7 Conceptual Framework

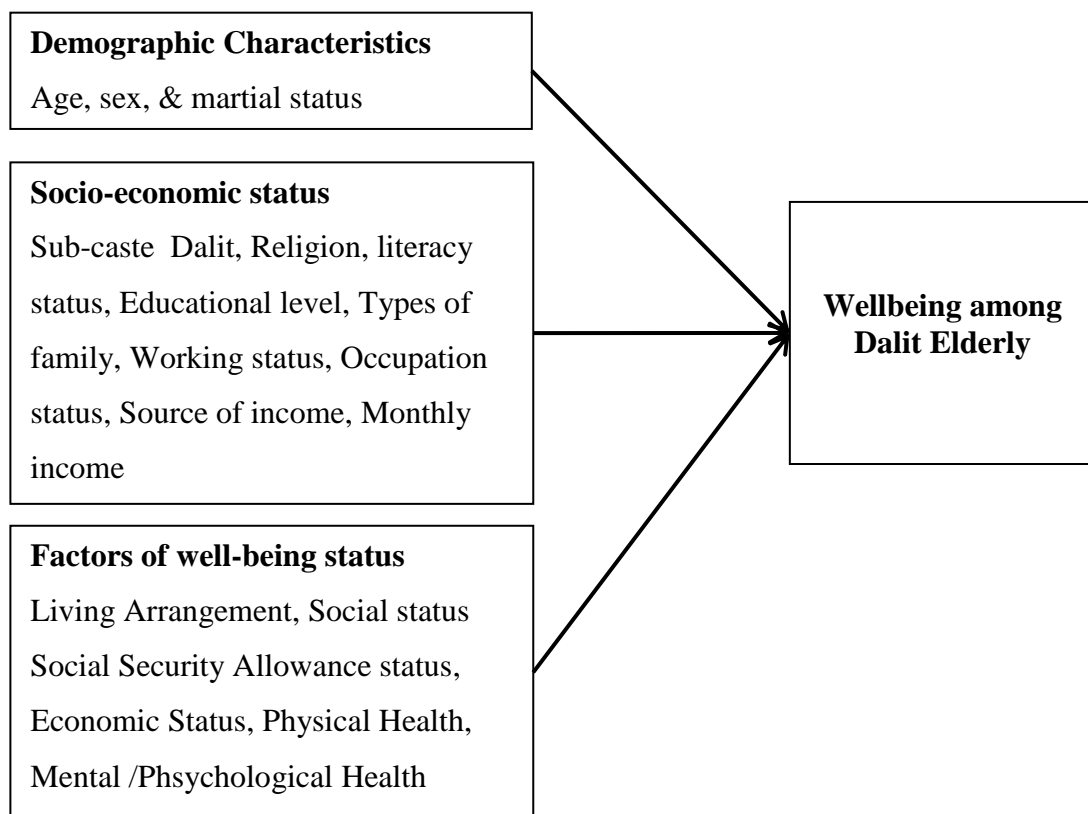
Ageing populations are a worldwide phenomena. It is a normal byproduct of the population's shift from high to low fertility and death rates. Improvements in environmental quality, medical advancements, and other factors lead to an increase in an individual's lifespan or an increase in the average lifespan of a group (Shryock & Siegel, 1993).

Classical demographic transition theory assumes that both birth rate and death rate are high in traditional societies but these rates are very low in modern society. In other words, birth rates and death rates transition from a high stationary stage to a low stationary stage along with the socio-economic development of a country (Comfort, et al., 1964).

Weeks states that the decline in mortality throughout the world has had even broader implications than more babies surviving to adulthood; it has meant more adults surviving to old age as well. As fertility rates have declined, the proportion of the population that is older also increases (Weeks, 2005).

Most historians accept the idea that the status of older persons was relatively high in pre-modern, agrarian societies; even though there may be considerable variety in exactly how high that status was the conceptual tie to the older has been provided by Donald Cowgill in 1979 (Kertzer, 1995). In Cowgill's model, four factors involved in modernization (such as health technology, economic technology, urbanization and education) combine to lower the status of the older. There are all intertwined aspects of demographic transition (Kudo et al., 2015).

Figure 1: Conceptual framework for illustrating the connections between several factors and Dalit elderly social and medical conditions.



A conceptual framework of the older presented in the research model is based on the review of various existing literature and studies. This conceptual framework mainly focuses on the demographic characteristics, health-related problems and existing provisions of order's security systems are included as a research study. This highlights a significant demographic shift: declining birth rates and increasing lifespans are leading to a rapid rise in the elderly population, including a growing number of very old individuals. However, government healthcare services are not adequately equipped to handle this growing demand for elder care.

The study focuses on the factors influencing the well-being of older adults. These factors can be broadly categorized into two groups:

- **Independent Variables:** These are the characteristics that may influence the well-being of the elderly. They include:
 - i. **Demographics:** Age, gender, marital status
 - ii. **Socioeconomic factors:** Education level, caste/ethnicity, family structure, occupation, income, housing situation
 - iii. **Health:** Physical and mental health conditions
 - iv. **Social Support:** Social security benefits, family support systems

- **Dependent Variable:** This is the outcome the study is trying to understand - the well-being among Dalit elderly.

In simpler terms, the study aims to understand how various factors such as age, income, health conditions, and family support impact the overall well-being of older adults, and how well healthcare systems are equipped to address their needs.

CHAPTER THREE

RESEARCH METHODOLOGY

This chapter covers every step of the research process, including the following: the study's area, research design, data nature, sample size, sampling process, questionnaire design, data collection tools and procedures, and data analysis.

3.1 Introduction of the Research Area

The demographic, socioeconomic, and health conditions of senior Dalits in Shivasatakshi, a municipality in the southeast of Jhapa District in the Koshi Province of eastern Nepal, have been extensively researched for this study. In 2072, the four pre-existing VDCs of Shivaganj, Satasidham, Dharampur, and Panchgachhi were combined to establish the new municipality. The Shivasatkshi Municipality is divided into eleven wards. Shivasatakshi Municipality has 74,366 residents in total. The researcher selected this study region because of its familiarity with the community. Despite being a municipality established by the Nepali government in 2015, this area is isolated and home to a diverse range of castes and ethnic groups. Numerous Dalit communities live there as well; they are impoverished, defenseless, and socially marginalized.

3.2 Design of Research

A cross-sectional and descriptive research design is used in this study. The demographic, socioeconomic, and health conditions of senior Dalit individuals in Shivasatakshi municipality, Jhapa district, are the primary subjects of this study. The goal of descriptive research is to precisely and methodically characterize a population, circumstance, or phenomena. It can respond to inquiries about what, where, when, how, and why. It can be applied to many different types of research methodologies in order to look at one or more variables. When the goal of the research is to find traits, frequency, trends, and classifications, this is a suitable option. Generally speaking, descriptive research is classified as a kind of quantitative study.

3.3 Sampling Method

3.3.1 Sample Selection

Before the selection of households' elderly Dalits, households were listed and prepared with the help of the voters' profile of the Municipality office. In this study, around 60+

senior Dalits from Shivsatakshi Municipality in Jhapa District were interviewed using a census methodology. Altogether 11 wards were selected for the study.

3.3.2 Determination of Sample Size

In this study, the census method was utilized to interview all elderly Dalits in the selected wards. The total number of respondents was 240, comprising 113 males and 127 females. Purposively determined the sample population and snowball sampling approach. This method ensures that every elderly Dalit in the study areas was included, providing comprehensive data on this demographic group.

The sample selection was carried out as follows:

- i. **Ward-Based Distribution:** The study was conducted across 11 wards. Each ward's respondents were identified and categorized by sex.
- ii. **Census Method:** Instead of sampling a portion of the population, the census method involves interviewing every respondents within the specified demographic—in this case, all elderly Dalits in each ward.
- iii. **Data Collection by Wards:** The number of male and female respondents from each ward was recorded, ensuring that all elderly Dalits were accounted for. The totals for each ward were then aggregated to form the overall sample size.

Table 3.1 A: Wards, Area, and Respondents Selected for Sample

| Wards | Sex of respondents | | Total |
|-------|--------------------|--------|-------|
| | Male | Female | |
| 1 | 6 | 7 | 13 |
| 2 | 2 | 9 | 16 |
| 3 | 9 | 10 | 19 |
| 4 | 11 | 10 | 21 |
| 5 | 7 | 10 | 17 |
| 6 | 14 | 16 | 30 |
| 7 | 9 | 18 | 27 |
| 8 | 20 | 15 | 35 |
| 9 | 14 | 14 | 28 |
| 10 | 8 | 12 | 20 |
| 11 | 8 | 6 | 14 |
| Total | 113 | 127 | 240 |

Source: Field Survey, 2023.

This approach ensured that the study included a balanced and comprehensive representation of the elderly Dalit population in the selected wards, thus providing accurate and reliable quantitative data.

3.4 Information sources

In this study, triangulation of data was attempted and both primary and secondary data were employed. The information was gathered using a mixed-method approach. Data was gathered from primary and secondary sources in order to address the study questions. A review of the literature was used to gather data in order to create guidelines for both qualitative and quantitative surveys. Using primary data, the research hypothesis was tested. Secondary sources, on the other hand, added to the empirical findings in a number of ways. Detailed notes were kept on observations pertinent to the study region during the fieldwork period. The researcher was particularly concerned with data triangulation.

a. Secondary Data

The analysis of the empirical results was enhanced by the use of secondary sources. These included all evaluation reports that were accessible, as well as reports from commissions on the Dalits and their raw data, publishing of seminar reports, conferences, journals, books on constitutional law, local government acts, and CBS reports. The study also made use of secondary sources, which were reports, public health offices, books and journals that were relevant to the data collection. This indicates that in order to assure the validity of the research, data was gathered from a variety of sources, including libraries, government and non-government institutions.

b. Primary Data Collection

Primary data were gathered through the use of instruments, such as direct interview techniques with Dalit participants who were 60 years of age or more.

Semi structure questionnaire

The researchers developed a special questionnaire to gather detailed information from elderly Dalit people in the Shivasatakshi Municipality area. This questionnaire wasn't a simple yes-or-no format. Instead, it included a mix of multiple-choice questions with clear answer options and open-ended questions that allowed participants to provide their own experiences and perspectives. This approach was chosen because there wasn't much existing research on this specific population. To ensure the questionnaire was clear and easy to understand, the researchers first tested it with elderly Dalit people outside the main study area. Based on this pre-testing, they made some revisions before using it for data collection. Even during the data collection process, minor adjustments were made, particularly to the multiple-choice questions, to improve clarity and get the most accurate information possible. Ultimately, the questionnaire was used to interview elderly Dalit

people aged 60 and above in the Shivasatakshi Municipality area. It gathered information about their background, demographics, socioeconomic situation, and health status. (You can find the full questionnaire in Appendix 3.1.)

3.5 Validation of Tools

A pre-test is conducted and an interview schedule is created initially. Following the pretest, a few pointless questions will be removed from the interview schedule, but other questions will be added and the order will remain consecutive.

3.6 Ethical Concern

Respecting the Rights of Participants in the Study of Elderly Dalit People This section outlines the ethical considerations taken during the research with elderly Dalit people in the Shivasatakshi Municipality area. Here are the key points:

- **Informed Consent:** Before participating, each respondent provided verbal consent after being briefly explained about the study's purpose, process, and potential outcomes.
- **Privacy and Confidentiality:** To ensure ethical treatment and privacy, several strategies were implemented:
 - i. **Transparency:** The researcher clearly introduced themselves and explained the research goals.
 - ii. **Permission for Notes:** Consent was obtained to take notes during the interviews.
 - iii. **Respect for Autonomy:** Participation was entirely voluntary. No pressure was exerted on anyone unwilling to be interviewed.
 - iv. **Data Security:** The collected data was handled with care to avoid misuse, manipulation, or breaches of privacy.

Overall, the study prioritized the well-being and rights of the elderly Dalit participants.

3.7 Data Collection Tools

The interview schedule is a structured questionnaire employed as the main tool of data collection. The interview schedule was designed to get the answers required for the objectives of the study. The interview schedule gathered the household and personal information of the respondents. The interview schedule was framed in simple language to make it understandable to all the respondents. Following the gathering of data, all of the data were compiled and then entered into the Statistical Package for Social Sciences computer program. At the moment of data entry, crucial information is coded and documented. Two approaches were taken in the utilization and analysis of the data from

different sources. Comparative logical analysis is used to assess qualitative data. Questionnaires with a semi-structure were used to gather quantitative data. Following the data analysis, cross-checks were performed to identify coverage and content flaws. The Chi-Square Test, frequency distributions, male-female proportion, and cross-tabulations were used to produce the results.

a. Processing, Editing, and Coding

This section dives into the process of transforming raw data collected from interviews into a format suitable for analysis. Here's a breakdown of the key steps:

1. Data Processing:

- i. **Organization:** The collected data is meticulously organized and presented in a clear and consistent manner.
- ii. **Scrutiny:** Each piece of data is carefully examined for accuracy and completeness.
- iii. **Preparation for Analysis:** The data is formatted for computer entry. This might involve double-checking for inconsistencies and making necessary corrections.

2. Data Editing:

- i. **Thorough Review:** Each questionnaire is reviewed in detail to ensure completeness, accuracy, and uniformity in responses.
- ii. **Maintaining Integrity:** Corrections are made carefully without erasing original entries.

3. Data Coding:

- i. **Assigning Labels:** Responses are categorized and assigned numerical codes or symbols for easier analysis.
- ii. **Creating Categories (if needed):** In the case of open-ended questions, the researcher may need to develop response categories based on the collected data.
- iii. **Consistency Checks:** The assigned codes are verified to ensure they fall within the designated ranges specified in a codebook.

In this study, the researcher used a mix of open and closed-ended questions. Open-ended responses were coded after data collection based on a pre-defined codebook. This process of processing, editing, and coding prepares the raw data for the next crucial stage – data analysis, where the researcher can identify patterns, trends, and insights to answer the research questions.

b. Tables of Cross Tabulation

Cross-tabs often show data for two or more variables on both the vertical and horizontal axes. We can cross-match the values of the data in this table to compare it. Cross tables were regularly employed in this study to make the goals of the investigation clear. In this study, information and data that have been gathered are examined using the cross-tabulation %.

c. Chi-Squire Test

When the test statistics are Chi-Squire distributed under the null hypothesis, the Chi-Squire test is a valid statistical hypothesis test. In one or more categories of a contingency table, the chi-squared test is used to assess if there is a statistically significant difference between the predicted frequencies and the observed frequencies. The observations are categorized into classes that are mutually exclusive in the conventional applications of this exam.

A test that compares expectations to actual observed data (or model outcomes) is called a chi-square (χ^2) statistic. A chi-square statistic can only be computed with random, unprocessed, mutually exclusive data that is obtained from a sufficiently large sample of independent variables. For instance, the outcomes of tossing a coin 100 times satisfy these requirements.

When assessing hypotheses, chi-square tests are frequently utilized.

The Chi-Square Formula is:

$$\chi_c^2 = \sum \frac{(O_i - E_i)^2}{E_i}$$

Where:

O = Observed value(s),

c = Degrees of freedom

E is the expected value (s).

It is necessary to evaluate the following dependent and independent variables using the null hypothesis ('Ho') and alternative hypothesis ('H1'). The hypothesis is tested using several independent and dependent variables. The quantitative data was analyzed using the Statistical Package for the Social Sciences (SPSS) version 20 in order to carry out the statistical tests and establish the study's hypotheses. Given that the independent and

dependent variables are on nominal scales, a Chi-Square Test with a 0.05 insignificance confidence level has been conducted.

Chi-Square Test: Comparing Expected and Observed Outcomes

The Chi-Square test is a powerful statistical tool used to assess whether there's a significant difference between what we expect to see (expected frequencies) and what we actually observe (observed frequencies) in our data. This test is particularly useful when analyzing data categorized into distinct groups, like a survey with multiple-choice answers.

Here's a breakdown of the key points:

- i. **What it Measures:** The Chi-Square test calculates how closely observed data aligns with expected values.
- ii. **When to Use it:** This test is ideal for situations where data falls into distinct categories (like yes/no answers or income brackets) and is drawn from a random sample.
- iii. **The Math Behind It:** The Chi-Square statistic uses a formula that considers observed and expected frequencies to determine the level of discrepancy.
- iv. **Hypothesis Testing:** The Chi-Square test is often used in hypothesis testing, where we have a null hypothesis (no difference between expected and observed) and an alternative hypothesis (there is a difference).
- v. **Software Support:** Statistical software like SPSS (Statistical Package for the Social Science) can be used to perform Chi-Square tests and analyze data.

In this study, the Chi-Square test was chosen (with a significance level of 0.05) because both the dependent and independent variables were nominal, meaning they represent categories rather than numerical values. By employing the Chi-Square test, the researcher can identify statistically significant relationships between the variables studied, providing valuable insights from the collected data.

d. Logistic Regression Formula

A binary outcome's probability is determined using the logistic regression model using one or more predictor factors.

The logistic regression formula is:

$$\ln\left(\frac{P}{1-P}\right) = \beta_0 + \beta_1 X_1 + \beta_2 X_2 + \dots + \beta_k X_k$$

$$\text{logit}(P) = \ln\left(\frac{P}{1-P}\right) = \beta_0 + \beta_1 X_1 + \beta_2 X_2 + \dots + \beta_k X_k$$

Where P stands for the likelihood that the event will occur.

• $\text{logit}(P)$ The natural logarithm of the outcome's probability is $\text{logit}(P)$.

The intercept is β_0 .

The coefficients for the predictor variables X_1, X_2, \dots, X_k are $\beta_1, \beta_2, \dots, \beta_k$.

The logistic function is used to transform the logit into a probability: P is equal to $\frac{1}{1 + e^{-(\beta_0 + \beta_1 X_1 + \beta_2 X_2 + \dots + \beta_k X_k)}}$

Logistic Regression Steps :

1. Determine the predictors' linear combination:

$$z = \beta_0 + \beta_1 X_1 + \beta_2 X_2 + \dots + \beta_k X_k$$

2. Utilize the logistic function to determine the likelihood:

$$P = \frac{1}{1 + e^{-z}} = \frac{1}{1 + e^{-(\beta_0 + \beta_1 X_1 + \beta_2 X_2 + \dots + \beta_k X_k)}}$$

3.8 Data Collection Procedure

After the tool was finalized the researcher requested the Central Department of Population Studies, to give the consent letter. Then the researchers visited to Shivasatakshi Municipality office with the letter given from the Central Department of Population Studies. With the consent of Shivasatakshi Municipality offices, selected households during the interview. Information was collected from the eldest respondents of the selected households who were more than 60 years old. During the interview, the researcher introduced herself to the respondents from the chosen families. Data was gathered from every individual who replied. Without a doubt, the researcher provided a succinct explanation of the goal before gathering the required data from respondents.

CHAPTER FOUR

DEMOGRAPHIC AND SOCI-ECONOMIC STATUS

The respondents' backgrounds are highlighted in this chapter. The objective of this chapter is to investigate the household's and the respondents' socioeconomic and demographic state including age and sex, marital status, religion, education, age at marriage, family size, family type, household head person, occupation, and source of income, knowledge of allowance, old age allowance, and service background at work.

4.1 Demographic Status

4.1.1 Composition of Age & Sex

The quantity of people in various age groups within a nation is referred to as its age composition. Male, female, and intersex individuals' physical characteristics are referred to as "sex." Given its impact on all other components, age-sex composition is a crucial factor to consider in demographic analysis. Among a population's most fundamental traits is this one. Globally, the issue of aging populations is becoming more pressing as the trend toward an aging population continues. To define old age only those persons 60 years of age and above are included in the study. The age-wise distribution of old people in Shivasatakshi Municipality of Jhapa is shown in Table, 4.1

Table 4.1: The respondents' age and sex distribution as a percentage

| Age groups | Male | | Female | | Total | |
|--------------|------------|-------------|------------|-------------|------------|------------|
| | Number | Percent | Number | Percent | Number | Percent |
| 60-64 | 37 | 32.8 | 37 | 29.1 | 74 | 30.8 |
| 65-69 | 33 | 29.2 | 35 | 27.6 | 68 | 28.3 |
| 70-74 | 23 | 20.4 | 33 | 25.9 | 56 | 23.4 |
| 75 and Above | 20 | 17.6 | 22 | 17.4 | 42 | 17.5 |
| Total | 113 | 47.1 | 127 | 52.9 | 240 | 100 |

Source: Field Survey, 2023

The study included 240 elderly Dalit from the Shivasatakshi Municipality area. When looking at age distribution, the largest group (around 30.8%) fell within the 60-69 age range. This was followed closely by the 65-69 age group (28.3%) and then the 70-74 age group (23.4%). The smallest group consisted of participants 75 years old and above (17.5%). Interestingly, the age distribution was similar when broken down by gender. Among the 113 male participants, the highest proportion (32.8%) was in the 60-64 age group, with the numbers steadily decreasing for older age groups. The same trend held true for females (127 participants). The largest group of females (29.1%) was also in the 60-64 age range, with the proportions dropping slightly for each older age group. Overall,

the survey participants were spread fairly evenly across the 60-74 age range, with a smaller number falling into the 75+ category. This pattern was consistent for both males and females.

4.1.2 Marital Status

A happy marriage is seen as a key factor in quality of life for older adults, especially since marital status affects their living situation, support systems, and overall well-being. While a spouse can provide crucial emotional and practical help, widowed or divorced women, particularly, often face challenges. Their traditional role of supporting their husbands can leave them drained later in life, and they may experience discrimination within families after losing their spouse. In contrast, a strong marital bond can offer ongoing support throughout life for both partners. The following table details the marital status breakdown of the study's participants.

Table 4.2: Respondents' percentage distribution according to marital status

| Marital Status | Male | | Female | | Number | % |
|-------------------------|------------|----------------|------------|-------------|------------|------------|
| | Number | % | Number | % | | |
| Currently Married | 83 | 48.8 | 87 | 51.2 | 170 | 70.83 |
| Window/widower | 29 | 42.0 | 40 | 58.0 | 69 | 28.75 |
| Separated | 1 | 100.0 | 0 | 0.0 | 1 | 0.42 |
| Total | 113 | 47.1 | 127 | 52.9 | 240 | 100 |
| Chi square value =2.038 | | P value =0.361 | | df =2 | | |

Source: Field Survey, 2023

Of the entire respondents, 71 percent of the elderly were married at the time, and 28.75 percent of widows or widowers were also married. Compared to older persons who are currently married, the percentage of widowed people is almost half. Likewise, only one respondent was discovered separated in the research region. Fifty-eight percent of respondents reported seeing a female widow, compared to forty-two percent of male widows. Of the female respondents, fifty-one percent were married, while forty-nine percent of the male respondents were married. According to the chi-square test, there is no discernible correlation between sex and marital status (df = 2, chi-square value = 2.038, P value = 0.361). In the Nepalese context, they have remained widows after the death of their husbands, remarriage was not found among females. Males were found to have married after the death of their wives. It was concluded that most of the respondents in this study area were married.

4.2 Social Characteristics

4.2.1 Religion

Religion is a strong belief in a supernatural power or powers that control human destiny. Religion can also have an impact on health knowledge because alcohol consumption is encouraged by social norms and beliefs. Most of the respondents are Hindu and Christian in the second position and the third position is Buddhist. The religion of the respondents also influences their knowledge about health awareness. Although it is considered a social norm and that having sex before marriage is forbidden in the Hindu religion, the beliefs of each religion vary, which has an impact on people's conduct. If a son is born, the parents' souls are thought to be saved.

Table 4.3: Distribution of respondents' percentages by religions

| Religion | Number | Percent |
|--------------|------------|--------------|
| Hindu | 227 | 94.58 |
| Christian | 13 | 5.42 |
| Total | 240 | 100.0 |

Source: Field Survey, 2023

Approximately 94.58 percent of the 240 respondents identified as Hindu, and 5.42 percent as Christian.

4.2.2 Caste status of the respondents

The Dalit community in the Shivasatakshi Municipality in Jhapa serves as the sole basis for this study. The B.K./Kami and Sunuwar castes are two of the numerous sub-castes that make up the Dalit caste, along with the Pariyar, Darji, and others.

Table 4.4: Distribution of respondents' percentages by caste category

| Category of Dalit | Number | Percent |
|-------------------------------|------------|--------------|
| BK/Kami, Sunuwar | 167 | 69.58 |
| Pariyar/Dami, Darji | 40 | 16.67 |
| Sarki, Harijan/Chamar | 23 | 9.58 |
| Hajam/Thakur, Gayak, Gandarva | 10 | 4.17 |
| Total | 240 | 100.0 |

Source: Field Survey, 2023

Among the respondents, the B.K./ Kami and Sunuwar caste groups accounted for 70 percent of the total, followed by the Pariyar/Darji and Darji castes (16.67%), Sarki and Harijan/Chamar castes (9.58%), and Hajam/Thakur, Gayak, and Gandarva castes (4.17%) respondents.

4.2.3 Educational Status

Greater levels of knowledge among the elderly reduces their likelihood of encountering health issues, both serious and less serious. The findings are in line with the research,

which explains why people with higher levels of education typically retain their fitness levels, healthy lifestyles, and physical well-being. Put another way, older people with higher levels of education will generally grasp the value of leading a healthy lifestyle better than older people with lower levels of education (Knodel, 2012).

Table 4.5: Respondents' percentage distribution according to level of education

| Literacy status | Respondents | | | | | |
|--|-------------|-------------|------------|-------------|------------|--------------|
| | Male | | Female | | Total | |
| | Number | Percent | Number | Percent | Number | Percent |
| Illiterate | 67 | 41.4 | 95 | 58.6 | 162 | 67.5 |
| Informal Education | 43 | 61.4 | 27 | 38.6 | 70 | 29.17 |
| Primary (1 to 5) | 3 | 50.0 | 3 | 50.0 | 6 | 2.5 |
| Secondary (6 to 10) and Intermediate above | 2 | 100.0 | 0 | 0.0 | 2 | 0.83 |
| Total | 113 | 47.1 | 127 | 52.9 | 240 | 100.0 |

Chi square value =9.731

P value =0.021

df =4

Source: Field Survey, 2023

Over 68 percent of respondents lacked literacy, 29.17 percent had some informal education, 2.5 percent had completed elementary school, and 0.83 percent had completed secondary and intermediate education or above. 41.4 percent of respondents who were men and more than 58.6 percent of respondents who were women were illiterate. Of those who responded to the survey who were literate, 38.6% of women and 61.4 percent of men obtained informal education. The substantial positive correlation between sex and literacy status is indicated by the p-value of -0.021.

4.2.4 Types of family

Families can be classified into two main categories: nuclear families and joint families. If grand-parents, parents, sons and daughters, then it is called as joint family and if there are parents and only sons/daughters, then it is called as nuclear family. Their role is eroding slowly with the proliferation of nuclear families resultant in the breakdown of the joint family. The nuclear family, urbanization, modernity, and social pressures including economic insecurity and poverty are destroying the support networks inside families, leaving elderly individuals to fend for themselves. Whether the respondents live in a nuclear family or a joint family is one aspect of the family composition. Whereas the nuclear family consists solely of the husband, wife, and their unmarried children, the joint family consists of the husband, wife, their children, father-in-law, mother-in-law, brother-in-law, and sister-in-law. Depending on the kind of family, there are differences in the

amount, kind, and form of violence. The respondents' different family kinds are displayed in the following table:

Table 4.6: Respondents were distributed according on their family kinds

| Types of Family | Number | Percent |
|------------------------|---------------|----------------|
| Nuclear | 119 | 49.6 |
| Joint | 114 | 47.5 |
| Living alone | 7 | 2.9 |
| Total | 240 | 100.0 |

Source: Field Survey, 2023

Out of 240 respondents, the highest proportion of the total family type is 49.6 for the nuclear family. There were 114 respondents with a joint family giving us 47.5 percent for the joint family group and 2.9 percent of respondents were living alone. This table clarifies that families system has been broken and developed (Table 4.6).

Nepal had an average household size of 5.4 according to the 2011 census. In Nepal, the average household size rose to 5.5 in 1971, 5.8 in 1981, and then decreased to 5.6 in 1991. Both nationally and throughout all ecological zones, the average household size was smaller in rural areas. This is most likely a hint of a large-scale migration occurring in Nepal's cities. However, as nuclear families and migration rise, Nepal's household sizes are shrinking in both rural and urban areas. The average household size of the respondents in this survey is approximately 5.4, which is less than the average for the country. The main cause of lower average family size is a breakdown of the joint family system and the increase in nuclear families.

4.2 .5 Working Status

From the perspective of their job activities, older adults who work are less likely to face health issues. This is also in line with Kumar's research, which shows that older people who work have better health than older people who do not work. The most crucial factor in maintaining one's health is engaging in regular physical activity (Kumar, 2016). Religion is a strong belief in a supernatural power or powers that control human destiny. The results of this study showed that 95.0 percent of respondents did not have a job at the time of the study and were not working at all for various reasons, including health issues.

Table 4.7: Respondents' percentage distribution according to their present employment position

| Age groups | Yes % | No % | Total | Non-agriculture % | Agriculture % | Total |
|--------------------|-----------|------------|------------|-------------------|---------------|-----------|
| 60-64 | 7.2 | 92.8 | 69 | 20.0 | 80.0 | 5 |
| 65-69 | 7.7 | 92.3 | 65 | 20.0 | 80.0 | 5 |
| 70 and above years | 2.0 | 98.0 | 50 | 0.0 | 100.0 | 1 |
| Total | 12 | 228 | 240 | 18.2 | 81.8 | 11 |

Source: Field Survey, 2023

Out of 240 respondents, only 18.2 percent of respondents whose current working status is non-agriculture, 81.8 percent of respondents were still involved in agricultural sectors. Similarly, 80.0 percent of respondents' age group 60-64 years and 65-69 years were engaged in the agricultural sector, and 1 respondent in the age group 70 and above years who was engaged in the agriculture sector. The percentage distribution of elderly individuals 60 years of age and older by employment status is displayed in this table. However, respondents who are 70 years of age and older continue to work in agriculture due to poverty; despite their advanced age, they are still able to perform certain tasks and are dependent on other family members.

4.3 Economic Features

4.3.1 Employment Situation

The term "occupation" describes a person's financial standing. Thus, it is the primary socioeconomic element as well. In order to safeguard and promote both individual and societal health, occupation is a critical factor. In Nepal, farming is the primary source of income for most people. Parental occupation is a significant factor in determining the social and economic standing of the household. The occupation determines one's educational standing. People with higher levels of education are almost definitely employed in a variety of non-agricultural fields. The occupation status of the respondents is displayed in the following table:

Table 4.8: Major occupational position as a percentage of respondents' households

| Occupational Status | | |
|---------------------|------------|--------------|
| | Number | Percent |
| Unemployment | 10 | 4.17 |
| Agriculture | 230 | 95.83 |
| Total | 240 | 100.0 |

Source: Field Survey, 2023

Of the 240 respondents, the largest percentage (95.83%) were employed in the agriculture sectors, while 4.17 percent were unemployed.

4.3.2 Agricultural Land Size of Land Holding Size

The amount of land owned also indicates the people's economic standing. Nearly 57 percent of respondents' households have no agricultural land and the rest 43.3 percent of respondents' households have agricultural land for production.

Table 4.9: Percentage of households divided by size of land holding and amount of agricultural land

| Agricultural Land | Number | | Percent | |
|-------------------|------------|--|--------------|--|
| Yes | 104 | | 43.3 | |
| No | 136 | | 56.7 | |
| Total | 240 | | 100.0 | |

| Size of Land Holding (In Dhur) | Sex of respondents | | | | | |
|---------------------------------|--------------------|-------------|-----------|-------------|------------|--------------|
| | Male | Percent | Female | Percent | Total | Percent |
| <10 Dhur | 34 | 60.7 | 22 | 39.3 | 56 | 53.85 |
| 10-14 Dhur | 4 | 57.1 | 3 | 42.9 | 7 | 6.73 |
| 15-19 Dhur | 5 | 41.7 | 7 | 58.3 | 12 | 11.54 |
| 20 Dhur | 19 | 65.5 | 10 | 34.5 | 29 | 27.88 |
| Total | 62 | 59.6 | 42 | 40.4 | 104 | 100.0 |

Chi-Square test =2.071 P value = 0.558 df= 3

Source: Field Survey, 2023

A total of 43.3 percent agricultural land, the highest 53.85 percent of households have less than 10 Dhur lands for the production of crops, 27.88 percent of households have 20 Dhur land for the production of crops, 11.54 percent of households have 15-19 Dhur, and 6.73 percent of households have 10-14 Dhur respectively. The results of the chi-square test indicate that there is no statistically significant correlation between sex and the size of land holding (df = 3, P value = 0.558, and Chi square value = 2.071).

4.3.3 Source of Income

A pleasant family life is heavily dependent on the economic source. Sufficient revenue stream to maintain their upscale lifestyle and provide for their family member. Elderly people's position is directly impacted by their financial level. In Nepal, those with high incomes enjoy a high standard of living and vice versa. Elderly folks do not have any opportunities to make money. The income of the respondent is determined by their source of income, and their economic status reveals their way of life. Their purchasing power is based on their income. The respondents' breakdown by income source is displayed in the following table:

Table 4.10: Respondent distribution according on income source

| Source of Income | Number | Percent |
|-------------------------|---------------|----------------|
| Old aged allowance | 185 | 77.1 |
| Agriculture | 45 | 18.8 |
| Pension | 5 | 2.1 |
| Others | 5 | 2.1 |
| Total | 240 | 100.0 |

Source: Field Survey, 2023

In relation to the distribution of income among the elderly, over 77.1 percent of respondents reported receiving elderly allowances, 18.8 percent reported receiving income from agriculture, 2.1 percent received income from pensions, and 2.1 percent reported receiving income from other sources.

4.3.4 Monthly Income

Income is an important component of economic factors. The income of the family determines their economic status. More family income is helpful to make family life more standard. Income helps to fulfil the needs of family members.

Table 4.11: Responses by monthly income distribution

| Monthly Income | Number | Percent |
|--------------------------|---------------|----------------|
| Less than Nrs. 1000 | 199 | 82.9 |
| Nrs. 1000-2500 | 37 | 15.4 |
| Nrs. 5000-7500 and above | 4 | 1.7 |
| Total | 240 | 100.0 |

Source: Field Survey, 2023

Approximately 83 percent of the 240 respondents have a monthly income of less than Rs. 1,000, 15.4 percent have an income between Rs. 1,000 and Rs. 2,500, and only 1.7 percent have an income between Rs. 5000 and Rs. 7500 or more. The data presented demonstrates the extremely low socioeconomic condition of the elderly Dalit respondents in the Jhapa district's Shivasatakshi Municipality.

CHAPTER FIVE

FACTOR AFFECTING WELL-BEING STATUS AMONG DALIT ELDERLY

Well-being is a comprehensive measure of how respondents perceive and experience respondent lives, influenced by various factors such as living arrangements, social status, social security allowances, economic status, and physical and mental health. Living arrangements impact well-being through housing quality, neighborhood environment, and whether one lives alone or with others. Social status affects access to resources, social networks, and recognition, while social security allowances provide financial stability, access to services, and dignity. Economic status, defined by income, education, and occupation, affects access to opportunities and financial stress. Physical health, including chronic illness management, lifestyle factors, and healthcare access, is crucial, as is mental and psychological health, encompassing emotional stability, mental disorders, and support systems. These factors are interconnected, with changes in one area often impacting others. Understanding these factors is essential for promoting overall life satisfaction and quality of life through holistic policies and intervention.

5.1 Living Person in their Family (Togetherness in the family)

Dalit elderly people lives with their spouse only due to a desire for mutual care and support, economic constraints, or cultural preferences for independence. Living arrangement allows them to maintain autonomy and privacy while providing mutual assistance. Living with a son and daughter-in-law is often driven by cultural norms that emphasize the responsibility, providing social support, and economic benefits .Conversely, living with a daughter and son-in-law may occur if the daughter is the primary caregiver or due to specific cultural practices where daughters take on the responsibility of caring for their elderly parents. Dalit elderly individuals who live alone may do so due to the loss of a spouse, migration of children for better job opportunities, or personal preference for independence despite potential challenges. Lastly, living with other relatives might occur due to the absence of immediate family members, providing a broader support network and ensuring that the elderly receive care and companionship. Each of these living arrangements reflects a complex interplay of cultural values, economic conditions, and social support systems.

Social support plays a crucial role in the well-being of older adults. Studies suggest that living alone can increase health risks for the elderly. Hairi et al. (2013) noted the challenges faced by visually impaired individuals living independently. Conversely, the presence of family members offers practical assistance and can significantly improve an elder's emotional well-being, ultimately impacting their health. Research consistently shows that strong family support has a positive influence on the health of older adults. Sharing a home fosters a sense of belonging and provides opportunities for shared interests, concerns, and activities. To understand the living arrangements of participants in this study, a question was posed regarding who they resided with.

Table 5.1: Distribution of respondents' percentages based on age and type of housing

| Age group | Spouse only | Son/daughter-in-law | Daughter/son-in-law | Alone | Others Relatives | Total no. |
|--------------|-------------|---------------------|---------------------|------------|------------------|------------|
| 60-64 | 47.8 | 46.4 | 1.4 | 2.9 | 1.4 | 69 |
| 65-69 | 40.0 | 52.3 | 3.1 | 4.6 | 0.0 | 65 |
| 70-74 | 32.0 | 50.0 | 8.0 | 8.0 | 2.0 | 50 |
| 75 and above | 26.8 | 64.3 | 3.6 | 5.4 | 0.0 | 56 |
| Total | 37.5 | 52.9 | 3.8 | 5.0 | 0.8 | 240 |

Source: Field Survey, 2023

Note: Nephew/niece-in-law and brother-in-law/sister-in-law are among the other relations. The largest percentage of respondents (52.9%) stated they were living with their son or daughter-in-law, then just their wives (37.5%) and other family members (2.0%). Approximately 8.0 percent of those studied said they were living with their daughter or son-in-law and were living alone.

5.2 Feelings of Satisfaction/Happiness about their Living Arrangements

By requesting the respondents' opinion on whether or not they were happy with their current living situation, information on the degree of contentment with the living arrangement was gathered.

Table 5.2: The respondents' percentage distribution according to their level of satisfaction or happiness with their living arrangements by gender

| Sex | Yes | | No | | Total |
|--------------|------------|-------------|-----------|-------------|------------|
| | Number | Percent | Number | Percent | Number |
| Male | 84 | 74.3 | 29 | 25.7 | 113 |
| Female | 92 | 72.4 | 35 | 27.6 | 127 |
| Total | 176 | 73.3 | 64 | 26.7 | 240 |

Chi-Square test = 0.110 P value = 0.740 df = 5

Source: Field Survey, 2023

Out of the 240 participants, over three quarters (73.3%) expressed satisfaction with their existing living arrangement, while the remaining 26.7 percent expressed dissatisfaction

with it. There was no significant correlation between sex and happiness with living arrangements based on sex, according to the Chi-square (P value=0.7401).

Table 5.3: Distribution of respondents' percentages according to age groups and sex and how satisfied they were with their living arrangements

| Sex | Good | Better | Best | Total |
|------------------|-------------|---------------|-------------|--------------|
| Male | 69.9 | 26.5 | 3.5 | 113 |
| Female | 77.2 | 22.0 | 0.8 | 127 |
| Age group | | | | |
| 60-64 | 71.0 | 26.1 | 2.9 | 69 |
| 65-69 | 76.9 | 21.5 | 1.5 | 65 |
| 70-74 | 76.0 | 22.0 | 2.0 | 50 |
| 75 and above | 71.4 | 26.8 | 1.8 | 56 |
| Total | 73.8 | 24.2 | 2.1 | 240 |

Chi-Square test = 1.119

P value = 0.981

df= 4

Source: Field Survey, 2023

More female respondents (77.2 %) were reported 'good' category compared to male respondents (69.6 %) in the study areas (Table 5.3). About 3.5 percent of male respondents were reported on the 'best' category while the corresponding figure for female respondents was only 0.8 percent. The satisfaction level of respondents was found to vary according to age group. A vast majority of respondents (77%) who were 65 to 69 years old said they were "good." In contrast, only 24.5 percent of respondents said they were in a better category, and only 2.1 percent said they were in the best category satisfaction level of arrangement. According to age, there was no significant correlation found in the Chi-square (P value=0.981) between sex and living arrangement satisfaction.

5.3 Access to Social Security Scheme

It includes understanding government benefits, receiving information about benefits, using benefits, and feeling that the allowance has raised family respect. It also covers the reasons behind reasons for not receiving benefits for the past year, as well as information about special facilities offered to the elderly in the areas of transportation, entertainment, and health. Finally, it covers the opinion of how adequate elderly benefits are.

5.3.1 Knowledge of Government Allowances

The Nepalese government offers various social security allowances to different groups. Everyone over 70 years old (or 60 for Dalit caste and Karnali zone residents), single

women over 60, people with disabilities, and endangered indigenous nationalities (Janajati) of any age are eligible for benefits. The amount varies by group:

- Elderly, single women, and Dalit: □ 1,000 per month
- Endangered indigenous nationalities: □ 1,000 per month
- People with disabilities: □ 300 to □ 1,000 per month depending on the severity of the disability

The Ministry of Local Development manages the allocation of funds and oversees the program nationally. Local municipalities distribute the allowances three times a year, providing four months' worth of support at each distribution. (Source: CDPS, 2012, p. 91) Knowledge about different types of allowances found varies according to the sex and age group of respondents . Male respondents have knowledge about different types of social security allowances than female respondents in the study area. It was reported that there was no significant variation among different age groups about the knowledge of different types of social security allowances.

Table 5.4: Distribution of respondents' percentages according to their awareness of government allowances

| Sex | Percentage who know allowances | | Total |
|--------------|--------------------------------|---------------|------------|
| | Know(%) | Don't Know(%) | |
| Sex | | | No. |
| Male | 100 | 0.0 | 113 |
| Female | 95.28 | 4.72 | 127 |
| Total | | | 240 |

Source: Field Survey, 2023

The table provides data on the awareness of knowledge of government allowances among male and female. It categorizes respondents into males and females and shows the percentage of each group that knows or does not know about allowances. In 240 respondents ,males, 100 percent are aware of allowances, with no males unaware, out of a total of 113. For females, 95.28 percent know about allowances while 4.72 percent do not know, from a total of 127 respondents.

5.3.2 Receiving Status of Government Allowances

All respondents were questioned about whether they had received any senior citizen, single woman, or Dalit stipend in the previous year in order to get information on obtaining the status of government.

Table 5.5 presents the age- and sex-specific percentage distribution of respondents who get old age, single women's, or Dalit allowance. There was a finding that around 95.8 percent of respondents were receiving their allowance. Ninety-six percent of the male respondents reported receiving them, whereas 3.5 percent did not. Similar to this, of all the female responders, 95.2 percent of them got government incentives, while 4.2 percent of them did not. A slightly smaller proportion of women than men.

Table 5.5: Percentage distribution of responders according on age and sex and their status as recipients of government benefits

| Sex | Yes | | No | | Total No. |
|--------------------------|------------|-------------|-----------|------------|------------|
| | Number | Percent | Number | Percent | |
| Male | 110 | 96.5 | 4 | 3.5 | 114 |
| Female | 120 | 95.2 | 6 | 4.8 | 126 |
| Total | 230 | 95.8 | 10 | 4.2 | 240 |
| 5 years age group | | | | | |
| 60-64 | 61 | 88.4 | 8 | 11.6 | 69 |
| 65-69 | 63 | 98.4 | 1 | 1.6 | 64 |
| 70-74 | 50 | 98.0 | 1 | 1.9 | 51 |
| 75 and Above | 56 | 100.0 | 0 | 0.0 | 56 |
| Total | 230 | 95.9 | 10 | 4.1 | 240 |

Source: Field Survey, 2023

According to the percentage distribution of respondents, 88.4 percent of respondents in the age categories 60–64 and older received some sort of allowance, while only 11.6 percent did not. In a similar vein, all responders (100%) who were 75 years of age or older received allowances. those aged 65 to 69 years received 98.4 percent of the total, while those aged 70 to 75 years earned 98.0 percent.

5.3.3 Using Government Allowances

The information on utilization of government entitlements was obtained by asking the question (i. e. how they utilize the allowance that they received?).

Table 5.6: Distribution of respondents' percentages according to their use of government allowances

| Use of Allowance | Sex of respondents | | | |
|-----------------------------|--------------------|--------|--------|---------|
| | Male | Female | Number | Percent |
| Expense for oneself | 17.6 | 23.3 | 86 | 41.0 |
| Own medical expense | 34.3 | 34.3 | 144 | 68.6 |
| Buying grains | 1.9 | 1.9 | 8 | 3.8 |
| Buying clothes | 1.4 | 1.0 | 5 | 2.4 |
| Education for grandchildren | 0.0 | 0.5 | 1 | 0.5 |
| Household expenses | 31.9 | 37.1 | 145 | 69.0 |

Source: Field Survey, 2023

(Note: Multiple responses and sum of percentage may exceed 100)

More than two-thirds (69.0 %) of respondents reported that they utilized allowance for household expenses, followed by own medical expenses (68.6%), expenses for own (41.0%), buying grains (3.8 %), expenses for buying clothes (2.4%) and support to

grandchildren education (0.5 %) in the study area. Male and female respondents used their allowances for their medical expenses (34.3 %)

5.3.4 Supportive / Caring Persons for Elderly People

The information on caregivers was obtained by asking the question directly to the respondents (i.e., who are your main caregivers?). In this case, the primary caregiver helps the elderly person directly with cooking, cleaning, laundry, and medication administration. Based on primary caregivers. In the research area, the majority of male respondents (63%) stated that their primary caregiver was their spouse, followed by their son or daughter-in-law (25%), daughter or son-in-law (5.3%), and grandchildren (3%).

Table 5.7: Respondents' percentage distribution by caregiver and sex

| Supportive person of Elderly people | Sex | | Total |
|-------------------------------------|------|--------|-------|
| | Male | Female | |
| Nobody | 6 | 9 | 15 |
| Spouse | 85 | 59 | 144 |
| Son/Daughter in Law | 22 | 49 | 71 |
| Daughter/son-in-law | 0 | 6 | 6 |
| Grand Children | 0 | 2 | 2 |
| Other Relatives | 0 | 1 | 1 |
| Others | 0 | 1 | 1 |
| Total | 113 | 127 | 240 |

Source: Field Survey, 2023

About 35.4 percent of the male respondents reported that they were taken care of by their spouse and 24.6 percent of female respondents reported that they were taken care of by their spouse. On the other hand, more female respondents 20.4 percent than male respondents 9.2 percent reported their main caretakers were sons and daughters-in-law, respectively. The proportion of respondents who said they were taken care of by nobody taking care of themselves was 2.5 percent for men and 3.8 percent for women. Only a few percent of female respondents were living with grandchildren, other relatives, and others respectively.

5.4 Elderly Care and the Family/Community Support System

It includes the elderly population with a primary caregiver, the elderly population with a primary person for caring activities, how families behave with the elderly, the expectations that the elderly have of their family, the perception that the family is not providing adequate care for the elderly, primary security concerns, and the migration of family members and elderly care.

5.4.1 Family Expectations

By directly asking respondents, "What do you expect from the family in old age?" information regarding their expectations from family was gathered. Based on respondent comments, the information was reported.

Table 5.8 Distribution of respondents by primary caregivers as a percentage based on age and gender

| Age and sex | Types of elderly expectations that they expect from their family | | | | | | Total No. |
|------------------|--|-------------|-------------------|----------------|--------------------------|------------------------|------------|
| | Protection | Respect | Financial support | Delicious food | Traveling to holy places | No expectations at all | |
| Sex | | | | | | | |
| Male | 35.7 | 26.8 | 10.7 | 17.8 | 7.2 | 1.8 | 112 |
| Female | 27.2 | 31.2 | 11.2 | 24.2 | 6.2 | 0.0 | 128 |
| Age group | | | | | | | |
| 60-64 | 33.9 | 24.2 | 14.5 | 22.6 | 4.8 | 0.0 | 62 |
| 65-69 | 30.6 | 32.3 | 14.4 | 19.4 | 3.3 | 0.0 | 62 |
| 70-74 | 37.7 | 20.8 | 9.4 | 18.9 | 13.2 | 0.0 | 53 |
| 75+ | 26.9 | 31.7 | 11.2 | 19.1 | 9.5 | 1.6 | 63 |
| Total | 32.0 | 27.5 | 12.5 | 20.0 | 7.5 | 0.5 | 240 |

Source: Field Survey, 2023

Among the 240 respondents, majority of respondents (32.0%) reported that they had expected 'protection' from their family, followed by 'respect' (27.5 %). About 20 percent of Dalit elderly people want to delicious food from their family and only about 8 percent of them expect to travelling to holy places. Of them, 7.5 percent respondents expect 'financial support' from their family.

5.4.2 Awareness of Government Health Care Programs

The Social Security Allowances (SSA) were raised to NPR 3000 in the budget year 2020–2021 after a protracted hiatus, and to NPR 4000 per month in the fiscal year 2021–2022. The senior citizen's allowance's minimum qualifying age has been lowered to 68 years old, which is the most recent modification.

Only respondents who reported knowing about the government-funded health care program for the elderly and its maximum payment plan of Rs. 4,000 were eligible to offer this kind of information. The question "Do you know the government provides (the maximum amount) Rs. 4000 yearly (in two instalments) for elderly health care?" was used to gather information on the medication and treatment status of the government's health care service. Based on his or her responses, the information was reported while the

person was receiving medication or supplies for the government hospital. Of the respondents, over 97.1 percent were unaware that government hospitals offer healthcare through an installment system with a maximum value of Rs 4000. Only 2.9 percent of respondents were aware that government hospitals offer healthcare.

Table 5.9: Respondents' percentage distribution by level of awareness of government programs for elderly health care

| Knowledge | Number | Percent |
|------------------|---------------|----------------|
| Yes | 7 | 2.9 |
| No | 233 | 97.1 |
| Total | 240 | 100.0 |

Source: Field Survey, 2023

5.4.3 Expectations from the Community and Society for the Elderly

Asking opinion-type questions (e.g., how can the community/society manage proper care of the elderly?) yielded information about expectations of the elderly from the community/society. Respondents' responses were used to report the information.

Table 5.10: Respondents' percentage distribution by age-related expectations of the community and society

| Expectations/needs of the Elderly | Number | Percent |
|--|---------------|----------------|
| Establishing daycare center | 40 | 16.7 |
| Management of entertainment | 15 | 6.3 |
| Management of Bhajan Mandali | 22 | 9.2 |
| Establish of meditation Center | 19 | 7.9 |
| Establishing a community health center | 18 | 7.5 |
| Geriatric ward | 25 | 10.5 |
| Free clinic | 14 | 5.8 |
| Mobile camp | 7 | 2.8 |
| Old age home | 80 | 33.3 |
| Total | 240 | 100.0 |

Source: Field Survey, 2023

About nearly one-third (33.3 %) of respondents reported that they had expected the provision of an established old age home, 16.7 percent respondents reported that they had expected the provision of an established daycare centre, the same 10.5 percent respondents reported that they had expected for geriatric ward at the hospital, 9.2 percent respondents reported that they had expected for the provision of establishing the club, management of Bhajan Mandali, 7.9 percent respondents reported that they had expected for the establish of a meditation center, 7.5 percent respondents reported that they had expected for the provision of establishing community health Centre, 6.3 percent respondents reported that they had expected for management of entertainment, 5.85 percent respondents reported that they had expected for a free clinic and so on. (Table 5.10)

The majority of the elderly respondents said that the government or the community's primary expectation for the elderly was the establishment of an old age home. They said that some of the elderly are childless in their Shivasatakshi Municipality of Jhapa district. They needed an old age home because they had no caretaker. The researcher observed that the government or community/society should provide old age homes for only those who are childless and who have poor economic status.

5.4.4 Feeling that Family and Society Are Not Caring Enough for the Elderly

An opinion-type question (i.e., "How do you feel about not taking care of yourself by family and society?") was used to gather information about the feelings of not caring for the elderly by family members. Based on his or her answers, the information was reported.

Table 5.11: Response rate by percentage of respondents who said their family didn't care

| The feeling of not taking care by the family | Number | Percent |
|---|---------------|----------------|
| Very much | 85 | 35.4 |
| Somewhat | 55 | 22.9 |
| No such feeling | 60 | 25.0 |
| Don't know | 40 | 16.7 |
| Total | 240 | 100.0 |

Source: Field Survey, 2023

The most of respondents (35.4%) stated that they felt their family members did not take care of them very much, followed by 25.0 percent who said they did not feel that way, 22.9 percent who said they felt somewhat about it, and 16.7 percent who stated they were unaware of it (table 5.11).

5.5. Health Status of the Respondents

The major part of the health is mental and physical, and measures of the treatment of their health information are to be collected by asking the questions to the respondents.

5.5.1 Physical health status

There are several problems, that have in found by elderly people at present and that is shown in the below table. Though people were affected by more than one disease, the analysis has been done by considering the major causes.

The physical health condition of the respondents was gathered by means of a closed-ended inquiry concerning their physical state. The information was provided in accordance with his or her comments regarding how they felt about their physical health.

Table 5.12: Distribution of respondents' percentages by sex and physical health issue

| Sex of respondent | Physical health problems | | | | Total | |
|----------------------------|--------------------------|---------------|-----------|------------|------------|--------------|
| | Yes | | No | | Number | Percent |
| | Number | Percent | Number | Percent | | |
| Male | 108 | 45.0 | 5 | 2.1 | 113 | 47.1 |
| Female | 121 | 50.4 | 6 | 2.5 | 127 | 52.9 |
| Total | 229 | 95.4 | 11 | 4.6 | 240 | 100.0 |
| Pearson Chi-Square=0.012 | | P value=0.912 | | df= 1 | | |
| Source: Field Survey, 2023 | | | | | | |

Out of 240 respondents, only 229 respondents have physical health problems and 11 respondents do not have physical health problems. Female respondents have 50.4 percent of physical health problems and male respondents have 45.0 percent of physical health problems. The P value of 0.912 indicates that there is no statistically significant correlation between respondents' sex and physical health issues.

Table 5.13: Physical health problem percentage distribution among responders by age groupings of 5 years

| 5 years of age groups | Physical health problems | | | | Total | |
|----------------------------|--------------------------|---------------|-----------|------------|------------|--------------|
| | Yes | | No | | Number | Percent |
| | Number | Percent | Number | Percent | | |
| 60-64 | 68 | 28.3 | 1 | 0.4 | 69 | 28.7 |
| 65-69 | 59 | 24.6 | 6 | 2.5 | 65 | 27.1 |
| 70-74 | 48 | 20.0 | 2 | 0.8 | 50 | 20.8 |
| 75 above | 54 | 22.5 | 2 | 0.8 | 56 | 23.3 |
| Total | 229 | 95.4 | 11 | 4.6 | 240 | 100.0 |
| Pearson Chi-Square =4.930 | | P value=0.177 | | df = 3 | | |
| Source: Field Survey, 2023 | | | | | | |

Out of 240 respondents, only 229 respondents have physical health problems and 11 respondents do not have physical health problems. Age groups 60-64 have 28.3 percent of physical health problems, followed by age groups 65-69 have 24.6 percent of physical health problems, age groups 70-74 have 20 percent of physical health problems, and 75 above 22.5 percent of physical health problems. In total 95.4 percent of respondents were suffering from physical health problems. The P value of 0.177 indicates that there is no statistically significant correlation between physical health problems and age groups of five years.

Table 5.14: Distribution of respondents' percentages according to their present state of health

| Health Situation | Better than peer friend | Same as peer friend | Weak than peer friend | Total Number |
|-----------------------------|-------------------------|---------------------|-----------------------|--------------|
| Ability of Vision | 30.4 | 41.2 | 23.3 | 240 |
| Ability of hearing | 36.2 | 35.8 | 27.9 | 240 |
| Memory power | 23.8 | 55.5 | 21.2 | 240 |
| Moving ability | 22.1 | 46.2 | 31.7 | 240 |
| Physical power | 17.1 | 38.3 | 44.6 | 240 |
| Smelling power | 27.1 | 52.9 | 20.0 | 240 |
| Reading and writing ability | 14.2 | 13.3 | 72.5 | 240 |

Source: Field Survey, 2023

Out of the 240 total respondents, 41.2 percent of respondents' ability of vision is the same as peer friends, 30.4 percent have better than peer friends' ability of vision and 23.3 percent have weak than peer friends' ability of vision. Comparatively speaking, 36.2 percent of respondents said their hearing was superior to that of their peers, 35.8 percent said it was equal to that of their peers, and 27.9 percent said their hearing was worse to that of their peers.

Memory power of the total respondents than the others friends, 23.8 percent of respondents have better than friends, 55.5 percent have same as peer friend and 21.2 percent have weak than others friends.

Moving ability of the total respondents is 46.2 percent have the same as peer friends, 31.7 percent have weaker than peer friends and 22.1 percent have better than peer friends. The highest 72.5 percent of respondents have reading and writing abilities very weak than other friends, 14.2 percent are better than peer friends, and 13.3 percent have the same as peer friends.

5.6 Mental Illness

Respondents have psychological/mental health problems by frequency of problem according to age group and sex by self-reported. Most of the males who responded said that they only infrequently experienced various kinds of mental health issues. But most of the female respondents said they experienced various kinds of mental health issues on a regular basis. The age group of the respondents in the study area revealed the similar tendency.

Among the responders, 89 percent had experienced depressive symptoms. Because of the nation's increasing influx of foreign immigrants, urbanization, and the nuclear family system, which encourages family separation, depression is a significant psychological and mental health issue for the elderly. Similar to this, according to self-reported data, 87.7 percent of respondents reported feeling alone or anxious around other people, 56.8 percent reported experiencing insecurity or boredom, nearly 19 percent reported losing their memory, and approximately 11 percent reported having a mental illness.

Table 5.15: Distribution of respondents by percentage according to psychological/mental health issues

| Feelings of Psychological problem | Number | Percent |
|--|---------------|----------------|
| Insecurity/boredom | 125 | 56.8 |
| Mental disorder | 23 | 10.5 |
| Depression | 195 | 88.6 |
| Loneliness/ Anxiety | 193 | 87.7 |
| Loss of memory power | 41 | 18.6 |
| Total | 240 | 100.0 |

Source: Field Survey, 2023

5.7 Psychological Abuse

The information on mental torture was obtained by asking the question i.e. do you feel any problem of mental torture in the family? Based on respondent comments regarding whether they perceive mental abuse as an issue in the family, the information was reported.

Table 5.16: Distribution of responders by sex in terms of percentages under psychological and mental abuse

| Sex | Yes | | No | | Total |
|--------------|---------------|----------------|---------------|----------------|--------------|
| | Number | Percent | Number | Percent | |
| Male | 72 | 62.6 | 43 | 37.4 | 115 |
| Female | 77 | 61.6 | 48 | 38.4 | 125 |
| Total | 149 | 62.1 | 91 | 37.9 | 240 |

Source: Field Survey, 2023.

Around 62.1 percent of respondents reported that they have felt psychological torture problems in the family. The problem of mental torture was reported to vary among male and female respondents. It was found that more male respondents (62.6%) reported that they have felt mental torture problems compared to female respondents (61.6 %). In the study area, about 37.9 percent of respondents self-reported that they had no mental torture issues.

Table 5.17: The percentage distribution of responses categorized by age categories based on psychological torture

| 5 years age group | Yes | | No | | Total Number |
|--------------------------|---------------|----------------|---------------|----------------|---------------------|
| | Number | Percent | Number | Percent | |
| 60-64 | 40 | 26.8 | 32 | 35.2 | 57 |
| 65-69 | 43 | 28.9 | 27 | 29.7 | 57 |
| 70-74 | 46 | 30.8 | 18 | 19.8 | 53 |
| 75 and Above | 20 | 13.5 | 14 | 15.3 | 28 |
| Total | 149 | 62.1 | 91 | 37.9 | 240 |

Source: Field Survey, 2023

About (30.8%) the age group 70-74 reported that they had felt psychological torture in the family, (28.9 % of) age group 65-69 reported that they had felt mental torture problem in

the family, followed by 26.8 percent respondents reported that they had felt mental torture problem in the family whose age group 60-64 and 13.5 percent respondents reported that they had felt psychological torture in the family whose aged 75 and above.

5.8 Experiencing Physical Health Issues

A closed-ended inquiry about the respondents' physical health (i.e., how is their health condition?) was used to gather data about their state of health. Based on his or her comments regarding how they feel about their physical health status, the information was reported.

Of all respondents, 41.2 percent reported having physical issues, while 58.8 percent reported having none at all. The percentage distribution of responders by the most significant health issues is displayed in the table below. Out of the total respondents, 41.2 percent reported experiencing physical pain, such as pain in the knee, back, stomach, or joints. Of those, 48.4 percent diagnosed these kinds of issues. The largest percentage of respondents (74.6%) reported having stomach issues, and 41.0 percent of those with stomach issues had received a diagnosis. The respondents have been diagnosed with high blood pressure (69.2%), heart disease (53.5%), respiratory disorders (73.6%), diabetes (65.2%), cholesterol (83.3%), and prostate diseases (80.0%).

Table 5.18: Distribution of respondents by serious health issues as a percentage

| Serious Health Issue | Yes | | No | | Total No. |
|---|-----|------|-----|------|--------------|
| | No. | % | No. | % | |
| Physical pain (joints, knee, back, stomach, etc.) | 99 | 41.2 | 141 | 58.8 | 240 |
| Physical pain-Diagnosed | 46 | 48.4 | 49 | 11.6 | 95 |
| Respiratory-Problem | 72 | 30.0 | 168 | 70.0 | 240 |
| Respiratory-Diagnosed | 53 | 73.6 | 19 | 26.4 | 72 |
| Blood pressure-Problem | 117 | 48.8 | 123 | 51.3 | 240 |
| Blood pressure-Diagnosed | 75 | 65.2 | 39 | 34.8 | 115 |
| Sugar (Diabetes) Problem | 25 | 10.4 | 215 | 90.0 | 240 |
| Sugar (Diabetes) Diagnosed | 9 | 69.2 | 4 | 30.8 | 13 |
| Gastric-Problem | 179 | 74.6 | 61 | 25.4 | 240 |
| Gastric-Diagnosed | 64 | 41.0 | 92 | 59.0 | 156 |
| Asthma-Problem | 108 | 45.0 | 132 | 55.0 | 240 |
| Asthma-Diagnosed | 37 | 37.8 | 61 | 62.2 | 98 |
| Heart disease-Problem | 58 | 24.2 | 182 | 75.8 | 240 |
| Heart disease-Diagnosed | 23 | 53.5 | 20 | 46.5 | 43 |
| Teeth Problem | 166 | 69.2 | 74 | 30.8 | 240 |
| Kidney/urinary | 47 | 19.6 | 193 | 80.4 | 240 |
| Uric acid | 34 | 14.2 | 206 | 85.8 | 240 |
| Cancer | 6 | 2.5 | 234 | 97.5 | 240 |
| Other disease | 23 | 9.6 | 217 | 90.4 | 240 |

Source: Field Survey, 2023

Comparably, 45.0 percent of respondents said they had experienced asthma attacks, and 37.8 percent said they had been diagnosed with the condition. 9.6 percent of cases were

classified as "others," which includes conditions including skin illness, alzar, cough, leg swelling, headache, jaundice, stone, hornia, polio, thairide, deafness, bone deterioration, and pregnancy/delivery-related issues.

5.9 Diagnosed by Health Personnel and Duration

Only responders who expressed concerns about their physical health were asked to provide this kind of information. One can find out about medical personnel's diagnosis by posing the query, "Has it been diagnosed by a doctor or other health worker?" Whether or whether the person had a diagnosis was determined by the facts reported based on their responses.

Table 5.19: The respondents' percentage distribution by disease type, based on diagnosis and length of treatment

| Diagnoses of diseased | Duration | | | |
|-----------------------|------------------|-----------|------------|------------|
| | Less than a year | 1-5 years | 6-10 years | 11+ years |
| Physical pain | 14.1 | 48.5 | 25.3 | 12.1 |
| Respiratory | 8.3 | 65.3 | 16.7 | 9.7 |
| Asthma | 10.2 | 60.0 | 24.1 | 5.6 |
| Heart disease | 24.1 | 56.9 | 12.1 | 6.9 |
| Blood pressure | 6.0 | 60.7 | 28.2 | 5.1 |
| Diabetes | 32.0 | 44.0 | 24.0 | - |
| Gastric | 11.2 | 57.5 | 25.1 | 6.1 |
| Teeth problem | 1.8 | 41.6 | 44.0 | 12.7 |
| Kidney/urinary | 36.2 | 51.1 | 4.3 | 8.5 |
| Uric acid | 44.1 | 50.0 | 2.9 | 2.9 |
| Cancer | 33.3 | 33.3 | 33.3 | - |
| Other Diseases | 30.4 | 52.2 | 13.4 | 4.3 |
| Total | | | | 240 |

Source: Field Survey, 2023

The study examined how long ago respondents received diagnoses for various health conditions. A majority reported receiving diagnoses from healthcare professionals.

- **Physical Pain:** Nearly half (48.5%) received diagnoses 1-5 years ago, followed by 25.3 percent diagnosed 6-10 years ago.
- **Respiratory Disease:** The majority (65.3%) were diagnosed with respiratory illness 1-5 years ago, with 16.7 percent diagnosed 6-10 years ago.
- **Asthma:** Most diagnoses (60%) occurred 1-5 years ago, followed by 24.1 percent diagnosed 6-10 years ago.
- **Heart Disease:** Over half (56.9%) received diagnoses 1-5 years ago, with a significant portion (24.1%) diagnosed within the past year.
- **Blood Pressure:** The highest percentage (60.7%) were diagnosed with blood pressure issues 1-5 years ago, followed by 28.2 percent diagnosed 6-10 years ago.

- **Diabetes:** Nearly half (44%) were diagnosed with diabetes 1-5 years ago, with a substantial number (32%) diagnosed within the past year.
- **Gastric Issues:** The majority (57.5%) received diagnoses 1-5 years ago, with 25.1 percent diagnosed 6-10 years ago.
- **Teeth Problems:** Diagnoses were more evenly spread, with 44 percent diagnosed 6-10 years ago, 41.6 percent diagnosed 1-5 years ago, and a smaller portion diagnosed within the past year or over 11 years ago.
- **Kidney Disease:** Over half (51.1%) were diagnosed with kidney problems 1-5 years ago, with a significant number (36.2%) diagnosed within the past year.
- **Acid Uric:** Shorter than a year: 44.1 percent, 1–5 years: 50.0 percent, 6–10 years old: 2.9 percent, Ages 11 and up: 2.9 percent.
- **Cancer:** Under a year: 33.3 percent, One to five years, 33.3 percent, 6 to 1 years 33.3 percent
- **Different Illnesses:** Under a year: 30.4 percent, 52.2 percent after 1 to 5 years, 6–10 years: 13.4 percent, 11+ years: 4.3 percent

Health professionals diagnosed the majority of responders with their particular illnesses. The majority of respondents who reported having a diagnosis during the last one to five years included those with physical pain, respiratory conditions, asthma, heart illness, blood pressure difficulties, diabetes, gastric issues, tooth problems, kidney/urinary problems, uric acid issues, cancer, and other disorders. There are differences, though, with certain illnesses exhibiting a significant proportion of diagnoses made less than a year ago or more than 11 years.

5.10 Current of Medication Assigned by Medical Professionals

The study investigated how the use of medication differed among participants with specific health conditions. Participants were asked if they took medication or received treatment for their ailments. Interestingly, all respondents reporting blood pressure or uric acid issues indicated using medication or receiving treatment. For other conditions, medication use varied: 57.1 percent of those experiencing pain (joints, back, etc.) used medication, while 42.9 percent did not. Similarly, 64.1 percent of respondents with respiratory disease reported medication use, compared to 35.9 percent who did not.

This section explores medication use among participants with reported health problems. Data was collected by asking participants if they took medication for their conditions. For blood pressure and uric acid, all respondents reported using medication or receiving treatment. For pain (joints, back, etc.), 57.1 percent of the 40 participants used

medication, while 42.9 percent did not. For respiratory disease, 64.1 percent of the 41 participants reported medication use, with 35.9 percent not using medication.

Table 5.20: Distribution of respondents' percentages by disease categories based on their use of medications and other treatments

| Diseases | Yes | | No | | Total |
|---|--------|---------|--------|---------|------------|
| | Number | Percent | Number | Percent | Number |
| Physical pain (Joints, knee, back, stomach, etc.) | 40 | 57.1 | 30 | 42.9 | 70 |
| Respiratory diseases | 41 | 64.1 | 23 | 35.9 | 64 |
| Blood pressure | 58 | 63.0 | 34 | 37.0 | 92 |
| Sugar/diabetics | 3 | 75.0 | 1 | 25.0 | 4 |
| Gastric | 65 | 43.3 | 85 | 56.7 | 150 |
| Asthma | 29 | 31.9 | 62 | 68.1 | 91 |
| Heart diseases | 17 | 44.7 | 21 | 55.3 | 38 |
| Teeth problems | 20 | 12.3 | 142 | 87.7 | 162 |
| Kidney/urinary | 12 | 34.3 | 23 | 65.7 | 35 |
| Uric acid | 6 | 33.3 | 12 | 66.7 | 18 |
| Cancer | 2 | 33.3 | 4 | 66.7 | 6 |
| Others | 3 | 42.9 | 4 | 57.1 | 7 |
| Total | | | | | 240 |

Source: Field Survey, 2023

Among 58 respondents who had suffered from high blood pressure, 63.0 percent had taken medicine and 37.0 percent did not take medicine. About 65 respondents had suffered from gastric, 43.3 percent of respondents had taken gastric medicine and 56.7 percent did not take medicine. About 20 respondents had suffered from teeth problems, 12.3 percent had taken medicine and 87.7 percent did not take medicine. About 17 respondents had heart diseases, 44.7 percent had taken medicine and 55.3 percent did not take medicine. 12 respondents had kidney problems, 34.3 percent had taken medicine 65.7 percent had not taken medicine, 6 respondents had suffered from uric acid and 34.3 percent had taken uric acid medicine. Only 2 respondents had suffered from cancer 33.3 percent of respondents had taken medicine and treatment for cancer and 66.7 percent had not taken medicine and treatments.

5.11 The respondents' treatment location

Respondents were feeling and physical health problems and medicine/treatment taking status according to place of treatment. The medicine/treatment-taking status was reported to vary for different categories according to treatment place.

Table 5.21: Respondents' percentage distribution by treatment location

| Place of Treatment | Number | Percent |
|---------------------------|---------------|----------------|
| Treatment at home | 2 | 0.8 |
| In-home with the doctor | 18 | 7.5 |
| Government Hospital | 196 | 81.7 |
| Private clinic | 19 | 7.9 |
| Dhami/Jhakri | 3 | 1.3 |
| Others | 2 | 0.8 |
| Total | 240 | 100.0 |

Source: Field Survey, 2023

The majority of respondents (82%) received their medical care from government hospitals, with 7.9 percent receiving care from private hospitals, 7.5 percent receiving care in a doctor's office, and 1.3 percent continuing to follow the Dami/Jhakri (faith healer) (Table 5.21).

5.12 Medical care and treatment cost support

The largest percentage of respondents, or 58 percent, reported that their son or daughter-in-law was in charge of their medical bills. This was followed by respondents who said their husband or wife was in charge of their bills (23.8 percent), respondents who said they were in charge of their bills (13.7 percent), respondents who said they were in charge of their bills themselves (4.2 percent), and respondents who said their son or daughter-in-law was in charge of their bills (only 0.8 percent) (Table 5.22).

Table 5.22: The treatment bill manager's percentage distribution of the respondents

| Manage person for Treatment | Number | Percent |
|------------------------------------|---------------|----------------|
| Self | 33 | 13.7 |
| Husband/Wife | 57 | 23.8 |
| Son/Daughter in Law | 138 | 57.5 |
| Daughter/son-in-law | 10 | 4.2 |
| Other relatives | 2 | 0.8 |
| Total | 240 | 100.0 |

Source: Field Survey, 2023.

CHAPTER SIX

ANALYSIS OF FACTORS AFFECTING WELL-BEING STATUS AMONG DALIT ELDERLY

6. Multivariate (Logistic regression) results

The logistic regression has been analyzed through using of SPSS. Where the dependent variable is the elderly care of Dalit people, which is measured on a nominal scale (Yes/No). Similarly independent variable is social security allowances and cofactor variables are marital status, education, currently married, family type, age (Ratio), and sex (Yes/No) used in the logistic regression analysis process. A logistic regression model is presented in Table 6.1 of elderly care of Dalit people.

The multivariate(logistic regression) result is presented in Table 6.1 for the elderly care of Dalit people. table 6.2 for the Physical Health Problems of Dalit elderly people, and Table 6. 3 for the analysis of factors affecting well-being status among Dalit elderly.

Independent variables

Dependent Variable

X1(Social Security Allowance)

X2 (Marital Status)

X3 (Education)

Types of family

Sex

Age

Well-being among Dalit elderly

The logistic regression model takes the values of the independent variables X1, X2, X3,... to determine the chance that the dependent variable YYY falls into a specific category. X1, X2, X3, \ldots X1, X2, X3, etc..

The model is commonly expressed as:

$$P = \frac{e^{\beta_0 + \beta_1 X_1 + \beta_2 X_2 + \dots + \beta_k X_k}}{1 + e^{\beta_0 + \beta_1 X_1 + \beta_2 X_2 + \dots + \beta_k X_k}}$$

$$\log\left(\frac{P}{1 - P}\right) = \beta_0 + \beta_1 X_1 + \beta_2 X_2 + \dots + \beta_k X_k$$

$$\logit(P) = \beta_0 + \beta_1 X_1 + \beta_2 X_2 + \dots + \beta_k X_k$$

where:

- P is the probability that Y=1 (e.g., good health or a specific living arrangement).
- β_0 is the intercept.

- The coefficients for the following are: $\beta_1, \beta_2, \dots, \beta_k$

Reference point

OD = explanation of Odds ratio comparing with other variables (from 1.00).

The correlation between an exposure and an outcome is measured by the odds ratio (OR). In comparison to the odds of the event occurring without that exposure, it shows the likelihood that an outcome will occur given a specific exposure.

The ratio for a given independent variable X_i is calculated as: $OR_i = e^{\beta_i}$

- An odds ratio of 1 ($OR_i = 1$) means that the independent variable X_i does not affect.
- If the odds ratio ($OR_i > 1$) is larger than 1, it indicates that there is a higher probability of the outcome for the independent variable X_i .

If the odds ratio ($OR_i < 1$) is less than 1, it indicates that there is a reduced probability of the outcome for the independent variable X_i .

Table 6.1: Result of Logistic regression model of elderly care of Dalit people

| Covariate | N | Odds Ratio | Chi-square | Df | P value | Nagelkerke R Square |
|--|-----|------------|------------|----|---------|---------------------|
| Omnibus Test of Model Coefficients | - | - | 20.316 | 6 | 0.002 | 0.112 |
| Social Security Allowance (Ref. No) N=240 | | | | | | |
| Yes | 230 | 0.460 | - | 1 | 0.347 | - |
| Marital Status (Ref. Other) N=240 | | | | | | |
| Currently Married | 170 | 0.259 | - | 1 | 0.000 | - |
| Education (Ref. Illiterate) N=240 | | | | | | |
| Literate | 78 | 1.482 | - | 1 | 0.215 | - |
| Type of Family (Nuclear Family) N=240 | | | | | | |
| Joint Family | 114 | 0.872 | - | 1 | 0.633 | - |
| Sex (Ref. Male) N=240 | | | | | | |
| Female | 127 | 1.298 | - | 1 | 0.371 | - |
| Age | 240 | 0.988 | - | 1 | 0.554 | - |

Table 6.2 reveals that the logistic regression model examines the relationship between several covariates and a binary result.

The model is statistically significant overall, indicating that at least one of the variables is significantly connected to the outcome, according to the omnibus test of model coefficients, which has a p-value of 0.002, 6 degrees of freedom, and a Chi-square value of 20.316.

The Nagelkerke R Square value of 0.112 indicates that the model explains approximately 11.2% of the variability in the result.

For the respondent covariates, those receiving a social security allowance have lower odds of the result (Odds Ratio = 0.460), but this effect is not statistically significant ($p = 0.347$).

Currently, married respondents have significantly lower odds of the result (Odds Ratio = 0.259), and this effect is statistically significant ($p = 0.000$).

Literate respondents have higher odds of the result (Odds Ratio = 1.482), but this effect is not statistically significant ($p = 0.215$).

Respondents from joint families have slightly lower odds of the result (Odds Ratio = 0.872), but this effect is not statistically significant ($p = 0.633$).

Females have higher odds of the result (Odds Ratio = 1.298), but this effect is not statistically significant ($p = 0.371$). Age has a very small effect on the odds of the result (Odds Ratio = 0.988), and this effect is not statistically significant ($p = 0.554$).

In conclusion, the logistic regression model identifies marital status as the only statistically significant predictor of the result, with currently married respondents having significantly lower odds of the result. While the overall model is significant, it explains a modest portion of the variability in the result (Nagelkerke R Square = 0.112). Other covariates, including social security allowance, education, type of family, sex, and age, do not show statistically significant effects on the result.

Table 6.2: Logistic regression of Physical Health Problems among Dalit elderly

| Covariate | N | Odds Ratio | Chi-square | Df | P value | Nagelkerke R Square |
|--|-----|------------|------------|----|---------|---------------------|
| Omnibus Test of Model Coefficients | - | - | 11.279 | 6 | 0.080 | 0.088 |
| Social Security Allowance (Ref. No) N=240 | | | | | | |
| Yes | 230 | 4.168 | | 1 | 0.999 | |
| Marital Status (Ref. Other) N=240 | | | | | | |
| Currently Married | 170 | 2.260 | - | 1 | 0.118 | - |
| Education (Ref. Illiterate) N=240 | | | | | | |
| Literate | 78 | 1.069 | - | 1 | 0.877 | |
| Type of Family (Nuclear Family) N=240 | | | | | | |
| Joint Family | 114 | 0.490 | | 1 | 0.92 | |
| Sex (Ref. Male) N=240 | | | | | | |
| Female | 127 | 0.764 | | 1 | 0.517 | |
| Age | 240 | 0.950 | | 1 | 0.121 | |

The logistic regression model provided examines the relationship between various covariates and a binary result.

According to the omnibus test of model coefficients, the model is not statistically significant overall, with a Chi-square value of 11.279 with 6 degrees of freedom and a p-value of 0.080.

Nagelkerke R Square value of 0.088 suggests that the model explains about 8.8% of the variability in the result.

Among the respondents covariates, having a social security allowance (Odds Ratio = 4.168) is not statistically significant ($p = 0.999$).

Being currently married (Odds Ratio = 2.260) shows a trend towards significance ($p = 0.118$), but is not statistically significant.

Education (being literate) has an odds ratio of 1.069 with a p-value of 0.877, indicating no significant effect.

Living in a joint family (Odds Ratio = 0.490) is not statistically significant ($p = 0.920$).

Female sex (Odds Ratio = 0.764) and age (Odds Ratio = 0.950) also do not have significant effects, with p-values of 0.517 and 0.121, respectively. Overall, none of the respondents covariates show statistically significant effects on the result in this model.

Table 6.3: Logistic regression of the analysis factors affecting well-being status among Dalit elderly.

| Covariate | N | Odds Ratio | Chi-square | Df | P value | Nagelkerke R Square |
|------------------------------------|-----|------------|------------|----|---------|---------------------|
| Omnibus Test of Model Coefficients | - | - | 28.151 | 6 | 0.000 | 0.212 |
| SSA (Ref. No) | | | | | | |
| Yes | 230 | 3.884 | | 1 | 0.999 | |
| Marital Status (Ref. Other) | | | | | | |
| Currently Married | 170 | 3.342 | - | 1 | 0.997 | - |
| Education (Ref. Illiterate) | | | | | | |
| Literate | 78 | 0.769 | - | 1 | 0.571 | |
| Type of Family (Nuclear Family) | | | | | | |
| Joint Family | 114 | 0.655 | | 1 | 0.313 | |
| Sex (Ref. Male) | | | | | | |
| Female | 127 | 0.684 | | 1 | 0.371 | |
| Age | 240 | 0.964 | | 1 | 0.248 | |

Results Explanation:

The logistic regression model provided assesses the impact of several covariates on a binary outcome, the condition of physical health problems among Dalit elderly people.

Overall Model Significance:

The model is statistically significant overall, as shown by the omnibus test of model coefficients, which produces a Chi-square value of 28.151 with 6 degrees of freedom and a p-value of 0.000.

The model appears to explain 21.2% of the variation in the result, according to the Nagelkerke R Square value of 0.212.

Individual Covariates:

Social Security Allowance (SSA): The odds ratio is 3.884, but it is not statistically significant ($p = 0.999$).

Marital Status (Currently Married): The odds ratio is 3.342, which is also not statistically significant ($p = 0.997$).

Education (Literate): The odds ratio is 0.769, not statistically significant ($p = 0.571$).

Type of Family (Joint Family): The odds ratio is 0.655, not statistically significant ($p = 0.313$).

Sex (Female): The odds ratio is 0.684, not statistically significant ($p = 0.371$).

Age: The odds ratio is 0.964, not statistically significant ($p = 0.248$).

In summary, while the model as a whole is statistically significant, none of the respondent covariates show statistically significant effects on the condition of physical health problems among Dalit elderly people.

CHAPTER SEVEN

SUMMARY, RESULTS, DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

7.1 Summary

All things in the earth, whether they are living or not, age over time. This is nature's universal law. All living things, including humans, inevitably age with the passage of time. In terms of demographics, ageing is simply the process of becoming older. The older population is becoming increasingly difficult to care for due to the dispersion of family members, which has caused the collapse of the large family and changed women's roles and status. The elderly can't manage their land and housing activities because young family members are moving from rural to metropolitan areas or overseas more frequently than they used to. This study is focused on factors influencing the elderly well-being of Dalits elderly in Shivasatakshi Municipality, Jhapa district in Koshi Province of Nepal.

7.1.1 Major Findings

i. Results of the socioeconomic and demographic analysis of senior Dalits

Total 240 respondents comprising with 113 (47.1%) males and 127 (52.9%) females, the highest proportion of respondents were 31 percent of age groups 60-64 and 65-69 with 28.3 percent, 70-74 with 23.4 percent and 75+ with 17.5 percent. Approximately (71%) of the elderly were married at the time, with 29% being widows or widowers. 5.42 percent of respondents identified as Christian, and nearly 95 percent of respondents identified as Hindu. The largest category, comprising 167 individuals (70%), includes BK/Kami and Sunuwar communities, 40 individuals (17%) belong to the Pariyar/Dami and Darji groups, Sarki, Harijan/Chamar communities represent 23 individuals (10%), and a smaller group consisting of Hajam/Thakur, Gayak, and Gandarva totals 10 individuals (4.17%). More than 68 percent of respondents were illiterate. Agriculture accounted for the primary household occupation for over (96%) of the respondents. Approximately (50%) of respondents were part of a nuclear family, (48%) were part of a combined family, and (3%) were single. More than 77.1 percent of respondent's source of income elderly allowances, 18.8 percent agriculture, 2.1 percent pension and 2.1 percent of respondents source of income others. Approximately 83 percent of respondents had a monthly income of less than Rs. 1,000, 15.4 percent had a

monthly income between Rs. 1,000 and Rs. 2,500, and 1.7 percent had a monthly income between Rs. 5000 and Rs. 7500 or more.

ii. Findings of the variables influencing the well-being of senior Dalit people

Only 38percent of respondents live with their spouse, 53 percent with their son or daughter-in-law, 4 percent with their daughter or son-in-law, 5.0 percent by themselves, and 0.8 percent with other family members. Total 176 respondents (73.3%) responded "Yes," and 64 respondents (26.7%) responded "No" . All age groups and sexes, 73.8 percent said "Good," 24.2 percent said "Better," and 2.1 percent said "Best". All age groups and male and female 32.0 percent of elderly respondents expect protection, 27.5 percent seek respect, 12.5 percent desire financial support, 20.0 percent wish for delicious food, 7.5 percent want to travel to holy places, and 0.5 percent have no expectations. Around 229 respondents (95.4%) having physical health problems, and 11 respondents (4.6%) not having them. Gastric problems are prevalent among (74.6%) of respondents. The highest issue is depression, affecting (88.6%) of respondents, followed closely by loneliness/anxiety at (87.7%). Insecurity/boredom is also prevalent, affecting 56.8% of respondents. Loss of memory power is reported by (18.6%) of respondents, while mental disorders affect (10.5%). The majority of respondents (81.7%) receive treatment at government hospitals and smaller percentage (7.9%) for treatment at private clinics. The major findings of various health conditions among the respondents, highlighting the diversity of health challenges faced by respondents.

iii. Analysis of the elements influencing the well-being condition of Dalit elderly

The logistic regression models that examine the correlation between different variables and physical health issues in older Dalit individuals. The omnibus test shows that the model is not statistically significant overall, with a Chi-square value of 11.279 with 6 degrees of freedom and a p-value of 0.080. With a Nagelkerke R Square of 0.088, the model can account for (8.8%) of the variation in the outcome. None covariates, including social security allowance, marital status, education, type of family, sex, and age, show statistically significant effects. Comparatively, the model presented is statistically significant overall, accounting for (21.2%) of the variability with a Nagelkerke R Square value of 0.212, 6 degrees of freedom, a p-value of 0.000, and a Chi-square value of 28.151. However, individual covariates in this model, such as social security allowance, marital status, education, type of family, sex, and age, also do not show statistically significant effects on the condition of physical health problem.

7.2 Discussion

The study showed that age is associated with poor health of elderly people which is consistent with the findings of Kumar & Kumar, (2012). It is universal that people in old age become fragile because of the wear and tear theory of the body. Thus, the elderly in Nepal need health promotion for better life expectancy. Furthermore, compared to men, women are less likely to be in good health, according to this study. Similar settings showed that women were more likely than males to report poor self-reported health status and to have a higher prevalence and incidence of impairment at older ages (Sharma, 2022; Alexander et al., 2012). Women in Asian countries were restricted in physical activities in ancient times which behavior is still handed over to current generations. Hence, promoting fitness programs for women and gender equity activities are still necessary to plan out.

Nevertheless, the study evidenced that elderly women are more likely to have less assets, lack of knowledge of social security scheme and lesser allowance. This evidence is supported by a similar study in which the absence of work invariably increased the chances of reporting poor health in comparison to working in the formal sector which is supported by the study of Kwon et al., (2016). Similarly, a small number of worldwide research have discovered a strong correlation between self-rated health and working past retirement. Consequently, job and professional responsibilities may contribute to the preservation of older individuals' sense of self-worth, community, and belonging, all of which have a significant impact on their health (Palladino et al., 2016).

In this study, knowledge of the importance of fruits, fresh and green vegetables and drinking habit of milk were revealed to be associated with the elderly's health status. The results are corroborated by Lee & Frongillo's (2001) study, which showed a link between low self-reported health status and food insecurity. As a result, older adults who experience food insecurity run the risk of having worse nutritional and health outcomes, regardless of the cause. In a similar vein, fostering good health throughout a person's life is crucial to ensuring their well-being as they age. Inadequate healthcare facilities, inadequate financial assistance, unstable socioeconomic conditions, and carelessness are prevalent issues faced by Bangladesh's elderly population (Gonzalez et al., 2020).

7.3 Conclusions

Aging is an inevitable process affecting all living beings, posing unique challenges for the elderly. This study focuses on the well-being among Dalit elderly in Shivasatakshi Municipality, Jhapa district, Nepal, highlighting how family dispersal and youth migration complicate elderly care. Among 240 respondents, a majority are married Hindus, predominantly illiterate, and engaged in agriculture, with most living in nuclear or joint families. Common health issues include gastric problems, depression, and loneliness, with most relying on government hospitals for treatment. Logistic regression analysis reveals no significant impact of social factors on physical health problems, underscoring the need for targeted interventions to address socio-economic and health disparities among the Dalit elderly. Among the several variables interlinked with health problems of elderly Dalits, social security allowance, marital status, education, family type, sex, and age, showed statistically significant effects on physical health problems in either model. According to the social and healthcare status of female elderly individuals in the study area is notably poorer compared to their male counterparts, highlighting a critical need for targeted interventions and support systems tailored to address these disparities. A number of factors, including illiteracy, poor access to sanitary facilities and safe drinking water, limited income opportunities, large family sizes, and a lack of knowledge about government health support programs and specialized elderly care services offered by Mechi district hospitals, have combined to create a major obstacle to the social and health care status of the elderly. Addressing these barriers through targeted policies and community-based interventions is essential to improving the overall well-being and quality of life for Dalit elderly people living in Shivasatakshi Municipality.

7.4 Recommendations

Elderly people are the nation's asset and source of pride. An inevitable stage of life is old age. It is the final stage of a person's existence. They contribute to our societies. The younger generation can learn from and absorb (adopt) from their wealth of experience. However, individuals of our current generation and family frequently overlook and disregard them. The life expectancy of senior citizens is rising steadily due to technology, improved healthcare facilities, and other factors. Although more continuity is a wonderful human achievement, it has raised expectations for the support and care of senior Dalit citizens.

The study's conclusions have guided the creation of the policy suggestions. The senior population in the research area would have better social and health conditions if these recommendations were put into practice along with the necessary policy modifications. The following are the main policy recommendations:

- i. Implement a policy for issuing travel, health cards for free treatment, old age homes for childless and poor elderly individuals for senior citizens.
- ii. Implement awareness programs about special health treatment schemes through government and non-government organizations.
- iii. Initiate income-generating activities or poverty reduction programs for the elderly in the study area to improve their economic condition.
- iv. Introduce Gerontology in higher education and include elderly care topics in school curricula.
- v. Increase the elderly allowance from Rs. 1000 to Rs. 2000 per month and ensure periodic revisions to meet their necessities

7.5. Areas of Further Research

This study uses a subset of socioeconomic and demographic factors to examine the social and health care conditions of the elderly in the Shivasatakshi Municipality area of Jhapa district. Today's world faces significant challenges related to aging in both developed and poor nations. Therefore, a wide range of topics related to aging require more study. There are also so many researchable issues regarding the area of ageing. Some of the areas suggested for future research are as follows:

Utilize elderly knowledge, skills, and experience for community development.

- i. Assess the effectiveness of government social security allowances for elderly people.
- ii. Formulate strong monitoring and evaluation mechanisms for free healthcare services to bridge the gap between policy and delivery.
- iii. Address high socio-religious diversion among elderly in socially deprived ethnic groups due to poverty by creating effective monitoring and evaluation for poverty eradication programs and a unified delivery system.
- iv. Conclude that family members are the best caretakers for the elderly, necessitating policies to strengthen the family support.

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APPENDICES

1. Name List of Dalit

Hill Dalits: Gandarbha (Gaine), Pariyar (Damai, Darjee, Suchikar, Nagarchee, Dhole, Hudke), Badi, Bishowkarma (Kami, Lohar, Sunar, Od, Chunara, Parki, Tamata), Mijar (Sarki, Charmakar, Bhool), Pode (Deula, Pujari, Jalari) and Chyame (Kuchikar, Chyamkal)

Tarai Dalits: Kalar, Kalkahia, Kori, Khatik, Khatwe (Mandal, Khang) Chamar (Ram, Mochi, Harijan, Ravidas), Chidimar, Dom (Marik), Tamta (Tandi, Das), Dushadh (Paswan, Hajara), Dhobi (Rajak, Hindu), Pasi Bantat, Musahar, Mestar (Halkhor) Sarbhang (Sarbariya), Natuwa, Dhandi and Dharikar/Dhankar.

1. QUESTIONNAIRE

INTERVIEW SCHEDULE

**Socio-economic and health status of elderly Dalits
In Shivasatakshi Municipality area of Jhapa District
Household Questionnaire**

Respondent's Name: **Age:** **Sex:**
Name of the household head : **Religion:**
Municipality: **Ward No:** **Marital status:**
House No: **Date:** **Education:**
Family Size **No of Male:** **No of Female:** **Total family size:**
Highest level of education completed by a family member:

Major household occupation:

Level of household income: (see the code of 602)

Possessing of agricultural land: 1. Yes 2. No

If yes, size of agricultural land owned/occupied by household:

Codes

| Marital Status | Religion | Education | Occupation |
|-----------------------|---------------|--------------------|------------------------|
| 01= Never married | 01= Hindu | 01= Illiterate | 01= Unemployment |
| 02= Currently/married | 02= Bouddha | 02=Non-formal | 02= Student |
| 03= Widow/Widower | 03= Christian | education | 03= Business |
| 04= Divorced | 04= Islam | 03= Primary (1-5) | 04= Government service |
| 05= Separated | 5= Kirat | 04=Secondary(6-10) | 05= Non-Governmental |
| 06= Other | 06=Other | 05=Intermediate | service |
| | | 06= Bachelors | 06=Foreign Employment |
| | | 07=Masters and | 07=Agriculture |
| | | above | 08= Industries |

| Q.N | Questions and Filters | Coding categories | Skip |
|-------|--------------------------------------|---|------|
| 101 | Caste group of respondents | a.B.K,Sunar,Ramdam.....1 b.Pariyar, Darji.....2 c.Nepali, Sarki, Harijan.....3 d. Gayak, Gandarva.....4 | |
| 102 | Is this the nuclear or joint family? | a. Nuclear.....1 b. Joint.....2 c.Living alone Family.....3 | |
| 103 | Who decided the following things? | | |
| 103.1 | Division of household labour | a.Self.....1 b.Spouse.....2 c.Son/Daughter in- law.....3 d. Daughter/Son in- law.....4 e. Grand Children.....5 f. Other.....6 | |
| 103.2 | Marriage of Offspring | a. Self.....1 b. Spouse.....2 c. Son/Daughter in- law.....3 d. Daughter/Son in- law.....4 e. Grand Children.....5 Other.....6 | |
| 103.3 | Selling and buying of valuable goods | a. Self.....1 b. Spouse.....2 c. Son/Daughter in- law.....3 d. Daughter/Son in- law.....4 e. Grand Children.....5 f. Other.....6 | |
| 103.4 | Important family ceremony | a. Self.....1 b.Spouse.....2 c.Son/Daughter in- law.....3 d.Daughter/Son in- law.....4 | |

| | | |
|--|------------------------|--|
| | e.Grand Children.....5 | |
| | f.Other.....6 | |

Living Arrangement

| Q.N | Questions and Filters | Coding categories | Skip |
|------------|---|--|-------------|
| 201 | How do you settled in this house? | a. Owner.....1 b. Rent.....2 c. Dan/chanda.....3 d. Relatives house.....4 e. Other.....5. | |
| 202 | To whom do you live now? | a.Spouse.....1 b.Son/Daughter in- law.....2 c.Daughter/Son in- law.....3 d.Brother.....4 e.Other relatives.....5 f.Alone.....6 g.Other.....7 | |
| 203 | Do you satisfied with present live? | a.Yes.....1 b. No.....2 | 305 |
| 204 | To whom do you wish to live? | a. Alone.....1 b.Son/Daughter in- law.....2 c. Daughter/Son in- law.....3 d. Religious institution.....4 e. Elderly homes.....5 f. Husband/wife.....6 g. Other.....7 | |
| 205 | Do you depend upon your offspring? | a. Yes.....1 b.No.....2 | |
| 206 | What is the level of care from your family? | a.Good.....1 b.Better.....2 c. Best.....3 D.worst.....4 | |
| 207 | How do you usually spend your day? | a.Religious activity.....1 b.Yoga.....2 | |

| | | | |
|--|--|--|--|
| | | c.Reading/listening news.....3 d.Working inside home.....4 e.Care of grand children.....5 d.Visiting temple/church.....6 e.Meeting peer group.....7 f.Talking with family members...8 | |
|--|--|--|--|

Family care system

| Q.N | Questions and Filters | Coding categories | Skip |
|-----|---|---|------|
| 301 | Who takes care of you? | a.Nobody.....1 b.Spouse.....2 c.Son/Daughter in- law.....3 d.Daughter/Son in- law.....4 e.Grand Children.....5 f.Other relatives.....6 g.Other(specify).....7 | |
| 302 | What is the level of care? | a.Best.....1 b.Good.....2 c.Satisfactory.....3 d.Worst.....4 | |
| 303 | In your opinion, what is the condition in practice of elderly care? | a.Same as earlier.....1 b.Better than earlier.....2 c.Worst than earlier.....3 | |

Involvement in social sector

| Q.N | Questions and Filters | Coding categories | Skip |
|-----|--|---------------------------|------|
| 401 | Do you involve in any elderly club/group? | a.Yes.....1 b.No.....2 | |
| 402 | Do you involve in any caste/ethnic institution? | a.Yes.....1 b.No.....2 | |
| 403 | Do you involve in any political institution/party? | a.Yes.....1 b.No.....2 | |
| 404 | Do you involve in any social organization/institution? | a.Yes.....1 b.No.....2 | |

Stigma of untouchability

| Q.N | Questions and Filters | Coding categories | Skip |
|-----|--|---|------|
| 501 | Do you feel the stigma of untouchability? | a.Yes.....1 b.No.....2 | |
| 502 | Did you ever experience the incident of untouchability? | a.Yes.....1 b.No.....2 | |
| 502 | What are the areas of untouchability? (Multiple responses possible) | a.Temple.....1 b.Home/kitchen.....2 c.School.....3 d.Party.....4 e.Religious ceremony.....5 f.Tap/well.....6 | |
| 503 | In your opinion, what is the condition of untouchability at present? | a.Same as earlier.....1 b.Less than earlier.....2 c.More than earlier.....3 d.No untouchability at all.....4 | |
| 504 | Do you feel the untouchability within the dalits? | a.Yes.....1 b.No.....2 | |

Information on Economic Status

| Q.N | Questions and Filters | Coding categories | Skip |
|-----|--|--|------|
| 601 | What is your Personal source of income? (Multiple responses possible) | a.Trade.....1 b.Investment/share.....2 c.Dan/chanda.....3 d.Aged allowance.....4 e.Agriculture.....5 f.Pension.....6 g.Other.....7 | |
| 602 | What is your income per month in Rs? | a.Less than Rs. 1000.....1 b.Rs.1000 – 2500.....2 c.Rs. 2500 – 5000.....3 d.Rs. 5000 – 7500.....4 e.Rs. 7500 – 10000.....5 f.Rs. | |

| | | |
|--|--------------|--|
| | 10000+.....6 | |
|--|--------------|--|

| Q.N | Questions and Filters | Coding categories | Skip |
|-----|---|--|------|
| 603 | What is your property ownership? (Multiple responses possible) | a.House.....1 b.Land.....2 c.House and land.....3 d.Cash.....4 e.Bank balance.....5 f.Ornaments.....6 g.Investment.....7 h.Other.....8 | |
| 604 | Who takes the responsibility for your special expenditure? | a.Spouse.....1 b.Son/Daughter in- law.....2 c.Daughter/Son in- law.....3 d.Grand hildren.....4 e.Other relatives.....5 f.Institution.....6 g.Other.....7 | |
| 605 | How do you support mainly in your home? | a.Counseling.....1 b. Skill providing.....2 c.Physical labor.....3 d.Provide cash.....4 e.Technical knowledge.....5 f.Household activities.....6 g.Other.....7 h.None.....8 | |
| 606 | Do you engage in any economic activity at present? | a.Yes.....1 b.No.....2 | |
| 607 | If yes, what is your current occupation? | a. Business.....1 b. Non-Governmental service....2 c.Foreign Employment.....3 d.Agriculture.....4 e. Industries.....5 | |

| | | | |
|-----|--|---|-------------------------------|
| 608 | If no, what is your past occupation? | a.Business.....1 b.Governmental servic.....2 c. Non-Governmental service....3 d.Foreign Employment.....4 e.Agriculture.....5 f. Industries.....6 | |
| 609 | Do you take elderly allowance? | a.Yes.....1 b.No.....2 | 613 |
| 610 | How do you receive elderly allowance? | a.From Ward office.....1 b.In home2 c.NGO's.....3 d.Family member.....4 e.From bank.....5 f.Other.....6 | |
| 611 | How much allowance do you receive per month? | a.Rs.300.....1 b.Rs.500.....2 c.Rs.1000.....3 | |
| 612 | What do you do from your allowance? (Multiple responses possible) | a.Expense for own..... 1 b.Own medical expense..... 2 c.Buying grains.....3 d.Buying clothes.....4 e.Education for grand children...5 f.House hold expenses.....6 g.Other (specify).....7 | For all options go to Q.N.614 |
| 613 | Why don't you receive the aged allowance? | a.Lack of citizenship certificate...1 b.No one helped me.....2 c.Unknown.....3 d.Not necessary.....4 e.Other.....5 | Go to Q.N.701 |
| 614 | Is your allowance adequate to fulfill your basic needs? | a.Yes.....1 b.No.....2 | |

Information on Health Status

| Q.N | Questions and Filters | Coding categories | Skip |
|-------|---|---|------|
| 701 | How do you feel your health situation comparing your counterparts? | | |
| 701.1 | Ability of vision | a. better than peer friend...1 b. Same as peer friend.....2 c. weak than peer friend.....3 | |
| 701.2 | Ability of hearing | a. better than peer friend...1 b. Same as peer friend.....2 c. weak than peer friend.....3 | |
| 701.3 | Memory power | a. better than peer friend...1 b. Same as peer friend.....2 c. weak than peer friend.....3 | |
| 701.4 | Moving ability | a. better than peer friend...1 b. Same as peer friend.....2 c. weak than peer friend.....3 | |
| 701.5 | Physical power | a. better than peer friend...1 b. Same as peer friend.....2 c. weak than peer friend.....3 | |
| 701.6 | Smelling power | a. better than peer friend...1 b. Same as peer friend.....2 c. weak than peer friend.....3 | |
| 701.7 | Reading and writing ability | a. better than peer friend...1 b. Same as peer friend.....2 c. weak than peer friend.....3 | |
| 702 | How do you feel about not taking care of yourself by family and society? | Not taking care, very much1 Not taking care, in some extent ...2 No feeling about not taking care..3 Do not know4 Not stated5 | |
| 703 | In the past 12 months, have you experienced disrespectful behavior? | Yes1 No2 | |

| | | | |
|-----|--|--|--|
| | | Not stated3 | |
| 704 | Who did the disrespectful behavior? <i>(Instruction: Multiple answers possible)</i> | Son/Daughter1 Spouse2 Friends3 Unknown person4 Office staff5 Health workers6 Community/neighbour7 Other (specify)8 | |
| 705 | In your opinion, what gives you pleasure, happiness and joy in old age? <i>(Instruction: Multiple answers possible)</i> | Family support1 Financial support2 Spiritual feelings3 Better personal health4 Own property5 Respect/honor6 Other (specify)7 | |
| 706 | In your own opinion, what cause sadness at old age? <i>(Instruction: Multiple answers possible)</i> | Physical disability1 Financial crisis2 Loneliness3 Neglected4 Isolated5 Hatred6 Other (specify)7 | |
| 707 | What according to you is your main security concern? | Physical security1 Health concerns2 Family security3 Financial security4 Psycho-social security5 | |

| Q.N | Questions and Filters | Coding categories | Skip |
|-----|---|-----------------------------|----------------|
| 708 | Do you have any physical health problems? | a. Yes.....1 b. No.....2 | 707 |
| | Types of Diseases | If yes has it | Since how long |
| | | | Are you |

| | | Yes.....1 No.....2 (go to next diseases) | been diagnosed by doctor or other health worker? Yes.....1 No.....2 | are you having this health problem? Less than 1 year.....1 1 – 5 yrs....2 6 – 10 yrs...3 11yrs Over..4 | taking regular medicine for it? Yes...1 No....2 |
|-----|---|---|---|---|--|
| | | (703) | (704) | (705) | (706) |
| 1. | Physical pain (joints, knee, back, stomach pain etc) | | | | |
| 2. | Respiratory diseases | | | | |
| 3. | Blood pressure | | | | |
| 4. | Sugar/diabetes | | | | |
| 5. | Gastric | | | | |
| 6. | Asthma/bath | | | | |
| 7. | Heart diseases | | | | |
| 8. | Teeth problem | | | | |
| 9. | Kidney/urinary problem | | | | |
| 10. | Uric acid | | | | |
| 11. | Cholesterol | | | | |
| 12. | Delivery/pregnancy related(for female only) | | | | |
| 13. | HIV/AIDS | | | | |
| 14. | Cancer | | | | |
| 15. | Prostate gland problem(for male only) | | | | |

| | | | | | |
|-----|--------------------------|--|--|--|--|
| 16. | Others (specify)..... | | | | |
|-----|--------------------------|--|--|--|--|

| Q.N | Questions and Filters | Coding categories | Skip |
|-----|--|--|------|
| 709 | Where do you go usually for treatment when you become sick? | a. Treatment at home.....1 b. In home with doctor.....2 c. Hospital.....3 d. private clinic.....4 e. Dhama/Jhankri.....5 f. Other.....6 | |
| 709 | Who does manage for your treatment? | a. Self.....1 b. Husband/wife.....2 c. Son/Daughter in- law.....3 d. Daughter/Son in- law.....4 e. Other relatives.....5 f. Religious institution.....6 g. Other.....7 | |
| 710 | Do you get discount from the private hospital in your treatment? | a. Yes.....1 b. No.....2 c. Don't know.....3 | |
| 711 | Do you know, the Government provides (the maximum amount) Rs.4000 Yearly (in 2 installment) for elderly health care? | a. Yes.....1 b. No.....2 | 713 |
| 712 | If yes, had you ever initiate to get that amount? | a. Yes.....1 b. No.....2 | |
| 713 | Have you ever had such health care facility? | a. Yes.....1 b. No.....2 | |
| 714 | In your opinion, what type of health services are needed to elderly from government side? (Multiple responses possible) | a. Paying cash.....1 b. Mobile camp.....2 c. Free treatment.....3 d. Free health check up.....4 e. Health awareness.....5 | |

| | | | |
|-----|--|---|---|
| | | f. Geriatric ward in government hospital.....6 g. Other.....7 | |
| 715 | Do you have any mental health problem? <i>(Definition: mental health problems refers to feeling of insecurity, boredom, loneliness, stress, neglect and depression)</i> | Yes1 No2 | → |
| 716 | Do you have any mental health problem? | insecurity.....1 boredom,2 loneliness,3 stress,.....4 neglect.....5 depression.....6 others.....7 | |
| 717 | If yes, what kind of problem or anxiety do you feel? <i>(Instruction: Multiple answers possible)</i> | Economic insecurity1 Deficiency in social relation....2 Dissatisfaction with old age... 3 Deficiency in interested activities..4 Fear of future..... 5 Fear with death..... 6 Dissatisfaction with family environment.....7 Dissatisfaction with the behavior of family members..... 8 Other (specify)9 | |
| 718 | Do you feel any problem of mental torture in the family? | Yes1 No2 | |
| 719 | In your opinion, how can community/society manage for adequate care of the elderly? | Establish of clubs1 Establish of day care center2 Provision of entertainment3 | |

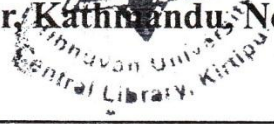
| | | | |
|-----|--|---|--|
| | <p><i>(Instruction: Multiple answers possible)</i></p> | <p><i>Bhajan/Mandali</i>4 Establish of medication center ..5 Establish of community health center.....6 Establish of legal advocacy center.....7 Geriatric ward8 Free clinic9 Mobile health camp10 Family health insurance system11 Other (specify)12</p> | |
| 720 | <p>Who do you stay with mostly at your leisure time?</p> | <p>Spouse1 Son2 Daughter3 Grand children4 Relatives5 Neighbour6 Other (specify)7</p> | |



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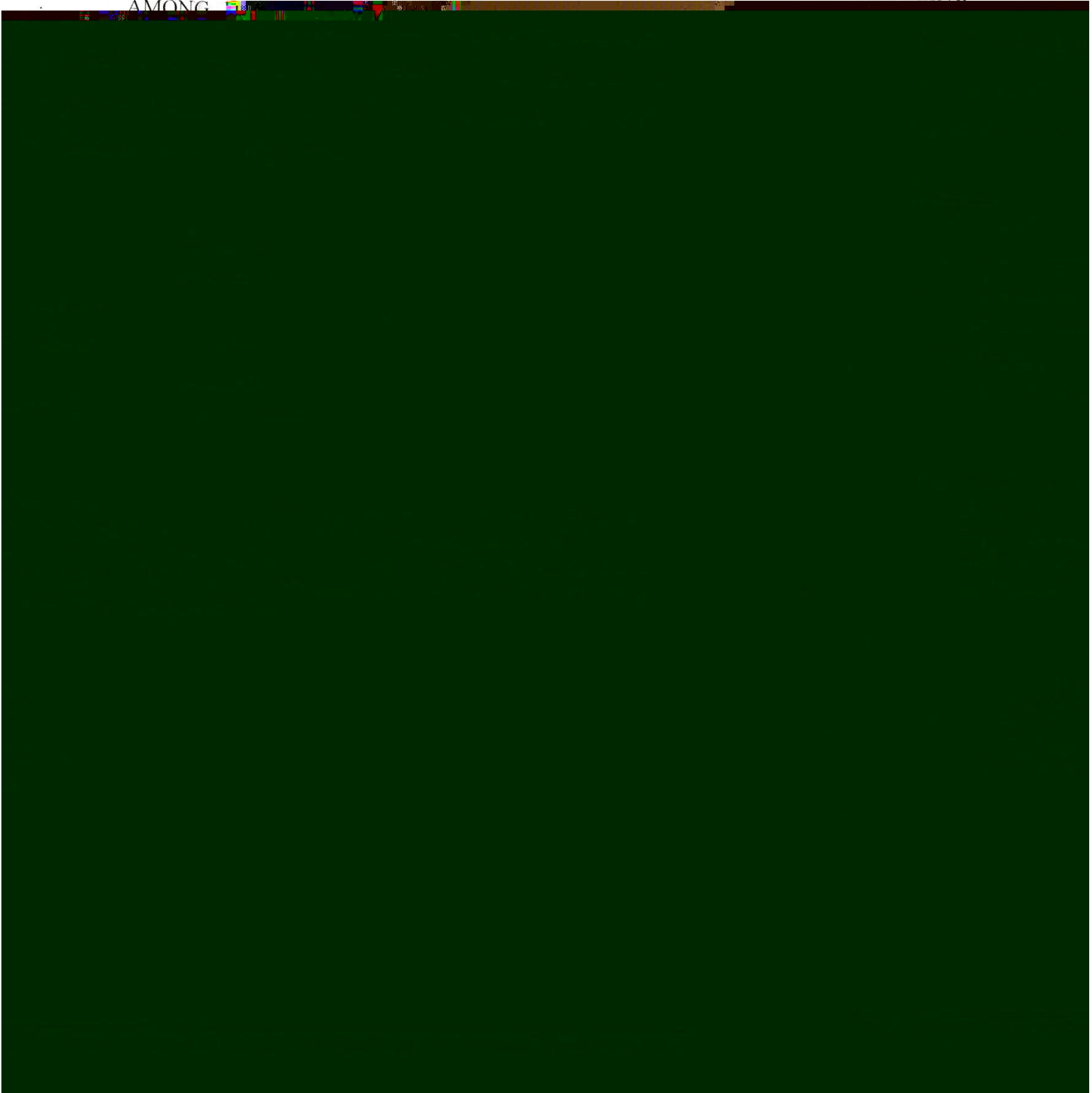


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SOCIO-ECONOMIC FACTORS INFLUENCING WEL-BEING AMONG DALIT ELDERLY (A Study of Shivsatakshi Municipality of Jhapa District) A thesis Submitted to The Central Department of Population Studies (CDPS) Faculty of Humanities and Social Sciences Tribhuvan University (TU) In Fulfillment of the Requirements for the Degree of Master of Philosophy in Population Studies BY SARITA BISTA Reg. No.: 9-2-245-100-2003 July2024 DECLARATION The study in this thesis is my own original research, unless stated otherwise in the text. Sarita Bista July 2024 ii RECOMMENDATION This is to certify that the thesis Submitted by Sarita Bista Entitled SOCIO-ECONOMIC FACTORS INFLUENCING WEL-BEING AMONG DALIT ELDERLY (A Study of Shivsatakshi Municipality, Jhapa District) Is Recommended for External Examination. Prof. Dr. Mahendra Prasad Sharma (Thesis Supervisor) Dr. Bijaya Mani Devkota (Internal Examine Date: July 2024 iii VIVA-VOCE SHEET We have conducted the viva voce examination of the thesis Submitted by Sarita Bista Entitled SOCIO-ECONOMIC FACTORS INFLUENCING WEL-BEING AMONG DALIT ELDERLY (A Study of Shivsatakshi Municipality, Jhapa District) and find that the thesis is an independent work of the student written according to the prescribed format. We accept the thesis as the partial fulfillment of the requirements for a Master of Philosophy in Population Studies. Evaluation Committee: Prof. Dr. Mahendra Prasad Sharma (Thesis Supervisor) Dr. Bijaya Mani Devkota (Internal Examiner) Associate Prof. Dr. Shiva Prasad Khanal (External Examiner) Prof. Dr. Yogendra Bahadur Gurung (Head, Central Department of Population Studies) July 2024 iv ACKNOWLEDGEMENTS I would like to express my sincere gratitude to all those who provided invaluable support and guidance throughout my thesis work. First and foremost, I am deeply grateful to my supervisor, Prof. Dr. Mahendra Prasad Sharma of the Central Department of Population Studies (CDPS), Tribhuvan University (T.U), Kritipur. His constant encouragement, expertise, and guidance were instrumental throughout my research journey. His unwavering support has been a source of immense inspiration. I am also thankful to Prof. Dr. Yogendra Bahadur Gurung, Head of CDPS, T.U., for his valuable suggestions on the study. My appreciation extends to Prof. Dr. Govind Subedi, Dr. Dhanendra Veer Shakya, Dr. Padma Prasad Khatiwada, Dr. Kamala Devi Lamechhane, Dr. Bijaya Mani Devkota, and Mr. Giri Raj Dahal