HEALTH STATUS AND CARING PRACTICE AMONG ELDERLY PEOPLE IN JALJALE VDC, TEHRATHUM DISTRICT, NEPAL:

A THESIS

SUBMITTED TO

THE CENTRAL DEPARTMENT OF POPULATION STUDIES (CDPS), FACULTY OF HUMANITIES AND SOCIAL SCIENCES, TRIBHUVAN UNIVERSITY (TU) IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF ARTS IN POPULATION STUDIES

BY

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DECLERATION

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

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June 2011

RECOMMENDATION

This is to certify that the thesis

Submitted by

Mr. Youba Raj Budathoki

entitled

Health Status and Caring Practice among Elderly People in Jaljale VDC, Tehrathum District, Nepal

is Recommended for External Examination

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26 June 2011 AD

VIVA-VOCE SHEET

We have conducted the viva-voce examination of the thesis
submitted by
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Health Status and Caring Practice among Elderly People in Jaljale VDC, Tehrathum District, Nepal

and find the thesis to be an independent work of the student written according to the prescribed format. We accept the thesis as the partial fulfillment of the requirements for Master of Arts in Population Studies.

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This dissertation entitled *Health Status and Caring Practice among Elderly People Living in Jaljale VDC, Tehrathum District* has been prepared for the partial fulfillment of master degree in Population Studies. This main concern of this study was to examine the health status and caring practice in three ethnic groups (Khas, Janajati and Dalit) by their demographic, social, and economic variables and status of media utilizations in the study area.

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ABSTRACT

Population ageing is an inevitable outcome of the demographic transition of population from high level of fertility and mortality to lower ones and increased in the life expectancy at birth. The proportion of ageing population is increased all over the world. But the share size is higher in developed than developing countries. On the other hand the growth rate of elderly population is higher in developing countries than developed. Similarly, there is different in the process of ageing with respect to modernization and technological diffusion in developed and developing countries respectively.

The study aimed to explore the health status and caring practice among elderly people in Jaljale VDC, Tehrathum district by using primary sources of information obtained from 165 elderly people ages 60 years and above. Among Khas, Janajati and Dalit each ethnic group consisted of 55 respondents on the basis of one respondent from a house. This study examined causal effects of variables considered were grouped as demographic, social, economic and media utilizations. Collected data were coded, recoded, tabulated and generated some indices as: Index of health status and index of caring practice. Selected variables were coded in ordinal scale and tested by Gamma Coefficients to analyze the strength of associations between concerned variables. Following variables were observed to have strong association with health status and caring practice.

Five strong variables in relation to health status of elderly people were: facilities of toilet (-.680 Gamma coefficient), level of income (-.471 Gamma coefficient), family size (-.394 Gamma coefficient), education attainment (.462 Gamma coefficients), and marital status 9.378 Gamma coefficient). Similarly, seven strong variables in relation to caring practice of elderly people were: literacy status (.539 Gamma coefficients), access of television (.-537 Gamma coefficient), self mobile (-.445 Gamma coefficient), family size (.451 Gamma coefficient), radio listeners (-.410 Gamma coefficient), education attainment (.403 Gamma coefficients) and marital status (-.548 Gamma coefficient). Overall scenario of observed variables indicated that among three ethnic communities Khas and Janajati have better positions of health status and caring practice followed by Dalit.

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ACRONYMS

AIDS	: Acquired Immune Deficiency Syndrome
CBS	: Central Bureau of Statistics
CDPS	: Central Department of Population Studies
DDC	: District Development Committee
ESCAP	: Economic and Social Commission for Asia and Pacific
GDR	: Gerontological Dependency Ratio
GOs	: Governmental Organization
HHs	: Households
HIV	: Human Immune Virus
ICPD	: International Conference on Population and Development
INGOs	: International Non-Governmental Organization
LDM	: Local Development Ministry
MDGs	: Millennium Development Goals
MOHP	: Ministry of Health and Population
MoWCSW	: Ministry of Women, Children and Social Welfare
NDHS	: Nepal Demographic Health Survey
NEPAN	: Nepal Participatory Action Network
NGs	: Non-Governmental Organization
NLSS	: Nepal Living Standard Survey
NPC	: National Planning Commission
NRs	: Nepali Rupees
SAARC	: South Asian Association of Regional Cooperation
SLC	: School Living Certificate
SPSS	: Software Programme for Social Science
UN	: United Nations
UNFA	: United Nations Population Fund
VDC	: Village Development Committee
WHO	: World Health Organization

HEALTH STATUS AND CARING PRACTICE AMONG ELDERLY PEOPLE IN JALJALE VDC, TEHRATHUM, NEPAL

CHAPTER ONE
INTRODUCTION

1.1: General Background

Human life ends crossing different stages from birth to death, such as infancy, childhood, adulthood, youth and old age. It is necessary to be clear, elderly population is the outcome of population of ageing. It is a natural process where gradually human being gets disabilities physically and mentally. Ageing is universal which leads to a man to old age or elderly stage, affects individual, family, community and society. In some cases or conditions, ageing and elderly population are taken as same. Actually, ageing and elderly population are closer to each other but they are not exactly the same (Acharya, 2006:79).

For some, ageing progressive attainment of ages of last state of maximum life span of human being, 100 to 110 year as general (Taber's cyclopedia medical dictionary; 1999). For others, ageing is growing older or maturing, progressive changes related to the passage of time. Despite its universality, ageing is difficult to define. Ageing is the ultimate manifestation of biological and demographical activities in individual human being and population at large (Singh, 2003:251).

Ageing in individual is affected to a great extent by genetic factors, social conditions and the occurrences of age related diseases. In addition in there is good evidence that ageing induced alternation in cells is an important component of ageing of the organism. Similarly, in collective sense ageing population means an increase in the share of the elderly peoples in the total population. It is closely related with the dynamic process of demographic and socio-economic transformation, whether a population is young or old or getting older or getting younger. It depends on the proportion of people at different age groups. In general, a population with more than 35 percent under age of 15 years is considered young and population with more 10 percent aged 65 years and above is considered old. In the most of the

countries, person with age of 65 years old and above is taken as an elderly but there is no universal definition of elderly around the world. Some accept elderly above 60 years and other some accept elderly above 65 years. Countries have their own basis for defining ageing, sometimes it is defined by the countries on the basis of their social or economic structure such as some use retirement age or age at which people are eligible for social security benefits. Several age limits have been prescribed for the specific purpose. For example, 58 years is specified for compulsory retirement from civil services, 62 years for UN employees (UN, 1999), and 65 years for constitution bodies (Bisht, 2006) .

The beginning of old age is characterized by the time for which the capacity to do work beings to affected by physical, mental and biological conditions of old age (NEPAN,2003:11). There are various factors that make a person old. Decrease in physical strength, increase in mental tension, decrease in immunity power and getting sick to a large extent are the major features that make a person aged. Elderly people also experience many physical changes. There is gradual drying and wrinkling of skin, decrease in touch feeling and taste sensation, extensive food indigestion, decrease in range of color and intensity of vision, failure of ability to distinguish color, loss of hearing power and weakening immune system with the increase in age people lose their creativity level, problem solving ability and learning skills as well as short term memory.

The decline in fertility levels, reinforced by continued decline in mortality levels, is producing fundamental change in the age structure of population, most notable record increases in proportion and number of elderly person including a growing number of elderly persons. Economic condition of country has been awfully discouraging, even small increase in size of elderly population may bring about an added hardship to already troubled economy (Singh, 2009:2).

There are many concerns and problems of elderly population. The concerned is for their health, diminished social status and insecurities about their importance among other people similarly difficulty in feelings of inadequacy in meeting daily life situations, loss of ability to socialize and elderly have to do service others in any way. In the contest of developed countries, elderly people are sent to nursing home to spend the rest of their lives because old

age has been viewed to be the period of loss of youth vitality and capability. Many retired persons in the developing and develop countries are being employed as supervisors, advisor and the consultants.

1.1.1: The Scene of Nepal

Since the mid of 1970s, the absolute number and volume of elderly population is increasing in Nepal. The census 2001 reported some 6.4 percent male and 6.3 percent female population in the age group of 60 and over. This census figure for males was higher than this estimation and it was observed as quite closer. Therefore, the process of ageing is much faster than anticipated by the social scientists in Nepal. Ageing the estimated figure for 2011 is about 6.6 percent. Again the estimated figure for 2016 is about 6.8 percent , which again would be crossed by observed pace of ageing much earlier and it indicates that problem of ageing would be much sever after a decade (Acharya, 2006:80-81).

The age structure of Nepali population has been changing over the years with a shift towards older ages indicating gradually declined fertility and relatively controlled adult mortality. Political awareness and change in traditional behavior have insisted people to migrate from distant hills and mountains to relatively developed areas where amenities are available. This movement of people has resulted in change food habits, health services seeking behavior, age at marriage, spacing, number of children and overall status of women. These factors contribute to ultimate increase in life expectancy at birth and alteration of age structure up wards with challenges to be addressed for the care of elderly people in Nepal (Acharya, 2006:80).

Ageing is considered as a problem in our society. Old people are even considered as burden for family. Ageing is not a problem if the caring of old people is developed as a social tradition. Caring of elderly people is a welfare scheme that provides meaningful support for the elderly people with a view to make their health physically and mentally sound and to continue the emotional of their life.

Traditionally, Nepalese elderly people are well adjusted in a joint family. In a joint family, all the members are showered with blessing by the elder members of the family. But with modernization, industrialization and urbanization the joint family system tends to break up and nuclear families

are encouraged. Young Nepalese families have begun to spend life away from their parents, grandparents and other elders.

The elderly proportion of population is growing consistently, during the last four decades. The rate of growth of elderly population is much faster than the average growth rate of total population. However, Nepal does not have any system of social security on a national basis. But old age security in the form of pension, provident fund, medical benefits, education and child allowances etc. are available to a small number of people who are either in government services or employed in semi government cooperation and universities. But most of the population is dependent on income from agriculture or other occupations or self government and are not covered by the old age security.

In the context, this study area (Jaljale VDC) was selected to understand the Health Status and Caring Practice among Elderly people who have higher number and proportion. They are living in vulnerable condition that of other age groups population in different aspects, which are necessary for them especially with respect to economic, political, cultural, security, family decision as well as for social security system.

1.2: Statement of the Problem

Elderly people are nation's property and source of knowledge. They had spent their whole life for contribution to family, society and nation. So their knowledge and experience can be very useful for younger generation to learn and adopt; but elderly people are physically and mentally weak. And need a special care.

Madrid convention (2002) focused on inter-generational gap and co-operation to strengthen the status elderly people in family. The increasing nuclear family system especially in urban area does not support this idea, in the one hand, they are supported and respected by saying *'Ago Tapnu Mudako, Kura Sunnu Budako*[1]*'* (Subedi, 1999:105). Father's Day, Mother's Day' etc are celebrated that symbolize the responsibility of younger

[1] A popular proverb in Nepali society - Take the warmth of a huge (old) timber log; and listen to the advises of an elderly person

generation to take care of elderly people in Nepal. On the other hand due to the poverty and social cultural practices elderly people have also faced some problem.

Nevertheless being almost equal in size (6.4 % males vs. 6.3 % females in 2001 (Singh, 2003:263) elderly women are facing more problems comparing to male counterpart. It does not necessarily mean that male elderly are spending respectful and restful life. But the statistics have shown that the working hour for male elderly was higher than female. It was 29.6 hours per week for males and 17.5 hours for females (NLFS, 1998/1999 Cited from Acharya, 2000:95). It is because prior to 2001 censuses the household works were not considered as work, where usually women spend more time in Nepal there is not sufficient social security system and source of own earning. The property having with elderly people should equally divide for sons who have equal rights by law is relevant for a clear understanding of the value of children. At present women have faced different reproductive problems due to high birth at past.

The globalization is another cause for vulnerability of elderly in Nepal. Especially the rural adult migrates to facilitated areas for getting education, employment, marriage, trading and agriculture (KC, 2003). It has developed inequality among in rural area which has raised the question in security system of elderly people in that place. As a result proportion of dependent population of elderly people is increased especially in rural areas in Nepal. In Nepal there were about 74.0 percent elderly people were economically active (Subedi, 1999:113) and they themselves do not want to say dependent for them.

In the context of Nepal, most of elderly persons are involved in general in agricultural occupation, and women in particular all the domestic work as well. Their offspring are busy on their business and other works, then the aged people should deal with problem arrives in household and take care of small children and cattle. Therefore, it is necessary to investigate whether all elderly people work or what is the nature of work, they have to do. In rural areas, there is still joint family system. They are slowly changing to nuclear family system. And most of economically active populations are either go in work. Therefore aged people remain alone and even with physical disabilities, have perform household and agricultural activities. So, it is

necessary to study the condition of aged people in rural areas. Likewise, people living in urban areas are extremely busy and showing growing preference towards nuclear family. It is also important to note that, elderly population from the so-called rich families of the urban areas is too in need of the family members. Most of ageing people have been isolated in their own family. In the other, rural elderly people are utilized in the formulation of semi cottage materials such as "Doko and Namlo".

The study area is one of the rural areas of Nepal. In this study area there seems socio-economic, demographic and health problem of the elderly people. In the past the eldest person particularly male was considered as the head of the family and leader of the community. Now a day's elderly people are considered as the burden of the family, they are neglected, so economic and social security is needed for them. Taking care of old parents has become more a burden then social obligations. Some take care of old parents only to inherit the property. Usually parents also deep their own proportion of the family property. They deep their parents with them only to make sure they leave behind those properties for them to enjoy. The problem of the study area is that they depend on their personal health, employment, socio-economic and demographic status.

1.3: Objectives of the Study

The general objective of this study is to analyze health status and caring practice among the elderly in Kahs, Janajati and Dalit community. However, some of the specific objectives (which are measurable and obtained during the course of study) are as follows;

1. To evaluate health status and caring practice of elderly by demographic variables.
2. To analyze health status and caring practice of elderly by social variables.
3. To examine the health status and caring practice of elderly by economic variables.
4. To examine the health status and caring practice by media utilization and variables related to psychological state.

1.4: Significance of the Study

The ageing population is an important part of the society or country. The effect of modernization and other infrastructure also affect the life of old people. The young people want to live with couples and children and separately which affect the elderly people to fulfill basic needs and other necessary things.

Elderly people in Nepal are taken both an opportunity and challenges. They are living in vulnerable condition being source of experience and ideas. It occurs when they become physically, mentally and socially frail. In our context unplanned and increasing proportion of elderly people is not the problem only for individual (elderly people) but for community and national level. Thus there is needed other scientific policies and program on elderly people. The increasing population over 60 years indicated of problems creates by these elderly people which are faced by the country.

Tehrathum is one of the remote district of Nepal so that study of status of elderly people is not done so far. This study will through light to identify the real socio-economic, demographic, current health status and caring practice and psychological status of elderly people of Jaljale VDC of Tehrathum district. And which will be helpful for GOs, NGOs and other organization as well individuals to lunch some programme and same area which are as follows;

It gives information on demographic context and socio-economic condition of study area, which is important for policy maker and provide guidelines for conducting for the researcher.

- It gives the information about physical condition, health status and caring practice of elderly people, which is important for improving the health services including mobile health camps, improving the health facilities needed and physical facilities program (drinking water, toilet facilities, roads etc.).
- It explores the problems faced by elderly people that are important for conducting welfare programmes such as: shelter, food, banding and financing etc.

- It gives information about psychological aspects faced by elderly people, which is important for improving the status of their interests and demands.
- It is significance for getting information an economic characteristic in study area which is also important to select the priority area of economic opportunities and creating new job opportunities.
- It will be helpful for getting the data in local level.

1.5: Limitations of the Study

Each and every research has their own limitations that determine the purpose of study cost and time. All the issues of elderly people were not included in this study was totally be concerned with the partial fulfillment of master degree in population studies from Tribhuvan University, Kirtipur. Second, it would have limited time and economic constrains, this study has its own limitations. The study area of this study was limited in the following area:

- This study was limited to the population who were above 60 years of age.
- This study was limited in Jaljale VDC of Tehrathum district.
- This study was based on 165 elderly people selected from Jaljale VDC of Tehrathum district.
- The interview schedule of this study was limited in the socio-economic, demographic, health status and caring practice of elderly people.

1.6: Organization of the Study

This purposed study is organized into eight chapters. Chapter first deals about general background of the study, problem statement, objectives, significance, limitations and organization of the study. Chapter second deals literature review and conceptual framework - theoretical and empirical literature, variables identified conceptual framework and formulation of hypothesis. Chapter three deals

methodology – research design, introduction to the study area, sampling and sample size, selection of cluster, selection of households, selection of respondents, questionnaire design, in-depth-interview, research's observation, data collection and processing, pre test of the questionnaire, field operation, data entry and processing, data quality, method of analysis and consideration of ethical issues. Similarly, chapter four deals introduction to study population – demographic, social, economic and media utilizations. Chapter five analyses of data – analysis of health status and caring practice of elderly people by selected variables (i. e. demographic, social, economic and media utilizations). Chapter six deals about analysis of qualitative information – case studies. Chapter seven statistical analyses – analysis of health status and caring practice of elderly people by using Gamma Coefficient by selected variables and chapter eight deals about summary of findings, conclusion and recommendation for policy implications as well as future researches.

CHAPTER TWO

LITERATURE REVIEW

Literature review is a very important aspect of academic research and an essential element of research design. Sometimes, research questions might emerge from the research own intuition personal experience but most often the study of exiting literature becomes the main source of research question, which ultimately lead to the statement of the problem. Literature review is the entry point for most scholarly words of academics and professionals (Neupane, 2009:8).

A literature review is an evaluation report of information found in the literature related to selected area of study. The review should describe, summarize, evaluation and clarify this literature. It should give a theoretical base for the researcher and help the researchers to determine the nature of research works which are irrelevant should be discarded and those which are peripheral should be looked at critically.

A literature review is more than the search for information and goes beyond being a descriptive annotated bibliography. While the form of the literature review may vary with different types of studies, the basic purposes remain constant. In general the literature should provide a context for the research, justify the research, insure research has not been done before, so where the research fits into existing body of knowledge, highlight flaws in previous research, outline gaps in previous research as well as shows that the work is adding to the understanding and knowledge of the field and help refine, refocus or even change the topic.

Therefore, reviews of completed research are most essential parts of ever research, because the researcher should gain out the experiences of others. It gives us how related our study done research to previous and ongoing research.

In this topic different theoretical issue, national and international socio-economic, demographic, health status and caring practice situation and policy as well programs are discussed.

2.1: Theoretical Literature

2.1.1: The Status of Elderly People

Different studies have been conducted so far to quantify the social process of ageing in the decade of 50s of 20th century. However, there is still lack of appropriate theories on ageing. Namely there are two ways of quantifying the social process of ageing they are: social enquiry and demographically.

Various sociological theories have developed. Burgess (1960) is one of the fathers of theory of ageing saw the ages being left out of social activities or being role less role is elderly people from the prospective of activity theory. Rose (1964) is another activity theorist, advocated that older person could possibly create a sub-culture to provide themselves with meaningful role and activities by their experience, understanding and utilizing the leisure time. Disengagement is a mutual withdrawal of the age from society. It ensures the society as optimal functioning. Disengagement theorists advocated that people want to escape from diminishing capacity of old age. Usually awareness and experiences at these stages are narrowing from the perception of death (Adhikari, 2008:5).

Rose (1964:46-50) has widely criticized to the disengagement theory for the bias of an industrial society. Butler (1976) has called it a myth. Other more have challenged the universality of disengagement. Personality theorists direct attention to the many variables of individual personality is: interest, motivation and awareness. Neugarten and Tobin (1961) have outlined four pattern of personality are: integrated, defended, passive and disintegrated. Neugarten has purposed the age 50 years as old age in continuity theory. By the late 60s of 20th century contemporary conflict theorists gained considerable creditability within sociology. They claimed that social inequality occurs between ages (young and old age). They further argue that social inequality mechanism is prime cause of conflict between generations. According to modernization theorists 'Modernization is good for most people but not equally good for all especially for older people (Cowgill, 1979 Cited from Subedi, 1999:103).

The demographic oriented researches on ageing have observed variously that in societies where children are the primary caretaker of elderly people.

Demand of security concern, especially by son is an inducement for high fertility. This proposition is related to the hypothesis of Caldwell (1976) 'Having many children is rational when wealth flows from children to parents.' It focuses that the parents investment to their children, leave opportunities for caring and raring from the motive of old age security. Leibenstein (1975) has also supported this proposition. While Lindert (1983) and other consider it negligible. Evidence from the study (1975-76) in rural community of 2100 persons in Maharashtra state of India Vlassoff and Vlassoff (1980) found little evidence to support this hypothesis.

The compressive review of Nugent (1985:76) put the issue as simply as possible. Old age security is likely to be an important motive for fertility when the relevant parents are both uncertain about his/her ability to be self-supporting in old age and dubious that there are other more reliable or more effective means of such support than their children. In what circumstances are these basic conditions likely to co-exist? It might be possible to distinguish the necessary and sufficient conditions for the motive to be improved. Nugent attempts to understand the connection by postulating eight conditions as:

- Underdeveloped capital market.
- Uncertainty about the accumulation of assets necessary for old age and disability.
- The absence or inefficiency of private or public old-age and disability insurance programs.
- Confidence in the loyalty of children to their parents.
- The absence of well developed labour markets for women.
- Children and non-standard labour.
- Underdeveloped markets for the goods and services that elderly people consume.
- The absence of a spouse who is of considerably younger age and the perception of old age as an appreciable portion of the life cycle.

The effect of social security programmes of old age pension on fertility is expected lower fertility (Rendall and Bahchieva, 1998:293-307). By contrast,

in developing countries where lack of social security system and its coverage is evident, the norms of living with children during old age are clearly evident and it is usual that at least one child remains co-resident (Knodel et al,1987). Thus, the old age security hypothesis is differed in developed and developing countries and also between less-developing countries (Cain 1977, 1986, Knodel et al 1987, Cited from Subedi, 2006:188-189). The economic value of children in rural India may be examined from two point of view (Vlassoff and Vlassoff, 1980) are the labour that young and adolescent children provide towards production within the household and the assistance given by offspring to father who have advanced beyond the prime period of life.

The large numbers of older women who are single, widowed or divorced are especially vulnerable, receiving few or none of the entitlements and in some instances even lacking comparable status in family and community levels. Especially in rural communities where pension schemes are the exception rather than the rule, older persons tends to work until they become too frail to continue to do so. At this point they may well become subject to abuse as their status in the household and community diminishes. Deterioration in health may be a feature of advancing age. Since some types of degenerative diseases are strongly associated with age and it is inevitably high for women (UNFPA, 2002). Families married person have higher life expectancy at birth comparing to unmarried. Because marriage promote people to well use materials. Socially integrated person have extensive social network and more frequent participation in social activities than that of their more isolated counterparts (Cain, 1981:375-388). By comparing one village of Bangladesh and two village of India form an indirect test Cain (1981) found that the Bangladesh village was characterized by considerably greater risks than Indian villages. All the villagers were poor but Indian villagers had better sources of credit. They had stronger lateral relation within extended family household and were able to adjust to calamities more easily than Bangladesh villagers. The Islamic practices had excluded women (especially to widowed women) form local market and more dependent on children. Higher percentage of widowed without surviving sons were forced to sell their land or if they did not possess land because destitute in Bangladesh village

than in India villages. The old age security motive is expected by female than male elderly (Vlassoff and Vlassoff, 1980:437-499).

2.1.2: Policy Response to Elderly people in World

In this topic the contribution of ICPD 1994, ICPD +5 and Madrid Convention on Ageing (2002) are discussed.

2.1.2.1: International Conference on Population and Development (ICPD), 1994

Major objectives mentioned in ICPD 1994 document about elderly people are as:

- To enhance self-reliance, optimize independence; promote quality of life of older people.
- To develop systems of health care services and economic and social security, recognizing the special needs of women; and
- To develop a social support system enhancing the ability of families to care for older family members.

It has separate action plan for the fulfillment of these objectives. It has recommended to all levels of governments to formulate medium and long-term socio-economic planning, develop social security system for intergenerational equity and made provision of long term support and services. It has also focused on full use of skills, abilities of elderly people and facilitating them for continued participation in society. It has suggested the governments to collaboration work with NGOs and other private sectors for avoiding all types of discrimination for the welfare of elderly people.

2.1.2.2: ICPD +5 (1999) on Ageing

The United Nations General assembly Special Session ICPD (1999) recommended that governments should:

Support research and develop comprehensive strategies at the national, regional and local levels to meet the challenges of population ageing;

- Invest more resources in gender sensitive research as well as in training and capacity building in social policies and health care for the elderly people, especially the older poor, in particular older women; support affordable, accessible and appropriate health-care

services; and promote the human rights and dignity of older persons and the productive and useful roles they play in society.

- Support system to enhance: the ability of families and communities to care for older family members; the ability of the elderly people to care for family and community members who are victims of HIV/AIDS.

In addition it has recommended the governments and civil societies including private sectors to create opportunities for elderly people. United Nations should provide that additional resources for documentation of positive experience of them in policies and programmes.

2.1.2.3: Madrid International Plan of Action on Ageing, 2002

It held in Madrid, Spain in 8-12 April 2002, adopt the international plan of action on ageing and political declaration.

International plan of action on ageing includes 19 articles. Moreover the countries are encouraged to accept force retirement age 58 years. It has emphasized on the opportunity of learning whenever they desire. People age with experiences and sorts of qualities and their potential is important to understand before crafting any policy for their welfare and social development.

It has advocated that the women's poverty is directly related to the absence of economic opportunity and autonomy, lack of access to economic resources, including credit and inheritance, lack of access to education and support services and their minimal participation in the decision making process. Poverty can also force women into situations in which they are vulnerable to sexual exploitation. Poverty is the main threat to the well-being of older persons. Many of the 400 million older people in developing countries are living below the poverty line (UNFPA, 2002). Meeting the MDGs of "Having the proportion of people living in extreme poverty by 2015" requires that poverty reduction strategies focus on the poorest and most vulnerable older persons, especially women. If this achievement is to be perpetuated, then the focus must also be on breaking the poverty cycle that runs from one generation to the next.

It has focused on inter-generational co-operation to strengthen the nature of elderly people in family because the inter-generational gap is seen all over

the world. There are three priority direction of Madrid Convention (2002) for an older person and developments are:

- Full participation in the development process and also share in its benefit.
- Advancing health and well being of old age and
- Ensuring enabling and supportive environment (UNFPA 2002:12).

It has also recommended and recognized active participation, employment opportunity, improving of living arrangement, alleviation of marginalization, integration, access to knowledge, education and training full utilization of potential and expertise, eradication of poverty, health promotion, universal and equal access to health care services and research on ageing etc are some key area of action plan.

2.1.3: Policy Response to Elderly people in Nepal

Ageing is not yet understood as a demographic problem and lack of adequate reflection in the policy and plan documents in the context of Nepal. However in the occasion of 'International Year for Senior Citizen's, 1999' of UN, Government of Nepal has brought some long term programmes to respect senior citizen as: providing discount in medical treatment, encouraging to provide subsidy in transport, publishing journal about elderly people, preparing inventory of organizations engaged in supporting elderly people. There is the provision of shelter, food, clothing etc for some of the frail and excluded elderly people in different religious places of some districts in Nepal (Adhikari, 2008:16).

2.1.3.1: Ninth Five Year Plan (1997-2002)

The eight five year plan (1992-1997) has mentioned about social security system of children, homeless, and defenseless women but nothing special programmes were mentioned for elderly people. However, the distribution of elderly allowance was initiated during this period. It has followed in successive plan period and was mentioned only in ninth five year plan (1997-2002) document. Social security system of elderly people prior to it was pension for retired civil servants. The most mentionable programmes of

this plan periods is to provide old age allowance. Some specific policies made during this period are:

- Development of family base social security system by giving priority and providing facilities in public services to the families that take care of older people.
- Classification of older people based on economic condition and bringing those economically poor within the purview of monthly allowances.
- Establishment of geriatric ward at all zonal level hospitals and provide subsidized in health care facilities and request private sector to provide special discount in health care of older persons.
- Establishment of elderly people homes at all development regions.
- Use the experience of elderly people in various sectors of national development.
- Provide subsidy in transport and entertainment facilities.
- Classification of elderly people in two groups i.e. 70-75 years and 75 years and above and a policy of engagement to former and social security.

Some of the separate programmes were made to meet those policies such as conducting census of older person in VDC and Municipality level and updating statistics, providing regular health check-up, using experience of older person in local level planning and reservation some of the quota in various kinds of transports for them.

2.1.3.2: Tenth five Year Plan (2002-2007)

It has long-term concept on elderly people to utilize the knowledge, skill and experiences in economic development. The specific quantitative objectives of this plan period are:

- Health of elderly people.
- Inclusion of knowledge and experience of elderly people in national development.

- Different other policies will be formulated to enhance the status of elderly people.

To meet these objectives some programmes are formulated as: formulating law, involve them in income oriented works, discount in health and transport, inclusion of issue of elderly people in school curriculum and conducting effective insurance programmes.

2.1.3.3: The Interim Constitution of Nepal, 2006

The Interim Constitution of Nepal, 2006 in the right of equality (Art. 13), for the senior citizens and others as stated above, there could be arrange separate law specially to protect the rights. It seeks to make equal where it is unequal. It means equal treatment between equal and unequal treatment between unequal. Article 35, section 17, says that the state shall pursue the policy of providing allowances to elder, weak women and unemployed in accordance to the legal provision.

2.1.3.4: Interim Plan (2007-2010)

This interim plan has similar kinds of programmes as successive plan (2002-2007). It has tried to address the following aspects of elderly people as:

- To make their life convenient.
- To utilize their knowledge.
- To create necessary infrastructure to allows them to level a dignified life in society.
- To create an environment for economic development.

It has extra policy to develop fund in local and national levels for welfare of elderly people. The role of MoWCSW and LDM is pointed for effective monitoring and evaluation in central level and WDO and DDC in local level.

2.1.3.5: Local Self Governance Act, 1998

There is provision for the protection and development of elderly people, helpless women and disabled people. The guidelines of the Ministry of Local Development includes following points to obtain old age, helpless and disable allowance;

- Men/women 75 years and above will be eligible for monthly allowance of Rs.200.
- Women 60 years and above being helpless due to the death of husband and living in the status of widow are eligible for monthly widow allowance Rs.15. (Dahal, 2007:4).

2.2: Empirical Literature

It has highlighted that about one in every seven older person. Approximately 90 million people live alone. The large majority of women 60 million live alone. The reason is that older women are less chance of getting remarriages after death of their husbands. Worldwide about 45 percent of women aged 60 years and above are currently married whereas it is 80 percent for male. The most common arrangement in the developed countries for older persons to live apart from their children, while large majority of older person in the developing countries live with their children. Around three quarters of older persons in less developing countries are living with at least one child or with their grandchildren. In Europe it is about 25 percent only (United Nations, 2002a).

It is essential to integrate the evolving process of global ageing within the larger process of development. Policies on ageing deserve close examination from the developmental perspective of a broad life-course and society-wide view. Taking into account of recent global initiatives and the guiding principles of the Madrid International Plan of Action ageing agreed in (2002). The central issue is poverty, in its various manifestations, but by ensuring older people are in the mainstream of development there is the realistic possibility of ensuring economic security and support from the community and government as well as through the traditional mechanisms of family support. The elderly people often receive attention in connection with the developed countries; however, the tempo of ageing is more rapid in less and least developed countries than more developed countries. The sex ratio of elderly people is higher in developing countries than developed. Since, there is difference in life expectancy at birth between sexes. However, the sex ratio of very elderly people is higher in developed countries; it is great challenge for less developed countries where social security system is either non-existed or poorly existed (United Nations, 2001: 42, 43).

In developed countries such as Japan, Australia, New Zealand etc the average household size is between 3 to 4 and elderly people account large size. In developing countries: Latin America, Asia the old age dependency ratio is increasing. The Australian government's national strategy on ageing focuses on four themes: independence and self-provision, attitude, lifestyle and community support; healthy ageing; and world-class care. Australia is also engaged in a number of initiatives to address issues relating to ageing. For example, a mature age employment strategy is being drafted to introduce legislation against age discrimination and to develop the capacity of older person to further contribute to national life. The government is also expanding its community age care programme to develop extended nursing care in the home to enable more people to stay in their own homes as long as possible. In Finland, the establishment of individual and universal mandatory pension rights has been an efficient way to eradicate poverty for both elderly men and women. The Finnish National Programme for ageing worker aims to create positive attitude towards staying longer in working life and encourages employers to recruit people age of 45 years and above. Israel's progress in addressing ageing issues includes improving access to services, expanding professional and academic training and research in gerontology and extending the retirement age of women from 60 to 65 years. The government of the Republic Korea has been implementing policies for older persons designed at enhancing their quality of life for promotion sustainable socio-economic development. In order to provide healthy and economically stable lives to older persons, the government is working towards strengthening the necessary social infrastructures that supports the role of the family as care taker (UNFPA, 2002).

Reviewed literature of ESCAP region from Japan to Pakistan revealed that the substantial proportion of elderly people is engaged in productive activities. Between 50 to70 percent elderly people remain economically active (ESCAP, 1996). In particular, population ageing raises critical issues for community and state level in areas such as economic growth, employment and retirement, pension, health care and social support service. Historians may well conclude that the most significant event of the 20th century was the growth of world population and in the 21st century the most significant event may likely b e the ageing humanity. Population ageing presents enormous

social, economic and political challenges for societies. Finally, sooner the necessary adjustment for population aging should be made (Chamie, 2007).

Changing age structure of population has diverse directions and dimensions while developed countries are faced with the problem of growing elderly population, developing countries are faced the problem of young population bulges. The customary basis of population to be considered getting older is its proportion in the respective age groups. While the proportion changes and the directions of changes are important measure of considering a population ageing. Which is more important and seldom considered in and overall context such changes have been taking place. It is also important in case of Nepal where the elderly population is between (6-8%) only. Thus it is proved that Nepal does not have faced the problem of ageing. The socio-economic changes have started to occur within such context. It will make an eminent problem than has been realized by most social scientists and policy makers now. But in Nepal the tempo of ageing is assumed to be unexpectedly high when fertility, as well mortality continues to decline and longer life expectancy at birth. The United Nations projection of age structure for Nepal shows that elderly population will continue to increase. Thus ageing will be serious problem in Nepal in coming future than other ages. Japan is unique case where about one fifth of total populations are elderly. It is good lesson for Nepal. Different empirical researches have shown that the increment of young and adult population will be positive but elderly people are always warrant and immediate attention for government (Subedi, 1996a:93-112).

A country such as Nepal whose economic growth has been awfully discouraging even a small increase in the size of elderly people brings an added hardship to the already troubled. Economy of the increment of elderly people will be very much because its pyramid is broad base and narrow top and just entered into demographic transition from high fertility and mortality to lower ones (Singh, 2003:253). The population of Nepal has changed from primitive stationary state in 1991 to present third stage of demographic transition in 2001. The growth rate of elderly population was 2.4 percent in 1991 and it reach to 4.2 percent in 2001, which is higher than growth rate of total population 2.25 (Pantha and Sharma, 2003:38). The old age dependency ratio also called gerontological dependency ratio that uses the

customary retirement age to divide the population into dependent and independent groups is 12.0 in Nepal. The educational attainment of elderly people seems to be very low than other age groups population. It represents the poor socio-economic and demographic condition of elderly people in Nepal (Singh, 2003:252).

Traditional family has been caring for their elderly parents both in rural and urban areas in Nepal. However, the ageing process is taking place together with social and economic changes that are affecting the role of family. With urbanization and development the family size is being smaller. Family and kinship ties are weakening. Families are started to become' less extended'. The number and proportion of elderly women is higher than men. The socio-economic situation of elderly people is neglected. Similarly the women are more deprived from using resources (Acharya, 2000:93-99).

Cohabitation of adult children may not provide sufficient support for all needs. In Nepal one ethnographic study of Sherpa elderly people suggested that more elderly people individuals live alone as a consequence of recent change of society. Eight percent elderly people are living with their adult children and 60 percent households head are elderly people in Nepal (Shrestha and Dahal, 2007). Four components of dependency in the context of Sherpa population in people are identified are as: biological function and physical fitness, the actual activities and work of the elderly people in particular the subsistence goods and services they produce themselves, the resources and wealthy controlled by the elderly people and the goods and services purchased by means of these and the goods and services obtained in addition to those produced directly by the elderly people themselves (Beall and Goldstein), 1982:141-147). They also have suggested that the single cultural system may produce highly successful solutions for some problems of ageing. Similarly, findings of the study of Gurung community Macfarlane (1976:113) is that old women in their seventies could still be carrying heavy loads of wood and water and people in their eighties went on with basket making and weaving. In fact, older women rather than older men continue either to run a household or to share in the domestic cores within the family.

It is known that these aged in the minority encounter harsher condition than majority of elder in terms of income, housing quality, education and rate of chronic illness. Country requires examination of the general relationship

between cultural variations and ageing within the social context (Subedi, 2006:69-78). In Nepalese context different anthropological and demographic studies have discussed about the value of children as source of labour and contribution in household economy. However, the traditional system of security is breaking down. Demographic researches on ageing have observed that in the societies where children are taken as the primary caretakers and the source of security of elderly people, tends to be higher fertility. This proposition is related with Caldwell (1976:321-366) hypothesis. 'Having many children is rational when wealth flows from children to parents. The evidence from Maharashta state India Vlassoff and Vlassoff (1980) found little evidence to support it. Nugent (1985:76) found important motive for fertility by postulating eight conditions. The findings in Nepal and Java indicate that children are economically valuable to their parents at young age (Nag et al, 1978).

The effect of social security programmes of old age pension on fertility is positive. Knodel et al (1987) found in developing societies where the lack of a social security programmes and its coverage is evident. The norms of living with children during old age is clearly evident and it is usual that at least one child remain co-resident. In the study of Dura population found less secure from their son when the family is poor and economically dependent (Subedi, 2001/2002). In Nepal where public welfare system is not elaborate as in developed countries and very few is known about retirement and pension and these are non-existent in private and semi-government sectors. Institutional arrangement programmes need to elderly people have been far fewer and limited. Ant social security programmes are existed only in paper because of problems related to economic stagnation, inflation, corruption and political instability (Acharya, 2006:84-87).

Among the three traditional, transitional and modern societies, the gap is much widened in transitional societies. Prevalent dualism of traditional and modern behaviour encourages controversy between the generations and many times such conflicts ruin the families. The difficulty to accept change among elderly people and lack of understanding of the needs of elderly among the young adults are the major barriers of a smooth family life. Government, non-government and private sectors' efforts to establish coherence between and among generations are required especially in the

transitional societies. A survey and cover story by Himal magazine (April 2005) depicted that there exists a considerable gap in generations in Nepal. The younger generation has ambitions of modernization and older generation wants to continue traditional norms and values. The gap is translated into family conflicts and migration of the member of younger generation towards urban centers or abroad (Acharya, 2006:83).

The work of KC (2003:121-158) identified five reasons of migration in the context of Nepal are: Trading, education, employment, agriculture, marriage. In these activities usually children, women and elderly people do not take part. Which has increased the opportunities is available. Thus migration is one of the reasons of determining the size of elderly people in Nepal. The rural to urban migration has increased the problem security of elderly people, which significantly occur from the motive of modern higher education. There were 87.6 percent urban residents were life time migrants in Nepal it has promoted to live separately between two generations (CDPS, 1996).

2.3: Variable Identified

Different dependent, intermediate and independent variable have used to show the cause and effect relationship in this study. Usually dependent variable is effect or outcome of intermediate and independent variables called cause. For obtaining objectives dependent, intermediate and independent variable are identified as follows;

2.3.1: Independent Variables

- Caste/Ethnicity
- Religion
- Social norms/culture
- Place of residence

2.3.2: Intermediate Variables 1

2.3.2.1: Social Variables

- Education

- Access to health
- Family system
- Family support system

2.3.2.2: Demographic Variables

- Number of children
- Son/daughter
- Age/sex

2.3.2.3: Economic Variables

- Occupation
- Land holding
- Households income

2.3.3: Intermediate Variable 2

- Social prestige of elderly
- Media exposure
- Social network

2.3.4: Dependent Variable 1

- Caring practice

2.3.5: Dependent Variable 2

- Health status of elderly people.

2.4: Conceptual Framework

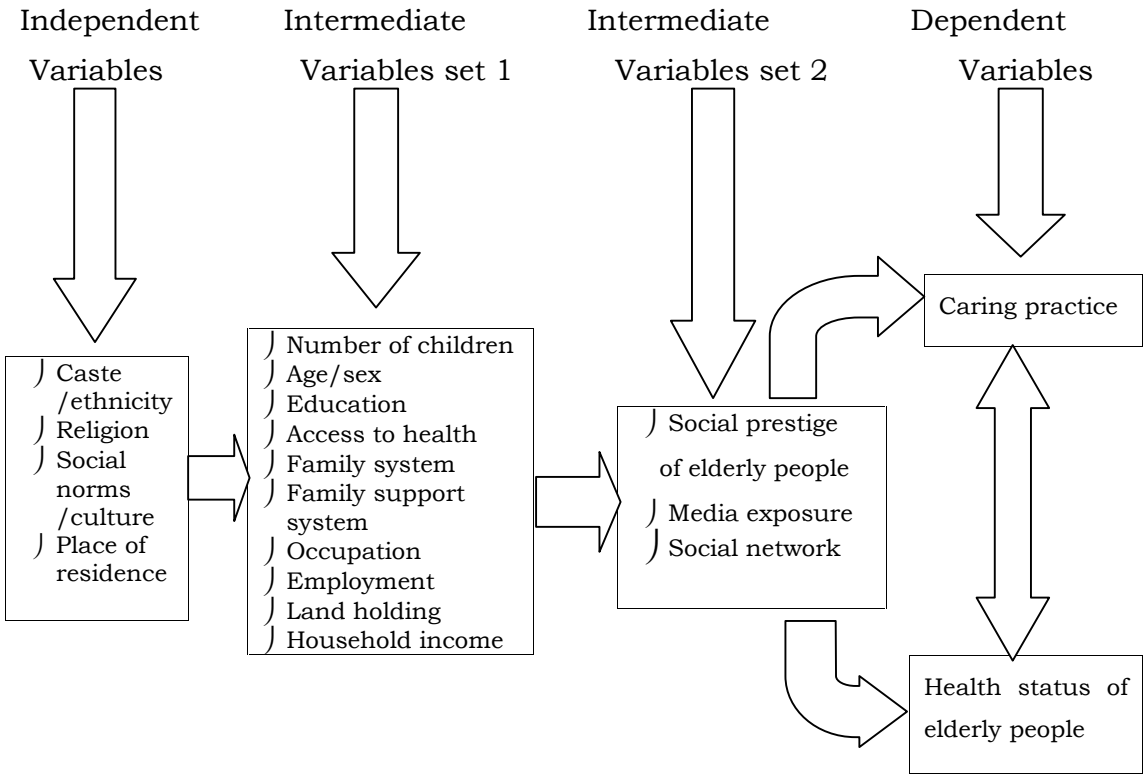
After reviewing different literatures it can say that ageing is a development issue in the today's world. Healthy older persons are resource for their families, communities and the economy. Despite fact that the elderly people is one of the most neglected, lonely isolated, physically disable, financially weak groups in our country. The number of elderly people in Nepal is increasing along with increasing life expectancy at birth. Quite inversely there is no any mechanism to provide and fulfill services for elderly people.

Having smaller size their needs, interests and aspirations have been given less priority in all development sectors and decision making in the family community and state levels.

Nepal is known as multi-lingual, multi-ethical, multi-religious country. Nepalese people have accepted different forms of ageing. It is bitter truth that in most on the rural areas, elderly are hated and disgusted by their needs. The social norms and values favor the elderly people. But modernization and urbanization creates some obstacles towards the elderly people in terms of rearing and caring. Government of Nepal has been made some efforts for improving status of elderly people but these are not sufficient. These efforts are limited on paper and weak in implementation.

Now it can be said that there is broad area of study about ageing. However, due to lack of resources, time and other obstacles this study is limited only in selected independent, intermediate and dependent variables in small sampled population and particular age only. Thus the result obtained from this study is not comparable with national levels data but gives general trend of ageing population because of exceptional fallacy in research process. A following conceptual framework is presented based on review of existing literatures and the objectives of this study where health status and caring practice of elderly people is taken as dependent variable which is directly as well as indirectly affected by other intermediate and independent variables such as: social prestige, media, exposure, social network, education, access to health, family support system, occupation, household income, caste/ethnicity, religion, social norms/ cultures, place of residence. These intermediate and independent variables are also related to each other. It means being poor condition of one variable other also tends to be affected.

Figure 1: Conceptual Framework



2.5: Formulation of Hypothesis

Based on the conceptual framework following hypothesis was set to test for identification of the relationship between and among variables.

- Higher the level of education higher the health status and caring practice.
- Higher the level of income higher the health status and caring practice.
- Higher the access of media utilization higher the health status and caring practice.

CHAPTER THREE

METHODOLOGY

3.1: Research Design

In this study, exploratory and descriptive research design has been applied for describing the findings. The study was concerned with exploring that might relate to the health status and caring practice element is exploratory aspect. By this way the study wanted to find out health status and caring practice among elderly people. Due to describing the facts of health status and caring practice among elderly people, the descriptive design was also taken.

3.2: Introduction to the Study Area

Nepal is an independent small land locked country situated on the southern slopes of the middle Himalayan. It stretches over a length of 885 km (east-west) and width of 145 to 241 km (north-south) surrounded by two most populated countries: Chaina in north and India in other three. It includes three ecological zones: Mountain, Hill and Tarai. The density, cultural behaviors and socioeconomic and demographic conditions are differed according to climate, altitude and physical infrastructures. It has four different levels from lowest to highest: Village Development Committees (VDC, 3915), Municipalities (58), Districts (75), Zones (14), and Development Regions (5). According to census the 2001, population was 23151423. Among them 11563921 were males and 11587502 were females. The population growth rate was 2.25 per annum. Sex ratio was 99.8 and population density was 157.5 people per sq.km. The total household number was 4253220. If the population increases in the same ratio it will double in 31 years (Pantha and Sharma, 2003:2-3).

Tehrathum is one of the mid-hill districts among 75 is situated in Koshi zone in Eastern Development Region of Nepal. It covers and an area of about 679 sq.km. The district border Panchther and Taplejung district in east, Dhankuta and Panchther district in west, Sankhuwasabha district in north and Dhankuta and Panchther district in south. It is endowed with a historical base, tourism potential and rich in natural resources. It has 32

VDCs, 11 Ilakas, and only one electoral area. According to census the 2001, population was 113111, population growth rate was 0.95 and density was 167 (Pantha and Sharma, 2003:45- 55).

Jaljale is one of the VDC among 32 in Tehrathum. It is situated in north from district headquarter (about 5km). It is surrounded by Simle VDC in east, Oyakjung VDC in north and west, Tamphula VDC in south. This place is highly agrarian and potential for tourism as well rich in natural resources. The main sources of earning in this VDC are agriculture and livestock. Paddy, millet, wheat, maize, barley, potato and oil seeds are major crops and cow/buffalos, goats, pigs, and poultry are major livestock in this VDC. It is also highly potential for cash crops like cardamom, tea, coffee, green vegetables and fruits. However, due to lack of transport and market the economic condition is not satisfactory. There were 893 HHs consisting 5485 total population having sex ratio 97 in 2005.There were Janajatie (416HHs), Khas (370HHs) and Dalit (107HHs) having average household size 6 persons per household. About half of the households were under the poverty line ($1per day) and literacy level was 82 percent higher for males than females as national level (Deurali Society, 2005). Piped water is main sources of drinking water ad most of the houses are made with mud and stones. Some of the households are depended in foreign labour services and pension facilities. Approximately 88 Indian and 20 British ex-armies or widowed women of them are getting such pension facilities. Even in few prices Indian Embassy as provided the solar power for 448 households. Thus the hydro power and solar power are main source of light. There is one higher secondary school, and at least one school in each ward except ward no. 6. The health service and care is limited only in sub-health post.

3.3: Sampling and Sample size

For this study, 165 households were chosen as sample size from study area. The households having elderly people were approximately 375 but only 165 households were chosen due to lack of time and cost.

3.3.1: Selection of Cluster

In the case of Dalit, it was not selected cluster due to the less number of households on the comparison of other castes. Because one of the main

objectives was taken to study comparatively among Khas, Janajati and Dalit in equal proportion. But in case of Khas and Janajati, whole VDC was divided into 9 clusters regarding the 9 wards. Among them, 4 wards were selected as clusters by lottery method of probability sampling.

3.3.2: Selection of Households

In this study, selections of households were selected purposively and randomly covering to the objectives. Janajati and Khas sample households were selected from 4 clusters and Dalit households were selected from whole VDC. While selecting sample households some criteria were taken as follows;

- Either one or more of the family members must be aged 60 and above.
- From the study area, 165 households were selected.
- The households were selected from the point of view of covering all caste/ethnicity, special naming as Khas, Janajati and Dalit. From each community, 55 sample households were selected.

3.3.3: Selection of Respondents

Elderly people, having age of completed 60 years and more than it were selected as a respondent and only one respondent was taken from a household either male or female. From the study area only 165 respondents were selected for interview, orienting to the objectives. Among the 165 respondents, 55 respondents from each ethnic community were questioned and interviewed.

3.4: Questionnaire Design

The questionnaire was designed based on the conceptual framework and as per the suggestion and guidelines of the research supervisor and also by reviewing the questionnaire of previous studies on the related topics and it was fully guided by the study objectives. The household questionnaire was designed to obtain the demographic, socio-economic and other information about household. Individual questionnaire was designed to obtain the information about health status and caring practice of elderly people either male or female who aged 60 and above.

3.5: Qualitative Tools

3.5.1: In-depth-Interview

In depth –interview is a useful open-ended tool for collecting qualitative information. In this tool individual interviews were conducted in specific issues such as: demographic condition, health facilities and care, cultural behaviour, and educational facilities of study area with elderly people, VDC secretary, NGO co-coordinator and teachers. The most important view and feelings were recorded at the time of in-depth-interview by written document.

3.5.2: Research's Observation

Observation involves looking and listening very carefully for particular objects, event or activities of population. Field research can be considered either broad approach to qualitative research or a method of gathering qualitative information. The essential idea is that the researcher goes into field to observe the phenomenon in its natural state. Likewise, the physical setting of study area, cultural behaviours, fashions, and food habits etc. of elderly were collected at the time of study and needed information were recorded by using written document to support quantitative information.

3.6: Data Collection and Processing

The needed data have been collected by questioning, the prepared questionnaire schedule from the direct interview. Both individual and household questionnaire were asked to related respondent of each sampled households covering the objectives and filled up questionnaires were edited after the completing of each day's interviewing for the accuracy and completeness.

3.6.1: Pre Test of the Questionnaire

Simple Nepali language was taken as questionnaire language in simple way. The pretest of the questionnaire was done for checking the working, sequence and the uses of language whether that was understandable or not for the respondent to ensure the validity of the tools. Five sample questionnaires were pre-tested at out of the study area in "Syuchatar VDC" and questionnaires were edited based on the feedback.

3.6.2: Field Operation

When the typing and printing of required questionnaires were finished, I visited in study area to get more detail information. First of all I visited to VDC office then asked information about physical setting and other characteristics of study population. Unfortunately there were not any kinds of information expect voter lists of Constitutional assembly Election 2064. All the records were damaged at the time of civil war and remaining records were in District Development Committee (DDC). I selected the required elderly from voter lists with assistance. Then I visited to the NGO officer working in this area (Deurali Society). I got little information about total population and study area. And then I was able to collect all the information within 20 day's period. Finally responses were tabulate and analyzed by using different computer programmes.

3.6.3: Data Entry and Processing

The whole filled up questionnaires were edited for accuracy and uniformity of the data. To make data entry and analysis easier, coding and recoding were done properly. The collected data from the field were entered and analyzed using Microsoft Excel Microsoft Word, EPi data and SPSS respectively.

3.7: Data Quality

The age heaping problem always occurs in research. The age always concentrated on the terminal digit 0 and 5. For measuring and correcting the data quality and age heaping, researcher used to Myers, Blended Index. The Meyers' Blended Index is one of the popular measures of age misreporting in demography. Meyers' index measures the digit preference of age between ranges of 10-89 years. The index may range from zero to ninety. If the index appears approximate, to zero indicates there is no age heaping in the given age data and ninety shows the absolute misreporting of age data (Shryock and Sigel 1976:116).

The Meyers' index calculated was found to be 0.04, which appeared near zero and that meant less age heaping for the total population of sample households. This indicated the quality of data was relatively high.

3.8: Method of Analysis

After completing the data entry, necessary tables were generated by using the different software from the data were processed into demy table, frequency table, cross tabulation, Meyers' Blended Index, Lorenz Curve and Gini-Concentration ratio, Gamma Coefficients. All these are discussion on the appropriate way.

Figure 2: Map of Nepal, Depicting Tehrathum District

Source: Map of Nepal (website)

3.9: Consideration of Ethical Issues

The researcher visited all the respondents individually in the study area who were related to the study. The researcher made them friendly, convincing that the collected data is only used for thesis purpose and won't be misused. They were behaved as a good manner/morally. Anyway they were also not compelled and threatened. So, they fully supported by answering and interviewing that were related and needed to the objectives of the study.

CHAPTER FOUR

INTRODUCTION TO STUDY POPULATION

There is no consensus among demographers and sociologists about when does one become old? At 50, 60, 65 or 70 years of age? It is different from individual to individual and in studies. The age 60 or 65 tears is equivalent to retirement age in most of the developing countries. Vienna Convention in 1982 has suggested the age 60 years as cut- off point of ageing, Helpage (1999) suggested the age 60 tears as cut-off point of ageing in third world countries. However, anthropologists do not support the age 60 years as the cut-off point of ageing but they see it as continuous process. A case study in Sherpa population in Helabu of Nepal Beall and Goldstein defined that ageing start at age 50 years of age. Following these different works, age 60 years has taken as the cut-off point of ageing within this study to make comparable it with other ones.

The proportion of elderly people is almost equal for both ethnicity Khas and Janajati but in case of Dalit, the proportion of elderly is very low in this VDC. There is traditional system of untochability from higher caste to lower one. Nepali language is spoken by majority of people. Hindu and Kirat religions are major here. Elderly people here are respected by saying 'Hajurba, Hajuraama', 'Baje, Bajoi' etc. But now the trend of saying 'Baba, Aama' is developed. Elderly men are considered to those who left all responsibilities to his son and women being to leave all the management of household to her daughter/ daughter-in-law due to age factors. The gradual change in physical appearance and mental situation that is another symptom of grow old in this VDC. However, elderly people's role is dominated in social and family ceremonies and development projects. Major festivals of this VDC are Dashain and Tihar. Usually followers of Kirat and Buddhism do not celebrate it. Birth, marriage and death ceremonies are differed by caste/ethnicity, religion and economic condition.

Whenever the elder son gets marriage then his family lives separately after sometimes. Thus elderly people should live either with younger son or alone. It is the life cycle of elderly people here. As well as most of the elderly people are living with women and children those are less productive than young

and adult sons. One of the reasons to be in this position of elderly people is due to family conflict. Another reasons for it is attraction younger generation towards modernization and development. When people turn towards ageing they take an interest about religious work and whenever they become frail their main duty is to take care of grand-children and household. Elderly people have faced different demographic problems including health care and services, economy, family conflict, security and cultural diffusion in this area.

4.1: Demographic Characteristics

This chapter deals with the demographic status of sample population. This includes age-sex composition, dependency status, marital status and family size by ethnicity.

4.1.1: Age and Sex Distribution of Sample Population by Ethnicity

Two characteristics of the population that receives most attention in demographic analysis are: age and sex. Although, sex is personal characteristics of population, that is obtained without any difficulty. However, information on age is difficult to obtain. And it is affected in interpretation from one culture to another and place to place. Social scientists of many types have a special interest in the age sex composition of population for various reasons: age sex composition is product of past trend of fertility, mortality and migration and is influenced by current level of birth, death and migration rates.

The total population of the study was recorded 918 of 165 households. Out of 918 sample population 34.4 percent were Khas, 32.9 percent were Janajati and 32.2 percent were Dalit. Similarly, 19.2 percent were of 0-14 age group, 53.9 percent were of 15-59 age group and 26.9 percent were of 60 years and above age groups. While analyzing population distribution by ethnicity, Khas consisted 19.1 percent for 0-14 age group, 57.5 percent for 15-59age group and 23.4 percent for 60 years and above age groups. As well as, Janajati consisted 16.9 percent for 0-14 age group, 53.6 percent for 15-59 age group and 29.5 percent for 60 years and above age groups. In the same way, Dalit consisted 21.6 percent for 0-14 age group, 50.3 percent for

15-59 age group and 28.1 percent for 60 years and above age group respectively.

Table 1: Distribution of Sample Population by Age, Sex and Ethnicity, Jaljale, Tehrathum, 2011

Age Group	Ethnicity						Sex ratio	Total
	Khas		Janajati		Dalit			
	Sex		Sex		Sex			
	Male	Female	Male	Female	Male	Female		
0-4	7	8	4	3	10	8	110.5	40
5-9	9	12	13	7	8	11	100.0	60
10-14	14	11	12	12	15	12	117.1	76
15-19	13	9	14	9	12	4	177.3	61
20-24	20	23	20	15	13	20	91.4	111
25-29	20	10	23	10	17	11	193.5	91
30-34	9	10	16	10	12	6	142.3	63
35-39	6	7	2	4	6	7	77.8	32
40-44	12	9	5	10	7	5	100.0	48
45-49	6	6	8	3	4	4	138.5	31
50-54	6	5	3	3	4	5	108.3	26
55-59	1	12	2	5	3	9	23.1	32
60-64	16	15	15	18	23	20	101.9	107
65-69	9	8	15	15	8	9	100.0	64
70-74	6	5	7	6	11	5	150.0	40
75 plus	8	8	8	5	5	2	140.0	36
Total	162	158	167	135	158	138	113.0	918

Source: Field Survey, 2011

It was found that the proportion of elderly people was the highest for Janajati and followed Dalit and Khas respectively. The sex ratio population is expressed as: Sex Ratio= Number of males*100/Number of females. By calculating the sex ratio of study population was 113.0. Which was more than national level figure (99.8) and also higher than the Tehrathum district in 2001 (94.0: Pantha and Sharma, 2003). Similarly, by ethnicity, sex ratio was 102.5 percent for Khas, 123.7 for Janajati and 114.5 was for Dalit (Table 1).

4.1.2: Dependency Status of Sample Population by Ethnicity

Dependency ratio is measured by age composition. Usually there are two types of dependency ratios in practice i.e. child and old age dependency ratio. Child dependency is used to express the number of children under age 15 years per 100 economically active aged (15-59 years). In this study, child

dependency ratio was 35.6 which were quite lower than national level figure in 2001 (70.7: Singh, 2003). It was found that there was high level of fertility and child mortality at past. However, there are now dramatically changed. There is low level of fertility and rarely listen about child mortality with the increasing awareness of health facilities and family planning programmes.

The old age dependency ratio also called gerontological dependency ratio (GDR) which uses the customary retirement age to divide population into dependent and independent group. Mathematically it is expressed as: GDR = Population over age 60*100/population of intermediate aged (15-59 years). By calculating it, the GDR of study area was found 49.9 per 100 population of economically active aged (15-59 years). It was quite higher than national level data in 2001 (12.0) and total dependency ratio was 85.5. There was ethnic variation for dependency ratio. Child dependency ratio was higher 40.9 for Dalit, followed by 33.2 for Khas and 31.9 for Janajati. Similarly, old age dependency ratio was higher 55.7 for Dalit, 54.9 for Janajati and 40.8 for Khas. Likewise, total economic dependency ratio was 98.7 for Dalit, 86.4 for Janajati and 74.0 for Khas. It suggests relatively lower level of fertility having higher level of life expectancy at birth as well significant proportion of young and adult population in study area.

Table 2: Distribution of Dependency Status of Sample Population, Jaljale, Tehrathum, 2011

Dependency Ratio	Ethnicity			Total
	Khas	Janajati	Dalit	
Child (0-14)	33.2	31.5	43.0	35.6
Old Age (60 plus)	40.8	54.9	55.7	49.9
Economic dependency	74.0	86.4	98.7	85.50
Index of Ageing	123.0	174.5	129.3	140.3

Source: Field Survey, 2011

The index of ageing is another measure of identifying if the population of a country is ageing. This measure expresses the total elderly population as proportion of the total younger population and its value is dependent upon relative changes in both the age groups namely those with ages less than 14 years and those with 60 and over. In this study, ageing index was 140.3.The index of ageing was observed 174.5 for Janajati, 129.7 for Dalit and 123.0 for Khas respectively. In this study, the index of ageing was found very high

because the main objective of this study was to take information about elderly people (Table 2).

4.1.3: Marital Status of Sample Population by Ethnicity

Marital status is another important characteristic of population. The child marriage is usually prohibited by law in Nepal. However, since 1981 information on marital status were collected only for age group 10 years and above. There are four classification of marital status as never married, married, widowed/widower and divorced/ separated (Chaudhary and Niraula, 2003). The information regarding marital status was obtained from the people age 10 years and above to make comparable it with other studies done.

There were total 818 eligible respondents for this purpose. Out of them 487 were married, 269 were unmarried and 62 were widowed. The characteristics of married and unmarried population were almost similar to all ethnicities but the numbers of widowed were higher for Khas ethnicity followed by Dalit and Janajati respectively. It may be due to strong socio-economic values and norms in Khas community. About three in fifth (59.5%) of the population it accounted 55.7 percent for male and 63.9 percent for female were married in study area, which was 58.8 percent for male and 66.4 percent for female in national level figure.

Table 3: Distribution of Marital Status of Sample Population Ten Years and Above by Ethnicity, Jaljale, Tehrathum, 2011

Marital Status	Ethnicity			Total
	Khas	Janajati	Dalit	
Married	161	160	166	487
Unmarried	96	101	72	269
Widowed	27	14	21	62
Total	284	275	259	818

Source: Field Survey, 2011

Similarly, about one third (32.9%) of the population were unmarried, which was 38.5 percent for male and 26.4 for female. In the national level figure was 39.2 percent for male and 30.3 percent for female. More number of study area were seen to be widowed/ widower than national level. There were 7.6 percent widowed/widower cases were reported including 5.7 percent male and 9.7 percent for female which was only 1.6 percent for male

and 3.7 percent for female in national level figure (Chaudhary and Niraula, 2003:279).

4.1.4: Family Size of Sample Population

Family size is the one part of demographic factor. The study area out of 165 households, family size to be 1-5 households were 45.5 percent and family size to be 6 and above households were 54.5 percent of the total study population. In the study area, the average family size was (5.6) less than national level average family size (5.8).

Table 4: Distribution of Family Size of Sample Population, Jaljale, Tehrathum, 2011

Family Size	Number	Percent
1-5	75	45.5
6 plus	90	54.5
Total	165	100.0
Average family size of Nepal: 5.8	Average family size of sample population of study area: 5.6	

Source: Field Survey, 2011

4.2: Social Characteristics

In Nepal though the Central Bureau of Statistics (CBS) already conducted ten decennial censuses since 1911, the taking of census considering the social components of population such as language, religion and ethnic/ caste groups is relatively a recent phenomenon. The inclusion of these social components in the Nepali census gradually started along with the advent of democratic revolutions in Nepal. The democratic revolution in Nepal in 1950 (which threw the autocratic Rana regime) motivated to include two important social components in the census taking; the 1952/54 census provided information on language (on the basis on mother tongue) and religion. The other important social component such as caste/ethnicity was included only in the 1991 census after the onset of democracy in Nepal in 1990 (the king became the constitutional monarch). There could be several reasons why the CBS has remained little skeptical throughout its history in providing such important data on language, religion and caste/ethnicity (Dahal, 2003:87).

4.2.1: Caste/ethnicity

Nepal is regarded as multiethnic group country. There were about 101 caste/ethnicity were identified. Under the social composition of population

caste/ethnicity regarded as one of the prime factors and it directly associated with living arrangement because culture of an area determines the life style and living arrangement.

Table 5: Distribution of Caste/Ethnicity of Sample Population, Jaljale, Tehrathum, 2011

Ethnicity	Sex				Total
	Male		Female		
	Number	Percent	Number	Percent	
Chhetri	90	50.3	89	49.7	179
Brahmin	72	51.1	69	48.9	141
Limbu	96	56.1	75	43.9	171
Bhujel	9	50.0	9	50.0	18
Newar	23	54.8	19	45.2	42
Tamang	39	54.9	32	45.1	71
Damai	45	52.9	40	47.1	85
Kami	63	54.3	53	45.7	116
Sarki	50	52.6	45	47.4	95
Total	487	53.1	431	46.9	918

Source: Field Survey, 2011

In total sample population of 918, highest number of population was observed for Chhetri (179), followed by Limbu (171), Brahmin (141), Kami (116), Sarki (95), Damai (85), Tamang (71), Newar (42) and Bhujel (18) respectively. In all cases, the number of male was observed higher than female population (Table 5).

4.2.2: Religious Composition of Sample Population

Only after restoration of democracy awareness on religion has increased in Nepal. The religion is seen to be affected by caste/ethnicity and also by geographical area of population.

More than two third (74.7%) of the sample population in study area reported that they followed Hindu religion which was slightly lower than national level figure (80.6%, Dhal, 2003:104). It was followed by Kirat religion. About one fifth (18.3%) sample population in study area reported that they were in this category of religion which quite higher than national level figure (3.6%). Buddhist was another religion in study area 6.6 percent sample population were in this category of religion which was lower than national level figure (10.74%). Only 0.04 percent people followed Christian religion. Hindu religion was followed by all people of Khas and Dalit community and 10.2

percent followed by Janajati. Buddhist, Kirat and Christian religions followed by only one Janajati community.

Table 6: Distribution of Religious Composition of Sample Population, Jaljale, Tehrathum, 2011

Religion	Ethnicity						Total	
	Khas		Janajati		Dalit			
	N	%	N	%	N	%	N	%
Hindu	320	46.6	70	10.2	296	43.1	686	74.7
Buddhist	0	0.0	61	100.0	0	0.0	61	6.6
Kirat	0	0.0	167	100.0	0	0.0	167	18.3
Christian	0	0.0	4	100.0	0	0.0	4	0.4
Total	320	34.9	302	32.9	296	32.2	918	100.0

Source: Field Survey, 2011 N=Number, %=Percent

4.2.3: Literacy Status and Education Attainment of Sample population

Education is one of the socio-economic factor that influence a person's behavior and attitudes. In general, higher the level of education higher the income, use of health facilities and well-being of population. Nepal has committed to dark Convention (2000) 'Education for All'. Separate National Plan of Action has formulated since 2001 in order to meet the target of MDGs (2000) where Nepal has committed to ensuring it by 2015, 'all the children, particularly girls, children in difficult groups have access to complete, free and compulsory and good quality primary education.'

Table 7: Literacy of Sample Population of Age Five years and Above, Jaljale, Tehrathum, 2011

Literacy Status	Ethnicity						Total	
	Khas		Janajati		Dalit			
	N	%	N	%	N	%	N	%
Literate	264	36.4	244	33.6	218	30.0	726	82.7
Illiterate	41	27.0	51	33.6	60	39.4	152	17.3
Total	305	34.7	295	33.6	278	31.7	878	100.0

Source: Field Survey, 2011 N=Number, %=Percent

Information about literacy and educational attainment for this study had collected for age group 5 years and above only. In this study literate population were defined to those having ability to read and write in any languages with understanding.

In Jaljale VDC out of 878 sample population of age 5 years and above, 726(82.7%) were literate. Based on ethnicity, 264 (86.4%) of Khas, 244(82.7%) of Janajati and 218(78.4%) of Dalit were literate. In the case of male and female, 92.2 percent male and 71.1 percent female were literate which was quite higher than national level figure (65.5% male and 42.8% female: Manandhar and Shrestha, 2003). Which was about 82.0 percent for study area in 2005 (Deurali Society, 2005) (Table 7).

In educational attainment, out of 80 people of higher education 45(56.3%) were from Khas, 31(38.8%) were from Janajati and only 4(5.0%) were from Dalit. Likewise, the proportion of Janajati and Dalit were found higher up to the primary and secondary level but their educational status was low at SLC and higher level. That may be due to higher drop out in Dalit and Janajati as compared to Khas (Table 8).

Table 8: Education Attainment of Sample Population of Age Five Years and Above, Jaljale, Tehrathum, 2011

Educational Attainment	Ethnicity						Total	
	Khas		Janajati		Dalit			
	N	%	N	%	Nr	%	N	%
Primary	67	30.9	73	33.6	77	35.5	217	33.6
Secondary	66	30.0	75	34.1	79	35.9	220	34.1
SLC	58	45.3	42	32.8	28	21.9	128	19.9
Higher	45	56.3	31	38.8	4	5.0	80	12.4
Total	236	36.6	221	34.3	188	29.1	645	100.0

Source: Field Survey, 2011 N=Number, %=Percent

4.3: Economic Characteristics

Economic background has prime role to determine the status of people. In also determines the living style and quality of life of people. The economic characteristic are generally types of occupation, current status or people's income and level of expenditure on goods or services.

4.3.1: Occupation Status of Sample Population

Information on occupational status of population was collected at the time of study. The occupational status of population in study area was collected for age group 5 and years and above. Major occupation in study area was agriculture. Out of 874 population, 505(57.8%) were involved in agriculture

and followed by study 269(30.8%), foreign labour 47(5.4%), services 34(3.9%) respectively.

Table 9: Occupation Status of Sample Population Age Five Years and Above, Jaljale, Tehrathum, 2011

Occupation	Ethnicity						Total	
	Khas		Janajati		Dalit			
	N	%	N	%	N	%	N	%
Agriculture	158	31.3	166	32.9	181	35.8	505	57.8
Services	23	67.6	10	29.4	1	2.9	34	3.9
Foreign Labour	10	21.3	19	40.4	18	38.3	47	5.4
Study	103	38.3	96	35.7	70	26.0	269	30.8
Labour	2	28.6	3	42.9	2	28.6	7	0.8
Business	8	88.9	1	11.1	0	0.0	9	1.0
Tailoring	0	0.0	0	0.0	3	100.0	3	0.3
Total	304	34.8	295	33.8	275	31.4	874	100.0

Source: Field Survey, 2011 N=Number, %=Percent

If that is analyzed based on ethnicity then the scenario becomes different. Out of 505 people involved in agriculture, the proportion of Dalit was higher in comparison to Khas and Janajati. Just opposite in services, higher proportion of population was involved from Khas followed by Janajati and very poor share from Dalit. Out of 34 persons only 1 from Dalit, 10 persons from Janajati and 23 persons from Khas respectively were involved in this occupation. The proportions Janajati and Dalit were almost two times higher than Khas for foreign labour. Data clearly illustrated that Khas was comparatively more involved in white color jobs and Janajati and Dalit were in blue colour jobs (Table 9).

4.3.2: Monthly Income of Sample Population

About 31.0 percent population was under the poverty line ($1 per day: NLSS, 2003/04) and about 50.0 percent in this VDC (Deurali Society, 2005). It refers the scenario of lack of good income sources in study area.

The average income of respondents was Rs. 2025 per month. The characteristics of respondents income by ethnicity were observed similar as earlier Khas and Dalit had more number of respondents in lower income i. e. up to Rs. 500 per month. Similarly, those respondents whose monthly income was more than 2000 were more (54.1%) for Janajati, 29.7 percent for Khas and only 16.2 percent for Dalit. The average monthly income of Khas

was Rs. 1630, Janajati was 3272 and Dalit was 1174 respectively. It was found that Janajati ranked in comparatively better than Khas and Dalit.

Table 10: Distribution of Monthly Income by Ethnicity, Jaljale, Tehrathum, 2011

Monthly Income of Respondents	Ethnicity						Total	
	Khas		Janajati		Dalit			
	N	%	N	%	N	%	N	%
0-500	18	32.1	14	25.0	24	42.9	56	33.9
500-1000	11	44.0	7	28.0	7	28.0	25	15.2
1000-1500	7	25.0	9	32.1	12	42.9	28	17.0
1500-2000	8	42.1	5	26.3	6	31.6	19	11.5
2000+	11	29.7	20	54.1	6	16.2	37	22.4
Total	55	33.3	55	33.3	55	33.3	165	100.0
Mean	NRs. 1630		NRs. 3272		NRs 1174		NRs. 2025	

Source: Field Survey, 2011 N = Number, % = Percent

However, the income distribution was not equal for all age groups population in amount. Now the income inequality in study area was discussed with Lorenz Curve and Gini-Concentration Ratio (Gi).

Lorenz Curve is used to measures inequalities in the distribution of wealth or income. It has also been used to depict the state of concentration of population and other demographic aggregates (Shryock and Siegel, 1976). Two independent variable i. e. sizes of population and average income were taken. The average monthly income is grouped in class interval according to proportion. Then the cumulated proportion of income (Xi) is plotted against cumulated proportion of elderly people (Yi). For comparison a diagonal line is drawn 45 degree to show the condition of equal distribution of income within population. More the curve deviates to diagonal less equal distribution of income. Gini-concentration Ratio (Gi) measures the proportion of the total area under the diagonal that lies in the area between the diagonal and Lorenz Curve. The proportion of area is computed by using the following formula.

$$Gi = \left(\sum_{i=1}^{n} Xi \,.Yi+1 \right) - \left(\sum_{i=1}^{n} Xi+1 \,.Y \right)$$

The value of Gini-Concentration Ratio occurs between 0-1. Lower the value more likely to equal distribution. If it equals to 0 income is equally distributed and if it equals to 1 income is concentrated in single population group only. Following the Lorenz Curve and Gini-concentration Ratio of income of elderly people in study area is computed as (Appendix- II).

The value of Gini-Concentration Ratio (Gi) 0.4242 (Appendix-II) in study area had concluded that it was likely to be unequal distribution of income within study populations. There was existed huge different between rich and poor. It was almost equal than national level figure (0.41). The Lorenz Curve and Gini-Concentration Ratio of income of elderly people is as (Appendix-II).

CHAPTER FIVE

ANALYSIS OF HEALTH STATUS AND CARING PRACTICE AMONG ELDERLY PEOPLE

5.1: Analysis of Health Status among Elderly People

"Health is a state of complete physical, mental and social well being and not merely the absence of disease and infirmity" (WHO). From this definition, it is clear that, a person who healthy by physical, mental and social status and can do daily activities, that is health. Overall health status of Nepalese population seems to be improving (MOHP et al, 2007). However, the health status of elderly people is still one of the major concerns that is rarely listened and implemented in policies, plans and programmes.

Elderly is the period of decrease ability and arise various types of health problem. In this period, elderly are physically weak and they are facing various physically problems such as vision problems, hearing problems and other physical hazardness.

In this study, the total questionnaires were 73 and their all were not measured on health status of elderly people. Only 12 questionnaires were measured on health status. As well as, the health status of elderly people measured on different four variables like social, demographic, economic and media utilization variables.

5.1.1: Health Status of Elderly People by Demographic Variables

Demographic variables are most important variables for analyzing the data. And which is closely related to the level of population and their structure. The variables current age of respondents, marital status and family size are related on demographic variables which are mentioned as follows.

5.1.1.1: Health Status of Elderly People by Current Age of Respondents

In the study area, the total number of elderly people was 26.9 which was higher than national level figure (18.89%, Singh, 2003:258). In this study, current age of respondents was categorized into five parts. Among total respondents only 27.9 percent had higher health status and they were concentrated on 75 years and above age groups. There were only 14

respondents of age 80 years and above, among them 3(21.4%) had low, 6(42.9%) had medium and 5(35.7%) had high level of health status. Likewise, there were 62 respondents of age group 60-64, among them, 29(46.8%) had low, 17(27.4%) had medium and 16(25.8%) had high level of health status respectively. After 75 years and above age, health status was seen increasing trend. Age group 80 years and above was observed as high level of health status and 60-64 years of age was observed as low level of health status (Table 11).

Table 11: Current Age of Respondents and Health Status, Jaljale, Tehrathum, 2011

Age Group of Respondents	Health Status of Category (Intra-group Comparison)						Total	
	Low(0.00-0.33)		Medium(0.34-0.66)		High(0.67-1.00)			
	N	%	N	%	N	%	N	%
60-64	29	46.8	17	27.4	16	25.8	62	37.6
65-69	14	32.6	18	41.9	11	25.6	43	26.1
70-74	9	31.0	12	41.4	8	27.6	29	17.6
75-80	6	35.3	5	29.4	6	35.3	17	10.3
80+	3	21.4	6	42.9	5	35.7	14	8.5
Total	61	37.0	58	35.2	46	27.9	165	100.0

Source: Field Survey, 2011 N = Number, % = Percent

5.1.1.2: Health Status of Elderly People by Marital Status

Marital status plays an important role for the longevity various and health status of the aged. Various studies have shown that married persons have passed longer life expectancy than that of unmarried, divorced, separated, widowed. Similarly married have better health condition than that of single, separated and widowed.

Table 12: Health Status of Elderly People by Marital Status, Jaljale, Tehrathum, 2011

Health Status Category (Intra-group Comparison)	Married		Widowed		Total	
	N	%	N	%	N	%
Low(0.00-0.33)	46	75.4	15	24.6	61	37.0
Medium(0.34-0.66)	38	65.5	20	34.5	58	35.2
High(0.67-1.00)	22	47.8	24	52.2	46	27.9
Total	106	64.2	59	35.8	165	100.0

Source: Field Survey, 2011 N = Number, % = Percent

Out of the 165 respondents, 106(64.2%) were married and 59(35.8%) were widowed. The level of health status of widowed elderly people was observed high 24(52.2%) than 22(47.8%) married elderly people. Total 106 respondents were married, out of them 75.4 percent had low, 65.5 percent had medium and 47.8 percent had high level of health status. Similarly, 59 respondents were widowed, among them, 24.6 percent had low, 34.5 had medium and 52.2 percent had high level of health status (Table12).

5.1.1.3: Health Status of Elderly People by Family Size

Family size is also important factor which affects the health status of elderly people. Among the 165 households, 45.5 percent households was to be 1-5 family size and 54.5 percent households was to be 6 and above family size. The level of health status of elderly people was observed as high 54.3 percent in family size 6 and above than 45.7 percent in family size 1-5 (Table 13).

Table 13: Health Status of Elderly People by Family Size, Jaljale, Tehrathum, 2011

Health Status Category (Intra-group Comparison)	Family Size				Total	
	1-5		6+			
	N	%	N	%	N	%
Low (0.00-0.33)	29	47.5	32	52.5	61	37.0
Medium(0.34-0.66)	25	43.1	33	56.9	58	35.2
High(0.67-1.00)	21	45.7	25	54.3	46	27.9
Total	75	45.5	90	54.5	165	100.0

Source: Field Survey, 2011 N = Number, % = Percent

5.1.2: Health Status of Elderly People by Social Variables

Social variables determine social status of people which are related on social values and norms. In this study, social variables were included caste/ethnicity, literacy and educational attainment and toilet facility. The social variables and their status on health status of elderly people is mentioned in this section.

5.1.2.1: Health Status of Elderly People by Ethnicity

Out of the 165 respondents, 46(27.9%) had high health status of elderly people. Among them, 34(73.9%) were from Khas, 7(15.2%) were from Janajati and only 5(10.9%) were from Dalit. Likewise, 58(35.2%) had medium health status of elderly people that constituted 32(55.2%) from

Janajati, equal 13(22.4%) from Khas and Dalit. Similarly, 61(37.0%) had low level of health status of elderly people in total respondents, among them, only 8(13.1%) were Khas, 16(26.2%) were Janajati and 37(60.7%) were from Dalit. Thus, Khas had high health status of elderly people as compared to Janajati and Dalit. As well as, Dalit elderly people had very low health than others (Table 14).

Table 14: Health Status of Elderly People by Ethnicity, Jaljale, Tehrathum, 2011

Health Status Category (Intra-group Comparison	Ethnicity						Total	
	Khas		Janajati		Dalit			
	N	%	N	%	N	%	N	%
Low(0.00-0.33)	8	13.1	16	26.2	37	60.7	61	37.0
Medium(0.34-0.66)	13	22.4	32	55.2	13	22.4	58	35.2
High(0.67-1.00)	34	73.9	7	15.2	5	10.9	46	27.9
Total	55	33.3	55	33.3	55	33.3	165	100.0

Source: Field Survey, 2011 N = Number, % = Percent

Likewise, 58(35.2%) had medium health status of elderly people that constituted 32(55.2%) from Janajati, equal 13(22.4%) from Khas and Dalit. Similarly, 61(37.0%) had low level of health status of elderly people in total respondents, among them, only 8(13.1%) were Khas, 16(26.2%) were Janajati and 37(60.7%) were from Dalit. Thus, Khas had high health status of elderly people as compared to Janajati and Dalit. As well as, Dalit elderly people had very low health than others (Table 14).

5.1.2.2: Health Status of Elderly People by Religion

Indicators of health status of elderly people showed that Christian religion followers had high 1(100.0%) health status as compared to Hindu, Buddhist and Kirat.

Table 15: Health Status of Elderly People by Religion, Jaljale, Tehrathum, 2011

Religion of Respondents	Health Status Category (Intra-group Comparison)						Total	
	Low		Medium		High			
	N	%	N	%	N	%	N	%
Hindu	47	38.5	34	27.9	41	33.6	122	73.9
Buddhist	2	22.2	6	66.7	1	11.1	9	5.5
Kirat	2	36.4	18	54.5	3	9.1	33	20.0
Christian	0	0.0	0	0.0	1	100.0	1	.6
Total	61	37.0	58	35.2	46	27.9	165	100.0

Source: Field Survey, 2011 N = Number, % = Percent

Among 165 respondents, 122(73.9%) followed Hindu, 33(20.0%) followed Kirat, 9(5.5%) followed Buddhist and only 1(.6%) followed Christian religion. Out of 122(73.9%) Hindu followers, 47(38.55%) had low, 34(27.9%) had medium and 41(33.6%) had high level of health status. Similarly, among 33(20.0%) Kirat, 12(36.4%) had low, 16(54.5%) had medium and 3(9.1%) had high level of health status. The low level (38.5%) of health status was seen that in Hindu religion followers (Table 15).

5.1.2.3: Health Status of Elderly People by Literacy and Educational Attainment

Education is one of the prime factors, which governs all the aspects of human life. The education affects the level of living standard and way of thinking as well as working styles of people. Especially, education makes people conscious and helps to obtain new knowledge and skills as well as to update and sharpen existing knowledge and skills (Budhathoki, 2007:73).

Table 16: Health Status of Elderly People by Literacy, Jaljale, Tehrathum, 2011

Level of Education	Health Status Category (Intra-group Comparison)						Total	
	Low		Medium		High			
	N	%	N	%	N	%	N	%
Illiterate	13	20.6	24	38.1	26	41.3	63	38.2
Literate	48	47.1	34	33.3	20	19.6	102	61.8
Total	61	37.0	58	35.2	46	27.9	165	100.0

Source: Field Survey, 2011 N = Number, % = Percent

There were 102(61.8%) literate and 63(38.2%) illiterate respondents in the study area. The data illustrated that illiterate had higher level of health status compared to literate. There were 46(27.9%) respondents who had high level of health status among them 20(19.6%) were literate and 26(41.3%) were illiterate. In low health status column, more numbers (48) were literate and in high health status column, high numbers (26) were illiterate. In this study, the health status of elderly people was seen very high in illiterate respondents. It may be various causes to be seen such types of result (Table 16).

Similarly, in educational attainment, out of 55 respondents, 42(76.3%) had primary education. Among them 17(40.5%) had low, 19(45.2%) had medium

and 6(14.3%) had high level of health status. Likewise, 9(16.4%) had SLC and above education. Out of them, 1(11.1%) had low, 3(33.3) had medium and 5(55.6%) had high level of health status. The level of health status was very high (55.6%) respondents who had SLC and above education. Data illustrated that as the level of educational attainment increase, health status also increase. In another word, higher level of educational status indicates the higher quality of life and vice versa (Table 17).

Table 17: Health Status of Elderly People by Educational Attainment, Jaljale, Tehrathum, 2011

Educational Attainment	Health Status Category (Intra-group Comparison)						Total	
	Low		Medium		High			
	N	%	N	%	N	%	N	%
Primary	17	40.5	19	54.2	6	14.3	42	76.3
Secondary	2	50.0	2	50.0	0	0.0	4	7.3
SLC and above	1	11.1	3	33.3	5	55.6	9	16.4
Total	20	36.4	24	43.6	11	20.0	55	100.0

Source: Field Survey, 2011 N = Number, % = Percent

5.1.2.4: Health Status of Elderly People by Toilet Facility

Toilet facility is also related with the health condition of people. It plays most important role for determining the health status of people. NDHS, 2001 and CBS 2001 showed that there were about 30.0 percent and 46.8 percent households respectively had any kinds of toilet facilities in Nepal (Cited from Kayastha and Shrestha, 2003:194).

Table 18: Health Status of Elderly People by Toilet Facility, Jaljale, Tehrathum, 2011

Facilities of Toilet	Health Status Category (Intra-group Comparison)						Total	
	Low		Medium		High			
	N	%	N	%	N	%	N	%
Yes	51	35.2	53	36.6	41	28.3	145	87.9
No	10	50.0	5	25.0	5	25.0	20	12.1
Total	61	37.0	58	35.2	46	27.9	165	100.0

Source: Field Survey, 2011 N = Number, % = Percent

The scenario was reported different in study area. Out of 165 households, 145(87.9%) households had toilet facility. Among them, 51(35.2%) had low, 53(36.6%) had medium and 41(28.3%) had high level of health status. In

another side, respondents who had no toilet facility, their level of health status was low (50.0%) (Table 18).

5.1.3: Health Status of Elderly People by Economic Variables

Economic background has prime role to determine the status of elderly people. It also determines the living style and quality of life of elderly people. For example people who have better economic status are more cared by their family member than who have low economic status.

5.1.3.1: Health Status of Elderly People by Occupation

Past occupation of elderly people also helps to understand their economic status. It is an important factor whereas it is necessary to be family with past occupation of elderly people. The total population was divided into two categories one was agricultural and other was non-agricultural sector. A majority of respondents 138(83.6%) were engaged in agricultural.

Table 19: Health Status of Elderly People by Past Occupation, Jaljale, Tehrathum, 2011

Past Occupation	Health Status Category (Intra-group Comparison)						Total	
	Low		Medium		High			
	N	%	N	%	N	%	N	%
Agriculture	51	37.0	45	32.6	42	30.4	138	83.6
Non-agriculture	10	37.0	12	44.5	5	18.5	27	16.4
Total	61	37.0	58	35.5	46	27.9	165	100.0

Source: Field Survey, 2011 N = Number, % = Percent

Out of them 5(37.0%) had low, 45(32.6) had medium and 42(30.4%) had high level of health status. In another side, 27(16.4%) respondents followed non-agricultural. Among them, 10(37.0%) had low, 12(45.5%) had medium and 5(18.5%) had high level of health status. There were not seen vast different in level of health status between agricultural and non-agricultural occupation (Table 19).

5.1.3.2: Health Status of Elderly People by Income

The level of income directly affects the living standard of people because it determines the expenditure needed materials. The respondent monthly income was divided into three categories. One was below 500(low), 501-1500(medium) and third was 1501+ (high). Those, whose respondents

income was below Rs 500 was 56(33.9%) and among them, 21(37.5%) had low, 17(30.4%) had medium and 18(32.1%) had high level of health status. When respondents income increased from Rs 501, the number of respondents with high level of health status slowly decreased. Similarly, 56 respondents had 1501 and more monthly income. Out of them, 18(32.1%) had low, 26(46.4%) had medium and 12(21.4%) had high level of health status. The overall pictures showed that when the level of income increased but the level of health status decreased. So it can say that only high level of income is not sufficient for good health. It is also affected by other various things (Table 20).

Table 20: Health Status of Elderly People by Income, Jaljale, Tehrathum, 2011

Income Category of Elderly People	Health Status Category (Intra-group Comparison)						Total	
	Low		Medium		High			
	N	%	N	%	N	%	N	%
Low (<500)	21	37.5	17	30.4	18	32.1	56	33.9
Medium (5011-500)	22	41.5	15	28.3	16	30.1	53	32.1
High (1501+)	18	32.1	26	46.4	12	21.4	56	33.9
Total	61	37.0	58	35.2	46	27.9	165	100.0

Source: Field Survey, 2011 N = Number, % = Percent

5.1.4: Health Status of Elderly People by Media Utilizations

Media is main source of information which gives the various types of information to people in different aspect. It also helps to people for getting good health status and caring because it gives the different information to the health.

5.1.4.1: Health Status of Elderly People by Radio Listeners

The total sample respondents were 165 of the study area. Respondents who listened radio were 115(69.7%). Those, whose 48(41.7%) had low, 36(31.3%) had medium and 31(27.0%) had high level of health status.

Table 21: Health Status of Elderly People by Radio Listeners, Jaljale, Tehrathum, 2011

Radio Listeners	Health Status Category (Intra-group Comparison)						Total	
	Low		Medium		High			
	N	%	N	%	N	%	N	%
Yes	48	41.7	36	31.3	31	27.0	115	69.7

No	13	26.0	22	40.0	15	30.0	50	30.3
Total	61	37.0	58	35.2	46	27.9	165	100.0

Source: Field Survey, 2011 N = Number, % = Percent

Similarly, out of 165 respondents, 50(30.3%) who did not listen radio. Those, whose 13(26.0%) had low, 22(44.0%) had medium and 15(30.0%) had high level of health status (Table 21).

5.1.4.2: Health Status of Elderly People by Access of Television

Television is a kind of audio-visual media of communication. So it is mostly effective for people to gain knowledge than other media radio, mobile etc. In this study, respondents who had access of television they had high (34.8%) level of health status than who had not access of television. Out of the 165 respondents, 96(58.25%) had access of television. Among them, 23(25.8%) had low, 35(39.3%) had medium and 31(34.8%) had high level of health status. Likewise, 76 (46.1%) respondents had not access of television. Out of them, 38(50.0%) had low, 31(30.1%) had medium and only 15(19.7%) had high level of health status (Table 22).

Table 22: Health Status of Elderly People by Access of Television, Jaljale, Tehrathum, 2011

Access of Television	Health Status Category (Intra-group Comparison)						Total	
	Low		Medium		High			
	N	%	N	%	N	%	N	%
Yes	23	25.8	35	39.3	31	34.8	89	53.9
No	38	50.0	23	30.1	15	19.7	76	46.1
Total	61	37.0	58	35.2	46	27.9	165	100.0

Source: Field Survey, 2011 N = Number, % = Percent

5.2: Analysis of Caring Practice of Elderly People

There is the lack of separate effective for elderly people's health care facilities in Nepal. Whatever facilities are rendered by the government, non-government and private agencies are for all and senior citizens have also be there to avail services. Specific clinics of elderly, separate wards or some special arrangements to ease their health hurdles and public expenditure segregated for these activities are in absence. Nonetheless, out of the total health expense a large share goes to the care of elderly is rather obvious (Acharya, 2006:87).

Out of 73 questionnaires, only 17 questionnaires were measured on caring practice of elderly people. In this study, respondents were divided into four categories like, demographic, social, economic and media utilizations.

5.2.1: Caring Practice of Elderly People by Demographic Variables

5.2.1.1: Caring Practice of Elderly People by Current Age of Respondents

The percent of 60+ years old had increased from 4.28 percent in 1991 to 7.46 percent by 2001 (Singh, 2003:257). The current age of respondents were divided into five age groups. Among them, the level of caring practice was high 9(52.9%) in age group 75-79. As well as low level of caring practice was 10(23.3%) in age groups 65-69.

Table 23: Caring Practice of Elderly People by Current Age of Respondents, Jaljale, Tehrathum, 2011

Age Group of Respondent	Caring Practice Category (Intra-group Comparison)						Total	
	Low		Medium		High			
	N	%	N	%	N	%	N	%
60-64	8	12.9	26	41.9	28	45.2	62	37.6
65-69	10	23.3	17	39.5	16	37.2	43	26.1
70-74	4	13.8	11	37.9	14	48.3	29	17.6
75-80	2	11.8	6	35.3	9	52.9	17	10.3
80+	1	7.1	6	42.9	7	50.0	14	8.5
Total	25	15.2	66	40.0	74	44.8	165	100.0

Source: Field Survey, 2011 N = Number, % = Percent

There were only 14(8.5%) respondents of age 80 years and above. Out of them, only 1(7.1%) had low, 6(42.9%) had medium and 7(50.0%) had high level of caring practice. Likewise, there were 62(37.6%) respondents of age group 60-64. Among them, 8(12.9%) had low, 26(41.9%) had medium and 28(45.2%) had high level of caring practice. After 70 years of age, level of caring practice was seen on increasing trend (Table 23).

5.2.1.2: Caring Practice of Elderly People by Marital Status

Out of 165 respondents, the proportion of married was found high (64.2%) which was lower than national level figure (male 86.46%, female 68.34% and total 77.48%). Among 64.2 percent married, 7(28.0%) had low, 41(62.1%) had medium and 38(78.4%) had high level of caring practice. Similarly, among 59(35.8%) widowed, 18(72.0%) had low, 25(37.9%) had medium and

16(21.6%) had high level of caring practice. The data illustrated that married had higher level of caring practice than widowed (Table 24).

Table 24: Caring Practice of Elderly People by Marital Status, Jaljale, Tehrathum, 2011

Caring Practice Category (Intra-group Comparison)	Married		Widowed		Total	
	N	%	N	%	N	%
Low	7	28.0	18	72.0	25	15.2
Medium	41	62.1	25	37.9	66	40.0
High	58	78.4	16	21.6	74	44.8
Total	106	64.2	59	35.8	165	100.0

Source: Field Survey, 2011 N = Number, % = Percent

5.2.1.3: Caring Practice of Elderly People by Family Size

The average family size was 5.8 of Nepal which was 5.6 in study area. The family size to be 1-5 households was 75(45.5%). Among them, 18(72.0%) had low, 33(50.0%) had medium and 24(32.4%) had high level of caring practice. Similarly, the family size to be 6 and above households were 90(54.5%).

Table 25: Caring Practice of Elderly People by Family Size, Jaljale, Tehrathum, 2011

Caring Practice Category (Intra-group Comparison)	Family Size				Total	
	1-5		6+			
	N	%	N	%	N	%
Low	18	72.0	7	28.0	26	15.2
Medium	33	50.0	33	50.0	66	40.0
High	24	32.4	50	67.6	74	44.8
Total	75	45.5	90	54.5	165	100.0

Source: Field Survey, 2011 N = Number, % = Percent

Out of them, 7(28.0%) had low, 33(50.0%) had medium and 50(67.6%) had high level of caring practice. It was seen that increasing the family size also increasing the level of caring practice (Table 25).

5.2.2: Caring Practice of Elderly People by Social Variables

5.2.2.1: Caring Practice of Elderly People by Ethnicity

Among 165 respondents, 74(44.8%) had high level of caring practice. Out of them, 23(31.1%) were from Khas, 28(27.8%) were from Janajati and 23(31.1%) were from Dalit. Likewise, 66(40.0%) had medium level of caring practice. Among them, 24(36.4%) were from Khas, 21(31.8%) were from Janajati and also 21(31.8%) were from Dalit. Similarly, 25(15.2%) had low level of caring practice. Out of them, 8(32.0%) were from Khas, 6(24.0%) from Janajati and 11(44.0%) from Dalit. Hence, Janajati had high level of

caring practice as compared to Khas and Dalit. Khas and Dalit had equal level of caring practice in high level (Table 26).

Table 26: Caring Practice of Elderly People by Ethnicity, Jaljale, Tehrathum, 2011

Caring Practice Category (Intra-group Comparison)	Ethnicity						Total	
	Khas		Janajati		Dalit			
	N	%	N	%	N	%	N	%
Low	8	32.0	6	24.0	11	44.0	25	15.2
Medium	24	36.4	21	31.8	21	31.8	66	40.0
High	33	31.1	28	37.8	23	31.1	74	44.8
Total	55	33.3	55	33.3	33	33.3	165	100.0

Source: Field Survey, 2011 N = Number, % = Percent

5.2.2.2: Caring Practice of Elderly People by Religion

More than two third (76.3%) of respondents in study area reported that they followed Hindu religion which was slightly lower than national level figure (80.6%, Dahal, 2003). It was followed by Kirat religion. One fifth (20.0%) elderly people in study area reported that they were in categories of religion which quite higher than national level figure (3.6%, Dahal, 2003). Among total respondents, 6(66.7%) Buddhist had high level of caring practice followed by Hindu religion 55(45.1%). There were no low levels of caring practice in Buddhist followers. Only one respondent followed Christian religion. But that respondent level of caring practice was found low level (Table 27).

Table 27: Caring Practice of Elderly People by Religion, Jaljale, Tehrathum, 2011

Religion of Respondents	Caring Practice Category (Intra-group Comparison)						Total	
	Low		Medium		High			
	N	%	N	%	N	%	N	%
Hindu	20	16.4	47	38.5	55	45.1	122	73.9
Kirat	0	0.0	3	33.3	6	66.7	9	5.5
Buddhist	4	12.1	16	48.5	13	39.4	33	20.0
Christian	1	100.0	0	0.0	0	0.0	1	.6
Total	25	15.2	66	40.0	74	44.8	165	100.0

Source: Field Survey, 2011 N = Number, % = Percent

5.2.2.3: Caring Practice of Elderly People by Literacy and Educational Attainment

Education is a key factor in sustainable development: it is at the same time a component of well-being and a factor in the development of well-being through its links with demographic as well as economic and social factors. Education is also a means to enable the individual to gain access to knowledge, which is a pre-condition for coping, by anyone wishing to do so, with today's complex world (ICPD, 1994:93).

The literacy rate (those who can read and write) for aged 65+ years was found as 27.0 percent for males and 4.07 percent for females. For both sexes, the literacy rate for aged 65+ years was found as 15.64 percent (Singh, 2003: 272).

Table 28: Caring Practice of Elderly People by Literacy, Jaljale, Tehrathum, 2011

Literacy Status	Caring Practice Category (Intra-group Comparison)						Total	
	Low		Medium		High			
	N	%	N	%	N	%	N	%
Illiterate	16	25.4	31	49.2	16	25.4	63	38.2
Literate	9	8.8	35	34.3	58	56.9	102	61.8
Total	25	15.2	66	40.0	74	44.8	165	100.0

Source: Field Survey, 2011 N = Number, % = Percent

There were 63(38.2%) illiterate and 102(61.8%) literate in study area. The data illustrated that literate had higher level of caring practice compared to illiterate. Among 102(61.8%) literate respondents, 9(8.8%) had low, 35(34.3%) had medium and 58(56.9%) had high level of caring practice. Similarly, 63(38.2%) respondents were illiterate. Out of them, 16(25.4%) had low, 31(49.2%) had medium and 16(25.4%) had high level of caring practice (Table 28).

Likewise, in educational attainment, high proportion 42(76.3%) had primary education. Among them 5(11.9%) had low, 14(33.3%) had medium and 23(54.8%) had high level of caring practice. Similarly, 9(16.4%) had SLC and above education. Out of them, 2(22.2%) had medium and 7(77.8%) had high level of caring practice. It was seen that when the level of education increased the level of caring practice is also increased (Table 29).

Table 29: Caring Practice of Elderly People by Educational Attainment, Jaljale, Tehrathum, 2011

Educational Attainment	Caring Practice Category (Intra-group Comparison)						Total	
	Low		Medium		High			
	N	%	N	%	N	%	N	%
Primary	5	11.9	14	33.3	23	54.8	42	76.3
Secondary	1	25.0	0	0.0	3	75.0	4	7.3
SLC and Above	0	0.0	2	22.2	7	77.8	9	16.4
Total	6	10.9	16	29.1	33	60.0	55	100.0

Source: Field Survey, 2011 N = Number, % = Percent

5.1.3: Caring Practice of Elderly People by Economic Variables

5.1.3.1: Caring Practice of Elderly People by Past Occupation

Occupation is the most important part for caring practice of elderly people. In study area, out of the 165 respondents more than four fifth (83.6%) respondents were reported that they followed agricultural. Among them, 21(15.2%) had low, 55(39.9%) had medium and 62(44.9%) had high level of caring practice. Likewise, 27 respondents followed non-agricultural. Out of them, 4(14.8%) had low, 11(40.7%) had medium and 12(44.4%) had high level of caring practice. It was found that there was almost equal level of caring practice between both occupations (Table 30).

Table 30: Caring Practice of Elderly People by Past Occupation, Jaljale, Tehrathum, 2011

Past Occupation	Caring Practice Category (Intra-group Comparison)						Total	
	Low		Medium		High			
	N	%	N	%	N	%	N	%
Agriculture	21	15.2	55	39.9	62	44.9	138	83.6
Non-agriculture	4	14.8	11	40.7	12	44.4	27	16.4
Total	25	15.2	66	40.0	74	44.8	165	100.0

Source: Field Survey, 2011 N = Number, % = Percent

5.1.3.2: Caring Practice of Elderly People by Level of Income

The respondents monthly income was divided into three categories. One was below 500 (low), 501-1500 (medium) and 1501+ (high). Those, whose monthly income was below Rs 500 were 56(33.9%) and among them, 10(17.9%) had low, 25(44.6%) had medium and 21(37.5%) had high level of caring practice. When respondents monthly income increased from 1501, the number of respondents with high level of caring practice also increased

and low was decreased. Similarly, 56(33.9%) had 1501 and above monthly income and among them, 7912.5%) had low, 15(26.8%) had medium and 34(60.7%) had high level of caring practice. The overall pictures showed that, when the level of income increased the level of caring practice also increased. Thus, the level of respondents monthly income also important variable in determining the level of caring practice (Table 31).

Table 31: Caring Practice of Elderly People by Level of Income, Jaljale, Tehrathum, 2011

Income Category	Caring Practice Category (Intra-group Comparison)						Total	
	Low		Medium		High			
	N	%	N	%	N	%	N	%
Low (< 500)	10	17.9	25	44.6	21	37.5	56	33.9
Medium (501-1500)	8	15.1	26	49.1	19	35.8	53	32.1
High (1501+)	7	12.5	15	26.8	34	60.7	56	33.9
Total	25	15.2	66	40.0	74	44.8	165	100.0

Source: Field Survey, 2011 N = Number, % = Percent

5.1.4: Caring Practice of Elderly People by Media Utilization

5.1.4.1: Caring Practice of Elderly People by Radio Listeners

The proportion of respondents who listened radio was found that very high (69.7%) than who did not listen radio (30.3%). And also found that the high (53.0%) level of caring practice on radio listener compared to (26.0%) non listener.

Table 32: Caring Practice of Elderly People by Radio Listeners, Jaljale, Tehrathum, 2011

Radio Listeners	Caring Practice Category (Intra-group Comparison)						Total	
	Low		Medium		High			
	N	%	N	%	N	%	N	%
Yes	15	13.0	39	33.9	61	53.0	115	69.7
No	10	20.0	27	54.0	13	26.0	50	30.0
Total	25	15.2	66	40.0	74	44.8	165	100.0

Source: Field Survey, 2011 N = Number, % = Percent

Among the radio listener, 15(13.0%) had low, 39(33.9%) had medium and 61(53.0%) had high level of caring practice. Similarly, respondents who did not listen radio, 10(20.0%) had low, 27(54.0%) had medium and 13(26.0%) had high level of caring practice. So it can say that radio is very powerful

media of communication. It helps to people for getting various types of information which helps to increase the level of caring practice of people (Table 32).

5.1.4.2: Caring Practice of Elderly People by Access of Television

Television is also very effective media of communication. It also helps to increase the different types of knowledge. In the study area, total 89(53.9%) respondents had access of television.

Table 33: Caring Practice of Elderly People by Access of Television, Jaljale, Tehrathum, 2011

Access of Television	Caring Practice Category (Intra-group Comparison)						Total	
	Low		Medium		High			
	N	%	N	%	N	%	N	%
Yes	6	6.7	31	34.8	52	58.4	89	53.9
No	19	25.0	35	46.1	22	28.9	76	46.1
Total	25	15.2	66	40.0	74	44.8	165	100.0

Source: Field Survey, 2011 N = Number, % = Percent

Out of them, 6(6.7%) had low, 31(34.8%) had medium and 52(58.4%) had high level of caring practice. Likewise, 76(46.1%) respondents had no access of television. Among them, 19(25.0%) had low, 35(46.1%) had medium and 22(28.9%) had high level of caring practice. It was found that respondents who had access of television their level of caring practice also high (58.4%) as compared to (28.9%) had not access of television (Table 33).

5.1.2.3: Caring Practice of Elderly People by Self Mobile

The media utilization is important part of the study of elderly people on caring practice. Now a day's so many people have access of different types of media of communication.

Table 34: Caring Practice of Elderly People by Self Mobile, Jaljale, Tehrathum, 2011

Self Mobile	Caring Practice Category (Intra-group Comparison)						Total	
	Low		Medium		High			
	N	%	N	%	N	%	N	%
Yes	2	4.8	14	33.3	26	62.0	42	25.5
No	23	18.9	52	42.3	48	39.0	123	74.5
Total	25	15.2	66	40.0	74	44.8	165	100.0

Source: Field Survey, 2011 N = Number, % = Percent

In the study area, it was found that people who had self mobile their level of caring practice also high (62.0%) than who had not self mobile. Out of the 165 respondents, only 42(25.5%) had self mobile. Among them, 2(4.8%) had low, 14(33.3%) had medium and 26(62.0%) had high level of caring practice. Similarly, 123(74.5%) respondents had not self mobile. Out of them, 23(18.9%) had low, 52(42.3%) had medium and 48(39.0%) had high level of caring practice (Table 34).

CHAPTER SIX

ANALYSIS OF QUALITATIVE INFORMATION

6.1: Case Studies

There were various cases observed during the researches field visit. Among them two cases are presented bellow.

6.1.1: Case One: Outcast of Young Couple Resulted in Grief

Naramya Nepali is a woman at age of 91 years old. She had given birth to her 12 offspring. They were 3 sons and 9 daughters. Now she lives with her widow daughter of age 65. Among the offspring, sons are already died and her husband also died some 15 years ago. She has no landholding except small cottage and its homestead area. She is poor of the poor. Until some 3 to 4 years ago, she used to fulfill her basic needs by begging in the village but now she is even unable to walk for begging. She, now, maintained her daily life from goods begged by her daughter and widow allowance received by both. Her daughter is also disabled now. Some 2 years ago, there happened an unusual event in their family. The son of her elder daughter and the daughter of her younger daughter were found sexually involved with each other. Until then, they had supported to these two elderly mother and grand-mother by their earning of wages. When their improper relationships were revealed the villagers had a meeting and they outcaste both of them from the village. So, her supporting stick was also broken down.

She was observed spending days staying at home with chronic types of health problems such as, asthma, swelling of hands and legs, deteriorating hearing and sight. No one was to care except her daughter living together. Other daughters and son-in-laws didn't care and support her. She had a great feeling towards the need of husband, sons and other family members. She recalled the days of the presence of her husband and sons when there were no problems. Had my sons and husband there, I would have some support for the livelihood was her version. It was just like a dream to her.

The involvement of brother-sister in sexual activity with each other and its result of their exile from the village had severely hampered the life of two

elderly women. The punishment was for these two old ladies, not for those young couple.

The arising thoughts are that - there must be some provisions for taking care of such elderly people in communities, so that their pain, grief and problems could be minimized.

Even though, government has been providing widow allowance, it gives only a little support. It is appreciable, but it is not sufficient. It would be better, if the government provides the facilities of fooding, clothing and health. She told that she have also a desire of dying in the place where she had been spending her life doing *daura* and *ghash* (collecting fuel wood and fodder), and walking ups and downs. She is now in the most critical condition of her life. Nothing except grief, pain and problems are in front of her but she is struggling with death for living.

6.1.2: Case Two

Laxman Adhikari is a Brahman aged of 70 years. He has no sons and daughters. After death of his parents, he has been living alone. According to him at a time in his life he had also got married, when his parents were with him. But, his wife left him and after that moment he never thought to marry again.

Since the time he knows, he has been doing hard labour because of poverty. He had no sufficient land to cultivate. Only one house was there with him that was also very old. He used to seek for the opportunity of wage labour in village and marketplace. If there was availability of work for wage he survived that day, otherwise he had to bear hunger. He didn't have any great expectation in his life except ill-less life. However, sometimes he had problem of illness and he sought support from his neighbors. Many times he wanted to seek help from neighborhood but they might consider it as nuisance, he attempted to manage alone. He feels sad in such conditions.

He started gradually to be victim of health problems. Such as losing hearing power, chest pain, cough as well physical disabilities. He thought that the greatest problem was losing hearing power for him, because when hearing power started to deteriorate, people started to abuse him too. He needed to speak loudly and needed loud voice to be spoken by others too. So people

didn't want to talk to him and relationship with the society was getting bad slowly. This made him worried.

He said that, life was getting more critical day by day. Furthermore, he was required to work daily for survival and he had no jobs to earn livelihood. Government has been providing old aged allowance, it is not sufficient to maintain the life. So, he was seeking humanitarian support for persons like him in the areas like food, clothing, and housing, as well as health facilities.

CHAPTER SEVEN

STATISTICAL ANALYSIS

7.1: Analyses of Gamma

A Gamma test tests the strength of association of the cross tabulated data when both variables are measured at the ordinal level. Values range from – 1 (100% negative association, or perfect inversion) to + 1 (100% positive association or perfect agreement). A value of zero indicates the absence of association (Sheskin, 2007, Cited from Khanal, 2009: 98).

The standard deviation of sampling distribution of a statistic is known as its standard error and its considered the key to sampling theory. Standard errors are important because they reflect how much sampling fluctuation a statistic shows. The inferential statistics involved in the construction of confidence intervals and significant testing are based on standard errors. The standard error enables us to specify the limits within which the parameters of the population are expected to lie with a specified degree of confidence. Such an interval is usually known as confidence interval. The standard error gives an idea about the reliability and precision of a sample. The smaller the standard error, the greater the uniformity of sampling distribution and hence, greater is the reliability of sample. The size of standard error depends upon the sample size to a great extent and it varies inversely with the size of sample (Kothari, 2007:164).

The level of significance is most important concept in the context of hypothesis testing (Kothari, 2007:186). The statistical significance of a relationship observed in a set of sample data, then, is always expressed in terms of probabilities. Significant at the 0.05 level ($p<0.05$) simply means that the probability of relationship as strong as the one observed being attributable to sampling error alone is no more than 5 in 100 (Babblie, 1990:298). Three levels of significance are frequently used in research: 0.05, 0.01 and 0.001.

7.1.1: Test of Health Status on Elderly People with Different Variables by Using Gamma Statistics.

Among demographic variables, current age of respondents had strong relation with health status of elderly people. It had positive relationship and had 0.128 Gamma coefficients with standard error 0.079 and 0.106 percent level of significance. Similarly, marital status of respondents had 0.373 Gamma coefficients with standard error 0.118 and almost 100 percent level of significance. Likewise, family size also had positive relationship and 0.032 Gamma coefficients with 0.128 standard error and 0.805 percent level of significance. It was found that, when the age of respondents and family size increased then level of health status also increased (Table 35).

Table 35: Gamma Coefficients Calculated indexes of Health Status on Elderly People with Different Variables, Jaljale, Tehrathum, 2011

Variables	Gamma Value	Asymp. Std. Error(a)	Approx. Sig.
Current Age of Respondents	.128	.079	.106
Marital Status	.373	.118	.003
Family Size	.032	.128	.805
Ethnicity	-.680	.071	.000
Literacy Status	-.471	.106	.000
Educational Attainment	.462	.215	.065
Toilet Facilities	-.193	.203	.348
Income Level	-.028	.100	.778
Radio Listeners	.197	.129	.135
Access of Television	-.394	.112	.001
Self Mobile	.029	.139	.834

A. Not assuming the null hypothesis
B. Using the asymptotic standard error assuming the null hypothesis.

Literacy status observed one of the strong negative relationships with health status of elderly people. It had -0.471 Gamma coefficients with 0.106 standard error and 100 percent level of significance. But level of education had positive association with health status of elderly people. It had observed 0.462 Gamma coefficients with 0.215 standard error and 0.065 percent level of significance. Similarly, ethnicity had negative association with health status of elderly people. It had observed as -0.680 Gamma coefficients with 0.071 standard error and 100 percent level of significance. That means as the ethnicity status changed from Khas to Janajati to Dalit the health status of elderly people decreased. Likewise, toilet facilities had negative relationship with health status. It had -0.193 Gamma coefficients with 0.203

and 0.348 level of significance. As well as, level of income had negative association with health status of elderly people. It had observed as – 0.028 Gamma coefficients with 0.100 standard error and 0.778 percent level of significance. It was seen that when the level of education status increased then the level of health status of elderly people also increased. In other side, lack of toilet facilities referred decreased the level of health status. As well as, also it was found that increased the level of income is not only sufficient for good health status of elderly people (Table 35).

Among media utilization variables, radio listeners had strong positive association with status of elderly people as comparatively other variables. It had 0.197 Gamma coefficients with 0.129 standard error and 0.135 percent level of significance. Similarly, access of self mobile observed as second strong positive relationship holder among media utilization variables. It had 0.029 Gamma coefficients with 0.139 standard error and 0.834 level of significance. But access of television had negative association with almost 100 percent level of significance on health status of elderly people. It had -0.394 Gamma coefficients with 0.112 standard error and 0.001 percent level of significance (Table 35).

7.1.2: Test of Caring Practice on Elderly People with Different Variables by Using Gamma Statistics.

Family size and caring practice in this study had strong relationship comparatively among demographic variables. It had observed as 0.451 Gamma coefficients with 0.112 standard error and 100 percent level of significance. It was observed that if the family size increased caring practice of elderly people also increased. Similarly, current age of respondents had -0.008 Gamma coefficients with 0.078 standard error and 0.916 level of significance. Marital status and caring practice had negative relationship. They had -0.548 Gamma coefficients with 0.105 standard error and 100 level of significance. It was found that marital status changed from married to widowed the caring practice decreased (Table 36).

Education widens the economic potentiality of an individual, helps to understand the consequences of various demographic events on their life and increase the decision-making capacity of individuals on various aspect of life (Acharya, 1998:42). In this study among social variables, literacy

status was observed strong positive association with caring practice of elderly people. It had 0.539 Gamma coefficients with 0.103 standard error and 100 percent level of significance. And also positive relationship with educational attainment and caring practice. It was found that when the literate proportion and level of education increased then caring practice of elderly people also increased.

Table 36: Gamma Coefficients Calculated for Indexes of Caring Practice on Elderly People by Selected Variables, Jaljale, Tehrathum, 2011

Variables	Gamma Value	Asymp. Std. Error (a)	Approx. Sig.
Current Age of Respondents	-0.008	0.078	0.916
Marital Status	0.451	0.112	0.000
Family Size	-0.548	0.105	0.000
Ethnicity	-0.032	0.111	0.776
Literacy Status	0.539	0.103	0.000
Educational Attainment	0.403	0.271	0.129
Level of Income	0.244	0.107	0.024
Radio Listeners	-0.410	0.119	0.002
Access of Television	-0.537	0.102	0.000
Self Mobile	-0.445	0.133	0.002

A. Not assuming the null hypothesis.
B. Using the asymptotic standard error assuming the null hypothesis.

Similarly, ethnicity had negative association with caring practice of elderly people, i.e. if ethnicity transformed from Khas to Janajati and Janajati to Dalit there would be observed decreased trend of caring practice had -0.032 Gamma coefficients with 0.111 standard error and 0.776 percent level of significance. Likewise, the level of income had positive relationship with caring practice of elderly people. It had 0.244 Gamma coefficients with 0.107 standard error and 0.024 percent level of significance. It was seen that if the level of income increased the caring practice of elderly people also increased (Table 36).

All media utilization variables had strong relationship with caring practice of elderly people. Among them, access of television had -0.537 Gamma coefficients with 0.102 standard error and 100 percent level of significance. Similarly, radio listeners had -0.410 Gamma coefficients with 0.119 standard error and almost 100(0.002) percent level of significance and also access of self mobile had strong relationship with 0.002 percent level of significance. It was found that respondents who had not access of media exposure their caring practice was decreased (Table 36).

CHAPTER EIGHT

SUMMARY, CONCLUSION AND RECOMMENDATION

8.1: Summary of Findings

The elderly people are property of family and society. Their knowledge and experiences can be taken as vital to the family, community as well as the country. Due to social structure and the socially contracted feeling, the elderly think that their sons are future security and deserve the rights to be taken care and respected by the sons and daughter-in-law. They also need love, care and affection.

The objective of this study was to examine health status and caring practice among three ethnicities in Jaljale VDC of Tehrathum district. The study primarily concentration health status and caring practice of elderly people (aged 60 years and above) by demographic, social, economic and media utilizations variables.

Basically, indexes for health status and caring practice of elderly people was constructed based on collected information and these indexes were cross tabulated and tasted by using Gamma statistics with demographic, social, economic and media utilization variables. Major findings of this study are mentioned as follows:

8.1.1: Summary of Household Characteristics

- The total population 918, 34.9 percent were Khas, 32.9 percent were Janajati and 32.2 percent were Dalit.
- Age group 0-14 consisted 19.2 percent, 15-59 consisted 53.9 percent and 60 years and above consisted 26.9 percent of the total population.
- Dalit had more numbers (21.6%) in age group 0-14, followed by Khas (19.1%) and Janajati (16.9%).
- Khas had more numbers (57.5%) in economically active age (15-59) compared to Janajati (53.6%) and Dalit (50.3%) respectively.
- Janajati had more numbers (29.5%) in 60 years and above ages compared to Khas (23.4%) and Dalit (28.1%).

- Sex ratio observed higher for Janajati (123.7) compared to Dalit (114.5) and Khas (102.5).
- Child ratio was higher for Dalit (43.0) followed by Khas (33.2) and Janajati (31.5) respectively.
- Old age ratio was higher for Dalit (55.7) followed by Janajati (54.9).
- Index of ageing was considerably higher for Janajati as compared to Khas and Dalit.
- The number of widowed was higher for Khas (27) than Janajati (12) and Dalit (21).
- The average family size 5.6 was of sample population.
- About 74.7 percent of people were found Hindu followed by 18.3 percent Kirat, 6.6 Buddhist and only 0.4 percent Christian respectively.
- About 82.7 percent of people were observed literate and among them 36.4 percent were Khas, 33.6 percent were Janajati and 30.0 percent were Dalit.
- Higher educational status was found for Khas 56.3 percent followed by 38.8 percent for Janajati and only 5.0 percent for Dalit.
- More number (67.6%) of service holder was Khas compared to more numbers (40.4%) of foreign labours were Janajati.
- Agriculture was main source of income for all ethnicity.
- Average monthly income was higher for Janajati (Rs 3272) moderate for Khas (Rs 1630) and lower for Dalit (Rs 1174).
- Total average monthly income was Rs 2025.

8.1.2: Findings of Health Status of Elderly People

- Age group 80 years and above observed as high health status group and age group 60-64 as low health status group for elderly people.
- Widowed had higher (52.2%) level of health status compared to married elderly people.

- High health status was found 54.3 percent family size to be 6 and above.
- Khas had observed better (73.9%) Janajati had moderate and Dalit had low health status on elderly people.
- Christian had better health status than other religions followers Hindu, Kirat and Buddhist.
- Illiterate had high (41.3%) health status than literate (19.6%).
- Respondents who had SLC and above education their health status was high (55.6%) as compared to others.
- Respondents who had toilet facilities their health status was also high.
- Elderly people engaged in agricultural activities had high level of health status.
- The level of income was not affected in health status on elderly people. Respondents who had less than Rs 500 monthly income their health status was high than monthly income to be 1501 and above.
- Respondents who had access of television their health status was high (34.8%) than who had not access of television.

8.1.3: Findings of Caring Practice of Elderly People

- Age group 75-79 observed as high (52.9%) level of caring practice of elderly people.
- Age group 65-69 had low caring practice than others age group.
- Married respondents had better (78.4%) caring practice than (21.6%) widowed.
- The average family size was to be 6 and above their caring practice was high (67.6%) compared to less than average family size 5.
- Janajati, Khas and Dalit had respectively high, moderate and low caring practice index.
- Buddhist had comparatively high caring practice index than other religion Kirat, Hindu and Christian.

- Literate elderly people had high caring practice index than illiterate.
- Respondents who had higher educational status their caring practice was also high (77.8%) than other level of education.
- Respondents engaged in both agricultural and non-agricultural activities had almost equal caring practice index.
- Respondents average monthly income was below Rs 1500 had moderate and low level of caring practice index than above Rs 1500 monthly income.
- Radio listeners respondents had high (53.0%) level of caring practice than non listeners.
- Elderly people who had access of television their caring practice index was high (58.4%) than others.
- To be access of self mobile respondents had high (62.0%) level of caring practice index.

8.2: Conclusions

On the basis of summary of findings the following conclusions could be drawn.

8.2.1: Conclusions Related to Health Status of Elderly People

- The perception towards health was better among much older people of age 80 and above compared to elderly at the age of 60s.
- Female widows' health status was better than currently married elderly people.
- Larger family is not an obstacle to the care of elderly.
- Ethnic background was related to health status being best for Khas group, moderate for Janajati and relatively poor for the Dalits.
- Christianity reflected better health status than others.
- Education was found not a determining factor for being in better health, rather educated people might have been affected by anxiety and other problems; therefore, perceived their health as in inferior condition.

- Having amenities and toilet facility in household was an indicator of better health and caring for elderly.
- Agricultural activity was found related to better health for the elderly.
- Income had no association with health status.

8.2.2: Conclusions Related to Caring Practice of Elderly People

- Elderly of higher ages were in better caring practices.
- Married respondents, especially the males had better caring.
- Caring for elderly was better in larger families.
- Caring was better among Janajatis, than among Khas and Dalit; and also the caring practice was high among Buddhist than others.
- Though health status was found better among elderly with low education, the caring was found to be better with increased education.
- Caring had no association with occupation of elderly.
- Income had no association with caring practice
- Media utilization had positive association with caring practice.

8.3: Recommendation

On the basis of summary of findings and conclusions the recommendation for policy implementations and future area for research are following.

8.3.1: Recommendation for Policy Implications

a. Health Status Related

- The elderly in 60s and 70s were found negligent related to their health status. A campaign for the public health awareness for these newly retired people is to be conducted.
- Currently married (living with husband) elderly women were found having low health status, which might be due to their burden of work to serve for the spouse and household errands. Their workload must be shared by the other family members, for which a door to door awareness campaign is suggested.

- Nuclear families were found with less time to care for elderly compared to larger ones. Therefore, nuclear family members are also to be motivated to serve for the elderly.
- Special programme to improve the health status among Dalits is recommended.
- Hindus and Buddhists are to be encouraged for the enhancement of health status of elderly people.
- High education was found the reason for anxiety and other health problems, therefore educated and retired people must be addressed in policies for enhancement of health status of elderly people.
- Economic statuses of the families are to be strengthened and supported to improve the health status of elderly.
- Active life of the elderly was found important, therefore elderly people are to be given programme with some physical level of activity.
- All the elderly people must be supported with pensions, allowances and other economic activities. Similarly, there must be the provision of rebate in charges of household consumption, and schooling as well as other social expenditures if the responsible persons or guardians are the elderly people.
- Qualitative studies showed that the strengthening the family is important for enhancing the health status of people, therefore, families with elderly people must be given priorities in all sorts of facilities by the state.
- The retirement age (58) and age of eligibility for old age allowance are different (70 for general and widow women 60). They must be made same irrespective of the sex and marital status of male and female.

b. Caring Practice Related

- Recently retired elderly people are to be oriented for the caring and self caring practices.
- Women living with spouses in elderly had low level of caring practices, therefore, specific pub-health related programmes are to launched focusing to these group of women with others too.

- Smaller and nuclear families are also to be motivated for the caring of the elderly people. In this context, a reward to the better care giver is to be given in the VDC and ward level by the communities.
- All people irrespective of their caste and ethnic groups are to be trained in the caring of elderly in community level.
- All elderly people must be supported with newspapers, media facilities and opportunity of informal education if they want to acquire knowledge. Special programmes with tips of caring practices are to be offered in grassroots levels.
- A separate high level government body or a separate ministry that is responsible for elderly people is to be established for policy making and implementation, as well as monitoring and evaluation of programmes on elderly.

8.3.2: Recommendation for Future Area of Research

- This study is limited only to Jaljale VDC; one of the rural areas of Tehrathum district of Nepal. Therefore, these types of researches should be conducted in other areas with relatively larger sample.
- The areas incorporated in questionnaire of this research cover a limited scope. However, more socio-economic, psychological, emotional and inter-personal related variables with both quantitative and qualitative approaches could be incorporated in future research.
- This study covered broadly the three ethnic communities; other researchers are recommended to be conducted in a comparative manner of various ethnic groups and religious segments of the country.
- The retirement age for the government job in Nepal is 58; however, this study covered the elderly people aged 60 and over. Future studies can include the people aged 58 and above.
- It is recommended that the future studies can use more sophisticated statistical tools than frequency, cross and mean tables.

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APPENDIX – ONE

TRIBHUVAN UNIVERSITY

CENTRAL DEPARTMENT OF POPULATION STUDIES

KIRTIPUR, KATHMANDU, NEPAL

HEALTH STATUS AND CARING PRACTICE AMONG ELDERLY PEOPLE AGED 60 YEARS AND ABOVE

A CASE STUDY ON JALJALE VDC TEHRATHUM DISTRICT

QUESTIONNAIRES

GENERAL INFORMATION

Q1. Respondent's Name (optional): .....

Q2.District: Tehrathum | Q3 : VDC : Jaljale | Q4. Ward No. : .....

Q5.Respondent's Mother Tongue: .....

Q6. Respondent's Caste/Ethnicity: .....

Q7. Respondent's Religion: 1. Hindu 2. Buddhist 3. Kirat 4. Christian

Q8. Caste structure of family: Is all members of your households are as a same caste/ethnicity?
1. Yes 2. No 8. Don't know 9. Not stated

Q9. How many members are there in your family?

SN Q9a	Name Q9b	Sex Q9c			Age Q9d	Occupation Q9e	Monthly income Q9f	Education Q9g	Marital status Q9h	Birth place Q9i		Survey identification Q9j		
01.		1	2	3						1	2	1	2	3
02.		1	2	3						1	2	1	2	3
03.		1	2	3						1	2	1	2	3
04.		1	2	3						1	2	1	2	3
05.		1	2	3						1	2	1	2	3
06.		1	2	3						1	2	1	2	3
07.		1	2	3						1	2	1	2	3
08.		1	2	3						1	2	1	2	3
09.		1	2	3						1	2	1	2	3
10.		1	2	3						1	2	1	2	3
11.		1	2	3						1	2	1	2	3
12.		1	2	3						1	2	1	2	3
13.		1	2	3						1	2	1	2	3
14.		1	2	3						1	2	1	2	3
15.		1	2	3						1	2	1	2	3

Q9a: Serial Number
Q9b: Name of the Family Members
Q9c: Sex: 1. Male 2. Female 3. Third sex
Q9d: Age
Q9e: Occupation
Q9f: Monthly Income
Q9g: Education: 0. Illiterate 1. One pass 2. Two pass ..., 11. SLC pass
12. Intermediate pass 13.Bachelor pass 14. Master's Degree and Above
Q9h: Marital status: 1. Married 2. Unmarried 3. Widowed

Q9i: Birth place: 1. Same place 2. Different place
Q9j: Survey identification: 1. Head of households 2. Respondent 3. Other members

Information for Family Status

Q10. Who manage your living arrangement?

a. Self	1. Yes 2. No 8. Don't know 9. stated
b. Husband/Wife	1. Yes 2. No 8. Don't know stated
c. Unmarried Son/Daughter	1. Yes 2. No 8. Don't know 9. Not stated
d. Son/Daughter –in-law	1. Yes 2. No 8. Don't know 9. Not stated
e. Others	1. Yes

Q11. How many times do you take food per day?

.....

Q12. Who prepares food for you?

a. Self	1. Yes 2. No 8. Don't know 9. Not stated
b. Husband/Wife	1. Yes 2. No 8. Don't know 9. Not stated
c. Unmarried Son/Daughter	1. Yes 2. No 8. Don't know 9. Not stated
d. Son/Daughter –in-law	1. Yes 2. No 8. Don't know 9. Not stated
e. Others	1. Yes

Q13. Who helps in your personal hygiene?

a. Self	1. Yes 2. No 8. Don't know 9. Not stated
b. Husband/Wife	1. Yes 2. No 8. Don't know 9. Not stated
c. Unmarried Son/Daughter	1. Yes 2. No 8. Don't know 9. Not stated
d. Son/Daughter –in-law	1. Yes 2. No 8. Don't know 9. Not stated
e. Others	1. Yes

Information for House and Household Characteristics

Q14. What is the source of drinking water?

a. Piped water	1. Yes 2. No 8. Don't know 9. Not stated
b. Spout water	1. Yes 2. No 8. Don't know 9. Not stated
c. River/Stream	1. Yes 2. No 8. Don't know 9. Not stated
d. Dug well	1. Yes 2. No 8. Don't know 9. Not stated
e. Others	1. Yes

Q15. Do you have toilet facilities?

a. Yes .....1 b. No .....2 (→Q17)

Q16. If yes, what types of toilet facilities do you have? (→ Q18)

a. Temporary .....1 b. Permanent.....2

Q17. Where does your family go for toilet?

a. Bank of river/stream	1. Yes 2. No 8. Don't know 9. Not stated
b. Open place	1. Yes 2. No 8. Don't know 9. Not stated
c. Forest	1. Yes 2. No 8. Don't know 9. Not stated
d. Others	1. Yes

Q18. What types of household ownership?

a. Owned	1. Yes 2. No 8. Don't know 9. Not stated
b. Rented	1. Yes 2. No 8. Don't know 9. Not stated
c. Rent-free	1. Yes 2. No 8. Don't know 9. Not stated
d. Institutional	1. Yes 2. No 8. Don't know 9. Not stated
e. Others	1. Yes

Q19. What types of house are you living in?

a. Temporary ..... 1 b. Permanent 2

Q20. What is the main source of light?

a. Electricity	1. Yes 2. No 8. Don't know 9. Not stated
b. Kerosene	1. Yes 2. No 8. Don't know 9. Not stated
c. Bio-gas	1. Yes 2. No 8. Don't know 9. Not stated
d. Solar Power	1. Yes 2. No 8. Don't know 9. Not stated
e. Others	1. Yes

Q21. Who makes decision in your household on following aspects?

1. Marriage of children 2. Selling and buying valuable goods
3. Important social and religious ceremonies 4. Division of household work

a. Self 1. Yes 2. No 8. Don't know 9. Not stated
b. Husband/Wife 1. Yes 2. No 8. Don't know 9. Not stated
c. Unmarried Son/Daughter 1. Yes 2. No 8. Don't know 9. Not stated
d. Son/Daughter –in-law 1. Yes 2. No 8. Don't know 9. Not stated
e. Others 1. Yes

Q22. Who do you live with now?

a. Self 1. Yes 2. No 8. Don't know 9. Not stated
b. Husband/Wife 1. Yes 2. No 8. Don't know 9. Not stated
c. Unmarried Son/Daughter 1. Yes 2. No 8. Don't know 9. Not stated
d. Son/Daughter –in-law 1. Yes 2. No 8. Don't know 9. Not stated
e. Others 1. Yes

Q23. Are you satisfied current residing?

a. Yes ..... 1 (⟶ Q25) b. No 2

Q24. Who do you want to live with?

a. Self 1. Yes 2. No 8. Don't know 9. Not stated
b. Husband/Wife 1. Yes 2. No 8. Don't know 9. Not stated
c. Unmarried Son/Daughter 1. Yes 2. No 8. Don't know 9. Not stated
d. Daughter/Son-in-law 1. Yes 2. No 8. Don't know 9. Not stated
e. Son/Daughter-in-law 1. Yes 2. No 8. Don't know 9. Not stated
f. Others 1. Yes

Q25. How do you spear your one day?

a. Religious activity 1. Yes 2. No 8. Don't know 9. Not stated
b. Reading news 1. Yes 2. No 8. Don't know 9. Not stated
c. Care of grand children 1. Yes 2. No 8. Don't know 9. Not stated
d. Yoga 1. Yes 2. No 8. Don't know 9. Not stated
e. Visiting temple 1. Yes 2. No 8. Don't know 9. Not stated
f. Working in side home 1. Yes 2. No 8. Don't know 9. Not stated
g. Meeting peer group 1. Yes 2. No 8. Don't know 9. Not stated
h. Others 1. Yes

Q26. Do you depend up on your offspring?

a. Yes ..... 1 b. No 2

Q27. At what time do you wake up?

.....

Q28. What is your condition of sleep?

a. Excellent ..... 1 b. Better ..... 2 c. Good 3
e. Worst .....4 e. Very worst.....5

Q29. What types of anxiety and curiosity do you have while sleeping?

a. Past activities 1. Yes 2. No 8. Don't know 9. Not stated
b. Present activities 1. Yes 2. No 8. Don't know 9. Not stated
c. Past event 1. Yes 2. No 8. Don't know 9. Not stated
d. Present event 1. Yes 2. No 8. Don't know 9. Not stated
e. Health situation 1. Yes 2. No 8. Don't know 9. Not stated
f. Dead family members 1. Yes 2. No 8. Don't know 9. Not stated
g. Others 1. Yes

Q30. In your opinion, what is the rationale of religious work?

a. Peace of soul 1. Yes 2. No 8. Don't know 9. Not stated
b. Karma 1. Yes 2. No 8. Don't know 9. Not stated
c. Save the tradition 1. Yes 2. No 8. Don't know 9. Not stated
d. Others 1. Yes

Q31. How often do you meet with your peers?

a. Always ..... 1 b. sometimes 2

Information on Economic Status

Q32. What is the main source of income?

a. Agriculture 1. Yes 2. No 8. Don't know 9. Not stated
b. Business 1. Yes 2. No 8. Don't know 9. Not stated
c. Old aged allowance 1. Yes 2. No 8. Don't know 9. Not stated
d. Dan/Chanda 1. Yes 2. No 8. Don't know 9. Not stated
e. Others 1. Yes

Q33. How much is your own average monthly income?

.....

Q34. What is your own property?

a. House 1. Yes 2. No 8. Don't know 9. Not stated
b. Land 1. Yes 2. No 8. Don't know 9. Not stated
c. House and Land 1. Yes 2. No 8. Don't know 9. Not stated
d. Cash 1. Yes 2. No 8. Don't know 9. Not stated
e. Ornaments 1. Yes 2. No 8. Don't know 9. Not stated
f. Investment 1. Yes 2. No 8. Don't know 9. Not stated
g. Others 1. Yes

Q35. Who helps on your expenditure?

a. Self 1. Yes 2. No 8. Don't know 9. Not stated
b. Husband/Wife 1. Yes 2. No 8. Don't know 9. Not stated
c. Unmarried Son/Daughter 1. Yes 2. No 8. Don't know 9. Not stated
d. Daughter/Son-in-law 1. Yes 2. No 8. Don't know 9. Not stated
e. Son/Daughter-in-law 1. Yes 2. No 8. Don't know 9. Not stated
f. Others 1. Yes

Q36. How do you support in your family occupation?

a. Counseling 1. Yes 2. No 8. Don't know 9. Not stated
b. Skill provides 1. Yes 2. No 8. Don't know 9. Not stated
c. Physical labour 1. Yes 2. No 8. Don't know 9. Not stated
d. Provide cash 1. Yes 2. No 8. Don't know 9. Not stated
e. Technical knowledge 1. Yes 2. No 8. Don't know 9. Not stated
f. Others 1. Yes

Q37. Are you getting old age allowance?

a. Yes ..... 1 b. No .....2 (→Q39)

Q38. How do you get old age allowance?

a. Office 1. Yes 2. No 8. Don't know 9. Not stated
b. In home 1. Yes 2. No 8. Don't know 9. Not stated
c. Family members 1. Yes 2. No 8. Don't know 9. Not stated
d. Institution 1. Yes 2. No 8. Don't know 9. Not stated
e. Others 1. Yes

Q39. Why do you not receive aged allowance?

a. Lack of citizenship 1. Yes 2. No 8. Don't know 9. Not stated
b. No necessary 1. Yes 2. No 8. Don't know 9. Not stated
c. No one help 1. Yes 2. No 8. Don't know 9. Not stated
d. Others 1. Yes

Q40. Have your fundamental needs get fulfilled from your income?

a. Yes ..... 1 b. No 2

Q41. What types of amenities you and your family have among following?

a. Radio 1. Yes 2. No 8. Don't know 9. Not stated
b. Television 1. Yes 2. No 8. Don't know 9. Not stated
c. Phone 1. Yes 2. No 8. Don't know 9. Not stated
d. Self mobile 1. Yes 2. No 8. Don't know 9. Not stated
e. Others 1. Yes

Q42. Do you listen to the radio?

a. Yes ..... 1 b. No ..... 2 (→ Q45)

Q43. Specially, what types of programmes do you listen to the radio?

a. News 1. Yes 2. No 8. Don't know 9. Not stated
b. Religious programmes 1. Yes 2. No 8. Don't know 9. Not stated

c. Musical programmes 1. Yes 2. No 8. Don't know 9. Not stated
d. Others 1. Yes

Q44. Have you listen any programme board casting for elderly?
a. Yes ..... 1 b. No 2

Information on Health Status and Caring Practice

Q45. Do you smoke?
a. Yes .....1 b. No ..... 2 (→ Q49)

Q46. Specially, what do you have in smoking?
a. Cigarette/Bindi 1. Yes 2. No 8. Don't know 9. Not stated
b. Surti 1. Yes 2. No 8. Don't know 9. Not stated
c. Tamakhu 1. Yes 2. No 8. Don't know 9. Not stated
d. Others 1. Yes

Q47. How much do you smoking?
a. Every day ..... 1 b. Mostly ..... 2 c. Sometimes 3

Q48. How much do you believe that you could give up smoking?
a. Highly believe .....1 b. Believe 2
c. Not believe.....3 e. Highly not believe 4

Q49. Do you have alcohol?
a. Yes ..... 1 b. No ..... 2 (→ Q51)

Q50. If so, how often do you have?
a. Every day ..... 1 b. Mostly ..... 2 c. Sometimes 3

Q51. Do your family members spend time on discussing with you?
a. Yes ..... 1 b. No 2

Q52. How much time per a week? .....

Q53. Do your family members have caring about your health condition?
a. Yes ..... 1 b. No 2

Q54. Do your family members take to you for checking up to health centre?
a. Yes ..... 1 b. No ..... 2 (→Q56)

Q55. How many times a month do your family members take to you health centre for checking?

.....

Q56. Specially, who helps you on the matter related to health?
a. Husband/Wife 1. Yes 2. No 8. Don't know 9. Not stated
b. Unmarried Son/Daughter 1. Yes 2. No 8. Don't know 9. Not stated
c. Daughter/Son-in-law 1. Yes 2. No 8. Don't know 9. Not stated
d. Son/Daughter-in-law 1. Yes 2. No 8. Don't know 9. Not stated
e. Others 1. Yes

Q57. Have you become ill at last 12 months?
a. Yes ..... 1 b. No ..... 2 (→Q59)

Q58. What types of sickness did you get?
a. Common ..... 1 b. Serious 2

Q59. What types of disease do you have?
a. Diabetes 1. Yes 2. No 8. Don't know 9. Not stated
b. Cancer 1. Yes 2. No 8. Don't know 9. Not stated
c. Headache 1. Yes 2. No 8. Don't know 9. Not stated
d. Blood pressure 1. Yes 2. No 8. Don't know 9. Not stated
e. Fever 1. Yes 2. No 8. Don't know 9. Not stated
f. Cough 1. Yes 2. No 8. Don't know 9. Not stated
g. Urine problem 1. Yes 2. No 8. Don't know 9. Not stated
h. Others 1. Yes

Q60. What types of means do you use while going out?
a. On foot ..... 1 b. Public vehicle 2
c. Private vehicle..... 3 d. Others 4

Q61. Now a day how is your health condition?
a. Excellent ..... 1 b. Better ..... 2 c. Good 3

d. Worst ..... 4 e. Very worst.....5

Q62. Where do you go for treatment?

a.	At home	1. Yes 2. No 8. Don't know 9. Not stated
b.	Calling doctor at home	1. Yes 2. No 8. Don't know 9. Not stated
c.	Dhami/Jhankri	1. Yes 2. No 8. Don't know 9. Not stated
d.	Health post/Hospital	1. Yes 2. No 8. Don't know 9. Not stated
e.	Private clinic	1. Yes 2. No 8. Don't know 9. Not stated
f.	Others	1. Yes

Q63. How many times a year do you go for health check up?

.....

Q64. How much money a month do you invest for your health facilities?

.....

Q65. Are you satisfied on it?

a. Yes ..... 1 (→Q67) b. No 2

Q66. If no, how much money do you have need? .....

Q67. In your opinion, what is the view of society upon elderly?

a. Excellent .....1 b. Better ..... 2 c. Good 3

d. Worst ..... 4 e. Very worst 5

Q68. In your opinion, what types of health services is needed to elderly from government side?

a.	Free treatment	1. Yes 2. No 8. Don't know 9. Not stated
b.	Free health check –up	1. Yes 2. No 8. Don't know 9. Not stated
c.	Paying cash	1. Yes 2. No 8. Don't know 9. Not stated
d.	Mobile camp	1. Yes 2. No 8. Don't know 9. Not stated
e.	Others	1. Yes

Q69. Have you got any free health services?

a. Yes ..... 1 b. No 2

Q70. In your opinion, which ages better for life?

.....

Q71. In your opinion, what is the sad and painful event of an elderly?

a.	Physical weakness	1. Yes 2. No 8. Don't know 9. Not stated
b.	Lack of economic	1. Yes 2. No 8. Don't know 9. Not stated
c.	Hated by family	1. Yes 2. No 8. Don't know 9. Not stated
d.	Isolation	1. Yes 2. No 8. Don't know 9. Not stated
e.	Others	1. Yes

Q72. In your opinion, who is responsible for take care of elderly?

a.	Self	1. Yes 2. No 8. Don't know 9. Not stated
b.	Husband/Wife	1. Yes 2. No 8. Don't know 9. Not stated
c.	Unmarried Son/Daughter	1. Yes 2. No 8. Don't know 9. Not stated
d.	Daughter/Son-in-law	1. Yes 2. No 8. Don't know 9. Not stated
e.	Son/Daughter-in-law	1. Yes 2. No 8. Don't know 9. Not stated
f.	Others	1. Yes

Q73. At last, do you like say anything about elderly?

.....

.....

.....

THANK YOU FOR PROVIDING VALUABLE TIME AND INFORMATION

APPENDIX – TWO

Computation of Lorenz Curve and Gini – Concentration Ratio (Gi) is calculated by using following formula:

$$Gi = \left(\sum_{i=1}^{n} Xi \,.Yi+1 \right) - \left(\sum_{i=1}^{n} Xi+1.Yi \right)$$

Where,

Xi = Cumulated proportion of income in size class (i)

Yi = Cumulated proportion of population in size class (i)

Xi+1 = Cumulated proportion of income in size class nest to (i) in descending order and all size class about it

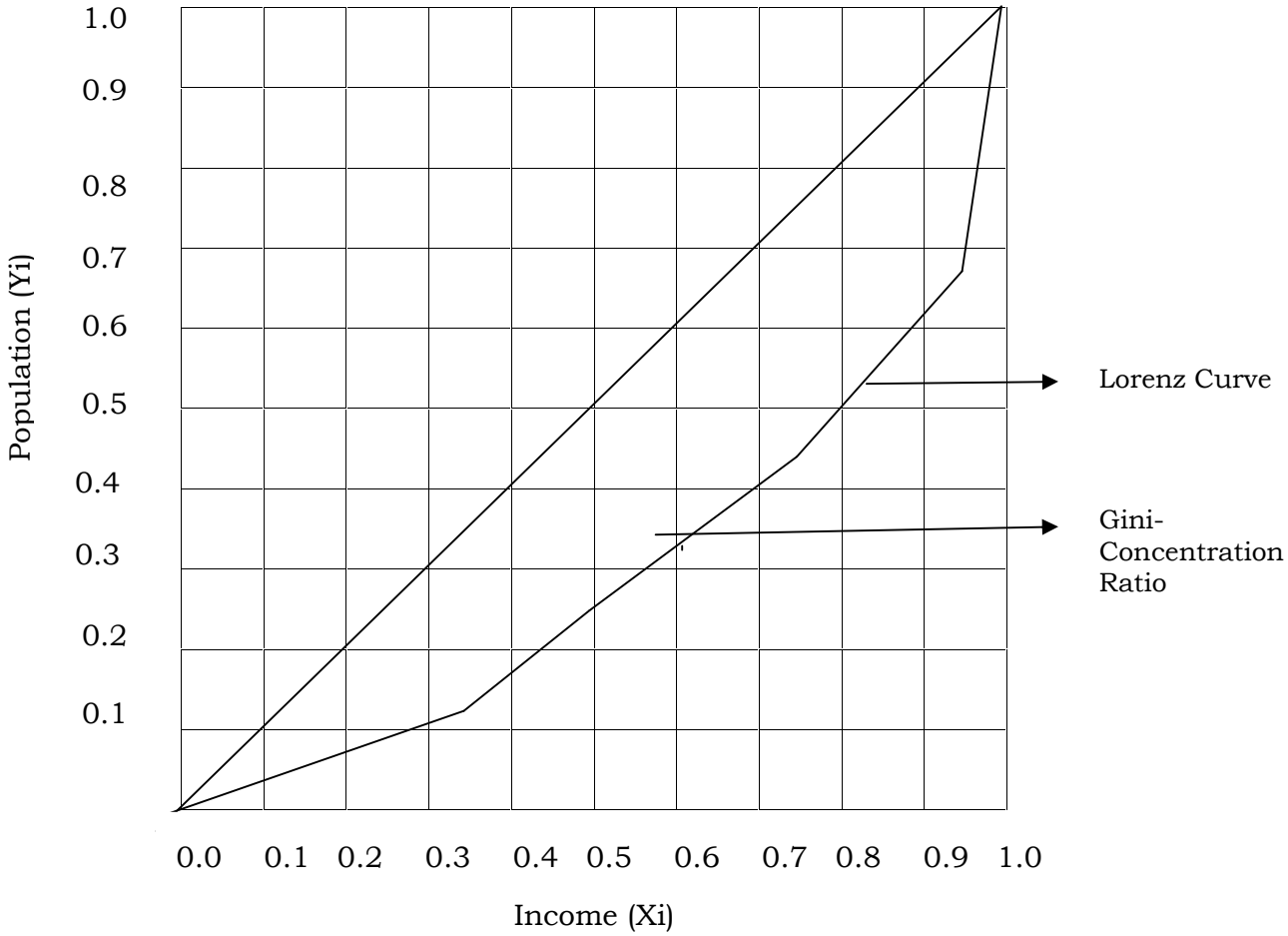
Yi+1 = Cumulated proportion of population in size class next to (i) in descending order and all size class about it

Computation of Proportion of Income and Population

Average Income	Population	Proportion		Cumulated Proportion		Xi.Yi+1	Xi+1.Y
		Income (Xi)	Population (Yi)	Income (Xi)	Population (Yi)		
1750	19	0.3500	0.1152	0.3500	0.1152	0.0933	0.0576
750	25	0.1500	0.1515	0.5000	0.2667	0.2182	0.2000
1250	28	0.2500	0.1697	0.7500	0.4364	0.4955	0.4146
1000	37	0.2000	0.2242	0.9500	0.6606	0.9500	0.6606
250	56	0.0500	0.3394	1.0000	1.0000	-	-
5000	165	1.0000	1.0000			∑Xi.Yi+1 =1.7570	∑Xi+1.Yi =1.3328

$$\text{The Gini-Concentration Ratio (Gi)} = \left(\sum_{i=1}^{n} Xi \,.Yi+1 \right) - \left(\sum_{i=1}^{n} Xi+1.Yi \right)$$

$$= 1.7570 - 1.3382$$
$$= 0.4242$$



Lorenz Curve and Gini-Concentration Ratio

APPENDIX – THREE

Gamma Coefficients of Health Status and Caring Practice by Different Variables

Count **Crosstab**

Age Group of Respondents	Health Status Category (Intra-group Comparison)			Total
	1.00 Low	2.00 Medium	3.00 High	
1.00 60-64	29	17	16	62
2.00 65-69	14	18	11	43
3.00 70-74	9	12	8	29
4.00 75-79	6	5	6	17
5.00 80+	3	6	5	14
Total	61	58	46	165

Symmetric Measures

		Value	Asymp. Std. Error(a)	Approx. T(b)	Approx. Sig.
Ordinal by Ordinal	Gamma	.163	.096	1.688	.091
N of Valid Cases		165			

a Not assuming the null hypothesis.
b Using the asymptotic standard error assuming the null hypothesis.

Count **Crosstab**

Marital Status	Health Status Category (Intra-group Comparison)			Total
	1.00 Low	2.00 Medium	3.00 High	
1 Married	46	38	22	106
3 Widowed, Widower	15	20	24	59
Total	61	58	46	165

Symmetric Measures

		Value	Asymp. Std. Error(a)	Approx. T(b)	Approx. Sig.
Ordinal by Ordinal	Gamma	.373	.118	2.953	.003
N of Valid Cases		165			

a Not assuming the null hypothesis.
b Using the asymptotic standard error assuming the null hypothesis.

Count **Crosstab**

Family Size	Health Status Category (Intra-group Comparison)			Total
	1.00 Low	2.00 Medium	3.00 High	
1.00 (1-5)	29	25	21	75
2.00 (6+)	32	33	25	90
Total	61	58	46	165

Symmetric Measures

		Value	Asymp. Std. Error(a)	Approx. T(b)	Approx. Sig.
Ordinal by Ordinal	Gamma	.032	.128	.247	.805
N of Valid Cases		165			

a Not assuming the null hypothesis.
b Using the asymptotic standard error assuming the null hypothesis

Count

Crosstab

Ethnicity	Health Status Category (Intra-group Comparison) 1.00 Low	2.00 Medium	3.00 High	Total
1.00 Khas	8	13	34	55
2.00 Janajati	16	32	7	55
3.00 Dalit	37	13	5	55
Total	61	58	46	165

Symmetric Measures

		Value	Asymp. Std. Error(a)	Approx. T(b)	Approx. Sig.
Ordinal by Ordinal	Gamma	-.680	.071	-8.037	.000
N of Valid Cases		165			

a Not assuming the null hypothesis.
b Using the asymptotic standard error assuming the null hypothesis.

Count

Crosstab

Literacy Status of Respondents	Health Status Category (Intra-group Comparison) 1.00 Low	2.00 Medium	3.00 High	Total
1.00 Illiterate	13	24	26	63
2.00 Literate	48	34	20	102
Total	61	58	46	165

Symmetric Measures

		Value	Asymp. Std. Error(a)	Approx. T(b)	Approx. Sig.
Ordinal by Ordinal	Gamma	-.471	.106	-3.990	.000
N of Valid Cases		165			

a Not assuming the null hypothesis.
b Using the asymptotic standard error assuming the null hypothesis.

Count

Crosstab

Education Attainment	Health Status Category (Intra-group Comparison) 1.00 Low	2.00 Medium	3.00 High	Total
1.00 Primary	17	19	6	42
2.00 Secondary	2	2	0	4
3.00 SLC and above	1	3	5	9
Total	20	24	11	55

Symmetric Measures

		Value	Asymp. Std. Error(a)	Approx. T(b)	Approx. Sig.
Ordinal by Ordinal	Gamma	.462	.215	1.844	.065
N of Valid Cases		55			

a Not assuming the null hypothesis.
b Using the asymptotic standard error assuming the null hypothesis.

Count **Crosstab**

Facilities of Toilet	Health Status Category (Intra-group Comparison) 1.00 Low	2.00 Medium	3.00 High	Total
1 Yes	51	53	41	145
2 No	10	5	5	20
Total	61	58	46	165

Symmetric Measures

		Value	Asymp. Std. Error(a)	Approx. T(b)	Approx. Sig.
Ordinal by Ordinal	Gamma	-.193	.203	-.939	.348
N of Valid Cases		165			

a Not assuming the null hypothesis.
b Using the asymptotic standard error assuming the null hypothesis.

Count **Crosstab**

Income Category of Elderly People	Health Status Category (Intra-group Comparison) 1.00 Low	2.00 Medium	3.00 High	Total
1.00 Low (< 500)	21	17	18	56
2.00 Medium (501 - 1500)	22	15	16	53
3.00 High (1501+)	18	26	12	56
Total	61	58	46	165

Symmetric Measures

		Value	Asymp. Std. Error(a)	Approx. T(b)	Approx. Sig.
Ordinal by Ordinal	Gamma	-.028	.100	-.282	.778
N of Valid Cases		165			

a Not assuming the null hypothesis.
b Using the asymptotic standard error assuming the null hypothesis.

Count **Crosstab**

Radio Listeners	Health Status Category (Intra-group Comparison) 1.00 Low	2.00 Medium	3.00 High	Total
1 Yes	48	36	31	115
2 No	13	22	15	50
Total	61	58	46	165

Symmetric Measures

		Value	Asymp. Std. Error(a)	Approx. T(b)	Approx. Sig.
Ordinal by Ordinal	Gamma	.197	.129	1.496	.135
N of Valid Cases		165			

a Not assuming the null hypothesis.
b Using the asymptotic standard error assuming the null hypothesis.

Count **Crosstab**

Access of Television	Health Status Category (Intra-group Comparison) 1.00 Low	2.00 Medium	3.00 High	Total
1 Yes	23	35	31	89
2 No	38	23	15	76
Total	61	58	46	165

Symmetric Measures

		Value	Asymp. Std. Error(a)	Approx. T(b)	Approx. Sig.
Ordinal by Ordinal	Gamma	-.394	.112	-3.304	.001
N of Valid Cases		165			

a Not assuming the null hypothesis.
b Using the asymptotic standard error assuming the null hypothesis.

Count **Crosstab**

	Health Status Category (Intra-group Comparison)			
Self Mobile	1.00 Low	2.00 Medium	3.00 High	Total
1 Yes	14	19	9	42
2 No	47	39	37	123
Total	61	58	46	165

Symmetric Measures

		Value	Asymp. Std. Error(a)	Approx. T(b)	Approx. Sig.
Ordinal by Ordinal	Gamma	.029	.139	.210	.834
N of Valid Cases		165			

a Not assuming the null hypothesis.
b Using the asymptotic standard error assuming the null hypothesis.

Count **Crosstab**

Age Group of Respondents	Caring Practice Category (Intra-group Comparison)			Total
	1.00 Low	2.00 Medium	3.00 High	
1.00 60-64	8	26	28	62
2.00 65-69	10	17	16	43
3.00 70-74	4	11	14	29
4.00 75-79	2	6	9	17
5.00 80+	1	6	7	14
Total	25	66	74	165

Symmetric Measures

		Value	Asymp. Std. Error(a)	Approx. T(b)	Approx. Sig.
Ordinal by Ordinal	Gamma	.053	.096	.552	.581
N of Valid Cases		165			

a Not assuming the null hypothesis.
b Using the asymptotic standard error assuming the null hypothesis.

Count **Crosstab**

	Caring Practice Category (Intra-group Comparison)			
Marital Status	1.00 Low	2.00 Medium	3.00 High	Total
1 Married	7	41	58	106
3 Widowed, Widower	18	25	16	59
Total	25	66	74	165

Symmetric Measures

		Value	Asymp. Std. Error(a)	Approx. T(b)	Approx. Sig.
Ordinal by Ordinal	Gamma	-.548	.105	-4.401	.000
N of Valid Cases		165			

a Not assuming the null hypothesis.
b Using the asymptotic standard error assuming the null hypothesis.

Count

Crosstab

Ethnicity	Caring Practice Category (Intra-group Comparison)			Total
	1.00 Low	2.00 Medium	3.00 High	
1.00 Khas	7	24	23	54
2.00 Janajati	7	21	28	56
3.00 Dalit	11	21	23	55
Total	25	66	74	165

Symmetric Measures

		Value	Asymp. Std. Error(a)	Approx. T(b)	Approx. Sig.
Ordinal by Ordinal	Gamma	-.049	.110	-.444	.657
N of Valid Cases		165			

a Not assuming the null hypothesis.
b Using the asymptotic standard error assuming the null hypothesis.

Count

Crosstab

Literacy Status of Respondents	Caring Practice Category (Intra-group Comparison)			Total
	1.00 Low	2.00 Medium	3.00 High	
1.00 Illiterate	16	31	16	63
2.00 Literate	9	35	58	102
Total	25	66	74	165

Symmetric Measures

		Value	Asymp. Std. Error(a)	Approx. T(b)	Approx. Sig.
Ordinal by Ordinal	Gamma	.539	.103	4.489	.000
N of Valid Cases		165			

a Not assuming the null hypothesis.
b Using the asymptotic standard error assuming the null hypothesis.

Count

Crosstab

Education Attainment	Caring Practice Category (Intra-group Comparison)			Total
	1.00 Low	2.00 Medium	3.00 High	
1.00 Primary	5	14	23	42
2.00 Secondary	1	0	3	4
3.00 SLC and above	0	2	7	9
Total	6	16	33	55

Symmetric Measures

		Value	Asymp. Std. Error(a)	Approx. T(b)	Approx. Sig.
Ordinal by Ordinal	Gamma	.403	.271	1.516	.129
N of Valid Cases		55			

a Not assuming the null hypothesis.
b Using the asymptotic standard error assuming the null hypothesis.

Count

Crosstab

Income Category of Elderly People	Caring Practice Category (Intra-group Comparison)			Total
	1.00 Low	2.00 Medium	3.00 High	
1.00 Low (< 500)	10	25	21	56
2.00 Medium (501 - 1500)	8	26	19	53
3.00 High (1501+)	7	15	34	56
Total	25	66	74	165

Symmetric Measures

		Value	Asymp. Std. Error(a)	Approx. T(b)	Approx. Sig.
Ordinal by Ordinal	Gamma	.244	.107	2.253	.024
N of Valid Cases		165			

a Not assuming the null hypothesis.
b Using the asymptotic standard error assuming the null hypothesis.

Count **Crosstab**

Radio Listeners	Caring Practice Category (Intra-group Comparison)			Total
	1.00 Low	2.00 Medium	3.00 High	
1 Yes	15	39	61	115
2 No	10	27	13	50
Total	25	66	74	165

Symmetric Measures

		Value	Asymp. Std. Error(a)	Approx. T(b)	Approx. Sig.
Ordinal by Ordinal	Gamma	-.410	.119	-3.109	.002
N of Valid Cases		165			

a Not assuming the null hypothesis.
b Using the asymptotic standard error assuming the null hypothesis.

Count **Crosstab**

Access of Television	Caring Practice Category (Intra-group Comparison)			Total
	1.00 Low	2.00 Medium	3.00 High	
1 Yes	6	31	52	89
2 No	19	35	22	76
Total	25	66	74	165

Symmetric Measures

		Value	Asymp. Std. Error(a)	Approx. T(b)	Approx. Sig.
Ordinal by Ordinal	Gamma	-.537	.102	-4.567	.000
N of Valid Cases		165			

a Not assuming the null hypothesis.
b Using the asymptotic standard error assuming the null hypothesis.

Count **Crosstab**

	Caring Practice Category (Intra-group Comparison)			
Self Mobile	1.00 Low	2.00 Medium	3.00 High	Total
1 Yes	2	14	26	42
2 No	23	52	48	123
Total	25	66	74	165

Symmetric Measures

		Value	Asymp. Std. Error(a)	Approx. T(b)	Approx. Sig.
Ordinal by Ordinal	Gamma	-.445	.133	-3.081	.002
N of Valid Cases		165			

a Not assuming the null hypothesis.
b Using the asymptotic standard error assuming the null hypothesis.