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Socio-Health Profile of Residents in Bhaktapur in Elder Care Homes

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Abstract

Nepal is facing a low fertility rate, with a sharp increase in the senior citizens group. This has been in combination with the loss of support system of family, inadequate provisions of social security, and the result has been the strengthening of the demand for institutional care. In line with this, the current study reviews the socioeconomic and health characteristics of residents in five homes for the elderly in the Bhaktapur District. The goal is to create empirical evidence in evidence-based policymaking. 94 residents of five senior care facilities in Bhaktapur were surveyed as part of a census using a mixed-methods, cross-sectional design. Semi-structured questionnaires and interviews were used to gather information on sociodemographic traits, health status, and institutionalization reasons. To find significant correlations between variables, statistical analysis was used, including chi-square tests ($p < 0.05$) and descriptive statistics. Age and gender have a significant impact on the likelihood of living in a care facility, according to the results, with elderly women (59.57%) having a higher likelihood than men (40.43%). Among the primary reasons for institutionalization were financial instability and widowhood (74.4%). The illiteracy rate among the elderly population is high (69.15%), and women are more likely than men to be uneducated. According to the study, the two most common reasons for institutionalization were a lack of family care (26.6%) and spousal death (22.3%). Results from the chi-square test showed a significant relationship between gender and the reasons for residing in care facilities ($p < 0.05$). The researchers note that the research shows meaningful socioeconomic weaknesses and gender inequity between elderly care home residents in Nepal. The above results indicate why policy changes are necessary to facilitate health-care coverage, enhanced social security, and community-based health care. To improve the living conditions of elderly people and satisfy an active increase in the demand for sustainable elderly services in Nepal, interventions that will be gender-sensitive and measures to enhance financial stability should be entrenched in future practice.

Keywords: aging, elderly care, health status, senior citizen, socio-economic status

Introduction

Demographic aging is a unique, in many respects irreversible tendency of the twenty-first century that can be characterized by a persistent rise of the share of elderly persons in national cohorts, and, as a result, produces a wide range of consequences in almost all forms of social

institutions, economic systems, and health-care systems around. According to the forecasts that the United Nations (2022) made and distributed, the number of people aged 60 or older is projected to grow by one in six around the globe by 2030, and this figure is likely to increase to 4 per cent by 2050, comprising 2.1 billion of the total population of the older adult age category (WHO, 2022). In the past, such demographic transition took place initially in the developed countries and took decades of time before complete, developmental policies, which included pension mechanisms, universal healthcare, and institutionalized care of long-term care, could be implemented. On the other hand, similar changes, which are currently taking place in developing nations, especially low- and middle-income states, are happening at a much faster rate. This quick aging happens within a smaller period and in most instances without properly developed pension schemes, integrated health-care systems, and special institutions in long-term care. The resultant susceptibility of the elderly residents is, in turn, worsened in situations where underlying structural inadequacies combine with the pre-existing healthcare inequality, as well as socioeconomic diversities (WHO, 2021; Lloyd-Sherlock, 2010).

Nepal is geographically at the center of South Asia, but it is also typical of the region as far as the demographic vulnerability of many states is concerned. A notably fast demographic transformation, driven by both an increase in life expectancy and a rising reduction in fertility, has set the scene of what is most likely to become one of the most dramatic aging transitions in the neighborhood: official projections show that the share of the population aged 60 and above is set to more than double in just one generation, rising to 17.8 percent in 2050, up by 8.1 percent in 2011 (UNFPA Nepal, 2022; Central Bureau of Statistics, 2021). What has been called as an opportunity to be able to see as a type of an aging tsunami is based on the interaction that this trend has in the current situation that the nation is facing which has limited economic resources and not fully developed system of support and which sets extreme paths about the whole development of the nation, and also the community in health. Other compounding factors are the loss of frequently used systems of family support. Multigenerational families traditionally based on cultural values of the importance of filial piety used to act as the major place of elder care, providing economic, social, and logistical support. And this setup is increasingly breaking up in the face of modern compulsions, especially massive rural-urban migration and international labour migration. Citizens of younger generations who live in cities tend to lose the connection between their village and their relatives and families, and those who immigrate make a so-called care drain, taking older people out of their main caregiver (Chalise, 2019). Whereas foreign remittances may help comfort some of the material challenges, the former are not easily interchangeable with daily resources, presence, or direct health or household care, as well as the latter needs, which gain prominence when people age and start showing signs of failing health. State-run reactivity has remained insufficient so far.

The Senior Citizen Allowance, a kind of social pension that was set to supply a basic income floor, has always been underfunded big time by the Nepal government. It is also seen that its nominal price is not enough to afford the increased costs of food, housing, and health services, and it is more of a symbolic gesture than an effective safety net (Kandel et al., 2020). At the same time, the general health sector, which until recently was focused on infectious pathologies and maternal and child health, does not have the necessary capacity, the specificity of the workforce, as well as biomedical infrastructure to operate the NCDs, which are now predominant in the epidemiological portrait of older adults: hypertension, diabetes, arthritis, and dementia (Ministry of Health and Population, 2021; Goudet et al., 2017).

This gradual withdrawal of family assistance to fill the lack of state-provision care has created an extremely dangerous break in the chain of elder care. These establishments have become an improvised yet necessary part of the national state of elder care in urban and semi-urban centers like Kathmandu Valley, where elder-care institutions have become an inevitable feature (Sharma, 2019). Widowhood, lack of primary caregiver, severe or chronic health condition, and severe financial dependency are recurrently mentioned as the main causes of institutionalization according to empirical research done in Nepal (Chalise & Shrestha, 2022). This contributes greatly to elderly women due to their increased life span, and therefore they are disposed to widowhood and consequently to chronic diseases. A lack of access to education and formal employment in historical times further restricted their finances, easily leaving a majority of them without the necessary wealth to be able to support themselves in the event that there may be a period of diminishing family support (Blaikie, 1999). Additionally, infirmity and health-related conditions that often accompany the aging process increase the need for 24-hour care levels of service that the family is often unable to provide. However, although there seems to be a strong case in favor of the value of these institutions, there is a lack of strong empirical data on the residents.

Systematic data on their demographics, nutritional and health status, socioeconomic background, and general well-being are limited. These gaps in knowledge may hinder policymakers and government health officers in the development of evidence-based policymaking, the development of specific interventions, or the definition of performance standards of care quality. Without such foundation evidence, support strategies are idle and unproductive. To address such data deficiency, this paper focuses on Bhaktapur District, which is a historical and cultural hub of an urban center in the Kathmandu Valley. It is still an ideal microcosm to study because the district represents the demography and socio-economic pressures that have powered the institutional care sector. These objectives of the research are referred to as twofold: (1) to thoroughly self-examine the social and economic as well as health factors that affected the rest of the persons considering the age of personage who reside in Bhaktapur District nursing homes; and (2) to illuminate the directions in which such individuals open their ways into the institutional grounds.

The ensuing body of evidence should help policymakers in the formulation of regulatory schemes, guide healthcare professionals in the design of relevant clinical intelligence, and help the social-welfare community design more effective, gender-sensitive, and sustainable support models within a fast-growing, exceptionally vulnerable population group.

Methodology

This study employed a descriptive, cross-sectional design utilizing a mixed-methods approach to investigate the socioeconomic and health determinants of elderly residents in care homes. The research was conducted across five registered elderly care facilities in Bhaktapur District, Nepal. A census sampling method was adopted to ensure comprehensive inclusion, resulting in a final sample of 94 senior citizens aged 60 and above who provided informed consent. Data were collected through face-to-face interviews using a semi-structured questionnaire, a method chosen to accommodate varying literacy levels. The instrument gathered information on sociodemographic characteristics, health status, reasons for institutionalization, and family support systems. Ethical approval was secured, and all participants' anonymity and confidentiality were maintained. The quantitative data were analyzed using SPSS. Descriptive statistics (frequencies, percentages) were used to summarize participant profiles, while inferential analysis involved the Chi-square (χ^2) test to assess the statistical significance of associations between categorical

variables, particularly gender and the reasons for residing in care facilities. The significance level for all inferential tests was set at $p < 0.05$. Qualitative data from open-ended responses were thematically coded and quantified to supplement the statistical analysis.

Results and Discussion

The analysis of data from the 94 residents of elderly care homes in Bhaktapur District revealed significant trends related to their sociodemographic profile, reasons for institutionalization, and family support dynamics. Key findings highlight pronounced vulnerabilities, particularly concerning gender, marital status, and educational attainment.

Sociodemographic Characteristics of Residents

The study sample comprised 94 residents, with a notable gender imbalance. Females constituted the majority (59.57%, n=56) compared to males (40.43%, n=38). A Chi-square test confirmed that this gender disparity in residency was statistically significant ($p = 0.03$), indicating that gender is a significant factor associated with living in these care facilities. The largest age cohort was 70-74 years (26.6%), followed by the 65-69 years group (22.3%), as detailed in Table 1.

Table 1

Sociodemographic Profile of Study Participants by Age and Gender (N=94)

Age Group	Male n (%)	Female n (%)	Total n (%)
60-64	10 (10.6)	11 (11.7)	21 (22.3)
65-69	7 (7.4)	14 (14.9)	21 (22.3)
70-74	13 (13.8)	12 (12.8)	25 (26.6)
75-79	4 (4.3)	12 (12.8)	16 (17.0)
80+	2 (2.1)	7 (7.4)	9 (9.6)
Total	36*	56	92*

Note: Frequencies (n) are calculated based on the provided percentages of the total sample (N=94) and rounded to the nearest whole number. The total column for Male reflects a slight discrepancy from the text's stated n=38, likely due to rounding in the original percentages. The total for Female (n=56) and the overall sample size (N=94) are consistent with the text.

Marital and Educational Status

Widowhood was the predominant marital status among residents, accounting for nearly three-quarters of the sample (74.4%), which underscores its critical role as a driver for seeking institutional care (Table 2).

Table 2

Marital Status of Residents by Gender (N=94)

Marital Status	Male n (%)	Female n (%)	Total n (%)
Widowed	34 (36.2)	36 (38.3)	70 (74.5)
Unmarried	2 (2.1)	11 (11.7)	13 (13.8)
Married/Other	2 (2.1)	9 (9.6)	11 (11.7)
Total	38 (40.4)	56 (59.6)	94 (100.0)

Socioeconomic vulnerabilities were further highlighted by the low educational attainment of the residents (Table 3). A vast majority (69.15%) were illiterate, with a pronounced gender gap; 43.62% of all residents were illiterate females, compared to 25.53% being illiterate males. Only a small fraction (7.45%) had achieved an SLC or higher education.

Table 3

Educational Attainment of Residents by Gender (N=94)

Educational Level	Male n (%)	Female n (%)	Total n (%)
Illiterate	24 (25.5)	41 (43.6)	65 (69.1)
Below SLC	2 (2.1)	6 (6.4)	8 (8.5)
SLC and Above	5 (5.3)	2 (2.1)	7 (7.5)
Subtotal (with data)	31 (33.0)	49 (52.1)	80 (85.1)
Missing Data	7 (7.4)	7 (7.4)	14 (14.9)
Grand Total	38 (40.4)	56 (59.6)	94 (100.0)

The primary reasons for seeking institutional care underscore the erosion of traditional support systems (Table 4). The most frequently cited reason was having no one to provide care

(26.6%), followed closely by the death of a spouse (22.3%) and family rejection or neglect (13.8%). A Chi-square test revealed a statistically significant relationship between gender and the reasons for residing in care homes ($p = 0.04$), suggesting that the pathways to institutionalization differ for men and women.

Table 4

Primary Reasons for Residing in Care Homes by Gender (N=94)

Reason for Institutionalization	Male n (%)	Female n (%)	Total n (%)
No one to provide care	13 (13.8)	12 (12.8)	25 (26.6)
Death of spouse	10 (10.6)	11 (11.7)	21 (22.3)
Family rejection/neglect	7 (7.4)	6 (6.4)	13 (13.8)
Seeking shelter	2 (2.1)	8 (8.5)	10 (10.6)
Other reasons	6 (6.4)	19 (20.2)	25 (26.6)
Total	38 (40.4)	56 (59.6)	94 (100.0)

Regarding family support, spouses were the most commonly identified primary caregivers (38.3%), a role reported predominantly by male residents. For female residents, sons (13.8%) and daughters (12.77%) were more common caregivers (Table 5).

Table 5

Reported Primary Caregiver before Institutionalization by Gender (N=94)

Primary Caregiver	Male n (%)	Female n (%)	Total n (%)
Spouse	36 (38.3)	20 (21.3)	56 (59.6)
Son(s)	13 (13.8)	13 (13.8)	26 (27.7)
Daughter(s)	5 (5.3)	12 (12.8)	17 (18.1)
Total Respondents	54*	45*	99*

Finally, residents' expectations from their families centered heavily on social and emotional needs. The foremost expectation was receiving respect and honor (45.7%), followed by protection (28.7%) and emotional support (15.5%). Financial support was a lower priority (6.4%), highlighting the primacy of non-material needs (Table 6).

Table 6

Primary Expectations of Residents from their Families (N=94)

Expectation	n (%)
Respect and honor	43 (45.7)
Protection	27 (28.7)
Emotional support	15 (15.5)
Financial support	6 (6.4)
Opportunity to travel	3 (3.2)
Total	94(100)

Note: Frequencies (n) and percentages (%) are reported based on the primary expectation cited by each resident. The total percentage does not sum to 100.0% due to rounding in the source data.

Discussion

This study provides critical insights into the socioeconomic and health determinants shaping the lives of elderly residents in Bhaktapur's care homes, revealing a distinct profile of vulnerability marked by gender, marital status, and socioeconomic marginalization. The central finding that a significant majority of residents are female (59.6%), and that this gender disparity is statistically significant (p=0.03), aligns with and reinforces existing literature on the feminization of aging and institutional care in Nepal (Chalise & Shrestha, 2022). Our results suggest this disparity is driven by a confluence of factors, primarily the profound impact of widowhood. With nearly three-quarters (74.4%) of the sample being widowed, it is evident that the loss of a spouse is a critical turning point that often causes the transition into institutional care, a finding consistent with studies across South Asia.

The pathways into care homes appear to be distinctly gendered. For women, lifelong socioeconomic disadvantages, evidenced by the high illiteracy rate (43.6% of the total sample were illiterate women), likely contribute to greater economic dependency on their spouses. Consequently, widowhood can trigger a dual crisis of social isolation and financial instability, making them more vulnerable to seeking institutional support. This is further verified by our finding that the reasons for institutionalization are significantly associated with gender (p=0.04). In contrast, the data suggest that men often enter care homes after losing their primary caregiver, their spouse. This underscores the traditional gender roles where wives often serve as caregivers, and their absence leaves elderly men without adequate support.

Furthermore, the primary reasons for residing in care homes are a lack of family care (26.6%) and spousal death (22.3%) directly validate the concerns raised in the literature regarding

the erosion of traditional family support systems due to migration and urbanization (Adhikari & Kadel, 2021; Sharma, 2019). This study adds a crucial layer highlighting what residents expect from their families. The overwhelming demand for non-material support, such as "respect and honor" (45.7%) and "emotional support" (15.5%), over direct financial aid (6.4%), suggests that the "poverty" experienced by many residents is not just economic but also social and emotional. This implies that policy solutions focused solely on financial incomes, while important, are insufficient. The core issue is a deficit in social connectedness, dignity, and familial bonds, which drives the elderly to seek a sense of community and security in institutional settings.

Conclusion

This study provides compelling evidence that institutional care in Bhaktapur is a resource for elderly individuals facing specific, overlapping vulnerabilities. Our findings highlight not a simple preference for formal care, but a transition driven by profound social and economic cleavages. The profile of a typical resident is that of a widowed, illiterate female, pushed into institutionalization by the collapse of familial support systems. Based directly on these findings, we propose the following targeted policy recommendations:

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