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## Elderly Well-being in Governmental and Non-Governmental Care Homes of Kathmandu

Min Raj Adhikari 

[minraj.adhikari@mrc.tu.edu.np](mailto:minraj.adhikari@mrc.tu.edu.np)

Mahendra Ratna Campus, Tahachal, Tribhuvan University

### Article Info

### Abstract

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*Aging leads to various changes in an individual's well-being, necessitating extensive care. In Nepal, the transition from joint to nuclear family structures, driven by declining fertility rates and increasing migration, creates challenges for elderly care. This study investigates the impact of governmental and non-governmental care homes on the physical and mental well-being of elderly residents. Sixty respondents aged 60 and above (37 from governmental and 23 from non-governmental care homes) were purposively selected from randomly selected One governmental and two non-governmental care homes. Selected respondents completed an interview schedule and standardized tools of Geriatric Depression Scale (GDS-15) and European Quality of Life Five Dimensions and Five Level (EQ-5D-5L), with data analyzed using Statistical Package for the Social Sciences Version 20 (SPSS 20). The results show a significant relationship between the governmental and non-governmental nature of care home and the physical and mental well-being of elderly individuals. Those in governmental care homes reported better general health and lower depression levels compared to those in non-governmental care homes. Specifically, elderly residents in governmental care homes were five times more likely (adjusted odd ratio (aOR)=5.18, 95% CI=1.12-24.00) to perceive their health positively, a statistically significant finding ( $p=0.036$ ). These findings reveal clear disparities in elderly well-being between governmental and non-governmental care homes, underscoring the need to improve conditions in non-governmental settings. Enhancing health care services, providing regular psycho-social support, and ensuring consistent monitoring are essential to strengthen elderly well-being in these care homes.*

**Keywords:** Elderly people, nature of care homes, mental well-being, old care home, physical well-being

Aging leads to an increase in the older population within a society. According to the UN (2020), this demographic shift signifies advancements in public health, medicine, and socio-economic development, contributing to injury prevention, disease control, and lower early mortality rates. UN (2019) emphasized that the combined effects of increasing life expectancy and declining fertility are shifting the population distribution toward older age groups. Many countries face challenges due to rapid population aging and insufficient institutional support for older adults. In developing nations, elderly care usually falls to adult children, but their migration often complicates this responsibility (Adhikari et al., 2011).

By 2050, people over the age of 60 in the world will be 2.5 times larger than that of 382 million in 1980 is predicted to approach 2.1 billion. Two-thirds of senior citizens resided in middle-income nations in 2020. About 1 in 6 persons will be 60 or older by 2030, and by 2050, that number will rise to 1 in 5. Remarkably, at least 14 percent of the older population more than 142 million people now finds it difficult to achieve their basic daily needs (WHO, 2020).

Paralleling the global trend towards an older population, Nepal is also seeing an aging population. In Nepal, those sixty years of age and over are officially considered elderly or senior citizens under the Senior Citizens Act (Senior Citizens Act, 2006). 2.97 million senior citizen, or 10.21 percent of the total population, were found in Nepal according to data from the census taken in 2021. The results of 2021 census of Nepal suggests a significant increase (38%) over the numbers from the 2011 to 2021 alone. The rapid increase in the elderly population is driven by declining fertility rates, improved life expectancy, and the continuous out-migration of working-age adults for employment and study (NSO, 2021). Together, these trends reduce the availability of family caregivers while increasing the demand for care services.

Due to causes including migration, urbanization, and globalization, the elderly population is more vulnerable to rising marginalization (Bhat & Dhruvarajan, 2001). Gupta et al. (2016) and Khattri and Nepal (2006) argue that the common health problems among the elderly population of Nepal include physical health difficulties and depression, which account for more than half of the cases, while loneliness and family abuse account for more than one-tenth. However, a lack of resources makes it difficult to meet the social and health requirements of older persons in Nepal (Bisht et al., 2012).

The need for comprehensive caring and support has increased due to the expanding aged population and the development in physical disabilities among older adults. Such a situation places pressure on a family's resources. The continued care of aging family members further necessitates professional expertise to meet these growing demands. Singh et al. (2021) estimate that eighty percent of Nepal's elderly population live with family, with a sizeable minority (18%) living alone or with their spouses. When older people in Nepal begin living alone in their latter years, their quality of life gradually declines, as highlighted by Subedi (2022). As a result, old age homes have gained importance in Nepal as a way to successfully handle the requirements and difficulties related to advanced age.

In situations when the conventional joint family structure is not present, elderly people frequently view old age institutions as their last option. When there is no family support system in place, elderly parents are forced to seek shelter at these facilities. For older people without other options or without family support, old age homes offer a sense of security and safety (Townsend, 2023; Wu et al., 2022).

In Nepal, joint families are increasingly being replaced by nuclear families due to several factors, including declining fertility rates, urban migration, a preference for smaller family sizes among the middle and upper classes in urban areas, and the emigration of adult children seeking greater personal freedom and a higher quality of life. This shift makes it more difficult to care for elderly parents, and reports of family violence have led to an increase in the number of older people preferring for long-term stays in care homes and other facilities (Davies & Knapp, 2024; Chalise & Paudel, 2020; Dhungana et al., 2004).

As a result, the number of governmental and non-governmental elderly care centers in Nepal has significantly increased (Republica Nepal, 2018 December 7). Nepal has policies and strategies such as the Senior Citizens Act (2006) and the Geriatric Health Service Strategy (2021-2030), but their implementation remains weak. Government-run institutional care homes are few, while most homes are operated by non-governmental sectors, where sustainability is often uncertain. In Nepal, government-run care homes are few in number and have a more cumbersome admission process compared to non-governmental care homes.

Empirical research comparing these two types of care homes is very limited. Therefore, this study aims to assess the physical and mental well-being of elderly residents and examine differences in well-being between governmental and non-governmental care homes.

### Methodology

A cross-sectional descriptive study was conducted in March 2023 using self-reported physical health questions and standardized tools namely the short version of the Geriatric Depression Scale (GDS-15), and the European Quality of Life Five Dimensions–Five Levels (EQ-5D-5L) scale. These

tools were used to assess the well-being of elderly individuals residing in governmental and non-governmental care homes in Kathmandu. The purpose of the self-reported physical health questions was to gather information on the general health perception of senior citizens, changes in their health from the previous year, and the existence of chronic conditions. The GDS-15, a standardized instrument with 15 items about mental health, was utilized to measure depression in senior citizens living in old care homes.

Two non-government/private operated care homes and one government-run care home were chosen using simple random sampling from among the eight functional care homes in the Kathmandu Valley (one governmental and seven non-governmental) to avoid the bias in the selection of the care homes. Elderly individuals from both governmental and non-governmental care homes were selected using purposive sampling based on their ability to hear and willingness to participate voluntarily. Purposive sampling was used because not all residents were able or willing to participate in the survey due to hearing difficulties or lack of interest. The inclusion criteria required respondents to voluntarily participate and be able to hear the interviewer, while the exclusion criteria applied to those with significant hearing impairment or unwillingness to take part in the interview.

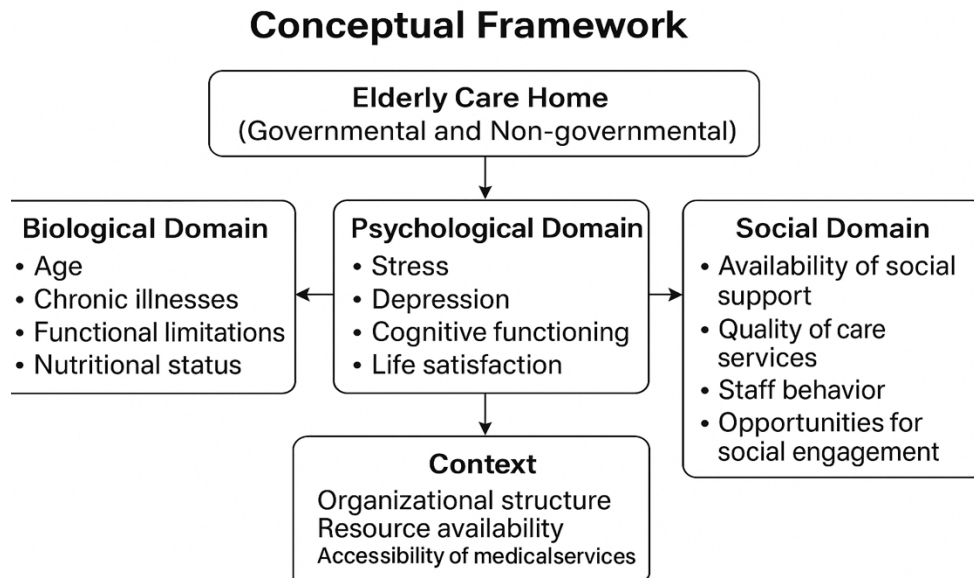
All eligible individuals who meet inclusion criteria were invited for interviews, resulting in a total sample of 60 elderly participants. Of these, 23 were selected from non-governmental care homes (including one privately run home 1 respondents was selected among 6 residents and 22 respondents were selected from 36 residents of NGO run care home), while 37 were selected from governmental care homes out of a total of 187 residents.

A modest sample size was selected for practical reasons: the number of eligible residents was limited, and several were unable or unwilling to participate because of health or hearing difficulties. Comparable institutional studies have used similar sample sizes—for example, Dave & Lakum (2025) included 60 participants (30+30), and Khanal et al. (2018) used a sample of 39 elderly residents in care-home research. Given these constraints, the present study is positioned as descriptive and exploratory, emphasizing effect sizes and confidence intervals rather than relying solely on hypothesis testing. This approach aligns with recommendations for research involving small or hard-to-reach institutional populations (White & Kirkendall, 2018).

Before the interviews began, the purpose of the study was explained to each participant, and their verbal consent was obtained. It was made clear to participants that their involvement was entirely optional and they might end it at any moment. This preserved research ethics by guaranteeing informed consent and willing involvement. To determine the relationship between different indicators of both physical and mental well-being, data were imported into SPSS 20 and subjected to bivariate and multivariate analysis.

### **Conceptual Framework**

Based on existing literature on the physical and mental well-being of older adults in institutional care, and guided by the bio-psycho-social model, this study proposes a conceptual framework illustrating how biological, psychological, and social factors shape elderly well-being in governmental and non-governmental care homes in Kathmandu. The biological domain includes age, sex, caste/ethnicity, chronic illnesses, activities of daily living, and physical functioning; the psychological domain comprises different dimensions of depression, cognitive functioning, and life satisfaction; and the social domain involves educational status, marital status, status of offsprings, family types, communication of family members, old age allowance. These domains collectively influence physical and mental well-being of the elderly individual living in governmental and non-governmental care homes. Differences between governmental and non-governmental care homes—such as resource access to medical services, staff–resident interactions—serve as contextual factors affecting these domains. This framework provides a systematic basis for analyzing how institutional settings impact the physical and mental well-being of elderly residents.

**Figure1***Conceptual Framework of Elderly Well-being of Governmental and Non-Governmental care homes*

### Results

The primary emphasis of this section is on the broad characteristics of senior citizens residing in government-run and non-governmentally owned assisted living facilities. It examines several indicators of mental and physical health that are connected to the governmental and non-governmental care homes. Moreover, it examines how senior citizens perceive the features of their assisted living facilities.

#### Socio-demographic Characteristics of the Respondents

About three-fifths (62%) of the respondents were female, and two-fifths (38%) were male. A higher proportion of females were found in governmental care homes (68%) compared to non-governmental care homes (52%). About 57 percent of the respondents were below 75 years old, while 43 percent were 75 years and above. The ages of the respondents ranged from 60 to 99 years, with median age of 73 years. In non-governmental care homes, the majority of the elderly (70%) were below 75 years old, whereas more than half (51%) were 75 years and above in governmental care homes.

More than half (57%) of the elderly belonged to the Brahman/Chhetri caste/ethnic group, with the majority found in governmental care homes (68%). Conversely, the majority of non-Brahman/Chhetri individuals were in non-governmental care homes. About two-thirds (68%) of the elderly were illiterate. A higher proportion of illiterate elderly were found in non-governmental care homes (78%) compared to governmental homes (59%). In contrast, a higher proportion of literate elderly were found in governmental care homes (40%) compared to non-governmental homes (22%).

About 63 percent of the elderly people living in care homes reported that their former occupation was non-agricultural. Non-agricultural work was the former occupation for the majority (87%) of elderly people in non-governmental care homes, whereas agriculture was the former occupation for the majority (51%) in governmental care homes.

About three-fourths of the elderly were married, while one-fourth were unmarried. There was no significant difference in marital status between the care home types. Among the married elderly, 61 percent had their own children. The vast majority (89%) of those with children were in non-governmental care homes, while the majority (57%) of those without children were in governmental care homes. Nearly half (48%) of the elderly came to the care home after living alone, 43 percent came from a joint families, and about 10 percent from a nuclear families.

About 62 percent of the elderly mentioned that they have no communication with their family members. A relatively higher proportion of elderly from non-governmental care homes (65%) compared to governmental care homes (59%) reported no communication with their family members. Communication with family members was reported as poor by 38 percent of the elderly in care homes,



but relatively higher communication was found among those in governmental care homes (40%) compared to non-governmental care homes (35%).

About 65 percent of the elderly had been in the care home for less than 5 years. A higher proportion of elderly from non-governmental care homes (74%) reported a duration of stay less than 5 years compared to governmental care homes (59%). A longer duration of stay (>5 years) was reported by more elderly in governmental care homes (40%) compared to non-governmental care homes (26%). More than half (52%) of the elderly in care homes were not receiving old age allowance, with the proportions being almost equal in governmental and non-governmental care homes.

**Table 1**

*Socio-Demographic Characteristics of Respondents by Nature of Care Homes*

Socio-Demographic Characteristics		Types of care center					
		Governmental		Non-Governmental		Total	
		N	%	N	%	N	%
Age group (Median age=73 years)	Less than 75 years	18	48.6	16	69.6	34	56.7
	75 years and above	19	51.4	7	30.4	26	43.3
Sex composition	Male	12	32.4	11	47.8	23	38.3
	Female	25	67.6	12	52.2	37	61.7
Caste/Ethnicity	Bhramn/Chhettri	25	67.6	9	39.1	34	56.7
	Non-Bhramn/Chhettri	12	32.4	14	60.9	26	43.3
Literacy status	Illiterate	22	59.5	18	78.3	40	66.7
	Literate	15	40.5	5	21.7	20	33.3
Former occupation	Agriculture	19	51.4	3	13.0	22	36.7
	Non-agriculture	18	48.6	20	87.0	38	63.3
Marital status	Unmarried	9	24.3	5	21.7	14	23.3
	Married	28	75.7	18	78.3	46	76.7
Status of Offspring	Yes	12	42.9	16	88.9	28	60.9
	No	16	57.1	2	11.1	18	39.1
Family types	Nuclear	3	8.1	3	13.0	6	10.0
	Joint	12	32.4	14	60.9	26	43.3
Communication with family member	Alone	22	59.5	6	26.1	28	46.7
	Yes	15	40.5	8	34.8	23	38.3
Duration of stat at care home	No	22	59.5	15	65.2	37	61.7
	Less than 5 years	22	59.5	17	73.9	39	65.0
Received old age allowance	5 years and above	15	40.5	6	26.1	21	35.0
	Yes	18	48.6	11	47.8	29	48.3
Total	No	19	51.4	12	52.2	31	51.7
		37	100.0	23	100.0	60	100.0

The majority of elderly people in non-governmental care homes were associated with the lower age group, male sex, non-Brahman/Chhetri caste/ethnic group, illiteracy, formerly non-agricultural occupations, having children, coming from joint families, not having communication with family members, and shorter durations of stay.

In contrast, the majority of elderly people in governmental care homes were associated with the higher age group, female sex, Brahman/Chhetri caste/ethnicity, literacy, formerly agricultural occupations, not having children, previously living alone, having communication with family members, and longer durations of stay.

### **Physical Well-being of the Respondents by Types of Care Homes**

Respondents were asked to assess their overall health condition. Fifty percent reported that their health was poor. More than three-fourths (78%) of respondents from non-governmental care homes perceived their overall health as poor, compared to 32% of those from governmental care homes. The association between care home type and health perception was statistically significant ( $p = 0.001$ ).

Compared to the previous year, about two-fifths (43%) of respondents reported poorer health, 30% reported no change, and 27% reported good health. A higher proportion of respondents from governmental care homes reported improved health compared to the previous year, while those reporting poorer health were predominantly from non-governmental care homes. All respondents from both types of care homes suffered from chronic diseases. All respondents from governmental care homes and 61 percent from non-governmental care homes had their health checked. More than half (53%) of the respondents had been suffering from chronic diseases for five years or more, with a higher proportion in governmental care homes (57%) compared to non-governmental care homes (48%). The average duration of suffering from chronic diseases was found 8.5 years in governmental care home and 5.6 years in non-governmental care home.

About one-third (32%) of respondents with chronic diseases were not taking medication. More than half (52%) of those not taking medication were from non-governmental care homes compared to governmental care homes (19%). The association between medication use and care home type was statistically significant ( $p = 0.007$ ). About one-third (30%) of respondents reported poor appetite, with a higher proportion in non-governmental care homes (39%) compared to governmental care homes (24%).

Nearly half (47%) of respondents reported poor sleeping status, with a higher proportion in governmental care homes. The association between sleep status and care home type was also statistically significant ( $p = 0.012$ ). About 38 percent of respondents reported sleeping less than 5 hours, with a higher proportion in governmental care homes (51%) compared to non-governmental care homes (13%).

About half (48%) of respondents reported urological and bowel dysfunction, with a significantly higher proportion in non-governmental care homes (87%) compared to governmental care homes (24%). Of those with urological and bowel dysfunction, about 37 percent experienced chronic urological and bowel dysfunction, with a higher proportion in non-governmental care homes (45%) compared to governmental care homes (25%).

More than three-fourths (77 %) of respondents living in care homes reported hearing loss, with no remarkable difference between governmental and non-governmental care homes. Similarly, about 72 percent reported visual impairment, with a higher proportion in non-governmental care homes (87%) compared to governmental care homes (62%). About 90 percent of respondents reported problems with physical functioning, with all respondents from non-governmental care homes and 84 percent from governmental care homes reporting such issues.

About 70 percent reported problems with activities of daily living, with a higher proportion in non-governmental care homes (87%) compared to governmental care homes (59%). About 70 percent of respondents reported slight/moderate pain and discomfort (body ache), while 30 percent reported severe pain. A significantly higher proportion of respondents from non-governmental care homes (65%) reported severe body ache compared to governmental care homes (8%).

The majority of elderly people in governmental care homes were associated with good perceived health conditions, stable health compared to the previous year, regular health check-ups, long-term chronic diseases ( $> 5$  years), taking medication for chronic diseases, good appetite, poor sleeping conditions, shorter sleep durations, and suffering from slight/moderate body ache (pain and discomfort).

**Table 2***Physical Well-being of Elderly People by Types of Care Homes*

Indicators of Physical Well-being		Types of Care Home					
		Governmental		Non-Governmental		Total	
		N	%	N	%	N	%
Perceived health condition**( $P=0.001$ )	Good	25	67.6	5	21.7	30	50.0
	Poor	12	32.4	18	78.3	30	50.0
Health Compared to Previous year	Good	13	35.1	3	13.0	16	26.7
	Same	15	40.5	3	13.0	18	30.0
	Bad	9	24.3	17	73.9	26	43.3
Prevalence of chronic Diseases	Yes	37	100.0	23	100.0	60	100.0
Health checked up	Yes	37	100.0	14	60.9	51	85.0
	No			9	39.1	9	15.0
Duration of suffering from chronic disease	Less than 5 years	16	43.2	12	52.2	28	46.7
	Five years and above	21	56.8	11	47.8	32	53.3
Intake of medication**(p=0.007)	Yes	30	81.1	11	47.8	41	68.3
	No	7	18.9	12	52.2	19	31.7
Status of Appetite	Good	28	75.7	14	60.9	42	70.0
	Poor	9	24.3	9	39.1	18	30.0
Status of Sleeping**(p=0.012)	Good	15	40.5	17	73.9	32	53.3
	Poor	22	59.5	6	26.1	28	46.7
Sleeping hours	<5 hours	19	51.4	3	13.0	22	36.7
	5 hours and more	18	48.6	20	87.0	38	63.3
Urological and Bowl Dysfunction	Yes	9	24.3	20	87.0	29	48.3
	No	28	75.7	3	13.0	31	51.7
Chronic Urological and Bowl Dysfunction	Yes	3	25.0	9	45.0	12	37.5
	No	9	75.0	11	55.0	20	62.5
Hearing loss	Yes	28	75.7	18	78.3	46	76.7
	No	9	24.3	5	21.7	14	23.3
Visual impairment	Yes	23	62.2	20	87.0	43	71.7
	No	14	37.8	3	13.0	17	28.3
Physical functioning	No problems	6	16.2			6	10.0
	Problems	31	83.8	23	100.0	54	90.0
Activities of daily living	No problems	15	40.5	3	13.0	18	30.0
	Problems	22	59.5	20	87.0	42	70.0
Body achy	Slight/Moderate pain	34	91.9	8	34.8	42	70.0
	Severe pain	3	8.1	15	65.2	18	30.0
Total		37	100.0	23	100.0	60	100.0

Note: \*\*\*Significant in Chi-Square test at  $p<0.001$ , \*\*= $p<0.01$  and \*= $p<0.05$  Na= Chi-Square test was not performed due to few numbers (<5) in cell.

#### **Prevalence of Different Chronic Diseases of Elderly People by Types of Care Homes**

All respondents from both types of care homes—governmental and non-governmental—reported suffering from chronic diseases. Nearly two-thirds (63%) of the respondents had hypertension, with a higher proportion in non-governmental care homes (74%) than in governmental care homes (57%). Only 5 percent of the respondents reported hypotension, and all were associated with governmental care homes.

About one-quarter (25%) of the respondents reported diabetes, with a higher proportion in non-governmental care homes (39%) than in governmental care homes (16%). The association between reported diabetes and care home type was statistically significant ( $p = 0.046$ ). About 18 percent reported

asthma, with a higher proportion in governmental care homes (24%) compared to non-governmental care homes (9%).

About 20 percent of the respondents reported neurological problems, with a higher proportion in governmental care homes (24%) compared to non-governmental care homes (13%). Similarly, about 45 percent of the respondents reported joint pain, with a higher proportion in non-governmental care homes (65%) compared to governmental care homes (32%). The association between reported cases of joint pain and care home type was also statistically significant ( $p = 0.013$ )

Nearly two-thirds (63 %) of the respondents reported backache, with a higher proportion in non-governmental care homes (74%) compared to governmental care homes (57%). About 40 percent reported gastritis, with a higher proportion in non-governmental care homes (52%) compared to governmental care homes (32%). About 25 percent reported urological problems, with a significantly higher proportion in non-governmental care homes (52%) compared to governmental care homes (8%). About 15 percent of the respondents reported heart diseases, with similar proportions in both types of care homes. About 12 percent reported uric acid problems, all of whom were associated with governmental care homes.

In summary, the majority of respondents in non-governmental care homes suffered from hypertension, diabetes, joint pain, backache, gastritis, and urological problems compared to those in governmental care homes. Conversely, a higher proportion of respondents in governmental care homes suffered from asthma, neurological problems, heart diseases, and uric acid issues compared to those in non-governmental care homes.

**Table 3**

*Prevalence of Different Chronic Diseases of Elderly People by Types of Care Homes*

Status of Chronic Diseases		Types of Care Home					
		Governmental		Non-Governmental		Total	
		N	%	N	%	N	%
BP High	Yes	21	56.8	17	73.9	38	63.3
	No	16	43.2	6	26.1	22	36.7
BP Low	Yes	3	8.1			3	5.0
	No	34	91.9	23	100.0	57	95.0
Diabetes*( $p=0.046$ )	Yes	6	16.2	9	39.1	15	25.0
	No	31	83.8	14	60.9	45	75.0
Kidney Diseases	No	37	100.0	23	100.0	60	100.0
Asthma	Yes	9	24.3	2	8.7	11	18.3
	No	28	75.7	21	91.3	49	81.7
Neurological	Yes	9	24.3	3	13.0	12	20.0
	No	28	75.7	20	87.0	48	80.0
Joints pain**( $p=0.013$ )	Yes	12	32.4	15	65.2	27	45.0
	No	25	67.6	8	34.8	33	55.0
Backache	Yes	21	56.8	17	73.9	38	63.3
	No	16	43.2	6	26.1	22	36.7
Gastritis's	Yes	12	32.4	12	52.2	24	40.0
	No	25	67.6	11	47.8	36	60.0
Urological	Yes	3	8.1	12	52.2	15	25.0
	No	34	91.9	11	47.8	45	75.0
Heart Diseases	Yes	6	16.2	3	13.0	9	15.0
	No	31	83.8	20	87.0	51	85.0
Uric Acid	Yes	7	18.9			7	11.7
	No	30	81.1	23	100.0	53	88.3
Total		37	100.0	23	100.0	60	100.0

Note: \*\*\*Significant in Chi-Square test at  $p < 0.001$ , = \*\*= $p < 0.01$  and \*= $p < 0.05$  Na= Chi-Square test was not performed due to few numbers ( $< 5$ ) in cell.



### Crude Odds Ratios and 95% CIs for Health Perception and Chronic Diseases in Elderly Care Home Residents

Logistic regression analysis was conducted to measure the strength of the association between self-perceived health, the prevalence of chronic diseases, and the type of care home. Table 4 shows that variables such as self-perceived health, hypertension, diabetes, joint pain, backache, and gastritis were significantly associated with elderly people living in care homes.

For instance, elderly people living in governmental care homes were 5 times more likely (cOR=5.18, 95% CI=1.12-24.00) to have good self-perceived health than those living in non-governmental care homes. Additionally, elderly residents of governmental care homes were 26 percent less likely to have hypertension, 36 percent less likely to have diabetes, 47 percent less likely to have joint pain, 68 percent less likely to have backache, and 49 percent less likely to have gastritis compared to those living in non-governmental care homes. Binary logistic regression analysis suggests that elderly people living in governmental care homes have better health outcomes than those living in non-governmental care homes.

**Table 4**

*Crude Odds Ratios (cOR) and 95% Confidence Interval (CI) for Health Perception and Chronic Diseases in Elderly Care Home Residents*

Self-Perceived Health and Chronic Diseases	Odds ratio	95% CI
Self-perceived health(p=0.036) *		
Poor	1.00	
Good	5.18	1.12 – 24.00
Hypertension(p=0.678)		
No	1.00	
Yes	0.74	0.16 – 3.33
Diabetes(p=0.590)		
No	1.00	
Yes	0.64	0.13 - 3.17
Joints pain(p=0.409)		
No	1.00	
Yes	0.54	0.12- 2.35
Backache (p=0.200)		
No	1.00	
Yes	0.32	0.06– 1.83
Gastritis's(p=0.440)		
No	1.00	
Yes	0.52	0.097-2.75
Constant	0.92	
-2 Log likelihood	61.68	
Cox & Snell R Square	0.26	

Note: \*\*\*Significant in Chi-Square test at  $p < 0.001$ ,  $= ** = p < 0.01$  and  $* = p < 0.05$

### Mental Well-being of the Elderly People

The mental well-being of the elderly was assessed using the short version of the Geriatric Depression Scale (GDS-15), which includes 15 questions. Among the 60 respondents, 3 percent were found to be normal, 40 percent had mild depression, 30 percent had moderate depression, and 27 percent had severe depression.

All respondents from non-governmental care homes and 95 percent from governmental care homes exhibited some level of depression. More than half (52%) of the respondents from non-governmental care

homes had moderate depression compared to 16 percent from governmental care homes. Additionally, 39 percent of respondents from non-governmental care homes had severe depression, compared to 19 percent from governmental care homes.

**Table 5**

*Indicators of Depression of Elderly People by Types of Care Homes*

Indicators and Level of Depression		Types of Care Home					
		Governmental		Non-Governmental		Total	
		N	%	N	%	N	%
Satisfied with life***( $p=0.000$ )	Yes	27	73.0	5	21.7	32	53.3
	No	10	27.0	18	78.3	28	46.7
Dropped many activities and interest	Yes	31	83.8	21	91.3	52	86.7
	No	6	16.2	2	8.7	8	13.3
Feeling of life is empty	Yes	28	75.7	21	91.3	49	81.7
	No	9	24.3	2	8.7	11	18.3
Often get boarded	Yes	19	51.4	12	52.2	31	51.7
	No	18	48.6	11	47.8	29	48.3
Good sprit in most of the time	Yes	24	64.9	2	8.7	26	43.3
	No	13	35.1	21	91.3	34	56.7
Afraid that something bad going to happen	Yes	3	8.1	6	26.1	9	15.0
	No	34	91.9	17	73.9	51	85.0
Feel happy most of the time	Yes	24	64.9	3	13.0	27	45.0
	No	13	35.1	20	87.0	33	55.0
Often feel helpless	Yes	25	67.6	18	78.3	43	71.7
	No	12	32.4	5	21.7	17	28.3
Prefer to stay at home rather than going out and doing new things	Yes	12	32.4	8	34.8	20	33.3
	No	25	67.6	15	65.2	40	66.7
Feeling of having more problems with memory than others*( $p=0.037$ )	Yes	19	51.4	18	78.3	37	61.7
	No	18	48.6	5	21.7	23	38.3
Wonderful to be alive	Yes	18	48.6	3	13.0	21	35.0
	No	19	51.4	20	87.0	39	65.0
Feeling of pretty worthless	Yes	25	67.6	18	78.3	43	71.7
	No	12	32.4	5	21.7	17	28.3
Feeling of full of energy***( $p=0.000$ )	Yes	27	73.0	6	26.1	33	55.0
	No	10	27.0	17	73.9	27	45.0
Feeling of situation is hopeless	Yes	28	75.7	21	91.3	49	81.7
	No	9	24.3	2	8.7	11	18.3
Thinking of most of people are better than me	Yes	31	83.8	17	73.9	48	80.0
	No	6	16.2	6	26.1	12	20.0
Level of Depression	Normal	2	5.4			2	3.3
	Mild	22	59.5	2	8.7	24	40.0
	Moderate	6	16.2	12	52.2	18	30.0
	Severe	7	18.9	9	39.1	16	26.7
Severity of Depression	Mild/Moderate	28	80.0	14	60.9	42	72.4
	Severe	7	20.0	9	39.1	16	27.6
Total		35	100.0	23	100.0	58	100.0

Note: \*\*\*Significant in Chi-Square test at  $p<0.001$ , \*\*= $p<0.01$  and \*= $p<0.05$  Na= Chi-Square test was not performed due to few numbers ( $<5$ ) in cell.

Nearly half (47%) of the respondents were not satisfied with their life. A significantly higher proportion of respondents from non-governmental care homes (78%) were dissatisfied with their life compared to those from governmental care homes. The association between life satisfaction and care home type was statistically significant ( $p < 0.001$ ).

More than sixty percent (62%) of the respondents felt they had more memory problems than others, with a significantly higher proportion from non-governmental care homes (78%) compared to governmental care homes (51%). The association between respondents' perception of memory problems and their living arrangement (type of care home) was statistically significant ( $p = 0.037$ ). About 55 percent of the respondents felt full of energy, with a significantly higher proportion from governmental care homes (73%) compared to non-governmental care homes (26%). The association between respondents' feeling of full energy and their living arrangement (care home type) was also statistically significant ( $p < 0.001$ ).

Overall, 97 percent of the respondents exhibited some level of depressive symptoms, with 27 percent experiencing severe depression. All normal respondents were from governmental care homes. A significantly higher proportion of severe depression was found among respondents from non-governmental care homes (39%) compared to governmental care homes (19%).

### Crude Odds Ratios and 95% CIs for Depression Severity in Elderly Care Home Residents

The association between depression severity and care home type was evaluated using logistic regression. Table 6 shows that the severity of depression was significantly associated with elderly people living in care homes. Elderly people living in non-governmental care homes were 2.5 times more likely ( $cOR=2.571$ , 95% CI=0.792-8.350) to have severe depression than those living in governmental care homes. Binary logistic regression indicates that elderly individuals in governmental care homes have less severe depression compared to those in non-governmental care homes.

**Table 6**

*Crude Odds Ratios (cOR) and 95% Confidence Interval (CI) for Depression Severity in Elderly People of Care Home Residents.*

Severity of depression	Crude Odds ratio	95% CI
Severity of depression( $p=0.016$ )		
Mild/Moderate	1.00	
Severe	2.57	0.792- 8.35
Constant	0.03	
-2 Log likelihood	75.39	
Cox & Snell R Square	0.04	

Note. \*\*\*Significant in Chi-Square test at  $p < 0.001$ , = \*\*= $p < 0.01$  and \*= $p < 0.05$ .

### Discussion

Wellbeing is a multidimensional concept that encompasses physical, mental, social, environmental and spiritual aspects. Based on indicators of physical and mental health, this study measures the wellbeing of elderly individuals living in governmental and non-governmental care homes. Physical health was assessed using self-reported questions and the EQ-5D-5L questionnaire, while mental health was measured using the GDS-15 tool. The study explores the relationship between care home types and the wellbeing of elderly residents.

The overall mean age of elderly residents in care homes was 73 years (76.3 years in governmental and 72.8 years in non-governmental care homes), consistent with previous studies (Eskimez et al., 2018; Chalise, 2014; Onunkwor et al., 2016), but lower than reported in other studies (Shah et al., 2021; Shrestha et al., 2020). Most respondents were female (62%), of Brahmin/Chhetri caste (57%), illiterate (67%), and married (77%), aligning with prior research (Shrestha et al., 2020; Shah et al., 2021).

Although Section 122 of the Civil Code (2017) requires that every sons and daughters to honor, respect, and care for their parents, 61% of the elderly individuals in this study were living in care homes despite having their own children. This proportion is slightly lower than the percentage reported by Shrestha et al. (2019). Approximately one-third of respondents were literate, which is higher than the

proportion reported by Chalise (2014).

Half of the respondents (50%) perceived their overall health as poor, similar to the finding of Eskimez et al. (2018) at 49%, but better than Mishra & Chalise (2019) reported 69%. All respondents reported chronic diseases, closely aligning with Chalise et al. (2014) at 94% and Mishra & Chalise (2019) by 90%, but higher than the rate reported by Eskimez et al. (2018) which was 74%. Comorbidities were reported by all respondents (100%), exceeding prevalence in previous studies (Chalise, 2014) i.e 93% and Onunkwor et al., (2016) by 83%. About one-third (32%) did not take medications regularly, higher than the 20% reported by Eskimez et al. (2018).

Insomnia, a serious health concern, can adversely affect physical and mental health. In this study, average sleep duration was 5.2 hours, with 47% reporting insomnia, exceeding the 31% reported by Mishra & Chalise (2019). Similarly, urological and bowel functions are essential for healthy living. Although normal aging generally does not affect these functions (Korfage et al., 2008), approximately 37% of participants (25% in governmental and 45% in non-governmental care homes) experienced chronic urological and bowel dysfunction.

Good hearing and vision are critical for healthy living; however, impairments are common in older adults. In this study, over three-quarters of respondents (77%; 76% in governmental and 78% in non-governmental care homes) reported hearing loss, higher than the 49% reported by Mishra & Chalise (2019). Similarly, 72% of respondents (62% in governmental and 87% in non-governmental care homes) reported visual impairment, consistent with Mishra & Chalise (2019, 43%).

Similarly, about 63 percent of the elderly were suffering from hypertension, which was higher than the 47 percent found in the study by Amonkar et al. (2018) and the 40 percent found in the study by Dhungana & Dhungana (2020). The prevalence of backache in older age is significant, with this study finding that about 63 percent of the elderly were suffering from backache, consistent with Mishra's (2018) study at 61 percent, but lower than the 72 percent, found in the study by Dhungana & Dhungana (2020).

For healthy aging, normal physical functioning, independence in activities of daily living (ADLs), and freedom from body aches are essential. This study found that a large proportion of respondents experienced difficulties: 84% in governmental and 100% in non-governmental care homes reported problems with physical functioning, while 59% in governmental and 87% in non-governmental care homes reported difficulties in ADLs. Severe body aches were reported by 8% of respondents in governmental care homes and 85% in non-governmental care homes.

The study assessed the well-being of elderly individuals based on care home type, revealing a significant impact. Elderly in governmental care homes reported better physical well-being, including good perceived health, stable health compared to the previous year, regular health check-ups, chronic disease medication, good appetite, better self-care status, and lower pain and discomfort than those in non-governmental care homes. Binary logistic regression analysis indicated that elderly in governmental care homes were five times more likely to have good self-perceived health (aOR=5.18, 95% CI=1.12-24.00), and less likely to have hypertension, diabetes, joint pain, backache, and gastritis.

This study revealed a 97% prevalence of depression (70% mild to moderate and 27% severe), which is substantially higher than the rates reported by Maharjan et al. (2024, 58.5%) and Khanal et al. (2024, 58%). Severe depression was more prevalent among the elderly in non-governmental care homes (39%) compared to governmental care homes (19%). Elderly in non-governmental care homes were 2.5 times more likely to have severe depression (cOR=2.571, 95% CI=0.792-8.350). Intake of medicine ( $p=0.003$ ) and pain/discomfort ( $p=0.010$ ) were statistically significant indicators of depression severity.

Elderly perceptions of care home characteristics varied by type. More elderly in governmental care homes reported good staff behavior, food quality, bed/bedroom conditions, and healthcare quality compared to those in non-governmental care homes. However, bathroom conditions were rated slightly better in non-governmental care homes. Food quality was statistically significant ( $p=0.020$ ). Overall stay perception showed no remarkable differences between care home types. Top of Form Bottom of Form

Residents of the non-governmental care home were mostly rescued from the streets by the organization or brought in by the police, making their entry conditions more vulnerable than those in



governmental care homes. The governmental care home had a better living environment, including adequate open space, whereas the non-governmental home was congested, lacked outdoor areas, and operated within a narrow three-storey building. Although the non-governmental home was run by compassionate individuals, it faced shortages of resources, affecting food adequacy, regular health checkups, and access to medication. In contrast, the governmental care home followed official guidelines, maintained minimum standards, and ensured adequate meals, routine health assessments, and necessary medical services. The differences in the physical and mental well-being of elderly residents may therefore reflect disparities in resource availability and caregiving practices between the two types of care homes. Although Section 20(2) of the Senior Citizens Act (2006) requires care homes to meet specified infrastructure standards and obtain approval from the concerned authority, the visited non-governmental care home did not comply with these provisions. These homes operated on an ad-hoc, emotionally driven basis rather than through proper planning, a concern also highlighted in the National Human Rights Commission's (2019) monitoring report.

This study is limited to elderly residents of selected care homes in the Kathmandu district and includes only 60 participants. Due to the small number of available facilities—one government-run, one non-governmental, and one privately operated—the study may not fully represent the wider care-home population. Individuals with severe physical or mental conditions and those with significant hearing impairments could not participate, resulting in their underrepresentation. Furthermore, the privately run care home had six residents, but only one met the eligibility criteria, making it inappropriate to generalize findings to privately operated or paid care homes.

### Conclusion and Implications

The study suggests an association between the type of care home among the elderly and their physical and mental well-being. Elderly residents of non-governmental care homes demonstrated poorer physical well-being than those in governmental care homes, reflected in lower overall health perception, weaker medication adherence, declining health compared to the previous year, poor health check-ups, reduced appetite, chronic urinary/bowel dysfunction, higher levels of body aches, hearing and visual impairments, and greater difficulties in activities of daily living.

Similarly, mental well-being—measured through levels of depression—was poor in both types of care homes, but the severity was twice as high among residents of the non-governmental home compared to those in the governmental home. Life dissatisfaction was also three times higher among elderly residents of the non-governmental care home than among those in the governmental facility.

The poorer physical and mental well-being of elderly residents in the non-governmental care home, compared to those in the governmental facility, highlights significant gaps in care quality. These gaps urgently need to be addressed by strengthening routine health checkups, ensuring adequate medication, and providing psychosocial support for residents experiencing severe depression. To reduce disparities between governmental and non-governmental care homes and to ensure quality care, regular monitoring and targeted support from concerned authorities are essential—especially for elderly in non-governmental care homes.

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