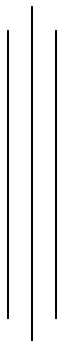
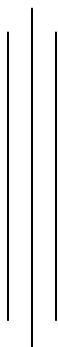


**Status Report on
Elderly People (60+) in Nepal on
Health, Nutrition and Social Status Focusing on Research
Needs**



Prepared for
**Government of Nepal
Ministry of Health and Population
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Executive Summary

The combined effect of lowered fertility and improved health and longevity has generated growing numbers and proportions of older population throughout the world. Sudden spurt in the population of elderly in a country is bound to pose multiple challenges for the government. Developing countries are going to face such a growth in a much quicker time as compared to the developed world which saw such a demographic transition earlier. To face up to the coming challenges, the government of Nepal is trying its best to prepare itself for implementation of suitable policies and programs. It is in this context that MoHP commissioned this review study. The recommendations based on the review are expected to provide strong base for guiding the future research works in Nepal in general and under the ministry, in particular.

This desk-review study is based on available secondary information from the published and unpublished sources including the web search. However, knowledgeable experts and specialized organizations in the country were contacted for validation and up-date of available information from the secondary sources. The review covers broad spectrum of countries and their programs with focus on socio-economic, health and nutrition aspects of elderly.

The review finds that countries with rapid demographic ageing and high socio-economic development are far ahead of other countries in introducing proactive measures in terms of social security, health and nutrition. Economically less developed regions have been slower to adopt ageing as a major public concern, despite the fact that older populations in many developing countries are growing more rapidly than are those of industrialized nations.

Most Nepalese enter old age after a lifetime of poverty and deprivation, poor access to health care and a diet that is usually inadequate in quality and quantity. However, health and nutrition interventions in Nepal are directed primarily toward infants and young children as well as pregnant and lactating women. This status report focuses on the key areas to identify priorities for future research and policy development based on the national and international policies and programs related to the elderly as well as the research works and the exemplary programs for the well-being of the older population.

Recommendations are based on the identified gaps during the review work and are presented under different sub-heads:

- Institutional Development and Human Resource
- Research or Information Generation
- Literature Development
- Awareness Building
- Policy Development

Specific programs are also proposed based on the experience of both the developed and developing countries that could be reasonably adopted for Nepali conditions with some adjustments or modifications.

Acronyms

ADB	Asian Development Bank
BRAC	Bangladesh Rural Advancement Committee
CACPs	Community Aged Care Packages
CBOs	Community Based Organizations
CBS	Central Bureau of Statistics
CHSC	Commonwealth Seniors Health Card
CSSA	Comprehensive Social Security Assistance
DFID	Department for International Development
DH	Department of Health
DHS	Demographic and Health Survey
DoHS	Department of Health Services
ENP	Elderly Nutrition Program
EPF	Employees' Provident Fund
ETF	Employees Trust Fund
FAO	Food and Agriculture Organization
FCHVs	Female Community Health Volunteers
GoN	Government of Nepal
HACC	Home and Community Care Program
HCPOP	Health Care Program for Older Persons
HRQoL	Health-Related Quality of Life
ICN	International Conference on Nutrition
IDA	Iron Deficiency Anemia
IDD	Iodine Deficiency Disorder
ILO	International Labor Organization
INGOs	International Non- Government Organizations
LAC	Latin America and the Caribbean
MAFF	Ministry of Agriculture, Fisheries and Food
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MIPAA	Madrid International Plan of Action on Ageing
MOH	Medical Officer of Health
MoHP	Ministry of Health and Population
MPF	Mandatory Provident Fund
NDHS	Nepal Demographic and Health Survey
NDNS	National Diet and Nutrition Survey
NEPAN	Nepal Participatory Action Network
NGOs	Non- Government Organizations
NHP	National Health Policy
NHSP-IP	Nepal Health Sector Program-Implementation Plan
NMSS	Nepal Micronutrient Status Survey
NNMB	National Nutrition Monitoring Bureau
NSS	National Sample Survey
OAA	Old Age Allowance
OAA	Older Americans Act

PROPSIN	Participatory Research on Older People's Situation in Nepal
RIS	Regional Implementation Strategy
SAARC	South Asian Association for Regional Co-operation
SENECA	Survey in Europe on Nutrition and the Elderly, a Concerted Action
SLTHP	Second Long- term Health Plan
SUDIN	Sustainable Development Initiative Network
UN	United Nation
VDC	Village Development Community
VWOs	Voluntary Welfare Organizations
WHO	World Health Organization

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Status Report on Elderly People (60+) in Nepal on Health, Nutrition and Social Status Focusing on Research Needs

Chapter One

1. Introduction

1.1 Background

Global ageing is the success story of the 21st century. As a result of declining fertility, mortality as well as improved public health interventions, population ageing has been a world-wide phenomenon. People today are living longer and generally healthier lives. This represents the triumph of public health, medical advancement, and economic development over disease and injury which have constrained human life expectancy for thousands of years.

Population ageing is pervasive since it is affecting nearly all the countries of the world. Nepal is also witnessing the expansion of life span and hence an enhancement in the population of the elderly. In Nepal, individuals over 60 years of age are considered elderly. According to the 2001 census of Nepal, there were 1.5 million elderly inhabitants, which constitute 6.5 percent of the total population in the country. During the years 1991-2001, the annual elderly population growth rate was 3.39 percent, higher than the annual population growth rate of 2.3 percent. Nepal has a high population growth rate and it is concurrently attempting to introduce population control programs. These programs have resulted in a lower birth rate which will subsequently result in an even greater proportion of elderly individuals. (Chalise, HN, 2006)

There are different basis for defining Senior Citizens. One of the most common in use is the chronological age. WHO defines senior citizens as people 60 years and above. The Senior Citizens Acts 2063, Nepal also defines the senior citizens as "people who are 60 years and above". The retirement age for military in Nepal is 45 to 48 years for lower class, for general government service 58 years, and for university teachers and the judiciary services 63 years. (Khanal S., 2009)

Demographic Changes

Life expectancy in Nepal has increased from approximately 27 years in 1951 to 64 years in 2008 (CBS, 2008). There has been a sharp rise in the relative and absolute size of the elderly population in the past four decades.

Socio- economic Conditions

The majority of elderly in Nepal are living in rural areas (85 %+). They are usually active and productive in their advancing years doing things such as taking responsibilities for child care, cattle herding, handicrafts and many more. Among 65+ years aged persons, 47.12% are found economically active with sex differential of 59.7% for males and 34.3% for females. This could be because women's contributions are generally not accounted for in market values. (MoPE, 2002)

A majority of elders depend upon agriculture and are living under the poverty. They suffer from deprivation, illiteracy, poor health and nutrition, low social status, discrimination and restriction on mobility. Because of poverty, they enter into old age in a poor state of health and without saving or material assets. They lack means to fulfill their basic needs such as food, clothes, shelter, health care, and safe drinking water. Gender inequality and discrimination against women is a common social phenomenon that elderly widows suffer the most. (NEPAN, 2002)

Living Arrangements of Old People

In Nepali tradition, sons are morally obligated to provide care and support to their parents. It is estimated that more than 80% of elderly in Nepal live with their children. Only 2.7% of the elderly in Nepal are living with their daughters which may be due to the cultural taboos that prevent parents from living with married daughters.

Several studies in Nepal show that the long established culture and traditions of respecting elders are eroding day by day. Younger generations move away from their birthplace for employment opportunities elsewhere. Consequently, more elderly today are living alone and are vulnerable to mental problems like loneliness, depressions and many other physical diseases.

Dependency Ratio

The elderly dependency rate computed for different time periods shows increasing trend from 7.5% in 1911 to 12.01% in 2001. Considering the time span of 90 years; the rate is very slow with the magnitude of only 0.05% increase per year. (Dahal, 2007)

Household Headed by Elderly

Traditionally the eldest persons in the household were considered the household head, irrespective of the authority that the elder could have used in making household decisions. A recent survey finding that above 17% of households are headed by people aged above 60 years has to be used very cautiously. The proportion of females headed household is 21% compared to about 17 percent for males.

Marital Status of Elderly

The marital status of elderly is important for their support systems and their well-being. The elderly that are still married tend to recover more rapidly from illness, have better

mental health, utilize more health services, socialize more and are generally more satisfied with their life than those elderly without a partner.

In 1961, only 73.17% and 32.13% of the elderly male and females were married. This increased to 88.3% for male and 71.7% for females in 2009. The lower proportion of married elderly women could be attributed to the social taboos for a widow to re-marry. In Nepalese culture, widower remarriage is accepted. The proportion of never married elderly in Nepal is low. A study in 2002 revealed that about 9.11% of males and 24.94% of females are widowers/widows. About 0.32% males and 0.50% females divorce with their life partners and live a single life.

Mortality Pattern of Elderly People

Among the people age 60 and above, the death rate of male is significantly higher than female. The death rate of male among the age group 60 to 64 is 17.96%; while the same age group female's death rate is almost 4% less, i.e. 14.02%. The death rate of elderly above 75 is very high among the male, i.e., 80.41% while it is low, i.e., 62.13% among the females of the same age group. (Source: Population Monograph of Nepal, 2003)

Government Initiatives

The government started to include plans, policies and programmes for family-based security system to enable elderly to lead a dignified life since the Ninth Five Year Plan (1997-2002). Since then many initiatives have been taken focusing on the followings:

Health

The Nepalese Council of Ministers on 2061-05-03 BS adopted a guidelines entitled Jeshtha Nagarik Swashtopachar Sewa Karyakram Karyanyowan Nirdeshika 2061BS (Senior Citizens Health Facilities Program Implementation Guideline, 2061BS) which attempts to provide medical facilities to the old age people.

The government has provision to establish Jeshtha Nagarik Swashtopachar Kosh (Senior Citizens Health Facilities Fund) in each district. The government allocates some fund each year for each district for the purpose.

Following the “Senior Citizens Health Facilities Program Implementation Guideline, 2061BS”, the poverty affected elderly people are provided free medicine and treatment up to NRs.2000 at a time in all 75 districts from the fund.

The Government has proclaimed through the budget speech of fiscal year 2066/67 that the government will provide free health service for heart and kidney patient of 75 years and above age.

The current fiscal year (2066/67) budget also has provision to establish one health center for the elderly “Aarogya Aashram” in each of the five development regions of the country.

However, these schemes have limited coverage and the government is severely constrained by the financial, trained human resources and institutional capacity to provide the needed support and care for elderly.

Social Security Services

The government is providing Old–Age-Allowance (OAA) of Rs. 500 per month to people age 70 and above. The government provides Rs 500 per month for widow 60+. The allowances is managed by Ministry of Women, Children and Social Welfare and distributed through the local units of Ministry of Local Development at the village level.

OAA provided by the state can put predictability into the lives of poor older people and their families by offering them a guarantee of a minimum standard of living for themselves and their families. And there is increasing evidence that this has transformed the economic behavior of poor families. It has also restored dignity to many older people who now live in deep poverty and are often treated as a burden by their families.

OAA is another form of recognition for older people, but there is little understanding of the impact and access of the pension on older people. Is it valued by them? Does the pension have equal economic impact on all kinds of older people? Does it change the status of older people? Does it have any social impact? Who benefits the most from the pension? In order to answer these questions, a study has to be undertaken.

The government has pension scheme for retired public servants and their widows and children. The government also adds 10% in the total pension amount to the pensioners who are aged 75years and above. However, only less than 7% of elders in Nepal benefit from this pension system. Majority of the population receive no pension and must depend on family support and personal savings.

Old-age Homes

There is an Old Age Home in the premises of temple Pashupati Nath (Pashupati Bridrashram) for the destitute elders. Ministry of Women, Children and Social Welfare operates the old-age home that has the capacity for only 230 elderly people. This is the only one shelter for elderly people run by the government which was established in 1976 as the first residential facility for elders.

There are about 70 organizations registered with the government (GCN 2010) spread all over Nepal. These organizations vary in their organizational status (government, private, NGO, CBO, personal charity), capacity, facilities, and the services they provide. Most of them are charity organizations. About 1,500 elders are living in these old-age homes at present.

These private organizations are providing services to elderly out of the individual's initiatives. The services are determined with the consent of the individual generosity. The services and care, virtually, do not include aspects that are essential to cater elderly in these Homes.

Despite these initiatives, the Government does not have any official records on how many old age destitute people are taking shelter in these Old Age Homes (Briddhashrams).

Legal Provisions

The Interim Constitution of Nepal, 2006 (Art. 13) has made a provision for separate Act, Rules and Regulations specially to protect the rights of elders. In accordance with the Madrid International Plan of Action on Ageing (MIPAA) 2002, the government has already formulated and promulgated separate Acts, Rules and Regulations. The National Plan of Action, 2062 developed for senior citizens deals with various aspects such as economic and social security, health and nutrition, participation and involvement, education and entertainment and legal condition and reforms. These legal instruments emphasize both equity and equality for elders. Different ministries are made responsible to ensure proper implementation of the provisions made.

The government has been supporting and promoting individuals, NGOs and the private sector organizations that are coming up to work for ageing population.

Despite these initiatives, the government is severely limited by the available trained human resources and the fund for effective and efficient implementation of the legal and institutional provisions developed so far.

This population ageing can be seen as a success story for public health policies and for socio-economic development, but it also challenges society to adapt, in order to maximize the health and functional capacity of older people as well as their social participation and security. With the process of ageing various problems like mental and physical health, malnutrition and decrease in social participations are the common issues faced by the elders throughout the world.

As a signatory of the Second Madrid International Plan of Action on Ageing (MIPAA) 2002, the government of Nepal committed to implement actions stipulated in the conference. But the effectiveness of the programs is not turn out to be as positive as it was speculated in the past. It is due to the gaps in terms of the policies, Regulatory measures, institutional strength and the resources constraints. The lack of trained human resources in the field Gerontology has limited the research capability. This has led to research gaps which in turn have made it difficult to implement programs based on research findings.

Ministry of Health and Population (MoHP) is committed to ensure the services and priorities recommended by MIPAA, 2002. The lack of the authentic studies on socio-economic, health and nutrition status of ageing population is always realized by the concerned ministries as well as the donor communities.

The popular programs on ageing like Old-Age-Allowance, Senior Citizen Health Treatment Fund (Jeshtha Nagarik Upachar Kosh) have been implemented more on the basis of general assumptions and common understanding of the society rather than with concrete research findings. As a consequence, the quantification of specific

achievements, planning based on past experiences, and building on the lessons learned has become a prominent need of today, hence the importance of this study. Further more, efforts are made by this study to identify basic research gaps in the implementation level that have posed difficulties to meet the commitment expressed in the international forums.

This report reviews the health and nutrition policies, regulatory frameworks and socio-economic status of elderly in Nepal. The best practices to address health and nutritional conditions of elders as well as the social security measures being practiced in SAARC and other countries are reviewed. Based on this review, research gaps are identified and recommendations made specific to suit conditions of Nepal. The review, among other things identifies the current knowledge and programmatic gaps, presents recommendations for appropriate interventions and approaches that could be effectively scaled-up to address the problem of social security, health and nutrition of elderly people nationally.

1.2 Objectives

MoHP commissioned this review study with the following objectives.

- Provide comprehensive information on health, nutrition and socio-economic condition of elderly (60+) based on the available published and unpublished literature from concerned agencies and individuals,
- Identify research gaps and suggest research agenda regarding the socio-economic, health and nutritional status of the elderly in Nepal, and
- Illustrate the best practices of research and programs in SAARC and other countries.

1.3 Scope and Limitations

This study is based on review of current policy documents and research works to identify the existing research gaps and moves on to suggest research topics relevant for Nepal on the issues of senior citizens. The study was completed within the given time of 25 days and similar budget limitation. The study reviews the national policy and programs for social security services of the elderly in Nepal. It assesses the National Health Policy 1991, Second Long Term Health Plan (1997-2017), Health Sector Strategy 2003, National Nutritional Status Survey 1998, National Plan of Action on Ageing 2062, Senior Citizen Act 2063, constitutional provision and other relevant rules and regulations. In the process, the study also covers review of some relevant research, policy and program documents of SAARC and other countries in an effort to identify alternative means for livelihood to senior citizens.

This study is based on review of available documents that were prepared by different agencies and in different times. So, all factors that limit the value of their contents also creep into this report. However, efforts are made to interpret those information in the most pragmatic way in the present context of Nepal. The figures and findings referred here are short of the value that could be attributed to those generated from the primary sources or the field work.

1.4 Methodology

This research adopted a desk research method. Information has been collected through various available sources, such as legislation and official reports downloaded from websites of the governments and agencies concerned. The information obtained is subsequently correlated and analyzed under each topic included within the scope of this study, i.e., Social Security, Health and Nutrition.

1.5 Organization of the Report

This Chapter provided basic information on the study background, objectives, scope and limitation and the methodology adopted. The second Chapter begins with literature review on social security. The review covers policy, legal and program documents and research works relevant to Nepal, SAAR countries and others. The third Chapter covers the health policies, legal and programs documents and research works relevant to Nepal, SAARC and other countries. Chapter Four presents nutrition policies, legal and programs documents and research works of Nepal, SAARC and other countries. Finally the report culminated into Chapter five with summary and recommendations.

Chapter Two

2. Social Security: Literature Review

2.1. Introduction

Nepal's demographic contours suggest a steep increase in the elderly population in the coming decades as a result of declining fertility, increasing expectation of life at birth and partly at later ages. Although the proportion of the elderly population in 2001 may be low having 1.5 millions elderly people in Nepal, the elderly population is increasing at the rate of 3.4 annually (Chalise,HN, 2006). This phenomenon, coupled with rapid social changes resulting in the gradual breakdown of the traditional joint family system and ever-increasing financial constraints at the national level, is likely to pose serious problems for the elderly.

Traditionally, family has been the key social institution that provided psychological, social and economic support to the individual at different stages of life. Elderly in the family enjoyed undisputed authority and power. They were considered as knowledge banks and ideal persons for the younger. However, the structure of family has undergone changes differently at different stages of social development in Nepal. One of the present needs in case of societies like that of Nepal is to strengthen the traditional value systems.

Industrialization and urbanization have brought changes to family structure in Nepal to a great extent. The extended family that existed in the society has changed to a nuclear family. This has affected the position of the elderly in the family as well as the family's capacity to take care of the aged. The family's capacity to provide quality care to older people is decreasing with the reduction of the available kin support. However, some agencies like GCN have initiated activities such as honoring families that provide the best care to their elders in their family (GCN, 2009). Such efforts of publicly felicitating the families that provide best care to their elders and publicizing their family history could encourage other members of the community to follow the suit. Similarly, efforts to develop literary works such as poems and drama could bring about positive attitude among general public towards the senior citizens (GCN, 2009).

In recent days, depleting socio-cultural value system, diversification in occupation from agricultural to non-agricultural, higher mobility of economically active persons for seeking job and better education, and replacing existing joint family system by nuclear family system have been causing problematic for the security of aged people in Nepal.

Much progress has been made in the quality and quantity of health care services in Nepal in the last few decades. However, improvements have been uneven with urban areas getting the best advantage of modern technological advances in Medicare. Much of the emphasis of health care delivery system was on mother and child programs with special emphasis on controlling population. The specific health needs of senior citizens are virtually ignored by the present health services system.

Elderly people in Nepal may have reasonable access to family care but they are inadequately covered by economic and health security measures. The government, which is already grappling with a number of pressing problems, does not have enough resources to address the issues concerning the social aspects of elderly.

However, with the commitment expressed in the international forum as well as the pressure from the several individuals and organizations working with older people, the government has recently started to respond to the social security needs of elderly and has initiated some programs at national level. Following is the review of some such documents.

2.2. National Policies, Acts and Regulations: Social Security

2.2.1. Civil Code 1963

The Civil Code has provisions for elderly people in its section on property rights distribution. In Civil Code, 1963 sec. 10, it is stated that; "If the parents want to live with a particular son or daughter, it has to be clearly stated in the Bandapatra (the legal note on property distribution) and that son and daughter should take care of the parents. If the older parents cannot survive on their own income and if the son/daughter with whom they are not living should take care of, feed, and clothe them as per their earning". Similarly, the Section 11 of the chapter of court management has a provision that the litigation of the elderly people above than 75 years or the people physically retarded should put in third priority in the hearing. The first priority has given to person under custody or the prisoner under trial and the second priority is to unclaimed children below 16 years age.

2.2.2. Local Self Governance Act 1999

Under the heading of duties, rights, and responsibilities of village development committee in the **Local Self Governance Act 1999**, there is a provision for protection and development of orphan children, helpless, women, older people and disabled.

2.2.3. Senior Citizen Policy 2058

Up till 2002, there was no specific policy for older persons in Nepal. Senior Citizen Policy 2058 is the key policy document of the government towards elderly in the country. It largely follows the working plan determined by the Vienna Conference and the United Nation Principles for Ageing. This policy has envisaged incorporating economic benefit, social security, health service facilities and honor, participation and involvement, and education as well as entertainment aspects to support the elderly people in having prestigious livelihood. The policy aims to enhance the respect and dignity of the elderly in their family, society and nation. It also determines to improve the potential of the elderly so that they continue to be active and productive in national development, and to create opportunities to assist them to continue to be self-reliant.

2.2.4. National Plan of Action on Ageing 2062

Following the Madrid Plan of Action on Ageing, 2002, the Government of Nepal has formulated National Plan of Action on Ageing. This action plan identifies the elderly as one of its main target groups. Although this marks an initial step in the provision of care for the elderly, institutional efforts are at its minimum as family and community are encouraged or expected to provide care to the elderly. The principle is that the institutional support should be the last resort. This plan of action has attempted to include the various spheres like economic, social security, health and nutrition, participation and involvement, education and entertainment and legal of elders for their empowerment and well being. It also aims at encouraging the provision of facilities for the elderly so as to ensure care and protection for them. Although the National Plan of Action on Ageing is a great step forward in preparing the Nepali society for a transition into an ageing society, one major issue that affects the welfare of the elderly is conspicuously absent from the Plan is monitoring system.

2.2.5. Senior Citizen Act, 2063 and Regulations 2065

The Government of Nepal enacted the Senior Citizen Act, 2006 to ensure the social, economic and human rights of the elderly citizens. The purpose of the Act is to protect and provide the social security of old age citizens. This act also ensures to nourishment and health care of old age; to maintain their dignity; ensuring their property and have right for use of their property; special facilities and exemption of transportation fair for old age.

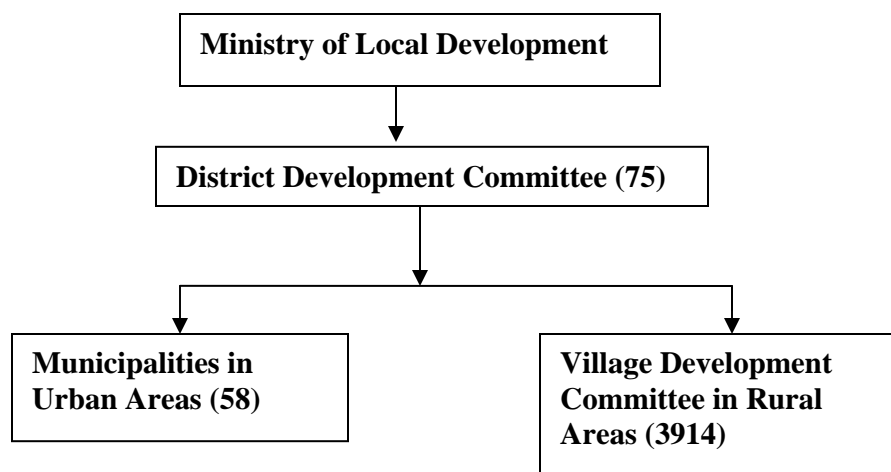
The Senior Citizens Regulations 2065 provides guidelines for the effective implementation of the Senior Citizen Act. It provides the detailed information on how to implement the policy and programs for the socio-economic well-beings for elders and the healthy ageing. It also provides the detailed procedures to be fulfilled to establish and run geriatric homes in the country. According to the regulation, specific terms and conditions must be considered to run Old Age Homes, Day Care Centers and Geriatric Centers.

2.2.6 Existing Programs

The Ninth Five Year Plan (1997-2002) pronounced the policy platform to improve the life of elderly people by emphasizing actions that would reinforce dignity, economic opportunities, respect and social security for the elderly. National Strategy for Senior Citizen has been implemented that focuses on the strategic interventions in order to utilize the knowledge and skills of the elderly, ensure social security, inculcate positive feelings towards the elderly and launch rehabilitative activities to fulfill basic needs of the elderly.

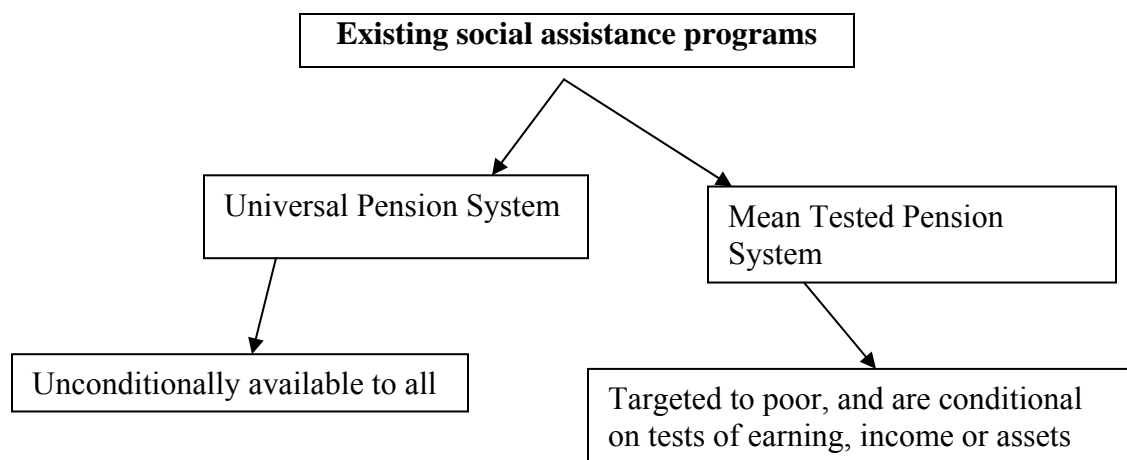
An Old–Age–Allowance (OAA) which came into effect as a step towards the fulfillment of the Directive Principle of the Constitution and the commitment expressed in the international forum on ageing. The scheme was first introduced in the fiscal year 1995/96 and partially modified after that. Now the Government provides Rs. 500 per to people age 70 and above. There is also a mean-tested pension, providing Rs. 500, for widows over age 60.

Organizational Structure of the Old-Age-Allowance Distribution System, Nepal



2.3. International Social Security Provisions

The income security for the old is an important mechanism to protect the old age from falling into hardship. There are, two distinct categories of social assistance programs prevailing throughout the world: a) universal non-contributory pensions and b) means-tested pensions. Universal pensions are unconditionally available to all, while means-tested pensions explicitly target the poor, and call for some sort of means testing of earnings, income, or assets.



2.3.1. Asia

Bangladesh

The Bangladesh government currently pays 150 Taka (US\$2.58) per month to extremely poor people aged 57 and above living in rural areas. The coverage has been very limited, but the government plans to expand the scheme to cover up to 1 million (14 per cent)

older people nationwide. Thailand has a similar scheme. India operates two means-tested old age assistance systems for their poorest elderly citizens, currently reaching about 6 million residents above age 65 (Ginneken, 2003: 61). An old-age pension of 75 Rupees a month (US\$1.50) is paid to women and men aged 65 and over who otherwise would be destitute. (Willmore, 2003: 23; Gorman, 2004).

China

The Chinese government actively develops social security systems of various forms, and priority is given to a special group of elderly people to be covered in the social security system in rural areas. These are elderly people who have lost the ability to work, who have no source of income, and who have no legal guardians whatsoever to support them, or their legal guardians do not have the ability to support them. They enjoy the state's "five guarantees" system, which means that their food, clothing, housing, medical care and burial expenses are taken care of and subsidized by the government. (Country Report: Peoples Republic of China, 2007)

Hong Kong

The Government of Hong Kong has designed three pillars retirement financial protection for elderly. They are:

- Publicly funded Comprehensive Social Security Assistance (CSSA) and Old Age Allowance (OAA);
- Mandatory Provident Fund (MPF) schemes; and
- Voluntary private savings and investment.

Under the First Pillar, the CSSA offers a safety net for those who could not support themselves financially, including the elderly. Elderly recipients receive special care through the provision of higher standard rates, special grants and supplements under the CSSA Scheme.

Besides the CSSA Scheme, the OAA also offers cash allowance to eligible elders of 65 or above to meet their special needs arising from old age. Both the CSSA and the OAA are non-contributory and funded by general revenue. While the CSSA is means-tested, the OAA is a largely non-means-tested scheme.

Besides financial assistance, the Public Pillar is complemented by a public support network for the elderly in need. This includes a highly subsidized public healthcare system, public housing programs, a wide network of elderly centers and centre-based services, as well as subsidized community and residential care services. (COP, 2007)

The Central Policy Unit is conducting a study to examine the sustainability of the three pillars of retirement protection. The Government will take into account the results of the study and explore ways to strengthen the three pillars. (COP, 2007)

Sri- Lanka

In Sri Lanka there are many social security schemes for elderly implemented by various agencies. Out of all, Public Service Pension Scheme and the Employees Provident Fund scheme are the two major schemes providing social security for the Government and the private sector employees in their old age. Various other contributory schemes in operation are established by the Government and the private sector organizations.

Indonesia

In 1998, Indonesia replaced the Social Assistance for the Elderly Law of 1965 by The Old Age Welfare Law of 1998. This law stipulates that elderly Indonesians have the same rights as any other citizens (GOI, 1998: section 5, subsection 1). They are entitled to various public services, including: 1) religion/spiritual service; 2) health care service; 3) employment service; 4) education and training service; 5) special privileges when using public utilities and legal services; and 6) access to social protection (for “infirm” elderly) and social assistance (for “able-bodied” elderly) schemes (ibid: section 5, subsection 2). Unlike earlier laws, the law also stipulates that the responsibility for the improvement of the elderly citizens’ welfare should be shared by the government, the community and the families of elderly citizens themselves (ibid: section 8). Finally, community members are authorized to engage in activities to improve the welfare of the elderly (ibid: section 22 and 23).

Singapore

In Singapore families are assumed to be the long-term care providers to the elderly. There is legal obligation on children to maintain their parents. Such a social policy deals with prevention and problems related to the neglect of elderly parents. In 1996, amendments to the Women's Charter provided channels for elderly parents to exercise legal action if they were victims of physical, mental or psychological abuse. Those without families, or the destitute, were dependent on the state for shelter and their material needs. Non-governmental organizations, such as religious bodies and ethnic associations, were commonly found to care for those who either did not succeed in obtaining government assistance or who preferred to cope without the state’s help due to pride, fear of stigmatization and other reasons. Unlike many non-Asian countries, where government assistance is viewed as an entitlement, in Singapore the general sentiment is that one only applies for the state’s help when one has no other options available. To many, it signals “failure” in life. Yet, as discussed in Chapter 1, in much of Asia, the family is no longer able to continue to take care of elderly members, because of the limited human and financial resources available to a smaller family, even if there is no convincing evidence that there is an erosion of family values (Liu and Kendig 2000; Ng et al. 2002).

2.3.2. Africa

Like Asian countries many African countries provide assisting supports to older population. Both universal social pension and mean tested social pensions are enacted in the African countries considering the socio economic constrains of the country. The schemes in South Africa and Senegal are means tested while those in Botswana, Mauritius, and Namibia are universal. Mozambique operates a cash transfer system that

targets households headed by chronically ill or disabled elders (Gillion, Turner, Bailey, & Latulippe, 2000; Gorman, 2004).

2.3.3. Latin America and the Caribbean

Argentina, Brazil, Chile, Costa Rica, Dominica, Mexico, and Uruguay all have means-tested programs that provide pensions for their poorest elderly citizens. Countries in Latin America and the Caribbean (LAC), such as Argentina, Brazil, Chile, Costa Rica, Cuba, Nicaragua, and Uruguay, provide pensions to poor who are 65 and older (except for Argentina and Uruguay where pension is 70). However, being poor in these countries is determined by means-tested, and benefits paid sometimes depend on the government budget. Costa Rica is the only country in the LAC that provides a non-contributory universal pension to persons aged 70 and up. Antigua and Bolivia offer a universal pension (Barrientos & Lloyd-Sherlock, 2003; Gorman, 2004).

2.3.4. Australia

Countries like Australia have arranged long term care for those elderly people whose level of disability prevents them from remaining in the community. The nursing homes cater for the most disabled elderly while the hostels provide services to least disabled. Around half of the nursing homes are run by private for the profit providers (47 percent), while hostels are almost all run by community and government organizations (98 percent). Community Aged Care Packages (CACPs) and community services under the Home and Community Care Program (HACC) provide assistance for people who wish to remain, and are able to be supported, in the community. CACPs provide hostel equivalent care for people with an equivalent level of dependency. The Commonwealth government finances all of these programs, with state governments also contributing to the HACC program. In all, government expenditure on such programs amounts to A\$ 5 billion, 2 ½ per cent of total public expenditure. Commonwealth subsidies for long-term residential care cover about ¾ of the costs of such care; residents pay the balance of the costs. (Carey, 1999)

2.3.5. Europe

Sweden

In Sweden, responsibility for the care of the elderly rests with three authorities acting at different levels. At national level, the Swedish Parliament (Riksdagen) and the Government realise policy goals through legislation and financial control measures. At regional level, the 21 county councils are responsible for the provision of health and medical care. At local level Sweden's 290 municipalities have a statutory duty to meet the social service and housing needs of the elderly.

Under the Social Service Act, Sweden has means- tested social pension system. Unlike other countries, Sweden now has a modern, politically stable pension system which automatically follows economic and demographic development. This gives long-term stability irrespective of development where there is no risk of the cost of income-based pensions being shifted on to future generations. It is a system that also puts Sweden in a good position for being able to provide long-term basic security in an acceptable manner.

Anyone who has not earned an adequate pension through the public pension system is guaranteed a top-up guarantee pension. This compensation is financed via the central government budget. (Report by the Government of Sweden)

2.4. Research

2.4.1. Research on Old Age Allowance in Nepal

Nepal introduced a non-contributory social pension scheme in 1995. This scheme is unique to Asia being the primary universal pension scheme in the region and a model for other developing countries. A study was undertaken by HelpAGE International with the primary aims to assess the social and economic impact of the non-contributory pension in Nepal. Despite its limitations, the study shows a glimpse of the effectiveness of the program. Despite being small in amount, the pension is recognized as an important part of older people's life and found to be highly valued. It has contributed to sustaining older people's lives through the purchase of medicine, food, and/or clothing. However, the socio-economic impact on beneficiaries was found to be different according to the situation of the older person. Rural dwellers valued the pension more highly than the urban dwellers. Older people living alone also valued the pension more than those living with others. (Help Age International, 2009)

2.4.2 Participatory Research on Older People's Situation in Nepal (PROPSIN)

Nepal Participatory Action Network (NEPAN) with assistance from HelpAge International conducted Participatory Research on Older People's Situation in Nepal (PROPSIN) in 15 districts of Nepal. The participatory research was designed with the objectives to prepare a report on the present condition of elderly people upon their opinions and experiences. Similarly the research action studied the contributions of the elderly people to family, society and nation and recommended the roles of the Government, NGOs, and international agencies to make the lives of elderly dignified and pleasant. The key finding of participatory research was published in a book entitled "Voice of Elderly".

2.4.3 Old Age Program in Nepal

Professor Dr. S Irudaya Rajan, Center for Development Studies, Thiruvananthapuram, Kerala, India assessed the efficiency and the implication of Old Age Allowance to Nepali older people and attempts to draw some general lessons. This review paper provides the context in which the Old Age Allowance programs exist by looking at the demographic characteristics of the country as well as available data on living arrangements and incomes of elderly households. It also describes the programs and presents data on key indicators such as coverage and cost at the national levels. On the basis of the survey carried out at the ward level, the review paper provides a close up look at how the scheme operates on the ground.

2.4.3 India: Assessment of Problems among Elderly Females of Ludhiana City

Department of Family Resource Management, Punjab Agricultural University, Ludhiana, Punjab, India conducted a study in Ludhiana city to explore the problems faced by elderly females and to seek suggestions by them to overcome these. According to the study, major physical problems faced by elderly females were reduced vision (81.25%), dental decay (77.50%), body weakness and pain (68.75%) whereas major economic problems were medical expenditure (85.0%) lack of freedom on spending (77.50%), reduced personal income (65.0%) etc. Amongst socio-psychological problems, stress and strain was the prominent problem (85%) followed by declining authority (77.50%), loneliness (72.50%) feeling of neglect (65.0%) and so on. The relationship between age and physical problems of elderly females was found to be non significant (2.824) whereas it was significant with respect to socio psychological problems (13.981). (N. Mehrotra and S. Batish, 2009)

2.4.3 Sri- Lanka: Population Ageing and the Labor Market

Based on a 2006 representative survey of old people in Sri Lanka, a case study was carried out to examine labor market consequences, focusing on retirement pathways and the determinants of labor market withdrawal. The study finds that a vast majority of Sri Lankan old workers are engaged in the informal sector, work long hours, and are paid less than younger workers. Moreover, the study shows that labor market duality carries over to old age: (i) previous employment is the most important predictor of the retirement pathway; (ii) older workers fall into two categories: civil servants and formal private sector workers, who generally stop working before they reach 60 because they are forced to do so by mandatory retirement regulations, and casual workers and the self-employed, who work until very old age (or death) due to poverty and insufficient income and who stop working primarily because of poor health; and (iii) the option of part-time work is used primarily by workers who held regular jobs in their prime age employment, but not by casual workers and self-employed. (Vodopivec, Milan and Nisha Arunatilake, 2008)

2.5. Discussion

Since the Second World Assembly on Ageing in 2002, efforts are being made to expand the social security programs for elderly by the signatory countries. Member states have adjusted their domestic legal frameworks to better promote and protect the rights of older persons through the promulgation of special rules and regulations. Every country has formulated national plan of action and national strategy that emphasize the promotion and protection of all human rights and fundamental freedoms of the elderly.

As the participants of the Second World Assembly on Ageing, Nepal have formulated Senior Citizens Policy and Working Policy 2058(2002), National Action Plan for Senior Citizens 2062(2005), Senior Citizens Acts 2063(2007) and Senior Citizens Regulation 2065(2009) to implement the policies and programs that ensure the social security to the elderly. International Conference on Population and Development (ICPD) also recommended the government to develop social security systems that ensure greater equity and solidarity between and within generations and that provide support to elderly people through encouragement of multigenerational families. Governments should also seek to enhance the self-reliance of elderly people so that they can lead healthy and

productive lives and can benefit society by making full use of the skills and abilities they have acquired in their lives.

The Senior Citizens Acts adopted by the Government has aimed to formulate policies to respect and utilize the knowledge, skills and experiences of senior citizens in nation development and social transformation. The provision made by the Senior Citizens Acts contradicts with the Civil Service Acts. The Civil Service Acts has obstructed the elderly people to be participated in the service. Age 58 is the retirement age for the Government civil servants while those working in the health sector retire at age 60 and furthermore in judiciary and university services, the retirement age is fixed at 63 years (MoHP, 2009).

Considering the increasing life expectancy, the retirement age bar as well as the definition of elderly according to the chronological age has to be reconsidered. The policy and program has to be promoted to utilize the resourceful elderly people in the development.

Chapter Three

3. Health: Literature Review

3.1. Introduction

The Ministry of Health and Population (MoPH) is the central body responsible for health planning, implementation and evaluation. The Ministry is also responsible for providing health services at district levels and below. Local village committees handle delivery of health services at the district levels and below through local health facilities, which are District Hospitals, Primary Health Care Centers, Health Posts and Sub-Health Posts.

The Nepal Government's National Health Policy (1991), Second Long –term Plan (1997-2017), and the current Three Year Interim Plan (2007- 2010) all give highest priority to extending the health care system to the poor, rural, marginalized and most vulnerable in the population. Special attention is to be focused on maternal child health, infectious diseases and out-patient care. In approaching these problems, the Health Sector Reform Strategy 2004 also emphasized the concept of “decentralization” and “public- private partnerships”.

3.2. Policies, Strategy Plans and Programs

3.2.1. Interim Constitution of Nepal 2007

Nepal's Interim Constitution, 2063 has defined that “every citizen will have the right to have free basic health care service as provisioned by the State” and thus has established health as a fundamental right of every citizen. To fulfill this mandate, the MoHP has launched various programs, making every effort to bring quality care within reach of every citizen. Considering the provision in the Interim Constitution 2006 on December 15, 2006 (BS 2063 Mangsire-29), through a cabinet decision, the GoN decided to provide essential health care services (emergency and inpatient services) free of cost to ultra poor, vulnerable, poor, senior citizens, people living with physical and psychological disabilities, and women volunteers known as Female Community Health Volunteers (FCHVs) at the level of sub-health posts, primary health care centers and district hospitals.

3.2.2. Three Year Interim Plan 2007/08 – 2009/10 (2064/64- 2066/67):

Three-Year Interim Plan accepted the universal principle of health as a fundamental human right and focuses its attention on the need of ensuring access to quality health services to all citizens, irrespective of the geographic regions, class, gender, religion, political ideals and socio-economic status they belong to.

The main objective is to ensure citizens' fundamental right to have improved health services through access to quality health services without any discrimination by region, class, gender, ethnicity, religion, political belief and social and economic status keeping in view the broader context of social inclusion. The constituent elements of such an objective are:

- To provide quality health service
- To ensure easy access to health services to all citizens (geographic, cultural, economic and gender)
- To ensure enabling environment for utilizing available health services

3.2.3. National Health Policy, 1991

The National Health Policy (NHP) was formulated in the country in 1991 with the objective to enhancing the health status of the population. This is the comprehensive health policy of Nepal that aims to extend the primary health care system to the rural population so that they benefit from modern medical facilities and trained health care providers (MoHP, 2006). The policy prioritizes the programs that directly help reduce child and child mortality rate. It also aims to encourage the participation of local communities and local bodies, NGOs and private sector in providing health services and for managing health institutions. The NHP assumes to operationalize research and studies to assess the effectiveness in the area of service delivery. The NHP is a comprehensive policy that encompasses service delivery within the administrative structure of the health system. The subsequent health plans that were developed were based on the NHP. However, the NHP does not specify any health programs to ageing population.

3.2.5. Second Long-term Health Plan 1997 -2017 (BS 2054- 2074)

In order to fulfill the objective of extending health services to the local level, integrated health service had to be adopted and implemented in 1975 AD. With the expanse of time the Plan did not cover the health problems of its population. In this context the Government of Nepal developed a twenty year The Second Long-term Health Plan 1997-2017 (SLTHP) to guide health sector development in the improvement of the health of the population. Its main objective is to improve the health status of the population of the most vulnerable groups, particularly, those whose health needs are not often met- women and children, the rural population, the poor, the underprivileged, and the marginalized populations. It also envisages the structural reforms to deliver quality health services in both rural and urban areas in an effective and efficient way. The role of NGOs, Private sectors and other development partners is accepted and encouraged to deliver consistent health services.

SLTHP has defined women, children and village populations as vulnerable groups and has mainly tried to reduce inequalities in equitable access to gender sensitive and quality health services. The plan has controversy between its priority area and its projection. On the one hand it aims to increase life expectancy to 68.7 year but it does not accept the fact that the elderly populations are vulnerable to health problem.

3.2.5. Health Sector Strategy, 2003

In December 2003, The GoN approved its Health Sector Strategy which focuses on attaining the MDGs of reducing child mortality; improving maternal health; and combating HIV/AIDS, malaria and other diseases by 2015. In order to implement the strategy, the Government prepared the Nepal Health Sector Program-Implementation Plan (NHSP-IP).

Nepal Health Sector Program has been implemented to address the strategies with specific emphasis on:

- Providing safety nets to the poor, under-privileged and socially excluded
- Developing alternative health financing scheme
- Providing quality health care services

But the strategy does not specifically cover the issues of elderly.

3.2.7. Nepal's Health Sector Program - Implementation Plan 2004-2009(NHSP-IP)

The Nepal Health Sector Program -Implementation Plan 2004-2009 (NHSP-IP) provides operational guidance for implementing the outputs of the Health Sector Reform Strategy. Its main emphasis is on ensuring the access of poor and vulnerable to essential health services. It also addresses the achievement of the health sector Millennium Development Goals (MDGs), with improved health outcomes for the poor and those living in remote areas and a consequent reduction in poverty. However, the plan neither defined who are vulnerable (destitute) nor link gender, caste and age with the word vulnerable.

3.2.7. Jyeshtha Nagarik Swasthya Upachar Nirdeshika (Senior Citizens Treatment Guidelines) 2061

The Ministry of Women, Children and Social Welfare has operationalized a guideline called Senior Citizen Treatment Service targeting to assist the health services to the older people. The guideline envisages offering the poor and sick elders basic health care service free of cost. According to the guideline, poverty affected elderly people are provided free medicine and treatment up to NRs.2000 at a time in all 75 districts. However these schemes have minimal coverage and government has no resources to provide support and care for elderly people who are in dire needs of assistance from the public sector. This is the first health program in Nepal that attempts to address the health issues of elderly though its effectiveness has yet to be assessed.

3.2.9. Free Health Service Program

With the objective to promote essential health care services to all citizens -especially ultra poor, poor, vulnerable, disabled, and senior citizens- and increase their access to health service, the GoN announced the free Health Care Service Program for target groups in fiscal year 2006/07 in hospitals and primary health centers for inpatients and emergency services and was made free for all citizens in all health posts and sub-health posts from fiscal year 2007/08(BS 2064/65 Marg 1). It was expanded in 2008 (BS 2065 Mansir 1) to include primary health services. In 2008 (BS 2065 Marg 1) hospitals with at least 25 beds provided listed medicines free to all citizens, while essential drugs and all services were made free for target groups (the ultra poor, vulnerable, poor, disabled, senior citizens, and female community health volunteers). In 2008 (BS 2065 Marg 1) institutional delivery was made free for all women.

3.3. International Provisions for Health

The aging population is currently one of the main issues facing international health care systems. The developed or industrialized countries have already developed long-term care for people with chronic illnesses. They are economically and technically in safe position to impart the health facilities to the citizens irrespective to the age. They have developed health insurance fund to assist for long-term care or training health professionals. Care for chronically ill and geriatric patients has become the key issue for the policy development of the developed countries.

However, the focus for most developing countries is on maternal and child health; health care for elderly people is neglected. Both facilities and trained personnel are lacking. Health workers that are the first point of contact for elderly people are inadequately trained and equipped to care for them. Few secondary and tertiary care institutions have separate services for elderly people. General outpatient departments and departments of general medicine provide care but there are long waiting times, the care is often inadequate, and minimal attention is paid to personal care and counseling. Separate inpatient facilities are rarely designated for elderly patients. Gerontology is not a popular specialty.

In many countries health and social services are delivered by different organizations. However, there are significant inequalities between the health care services of the developed and least developed countries. Many countries have provisions of free health care services for poorest sections of the society particularly socially excluded and vulnerable groups as well as elders.

3.3.1. Asia

China

The Chinese government has established a basic medical insurance system which combines the unified planning program with individual accounts for urban employees. Under this system, retirees do not have to pay the basic insurance premiums, and they are given appropriate consideration in the ratio of medical costs paid between what is put into their individual accounts by their former employers and the part they have to pay personally. (Country Report: Peoples Republic of China, 2007).

The Chinese government has taken supplementary medical care measures to reduce the burden of medical costs for the elderly, and has set up a medical subsidy program for civil servants, and such expenditure, including the part for retirees, is covered by the state revenue. The government encourages the establishment of a subsidy system to cover hefty medical costs throughout the country. (ibid).

A rural medical aid system has been established, with funds from government appropriations and public donations to help the elderly covered by the "five guarantees" system and poor farmers to join the new type of rural cooperative medical system. The medical aid system provides certain subsidies to poor farmers whose high medical costs

for serious diseases have affected their basic family life, and has to a certain degree alleviated the basic medical burdens on the aged. (ibid).

The Chinese government encourages large- and medium-sized medical institutions, where conditions permit, to open special departments or outpatient departments for senile diseases to provide specialized services to seniors. Urban community health service system has been speeded up nationwide, with emphasis on medical and health work for the aged, so as to provide safe, efficient, convenient and economical health services to the elderly. (ibid).

In consideration of health and physical characteristics of the aged, the Chinese government has made positive efforts in organizing hygiene and health care publicity work. Radio, TV, newspapers and community bulletin boards are all used to publicize common knowledge of how to keep fit and healthy in old age. Hospitals at various levels provide regular health lectures throughout the year to local communities, providing health advice to those suffering from chronic diseases. (ibid)

India

In India, the elderly are taken care of at primary, secondary, and tertiary levels of health care, which is provided by the government, including geriatric clinics, and wards. There are separate queues for the elderly in clinics and hospitals, for billing and at pharmacy counters. There is a National Policy on older persons. Moreover, the government has provided services under each level of health care that will be strengthened to meet the requirements of the elderly. Health insurance policies at subsidized rates are also provided for poor older people.

Interestingly, rural mobile health services are provided by medical colleges. Furthermore, NGOs like HelpAge India are running mobile medical services for the aged in remote areas and providing eye check-ups and cataract surgeries. Voluntary organizations like the Lions Club are organizing free eye camps and cataract surgery. Besides the government and NGOs, there are 10 geriatric clinics and one geriatric hospital in the private sector in various parts of the country.

Sri- Lanka

In Sri Lanka, as in many other developing countries, the main priority for health Programs has been maternal and child health. It is only recently that the growing elderly population has been recognized as a health issue, calling for an appropriate program which takes into account the health care, psychological and social needs of this age group. (Mendis, 2007)

In 1998 the Ministry of Health appointed a Director (Youth Elderly, Disabled & Displaced) for planning, implementing monitoring, and coordinating delivery of health care services to the elders. In the year 2000, a pilot project in active ageing was started in fifty Medical Officer of Health (MOH) areas and was community driven to ensure sustainability. The strategies adopted include:

- improving the care-giving capacity of the family through trained health volunteers;
- strengthening the inter-sectoral collaboration within each MOH area,
- encouraging and improving community participation,
- conducting research and disseminating results,
- providing appropriate education and training,
- creating awareness on active aging among all members of the community using identified advocacy target groups such as public sector officials, school children, school teachers, formal and informal leaders in the community, elders and their family

One of the eight Goals of the National Population and Reproductive Health Policy formulated by the Government in 1998 was on elderly care. The policy presented the following strategies for the care of the elderly:

- Encourage the private sector, NGOs, CBOs and the local community to provide community care and services to the elderly,
- Initiate social security schemes for the elderly not already covered by EPF, ETF, etc.
- Provide incentives to families to care for the elderly at home
- Provide appropriate training for out of school youth awaiting employment to enable them to take care of the elderly at home
- Provide special care units for the elderly in the State Health Care System
- Establish a cadre of Community Health Nurses with responsibility for the care of the elderly. (Mendis, 2007)

3.3.2. Europe

Sweden

The Swedish Riksdag adopted in April 2003 a national health policy stipulating eleven general objectives that cover the most important determinants of Swedish public health. In addition, improving the health of those groups that are most vulnerable to ill-health is particularly important.

Health and medical care in the Swedish health care system is shared responsibility of the state, county councils and municipalities. The County Councils operate the hospitals and out-patient centres while municipalities are responsible for health care in special housing. Sweden's entire population has equal access to health care services.

The Swedish health care system is government-funded and heavily decentralized. More focus on the old person's social situation, improved research, technological development, better special housing, high quality dementia care, adequate medication, rehabilitation, nutrition and more doctors in elderly care are priority areas. (Report by the Government of Sweden)

Philippines

The Department of Health formulated the Health Care Program for Older Persons (HCPOP) in 1998 to set the policies, standards and guidelines for local governments to implement the program in collaboration with other government agencies, non-government organizations and the private sector.

The program intends to promote and improve the quality of life of older persons through the establishment and provision of basic health services for older persons, formulation of policies and guidelines pertaining to older persons, provision of information and health education to the public, provision of basic and essential training of manpower dedicated to older persons and, the conduct of basic and applied researches.

The Department of Health designed national goal (2005-2010) for older persons to promote a healthy and productive lifestyle and better quality. This aims to reduce morbidity rate from all causes by 50 percent and increase mean life expectancy to 72 years of age (70 years for males and 75 years for females). The main thrust of the strategy is to build the capacity of health human resources towards the promotion, prevention, cure and supportive care for older persons. (Galon, Margarita M., Villar Florita R., Ms. Agcaoili, Suzette M., and Ronquillo, Kenneth G., 2007)

3.3.3. Australia

Australia has a universal public medical insurance scheme, known as Medicare. It subsidizes access to ambulatory care in the private sector and to pharmaceuticals and finances Medicare-designated (i.e. public) hospitals; they are open to all citizens. In all, government finances about 69 per cent of total health-care expenditures. These outlays are financed from general taxation, supplemented by the Medicare levy (1.5 per cent of taxable income). Around 60 per cent of public expenditure is used to subsidize access to private providers in the areas of: community-based medical care; hospital-based medical care; pharmaceutical products; allied health care by optometrists and dentists; domiciliary care; and long-term care for the elderly. The remaining 40 per cent of public expenditure mainly finances Medicare-designated (i.e. public) hospitals. Private outlays are essentially for out-of-pocket costs (i.e. not reimbursed) and private insurance. Pensioners, including part-pensioners, may be eligible for a Pensioner Concession Card, which entitles the holder and dependants to concessional pharmaceuticals and other concessions which vary in each State and Territory. The Commonwealth Seniors Health Card (CHSC) provides equivalent pharmaceutical concessions to non-pensioners whose income is below the pension income test cut off (around A\$ 22 000), but who are not eligible for the pension due to assets. (Carey, David, 1999)

3.3.4. America

Argentina

In an effort to create programs that will advance the goals of the Madrid Plan, Argentina has adopted a number of key initiatives to strengthen health and long-term care for older persons and ensure their right to an active life. The Ministry of Social Development has designed four educational programs that will enhance the effectiveness of health professionals, social workers and community leaders, and of caregivers and other

individuals whose careers, occupations, family situations or vocational interests involve interaction with older persons. These initiatives include a two-year postgraduate program in gerontology, a program for the prevention of abuse and harassment, a program focusing on social volunteerism, and a national program aimed at improving residential care for older persons. In 2006, the Consejo Federal de los Mayores was established to mainstream the collaboration of older persons, their representatives, and local governments in the definition, implementation and assessment of public policy affecting the well-being of this population group. Access to health care for older persons is provided through the social security system. Price discounts on medications are far-reaching and freely available to people without resources or with prevalent chronic diseases. A number of programs were instituted in 2002 to meet the basic needs of older persons, including Remediare, which supplies free generic medications. (Alicia Kirchner, 2007)

3.4. Research

3.4.1 Nepal Demographic and Health Survey (NDHS), 2006

The Nepal Demographic and Health Survey, 2006 is the third comprehensive survey conducted in Nepal as part of the worldwide Demographic and Health Surveys (DHS) project. The primary purpose of the NDHS is to furnish policymakers and planners with detailed information on fertility, family planning, infants, child, adult and maternal mortality, maternal and child health, nutrition and knowledge of HIV/AIDS and other sexually transmitted infections. In addition, the survey is the first DHS survey in Nepal to provide population - based prevalence estimates for anemia among women age 15-49 and children age 6-59 months. However, the NDHS could not include the health and nutrition status of elderly citizens. (MoHP, 2007)

3.4.2 India

There are some excellent studies of the various dimensions of the elderly phenomenon in India for an excellent review of the elderly situation, Irudayarajan (2001) for a review of the effectiveness of social assistance for poor elderly, Reddy (1996) for a review of the social security for elderly in India and Kumar (1999) for the health situation of elderly women), there have been fewer multivariate analyses of the determinants of health status. The most recent one (Gupta *et al.*; 2001) used the Human Development Indicator Survey of 1994-95 to analyze the health-seeking behaviour of the elderly, and concluded that income and education played 2 key roles in determining who sought care.

Following these studies, Indrani Gupta and Deepa Sankar assess the key determinants of health status of the elderly by using data from the 52nd round of the National Sample Survey (NSS) OF India. (Gupta, I. and Sankar, D., 2001)

3.4.3 Bangladesh

A study was carried out to assess the impact of old age allowance on health- related quality of life among elderly persons in Bangladesh. This study examines the impact of small-scale old age allowance (per capita US\$3 per month in cash) on health-related quality of life (HRQoL) of elderly persons initiated by the government of Bangladesh in

1998. A cross-sectional study was conducted in 10 of the 64 districts of Bangladesh including 4,498 elderly persons (≥ 60 years) where Bangladesh Rural Advancement Committee (BRAC) has been maintaining a demographic surveillance. HRQoL was assessed using a multi-dimensional generic instrument.

Multivariate analyses revealed that receiving old age allowance was significantly associated with attaining higher scores in the social and economic dimensions and lower scores in the physical dimension of HRQoL compared to the eligible non-beneficiaries (adjusted for sex, age, education and marital status). A significant impact of old age allowance on some specific dimensions of HRQoL albeit small, justifies its continuation and expansion to bring more individuals in its net.

3.5. Discussion

With the population ageing, care for chronically ill and geriatric patients has become the key issue for the policy development of the countries. Efforts are made to provide health care services to the needs of the elderly people so that they could lead healthy and productive lives.

Most of the countries have provisions of free health care services for the poorest sections of the society particularly socially excluded and vulnerable groups as well as elders. However, the focus for most developing countries is on maternal and child health; health care for elderly people is neglected. Both facilities and trained personnel are lacking. Separate inpatient facilities are rarely designated for elderly patients. Gerontology is not a popular specialty.

In Nepal, as in many other developing countries, the main priority for health programs has been maternal and child health. It is only recently that the growing elderly population has been recognized as a health issue, calling for an appropriate program which takes into account the health care, psychological and social needs of this age group. The Government has adopted Jyeshtha Nagarik Swasthya Upachar Nirdeshika (Senior Citizens Treatment Guidelines) 2061 to deliver health care services to the elderly people. It is stated in the Senior Citizens Acts that "each organization providing health services shall provide health services by giving priority to the senior citizens". There is also the provision to provide separate geriatric wards in the public hospitals. The lack of specific planning and monitoring system as well as other limitations, the public hospitals are not able to meet the provisions made by the government.

Geriatric and care approaches for older persons in Nepal are not well developed. Clinical staffs often lack specific knowledge of age-related health issues and the expertise necessary for optimal service provision. In this context, the government in collaboration with the concerned agencies has to initiate various measures to promote health and well-being of older persons. These include education on health risks from unhealthy behaviors and education for older persons and the public on specific nutritional problems and needs of older persons.

Chapter Four

4. Nutrition: Literature Review

4.1 Introduction

Nutrition is an input to and foundation for health and development. Interaction of infection and malnutrition is well-documented. Better nutrition means stronger immune systems, less illness and better health. Healthy children learn better. Healthy people are stronger, are more productive and more able to create opportunities to gradually break the cycles of both poverty and hunger in a sustainable way. Better nutrition is a prime entry point to ending poverty and a milestone to achieving better quality of life (WHO, 2008). Poor nutritional status is a primary concern for the elderly. They are more susceptible to nutritional disorders because of age-related changes and the increased prevalence of disease. Ageing is associated with a decline in energy expenditure, which is often accompanied by a reduction in food intake. Also, aged people are likely to be taking multiple medications and are susceptible to particular psychological and social problems, all of which can influence nutrition.

Nutrient deficiencies appear to increase with age. Unintentional weight loss and malnutrition are common problems in the elderly. Taste and smell changes, as well as feelings of loneliness and depression, contribute to decreased appetite, while many elderly people may eat less because of chewing difficulties, fatigue, and social reasons. If bones decrease in density, then osteoporosis (bone loss) develops over time. Bone degeneration is due not only to calcium deficiency but also partly to genetics. These changes can contribute to decreased food intake, unintentional weight loss and malnutrition.

The International Conference on Nutrition (ICN), convened jointly by FAO and WHO in 1992, was the first global intergovernmental conference on nutrition and served as a motivating force for countries around the world to develop and implement food and nutrition policies and plans of action.

As a signatory to the ICN, Nepal has initiated the nutritional programs and strategies though targeting on children and pregnant women. Initiatives have been underway for more than three decades with national nutritional strategies developed in 1978 (National Nutrition Strategy), 1986 (National Nutrition Strategy for Nepal), and 1998 (Nepal National Plan of Action). Several programs with an explicit nutrition component have been launched in Nepal under the initiative of the Nutrition Section of the Ministry of Health and Population. It was in 2004-05 that a National Nutrition Policy and Strategy was compiled and approved, which provided a comprehensive documentation on nutrition policy and strategy (Ministry of Health and Population, 2006).

4.2 National Nutritional Plan and Policies

4.2.1 Three Year Interim Plan (2007-2010)

The current Interim Plan talks about nutrition programs especially targeting the malnutrition of the unborn, infants and expecting mothers. It has also envisioned to establishing a national nutrition center for the coordination, planning, program development, supervision and evaluation of nutrition information and program.

4.2.2 National Nutrition Policy and Strategy

National Nutrition Policy and Strategy (revised edition) includes the current nutritional situation, guiding principles, overall nutrition policy and strategy, goal and targets set by Second Long Term Health Plan and Millennium Development Goals.

This revised National Nutrition Policy and Strategy introduces the causes and the consequences of various types of malnutrition commonly seen in Nepal; the current nutritional situation in Nepal; and the current government actions on in the nutrition sector. It also introduces the overall goal, objectives and targets of each strategic approach. Specific objectives are induced as prerequisite condition to solve the cause of each nutritional problem. Strategies are set to accomplish each specific objective, and activities are set as components for supporting corresponding strategies. Responsible bodies for the implementation of these activities are also listed.

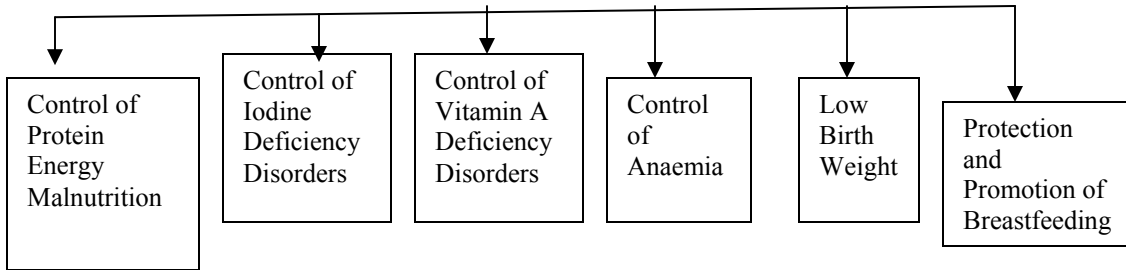
The policy and strategy prioritizes infants, young children, pregnant and nursing women, disabled and the elderly within poor households are the most nutritionally vulnerable groups. It is stated that priority must be given to them for the protection and promotion of their nutritional well-being. Though not specific to any age groups, the policy aims to improve household food security to ensure that all people can have adequate access, availability and utilization of food needed fore the healthy life. (MoHP, 2008)

4.2.3 National Nutrition Program

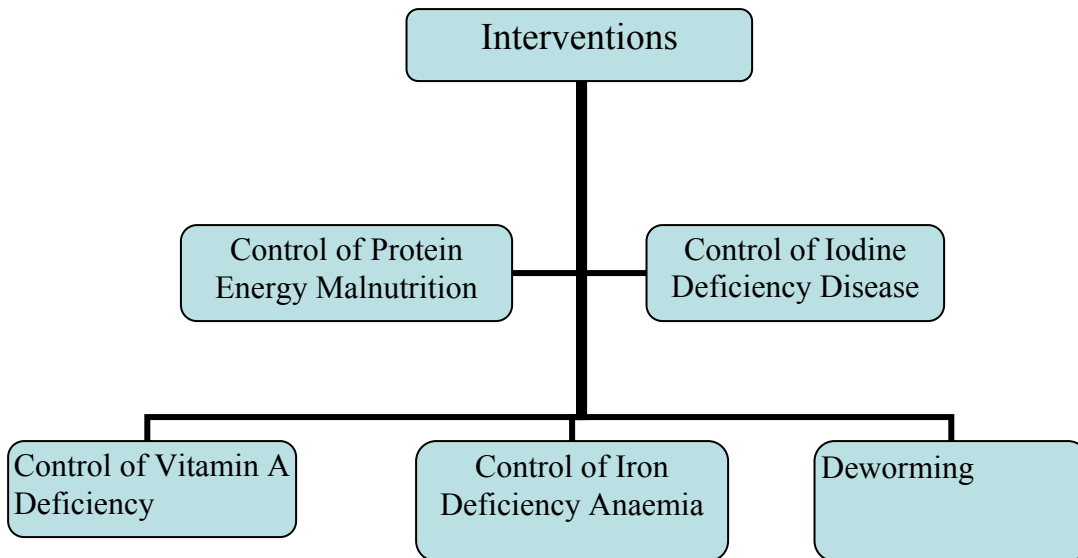
The National Nutrition Program under Department of Health Services has laid the vision as “all Nepali people living with adequate nutrition, food safety and food security for adequate physical, mental and social growth and development and survival.” The mission of Nutrition Program is to improve the overall nutritional status of children, pregnant women, women of child bearing age and all ages through the control of general malnutrition and the prevention and control of micronutrient deficiency disorders.

In order to improve the overall nutritional status of children and pregnant women, the national nutrition program has set the objectives like Control of Protein Energy Malnutrition, Control of Iodine Deficiency Disorders, Control of Vitamin a Deficiency Disorders, Control of Anaemia, Low Birth Weight, Protection and Promotion of Breastfeeding and deworming program. (DoHS, 2007/08)

Objectives of Nutrition Program, Nepal



Nutrition Interventions Areas



4.3 International Nutritional Provisions

The Global Plan of Action for Nutrition was designed to provide guidelines for governments, acting in partnership with non-governmental organizations (NGOs), the private sector, local communities, families and households and the international communities, including international organizations, multilateral financing institutions and bilateral agencies, to achieve the objectives of the World Declaration on Nutrition adopted by the International Conference on Nutrition (ICN). It contains recommendations on policies, programs and activities that resulted from an intensive ICN consultative process involving country-level preparations of national plans and regional consultations that included country representatives.

This Plan of Action builds upon preceding work and represents a major step in preparing and implementing national nutrition improvement plans in coming years. Similarly the

Plan of Action specifically categorizes infants, young children, pregnant and nursing women, disabled people and the elderly within poor households as the most nutritionally vulnerable groups. Priority must be given to protecting and promoting their nutritional well-being. Towards this end, their access to adequate care within the household and to health, education and other basic social services, such as family planning, maternal and child health (MCH) clinics and social security schemes, should be ensured. Special attention must be given to the nutritional, health and educational needs of female children and adolescents, which have often been overlooked in the past. Other groups that may be at risk include some indigenous populations, refugees and displaced persons, and these groups may require particular care and services to ensure their nutritional well-being.

The Nutrition Action Plan by the department of Health on England intends to talk about malnutrition in older people in hospitals and care homes in the region. The action plan offers guidance for health and social care staff and managers on how to provide good nutrition and effective nutritional care to older people. It outlines five priorities for health and social care services, assignation of relevant training for frontline staff and managers on the importance of nutrition, fortification of inspection and regulation in the area.

Although older adults in North America do not suffer from overt nutrient deficiencies, surveys reveal a prevalence of marginal nutrient intakes, an increased risk of malnutrition and sub-clinical deficiencies that may affect function and quality of life. Lower energy requirements with aging, associated with loss of lean body mass and less physical activity, contribute to these nutrition problems. Thus, from the nutrition perspective, older adults represent a group at potential risk. (Ministry of Health Service: British Columbia, 2004)

The Dietary Guidelines for Chinese Residents are founded on principles of nutritional science and the present national situation of China. The guidelines were prepared by a commission composed of experts from the Chinese Nutrition Society and the Chinese Academy of Preventive Medicine.

For the specific requirements of people who have different nutritional needs, the commission proposed "the Recommendations for Particular Groups of People" as a supplement to the guidelines. These groups are: Infants, toddlers and preschool children, school-age children, adolescents, pregnant women, lactating mothers and the aged. In this way, China puts the elderly people nutritionally vulnerable and realizes special attention to keep them nutritionally intact.

4.3.1 Asia

India

In India, the National Policy on Older Persons announced in January 1999 provides a framework for welfare of the elderly persons including improved financial security and increased access to health and nutrition services. The policy also recommends research to expand the knowledge base on nutritional needs of the elderly.

4.3.2 America

The Elderly Nutrition Program (ENP), administered by the U.S. Department of Health and Human Services Administration on Aging, provides funding for two senior nutrition programs: congregate meals and home-delivered meals. Both of these services are offered to seniors at no cost. The meals must provide recipients with at least one third of their daily recommended dietary allowances, and are cooked to take into account special senior nutrition considerations (such as low-fat, low-sodium diets). In addition to providing meals, ENP volunteers provide nutrition screening, nutrition education, and meal-planning counseling.

The Older Americans Act (OAA), which authorizes and funds the Administration on Aging and all of its programs, also authorizes and funds the ENP. Title III of the Act provides grants to state and community programs on aging; Title VI provides grants to Native American organizations. These grants are used to fund local congregate and home-delivered meals programs. (Elderly Nutrition Program Fact Sheet)

4.3.3 Africa

Few countries in Africa offer social and welfare assistance programs for older adults. In terms of formal economic support, only three countries—South Africa, Namibia and Mauritius— provide an old-age pension system that is noncontributory and means tested. Furthermore, the elderly are not currently viewed as a priority group for nutrition services. Nutrition interventions in African countries, when available, are directed primarily toward infants, young children, and pregnant and lactating women.

Mauritius

The Ministry of Social Security and National Solidarity is responsible for the distribution of pensions to people over 60 years. This Ministry, in consultation with the Nutrition Unit of the Ministry of Health and Quality of Life, also provides advice on budgeting. The two ministries concerned work jointly so as to have a stronger focus on healthy nutrition and physical activity among the elderly. Mauritius has strived to reduced the numbers of food deficiencies of the pensioners by providing adequate food both quantity and quality through its national program. (Mauritius: National Plan for Nutrition, 2009)

The national Plan of Action for Nutrition aims to establish dietary recommendations for adults for the prevention of chronic diet-related diseases based on the World Health Organization's population nutrient intake goals.

4.4 Research

4.4.1 Nepal Micronutrient Status Survey (NMSS) 1998

In order to review the overall nutrition and micronutrient status of the population, a comprehensive Nepal Micronutrient Status Survey was conducted in 1998. The overall objective of the Survey is to assess the distribution and severity of micronutrient malnutrition and to measure the progress achieved by different interventions. Anaemia is a major nutrition problem among the women and children of Nepal. The survey mostly covers under-nutrition in mother and child as the main nutrition problems and puts aside the nutritional status of elderly. (MoPH, 1999)

4.4.2 Nepal Demographic and Health Survey, 2006

The poor nutritional status of children and women has been considered a serious problem in Nepal for many years. The Nepal Demographic and Health Survey, 2006 assess the nutritional status of children and women in Nepal. The specific issues discussed are infant and young child feeding practices, including breastfeeding and feeding with solid/semi-solid foods; diversity of foods fed and frequency of feeding; micronutrient intake among children and women; and prevalence of anemia. The survey also covers anthropometric assessment of the nutritional status of children under five years of age and the nutritional status of women 15 to 49 years of age. (MoHP, 2007)

According to the NDHS, the most common forms of malnutrition in the country are protein energy malnutrition (PEM), iodine deficiency disorders (IDD), vitamin A deficiency (VAD), and iron deficiency anemia (IDA).

4.4.3 Jajarkot Nutrition Survey 2008

In December 2008, Sustainable Development Initiative Network (SUDIN) -Nepal conducted on request of Concern Worldwide a nutrition survey in Jajarkot district, mid western development region of Nepal. The survey was designed to evaluate the nutritional status of children aged 6 to 59 months in the context of Jajarkot district. This Jajarkot Nutrition Survey 2008 provides data on the nutritional status of children, relevant household information, health seeking behavior, breastfeeding practices, food availability and food consumption patterns in the targeted population. This study also provides casual factors and their correlation with the nutritional status of children under five years of age.

4.4.4 Cross -Cultural Research

Realizing the need to focus on the growing population of the elderly, and cognizant of the important role that nutrition plays in health and functional ability, representatives from five Asian countries (China, Indonesia, Malaysia, the Philippines, and Thailand) and three Latin American countries (Brazil, Guatemala, and Mexico), together with three European countries (Germany, Italy, and the Netherlands), decided to undertake a new cross-cultural research study of nutrition and the elderly. The aim of this multi-centre, multicultural study was to describe the food habits and the health and nutritional status of the elderly as well as to generate and test hypotheses by examining the relationships between nutritional and non-nutritional variables. (V.C.Corazon, Barba and Rabuco Lucila B.)

4.4.5 India

The National Nutrition Monitoring Bureau (NNMB) is responsible for the nutrition status of the population. In 2004, the NNMB carried out a study to assess the diet and nutritional status of the elderly population in rural India. The results suggested that the consumption of a majority of foods except cereals and millets, and roots and tubers among the elderly of both sexes, and other vegetables among females, was below the recommended dietary allowances for Indians. The intakes of energy, total fat, calcium and thiamin in both sexes and protein intakes among females were comparable to the recommended levels for adults. The prevalence of chronic energy deficiency as assessed

by body mass index was higher in the males, while the prevalence of obesity was higher among females. (N. Arlappa, et al, 2003)N. Balakrishna, Sharad Kumar, G. N. V. Brahman, K. Vijayaraghavan

4.4.6 Great Britain

In Great Britain, in a joint venture between the Ministry of Agriculture, Fisheries and Food (MAFF) and the Department of Health (DH), the National Diet and Nutrition Survey (NDNS) carried out with the aims to provide a comprehensive, cross-sectional picture of the dietary habits and nutritional status of the ageing population in Great Britain, both living in the community and in institutions.

The survey was designed to meet the aims of the NDNS program in providing detailed information on the current dietary behavior and nutritional status of people aged 65 years and over (older adults) in Great Britain, both living in the community and in institutions. Additionally, this survey aims to provide data to assist with the development of quantitative dietary and nutritional guidelines for older adults.

4.4.7 Finland

With the primary aim to investigate the nutrition status and its associated factors of elderly nursing home residents and long-term care patients in Finland, a study was carried out in 2007 Finnish Nursing Homes and Hospitals. It also aims to find out how care givers and the nurses recognize malnutrition and if the nursing or nutritional care factors are associated with the nutritional status. It further assesses if the nutrition training of professionals leads to changes in their knowledge and further translate into better nutrition for the aged residents of dementia wards.

The result shows that malnutrition was common among elderly residents and patients living in nursing homes and hospitals in Finland. Although residents- and patient-related factors mainly explained malnutrition, nurses recognized malnutrition poorly and nutritional care possibilities were in minor use. Professionals' nutrition education had a positive impact on the nutrition of elderly residents. (Suominen, M. 2007)

4.4.8 Switzerland

In Switzerland the longitudinal SENECA study (Survey in Europe on Nutrition and the Elderly, a Concerted Action of the 3rd European Framework Programme) was implemented in the city of Yverdon-les-Bains. The study investigated the nutritional and health status of 70 to 75-year old elderly living at home, in relation with their food habits, life style, social network and physical activity with a follow-up study 4 years later. Results of the follow-up study, with the subjects aged 74 to 79 years, and changes observed over the 4 years are presented in the report. The participants reported a rather good self-assessed health and were quite independent in their daily activities. Food and nutrient intakes decreased over the 4-year follow-up, as did physical activity, independence in daily activities and height. However, biological markers (haemoglobin, haematocrit, albumin, lipids and vitamins) of nutritional status showed little change and remained mostly in the normal range. Low energy intake was measured in 21% of the men (< 1500 kcal/d) and in 24% of the women (< 1200 kcal). This is a source of concern

since such low energy intakes make it difficult to cover micronutrient requirements. It is therefore important to find ways to maintain or increase the quality of the diet and adequate nutrient intakes. (Decarli B., Dirren H., Schlettwein-Gsell D. 1998)

4.4.9 Taiwan

To assess the nutritional status, the relationship between nutrition and health, and factors influencing nutritional status in elderly people, the Elderly Nutrition and Health Survey in Taiwan (1999- 2000) is a milestone in the history of nutritional surveys in Taiwan. This is the first nutritional survey of a representative sample of elderly people across the whole of Taiwan.

The survey provides the information about average calorie and nutrient intake were obtained in a representative sample of elderly persons in Taiwan. In order to develop an understanding of factors influencing the nutritional status of elderly persons, detailed information about knowledge, attitudes, and practice was also collected including familiarity with the idea of a balanced diet and attitudes about not eating certain culturally forbidden foods. In addition, in order to help demonstrate the importance of nutrition in the elderly, detailed assessment was made of health status, medical history, ability to perform activities of daily living, quality of life and cognitive function. This enabled the development of a deeper understanding of the relationship between nutrition and physical and mental functioning in elderly persons. (Pan WH , etal , 1999)

4.4.10 Africa

In Africa, the lack of attention to the elderly in policies and programs is mirrored by the paucity of information from research studies on their condition. The scant information that is available suggests that the nutrition problems of the elderly are sizable.

On this context, Nutrition & Dietetics Unit, Department of Medicine, University of Cape Town undertook a situation analysis focusing on two key areas to identify priorities for future research and policy development: the nutritional status of older Africans and determinants of under-nutrition. Based on the scant evidence available, the prevalence of under-nutrition is high in older African men (9.5–36.1%) and women (13.1–27%); however, in some urban areas there is evidence that older adults are experiencing the nutrition transition. Information on micronutrient status is sparse, yet it appears that anemia related to suboptimal folate status is a particular problem. Important determinants of poor nutritional status in the elderly in the African context include inadequate household food security, war and famine, and the indirect impact of HIV infection and AIDS. (Charlton and Rose, 2001)

4.5. Discussion

Poor nutritional status is a primary concern for the elderly. Nutritionally inadequate diets can contribute to or exacerbate chronic and acute diseases and hasten the development of degenerative diseases associated with aging.

Policies and programs of the most countries target on under-nutrition in mothers and children. Most of the governments are determined to bring about improvements in the

condition of malnutrition among the children, lactating mothers, and pregnant women but the elderly population as the target group is not specifically mentioned.

The International Conference on Nutrition (ICN) held in Rome was the milestone in preparation and adoption of the Plan of Action for Nutrition. The Plan of Action recommended the areas for nutrition intervention for the countries. The areas that were identified for nutrition intervention are: starvation and famine; widespread chronic hunger; under-nutrition, especially among children, women and the aged; micronutrient deficiencies; diet related communicable and non-communicable diseases; impediments to optimal breast feeding; and unsafe drinking water.

The present nutrition program in the MoHP aims to ensure improvement in the overall nutritional status of vulnerable groups. It identifies nutritional issues of children, pregnant women and lactating mothers as major interventions area to be improved. In recent years, the Government of Nepal has taken a multi-sectoral approach to address the issue of malnutrition, involving the Ministry of Agriculture, the Ministry of Health, and the Ministry of Education. Despite these multi-sectoral approaches, none of the ministry is responsible for the implementation of nutrition program for the elderly.

Chapter Five

5.1 Summary and Recommendations

5.1.1 Social Security

The assessment of the national and international provisions of social security, healthcare and nutrition and their accessible to the elderly people was presented in previous Chapters. After the MIPAA 2002, population ageing has become the mounting concern for both developed and under developed countries. More or less, all the countries have initiated some programs and policies to extent social security coverage to the growing number of unprotected older people. All the countries have come up with national strategy, policies and plans of action to ensure three priorities areas identified by MIPAA, i.e., i) older persons and development; ii) advancing health and well-being into old age; and iii) ensuring and enabling a supportive environment for international efforts.

Access to social security is internationally acknowledged as a human right issue. Countries throughout the world have endeavored to ensure the social security to the most vulnerable sections of the society. Besides pension systems, both contributory and non-contributory pensions systems are in practice as a means of social protection in their later life for ageing population. In most nations, social protection encompasses the followings:

- a system of social security funded through contributions from employers, workers and the Government;
- public health-care and other public-led social assistance programs; and
- support schemes that target vulnerable populations and are aimed at poverty reduction.

Besides these, a significant numbers of developed and developing countries are providing non-contributory cash transfers to older people. The non-contributory cash transfers scheme is operating under two broad categories: means-tested and universal. In many developing countries, universal non-contributory pension to older people has proved to be a comprehensive program of social protection to poor.

Nepal has introduced a non-contributory social pension scheme in 1995 to ensure the social security to the older people. This scheme is unique to Asia being the primary universal pension scheme in the region and a model for other developing countries. The primary motive behind this scheme is to promote long established tradition of taking care of elderly by their family. All the Policy, Acts and Regulation for elderly have focused special attention on the promotion of the family support for the well-being of the older people.

In some developed countries, state pensions ensure old-age income security for a significant proportion of the population, while in developing countries relatively few have access to retirement pensions. In countries with low rates of occupational or retirement pension coverage, other social policy instruments are in operation to ensure the access to cash and/or in-kind assistance for older persons. Social pension programs,

which provide small cash grants to poor older persons not usually covered by contributory schemes, may represent a particularly attractive option for middle and low income countries. Such schemes are known to have improved the economic situation of older persons in Bangladesh, Bolivia, Brazil, and other countries.

Existing social pension programs that do not provide adequate income or coverage may need to be expanded for wider coverage. Such schemes can be financed in different ways, including through general taxation, special levies on specific activities or sectors, or the imposition of an earnings-based “solidarity” tax or contribution by those participating in employment pension programs.

5.1.2 Health

Most national constitutions acknowledge that all the citizens irrespective to age groups have the right of equal access to health services. However, the reality is that budget limitations and the scarcity of public resources limit all the countries to establish health-care priorities. A major goal in policy development is to ensure that vulnerable or disempowered groups such as older persons are treated fairly and without discrimination in any resource prioritization framework.

Primary health-care schemes in most developed countries are paying increasing attention to older persons and their needs. In the majority of developing countries, however, it is widely recognized that preventive and primary healthcare are the best strategies for dealing with the health challenges of ageing. The WHO has formally acknowledged the critical role primary health-care centers play in the health of older persons worldwide and has emphasized the need for these facilities to be accessible and adapted to the needs of older populations. A key objective for each country is to identify affordable primary health-care interventions for conditions that occur frequently within the older population.

MIPAA calls for older persons to enjoy full entitlement and access to preventive and curative care, including rehabilitation and sexual health care. Additionally, health-care services must recognize that health promotion and disease prevention throughout life need to focus on maintaining independence, prevention and delay of disease and disability treatment, as well as on improving the quality of life of older persons who already have disabilities.

Nepal has developed various policies and programs to expand the health care services to its population. It is stated in the Constitution to provide essential health care services free of cost to ultra poor, vulnerable, poor, senior citizens, people living with physical and psychological disabilities, and women. However, none of the programs are designed targeting on the health needs of the older population in Nepal. The focus of the national health policy is on maternal-child health, infectious diseases and outpatients; health care for the elderly people is neglected. The SLTHP is the milestone in the health sector program. The SLTHP gives highest priority to extending the health care system to the poor, rural, marginalized and most vulnerable in the population. The SLTHP has defined women, children and village populations as vulnerable groups and has mainly tried to reduce inequalities in equitable access to gender sensitive and quality health services.

Few countries give priority to moving towards universal coverage of a minimum package of health-care services, especially one that targets older persons. Several countries managed to enhance accessibility of older persons through locally-based health-care providers, as well as basic health education in rural areas intended to prevent the spread of infectious diseases. Education on health risks in contrast with unhealthy behavior has been promoted. Fewer countries provide training for the public health-care givers and social workers in basic gerontology and geriatrics, and support the development of palliative care.

Several countries have initiated various measures to promote health and well-being of older persons. These include education on health risks from unhealthy behaviors and education for older persons and the public on specific nutritional problems and needs of older persons. Viet Nam has strengthened its nutritional, physical exercise and health-care education programs for older persons. Asian countries like China; Hong Kong; the Democratic People's Republic of Korea; Japan; Singapore; and the Republic of Korea encourage older persons to become more active through regular exercise routines and healthy life-styles, especially for persons with chronic diseases. Environmental health education and nutritional projects have also been taken up as a matter of urgency by international agencies.

Low and middle income countries like Brunei; Malaysia; Mongolia; Sri Lanka; and Thailand and high income economic such as Australia; Japan; New Zealand; Republic of Korea, Singapore; and Hong Kong, China are close to achieving universal health care coverage. They are trying to provide the most effective ways of ensuring access of the older population to comprehensive health care services.

On one hand, Singapore has a multi-layered health-care financing system and has adjusted allocations from the Central Provident Fund, together with varying levels of cost-sharing and subsidies in a public-private mix of health services. China, on the other hand, has a co-payment system involving central government, provincial and employer contributions with the workers contributing to an insurance scheme but also sharing the cost of treatment each time.

Countries including Australia, Hong Kong, Macao, China, New Zealand and Singapore provided broad-based support to family care-givers, which typically consisted of counseling and coping, training on caring skills and respite services. Some countries, notably Singapore, have encouraged the traditional values system of caring for the older persons by way of policy initiatives, for example, making priority allocation of housing or allowing tax incentives to those children who take responsibilities of the care and maintenance of parents.

In many developing countries, geriatrics and care approaches for older persons are not well developed. Clinical staffs often lack specific knowledge of age-related health issues and the expertise necessary for optimal service provision. A number of universities and training institutions have introduced geriatrics and gerontology into their medical and

academic programs, but much remains to be done to build the essential foundations for effective elder care.

5.1.3 Nutrition

Poor nutritional status is a primary concern for the elderly. Nutritionally inadequate diets can contribute to or exacerbate chronic and acute diseases and hasten the development of degenerative diseases associated with aging. In the past, it has been difficult to determine the scope of nutritional problems among the aged; however, methods of assessing dietary intake have improved. Providing information on the relationship of socioeconomic and other factors to nutrient intake is basic to improving the health and well-being of the elderly.

Policies and programs of the most countries target on under-nutrition in mothers and children. Most of the governments are determined to bring about improvements in the condition of malnutrition among the children, lactating mothers, and pregnant women but the elderly population as the target group is not specifically mentioned.

The International Conference on Nutrition (ICN) held in Rome was the milestone in preparation and adoption of the Plan of Action for Nutrition. The Plan of Action recommended the areas for nutrition intervention for the countries. The areas that were identified for nutrition intervention are: starvation and famine; widespread chronic hunger; under-nutrition, especially among children, women and the aged; micronutrient deficiencies; diet related communicable and non-communicable diseases; impediments to optimal breast feeding; and unsafe drinking water.

More specifically with regard to women, children and the elderly, the Declaration and the Plan of Action call for basic and applied scientific research to more clearly identify factors that contribute to their particular problems of malnutrition and to identify the ways and means to eliminate them. Finally, the Declaration recognizes the importance of the family in providing adequate food, nutrition and a proper caring environment for meeting the physical, mental and emotional, and social needs of children and other vulnerable groups, including the elderly.

The present nutrition program in the MoHP aims to ensure improvement in the overall nutritional status of vulnerable groups. It identifies nutritional issues of children, pregnant women and lactating mothers as major interventions area to be improved. Major components of the program include: promotion of breastfeeding, growth monitoring of children below three years, prevention of iodine deficiency and vitamin A deficiency disorders, control of anemia, and nutrition education for mothers to help them meet the daily nutritional requirements of their children through locally-available resources. However, there is still a lack of comprehensive studies of the health and nutritional state and the quality of life of elderly people in Nepal.

According to the mandatory of the ICN multinational countries from the various continents undertaken a cross-cultural research study of nutrition and the elderly. The research concentrated upon the food habits and the health and nutritional status of the

elderly across the countries. The nutrition, diet and health survey of elderly people in developed countries have been conducted in Netherlands, the United States and fourteen European countries. Multi-center research encompassing industrialized, transitional, and deprived populations of elderly people has been conducted in the Southern Pacific region and is in progress elsewhere. However, there are still major gaps in our knowledge of the profiles of nutritional status, pattern of intake, and health status of the elderly in most of Asian countries in general and Nepal in particular.

5.2 Recommendations

Following recommendations are made based on the reviews conducted for this study.

5.2.1 Institutional Development and Human Resource

- Identify the human and other resources needs of MoPH for building the capacity for effective design and implementation of programs related to ageing population.
- Program for short and long term training and study tours for the key government officials in universities and training institutes abroad should be developed on annual basis. This would require the support from the national and international institutions in the government and non-government sectors including the donor community such as WHO, ILO, UN Agencies, WB, ADB, DFID and other INGOs working in health and social sectors in Nepal
- In-country training programs for the district and VDC level health workers on caring of elders and run such programs should be developed.
- Revise and strengthen the existing curriculum of formal health education system of the country to incorporate subjects of Gerontology and Geriatrics with higher emphasis. Work with Universities and colleges for the purpose.
- Strengthen National Health Training Center for the purpose of training health practitioners (nurses), health teachers, old age home managers and care takers. Educational programs to enhance the effectiveness of health professionals, social workers and community leaders, and of caregivers and other individuals whose careers, occupations, family situations or vocational interests involve interaction with older people should be developed.
- Work with international and bilateral agencies in general and with UN agencies in particular for institutional and procedural development to implement the current National Plan of Action on Ageing guided by the MIPAA.
- Establish a special cell in the ministry and line agencies to oversee programs on ageing population.

5.2.2 Research or Information Generation

Socio -economic

- Conduct study for identification of institutional and procedural measures required to implement the existing legal provisions made by the government for catering the needs of elders.
- Conduct baseline study with multiple indicators to assess the status of elderly
- Organize national, regional and selected districts level workshops and seminars for identification of existing opportunities and constraints as well as research gaps in addressing the needs of ageing population at different levels, i.e. VDCs, District, Region and the national level.
- Socio-economic survey of elderly population and their distribution by geo-climatic regions; districts, and VDCs by age group, economic brackets, gender, ethnicity, health status, professions, living arrangement, service needs and so on has to be carried out as a national program. MoHP should work with Central Bureau of Statistics (CBS) in design and implementation of National Census program scheduled for 2011.
- Review the current social security measures and its effectiveness (Family Support System, Old Age Allowance and Health Concessions offered by the government) in Nepal. Such suggested study should answer basic questions such as, can these systems continue to support an increased elderly population in future and what changes are necessary?
- Macro level study on changing family structures: Implications for intergenerational solidarity and elder support, should be carried out.
- A study on implication of urbanization and migration for older persons should be carried out.
- A macro-level study on roles and contributions of older persons to family, community and society should be carried out.
- Carry out a study to identify the potential income generating activities particularly suited for senior citizens in urban and rural settings.
- Design a survey to assess on the isolation of older persons in rural areas, and measures to promote their participation in social, political and economic activities.
- Review/assess the present provision for compulsory retirement to increase the retirement age, as continued employment provides a sense of worth, dignity and financial independence to older persons.
- Undertake a feasibility study to develop sustainable social security for senior citizens like "Many Helping Hands" policy in Singapore. (In Many Helping Hands policy, the community and the government are expected to lend a hand to ageing families in order to reduce the stress of taking care of older members. This policy emphasizes that the government expects to work hand-in-hand with civic bodies such as voluntary welfare organizations (VWOs), religious institutions, ethnic-based organizations and secular bodies. The support given to these organizations is in the form of funding, land leased at special rates, training of staff and guidance in program planning).

Health

- Micro-level study on household level resource allocation patterns and effects on health and well-being of older persons living in different region, and socio-economic environment.
- Assess the impact of HIV/AIDS on older persons, family and communities. Older persons as care giver for HIV/AIDS affected persons.
- Criteria for identifying vulnerability, i.e., living alone, remoteness, isolation, poverty, disability/illness, lack of knowledge etc should be developed based on primary data.
- Socio-economic, health and nutritional survey of conflict affected elderly population should be carried out with high priority.
- Promote health research activities in collaboration with universities, colleges and old-age homes both in private and public sectors.
- Develop research programs on various Geriatric Health Problems and strengthen National Health Research Center for the purpose.
- Carry out a monitoring and evaluation study to improve upon the existing system of subsidy for hospital beds to older people.
- Conduct a review study on social, economic and environmental determinants of healthy ageing.
- Carry out a feasibility study on providing health and medical services for healthy older persons and frail older people living in their own homes. Experience from Singapore could be good value for Nepal.
- Prepare feasibility study for establishment of modern and well equipped Geriatric Centers and Old Age Homes in different parts of the country.

Nutrition

- Design a survey to provide detailed information on the current cross-sectional picture of the dietary behavior and nutritional status of the elderly and to assist with the development of qualitative dietary and nutritional guidelines for older adults.
- Critical assessment of traditional methods of treatment and prevention of age-associated diseases.
- Research on older survivors of starvation and malnutrition in rural and remote areas of the country.
- Promote research on nutrition-related aspects of transmission and management of infectious diseases, taking into account all socio- economic aspects, and ensure the application of relevant findings.

5.2.7 Literature Development

- Promote activities to generate literature on issues and concerns of elderly population. Activities such as poetry competition, essay competition and so on at different levels i.e., school, community, VDC, district, and National levels.
- Collect and translate relevant document published from UN and other agencies to adopt in Nepali context.
- Promote and support literarily figures for developing literary works in Nepali language on ageing population in the context of Nepal.

5.2.8 Awareness Building

- Develop audio-visuals and print materials for awareness building on issues and concerns of ageing society.
- Use Radio, TV and Print Materials for mass awareness building on issues and concerns of ageing society.
- Provide technical and financial support to private sector for enhancing the effectiveness of awareness building programs at different levels (individual, family, community and national).
- Educate people to raise awareness of the link between nutrition and good health and that malnutrition can be treated.

5.2.9 Programs Development

- Programs that promote attitude changes towards elder people and support active ageing (support programs for life-long-learning, networking and activities of pensioner associations, possibilities for voluntary work on behalf of retirees, etc.) should be designed and implemented on a pilot basis.
- Develop hospital cum geriatric wards.
- Develop Nepal specific program similar to Finnish "Generation Contract" program. (In the Finnish case the 'generation contract' is defined as follows: the working age population is not directly financially responsible for their own parents, instead, there is a collective responsibility on behalf of the state and society with regard to elder people).
- Promote and support private entrepreneurs engaged in providing goods and delivering services to meet needs of ageing population. The support could be in the form of a) scholarship for higher education, and short and long training; b) tax-deduction or subsidies, c) grants and so on.
- Long term care within the family could be promoted by using alternatives like cash payment and pension for the care-taker as already practiced by developed countries. The sustainability of those measures also needs to be evaluated, according to other countries' experiences.
- Formal and informal programmes for providing economic security in old age, e.g., social and occupational pensions.
- Data bank or information center on ageing population should be created or strengthened within National Health Research Center. The program should ensure functional coordination and cooperation with national and international agencies working in the field of elderly population in Nepal.
- Designing health insurance schemes to provide long-term security to the older population particularly from disadvantaged and marginalized population.
- Program should be developed to ensure that older people are not placed at risk of poverty and can enjoy a decent standard of living; that can share in the economic well-being of the country and can accordingly participate actively in public, social and cultural life.
- Develop National Nutrition Department responsible for the nutritional program for elderly.

5.2.10 Policy Development

- Pursue the policy and programs to promote the role of private insurance companies in financing health services to attract the young and healthy individuals who have low probability of using services as in Mexico.
- Develop legal provisions for the inclusion of older people in clinical trials and services from which they might benefit.
- Revising the existing Old Age Allowance Scheme and Disabled and Widow's Pension Scheme to make them sensitive to older people's needs and concerns.
- Revise the current Acts and Policy on ageing with a vision of achieving an age-integrated society. (In Singapore, three-pronged approach has been adopted towards achieving social integration: developing the "heartware" (positive attitudes and values towards older people), "software" (policies, programmes and services) and "hardware" (the built environment, including transport).
- Strategy for prevention and effective intervention for various diseases of older persons in different locations and socio-economic conditions.

5.2.11 Priority recommendations that could lead to Pilot Scale/Area program implementation

- Develop Training Manual on "Caring of Elders" to provide a week long on-the-job training to district and VDC level health workers. Conduct five training, one in each of the five development regions, based on the manual for testing or validation of the content and the methodology used. Revise and improve the manual guided by the experience gained and lessons learned from each training conducted. Finalize the manual after the fifth training. Thus tested and improved manual could then be prescribed for inclusion in the regular training program of the National Health Training Center and other interested institutions. This process would result, among others:
 - contribute in building awareness among mass in general and among the grassroots level health workers, in particular,
 - National Health Training Center will be well equipped with training materials and suitable methodology for conducting training on a regular basis to cover more number of grassroots level health workers each year.
 - A basis for developing Training Program for middle and higher level health workers on Gerontology and Geriatrics Care will be established with the feed back from both the trainees and trainers involved. Thus, training and training materials more specific to issues of elderly living in different parts of the country could be designed in the future.
 - Training capability of National Health Training Center (NHTC) will be strengthened and improved. Based on the feedback of the training, NHTC will be better equipped to guide curricula development process for inclusion of Geriatrics and Gerontology subjects in the formal health education systems of the country.
- Conduct baseline survey on socio-economic and health status of elderly in the selected 15 districts of Nepal. Three districts from each of the five development regions, representing high mountains, mid-hills and terai, should be selected. Information generated from such survey could: a) enable policy makers and planners

to develop criteria for defining vulnerable elders in quantifiable terms such as living arrangements, remoteness, isolation, poverty, disability/illness, lack of knowledge; and, b) provide a strong basis to design policies and programmes that cater for the specific needs of elders living in different socio-economic, climate and cultural settings of Nepal.

- Conduct nutrition survey that would give the cross-sectional picture of the dietary behavior and nutritional status of the elderly. Such a study could provide a base for the development of qualitative dietary and nutritional guidelines for older adults.
- Provide support for mass awareness building activities that include developing literature on issues and concerns of elderly population. Activities such as poetry competition, essay competition and so on at different levels i.e., school, community, VDC, district, and National levels. Other activities could include translation of relevant documents of UN, WHO and other agencies in Nepali language, developing audio-visuals and print materials for awareness building on issues and concerns of ageing society.
- Provide government support to private entrepreneurs engaged in providing goods and delivering services to meet needs of ageing population. The support could be in the form of: a) scholarship for higher education, and short and long term training; b) tax-deduction or subsidies, and c) grants in cash or kind.
- Conduct feasibility study for pilot scale implementation of Active Ageing Program that would allow the retired individuals to work as teachers, and similar other jobs involving less physical work, preferably in their own community, provided they are willing and able to assume such responsibilities. The number of healthy and educated people in urban and rural area is increasing with the increased life expectancy and literacy rate. Though retired, their knowledge and skill could still be useful in delivering government services in the local community through their involvement in physically less challenging government jobs such as School Teaching, serving as VDC Secretary, and so on. In absence of such openings, a healthy, educated and retired individual is either forced to seek job in the private sector or live an unproductive idle life. If found feasible and if successful in pilot scale implementation, such Active Ageing Program could bring about many desirable changes in the society as a whole.

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